CHAPTER V

HOSPITAL MANAGEMENT – CONCEPT AND PERCEPTION.

- Hospital Management
- Human Resource Management
- Patient Satisfaction
- Hospital Waste Management
- Conclusion
5.1: HOSPITAL MANAGEMENT

Within many health care systems worldwide, increased attention is being focused on human resources management (HRM). Specifically, human resources are one of three principle health system inputs, with the other two major inputs being physical capital and consumables (WHO, 2000\(^1\)). Chart 5.1 depicts the relationship between health system inputs, budget elements and expenditure categories. Human resources, when pertaining to health care, can be defined as the different kinds of clinical and non-clinical staff responsible for public and individual health intervention. As arguably the most important of the health system inputs, the performance and the benefits the system can deliver depend largely upon the knowledge, skills and motivation of those individuals responsible for delivering health services (WHO, 2000).

As well as the balance between the human and physical resources, it is also essential to maintain an appropriate mix between the different types of health promoters and caregivers to ensure the system's success. Due to their obvious and important differences, it is imperative that human capital is handled and managed very differently from physical capital. The relationship between human resources and health care is very complex, and it merits further examination and study. Both the number and cost of health care consumables (drugs, prostheses and disposable equipment) are rising astronomically, which in turn can drastically increase the costs of health care. In publicly-funded systems, expenditures in this area can affect the ability to hire and sustain effective practitioners. In both government-funded and employer-paid systems,

\(^{1}\) World Health Report 2000.
HRM practices must be developed in order to find the appropriate balance of workforce supply and the ability of those practitioners to practice effectively and efficiently. A practitioner without adequate tools is as inefficient as having the tools without the practitioner.

Chart 5.1 Relationship between health system inputs, budget elements and expenditure categories.


5.1.1: Issues

When examining health care systems in a global context, many general human resources issues and questions arise. Some of the issues of greatest relevance that will be discussed in further detail include the size, composition and distribution of the health care workforce, workforce training issues, the migration of health workers, the level of economic development in a particular country and socio-demographic, geographical and cultural factors. The variation of size, distribution and composition within a county's health care workforce is

\[\text{Pg. } 75, \text{http://www.who.int.proxy.liv.uwo.ca:2048/whr/2000/en/whr00_ch_en_pdf.}\]
of great concern. For example, the number of health workers available in a
country is a key indicator of that country's capacity to provide delivery and
interventions (WHO, 2003). Factors to consider when determining the demand
for health services in a particular country include cultural characteristics, socio-
demographic characteristics and economic factors (Zurm et. al, 2004). Workforce training is another important issue. It is essential that human
resources personnel consider the composition of the health workforce in terms
of both skill categories and training levels. New options for the education and
in-service training of health care workers are required to ensure that the
workforce is aware of and prepared to meet a particular country's present and
future needs. A properly trained and competent workforce is essential to any
successful health care system.

The migration of health care workers is an issue that arises when
examining global health care systems. Research suggests that the movement of
health care professionals closely follows the migration pattern of all
professionals in that the internal movement of the workforce to urban areas is
common to all countries. Workforce mobility can create additional imbalances
that require better workforce planning, attention to issues of pay and other
rewards and improved overall management of the workforce. In addition to
salary incentives, developing countries use other strategies such as housing,
infrastructure and opportunities for job rotation to recruit and retain health
professionals, since many health workers in developing countries are underpaid,
poorly motivated and very dissatisfied. The migration of health workers is an
important human resources issue that must be carefully measured and
monitored.

3 World Health Report 2003
4 Zurn P, Dal Poz MR, Stilwell B, Adams O: 'Imbalance in the health workforce'. Human Resources for
Health 2004, 2:13
Another issue that arises when examining global health care systems is a country's level of economic development. There is evidence of a significant positive correlation between the level of economic development in a country and its number of human resources for health. Countries with higher gross domestic product (GDP) per capita spend more on health care than countries with lower GDP and they tend to have larger health workforces. This is an important factor to consider when examining and attempting to implement solutions to problems in health care systems in developing countries. Socio-demographic elements such as age distribution of the population also play a key role in a country's health care system. An ageing population leads to an increase in demand for health services and health personnel. An ageing population within the health care system itself also has important implications: additional training of younger workers will be required to fill the positions of the large number of health care workers that will be retiring. It is also essential that cultural and geographical factors be considered when examining global health care systems. Geographical factors such as climate or topography influence the ability to deliver health services; the cultural and political values of a particular nation can also affect the demand and supply of human resources for health. The above are just some of the many issues that must be addressed when examining global health care and human resources that merit further consideration and study.

