# Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

## SOP-7 Post Partum Centre

Name of Facility:

# Objectives of Post Partum Centre

1. To increase community awareness on post partum services including family planning.
2. To create public awareness of the entitlements (FP services, FP insurance scheme, compensation for Family Planning indemnity scheme)
3. To maintain privacy confidentiality & dignity of client/ patient
4. To ensure empathetic & courteous behavior of the staff
5. Compliance of all Infection Prevention & Bio Medical Waste management protocols & procedures
6. To increase PPIUCD user rate by 5% from existing rate in one year



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## SOP 7: Post-Partum Unit/ Centre

### 1. Purpose:

The purpose of this procedure is to develop a system for managing: Post-Partum Centre (PPC) for Quality client care.

### 2. Scope:

**It covers all the services that are provided in the Post-partum unit:**

- Female sterilization services in the interval period
- ***Male sterilization services***
- Post-partum sterilization services
- Post abortion sterilization services
- Abortion services including adolescents.
- Spacing methods for post-partum, interval and post abortion period.
- Oral and injectable contraceptive services for females
- Family planning counselling services
- Post-natal counselling and follow up services

### 3. Responsibility:

i. **Post-Partum Centre In-charge** (assisted by Nurse In-charge for PPC)

a) To look after administrative aspects of PPC, such as:
   - Services for Post partum Counseling of Mother in 'lying in' period
   - FP counseling services in OPD
   - Services for spacing & Limiting methods
   - Counseling for abortion, ($1^{st}$& $2^{nd}$ trimester abortion services)
   - Post pregnancy family planning services

b) To develop and implement aseptic practices according to Infection Control and Hygiene procedure guidelines.
c) To formulate the OT protocols and standard procedures.
d) To disseminate the information in the form of leaflets, wall writing, posters etc.
e) To ensure display of the services & the entitlements available in the department. (eg. Compensation for family planning indemnity scheme, FP services, FP Insurance Scheme).
f) To maintain the privacy, confidentiality & dignity of the client / client& related information.
g) To ensure that the staff is empathetic and courteous.





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h) To update staff's knowledge about reproductive rights of the clients.

**ii. OT Assistant (Senior / Junior Sister or staff nurse):**

a) Is responsible to schedule the cases to be performed in PPC OT.
b) Ensures provision of autoclaved / sterilized instruments and linen and treatment/disposal of the same.
c) Performs routine Check & recording of proper functioning of equipment with the help of checklist, to be subsequently signed by In-Charge PPC before commencement of OT on daily basis.
d) Ensures that infected cases are taken at the end of the list of surgeries for the OT.
e) Ensures that PPC OT is fumigated; instruments / equipment are disinfected and cleaned after infected cases are operated.

**iii. Staff Nurse:**

a) To receive & hand over the client along with case file, diagnostic reports duly filled and signed by concerned doctor.
b) To facilitate the clients in filling the consent form with full signature, date & time.
c) To prepare the client for operation (ensuring site shaving, antiseptic application and draping of the site).
d) To set up the OT table for specific operation or IUCD insertion with required instruments / linen / equipment.
e) To assist the gynecologist / doctor during the entire process of operation/insertion

**iv. Sweeper:**

a) To clean / Scrub the PPC OT, minor OT, recovery room and associated area as per procedure specifications provided by the infection control programme.
b) To collect the waste and hand it over to the Biomedical Waste collection personnel.
c) To assist OT I/c & Staff Nurse in Fumigation / Sterilization / Autoclaving inside PPC including OT, minor OT etc.

## 4. Infrastructure

| Sl. No. | Activity | Responsibility | Reference Document/Record |
|---|---|---|---|
| 1 | PPC OPD has the registration counter, a dedicated room / area for counseling. | • Doctor I/c | • Registration register |
| 2 | Facility has the examination cum minor procedure room for IUCD insertion. | • Doctor I/c | |
| 3 | Presence of well equipped OT | • Doctor I/c | |
| 4 | Facility has Post operative / Post partum ward | Doctor I/c | |



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## 5. Procedures:

| SN | Activity | Responsibility | Reference Document/Record |
|---|---|---|---|
| I. | **Family Planning Spacing Methods** | | |
| | • Cafeteria approach for assisting client in decision making<br>• Counseling for FP in ANC, PNC ward by counselors.<br>• Informed about the advantages of spacing methods<br>• Take informed consent before treatment and procedures.<br>• In case of abortion informed consent on prescribed form 'C' for abortion<br>• Client is informed about the availability of free services, free drugs, consumables and contraceptives. | • Doctor on Duty & PPC Incharge | • PPC Register |
| | **Condom**:<br>• Available free of cost in any govt. health facility, provides protection from RTI / STI. | | |
| | **Oral Contraceptive Pills:**<br>• Oral contraceptive pills contain hormones and are one of the most important and reliable methods of contraception.<br>• The 28-day pack contains both the hormones in the first 21 pills and the last 7 pills have no hormones and are referred to as the spacer pills. In some packs, these spacer tablets contain iron.<br>• The pills are to be consumed daily at the same time<br><br>**Emergency contraceptive pills:**<br>• Emergency contraceptive pills are meant to be used for | | |



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| | emergency only. These are not appropriate for regular use as a contraceptive method because of the higher possibility of failure compared to other contraceptive method.<br>• Take the pill immediately after unprotected/accidental intercourse or as soon as possible within next 3 days (72 hours).<br>• If 2 pills of Levonorgestrol or COCs are used as an emergency contraceptive, second dose to be taken after 12 hours of first dose. | | |
| | **Interval Intra-uterine Contraceptive Device-CuT:**<br>• Step I: Makes the client empty her bladder and wash her perineal area.<br>• Step 2: Palpates the abdomen.<br>• Step 3: Inspects the external genitalia<br>• Step 4: Insert a high level disinfected/sterile speculum to visualize the cervix.<br>• Step 5: Cleanse the cervix and vagina with an appropriate antiseptic<br>• Step 6: Grasp the anterior lip of cervix with HLD/ sterile volsellum and apply gentle traction.<br>• Step 7. Insert the high-level disinfected/sterile sound.<br>• Step 8. Advance the sound into the uterine cavity, and STOP when a slight resistance is felt.<br>• Step 9. Determine the angle/direction of the uterine cavity. | • Doctor on Duty & PPC Incharge | |



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| | • Step 10. Determine the length of the uterus.<br>• Step 11. Loading the IUCD in its Sterile Package.<br>• Step 12. Keep the client comfortable.<br>• Step13. Apply gentle traction on the cervix with the volsellum.<br>• Step 14. Insert the loaded IUCD.<br>• Step 15. Gently advance the loaded IUCD into the uterine cavity.<br>• Step 16. Release of IUCD arms in the uterine cavity.<br>• Step 17. Ensure that the arms of the T are as high as possible in the uterus.<br>• Step18. Removal of the insertion tube.<br>• Step 19. Use high- level disinfected (or sterile) sharp scissors to cut the IUCD strings at 3 to 4 cm of length.<br>• Step 20. Removal of the volsellum.<br>• Step 21. Examine the woman's cervix for bleeding.<br>• Step 22. Removal of the speculum.<br>• Step 23. Allow the woman to rest.<br>**PPIUCD:**<br>• The CuT-380A & Cut-375 is approved for immediate postpartum insertion as a method of contraception.<br>• The PPIUCD is placed after counseling and obtaining a written informed consent by the woman.<br>• The PPIUCD may be placed immediately following delivery | | |



