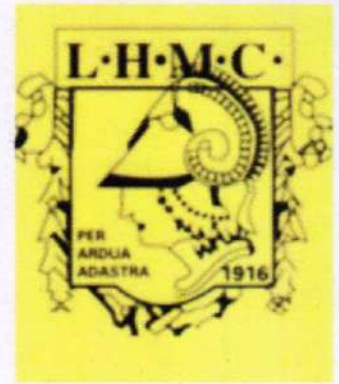




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POLICIES ON HOSPITAL

INFECTION CONTROL &

COMMITTEE (HICC) -

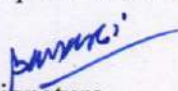
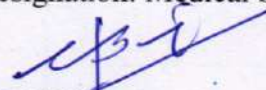
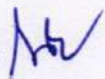
2026.

**BIOMEDICAL WASTE
MANAGEMENT POLICY LHMC-
HICC-IPC-POL-2026-001-V1.0**

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	Bio Medical Waste Management Policy
Document No.	LHMC-HICC-IPC-POL-2026-001-V1.0
No. of pages:	08
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent  Signature
Reviewed By	Name: Dr. Manoj B. Jais Designation: Medical Superintendent  Signature
Approved by:	Name: Dr. Sarita Beri Designation: Medical Director Signature 
Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

BIOMEDICAL WASTE MANAGEMENT POLICY

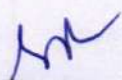
POLICY IDENTIFICATION DETAILS

Field	Description
Policy Code	LHMC-HICC-IPC-POL-2026-001-V1.0
Domain	Infection Prevention & Control / Environment
Category	Policy
Issuing Office	Additional Medical Superintendent
Approved By	Director, LHMC & Associated Hospitals
Date of approval	
Effective From	
Review Due On	
Version	V1.0
Supersedes	Nil
Confidentiality Status	Internal (Infection control, Regulatory & Safety)

APPLICABILITY

This policy applies to all departments, healthcare workers, students, contractual staff, housekeeping personnel and waste handlers involved in generation, segregation, storage, transport and disposal of biomedical waste at LHMC, SSKH and KSCH.

APPROVAL


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

1. PURPOSE

To ensure safe, scientific and environmentally sound management of biomedical waste so as to prevent infection, injury and pollution, in compliance with **Biomedical Waste Management Rules, 2016 (and amendments)**, NABH and Kayakalp guidelines.

2. SCOPE

This policy covers:

- Segregation, collection and storage of biomedical waste
 - Internal transportation and disposal
 - Occupational safety of handlers
 - Training, monitoring and documentation
-

3. DEFINITIONS

Biomedical Waste: Any waste generated during diagnosis, treatment or immunisation of human beings or animals, or in research activities.

BMW: Biomedical Waste.

4. POLICY STATEMENT

LHMC & Associated Hospitals are committed to strict compliance with BMW Rules through segregation at source, use of colour-coded containers, training of staff and continuous monitoring to ensure patient, worker and environmental safety.

5. CATEGORIES OF BIOMEDICAL WASTE

Biomedical waste shall be managed as per the **four-colour coding system** prescribed under BMW Rules.

6. SEGREGATION AT SOURCE

- 6.1 Biomedical waste shall be segregated at the point of generation.
 - 6.2 Colour-coded bins with liners shall be placed at all waste generation points.
 - 6.3 Mixing of general waste with biomedical waste is strictly prohibited.
-

7. COLLECTION & STORAGE

- Waste shall be collected at regular intervals
 - No biomedical waste shall be stored beyond 48 hours
 - Temporary storage areas shall be secure and labelled
-

8. INTERNAL TRANSPORTATION

- Dedicated trolleys for BMW transport
 - No manual handling without PPE
 - Fixed routes and schedules
-

9. TREATMENT & DISPOSAL

- Waste shall be handed over to authorised **Common Biomedical Waste Treatment Facility (CBWTF)**
 - Records and manifests shall be maintained
-

10. OCCUPATIONAL SAFETY

- Use of appropriate PPE by waste handlers
 - Hepatitis B and Tetanus immunisation
 - Reporting and management of injuries
-

11. ROLES & RESPONSIBILITIES

Authority	Responsibility
Director	Overall oversight
Medical Superintendent	Policy implementation
BMW Management Committee	Monitoring & compliance
Heads of Departments	Departmental compliance
Nursing & Housekeeping	Segregation & handling

12. TRAINING & AWARENESS

- Induction and refresher training
- Display of colour-coding charts
- Periodic sensitisation programmes

13. MONITORING, AUDIT & REPORTING

- Internal audits
- Submission of annual reports to SPCB
- Review of non-compliance

14. REVIEW & AMENDMENT

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

15. REFERENCES

- Biomedical Waste Management Rules, 2016 & amendments
- NABH Hospital Accreditation Standards
- Kayakalp Guidelines

16. ANNEXURES

ANNEXURE – I

COLOUR CODING & BIOMEDICAL WASTE CATEGORIES

Colour	Type of Waste	Examples
Yellow	Infectious & pathological waste	Human tissues, soiled waste
Red	Contaminated recyclable waste	IV sets, catheters
White (Translucent)	Sharps	Needles, blades
Blue	Glass & metallic implants	Broken glass, vials

