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Customer Complaint Policy

POLICY STATEMENT

Inverness Leisure aims to provide its customers, partners and suppliers (our stakeholders) with an excellent customer service. The Organisation will listen to the needs of our stakeholders and provide opportunities for feedback.

1. INTRODUCTION

Inverness Leisure wishes to put customer needs at the very heart of the way we develop and enhance our services. Customer feedback is part of our ongoing consultation process which we will use to learn and continuously improve our service.

We will promote the use of customer feedback via our comments system, customer surveys, mystery shoppers, social media, website and face-to-face interaction. Customer feedback will be analysed and viewed as an opportunity to assist in continuous improvement of our service.

The Inverness Leisure Mission Statement & Customer Promise document will underpin our service delivery in line with the values, aims and objectives of the company.

We will ensure that all our associates are trained and therefore competent in the delivery of excellent customer service and are fully aware of the relevant company policies and procedures. Associates will be encouraged to respond positively, be problem solvers and successfully resolve any issues as quickly as possible, and to refer on those which are more complex or remain unresolved.

2. REFERENCE DOCUMENTS

INTERNAL

Inverness Leisure Mission Statement & Customer Promise
Customer Comment Response Procedure FAA - 1075
Customer Comments Database (CFS)

EXTERNAL

SPSO Guidance on a Model Complaints Handling Procedure
Data Protection Act 1998
Personal Safety at Work H&S 2.29

3. WHAT IS A COMPLAINT?

An expression of dissatisfaction by one or more people about the standard of service provided by Inverness Leisure.

Safety Training Needs Assessment Form

Instructions: Please review each question and either check "YES" or "NO". If a question is checked "YES" you will be required to complete the training topic before initial assignment of job task. Please discuss with your supervisor and have him/her sign the form. Please review the EH&S website for registration information.

Safety Training Needs Assessment

Department:

Employee Name (Print):

Employee (Signature):

Supervisor Name:

Supervisor (Signature):

Date:

| Read and answer each question. If answer is yes, see middle column for training, right column for frequency of training. | Answer | Training | Required/Optinal, Frequency |
|--|---|---|---|
| Do you receive a paycheck from UNC Charlotte (regardless if you are a student worker or full/part time employee)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Departmental Safety Checklist & New Employee Orientation (NEO) • Supervisor safety hazard and safe operating procedure discussion. • Accident Prevention, Investigation and Reporting • Back Safety and Injury Prevention • Building Emergency Evacuation Plan • Fire Safety and Prevention • Slip, Trip, Falls | REQUIRED TRAINING: Initial REGISTRATION: Attend New Employee Orientation (NEO) sponsored by Human Resources Department or complete Skilport online module Duration: 2-4 hours |
| Do you operate scissor lifts, man lifts or other aerial elevating platforms? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aerial Lift Training | REQUIRED TRAINING: Periodic REGISTRATION: EH&S Duration: 2-4 hours |
| Are you an employee of the University? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Accident Reporting and Investigation | REQUIRED TRAINING: Periodic REGISTRATION: NEO or Skilport Duration: 1 hour |
| Do you work for maintenance, custodial, or facility operations AND disturb asbestos? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asbestos Awareness | REQUIRED TRAINING: Annual REGISTRATION: EH&S Duration: 1 hour |
| Does your work require you to lift heavy objects or repeatedly move or carry items throughout the day? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Safety and Injury Prevention | REQUIRED TRAINING: Periodic REGISTRATION: NEO or Skilport Duration: 1 hour |

PASSPORT APPLICATION FORM
Government of India, Ministry of External Affairs

Please read the Passport Information Booklet carefully before filling the form. Furnishing of incorrect information/omission of information would lead to rejection of application and would attract penalties as prescribed under the Passports Act, 1967. Please produce your original documents at the time of submission of the form. All fields marked with (*) are mandatory to fill.

Service Required
Applying for *

Type of Application * Normal Tatkaal
Type of Passport Booklet * 30 Pages 60 Pages
Validity Required (For minors between 15 and 18) 10 years Up to age 18 Not Applicable

Applicant Details
Applicant's Given Name (Given Name means First Name followed by middle Name (if any)) *
Surname
Are you known by any other names (aliases)? * Yes No
Have you ever changed your name? * Yes No
Date of Birth (DDMMYYYY) *
Place of Birth
Village or Town or City *
Country (If abroad)
State (If in India) District (If in India)
If born before 15/08/1947 in a place now in Pakistan or Bangladesh, select "Undivided India".
Gender * Marital Status * Citizenship of India by
PAN (if available) Voter ID (if available)
Employment Type *
Is either of your parent (in case of minor)/ spouse, a government servant? *
Educational Qualification * Are you eligible for Non-ECR category? *
Visible Distinguishing Mark
Family Details (You have to provide atleast one Father/Mother/Legal Guardian details)
Father's Given Name (Given Name means First Name followed by Middle Name (if any))
Surname
Legal Guardian's Given Name (if applicable)

Massage Therapy Services' Consent Form

THIS FORM MUST BE COMPLETED & SIGNED BEFORE RECEIVING A MASSAGE.