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| | of the placenta, during cesarean section or within 48 hours following childbirth.<br>• The IUCD is inserted only by a trained service provider.<br>• PPIUCD insertion is done in a healthcare facility that provides delivery services and has acceptable standards of infection prevention.<br><br>The usual timings are:<br>• Immediate Postpartum:<br>• Post placental: Insertion within 10 minutes of expulsion of the placenta following a vaginal delivery on the same delivery table.<br>• Intra cesarean: Insertion that takes place during a cesarean delivery, after removal of the placenta and before closure of the uterine incision.<br>• Within 48 hours after delivery: Insertion within 48 hours of delivery and prior to discharge from the postpartum ward.<br>• **Post abortion**: Insertion following an abortion, if there is no infection, bleeding or any other contraindications. No uterine sound is used here. | | |
| | **Injectable Contraceptive**<br><br>Contraceptive injective is a very safe and effective three monthly temporary method of family planning<br><br>The first dose of injection can be administerd by a trained doctor or a | • | |



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| | trained staff nurse/ANM under the supervision of a doctor<br><br>**Pre-injection preparation**<br><br>• Check vial for expiry date<br>• Shake the vial well. if the vial is cold, warm to body temperature by rubbing between palms before giving the injection.Ensure that all the microcrystals are dissolved completely in the fluid of vial reservoir.<br>• Wash hands with soap and water.<br>• For IM injection, withdraw full quantity of solution from the vial into the disposable syringe with needle, taking care not to push any outside air into the vial.<br><br>**Administering the IM injection**<br><br>• Intramuscular MPA is usually given in the deep muscle of the arm, anterolateral gluteal region of the hip, or gluteal muscles of the buttocks. The choice of the site should depend mainly on the women's preference.<br>• Clean site of the injection with an antiseptic.<br>• Allow the antiseptic to dry before administering the injection.<br>• Insert sterile needle deep into the chosen site for injection.<br>• Aspirate first to ensure that the needle is not in a vein. | | |



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| | • Inject the contents of syringe fully.<br>• If there is little oozing, just apply gentle pressure for few seconds.<br>• Do not massage the injection site; just leave the site as it is.<br>• Ask the client to remain within facility for 5-10 minutes after receiving the injection. | | |
| | **Centchroman (Ormiloxifene)**<br><br>It is a non-steroidal, once a week oral contraceptive pill which does not contain any hormone. It acts as selective oestrogen receptor modulator (SERM).<br>Available as a pill pack with each pill containing 30 mg.<br><br>**Schedule of dosage:**<br>• For initiation of centchroman, the first pill is to be taken on the first day of period.<br>• Second pill, 3 days later.<br>• This pattern of days is repeated through the first three months.<br>• From fourth month, the pill is to be taken once a week on the first pill day and should be continued on the weekly schedule **regardless of her menstrual cycle.** | • | |
| **II.** | **Family Planning Limiting Methods** | | |
| | **Laparoscopic tubal Ligation:**<br>When to perform –<br>• After menstruation, within 7 | • Trained gynecologist performs the surgery. Staff nurse assists. | • Reference Manual for Female Sterilization-2014 |





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| | days<br>• After 42 days of delivery<br>• After abortion / MTP (up to 12 weeks) within 7 days, if no infection / complication.<br><br>**Pre-procedure assessment of client-**<br>Greet client, counsel about procedure, assess throughMEC and obtain inform consent.<br><br>**Pre- procedural steps performed**<br><br>• **Sedation and Analgesia:**<br>The anxiolytic, sedative, light muscular relaxant and amnesic effect produced in the client following administration of sedatiion allow sterilization procedure to be performed smoothly under local anaesthesia.<br><br>• **Administer Anesthesia:**<br>Lignocaine is the recommended local anaesthetic and the recommendedconcentration is 1% lignocaine without adrenaline.<br><br>• **Creating Pneumoperitoneum**<br>Make a 1.5-2 cm incision along the rim of the inferiorumbilical margin.Create pneumoperitoneum through veress needle and the client position (Trendelenberg Position not more than 20 degrees). Ensure intra abdominal not to exceed 15 mmHg<br><br>• **Abdominal Access made:**<br>Laparoscope is inserted through the small nick given near the umbilicus | | |



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| | of woman through trocar.<br><br>• **Perform Tubal occlusion**<br>Tubes are identified and fallopian ring from the inserter is put to block the tube on both sides one by one. The incision is closed by one stitch and sealed by adhesive tape.<br><br>• **Post-operative task done with instruction**<br>Analgesics and antibiotics are provided. Woman is allowed to take rest for a day or two, bath after 24 hours, follow up visitis necessary after one week. As absorbable stitch material is used hence no need of removal of stitch<br><br>- .<br>• **Mini-Lap tubal Ligation:**<br><br>WHEN TO PERFORM –<br><br>▪ After menstruation, within 7 days<br>▪ After delivery within 7 days<br>▪ After abortion within 7 days, if no complications / infections.<br><br>SURGICAL APPROACHES-<br><br>▪ Minilap Tubectomy is performed by two approaches:-<br>▪ 1-Sub-umbilical approach is appropriate in the immediate postpartum period and within 7 days of childbirth. (PostPartum Sterilization).<br>▪ 2 Supra pubic approach is appropriate for Interval Minilap | | |



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| | Tubectomy.<br>▪ The procedure involved in the two approaches is the same except for the site of incision.<br><br>▪ 1-Sub-Umbilical Approach (Post Partum Sterilization)<br>▪ Registration Of Client-<br><br>PRE-PROCEDURE ASSESSMENT OF CLIENT-<br><br>Greet client, counsel about procedure, assess throughMEC and obtain inform consent.<br><br>PRE-PROCEDURE TASKS-<br><br>▪ Review client's case record, if necessary repeat bimanual P/V examination on the OT table.<br>▪ Check informed consent obtained and verify client's identity<br>▪ Take and record vital signs.<br>▪ Apply antiseptic solution to the incision area two times using a circular motion<br>▪ Prepare 20 ml of 1% lignocaine solution by diluting 10ml of 2% lignocaine with equal volume of sterile distilled water or normal saline.<br><br>LOCAL ANAESTHESIA-<br>▪ Raise a small skin wheal at the centre of incision site using 1% | | |



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| | lignocaine (or equivalent) in a 10 or 20 ml sterile or high level disinfected syringe (dose 5mg/kg).<br>▪ Aspirate to ensure the needle is not in a blood vessel; then, while injecting 3-5 ml of lignocaine<br><br>OPERATIVE PROCEDURE-<br><br>▪ Make transverse/ vertical, subumblical skin incision, approximately 3 cm long at the preselected incision site.<br>▪ Identify and grasp fascia at two places with the Allis forceps and cut with scissors. Confirm identification of peritoneum.<br>▪ While elevating the peritoneum with the forceps, make a small nick in the peritoneum with knife/scissors after confirming that there is no underlying bowel or abdominal viscera.<br><br>LOCATING FALLOPIAN TUBES-<br><br>▪ With the retractors in place, gently reposition the incision over the right or left adnexa by manipulating the uterus through the abdominal wall.<br><br>GRASPING THE FALLOPIAN TUBES-<br><br>▪ Identify mid portion of fallopian tube and gently grasp that with | | |