5.1.2: Significance of HRM in hospital

When examining global health care systems, it is both useful and important to explore the impact of human resources on health sector reform. While the specific health care reform process varies by country, some trends can be identified. Three of the main trends include efficiency, equity and quality objectives. Various human resources initiatives have been employed in an
attempt to increase efficiency. Outsourcing of services has been used to convert fixed labor expenditures into variable costs as a means of improving efficiency. Contracting-out, performance contracts and internal contracting are also examples of measures employed.

Many human resources initiatives for health sector reform also include attempts to increase equity or fairness. Strategies aimed at promoting equity in relation to needs require more systematic planning of health services. Some of these strategies include the introduction of financial protection mechanisms, the targeting of specific needs and groups, and re-deployment services. One of the goals of human resource professionals must be to use these and other measures to increase equity in their countries.

Human resources in health sector reform also seek to improve the quality of services and patient’s satisfaction. Health care quality is generally defined in two ways technical quality and socio-cultural quality. Technical quality refers to the impact that the health services available can have on the health conditions of a population. Socio-cultural quality measures the degree of acceptability of services and the ability to satisfy patient’s expectations. Human resource professionals face many obstacles in their attempt to deliver high-quality health care to citizens. Some of these constraints include budgets, lack of congruence between different stakeholders values, absenteeism rates, high rates of turnover and low morale of health personnel.

Better use of the spectrum of health care providers and better coordination of patient services through interdisciplinary teamwork have been recommended as part of health sector reform. Since all health care is ultimately delivered by people, effective human resources management will play a vital role in the success of health sector reform.
5.1.3: THE QUALITIES OF HOSPITAL ADMINISTRATOR

Hospital administration is a challenging profession. The Qualities of head and heart that hospital administrator seeks:

1. **Keen observer:** 360 Degree of vision should be able to step back and look at the bigger picture and then devise solution. Should possess ability to have both macro and micro perspective on any issue before him.

2. **Effective communicator:** Good administrator should be able to convey the things with clarity and as simply as possible without patronizing or scaring other with the command of his vast knowledge or intellect.

3. **Good listener:** Hospital requires a lot of patience and sympathy. At times people only need a good listener, e.g. though their problems cannot be solved - at times they may also realize this - but all that they need is to know that people in authority are aware of their frustrations and anxieties. He should be able to understand this.

4. **Respect for fact and intellectual honest:** Administrator should not speak without facts and should have patience to find the whole truth.

5. **Should behave gracefully:** Administrator should never lose temper even under stress.

6. **Transparently honest:** He should not be bluff. Truth is always more convenient in today's busy world. He should know how to say no if that is what situation demands, without hurting people as far as possible.

7. **Good leader:** A hospital administrator must have leadership skill. Nowadays almost all corporate are realizing the importance of leadership in the management. He should be able to influence people to act with zeal and
enthusiasm to achieve the target goal. He should be able to lead people and not seek directions from them in difficulty. He should inspire confidence - encourage them to give suggestions. Take responsibility for the mistakes of your juniors if committed without motive, i.e. you should be able to know your men.

8. **Should not panic:** In the face of problems or difficulties, he should be able to keep cool even in scary situations. When chips are down he should be able to stand i.e. hold his ground and be counted. Should be able to cope with change effortlessly in today's ever changing environment and should not feel rattled by change. Should react proportionately to the degree of change. Change is the currency of times we are living in.

9. **Good judge:** This is the most essential quality for any administrator; you would need it all the time.

10. **Should be sensitive:** He should be sensitive to other's suffering and problems even if they are self inflicted or you are not able to help much.

11. **Should be habitually objective:** He should be habitually objective with a deep sense of fair play and justice. You should not be hesitant to give credit where it is due and share honor if the situation rightfully demands so.

12. **Time management:** Time and tide waits for none. Once the time is lost it is lost forever. So a particular task should be completed in the allotted time frame.

   Ability to deal with people from diverse background is an essential quality of hospital administrators. They should hence be sympathetic, tactful and patient listeners. Problem solving is required at all times hence the ability to be a team leader with a positive approach is essential. Hospital administrators must understand organizational development, financial budgeting, material
management, medical purchasing and maintenances, building regulations and above all must have good public relations skills. Interests in service, in health care and in welfare are at the core of this profession. Hospital administrators convene meetings at various levels and hence need good communication skills (Joshi, 2009)\(^5\).

