Standard Operating Procedures

For Hospitals in Chhattisgarh

Department of Health and Family Welfare,
Government of Chhattisgarh

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CHAPTER 1

Infection Control Services and Biomedical Waste Management

Purpose/Objective:

To provide safety for patient and employee within the hospital environment through an infection control program.

Scope and Objectives:

As stated above, the goals of the hospital infection control programme are to prevent or minimize the potential for infections to patients as well as to staff. The programme itself will have the following objectives & scope.

- To develop written policies, procedures and standards for cleanliness, sanitation and asepsis in the hospital.
- To interprete, uphold and implement the hospital infection control policies and procedures in specific situations.
- To provide surveillance for different types of infections.
- To review and analyze infections, those occur, in order to take corrective steps.
- To develop preventive measures designed to control, prevent or minimize the risk of nosocomial infections.
- To develop a mechanism to supervise infection control measures in all phases of hospital activities.

Activities and Responsibilities

Activities	Responsibility
Formation of Hospital Infection Control Committee (HICC) A committee formed under the Chairmanship of Civil Surgeon will be responsible for Hospital Infection Control Programme. Committee will consist of the following: Civil Surgeon — Chairman RMO — Member Secretary Specialist from Each Department — Member Hospital Consultant — Member Matron — Member OT Incharge — Member Pathologist/Senior Lab Technician — Member Pharmacist — Member	Civil surgeon
Roles and Responsibilities of HICC: The HICC will supervise the implementation of the hospital infection control programme. • To ensure the proper conduct of sterilization and disinfection practices • Ensure that the Bi Medical waste management is being carried out.	HICC Members

• Conduct Internal Surveillance of Hospital acquired infections. • Develop and implement preventive and corrective Programmes in specific situations where infection hazards exist. • Advice the Medical Officers on matters related to the proper use of antibiotics, to develop antibiotic policies and to recommend remedial measures when antibiotic resistant strains are detected. • Review and update hospital infection control procedures from time to time. • Help provide employee training regarding matters related to hospital acquired infections. • The Hospital Infection Control committee Review Meetings should be held every month. • To act on recommendations related to infection control, received from the administration, departments, services and other hospital committees • To analyze and interpret data arising out of surveillance and reporting to recommend remedial measures and to ensure follow up action.	

Format For Review recording of Minutes of Meeting and Review

Date of Meeting: ……..

Members Present:
1……
2……
3……

Agenda of Meeting:
……..

Date	Issues Discussed	Action Taken	Remarks

Signature of Civil surgeon

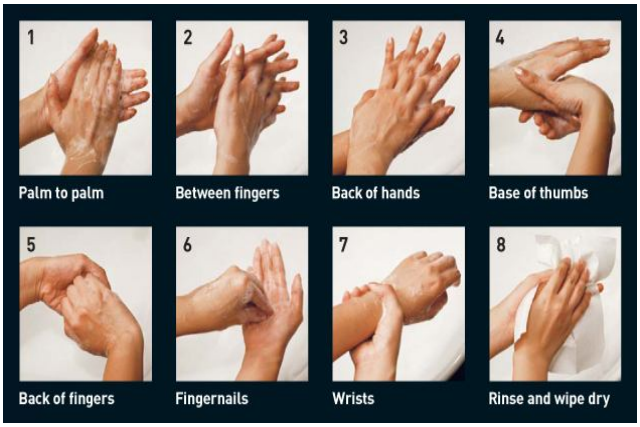
Personnel Safety and Universal Precautions

In a hospital setting personnel protection should be considered as the utmost priority. The principle of universal precautions is to provide a barrier between the HCW and the patient's body substance when they have to come in close proximity. Blood, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, salival in dental procedures, semen, vaginal secretions, any body fluid that is visibly contaminated with blood; any unfixed tissue or organ from a human ; HIV containing culture medium or other solutions; blood or other tissues infected with HIV

or hepatitis B, C or non A non B are considered as the source of potential infection ,for which following Precautions and instructions should be followed:

Barrier	User of Barrier
Hand washing	Before and after patient contact after using gloves, immediately after contact with blood and care workers who have exudative lesions or weeping dermatitis should refrain from all patient care activities that involve direct contact and from handling patient care equipment.
Masks and other protective equipment such as face shields and goggles.	When one is likely to be splashed in the face with infective material, which may lead to contamination of the eyes, nose or mouth.
Gloves	When direct contact with blood and body fluids, mucous membranes non-intact skin surfaces or infectious material is anticipated when performing vascular access or other invasive procedures and when handling specimens, cultures, or tissues that are visibly contaminated with blood or other infectious material. . Hands must be washed each time gloves are removed. Those with non intact skin must wear gloves when indirect handling of infectious material is a possibility.
Protective clothing Gowns, lab coats, caps, hoods, shoe covers, boots, or other such paraphernalia.	When the HCW is likely to be soiled by the splattering of infectious material. These must be removed and discarded properly immediately after use.
Handling Needles and small sharps	Never recap or bend the needles unless by using an instrument or by no touch technique. Dispose of used needles and disposable small sharps in puncture proof containers that are located as close to the area of use as possible.

Universal Precaution Instruction



Blood, body fluids, synovial fluids and tissue of all patients are considered potentially infectious and therefore should be handled accordingly. This is also called as standard precautions.

- Wash hands before and after all patient/specimen contact
- Handle blood of all patients as potentially infectious
- Always use gloves for contact with blood/body fluids
- Place used syringes in puncture proof containers
- Do not recap or manipulate needles
- Wear protective eye-wear and masks if splash/splatter of blood/body fluids is possible e.g. during oral surgery, bronchoscopy etc.
- Wear gowns and aprons when splash with blood/body fluids is expected
- Lab staff should not use mouth pipette
- Wear masks while examination and Rx of TB patients
- When there is any breach in skin, seal it with strongly water proof adhesive tape

Protocols for Gloves

- Use of Disposable gloves to be ensured
- In high risk cases; double gloving should be done; routine cases single
- Gloves should be changed if duration of procedure/operation is > 3 hours
- Any pair of gloves can be used for total time of 3 hours
- Between patients; gloved hands should be disinfected for at least 30 seconds
- Surgical hygienic hand (w) should be done before and after use of gloves
- Check gloves for gross defects before putting on Cover cuts with waterproof dressing before gloving
- Discard gloves immediately on suspicion of puncture

Protocols for Masks

- Masks are mandatory for infections patients esp. airborne infection
- Ideally masks should be disposable; if not cotton masks can be used
- Masks should fit properly and cover both mouth and nose.
- Masks should be changed after every proc/surgery lasting > 20 minutes
- Cotton masks should be disinfected with liquid bleach before washing and reuse

Safe Handling Of Sharps

- Pass syringes and needles in a tray, cut it with electric /manual needle cutlers after use
- Put needle and syringes in a puncture proof white container , containing 2% hypochlorite solution
- Remove cap of needle near the site of use
- Pick up open needle from tray/drum with forceps
- Destroy syringes by burning their tips/cutters not available
- Never pass syringe and needle on directly to next person
- Do not bent/or break used needle with hands
- Never test the fineness of the needle's tip before use with bare or gloved hand
- Never pick up open needle by hand
- Never dispose it off by breaking it with hammer/stone
- Always dispose of your own sharps, into a Sharp pit
- During exposure-prone procedure, the risk of injury should be minimized by ensuring that the operator has the best possible visibility, e.g. by positioning the patient, adjusting good light source and controlling bleeding

Infection Control in the facility and the High Risk Areas:

Basic minimum sanitation and hygiene, with proper cleaning of hospital twice a day (once in the morning and once in the Evening) with disinfectants should be practiced. Apart from this specific attention should be provided to the High risk areas in the hospital to ensure optimum infection control n the hospital. The High Risk Areas in the Hospital include:

- Operation Theatre
- Labor room
- Intensive care unit/Burn Wards

Activities	Responsibility
Following procedures should be followed for ensuring optimum infection control in the High risk areas: • **The floor of the OT and labor room should be cleaning regularly twice every day , and after each procedure performed with use of proper disinfectant** • **The floor should preferably of marble, or rubber painted to prevent accumulation of germs in the gaps and facilitate dryness.** • **Unauthorized entries in the OTs and Labor room should be restricted and Direct access of attendants and other patients to these areas should be avoided.** • **Use of personnel protective gears should be encouraged, while working inside the OT, LR .** • **All the instruments used should be properly sterilized, either by autoclaving or using manual sterilizers.** • **Separate entry and exit routs for patients and waste should be defined to prevent cross infection.** • **Fumigation should be performed at fixed intervals preferably after each procedure.**	Incharge of the respective Department (OT incharge. Matron, etc)

• **Different registers for Autoclaving, fumigation etc to be maintained.** • **Air sampling, environment sampling, swab cultures etc to be performed every month.** • **OT preferably should be without windows to prevent the accumulation of dust and germs.** • **Installation of Air conditions (Exhaust fans, where AC is not available) should be practiced to allow flow of fresh air.**	

Format for Maintenance of Autoclave/Fumigation

S.No	Time	Date	Signature

Guidelines for management of Medical Asepsis

- Remember that thorough hand washing is the most important and basic technique for infection control,
- Always know a client's susceptibility to infection. Age, nutritional status, stress, disease processes, and forms of medical therapy can place clients at risk.
- Recognize the elements of the infection chain and initiate measures to prevent the onset and spread of infection**.**
- Never practice aseptic techniques haphazardly. Rigid adherence to aseptic procedures is the only way *to* ensure that a client is at minimal risk for infection,
- Protect fellow health care workers from exposure to infectious agents. Nosocomial infections occur with greater frequency when clients become exposed to health care workers who are carriers of infection.
- Be aware of body sites where nosocomial infection is most likely to develop. This enables the nurse to direct preventive measures at infection control.

Element Of Infection Chain	Medical Aseptic Practices
Infectious agent **(pathogenic organism capable of causing**	Cleanse contaminated objects, Perform disinfection and sterilization

Reservoir (site or sources of microorganism growth)	Eliminate sources of body fluids and drainage. Bathe with soap and water. Change soiled dressings. Dispose off soiled tissues, dressings, or linen in moisture resistant bags, Place syringes, uncapped hypodermic needles, and intravenous needles in moisture-resistant, puncture-proof containers. Do not leave bottled solutions open for prolonged periods. Keep solutions tightly capped. Empty and dispose off drainage suction bottles **according to agency policy.**
Portal of exit (means by which microorganisms leave site)	**Respiratory** Avoid talking, sneezing, or coughing directly over wound or sterile dressing field. Cover nose and mouth when sneezing or coughing. Wear mask if suffering from respiratory tract infection, **Urine, feces, emesis. and blood** Wear disposable gloves when handling blood and body fluids. Wear gowns and eyewear if there is a chance of splashing fluid. Handle at! laboratory specimens as if infectious.

Biomedical Waste Management

Handling and Segregation of bio-medical waste is done at the point of generation/source and is put into a different color bags in same color bins. The “Bio Medical Waste Management and Handling Rules, 1998” are followed for the proper handling and final disposal of Bio Medical Waste.

Biomedical waste is the leading cause for spreading of nosocombial infections in the hospital. Improper maintenance of Biomedical Waste may lead to increased risk of blood born; air born and needle prick injuries in the Staff as well as the patients and their attendants. For Proper treatment and Disposal of Biomedical Waste in the facility following steps should be ensured.

Nomination of Biomedical Waste Management In-charge:

From within the Hospital Infection Control Committee, one member preferably the Hospital consultant or the Matron should be nominated as the biomedical waste management in charge in the facility.

Roles and Responsibilities of BMW In-charge includes following but not limited to

- Daily inspection of waste segregation and reporting
- Supervising the maintenance of registers
- Ensure availability of equipments like needle cutters, autoclaves and sterilizers, waste carrying trolleys, personnel protective gears (masks, apron , gloves etc) and other materials like bleaching solution or hypohloride solution.
- Ensuring availability of color coded bins and bags as per Biomedical Waste Management and Handling Rules, 1998.

- Formation of Monthly and Annual reports.
- Maintain records about various categories of waste generated in the hospital, if outsourced maintaining the records of the receipts and other documents related to Biomedical Waste Management

Collection Treatment and Disposal of Various Categories of Waste in the Hospital

Segregation, Treatment and Disposal Options			
Colour Coding	**Type of Container**	**Waste Category**	**Treatment and Disposal Options**
Yellow	Plastic Bag – Non Chlorinated	Cat -1 Human Anatomical Waste Cat -2 Animal Waste Cat -3 Microbiology & Biotechnology Waste Cat-6 Soiled Waste	Incineration/ Deep Burial
Blue	Plastic Bag	Cat -7 Solid Waste	Autoclaving / Microwave/ Chemical Treatment(with 1 percent hypochloride sholution or bleaching powder for 4 hrs) and Destruction(mutilation) / Shredding
White/ Translucent	Puncture Proof Translucent Container	Cat – 4 Sharps Waste	Autoclaving/ Microwave/ Chemical Treatment (with 1 percent hypochloride sholution or bleaching powder for 4 hrs) and Destruction / Sharp pits.
Red	Disinfected container / plastic bag	Cat-3 Microbiology & Biotechnology Waste Cat – 6 Soiled Waste Cat-7 Solid Waste	Autoclave/ Microwave/ Chemical Treatment(with 1 percent hypochloride sholution or bleaching powder for 4 hrs)
Black	Plastic bag	Cat-5 Discarded Medicine & Cytotoxic Drugs Cat – 9 Incineration Ash Cat – 10 Chemical Waste (solid)	Disposal in Secured Landfill

Protocols for Mercury Spillage

1. Remove everyone from the area that has been contaminated with mercury.
2. Keep the heat below 20^0 C and ventilate the area.
3. Put on face mask in order to prevent breathing of mercury vapor.
4. Remove all jewelry from hands and wrists.
5. Use Personal Protective Equipment while handling mercury.
6. Cardboard sheets should be used to locate and push the spilled beads of mercury together.

7. Mercury should be placed carefully in a container with some water.
8. Never us a broom or vacuum cleaner.
9. It should be disposed off at hazardous waste facility or given to a mercury-based equipment manufacture.