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| | Babcock's forceps<br><br>TUBAL OCCLUSION-<br>▪ While grasping the mid-portion of tube, transfix the tube with chromic catgut 1- 0 making a loop of about 2-3 cms.<br>▪ Cut out one end of the loop and then the other with scissors ensuring that at least one cm. of the tubal stump above the ligature has been left behind.<br>CLOSURE<br>▪ Secure the rectus sheath edges with interrupted/ continuous sutures<br><br>POST-OPERATIVE TASKS-<br>▪ Ensure that client is safely transferred to the post-operative also ensure monitored at regular intervals and that vital signs are taken. | | |



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## 6. Client registration and admission (Reference standard - ME E1.1)

| SN | Activity | Responsibility | Record |
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| 1. | **Client Registration & Admission for walk –in client** | | |
| | • Registration shall be done at registration counter during OPD hours and at emergency department during non OPD hrs.<br>• Every client who is registered shall be provided with a unique identification number mentioned in the OPD/IPD slip<br>• A written order of the doctor in family planning clinic or doctor at OBG OPD shall be provided at the registration desk for initiating admission formalities | • Treating Doctor /Casualty Medical Officer | • OP ticket & Admission slip |
| 2. | **For inclients at maternity ward no further re-registration or admission formalities are required** | • Treating Doctor | |
| 3. | **Admission criteria for Female Sterilisation** | | |
| | • Client assessment for eligibility to undergo female sterilization is a key factor in minimizing risk of complications and ensuring quality of service delivery : 4 criteria must be followed – Accept, Caution, Delay & Special<br>• Clients should be married (including ever-married).<br>• Female clients should be below the age of 49 years and above the age of 22 years.<br>• The couple should have at least one child whose age is above one year unless the sterilization is medically indicated.<br>• Clients or their spouses/partners must not have undergone sterilization in the past (not applicable in cases of failure of previous sterilization).<br>• Clients must be in a sound state of mind so as to understand the full implications of sterilization.<br>• Mentally ill clients must be certified by a psychiatrist, and a statement should be given by the legal guardian/spouse regarding the soundness of the client's state of mind. | • Doctor | • Reference Manual for Female Sterilization-2014 |



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| 4. | **Admission criteria for abortion cases** | • Doctor | • CAC Training and Service Delivery Guideline |
| | • # The continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated<br>• # The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman<br>• # The continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman<br>• # The continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, or injury to the physical or mental health of any existing child of the family of the pregnant woman<br>• # There is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.<br>• # Or in emergency, certified by the operating practitioner as immediately necessary:<br>• # To save the life of the pregnant woman or to prevent grave permanent injury to the physical or mental health of the pregnant woman | | |

**7. Department has documented procedure for providing appointment/day and date for the surgery**

| S.N | Activity | Responsibility | Record |
|---|---|---|---|
| 1. | • Client shall be counsel throughout ANC visit and at time of Delivery. | • Family Planning Counsellor | • Counselling Register |
| 2. | • When client is ready for family planning, counsellor shall inform client to visit doctor | • Family Planning Counsellor | • BHT |





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| 3. | • Assessment of client shall be done by the treating doctor for their eligibility for the procedure. | • Doctor | • BHT |
| 4. | • If client fits in eligibility criteria she will be informed of the date and time for family planning procedure by the consulting doctor. | • Doctor | • BHT |

**8. Initial assessment**

| S.N | Activity | Responsibility | Record |
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| 1. | **Initial assessment** | | |
| | **On receiving the client, clinical history regarding the following shall be taken:**<br>• Past medical history<br>• Immunization status of the women for tetanus<br>• Current medications<br>• Past history of contraceptive use.<br>• Menstrual History: Date of last menstrual period<br>• Obstetric history | • Nursing staff | • Initial assessment form |
| | **Physical examination of the client on the following parameters shall be carried out:**<br>• Pulse<br>• Blood pressure<br>• Respiratory rate<br>• Temperature<br>• Body weight<br>• General condition and pallor<br>• Auscultation of heart and lungs<br>• Examination of abdomen<br>• Pelvic examination, and other examinations as indicated by theclient's medical history or general physical examination. | • Nursing staff & doctor | • Initial assessment form |
| | **Preparation of patient before surgery/ Pre-operative procedure-Reference standard – ME G4.2** | | |
| a. | Surgeon gives written pre-operative instructions to | • Staff Nurse | |





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| | ward nurse. | | |
| b. | Part Preparation (Dress, removal of jewellery) is done | • Staff Nurse | |
| c. | Staff nurse receives the patient and transfers her to the pre-operative area. | • Staff Nurse | |
| d. | Written Consent for Surgery or IUCD insertion or removal, MTP, D & C is obtained from the client. | • Staff Nurse | • Consent form |
| e | Staff nurse conducts the following pre-operative checks.<br>➢ Medications as per prescription<br>➢ Clients identification<br>➢ Case Record and Investigation Reports / Films<br>➢ I.V. Fluids<br>➢ Blood Requirements<br>➢ Prophylactic Antibiotics (If prescribed) | • Staff Nurse | • Preoperative Checklist |
| **1.** | **Pre-operative Anesthetic Checks** | | |
| a. | A pre-operative evaluation of the patient is done by the surgeon / anesthetist. In case the patient is not deemed fit for surgery, the Surgeon and Nursing In-Charge for OT is informed.<br>In emergency cases pre-operative check up is done in Emergency / OT by the doctor. The PAC notes are documented on the case sheet. | • Anesthetist | • PAC form |
| b. | On receiving the patient at the OT, Nursing staff and the anesthetist verifies the identity against the details provided in the case sheet<br>The OT nurse does a quick evaluation of the patient's vitals and records the same. | • Anesthetist | • Case Sheet |
| **2.** | **In Process Checks during Surgery ( If abdominal ligation or CS with ligation being conducted in major OT)** | | |
| a. | The Scrub Nurse counts the number of sponges on the table. At the commencement and the closure of the surgical incision.<br>If satisfied, informs the surgeon accordingly. | • Scrub Nurse | |
| b. | The surgeon verifies that all swabs have been counted for, before the closure of the surgical incision. In case of any discrepancy, the surgeon records this fact on the case sheet and informs the Superintendent In Chief / CMS. | • Surgeon | • Case Sheet |