- Hospital administrator must be diplomatic, tactful and patient.
- He must have strong analytical and decision making abilities.
- He must have excellent interpersonal and communication skills
- Administrator must have good organizing capacity and must be firm but considerate while handling people.
- He must have a sense of responsibility and take his job seriously.
- He must be an intelligent judge of human nature which quality is essential while selecting personnel.
- He must be expert at educating and providing direction to his subordinates.
- He must be a man with a fine business sense so that he can secure value for money for the hospital.
- He must be capable of working with everyone cordially, regardless of their position of status in the hospital.
- He must have strong time management skill (beat the clock).
- He must review performance and speak with power.

5.1.4: MOTIVATIONAL FACTOR

Today, virtually all people practitioners as well as scholars – follow their own definitions of motivation. Usually one or more of the following words are included: desires, wants, wishes, aims, goals, needs, drives, motives and

incentives. Based on the finding of various research studies carried out in this field in the past, we have attempted to catalogue strategies that operating managers can apply in order to create requisite ‘desires’ within their people to deliver their best to the organization.

Providing career growth, learning and development opportunities: What a present day knowledge worker needs is adequate opportunities to learn and grow so that he remains employable in the current competitive business environment.

5.1.4.1: Providing an exciting and challenging work environment: So that he can put all his existing skills to good use.

5.1.4.2: Appreciating good performance: A manager should feel that he is a part of the team and his contribution is being noticed.

5.1.4.3: Providing regular feedback: As Ken Blanchand, author of the One Minute Manger says, “Feedback is the breakfast of champions” i.e. they want to know how they are delivering.

5.1.4.4: Soliciting employees’ opinions: In order to involve them in decisions that affects their jobs.

5.1.4.5: Opening channels of communication: Regular question and answer sessions, small group forums with the head of the organization and an open door policy are some ways that might encourage managers to speak up.

5.1.4.6: Ensuring job rotation: Demonstrate your respect for individuals by responding to signals they put out about how they want to be treated and the kinds of assignments that interest them.
5.1.4.7: Personally congratulating employees for a job well done: In other words, make praise specific and timely.

5.1.4.8: Maintaining frequent contacts with your people: It will underscore the importance of your relationship with them.

5.1.4.9: Dashing off small, personal notes: Written congratulations are tangible, the effects of which last longer.

5.1.4.10: Giving them a good job to do: It has been felt that nothing saps employee motivation quicker than routine and unchallenging work.

5.1.4.11: Recognizing employee’s personal needs: This can be done in terms of making arrangements for on-site day care, providing flexible work schedules and special equipment.

5.1.4.12: Fostering a sense of camaraderie: A company that creates this sense has gone a long way towards creating the kind of organization that people want to work for.

5.1.4.13: Doling out cash rewards: Adequate and equitable financial rewards should be based on performance—both of the company and of the individual. Finally, performance is about what happens every day. And, motivation is really about treating people with dignity—something today’s burned out, shell-shocked employees desperately need.

5.2: PATIENT SATISFACTION

One of the significant trends in the development of modern healthcare is the involvement of patient/clients in the management of their care and treatment. This is recognized in current health strategies both in Ireland and in
other jurisdictions. The Health Strategy—Quality and Fairness (DOHC 2001 Department of Health and Children)\textsuperscript{6} makes a particular reference to the inclusion of patient/clients in both the principles and the national goals. To support this development it is important to acknowledge that the experiences of patients/clients of health care vary considerably. Some may have an occasional intervention while others have a more permanent and long-term relationship with a service provider depending on the nature and extent of their need.

Person centered health care respects the dignity and value of each person. It is entirely desirable and proper that the views of patient/clients should be sought on their experiences and expectations of health care.

Action 48 of the National Health Strategy: Quality and Fairness—a Health System for you (DoHC, 2001) identifies the need for a national standardized approach to the measurement of patient satisfaction. It is consistent with objective one of the strategy that the patient/client is at the centre in the delivery of care. A people centered health system:

- Identifies and responds to the needs of individuals;
- Is planned and delivered in a coordinated way; and
- Helps individuals to participate in decision making to improve their health.

Feedback from patients/clients can influence the whole quality improvement agenda and provide an opportunity for organizational learning and development. It provides crucial information on what the patients/clients expectations are and how they perceive the quality of care, which may be different from that of all staff providing that care.

