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# POLICIES ON

# KAYAKALP-2026.

# Policy on Kayakalp Implementation

**LHMC-Kayakalp-POL-2026-001-V1.0**

## Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

***(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)***

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

## Details of the Document

| | |
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| Document Name | Policy on Kayakalp Implementation |
| Document No. | LHMC-Kayakalp-POL-2026-001-V1.0 |
| No. of pages: | 08 |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Review By | Name: Dr. Manoj B. Jais<br>Designation: Medical Superintendent, SSKH<br>Signature |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Name: Chairperson Kayakalp Committee |

# LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS

## (LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children's Hospital)

# POLICY ON KAYAKALP IMPLEMENTATION

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## POLICY IDENTIFICATION

| Field | Details |
|---|---|
| Policy Title | Policy on Kayakalp Implementation |
| Policy Code | LHMC-Kayakalp-POL-2026-001-V1.0 |
| Domain | Quality, Cleanliness & Patient Safety |
| Category | Policy |
| Prepared By | Dr. Banarsi, Additional Medical Superintendent |
| Reviewed By | Kayakalp Committee |
| Approved By | Director LHMC |
| Date of Approval | |
| Effective From | |
| Review Due On | |
| Version | V1.0 |
| Supersedes | Nil |
| Confidentiality Status | Public (Cleanliness & Safety) |

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## 1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to providing clean, hygienic, safe and patient-friendly healthcare services. The **Kayakalp Initiative**, launched by the Ministry of Health & Family Welfare, Government of India, aims to promote cleanliness, hygiene, infection control and patient satisfaction in public healthcare facilities.

This policy provides a structured framework for systematic implementation, monitoring and continuous improvement of Kayakalp standards across LHMC and its Associated Hospitals.

## 2. OBJECTIVES

The objectives of this policy are to:

- Implement Kayakalp guidelines in a structured and sustainable manner
- Improve cleanliness, sanitation and infection control practices
- Enhance patient experience and satisfaction
- Promote a culture of quality, hygiene and accountability
- Achieve and sustain high Kayakalp scores

## 3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall cover all Kayakalp thematic areas including:

- Hospital Upkeep
- Sanitation & Hygiene
- Waste Management
- Infection Control
- Support Services
- IEC & Behaviour Change

The policy shall be applicable to all staff, students, outsourced agencies, patients and visitors.

## 4. DEFINITIONS

**Kayakalp:** A national initiative to promote cleanliness, hygiene and infection control practices in public healthcare facilities.

**Kayakalp Assessment:** Periodic internal and external assessment conducted as per MoHFW guidelines.

**Thematic Areas:** Defined domains under Kayakalp assessment framework.

# 5. GOVERNANCE STRUCTURE

## 5.1 Competent Authority

The Director /Medical Superintendents/ Principal, LHMC shall be the Competent Authority for implementation of this policy.

## 5.2 Kayakalp Core Committee

A Kayakalp Core Committee shall be constituted through Office Order.

**Composition (indicative):**

- Chairperson: Medical Superintendent, SSKH
- Co-Chairperson: Medical Superintendent, KSCH
- Members: Additional Medical Superintendents (SSKH & KSCH), Nursing Head, SSKH & KSCH, HICC Chairperson, Chairperson Operation & Maintenance, Chairperson Sanitation Committee, Chairperson security Committee, DDA, Quality Officer
- Member Secretary: Nodal Officer – Kayakalp

## 5.3 Sub-Committees / Nodal Officers

Thematic sub-committees and nodal officers shall be designated for each Kayakalp domain.

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# 6. KAYAKALP THEMATIC AREAS & IMPLEMENTATION

Kayakalp shall be implemented across the following thematic areas:

- Hospital Upkeep
- Sanitation & Hygiene
- Waste Management
- Infection Control
- Support Services
- IEC & Behaviour Change

Each thematic area shall have defined action plans, SOPs, monitoring indicators and documentation.

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# 7. IMPLEMENTATION STRATEGY

- Baseline gap analysis against Kayakalp checklist
- Preparation of annual Kayakalp action plan

- Allocation of responsibilities and timelines
- Resource allocation and infrastructure improvement
- Regular review meetings and corrective actions

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## 8. MONITORING, ASSESSMENT & AUDIT

- Monthly internal audits using Kayakalp checklists
- Periodic mock assessments
- Documentation of scores, gaps and corrective actions
- Preparation for external Kayakalp assessment

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## 9. DOCUMENTATION & RECORD KEEPING

- Kayakalp files for each thematic area
- Audit reports and score sheets
- Photographic evidence and compliance records
- Action taken reports (ATR)

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## 10. TRAINING & CAPACITY BUILDING

- Orientation and refresher training on Kayakalp guidelines — all staff
- Training for housekeeping, nursing and support staff
- Awareness programs for patients and attendants

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## 11. IEC & COMMUNITY PARTICIPATION

- Display of Kayakalp IEC materials
- Patient feedback and suggestion mechanisms → feedback record
- Engagement of staff and patients in cleanliness drives

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## 12. INCENTIVES & MOTIVATION

- Recognition of best-performing departments
- Appreciation certificates and internal awards
- Encouragement of innovation and best practices

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## 13. COMPLIANCE & ACCOUNTABILITY

Non-compliance with Kayakalp implementation plans shall attract corrective actions as per institutional rules.

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## 14. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to changes in Kayakalp guidelines or institutional needs.

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## 15. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

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## 16. APPROVAL

**Sarita Beri**
**LHMC & Associated Hospitals, New Delhi-110001**

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# ANNEXURES

## Annexure – I: Kayakalp Core Committee – Composition & Roles

| Designation | Role |
|---|---|

## Annexure – II: Kayakalp Thematic Area-wise Checklist (Indicative)

| Thematic Area | Key Indicators | Responsible Officer |
|---|---|---|

## Annexure – III: Kayakalp Internal Audit Format

| Date | Area | Score | Gaps Identified | Corrective Action |
|---|---|---|---|---|

## Annexure – IV: Kayakalp Action Plan Format

| Area | Activity | Responsibility | Timeline | Status |
|---|---|---|---|---|

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*All annexures form an integral part of this policy and shall be implemented and monitored by the Kayakalp Core Committee.*

*End of Policy Document*

# Policy on Cleanliness and Sanitation

**LHMC-Kayakalp-CS-POL-2026-002-V1.0**

**Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001**

***(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)***

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

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| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Reviewed by: | Name: Dr. Manoj B Jais<br>Designation: Medical Superintendent<br>Signature |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Hospital Sanitation Committee |

# POLICY ON CLEANLINESS AND SANITATION

## POLICY IDENTIFICATION

| Field | Details |
|---|---|
| Policy Title | Policy on Cleanliness and Sanitation |
| Policy Code | LHMC-Kayakalp-CS-POL-2026-002-V1.0 |
| Domain | Sanitation / Support Services |
| Category | Policy |
| Prepared By | Dr. Banarsi, Additional Merdical Superintendent |
| Reviewed By | Kayakalp Committee |
| Approved By | Director LHMC |
| Date of Approval | _____ |
| Effective From | |
| Review Due On | (After 3 Years) |
| Version | V1.0 |
| Supersedes | Nil |
| Confidentiality Status | Public (Cleanliness & Safety) |

## 1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to maintaining the highest standards of cleanliness, sanitation and hygiene to ensure patient safety, infection prevention, staff well-being and a clean hospital environment. Cleanliness and sanitation are critical components of quality healthcare delivery and are essential for compliance with national guidelines, accreditation standards and public health expectations.

This policy establishes a comprehensive framework for planning, implementation, monitoring and continuous improvement of cleanliness and sanitation practices across all areas of the institution.

## 2. OBJECTIVES

The objectives of this policy are to:

- Ensure a clean, safe and hygienic environment for patients, attendants, staff and visitors
- Prevent healthcare-associated infections through effective sanitation practices
- Define standards, responsibilities and procedures for hospital cleanliness
- Ensure compliance with Swachh Bharat Abhiyan, Kayakalp, NABH and MoHFW guidelines
- Establish monitoring, documentation and accountability mechanisms

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# 3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall cover all areas including:

- Patient care areas (wards, ICUs, OTs, OPDs, emergency), Dialysis Units
- Diagnostic and laboratory areas
- Administrative offices and academic blocks
- Public areas, toilets, corridors and waiting areas
- Hostels, residential areas and kitchens

It shall be applicable to all housekeeping, sanitation staff, nursing staff, medical staff, outsourced agencies and supervisors.

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# 4. DEFINITIONS

**Cleanliness:** State of being free from dirt, waste, dust and visible contaminants.

**Sanitation:** Maintenance of hygienic conditions through cleaning, disinfection, waste disposal and pest control.

**Housekeeping Services:** Services related to cleaning, sanitation, waste management and upkeep of hospital premises.

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# 5. GOVERNANCE STRUCTURE

## 5.1 Competent Authority

The Director / Medical Superintendents/ Principal, LHMC shall be the Competent Authority for implementation of this policy.

## 5.2 Nodal Committee

The Hospital Sanitation Committee / Hospital Infection Control Committee (HICC) shall act as the nodal committee for oversight, monitoring and review.

## 5.3 Nodal Officers

- Medical Superintendent (SSKH / KSCH)
- Nodal Officer – Sanitation / Housekeeping
- Infection Control Nurse
- Engineering / Estate Officer

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# 6. STANDARDS OF CLEANLINESS AND SANITATION

- Daily wet and dry cleaning of all areas
- Use of approved disinfectants as per area-specific protocols
- Colour-coded cleaning equipment and mops
- Separate cleaning schedules for high-risk and low-risk areas
- Regular cleaning and disinfection of toilets and washrooms
- Adequate availability of hand hygiene facilities

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# 7. ROLES AND RESPONSIBILITIES

## 7.1 Housekeeping Staff

- Perform cleaning and sanitation as per duty rosters and SOPs
- Use PPE and cleaning agents correctly
- Report spills, damages and sanitation issues promptly

## 7.2 Nursing & Clinical Staff

- Ensure maintenance of cleanliness in patient care areas
- Report deficiencies to housekeeping supervisors

## 7.3 Supervisors / Outsourced Agency

- Ensure adequate manpower and supplies

- Monitor performance and maintain records

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## 8. CLEANING FREQUENCY & METHODS

- High-risk areas: Minimum twice daily and as required
- General areas: Daily
- Toilets: Thrice daily or more as required
- Terminal cleaning after discharge or procedures

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## 9. MONITORING, AUDIT & DOCUMENTATION

- Daily checklists and supervisory rounds
- Periodic audits by Sanitation / HICC committees
- Patient feedback and grievance review
- Maintenance of sanitation registers

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## 10. TRAINING & AWARENESS

- Induction and refresher training for housekeeping staff
- Awareness programs for staff and patients
- Display of cleanliness and hygiene signage

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## 11. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract corrective and administrative action as per institutional rules and contract conditions.

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## 12. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to changes in guidelines or operational needs.

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## 13. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

## 14. APPROVAL

Dr. Sarita Beri
Director, LHMC & Associated Hospitals, New Delhi-110001

# ANNEXURES

## Annexure – I: Area-wise Cleaning and Disinfection Schedule

| Area | Risk Category | Frequency | Cleaning Agent / Disinfectant | Responsible Staff | Record Maintained |
|---|---|---|---|---|---|
| Operation Theatre | High Risk | After each case & terminal cleaning | Approved surface disinfectant | Housekeeping OT staff | OT Cleaning Register |
| ICU / NICU | High Risk | Minimum 3 times daily | Approved disinfectant | Assigned HK staff | ICU Cleaning Log |
| Wards | Moderate Risk | Twice daily | Phenyl / approved disinfectant | HK staff | Ward Checklist |
| OPD | Moderate Risk | Daily | Approved disinfectant | HK staff | OPD Checklist |
| Toilets | High Risk | Thrice daily | Hypochlorite solution | HK staff | Toilet Log |
| Corridors / Public Areas | Low Risk | Daily | Detergent / disinfectant | HK staff | Supervisor Log |

## Annexure – II: Daily Housekeeping Checklist

| Date | Area | Cleaning Done (Yes/No) | Time | Name of Staff | Supervisor Signature |
|---|---|---|---|---|---|

## Annexure – III: Toilet Cleaning and Sanitation Checklist

| Location | Time | Cleaning Agent Used | Fixtures Cleaned (WC, Basin, Floor) | Staff Name | Supervisor Signature |
|---|---|---|---|---|---|

## Annexure – IV: Spill Management Procedure (Blood & Body Fluids)

1. Restrict the area and use appropriate PPE.
2. Absorb spill using disposable absorbent material.
3. Clean area with detergent and water.
4. Disinfect with 1% sodium hypochlorite solution.
5. Dispose waste as per Biomedical Waste Management Rules.
6. Perform hand hygiene after completion.

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## Annexure – V: Sanitation Audit & Monitoring Format

| Audit Date | Area Audited | Observations | Non-Compliance | Corrective Action | Timeline | Auditor Signature |
|---|---|---|---|---|---|---|

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## Annexure – VI: Complaint & Feedback Register (Cleanliness & Sanitation)

CANS/SNO

| Date | Area | Complaint / Feedback | Source (Patient / Staff) | Action Taken | Status | Remarks |
|---|---|---|---|---|---|---|

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## Annexure – VII: Training Record for Housekeeping & Sanitation Staff

| Date | Topic | Trainer | Participants | Duration | Signature |
|---|---|---|---|---|---|

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*All annexures form an integral part of this policy and shall be implemented, monitored and reviewed by the Hospital Sanitation Committee / HICC.*

*End of Policy Document*

# Policy on Pest Control

LHMC-Kayakalp-CS-PC-POL-2026-003-V1.0

**Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001**

***(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)***

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

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| Document No. | LHMC-Kayakalp-CS-PC-POL-2026-003-V1.0 |
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| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Reviewed By: | Dr. Manoj B. Jais<br>Designation: Medical Superintendent<br>Signature |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Chairperson Sanitation Monitoring Committee |

# POLICY ON PEST CONTROL

## POLICY IDENTIFICATION

| Field | Details |
|---|---|
| Policy Title | Policy on Pest Control |
| Policy Code | LHMC-Kayakalp-CS-PC-POL-2026-003-V1.0 |
| Domain | Facility Management / Infection Prevention & Control |
| Category | Policy |
| Prepared By | Dr. Banarsi, Additional Medical Superintendent |
| Reviewed By | Kayakalp Committee |
| Approved By | Director LHMC |
| Date of Approval | |
| Effective From | |
| Review Due On | (After 3 Years) |
| Version | V1.0 |
| Supersedes | Nil |
| Confidentiality Status | Public (Regulatory & Safety) |

## 1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to maintaining a safe, hygienic and pest-free healthcare environment. Presence of pests such as rodents, insects and other vectors poses risks of infection, contamination, structural damage and poor patient experience.

This policy establishes a structured framework for prevention, control, monitoring and documentation of pest control activities across LHMC and its Associated Hospitals.

## 2. OBJECTIVES

The objectives of this policy are to:

- Prevent infestation of pests in hospital premises
- Reduce risk of healthcare-associated infections and contamination
- Ensure patient, staff and visitor safety
- Standardize pest control practices and accountability
- Ensure compliance with NABH, Kayakalp and statutory guidelines

# 3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- All buildings, wards, ICUs, OTs, OPDs, stores, kitchens and public areas
- All housekeeping, maintenance and outsourced pest control personnel

# 4. DEFINITIONS

**Pest Control:** Measures taken to prevent, reduce or eliminate pests including insects, rodents and other vectors.

**Integrated Pest Management (IPM):** A systematic approach combining preventive, physical, chemical and biological measures to control pests safely and effectively.

# 5. GOVERNING PRINCIPLES

- Prevention is the first line of pest control
- Use of safe, approved and least-toxic methods
- Minimal disruption to patient care
- Documentation, monitoring and accountability
- Continuous improvement

# 6. GOVERNANCE STRUCTURE

## 6.1 Competent Authority

The Director / Medical Superintendent/ Principal, LHMC shall be the Competent Authority for implementation of this policy.

## 6.2 Oversight

Pest control activities shall be overseen by Hospital Administration in coordination with:

- Housekeeping Services
- Hospital Infection Control Committee (HICC)
- Engineering / Maintenance Department

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# 7. TYPES OF PESTS COVERED

- Rodents (rats, mice)
- Crawling insects (cockroaches, ants)
- Flying insects (mosquitoes, flies)
- Termites and other structural pests

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# 8. PREVENTIVE MEASURES

- Maintaining cleanliness and proper waste disposal
- Sealing of cracks, crevices and entry points
- Proper food storage in kitchens and pantries
- Elimination of stagnant water

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# 9. PEST CONTROL METHODS

## 9.1 Non-Chemical Methods

- Traps and physical barriers
- Environmental sanitation

## 9.2 Chemical Methods

- Use of approved insecticides and rodenticides
- Application by trained and authorized personnel
- Avoidance of spraying in patient areas during service hours

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# 10. SCHEDULING OF PEST CONTROL ACTIVITIES

- Routine pest control as per defined schedule
- Emergency pest control on complaint or detection
- Advance intimation to departments before treatment

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## 11. SAFETY PRECAUTIONS

- Use of PPE by pest control personnel
- Removal or covering of food, medicines and equipment
- Display of warning signage during pest control operations

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## 12. MONITORING & SUPERVISION

- Regular inspections by housekeeping supervisors
- Review of pest sightings and complaints
- Coordination with outsourced agency

---

## 13. COMPLAINT & RESPONSE MECHANISM

- Reporting of pest sightings by staff or patients
- Time-bound response and corrective action

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## 14. DOCUMENTATION & RECORD KEEPING

- Pest control schedules and service reports
- Chemical usage records
- Complaint and corrective action logs

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## 15. TRAINING & AWARENESS

- Training of housekeeping staff on pest prevention
- Awareness among staff regarding reporting mechanisms

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## 16. MONITORING, AUDIT & QUALITY IMPROVEMENT

- Periodic audits of pest control effectiveness
- Review during Kayakalp and NABH assessments

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## 17. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

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## 18. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required.

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## 19. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

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## 20. APPROVAL

**Dr. Sarita Beri,**
**Director LHMC**
**New Delhi**

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# ANNEXURES

## Annexure – I: Pest Control Schedule Format

| Area | Type of Pest | Frequency | Method | Agency |
|---|---|---|---|---|

## Annexure – II: Pest Sighting / Complaint Register

| Date | Area | Pest Noted | Reported By | Action Taken |
|---|---|---|---|---|

## Annexure – III: Pest Control Inspection Checklist

| Parameter | Compliant (Yes/No) | Remarks |
|---|---|---|

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*All annexures form an integral part of this policy and shall be implemented and monitored by Hospital Administration and Housekeeping Services.*

*End of Policy Document*

# HOSPITAL VISITOR POLICY LHMC-Kayakalp-AD-POL-2026-004-V1.0

**Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001**

*(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)*

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

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| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Reviewed By: | Dr. Manoj B. Jais<br>Designation: Medical Superintendent SSKH |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Concerned Additional Medical Superintendent/ Chairperson Security Committee<br>Next Update in three year |

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

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| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br><br>Signature |
| Reviewed By: | Dr. Manoj B. Jais<br>Designation: Medical Superintendent SSKH |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br><br>Signature |
| Responsibility of updating: | Concerned Additional Medical Superintendent/ Chairperson Security Committee<br>Next Update in three year |

# 1. PURPOSE

The purpose of this policy is to regulate hospital visitors in order to ensure patient safety, privacy, infection prevention, security and smooth functioning of hospital services, while allowing reasonable access to patients by their attendants and family members.