Protocols for cleaning Spillage of Blood

1. Wear Gloves
2. Pour, without splashing, a disinfectant appropriate for the size and surface contaminated, e.g. Isopropyl alcohol, Dakin's or house hold bleach 1: 100 dil or 1: 10 dilution.
3. Place absorbent paper (e.g. news / tissue paper over the spill. Allow a contact time of 20 minutes.
4. Wipe up the spill. Put absorbent paper in the yellow bag. Wash hands (with gloves on).
5. Remove gloves.
6. Wash hands.

Do's and Don'ts in Bio Medical Waste Management

Do's

1. Segregate waste as soon as it is generated into different categories of waste.
2. Collect the waste in properly labeled specific color coded covered bins.
3. Keep same color bags in the bins.
4. Clean regularly with soap and water and disinfect the bins.
5. Collect the domestic waste (eatables, wrappers, fruit peels, papers etc., in green bin).
6. Use dedicated waste collection bins/trolleys/ wheel barrows for transporting waste.
7. Transport waste through a pre- defined route and time within the hospital.
8. Mutilate and disinfect the needle soon after administration of injection.
9. Mutilate and disinfect solid waste (plastic waste) as soon as it is generated.
10. Always disinfect the sharps and the solid waste with either hypochlorite solution or Bleaching powder before disposing.
11. Disinfect needle and solid waste (plastic) after mutilation.
12. Dispose body parts in yellow bin.
13. Dispose waste within 48 hours.
14. Always use protective gears while handling the waste.

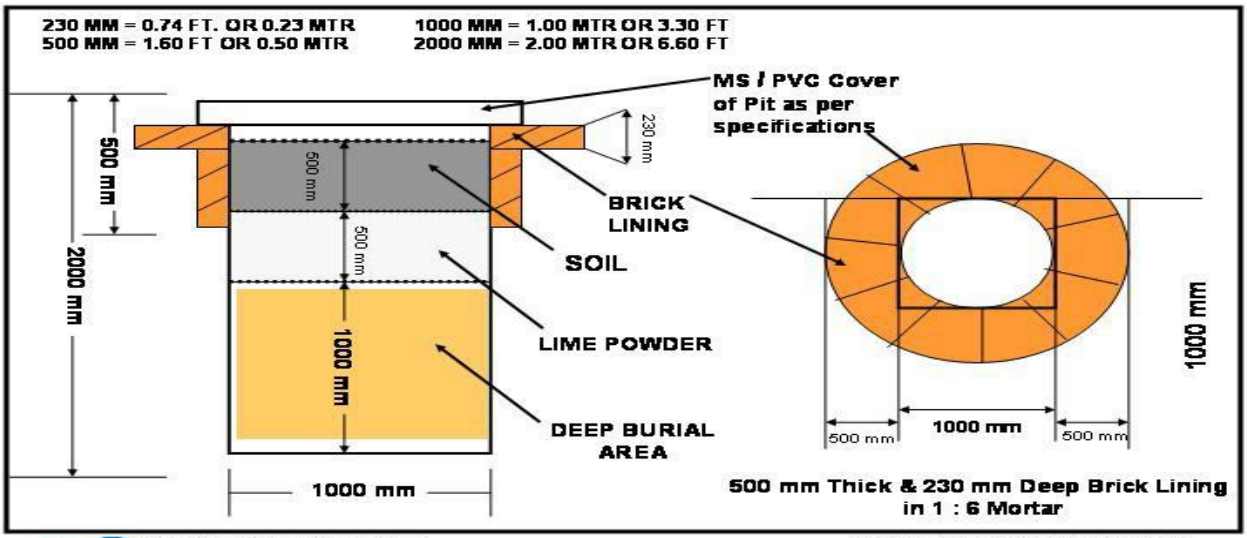
Don'ts

1. Never mix infectious and non- infectious waste
2. Never mix plastic wastes with the waste which goes for incineration.
3. Never overfill the bins.
4. Never store waste beyond 48 hours.
5. There should not be any spillage of waste on the way of transport.
6. Avoid transport of waste through crowded areas.
7. Do not put infectious waste into general waste.
8. Don't dispose the body part into deep burial where population is more than 500000.
9. Don't dispose waste sharps with other wastes.
10. Don't dispose the solid waste and sharp waste without mutilation and disinfection.
11. Overloading of the Bags and the bins should be avoided. Colour coded bags to be replaced when half full.
12. Never drag filled waste liners

Standard For Deep Burial and sharp pit

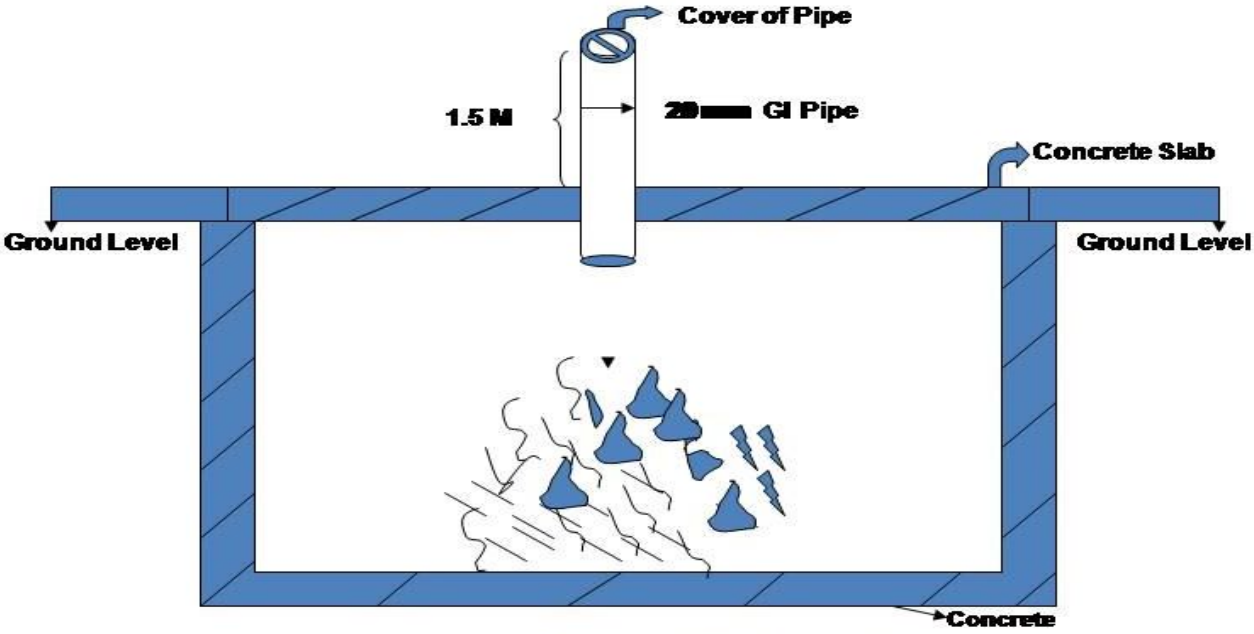
- A minimum of 2x2 of pit should be made.
- The site of the pit should be such that it avoids surface or ground water contamination
- The Pit should be fenced from all the sides and should be covered to prevent entry of steet dogs rodents and other scavengers.
- After every burial the pit should be closed with 10 cm of soil layer and 10 cm of lime layer.
- New pit should be made as soon as the old pit is half fill and should be closed by covering with lime and soil.

DEEP BURIAL PIT SPECIFICATION



SECTION OF PIT
(NOT TO SCALE)

MOUTH OF THE PIT
Approved by: MPPCB (NOT TO SCALE)

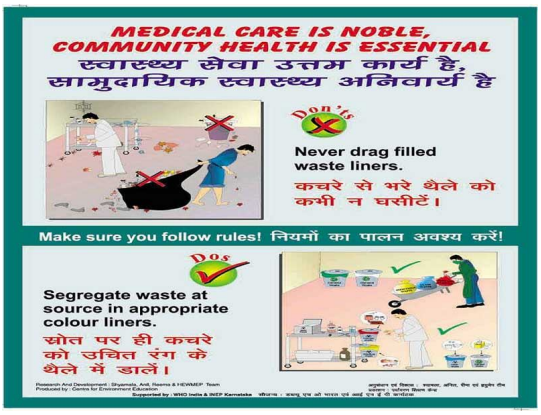


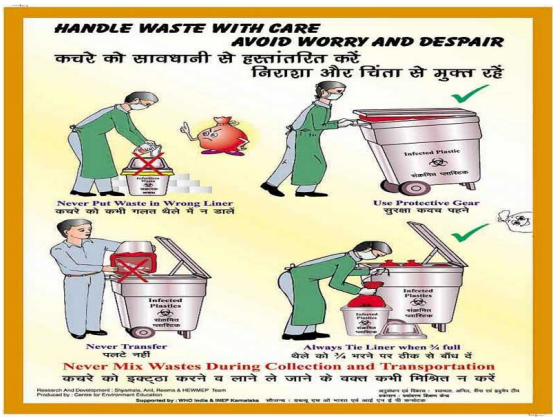
SHARP PIT SPECIFICATION

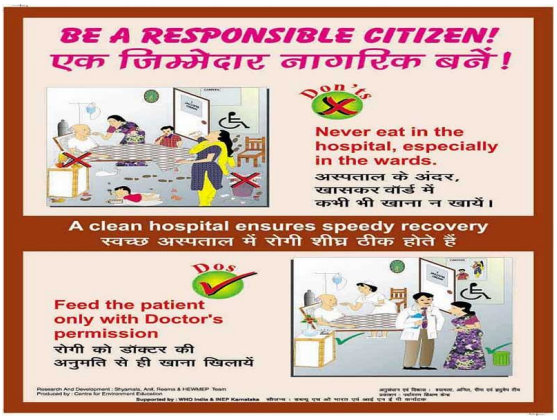
Format For Maintainance of Record of Biomedical Waste Management

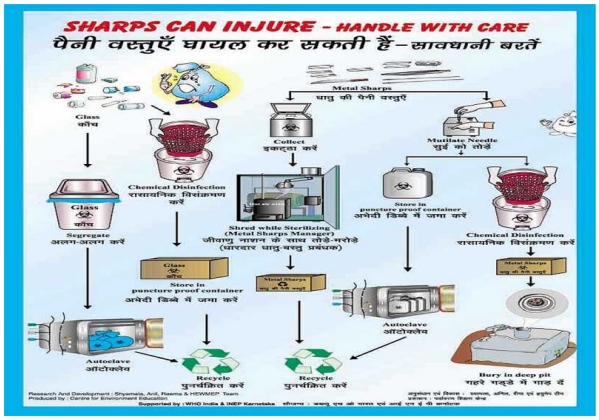
Sl. No.	Date	BMW is handed over to CBMWTF							Signature	
		Yellow Colour		Red Colour		White (PPC)		Total Qty. kg.	TF	HCE
		Nos.	Qty. kg	Nos.	Qty. kg	Nos.	Qty. kg			
1										
2										
3										
4										
Monthly total										
Annual total										

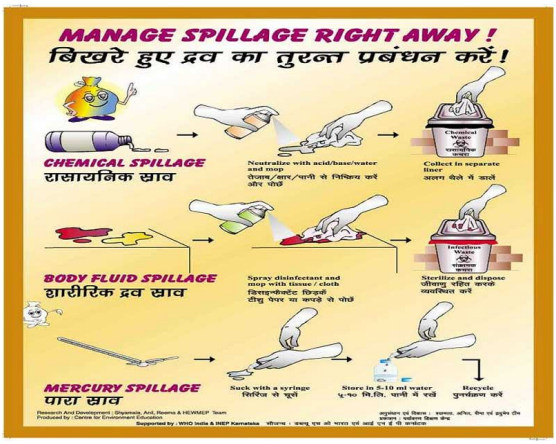
To prepare 1% Hypochlorite solution by Bleaching Powder				
Water in Litres	**Bleaching poweder in Gms**	**Tea spoon (standard 5 gms)**	**Table spoon (Standard 15 gms)**	**Bowl (Standard 30 gms)**
1	**30**	**6**	**2**	**1**
5	**150**	**30**	**10**	**5**
10	**300**	**60**	**20**	**10**
15	**450**	**90**	**30**	**15**
20	**600**	**120**	**40**	**20**
25	**750**	**150**	**50**	**25**
30	**900**	**180**	**60**	**30**
35	**1050**	**210**	**70**	**35**
40	**1200**	**240**	**80**	**40**
45	**1350**	**270**	**90**	**45**
50	**1500**	**300**	**100**	**50**
55	**1650**	**330**	**110**	**55**
60	**1800**	**360**	**120**	**60**
65	**1950**	**390**	**130**	**65**
70	**2100**	**420**	**140**	**70**
75	**2250**	**450**	**150**	**75**
80	**2400**	**480**	**160**	**80**
85	**2550**	**510**	**170**	**85**
90	**2700**	**540**	**180**	**90**
95	**2850**	**570**	**190**	**95**
100	**3000**	**600**	**200**	**100**
1% Hypochlorite solution use before disposing the category 7 waste (solid plastic waste). Dip in the water for 3 - 4 hours				


MEDICAL CARE IS NOBLE,
COMMUNITY HEALTH IS ESSENTIAL
स्वास्थ्य सेवा उत्तम कार्य है,
सामुदायिक स्वास्थ्य अनिवार्य है
Don'ts
Never drag filled waste liners.
कचरे से भरे थैले को कभी न घसीटें।
Make sure you follow rules! नियमों का पालन अवश्य करें!
Dos
Segregate waste at source in appropriate colour liners.
स्रोत पर ही कचरे को उचित रंग के थैले में डालें।


HANDLE WASTE WITH CARE
AVOID WORRY AND DESPAIR
कचरे को सावधानी से हस्तांतरित करें
निराशा और चिंता से मुक्त रहें
Never Put Waste in Wrong Liner
कचरे को कभी गलत थैले में न डालें
Use Protective Gear
सुरक्षा कवच पहनें
Never Transfer
पलटें नहीं
Always Tie Liner when ¾ full
थैले को ¾ भरने पर ठीक से बाँध दें
Never Mix Wastes During Collection and Transportation
कचरे को इक्ट्ठा करने व लाने ले जाने के वक्त कभी मिश्रित न करें