ANNEXURE – II

BMW SEGREGATION DISPLAY CHART (WARD / OPD / LAB)

- Segregate waste at source
- Use only colour-coded bins with liners
- Do not mix general waste with BMW
- Dispose sharps immediately in white containers

ANNEXURE – III

BMW DAILY RECORD REGISTER FORMAT

Date	Ward / Area	Yellow (kg)	Red (kg)	White (Nos.)	Blue (kg)	Signature
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ANNEXURE – IV

BMW AUDIT CHECKLIST

Sl. No.	Parameter	Compliant / Non-compliant	Remarks
1	Segregation at source followed		
2	Colour-coded bins available		

Sl. No.	Parameter	Compliant / Non-compliant	Remarks
3	Sharps disposed correctly		
4	PPE used by handlers		
5	Records maintained		

ANNEXURE – V

BMW INJURY / SPILL MANAGEMENT FLOWCHART

Spill / Injury Occurs



Immediate containment & first aid



Inform supervisor & Infection Control Team



Disinfection & clean-up



Documentation & corrective action

(End of Policy Document)

POLICY ON HOSPITAL INFECTION CONTROL COMMITTEE (HICC)

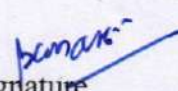
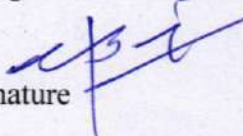
LHMC-HICC-POL-2026-002-V1.0

**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

Details of the Document

Document Name	POLICY ON HOSPITAL INFECTION CONTROL COMMITTEE (HICC)
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Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent  Signature
Reviewed by	Name: Dr. Manoj B. Jais Designation: Medical Superintendent  Signature
Approved by:	Name: Dr. Sarita Beri Designation: Medical Director Signature
Responsibility of updating:	Chairperson Hospital Infection Control committee

- Prevent and reduce healthcare-associated infections (HAIs)
 - Ensure implementation of standard infection prevention & control practices
 - Monitor infection trends and outbreaks
 - Promote rational use of antimicrobials in coordination with AMSP
 - Ensure compliance with NABH and statutory 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 be applicable to:

- All clinical and non-clinical areas
 - All healthcare professionals, students and support staff
-

4. DEFINITIONS

Hospital Infection Control Committee (HICC): A multidisciplinary committee responsible for planning, implementing and monitoring infection prevention and control activities.

Healthcare-Associated Infection (HAI): Infection acquired during the course of healthcare delivery that was not present at the time of admission.

5. GOVERNING PRINCIPLES

- Patient and staff safety
 - Evidence-based infection control practices
 - Surveillance, prevention and early containment
 - Accountability and continuous improvement
-

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 Constitution of HICC

The Hospital Infection Control Committee shall be constituted with the following members:

- Chairperson: Director
- Medical Superintendents (SSKH & KSCH)
- HOD Microbiology
- Microbiologist (Infection Control Officer)- Member Secretary
- Nursing Superintendent
- Heads / Representatives of Clinical Departments
- Hospital Administrator
- Biomedical Waste Management Officer
- CPWD/ O&M Representative
- Quality Manager
- Member Secretary: Infection Control Nurse / Officer

7. ROLES & RESPONSIBILITIES OF HICC

- Formulate and review infection control policies and SOPs
- Conduct HAI surveillance and data analysis
- Monitor compliance with standard precautions
- Investigate infection outbreaks and recommend control measures
- Coordinate infection control training and awareness
- Advise hospital administration on infection control matters

8. INFECTION SURVEILLANCE & REPORTING

- Regular surveillance of HAIs (CLABSI, CAUTI, SSI, VAP etc.)
- Analysis and reporting of infection rates
- Timely reporting of outbreaks to authorities as required

9. STANDARD PRECAUTIONS & TRANSMISSION-BASED PRECAUTIONS

- Hand hygiene compliance
- Use of PPE
- Isolation precautions
- Environmental cleaning and disinfection

10. TRAINING & AWARENESS

- Induction and periodic training for staff
 - IEC activities on infection prevention
-

11. MONITORING, AUDIT & QUALITY IMPROVEMENT

- Regular audits of infection control practices
 - Feedback to departments
 - Corrective and preventive actions
-

12. DOCUMENTATION & RECORD KEEPING

- Maintenance of HICC meeting minutes
 - Surveillance records and audit reports
-

13. MEETINGS OF HICC

- HICC shall meet at least once every quarter
 - Emergency meetings during outbreaks
 - Documentation of decisions and action points
-

14. COORDINATION WITH OTHER COMMITTEES

- Antibiotic Stewardship Committee
 - Biomedical Waste Management Committee
 - Quality & Patient Safety Committee
-

15. COMPLIANCE & ACCOUNTABILITY

Non-compliance with infection control guidelines shall attract administrative action as per institutional rules.

