LOGO
CENTRE NAME
CENTRE ADRESS

DOCUMENT NAME	**POLICY MANUAL- (FMS) FACILITY MANAGEMENT AND SAFETY**
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PREPARED BY	**Name & Designation: DOCTOR NAME DESIGNATION OF DOCTOR** **Signature:**
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APPROVED BY	**Name & Designation: DOCTOR NAME DESIGNATION OF DOCTOR** **Signature:**
ISSUED BY	**Quality Department**

AMENDMENT SHEET

Sl. No.	Section No & Page No	Details of amendment	Reasons	Signature of preparatory authority	Signature of approval authority
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CONTROL OF THE MANUAL

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

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

The amendment sheet, to be updated (as and when amendments received) and referred for details of amendments issued.

The manual is reviewed once a year and is updated as relevant to the hospital policies and procedures. Review and amendment can happen also as corrective actions to the non-conformities raised during the self-assessment or assessment audits by NABH.

The authority over control of this manual is as follow

Preparation	Approval	Issue
CARETAKER NAME	DOCTOR NAME	ACCOUNTANT NAME
Caretaker	**(Ayurveda Consultant)**	**(Accountant)**

The procedure manual with original signatures of the above on the title page is considered as ‘Master Copy’, and the photocopies of the master copy for the distribution are considered as ‘Controlled Copy’.

1.0 PURPOSE

To provide safe and secure environment CENTRE NAME)

2.0 SCOPE:Hospital Wide

3.0 RESPONSIBILTY:

- Medical Superintendent:
- Core Member:
- Resident Medical Officer:
- Medical Office:
- Safety Committee:

1) **Objective of Policy:** The organization has a system in place to provide a safe and secure environment.
2) **Procedure:**

1. **Safety committee coordinates development, implementation and monitoring of the safety plan and policies.**

   Safety committee: The Safety Committee shall conduct Hazard Identification and Risk Analysis (HIRA) and accordingly take necessary steps to eliminate or reduce such hazards and associated risks. The committee shall comprise of the following members:

   - Chairman:
   - RMO:

2. **Patient safety devices are installed across the organization and are inspected periodically.**

a) Grab-bars

b) Bed-rails

c) Sign postings

d) Safety belts on stretchers and wheelchairs

e) Alarms – both visual and auditory

f) Warning signs – radiation or biohazard

g) Fire safety devices

3. **The organization is a non-smoking area and signage are displayed at various places.**
4. **Facility inspection rounds to ensure safety are conducted at least twice in a year in patient care areas and at least once in a year in non-patient care areas.**

i. Preventive and breakdown maintenance Schedule shall be prepared, monitored and carried out by the Maintenance department, Site Engineer, Electrical Engineer & Electrician, and House Keeping Supervisor.

ii. A comprehensive safety inspection shall be done four times in a year in patient care areas and twice a year in other areas by Site Engineer and Electrical Contractor.

5. **Inspection reports are documented and corrective and preventive measures are undertaken.**

i. A team (RMO, Ass. RMO, MO, supervisor) shall be generated report after each inspection by maintenance department in-charge which shall be discussed in Facility Management and Safety Committee Meeting and shall form the basis for safety.

ii. Records are maintained and monitored at the time of reporting for taking corrective and preventive action.

iii. Response times are monitored from time of reporting to time of inspection and time of implementation of corrective actions

6. There is a safety education programme for staff.

a) All staff are educated about safety requirements – in both patient care areas and non- patient care areas

b) There shall be regular safety training covering Fire safety, Hazardous materials, use of Personal Protective Equipment, Bio-Medical waste Management, etc.

7. Fire escape route is displayed in suitable places.

8. Fire EXIT signage is provided in red Color.

9. Administration shall be conversant with the laws and regulations and knows their applicability to the organization.

10. Administration shall regularly updates any amendments in the prevailing laws of the land.

11. Administration shall ensure implementation of these requirements.

12. There shall be a mechanism to regularly update licenses/ registrations/certifications.

13. The hospital adheres to the following applicable laws and regulations:

a) Bio-medical Waste Management and Handling Authorization

b) Registration With Local Authorities.

c) *Pharmacy* license

14. The hospital has identified as the person who will maintain a record of the above Licenses and regularly update their renewals.