BE A RESPONSIBLE CITIZEN!
एक जिम्मेदार नागरिक बनें!
Don'ts
Never eat in the hospital, especially in the wards.
अस्पताल के अंदर, खासकर वॉर्ड में कभी भी खाना न खायें।
A clean hospital ensures speedy recovery
स्वच्छ अस्पताल में रोगी शीघ्र ठीक होते हैं
Dos
Feed the patient only with Doctor's permission
रोगी को डॉक्टर की अनुमति से ही खाना खिलायें


SHARPS CAN INJURE - HANDLE WITH CARE
पैनी वस्तुएँ घायल कर सकती हैं– सावधानी बरतें
Metal Sharps
धातु की पैनी वस्तुएँ
Glass
कांच
Collect
इकट्ठा करें
Mutilate Needle
सूई को तोड़ें
Chemical Disinfection
रासायनिक विसंक्रमण करें
Glass
कांच
Segregate
अलग-अलग करें
Shred while Sterilizing (Metal Sharps Manager)
जीवाणु नाशन के साथ तोड़-मरोड़े (धारदार धातु-वस्तु प्रबंधक)
Store in puncture proof container
अभेदी डिब्बे में जमा करें
Chemical Disinfection
रासायनिक विसंक्रमण करें
Glass
कांच
Store in puncture proof container
अभेदी डिब्बे में जमा करें
Autoclave
ऑटोक्लेव
Recycle
पुनर्चक्रित करें
Recycle
पुनर्चक्रित करें
Autoclave
ऑटोक्लेव
Bury in deep pit
गहरे गड्ढे में गाड़ दें

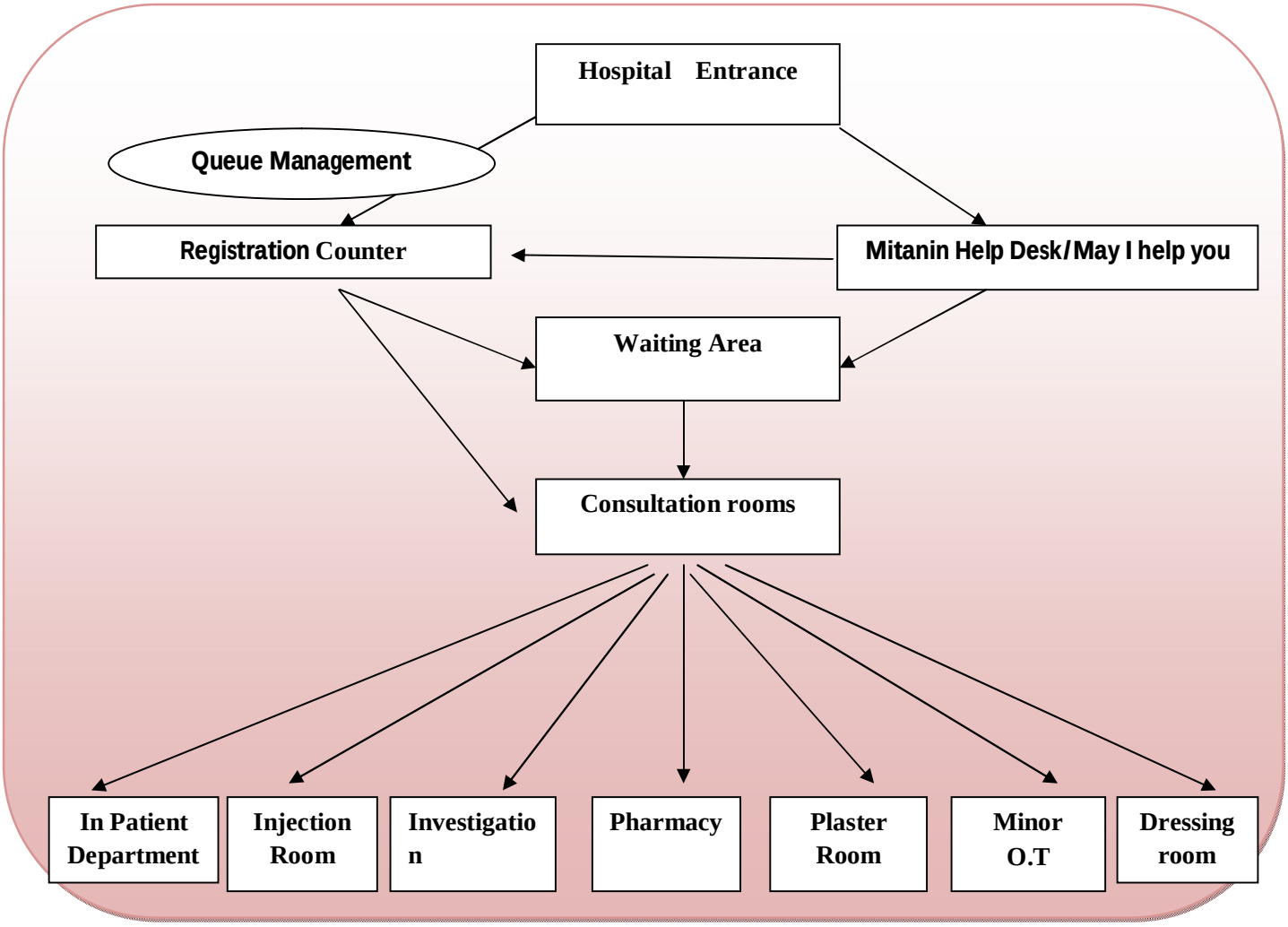

MANAGE SPILLAGE RIGHT AWAY !
बिखरे हुए द्रव का तुरन्त प्रबंधन करें!
CHEMICAL SPILLAGE
रासायनिक स्राव
Neutralize with acid/base/water and mop
BODY FLUID SPILLAGE
शारीरिक द्रव स्राव
Spray disinfectant and mop with tissue / cloth
MERCURY SPILLAGE
पारा स्राव
Suck with a syringe
Store in 5-10 ml water
Recycle


INFECTIOUS WASTE
YELLOW
Anatomical, pathological waste, soiled cotton, dressings, animal carcasses and other organic infectious material
INFECTED GLASS
BLUE
Whole and broken glass, ampoules, test tubes, vials and sample bottles
INFECTED LINEN
RED
Infected pillow cases, bed sheets, mattresses, pyjamas, cloth masks, caps and aprons

CHAPTER 2:

Out Patient Department

Infrastructure:



1. **Location**: The Location should be as such that Diagnostic and Treatment facilities are adjacent and are easily accessible without intermixing in the Inpatient area
2. **Entrance**: The entrance should be a barrier free entry so that the wheel chair and the stretcher can easily pass through it.
3. **Ramp:** Ramp facility should be available with the hand rails attached to the side of the ramp, for physically challenged person.
4. **Mitanin Help Desk:** A Mitanin Help Desk should be present. The Mitanin present should have all the information regarding the Hospital and good understanding of the Hospital.
5. **Registration:** Depending upon the patient load the number of registration counter should be decided.

   A hospital where the O.P.D.load is more than 200/Day can have four categories of Registration counter for easy access

   A. Male Registration Counter
   B. Female Registration Counter

C. Senior Citizen Counter
D. Physically Challenged Counter

The various counters may be managed by 1-2 people as the senior citizen counter and the physically challenged counters will not have much load.

On the Registration counter the charges for various services provided and citizen charter should be clearly displayed. The Registration counter can be computerized or manual.

6. **Waiting Area:**
   - **a.** The waiting area should have adequate number of seats for Patients and their attendants and other amenities like drinking water and fan.
   - **b.** The waiting area should have separate toilets for males and females. Availability of toilet may be determined by the patient load of the OPD.
   - **c.** The waiting area must have information board which clearly displays the name of the Consultants, specialization, and also regarding services available in the hospital like immunization, family planning and Medical board. Timings of the services provided should be clearly mentioned.
7. **Consultation and Examination room:**
   - **a.** All consultation room should clearly indicate the
   - (a) Room Number.
   - (b) Name of the Consultant with their specialisation.
   - **b.** The consultant room should provide adequate accommodation for examination table and other equipments required for patients examination.
   - **c.** The privacy of patients during consultation should be assured. Curtain should be present near the examination table.
   - **d.** The Consultation room should have proper hand washing facility.

Human Resource:

1. **For Registration Counter:** One attendant for each registration counters**.**
2. **For Consultation Room:** One ward boy or attendant per Consultation room.

Services:

a. Patients go to the registration counter and deposit the registration fee. The patient receives the OPD slip at the registration counter after submitting the charges.
b. Patient with OPD slip goes to respective doctor for consultation in Consultants room.
c. At the time of examining in the OPD, if the consulting doctor feels that the patient needs admission and treatment, he/she advises for admission on the OPD slip and patient gets admitted in the Inpatient Department after IPD registration.

Some of the Areas to be attached to the OPD:

I. Injection room.
II. Dressing room.
III. Drug Dispensary.
IV. Pathological Laboratory.
V. Radiology.
VI. Minor operation theatre.
VII. Plaster Room.

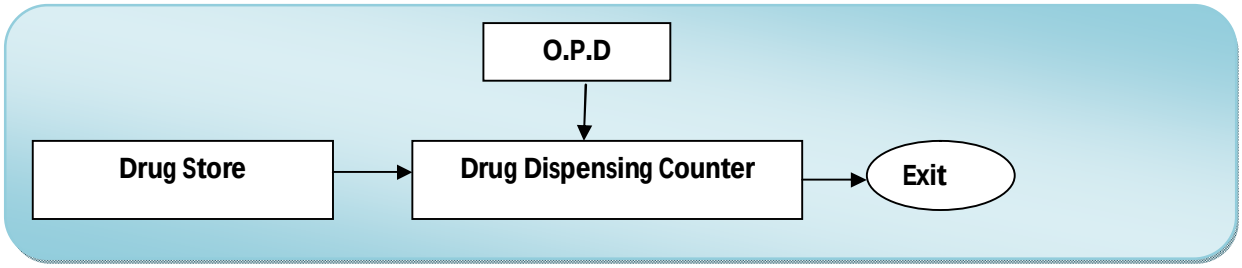
In the OPD complex, signage should be present which will help the patient to reach to the designated area.

Chapter 3

Drug Dispensing Counter

Infrastructure:

The Drug Dispensing Counter (Pharmacy) should be located near the Out Patient Department:



There should be a window where drug dispensing is done.

Human Resource:

1. Two Pharmacists should be present during each shift.

2. One ward boy or helper to bring the medicines from the drug store as per the need.

Services:

- The Pharmacist checks the availability of the drugs prescribed by the MO.
- If the Drug is available the pharmacist provides the prescribed medicines and makes an entry into the records pertaining to the quantity of the drug.
- At the end of the shift the pharmacist makes an entry of the total medicines dispensed and reduces the same from the stock book.
- First In First Out (FIFO) principle should be followed for moving the drugs in stock.
- Buffer stock of drugs should be maintained as per the patient load.

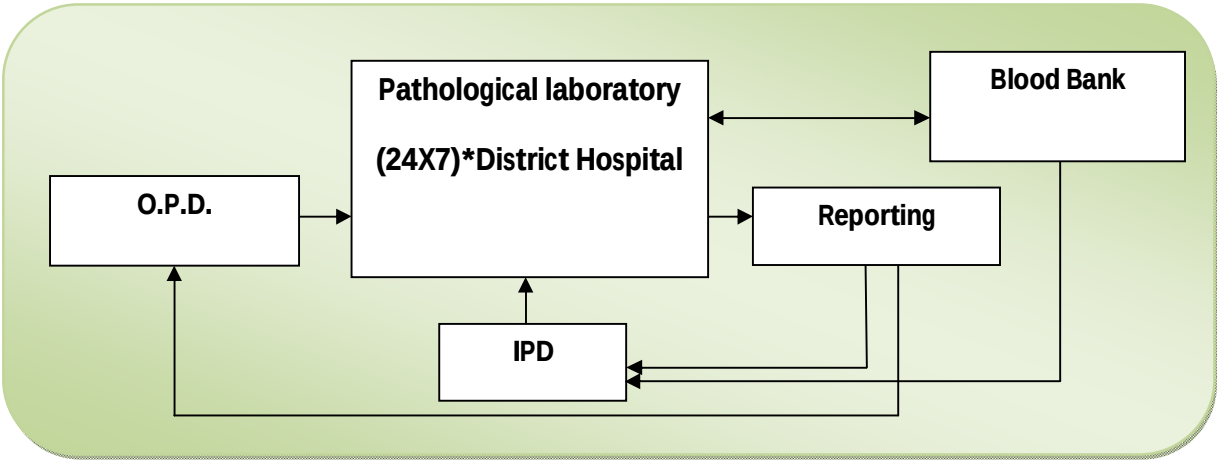
Important Activities:

1. If the Pharmacy is not functional 24X7, the time of opening and closing of the Pharmacy should be mentioned.
2. The List of the “Drugs Available” should be displayed outside the pharmacy and updated periodically.
3. Drugs available and not available in the stock from the State Drug list should be displayed along with quantity and date of expiry.
4. Before the medicines are dispensed the date of expiry should be checked.
5. While disbursing the medicines, the pharmacist should clearly explain the dosage and timing of drugs.
6. The Pharmacy in charge should take stock of the drugs in the Pharmacy twice in a week and as per the requirement indent should be sent to the drug store.

CHAPTER 4

Pathology Services

Infrastructure:



The pathology laboratory complex should have

1. Waiting Area: The waiting area should be present as in many cases patient have to wait for providing a repeat sample. The waiting area should have drinking water and toilet facility
2. Sample Collection Area**:** The Sample Collection area should have adequate number of counters. The Sample received should be immediately coded and preserved as per the requirement by the lab technician. The report giving time and the charges of the all the tests conducted should be displayed clearly.
3. Examination and testing area**:** The Laboratory should have good illumination for the microscope.
4. Reporting area

Human Resource:

1. Pathologist: The Pathologist should be an M.D.(Patho)or Diploma in Pathology.
2. Lab Technician: The lab technician should be available 24x7 in District Hospital and during the duty hours in CHC/ PHC.

Services:

In Sample Collection Area:

1. The Lab technician should follow **universal precaution** while withdrawing and collecting the samples from the patient.
2. All blood/urine/sputum samples are to be collected after wearing gloves.
3. Maintenance of records in the prescribed registers be done.

