सार्वजनिक आरोग्य विभाग
महाराष्ट्र शासन

NHM
राष्ट्रीय आरोग्य अभियान
महाराष्ट्र

HOSPITAL ADMINISTRATION MANUAL

(PART-II)







This publication can be obtained from:

Arogya Bhawan,St George Hospital, P D'Mello Rd,
Chhatrapati Shivaji Terminus Area, Fort, Mumbai, Maharashtra 400001
Government of Maharashtra

मिलिंद म्हैसकर, भा.प्र.से.
अपर मुख्य सचिव (१)
Milind Mhaiskar, I.A.S.
Additional Chief Secretary (1)

महाराष्ट्र शासन
सार्वजनिक आरोग्य विभाग
१०वा मजला, गोकुळदास तेजपाल रुग्णालय संकुल इमारत,
ए विंग, जी. टी. मार्ग, जसिक मंत्रालय, मुंबई- ४०० ००१.
☎ ०२२-२२६१७३८८/२२६३२१६६
psec.pubhealth@maharashtra.gov.in
GOVERNMENT OF MAHARASHTRA
Public Health Department
10th Floor, G.T. Hospital Complex Building,
A wing, L.T. Marg, New Mantralaya, Mumbai- 400 001.
☎ 022-22617388/22632166
psec.pubhealth@maharashtra.gov.in

Foreword



In the ever-evolving field of healthcare, effective management plays a pivotal role in ensuring the delivery of high-quality patient care, optimizing hospital operations, and maintaining a safe and efficient environment for both staff and patients.. Previously, Hospital Administration Manual volumes I & II were published by the Government of Maharashtra in 1976. There was a need for updation of these manuals to include new programmes, services and protocols.

This updated Hospital Administration Manuals (Vol I and Vol II) are designed to provide clear, comprehensive, and practical directions for achieving these goals and upholding the highest standards of care within our institution. They are intended to be a resource for all hospital staff, from leadership to frontline employees, ensuring that we maintain consistency, foster accountability, and promote a culture of excellence. They encompass a wide range of critical areas, including patient safety, quality control, staff management, regulatory compliance, and financial stewardship.

I encourage all hospital personnel to familiarize themselves with these updated guidelines and use them to enhance their individual roles and contribute to the broader mission of the hospital. By working together, we can ensure that our institution remains a trusted and leading provider of healthcare services in our community.

I extend my heartfelt appreciation to Director of Health Services, Pune, & Executive Director, State Health Resource Centre (SHSRC), State Institute of Health & Family Welfare (SIHFW), Nagpur and the entire team for compiling this manual.

Let us move forward with a shared vision of excellence, compassion, and responsibility as we continue our important work in the service of others.

Milind Mhaiskar
Additional Chief Secretary,
Public Health Department,
Government of Maharashtra

Amgothu Sri Ranga Naik, I.A.S.
Commissioner, Health Services &
Director, National Health Mission
Maharashtra

GOVERNMENT OF MAHARASHTRA
Commissioner (HS) & Mission Director (NHM)
Maharashtra
Web : www.arogya.maharashtra.gov.in
www.nrhm.maharashtra.gov.in

Preface

As per National Health Policy 2017, for attaining the highest level of health and wellbeing for all, the concerted efforts were made by Public health Department, Maharashtra. The last decade has shown tremendous advancements in the medical and technology field. The focus of healthcare service delivery is shifted towards reducing the out of pocket expenditure of patients leading to provide the equitable access to them for timely and comprehensive health services.

Previously, Hospital Administration Manual volumes I & II were published by the Government of Maharashtra in 1976. Since then, there is seachange in Medical procedures, guidelines and equipements, coonsidering X-rays were backbone of radiology in good old days transformed to CT Scan and MRI in todays world. Health system now runs as per golden standards, known as IPHS 2022. Every chapter has been revised keeping these standards at the center of it.

With respect to that, there is a dire need for timely updations of these volumes for smooth administration at government hospitals. It was considered necessary to revise the manual and updates; in the context of recent advances and developments in the field of hospital administration.

The manual revision activity has been initiated at State Health System Resource Center, Maharashtra, by formulating a committee for it. The State Health System Resource Centre (SHSRC) team along with more than 100 expert members across Maharashtra, have worked collaboratively for hospital administrative manual revision.

I am sure that the manual will be very useful and friendly to all staff working in the Public Health Department of Maharashtra. The hospital Manual has been meticulously crafted to equip Medical Officers with the latest guidelines, strategies, and protocols aligned with national programs and hospital administration, in order to deliver excellence in healthcare at Rural Hospitals onwards. The book does not claim to be comprehensive on the subject. However, its importance is nondeniable and self-evident.

I would like to thank all subject experts who contributed for their efforts towards the revision of this manual. I also thank all the Officials from Public Health Department and SHSRC for their valuable input.

(Amgothu Sri Ranga Naik, IAS)

COMMISSIONERATE OF HEALTH SERVICES
(Government of MAHARASHTRA)
AROGYA BHAVAN " St George Hospital Compound)
P'Dmello Road, Mumbai— 400001

Office Phone No	022 - 22620292	Website:http://arogya.maharashtra.gov.in Email: director.dhs-mh@gov.in
	022 - 22621006	
	No. / / / 2025 Dated: / /2025	

Acknowledgement

I am delighted to acknowledge the release of the revised edition of Hospital administration Manual for Medical Officers in Maharashtra. This comprehensive resource incorporates the latest advancements in healthcare delivery in the State.

Last edition of hospital administration manual was released 47 years ago. There is a seachange in clinical filed as well as administration since then. With the new advancement in health sector, it was imperative to work on revision of hospital administration manual.
The independent committee was formulated and approximately, more than 100 committee members/Subject experts have worked collaboratively to update the manual. This manual will become a paradigm between the hospital administration and public relations while working in the health system. The manual will help all the officers to update themselves about the guidelines and take decisions accordingly in routine manner. I am sure that the manual will be very useful and friendly to all staff working in Public health department, Maharashtra. This manual addresses the duties of the team individuals, principles of hospital management, medicolegal issues while dealing with the patients and other

I thank to Hon. Additional Chief Secretary and Hon. Commissioner and MD (NHM) for guiding throughout the process of preparation of manual. I extend my gratitude to the whole team of State Health System Resource Center. The team completely engulfed in changes to be enlisted in the revised manual. I thank to all Bureau Chiefs and all the Committee Members for their compounded efforts in revising this manual.

This resource will undoubtedly support Medical Officers in delivering exceptional services. This guide book will help the officers to address these challenges and will help to take appropriate decisions in prompt manner.

(Dr. Nitin Ambadekar)
Director Health Services, Mumbai &
Executive Director, SHSRC Pune

Acronym

CT	Computer Tomography
PRO	Public Relation Officer
A.N.C	Antenatal Care
A.R.V	Anti-Rabies Vaccine
AAY	Antyoday Anna Yojana
ABG	Arterial Blood Gas
AB-PMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
ACS	Additional Civil Surgeon
ADHS	Assistant Director Health Services
AERB	Atomic Energy Regulatory Board
AIM	Atal Innovation Mission
ACLS	Advanced Cardiac Life Support
AMC	Annual Maintenance Grant
ANM	Auxiliary Nurse Midwifery
AO	Administrative Officer
APL	Above Poverty Line
ASV	Anti Snake Venom
BLS	Basic Life Support
BMW	Biomedical Waste Management
BNHRA	Bombay Nursing Home Registration Act 1949
BPL	Below Poverty Line
BSL	Blood Sugar level
BVM	Bag Valve Mask
C.A.O	Chief Administrative Officer
CABG	Coronary Artery Bypass Grafting
CAD	Coronary Artery Disease
CAT	Computerised Axial Tomography
CBC	Complete Blood Count
CCC	Comprehensive Cardiac Care
CME	Continuing Medical Education
CMO	Casualty Medical Education
CPCB	Central Pollution Control Board
CPR	Cardiopulmonary Resuscitation
CS	Civil Surgeon
CSR	Corporate Social Responsibility
CSSD	Central Sterile Services Department
CWTDF	Common Waste Treatment Disposal Facility
CVTS	Cardiovascular Thoracic Surgery
D.O.	Demi Official

Acronym

DAMA	Discharge against Medical Advice
DARPG	Department of Administrative Reforms and Public Grievances
DDHS	Deputy Director of Health Services
DEIC	District Early Intervention Center
DGIPR	Directorate General of Information and Public Relations
DGO	Diploma in Gynecology and Obstetrics
DHO	District Health Officer
DPHN	Public health Nurse
DQAC	District Quality Assurance Coordinator
DSUs	District Surveillance Unit
DTT	District Training Team
E.N.T.	Ear, Nose and Throat
ECG	Electrocardiography
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EOC	Emergency Operation Centers
ERC	European Resuscitation Council
ERCP	Endoscopic Retrograde Cholangiopancreatography
ERO	Emergency Response Officer
ERS	Emergency Restoration System
FBNC	Facility based Newborn care
FDA	Food and Drug Administration
FDS	Fire Dynamics Stimulator
FEFO	First Expired First Out
FIFO	First In, First Out
FIR	First Information Report
G.P.F.	General Provident Fund
GeM	Government e-Marketplace
GFR	Glomerular Filtration Rate
GP	General Practitioner
GR	Government Resolution
H.D	Hemodialysis
HACC	Health Advice Call Center
HER	Electronic Health Records
HFWTC	Health and Family Welfare Training Center
HLD	Hyperlipidemia
HMIS	Health Management Information System
HOD	Head of the Department
HR	Human Resource

Acronym

HSG	Hysterosalpingography
HTT	Hospital Training Team
ICD-10	International Classification of Disease - 10
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
ICU	Intensive Care Unit
IDSP	Integrated Disease Surveillance Project
IEC	Information Education Communication
IPD	Indoor Patient Department
IPHS	Indian Public Health Standards
IUCD	Intra Uterine Contraceptive Device
IYCF	Infant Young Child Feeding
J.A.O	Junior Administrative Officer
JSSK	Janani Shishu Suraksha Karyakram
KMC	Kangaroo Mother Care
KYC	Know Your Client
LAMA	Left Against Medical Advice
LAQ	Loksabha Question
LHV	Lady Health Visitor
LMP	Last Menstrual Period
LSCS	Lower Segment Caesarian Section
MAA	Mother Absolute Affection
MC	Municipal Corporation
MCI	Medical Council of India
MCSR	Maharashtra Civil Services Rule
MEMS	Maharashtra Emergency Medical Services
MIS	Management Information System
MJPJAY	Mahatma Phule Jan Arogya Yojana
MLC	Medicolegal case
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MO-IC	Medical Officer In charge
MPCB	Maharashtra Pollution Control Board
MRI	Medical Resonance Imaging
MS	Medical Superintendent
MSW	Medical Social Worker
MTP	Medical Termination of Pregnancy
NBC	National Building Code of India
NDMA	National Disaster Management Authority

Acronym

NGO	Non-Government Organization
NHSRC	National Health System Resource Center
NICU	Neonatal Intensive Care Unit
NOC	No Objection Certificate
NPA	Non-Practicing Allowance
NRC	Nutrition Rehabilitation Center
NSV	Non-Scalpel Vasectomy
O.P.D.	Out Patient Department
OBGY	Obstetrician Gynecologist
MPCB	Maharashtra Pollution Control Board
MS	Medical Superintendent
OPD	Out Patient Department
OPE	Out of Pocket Expenditure
OS	Office Superintendent
OT	Operation Theatre
P.A.	Personal Assistant
P.H.	Public Health
P.N.C.	Post Natal Care
PC	Project Coordinator
PCNL	Posterior Nephrolithotomy
PCPNDT	Pre-clinical Prenatal Diagnostic Technique
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PFMS	Public Financial Management System
PHD	Public Health Department
PHN	Public Health Nurse
PID	Pelvic Inflammatory Disease
PIP	Programme Implementation Plan
PMJAY	Pradhan Mantri Jan Arogya Yojana
PMMVY	Pradhan Mantri Matru Vandana Yojana
POCSO	Protection of Children from Sexual Offence
PPIUCD	Post-Partum Intra Uterine Contraceptive Device
PRC	Platelet Rich Concentrate
PRO	Patient- Reported Outcomes
PSM	Preventive and Social Medicine
PSU	Public Sector Undertaking
PWD	Persons with Disabilities
RDA	Recommended Daily Allowance
RGJAY	Rajiv Gandhi Jan Arogya Yojana

Acronym

RMO	Resident Medical Officer
RTI	Right to Information Act
RTPCR	Reverse Transcriptase Polymerase Chain Reaction
S.A.O.	Senior Administrative Officer
SAANS	Social Awareness And Action To Neutralize Pneumonia
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SC	Supreme Court OF India
SDH	Sub District Hospital
SHG	Self Help Group
SIHFW	State Institute of Health and Family Welfare
SNCU	Special Newborn Care Unit
SOP	Standard Operating procedure
SQAC	State Quality Assurance Committee
SSI	Surgical Site Infection
STEMI	ST-Segment Elevation Myocardial Infarction
SUMAN	Surakshit Matritva Aashwasan
TAT	Turn around Time
TB	Tuberculosis
TBC	Tissue Bonding Cystostomy
TCU	Transitional Care Unit
TLD	Thermo luminescent Dosimeter Badge
TOR	Terms of reference
TPA	Tissue plasminogen Activator
UD	Urethral Diverticulum
UNICEF	United Nations International Children Emergency Fund
USG	Ultrasound Sonography Test
UTI	Urinary Tract infection
UTs	Union Territory
VAP	Ventilator-Associated Pneumonia
VC	Video Conference
WHO	World Health Organization
ZP	Zilla Parishad

Content

CHAPTER I - HOSPITAL PHARMACY AND DISPENSING 13

CHAPTER II- KITCHEN AND DIET 34

CHAPTER III - STOCKS AND STORES 47

CHAPTER IV - LINEN 55

CHAPTER V - MEDICAL RECORDS AND HOSPITAL STATISTICS 69

CHAPTER VI - AMBULANCE SERVICES (Include EMS) 77

CHAPTER VII - PRADHAN MANTRI JAN AROGYA YOJANA AND INTEGRATED MAHATMA JYOTIRAO PHULE JAN AROGYA YOJANA 85

Chapter VIII - HEALTH CARE MANAGEMENT IN DISASTER 93

CHAPTER IX - HOSPITALS AND FAMILY WELFARE 107

CHAPTER X - OFFICE ADMINISTRATION 126

CHAPTER XI - INTRA AND INTER-DEPARTMENTAL CO-ORDINATION 137

CHAPTER XII - INSPECTIONS 165

CHAPTER XIII - DUTIES OF STAFF MEMBERS 173

CHAPTER XIV- PUBLIC RELATIONS AND PATIENT SATISFACTION 212

CHAPTER XV - HEALTH EDUCATION 226

CHAPTER XVI –VARIOUS POLICIES IN HOSPITALS 231

CHAPTER XVII - MEDICAL LAWS, RULES & ETHICS 270

CHAPTER XVIII: NEW INITIATIVES IN HOSPITAL 274

Executive Summary

Rampant globalisation and its impact on health tend to lead to medical and public health advances. However, medical professionals encounter many issues due to mismanagement of resources, improper communication, lack of coordination, and improper client orientation. The various facets of medical and health services include components like diet, coordination, stock and supplies, etc.

A growing population and an increased need for trained and experienced staff to deliver services at various hospital levels are inescapable.

The hospital administration manual prepared in 1976 was a self-evident and comprehensive document. It helped the administrators manage the hospitals and guided medical personnel in delivering curative services. It is urgent and crucial to appropriately guide these staff from rural hospitals to District Hospitals to deliver services efficiently and in an updated manner. With the changing pattern of healthcare administration in government institutions, various components like PMJAY & MJPJAY, healthcare management in disasters, various newer initiatives in hospitals, etc., need to be incorporated into health services.

Establishing norms or standards for hospital administration will streamline hospital services. If rules and practices change with each facility, it will create ambiguity among administrators, and such rules or regulations will be interpreted and implemented in a variable manner state-wide.
Part B of the hospital administration manual suggests improving other aspects of administration besides clinical services, such as linen management, provision of diet, ambulance services, etc., to provide the administrative and legal paradigm for administrative actions.

The given context suggests considering various guidelines and policies prepared by the Ministry of Health and Family Welfare, Government of India, apart from various Government Resolutions and circulars from the Public Health Department, Government of Maharashtra, as referred to in this revised manual. These updated guidelines will be supportive for new entrants and trainees in the Public Health Department, Government of Maharashtra.

This manual does not describe the layouts of various hospital departments or the non-available job charts required for hospital services.

In comparison to the old hospital administration manual, the newly revised manual has various additional components such as PMJAY & MJPJAY, healthcare management in disasters, various newer initiatives in hospitals, etc., as mentioned above. These new chapters in Part B add to the value of the book and will be useful for raising awareness among the young officers. The services related to public health, such as health education, counselling, public relations, etc., are also described in this book to improve doctor-patient communication and promote team spirit in hospitals, which has positive repercussions on the administrators' leadership.

Similarly, the new manual needs to be comprehended as an important handbook for all hospital service providers and support staff.

CHAPTER I

HOSPITAL PHARMACY AND DISPENSING

Service regarding drugs and medicines constitute an important part of hospital services. Failure to render service of the required quality will lead to complications in the treatment of patients and will also attract the provision of drug control administration.

The object of an efficient drug service is to ensure that the quality of drugs purchased is good (Qualitatively, quantitatively, and timely), that the drugs are stored under the required conditions, and that they are dispatched according to the prescriptions written by doctors.

1.1 Infrastructure

Area- The total area required for the various types of stores in a hospital is estimated at about 20 to 25 sq. feet per bed. Construction of medical stores in hospitals should be therefore planned on this basis.

The space of the store is needed to accommodate the following components.

1) Medicine, IV Fluids, Syrups and lotions, Disinfectants, Surgical and Disposables, Instruments and Equipment, and Suture Materials, among others.
2) Linen
3) Oxygen and Nitrous Gas, Spirit
4) Vaccine and cold storage Equipment
5) Receipt and issuing Section.
6) Store office and Record Section. And Lavatories.
7) Near Expiry and Expired Medicine storage section

Area of store will be according to FDA norms.

Apart from this the indenting department should have the facility of small dedicated medicine store room with A.C. facility, e.g. Walk-in cooler.

Location of Medical Stores:

A. Location:

1. The medical stores should as far as possible be located in the on the ground floor of the hospital building and it should be away from areas where heat is generated, for example sterilization section or laundry.
2. The medical stores should be situated at a conveniently central place where the movements from various sections of the hospital would be easy.
3. All measures should be taken to keep the medical stores dust-free and the location should be chosen from this point of view.
4. Easily accessible Main Entrance & Emergency Exit Door.
5. Easily truck loading unloading Platform.

B. Requirements:

It should have sufficient number of shelves to stock the medicines. Steel racks /compact

storage system are preferable. The height should be such that the stores can be handled easily. The lower most rack on the shelf should be at some distance from the floor say at least 30 cms so as to allow proper dusting and washing as and 60 to 90 cm away from the wall to prevent moisture and termite per IPHS Guidelines 2021

1) Plantation of shaded trees along the borders to reduce internal temperature of store
2) Room height must be 11 feet to 17 feet.
3) Should have power backup
4) Should have linkage with common bio medical waste facility
5) Store should have complaint and suggestion box with details of officers responsible for redressal
6) Should have signages like parking, no-parking, no- smoking, CC TV
7) Store should be environment friendly practicing eco design
8) Store should adopt **"3 R"** concept REDUCE, REUSE, RECYCLE
   (As per NHSRC 2021 Guidelines)

The medical stores should be arranged in various sections in such a way that it is easy to check the various items. The arrangement should help to make quick supplies to the dispensing room to the sub-stores and to the different units of the hospital.
Material handling equipment must be available in store. Medical store must pest controlled periodically & rodents should be available. Store should be covered under CCTV.

1) Medical Store should have and displayed Drug License (issued by Food & Drug Authority.)
2) Registration Certificate of Pharmacy Officer should be displayed.
3) Fire Alarm system & Fire Extinguisher should be available & Staff should be trained about its use.
4) Sufficient Fan, Exhaust Fan, Refrigerator & Deep Freezer should be available.
5) Store should have single entrance & Emergency Exit. Entry prohibited for general public.
6) Separate room along with computer, internet facility, scanner, printer.

Human Resource :

Provide adequate number of Pharmacy Officer &Gr. D/ servants for medical store.

Reading of case paper , Entry of medicine in Reg. Dispensing and counselling takes at least 3-4 minutes

(Dispensing Section Load of OPD patients 90 to 120 / Pharmacist)

[Maharashtra Civil Medical Code Volume I & II, June 1976, Page no 52 (9.15)]

The arrangement should be such that drugs can be issued on the basis of 'First expiry First out'.

The medical stores usually stock allied material like oxygen cylinders, splints, etc. To facilitate movement of drugs and other materials every medical store should have trollies or wheel barrows.

1.2 Components of a Medical Stores Section (DH):

A full-fledged medical store section will have the following sections: -

The components of a medical store are as follows:

a) District warehouse: located at District Hospital Headquarter.
b) Central Medical store at every Hospital.
c) Peripheral stores at sub district and rural hospitals.
d) Hospital OPD Pharmacy & dispensaries.

Sections: The medical stores should be arranged in proper sections so that it is easy to check the items as well as make supplies to the dispensing room or to the sub-stores as often as required.

1. Allopathic – Therapeutic Grouping like Antihypertensive, Antibacterial, Antidiarrheal etc. & viz. a) Tablet Capsules b) Injections c) IV fluids d) Liquids e) Others
2. AYUSH – Ayurvedic, Unani & Homeopathy etc.
3. Surgical, Dressing Material & Disposables.

In those hospitals where there is no hospital Pharmacy there will be only the medical stores and dispensing. Ward Sub Stores.

Two points require attention regarding the sub-stores:

1) The presence of sub-stores should not lead to excess stock being held as a whole in the hospital. This might happen if the stock in the sub-stores is not taken into account while placing fresh orders. The stock in sub-store should be taken into account while ordering a fresh stock.

2) The account keeping in sub-stores should be simple, so that there is no duplication of all accounts in the main stores and the sub-stores.

Every hospital should have one or two sub-stores in addition to the central stores. Apart from this being convenient for meeting the indents from different units of the hospital DH/SDH/RH, the arrangements is also useful to prevent easy access to the Central Stores. The Central Stores in larger hospitals stock drugs and materials costing several lakhs of rupees. The easier the access the more chances are there of pilferage. In smaller hospitals the sub-store may be located in the dispensary and Each ward itself. The sub-store should keep sufficient supplies by indenting from the central stores every week or fortnight.

Supervision:

The hospital medical stores, hospital Pharmacy and dispensing need personal attention and supervision of the Civil Surgeon/ Superintendent to maintain the best standard of service. The Medical Officers should keep a good liaison with Officers of the Drugs Control Administration. This will contribute greatly towards maintaining the level of work in this area in a good state. The Medical Officers should invite frequent inspections of medical stores, dispensing etc., by the

Officers/Inspectors of the (DHS Circular No. MDS/1071/H of 71, dated 17th July 1971, addressed to all Deputy Directors of Health Services).

In order to manage the section properly, duly qualified persons should be given responsibility. In other hospitals with 200 beds and above, the graduate Senior Pharmacy Officer should be in charge of a store. Hospital central medical store is under supervision of Civil Surgeon and Medical Superintendent. Additional Civil Surgeon is In charge of the medical store. In smaller hospitals (30 bed, 50 bed) Medical Ssuperintendent/Medical OfficerIn charge of Pharmacy is assisted by Pharmacy Officer.

1.3 Details of Equipments

Various equipments are required in hospital, based on the bed capacity and speciality services. For the equipment norms as per bed capacity, *refer Annexure 1.1*

1.4 Storage of Drugs-

- **Ordinary Drugs. -** In addition to the steel racks and shelves referred to above, the area in which general drugs are stored should have hard plastic platform.

- Narcotic drugs and psychotropic substances should be stored in separate cupboards with double lock and their keys should be kept with in charge of medical store and pharmacy officer. The Officer concerned should check the accounts of drugs in these cupboards at least once a month. The physical verification should be entered in a register and signed by the concerned under a dated signature.
- **Drugs Requiring Cold Storage. -**Certain categories of drugs are required to be kept at low temperature to retain their potency. Some require storage at a temperature of 2-10°C, while others require storage between 15-20°C. To the first category belong drugs such as sera, vaccines, glandular preparations and other products affected by heat. Every hospital should draw up a list of such drugs which are in use. The list including the brand name should be exhibited prominently in the medical store. The authority should also take help of the instructions which are given by the manufacturers on the packing of such drugs.

For cold storage, there will have to be a sufficient number of refrigerator or a separate cold storage room. The temperature should be actually checked by a thermometer twice a day and a register should be maintained to make entries regarding this verification. It is obvious that the refrigerator must be maintained in a good condition. Drugs requiring cold storage should not be kept in the freezing apartment of the refrigerator. Antibiotics, and certain other preparations, require only a cool temperature of between 15 to 20°C. The Medical store should prepare a list of such drugs, also. Ideally, these drugs require air-conditioned store. They do not require cold storage but only cool storage.

- **Storage of Drugs with near Expiry Date**. -It is desirable that near expiry dated drugs are preserved in a particular separate area of the medical store. Thereby it is easier to check

their stock. Those with a near expiry date should be kept in the front and those with a long expiry datecan be stored at the back

- **Other Drugs. -**Some drugs require protection from light and moisture.They should be preserved accordingly.

Inflammable articles like spirit, ether etc. should be kept away from other stores. They should not be kept in wooden boxes or wooden cupboards. As far as possible they should be stored in a separate room. If such a room is not available, they should be kept in a corner. The question of such articles causing fire, and availability of firefighting equipment to meet such contingencies should be always kept in mind.

The various racks on which medicines are kept should be given identification numbers for easy access. The numbers should be given in alphabetical order in addition to serial numbers. It is advantageous to store the drugs according to therapeutic classification groups.

1.5 Role of e-Aushadhi:

Since the inception of e-Aushadhi it is easy to find expiry date of the medicines and track them easily. In e-Aushadhi first of all we take the entry of medicine. In this step the detailed information (name, batch no, manufacturing date, expiry date, invoice no. invoice date, purchase order no., purchase order date, page no. of Central stock book etc.)about medicine is filled properly. Then quarantine status of the medicine is shown in the system. If the medicine is out of quarantine and ready to use then we distribute it to wards and other RH, SDH, WH etc. hospitals and their distribution details are taken on E-Aushadhi. So, we can get the detailed record and journey of medicine.

Also, the stock in hand, active and inactive status of medicine, expiry details, quarantine status, pipeline stock, adverse drug reaction report etc.

e-Aushadhi entries should be checked daily by the Medical Officer In charge of the medical store.

Stock of drugs nearing the expiry date should be physically checked by the in charge of the medical store as regards colour, and any other changes in appearance. It is possible that some of the drugs may have already been useless. Such drugs should not be administered to patients. The Officer in charge of the medical store should contact the manufacturer of those drugs which become useless before the expiry date. Remarks should be made in the expiry date register about disposal of such drugs and about the correspondence if any.

In certain cases, it may be possible to return drugs nearing expiry dates to the manufacturer in cases it is anticipated that they cannot be used in the hospital. Preventive steps must be taken to see that the stock of expiry dated drugs does not accumulate. This can be done by resorting to realistic indenting of drugs.

It may happen that the expiry dated drugs cannot be destroyed immediately on account of certain administrative problems like correspondence with the manufacturer etc. In such cases these drugs should be kept in an altogether separate area of the medical store exhibiting the board date expired drugs- *not to be used.*

The Officer In charge of the medical store should visit the ward and other units of the hospital to check whether the drugs are being properly stored there.

1.6 Records and Registers:

Adverse event Register

The Pharmacy Officer In charge of the store should take all necessary steps regarding adverse event communicated to him such as isolating the batch of medicine, stop use of the medicine in question, preserving samples for examination by FDA etc. and record action taken in this register.

Steps taken after complaint received.

1. Complaint should be received from Hospital Staff in prescribed format.
2. Hospital administration should give information and documents to FDA.
3. Use of drug should be immediately stopped and returned back to medical store. After collection of all the stock, it will be stored separately with proper labelling.
4. Other institutes should be communicated through email regarding stoppage of the drug having same batch number.
5. After receiving reports whether drug is of standard quality or not, accordingly action should be taken.
6. Non-standard drugs should not be used and should be discarded according to FDA and biomedical waste Management 2016 rules.
7. Proper action should be taken against the supplier according to Government guidelines.

The adverse event register may show the following columns:-(1) S. R. No., (2) Date of Complaint, (3) Ward No. from which complaint received, (4) Name of the Drug, (5) Manufacturer's name (6) Batch Number (7) Nature of the complaint, (8) Action taken by the Hospitals/Drugs Control Authorities, (9) Final remarks, (10) Whether drugs from the batch was issued to other patients and whether any untoward reaction has been reported. All M. O's should, toxic reactions of drugs especially new drugs report.

Entries may also be made in the complaint register about those drugs which have deteriorated before the expiry date.

Expense Register- The Expense Book of Drugs should be maintained in the form of Register C. M. 71(e).

1.7 Indents from Wards/ Units of the Hospital

1.7 Indents from Wards/ Units of the Hospital

Drugs are usually supplied to different units from the sub-store or the central store. The indents are usually prepared by the sister in charge of the units and countersigned by a responsible medical officer. The Additional Civil Surgeon (ACS) countersigns such indents. He should take particular care to check the quantity, especially in respect of costly drugs. The ACS should also occasionally verify the correctness of indents by actually calling for case papers.

Indents are sent by the ward to medical stores for supplies of drugs periodically usually every week. The indents are required to be written by hand thus making it necessary for nurses to spend considerable time. It is therefore advisable to have printed indent forms. The items printed should be those commonly required, divided as A and B' categories and some blank space should be left below for entry of items not in the list which may be required. Items of 'C' category may be indented for 3 months stock. This will reduce supplementary indents. The indent forms should be filled by sister in triplicate and sent on a prescribed day (every week or every fortnight) to the Medical Officer for countersignature. After the sanction, the original and duplicate should be sent to the sub-store/store and triplicate retained in the ward. The store will keep the original and return the duplicate along with supplies. The store will also make the necessary entries regarding actual supplies on the original and duplicate. The duplicate indent when received back in the ward should be pinned to the triplicate ward copy. The sister or a responsible nurse should take delivery of supplies after recording the receipt on the original indent. If there is any discrepancy in the supply the store should be informed within 24 hours. If there is no such intimation the store is to presume that the supplies have been made properly. As the drugs required in different hospitals will be different, the printing of indent forms should be left to the individual Medical Officers.

No entry in the indent should be overwritten and modifications or corrections should be made after cancelling the original entry. They should be duly attested by the Officer who approves the indent. A sample check must be carried out monthly or more often of 5 per cent of triplicate ward copies and original copies kept in the store by a responsible Medical Officer to ensure that the procedure is working satisfactorily.

Another desirable step which may be taken is that the store should issue a delivery challan for the stores supplied. This can be compared with the original and duplicate from time to time.

Indent for very costly drugs should be prepared patient-wise only, giving all the particulars.

The stores should supply drugs to the units as far as possible in the original packing of the manufacturer. If this is not possible, they should be supplied in containers which will preserve the drugs well. The name of the drug, the strength and the quantity should be labelled properly on the container.

A reasonable quota should be fixed for different medicines required in various sections on a weekly basis. This is necessary to prevent empirical demands being made and to lessen or even eliminate occasions for supplementary indents. It must be remembered that supplementary indents mean considerable extra labour to both nursing staff inwards and the staff of medical stores/sub-stores. The weekly quota may be changed at certain intervals of time, say every 6 months or one year if necessary. The change in weekly quota may be due to changed requirements and changing prescription practices due to arrival of new drugs and departure of old ones.

The medical officer countersigning the indents should be readily available for the same. In the absence of such simple arrangements, the whole process of weekly indents will be thrown out of gear.

Some drugs are required for pediatric use in smaller doses. Sufficient stock of pediatric formulations should be available in medical stores, otherwise there is a tendency to supply capsules or tablets etc. in adult doses instead, which will cause wastage of drugs.

Indents of Drugs for Purchase from Suppliers

E Aushadhi online drugs inventory programme is existing for all hospitals. In month of April all drugs and consumables yearly demand to be generated in E-Aushadhi, every year. District level committee will scrutinize all online demands with the help of medical specialist and pharmacy officer. Purchasing should be done as per existing procurement policy.

All such indents should be prepared carefully by pharmacist and approved by concerned Medical Officer. It is therefore a good idea for the Medical Officer In charge of the hospital to arrange a meeting of the heads of units in the hospitals to discuss with them which drugs should be indented and which should be dropped. It is advisable to appoint a committee of Senior medical officers chaired by ACS/MS to control and supervise the indents.

After receipt of supplies a check should be carried out by the Officer In charge of the medical store to verify if drugs and the quantity received are correct, and the quality up to the mark. (as is possible by visual inspection, date of expiry etc.) If there is any suspicion about the quality of drugs the matter should be reported to the Drugs Control Administration and the drugs should be used only when clearance is obtained from that authority.

Account of Drugs and Watch overExpenditure

A careful check is necessary over expenditure on medicines especially of costly drugs. The budget grant allotted for the purpose has to be kept in mind constantly. An up-to-date account of total expenditure, and the cost of drugs already ordered but yet to be received should be taken into account. The liability registers as prescribed by Government if well maintained will give adequate information regarding the expenditure. This will enable the Medical Officer to ask for supplementary grants in time as well as to control expenditure over certain items.

The account of drugs is to be written in prescribed expense books of drugs. Separate books are usually maintained when the hospital is large and numerous drugs are in use for various categories such as for injections, tablets, capsules, powder, liquid medicines etc. The expense books should make an entry about the shelf number on which the drug is stocked. This will help easy access to the drugs. The expense book should also enter the authority for receipt of drugs and for issue of drugs.

1.8 Stock Management in Hospital

Maximum and Minimum Level:

There are numerous occasions when it is suddenly discovered that a particular drug is out of stock. Similarly, a critical review is taken certain drugs are found much in excess of requirements with no possibility of the stock being used. The former leads to distress local purchase which means some loss of Government money, besides endangering treatment of patients. The latter means a clear loss to Government. A mechanism should therefore be available to avoid such contingencies. From this point of view, each page of the expenditure book should have the following columns printed at the top

Minimum level.
Maximum level.
Month of expiry.

The minimum level should indicate the safe level upto which the stock of a particular drug may go down. If it drops below this, steps should be immediately taken to indent a fresh stock. The minimum level should be fixed with reference to "Lead time" i. e. the time between ordering a drug and its actual receipt.

The maximum level would indicate the maximum safety level. Any stock above this would indicate lack of planning in purchase and possibility of loss to Government. The stock at any given time must be below the maximum level. These levels can be fixed on the basis of average consumption per month.

Disposal of Empties

Empty khokas, bottles, and tins should be disposed off by auction periodically. A register of empties must be maintained. Cartons, ampoules and containers which are likely to be misused by spurious manufacturers should be destroyed.

Drugs in Stock

All medical officers working in a hospital should be in the know of drugs and other items that are available in the medical stores. In absence of such a knowledge Medical Officers are likely to give different prescriptions according to their inclination and also prescribe drugs from outside when they are in stock. The Medical Officer In charge of the hospital should circulate a list of medicines etc. available in the medical store at fixed intervals. In addition, whenever a new stock of drug is

received information should be given to Medical Officers by a circular. Such lists should be available in the wards, and other units like O.P.D., Operation Theatre etc.

Medical Officers should be directed not to give prescription from outside, without ascertaining hospital stock position.

Dangerous and Narcotic Drugs

Narcotic drugs and Psychotropic substance act 1985: Under this category drug storage care should be taken to prevent their misuse. All drugs of this category should be dispensed on the prescription of Psychiatrist by the registered pharmacist. All accounts of drug should be kept as per instructions laid down in above act.

Ward Accounts

The ward should maintain drugs expense register in format for costly and scheduled drugs including psychotropic substance and Narcotic Drugs. Also, ward should maintain expense of costly consumables. Ward In charge, Medical Officer/Additional Civil Surgeon/Medical Superintendent should verify 10 Percent of issue of costly drugs and consumables with reference to the prescription on the case papers. Above officer should ensure stock position as per expense book in their ward visit.

Emergency Drugs:

List of emergency Drugs means vital Drugs list is uploaded in e-Aushadhi drugs inventory programme. All Hospitals Central Drugs store and sub-stores shall keep all vital drugs in their department, i.e.Anti-Snake Venom Serum (ASVS). Anti-rabies vaccine, Anti rabies serum, anti-Scorpion venom serum. Human rabies immunoglobulin shall be kept in sufficient quantity for rabies treatment.

Pilferage of Drugs

Pilferage of drugs from hospitals is a complicated problem having numerous ramifications. The Hospital administrator has to try every possible method to check the incidence of pilferage. In this connection the following steps are recommended: -

(a) Stamping of Cartons etc.-According to the rules of supplies of drugs by supplying agencies firms, each carton must be stamped "for use of Government of Maharashtra only" Medical Officers should not accept a supply which does not bear a mark as above.
All ampules stocked in Government hospitals should be marked with a distinguishing mark of the hospital.

It is desirable to have a specific mark on each tablet supplied to Government hospitals. The tablets and capsules may also be supplied in strip packs, with the mark" For Government of Maharashtra use only".
Local purchased medicines can be excluded from stamping.

(b) Dispensing of medicines in hospitals should be done only in the O.P.D. and not at any other place.

(c) Prescription in a hospital should be according to the drugs rules and duly signed. Incomplete prescriptions should not be complied with.
All prescriptions should bear a seal of medical officer since Pharmacy Officer cannot know or identify signatures of all medical officers.

Prescription audit:

A committee of specialists should review the quality and trend of prescriptions from time to time and issue instructions to medical officers for guidance. Large hospitals can issue a "Prescriber's journal" for the same purpose.

The committee should decide the policies of rational use of medicine such as antibiotic policy, adverse drug reaction policy, Drug interaction policy etc.

(d) **The dispensing section should give code numbers to the various formulae.**
It is desirable to have a common formulary for all Government hospitals, preferably showing the generic names of drugs. Drugs should be prescribed from this formulary only barring exceptional circumstances.

(e)Staff- The reason why the professor of Pharmacology or a senior Medical Officer assisted by a graduate pharmacist or senior diploma holder in Pharmacy should be in charge of medical stores is that it is only such persons who can do rational classification of drugs, arrange them methodically and know the implications of uses, actions, and dangers etc. of drugs. The ideal combination is to keep the stores under charge of Medical Officers, the store keeper being a pharmacist.
Chief pharmacy officer, on a seniority basis, must be made responsible for inventory management.
(शा नि/प्र क्र ३४९/आरोग्य दि. १७ फेब्रुवारी २०१०)

(f)Used Ampules. - These should be disposed of as per Bio medical waste rules 2016

(g) **Routine and Surprise Physical Verification:** The Civil Surgeons and Superintendents should see that medical store accounts are maintained properly in prescribed registers. They should also check the stock in medical stores every month and enter their findings under dated signatures. In addition, frequent surprise checks should also be made.

Orders have also being issued regarding periodical verification of consumable stores by Finance Department, vide their Circular No. MCE/1072/ 16/F-I, dated 18th October 1972. Please see Appendix 39.

Physical verification of stock covers stock in central stores, sub-stores and stores in the dispensary, O.P.D. etc.

*(i)**Central Purchase**.* -Instead of each hospital purchasing the requirements individually, an attempt should be made to purchase in bulk quantity by consolidating the requirements.

(j) The system of indenting storage, receipts, issues, accounting etc. should be under constant review.

(k) ***Security Arrangements***. -The hospital should enforce security arrangements by issuing gate passes and by a check on outgoing material. In general, the security measures should be tightened.

(l) Avoid over-stocking by preparing indents for purchase on the basis of realistic assessment. The purchase of stores must be checked by a responsible Medical Officer. The figures of past consumption, bed-strength, attendance, storage space available, budget grant etc. should be taken into consideration.

(m) It should be ensured that the medicine containers especially containers of liquid medicines have pilfer proof corks, or lids.

***(n)O.P.D. Drugs*.** -A list of drugs to be issued in the O.P.D. should be drawn by each hospital. As far as possible drugs should not be supplied in original containers. O.P.D. case papers could have a printed serial number to prevent faking of O.P.D. papers with the same number. The doctors should sign their full name below prescriptions on the case paper. A proper account should be kept of drugs used for stock mixtures.

(o)Non-moving Items. - Certain drugs are found in stock which remain unused. This may encourage pilferage, as nobody is aware of the drugs, or loss due the drugs becoming useless. A list of such drugs should be prepared. The Medical Officer in charge of the hospital should review the situation and find out reasons for the drugs not being used. This work he may do with the help of the other doctors in the hospital. The review is expected to bring into light defective procedures which can be rectified.

p)Over indenting by Wards- If there is no proper scrutiny, there may be excess stock of drugs in the wards, which is not used for patients at all. Such stock can later on be removed by staff members for irregular use.

(*q)Self-prescribing.* -There is a temptation for many staff members to self-prescribe vitamin and tonic preparations, food products etc. and misuse them. All such prescriptions must be written with great care and scrutinized too from time to time.

(r)Decentralized Dispensing. **-** With centralized dispensing packets of tablets etc. are given on the spot to patients in the section where they are examined. If proper account is not kept of these packets there is likelihood of pilferage.

Oxygen, Nitrous Oxide gas and Carbon dioxide Cylinders.

Great care should be taken to keep a sufficient number of oxygens, Nitrous oxide and *Carbon dioxide* gas cylinders in the medical stores. The total number of oxygen cylinders should be provided so as to make a constant supply of full oxygen cylinders available to the wards. Each ward should have at least two oxygen cylinders--one full and one in use. The total number of cylinders should also be decided with reference to the time required for their dispatch, for filling up, up to the time of their receipt back. In big hospitals, Medical Gas Pipeline System (MGPS) installation, supply connections should be given on priority to ICCU, ICU, OT and SNCU/NICU.

1.9 Hospital Pharmacy:

Presently, all Hospitals have a supply of Drugs and Consumables in prepared form, i.e., Tablets, Injections, I.V. Fluids, Syrups, Ointments, and Creams; hence, there is no need to run a hospital pharmaceutical plant.

Hospital Pharmacy means a dispensary to be established in the following manner.

1) Minimum 4 widows for dispensing -1 male, 1 female, 1 senior citizen, 1 physical challenged persons and Government Servants.
2) Hospital pharmacy – Dispensary should have glass cover medicine rack system, still cupboards, Desktop Computer with printer and Network connection. A. C's& fans. The ceiling must be in RCC format.
3) All Drugs dispensing work should be run by registered pharmacist.
4) Pharmacist should do proper, counseling which is lead down in pharmacy practice Regulations, 2015.
5) Pharmacist should be punctual in their work; they should keep in mind that no any patients will waiting in front of dispensing window before their entry in dispensary.

General Instructions about Dispensing

This connection invites attention to the "Organization of the outpatient department." The modern tendency is to substitute tablets for stock mixtures.

1.10 Material Management

The main goal of Supply chain management is to make available material of right Quality, at right time, in right quantity, so quarterly, half yearly, yearly forecasting of material and supplies should be done properly.

About 30-40 per cent of budget allotted to a hospital is spent for purchasing various materials required in a hospital.

There are five 'M' in hospital administration viz. Men, Money, Methodology, Means and Material.

And five S - System

1. **Sort** – Keep only what is necessary and discard everything else- when in doubt, throw it out,
2. **Set in order** – Arranging and label only necessary items for easy use and return by any one,
3. **Shine**: keeping everything swept and clean for inspection for safety and preventive maintenance of equipment and others,
4. **Standardize**: The State that exists when the first three pillars or S's are properly maintain.
5. **Sustain**: Making a habit of properly maintain correct procedure.

Material management has come to occupy a very important place in modern methods of hospital administration. Many of the points about material management have been dealt with in paragraphs above.

Though material management applies to all stores, consumable and non-consumable, the principles as applied to medical stores can well be applied to all types of stores.

The object of material management is to ensure an appropriate stock of articles, (not too low, not too high), proper storage and proper distribution as required. The money available must be used in a most economical manner consistent with quality. Maximum quantity of patient care per unit of cost subject to acceptable levels of quality is the aim.

The following procedures are necessary:

1) Make a list of items required, estimate the quantity and specify the quality.
2) Make purchases from sources so as to achieve utmost economy consistent with quality. Standardization of items is a great help.
3) To see that the items are received in time, according to demand (quantity and quality) and to make prompt payments. Distress purchases at the end of a financial year are to be avoided.
4) To store them properly and keep correct accounts.
5) To develop a good inventory control.
6) To develop a system of good accounting and distribution in the units where the items are distributed.
7) To check pilferage.

The items required should be scientifically classified, for example Antibiotics', 'Hormones', 'Drugs acting on cardiovascular system' etc. The stock should be arranged according to therapeutic classification. This will show at a glance if duplicate or alternate medicines are stocked for the same disease thereafter, on the basis of past experience and individual merit, one can decide which ones to keep and which ones not to keep. This exercise will reduce the inventory list to the minimum, a basic tenet of inventory control. Once such a list is finalized, no addition should be made unless an equal number is reduced as far as possible. An exception must be made in case of life saving drugs so that a certain minimum quantity must be held in

stock, irrespective of past consumption. In short, the object is to reduce the varieties of items to the minimum.

Inventories involve in addition to the price of articles. The cost on account of storing and handling the item plus the interest on the sum spent.

The number of items should therefore be reduced to the minimum. Help of formularies and actual past experience should be taken. Stocking items which are not used means loss of money. One and the same drug may be known under different trade names and this should be kept in mind to avoid duplicate indents. It is unnecessary to purchase costly medicines when cheaper substitutes are available.

While ordering purchase, specifications should be clearly mentioned so as to leave no ambiguity.

Quantity required must be assessed in a realistic manner looking to the nature of hospital, past consumption, future expansion etc.

Economy is to be exercised by purchasing from right sources in bulk if possible and by economical use after receipt. Local purchase from non-authorized sources must be based on calling of quotations and comparing prices. Advantages of purchases from authorized sources is quality and economy, since local purchase is usually costly.

Inventory control is necessary to maintain stock in an economical manner. It aims to keep the stock at an optimum level. The control involves a system which answers the questions "when to order" and "how much to order".

Items required in large quantities should be ordered frequently and those consumed on a low level should be subjected to less frequent orders. This is in terms of value.

There are two systems of inventory control:

i. ***Cyclic System. -*** The stock position is reviewed at fixed periods, with regard to availability, rate of consumption etc.
ii. ***Bin System. -***Orders are placed for fresh stock, when the stock of an item drops below the "minimum level". (Actually, the stock is kept in 2 bins. In one there is a quantity equal to order point and in the second a quantity equal to difference between order point and maximum. When stock in the latter bin is used, it is a signal for reordering).

It is advisable to adopt the first method for placing orders on Government Medical Stores and the second one for orders on rate contract firms/tendering.

Certain terms are intimately associated with the concept of Inventory control and they must be mentioned here.

(a) ***Lead Time***.-This is the average duration in days between placing an order and actual receipt of articles. It follows that this factor must always be taken into consideration, so that the quantity at the time the order is placed is sufficient to last till the material is received.

(b) ***Buffer Stock***.-This is the stock which is kept for emergencies. It is calculated by multiplying the difference between maximum and average consumption rate per day by the “Lead Time" for the particular article. It can be treated as the minimal level below which stock should not drop.

(c*) Reorder Level.-* This indicates the stock level at which a fresh order is to be placed. This is calculated as average consumption per day x lead time buffer stock. This level assures the store officer that a given item will not be "out of stock" when required.

The buffer stock or safety factor may initially be calculated as below:

Group according to ‘A’ ‘B’ ‘C’ analysis.	Safety factors
‘A’ items	50 per cent of lead time consumption
'B' items	100 per cent of lead time consumption.
'C' items	300 per cent of lead time consumption

As experience is gained the safety factor can be tightened further to minimize stock.

It has been found that a minimum capital investment is obtained when the number of orders for an item is proportional to the square route of turn over value of the item. (The turn over value = Quantity used in a year X price).

(d) ***Economic Order Quantity or E.O.Q.-*** This indicates the quantity for which order is to be placed. In cyclic system it is the requirement in review period and lead time buffer stock the stock in hand.

In the 2 bin system it is calculated as follows: - Q=>2 RS/IC

Where ‘R’ is the annual demand for the item ‘C’ is the unit cost of item, ‘S’ is the cost of placing one supply order and 'I' is the carrying cost of the article per year (per rupee, expressed as percentage of average inventory value). The carrying cost in an Indian Industry various from 15-35 per cent. For a hospital 20 per cent may be taken as reasonable. Similarly the cost of placing one supply order in a hospital could be taken as Rs. 15. Such a calculation may not be possible at all places or may be difficult. It will be sufficient if all ‘A' items (A B C analysis) are purchased for only two months and B' items for three months.

Annual quantity required divided by the order quantity gives the frequency at which orders will be required to be placed. All the above levels should be reviewed periodically, say yearly since the quantum of work in a hospital is always changing.

ABC Analysis.- This is a method of "Selective Inventory Control". This enables us to separate the inventory into three categories i.e. A', 'B' and 'C'. To do this we first prepare a list of all articles based on their annual consumption value, in descending order, i.e. the one with highest consumption value will be at the top, and the one with consumption value next, will follow and so on. Here it is necessary to state that 'Price' is not the consideration that matters but the "total consumption value" during a financial year. This usually shows that about 10 per cent of items account for 70-80 per cent consumption-items "A". About 20 per cent account for 20-25 per cent -items "B". About 70 per cent items account for only 5-10 per cent of consumption value-items "C".

We can concentrate our attention on economic purchase of 'A' and 'B' items. 'A' items could be purchased more frequently as and when required instead of they being stocked in large quantities. 'B' items could be ordered every quarter. In the first quarter the order should be based on 6 months demand and then every quarter that much should be ordered equal to the fall in quantity during the quarter. In respect of 'C' items it would be convenient to order annual stock at one time. Actually, it should be 10 months requirement minus the buffer stock. Instead of ordering all 'C' items in one lot, which may be difficult, 25 to 30 items may be ordered every month. The grouping should be done in such a way that they can be purchased from a common source, thus promoting economy. 'A' items should be controlled by Civil Surgeon/ Superintendent and 'B' items by the Medical Officer in charge of the stores. 'C' items by pharmacist, though 'B' and 'C' categories also require some supervision at highest level now and then ABC analysis, should be supplemented by "V.E.D." analysis. This is based on how for the drugs are essential. "V.E.D." denotes 'Vital', 'Essential' and 'Desirable'. The V. E. D. analysis should be made for each of the categories A, B and C. Thus a drug may come under "C" category on the basis of ABC analysis but it may be vital from V.E.D. point of view. Procurement should therefore be based on both ABC and V.E.D. analysis.

'Vital' drugs are those which if not administered to a patient may result in fatality. The drug should be available in a short period, say one hour. Generally speaking, there are no alternative drugs available.

'Essential' are those which could be made available in a day or two and for which alternative medicines are available.

'Desirable' are those which are required for the treatment of chronic or less serious diseases. They may be required for preventive use during convalescent period or for hygienic purposes.

Stock Turnover.- Proper turnover is essential so that drugs are used before their expiry date. For this purpose in general, stock should be so arranged on shelves that the oldest consignment is at the front, and those drugs purchased later on are behind it, in that order. In other words it should be "First Expiry, First out".

Obsolete Items.- Strictly speaking medical stores if well managed should not have such items. Nevertheless if such items are in stock, an attempt should be made to use them either in the same institution or in some sister institutions. If none is possible, they may be destroyed.

Distribution of Supplies.- Usually indents are sent by wards/units to stores/ sub-stores for replenishment of supplies.

Costly medicines should be requisitioned by special indents along with the relevant case paper. Prepacking and strip packing of tablets helps in easier supply.

Material management of good quality will automatically contribute towards checking of leakage and pilferage. This question has already been discussed in Para 1.7.

Attention is also invited to Appendix 128 of the Civil Medical Code, which contains certain instructions regarding the management of medical stores.

Writing off

No occasion should arise to write off medicines. Purchase of stock not likely to be used is irregular. These should be no waste due to undue storage. An inventory of stock unused for one year should be made and stock not required should be transferred to other institutions. If these instructions are not followed. The cost is liable to be recovered from responsible persons.

In spite of this if it becomes necessary to write off any stock, this should be done according to financial powers delegated at various levels.

1.11 Sources of Purchase

Medicines, dressings, chemicals, suture materials etc. are purchased by Government hospitals from different sources as follows:-

(a) Central Purchase – This type of purchase is the policy decision of Government. These types Medicines and Consumables are supplied through Government appointed agency or regional warehouses.

(b) Quantity/*Rate Contract.* - *Quantity/*Rate Contract is fixed by Government of Maharashtra with certain firms by open tendering by appropriate authority GovornamentCorporationas per Maharashtra Medical Goods Procurement Authority Act 2023. Medical Officers are designated as "Direct Demanding Officers" can place demand tthrough proper channel to GovornamentCorporation.The list of Direct Demanding Officers includes the Directors of Health

Services, and Medical Education and Research, Deans, Principal College of Nursing, Superintendents, Civil Surgeons, Medical Officers in charge Cottage Hospitals and other Hospitals, District Health Officers, Chief Executive Officers, Deputy Directors of Health Services etc.

The Senior Pharmacy Officer should consolidate requirement of the hospital annually in the month of March/April and submit to higher authorities. The Demanding officers can also purchase medicines as per procedures like local purchase as per prevailing guidelines.

All purchases should be done according to existing purchase policy as modified from time to time.

(c) ***Central Rate Contract***. -A rate contract is also fixed by Director General of Supplies and Disposals, Government of India. Hospitals can place orders for purchase on firms according to that rate contract, in case of non-availability from other sources and in case the prices are cheaper. The orders must be routed through the Director of Health Services or Director of Medical Education and Research.

(d) ***Government of Maharashtra Undertakings***. -Items available with Haffkine Institute, Department of Fisheries, etc. all to be purchased from them at rates as fixed by them, unless they are available from other authorized sources at cheaper prices.

(e) ***Local Purchase***. -In unforeseen emergencies, medical officers are allowed to make purchase from local Drug dealers.

Local purchase of medicines is allowed at a time to the extent of Rs. 250 by calling quotations and to the extent of Rs. 50 at a time without calling for quotations. Similarly certain other items like syringes are purchased locally from time to time. Sometimes the local purchases are made even when items are on rate contract because they are urgently required and there is no time to approach rate contract firm. It is often seen that such local purchases are made without any system and as the demand arises. For example, ward A may demand 10 syringes of 2 ml. today and so quotations are called for supply of the same. Again after 2-3 days, ward B requires, the same articles and quotations are again called for the same item. The same can happen in respect of drugs. Such a system in addition to causing a delay in supply will cause extra expenditure since prices quoted for such quick local purchases are always higher than normal. Such transactions can give plenty of scope for abuse. In one hospital, it was noticed that drugs were routinely purchased from a particular shop up to Rs. 50 repeatedly, even several times in one day.

To avoid this, all items must be purchased from rate contract firms in time so that occasions for local purchase are minimized if not eliminated. Secondly if there is no rate contract, requirements should be assessed for a year and purchases made in bulk after scrutiny by a senior officer.

Details regarding the above modes of purchases will be found in Chapter No. 21 of Civil Medical Code.

1.12 Payment of Bills and Budget Provision:

The bills should be paid within a period of one month. As soon as the bills are received, the stock shown in the bill should be checked with the invoice. The bills are received by the Steward or Clerk-in-charge of the Medical Stores. In either case, the bill should be sent to the Pharmacist who is maintaining the Expense Book, and the latter should certify that correct quantities have been received and entered on a particular page of the Expense Book. This certificate should be countersigned by the Resident Medical Officer and the "Pay Order" should then be given by the Drawing and Disbursing Officer. In order to prevent circumstances in which one bill may be certified twice, an entry should be made in the Expense Book that a particular bill has been certified, against a particular entry of the Expense Book.

Budget provision is to be made carefully by assessing the average requirements and also the expenditure for the previous three years. Revised estimates should also be sent in time.

1.13 Miscellaneous

Transport of Medicines. -Medicines are sometimes carried by Hospital Ambulances from the suppliers or from Railway Station etc. to hospitals. Care should be taken to see that the medicines are packed properly. Bottles should not be carried loose without packing cases. Non-observance of such a simple precaution has no occasions resulted in unnecessary breakage and loss.

References:

1. Dr. A. Timappaya. Materials Management in Hospital. Background Document. NIHAE, XVI Hospital Administration Course.
2. A Manual of the working on Hospital Stores by Central Drugs Standard Control Organization, Director General of Health Services, New-Delhi. Background Document NIHAE, XVI Hospital Administration Course.
3. P. P. Parikh. Need to control medical items in Hospital Administration. NIHAE Bulletin, Volume III, No. 2-1970.
4. Surinder P. S., Pruthi, Project Report on J. J. Group of Hospitals.
5. Maharashtra Medical Goods Procurement Authority Act 2023
6. शा नि क्र -भा ख स-२०१४/ प्र क्र ८२/ भाग III/ उद्योग ४ दि. 1 डिसेंबर २०१६. Revised Manual of Office Procedures for procurement for government departments. Department Industry, Energy and Labour
7. शा नि क्र भांखस-२०२१/ प्र क्र ८/ उद्योग ४. दि. ७ मे २०२1. दर पत्रकाच्या आधारे करण्यात येणाऱ्या खरेदीची मर्यादा रु. ३ लाखावरून र. १० लाखापर्यंत वाढविणेबाबत

CHAPTER II
KITCHEN AND DIET

2.1 General

Hospital Diets form an important part of treatment regimen in hospitals. The diet service therefore requires proper planning and execution. The object of the diet section in a hospital is to serve appetizing and nourishing meals to patients. In addition, the diet must have treatment value. The expenditure on diet also requires to be controlled from the point of view of economy. The hospital diet section has therapeutic, educational and administrative responsibilities.

For proper menu selection, preparation, distribution of diet (including breakfast, lunch, evening tea and dinner) to patients in all hospitals, Similarly, dietitian is required for nutrition health education and demonstrations and exhibitions to the patient.
Certain larger hospitals have a post of Dietician of the staff. In other hospitals some members of the nursing staff should be trained to look after the work of Dietician.

The Nutrition wing of the Public Health department, Maharashtra has prepared detailed charts and instructions regarding diets in government Hospitals. The diet charts give the quantity, the details of different diets to be served to patients in different diseases, and they also give a broad outline of the menus. The principles underlying the different diet formulae are also mentioned. Please refer to" Government of Maharashtra GR for Government Hospital Diet dated 23rdApril 2019, recommended in Health and Disease" under Public health department.
The dietary habits of hospital patients vary from region to region. Within the scales prescribed by Government it is possible for the dietician to workout menus which will be palatable and attractive, suitable to a particular locality.

Many of the hospital patients bring diet from their homes. In such cases it is natural that they will ask a question as to what should be eaten. To answer such a question properly the hospital staff and especially the dietician must be able to give adequate advice depending on the patient's disease as well as his habits, economic condition and surroundings.

The Medical Officers should pay as much attention to the selection, prescription of diets as they do for prescription of medicines. In order to do this the Medical Officers should be fully aware and should have made a study of the hospital diets prescribed by Government of Maharashtra given as above. There is separate diet sheet on which the Medical Officers are required to prescribe. The summary diet sheet of all patients admitted in the ward should be cross checked and signed by the Metron/Assistant Metron/ Incharge sister/Senior Staff Nurse and send it to the dietitian for proper distribution. The hospital diet plays an important part in treatment of certain diseases like anemia, nutritional diseases, diabetes etc. For those patients who remain in the hospitals for a long time, the diet is important to overcome nutritional deficiency.

Additional civil surgeon will be the overall in charge of the kitchen. But the Special Nodal Medical Officer should be given the responsibility of kitchen. Incharge of kitchen should regularly conduct regular health checkup and necessary investigations of kitchen staff quarterly.

2.2 Infrastructure

Kitchen Building

The kitchen areas/units should be so designed to ensure an easy flow of staff and articles from one unit to the other from a functional point of view. The sizes of units would depend on the size of the hospital.

Location of the Kitchen Department:

If feasible, the kitchen department needs to be located away from the patient care areas in a separate building. It is preferable if the kitchen department is located on the ground floor of the hospital, where there is easy accessibility for receiving raw materials and distribution of food through food trolleys. The location should ensure that any noise or cooking odours emanating from the department do not cause any inconvenience to the other departments. The location should involve the shortest possible time in delivering food to the wards.

Adequate ventilation should be provided. Exhaust fans should be available in the cooking area to exhaust the hot air generated by stoves. A chimney should be installed to throw the smoke out of the kitchen.

The kitchen should have the following areas/units.

(a) Receiving Area. - This should have a raised platform, to receive articles and an adjacent space to examine them. There should be a weighing scale in this area. The area should be separate for vegetarian and non-vegetarian sections.

(b) Storage Space. -This will have to be subdivided into (1) dry and general stores (2) vegetable and fruit stores, (3) cold storage, (4) cylinder stores and (5) utensil stores. Fish and perishable articles, if requiring storage for 3-4 days must be preserved in cold storage.