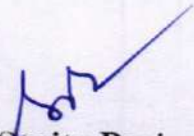
16. REVIEW & AMENDMENT

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

17. EFFECTIVE DATE

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

18. APPROVAL


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

ANNEXURES

Annexure – I: HICC Constitution Order (Indicative)

Name	Designation	Role
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Annexure – II: HICC Meeting Agenda & Minutes Format

Agenda Item	Discussion	Decision	Action	Timeline
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Annexure – III: Infection Surveillance Reporting Format

Infection Type	Unit	Number of Cases	Rate	Remarks
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All annexures form an integral part of this policy and shall be implemented and monitored by the Hospital Infection Control Committee.

End of Policy Document

POLICY ON HOSPITAL INFECTION CONTROL COMMITTEE (HICC)

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Hospital Infection Control Committee (HICC)
Policy Code	LHMC-HICC-POL-2026-002-V1.0
Domain	Infection Prevention & Control / Patient Safety
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendents
Approved By	Director LHMC
Date of Approval	
Effective From	
Review Due On	(After 3 Years)
Version	V1.0
Supersedes	Nil
Confidentiality Status	Internal (Regulatory & Safety)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to preventing and controlling healthcare-associated infections (HAIs) to ensure patient safety, staff safety and quality of care. A structured and empowered Hospital Infection Control Committee (HICC) is essential to plan, implement, monitor and continuously improve infection prevention and control practices across the institution.

This policy establishes the constitution, roles, responsibilities and functioning of the Hospital Infection Control Committee (HICC) at LHMC and its Associated Hospitals.

2. OBJECTIVES

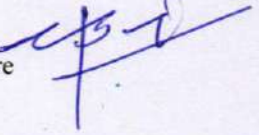
The objectives of this policy are to:

HAND HYGIENE POLICY
LHMC-HIC-IPC-POL-2026-003-V1.0

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

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	Hand Hygiene Policy
Document No.	LHMC-HIC-IPC-POL-2026-003-V1.0
No. of pages:	07
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent  Signature
Reviewed by:	Name: Dr. Manoj B. Jais Designation: Medical Superintendent  Signature
Approved by:	Name: Dr. Sarita Beri Designation: Medical Director Signature
Responsibility of updating:	Chairperson HICC

HAND HYGIENE POLICY

POLICY IDENTIFICATION DETAILS

Field	Description
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Domain	Infection Prevention & Control
Category	Policy
Issuing Office	Additional Medical Superintendent
Approved By	Director, LHMC & Associated Hospitals
Date of Issue	
Effective From	
Review Due On	
Version	V1.0
Supersedes	Nil
Confidentiality Status	Public (Patient Safety)

APPLICABILITY

This policy applies to all healthcare workers, students, contractual staff, housekeeping personnel, patients and visitors within LHMC, SSKH and KSCH.

APPROVAL

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

1. PURPOSE

To prevent healthcare-associated infections (HAIs) by ensuring effective and consistent hand hygiene practices in accordance with WHO, NABH and Kayakalp guidelines.

2. SCOPE

This policy covers hand hygiene practices in all patient care and non-patient care areas including OPDs, wards, ICUs, OTs, laboratories, and public areas.

3. DEFINITIONS

Hand Hygiene: A general term referring to any action of hand cleansing, including handwashing with soap and water or hand rubbing with alcohol-based hand rub (ABHR).

4. POLICY STATEMENT

LHMC & Associated Hospitals are committed to promoting hand hygiene as the single most effective measure to prevent infection transmission and to ensure patient, staff and environmental safety.

5. INDICATIONS FOR HAND HYGIENE

Hand hygiene shall be performed:

- Before touching a patient
 - Before clean/aseptic procedures
 - After body fluid exposure risk
 - After touching a patient
 - After touching patient surroundings
-

6. METHODS OF HAND HYGIENE

6.1 Handwashing with Soap and Water

- When hands are visibly soiled
- After contact with blood/body fluids
- After using toilet

6.2 Alcohol-Based Hand Rub (ABHR)

- Preferred method when hands are not visibly soiled

- Use WHO-recommended formulation

7. HAND HYGIENE TECHNIQUE

- Follow WHO-recommended steps
- Duration: 40–60 seconds (handwashing), 20–30 seconds (ABHR)

8. INFRASTRUCTURE & SUPPLIES

- Adequate handwashing stations
- Availability of soap, ABHR and disposable towels
- Regular replenishment and maintenance

9. ROLES & RESPONSIBILITIES

Authority	Responsibility
Director	Oversight
Medical Superintendent	Implementation
Infection Control Committee	Monitoring & audit
Heads of Departments	Compliance
All doctors, Nursing & Housekeeping Staff	Adherence

10. TRAINING & AWARENESS

- Induction and refresher training
- Posters and visual reminders
- Hand hygiene campaigns

11. MONITORING & COMPLIANCE

- Direct observation audits
- Hand hygiene compliance indicators
- Feedback to departments

12. NON-COMPLIANCE

Repeated non-compliance may invite corrective actions as per hospital rules.

