Emergency Kit-

Emergency medicines available for Agnikarma Procedure- For management of complications occur during and after Agnikarma procedure, following drugs are routinely used.

1. To subside (Daha) burning sensation and pain at Agnikarma site : Application Kalka of Kumara Patra (Aloevera pulp), Shatdhaut Ghrita.
2. For management of deep burn: Application of honey with plain Ghrita, Yashtimadhu Ghrita, Shatdhaut Ghrita, Jatyadi Ghrita, Madhuchisthaadi lepa
3. Cleaning of local site before Agnikarma to prevent infection: Panchvalkal kwath and Triphala kwath are used for
4. To relive burnig sensation: Triphala Guggulu, Godanti, Kaishor Guggulu

Emergency kit for Ksharsutra Procedure-

Following drugs are kept in Ksharasutra room for management of complications during and after Ksharsutra procedure.

1. Pain and burning sensation – Majority of patients experience mild to moderate degree of pain during changing of Ksharsutra. This is managed effectively by using local anesthetic agent like lignocaine or locally application Xylocaine jelly 2% or Matrabasti/locally application with soothning medicated oil like Jatyadi oil.
2. Post-operative pain managed by analgesics drugs like Triphala guggulu, Gandhak rasayana, Sanjivani vati, Diclofanac, Aceclofanac etc.
3. Fever – Tribhuvankirti rasa, Godanti bhasma, Sanjivani vati, Sudarshana Ghan vati, Amritaarishta etc are used in case of post operated Ksharsutra procedure.
4. Bleeding – Nagkesar churna, Lodhra churna, Bolbaddarasa,Shonitargala rasa,kaharva pishti,Sphatika bhasma, Kasisadi oil etc are used in case of post-operative bleeding of haemorrhoids.
5. Bleeding is very rare in case of fistula in ano and simple application of pressure adrenaline gauze piece is sufficient to control bleeding.
6. Skin erosions – patients sometimes presented with erosion in the perianal skin with itching and burning sensation. It is managed by local application of medicated oil and ghee.
7. Wound management by Panchvalkal kwath, Jatyadi taila/ghrita, Apamarga kshar taila, Priyanguadi taila etc.

Emergency kit is available for Leech therapy Procedure-

Emergency kit is available for leech therapy.

Following drugs are used for management of complication during and after leech application.

1. For continuous oozing from biting site: Haridra powder, Sphatika bhasma, sterile bandage are used for hemostasis.

3. To detach leech from site if pain arises: Uses of Saindhavalavana or Haridra powder on its mouth.

4. For management of pain, burning, itching at the site of bite: application of Jatyadi ghrita, Shatdhauta ghrita, yashtimadhu ghrita

Advanced emergency Kit also available

INJ. - GLYCOPYROLATE	INJ. - EMSET		SOFRAMYCIN OINTMENT
INJ.-ATROPINE	INJ. - PERINORM		T-BACT OINTMENT
INJ.-LIGNOCAINE 2%	INJ. –EPSOLIN		METROGYL-P OINTMENT
INJ.-LIGNOCAINE 1%	INJ. - CALCIUM GLUCONATE		ASTHALIN INHALER
INJ.-LIGNOCAINE WITH ADRENALINE 2%	INJ. - SODIUM BICARBONATE		BUDECORT REPSULES
LOX 10% SPRAY	INJ. - POTASSIUM CHLORIDE		ASTHALIN REPSULES
XYLOCAINE 2% JELLY	INJ. - PAN 40		LEVOSALBUTAMOL REPSULES
INJ.-ANAWIN 5%	INJ. - RANTIDINE		DUOLIN REPSULES
INJ.-ANAWIN HEAVY 5%	INJ. - TRENEXA		**OTHERS-**
INJ. - FENTANYL	INJ. - METROGYL		OXYGEN CYLINDER
INJ. - LOBETALOL	INJ. - AMIKACIN		NEBULIZER
INJ. -METAPROLOL	INJ. - GENTAMYCIN		PULSE OXYMETER
INJ. -AVIL INJECTION	INJ. – MONOCEF-SB		GLUCOMETER AND STRIP
INJ. – DEXONA	INJ. –CEFOTAXIME		IV SET
INJ. - HYDROCORTISONE	INJ. – AUGMENTIN		IV CANULA
INJ. - DERIPHYLINE	INJ. - NEOMOL		DISPOSABLE SYRINGES
INJ. - LASIX	**IVF-**		FOLEY'S CATHETER
INJ. – FORTWIN	D 5% 500ML		RYLE'S TUBE
INJ. - MIDAZOLAM	D 10% 500ML		FEEDING TUBE

INJ. - DIAZEPAM	D 25% 100ML		K-90
INJ. – TRAMADOL	RL 500ML		E.T.TUBE
INJ. - DYNAPAR	NS 500ML		LYRYNGOSCOPE
INJ. –DICYCLOMINE	NS 100 ML		GUEDEL'S AIRWAY
INJ. -DROTIN	DNS 500ML		SUCTION APPARATUS
INJ. - PHENARGAN	INJ. – MANNITOL 20%		INSTRUMENT TRAY
INJ. – ADRENALINE	ISOLYTE P INJECTION		
INJ. - DOPAMINE	HAEMACELE INFUSION		
INJ. - DOBUTAMINE	BETADINE OINTMENT		
INJ. - NORAD	BETADINE SOLUTION		

ALL INDIA INSTITUTE OF AYURVEDA HOSPITAL

SAFETY MANUAL

Doc No: AIIA/SM/DOC 03

PREPARED BY	Dr. Rajagopala S, Associate Prof, Dept. of Kaumarabhritya
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MANUAL REVIEWED BY	Dr. Rajagopala S, Additional Medical Superintendent
MANUAL APPROVED BY	Prof.(Dr.) Tanuja Manoj Nesari, Director

AMENDMENT SHEET

Sl. No.	Section No & Title along with Page No	Details of amendment		Signature of preparatory/revising authority	Signature of approval authority
		Before Amendment	To be changed		
1.	Title page Page No.1	No mention of revised by	Revised by Dr. Alka Kapoor		
2.	Title page Page No.1	Reviewed by Prof.(Dr.) S K Gupta	Changed as Reviewed by Dr Rajagopala S		
3.	Title page Page No.1	Approved by Prof Abhimanyu Kumar	Changed as Approved by Prof.(Dr.) Tanuja Manoj Nesari		
4.	6.1 Hospital safety committee Page No. 9	Medical superintendent	Medical superintendent/Additional Medical Superintendent		
5.	6.2 Emergency Codes Page 11-12	-	Modified		
6.	6.2 Emergency codes Page No 12	CODE ORANGE	CODE YELLOW		
7.	1 Code Blue Page No 15-16	Not mentioned	1.7 CPR Policy added		
8.	6.2 Emergency codes Page No. 20-22	Not mentioned	3 Code Purple - Physical altercation/ fight added		