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# 2. SCOPE

This policy covers:

- Inpatients and their visitors
- Emergency, ICU, special care areas and wards
- OPD and waiting areas
- All categories of visitors including attendants, relatives and caregivers

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# 3. DEFINITIONS

**Visitor:** Any person other than hospital staff visiting a patient.

**Attendant:** A person authorised by the patient or family to provide basic non-clinical support.

**Restricted Areas:** ICUs, operation theatres, labour rooms, NICU/PICU and isolation wards.

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# 4. POLICY STATEMENT

LHMC & Associated Hospitals are committed to maintaining a safe, secure and patient-friendly environment. Visitor access shall be regulated to balance patient comfort with clinical care, infection control and security requirements.

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# 5. GENERAL VISITOR GUIDELINES

5.1 Visiting hours shall be notified and displayed prominently in all wards and public areas.

5.2 Only **one attendant per patient** shall be permitted during visiting hours, unless otherwise permitted.

5.3 Visitors must wear **valid visitor passes / identification badges** issued by the hospital.

5.4 Children below a 12 year shall not be allowed in restricted areas.

5.5 Visitors must follow hospital rules, signage and instructions of hospital staff and security personnel.

---

# 6. RESTRICTED AREAS & SPECIAL UNITS

6.1 Entry into ICUs, NICU, PICU, labour rooms, OTs and isolation wards shall be strictly regulated.

6.2 Visiting in these areas shall be:

- Limited in number and duration
- Allowed only with permission of treating team
- Subject to infection control protocols

6.3 Visitors shall follow hand hygiene, PPE and other infection prevention measures as advised.

---

# 7. VISITOR CONDUCT

Visitors shall:

- Maintain decorum and silence
- Not interfere with medical or nursing care
- Refrain from photography or videography without permission
- Avoid bringing prohibited items
- Respect privacy and dignity of all patients

Violation may lead to cancellation of visitor privileges.

---

# 8. EMERGENCY & EXCEPTIONAL SITUATIONS

8.1 In emergency situations, limited access may be provided to one attendant as decided by the treating team.

8.2 Special consideration may be given in end-of-life care, paediatric and vulnerable patient situations, subject to clinical discretion.

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# 9. ROLES & RESPONSIBILITIES

| Authority | Responsibility |
|---|---|
| Director | Overall policy oversight |
| Medical Superintendent | Implementation and monitoring |
| Heads of Departments | Enforcement in clinical areas |
| Nursing In-charge | Patient and attendant counselling |
| Security Officer | Visitor regulation and access control |

# 10. COMPLIANCE & MONITORING

Compliance shall be monitored through:

- Security reports
- Patient feedback
- Infection control audits

# 11. AWARENESS & COMMUNICATION

- Display of visiting hours and rules at entry points and wards
- Information through IEC materials and announcements
- Orientation of staff and security personnel

# 12. DOCUMENTATION & RECORDS

- Visitor pass registers
- Incident / violation records

# 13. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to statutory, public health or operational needs.

# 14. REFERENCES

- NABH Hospital Accreditation Standards
- Infection Prevention & Control Guidelines, MoHFW
- Disaster & Public Health Emergency Guidelines

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# 15. ANNEXURES

## ANNEXURE – I

### VISITOR PASS FORMAT

### LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS

Visitor Pass No.: _____

| Field | Details |
|---|---|
| Name of Visitor | |
| Relation with Patient | |
| Name of Patient | |
| UHID / IP No. | |
| Ward / Unit | |
| Date | |
| Visiting Time | From ____ To ____ |
| Issuing Authority | |

**Conditions:**

- This pass is non-transferable
- Must be displayed prominently at all times
- Valid only for the specified date and time

Signature of Issuing Staff: _____

---

## ANNEXURE – II

### DISPLAY BOARD CONTENT – VISITING HOURS & RULES

**VISITING HOURS**
Morning: _____
Evening: _____

**VISITOR GUIDELINES**

- Only one attendant allowed per patient
- Children below 12 years are not allowed
- Follow hand hygiene and infection control practices
- Photography and videography are prohibited
- Maintain silence and cleanliness
- Follow instructions of hospital staff

Violation of rules may result in cancellation of visiting privileges.

---

## ANNEXURE – III

### RESTRICTED AREAS – ACCESS CONTROL NOTICE

The following areas are **RESTRICTED**:

- ICU / NICU / PICU
- Operation Theatres
- Labour Rooms
- Isolation Wards
- Kitchen
- Laundry
- CSSD

Entry is permitted only with authorisation of treating team and subject to infection control protocols.

---

## ANNEXURE – IV

### EXCEPTION APPROVAL FORMAT (SPECIAL CIRCUMSTANCES)

Name of Patient: _____

UHID / IP No.: _____

Ward / Unit: _____

Reason for Exception (End-of-life / Paediatric / Other):

_____

Duration of Permission: _____

Approved By (Name & Designation): _____

Signature & Date: _____

_____

**(End of Policy Document)**

# Policy on Solid Waste Management

**LHMC-Kayakalp-CS-ENV-POL-2026-005-V1.0**

## Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

***(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)***

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

## Details of the Document

| | |
|---|---|
| Document Name | Policy on Solid Waste Management |
| Document No. | LHMC-Kayakalp-CS-ENV-POL-2026-005-V1.0 |
| No. of pages: | 08 |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Reviewed by: | Name: Dr. Manoj B Jais<br>Designation: Medical Superintendent<br>Signature |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Chairperson Sanitation Monitoring Committee |

# LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS

## (LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children's Hospital)

# POLICY ON SOLID WASTE MANAGEMENT

---

## POLICY IDENTIFICATION

| Field | Details |
|---|---|
| Policy Title | Policy on Solid Waste Management |
| Policy Code | LHMC-Kayakalp-CS-ENV-POL-2026-005-V1.0 |
| Domain | Environment / Waste Management |
| Category | Policy |
| Prepared By | Dr. Banarsi, Additional Medical Superintendent |
| Reviewed By | Hospital Sanitation Committee & HICC |
| Approved By | Director LHMC |
| Date of Approval | _____ |
| Effective From | |
| Review Due On | (After 3 Years) |
| Version | |
| Supersedes | |
| Confidentiality | Public |

---

## 1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) generate various types of solid waste during healthcare delivery, academic activities and routine operations. Improper handling of solid waste poses risks to public health, environment and occupational safety.

This policy aims to ensure safe, systematic and environmentally responsible management of solid waste in compliance with Solid Waste Management Rules, 2016 (as amended), Swachh Bharat Abhiyan, Kayakalp guidelines and applicable local authority norms.

## 2. OBJECTIVES

The objectives of this policy are to:

- Ensure scientific management of solid waste generated in the institution
- Minimize health and environmental risks due to improper waste handling
- Promote segregation, reduction, reuse and recycling of waste
- Define roles, responsibilities and accountability
- Ensure compliance with statutory and regulatory requirements

## 3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall cover management of:

- Municipal solid waste (biodegradable and non-biodegradable)
- Recyclable waste (paper, plastic, metal, glass)
- Domestic waste from hostels and residential areas
- Excludes biomedical waste which is governed by a separate BMW policy

This policy shall be applicable to all staff, students, outsourced agencies, patients and visitors.

## 4. DEFINITIONS

**Solid Waste:** Any solid or semi-solid waste excluding biomedical, hazardous and e-waste.

**Biodegradable Waste:** Waste that can be decomposed naturally such as food waste.

**Non-biodegradable Waste:** Waste that does not decompose easily such as plastics and metals.

**Recyclable Waste:** Waste materials that can be processed and reused.

# 5. GOVERNANCE STRUCTURE

### 5.1 Competent Authority

The Director / Medical Superintendents/ Principal, LHMC shall be the Competent Authority for implementation of this policy.

### 5.2 Nodal Committee

The Hospital Sanitation Committee, in coordination with the Hospital Infection Control Committee (HICC), shall be the nodal body for oversight and monitoring.

### 5.3 Nodal Officers

- Medical Superintendent (SSKH / KSCH)
- Nodal Officer – Sanitation
- Engineering / Estate Officer
- Representative from outsourced sanitation agency

---

# 6. WASTE SEGREGATION

- Waste shall be segregated at source into biodegradable, recyclable and non-recyclable categories
- Colour-coded bins as per Solid Waste Management Rules shall be used
- Mixing of solid waste with biomedical waste is strictly prohibited

---

# 7. COLLECTION, STORAGE & TRANSPORT

- Waste shall be collected daily from all areas
- Temporary storage areas shall be designated and maintained hygienically
- Covered trolleys shall be used for internal transport
- Waste shall be handed over to authorized municipal / agency collectors

---

# 8. TREATMENT & DISPOSAL

- Biodegradable waste shall be composted or disposed through municipal systems
- Recyclable waste shall be sent to authorized recyclers
- Non-recyclable waste shall be disposed as per local body guidelines

---

# 9. ROLES AND RESPONSIBILITIES

### 9.1 Housekeeping & Sanitation Staff

- Ensure proper segregation and collection
- Maintain cleanliness of storage areas

### 9.2 Supervisors / Outsourced Agency

- Ensure adequate manpower and equipment
- Maintain records and logs

### 9.3 All Staff & Users

- Segregate waste correctly at source
- Follow institutional guidelines

---

# 10. OCCUPATIONAL SAFETY

- Use of PPE during waste handling
- Training on safe handling practices
- Reporting of injuries or incidents

---

# 11. MONITORING, AUDIT & DOCUMENTATION

- Daily supervision and checklists
- Periodic audits by Sanitation Committee
- Maintenance of solid waste registers

---

# 12. TRAINING & AWARENESS

- Regular training of staff
- IEC activities on waste segregation
- Display of signage at waste generation points

---

# 13. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract corrective and administrative action as per institutional rules and contract conditions.

## 14. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to changes in statutory rules.

## 15. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

## 16. APPROVAL

**Sarita Beri**
**LHMC & Associated Hospitals, New Delhi-110001**

# ANNEXURES

## Annexure – I: Colour Coding for Solid Waste Segregation

| Waste Category | Colour of Bin | Examples |
|---|---|---|
| Biodegradable | Green | Food waste, garden waste |
| Recyclable | Blue | Paper, plastic, metal |
| Non-recyclable | Black | Soiled packaging, inert waste |

## Annexure – II: Area-wise Solid Waste Collection Schedule

| Area | Frequency | Responsible Staff | Record Maintained |
|---|---|---|---|

## Annexure – III: Solid Waste Audit Checklist

| Area | Segregation Correct | Bin Condition | Remarks |
|---|---|---|---|

## Annexure – IV: Solid Waste Register Format

| Date | Area | Quantity | Category | Disposal Method | Remarks |
|---|---|---|---|---|---|

---

*All annexures form an integral part of this policy and shall be implemented and monitored by the Hospital Sanitation Committee.*

*End of Policy Document*

# Policy on Toilets & Public Area Maintenance

LHMC-Kayakalp-CS-POL-2026-06-V1.0

**Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001**

***(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)***

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

## Details of the Document

| | |
|---|---|
| Document Name | Policy on Toilets & Public Area Maintenance |
| Document No. | LHMC-Kayakalp-CS-POL-2026-06-V1.0 |
| No. of pages: | 07 |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Reviewed by: | Name: Dr. Manoj B Jais<br>Designation: Medical Superintendent<br>Signature |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Name: Chairperson Sanitation Committee |

# POLICY ON TOILETS & PUBLIC AREA MAINTENANCE

## POLICY IDENTIFICATION

| Field | Details |
|---|---|
| Policy Title | Policy on Toilets & Public Area Maintenance |
| Policy Code | LHMC-Kayakalp-CS-POL-2026-06-V1.0 |
| Domain | Housekeeping / Facility Management / Patient Safety |
| Category | Policy |
| Prepared By | Additional Medical Superintendent |
| Reviewed By | Medical Superintendents (SSKH ) |
| Approved By | Director LHMC |
| Date of Approval | |
| Effective From | |
| Review Due On | |
| Version | V1.0 |
| Supersedes | Nil |
| Confidentiality Status | Public (Cleanliness & Safety) |

## 1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to providing a clean, safe, hygienic and patient-friendly environment. Toilets and public areas are high-footfall zones and play a critical role in patient satisfaction, infection prevention, safety and public perception of hospital services.

This policy establishes standardized procedures for maintenance, cleaning, monitoring and continuous improvement of toilets and public areas across LHMC and its Associated Hospitals.

## 2. OBJECTIVES

The objectives of this policy are to:

- Ensure cleanliness, hygiene and safety of toilets and public areas
- Prevent healthcare-associated infections and environmental contamination
- Enhance patient, attendant and visitor satisfaction
- Standardize housekeeping practices and accountability
- Ensure compliance with NABH, Kayakalp and Swachh Bharat guidelines

---

# 3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- All public toilets (patient, attendant and staff)
- OPD areas, corridors, waiting areas, staircases, lifts and entrances
- All housekeeping, sanitation and maintenance staff

---

# 4. DEFINITIONS

**Public Areas:** Areas accessible to patients, attendants and visitors including corridors, waiting halls, staircases, lifts and lobbies.

**Housekeeping Services:** Services responsible for cleaning, sanitation and upkeep of hospital environment.

---

# 5. GOVERNING PRINCIPLES

- Cleanliness as a patient safety priority
- Regular, systematic and documented cleaning
- Accountability and supervision
- Patient-friendly and gender-sensitive facilities
- Continuous monitoring and improvement

---

# 6. GOVERNANCE STRUCTURE

## 6.1 Competent Authority

The Medical Superintendent/ Principal, LHMC shall be the Competent Authority for implementation of this policy.

### 6.2 Oversight

Housekeeping Services shall function under the supervision of Hospital Administration and in coordination with:

- Hospital Infection Control Committee (HICC)
- Kayakalp / Swachh Bharat Committee

---

## 7. TOILET MAINTENANCE STANDARDS

- Adequate number of functional toilets for patients, attendants and staff
- Separate toilets for males, females, other sex and persons with disabilities
- Continuous water supply and functional fittings
- Availability of soap, handwash, toilet paper and waste bins

---

## 8. CLEANING & SANITATION PROTOCOLS

### 8.1 Toilets

- Cleaning at defined frequencies (minimum 4–6 times daily or as per footfall)
- Use of approved disinfectants and cleaning agents
- Focus on high-touch surfaces (flush handles, taps, door knobs)

### 8.2 Public Areas

- Sweeping, mopping and dusting at defined intervals
- Immediate cleaning of spills and visible soiling

---

## 9. MANPOWER & RESPONSIBILITIES

- Deployment of adequate housekeeping staff per shift
- Clearly defined duties and area allocation
- Use of PPE by sanitation staff

---

## 10. WASTE MANAGEMENT

- Proper segregation and disposal of waste from toilets and public areas
- Coordination with Biomedical Waste Management policy

---

## 11. SAFETY & OCCUPATIONAL HEALTH

- Use of appropriate PPE
- Training in safe handling of cleaning chemicals
- Management of spills and accidents

---

## 12. MONITORING & SUPERVISION

- Regular inspection by supervisors
- Use of checklists and logbooks
- Surprise inspections by administration

---

## 13. FEEDBACK & GRIEVANCE REDRESSAL

- Display of QR codes / complaint numbers
- Prompt redressal of complaints related to cleanliness

---

## 14. TRAINING & AWARENESS

- Training of housekeeping staff on cleaning protocols
- IEC displays promoting toilet hygiene

---

## 15. DOCUMENTATION & RECORD KEEPING

- Cleaning schedules and checklists
- Complaint and corrective action records

---

## 16. MONITORING, AUDIT & QUALITY IMPROVEMENT

- Periodic internal audits

- Kayakalp assessment and scoring
- Corrective and preventive actions

---

## 17. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

---

## 18. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required.

---

## 19. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

---

## 20. APPROVAL

**Dr. Sarita Beri,**
**Director, LHMC & Associated Hospitals,**
**New Delhi.**

---

# 21. ANNEXURES

## Annexure – I: Toilet Cleaning Checklist

| Date | Time | Area | Cleaning Done | Supervisor Signature |
|---|---|---|---|---|

## Annexure – II: Public Area Cleaning Schedule

| Area | Frequency | Method | Responsible Staff |
|---|---|---|---|

## Annexure – III: Toilet & Public Area Inspection Checklist

| Parameter | Compliant (Yes/No) | Remarks |
|---|---|---|

---

*All annexures form an integral part of this policy and shall be implemented and monitored by Housekeeping Services and Hospital Administration.*

***End of Policy Document***

# Policy on Swachh Bharat Abhiyan Implementation

**LHMC-Kayakalp-QS-POL-2026-007-V1.0**

**Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001**

***(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)***

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

## Details of the Document

| | |
|---|---|
| Document Name | Policy on Swachh Bharat Abhiyan Implementation |
| Document No. | LHMC-Kayakalp-QS-POL-2026-007-V1.0 |
| No. of pages: | 07 |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Reviewed by: | Name: Dr. Manoj B. Jaisi<br>Designation: Medical Superintendent SSKH<br>Signature |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Name: Chairperson Bio Medical Waste Committee<br>Designation: HOD Microbiology |

# POLICY ON SWACHH BHARAT ABHIYAN IMPLEMENTATION

## POLICY IDENTIFICATION

| Field | Details |
|---|---|
| Policy Title | Policy on Swachh Bharat Abhiyan Implementation |
| Policy Code | LHMC-Kayakalp-QS-POL-2026-007-V1.0 |
| Domain | Cleanliness, Sanitation & Quality |
| Category | Policy |
| Prepared By | Dr. Banarsi, Additional Medical Superintendent |
| Reviewed By | Kayakalp Committee |
| Approved By | Director LHMC |
| Date of Approval | _____ |
| Effective From | _____ |
| Review Due On | _____ (After 3 Years) |

## 1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to the national vision of a clean, hygienic and healthy India as envisaged under the **Swachh Bharat Abhiyan (SBA)** launched by the Government of India. Cleanliness and sanitation in healthcare institutions are critical for infection prevention, patient safety, staff well-being and public confidence.

This policy provides a structured framework for implementation, monitoring and sustenance of Swachh Bharat Abhiyan initiatives across LHMC and its Associated Hospitals, in alignment with Kayakalp, NABH standards and MoHFW guidelines.

## 2. OBJECTIVES

The objectives of this policy are to:

- Promote cleanliness, hygiene and sanitation across hospital premises
- Support national Swachh Bharat Abhiyan goals within healthcare settings
- Improve patient experience and satisfaction

- Strengthen infection prevention and environmental safety
- Establish accountability and continuous monitoring mechanisms

---

# 3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall cover all areas including:

- Clinical and patient care areas
- Public areas, toilets, corridors and waiting halls
- Academic blocks, hostels and residential areas
- Support services such as housekeeping, sanitation and waste management

The policy shall be applicable to all staff, students, outsourced agencies, patients and visitors.

---

# 4. DEFINITIONS

**Swachh Bharat Abhiyan (SBA):** A national mission to ensure cleanliness, sanitation and hygiene across India.

**Clean Hospital Initiative:** Activities aimed at maintaining cleanliness, sanitation and infection control in healthcare facilities.

---

# 5. GOVERNANCE STRUCTURE

## 5.1 Competent Authority

The Director /Medical Superintendent/ Principal, LHMC shall be the Competent Authority for implementation of this policy.