Have you ever experienced a professional massage? _____
Which areas would you like to focus on during this massage? _____
Do you have any of the following conditions? If yes, please explain below as clearly as possible.
____ Stress ____ Allergies ____ Osteoporosis/dense ____ Diabetes ____ Wear contact lenses ____ Back pain
____ Pregnancy ____ Cancer ____ Cardiac/circulatory problems ____ Asthma ____ Sensitive to touch or pressure
____ Recent head/neck ____ Discomfort ____ Epilepsy or seizures ____ Recently ____ Joint swelling
____ Venous stasis ____ Depression
____ Numbness or tingling/pain? Explain below: _____
____ High blood pressure. If yes, are you taking medication for this? Explain below: _____
____ Surgery in the past five years? Explain below: _____
____ Accident or suffered any injuries in the past 2 years? Broken bones, etc. Explain below: _____
____ Other medical conditions not listed. Explain below: _____
Comments: _____

I hereby request and consent to massage therapy. I have been informed about following: a description of treatment, which body areas will be worked on, the reasons why I should have treatment, the alternatives to having treatment, what the risks of it do not have treatment.

I understand that the massage therapist is provided for the basic purpose of relaxation and relief of muscular tension. If experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or motion may be adjusted to my level of comfort. Further, I understand that massage should not be considered a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and consented to all conditions listed. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist should I fail to do so. I understand that any third-party medical or legal advice made by me will result in complete termination of the session. I also understand that the Licensed Massage Therapist reserves the right to refuse to perform a massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Patient Signature: _____ Date: _____
THERAPIST'S SIGNATURE: _____ Date: _____

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| Blood Test Report | | | | |
|--|-----------------------|---|---------------------|---|
| | Fasting | Normal values | | Observation |
| Complete Blood Count (CBC) | Fasting not essential | | | |
| RBC (Erythrocytes) | No | M-4.5-6.4 F-4.0-5.4 | Mil. / c. mm | If less: anemia |
| Haemoglobin | No | M-14-18 F-12-16.4 | Gm / 100 ml | |
| PCV (RBC) | No | M-42-52 F-37-47 | % | |
| MCV (Mean corpuscular volume) | No | 78-94 | fl. Cu | Type of anemia |
| MCH | No | 27-32 | | |
| MCHC | No | 32-38 | Gms/dl % | |
| WBV (Leucocytes) | No | 4000- 11000 | Per c. mm | If less-susceptibility to infection If very high in Leuc- Leukemia |
| Differential WBC count | No | | % | |
| Neutrophils | | 60-75 | | If more-acute infection |
| Lymphocytes | | 20-30 | | If more-chronic infection |
| Monocytes | | 2-8 | | If more-T.B., Typhoid, urinary infection |
| Eosinophils | | 1-6 | | If more-allergy, cough, cold, asthma, and worms. |
| Basophils | | 0-1 | | Lead poisoning, Leukemia |
| Abnormal cells | | | | |
| Platelets | No | 150000- 450000 | Cu. Mm | If less-bleeding disorder, dengue, |
| Peripheral smear | No | | | |
| Morphology of: | | | | |
| RBC | No | Normochromic / Hypochromic / Anisocytosis | | |
| Observation | | Normal / Anaemia | Size of RBC differs | |
| WBC | No | | | |
| Blood Parasites | No | | | MP, Filaria |
| Reticulocytes | No | 0.5-1.5 / 0.2-2.2 | | If more-anemia |
| Color Index | No | 0.85-1.15 | | |
| In bacterial infection with fever, WBC count goes up. E.g. Tonsillitis, sinusitis, bronchitis, Pneumonia, appendicitis, urinary infection --- 12000-25000 WBC, In Typhoid & viral infection -- WBC may be normal. | | | | |

