Standard Operating Procedures (SOPs) for (JDW/NRH)

Quality Assurance and Standardization Division (QASD)

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This publication contains the collective view of stakeholders from different clinical background.

Edited and compiled by:

1. Mr. Dechen Choiphel, Offt'ng Program Director, QASD
2. Mr. Kinley Wangchuck, APO, QASD
3. Mr. Thinley Namgay K, APO, QASD

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The Hippocratic Oath (Modern Version)

"I swear to fulfil, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of over treatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sounds of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help."

"The Hippocratic Oath: Modern Version" *Doctors' Diaries*. NOVA. Retrieved 2010-02-08.

FOREWORD

As Bhutan is witnessing a significant change in terms of development in the current era of Globalization, the Ministry of Health is now shifting its focus from mere provision of universal access of primary health care to quality of service. Ensuring quality services has become one of the most essential components in the health care system. However, lack of health care standards in terms of input, process and outcome standards have made quality assurance a difficult task. Nevertheless, with the gradual effort on the part of the Ministry of Health, few standards have already been developed and are used throughout the nation. These standards, aming towards achievement of international standards are the ministries initial step towards quality evolution whether for accreditation, certification or grading.

This standard Operating procedure (SOP) for JDWNRH is intended to describe and address various important areas like admission procedure, on call process of the doctors, interdepartmental consultation, patient discharge process and verity of other areas which was so far solely based on verbal instruction in the workplace by the seniors which very often led to mishaps and other associate problems. This SOP, though not comprehensive, would serve as a guidebook for newly recruited health staff as well as a reference book for existing health professionals in JDWNRH while delivering health care services.

It is with this hope that this Standard Operating Procedure for JDWNRH has been developed. Therefore, I would urge all the stakeholders of JDWNRH to follow the SOP consistently so as to provide basic standard of quality services.

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- ✓ Dr. Pandup Tshering — Medical Superintendent, JDW/NRH
- ✓ Mr. Lungten Jamtsho — Chief Administrative Officer, JDW/NRH
- ✓ Dr. K.P Tshering — Paediatrician, JDW/NRH
- ✓ Dr. Kunzang Getshen — Ophthalmologist, JDW/NRH
- ✓ Dr. Tenzin Norzang — ENT Specialist, JDW/NRH
- ✓ Dr. Lotey Tshering — Surgical Specialist cum Urologist, JDW/NRH
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- ✓ Dr. Tashi Tenzin — Surgical Specialist cum Neurologist, JDW/NRH
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- ✓ Dr. Pema Rinzin — Dermatologist, JDW/NRH
- ✓ Dr. Gosa Pemba — Anaesthesiologist, JDW/NRH
- ✓ Dr. Chencho Dorji — Psychiatrist, JDW/NRH
- ✓ Ms. Tandin Pem — Nursing Superintendent, JDW/NRH
- ✓ Ms. Chimi Lhamu — Deputy Nursing Superintendent, JDW/NRH
- ✓ Mr. Passang Dorji — Chief Nurse, Casualty, JDW/NRH
- ✓ Mr. Tashi Norbu — Chief Nurse, Psychiatric Ward, JDW/NRH
- ✓ Mr. Pema Dorji — Chief Nurse, ICU, JDW/NRH
- ✓ Mr. Kanti Ram — Chief Nurse, ENT Ward, JDW/NRH
- ✓ Mr. Tshering — Nurse Anaesthetist, JDW/NRH
- ✓ Mr. Tshering Tobgay — Chief Nurse, Cabin, JDW/NRH
- ✓ Mr. Tshering Wangchuk — Staff Nurse, OT, JDW/NRH

✓	Ms. Meena Kumari Gurung	Staff Nurse, Paediatric Ward, JDW/NRH
✓	Ms. Dechen Om	Chief Nurse, NICU, JDW/NRH
✓	Ms. Jamphel Yangzom	Staff Nurse, OT, JDW/NRH
✓	Ms. Wang Chhozom	Chief Nurse, Orthopaedic Ward, JDW/NRH
✓	Ms. Geeta Giri	Chief Nurse, Gyne & Obs. Ward, JDW/NRH
✓	Ms. Yangden	Chief Nurse, Labour Ward, JDW/NRH
✓	Ms. Champa Kumari Rai	Chief Nurse, Medical Ward, JDW/NRH
✓	Ms. Sabitri Sunwar	Chief Nurse, Dialysis Unit, JDW/NRH
✓	Ms. Jasoda Mongar	Chief Nurse, CSSD, JDW/NRH
✓	Ms. Tshering Dema	Asst. Nurse, Endoscopy Unit
✓	Ms. Madhu Ghalley	Staff Nurse, Surgical Ward, JDW/NRH
✓	Mr. Dechen Choiphel	Offt'ng Program Director, QASD
✓	Mr. Kinley Wangchuk	Assistant Program Officer, QASD
✓	Mr. Thinley Namgay K	Assistant Program Officer, QASD

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Acronyms

ABCD	*Airway, Breathing, Circulation, Drug*
ABG	*Arterial Blood Gas*
AFI	*Amniotic Fluid index*
ALLS	*Advance Cardiac Life Support*
APH	*Ante Partum Hemorrhage*
B2O	*HIV Positive*
BES	*Bio-medical Engineering Services*
CBC	*Complete Blood Count*
CD	*Coltrolled Drug*
CMS	*Central Medical Store*
CPD	*Cephalo Pelvic Disproportion*
CPR	*Cardiopulmonary Resuscitation*
CS	*Caesarean Section*
CSSD	*Central Sterile Supply Department*
CT	*Computed Tomography*
MIR	*Magnetic resonance and imaging*
CTG	*Cardiotocograph*
DIE	*Disseminated Intravascular Coagulation*
DPM	*Drop per minute*
ECHO	*Echocardiogram*
ERCP	*Endoscopic retrogrsdechaligiopancretography*
ETCO2	*End Tidal Carbon dioxide*
ETT	*Endo Tracheal Tube*
GCS	*Glasgow Coma Scale*

HD	*Haemodialyisis*
HELLP	*Hemolytic anemia Elevated Liver Transminase, Low Platelets*
ICD	*International Code of Disease*
IJV	*Intra Jugular Venous*
IM	*Intra Muscular*
IUFD	*Intra Uterine Fetal Death*
IUGR	*Intra Uterine growth retardation*
IV	*Intra Venous*
IVF	*Invitro Fertilizer*
LFT	*Liver Function Tesat*
LSCS	*Lower Segment Caesarean Section*
NG	*Nasogastric*
NIBP	*Non Invasive blood pressure*
NICU	*Neonatal Intensive Care Unit*
NPO	*Nil Per Orally*
OR	*Operation Room*
PAC	*Pre-Anaesthetist Check-up*
PEA	*Pulseless Electrical Activity*
PIH	*Pregnancy Induced Hypertension*
POP	*Plaster of Paris*
PPE	*Personal Protective Equipment*
PPH	*Post Partum Haemorrhage*
PRN	*As and when required*
PROM	*Premature Rupture of Membrane*
Q2H	*Two Hourly*
Q4H	*Four Hourly*

OD	*Once a Day*
RBS	*Random Blood Sugar*
RFT	*Rental Function Test*
RHU	*Regional Health Unit*
RTA	*Road Traffic accident*
SSD	*Sterile Supply Department*
TL	*Tubal Ligation*
TPN	*Total Parent Nutrition*
VIP	*Very Important Person*

Introduction

Standard Operating Procedures (SOPs) is a written set of instruction that someone should follow to complete a job safely, with no adverse effect on personal health or the environment, and in a way that maximizes operational and production efficiency. As per Donabedian, standards are professionally developed expression of the range of acceptable variation of a norm or creation. Studies have shown that standards have significant potential to enable provider organization to improve quality without increasing cost. SOPs have been found to be of immense use in proper working, training of personnel and favourable outcomes. Thus SOPs are essential pre-requisites for any quality initiatives.

With the increasing awareness amongst general population, JDWNRH being the apex hospital of the nation is constantly scrutinized for not meeting the demands of the people. Though new buildings and equipments have been funded for by the government, lack of written standards makes the operation of the hospital unmanageable either with the patients or amongst health workers. Therefore, understanding the pressing need of the hospital, this SOP for JDWNRH has been specially developed in consultations with the relevant stakeholders. It has been specifically designed to address the pressing needs and issues which impediments the smooth functioning of the hospital system. Priority areas like admission procedure, discharge procedure, interdepartmental consultation and many more which so far have never been written down, have been discussed in detail. This SOP would:

1. Serve as an orientation document for new recruits and transferred cases to JDWNRH.
2. Provide employees with operational information necessary to perform a job properly.
3. Act as a clinical guideline.
4. Help in reduction in variations of practices and offers continuous quality improvement initiatives in place.
5. Specify job steps that help standardize services and therefore quality.

Though this SOP is not comprehensive, it is a small effort on the part of the division to ensure that continuous quality improvement (CQI) is in place. As phrased 'a journey of a thousand miles begins with a step', the division hopes that with this initial initiative, the division would gradually bring about some new innovations and quality improvement measures which would in the long run lead to grading, certification or accreditation of health services and facility.

CHAPTER 1 : ADMISSION

- Doctor admitting the patient should check for availability of bed in the ward before admitting any patient.
- Greet the patient and party/attendants.
- Explain to the patient the reason for his/her admission.
- Fill in the admission form and the indoor register. Always ask for old registration number. And if not, send for new one.
- Include the patient's surname wherever necessary.
- Maintain the correct permanent and current address of the patient.
- Obtain the address of Gup/village leader for patients who do not have anybody to look after.
- Assess patient's condition for immediate care plan.
- Check patient's file to ensure that the orders are carried out completely.
- Follow up investigation(s) sent from transferring unit (if it is a transferred patient).
- Read out or explain the hospital rules and regulation to the patient and attendants and get informed consent.
- In times of emergencies, no time should be wasted in such procedures rather the patient should be attended to and managed immediately.
- Orientation to patients and their attendants about ward, toilet and visiting time and meal time.
- Handover the visitor's card (two cards) and attendants' card (one card).
- Introduce the patient to other patients.
- Hand over the bed linens to the patients (as far as possible try to avoid patient's home linens).
- Check and record vital signs.
- Read the Patient's case sheet thoroughly.

- Ensure **YELLOW** alert sticker is placed on all documentation for patients with similar names.
- Place the Patients identification wrist band.
- Carry out all doctor's order.
- Inform the patient and party not to keep any valuables in the hospital. The hospital and staff will not be responsible for loss.
- Place relevant forms in the respective places
  - ✓ TPR sheet, I/O charts Nurses note and relevant chart at the bedside.
- Explain in case patient needs to remain fasting overnight or any other issues.

1.1 ADMISSION PROCEDURE SPECIFICS TO DIFFERENT UNITS

1.1.1 INTENSIVE CARE UNIT

- Admit those patients who require ventilator support.
- All patients with impending respiratory failure or needing ventilator support.
- Patients with unstable cardio-respiratory status requiring continuous monitoring.
- Patients with severe septicaemia and multi-organ failure.
- Patients with DIC (disseminated intravascular coagulation) and thromboembolism.
- Patients with diabetic ketoacidosis
- Patients with severe PIH (pregnancy induced hypertension), HELLP syndrome and ecclampsia.
- Post-operative cases on advice of anaesthesiologist and the surgeon.
- All head injuries with Glasgow Coma Scale less than 8.

Receiving Patient to Unit

- The patient should be brought to ICU accompanied by staff from all wards and Emergency Department. However if the patient is taken to OR from ED, ICU staff should collect the patient otherwise respective ward to collect from OR and handover to ICU.

1.1.2 PEDIATRIC DEPARTMENT

Neonatal Intensive care unit indications:

- All patients with impending respiratory failure or needing ventilator support.
- Patients with unstable cardio-respiratory status requiring continuous monitoring.
- Patients with severe septicaemia and multi-organ failure.
- Post-operative cases on advice of anaesthesiologist and the surgeon.
- All head injuries.

1.1.3 GYNE OBSTETRICS WARD

- Patients coming for admission to the Gyne & Obs. ward should either come from Birthing Centre, Emergency Department or OPD. No one should come without routing through these paths. RHU of JDW and Satellite Clinics should not admit patients, but refer to the doctors in OPD/on call/Casualty.
- All labor patients who are in active phase of labor should be sent to labor room for admission.
- All the nurses working in the labor room should be always prepared to receive and manage any obstetric emergencies. They should also be friendly and make an effort to make birthing a joyful and pleasant experience.

1.1.4 HISTORY TAKING

- Complete the maternity history sheet for those in active labor.
- If the patient is in pain/mentally retarded/unconscious and not able to respond, collect the information from the attendant.
- Examine the patient records and other documents.
- Explain and maintain privacy during all procedures.
- Check the vital signs, abdominal examination, vaginal examination and CTG and record the findings.
- Any abnormality in the above findings should be notified to the doctor on call.
- All primigravidas in active phase of labor and all mutiparas with good contractions should be sent to Birthing Centre after informing staff there.
- Communicate all the findings/diagnosis to the patient party and explain what it means.
- All investigations that are ordered should be carried out and collect the reports after 2-4 hours and filed it properly. Communicate the reports to doctor on call if abnormal.

1.1.5 DIALYSIS UNIT

- All admission of patient for haemodialysis should be done by medical doctor.
- In OPD case, patient should come for HD date and in case of inpatient, the ward should inform.
- Enter in dialysis register, make appointment and call patients accordingly.
- All cases should be entered in admission register for record.

1.1.6 EMERGENCY DEPARTMENT

- All patients presenting at the ED should be registered at the reception except those who are critically ill. Those cases will be registered inside the resuscitation room.

- The OPD patients requiring admission to the ward should not be routed through ED.

1.1.7 DEPARTMENT OF OPHTHALMOLOGY

- All non-emergency ophthalmologic cases needing admission to the eye ward should be done from the eye OPD on any working days.
- The treating ophthalmologist will be responsible for making all the admission notes. Proper admission protocol should be followed as per the hospital norm.

1.1.8 PSYCHIATRY DEPARTMENT

- Admission of patient should be done at the discretion of or in consultation with the psychiatrist and on availability of bed. No patients should be accepted in the ward without the knowledge of psychiatrist or without prescription.
- All admission should be routed through the Psychiatry OPD during normal hours and through ED during off hours.
- ED should ensure that psychiatrists are consulted prior to admission of any psychiatric or drugs and alcohol dependent patients.
- Psychiatrists or medical officers must write admission notes on the history sheet clearly before admission.
- Upon arrival of the patient in the ward, nurse(s) on duty should duly fill up all the necessary forms.
- Admitting nurse should do a detailed psychosocial assessment of the case and make a written note as per guideline (appendix 4).
- Admitting nurse shall explain the ward rules and regulations and take informed consent from the patient and their relative as per the protocol (appendix 2).
- Admitting nurse should carry out spot checking of the patient's and attendant's belongings for possession of weapon such as knife, blades, razors, drugs, alcohol and of any valuable items. If these items are found,

they shall be confiscated, sent back home or kept in safe custody and returned only on patients discharge.

- Patients who are intoxicated either with drugs or alcohol should not be admitted.

1.2 CABIN ADMISSION PROCEDURE

- The patients seeking admission in cabin are on payment basis in accordance to the room they opt for.
- At present the cabin charges are as follows:
  - ❖ Single room- Nu. 1200/night
  - ❖ Single standard room- Nu. 1400/night
  - ❖ Deluxe room- Nu. 2000/night
- The patient's attendant should get cabin allotment and admission card issued from the office of administration and finance. Patients and attendants seeking admission after office hours, weekends and government holidays should get admission and allotment cards on the next working day.
- Patients and attendants should deposit Nu. 5000 as security deposit. This deposit will be deducted in the final payment on discharge.
- Staff should inform the accounts to collect cabin charges during government holidays and weekends.
- Patient and attendant should pay cabin fee at the end of every week.

1.3 HOME DIET FOR INDOOR PATIENTS

- Home diet should be allowed for the patient with consultation and permission from the dietician.

1.4 MEDICATION

- Medication should be done by the registered nurses (If the RIHS student does it, it should be done under supervision).

- Pre-operative care and post-operative care should be followed as per the Nursing procedure manual.
- I.V Canula Insertion, I.V Injection, and I.V fluid should be done by registered nurses, following aseptic technique.

The following equipments and drugs should be kept ready and fully functional in all the wards:

- Oxygen
- Suction machine
- Resuscitation tray and emergency drugs
- Pulse Oxymeter etc

1.5 PROTOCOL FOR MANAGING LONG STAY PATIENTS (more than one month)

- Ward clinical staff have to ensure that as far as possible, arrangement should be made so that patients are admitted, treated and discharged within one month duration so that hospital resources can be saved and the bed is made available to another patient. Patient staying/admitted for more than one month duration should be notified to the hospital administration for their action.

1.6 CROWD CONTROL IN THE WARD

- Call G4S and help them to control the visitors.
- G4S should be responsible for the security of the ward. In case of any disturbance in the ward by any unauthorized person, G4S should be informed.
- Check for visitor's card.
- Ensure there are only three people beside patient during visiting hours and one attendant during other times.
- Seize the cards if there is misuse.

1.7 CONTROL OF DRUNK ATTENDANT

- Call G4S/Personal Relation Officer any time.
- Reassure the patient.
- Observe if he/she is damaging any of the hospital equipments.

CHAPTER 2 : CONSENT PROCEDURE

- Informed consent regarding various treatment procedures should be obtained from the patient/party by the treating physician.
- The doctor should explain the details of the procedures to the patient.
- For children below the age of 18 years, informed consent should be obtained from their parents or guardians.
- If the patient condition is serious, like in profound shock, ecclampsia etc., high risk consent must be taken.
- If there is no one to give consent or the patient is unconscious/ unable to give consent, the doctor and the nurse should take a collective decision in the best interest of the patient after informing the hospital administration.
- OT staff must check the consent form on receiving the patient and also before starting surgery (refer surgical safety checklist list)

2.1 CONSENT PROCEDURE SPECIFICS TO DIFFERENT UNITS

2.1.1 DIALYSIS UNIT

- Inform concern ward to take consent before sending patient for dialysis.
- Before taking consent and starting procedure explain to patient/party about procedure [making subclavin and IJV (Intra Jugular Venous) access].

CHAPTER 3 : ON CALL PROCESS

- Prepare duty roster monthly and appoint 2 staff for on call.
- Duty roster should be distributed in the ward, OT, ED, Labor Room, PABX, cabin etc.
- On call information board should be maintained strictly on daily basis. On call physicians should start their morning round in the ED if there are patients due for consultation.
- Concerned specialist on call should be consulted over phone depending upon the triage level. If necessary the specialist should be called to attend the case in person.
- If on call doctor, is too busy, next on call doctor should be informed. This should preferably be done by doctors not by nurses.
- If there are acute emergencies like severe and intractable PPH (Post Partum Haemorrhage), next doctor on call should help. Second opinion must be taken before resorting to hysterectomy.

3.1 ON CALL PROCESS SPECIFICS TO DIFFERENT UNITS

3.1.1 EMERGENCY DEPARTMENT

- Concerned specialist on call should be consulted over phone depending upon the triage level. If necessary the specialist will be called to attend the case in person.
- On call information board should be maintained strictly on daily basis.
- On call physicians should start their morning round in the ED if there are patients due for consultation.

3.1.2 INTENSIVE CARE UNIT (ICU)

- Nurse on duty should inform concerned specialist if there is change in the condition and other parameters (low BP, decreased urine output, deranged blood reports, etc) of the patient.
- If SpO2 falls and or the level of consciousness worsen (GCS less than 8) or if patient suffers from cardiac arrest, anaesthesiologists should be consulted.
- Record in the nurses note with time and date.

CHAPTER 4 : PATIENT TRANSFER PROCEDUR (INTER DEPARTMENTAL TRANSFER)

- Transferring unit should inform the recipient ward before sending the patient.
- Treating physician should mention which ward the patient should be transferred to.
- Ensure the patient condition is fully stabilized while transferring to ward.
- Handing taking of patient should be done by nursing staff.
- Complete patient documents should be handed over.

4.1 PATIENT TRANSFER PROCEDURE SPECIFICS TO DIFFERENT UNITS

4.1. DEPARTMENT OF ANESTHESIA

Receiving patient from ward to the pre-operative room

- Ensure that the patient is wearing on only the gown and that the patient's nails are free from nail polish.
- Check name, age and the type of operation to be done.
- Check if informed consent is properly signed.
- Inquire if patient has taken any food or drink orally within the last 6 hours.
- Check if blood is ready in blood bank, if it is ordered.

4.1.1 GYNE OBSTETRICS WARD

4.1.1.1 Ward to Birthing Centre:

- All those in active labor (primigravida with > 4 cm dilatation and multipara with active contractions) should be transferred to Birthing Centre.
- Those induced for missed abortion/IUFD (Intra Uterine Fetal Death) should be transferred when Os is open if no heavy bleeding. If bleeding is heavy, she should be managed in OT.

- First, staff in Birthing Centre should be informed about patient status. Any particular information regarding the patient should be communicated before spare hand.
- Patient should be sent in wheel chair/trolley with staff or ward boy. Ensure her file is also taken.

4.1.1.2 Birthing Centre to Ward:

- Those with false labor, premature PROM (Premature Rupture of Membrane), threatened preterm labor and those in latent phase should be transferred to ward.
- Those patients that undergo emergency LSCS should be transferred to ward post-operatively. As soon as decision to do emergency CS (Caesarean Section) is taken the ward should be informed.
- All postpartum patients with PIH, PPH needing evacuation or blood transfusion (except acute ones), and those with medical problems should be transferred to ward.
- Mothers whose babies have feeding problems should be transferred either to Neonatal or Maternity ward depending on baby's condition.
- All those that came to Birthing Centre from ward should be transferred back after 2 hours of delivery.