## 5.2 Swachh Bharat / Kayakalp Committee

A Swachh Bharat / Kayakalp Committee shall function as the nodal body for planning, implementation and monitoring of SBA activities.

## 5.3 Nodal Officers

- Medical Superintendents (SSKH & KSCH)
- Nodal Officer – Swachh Bharat Abhiyan
- Sanitation / Housekeeping Officer
- Infection Control Nurse

---

## 6. KEY COMPONENTS OF SWACHH BHARAT IMPLEMENTATION

- Cleanliness and upkeep of hospital premises
- Sanitation and toilet hygiene
- Solid and biomedical waste management
- Hand hygiene and personal hygiene promotion
- Pest control and environmental sanitation
- Aesthetics, landscaping and greenery

---

## 7. IMPLEMENTATION STRATEGY

- Baseline assessment of cleanliness and sanitation
- Preparation of annual Swachh Bharat action plan
- Allocation of responsibilities and timelines
- Integration with housekeeping, waste management and IEC policies
- Regular cleanliness drives and campaigns

---

## 8. MONITORING, AUDIT & DOCUMENTATION

- Daily supervisory rounds and checklists
- Monthly internal audits
- Patient feedback and grievance review
- Documentation of activities, photographs and reports

---

## 9. IEC & COMMUNITY PARTICIPATION

- Display of Swachh Bharat IEC materials
- Awareness programs for patients, attendants and staff
- Observance of Swachhata Pakhwada and cleanliness drives
- Encouragement of public participation and feedback

## 10. TRAINING & CAPACITY BUILDING

- Training of housekeeping and sanitation staff
- Sensitization of clinical and non-clinical staff
- Orientation of new staff and students

## 11. INCENTIVES & MOTIVATION

- Recognition of cleanest departments
- Appreciation of staff contributions
- Promotion of best practices and innovations

## 12. COMPLIANCE & ACCOUNTABILITY

Non-compliance with Swachh Bharat Abhiyan guidelines shall attract corrective actions as per institutional rules and contractual obligations.

## 13. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required due to changes in national guidelines or institutional needs.

## 14. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

## 15. APPROVAL

Dr. Sarita Beri
LHMC & Associated Hospitals, New Delhi-11001

# ANNEXURES

## Annexure – I: Swachh Bharat Abhiyan Action Plan Format

| Area | Activity | Responsibility | Timeline | Status |
|---|---|---|---|---|

## Annexure – II: Cleanliness & Sanitation Monitoring Checklist

| Area | Cleanliness Adequate (Yes/No) | Observations | Action Taken |
|---|---|---|---|

## Annexure – III: Swachhata Drive / Campaign Record Format

| Date | Activity | Location | Participants | Remarks |
|---|---|---|---|---|

## Annexure – IV: Patient Feedback on Cleanliness Format

| Date | Area | Feedback | Action Taken | Status |
|---|---|---|---|---|

---

*All annexures form an integral part of this policy and shall be implemented and monitored by the Swachh Bharat / Kayakalp Committee.*

*End of Policy Document*

# POLICY ON LINEN & LAUNDRY SERVICES

**LHMC-Kayakalp-LL-POL-2026-008-V1.0**

**Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001**

***(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)***

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

## Details of the Document

| | |
|---|---|
| Document Name | POLICY ON LINEN & LAUNDRY SERVICES |
| Document No. | LHMC-Kayakalp-LL-POL-2026-008-V1.0 |
| No. of pages: | 08 |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Reviewed by: | Name: Dr. Manoj B. Jais<br>Designation: Medical Superintendent SSKH<br>Signature |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Concerned Addl. MS |

# POLICY ON LINEN & LAUNDRY SERVICES

## POLICY IDENTIFICATION

| Field | Details |
|---|---|
| Policy Title | Policy on Linen & Laundry Services |
| Policy Code | LHMC-Kayakalp-LL-POL-2026-008-V1.0 |
| Domain | Support Services / Infection Control |
| Category | Policy |
| Prepared By | Dr. Banarsi, Additional Medical Superintendent |
| Reviewed By | Kayakalp Committee |
| Approved By | Director LHMC |
| Date of Approval | |
| Effective From | |
| Review Due On | (After 3 Years) |
| Version | V1.0 |
| Supersedes | Nil |
| Confidentiality Status | Internal (Infection control, Regulatory & Safety) |

## 1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) recognize that proper management of hospital linen and laundry services is essential for patient comfort, infection prevention and maintenance of hygiene standards. Linen contaminated with blood and body fluids can act as a source of infection if not handled, processed and stored appropriately.

This policy establishes standardized procedures for collection, segregation, transportation, washing, disinfection, storage and distribution of hospital linen to ensure safety, quality and continuity of patient care.

## 2. OBJECTIVES

The objectives of this policy are to:

- Ensure availability of clean, safe and adequate linen

- Prevent hospital-acquired infections through proper linen handling
- Standardize linen and laundry processes
- Define roles, responsibilities and accountability
- Ensure compliance with infection control and accreditation standards

---

# 3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- All clinical and non-clinical areas
- All types of hospital linen including bed sheets, pillow covers, gowns, curtains, OT linen, uniforms and drapes
- All staff involved in linen handling, including outsourced laundry services

---

# 4. DEFINITIONS

**Hospital Linen:** All reusable fabric items used in patient care and hospital operations.

**Soiled Linen:** Linen contaminated with blood, body fluids or other infectious material.

**Clean Linen:** Linen that has been processed, disinfected and is ready for use.

---

# 5. GOVERNING PRINCIPLES

- Infection prevention and control
- Segregation of clean and soiled linen
- Occupational safety of staff
- Traceability and accountability
- Compliance with biomedical waste and hygiene standards

---

# 6. GOVERNANCE STRUCTURE

## 6.1 Competent Authority

The Director/Medical Superintendents / Principal, LHMC shall be the Competent Authority for implementation of this policy.

### 6.2 Linen & Laundry Management Committee

A Linen & Laundry Management Committee shall oversee implementation and monitoring.

---

## 7. LINEN REQUIREMENT & INVENTORY

- Adequate linen shall be maintained as per bed strength and service requirements
- Periodic assessment of linen requirement and replacement
- Linen inventory registers shall be maintained

---

## 8. COLLECTION & SEGREGATION OF SOILED LINEN

- Soiled linen shall be segregated at point of use
- Linen heavily soiled with blood/body fluids shall be handled with PPE
- Linen shall not be shaken or sorted in patient areas

---

## 9. TRANSPORTATION OF SOILED LINEN

- Soiled linen shall be transported in closed, leak-proof bags or trolleys
- Dedicated routes and timings shall be followed where feasible

---

## 10. LAUNDRY PROCESSING

- Washing, disinfection and drying shall be done as per standard protocols
- Use of appropriate detergents, disinfectants and water temperature
- OT and isolation linen shall be processed separately

---

## 11. STORAGE & DISTRIBUTION OF CLEAN LINEN

- Clean linen shall be stored in clean, dry and designated areas
- Segregation of clean and soiled areas shall be ensured
- Distribution shall be as per ward requirement

## 12. HANDLING OF INFECTED / ISOLATION LINEN

- Linen from isolation areas shall be handled as per infection control guidelines
- Appropriate labeling and processing shall be followed

## 13. OCCUPATIONAL SAFETY

- Staff shall use PPE while handling soiled linen
- Training on safe handling and ergonomics
- Needle stick injury precautions

## 14. QUALITY CONTROL & MONITORING

- Periodic inspection and audits of linen quality
- Monitoring of laundry processes
- Feedback from user departments

## 15. OUTSOURCED LAUNDRY SERVICES

- Outsourced agencies shall comply with hospital policies
- Service Level Agreements (SLAs) shall be defined
- Regular monitoring and audits of outsourced services

## 16. DOCUMENTATION & RECORD KEEPING

- Linen issue, receipt and condemnation records
- Maintenance of registers and checklists

## 17. TRAINING & AWARENESS

- Training of staff on linen handling and infection control
- Induction training for new and outsourced staff

## 18. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

---

## 19. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required.

---

## 20. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

---

## 21. APPROVAL

Issued with the approval of the Director LHMC & Associated Hospitals.

---

# ANNEXURES

## Annexure – I: Linen Inventory Register Format

| Item | Quantity Issued | Quantity Returned | Balance | Remarks |
|---|---|---|---|---|

## Annexure – II: Linen Issue & Receipt Register (Ward Level)

| Date | Ward | Item | Issued | Returned | Signature |
|---|---|---|---|---|---|

## Annexure – III: Linen Condemnation & Replacement Format

| Item | Condition | Reason | Approved By | Date |
|---|---|---|---|---|

## Annexure – IV: Laundry Quality Inspection Checklist

| Parameter | Compliant (Yes/No) | Remarks |
|---|---|---|

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*All annexures form an integral part of this policy and shall be implemented and monitored by the Linen & Laundry Management Committee.*

***End of Policy Document***

# Dress Code Policy LHMC Kayakalp-ADMIN/HR/DCP-2026-09-V.01

Lady Hardinge Medical College &
Associated Smt. Sucheta Kriplani and
Kalawati Saran Children Hospital
New Delhi

**Government of India**
**Director General of Health Services**
**Lady Harginge Medical Collage & Associated Hospitals**
**Shaheed Bhagat Singh Marg, New Delhi**

**Details of the document**

| | |
|---|---|
| Document Name | Dress Code Policy |
| Document No. | LHMC-Kayakalp-ADMIN/HR/DCP-2026-09-V.01 |
| No. of pages: | 13 |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Reviewed by: | Name: Dr. Manoj B Jais<br>Designation: Medical Superintendent SSKH<br>Signature |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Concerned AMS/ Deputy Director Admin |

# DRESS CODE POLICY

## 1. Document Control

| Item | Details |
|---|---|
| Policy Title | Dress Code Policy |
| Policy Number | LHMC Kayakalp-ADMIN/HR/DCP-2026-09-V.01 |
| Version | 1.0 |
| Effective Date | |
| Review Date | Every 3 years or as required |
| Supersedes | New Policy |
| Prepared By | Dr. Banarsi, Additional Medical Superintendent |
| Approved By | Director, LHMC |
| Responsible for Implementation | Medical Superintendent/All HODs / In-charges/DDA |
| Responsible for Review | AMS (S)/DDA |

## 2. Policy Statement

Lady Hardinge Medical College & Associated Hospitals shall ensure that all employees adhere to a standardized dress code and wear official identity cards during duty hours to promote professionalism, patient safety, infection control, and institutional discipline.

## 3. Purpose

This policy is intended to:

- Maintain professional appearance and etiquette among hospital staff
- Enable easy identification of staff by patients, attendants, and visitors
- Prevent unauthorized access to restricted hospital areas

- Ensure compliance with infection control, safety, and statutory requirements

---

**4. Scope**

This policy applies to:

- All regular employees of LHMC & Associated Hospitals
- Contractual, ad-hoc, and outsourced personnel
- Clinical and non-clinical staff
- All departments, wards, laboratories, operation theatres, and administrative offices

---

**5. Definitions**

- **Uniform:** Prescribed attire approved by hospital administration for specific staff categories
- **Protective Clothing:** Apparel worn to safeguard personal safety, patient safety, and infection control
- **Outsourced Staff:** Personnel deployed through third-party agencies

---

**6. Dress Code Committee**

The Dress Code Policy shall be monitored and reviewed by the following committee:

1. Medical Superintendent – Chairperson
2. Head of Department, Physiology – Member
3. Medical Officer – Member
4. Deputy Director (Administration) – Member
5. Chief Nursing Officer – Member

---

## 7. General Guidelines

7.1 All staff shall wear the prescribed uniform during duty hours.
7.2 Official Identity Card must be worn prominently at all times while on duty.
7.3 Uniforms shall be clean, neat, and appropriate to the assigned role.
7.4 Heavy jewellery, ornaments, and accessories are prohibited in clinical areas.
7.5 Casual attire such as jeans, T-shirts, or flashy clothing is not permitted.
7.6 Non-compliance shall attract disciplinary action as per applicable rules.

---

## 8. Category-wise Dress Code

### 8.1 Doctors

- White full-sleeve apron
- Apron must display:
  - College Logo
  - Name
  - Department
  - Designation

---

### 8.2 Nursing Staff

| Category | Prescribed Uniform |
|---|---|
| Chief Nursing Officer | Blue sari with full-sleeve white apron |
| Assistant Nursing Superintendent | Purple sari with white apron |
| Senior Nursing Officers | Onion-colored sari with white apron |
| Nursing Officers (Female) | Camel-colored suit salwar with white apron |
| Nursing Officers (Male) | Camel-colored shirt & pant with white apron |

---

### 8.3 Paramedical Staff

(Laboratory Technicians, Radiology Staff, Pharmacists)

- Full-sleeve white apron
- Green pocket strip
- College logo, name, department, and designation to be displayed on apron

---

### 8.4 Administrative Staff

- Formal attire only
- Casual wear, jeans, and T-shirts are strictly prohibited

---

### 8.5 Support Services Staff

| Category | Uniform |
|---|---|
| Nursing Orderlies | White shirt and white pant |
| Safaiwalas | Dark blue full-length gown, heavy-duty gloves, mask, gum boots |
| Housekeeping Staff | Uniform prescribed by outsourced agency |

---

## 9. Protective Clothing

Protective clothing shall be used by staff based on their functional requirements, considering:

- Patient safety
- Personal safety
- Infection prevention and control
- Occupational health and safety
- Statutory and regulatory obligations

---

## 10. Dress Code During Specific Procedures

### 10.1 Radiation Procedures

- Lead apron
- Dosimeter
- Lead gloves
- Thyroid shield

---

### 10.2 Operation Theatre – Surgery

- Doctors: Light Blue / Green Kurta Pajama
- Paramedics: Green Kurta Pajama

---

### 10.3 Operation Theatre – Gynaecology

- Cap
- Mask
- Light Blue / Green theatre suit
- McIntosh sheet
- Disposable theatre gown

---

## 11. Identity Card Policy

11.1 Every employee shall be issued an official Identity Card.
11.2 Identity Card must be worn during duty hours.
11.3 Identity Card shall contain name, employee ID, and department.
11.4 Failure to wear ID card shall result in disciplinary action.

---

## 12. Outsourced Staff

12.1 Uniforms for outsourced staff shall be provided by the respective agency.
12.2 Uniform design and standards shall be approved by hospital administration prior to use.

---

**13. Compliance and Enforcement**

- Heads of Departments, In-charges, and Supervisory Officers shall ensure compliance.
- Repeated non-compliance shall be dealt with as per service rules and contract conditions.

---

**15. Approval**

**Dr. Sarita Beri,**
**Director, LHMC & Associated Hospitals,**
**New Delhi.**

---

**16. Review and Amendment**

This policy shall be reviewed every three years or earlier if required due to administrative, regulatory, or operational changes.

---

## ANNEXURE – I

### Category-wise Uniform Chart

| S. No. | Staff Category | Prescribed Uniform |
|---|---|---|
| 1 | Doctors | White full-sleeve apron with College Logo, Name, Department & Designation |
| 2 | Chief Nursing Officer | Blue sari with full-sleeve white apron |
| 3 | Assistant Nursing Superintendent | Purple sari with white apron |
| 4 | Senior Nursing Officers | Onion-colored sari with white apron |
| 5 | Nursing Officers (Female) | Camel-colored suit salwar with white apron |
| 6 | Nursing Officers (Male) | Camel-colored shirt & pant with white apron |
| 7 | Lab Technicians | White full-sleeve apron with green pocket strip |
| 8 | Radiology Staff | White full-sleeve apron with green pocket strip |
| 9 | Pharmacists | White full-sleeve apron with green pocket strip |
| 10 | Administrative Staff | Formal attire only |
| 11 | Nursing Orderlies | White shirt and white pant |
| 12 | Safaiwalas | Dark blue full-length gown, gloves, mask, gum boots |
| 13 | Housekeeping Staff | Uniform prescribed by outsourced agency |

## ANNEXURE – II

### Protective Clothing Requirements

Protective clothing shall be used as per job role and work environment.

| Area / Activity | Mandatory Protective Clothing |
|---|---|
| Radiation Procedures | Lead apron, dosimeter, lead gloves, thyroid shield |
| Operation Theatre (Surgery) | Theatre suit, cap, mask |
| Operation Theatre (Gynae) | Theatre suit, cap, mask, McIntosh sheet, disposable gown |
| Cleaning & Waste Handling | Heavy-duty gloves, mask, gown, gum boots |
| Laboratory Work | Lab coat/apron, gloves, mask (as required) |

**Note:**
Protective clothing is mandatory for:

- Patient safety
- Personal safety
- Infection prevention & control
- Statutory and occupational safety compliance

## ANNEXURE – III

### Identity Card (ID Card) Guidelines

1. Every employee shall be issued an official Identity Card by the hospital administration.
2. The ID Card shall contain:
    - Name of employee
    - Employee ID number
    - Designation
    - Department
    - Photograph
3. Wearing of ID Card during duty hours is **mandatory**.
4. ID Card must be displayed prominently.
5. Loss of ID Card shall be reported immediately to the concerned section.
6. Non-wearing or misuse of ID Card shall invite disciplinary action.

**ANNEXURE – IV**

**Compliance & Monitoring Checklist**

(To be used by HODs / In-charges)

| S. No. | Parameter | Yes / No | Remarks |
|---|---|---|---|
| 1 | Staff wearing prescribed uniform | | |
| 2 | ID Cards worn during duty hours | | |
| 3 | Aprons with proper identification | | |
| 4 | Protective clothing used where required | | |
| 5 | No unauthorized attire in clinical areas | | |
| 6 | Outsourced staff in approved uniform | | |

**Reviewed By:** _____
**Designation:** _____
**Date:** _____

## ANNEXURE – V

### Disciplinary Action for Non-Compliance

1. Verbal warning for first instance
2. Written warning for repeated violation
3. Reporting to competent authority
4. Action as per CCS Rules / Contract Terms / Hospital Administrative Rules

---

**(End of Policy Document)**

# Policy on Water Quality & Drinking Water Safety

**LHMC-Kayakalp-WQWS-POL-2026-10-V1.0**

## Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001

***(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)***

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

## Details of the Document

| | |
|---|---|
| Document Name | Policy on Water Quality & Drinking Water Safety |
| Document No. | LHMC-Kayakalp-WQWS-POL-2026-010-V1.0 |
| No. of pages: | 07 |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Reviewed by: | Name: Dr. Manoj B. Jais<br>Designation: Medical Superintendent SSKH<br>Signature |
| Approved by: | Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |
| Responsibility of updating: | Name: Chairperson HICC<br>Designation: HOD Microbiology |

# POLICY ON WATER QUALITY & DRINKING WATER SAFETY

## POLICY IDENTIFICATION

| Field | Details |
|---|---|
| Policy Title | Policy on Water Quality & Drinking Water Safety |
| Policy Code | LHMC-Kayakalp-WQWS-POL-2026-10-V1.0 |
| Domain | Facility Management / Infection Prevention & Control / Patient Safety |
| Category | Policy |
| Prepared By | Dr. Banarsi, Additional Medical Superintendent |
| Reviewed By | Kayakalp Committee |
| Approved By | Director, LHMC |
| Date of Approval | |
| Effective From | |
| Review Due On | |
| Confidentiality Status | Public |

## 1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to providing safe, adequate and potable water for drinking, patient care, clinical services and other hospital operations. Safe water is essential for prevention of water-borne diseases, infection control, patient safety and public health.

This policy establishes a standardized framework for ensuring water quality, safe drinking water supply, monitoring, maintenance and corrective actions across LHMC and its Associated Hospitals.