9.	6.2 Emergency codes Page No. 22-23	Not mentioned	4 Code Grey – Internal Disaster added		
10.	6.2 Emergency codes Page No.24-25	Not mentioned	5. Code Pink - Flow Chart added.		
11.	6. Code Yellow Page No.26	Not mentioned	Flow chart added.		
12.	6.2 Emergency codes Page No. 27-30	Not mentioned	7 Code Orange -Hazmat Spill/Leakage Of Hazardous Material/Gas added		
13.	6.2 Emergency codes Page No. 30-31	Not mentioned	8. Code Black- Bomb Threat/Suspicious Bomb Parcel – Flow chart added.		

TABLE OF CONTENT

1. ABREVIATIONS:

Acronyms	Description
AH	Ayurveda Hospital
NABH	National Accreditation Board for Hospitals and Health care providers
IP	In patient
OP	Out Patient
PM	Preventive Maintenance
PPE	Personal Protective Equipment
TOR	Term of Reference
DAQ	Department of Accreditation & Quality
BME	Biomedical Engineering Dept.
MSDS	Material Safety Data Sheet
ADE	Adverse Drug Event
PTC	Pharmacy and Therapeutic committee
BLS	Basic Life Support
ACLS	Advanced Cardiac Life Support
HAZMAT	Hazardous material

2. DEFINITION:

2.1 **INCIDENT REPORTING:** A potentially significant event which is inconsistent with the normal or expected operations of the hospital. The potential for injury is sufficient to be considered an incident, actual injury need not occur, however to report it.

2.2 **NEAR MISS:** Any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of an adverse event "un anticipated, undesirable or potentially dangerous occurrence" in the hospital.

2.3 **SENTINEL EVENTS:** A sentinel event is an unexpected occurrence unrelated to the natural course of patient's illness or underlying condition involving death or serious physical or psychological injury, major permanent loss of function, wrong site, wrong procedure, wrong patient surgery or the risk thereof including, without limitation, any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

2.4 **MEDICATION ERROR:** Any preventable medication management and use process variation -during any phase of medication management (selecting, procuring, storing, ordering/prescribing, transcribing, distributing, preparing, dispensing, administering, documenting, and monitoring of medication therapies)- that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to processional practice, health care products, procedures, and systems including: prescribing order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

2.5 **ADVERSE DRUG REACTION:** An adverse drug reaction is defined as: "Any response to a drug that is noxious and unintended, and that occurs at doses used in humans for prophylaxis, diagnosis or therapy, excluding failure to accomplish the intended purpose."

2.6 **EMERGENCY:** An emergency is any unplanned event that can cause deaths or significant injuries to patients, staff or the public; or can shut down the facility, disrupt operations, cause physical or environmental damage or threaten the facility's financial standing or public image.

2.7 **DISASTER MANAGEMENT:** Any occurrence that causes damage, ecological disruption, loss of human life, deterioration of health and health services, on a scale sufficient to warrant an extraordinary response from outside the community.

2.8 **QUALITY CONTROL:** It is a mechanism or laboratory activity intended to verify whether test conditions are functioning appropriately to yield reproducible results.

3. PURPOSE:

This Safety Management Plan serves to describe the policies and processes in place to minimize safety risks to patients and staff through a comprehensive hazard surveillance program and analysis of aggregate information.

4. SCOPE:

The scope of the safety program includes the following:

4.1 Safety Committee

4.1.1 Safety and Security Risk

4.1.2 Monitoring safety plan and policies

4.2 Facility inspection rounds

4.2.1 Corrective preventive measures

4.2.2 Implementation

4.3 Safety Orientation and Training Program

4.4 Safe and Secure Environment

4.5 Preventive and Breakdown Maintenance of Equipment

4.6 Fire and Non fire emergencies plan

4.7 Smoking elimination Plan

5. RESPONSIBILITIES:

5.1 Administrative Department.

5.2 Maintenance Department.

5.3 Biomedical department.

5.4 All hospital safety Committee Members.

6. PROCEDURE:

6.1 **Hospital safety committee**

The committee includes the following members

Chairman: Medical superintendent/Additional Medical Superintendent

Convener: Deputy Medical superintendent

MEMBERS:

1. Assistant Nursing Superintendent
2. Engineer
3. Radiologist
4. Casualty medical officer
5. Others as appointed by Chair

Safety Committee Terms of Reference:

1. To develop, implement and monitor safety plans and policies.
2. To conduct facility inspection rounds at least twice in a year in patient care areas and at least once in a year in Non patient care areas.
3. To take appropriate corrective and preventive measures based on the facility inspection report.

4. Analyzing Quality indicators related to hospital safety aspects.
5. Safety shall include the following:
   - 5.1 Equipment safety
     - 5.1.1 Clinical equipment
     - 5.1.2 Support service equipment
   - 5.2 Water safety
   - 5.3 Fire safety
   - 5.4 Electrical safety
   - 5.5 Laboratory safety
6. To identify and develop content for training of staff, patient and visitors in safety related topics.

Emergency Preparedness

The Preparation of Emergency Procedures to be followed in the event of likely natural calamities or untoward is done by the Hospital Safety Committee in coordination with the Quality department which looks into Quality Control and accreditations in addition to academic affairs.