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| c. | The surgeon helps the scrub nurse informed of the location of swabs in the operational field and facilitates her in counting.<br>- After the first count has been taken, the scrub nurse and the surgeon carefully check the number of swabs still in use.<br>- Before the closure of the incision a final count is to be done | • Surgeon | • PPC register & Case sheet |
| d. | The scrub nurse checks all the instruments on the operating table and the hemostat clamps immediately before the operation.<br>- Under the supervision of the surgeon the scrub nurse checks the instruments and hemostat clamp0s again before the closure of the surgical incision | • Surgeon | • PPC register & Case sheet |
| e. | The scrub nurse counts all the needles on the table before the commencement of the operation.<br>As a rule, the scrub nurse does not part with the second needle till the first is returned to her by the surgeon. If more than one needle is being used at the same time, the scrub nurse takes care to see that all the needles are returned to her.<br>The scrub nurse makes a count of the needles before the closures of the surgical incision. In case of any discrepancy, the surgeon is informed promptly. | • Surgeon | • PPC register & Case sheet |
| **3.** | **Post Operative Care of the Patient** | | |
| | **Handing over from OT to ward** | | |
| a. | Inform respective ward when client is ready to be transferred and Inform ward nurse regarding client's condition and post-operative instructions from surgeon/anaesthetist. | • PP OT nursing staff | • Inter-dept transfer register |
| b. | A provisional Surgery Note containing the details of the surgery is prepared by the surgeon with his signature before the patient is transferred out of OT complex. | • Surgeon | • PPC register & Case sheet |
| c. | Detailed post operative care instructions are documented in the case sheet by the surgeon. | • Surgeon | • Case Sheet |
| d. | The Surgeon/anesthetist orders the transfer of the patient from recovery room to post operative ward after verifying her progress. | • Surgeon /Anesthetist | • PPC register & Case sheet |



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| e. | Remove all monitoring devices from client, transfer client on stretcher and cover client properly making sure no limbs are exposed. Hand over client case sheet & transfer register to the ward boy. | • PP OT nursing staff & ward boy | • Inter-dept transfer register |
| f. | The ward boy shall give hand over to ward nurse and receive acknowledgement signature from the nurse on the Inter-dept transfer register. | • OT ward boy, ward nurse | • Inter-dept transfer register |
| | In the post-operative period, the client should be kept under observation by nurse/doctor.<br>Following are the tasks to be carried out in the post-operative period in the ward:<br>• Receive the client from the operating theatre; review the client record.<br>• Make the client as comfortable as possible (handle the woman gently when moving her).<br>• Make sure that an over sedated client is never left unattended.<br>• Monitor the client's vital signs - check blood pressure, respiration and pulse every 15 minutes for one hour following surgery or till the patient is stable and awake. Thereafter, check vitals every one hour until four hours after surgery. Record vital signs in the client record each time they are checked.<br>• Check the surgical dressing for oozing or bleeding.<br>• For 'interval' cases (female sterilization) check for vaginal bleeding other than menstruation. If the client is bleeding, the surgeon should check for possible injury to the cervix that may have been caused by the vulsellum<br>• Administer drugs or treatment for symptoms according to the doctor's orders.<br>• Provide water, tea and fruit juices when the client feels comfortable.<br>• Complete the client record form. | | |
| g | Surgeon supervises the Patient in the Post Operative Ward for the progress. | • Surgeon | |
| **2** | **Client Referral** | | |
| | If client requires diagnostic tests or further care that is not available at the hospital then the client | • Doctor, Staff nurse | • Referral slip |



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| | shall be referred to the nearby referral centre. | | |
| | Whenever needed ambulance shall be provided by the hospital for quick transportation of clients. | • Nursing staff , ambulance driver | • Nil |
| | An advance telephonic communication with the referral centre shall be done to ensure the required service is available and intimate the staff of the higher centre about the referral. | • Nursing staff | • List of contact details of ambulanc e |
| | Client along with the referral slip and case sheet shall be referred to the higher centre. | • Nursing staff | • Referral slip |
| | The nursing staff shall also contact the referral centre and follow up about the condition of the client post referral. | • Nursing staff | • Refer In-Out register |

**Reference standard -** ME G4.2, ME E3, ME E2

### 9. ClientCounseling

| S.N | Activity | Responsibility | Record |
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| 1. | Counselling services shall be provided for the following services<br>**a.** Family planning counselling-Interval period<br>**b.** Post-natal counselling.<br>**c.** Counselling on safe abortion | • Doctor, Family planning counsellor | • Couns elling register |
| 2. | Counselling for the mentioned services shall be carried out by trained and skilled counsellors/ doctors. | • Doctor, Family planning counsellor | • Couns elling register |
| a. | **Family planning counselling** | | |
| | The family planning clinic shall have a dedicated counselling room and a trained counsellor for counselling couples. | • Family planning counsellor | • Couns elling register |
| | • The couple/client shall be given full information about optimal pregnancy spacing and the benefits of it as a part of FP health education and counselling.<br>• Client shall be counselled about the options for family planning available.<br>• The importance of timely initiation of an FP | • Family planning counsellor | • Couns elling register |



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| | method after childbirth, miscarriage, or abortion shall be emphasized.<br>• The client shall be informed about the use of condoms for the prevention of sexually transmitted infections (STIs) & HIV.<br>• The client should be given full information about the risks, advantages, and possible side effects of OCP's. | | |
| b. | **Post-pregnancyFamily planning counselling** | | |
| | The counsellor shall also take daily rounds of the post-natal wards to counsel the mothers on family planning methods their long-term effects and benefits.<br>Provide general information about benefits of spacing/ limiting births (if client wants more children in future or has not yet decided whether she wants more children or not):<br>• Inform that to ensure her and her baby's health she should wait at least two years after this birth before trying to get pregnant again<br>• Inform about the return of fertility postpartum and the risk of pregnancy<br>• Inform how LAM and breastfeeding are different<br>Provide information about the health, social and economic benefits of family planning.<br>Briefly provide general information about those contraceptive methods that are appropriate for woman based on her facts to questions asked before<br>• How to use the method?<br>• Effectiveness<br>• Possible common side effects<br>• Need for protection against STIs including HIV/AIDS<br>Inform combined oral contraceptive pills will not be appropriate in the postpartum period and may be taken later.<br><br>Male involvement in Post-partum family planning<br>Post-partum family planning usually focuses on women. The role of men can influence the decision to choose and use a family planning method correctly like many other decisions made | • Family planning counsellor | • Counselling register |



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| | in the family The counsellor/ nurse should take necessary steps to ensure that a joint decision is made by the couple | | |
| c. | **Counselling service for abortion** | | |
| | • Pre-procedure counselling on the abortion method, benefits, and post complication involved if any shall be provided.<br>• Post-operative instructions and information on follow up care shall be provided.<br>• During various follow –up visits, counselling shall also be carried out on precautions to be taken if any, diet & nutrition, further medication and care. | • Doctor | • PT register |
| | • Details of the counselling service, i.e. counsellor and client who received counselling shall be maintained in the register.<br>• Along with verbal counselling educative material on the same in the form of handouts shall be provided to the clients.<br>• The family planning clinic shall have standard IEC material on safe family planning method displayed. | • Family planning counsellor | • Counselling register |