\textsuperscript{6} www.dohc.ie/publications/quality_and_fairness.html
Many healthcare organizations currently collect feedback but a study by the Irish Society for Quality and Safety in healthcare on behalf of the Health Services National Partnership Forum showed that there was no structured method utilized. A structured framework to collect information about patient/client satisfaction to ensure a systematic methodology that will facilitate benchmarking and allow collected information to be feed back into the overall decision making process.

“The ‘people-centered’ health care system of the future will have dynamic, integrated structures, which can adapt to the diverse and changing health needs of society generally and of individuals within it. These structures will empower people to be active participants in decisions relating to their own health.”

Satisfaction, like many other psychological concepts, is easy to understand but hard to define. The concept of satisfaction overlaps with similar themes such as happiness, contentment, and quality of life. Satisfaction is not some pre-existing phenomenon waiting to be measured, but a judgment people form over time as they reflect on their experience. A simple and practical definition of satisfaction would be the degree to which desired goals have been achieved. Patient/Client satisfaction is an attitude—a person’s general orientation towards a total experience of health care. Satisfaction comprises both cognitive and emotional facets and relates to previous experiences, expectations and social networks (Keegan et al, 2003). Meredith and Wood (1995) have described patient satisfaction as ‘emergent and fluid’. It also has been described as a particularly passive form of establishing consumer’s views. Satisfaction is achieved when the patient/client’s perception of the quality of care and services

---

that they receive in healthcare setting has been positive, satisfying, and meets their expectations.

5.2.2: Patient expectation

The meeting of patient/client expectations is assumed to play a role in the process by which an outcome can be said to be satisfactory or unsatisfactory. Expectations are an important influence on the patient/client's overall measurement of satisfaction with a health care experience. Patient/client satisfaction is influenced by the degree to which care fulfils expectation. Some literature however suggests that a link between satisfaction and fulfillment of patient/client expectations is not necessarily the case, since it is possible that the patient/client's evaluation of a service may be largely independent of actual care received.

5.2.2.1: Age: Older respondents generally record higher satisfaction possible explanations include lower expectations of health care and reluctance to articulate their dissatisfaction.

5.2.2.2: Illness: While some studies have found that sicker patient/clients and those experiencing psychological stress are less satisfied, with the possible exception of some chronically ill groups, distinguishing between the experience of sickness or experience of health service treatment or other factors as causes of dissatisfaction has proven difficult (Hall and Milburn, 1998, Cleary et al, 1992).

---


5.2.2.3: Prior experience of satisfaction: Crow et al, (2003)\textsuperscript{12} in their review of literature identified that satisfaction was linked to prior satisfaction with health care and granting patient/clients' desires (e.g. for tests).

5.2.2.4: Patient/client–professional relationship: There is consistent evidence across settings that the most important health service factor affecting satisfaction is the patient/client-practitioner relationship, including information and technical competence.

5.2.2.5: Choice of service provider: Choice of service provider is associated with higher satisfaction. Care provided under fee-for-service arrangements generates greater satisfaction than that delivered with prepaid schemes. Gatekeeping organizations, where patient/clients have little or no choice in their treatment or are assigned treatment, score relatively poor on satisfaction.

5.2.2.6: Gender, ethnicity, and socio-economic status: Evidence about the effects of gender, ethnicity, and socio-economic status is equivocal due to the small amount of literature available on each (McGee, 1998; Crow et al, 2003)

5.3: HOSPITAL WASTE MANAGEMENT

Hospital is a place of almighty, a place to serve the patient. Since beginning, the hospitals are known for the treatment of sick persons but we are unaware about the adverse effects of the garbage and filth generated by them on human body and environment. Now it is a well established fact that there are many adverse and harmful effects to the environment including human beings which are caused by the "Hospital Waste" generated during the patient care. Hospital waste is a potential health hazard to the health care workers, public and

flora and fauna of the area. Hospital acquired infection, transfusion transmitted
diseases, rising incidence of hepatitis ‘B’ and ‘HIV’, increasing land and water
pollution lead to increasing possibility of catching many diseases. Air pollution
due to emission of hazardous gases by incinerator such as furan, dioxin,
hydrochloric acid etc. have compelled the authorities to think seriously about
hospital waste and the diseases transmitted through improper disposal of
hospital waste. This problem has now become a serious threat for the public
health and, ultimately, the central government had to intervene for enforcing
proper handling and disposal of hospital waste and an act was passed in July
1996 and a bio-medical waste (handling and management) rule was introduced
in 1998.