6.2 **EMERGENCY CODES:**

EMERGENCY CODES RESPONSE		
Code	**Situation**	**Emergency Responsible Team**
Code Blue	In case of Cardiac Arrest/ Incase patient, staff or visitor collapsed	1. Team Leader – Doctor 2. BLS / ACLS trained nursing staff 3. Biomedical staff 4. Security staff 5. Receptionist
Code Red	In case of Fire	1. Hospital safety committee 2. Security Officer 3. Security staff 4. NS & Nursing staff 5. Staff from various department 6. Receptionist
Code Purple	Physical altercation/Fight	1. Chairman Hospital committee 2. Security Officer 3. Security Supervisor 4. NS & Nursing Staff 5. Staff from JE and IT
Code Grey	Internal Disaster (Collapse of wall, electrical short circuit etc.)	1. Committee Chairman and Convener 2. Security Officer 3. Housekeeping Supervisor 4. Nursing Staff

Code Pink	Baby abduction/ missing patient If Baby is abducted/ patient is missing	1. Safety Officer 2. Security Officer 3. Administrator 4. Nursing staff 5. Security staff 6. Receptionist
Code Yellow	External disaster Any community disaster /mass causality incident	1. Administrator 2. Nursing Superintendent 3. Nursing in-charge at time of disaster 4. Nursing staff 5. Security staff 6. Receptionist
Code Orange	HAZMAT spill Spillage/ leakage of hazardous materials/gas	1. Safety committee convener 2. Housekeeping In charge 3. Housekeeping staff 4. Receptionist
Code Black	Bomb threat Bomb threat call/ suspicious bomb parcel	**1.** Medical Director **2.** Administrator **3.** Safety Officer **4.** Security Officer **5.** NS **6.** Receptionist

1. CODE BLUE: INDIVIDUAL DISASTER/CARDIAC RESUSCITATION

1.1 **Purpose:** To provide Immediate Life Saving Measures in Cases of Life threatening Emergencies

1.2 **Scope**: Covers the following cases

1.2.1 Accidents, burns, blasts

1.2.2 Medical emergencies E.g.: Cardiac arrest, respiratory arrest, poisoning etc.

1.2.3 Surgical Emergencies, E.g.: shock, peritonitis

1.3 **Abbreviations and Definitions**

1.3.1 CPR: Cardio Pulmonary Resuscitation

1.3.2 Code blue: It is an event of utmost emergency, a mode of alerting all medical, nursing, paramedical and allied health care services and other personnel (housekeeping, bio-medical, transport, maintenance, and security etc.).

1.4 **Diagnostic Facilities and Equipment:**

1.4.1 Cardiac monitor

1.4.2 Pulse oximeter

1.4.3 Cardiac defibrillator

1.4.4 AMBU bag

1.4.5 Airway equipment

1.5 **Responsibilities:**

1.5.1 Emergency Medical Officer is responsible for quick evaluation of the patient in need of emergency aid.

1.5.2 The emergency room physician coordinates with the consultant and duty anaesthesiologist for intubations, resuscitation and defibrillation. He arranges for the announcement of code blue through the intercom to the concerned hospital staff. The Emergency Medical Officer and Medical Superintendent are informed in case any help is required.

1.5.3 Medical Superintendent (MS): coordinates if any help is required.

1.5.4 The Resident doctor of the ward concerned is responsible for quick assessment and the announcement.

1.5.5 The Emergency Medical Officer / anaesthesiologist aids in resuscitation.

1.6 **Procedure**

1.6.1 The staff nurse on duty or the resident doctor or any other staff member may find a patient in any part of the hospital, becoming critically ill or in cardiopulmonary arrest. Primary basic life support is provided to the patient on the spot.

1.6.2 The concerned nurse / resident doctor shall inform the emergency department to announce code blue to the concerned code blue team members clearly mentioning the location where the team needs to reach. The announcement will be made immediately with reasonable clarity and precision to enable all concerned personnel to respond as quickly as possible and reach the place of incident in the shortest possible time.

1.6.3 Soon after the announcement is heard, all the concerned persons from different departments shall reach to the place of incident. The anaesthesiologist on duty and the nurses / resident doctors from the nearest nursing station, to start basic life support measures within 60 seconds. The doctors on duty, the nursing supervisor, and transport boy with a stretcher and ECG technician shall reach the place of incident as soon as possible or not later than two minutes.

1.6.4 The crash cart with all emergency care equipment and drugs located in the floor shall be moved instantaneously to the concerned floor. After the use of the crash cart the concerned staff nurse / nursing supervisor shall replenish all the drugs and equipment and keep the crash cart ready.

1.6.5 The lift boy shall keep lift ready to receive the patient on the concerned floor. At this juncture no other person shall use the lift.

1.6.6 The Emergency Medical Officer / anaesthesiologist shall work as the team leader to coordinate the CPR. Overcrowding and confusion created by too many physicians giving conflicting orders to the nursing personnel shall be discouraged.

1.6.7 Other doctors and nurses after reaching the unit / ward can leave for their respective department once they are sure that there is adequate number of concerned personnel to take care of the patient.

1.6.8 Nursing supervisor shall supervise the nursing care and ensure that any emergency investigations are ordered are done on a priority basis.

1.6.9 Once the patient is resuscitated and stabilized in the ward or labour room, he / she shall be immediately shifted to the concerned inpatient care area. The resident doctor on duty and staff nurse shall accompany the patient and hand him / her over to the concerned inpatient care area staff nurse.

1.6.10 The concerned consultant shall be informed immediately.

1.7 CPR POLICY

1.7.1 **Purpose:**

To provide guidelines for uniform resuscitation of the patients throughout the organization.

1.7.2 **Scope**: Hospital wide.

1.7.3 **Policy Guidelines:**

i. Assess the condition of the patients to ascertain the need of CPR.

ii. Assess the responsiveness by shaking and calling the patient.

iii. Assess the cardiac and respiratory status of the patient (Presence of respiration and pulse) and previous history of cardiac arrest.

iv. Check that CPR kit is complete.

1.7.4 Follow the steps of CAB of basic life support (BLS) –

1.7.4.1 **Chest compressions**

i. The rescuer should initially ensure that the scene is safe when the rescuer first sees a potential victim.

ii. A victim who is unresponsive with no normal breathing and no pulse needs CPR.

iii. To identify cardiac arrest in an unresponsive victim with no breathing (or no normal breathing), a healthcare provider should check pulse for no more than 10 seconds.

iv. It is important to compress to the appropriate depth during CPR to create blood flow during compressions.

v. The depth of chest compressions for an adult victim should be at-least 2 inches (5cm).

vi. The depth of chest compressions for an infant is at-least one third of the depth of the chest, approximately 1 ½ or 1.5 inches (4cm).

vii. Rate of performing chest compressions for victims of all ages is at-least 100 compressions per minute.

viii. Hands are placed on the lower half of the chest bone to perform chest compression on the adult.

ix. In 2-rescures CPR, while the first rescuer begins chest compressions, the second rescuer maintains an open airway and gives ventilation.

x. Preferred chest compressions technique for 2-rescuer CPR for the infant is the 2 thumb encircling hands technique.