4.1.1.3 Birthing Centre to Neonatal Ward:

- When there is fatal distress or preterm labor, birth asphyxia or suspected congenital malformations, inform Paediatrician on call.
- This information should be first given to doctor on call and he/she must decide if the Paediatrician needs to be informed or not.
- Those babies with feeding difficulties also may be transferred to Neonatal ward, depending upon the decision of the Paediatrician on call.
- Inform NICU staff so that they are prepared to receive the baby.
- While transferring baby, transfer forms should be duly filled and baby must be transferred in Incubator escorted by staff.

4.1.1.4 Gyne & obs. Ward to Neonatal Ward:

- When births of preterm or sick babies are anticipated/ planned, NICU should be informed so that there is place for the baby, especially when ventilation may be needed. Information should be given by the caring Obstetrician to the Paediatrician/Paediatric Surgeon.
- When babies are found to be sick at birth in OT, Paediatrician should be called, and he/she decides where to transfer the baby. Babies must be transferred in incubator. OT should keep one transporting incubator for such situations.
- When babies develop feeding difficulty, fever or jaundice, Paediatrician should be informed and decide whether to transfer the baby or not.
- When babies are transferred to Neonatal ward, form must be filled and baby escorted by a staff.

4.1.1.5 Emergency Department to Gynaecology Ward and Birthing Centre:

- All women coming in labor should be examined in the ED; only if found to be in active labor, patients must be sent to Birthing Centre. A primigravida should have a fully effaced cervix with at least 4 cm dilatation and mutigravida with active contractions.
- Those antenatal patients that come with PIH, post-dated pregnancy, PROM and medical diseases, should be transferred to Gyne ward after consulting OBGYN on call.
- Early pregnancy complications may be either taken to OT first or transferred to ward. The decision depends upon OBGYN on call.
- All cancer patients and other gynaecological cases referred from other centres may be transferred to ward after informing staff.
- Proper handing taking over should be completed. If investigations are done, reports must be sent with the patient.
- Patient must be accompanied by ward boy/staff.

4.1.1.6 Gynaecology Wards to other Wards/Cabin:

- Once decision is made to transfer a patient to another ward or cabin, there should be proper handing taking over of patient. If patients had any surgery; nature of surgery and any special instructions must be communicated.

4.1.1.7 Ward/Birthing Centre to OT:

- Patient should be properly prepared and gowned.
- Consents should be taken and signed by a doctor.
- Patient should be preferably transferred by trolley and accompanied by a nurse with the case sheet.
- OT staff on receiving patient must check everything is in place.

4.1.1.8 OT to Ward:

- Post-operative patients should be sent back after they are stable.
- Proper handing taking over should be done between OT staff and ward staff. A nurse should come to receive the patient.
- If a patient is to be transferred from OT to ED, then the OT should inform the ED ward and that ward should receive the patient accordingly.
- If the patient is required to be shifted to different ward after surgery, then the sending ward should receive the patient and handover to other concerned ward.

4.1.2 PEDIATRIC DEPARTMENT:

- For Surgery/diagnostic procedures, the patient should be prepared according to the guidelines and instructions from the physicians.
- Take informed consent for the procedure.
- Before sending the patient, re-confirm the appointment for the procedure.

- Patient should be accompanied by a staff with the necessary emergency kits.
- In critically ill patients, continuous monitoring and supportive care should be ensured.
- After the procedure, the patient should be transferred back to the ward and vital parameters should be monitored.

4.1.2.1 Transfer of babies from the birthing centre and maternity ward:

- Whenever newborn babies are transferred to the neonate ward, NICU staff should be informed.
- All detail history about the delivery, interventions and complications should be noted and all relevant form should be duly filled and sent along with the patient.
- Babies should be transferred in the incubator with oxygen whenever necessary and should be accompanied by a nursing staff.

CHAPTER 5 : INTERDEPARTMENTAL CONSULTATION

- Indoor patient consultation should be given priority and seen on the same day.
- Request for the consultation should be written down by the treating specialist at the bedside on the same day.

CHAPTER 6 EXAMINATION PROCESS

6.1 EXAMINATION PROCESS SPECIFICS TO DIFFERENT UNITS:

6.1.1 GYNAE & OBSTETRICS WARD:

- Explain and maintain privacy during all procedures.
- Check the vital signs, abdominal examination, vaginal examination, CTG and do recording.
- Any abnormality in the above findings should be notified to the doctor on call.
- All patients in active phase of labor should be monitored using pantograph.

6.2 FEMALE EXAMINATION:

- When examining female patient, female attendant is required.

6.2.1 PEDIATRIC DEPARTMENT:

- For any female child examination, one attendant preferably the mother should be present during the examination.
- The purpose of the examination should be explained to the parents particularly for genital examinations.
- One female nurse should be present during the examination of the female child in absence of the mother or a female attendant.

CHAPTER 7 : HANDING AND TAKING OVER

- Detail handing and taking over of the unit/ward should be done by the staff on duty and the patient should be handed over at the bedside.
- Doctor's order should be carried out before handing over to the incoming staff.
- The team leader of the outgoing team should lead the handover.
- Outgoing staff should communicate information accurately, succinctly and professionally.
- The outgoing team leader should introduce the incoming team members to the patient.
- All incoming staff should attend taking over responsibility.
- The incoming staff should check all drugs and ensure that articles and emergency equipments are functional in every shift.
- Update the hand over report in every shift.
- Check that all the bedside charts are complete prior to handover.
- Allow the patient to seek clarification, and ask question and confirm information.
- Confidentiality should be maintained at all time. Sensitive information should be shared within professionals only.
- During handover, incoming staff should undertake a safety check of the patient's environment.
- Ensure patient care is continued without any lapses during handing taking process.
- The staff on duty is/are solely accountable and answerable for any events/ activities that occur during their duty time.

KEY ITEMS TO CONSIDER ARE:

- The patient call bell is within the reach.
- Suction, oxygen, or other equipments are in working condition and easily accessible.
- Dressings, drain, intravenous fluids, and infusion pumps are secure and correct.

ARTICLES

- Handing and taking over of the articles should be done in every shift by the nurses before taking over of the patients.
- All basic articles should be checked for functionality.
- Sign on the register/articles list after taking over.

CHAPTER 8 : DISCHARGE OF THE PATIENT

8.1 DISCHARGE:

- The discharge plan should be conveyed to the patient before 24 to 48 hours of the discharge, so that the patient is prepared mentally to leave the hospital.
- Explain to the patient that the medicines will be issued at the bedside.
- Explain instructions to the patient and when to come for follow up.
- A patient who needs Physiotherapy consultation and devices should be referred to Physiotherapy Department before discharge.
- The discharge sheet should be written by the doctor during the round at the patient's bed side.
- Proper diagnosis with ICD code should be written by doctors.
- The nursing staff should check if the doctors have completed the discharge formalities.
- Check that all discharge certificates have admission registration number.
- Relevant laboratory report should be written on the discharge certificate by the concerned doctor.
- If any gauze etc., inserted during surgery, it must be removed before discharge.
- The hospital property such as the visiting cards, attendant's card and the linens used should be checked and received.The nurse should make sure that all discharged patients receive medicines at their bedside which will be dispensed by the pharmacy personnel.
- The nurse should ensure that the patient's document is complete and sent to the medical record section.
- If patient wishes to go home against medical advice make sure that the patient sign an undertaking risk form.
- At the nurse station, write in the indoor register – diagnosis, date and time of discharge, patient days in the appropriate columns in the register.

- Inpatient pharmacy technicians should be informed about the discharges of the patients so that the medicines can be provided before their discharge.
- The completed discharge certificate should be given to the inpatient pharmacy for the distribution of drugs.
- The patient and accompanying person should be advised regarding the follow up.
- On the day of discharge the patient should be explained about the discharge instructions and check their understanding of the instructions.
- Ensure that patients needing the walking support is issued crutches and able to walk with the support.
- Nurses shall ensure that patient and family have replaced any damage to hospital property before discharge certificate is issued.
- Take over the linens, blanket, pillow and visiting card before handing over the discharge papers.
- Sweepers should collect bedpans, urinals, sputum mugs, tray from patient.
- Refill the patient chart with history sheets, undertaking form, and face sheet, for immediate next use.
- The bed(s), I.V stands should be cleaned by ward boy

8.2 DISCHARGE SPECIFICS TO DIFFERENT UNITS:

8.2.1 ORTHOPEDIC DEPARTMENT:

- Inform the patient/family to go to orthopaedic OPD chamber for follow up but not to come during operation days (Monday, Thursday or government holidays and Sundays)

8.2.2 GYNE AND OBS

8.2.2.1 Obstetric patients

- All antenatal patients on discharge should be advised on proper follow up till delivery.

- All patients that have given normal vaginal births are discharged the next day unless she has medical problems.
- Exclusive breastfeeding and baby care, perineal wound care, nutrition and maintenance of personal hygiene should be taught to the patient and the care giver.
- Establish breast feeding before discharge.
- Make sure the mother is not bleeding, not having fever or her BP is settled (if she had PIH).
- Explain about the danger signs in mothers and the newborn during the post partum period.

8.2.2.2 Gyne patients should be discharged as any other patient; however, the following should be completed:

- Proper diagnosis with ICD code should be written by doctors.
- Wound care should be done before discharge and advice on dressing/ suture removal given.
- When and where to collect HP report should also be instructed properly.
- Ensure doctors have written follow up investigations; example in molar pregnancy and patients on chemotherapy.
- Make sure that the doctor writes all the instructions on the patient's discharge sheet and signs the maternity leave form and birth certificate.
- The baby should be seen and the discharge sheet signed by the paediatrician.
- The baby should get the first dose of vaccination before discharge, however if the discharge day falls on Sundays and holidays, they should be instructed to come the following day.
- Instructions regarding further care, medication, family planning, nutrition and follow up activities should be clearly written and interpreted to the patient and party.
- Make sure the attendant goes to the general office to get hospital seal on the birth certificate and the maternity leave form.

8.2.3 PAEDIATRIC DEPARTMENT

- The parents should be informed about the tentative date of discharge.
- Check the confidence of the parents regarding the child care and willingness about the discharge plan.
- Clarify any doubts and questions regarding the child's disease.

8.2.4 PSYCHIATRY DEPARTMENT:

- All normal discharges should be done in consultation with the treating psychiatrist. He/she should write the discharge summary including the diagnosis, ICD code, and follow up treatment advice.
- Patients should leave the ward in the company of their family or relatives. Patients and family should be told to report immediately if there is relapse of symptoms or adverse effects of drugs

8.3 DISCHARGE AGAINST MEDICAL ADVICE:

- Patients absconding from ward or not returning to ward after day leave for more than six hours will automatically be discharged and their bed will be allotted to new patients.
- Patients seeking discharge against medical advice should be properly counselled and discouraged to leave as far as possible**.**
- If the patient still insist to leave, the patient should be discharged after signing on the case sheet and mention on the discharge slip.

8.3.1 ABSCONDING OF PATIENT

- Attendant(s) should be kept all the time with the patient to prevent patient from absconding. In case, patient absconds from the hospital, his/her next kin as well as the police, hospital administration and the respective department heads/unit heads should be informed.
- If the absconded patient does not turn up within 6 hours, he/she shall be automatically discharged and reflected as absconded.

8.3.2 HOME LEAVE

- Home leave should be given to patients only on the recommendation of treating specialist and ward in-charge.
- A maximum of 2 hours leave can be given at a time. If more than 2 hours leave is requested the patient should be discharged against medical advice.
- When patient is sent on leave, proper undertaking letter should be taken and time out should be mentioned.

CHAPTER 9 : CARE OF THE DEAD BODY

9.1 CARE OF THE DEAD BODY

- Death should be declared by the doctors only.
- Nursing staff should remove the I.V tubings, cannula, catheter, NG tube etc from the body.
- The body should be removed within 1-2 hours time, if not the body should be shifted to the mortuary.
- No hospital linens should be taken with the dead body.
- Stretchers can be taken for transportation provided that it must be returned at the earliest to the respective units (keep the contact number of the deceased party).
- Unclaimed bodies should be taken to the mortuary and the hospital administration should be duly informed.
- Inform the hospital Lam if requested.

9.2 DEATH CERTIFICATE PROCEDURE FOR HOSPITAL DEATH

- The death certificate should be issued by the treating doctor /doctor declaring death.
- Ensure to fill in all the details in the death form.
- Ensure that the office copy is legible and clear. The 2nd copy should be sent to the record section and the 3rd copy should be retained in the ward.

CHAPTER 10 : INFECTION CONTROL & WASTE MANAGEMENT

- All health professionals should follow the infection control and waste management guideline.

10.1 OBJECTIVE:

- Institute a waste management plan for the hospital to comply with the law.
- Protection of environment by minimizing polluting materials like Mercury, PVC etc.
- Identify a responsible waste manager and institute a waste management team.
- Identify spaces required to support the waste plan e.g. space planning for storage, define disposal pathway etc.
- Implement good infection control measures.

10.2 KEY REQUIREMENT OF WASTE DISPOSAL MANAGEMENT

- Segregate waste at source.
- Use designated colour containers.
- Transport the waste in designated vehicles by authorized personnel.
- Treat infectious waste according to prescribed standards.

10.3 TRANSPORTATION & SCHEDULING

While transporting waste the following guidelines need to be followed:

- They should be in the respective colour coded bags (if at all they are all put into one bag).
- Transport waste to the disposal site twice a day.
- Waste can be transported on specially allocated trolleys and collect floor wise to the storage/ disposal area.

- Care must be taken to ensure that the bags are not torn and spill the waste from the bag during transportation.
- All waste spills should follow the infection control guidelines and injury or incidents be reported to the Infection Control Officer.
- All bags should be secured/tied at the neck prior to transportation.
- Any sharp found in the bags during transportation should be reported and follow the Sharps management policy.

10.3.1 BLOOD TRANSFUSION

- Blood transfusions to be carried out at the orders of the treating physician.
- While transfusing blood to the patients, strict blood transfusion protocol must be followed.
- If there is transfusion reaction, adverse reaction form must be filled up and inform the blood bank.

10.4 CD DRUG MANAGEMENT PROCESS

- CD drug list should be maintained and updated whenever the drugs are used.
- The pharmacy technicians should be responsible for topping up of the CD drugs in the ward.
- CD drugs should be stored in a safe place with lock and key. The key should be handed over to the in-charge of the shift. The key should not be kept in open place to prevent CD drug theft.
- In case of theft or missing of the CD drugs the staff should inform the administration immediately.

CHAPTER 11 : ANAPHYLACTIC REACTION/SHOCK

11.1 REACTION/SHOCK

- Anaphylactic tray provided by the pharmacy should be checked daily by nurse shift duty in-charge.
- In case of anaphylactic reaction/shock, follow the protocol.

CHAPTER 12 : EMERGENCY IN THE WARD

12.1 EMERGENCY

- In case of any emergency in the ward, the duty staff should initiate emergency care and inform the doctor immediately.

12.2 EMERGENCY SPECIFIC TO DIFFERENT UNITS

12.2.1 DEPARTMENT OF ORTHOPAEDIC SURGERY

- All orthopaedic emergencies should be channelled through the Emergency Department (ED) like any other emergencies.
- The ED staff should receive all emergency cases, perform triage, render first-aid treatment and carry out all relevant investigations for all the patients.
- When called, the orthopaedic emergency on-call personnel should report to the ED to attend the emergency without any undue delay. He or she should perform additional emergency procedures or investigations and if required inform the surgeon on-call for further instructions.
- Any patient requiring minor procedures should be done in the MOT of the Emergency Department.
- All serious cases which require expert management should be attended by the on-call surgeon upon information by the assistant.

- The orthopaedic emergency services team should consist of one Ortho-surgeon and Ortho-Tech. Another such team should be kept on standby to act as back-up personnel in case of major emergencies.
- The on-call team should request the back-up team to cover up in events when any member of the first on-call team is unable to attend emergency call duties.
- In the event of a major disaster, all the staff members of the Orthopaedic Surgery Department should immediately attend to help the emergency team.
- The emergency on-call staff's (Ortho-Techs') first responsibility is to attend to emergency cases/perform emergency operations.
- In case of multiple injuries, other relevant specialists should also be called to attend the case.

12.2.2 EMERGENCY OPTHALMOLOGICAL SERVICES

- Any patient requiring urgent eye consultation should be referred to the on call ophthalmologist by the concerned department staff.
- Emergency eye surgeries should be carried out at any time as per the availability of the OT.
- Necessary consultation with the anaesthetist on call should be carried out for patients needing general anaesthesia.
- For emergency cases seen in the casualty, separate register should be maintained. All on call staff should register the patients seen in the casualty. The register should be made available in the eye ward.

12.2.3 GYNAE AND OBS

- Patients going into labor but with high risk of having Caesarean section
- Trial of labor
- Induction
- Past caesarean section

- Suspected CPD
- IUGR/severe oligohydramnios
- Severe PIH/ecclampsia
- APH
- Diabetes with macrosomia
- Poor progress of labor
- All malpresentations
- Multiple pregnancies especially if first twin is not in cephalic presentation
- Malposition
- Bad obstetric history

For all the above cases, nurses should vigilantly asses the patient as per the standards of intra-partum care and carefully scrutinize antenatal card and inform the doctor on call in time and keep him or her informed about any delays in progress, maternal distress, fatal distress and other related problems.

From the onset of Labor:

- No solid meals
- Early labor - water only.
- Late labor – I.V fluid only
- Close monitoring (maternal and fatal)
- Blood CBC and crosshatching
- Ranitidine and maxeron orally
- Patient on left lateral position
- Keep record of all the procedures and findings with date and time

12.2.3.1 When Emergency Caesarean is eminent (Decided by doctor on call)

- Explain to the patient and the attendants about the need of emergency caesarean and the possible risks associated with anaesthesia and surgery.
- Inform OT staff/call anaesthetist on call and Paediatrician, if fatal distress present.
- Take written consent. Include TL form if patient desires it.
- I.V fluids only.
- Catheterization (indwelling).
- Injection Ranitidine and Maxeron 1 amp each by IM route.
- Remove all jewellery, nail polish, under wear and pad.
- Put on patient gown.
- Check the patients' case sheet to see that CS form, laboratory reports and consent forms are included before patient leaves for labor room.
- CS set should include additional equipment (cord cutting scissors, cord tie).
- This staff must check everything in OT (suction machine, O2 etc) before caesarean section starts.
- In cases of fatal distress, patient should be given oxygen immediately and she should be in left lateral position.
- The staff going to receive baby must take baby.

Standard operation procedures for various departments of JDWNRH with inpatient wards

CHAPTER 13 : DEPARTMENT OF ANESTHESIA

13.1 PRE-OPERATIVE ASSESSMENT

- Develop a professional relationship with the patient.
- Take a medical history.
- Do a relevant physical examination.
- Check the result of tests or investigations.
- Order relevant investigation if needed.
- Prescribe pre-medication if needed.
- Explain to the patient the aesthetic techniques to be used.
- Discuss the risk and complication which may results from the proposed aesthetic technique so as to enable informed consent.
- Assess blood transfusion requirement and order blood if required.
- If drugs are required to be taken by the patient, order on the PAC form.
- Record all relevant information on the PAC form.

13.2 ANESTHESIA APPARATUS CHECK OUT

- The SSCL should be conducted before administration of anaesthesia by the OT technician and also by the anaesthetist.

13.3 EMERGENCY VENTILATION EQUIPMENTS

- Check backup ventilation equipment is available and functioning (bag-mask ventilation equipment).

High pressure system

- Check oxygen cylinder supply.
- Open oxygen cylinder and verify at least half full (1000 psi).
- Close cylinder.
- Check central pipeline supplies.
- Check that the hoses are connected and the pipeline gauges read about 50 psi.

Low pressure system

- Check initial status of the low pressure system.
- Close flow control valves and turn vaporizers off.
- Check fills level and tighten vaporizers' filler cap.
- Perform leak check of machine low pressure system.
- Verify that the machine master switch and flow control valves are off.
- Attach "suction bulb" to common (fresh) gas outlet.
- Squeeze bulb repeatedly until fully collapsed.
- Verify that the bulb remain collapsed for at least 10 seconds.
- Open one vaporizer at a time and repeat above last 2 steps.
- Remove suction bulb and reconnect fresh gas hose.
- Turn on machine master switch and all other necessary electrical equipments.
- Test flow meters.
- Adjust flow of all gases through their full range, checking for smooth operation of floats and undamaged flow tubs.

Breathing system

- Calibrate oxygen monitor.
- Ensure monitor reads 21% in room air.

- Verify that low oxygen alarm is enabled and functioning.
- Reinstall sensor in circuit and flush breathing system with oxygen.
- Verify that monitor now reads greater than 90%.

Check initial status of breathing system

- Set selector switch to "bag" mode.
- Check that breathing circuit is complete, undamaged and unobstructed.
- Verify that CO2 absorbent is adequate.