A modern hospital is a complex, multidisciplinary system which
consumes thousands of items for delivery of medical care and is a part of
physical environment. All these products consumed in the hospital leave some
unusable leftovers i.e. hospital waste. The last century witnessed the rapid
mushrooming of hospital in the public and private sector, dictated by the needs
of expanding population. The advent and acceptance of "disposable" has made
the generation of hospital waste a significant factor in current scenario.

5.3.1: Types of waste

It is important to know the categorization and other steps of waste
management

a) Bio-medical waste: Bio-medical waste means “any solid, fluid or liquid
waste, including its container and any intermediate product, which is
generated during its diagnosis, treatment or immunization of human beings
or animals, in research pertaining thereto, or in the production or testing of
biological and the animal waste from slaughter houses or any other like
establishments.”
b) **Medical waste:** It is a term used to describe “any waste that is generated in the diagnosis, treatment or immunization of human beings or animals, in research pertaining thereto, or in the production or testing of biological.”

c) **Clinical waste:** It is defined as “any waste coming out of medical care provided in hospitals or other medical care establishments, but does not include waste generated at home.”

d) **Hospital waste:** Refers to all waste, biological or non-biological that is generated from a hospital, and is not intended for further use.

e) **Pathological waste:** Is defined as “waste removed during surgery/autopsy or other medical procedures including human tissues, organ, body parts, body fluids and specimens along with their containers.”

f) **Infectious waste:** Refers to that portion of bio-medical waste which may transmit viral, bacterial or parasitic diseases, if concentration and virulence of pathogenic organisms is sufficiently high.

g) **Hazardous waste:** Refers to that portion of bio-medical waste which has a potential to cause hazards to health and life of human beings.

**In addition, other types of waste generated in hospitals are:**

a) **Radioactive waste:** Which includes waste contaminated with radio-nuclides, it may be solid, liquid or gaseous waste. These are generated from in-vitro analysis of body fluids and tissues, in-vitro imaging and other therapeutic procedures.

b) **Pressurized waste:** Include compressed gas cylinders, aerosol cans and disposable compressed gas containers.

c) **General waste:** Includes general domestic type waste from offices, public areas, stores, catering areas, comprising of newspapers, letters, documents, cardboard containers, metal cans, floor sweepings and also includes kitchen waste.
d) **Recyclable waste:** Includes the following: Glass after cleaning and disinfection, paper, corrugated cardboard, aluminum, x-ray film, reclaimed silver from x-ray developing solution, plastics after disinfection and shredding.

### 5.3.2: Categorization of bio-medical wastes

Before conducting the research work in visualizing hospital management and administration, it is very important to understand various aspects of it. The previous section of this chapter has however introduced and illustrated about hospital management with respect to human resources. But however, one of the prime aspect of the research work is also related to the waste management. Hence it is important to analyze various classification /categorization of the bio-medical waste. Following table discusses about various categories along with waste type.

<table>
<thead>
<tr>
<th>Option</th>
<th>Waste category</th>
<th>Waste content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category No.1</td>
<td>Human anatomical</td>
<td>Human tissues, organs, body wastes parts</td>
</tr>
<tr>
<td>Category No.2</td>
<td>Animal wastes</td>
<td>Animal tissues, organs, body parts carcasses, bleeding parts, fluid, blood and experimental animals used in research, waste generated by veterinary hospitals, discharge from hospitals, animals houses</td>
</tr>
<tr>
<td>Category No.3</td>
<td>Microbiology and biotechnology waste</td>
<td>Waste from laboratory cultures, stocks or specimens of micro-organisms live or attenuated vaccines, human and animal cell culture used in research and infectious agents from research and</td>
</tr>
<tr>
<td>Category No. 4</td>
<td>Waste sharps</td>
<td>industrial laboratories, waste from production of biological, toxins, dishes and devices used for transfer of cultures</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Category No. 5</td>
<td>Discarded medicines</td>
<td>Waste comprising of outdated contaminated and discarded medicines</td>
</tr>
<tr>
<td>Category No. 6</td>
<td>Solid waste</td>
<td>Items contaminated with blood, and body fluids including cotton, dressings, solid linen, plaster casts, linen, beddings, other material contaminated with blood</td>
</tr>
<tr>
<td>Category No. 7</td>
<td>Solid waste</td>
<td>Wastes generated from disposable items other than the waste sharps such as tubings, catheters, intravenous sets etc.</td>
</tr>
<tr>
<td>Category No. 8</td>
<td>Liquid waste</td>
<td>Waste generated from laboratory and washing, cleaning, housekeeping and disinfecting activities</td>
</tr>
<tr>
<td>Category No. 9</td>
<td>Incineration ash</td>
<td>Ash from incineration of any bio-medical waste</td>
</tr>
<tr>
<td>Category No.10</td>
<td>Chemical waste</td>
<td>Chemicals used in production of biological, chemicals used in disinfection, as insecticides, etc.</td>
</tr>
</tbody>
</table>