**Reference standard -** ME G4.2, ME E3, ME E2



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**10.** Taking informed consent of client

| S.No | Activity | Responsibility | Record |
|---|---|---|---|
| 1. | Informed consent of the client shall be taken before initiating treatment and procedure. Informed consent shall be taken for the following procedures<br>- IUD insertion<br>- Family planning surgeries<br>- Abortion | • Surgeon | • Informed consent form |
| 2. | On the day of surgery, the surgeon shall explain the client/ couple (in family planning surgeries/ IUD insertion) about the surgery, benefits, post operative care, complication involved if any and follow up care. Information shall be given in a way that the client/ couple can understand and hence are enabled to take informed decision about their care. | • Surgeon | • Informed Consent form |
| 3. | The couple/client shall be allowed to decide whether they will agree to the procedure or withdraw consent at any time before the procedure is conducted. | • Surgeon | • Informed Consent form |
| 4. | Further to explaining ,signature of the client/ couple shall be taken in the consent form | • Surgeon | • Informed Consent form |
| 5. | Consent shall be taken in the presence of two witnesses, one from the client's side and one from the doctor's side. | • Surgeon, Nursing staff | • Informed Consent form |
| 6. | Consent for surgery, Anaesthesia and blood transfusion shall be mentioned in the consent form. | • Surgeon | • Informed Consent form |

**Reference standard -** ME B4.1



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**11.** Arrangements during non-availability of beds

| SN | Activity | Responsibility | Record |
|---|---|---|---|
| 1. | All efforts shall be made to accommodate client coming for admission as far as possible. | • Management , Ward In-charge PP unit | • Nil |
| 2. | The hospital doctors shall try to discharge the recovered clients in time to manage the beds for new admission. | • Doctors | • Nil |
| 3. | Alternative arrangements shall be made like putting extra beds or placing client in a different ward until beds are available. | • Ward In-charge of PP unit , nursing staff | • Nil |

**Reference standard -** ME E1.4



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## 12. Requisition for diagnostics, collection & transfer of samples and receiving of reports

| S.N | Activity | Responsibility | Record |
|---|---|---|---|
| 1 | **All the diagnostic tests shall be provided free of cost to the clients.** | • Doctor in charge | • Medical audit records |
| 2 | Treating doctor shall prescribe the investigations in the requisition form/doctor's note and counter sign the same with name, date and time. | • Doctor | • Investigation requisition form/doctor's note |
| 3 | Point of care diagnostics- The facility shall make available tests such as UPT, haemoglobin, Urine analysis for sugar and albumin, HIV at the point of care (PPU). | • Nursing staff | • Stock register |
| 4 | For laboratory test, the sample shall be collected by Nursing staff following aseptic procedure. The sample shall be transported to the lab by the ward boy/aaya by the use of transportation boxes. The samples shall be labelled with the client name, ID and test name. | • Nursing staff | • Sample dispatch register |
| 5 | For emergency test requisitions the labels shall be marked with EM. and lab staff shall be intimated over the phone too. | • Nursing staff | • Sample dispatch register |
| 6 | After all tests are done, reports shall be received from the concerned diagnostic area as per the turnaround time for test. | • Nursing staff | • Test Report |
| 7 | The reports received should be discussed with the doctor during his/her rounds. In case of any critical results the doctor shall be immediately intimated through phone or by a | • Nursing staff | • Test Report |



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**Reference standard** - ME G4.2

**13. Nursing care**

| S.N | Activity | Responsibility | Record |
|---|---|---|---|
| 1. | **Correct Identification of client** | | |
| | The correct identification of the client shall be ensured at all point of care and especially before initiating any invasive procedure. | • Nursing staff | • Nil |
| | Client id band/ Pt id no, verbal confirmation and Bed no, any two of the identification marks shall be followed to correctly identify the client. | • Nursing staff | • Client case sheet |
| 2. | **Timely and accurate nursing care** | | |
| | Treatment charts shall be maintained and updated. Drugs given shall be documented in case sheet. The drug dosage given should Co-relate it with drugs, duration and doses prescribed. | • Nursing staff | • Client case sheet |
| 3. | **Care of Vulnerable Clients** | | |
| | Vulnerable clients such as disabled, mentally retarded, victims of domestic violence or sexual assault/abuse etc should be provided special care. All measure should be taken to ensure their safety, security and privacy. | • Nursing staff | • Client case sheet |
| 4. | **Ensuring accuracy of verbal/telephonic orders** | | |
| | Verbal or telephone orders shall be accepted only on emergency when it is impossible or impractical for the physician to write them. | • Nursing staff, doctor | • Verbal order register, client case sheet |



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| | Abbreviations should not be used when an order is given or received. | • Nursing staff, doctor | • Verbal order register |
| | Read back the order to the physician including the client's name, treatment order/drug name and spelling of the drug to avoid an error due to sound alike drugs, Dosage, pronouncing it in single digits (e.g. 15 mg should be read as one five), route, frequency (e.g. three times daily, not TID). | • Nursing staff | • Verbal order register |
| | Document the order immediately including the date, time, and physician's name. Receiver's name and signature. | • Nursing staff | • Verbal order register |
| | Ensure the order is countersigned by the same doctor within 24 hours of communication of the verbal order. | • Nursing staff, doctor | • Verbal order register, client case sheet |
| 5. | **Nursing Hand-over** | | |
| | The nursing staff shall follow handing over formalities after every shift. A Nursing hand-over register shall be maintained for the same. | • Nursing staff | • Nursing hand-over register |
| | During change of each shift, client handover shall be given; A practice of giving bedside client handover shall be carried out. | • Nursing staff | • Nursing hand-over register |
| | All details of client condition, treatment given and care to be given next shall be explained to the next nursing staff on-duty. | • Nursing staff | • Nursing hand-over register |
| | All details explained shall be documented in the nursing hand-over register and signature of the nursing staff giving and taking handover shall be | • Nursing staff | • Nursing hand-over register |



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| | documented in the register. | | |

**Reference standard** - ME .E 4

### 14. Safe Drug Administration

| S.N | Activity | Responsibility | Record |
|---|---|---|---|
| 1. | All the drugs and consumables shall be provided free of cost to the clients. The drugs shall be prescribed only under generic names. | • Doctor In charge | • Medical audit records |
| 2 | Standard treatment guidelines (STG) should be available in the department and drugs and dosages prescribed therein should be adhered to. | | |
| 3 | Following parameters shall be verified before administration of drugs by the person administering the drug<br>✓ Written medication order (For verbal order refer the document 'written orders for medications'<br>✓ General appearance (physical incompatibility) of the medicine for administration (for e.g. melting, clumping etc.)<br>✓ Client identification<br>✓ Dosage of medication<br>✓ Route of administration<br>✓ Time of administration | • Nursing staff | • Drug chart, Nursing notes |
| 4 | All the medications administered in In-clients shall be documented in drug order sheet and nurses chart | • Nursing staff | • Drug chart, Nursing notes |
| 5 | Clients should be informed about dosage and timings of drug for self-drug administration. | • Doctor/nursing staff | • Nil |
| 6 | In case of any adverse reactions, the treating doctor shall be notified as soon as possible and details of the event shall be documented in the incident reporting form | • Nursing staff | • Drug chart, Nursing notes |





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| 7 | Any high risk medication shall be administered by/under the supervision of a senior Nursing staff only | • Nursing staff | • Drug chart, Nursing notes |
| 8 | Close monitoring of the client after the drug administration shall be carried out | • Nursing staff | • Drug chart, Nursing notes |

