CARE HOSPITALS

DATE: 23.06.2026

To,
The Environmental Engineer Regional Office.
TGPCB Hyderabad.

Subject : - Annual Report Submission Year 2025 (Form - IV and Form I).

Dear Sir/Mam,

Please Find the enclosed annual report of bio medical waste management at CARE Hospitals, Road no 10, Banjara Hills, Hyderabad for the period of January 2025 to December 2025 in form IV and form I along with MOM.

Please acknowledge the same.

Thanking You,

With Regards,

QUALITY CARE INDIA LTD. Road No:1, Banjara Hills HYDERABAD

Mr Abhinav Joshi
HCOO
Care Hospitals Banjara Hills Rd no 10

TELANGANA POLLUTION CONTROL BOARD-REGIONAL OFFICE-HYDERABAD
Inward No.....
24 JUN 2026

CARE HOSPITAL
Banjara Hills: 6-3-248/2, Road No.1, Hyderabad - 500 034, Telangana, Tel:(B) 040-68159836 | (M): 040-68159835 | (P): 040-68159837
(R):040-68159831 | (F): 040-30418488
Banjara Hills - CARE Outpatient Centre: Road No.10, Hyderabad - 500 034. Telangana, Tel:(B) 040-39310617 | (M): 040-39310617 | (M): 040-39310612
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Form - IV (See rule 13)
ANNUAL REPORT

[To be submitted to the prescribed authority on or before 30th June every year for the period from Januaryto December of the preceding year, by the occupier of health care facility (HCF) or common bio-medical waste treatment facility (CBWTF)]

Sl. No.	**Particulars**		
1 .	Particulars of the Occupier	:	
	(i) Name of the authorised person (occupier or operator of facility)	:	Mr. Abhinav Joshi
	(ii) Name of HCF or CBMWTF	:	M/S CARE HOSPITAL (A Unit Of Quality Care India Ltd)
	(iii) Address for Correspondence	:	Care Hospitals Outpatient Centre, Babukhan Chambers, Road No. 10, Avenue, Banjara Hills, Hyderabad, Telangana – 500034.
	(iv) Address of Facility		Care Hospitals Outpatient Centre, Babukhan Chambers, Road No. 10, Avenue, Banjara Hills, Hyderabad, Telangana – 500034.
	(v)Tel. No, Fax. No	:	040-30418888
	(vi) E-mail ID	:	abhinav.joshi@carehospitals.com
	(vii) URL of Website		http://www.carehospitals.com
	(viii) GPS coordinates of HCF or CBMWTF		Latitude : 17.4143 N Longitude : 78.4465 E
	(ix) Ownership of HCF or CBMWTF	:	Private
	(x). Status of Authorisation under the Bio-Medical Waste (Management and Handling) Rules	:	Order No.: 326/HYD/ZOH/BMWA/2023-1918 valid up to : 31.05.2032.
	(xi). Status of Consents under Water Act and Air Act	:	Valid up to: 31.05.2032.
2.	Type of Health Care Facility	:	Allopathic Speciality Healthcare Facility.
	(i) Bedded Hospital	:	No. of Beds : 30
	(ii) Non-bedded hospital (Clinic or Blood Bank or Clinical Laboratory or Research Institute or Veterinary Hospital or any other)	:	NA
	(iii) License number and its date of expiry		Regd No . 07F-TSCEA-0701 Date Of Expiry :- 24.06.2029.

3.	Details of CBMWTF	:	
	(i) Number healthcare facilities covered by CBMWTF	:	NA
	(ii) No of beds covered by CBMWTF	:	NA
	(iii) Installed treatment and disposal capacity of CBMWTF:	:	NA
	(iv) Quantity of biomedical waste treated or disposed by CBMWTF	:	NA
4.	Quantity of waste generated or disposed in Kg per annum (on monthly average basis)	:	Yellow Category : 1008.30 Red Category : 1195.86 White : 35.66 Blue Category : 124.68 General Solid Waste : 1420.08
5	Details of the Storage, treatment, transportation, processing and Disposal Facility		
	(i) Details of the on-site storage facility	:	Size : 145 sq.ft Capacity : 100 Bags. Provision of on-site storage: (The Bio Medical Waste is Stored in a Designated Storage Room)
	disposal facilities		Type of treatment equipment / No of units / Capacity Kg/day / Quantity treated or disposed in kg per annum Incinerators Plasma Pyrolysis Autoclaves Microwave Hydroclave Shredder Needle tip cutter or Sharps encapsulation or Deep burial pits: NA Chemical disinfection: Any other treatment equipment: NA