In examination and testing area:

1. The Illumination should be proper.

2. The reagents should be properly marked and should be checked for their date of expiry.
3. The temperature of the refrigerator in which the reagents are preserved should be monitored and temperature chart should be maintained properly.
4. The equipments used in pathological lab should be calibrated annually.
5. The annual mainatainace schedule of the equipments should be undertaken.
6. Universal precautions for infection control should be followed.
7. Maintenance of records in the prescribed registers be done.

In Reporting area

1. The Reports of the investigation should be properly maintained
2. After providing the reports receipt should be taken of report collected.
3. Maintenance of records in the prescribed registers be done.

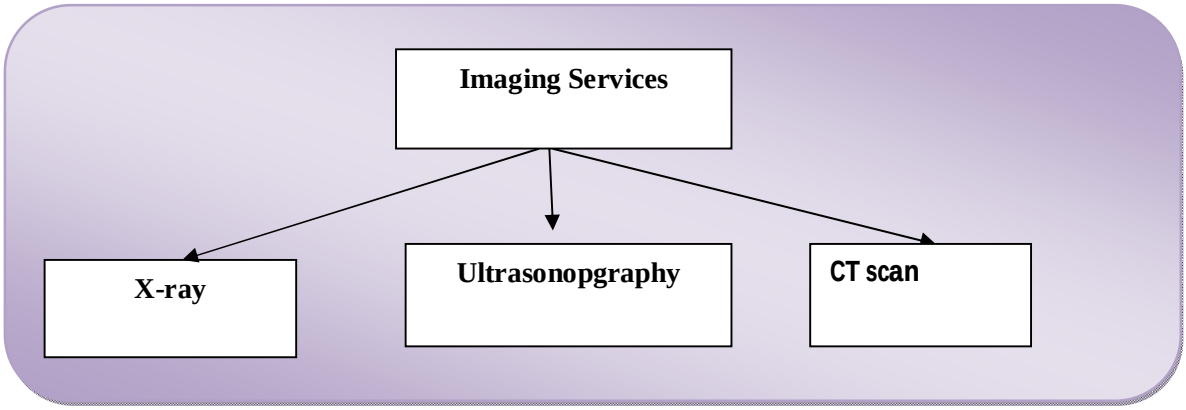
Record of Reagents

		Department of Pathology		
S.No	**Name of the Reagent**	**Date of issue**	**Date of Expiry**	**No. of Units**

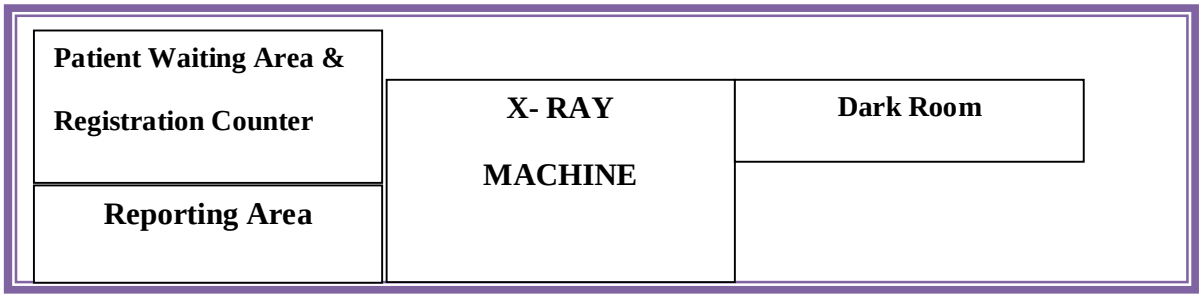
CHAPTER 5

Imaging Services

Infrastructure:



X-Ray Unit



Human Resource

1. Radiologist.
2. Radiographer (24x7 for District Hospital).
3. Dark Room Attendant.

Precautions to be followed:

1. The Technician should always wear TLD badges before performing the X-ray.
2. The technician should always wear lead apron if the technician will be exposed during the X-ray.
3. All married female should be enquired about pregnancy.
4. The walls of the X ray room should be as per the AERB guidelines.
5. There should be sufficient area for the movement of trolleys and patients.
6. The TLD bathes should be sent to designated Lab for Radioactive Calculation of TLD batches.

Ultrasound

Infrastructure:

- The Size of the room should be adequate enough for the movement of trolley or wheel chair.
- The Ultrasound room should have a comfortable couch for patients to lie down.
- There should be waiting area and proper sitting facility for the patients.
- There should be a toilet nearby.
- The PNDT act should be well displayed outside the USG room. The Charges of the various processes should be displayed.
- There should be an air conditioner in the room.

Human Resource

1. Ultrasonologist/ Medical Officer trained in USG.
2. Staff Nurse for assisting female patients.

Process:

1. If Patient is a pregnant female, before performing the USG the patient or attendant should sign the PNDT consent.
2. The register as advised under PNDT act should be maintained by the Nurse in Charge of the USG services.
3. All reports must be kept in duplicates in cases of MLC.

CT- Scan

Infrastructure:

- The Size of the room should be adequate enough for the movement of trolley or wheel chair.
- The Area of the room should be as per the AERB guidelines.
- There should be waiting area and proper sitting facility for the patients.
- There should be a toilet nearby.
- The Charges of The various processes should be displayed.
- There should be an air conditioner in the room

Human Resource

1. One Radiologist trained in CT SCAN
2. Technician trained in Operating CT-Scan.

CHAPTER 6
Operation Theatre

Location:

The OT complex should be located on the ground floor as the OT department should be easily accessible to the CSSD, Emergency and surgical wards.

Size:

- Optimum size of OT should be 18ft X 18ft.
- Wall: the floor height(tiling on the walls) must be 7-10 ft so that it can be easily cleaned and disinfected.
- Doors and Windows: Doors should be of 2 leaf type and self closing, at least 5ft wide. Windows should be 3ft and 4 inches above the floor and should be covered with glass panes.
- Floor: The floor should be easily washable and non staining.

Zoning in OT:

The OT complex should comprise of following zones:

1) **Protective zone**: this is the outermost zone and includes the changing room, toilets etc. this is the area where everyday clothes can be worn.
2) **Clean zone:** Anesthesia preparation, pre medication, anesthetists' office, stores for sterile supplies, laying of sterile equipments, and scrubbing facility is provided. Sterilization room with autoclave is also a part of the zone.
3) **Sterile zone:** The main OT remains in this zone where patient and staff enters only after changing into sterile clothing.
4) **Disposal zone:** It comprises of the area where used instruments, waste material and soiled linen are temporarily stored before being collected. The zone must have separate passage from OT and should have independent connection to outside. All the taps inside the OT should be elbow operated taps.

Advantages of Zoning:

1) Minimizes the risk of hospital infection
2) Minimizes unproductive movement of staff, supplies and patients.
3) Increases efficiency of staff working in the operation suites and ensures smooth workflow.
4) Reduces hazards in the operating suites.
5) Ensures proper positioning of the equipment.
6) Ensures optimum utilization of the operating suites.

Items required:

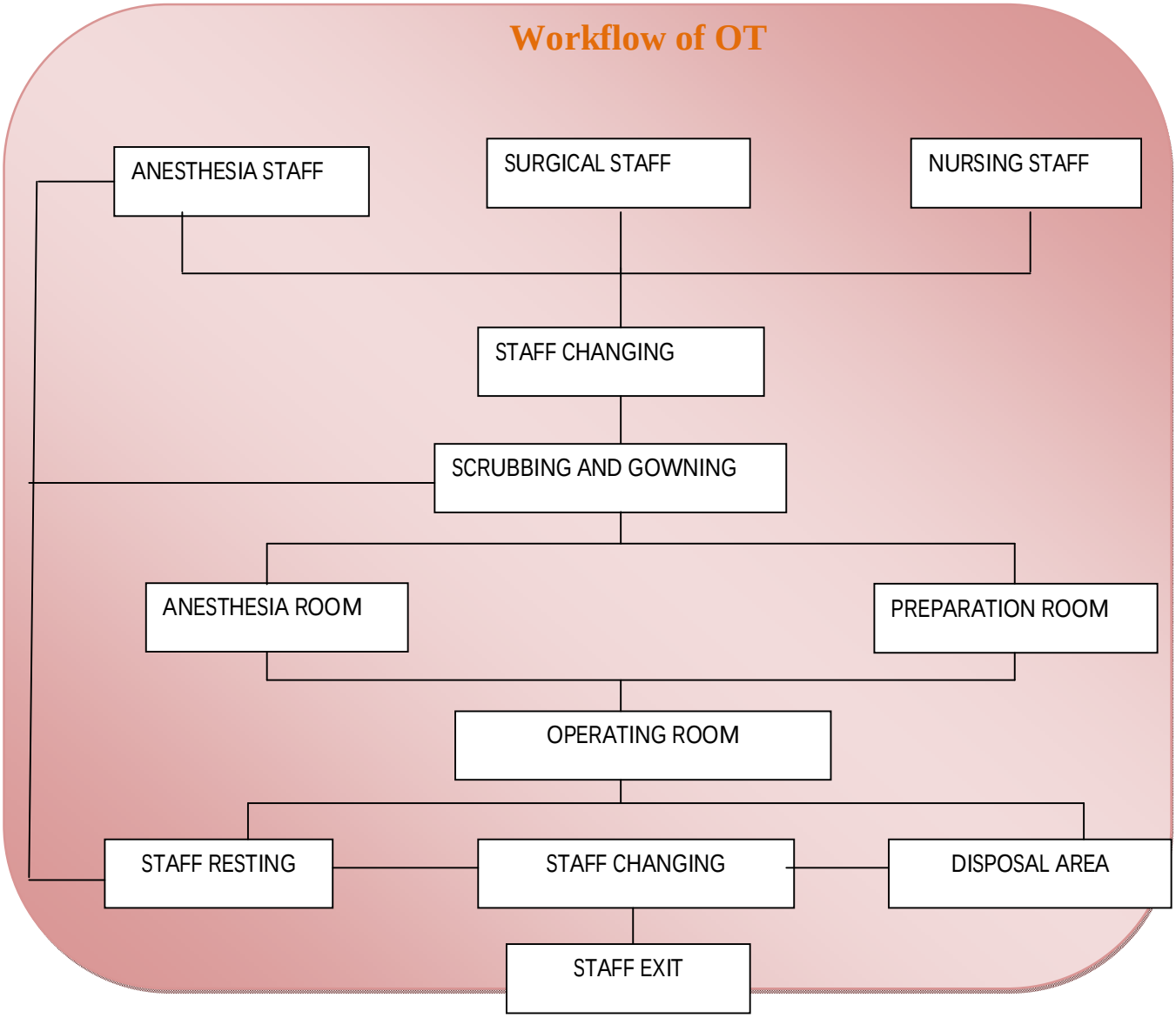
1) Slipper stand
2) Clean slippers
3) Emergency tray with drugs (Drug list along with expiry dates to be pasted above it)
4) Drug trolley (this should have anesthetic drugs as well as emergency drugs and IV fluids)
5) Instrument Trolley
6) Hub cutter

7) Macintosh for OT tables
8) Cupboards for storing instruments
9) Bio Medical Waste Bins
10) Generator/ Invertor

Equipments:	**Instruments**
1) **Laryngoscope with different sizes of endotracheal tubes and airways.** 2) **Boyles Apparatus** 3) **Cautery machine** 4) **Multi-para Meter** 5) **Suction machine(electric/ foot operated)** 6) **Oxygen Cylinder with Mask** 7) **Nitrous Oxide cylinder.** 8) **Shadowless lamps**	1) Instruments for various surgeries like LSCS/ Hysterectomy/ TT/ MTP/ General surgery instruments like laparotomy instruments. 2) 2-3 sets of all the above instruments. 3) Suture material as per requirement 4) Laparoscope wherever laparoscopic TT is performed.

Sl. No	PProcedures Procedures	RE Responsibility
1.	Before bringing the patient to the OT complex, the fitness of the patient for undergoing surgery should be checked.	**Surgeon**
2.	PAC (Pre Anaesthesia Check up) should be done before surgery and the documents should be stored.	**Anaesthetist**
3.	All the happenings during the surgery should be properly documented for Medico Legal Purposes.	**Anaesthetist**
4.	Slipper stand should be stationed at the entrance of the OT complex and any entrance in outside slippers should be prohibited.	**OT In - charge Nurse**
5.	**OT store**	**OT In - charge Nurse**
6.	Consumables and other supplies like gloves, catheters, Ryles tubes, Infact feeding tubes, suction cannula, mucus extractors etc should be kept in buffer as per the load. OT store register should be maintained properly.	
7.	**Consent Form**	
	Consent form for the surgery should be obtained from the relatives of the patient. The relatives should always be counselled regarding the type of surgery and its pros and cons.	**Anaesthetist**
	It should be clearly mentioned on the consent form that the jewellery and other valuables of the patients have been returned to the patient attendants. The list of valuables should be clearly mentioned.	**OT In charge Nurse**
8.	**Infection Control Measures in OT**	**OT In charge Nurse**
9.	Fumigation should be done routinely and periodically. Separate fumigation register should be maintained.	
	Swab culture and sensitivity test of OT (OT Table/ shadowless lamp/ floor/ OT trolley/ Shelf or platform over which sterilised drums are kept) has to be done. Register of the same as well as documents in case of any positive growth of organism is found, should be maintained	
	Instruments should be sterilised and arranged properly on the drug trolley for ready use.	
	Cleaning of floors and other area should be done as specified in the housekeeping SOP.	
	Proper Fumigation should be done at frequent intervals and a fumigation register should be maintained.	
	Air Conditioner should be installed inside the OT. Split AC is better than Window AC.	
	Blood spills should first be covered by 1% Sodium Hypochlorite Solution/ Bleaching solution for 10 mins and then cleaned.	
	Hand Hygiene: Adequate hand washing facility should be available in all patient care areas. Elbow operated taps and washbasin and soap solution should be used.	**OT In charge Nurse**
	Standard Hand washing techniques as described in Infection control and BMW management SOP should be followed.	
	Cleaning of OT tables	
	The tables should be covered with Macintosh.	