FMS-02

1) Purpose: To provide safe and secure environment to patients, their families, staff and visitors in

2) Scope:

Hospital wide

3) RESPONSIBILTY:

. 3.1 Medical Superintendent:
. 3.2 Dy medical superintendent

. 3.3 Core Member

. 3.3 Resident Medical Officer:

. 3.4 Member Secretary:

. 3.5 Medical Officer:

. 3.6 Clinical Registrar

. 3.8 Safety Committee

4) OBJECTIVE OF POLICY:

The organization's environment and facilities shall operate to ensure safety of patients, their families, staff and visitors

5) PROCEDURE:

1. **Facilities are appropriate to the scope of services of the organization.**

i. The hospital aims to provide a safe facility for all its occupants.

ii. This shall be accomplished by a Facility management and Safety Committee, which shall oversee all aspects of Facility Safety.

iii. The provision of space shall be in accordance with the available literature by

decided CCIM on good practices.

2. **Up-to-date drawings are maintained which detail the site layout, floor plans and fire escape routes.**

i. Drawings (site layout, floor plan and fire escape route) shall be maintained in each floor in a visible manner.

ii. Fire escape route in the display of escape route drawing is marked in Red color.

iii. Fire EXIT signage is provided in Green Color through self-illuminating stickers.

3. Internal and external sign posting in the organization shall be maintained in a language understood by patient, families and community

4. The provision of space shall be in accordance with the available literature on good practices (Indian or International Standards) and directives from government agencies.

i. The provision of space shall be in accordance with the available literature by decided CCIM on good practices.

ii. Space is provided for the proper functioning of the department

5. **Potable water and electricity are available round the clock.**

RO water and electricity are available round the clock. The organization shall make arrangements for supply of adequate potable water and electricity. The potable water quality is monitored quarterly or more frequently and documented. Alternate sources of electricity and water are provided as backup for any failure/shortage.

i. At the outset, the organization shall ensure that there is sufficient water supply to meet the requirements. Further, the electric load applied for shall be appropriate to the requirements of the organization and adhere to the regulatory requirements.

ii. In case of a shortfall in water or electricity, then also alternate sources shall be required.

iii. The organization could consider having multiple alternate sources depending on the criticality of the activity.

6. **The organization regularly tests these alternate sources.**

The results of these tests shall be documented. In case of water, the testing includes bio- chemical and microbiological analysis.

7. **There are designated individuals responsible for the maintenance of all the**

facilities. A team shall be generated report after each inspection by maintenance department in-charge which shall be discussed in Facility Management and Safety Committee Meeting and shall form the basis for safety

8. **There is a documented operational and maintenance (preventive and breakdown) plan.**

i. Breakdown Maintenance:

a. All breakdown entries are made in the Registers.

b. The complaint is registered and complaint number is generated.

c. If the problem is not solved, is put forward to the RMO depending upon the warranty/AMC and further plan of action is decided.

d. Average down time depends on the type of breakdown

e. The details are updated in to the daily breakdown report and follow up is done.

ii. Preventive maintenance:

- The HOD/RMO prepares and maintains a maintenance plan as per the list of available equipments.
- The Preventive Maintenance of instrument having an AMC contract is done by
- All medical equipments undergo preventive maintenance at pre scheduled period.
- The concerned department is informed about the schedule of the equipment for preventive maintenance well in advance, so that they can keep the equipment free for required time period.
- The availability of necessary spares, consumables, tools and necessary materials are ensured through standardization and /or advance planning,
- After completion of maintenance (whether preventive or breakdown) the OK report is taken from the user department and also an acknowledgment is taken from user department and maintain in the above said register.

9. **Maintenance staff is contactable round the clock for emergency repairs.**

10. **Response times are monitored from reporting to inspection and implementation of corrective actions.**

All breakdown entries are made in the Registers. The complaint is registered and complaint number is generated.

FMS-03

1) Purpose:

1.1 The organization has a program for engineering support services.

2) Scope:

2.1 Hospital wide

3) RESPONSIBILTY:

3.1 Medical Superintendent:
3.2 Core Member
3.3 Resident Medical Officer:
3.4 Medical Officer:
3.5 Safety Committee

4) Policy:

The organization has a program for engineering support services.

5) Procedures:

5.1 The organization plans for equipment in accordance with its services and strategic plan.

a. The organization has proper equipment planning system that take in to account the future requirements of the organization in accordance with its scope of services and strategic plans.
b. Periodic requirement of equipment is prepared by each department and fully implemented.
c. The plans are reviewed periodically or as when required.