5.3.3: Role of personnel involved in waste management

The following paragraph outlines the roles and responsibilities of the various personnel in confirmation to the Bio-Medical Waste Management (management and handling) Rules 1998:
The functions of hospital waste management committee are as follows:

1. To ensure the circulation of enough copies of bio-medical waste rules and guidelines for implementation of the same in clinical departments. The responsibilities of the individual professionals will be highlighted in these guidelines.

2. To conduct “Awareness Programme”, clinical combined/grand round will be held for making the faculty and the residents aware of the “Biomedical Waste (Management and Handling) Rules 1998”.

3. To conduct training programmes for medical professionals, nursing professionals and sanitation professionals.

4. To hold meeting of the hospital waste management committee and formulate the detailed plan of action in regard to segregation, collection, storage and transport of waste from all the patient care areas. To procure the items required in this regard and make them available in all patient care areas.

5. Each clinical department (Unit), lab services, blood bank, microbiology, pathology will make one faculty member responsible for supervision of segregation in their area of activities.

6. Floor wise one nursing sister (nursing supervisor) will be responsible for supervision of segregation in the wards of each floor. In each and every OT the same instruction of supervision will be followed and one sister incharge will be responsible.

Role of officer incharge of waste management

The officer incharge of waste management will be incharge of implementation and will liaise with the heads of departments, infection control officer and matron. He will be the member of the hospital waste management committee. He will be responsible for monitoring the programme from time to time at various levels i.e. generation, segregation, collection, storage,
transportation and treatment including disposal. He will be responsible for
circulation of all policy decisions and the hospital waste management manual.
He will be responsible for accident reporting in form III to the prescribed
authority.

Role of concerned heads/incharge of labs, units/depts.

They will be responsible for the formulation and implementation of waste
management procedures for their departments in conformity with the general
guidelines issued by administration. They will also be responsible for getting all
staff, doctors, nurses, paramedics and group-D staff, trained in hospital waste
management, and will liaise with the officer incharge of waste management for
administrative support. With regard to the departments which generate
radioactive waste one of the consultants should be designated as radiation
protection officer and he will be responsible for implementation of the
necessary guidelines.

Role of matron

The matron will designate one of the senior administrative level deputies
as sister incharge of hospital waste management, who will be responsible for
close monitoring of the activity. She will conduct surprise rounds and will
review and evaluate the various aspects of scientific hospital waste management
at all levels from generation and segregation to final disposal. She will also
attend the meetings of hospital waste management committee on behalf of the
matron and co-ordinate the training of nurses on hospital waste management
with administration.
Role of I/C sanitation inspector

The incharge sanitation inspector will be responsible for the implementation, monitoring and evaluation of hospital waste management from collection and storage of hospital waste to its final disposal. He will attend the hospital waste management committee meetings and will ensure the training of the staff posted under him. Regular in-service training and evaluation of the sanitation attendants will be carried out by him. He will also provides feedback information to officer incharge waste management in case of accidents and spills.

Training on hospital waste management

In order to be able to comprehend and implement the Bio-Medical Waste (Management and Handling) Rules’ 1998, it is mandatory to provide training to all categories of staff i.e. resident doctors, nurses, paramedical staff, hospital and sanitation attendants, patient and their attendants, canteen staff, operation of bio-medical waste treatment facilities. Before the training is carried out the training needs to be identified content varied accordingly. It should be interactive and should include awareness sessions, demonstrations and behavioral science inputs. It should definitely include the following:

- Awareness of different categories of waste and potential hazard
- Waste minimization, reduction in use of disposables
- Segregation policy
- Proper and safe handling of sharps
- Use of protective gear
- Colour coding of containers
- Appropriate treatment of waste
- Management of spills and accidents
- Occupational health.
5.4: CONCLUSION

This chapter introduces the brief description of hospital management with respect to human resource management. It also put the significance of it in healthcare sector. The second phase of the chapter discusses about patient satisfaction along with discussion on various factors that has an impact on patient satisfaction. Finally, this chapter discusses about hospital waste management system along with various illustration of types and categories of waste.