1) **Dry and General stores** - All food grain storage should be done on raised pallets/stands with a minimum clearance of 8-12 inches from the floor. Food grains should be stored in galvanized tins. Condiments and spices should be kept in tins with lid. (Letter of Director of Health Services, Bombay, Guideline for improvement in hospitals Dietetics, Dt. 06/10/1988) Pallets should ideally be made of metal as wooden ones are not easy to clean.
2) **Cold storage-** All refrigerators, freezers and other floor-based equipment should have the same clearance above the floor. Storage pallets, refrigerators should have clearance from all sides to enable inspection and cleaning. The storage room should not have high temperature. An AC should be installed, if possible, an exhaust fan should be installed if an AC is not available. The windows should be kept closed at all times. A thermometer to measure room temperature should be available in the room and a daily log of the same should be maintained. Vegetables and fruits should be stored in the refrigerator at 2-4°C temperature. Monitor the temperature of all refrigerators by placing a thermometer inside them and record the readings at least once daily. The temperature should be maintained between 2-4°C. Electronic sensors may be used, if available.

(c) Preparation Area. -This should have work tables with top preferably of stainless steel and sinks and wooden chopping boards to chop food articles. The sinks should be fitted with water

taps and good drainage. Hand wash basins should be available in the food preparation area. These should be separate from the basin used to wash raw food. Alcohol hand rub should be available in the food preparation area.

(d) Separate vegetarian and non-vegetarian kitchens, sinks and good drainage are necessary. Proper marble or stone top platform or tables of comfortable height should be provided for chapati rolling.

(e) Pots and Pan Wash Area. -This should be easy of access from the preparation area and kitchen. There should be sufficient number of sinks with water taps. Replacement of water supply and sanitary installation like water tanks, WC cistern, wash basins, kitchen sinks, pipes etc. Racks for keeping cleaned utensils are necessary.

(f) ***Garbage Disposal Area*****. -** This is necessary to keep the kitchen hygienic. It should be near service entrance or outside exit so that garbage can be easily removed. There must be arrangement for washing of garbage cans.

(g) Servant's Room. -This is essential to ensure cleanliness. The room should have lockers for cooks, cook mates etc. The staff members should take a good wash in this room, put on clean uniform and then enter the working area. A dedicated toilet for use by kitchen staff

(h) Office Room. -This will be useful for the dietician, diet clerk, etc. There should be separate toilet arrangements for office staff.

The doors and windows of hospital kitchen as well as the doors of kitchen cupboards should be protected by wire gauze to make the whole section fly proof. Fly traps should be used along with antirodent measures. The floor and sides upto 2 feet from the ground should be tiled in such a way that they are capable of being washed easily.

There should be raised platform for gasburner in the kitchen. There should be chimney in the kitchen. Plaster & Paint-The hospital kitchen should be plastered evenly for smoother surfaces and should be painted both from outside and inside in a uniform colour scheme which reflects a stress free and calm environment. The facility should regularly check for any chipping of plaster and fading of paint. Regular maintenance of plaster and paint needs to be a part of periodic maintenance programme.

White washing should be done at least twice a year in the kitchen building. The doors and windows should be protected by bars and they should be strong so that if they are locked, no pilferage can occur.
Proper daily cleaning of utensils must be ensured by adequate supervision. Some utensils may require tinning and this should be attended to in time.
It is advisable to discontinue use of aluminum utensils.

2.3Hygiene and medical examination of food handlers

Daily hygiene of staff working in the kitchen should be checked by medical officer or Dietitian including clothes, complete uniform, nail (trimmed), hair properly clipped, etc.All persons handling food will undergo periodic medical examination and laboratory testing at the time of:

I. Initially, before joining the job
II. Subsequent medical examination should be done as under:

- Complete physical examination – once a year.
- Stool examination for ova, cysts and parasites – every three months
- Stool culture for salmonella – every three months.
- Routine complete blood counts (CBC) – every three months
- Other investigations, such as chest x-ray, Widal test, stool culture for cholera, etc. should be done as and when required based on the findings of routine testing or reported symptoms
- Testing frequency of relevant tests should be increased during an outbreak of diarrheal disease. All food handlers should be vaccinated against Hepatitis B.

2.4 Wastage of Diet:

Hospital diet is an area where constant awareness is needed to bring about economic expenditure. Wastage of diet must be prevented. It is found that diets are continued or prescribed for patients who are just about to be operated on or who, on account of their post-operative status, are not able to eat. There are also a good number of patients who cannot consume the full diet as per scale. The Medical Officers and nursing staff should, therefore, carefully assess the needs of individual patients. Sometimes, half of the diet should be prescribed even for adult patients. Before deciding whether the patient can consume the hospital food or not, it should be scrutinized whether the patient cannot eat because of an unsatisfactory diet. If this be the reason, it will require rectification. The remedy in such cases is not to reduce the quantity of diet but to improve its quality and attractiveness.

Good accounting, checking of the stores purchases, proper storage of raw materials, effective system of ordering diet materials and distribution will help to eliminate wastage as well as pilferage.

A common objection raised many a time is regarding wastage of diet on account of patients who are discharged and yet for whom the diet is already requisitioned. In order to overcome this difficulty, the discharge of patients should be planned in advance as far as possible. In respect of those patients who have to be discharged without advance intimation, an attempt should be made to utilize their diet for newly admitted patients.

2.5Diet Scales:

In order to enable medical officers and the nursing staff, as well as staff working in the kitchen, to be well aware of the diet scales, boards should be put up in the hospital kitchen and the wards. Typed or printed sheets should be put up in glass cases so that they are not soiled. It is common to see diet charts put up in such a way that they are not legible. The Medical Officers and Nursing staff should also know the changes that occur in weight by conversion of raw material into cooked food. In this connection, it may be mentioned here that cooked rice weighs approximately three times as much as dry rice, and cooked dal weighs four times as much as dry

dal. The measures given in the diet scales are of uncooked food. It is only by such knowledge that, it would be possible to check the quality and quantity of hospital food. Nurses should be trained in serving diets to patients, preparation of therapeutic diets, schedules of diet and about preservation and avoidance of wastage and pilferage by the dietitian. Weighing/measuring apparatus for raw and clean/cooked foods should be separate, e.g., different jugs should be used to measure raw and heated milk.

The matron/assistant matron/Incharge Sister/Senior Staff Nurse should also ensure that diet sheets are filled by the sister in charge/Medical Officers. During their rounds, one or more nurses should be trained by dietician and then sent to kitchen in the absence of dietitian.

2.6 Emergency Diet

If a patient is admitted in the hospital in the afternoon, unless there is a system of emergency diets, he is likely to receive his food only from third day after his admission. In order to overcome this, every hospital should have a system of "Emergency diet".

This gives guidance as to serving of diet to patients admitted at an odd time. In any case the hospital can always arrange to keep extra bread and milk in stock for such distribution.

If skimmed milk powder is not available the Medical Officer may instruct the contractors to bring 10 per cent extra supplies which could be kept as imprest stock.

An imp rest stock of dal, rice and atta can be always kept in the wards for patients admitted late.

2.7 Diet Committee

As per Government orders a diet advisory committee is to be formed at each hospital consisting of CS/ACS/DS/MS, Dietician, Specialist or MO Incharge of kitchen, Matron, Diet clerk to advice on the successful working of various diet scales. The Committee should look after the work of drawing up menus from day to day and ensure that there is variety in the food served. The Committee should see that there is no leakage of ration or food and that the patients get in full whatever is intended for them. The Committee should also carryout surprise check of diets supplied to patients.

Instructions have been also given that the Civil Surgeons / Superintendents or Medical Officers In charge of the hospitals should check all hospital food stuff and dietary articles, do surprise checks and to keep records of the same for perusal of the higher authority. The diet Committee should also similarly keep a record of surprise checks

The actual composition of diet Committee may vary from hospital to hospital. The duties of diet Committee mentioned below are of supervisory nature and are to be carried out now and then, singly or jointly by the members. The Committee should check quantity and quality of dry ration as well as vegetables, milk etc., received every day from time to time. For checking the quality of dry ration, a comparison should be made with the samples provided supplied by the steward/ diet clerk supplier. It is preferable to keep the standard sample in two sealed glass bottles one remaining with the steward/ diet clerk and the other in the hospital kitchen. The dietician will be the Member Secretary of the diet committee when available or but in her/his absence the matron can conveniently act as a Member Secretary.

- The Dietician or the person supervising the kitchen should conduct the diet committee meeting every month and minutes of the meeting should be recorded and should be signed by all members
- The Special Nodal Medical Officer, Incharge of kitchen in the diet committee should not be on rotation
- Diet committee should ensure that Poshan Month, iodine deficiency Disorder Day and other such nutrition related health programs are celebrated in the hospital. All the PHN, NRC dietician, Staff nurse and other staff member are expected to work along with regular dietician to make health and nutrition program successful.

The following instructions will serve as useful guidance for checking the quality of various articles:

The members of the diet committee should fix the varieties of vegetables which should be supplied by the contractor from time to time depending upon the season. They should change the diet menus from time to time in order to make them attractive to the patients. They should supervise every phase of the preparation of the diet right from the receipt of dry rations and other ration up to the distribution inwards and consumption of food. The duties should be taken by rotation, i.e. the various members of the Diet Committee should do the work on a particular day individually or in groups. The cooked food should be actually tasted by random sampling. If any defects are found in the supply of raw materials, the hospital authorities have got a right to either return the supply and force the contractor to supply articles of the required quality or to take disciplinary action against the contractor by fining. The members of the Diet Committee should also arrange to collect and send samples for analysis with a view to find whether there is any adulteration, when necessary and also at random. A register should be maintained of findings of the diet Committee. The Civil Surgeon (CS) /Additional Civil Surgeon (ACS) /Dy.Superintendent/Medical Superintendent (MS) should make surprise check of balances in kitchen stores, especially in respect of articles purchased in bulk and the finding should be entered in the relevant register under dated signature.

It is often found that difficulty arises in distribution of food from kitchen to all the wards of the hospital at the same time. This is on account of the fact that the staff cannot bear the load of distribution to all the wards simultaneously. In order to solve this difficulty, the schedule of timing of supply of diet articles to different wards may be somewhat different and not uniform. This will help to reduce the load of distribution at one and the same time. Alternatively, the distribution could be decentralized if possible. In the latter case, the ward staff will have to go to the kitchen and get the required quantity of food for the ward.

There should be a board outside the kitchen showing at a glance the number of patients receiving the diets, the type of diets and the total number of diets.

The supply of diet ration should be received from the contractor in the early morning. It is a common experience that certain articles like, fruits and vegetables are not received by the hospital in time. This delays the service of food to patients. The contractor should be suitably instructed and if necessary disciplinary action taken against him.

2.8 Kitchen Hygiene and Sanitation

The following are the important points to be noted to ensure a reasonable level of kitchen sanitation: -

a) The staff working in the kitchen should undergo medical check up quarterly and their health record maintained.
b) The staff should not be allowed to come on duty if there is an obviousinfectious disease.
c) The kitchen employees should be asked to keep their hands clean all the time they are handling food etc. This can be brought about by suitable training and strict supervision. The staff members should not be allowed to smoke or expectorate. Dirty articles, garbage, rubbish and soiled clothing should not be allowed to collect in the working rooms.
d) Equipment such as tables and food preparation and holding counters should be wiped with chorine solution containing 500 ppm of chlorine (1% dilution of Sodium hypochlorite) at least twice a day or before and after food preparation, whichever is suitable. The solution should remain wet on the surfaces for at least one minute.
e) Weighing machines used to weigh should be cleaned before and after use with soap water solution.
f) Cooking stoves should be wiped clean with soap water before and after use. They should always appear clean. Cooking gas cylinders attached to the gas stove should also be wiped with soap and water once a day.
g) Change the mop heads/mop and brushes when they become frayed or at least every two weeks, whichever is earlier. Clean with soap and water before next use

Perishable and non-perishable articles should be stored with due protection, from rodents, insects etc.

Pest and Animal Control

Pests and animals are attracted to health facilities in search of food, water, shelter and optimal temperatures and pose a number of health threats through the spreading of microbial infections and communicable diseases. Therefore, having a pest control plan and an animal and pest free environment is of utmost importance for healthcare facilities. The entire kitchen area should be sprayed with pesticides every three months and whenever large numbers of pests are detected the kitchen premises should undergo pest control and rodent control measures quarterly.

After receipt of dry store as well as perishable stores, they should be cleaned before they are utilized for cooking. Vegetables and fruits should be washed properly, Milk should be collected in milk cans which can be locked.

Cooked food requires to be dispatched to different wards. If the distance between the kitchen and the ward is long the food gets cold and so less palatable. Firstly, therefore there should be arrangements to warm the food in the wards before serving it, if necessary, and secondly, decentralization of preparation of food should be tried to the extent possible. At least tea, snacks, milk and sugar can be supplied to the wards in lump quantity and distributed to the patients from there. Insulated food trollies are available. If food is distributed in such trolleys, it will retain its warmth. Thermograms with taps can be used for tea and milk.

2.9 Distribution in the Wards:

A close watch should be kept over distribution of food in the wards. It is a common experience that the food does not actually reach the patients in the quantities in which it is distributed. For example, mutton meant for patients is often found to be without the mutton pieces by the time it reaches the patients.

The dietician, the ward sister, the nursing staff, the Medical Officer in charge of the ward and members of the Diet Committee individually or jointly have a duty to perform in supervising correct distribution of food when it reaches the ward. The main person concerned is the ward sister under whose direct supervision the distribution should be made. While distributing the food the wards sister should check if the food received is according to the prescriptions on the diet sheets and according to the schedules as given in the diet charts.

Patients themselves should be made aware of their food entitlement to set in motion an effective method of self-checking.

Food Tables

The ambulant patient should be encouraged to take their food in a dayroom attached to the ward if available. In respect of those patients who cannot move, food tables should be supplied as otherwise, in addition to the inconvenience caused to the patient, there is unnecessary soiling. Certain patients are unable to eat by themselves, and if help from their relatives is not forthcoming, the nursing staff should undertake the work of feeding such patients.

After the patients have finished eating the food, the ward servants should immediately collect any remnants as per the Biomedical Waste Management Guidelines 2016.

The patients and relatives should be educated not to throw food bits and fruit peelings anywhere except in covered dustbins.

As hospital diet forms a very important part of hospital service, the satisfaction of patients' needs to be elicited from time to time, and for this purpose, their opinions should be asked for. This should be done by the ward staff and the supervisory staff, who should ask questions about the quality and quantity of food they receive. The questionnaire also includes this question in connection with "Exit Interview" Members of the Hospital Visiting Committee can also play their part during their rounds.

Help of Food Inspectors appointed by Government or Municipalities should be taken in checking the quality of various articles received. This may be done by way of routine as well as whenever specific suspicion arises. Help of the inspectors may also be taken for fixing the specifications of various articles included in the tenders.

2.10 Health Education and Social Welfare

Particular care should be taken to teach patients about balanced food to the extent possible within the conditions of social, economic and religious influences operating in the area.

On medical grounds the patients are often prescribed diet which is quite different from one usually taken by them. In such circumstances it is obvious that the patient would have many questions to ask. The dietician can explain the implications of the diet prescribed. Visit of the dietician or staff member to the patient when he is actually taking the meal is the most suitable time. The patient should also be given advice regarding follow up instructions which he may have to observe after leaving the hospital.

Hospitals should also see if it would be possible to conduct dietary training in the outpatient department. This will give a good impact to Community health, and such training is therefore desirable.

Social workers if attached to hospitals should be associated with thework of supervision over kitchen and diet arrangements in the hospital. Theywill be of great help to the regular hospital staff.

2.11 Stock management

Indents

The Ward-Sister/Sister in charge should send an indent for the diets of the subsequent day to the dietician/Diet Clerk by 2-00 p.m. and another supplementary by 6.00 p.m. on any day. The dietician /Diet Clerk should prepare a consolidated indent in triplicate, send two copies to the contractor, and retain one copy with him. The contractor should send back one copy of the indent along with the supply, inserting the quantity supplied, and the remaining copy should be kept by the contractor for the preparation of bills.

Payment of Bills

According to the rules given by the Tender Form, bills for a particular month should be paid before the 7th day of the subsequent month. Bills from the various contractors should be received carefully, as non-receipt in time leads to considerable confusion.

Tenders

Various rules regarding the procedure to be followed regarding tenders for dietary articles are given in GR dated 1st December 2016 and 7th May 2021 or as per the rules modified from time to time.

Surprise visits are paid by Civil Surgeon/Additional Civil Surgeon/Deputy Superintendent/Medical Superintendent/Matron to the Kitchen to check the indent, preparation and distribution of diets to patients and general management of dietary services. Reports of such visits containing observations for overcoming defects are sent to the concerned Incharge Kitchen medical officers, amongst others. These instructions should be carefully acted upon by the Incharge Kitchen medical officers.

The following observations made by the Officer require to be acted upon by medical officers in charge of hospitals where diets are served.

1) The local hospital diet committees need to be more active and vigilant.

2) In general, the nursing staff still does not appear fully conversant with dietary allowances for different categories of patients, especially regarding the quantity of milk in the diet scales, fruits and vegetables in diabetic diets, etc.
3) Every ward needs to keep a daily diet distribution chart for constant reference of the nurses in charge of pantry duty.
4) Senior nursing staff also need to pay more attention and supervise the actual service of breakfast, meals and important foods like milk, fruits, eggs, etc., which can be easily pilfered.
5) Standard weights, measures, serving spoons, etc., must be provided to ward sisters for the distribution of diets.
6) Modern equipment, such as hot food trollies, compartment trays, hot tea urns, etc., will help distribute warm food in a hygienic manner and in an attractive style.

The medical officer in charge of the hospital must devise ways of preventing pilferage by studying in detail the procedures adopted from the time the articles are received until they are distributed. Important articles should be received and distributed under the guidance of trained staff. Transportation of food from the kitchen requires supervision to prevent pilferage.

2.12 Records and Registers

It is necessary to maintain certain registers to keep a proper account, of dietary articles: -

a) *Register of non-perishable stores* (like rice, sugar, oil). The register contains the following columns: Date, Opening Balance, Receipts, Total Issues and Closing Balance. This is to be written daily.
b) *Abstract of Daily Diets Table*- This is based on information received from the wards, from this, the total quantity of articles required is calculated and communicated to the contractor. Receipts from the contractor are also entered in this register. This register is written daily.
c) *Monthly Abstract Register*. -In this register, a total of daily diets for the month is entered, which enables the office to pay bills of contractor.
d) *Register of Tasting of Food.* -Tasting is done by such Officers as Civil Surgeon, Additional Civil Surgeon/ Deputy Superintendent Medical Superintendent CAO/Matron/AO/Incharge MO on rotation basis, and remarks entered in the register. This is to be written daily.
e) *Food Received Register.* - This is prepared by the dietician and sentto the ward. The signature of ward sister in token of receipt of food is takenin the register and entries are made in this register daily.
f) *Issue and receipt register* – Daily record of perishable and non-perishable items is kept near Dietitian/Diet clerk.
g) *Food sample register (File)* – Monthly random raw food items (e.g.: rice, wheat, dal, salt, etc.) are sent to the Public Health Laboratory for testing and its record should be maintained.
h) *Water sample register*– It is mandatory to do testing of water daily Cleanliness of water tank (source) must be done once in a quarter Its record including date and signature of concerned personnel must be maintained.
i) Staff medical examination register Table -4 – General examination (nails, hair, uniform, etc.) should be done daily. While the medical examination is done quarterly and its record maintained. In case any of the kitchen staff member is suffering from communicable diseases like typhoid, Covid-19, jaundice, etc. should be compulsorily sent on leave as per the advice of hospital physician. Kitchen Staff must be in proper uniform- Cotton Saree, cotton clothes, cap mask, apron etc. Hand jewellery should not be worn while on duty. Hand washing should

be done on resuming duty, after completing a task (e.g., vegetable cutting, cooking the food, etc.) and whenever the hands are visibly dirty/soiled. Hands should also be washed after using the washrooms, after eating food and before leaving duty. Hands should be disinfected using an alcohol hand rub before handling raw food, before beginning cooking, before dispensing cooked food, after washing utensils, before leaving duty.

j) Ward diet sheet register - The summary diet sheet of all patients admitted in the ward should be cross checked and signed by the On Duty Medical Officer of the Ward and send it to the dietitian for proper distribution and its record should be present in the kitchen.

k) Cleaning register – Daily mopping of floor (thrice per day) and cleaning of bathroom and toilets (twice per day) by concerned personnel is done. Proper record keeping should be done.

l) Floor, Walls and Surfaces of Kitchen should be clean round the clock at least once in a shift with soap or Quaternary ammonium compound. Spot cleaning should be done as required. Intensive deep cleaning should be done weekly or on holidays. Its evaluation should be done quarterly.

m) Nutrition Education registers- Daily Counseling of OPD / Indoor patient (pregnant, lactating mother, Paediatric, therapeutic diet) is done by dietitian and its register should be maintained.

n) Feedback register- At least two patients feedback from each ward regarding diet is recorded in feedback register.

o) Diet Committee Member Remark register – Monthly all members during Diet committee meeting should visit the hospital and should write their remark. The remarks should be reviewed in the committee meeting.

p) Specific gravity registers – of whole milk received in the kitchen is taken. Record should be maintained.

q) Stock register – of raw food including condiment and species is maintained.

r) Visit Register- Visit of any higher Authority in the kitchen should be recorded.

2.13 Duties of Dietician and Cook

Duties of Dietician

a. She/He must supervise over the cooking of food articles and ensure cleanliness of food utensils and kitchen building.

b. She/He She should prevent pilferage of food articles.

c. She/He has to plan the diet menu.

d. She/He should make a surprise check of diets in the wards and discuss with ward sister and matron to overcome difficulties in serving of diet, if any.

e. If any food articles fruits are donated to the hospitals she should arrange for their proper distribution.

f. She/He should arrange Diet Committee Meetings and keep minutes of the same.

g. The Dietician should give therapeutic advice to the patients who are referred to her by wards/units.

h. She/He should assist the Stewardor Diet clerk in purchase of food and other equipment and supplies needed for the diet section.

i. She/He is responsible for proper storage of food in the kitchens as well as advising ward staff for the same.

j. She/He has to dispatch the food articles from the kitchen to the wards and distribute them properly.

k. She/He is responsible for training, assignment of duties, and supervision of personnel working in the diet section.

l. She/He is responsible for maintaining adequate records and should also help in keeping accounts, planning budget etc.

m. Dietician may also have the duty of training certain persons like student nurses, dietetic interns, kitchen staff, etc.

n. In many hospitals the responsibility of dry and wet ration is given to the contractor. So, each time contractor should take suggestion from dietitian. So that the quality and quantity, will be maintain. Rotation menu (fruits, veg. and dal) and cyclic menu should be planned by the dietician and handed over to the contractor weekly.

o. The Dietician should fix the days for Nutrition Education to patients, relatives, mother attending children in pediatric wards and A.N.C./ P.N.C. mothers in the hospitals. The Dietician should arrange diet clinic, thrice a week, in which she will give therapeutic diet advice to patients referred to her by wards / units. Dietician should arrange diet counseling session in OPD for relatives of mental patient in mental hospital. Report about all these activities monthly to Senior Scientific Officer, Bureau of Nutrition, Nagpur (Letter of Director of Health Services, Bombay, Guideline for Improvement in Hospitals Dietetics, Dt. 06/10/1988).

p. While Hospital Rounds of Higher authorities, Dietitian should also be present in the round to know the problems in distribution of food, patients feedback or any other complaint related to food, etc.

Duties of Cook

1) Receive food articles according to indent from Dietitian.
2) Preparation of food according to menu.
3) Cook should see that there should not be wastage and spoilage of food.
4) Care and maintenance of the equipment and other appliances and they should be clean and in good condition.
5) Ensure sanitation and cleanliness of the department.
6) Observe strict personal hygiene.
7) Clean cotton uniform, mask, head cap should be worn.
8) Maintain a high standard of food preparation.
9) Receive supplies in absence of Diet clerk.
10) Supervise food service at kitchen level.
11) Ensure timely service of meals.
12) Take safety precautions to prevent fire and injuries to those working in the kitchen

Licence regarding Food:

The food license is mandatory as per the norms. The records should be maintained as per FSSAI norms. The renewal should be as per Food Safety and standard Act 2006. For more details, please refer the annexures 2.1 to 2.27, comprehensively.

List of References:

1. Standardized diet for hospitals. Report of the Sub-Committee of the National Nutrition Advisory Committee's
2. Mrs. P. Kaushik. Organization and Management of Hospital Dietary services. NIHAE XVI Hospital Administration Course.
3. Guidelines for Standardized Diets for Hospitals
4. Biomedical waste management guidelines 2016
5. शा नि क्र -भा ख स-२०१४/ प्र क्र ८२/ भाग III/ उद्योग ४ दि. 1 डिसेंबर २०१६. Revised Manual of Office Procedures for procurement for government departments. Department Industry, Energy and Labour
6. शा नि क्र भांखस-२०२१/ प्र क्र ८/ उद्योग ४. दि. ७ मे २०२1. दर पत्रकाच्या आधारे करण्यात येणाऱ्या खरेदीची मर्यादा रु. ३ लाखावरून र. १० लाखापर्यंत वाढविणेबाबत

CHAPTER III
STOCKS AND STORES

3.1 General Maintenance of Stocks and Stores

Exhaustive instructions have been given in Government Resolution, Urban Development and Public Health Department, No. BOS-1059/B, dated 3rd October 1961 and Urban Development and Public Health Department, No. VOS-1062/17879/B, dated 22nd April 1965 (Appendix 40 and Appendix 40-A) for maintenance of stocks and stores, and they should be followed in every detail.

Activities in Store

Every category of store requires to be considered with respect to the following: -

(1) Indenting,
(2) Receipt and unpacking,
(3) Storage and accounting,
(4) Issues and transfers
(5) Payment of bills
(6) Writing off,
(7) Physical verification,
(8) Registers

Principles of Material Management have been stated in Chapter I.

3.2 Instrumentsand Appliances

Indents

Certain instruments are available with Government Medical Stores and certain others from rate contract firms. The list of firms who are included in Rate Contract is decided by the Director of Industries and Central Stores Purchasing Officer in consultation with an expert committee, after inviting tenders etc.

As per the Government of Maharashtra GR dated 01/12/2016, the office purchase procedure should be followed.

In any case Government sanction for purchase is necessary if the cost exceeds that permitted by Delegation of Powers, since such items are considered as items of Special contingency'. Certain items of equipment are now centrally purchased by Directorate of Health Services such as X-ray machines, suction apparatus, operation tables etc. after ascertaining demands from various medical officers.

Receipt and Unpacking

The unpacking should be done under supervision of a responsible medical officer who should verify if the article received is intact and according to the quality and quantity for which the order as placed. Appliances and equipment require assembling and a particular type of maintenance in certain cases. Adequate attention must be given to this aspect.

If after unpacking it is found that there is any difficulty in assembling an equipment, a representative of the Manufacturer should be called to help. In all cases a pamphlet containing

detailed instructions for assembling, use, servicing and repairs should be obtained from the Manufacturer. Where necessary more than one member of staff such as 2 Staff Nurses and 2 Group D servants etc. should be trained by the Manufacturer's representative, the idea being that there should be no dislocation of work if one of the staff members goes on leave.

The time of receipt of equipment should be co-related with its functioning in such a way that the necessary buildings are ready for installation of the equipment. Electrical installations, water supply, creation of necessary posts of staff, residential quarters, if any, should be ready. In the absence of such requisites the equipment may lie unoperated for months together please.

Storage, Accounts, Issues and Transfers

Rules regarding Accounts and Issues etc. are embodied in Government orders referred to in para 16.1. The appliances, instruments, etc. should be preserved well according to the usual rules for such appliances. They should be periodically cleaned, serviced and lubricated, if necessary. The equipment should be operated by trained persons. Quick steps should be taken for repairs. For instructions regarding preservation of rubber goods.

Budget Provision

Proposals for purchase of equipment are often made as the occasion arises, without any proper planning and anticipation. Thus, they are received by the Head office at any time during the financial year. Apart from causing considerable inconvenience to the hospital concerned, an appreciable time is required to get Government sanction, and follow the required procedures for purchase. Such untimely purchases make bulk purchases difficult or impossible. Bulking of purchases is an essential requirement of economic purchases. The medical officers should therefore anticipate their requirements well in advance and include the necessary proposals in regular budget proposals with full justification. After the budget grants are sanctioned, it will be easy for the Directorate of Health Services to consolidate the requirements and make bulk purchases.

In case of unforeseen emergencies, proposals for replacement/purchase will be required to be made at any time as the need arises but the whole point is that the emergency procedure should not become a routine.

Writing off

The power to write off is equivalent to the power to purchase. The rules about writing off are mentioned in the Government Resolution referred to at the beginning of this Chapter (The power of writing off in general are mentioned in the Manual of Financial Powers).

In case of specialized equipment, the Medical Officers should obtain a certificate from the manufacturers about the article being irreparable before writing off, wherever possible. In case this is not obtainable and if no other expert opinion is available, the medical officer may decide as per his discretion.

Breakages and Losses

All reports about loss or breakage of articles should be made immediately in the prescribed form in a book; as otherwise the shortage results in inconvenience to the Hospital work. It moreover, becomes difficult to trace the loss or breakage and to fix the responsibility. After receipt of information in the prescribed form, the S.A.O./J.A.O./Resident Medical Officer or the Superintendent should himself investigate or entrust the work to the Medical Officer in charge of Ward or Section. Attempts should be made to fix the responsibility for the loss or breakages.

In a number of cases, articles which have broken or stopped working have to be repaired. Such articles are either sent to Health Equipment Repairs unit or to some workshop or necessary action is taken for the repairer to visit the Hospital itself. Quotations, etc, are called. Before any action is taken for repair, there should be an investigation as to how and why the article got broken or out of use, with a view to fix the responsibility and also to ensure that proper use of the equipment is being made.

Store-keepers have been appointed under the scheme of Minimum Requirements in most of the Hospitals. It should be their duty to keep a proper vigilance over the condition of equipment in different sections. They should take steps to get any necessary repairs done, as early as possible and if they have any difficulty, they should contact the S.A.O./J.A.O. or the Resident Medical Officer. It should be duty of one of them to see that the Store Keeper takes steps to get articles repaired without delay. Simply relying on writing is at times not enough. Contact by telephone or personally should be established and repairs expedited. An article, which is to be repaired, should be transferred from the Sectional Register to the Central Register in charge of the Store Keeper. It will then be responsibility of the Store-Keeper to account for the article.

As per rules, a sample stock of the articles in each Section is to be taken every month by the Sister In-charge of the Section. If there are any articles found short, the fact should be carefully noted, and reported. There should be no attempt to write off all these articles as unserviceable, unless a proper enquiry or inspection is done to exclude the possibility of misuse or bad handling. As regards fixing responsibility the principle to be applied should be that if responsibility cannot be fixed on a particular person, then the whole group of individuals dealing with that article will have to be held responsible. If breakages and losses are reported, as indicated above, the fixation of responsibility is easier and, in that case, occasions, when the responsibility has to be fixed on a group of persons will be few.

Whenever the responsibility for breakage or loss is fixed on one individual or group of individuals, the person or persons concerned, should be given an opportunity to put forward their case orally and in writing, if they so desire, unless the investigating officer is convinced that the breakage has been due to unforeseen circumstances. In other cases, if the investigating officer is convinced that the breakage was not genuinely due to unforeseen circumstances, and in all cases of loss, the cost should be recovered from the person or persons concerned. Before loss is actually recovered, a Show Cause Notice is essential to be given.

Whenever decision is taken to recover any amount from the person or persons concerned the fact should be informed to the Steward, Establishment Section and Accounts Section in writing, whose duty it should be to make the necessary recovery. Such recoveries should be entered in the recovery register showing collection in lump sum or periodical collection, if it is by instalment and the supervising officer should see this register every month and initial it. He must take steps to see that collection is being done as may have been ordered in each case. In case the incumbent against whom the recovery is pending is transferred to another institution, the note of recovery should invariably be made in the last pay certificate.

Occasions arise when certain articles have to be disposed of by public auction or by obtaining quotations from local dealers. (Quotations should be called as per G.R. of Govt. of Maharashtra Dated 1/12/2016) This should be done with the sanction of the higher authorities. It is necessary to decide the upset price of the appliance, with the help of a competent authority before auctioning for example the Deputy Director of Health Services (Transport) and Central Stores Purchasing Officer may be consulted, for the upset price of ambulance car or an autoclave.

3.3 Maintenance and Repairs

Preventive Maintenance. -Equipment cannot be kept in good working order without proper planning in the shape of Preventive Maintenance Programme. Such a programme can achieve;
(a) Extension of life,
(b) Prevention of break-down,
(c) Economy,
(d) Readiness of equipment to give service whenever required,
(e) Working of equipment at optimum level of functioning,
(f) Better patient and public satisfaction as an indirect result.

The principles of Preventive maintenance are applicable also to Hospital Buildings.

Periodic inspections and servicing is the vital element in preventive maintenance.

It also anticipates wear and tear, thus making timely replacement possible. Instances where patients are unnecessarily detained in the hospital due to breakdown and non-functioning of equipment are not uncommon. Preventive maintenance will minimize or eliminate such occasions, unnecessary detention of patients affects patient's turnover and increases hospitals running cost.

The loss due to absence of preventive maintenance is thus both direct and indirect. It is obvious that if the hospital charges were to be based on cost of equipment, as one of the factors, lack of preventive maintenance will result in heavier charges to patients.

There will of course be incidents where equipment goes out of order on account of unforeseen circumstances, but compared to these, the incidents of breakdown due to lack of preventive maintenance are many times more.

The medical officer in charge of the hospital must take a lead in this matter.

First, he must draw-out a list of all equipment which requires periodic inspection and servicing. Then he must make a study and find out what exactly needs to be done in respect of each item. Thirdly the periodicity of inspection and servicing ought to be decided. Detailed typed printed instructions should be drawn out and put up in the appropriate sections. Spare parts should be kept in stock. All this will have to be done with the help of the manufacturers/ suppliers.

The duties of preventive maintenance will have to be entrusted to whatever staff is available in the section in which the equipment is located.

Whenever it is found that equipment cannot be maintained properly due to lack of facilities, thought should be given to decide if the use of equipment can be dispensed with and simpler methods followed (for example working a suction apparatus by foot instead of by electricity).

Health Equipment Repair Unit

Hospitals use simple as well as complicated equipment, mechanical, electrical and electronic or it may out sourced agency for repair services.

There is an organization for maintenance and repairs of such equipment under Deputy Director of Health Services (Transport), Pune. The Project started in January 1972 with UNICEF assistance and has been taken over by Government from January 1974.

The unit has following staff:-

1) Health Equipment Maintenance Officer Class II .. 1
2) Senior Clerk Class III 1
3) (Health Equipment Repair Technicians Class III -
   - (a) Refrigeration and air conditioning 3
   - (b) Electrical 3
   - (c) Mechanical 1
4) Health Equipment Repair Helpers Class IV 2

The staff is located at Pune and the unit caters to the need of all districts in Maharashtra State. The technicians visit the districts, and after inspecting the equipment either carry out the necessary repairs or advice the concerned officer regarding the steps to be taken. Repairs are carried out at various institutions by collecting spare parts from market on behalf of the institutions. No labour or service charges are levied.

Bigger hospitals should stock spare parts as advised by the staff of unit.

Hospitals should contact this unit for repairs at the following address, and take full advantage of its services.

"Health Equipment Maintenance Officer, C/o State Health Transport Organization, Dr. Naidu Hospital Compound, Kennedy Road, Pune-411 001".

(D.H.S. Circular No. HTO/HER/Repairs, of 2nd August 1974 addressed to all Civil Surgeons etc).

The hospitals are given advance intimation of visit by unit staff for carrying out inspection and repairs. As far as possible, the necessary repairs are carried out on the spot. As regards spare parts, the unit gives a detailed report and estimates. The medical officer concerned should send the required amount as estimated, to the Deputy Director of Health Services (Transport), Pune. The Deputy Director will purchase the necessary spare parts and undertake repairs immediately. The bills and vouchers will be subsequently sent to the medical officer concerned. Any amount remaining will be returned.
(Jt. D.H.S. Pune's Circular No. HTO/HER/Equip-Repair/Funds of 21st June 1975).

In order to expedite repairs of hospital equipment, a special procedure of decentralizing the work and delegating certain financial powers to medical officers has been laid down. A reference may be made in this connection to Circular No. HTO/EST/1 (19) (2)/T, dated 23rd January 1976 from Joint Director of Health Services, Pune addressed to all Deputy Directors of Health Services, Civil Surgeons and District Health Officers. (Please refer annexure 3.3)

3.4 Cost Analysis

Budgeting and cost analysis are two important tools available to a hospital administrator to bring about economy in expenditure, and give maximum services with minimum input. Cost analysis aims at scrutiny of Cost data from records of a hospital to arrive at the cost of services rendered. Where there are more than one hospital at one place, a comparison of costs of a particular item in the different hospitals will bring out certain information which will throw light on different practices in the various hospitals, good or bad and this can be instrumental in eliminating uneconomic practices. For example, cost of diet; cost of linen services; cost of medicines per O.P.D. and indoor patient and so on. Where there is only one hospital at a place, the cost of services if studied over a period of time will bring up similar useful information. For example, cost of linen service would depend upon.

(a) Frequency of linen-change;
(b) Nature of washing;
(c) Linen in circulation;
(d) Proper usage and
(e) Rate of replacement.

The cost analysis of linen service could be done on the basis of information about the following:

1) Per Bed linen in circulation.
2) Value of linen condemned (in rupees) during one year per bed.
3) Cost of washing during the year.
4) Cost of linen condemned during the year.
5) Pay roll of whole-time linen service staff.
6) Total cost of linen service during the year (3+ 4+ 5).
7) Total patient days during the year.
8) Cost of linen service per patient day.

The data can be compared for different hospitals at one place or for different successive periods in the same hospital.

3.5 Internal Audit

Internal audit is designed to review accounting and financial matters of a hospital. Internal audit is to be conducted by the hospital itself or by the concerned Directorate by examination of financial and operational data in depth.

Such audit in very useful in respect of purchases made by a hospital, since 30-40 per cent of hospital budget is utilized for purchasing various materials. Purchasing involves not only buying but also storing, issuing and accounting.

Internal audit should establish a method of internal control for actual purchases in such a manner that responsibility for shortage of cash or goods devolves upon more than one person, i.e. collusion of two or more employees alone can cause such shortage. The purchasing processes are appraised to bring about efficiency.

The hospital administrator should study Internal Audit Reports and take appropriate decisions.

Proper financial control coupled with streamlined procedures will bring about very satisfactory results

Appraisal and scrutiny is to be made by the Internal Audit team in reference to Government standing orders and instructions, wherever such are applicable.

The functions of Internal Audit can be summarized as below:

a) To examine adequacy of application of accounting financial, and operating controls (compliance).
b) To examine steps taken to prevent losses of all kinds.
c) To find out reliability of accounting and financial data.

Internal Audit will create an awareness in staff that a watchful eye is being kept on them.

Internal Audit is required to be done with due consideration of quality of medical care.

3.6 Registers

Registers should be maintained in the form of C.M. 125(a) and C.M. 118 (e).The unit staff keeps a record of survey of hospital equipment in a prescribed form.

References:

1. Dr. P. N. Ghei and Claudius K. Tewari. Preventive Maintenance Programme is a must in every hospital. "Hospital Administration" March 1971.
2. Dr. T. R. Anand Dr. J. P. Gupta. The role of cost analysis in Hospital Administration "Hospital Administration" March 1971.
3. N. Luther. The Internal Audit of the purchasing function. Hospital Progress Vol. 62, No. 7 July 1971. "Hospital Administration " March 1972.
4. Richard S. Smith. Why not Internal Auditing Hospital Progress January 1968 Vol. 49, No. 1 NIHAE Bulletin Vol. 1, No. 2, 1968.
5. शा नि क्र -भा ख स-२०१४/ प्र क्र ८२/ भाग III/ उद्योग ४ दि. 1 डिसेंबर २०१६. Revised Manual of Office Procedures for procurement for government departments. Department Industry, Energy and Labour
6. शा नि क्र भांखस-२०२१/ प्र क्र ८/ उद्योग ४. दि. ७ मे २०२1. दर पत्रकाच्या आधारे करण्यात येणाऱ्या खरेदीची मर्यादा रु. ३ लाखावरून र. १० लाखापर्यंत वाढविणेबाबत.

CHAPTER IV
LINEN

The provision of clean linen is a fundamental requirement for patient care. Incorrect procedures for handling or processing of linen can cause infection risk both to staff and patients who subsequently use it. Hence, correct linen management is important to prevent hospital acquired infection and ensure a better hygienic hospital environment.

The term 'hospital linen' includes all textiles used in the hospital including mattresses, pillow covers, blankets, bed sheets, towels, screens, curtains, doctors' coats, theatre clothes and table clothes etc. The hospital receives all these materials for different areas like OT, wards, outpatient departments and office areas.

4.1. *Classification*

Linen required for Government hospitals can be divided into the following categories: -

(a) Bedding and associated linen.

(b) Clothing to patients.

(c) Operation theatre linen.

(d) Uniform to staff members.

For laundry purposes, linen in the hospital is classified into two categories:

- **Dirty Linen**: Dirty linen is the used linen, but not visibly soiled with blood or bloodtinged body secretions.
- **Soiled Linen**: Soiled linen is known, or potentially, infected/infested linen. All linen which is contaminated with excreta, blood or body fluids or contaminated linen from patients who is known or clinically suspected, to be infected with diseases like salmonella, hepatitis A, B, or C, open pulmonary tuberculosis, HIV etc.

Different types of linen needed in the hospital include:

- General Purpose Linen: This includes linen which is not used for patient care like curtains, drapes, table clothes and similar items commonly used in all parts of the hospital
- Patient Linen: This consists of patient clothing such as pyjamas, shirts, gowns, coats etc. worn by patients.
- Bed Linen: This consists of bed clothing such as bed sheets, pillow covers, blankets used by the patient.
- OT, Labour Room, Procedure Room Linen: This includes items such as pyjamas, kurtas, gowns, coats, shirts etc. worn by surgeons, anesthetists, OT personnel and also surgical gowns, caps, masks, trolley covers, OT towels etc. required in OT, labour room and procedure room.

Management of Linen Department must be efficient and smooth, clean and adequate linen is necessary not only from the point of view of maintenance of hygienic and aseptic conditions in the hospital, but is also required to carry out hospital procedures properly and to ensure patient satisfaction.

Before budget estimates are prepared and submitted to higher authorities, the hospital office should get the requirements of linen articles for the next year from the linen keeper. The linen keeper should estimate the requirements on the basis of certain norms and ratios.

Number of Linen Sets Hospitals need to ensure that they have at least four sets of linen per day, even though six sets are preferable.

Classification of six sets of linen needed in hospitals is as follows:

Sr No	Item	No of Sets
1	already in use (on bed)	01
2	ready to use (in sub store)	01
3	in transit-route to laundry or to the ward	01
4	in washing cycle in laundry	01
5	in stock (in central store)	02
	Total -	**06 Sets**

Thus, in an ideal situation, for a 100-bedded hospital, 600 bed sheets are needed.

In addition to above mentioned sets, 30% sets should be ready to deal with emergency situations like, Mass casualty, Disasters, epidemic/Pandemic and special needs of patients.

Hospitals need to maintain the linen stock register for available linen in the central store or with laundry in-charge of the hospital.

In this connection Appendix No. 32 may be seen which gives the norms and ratios. In order to ensure a sufficient stock, and as linen is always subject to considerable wear and tear, the total stock should be calculated on the basis of the ratios plus 30 per cent extra.

After receipt of intimation regarding actual budget allocation, the steward should immediately inform the linen keeper about the same. This will give an idea about money available for expenditure on linen to the linen keeper at the beginning of financial year. The linen keeper can then plan the purchases properly, methodically and in such a manner as not to raise audit objections. It is not uncommon to find "Distress purchase" being made in the last quarter of a financial year to avoid lapse of budget grants.

The whole object of having a central linen service is to reduce time spent by nurses in doing non-technical work. The arrangement will help to reduce extra traffic from and to the wards which are always overcrowded. Central linen department results in more equitable distribution of linen according to the requirements depending on the type of disease, for example semiconscious and unconscious patients, those with incontinence, paralysis, bed sores etc. will require more clothes compared to other patients, chances of theft are reduced with a central linen service as, wards will not have too much of stock.

4.2. Preparation, Distribution and Washing of Hospital Linen.

All linen purchased should be kept in the Central linen store and the required number of clothes got prepared by the linen keeper with the help of hospital tailors, or agencies as fixed by government from time to time such as jails, Beggar homes, resettlement colonies etc. The linen keeper should distribute linen according to requirements to the various units of the hospital. For this the units must put on their demands in the prescribed indent forms on days fixed as per hospital standing orders. The ward sisters/unit sisters should maintain adequate stock of linen i.e. the quantity according to ratios, plus 20 to 30 per cent more for emergencies. The ward sister should send all soiled linen to the central store for washing and the linen keeper should supply an equal quantity from day to day that is the supply on a particular day should be equivalent to the quantity of soiled linen received on the previous day. It is necessary that the sister first receive the washed linen of previous day before sending another batch of soiled linen on a particular day, otherwise the patients will be inconvenienced.

The unit sister before sending soiled linen to the central store must necessarily ensure that *primary cleaning and washing whenever necessary is done in the unit.* Such cleaning is to be done by the sweeper of the unit and cannot be done by Dhobis or any staff of linen store. If this is not done the central linen store will become filthy and this may create an intolerable situation there. The idea in channeling the washing through the central linen store is to minimize the non-medical work load of nursing staff. Where there are no laundry machines, Dhobi hat in hygienic surroundings must be provided. List of linen required for hospital set up, may be seen in annexure 4.1.

4.3. Linen Keeper

There ought to be a central linen store in each hospital and the linen keeper should be in charge of the store. All transactions regarding linen should be processed through this store and through the linen keeper. The linen keeper should keep the hospital stretchers neat and tidy by replacing the stretcher-cloth as frequently as possible. The stretcher should be maintained in a good state of repairs and should be always used with a rubber and cloth cover. If in spite of this precautions the stretcher cloth gets soiled or torn beyond repair and washing it should be discarded and replaced by new cloth.

Mending. -The linen keeper is responsible for mending of torn hospital clothing wherever possible. For this purpose, such clothing should be sent to the central linen store by the different units. The mending should be arranged with the help of tailors who may be on the staff of the hospital or with the help of outside agencies. The linen keeper may pay a visit to the concerned unit to see if the pieces are such as can be mended.
In the meanwhile, the linen keeper should supply an equal quantity of fresh articles to the unit and these may be taken back after supply of mended articles.

4.4 Linen Management

The basic principles of linen management are as follows:

A) In-house Processing of Soiled Linen: -

1) Place used linen in appropriate bags at the point of generation

2) Contain linen soiled with body parts or fluids within suitable impermeable bags and close the bags securely for transportation to avoid any spills or drips of blood, body fluids, secretions or excretions

   - Do not rinse or sort linen in patient care areas (sort in appropriate areas)
   - Handle all linen with minimum agitation to avoid aerosolization of pathogenic micro-organisms
   - Separate clean from soiled linen and transport/store separately

3) Wash used linen (sheets, cotton blankets) in hot water (70°C to 80°C) and detergent, rinse and dry preferably in a dryer or in the sun
4) Wash woolen blankets in warm water and dry in the sun, in dryers at cool temperatures or dry-clean.
5) BEDDING:

   - Mattresses and pillows with plastic covers should be wiped over with mild disinfectant.
   - Mattresses without plastic covers should be steam cleaned if they have been contaminated with body fluids. If this is not possible, contamination should be removed by manual washing, ensuring adequate personnel and environmental protection.
   - Wash pillows either by using the standard laundering procedure described above, or dry clean if contaminated with body fluids.

B) Outsourcing of Linen for Processing: -

1) Segregate soiled / dirty linen from unsoiled used linen at the point of generation
2) Count and record the soiled linen and pack in separate bag.
3) Label the bag for appropriate Bio hazard precautions.
4) Count and pack used but unsoiled linen in separate bag.
5) Handle all used linen with proper bio septic precautions.

Format for Record of In-house Laundry Services:

Sr No	Description	COLOR	No sent to Laundry	Sign of Sister Incharge/ Staff Nurse	Sign of Laundry man	Remarks

Format for Record of Laundry Outsource Services

Sr. No	Description	COLOR	No sent for Laundry		No received from laundry	Signature of Linen Keeper	Signature of Incharge of	Remarks
			Soiled/Infected	**Unsoiled**				

							Outsourc e Agency	

PROCESS OF LINEN MANAGEMENT IN THE HOSPITAL

LABELING OF LINEN

All linen being used in hospitals needs to be labelled for identification and traceability. Proper labelling of the linen also helps in proper inventory management. The label of the linen includes the following minimum details:

- Name of the hospital (XYZ)
- Name of the Department or Number of ward (ICU/OBS/WARD)
- Type of linen like Bed Sheets (BS), Patient Gown (PG), Pillow Cover (PC)
- Number of linens i.e. 1, 2, 3…
- Doctors coat labelled with Doctor's name for example, bed sheets used in ICU of hospital can be labelled as: XYZ/ICU/BS/1, similarly bed sheet in general ward 1 can be labelled as: XYZ/GW1/BS/06

LINEN COLLECTION AND SEGREGATION

- The hospital should have fixed schedule for the collection of linen from different areas of the hospital
- All the linen of critical areas like OT and ICU etc. need to be changed daily
- The staff linen needs to be changed on weekly basis or as required.
- While collecting linen, care should be taken to ensure all sharps or patient equipment are removed.
- Staff should wear appropriate PPE like heavy duty gloves, apron and mask during linen handling. Any skin lesions on hands should be covered.
- Hand hygiene should be practiced after linen handling.
- Linen needs to be collected in bags and trolleys and should not be placed on the floor or any other surfaces.
- All the linen generated from patient care areas should be segregated into dirty and infected linen. Linen generated from different areas of the hospital needs to be collected in different colour coded trolleys.
- Dirty linen needs to be collected in a green colored trolley and soiled linen in yellow colored trolley. The laundry management protocol of the hospital needs to include segregation guidelines for all the staff of the hospital.
- To minimize aerosoliznation of any organisms contaminating linen, linen should not be rinsed, shaken or sorted in the clinical area. The personnel should keep his/her hands away from face while handling linen.

- The collected linen needs to be stored at a designated place i.e. in dirty utility of the area of generation.
- The attendant/sister in-charge of the area needs to update the daily transaction register every time linen is collected from the area. The transaction register should include the details of the number of different types of linen items collected from the particular area. A separate register has to be maintained in different areas for the same.

TRANSPORTATION OF LINEN

- Linen collected from different areas of the hospital needs to be transported in the covered trolleys to the laundry.
- Dirty and soiled linen needs to be transported in separate trolleys.
- A dedicated trolley for transportation of linen needs to be used and trolleys used for waste collection or any other purpose should not be used for transportation of linen
- During transportation it is to be ensured that the bags used for collection of linen are properly tied.
- In case of any spillage of the soiled linen during transport, the linen needs to be securely placed in the transportation trolley and cleaning of the surface is undertaken as per the spill management protocol of the hospital.

RECEIVING IN THE LAUNDRY

The person responsible for receiving linen in the laundry needs to enter the details of the linen in the receiving and distribution register at the laundry. The details include type and quantity of linen received, the department from where linen is received, time and date of receiving. Records are necessary to ensure quality assurance of linen and laundry management in the hospital.

DISINFECTION AND SLUICING

The first step of processing of the soiled linen is disinfection and sluicing of the linen. All infected linen needs to be soaked in 0.5% bleaching solution for 30 minutes, then thoroughly rinsing of the linen is carried out with plain water to remove the bleach. The linen is then handed over for washing. If the laundry services are outsourced, it is the responsibility of the hospital to disinfect and sluice the soiled linen within the facility itself before handing over the same to the outsourced agency or personnel for further processing.

WASHING

- Washing by Hand

STEP 1: Wash heavily soiled/infected linen separately from non-soiled linen

STEP 2: Wash the entire item in water with liquid soap to remove all spoilage, even if not visible

REMEMBER: Presoak in soap, water and bleach ONLY if linen is soiled

- Use warm water if available
- Add bleach (for example, 30–60 ml [about 2–3 tablespoons], of a 5%chlorine solution) to aid cleaning and bactericidal action
- Add sour (a mild acid agent) to prevent yellowing of linen, if desirable

STEP 3: Check the item for cleanliness. Rewash if it is dirty or stained

STEP 4: Rinse the item with clean water.

- Machine Washing

STEP 1: Wash heavily soiled linen separately from non-soiled linen

STEP 2: Adjust the temperature and time cycle of the machine according to manufacturer's instructions and the type of soap or other washing product being used

STEP 3: When the wash cycle is complete, check the linen for cleanliness. Rewash if it is dirty or stained. (Heavily soiled linen may require two wash cycles)

Dirty Linen: Dirty linen (non-infected linen) is to be washed in the first batch, with plain water and detergent. Use of hot water with temperature > 71°C is recommended.

Soiled & Infected Linen: Infected linen is defined as linen derived from known infectious patients, including those with HIV, Hepatitis B, C and other infectious agents. After sluicing the infected linen is treated with hot water and detergent having temperature of more than 71°C with a minimum wash cycle for 25 minutes.

HYDRO EXTRACTING AND DRYING

- Washed linen is put in the mechanized hydro-extractor for extraction of water from the processed linen. If hospital does not have the facility of hydro extracting the linen can be put to air dry in direct sunlight
- During the process of drying of the linen it is to be ensured that the linen is kept off the ground and away from dust exposure.

REPAIR OF LINEN (IF NECESSARY)

- All the linen is checked for any damage, wear and tear
- In case of any damage like minor hole or tear observed, it should be sent for repair and mending
- If the linen is severely damaged and cannot be repaired, the same can be discarded or condemned as per the hospital condemnation policy, by the laundry supervisor.

CALENDERING AND IRONING

- Bed sheets and other heavy linen needs to be calendared with mechanized calendaring machines installed at the hospital.
- If the hospital does not have the facility of calendaring machines, the linen needs to be ironed using flat work iron and is folded properly.

DELIVERY OF CLEAN LINEN

- The processed linen is transported in clean covered trolley to the central store.
- It is to be ensured that the storage of clean linen before distribution is separate from dirty linen
- From the central store the clean linen is issued to respective departments based on the indent generated from the departments

- From the central store the linen is distributed to respective departments in the clean trolleys
- Record of issued linen needs to be updated in the central store room while the respective departments need to update the transaction register with the details of linen received in the department.

4.5 BEDDING

- Mattresses and pillows with plastic covers should be wiped over with disinfectant such as 70% alcohol or 1% chlorine solutions.
- Mattresses and pillow cover without plastic covers should be washed with water and detergent and left for air drying after discharge of every patient, or on weekly basis if occupied by same patient
- Blankets may be dry cleaned or hand washed. It can be done by soaking for 15 minutes in lukewarm water. Then soap suds are squeezed through the blanket and then rinsed in cold water at least twice. The blanket should not be twisted or wrung. It should be dried by spreading on clean surface.

Care of Mattresses. - As per possibility, use coir mattresses in hospitals since they are washable. However, with proper precaution cotton mattresses could also be used in certain cases. The mattresses should be covered by mattress covers and in addition by bed sheet, drawsheet and mackintosh. The mattresses should be protected by a carpet below it. Durries should also be used if mattresses are put on the floor. If the mattresses are put directly on the cots or on the floor, they are likely to get torn easily.

4.6. Change of Linen.

The patient's condition demands the linen must be changed whenever soiled. Every patient on admission must have fresh linen including the wearing apparel.
In order to transform the hospital, it has been instructed to provide clean sheets and pillow covers to the patient each day with colour coding, in practice.

Monday and Thursday	White sheets
Wednesday and Saturday	Pink / Blue sheets
Tuesday, Friday and Sunday	Green sheets

4.7. Purchase, Preservation and Accounts.

The linen keeper is to keep account of linen in a prescribed register i.e. CM 160(e) and CM 118(e). Linen Keeper should preserve the linen properly well protected from dust, moisture, insects and termites etc. It is necessary to turnover those pieces, which remain unused for a long time, frequently. Pest control measures should be carried out, and naphthalene balls etc. should be used.

Articles of hospital linen is required to be purchased from various sources. (Please see Civil Medical Code, Chapter 21). Requirements of Khadi may be intimated in advance to Khadi

Bhandars. The hospital steward should apprise the linen keeper thoroughly about the latest government orders in this regard. A set of such standard orders should be available in the hospital office as well as in the central linen store. For details, please see Chapter 21 of Civil Medical Code. The purchases should be made in consultation with users.

The Civil Surgeon/Medical Superintendent of the hospital should form a small committee (linen committee) to select suppliers on the basis of their samples and their rates. In this connection it is worthwhile noting that as far as mill cloth is concerned, Indian standards Institute specifications are available and they may be taken into consideration before purchasing mill cloth.

Records: List of files and registers to be maintained for linen management in the hospital:

- Linen stock register at the central store
- Area wise daily transaction register
- Laundry and linen receiving register and distribution register at the laundry.
- For Register for recovery, refer annexure 4.2

4.8. Preventing Theft and Misuse.

Hospital linen is always subject to theft. Frequent check up on linen articles in different units of the hospitals should be made in order to detect missing articles. In fact, it has been recommended that the wards and units should make a daily count of linen articles. If this is done theft can be detected in time. Secondly, all hospital linen articles should have an ingrained emblem of the hospital or should be stamped in such a way that the imprint is indelible. The stamp should be as follows:

"For …… Hospital use only. "

This work should be arranged by the linen keeper. Staff members should not be allowed to use hospital clothing outside the hospital for private work and if any such cases are found the necessary disciplinary action should be taken against the erring staff members.

Incidents of theft are more common in the maternity and children's wards. In the maternity ward there is a large number of small articles and it is easier for the theft to occur. Particular care must be taken to prevent thefts in this section.

Government have issued orders regarding standard procedures of recovery of breakage and loss of equipment and linen in government hospitals and nursing homes attached to government hospitals.

4.9. Condemnation of Linen.

Condemnation of linen articles is required to be done from time to time. It would be convenient if the linen committee referred to above is also entrusted with the work of deciding as to which articles of linen are to be condemned. The linen keeper should arrange for periodical meetings for condemnation of linen in the hospitals. The unserviceable articles should be torn into pieces which can only be used as dusters. They may be supplied to jails which use them for preparing paper.

1. Soiled linens are discarded in non-chlorinated yellow plastic bags as per BMW rules 2016 and as per CPCB guidelines
2. Severely damaged linens are discarded or condemned as per the facility condemnation policy

In some hospitals some wily persons play a trick by replacing good pieces of linen articles by those which are condemned. Hence the linen which is condemned should be torn and used as rags. In rush of routine hospital work it may be difficult for hospital staff to detect substitution of the type referred to above, but a close watch over the disposal of condemned articles will put a halt to such practices.

Approval to condemned linen should be given by the District Surgeon/Medical officer. The ward in charge should send the condemned linen to linen keeper and should take the note of it in the register. Also, linen keeper should take a note of it and submit the condemned linen to the storekeeper.

CONDEMNATION COMMITTEE:

Hospitals need to form a Condemnation Committee for carrying out the activities of condemnation of junk from the health facility. The Condemnation Committee needs to have a representation from different categories of staff, as prescribed in the state level condemnation policy.

The suggested membership of the Condemnation Committee to be formed at the hospital is as follows:

- Civil Surgeon/Medical Superintendent of the institution.
- Additional Civil Surgeon/Senior Medical Officer.
- CAO/AO/OS
- Nursing Superintendent/Matron/Incharge Sister/Senior nursing staff of the institution
- Store in charge/Storekeeper/Linen keeper.

The constitution of the committee may vary from institution to institution depending on the availability of the mentioned posts; the changes may be made by the Head of the institution.

Meeting Schedule:

The Condemnation Committee formed at the hospital needs to meet at least once in six months or when required.

Responsibilities of Condemnation Committee

The major responsibility of the Condemnation Committee formed at the facility may include following:

- To frame/follow the condemnation policy at the hospital
- To inspect all the areas of the hospital for any junk material present/accumulated in various areas of the hospital
- To decide the minimum offset for which tendering is required and minimum offset for which public auctions can be made.
- To gather and maintain information or list of items from different areas of the hospital that need to be condemned or are beyond use.
- To maintain a list of items that are stored in the hospital for condemnation
- To inform all concerned regarding the condemnation activity to be undertaken by the facility
- To approve the condemnation of junk and other materials
- To demarcate and allocate space within the hospital for storage of junk material before its disposal
- To maintain records of the items that are condemned by the health facility
- To follow relevant rules while disposing of the condemned articles e.g. E-waste management rules, BMW management rules etc.

4.10 Miscellaneous:

Useful Hints.

On an average the life of hospital linen varies from 1 to 3 years-In view of this 100 per cent stock will require to be replaced where life of the linen is for 1 year and about 33 per cent where the life of the linen is about 3 years. It is possible to know which articles will last for 1 year, 2 years, 3 years etc., if a watch is kept for a period of 2 to 3 years. Although ratios have been prescribed for various types of linen the actual quantity in stock is in many cases less than what it should be. A survey should therefore be undertaken by hospitals to bring the quantum of linen on a proper level. The inspecting authorities should also keep this in mind and make specific comments in this matter. As already referred to the idea is to have about 30 per cent extra linen over and above the admissible ratio.