5.2 Equipments are selected updated or upgraded by a collaborative process.

a. All equipment are selected, updated or upgraded by a collaborative process and there is involvement of end-user, management, finance and engineering

department.

5.3 Equipments are inventoried and proper logs are maintained as required.

a. All equipment are inventoried and proper logs are maintained in the Registers.
b. Asset tags are allotted to all equipment.
c. All manufacturer factory test certificate are retained for every equipment.

5.4 Qualified and trained personnel operate and maintain the equipment.

a. Qualified and trained personnel only operate the equipment and utility systems.

b. Maintenance of equipment and utility systems is done by qualified and trained personnel along with AMC personnel.

5.5 There is a documented operational and maintenance (preventive and breakdown) plan.

a. Routine maintenance:

a.1. Responsible for daily maintenance of equipment based on daily monitoring checklist/Weekly monitoring /monthly monitoring.

a.2. Deficiency details are documented in equipment break down book and the same is communicated to

a.3. The Preventive Maintenance of instrument having an AMC contract is done

a.4. A schedule is prepared by the biomedical for preventive maintenance as per the manufacturer recommendation.

a.5. All medical equipment undergo preventive maintenance at pre scheduled period.

a.6. The concerned department is informed about the schedule of the equipment for preventive maintenance well in advance, so that they can keep the equipment free for required time period.

a.7. The availability of necessary spares, consumables, tools and necessary materials are ensured through standardization and /or advance planning, through Stores and guidance (by CENTRE NAME) After completion of maintenance (whether preventive or breakdown) an acknowledgment is taken from user department and maintain in the above said register.

b. Breakdown Maintenance:

b.1 All breakdown entries are made in the Registers.

b.2 The complaint is registered and complaint number is generated.

b.3 Caretaker has been assigned or directed to the site for rectification as per first line service guidelines.

b.4 If it is minor break down, corrective actions are taken by the with the available spare parts in-house within 2-3 hours and the same is documented in the breakdown register with the time of rectification details and it is counter signed by the who have performed the tests.

b.5 Average down time depends on the type of breakdown and the details are updated in to the daily breakdown report and follow up is done.

5.6 There is a maintenance plan for the water management.

a. Water storage tanks are cleaned at regular interval (6 month).
b. RO units and water coolers have been installed in OPD and IPD units.
c. Organization has its own bore well as well as water supply
d. RO units and water coolers are maintained through AMC contract.
e. Technical staff of estate department of the organization maintains the regular availability of water.

5.7 There is a maintenance plan for electrical systems.

a. Technical staff of estate department of the organization maintains the un-interrupted availability of electricity.
b. HT/ LT panels are also maintained by electricians of estate department of the organization, if required, the major technical faults are corrected with the help of Engineers of PWD.
c. DG sets are regularly maintained by AMC contract under the direct supervision of Estate In charge and Store Officer.

5.8 There is a maintenance plan for heating, ventilation and air-conditioning.

a. Room heaters and Coolers are provided by the organization according to seasons.

b. Room heaters and coolers are maintained by technical staff of estate department of the organization regularly.

5.9 There is documented procedure for equipment replacement and disposal.

a. All the units maintain the regular availability, storage, usage, up gradation, replacement, disposal and equipment log through the staff held responsible for the same under the direct supervision of the concerned unit heads.

b. Organization disposes the equipment in a systemic manner through central store unit under the direct supervision of store officer and deputy director.

c. All records pertaining to condemnation of equipment are maintained by each concerned unit and central store.

FMS-04

1. Purpose:

1.1 The organization shall have programme for bio-medical equipment management.

2. Scope:

2.1**Hospital wide**

3. RESPONSIBILTY:

. 3.1 Medical Superintendent:
. 3.3 Resident Medical Officer:

. 3.4 Member Secretory:
. 3.5 Medical Officer
. 3.8 Safety Committee

4. Objective of Policy: The organization shall have programme for bio-medical equipment management.

5. Procedure:

5.1 The organization plans for equipment in accordance with its services and strategic plan.

a) The organization has a proper equipment planning system that takes in to account the future requirements of the organization in accordance with its scope of services and strategic plans.

b) The plans shall be reviewed periodically or as and when required.

c) There is involvement of the end-users, management, finance, engineering and biomedical departments in the selection of equipment.

5.2 Equipment are selected, updated or upgraded by a collaborative process.
5.3All equipments are inventoried and proper logs are maintained as required and are allotted asset tags.