	Macintosh should be first wiped with Na hypochlorite solution and then with disinfectant.	
	TSSU(Theatre Sterile Supply Unit)/ Autoclave Room	**OT In charge Nurse**
	Autoclaved materials should always be used within 72 hrs.	
	The autoclave indicator should be pasted on the packs.	
	Following conditions should be maintained for operating Autoclave.	



CHAPTER 7

Labor Room

Location: The labor room complex should house a pre-partum room, post partum room and labor room. It should be located adjacent to the obstetric ward for easy transportation of pregnant women from and to the ward.

The walls of the labor room should be tiled minimum up to a height of 7 ft. There should be an Air Conditioner or an exhaust fan.

The toilet in the labor complex should not have any opening directly to the Labor Room.

Items required:

1. Slipper stand
2. Clean slippers
3. Curtains for privacy
4. Emergency tray with drugs
5. Drug trolley
6. Macintosh for delivery tables
7. Cupboards for storing instruments
8. BMW Bins

Equipments required

A) **New Born Care Corner (NBCC)**

1) Open care system: radiant warmer
2) Resuscitator, hand-operated, neonate, 500ml
3) Weighing Scale
4) Pump suction, foot operated
5) Thermometer
6) Hub Cutter

B) **Other equipments**

1) Stethoscope
2) Shadow less lamp
3) Fetoscope
4) Oxygen cylinder with mask
5) Vulcellum
6) Artery Forceps-2
7) Cord Cutting Scissors-1
8) Sponge Holder - 1
9) Straight Stitch Scissors
10) Kidney Tray
11) Dressing Drum
12) Episiotomy tray
13) IV Stand
14) Mayo's Trolley

Sl. No	Activities	Responsibility
1)	Slipper stand should be present at the entrance of the labor room and any entrance in outside slippers should be prohibited.	**Nurse-in-charge**
2)	The labor room should have facility of 24X7 tap water and warm water when required	**Hospital Consultant**
3)	There should be curtains in between each table for maintaining privacy.	**Nurse-in-charge**
4)	New Born Care Corner (NBCC) should be present inside the labor room.	**Nurse-in-charge**
5)	Instruments should be sterilized and arranged properly inside the cupboard for ready use. A list of the instruments should be pasted.	**Nurse-in-charge**
6)	There should be 2 delivery kits for each delivery table in the labor room.	**Nurse-in-charge**
	Infection Control Measures in Labor room	
1)	Cleaning of floors and other area should be done as specified in the housekeeping SOP.	**Housekeeping In charge**
2)	**Hand Hygiene:** Adequate hand washing facility is available in all patient care areas. Elbow operated taps and washbasin and soap are available	**Hospital Consultant**
3)	**Cleaning of Delivery tables**	
3.1	The delivery tables should be covered with Macintosh and deliveries should not be conducted on bare table top.	**Nurse-in-charge**
3.2	Macintosh should be first wiped with Na hypochlorite solution and then with disinfectant	**Nurse-in-charge**
3.3	Similarly any blood spilled area in the delivery table as well as floors should be first cleaned with hypochlorite solution.	**Nurse-in-charge**
4)	**Management of Labor**	**Gynecologist, Nurse-in-charge**

	It should be done as per the SBA training protocols	
5)	**Immediate Postpartum Care-** • Weight of new born is measured. • Sanitary napkins are used. • Assessment of blood loss is done by counting the blood soak pads. • Vitals are monitoredat periodic intervals. • Mother and newborn is kept together. Breast feeding is encouraged. • Birth Companion is asked to stay with the mother. • Information of mother and new born is recorded in labour register.	**Gynecologist, Nurse-in-charge**
6)	**Essential Care of New Born** Essential new born care is given including maintaining body temperature, maintaining airway & breathing, breast feeding of new born, care of cord and eyes.	**Nurse-in-charge**

Checklist of Drugs in LR

Sl.No	Checklist for drugs in LR	Expiry Date

Housekeeping Protocol for Labor Room

1. Radiant Warmers:

- Daily: canopy and mattress should be cleaned with detergent solution and dried.
- Weekly: throught cleaning after dismantling weekly and every time after shifting of baby.

2. Cots and mattresses:

- Clean daily with 3%Phenol or 5% Lysol
- Replace mattresses whenever surface covering is broken

3. Suction apparatus:

- Suction bottle should contain 3%Phenol or 5%Lysol
- Suction bottle should be cleaned with detergent and changed daily.
- Change tube connected to bottle daily. Flush with water and dry. Soak for disinfection in 2% gluteraldehyde.
- Use disposable suction catheter.

4. Oxygen hood

- Clean with detergent daily and after each use

5. Thermometer

- Wipe with alcohol after use
- Store in bottle containing dry cotton

Housekeeping routines for Labor Room

1. Floors and walls

- Walls and sinks mist be cleaned with 3%Phenol or 5 % Lysol at least once a day
- Wet mopping of the room should be done three times a day
- Avoid sweeping and dry dusting

2. Disposal of waste and soiled linen

- Waste disposal bins with covers should be available.
- The bins must be kept covered and emptied at regular intervals
- Plastic bags should be used in the bins and these bags should be sealed before they are removed.
- The waste bin should be cleaned and washed properly under running water every day.

3. Cleaning of Spills

- Use 10g of bleach in 1 Liter. Cover the area with solution for at least 20 min and mop with newspaper or cloth.

4. **Needles and Sharps**. : Discard in polar bleach in a needle proof container

New Born Care Corner (NBCC)

Every labor room should have a New Born Care Corner .The standard protocols are as follows:

Grading of Hypothermia

- Temperature of the room should be : 37.5˚ C -36.5˚ C
- Cold Stress : 36.4˚ C -36.0˚ C
- Moderate Hypothermia:35.9˚ C-32˚ C
- Severe Hypothermia:<32˚ C

Management of Hypothermia

- Record actual body temperature
- Re-warm a hypothermic baby as quickly as possible.
    - Severe Hypothermia----- Radiant Warmer
    - Mild to moderate hypothermia----- Kangaroo mother care or radiant warmer.

Management of Severe Hypothermia

1. Keep under radiant warmer
2. Reduce further heat loss.
3. Infuse IV 10%Dextrose @60ml/Kg/day
4. Inject Vitamin K1.0 mg intramuscular
5. Provide Oxygen
6. Consider and asses for Sepsis.

Prevent Hypothermia; Warm Chain:

Baby must be kept at all times right from birth. The Warm Chain is a set of 10 interlinked

1	**Warm delivery room(>25˚C)**	**6**	**Bathing and weighing postponed**
2	Warm resuscitation	7	Appropriate clothing and bedding
3	Immediate Drying	8	Mother and baby together
4	Skin to skin contact between baby and mother	9	Training/Awareness raising of healthcare provider
5	Breast feeding	10	Warm Transportation

Quality Measures in Antenatal Care

Level1(SBA Level)	Level 2 Institutional (basic level)	Level 3 Institutional (comprehensive level)
Delivery by SBAs(Sub-Centre, PHC, not functioning as 24x7 and home deliveries conducted by SBA	PHC-basic obstetric and neonatal care (24x7PHC, CHCs other than FRUs)	FRU-Comprehensive Obstetric and Neonatal care(DH, SDH,FRU, RH, and Selected CHCs)
ANC session should include: • Registration (within12 weeks) • Physical examination+ weight + BP+ abdominal examination • Identification and referral for danger signs • Ensuring consumption of at least 100 IFA tablets (for all pregnant women)/200(for anemic women). Severe anemia needs referral. • Essential Lab investigations(HB% urine for albumin/Sugar, pregnancy test) • TT immunization (two doses at interval of one month • Counseling on nutrition , birth preparedness, safe abortion family planning and institutional deliveries • Assured referral linkages for complicated pregnancies	All in level 1 + blood grouping and Rh typing, Wet mount(saline/KOH), RPR/VDRL Management and provision of all basic obstetric and newborn care including management of complications other than those requiring blood transfusion or surgery, Linkages with nearest ICTC/PPTCT centre for voluntary counseling and testing for HIV and PPTCT services.	All in level 1 + blood cross matching + management of severe anemia Management of complications in pregnancy referred From levels1 and levels 2.

Quality Measures in Intranatal Care

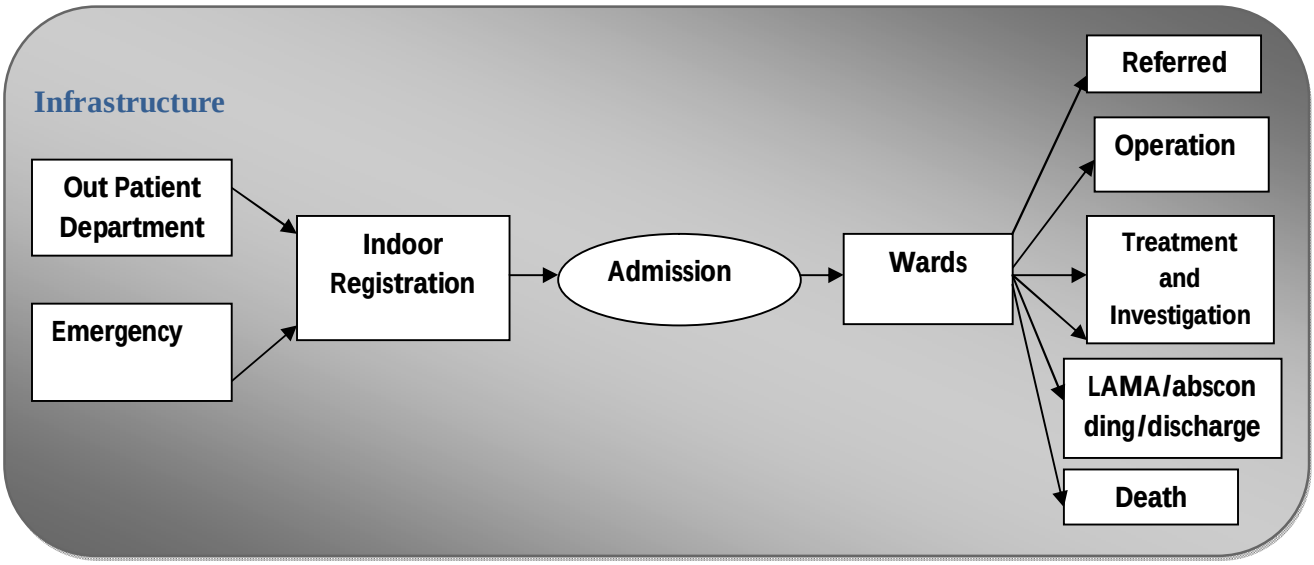
Level1(SBA Level)	Level 2 Institutional (basic level)	Level 3 Institutional (comprehensive level)
Delivery by SBAs(Sub-Centre, PHC, not functioning as 24x7 and home deliveries conducted by SBA	PHC-basic obstetric and neonatal care(24x7PHC, CHCs other than FRUs)	FRU-Comprehensive Obstetric and Neonatal care(DH, SDH,FRU, RH, and Selected CHCs)
• **Normal delivery with use of partograph** • **Active management of third stage labor** • **Infection prevention** • **Identification and Referral for danger signs** • **Pre referral management for obstetric emergencies, e.g. eclampsia, PPH, shock** • **Assured referral linkages with higher facilities** **Essential newborn care will include:** • **Neonatal resuscitation** • **Warmth** • **Infection Prevention** • **Support for initiation of breast feeding within a hour of birth** • **Screening for congenital anomalies** • **Weighing of newborns**	All in level 1 + Availability of Following services round the clock: • Episiotomy and suturing cervical tear • Assisted vaginal deliveries like outlet forceps, vacuums • Stabilization of patients with obstetric emergencies , e.g. eclampsia, PPH , sepsis, shock • Referral with higher linkages **Essential newborn care as in level 1+** • Antenatal corticosteroids in case of preterm babies to prevent respiratory distress syndrome(RDS) • Immediate care of LBW newborn(<1800 grams) • Vitamin K for premature babies	All in level 2+ availability of following services round the clock • Management of obstructed labor • Surgical interventions like cesarean section • Comprehensive management of all obstetric emergencies , e.g. PIH/eclampsia,Sepsis, PPH, retained placenta, shock etc. • In house blood bank or blood storage unit • Referral linkages with higher facilities including medical college **Essential newborn care as in level 2 +** • Care of LBW newborns • Care of sick newborns • Vitamin K for premature babies

Quality Measures in Postnatal Care

Level1(SBA Level)	Level 2 Institutional (basic level)	Level 3 Institutional (comprehensive level)
Delivery by SBAs(Sub-Centre, PHC, not functioning as 24x7 and home deliveries conducted by SBA	PHC-basic obstetric and neonatal care(24x7PHC, CHCs other than FRUs)	FRU-Comprehensive Obstetric and Neonatal care(DH, SDH,FRU, RH, and Selected CHCs)
• **Minimum 6 hrs of stay post delivery** • **Counseling for feeding, Nutrition, Family planning, Hygiene, Immunization and Post natal Checkup** • **Home visits o 3rd , 7th, and 42nd day for both mother and baby. Additional visits are needed for the newborn on 14, 21 and 28. Further visits may be necessary for LBW sick newborns** • **Timely identification of danger signs and complications, and referral of mother and baby** **New born care:** • **Warmth** • **Hygiene and Cord care** • **Exclusive breastfeeding for 6 months** • **Identification and management and referral of sick neonates , low birth weight and preterm newborns** • **Referral linkages for management and complications** • **Care of LBW newborns <2500grms** • **Zero day in immunization OPV, BCG and Hepatitis B.**	**All in level 1 +** • 48 hrs of stay post delivery and all postnatal services for zero and third day to mother and baby • Timely referral for women with post natal complications • Stabilization of mother with postnatal emergencies e.g. PPH, Sepsis, Shock, retained placenta • Referral linkages with higher facilities **New Born care As in level 1 +** • Stabilization of complications and referrals • Care of LBW newborns >1800gm • Referral services for newborns <1800 gms and other new born complications • Management of sepsis	**All in level 2+** • Clinical management of all maternal emergencies such as PPH, Puerperal Sepsis, Eclampsia, Breast abscess, post surgical complications, sock and any other post natal complications such as RH incompatibility etc. **New Born care as in level 2+ in DH through SNCU** • Management of complications • Care of LBW newborns <1800 gm • Establishment of referral linkages with higher facilities

CHAPTER 8

In Patient Department



Wards:

- **The wards are usually of two types:**
  - **i.** Nightingale type: The beds are aligned perpendicular to the wall.
  - **ii.** Cabin type: 4-10 beds are kept in the cabin which reduces nosocomial infection.
- The distance between two beds should be 6ft from the centre of the beds. This is required for two reasons mainly, one for the free movement of the trolleys/ wheelchairs and secondly to reduce nosocombial infection.
- There should be bedside lockers along with all the beds
- The wards must be well illuminated and ventilated.