The hospital authority should find out whether there is adequate storage space for the various articles of linen. The Central store must be spacious to accommodate all linen which is not distributed. The various units should also have sufficient storage space in the shape of linen cupboards or the rooms meant for storing linen should have adequate racks preferably of steel.

It is a common experience to see that there is an appreciable gap of time between the placing of indent for linen articles and the actual time of receipt. Keeping this in view the Medical Officer Incharge of hospital should see that the hospital has at any time a sufficient stock of linen to last at least for 6 months, The indents should be prepared with a view to keep this margin.

The central register of linen should invariably mention the cost of article of linen and also the cost of stitching.

Linen keeper should maintain a length account so as to ensure that the quantity issued for preparing clothes does not exceed the prescribed schedule. This system will ensure a check over the conversion of cloth into patient's clothing and over the number of articles received from a tailor. It is advisable for a small hospital to have the post of Ward boy cum tailor. In absence of such a post at least two ward boys should be trained to do minor tailoring work. In bigger hospitals there should be one or more tailors on the staff depending upon the size of the hospital.

The hospitals should provide adequate facility for sterilization of mattresses and blankets. For thismattresses sterilizer will be necessary.

In those hospitals where there is no post of a linen keeper, one of the clerks from the hospital should be entrusted with this work. The whole idea is to reduce the non-medical work on the part of nursing staff. As already referred to articles of soiled linen before being given to a dhobi must undergo a primary wash at the hands of sweepers. It is obvious that there should be adequate arrangements for drying such clothes. Similarly, the dhobis must be provided with adequate space with shade for drying. Absence of such arrangements is particularly troublesome during rainy season. Any drying place in the hospital compound should be protected by a compound of barbed wired to prevent theft.

While putting a stamp on articles of hospital linen, the staff uniform also should be included. The stamp should show the month and year of purchase. This will help to investigate cases of loss and also at the time of condemnation of linen.

Inventory Control. - Management of linen store is subject to the usual principles of material management and inventory control. Norms for linen are given in annexure 4.3.

Responsibility duties of linen management staff:

- Change of Linen - Staff Nurse/Ward Attendant
- Sorting and storing of used Linen - Ward Attendant/Housekeeping Staff
- Disinfection of Soiled/Infected Linen - Housekeeping/Laundry Staff
- Collection of Used/Soiled Linen - Laundry staff
- Counting of Collected Linen - Laundry Staff/Nursing In-charge
- Transporting Dirty Linen - Laundry Staff
- Washing, Drying and Ironing - Laundry Staff
- Receipt of Washed Linen in Departments - Nursing In-charge
- Storage and Issue of Washed Linen - Nurse In-charge

Canvas Bags. -All units should be provided with canvas bags for washerman to collect the soiled pieces of clothing. It is a common site to see the dhobis tying all the dirty clothes in a bed sheet or some such piece of cloth. This leads to unnecessary wear and tear of hospital clothes and they also get more soiled.

Dos and Don'ts: (refer annexure 4.4)

Do's

- A rack for keeping used and ready linen should be available close to the point of use.
- Sharps to be removed from the linen.
- Appropriate tagging and labeling of linen bags.
- Decontaminating hands immediately following removal of PPE after handling used linen and before handling clean linen.
- A disposable plastic apron should always be worn when handling used linen and disposable gloves should be worn where linen is soiled/foul.

Don'ts

- Carry used linen close to the body.
- Drop linen on the floor.
- Shaking linen as this will result in the dispersal of potentially pathogenic micro-organisms.
- Overfilling of used linen bags
- Linen bags containing used linen stored in corridors (should be kept in a separate designated area)
- Storing clean and used linen in the same area.

RECORDS

List of files and registers to be maintained for linen management in the hospital:

- Linen stock register at the central store
- Area wise daily transaction register
- Laundry and linen receiving register and distribution register at the laundry.
- For Register for recovery, please refer annexure 4.3.

References:

1. Guidelines for Implementation of "KAYAKALP" initiative, Ministry of Health, Government of India, 2015
2. Hospital administration manual (revised) volume –II, June 1976, Para 13.2, appendix 32 no 124/68972/D of 1956 dt 29/12/1956).
3. Directorate of Health Services, Government of Maharashtra, Mumbai vide letter no. DHS/TRANSFORMATION/RIVIEW/DIRECTORS ROOM/2015 DATED 12/02/2015
4. Safety & Quality Self-Assessment Tool for healthcare facilities (SaQushal), Ministry of Health and Family welfare, Government of India, 2016
5. GR No VAPR-2013/Q.NO 30/2013 dated 17th April 2015 Finance Department, Government of Maharashtra
6. Guidelines for Central Sterile supply department (CSSD) and mechanized laundry, Ministry of Health and Family welfare ,Government of India.

CHAPTER V

HOSPITAL STATISTICS AND MEDICAL RECORDS

Hospital Statistics.

5.1 Introduction

Hospital statistics deals with quantitative and qualitative aspects regarding hospital performance. Hospital Statistics is an integral part of logic of all scientific methods. It is necessary to make observations and interprete them. It enables administration to take informed decisions in health planning. Measurement and monitoring of quantity or quality of work, (Efficiency and Effectivity), study of causative factors in disease can all be perused on the basis of hospital statistics.

HMIS (Health Information and Management System) is necessary for preparation and submission of various periodical and statistical returns. Compilation of hospital statistics means application of scientific outlook to principles. Accurate and reliable statistics will be of great value in measuring past performance in comparison with today's performance so that a projection can be made into the future. The statistics serves as an important link in hospital administration. Statistics is particularly valuable for expanding hospital care. It is used to identify special risk groups, detect new health threats, plan public health programs, evaluate their success, and prepare financial planning of Hospitals.

Health Management Information System (HMIS) is a Government to Government (G2G) web-based Monitoring Information System that has been put in place by Ministry of Health & (MOHFW), Government of India to monitor the National Health Mission and other Health programmes and it provides key inputs for policy formulation and appropriate programme interventions.

HMIS is being utilized for grading of health facilities, identification of aspirational districts, review of state programme implementation plan (PIPs) etc. The analytical reports generated through HMIS also provide gap analysis and evidence-based course correction. HMIS was launched in October 2008. Currently, around 2 lakh health facilities (across all States/UTs) are uploading facility wise service delivery data on monthly basis, training data on quarterly basis and infrastructure related data on annual basis on HMIS web portal.

HMIS captures facility-wise information as follows:

- **Service Delivery** (Reproductive, Maternal and Child Health related, Immunization family planning, Vector borne disease, Tuberculosis, Morbidity and Mortality, OPD, IPD Services, Surgeries, NCD, Mana shakti Clinic etc. data) on monthly basis.
- **Training Data** (Trainings imparted to Medicals and Paramedics staff at District, Regional and State level data) on quarterly basis.
- **Infrastructure** (Manpower, Equipment, Cleanliness, Building, Availability of Medical Services, Super Specialties services, Diagnostics, Para Medical and Clinical Services etc. data) on annual basis.

5.2. Overview of Hospital statistics:

Health statistics It is science of collecting, analysing, presenting, and interpreting Health and Medical data.

1. Measuring Hospital performance in terms of
    a. Output indicators
    b. Outcome indicators
    c. Process indicators
    d. Validation indicators
    e. Morbidity and Mortality indicators
2. Establishing benchmarks of various indicators
3. Identification of processes and protocols for qualitative uploading of data on portal in order to get correct information to administration and Health planners
4. Dissemination of measures to be taken in uploading correct data to Health care providers.
5. Analysis of data and drawing conclusions from it.
6. To track and monitor trends and patterns of diseases and see the impact of Health policy.
7. Assess the quality, mortality and morbidity information, processes involved along with validation of data
8. Making predictions about future events and behaviour.

The various indicators in hospitals for analysis are as given in annexure 5.1.

5.3 Uploading of Health statistics:

Data is to be collected in data sheets from all departments in Hard copy on 3rd and 4th of every month. Data entry to be done on 5th of every month. For data quality validation Committee meeting to be conducted on 6th of every month. Data collected is then validated and possible data errors are to be removed. Hospital Data thus finalised up to 7th of every month.

5.4 Validation Committee:

Responsibilities – In District Hospitals Statistical Assistant is placed. In Sub District Hospital, Rural Hospitals this work is handled by Staff Nurses. Additional Civil Surgeon, Matron, Staff Nurses of various departments along with Statistical assistant prepares hospital report monthly.

Validation Committee at RH/SDH-

- Med. Supt – Chairman
- Med. Officer – Member
- Assistant Metron/Incharge Sister/Staff Nurse – Member
- Pharmacist – Member Secretary

Validation Committee at DH/GH/WH-

- Additional Civil surgeon – Chairman
- Matron – Member
- Pharmacist – Member
- M & E Officer – Member Secretary

Hospital Statistics is used for various meetings, furnishing information under RTI, replying assembly questions, research, evidence-based management – for different proposals, expansion, new facility creation

Patients Feedback System – Mera Aspataal

This application is developed by Government of India to assess hospital services. Both Online and offline methods are available. In online method data will automatically be transferred to Mera Aspataal portal from E-hospital portal. In offline method OPD clerk will enter details of patients in 9 Columns format and upload it of Mera Aspataal portal. Patients feedback on different areas of hospital work such as Cleanliness, Doctors Behaviour, Nurses Behaviour, gets generated through this portal.

5.5 Births and Deaths Registration

Births and Deaths Registration Act 1969 which is enforced in urban and rural areas of Maharashtra State from April 1970, and Government notification dated 12/04/2018 all hospitals are supposed to establish birth and death registration system. Separate portal is made available under Civil Registration System by GOI. Birth and Death events occurred inside Hospital are to be registered and issue certificates to beneficiaries. All hospitals should keep the following books:

(1) Physicians Handbook of medical certification of cause of death, 1968.
(2) International Classification of diseases, Volumes I and II, 1965 (ICD 11)

Medical Records*:*

5.6 Rules and Regulations.

All hospitals must procedures to maintain records and in this connection, rules and regulations laid down by higher authorities must be observed. Doctors in different hospitals sometimes resort to their own "medical shorthand " while writing history or notes. This practice must be discouraged and records written in a uniform manner. Local shorthand may cause errors in interpretation and inability of other doctors to grasp what is written.

5.7 Contents of Medical Records.

There are three main areas where medical records are written viz. (a) Registration and admission section (b) O.P.D. and (c) Indoor wards. The records can be considered according to the following classification:

Administrative and Sociological Data. -The outdoor and indoor case papers have columns such as name, age, address, occupation, income etc.

These could be called administrative and sociological data. The registration number, the name of chief of unit, the department, the number of unit and ward and time of arrival of patient in the ward must be written. Date and time of admission, the date, time and mode of discharge or death, signature of sister Incharge, the consultant and assistant doctor/doctors, the provisional and final diagnosis, operation notes, complications and cause of death should be written.

The reverse of first indoor sheet should show the following:

Admitting officers' notes and treatment and orders given by him. Particulars regarding medico legal and Police cases. Receipt of any cash or ornaments of patients. Consent for diagnostic investigation, operation, anaesthesia, transfusion. Whether relatives were present or not present at the time of patient's death.

(B) Medical Section of the Record.
This will contain History of the patient: -
Physical examination, Investigations, Provisional diagnosis, Treatment and orders, Progress notes, Condition on discharge, Final diagnosis, Autopsy report.

In this category of records facts must be stated first before giving any opinion or conclusions.

Provisional diagnosis is naturally a tentative one but the final diagnosis should be complete and accurate and should include a etiology and anatomical to or physiological system involved.

When opinion of colleagues or other consultants is solicited, it should be obtained in writing.

Similarly written reports of investigations signed by a competent authority should be obtained.

All orders for treatment must be written, signed and dated by the attending doctor. He can give oral orders to his assistants, who will then write down the orders for him, with signature and at the same time indicating who have ordered. On the next visit the attending physician should sign such orders. Details of medication, diet and other treatment should be written.
The A separate treatment card for the attending doctor is desirable. He can find out at a glance what treatment he has prescribed. The Nurses can more easily find out which treatment has been started when and when it is stopped a part of medical record of the patient.

If treatment is operative, the record must show the diagnosis and fitness the patient to undergo operation.

Prior to anaesthesia, the Anaesthetist must record his findings of the patient. He should also fill in details pertaining to his section "operation note ", including post-anesthetic condition of the patient.

All notes regarding pre and post operative diagnosis, mode of operation should be filled as per columns on the "Operation Note" by the attend doctor or under his supervision. These notes must be entered immediate after the operation.

"Daily notes" should be written on the case paper as often as there is so thing to report. The progress notes should be accurate and definite and not vague.

The final progress note is "Condition on discharge ". It should show the general condition of the patient, the condition of the particular disease, prognosis with reference to resuming usual work, further treatment to be carried out and follow up instructions.

The first sheet is a summary sheet and it must contain notes as indicated b various columns and signature of the attending doctor. Only then can the record be called complete.

A set of forms of Case Sheets, operation notes, Radio diagnosis and laboratory reports etc. Should be preserved and attach to record.

5.8 Preservation of Medical Record.

Writing good medical records will be of no use if they are not easily retrievable. The record must be preserved suitably to make it available easily when required. After the patient's discharge the record is filed numerically and indexed in a patient's index, so that it is easily available if the patient attends the hospital again. In addition, the preserved record is useful for evaluating patient care, evaluating arrangement of the hospital, for preparing various reports and analysis, for evaluating doctor work, for research etc. Bigger hospitals must have a separate Medical Record Department for this purpose. The retention period of medical records is as per given in Annexure 5.2.

5.9 Legal Aspects of Medical Records.

Medical Records are a property the hospital. Personal data of the patient is a confidential communication and is a property interest of the patient. The hospital can of course use the records for its legitimate functions. The personal data cannot however be released unauthorized.

A patient wanting access to his record should be directed to his attending doctor.

Sending of medical records, wholly or in part outside the hospital except in response to a summons of the court is subject to criticism.

Medical Records are required for: -
(a) Insurance cases;
(b) Ccompensation;
(c) Personal Injury suits;
(d) Malpractice suits;
(e) Will cases;
(F) Criminal cases for murder, assault, rape, certification of mental patients etc.

5.10 Release of Information.

Any third-party wanting information from record should produce a signed and dated consent from the patient concerned. If the patient is a minor or legally incompetent the consent should be signed by the parent, guardian or legal representative. Though legally not necessary, the attending doctor's signature should also be obtained as a matter of courtesy. This policy applies to enquiring doctors also.

When the patient dies the administrator or executor of the estate usually has the right to authorize the release of information.

Under no circumstances should the Medical Record Cleark, or any other hospital personnel such as nurses, interns, or even doctors, release information from the medical record, without the authorization of the patient or responsible relative.

Abstracts or summaries may be sent to physicians to whom the patients are being transferred, or to a physician who referred the patient to the hospital, or to a hospital or nursing

home or other institution to which a patient is being transferred. If the request for an abstract or summary comes from the attending physician, or from a hospital in which the patient is currently hospitalized, authorization of the patient is not generally considered necessary.

General Policies for the Release of Information.
(i) Apart from the physician treating the patient, no information of a medical nature should be revealed by any employee of the hospital.

(ii) The hospital should not voluntarily use the record in any manner why will jeopardize any of the interests of the patient with the exception that the hospital itself will use the record, if necessary, to defend itself or it's agent against unjust accusations made by patients or others.

(iii) Members of the resident and attending medical staff may freely consult in the medical record department such records as pertain to their work, unless there be suspicion that one of these individuals wishes to consult a record for purposes not favorable to the interests of the patient or the hospital. Should there be such doubt in the mind of the medical record staff, access to the particular record may be refused, and the matter referred to the head of institution for decision.

In no instances are copies of medical records to be made without the special approval of the person in charge of Medical Records who will confer with the administration in case of doubt. No member of the resident medical staff may issue any verbal or written information to persons outside the hospital origination without the written approval of the administration in each such instant (Exception; discussion of progress of each case with relatives or friends when have a legitimate interest).

(iv) Staff doctors may not give authorization to insurance companies or lawyers to secure medical records.

(v) The social service and follow-up departments shall have access to medical records and hospital may reveal the social contents of the same to regularly organized and reputable social agencies who have a legitimate reason

(**vi)** Requests by patients for information concerning their own recording should be referred to the attending physician in charge of the same.

(vii) All requests for information should be in writing. Individuals requiring medical information should be referred to the attending doctors.

(viii) Information may be given to hospital's legal representative, to enable him to protect the hospital's interest.

(ix) Outside doctors enquiring for information are treated with courtesy. However, supplying the information from either the Medical Records Department or from any other section of the hospital is subject to proper authorization from the patient.

(x) Medical Records should not be taken from one section of the hospital to another except for legitimate hospital work. It is preferable to study the record in the record section itself. The administration can authoringze use of record for research by hospital doctors. Outside doctors will require authorization from the administration.

(xi) If any record is retained by a Court, a receipt for the same should be obtained and kept in hospital record. Pages should not be removed while handing over record.

5.11 Correction of Original Data.

If the patient in a hospital desire to correct data in his respect, he should give a written application for the same, at no corrections should be made after the patient leaves the hospital, unless he produces an affidavit from a magistrate.
Any mistake in writing notes should be lined through with signature and date and the correction written immediately thereafter.

A signature of a staff member signifies agreement with data above the signature. Rubber stamps and merely initialling should be avoided.

5.12 Responsibility and Supervision of Medical Record

It is the duty of medical staff to follow all rules and regulations for writing correct medical records. The administrative staff must supervise and enforce whatever norms are decided. The attending doctor is primarily responsible for accurate and adequate medical record, though physically it might have been written by his assistants. The attending doctor should check for completeness of the record (History. physical examination, investigation reports, operation notes, prenatal and arbour record, record about consultations, progress notes, nurses' records and charts, diagnosis column, signatures etc.).

The head of the institution should study records of patients discharged in the previous month on the basis of sample percentage. He should apprise the concerned doctors about defects and give them the necessary instructions.

The chief of the unit should review the records of his unit during his daily rounds in the wards.

Common Defects. The following defects are commonly noticed even taking into account that there may be no special staff:

a) The work of the medical record section starts after all necessary entries are made on case papers. Here, a great amount of indifference is found on the part of medical and nursing staff. Recording is done as a mere ritual.
b) Standard nomenclature of diseases, standard terms, forms and procedures are not followed.
c) Incomplete entry of diagnosis or leaving the column blank especially regarding the Final Diagnosis" and diagnosis on O.P.D. case papers.
d) Issuing verbal instructions.
e) Incomplete record in general.
f) Unsatisfactory preservation. The record is difficult to retrieve and when available it is torn and disfigured.
g) O.P.D., Indoor and Operation registers are incomplete and defective.
h) Statistical report are prepared as a mere ritual.
i) Staff thinks that this work is mere waste of time.
j) There is no co-ordination between different sections of the hospital especially for preparing hospital statistics.

In fact, much can be done even without special staff to write the medical records properly which is entirely the responsibility of medical and nursing staff.

References:

1) Circular dated 12/04/2018 to establish birth and death registration system in all hospitals.
2) F No A 12034/3/2014-MH-II/MH-I dated 28th Oct 2014. Ministry of Health and Family Welfare, Directorate General of Health Services, Government of India.
3) Maharashtra Registration of births and Deaths Rule 2000

CHAPTER VI

AMBULANCE SERVICES (WITH EMS)

6.1. Introduction

The Ambulance Driver should be held fully responsible for the proper maintenance of the ambulance and for its repairs in time. For this purpose,inspection should be done by a responsible person.

The Driver must have strict instructions to check the water and coolant, oil, Fuel, Adblue level (for Euro VI & BS VI Vehicles Only) brakes and Electrical Lights & Indicators every day at a particular hour in the morning.

A periodical servicing must be ensured and where there is only one ambulance alternate arrangement for transporting Emergency cases must be made during servicing and repairs. The necessary repairs should be carried at District Workshop (Transport/ Authorized dealers/ Local workshops) with the help of Service Engineer.

In order to maintain the ambulance in good condition each one should be provided with a garage. Since the ambulance may be required at any time of the day and night, it is obvious that the ambulance Driver must be available on the spot and for this reason he must be provided with quarters in the hospital premises.

6.2. Rules for Use

The ambulance should not be used for extraneous purposes, other than those mentioned in the rules. All the rules regarding the use of ambulance in Government Hospitals have been embodied in Urban Development and Public Health Department Resolution No. BMS 2160/B, dated 16th August 1961.

Keys-The keys of the ambulance garage should be with the ACS or a responsible Medical Officer.

Conveyance of Dead Bodies

The Ambulance should not be used forcarrying dead bodies It is sometimes necessary to use great tact and persuasion while refusing ambulance for such a purpose.

Appointment of Substitute Driver

There are occasions when the regular ambulance drivers goes on casual leave. There is a provision that under such circumstances another driver can be temporarily appointed by Civil Surgeons and this should be done before the driver is allowed to proceed on leave The driver is to be paid from ‘Contingencies’.

Though according to rule, use of the ambulance is allowed for the transport of Medical staff and hospital stores in special circumstances, due care should be taken that such a provision is not utilised in a routine way.

Log Book-Government have framed rules regarding maintenance of log book and for proper and economic use of Government vehicles, vide Government Circular, F.D. No. FNR 1067/967/VII, dated 1st July 1968. These rules should be scrupulously observed.

The driver should write a monthly summary containing the following entries:

1. Total mileage covered in the month.
2. Total fuel consumed in the month.
3. Mileage per litre.
4. Total of ambulance charges recovered during the month.
5. Details of repairs with cost.
6. Date of servicing.

The ACS should initial against each and every entry, in the log book as well as in the monthly summary book.

Payment of fuel Bills- The Steward should check up the log book, before paying the fuel bills. A careful watch should also be kept to see that the quantity of fuel as indented is actually filled in.

Stretcher Bearers- When an ambulance is sent out to bring a stretcher case, Class IV servants or stretcher bearers if available, should be sent in the ambulance to help the patient on the stretcher and carry the stretcher and aid the patient in ambulance. They must also unload the patient at the destination. Asking relatives to do this should be avoided as it in not expected and many times resented. Such help if voluntarily forthcoming and if required may be utilized.

6.3. State Health Transport Organization

The Deputy Director of Health Services (Transport) looks after *State* Health Transport Organization.

It has been decided that all matters regarding purchase repairs, condemnation and write off of Health Department vehicles including Government hospital ambulance should be looked after by Deputy Director of Health Services (Transport), Pune. Proposals for purchase, repairs etc. should be placed before this officer whenever need arises.

The organization maintains a District workshop at each District Headquarters, with certain staff.(1 Service Engineer, 1 Foreman, 1 Skilled Artisan, 1 Electrician & 1 Unskilled Artisan)

Quarterly programmes are chalked out by D.D.H.S. (Transport) / Service Manager (Transport) for visits to various places. The Programme is circulated to all vehicle's users. A technical inspection is done of all vehicles in the area.

If the repair to be carried out is minor, the District Workshop unit carries out the same free of charge. If the repairs are major, on the basis of urgency, local repairs are advised. Sometimes major repairs are carried out at (Divisional Workshops Located at all Circle Levels).

There are Divisional workshops at all Circle levels with Service Managers.

Pooled grants are placed at the disposal of State Health Transport Organization for purchase of spare parts as detailed in the succeeding para. If amount in excess of this is required, the vehicle user must provide it.

Pooling of Grants- A pooled grant is kept at the disposal of State Health Transport Organization for maintenance and repair of all vehicles of Health Department 80% of sanctioned Grant of Detail Head 51-Motor Vehicles for each Major Head.

6.4. Preventive Maintenance & Repair of Ambulance

Preventive maintenance & Repair of Ambulances is done by District level officers as per prevailing guidelines & laid down procedure for Preventive Maintenance & Repair of Ambulance. Vehicle maintenance programme should be followed as given in annexure 6.4

Condemnation of Ambulance. -Government have laid down a procedure for condemnation of vehicles under Health Department. All Head of offices, Regional Head of Departments, Head of Departments & Administrative Departments are authorized to condemn Government Vehicles as perprevailing terms & conditions

Powers to Carry out Repairs. -Officers as mentioned below are given powers to incur expenditure to the extent shown against them, for repairs of ambulance vans using funds received from National Health Mission under Activity Referral Transport

Sr.No.	Post of Officer	Financial Limit
1	District Level Civil Surgeons/District Health Officer /	Rs.60,000/-
2	Deputy Director of Health Services (Transport) Pune	Above Rs.60,000/-

For funds received in regular budget of Public Health Department

Sr.No.	Post of Officer	Financial Limit
1	Head of Offices	For Petrol Vehicles Rs.15,000/- per year per vehicle For Diesel Vehicles Rs.13,500/- per year per vehicle
2	Regional Head of Departments, Head of Departments	For Petrol Vehicles Rs.50,000/- per year per vehicle For Diesel Vehicles Rs.60,000/- per year per vehicle
3	Administrative Departments	Full Rights

(Vide Finance Department Government Resolution FRP-2013/Section 30/2013/Finance Rules, Part 2, Dated 17th April, 2015. Sr.No. Of Book 19, Rule No. 69)

As per Finance Department Government Resolution FRP-2015/Section 20/2015/Finance Rules, Dated 19th January, 2016 yearly 5% increase in above limits as per natural incremental is sanctioned.

6.5 Other

Insurance of Ambulance. - Under sub-section (2) of Section 146 of the Motor Vehicles Act, 1988, Vehicles owned by the Central or a State Government, and used for Government purposes unconnected with commercial enterprise, are not required to be insured. Government ambulance is exempted from insurance against third party.

Accident Reports. -Reports of accidents to Government Vehicles are required to be submitted to Audit Office in the manner prescribed in Rule (1) in Section II of Appendix-20 to the Bombay Financial Rules, 1959, even though the extent of loss, if any, due the accident is not readily known.

A similar report should also be made by medical officers while sending reports to higher authority. The accident report form is given in annexure 6.5.

Driving by Unauthorized Persons. -All Government ambulance (like all Government vehicles in general) should bear the words "Government of Maharashtra" in a prominent way. The vehicles should not be driven by persons other than drivers appointed for the purpose.

A set of useful instructions, regarding various points about ambulance vehicles used in Health Organization may be seen.

Maharashtra Emergency Medical Service (MEMS):Outsourced Activity

6.6 MEMS Introduction

Public Health Department, Government of Maharashtra, launched Maharashtra Emergency Medical Services (MEMS), an ambitious initiative to serve entire population of Maharashtra. It provides 108 based Toll-free medical access to services of advanced life support and basic life support services anywhere in Maharashtra. It can be dialed from any landline or mobile phone to avail this service.

State of the art Emergency Response Centre (ERC)/control room is established at Pune to respond to toll-free “108” number. ERC can select the ambulance and hospital in seamless manner.

Emergency Medical Services is specialized field where emergency healthcare needs are addressed through well-defined care processes by trained EMS professionals.

Important aspect of EMS includes early detection of any emergency, immediate response, reporting, on-scene care, enroute care and transfer to appropriate definitive healthcare facility.

It is well proven that an integrated approach by Medical, Police and Fire is essential for effective delivery of emergency patient care.

Access to EMS system:

Any person in distress should access EMS system by dialing 108 from any landline or mobile throughout the state.

The caller needs to provide the following information after calling 108:

- Name of the caller
- Exact location of the incident with landmarks
- Type of emergency
- Number of persons involved
- Any existing or possible hazards

The details about Equipment Maintenance Programme and Daily Equipment checks are given in Annexure 6.2 and 6.3 respectively.

Objective

To provide 24x7 hours pre-hospital emergency medical service response services across Maharashtra, including disaster situations in the state

Scope

1. Develop & Operate Emergency Response service/ Ambulance Service which will provide quality, reliable & trustworthy Emergency Response Service.
2. To provide 24x7 pre-hospital EMS across Maharashtra state
3. Develop mechanism in consonance with Police & Fire Department operated through a single toll free number 108
4. Effective Logistics to maintain Response time below 20 mins. in urban & below 30 mins. in rural areas after full-fledged operations.
5. 1 ALS per 100000 population and 5 BLS against 1 ALS.

Key components of ERC operations Management :

1. Emergency Response Centre management
2. Field operations management
3. Fleet Management
4. Human Resource Deployment and Management Plan
5. Supply chain management
6. Quality management
7. Disaster management process
8. Government Dashboard – Monitoring at district and state level

6.7 Emergency Response Center

When an emergency call is received at the call center, the dial up software integrated with Computer Aided Dispatch (“CAD”) which captures the details of the caller and nature of emergency in the CAD software. Then the GPS enabled software is used to track the nearest available ambulance for the accident site. The Emergency Response Officer (ERO) generates Unique ID of every case and dispatches nearest available ALS/BLS ambulance to the site using above software. ERO is expected to respond to the emergency calls on an average within 5 rings.

ERC is expected to actively engage in receiving feedback from the patients / beneficiaries for the service provided on the emergency incident. The feedback shall be solicited from the patients / beneficiaries post 48 hours of the incident. Feedback captures overall experience

including reasons for the feedback. The questions cover about EMT attending the incident, cleanliness of ambulance, equipment in ambulance etc. The details regarding tablets/mobile in vehicle is given in annexure 6.5.

Emergency Response Centre Management

Emergency response center plays important role of taking in patient information, identifying the appropriate resource, deployment for the patient and storing vital information

Dispatch process –

Emergency Response office performs the job of smooth and quick ambulance dispatch process. Early, amicable and reassuring response to the caller is very important in ERS delivery. Taking appropriate information related to the incident in minimal possible time becomes one of the important skills of the call to Maharashtra EMSin ERS. Compliance for dispatch process is important in each call for efficient response.

ERO also performs medical triage before dispatching appropriate ambulance.

Prearrival instructions –

Professionals including Emergency Response Officer, Emergency Medical Technician and Emergency Response Call Physician (ERCP) play important role for execution of prearrival instructions. After taking appropriate information related to incident second important step in emergency dispatch is finding appropriate resource which can alleviate the problem. Identifying appropriate resource and allocating it to the incident is second most important activity in the dispatch process. While on the run either EMT in the ambulance OR dispatcher from response center provides prearrival information to patient, patient relatives or bystander who takes care of patient and provides lifesaving first aid to the patient.

Training of Emergency Response Officer – Emergency Response Centre (ERC) manager is responsible for organizing and evaluating training for dispatcher/Emergency Response Officer. At the beginning dispatcher is trained in geographic information, medical terminology and dispatch process. On the ongoing basis training needs are identified by internal auditor, team leaders and response center managers for design and delivery of customized refresher training for dispatchers.

Call audits – Quality professional performs call audits for consistency in performance of ERC. Call audits are performed on random sample basis. Audit also gives input for training and correction in the skill, knowledge and attitude gap identified through call audits.

Direct supervision of the calls through Key Performance Indicators (KPI) – ERC manager ensures that he personally monitors performance for overall protocol compliance, abandoned calls and call waiting in the response center. Team leaders in emergency response center also monitor protocol compliance for all communication officers and dispatch officers on ongoing basis with close reporting on customer service and time spent by call to Maharashtra EMS and dispatcher/Emergency Response Officer on call. Each dispatcher/Emergency Response Officer ensures that laid out protocol is followed in each call, make efforts to attend each call and spend minimum possible time for taking in information and dispatching the ambulance. They also ensure that patients receive best possible service through the response center.

Multi-casualty incidents (MCI) management through Dispatch center - MCI require special focus and attention on allocation and monitoring of resource management Command

and control center monitor's the activities of MCI. This will enable Emergency Response Centre to provide adequate resources for MCI management, collect, collate and share information with relevant agencies and update the response plan for future such incidents.

Field operations management

Single and most important goal of ERS field operations is to provide timely and medically appropriate response to each emergency patient.

Pre hospital care in the ambulance includes patient assessment & managing the patient by doing different procedures like airway management (Bag Valve Mask Ventilation, suctioning, insertion of Oropharyngeal and Nasopharyngeal Airway, Nebulization in respiratory distress patient), trauma care like splinting cleaning & dressing the wound, maintain spinal precautions, conducting deliveries, giving care for cardiac patients like taking ECG, performing CPR on unresponsive patient.

Experienced instructor performs a surprise check of the ambulance. Instructor rides with the EMT for Emergency Response Services (ERS) calls. He evaluates the performance of Emergency Medical Team (EMT) and pilot by using objectively structured criteria. This evaluation is put on record of concerned EMT and pilot. EMT and pilots are assessed for their capability to provide effective ERS. Necessary corrective actions are taken if they fall below standard performance criteria.

Quality patient care in pre-hospital is extremely important for appropriate outcome of emergency patients. It enables ERS management to understand real time assessment contributing in correct pre-hospital care and mentor the EMT immediately on the skills, knowledge & desired attitude.

Focusing on the "5Ds" has helped Maharashtra EMS to examine the results of the care they render:

1. Death: Did the patient survive to hospital discharge?
2. Disability: Was there an improvement in the patient's functional status as a result of patient care rendered?
3. Discomfort: Was there improvement in the patient symptoms (e.g., alleviation of pain; improved breathing)?
4. Dissatisfaction: Was the patient (and/or family) satisfied with service rendered?
5. Destitution: Was the treatment provided at lowest cost to the patient, the payer and to society as a whole?

6.8 MEMS Grievance Redressal System

Grievance is defined as a formal written complaint. The complaint alleges a wrong doing, inequity or injustice committed by a person or company against another. How to file a grievance varies with company policies and governmental guidelines.

- Understand the terminology involved in filling a grievance.
- Know the mandatory timelines and deadlines for filling required documents.
- Complete steps to file a grievance. (Exp: Single record printout)
- Prepare the grievance fact column to outline the details.
- Use mediation to resolve the problem or reach an agreement.
- Co-ordinate & conference & mail to Grievance location. (Mail to DM & ZM & Operation Head)

Type of Grievance Registered –

- Caller Concern
- EMT & Pilot Misbehaviour
- EMT/Pilot Tips and Gifts.
- Response Time Issues
- ERC concern
- Technical Issue
- Ambulance Unavailability
- Base Location Issue
- Stake Holder Issues
- Suggestions
- Network Issue

After resolution of grievance action is taken on concern employee or is scheduled with Zonal Disciplinary Hearing.

References

1) P.H.D. GR No. Post Review 2007/Section 117/Seva - 1, Dt.06/08/2007
2) Circular by Commissioner Health Services & Director NHM, Mumbai vide outward No. SHS/RT/109225-485/2018, Dated 17th February, 2018
3) Government Resolution FRP-2013/Section 30/2013/Finance Rules, Part 2, Dated 17th April, 2015. Finance Department Sr. No. of Book 19-d, Rule No. 69

CHAPTER VII

PRADHAN MANTRI JAN AROGYA YOJANA AND INTEGRATED MAHATMA JYOTIRAO PHULE JAN AROGYA YOJANA

7.1 Introduction:

State Government's Mahatma Jyotirao Phule Jan Arogya Yojana is being implemented in the state from July 2, 2012 and Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana, is a health insurance scheme of the central government. PMJAY scheme is admissible to each member of family (83.63 lakh families) whose name is included in the list of SECC data. It was implemented in the state from September 23, 2018.Ayushman Cards and photo IDs are given to family members of these families through UTIITSL, COLOURPLAT, ZEYFER and Common Service Centers in Maharashtra.

As per the government decision dated February 26, 2019, it has been decided to combine the Ayushman Bharat-Prime Minister Jan Arogya Yojana with the Mahatma Jyotirao Phule Jan Arogya Yojana and implement both the schemes together in the state. Accordingly, the revised plan is being implemented in the state from 01.04.2020. The existing Mahatma Jyotirao Phule Jan Arogya Yojana and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana combined scheme and the matter of making some changes and expanding the scheme was under the consideration of the government. As per this scheme, Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY) health protection per family per year is Rs. 5 lakhs while of Mahatma Jyotirao Phule Jan Arogya Yojana (MJPJAY) providing health protection per family per year upto1.5 lakhs.

In year 2023, Government has integrated both the schemes with changes in protection amount and included procedures.

7.2 Salient Features

1) Previously, 991 treatments were covered under Mahatma Jyotirao Phule Jan Arogya Yojana and 1209 under Pradhan Mantri Jan Arogya Yojana. Out of these, 181 undemanded treatments are now scrapped. While 328 in-demand new treatments are included afresh. In the Pradhan Mantri Jan Arogya Yojana, the total number of treatments has increased by 147 to 1356 and same number of procedures are now included in the Mahatma Jyotirao Phule Jan Arogya Yojana. Out of the said 1356 treatments, 119 treatments will be reserved for Government Hospitals only,(please refer Annexures 7.1 to 7.3)

Specialty and Procedures

Sr. No.	Specialty	1356 packages for integrated scheme	119 Treatments compulsory in Government Hospitals
1	Burns	10	0
2	Cardiac And Cardio-thoracic Surgery	106	0
3	Cardiology	32	0
4	Cardiology/ Interventional Radiology	1	0
5	Critical Care	13	0
6	Dermatology	7	0
7	Endocrinology	12	0
8	ENT	66	25
9	General Medicine	13	0
10	General Medicine/Cardiology	3	0
11	General Medicine/ Endocrinology	1	0
12	General Surgery	98	39
13	General Surgery/ Cardiovascular Surgery	1	0
14	Gynaecology and Obstetrics Surgery	29	17
15	Hematology	13	0
16	Hematology/ Medical Oncology	5	0
17	Infectious Diseases	3	0
18	Interventional Radiology	47	0
19	Interventional Radiology/ Nephrology	1	0

20	Maxillo facial Surgery/ Plastic Surgery	2	0
21	Maxillo facial Surgery/ polytrauma	2	0
22	Medical Gastroenterology	35	0
23	Medical Gastroenterology/ Surgical Gastroenterology	1	0
24	Medical Oncology/ Haemato-oncology	73	0
25	Mental Health Packages	6	1
26	Neonatal and Pediatric Medical Management	67	0
27	Neonatal and Pediatric Medical Management/ Nephrology	2	0
28	Nephrology	12	0
29	Nephrology/ Gastroenterology	1	0
30	Neurology	14	0
31	Neurology/ Nephrology	1	0
32	Neurology/ Pediatric	1	0
33	Neurosurgery	71	1
34	Neurosurgery/ CVTS	1	0
35	Neurosurgery/ Pediatric Surgery	1	0
36	Neurosurgery/ Plastic Surgery	2	0
37	Onco-hematology / Medical Oncology	48	0
38	Onco-surgery/ Neurosurgery	1	0
39	Ophthalmology Surgery	45	6
40	Orthopedics/ Polytrauma	6	0
41	Orthopedics surgery and procedures	77	15

42	Pediatric Surgery	47	1
43	Pediatric Medical Management	6	0
44	Plastic Surgery	20	1
45	Plastic Surgery/ Pediatric Surgery	2	2
46	Polytrauma	14	0
47	Polytrauma/ Burns	2	0
48	Polytrauma/ Ophthalmology	13	0
49	Polytrauma/ Orthopedics	1	0
50	Prothesis and Orthosis	7	0
51	Pulmonology	11	0
52	Radiology Oncology	14	0
53	Rheumatology	11	0
54	Rheumatology/ Endocrinology	1	0
55	Surgical Gastroenterology	37	0
56	Surgical Gastroenterology/ General Surgery	1	1
57	Surgical Oncology	120	0
58	Surgical Oncology/ Cardiac And Cardiothoracic Surgery	2	0
59	Surgical Oncology/ ENT	17	0
60	Surgical Oncology/ General Surgery	3	0
61	Surgical Oncology/ Pediatric Surgery	1	0
62	Surgical Oncology/ Surgical Gastroenterology	5	0
63	Surgical Oncology/ Urology	15	0
64	Urology	76	10
	Total	1356	119

2) Now under the Mahatma Jyotirao Phule Jan Arogya Yojana, health protection per family per year will be Rs.5 lakhs.

3) Ttreatment cost limit per patient in Mahatma Jyotirao Phule Jan Arogya Yojana for kidney surgery enhanced from Rs. 2.5 lakhs to Rs. 4.50 lakhs.

4) Total 1350 Hospitals are empanelled under this scheme across State including Maharashtra - Karnataka Border Hospitals (10 hospitals from 4 districts of Karnataka). Apart from this, all government hospitals will be adopted in this scheme.

5) All the newly opened hospitals in the backward areas if such hospitals so desire, will be adopted in this consolidated scheme, apart from the hospitals mentioned in (4).

6) All ration card and domicile certificate holder families in the state are entitled under this scheme.

7) In 2020, Late Balasaheb Thackeray Road Accident Insurance Scheme started for 74 road accident procedures with cost limit of Rs. 30,000/-. It is now included in this revised scheme with 184 road accident procedures with cost limit of Rs. 1,00,000/- (Please refer annexure 7.4)

8) In future, funds received from this scheme will be kept at hospital level and permission will be given for utilization.

   At present as per GR dated 11 January, 2019, following distribution is permitted to utilize funds received through insurance company.

   1. 25% will be given back to Government finance department.
   2. 20% will be utilize by hospital for incentive measures to treating doctors and other staff.
   3. Up to 3% will be given to outsource agencies for claims and necessary documentation.
   4. 52% will be permitted to utilize in hospital for the items mentioned in Appendix-A of same GR, subject to approval of committee headed by Civil Surgeon/ Medical Superintendent of respective institute.

7.3 Beneficiary:

Beneficiary Components: Beneficiaries identified under MJPJAY and PMJAY are enlisted in annexure 7.5

Beneficiary Identification: E-card, ration card, Domicile certificate, photo ID proof, Aadhar Card, voter card, PAN card, etc., as given in annexure 7.6.

Mahatma Jyotirao Phule Jan Arogya Yojana and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana have different beneficiaries. The State Health Assurance Society will verify the beneficiary list twice a year to avoid duplication of beneficiaries (same family will not be included in both schemes).

Insurer: From 02-07-2012 to 31-03-2020 scheme was implemented by insurer National Insurance Company (Public Sector undertaking). 01-04-2020 onwards Integrated scheme (MJPJAY and PMJAY) is implemented by United India Insurance Company(Public Sector undertaking).

7.4 Committees:

For effective implementation of both the schemes State and District level committees are formed as given in annexure 7.7.

1. **State Monitoring and Executive Committee**-(headed by Additional Chief Secretary/Principal Secretary/Secretary, Public Health and Family Welfare Department)

2. **State Level Co-ordination, Adoption and Disciplinary Committee** -(headed by CEO of State Health Assurance Society)

3. **Central Claim Committee -** (headed by CEO of State Health Assurance Society)

4. **State Grievances Redressal Committee** - (headed by CEO of State Health Assurance Society)

5. **District Monitoring and Grievance Redressal Committee** - (headed by Collector of respective district)

State Monitoring and Executive Committee will meet quarterly or as per requirement. At least two meetings of one i.e. Regulatory Council shall be held once in a month or as required.

Financial Burden: - Under the Pradhan Mantri Jan Arogya Yojana (PMJAY), the share of the Central Government will be 60% and the share of the State Government will be 40%. State government will be responsible for Financial Burden of PMJAY (40%) and MJPJAY (100%). Being State owned scheme, MJPJAY is fully funded by Government of Maharashtra.

Human Resources (HR): -The Chief Executive Officer, State Health Assurance Societies have the authority to appoint the officers and staff required for the schemes on contractual basis.

Financial Powers:- The State Health Society will have the rights of pay/allowance expenditure of employees, Office expenditure, insurance company expenses and claim expenses.

Claim Status and Action to be taken: (*Refer Annexure 7.8*).

7.5 Expectations

(From Deputy Directors, Civil Surgeons and Medical Superintendents of empaneled Hospitals)

1. Appointment of dedicated MCO as per clause 10 of SLA - to be appointed by the Hospital to act as the medical coordinator
2. Clause 14.2 of the SLA - Provide Internet facility to the counter, Personal Computer, Printer, Scanner, Digital Camera, Webcam, Bar code reader, Mike, Speakers, Stationary, minimum two biometric devices as per specifications provided by SHAS/ TPA from time to time etc.

3. Joint account in Nationalized Bank Clause 25.2 – CS and AO, MS and OS/AS
4. Scheme review at time of monthly meeting of MS.
5. Scheme review by DDHS in Divisional meeting
6. Follow up for making Laminar OT at District Hospitals for approval of Joint replacement procedures.
7. Expectations at time of Hospitals visit
   A. Contact patients with per-authorized approved and see whether treatment given matches with per-authorized approved
   B. Enquire whether there is money collection or OPE (Out of Pocket Expenditure) or any other complaint, if so raise Grievance
   C. Contact to patients whose treatment falls under scheme but preauth not raised and confirm whether they really want cash treatment (Clause 3.9.5 and 3.9.6 of SLA).
8. Monitoring and review procedure of Medical Coordinator regarding pending cases of assurance mode at hospital given in ***Annexure 7.9***
   Description of awards is given in the annexure 7.10

References:

1) Web Site Link:

https://www.jeevandayee.gov.in/MJPJAY/FrontServlet?requestType=CommonRH&actionVal=RightFrame&page=undefined%3E%3E%3Cb%3ERGJAY%20Government%20Resolution%3C/b%3E&pageName=RGJAY_Government_Resolution&mainMenu=About&subMenu=RGJAY_Government_Resolution.

2) महात्मा ज्योतीराव फुले जन आरोग्य योजने अंतर्गत सार्वजनिक विभागाच्या नियंत्रणाखालील आरोग्य सेवासंचालनालयाच्या अधिनस्त संस्थाच्या माध्यमातून जमा होणाऱ्या निधीचा विनियोग करण्याबाबत ,महाराष्ट्र शासन सार्वजनिक आरोग्य विभाग,शासन निर्णय क्र: मफुयो-२०१८/ प्र.क्र.२५७/आरोग्य-६/दिनांक: ११जानेवारी,२०१९.

3) विद्यमान एकत्रित महात्मा ज्योतीराव फुले जन आरोग्य योजना व प्रधानमंत्री जन आरोग्य योजनेसाठी निवड करण्यात आलेल्या विमा कंपनीशी झालेल्या सामंजस्य करारनाम्यास मुदतवाढ देण्याबाबत, महाराष्ट्र शासन सार्वजनिक आरोग्य विभाग , शासन निर्णय क्र.निविदा-२०२३/प्र.क्र.२३/आरोग्य-६/दिनांक:२१ जून,२०२३

4) महात्मा ज्योतीराव फुले जन आरोग्य योजना व आयुष्मान भारत - प्रधानमंत्री जन आरोग्य योजना या एकत्रित योजनेचे विस्तारीकरण करण्याबाबत महाराष्ट्र शासन सार्वजनिक आरोग्य विभाग ,शासन निर्णय क्र: मफुयो-२०२३/प्र.क्र.१६०/आरोग्य ६/दिनांक :२८जुले,२०२३ .

CHAPTER VIII

HEALTH CARE MANAGEMENT IN DISASTER

8.1. Background

The Word disaster derived from “disasters” (French) and “disastra” (Italian), which in turn comes from Greek as bad (dus) and (aster) meaning bad star. Here Calamity is blamed to Position of planets. Disaster means Malalignment of stars (Disaster).

Definition:

Disaster is defined as serious disruption to functioning of a community that exceed its capacity, to cope using its own resources. A disaster is an event that occurs suddenly and unexpectedly, causing severe disturbances to people, objects, and the environment, resulting in loss of lives, property and the health of the population.

Everyday world is facing different types of disasters. In past, world had faced major disasters like earthquakes, tsunamis, volcanos. Blasts, wars, major vehicular, avian, rail accidents and nuclear-related disasters etc. It pays greatest cost when, a disaster hits. India is most vulnerable country for various types of disasters like Bhopal Gas tragedy, earthquakes 1993(Latur, Killari). 2001 (bhooj) 2005 (Kashmir). Fire and road accidents and floods are common in Maharashtra, creating financial loss along with heavy mortality&morbidity. Post disaster infections, epidemic, mental health challenges also need to be addressed as a sequela of it.
A disaster is a serious disruption occurring over a short period that affects the functioning of a community or society.Disaster phase requires immediate intervention and their forecasting of disaster management emergency or casualty services of hospital. Hospital plays important & varied role in disaster, ranging from accidents to chemical/Gas poisoning to minimize morbidity & mortality. Disasters may add an extra and immense load to the normal functioning of health system

The government of India prepared a Comprehensive disaster management action plan. In 2005, India enacted the Disaster Management Act, under which NDMA with an institutional network up to the district level was established.

Comprehensive health care delivery is multifaceted exercise and requires coordinated development of health personals and resources from various agencies of government. It also involves upgradation of hospital facilities, trauma care centers functioning EMS services, Onsite help team, golden hour hospital management. Training, Logistics, MIS & coordination with other stakeholders in society is important component in this complex activity.

Emergency medical care is very challenging in any location. Emergency care demands sound logistics that include equipment, medicines, vehicles and trained man power as well as

communication facility. The responsibility of EMS Start from incident site and extent to the hospital emergency room at same time.

8.2 Classification of Disasters:

As per gravity of incidence:

- Major
- Minor

Another Classification:

a. **Natural**– flood, cyclones, earthquakes, draught, fires, epidemics, Extremetemperature (SUNSTROKE), cold spells, building collapse, Tsunamis, Landslides Hurricanes, Lighting etc.
b. **Man Made** – Vehicle accidents, wars, fires, riots, terrorisms, disasters due to chemical, biological radiological, nuclear weapons (CBRN), Power failure.

Hospital disasters

It is classified as:

- **Internal factors:** Disaster occurring in hospital building with no external causative factor.
- **External factors:** disaster occurring outside hospital.
- **Hospital Internal Disaster :** Building collapse, fire, electrical short circuit, Gas leakage,chemical poisoning, drug side effects on a large scale, chemical spillage, blast, stampede etc. are classified as internal disasters.

8.3 Colour code for disaster Management

Red – Fire internal disaster
Blue – Cardiac arrest
Yellow- External disaster
Pink – child abduction or Paediatric Emergency.
Orange – Mass casualty
Brown – Chemical Hazard
White – Bomb threat
Green – Rapid response team and evacuation

8.4 Hospital Disaster Management Plan

There are three important phrases in hospital emergency plan.

1, Pre-disaster phase

2. Disaster phase

    A) Alert Phase

    B) Impact Phase

    C) Post-impact phase

3. Post-disaster Phase

Relief, Reconstruction & Rehabilitation Phase, Plan should be predictable, simple, flexible concise, comprehensive, adjustable, anticipatory, as part of regional health plan (include Provision for vulnerable groups staff training /drills equation/ drills revision of hospital disaster plan). Disaster plan should be complete, inclusive of all phases of disaster.

Management of Pre disaster phase:

- Risk Assessment
- Training, Mock drill
- Planning of programme
- Logistic management
- Identify help from external source

These Hospital planning is to be carried out in the Pre disaster phase. Each health institute needs to put systems in place for effective management disaster. For effective management of disaster needs planning, organization, co-ordination among all employees of hospitals is needed.

Each hospital should have written document which called as disaster management manual, which covers details about hospital disaster management plan. This plan should include hospital disaster management committee under the chairmanship of hospital head with technical & non-technical and supportive services personals

Training should be given to all technical, non-technical employees of hospitals frequently with help of other departments to manage various types of disasters. Mock drills should be carried out, regularly.

Pre-disasters hospital planning includes

1. Formations of hospital management committee
2. Initiation of central command system (EOC, control room etc.)
3. Preparation of job cards
4. Plan activation of different area of hospital
5. Increase bed capacity
6. Strengthening information system
7. Security planning
8. Llogistics planning,
9. HR & finance planning
10. Information of hospital private hospital networking

2. Management in disaster phase

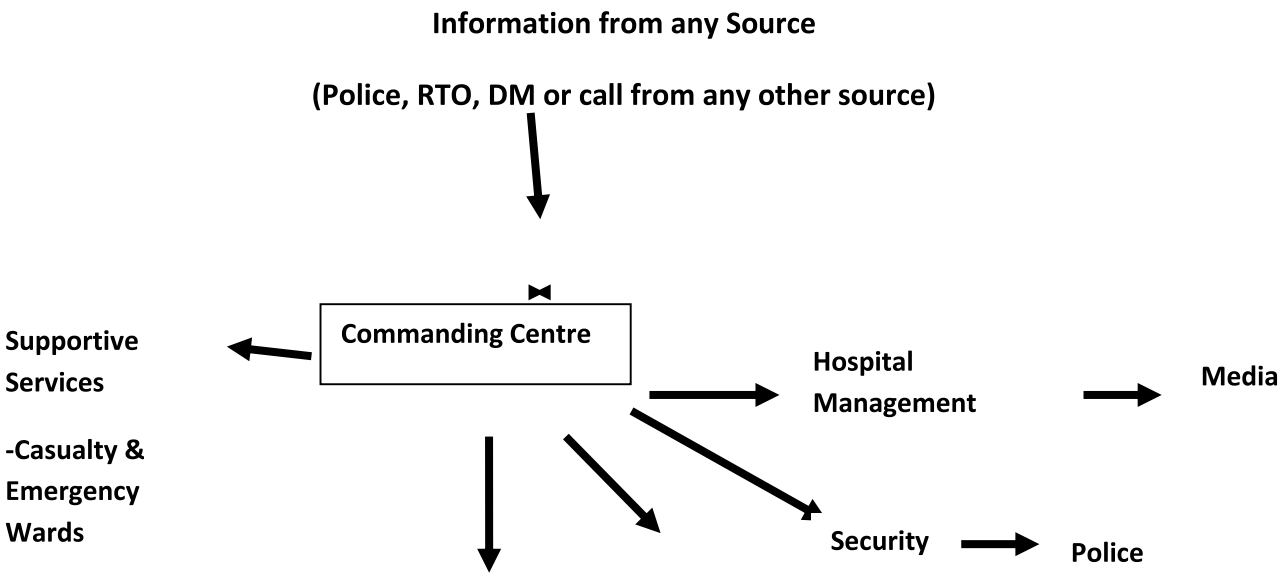
In Disaster, hospitals have the primary responsibility to provide emergency services for 24x7 periods. Hospital should provide diagnosis, treatment and follow up, facility to both physically and psychologically affected patients.

Hospital disaster management committee quickly respond to mass casualty. There should be effective plan for command system to avoid confusion in staff members.

Actual Operation modalities in Mass casualty management

As soon as information regarding disaster is received at hospital by any sources, hospital management committee will be activated, job cards will be issued. At Hospital level, HEOC will be functional (as shown in and figure) and same time, Rapid response team will rush at disaster site.

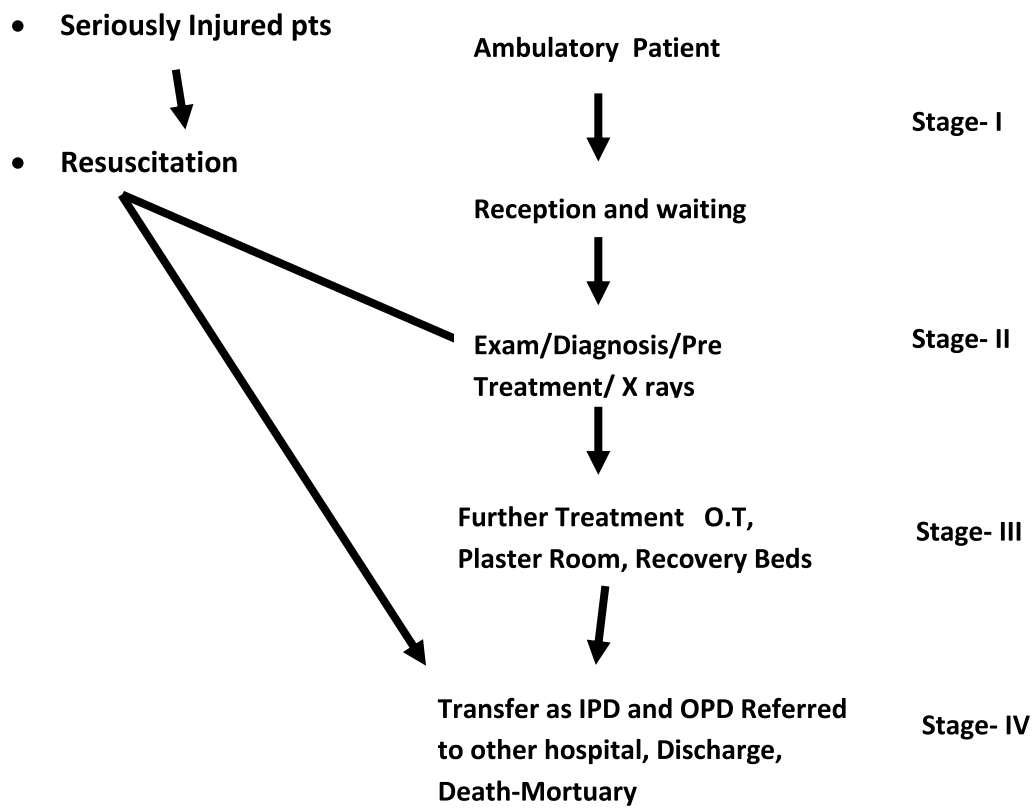
HEOC (Health Emergency Operation Center):



Triage will be carried out by triage officer of trauma management team in patient receiving room .The process of triaging patients is difficult task & should be entrusted to senior physician or surgeon.

Category 1 : Immediate Treatment (approx. 20%)
Category 2 : Delayed Treatment (Approx 40%)
Catogory 3 : Minimal treatment (Approx 40%)

Stages through which a patient may pass in an accident Emergency Department



Golden Hours:-

It is time taken for medical relief after the onset of disaster. If during this period extensive medical relief provided, mortality, morbidity will be reduced.

Stage I -III is considered as golden hours during mass casualty management. Job card will be issued by commanding center to ACS, RMO (Outreach) Matron/Nursing Superintendent, MSW, AO, Security Officers, Reception officers, specialist, nursing staff, housekeeping staff, attendants, dietician, plumber, electricians, ambulance drivers, blood bank, ICU, radiology pharmacy, operation theatre department etc.

As per job chart, all departments shall be activated and employees to work according to job charts. Additional staff will be made available by hospital management.

Information management system

During disaster management phase, information documentation will be activated. PRO will be available for 24x7 periods. Generally, in government hospitals, ACS is designated as PRO. At hospital, details of victims will be documented daily & same information will be given to police, representatives to avoid fake news.

Health Management during CBRN (Chemical, biological,Radiological, nuclear weapons **) disasters**

Even developed countries are having very limited resources to overcome CBRN disasters. The best example is COVID 19 pandemic which said to be biological disaster where world faced very bad consequences. Each hospital should have separate disaster management plan to manage CBRN disaster.

Effects of CBRN Disaster will depend on the agent, area involved. Vision is to prevent the incidence by taking all reasonable technical safety and security measures so that life of patient could be saved with safety of service providers.

Actions to be taken are triage, resuscitation, decontamination, referral and transport. Over all CBRN Disasters planning includes avoidance, detection, protection, decontamination and consequence management.

3. Management of Post disaster phase

(RELIEF, REHABILITATION AND RECONSTRUCTION)

Post-disaster recovery planning shall be part of the Hospital Disaster Management planning process and it shall be performed at the onset of response activities. This plan should include

1. Various measures include Safe drinking water & food, Sanitation measures. Immunization, Rodent/Mosquito control
2. Damage assessment
3. Management of Relief camps (health related issues)
4. Management of nutrition and public health issue like epidemic, infectious diseases
5. Establishing a post disaster mental health intervention program.
6. SWOT analysis of event, by hospital management team. Corrective & preventive measures to be planned
7. Disaster preparedness and IEC activities at the community level
8. Community awareness: - It plays a crucial role in prevention and early execution of the disaster management in the initial few hours of the disaster and hence every effort should be taken to make the local community aware of the probable disasters and essential preparedness and management of the same.

Stake holders who take early action in the event of a disaster are

a) Panchayat Raj Committee members (PRC) members,
b) The community
c) The local health personal,
d) The local authorities,
e) NGO's and individuals;

They support in the localities with rescue work, communications, transport, shelter and food supply.

IEC activity can be carried out

a) Organization of the disaster preparedness classes, film shows anddiscussionn
b) Group talks, house to house visits/campaigns etc.

c) Mock drills in institutions
d) Volunteers Skill development training in dealing the disaster victims
a) Convening of disaster preparedness plan to various stakeholders' community including public leaders, community NGOs through various media.

8.5 Hospital internal disaster management action plan (inside hospital)

1. As soon as alarm heard, message will be the given to control room by staff of affected area.
2. Code of hospital disaster will be announced by commanding center
3. Hospital disasters management committee will be activated
4. Concerned employee will turn off the lift and power supply (related disaster) Evacuation of patient for source will be started as per protocol
5. Health management will be done as per type of disaster.
6. when situation is under control, announcement should be made.

8.6 Hospital Safety Framework

Action frame work has to be developed on basis of priority Areas:

1. Disaster Planning and preventive measures
2. Reduction of structural mitigation
3. Strengthening of institutional mechanism
4. Awareness generation
5. Capacity building
6. Preparedness and response

Fire Safety Management In Hospital

(Fire disaster code –Red)

The Fire NOC from competent authority, regular electrical audit, fire audit are mandatory. Periodic mock drills shall be performed in every hospital.

Fire protection management is to plan and carry out measures to prevent fires and minimize the damage caused.

Health worker should protect his/her own life and hospital properties, this is the basic principle of fire protection management and disaster protection management. We need to improve fire and disaster protection measures to prevent fire and mitigate to damage from disaster.