Perform leak check of the breathing system

- Set all gas flow to zero
- Close APL valve and occlude Y-piece
- Pressurize breathing system to about 30 cm H20 with oxygen flush
- Ensure that the pressure remains fixed for 10 seconds
- Opens APL valve and ensure that pressure decreases
- Test ventilator system and unidirectional valves
- Place a second breathing bag on Y-piece
- Set appropriate ventilator parameters
- Switch ventilator to ventilation mode
- Turn ventilator ON and fill bellows and breathing bag with Oxygen flush
- Verify that during inspiration, bellows deliver appropriate tidal volume and during expiration
- Bellows fill completely
- Set fresh gas flow to about 5/L/min
- Verify that the bellows and stimulated lungs fill and empty appropriately at the end of expiration
- Turn ventilator off and switch to manual ventilation mode
- Ventilate manually and ensure inflation and deflation of the stimulated lungs and

- Appropriate feel of system resistance and compliance
- Remove second breathing bag from Y-piece

Check, calibrate and/or set alarm limits of the monitors

- Capnometer, Pulse oximeter, Oxygen analyzer
- Pressure monitors with high and low airway alarms

Check final status of the machine

- Vaporizer off
- APL valve open
- Selector switched to bag
- All flow meters to zero
- Patient suction level adequate
- Breathing system ready to use

13.4 ANESTHETIC DRUGS AND EQUIPMENTS

- Drugs are reconstituted in proper dilution
- The syringes are labelled properly with the name of drug and strength
- Aseptic precautions are used during preparation of the drugs
- Date should be put on the label
- Ensure that the different size ET tubes are sterileEnsure that the laryngoscope blades are clean and battery and bulb are functioning
- Ensure that the suction machine is functioning
- Ensure that suction catheter is available
- Ensure that tape is available for fixing the ET tube
- Ensure that the breathing system and face mask are clean
- Ensure that filter is put at the expiratory limb of the breathing circuit
- Ensure that CO2 absorber is not exhausted

The OT technician and the anaesthetist will receive the patient from the pre-operative room and transfer the patient on to the operation table. Care should be taken during transfer of the patient from the trolley to the operation table. Once the patient is on the operation table, the following should be done:

- Make the patient comfortable on the table by providing pillow and blanket cover
- Be considerate to female patients and their modesty
- Attach all monitors, check BP, HR and ECG
- Inset intravenous lines if the patient does not have one
- Check consent form once more and any relevant information
- Verify the operation with the surgeon
- Proceed with anaesthesia

13.4.1 GENERAL ANESTHESIA

- Check the patient PAC form for allergies, medication and disease condition
- Confirm the operation from the surgeon
- Check for informed consent
- Plan the aesthetic technique
- Attach all the essential monitors
- Check vital parameters before inducing the patient
- Monitor and maintain vitals during the intra-operative period
- Check and observe for blood loss and replace if needed
- Maintain adequate urine output
- Maintain intra-operative record
- Reverse and send to PACU after the patient is adequately reversed

13.4.2 SPINAL, EPIDURAL AND CAUDAL ANESTHESIA

- Inform the patient regarding the process
- Place the patient in the required position
- Perform hand scrub
- Wear sterile gloves and prepare the instrument and drugs
- Prepare the field of injection with antiseptic and drape the field
- Using aseptic technique to perform the procedure
- Monitor and maintain vitals during the operation

13.4.3 REGIONAL ANESTHESIA

- Inform the patient what procedure is to be done
- Place the patient in the required position
- Perform hand scrub and wear sterile gloves
- Prepare drugs and instrument in a trolley
- Prepare the field of injection with antiseptic and drape the field
- Anesthetize the injection site with local aesthetic
- Perform the regional anaesthesia using aseptic precaution
- Monitor and maintain vitals during the operation

13.4.4 STANDARD MONITORING DURING ANESTHESIA

- The following standard monitors should be used when providing aesthetic care
- Pulse oximeter
- NIBP
- ECG
- End tidal carbon dioxide (ETCO2)

13.4.5 POST ANESTHESIA CARE UNIT

- Receive patient from the OT
- Access vitals, level of consciousness, type of operation doneMonitor the patient's SPO2
- Check airway and adequacy of ventilation
- Provide oxygen to patient
- Monitor the BP
- Monitor ECG if needed
- Monitor urine output
- Assess consciousness before sending patient to ward
- Observe for bleeding from the surgical site
- Access pain and inform anaesthetist for pain relief
- Ensure that intravenous fluids/blood are given as per instruction
- Record BP/Pulse/HR/SPO2 on the chart before sending patient to ward

13.5 ANESTHETIC SERVICE FOR CT/MRI

- Check and ensure that all necessary airway equipments are available and functioning
- Check and ensure that oxygen is available in the oxygen cylinder
- Check and ensure that the patient is fasting for 6 hours
- Check and ensure that the pulse Oxymeter is functioning properly
- Check and ensure that all essential drugs are available
- Insert an intravenous cannula in the patient
- Provide sedation according to the weight of the patient
- Monitor pulse Oxymeter during the scanning procedure
- Use radiation proof apparel during CT scan if required to remain with the patient inside the scan room.

- Observe the patient in the induction room and monitor pulse Oxymeter continuously
- Discharge the patient after recovery from sedation or aesthetic
- Clean all used equipments
- Close the oxygen cylinder
- Replace used drug in the drug kit

13.6 INSERTION OF OROPHARYNGEAL AIRWAY (ADULT):

- Select the proper size. It should extend from the corner of the lip to the angle of the jaw or to the tip of the earlobe.
- Insert with curvature pointing up toward the roof of the mouth and then gently rotate it until it reaches the proper position.
- Continue until the flanges rest on the patient's teeth.

13.6.1 INSERTION OF OROPHARYNGEAL AIRWAY (INFANT AND CHILDREN)

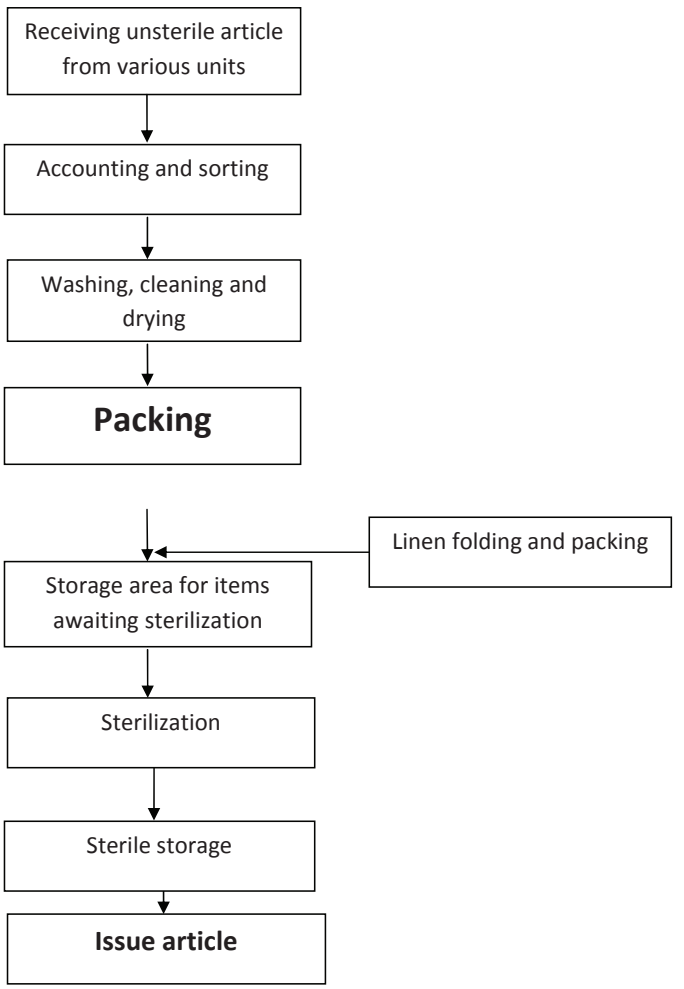
- Select appropriate size airway.
- Open the patient's mouth and insert the tongue depressor and press down.
- Insert the airway in its normal upright position.
- Stop when the flange is seated on the patient's teeth.

CHAPTER 14 : CENTRAL STERILE SUPPLY DEPARTMENT (CSSD)

14.1 THE MAIN FUNCTIONS WILL INCLUDE (DECONTAMINATION):

- **Receiving and Counting of un-sterile equipments.**
- **Sorting** of contaminated instruments and equipments for appropriate cleaning.
- **Rinsing** of articles should be done in washing area by a trained staff.
- **Cleaning** of instruments and equipments.
- **Inspecting**, **assembling**, **wrapping** and **labelling** of procedure packs, trays and instruments sets.
- **Sterilization** of procedure packs, trays, and /or instruments sets. All sets need to have an indicator slip, which changes colour on exposure to correct temperature, pressure and time. The sets also have to be labelled with the name of the set and expiry date.
- **Storage** of sterilized supplies in sterile area.
- **Distribution** of clean and/or sterilized supplies and equipments to the appropriate user departments.
- **Inventory** and charge control of supplies and equipment delivered.

14.1.1 WORKING FLOW CHART



Flow Chart of CSSD

The CSSD should be designed in such a way that the flow of activities must be **Unidirectional** from unclean to clean area. There should be limited cross movement to reduce the risk of cross contamination.

14.2 MAIN AREAS OF STERILIZATION DEPARTMENT:

14.2.1 DECONTAMINATION AREA

- All the user departments are to rinse the instruments prior to sending them to the Sterilization Department.
- Infected instruments should be labelled "INFECTED", by the user department whereby a disinfection process would be carried out in the washing area. The disinfection cycle of the instruments will be carried out by autoclaving the instruments without opening the packet.
- Dirty instruments will be received in the Decontamination Area or receiving area, where they will be cleaned and dried. Any instrument with stains is to be washed manually with detergent.
- Decontamination area is considered a restricted area with increase potential for contamination from blood or body fluid pathogens on the soiled utensils, carts, and materials. So all the personal dealing with dirty and infected instruments should take safety measures. They should be strictly instructed to use **Personal Protective Equipment (PPE)** such as gowns, aprons, masks, gloves, head coverings and shoe covers.
- Each item should be inspected for functionality, defects, and breakage then appropriately assembled if required.

14.2.2 PREPARING AND PACKING

- Generally called "Prep and pack", this is a clean area where items processed for decontamination are received, inspected, reassembled, wrapped, and sterilized.
- Articles for sterilization should be packed in porous Lenin.
- Labelling: Each pack should be marked with Date of Sterilization, Date of Expiry, Pack Number, Produce Name, and List of Contents (in a double pack).
- Sterilization equipment is a part of this area; storage also is required for supplies used in assembling instrument sets and other sterilized items. Strictly quality control policies and procedures must be followed in sterilization processes.

- Instructions regarding the operation of the machines should be explicitly explained to all the personnel of the department.
- Routine periodic inspection of all the machines will be done to ensure that the outsourced agency is providing regular and periodic maintenance as per their annual maintenance contract.
- The temperature and the loads to be put into the machines are to be monitored, to ensure optimum utilization of the equipment under given standards.

14.2.3 ISSUE OF STERILE SUPPLIES

- The issue system to be employed shall be as follows:
  - Each user department will be allocated a pre-determined number of sets of instruments.
  - As and when the materials/set is used the same will be sent to the SSD periodically and deposited in credit.
  - This set will be rendered sterile and made available to the user department within a time period of 24 hours. Emergency requisitions shall be treated accordingly.

14.2.4 ISSUE OF STERILE SUPPLIES

The issue system to be employed shall be as follows:

- Each user department should be allocated a pre-determined number of sets of instruments.
- As and when the material/set is used, the same should be sent to the CSSD periodically and deposited in credit.
- This set should be rendered sterile and made available to the user department within a time period of 24 hours. Emergency requisitions should be treated accordingly.

The advantages of this system are:

- The user department itself gauges the requirement of sterile stock depending upon its experience.

- Since each department will have its own stock of material dedicated, the management can assess the performance of the user staff in handling of the material supplied by the SSD.

14.2.5 SHELF LIFEE

- The shelf life of packaged sterile item depends upon:
- Quality of wrapper material – Porous Linen
- Storage condition
- Conditions during transport
- Amount of handling

A sterile tray packed in porous linen and stored under clean conditions and not handled unnecessarily may be fit for use for 72 hrs to one week.

14.2.6 EQUIPMENT MAINTENANCE

- In case of any wrong reading being detected or the equipment not performing appropriately, the in-charge should be informed through the maintenance requisition slip, who would then initiate appropriate action.
- All maintenance records should be maintained determining the equipment down time and the repairs conducted for the equipment.
- Any equipment to be scrapped should be done only under the authorization of the In-charge and BES.

14.3 QUALITY CONTROL

- The parameters to be taken into consideration to maintain sterility of equipment should be referred to quality control parameter listed in the guideline. CHEMICAL PARAMETERSSign log [Steam indicator tape] should be affixed on every pack before loading. Once the required temperature is achieved in the chamber, the colour of the tape changes [white to black]

14.3.1 CHEMICAL PARAMETERS

- Periodically, once in two weeks a capsule [biological indicator] consisting of bacillus stereothermophilus should be kept along with a load. After the cycle is over, the capsule should be sent to the Microbiology Laboratory where the viability of the organisms is checked. These organisms are supposed to be the most resistant to the heat. If they are killed, it can be presumed that the packs are sterile.
- In case of any aberrant results while testing any of the parameters, the BES personnel should be informed for performing an equipment check.
- Sterile area should be fumigated once a week.

14.3.2 MICROBIOLOGICAL TESTING:

- Periodically, once in two weeks a capsule [biological indicator] consisting of bacillus stereothermophilus should be kept along with a load. After the cycle is over, the capsule should be sent to the Microbiology Laboratory where the viability of the organisms is checked. These organisms are supposed to be the most resistant to the heat. If they are killed, it can be presumed that the packs are sterile.
- In case of any aberrant results while testing any of the parameters, the BES personnel should be informed for performing an equipment check.
- Sterile area should be fumigated once a week.

14.3.3 RECORD AND REPORTS TO BE MAINTAINED IN STERILIZATION DEPARTMENT

The following records should be maintained:

- **Receipt Register:** This option will allow user to receive all soiled, used articles from different departments. Where user will enter the data like department code, department name, list of packs, items received with quantity, time of receipt, name of the person who brought all items from department to CSSD etc.

- **Issue item:** This option will allow user to issue items to user departments depending upon the issue system.
- **Replacement items:** This option will allow CSSD to replace damaged or unused items and instruments with new articles for user department.
- **Equipment log book:** This option will allow user to maintain a complete log book of all equipment and contain the following features like equipment breakdown time, period, engineer, type of service (AMC or any other), performance, calibration reports data (periodic or randomly) etc. This feature must be networked with BES.
- Daily Activity recording equipment-wise e.g. daily recording of each sterilization cycle with temperature, pressure, load, time period etc.
- **For Steam Sterilizer:**
  - ❖ Sterilizer Instruction Manual
  - ❖ Record of each cycle
  - ❖ Record of thermographs of each cycle
  - ❖ Chemical Indicator
  - ❖ Daily Air Removal Indicator Test
  - ❖ Weekly Vacuum Leak Test
  - ❖ Weekly Spore Test or Biological Indicator Result
- **Random & Planned Micro-biological testing or infection control auditing**

  Reports: To measure and check the degree of infection in CSSD, random and planned micro – biological tests should be carried out. These tests should also be recorded (Test no., Date, type of test, Name of the test, test done by, Result, conclusion, recommendations, follow-up & post-follow-up testing).

14.3.4 MONTHLY REPORT

- Monitor infection control tests and their result and recommendations monthly.

14.4 SAFETY AWARENESS IN CENTRAL STERILE SUPPLY DEPARTMENT

- All personnel should follow established work and traffic flow patterns.
- All staff should wear appropriate personnel protective equipment designated for the department.
- Staff should adhere to dress code and polices before entering and when leaving the area.
- Staff should follow and practice hand washing guidelines (before and after each task).
- If spills occur, refer to management of body fluids spillages in infection control guideline (*3rd edition, infection control and waste management guideline 2006, page 83-84*)

14.5 DEPARTMENT DRESS CODE

- Upon entering the sterile supply department, all staff should change into the dresses provided by department in the changing room.
- Staff engaged in the handling and processing of incoming equipments in the wash area should put on an extra protection, gown or apron, gloves and protective goggles (when splashing is anticipated in addition to the departmental uniform).
- When leaving the wash area, staff should remove apron and discard the gloves, mask and wash their hands.
- Visitor entering the preparation area should wash and dry their hands.
- Staff visiting from other areas should wear the department uniform and must comply with the dress code while moving within the areas of the department.

CHAPTER 15 : DIALYSIS UNIT

15.1 RULES

- Dialysis is done twice a week
- Dialysis is closed on Sunday.
- Emergency dialysis is available for 24 hours
- Vital signs to check hourly
- Inj. ferittin to be given after one hour of dialysis
  - ✓ Monthly investigation of Hb%, CBC, , RFT, ferittin level
  - ✓ Pt counselling on diet and dialysis
- Change shoes/slipper before entering Dialysis unit.
- All the staff should wear dialysis dress before starting procedure.
- No visitor will be entertained in unit other than patient.
- Only one visitor at a time for serious patient.
- No personal belongings should be allowed, except feeding article is allowed during dialysis.
- Staff should not be held responsible for loss of any belongings.
- Keep all the protocol for dialysis, infection control, Blood transfusion and emergency resuscitation in the unit.

15.2. DIALYSIS MACHINES STERILIZATION

- Follow as per the protocol.

Procedure:

- Cleaning dialysis machines in every shift.Disinfect with CITROSIL solution.
- In case of malfunction of machine, contact BES for maintenance.

15.3 SPECIFIC TO DIALYSIS

- Water Service
- Priming of Bloodlines n Dialyzer
- Dialyzer Reprocessing
- Washing and disinfect of dialyzer n bloodlines.

15.4 DIALYSIS PATIENT

- Checking of vital signs half hourly, treat complications if any.
- Monthly blood test for Hb, RFT, Ferritin level. If low, follow the Protocol.

15.5 INSERTION OF SUBCLAVIN AND INTERNAL JUGULAR CATHETER

- Prepare the patient and sterile insertion set.
- Obtain informed consent for procedure.
- Check vital sign and blood report Hb% and viral markers.
- Maintain sterile technique during the procedure and also during every dialysis.
- Sterile dressing before and after dialysis.

15.6 PROCEDURE BEFORE STARTING DIALYSIS

- Operating of RO machines.
- Operating of Dialysis machines and preparing for dialysis.
- Water service for dialyzer.
- Priming of dialyzer and bloodlines.
- Setting of weight i.e., ultra filtration.
- Vital signs.
- Preparation of fistula set and dressing set (for IJV and sub-clavin Access).

15.7 PRE DIALYSIS PROCEDURE FOR PATIENTS

- Weight
- Vital signs
- Choice of Dialyzer
- Medication (Anti Hypertensive and Anti diabetic)
- History of bleeding
- History of surgery if any indoor patients
- Preparing of Heparin doses
- Diet
- General and physical, emotional state
- Any problem during last dialysis
- Condition of Access
- Number of hours per treatment
- Checking of blood reports for viral markers (New case)

15.8 DRESSING PROCEDURE AND FISTULA NEEDLE INSERTION

- Sterile technique should be followed.

15.9 COMPLICATION DURING DIALYSIS

- Hypotension , Hypoglycemia and cramps
- To treat patients for HD related complications during dialysis
- Keeping close observation of the patient during dialysis

15.9 POST-DIALYSIS PROCEDURES

Discontinuing of dialysis includes:

- Vital signs
- Administration of erythropoietin injection

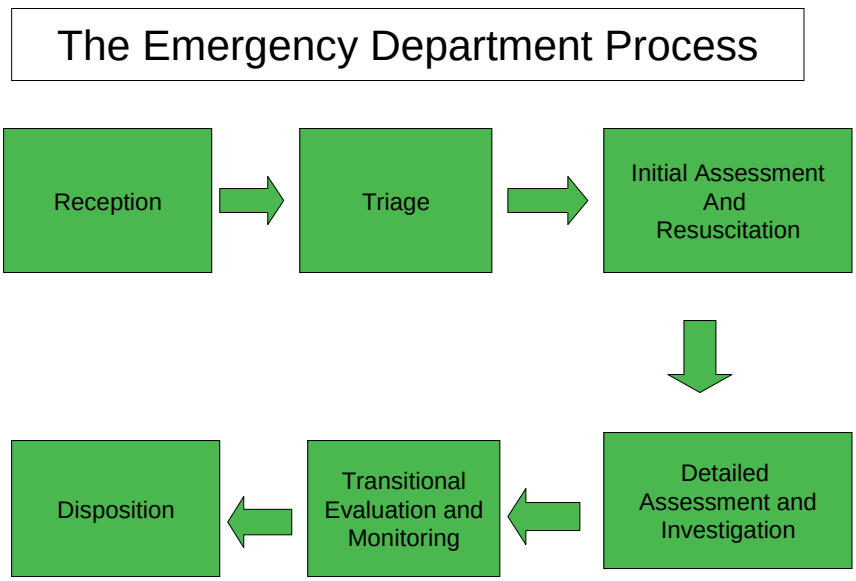
- Returning of blood back to the patient
- Checking of post weight
- Giving appointment for next dialysis

Ending Process:

- Cleaning of dialyzer and bloodlines.
- Disinfect it with 4% formalin.
- Proper storage of bloodlines and dialyzer in shelf as per patient's name for reuse of the same patient in the next shift.
- Cleaning of Dialysis machine in every shift with 1 % bleaching solution.
- Disinfection of machine with citrosil and every Saturday with hypochlorite solution.
- Moping with disinfectant and preparing for next morning shift.

CHAPTER 16: EMERGENCY DEPARTMENT

16.1. EMERGENCY PROCESS



16.2. TRIAGE

All the patients should be triaged according to the triage protocol which will decide the level of care by the nurse. Triage category IV and V will be directed to the ACO chamber and rest should be directed to the treatment room for the further assessment by the doctor on duty.

Resuscitation room care:

- Patients should be managed accordingly as per the resuscitation protocol.
- **Isolation Room Care**: Patients with the suspected communicable illness should be observed in this room until further disposition.

***Observation Room Care**:*

- The nurse should perform the initial assessment. This should be further assessed by the doctor.