13. REVIEW & AMENDMENT

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

14. REFERENCES

- WHO Guidelines on Hand Hygiene in Health Care
 - NABH Hospital Accreditation Standards
 - Kayakalp Guidelines
-

15. ANNEXURES

ANNEXURE – I

WHO FIVE MOMENTS OF HAND HYGIENE

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

ANNEXURE – II

HAND HYGIENE TECHNIQUE (STEPS)

Handwashing with Soap & Water (40–60 seconds):

- Wet hands with water
- Apply soap
- Rub palms, back of hands, between fingers, thumbs, fingertips
- Rinse thoroughly
- Dry with disposable towel

Alcohol-Based Hand Rub (20–30 seconds):

- Apply adequate amount
- Rub all hand surfaces until dry

ANNEXURE – III

HAND HYGIENE AUDIT TOOL

Sl. No.	Observation Area	Opportunity Observed	Action Taken	Compliant / Non-Compliant
---------	------------------	----------------------	--------------	---------------------------

Audit Conducted By: _____

Date: _____

ANNEXURE – IV

HAND HYGIENE COMPLIANCE MONITORING FORMAT

Department	Month	Opportunities	Compliance (%)	Remarks
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Reviewed By (ICC): _____

Date: _____

(End of Policy Document)

Policy on Infection Surveillance

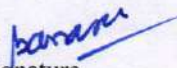
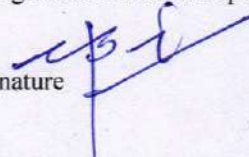
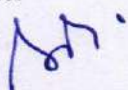
LHMC-HIC-POL-2026-004-V1.0

**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 Designation: Additional Medical Superintendent  Signature
Reviewed By	Name: Dr. Manoj B. Jais Designation: Medical Superintendent  Signature
Approved by:	Name: Dr. Sarita Beri Designation: Medical Director  Signature
Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

POLICY ON INFECTION SURVEILLANCE

POLICY IDENTIFICATION

Field	Details
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Domain	Infection Control & Patient Safety
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendent
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 preventing and controlling healthcare-associated infections (HAIs) to ensure patient safety, quality of care and compliance with national and international infection control standards.

Infection surveillance is a systematic, continuous process of collection, analysis, interpretation and dissemination of data related to infections. This policy establishes a standardized framework for effective infection surveillance across LHMC and its Associated Hospitals.

2. OBJECTIVES

The objectives of this policy are to:

- Detect, monitor and reduce healthcare-associated infections
- Identify infection trends and outbreaks at an early stage
- Monitor compliance with infection prevention practices
- Support evidence-based decision making and corrective actions
- Fulfil NABH, Kayakalp and MoHFW infection control 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 infection surveillance in:

- Inpatient and outpatient departments
- ICUs, NICUs, PICUs and OTs
- Dialysis units and procedure areas
- Laboratories and support services

The policy shall apply to all healthcare workers, students, support staff and outsourced personnel.

4. DEFINITIONS

Healthcare-Associated Infection (HAI): An infection acquired during the process of care which was not present or incubating at the time of admission.

Infection Surveillance: Ongoing systematic collection, analysis and interpretation of infection data for planning, implementation and evaluation of infection control practices.

Device-Associated Infection: Infection associated with use of medical devices such as ventilators, catheters or central lines.

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 Nodal Committee

The Hospital Infection Control Committee (HICC) shall be responsible for planning, implementation, monitoring and review of infection surveillance activities.

5.3 Infection Control Team

- Infection Control Officer
- Infection Control Nurse(s)
- Microbiologist
- Nursing Representatives

6. TYPES OF INFECTION SURVEILLANCE

Infection surveillance shall include, but not be limited to:

- Healthcare-associated infection (HAI) surveillance
- Device-associated infection surveillance (VAP, CAUTI, CLABSI)
- Surgical site infection (SSI) surveillance
- Antimicrobial resistance (AMR) surveillance
- Needle stick injury surveillance
- Outbreak surveillance

7. SURVEILLANCE METHODOLOGY

- Standard case definitions shall be used
- Data shall be collected prospectively and retrospectively
- Laboratory and clinical data shall be correlated
- Surveillance data shall be analysed periodically

8. DATA COLLECTION & ANALYSIS

- Daily data collection by Infection Control Team
- Monthly compilation and trend analysis
- Calculation of infection rates and indicators
- Identification of high-risk areas and practices

9. REPORTING & FEEDBACK

- Regular reporting to HICC and Medical Superintendents
- Department-wise feedback and corrective actions

- Immediate reporting of unusual trends or outbreaks
-

10. OUTBREAK INVESTIGATION & RESPONSE

- Prompt identification and confirmation of outbreaks
 - Formation of outbreak investigation team
 - Implementation of control and containment measures
 - Documentation and reporting of outcomes
-

11. TRAINING & AWARENESS

- Regular training of healthcare workers on infection surveillance
 - Sensitization on reporting and preventive practices
 - Inclusion of surveillance findings in training programs
-

12. DOCUMENTATION & RECORD KEEPING

- Maintenance of infection surveillance registers
 - Confidential handling of patient data
 - Preservation of records for audit and review
-

13. COMPLIANCE & ACCOUNTABILITY

Non-compliance with infection surveillance processes shall attract corrective actions as per institutional rules.