	(iii) Quantity of recyclable wastes sold to authorized recyclers after treatment in kg per annum.	:	NA
	(iv) No of vehicles used for collection and transportation of biomedical waste	:	07
	(v) Details of incineration ash and ETP sludge generated and disposed during the treatment of wastes in Kg per annum		NA
	(vi) Name of the Common Bio-Medical Waste Treatment Facility Operator through which wastes are disposed of	:	GJ Multiclave (India) Pvt.Ltd. Sy No. 179&181, Edulapally (V), Nandigam, Shad Nagar Rangareddy, Telangana.
	(vii) List of member HCF not handed over bio-medical waste.		NA
6	Do you have bio-medical waste management committee? If yes, attach minutes of the meetings held during the reporting period		Yes, Bio Medical Waste Related Issue are Discussed in Hospital Infection Control Committee.
7	Details trainings conducted on BMW		
	(i) Number of trainings conducted on BMW Management.		12
	(ii) number of personnel trained		720
	(iii) Number of personnel trained at the time of induction		432
	(iv) number of personnel not undergone any training so far		NA
	(v) whether standard manual for training is available?		Yes
	(vi) any other information)		Nil
8	Details of the accident occurred during the year		1
	(i) Number of Accidents occurred		1
	(ii) Number of the persons affected		1
	(iii) Remedial Action taken (Please attach details if any)		NA
	(iv) Any Fatality occurred, details.		No

9.	Are you meeting the standards of air Pollution from the incinerator? How many times in last year could not met the standards?		NA
	Details of Continuous online emission monitoring systems installed		NA
10.	Liquid waste generated and treatment methods in place. How many timesyou have not met the standards in a year?		STP & ETP for Hospital Waste Water Treatment Available in HCF and Periodically its been tested and ensured that it is meeting the standards. We are meeting all the Standards all the time.
11	Is the disinfection method or sterilization meeting the log 4 standards? How many times you have not met the standards in a year?		Disinfection method is meeting the Log 4 Standard all the time.
12.	Any other relevant information	:	NA

Certified that the above report is for the period from **1st January 2025 till 31st December 2025.**

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QUALITY CARE INDIA LTD. Road No:1, Banjara Hills HYDERABAD

Name and Signature of the Head of the Institution.

Date: 24/06/2026
Place : Hyderabad.

FORM – I

[(See rule 4(o), 5(i) and 15 (2)]

ACCIDENT REPORTING

1. Date and time of accident : 22/10/2025

2. Type of Accident : NSI

3. Sequence of events leading to accident :

   1. Surgical procedure was in progress in OT-6.
   2. Scrub nurse was assisting during the surgery.
   3. Nurse was mopping blood from the incision site.
   4. During mopping, there was unintentional contact with a needle present in the surgical field.
   5. Scrub nurse sustained a needle stick injury.

4. Has the Authority been informed immediately : As the above 1 accidents are classified as minor incidents, they will be included in our annual report

5. The type of waste involved in accident : White

6. Assessment of the effects of the accidents on human health and the environment:
   Human Health:
   - The staff member received prompt medical attention, including post-exposure prophylaxis (PEP) as per hospital protocol.
   - All the staff member was already vaccinated against hepatitis B.

   Environmental Impact:
   - The incident did not result in any environmental contamination or harm.

   Overall, prompt medical attention, vaccination, and proper wound care minimized the risk of infection and ensured the staff member's safety.

7. Emergency measures taken :

   1. Immediate reporting of the incident to the supervisor and infection control team.
   2. Provision of first aid, including washing the affected area with soap and water.
   3. Administration of post-exposure prophylaxis (PEP) as per hospital protocol.
   4. Counseling and support provided to the staff member.

8. Steps taken to alleviate the effects of accidents :

   1. The staff member was sent for medical evaluation and follow-up.
   2. Sharps containers were checked to ensure they were securely closed and easily accessible.
   3. Additional training was provided to housekeeping staff on safe handling and disposal of sharps.
   4. The staff members received training on proper segregation and biomedical waste management to ensure a safe and healthy work environment.

9. Steps taken to prevent the recurrence of such an accident :
   1. Training Sessions: Regular training sessions have been conducted for all the staff on safe handling and disposal of sharps.
   2. Poster Demonstration: Posters have been displayed in strategic locations to

demonstrate proper procedures for handling sharps.