Human Resource:

MO in charge of the ward must take rounds periodically.

Staff Nurse: One Staff Nurse /6beds/ Shift in general ward.

One Staff Nurse /4beds/ Shift in private ward

One Staff Nurse /bed/ Shift in ICU.

Class IV employee: One Aya and one ward boy and one sanitary worker/Shift

Process:

The Inpatient department includes

1. Admission of Patients
2. Treatment of the patient
3. Investigations.
4. Operation
5. Information of Medico Legal cases to Police.
6. Physiotherapy
7. Counseling
8. Discharge.

I. Admission:

1. Before admission the doctor must have examined the patient .He should give clinical diagnosis, advise investigations and prescribe treatment on the case sheet so that the treatment can be started.

2. All admissions are to be done in registration counter where all the entries be filled.

3. After admission in the wards, entry must be made in the ward register clearly indicating the time and date of admission in the ward. Meanwhile the treatment should be started.

4. The treatment given should be entered into the records.

II. Process or Provision of care:

1. Patients transferred to the hospital with I.V.line and indwelling catheter should be changed with new, on arrival into the Hospital.

2. At the time of admission patient should be provided fresh linen. Patient linen should be changed every day or as and when it is soiled.

3. Care should be taken that soiled linen should not transmit infection to other wards.

4. Aseptic techniques are to be followed.

5. All invasive procedures should be done by nursing staff only after wearing gloves and following universal precautions.

6. During shift change the nursing staff should give a detail description in regards to condition of the patient and the treatment being given in the handover register.

7. Infected Patients should be treated in the Isolation room as far as possible.

8. During the rounds by the consultant the instruction given by the consultant should be thoroughly recorded and followed by the nursing staff.

9. If the patient is absconding from bed for more than 30 minutes the same should be recorded and reported to the authorities.

III. Investigation:

1. For pathological investigation, sample may be taken from the ward and be sent to the laboratory for investigation. The reports of the same will be sent to the wards / collected from laboratory for further course of treatment.
2. The non ambulatory patients are shifted for radiological investigations like X – ray, USG or CT Scan by wheel chair or stretcher.

IV. Operation Theatre:

As per the instruction of the surgeon, Pre operative Anesthetic Check up (PAC) should be done before the patient is shifted to the OT and post operative care is provided in the wards.

V. Medicines and Ward Store:

1. All the inventories of drugs, linen and other utilities should be maintained properly.
2. FIFO system of inventories should be followed for drugs.
3. Stock registers and daily medicine expenditure register should be maintained.

VI. Equipments:

1. Oxygen cylinder with key and disposable mask
2. Suction apparatus(electric/ foot operated)
3. Laryngoscope with endotracheal tubes.
4. Torch
5. Stethoscope
6. BP apparatus
7. Thermometers

VII. Medico Legal cases:

All records of the medico legal cases should be kept in the wards with the file clearly mentioning “MLC” in red ink at the top of it.

VIII. Physiotherapy:

Bedside physiotherapy is provided to all the patients who require the same. If any specific treatment is required, patient may be shifted to the physiotherapy unit.

IX. Counseling:

Counseling of patients as well as relatives/ attendants regarding the course and fate of the treatment should be done with due privacy.

X. Discharge:

1. Before discharge the patient should be made aware about his present condition further treatment and medications to be followed as well as about his follow up visit details.
2. The condition of the patient as well as detailed summary of the case as regards to the procedures done, investigations and treatment provided in the hospital at the time of discharge should be properly mentioned in the discharge summary by the doctor.
3. After the patient has been discharged the file should be sent to the Medical Records Department for storage. If the patient wants a copy of the records the photocopy of the same may be given.

XI. Important Instructions:

1. All the wards should maintain the emergency drug list and emergency drug tray.
2. Indiscriminate movement of the people in the I.P.D. area should be discouraged. Visitors' time into the IPD should be fixed, displayed and properly maintained.
3. Once in month the beds along with patients should be wheeled out so that the floors may be thoroughly cleaned.
4. Reusable items should be properly sterilized or autoclaved.

Performance Indicators

The following performance indicators should be analysed and displayed in the IPD Nursing station.

1. **Bed Occupancy Rate**: $\frac{\text{No of patient days (based on discharges) during a given period}}{\text{Bed compliment days during the same period}} X100$
2. **Average Length of stay(ALOS):** $\frac{\text{No of patient days during a given period}}{\text{Total discharge (including deaths) during the same period}}$

CHAPTER 9

Housekeeping, Sanitation and Laundry Services

Housekeeping Services Includes:

1) Wet Mopping
2) Dusting
3) Changing curtains
4) Sanitation of Toilets and Bathrooms
5) Changing linen

Laundry activities include:

1) Maintaining Inventory of linen
2) Receiving used/ soiled linen from each department.
3) Washing linen
4) Drying linen
5) Returning the clean linen to the respective departments.

Areas to be cleaned:

1) Floor (Bathrooms, OT, IPD, OPD, LR, Laboratory, Radiology, Blood Bank, Kitchen, Injection room. Pharmacy, Store, etc)
2) Furniture (Cupboards, shelves, beds, lockers, IV stands, stools and other fixtures)
3) Walls (differs according to the type of ward/ specialty/ OT/ LR/ Laboratory)
4) Ceilings
5) Bathrooms

Materials required:

1) Brooms
2) Detergent
3) Phenyl
4) Gloves, masks and shoes for housekeeping staff.

Activities:

Sl. No.	Activity	Responsibility for supervision
1)	Floors of all the departments should be mopped once in each of the 3 shifts	**HC/ Nurse In charge**
2)	The walls, furniture should be mopped once daily	
3)	Clean doors, hinges, facings, glass inserts and rinse with a cloth moistened with detergent.	

4)	Cobwebs should be cleaned from the ceilings and walls	
5)	Curtains across all the departments should be changed once in 15 days and sent for laundry.	
6)	Bedpans should also be washed and disinfected by phenol.	
7)	The housekeeping staff should use PPEs (gloves, shoes and masks)	
8)	Bed sheets/ Pillow covers should be changed everyday. Every ward should have at least 4 sets of linen per bed.	**Nurse – In - charge**
	Housekeeping Process for Toilets and Bathrooms (Sanitation)	
1)	• The floor of bathrooms is to be cleaned with a broom and detergent once a day and then with disinfectant solution. • Toilets are cleaned with a brush using a detergent Disinfection with Phenyl is done. • Stain removal using Hydrochloric acid may be used. • Wash basins are cleaned with detergent powder once in each shift	**HC**

Housekeeping Checklists for departments

Sl. No	Areas	Activity	8AM-2PM (to be signed by Nurse incharge and Hosp Consultant)		2AM-8PM		8AM-8AM	
1)	**Floor**	**Mopping**						
2)	**Walls**	**Cleaning with wet cloth**						
3)	**Ceilings**	**Cobwebs**						
4)	**Lights and other fixtures**	**Dusting**						
5)		**Cleaning**						
6)	**Furniture**	**Dusting**						
7)		**Cleaning**						
8)	**Curtains**		Once in 15 days(date of changing with signature)					

Checklist for sanitation (toilets and Bathrooms)

Sl. No	Areas	Activity	8AM-2PM (to be signed by Nurse incharge and Hosp Consultant)		2AM-8PM		8AM-8AM	
1)	Floor	cleaning						
		Mopping						
2)	Walls	Dusting						
		Cobwebs						
3)	Lights and other fixtures	dusting						
		Cleaning						
4)	Basins	Cleaning						
		Mopping						
5)	Commodes	Cleaning						

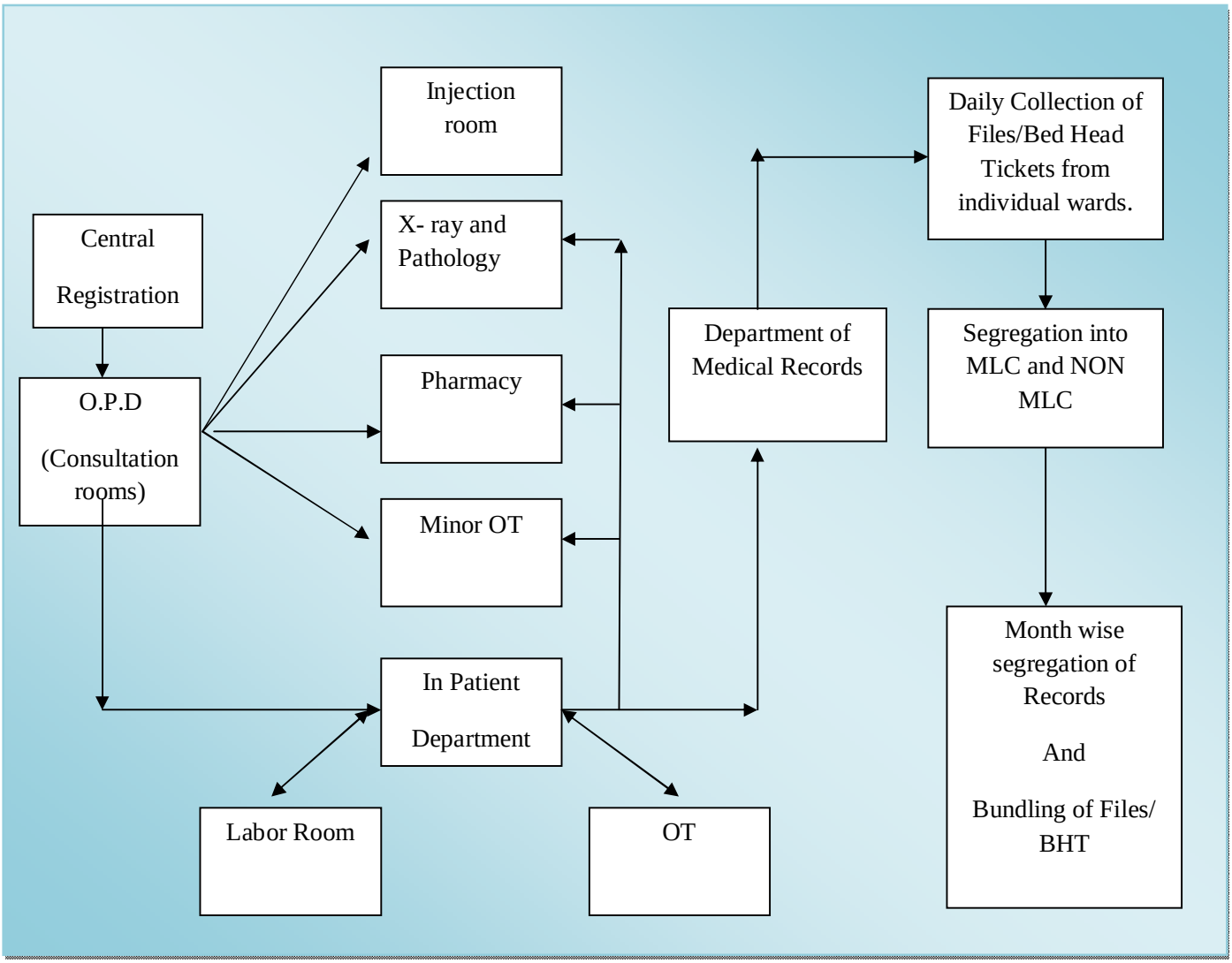
Laundry Services:

1) It has been found that breakdown of linen supply causes 3-4% of infection spread due to linen and 3-4% of cancellation of operation.
2) Washed and clean linen always signifies quality care in the hospital.
3) Frequency of change of linen should ideally be everyday or thrice in a week depending upon workload and availability of the linen.
4) There should be 4 sets of linen per bed, distribution of which is as follows:
    a. 1 in use
    b. 1 ready for use
    c. 1 being processed(given for washing on the particular day)
    d. 1 in transit (washed and to be delivered)
5) Classification of linen
    a. Body linen
    b. Bed linen
    c. Operation theatre linen
    d. Staff linen
6) Contaminated and infected linen should be disinfected before giving to the laundry.
7) Registers for laundry should be maintained by the Nurse – in – charge.

CHAPTER 10

Medical Records

Infrastructure: All these facilities maintain their own individual records



The Medical Record Department should have adequate number of Shelves for the storage of records.

Types of records to be maintained in the MRD:

1. Central Registration OPD/IPD

   The Records should contain.

   - Yearly Number.
   - Daily Number.

2. In Patient Records: It should be available in individual wards and Birth/Death register should be separately maintained in all wards.

3. Record of certain Diseases like Cholera, malaria, DVD, Epidemics, should be maintained separately.
4. MLC / Non – MLC case sheets should be separately compiled.
5. All the departments like Pharmacy, X-Ray, Pathology, Minor OT, dressing room, Plaster Room, OT, Labor Room etc should maintain their own records so that they can be traced if needed.

Human Resource:

1. R.M.O. should be made the in charge of medical records.
2. Hospital Consultant should compile the whole records.
3. Pharmacist will help Hospital consultant.

Services:

1. Medical record in charge collects and compiles the reports of cases referred to higher centers for treatment.

2. Medical record in charge collects and compiles the cases referred from other centres to the hospital.

3. Medical record in charge collects and compiles the cases left against medical advice (LAMA)./Absconding and Death.

5. The Medical record in charge assembles the medical records and checks for the completeness of records collected from the wards after discharge/death of patients and files the same in a serial number.

Records

Checklist for Completeness of Medical records	
1.Bed Head ticket	
2. Investigation Report.	
3.Consent Form	
4.Operative Notes	
5.Copy of Discharge Summary	

CHAPTER 11:

Legal Issues In Hospital Care

Law: Law is defined as Rules which the courts and judicial organizations lay down for the determination of rights and duties.