14. REVIEW & AMENDMENT

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

15. EFFECTIVE DATE

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

16. APPROVAL


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

ANNEXURES

Annexure – I: HAI Surveillance Data Collection Format

Patient ID	Ward/ICU	Type of Infection	Date of Onset	Organism	Outcome
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Annexure – II: Device-Associated Infection Surveillance Format

Unit	Device Type	No. of Device Days	No. of Infections	Rate
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Annexure – III: Surgical Site Infection (SSI) Surveillance Format

Patient	Surgery	Date	SSI (Yes/No)	Remarks
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Annexure – IV: Monthly Infection Surveillance Report Format

Month	Area	Infection Type	Rate	Corrective Action
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All annexures form an integral part of this policy and shall be implemented and monitored by the Hospital Infection Control Committee.

End of Policy Document

Policy on Needle Stick Injury (NSI) and Post-Exposure Prophylaxis (PEP)

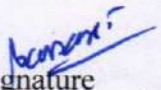
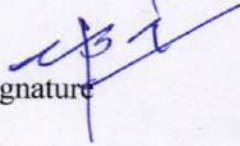
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**Lady Hardinge Medical College &
Associated Smt. Sucheta Kriplani And
Kalawati Saran Children Hospital New
Delhi-110001**

*(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 Name	Policy on Needle Stick Injury (NSI) and Post-Exposure Prophylaxis (PEP)
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Reviewed by:	Name: Dr. Manoj B. Jais Designation: Medical Superintendent  Signature
Approved by:	Name: Dr. Sarita Beri Designation: Medical Director Signature
Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

POLICY ON NEEDLE STICK INJURY (NSI) AND POST-EXPOSURE PROPHYLAXIS (PEP)

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Needle Stick Injury (NSI) and Post-Exposure Prophylaxis (PEP)
Policy Code	LHMC-HIC-POL-2026-005-V1.0
Domain	Infection Control / Occupational Health
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendent, SSKH
Approved By	Director LHMC
Date of Approval	
Effective From	
Review Due On	(After 3 Years)
Supersedes	Not Applicable (New Policy)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) function under the Ministry of Health & Family Welfare, Government of India and provide tertiary level healthcare services, teaching and research. Healthcare workers are at occupational risk of exposure to blood and body fluids through needle stick injuries and other sharps injuries, which may result in transmission of blood-borne infections such as HIV, Hepatitis B and Hepatitis C.

In order to ensure safety of healthcare personnel, students and support staff, and to provide timely and standardized management of such exposures, this Policy on Needle Stick Injury (NSI) and Post-Exposure Prophylaxis (PEP) is hereby issued.

2. OBJECTIVES

The objectives of this policy are to:

- Prevent needle stick and sharps injuries through safe practices
 - Ensure prompt reporting and standardized management of NSI
 - Provide timely access to Post-Exposure Prophylaxis (PEP)
 - Reduce occupational transmission of blood-borne infections
 - Establish clear roles, responsibilities, documentation and 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 be applicable to:

- Doctors (Faculty, Residents, Interns)
 - Nursing personnel
 - Paramedical staff
 - Laboratory staff
 - Students
 - Sanitation, housekeeping and waste-handling staff
 - Any person exposed to occupational needle stick or sharps injury within the institution
-

4. DEFINITIONS

Needle Stick Injury (NSI): Accidental puncture wound caused by a needle or sharp instrument contaminated with blood or body fluids.

Sharps Injury: Injury caused by sharp medical devices such as scalpels, lancets, broken ampoules or glass.

Exposure: Contact with blood or potentially infectious body fluids through percutaneous injury, mucous membrane or non-intact skin.

Post-Exposure Prophylaxis (PEP): Short-term antiretroviral treatment and other preventive measures initiated after potential exposure to prevent infection.

5. GOVERNANCE STRUCTURE

5.1 Competent Authority

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

5.2 Nodal Committee

The Hospital Infection Control Committee (HICC) shall be the nodal committee responsible for oversight, monitoring and periodic review of this policy.

5.3 Nodal Officers

- Medical Superintendent (SSKH / KSCH)
- Nodal Officer, Infection Control
- ART Centre In-charge

6. PREVENTIVE MEASURES

- Strict adherence to Standard Precautions
- Use of personal protective equipment (PPE)
- No recapping of needles
- Use of safety-engineered devices wherever available
- Proper segregation and disposal of sharps in puncture-proof containers
- Regular training and sensitization of staff

7. MANAGEMENT OF NEEDLE STICK INJURY

7.1 Immediate First Aid

- Wash the affected area immediately with soap and running water
- Do not squeeze or scrub the wound
- Flush mucous membrane exposure with clean water or saline

7.2 Reporting

- All NSIs shall be reported immediately (preferably within 1 hour) to the concerned supervisor and Infection Control Team
- Incident reporting form shall be filled

7.3 Risk Assessment

Risk assessment shall include:

- Type of exposure
- Source patient status (HIV, HBV, HCV)
- Vaccination status of exposed person