- Doctor and nurses should follow ethical code of conduct and universal precautions.
- Assessment, evaluation and monitoring of the patient should be done as per the ED protocol.
- All the investigations (Laboratory, Radiology, etc.) should be done as soon as possible and reports to be collected at the earliest.
- Concerned specialist should be informed as soon as possible. Meanwhile detail information should be obtained from the family/party.
- Effective treatments should be started as soon as possible.
- Drugs and equipments should be checked and monitored on every shift of duty.
- Hygiene and sanitation should be maintained at all time. Infection control and waste management protocol should be strictly followed.
- All important information regarding patients should be written on the information board and updated on time.
- Documentation and record should be maintained properly and strictly.

16.3. MONITORING

- Monitoring of the patients should be done strictly as per protocol.

16.4. DISPOSITION

- Disposition of the ED patients should be done within 24 hours as far as possible.
- After consultation with the specialist, if the patient is sent to OT, the concerned specialist and the ward should be informed.
- All patients discharged from the ED should be given appropriate information regarding medicines, diet, care and follow up.
- Death certificate will be given to only those patients who die in ED or those who die under medical escort.
- Patient brought dead to ED should be reported to police and forensic specialist.

16.5 CASE MANAGEMENT FOR SPECIFIC DISORDERS

- Case management for specific disorders should follow the protocol provided by respective departments.

16.6. MASS CASUALTY

In the event of mass casualty following guidelines should be followed:

- Hospital administration should be alerted.
- All the HODs and In-charges should be informed for the activation of their staff.
- Police should be informed.
- Necessary infrastructure, human resource and logistics should be provided.
- Further management should be carried out as per protocol.
- Registration and Triaging should be carried out at the same time.

16.7 CODE BLUE (CARDIAC ARREST):

- The emergency team should attend to code blue any time.
- Code blue announcement and response should be carried out as and when situation arises.

CHAPTER 17 : ENDOSCOPY UNIT

17.1. REGISTRATION

- Maintain register for patients.
- Give appointment date, if there is advice from the concerned doctor.
- Instruct the patient to come for NPO one night before endoscopy.
- Enter patient details in the register and give token to the patient.
- Confirm the patient whether he/she is fasting or not.
- Enquire if the patient has denture and remove denture if any.

17.1.1. LOCAL ANAESTHESIA

- Apply Xylocaine spray in the patient's mouth 2 – 3 times and ask them to hold for few seconds and swallow.
- Explain to patients not to worry as numbness and nausea would be felt.

17.1.2. BIOPSY

- Biopsy should be labelled accurately.
- If biopsy has been taken, explain patients and attendants to collect biopsy report from surgical chamber after 10 days.

17.1.3. MEDICINES

- If medicines are prescribed by the concerned doctor, explain patients or attendants to collect medicines from the pharmacy.
- Instruments preparation, end of procedure.

17.2. COLONOSCOPY

17.2.1. REGISTRATION

- Maintain register for patients.
- Give appointment date, if there is advice by the concerned doctor.
- Explain instructions to the patient regarding NPO the night before colonoscopy.
- Ask patient whether she/he had taken Peglac for bowel preparation from the OPD.
- Enter patient details in the register and give token to the patient.
- Confirm if patient is fasting or not.

17.2.2. BIOPSY

- Biopsy should be labelled accurately.
- If biopsy has been taken, explain patients and attendants to collect biopsy report from surgical chamber after 10 days.

17.3. ERCP

17.3.1. REGISTRATION

- Maintain register for patients.
- Give appointment date, if there is advice by the concerned doctor.
- Explain instructions to the patient regarding NPO the night before endoscopy.
- Enter patient details in the register and give token to the patient.
- Confirm the patient if fasting or not.
- Loosen the belt and ask about denture. Remove denture if any.
- Explain procedure to the patient.

- Take the patient to pre – operative room for I.V line.
- Inform concerned doctor.
- Sedate patient with injection Pethidine and Medazolam as per protocol, and provide oxygen, and monitor SpO2.

17.3.2. CARE OF SCOPES /STERILIZATION

- Scopes should be washed and rinsed thoroughly in plain water, soak in Cidex for 10 minutes and rinse in distilled water after each use as per the sterilization protocol.
- Wash the scopes thoroughly and dry hang in wooden cupboard with net.

17.3.3. MAINTENANCEE

- Clean the endoscopy machine and trolley before starting procedure.
- BES personnel should check scopes monthly.

17.4. EMERGENCY TRAY

- Endoscopy unit in charge should keep emergency medicines and equipments ready at all times as per the emergency protocol.

CHAPTER 18 : ENT

18.1. OPD

- Register with token.
- First time patients should be screened by technicians and then referred to appropriate specialist.
- Follow-up patients should be directed to concerned specialist.
- Consent should be obtained for any minor OPD surgical procedure.

18.2 DUTIES OF TECHNICIAN

- Screen community for hearing disability and treat where possible.
- Assist ENT surgeon in OPD Care of ENT equipment.
- Screen patients during OPD.
- Perform minor procedures (e.g. wax removal, ear toileting etc).
- Assist surgeon during surgery.
- Technician is NOT a substitute for ENT surgeon.

18.3. ADMITTED PATIENTS

- Admission number should be issued to all patients.
- All written instructions should be followed.
- Any change in instructions should be documented in the case sheet.
- All discharge instructions should be explained to patient by the discharging physician.

18.4. PRE-OPERATIVE PREPARATION

18.4.1. GENERAL:

- Ensure Informed Written Consent is done.
- Ensure all documentation is complete (e.g. PAC, Investigation results etc).
- Follow all preparation instructions of surgeon and anaesthetist.
- Deliver first listed patient to OT by 9.00 am.

18.4.2. EAR SURGERY

- Ensure hair is washed properly.
- Shaving where indicated.

18.4.3. TONSILLECTOMY

- Nose should be decongested with nasal decongestant pack for smooth nasal intubation.

18.4.4. NOSE SURGERY:

- Nose should be decongested with nasal decongestant pack prior to sending to OT.

18.5. TRACHEOSTOMY CARE

Cuffed tracheostomy tube:

- Cuff should be deflated every ½ hour for 5 minutes.
- Tracheal suction should be done regularly.
- Suction cannula should be kinked before inserting into trachea.

Metallic tube:

- Inner tube should be removed and cleaned 2 – 3 times a day.
- Inner tube should be removed and cleaned in case of tube blockage.

18.6. EPISTAXIS

- Monitor and record vital parameters.
- Pinch nose for 15 – 20 min (longer than clotting time).
- Look for and try to identify bleeding point.
- Cauterise with chemical/ electro cautery in case of small and accessible bleeding point.
- Apply anterior nasal pack with/ without posterior nasal pack if bleeding is not controlled.
- Look for and treat cause of epistaxis (e.g. hypertension, bleeding disorders etc).

18.7. AERODIGESTIVE TRACT FOREIGN BODY

- Immediate x-ray to confirm presence and position of foreign body.
- Explain requirement of surgical procedure to patient for removal.
- Inform specialist and technician on call.

18.8. AIRWAY OBSTRUCTION:

- Monitor oxygen saturation.
- Inform specialist and technician on call.
- Perform cricothyrotomy if required (wide bore needles, mini trach set etc).

18.9. EMERGENCY CALL

- If the patients comes to ENT ward through Casualty Department after consultation with the ENT Specialist (if ENT patient) or Eye or Dental (if Eye or Dental patient), then prepare accordingly and inform the surgical team and OT staff on emergency duty.

18.10. MISCELLANEOUS

- Infection control measures should be followed as per the protocols/guidelines.
- Life saving drugs and equipments should be kept ready and available at all times to combat anaphylactic shock, post operative shock, cardiac arrest, etc.
- Dignity and privacy of patients should be maintained at a highest level.
- Inform the Hospital Administration about incident, RTA cases, Assault cases, Prisoner and VIP cases admitted in the unit.
- Hospital waste segregation should be strictly followed as per protocols/guide lines.
- Patients file documented by the Doctors and Nurses should be kept as confidential.
- Any patient admitted in the unit with B2O must be kept as confidential.
- Ward should be kept clean and tidy, silence and visitor control should be observed before ward round.

CHAPTER 19. INTENSIVE CARE UNIT

19.1. EQUIPMENTS COMMONLY USED IN THE ICU

- Monitors
- Defibrillators
- Mechanical ventilators (respirators)
- Syringe pumps
- ECG machines
- Intravenous catheters (tubes) CVP catheters
- ABG machines

19.2. ADMISSION

19.2.1. CRITERIA:

- Follow ICU admission guideline.
- Refer ICU nursing procedure manual, 2010, page 3.

19.2.2. PROCESS

- Follow ICU standing order guideline, page

19.2.3. RULES AND REGULATIONS:

- Explain rules and regulations to patient's attendants and get signed as per the protocol.
- Refer ICU nursing procedure manual, 2010, page 75.

19.3. CARE TEAM:

- Anaesthesiologists/nurse anaesthetists, medical specialists, surgeons.
- ICU nurses who are specialized in caring for critically ill patients should provide round the clock bedside care and monitoring.

- Physiotherapist/Physiotherapy technicians should provide chest physiotherapy and help patients maintain flexibility and muscle strength to prevent disability and recovery.
- Nutritionist/Dietician to assess nutritional support in critically ill patients.

19.4. ROUND TIMIE

- Anaesthetists 9.00AM and emergency calls
- Surgeon after ED round and emergency calls
- Medical Specialist after ED round and emergency calls
- Nurses morning – 8.00 AM - 2.00 PM

  Evening – 2.00 PM -8.00 PM

  Night _ 8.00 PM - 8.00 AM

19.5. INCIDENTAL REPORT

- Record all incidents in the incident register and report to concerned authority.

19.6. PATIENT SAFETY:

Patients are at risk of adverse events:

- Medication errors
- Falls
- Post-intervention complications
- Incidences of "failure to rescue"Inpatient deaths subsequent to patients experiencing complications.

19.6.1.ACCIDENTAL REPORT

- Record in the register and report to infection control focal person.

19.7. INTERDEPARTMENTAL CONSULTATION

- Concerned specialists should examine the patient immediately if urgent or as and when requests are made for their expertise by treating specialists and duty nurse.

19.8. EQUIPMENT MAINTENANCE

- Nurses should maintain stock ledger for old and new supplies.
- BES personnel should carry out equipment maintenance quarterly and as and when required.
- Cleaning of equipments such as monitors, ventilators, defibrillators, syringe pumps, ECG machines, etc should be done daily by the duty nurse and support staff.
- Proper handing and taking over of the equipments should be done on each shift.
- Check if the equipments are functioning.
- Malfunctioning and defunct equipments should be sent to Biomedical Engineering Unit for repairing or replacement.
- All the damaged equipments should be handed over to CMS with condemned certificate issued by biomedical engineer.

19.9. INFECTION CONTROL AND WASTE MANAGEMENT

- Follow infection control and waste management guideline, 3rd edition, 2006.

19.10. CARE OF BODY AFTER DEATH

- Follow guideline for general care of body after death.

19.11. HAZARDS

- Refer ICU guideline, 2010, page 92

For following procedures refer ICU Nursing manual, 2010 **Page No.**

For following procedures refer ICU Nursing manual, 2010 **Page No.**

19.12. ICU STANDING ORDER

- Check the monitors, ventilators and ECG machine daily.
- Check emergency trays with drugs. Intubation sets (adult & paed) should be checked by duty staffs.
- During admission – examine the patient thoroughly for any sores or wound, IV sites (any swelling), type of IVF, drainage, NG tube, investigations (CBC, LFT, RFT, Serum, electrolytes with calcium HbsAg, HCV, HIV).
- Change .V sites every 48 hours or whenever necessary and urinary catheter every 14 days.
- Get handover from escorting staff properly and note down in the nurses note.

- Provide slippers to patients' attendant and instruct them to wear properly at all times.
- Go through doctors' order and follow them strictly.
- Explain ICU rules and regulations to the patients' attendant.
- Maintain critical chart strictly for every patient.
- For x-ray and USG follow doctor's order.
- ECG stat and daily for all cardiac cases.
- Position changing Q2H and ETT/tracheal tube suctioning Q4H and PRN.
- Maintain GCS for all unconscious patients.
- Personal hygiene before bed making every morning.
- RBS OD for all patients in coma, on ventilator, diabetic and TPN if not advised by doctors, otherwise follow orders. To consult dietician if required.
- Consult for Trans out for stable cases with concern doctors.
- Thorough washing of the unit on every Saturday morning. Mopping should be done on every shift.
- Washing of slippers alternate days.
- Check articles/controlled drugs every shift and maintain with registration No. of the patients.
- Stick one attendant per patient strictly.
- Send the procedure/dressing sets/cheatle forceps daily to CSSD.
- Bleaching solution should be changed every 24 hours.
- Used ventilator tubing's should be soaked in cidex, washed and rinsed in running water. Then sent for autoclaving with proper labelling.
- Unused ventilator tubing's should be sent for autoclaving every 7 days.
- Educate patients' attendant on waste disposal.
- Send WB/WG/cleaner to reach soiled linens and to collect the washed linens from the laundry unit daily.
- Check the medication by two nurses while preparing and giving to avoid Medication errors.
- Take consent for every invasive procedure.

CHAPTER 20: MEDICAL WARD

20.1. WARD ROUND

- Visitor control, one attendant for one patient.
- No O.P.D. consultation and appointments for other patients.
- Round time 9:00 AM sharp.
- Start round alternately in male/female side.
- Carry out new orders immediately;Fill up lab. forms and place in the lab file
  - ❖ Note changes in the drug chart
  - ❖ For procedure(s) prepare sets so that time is not lost
  - ❖ Plan discharge and inform patient/ attending person
  - ❖ Note in the round for handing over to the next shift
  - ❖ Clear away files for appointment(s)/discharge process/ place back in place.

20.1.1. PREPARATION FOR ROUND TROLLEY

- Clean trolley
- Patient's file
- Drug chart
- Round book
- Torch
- Hand rub solution (alcohol base hand rub)
- Knee hammer
- Gloves
- Investigation forms
- Discharge slips
- Waste container
- Scissors
- Plaster

20.1.2. WARD ROUND DUTY

- Specialist on duty
- Doctors on attachment
- Nurse in charge
- Available nursing staff (One staff will remain in station to carry out orders, attend calls and liaise).
- Students if there are no other work at hand.

20.2. LABORATORY SAMPLE AND REPORT COLLECTION

20.2.1. INVESTIGATION

- Complete the investigation form.Enter in the report collecting register all the details for tracing report(s) later.
- Keep the form in the laboratory request file for laboratory technician.
- In case of Emergency and urgent investigations, write "urgent" on the top of the form and inform the lab technician on duty for collection of samples.

20.2.2. FOR USG PATIENT PREPARATION AS PER GUIDELINE/PROTOCOL

- The physician should fill up the USG request form and sign.
- Request portable for bedridden patients.
- Get appointments for USG Doppler.
- Send the patient with file on the given date.

20.2.3. ECHO

- Send the file for appointment date.
- Send file on the given date to the echo unit and wait for the call to send the patient.

20.2.4. ENDOSCOPY

Preparation

- Send the file for appointment date.
- Fasting overnight (from 10 pm) before endoscopy.
- Send the file on the given date and wait for the call.

20.3. ASSESSING & PREPARATION REFER TO NURSING PROCEDURE MANUAL

- Lumber Puncture
- Bone Marrow Aspiration
- Chest drainage (Thoracocentesis)
- Pleural Fluid Tapping
- Abdominal Fluid Tapping (Paracentesis)
- Cut down set
- Dressing

CHAPTER 21: GYNECOLOGY AND OBSTETRICS CARE

21.1. PREPARATION FOR CESAREAN SECTION

- Explain the patient and party on indication of emergency LSCS.
- Give 1 ampule each of Inj. Ranitidine and Inj. Maxeron by IM route.
- Send blood for CBC and cross-match with two donors.
- Collect the report at the earliest.
- Inform the OT staff on duty.
- Inform Paediatrician regarding the LSCS and its indication on case by case basis.
- Take consent from the patient party for LSCS.
- Give gown to patient.
- Remove all jewellery, nail polish, under wear and pads.
- Insert indwelling catheter.
- Trim pubic hair if hair line is very high or remove with hair removal cream. Take patient to OT when it is ready.
- Staff that receives the baby from OT must take the following:
  - ❖ A pair of sterile scissors
  - ❖ 2 Sterile cord ties
  - ❖ 1 Baby blanket
  - ❖ 4 Cotton Napkins

21.2. POST OPREATIVE CARE FOR CAESAREAN PATIENT:

- Receive patient from OT after assessing the general condition/instructions from OT staff with patient file.
- Ensure patient is fully recovered.
- Place the patient on the bed.
- Note time of patient warding.
- Hang the I.V fluid on I.V stand.
- Check the operated area for bleeding.
- Check the catheter, drain and fix them properly.
- Carry out the post up orders from Surgeon/Anaesthetist.
- Check BP, pulse, respiration and temperature and repeat as per instructions. Chart properly. Inform any fluctuations of vital signs.
- Give I.V N/S with oxytocin 20 IU@15 to 20 DPM/as per order of doctor.
- Check abdomen, bleeding per vaginal ½ hourly to one hourly for 6hours. If there is bleeding PV, remove clots from lower segment if possible, give Injection Methergin 1amp IM stat and repeat after 3hours. *(DO NOT GIVE INJECTION METHERGIN TO PATIENTS WITH PIH/HD)*.
- Inform doctor on call if bleeding continues.
- Give Misoprostol 800 mcg rectally if bleeding does not stop.
- Maintain I/O chart properly.
- If any telephonic consultation done, note date and time along with instructions given by the doctor. Nurse informing and carrying out the order should also write his/her name and sign on the file.

21.2.1. BABY

- Put the baby for breast feeding as early as possible, within one hour.
- Teach mother how to breastfeed the baby.

21.3. INDUCTION OF LABOURLABOR

21.3.1. PURPOSE OF INDUCTION:

- Stimulating the uterus to bring on the onset of labor pain.
- As far as possible, start induction early in the morning.

21.3.2. COMMONLY USED DRUGS FOR INDUCTION

- Oxytocin
- Misoprostol

21.3.2.1. Instruction for using Oxytocin on:

Multi gravid (G4 or >):

- Use 2.5 IU of oxytocin in 500 ml in NS.
- Start with 10 drops /min.
- Increase by 10 drops/min ½ hourly until it reaches 60drops/min.
- If the target of uterine contraction is not achieved, use second bottle with same regimen.
- Check heart, contractions ½ hourly and pulse and BP and temperature 2 hourly.
- Ask patient to pass urine 2 hourly.
- If the result is not achieved, repeat induction for 3 consecutive days.

Primi Gravida:

Primigravidas with favorable cervix (Bishop score > 6) should be induced with Oxytocin

- Use 5 IU of oxytocin with 500 ml of NS
- Start with 10 drops /min.
- Increase by 10 drops/min. ½ hourly until it reaches 60 drops/min.
- If the target of uterine contraction is not achieved use second bottle with same regimen.
- Check heart and contraction ½ hourly and BP, pulse and temperature 2 hourly.
- Ask patient to pass urine 2 hourly.
- If the result is not achieved, repeat induction for 3 consecutive days.

Note: *If the uterine contraction is lasting >60 sec. or there are >4 contraction in 10 minutes, stop oxytocin infusion immediately. Turn patient to left lateral position, give oxygen 4-5 l/min and inform doctor on call.*

21.3.2.2. Instruction for using Misoprostol

Misoprostol is a Prostaglandin E analogue and used mainly for priming of unfavourable cervix (Bishop score less than 6)

- Admit patient and explain procedures to patient and party.
- Caesarean section facilities are available.
- Medications to deal with hyperstimulation are available like nifidifine & salbutamol.
- AFI status must be checked.
- CTG must be done for 20 minutes before insertion of Misoprostol.
- Repeat CTG after 2 hours of Misoprostol insertion (this is to rule out hyperstimulation of uterus).
- Inform doctor on call if there is abnormal CTG.

21.3.2.3. Doses

Primigravida

- Insert 50 mcg in the posterior fornix of the vagina.
- Make patient lie down for 2 hours.
- Do CTG after 2 hours for 20 minutes.
- Repeat if no progress for three consecutive doses.
- The total dose per patient should not be more than 200 mcg.

Multigravida

- Insert 25 mcg in the posterior fornix of the vagina.
- Make her lie down for 2 hours and do CTG for 20 minutes.
- Repeat if no progress for three consecutive doses at an interval not < 6 hours.
- The total dose per patient should not be more than 200 mcg.

Note: *Do not use oxytocin either for induction or augmentation within 6 hours of misoprostol insertion!*

21.3.2.4. Contraindications of Misoprostol

- Sensitivity to Misoprostol
- Scarred uterus including past caesarean section, myomectomy and hysterotomyGravida more than 3
- History of bleeding (APH)
- Membrane rupture (SROM)
- Favorable cervix (Bishop score > 6)
- Multiple pregnancy
- Mal-presentation of foetus

Note: *Do not use misoprostol for augmentation of labor*

CHAPTER 22: OPERATING THEATRE COMPLEX

22.1. RESPONSIBILITIES OF THE FIRST ASSISTANT:

- The first assistant practices in an expanded role in surgery by rendering assistance to the surgeon to facilitate quality care of patients undergoing surgical procedures.
- The first assistant should practices in collaboration with surgical team and under the direction of the surgeon.

22.2. RESPONSIBILITIES OF THE SCRUB NURSE

- Should work effectively with circulating nurse to prepare the operating room by following defined procedures for Establishing and Maintaining the Sterile Field.
- Assist with the positioning of the patient as needed.
- Assist surgeon in wearing gown and glove whenever possible to ensure appropriate sterile technique.
- Perform the passing of supplies, equipment, or instruments to the surgeon or assistant.
- Perform sponging or suctioning of the operative site as directed.
- Keep instruments clean of blood and debris by wiping them with a sterile water moistened sponge.
- Prepare and cut suture material.
- Prepare medications on the sterile field such as local aesthetic or antibiotic for irrigation under the direct supervision of the surgeon.
- Hold but should not place retractors.
- Perform counts of required items per procedure such as sponges, needles, other supplies, and instruments with the Circulating nurse.