3. Demonstration Sessions: Hands-on demonstration sessions have been conducted to educate staff on proper techniques for handling and disposing of sharps.
4. Regular Audits: Regular audits have been conducted to ensure compliance with sharps handling and disposal policies.
5. Workshop on Safety: A workshop on safety has been organized to educate staff on best practices for preventing needle stick injuries.
6. Exhibition on Safety: An exhibition on safety has been organized to showcase best practices and innovative solutions for preventing needle stick injuries.

10. Does you facility has an Emergency Control policy?

Yes we have fire Safety Policy, Spill Management Policy, Needle stick Injury

Policy and Disaster Management Policy.

Date: 24/06/2026

Signature .....

QUALITY CARE INDIA LTD. Road No:1, Banjara Hills HYDERABAD

Place: HYD

Designation HOD

Incident Report

Incident Number : INC/2025/6,500

Incident date & time : 22-Oct-2025 01:20 am

Unit : COPC

Location of the incident : OT-6

Category : Adverse event

Sub-category : Needle stick injury

Incident description:

During surgery while mopping the blood on incision site scrub nurse had needle stick injury

Corrective Actions:

Immediately wash under running water 15 to 20 minutes. checked patient viral status and advised taken from microbiology doctor for further evaluation, checked his vaccination details. And also send his ANTI HBs titers. report came more than 250mlu/ml. staff has under gone gastroenterologist consultation.

Preventive Actions:

Briefing done by infection control nurse regarding NSI for all department staff. strengthening the NSI protocol. advised exposed staff to take training for remaining staff in the department.

Steps taken to prevent the recurrence of an accident - Needle stick injury reported in 2025

1. Training Sessions: Regular training sessions have been conducted for all the staff on safe handling and disposal of sharps. (Implementation of Biomedical waste trolleys for educations)

2. Poster Demonstration: Posters have been displayed in strategic locations to demonstrate proper procedures for handling sharps.

3. Demonstration Sessions: Hands-on demonstration sessions have been conducted to educate staff on proper techniques for handling and disposing of sharps.

4. Regular Audits: Regular audits have been conducted to ensure compliance with sharps handling and disposal policies.

5. Workshop on Safety: A workshop on safety has been organized to educate staff on best practices for preventing needle stick injuries.

6. Exhibition on Safety: An exhibition on safety has been organized to showcase best practices and innovative solutions for preventing needle stick injuries.

Minutes of the Meeting

CARE HOSPITALS BANJARAHILLS , HYDERABAD

Committee : **Hospital Infection Prevention Control Committee**	Date: 29th August 2025	Time: 3:30 PM	Venue: Auditorium	Ver no 2 Rev No 1 F/QUA/COM/005

Chairperson: Dr.K C Misra

Secretary: Ms Anitha K

Member Present: Dr Jhansi Vani, Dr Mamatha Reddy,Dr Satish Raju, Dr Abjhit , , Mr Mahesh, Mr Murali Mohan, Mr Narasiah, Mr Manjunath,Ms Sonal,

Member Absent: Dr. D Chandra Sekhar, Dr Rahul Agarwal, Dr Ather Pasha, Dr Kranti Shilpa, Dr Bhuwaneshwar Raju, Dr Venkatesh,,Dr Somita,,Ms Shobha Rani, Dr T Likhita

Invitees Present: - Mr Rajeev Chourey, All Inursing Incharges, Mr Sri Harsha.

Sr No	Agenda	Key Discussion among members	Actionable area	Assigned to	Timeline
I	**Previous Minutes of the Meeting**	1. The committee decided that the Infection Control Nurse posted at the Care Outpatient Department should be responsible for educating patients and their attendants on MDRO (Multi-Drug Resistant Organisms) guidelines. 2. It was agreed that certain areas require experienced and consistent staff to maintain infection control	1. Infection Control Nurse in COPC to be tasked with providing MDRO-related infection control guidance to all identified patients and their attendants. 2. Housekeeping experienced staff are not to be rotated frequently in critical care areas	ICN-COPC HK	**5 Days** **5 Days**