8. POST-EXPOSURE PROPHYLAXIS (PEP)

- PEP shall be initiated as early as possible, preferably within 2 hours and not later than 72 hours
- HIV PEP regimen shall be as per National AIDS Control Organisation (NACO) guidelines
- Hepatitis B immunoglobulin and vaccination shall be provided as indicated
- No PEP is currently available for Hepatitis C; follow-up testing shall be done

9. FOLLOW-UP AND MONITORING

- Baseline and follow-up testing shall be done as per national guidelines
- Counseling and psychological support shall be provided
- Compliance to PEP shall be monitored

10. DOCUMENTATION & RECORD KEEPING

- All NSI incidents shall be documented in NSI Register
- Records shall be maintained confidentially by Infection Control Team

11. TRAINING & AWARENESS

- Regular training programs shall be conducted
- Policy shall be disseminated to all departments

12. COMPLIANCE & ACCOUNTABILITY

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

13. REVIEW & AMENDMENT

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

14. EFFECTIVE DATE

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

15. APPROVAL


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

ANNEXURES

Annexure – I: Needle Stick Injury (NSI) Incident Reporting Form

Particulars	Details
Name of Exposed Person	
Designation	Faculty / Resident / Intern / Nurse / Technician / Student / Housekeeping
Employee ID / Roll No.	
Department / Unit	
Contact Number	
Date & Time of Injury	
Place of Incident	Ward / OT / ICU / OPD / Lab / Other
Nature of Exposure	Needle stick / Sharp injury / Splash
Type of Device	Hollow bore needle / Solid needle / Blade / Glass
Depth of Injury	Superficial / Deep
Source Patient Identified	Yes / No
Immediate First Aid Taken	Yes / No (Specify)

Reported To (Name & Designation)

Date & Time of Reporting

Signature of Exposed Person

Signature of Reporting Officer

Annexure – II: NSI Risk Assessment & PEP Decision Flow (Narrative Format)

1. Confirm occurrence of needle stick / sharps injury or splash exposure.
2. Provide immediate first aid as per protocol.
3. Assess type of exposure:
 - Percutaneous (needle stick / cut)
 - Mucosal (eye, mouth)
 - Non-intact skin
4. Assess source patient status:
 - Known HIV / HBV / HCV positive
 - Unknown status
 - Source not identifiable
5. Assess vaccination and immune status of exposed person (HBV).

6. Categorize risk as Low / Moderate / High.
7. Initiate HIV PEP preferably within 2 hours (not later than 72 hours) if indicated.
8. Refer exposed person to ART Centre for evaluation and follow-up.
9. Document incident and initiate follow-up testing schedule.

Annexure – III: HIV Post-Exposure Prophylaxis (PEP) Regimens (As per NACO Guidelines)

Exposure Risk Category	Recommended Regimen	Duration
Low / Moderate Risk	Tenofovir + Lamivudine + Dolutegravir	28 Days
High Risk Exposure	Regimen as advised by ART Centre	28 Days

Note: Regimen may be modified by ART Centre based on individual risk assessment, drug tolerance and national guidelines.

Annexure – IV: Follow-up Testing Schedule After NSI

Investigation	Baseline	6 Weeks	3 Months	6 Months
HIV Test	✓	✓	✓	✓
HBsAg	✓	As advised	As advised	As advised
Anti-HCV	✓	As advised	As advised	As advised

Additional testing shall be done as per ART Centre / HICC recommendation.

Annexure – V: Needle Stick Injury (NSI) Register Format

Sl. No.	Name	Designation	Dept	Date of Injury	Type of Exposure	Source Status	PEP Given (Yes/No)	Outcome	Remarks
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All annexures shall be used in conjunction with this policy and maintained confidentially by the Hospital Infection Control Team.

End of Policy Document

POLICY ON CENTRAL STERILE SUPPLY DEPARTMENT (CSSD)

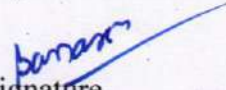
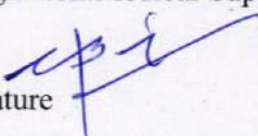
LHMC-HIC-CSSD-POL-2026-006-V1.0

**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 CENTRAL STERILE SUPPLY DEPARTMENT (CSSD)
Document No.	LHMC-HIC-CSSD-POL-2026-006-V1.0
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Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent  Signature
Reviewed By	Name: Dr. Manoj B Jais Designation: Medical Superintendent  Signature
Approved by:	Name: Dr. Sarita Beri Designation: Medical Director Signature 
Responsibility of updating:	HOD Anaesthesia/ CP HICC

POLICY ON CENTRAL STERILE SUPPLY DEPARTMENT (CSSD)

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on Central Sterile Supply Department (CSSD)
Policy Code	LHMC-HIC-CSSD-POL-2026-006-V1.0
Domain	Infection Prevention & Control / Support Services
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendent
Approved By	Director LHMC
Date of Approval	
Effective From	
Review Due On	(After 3 Years)
Version	V1.0
Supersedes	Nil
Confidentiality Status	Internal (Regulatory & Safety)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) are committed to ensuring patient safety through effective infection prevention and control practices. The Central Sterile Supply Department (CSSD) plays a critical role in providing sterile and disinfected instruments, equipment and consumables required for safe patient care.