Fire response plan that is red code is to provide guideline for hospital personal to follow duties. This plan is providing safety of patients, visitors, employees, other occupants in hospital buildings. Property loss is secondary importance. Hospital and Nursing homes have certain features which are not identical other categories of the building. As per National building code (NBC) 2006, these buildings have been categorized under group – C1.

8.7 The Maharashtra Fire Prevention and Life Safety Measures Act 2006

Licensing authority – The chief fire officer or nominated officer Director

- Application to fire officer in prescribed format
- Inquiry by chief officer with the of fire audit agencies accredited by government of Maharashtra
- Grant license for one year after satisfactory inquiry report
- Occupier should appoint fire officer or (Hospital I/c)
- If height of building is more than 30 meters
  a. Minimum requirement for fire instillation
  b. For hospital building C – 1 as mentioned on page no 31,32
  c. Provisions of building structure as per mentioned on page no 42

8.8 CLASSIFICATION OF FIRES

(Indian standard (IS) 15683/2018)
Class A Fires- ordinary fires, wood, cloths, plastic.
Class B Fires- Liquids & Gases
Class C Fires- Electrical fires
Class D Fires- Metalic fires
Class K Fires- Grease or cooking fires

8.9 Causes of fire

May be due to accidental or Negligence

1) Kitchen – very common due to fuel
2) Electrical malfunction and overload
3) Heating system defect
4) Appliances defect
5) Laundries defect
6) Care less smokers
7) Airing linen as fire guards
8) Intentional acts

Hazard Analysis

A) Equipment Hazards – Due to rapid technological advancements in medical science hospital nursing home are well equipped with new equipment CAT, MRI, Lasers, Heaters, Boilers.

B) Chemical hazards-

1) Flammable chemical 2) Alcohol

3) Acids 4) Ethers

5) Spirit 6) various Solvents

C) Gas stores -

1) LPG cylinder 2) Oxygen Cylinders

3) Nitrous Oxides etc.

D) Plants

1. Laundry & Sterilization plants
2. A/C Plants & Ducts
3. X- ray units
4. Kitchen & Canteen
5. General & Medical stores
6. Cars parking area
7. Mattresses, Bedding, furniture.
8. Various Gas Cylinders In ward

Most High risk areas in Hospital

a) SNCU, NICU & ICU
b) AC Plants & ducts
c) Operation Theater
d) Electricity station
e) Radio diagnostic unites
f) Various gas stores
g) Medical store
h) Kitchen

Essential Fire safety measures in hospitals

1) Good housekeeping in all areas of hospital
2) No Smoking Zone should be enforced
3) Regular inspection and maintenance of electrical system & Appliances
4) Stair lobby and landing should be free from any obstruction with sufficient no. of exit routes at each floor.
5) Separate gas storage & supply system
6) Training to staff in relation to dealing with the fire extinguisher and fire fighting system.
7) Construction & alteration of building as per norms with non-combustible material that resist to fire.
8) Appointment of fire Protection manager
9) Emergency / Evacuation plan should be prepared and updated regularly
10) Fire signs should be displayed in proper places
11) The guidelines and instructions issued by Fire department, local bodies shall be displayed and followed.
12) Checking, testing, and maintain of all fire protection and detection system to keep in working condition
13) Electrical safety audit at regular specified interval (*to be added) Once in two years as per national guidelines
14) Pest control
15) AMC of equipments

Protective measures

1) Separate reservoir as per national building Code without water

2) Replenishment facility
3) Fire hydrant System installation.
4) First aid System Provision
5) Sprinkler System should be in place.
6) Firefighting extinguisher Should be provided asnorm
7) Main Fire Pump with Stand by Pump
8) Automatic Fire detection & alarm system should be Provided
9) Public address System with two-way communication
10) Emergency Power supply should be available
11) Electrical installation as per Central electricity Authority (Safety) notification regulations 2010
12) Installation & transformers at different Places
13) Installation of Lightning arrester masts on the building
14) Fix responsible person for monitoring

8.10 Employee and staff response

Personnel, including technical staff who are at or near the point of origin, should follow the procedures out lined by R.A.C.E (Rescue, Alarm, confine and extinguish/evacuation) system upon activation of code red. Staff should move away from the point of origin and should follow instructions, announced by commending System.

Emergency response team will be activated & will respond to code red Incidents.

Evacuation Plan:

The evacuation procedure depends on defective, reactive and travel time

Key elements of SOPs

i. To identify the fire escape route
ii. To identify the location & Fire fighting system
iii. Conduct firefighting mock-drills

Evacuation Works as per Principles

1. Partial evacuation
2. Horizontal evacuation
3. Vertical evacuation.
4. Complete evacuation

Standard operating procedures (SOPs)

Main objective:

1. To protect the occupant
2. To protect the assets
3. To secure the Continuity of the operation
4. To protect environment

Fire protection managers need to conduct following

1. Preparations of Fire Protection Plan
2. Training & fire fighting, Emergency, Reporting and evacuation
3. Inspection and regular maintenance of fire protection equipment's,
4. Guidance for Proper handling of open flames, Heaters etc
5. Management and maintenance of evacuation system, Fire Prevention System equipment.
6. Control of number of people in hospital.
7. Evacuation and fire drills

Fire command Structure

Additional Civil Surgeon (ACS)/Medical Superintendent (MS) will act as the commanding officer during disaster time. He will be responsible for fire order and operation plan execution.

Actual Plan of evacuations.

i. A clear Passage way to all escape routes.
ii. Clearly marked escape routes.
iii. Entry &Exit doors that opens easily
iv. Emergency lighting where needed
v. Training to all employees to know the evacuation plan system
vi. The use of escape routes.

Following Firefighting facilities

1) Installation of sprinkler System.
2) Fire and smoke check doors.
3) Automatic smoke detector/ Heat detector cum alarm system
4) Supply of sufficient Fire extinguishers as per norm (Refer the Annexure 8.2)

TRAUMA CARE UNITS (TCU)

8.11 Introduction:

The Government has taken progressive initiatives to road safety including improving trauma care services along high ways. Basic aim of trauma care unit is to avoid predictable and preventable deaths, by ensuring injury management, initial stabilization, fluid replacement, quicker transport to health facility along with specialized management at higher centers. As per statistics of 2012 available, Maharashtra had 47247 accidents in year with 13936 deaths. (30 death per 100 accidents.)

Objectives: The main objectives are:

- To bring down preventable deaths due to Road Traffic Accidents (RTA) to 10% (Cross check)
- The criteria for establishment of TCU are defined by Government of Maharashtra, the criteria are as follows

Criteria:

A. The distance between two Trauma Care Units (TCU) shall be more than 100 km.

B. It Should be established in hospital more than 100 beds

Based on facilities and infrastructure available, TCUs are designated as level I,II,III & IV Here, Level I is highest facility center & Level IV is mobile hospital /ambulance.

Level 1: - Highest level of comprehensive care unit with super specialty services round the clock. Need not to be on highways but distance between 2 such centers at a distance of less than 750 to 800 kms.

Level 2 :-facilities of Level III with addition of neuro &pediatrician on call, in house diagnostic & ICU facilities with 300 to 500 bed hospital.
Level 3:-Located at 100-200 beded hospital with availability of physician, surgeon and anesthetist with blood facility (5 ICU Beds as per GR trauma care 2020
Level 4:-Mobile units/Ambulances

Level 1 & 2 are to be run by Medical Education department & Level 3, 4 are controlled by public Health Department

Level III trauma care facility provides initial evaluation and stabilization (surgically if appropriate) to the trauma patients. Comprehensive medical and surgical inpatient services to be made available to those patients who can be maintained in a stable or improving condition without specialized care.

Emergency Doctors and Nurses are available round the clock. Orthopedic Surgeon, General Ssurgeon, Physicianand Anesthetist would be available round the clock to assess, resuscitate, stabilize and manage as necessary to a higher-level trauma care service. Such units will have limited intensive care facility, diagnostic facility, blood bank and other supportive services.

For details of staffing pattern refer annexure 8.3
For details of equipments,/instruments, for Trauma Care Units, please refer annexure 8.4.

Capacity building :
Skill training & capacity building of all Staff including medical & paramedical staff with 108 EMS Ambulance periodically to reduce casualties , reduce morbidity & mortalities.

Communication network:
Integrated communication network to enable the public to reach trauma care system and for various component of the system viz. Trauma centers, Ambulances, Higher referral centers, police, Highway authorities etc for interactive communication

Ambulance Service:
To receive definitive treatment in golden hour, basic & advanced life support ambulances are integral part of EMS

It includes:

I. Early detection of any emergency
II. Immediate response

III. Reporting
IV. Enroute care
V. Transfer to appropriate definitive health care facility

Basic life support ambulances (BLS) at every 50 km along Highway to bring victims to Trauma units. Advanced Life support ambulances (ALCS) to be with Trauma unit for inter facility & higher center transfers.Disaster Preparedness at MEMS (Please refer the Annexure 8.5)

Reference:

1) HEOC (Health Emergency Operation Center) Framework for Establishing and Operationalizing State level Health Emergency Operations Centres (HEOC): A Guidance Document**,** Ministry of Health and Family Wealfare, Government of India
2) आयुक्त (आरोग्य सेवा) व अभियान संचालक रा.आ.अ.मुंबई यांचे पत्र क्र.आ.आ.से/कक्ष-३/फायर सेफ्टी ऑडीट/टे.६/३९९-४६०/२१.दिनांक.०९/०१/२०२१.
3) Central electricity Authority (Safety) Notification, Part III Section 4,The Gezzete of India 2010
4) Capacity building fordeveloping trauma care facilities on national highways operational guidelines ministry of health and family welfare govt of India
5) शा.नि.क्र संकीर्ण २०१८/प्र.क्र.१९०/आरोग्य ३. दि.१८ सप्टेंबर २०२०. ट्रौमा केअर युनिटची व्यवहार्यता तपासून केंद्र शासनाच्या मार्गदर्शक सूचना नुसार ट्रौमा केअर सेंटर बाबत शासनास शिफारस करण्यासाठी गठीत तांत्रिक समितीच्या अहवालावरील कार्यपूर्तता अहवालाबाबत.

CHAPTER IX
HOSPITALS AND FAMILY WELFARE

9.1. General

Success of Family Welfare Programme is dependent on total involvement of all health agencies including hospitals. Hospitals being very important health centers have to play a significant role in implementation of Family Welfare programme (which is one of top priority.) Hospitals can be considered of strategic importance in this respect. In this connection some significant aspects have to be kept in mind.

Hospitals provide very good situations for education and motivation as a large number of patients attend hospitals daily along with their relatives and friends. Their number will run into lakhs. These people are available for effective motivation in the peculiarly intimate atmosphere of the hospital, an atmosphere which probably will not be obtainable under any other circumstances. Giving of advice on the subject and its acceptance can be considered as a normal routine activity particularly so in maternity section. Advice on Family Welfare can therefore be made a routine part of patient care in a hospital.

Hospitals have another advantage, viz. that they are able to demonstrate the practical aspects of advice then and there and carry out any manipulations including operative ones if the patient so desires. Thus whatever advice is given is not merely in an abstract manner but one which can immediately be practiced by the patients.

In the circumstances obtaining in our country, more reliance is required to be placed on Vasectomy, Tubectomy and IUCD rather than on conventional contraceptives. Such procedures are obviously possible only in a hospital, may be a temporary hospital organized for such procedures. Again such procedures require a considerable amount of follow up care, for which again hospitals are necessary. The expertise for above is available only in a hospital.

If services of the type referred to above were to be organized outside a hospital, great care would be required in arranging for accommodation of patients and staff, in making transport arrangement for patients, in providing them with diet and in giving and supervising follow up care. The difficulties in the rent in such a situation, and in obtaining the necessary managerial skill are done away with in a hospital situation. Medical Termination of pregnancy is now being accepted more and more. Though this is not primarily intended to be a Family Welfare measure, nevertheless its impact on Family Welfare is obvious. All these programmes can be intensified in hospitals.

Hospitals are also very important as training centers for medical and paramedical staff in the technique of Family Welfare procedures, medical termination of pregnancy etc.

Education and motivation of patients by hospital staff towards Family Welfare is particularly successful since the same staff which has attended during antenatal delivery and post-natal period is also the staff giving the necessary advice and by this time a sort of familiarity has already

developed. Such advice may be given particularly at the time of discharge or for operations, during the stay of patients in the hospital.

Familiogram

In order to identify eligible persons and to well an obstetrician to select patients in the maternity ward for Family Welfare advice, Government has directed that" Familiogram" be stamped on every outdoor case paper. The Familiogram gives details of obstetric history, children living, children dead etc. A glance at this can help the obstetrician to select cases. The form of record in a Familiogram may be seen. In addition this procedure is to be adopted by all clinical departments in the hospital so that the message of Family Welfare will reach every individual attending a hospital for medical care.

Motivation of Staff

It is obvious that with hospitals being such important centres for doing Family Welfare work, the hospital staff itself must clearly imbibe the current policy regarding this matter, understand all its implications and gear itself enthusiastically to carry out the work to the bet of its ability. The medical officer in charge of the institution and the staff of urban family welfare planning centers in the hospitals must take the necessary lead in educating and motivating the staff with reference to the current policy. A point which particularly needs to be kept in mind is that hospital staff is important, not only at particular level, but rather at all levels including ward servants and sweepers. The staff should be well aware of all methods of Family Welfare being practiced in the hospitals and should be able to give information regarding the same to all with whom they come in contact with in the routine course.

Inter departmental coordination to be taken to promote family welfare program.

Advice on Other Matters

It is possible that persons approaching hospitals for Family Welfare advice or family 'planning operations, may seek clarification, guidance or treatment for other matters and this should be attended to. On the other hand, if doctors discover certain ailments while carrying out Family Welfare work, they should render similar medical aid. This will create a sense of confidence in the Family Welfare Programme apart from doing considerable good to the patients. e.g. heart disease, hepatitis, hematological disorders, sickle cell anaemia, thalassemia, HIV etc.

9.2 Exhibition Panel

In the outpatient department of a hospital, an exhibition panel should be set up on the wall, giving basic information on Family Welfare Services. Informative posters and charts should be front-lit, back-lit, etc.
Family welfare corners should be displayed in RH, SDH& above institutions.

Family Welfare Corner should have 1 table with the following materials displayed.

Copper T 375	- 5 pieces
Copper T 380 A	- 5 pieces
Condom	- 5 pieces
Mala N	- 5 pieces
Antara	- 2 vials

Chhaya - 5 packets

EZeepill - 5 pieces

9.3 Information of contraceptive methods

Above table should have flex displaying contraceptive methods, its usage & advantages.

All public health institutes eg. PHC,RH, SDH,DH should have this corners, whose maintaining responsibility to be assigned to one health personal/ANM/SN/PHN. Board should mention his/her name & contact number, so that, further inquiries can be consulted by public with these persons.

These will enable waiting patients to get them selves educated and stimulate them think on all aspects of Family Welfare. The staff of the Family Welfare centre in the hospital should visit the section and give talks on the subject.

Spacing Methods

These should be made available to all such persons who have been properly motivated along with their spouse for using them, otherwise it is so much waste of money and expenditure. Adequate motivation should be given to women admitted in hospitals but conventional contraceptives may be given to all conventional contraceptive corners.

TemporaryMethods of Family Welfare Program:

Sr.No	Types of Method	Beneficiaries
1	Condom Contraceptive	To be used by male, Easy for use , single use, Prevents STD's Freely available, Low cost, Wide acceptance by public ,can be used by all ages, No major side effects
2	Centchroman	Chaya tablets can be used by non-pregnant mother it can be used by any age child bearing or non-child bearing those affected by side effect of MALA N, MALA D, it does not affect lactation. To be administered by trained Health staff side effects are very few, in some cases delay may occur in 1st Three months.
3	PPIUCD	At least 25% of Hospital Deliveries should be inserted PPIUCD, Trained MO / Staff, Inserted in Fit Patients after 10 min of expulsion of placenta.Beneficiaries are all delivered mothers except those having chorioamnionitis, post-partum infection postpartum hem rage

		not responding. Prolonged, rupture of membranes. side effects are excessive virginal discharge pain in abdomen, fever spontaneous expulsion
4	Injectable ContraceptiveMPA (ANTARA)	To be used under Supervision of trained Health worker to be stored away from direct sunlight not to be freezed. Can be used by all women after 42 days of deliveries, easy to use few side effects.
5	Emergency Contraceptive	Emergency contraception refers to backup methods for contraceptive emergencies which women can use within first few days after unprotected intercourse to prevent unwanted pregnancy. It is to be used within 72 hours of unprotected vaginal intercourse. The high doses of progestogen only and combined Ethinyl estradiol & Levonorgestrol or Copper realising intra uterine devices such as CuT 380A.

Ref.

1. *Deputy Commissioner MOHFW New Delhi Letter no. 11027/2016 Dated: 22/06/2017.*
2. *Additional Director Letter no. 18895 Dated: 02/04/2016.*

9.4 General Aspects of Sterilization

Sterilization Services in 'Fixed Day Static' Mode

'Fixed Day Static' Approach : FDS ('Fixed Day Static') approach in Sterilization Services is defined as “providing sterilization services in a health facility by trained providers posted in the same facility, on fixed days, throughout the year on a regular and routine manner".

Advantages of FDS

- Availability of regular services (breaking the seasonal trend).
- Availability of trained provider at the facility.
- Larger pool of providers for sterilization services.
- Increased opportunity for conducting PPS.
- Increased availability of services below district and sub district level.

Steps to Enhance focus on Static Services in Sterilization

Assessment of Resources (Facility Mapping)

Range of services

1. NSV/Conventional Vasectomy.
2. Minilap Tubectomy.
3. Laparoscopic Tubal Occlusion.

Periodicity of services (Suggestive)

District Hospital	Twice a week
Sub District Hospital	Weekly
RH/ Block PHC	Fortnightly
24X7 PHC	Monthly

However those facilities which are already providing the services in a frequency more than what is suggested above may rationalize the distribution of the providers among the various facilities in the district and strive to augment the services even further to address the prevailing huge unmet need.

Empanelled Surgeon	Sterilization	Service	Basic Qualification Requirement of Service Provider
	Female	Minilap	i)DGO, MD/MS in ObGyn ii) Specialists in other surgical fields iii) MBBS
		Laparoscopic sterilization	i)DGO, MD/MS in ObGy ii) Specialists in other surgical fields Trained in laparoscopic iii) MBBS performing Minilap sterilization
	Male	Conventional Vasectomy	i)MBBS and above (trained in No Scalpel Vasectomy)
		No-scalpel vasectomy (NSV)	i)Conventional i) MBBS and above (trained in) vasectomy

Eligibility of Providers to Perform Sterilization procedure

1. The state should maintain a district-wise list of doctors empanelled for performing sterilization operations in public and accredited private/NGO facilities based on the above criteria.
2. State should maintain a separate list for Minilap, Laparoscopic tubectomy, Conventional and No Scalpel Vasectomy providers.

Eligible criteria for Case Selection:
(Self-declaration by the client will be the basis for compiling this information. No eligible client should be devoid of Family Welfare services)

- Female clients should be above the age of 22 years and below the age of 49 years.

- Male clients should be above the age of 22 years and below the age of 60 years.
- The couple should have at least one child, whose age is above one year unless the sterilization is medically indicated.
- Clients or their spouses/partners must not have undergone sterilization in the past (not applicable in cases of failure of previous sterilization).
- Clients must be in a sound state of mind so as to understand the full implications of sterilization.
- Mentally challenged clients must be certified by a psychiatrist and a statement should be taken from the legal guardian /spouse regarding the soundness of the client's state of mind.

Counselling

Counselling in Family Welfare is the process of facilitating and enabling clients to make well informed, well considered and voluntary decisions about fertility and to choose a contraceptive method. Counselling is a client centered approach that involves communication between a service provider/counsellor and client. Counselling enables the service provider to understand client's perception, attitudes, values, beliefs, Family Welfare needs and preferences and accordingly the counsellor can guide her/him towards decision making. The provider/counsellor should be non-judgmental. Privacy (auditory and visual) and confidentiality should be maintained during the process of counselling.

Clients may not have complete information about sterilization and its effect which is further compounded by misconceptions and concerns. These should be dispelled by providing correct information.

Informed Choice and Informed Consent

The concepts of informed choice and informed consent are related but quite different in their intent. The purpose of informed choice is to ensure that all clients choose the best option/s for their health care needs after getting full information about all available options. Informed consent means that a client understands the surgical procedure and other options and then decides to receive the care. However, informed consent alone does not constitute informed choice (Annexure 1).

The consent of the partner is not required for sterilization. However the partner should be encouraged to come for counselling.

9.5 Standards for Female Sterilization

Clinical Assessment and Screening of Clients

Prior to the surgery, compilation of the client's medical history, physical examination and laboratory investigations as specified below needs to be done in order to ensure the eligibility of the client for surgery. The details are specified in the 'Reference Manual for Female Sterilization (2014)'.

Demographic Information

The ensuing information is required: Name of the client, spouse's name, age, address, marital status, occupation, religion, educational status, number of living children and age of the youngest child. If possible, contact telephone number of client, ASHA/ANM (if available).

When to perform Female Sterilization:-

Woman's Situation	When to Perform
Having Menstrual Cycles	• Any time within 7 days after the start of her menstrual bleeding. • Any time of menstrual cycle, provided it is reasonably certain that she is not pregnant.
Switching from another Method	• OCP: To be done any time, but she can continue the pill until the pack is finished to maintain her regular cycle. • IUCD: To be done anytime, concurrently with removal of IUCD.
No monthly menstrual bleeding	• Any time provided it is reasonably certain she is not pregnant.
After childbirth	• When to perform within 7 days after giving birth (only Post-Partum Minilap tubectomy can be performed). • Any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant. (Interval Sterilization).
After MTP	• Concurrently with surgical MTP or within 7 days post MTP. • In case of Medical Abortion the tubectomy should be done after next menstrual cycle. • Laparoscopic tubal occlusion procedure can be performed only in MTPs up to 12 weeks of gestation.
After miscarriage or Abortion	• Within 7 days, if no complications.
After using emergency contraceptive pills (ECPs)	• Within 7 days after the start of her next monthly bleeding or any other time if it is reasonably certain she is not pregnant.

Laparoscopic tubal occlusion should not be done concurrently with second-abortion and in the early post-partum period up to 42 days.

Physical Examination:

- General Examination-Check and record pulse, blood pressure, respiratory rate, temperature, body weight, general condition and nutritional status and signs of anaemia (such as pale skin or conjunctiva, rapid pulse (>100/min), systolic murmurs)
- Abdominal Examination-for any tenderness, mass etc.

- Pelvic Examination - Inspect external genitalia for abnormalities and lesions, enlarged groin nodes.

Ensure that the client has passed urine before performing a pelvic examination

- Speculum Examination - check for abnormal vaginal discharge, cervix for purulent cervicitis. If indicated by history, physical findings and microscope is available, obtain specimens of vaginal and cervical discharge for diagnostic studies. Rule out RTI/STI.
- Bimanual Pelvic Examination-Rule out PID, Uterus-size, position, mobility, adnexa, pouch of Douglas etc.
- Any other examination, as indicated by the client's medical history or general physical examination.

Laboratory Examination

Blood test for hemoglobin, urine examination for sugar and albumin and pregnancy test, if needed.

Caution: Clients with Hemoglobin<7 gm/ dl should not be accepted for sterilization and referred to higher centres for management.

Preoperative Instructions (For Clients)

- Bath and wear clean and loose clothes to the OT.
- Not to take anything orally (not even water) at least 4 hours prior to surgery and milk or tea at least 6 hours prior to surgery. any solids,
- Empty her bowels on the morning of the surgery and pass urine before entering the OT. She should remove her glasses, contact lens, dentures, jewellery, if she is wearing any of these items.
- A responsible adult must be available to accompany the client back home after the surgery.

Part Preparation

- The operative area should not be shaved. The hair can be trimmed if necessary, since shaving the operative site on the eve of the surgery increases colonization of microorganisms. However, shaving done just prior to surgery is acceptable.
- The operative site should be prepared immediately preoperatively with an antiseptic solution, such as Iodophore (Povidone iodine) or chlorhexidine gluconate (Cetavalone).
- The antiseptic solution should be applied twice in a circular motion, beginning at the site of incision and working out for several inches. This inhibits the immediate re-contamination of the site with local skin bacteria.
- After preparing the operative site, the area should be covered with a sterile drape.

Premedication/Anaesthesia/Analgesia

Local anesthesia is recommended both for Minilap tubectomy and Laparoscopic tubal occlusion which has enabled health institutions to provide sterilization services safely even in settings with limited resources.

Premedication

Reassurance and proper explanation of the procedure go a long way in allaying the anxiety and apprehension of the client. However, if needed, preferably Tablet Alprazolam (0.25 to 0.50 mg) or Tablet Diazepam (5 to 10 mg) can be given one hour before the operation. Local Anaesthesia is safer than general anesthesia. The key to safe use of a local anesthetic is to be sure that it is not injected directly into a vein and to use the lowest effective dose

General Anaesthesia (GA)

This is rarely necessary. However, it may be required in the following conditions:

- Non-cooperative patient.
- Obesity.
- History of allergy to local anesthetic drugs.
- Anticipated difficult surgery.

Sterilization under GA and regional anesthesia should be done in centres where all routine and emergency back-up facilities are present for providing such anesthesia and to be administered by a qualified/competent anesthetist.

9.6 Monitoring

Client monitoring must be a routine practice in performing sterilization procedure. It is of special importance during the use of local anesthesia, especially if sedatives and analgesics are also used, as the drugs may cause respiratory and cardiovascular depression, hypersensitivity reactions or central nervous system toxicity.

Steps of Monitoring:

I) Medical records are to be maintained relating to the vital signs (pulse, respiration and blood pressure), level of consciousness, vomiting and any other relevant information. The name of the drug(s), dosage, route and time of administration must be recorded (Annexure 3).

ii) Monitoring is to be done as described below:

- Preoperatively: Pulse, respiration and blood pressure should be taken prior to premedication and thereafter every 10 minutes.
- Intra-operatively: (a) Maintain verbal communication with client; and (b) check pulse, respiration and blood pressure every 5 minutes, especially during the time of gas insufflation and at the time of tubal ligation.
- Post-operatively: Pulse, respiration, blood pressure and also skin color (nail bed) should be monitored and recorded every 15 minutes for one hour following surgery or longer, if the patient is unstable or not awake.

Post-operative Care

In the post-operative period, the client should be kept under observation by a nurse/doctor. Following are the tasks to be carried out in the post-operative period.

- Receive the client from the operating theatre; review the client record.

- Make the client as comfortable as possible (handle the woman gently when moving her).
- Make sure that an over sedated client is never left unattended.
- Monitor the client's vital signs check blood pressure, respiration and pulse every 15 minutes for one hour following surgery or till the patient is stable and awake. Thereafter, check vitals every one hour until four hours after surgery. Record vital signs in the client record each time they are checked.
- Check the surgical dressing for oozing or bleeding.
- For interval cases, check for vaginal bleeding other than menstruation. If the client is bleeding, the doctor should check for possible injury to the cervix that may have been caused by the vulsellum.
- Administer drugs or treatment for symptoms according to the doctor's orders.
- Provide water, tea and fruit juices when the client feels comfortable.
- Fill in the client record form.

The client may be discharged when the following conditions are met:

- After at least 4 hours of procedure, when the vital signs are stable and the client is fully awake, has passed urine and can talk, drink and walk.
- The client has been seen and evaluated by the health care provider. Whenever necessary, the client should be kept overnight at the facility.
- The client must be accompanied by a responsible adult, while returning home.
- Analgesics, antibiotics and other medicines may be provided and/or prescribed as required.
- After sedation has worn off and before discharge, a trained staff member should repeat the postoperative instructions to the client or designated accompanying person. A written copy of the postoperative instructions should also be provided.

Failure of Operation Leading to Pregnancy

Female Sterilization is one of the most effective methods but carries a small risk of failure. The incidence of failure is less than one pregnancy per 100 women over the first year after having the sterilization procedure (5 per 1000). This means that 995 of every 1000 women relying on female sterilization will not become pregnant. However, a small risk of pregnancy remains beyond the first year until women reach menopause. The failure over 10 years of use is about two pregnancies per 100 women (18 to 19 per 1000 women). Ectopic pregnancy must be ruled out as female sterilization predisposes to this condition.

In case of missed menstrual period, the clients are advised to report to the health care facility within two weeks for confirmation about the failure of her sterilization procedure. She should be offered MTP and repeat sterilization procedure free of cost or be medical supported throughout the pregnancy if she wishes to continue.

Reversal of Sterilization

The wide spread prevalence of female sterilization particularly those opting for it at a younger age has led to an increasing number of requests for reversal procedures. Most women and their partners are satisfied with the procedure but life's circumstances and outlook can change which may need reversal of female sterilization. Women considering female sterilization

should not think it is reversible. The female sterilization reversal is a major surgical procedure involving end to end anastomosis of the ligated/occluded fallopian tube(s) i.e. Tuboplasty. Hence, the success of this procedure cannot be guaranteed.

9.7 Standards for Male Sterilization

Clinical Assessment and Screening of Clients

Demographic Information

The ensuing information is required: Name of the client, spouse's name, age, address, marital status, occupation, religion, educational status, number of living children and a of the youngest child.

History

Specific information which should be obtained as part of the history includes:

- **Medical History**
  - History of illness or other medical conditions in the past or present to screen out the diseases mentioned under the medical eligibility criteria and also to rule out acute febrile illness, uncontrolled diabetes, bleeding disorders, sexual problems and mental illness.
  - Immunization status of men for tetanus.
  - Current medications, if any.
  - Current use of contraception by the couple.
  - Last menstrual period (LMP) of the wife.

Physical Examination

Pulse and blood pressure, temperature, general condition and local examination of penis, testicles and scrotum. Further examinations as indicated by the client's medical history.

Laboratory Examinations: Urine analysis for sugar and other laboratory examinations as indicated.

Timing of the Surgical Procedure: Male sterilization can be done at any convenient time on healthy and eligible clients.

Skin Preparation and Surgical Draping

- The pubic hair can preferably be trimmed, if not done earlier, since shaving the operative site on the eve of the surgery increases colonization of micro-organisms. However, shaving done just prior to surgery is acceptable.
- The operative site should be prepared immediately pre-operatively with an antiseptic solution such as Iodophore (Povidone iodine).
- The antiseptic solution should be applied twice in a circular motion, beginning at the site of incision and working out for several inches. This inhibits the immediate re-contamination of the site with local skin bacteria.
- Entire scrotum should be painted beginning at the site of incision/puncture.
- After preparing the operative site, the area should be covered with a sterile drape.

Premedication/Anaesthesia/Analgesia

a. **Premedication** is not necessary in vasectomy. However if the client is very anxious and to assist in relaxing the scrotum, tablet preferably Alprazolam 0.25-0.5 mg or Diazepam 5-10 mg may be given one hour prior to surgery with a sip of water.
b. **Local Anaesthesia** is recommended for vasectomy procedures. Good local anaesthetic technique is essential for a pain-free vasectomy. The local anaesthetic to be used is 1% lignocaine without adrenaline. The maximum individual dose of lignocaine without adrenaline should not exceed 3 mg/kg of body weight. In general, it is recommended that the maximum total dose does not exceed 200 mg or 20 ml of 1% lignocaine or 10 ml of 2% lignocaine (2% lignocaine, to be diluted with an equal amount of distilled water).

i) Adequate time must be allowed for the medication to be effective.
ii) Communication must be maintained with the client throughout the operation.

Post-operative and Follow-up Instructions

- Tell client that he should report to the clinic for semen examination three months after the surgery.
- If sperms are still present then semen is tested every month till six months.
- Failure of vasectomy should not be declared till six months.
- If sperms are still present after six months re-vasectomy should be considered

Post Surgery(both conventional and No-scalpel vasectomy)client should:

a. Wear Scrotal support: for one week, until the stitches are removed.
b. Limit activities after surgery for 24 hours. Light activities can be resumed after two or three days but should avoid heavy work for a week or so after removal of stitches.
c. Refrain from bathing for at least 24 hours after surgery.

The client may resume sexual activity as and when he feels comfortable but should use either condom or another method of Family Welfare until it is confirmed that sperms are no longer present in the semen. A slight pain may be felt or blood may be noticed in semen which is normal.

9.8 Infection Prevention and Control (IPC)

Standard Universal Precautions for infection prevention include hand washing, self-protection by wearing attire, safe practices to prevent injuries from sharps, maintaining proper environmental asepsis, processing instruments and reusable items, and proper waste disposal.

Hand Wash is the most effective way to reduce transmission of infection

- Routine Hand Wash using Soap & water: should be done before wearing and after removing gloves, after having any direct contact with a client and after contact with body fluids.
- Surgical Scrub The surgeon and assistants must scrub both their hands and forearms above the elbows thoroughly with soap and running water or antiseptic agents for 3-5

minutes repeating procedure for at least three times. The hands and forearms should be dried with sterile towel or air dried.

- Hand Wash with antiseptic hand-rub: Ideally, the surgeon and the assistant should scrub thoroughly between each procedure. In high case load (like camp settings), in order to prevent re-colonization of the skin by micro-organisms, the surgical staff should do surgical scrub every hour or after every five cases (whichever is earlier) or if the surgeon (and/or the surgical stuff) goes out of the OT, or touches any infected item or if the glove is torn. In between antiseptic alcohol scrub should be done

Self-protection by using Attires: like gloves, cap, eye shield, mask, apron OT shoes

All health service providers should wear protecting gloves during all procedures involving contact with any client and biological fluids. Three types of gloves are used in the clinical practice:

- Examination: used for taking intravenous samples; in OPD while performing bimanual examination of non-pregnant women; touching intact skin and mucosa.
- Surgical: used for surgical procedures.
- Utility: used to clean the used instruments, linens, surfaces and handling waste.

Environmental Asepsis:

Theyshould be and Asepsis protocols should be followed at all the facilities. 0.5% chlorine solution and detergent should be used for scrubbing of procedure rooms from top to bottom and before surgery and after surgery, operating table, table/counter top and light handles with a cloth. 0.5% chlorine solution should be used for cleaning floor and managing spills. OT, when not in use s locked and cleaned weekly by scrubbing top to bottom with 0.5% chlorine solution detergent. The entry of people and their movement inside the OT should be minimal.

Processing of Equipment, Instruments and Other Reusable Items

Proper processing of instruments and other reusable items minimizes the infection.

Steps for Instrument Processing:

a) Decontamination: Used Surgical instruments, reusable gloves and before cleaning should be decontaminated by soaking in 0.5% Chlorine solution for 10 minutes. It assists disinfection and protects from HIV, HBV/HCV and removes tissue and body fluids. A fresh chlorine solution should be prepared at the beginning of each day. The chlorine solution should be discarded after 24 hours or earlier when it is visibly dirty. Laparoscope should be decontaminated prior to HLD with cotton/gauge swab soaked in spirit. Chlorine solution should not be used for decontamination of laparoscope.

b) Cleaning: The instruments and other items should be scrubbed brush in water with detergent solution to remove all blood, tissue, other residue and reduces the number of micro-organisms and endospores. The items should then be rinsed thoroughly with water and allowed to dry with soft cloth or air-dried or placed directly for HLD by boiling vigorously with a tooth

c) High-level Disinfection (HLD): is effective in eliminating all micro-organisms except endospores and acceptable for processing instruments and other items for reuse, if sterilization

is not possible. HLD can be achieved either by boiling or by soaking in a highlevel disinfectant for 20 minutes by soaking in a chemical solution like 2% Glutaraldehyde solution.

d) Sterilization eliminates all microorganisms, including endospores. It can be done by using steam (autoclaving at 15 lb/sq. inch pressure for 20 minutes for unwrapped instruments and 30 minutes for wrapped instruments and linen) or soaking in a chemical solution like 2% glutaraldehyde solution for at least 8 hours.

e) Storage: Use high-level disinfected or sterilized instruments and linens immediately, or store them for up to 1 week in a high-level disinfected or sterilizedair-tight container accordingly with a tight-fitting cover.

ITEM-WISE RECOMMENDED METHODS

Material	Method	Procedure
Linens (drapes, sponges, scrub suits etc)	Autoclave	At 15 lbs/Sq. inch pressure for 30 minutes. Use within one week but if drum is opened, use within 24 hours.
Rubber items (gloves, catheters and rubber tubing)	Autoclave	Wrap rubber items in paper/newspaper before Autoclaving at 15 lbs/Sq. inch pressure for 30 minutes. Gloves should always be used 24-48 hours after Sterilization, so that they regain their elasticity.
	HLD by boiling	Boil them in an immersed state for 20 minutes after water comes to rolling boil, then use immediately.
Surgical Instruments	Sterilization by Chemical	Immerse in either Chemical HLD by minutes. Paracetic acid: for 30 minutes (or)Glutareldehyde 2%: 8-10 Hours
	Autoclave	At 15 lbs/Sq. inch pressure, 30 minutes for wrapped and 20 minutes for unwrapped items.
	HLD by boiling	After water comes to rolling boil, boil in immersed state for 20 minutes
	HLD by Chemical	Paracetic acid: 10 Minutes (or) Glutareldehyde 2%: 20 Minutes

9.9 Biomedical Waste Management

There are four steps in the waste management plan:

1. Segregation: Health facilities should use color coded bags or containers to collect different types of waste like

- Black bin: for general waste.

- White/Blue bin/Puncture-proof container: for sharps such as needles, blades, broken glass etc.
- Yellow bin: for anatomical waste such as placenta, body parts, swabs etc.
- Red bin: for infected plastics, syringes, dressings, gloves, masks, blood bags, urine bags.

2. Collection and Storage: Waste should always be collected in covered bins and filled upto not more than three-fourth level. Never overfill the bins and store waste beyond 48 hours.
3. Transportation: Transportation of waste should always be in closed containers.
4. Disposal of Waste: It should be done as per Biomedical Waste Management Rules 2016.

9.10 Certificate of Sterilization,Reporting of Sterilization Deaths, Complications and Failures

Certificate of Sterilization

For payment of compensation for undergoing sterilization operation, discharge slip/card will be considered a valid proof of undergoing Sterilization.

In case the surgeon was unable to identify the vas on one side and thereby could occlude/ligate it, he/she should document it on the case sheet and inform the client accordingly that the sterilization procedure has not been successful. This documentation o the case sheet should also be countersigned by the client or their thumb impression taken (if illiterate). In such cases sterilization certificate should not be issued. Such cases where eligible for sterilization certificate has not been issued are not compensation for 'failure' under Family Planning Insurance scheme (FPIS)

Report on Sterilization Deaths

Following procedures are to be adhered to for reporting of sterilization deaths

Sterilization Death Notification

Sterilization deaths are to be reported in the Death Notification Formto the District CMO, i.e. the convener of the District QAC, within 24 hours of death by telephone, e-mail, or in person. The operating surgeon of the case should also be informed simultaneously of the occurrence of death so that he/she may fill up Death Notification Form within 7 days of intimation and send it to the District QAC.

- It is the responsibility of the Medical Officer at the institution where the death occurred to fill in Death Notification Form.
- A copy of the Death Notification Form must also be sent to the state-level convener.

Following the immediate notification of death by the medical officer, the operating surgeon should review the records and complete on sterilization deaths and send it to the convener of the District QAC within 7 days. A copy of the records and the autopsy report and other pertinent information should be forwarded along with this report to officials as indicated earlier.

Death Audit Report

The District QAC will review the report, discuss the findings, conduct a field investigation and make recommendations for corrective action. The District QAC will then complete the Death Audit Report.

The Death Audit Report should be presented by the District QAC within 30 days to the state-level committee, which will then forward it to the Government of India with their comments.

Report on Sterilization Complications

The report on complications requiring hospitalization attributable to sterilization is to be filled in by the District QAC of the district where the client has reported.

The reportable complications are as follows:

- Any problem directly related to surgery and/or anaesthesia that occurs within 60 days of the operation and intervention or management beyond what is normally required and that necessitates hospitalization
- Blood transfusion is required;
- Any problem arising out of additional unplanned surgery other than that of the fallopian tubes, mesosalpinx or vas deferens at the time of the sterilization procedure,
- Any subsequent operation/operations related to the original surgery.

The DQAC should conduct a field investigation/enquiry, review the case record, discuss the findings and make recommendations for corrective action.

Report on Sterilization Failures

Sterilization failure is defined as any pregnancy that occurs after certification of the sterilization operation. In case of suspected pregnancy after the sterilization procedure, investigations such as urine test for pregnancy, USG and semen examination (in the case of male clients) should be conducted.

The report on failure attributable to sterilization is to be filled in by the District QAC of the district where the client has reported within two weeks of reporting. The District QAC will conduct a field investigation /enquiry, review the case record and report the findings to the state committee.

A final report of the audit is to be sent to all those who are involved in the audit process, including the Medical Superintendent /Officer In-Charge/Administrator and other appropriate persons concerned at the institution where the death has occurred. The recommendations are to be shared with the concerned staff.

The audit records should be kept for ten years for the purpose of comparison and for facilitating future audits. Copies are to be kept in a medical audit binder.

The processing and settlement of the death, failure and complication claim should be done by the District QAC where the client has reported.

The District QAC will also be responsible for communicating information related to the concerned SQACs for compensation in case of complications/failures/deaths.

Vasectomy Reversal

Most men and their partners are satisfied with the procedure but life's circumstances and outlook can change which may need reversal of vasectomy. Men considering vasectomy should not think it is reversible. Reversal of vasectomy or Vaso-vasostomy is a microsurgical procedure requiring considerable skills. Vaso-vasostomy is effective at achieving pregnancy in a variable percentage of cases but its success rate cannot be guaranteed. After reversal, sperm counts and motility are usually much lower than pre-vasectomy levels.

There is no association of prostatic or testicular cancer and cardiovascular disorder with vasectomy

9.10 Miscellaneous

Leave Concessions (GR dated 14/07/1981 No 1480-CL-1399/SER-9)

- Those male employee who undergoes vasectomyoperation should be given special casual leaves of six days
- Those female employees undergoing tubectomy operation to be given special casual leave of 14 days.
- That female employee undergoing copper T should be given special leave on that day.
- That female employee undergoing sterilization operation after medical termination of pregnancy should be given special casual leave of 14 days.
- That male employee whose first operation has failed then for 2ndoperation should be given 7 days special casual leave.
- That male employee whose wife undergoes family welfare operation should be given 7 days special casual leaves.
- Those employee (Male/Female) developed complications after operation and requires additional days leaves as certified by competent authority of hospital to be granted special casual leaves for additional days.
- Those requiring rest after discharge from hospital and is unable to perform normal work, as certified by competent authority should be granted special casual leaves for 7 days to male and 14 days to female employee.
- That employee undergoing recanalization operation should be given 21 days leave or actual stay in hospital whichever is less.

Family Welfare Centres and immunization program

Post-Partum Centres and Family Welfare Planning Centre in hospitals and medical institutions in urban areas should arrange for immunization as per revised schedule , of children and tetanus immunization of pregnant mothers in as many cases as possible. The idea that such immunization should be carried out only in rural areas is not correct. Private practitioner too

should be involved in this programme. The Family Welfare Centres in hospitals have thus to pay sufficient attention to this work also.

Antenatal and Postnatal advice

Since antenatal and postnatal periods are very important from the point of view of motivation and advice regarding Family Welfare, medical officers incharge of hospitals should ensure that all antenatal and postnatal records should show advice and instructions given to persons in connection with Family Welfare, and similar records should be entered on case papers of patients who are discharged.

References -

1) Government of India's Module Standards & Quality Assurance in Sterilization S Services. Nov. 2014.
2) Reference manual for Female Sterilization Family Planning Division, Ministry of Health & Family Welfare Government of India 2014
3) Operational Guidelines on Fixed Day Static Approach for sterilization services under National Family Planning Program 2008.

CHAPTER X
OFFICE ADMINISTRATION

Various Government orders about running of offices in this department as well as orders of a general nature have been mentioned in Chapter 32 of the Civil Medical Code. Office administration. Instructions are given below about certain important aspects of hospital

10.1. General

A number of beneficial schemes have been started by Government especially as a part of the 5-year plans. The advantages of such schemes will, however not reach the public unless the office administration is efficient. "A chain is as strong as the weakest link".

Office work must be done in a systematic manner, from the stage of receipt of papers to the stage of final disposal. The various standing instructions must be communicated to the office staff repeatedly and the Chief Administrative Officer/ Administrative Officer should see that they are observed properly. A thorough knowledge on the part of C.A.O./A.O. himself is obviously a prerequisite to enable him to do this duty properly.

Coordination between Various Tables

A common experience is to find one and the same subject being dealt with on more than one table without one table being aware about the other table dealing with it. This occurs because at the higher-level steps are not taken to coordinate the work. In order to achieve this, emphasis must be laid on subject matter rather than disposal of individual files as sent from different branches. Files on one and the same subject have their own way of starting with perhaps a little variation. One may arise as a result of a conference, a second from a newspaper cutting, a third from an inspection note, the fourth from a resolution passed by some institution and so on.Dealing with such files individually leads to piecemeal decisions.

It is also often seen that there is a big communication gap between different branches. If one branch requires certain information from the other branch, either no efforts are made to obtain it at all, or a written communication is sent to the branch though the information can be gathered in a matter of minutes by personal approach. In such cases also, the Senior Administrative Officer, Junior Administrative Officer should see that effective coordination is achieved.

An item of correspondence may contain a number of issues which are dealt with by different branches/ tables

Here also the C.A.O./A.O. /Office Superintendent must pay a good amount of attention to coordination, so that a complete reply can be formulated.

Arrangement of Papers/Files

In spite of precise Government orders, regarding arrangement of papers, they are mostly kept in a disorderly fashion. Thus, the clerk sitting on a particular table cannot find his own papers. There is a complete standstill if the clerk is on leave or absent due to any other reason. A common experience is to get the reply: "Not available" or "cannot be traced" at the eleventh

hour, even when important matters are being handled and when reply has to be given to Government, may be, even for the purposes of Legislative Assembly matters/ RTI Act 2005. For arrangements of papers, the six-bundle system is the most effective way to restore all the documents with the concerned table clerk. The procedure of following six bundle system as mentioned in annexure 10.1.

Each clerk must devote a adequate time every day at the end of the day for arranging his papers and files as per Government orders, unless this is done the same way as writing a Cash book, there will be chaos. Any arrears in this work means an unmanageable accumulation of papers and increasing difficulty in finding out the paper/file when required. A cashbook is an important document in any office and it should be stored for a period of 30 years in a safe custody.

Discipline in the Office

The office should not allow loitering amount of valuable time. No time should be wasted in mutual discussion pertaining to extraneous matters in the office itself. Duty of every Government Servant to maintain integrity devotion to duty as per MCS (conduct) Rule 1979 and updated upto 31st Dec 2016.

10.2 Standing Orders

It is said that one of the important characteristics of any office is to rely heavily on precedents rather than taken independent initiative and judgment. Apart from the correctness or other-wise of such a statement, it can be confidently said that empirical noting cannot be made at a lower level on each question as it presents itself. Such replies may be based on common sense but they are bound to land every-body in trouble and offer but little guidance. Even staff at higher level cannot change precedents or previous decisions without giving due consideration to them. The whole point is that if precedents are to be broken the person who does so should first be aware of the existence of the precedent. If a fresh decision is taken with due cognizance of the precedent there is no objection, but if such a decision is taken because of ignorance of the precedent or non-availability of standing orders due to unsatisfactory filing then it is undesirable.

All orders and circulars, therefore, which are of a standing nature and which will act as guidance for future reference must be compiled together. If they are filed in a bundle one after the other practically no benefit can result. A reference to such a jumbled file is difficult and impracticable. The standing orders files should, therefore, be subject wise and in chronological order. In fact, there should be a sort of library or reference section in each office.

One clerk should entirely look after the work of collecting standing orders and putting them in position. The file bureau should help the officers and the other staff members in the office by producing the necessary reference when required. If this is done, the time required

by officers to take decisions, officers to take decisions, and time required for final disposal of the file will be considerably reduced.

Besides the regular Government Resolutions and Circulars issued at various levels, important decisions taken from time to time should also be collected as standing orders.

10.3 Disposal and of Tapals, Inward and Outward letters, D.O. Letters, Legislative Assembly Questions

Zero Pendency and disposal of the record should be done as per GR dated 15th February 2018, Government of Maharashtra as given in annexure 10.1

Regarding the disposal of papers one has to start with reading the Tapal received every day very carefully, otherwise a number of papers/letters/tapal may be missed. The Head of the office must see all Tapal received from offices and the Chief Administrative Officer/ Administrative officers must see all the Tapal received in the office. This will reduce the need for reminders by other offices.

Those items of correspondence which do not require any thinking or reference to file or discussion, study, planning, visits to other offices, or finding outs formation, etc. should be dealt with on the spot. They should be classified as Tatkal/Tatadiche (as per revised Office Procedure Manual) For example, a paper is to be sent to another office for remark or the date of joining of a particular incumbent is to be informed. There is no reason why this paper also should come up in the chronological order. If the reply can be given effortlessly it should be done immediately. Thus, as soon as receipts are received and as the contents are gone through the disposal decided and dealt with.

Other papers should be arranged in three sections,' ordinary', 'urgent', and 'immediate' each in chronological order and disposed of accordingly within a stipulated time period.

No time should be lost in discussing "Please discuss" cases. Discussion becomes more and more difficult as delay progresses. As per Office Procedure Manual, discussion should be held within 24 hrs.

While sending replies, the attitude should not be to simply supply the requisite information against the queries raised mechanically but it should be constructive and helpful. If certain additional facts are going to help the disposal of correspondence quicker and more efficiently than they should be included even though they may not form a part of the query.

The C.A.O/A.O. the Civil Surgeon/Superintendent should scrutinize papers signing, even if drafts are approved. The typed copy must be read as one is not sure of the accuracy of typing and omission of vital words may change the meaning completely.

There are a number of references which require stereotyped replies. Each office should have the necessary Computerized forms kept ready for this purpose. As far as possible printed reminder forms and acknowledgement forms should be used.

Now a days, in every Civil Surgeon/RH/SDH office, the introduction of E-Officehas made computer training mandatory for the office staff. *(as per circular dated on GR 11 November 2013)*

ई ऑफिस सॉफ्टवेअरचा वापर बंधनकारक करण्याबाबत (शासन परिपत्रक क्रमांक ईजीव्ही-२०१३/प्र क्र ४६/ ई गव्हर्नन्स दिनांक ११ नोव्हेंबर २०१३

Inward Letters

Many a time letters sent by the inward clerk to various clerks are not accepted in time. The letters should therefore be sent along with a dispatch book containing the numbers of these letters. The receiving clerk should sign in the dispatch book in token of having received the letters and send the book back to the inward clerk. The receiving clerk should record the time and date. The object is that the receipt of *inward letters* must be completed within 24 hours of arrival of letters.

Medico-legal Correspondence

All letters regarding medico-legal matters should be sent to the Additional Civil Surgeon (ACS)/ Medical Superintendent (MS)/ Senior Medical Officer.A separate work sheet, should be kept for this correspondence. Outward letters should be signed by the Additional Civil Surgeon (ACS)/ Medical Superintendent (MS)/ Senior Medical Officer or Civil Surgeon/Superintendent.

D.O. Letters, Legislative Assembly Questions

All D.O. letters should be replied in 48 hours. At least an interim reply should be given and the situation reviewed weekly.

Replies to assembly/Council/Loksabha and Rajyasabha questions must be completed and sent in time. If the question is starred a full supplementary note must be sent. Information required should be obtained by letter, email,telephone or by a messenger, whichever is necessary.

Separate record is to be kept of Government References, D.O. letters and Assembly questions.

Reminders

At present reminders are issued by the clerks from time to time solely depending on their memory. A more systematic way would be to maintain Reminder diaries. Each Clerk should have one. As soon as the letter is dispatched in the outward, he should have one. As soon as the letter is dispatched in the outward, he should write in this diary on the appropriate date that a reminder is to be sent for a particular correspondence. On any day as soon as the clerk opens the page corresponding to the date of that day, he can see at a glance the letters to which reminders have to be sent. In other words, the system of sending reminders will be automatic. The Office Superintendent should see that such reminder-diaries are maintained and should maintain one themselves.

This diary could also be utilized for periodical returns by entering on appropriate dates which should be well in advance of the prescribed day, a note stating that a particular periodical return is to be taken in hand or sent. Simply maintaining an await file does not help in issuing reminder in as precise a way as a Reminder-diary does. If an interim reply is received, a fresh reminder-date should be entered in the diary, so that the file is not closed only on account of receipt of an interim reply.

When no reply is forthcoming after two reminders, a D.O. letter should be addressed. Telephonic reminder or personal visit/ Video Conferencing is sometimes necessary, the letter when the office from which a reply is due is located in the same place.

Rubber Stamping

Cases of delay in correspondence often require investigations. A difficulty commonly met with is to trace the clerk or clerks who were dealing with the papers. Clerks get shifted on account of transfers or change of tables. The inward-clerk should therefore rubber-stamp the name of the clerk to whom the letter is sent. If the letter is handed over from "A" to "B" the name of "B" should also be rubber stamped. Whenever a paper is transferred from one person to another, the person sending the paper and the person receiving it must initial and date such a transfer.

10.4 Records and Data Management

Data Bank

All offices are in the habit of asking for information from other offices when it is in fact already available in their own office. This should be strictly avoided. During the course of official correspondence, important statistical information is automatically received and this should be complied institution-wise, so that it becomes a permanent record. Every section of an office must maintain Basic Data'. This should be kept up-to-date by carrying out the required alterations after receipt of fresh information.

All hospitals should maintain up-to-date Basic Data as required (a) by inspecting authorities, and (b) for statistical returns.

Answers to L.A.Q., L.C.Q., L.S.Q. and R.S.Q. provide valuable data collected with some effort, and they should be preserved subject wise and institution wise wherever possible for at least 10 years. Those commenting on incidents of no permanent value may be preserved according to ordinary rules.

The data should be stored in electronic form by the concerned office staff.

Confidential Records

The way these records are kept is often, regrettably, scandalous. Proposals for continuation, promotion etc. suffer so seriously that they may remain pending for years together.

The confidential reports ought to be preserved properly and transferred to the proper destination along with the transferee. Superintendent/ Chief Administrative Officer/ Administrative Officer Confidential reports should be kept under lock and key by the Civil Surgeon/ depending on the class of employee.

Destruction of Records

Destruction of records should be done periodically as per instruction given in Chapter 23 of Civil Medical Code and Bombay Financial Rules1959.

10.5 Handing over and taking over of Charge

Whenever a person is changed from one table to another or transferred there should be a regular handing over and taking over of papers and files. The immediate head or O.S/A.O. should be responsible to see that this is invariably followed. A detailed list of papers and files should be drawn up and this should bear dated signatures of both parties along with O.S/A.O./C.A.O.

10.6 Disciplinary Action

Disciplinary action is often set at naught because of defective procedures. Such action cannot be taken on the basis of general knowledge. Specific know-how about rules for taking disciplinary action, minor or major is necessary. Medical Officers are often appointed as Enquiry Officers in the process of Departmental Enquiry cases. Energy is wasted on account of procedural laws. The cases are not finalized for years together. Many times, Departmental Enquiries are required to be repeated over and over again in the same case. Termination of service of a temporary government servant after one month's notice which is permissible has to be set-aside because the condition" without assigning any reasons" is not observed, Sometimes the contents do not disclose the reasons but the title of "Subject" does so. Instances of this nature can be multiplied.(As per departmental enquiry rule book 1991, Govt. Of Maharashtra)

Officers and office staff should therefore keep an up-to-date file of standing orders and instructions regarding disciplinary action matters and study them whenever such matters are required to be dealt with. Attention is invited to Chapter 33 of the Civil Medical Code.

10.7 Financial and Procurement Related Office Procedures and Reimbursements

Budget Estimates and Budget Grants

The Budget Estimates should be prepared carefully. Their preparation should be taken on hand well in advance. The dates on which the Budgets are to be sent to the higher office every year are more or less fixed. It is, therefore, not necessary for the office to wait for specific instructions regarding this every year. Similarly, the preparation of Revised Budget Estimates should be taken well in advance. The figures provided in the Budget estimates should be carefully considered. They should be scrutinized by the Civil Surgeon-Superintendent himself as usually these matters are left entirely to the clerical staff. Instructions regarding preparation of performance Budgets are given in Chapter 14 of the Civil Medical Code.

The distribution of expenditure in the different quarters of a year is often inequitable. As much as 60 to 80 per cent of the grant is often spent during the last quarter only. On account of lack of a carefully prepared plan, the authorities have to concentrate on incurring the expenditure in the last quarter. There should be no expenditure simply because the money will lapse and there should not be any withdrawal from Treasury, because the end of financial year is approaching, in absence of receipt of articles. Lack of watch on liability register also results in excess or less expenditure. Similarly, items indented must be in proportion to requirements and common items required often must take precedents on rarely used items. It is common to find that certain items like bedding and clothing to patients are not regularly replenished with the result that Hospital linen is wanting or in great demand requiring large amount or replacement at one time. This is easily avoided if an attempt is made to replace the clothing every year.

Expenditure has to be kept within the bounds of budget grants. Medical emergencies and genuine medical interest, sometimes, make it necessary to exceed the budget grants in anticipation of sanction, but the higher officers should be kept posted in time. If the Medical Officer in charge regularly reads the audit objections of previous years, he would come to know the common faults and would be able to avoid them in future. Besides, this will help to give prompt replies to audit notes.

Purchases

For details, Purchase Procedure should be done as per the procedure given Chapter 21 of Civil Medical Code and revised office purchasing procedures rule book along with GR dated 01.12.2016 and GR Dated 07.05.2021 and as per prevailing guidelines from time to time.

Reimbursement

There is considerable work regarding reimbursement of State Government Servants' and Central Government Servants' bills. The correspondence should be attended to promptly and early, as otherwise the whole object of reimbursement is nullified. The Civil Surgeon/ Additional Civil Surgeon (ACS)/ Medical Superintendent (MS)/ Senior Medical Officer have to take great care in scrutinizing the reimbursement bills, to see if the right drugs have been prescribed for the right period. The Medical Officers will have to work in this field without fear or favour.

10.8 Service Books

Service Books should be completed in all respects. Persons who have been transferred from one place to the other often find that their service-books have remained at a place which is out of their reach. It becomes a problem even to locate the service-books not to speak of completing all the entries. It may take not only months but years for the persons to get the service book and in the meanwhile the increment remains pending. If the simple precaution of making a service-book of every new person appointed and making sure that the service-book of a person coming on transfer is received is followed this irritating situation will be avoided. Whenever an individual is transferred it is the duty of the head of the office from which the

individual is transferred to see that the service-book is completed up-to-date and this along with the Last Pay Certificate is sent immediately the individual leaves the office. The officer who receives the individual on transfer must make sure that the service-book and last pay certificate is received within a fortnight of the arrival of the individual failing which he should remind the previous office.

Since duplicate service-books are to be maintained in their own interest individuals should see that the duplicate copy is also got completed.The verification of the service book should be updated every year in the month of May and report to higher authority every year in the month of Sept. (as per MCS (General condition of Services)Rule1981 vide rule 35-49).

There are number of persons on the establishment whose date of increment has to be watched carefully in the office in the month of January/ July as otherwise it is missed. The staff members themselves not being so particular or vigilant also lose sight of this.

10.9 Distribution of Work in Office

The distribution of work in the office is mainly divided into two sections, viz. the head clerk's section and the section. It is considered that the distribution of subjects between these two sections should normally be as follows:

Clerical Section

1) All establishment matters of the hospital and other hospitals and dispensaries under the control of the office.
2) Maintenance of service-books and leave accounts.
3) Preparation of pay-bills and T.A. Bills.
4) Periodical returns.
5) Five-year plans.
6) Major and minor works.
7) Legislative Assembly questions.
8) Maintenance of files of annual confidential reports.
9) Meetings.
10) Indents of stationery and forms.
11) Proposals for additional staff.
12) Maintenance of confidential and D.O. letters registers.
13) All statistical work.
14) Maintenance of register of all periodical returns.
15) All pension papers.
16) Maintenance of muster rolls and attendance registers of the staff
17) Maintenance of casual leave account of the staff.
18) Medical examinations-Issue of certificates such as medico-legal, death certificate, admission and discharge certificates, physical fitness, leave, compensation certificates, birth certificates, etc.
19) Reimbursement claims of Government servants.
20) daily checking of tapal; inward and outward.
21) Maintenance of service postage stamps accounts.

22) RTI Act section.

Accounts Section

1) Preparation of budget estimates.
2) Budget grants.
3) Periodical returns regarding the budget grants,Income tax documents.
4) Tenders of hospital-supplies.
5) Purchase of medicines and instruments.
6) Purchase of and maintenance of account of petty supplies.
7) Repairs of instruments, linen and other dead stock articles, etc.
8) Store accounts.
9) Preparation of contingent bills and maintenance of register.
10) Maintenance of all cash-books and registers of all accounts.
11) Maintenance of register of patient's property.
12) Maintenance of register regarding issue of Government drafts and PFMS/EFT to parties.
13) Stock Register and receipts.
14) Register of bills sent to treasury.
15) Register of pay and allowances.
16) Hospital library.
17) Register of bills received for payment showing dates of receipt and payment.
18) Levy of hospital fees and maintenance of hospital fees register.
19) Control over kitchen and cooks-check and receipt diet supplies daily and see that they are of good quality and quantities received are correct.
20) Vehicle Log book

However, the Medical Officer In charge of the hospital will have a right to decide which subject should be allotted to particular section and redistribute the subject as he may think proper for efficient working of the hospital.