**Reference standard** - ME E.7



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## 15. Maintaining, updating of clients' clinical records, their storage andretrieval

| S.N | Activity | Responsibility | Record |
| --- | --- | --- | --- |
| 1. | **Maintaining and updating of records** | | |
| | All the assessments, re-assessment, investigations, surgery notes, treatment and medication details shall be recorded and updated. | • Nursing staff | • Associated forms and formats |
| | Standard forms and formats like treatment charts, surgery notes, investigation chart, medicine register, nursing handover register, eligible couple and sterilization register etc shall be used for the same. Records on family planning (FP) (including the number of clients counselled and the number of acceptors) shall be maintained. | • Nursing staff | • Associated forms and formats |
| | All records maintained shall be legible and complete in terms of name and signature of staff making entry along with date and time of entry. | • Nursing staff | • Associated forms and formats |
| | All registers/records shall be identified and numbered. | • Nursing staff | • Associated forms and formats |
| 2. | **Storage of records** | | |
| | All medical records of the client shall be complete & legible with proper name & signature of the author with date & time. | • Nursing staff | • Client case sheet |
| | The client information shall only be shared amongst the care providers. While on use the files should be stored in nursing station under the custody of the ward nursing staff. | • Nursing staff | • Client case sheet |
| | On client discharge the file shall be checked for completion and sent to MRD for storage. Only | • Nursing staff | • Client case sheet |



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| | copy of the discharge summary shall be handed over to the client during his discharge. | | |
| 3. | **Retrieval of records** | | |
| | Access to clinical records of client is allowed to entitled personnel only on request. Whenever the clinical record of a follow up client is sought after by the treating doctor, he/she shall fill in a record requisition register at MRD for availing the same. For retrieval of case sheet of an MLC client, court permission shall be soughted | • Nursing staff | • Record requisition register |
| 4. | **Maintaining confidentiality of records for abortion cases** | | |
| | No entry shall be made in any case sheet, PT register, follow-up card or any other document, register indicating there in the name of the pregnant women. Only reference serial no. shall be mentioned on all the document. | • Nursing staff | • Associated records for abortion cases |

**Reference Standard:** ME.E8

### 16. Client discharge

| S.N | Activity | Responsibility | Record |
|---|---|---|---|
| 1. | Discharge planning involves the following activities:<br>- Development of a care plan for post discharge care.<br>- Arranging for the provision of services, including client/family education and referrals.<br>- The Nurse in charge as well as the Registrar is responsible for coordinating the discharge with other team members. | • Treating Doctor | • Client vital sheets, investigation results, nurses notes etc. |
| 2. | The Discharge process shall be planned in consultation with the client and/or family. | • Treating Doctor, Nursing staff | • Client vital sheets, investigation results, |



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| | | | nurses notes etc. |
| 3. | Discharge planning shall be initiated on the basis of assessment of clients' condition. | • Treating Doctor | • Doctor's notes |
| 4. | Assessment of the client shall be made for being 'medically stable' and fit for discharge. This may include assessment of functional, medical, medication, and nutritional needs. | • Treating Doctor | • Client vital sheets, investigation results, nurses notes etc |
| 5. | The Treating doctor shall write the discharge orders in the IP case paper to initiate the necessary formalities for discharge. | • Treating Doctor | • Doctor's note |
| 6. | A Discharge Summary shall be prepared and signed by the treating doctor or Medical officer on duty (in case of non-availability of treating doctor) and given to the client. | • Treating Doctor/ Medical officer on duty | • Discharge Summary |
| 7. | In case of Medico Legal Case, police shall be informed before the client is discharged. | • Treating doctor, Nursing staff | • client case sheet |
| 8. | A copy of discharge summary shall be attached with IP case paper | • Nursing staff | • Client case sheet |
| 9. | Details of the discharge shall be entered in the discharge register | • Nursing staff | • Discharge register |
| 10. | The discharge summary shall contain the following information<br>- Details of the client including Hospital IP Number<br>- Date of admission and date of discharge<br>- Name of the doctor in charge of the case<br>- Client history<br>- Reason for admission. | • Manageme nt | • Discharge summary form |



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| | - Significant findings.<br>- Diagnosis<br>- Investigation results.<br>- Details of any procedure performed.<br>- Medication.<br>- Other treatment given.<br>- Course in the hospital<br>- Follow up<br>a. Advice.<br>b. Medication<br>- Instructions regarding when and how to obtain urgent care | | |
| 11. | During discharge, the client shall be counselled on Medication intake, care at home, diet intake, any medical precautions if any and identifying symptoms requiring immediate medical care. | • Nursing staff | • Client discharge checklist |

**Reference Standard:** ME G4.2



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## 17. Equipment Management

| S.No | Activity | Responsibility | Record |
|---|---|---|---|
| **Calibration of Equipments** | | | |
| 1. | All the measuring equipments/ instrument shall be calibrated. | • WardIn-charge/ FP OT In-charge | • Nil |
| 2. | An ISO certified calibration agency shall be identified to calibrate the equipments/instruments. | • Ward In-charge/ FP OT In-charge | • Nil |
| 3. | Calibration labels/stickers shall be placed on the equipment denoting the date of calibration and indicating the status of calibration/ verification when recalibration is due. | • Ward In-charge/ FP OTIn-charge | • Equipment register |
| 4. | All calibration certificates shall be maintained by the In-charge or centrally stored by the Store In-charge of the hospital. | • Ward In-charge/ FP OTIn-charge | • Calibration certificate |
| 5. | The ward shall maintain an equipment register to document details of equipment and calibration status. | • Ward In-charge/ FP OTIn-charge | • Equipment register |
| 6. | It shall be the duty of the In-charge to ensure updation of calibration for all equipments as per their schedule. | • Ward In-charge/ FP OT In-charge | • Equipment register |
| **General Maintenance** | | | |
| 7. | Up to date manufacturer's instructions for operation and maintenance of equipments shall be kept in the department so that the same can be readily available to staff when required. | • Ward In-charge/ FP OT In-charge | • Manufacturer's instruction |



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| 8. | Defective/Out of order equipments shall be labelled and stored appropriately away from traffic area, until it has been repaired | • Ward In-charge/ FP OTIn-charge | |
| 9. | Daily dusting/ dry wiping of equipments shall be done by housekeeping staff. The laboratory technician shall do a daily check on the functioning of equipments every morning before commencement of testing procedure. | • Ward In-charge/ FP OTIn-charge | • Nil |
| 10. | An equipment register shall be maintained to document details of equipment - name, hospital code, and date of installation, name of manufacturer, maintained in A house/maintained by external agency or manufacturer, Warranty Period, under AMC/CMC. | • Ward In-charge/ FP-OT In-charge | • Equipment register |
| **Preventive and Breakdown Maintenance** | | | |
| **Preventive Maintenance** | | | |
| 11. | All equipments shall be covered under AMC/CMC including Preventive maintenance. | • Ward In-charge<br>FP OT In-charge | • Equipment register |
| 12. | • The lab-Incharge shall maintain an updated record on AMC & Preventive maintenance in equipment register this should include details like :<br>• Frequency of Preventive | • Ward In-charge<br>FP OT In-charge | • Equipment register |