This policy establishes a standardized framework for the organization, functioning and quality assurance of CSSD services at LHMC and its Associated Hospitals.

2. OBJECTIVES

The objectives of this policy are to:

- Ensure availability of sterile and safe instruments and equipment
- Prevent healthcare-associated infections through standardized reprocessing

- Establish uniform procedures for cleaning, disinfection and sterilization
 - Ensure compliance with NABH and infection control standards
 - Promote traceability, accountability and quality improvement
-

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:

- Central Sterile Supply Department (CSSD)
 - Operation Theatres, ICUs, wards, OPDs and procedure areas
 - All staff involved in reprocessing of medical devices
-

4. DEFINITIONS

CSSD: Central Sterile Supply Department responsible for cleaning, disinfection, sterilization, storage and distribution of sterile supplies.

Sterilization: Process that eliminates all forms of microbial life.

Disinfection: Process that eliminates many or all pathogenic microorganisms except bacterial spores.

5. GOVERNING PRINCIPLES

- Patient safety and infection prevention
 - Standardization and validation of processes
 - One-way workflow (dirty to clean to sterile)
 - Traceability and documentation
 - Continuous monitoring and improvement
-

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 CSSD Oversight

CSSD shall function under the guidance of:

- Hospital Infection Control Committee (HICC)
- Operation Theatre Committee

7. CSSD INFRASTRUCTURE & ZONING

- Decontamination (dirty) zone
- Preparation & packing (clean) zone
- Sterilization & sterile storage (sterile) zone
- Restricted access and environmental controls

8. PROCESS FLOW IN CSSD

8.1 Collection & Transportation

- Safe collection of used instruments in covered containers
- Segregation as per risk and type

8.2 Cleaning & Decontamination

- Manual and mechanical cleaning methods
- Use of approved detergents and disinfectants

8.3 Inspection, Assembly & Packaging

- Visual inspection for cleanliness and integrity
- Proper assembly and packaging with indicators

8.4 Sterilization

- Steam, ETO, plasma or other approved methods
- Validation and monitoring of sterilization cycles

8.5 Storage & Distribution

- Controlled storage conditions
 - FIFO (First In–First Out) principle
-

9. QUALITY ASSURANCE & MONITORING

- Physical, chemical and biological indicators
 - Load records and sterilization logs
 - Regular audits and validation
-

10. TRACEABILITY

- Linking sterilized items to patient and procedure
 - Maintenance of batch and load records
-

11. SAFETY & OCCUPATIONAL HEALTH

- Use of PPE by CSSD staff
 - Training in handling sharps and chemicals
 - Management of spills and exposures
-

12. TRAINING & COMPETENCY

- Induction and periodic training of CSSD staff
 - Competency assessment and documentation
-

13. DOCUMENTATION & RECORD KEEPING

- Sterilization records and registers
 - Maintenance and calibration records of equipment
-

14. MONITORING & AUDIT

- Internal audits by HICC

- Review of non-conformities and corrective actions

15. COMPLIANCE & ACCOUNTABILITY

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

16. REVIEW & AMENDMENT

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

17. EFFECTIVE DATE

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

18. APPROVAL


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

ANNEXURES

Annexure – I: CSSD Workflow Diagram (Narrative)

Dirty Zone → Cleaning → Inspection & Packing → Sterilization → Sterile Storage → Distribution

Annexure – II: Sterilization Load Record Format

Date	Sterilizer	Load No.	Items	Indicators	Released By
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Annexure – III: CSSD Audit Checklist

Area	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 CSSD and HICC. End of Policy Document.

End of Policy Document

Policy on IEC & Hygiene Promotion

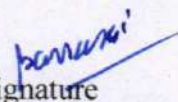
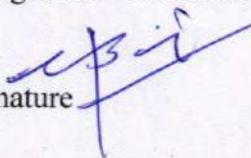
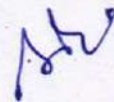
LHMC-HIC-HP-POL-2026-007-V1.0

**Lady Hardinge Medical College &
Associated Smt. Sucheta Kriplani And
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*(Applicable to LHMC, Smt. Sucheta Kriplani Hospital & Kalawati
Saran Children Hospital)*

GOVERNMENT OF INDIA
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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 IEC & Hygiene Promotion
Document No.	LHMC-HIC-HP-POL-2026-007-V1.0
No. of pages:	08
Date created:	17/01/2026
Prepared By	Name: Dr. Banarsi Designation: Additional Medical Superintendent  Signature
Reviewed By	Name: Dr. Manoj B. Jais Designation: Medical Superintendent  Signature
Approved by:	Name: Dr. Sarita Beri Designation: Medical Director  Signature
Responsibility of updating:	Name: Chairperson Bio Medical Waste Committee Designation: HOD Microbiology

POLICY ON INFORMATION, EDUCATION & COMMUNICATION (IEC) AND HYGIENE PROMOTION

POLICY IDENTIFICATION

Field	Details
Policy Title	Policy on IEC & Hygiene Promotion
Policy Code	LHMC-IC-POL-2026-007-V1.0
Domain	Infection Control / Public Health Promotion
Category	Policy
Prepared By	Dr. Banarsi, Additional Medical Superintendent
Reviewed By	Medical Superintendent
Approved By	Director / Principal, LHMC
Date of Approval	
Effective From	
Review Due On	(After 3 Years)

1. PREAMBLE

Lady Hardinge Medical College & Associated Hospitals (LHMC, SSKH & KSCH) recognize that effective Information, Education and Communication (IEC) and continuous hygiene promotion are essential components of infection prevention, patient safety, quality healthcare delivery and public health awareness.