Distribution of Work among Medical Officers

At present the whole brunt of administrative duties is borne by the Civil Surgeon/Superintendent and the Additional Civil Surgeon/ Senior Medical Officer as far as the Medical Officers are concerned. It is a misconception to presume that the other Medical Officers need not pay any attention to administrative duties. Every Government Medical Officer should therefore acquaint himself with the rules and regulations regarding administrative matters. All the Medical Officers should be conversant with the duties of various categories of hospital servants and rules for maintaining dead stock registers and medicine accounts. These duties along with other duties like maintaining sanitation and cleanliness taking administrative rounds in particular sections of the hospital, supervising office correspondence as regards the patients who are in their charge, etc. should be divided among the respective Medical Officers, i.e. ward by ward, section by section. In fact, the Medical Officer working in a particular ward, section or area should be held responsible for maintenance and supervision of sanitation, dead stock, duties of personnel working etc. The overall supervision will, of course, rest with the Civil Surgeon/Superintendent and the Additional Civil Surgeon/ Senior Medical Officer. Medical Officers should undertake such administrative duties as this acts as a good training ground to take over such duties in future without difficulty.

All correspondence about nursing matters should be dealt with by matron.

10.10 Miscellaneous

Periodical Returns

Every table must maintain a calendar of periodical returns. The date of this periodical return should be entered in the desk-diary (reminder diary). Another date should be marked in the desk-diary 2 to 3 weeks in advance of that date so that the person concerned will automatically be reminded well in advance, and will be in a position to send the periodical returns in time.

Superintendent's Order Book

The Civil Surgeon/Medical Superintendent/C.A.O. / A.O. have occasions to call subordinate staff in the office and give them instructions. There is however, no arrangement for any record and so the matters are forgotten by both the parties when their attention becomes engaged elsewhere. Persons who are called to see their superior officers should invariably keep a diary with them in which they should take down the gist of orders given. They should show the action taken on these items every day. In this register there is an entry on the left side showing the order made by the Superintendent and on the right side the signature of the persons who has to take action and the detail of action taken. It would be worthwhile following such a practice in the hospital offices, otherwise the same instructions have to be repeated again and again and reminders have to be made on the same topic day after day.

Proposals for Improvement of Hospital

Proposals for improvement of hospitals are sent by Medical Officers, or are called from time to time by the higher officers. The Civil Surgeons/Superintendents are transferred from one place to the other. The proposals for improvement (staff buildings and equipment) are also not kept together in one bunch. The result is that there is no proper co-ordination between the various proposals. Different sets of proposals are received on the same point. The Medical Officer in charge of the institution is not aware at a given time, about the up-to-date position of a proposal which might have been sent some time previously, and at times he even does not know that such a proposal has been sent at all. Persons in the office may also be unaware of the papers on account or transfers or shift of tables.

The Medical Officers should therefore take particular care to co-relate the proposals properly. Any proposals sent by them should be based on previous ones, and if they desire to differ in their recommendations, a clear-cut case should be made giving reasons, with reference to recommendations in the previous proposals.

For the condemnation of vehicles, hospital cold chain equipment; may be sold out as per the e-Auction guidelines of NIC (Please refer Annexure 10.3).

Non-functional equipment and other articles may be sold out as per the guidelines given in Annexure 10.4. The final condemnation of the articles may be done as per Annexures 10.5

References:

1) संकीर्ण प्र क्र ९ कार्यासन १८ (र.व.का) Zero Pendency and disposal of the record, महाराष्ट्र शासन दि. १५ फेब्रुवारी २०१८
2) Bombay Financial Rules 1959, General Administration Department, Government of Maharashtra
3) Maharashtra Manual of Office Procedures, Administrative Reforms, Organization and Methods, General Administration Department, Government of Maharashtra 2023
4) शा नि क्र भांखस-२०१४/प्र क्र ८२/भाग III/उद्योग ४. दि. 1 डिसेंबर २०१६. शासकीय विभागांनी करावयाच्या कार्यालयीन खरेदीसाठीच्या कार्य पद्धतीची सुधारित नियम पुस्तिका, उद्योग, उर्जा व कामगार विभाग, महाराष्ट्र शासन.
5) शा नि क्र भांखस-२०२१/ प्र क्र ८/ उद्योग ४.दि. ७ मे २०२१दर पत्रकाच्या आधारे करण्यात येणाऱ्या खरेदीची मर्यादा रु. ३ लाखावरून र. १० लाखापर्यंत वाढविणेबाबत.
6) शा नि क्र संकीर्ण-२०१६/प्र क्र १२१/आरोग्य-४. दि. १८ ऑक्टोबर २०१७. विभागांतर्गत निर्लेखित वाहन, रुग्णालयीन शीत साखळी उपकरणे व इतर साहित्य यांची ई लिलावाद्वारे विल्हेवाट लावण्यासाठी NIC कडील ई लिलाव आज्ञावली या संगणक प्रणालीचा वापर करण्याबाबत.
7) शासन परिपत्रक क्र. डीएफपी-१०१६/प्र क्र ०७/१६/विनियम. दि. २२ जून २०१६. निरुपयोगी, दुरुस्ती न होण्याजोग्या अथवा गरजेपेक्षा अतिरिक्त असलेल्या शासकीय भांडार वस्तू, यंत्र सामुग्री, वाहने इत्यादींची लिलावाने विक्री करण्याची व्यवस्था.
8) शासन परिपत्रक क्र. डीएफपी-१०९१/प्र क्र ४/विनियम. दि. २२ जून २०१६. निरुपयोगी, दुरुस्ती न होण्याजोग्या अथवा गरजेपेक्षा अतिरिक्त असलेल्या शासकीय भांडार वस्तू, यंत्र सामुग्री, वाहने इत्यादींची लिलावाने विक्री करण्याची व्यवस्था.
9) शा नि क्र १०९१/प्र क्र १२/ विनियम. दि. 1 ऑक्टोबर १९९१. वाहने निरुपयोगी ठरविण्याबाबत सुधारित अटी.

CHAPTER XI
INTRA AND INTER DEPARTMENTAL CO-ORDINATION

11.1. Introduction

A hospital is a complex organization where people ranging from illiterate to highly qualified specialist work together. They all have different knowledge, motivation level and qualities. A hospital needs the coordinated approach to deal with.

It is thus a challenging task for administration to run it as a well-knit organization where all groups work in harmony to each other. The administration should set up strategies, practices, frame rules and regulations where responsibilities are clearly defined and lapses can be pin pointed.

Organization of various departments in a hospital has been described in the previous chapters. No section of a hospital can work as an entirely independent unit. Coordination between the various departments is obviously necessary, the whole object being that "the patient always comes first." Each department must realize that it is a part of one institution each one is concerned as much as the other. Thus it is the duty of every one to be helpful to the patient irrespective of the fact whether he is directly concerned or not. Shunting the patient away without proper direction simply because the Medical Officer is not concerned is incorrect and unethical and is a disservice to the institution. Unless the different pieces of work regarding a patient fall into juxtaposition, there will be no clear cut pattern emerging. Occasions, when a patient can be handled independently in one section of a hospital without any reference to another section are practically nil. Even if a patient's treatment is capable of being completed say in the O.P.D. without the help of any investigation or indoor hospitalization the records on the O.P.D. case paper will have to be completed for the purpose of the statistical department. The patient may require a certificate for which he will have to visit the office and so on.

The basic information as to how this co-ordination is to be achieved has already appeared in the description of organization of the various departments.

The supervisory staff in a hospital consisting of the Civil Surgeon/Additional Civil Surgeon/Dy.Superintendent/ Medical Superintendent/Matron/Asst. Metron and Incharge Sister, has more responsibility in this matter than the subordinate Medical Officers and other subordinate staff.

There should be a dedicated nodal person or officer with appropriate staff and office for coordinating different departments in and outside the hospital like PRO. He should take the lead role and responsibility for smooth functioning of all departments. He should assist Additional Civil Surgeon/Dy.Superintendent/ Medical Superintendent/ Matron.

The nodal person should identify problematic departments serving in hospital 24x7 days. He should have availability of adequate funds and decision power in emergency situations to

address the problem. Telemedicine facility manager or assistant should help the nodal person in such situation.

The nodal person should ensure preparedness, additional arrangements with adequate infrastructure.

Regular meetings should be held by head of the institute with all concerned officers and employees regarding hospital coordination and review it with records and minutes of the meeting.

Inter departmental coordination envisages a link not only in the different departments of a hospital but between the hospital and other offices of the health department and offices of other departments.

The various departments to coordinate in health institute (Intra department) as given in table I & II respectively.

Table 1: Departments within hospital

Within the Hospital		
Emergency	**Non-Emergency**	**Administrative**
OPD/Casualty	IPD	Accounts
ICU/NICU	Specialist services	Purchases
OT	Referrals(cross/out)	Certificates and reports
CSSD	Counseling	Circulars
Mortuary	Training	CME
Lab X-ray CT Scan	Kitchen	Social Services
Ambulance	Library	
Drug store	Hostel	
Support services	Tele Consultation	
Electricity supply/Generator		

Table 2: Stakeholders outside the hospital

Coordination outside the hospital	
Government	**Non Govt./Private**
Other Government Health Institutes /Hospitals	Private Hospitals
Woman &Child Welfare Department	Press
Police Department	Non Governement Orgnisation
Municipality/ Corporation/Zilla Parishad	CSR activities
Public Works Department	Electronic Media
Animal Husbandary Department	Social Activist
Law and Judiciary	
Social welfareDepartment	
Revenue Department	
Food & Drug Administration Department	
Tribal Welfare Department	

11.2. Linking of various departments

O.P.D.

All the patients coming to seek advice and treatment from hospital for routine and non emergency issues are seen and attended in OPD. The general and specialist medical officers are supposed to attend the OPD in scheduled time and place. A display chart mentioning details of this arrangements, fees, documents required and protocol should also be displayed at entrance and main gate.

Hospital authority should create help desks and announcement system at all floors and prominent places for smooth functioning in OPD.

The hours of work in the various departments must be co-related with one another. Patient sent from the O.P.D. to the X-Ray and Laboratory Sections will have to be attended to without delay. Similarly, if the patient requires any certificates or if there are any other matters

of correspondence regarding the patient's case, care will have to be taken to dispose of these items, in time.

Hospital and Hospital Office.- Hospital is always maintained and run by efficient hospital administrative system. Therefore the involvement and action from the hospital office directly affect the hospital performance and outcome. The hospital authority should therefore coordinate the clinical departments with the hospital office and monitor its smooth functioning regularly.

Certificate Cases.-. A large number of cases attend Government Hospitals for Physical Fitness and various other types of certificates.

Table 3: Various types of certificates/registrations

A.Certificates issued	B.Registration given	C.Registration /NOC required
Medical Fitness certificate	MNHRA (Renew after 3 years)	Biomedical waste (BMW) (Renew after 5 Years)
Sick certificate	PCPNDT (Renew after 3 years)	Occupancy certificate from MC (Once)
Disability Certificate	MTP (Once)	Fire NOC (Periodical)
Fitness certificate (Fire arm holding)		EnvironmentalNOC by MPCB(Once)
Birth certificate		Electrical NOC (Periodical)
Death Certificate		Structural Audit (Once/as per need)
		Registration for Drug Store from FDA (Renew after 5 years)
		Registration for Radiology from AERB (Renew after 2 years)
		Blood bank License (once and to be renewed as per rule)
		Pharmacy Registration

The head of District hospital (CS/MS) issues medical fitness certificate to government servants (Group C & D) referred by their departments through district hospital medical board. The government servants are given a printed format of medical checkup examination. (The format is attached herewith). They are referred to various specialties and routine/special investigations on many occasions before their certificates are completed. Arrangements will therefore have to be made to attend to them promptly, in the speciality departments.

The persons seeking such certificates come from far and near, and may have to undergo considerable hardships, by waiting. The time table of the medical authority, competent to sign such certificate is also of importance. It should be made known to all so that the certificates cases will visit the hospitals at appropriate times. In some hospitals cases seeking physical fitness certificates are referred to all specialties in turn (Dental, Eye, E.N.T. etc.), and it may take 4-5 days before the certificates are finalized. The hospital authorities should in fact put up a board, giving a detailed time-table for such certificate cases. Explanatory instructions should be added for the people's guidance. Such instructions should also be addressed to various heads of other offices for their information. If the competent authority is not available on account of any reason,

the fact should be prominently displayed on the board. Certificates are signed after they are entered in the register and the Medical Officer should see the register next day to make sure that the certificates were either handed over or dispatched to the person concerned on the same day. A notice board should be put up outside the office indicating that no payment should be made without obtaining a printed government receipt. It should also show the type of certificate charged for and the amount payable.

The format of Medical checkup and fitness certificate from the health authority is attached for reference.

Since last few years disability certificates are being issued by medical board online (Swavalamban Portal of GoI).

- In this system the patient or PWD registers himself first with necessary documents like Adhar and Ration card at Maha E-seva Kendra / Setu.
- He will be given an enrollment number and appointment date in the preferred institute or hospital.
- The patient or PWD carries the print out of registration and ID proofs/Documents to the certificate section of the hospital on day of appointment at a given time.
- The certificate department/Coordinator/ Data Entry Operator process and validates this information and assign the patient to concerned specialty.
- The specialist enters the disability details online and disability percentage, severity, nature and need to be reviewed after some time.
- The coordinator verify the details and input from specialist and generate disability certificate and card.
- Fitness certificate are issued offline in duplicate in a printed format with photograph ID proofs and two identification marks.
- All certificates with its application from the concerned person and additional supportive documents should be preserved by the record keeping section.
- Certificates likes MTP, PCPNDT, MNHRA, reimbursement and NOC's should be prepared in duplicate and OC should be preserved with all supportive documents and along with its application from the concerned person.
- Certificate of license for drug store in the hospital is renewed online once every five year with Food and Drug department. The hospital administration and concerned pharmacy officer has to submit KYC and educational qualification documents.
- Every Hospital shall follow AERB regulations for equipment and Manpower.
- The jurisdiction of handicap certificate board is defined by govt from time to time.

11.3.Coordination in Casualty Department/Emergency

This is the first point of contact for all emergency and routine cases coming besides routine/fixed hospital hours. In this department patients are examined, treated, investigated and referred to Emergency/Indoor Wards of the same hospital or other hospitals as per the necessity.

The In charge/Casualty Medical officer should be able to communicate and manage the emergency cases effectively with the help of hospital coordinator/nodal person. The patient is stabilized and then referred to respective department/other hospital/higher center after

confirmation of bed and consultation of specialist. Adequate information and infra-structure should be available for effective coordination and patient management in casualty.

Round-the-clock services should be organized in all hospital sections (wards, Radiology and Laboratory sections, Operation Theatre, Labor Room, Blood Bank, mortuary) to meet any situation arising in the Casualty Department. Excellent coordination between ambulance service and stretcher-bearing service is necessary.

CS/ACS/MS should be informed about mass casualties, deaths, major disease outbreak, important medicolegal work and its outcome by Casualty medical officer.

Indoor cases are usually received from OPD/casualty/other hospitals. Indoor patients should be monitored, examined, and managed by the MO in charge and/or a specialist. These cases are the responsibility of hospital administration. Therefore, proper care and attention (medicine, diet, supportive care, and cleanliness) of all indoor cases is very important and is the responsibility of the ward in charge/HOD.

Indoor cases should be given their appropriate and correct medical certificates when they are discharged or referred. The patient should not have to wait for receipt of certificates in their cases, even after they are discharged.

Indoor cases may require shifting to either ICU/ from one ward to another ward. Indoor cases may be transferred to other government/private hospital. In such cases the indoor patients should be referred with a transfer memo/chit with proper counseling and adequate medical supervision. After completion of treatment/ on request indoor cases are discharged in coordination with the referring hospital/doctor. The patient should be counseled, prescribed medicine and followed up for future treatment. They are sometimes referred to various specialists. Instances occur when the ward/hospital to which the case is transferred refuses to accept it. This is because no previous intimation is given to the concerned Medical Officer or the Sister. If a case requires transfer from one Medical Officer to another, this should not be done without mutual consultation and adequate information. The hospital administration should ensure that the case is received and further management is done in the referred institute and proper record should be maintained.

11.4. Coordination between Operation Theatre and Wards

Operation theaters and ward in any hospital are very critical and active departments in which the patients is managed as per protocol. O.T and wards receive their clients from their OPD/Casualty and other hospital.

The hospital authority should monitor the admission and management of all the patients in OT and wards through the in charge of that department. All critical serious cases, medico legal cases and cases of public health importance should be given priority and highest of attention and care. All necessary infra-structure, facilities, equipment and medicines should be made available 24x7 at these places. A detailed SOP/Guideline should be issued and percolated to all concerned to avoid any lapses and if occurs then responsibility should be fixed.

Dispatch of indoor cases to and their receipt back from Operation Theatre, Radiology department etc. should be well coordinated. The time table of dispatch and receipt of the

patients should be fixed by mutual consultation with those departments, and patients sent and brought back at predetermined times, as far as possible.

11.5. Coordination of National health Programme Offices and hospitals:

Many times, disease of public health importance like TB, Malaria, Leprosy, Covid-19 etc. are admitted in hospital's infectious or Isolation wards, which requires proper care and public health measurements to prevent its spread.

Diseases of public health importance are mentioned in IDSP guidelines and norms. Accordingly, their record should be maintained in S, P & L forms and follow up is done.

Whenever cases of notifiable diseases, or diseases, which are important from Public Health-point of view are admitted in infectious or Isolation wards, it should be immediately reported to appropriate health authorities like DHO/MC in given formats.

National Vector borne Disease control Programme

It includes National Malaria Eradication Programme and Filariasis control Programme.

The Malaria surveillance, maintenance and eradication Programme as well as Filarial Eradication Programme require that blood slides be taken of all fever cases, and at night for detection of Filaria. Surveillance means detection and radical cure of all malaria cases in the community. Surveillance can be active and passive.

The hospitals must play their part in Passive Surveillance. At least 15 % of total OPD cases, their blood smears are to be collected from all fever cases, irrespective of clinical diagnosis. The treating medical officer should coordinate with lab for checking of blood samples for malaria/dengue/Filaria. After examining smears for malarial parasites, positive cases must be radically treated. It is important to collect blood smear from every fever case. The reason is that malarial fever may not exhibit a classical pattern. Infections with “Plasmodium falciparum” show varying clinical features. Malaria can also be associated with other diseases. Both thick and thin smears should be prepared. A thick smear helps to show the presence of “Malarial Parasite’’ while a thin smear helps to identify the species and stage of development. All positive/diagnosed cases of malaria should be admitted for treatment in hospital and radical treatment is advised. This management has to be coordinated by treating medical officer and health authorities.

The hospital authorities should coordinate and report the positive cases to appropriate health authorities and corporation for preventive and social measures.

The diagnosed cases of filariasis should be recorded, adequately treated and reported to appropriate health authorities and corporation for preventive and social measures.

Many patients of filariasis in addition to their physical morbidity suffer from hydrocele for which the case has to be managed surgically for effective cure. This facility and management should be monitored by the treating medical officer and district health authorities.

11.6 Case Records

The hospital generates huge case records every day. It needs to be classified, recorded and maintained in hospital record section. Usually there are two types of case records -Medico legal and routine.

Medico legal record has to be preserved till the final result of the case is decided. The OPD cases papers should be preserved for 2 years and IPD papers for 5 years, before being discarded or condemnation as per prevailing rules. The hospital administration assigns the duties of record keeping to medical record keeper/responsible person in office. He is responsible for communication, classification and preservation of the case records available in his/her custody. A detail record register should be maintained by the record keeper and monitored regularly by hospital authorities.

The case records on the outdoor and indoor case papers should be written with diagnosis in such a way that they contribute the required information for preparing statistical returns as per ICD- 10.

11.7 Communication:

Communication Gap

Important orders, circulars and instructions received in the office as well as any other important developments in the hospital should be communicated to all concerned staff members. The position about availability of medicines, expiry dated medicines etc. must be communicated to all medical officers. Failure to communicate in the above manner leads to embarrassing situations in the hospital which are entirely avoidable. Important matters such as above must be circulated in writing and signature of concerned members obtained in token of receipt.

Ways of communication:

Items of correspondence are received in the office every day which require circulation. Important orders, circulars and instructions should be sent to the various members of the staff. During the course of inspection of various hospitals, recently, it was frequently observed that many members of the staff did not know about such an important and significant development as the 'Minimum Requirements'. All orders and developmental matters or any other items of significance must be circulated in writing or email or electronic social media or display boards and signature of staff members taken as a token of receipt. Notice board should be available at prominent places and main gate.

Similarly audit officers always mention the occurrence of irregularities; minor or major in their reports. They should be communicated to staff and discussed and regular compliance of the audit objection should be submitted in time with proper explanation.

11.8 Intra Departmental Coordination at various occasions:

Standing orders, SOPs and important instructions are very important for intra-departmental coordination. All such information/orders are printed and circulated to different sub-ordinates, Medical Officers/staff/administrative section in hospital. Head of the institute should ensure that they are distributed and received by every one concern. Hospital management should arrange workshop, seminars, and webinars/VC meetings, if necessary for

the important instructions to be circulated. This data has to be maintained and record is kept in a separate file.

The budget allocations and supplementary budget grants by NHM/ administration should be communicated to important staff members with proper written guidelines in advance and followed up regularly.

There is often no reciprocity between the 'Office' section and the 'hospital' section. This leads to a number of complications.

Blood banks/ Blood centers

The process of summoning of a donor, tapping him, collecting of blood, determination of the patient's blood group, cross matching, these all take time and Medical Officers, demanding blood must consider these as factors to be reckoned with. Dispatch of blood from the bank and its receipt should be timed in such a way that the bottle on receipt is not retained for prolonged time.

The Operation Theatre, Blood Bank, Radiology Department and the Laboratory should adjust their working for emergency cases in order to avoid unnecessary overstay. The necessity to reduce the waiting time of patients has already been stressed.

Fasting Patients

The Radiology department and Laboratories should take care to relieve fasting patients as early as possible. They have to adjust this by giving proper instructions to the O.P.D. patients as well as the Sister in charge of ward.

Telephone Messages

Telephone messages received in the hospital for patients or their relatives, should be promptly transmitted to the respective wards from the telephone room. Sometimes such messages are received in the 'office' section and should not therefore on that account take an unduly long time to filter to the wards.

Referral Services

When a case is transferred or shifted to other department/hospital for further investigation/management this service is called as referral service. Referral services are of two types- Referred In & Referred out.

Referred In

A case/patient received in the hospital from any other institute is named as referred in case. Each such case should be recorded, classified and informed to appropriate health authority. Referred in cases should be given all possible care and treatment for which it is admitted as soon as possible. The hospital doctor should not go entirely by the reports of these institutions. They should independently assess the condition of the patients.

Referred Out

The patient referred to another hospital/specialist is named as referred out patient. This process should be ordered, monitored and followed by concerned ward in charge/specialist. The patient should be given a detailed referral letter mentioning its personal details, present condition and further management required.

The patient should be shifted in consent with the patient and relatives in an ambulance as per the need/choice of the patient. The referred-out patients should be provided with adequate medical care and monitoring while transferring to other institute. The referring health authority should confirm the availability of management, specialist and beds in the referred institute.

The hospital authority/referring specialist should confirm the outcome and record it in case paper and inform to appropriate authority.

It will be seen from the above paragraphs that inter-departmental co-ordination involves adjustment, not only between the different departments of the same hospital, but between the hospital and other medical institutions, as well as the hospital and other Government Departments.

11.9 Facilities for Training Programmes

District health facility has many training programmes and there are many departments which implements this work as follows.

1. State Institute of Health and Family Welfare (SIHFW)
2. State Health System Resource center (SHSRC)
3. Health and Family Welfare Training Centre (HFWTC)
4. State Tuberculosis Training & Demonstration Centre (STTDC)
5. Hospital Training Center (HTC)
6. Nursing School
7. District Training Center (DTC)

These institutes offer and carry out disciplined training programmes in various health subject and programmes regularly round the year. The district health authorities (DHO/CS/MS) should monitor and arrange necessary and mandatory training for all categories and cadres as per the government rules. They should coordinate the schedule and subjects in accordance with the need of health system and patients care.

Apart from training of medical students in teaching hospitals, many non teaching hospitals offer training to nurses. Doctors are also given training in tubectomy, medical termination of pregnancy (MTP), Ventilator training etc. It is obvious that various sections of a hospital must orientate their functioning with a view to afford the necessary facilities for such training programmes. The doctors and technical staff after the training should be appointed at appropriate places so that the health system and patients are benefited.

A system of feedback from patients or relatives or staff should be developed so that suggestions can be received for improvement of hospital functioning

Training of staff and modern management techniques should be adapted to the maximum extent.

Modern information technology tools like internet, email, computers, fax, scanners, and announcement system should be made available.

11.10 Examples/SOP of inter-departmental coordination

a) Coordination between hospital and Municipal Corporation.

Hospital/Nodal person should have regular interaction and coordination with MC for proper disposal of general waste (Noninfectious and nontoxic) and also for drainage, cleaning matters and disposal of dead bodies etc.

Coordinated efforts should be made to form norms/practices/ frequency/ timetable for transport of waste and regular cleaning.

Coordinated efforts should be made along with MPCB for creation of CTDF, training of man power and plan for STP/ETP

b) Coordination between hospital and PWD

Nodal person responsible should regularly inspect hospital building (including electric fixtures, firefighting system and sewage) and premises. He should communicate details with requirements to PWD through head of the institute.

Time table for regular inspection, audit and repair should be prepared

Emergency arrangement or repairs should be planned and available round the clock.

c) Coordination between hospital and Police-

Hospital/nodal person should have all the information about the protocol, rules and working of police department.

All suspected and confirmed medicolegal cases should be immediately communicated in writing to police and a copy of its receipt should be preserved.

The authority should inform and take help in all cases related to law and order like mass casualties, PCPNDT/MTP issues, decoy cases, socially sensitive cases and complex situations.

The authority should demand their opinion in serious complex situation where legal issues may arise and also give valuable and honest opinion when ask by police department.

d) Coordination between hospital and health department of ZP, Women and child welfare Department, ICDS, IDSP, Tribal, Social Welfare Department etc.

Many health programmes/trainings/health issues are commonly implemented and monitored by CS as well as DHO. All such activities should be coordinated for effective clinical and social outcomes.

The inter-departmental cooperation and coordination between the institutes headed by CS and DHO must be mutually discussed and monitored for smooth functioning.

The funds and management under NHM/state funds received should be distributed and manage effectively by coordinated efforts.

e) Coordination between hospital and Private Hospitals

The hospital authority should ideally know the status and facility of all major private hospitals and should sought out their role in public health management.

The hospital authority should invite and take initiative to start all specialty work and patient care in government hospital with the help of private hospitals.

The private hospitals technical skills and facilities should be used for poor and needy patients at concessional rates.

Various diagnostic and operative camps should be organized in coordination with private hospitals and this should be reciprocated by giving full cooperation in administrative issues to them.

f) Coordination between hospital and Media:

The hospital authority should brief all major events, activities, programmes, appropriate information, best practices, newer initiatives and achievements to the press in official press note.

All positive outcomes, extra ordinary works and good feedback from community or government should be given wide publicity to enhance the image of department.

Print and audio-visual media should be used to promote social health and wellbeing by arranging talks, interviews, write up/ articles and photography.

CHAPTER XII

STAFF MEETINGS, IN-SERVICE TRAINING AND PERSONNEL MANAGEMENT

One of the cardinal principles of achieving efficiency and co-ordination in any institution is a free flow of communications vertically and horizontally. Communication has to flow from the highest to the lowest level and vice-versa, as well as in groups of the same level.

12.1 General Aspects of Personnel Management

The various aspects referred to below in this chapter must be constantly kept in mind by the Medical Officer in charge of the hospital and by the "middle managers". The Medical Officer should train the middle managers on the implications of these various factors. These aspects assume special significance in the case of management of subordinate staff, which is considered a "problem of problems". It is a common experience to find public saying "the doctors are very good but what about of lower staff?" Concerted efforts are necessary to tackle the question of management of subordinate staff.

The hospital administrator must make special efforts to keep relations between groups of hospital staff, congenial. For example, good relationship between nursing staff on the one hand and the ward servants and sweepers is very important. Similarly, the relationship between ward servants and sweepers that each person feels he is part of not only his group but of whole hospital team. Similarly, each group must establish helpful and healthy relations with other groups.

The subordinate staff often becomes an agency for touting and canvassing on behalf of particular Medical Officers. This is derogatory to the reputation of the hospital. Certain members of the subordinate staff have also a way of asking for a consideration for a piece of work which in fact is their lawful duty. Patients are also induced to give a consideration for getting their work done early. This aspect requires constant supervision and can be counteracted by questioning individual patients and advising them not to encourage such unsocial activity but to immediately report such individual to the doctor in charge of the section.

Roll Call- Mukadam should take roll call of Group D staff and follow up by taking rounds in various sections, shortly after roll call to find out if persons who report for roll call have actually started working. The sisters/ nurses should also take roll of Group D staff at the time they are supposed to start work in the wards etc.

For constant efforts

12.2. Necessity of Staff Meetings

During the course of work of an institution, it becomes necessary for the higher authorities to give various instructions to the subordinate staff. Some matters require discussion before decisions are taken. Similarly, the lower staff requires opportunities to communicate their views to the higher authorities. Obviously, opportunities have to be provided for this, and that is the reason, why frequent meetings at different levels are necessary. Such meetings should be at a fixed time and should be of short duration.

Meeting Schedule

Sr.No.	Name of meeting	Periodicity	Conducted by	Topics
1	All Dept. Heads (Class I Specialists)	Weekly	CS,ACS& Matron	1] Clinical issues 2] Logistic issues 3] BMW issues 4] M.O. & staff issues 5] OPD/ IPD issues
2	All Medical Officers (DH)	Monthly	CS,ACS,C.A.O. & Matron	1]Performance review 2] Dept. wise issues 3] Personal problems
3	All Para Medical Staff	Monthly	CS, ACS, RMO (OR) C.A.O. & Matron	1]Performance review 2] Dept. wise issues 3] AMC & CMC 4] Personal problems
4	All office staff (DH)	Monthly	CS, ACS, RMO (OR) C.A.O. & Matron	1] Section wise work performance 2] Pending work 3] Staff Bills 4] Service book completion 5] Enquiries 6] Personal problems
5	In charge Sisters (DH)	Fortnightly	ACS, Matron	1] Ward wise review 2] Logistic issues

				3] BMW issue 4] Personal problems
6	Asst. Supdt. (Peripheral Health Inst.)	Monthly	CS, ACS, RMO (OR) C.A.O. & Matron	1] Section wise work performance 2] Pending work 3] Staff Bills 4] Service book completion 5] Enquiries 6] Personal problems
7	In charge Staff Nurse ((Peripheral Health Inst.)	Monthly	CS, ACS, RMO (OR) C.A.O. & Matron	1] Inst. Wise Health Indicator review 2] Logistic issues 3] Staff & Personal Problems
8	Med. Supdt. ((Peripheral Health Inst.)	Monthly	CS, ACS, RMO (OR) C.A.O. & Matron	1] Inst. Wise Health Indicator review 2] Logistic issues 3] National Health Programme 4] Compliance & News paper 5] Office issues
9	RBSK M.O.	Monthly	CS, ACS, RMO (OR)	1] Team wise work performance 2] Referral Services Review 3] Personal Problems
10	NHM Staff (DH)	Monthly	CS, ACS, RMO (OR) C.A.O. & Matron	1] Programme wise Review 2] Pending issues and compliance 3] Personal problems
11	Infection Control Committee	Monthly	CS, ACS, Pathologist C.A.O. & Matron	1] Ward / Section wise review 2] Logistic issues 3] Transport issue

MDR committee, Death Audit committee, Diet committee, RKS meeting. Vishakha Committee,NBSU/SNCU death audit committee, PCPNDT/ Advisory Council and Executive Committee under NHM, Drug Expiry Committee, Condemnation committee are present in hospital. The meeting of these committees will be arranged as per guidelines.

There are certain committees in the districts under chairmanship of District Collector and Chief Executive Officer, Z.P. Civil Surgeon or Representative will attend the meetings.

12.3. Types of Staff Meetings

Staff meetings in a hospital can be held conveniently for different groups of staff members.

(1) Meeting of Medical Officers-The Civil Surgeon/Superintendent should meet the full-time Medical Officers. During such meetings, the following subjects should be discussed:

a. Any important development or event as regards the hospital which might have occurred since the last meeting.
b. Review of technical work by a study of a few O. P. D. and indoor cases. Such a study should focus attention on correctness of diagnosis,treatment and records. (Medical Audit).
c. “Mortality Conference" should be a part of such meeting. There should be a critical study of case papers of patients who have died in the hospital since the last meeting. The object of (b) and above is to constantly strive for improvement in technical care. Any attempt at unnecessary criticism or belittling the knowledge of the Medical Officers should be avoided, the idea being to educate Medical Officers and to avoid errors, if any.
d. Complaints, oral or written, received from patients or from higher offices for enquiry. Such complaints are often of a confidential nature. The personal identities should not be disclosed.
e. Any circulars or standing orders received from Government or higheroffices.
f. Any suggestions brought forward by any Medical Officer for improving the working of the Hospital.
g. Newspapers frequently publish complaints about hospitals. Even if they are about other hospitals, they should be read out with a view to analyses the origin of such complaints and to avoid their occurrence in the hospital.
h. Budgetary position should be communicated from time to time.
i. Matters regarding handling of important equipment with special Reference to defective handling, if any, noticed.
j. Use and abuse of medicines. -Knowledge of what medicines are available in Medical Stores and about those which are unnecessarily lying unsold. Contents of Rate Contracts should be known to every Medical Officer.

It is upto the Civil Surgeon or Superintendent to consider how many or whether all of these subjects should be discussed. It can, however, be said that, even if the entire above are discussed each time it would not take excessive me. With a little experience, it would be possible to deal with them in a comparatively short time if discussions are brief and to the point. As matter of fact, it is preferable to deal with all of them at each session, negative points being just skipped over.

One of the Medical Officers should act as a Secretary turn by turn and keep minutes of the meeting. Whenever, there is nothing positive to discuss about any of the above matters, he should just put a (dash) against it and proceed with the next subject. Forms mentioning the above points should be kept ready and the result of discussions entered against each one. These meetings may be held every week.

(2) Clinical Meetings.-"Clinical Meetings" should be held, at least every fortnight. It is desirable to utilize the wealth of material always available in the hospitals. All Medical Officers, including Contractual Doctors should attend. Special efforts should be made to associate the local private practitioners. The help of Local Medical Association, if any, should be taken. Staff from other Hospitals in the town, if any, should be invited.

(3) Meetings of Nursing Staff- The matron should hold a meeting with
Representatives of nursing staff every week to discuss administrative as well as technical problems. If possible and practicable all members of nursing staff can be invited to such a meeting.

(4) Meetings with Other Para-medical Staff:-A meeting of Pharmacy Officer, X-ray and laboratory technicians should be arranged by the Civil Surgeon/Superintendent once a month

(5) Meetings of Class IV Staff-A meeting with Class IV servants should be held once every three months

(6) Meetings of Office Staff.-Meeting with office staff should be arranged every month. The Civil Surgeon, ACS, RMO (OR), Metron and Senior Administrative Officer/Junior Administrative Officer should attend.

(7)Diet Committee Meetings should be held monthly.-If any particular person, ordinarily not expected to attend a meeting is required for a specific purpose, he or she should be invited.
Proceedings of each meeting should be maintained by a "Secretary" and they should be considered confidential.

Guidelines for conducting Meetings:

The sole object of these meetings is to analyses, admit mistakes frankly, find out ways to avoid them in future, discuss constructively, take decisions and implement them. Without the last step, it is as well if no meetings are held at all.

At all such meetings every individual should be made to feel that he is an important member and that his views are also heard. Such an attitude will enthuse people to work with initiative.

12.4 Middle Managers in Hospitals

As per para 12, certain staff members are in direct contact with the work area, where they have to supervise and guide workers who areactually carrying out the work. At the same time, they are accountable to the high-level hospital administrators. Ward sisters, Chief Pharmacy officers, Senior X-ray and laboratory Scientific Officers, Senior Administrative Officers, /Junior Administrative Officers could be called middle managers in a hospital. The brunt of routine administration falls on these middle managers, who are close to the managers and workers. Since decisions taken at a higher level cannot be implemented without the help of these middle managers, the importance of their training is obvious.

12.5Personnel Management

A hospital has to perform complicated functions. The institution differs from all others in that it has to deal with human beings constantly to alleviate their physical and mental suffering under the watchful eyes of the public. Success wholly depends upon the teamwork of hospital staff. Personnel management thus assumes an exceptionally important role in all hospitals.

Personnel administration is necessary to tap human ability, energy, interest and loyalty.

The following components require consideration:

(A) Proper Selection and Assignment of Duties

The in charge of the hospital should as far as possible within his power, select appropriate persons for various jobs. Even wherein persons are appointed by a higher authority, it may be possible to place the persons in a suitable manner according to the aptitude. For example, certain nurses and ward boys will be found more suitable than others for work in the casualty department, operation theatre and so on. Even in the hospital office certain staff members will be found to be more suitable for a particular table than others. This will have to be done with reference to two points which need consideration:

i. There should be no avoidance of difficult or tedious duties under the pretext of suitability; and
ii. Exposure to work in different sections from the point of view of duties by rotation and to make the person fit for a higher post on promotion. While assigning duties, the distribution of work should be on equitable basis to the extent possible.

It is a common experience to find that certain staff members are overloaded with work while certain others are excessively relaxed on account of quantum of work being much less. It is often possible to remove this imbalance by a close study of the situation by the supervisory staff.

(B) Define Duties and Responsibility:

A very common defect noticed is that workers are not aware of their exact duties and responsibilities, though they may have worked in the hospital for years together. There is a halfhearted attempt to refer to this matter during investigation of complaints and negligence etc. but soon the matter is forgotten. Even staff members who have undergone regular institutional training require clear instructions on this point since the methodology of hospital work differs from place to place and hospital to hospital. In this connection it must be stated that

Government orders are available by way of defining duties for most of the categories of hospital staff. However, these orders require interpretation by way of practical and detailed instructions ward wise and section/department wise. If this is the case with regard to institutionally trained staff, there is so much the more necessity for it in respect of other staff members who are not institutionally trained for hospital work such as Class IV servants, clerical staff etc.

On account of the vague situation regarding exact duties, it is a common experience to find that responsibility for lapses cannot be fixed and the toning up and improvement which ought to occur as a result of investigations is not forthcoming.

All wards and sections/departments of a hospital should therefore exhibit standing orders in respect of various categories of staff members and it should be seen that the concerned staff members are apprised about the same. It is important to keep the standing orders up-to-date to reflect changes which might occur in methods of hospital work either introduced by hospital authorities or by higher authorities.

(C) Guidance and Training: All new staff require guidance and training to enable them to perform their duties efficiently. Even thereafter, it is a continuing process.

(D) Delegation of Powers

Apart from delegation of powers authorized by Government to Government Officers at different levels, head of each hospital has to repose trust in his own staff. After assigning the duties the staff members must be allowed to do their routine duties without interference in day to day work to enable them to use their powers fully and develop a sense of decision making and judgement. Interference is only justifiable if any change is to be introduced as a result of work study analysis, or due to fresh instructions from higher authorities. Concentration of power in one hand introduces an element of lethargy and inefficiency at all levels.

(E) Participation

Hospital team work can succeed only if there is per situation and not pressure. The staff members must be apprised fully of the objectives and policies of the hospital. Staff member's conscious of objectives and policies are an asset to the hospital. They will perform their duties with understanding, enthusiasm and in an enlightened manner. On the other hand staff members who perform their duties mechanically without enlightenment will be a hindrance rather than an asset.

Whenever the head of the hospital desires to introduce a change on his own (as separate from orders given by higher authorities) he should do so after consulting the concerned staff. Even if certain proposals are not approved by staff and the head of the hospital would still like to introduce them being convinced that they are for the good of the hospital he can explain why he must do it. On the other hand, Consultation may make it possible to have a common meeting ground. Objects of changes ordered by higher authorities should be similarly explained to staff.

(F) Communications

A free flow of communications, vertically as well as horizontally is absolutely essential. The In charge of the hospital, the Deputy Superintendent or Additional Civil Surgeon/Outreach, Matron, Senior Administrative Officer etc. must be accessible to lower staff. The staff should be able to see the higher officials by appointment if possible or by the

"Walk in" method. Since the duties of staff members and their hours of attendance vary from section to section, it is not possible to see every person by appointment. Opportunity must thus be given to staff members to ventilate their ideas. Comments, doubts and difficulties and to get the latter resolved. It has been definitely proved that staff members who are satisfied in this respect givenbetter services to patients. For example, if in a ward, the sister is non-communicative, it has been shown statistically that the patients in turn receivepoor service from the nurses and vice versa.

(G) Grievance Machinery

Every hospital must have a grievance machinery to redress staff grievances to the extent possible as per powers given to the head of the hospital. Absence of such machinery is a potent cause of frustration. Grievances of a general nature must be forwarded to higher authority with comments promptly.

Staff meetings and staff councils referred to in this chapter in the beginning can take care of problems relating to (E), (F) and (G) above.

(H) Working Conditions

The head of the hospital must do whatever is possible to improve the working conditions of staff members. Some improvement can be brought about by supplying the necessary furniture providing lighting arrangements, improving water supply, adjusting hours of attendance etc. It may be possible to bring about these improvements even without any extra grants. The main point is that the Hospital Incharge must be aware of remediable situations. In genuine cases where extra budget grants are required, a proper representation should be made to the higher authorities.

(I) Behavior of Superiors: As a rule, basically this should be friendly courteous and pleasant. There is absolutely no point in taking initiative to create an uncongenial atmosphere in which staff members feel angry and/or humiliated.

Example is better than precept and unless superior officers show an exemplary behavior toward patients it will be futile to expect the lower staff to do so. Similarly, the Medical Officers must demonstrate visibly that they are interested and personally concerned with welfare and progress of the patient if they are casual and indifferent in their approach to the patients, the nurse and ward boys will be more so.

(J) Welfare Measures and Establishment Matters

The superior staff ought to be concerned with welfare measures for subordinate staff. Giving medical care to the maximum extent possible to the staff member and his family highly essential. As far as possible a separate time should be reserved for them to enable prompt attention. Benefits of all RCH activity and nutrition programmers, Bio Medical Waste etc. should be given to the staff. Particular care should be taken of staff working in the Radiology department

Residential accommodation should be given strictly according to rules laid down for the purpose. Staff members should not be utilized for private work.

The staff members should be encouraged to start their own library.

A" Hospital Day" should be celebrated once a year, where all staff joins and mixes freely in a common programmer. This will consist of programmers like sports, entertainment etc. Expenses, if any, can be met by contributions.

The hospital office should be watchful alert and prompt about establishment matters such as keeping service book up-to-date, increment, promotion, sanctioning of leave, pay slips, confidential records, last pay certificate, transferring service books and confidential record to the place of transfer etc. Generally it is found that scant attention is paid to it and the result is nothing but demoralization, frustration and cynicism.

Similarly prompt attention should be paid to correspondence about reimbursement.

(K)Supervision

Work of different staff members must be supervised by the supervisory Officer. The "middle managers" referred to in earlier para graph can do so in respect of staff directly under them. Higher officers will have to supervise the work of "middle managers" and occasionally of staff subordinate to them.

The point is that every person should be aware that he is being watched inhis actions. Constant supervision and surprise checks are very essential. This will help to give benefit of encouragement and appreciation to deservingpersons and create a desire in casual workers to correct themselves.

(L) Encouragement and Appreciation.

Encouragement and appreciation for good work must not only be present but must be demonstrably shown and visible to staff members. The good effect generated by such appreciation is "infectious ".

(M) Disciplinary action

Disciplinary action should be considered as the last step in personnel administration. If a person is found not amenable to guidance and if he does not improve when opportunities are given and if his intentions behind repeated lapses are mala fide, there is no alternative but to

take disciplinary action commensurate with the gravity of lapse. If there is gross negligence in doing duties with no reasonable extenuating circumstances, the question of giving any opportunity for improvement does not arise, and disciplinary action will have to be taken straightway. In other cases, the person should be called and apprised about his lapse and given proper advice about how he should improve. The instructions should be recorded in writing. Special efforts are required to improve those members of the staff who turn out to be resistant to the persuasions of staff meetings. Staff councils and in-service training. Such persons should be called by the Civil Surgeon/ Additional Civil Surgeon/ Superintendent/ effort should be made to make the person realize his mistake. This should never be done in the presence of other staff members, as this will invariably generate resentment and a feeling of humiliation. The person should be called aside, preferably in the office when nobody else is present. The person concerned should be given a full opportunity to explain his point if any. Staff members are very sensitive to being chided in the presence of other members but a person-to-person talk is expected to create an urge for co-operation and improvement.

No decision should be taken for any disciplinary action without proper investigation. It should not be hasty.

There are outsiders who interfere in such matters. Attempts are often made by aggrieved parties to get material published in newspapers.The higher officers may even receive threats.

Any officer must therefore weigh the case thoroughly and then decide it on its merits. Having once decided upon disciplinary action, there should not be a situation in which the decision is required to be withdrawn. Withdrawal will damage integrity of hospital administration and encourage recalcitrance on the part of the concerned staff. It is another matter if the decision is reversed by the higher authority.

Full record should be kept even of minor disciplinary actions like warning.Many a time warning is given orally when it ought to be recorded, the lapse isforgotten and this subsequently creates difficulties if further action is to betaken. If the case is fit only for a verbal warning, the fact that it has been sogiven should be recorded. If there is no improvement after one or two verbalwarnings, a regular written warning should be given.

During investigation, statements of concerned persons should be taken in writing. Hot cases will lose importance after they become Cold and investigation, if it is to be done, must be prompt and not after lapse of undue time.

All disciplinary action involves a full knowledge about Maharashtra Civil services Rules 1981 (MCSR) and procedure required to be followed before the action is taken. Action taken without following rules is so much waste of time.

12.6 Training

Training is essential part of implementation of any programme. Trained manpower is essential to provide qualitative services.

In-Service Training

The Directorate of Health Services now organizes regular training courses for hospital staff at different levels with the help of State/Regional and District-Level Training Centers. Apart from such courses, much can be achieved by the staff's day-to-day training.

Practical training of the later type is an essential requirement in running any institution successfully. This is perhaps moretrue of hospitals than others.

Modes of treatment and individual predilections cannot be expected to show a machine-like uniformity. Five Surgeons performing the same operation, will each use a slightly different method. Modes of medical treatment have also a stamp of individuality.

Senior Medical Officers should impart tips to other medical officers and nursing staff during the course of their work in the wards, O.P.D. and operation theatre. If the Senior Medical Officers do not find something to their liking. They should not loose temper but in the first instance give proper guidance and training. Postoperative instructions for instance often require detailed advice, guidance and training. The Senior Medical Officer must clarify what he expects, what mistakes have occurred and what should be done to remedy them. A little time spent for such guidance and training is better than time spent in making complaints against staff members, since many acts of commission and omission are due to lack of practical guidance and training.

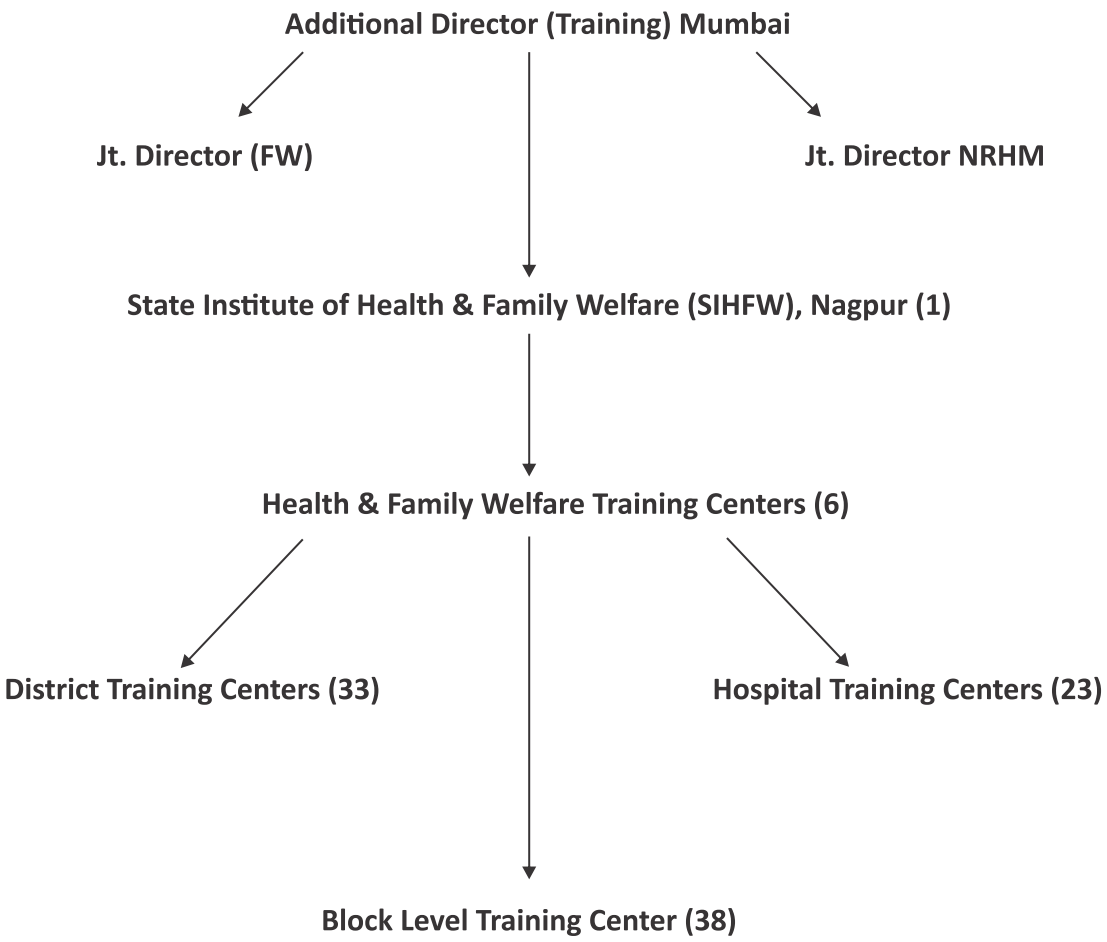
Apart from Medical Officers and nursing staff, other staff like Pharmacy Officer X-ray and laboratory technicians, office staff etc. should also receive similar guidance during their day-to-day work.

What is said above does not mean that there should be no complaints in genuine cases. All senior persons must remember that they were juniors at some time and received guidance and training from their seniors. The knowledge they possess is gathered over years and must now be imparted to their juniors in turn.

12.7Training Infrastructure in State

Maharashtra state has strong Training Infrastructure at present. Currently one SIHFW at Nagpur, Six H.F.W.T.C's at Divisional Head Quarters, 33 District Training Teams, 23 Hospital Training Centers at DH and 38 Block Level Training Centers. In future as per need the training institute number may increase.

TRAINING INFRACTURE IN STATE



HTC are attached to District Hospital, these centers mainly conduct clinical trainings. Sometimes other National and State level health programme training are also conducted as per guidelines.

Structure of Health & Family Welfare Training Centers (HTC):

1] Medical Officer Class I
2] Statistical Assistant Class III
3] Group D Servant
4] Nursing Sister from Nursing School with additional charge

Specialty trainings are arranged by other Health Institutes/Hospitals as per State Government Orders. HTC will select the Doctors/ Staff and co-ordinate the trainings.

12.8 Skill Training in Sterilization for Doctors

1 Training Needs Assessment

An important element of Quality of care is dependent on the knowledge, skill and at health care providers during their service delivery. A situational analysis of the current set service providers at the different levels of health facilities in the district will help to ide gaps and performances. This will help to determine and plan the most appropriate interval such as Refresher Training and Induction Skill Training, so that a cadre of competent providers can be developed. Based upon the need of the districts the service providers trained in various sterilization procedures. The training load can be calculated using following RAG analysis.

Calculation of the Training Load

Technique of Sterilization	DH/SDH			CHC/BPHC			PHCS		
	R	A	G	R	A	G	R	A	G
Minilap									
Laparoscopy									
Conventional Vasectomy									
NSV									

R-Required; A-Available; G-Gap (RAG)

2. Criteria for Designation of Training Centres

The public health care facilities conducting an average of 600 sterilization (laparoscopic Minilap abdominal tubectomy each) cases per year (an average of 50 cases per month) and average of 300 NSV cases per year (an average of 25 cases per month) can be designated Training Centers'. These training centers should have a training room and audio visual a The States should aim at developing at least 1 'Clinical Training Centre' per district. The training centres can be in district and sub district facilities providing RCH Identification and designation of these training centres at State and District level will be responsibility of SQAC/Director Family Welfare and DQAC/CMO whichever is applicable

3. Criteria for Designation of "Trainers'

Trained service providers (MBBS and above) with competency/proficiency in the skull counselling and technique of sterilization procedures (either female or male) and experiences in such service for at least three years, in a static center which performs an average 600 sterilization cases per year (an average of 50 cases per month) and also willing to be trainer and spare time to conduct training and follow-up visits for onsite support/handhold if required, can be

designated as a trainer by SQAC/Director Family Welfare at State level by DQAC/CMO at District level.

4. Criteria for selection of Trainee':

The eligibility criterion for selection of a trainee is detailed as follows

Sterilization	Training	Basic Qualification Requirement of Service Provider
Female	Minilap sterilization	• Specialists in surgical fields other than ObGyn • MBBS
	Laparoscopic sterilization	• DGO, MD/MS in ObGyn • Specialists in other surgical fields • MBBS performing Minilap sterilization
Male	Conventional Vasectomy	• MBBS and above
	No-scalpel vasectomy (NSV	• MBBS and above

5. Duration of Training

- Refresher Training — 03 working days
- Induction Skill Training — 12 working days (for female sterilization) and 05 working days (for male sterilization)

6. Training Design

Each trainee must observe/assist at least five sterilization procedures (minitap/ laparoscopic sterilization/conventional/no-scalpel vasectomy) and perform at least five independently to be certified as service provider for that method.

7. Certificate of Training

Certification of the trainee will depend on the trainees' skill and ability to perform the sterilization procedure of the respective method, which indicates that the trainee has demonstrated the competency needed to perform the procedure independently. Once the trainer is fully satisfied about the trainees' skill acquisition and competency to perform the procedure independently, the Hospital that conducts the training shall issue a 'Certificate of Training to be signed by the Trainer and In Charge of the hospital (MS/CS/MOI/C)

Schedule for Refresher and Skill Induction Trainings for different procedure of Female and Male Sterilization are given in the 'Reference Manual for Female and Male Sterilization'.

List of References

1. Dr. T.R. Anand. Training Needs for the Organization and Management of a Teaching
2. Hospital Complex. XVI Hospital Administration Course NIHAE
3. Dr. J.P. Gupta and Dr. T.R. Anand. Training of Middle Managers in Hospitals.
4. "Hospital Administration June 1970.
5. N.N. Kapoor, Extracts from Book on "Inter Personal Relations in Hospitals.
6. G.J. Ambwani, Review in retrospect of the Seventh Staff College Course on Hospital Administration. NIHAE Bulletin, Volume IV, No. 3-1971.
7. Commissionerate of Health Services, Mumbai

CHAPTER XIII
INSPECTIONS

Inspections of hospitals are required to be done at various levels by different officers. Inspections are necessary to supervise and assess the working hospitals, an essential component of administration.

13.1 Importance and Process of Inspections

Inspections can be (a) Daily round (b) Regular, periodical ones, (c) by surprise and (d) for specific purposes. Each has its own value.

It is incumbent upon various officers to carry out regular periodical inspections as laid down by order in the matter.

Importance of surprise inspections is obvious. A number of points, likely to be missed in regular inspections will come out during surprise visits. These will give a true picture of how the hospital is functioning. The element of surprise must be genuine and even in the office of the inspecting officer, only one or two reliable persons only should know about such visits.

Need for special inspections arise from time to time for specific purposes. Visits of officials of a level higher than the inspecting officer, investigations of particular complaints, scrutinizing specific proposals regarding the hospital etc. are instances necessitating special inspections. The object of such visits a limited one. The object of a surprise visit is more encompassing, while the object of regular periodical inspections is most comprehensive entailing a very detailed scrutiny. The term Inspection' is more often used for the regular visits, while the term visits' is often used for the other occasions.

Methods of Inspection:

- Once a year, team should visit health facilities and fill the ‘Hospital Inspection Checklist’ (Please refer annexure 13.1 for details)
- Head of the institute should follow ‘Hospital daily monitoring Checklist’
- Regular visiting officer should fill up ‘Hospital Quick inspection form’For Hospital daily Monitoring checklist and Hospital Quick Inspection Form, please refer annexure 13.2.

Objects of Regular Inspections

To the question why inspections are necessary, the answer apart from stating that they are essential for proper supervision would include the following points.

a) Evaluation of the way the hospital is functioning taking into consideration, general management, financial and accounting aspects, security arrangements and functions of the particular hospital.
b) In certain cases, evaluation of the quality of medical care-Medical Audit.
c) To ensure uniformity in the working of different Government institutions.
d) To ensure compliance of orders and instructions issued from time to time by higher offices. Many of them are a result of meetings, committees, seminars, conferences, work-shops etc., and deserve due respect.
e) To scrutinize by way of " Follow up" of past instructions especially arising from past inspections,
f) To activate and motivate the medical officer in-charge of the inspected institution to do better work and keep up the function of “inspection" by himself as a continuing process.
g) Communicating new programmes and policies.
h) To give opportunity to hospital staff and local public to communicate and discuss ideas, difficulties and grievances etc.
i) To keep in touch with members of the hospital visiting committee.
j) To keep in touch with the latest developments in the hospital.
k) To finalize issues and take decision on the spot to the extent possible especially in respect of items under correspondence back and forth for a long time.

Inspections carried out properly serve as a key to remote control of hospitals for which the inspecting authority is responsible.

The Inspecting Officer

It is self-evident that the inspecting officer must himself be adequately equipped with knowledge about technique of inspecting and reporting. He must be in the know of uptodate storage of all correspondence regarding the hospital, especially arising from the part inspections and instructions issued to the hospital from time to time. He should study fully the situation regarding these matters before proceeding for inspection. The inspecting officer must project an image of competent efficiency. He should be aware of hospital administration methods, and especially of qualitative and quantitative control over such institutions.

The inspecting officer must show a judicious combination of firmness, alertness and friendly atmosphere.

The inspecting officer should remember that he has to write the confidential reports of medical officers of hospitals under his charge and this is really not possiblewithout the necessary contact established through inspections and visits.

Instructions Regarding Inspections

The Director of Health Services has issued detailed instructions regarding periodicity of inspections vide Circular No. DHS INSP 1973/B, of 1974, dated 18th February 1974 vide his Appendix 54.

Some of the areas needing vigorous attention have been stressed by the Director of Health Services in his Circular D.O. Letter No. DHS PHC 1175 H 1975 dated, 27th August 1975

Attention is also invited to appendices 10, 11 and 11-A of Civil Medical Code in chapter" Deputy Directors of Health Services." Complaints are sometimes received by the Director of Health Services regarding poor and ineffective supervision by Divisional and District Officers. The Deputy Directors of Health Services and District Health Officers who are supposed to tour about 15 days in a month should inspect as many institutions as possible. In consultation with higher officers and Chief Executive Officers of the Zilla Parishad they should attend only important meetings and should not allow their routine tour programme to be disturbed.

Officers should carry out as many surprise inspections as possible in addition to regular inspections. Irregularities, pilferages, and defalcations detected during such surprise checks will not be considered a reflection on the supervisory officer. Rather, they will be considered points of merit and noted in the confidential record accordingly.

Various officers (Civil Surgeons, Directors of Health Services, Deputy Directors, Assistant Directors) of the Health Department are empowered to give technical guidance and assistance to Zilla Parishads. A specific number of visits by officers of the State Sector has been prescribed for inspection of the Zilla Parishad and Panchayat Samiti office.To avoid issuing the same instructions repeatedly, medical officers whose institutions are inspected should send a compliance report regarding items they have to implement. The file should not be closed until the compliance report is complete. During Inspection and round, specified areas and work to be followed as per IPHS guidelines.

Period of Inspections:

Inspection work should be done sparingly in the months of February and March since financial matters, tenders, etc., are to be given priority during this period. Inspections should be done, if at all, during these months very sparingly.The main programme of inspections should be spread during the period from April to January.

Mode of Inspections

If one may say so, inspections of hospitals deal broadly with the structure and functioning of the hospital the anatomy, physiology and pathology of the hospital. Inspection can be divided into two parts.

(a) Collection of information which will give a full idea about structure and functioning of the hospital.

(b) Scrutiny of work, department by department and section wisei.e. observations made by the inspecting authority.

Form of Inspection

The following form is suggested. The inspecting authority may add to it according to local circumstances.