## 2. OBJECTIVES

The objectives of this policy are to:

- Ensure continuous supply of safe and potable drinking water
- Prevent water-borne infections and outbreaks
- Establish routine water quality monitoring and testing
- Define roles and responsibilities for water safety management
- Ensure compliance with NABH, BIS and public health guidelines

---

# 3. SCOPE

This policy shall apply to:

- Lady Hardinge Medical College (LHMC)
- Smt. Sucheta Kriplani Hospital (SSKH)
- Kalawati Saran Children's Hospital (KSCH)

It shall be applicable to:

- Drinking water supplied to patients, attendants and staff
- Water used in wards, ICUs, OTs, laboratories, kitchens and dialysis units
- All water storage, treatment and distribution systems within hospital premises

---

# 4. DEFINITIONS

**Potable Water:** Water that is safe for human consumption and meets prescribed quality standards.

**Water Quality Monitoring:** Periodic testing of water to ensure compliance with physical, chemical and microbiological standards.

---

# 5. GOVERNING PRINCIPLES

- Patient safety and public health priority
- Compliance with statutory and accreditation standards
- Preventive maintenance and monitoring
- Prompt corrective and preventive actions
- Documentation and accountability

---

# 6. GOVERNANCE STRUCTURE

## 6.1 Competent Authority

The Director / Principal, LHMC shall be the Competent Authority for implementation of this policy.

### 6.2 Oversight & Coordination

Water quality management shall be overseen by Hospital Administration in coordination with:

- CPWD/ HSCC/Maintenance Department
- Hospital Infection Control Committee (HICC)
- Housekeeping Services

---

## 7. WATER SOURCES & SUPPLY SYSTEM

- NDMC water supply
- Borewell / alternative sources (where applicable)
- Water storage tanks (overhead and underground)
- Internal distribution pipelines
- Water bottles

---

## 8. WATER TREATMENT & SAFETY MEASURES

- Filtration, chlorination or RO treatment as applicable
- Periodic cleaning and disinfection of storage tanks
- Maintenance of water purifiers, RO units and coolers

---

## 9. DRINKING WATER SAFETY

- Provision of clearly marked drinking water points
- Regular cleaning and maintenance of water coolers and dispensers
- Prevention of cross-contamination at dispensing points

---

## 10. WATER QUALITY MONITORING & TESTING

- Routine physical, chemical and microbiological testing
- Testing frequency as per NABH / BIS guidelines
- Testing through NABL-accredited laboratories

---

## 11. RESPONSE TO NON-COMPLIANT WATER QUALITY

- Immediate restriction of use for drinking if contamination detected
- Provision of alternative safe drinking water
- Corrective actions and retesting

---

## 12. SPECIAL AREAS

- Dialysis units
- ICUs and OTs
- Kitchens and food preparation areas
- Neonatal and paediatric units

---

## 13. DOCUMENTATION & RECORD KEEPING

- Water testing reports
- Tank cleaning and maintenance records
- Corrective action reports

---

## 14. TRAINING & AWARENESS

- Training of engineering and housekeeping staff
- Awareness among staff regarding reporting of water quality issues

---

## 15. MONITORING, AUDIT & QUALITY IMPROVEMENT

- Periodic internal audits
- Review during NABH and Kayakalp assessments
- Continuous improvement measures

---

## 16. COMPLIANCE & ACCOUNTABILITY

Non-compliance with this policy shall attract administrative action as per institutional rules.

## 17. REVIEW & AMENDMENT

This policy shall be reviewed every three years or earlier if required.

## 18. EFFECTIVE DATE

This policy shall come into force from the date of approval by the Competent Authority.

## 19. APPROVAL

**Dr. Sarita Beri,**
**Director, LHMC & Associated Hospitals**
**New Delhi.**

# ANNEXURES

## Annexure – I: Water Quality Testing Schedule

| Location | Parameter | Frequency | Laboratory |
|---|---|---|---|

## Annexure – II: Water Tank Cleaning & Disinfection Record

| Tank Location | Date Cleaned | Method | Next Due Date | Signature |
|---|---|---|---|---|

## Annexure – III: Water Quality Non-Compliance & Corrective Action Log

| Date | Issue Identified | Area | Action Taken | Status |
|---|---|---|---|---|

*All annexures form an integral part of this policy and shall be implemented and monitored by Hospital Administration and Engineering Services.*

*End of Policy Document*

# RECORD DISPOSAL POLICY

## LHMC/ADMIN/RM/RDP/11

**Lady Hardinge Medical College &
Associated Smt. Sucheta Kriplani
And Kalawati Saran Children
Hospital New Delhi-110001**

***(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)***

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

## Details of the Document

| | |
|---|---|
| Document Name | **RECORD DISPOSAL POLICY** |
| Document No. | LHMC/ADMIN/RM/RDP/11 |
| No. of pages: | 08 |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br><br>Signature |
| Approved by: | Name: Dr. ~~L. H. Ghotekar~~ Manoj B. Jain<br>Designation: Medical Superintendent<br><br>Signature<br><br>Name: Dr. Sarita Beri<br>Designation: Medical Director<br><br>Signature |
| Responsibility of updating: | Name: Chairperson Bio Medical Waste Committee<br>Designation: HOD Microbiology |

**RECORD DISPOSAL POLICY**

**Lady Hardinge Medical College & Associated Hospitals**
(Under Directorate General of Health Services,
Ministry of Health & Family Welfare, Government of India)

## 1. Document Control

| Item | Details |
|---|---|
| Policy Title | Record Disposal Policy |
| Policy Number | LHMC/ADMIN/RM/RDP/11 |
| Version | 1.0 |
| Effective Date | _____ |
| Review Date | Every 3 years or as required |
| Supersedes | New Policy |
| Prepared By | AMS (S) |
| Approved By | Medical Superintendent & Medical Director |
| Responsible for Implementation | All HODs / Record Custodians |
| Responsible for Review | Medical Records Committee |

## 2. Policy Statement

Lady Hardinge Medical College & Associated Hospitals shall ensure systematic, secure, and lawful disposal of records after completion of their prescribed retention period, in compliance with Government of India rules, medico-legal requirements, and confidentiality standards.

## 3. Purpose

The purpose of this policy is to:

- Ensure safe and timely disposal of obsolete records
- Prevent unauthorized access or misuse of sensitive information
- Free physical and digital storage space
- Ensure compliance with legal, audit, and medico-legal requirements
- Standardize record disposal practices across departments

## 4. Scope

This policy applies to:

- Medical records (OPD, IPD, emergency, investigation reports)
- Administrative records
- Financial and accounts records
- HR and personnel records
- Legal, medico-legal, and court-related records
- Physical and electronic/digital records

## 5. Definitions

- **Record:** Any document, file, register, electronic data, image, or report created or received during hospital operations
- **Retention Period:** Duration for which records must be preserved before disposal
- **Record Disposal:** Authorized destruction or deletion of records after retention period
- **Custodian:** Officer/Department responsible for safe keeping of records

## 6. Record Disposal Committee

A **Record Disposal Committee** shall be constituted comprising:

1. Medical Superintendent – Chairperson
2. Deputy Director (Administration) – Member
3. Head, Medical Records Department – Member
4. Representative from Accounts Section – Member
5. Legal/Medico-Legal Officer – Member
6. IT In-charge (for digital records) – Member

## 7. General Principles

7.1 Records shall not be destroyed without verifying completion of retention period.
7.2 Records related to medico-legal cases, RTI, audits, vigilance, or court matters shall **not be disposed** without written clearance.
7.3 Confidentiality and data protection shall be ensured at all stages.
7.4 Disposal shall be done only after approval of the competent authority.

## 8. Record Retention Schedule

Retention of records shall be as per **Government of India guidelines**, hospital rules, and statutory requirements.

**Indicative Retention Period**

| Record Type | Minimum Retention Period |
|---|---|
| OPD Records | 3 years |
| IPD Records | 5 years |
| Medico-Legal Case Records | 10 years or till final disposal |
| Birth & Death Records | Permanent |
| Operation Theatre Registers | 10 years |
| Laboratory Records | 5 years |

| Record Type | Minimum Retention Period |
|---|---|
| Financial Records | As per GFR / Audit Rules |
| Service Books | Permanent |
| RTI Records | As per RTI Act |
| Court Case Records | Till final judgment + appeal period |

*(Final retention shall follow prevailing GoI rules)*

## 9. Record Disposal Procedure

### 9.1 Identification

- Concerned department shall identify records due for disposal annually.

### 9.2 Scrutiny

- Record Disposal Committee shall verify:
  - Retention period completion
  - Absence of legal/audit/RTI issues

### 9.3 Approval

- Proposal for disposal shall be submitted to the Medical Superintendent for approval.

### 9.4 Mode of Disposal

- **Paper Records:** Shredding / pulping / incineration
- **Electronic Records:** Secure deletion with backup verification

### 9.5 Documentation

- Disposal shall be recorded in a **Record Disposal Register**.

## 10. Confidentiality & Data Security

- Records shall be disposed in a manner that prevents reconstruction or misuse.
- Outsourced disposal agencies, if used, shall sign confidentiality agreements.

- Personal and medical information shall remain protected as per law.

## 11. Digital Records

- Digital records shall be backed up before deletion.
- Disposal shall be logged and certified by IT In-charge.
- Access controls and audit trails shall be maintained.

## 12. Prohibited Disposal

The following records **shall not be disposed** without explicit approval:

- Medico-legal records
- Court case files
- Vigilance/disciplinary records
- Records under RTI or audit scrutiny

## 13. Roles & Responsibilities

| Role | Responsibility |
|---|---|
| HOD / In-charge | Identification & safe custody |
| Record Custodian | Maintenance & listing |
| Record Disposal Committee | Scrutiny & recommendation |
| Medical Superintendent | Final approval |
| IT In-charge | Digital record disposal |

## 14. Compliance & Monitoring

- Compliance shall be monitored through periodic audits.
- Any unauthorized disposal shall invite disciplinary action as per rules.

## 15. Review & Amendment

This policy shall be reviewed every **three years** or earlier if required due to changes in law, technology, or administrative instructions.

---

## ANNEXURES

### Annexure – I: Record Disposal Register Format

| S. No. | Dept | Record Type | Year | Quantity | Mode of Disposal | Approval Ref | Date |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

### Annexure – II: Annual Record Disposal Checklist

- Retention period verified
- No legal/audit/RTI case pending
- Committee approval obtained
- Disposal method approved
- Entry made in disposal register

### Annexure – III: Certificate of Record Disposal

Certified that the records listed above have been disposed of as per the approved Record Disposal Policy of LHMC & Associated Hospitals and no legal or administrative issues are pending.

Signature: _____
Name & Designation: _____
Date: _____

**Approval**

**Director**
LHMC & Associated Hospitals

# Standard Operating Procedures (SOPs) for Disposal of Expired or Unused Medicines

## LHMC/ADMIN/RM/RDP/12

**Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001**

*(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)*

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

## Details of the Document

| | |
|---|---|
| Document Name | **Standard Operating Procedures (SOPs) for Disposal of Expired or Unused Medicines** |
| Document No. | LHMC/ADMIN/RM/RDP/12 |
| No. of pages: | 22 Pages |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br><br>Signature |
| Approved by: | Name: Dr. Manoj B. Jais<br>Designation: Medical Superintendent<br><br>Signature<br><br>Name: Dr. Sarita Beri<br>Designation: Medical Director<br><br>Signature |
| Responsibility of updating: | Name: Chairperson Bio Medical Waste Committee<br>Designation: HOD Microbiology |

**LHMC/ADMIN/RM/RDP/12 Standard Operating Procedures (SOPs) for Disposal of Expired or Unused Medicines**

**Standard Operating Procedures (SOPs) for Disposal of Expired or Unused Medicines**

**Lady Hardinge Medical College & Associated Hospitals New Delhi**

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**Document Control Information**

**Effective Date:** February 2026

**Review Date:** February 2027

**Approved By:** Medical Superintendent / Hospital Administration

**Version:** 1.0

---

## 1. Purpose and Scope

### 1.1 Purpose

This Standard Operating Procedure (SOP) establishes comprehensive protocols for the safe, legal, and environmentally sound disposal of expired or unused medicines at Lady Hardinge Medical College (LHMC) and its associated hospitals. These procedures are designed to ensure compliance with the Central Drugs Standard Control Organization (CDSCO) Guidance Document on Disposal of Expired/Unused Drugs (May 2025) and the Bio-Medical Waste Management Rules, 2016[1][2].

### 1.2 Scope

This SOP applies to:

- All departments, units, and wards within LHMC and associated hospitals
- All categories of pharmaceutical waste including tablets, capsules, syrups, injections, vaccines, and other medicinal preparations
- All staff members involved in medicine handling, storage, and disposal including pharmacists, nurses, doctors, and waste management personnel
- All expired, deteriorated, contaminated, or unused medicines regardless of source or procurement method

### 1.3 Objectives

1. Protect human health and environment from hazardous pharmaceutical waste
2. Prevent unauthorized access, diversion, and misuse of expired or discarded medicines

3. Mitigate the risk of Antimicrobial Resistance (AMR) through proper disposal
4. Ensure full compliance with CDSCO guidelines and Bio-Medical Waste Management Rules, 2016
5. Maintain accurate documentation and traceability of all disposal activities
6. Establish accountability and responsibility across the pharmaceutical waste management chain

---

## 2. Regulatory Framework and References

### 2.1 Primary Regulatory References

- CDSCO Guidance Document on Disposal of Expired/Unused Drugs (May 2025) [1]
- Bio-Medical Waste Management Rules, 2016 (as amended) [2]
- Drugs and Cosmetics Act, 1940 and Rules, 1945
- Water (Prevention and Control of Pollution) Act, 1974
- Environment Protection Act, 1986
- Motor Vehicles Act, 1988 (for transportation requirements)
- Atomic Energy Act, 1962 (for radiopharmaceuticals)

### 2.2 Key Regulatory Principles

According to CDSCO guidelines issued in May 2025, government and private hospitals may directly dispose of expired/unused drugs in accordance with Bio-Medical Waste Management Rules, 2016. If the hospital wishes to return unused/expired drugs to the supplier, the same shall be returned within 30 days after expiry date[3]. All disposal activities must be properly documented with disposal certificates maintained for regulatory verification.

---

## 3. Definitions and Terminology

### 3.1 Key Definitions

**Expired Medicines:** Pharmaceutical products that have passed their labeled expiration date and are no longer suitable for therapeutic use.

**Unused Medicines:** Pharmaceutical products that remain unutilized due to discontinuation of treatment, patient discharge, change in prescription, or excess stock.

**Pharmaceutical Waste:** All discarded medicines including expired, deteriorated, contaminated, or surplus pharmaceutical products.

**Cytotoxic Drugs:** Anticancer and chemotherapeutic agents that are toxic to cells and require special handling and disposal protocols.

**Bio-Medical Waste (BMW):** Any waste generated during diagnosis, treatment, or immunization of human beings or animals, or research activities pertaining thereto, or production or testing of biologicals.

**Common Bio-Medical Waste Treatment Facility (CBWTF):** A centralized facility established for collection, reception, storage, transportation, treatment, disposal, or any other form of handling of bio-medical waste.

**Incineration:** High-temperature combustion process for treatment and disposal of pharmaceutical waste.

**Encapsulation:** Waste immobilization technique involving sealing waste in containers with immobilizing material.

**Inertization:** Process of mixing waste with cement, lime, and water to produce an inert solid mass.

---

## 4. Roles and Responsibilities

### 4.1 Medical Superintendent / Hospital Administrator

- Overall responsibility for implementation and compliance with this SOP
- Allocation of resources for proper pharmaceutical waste management
- Approval of authorized vendors for waste disposal
- Review of periodic compliance reports
- Liaison with regulatory authorities

### 4.2 Chief Pharmacist / Pharmacy In-charge

- Day-to-day management of pharmaceutical waste disposal program
- Maintenance of master inventory of expired/unused medicines
- Coordination with suppliers for return of expired stock
- Supervision of segregation, labeling, and storage procedures
- Maintenance of disposal records and certificates
- Training of pharmacy staff on disposal procedures
- Quarterly audits of medicine expiry dates

### 4.3 Bio-Medical Waste Management Officer (BMWO)

- Coordination with CBWTF or authorized vendors
- Ensuring compliance with BMW Rules, 2016
- Supervision of collection, storage, and transportation
- Maintenance of waste disposal registers
- Obtaining and archiving disposal certificates
- Reporting to State Pollution Control Board as required

### 4.4 Department Heads / Ward In-charges

- Identification and reporting of expired/unused medicines in their areas
- Ensuring proper segregation at point of generation
- Preventing unauthorized access to pharmaceutical waste
- Cooperation with pharmacy and BMWO in disposal activities

### 4.5 Nursing Staff and Healthcare Workers

- Identification of expired medicines during routine checks
- Proper segregation of pharmaceutical waste in designated containers
- Reporting expired/unused medicines to pharmacy or ward in-charge
- Compliance with infection control and safety protocols

---

## 5. Classification and Categorization of Pharmaceutical Waste

### 5.1 Bio-Medical Waste Categories (As per BMW Rules, 2016)

Pharmaceutical waste falls under specific categories as defined in Schedule I of the Bio-Medical Waste Management Rules, 2016[2]:

| Category | Description | Treatment and Disposal |
|---|---|---|
| Yellow Category | Expired or discarded medicines including all items contaminated with cytotoxic drugs; glass or plastic ampoules, vials etc. | Incineration, plasma pyrolysis, or encapsulation in metallic container followed by disposal in secured landfill |
| Blue Category (for specific medicines) | Glass vials and ampoules (after safe removal of pharmaceutical contents) | Disinfection or autoclaving followed by shredding; treated waste sent for energy recovery |

Table 1: Bio-Medical Waste Categories for Pharmaceutical Waste

### 5.2 Special Categories Requiring Additional Precautions

- **Cytotoxic and Chemotherapeutic Agents:** Require separate, secure storage in yellow containers; must never be mixed with general pharmaceutical waste
- **Controlled Substances (Narcotics and Psychotropics):** Disposal must be witnessed and documented with additional security measures
- **Antibiotics:** Priority for proper disposal to prevent AMR development
- **Vaccines and Biologicals:** Inactivation before disposal
- **Radiopharmaceuticals:** Disposal as per Atomic Energy Act, 1962 and rules thereunder
- **High-Risk Drugs (CDSCO Flush List):** 17 specific drugs that may be disposed through sewers under controlled conditions [3]

---

## 6. Identification and Segregation Procedures

### 6.1 Identification of Expired/Unused Medicines

#### 6.1.1 Routine Monitoring

1. **Monthly Stock Review:** Pharmacy department shall conduct monthly review of all medicine stocks to identify items approaching expiry (within 3 months)
2. **Ward/Department Checks:** Ward in-charges shall conduct weekly checks of emergency medicine stocks and report expired items
3. **Patient Discharge:** Unused medicines from discharged/deceased patients shall be immediately identified and segregated
4. **Discontinued Treatments:** Medicines from discontinued treatment protocols shall be returned to pharmacy for assessment

#### 6.1.2 Criteria for Classification as Pharmaceutical Waste

Medicines shall be classified as waste if they are:

- Beyond labeled expiration date
- Damaged, deteriorated, or contaminated
- From completed or discontinued treatments
- Returned from wards/departments as surplus
- Part of patient belongings from deceased patients
- Subject to drug recall or quality concerns
- Stored improperly and no longer fit for use