1.7.4.2 **Airway**

i. After the airway is opened, the proper technique for delivering mouth to mouth ventilation is required. The rescuer opens the airway, seals his or her mouth over the victim's mouth, pinches the victim's nose closed, and gives 2 breaths while watching for the chest to rise. If ambu bag is present, prefer it.

1.7.4.3 **Breaths**

i. The rescue breath for an adult, child or infant is effective when the chest rises visibly.

ii. During Bag-mask ventilation, giving a breath just until you see the chest rise is recommended to minimize the risk of gastric inflation.

iii. The compression-to-ventilation ratio for adult CPR is 30:2.

iv. The compression-to-ventilation (or breaths) ratio for 2-rescuer child/infant CPR is 15:2.

v. Compression and ventilation rates for 2-rescuer CPR in the presence of an advanced airway is to compress at a rate of at-least 100 per minute, 1 breathe every 6 to 8 seconds.

vi. When administering breaths by using a bag and mask device for a child who is not breathing but does have a pulse, the rescuer should give breaths at the rate of 1 breathe every3 to 5 seconds.

vii. Bag-mask device/technique is not recommended for a single rescuer to provide breaths during CPR.

1.7.5 After Care of the patient –

1.7.5.1 Make the patient comfortable.

1.7.5.2 Observe for any complications again and take appropriate actions.

2 CODE RED –FIRE EMERGENCY RESPONSE PLAN

Fire Emergency Pre-Plan:

1. Know the location and how to use the nearest fire alarm
2. Know the emergency number to dial. Dial 101
3. Know how to contain smoke and fire.
4. Know where and how to transfer to areas of refuge.
5. Know the location of fire extinguishers and how to use them.
6. Know the location of all exits.
7. Know area specific fire-response duties.
8. Know proper evacuation procedures and routes.

2.1 Fire Extinguisher:

Fire extinguishers, in appropriate sizes and types (ABC), are provided throughout the hospital in every floor of the hospital. Extinguishers are inspected as required by a qualified contractor. The theft of or tampering with an extinguisher should be reported immediately to the Maintenance In-charge.

2.2 Emergency Evacuation:

To establish a systematic method of safe and orderly evacuation of an area or building, by and of its occupants, in case of fire or other emergency. The following procedures are observed to minimize the effects of Fire Accidents in the hospital:

2.2.1 The R.A.C.E. Procedure is followed:

2.2.1.1 **RESCUE -** Remove patients or others in immediate danger, and the door behind are closed. If the person is busy in rescue effort; he should shout “CODE RED” so that other employees can pull the alarm.

2.2.1.2 **Alarm -** Break open Alarm system are placed in different parts of the hospital, which can be activated at the time of fire by breaking the glass panel. Smoke detectors are also located in different parts of the hospital, which in the event of detecting smoke will activate the alarm system in the in-house telephone exchange.

2.2.1.3 **Contain -** Contain the fire by closing doors and windows so that it does not spread to other parts of the hospital.

2.2.1.4 **Extinguish/evacuate**

i. Extinguish fire if possible.
ii. Use correct extinguisher for the type of fire.
iii. Evacuate all persons to a safe area, if necessary.
iv. Follow directions of Safety Officer, Fire Department.

2.3 Fire plan is placed in every floor which indicates the exact location of the **fire exits** and **fire extinguishers**. Hence in case of any fire accidents; the nearest fire exit in the floors can be easily traced.

2.4 The procedure for use of any fire extinguisher is:

1. Pull Pin (from handles)
2. Aim at base of fire
3. Squeeze handles
4. Sweep nozzle or hose from side to side:

Orientation and Education To Fire Safety Program:

1. Volunteers, students and physicians will be trained in their specific role and responsibilities in the fire plan.
2. All new employees will receive general fire safety information at the facility wide orientation program.

3. All employees will be in serviced at least annually in a mandatory continuing education program, which will include the Fire Safety Program and The Safety Officer will maintain a record for the same.

3 CODE PURPLE- PHYSICAL ALTERCATION/ FIGHT

3.1 **Purpose**:

3.1.1 The purpose of code Purple team of the Hospital/institute is to ensure critical situation in the safety design for prevention of abuse, aggressive/threatening incident, physical altercation or fight in the entire premise in the hospital.

3.1.2 In the event of either miscreant or malicious attack, preparedness of staff is essential to contact. Abuse, aggressive and miscreant person/staff members of hospital/institute need to have working knowledge of how to call security staff or police and to avoid panic as well as to create safe environment.

3.1.3 Understanding of key principles will help staff members taking good decision during a chaotic event. The principles include as follow:

i. An organization culture should be developed to focus on prevention of abusive, aggressive and miscreant activities.

ii. Staff should be educated about organizational culture and motivated to prevent the occurrence of such events.

iii. Mock drill should be carried out in every 3 months to access the preparedness of staff for prevention and combating such events and observation should be explained after the incident.

iv. The collaboration and communication should be developed among departmental teams and individuals.

v. A focus should be on process of improvement rather than the blaming to each other.

vi. Patients and their family members should be educated about their roles and responsibilities in ensuring patient safety.

3.2 **Scope:**

3.2.1 Formation of a team: Team Purple for dealing with the cases of physical altercation or fight.

3.2.2 Training of staff to prevent the occurrence of such events.

3.2.3 Defining of effective plan in case of any incident which is simple to follow, flexible to adapt in variety of situations, self-sufficient even at the unit level to overcome the situation without causing major loss.

3.2.4 Defining Holding sites for patients.

3.2.5 Preparation guidelines/policies when situations are uncontrolled.

3.3 **Responsibilities:**

3.3.1 Abuse, aggressive patients or relative dealing is the responsibility of each and every staff member, administrative, medical and nursing staff leaders are responsible for creating a peaceful environment in the Hospital/institute.

3.4 Other members will be invited to participate depending on the issues identified. Security officer of the hospital will work as the team liaison officer, who will be responsible for coordination and co-operation with civil authorities and police.

3.5 It may be necessary at times, to evacuate patients to holding sites before transportation resources and/ or receiving destinations are available. If the medical facility cannot accommodate a horizontal safe site location on the same floor safe from danger, then assembly points located away from the main clinical areas should be identified and designated.

3.6 Full evacuation of the hospital/institute should generally be considered as a last resort when mitigation of other emergency response efforts are not expected to maintain a safe care environment.

3.7 When difficult choices are to be made leaders and staff must focus on the "Greatest good for the greatest number".

3.8 Code purple management team will ensure that all departments, medical services, canteen services and Admin block function as per Hospital/institute rules and regulations.