(a) Factual Information:

The following factual information should be kept ready at the time of inspection:

1. Name of the Hospital or Institution,
2. Established in,
3. Name of the Medical Officer in-charge,
4. Date from which the charge has been taken,
5. Date of last inspection,
6. Date of current inspection,
7. Population of the town.

Reports of inspection should be signed by:

1. Medical Superintendent/Health Facility In charge OR
2. Deputy Medical Superintendent/Hospital Manager OR
3. Nursing Superintendent/Matron/Nursing In charge OR
4. Any Other (Name & Designation)

13.2 Inspection Visit Reports

It is mandatory for inspecting officers to send their inspection reports to higher officers, and to the medical officer in charge of the inspected institution, the inspecting officer keeping one copy with himself.

Inspections of hospitals should be comprehensive to enable the inspecting officer to assess work and absolve difficulties. Particular attention must be paid to irregularities about stocks and stores. Work of Contractual Medical Officers and other members of the hospital should be considered. The Deputy Directors should send their report in the form laid down in the Hospital Administration Manual together with additional points, if any.

13.3 Useful Points for Inspection

No number of instructions can replace the requirement that an inspecting officer must have an eye for detection. Thus a ward may be swept and swabbed clean, but will show dust on the top of the cupboard used by the Sister, which is not seen but has to be looked for. Cupboards which are locked should be opened and similarly Store Rooms also be inspected. Unscrupulous persons hide material in all sorts of nooks and corners and even under the dirty linen due to be sent for washing.

Beds may appear well made with clean sheets, but if the mattress is pulled up it may show signs of rusting as it is not turned for days. It should be ascertained if mattresses are infested with bed bugs.

Inquiries should be made with certain patients regarding the quality of care and service they get (Attention from medical, nursing and other staff, medicines, linen, diet etc.) Some case papers should be checked with the Daily Order Book, to see if patients get what is ordered.

It should be ascertained if instructions about identification of mothers and new born children are followed.

Medico-legal records should be particularly checked to see if post-mortem examinations are being properly carried out, if post-mortem reports are written properly and sent in time, if records of other medico-legal cases are accurate and medico-legal certificates are worded properly and sent in time.

A round should be taken in the hospital compound. Some of living quarters in general and of Class III and IV staff in particular should be seen to find out if there is adequate sanitation.

13.4 Medical Audit (importance and method)

Medical Audit is now an accepted method of evaluation of hospital work.

Medical audit has been objective method for applying a yard stick to the quality of medical care- professional competence. The medical administrator can thereby uncover inefficient service. It points the way to assessment standards in hospital. Medical audit cannot be better than the relevant medical records which thus ought to be complete and accurate.

A physician's main clinical. He should interested not in the fact that blood bottle administered patient without any reaction, but in whether blood transfusion was justified. Similarly he should be interested in whether particular operation was justified rather than the fact the operation was done without any untoward effect. Such type of evaluation is required to assess quality of medical care. Medical audit aims at insurance against license without responsibility. Medical audit should also deal with such matters as incidence of hospital infections.

Evaluation has been defined as the" process determining the value or amount of success achieving predetermined objective", in this case maximum reliefto the patient. Medical audits to be carried out with this in mind.

Some years back audit meant only evaluation in relation to financial transactions. It is recently that the subject medical audit has come into prominence. It is necessary remember that financial deficiencies can be remedied but medical deficiencies may cost lives.

Medical audit should be able to answer the following questions

a) what was patient suffering from
b) what treatment was given him
c) was it optimum and
d) if not, why not?

This means medical audit involves scrutiny of professional dealings by doctors’according’s to a standard based on data from medical record.

Need for Medical Audit

Diseases have become more complex due to rapid industrialization, urbanization, improvement in transport facilities, changes in social outlook and concepts of morality, lowering of death and population explosion. The general public is now more hospital-minded and more aware of rights. Procedures followed in hospitals are now more likely to question their adequacy quality. It is necessary to route incompetence, negligence, proper equipment and appliances and poor organization from any hospital. Medical audit is the only scientific method by which this can be done and the public is assured.

What can be achieved by medical audit?

1) Improvement patient care.
2) Assessment of individual doctors.
3) Highlights of deficiencies in the hospital working with a view to rectify them.
4) Comparison of functions of different doctors and different
5) Assessment job done hospital administrator.
6) Improvement regards accuracy diagnosis and mode of treatment, education.

Methods Carrying out Medical Audit

Medical audit usually carried out by medical Officers of the hospital itself, a sort of auto inspection. In some cases, outside agency will responsible to carry it out for example a Civil Surgeon inspecting Cottage & rural hospitals and dispensaries. In any case the inspecting authority ought to be able to tackle this matter to a certain extent upto level district hospital or appreciate situations in a way which enable him comment on the matter.

Medical Officers, of hospital may form Committee internal audit. In this connection it is stated every hospital should hold "Death Conferences" or "Mortality Conferences". At such Conferences, case papers and records of patients who have died the hospital from time of previous such conference should collected and scrutinized thoroughly. If necessary, matron and sister in charge the concerned ward or any other staff member may be called short while required.

After a full scrutiny of the records, the matter should be discussed if everything possible was done for the patients to the optimum extent, if the diagnosis column has been properly filled in etc. The medical audit committee should also meet consider a sample of outdoor and indoor cases especially complicated cases.

Proceedings of such meetings should be recorded in a “Medical Audit" book by one of the medical officer who should act as secretary turn by turn. The meeting has to be conducted in spirit healthy constructive friendly atmosphere and one recrimination.

There may be occasions when special "external auditors" may have to be appointed to evaluate specific matter. Since inspecting offers are frequently called upon to investigate complaints of technical nature, must retain and develop sufficient knowledge carry out work upto level of district hospitals.

Acceptance system of Medical Audit indicates a progressive and scientific attitude. It is the basic for evolving standards of hospital care. The well-known Mudaliar Committee has stressed into importance of medical audit.

Certain Useful Indices for Medical Audit

Broadly speaking the following indices and standards can be considered as useful.

a) The average bed occupancy rate: 75-80 per cent can speaking be considered as top limit.
b) Average length of stay of patient 5-13 days.
c) Death rate: overall 3 4 per cent. Average post-operative deaths should not be more than 1-2 per cent.
d) Analysis of how many patients treated and out of them how many recovered, improved, not recovered and worsened.
e) Scrutiny if appropriate consultants were consulted when the situation warranted it.
f) Infection rate in surgical and obstetrical cases it should not be more than 1-2 per cent.
g) Complications in clear surgical, medical and obstetrical cases should not be more than 3-4 per cent.
h) Unnecessary surgery for example Cesarean sections (LSCS). The incidence of such cases should not be more than 5 per cent at the most.
i) Autopsy rate: This shows scientific attitude of medical officers. It should be minimum 25 per cent.
j) Frequency of staff conferences.

It must however be clearly stated here that we have to evolve our own standards regarding the various indices by a close study over a period of time.

Conclusion

Medical audit thus offers an excellent opportunity to hospital doctors to educate themselves, especially in view of the fact that the science of medicine is a dynamic one. It keeps them alert and skillful, makes them take more interest, and stimulates them to do their best.

List of References:

1) Dr. F. E. Marker. Director, Medical Records Department. Sir J. J. Group of Hospitals, Bombay. Introduction to organization of Medical Record Departments in India.
2) H. B. Joshi, Medical Audit and its limitations, 1971. Hospital Administration" March
3) N. Luther, The Medical Audit-A powerful tool for upgrading medical care. Hospital Progress Vol. 51 July 1970. "Hospital Administration" September 1971. 4. Dr. A. Timappaya, Materials Management in Hospital. NIHAE XVI Hospital Administration Course
4) Directorate of Health Services, Public Health Department, Government of Maharashtra, 2024

CHAPTER XIV
DUTIES OF STAFF MEMBERS

14.1. Duties of Civil Surgeon/Medical Superintendent

1) He should attend Out-patient Department at least twice a week and conduct it for general cases and his own speciality. He should also see other cases referred by Medical Officers.
2) He should supervise the work in different O.P.D. sections from time to time. He exercises complete professional and administrative control over the hospital.
3) He should take a daily round of his cases in the morning and of important cases on operation and O.P.D. days. He should take a night round daily of important cases. He should periodically go round other patients in the hospital for general supervision.
4) He should take surprise rounds of the hospital from time to time and record defects noticed, if any, and action taken in their respect.
5) He should take an administrative round every week along with the Additional Civil Surgeon Matron and Mukadam/Jamadar of Group D staff in the hospital and hospital compound. Sanitary round should form a part of this.
6) He should check O.P.D. and indoor case records from time to time.
7) He should supervise medico-legal work issue of medico-legal certificates and post mortem examination reports. In respect of last, he should comment on the spot-on post-mortem reports received by him and communicate the remarks to the Medical Officer concerned.
8) He should guide the whole staff subordinate to him in technical and administrative matters.
9) He should ensure that the equipments for sterilization in different sections are adequate and functioning well.
10) He should ensure good use of important equipment and take timely steps for their maintenance and repair. As per need he should do annual / cumulative Maintenance contracts.
11) He should scrutinize the roll-call book of the staff.
12) He is responsible for efficient working of kitchen and satisfactory diet to patients. He should taste the food by surprise rounds periodically.
13) He is responsible for arranging and conducting various meetings like visiting committee meetings, staff meetings, etc.
14) He should exercise over-all control over budget, accounts and dead stock registers.
15) He should ensure discipline, punctuality, regularity and courteous Conduct amongst staff members. He should set up a standard in all these Matters by his own example.
16) He should supervise the work done by contractual Medical Officers.
17) He should investigate into any complaints promptly whether by stall or by patients and inform the complainant of the results. He should in general ensure due observance of rules meant for maintaining good public relations.

18) He should examine certificate cases in which he is the competent authority to sign himself, ensure that there are no complaints about certificates in general, and particularly ensure that they are issued on the very day.
19) He should strive to achieve economy in expenditure as far as possible.
20) He should pay personal attention to prisoners and alleged lunatics sent for certification.
21) He should do surprise physical verification in different sections of the hospital in general and in Medical Stores in particular. He should personally scrutinize major medical indents. Routine physical verification and condemnation should be done once a quarter.
22) He should ensure efficient office administration and particularly attend to D.O. letters, official emails, Government references, Legislative Assembly Questions (LAQ) and Plan items.
23) He should co-operate with other Government Departments and Offices, when necessary, and should project a good image of the hospital amongst the public. He should take particular care to give every possible co-operation for Family Planning. Epidemics, Health Education, and other matters which are important from Public Health angle.
24) He should inspect Quarterly once the medical Institutions under him as per rules as a routine and by surprise by her/him or his/her nominated team. He should ensure compliance of his reports. He should on the other hand comply with points made by an officer inspecting his institution.
25) Duties as mentioned in appendix 57. Please also see para.5:43 onwards Civil Medical Code (Part I June 1976 page no 36)
26) He should attend at 9.00 am each morning and should not leave until the work is over. In addition, he should attend for emergencies, evening and surprise rounds. He should check, as far as possible, the night super's report, the first thing in the morning.
27) He should check the cash in the office once a month as a routine and also by surprise once a month.
28) He should inspect the office at least once a year. He should get the Summary of work sheets at least once a fort night.
29) He should ensure that standing orders are filed subject wise and that they are followed.
30) He should inspect unserviceable items and issue orders for their being written off and disposed, as per rules.
31) He should attend to matters of maintenance and repair of hospital building and should prepare lists of major and minor works.
32) He should attend to matters of staff welfare in general.
33) He should attend Prisoner ward wherever necessary.
34) He should see the ambulance and other Government vehicles for their proper maintenance.
35) He should see that stocks of medicines are adequate and that no out of Expiry date medicines are lying either in ward or stores.
36) He should meet the Medical Officers and all program contractual Medical Officers at Monthly meetings.
37) He should pursue implementation of plan schemes vigorously.

14.2 Duties of Additional Civil Surgeon:

- He should attend daily at 8-30 a.m. and remain on duty until all O.P.D. cases, and certificate Cases are disposed of, until the work in different sections like Operation Theatre, etc. is completed and until all morning patients are admitted and their treatment started.
- He should attend the O.P.D. at least twice a week and conduct the same.
- He should attend Prisoner cell and all admitted medicolegal cases
- He should arrange duties of Medical Officers, including casualty duties.
- He should guide Medical Officers in Professional and Administrative matters and should co-operate with the Civil Surgeon in these matters.
- He should take a round of the wards once in the morning and Surprise at night. During these rounds, he should particularly check utilization of Diet and medicines.
- He should do surprise randomly physical verification of stocks and stores in every month and detailed physical verification of stocks and stores quarterly with the help of Medical officers. Especially of medical stores and record his findings in the appropriate registers.
- He is to be in complete charge of all dead-stock and should initial various entries in the registers. He should ensure proper maintenance of dead stock registers, central and sectional, and see that routine verification is done periodically as per rules.
- He should ensure comfort of patients. He should question patients in different words and enquire regarding treatment, nursing, diet, etc. they receive.
- He is responsible for discipline amongst Group D staff. These Duties should be done by him in association with Matron.
- He should initial all entries in Ambulance Car Log Book. He should be in charge of the Ambulance Car in general matters, like permission to give it for use of patients etc. He should keep the key of the Ambulance Garage and the car.

- He is primarily responsible for taking the necessary steps as regards
  a) Preparing medical indents.
  b) maintenance and accounts of Medical Stores,
  c) taking action on breakage and loss reports,
  d) Maintenance and repair of equipment.
  e) Diet committee functioning.
  f) preliminary enquiries in respect of any hospital incidents like theft, insubordination, negligence, etc.,
  g) writing off,
  h) Preparing statistical returns.
- He should be responsible for organization of the staff in extra ordinary incidents like floods, bus and railway accidents, etc. as per orders of the Civil Surgeon.
- He should accompany the Civil Surgeon in taking weekly administrative round.
- He should supervise the issue of various types of certificates in general.
- He has to Supervise all medico-legal work, and medico-legal correspondence.
- He should look after cleanliness and sanitation in hospital compound and supervise all the Bio- medical waste practices.
- He should arrange duties of Group D staff in different sections,together with their off days and should be the sanctioning authority for their Casual leave. This work should be done in association with the Matron.

- He should be the sanctioning authority for indents from different sections of the hospital.
- He should be available daily to listen to complaints and enquiries from patients, their relatives and friends and also for complaints from staff.
- He should acquaint the Civil Surgeon with important developments in the hospital.
- He should carry out orders given by the Civil Surgeon/Medical Superintendent in general.

14.3 Duties of Medical Officer, Group A:

1) They should attend the Hospital OPD at 8-30 a.m.to 12:30 pm and 4:00 pm to 6:00 pm daily along with assigned IPD duties and should not leave the hospital until the Whole work is over.

1) They should take a complete round of their patients every morning; they should visit the wards again before leaving the hospital. They must accompany Specialist on their rounds.
2) They should attend their wards in the evening for 2 hours to examine newly admitted cases. They should write case-notes and give orders which would ordinarily take care of the patients till the next morning.
3) They shall attend to emergencies as required. They should communicate with specialists whenever necessary.
4) They should start working in Out-patient Department and Operation Theatre at 8-30 a.m. sharp. However, they should adjust their ward-rounds on these days, has already been described elsewhere and they should adhere to those instructions.
5) They should superviseall IV Injections.
6) They should attend to casualty duties, as allotted by Additional Civil Surgeon.
7) They should take particular care in dealing with correspondence matters in general with which they may be required to deal and medico-legal Correspondence in particular.
8) They should examine all certificate-cases where they are the competent authorities to sign themselves and ensure that all certificates are handed over to the parties concerned as promptly as possible.
9) They should deal with sectional dead-stock registers and section indents, as per instructions from Civil Surgeon/Additional Civil Surgeon.
10) They should attend to administrative matters in general which might be entrusted to them by the Civil Surgeon/ Additional Civil Surgeon.
11) They should strive to maintain congenial public relations and co-operate with Civil Surgeon/ Additional Civil Surgeon, in all matters.
12) They are responsible for adequate records on the indoor case-sheets and other related paper reports etc., of all patients under their charge till they are finally sent to the Medical Records Department.
13) They are responsible to see that proper case-notes are written daily and that when a patient is seen often, all visits are recorded chronologically. They are responsible to see that instructions given by Subject Specialist or Civil Surgeon are either written by the officers themselves or by them. In the Latter case they should get them initiated to verify the correctness of the entry.
14) Medical Officers working at different types of Hospitals has to obey the Orders / additional responsibilities given by Hospital in-charge.

14.4 Duties of Specialist Cadre Class I:

1) Specialists are responsible for medical care of all patients being treated in their units.
2) They should see all patients admitted under their charge as early as possible. Consultation with and examination by other doctors should be ensured by them whenever necessary especially in serious cases.

3) They should be available at any time of day and night for consultation and attendance in regard to their patients.
4) Discharge of their patients should ordinarily be only with their approval.
5) They are responsible to see that case papers and other records are written and maintained properly in respect of their cases.
6) They are responsible to keep their patients on "dangerously ill list" and seriously ill list" as the case may be and to relay this information to the enquiry window. Such cases should also be explained by them to the patients' guardians/relatives/friends who should be sent for if not available on the spot.
7) They should record their findings and instructions on case papers in case of attendance on serious patients and ensure that other consultants whose assistance may be sought also do so. In case of a surgical operation a description of surgical approach, findings at operation; operative treatment carried out; diagnosis made and post operative orders should all be recorded on the case paper.
8) The Specialist should assume responsibility for upkeep and maintenance of his ward. He should lay down a specific procedure to be adopted during certain emergencies and see that the concerned staffs are well trained in following the same.
9) He should monitor all logistics needed inward and all time it should be in appropriate quantity.
10) He should monitor medicine/ instrument/ equipment etc. needed day to day in wards and see for their sufficient quantity.
11) He should supervise the day to day work done by medical officers, nursing staff and para-medical staff.
12) He should supervise the Bio- medical wastage / Cleanliness / Fire safety measure etc.

14.4.1 Duties of Anesthetist:

1) He is responsible for maintenance of all anesthesia equipment in the Operation Theatre.
2) He should examine each case before administration of Anaesthesia and again after the operation is over, and issue the necessary instructions in Writing.
3) He should attend in the Operation Theatre from 8:30 am. Till all operations are over and also in case of emergencies, according to the duties fixed.
4) He should give instructions about premedication, etc., and also postoperative treatment and ensure that both are carried out.

14.4.2 Duties of Pathologist:

1) He should attend the Laboratory from 8-30 a.m. to 1-30 p.m. and again from 4 to 6 p.m.
2) He is responsible for professional and administrative matters in respect of all laboratory work.

14.4.3 Duties of Radiologist.

- He should attend the hospital at 8-30 a.m. daily and should not leave the hospital till work is over.
- He should take a complete round of the patients under his unit every morning and before leaving the hospital.
- He should attend the emergencies as required and should communicate about the case to the Head of Institute as and when required
- He should ensure discipline, punctuality, regularity and courteous conduct amongst staff members. He should set up the standard in all these matters by his own example.
- He should strive to maintain congenial relations with public and cooperate with Head of Institute/Civil Surgeon and Resident Medical Officers in all matters.
- He should attend any other work assigned by Head of Unit or Civil Surgeon
- He is responsible for professional and administration matters in respect of X ray section including protection from Radiation Hazards.

14.4.4 Duties of Psychiatrist:

• Psychiatrist is overall Incharge of all services related to mental health in the district.
• Should give OPD and IPD services daily including liaison.
• Should do assessments for disability on fixed days.
• Should examine all medico legal cases and give appropriate opinions if requested.
• Should monitor works of other mental health services providers of the department.
• Should ensure proper documentation and maintenance of various registers.
• Should take monthly review of all services and give appropriate instructions for smooth functioning.
• Should arrange and conduct trainings /camps/stress management programmes.
• Update Civil Surgeon about all works of the department.

14.4.5 Duties of Paediatrician:

- Examining and treating paediatric/newborn patients coming to OPD, visits to Ward/SNCU, examining all patients including infants as required and on call.

- Supervise and guide the work of Medical Officers in the Special Neonatal Care Unit, enhance the technical skills of the Medical Officers and Staff Nurses working in the Special Neonatal Care Unit,
- Running a follow-up outpatient department, running a follow-up clinic for high-risk newborns,
- Emergency cases/S.N.C.U daily report to be submitted online to District Civil Surgeon, supervising SNCU software data regularly.

- He should take round as well as examine emergency cases
- Apart from this, it is necessary to carry out the any other work prescribed by the District Civil Surgeon from time to time.
- He should discipline, punctuality & regularity.
- He should check equipments and instruments as well as medicine from time to time.

14.4.6 Duties of Orthopaedic Surgeon:

- He should attend the hospital at 8.30 am daily and should not leave the hospital till work is over.
- He should take a complete round of the patients under his unit every morning and before leaving the hospital.
- He should attend the emergencies as required and should communicate about the case, to the head of the institute as and when required
- He should attend Outpatient Department at least twice a week and conduct it for his speciality. He should also attend and see cases referred to him or to his units.
- He should check OPD and indoor case papers time to time and should see that records are maintained properly.
- He should ensure discipline, punctuality, regularity and courteous conduct amongst staff members. He should set up the standard in all these matters by his own example.
- He should see that the stocks of medicines and instruments related to Orthopaedics from time to time.
- They are responsible to keep their patients on “Dangerously ill list” and “Seriously ill list” as the case may be and to relay the information to enquiry window and to the head of institute.
- He should strive to maintain congenial relations with public and cooperate

14.5 Duties of Dental Surgeon:

- To take the clinical load of the Department allotted by the Hospital in-charge
- To maintain the dead stock and the perishable stock.
- To indent for material for the clinics.
- To carry our work given by the Hospital in-charge in connection with the clinical work etc. supervision of servants, cleanliness on the Department etc.
- To Carry out Clinical work in Morning and Evening OPD and attend the indoor patient.
- Dental Surgeon working at different types of Hospitals has to obey the Orders / Additional Responsibility given by Hospital in-charge.

14.6 Duties of Nursing Staff:

A bed side nurse plays a vital role in giving service to the patients. She has the closest continuous contact with the Patient. The principle aspects of her duties are as follows:-

a) To give safe and effective physical care and to maintain and comfortable environment.
b) To carry out and help in treatment and diagnostic procedures.
c) To give emotional support to patients especially to alleviate pain.

d) To interpret line of treatment to the patient and his relatives and Friends and to see they understand the same.
e) To develop confidence of the patients in doctors and hospital.
f) To observe, report and record patient's physical and mental state.
g) To give health education to patients and their relatives and to act as liaison between hospital and community.
h) To give information to patients/relatives about the hospital, and hospital doctors with reference to the patient's illness.

In general nurses are the most important link between patients and the Medical team.

The nurses can fulfil these functions properly only when hospital policy and thinking of the medical team is attuned to support and encourage performance of such duties. Moreover the necessary equipment and facilities should be made available to them to enable them to perform the duties satisfactorily. Their paper work should be reduced.

The nurses require considerable amount of inservice training to inculcate in them a sense of total duties towards the patient as a whole and to discourage them doing their work mechanically.

In short what is required is comprehensive, safe, effective and well organisedNursing care to patients according to individual needs.

14.6.1 Nursing Cadre:
(As per Deputy Director of Health Services, (Nursing), Mumbai)

अ.क्र.	पदनाम	पदसंख्या
1	अधिसेविका वर्ग-३	34
2	सहाय्यक अधिसेविका	139
3	सार्वजनिक आरोग्य परिचारिका निर्देशिका	11
4	शुश्रुषा अधिकारी/पाठयानिर्देशिका/चिकित्सालयीन निर्देशिका	269
5	सार्वजनिक आरोग्य परिचारिका	249
6	मनोरुग्ण तज्ञ परिचारिका	147
7	बालरुग्ण तज्ञ परिचारिका	134
	एकूण	**983**

14.6.2 Nursing Officer:

1. Nursing Officers will be responsible to carry out the correspondence regarding the Schools with the Deputy Director (Nursing).

2. Nursing Officer will see that the advertisement and selection etc. to the course is done in time.
3. The Nursing Officer will be responsible to plan the syllabus and the teaching programme in the urban and the rural field.
4. The Nursing Officer is responsible for the submission of detailed information regarding the examination to Deputy Director (Nursing).
5. The Nursing Officer will be responsible for the environmental hygiene in the Nurses Hostel or wherever the nurses are accommodated. However, the Matron will be responsible for the maintenance of accounts and the control of nursing mess. The Nursing Officer will assist her in the duties.
6. The nursing Officer will be a liaison officer between the students and the hospital authorities.
7. The Nursing Officer may delegate duties to other tutors regarding the teaching programme, equipment upkeep, etc.
8. The Nursing Officer will be responsible for arranging and supervising the student's extracurricular activities and counselling them.
9. The Nursing Officer will be responsible to the hospital's Matron, who will guide and advise the Officer in performing all the above duties.
10. He/She should not remain absent without intimation to the Matron.
11. Any other duties assigned by Matron.

14.6.3 Sister-Tutor / Master-Tutor:

1. The Tutor will assist the Matron in security of applicants of candidates for training and selection of candidates.
2. Tutor shall be responsible for arrangement of the teaching programmes which should be approved by the Matron.
3. He/She shall undertake the training in the class room, hospital wards and departments in accordance with the prescribed curriculum.
4. He/She shall undertake theory, practical, Tutorials and clinical sessions of the students.
5. He/She shall be responsible for joint meeting of teachers including Ward Sister, Public Health Nurse and correlate theory and practice.
6. He/She is responsible for maintaining Registers of attendance to Lectures of student, practical experience examination, result etc.
7. He/She is responsible for maintaining of up to date record practical work etc. of each student
8. He/She is responsible for arranging and supervising of extracurricular activities and for counseling of students.
9. He/She may be required to maintain health record of students.
10. He/She will take charge of the Class room and will keep an inventory of equipment and mannequins of Skill Labs.
11. He/She will take charge of the Nurses Library
12. He/She will attend regularly Staff meeting and participate in the in-service training of Staff.
13. He/She will do such other duties that are allotted to him/her from time to time and work amicably with the Matron and him/her Assistant Matron.

14.6.4 Staff Nurse:

1. A Staff Nurse is entirely under the administrative control of Matron/Assistant Matron/In charge Staff Nurse and must carry out her order to the best of her ability.
2. It is expected that the Staff Nurse will act loyally, co-operatively and amicable with all the Medical Staff and Students and that she shall help them wherever it is possible to do so.

3. Training Students Nurse – This is Staff Nurse'sprimary duty as on this factor depends almost entirely the efficient nursing of the patients. The Staff Nurse is responsible for instructing Nurses in all the Subjects specified in their training charts etc. and for seeing that the theory taught in the class room is practiced in the Wards and for training student nurses in the habits of observation accuracy, neatness and economy. He/She shall co-operate with the Staff Nurse with whom he/she shall establish a good working relationship, in effecting good nursing procedure and teaching of students Nurses.

Nursing of patients :

1. 1 The Staff Nurse is responsible for the arrangement of proper assistance to be given to the Medical Officer for the Examination and treatment to patients.

   The Staff Nurse is responsible for the efficient nursing care of the patients. He/She will arrange for all treatment to be carried out including diet and medicines. The Staff Nurse will personally supervise the serving and distribution of the patient's food complying with latest particulars of the patients whenever possible.

2. Care and maintenance of Ward equipment and general management - The Staff Nurse is responsible for the cleanliness order and ventilation of her wards, service rooms, pantry and sanitary annex. She/he will also pay attention to the cleanliness of cupboard, floor, utensil etc. She is responsible for the work of the Ward domestic staff. She/he is in charge of the linen and all Ward equipment. She/he is responsible for the arrangement of duties of Nursing and domestic staff assigned to her Wards and also to arrange and conduct regular staff meetings.

3. She/he is responsible for diet sheet, indent of drugs and stores and for the safe keeping of H scheduled drugs and consumables.

4. If there is any infringement or any misconduct by patients or their relatives, the staff nurse shall report it immediately to the Matron. The staff nurse should maintain the admission and discharge register in her Ward and exercise particular care in the event of discharge, transfer or death of a police case. Transfer of patients from one ward to another should be made in collaboration with the Medical Officer.

5. The staff nurse should accompany the Additional Civil Surgeon/Medical Superintendent, and Matron during their ward rounds.

6. Staff Nurse shall give the Matron the earliest possible information of any serious cases or operations in connection with her Ward and shall duly report to her/him, if any of her Nurses appear to be out of health and in need of professional advice.

7. The Staff Nurse shall be careful that no visitors are admitted to the Wards other than the visiting hours.

8. The Staff Nurse or her deputy shall make a general survey of her/him wards before leaving for the night and shall give the night nurse full instructions for the performance of their duties, pointing out any special orders regarding the treatment of any particular patient or patients which may have been given by the Medical Officer, incharge of the case and any change in condition or symptoms of any patient which require special attention. The night nurse on being relieved in the morning by

Staff Nurse shall similarly inform the Staff Nurse of any change in symptoms or treatment which may have taken place during her term of duty.

9. All Staff Nurses are held responsible for any unnecessary use of light and fans and gas appliances.

10. In case of fire they should turn off all switches, controlling the burning area and at once inform the Medical Officer on duty.

11. The Staff Nurse will do such other duties as are allotted to her/his from time to time.

14.6.5 Theatre Nurse:

1. The theatre nurse will look after the setting out, disinfection, and sterility of the furniture, alarmist, trolleys, instruments, etc. in the operation theatre.
2. She/he shall be responsible for making adequate arrangements for any operation that may be performed.
3. She/he shall train any Nurses placed under the authorities in practical work and give demonstrations in theatre work to senior nurses preparing for examinations.
4. The servants working in the Theatre shall be under her/his control.
5. She/he shall keep a book in which anyone taking instruments or surgical appliances from the Theatre shall sign her/his name. On return of the article, the nurse shall cancel the entry over her/his signature in the presence of the party concerned. The dates of removal and return should be shown.
6. She/he will submit regular indent for all possible requirements through the Matron to the Medical Superintendent.
7. Every quarter she shall prepare and submit to the Superintendent through the Matron, a list of instruments requiring repair and also of any unserviceable dead stock,
8. On relinquishing charge of the Theatre, the nurse shall go over the whole stock with the relieving nurse and she/he shall respectively sign a delivery and receiving certificate specifying any deficiencies.

14.7 Duties of Administrative Officer (A.O), Group-B

1) To be in charge of lay administration of Officers, Hospitals, and Medical Colleges wherever they may be posted.
2) To perform duties of drawing and disbursing officer of the institution to which they are posted.
3) To deal with accounts matter.
4) To be responsible for the institutes' cash transactions where they are posted.
5) To be responsible for the service matters of the persons working in the institution.
6) Responsible for audit compliance, disposal of audit notes work, and compliance with store verification reports.
7) To be responsible for the budgetary control of the institution.
8) To be responsible to the Head of the institution in charge of their duties.
9) To supervise the personnel of the concerned Desk/Office.
10) To be responsible for disposingof non-professional and routine correspondence from the hospital/institution/office.

11) To watch the progress in the institution's expenditure with reference to relative budget grants.
12) To ensure that the expenditure initially incurred from the Zilla Parishad funds is reimbursed too promptly as possible when posted to the D.F.W.C.
13) To ensure that all stocks and supplied are properly stores and accounted for and supply line is maintained through the year when posted to D.F.W.C.
14) To carry out physical verification of stock and stores and ensure that all the stock is properly utilized without allowing any article to occur.
15) To ensure that necessary indents for supply of articles are placed in good time and supplies secured promptly so that the work does not suffer.
16) To be responsible custody and the maintenance of all vehicles.
17) To be responsible for the custody and the maintenance of accounts of the permanent advance sanctioned for the sterilization and JUCD performances. He should ensure prompt settlement of claims for sterilisation, operation and continuous flow of amounts from a permanent advance from the Head Quarter up to Primary Health Centers levels and arrange for prompt and timely recoupment of the permanent advance.

14.8 Group C cadre staff (54)

क्र	वर्ग क पदे
१	गृहवस्त्रपाल
२	भांडार नि वस्त्रपाल
३	प्रयोग शाळा वैज्ञानिक अधिकारी
४	प्रयोग शाळा सहाय्यक
५	क्ष किरण तंत्रज्ञ
६	रक्तपेढी तंत्रज्ञ
७	औषध निर्माण अधिकारी
८	आहार तज्ञ
९	ईसीजी तंत्रज्ञ
१०	दंत यांत्रिकी
११	डायलिसीस तंत्रज्ञ
१२	वाहन चालक
१३	शिंपी
१४	नळ कारागीर
१५	सुतार
१६	नेत्र चिकित्सा अधिकारी
१७	मनोविकृती सामाजिक कार्यकर्ता
१८	भौतिकोपचार तज्ञ
१९	समोपदेष्टा
२०	व्यवसोपचार तज्ञ

२१	अभिलेखापाल (ग्रेड पे १९०० ते २८००)
२२	कनिष्ठ लिपिक
२३	सांख्यिकी अन्वेषक
२४	वरिष्ठ लिपिक
२५	वैद्यकीय सामाजिक कार्यकर्ता
२६	क्ष किरण सहाय्यक
२७	ई ई जी तंत्रज्ञ
२८	हिस्टोपेथी तंत्रज्ञ /पेशी तंत्रज्ञ
२९	मोल्ड रूम तंत्रज्ञ / किरणेपचार तंत्रज्ञ
३०	पर्फ्युजीनिस्ट
३१	ग्रंथपाल
३२	ओर्थोटिक्स कम प्रोस्थेटिक्स तंत्रज्ञ
३३	स्वच्छता निरीक्षक
३४	दंत आरोग्य तज्ञ
३५	वैद्यकीय अभिलेखापाल
३६	वैद्यकीय अभिलेख तंत्रज्ञ
३७	केथलेब तंत्रज्ञ
३८	भौतिक शास्त्रोवेत्ता
३९	पाठ्य निर्देशिका
४०	सार्वजनिक परिचारिका/निर्देशिका
४१	परिचारिका
४२	मनोरुग्ण परिचारिका
४३	परिसेविका
४४	अधिसेविका वर्ग ३
४५	सहाय्यक अधिसेविका
४६	सहाय्यक परिचारिका प्रसाविका
४७	अधीक्षक
४८	सहाय्यक अधीक्षक
४९	लघुलेखक
५०	लघुटंकलेखक
५१	सांख्यिकी सहाय्यक
५२	सांख्यिकी पर्यवेक्षक
५३	आरोग्य सहाय्यक
५४	दूरध्वनी चालक

For job responsibilities of Group C cadre, refer annexure no 14.1

14.9 Group D cadre staff: (21 cadres)

क्र	वर्ग ड पदे
१	शिपाई
२	वार्ड बॉय
३	अंधार खोली सहाय्यक/परिचर
४	मदतनीस
५	प्रयोगशाळा परिचर
६	अपघात विभाग सेवक
७	बाह्यरुग्णसेवक
८	रक्तपेढीपरिचर
९	क्ष किरण परिचर
१०	कक्ष सेवक
११	स्वच्छक
१२	उद्ववाहन चालक
१३	माळी
१४	मुकादम
१५	न्हावी
१६	धोबी
१७	सफाईगार
१८	संदेशवाहक
१९	स्वच्छक मुकादम
२०	सफाईगार मुकादम
२1	मुकादम

For job responsibilities of Group D cadre , refer annexure no 14.2.

14.10 Human resources in special areas:

14.10.1 New-born care services:

a) A 12-bedded unit (plus 4 beds for the step-down area) requires at least one pediatrician or a trained doctor round-the-clock. Assuming that one doctor provides back-up of 8hours, at least three to four trained doctors should be available at the facility. It is proposed that one pediatrician trained in neonatology should be posted at the unit, supported by three to four medical officers trained in FBNC.

b) Such a unit will also require three nurses in each shift, round-the-clock. In addition, there should be sufficient nurses recruited to provide for leave vacancy and contingency.

c) In addition to doctors and paramedics, dedicated support staff should be available to clean the nursery at least once during every shift and more often depending on the need. In addition, apart-time laboratory technician and a data operator will be required for the unit.

Medical Officer-

- Minimum 8 hours daily shift duty in Neonatal Care Unit,
- Examination and treatment of newborns admitted for emergency
- Regular visits of newborns in SNCU
- Submitting daily report of SNCU to pediatrician through online mode.
- Medical Officer should work under the supervision of unit head.

Incharge sister -

- Regular updating and preservation of records/registers in SNCU.
- After the discharge of the baby, to inform the concerned THO regarding follow up of the baby regularly.
- To maintain the equipment in the SNCU and ensure that it is in good condition.
- Keeping the register up to date, ensuring that treatment and infection control protocols are followed in SNCU, training of all staff in SNCU, ensuring FBNC training of staff nurses as per guidelines and training of mothers/guardians in SNCU on Family Participatory Care etc. Daily report to Pediatrician.

Data Entry Operator:

- The working hours will be from 9 am to 5 pm. Updating and maintaining daily records and registers in SNCU. Information must be entered into the SNCU software in a timely and accurate manner.
- To increase the amount of social and institutional level follow-up by frequent follow-up of concerned patients.
- To inform the concerned THO promptly after the discharge of the child for the community follow up.
- To provide the necessary basic information for the software of the admitted newborn.
- To submit weekly and monthly report of SNCU to the pediatrician.
- To perform the tasks as per pediatrician's advice.

14.10.2 Psychiatry Services:

Clinical Psychologist

- Should do objective assessments by applying various psychometric tests, mental illness scales, personality tests, Intelligence tests etc.
- Submit assessments reports to psychiatrist and participate in planning and execution of psychotherapies.
- Do individual and group therapies for different disorders.
- Should do objective assessments of all patients who come for disability certificates and help in procuring certificate at the earliest.
- Should participate in trainings/camps/stress management programmes.
- Any other work as instructed by psychiatrist.

Psychiatric Social Worker

- Should do counseling of patients and guide them for psychosocial rehabilitation.
- Should provide information to patients and relatives about services given at hospital and community level.

- Should keep and provide information to patients and relatives about social organisations/ NGOs, other hospitals where they can avail of mental health services, rehabilitation services, special schools, monetary benefits, handicap allowances etc.
- Should do active intervention and communication with social organisations for rehabilitation of poor patients or patients who do not have relatives.
- Should participate in trainings/camps/stress management programmes.
- Should coordinate with all other government offices/NGOs and authorities for patient management.
- Any other work as instructed by psychiatrist.

Trained Attendants

- Should manage sitting/waiting arrangement of patients in OPD.
- Should help in management of excited/aggressive patients in OPD and IPD.
- Should help while giving treatments to OPD/ IPD patients.
- Should help in shifting of patients to wards.
- Should help in arrangement of trainings/camps/stress management programmes.
- Any other work as instructed by psychiatrist.

14.10.3 Intensive care unit

Sr. No	Category	Job Description
1	Intensivist	• An Intensivist is a specialist who has been trained to manage critically ill patients. • The first choice for an intensivist should be a specialist who has a post-graduation degree in anesthesiology, medicine, pediatrics, or chest medicine and additional specialized training of at least a year in intense care with a structured exit exam and a certification process. • In case of intensivists are not available, Anesthesiologist/Internal Medicine Physicians, Chest Physicians, and Pediatricians by virtue of their experience in the field of critical care medicine as well as because of their curriculum prescribed under their respective subject of training can also function as Intensivists.
2	Specialist	• Specialists of different disciplines will take round of the patients admitted under them on visiting and during day-on-call. • They will suggest their treatment decisions which will be implemented after consultation with the intensivist who is in charge for the ICU.

3	Medical Officer	• Baseline management and supportive care during 8 hrs. shift duty. • Handling equipment present in the Unit. interpreting basic pathological/biochemical test, performing basic tests like POC or procedures like CPR, ABG, Central Line Insertion etc. • One of the MO's will be in charge and will perform additional administrative duties.
4	Nurse In charge	• Work under the intensivist/ICU In charge and help in improving clinical, administrative services of ICU care. • Preparing duty roster of nursing staff, supervisory, logistic management and regular reporting.
5	Nurse	• General nursing care, Basic Life Support, assisting all resuscitative and advanced life support clinical work in ICU, Airway suction and nebulization, ECG, BSL, administration of drugs through all routes. • Maintenance of records, charts, ready stock of drugs, equipment, consumables. • Monitoring of clinical parameters & ventilator parameters.
6	Technician	• Basic Life Support, Chest physiotherapy, Oxygen therapy including handling oxygen manifold & centralized oxygen supply, assisting MO's performing different procedures, assisting bedside dialysis. • Blood sampling by peripheral venipuncture, assisting USG, ECG, X-Ray. • Basic blood test by Biochemical analyzer/cell counter/glucometer/Arterial blood gas analyzer/Electrolyte analyzer. • Maintenance of all equipment present in the unit. • Computation & clerical work.
7	Housekeeping	• Cleaning and mopping of equipment, beds, floors, ceilings, toilets with disinfectant. • Transportation and storage of all waste material including bio medical waste at designated BMW storage room. • Cleaning blood spills and other such as human excrement, urine, vomitus, sterile body fluids is responsibility of cleaning staff.
8	Security	• A security guard should be on duty constantly to ensure the safety of the staff, property, and the critical supplies. For restricted access, security is also necessary.

		• Security personnel ought to receive training in patient shifting during emergencies, bereavement counselling techniques, crowd control, and empathy.
9	Dietician	• Therapeutic diet of patients will be determined during rounds with doctors based on clinical condition and food habits.
10	Physiotherapist	• Advise patients admitted in critical care areas, for stroke, respiratory distress, chronic bed rest during daily rounds.
11	Bio-medical Engineer	• Oversee equipment maintenance.

14.11 Duties Of Drawing And Disbursing Officers

1. The officers who by virtue of their position as head of office or to whom powers have been delegated by their heads of offices are authorized to draw money from the treasury and make disbursements are called drawing and disbursing officers. Since 1962 a special authorization from the Accountant General is required for a new drawing and disbursing officer before presenting any bill on the treasury for the first time after opening of a new office. Specimen signature of the D.D.O. is required to be sent to the treasury on his taking charge.

2. Such officers have powers to enface chalans whenever any to be credited to Government and sign the bill money whenever any to be credited to Government and sign the bill money whenever is to be drawn from the treasuries.

3. In relation to revenue collection. Such officers are required to keep a demand register and keep a close watch on the collection of revenue. The Govt. Officers have been authorized to accept amounts of less than 300/- themselves. If such amounts are received, they have to be received in legal tender coins or notes only or by cheque or or demand drafts. For amounts realized in cash immediate official receipt is required to ensure that it is recorded in the office cash book. When cash being collected at different counters in the same office. Subsidiary registers are kept for each counter mind the total cash collected in entered in the cash book. When money is received in the form of cheque the officer concerned is required to issued. Before signing such a receipt the officer concerned is required to ensure that it is recorded in the office cashbook. When cash is being collected at different counters in the same office subsidiary registers are kept for each counter mind in the total cash collected is entered in the cash book. When money is received in the form of cheque the official receipt is issued only after realization of the cheque. In no case a duplicate receipt is to be issued on the ground that the Pt original has been lost. Receipt books required for this purpose are indented from the Yerwada Prison Press. Only one receipt book should be in use at one time as far as may be possible.

4. The collection of revenue is required to be credited to Government account immediate on the next day. The drawing officer should ensure before signing the entry in the cash book that

the chalan sent along with the collection is duly received by the Bank and the amount receive is expressed both in words and figures. In the case of cheques sent to the Bank for collection it is necessary to keep a proper watch on the return of receipt till the realization of cheques. The drawing officer is responsible for the correct account classification recorded on the chalan. Incorrect classification on the chalan is likely to result in misclassification of of receipt in the Government account and hence the precaution.

5. If the officer in the course of his duties is receiving money either directly or by recovery from the bills of employees which does not belong to Government a separate account of such money in the same form in which he maintains the office cash book is required to be kept by him, till such amounts are either credited to Government or disbursed to the proper payees. If he is permitted to open a personal ledger account in the treasury he has to ensure that the amount is credited immediately to such account. For making withdrawals from such personal ledger accounts, he is empowered to issue cheques on the treasury for which purpose blank cheque books are issued by the treasury on demand. Passbooks for such personal ledger accounts should be got completed from the treasury and monthly reconciliation between the treasury balance in the departmental accounts is required to be carried out.

6. Such a drawing officer has to draw bills for various purposes from the treasury. The amounts received from the treasury will be in the form of cheques. These cheques are paid at the Bank to the messengers of the drawing officer in whose favor and authority is recorded on the reverse of the cheque by the drawing officer. The drawing officer is neither in possession of the cheque nor the money during the period the cheque is in possession of the messenger. With a view to keep a record of cheques received and the acknowledgement of the peon or messenger who has been authorized to receive money from the bank. Before sending the cheque to the Bank it is necessary to record its receipt in the cash book.

7. One of the main functions of the drawing officer is to sign establishment bills, Since January 1990 the Government has issued orders that as far as may possible, the pay of Class III and Class IV establishment should be drawn in one in one bill for the entire office. No office copies of the establishment bills are kept but a continuous salary register in which a separate page is allotted to each individual is kept as office record. The establishment bills should show clearly the sanctioned strength of each cadre along with authority for each of them. It is the duty of the drawing officer to ensure that this sanctioned strength is not exceeded. He is also required to ensure that increments become due in the same month are prepared, duly signed and one attached to establishment bills. All other accompaniments such as recovery schedules in respect o recoveries effected from pay should be correctly prepare. In respect of schedules pertaining to G.P.F. accounts are likely to show missing credits. According to the orders issued by the Government the salaries excepting those pertaining to the month of March is payable on specific dates: on the last two working days of the current month and the first day of the next month. With a view to ensure that the employees get salary on due date he should see that the bills are signed at least 4 days in advance and submitted to the treasury. All other instructions regarding the preparation of in general should be clearly followed.

8. With a view to ensure the release of increments on due dates it is necessary to kept a calendar of increments mentioning the names of person whose increments are due in a particular month and to see that it is being put up to him along with establishment bills every month.

9. When the bills is prepared and is ready for being sent to the treasury it has to be entered in a register called "bill register" and further progress of passage of the bill is to be watched through it nothing there in the token number, the cheque number of the passed bill, date of encashment of the cheque and the entry in the cash book.

10. The bill has also to be entered into what is known as "Treasury Token Register" where in addition to the tokens exchanged for every bill, an acknowledgement is also given to the D.D.O. The total number of bills presented on each date is to be shown by D.D.O. in words and figures to prevent unauthorized bills being presented to the Treasury. This register is to be used for all kinds of bills sent to the treasury.

11. It is duty of the drawing officer to ensure that only one messenger to whom an identity card is given by his office is sent to the treasury for presenting the bills and for collecting the cheques. At the end of the duty it is necessary to ensure that the number of tokens in possession of the messenger agrees with the number of bills pending with the treasury.

12. There is a system of sending the voucher slip to the drawing officer by the treasury after the voucher is accounted for in the Government accounts. It is the duty of the D.D.O. to ensure that the Voucher numbers are noted in the appropriate column of the bill register and that all the bills have been passed for the correct amount and no bill which was not presented by D.D.O. has been passed by the treasury.

13. In respect of salary bills the acknowledgement duly stamped are required to be obtained from the employees to whom the salary is disbursed. These are required to be obtained in the prescribed form of acquaintance rolls. Such of the payments which can not be disbursed to treasury are required to be noted in the register to undisbursed pay and allowances and further disbursement of such items is required to be watched. The amounts which remains undisbursed should be refunded to Government by short drawal but if necessary they can continue to be retained in the office up to a period of three months. At the end of three months however, the amount should necessarily be refunded to Government. It is also necessary to draw an abstract of undisbursed. pay and allowances in the register and compare the total with the balance shown in the office cashbook under the column 'Pay-Allowances'.

14. Rules permit grant of advances to Government servants for various purposes. It is duty of the drawing and disbursing officer to keep a proper record of such advances given in prescribed registers and to watch recoveries thereof. It is necessary to take a review of long outstanding items and to speedy recovery periodically.

15. In regard to contingent expenditure a register in prescribed form is kept in every office and a record of all expenditure incurred is required to be properly kept. The register should be closed month and progressive totals should be worked out. The register will cover all the contingent expenditure irrespective of the fact that the initial expenditure was incurred from Permanent Advance by drawal of abstract contingent bill of detailed payable contingent bill. Account of permanent Advance or the office is required to be kept in the prescribed Permanent Advance Register.

16. One of the important jobs of the drawing and Disbursing Officer is to maintain the service books of the employees. In his office. The rules regarding maintenance of book care prescribed in Maharashtra Civil Services (General Condition of Service) Rules 1981 & they are required to owed strictly. D.D.O. should see that the duplicate service books in possession are require of the employees are periodically updated & their signatures in token of correctness of entries are obtained in the original copy. All entries affecting pension of a Government servant are required to be noted in red ink on a separate page of the service book. Whenever Government servant is transferred to a new office the entries in the service book are required to be completed till the date of his relief, his leave account is to be updated till that date , the service verification certificates up to the date of relief are to be given and the service book is required to be independently, not through the employee concerned, transferred to his new office long with last pay certificate giving details of pay drawn, GPF Account Number, other pending recoveries of advances etc. to enable, the government employee concerned to receive his pay and to make possible for his new head of office to effect the pending recoveries.

17. The drawing officer is also responsible for recovery of proportionate income tax from the salaries of the employee, according to the provisions of Income Tax Act. This responsibility has now increased owing to the fact that their offices are drawing the salaries of the Gazetted officers, which were being independently drawn by them so far. For this purpose the drawing officer should obtain the estimates of annual salary income along with permissible deductions and relatable investments etc. from the officers concerned at the beginning of the year and deduct proportionate tax from them monthly. The Act does not permit postponement of recovery till the closing period of the financial year. Each drawing officer is required to obtain the registration number from the Income Tax Department, issue certificates of deduction of tax to the employees, and submits in the month of may every year a return of recoveries of tax to the income tax officer concerned. It is necessary for every drawing officer to be familiar with the provisions, of Income Tax Act in so far as they relate to salaries, as soon as possible after the passage of the Finance Act of Central Government.

18. Each head of officer is an estimating officer for preparation of annual budget. Generally speaking the budget of an ordinary Government office which does not deal with any planned scheme mainly relates to estimates of salaries, travelling allowance and contingent expenditure. The budget relating to salary is based on the sanctioned posts which are not vacant and the details of estimated salaries payable during the next financial year are required to be prepared all on the basis of pay actually drawn by each incumbent. The estimates of travelling allowance and contingent expenditure are more or less based on the average expenditure for the last three years. Time schedule is very important and the drawing officers should ensure that it is strictly observed. In regard to planned expenditure the phasing of the

scheme, the staff sanctioned. For the same and the special progress expected to be achieved during the ensuring year are to be taken into account while preparing the estimates. The expenditure on plan schemes which continues, after the plan period becomes non-plan expenditure.

19. Constant watch on the progress of expenditure is required to be kept. With a view to enable the drawing officer to estimate his expenditure properly during the year a register called liabilities register has been prescribed. This register should be used for entering the items of expenses for which commitments have been made and which are likely to be met before the close of the year. This register is very useful while revising the estimates during the course of the year.

20. Coupled with this proposals for continuance of the temporary posts are required to be sent to the appropriate higher authorities by the end of December every year so that the sanctions for continuance can be issued by Government in proper time. In the absence of such sanctions the employees who are working in temporary posts are likely to suffer owing to non-receipt on their salaries.

21. The accounts of G.P.F. of Class IV employees are to be kept in each Government Officer according to the instructions issued in this behalf by the Government. These accounts consist of individual accounts and broad sheets. The recoveries from pay bills are required to be recorded Every month in the broad sheets as also in individual accounts. The withdrawals are noted in the broad sheets and ledger when the drawing officers sign the bills for them. The total of recoveries posted in the broad sheets should agree with the amount of recovery shown in the Certificates, attached to the pay bills. At the end of each year the interest is worked out in the manner laid down in G.P.F. Rules add credited in the broad sheet and the individual ledger. Simultaneously the amount of interest is required to be intimated to the head of department to enable him to communicate proper account adjustment of interest in. Government account to the Accountant General. On the basis of completed annual accounts to the Accountant General. On the basis of Completed annual accounts the passbooks given to the employees are required to be. Completed and handed over to them. The nominations received from the employee are to be kept securely in the office concerned after their acceptance. When due to retirement or death of an employee the balance in his account becomes payable. His account has to be closed expeditiously and the amount paid before the expiry of six months from the due date together with interest up to the end of the month preceding the month in which the final payment is made. The families of the employees who die while in service are also entitled to bonus equal to the average balance in G>R.F. account of the deceased employee during the last three years subject to a maximum of Rs.40,000/-. These amounts should also be paid as soon as passion.

22. One of the most important functions of the head of the office is to prepare the pension cases of employees of all the classes including himself. With the simplification of pension rules and procedures the preparation of a pension case has become comparatively very simple. The necessary forms as indicated in the M.C.S. (Pension) Rules 1982 are to be filled in and submitted to the Accountant General. Along with the service book of the Government

servant, The completion of service book which at times proves very difficult is to be taken up two years in advance of the rules wherein service books can be sent to the A.G. after completion of 25 years of service for verification. If this is done in time the subsequent service can be established with the aid of record which is comparatively recent and easily available. The pension Case along with application for retirement of the Government servant. The pension cannot be finally authorized by the Accountant General unless he receives" no demand and no inquiry" certificate in the prescribed form, from the appointing authority of the employee. If the pension is not authorized oh due date a provision for sanction of provisional Pension and gratuity by the head of office and for communication of provisional pension has been made in the rules to avoid hardship the employee concerned.

23. Another area where the drawing and disbursing officer has to pay attention is regarding the nominations received from the employees. Nominations for provident fund are to be sent to the Accountant General in case of employees other than Class-IV servants and those in respect of Class IV servant\s should be retained in the personal custody of the head of office. Nominations for gratuity should also be obtained and kept with the service book of the Government servant concerned. Similar nominations are required to be obtained in respect of Group Insurance Scheme. Ail these papers should be properly preserved since non-availability of the nomination is likely to result in great financial suffering to their families of those who die while in service.

24. It is also the duty of the had of office / D.D.O. to ensure that medical examination of new employee is done as early as possible even though rules provide that it should be got done within six months from the date of joining the service. This is necessary since the rules regarding death gratuity and family pension provide that having less than one year service the benefits in case of employees such as death gratuity and family pension are admissible only if such an employee has been certified, after medical examination, to be fit for Government Service.

25. This note takes into account the duties where the financial implications are involved, and not relating to any administrative matter, which may also be entrusted to the drawing and disbursing officer.

List of References

(1) Mrs. A. D. Malhotra M. A. (Nursing Administration) Improving Hospital Image "Hospital Administration" March 1971.
(2) 1. N. Kappuswami, Duty list of medical staff in general hospitals. "Hospital Administration" March 1972, (3) Mrs. A. D. Malhotra, The role of a Nurse Administrator. "Hospital Administration" June 1970,
(3) Mrs. Prem Misra Improving patient satisfaction. "Hospital Administration " March 1970.
(4) IPHS Manual of Government Of India 2022

CHAPTER XV
PUBLIC RELATIONS AND PATIENT SATISFACTION

15.1 General

It is said that the motto of a hospital should be “To cure to relieve often, but to comfort always”. From this point of view the question of public relations and patient satisfaction, assumes a great importance. In any branch of social service especially in a democracy where the “Government is of the people, by the people and for the people “, success cannot be said to have been really achieved, unless the public is satisfied. Congenial public relations will actually contribute towards earlier recovery of patients. Patient satisfaction will lead to satisfaction of the community, and this depends on how services are given.

This aspect of hospital administration is particularly important in the Outpatient department, indoor wards, the casualty department and emergency wards or sections.

The hospital administrator must first create a feeling of goodwill and understanding in the hospital staff. It is true beyond question that satisfactory service to the patients and public is absolutely dependent on a satisfied hospital staff. For this purpose the internal communications amongst staff members should be of a high order.

It will be a good idea to prescribe some “Dos and Don’ts” for health care provider attending the patients. Patients and accompanying relatives should be made aware about their rights and responsibilities through proper counselling. This will introduce them to the working of hospital and create an understanding in their minds.

A major share of creating the proper physical, psychological, social and even spiritual environments which are all necessary for the recovery of a patient goes to the nursing staff. This staff has to understand the society it is serving and the problems of human relations. A hospital can be compared to a family house, the staff to a family group and the patients could be considered as guests.

A hospital must become service oriented specially as patients are under physical and emotional stress. They should be considered as human beings and not simply as clinical material or a nuisance. Here an important consideration is that the patient should not be considered in isolation but always along with his family and he should be treated with respect so that he maintains his dignity**.**There should be no discrimination in care of patients on the basis of age, sex, physical and mental status (disability), socio-economic status, religion. There should be easy access to visually disabled, and elderly people,infrastructural norms in line with the ‘Guidelines and Space Standards for the barrier-free built environment for Disabled and Elderly (‘Rights of Person with Disability Act 2016)’ Public health facilities should adhere to the highest ethical and

behavioral standards, States must orient health professionals to discharge their duties in a professional and courteous manner, facilitating greater acceptability of the community.

Soft skills including an empathetic attitude, manners and courteousness at bedside should be a core value, especially towards the marginalized and vulnerable strictly adhered to. Uniform and Dress code (with a name badge) and adherence to punctuality should be emphasized as perConduct and Behavioral Standards Maharashtra Civil Service (Conduct) Rules 1979.

Maintaining public relations and ensuring patient satisfaction does not require any extra expenditure recurring or non-recurring. All that is required is a change in the attitude of the hospital staff.

Instead of applying rigidly a set of rules to the patients, it would be preferable to protect their individuality. For this their physical and mental status requires proper observation.

It would not be out of place to state that the science of medicine is to be practiced not only as a science but also as an art.

15.2 General Hints

The following hints will be useful:

1. The general behaviour should be such as not to give offence to a patient or his relatives and friends. Treat all with courtesy and try and understand their problems or difficulties and help them to overcome them. The nurses can combine pleasant manners with firmness. A smiling “Namaste “on arrival in the morning will cheer the patients and give them confidence. Every hospital should organize courteous telephone service.

2. Be patient and sympathetic. It can easily be appreciated that the busy staff working in a public hospital cannot devote a substantial amount of time in conversation with public, but a kind word here, encouragement and reassurance there and a smiling face will work wonders. A word of sympathy and regret after every death in hospital is a must.

3. An eminent teacher used to tell his students, “You have no right to be angry under any circumstance. If it is your fault, you have no right to get angry. If you are not at fault, why waste your breath by getting angry?” It is worthwhile remembering this dictum which will pay more dividends than a heated argument which is not worth your winning if you lose the goodwill. Above all, remember the patient is suffering and the relatives are anxious and their behaviour is likely to be abnormal, exacting and at times even irritating.

4. It must appear to the patient that for the moment, the doctor and/or the nurse is concentrating on his and his case alone.

5. Strict regularity and punctuality must be maintained. The waiting Period of patients must be reduced to the minimum in each and every section of the hospital.

6. Operations must not be postponed for reasons other than those which can be ascribed to the condition of the patient himself, except in cases of exceptional break-down or where the operating surgeon himself cannot attend due to genuine reasons.

7. The patients must be given their due nursing comforts. Sponging, making the bed, cleaning the mouth etc. must be attended to properly. Attention of the Class IV staff in time must be ensured, especially, of the sweepers. Linen must be changed at set intervals and also when necessary.

8. An efficient Nurse tries to learn from the doctor every-thing about the case and if she is armed with the information it is easy for her to answer the queries of the patient or his relatives.

9. The nursing staff should act as a bridge between the doctors and the patients by interpreting doctor's advice to the patients and by interpreting the view-point of the patients and the public to the doctors. Any complaint or request made by the public should be put up by the staff before the medical officers for their consideration.

10. Serving diet at the appropriate time, with the necessary check on quality and quantity will go a long way in aiding medical care. The menus should provide variety and the food should be palatable and served in an attractive way. Pantries should be utilised to ensure serving of hot meals. Provision of special diets on days of religious festivals, Independence Day, Republic Day etc. should be arranged.

11. Their should be no prescription of outside medicine ('Free Drug Service Initiative' of GoI,) All essential medicines should be available free of cost in all public health facilities a proportion of medicines that are critical for service delivery in OPD, IPD and the Emergency and ensure that these are available round the Clock Essential drugs and diagnostics to be made available. They can also procure Essential drugs/ diagnostics not available at the health facility from RKS and other available funds. However, such local purchases must only be seen as a short-term measure.(section7.3. MEDICINES- Anx. 8/ IPHS) Though from a technical point of view such needs arise when the patient's condition takes a sudden turn for the worse, the action is invariably construed by public as neglect to follow a correct line of treatment in the beginning of illness, and as waking up at the eleventh hour. It is possible to minimise such contingencies by giving such prescriptions as early as possible. Care should be taken to see that occasions do not arise for one doctor to change a set of prescriptions given by another doctor, except specialist or senior consultant as otherwise, the patients are bound to lose faith in the medical treatment and it is also an unnecessary financial burden.

12. The concerned persons should be given an idea about the seriousness of a case in time, and also any advice referring the case to another institution for better and more expert

care.Condition of patient should be informed to relatives and their involvement shall be in decision making in treatment of patient

13. The hospital staff should not discuss matters of internal administration in front of the patients and public. Arguments, counterarguments, rebuking, taking disciplinary action, pleading ignorance of matters, throwing responsibility for lapses on others all have their own appropriate time and place, but certainly not in the open and before patients or their relatives. The behaviour of doctors and nurses in the wards and the Hospitals must be strictly “Official” and idle or social talk must be avoided as this, howsoever innocent it may be to them, appears to the patients or relatives who need the doctor or the nurse to be entirely out of place.