### 6.2 Segregation at Point of Generation

#### 6.2.1 Segregation Materials

All pharmaceutical waste shall be segregated using:

- **Yellow Colored, Non-Chlorinated Plastic Bags or Containers** as per BMW Rules, 2016
- Clearly labeled with "PHARMACEUTICAL WASTE" or "EXPIRED MEDICINES"
- Separate containers for cytotoxic drugs (marked "CYTOTOXIC WASTE - HANDLE WITH CARE")
- Leak-proof, puncture-resistant containers for liquid formulations
- Secure, tamper-evident containers for controlled substances

#### 6.2.2 Segregation Protocol

1. Identify expired or unused medicine
2. Remove from regular medicine storage immediately
3. Record details in departmental register (name, batch number, quantity, expiry date)
4. Place in designated yellow pharmaceutical waste container
5. Do NOT mix with other categories of bio-medical waste
6. Do NOT mix cytotoxic drugs with general pharmaceutical waste
7. Seal container when 3/4 full or at end of shift
8. Label with date, ward/department, and person responsible
9. Store in secure, designated area pending collection

---

## 7. Storage Requirements

### 7.1 Storage Location and Conditions

#### 7.1.1 Primary Storage (Ward/Department Level)

- Dedicated, lockable cupboard or room for pharmaceutical waste
- Well-ventilated, dry, and cool conditions
- Away from direct sunlight and heat sources
- Restricted access - authorized personnel only
- Clearly marked with warning signage

- Separate storage for cytotoxic and radioactive pharmaceutical waste
- Fire safety equipment available

### 7.1.2 Central Storage (Hospital BMW Storage Area)

- Designated secure area within main BMW storage facility
- Separate section for pharmaceutical waste (yellow category)
- Concrete or impermeable flooring with drainage
- Adequate lighting and ventilation
- 24-hour security and access control
- CCTV surveillance recommended
- Temperature monitoring for heat-sensitive waste
- Spill containment and cleanup materials available

### 7.2 Storage Duration

As per BMW Rules, 2016:

- **No untreated bio-medical waste shall be stored beyond 48 hours**
- If storage beyond 48 hours is necessary due to quantities or other factors, cold storage facility (temperature < 10°C) must be provided
- Cytotoxic waste should be collected and transported daily or as per CBWTF schedule

### 7.3 Storage Safety Measures

- Prevent unauthorized access at all times
- Ensure no leakage or spillage from containers
- Maintain segregation of different waste categories
- Provide personal protective equipment (PPE) for handling staff
- Display emergency contact numbers
- Maintain spill response kit
- Conduct daily inspection of storage areas

---

## 8. Disposal Methods and Procedures

### 8.1 Primary Disposal Route: Common Bio-Medical Waste Treatment Facility (CBWTF)

**LHMC/ADMIN/RM/RDP/12 Standard Operating Procedures (SOPs) for Disposal of Expired or Unused Medicines**

As per CDSCO guidelines, LHMC and associated hospitals may directly dispose of expired/unused drugs in accordance with Bio-Medical Waste Management Rules, 2016[3].

### 8.1.1 CBWTF Disposal Procedure

1. **Authorization:** Ensure hospital has valid authorization from Delhi Pollution Control Committee (DPCC) for BMW generation and memorandum of understanding with authorized CBWTF
2. **Notification:** BMWO notifies CBWTF of pharmaceutical waste ready for collection
3. **Preparation:** Pharmaceutical waste containers checked, sealed, labeled, and documented
4. **Weighing:** All waste weighed and recorded before handover
5. **Transportation:** CBWTF collects waste using authorized vehicles complying with BMW Rules and Motor Vehicles Act, 1988
6. **Documentation:** Collection documented with weight, date, vehicle number, and signatures
7. **Treatment:** CBWTF treats waste through incineration, plasma pyrolysis, or other approved methods
8. **Certificate:** CBWTF provides disposal certificate within specified timeframe
9. **Record Maintenance:** All certificates and records archived for minimum 5 years

### 8.2 Approved Treatment and Disposal Methods

As per CDSCO guidelines, the following methods may be used for disposal of pharmaceutical waste [3]:

| Method | Description and Application |
|---|---|
| Incineration | High-temperature combustion in authorized incinerators. Primary method for most pharmaceutical waste. Ensures complete destruction of active pharmaceutical ingredients. |
| Encapsulation | Sealing waste in drums or containers with immobilizing material (concrete, plastic foam). Suitable for solid pharmaceutical waste. Encapsulated waste disposed in secured landfill. |
| Inertization | Mixing pharmaceutical waste with cement, lime, and water to produce inert solid mass. Prevents leaching and environmental contamination. |
| Chemical Decomposition | Use of chemical agents to neutralize or decompose pharmaceutical compounds. Applicable for specific categories under expert supervision. |

| | |
|---|---|
| Plasma Pyrolysis | Advanced thermal treatment using high-temperature plasma. Effective destruction with minimal emissions. |
| Sewer Disposal | Only for 17 specific high-risk drugs listed in CDSCO Flush List. Requires prior approval and documentation. Prevents harm from accidental ingestion. |

Table 2: Approved Disposal Methods for Pharmaceutical Waste

### 8.3 Alternative Route: Return to Supplier

As per CDSCO guidelines, if hospitals wish to return unused/expired drugs to the supplier, the same shall be returned within 30 days after expiry date [3].

#### 8.3.1 Return to Supplier Procedure

1. **Identification:** Identify expired medicines eligible for return (within 30 days of expiry)
2. **Verification:** Check purchase records and supplier details
3. **Communication:** Contact supplier/manufacturer regarding return authorization
4. **Documentation:** Prepare detailed list including drug name, batch number, quantity, expiry date, purchase invoice number
5. **Packaging:** Pack medicines securely maintaining segregation of drug categories
6. **Transportation:** Arrange transportation as per supplier instructions
7. **Acknowledgment:** Obtain written acknowledgment from supplier with date and authorized signature
8. **Follow-up:** Track disposal by supplier and obtain disposal certificate if available
9. **Record Keeping:** Maintain records of returned medicines and supplier acknowledgments

#### 8.3.2 Conditions for Return to Supplier

- Must be within 30 days of expiry date
- Supplier must be contactable and willing to accept return
- Medicines must be in original packaging where possible
- Proper documentation must be maintained
- If supplier does not accept return within 30 days, medicines must be disposed through CBWTF route

### 8.4 Special Disposal Procedures

#### 8.4.1 Controlled Substances (Narcotics and Psychotropics)

- Disposal must be witnessed by at least two authorized personnel including one senior officer
- Detailed record maintained including drug name, quantity, batch number, witnesses
- Physical destruction before disposal (crushing tablets, emptying vials)
- Disposal certificate marked "CONTROLLED SUBSTANCE"
- Compliance with Narcotic Drugs and Psychotropic Substances Act, 1985
- Report to Drugs Controller as required

### 8.4.2 Cytotoxic and Chemotherapeutic Agents

- Stored separately in dedicated yellow containers marked "CYTOTOXIC"
- Handled only by trained personnel wearing appropriate PPE (double gloves, gown, mask, eye protection)
- Never mixed with other pharmaceutical waste
- Collected daily or as frequently as possible
- Disposed only through incineration at temperatures > 1200°C
- All handling areas decontaminated after collection

### 8.4.3 Radiopharmaceuticals

- Disposal strictly as per Atomic Energy Act, 1962 and Atomic Energy Regulatory Board (AERB) guidelines
- Coordination with Radiation Safety Officer
- Decay storage until activity reduces to safe levels
- Specialized disposal through authorized radioactive waste management facility
- Detailed documentation and regulatory reporting

### 8.4.4 Vaccines and Biologicals

- Inactivation before disposal (chemical or thermal methods)
- Segregated in yellow containers
- Disposed through incineration
- Cold chain waste (ice packs, vaccine carriers) handled separately

## 9. Documentation and Record Keeping

### 9.1 Mandatory Registers and Records

#### 9.1.1 Expired/Unused Medicines Register (Pharmacy Department)

To be maintained in the following format:

| Date | Medicine Name | Batch No. | Qty | Expiry Date | Source (Ward/ Store) | Disposal Method | Certificate No. |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Table 3: Expired/Unused Medicines Register Format

#### 9.1.2 Bio-Medical Waste Disposal Register (BMWO)

Maintained as per BMW Rules, 2016 including:

- Category of waste (Yellow - Pharmaceutical)
- Quantity (weight in kg)
- Date and time of handover to CBWTF
- Vehicle number and driver details
- Receiving person signature from CBWTF
- Disposal certificate number and date

#### 9.1.3 Return to Supplier Register

| Date | Medicine Name & Batch | Quantity | Expiry Date | Supplier Name | Return Date | Acknowledgment |
|---|---|---|---|---|---|---|
| | | | | | | |

Table 4: Return to Supplier Register Format

#### 9.1.4 Controlled Substances Disposal Register

Separate detailed register for narcotic and psychotropic disposal including:

- Complete drug details (name, strength, quantity, batch, expiry)
- Authorization details

- Names and signatures of witnesses
- Method of physical destruction
- Date, time, and place of disposal
- Disposal certificate details

### 9.2 Disposal Certificates

- Every disposal through CBWTF must be accompanied by a disposal certificate
- Certificates obtained from CBWTF within 7 days of collection
- Certificates must include: date of disposal, quantity disposed, method of treatment, CBWTF authorization number
- All certificates maintained for minimum 5 years
- Available for inspection by regulatory authorities at any time

### 9.3 Annual Reporting

- BMWO shall prepare annual report on pharmaceutical waste generation and disposal
- Report submitted to Medical Superintendent and Delhi Pollution Control Committee
- Report includes: total quantity of pharmaceutical waste, disposal methods used, CBWTF details, any incidents or deviations

---

## 10. Transportation Requirements

### 10.1 Internal Transportation (Within Hospital Premises)

- Dedicated trolleys or carts for pharmaceutical waste transport
- Clearly marked "BIO-MEDICAL WASTE - PHARMACEUTICAL"
- Covered during transport
- Transported by trained personnel wearing PPE
- Transport during designated times (preferably early morning or evening)
- Routes planned to avoid patient care areas where possible
- Trolleys cleaned and disinfected after each use

### 10.2 External Transportation (To CBWTF)

As per CDSCO guidelines and BMW Rules, 2016:

- Vehicles must comply with Motor Vehicles Act, 1988 and BMW Rules, 2016

- Vehicles must be authorized and registered with State Pollution Control Board
- Separate compartment for bio-medical waste
- Leak-proof and easy to clean
- Clearly marked with bio-medical waste symbol
- Driver and attendant trained in BMW handling
- Vehicle registration and fitness certificate valid
- GPS tracking system installed (as per CPCB guidelines)
- Emergency contact information displayed
- Spill response kit available in vehicle

---

## 11. Safety Measures and Personal Protective Equipment (PPE)

### 11.1 Personal Protective Equipment for Handling Pharmaceutical Waste

All personnel handling pharmaceutical waste shall use appropriate PPE:

| Activity | Required PPE |
|---|---|
| General pharmaceutical waste handling | Gloves (nitrile or latex), gown/apron, closed-toe shoes |
| Cytotoxic drug waste handling | Double gloves, disposable gown, N95 mask or respirator, eye protection (goggles or face shield), shoe covers |
| Liquid pharmaceutical waste | Waterproof apron, gloves, eye protection, closed-toe boots |
| Spill cleanup | Full PPE including double gloves, gown, mask, eye protection, shoe covers |
| Transportation | Gloves, gown, closed-toe shoes |

Table 5: PPE Requirements for Pharmaceutical Waste Handling

### 11.2 Safety Protocols

- Never eat, drink, or smoke while handling pharmaceutical waste
- Wash hands thoroughly with soap and water after handling waste, even with gloves
- Report any exposure, spillage, or injury immediately

- Never overfill waste containers
- Never compact pharmaceutical waste
- Use mechanical aids for lifting heavy containers
- Maintain good ventilation in storage areas
- Keep emergency contact numbers readily available

### 11.3 Spill Management

#### 11.3.1 Spill Response Procedure

1. Alert nearby personnel and restrict access to spill area
2. Wear appropriate PPE before approaching spill
3. Contain spill using absorbent material
4. Collect contaminated material in yellow pharmaceutical waste bag
5. Clean area with detergent and water
6. Disinfect area with appropriate disinfectant
7. Dispose all cleanup materials as pharmaceutical waste
8. Document incident in spill register
9. Report to BMWO and department head

#### 11.3.2 Cytotoxic Drug Spill

- Use cytotoxic spill kit specifically designed for chemotherapy spills
- Wear full protective equipment including double gloves and respirator
- Isolate area and post warning signs
- Use spill absorbent pads designed for cytotoxic materials
- Place all materials in cytotoxic waste container
- Decontaminate area three times with appropriate agents
- Notify Infection Control and Safety Officer

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## 12. Training and Capacity Building

### 12.1 Training Requirements

All personnel involved in pharmaceutical waste management shall receive training covering:

- Overview of CDSCO guidelines and BMW Rules, 2016

- Health and environmental hazards of pharmaceutical waste
- Identification and segregation procedures
- Use of color-coded containers and labeling
- Storage requirements and safety measures
- PPE selection and proper use
- Spill management and emergency response
- Documentation and record keeping
- Regulatory compliance requirements

### 12.2 Training Schedule

- **Induction Training:** All new staff within 1 week of joining
- **Refresher Training:** Annual training for all existing staff
- **Specialized Training:** For personnel handling cytotoxic or radioactive waste
- **Emergency Response Training:** Bi-annual drills for spill response

### 12.3 Training Records

- Attendance records maintained for all training sessions
- Training curriculum and materials documented
- Competency assessment conducted after training
- Records maintained for minimum 5 years

---

## 13. Monitoring, Audit, and Compliance

### 13.1 Internal Monitoring

#### 13.1.1 Daily Monitoring

- Inspection of storage areas for safety and security
- Verification of proper segregation
- Check of container labeling and sealing
- Review of collection schedule adherence

#### 13.1.2 Monthly Monitoring

- Review of disposal records and certificates
- Stock audit for near-expiry medicines

- Assessment of training needs
- Review of any incidents or deviations

### 13.1.3 Quarterly Monitoring

- Comprehensive audit of entire pharmaceutical waste management system
- Review of CBWTF performance
- Assessment of compliance with SOP
- Identification of improvement opportunities

### 13.2 Key Performance Indicators (KPIs)

- Percentage of pharmaceutical waste disposed within 48 hours: Target > 95%
- Disposal certificate receipt within 7 days: Target 100%
- Staff trained in pharmaceutical waste management: Target 100%
- Incidents/spills per quarter: Target < 2
- Medicines returned to supplier within 30 days of expiry: Track and report
- Regulatory non-compliances: Target 0

### 13.3 External Audits and Inspections

- Facilitate inspections by Delhi Pollution Control Committee
- Cooperate with CDSCO or State Drug Control inspections
- Prepare documentation and records for regulatory review
- Implement corrective actions from audit findings within specified timeframes
- Maintain audit reports and compliance certificates

---

## 14. Incident Reporting and Corrective Actions

### 14.1 Reportable Incidents

The following incidents must be reported immediately:

- Spills or releases of pharmaceutical waste
- Unauthorized access to pharmaceutical waste storage
- Missing or unaccounted controlled substances
- Exposure of personnel to hazardous pharmaceutical waste
- Non-compliance with disposal procedures
- Failure to obtain disposal certificates

- CBWTF service disruptions affecting waste accumulation
- Any environmental contamination

### 14.2 Incident Reporting Procedure

1. Immediate verbal notification to BMWO and department head
2. Written incident report within 24 hours
3. Investigation of root cause
4. Implementation of corrective and preventive actions
5. Documentation in incident register
6. Reporting to regulatory authorities as required
7. Follow-up to ensure effectiveness of corrective actions

### 14.3 Continuous Improvement

- Regular review of SOP effectiveness
- Incorporation of best practices and new technologies
- Feedback from staff and stakeholders
- Benchmarking with other leading institutions
- Annual SOP review and update

---

## 15. Annexures

### Annexure A: Contact Information

| Authority/Agency | Contact Details |
|---|---|
| LHMC BMWO | [Insert Name, Phone, Email] |
| Chief Pharmacist | [Insert Name, Phone, Email] |
| Medical Superintendent | [Insert Name, Phone, Email] |
| Authorized CBWTF | [Insert Facility Name, Address, Phone, Authorization No.] |
| Delhi Pollution Control Committee | [Insert Address, Phone, Website] |
| Delhi State Drug Control | [Insert Address, Phone, Email] |
| Emergency Contact (Spills) | [Insert 24-hour Contact Number] |

Table 6: Key Contact Information

**Annexure B: CDSCO Flush List (17 High-Risk Drugs)**

The following 17 drugs may be safely flushed down the sink or toilet as per CDSCO guidelines to prevent accidental harm[3]:

1. Fentanyl transdermal system and related formulations
2. Morphine sulfate preparations
3. Oxycodone formulations
4. Hydromorphone preparations
5. Methadone tablets and solutions
6. Buprenorphine transdermal system

**Note:** Sewer disposal permitted only for these specific drugs and should be documented. General pharmaceutical waste must NOT be disposed through sewers.