- Perform the disposition of any specimen/specimens or cultures according to procedure.

22.3. RESPONSIBILITIES OF THE CIRCULATING NURSE

- Collaborate with scrub personnel and anaesthesia prior to the surgical procedure to carry out the plan of care.
- Confirm patient identity with clinical chart and reading out of surgical safety checklist.
- Verify surgical site with the patient, clinical chart, anaesthesia and the surgeon.
- Oversee and assists as needed the safe transport of the patient to the OT bed/ table.
- Collaborate with scrub person to prepare the operating room by gathering sterile supplies, instruments and equipment following aseptic technique.
- Direct or complete the placement of the electrosurgical grounding pad.
- Ensure the patient is not left alone in the OT.
- Oversee the positioning of the patient following the Positioning Procedure.
- Oversee and/or complete the skin preparation prior to the surgical incision.
- Whenever possible, keep the doors to the OT closed to limit the flow of personnel in and out of the OT.
- Oversee visitors/students in the OT and directs their observation to prevent contamination of the sterile field.
- Provide additional sterile instruments or supplies as needed by scrub personnel.
- Conduct the "Counting Procedure" to ensure timely counting of required items with the scrub personnel and record counts in the clinical record.

- Specimen/culture label and record in specimen register, dispatch the specimen (ascetic fluid, pus, peritoneal washings, swabs) to the ward.
- Provide the dressing material, drains, and other material as needed.
- Assist with the application of the dressings at the end of the procedure.

❖ *should be physically present throughout the procedure.

22.4. GENERAL POLICIES

22.4.1. DEFINITION

- OT personnel include all types of surgeons, anaesthesia staffs, scrub Nurses, technicians from the services of ENT, Orthopedics and Ophthalmology, housekeeping staff, students and visiting doctors.

22.5. TIMING

- All the surgeons and anaesthesiologists should be in OT by 9.00 am.
- All surgery should start at 9.10 am sharp.
- All Nurses, Technicians and nurse anaesthetists should be in OT by 9.00am.
- Major surgery and General Anaesthesia case should not be taken after 2.30pm. Only short surgery case and anaesthesia should be accepted after 2.30 pm.
- All the supporting staff should be in OT by 8.00 am and get checklist sign from night duty staff.
- Students posted from RIHS should report to OT incharge as per the RIHS guideline.

22.6. FUNCTIONS

- ALL staff should not handle narcotic drugs. Only anaesthesiology and nurse anaesthetist will handle under strict hospital narcotic guidelines.
- Handing taking during the shift should be done strictly.

- Maintain professional working relationship amongst surgeons, anaesthesia personnel, nursing personnel, housekeeping, and other employees to maintain an efficient, effective and safe work environment.
- Adhere to the Principles of Aseptic Technique and infection control and waste management guideline.
- In case of any event resulting from negligence/non-adherence, the management should be notified.
- Facilitate the protection of patient's rights in relation to confidentiality, privacy, beliefs, values, and wishes.
- Confirm right patient and surgical site with the patient's chart and the surgeon (follow Safe surgical checklist).
- Communicate the surgical site to other members of the surgical team as needed.
- Demonstrate adherence to the Surgical Attire Procedure.
- Keep cell phone on silence mode and do not use the cell phone and maintain low level of noise when in presence of the patient.
- All the staff should follow hospital code of conduct.
- Maintain the room temperature in the operating theatre that is appropriate for the patient (17-21 degree Celsius).
- Whenever possible, reduce the traffic flow of personnel in and out of the OT.
- Ensure all visitors/students to stand away from the sterile field to avoid contamination.
- Keep OT doors closed except as needed for passage of equipment, personnel and the patient.
- Limit the number of personnel entering the OT to only those necessary for the surgical procedure. The microbial level in the OT is directly proportional to the number of people moving in and out of the theatre.

22.7. THE NUMBER OF PERSONNEL IN THE THEATRE AND AROUND THE SURGICAL FIELD SHOULD BE LIMITED TO A MINIMUM OF

- 1Surgeon
- 1 Anaesthesiologist/ nurse anaesthetist
- 1 Anaesthesia assistant (2 can be assigned to difficult cases)
- 1 First Assistant (2 can be assigned to difficult cases)
- 1 Scrub nurse
- 1 Circulating nurse (2 can be assigned to difficult cases)
- 1 observer/student (2 can be assigned to cases/room by approval of the OT in-charge)

22.8. THE SURGICAL SUITE SHOULD HAVE 3 ZONES/LEVELS OF INCREASINGLY RESTRICTED ACCESS

222.8.1. ACCESSIBLE AREAS:

- Street clothes are permitted
- Includes changing area
- May also include pre op and post op holding area (red line)

22.8.2. SEMI-RESTRICTED AREAS:

- OT dress with only undergarments is permissible
- Staff lounge
- OT Supervisors office
- Clean and sterile storage areas, support areas such as housekeeping, corridors leading into theatres

22.8.3. RESTRICTED AREAS:

- OT dress with complete surgical attire is required.

- Includes any area where scrub personnel are present and/or sterile supplies are opened, scrub sink area while surgical scrub is in progress.

22.9. VISITORS

- All visitors should report to/or communicate with the reception desk and receive authorization and directions as to traffic flow and dress protocol.

22.10. STERILIZATION

- Only confirmed cases of infectious disease such as B20, HbsAg should be decontaminated in OT and sent to the CSSD.
- All the sets should be cleaned and sharps should be removed.
- Proper hand over of used sets should be given to CSSD.

22.11. RECORD AND CHARTING:

- Scrub Nurse should record counting book and surgical checklist as per the protocol.
- Fill up the log book.

22.12. HAZARDS IN OPERATION OT

- Electrical power and power failure alarm.
- Examine the integrity of the power cord and plug.
- Ensure the power cord is connected directly to an UPS (un-interrupted power supply) socket and turn on all machines and monitors.
- Unplug the power cord with the machine turned on after using.
- Ensure the audio and visual power failure alarms are activated.
- Ensure the battery backup power (if available) is functioning.
- Scavenging system (active)
- Check all the air condition and air flow systems of OT.
- Follow all the infection universal precaution.

CHAPTER 23: DEPARTMENT OF OPHTHALMOLOGY

23.1. OUTPATIENT EXAMINATION

23.1.1. REGISTRATION

- Tokens for eye OPD should be collected from registration area of the Eye Department.
- Registration for eye consultation for both new as well as review patients should be done.
- On the sub-specialty clinic days, regular registration at the reception desk should continue.
- Separate and detailed registration should be done by the staff of the sub-specialty clinic unit.

23.1.2. MATERIALS REQUIRED

- Separate registers for new and review patients and OPD card.
- Sub speciality clinic registers.

23.2. VISUAL ACUITY (VA):

Location for VA screening: Chamber no 8. of the eye OPD.

Responsibility: Ophthalmic assistant or ophthalmic technician (OA):

- Trained Orthoptician to carry VA checks for all paediatric patients below five years in chamber no 2.
- Technical SOP for testing VA should be followed and carried out on all patients.
- Documentation of the VA to be done on the patient's OPD card.

23.3. REFRACTION

23.3.1. BEFORE CONSULTATION:

- All new patients with visual acuity less than 6/6 but better than 6/60.

23.3.2. AFTER CONSULTATION:

- All patients for follow up
- Patients with less than 6/60 VA
- Difficult refraction should be cross checked by Orthoptician before giving final prescription for spectacles.
- Follow Technical SOP for Refraction

23.4 CONSULTATION

Indications

- All patients needing general and specialized ophthalmic services
- **Location**: chambers no 3, 4 and 5 of eye OPD
- **Responsibility**: All ophthalmologists in the respective chambers
- **Timing of consultations**: Monday to Friday 9 am to 3 pm
  Saturday - 9 am to 1 pm

23.5. SUB-SPECIALTY CLINICS

Indication

- Patients with complex eye problems related to sub-specialty fields of ophthalmology.
- **Time**: Clinics will open from 9.00 am on the designated days so that far off patients can return home the same day.

- Days designated for the clinics
  - ❖ **Every Wednesday**: clinic for Cornea and Anterior Segment should be held in chamber no 5
  - ❖ **Every Tuesday**: clinic for Paediatric Ophthalmology and Adult Strabismus in chamber no 3.
- **Responsibility**: Ophthalmologist trained in this sub-specialty assisted by OA for registration and consultation.

23.6. IN PATIENT EYE DEPARTMENT

23.6.1. EYE SURGERIES:

23.6.1.1. Designated days:

- Eye cases needing general anaesthesia should be admitted on Saturday or Sunday and be posted on Mondays for surgery.
- Eye cases done with local anaesthesia should be posted on Mondays and Thursdays as day care patients.
- Preoperative counselling should be done while admitting the patients or when appointment is completed before the day of surgery either by the physician, eye ward nurse, in-charge or a counsellor.

23.6.1.2. For routine day care surgeries:

- Follow the list of necessary pre-operative procedures in the technical SOPs for each type of eye surgery. These lists should be carried out few days prior to surgery day.
- The enlisted relevant investigations should also be completed in the pre-operative period.

- **OT list**: It should be prepared and approved by any ophthalmologist latest by every Wednesday and Saturday and circulated to the OT nurse I/C, eye ward nurse I/C and the administrative office.
- The patient's gowns should be made available in the OT waiting area.
- Post-operative follow up should be done in Eye OPD the following day of surgery.

23.6.1.3. For admitted eye cases:

- For all admitted patients, all preparations should be done in the ward on a day prior to surgery.
- The ward patients undergoing surgery should have the gowns changed in the ward itself.

23.6.1.4. Post operative care:

- Follow-up should be done in the ward for admitted patients. After surgery, the ward nurse should visit every postoperative patient and give the essential instructions.
- Follow-up of admitted cases: Each day the admitted patients should be reviewed in the ward by the on call ophthalmologist during the morning rounds.
- All operated day care patients should be remained in OPD only the next day.

CHAPTER 24: DEPARTMENT OF ORTHOPEDIC SURGERY

24.1. POST OPERATIVE CARE

- Upon receipt of the patient from the O.R., post-op orders must be read carefully and all the instructions carried out scrupulously.
- Patient's vital signs must be checked carefully and monitored regularly till the patient's stability is ensured.
- Any untoward incidents, i.e. excessive soakage at the operation site, fall of B.P, etc. the surgeon or the anaesthetist should be informed accordingly.

24.2. WOUND CARE AND DRESSING CHANGES

- Dressing changes for the open wounds and post-operative wound cares should be carried as per protocol in nursing manual.

24.3. PIN SITE CARE

- Patients with External Fixator Pins or k-wires protruding outside the skin should receive proper pin care as per the pin-care protocol.

24.4. SKIN TRACTION

- Skin traction is a ward procedure and all the orthopaedic ward nursing staff should be able to carry out this procedure whenever such is advised by the doctor upon the patient' admission.

24.5. SKELETAL TRACTION

- The application of skeletal traction is the job of the OPAs/Ortho-Techs. Therefore, when the patients in the ward are advised of skeletal traction, one OPA/Ortho-Tech should be asked to be deputed to carry out the procedure. If this procedure is to be done after the office hours, then the emergency on-call should be called.

24.6. CARE OF SPINAL CORD INJURY PATIENTS

- Spine injury patients with cord injuries (paraplegia/quadriplegia) calls for special attention and care by the nursing staff as improper handling by the staff can cause further harm to the patient. "FIRST DO NO HARM "principle.
- Therefore, upon admission of such a patient to the ward, the nursing staff on duty should study the case file properly and clearly understand the neurological status of the patient.
- If neurological impairment has been documented in the case sheet, then spinal cord injury patient care protocol should be followed strictly at all times.

24.7. CARE OF PATIENT WITH PLASTER OF PARIS

- Patients with POP splints and casts must be monitored for splint/cast tightness as per the POP splint/cast care protocol.
- Any negligence in this protocol by the nursing staff on duty can lead to serious consequences to the patients, i.e., compartment syndrome with all undesired squeal.

24.8. PREPARATION OF PATIENTS FOR EMERGENCY OPERATION:

- All patients going for emergency operation should have all the documents signed by the patient/patient's guardian. Complete preparations should be carried out before sending the patient to O.R.
- When patients are called to the O.R, prompt actions should be taken in order to avoid any undue delays.
- Call should be made to all the concerned emergency on-call personnel and time of the operation must be intimated correctly.

24.9. PREPARATION OF PATIENTS FOR ROUTINE OPERATIONS: [MONDAY TO FRIDAY]

- Preparation of routine O.R. list should be done one day prior to the operation day.

- All the patients undergoing major operations should be admitted one day prior to the operation. Only minor operations which can be done under local anesthesia may be admitted on the same day of the operation.
- All pre-operative preparations (document signing and patient preparation) should be carried out and it's completeness checked by the evening duty nursing staff.
- Any additional cases listed for the next day that comes after the office hours should be added in the operation list by the evening/night duty staff.
- Any other case that is admitted in the night but if operation is not confirmed should be kept NPO till confirmed by the doctor in the morning.
- If a patient listed for operation is detected to have hypertension, the anesthetists should be notified before the patient is taken to the O.R.

CHAPTER 25 : PEDIATRIC DEPARTMENT

25.1. NEONATAL WARD/NICU/PEDIATRIC WARD

25.1.1. ADMISSION CRITERIA TO NICU/NEONATE

- Severe respiratory distress,
- Preterm
- Transient tachypnea of new born,
- Meconium aspiration syndrome,
- Birth asphyxia.
- Apnea and
- Those who requires continuous monitoring and ventilation
- Neonatal jaundice
- Feeding difficulty
- Neonatal pneumonia
- Congenital anomalies
- NEC
- Hypoglycemia
- Hypothermia
- Neonatal convulsions
- Suspected case of sepsis
- Post-operative neonatal surgical cases

25.1.2. ADMISSION CRITERIA FOR PEDIATRIC WARD: D

- Pneumonia
- Acute gastroenteritis with dehydration
- Hypereactive airway disease

- Septicemia
- Nephrotic syndrome
- Acute glomerulonephritis
- Severe laryngotracheobronchitis
- Severe malnutritions
- Malignancies
- Blood disorders
- Cerebral with complications
- Pyrexia of unknown origin
- Dengue haemorrhagic fever
- Severe malaria
- Typhoid fever
- Seizure disorder
- Any child who needs continuous monitoring
- Paediatric surgical cases up to age 5 and below

25.2. WARD ROUTINE

This should include

- Times and frequency of observations.
- Medication times.
- Medical ward rounds.
- Nursing shifts.
- Dietician visits.
- Relaxation therapy.
- Personal hygiene routine (mouth care, central venous catheter care, daily shower).

CHAPTER 26: PSYCHIATRY DEPARTMENT

26.1. SECURITY AND SAFETY

- Security and safety of patients, their relatives and staff are paramount to maintain a safe, quiet and healing atmosphere in the hospital. Psychiatry patients and particularly drugs and alcohol dependent patients are high risk of becoming aggressive and violent due to the nature of their disorders. Therefore, the psychiatry ward and the drugs and alcohol detoxification unit should be safeguarded by adequate security 24 hours a day.

26.1.1. TERMS OF REFERENCE (TOR) FOR SECURITY PERSONNEL:

- Security personnel should guard the ward entrance 24 hours.
- Security personnel should only allow one visitor per patient inside the ward at a time.
- Security personnel should help nurses physically search and screen patients for drugs and sharps during admission and while returning to ward from home leave or consulting other doctors.
- Security personnel should help staff restrain from patients physical action when necessary.
- Security personnel should prevent patients from absconding from the ward.
- Security personnel should allow only children of patients into the ward.
- Security personnel should not allow people who are suspected to be under the influence of alcohol or drugs into the ward.
- Security personnel should not allow OPD or ED patients inside the ward. They should direct patients to the respective chambers.

26.2. COLLECTION OF INFORMATION ON PATIENT THROUGH TELEPHONE AND EMAIL

- History taking especially psychosocial history is very important to formulate a comprehensive management plan for psychiatric and drugs and alcohol patients. Many a time psychiatric, drugs and alcohol patients cannot give complete history by themselves and there are no reliable family members or relatives to corroborate history. In such cases, telephone or email should be used to obtain more information from relevant people.

26.3. RANDOM PHYSICAL SCREENING OF PATIENT AND THEIR BELONGINGS

- Whenever it is suspected that patients are abusing or smuggling drugs and alcohol in the ward, staff should do on the spot random physical checking including urine screening of drugs (if facility is available) and search his/her belongings. If the patients are caught in the possession of these contraband items, they should be discharged as per the protocol.

26.4. RANDOM URINE TESTING FOR DRUGS AND BREATHALYZER TESTING FOR ALCOHOL

- Whenever it is suspected that patients are abusing drugs or alcohol in the ward, staff should do on the spot random urine screening for drugs, breathalyzer for alcohol and collect blood samples for drug confirmation. If patients are found positive for drugs and alcohol, they should be discharged.

26.5. PROTOCOL FOR DEALING WITH DIFFICULT PATIENTS & RELATIVES:

26.5.1. VIOLENCE BY PATIENT:

- Psychiatric, drugs and alcohol patients are high risk for violence due to their mental condition and therefore it is not uncommon to find violence in the ward sometimes. Staff should follow specific instructions for treatment of such patients if any. Otherwise, psychiatrist should be informed immediately. Mobilize support from security services and staff of other wards if patients need physical restraint.

26.5.2. VIOLENCE BY RELATIVE

- Violence is also not uncommon among relatives and visitors of drugs and alcohol patients, who may be abusing drugs and alcohol themselves. In such cases, hospital administration and the police should be informed.

26.5.3. DESTRUCTION OF HOSPITAL PROPERTY:

- It is also not uncommon for the psychiatric, drugs and alcohol patients and their relatives to destroy hospital property. Any deliberate damage to hospital property should be replaced or paid in equivalent value by the concerned patient or his/her relative.

26.5.4. INTOXICATION AND SMUGGLING OF ALCOHOL AND DRUGS INTO

- If patients are found intoxicated either with drugs or alcohol while being admitted in the ward, they should be discharged as this behaviour is in contradiction to the objective for which the patient is admitted. If a patient displays violence toward staff or other patients, police may be called for intervention. Intoxication of relative or importation of alcohol or drugs by visitor, family or friend should be treated as a serious offence which will invite police intervention and discharge of patient concerned.

26.6. CASE MANAGER

- In order to improve the management of cases both in terms of gathering information or developing a therapeutic relationship with the patient, individual staff should be allocated cases. The nurse who admits the patient will become the case manager for that particular case.

26.6.1. RESPONSIBILITIES OF THE CASE MANAGER:

- The case manager should obtain detail history and other information from patient and family.
- The case manager should do mental state examination on admission and formulate a complete management plan for the patient.

- The case manager should present the details of the case during ward rounds.
- The case manager should follow up on patients and their relatives during admission.

26.7. WARD ROUND SCHEDULE

One psychiatrist shall do ward round for psychiatry patients and other psychiatrist should do ward round for drugs and alcohol patients as per schedule below:

Monday:	9 AM – 11 AM	Psychiatry patients	Dr. Chencho Dorji
Tuesday:	9 AM – 11 AM	Alcohol & Drugs patients	Dr. Damber K Nirola
Wednesday:	9 AM – 11 AM	Psychiatry patients	Dr. Chencho Dorji
Thursday:	9 AM – 11 AM	Alcohol & Drugs patients	Dr. Damber K Nirola
Friday:	9 AM – 11 AM	Grand Round and CME	All Staff

26.8. ELECTRO CONVULSIVE THERAPY (ECT) PROCEDURE

- ECT should be introduced very soon in the ward. Informed consent for ECT should be taken from the patient if he/she is in a position to do so. Otherwise, it should be taken from the patient's relative. The procedure should follow clear standard guidelines. ECT should be given under general anaesthesia and muscle relaxation under the supervision of anaesthetist. The first room near the nurses' station should be identified as the ECT room. Patients requiring ECT should be kept in that room.

26.9. DAY CARE CENTRE

- Day Centre is the place for both inpatient and OPD patients to learn or participate in training sessions or engage in meaningful activities such as making envelopes, paper bags etc. under the supervision of staff when not involved in ward rounds or staff meetings. Staff should follow a structured schedule of activities at the day centre (as per schedule in appendix 6).

- Self Help Sober Group Meetings such as AA/NA should be held at the Day Centre on Tuesdays, Thursdays and Saturdays from 5.30PM - 7.30 PM. This Centre should be used only for meetings and not for other events such as birthday celebrations, dinner party etc.
- Day Centre should also be used as recreational and TV centre at other times. Patients or attendants using day centre facilities should maintain cleanliness and silence.
- Television in the ward should be put off at 8PM to allow patients to sleep peacefully.

26.10. DAILY ACTIVITIES FOR ALCOHOL AND DRUG PATIENTS

- Alcohol and drug patients should follow the daily schedules (appendix 6) and follow protocol for the cognitive behavioural therapy (appendix 5).

26.11. REFERRAL TO REHABILITATION CENTRE

- Alcohol and drugs patient needing rehabilitation should be referred according to the protocol (appendix 1).

26.12. ALCOHOL/DRUGS SUPPORT GROUP MEETING:

- Members of the support group should follow ward rules and regulations and timings strictly.
- Members should maintain silence to avoid disturbing patients in the ward. Only one member of the support group should visit the ward to call the in-patients to join the meetings.
- Members of the support group should safeguard the property and maintain cleanliness of the hall at all times.
- Members of the support group should not bring in clients/friends who are intoxicated. Similarly they should not come to the meeting or the ward under intoxication.