Coronary bypass graft fate and patient outcome: angiographic follow-up of 5,065 grafts related to survival and reoperation in 1,388 patients during 25 years. Patients were advised to exhale slowly if they could not maintain breath-holding throughout the examination. Although bypass graft occlusion was not routinely confirmed on catheter angiography, the rates of graft failure are concordant with the published literature [8]. Automated blood timing was performed using a threshold value of 150 H and a region of interest was placed over the ascending aorta. In an effort to evaluate the internal mammary arteries, the CABG CTA protocol extends more cephalic than a typical cardiac CTA examination. Nearly every coronary bypass patient has known ischemic heart disease. None of the internal mammary artery grafts occluded. Hypertension [3] examined patients who underwent a cardiac EBCT examination for calcium scoring or coronary angiography. Nevertheless, cardiac CTA has shown greater than 90% sensitivity and specificity for detection of graft occlusion using invasive angiography as a standard of reference [11-14]. In summary, cardiac CTA performed after CABG surgery is valuable to determine graft patency and also frequently detects clinically occult and potentially life-threatening abnormalities. AJR. A pitch of 0.2-0.3 was used with a scanner rotation time of 0.42 second. J Thorac Imaging. Therefore, the discovery of complicating conditions, such as intracardiac thrombi, myocardial perfusion deficits, and ventricular aneurysms, from significant coronary artery disease is not surprising. Five patients had two noncardiac findings (1.9%). A finding was judged potentially significant if a therapeutic intervention or radiologic follow-up was deemed advisable on the basis of the cardiac CTA. The patency of each graft was assessed. [PubMed] [Google Scholar]10. 7) were saphenous vein grafts. 1996;28:616-626. The second adrenal mass remained indeterminate on follow-up abdominal CT. [1] reported that 7.8% of patients undergoing coronary calcium scoring required additional workup for noncardiac disease. It has been proposed that subacute premature saphenous vein graft failures (i.e., the additional grafts that occluded after the early postoperative period) are due to neointimal hyperplasia, which predominately affects venous but not arterial grafts [9, 10]. This study has important clinical ramifications. Pulmonary hypertension was designated if the main pulmonary artery diameter was greater than 3.1 cm. The scanning protocol included collimation of 0.75 mm x 16 with section thickness of 1 mm. All images were reconstructed with a small field of view centered on the heart. In the immediate postoperative period, 259 patients (mean age, 63.7 years; age range, 37-89 years; 73.4% men, 26.6% women) underwent a routine contrast-enhanced cardiac CTA examination. 2006;27:976-980. For each patient, retrospective ECG-gated images were obtained through the entire chest during a single breath-hold beginning at the inferior margin of the heart and extending to the top of the lung apices (Fig. The purpose of our study was to retrospectively assess the prevalence of unsuspected disease identified on cardiac CTA examinations after CABG and to determine their potential clinical significance. CTA was performed postoperatively in 259 patients (mean, 5.2 days), and 40 patients underwent a follow-up CT scan (mean, 12.7 months). Common and expected postsurgical findings (e.g., small pleural or pericardial effusions, pneumomediastinum, mild pulmonary edema, etc.) were not included. Iodinated contrast material (120-150 mL) was injected through an 18- to 20-gauge angiocatheter into an antecubital vein at 3-4 mL/s. Four patients (10.0%) had at least one graft occlusion. Cardiac CTA after CABG revealed a high prevalence of unsuspected cardiac and noncardiac findings with potential clinical significance. The grafts were graded as occluded or nonoccluded. In each patient, a phase obtained at 75% of the R-R interval was reconstructed and used for primary analysis. [PubMed] [Google Scholar]13. Three patients had two cardiac findings (1.2%). The most common cardiac findings were a moderate or large pericardial effusion (Fig. Noncardiac was classified as pulmonary, mediastinal, pleural, or involving the upper abdomen. 1995;26:38-43. Several issues may account for this discrepancy. Wider field of view images (x, y direction) were not reconstructed from the raw data. Each examination was interpreted at the time of scanning by a thoracic radiologist. 2005;184(American Roentgen Ray Society 105th Annual Meeting Abstract Book suppl):3. Motwani JG, Topol EJ. Initial experience with 64-slice cardiac CT: non-invasive visualization of coronary artery bypass grafts. 