Law could be

- Civil
- Criminal
- Medico Legal

Violation of Law is termed as an Offence.

Laws/ Acts Applicable to Health care:

1) **The drugs and Cosmetic Act 1940**
2) MTP Act 1970
3) Consumer Protection Act 1986
4) Organ Transplantation Act
5) PNDT Act 1994
6) Indian Mental Health Act 1987
7) Contract labor Act 1970
8) Maternity benefit Act 1961
9) Bio Medical waste Handling Rules 1998
10) Birth and Death Registration Act
11) Prevention of Food Adulteration Act
12) ESI Act

Medico Legal Cases:

Road traffic accidents, poisoning cases, criminal assaults, burn injuries, industrial accidents, attempted suicide, homicide etc. and any patient brought dead to the casualty and the attending doctor suspect's foul play is considered a medico-legal case. All statutory laws and regulations as regards MLC are followed.

1. The Hospital should have an in-house Police Station.
2. The local police station is informed about the patient for any medico-legal proceedings that may be required and the details are entered in the Police Information Register.
3. First aid and immediate care is given to the patient after recording the time of arrival, vitals, level of consciousness etc.

4. Medico legal reports are generated for the Medico Legal cases and these cases are summarized in the Medico Legal Register and the details of the post mortem cases are entered in the Post Mortem Register.

5. History has to be taken from the patient if he / she is fully conscious or history is taken from the person who brings the patient to the emergency and recorded.

6. In case of poisoning the first sample of gastric Lavage / vomitus is preserved, sealed and handed over to police along with the MLC report.

7. The concerned consultant is informed for further management of the patient.

8. Admission or discharge to home or transfer to another organization/hospital.

9. There is a detailed documentation and record of admissions and discharges of patients who are seen in Emergency room.

10. After emergency care has been given and the patient has stabilized, patients are sent back home or referred to OPD or IPD transferred to another hospital.

11. If the patient has to be shifted to another hospital it is ensured that a well-equipped ambulance with trained medical and Para medical staff are available to do so.

12. The details of the referred patients are recorded in the referral register.

13. Patient is clearly explained the reason for transfer or discharge in a language which they understand.

Do's	**Don'ts**
Mention your qualifications	Wherever in doubt don't hesitate to discuss with your colleagues.
Record date and Time of consultation	Don't hesitate to discuss with patients or attendants
Record age, sex and weight (of child)	Don't write ayurvedic formulations along with allopathic drugs
Findings (specially complicated ones) should be recorded.	Don't examine patients when you are sick, exhausted or under effect of alcohol.
Make a note of refusals	Never talk loose.
Mention c0ondition of patient and make a note in case sheet.	Don't criticize your colleagues
Boldly write about drug allergy	No experimental methods of treatment.
Write prescription clearly.	
Mention additional precautions as required.	
Prognosis explanation, in case of serious patients.	
Specify follow up writing	
Mention where patient should contact you	
Keep updating your knowledge through CME programs	

PC-PNDT ACT 1994 Guidelines for Districts

The mission of PNDT act is to improve the sex ratio at birth by regulating the preconception and prenatal diagnostic techniques misused for sex selection.

- In District All Sonography centers must be registered as per the Act.
- Districts must have District Appropriate authorities (DAA) for the better Implementation of the Act.
- All Districts must ensure the proper Implementation of PC-PNDT (Pre- Conception and Pre Natal Diagnostic Technique) Act 1994, as given in the act.
- Districts must have an F-Form Copy of each registered Sonography Center for the Audit of the centers.
- Districts must ensure the proper Investigation of registered Sonography Centers through Formulation of Inspection and Monitoring committees.
- Ensuring the Timely Renewal of Registration of Centers with proper record maintenance, Review and evaluation of registration records.
- Each Registered Center must have a Registration copy of the center on the wall along with oath of Implementation of the act and Non- Sex selection procedure In two languages one in English and another in a Local language.
- Centers must have a Qualified Person for Sonography procedures as given in the Act.
- Each District must send timely Reports the Monthly Progress Report and Quarterly Progress Report to the State PNDT Cell as per the given Instructions and formats

  (So that State can send a compile report of each month and quarter to the PNDT Cell of Government of India)–

For Monthly Report – till 5th of the Following month &
For Quarterly Report of PNDT Act 5th of the Following Month just after the each quarter end

(Report Calendar as given below)

त्रैमासिक रिपोर्ट के लिए कैलेंडर :-

- 1 जनवरी से 31 मार्च की त्रैमासिक रिपोर्ट -10 अप्रैल तक।
- 1 अप्रैल से 30 जून की त्रैमासिक रिपोर्ट -10 जुलाई तक।
- 1जुलाई से 30 सितम्बर की त्रैमासिक रिपोर्ट -10 अक्टूबर तक ।
- 1 अक्टूबर से 31 दिसम्बर की त्रैमासिक रिपोर्ट -10 जनवरी तक ।

व् हर माह की मासिक रिपोर्ट आगामी माह की 5 तारीख तक ।

- Timely Meeting of Advisory Board and Committee at the district level and Timely Information of meetings along with Meeting Minutes,to be send to the State PNDT cell. (As given in the Act)
- Each District must have a Records of Gazette of India –PNDT and Notifications of PNDT act Copies.

- Ensure Strictly Implementation of the Act in District as the Act, along with Awareness via IEC/BCC/IPC Campaigns in the Community about the Sex-Selection Prohibition as per the Act along with save the girl child massages.
- Each District Must increases the monitoring visits and mustsend each and every report to State PNDT-Cell about the Findings and Action Taken while investigating a centre.
- Strict action must be taken like cancellation of registration along with Filing of Court cases against the registered /unregistered centers and at those centers that are doing sex selection.
- Monitoring of sex ratio at birth through civil registration of birth data in Each Districts Must be ensured.
- Districts must work upon on these points as well –
  Online availability of PNDT registration records
  Online filling and medical audit of form Fs
- Ensure regular reporting of sales of ultrasound machines from manufactures.
- Enumeration of all Ultrasound machines and identification of un-registered Ultrasound machine -Ensure compliance for maintenance of records mandatory under the Act.

Format for Data collection of Ultrasound Centers and Machines

S. No	Name of The Doctor	Name of the Organization	Registration Number	Date of Registration	Number of Sonography Machines	Date till Validation	Remarks

प्रपत्र का हिंदी प्रारूप :-

अल्ट्रासाउंड मशीनों व् केन्द्रों के लिए आंकड़ा संकलन प्रपत्र

क्र .सं	चिकित्सक का नाम	केंद्र या संस्था का नाम	पंजीयन क्रमांक	पंजीयन तिथि	सोनोग्राफी मशीनों की संख्या	वैधता दिनांक	विशेष (रिमार्क्स)

Chapter – 12

Guidelines for Quality Management System at Public Hospitals in Chhattisgarh

1. **Constitution of committee**: An Institutional quality committee to be constituted at each ISO certified facility under the Chairmanship of CS/Facility in-charge. It should have members from all the departments' viz. Medicine, Surgery, Pathology, Pharmacy etc and from all classes, like doctors, nurses, and other paramedical staff.

A. Block level Quality Assurance Committee:

1. Block Medical Officer
2. Block Programme Manager
3. Lab Technecian
4. Sr.Nursing Staff or Nursing Sister

Scope of Work:

- To monitor Standard Protocols in CHC PHC/SHC in terms of ANC/Labor Room /Post natal Quality Care
- The Block level Committee will carry out the inspection of Peripheral institutes other than District Hospital under the guidance of at least one person from State Level inspection committee. .
- The assessment would be done every 3 to 4 months.
- The team would be assisted by at least one member from the state Quality Assurance Steering Committee.
- The team will identify the gaps, assess the compliance, and suggest ways to improvement.

B. Facility level Quality Assurance Committee:

To carry out the facility level inspection/monitoring and sustenance of the Hospitals a facility level committee is to me formed which will constitute of the Following:

I. District Hospital

1. Civil Surgeon	Chair Person
2. RMO	Member Secretary
3. Hospital Consultant	Member
4. Matron	Member
5. Pathologist/ Sr. Lab Technician	Member
6. Steward	Member
7. Sr. Pharmacist	Member

II. Community Health Centre Level:

1. BMO	Chair Person
2. Medical Officer	Member Secretary
3. Block Programme Manager	Member
4. Nursing Sister/ Sr. Staff Nurse	Member
5. Pathologist/ Sr. Lab Technician	Member

Scope Of work

The committee would be responsible for overall implementation of quality assurance in the respective facility. The scope of work will include,

- Management of documentation
- Revision and compilation of Objectives
- Conducting Patient satisfaction survey and Employee satisfaction survey,
- Conducting meetings of hospital departments.
- Conduction of internal audit.
- The committee will also Produce a compliance report every 3 to 4 months which would be submitted to the Quality assurance Steering committee at the State Level.
- The team would assist the state level and district level team while inspection. They would then be responsible for documentation of the gaps found and formation of report. The report would then be submitted to the state level committee.
- Preparation of future action plan for the identified gaps after inspection.

2. **Nomination of key functionaries**: In order to fix the accountability be needed in the case of transfer, superannuation etc., Some key functionaries requires to be nominated like Internal quality in charge, Documentation in charge, Training in charge, from within the facility level Committee.
3. **Management of quality document**: The documentation in-charge may have following functions, Updating ,retaining, stamping, filing of revised documents like quality manuals, SOPs quality objectives, forms and formats like patient satisfaction survey and employee satisfactions surveys, External documents, like Guidelines of GOI, Rules ,as an when required.
4. **Periodic revision of Objectives**: Objectives should be periodically revised, even if there is no revision for quality document. Each department should have its own objective which should then be collated to get the objectives of the hospital.
5. **Conducting meetings of Hospital Committees**: A monthly meeting should be conducted of all the departments, like, Hospital infection control committee, hospital audit committee, in the first week of every month.
6. **Training of Hospital staff:** a training plan is to be developed in the beginning of every year in each hospital. Copies of training schedule and attendance of participants to be retained by the training in-charge.
7. **Patient Satisfaction survey** s to be done for a minimum of 30 IPD and OPD patients every month in the form of exit interviews and would be analyzed on monthly basis along with the complaints received to take appropriate measures
8. **Employee Satisfaction surveys** should be carried out every 6 months.
9. **Conduction of Audits**: Internal audit committees should carry out the internal audit every month. **In every 3 to 4 months inspection would be carried out in the facilities by the State level and District level inspection teams, and once in a year by the state level Quality assurance steering committee**.
10. **Reporting:** The facility level committee should submit quarterly reports to the State Level Quality Assurance Steering Committee and one annual report on 31st March of every year. The report should include the inputs of review meetings, feedbacks of patients , audits the gaps analyzed and the Future action plans

Chapter - 13

Standards and Guidelines for Mother- and Baby- Friendly Health Services – Unicef

STANDARD 1

Facility ensures right of the mother and baby to stay safely and with dignity

Objective : To make the mother feel welcome respected, and treated with dignity.

Process Criteria

Attitude and behavior of staff

- ✓ Irrespective of age ancestry, clients are greeted, treated with respect which encourages them to seek information without fearing ridicule or shouted at.
- ✓ Procedures (eg registration, investigation, discharge) are streamlined to minimize discomfort and avoid time wastage.
- ✓ Steps and procedures are explained to the client and their concerns are heard.
- ✓ Privacy is provided at every stage so that the woman fells comfortable to share confidential information. This can be done by hanging curtains on all windows, automatic door closer, signs related to restricted entry, signs related to restricted entry etc.
- ✓ Stillbirths and maternal deaths are handled with sensitivity by the staff .

Facility environment

- ✓ Waiting area and wards are organized to avoid overcrowding and provede basic comfort to the mother and baby.
- ✓ Sufficient space is available for the family members and birth companion.
- ✓ Facility has boundary wall, intact doors and windows and all areas well Lit, to make the client feel safe and Secure.
- ✓ Clean, functional toilets are available for the use of clients and relatives.
- ✓ Mechanism is in place to prevent entry of stray animals in the facility.
- ✓ One family member is allowed to stay with the mother all the time in the facility.
- ✓ Visitors are allowed only during the fixed visiting hours to avoid overcrowding and provide safety and privacy to the mother.
- ✓ Drinking water facility is available.
- ✓ Client's Feedback is shared regularly with staff to identify areas of improvement.

Ensuring Standards

- ✓ Staff capacity is built to provide services and support to mother and baby as per standards.
- ✓ In addition to the regular staff availability of hospital manager, counselor, social guide/s will be required to ensure that this standard is implemented.

Indicators

- ✓ 80% of staff is trained to provide services to meet the standards.
- ✓ 80% of client volunteering to give feedback (on safety, comfort cleanliness, privacy, confidentiality, respect, ease of communication with service provider, clarity of information and procedure time taken from registration, Discharge, etc), provide positive feedback.
- ✓ 80% of infrastructure meet the required physical standards.

Monitoring Tools

- ✓ Facility records
- ✓ Exit interviews
- ✓ Periodic facility observation
- ✓ Checklist

STANDARD 2

Infrastructure is designed optimally of easy mobility and comfortable stay of the client

Objective

To provide easy and comfortable access of services to the mother and newborns.

Process Criteria

- ✓ Facility has space to provide services as per GoI norms to L1, L2, L3.
- ✓ Infrastructure has the capacity to cater to the anticipated case load in terms of space, equipment and human resources.
- ✓ Help desk at the entrance to triage patients brought by prenatal transport .
- ✓ Maternity wing is clean, well-lit and well-ventilated.
- ✓ Maternity wing (Pregnant women waiting area, labour room, and Maternity ward) and newborn care area located near each other in the same complex.
- ✓ Separate, wkll-lit and functional toilets for female clients fitted with railing, waste basket and running water and separate toilets for male visitors in the maternity wing.
- ✓ Labour room, maternity ward and newborn corner have necessary furniture, fixed and potable equipment ,safe and well maintained instruments, drugs, consumables, (e.g linen, cleanings agents, cotton) electrical fittings, water supply, mosquito-proof doors and windows as per norms (for details refer to operational guideline for maternal and newborn health, NRHM 2010.)
- ✓ Regular maintenance chekup records are maintained and updated periodically to avoid accidents.
- ✓ A maintenance contract is available for repairing of replacing the equipment without loss of time, or inconvenience to the client.
- ✓ The location of the waste pit is well marked and easily accessible.
- ✓ Facility has signage(Written and pictorial) prominently showing labour room, emergency, laboratory, etc,
- ✓ Facility information displayed in strategic locations prominently, eg working hours, staff names and contact numbers, duty roster, entitlements for mothers and their babies, contact person for grievance Redressal, Blood bank, Name of the various departments, available drugs, whom to contact in case of any breakdown.
- ✓ Display of appropriate IEC materials in different wards in the facility.
- ✓ Facility entrance is designed to allow easy entry into the facility .
- ✓ Facility has boundary wall, fence intact doors and windows to keep out stray animals.
- ✓ 24x7 running water supply and electricity backup is available.