26.13. PEER COUNSELOR COUNSELLORSWORKERS

- Peer counsellors should come in formal dress to the ward and should strictly follow the ward rules and regulations.
- They should be punctual and remain in the ward until office time.
- They should not visit the ward at other times.
- They should not bring in their friends to the ward.
- Peer counsellors should be accountable to the nurse on duty and other staff of hospital. They should be present during the ward rounds especially of alcohol and drug patients.
- Peer counsellors should liaise with the Rehabilitation Centre and facilitate admission there.
- They should follow up alcohol and drugs cases discharged from the ward.

26.14. SOCIAL SUPPORT & WELFARE OF PATIENTS

- Although hospital facilities and services are geared to provide only medical care services to patient, the staff of the ward comes across many patients who do not have any family or other social support. The number of self claimed destitute patients are increasing year by year. They create a special problem for the staff on their discharge.
- In the absence of social workers in the hospital and lack of dedicated social services department in the government, the clinical staff has been playing a dual role, also as social workers in the wards. Patients who do not have money to buy essential items such as change of clothes or tooth brushes and tooth paste etc. are supported with money up to Nu. 1000 per patient from the patient's welfare fund. Some patients who do not have money to buy their return bus tickets on discharge are given money from the patient's welfare fund.Until such a time, the hospital and the government set up a full fledge social service department and social workers, these social services should be continued to be provided by clinical staff.

CHAPTER 27: SURGICAL WARD

27.1. CONTENT

- PAC (Pre- Anaesthetist Check-up)
- Pre Operative Order
- Lab Investigation, USG X – rays etc.
- Pre Operative Care
- Post Operative Care
- Plan Discharge

27.2. ONCOLOGY

27.2.1: LAB INVESTIGATION

- Blood CBC
- ABO/RH
- Urea + Creatinine
- Serum Electrolytes
- HCV
- Hbs Ag
- HIV
- ECG

27.2.1. LAB INVESTIGATION

- NPO as per the protocol
- Bowel preparation as per the surgeons advice
- Parenteral Nutrition
- Informed Consent
- Pre – OP. medication (Eg. AB Injection ceftriaxone 1 gm I.V stat on the day of surgery at 6 am)

27.2.2. PRE- OPERATIVE CARE (CA. STOMACH):

- Monitor vital signs
- Pain analgesics
- Wound soakage for signs of bleeding
- Check I.V site
- Monitor intake/output chart
- Inform as required

27.2.4. CARE OF DRAINS:

As per nursing procedure manuals

- N.G tube
- Urinary Catheter
- Drainage bag etc.

27.2.5. DRESSING, MEDICATION:

- As per nursing procedure manual

27.3. DISCHARGE PLAN:

- Follow up as per the doctor's instruction
- Collect Bx report from respective chambers after one week.
- Follow up for Chemotherapy
- Care of wounds
- Change of colostomy bag
- Diet etc.

27.4. UROLOGY

27.4.1. LAB INVESTIGATION:

- Blood CBC
- ABO/RH
- Urea + Creatinine
- Serum Electrocytes
- HIV
- Hbs Ag
- HCV
- Urine R/E & C/S for BPH & Stones

27.4.2. OTHER INVESTIGATIONS

- CT/KUB- on the day of surgery for Urinary stones.
- Bowels wash 6 AM on the day of surgery for Radical Nephrectomy, Prostatectomy etc. X – ray KUB for uretertic stone and bladder stones.

27.5. NEUROLOGY (Head Injury)

- Monitor neurological assessment as per GCS guideline.
- Transfer patient to ICU if GCS< 8/15 after consultation with neuro surgeon.
- Maintain SPO2> 95% with oxygen.

27.6. LAP CHOLE:

- Consent form – Informed consents and interpret to sign and write the name.
- To check blood
- CBC, ABO, LFT reports if not done to do.
- If H/o Jaundice do = HBSAg, HCV
- Tab. Senna- 2 HS
- Tab Cipro -500 mgs (6 Am)

- Cleaning of Umbilicus with povodine Iodine.
- Pass urine before sending to OT.

27.7. BURNS

- Fluid balance
- Antibiotics
- Wound care
- Nutrition
- Physiotherapy

27.8. EMERGENCY SURGERY:

- Check vital signs and record.Informed consent by the concerned surgeon on call.
- Inform OT staff and anaesthetist during GH and holidays or call PABX to inform them.
- Clean gowns to change.
- Inform surgeon on call.
- Accompany patient to OT by the duty nurse.

27.9. DAY CARE SURGERY/ MINOR PROCEDURES

- Concern department should make sure that the cases are managed and disposed without hampering the routine work of the ED, separate minor OT and space for day care surgery may be initiated in the burns unit.

CHAPTER 28 : NURSING SERVICE/ADMINISTRATION

28.1. CODE OF CONDUCT

- All the nurses are expected to perform their tasks as per the duties assigned by the nurse in charge.
- A nurse is expected to be punctual in attendance and duty timings. In case she/he is late for any genuine reason then the same should be presented to the nurse in charge in writing.
- Nurses are liable to be transferred from one ward to another and must accept the decision of the nursing superintendent. In case of any genuine reasons for not accepting the transfer, the same would have to be stated in writing to the nursing superintendent.
- In case a nurse wants a transfer, the same would have to be addressed to the nursing superintendent in writing.
- Nurses should not accept and/or demand any gifts in cash or kind from clients or their relatives.
- All patient information and other hospital information are to be considered confidential and should not be communicated in any form to any unauthorized staff/person.
- All nurses shall register with the Bhutan Medical and Health Council for practice in the institution.
- As employees of the hospital, nurses are strictly prohibited from giving any medicine to any person except to those it is ordered to be given by the treating doctor to the clients.
- Prior intimation about daily duties of the Nursing staff will be appropriately notified, in the duty schedule. Any changes in the duty would require prior written request and approval of the nurse in charge.
- The admitting nurse must carry out all the ward formalities promptly and courteously, as this is perhaps could be the first contact for the client and their family with the hospital.

- Clients look for security, skilful care, clean and hygienic environment and staff should understand them.
- Good nursing practice should be followed 24 hour schedule of nursing care from the time of admission to discharge.
- The nursing staff should ensure that effective client care is being provided in the hospital.
- At the time of discharge the nursing staff should educate the client regarding the post operative instructions and care they need to take at home.
- On duty, nurses should be in station and be attentive all the time.
- Sleeping during duty hours is prohibited.

28.2. DRESS CODE

- On duty the nurses should wear clean and tidy uniforms as prescribed by the institution.
- All the nurses should be well groomed with short unpolished nails and no jewellery to be worn.
- All the nurses should always put on their respective identity cards for security purposes.
- Uniform allowances are provided once a year.
- Act with composure towards all the clients even if the client is being troublesome and/or is in the wrong. Report the matter to the Nursing Superintendent who would do the needful.

28.3. EQUIPMENT MAINTENANCE:

- Ensure that all the equipments are in good working condition and are providing the correct information/data.
- All the equipment should be handled by the nurses and/or technicians and no other unauthorized person should be allowed to handle any of the equipments.

- All the required material for the functioning of the equipment should be requisitioned on a regular basis and inventory records for the same should be maintained.
- Nurse in-charge should inform the Bio-Medical/Maintenance engineer, if the required periodic/annual maintenance of any equipment has not been carried out.

28.4. RECORD KEEPING:

Appropriate records are to be maintained for the department functioning in the areas of:

- Inventory of drugs – emergency.
- Bed occupancy of the ward.
- Cases of clients with the name of the treating physician/consultant.
- Maintain a log book for recording the breakdown of any equipment (the data required would be equipment name, company name, if on maintenance contract (yes/no), time/date of failure, time/date of equipment made functional, reported to whom).
- Record has to be maintained, if the equipment is borrowed by any department or service area and when it has been returned.
- Other records for management purposes should be maintained like:
  - Ward rounds – timings.
  - Provide inputs to the nursing superintendent of any other records to be maintained for the better functioning of the ward/department.
  - Ensure that all the clinical records are being maintained appropriately by the respective treating doctors.

28.5. WARD MANAGEMENT

- The Nurse should know her ward thoroughly with detailed knowledge of the activities, equipment status, doctor visits, ward procedures etc. He/She must be completely aware of the hospital policies and their implications on the ward operations and the interrelated departments of the hospital.
- Nursing staff should follow the nursing procedure manual for any standard procedure.
- The nurses should be familiarized with ward/OT procedures, equipment functioning, furniture and fixtures, types of cases admitted -their criticality and level of care etc.
- The nurse in-charge is to draw a schedule of activities on a daily basis, to be followed by the other nurses.
- The nurse should not leave the station until and unless the next duty nurse has reported to duty and the new nurse being briefed.
- Orientation of all new nursing staff is required to guide and instruct them with the policies of the ward management, duty structuring, routine for emergencies, familiarize with the equipment, supplies, store and medicines of the ward.
- The New staff should be assigned to a senior staff nurse for one week to become conversant with the procedures of the ward.
- All the medicines and other items indented are to be maintained in a log book, which would enable check pilferage.

CHAPTER 29 : HOUSE KEEPING

29.1. TASK STANDARDS

The specific tasks expected to be completed when the area is cleaned, include the following

- *Routine cleaning tasks* - Empty trash; dust furniture; vacuum; spot-clean carpeting (if any), doors, and walls; replenish supplies; dust and wet mop.
- *Weekly cleaning tasks* - Vacuum vents and grilles; vacuum drapes and upholstered furniture; polish metals and furniture.

29.2. QUALITY STANDARDS

- The following are quality standards of the housekeeping department, which should be followed by the sanitary attendants:
- Ceilings cleaning: Free of dust and spots, cobwebs, paint intact, vents clean and free of dust and lint, lights replaced.
- Room walls: Clean, paint intact, free of finger marks and spit stains.
- Floors: Free of dust, lint, and stains, no accumulation of dirt in corners.
- Cove bases: Clean and clear, no mop marks and accumulation of soil in corners.
- Doors Cleaning: Free of marks, finish intact, kick plate (on swing doors like in the OT) clean and shiny, top free of dust and lint, edges clean, handle or knob clear and clean. Hinge facing and door-frame clean, door vent clean and free of dust, window and frame clean and free of dust (inside and outside).
- Windows: Clear and clean, not in need of immediate washing, frame clean; glazing intact; sill cleans; paint in good condition.
- Window drapes: Free of dust; properly hung on tracks; not faded; no stains, yellowing, or tears; pulleys and pull cords intact and working; pins installed correctly in drapes and on carriers.
- Cubicle curtains/screen: Clean and free of stains, not faded, pull freely in tracks, properly mounted, no tears, adequate length and width.

- Beds: Headboards and foot boards clean, metal upright and horizontal frame members clean, linen clean and free of stains and tears, bed properly made, undercarriage free of lint and soil, wheels clean.
- Mattresses: Clean, free of stains, in good repair without rips or tears, mattress turned on each discharge.
- Chairs: Clean, free of lint and dust.
- Television sets: Clean, free of dust and lint; shelf clean & free of dust and lint.
- Toilets: Toilet bowl clean inside and outside; no stains, streaks, or residue; toilet seat clean, free of spots, stains, or streaks, and tightly fastened to toilet, plumbing fixtures clean, free of dust, spots, and base of toilet free of soil build-up and stains.
- Sinks: Clean, free of spots and streaks; plumbing connections to toilet free of alkali build-up.
- Mirrors: Clean, free of spots and streaks; frame top and edges free of dust and lint; shelf clean, free of spots and streaks.
- Bathrooms: Walls clean, free of soil build-up on caulking, caulking intact, fixtures free of spots and streaks.
- Dispensers: Soap, paper towel, and seat cover dispensers clean, free of dust and lint on top and underneath, free of spots and streaks, supplies replenished.
- Refrigerators: Clean, free of dust spots and stains, freezer clear and free of stains, motor vent clean and free of dust and lint.
- Counter tops: Clean, free of dust, stains, and finger marks.
- Telephones: Clean, free of dust and lint; receiver, mouthpiece, and dial free of dust and lint.
- Water Coolers: Stainless steel free of spots and streaks.

29.3. FREQUENCY STANDARDS

- Frequency standards schedules should inform the housekeeping employee how often to clean an area and inform others how often the area is cleaned.

Time of Cleaning Standards

- OPD: *Routine tasks* => 7am and 3pm. daily
- Weekly tasks => washing the area
- Ward: *Routine tasks* => thrice a day (morning, afternoon after the lunch and evening after dinner)
- Weekly tasks =>Washing and thorough infection control measures,
- Completed before 8.00 am
- OT: *Routine Tasks* => Prior (before 7.30 am) and after every procedure,
- Weekly or after every infected case => thorough washing and cleaning.
- Administrative Area: *Routine tasks* => once in a day after OPD hours.
- Waiting area, Lobby and Corridors: *Routine cleaning* => every shift and as and when required.

29.4. QUALITY CONTROL

- The quality control program of the housekeeping department should adhere to the standards, continuous monitoring, control and improving the standards. It is a system of visually inspecting the areas, measuring the degree of cleanliness, and recording and reporting the findings. An effective quality control program ensures follow-up of employee work performance, indicates areas where cleaning program frequencies need adjustments, pints out employee training needs, ensures cleaning of all areas, creates good public relations among housekeeping, other departments, clients and corrects deficiencies before they become complaints.
- To ensure that the employees are doing high-quality cleaning and completing the assigned tasks; 'employee task completion cards' can be used. These cards may be valuable not only to know that the employee does his duty but also in cases to solve client dissatisfaction, of not cleaning certain areas (when the client may not be present at the time of cleaning).

CHAPTER 30 : LAUNDRY

30.1. SORTING OF LINENS

- The linen after collected from the different wards/units has to be sorted out in the laundry. The soiled, stained, and normal dirty linen has to be sorted out.

30.2. REMOVAL OF SOILS/STAINS

- It is recommended that 14.5 grams of bleaching power for every litre of warm water and dipping the clothes for at least 10 minutes is recommended for removal of soils and stains.
- The person handling the soiled, stained linen should use a thick rubber gloves that can tolerate bleach and Luke warm water.

30.3. WASHING

- Warm water is recommended for washing machines, this can acts as disinfecting agent too. The time of linen in the washing machine depends on different types of linen. Usually it is recommended for 30 minutes in the mode of strong wash.

30.4. WATER EXTRACTOR AND DRYERS:

- The washed linen should be put in the water extractor for 3-5 minutes and then sent to dryer for drying.

30.5. SORTING OF LINENS FOR TAILORING:

After drying, the linen is checked for wear and tears, the torn clothes should be sent for tailoring or the condemnation committee should condemn it.

The condemnation committee should consist of the following:

- Laundry supervisor
- Tailor

- Store officer
- Responsible person from the users

Separate register should be maintained for the condemnation materials and record has to be maintained for the replaced materials, and linen turnover.

30.6. FOLDING AND PRESSING:

- A pressing machine that can generate its own steam is recommended, this can help in saving electricity and wastage of steam.

30.7. DISTRIBUTION

- The finished goods are to be stored in the clean storage before distribution.
- The clean linen should be checked for quantity before delivery.
- The receipt voucher should be signed by the receiving person.
- The linen should be distributed to different wards/units in separate trolley which are not used for collection.

30.8. STORAGE SYSTEM:

- The storage system should be designed as to enable items to be stored at least 8 inches from the floor.
- 2 inches from the outside wall.
- At least 18 inches from ceiling fixture.

30.9. DOCUMENT TO BE MAINTAINED:

- Instruction manual for all equipments.
- Record of all preventive, maintenance, calibration, and repairs of equipment.
- Load records including contents of each load, initials of the operator, equipment number or other identification and the date and time of cycle.

30.10. MAINTENANCE OF THE CLEANLINESS OF THE UNIT

- Laundry area should be cleaned in every shift before and after washing.
- High dusting and drain washing should be done once a week.
- Unauthorized personnel are not allowed to enter in the laundry.

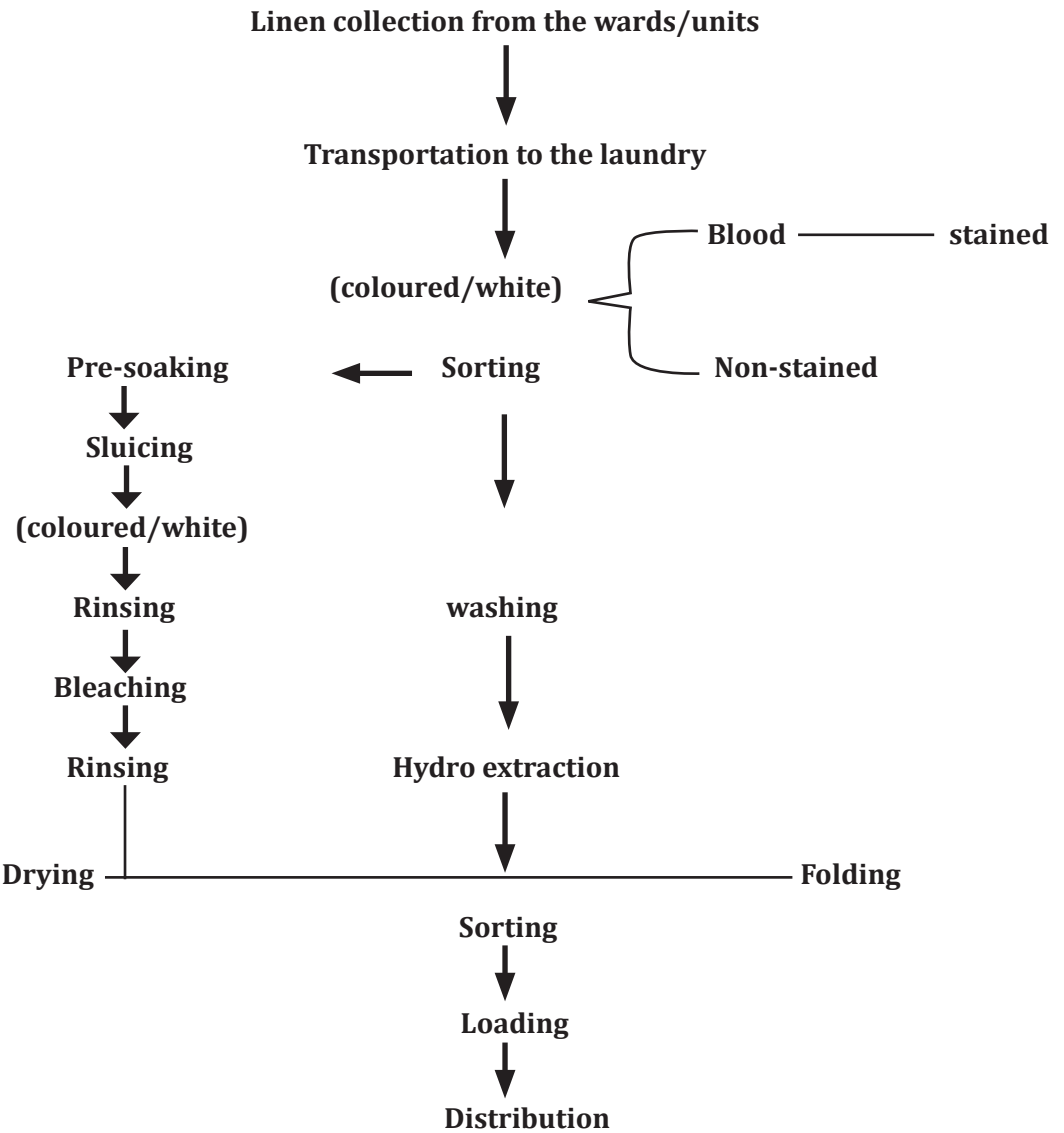
30.11. STANDARD ATTIRE

- The uniform should not be worn outside the hospital.
- The uniform should consist of clean scrub attire, provided by the hospital.
- Head covering –caps should be worn completely covering the hair.
- Jewelleries – wearing of jewellery is discouraged, due to contact with chemicals.

30.11.1. SPECIAL ATTIRE

- Shoe cover – should be worn while working in the laundry.
- Gowns - which covers arms should be worn by all workers working in the decontaminated area, linen and packing area.
- Gloves - should be worn while working in any section.
- Masks - should be worn by all.

30.12. ACTIVITY FLOW CHART



Appendix 1: Criteria for Admission to the Rehabilitation Centre

i. Admission to rehabilitation centre is open to any person with drug or alcohol use problem, who is motivated to quit them.

ii. Persons opting to go for rehab shall agree to comply with the rules and regulations of the rehabilitation centre.

iii. Clients shall be admitted to rehab centre only on referral by the psychiatrist.

iv. Parents, family members or attendants and per workers shall ensure that such persons referred to rehab centre will not take drugs or alcohol while they are in transit.

v. Intoxicated persons will not be accepted in rehab centre.

vi. Residents have to provide for their own beddings, toilet items and clothes.

vii. No sharp items including scissors, penknives, shaving blades and expensive jewellery and medicines without valid prescriptions or money shall be allowed to be kept with resident.

viii. All persons will be mandatorily screened for drugs and other prohibited items on admission.

Appendix 2: Rules and Regulations & Consent Form

1. Rights of admission are reserved by the hospital administration:
    - Clients/patients will only be admitted on the recommendation of psychiatrists.
    - Clients/patients under the influence of alcohol and drugs will not be admitted.
    - Clients/patients without attendant will not be admitted.
2. On admission, it is mandatory that all the clients/patient and his/her belongings are searched for the following articles to ensure safety of clients/patient and others:
    - Razors, penknife, knife or any other articles, which can be used as weapon.
    - Alcohol and drugs, which can be consumed in the ward.
    - Valuable items such as watches, jewellery, mobile phones and electronic goods, which can be stolen. Keep minimal personal belongings with the client in the ward. The hospital shall not be held responsible for the loss of any clients' personal belongings.
    - If any of the above mentioned items are found at the time of admission, they will be either returned to clients' party or kept with ward staff to be returned on discharge.
3. If client/patient is on any prior prescription drugs, these shall also be handed over to ward staff.
4. Clients/patient and attendants or visitors are not allowed to bring any tobacco products, alcohol or drugs into the ward. Smoking and consumption of alcohol or drugs, chewing doma and spitting inside the wards is strictly prohibited.
5. Surprise checks will be conducted in the ward when client(s)/patients or attendant(s) is suspected of consumption of drugs or alcohol. If any client/patient or attendant is found in possession of or has consumed alcohol or drugs while being admitted, client(s)/patients will be discharged immediately.