5.4 Qualified and trained personnel operate and maintain the equipment.

5.5 There is a documented operational and maintenance (preventive and breakdown) plan.

5.6 There is a maintenance plan for heating, ventilation and air-conditioning.

5.7 There is documented procedure for equipment replacement and disposal.

a) Designated staff is responsible for daily maintenance of equipments based on daily monitoring checklist/Weekly monitoring /monthly monitoring.

b) Deficiency details are documented in equipment break down book and the same is communicated to the concerned department.

FMS-05

1. **Purpose:**

1.1 The organization shall have programme for medical gases, vaccum and compressed air if applicable.

2. **Scope:**

2.1 **Hospital wide**

3. **Policy: Hospital wing, OPD has a programme for medical gases**

a. Documented procedures govern procurement, handling, storage, distribution, usage and replenishment of medical gases (Oxygen and Nitrous oxide)

1. Regarding the procurement of medical gases the CENTRE NAME is having the regular rate contract with authorised supplier for one year with the firm that deal with the supply of medical gases oxygen & nitrous oxide.
2. The units CENTRE NAME maintain the regular availability, handling, storage, usage and replenishment through the staff held responsible for the same under the direct supervision of the concerned unit head.
3. The supplier having the rate contract supply the oxygen & nitrous oxide on getting the order of the same on the same day/as per availability.
4. The bills are verified after the stock entry being done by the unit head & than forwarded for the bill payment to administrative wing.

b. Medical gases are handled, stored, distributed and used in a safe manner.

1. Color coding of the cylinders of Oxygen are black must be maintained.
2. Medical gases are handled, stored, distributed and used in safe manner following the standard guidelines.

c. The procedures for medical gases address the safety issues at all levels.

The procedures for medical gases address the safety issues at all levels.

d. Alternate sources of medical gases oxygen/nitrous are provided for in case of any failure/shortage.

e. The organization regularly tests these alternate sources.

FMS-06

1) Purpose:

1.1 The organization shall have plans for fire and non-fire emergencies within the facilities.

2) Scope:

2.1 Hospital wide

3) RESPONSIBILTY:

. . 3.8 Safety Committee

4. Objective of Policy: The organization shall have plans for fire and non-fire emergencies within the facilities.

5. Procedure:

5.1. The organization has plans and provisions for early detection, abatement and containment of fire and non-fire emergencies.

1. The organization has plans and provisions for early detection, containment and abatement of fire and non-fire emergencies made as per the guidelines received from representatives of district disaster management department.
2. The directions/floor plans/exit plans & signs to be followed in case of fire and non-fire emergencies are displayed in appropriate places following the standard guidelines representatives of district disaster management department.
3. The safety equipments in concern to the fire emergencies (fire extinguishers) are installed at the appropriate places as per the guidelines.
4. There is maintenance plan for fire-related equipments which work under the direct supervision of concerned unit heads in which the equipments are installed.

5.2 The organization has a documented safe-exit plan in case of fire and non-fire emergencies.

a) Alert all inmates one by one and room by room of the emergency situation without causing undue panic and commotion while informing the matter.

b) Evacuate all the patients first with the help of stretcher, trolleys or by the wheeled cots.

c) The medical documents of the particular patient should be sent along as well.

d) The only route to be used for evacuation of such patients should be the hospital Staircase.

e) Ambulatory or semi-ambulatory patients should be evacuated one by one using wheel chairs.

f) The patient's medical documents should be sent along.

g) Evacuation should be done in an orderly manner without causing confusion or panic.

h) These patients will occupy the vacant beds on the other wards except the affected area.

i) opd observation beds or crisis management beds on the ground floor shall also be used.

j) The duty personnel will leave the emergency affected floor last after ensuring that all the patients, their personal belongings and medical documents are safely evacuated.

5.3 Staff is trained for its role in case of such emergencies.

i. Training programmes concerning the inclusion as well are reorientation of the above said staff shall be organised time to time as a regular affair.

ii. All staff takes part the drill which gives emphasis of safe evacuation of the patients and occupants in the affected areas or hospital in general, as the fire-fighting and containment activity is under progress.