**Annexure C: Pharmaceutical Waste Segregation Quick Reference**

| Waste Type | Container Color | Treatment Method |
|---|---|---|
| General pharmaceutical waste (tablets, capsules, syrups) | Yellow (non-chlorinated plastic) | Incineration / Encapsulation / Inertization |
| Cytotoxic drugs | Yellow (marked CYTOTOXIC) | Incineration at high temperature ($>$1200°C) |
| Glass vials/ampoules (empty) | Blue | Disinfection + Shredding |
| High-risk drugs (Flush List) | Yellow or sewer disposal | Documented sewer disposal permitted |
| Controlled substances | Yellow (with witnessing) | Physical destruction + Incineration |

Table 7: Quick Reference Guide for Pharmaceutical Waste Segregation

**Annexure D: Disposal Certificate Format**

**PHARMACEUTICAL WASTE DISPOSAL CERTIFICATE**

- Certificate No.: _____
- Date of Disposal: _____
- Generator Name: Lady Hardinge Medical College & Associated Hospitals

- Generator Address: New Delhi
- Authorization No.: _____
- Quantity of Waste Disposed: _____ kg
- Type of Waste: Pharmaceutical Waste (Yellow Category)
- Method of Treatment: Incineration / Encapsulation / Other (specify)
- CBWTF Name: _____
- CBWTF Authorization No.: _____
- Signature of Authorized CBWTF Representative: _____
- Date: _____

**Annexure E: Flowchart - Pharmaceutical Waste Disposal Process**

**[A visual flowchart would be inserted here showing the complete process from identification through final disposal]**

**Process Summary:**

1. Identification of Expired/Unused Medicine
2. Immediate Removal from Regular Storage
3. Documentation in Register
4. Segregation in Yellow Container
5. Secure Storage (Not exceeding 48 hours)
6. Decision Point: Return to Supplier or CBWTF Disposal?
    - Return to Supplier: Within 30 days of expiry → Document return → Obtain acknowledgment
    - CBWTF Disposal: Handover to authorized CBWTF → Treatment (Incineration/Other) → Obtain disposal certificate
7. Record Keeping and Archival (Minimum 5 years)

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**16. Review and Revision History**

| Version | Date | Changes Made | Approved By |
|---|---|---|---|
| 1.0 | Feb 2026 | Initial SOP based on CDSCO May 2025 guidelines and BMW Rules 2016 | [Name] |
| | | | |

**.LHMC/ADMIN/RM/RDP/12 Standard Operating Procedures (SOPs) for Disposal of Expired or Unused Medicines**

Table 8: SOP Revision History

**Next Review Date:** February 2027 or upon regulatory changes, whichever is earlier.

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### 17. Approval and Authorization

This Standard Operating Procedure has been reviewed and approved by:

| Name & Designation | Signature | Date |
|---|---|---|
| Medical Superintendent | | |
| Chief Pharmacist | | |
| Bio-Medical Waste Management Officer | | |
| Hospital Administrator | | |

Table 9: SOP Approval Signatures

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### References

[1] Central Drugs Standard Control Organization (CDSCO). (2025). Guidance Document on Disposal of Expired/Unused Drugs. Ministry of Health and Family Welfare, Government of India. https://cdsco.gov.in/opencms/resources/UploadCDSCOWeb/2018/UploadPublic_Notices Files/Guidance document on disposal.pdf

[2] Ministry of Environment, Forest and Climate Change. (2016). Bio-Medical Waste Management Rules, 2016 (as amended). Government of India. https://hspcb.org.in/uploads/laws/BMW_Rules.pdf

[3] Compliance Calendar. (2025, May 25). CDSCO Releases Guidance for Safe Disposal of Expired and Unused Medicines. https://www.compliancecalendar.in/learn/cdsco-guidelines-for-safe-disposal-of-expired-and-unused-medicines

[4] Lex Plosion. (2025, November 10). CDSCO Guidelines for Safe Drug Disposal: A Sustainable Shift for Indian Pharma. https://lexplosion.in/cdsco-guidelines-for-safe-drug-disposal-a-sustainable-shift-for-indian-pharma/

[5] IR Global. (2025, October 27). CDSCO Guidelines for Safe Drug Disposal. https://irglobal.com/article/cdsco-guidelines-for-safe-drug-disposal-a-sustainable-shift-for-indian-pharma/

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**END OF DOCUMENT**

# Standard Operating Procedures for Cleanliness and Sanitation

## LHMC/ADMIN/RM/SOP/13

**Lady Hardinge Medical College & Associated Smt. Sucheta Kriplani And Kalawati Saran Children Hospital New Delhi-110001**

*(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati Saran Children Hospital)*

**GOVERNMENT OF INDIA**
**MINISTRY OF HEALTH & FAMILY WELFARE**
**DIRECTORATE GENERAL OF HEALTH SERVICES**
**LADY HARDINGE MEDICAL COLLEGE & ASSOCIATED HOSPITALS**
**SHAHEED BHAGAT SINGH MARG, NEW DELHI-110001**

## Details of the Document

| | |
|---|---|
| Document Name | **Standard Operating Procedures for Cleanliness and Sanitation** |
| Document No. | **LHMC/ADMIN/RM/SOP/13** |
| No. of pages: | 42 Pages |
| Date created: | 17/01/2026 |
| Prepared By | Name: Dr. Banarsi<br>Designation: Additional Medical Superintendent<br>Signature |
| Approved by: | Name: Dr. Manoj B. Jais<br>Designation: Medical Superintendent<br>Signature<br>Name: Dr. Sarita Beri<br>Designation: Medical Director<br>Signature |

| | |
|---|---|
| Responsibility of updating: | Name: Chairperson Bio Medical Waste Committee<br>Designation: HOD Microbiology |

# Standard Operating Procedures for Cleanliness and Sanitation

**Lady Hardinge Medical College & Associated Hospitals, New Delhi**

**Based on Kayakalp Guidelines and National Guidelines for Clean Hospitals**

## 1. Introduction and Scope

### 1.1 Purpose

These Standard Operating Procedures (SOPs) have been developed to ensure the highest standards of cleanliness, hygiene, and infection control at Lady Hardinge Medical College & Associated Hospitals in accordance with the Kayakalp initiative launched by the Ministry of Health & Family Welfare, Government of India.

### 1.2 Objectives

- To promote cleanliness, hygiene, and infection control practices throughout the hospital
- To reduce hospital-acquired infections (HAIs) through effective environmental cleaning
- To create a clean, safe, and aesthetically pleasing environment for patients, staff, and visitors
- To ensure compliance with Kayakalp guidelines and achieve excellence in hospital sanitation
- To establish clear accountability and monitoring mechanisms for cleanliness standards

## 1.3 Scope of Application

These SOPs apply to all areas of Lady Hardinge Medical College & Associated Hospitals including:

- Patient care areas (wards, ICUs, Operation Theatres, Labour Rooms)
- Outpatient departments and clinics
- Emergency and Casualty departments
- Diagnostic and treatment areas (laboratories, radiology, physiotherapy)
- Support service areas (laundry, kitchen, mortuary)
- Administrative offices and public areas
- Hostels and staff quarters

# 2. Thematic Areas of Kayakalp

As per Kayakalp guidelines, these SOPs are organized under six thematic areas[1]:

1. Hospital Upkeep
2. Sanitation and Hygiene
3. Waste Management
4. Infection Control
5. Hospital Support Services
6. Hygiene Promotion

# 3. Risk Categorization of Hospital Areas

## 3.1 High-Risk Areas

**Definition**: Areas with vulnerable patients, invasive procedures, or significant infection risk[2].

**Areas included**:

- Operation Theatres (OT) and associated areas
- Intensive Care Units (ICU, NICU, PICU)
- Labour Rooms and Delivery Suites
- Dialysis Units
- Burn Units

- Casualty and Emergency
- Central Sterile Supply Department (CSSD)
- Neonatal Units

**Cleaning frequency**: Every 2 hours + spot cleaning as required

**Disinfection level**: Intermediate to High-Level Disinfection

## 3.2 Moderate-Risk Areas

**Definition**: Areas with patient contact but lower infection risk[2].

**Areas included**:

- General patient wards (Medical, Surgical, Paediatric, Obstetrics)
- Procedure rooms
- Outpatient departments
- Laboratories (Clinical Pathology, Microbiology, Biochemistry)
- Radiology and Imaging departments
- Pharmacy
- Medical Records

**Cleaning frequency**: Every 4 hours + spot cleaning as required

**Disinfection level**: Low-Level Disinfection

## 3.3 Low-Risk Areas

**Definition**: Areas with minimal patient contact or infection risk[2].

**Areas included**:

- Administrative offices
- Conference rooms and auditoriums
- Libraries
- Staff rest rooms
- Corridors and lobbies
- Waiting areas (non-clinical)
- Store rooms

**Cleaning frequency**: Once or twice per shift + spot cleaning as required

**Disinfection level**: Cleaning with detergent only

| Risk Category | Frequency | Level | Example Areas |
|---|---|---|---|
| High Risk | Every 2 hours + spot | Intermediate/High-Level Disinfection | OT, ICU, Labour Room, NICU |
| Moderate Risk | Every 4 hours + spot | Low-Level Disinfection | Wards, OPD, Labs |
| Low Risk | 1-2 times/shift + spot | Detergent cleaning only | Offices, Corridors, Stores |

Table 1: Risk-based cleaning frequency and standards

# 4. Hospital Upkeep and Infrastructure Maintenance

## 4.1 General Infrastructure Maintenance

**Daily maintenance activities**:

- Removal of choked drainage pipes
- Restoration of water supply
- Replacement of blown fuses and faulty switches
- Watering of plants
- Lawn mowing and hedge cutting
- Sweeping of leaf falls

**Annual repair activities**:

- Whitewashing and colour washing (every 2 years)
- Painting of walls and exteriors (every 3 years)
- Patch repair to plaster
- Replacement of glass panes
- Replacement of damaged switches and sockets
- Gap filling of hedges and trimming of plants

**Maintenance standards**[1]:

- No cracks, seepage, chipped plasters, or broken floors
- No broken windows or glass panes; all windows properly guarded
- No loose or hanging electrical wiring

- All electrical panels placed inside closed cabinets
- Intact boundary wall with adequate height
- No growth of algae, mosses, or vegetation on roofs and walls
- Uniform colour scheme throughout the facility

## 4.2 Pest and Animal Control

**Requirements** [1]:

- Engage licensed pest control agency for monthly pest control activities
- Conduct anti-termite treatment for wooden furniture and fixtures annually
- Maintain intact hospital boundary wall (minimum 2.5 metres height)
- Install cattle traps at all entrances and exits
- Ensure proper drainage to prevent mosquito breeding
- Cover all water storage tanks
- Weekly cleaning and checking of water tanks
- Maintain records of all pest control activities

## 4.3 Parking Area Maintenance

- Provide covered porch parking for ambulances and emergency vehicles
- Properly demarcate parking areas for different categories
- Reserved parking near lifts for persons with disabilities
- Adequate directional signage for parking areas
- Proper illumination of all parking spaces
- Regular cleaning and maintenance of parking surfaces

## 4.4 Landscaping and Gardening

**Standards** [1]:

- Maintain well-designed gardens with aesthetic appearance
- Provide barricades, fences, and gates to prevent unauthorized entry
- Daily removal of dry leaves and green waste
- Regular trimming of overgrown shrubs, weeds, and grass
- Establish herbal garden with medicinal plants (using organic fertilizers only)
- Ensure no overgrown branches or wild vegetation in open areas

## 4.5 Signage System

**Types of signage's required** [1]:

1. **Regulatory Signage's**:
    - PCPNDT Act signage
    - No Smoking signage
    - Radiation warning (AERB guidelines)
    - Biomedical Waste with biohazard symbol
    - CCTV surveillance signage
    - Illuminated fire exit signage
    - Display of licenses and certifications
2. **Locational/Departmental Signages**:
    - External location signage with hospital name (illuminated)
    - Emergency Department signage (illuminated in RED)
    - Hospital layout at entrance
    - Internal location signage for all departments
3. **Directional Signage's**:
    - External directional signage leading to hospital
    - Internal directional signage for departments and facilities
    - Floor directories at lifts and building entrances
4. **Other Signage's**:
    - Citizen Charter including patient rights
    - Display of rate lists
    - Important contact numbers
    - Complaint redressal procedure
    - Scope of services and timings

**Signage standards**:

- Uniform colour scheme
- Bilingual (English and Hindi)
- Clear, legible font visible from distance
- Positioned at natural line of vision
- Concise and unambiguous content

## 4.6 Water Conservation

**Measures** [1]:

- Target: 350-400 litres per bed per day
- Regular tank cleaning and RO maintenance
- Rainwater harvesting system implementation
- Use of low-flow faucets
- Regular inspection of leaking taps, pipes, and dysfunctional cisterns
- Staff duty assignment for periodical inspection

## 4.7 Workplace Management (5S Implementation)

**5S Methodology** [1]:

1. **Sort (Seiri)**: Remove unnecessary items from workplace
2. **Set in Order (Seiton)**: Organize and label items properly
3. **Shine (Seiso)**: Clean and inspect workplace
4. **Standardize (Seiketsu)**: Establish standards and procedures
5. **Sustain (Shitsuke)**: Maintain and review standards regularly

# 5. Sanitation and Hygiene

## 5.1 General Principles of Environmental Cleaning

**Fundamental principles** [2]:

- Clean from least soiled to most soiled areas
- Clean from high areas to low areas
- Clean from clean areas to dirty areas
- Use separate color-coded equipment for different risk areas
- Never re-dip cleaning cloths into cleaning solution (prevents cross-contamination)
- Change cleaning solutions after cleaning 240 square feet
- Always use Personal Protective Equipment (PPE)

**"Hospital Clean" standard** [2]:

- "Hotel Clean" (dust/soil removal, waste disposal) PLUS
- Disinfection of surfaces
- Increased frequency of cleaning
- Regular auditing and monitoring
- Infection control measures in patient care areas

## 5.2 Personal Protective Equipment (PPE)

**Mandatory PPE for sanitation staff** [2]:

- Heavy-duty rubber gloves for cleaning
- Rubber boots
- Waterproof aprons
- Face shields or goggles (when splashing likely)
- N95 masks (for high-risk areas and during specific procedures)
- Uniform with name badge

**PPE protocols**:

- Inspect gloves before each use; discard if torn or damaged
- Wash hands before wearing and after removing PPE
- Never touch face while wearing gloves
- Remove and dispose/decontaminate PPE immediately after task completion
- Launder uniforms daily at 70-80°C or with 0.5% bleach solution

## 5.3 Cleaning Materials and Equipment

**Three-bucket system** [1][2]:

1. **Bucket 1 - Red**: Detergent solution for cleaning
2. **Bucket 2 - Blue**: Clean water for rinsing
3. **Bucket 3 - Yellow**: Disinfectant solution for final wipe

**Equipment requirements** [2]:

- Microfiber mops and cloths (preferred over cotton)
- Color-coded mop heads and buckets (separate for critical/general/toilet areas)
- Dust control mops (dry mopping)
- Wet loop mops with wringer buckets
- Scrubbing machines for large areas
- Vacuum cleaners (HEPA filter for high-risk areas)
- Trolleys for transporting equipment and supplies
- Separate sets for high-risk, moderate-risk, and low-risk areas

**Equipment maintenance** [2]:

- Clean mop heads and cloths daily after use
- Launder at 70-80°C or soak in 0.5% bleach solution for 30 minutes
- Dry completely before storage (prevent microbial growth)

- Store equipment in designated janitor rooms/cupboards
- Inspect equipment daily; replace damaged items immediately

## 5.4 Cleaning Agents and Disinfectants

**Categories of cleaning agents** [2]:

| Agent Type | Use | Examples |
|---|---|---|
| Detergents | Removal of dirt, grease, organic matter | Neutral detergent, enzymatic cleaners |
| Low-level disinfectants | Non-critical items, low-risk areas | Quaternary ammonium compounds (QUATs), phenolics |
| Intermediate disinfectants | Moderate to high-risk areas | Alcohols (60-90%), hydrogen peroxide (3-6%) |
| High-level disinfectants | Critical equipment, high-risk areas | Aldehyde-based (glutaraldehyde, ortho-phthalaldehyde) |
| Chlorine-based | Spills, toilets, high contamination | Sodium hypochlorite (0.1-1.0%) |

Table 2: Cleaning agents and their applications

**Dilution and contact time** [2]:

- **0.1% chlorine solution (1000 ppm)**: General disinfection; 10 minutes' contact time
- **0.5% chlorine solution (5000 ppm)**: Blood/body fluid spills; 10 minutes' contact time
- **1.0% chlorine solution (10000 ppm)**: Heavy contamination; 10 minutes' contact time
- **70% alcohol**: Quick disinfection of surfaces; 30 seconds contact time
- **Hydrogen peroxide (3-6%)**: Equipment surfaces; 5 minutes' contact time

**Safety precautions** [2]:

- Always read Material Safety Data Sheets (MSDS) before use
- Never mix different chemical agents (risk of toxic fumes)
- Use chemicals in well-ventilated areas
- Store chemicals in properly labeled, closed containers
- Keep chemicals away from direct sunlight and heat sources
- Train all staff on proper dilution, use, and storage

# 5.5 Standard Operating Procedures for Cleaning

## 5.5.1 Patient Care Area/Ward Cleaning

**Daily routine cleaning** (minimum 3 times daily) [2]:

**Morning cleaning (6:00-8:00 AM)**:

1. Perform hand hygiene
2. Wear appropriate PPE (gloves, apron, boots)
3. Open windows for ventilation
4. Empty and clean dustbins; replace with fresh liners
5. Remove soiled linen and place in designated bags
6. Dust high surfaces (window sills, shelves, AC vents) using damp cloth
7. Wipe door handles, light switches, call bells with disinfectant
8. Clean bedrails, over bed tables, bedside lockers with disinfectant
9. Wipe medical equipment (BP apparatus, pulse oximeter stands)
10. Clean patient bathroom (refer Section 5.5.3)
11. Dry mop floor using microfiber dust control mop
12. Wet mop floor using three-bucket system (detergent, rinse, disinfectant)
13. Mop from farthest corner toward door (figure-8 technique)
14. Allow floor to dry; place "Wet Floor" signage
15. Remove PPE; perform hand hygiene
16. Document cleaning in register

**Afternoon cleaning (1:00-3:00 PM)**:

1. Spot cleaning of spills and soiled areas
2. Empty dustbins
3. Wipe high-touch surfaces (bedrails, call bells, door handles)
4. Clean bathrooms
5. Mop floors

**Evening cleaning (6:00-8:00 PM)**:

1. Repeat morning cleaning protocol
2. Ensure adequate supplies (toilet paper, soap, hand towels)
3. Check lighting and report defects

**Spot cleaning**: Immediate response to spills, stains, or visible soiling throughout the shift.

**Discharge/Transfer cleaning** [2]:

After patient discharge or transfer to another area:

1. Remove all linen and send for laundering
2. Strip mattress and pillows
3. Clean and disinfect mattress (both sides), mattress cover, pillows
4. Inspect for tears, stains, or damage; report for replacement if needed
5. Clean and disinfect entire bed frame, including wheels
6. Clean and disinfect all furniture (bedside table, chair, locker)
7. Clean windows, window sills, and curtains (if soiled)
8. Wipe all walls, especially around bed area
9. Clean light fixtures and switches
10. Thoroughly clean bathroom
11. Wet mop entire floor with disinfectant
12. Allow room to air-dry for at least 30 minutes before admitting new patient
13. Make bed with fresh linen
14. Document discharge cleaning in register

## 5.5.2 Operation Theatre (OT) Cleaning

**Before first case (start of day)** [1][2]:

1. Perform hand hygiene
2. Wear sterile OT attire, shoe covers, cap, mask, gloves
3. Damp dust all horizontal surfaces (OT table, lights, equipment, shelves, counters)
4. Wipe from top to bottom
5. Clean anesthesia equipment surfaces
6. Wet mop floor using three-bucket system
7. Start from corners and move toward exit
8. Use fresh mop head reserved for OT only
9. Allow floor to dry completely
10. Check adequate supplies (towels, linen, cleaning materials)

**Between cases (intra-operative)** [2]:

1. Remove all used instruments, linen, and waste (as per BMW rules)
2. Wipe OT table with disinfectant (allow 5 minutes' contact time)
3. Wipe OT lights and anesthesia equipment

4. Spot clean any blood or body fluid spills (refer Section 5.5.9)
5. Wet mop floor with disinfectant (high concentration 0.5% chlorine)
6. Allow 5-10 minutes drying time before next case
7. Replace fresh linen on OT table

**End of day (terminal cleaning)** [1][2]:

1. Remove all equipment, instruments, linen, and waste
2. Dust and wipe all surfaces systematically:
    - Ceilings and walls (damp wipe)
    - OT lights (inside and outside)
    - OT table (top, sides, base, wheels)
    - Anesthesia machine
    - Monitors and equipment
    - Shelves, cabinets, counters
    - Doors, door handles, switches
    - Suction apparatus
    - Trolleys and stools
3. Wet mop floor thoroughly (entire surface including corners)
4. Leave disinfectant on floor for minimum 10 minutes before drying
5. Clean scrub area, gowning area, and corridors
6. UV light sterilization (if available) for 30 minutes after cleaning
7. Document terminal cleaning with date, time, and signature
8. Conduct weekly/fortnightly fumigation as per protocol

**Scheduled deep cleaning** [2]:

- **Weekly**: Clean OT lights (inside), air vents, high dusting, wall washing
- **Monthly**: Detailed cleaning of entire OT complex including changing rooms, storage areas
- **Quarterly**: Settle plate testing, air sampling, surface swab cultures