14. It is very damaging to public relations for one doctor to be jubilant for “Victory over other doctors” and to air contradictory views on technical matters. Professional jealousy prompts most of us to do this, but the temptation must be strongly resisted. The public cannot judge these matters and these only results in ridicule of the hospital and the staff. Besides, this is unethical.

15. Charts, maps, indicators, boards etc. signages should make it easy for patients to locate different sections in a hospital. They should be liberally provided everywhere in local language. Services available, various Government schemes ex. PMJAY, PMMVY, JSSK etc. Should be displayed.

16. The Enquiry Window must genuinely function in the spirit of “May I Help You?”The functions have been detailed in the Chapter on Out Patient Department. There should be proper arrangements to receive telephones and deliver messages in the appropriate quarters.

17. In Hospitals identified as SUMAN Facilities "SUMAN HELP DESK" should be established. All the complaints should be entered in SUMAN Portal for timely redressal of grievances. (SURAKSHIT MATRITVA AASHWASAN (SUMAN), MUSQAN Standard Operational Guideline or as per system prevailing

Privacy of patients must be respected and preserved. Commonly, scant attention is being paid to this aspect.

15.3 Treatment of Government Servants:

Under the Hospital fee rules framed by the Government of Bombay, all Government servants and their families are entitled to free medical attendance and treatment. It has been brought to the notice of the Government that Government servants are unable to take advantage of the facilities available at Government Hospitals mainly because no prompt attention is given to them under the present circumstances, and they have to wait for a long time at the Hospitals. The government is, therefore, pleased to direct that Government servants

visiting Government Hospitals or Dispensaries should first contact the Resident Medical Officer of the Hospital concerned, who should direct them to the appropriate Medical Officer or Department for examination and treatment. The Superintendents or the Medical Officer in charge of the Government Hospitals and Dispensaries are requested to impress on the staff under them that due and prompt attention should be paid to all Government servants who visit their Hospitals for examination and treatment. The Heads of all offices are requested to issue a letter in the following form addressed to the Additional Civil Surgeon of the Hospital concerned whenever Government servants from their offices visit the Government Hospitals or Dispensaries.
(Medical Care of Government Servants, Government of Bombay Local self-government and Public Health Department Resolution no. TBC. 1057/S Sachivalaya, Bombay, 31st may 1957 Circular of Government)

15.4 Reserve Time for Public Relations:

In order to satisfy enquiries of patients and their relatives and friends and to be able to explain them some facts about diagnosis, treatment, operation etc. some systematic mechanism is necessary. We often hear remarks to the effect that a particular patient is “nervous “. There are really very few patients who exceed the norm in this matter. In the majority of cases the “nervousness’’ is natural, genuine and at a normal level. Operation to a doctor is a daily routine but for the patient and his relatives it is the first anxious event. Lack of response to questions may induce people to visit the residence of doctors, resulting in more irritation all around and creating a vicious circle. That is why we always hear the remark “Nobody takes any Notice “.

It is possible to remedy this situation. Firstly the timetable of doctors in Outpatient Department, Wards, and Operation Theatre etc. should be known to the patients and their relatives. This can be done by exhibiting appropriate boards in the Departments. The public will know, what is going on and when and where. The public often do not know when the doctors attend and go away. They do not know when and how they should be contacted, secondly, in every section, say after the round in the wards, after operations and after work in the Outpatient Department the doctors should reserve a bit of time for Public Relations’. Even a quarter of an hour will work wonders. This time should be known to the public. During this time everybody should be free to ask questions regarding a case and it would be possible to satisfy the public by giving relevant short answers. Visits of heads of units to the wards during visiting hours would improve the atmospheres considerably, such visits being reserved only for Public Relations. There could be a round separate from clinical round in the wards for communication with patients to answer questions. There should be arrangement to explain condition of a patient in Labour Room Family interviews should be arranged for major operations.

15.5 Ambulant Patients

Ambulant patient shall be made aware of the various departments of the hospital. Hospital Office

Patients attending the hospital have often to deal with the office section and they do not know anything about the procedure. There should be a similar arrangement in the office to explain the office procedure by reserving a few minutes for Public Relations'. The clerk at the receipt counter should be able to inform visitors correctly what, where and how work will be done. Make available all necessary facilities to facilitate recording of feedback or opinion given by patients and relatives in their preferred language and means of communication, display the board of Right to information Act 2005 with all Appellate authority details.

15.6 Dealing with Complaints:

Government have already issued orders that complaint books should be exhibited at easily accessible places, together with writing material and clients complaint box / suggestion box should be available at Hospital. There is Toll free Grievance redressal number (104) for addressing Grievances for general Public and employees in the department. The complaint books should be scrutinized every week. Every genuine complaint should be investigated and if necessary, the complainant should be called. In any case, the result of the investigation should be invariably communicated to the complainant. This will instil confidence in public. The complaint book should be kept before the Board of Visitors/Visiting Committees. If there is a medical social worker in the hospital, she may receive complaints. As people may be reluctant to write down complaints verbal complaints should be listened to with due sincerity. All complaints should be registered.

A number of complaints are sent by the public to the office of the Director/ Deputy Director of Health Services. These complaints are often passed on to the Civil Surgeon/Superintendent for enquiry and report. The correct procedure in cases where enquiry and report is called for is that the complainant should be heard first without disclosing the contents of the complaint to anybody, and then only, should the statements of the concerned staff members be taken. It should never be the other way round. It is often observed that the reports received in the head office are incomplete, in as much as several points made in the complaint are not commented upon. This results in unnecessary cross correspondence and delay. While investigating, there should be a spirit of trying to find the truth and there should be no "covering up "because the prestige of the institution is concerned. While writing the report, the medical officer should give specific opinion. It is no use sending a non-committal report, except in a few cases. The medical officer being the investigating officer on the spot, and having watched reactions and counteractions and having heard the arguments and the counterarguments, should be in a position to come to specific conclusions, in most of the cases. Thus the complaints sent for enquiry and report require a personal enquiry on the spot. The Medical Officers should deal with complaints promptly. Delay in disposing of such cases in time can attract adverse remarks in confidential reports. The complaints should be processed within 3 days of receipt and difficulties if any should be indicated in that time. Officers at various levels should forward reports from subordinate officers to higher officers promptly.

Complaints about corruption, or about treatment given by Doctors are required to be enquired into thoroughly and expeditiously by Civil Surgeons and concerned medical officers.

Reports regarding complaints should cover all the points raised in the complaints. They should also contain additional supplementary information conducive to the final report on the complaint. Case papers and the other relevant records should be sent along with the report. This will avoid unnecessary correspondence.

The object of contacting the complainant first before hearing the hospital staff during the investigation of a complaint is to elicit details, amplification and proof for the various allegations made by him. The report should be self-contained and in the following form:

Serial No.	Contents of the Allegations	M. O.'s Comments and Analysis.	Conclusion	Name andDesignation of the staff member responsible forLapse, if any and if so, what lapse.	Specific recommendations Regarding action againstStaff members.	General Remarks
1	2	3	4	5	6	7

(Director of Health Services Circular No. MMS-2270/A, dated 14th June, 1971) O 4672-3

Entertainment.-Entertainment amenities, books, newspapers and periodicals, indoor and outdoor games, entertainment programmes, outdoor programmes in the hospital compound, film shows etc. should be provided for the patients. Care must be taken to get reading and other materials in both regional and other languages.

Children's wards should be appropriately equipped with toys and attractive buntings etc. There should be arrangements for recreation of children. Some decoration in the wards can also be arranged on festival days through, various provisions such as insurance schemes, CSR, donations etc.

15.7 Social Workers

There should be some arrangement to attend to minor requirements of the patients. This can be done by Social Workers, for example, writing letters and reading them to illiterate patients and the patients from hard to reach area and tribal communities should be supported for appropriate reception in hospital and care of patient while admission, in patient care and referrals if needed to higher centre.

15.8 Advisory Committee

The Government have constituted" Boards of Visitors" and "Visiting Committees" consisting of prominent non-officials and some officials s in the Government Hospitals at different levels such as Teaching Hospitals, District Hospitals, Cottage Hospitals, Women's Hospitals, Mental Hospitals, and Tuberculosis Hospitals etc. The duties and functions of these Committees have also been defined. The Committees have been given wider powers compared to what they had some years back. The details may be seen in Chapter No. 15 of "Civil Medical Code.''

These Committees can help to a substantial extent in improving the image of the hospital by initiating a change in the attitude of the hospital staff as well as the public.

There should be display of boards showing members of committee, such as district grievance redressal committee, district quality assurance committee, institute level Rugna Kalyan Samiti/ Jan Arogya Samiti, Vishakha Samiti etc.

The members of the Committees should take an active interest in welfare of the public attending the hospital. On the other hand, they should be in the full know of the equipment and staff position of the hospital. They should teach the public what they can expect from the hospital. They should act as liaison between the public and the hospital staff and try to reduce misunderstanding on both the sides.

The medical officers should try to create a feeling amongst the members of these Committees that they have an important role to play in improving the hospital services. This can be done by the medical officer taking the members round the hospital, consulting them on different problem of the hospital and closely associating them with all public and important functions in the Hospital.

Medical officers often report that certain committee meetings could not be held as there was no quorum. In this connection, it is necessary to state that there is no provision of quorum for Committee meetings, and the medical officers should carry on the meetings irrespective of the number of members attending, as clarified in Chapter-15 of the Civil Medical Code.

Every member of the Committee should be given a badge as the case may be. The members should wear this badge whenever they visit the hospital. Instances may occur when the hospital staff not knowing that certain persons are Committee members, may refuse to entertain them under the impression that they are not entitled to enter the hospital at particular or to ask certain questions. The Committee members should be introduced to all the hospital staff as routine.

The members of the Committees should help in propaganda for collecting blood for patients. They should also encourage the members of public to contribute to CSR fund not by coercion but by influence and persuasion. They should try to arrange entertainment programmes in aid of the hospitals. They should also take an active part during campaigns such as T.B. Campaign, Blood Bank Week etc.

The Civil Surgeon/Superintendent should inform the Committee members about important developments in the hospital.

15.9 Private Practice

Medical officer is not allowed to do any kind of private practice at all. All Medical officers receive NPA (Non Practice allowance). In all hospital a board should be displayed at prominent places about “Doctors in this hospital are not allowed for private practice”. It should be followed as per Government GR published time to time. (Government resolution no. MMO - 2011/c.n.626/11/Services-3 Date 07.08.2012)

15.10 Certificate Fees

Physical fitness, age and unfit certificates, Medical fitness/ Sickness certificates etc. Certificates are issued by Hospitals. These certificates should be issued in prescribed formats only by authorized Medical Officer, Medical Boards.

(GR No. Sankirn 2013/C.N.462/Part 2/ Health 3, Dated 28th December 2015)

There are certain rates of fees to be charged by Medical Officers and Medical Boards to issue this type of certificates.

(GR No.2013/C.R. 462/part 2/Health 3, issued by Govt. of Maharashtra, Public Health Dept. Dated 28th December 2015)

All the collections should be acknowledged by written receipts.

The funds are indented solely for the benefit of patients and is to be spent for their increased comforts and welfare. Cash book and order books should be maintained separately. Articles Purchased from this fund should be entered in general stock book with remarks "Patients relief funds"

Private practitioners should be encouraged to notify the notifiable diseases such as TB and timely benefits should be given to them in the form of incentives as per guidelines. (Revised TOR/Guidelines for Epidemiologist at the State Surveillance Units (SSUs) and District Surveillance Units (DSUs) under IDSP. T.18015/92/2010-IDSP, National Centre of Disease Control, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, 2011

The private practitioners should be given all the help that is possible according to the rules. The view for giving such facilities should incline towards a liberal one. The private practitioners should be encouraged to take benefit of hospital services.

For the services which are not available in Government Hospitals then the Patients eligible for various Schemes such as MJPJAY etc. can be referred to empanelled pprivate Hospital

for specialist opinion and treatmentas per Operational Guidelines of MJPJAY and Clinical Protocol Guidelines.

Whenever patients are referred by private practitioners for specialist opinion and treatment the result of investigation and the progress of the case should be communicated to the private practitioner concerned. The patient should also be referred back to the same private practitioners who sent him, with instructions for the “Follow UP” at the time of his discharge. Attempt should always be made to bring about closer association between the hospital and the private practitioners by making them participate in hospital functions. They should be given facilities to observe any special procedures like major operations etc. if they so desire. They should also be made to participate in the clinical meetings which should be arranged by the hospital. If this is done, the private practitioner will be really grateful, as they will have an excellent opportunity to remain in touch with modern developments in medicine.

Where specialists not available in the institute then the specialist from private can be hired as per IPHS standards 2022

15.11 Other Hints

Orders already exist saying that medical officers should not purchase any article from contractors, who are also suppliers of the hospital. These should be strictly followed, lest there should be any suspicion in the mind of the public about such transactions.

Each hospital should prepare a booklet Know Your Hospital A few copies should be prepared and put up in different sections for the benefit of the general public.

The Hospital should maintain good relations with patients at the time of payment of bills. Often, there is an atmosphere of bitterness and hostility during this transaction.

The Hospital must be swift to arrange for quick disposal of dead bodies. This question assumes importance and significance in medico-legal cases. The staff should be in the know of religious customs of different communities for such occasions.

Occasions should be created to associate the community with the hospital. (Lectures, health talks, hospital day etc.)

15.12 Exit Interview

There should be a system of eliciting views of patients, who have been treated in the hospital. For this purpose, an “Exit Interview” is recommended in a certain percentage of cases. An interview can be held of discharged patients before they leave the hospital. Clients feedback should be taken from OPD and discharge from IPD (at least 10%) patients, As an alternative or as an addition a Questionnaire can be prepare din local language and sent to a certain number

of patients by post say a week after their discharge. The patients while replying may or may not sign.

Suggestion box or feedback system, mobile and portal entry, information board, Toll free complaint Number 104 HACC, contact numbers of first Appellate authority and Citizen Charter should be displayed (Mera Aspataal-Ministry of Health, Government of India initiative). The signature should not be insisted upon. This will encourage the patients to give their opinion freely. After studying the replies, the various point arising out of the analysis should be communicated to staff members for their information and necessary action. For this purpose,

15.13 HELP Desk Counter/ Registration Counter:

E-Sushrut/ E-Hospital system is available in all district hospitals. In this system, patient registration in the software (bio-data and details), sorting out the patients according to their health conditions and refer in, inter and intradepartmental referral, as per requirement also help the patient according to their priority and convenience. (e-Sushrut- Hospital Management Information System).

15.14 Out Patient Department (OPD)

She should help the patients in forming queues and getting their O.P.D. tickets. For this, she should extract, if necessary, and give information to the Case-writer. She should help patients who have lost their Outdoor slips in finding their old case-paper records. She should guide the patients to the different rooms. She should ensure that patients do not manage to get themselves examined out of turn. She should be able to explain the routine and the time table of the hospital and details of attendance by Specialists on particular days. She should concentrate her attention in finding out ways to minimize the waiting time of patients. For this purpose, she has to constantly move in and out of the different rooms in the Outpatient Department. She should consider whether in respect of a patient who has to get an injection, a dressing and also medicine etc. she can co-ordinate the movements in such a manner that the patient need not wait for each of these items. For example, the patient can get his medicine first if he is going to take a long time to get his turn for the injection. She should sort out serious cases and see that they are given preferential treatment without delay. She should arrange for invalid patients and children along with serious cases to get treated as early as possible. She should arrange to give some nourishment to waiting children and invalid patients. She should see that stretcher service is given to patients who are in need of it.

The Receptionist should be able to supply broad information to the out-door patients. She can explain the nature of minor operation, which would be carried out in Out-patient Department or major operation for which the patient must be admitted.

Patients are often baffled when they are asked to go to X-ray and Laboratory departments which are mostly located outside the Out-patient Department. The Receptionist

can give them good guidance in such cases. The Receptionist should be specially useful to illiterate patient who cannot read boards, Charts, indicators etc.

OPD Guide Charts and Indication boards

OPD Guide charts and indication board is the most important factor in deciding the quality services provided by a hospital. A large number of illiterate persons attend the Government Hospitals and since they are unable to read the sign Boards, they find it difficult to find their way to the various Departments. To facilitate locations of the different Department for this class of patients, OPD Guide chart and indicator system is practiced which is more patient friendly, makes infrastructure more accessible, leaves no- one unattended, people will not need any assistance in reaching their need inside your hospital if the guide charts are clear enough. (NQASfor Public Health Facilities 2020)

Various services provided through different departments should be provided under one roof for the convenience of patient in OPD section (Guidelines on Integrated Public Health Laboratories 2021)

15.15 Indoor Wards

The Social Worker has a very important role to perform in this section. It is, absolutely necessary for the patient to have a full and correct idea of what facilities are available in the Hospital. The Social Worker should, therefore, contact every newly admitted patient in a hospital and explain to him the working procedure. While dealing with the indoor patients, the Social Worker has to remember that it is not the patient only who requires to be informed, but also the anxious friends and relatives. The patient should know the medical officer under whose charge he is and who are his assistants. The patient should be explained in general as to the object for which he has been admitted and how it is proposed to treat him. If the patient has any questions to ask as regards operative procedure, they should be answered fully. The Social Worker should inform the patients about the time-table of the medical officer under whose care he is and the time which is reserved by the doctor for public relations. Even if the Social Worker gives full answers, human nature being what it is, some patients will not be satisfied unless they see the "Bada Sab." Earmarking of certain time by the doctors for public relations, is therefore necessary even if a receptionist exists.

The Social Worker should teach the patients how to recognize the various members of the hospital staff like Sisters, Nurses, sweepers etc. enlighten them about the sanitary facilities available in the Ward.

The Social Worker has another very important duty to perform viz. she has to teach the patients as to how they should behave in the hospital. The patients must be taught how to co-operate with the Hospital staff and how not to make exorbitant demands. Their attention should be drawn on the rules for preserving cleanliness and hygienic conditions in the Wards.

Many patients seek clear instructions as regards the diet they should eat. It is a common experience that this is a matter on which no adequate instructions are available to the patients. The patient has got his own doubts even when Hospital diet is given. In those cases, where the patients have to bring their own diet, there are of course, a large number of questions awaiting clarification. The Social Worker should give answers to such questions and advice about the diet or call a dietitian where available to do so. The Social Worker should enlighten the patients as to why it is necessary for them to purchase drugs from the market. The patients should be assured that the drugs purchased by them would be used for them in a proper way. If there are difficulties which cannot be remedied by the Social Worker should communicate them to the sister in charge of the ward.

Many a time cases are admitted in the ward without the knowledge of their friends and relatives. In such cases, the Social Worker will have to take the names and addresses of friends and relatives and approach the office section, so that intimation can be given to them.

At times, different relatives of one and the same patient seek clarification of various doubts which are often of one and the same nature and it is not possible for the hospital-staff to go on explaining matters to a number of relatives at different times. It should be impressed upon the patients that any clarification given to any relatives should be passed on to others interested in the patient.

The matter as to who should be responsible relative or friend should be decided by the patient and the relatives by mutual discussion and the Social Worker and the sister should ascertain as to which particular persons are responsible friends or relatives. The patient should be informed that he should not resent if questions asked by persons other than the responsible relatives are not answered. Some of the relatives may be staying in the Dharmashala, or Rest House. Being illiterate and poor, they may not know whom to approach for clarification of their difficulties. The Social Worker should, therefore, pay a visit to the Dharmashala, make Enquiries and satisfy the relatives. The Social Worker should also impress the importance of cleanliness on the occupants of the Dharmashala.

The functions as described above may require a varying number of Social Worker, depending upon the size of the hospital, or else, one or two may be allotted this work exclusively and others as a part of their usual duties made to work in this field.

References:

1. Mrs. A. D. Malhotra, M. A. (Nursing Administration) “Improving Hospital Image.” “Hospital Administration” March 1971.
2. T. C. Rooney, Hospital Community Relations-1 “Hospital Administration “March 1971.
3. A. L. Goswami Review in Retrospect of the sixth staff college Course held at NIHAEIn 1969. NIHAE Bulletin Vol. III No. 2, 1970.
4. Shri Nirmal Sing Public and Human Relations “Hospital Administration” March 1970.
5. J. K. Mangal and P. D. Makashir. A sociological study of attitude of patients towards hospitalisation Hospital Administration.” March 1972.

6. दिव्यांग व्यक्ती हक्क अधिनियम २०१६ (The rights of persons with disability Act, 2016) नुसार दिव्यांग तपासणी, मुल्यमापन व प्रमाणपत्र वितरण साठीच्या मार्गदर्शक सुचना. शासन निर्णय क्र. अप्रावि-२०१८/प्र.क्र.४४/आरोग्य-६ दिनांक १४ सप्टेंबर २०१८
7. Section 7.2.7, Conduct and Behavioural Standards, Indian Public Health Standards, Ministry of Health and Family Welfare, Government of India, 2022
8. Maharashtra Civil Sservices (Conduct) Rules 1979, (updated on 31st December 2016), General Administration Department, Government of Maharshtra, 2017
9. Operational Guidelines “Free Drug Service Initiative”, Ministry of Health and Family Welfare, Government of India, 2015
10. GR no.MAG 2005/9/C.n.1/Health 3, Dated 19th March 2005)
11. Surakshit Matritva Aashwasan (SUMAN) Standard Operating guidelines, National Health Mission, Ministry of Health and Family Welfare, Government of India
12. Medical Care of Government Servants, Government of Bombay, Local selfgovernment and Public Health Department Resolution no. TBC. 1057/S Sachivalaya, Bombay, 31st may 1957
13. GR No. Sankirn 2013/C.N.462/Part 2/ Health 3, Dated 28th December 2015
14. Revised TOR/Guidelines for Epidemiologist at the State Surveillance Units (SSUs) and District Surveillance Units (DSUs) T.18015/92/2010-IDSP, National Center of Disease Control, Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, 2011
15. Operational Guidelines MJPJAY Scheme, Government of Maharashtra
16. Mera Aspataal Guidelines, Ministry of Health &Family Welfare, Government of India
17. e-Shushrut- Hospital Management Information System, Ministry of Electronics and Information Technology, Government of India, 2021
18. Guidelines on Integrated Public Health Laboratories, Ministry of Health and Family welfare, Government of India, 2021
19. National Quality Assurance Standards for Public Health Facilities, Ministry of Health and Family welfare, Government of India, 2020.

CHAPTER XVI

HEALTH EDUCATION

16.1. Types of Health Education

Health education. given in a hospital can be of two types i.e. specific and general. Specific health education would be about the causation, prevention, and spread of diseases from which the patients are suffering. Many diseases are not only preventable but easily so for e.g. diarrhea, dysentery, scabies, eye diseases, burns, tetanus, communicable diseases etc. Since treatment in early stages is very effective in all cases, the patients can be informed about early detection of the diseases. Advice about the disease from which the patient himself is suffering is obviously most effective from a psychological point of view.

Health Education in general matters will include knowledge about personal and preventive hygiene, eating habits. Family Planning, child and mother care, accidents, immunization, prenatal and postnatal care, water and fly borne diseases, common skin diseases, leprosy, tuberculosis, worms, drinking of clean water, dental care, venereal diseases etc. A propaganda for blood donation can also be conveniently made during such talks.

The Hospital should exploit every situation to impart health education. The hospital staff must orient itself towards the fact that this duty is as important as giving of curative care, e.g. preventive advice on the common accidents, burns, is much more useful than attempts at opening more and more " burns wards

The hospitals themselves must be clean and sanitary in order to produce the required impact on patient's mind.

In order that health education be effective, the hospitals must study the attitude, beliefs, culture and local customs of the community.

16.2. Objects of Health Education

The main object of health education is to develop in the community an awareness, interest and desire for health measures. Any health education must bring about a conviction which would result in adoption of attitudes and practices of lasting value. A transient effect will do no good. The principles to be emphasized in a health education campaign are:

1) Health is a most valuable asset to an individual as well as any community. Here the correct definition of health must be kept in mind viz., that it is '` a state of complete physical, mental and social well-being and not merely absence of disease or infirmity
2) Individual teaching will enable not only the person taught to take care of himself but also of those around him.

3) Prevention is so much better than cure.

Even in the early days Florence Nightingale advocated the employment of trained visitors to advise mothers in their homes. In our busy hospital practice, Health Education is apt to be relegated to the background.

In other words, Health Education should be spoken and written in a language which the people will understand. If advice is given in abstract, it will fall on deaf ears. For example, if, we simply prescribe so many calories of proteins, fats and carbohydrates as being required daily, it will have no impact. If we, however, say with reference to the usual daily habits that so much rice, or bread, etc. should be taken it will at once create the required impression and enlightenment.

Side by side with health education the patients and the people accompanying them should be given a clear picture about health care. Institutions available near their residence e.g. they should be told which centre nearest to their residence will carry out immunization programmes or early detection of disease etc.

16.3. Who should give Health Education ?

The hospital staff as a whole must accept that health education is a part of their duty. The doctors working in a hospital will have to take a lead in this respect because they are the most esteemed members in the eyes of the patients and public. The nurses also will have to contribute substantially because it is they who come into the longest and most intimate contact with the patients. Other para-medical staff like X-ray and laboratoryScientific Officer, Pharmacy Officer, occupational-physiotherapists may also play their part.

Even if the hospitals have special staff for imparting health education there should be no feeling of complacency amongst the other hospital staff regarding this matter that they are not concerned with it.

16.4. Human Resources trained in Health Education:

Hospital should have a qualified Health Educator with medical or social science training and he should be assisted by a number of medico-social workers trained in Health Education. A projectionist to operate and audiovisual equipment and artist- cum-photographer for preparing education aids should also be available. District hospitals should have medico social workers.

It is repeated that presence of such staff does not mean that the ordinary staff of the hospital has no further responsibility. The major part of health education must be carried out by the usual staff alone and the special staff can only be of some assistance and for giving training to certain staff members.

The Health Educator where available will carry out planning, collect information, procure aids and establish good relations with people. He should prepare programmes for imparting health

education. The medico social worker at district hospital should be responsible for planning and should take help of State Health Education Bureau.

Health Education in hospitals should be modulated along practical lines. For this purpose as already stated the habits and environment of particular communities and individuals have to be taken into account. The suggestions have to be couched in a language which first taken into account the habits and environment, mentions them and then suggests the proper way in which certain things he done.

Hospitals should have a LED Display which can play AV material,16 mm projector, a portable screen, a slide cum film strip projector, a flip chart stand and other accessary for public address system. Printed material, educational kit, photographic equipment and art materials are necessary. The State Health Education Bureau can help with films and film strips.

The State Health Education unit can provide audiovisual equipment and health education material to district, Cottage/Rural hospitals and voluntary institutions. Social and community welfare institutions should be approached for help and induced to work on Health Education Committees which can be established in every hospital.

16.5. Methods for imparting Education:

A Large Number of Methods are Available for Imparting Health Education

a)Personal contact and talk—*This is* the most useful method as it gives direct and intimate approach and gives an opportunity to patients and persons accompanying them to discuss matters and to get any doubts or difficulties resolved. This will to have to be done mostly by doctors and nurses. The talks need not be lengthy. They can be short and given at the time the patient is discharged, when there is optimum receptive mood for receiving instructions. The talk can be with individual patients at such times. There can also be group talks for a group of patients, outdoor and indoor, especially demonstration talks.

b) Film shows, film strips and slides can be shown from time to time.

c) Printed Material. —Printed handouts, pamphlets, brochures, articles in newspapers, magazines etc. Special efforts should be made to inform patients of success achieved in eradicating or ameliorating ravages of diseases due to adoption of preventive and sanitary measures. In order to minimize expenditure on such printed material a nominal price can be charged for the same or else, the material should be lent out only as in a library.

Posters and charts should be exhibited at places where patients gather, and have to wait, especially in the outpatient department. The patients and those who accompany them would definitely, prefer to have a look at these posters and charts instead of whiling away their time anyhow. They will be particularly interested in the ones connected with diseases for redress of which they have approached the hospital. These should be simple and yet attractive. They may be changed from time to time to give up to date information and to avoid monotony.

(d) Models, Exhibits, tape records puppet shows should be arranged wherever possible.

(e) Education as regards Family Planning should be given by Social Workers attached to Family Planning Clinics in the hospitals. In addition, in view of the extraordinary importance of the subject ; the whole staff must treat it as a subject of first importance.

(f) There are a number of "days" observed to stress the importance of Public Health subjects. One of the programmes is a public meeting. There is every reason why such meetings should be held in the Recreation Hall or compound of a hospital.

(g) Radio programmes pertaining to Health Education should be conveyed to patients with the help of radio and TV interviews of experts with the help of tv internet loud-speakers.

(h) There are some intelligent patients whose stay in the hospital is not short. They should be induced to take up this work and to teach others. It is considered that this suggestion will be gratefully accepted.

(i) Essay and elocution competitions can be arranged amongst patients and prizes awarded to winners.

16.6.Duties of a Health Educator

(a) Planning.—*A* health educator should study people's beliefs and practices regarding various diseases. Social and cultural barriers aggravating morbidity and mortality should be identified. A plan of operation should be developed on this basis. Selection of health education media should be made on basis of suitability. The health educator must bring about involvement of hospital staff.

(b) Training.—*The* health educator should train certain hospital staff on the basis of information as above.

(c) Communicating.—*The* health educator must communicate effectively with the patients and hospital staff requiring training.

(d) Co-ordination. —*The* health educator should bring about co-ordination between health education activities of the hospital and outside agencies.

(e) Evaluation. —*This* is a very complicated problem. What is envisaged herein is an evaluation of impact of health education methods on hospital patients as well as outside community. The latter is a major job which will require help of outside volunteers.

16.7. Instructions from the Director of Health Services:

The Director of Health Services incorporated several instructions regarding the achievement of integrated health services, including the propagation of health education by hospitals, into his circular, issued in May 1974.

References:

(1) Dr. R. F. Bridgman, Organization of a Hospital system as part of Community l Services with particular reference to Developing Countries—past, present and future. NI XVI Hospital Administration Course.

(2) S. R. Mehta, Health Education in the Hospital. (Hospital Administration)

CHAPTER XVII

VARIOUS POLICIES IN HOSPITALS

Hospital is multifaceted organization, dealing with patients, doctors, paraclinical and administrative staff. Being a public place, it encounters attention of common people, various govt organizations ranging from police to social welfare. Running of hospital requires some policies to abide for. In relation with patients, free drug, consent, antibiotic, referral and grievance redressal needs to have some policies in every Hospital. Regarding staff of hospital, Dress code, judicious use of PPE, Managements of Beds, records,Condemnation requires policies for uniform functioning.

17.1 Dress Code:

- Hospitals need to have uniform dress code policy which outlines professional image and to help visitors and employees feel safe, confident and comfortable.
- It is preferable if hospitals have dress code for every category of staff for easy identification for patient and visitors.
- All the staff should adhere to the dress code policy within the premises of the hospital.
- Religious beliefs of the staff and the visitors shall be taken into account while drafting the dress code policy.
- Every officer and staff members should wear the Govt. ID card/name plate.

Dress code policy shall have explicitly defined standards for:

- General Appearance: Acceptable and non-acceptable practices related to good personal hygiene, hair, nails, jewellery, tattoos, make-up, perfume
- Uniform details for different categories of staff (both male and females)- top, lower, colour, fabric, shoes, socks, lab coats, aprons, etc.

***Dress Code for State Government Officers, Employees, Contractual Staff**

For Males

What should be worn- Clean, formal shirt and trousers; footwear should be shoes or Sandals; slippers are not allowed.

What should not be worn t-shirt or dark-colored shirt, shirts with embroidery

For Females

What should be worn Saree, Salwar-chudidar-kurta and dupatta (optional), trousers with kurta or shirt; footwear should be chappals, sandals or Shoes.

What should not be worn t-shirt, skirt, Onepiece.

KHADI once a week- All officers and employees should wear khadi at least once a week (Friday) to promote khadi.

Adherence to Dress Code:

Management shall ensure that all categories of staff adhere to the dress code policy including doctors, nurses, technicians, paramedics and Group-D staff. The policy needs to be applicable to regular, outsourced, and contracted staff.

- **Doctors. -**It will be convenient if all the Medical Officers in a Hospital including the Contractual Medical Officers wear an apron when on duty. The apron should be with half sleeves. It should be of white cloth. The name of the doctor and the designation should be printed or embroidered on the left side of the chest portion of the apron. The name and designation should be in Marathi.

- **Technicians etc.**-X-ray Technicians, Laboratory Technicians, Family Planning Workers, Compounders/Pharmacists etc., and Enquiry Clerks should have white aprons, when on duty and their name and designation also should be printed or embroidered in Marathi as above.

- **Other Staff. -**Uniforms have already been prescribed for other staff members like sweepers, ward-servants, cook-mates, etc. The uniform of all these persons should be stamped with the hospital name. It would be also easy for identification if a number is given to each staff member. Female sweepers may be given green bordered white sarees, Male sweepers-Khaki colour uniforms. Female ward servants-white sarees and white blouses with half sleeves. Male ward servants-white dress. The dress of the male sweeper and male-ward servants should be Bush-coats buttoned upto the neck and half pants. Male cooks and cook-mates half pant and white banyan with half sleeves and V shaped collar with no buttons in front. Female cooks, sarees and blouses blue in colour. Ambulance Driver-Khaki Uniform as at present. Stamping of hospital name will facilitate their not being used outside the hospital. It will also help the patients. to identify the Hospital Staff members, and to minimize thefts from the hospital.

Clothing of all the above type should be supplied at prescribed intervals without delay. Cleanliness of uniforms and their use only when on duty should be strictly enforced. All uniforms should be of correct measurements to avoid complaints.

Identity cards and name plates:

Hospital name badges/name plates should be provided to all healthcare providers, in accordance with the hospital policy. The identification badges should be worn with the name and picture facing out.

17.2 Staff Hygiene:

Occupational Health and Safety

The healthcare staff is at potential risk of infection owning to their exposure to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces or contaminated air. Therefore, prevention strategies have to be the part of Hospital Infection Control Programme. Infection control objectives of the personal health service should be an integral part of a healthcare organization's general programme for infection control. The objectives maybe:

- Educating healthcare staff on the principles of infection control and individual responsibility.
- Teaming up with the infection control department in monitoring and evaluating potentially harmful infectious outbreaks and exposures
- Providing care if a healthcare staff is exposed to an occupational hazard
- Identifying work related risks and constituting preventive measures to mitigate them
- Reducing costs by preventing infectious diseases that result in absenteeism and disability.

The elements of healthcare staff safety can be elaborated as:

- **Coordination with Other Departments**
  For achieving appropriate standards of infection control, the activities of healthcare staff should be coordinated with infection control and other appropriate department personnel. This would help in adequate surveillance of infections and provision of preventive services.

- **Pre-Placement Evaluations**
  Medical evaluation of the staff prior to their placement in a health facility can ensure that they are not placed in jobs that would pose undue risk of infection to them, other staff, patients or even visitors. The evaluation should include details of immunization status and obtaining histories of any condition that might predispose personnel to acquiring or transmitting communicable diseases. A detailed physical examination needs to be carried out for all personnel joining the facility.

- **Healthcare Staff Health and Safety Education**
  To increase compliance of the staff to infection control measures, staff orientation, education and training on basic infection control principles is imminent. Clearly written policy, guidelines and SOPS give clarity of instruction and ensure uniformity, and effective coordination of activities.

- **Immunization Programmes for Service Providers:** A continuous ongoing vaccination programme would be required in the facility and all staff need to be immunized against potential exposure to communicable diseases especially tetanus and Hepatitis B. A comprehensive medical check-up needs to be undertaken for every staff at the time of joining.

- **Regular Health Check-up of the Staff:** It has to be ensured by the health facility that it has a policy of conducting regular health check-up of all staff including contractual cleanliness workers, food handlers. Regular health check-up should include comprehensive medical

assessment, immunization status and deworming of the staff especially that of food handlers and housekeeping staff.

Cleaning Services:

One often finds hospital premises unclean and we were set thinking as to how patients and hospital staff should have positive approach towards cleanliness. In periodical meetings we emphasized that uncleanliness starts from small habits. The staff nurse throw away even iodine swabs after injections on the floor, sisters and attendant throw away removed plaster casts on the bed or floor, nurses and dressers make a mess of various liquids and soiled dressings on the floor. Patients and relations add to this by throwing arrange peels and remnants of food on the floor. Everybody concerned is told that by so acting he would become an enemy of cleanliness and increase the work of scavengers. Sometimes we told hospital staff that the name of such an enemy would be put up on the board and we found that this acted as a deterrent. Sisters were given sufficient buckets and all were instructed to throw waste things in the bucket. Nurses, are now very careful to see that even saline and blood does not spoil the floor and they spread a rubber sheet on the ground and keep a bucket by the side before starting any intravenous drips.

17.3. Maintenance of Employee's Health Records

It is to be ensured by the health facilities that they maintain all health records of the employees of the hospital. The health records contain details of comprehensive medical assessment, immunization status, PEP (if any), and deworming records. These records need to be stored along with the personal records of the employees and confidentiality of the same has to be ensured.

Nursing Home Section – Nursing Home Sections are attached to most of the hospitals. The Medical Officers while attending these patients, should take care to see that no sense of discontentment arises in other class of patients in the Hospital.

17.4 Allotment of nursing staff for serious, important and chronic cases:

A reference has been made in the chapter "Indoor wards" to the concept of progressive patient care and "Intensive care units". As a beginning it would be profitable to train certain nurses to look after serious and important cases. Such nursing staff may not be shifted from one ward or unit to another one until equally trained substitutes are available, otherwise experience teaches us that the nursing staff attending on serious and important cases has to be given instructions every time. As the persons go on changing and then it is difficult to have a sense of confidence that instructions would be followed reliably. For example attending the Tracheostomy cases or patients who have undergone repair for Vesico-vaginal and Recto-vaginal fistula are special jobs requiring minute attention to the last detail. One wrong step may vitiate the efforts which have been taken for long time. The nurses should be trained in such a way that there is at least one expert person available during each eight hourly duty. This may be done wherever practicable.

In the absence of Infirmaries or Convalescent Homes, many chronic incurable patients not requiring much active, treatment are required to be kept in a hospital for weeks, months or even years. It is worth trying to group such patients in a separate section along with those not chronic patients requiring minimal attendance and allot comparatively less nursing staff compared to the usual ratio. An important precaution to be taken is to see that a psychological atmosphere does not develop (a) for patients that they are dumped in the chronic ward without any attention, and (b) for nurses and other staff that patients in this ward can be conveniently neglected. If the hospital has an occupational therapy department, it can teach these patients certain crafts.

The medical officer in charge of a hospital may also try to see if chronic cases can be taken care of by voluntary agencies. The Social Welfare Department may be able to help.

In this connection, the medical officers may note that, the Director of Social Welfare has informed recognized homes for Aged and Infirm to admit patients suffering from incurable diseases directed by Government hospitals in their institutions subject to availability of vacancies.He has further informed them that such cases will be treated as admissible to receive grant-in-aid under the scheme.

A decision has been taken in the Cabinet meeting on 30th September 2013, regarding the comprehensive senior citizen policy of the Maharashtra state. Accordingly, for the matters mentioned in the said government decision, the age limit of senior citizens was being made 60 years or more.

17.5 Comprehensive Senior Citizen Policy:

Following the principles laid down in the National Policy, the focus is mainly on the following factors.Senior Citizen Policy2013, G.R. No. S.C.2016/Letter No.79 Dated 09/07/2018.

a. Financial planning for senior citizens.
b. Taking care of the health of senior citizens.
c. Empowering senior citizens to cope with stress.

Highlights of policy:

1) An appeal should be made by the state government to help the destitute and seriously ill senior citizens by charitable organizations/volunteer organizations.

2) Early diagnosis of illness and prevention plan to prevent illness. It should be prepared for senior citizens. It is promoted from time to time. Health camps should be conducted.

3) Health education programs should be extended to senior citizens. Mental health services for seniors should be increased.

4) 5% beds should be provided for the elderly in hospitals affiliated to medical colleges.

5) There will be separate facilities for senior citizens in hospitals under the jurisdiction of the governmentAlso they should be given priority. Counseling for themA specific time should be reserved Counseling.

6) Charitable Ambulance service for providing medical services and ambulance services for senior citizens.Efforts should be made to increase the participation of institutions.

7) Private medical facilities/hospitals/trusts should be requested to give 50% discount to senior citizens above 60 years. Also, the doctors providing private medical services should be requested to give concession in fee for senior citizens. For this, there should be coordination with the representative organizations in the medical field.

8) Trained professionals / social workers should be appointed for medical services and psychological treatment and counseling.

9) Medical services should be provided to senior citizens on the lines of destitute persons.

10) "Geriatric medicine" should be included in public health program.

11) "Senior Citizen Medical Department" and "Separate Reception for Senior Citizens" in hospitalsRoom" should be included.

12) Efforts should be made to establish free dialysis centers for senior citizens in government hospitals through NGOs.

13) Health checkup and treatment camps should be organized for senior citizens. Currently organizing such camps in some places with the help of senior citizensshould come.

14) In respect of treatment and rehabilitation of senior citizens in regional psychiatric hospitals of the state. Time bound training programs should be organized for the employees.

15) The benefit of Mahatma Jyotirao Phule Jan Arogya Yojana (MJPJAY), Pradhan Mantri Jan Arogya Yojana (PMJAY) is given every year to eligible people.However, efforts should be made to provide free health care to senior citizens under the said scheme.

16) Health Department through Information and Public Relations Office for the elderly and health problems of the elderly through radio, TV. Health related programs should be organized for senior citizens through Also radio jingles/TV through IEC Bureau. Footnotes and advertisements should be given above.

17) Action should be taken regarding establishment of memory clinic.

18) To find out the health problems of senior citizens through survey and implement policies to treat them.

19) If a senior citizen contacts the health center, they will immediately report the complaint to the concerned doctor after conducting primary health check-up. So that elderly patients should be treated immediately.
20) Government health services will focus on preventive and disease-free treatment of senior citizens as well as health education. For this, Primary Health Centers should be empowered as per World Health Organization (WHO) guidelines. Adequate medical officers, nurses, medicines, medical facilities should be provided in all government hospitals, municipal and municipal hospitals, primary health centers / sub-centers.

21) Time-bound camps for senior citizens should be conducted in Government Hospitals, Municipal Corporation / Municipal Council / Municipality Hospitals as well as Primary Health Centers and a report should be submitted to the concerned Senior Citizens Unit.

22) Efforts should be made to use and strengthen mainstream media and other communication channels for the purpose of ensuring health and education programs for the elderly.

23) The services of health workers and hospital should be made available as part of extended program services so that senior citizens can benefit from regular health and psychological counseling. Private hospitals and specialists should also be involved in it.

24) Private medical doctors should be urged to give discount on "fee" to senior citizens.

The following days related to senior citizens should be celebrated.

a)	**June 15**	**World Elderly Abuse Awareness Day**
b)	September 21	World Alzheimer's Day
c)	October 1	International Day of Older Person

17.6 Help of Patient's Relative/Friends

We always see that many relatives/friends of patients are sincerely and genuinely anxious to give nursing services and other help to patients admitted in the hospital. While it is accepted beyond doubt that visitors should not be admitted in the wardsin such a way that they will make a nuisance of themselves, a question arises if we should totally ignore intelligent and sincere persons, or whether we should tap this square of energy judiciously. Even at present, passes are given to relatives to attend at any time during day and night, or to bring food etc. in respect of certain patients. There is, however, no systematic attempt to take their help. It is considered that hospital administrators may give careful consideration to this aspect. There should be no objection on the part of sister incharge of the ward to find out if intelligent relatives/friends are available for carrying out simple instructions. This task will be very easy if it is known to the public that such help is used by the hospital. In that case, instead of the sister finding out such information, volunteers will approach her by themselves to offer services. Such

persons being genuinely interested in patient's welfare and his early recovery are expected to work in a positive manner. Help of such persons could be availed on the following conditions:

(a) They are intelligent enough to grasp instructions given to them.

(b) They are willing to carry out the instructions.

(c) They are willing to obey the orders given by doctors, sisters and senior nurses without questions and reservation

(d) They are able to keep a written record of what they have done.

17.7 Proposals for purchase of Equipment

All such proposals should be processed according to existing procurement policy. Amendments to the procedure policy for office procurement to be done by the government departments Regarding the adoption of the procedure of the Government e-Marketplace (GeM) portal developed by the central government for the procurement of goods and services by the state government.*(GR No Miscellaneous-2016/P.No.215/Industry-4 Madam Cama Road, Hutatma Rajguru Chowk, Ministry, Mumbai 400 032 dated 24th August, 2017)*

The central government has made major changes in the procurement process under the National Public Procurement Policy. Government e-Marketplace (GeM) is a portal developed by Central Government for procurement of goods and services from Government Departments/Institutions. While purchasing on GeM portal, the facility to change the tender form, item wise specification as per the requirements of the buyer department is available on the portal, the procurement process implemented through the portal is without human intervention and will be implemented entirely online. Due to this, there will be transparency in the procurement process and supply of exact and well-known quality goods will be available at reasonable prices.

The use of the Government e-Marketplace (GeM) portal will lead to time savings, supply of quality goods, fair pricing and transparency in the entire procurement process by government departments. Considering all these aspects, the state government was considering implementing the procurement procedure through the GeM portal developed by the central government. Accordingly, the government has made the following decisions: Government decision Functionality of Government e-Marketplace (GeM) portal developed by Central Govt., State Approval is given to the government to procure goods and services. Paragraphs No. 3.2.2 and 3.2.3 of the revised procurement rule book dated 01/12/2016 have been amended as follows, and the following instructions have been given for using the Government e-Marketplace (GeM) portal. In case there are two or more suppliers of goods and services available for purchase on the Government e-Marketplace (GeM) portal, for procurement of the said goods and services on the Government e-Marketplace (GeM) portal, in paragraph 2.4 of the Procurement Policy dated 01 / 12 / 2016 binding to the specified target departments/offices.

17.8 Untoward Incidents:

Such incidents often occur in hospital and they require investigation. The Civil Surgeon/Superintendent should set in motion, the process of enquiry expeditiously. The enquiry should be made by contacting the persons involved and taking their statements in detail. The statements should be signed by the concerned persons. If the persons desire to refer to some records and desire to give a detailed statement later on, they can do so. The statement pertaining to facts which do not require references to records should, however, be taken immediately. The statement taken in this manner will preclude modification of factual information in subsequent statements and help in comparing and analyzing further statements.

The head of the Medical institution should immediately submit a report in brief of anyuntoward incident to Government as well as to the Deputy Director of Health Services concerned and the Director of Health Services. The report should indicate the circumstances in which the incident occurred and the action taken by the head of the medical Institution. Thereafter, a detailed report in that respect should be forwarded to Government, Deputy Director of Health Services, and Directorate of Health Services in due course.

(Government Circular, U.D., P.H. & H.D., No. MRO/1469/53485/B, dated 20th March1970.)

The idea behind the above instructions is that the higher authorities should not come to know about such incidents from sources other than the institution. (Newspapers, complaints by public etc.). The preliminary report must befollowed by a detailed report along with information about steps taken to avoid repetition of suchincidents and recommendations about actions against staff members who may be responsible for any lapse.

Some types of untoward incidents are reported to the police, for example patients absconding from the hospital, patients getting injured in accidents in the hospital etc. Though the police are informed, the Medical Officer in charge of the hospital should himself carry out adetailed investigation from the point of view of Hospital administration and send his report thehigher authorities. The first report should be a preliminary one and the next a detailed one.

17.9 Administrative Rounds:

The Civil Surgeons and Medical Officer should take administrative rounds along with the Matrons, Resident Officers and S.A.O/J.A.O. at least once a week. They should go round all the hospital to find out shortcomings and difficulties and set things right on the spot as far as possible. The round should also be utilized to ensure general cleanliness and sanitation. The round should include going over the whole area of the hospital compound, also.

A record should be kept of the instructions issued and decision taken as a result of all the administrative rounds.

17.10 Arrangements during Absence:

It was found that heads of medical institutions and responsible medical officers do not keep instructions at their residence about their whereabouts if they have gone out and about the probable time of their return. This creates a situation in which a subordinate must make a decision in certain matters, which is likely to give rise to complications. The Medical Officers should keep with some responsible member of their family the address where they will be available and the time during which they can be contacted at that place.

If available, the place's telephone number should also be informed to the family member. If no family member can keep such information, the message should be conveyed to the Casualty Medical Officer on duty.

17.11 Hospital Day

It is advisable that the Medical Officers incharge of the Hospitals organize a "Hospital Day". For this purpose a general meeting of all staff members including Group D servants could be called and Committee of certain staff members appointed to prepare a programme of annual day celebration. After the programme is finalized all the staff members can be informed about the same by a circular. In addition to the main Staff Committee, some sub-committees may be formed, like the Sports Committee, Entertainment Committee, Recreation and Drama Committee, etc. Subscriptions can be collected from the staff to meet the expenses of the annual day celebration. The programme should be arranged in such a way that hospital staff on different shifts can participate, and for this purpose, it could be extended to more than one day. Items such as sports, music, drama, fish pond, etc., are suggested.

17.12 Admission of Leprosy Patients in General Hospitals:

Leprosy cases require admissions in general hospitals for treatment of diseases other than Leprosy. Hospitals must give proper help to such cases by indoor hospitalization. The infective cases should be admitted in isolation wards and the non-infective cases can be admitted in general wards.

17.13 Fire Safety in Hospital

As per the Maharashtra Fire Prevention and Life Safety Measures Act 2006, the head of the institute should strictly follow these guidelines and any guidelines received from the higher authority from time to time.

17.14 Periodical Meetings, Trainings and Supervision

a) For an efficient and smooth running of hospital administration, it is necessary to enforce regularity among the Medical Officers, contractual staff, Medical Officers, and Technicians attached to the Radiology, Laboratory, T. B. Clinic, Family Planning Clinic, pharmacy Officer, nursing Staff, Clerks, and others.

b) Hospital staff can be broadly divided into two categories. The first being the senior staff entrusted with the additional duty of supervision on the junior staff. Senior staff will include for example Civil Surgeon/Additional Civil Surgeonhas to supervise, control and co-ordinates, the working of all the departments and has mainly to supervise the working of the Doctors and contractual staff. The Matron is responsible for the entire Nursing staff. The Resident Medical Officer for discipline among the Group C and Group D. Servants, Sister Tutor who is responsible for work of student Nurses, and who is next to Matron, the Personal Assistant for supervising the entire clerical side, the O.P.D. Sister for the working of the daily O.P.D., etc. Pathologist who is responsible for Laboratory functioning.

c) The main burden of the hospital working lies on the regularity, efficiency and co-ordination of senior staff. It is desirable that the senior staff should develop an attitude of avoiding administrative laxity. With this end in view, it is necessary to bring to their frequent notice and emphasize the need of solving administrative difficulties and problems arising in daily working. For this purpose it is always desirable to convene regularly weekly meetings by enforcing strict attendance, where these administrative problems would be discussed and solutions found. These regular meetings in course of time serve as schools where officers and senior staff get training for gearing up the administration, in proper channels. These meetings have also the effect of forming a mental habit of avoiding delay, wastage and laxity in administration.

d) Weekly meeting of Medical Officers on fix day at 8.15 a.m.It is necessary to start the working of the hospital so far as patients are concerned exactly at 8.30 a.m. Practice was introduced in this hospital of convening a meeting of Medical Officers at 8.15 a.m. daily in the out-door department. All Medical Officers including the Civil Surgeon make it a point to attend it.—

- To ensure regular attendance of Medical Officers.
- To guide the Medical Officer on problems of Medical treatment of a general character and suggest solutions.
- To discuss the ways of minimizing public complaints and of reducing public grievances. They of the dangers of being effected in medico-legal cases and the risk to which they are liable if the doctor exhibited carelessness or negligence priority should be given to be handle POCSO/sexual assault cases.
- To impress on the hospital staff as to how such incidents should not crop up in our institution. If any complaints about hospital appear in newspapers.
- To build up confidence in dealing with the treatment problems, dealing the public.
- To pay attention to the fact that administering drugs is not the only element in treatment of diseases but the Medical Officers have to bear in mind the psychological condition of patients and his relations.

- To win the confidence of every patient adopt considerate, sympathetic and wholesome psychological attitude.

- Weekly meeting of Technicians with Additional Civil Surgeon& matron's meeting with nursing staff to attend and address any difficulties arising the working of departments. This enforced punctuality attendance and this created assurance their minds that there somebody who is coming and addressing them for solving their difficulties. And also to tighten up the working of the all departments.

Daily attendance of Group D staff at 7 am:

The night duty male female staff and day duty staff meet the senior Group D (MUKADAM) the morning parade. who can exercise effective control over entire Group D Staff, arrange their make arrangements during casual and earned leave and to that they discharge their work and not the hospital during duty time. It MUKADAM's to bring to the notice of Additional Civil Surgeon instances of absentees, and irregularities on failure of duty. It is physically impossible for Additional Civil Surgeon to attend simultaneously to all departments and watch the working of menial staff. It is essential provide the service of a MUKADAM to the Additional Civil Surgeon for leaving him of his burden to some extent for enabling him greater attention medical work. The MUKADAM who daily trained by senior officers, tries to inculcate on the minds of menialstaff the instructions he received from Civil Surgeon, Additional Civil Surgeon, Matron Sisters I/C wards. He explains in Marathi the circulars conveyed to him by these officers. He to guide in main training cleanliness in hospital premises and instructs in carrying their duties efficiently and manner which they should with members the public. The MUKADAM reports the senior officers the deficiencies in equipment so far the menial staff concerned.

Periodical meeting of the Contractual Staff

With Civil Surgeon/ Additional Civil Surgeon and Medical Superintendent at such meeting the difficulties experienced by the contractual and shortage equipment, can be discussed. Administrative questions are discussed and some discussions reached. This contributes to smooth working, coordination improvement of individual department and has generating confidence in the contractual staff that continuous efforts are being made to maintain and increase the efficiency of the hospital. A possible tendency towards slackness on the part of a member is automatically discouraged.

Educative meeting for staff nurses and Sisters:

Arrange meeting once in a month where the civil surgeon/Additional Civil Surgeon/Matron guide them by speaking to them on nursing procedures to be carried in their wards. For example, the E.N.T. Surgeon will speak on pre-operative and full post-operative treatment on Tonsillectomy or Gynaecologist/Surgeon will talk on post-operative treatment of Vesovaginal fistula and so on. This ultimately makes the Nurses more confident and better informed regarding the procedures they are called up to do every day.

- Training should be periodically held where sweepers are taught methods of cleaning the wards and hospital surrounding. Group D staff have to be told rediments of hygienic,

spread of infection, disinfection, nuisance of flies, etc. for example Bio-Medical waste management training, Infection control committee meetings.

- On particular occasions such as World Health Day & all health days, it necessary to held general meeting of the staff for explaining them the purpose and details of the scheme initiated by the Government. The object of such meeting is to implement the working of these campaigns and prepare the hospital staff to further them.

- Send-off/Tea parties/Welcome Parties/Felicitation/appreciation program should be arranged. These occasions are fully utilized to increase the spirits of Hospital staff, to make them more national minded and develop pride and interest in their work in the institution.

17.15 Badges for X-Ray Technicians:

From the Atomic Energy Establish exposure to X-Ray Technician radiation. Every weekly the badges to the commission and receive report whether the Technician received overdose. In case of an overdose, we prevent him from doing X-Ray work for sufficiently long interval prescribed the commission. His services get utilized in some other department.

Instructions of the Civil Surgeon / Head of Institution:
Whenever Civil Surgeon was having his usual rounds and even in his daily working, he issued oral instructions if certain shortcomings irregularities came notice. But these instructions being verbal were often forgotten. Now the Civil surgeon has kept two registers, table office, which he writes about the irregularity noticed by him. Instructions are reduced in writing. These books sent to persons concerned for doing the needful.

17.16 A Note book for contractual staff

Start keeping note book wherein the staff can convey their needs. The book remain with the Matron is circulated to them in the first week of each month. If the staff have any suggestions, they can get the book which is readily available in the OPD. With the sister and record their suggestions in it for doing the needful. Also maintain 'Abhi pray Note Book'.

17.17 Involvement of Voluntary Organization in Health Programme

Teachers and lecturers from schools and colleges who are free during vacations should be tapped for organizing medical camps and such other work. National social services agencies should also be contacted. In short, volunteers, social workers, etc., should be contacted for such programmes. (DHS. D. O. Letter No. DHS/3076/XV/75, dated 21st February 1975.) Addressed to District Health Officers and copy to Deputy Directors of Health Services.)

17.18 Hospital Plans, Hospital Library and Publications, Quality of healthcare

Plans and estimates are prepared by the agencies of Public Works Department and they are countersigned by Officers of this department at different levels before they are finally submitted

to Government. At such times great care should be taken right from the time of formulation of plans to the stage of countersignature by different authorities before sub- mission to Government. The first important thing is to make a list of all the requirements in consultation with the actual users. The whole plan should be based on requirements. The plan should be invariably shown to the Matron for comments. It is often found that plans once approved are changed again and again by the same Medical Officer or countersigning Medical Officers. This results in a considerable amount of a embarrassment and delay. The plans should, therefore, be scrutinized by personal visit, if necessary, on the spot and discussed thoroughly with concerned officers. Once they are approved, they should not be changed.

Monthly Newsletters.

Some of our hospitals have a very large number of patients in the outdoor and indoor departments. The teaching hospitals have adequate, highly qualified staff. Some of the non-teaching hospitals also have well-qualified staff in sufficient numbers. It would be a good idea if a monthly newsletter is published on behalf of such Government hospitals for circulation to all hospitals and other institutions. This should include educational material mainly from a technical point of view, such as prescribing methods, new drugs, new methods of diagnosis and treatment, etc. It may also contain tips on administrative problems.

Civil surgeons should take full advantage of the schemes introduced by the government to keep them updated on the latest developments through clinical conferences and refresher courses.

Hospital Library

It may not be possible for each and every hospital to have a good library, but every district hospital should maintain a library of medical journals and books. The district hospitals should circulate the journals and books to other institutions in the district. It should not be difficult to subscribe to certain standard journals and purchase certain annual publications and other books, even from the grants presently placed at the disposal of the hospital. The staff in charge of Medical Institutions should also be induced to take advantage of the libraries maintained by local associations like "The Indian Medical Association".

The District Hospitals should also maintain a library for nurses. Books on nursing careand nursing journals should be subscribed to. As it is, nurses never get a chance to refresh their knowledge after they are qualified.

Standards and Norms forHospitals.

The standards and norms for hospitals should be followed as per prevailing guidelines of Indian Public Health Standards (IPHS).

Private Practice in Public Health

The Medical Officer in charge of a hospital should keep a careful watch on private practice carried out by subordinate medical Officers. Government Medical officer is not allowed to private practice as per government rules. He should also keep a watch to ensure that medical officers in receipt of non-practicing allowance do not carry out private practice.

Government of Maharashtra has issued a G.R dated 7.8.2012, sanctioning 35% of basic pay as Non-Practicing Allowance (N.P.A) to Group ‘A’ Medical Officers in Public Health Department.

Qualitative & Quantitative Aspects of Hospital Care:

A. NQAS, LAQSHYA, IPHS, Kayakalp, SUMAN etc. are the various guidelines which should be implemented by the hospitals to bring about improvement in the quality of the health services.
B. "Zero Pending and Daily Disposal": The management of government and semi-government offices must be well-organized according to the rules and regulations for the speedy execution of citizens and administrative work. For this purpose, keeping the records updated and preserved in every government office, registers in the office are regularly written and abstracted, the head of the office regularly reviews the received settled and pending cases in his own and the supervisory office and the pending cases will be settled within a specific time frame.

No. 1 :- Classification, classification and updating of records in the office as well as in the records room.
No. 2 :- To update the records of all government and semi-government offices and record rooms in the state, to avoid delays in citizens and administrative work and to dispose of all outstanding cases and to dispose of the references and cases received in each office within a specific time limit.

17.19 Hospital policies:

16.19.1 Antibiotic Policy

Service Name :	Antibiotic Policy
Date Created :	
Approved By :	Medical Superintendent Name : Signature :
Reviewed By :	District Coordinator of Hospital services Name : Dr. Signature :
Responsibility of Updating :	General Physician Name :Dr. Signature : Frequency of revision-every Year

A. Purpose:

- Improve patient care by promoting the best practice in antibiotic prophylaxis and therapy.
- Make better use of resources by using cheaper drugs where possible.
- Retard the emergence and spread of multiple antibiotic – resistant bacteria.
- Improve education of junior doctors by providing guidelines for appropriate therapy.
- Eliminate the use of unnecessary or ineffective antibiotics and restrict the use of expensive or unnecessarily powerful ones.