Indicators

- ✓ 80% of the clients volunteering to give feedback mention the ease of identification to the department, access, and functionality of the infrastructure.
- ✓ Zero breakdown of failure of infrastructure/ equipment.

Monitoring Toos

- ✓ Clint feedback form.
- ✓ Monthly maintenance report and time take from the time of breakdown to repair and restoration of services.
- ✓ Report of the hospital manager.
- ✓ Suggestion Box.

STANDARD 3

Service providers have necessary behavioral and technical Skills to provide integrated maternal and newborn services

Objective

- ✓ To enhance capacity to service providers in necessary skills for mother and newborn care services.
- ✓ To ensure implementation of skills in their day-to-day functioning.
- ✓ To enhance capacity of support staff to understand the client's needs.

Process criteria

- ✓ Facility has adequate number of healthcare providers to avoid overload.
- ✓ All healthcare providers have basic skills related to care services.
- ✓ Cadre and phase- wise skill-based (hands on) refresher trainings are conducted periodically.
- ✓ Periodic assessment of trained personnel on both technical and behavioral skills.
- ✓ Need-based orientation on a periodic basis.
- ✓ Meetings to discuss mis-managed/complicated cases and deaths are held on periodic basis.

Indicators

- ✓ % of functional trained staff.
- ✓ % of staff provided training on newer techniques and technology.
- ✓ % of trained staff qualifying in periodic assessments.
- ✓ Number of reorientation sessions conducted by the facility in a year.

Monitoring Tools

- ✓ Comprehensive training plan in place for existing and newly appointed staff and reviewed regularly as per training needs.
- ✓ Pre and post-test evaluated.
- ✓ List of practical skills imparted.
- ✓ Demonstration of Skill by staff (on dummy).
- ✓ Training and reorientation report.
- ✓ Clint feedback on quality of service and behavior.

STANDARD 4

Protocols for clinical care for mother and newborn are in place and implemented

Objective

To ensure that mother and baby receive health services as per established protocols (eg ANC,INC, NBC, infection prevention and biomedical waste, FP safe abortion).

Process Criteria

- ✓ The staff has undergone skill-based trainings according to their job responsibility
- ✓ Staff has knowledge about their respective job description.
- ✓ The skilled staff is deployed rationally so as to enable them to practice their skills.
- ✓ Facility has enabling environment for the service providers to practice the standard protocols, in form of supportive supervision and mentoring.
- ✓ There are adequate numbers of Labour room and 1st stage beds as per the delivery case lad.
- ✓ The facility has the required equipment, infrastructure, drugs, supplies, and consumables needed to provide services according to the protocols.
- ✓ There is proper recording, reporting and monitoring system to reflect provision of protocol-based services.
- ✓ Mother & Child Protection (MCP) cards are available and used for tracking mother and the Child.
- ✓ MCTS and HMIS is functional and regularly used for reporting.
- ✓ Monitoring systems are in place to monitor patient outcome, microbiological reports, breakdown time of equipment and obstetric care through filled partograph.
- ✓ Display of charter guarantees and entitlements.
- ✓ The facility has displayed Standard Operation Procedures (SOPs)
- ✓ Prominently at places needed.

Indicators

- ✓ % case records reviewed that followed clinical and housekeeping protocols, sepsis rate, hand washing rate, etc.
- ✓ % of staff who are able to demonstrate stipulated skills.
- ✓ Proportion of trained staff placed in appropriate service locations.
- ✓ Number of months in year when there was no stock-out of required drugs and supplies.
- ✓ Number of months in a year when all staff meeting is held to discuss gaps and issues and action taken.
- ✓ % of increase in target population covered.
- ✓ % clients who are aware of the charter, guarantee , and entitlements.
- ✓ % of facility sites displaying SOPs.

Monitoring Tools

- ✓ Duty roster.
- ✓ Service registers, Tock and store register.
- ✓ Display of protocols in appropriate locations in labour room and maternity wards.
- ✓ Detection of expected complications among regular care seekers.
- ✓ Minutes and proceedings of all staff meeting.

STANDARD 5

Early initiation of breastfeeding, exclusive breastfeeding for six months and rooming-in

Objective

- ✓ To ensure early initiation of breastfeeding by all women undergoing institutional delivery and to ensure that all women receive adequate information on infant and young child Feeding practices.
- ✓ To ensure that newborn is with the mother 24x7.

Process Criteria

- ✓ Maternity wing staff is trained on priority basis on infant and young Child Feeding (IYCF) practices.
- ✓ Breastfeeding counseling is started in antenatal period.
- ✓ In all women who are Heamo dynamically stable, early intiation of breastfeeding is facilitated on the labour table itself All mothers are encouraged to initiate breastfeeding within one hour of delivery.
- ✓ Staff is skilled to provide basic care to LBW and sick newborns.
- ✓ All stable and normal newborns are handed over to the mother to facilitate early initiation of breastfeeding and to prevent hypothermia.
- ✓ Within the health facility premises, materials in local Language should be prominently displayed to highlight the importance of early initiation and exclusive breastfeeding for six months.
- ✓ 10 steps of Baby friendly of Baby Friendly Hospital Initiative (BFHI) are displayed and practiced in the facility.
- ✓ Birth companions/family members are explained the importance of early initiation of breastfeeding.
- ✓ Mothers and Birth companions are counseled on exclusive breastfeeding.
- ✓ Facilities abide by the International Code of marketing breast mild substitute .
- ✓ Mothers and family members are counseled on postpartum family planning.
- ✓ Beds in postnatal ward are adequate for the delivered women to stay for minimum 48 hours.

Indicators

- ✓ % birth companions / family members oriented on early institution of breastfeeding.
- ✓ % mothers and family members who could recall information.
- ✓ % women delivering in health facility increases in the number of women breastfeeding exclusively .
- ✓ % mother counseled for postpartum family planning.
- ✓ % women who delivered staying for 48 hours in the facility.

Monitoring Toos

- ✓ Records of each case in facility.
- ✓ Labour room register.
- ✓ Direct observation by supervisors.
- ✓ Exit interviews.

STANDARD 6

Infection prevention/ control practices and biomedical waste management implemented

Objective

- ✓ To limit cross infection within the facility.
- ✓ To keep the facility clean and hygienic.

Process Criteria

- ✓ Staff is oriented on infection prevention and biomedical waste management.
- ✓ Required human resource, logistics and supplies is available to practice infection prevention.
- ✓ Health providers practice universal precaution.
- ✓ Adequate facility for hand washing is available specially in labour room, and before handling newborns.
- ✓ There is a system of segregation, treatment, transportation and disposal of biomedical waste.
- ✓ Periodic microbiological and hand washing audit are done.
- ✓ Certification from pollution Control Board is acquired and renewed periodically.
- ✓ The maternity ward, labour room, and related areas disinfected and pest controlled as per protocol on a regular basis.
- ✓ Mother and birth attendant are counseled and trained of hand washing .

Indicators

- ✓ % facilities with clear SOPs and coloured bins for segregation of hospital waste.
- ✓ % healthcare providers having needle stick injury in last 3 months.
- ✓ % reduction in nosocomial infections.
- ✓ % of positive culture report.
- ✓ % times single use syringe, needle and IV set are not used.

Monitoring Tools

- ✓ Random observation of hand washing practices.
- ✓ Service delivery records.
- ✓ Records of disinfection and pest control carried out.
- ✓ Lab culture report.
- ✓ Pollution Control Board certificate.

STANDARD 7

Establishment of referral linkages with availability of prenatal transport

Objective

To ensure timely transfer of pregnant mother and sick newborns to healthcare facility.

Process Criteria

- ✓ Call centre contact number is widely disseminated in the community.
- ✓ Patient is received and triaged at the MBFH.
- ✓ Functional vehicles with tele-connectivity and drivers are available 24x7.
- ✓ Clear identification of referral centre, and teleconnection with the referral centre, prior information when patient referred.
- ✓ All transfer outs are escorted by a skilled professional trained in skilled birth attendance and in emergency management.
- ✓ The vehicle is equipped as per the established norms for personal and equipment.
- ✓ Clear protocols for care during transit are available and used.
- ✓ Clear protocols on when and where to refer are followed and recorded.

Indicators

- ✓ Appropriate referral.
- ✓ Numbers of mothers/newborns being referral institution.
- ✓ Follow-up information on all referrals, and their outcomes.

Monitoring Tools

- ✓ Logbook entries in the vehicle.
- ✓ Feedback from clients
- ✓ Feedback from grassroots level workers.
- ✓ Report on outcome.

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STANDARD 8

Grievance Redressal system is functional

Objective

To ensure that the grievances are heard and action is taken specified timeframe.

Process Criteria

- ✓ Information displayed about the nature of complaint by the client (eg lack of privacy, poor staff conduct, medical negligence , molestation, asking for bribes,etc)
- ✓ In any of the above situations., a help desk is available where complaints can be lodged immediately.
- ✓ Suggestion box is placed at the reception for anonymous complaints suggestions.
- ✓ Name and contact details of the hospital staff on duty are displayed.
- ✓ Grievance Redressal committee is formed which includes Rogi Kalyan Samiti (RKS) Member and MBFHS coordinator.
- ✓ Grievance Redressal board prominently displayed with contact details of members and chairperson of the grievance Redressal committee. Installation of complaint boxes at various public locations of the hospital premises.
- ✓ Log book/complaint register is maintained for registering verbal or written complaints received by the hospital authorities.
- ✓ Specific time frames are set to review grievance and provision of as response.
- ✓ Grievance and its resolution are recorded , analyzed, shared with staff and used for internal performance measurement.
- ✓ Grievance review is notified to the complainant in writing which includes the steps taken and results of the grievance Redressal process.
- ✓ Code of Conduct both for service provider and clients is displayed.
- ✓ Periodic client interviews to assess and chek out- of-pocket expenses of the clients.

Indicators

- ✓ 80% of the clients (who made complaints) feel that their complaints are attended to within a specified period of time.
- ✓ Number of grievance committee meetings held and records maintained.
- ✓ 80% of the clients feel that the information given regarding the grievance Redressal system is user friendly and easy to understand.
- ✓ 80% clients with complaints get feedback from the committee within the specified time on the status, process adopted and result of their complaints .
- ✓ Over 80% feel they are treated with dignity and respect.

Monitoring Tools

- ✓ Exit interview and observations.
- ✓ Minutes and proceedings of grievance committee meetings.
- ✓ ATR reports.

STANDARD 9

Audits are done periodically

Objective

To evaluate the quality of mother and baby friendly health services to be provided.

Process Criteria

- ✓ Services are clean, friendly, warm and polite.
- ✓ Evidence based protocols are being followed.
- ✓ Service providers have necessary skills.
- ✓ Immediate and exclusive breastfeeding is being practiced.
- ✓ Infection prevention and biomedical waste management is appropriate.
- ✓ Timely payments are done for JSY/JSSK.
- ✓ Linkage and networking with prenatal transport is in place.
- ✓ Grievance Redressal system is in place.

Indicators

- ✓ % clients being provided counseling and other support services.
- ✓ % clients who volunteered to provide feedback on the services.
- ✓ % complaints received by grievance cell which were resolved.
- ✓ % increase in the SNCU admission.
- ✓ Mortality rate in inborn vas out born.
- ✓ % cases refereed with correct indications
- ✓ Infection and readmission rate.

Monitoring Tools

- ✓ Social audit (by RKS members)
- ✓ Medical audit (by facility in- charge, MO).
- ✓ Physical audit (by MBFHS coordinator using checklist)

STANDARD 10

Self- appraisal, recertification system established

Objective

- ✓ To set and maintain standards for MBFHS.
- ✓ To ensure that MBFHS working as per standards.

Process Criteria

- ✓ Facility has policy statement and is displayed Cleary.
- ✓ MBFHS standards are written in the waiting area.
- ✓ Facility is self-appraised every quarter.
- ✓ Recertification is done every 2 years.
- ✓ Adaptation and modification of WHO- BFHI form to fit MBFHS.
- ✓ Expert Group is constituted of a gynecologist, pediatrician, public health expert and nursing cadre and are oriented/trained in MBFHS.
- ✓ These experts are selected by name from both public and private sector
- ✓ To get a certification the facility should qualify with minimum marks/percentage in each segment (for details refer to Chapter 2 FFHI Checklist, FFHI NRHM- NHSRC 2010)

Indicators

- ✓ % facilities with MBFHS certificate
- ✓ % facilities that drop out.
- ✓ Number of newly certified MBFHS

Monitoring Tools

- ✓ Self appraisal form.
- ✓ Certification Form.
- ✓ Review report.
- ✓ Policy & Protocol statement .

Recommendations

Following are the suggested recommendation to implements the standards and make a facility accredited for Mother- & Baby friendly Health Services (MBFHS):

1. Standards are endorsed by professional bodies such as FOGSI, NNF, TNAI, IMA, INC, IAP, and ICMR.
2. Accreditation of facilities for MBFHS should be done by National Accreditation Board for Hospitals and Healthcare Providers (NABH)
3. To ensure ownership of this process, programme management structure at national and state Level should be identified:
   - ✓ Incorporating the process in national and state PIP to Institutionalize the process (allocation of budget, staff, and other required resources)
   - ✓ Dedicated focal point
   - ✓ Monitoring committees at national, regional and state Levels
   - ✓ Capacity Building process should include healthcare providers as well as the management and support staff.
4. Develop national guidelines on audit grievance Redressal, self-appraisal/recertification.
5. Suitable mechanism of the region should be explored to encourage private sector to adopt MBFH .