## 5.5.3 Bathroom and Toilet Cleaning

**Cleaning frequency** [2]:

- High-risk areas: Every 2 hours
- Moderate-risk areas: Every 4 hours (minimum 3 times daily)
- Low-risk areas: Twice daily

- Spot cleaning: Immediately upon soiling

**Routine bathroom cleaning protocol** [2]:

1. Perform hand hygiene; wear PPE (gloves, apron, boots, mask if needed)
2. Ventilate bathroom by opening windows/exhaust fans
3. Remove all visible waste; empty dustbins
4. Apply toilet bowl cleaner inside toilet bowl; allow to sit
5. Clean from cleanest to dirtiest areas:
    - Clean mirrors and glass surfaces (glass cleaner)
    - Wipe counters, shelves, and soap dispensers (disinfectant)
    - Clean hand wash basin (inside, outside, faucets, drain)
    - Clean shower area (walls, floor, fixtures, drain)
    - Scrub toilet bowl (inside and outside) using dedicated toilet brush
    - Clean toilet seat (top and bottom), lid, hinges
    - Wipe flush handle/button with disinfectant
    - Clean toilet paper holder and other fixtures
    - Wipe walls, especially around toilet and sink
    - Wipe door, door handles (inside and outside)
    - Sweep and wet mop floor with disinfectant (0.1-0.5% chlorine)
6. Refill consumables:
    - Liquid soap in dispensers
    - Toilet paper
    - Hand towels (paper or cloth)
    - Air freshener (if used)
7. Remove PPE carefully; dispose in appropriate bin
8. Perform hand hygiene
9. Document cleaning in checklist

**Special attention areas** [2]:

- High-touch surfaces: Door handles, flush buttons, faucet handles, light switches
- Grout lines between tiles (prevent mold growth)
- Drains (prevent clogging and odors)
- Ensure no leaking taps or dysfunctional fixtures; report immediately

## 5.5.4 Floor Mopping Techniques

**Dry mopping (dust control)** [2]:

1. Use microfiber dust control mop
2. Start from farthest corner; work toward exit
3. Use overlapping figure-8 strokes
4. Do not lift mop off floor (traps dust)
5. Shake mop outdoors or vacuum to remove dust
6. Launder or replace mop head when visibly soiled

**Wet mopping (three-bucket system)** [2]:

1. Prepare three buckets:
    - Bucket 1 (Red): Warm water + neutral detergent
    - Bucket 2 (Blue): Clean water for rinsing
    - Bucket 3 (Yellow): Disinfectant solution (appropriate for area)
2. Use clean mop head (laundered and dried)
3. Remove gross soil by dry mopping first
4. Dip mop in detergent solution (Bucket 1); wring excess water
5. Mop small area (maximum 120 square feet per dip)
6. Rinse mop in clean water (Bucket 2); wring
7. Dip mop in disinfectant solution (Bucket 3); wring
8. Mop same area with disinfectant
9. Use figure-8 technique; overlap strokes
10. Start from farthest corner; work toward exit
11. Change all three solutions after cleaning 240 square feet
12. Allow floor to air-dry; place "Wet Floor" signage
13. Clean and dry mop head; store properly

**Microfiber wet mopping** [2]:

1. Use flat microfiber mop with velcro pad
2. Pre-wet microfiber pad with appropriate solution (detergent or disinfectant)
3. Use overlapping S-strokes or figure-8 technique
4. Change pad when visibly soiled or after 240 square feet
5. Launder pads at 70-80°C or with bleach solution

## 5.5.5 ICU and NICU Cleaning

**Specific considerations for critical care areas** [1][2]:

- Minimize disturbance to patients during cleaning
- Clean one bed space at a time
- Never shake linen or create dust
- Use damp dusting only (never dry dusting)
- Clean from least contaminated to most contaminated areas
- Pay special attention to high-touch surfaces around patient

**Cleaning protocol**:

1. Perform hand hygiene; wear appropriate PPE
2. Clean in the following order:
    - Medical equipment surfaces (ventilators, monitors, IV poles)
    - Bedrails, bed controls, mattress edges
    - Bedside tables, lockers, chairs
    - Window sills, counters, sinks
    - Door handles, light switches, call bells
    - Walls (especially around bed)
    - Floor (wet mop with disinfectant)
3. Use separate mop and cloth for each bed space
4. Clean sinks and hand wash areas last
5. Ensure adequate stock of hand hygiene products (ABHR, soap)
6. Document cleaning with time and signature

**Frequency** [2]:

- High-touch surfaces: Every 2 hours
- Complete cleaning: 3 times per day (morning, afternoon, evening)
- Discharge cleaning: After every patient discharge

## 5.5.6 Labour Room and Delivery Suite Cleaning

**Between deliveries** [1][2]:

1. Remove all used linen, instruments, and waste (as per BMW rules)
2. Wipe delivery table with 0.5% chlorine solution
3. Clean radiant warmer and resuscitation equipment surfaces
4. Wipe all high-touch surfaces (lights, switches, door handles)
5. Spot clean any blood or amniotic fluid spills immediately
6. Wet mop floor with disinfectant (0.5% chlorine)

7. Allow to dry before next delivery
8. Replace fresh linen on delivery table

**End of day cleaning**:

1. Complete terminal cleaning similar to OT protocol
2. Clean all walls, ceilings, fixtures, equipment
3. Disinfect labour table thoroughly
4. Clean scrub area, hand wash sinks
5. Wet mop entire floor; allow 10 minutes' contact time
6. Restock all supplies

## 5.5.7 Outpatient Department (OPD) Cleaning

**Morning cleaning (before OPD starts)**:

1. Open windows for ventilation
2. Empty dustbins; replace liners
3. Dust all horizontal surfaces (desks, counters, chairs)
4. Wipe door handles, light switches, patient seating areas
5. Clean examination couches with disinfectant
6. Clean doctor's desk, telephone, keyboard
7. Sweep and wet mop floors
8. Clean waiting areas (benches, chairs, tables)
9. Clean registration counter and pharmacy counter
10. Ensure adequate supplies (hand sanitizer, tissue paper)

**During OPD hours**:

- Spot cleaning of spills and soiled areas
- Empty overflowing dustbins
- Wipe examination couch between patients
- Keep waiting areas tidy

**After OPD closure**:

- Repeat morning cleaning protocol
- Thoroughly mop all floors
- Clean and disinfect all patient contact surfaces

## 5.5.8 Laboratory Cleaning

**Daily cleaning** [1]:

1. Clean all work benches and counters with disinfectant before and after work
2. Wipe down all equipment surfaces (microscopes, analyzers, centrifuges)
3. Clean sinks, faucets, and drainage areas
4. Wipe storage shelves and refrigerator exteriors
5. Empty and clean sharps containers (as per BMW rules)
6. Wet mop floors with disinfectant
7. Special attention to specimen collection areas

**Weekly cleaning**:

- Deep clean of all equipment
- Clean interior of refrigerators and freezers
- Wash walls, especially around work areas
- High dusting of shelves and cupboards

**Spill management**: Immediate cleaning with 1% chlorine solution; allow 10 minutes' contact time.

## 5.5.9 Cleaning Blood and Body Fluid Spills

**Immediate response protocol** [2]:

1. Wear appropriate PPE immediately:
    - Heavy-duty gloves
    - Waterproof apron
    - Face shield or goggles
    - Mask
    - Shoe covers
2. Contain the spill:
    - Cordon off area; place warning signs
    - Prevent foot traffic through contaminated area
3. For small spills (less than 10 ml):
    - Cover spill with absorbent material (paper towels, cloth)
    - Pour 0.5% chlorine solution directly over absorbent material
    - Allow 10 minutes' contact time
    - Wipe up carefully using disposable materials

- Dispose in yellow bag (biomedical waste)
- Clean area with detergent and water
- Final disinfection with 0.1% chlorine solution

4. For large spills (more than 10 ml):
    - Cover spill with absorbent material
    - Pour 1.0% chlorine solution over spill
    - Allow 20 minutes' contact time
    - Carefully remove absorbent material with disposable scoop/dustpan
    - Dispose in yellow bag
    - Wash area with detergent and water
    - Apply 0.5% chlorine solution; allow 10 minutes
    - Rinse and dry
5. Remove PPE carefully (most contaminated items first)
6. Perform thorough hand hygiene
7. Document spill incident

**Special spills**:

- **Urine spills**: Use 0.1% chlorine solution
- **Fecal matter**: Remove gross soil first; then disinfect with 0.5% chlorine
- **Vomit**: Remove solid matter; disinfect with 0.5% chlorine

## 5.5.10 Equipment Cleaning

**Patient care equipment** (BP apparatus, pulse oximeter, thermometers, stethoscopes) [2]:

- Wipe with hospital-grade disinfectant after each patient use
- Use 70% alcohol or appropriate disinfectant wipe
- Allow adequate contact time (minimum 30 seconds)
- Clean cables, cuffs, probes thoroughly
- Ensure equipment is dry before next use

**Furniture** (beds, trolleys, wheelchairs):

- Clean with detergent and water
- Disinfect with low-level disinfectant
- Pay attention to wheels, handles, armrests
- Check for rust; apply anti-rust treatment if needed
- Lubricate wheels and moving parts

**IV poles, drip stands**:

- Wipe entire pole from top to bottom
- Disinfect hooks and adjustment knobs
- Clean base and wheels

## 5.6 Drainage and Sewage Management

**Requirements** [1]:

- Maintain closed drainage system throughout hospital
- Weekly cleaning of all drains
- Connect to municipal sewage system or approved septic tanks
- Desludge septic tanks every 6-12 months
- Install soakage pits for sullage water (minimum 20 metres from water sources)
- Use drain covers with fine mesh to prevent clogging
- Pour disinfectant solution in drains weekly
- Immediately address any choked or overflowing drains

**Drain cleaning protocol**:

1. Wear heavy-duty gloves and boots
2. Remove drain covers and clean with detergent
3. Remove visible debris from drain
4. Flush with high-pressure water
5. Pour 0.5% chlorine solution
6. Allow 30 minutes' contact time
7. Flush again with water
8. Replace drain covers

# 6. Biomedical Waste Management

## 6.1 Legal Framework

All biomedical waste management at LHMC & Associated Hospitals shall comply with:

- Biomedical Waste Management Rules, 2016
- Biomedical Waste Management (Amendment) Rules, 2018
- State Pollution Control Board regulations

- Room should be:
  - Well-ventilated with exhaust fans
  - Easily accessible for collection vehicles
  - Protected from animals and unauthorized persons
  - Equipped with water supply and drainage
  - Illuminated and labeled with biohazard symbol

- Store waste for maximum 48 hours at facility level
- Maintain storage in segregated manner (color-wise)
- Clean storage area daily with disinfectant

## 6.4 Final Disposal

**Common Biomedical Waste Treatment Facility (CBMWTF)**[1]:

- Contract with authorized CBMWTF within 75 km radius
- Handover BMW daily or as per agreed schedule
- Obtain receipt with weight category-wise
- Maintain disposal records for minimum 5 years

**Alternative: Deep burial pit** (where CBMWTF unavailable) [1]:

- Obtain prior approval from State Pollution Control Board
- Locate pit away from habitations and water sources
- Dimensions: minimum 2m x 2m x 2m
- Use for anatomical waste and soiled waste only
- Cover waste with lime powder and soil layers
- Maintain pit register

## 6.5 Sharps Management

**Needle stick injury prevention** [1]:

- Never recap, bend, or break needles
- Use needle cutters or destroy needles immediately after use
- Dispose needles and syringes in puncture-proof white/blue containers
- Fill sharps containers only up to 3/4th capacity
- Seal and label containers before disposal
- Disinfect sharps container exteriors before handover

## 6.2 Segregation at Source

**Color-coded bins and bags** [1]:

| Color | Type of Waste | Disposal Method |
|---|---|---|
| Yellow | Anatomical waste, soiled waste, expired medicines, chemical waste | Incineration or deep burial |
| Red | Contaminated recyclable waste (gloves, IV sets, catheters) | Autoclaving and recycling |
| White/Blue | Sharp waste (needles, syringes, blades, glass) | Autoclaving, shredding, disposal |
| Green | General non-hazardous waste (kitchen waste, paper) | Disposal as municipal solid waste |

Table 3: Biomedical waste segregation

**Segregation principles** [1]:

- Segregate waste at the point of generation
- Use color-coded bins with foot-operated lids
- Fill bags/containers only up to 3/4th capacity
- Label each bag with: waste category, department, date, time
- Display biohazard symbol on all BMW bins and storage areas
- Never mix different categories of waste
- Display instructions for segregation prominently

## 6.3 Collection and Transportation

**Internal collection** [1]:

- Collect BMW from all departments twice daily (morning and evening)
- Use dedicated trolleys for BMW transportation (separate from general waste)
- Close bags securely before transportation
- Transport via designated routes (avoid patient care areas if possible)
- Maintain collection register with department-wise records

**Temporary storage** [1]:

- Establish central BMW storage facility (away from patient areas)

**Post-exposure prophylaxis** [1]:

In case of needle stick injury:

1. Wash wound immediately with soap and running water
2. Encourage bleeding by gently squeezing
3. Report to Occupational Health Department immediately
4. Complete needle stick injury reporting form (Annexure VI)
5. Assess source patient HIV, HBV, HCV status
6. Initiate post-exposure prophylaxis as per protocol
7. Follow up as per guidelines

## 6.6 General Waste Management

**Non-hazardous waste** [1]:

- Segregate as biodegradable and recyclable
- Use green bins for general waste
- Collect and transport separately from BMW
- Establish composting/vermicomposting pits for biodegradable waste
- Contract with municipal authorities for regular collection
- Maintain records of waste generation

## 6.7 Liquid Waste Management

**Pre-treatment before disposal** [1]:

- Disinfect all liquid waste with 1-2% hypochlorite solution
- Allow 30 minutes' contact time before disposal
- For large-volume generators: Install Effluent Treatment Plant (ETP)
- Test pH, BOD, COD regularly to ensure compliance with standards
- Maintain liquid waste disposal records

## 6.8 Training and Awareness

**Mandatory training for all staff** [1]:

- Induction training for new employees (BMW rules, segregation, safety)
- Refresher training every 6 months
- Display color-coded segregation posters in all clinical areas

- Provide hands-on demonstration of proper segregation
- Training on spill management and post-exposure prophylaxis
- Document all training sessions

## 6.9 Statutory Compliance

**Legal requirements** [1]:

- Obtain authorization from State Pollution Control Board (Form II)
- Constitute Hospital BMW Management Committee (meets quarterly)
- Appoint nodal officer for BMW management
- Maintain annual reports (Form IVA)
- Report accidents within 24 hours (Form I)
- Conduct internal audits twice yearly
- Display authorization and annual reports publicly

# 7. Infection Control

## 7.1 Standard Precautions

**Hand hygiene** (5 moments) [1]:

1. Before touching a patient
2. Before clean/aseptic procedure
3. After body fluid exposure risk
4. After touching a patient
5. After touching patient surroundings

**Method**:

- Alcohol-based hand rub (ABHR) for non-visibly soiled hands (20-30 seconds)
- Soap and water for visibly soiled hands (40-60 seconds)
- Ensure ABHR dispensers at all point-of-care locations
- Display hand hygiene technique posters prominently

**Personal protective equipment** [1]:

- Use PPE based on anticipated exposure
- Gloves: For contact with blood, body fluids, mucous membranes

- Gowns/aprons: When clothing may become contaminated
- Masks: For procedures generating aerosols or droplets
- Face shields/goggles: When splashing anticipated
- Remove PPE before leaving patient area
- Perform hand hygiene after PPE removal

## 7.2 Transmission-Based Precautions

**Contact precautions** (MRSA, VRE, C. difficile) [1]:

- Single room or cohort patients
- Gloves and gowns for all patient contact
- Dedicated or single-use equipment
- Daily cleaning and disinfection of patient environment
- Enhanced terminal cleaning after discharge

**Droplet precautions** (influenza, pertussis, meningitis) [1]:

- Single room (or maintain 2-meter distance between patients)
- Surgical mask for close contact (within 2 meters)
- Limit patient movement

**Airborne precautions** (tuberculosis, measles, varicella) [1]:

- Airborne infection isolation room (negative pressure)
- N95 respirator for all entering room
- Keep door closed
- Limit patient movement; use surgical mask if patient must leave room

## 7.3 Instrument Reprocessing

**Spaulding classification** [1]:

| Category | Definition | Reprocessing |
|---|---|---|
| Critical | Enters sterile tissue or vascular system | Sterilization (autoclave 121°C/30 min or 134°C/18 min) |
| Semi-critical | Contacts mucous membranes or non-intact skin | High-level disinfection (HLD) |
| Non-critical | Contacts intact skin only | Low-level disinfection (LLD) |

Table 4: Spaulding classification for instrument reprocessing

**Reprocessing steps** [1]:

1. **Transport**: In closed container to decontamination area
2. **Cleaning**: Remove organic material (manual or ultrasonic)
3. **Drying**: Thoroughly dry all surfaces
4. **Packaging**: Wrap critical items before sterilization
5. **Sterilization/Disinfection**: As per classification
6. **Storage**: In clean, dry, designated area
7. **Monitoring**: Mechanical, chemical, and biological indicators

## 7.4 Hospital Acquired Infection (HAI) Surveillance

**Monitoring and reporting** [1]:

- **Surgical Site Infections (SSI)**: Monitor per 100 procedures
- **Catheter-Associated UTI (CAUTI)**: Monitor per 1000 catheter days
- **Ventilator-Associated Pneumonia (VAP)**: Monitor per 1000 ventilator days
- **Central Line-Associated BSI (CLABSI)**: Monitor per 1000 central line days
- Maintain infection rates by department
- Report to Infection Control Committee monthly
- Use Annexure VII format for SSI reporting

**Environmental surveillance** [1]:

- OT air sampling: Monthly
- OT surface swab cultures: Monthly
- Water sampling: Quarterly
- Sterility testing of sterilized instruments: Weekly
- Corrective action for positive results: Re-clean, re-disinfect, re-test

## 7.5 Isolation and Barrier Nursing

**Patient isolation criteria** [1]:

- Confirmed or suspected communicable disease requiring precautions
- Multi-drug resistant organisms (MDRO)
- Immunocompromised patients (protective isolation)

**Isolation room requirements**:

- Single room with attached bathroom
- Adequate ventilation (negative pressure for airborne infections)
- Ante-room for donning/doffing PPE (preferred)
- Hand wash sink inside room
- Display isolation sign on door
- Dedicated equipment for patient use

**Barrier nursing practices**:

- Restrict visitors (essential only)
- Maintain 1.2-meter spacing between beds in general wards
- No external footwear in critical areas
- Use curtains between beds as physical barrier
- Clean isolation rooms last during routine cleaning rounds
- Enhanced terminal cleaning after patient discharge

# 8. Hospital Support Services

## 8.1 Laundry Services and Linen Management

**Linen requirements** [1]:

- Minimum 4-6 sets of linen per bed
- Separate color-coding for different departments (if feasible)
- Adequate stock to allow 24-hour turnaround

**Soiled linen handling** [1]:

- Handle soiled linen with minimal agitation (avoid shaking)
- Segregate at point of use:
  - Foul linen (heavily soiled with blood/body fluids) - separate bag
  - Infected linen (from isolation patients) - red biohazard bag
  - General soiled linen - regular laundry bag
- Transport in closed carts/trolleys
- Never sort soiled linen in patient care areas
- Wear PPE (gloves, apron) when handling