B. Scope:

- Consider whether or not the patient actually requires an antibiotic
- Avoid treating colonized patients who are not actually infected.
- In general do not change antibiotic therapy if the clinical condition is improving.
- If there is no clinical response within 72 hours, the clinical diagnosis, the choice of antibiotic and/or the possibility of a secondary infection should be reconsidered.
- Give the antibiotic for the minimum length of time that is effective.
- Review the duration of antibiotic therapy after 5 days.
- For surgical prophylaxis start the antibiotic one day before induction of anesthesia and continue for a maximum of five days.
- Use catheters only when essential; remove when no longer essential
- Target the pathogen – obtain cultures from the patient; target empiric therapy to likely pathogens; target definitive therapy to known pathogens.
- Isolate the pathogen – use standard infection control and isolation precautions
- Break the chain of contagion – KEEP YOUR HANDS CLEAN

C. Guideline for Antibiotic Treatment and Prophylaxis:

Common Pathogen	1st Line	2nd Line	Comment
Acute viral infection	No Antibiotic	Antiviral	Symptomatic
Viral with secondary infection	-Penicillin derivatives -Macrolides	Quinolone Cephalosporin	-
Acute Bacterial	-Clotrimazole -Penicillin derivatives -1st generation quinolones -1st and 2nd gen cephalosporin	2nd and 3rd Generation quinolones 3rd generation Cephalosporin	-

Mix Bacteria infection **Gram+ve, Gram-ve**	Broad spectrum antibiotic of any generation Aminoglycosides	As per culture sensitivity result	-
Mix Anaerobic infection	Broad-spectrum antibiotic Aminoglycosides Tinidazole Metronidazole Ornidazole Secnidazole	As per culture sensitivity result	-
Worms infestation	Anthelminthic Specific or Broad specific		-
Fungal	Kelacenazole, Macunzole, Fluconazole	With suitable Antibiotics	-
Tuberculosis	As policy of DOT's clinic		-
Amoebic infection	Anti-amoebic		-
Malarial Parasite	Chloroquines and Primaquines	Artisunate Artimether	Resistant cases Quinine Derivatives

17.19.2 Barrier Free Accessibility and Disable Friendly Services

POLICY: Barrier free environment is one which enables people with disabilities to move about safely and to use the facilities with the built environment

PURPOSE: The purpose of barrier free design is to provide an environment that supports the independent functioning of individuals so that they can get to, and participate without assistance.

The purpose of the policy is to ensure barrier free accessibility to all citizens and disable friendly services for physically challenged patients.

SCOPE: To all hospital staff

RESPONSIBILITY: To all hospital staff
DISTRIBUTION: To all the departments
PROCESS DETAIL:

- The entrance of the hospital should be barrier free
- At the entrance of the hospital, there should be provision of railing for support
- Easy availability of wheel chair at the entrance with safety belts
- The outpatient corridor should be provided with railing towards one side for support and easy access to disable patients
- Public announcement system for visual impaired patients
- Glowing signage's for hearing impaired patients contrasting color arrangements for limited vision.

- Separate disable friendly toilets in every floor and every ward
- Provision of hand rails in toilets with non slipper floor
- If the patients are vulnerable, priority to be given for registration and consultation
- A provision of separate help disk for disable patients.
- Monitoring and supervision by MO

17.19.3 Condemnation Policy

Condemnation/Disposal :- Whenever a capital or inventory asset whether large or small is disposed of, a condemnation/disposal form should be completed by the in-charge of the department and counter signed by the MoIC/ MO. For straight forward disposals the form should be completed by filling in as much information as possible. In the case of sale to a third party the recipients details should be documented together with disposal proceeds or an estimation to be confirmed on completion of the sale. The form should then be signed and dated by Committee Chairman .One copy should be sent to Finance and one copy retained for departmental records.

- The constitution of the Committee in a Hospital may vary subject to the availability of respective posts, which may be decided by the head of the institution. In smaller institution where a condemnation Committee cannot be constituted, the head of the institution is permitted to inspect the articles and approve the condemnation, subject to obtaining the inspection report on the irreparable state of the articles from the technical expert as mentioned above.

- The Condemnation Committee shall meet annually once and complete the condemnation of all the unused items.

- Wherever buy-back policy for equipment is offered, the committee shall consider the same before approving the condemnation.

- All stores including steel items, empty containers of drugs and dressings that are found to be unserviceable inwards / Theatres / Department / Nurses Quarters etc., should be returned to the main stores. The officer-in-charge of main stores (Medical Stores Officer /Chief Pharmacist / Assistant) should take steps to condemn them which are beyond repairs.

- Linen items which are worn out due to wear and tear in the wards, theatres and department shall be listed out and consolidated by the ANM In-charge and should be placed before the condemnation committee for its approval.

A. Parameters to be considered by the Condemnation Committee:

- Life of the equipments as per manufacturers' description.
- Uneconomical repairable condition of the equipment certified by the Service Agency.
- Disposable value of the items proposed for condemnation. The limit to be considered for disposal of condemned items may be fixed as up to Rs.5.00 lakhs of original cost of each item of equipment / machinery. For items of value of more than Rs.5.00 lakhs respective DHO to take final decision after recommendation of the Condemnation Committee.

- Committee is fully empowered to condemn the items up to Rs.5.00 lakhs for each item and to recommend to DHO for more than Rs.5.00 lakhs for each item and shall record the reasons for condemnation specifically for each item whenever necessary and the members shall sign thereto.

B. Procedure for disposal of condemned items:

- All the items condemned should be brought to the general disposal register The entries in the general disposal register should tally with the items condemned and reduced in the main stock register of instruments, accessories, furniture etc. The stock in the general disposal register shall be reduced as and when such items are disposed.
- Limited tender System shall be adopted if the earning revenue value is more than Rs.25,000/- and less than Rs.1,00,000/- and the DHO shall themselves finalize the Limited tender. As regards rare cases where, the earning revenue value is expected to exceed Rs.1 lakh The Andhra Pradesh Tender Act will be followed and respective DHO to finalize and dispose the tender.
- Public Auction shall be conducted if the earning revenue value is less than Rs.25,000/- in each hospital and the Medical Officer can conduct the Public auction. DHO himself can post-approve the auction sale.
- Upset price for disposal of the condemned items shall be fixed locally by the DHO except in respect of empty saline bottles / pouches.

C. Disposal of used & X-ray film / Waste Hypo solution:-

The rate for the disposal of the above items may be fixed by the. Civil Surgeons for the institutions under their control every year by assessing the sale price by a committee constituted at his level.

D. Disposal of empty saline pouches:-

To be disposed to the Common Treatment Facility operator as a Bio Medical Waste.

17.19.4 Consent Policy

Consent represents the legal and ethical expression of the basic right to have one's autonomy and self-determination. If a medical practitioner attempts to treat a person without valid consent, then he will be liable under both tort and criminal law.If there is written consent, the medical practitioner would have greater ease in proving consent in case of litigation.

POLICY:

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

- Consent is taken for Patient and /or his family members and are informed on risks benefits, alternatives and as to who will perform the requisite procedure in a language they can understood.

PURPOSE:

The purpose of obtaining a patient's consent is to ensure that patient is informed about the medical care, nursing care, risks and benefits that will be provided to the patient based on which he / she takes decision.

DEFINITION:

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

Informed consent is a legal condition whereby a person can be said to have given consent based upon a clear appreciation and understanding of the facts, implications and future consequences of an action. In order to give informed consent, the individual concerned must have adequate reasoning faculties and be in possession of all relevant facts at the time consent is given

SCOPE: Outpatient and Inpatient areas and Registration

RESPONSIBILITY: Registration clerk, Nurse in-charge of the patient, treating physician

DISTRIBUTION: All patient care areas and registration

PROCESS DETAILS:

DESCRIPTION OF THE PROCESS:

- When a patient comes to a doctor for treatment of an ailment implies that he is agreeable to medical examination in the general sense. This is implied consent and would encompass physical examination (not intimate examination), palpation, percussion, auscultation and routine Sonography.
- General consent to treatment and release of information
- Written general consent with signature shall be obtained at the time of admission by admission officer.
- Consent shall be taken in language understood by the patient / relative
- Components of general consent to treatment and release of information form shall be explained clearly to the patient and / or relative in the language understood by them
- Name of the patient, relative, Relation of the relative and signature of the person giving consent shall be properly endorsed.
- The form shall be attached in patient’s file

Informed Consent is to be given by:

- Informed consent from the patient / family is required whenever patient is undergoing any procedures or special treatment.
- The doctor should explain risks and benefits to the patient and family members
- The patient, unless he or she is a minor, under effect of alcohol or other sedative drugs
- If patient is incapable of informed decision making, consent shall be obtained from next of kin / parent / guardian, as per law of the land.
- In situations when there is no consensus amongst children of the patient, they are asked to nominate one of their siblings in writing with signatures of two witnesses. The informed consent is obtained from the nominated person.

- In case of unidentified patient in unconscious condition, treating doctor shall take a decision in life threatening circumstances.
- In life threatening situation, where no next of kin is available the MoIC will give permission for the procedures that needs to be done.

17.19.5 Dress Code Policy

Service Name :	Dress Code Policy
Date Created :	
Approved By :	Medical Superintendent Name : Signature :
Reviewed By :	District Coordinator of Hospital services Name: Dr. Signature :
Responsibility of Updating :	General Physician Name :Dr. Signature : Frequency of revision-every Year

POLICY: Hospital staff practices uniform dress code with ID cards during working hours

PURPOSE: To ensure that the hospital staff adhere to their professional etiquette in respect their uniform and ID card

SCOPE : All hospital staff

RESPONSIBILIES: HODs, CS, ACS and Medical Superintendent

PROCESS DETAILS:

DESCRIPTION OF THE PROCESS:

- Both male and female employees should wear the hospital dress without fail.
- In areas of Intensive care, the employees should wear the prescribed dress with all necessary PPE to reduce the cross infection.
- All the Doctors should wear knee length long sleeve white apron
- Paramedical shirt length short sleeve white apron
- Nursing staff with white saree, white apron and nurses' cap.
- Ministerial staff should wear formals,(no fancy jeans and shirts or T-shirts)
- Housekeeping staff uniform color dress with over coat.

- MNO and other subordinates white shirt and white pants.
- Heavy jewelry during working hours is not allowed.
- For clinical staff (female) long hanging earrings, too many bangles are not allowed professional etiquette is to be followed
- Non compliance to the dress code will lead to disciplinary action.

DISTRIBUTION: To all the departments

17.19.6 End of Life Care Policy

Purpose

- To provide guidelines to the hospital staff for providing quality services and care to a patient and their family at the end of his/her life, and involving their next of kin in medical management.
- To ensure all patients at the end of their life and receive appropriate care and medical management.
- To ensure that all patients are accorded their rights to die with dignity and respect by enhancing the documentation and communication between patients, next of kin and healthcare providers.

Scope: Hospital Wide

Policy

- By enhancing the documentation and communication between patients, next of kin and healthcare providers all patients treated according to this policy.
- Patients and their next of kin will be involved in the medical management and care.

Definition: 'End of Life':

- 'End of Life' is defined as that time when congenital abnormalities, terminal illness, acute or chronic illness, or age itself is expected within weeks to month and can no longer be reasonably forestalled by medical intervention.
- Terminal illness is defined as one having a debilitating condition, which is considered to be medically incurable or untreatable and which can be expected to cause death.

Next of Kin refers to:

- Next of kin consist of spouse and relatives.
- All those descending from the same family shall be deemed as relatives/next of kin.
- First degree: Parents, children (competent adult), spouse (competent adult)
- Second degree: grandparents, grandchild (competent adult), brother and sister (competent adult)
- This sequence of kinship is followed for the subsequent degrees.
- If next of kin as per the above-mentioned sequence/levels is not available, then relatives available from the same family of the spouse.

Implementation

Sr. No.	Procedure	Responsibilities
1	Discussion shall be carried out with patients, if conscious and possess decision making capacity, or with their next of kin to develop plan of care	MO/ANM
2	Discussion with the patient and next of kin shall be documented in the patient's medical record and shall include date, time and name of the person involved	MO
3	Family conference with next of kin, nursing, physician and other multidisciplinary team member shall be conducted when possible and documented in the case note	GP/ ANM
4	The Medical Officer should collaborates with others in the multidisciplinary team to identify, understand and relieve patient suffering in the physical, psychological, social and spiritual domains	Medical Officer/Health care team
5	Medical Officer with others in multidisciplinary team must assess and reassess response to appropriate pharmacological and palliative relief measures	Medical Officer/Health care team
6	Nurses and other health care staff must assess and reassess team illness, coping mechanism, grief and loss reaction	Nurse/Health care team
7	Nurses and other health care staff should assess and reassess team relationship with patient, such as their reaction to patient mechanism, grief and loss	Nurse/Health care team
8	Nurses and other health care staff should assess and reassess team kin need for patients request religious counselling; the staff nurse should facilitate the arrangement	Nurse/Health care team
9	During situations when patient dies in the hospital and the cause of death is known and natural, the Medical Officer or more senior physician must clarify death	Medical Officer
10	After death, the bereaved family should be dealt sensitively, in a culturally appropriate manner	Medical Officer
11	Hospital Administrative Staff shall provide all logistical support such that the deceased person is transferred out from the hospital in a timely and dignified & culturally appropriate manner (take inputs from family as needed)	Administrative Staff
12	Provide presence and support to the family As well as privacy and space to the family	Hospital Staff
13	Provide Timely and correct verification and issue of certification of death to the family	Medical Officer

17.19.7 Ensuring Free of Cost Treatment for All

POLICY: This policy is to ensure that patients are treated free of cost irrespective of caste, creed and religion.

PURPOSE: To ensure free of cost and accessibility to all citizens

SCOPE: Registration dept, OPD services, Diagnostic Services, Pharmacy, IPD services,. Diet and ambulance services

RESPONSIBILITY: Registration dept, OPD services, Diagnostic Services, Pharmacy, IPD services, Diet and Ambulance services. MoIC is responsible person.

DISTRIBUTION: Registration dept, OPD dept, Diagnostic dept, Pharmacy dept, IPD dept. Diet and ambulance services

PROCESS DETAILS:

- Thehospital ensures all services are free cost to all citizens and same is displayed in prominent places in order to free access by the clients.
- For BPL card holders, as per the National & state flagship programs / schemes like JSY, JSSK etc. are also ensured as per the guidelines.
- The MoIC ensure the service provision id provided as per the guideline

17.19.8 Grievance Handling Mechanism Policy

POLICY:

Grievance redressal procedure shall be addressed to the patients during the hospital stay and consultation so that hospital can address their grievances

The redressal procedure shall address the grievance with help and advice of the MoIC/ MO.

Appropriate actions shall be taken to redress the grievance by the MoIC/ MO Counseling sessions shall be scheduled, with the individual and all attempts shall be made to ensure that there is a redressal of the grievance to patient/ client satisfaction.

PURPOSE:

a) The purpose of this policy and procedure is to provide a complaint and Grievance handling framework for the complainants as well as complaint Recipients, *and;*
b) To provide guidelines on how to lodge a complaint or grievance and how that Complaint or grievance will be dealt with.

DEFINITION:

Grievance: Grievance would only mean a grievance relating to any patient / client arising out of the implementation of the policies/rules or decisions of the Hospital.

SCOPE: This policy and procedure sets out the essential elements for the management of complaints from inception to final outcome.

RESPONSIBILITY: MoIC/ MO

DISTRIBUTION: All the employee of the Hospital**.**

PROCESS DETAILS:

- Provision of compliant box in the patient care areas
- Display of grievance redressal mechanism in prominent areas
- Display of important mobile number like MoIC/ MO for effectiveness.
- Any person coming to the hospital having a complaint, can register on toll free number 104.

Minor complaints will be resolved within 48 hours.

Complaints Handling:
The complaint will be taken from the complaint box /written complaint/anonymous and press clippings will be recorded in the compliant register.

Grievance Procedure
After registering the complaints, a preliminary enquiry will be called for. The findings will be shared with the MoIC for resolution. If the authority not satisfied, a secondary investigation may be asked for more findings for non-partial resolution. The findings will be discussed with accused / department and complainant for rectification and preventive action.
The final authority is MoIC to monitor and address the grievance redressal mechanism

17.19.9 Interdepartmental Transfer of Patients

POLICY: Patients who require additional intervention, diagnosis, treatment from one department to another department for better services of hospital care.
This policy ensures that the patient is transferred in a safe manner and without any discomfort to enhance the service levels.
PURPOSE: To ensure that there is a laid down procedure for transferring of patients from department to another department without any delay in the delivery of care.

SCOPE: All Patient area, Diagnostic Department

RESPONSIBILITY: MO and Nurse

PROCESS DETAILS:

- In OPD if the MO needs a second opinion from another MO/MoIC, the MO/MoIC shall write a note on the OPD slip for required details from the MO/MoIC and direct the patient / client to the specific consultation room stating the room number.
- In IPD if the patient requires a cross consultation, or transfer the patient under another MO/MoIC, the present treating MO/MoIC shall write a memo on the Bed head ticket stating the reason for transfer and treatment given with date, time and signature.
- The transfer of patient will be done with duly filled bed head ticket as handover and taken over by the both physicians along with notes.

- If the patient has to be shifted from one ward to another ward, the patient should be shifted in the wheel chair or stretcher with safety belts, covered with bed sheet.
- Prior information should be communicated to the ward where the patient is being shifted to avoid delay in patient shifting and treatment.
- Nurse's notes should be accurate and timely.
- While transferring the patients, all IV fluids should be stopped and reinitiated after shifting the patients.

17.19.10 Judicious use of PPE

POLICY:

Use of PPE shall be strictly adhered to by all healthcare staff in all situations as indicated in the document. Infection control committee shall monitor the adherence of PPE by healthcare staff. Regular training shall be provided by Infection control committee on use of PPE

PURPOSE:

Thepurpose of this policy is to establish standard policy on use of PPE for infection control toprotect against transmission of blood borne viruses including HIV, HBV and HCV in the health care setting.

DEFINITION: PPE are meant to reduce the risk of transmission of blood borne and other pathogens from both recognized and unrecognized sources.

SCOPE: Hospital wide

RESPONSIBILITY: Infection control Committee

DISTRIBUTION: Hospital-wide
Personal protective equipment (PPE)

- Mask , eye protection or a face shield and cap
- Clean, non-sterile fluid-resistant gown or sterile
- Clean non-sterile gloves or sterile

Gloves

- When touching blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, gloves to be worn.
- It should be changed between tasks and procedures on the same patient after contact with potentially infectious material.
- It should be removed after use, before touching non-contaminated items and surfaces, and before going to another patient.
- Hand wash / rub to be followed immediately after removal.

Facial protection (eyes, nose, and mouth)

- Before Surgical procedure mask and eye protection (face shield, goggles) to be worn, to protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

Gown

- Worn to protect skin and prevent soiling of clothing during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
- Soiled gown to be removed as soon as possible, and perform hand hygiene.

17.19.11 Maintaining Patient Records and Information

POLICY:
To ensure that the medical record department shall apply various methods and tools to prevent any damage / tampering to medical records occurring due to misplacements, pests, fire or any other factor

PURPOSE:
It is to ensure the protection of records from any damage, tamper or loss. All information related to patient should keep in confidential.

SCOPE:
This document is applicable to medical records department.

RESPONSIBILITY:
Medical Record Department, Pharmacist, Nurse, MO/MoIC.

DISTRIBUTION:
Medical Record Department and inpatient departments

PROCESS DETAILS:
DESCRIPTION OF THE PROCESS:
The MRD shall apply various methods and tools to prevent any damage /tampering to the medical records occurring due misplacement, pests, fire or any other factor.
Safe guarding the data and records in medical records:

A. No files will be taken out of department except for the conditions mentioned in the document
B. A retrieval process is in place to take care of files issued.
C. The medical record in charge will make a note in the outward register to issue the concerned records against the receiver's name with date, time and signature of the receiver, where the file should be returned within 48 hours.
D. Telephone call is made to the person on the expected date of return and a request is made to return the file.
E. If any extension is to be made, the same is noted down in the register
F. In case the file is still not returned and no extension has been sought, the medical record technician goes to the person to collect the documents.
G. If any file is lost by the department, immediate information should be passed onto the medical superintendent and FIR can be lodged with further orders of the medical superintendent .

Additionally:

1. MRD shall be a restricted area.

2. Fire extinguishers shall be placed **accessible to MRD.**
3. The staffs are trained in handling of all types of fire extinguisher.
4. Pest control is done on a predetermined schedule and housekeeping that it is followed also makes a check.
5. The MLC and death cases records are kept under lock and key. Patient information should not be disclosed.

ACTIVITY AND RESPONSIBILITY:

S.No	Activity	Responsibility
1	Various methods and tools to prevent any damage /tampering to the medical records occurring due misplacement, pests, fire or any other factor must be followed.	Medical Records Department
2	All the instructions for safeguarding of data medical records must be followed.	Medical Records Department
3	Special care must be taken for storage of Death Cases & Medico Legal Cases.	Medical Records Department

17.19.12 Managing Patient during Non-Availability of Beds:

POLICY:

All efforts shall be made to accommodate a patient for admission as far as possible.
Nurse Staff shall try to transfer the stable patient's from one ward to another, in case of non-availability of beds for new admissions.

If there is no vacant beds in a particular ward, patients who do not require active treatment or medical interventions are shifted to another wards / rooms till the bed / room is vacant.

If there is no vacant beds in particular ward patient who do not require active treatment or medical interventions are shifted to Medical Ward in case of non-contagious diseases not requiring isolation, exceptions are:

- Surgical patients (pre and post-surgery)
- Pediatric cases
- Obstetrics and Gynecology cases

The hospital maintains bed strength of 3 as buffer beds.
If there are no vacant beds in the hospital even after using buffer beds, in case of any disaster or mass casualty incidents, long benches are used in corridors for stop gap management.
These activities shall be monitored under the supervision of the MoIC.

17.19.13 Prescription of Drugs Policy

POLICY:

- All the drugs to be prescribed in generic names
- No medicines shall be dispensed from pharmacy store without a written prescription order, except in emergency cases, where the nurse can collect the medicine from pharmacy and prescription can be sent after the patient is stabilized.
- Drugs can be prescribed to the patients only by MoIC/MO.
- All orders for medication shall be written in medical records of the patient and shall be in appropriate location. These orders shall be crosschecked by MoIC/MO and shall be signed, named, timed and dated.
- Prescription shall be written and signed by the MO-IC/MO and shall be clear, legible, dated, timed, named and signed.
- For verbal orders of medications, the patient case sheet has to be counter signed by the MoIC/MO
- The medications are not dispensed without prescription.
- Special care shall be taken while prescribing high-risk medication.

PURPOSE:
To develop and maintain processes for prescription ordering by the Treating physician.

SCOPE:

The policy applies to MO-IC/MO Inpatient area and Out-patient Department.

RESPONSIBILITY:

MO-IC/MO

DISTRIBUTION:

MO-IC/MO and Nurses

PROCESS DETAILS:

The responsibility for medications to be administered to a patient is ordered by the MoIC/MO in his/her written orders on the patient's order sheet. Only orders received and written by a legally authorized practitioner with clinical privileges will be processed.

ACTIVITY AND RESPONSIBILITY:

S. No.	Procedural steps	Responsibility
1.	Drugs shall be prescribed on medical records of the patient	MoIC/MO
2.	The prescription shall be entered in Hospital software and case sheet	pharmacist
3.	Cross check the medication transcribed in the treatment chart	Pharmacist/Nurse

4.	Medicines are issued only in case of proper prescription	Pharmacist
5.	Pharmacist checks the expiry date, patients name, medicines name, strength/dosing, the route of administration and the prescribing doctor's info, if written properly then only the medicines are dispensed.	Pharmacist / Nurse
6.	Once the medicines are dispensed to patients, the patients are explained on how to take it and when to take and possible side effects of medicines are also explained to the patient.	Nurses

17.19.14 Referral of the Patient, if service is not available

POLICY:

This policy is to ensure that patients on arrival to the registration / casualty is referred to another centre if the required service is not available in the hospital.

PURPOSE:

The purpose of this policy is to ensure the basic service and to protect the patient rights to avail appropriate service for which she/he deserves

SCOPE:

Scope of registration includes all patients in OPD, diagnostic and Emergency Department and Ambulance service

RESPONSIBILITY

Registration clerk, OPD staff and casualty staff

DISTRIBUTION

Registration, all OPDs and casualty

PROCESS DETAILS:

- All patient transfers shall be well co-coordinated with the facility where patient is being transferred.
- The concerned treating MO will decide on transfer/referral and intimate the patient and relatives with reasons.
- Patients coming in for Emergency shall be provided with first aid treatment and stabilised, if required, before transferring.
- All patients who are being transferred to external facility (including transfers from emergency) shall be provided with a case summary mentioning the status of patient, significant findings and treatment given in the hospital.

ACTIVITY AND RESPONSIBILITY:

S. NO.	ACTIVITY	RESPONSIBILITY
1.	Registration is done for all patient requiring OPD and IPD services.	Registration clerk
	For OPD Registration : - For General OPD: - ❖ Morning OPD: 08:30 am to 12:30 pm ❖ Evening OPD: 04:00 pm to 06:00 pm Casualty services for 24 hours	
	Patient will be referred only if the concerned equipment / specialist is not available in the service provision of the hospital	
3.	If the patient comes to the casualty directly, assessment and basic treatment will be provided and if required the MO will take decision to refer the patient to tertiary centre for better treatment and follow up.	MO
4.	For in patients, during the stay in the hospital, if the patients need tertiary care, the patients will be referred to higher centre	MO
5	The patient shall be transported by the support of 108 ambulance, and if not possible then the hospital ambulance will be allocated for shifting of the patient	MO I/C/MO /Nurse

17.19.15 Reporting of Adverse Drug Reaction (ADR) Policy

POLICY:
The policy is pertaining to adverse drug reaction reporting and Follow-up

PURPOSE:
To describe the procedure and reporting a adverse drug reaction for multi disciplinary review to all follow-up and prevent future medication errors

DEFINITION:
Adverse Drug Reaction (ADR) - any response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.

ABBREVIATION:
ADR: Adverse Drug Reaction

SCOPE:
In patient wards, Immunization

RESPONSIBILITY:
MO I/C / MO/Nurse and Pharmacist

DISTRIBUTION:
Pharmacist, Nurses, Consultants

PROCESS DETAILS:

- Always suspect an ADR in the unwell patient taking any medication
- The first step in management is to withhold or withdraw the suspected drug
- Further treatment should be decided on an individual basis
- Always tell the patient of a suspected ADR so that they are able to take precautions in the future

Reporting of ADR

Adverse drug reactions are reported immediately to the doctors on duty by the nurses. Patient is also informed of the ADR. In case adverse reaction is not controlled within 10 to 15 minutes, treating physicians are informed by the DMO for further management. Adverse drug reaction forms are completed with 24 hours. A copy of adverse drug reaction form is also to be kept in patient's file.

Compiling and Analysis of Adverse Drug Events

Adverse drug events due to IV infusions of fluids, blood and blood components are recorded with details of the batch No., expiry date, manufacturing date of I/V fluids, IV sets, blood, blood transfusion sets. The infusions is discontinued, immediately, bottle and I/V transfusion set are sealed and sent to the laboratory for cultures and incompatibility if any. After getting the report from the lab / blood bank the event is analyzed, the pharmacy is instructed to stop issuing the concerned lot with same batch no. and distributor / manufacturer is intimated. Corrective and preventive actions are taken on the basis of analysis of data. Pharmacotherapeutics / Formulary Committee shall analyze ADR and take necessary preventive actions for reducing the risk of ADRs.

ACTIVITY AND RESPONSIBILITY:

Sr. no.	Procedural steps	Responsibility
1.	After administration of the medicine, patient shall be monitored	Nurse/MO
2.	If a patient suffers from ADR immediate Treatment must be prompted	MO
3.	Adverse drug Reaction are reported immediately to the duty Medical officer	Nurse
4.	Adverse event reporting form is filed up within 24hrs of ADR	Nurse/ Medical officer

5.	A copy of Adverse event reporting form is also to be kept in patient's file.	Nurse
6.	Pharmacotherapeutics / Formulary Committee shall analyze ADR and take necessary preventive actions for reducing the risk of ADEs.	Pharmacotherapeutics / Formulary Committee

17.19.16 Visitors Policy

PURPOSE:
The purpose of this policy is to reduce the rate cross infection, overcrowding during working hours and to ensure safety and comfort of the patient in relation to the visitors to the hospital.

SCOPE:
Nursing staff, Security Staff

RESPONSIBILITY:
Registration clerk, Security staff and Nursing staff

DISTRIBUTION:
Registration clerk, Security staff and Nursing staff

PROCESS DETAILS:
DESCRIPTION OF THE PROCESS:

- Only one attendant is allowed to stay with the patient during his/her stay in the hospital.
- During admission process the attendants are handed over 1 attendant pass and 1 visitor pass.
- Children below the age of 14 are not allowed as visitors in the hospital, this is to protect them from getting cross infected as they are susceptible to contract infections.
- During morning hours the attendant of the patient can come out of the ward and send another attendant as an exchange.
- Morning from 9:00 am to 12:00 noon restricted to visitors.
- Evening from 04:00 pm to 06:00 pm visiting hours, without the visitor's card the visitor is not allowed inside.
- In case of critical case if the case prognosis is bad, with the permission of the treating physician 3 or 4 attendants can be allowed.
- The security should maintain IN and OUT register.
- Alcohol beverages, cigarettes, gutkha, khaini, coconuts and food item in plastic covers are not allowed in the hospital premises.

Dos

- Ask the patient permission to visit before the visitors arrive
- Turn of the cell phone or keep them in vibration mode
- Stay for a short time
- Leave the room if the doctor arrives to examine or talk to the patient.

Don'ts

- Do not enter the hospital, if you have any symptoms that could be contagious like cold, flu, etc.
- Do not smoke, chew tobacco/narcotics, or drink alcohol in the hospital premises.
- Children are not allowed for visiting.
- Don't argue/ Don't Shout / fight with security guards, they are only doing their duty.

References

1. "Zero Pending and Daily Disposal" Office Work Procedures for Government and Semi-Government Offices. Date: 15 February, 2018
2. Indian Medical Council Rules, 1957 No F.5-2/57-MI, Ministry of Health and Family
3. Welfare, Government of India, New Delhi, 16th April 1957
4. Indian Public health Standards, Ministry of Health and Family welfare, Government of India, 2022
5. National Quality Assurance Standards, Ministry of Health and Family welfare, Government of India, 2020
6. Surakshit Matritva Ashwasan (SUMAN) Standard Operating Guidelines, Ministry of Health and Family welfare, Government of India, 2020
7. Labour Room Quality Improvement Initiative, Ministry of Health and Family welfare, Government of India, 2017

CHAPTER XVIII

MEDICAL LAWS, RULES & ACTS

Hospital staff, working in hospital needs the knowledge of laws, acts & ethics related to medical field as they are dealing with various cases & MLC. For ready reference, for hospital administrates & working doctors following important acts, ordinance and rules are enlisted:

Sr.No	Name of Act/Rules	Year/Amendment
1	Indian Medical Council Act	1956
2	Professional conduct, etiquette and ethics) Regulation	2002
3	Maharashtra Medical Council (MMC) Act	1965
4	Drugs and cosmetic Rules	1945
5	Drugs and cosmetic Rules (Amendment)	2018
6	Drugs and Cosmetic Act	1940
7	Drugs and Cosmetic Act (amendment)	1998/2005
8	Pharmacy act	1948
9	PCPNDT Act (Pre- Conception and Pre-natal Diagnostic Techniques)	1994
10	PCPNDT Act (Pre- Conception and Pre-natal Diagnostic Techniques) (Amendment)	2003
11	Pre conception and prenatal diagnostic techniques (prohibition of sex selection) Rules (Amendment)	1996/2002
12	Medical Termination of Pregnancy (MTP) Act and rules	1971/1997
13	Medical Termination of Pregnancy (MTP) Act (Amendment)	2022
14	Transplantation of human organ Act /Rules	1994/1995
15	The Epidemic disease Act	1897/2020
16	The Epidemic disease Act (Amendment)	2021
17	Maharashtra Essential service maintenance Act (MESMA)	2011
18	Biomedical Waste management handling rules	2016

19	Biomedical Waste management handling rules (Amendment)	2018
20	Radiation protection rules	1971/2001
21	Disaster management Act	2005
22	Charitable and religious trust Act	1920
23	Fire safety rules	1987/2006
24	Maharashtra Nursing homes registration Act	1949/2005
25	Maharashtra Nursing homes registration Act (Amendment)	2021
26	Right to information act (RTI)	2005
27	Consumer Protection Act and Medical profession	1986
28	Food Safety & Standard Act	2011
29	Clinical Establishments (Regulation&Registration) Act	2010
30	Mental Health Act	1987
31	Mental Health Act (Amendment)	2017
32	Blood Bank regulation under Drugs and cosmetic (2nd amendment) Rules	1999
33	Protection of Human right Act	1993
34	Radiation protection Rules	1971
35	Prohibition of smoking in public places Rules	2008
36	Birth & Death & Marriage registration Act	1986
37	The Prohibition of sexual harassment of women at work place Act	2010
38	Atomic Energy Radiation protection Rules promulgated under Atomic Energy act 1962	2004
39	Central excise Act(for Permit to use and store sprite)	1944
40	Prohibition of sexual harassment of women at work place bill	2010
41	Maternity benefit (amendment) Act 2008	2008
42	Epidemic disease ordinance 1897	1897
43	Epidemic disease (Amendment) ordinance	2020

CHAPTER XIX

NEW INITIATIVES IN HOSPITAL

19.1 Ayushman Bharat Digital Mission (ABDM)

The Ayushman Bharat Digital Mission (ABDM) aims to develop the backbone necessary to support the integrated digital health infrastructure across the country. It will bridge the existing gap amongst different stakeholders of Health care ecosystem through digital highways. ABDM envisages to create an Inclusive, Accessible, Affordable, and Efficient Digital Health Infrastructure across the Country in a Safe and Time-bound manner.

Aim of Ayushman Bharat Digital Mission (ABDM) is to create digital Health Ecosystem, which will support Universal Health coverage in an efficient, accessible, inclusive and affordable manner to provide data, information and infrastructural services.

Principles of A.B.D.M :

- Privacy and security by design
- User inclusivity
- Voluntary participation
- Wellness Centric
- Single Source of Truth
- Federated Architecture
- Open APIS and interoperability
- Standard frameworks

Benefit of ABDM :

For Citizens

1. Access to all medical records
2. Information and details of doctors, hospitals and labs
3. The choice to consult doctors remotely

For Healthcare professionals and facilities

1. Access to patient's medical history and ensure follow-ups
2. Connect with patients remotely
3. Ease of doing business

For Policy makers

1. Sufficient Information of diseases and needs for policy formulation\
2. Providing monitoring mechanism

19.1.2 Registries for ABDM (Step by Step activity)

Ayushman Bharat Health Account (ABHA)

It is important to standardize the process of identification of an individual across healthcare providers. This is the only way to ensure that the created medical records are issued to the correct individual or accessed by Health Information User through appropriate consent. In order to issue the UHID, the system must collect certain basic details including demographic and location, family/relationship, and contact details. Ability to update contact information easily is the key. The ABHA (Ayushman Bharat Health Account) Number will be used for the purposes of uniquely identifying persons, authenticating them, and threading their health records (only with the informed consent of the patient) across multiple systems and stakeholders.

14 - digit unique identifier to create longitudinal health records of people.

Supported by ABHA App via Goole play store.

A) Health care Professional Registry

- List of verified professionals.
- 14- digit unique no. to professionals.

B) Health Facility Registry

- List of verified Facilities
- 12- digit unique No. to facilities

C) Drug Registry

- List of verified drugs
- Unique code to each strip

Health Records Linkage

1.Scan and Share token generation

2.Share Scan and Implemented facilities

19.1.3 ABDM Adoption in Private Sector:

For ABDM adoption among private facilities and professionals, microsites have been created, currently we have 10 microsites in Maharashtra and will extend it to other potential areas also. Participation of development partners & interfacing agencies is being taken for implementation.

At present Maharashtra rank 2nd in ABHA CARD creation, 3rd in Health facilities registration & 6th position in Registration of Health Professionals.

19.2 e- Sushrut in Hospitals (Hospital Management Information System - HMIS)

e-Sushrut (C-DAC's Hospital Management Information System (adopted by CHS Maharashtra For State Wide Digitization of Health Service in 36 DH and 710 PHC's) is a major step towards adapting technology to improve healthcare. HMIS incorporates an integrated computerized clinical information system for improved hospital administration and patient health care.

This is digital transformation of Hospital HMIS, starting from registration counter. The patients are being registered, admitted, and discharged and even transferred to another hospital through this system.
HMIS will connect all sections of Hospital online.

There are total 20 Modules: -

a. Registration
b. Emergency
c. OPD
d. ADT
e. Investigation
f. Blood Bank
g. Billing
h. Enquiry
i. Human Resource
j. Transport
k. Operation Theater
l. Service Area
m. IPD
n. B Med,
o. Laundry
p. Inventory
q. MRD
r. BMW
s. CSSD
t. Diet Kitchen
u. Global

All the 20 modules are operational in both the pilot hospitals Civil Hospital Alibag & RRHNashik hospital. Patient Investigation details of various departments are being recorded in the application.Applicablebilling is being done through the application. Blood bank information, medicine stock, OT record etc. arebeing recorded in the application. The related summarized reports with real-time data have been designEdand shown through the Dashboard in the application

MoU is signed with CDAC toinitiate the work on 8th Dec 2021 for the same. e-Sushrut application will be rolled out in 746 healthfacilities under this MoU.

19.2.1 ABDM & e-Shushrut

- Ayushman Bharat Health Account (ABHA) or Health ID is an initiative of the Indian

government under the Ayushman Bharat Digital Mission (ABDM) for Indian citizens to establish a centralized database of all their health-related data.

- e-Sushrut Maharashtra application compliance with Ayushman Bharat Digital Mission (ABHA Id).
- By using ABHA Scan & Share, Patient can Skip long queue & get his case paper instantly through token number.



19.2.2 Requirement for e-Sushrut:

1. 20 Module software
2. Hardware & Networking
3. Human Resources
4. Training of e-Sushrut HMIS software
5 Linkage to National Health Registry for data store through Scan & share

19.2.3 Implementation Phases:

1. Civil Hospital Alibaug & RRH Nashik hospital--- All 20 modules operational
2. District level Hospital --- Hardware and Networking establish Registration and Emergency Module started. Some of district hospital advanced to 16 module operational stage

Status of District level Hospitals: -

- Training for all modules has been conducted for all district level hospitals.
- Currently we have 31DH level hospitals,3 are handed over to medical college and 2 hospitals are shifted to NIC Next Gen application
- Other Hospital--- 710 institution started Registration module

Status of other Hospitals (SDH,RH,PHC&HWCof 6 Districts) :

- CDAC Team visited SDH100, SDH50, RH, HWC from Nashik & Raigad districts & PHC from Pune district to collect sample master data for configuration.
- Configuration of 2 modules(Registration &Emergency) has been completed for all the 710 hospitals from 6 Districts i.e,Amravati,Aurangabad,Bhandara,Nashik,Pune,Raigad .
- Out of 710 hospitals 689 hospitals have started using registration module (at least one)

- These 689 hospitals include SDH100,SDH50,RH,PHC and HWC from 6 districts.
- Review Meetings were held for all the 36 DH level hospitals to check the status of work completed in the given timeline.
- Configuration of ADT and Investigation modules is completed.
- Users are created for all the710 institutions for Registration and Emergency modules.

19.3 Green Hospital concept

WHO defines a sustainable health care facility as one that "improves, maintains, or restores health while minimizing negative impacts on the environment and leveraging opportunities to restore and improve it, to the benefit of the health and well-being of current and future generations."

Green hospital is a hospital that improves people's health by continuously reducing environmental impacts on sustainability and meets its share of the burden to disease.

Definition: A Green Hospital Building can be defined as one, which enhances patient well-being, aids the curative process, while utilizing natural resources in an efficient environment-friendly manner.

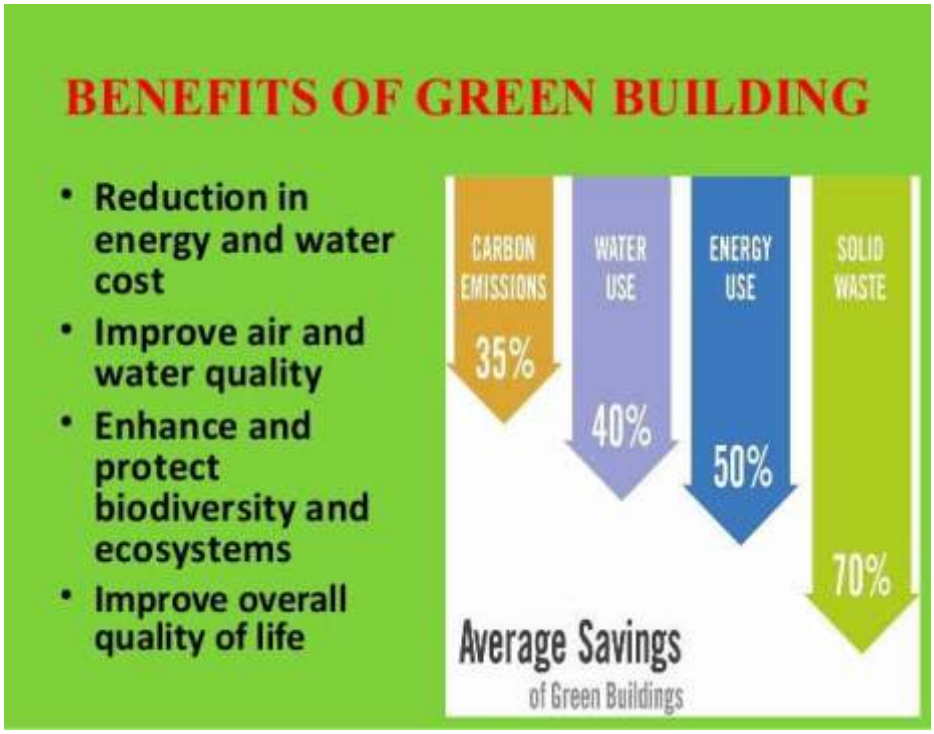
Make your hospital go green (sustainable health care facility) by using number of strategies.

Parameters :

- Integration of renewable energy sources: Energy efficient lighting systems and appliances, Maximize daylight, use of low energy consumption ,use of sensors, use of minimum 3 star rating from BEE proper calibration of devices
- Water Conservation methods: Rainwater harvesting and reuse, efficient designing of plumbing fixtures, No leaks and drips.
- Air Quality control: monitoring standards of temperature, Humidity , particulate matter and gas quality levels , Should have proper ventilation.
- Indoor air quality: avoiding use of fossil fuel, air filtration devices use
- Use of eco-friendly sustainable raw materials.
- Implementation of daylighting solutions & Use of passive solar design principles
- Inclusion of vegetation and green spaces
- Installation of cool or green roofs
- Site selection: soil erosion free, resilient to flood, construction to reduce noise pollution, air pollution, airborne dust generation
- Transportation: Use alternative fuels for hospital vehicle fleets; encourage walking and cycling to the facility; promote staff, patient and community use of public transport; site health-care buildings to minimize the need for staff and patient transportation
- Food: provide sustainably grown local food for staff and patients.
- Waste: Reduce, re-use, recycle, compost; employ alternatives to waste incineration.
- Biomedical Waste Management
- Green Housekeeping : High level of Hygiene and sanitation, Effective and Efficient cleaning Methods, Use of non-toxic cleaning solutions, Waste water treatment System (STP and ETP… Sewage and Effluent water treatment plants.)

- Sustainable material procurement practices: Environmentally preferred Purchasing (EPP). Green building material, products & equipments.

Benefits of Green Hospital:
Sustainable health care design ultimately aims to reduce the overall environmental impact of the facility itself while at the same time improving social equity, patient comfort, and the productivity of health care providers.



Reference :

1. CHS public Health Dept DHS/Desk 3/Table-14/esushrut/Expansion/Training/09/19)
2. CHS public Health Dept DHS/Desk 3/Table-14/esushrut/Networking/2313-14/2023 dated 21/03/2023
3. CHS public Health Dept DHS/Desk 3/Table-14/esushrut/ECRP/RH/Purchase/9966-67/04/09/2023
4. CHS PHD/Desk3/Te-14/PIP-22-24-HMIS/1226-1242/17/01/2024

ANNEXURE DETAILS PART B

Chapter I — **Hospital pharmacy and Dispensing**
Annexure : 1.1 — Equipment Norms

https://drive.google.com/file/d/1u0yyjWkwsgUNpQhXGEgv1R_YkOm-ifa2/view?usp=drive_link

---

Chapter II — **Kitchen and diet**

Annexure : 2.1
प्रस्तावित प्रमाणित आहार (प्रवर्ग - स्तनपानावरील शिशुचा आहार (आय.बी.एफ.))
प्रस्तावित प्रमाणित आहार वाटप विवरण
(प्रवर्ग - स्तनपानावरील शिशुचा आहार (आय.बी.एफ.))

Annexure : 2.2
प्रस्तावित प्रमाणित आहारद्य(प्रवर्ग - स्तनपान उपलब्ध नसलेल्या शिशुचा आहार)
प्रस्तावित प्रमाणित आहार वाटप विवरण(प्रवर्ग - स्तनपान उपलब्ध नसलेल्या शिशुचा आहार)

Annexure : 2.3
प्रस्तावित प्रमाणित आहार (वर्ग - बालरुग्ण संपूर्ण आहार (बा.सं.आ.))
प्रस्तावित प्रमाणित आहाराचे विवरण (प्रवर्ग - बालरुग्ण संपूर्ण आहार (बा.सं.आ.))

Annexure : 2.4
प्रस्तावित प्रमाणित अतिप्रथिनयुक्त आहार(बालरुग्ण, कर्करुग्ण, जळीतरुग्ण)
खाद्यपदार्थाचे प्रमाण (ग्रॅम)
स्तनपान असलेले व नसलेल्या बालकांचा शस्त्रक्रीये नंतरचा पातळ आहार (० ते १२ महिने)

Annexure : 2.5
स्तनपान असलेले व नसलेल्या बाळांचा शस्त्रक्रिये नंतरचा पातळ आहाराचे विवरण
(० ते १२ महिने) IBF & ITF
प्रस्तावित प्रमाणित आहार प्रवर्ग - बालरुग्ण पातळ आहार (बा.पा.आ.)

Annexure : 2.6
प्रस्तावित प्रमाणित आहारशिशुचा संपूर्ण आहार (नविन)
प्रस्तावित प्रमाणित आहार(प्रवर्ग - ७-१२ महिने शिशुचा संपूर्ण आहाराचे विवरण (नविन))

Annexure : 2.7
प्रस्तावित प्रमाणित आहार(प्रवर्ग - प्रौढ रुग्ण (पुरुष, स्त्री))
प्रस्तावित प्रमाणित आहाराचे विवरण(प्रवर्ग - प्रौढ रुग्ण (पुरुष , स्त्री))
प्रस्तावित प्रमाणित अतिप्रथिनयुक्त पुरक आहार (प्रवर्ग प्रौढरुग्ण, कर्करुग्ण, जळीतरुग्ण)
प्रस्तावित प्रमाणित आहारप्रवर्ग - पातळ आहार,ताक आहार व हलका आहार रुग्ण
(पुरुष व स्त्री) शस्त्रक्रिया, क्षयरोग, कर्करोग (अतिदक्ष)

Annexure : 2.8
प्रस्तावित प्रमाणित आहार(प्रौढ मनोरुग्ण (पुरुष, स्त्री))

Annexure : 2.9
प्रस्तावित प्रमाणित आहाराचे विवरण(प्रवर्ग - प्रौढ मनोरुग्ण (पुरुष , स्त्री))

Annexure : 2.10
उपचारात्मक आहार (नविन)प्रस्तावित प्रमाणित आहार (प्रवर्ग - प्रौढ रुग्ण - मधुमेह/हदयरोग
(पुरुष, स्त्री))
प्रस्तावित प्रमाणित आहाराचे विवरण (प्रवर्ग - प्रौढ रुग्ण - मधुमेह/हदयरोग (पुरुष, स्त्री))

Annexure : 2.11
प्रस्तावित प्रमाणित आहार(प्रवर्ग - प्रौढ रुग्ण-मुत्रपिंड विकार (प्रथिने-४०ग्रॅम) (पुरुष, स्त्री) डायलिसीस)

Annexure : 2.12
प्रस्तावित प्रमाणित आहाराचे विवरण(प्रवर्ग - प्रौढ रुग्ण - मुत्रपिंड विकार (प्रथिने-४०ग्रॅम)
(पुरुष, स्त्री) डायलिसीसप्रवर्ग - प्रौढ रुग्ण - मुत्रपिंड विकार (प्रथिने-४०ग्रॅम) (पुरुष, स्त्री) डायलिसीस)

Annexure : 2.13
शस्त्रक्रिये नंतर (राईल्स टयुब फीड करीता आहार विषयक पायऱ्या)
प्रस्तावित प्रमाणित आहाराचे विवरणप्रवर्ग - राईल्स टयुबफीड (नमुना आहार)

Annexure : 2.14
(हा आहार शस्त्रक्रियेच्या तिसऱ्या दिवसांपासुन देता येवु शकेल)
पोषण पुनर्वसन केंद्रातील बालकांचा आहार (F ७५): (सुरुवात आहार'-

Annexure : 2.15
(बालकांना स्थीर करण्यासाठी आणि वाढीसाठी))
पोषण पुनर्वसन केंद्रातील बालकांचा आहार (पुनर्वसनस्थिती (कॅचअप) आहार?

Annexure : 2.16
(२ ते ७ दिवसानंतर देण्यात येणारा)
प्रस्तावित प्रमाणित आहार (प्रवर्ग बालरुग्ण ताक आहार विवरण (अतिसार रुग्ण))

https://drive.google.com/file /d/1CFcuPRk6RTzI6pA0m4O9UJgCYVlUYVrv/view?usp=drive_link

Chapter III		**Stocks & Stores**
Annexure Volume II: 3.1		Preferment of Claims Against Railway
Annexure Volume II: 3.2		Preferment of Claims Against Railway Accompaniments to Government Circular, Finance Department, No. AIF-1763/ XX;, Dated 8th May 1963.
Annexure Volume II: 3.3		Decentralization and Delegation Of Powers in respect of Repairs condemnation and replacement.

https://drive.google.com/file/d/15pPssuTPdcvf0g76fMqd-LQV0Lmt4E-f/view?usp=drive_link

---

Chapter IV	**Linen**
Annexure 4.1	List of Linen required for Hospital Set up
Annexure 4.2	Register for Recovery
Annexure 4.3	Norms of linen
Annexure 4.4	Do's and Don't

https://drive.google.com/file/d/1PNLJzQoTuSkt3Cv0DQ_aZ1zipdqC1dT6/view?usp=drive_link

---

Chapter V	**MEDICAL RECORDS AND HOSPITAL STATISTICS**
Annexure : 5.1	Retention Period of Medical Records
Annexure : 5.2	Different Indicators are developed to analyse hospital Data.

https://drive.google.com/file/d/16QCHFv8LKb5PLs04Uw5cmhsc6gyC29af/view?usp=drive_link

---

Chapter VI	**AMBULANCE SERVICES (Include EMS)**
Annexure 6.1	Tablet/Mobile in Vehicle
Annexure 6.2	Equipment maintenance program
Annexure 6.3	Daily equipment checks
Annexure 6.4	Vehicle maintenance record
Annexure 6.5	Accident Report Form

https://drive.google.com/file/d/1ABCvF8gOu9CAP2nctpOwFcd8nIMzJYpY/view?usp=drive_link

---

Chapter VII	**Pradhan Mantri Jan Arogya Yojana and Integrated Mahatma Jyotirao Phule Jan Arogya Yojana**
Annexure 7.1	List of 1356 procedures under MJPJAY AND PMJAY
Annexure 7.2	List of 119 Treatments compulsory in Government Hospitals under MJPJAY and PMJAY
Annexure 7.3	List of 262 procedures follow up treatments under MJPJAY and PMJAY
Annexure 7.4	List of 184 Road Traffic Accident treatment
Annexure 7.5	Claim ProcessMonitoring and review procedure of Medical Co-ordinator
Annexure 7.6	

https://drive.google.com/file/d/16QCHFv8LKb5PLs04Uw5cmhsc6gyC29af/view?usp=drive_link

Chapter VIII	**HEALTH CARE MANAGEMENT INDISASTER& TRUAMA CARE UNITS(TCU)**	
Annexure 8.1	Design and Safety of hospital building	
Annexure 8.2	Fire extinguisher	
Annexure 8.3	Staffing pattern (ref as per GR)	
Annexure 8.4	List of Equipment/Instruments for TCU	
Annexure 8.5	Disaster Preparedness at MEMS	

https://drive.google.com/file/d/1ronKDIC_2vQPGlURDHazz0DSOXfhLKeB/view?usp=drive_link

---

Chapter IX	**HOSPITALS AND FAMILY WELFARE**	
Annexure 9.1	Sterilization Services in Camp Mode	
Annexure 9.2	Human Resource Development for FDS in Male and Female Sterilizations	
Annexure 9.3	Quality Assurance in Sterilization Services	
Annexure 9.4	Family Welfare Indemnity Scheme	

https://drive.google.com/file/d/1AKbf5TurgBAxUrPo-NuK62w3uOAM-Y6o/view?usp=drive_link

---

Chapter X	**OFFICE ADMINISTRATION**	
Annexure 10.1	Zero Pendancy and disposal of the record, Government of Maharashtra, GAD, G.R. dated -15/02/2018.	
Annexure 10.2	विभागांतर्गत निर्लेखित वाहने,रुग्णालयीन आणि शितसाखळी उपकरणे व इतर साहित्य यांची ई-लिलावाद्वारे विल्हेवाट लावण्यासाठी NIC कडील ई-लिलाव आज्ञावली या संगणक प्रणालीचा वापर करण्याबाबत.शा.नि.क्र.संकीर्ण - २०१६/प्र.क्र.१२१/आरोग्य-४,दिनांक.१८ ऑक्टोबर,२०१७.	
Annexure 10.3	उपसंचालक,आरोग्य सेवा (परिवहन),पुणे,निर्लेखित वाहने ,साहित्याची हातची किंमत ठरविणे, ई-लिलाव करणे./८८७६-९०५०/२०१७,दिनांक.२७ डिसेंबर,२०१७	
Annexure 10.4	आरोग्य सेवा संचालनालय (महाराष्ट्र शासन), क्र.संआसे /जड संग्रह वस्तू निर्लेखण परिपत्रक ४-३,२०१४, दिनांक.११ ऑगस्ट २०१४.	
Annexure 10.5	निरुपयोगी , दुरुस्ती ण होण्याजोग्या अथवा गरजेपेक्षा अतिरिक्त असलेल्या शासकीय भांडार वस्तू , यंत्रसामग्री ,वाहने इत्यादीची लिलावाने विक्री करण्याची व्यवस्था, शासन परिपत्रक क्र.डीएफपी-१०१६/प्र.क्र.०७/१६/विनियम,दिनांक.२२,जून,२०१६	
Annexure 10.6	संगणक ,प्रिंटर व इतर आगटी उपकरणाचे आयुष्मान (Life) ठरविणे व कालबाह्य झालेल्या उपकरणाची विल्हेवाट लावणेबाबत.शा.नि.क्र.मातांस/नस्ती ०७/प्र.क्र.८९/३९, मंत्रालय,मुंबई दिनांक.०१ ऑगस्ट २०११.	
Annexure 10.7	आरोग्य सेवा संचालनालय (महाराष्ट्र शासन), क्र. संआसे/रुग्णालयीन व शीतसाखळी उपकरण निर्लेखन- जाहीर लिलाव कार्यवाही/ परिपत्रक/दिनांक.१८ जानेवारी २०१२.	

https://drive.google.com/file/d/1-191zRVQjxswxvHHiazYV-gwDzMjOMyK/view?usp=drive_link

Chapter XII

STAFF MEETINGS, IN-SERVICE TRAINING AND PERSONNEL MANAGEMENT

Annexure 12.1

Training information HTT

https://drive.google.com/file/d/1ApQB8Ti8q6VFjZfESOyreZSmd-X2BWwv/view?usp=drive_link

---

Chapter XIII

Annexure 13.1

Annexure 13.2

Inspections

HOSPITAL INSPECTION CHECKLIST

Hospital Quick Inspection form

Hospital Daily Monitoring Checklist

https://drive.google.com/file/d/1RngA9-MlLMsaOtmDyIxIhC6DBAnPdjt6/view?usp=drive_link

---

Chapter XIV

Annexure 14.1

Annexure 14.2

Duties of staff members

Job Duties and Responsibilities of Group C

Job Duties and Responsibilities of Group D

https://drive.google.com/file/d/1ymqU03P35_mnULDIEMRfPGkyC7HMcsRI/view?usp=drive_link

CONTRIBUTOR LIST

State Technical Group

1. Dr Nitin Ambadekar, Director Health Services, Mumbai
2. Dr Vijay Kandewad, Additional Project Director, MSACS, Mumbai
3. Dr Sunita Golhait, Jt. Director Health Services (Hospitals), Mumbai
4. Dr Shashikant Shambharkar, Jt. Director (Procurement), Mumbai
5. Dr Kanchan Wanere, Deputy Director of Health Services, Nagpur Circle
6. Dr Purushottam Madavi, Physician, Class I, Daga Memorial Hospital, Nagpur
7. Dr Amod Gadikar, Assistant Director of Health Services, State Family Welfare Bureau, Pune
8. Mr. Jayant G Muley, Assistant Director of Health Services (Transport)
9. Dr Purushottam Nandeshwar, Assistant Professor, SIHFW, Nagpur
10. Dr Shafiya Fatema, Assistant Professor, SIHFW, Nagpur
11. Dr Supriya Deshmukh, Principal, Health and Family Welfare Training Centre Kolhapur
12. Dr Satishkumar Solanke, Additional Civil Surgeon, Gadchiroli
13. Dr Prashant Ghodam, Resident Medical Officer (Outreach), Amaravati District Hospital
14. Dr. Pankaj Gajare, Pediatrician, Class I, Nashik District Hospital
15. Dr Sarita Thorat, Medical Superintendent, Khupere RH, Kolhapur
16. Dr Sunanda Gaikwad, Medical Superintendent, Panhala RH, Kolhapur
17. Dr Sheetal Mohane, Medical Officer, Nutrition Bureau, Nagpur
18. Mr. Namdev More, Chief Administrative Officer, DDHS office Kolhapur
19. Mr. Rajdeep Kulkarni, Chief Administrative Officer, NVBDCP, Pune
20. Mr Sandesh Balwant Kothawade, Senior Pharmacy Officer, Procurement Cell, DHS Mumbai
21. Mrs Kalpana Barde, Nutrition Officer, Nutrition Bureau, Nagpur
22. Mrs Amita Pillewan, Nutrition Officer, Nutrition Bureau, Nagpur
23. Mr. Abhishek Gosavi, Staff Nurse, Nashik District Hospital
24. Mrs. Gauri Pise, Senior Pharmacy Officer, DDHS Office, Pune
25. Mr Murli Peddishetty, Senior Pharmacy Officer, Pune District Hospital
26. Mrs Ranjita Sharma Chobe, Dietician, Dhule District Hospital
27. Mrs Ajeeta Joshi, Statistical Officer, Thane District Hospital

SHSRC Technical Group

1. Dr. Sanjay Deshmukh, Deputy Executive Director, State Health System Resource Center, Maharashtra
2. Dr Swapnil Nimkar, Sr. Consultant-Research & Documentation, State Health System Resource Center, Maharashtra
3. Dr Geetanjali Ghule, Programme Manager, State Health System Resource Center, Maharashtra.

Technical Experts Group (Ex Service)

1. Dr Satish Pawar, Retd. Director of Health Services, Mumbai & Additional Mission Director (NUHM), Mumbai
2. Dr Archana Patil, Retd. Additional Director Health Services, State Family Welfare Bureau, Pune
3. Dr Suresh Navade, Retd. Director, State Institute of Health & Family Welfare, Nagpur
4. Dr B D Pawar, Retd Jt. Director Health Services NVBDCP
5. Dr Sanjay Jaiswal, Retd Deputy Director Health Services, Nagpur Circle
6. Dr Riyaz Farooqui, Retd. Deputy Director of Health Services, Akola
7. Dr Bahubali Nagaonkar, Retd Assistant Director Health Services, SHAS, Mumbai
8. Dr Ulhas Marulkar, Retd. Assistant Director Health Services (Hospitals), Mumbai
9. Mr Mahajan, Retd Assistant Director Health Services (Transport)
10. Dr Devendra Paturkar, Retd Civil Surgeon, Nagpur
11. Dr Ganesh Phadnis, Retd Civil Surgeon, Parbhani
12. Dr Sandhya Dange, Retd. Additional Civil Surgeon, Daga Smriti Memorial Hospital, Nagpur
13. Dr P G Darshane, Retd. Medical Superintendent, Tal. Manchar, Pune
14. Smt. Pratibha Gosavi, Retd. Matron, Nashik District Hospital
15. Smt. Shalini Udhiwal, Retd Assistant Matron, Nashik District Hospital
16. Smt. Shama Mahulikar, Retd Tutor, Nursing Training College, Nashik
17. Mr Rajan R. Inamdar, Retd Tutor, Nursing Training College, Nashik





सार्वजनिक आरोग्य विभाग
महाराष्ट्र शासन

This publication can be obtained from:

Arogya Bhawan,St George Hospital, P D'Mello Rd,
Chhatrapati Shivaji Terminus Area, Fort, Mumbai, Maharashtra 400001
Government of Maharashtra