6. Attendant(s):
    - One attendant shall stay with the client/patient at all times to ensure client's safety and security while in the ward to prevent client/patient from absconding and to learn from ward staff how to manage client(s) at home once the client gets discharged.
    - To avoid overcrowding in the ward, only one attendant shall be permitted at any given time. Only in exceptional cases, two attendants may be allowed on the recommendation of the treating doctor.
    - Visitors or attendants under the influence of alcohol or drugs shall be barred from entering the ward.
    - Client's/patient's attendants or visitors are not permitted to sit or sleep on the client's bed.
    - Attendants are notallowed to eat in the wards.
7. Visiting time shall be strictly adhered to as follows and again please be reminded that only one visitor shall be allowed at a time.
    - ❖ Morning : 6.30 am to 7.30 am
    - ❖ Afternoon : 12 noon to 1.00 pm
    - ❖ Evening : 7.00 pm to 9.00 pm
8. Ward gate will be closed at 8.00 pm, thereafter no entry for visitors.
9. Any activity, either by clients/patients, attendants or visitors that disturbs other clients/patients in the ward shall not be permitted. All clients/ patients shall be in bed by 9.00 pm.
10. Panel heaters are provided in winter months in all the rooms. Clients/ patients and attendants shall take maximum care to ensure continuous functioning of heaters and electrical switches. No private beddings (private blankets, bed sheets, pillow case, etc.,) shall be permitted in the ward.
    - Steel lockers and bedside tables are provided to each patient to store a reasonable amount of essential goods for the patient and attendant. Patients shall not keep anything outside these lockers.

- Patients and attendants shall bring only essential personal items to the ward. This is to ensure the ward is kept clean and hygienic to prevent hospital acquired infection and cross infection.

11. Hospital gowns will be provided to all clients while admitted in the ward. All clients/patients shall wear it.
12. Clients/patients and attendants shall keep their beds, bedside lockers and rooms clean. They shall use waste bins for disposal of their waste materials.
13. Cooking or use of water boilers is prohibited in the wards to ensure safety of clients/patients and others in the ward.
14. Clients/patients will be permitted to take short leave from the ward after seeking prior permission from the staff on duty. While seeking leave, clients shall be accompanied by one attendant.
15. Discharge of clients/patients is made on the discretion of treating physician/s.
16. Simple recreational facilities such as TV, carom, chess, Chinese checker and scrabbles are provided. Clients and attendants shall avail these facilities during the day according to the timings displayed at the entrance door of the Day Centre. Maintain as minimum noise as possible while carrying out recreational activities. Please take care of the facilities provided.
17. Clients/patients and attendants shall respect the privacy of other clients/ patients.

Informed Consent & Undertaking by Patient/Client Party

I, ……..……., the attendant of ……..……

Bed No……. have read and/or explained the Hospital Rules and Regulations Regarding Indoor Admission in the language that I understand and I hereby agree to abide by these. I will also ensure that other family members who will come and stay with the client will abide by these rules and regulations. I undertake that failure to abide these regulations, my ward will be discharged immediately.

Signature of Client

Contact Number:

Signature of Attendant

Contact Number:

Appendix 3 : Equipment and Drugs Check List

1. Resuscitation Tray - AMBU bag – adult and Child
2. Anaphylactic tray – drugs: dexamethasone, phenargan, adrenaline,
   Equipments: iv line and fluids, syringes and needles, spirit swab
3. Oxygen cylinder, oxygen mask and tubes
4. Suction machines
5. Torch – battery, bulb
6. Laryngoscope
7. Scissors
8. Controlled Drugs
9. CD keys
10. Computer and accessories
11. Television
12. CD Player
13. VCR
14. Water boiler
15. Stapler
16. Punching Machine
17. Buckets
18. Infection check list

Appendix 4: Biopsychosocial Assessment

Date:

1. **Identifying Information**

Name: DoB: Gender: M / F

Marital Status: married/single/divorced No of children: 1 / 2 / 3 / 4 / 5 /<5

Current employment: Govt./Corp./Pvt. / Self Job title:

Address: Contact Number:

2. **Education**: None/NFE/Pry/Secondary/Tertiary
3. **Family history:**

List down the immediate family members who live with patient presently:

Name	Age	Relationship to patient	whether having similar illness
……	…..	……	……
……	…..	……	……
……	…..	……	……
……	…..	……	……
……	…..	……	……
……	…..	……	……
……	…..	……	……

Has anyone committed suicide? Who? When?

Is there a family history of violence? Who? When?

Relevant family dynamics:

4. **Income of patient & his family per month:** less that Nu.10, 000 / Nu.10, 000 – 20,000 / Nu. 20,000 – 30,000 / Nu. 40,000 – 50,000 / >Nu. 50,000.

5. **Presenting problem:**

Problem as stated by client:

Problem as stated by referring person:

Onset of the problem, duration, severity:

Current stressors in addition to presenting problem:

6. **Past history:**

Any history of similar problems in the past:

Any history of treatment in the past:

7. **Current Functioning:**

A. **General health status:**

B. **Mental status exam:**

a. Appearance: dressing, grooming: (*Describe the appearance if abnormal):*

b. Behaviour: agitated /disturbed / violent / calm & quiet /withdrawn / slowed down /catatonic - *(Describe the behaviour if abnormal):*

c. Communication: verbal /non verbal language /speech- coherent / incoherent /relevant /non relevant /aphonia /aphasia /pressure of speech / paucity of speech /thought disorder *(Describe the speech problem if present):*

d. Affect/emotion/mood/feelings: depressed / dysphoric / hopelessness / helplessness / Worthlessness / euthymic / elated / euphoric /angry / irritable / suspicious / paranoid /

(Describe the emotional problem if present):

e. Perceptions: – hallucinations: auditory / visual / tactile / gustatory / olfactory

(Describe the hallucination if present):

f. Cognitive functions:

- Memory- short/long term: - normal / impaired
- Attention/concentration: - normal / impaired
- Orientation – time / place / person: -
- Insight: intact / absent
- Intelligence: – average / above average / below average
- Thought disorder: present / absent – (*describe the thought disorder if present):*
- Delusions: present / absent – (*describe the delusion if present):*
- Judgment: - intact / lost

g. Assessment of risk for:

Suicide: present / absent: *(describe if present):*

Homicide: present / absent: *(describe if present):*

Domestic violence: present / absent: *(describe if present):*

Child or elder abuse: present / absent: *(describe if present):*

Other violence: present / absent: *(describe if present):*

Substance / alcohol use: present / absent: *(describe if present):*

8. **Summary**

1. Issues:
2. Stressors:
3. Strengths / Coping skills:
4. Social Support:

Plan for treatment

What are the desired outcomes of treatment?

What interventions are needed to reach the goals and who will provide the intervention?

Interventions	***goals***	***who will provide intervention***
1……	*……*	*……*
2……	*……*	*……*
3……	*……*	*……*
4……	*……*	*……*
5. ……	*……*	*……*

Staff

Name/Signature/date

Appendix 5: Protocol for Psychological Rehabilitation of Drugs and Alcohol Patients in the Detoxification and Treatment Ward – Department of Psychiatry, Psychiatry Ward, JDWNRH, Thimphu.

The following steps are to be completed by the patient under the supervision of the ward staff during their stay in the ward. It is mandatory that each patient complete these steps and show to treating psychiatrist before discharge from ward. If a patient is illiterate and not able to write these steps himself, his family or attendant can help the patient to complete this. The information given by the patient in these exercises will be kept confidential and only shown to other persons after getting permission from the patient. However, it is expected that patients voluntarily share their work and experiences with other patients in the ward for the purpose of learning from each other.

1. **Information about your self**

Write down in detail about what you do now, where you live, with whom you live, your income, if no income, sources of income etc.

2. **Information about your family**

Write down in detail about your family, your parents, your siblings, where they live, what they do, what is the family income, any issues in the family.

3. **Information about your friends**

Write down in detail about your friends – current and past, what they do, where they live and if they use drugs and alcohol.

4. **Alcohol and drug history**

Write an honest detailed history about your drugs and alcohol history, starting from the day when you first took drugs or alcohol to the present. Take your time to remember the details: write type of drugs or alcohol used at what age, quantity, when, where, with whom etc.

5. **Estimate of expenses on drugs and alcohol**

Write down a rough estimate about the expenditure on drugs and alcohol so far in your life, include drugs and alcohol which are not purchased but got free such as from home production or given as gifts. Try to remember as far back when you first started taking drugs and/or alcohol, write the estimate for a day, a week, a month, a year etc. and then add up the expenditure for the total number of years of consumption. Also include any money or loan you owe to others.

6. **Social cost of drugs and alcohol**

Social costs include relationship problems you have had with your family, your parents, your spouses, your children, your friends, your workmates, your bosses etc. Write down in detail any relationship problems you have with them.

Social costs also include the mis-opportunities in your studies, career or work due to your drugs and alcohol abuse. Write down in detail the number of days you missed your classes or work in a year due to your drug or drinking problem. Any warnings, suspension from school or work place due to your drugs and alcohol problem.

7. **Health cost of drugs and alcohol**

Write down any health problems you have suffered so far in your life, any admission to hospital for any medical problem, any medication you are taking so far. Did any health worker or doctor remind or warn you about your health problems and your drugs and drinking habits. Do you believe that you have any health problem as a result of your drugs and drinking problem? Do you want to take treatment for these problems?

8. **Legal issues related to drugs and alcohol**

Have you ever had an accident so far in your life? If so, please write a detailed account of the accident and determine if it was related to your drugs and drinking habits. Did you have to attend a court for any reason in your life so far? If so, for what reason? Write down in detail about the outcomes of these court cases. Were you ever taken to police custody so far in your life? If so write down in details about them.

9. **Advantages and disadvantages of drugs and alcohol use**

Make two columns: under one column, write down the advantages of drugs and alcohol, how drugs and alcohol have helped you? What sort of benefits you get from drugs or alcohol? Why do you continue to take drugs and alcohol on a regular basis even when you knew that drugs and alcohol were harming you?

In another column, write down the disadvantages or the negative effects of drugs and alcohol in your life, you can re-visit your earlier write up on effects of drugs and alcohol on your social, financial, health and legal issues and write a summary here.

10. **Reasons why patient wants to stop drugs or alcohol now**

You have thought of stopping or cutting down on drugs and alcohol in the past several times but didn't materialize so far. What made you decide to stop drugs or alcohol this time? Why do you think this time it is different? Do you think you can stop drugs or alcohol on your own? Do you need help from us for stopping your drugs and alcohol habits? If you need help, in what way, we can help you? Do you need help from your family and friends? What sort of help you need from them?

11. **Assessment of motivation and social support available to the patient**

Summarize the history and assess the motivation of the patient to stop his drugs or alcohol habits. Assess the social support available to the patient while patient is in the ward and later after discharge. Talk to the patient's family about the treatment programme and protocols and their role in the treatment process

12. **Use of motivational interview techniques such as:**

a. Cognitive dissonance
b. Urge surf
c. Roll with resistance

13. **Introduction to stages of recovery cycle**

Explain the recovery processes and cycle using Prochaska and Declimente model –

a. Pre-contemplation – denial stage or not accepting that the patient has a problem with his drug or alcohol problem.

b. Contemplation – accepting the addiction problem or realizing that he has a problem related to his drug and alcohol habit.

c. Determination – taking a decision to stop using the drug or alcohol.

d. Action – actually acting on his decisions and abstaining from drugs or alcohol.

e. Maintenance - continuing to remain abstinent and finding measures and plans to remain sober such as through attending AA or NA meetings and fellowships.

f. Recovery – working towards complete recovery, which can be a lifelong pursuit.

g. Relapse – realizing that relapse is an everyday threat and one can relapse from any of the stages achieved so far.

14. **Drawing on analogy of samara and recovery cycle**

The six realms of samsara – higher realms: human, gods and demi-gods; lower realms: animal world, hell and hungry ghosts' realms can be compared to various stages of recovery and relapse. Just like in recovery cycles, one has to move from one stage to another in the process of recovery and there is no short cut, so also in samsara model, one has to accumulate enough virtues and good karma in the lower realms to go to the higher realms. But relapse can happen any time from any of the stages of recovery and land up in the pre-contemplation stage. Similarly, one can land up in any of the six realms of samsara depending upon the karma in one realm.

15. **Identifying triggers and urges to drugs and alcohol**

Patients go through a brain storming session under the supervision of ward staff and identify the triggers which make them urge to take drugs or alcohol. Triggers may be related to events, circumstances, environments, mood states, or particular times of day etc. Later, each patient has to make their own personal list of triggers under different headings.

16. **Learning to deal with triggers and urges to drugs and alcohol**

Make two columns. Under one column, list the triggers you have identified in the last exercise under different headings such as emotion, environment, events etc. Under the other column, list the activities which you can do to deal with the triggers and urges. If patients have difficulty doing this on their own, do a brain storming

session first under the supervision of wards staff. Once each individual understand the concept, ask them to write their own individual responses.

17. **Planning a daily activity schedule**

This is an important step and strategy in the recovery process. Addicts spend lot of their time or some of them virtually all their waking hours finding drugs or alcohol, taking the drugs or alcohol, enjoying the effects, later, when the drugs and alcohol effect wanes in their body, they suffer withdrawal symptoms, which trigger the urges to find more drugs and alcohol. So they spend all their time on drugs and alcohol. His work, family and his social standing is no more important to him. Drugs and alcohol become the primary objective of his life. When these patients stop taking drugs or alcohol, they have an "enormous amount of time" in their hands and this can become a burden if they are not prepared to use it judiciously. Therefore, the need to plan their day so that they are not caught off guard due to boredom or other triggers they are not prepared to face. The day structure should be as practical or compatible to the person's social background and life style and not be an idealistic one, which the patient will never apply.

18. **Planning a weekly activity schedule**

As the patient becomes comfortable, planning his daily schedule and practicing them in the ward, the next step is to learn to plan for longer periods of time such as for a week. If a person has a job and is planning to work soon after discharge, let this person plan his daily schedule as per his working hours with some variation in the recreational and family activities. For unemployed patients, the weekly schedule should include time for venturing out of homes to look for jobs, or get training or family visits etc. Particular emphasis should be given for weekends and public holidays when patients have more time at home.

19. **Planning a monthly activity schedule**

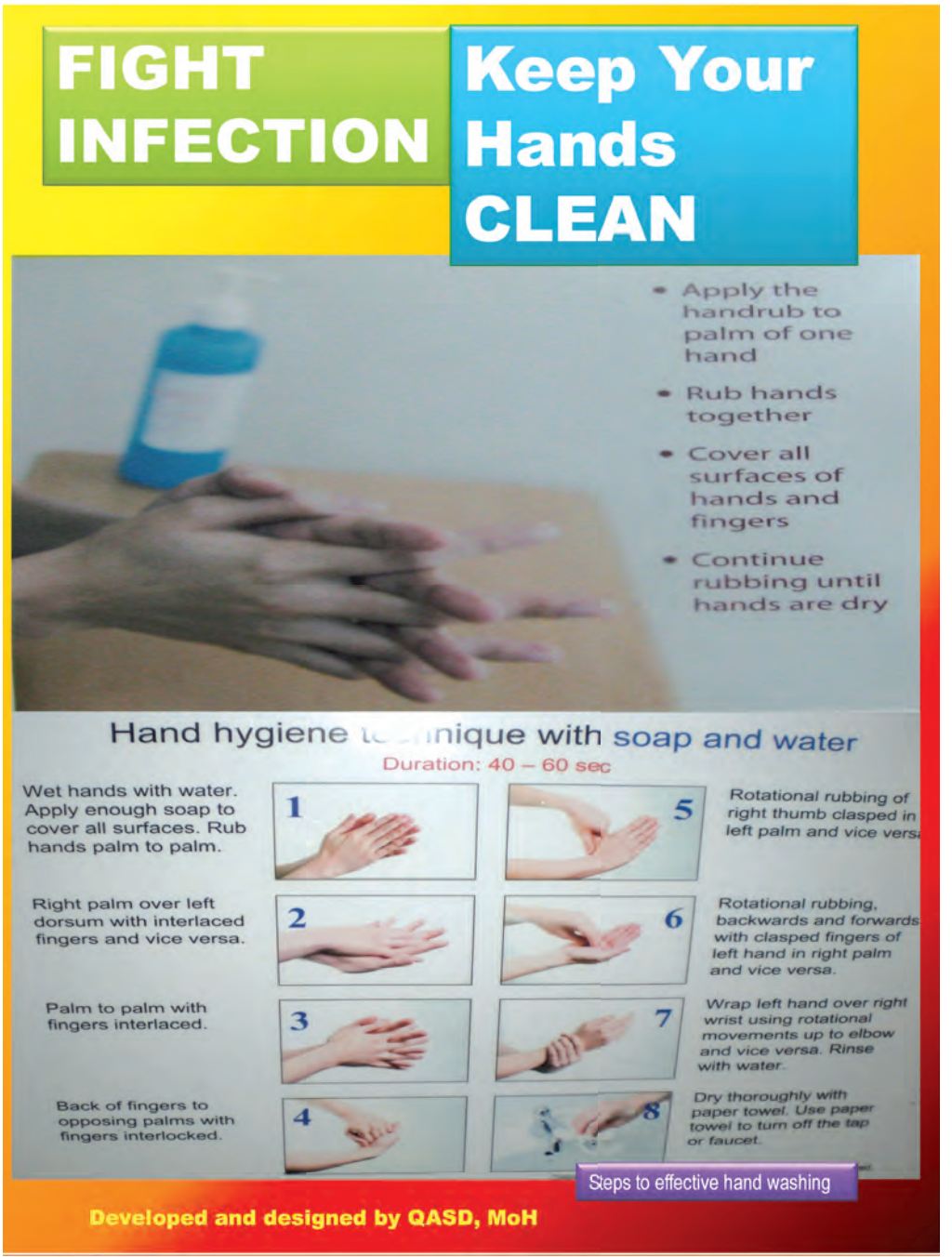
An addict's life revolves around his drug and alcohol habits on a day to day basis. They do not have long term goals and ambitions. Learning to Plan their life in a systematic and structured way will give them a sense of direction in their life, to learn to look in the future, set realistic goals, to take control of their lives. This is important for long term sustenance of their sobriety.