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| | Maintenance/Calibration<br>• As per manufacturer guidelinesPresently being followed<br>• Preventive maintenance/Calibration Done OnPreventive Maintenance/Calibration Due OnExpenditure with cost and details<br>• Remarks with Functional Status | | |
| 13. | Preventive maintenance shall be carried out as per Maintenance Schedule for each individual equipment based on manufacturer's recommendations. | • Ward In-charge<br>FP OT In-charge | • Equipment register |
| 14. | The following shall be checked during a preventive maintenance-<br>• Physical condition of the equipment/ facility<br>• lubrication, calibration, cleaning or replacing parts that are expected to wear or which have a finite life<br>• Maintenance report verification<br>Maintenance / Service report shall be obtained from service agency and after verification marked as O.K. /Not O.K. | • Ward In-charge<br>FP OTIn-charge | • Equipment Service Report |
| **Breakdown Maintenance** | | | |
| 15. | Faulty or defective equipment shall not be used regardless of how minor is the problem and must be reported in the first instance to the in-house maintenance engineer /outside agency hired for maintenance as soon as | • Ward In-charge<br>FP OTIn-charge | • Equipment register |



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| | possible and seen that the problem is attended to as soon as possible. | | |
| 16. | A label of "out of order" shall be attached to the equipment and information regarding breakdown shall be passed to all staff including any shift changes. | • Ward In-charge<br>FP OT In-charge | • Nil |
| 17. | On restoration of the equipment, the Equipment Breakdown Record should be updated. This indicates that the breakdown/maintenance is performed of the equipment.<br>The "out of order" sticker shall be removed after the restoration of the equipment. | • Ward In-charge<br>FP OTIn-charge | • Nil |
| 18. | All the breakdowns occurring in the department should be maintained in the equipment register and include the following<br>• Breakdown Date and Time<br>• Breakdown Details (Technical fault or other reasons)<br>• Date and Time of Rectification<br>• Total Time Taken (Rectification Time – Breakdown Time)<br>• Rectification Details with expenditure including cost (if any)<br>• Remarks with functional status<br>• Reasons for delay if any | • Ward In-charge<br>FP OT In-charge | • Equipment register |

**Reference Standard:** ME G4.2



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## 18. Storage and Inventory management of drugs and consumables

| S.N | Activity | Responsibility | Record |
|---|---|---|---|
| **Inventory Management** | | | |
| 1. | All drugs and consumables to be used shall be stored under the supervision of ward In-charge in cupboards at ward store room/nursing station. | • Ward In-charge, Nursing staff | • Stock register |
| 2. | The stock stored shall be kept in original packages/labelled containers on labelled racks. | • Ward In-charge, Nursing staff | • Stock register |
| 3. | Stock level shall be daily checked and updated in a stock register. The expiry date for each batch of drugs shall also be mentioned in the register. | • Ward In-charge, Nursing staff | • Stock register |
| 4. | A system of timely forecasting and indenting of drugs and consumables shall be practiced .The ward In-charge shall ensure there is a buffer stock available for emergency use before putting an indent for new stock. | • Ward In-charge | • Stock register |
| 5. | A crash cart for storage of emergency drugs equipment and consumables shall be maintained and a crash cart checklist shall be used for daily (in very shift) stock checking and updation of the same. | • Ward In-charge, Nursing staff | • Crash cart checklis t |
| **Storage of drugs and consumables for daily use** | | | |
| 6. | All drugs and consumables required for daily use shall be kept neatly arranged in a medicine trolley. | • Nursing staff | • Nil |
| 7. | The all drug and consumable containers shall be labelled. | • Nursing staff | • Nil |
| 8. | A medicine trolley register shall be maintained to | • Nursing | • Medicin |



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| | record details of usage. | staff | e trolley register |
| 9. | Oxygen cylinder if kept in the ward shall be placed vertically chained onto the oxygen cylinder stand. A daily checking form shall be used on the cylinder. | • Nursing staff | • Oxygen cylinder checking checklist |
| **Storage of Narcotic & Psychotropic Drugs** | | | |
| 10. | Narcotic & Psychotropic drugs shall be kept locked under the custody of the In-charge. A register shall be maintained for the same for daily stock updation. | • WardIn-charge | • Narcotic & Psychotropic drug register |

**Reference Standard:** ME D.2.1, ME D.2.5

**19. Infection control practices**

| S.N | Activity | Responsibility | Record |
|---|---|---|---|
| **1.** | **Linen Management** | | |
| | Change of Linen<br>Patient bed linen is changed:<br>• Once daily in the morning<br>• Whenever a new patient comes on the bed.<br>• Whenever it gets soiled with vomiting, faeces, blood spills, urine etc; Staff Nurse/ ANM/ Trainee/Ward Attendant Work Instructions for Bed Making<br><br>Sorting of used Linen | | |



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| | • Collected linen shall be sorted out as soiled, stained and dirty linen.<br>• Soiled and Infected linen shall be segregated from the dirty one<br>• The wards shall maintain two bins one soiled and dirty linen bin; all infected/stained linen shall be collected in the infected linen bin. Ward Attendant/ House Keeping Staff Work instructions for Sorting & Handling of Infected Linen<br><br>Disinfection of soiled/ infected linen<br>• All wards shall maintain a linen disinfection bin<br>• All Infected/stained linen shall be disinfected in the bin by soaking it in 1% Chlorine solution in the bathroom for one hour before sending it to laundry.<br>Ward Attendant/ Housekeeping Staff<br>Sorting of Linen in OT<br>• All Linen (e.g. surgical drapes, gowns, wrappers) used in procedures in the OT are considered to be infectious even if there is no visible stain.<br>• Disposal Zone of OT is where all the used linen is collected. OT Technician/ Attendant<br>IMEP guideline<br><br>COLLECTION OF DIRTY LINEN FROM WARDS<br>• The staff of in-house laundry /dhobi of outsourced agency shall collect linen from each ward/OT.<br>• The dhobi/laundry staff shall use gloves while handling the linen and check for any damage or tear if | | |



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| | any.<br>• The ward staff nurse shall be present during the collection to check the count of linen and damage if any, she shall then mention details in the linen book, sign, take signature of the laundry staff /dhobi too, and handover a copy to the laundry staff.<br>• All the linen is transported in closed leak proof bags, containers with lids or covered carts to washing area. Infectious and non-infectious linen is transported separately. The infectious linen should be transported in a yellow bag/container.<br>• The linen bag must be tied once 2/3th full and taken to the appropriate area to store neatly. Any bag which is overfilledshall be split within 2 bags. In-house laundry staff /dhobi of outsourced agency<br>Laundry book | | |
| **2.** | **Hand Hygiene** | | |
| | • Availability of wash basin with running water, soap, clean towel/tissue paper/hand dryer shall be ensured at the casualty.<br>• Poster depicting steps of hand washing shall be displayed near all wash basins.<br>• All staff involved in client care shall be trained on hand hygiene practices.<br>• The Infection control nurse shall monitor for adherence to hand hygiene practices.<br>• Alcohol based Hand rubs shall be available at wards.<br>• The scrub station at FP OT shall have elbow operated taps and sink wide and deep enough to prevent | • Nursingstaff | • Hand hygiene monitoring checklist |