		standards.			
2	Lack of Man-Power	The Committee discussed the issue of reduced manpower in CSSD and emphasized the need to maintain proper cleanliness, hygiene standards and ensure timely packing of CSSD sets	Provide an increase in manpower	Housekeeping Department	5 days
3	Bio-Medical Waste Transportation	During the committee meeting it was discussed about the need to ensure a separate timing for transportation of biomedical waste as it is critical for environmental protection and public health	Create a scheduled timeline for biomedical waste transport	Housekeeping Department	5 days
4	Risk Assessment	Infection Control Risk Assessment and Pre-Construction Risk Assessment is being conducted without the approval of the Hospital Infection Prevention Control Committee	Conduct Infection Control Risk Assessment and Pre-Construction Risk Assessment along with the Hospital Infection Prevention Control Committee team.	Medical Administration	5 days
5	Terminal cleaning	An increase in training for housekeeping staff by the ICN can ensure that deep cleaning occurs in order to maintain the standards	Training has to be provided for housekeeping staff by the ICN to ensure deep cleaning occurs in order to maintain the standards	ICN	5 days
6	Test Reports	The test reports needs to be received by the microbiology department from the maintenance team	Test reports has to be provided to the microbiology department along with its frequency	Maintenance	5 days
7	Tegaderm	The committee had discussion on the structure of tegaderm	A mail has to be shared to the purchase team regarding tegaderm	ICN	5 days
8	Blood Cultures	The Chairperson recommended to to all the	Blood culture to be taken by the nursing team	ICN	5 days

Minutes of the Meeting

Committee: Hospital Infection Prevention Control Committee	CARE HOSPITALS BANJARAHILLS , HYDERABAD			
	Date: 29th August 2025	Time: 3:30 PM	Venue: Auditorium	Ver no: 2 Rev.No:1 F/QUA/COM/005

	members that blood cultures has to be withdrawn by the nursing team and training to be arranged for the nursing team on this	and training to be done		
Lack of Hooks	The Committee discussed the lack of hooks required for operating the curtains and highlighted the need for appropriate fixtures to ensure smooth functionality	The Maintenance Department is requested to install adequate curtain hooks in the identified areas to ensure smooth and functional usage	*Maintenance*	*5 days*
CSSD sets and linen transport not following protocols in trolleys.	1. Members observed that CSSD sterilized sets and soiled/clean linen are not being transported as per infection control protocols. 2. Non-compliance with dedicated, closed trolleys for sterile and unsterile items was noted. 3. Identified risk of cross-contamination due to improper handling. 4. Discussed need for regular staff training and reinforcement of SOPs.	CSSD In-charge to ensure sterilized sets are transported only in closed, disinfected trolleys. Linen In-charge to strictly separate soiled and clean linen with color-coded, closed trolleys. Biomedical/Support Services to provide sufficient number of trolleys for compliance. Nursing & Housekeeping Supervisors to monitor and report non-compliance. Infection Control Team to conduct surprise audits and feedback sessions.	*Hk hod/cssd team*	*7days*

		Training session to be scheduled for all staff handling CSSD and linen with in 1 week		

Member Secretary

Chairperson Committee

Copy to : Chairperson / Administrative Officer / Consultant Groups / Members / All HODs / Invitees - (Through Email/ official working group)

MINUTES OF THE MEETING

CARE HOSPITALS BANJARAHILLS , HYDERABAD

Committee : **Hospital Infection Control Committee**	Date : 17th January 2025	Time: 3 PM	Venue: Board Room	Ver no: 2 Rev.No:1 F/QUA/COM/005

Chairperson: Dr. Bhavani Prasad Secretary: Mrs Anitha K **Member Present:** Dr. Jhansi Vani, Dr Somita, Dr Gururaj, Ms Shobha Rani, Dr Ashish Mathur, Mr Lalith (Mr Anand), Mr Pritish Tripathy, Dr Likitha **Member Absent:** Dr Vikranth Reddy, Dr Chandra Sekhar, Dr Rahul Agarwal, Dr Aether Pasha, Dr Shilpa, Dr B Raju, Dr Venkatesh, Dr Satish, Mr Murali, Mr Narasaiah	**Invitees Present:** Mr Mahender, Mr Ravinder , Ms Swapna Rani, Mr Ratnam **Invitees absent:**

Sr No	Agenda	Key Discussion among members	Actionable area	Assigned to	Timeline
1	Biomedical waste and linen transportation	Members discussed the need to streamline biomedical waste and linen transportation to ensure timely and safe transfer as per IPC protocols. The feasibility of modifying CSSD trolleys was reviewed to improve ergonomics and infection control measures.	A dedicated schedule is to be established for regular and safe transportation.	HK HOD	
2	2. Allocation of scrub and fogging machines across departments	Members discussed the necessity of maintaining separate scrub and fogging machines for: Medical departments Surgical departments	Members also reaffirmed the urgency of scheduling deep cleaning for high-risk areas as previously identified.	HOD HK	