**Laundering process** [1]:

- **General linen**: Hot wash at 70-80°C with detergent

- **Foul/infected linen**: Pre-treatment with 0.5% bleach solution for 30 minutes, then hot wash
- **OT linen**: Autoclave after laundering (if used for sterile procedures)
- Tumble dry at high temperature
- Iron if required
- Store in clean, dry area

**Clean linen distribution**:

- Transport clean linen in covered trolleys (separate from soiled)
- Store in clean linen cupboards in wards
- Maintain adequate par levels
- First-in, first-out system

## 8.2 Kitchen Services and Food Safety

**Kitchen hygiene standards** [1]:

- Food handlers: Annual health checkup, valid health certificate
- Mandatory use of cap, apron, gloves, mask while handling food
- No jewelry or artificial nails permitted
- Hand hygiene before food handling
- Separate areas for vegetarian and non-vegetarian food preparation
- Use color-coded cutting boards (red: meat; green: vegetables; white: dairy; yellow: poultry)

**Kitchen cleaning** [1]:

- Clean work surfaces before and after each meal preparation
- Daily cleaning of floors, walls (tiled areas), sinks, drains
- Weekly deep cleaning of equipment (ovens, refrigerators, exhaust hoods)
- Monthly pest control
- Maintain kitchen cleaning log

**Food storage**:

- FIFO (First in, First Out) system
- Proper labeling with date of receipt
- Adequate refrigeration (0-5°C for chilled; below -18°C for frozen)
- Temperature monitoring and documentation
- Separate storage for raw and cooked foods

## 8.3 Security Services

**Sanitation-related security functions** [1]:

- Monitor and prevent unauthorized entry through boundary walls
- Restrict thoroughfare through hospital premises
- Install cattle traps at entry/exit points
- Ensure no encroachment by unauthorized vendors
- Monitor parking areas
- Coordinate with sanitation staff for after-hours issues

## 8.4 Outsourced Services Management

**For contractual sanitation services** [2]:

- Contract must clearly define infection control responsibilities
- Include mandatory training requirements
- Specify cleaning frequencies, standards, and auditing mechanisms
- Build in penalties for non-compliance
- Regular joint monitoring with hospital staff
- Monthly performance review meetings
- Ensure contractor provides adequate PPE to staff
- Verify employee health screening

# 9. Hygiene Promotion

## 9.1 Staff Hygiene and Dress Code

**Personal hygiene for all hospital staff** [1]:

- Daily bath before reporting to duty
- Clean, ironed uniform
- Short, clean nails (no artificial nails)
- No jewelry (except wedding ring and small earrings)
- Hair tied back neatly (cap for critical areas)
- No strong perfumes or scented products
- Regular handwashing and hand hygiene

**Uniform standards**:

- Sanitation staff: Color-coded uniform with name badge, rubber boots

- Clinical staff: White or color-coded uniform as per department
- Change uniform if visibly soiled
- Launder uniform daily at high temperature
- Do not wear uniform outside hospital premises

## 9.2 Information, Education, and Communication (IEC)

**IEC materials to be displayed** [1]:

- Hand hygiene technique and 5 moments (at all hand wash areas)
- Cough etiquette (in waiting areas, OPDs)
- Biomedical waste segregation (in all clinical areas)
- No spitting, no tobacco use
- Kayakalp and Swachh Bharat Abhiyan posters
- 5S implementation posters
- Good toilet practices
- Waste management instructions
- Occupational safety (spill management, needle stick injury prevention)

**Patient and visitor education**:

- Orientation for attendants on hospital cleanliness expectations
- Use of dustbins (not throwing waste on floor/grounds)
- Hand hygiene promotion
- Cough and respiratory etiquette
- Proper use of toilets and bathrooms

## 9.3 Community Monitoring and Patient Participation

**Feedback mechanisms** [1]:

- Display complaint/suggestion boxes in visible locations
- Patient satisfaction surveys (include cleanliness questions)
- Grievance redressal system with designated officer
- Regular patient/attendant feedback rounds
- Act on feedback; communicate corrective actions

**Community engagement**:

- Rogi Kalyan Samiti meetings (discuss cleanliness issues)
- Display cleanliness audit scores publicly
- Celebrate Kayakalp achievements
- Involve local community in health awareness programs

## 9.4 Leadership and Teamwork

**Sanitation committee** [1]:

- Chairperson: Medical Superintendent/Director
- Members: Nursing Superintendent, Infection Control Officer, Sanitation Officer, Engineering Officer, Representative from State/UT
- Meet monthly
- Review cleaning standards, audit reports, HAI rates
- Approve policies and SOPs
- Allocate resources

**Leadership responsibilities**:

- Prioritize cleanliness and sanitation
- Ensure adequate budget allocation
- Provide necessary infrastructure and equipment
- Recognize and reward good performance
- Initiate disciplinary action for non-compliance
- Lead by example

# 10. Monitoring and Quality Assurance

## 10.1 Cleanliness Assessment Methods

**Visual inspection** [2]:

- Most practical method for daily monitoring
- Supervisor/Nursing staff visual checks after cleaning
- Use standardized checklist (Annexure III format)
- Document findings with date, time, and signature

**Fluorescent gel marking** [2]:

- Apply invisible fluorescent gel to high-touch surfaces before cleaning
- Check with UV light after cleaning
- Gel removal indicates surface was wiped
- Useful for training and spot audits

**ATP (Adenosine Triphosphate) bioluminescence** [2]:

- Measures organic material on surfaces
- Immediate results (Relative Light Units - RLU)
- Useful for monitoring trends
- Recommended RLU threshold: <500 for patient care areas

**Microbiological cultures** [2]:

- Settle plate method for OT air
- Surface swab cultures for high-risk areas
- Not for routine monitoring; use for surveillance or investigation
- Frequency: Monthly for OT; quarterly for other areas

## 10.2 Audit and Inspection Schedule

| Area/Activity | Frequency | Responsibility |
|---|---|---|
| Daily post-cleaning inspection | Daily | Sanitation Supervisor, Ward In-charge |
| High-risk areas audit | Weekly | Sanitation Officer, Infection Control Nurse |
| Moderate-risk areas audit | Fortnightly | Sanitation Officer |
| Low-risk areas audit | Monthly | Sanitation Inspector |
| Equipment maintenance check | Weekly | Sanitation Officer |
| Chemical stock and MSDS review | Monthly | Sanitation Officer, Store Keeper |
| BMW management audit | Quarterly | BMW Committee |
| Comprehensive facility audit | Quarterly | Sanitation Committee |
| Internal Kayakalp assessment | Half-yearly | Assessment Team |

Table 5: Audit and inspection schedule

## 10.3 Performance Indicators

**Key Performance Indicators (KPIs) for sanitation services** [2]:

- Cleaning completion rate: Target 100% on schedule
- Post-cleaning audit scores: Target >90%
- ATP test pass rate: Target >90% of tests <500 RLU
- OT air colony counts: Target <10 CFU/$m^3$
- Complaint resolution time: Target <24 hours
- Staff training completion: Target 100% (induction + refreshers)
- BMW segregation accuracy: Target >95%
- HAI rates: Downward trend
- Kayakalp score: Target >85% (towards award)

## 10.4 Reporting and Documentation

**Daily documentation** [2]:

- Cleaning completion checklists (by area)
- Staff attendance and duty roster
- Equipment usage log
- Chemical consumption record
- Complaint register
- Spill incident reports

**Monthly reports**:

- Consolidated cleaning compliance report
- Audit scores (area-wise)
- Staff training conducted
- Equipment maintenance activities
- Chemical stock and consumption
- Pest control activities
- BMW generation and disposal statistics
- HAI surveillance data

**Annual reports**:

\begin{itemize}
\item Comprehensive Kayakalp self-assessment
\item Infection control annual report
\item BMW annual report (Form IVA to SPCB)
\item Budget utilization and requirements for next year
\end{itemize>

## 10.5 Corrective Action

**Non-compliance handling** [2]:

- Identify gap through audit or complaint
- Immediate corrective action (re-clean, re-disinfect)
- Root cause analysis
- Retraining if knowledge gap identified
- Supervision intensification
- If systemic: Revise SOP or add resources
- Document corrective action and verify effectiveness

**Penalties for contractual staff** (if applicable) [2]:

- Absenteeism without replacement: Penalty as per contract
- Unsatisfactory cleaning: Warning, then penalty
- Repeated non-compliance: Contract termination clause
- Positive motivation: Performance-linked incentives

# 11. Training and Capacity Building

## 11.1 Training Framework

**Induction training for new sanitation staff** [1]:

**Duration**: 8-24 hours depending on risk category of assigned area

**Topics covered**:

\begin{itemize}
\item Hospital organization and sanitation department structure
\item Importance of cleanliness in healthcare settings
\item Risk categorization of hospital areas
\item Standard precautions and infection control basics
\item Hand hygiene: 5 moments, technique
\item Personal protective equipment: Types, donning, doffing
\item Biomedical waste management: Segregation, color coding, handling
\item Cleaning agents and disinfectants: Types, dilution, safety (MSDS)

\item Equipment: Use, cleaning, maintenance
\item Standard Operating Procedures for assigned areas
\item Spill management
\item Occupational hazards: Needle stick injury, chemical exposure, back injury prevention
\item Reporting and documentation
\item 5S methodology
\item Code of conduct and dress code
\end{itemize>

**Refresher training** [1]:

| Staff Category | Frequency | Focus Areas |
|---|---|---|
| High-risk area staff (OT, ICU, Labour Room) | Monthly | Advanced infection control, OT protocols, HAI prevention |
| Moderate-risk area staff (Wards, OPD) | Quarterly | Routine SOPs, waste management, customer service |
| Low-risk area staff | Half-yearly | General cleanliness, safety |
| Supervisors and Officers | Quarterly | Leadership, monitoring, new guidelines, audit tools |

Table 6: Refresher training schedule

**Special training programs**:

- New SOP rollout training (as needed)
- Equipment operation training (for new machines)
- Outbreak response training (during outbreaks)
- Fire safety and disaster management (annually)

## 11.2 Training Delivery Methods

- Classroom lectures with audiovisual aids
- Hands-on demonstrations
- On-the-job training and mentoring
- Display of SOPs and IEC materials at work sites
- Regular toolbox talks (10-15 minutes daily briefings)
- External training programs and workshops

## 11.3 Training Documentation

- Maintain training register with:

  - Name of employee
  - Date of training
  - Topic/module
  - Duration
  - Trainer name
  - Signature of trainee
  - Assessment scores (pre/posttest)
- Issue training certificates
- Maintain individual training files
- Include training compliance in performance appraisal

## 11.4 Competency Assessment

- Pre-training and post-training knowledge tests
- Practical skill demonstration and observation
- Supervisor assessment of on-job performance
- Quarterly competency evaluation
- Re-training for staff not meeting standards

# 12. Occupational Health and Safety

## 12.1 Hazards and Risks

**Occupational hazards for sanitation staff** [2]:

- **Biological**: Exposure to blood, body fluids, infectious agents
- **Chemical**: Exposure to cleaning agents, disinfectants (skin/eye irritation, respiratory issues)
- **Physical**: Slips, trips, falls; back injuries from lifting; burns from hot water
- **Sharps injuries**: Needle sticks, cuts from broken glass
- **Ergonomic**: Repetitive movements, prolonged standing

## 12.2 Safety Measures

**General safety protocols** [2]:

- Mandatory use of PPE at all times
- Never eat, drink, or smoke while working
- Do not touch face, eyes, or mouth with gloved hands

- Report all injuries, exposures, and near-misses immediately
- Use correct lifting techniques (bend knees, not back)
- Use trolleys for transporting heavy loads
- Place "Wet Floor" signs during and after mopping
- Ensure adequate lighting in all work areas
- Wear non-slip footwear

**Chemical safety** [2]:

- Read MSDS before using any chemical
- Use chemicals in well-ventilated areas
- Wear gloves, aprons, goggles as recommended
- Never mix chemicals (especially chlorine with acids or ammonia)
- Store chemicals in original labeled containers
- Keep chemicals locked; away from food storage
- Have eyewash stations and safety showers accessible
- Spill kits available for chemical spills

**Biological safety**:

- Follow standard precautions always
- Hepatitis B vaccination for all sanitation staff (mandatory)
- Annual health checkups including chest X-ray, blood tests
- Post-exposure prophylaxis protocol in place
- Immediate reporting of all exposures
- Maintain confidentiality of health records

## 12.3 Employee Health Program

**Pre-employment health screening**:

- General physical examination
- Chest X-ray (TB screening)
- Blood tests: CBC, HBsAg, Anti-HCV, HIV (with consent)
- Fitness certificate from Occupational Health physician

**Vaccinations** (recommended)[2]:

- Hepatitis B (mandatory - 3 doses)
- Tetanus toxoid booster (every 10 years)
- Influenza (annual)

- COVID-19 (as per national guidelines)

**Periodic health surveillance**:

- Annual medical checkup for all staff
- Vision and hearing tests
- Lung function tests (for chemical exposure)
- Skin examination
- Work-related illness reporting and investigation

## 12.4 Incident Reporting and Investigation

**Reportable incidents**:

- Needle stick injuries and sharps exposures
- Blood/body fluid exposures
- Chemical spills and exposures
- Slips, trips, and falls
- Equipment-related injuries
- Assault or violence

**Incident management process**:

1. Immediate first aid and medical attention
2. Report to supervisor and Occupational Health within 1 hour
3. Complete incident report form
4. Investigation by Safety Officer
5. Root cause analysis
6. Corrective and preventive actions
7. Follow-up and closure
8. Periodic review of trends; implement systemic changes

# 13. Implementation Plan

## 13.1 Phased Rollout

**Phase 1 (Months 1-3): Foundation**

- Constitute Sanitation Committee and sub-committees
- Appoint/designate Officers and Nodal persons

- Conduct baseline assessment of current status
- Develop detailed implementation plan
- Procure necessary equipment, supplies, PPE
- Upgrade infrastructure (janitor rooms, storage, signage)
- Conduct comprehensive staff training (all levels)
- Pilot implementation in 2-3 departments

**Phase 2 (Months 4-6): Expansion**

- Roll out SOPs to all departments in phases (high-risk first)
- Intensify monitoring and auditing
- Establish feedback mechanisms
- Conduct refresher training
- Address gaps identified in pilot phase
- Initiate IEC campaigns
- Begin HAI surveillance integration

**Phase 3 (Months 7-12): Consolidation**

- Full implementation across entire hospital
- Regular audits and quality assessments
- Internal Kayakalp self-assessment
- Continuous quality improvement initiatives
- Recognition and reward programs
- Prepare for external Kayakalp assessment
- Document best practices and success stories

## 13.2 Roles and Responsibilities

**Medical Superintendent/Director**:

- Overall responsibility and leadership
- Chair Sanitation Committee
- Budget allocation and resource approval
- Monitor progress; remove barriers

**Officer In-charge Sanitation**:

- Develop and update SOPs
- Overall supervision of sanitation services

- Training coordination
- Liaison with other departments
- Reporting to top management

**Sanitation Officers and Inspectors**:

- Day-to-day supervision
- Audit and monitoring
- Staff management and deployment
- Supplies and equipment management
- Immediate problem solving

**Infection Control Officer/Committee**:

- Integration of cleaning with infection control policies
- HAI surveillance and reporting
- Training on infection control aspects
- Outbreak investigation and response

**Nursing Staff**:

- Point-of-care supervision
- Immediate feedback to sanitation staff
- Daily visual inspections
- Patient education on hygiene

**All Hospital Staff**:

- Personal hygiene and cleanliness
- Proper waste segregation
- Report cleanliness issues
- Cooperate with sanitation staff

## 13.3 Budget and Resource Requirements

**Capital expenditure** (one-time):

- Mechanized cleaning equipment (scrubbers, vacuums, etc.)
- Infrastructure upgrades (janitor rooms, storage, sinks)
- Signage (regulatory, directional, IEC)
- Furniture (dustbins, trolleys, storage racks)

- Landscaping and boundary wall repair
- Training hall equipment (projector, chairs, etc.)

**Recurring expenditure** (annual):

- Manpower (salaries or contract payments)
- Cleaning materials and chemicals
- PPE and uniforms
- Equipment maintenance
- BMW disposal (CBMWTF charges)
- Pest control services
- Training programs
- Audit and certification costs
- Awards and incentives

**Budgeting principles**:

- Allocate adequate budget (cleanliness is non-negotiable)
- Prioritize patient care areas
- Invest in durable, quality equipment
- Ensure timely availability of supplies
- Link budget to quality outcomes

# 14. Sustainability and Continuous Improvement

## 14.1 Sustaining Excellence

**Long-term strategies**:

- Regular refresher training and skill upgradation
- Performance-linked incentives
- Recognition programs (Employee of the Month, Best Ward)
- Career progression opportunities for sanitation staff
- Periodic benchmarking with other hospitals
- Adoption of new technologies and best practices
- Continuous stakeholder engagement
- Embed cleanliness in hospital culture

## 14.2 Quality Improvement Cycle

**Plan-Do-Check-Act (PDCA) approach**:

1. **Plan**: Identify problem; set improvement goal; develop action plan
2. **Do**: Implement plan on small scale (pilot)
3. **Check**: Monitor results; collect data; analyze
4. **Act**: If successful, standardize; if not, revise and repeat cycle

**Regular review meetings**:

- Daily huddles: Sanitation supervisors (15 minutes)
- Weekly reviews: Departmental cleaning issues
- Monthly Sanitation Committee meetings
- Quarterly Kayakalp review with all stakeholders

## 14.3 Innovation and Best Practices

**Encourage innovation**:

\begin{itemize}
\item Suggestion scheme for staff at all levels
\item Pilot testing of new products and methods
\item Study visits to award-winning hospitals
\item Participation in conferences and workshops
\item Documentation and sharing of innovations
\end{itemize>

# 15. Conclusion

These Standard Operating Procedures provide a comprehensive framework for achieving and maintaining the highest standards of cleanliness and sanitation at Lady Hardinge Medical College & Associated Hospitals. Strict adherence to these SOPs, coupled with strong leadership commitment, adequate resources, continuous training, and regular monitoring, will ensure:

- Significant reduction in hospital-acquired infections
- Enhanced patient safety and satisfaction
- Improved staff morale and productivity
- Compliance with Kayakalp guidelines and achievement of awards
- A clean, safe, and healing environment for all

**All staff members are expected to internalize these SOPs and contribute actively to the collective goal of making LHMC & Associated Hospitals a model of excellence in hospital cleanliness and hygiene.**

# References

[1] Ministry of Health and Family Welfare, Government of India. Guidelines for Implementation of "Kayakalp" Initiative. National Health Systems Resource Centre; 2015.

[2] Ministry of Health and Family Welfare, Government of India. National Guidelines for Clean Hospitals: Applicable to Tertiary Care Hospitals, Hospitals associated with Medical Colleges & Super-specialty Hospitals in India. 2015.

**Document Control:**

| Version | Date | Prepared By | Approved By | Next Review Date |
|---|---|---|---|---|
| 1.0 | [Current Date] | Sanitation Committee, LHMC | Medical Superintendent, LHMC | [One year from issue] |

**Distribution:**

- All Heads of Departments
- All Ward In-charges
- Nursing Superintendent
- Sanitation Department (all staff)
- Infection Control Committee
- BMW Management Committee
- Hospital Website
- All Notice Boards

END OF THE DOCUMENT