20. **What you want to achieve in one year from now**
21. **What you want to achieve in five years now**
22. **Introduce to concept of rehabilitation**
23. **Preparing for discharge – introduce 10 steps program of relapse prevention**
24. **Introduce to relapse prevention strategies**
25. **Follow up and review with psychiatrists**
26. **Arrangement for Support Groups and Meetings after discharge**

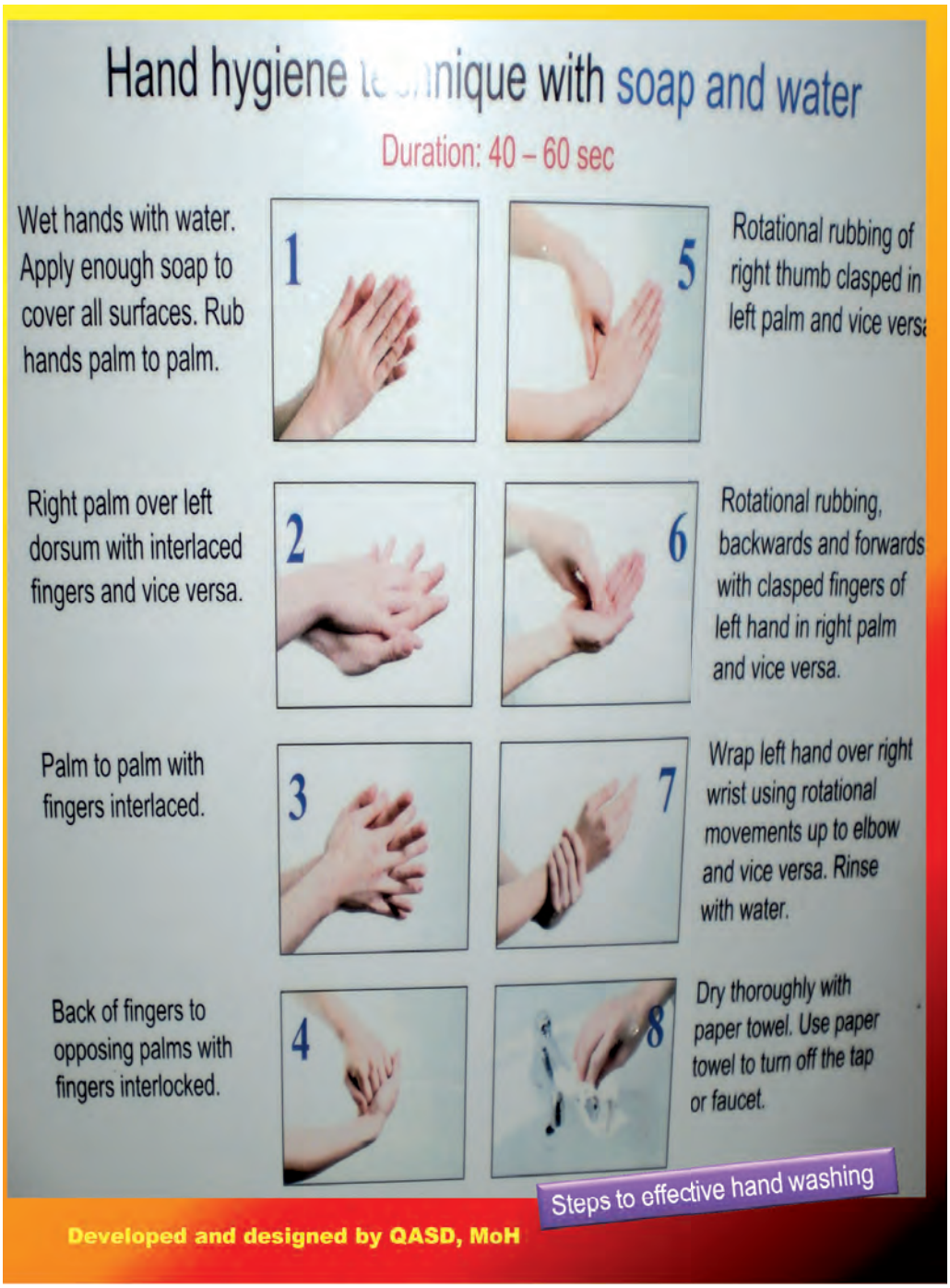
Appendix : 6.1


Standard procedure for quality improvement
✓Meet with all staff to orient them on quality and discuss the facility main quality issues
✓Define a Quality Indicator (QI) for each quality issue selected as a priority for the coming year
✓Measure baseline values for all QIs selected
Baseline values on QIs
100
80
60
40
20
0
Indicator 1
Indicator 2
Indicator 3
Baseline
✓Develop and implement Action Plan for Quality Improvements
Improvement in QIs
100
80
60
40
20
0
Indicator 1
Indicator 2
Indicator 3
Baseline
Quarter1
Developed and designed by QASD, MoH

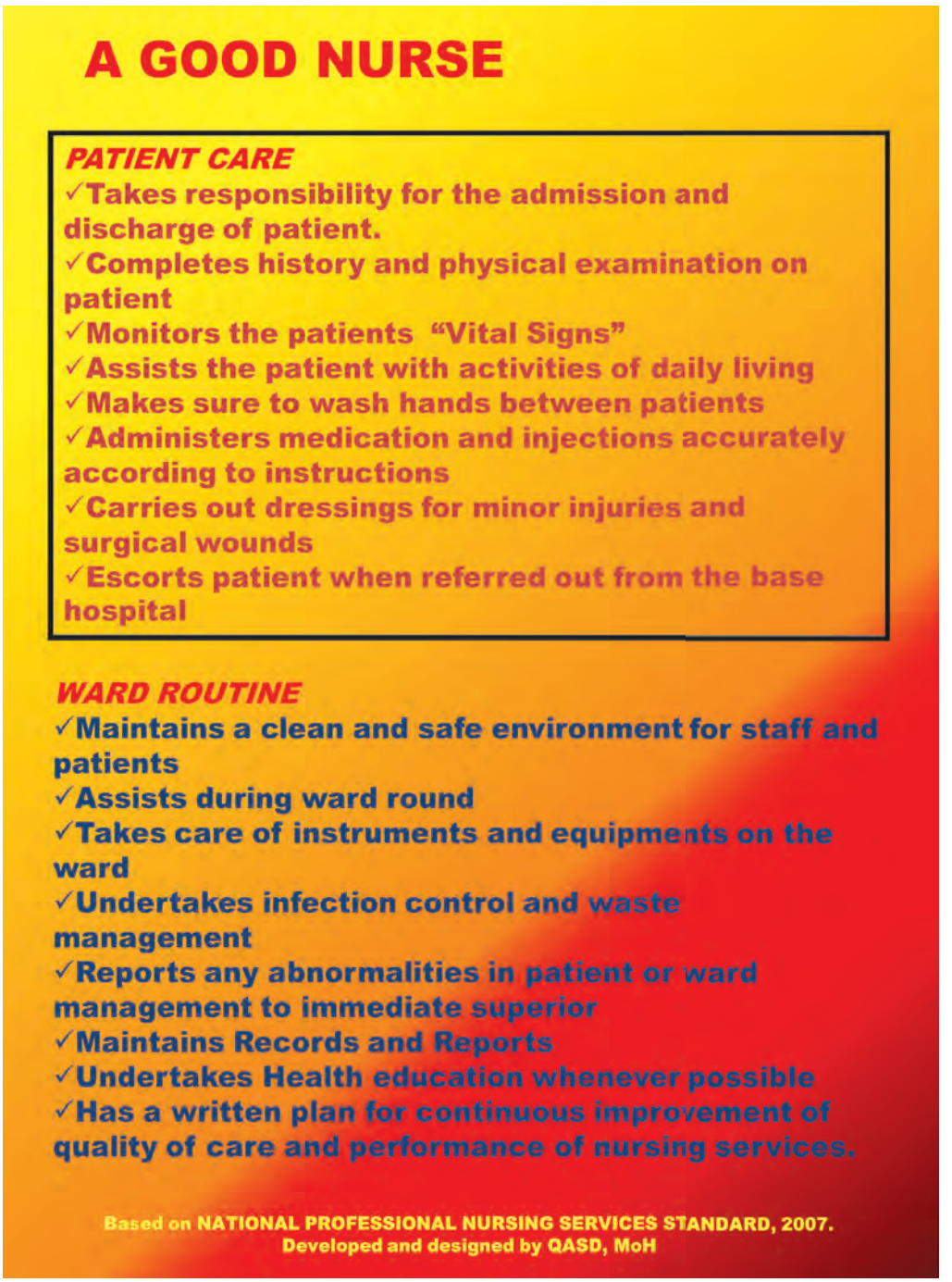
Appendix : 6.2


FIGHT INFECTION
Keep Your Hands CLEAN
Apply the handrub to palm of one hand
Rub hands together
Cover all surfaces of hands and fingers
Continue rubbing until hands are dry
Hand hygiene technique with soap and water
Duration: 40 – 60 sec
Wet hands with water. Apply enough soap to cover all surfaces. Rub hands palm to palm.
Right palm over left dorsum with interlaced fingers and vice versa.
Palm to palm with fingers interlaced.
Back of fingers to opposing palms with fingers interlocked.
Rotational rubbing of right thumb clasped in left palm and vice versa
Rotational rubbing, backwards and forwards with clasped fingers of left hand in right palm and vice versa.
Wrap left hand over right wrist using rotational movements up to elbow and vice versa. Rinse with water.
Dry thoroughly with paper towel. Use paper towel to turn off the tap or faucet.
Steps to effective hand washing
Developed and designed by QASD, MoH

Appendix : 6.3


Hand hygiene technique with soap and water
Duration: 40 – 60 sec
Wet hands with water. Apply enough soap to cover all surfaces. Rub hands palm to palm.
1
Right palm over left dorsum with interlaced fingers and vice versa.
2
Palm to palm with fingers interlaced.
3
Back of fingers to opposing palms with fingers interlocked.
4
5
Rotational rubbing of right thumb clasped in left palm and vice versa
6
Rotational rubbing, backwards and forwards with clasped fingers of left hand in right palm and vice versa.
7
Wrap left hand over right wrist using rotational movements up to elbow and vice versa. Rinse with water.
8
Dry thoroughly with paper towel. Use paper towel to turn off the tap or faucet.
Steps to effective hand washing
Developed and designed by QASD, MoH

Appendix : 6.4


A GOOD NURSE
PATIENT CARE
✓Takes responsibility for the admission and discharge of patient.
✓Completes history and physical examination on patient
✓Monitors the patients "Vital Signs"
✓Assists the patient with activities of daily living
✓Makes sure to wash hands between patients
✓Administers medication and injections accurately according to instructions
✓Carries out dressings for minor injuries and surgical wounds
✓Escorts patient when referred out from the base hospital
WARD ROUTINE
✓Maintains a clean and safe environment for staff and patients
✓Assists during ward round
✓Takes care of instruments and equipments on the ward
✓Undertakes infection control and waste management
✓Reports any abnormalities in patient or ward management to immediate superior
✓Maintains Records and Reports
✓Undertakes Health education whenever possible
✓Has a written plan for continuous improvement of quality of care and performance of nursing services.
Based on NATIONAL PROFESSIONAL NURSING SERVICES STANDARD, 2007.
Developed and designed by QASD, MoH

Appendix : 6.5

QUALITY IMPROVEMENT METHODS

QUALITY IMPROVEMENT METHODS CAN BE THOUGHT OF IN THREE CATEGORIES: GROUP PROCESS, STATISTICAL AND SCIENTIFIC THINKING, AND GRAPHICAL METHODS.

❑Group Process

These methods refer to those approaches used to facilitates the effectives functioning of people when working together.
Group process skill include:
✓Knowledge of basic meeting skills, idea generation and reduction
✓Management of fundamental group Processes such as listening, Participation and conflict

❑Statistical and scientific Thinking

These methods address the study of variation and cause and effect.
These methods include:
✓flow charts
✓Pareto chart
✓special diagrams
✓causes/effect diagram
✓run charts
✓force field analysis

❑Graphic Devices

These methods refer to the importance of creating visual pictures of data and information. Hence, graphs of data overtime are used rather than point-in-time tables of numbers. This category of methods includes the use of storyboards or posters that teach and make visible the steps and thought process used in the systematic improvement of work processes.

Developed and designed by QASD, MoH

Appendix : 6.6

SURGICAL SAFETY CHECKLIST

Name: .....**Age/Sex:** ..... **Diagnosis**.....**Procedure:** .....

Hospital: .....**Reg. No.** .....**Ward/Unit:** ..... **Bed No:** ..... **Date/time:** .....

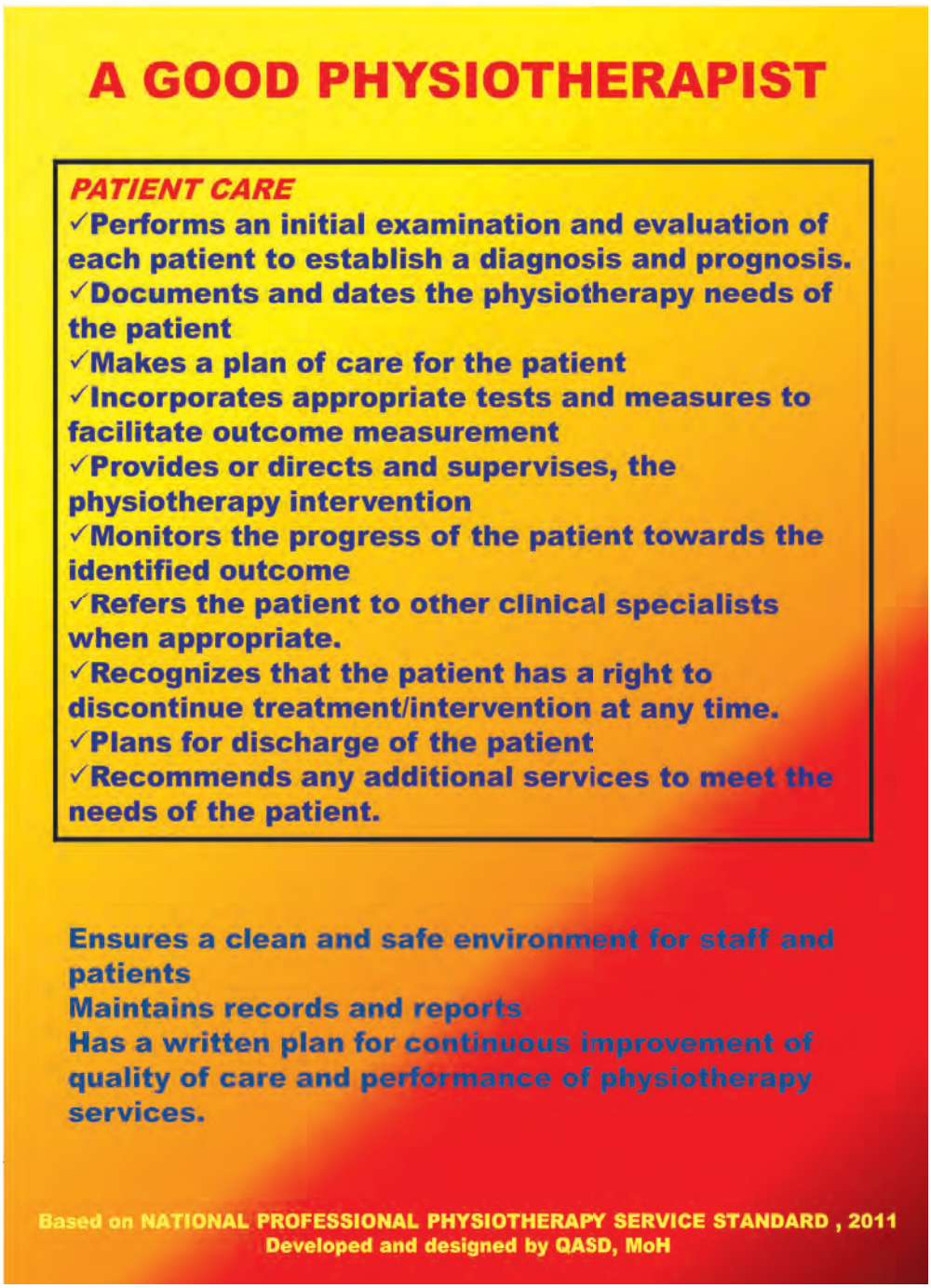
SIGN IN - Briefing (Before induction of anaesthesia - with Nurse, Anaesthetist and Surgeon)	TIME OUT (Before skin incision - with Nurse, Anaesthetist and Surgeon)	SIGN OUT – Debriefing (Before patient leaves operating room - with Nurse, Anaesthetist and Surgeon)
Has the patient confirmed his/her identity, site, procedure, and consent? ☐ Yes Is the site marked? ☐ Yes ☐ Not applicable Is the anaesthesia machine and medication check completed ☐ Yes Is the pulse oximeter on the patient and functioning ☐ Yes Does the patient have a: Known allergy? ☐ No ☐ Yes Difficult airway or aspiration risk? ☐ No ☐ Yes, and equipment / assistance available Risk of >500ml blood loss (adult) or more than 7ml/kg (children) ☐ No ☐ Yes, and two IVs/central access and fluids planned	☐ Confirm all team members have introduced themselves by name and role ☐ Confirm the patient's name, procedure, and where the incision will be made Has antibiotic prophylaxis been given within the last 60 minutes? ☐ Yes ☐ Not applicable	Nurses (s) review(s) with entire team: ☐ The name of the procedure ☐ Completion of instrument, sponge and needle counts ☐ Specimen labelling (read specimen labels aloud, including patient name) ☐ Important intra-operative events ☐ Whether there are any equipment problems to be addressed
	Anticipated critical events To Surgeon: ☐ What are the critical or non-routine steps? ☐ How long will the case take? ☐ What is the anticipated blood loss?	Surgeons(s) review(s) with entire team: ☐ Procedure ☐ Important intra-operative events ☐ Fluid balance/management
	Anticipated critical events To Anaesthetist: ☐ Are there any patient-specific concerns?	Anaesthesiologist(s) review(s) with entire team: ☐ Important intra-operative events ☐ Recovery plans (including post-operative ventilation, pain management, glucose and temperature) ☐ Changes to post-operative destination?
Surgeon(s) review(s) ☐ Specific patient concerns and critical steps, and special instruments and implants	Anticipated critical events To Nursing Team: ☐ Has sterility (including indicator results) been confirmed? ☐ Are there equipment issues or any concerns?	
Anaesthesiologist(s) review(s) ☐ Specific patient concerns and critical resuscitation plans	Is essential imaging displayed ☐ Yes ☐ Not applicable ☐ Final optimal positioning of patient ☐ "Does anyone have any other questions or concerns before proceeding?"	To Surgeon, Anaesthetist and Nurses: ☐ What are the key concerns for recovery and management of this patient? ☐ Could anything have been done to make this case safer or more efficient?
Nurses(s) review(s) ☐ Specific patient concerns, sterility indicator results and equipment or implant issues ☐ Patient positioning and support/warming devices ☐ Special precautions		

Name and signature of the Operating Team;

1. Anaesthetist.: ..... 2. Surgeon: ..... 3.Nurse: .....

Adapted from the Canadian (2009) & WHO (2009) Surgical Safety Checklist.
Developed and designed by QASD, MoH

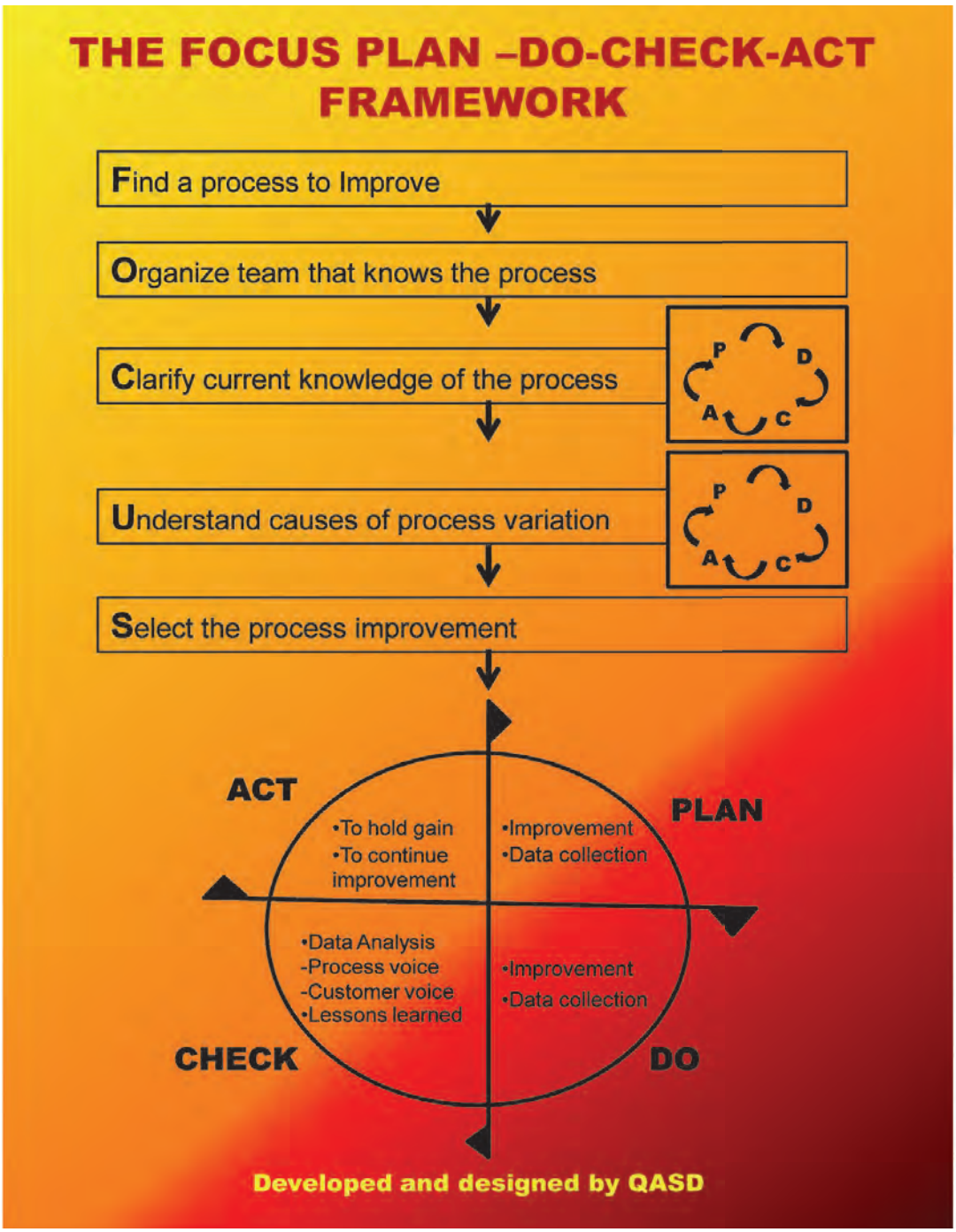
Appendix : 6.7


A GOOD PHYSIOTHERAPIST
PATIENT CARE
✓Performs an initial examination and evaluation of each patient to establish a diagnosis and prognosis.
✓Documents and dates the physiotherapy needs of the patient
✓Makes a plan of care for the patient
✓Incorporates appropriate tests and measures to facilitate outcome measurement
✓Provides or directs and supervises, the physiotherapy intervention
✓Monitors the progress of the patient towards the identified outcome
✓Refers the patient to other clinical specialists when appropriate.
✓Recognizes that the patient has a right to discontinue treatment/intervention at any time.
✓Plans for discharge of the patient
✓Recommends any additional services to meet the needs of the patient.
Ensures a clean and safe environment for staff and patients
Maintains records and reports
Has a written plan for continuous improvement of quality of care and performance of physiotherapy services.
Based on NATIONAL PROFESSIONAL PHYSIOTHERAPY SERVICE STANDARD , 2011
Developed and designed by QASD, MoH

Appendix : 6.8


HOSPITAL INFECTION
WHERE IS THE PROBLEM?
IS IT HIM?
Doctor
IS IT HER?
Sister
IS IT HER?
Technician
IS IT HER?
Technician
IS IT HIM?
Cleaner
Developed and designed by QASD, MoH

Appendix : 6.9


THE FOCUS PLAN –DO-CHECK-ACT FRAMEWORK
Find a process to Improve
Organize team that knows the process
Clarify current knowledge of the process
Understand causes of process variation
Select the process improvement
P
D
A
C
ACT
•To hold gain
•To continue improvement
PLAN
•Improvement
•Data collection
•Data Analysis
-Process voice
-Customer voice
•Lessons learned
CHECK
•Improvement
•Data collection
DO
Developed and designed by QASD

Appendix: 6.10