3.9 **Mock Drill:** Mock drills are designed to ensure regular training of staff members which will-

3.9.1 Impart knowledge and understanding of the Hospital/institute rules and regulations and efficient safety plan so that they can act swiftly, safely and in an orderly manner.

3.10 **Action Cards**:

Action cards are brief summaries that define each role in an emergency situation and details of the tasks assigned to this role. All staff members should have a general knowledge and understanding of variety of roles as a single staff member and may be tasked with more than one or may be required to undertake different role in a given situation.

4 CODE GREY – INTERNAL DISASTER

4.1 **Emergency Response Plan**

1. Know the location.
2. Know the emergency number to dial.
3. Know where and how to transfer to areas of refuge.
4. Know the location of all exits.
5. Know area specific emergency response duties.
6. Know proper evacuation procedures and routes.

4.2 **Emergency Evacuation:** to establish a systematic method of safe and orderly evacuation of an area or building, by and of its occupants, in case of emergency.

4.3 The **R.E.A.C.T** procedure is followed to minimize the effects of internal disaster accidents in the hospital:

4.3.1 **R**emove persons from immediate danger area while calling out "Code Grey". State the location and ask for help.

4.3.2 **E**nclose internal disaster room. Identify the room with an object in front of the door.

4.3.3 **A**ctivate the alarm system pull stations.

4.3.4 **C**all hospital switchboard/locating (ext. XXXX). Give exact location and nature of the incident.

4.3.5 **T**ry to manage the situation, if it is small, it is safe to do so, continue evacuation.

5 CODE PINK – CHILD MISSING/BABY ABDUCTION/ MISSING PATIENT

CHILD ABDUCTION PLAN

Alert for persons exhibiting unusual behavior / loitering at the nursery extensively / inappropriate questions about staff procedures or security measures/Child abduction from Hospital.

↓

Within 60 seconds

Announcement to be made through control room (8888) by alerting code pink team with suspicion of child abduction in specific area

↓

Within 2 minutes

↓

Information will be conveyed to

Chairman code pink committee

↓

Networking with other hospitals via Telephone, fax & personal contacts regarding child abductions.

calling senior supervisor security department with extra man power

1.Segregate and barricading area
2. Extra security staff deployed

any employee who heard code pink paged overhead should cover the nearest exit or stairwell / Recommend any employee to stand in the open door of the stairwell to get proper coverage.

↓

Check the child and/or adult for hospital ID band / Gate pass

(Parents/legal guardians of In-Patients children are given an ID band to identify them with their child)

↓

Employee identifying the abductor- ask them to come with them to an area with a phone and call security (At no time should the staff member place themselves in danger).

↓

1. One employee will contact security staff while the other employee will follow the suspect to their vehicle and obtains a description if possible license plate number

2. Security will respond and attempt to block the vehicle, the suspected person will be handed over to authorities or moved out of the premises.

↓

Administrative supervisor will declare the code pink, all clear upon confirmating that the child / infant has been located and returned

Security should call the police department

↓

Police department determines the need for and the initiation of the amber alert plan

↓

If the child / infant is not located, administrative supervisor will notify-

1. Admin on call
2. Quality management
3. Public relations
4. Other personnel as required

NOTE-

1. All staff is prohibited from releasing any information to the media.
2. Employee calls to the operators and security should be limited to emergency only during code pink.
3. All patient information obtained will remain strictly confidential.

6 CODE YELLOW - EXTERNAL EMERGENCY DISASTER & PREPAREDNESS PLAN

1. Announce the codes 3 consecutive times and locations through public announcement system.
2. Emergency evacuation as per the investigation reports.

FLOW CHART

EXTERNAL DISASTER (TREATING OUTSIDE EMERGENCY/DISASTER NOT IN THE SCOPE OF SERVICES OF AIIA HOSPITAL)

↓

IF ANY INFORMATION OF SUCH INCIDENCE COMES IN THE NOTICE IF SECURITY PERSONAL AT MAIN GATE

↓

INFORMATION WILL BE PASSED TO THE SECURITY OFFICER/ NS/ CASUALTY MEDICAL OFFICER/M.S/AMS

↓ (WITHIN 1-5 MINUTES)

ANNOUNCEMENT WILL BE MADE THROUGH CONTROL ROOM BY ALERTING CODE YELLOW TEAM ABOUT THE INCIDENCE.
(WITHIN 2 MIN)

↓	↓
CODE YELLOW TEAM WILL REASSESS THE SITUATION EXTRA DEPLOYMENT OF SECURITY STAFF, IF REQUIRED.	IN CASE OF INJURED/ SERIOUSLY INJURED PATIENT WILL BE ADVISED TO GO TO ANY NEARBY GOVT.HOSPITAL
↓	↓
LOCAL POLICE WILL BE CALLED, IF NEEDED.	(AS EXTERNAL DISASTER IS NOT COVERED IN THE SCOPE OF SERVICES OF AIIA HOSPITAL)

7 CODE ORANGE-HAZMAT SPILL/LEAKAGE OF HAZARDOUS MATERIAL/GAS

7.1 HAZMAT Materials:

Hazardous Materials that contain ingredients those are harmful to health. These include materials that are lethal and non-lethal, corrosive, toxic, irritant, sensitizing, mutagenic, teratogen or carcinogenic. The concentration level of each ingredient in a mixture is taken in to account in determining whether the mixture as a whole is determined to be hazardous.

7.2 Purpose:

7.2.1 In the event of a spill, competent and prompt action is necessary for immediate cleaning, to reduce and eliminate the hazards present.

7.2.2 The handling, storage and use of hazardous materials are controlled and hazardous waste is disposed with safety.

7.3 Body fluid spillage-

i. Wear gloves
ii. Cover spill with absorbent paper,
iii. Pour 1% sodium hypo-chlorite solution over it.
iv. Wait for 15-20 min before moping it.

7.4 If the spill is >30 ml

i. Call the HAZMAT TEAM promptly.
ii. Remove the bag.
iii. Fill up an incident form chemical/hazardous material spillage.
iv. Spills are handled by HAZMAT TEAM.

7.5 Minor spill: <30cc

i. Place tissue over spill.
ii. Wear Nitryl gloves.
iii. Place in Black plastic bag.
iv. Place this bag in another black plastic bagand.
v. Label it as e.g. “Formalin/Cidex Spill”.

vi. Ask housekeeping to mop area.

vii. Fill up an incident form. Minor/Major Spill.