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| | splashing and retention of water.<br>• Surgical scrub method should be adhered to;the procedure should be repeated several times so that the scrub lasts for 3 to 5minutes.<br>• The hands and forearms should be dried with a sterile towel only. | | |
| **3.** | **Standard practices and materials for antisepsis** | | |
| | • Antiseptic solutions shall be made available at all client care points.<br>• Proper cleaning of procedure site with antisepsis like before giving IM/IV injection, drawing blood, putting Intravenous and urinary catheter should be practiced.<br>• Cleaning of cervix before IUD insertion with antiseptic solution should be done<br>- Surgical site should be covered with sterile drapes; sterile instruments should be kept within the sterile field. | • Nursing staff | • Nil |
| **4.** | **Use of PPE** | | |
| | • The staff should always adhere to the use of PPE like surgical gloves, uniform.<br>• Elbow length gloves should be used for obstetrical purpose.<br>• No reuse of disposable gloves, masks, caps and aprons shall be practiced. | • Nursing staff | • Nil |
| **5.** | **General cleaning** | | |
| | • Wet mop floor using detergent and standard disinfectant/0.5%chlorine solution.<br>• Clean all furniture and lights using warm water, detergent and disinfectant/0.5% chlorine solution | • Housekeeping staff | • Nil |



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| | every morning.<br>• Clean the toilets and corridor daily with detergent water and disinfectant.<br>• Prepare cleaning solutions daily or as needed, and replace with fresh solution frequently.<br>• Cleaning equipments like broom shall not be used in client care areas.<br>• Double bucket system for mopping shall be used. | | |
| | **Terminal cleaning** | | |
| | • Use vacuum cleaner to clean the AC Vent and ducts if available, once in a month.<br>• Wet-dust horizontal surfaces by moistening a cloth with a small amount of a recommended hospital detergent/disinfectant.<br>• Avoid dusting methods that disperse dust (e.g., feather-dusting).<br>• Close the doors of immunocompromised clients' rooms when vacuuming, waxing, or buffing corridor floors to minimize exposure to airborne dust.<br>• Fumigation of the FP OT shall be carried out once in week. | | |
| **6.** | **Waste Management** | | |
| | The following colour - coding system shall be used in waste management segregation.<br>**Red Bag:**<br>• Syringes<br>• Tubings<br>• Saline bottles<br>**Puncture Proof containers: Blue** | • Housekeeping staff | • Nil |



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| | • Broken glass articles<br>• Medicine vials<br>**Puncture Proof containers: White**<br>• Needles (to be disposed only after burning)<br>• Scalpels<br>• Metal articles, like forceps to be disposed.<br>**Yellow Bag:**<br>• Blood stained bandages, gauze, cotton, tissues, and gloves<br>• Infectious wastes<br>• Human organs<br>**Black Bag:**<br>• Paper<br>• Plastic & other general waste | | |
| **8.** | **Microbiological surveillance** | | |
| | *As an infection control measure to check the sterility of the environment and surfaces in I.C.U, swabs shall be collected from client care surfaces,utilities,floor,instruments & A.C vent to be sent for microbiological culture surveillance .* | • Infection control nurse/ FP OT In-charge | • Culture sensitivity report |
| **9.** | **Water testing** | | |
| | Once in a month overhead water tank cleaning and water testing shall be done to check sterility of water. | • Infection control nurse/ FP OTIn-charge | • Water testing report |
| **10.** | **Processing of equipments and instruments** | | |



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|---|---|---|---|
| | • Procedure surface like OT Table, Stretcher/Trolleys etc. shall be wiped with 5% chlorine solution.<br>• Instruments like ambubag, suction cannula, Surgical Instruments shall be decontaminated by soaking in 0.5% Chlorine Solution/ wiping with 0.5% Chlorine Solution or 70% Alcohol as applicable.<br>• Contact time for decontamination shall be maintained to 10 minutes.<br>• The instruments should be cleaned after decontamination with detergent and running water.<br>• Cleaned instruments shall be sent to TSSU/CSSD for autoclaving and sterilization. | • Infection control nurse/ FP OT In-charge | |
| 11. | **Use of standard disinfectants** | | |
| | • Standard disinfectants like chorine solution, sodium hypochlorite solution, phenyl , formaldehyde/gluteraldehyde should be used | • Infection control nurse/ FP OT-In charge | |

**Reference standard** - ME G4.2

## 20. Quality assurance

| S.N | Activity | Responsibility | Record |
|---|---|---|---|
| 1. | Department In charge shall be vigilant about the key characteristics. Based on the observation, every month Department-In charge shall record his / her remark against the key characteristics as to whether the key characteristics meet the acceptance norms or not. Specific comments for the key characteristics may also be written. | • In charge | • Nil |



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| | | | |
|---|---|---|---|
| 2. | All reports shall be verified and signed by the radiologist/sonologist and then dispatched. | • In charge | • Reports |
| 3. | **Measuring productivity, efficiency, clinical care and safety indicators (ME H1.1 - 3.1)**<br>These quality indicators relating to productivity, efficiency, safety, service etc shall be maintained by the technicians and reviewed by the In charge:<br>- IUD insertion per 1000 eligible female<br>- Vasectomy performed<br>- Tubectomy performed<br>- No. of family planning counselling done per 1000 client<br>- Proportion of clients agreed for family planning methods out of total counselled<br>- Surgical Site Infection rate<br>- No of adverse events per thousand clients<br>- No. of complication per 1000 male sterilization surgeries<br>- No. of complication per 1000 female sterilization surgeries<br>- No. of post operative deaths per 1000 surgeries<br>- No. of sterilization failure per 1000 surgeries<br>- No. of sterilization failure per 1000 surgeries | • In charge | • Indicator register |
| 4. | **System for periodic review as Internal Audits/ assessments, medical and dealth and prescription audit.**<br>**Reference Standard:** ME G6.1 to 6.5<br>• Audits shall be conducted as per pre scheduled audit plan and organized and carried out by | • Auditor & Auditee | • Internal Audit report CAP |



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| | designated internal auditors.<br>• While planning Audit it should be ensured that the internal auditors do not audit their own activities.<br>• A Quality management system procedure for Internal Audit shall include the following<br>– Selection of Internal Auditors.<br>– Criteria for Internal Auditors.<br>– Audit Planning and methodologies.<br>– Audit recording, non-conformance and summary report preparation.<br>• Where audit findings indicate deficiencies or the opportunity for improvement corrective or preventive action is promptly taken, this is documented and carried out within an agreed upon time.<br><br>**Note:** Refer Internal Audit procedure in Lab Manual for details | | A repo rt |

Annexure: Clinical protocols

- IUD insertion
- Male & Female sterilization
- Administration of emergency contraceptive
- Techniques for contraception

**Family planning Indemnity scheme-MEB1.2**



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| S.No | Activity | Responsibility | Record |
|---|---|---|---|
| 1 | Orientation of staff about family planning indemnity scheme and family planning compensation. | Doctor In charge | Training records |
| 2 | Compensation for the beneficiaries for uptake of services and those in the event of failure and complications (indemnity scheme) should be prominently displayed in the PP Unit | | |
| 2 | Ensuring availability of various forms and manuals viz., consent forms, Manual for Family planning indemnity scheme, Claim form. | Nurse In charge | |



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