5.4 Regular Fire Training programs are held at least twice a year in hospital premises.

5.5 Hospital has a maintenance plan for fire related equipment.

a. This shall adhere to manufacturers and/or statutory recommendations

Non Fire Emergencies:

Disaster Management Committee:
Members

Roles & Responsibilities

- To establish and review the disaster Management Plan of the Institution.
- To ensure adequate training of the staff on Disaster Management Plan.
- To ensure availability of adequate resources for Disaster Management.
- To test the documented disaster management plan (mock drills) and take appropriate corrective / preventive action.
- Staff is adequately trained for handling such kind of emergencies and trained time to time by person expert in handling such kind of emergencies.

FMS-07

1. Purpose:

1.1 The organization shall have a plan for the management of hazardous materials.

2. Scope:

2.1Hospital wide

3. RESPONSIBILTY:

. 3.2 Safety Committee

4. Objective of Policy: The organization shall have a plan for the management of hazardous materials.

5. Procedure:

5.1 Hazardous materials are identified within the organization.

CENTRE NAME has planned for management of various hazardous materials and has managed display symbols of Biological Hazards in the following manner:

Controlled by Chairman

……STATE NAME…..Pollution Control Board (Govt.)

↓

STATE NAME

Pollution Control Board (Govt.)

We manage Bio-Medical waste by keeping them in different coloured Bags according to

norms of Pollution Control Board daily.

CENTRE NAME have identified, listed and documented the hazardous materials and had a documented procedure for there:

Sorting, storage and handling (these are controlled by Housekeeping

Transpositions, disposal mechanism, and method for managing spillages and adequate training of the personnel for these jobs (these are controlled .....)

Biological materials like blood and body fluids, mercury:

Yellow Bags	Syringes, expired tablets, chemical labs
Black Bags	Kitchen and food waste
Green Bags	Landfills by recycling biodegradable
White Bags	Sharp and solid waste
Red Bags	Microbiology and Biotechnology Soiled and Solid waste

Medical gases, LPG gas, steam, etc., are some of the other common hazardous materials are controlled by fire controlling board through the unit heads.

5.2 The organization implement processes for sorting, labelling, handling, storage, transporting, and disposal of hazardous material.

CENTRE NAME has conducted an exercise of hazard (Biomedical wastes) through identification and risk analysis (HIRA) associated with handling of hazardous materials and accordingly taken all necessary steps to eliminate or reduce such hazards and associated risks through:

1. OPD In charge controlled in OPD campus.
2. Panchkarma department incharge
3. IPD by staff nurse.

CENTRE NAME has ensured display of Material Safety Data Sheets (MSDS) for all hazardous materials and has accordingly

arranged training of personnel (concerned units like panchkarma, housekeeping, opd and ipd department) who handle such materials.

We have managed HIRA so that any emergency situation arising out of process of storing, handling, storage, transportation and disposal of such hazardous materials are met effectively.

CENTRE NAME has the requisite training need identification for material handling and those trainings are included in the CENTRE NAME training calendar and we have decided the training date and training by DOCTOR NAME as per norms of STATE NAME pollution control board, Government of STATE NAME.

5.3 CENTRE NAME has plan for managing spills of hazardous materials CENTRE NAME has HAZMAT kit(s) for handling spills.

Procedure for Spills (with possible aerosol formation)

1. Evacuate the area or room and alert all personnel regarding the spill and take care not to breathe in aerosolized material
2. Close doors to the affected area and keep it closed for 30 min.
3. Only the designated staff has to enter the area to clear the spill and the staff cleaning the spill should ensure that they use the appropriate PPE (gloves, mask).
4. Use disposable paper towels or tissue to wipe off the liquid in the spillage and discard the tissue into a container meant for infected wastes.
5. Carefully clean the spill site of any visible material from the edges of the spill to the center with an aqueous detergent solution.
6. Pour disinfectant (1% sodium hypochlorite) over the entire area of the spillage and let it remain for 20 min.
7. Absorb the detergent with an absorbable material and dispose in the infected container.
8. Rinse the spill site with soap and water and air dry.

FMS-08

9. Purpose:

9.1 The organization shall have herbal plantation.

10. Scope:

10.1 **Hospital wide**

11. RESPONSIBILTY:

. 3. **Objective of Policy:** The organization shall have herbal plantation.

12. Procedure:

12.1 CENTRE NAME have herbal plantation at the entrance of the

12.2 . Example of herbal plants includes Tulsi, Neem, Aloe Vera, Brahmi, Mint, etc.

12.3 The herbal plants are having display card with its scientific name, common name & its uses.