7.6 Major Spill: >30 ml

i. Place tissue paper over the spill.

ii. Place inverted trash can over the spill.

iii. Inform HAZMAT team to clean up.

iv. Fill up an incident form.

v. Patients' exposure to body fluids.

7.7 Accidental exposure to body fluids has to be treated the same way as needle injury.

i. Send appropriate samples for examination.

ii. Inform the Infection Control Officer.

iii. Fill up an incident form.

7.8 **Spillage at Laboratory Area-**

7.8.1 **Incident report:**

i. The supervisor must be informed about the incident at the earliest.

ii. The supervisor is duly advised to prepare a report of the incident, using the incident report work sheet and the safety committee convener has to be informed.

iii. The laboratory In-charge (in case of laboratory spills) will have to ensure that the appropriate PEP/treatment has been followed

7.8.2 The following four symbols may be used to communicate the extent of risk at the place of incidence-

i. **NOTICE**-states a policy related to safety of personnel or property but not a physical hazard.

ii. **CAUTION-**indicates a potentially hazardous situation, which may result in minor or moderate injury

iii. **WARNING-** indicates a potentially hazardous situation, which may result in death or serious injury.

iv. **DANGER**-indicates an imminently hazardous situation that if not avoided, will result in death or serious injury.

7.8.3 **Decontamination of Spills**

7.9.3.1 **Major spills (with possible aerosol formation)**

i. Evacuate the area or room and alert all personnel regarding the spill and take care not to breathe in aerosolized material
ii. Close doors to the affected area and keep it closed for 30 min
iii. Only the designated staff have to enter the area to clear the spill and the staff cleaning the spill should ensure that they use the appropriate PPE (gloves, Google mask)
iv. Use disposable paper towels or tissue to wipe off the liquid in the spillage and discard the tissue into a container meant for infected wastes
v. Pour disinfectant (4% sodium hypochlorite) over the entire area of the spillage and let it remain for 30 min
vi. Absorb the detergent with an absorbable material and dispose in the infected container
vii. Rinse the spill site with soap and water and air dry
viii. Discard the gloves and mask used for clearing the spillage site into the container for infected items
ix. Wash hands with soap and water

7.9.3.2 **Minor spills:**

i. Similar to the procedure for major spills except evacuation of personnel working in the area may not be essential

8 CODE BLACK- BOMB THREAT/SUSPICIOUS BOMB PARCEL

FLOW CHART

Suspicious bags /items Laying/ information received telephone/ message and person at information should be passed to coordinator/ S. O/ Control Room/ Security Supervisor on duty

↓ Within 60 Second

Announcement will be made through control room by alerting Code Black team with location of suspicious items.

↓ Within 2 Min

Information will be converged to

- Informed to MS/DMS
- Calling S. Supervisor with extra manpower

1. Segregate and barricading the area
2. Extra security staff deployed

Evacuation Coordinator

↓

Security Officer

↓

Security, Housekeeping & Maintenance Supervisor and Duty Staff of IPD

↓

If required – Evacuate the patient from incident place

Local police, PCR, Fire brigade & Ambulance Should be called upon

Suspicious Bag/Items/ Explosive/bomb should be handover to Police/Competent Authority for final disposal.

6.3 FACILITY INSPECTION ROUNDS

1. Administration department along with Safety officer, Quality department, Maintenance dept., BME dept. and housekeeping Dept. conducts facility inspection rounds.
2. In patient care area the facility inspection round conducted twice in a year, and in non-patient care area facility inspection rounds has to be conducted once in a year.
3. The findings will be reported to management as soon as completed the inspection.
4. Corrective and preventive action will be discussed in safety committee for major findings.
5. The implementation will be done by administrative dept. with the help of management.

6.4 SAFETY ORIENTATION PROGRAM

1. New employees may be oriented to the Safety Program as part of the New Employee Orientation Program. A representative appointed by the Hospital Safety Committee (Safety Officer) reviews general safety policies, safety resources and employee responsibilities in the reporting of accidents and employee rights to be informed on hazardous materials in the work place.
2. New laboratory employees and others potentially exposed to hazardous chemicals attend the General Chemical Safety Training or Laboratory Safety Training Program, as appropriate.
3. Periodic safety training programs are conducted by the Departments of Infection Control or Nursing Education. The Safety Committee assists departments in such efforts, upon request.

6.4.1 **MOCK DRILL**

6.4.1.1 Fire drills will be held at least twice in a year. At least 50% of the drills will be unannounced. All fire drills will be critiqued to the extent necessary to ensure that the facility's fire plan aspects have been met.

6.4.1.2 A random sample of personnel shall be verbally quizzed following each drill. Their knowledge of the following will be assessed:

i. Containment of smoke and fire
ii. Transfer to areas of refuge
iii. Fire extinguishment
iv. Assignment of specific duties
v. Preparation for building evacuation

6.4.1.3 Fire drills shall be designed to test staff knowledge of general organization fire protocols and all aspects of response that may be unique to an employee's specific work area including but not limited to:

i. How to identify the location of the fire and what their response would include
ii. The use and functioning of fire alarm systems
iii. The transmission of alarms
iv. How to contain smoke and fire
v. How to transfer patients, visitors and staff to safe area
vi. How to extinguish a fire
vii. What are their specific fire response duties
viii. How to prepare for building evacuation

6.4.1.4 All fire drills will be evaluated and critiqued for the purpose of identifying deficiencies and opportunities for improvement by minimum one observer.

6.4.1.5 A written report documenting the evaluation of each drill and the corrective actions recommended or taken for any deficiencies found will be completed by a member of the Safety Committee and filed with the Safety Officer.

6.4.1.6 The Fire Safety Manual including plans policies procedures will be kept current and available in every department. Personnel are expected to read this manual, and the effective performance of responsibilities under the plan is a condition of employment.

6.5 SAFE EXIT PLAN

Activity / Responsibility

1. If a disaster occurs in a patient care area, or threatens a patient care area, all the hospital employees should remove patients who are in immediate danger. *DO NOT WAIT FOR INSTRUCTIONS*. Patients should be taken to the nearest safe area on the same floor if possible (horizontal evacuation). If the patients are not in immediate danger and the alarm has been activated, **WAIT** for evacuation orders.

2. Do not leave patients unattended. For example, appropriate hand-off must be conducted before leaving any patient.

3. Security staff, using radios or an alternate communications system, should be located at exit(s) of patient care units to ensure that all patients, visitors and staff area counted for.