IEC activities support behavior change among patients, attendants, healthcare workers and visitors by promoting hygienic practices, hand hygiene, sanitation, waste segregation and prevention of healthcare-associated infections. This policy establishes a structured framework for planning, implementation, monitoring and evaluation of IEC and hygiene promotion activities across LHMC and its Associated Hospitals.

2. OBJECTIVES

The objectives of this policy are to:

- Promote awareness and adoption of good hygiene practices
- Strengthen infection prevention and control through behavior change communication

- Educate patients, attendants, staff and visitors on hygiene and sanitation
- Support Kayakalp, Swachh Bharat Abhiyan and NABH initiatives
- Ensure standardized IEC messaging across all hospital areas

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 IEC and hygiene promotion activities related to:

- Hand hygiene
- Respiratory hygiene and cough etiquette
- Environmental cleanliness and sanitation
- Safe water and food hygiene
- Biomedical waste segregation
- Personal hygiene and toilet use

The policy shall apply to all healthcare workers, students, patients, attendants, visitors and outsourced staff.

4. DEFINITIONS

Information, Education & Communication (IEC): Planned educational activities using multiple communication methods to improve knowledge, attitudes and practices.

Hygiene Promotion: Systematic efforts to encourage hygienic behaviours to prevent disease transmission.

Behaviour Change Communication (BCC): Communication strategies aimed at influencing positive health-related behaviours.

5. GOVERNANCE STRUCTURE

5.1 Competent Authority

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

5.2 Nodal Committee

The Hospital Infection Control Committee (HICC) shall be the nodal committee responsible for planning, implementation, monitoring and review of IEC and hygiene promotion activities.

5.3 Nodal Officers

- Medical Superintendent (SSKH / KSCH)
 - Nodal Officer – Infection Control
 - Nursing Superintendent / CNO
 - Public Health / Community Medicine Representative
-

6. IEC & HYGIENE PROMOTION STRATEGIES

- Display of posters, charts and signages at strategic locations
 - Audio-visual IEC through screens and public announcement systems
 - Distribution of pamphlets and leaflets
 - Demonstrations on hand hygiene and cough etiquette
 - Observance of national and international health days (Hand Hygiene Day, Swachhata Pakhwada)
 - Patient and attendant counselling at point of care
-

7. KEY IEC CONTENT AREAS

- Hand hygiene (WHO 5 Moments)
 - Respiratory hygiene and mask use
 - Toilet hygiene and sanitation
 - Safe drinking water and food practices
 - Biomedical waste segregation (colour coding)
 - Prevention of hospital-acquired infections
-

8. ROLES AND RESPONSIBILITIES

8.1 Hospital Infection Control Committee

- Develop IEC plans and materials
- Ensure consistency and accuracy of messages
- Monitor implementation and effectiveness

8.2 Nursing & Clinical Staff

- Reinforce hygiene messages during patient care

- Participate in IEC activities and demonstrations

8.3 Housekeeping & Support Staff

- Adhere to hygiene practices and act as role models
 - Assist in display and maintenance of IEC materials
-

9. MONITORING, EVALUATION & DOCUMENTATION

- Periodic audits of IEC display and visibility
 - Observation of hand hygiene compliance
 - Feedback from patients and staff
 - Documentation of IEC activities and events
-

10. TRAINING & CAPACITY BUILDING

- Orientation and refresher training on IEC and hygiene promotion
 - Capacity building of staff involved in IEC delivery
 - Training records to be maintained
-

11. COMMUNICATION & LANGUAGE

- IEC materials shall be multilingual (Hindi / English and local language as required)
 - Messages shall be simple, culturally appropriate and visually clear
-

12. COMPLIANCE & ACCOUNTABILITY

Non-compliance with IEC and hygiene promotion guidelines shall attract corrective action as per institutional policy.

13. REVIEW & AMENDMENT

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

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-110001

ANNEXURES

Annexure – I: List of IEC Materials for Hygiene Promotion

Sl. No.	IEC Material	Target Audience	Location
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Annexure – II: Hand Hygiene Demonstration Checklist

Step	Description	Complied (Yes/No)
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Annexure – III: IEC Activity Logbook Format

Date	Activity	Location	Participants	Remarks
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Annexure – IV: IEC Monitoring & Audit Tool

Area	IEC Display Available	Visibility Adequate	Remarks
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All annexures form an integral part of this policy and shall be implemented and monitored by the Hospital Infection Control Committee.

End of Policy Document