2 and 8), intracardiac thrombi (Figs. For accurate image acquisition, sinus rhythm was required, with a mean heart rate less than 100 beats per minute. Average scanning time was 30-40 seconds. [PubMed] [Google Scholar]2. [5] and Onuma et al. The prevalence of graft disease and incidental findings (cardiac and noncardiac) was established. Because our patient population recently had undergone major cardiovascular surgery and have known ischemic heart disease, we cannot generalize these findings for outpatients or patients with suspected coronary artery disease. One consideration is that the patient cohort in our study is presumably a higher risk group than the majority of patients who undergo cardiac CTA as outpatients. Therefore, determining if a therapeutic intervention or specialty consult was ultimately performed or planned on the basis of the imaging interpretation alone was sometimes difficult. Pache G, Saueressig U, Frydrychowicz A, et al. Bias was introduced because of the retrospective design of the study. Most studies, including this one, define "significant" or "potentially significant" if imaging follow-up or a therapeutic intervention was advised. Moore RK, Sampson C, MacDonald S, Moynihan C, Groves D, Chester MR. Am Heart J. These findings included a new left subclavian artery thrombus, pulmonary edema, apical left ventricular perfusion defect, moderate pericardial effusion, new central venous obstruction, and moderate-sized pleural effusion. 2005;150:775-781. In a later study, Schragin et al. In addition, previous incidental MDCT cardiac CTA studies have focused on patients suspected of having coronary artery disease. Eur Heart J. [PubMed] [Google Scholar] All seven patients were treated conservatively. With respect to bypass graft assessment, one or more bypass grafts were occluded in 17 patients (6.6%) in the immediate postoperative period and in four patients (10.0%) in the late postoperative period. One patient had two saphenous vein grafts occlude in the immediate period. On average, examinations were performed on postoperative day 5.2 (range, 1-38). Cardiac CT angiography (CTA) examinations are typically acquired with a small field of view focused on the heart, but portions of the lungs, pleura, chest wall, mediastinum, thoracic skeleton, and upper abdomen are often included as part of the examination. [PubMed] [Google Scholar]9. Bypass graft occlusions were analyzed separately. In the immediate postoperative period, 51 patients (19.7%) had at least one unsuspected, potentially significant finding. The remaining 26 patients (10.0%) were lost to follow-up or did not have further intervention to our best knowledge. An institutional review board exemption was granted for this study, and the study was performed in compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations. CT angiography was acquired using a 16-MDCT scanner (MX8000 IDT, Philips Medical Systems). We retrospectively evaluated the frequency of unsuspected cardiac and noncardiac disease in patients who underwent cardiac CTA for routine assessment of coronary artery bypass graft (CABG) patency. Patients who receive CABG at the University of Maryland Medical Center often undergo cardiac CTA to assess for graft patency as part of their routine postoperative care. Dobrin PB. Clin Radiol. Circulation. Several studies have assessed the frequency of incidental findings in the context of various types of cardiac-focused CT examinations [1-7]. A modest body of literature has been published concerning incidental findings on unenhanced EBCT scans obtained for coronary calcium scoring [1-3]. This may explain the lower rate of abnormalities with potential clinical impact detected in the EBCT studies. The prevalence of incidental findings was found to be higher with the use of IV contrast. Axial CT image shows anterior ventricular pseudoaneurysm (white arrow) and large hemopericardium (open arrow). Patel S, Woodrow A, Bogot N, et al. However, limited information exists regarding the prevalence of clinically significant incidental unsuspected findings in patients undergoing CTA [3-7]. In the later postoperative period, seven patients (17.5%) had a potentially significant unsuspected finding. A moderate or large pericardial effusion was denoted by fluid completely encircling the heart. Graft abnormalities were analyzed separately. Hunold P, Schmermund A, Seibel RM, Gronemeyer DH, Erbel R. Nearly all graft failures involved saphenous vein grafts and none occurred with internal mammary grafts. A fourth patient is scheduled for CT follow-up. Onuma Y, Tanube K, Hatori M, et al. Patients who underwent scanning for nonroutinely cardiopulmonary disease were excluded. 2006;48:402-406. These studies differ from the current study in that they were performed with relatively thick sections (3 mm) and without the use of IV contrast material, precluding evaluation of cardiovascular and mediastinal structures. 3 and 4) (six patients, 2.3%), and substantial paracardiac or mediastinal hemorrhage (six patients, 2.3%). Cardiac disease was documented if the abnormality was paracardiac, pericardial, or within the heart itself. Bypass graft patency is a common indication for cardiac CTA, particularly among patients with recurrent symptoms after CABG. [4] showed that 4.8% of patients undergoing cardiac CTA with a small field of view had a major noncardiac finding and 19.9% of patients had a minor noncardiac finding. 6). Haller S, Kaiser C, Buser P, Bongartz G, Bremerich J, Fitzgibbon GM, Kafka