4. The proper sign boards are displayed in hospital.

5. Fire exit door are kept open for easy movement of patient and family, visitors and staffs

6.6 SAFE WATER, ELECTRICITY AND MEDICAL GASES

8.1.1 **Electricity Supply:**

i. In case of any breakdown, in the power supply the hospital has one generator of an alternate source of power

ii. The electrician checks the wiring system regularly to locate any fault such as short circuit etc. and immediately rectifies the same.

iii. The generators are regularly tested by the electrician in order to locate any fault in the same; this is done to ensure that there is no interruption in power supply. The generators are also under AMC; record of the same is maintained by the Maintenance In-charge.

8.1.2 **Water Supply System**

i. The hospital has own deep wells in the campus for its needs with sufficient underground storage tanks and overhead supply tanks.

ii. Water supply is supervised by civil maintenance team and incase of any complaints with the water supply of the hospital, the civil in charge with civil maintenance team will attend to rectify the complaints.

iii. The pump operator regularly fills the water tanks and plumber under the supervision of civil works in charge, checks the water lines and system regularly to locate any fault and rectifies them as early as possible. Electrical part of the water supply system is maintained by the electrical supply department.

8.1.3 MEDICAL GASES **:** Refer*:* AH/FMS/DOC/05

6.7 FACILITY MAINTENANCE

1. In each department the Department head will be responsible for facility maintenance
2. The department in charge can inform to BME/ maintenance department through administration department.
3. The administrative department will take care of this issue. Other than that they will conduct a facility Audit in patient care areas along with the Quality dept., Maintenance Dept., BME and Safety Officer.

4. Patient care area (Panchakarma Theater, OP, IP, casualty etc.) the audit will be conducted twice in a year and in non-patient care (canteen, Different Depts., front office etc.) area the audit will be done once in a year.
5. The findings will be noted during the audit and Corrective and Preventive actions documented for each finding.
6. The major problems are discussed in the hospital safety committee and corrective preventive actions are implemented by the administrative dept.
7. The status will be checked periodically and further action taken by the administration.

6.7.1 Drawings and Sign boards

1. Display of Hospital Layout (Floor Wise)
2. Display of Fire Exit Route Map (each department and rooms)
3. The signboards are visible and bilingual. Both internal and external sign posters are in a language understood by the Staff, visitors, patient, and their family.

6.8 EQUIPMENT MAINTENANCE

All equipment should be checked prior to use. All equipment will be set up on a preventive maintenance program and scheduled for a re-testing as and when required.

Activity / Responsibility

Sl. No.	STEPS	RESPONSIBILITY
1	Identify the **need** to prepare list of major equipment	Administration, BME, Maintenance dept.
2	Provision shall be made of **appropriate infrastructure and services** in the hospital for major equipment	Administration, BME, Maintenance dept.
3	Proper **storage and disposition** of equipment shall ensure	Administration, BME, Maintenance dept.

4	Prepare **final list** of all the major equipment	Administration, BME, Maintenance dept.

1. The newly procured equipment is entered in the equipment inventory with all the necessary details.
2. All medical and non-medical equipment are operated and maintained by trained personnel. Whenever major equipment is procured, the potential operators are given training on how to use them properly.
3. They shall be given some basic training on its maintenance and periodic checkups.
4. Only authorized persons shall operate the particular equipment and they should report and document any malfunctions and breakdowns.

Note: clinical and support services list is regularly updated by administration department (refer annexure 9.2)

6.8.1 Operational and maintenance (preventive and breakdown) plan.

Individuals who are qualified and available to do preventive maintenance must be identified. A list should be drawn up of personnel who are readily available. Once the personnel have been listed, specific responsibilities should be assigned, perhaps in the form of a work order, giving clear instructions for the task. Each person should have a clear knowledge of his or her responsibilities. Job assignments must correspond to the training, experience and aptitude of the individual.

i. Each month, manager will create the schedule. This schedule will cover all equipment to receive a preventive maintenance inspection.

ii. The assigned engineer or technician shall document the maintenance, including any pertinent observations on the work order. When maintenance and documentation are completed, the work order will be returned to the manager for review and filing of the work order.

iii. If scheduled work cannot be completed or performed (i.e., parts are needed), the reason is documented on the work order and it is returned to the administration. The work order will be placed under "Outstanding Jobs", which will later be compiled as part of the 30 or 60 day report.

If equipment must be removed from the user area for more than one (1) day, the biomedical engineer will prepare a corrective maintenance order. One (1) copy of this order will be forwarded to the HOD/In charge of the user department.

6.8.2 Maintenance in break down situation:

i. While receiving a call from any department regarding the equipment breakdown, the biomedical/ maintenance department will be responsible for the rectification.

ii. The department in charge will raise complaint in complaint register to the BME/ maintenance department through administration department.

iii. The concerned persons who can rectify the breakdown and take necessary preventive, maintenance, or rectification of breakdown.

iv. The biomedical or maintenance department staff will take action regarding the same; in problem solving equipment manual shall be used as a referral tool.

v. If any component is damaged check for availability of the component and replace it, the responsible person (from biomedical /maintenance) will inform to Administration department.

vi. The date and time of complaint solved shall be documented in the complaint register.

vii. If correlated medical equipment problem arises inform to the related service centre and supervise the troubleshooting done.

6.9 LAB SAFETY

Refer (AH/LM/01)

6.10 INCIDENT REPORTING

6.10.1 INCIDENTS & NEAR MISS

6.10.1.1 Any person will report incidents and near misses involving patients and / or visitors, staff & equipment as soon as possible or within 24 hours. An incident, which is of a sensitive or urgent nature, should be reported verbally to concerned HOD, Quality department person and Administrator immediately.

6.10.1.2 The incident must be reported on the Incident Report form. These forms are available in all departments. The information on this report is confidential and duplication of the report is prohibited. The report will be completed legibly and objectively, without extraneous comment, personal opinion.

6.10.1.3 The concerned department in-charge will receive and review all Incident Report forms.

6.10.1.4 Recording the comments and actions taken in the form, same shall be forwarded to Department of Accreditation and Quality (DAQ)

6.10.1.5 A detailed investigation of the incident, as deemed necessary according to the nature of case shall be conducted by Quality department in cooperation with concerned department staff and forward the recommendations to the concerned in charge and Administration for effective implementation.

6.10.1.6 As necessary and appropriate, significant findings, conclusions, actions and recommendations will be communicated to Hospital Administration and to the top management through established mechanisms.