3	Water Culture Testing	Isolation rooms Need for routine water culture testing across hospital points.	Comprehensive schedule and designated locations to be Finalized.	Maintenance
4	Discussion on staffing-related concerns in critical areas	Emphasis was placed on ensuring infection prevention protocols are strictly followed in high-risk areas. Concerns were raised about the frequent rotation of trained staff in specialized units, potentially compromising infection control practices. It was agreed that certain areas require experienced and consistent staff to maintain infection control standards.	Departments including Cath Lab, GOT, CTOT, Medical ICUs, and Surgical ICUs must ensure experienced staff are not rotated frequently. These areas require trained personnel familiar with infection control protocols to maintain high standards of care. Additional buffer staff should be identified and kept on standby to cover leaves or emergencies, without disrupting core teams in sensitive areas.	HOD HK
5	Strengthening antibiotic escalation and de-escalation protocols	The committee discussed recent audits and observations highlighting noncompliance in high-end antibiotic usage documentation. Concerns were raised regarding inconsistent practices in filling antibiotic justification forms, particularly in relation to high-end and restricted antibiotics. It was noted that protocols for antibiotic escalation and de-escalation are not being followed consistently across departments. Members agreed on the urgent need to reinforce antimicrobial stewardship efforts.	Reinforce the mandatory completion of antibiotic justification forms. Monitor trends of noncompliance and report them to respective unit heads for corrective action. Re-educate clinicians and prescribing teams on the importance of timely antibiotic escalation based on culture sensitivity and appropriate de-escalation when indicated. Incorporate daily review of antibiotics as part of clinical rounds in ICUs and critical care areas.	MEDICAL SERVICES/CLINICAL PHARMACOLOGY

6	Review of Central Line Dressing Protocols	The committee reviewed current practices related to Central Line Dressing. Concerns were raised regarding consistency and adherence to protocol.	Members emphasized the importance of documentation and compliance monitoring to reduce the risk of catheter-related bloodstream infections (CRBSIs).	PURCHASE
7	Patient and Attendant Education on MDRO	The committee decided that the Infection Control Nurse posted at the Care Outpatient Department should be responsible for educating patients and their attendants on MDRO (Multi-Drug Resistant Organisms) guidelines.	Infection Control Nurse in Care OPD to be tasked with providing MDRO-related infection control guidance to all identified patients and their attendants.	COPC-ICN
8	Rational antibiotic usage and antimicrobial stewardship Compliance with high-end antibiotic policy	The committee discussed the need for improving antibiotic stewardship through better documentation and monitoring. It was recommended that the clinical pharmacologist should include the dose and duration of antibiotics in presentations (PPTs) to enhance clarity during clinical reviews and audits. The committee also emphasized that departments must fill high-end antibiotic usage forms to ensure compliance with hospital antibiotic policy.	Clinical Pharmacology Team to update all relevant presentations with clear mention of antibiotic dose and duration. All departments to strictly follow the protocol of filling the high-end antibiotic justification forms before administration. Infection Control and Clinical Pharmacology Teams to audit compliance and report findings in the next HICC meeting.	CLINICAL PHARMACOLOGY
9	Data reporting for vascular procedures	The committee suggested enhancing infection surveillance by including surgical case volumes in presentations.	Total vascular surgery case numbers to be regularly included in HICC presentation slides moving forward.	COPC-ICN

		Specifically, it was recommended that the total number of vascular-operated cases be clearly mentioned in the infection control PPT presentations to provide context for infection rates and outcomes.	Comparative analysis to be done between number of cases and infection/complication rates for better evaluation.	
10	Review of disinfection and sterilization practices in departments	It was identified that the CT OT department has been using Cidex (Glutaraldehyde) for disinfection purposes. Upon review, it was observed that Cidex is not currently recommended or approved for use in that area based on standard infection control guidelines. The committee acknowledged that alternative and necessary disinfection supplies need to be arranged and provided to ensure adherence to proper protocols. The need for regular checks and standardization of disinfectant usage across departments was emphasized.	Required and approved disinfectants to be supplied to CT OT based on their instrument reprocessing needs. Coordination with the CSSD and Procurement Team to ensure timely availability.	MEDICAL SERVICES/CT-OT INCHARGE
11	3. Identification of isolation rooms	Discussed the urgent need to identify designated isolation rooms on each floor/unit to accommodate patients with communicable diseases. Emphasis on ensuring these rooms have negative pressure capability (if required) and are clearly marked. Noted that some wards do not have clear protocols for isolation room designation.		MEDICAL SERVICES /OPERATION ROOMS

Member Secretary

Chairperson Committee

Copy to : Chairperson / Administrative Officer / Consultant Groups / Members / All HODs / Invitees - (Through Email/ official working group)