6.10.2 SENTINEL EVENTS

6.10.2.1 Once a sentinel event has occurred, then the following steps have to be taken. The employee reports the incident/occurrence to the supervisor or in charge of the department.

6.10.2.2 The supervisor or in charge of the department with administration undertakes immediate remedial action to mitigate the harm to the patient. The supervisor will investigate the incident and completes the incident report and forwards it to the Quality Department through administration department.

6.10.2.3 The Sentinel event team, investigation assigned by hospital administration and the head of Quality department immediately, will review sentinel events.

6.10.2.4 All relevant documents, medications, vials, equipment should be collected and retained for examination.

6.10.2.5 The sentinel event investigation team conducts Root Cause Analysis, focusing on process and system factors, with staff involved in the event.

6.10.2.6 The Head of Quality will formulate recommendations and improvement plan.

6.10.2.7 If the root cause analysis determines that the sentinel event is related to an organizational systems or process problem, the team will utilize the organizational performance improvement model FOCUS-PDCA to design, implement and evaluate an improvement plan to correct the system issue and/or problem.

6.10.2.8 If the root cause analysis finds the sentinel event to be caused by the performance and/or competence of a practitioner holding clinical privileges, the corrective action will be managed under the supervision and direction of the Medical superintendent.

6.10.2.9 The following is an established list of sentinel events related to this policy and procedure:

1.**Patient Protection Events:**

i. Patient death or serious disability from the hospital

ii. Patient suicide or attempted suicide, or deliberate self-harm resulting in serious disability

iii. Administering wrong medical gas for the patient

iv. Nosocomial infections or disease causing patient death or disability.

2.**Care Management Events:**

i. Medication errors like omission errors, dosage errors, dose preparation errors, wrong time errors, wrong rate of administration errors, wrong administrative technique errors, wrong patient errors.

ii. Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal results.

3.**Device or Product Events:**

i. Patient death associated with the usage of contaminated drugs, devices, products, usage of devices or functions other than their intended use, breakdown of medical equipment.

4.**Surgical events:**

i. Surgery performed on wrong body part.

ii. Surgery performed on wrong patient

iii. Wrong surgical procedure performed on wrong patient.

iv. Patient death during or immediately post-surgical/ Para-surgical procedure

v. Anesthesia related event

5.**Environmental Events:**

i. Patient death or serious disabilities associated with burns, slip or fall, electric shock, bed soar etc. while being hospitalized.

6.**Criminal events:**

i. Any instance of care ordered by or provided by an individual impersonating a clinical member of staff.

ii. Abduction of a patient

iii. Sexual assault on a patient within or on grounds of the healthcare facility

iv. Death or significant injury of a patient or staff member resulting from a physical assault or other crime that occurs within or on the grounds of the healthcare facility.

Root cause analysis

Purpose of Root Cause Analysis The purpose of the Root Cause Analysis is to understand how and why a Sentinel or High Risk Event occurred and to prevent the same or similar Event from occurring in the future. The Root Cause Analysis is expected to uncover any underlying Holistic center's systems and processes that can be changed to reduce the likelihood of human fallibility in the future.

Documents related to sentinel events are confidential

The Root Cause Analysis, Action Plan, and other related documents produced by the committee are confidential Root Cause Analysis and the Action Plan are documents prepared by the committee and constitute final product containing recommendations identifying strategies that the Holistic center intends to implement to reduce the risk of Sentinel Events occurring in the future.

6.10.3 MEDICATION ERROR

In the event of a medication error involving a patient, there shall be an immediate verbal report and response on the part of all individuals involved, to minimize unwanted effects to the patient. Other medication errors shall be notified as soon as possible but no longer than one week.

1. If the medication reached the patient or a clinically significant omission or delay occurred, the responsible attending physician or house staff physician shall be notified immediately. It is the responsibility of the physician involved to discuss the medication variance with the patient and/or family as necessary.

2. Quarterly reports will be prepared for presentation to the pharmacy and therapeutics committee.

3. The committee on reviewing trends of medication errors and identifying action plans for improvement shall coordinate education on safe medication use processes.

6.10.4 ADVERSE DRUG REACTION

6.10.4.1 Reporting of ADR

6.10.4.2 Ref. *ADR reporting policy* (AH/MOM/Doc 08)

6.11 NO SMOKING POLICY

Refer *No smoking Policy (*AH/FMS/ DOC 06)

7. DOCUMENTS

7.1 Safety training record

8. REFERENCE

8.1 NABH standard for Ayurveda (2nd Edition)

8.2 Lab manual (AH/LM 01)

8.3 AH/COP/DOC 03

8.4 No smoking policy (AH/FMS/DOC 02)

9. ANNEXURE

9.1 List of Panchakarma equipment

Sl. No	Equipment
1	*Droni*

2	Stand for fix *Droni*
3	Footstool
4	Arm chair
5	Heating facility
6	*Shirodhara* stand & *Shirodhara* table
7	*Basti-Yantra*
8	*Uttara Bastiyantra*
9	Bed pan
10	*Vamana* set
11	*Nadi Swedana Yantra*
12	*Sarvanga Swedana* box

9.2 List of Biomedical Equipments.

Sl. No	Equipment Name
1	Abdominal exercises
2	Aqua guard
3	Autoclave
4	BP Apparatus
5	Centrifuge
6	Direct Ophthalmoscope
7	e-scope(Otto scope)
8	ESR stand
9	Flow meter
10	Glucometer
11	Manual Treadmill
12	Mariners Wheel
13	Medical Heat treatment apparatus
14	Microscope
15	N2 cylinder
16	Temperature sensor

17	Thermometer
18	Tilting table
19	Torch
20	Traction machine
21	Trial Set
22	Vibrator

9.3 Support Service

Sl. No	Items
1	Ceiling Fan
2	Weighing Machine
3	Exhaust Fan
4	Exhaust Fan Heavy
5	4 Feet tube light
6	2 Feet tube light
7	4 Feet tube fittings
8	2 Feet tube fittings
9	CFL holder type
10	CFL thread type
11	Fancy light
12	2 ton A/C
13	1 ton A/C
14	Window A/C
15	Mixy
16	Fridge
17	Heater
18	Cooler Machine
19	Aqua guard
20	Steamer
21	Panel board
22	DB
23	Mirror Optics
24	Mirror
25	Towel rod

26	Washbasin
27	Tap
28	Soap dish
29	Calling bell
30	Switch
31	Socket
32	Regulator