Quality Assurance Programme in the State of Uttar Pradesh

Standard operating Procedures for District Women Hospital

Ministry of Health and Family Welfare,

Government of Uttar Pradesh

Arvind Kumar, IAS
Principal Secretary,
Medical Health and Family Welfare,
Uttar Pradesh

FOREWORD

Uttar Pradesh is a vast State and providing essential and emergency medical services to the population is a challenge. The government hospitals are an integral part of health care system, catering especially to the poor and the underserved, for which out of pocket expenditure on health is a major concern. Therefore, initiating & maintaining the quality of equitable, accessible and affordable health services is the need of the hour.

In order to achieve the above mentioned goal, it is essential to establish, enforce & sustain uniform work standards and operating procedures in the health facilities across the State so that the beneficiaries gets optimum health care at all levels. Therefore, the standard operating procedures are important in establishing and enforcing work standards. They serve to define the acceptable level of performance for a task. They instruct the worker on how to accomplish a task effectively, efficiently and consistently.

The SOPs have been designed for individual service providers and also for the team, depending upon whether the individual alone or the team can reasonably ensure the desired outputs/outcomes. Therefore, SOP of a particular department should be shared by the In-charge of the department with the concerned staff.

This document will facilitate the process of improving performance to achieve the set goals and targets for the different thematic areas under the programmes by monitoring the performance.

I am confident, that the hospital In-charge will ensure optimal use of this document to improve performance of service provides which will not only deliver good quality services but also enhance patient satisfaction level among users of the Government Health Facilities and reposing trust in the Public Health System.

(Arvind Kumar)

Amit Kumar Ghosh, IAS
Mission Director,
National Health Mission,
Uttar Pradesh

MESSAGE

The Department of Medical Health and Family Welfare, GoUP is committed to provide good Quality Health Care to the citizens of Uttar Pradesh in an affordable and equitable manner. The National Health Mission has rolled out a comprehensive plan to provide Quality Health Care to all the citizens. One important way to improve productivity and efficiency for providing essential and emergency medical services is to standardize the 'Operating Procedures' in all the departments in the hospitals across the State.

Standard Operating Procedures are important in establishing and enforcing work standards. They help to ensure that the same task is consistently performed by all workers; also SOPs serve to define the acceptable level of performance for a task. They instruct the worker on how to accomplish a task effectively, efficiently and consistently.

I am confident that apex level health administrators and programme managers will make optimal use of this document to improve the performance of service providers and thereby achieve a quantum jump in the quality of service delivery at the health facilities particularly at the District Hospitals.

Quality Assurance (QA) is a cyclical process which needs to be continuously monitored against defined standards and measurable elements. Regular assessment of health facilities by the hospital staff and the State level Monitors which provides critical inputs in preparing the action plan for traversing the observed gaps, is the only way to have a viable quality assurance programme in public health. The need is to create an inbuilt and sustainable quality assurance system at Public Health Facilities which not only delivers good quality but is also perceived by the clients to do so.

I hope these Operational Guidelines and accompanying compendium of check-list will facilitate the build up of a sound and credible quality system at the district level Public Health facilities in Uttar Pradesh.

(Amit Kumar Ghosh)

Dr. Renu Jalote
Director General,
Medical Health and Family Welfare,
Uttar Pradesh

ACKNOWLEDGEMENT

Quality Assurance Programme has been rolled out across the State in November 2014 with an aim to ensure equitable and affordable health services in all the public health facilities. A total of 414 health facilities have been included in the programme, out of which 40 hospitals have been selected for NQA Certification in the FY 2015-16.

The Government of India has laid down certain quality parameters which should be fulfilled by the hospitals in order to achieve NQA Certification. Several activities such as awareness of the programme and orientation of the concerned officers, Service Providers training, Internal and external assessors training etc. are being conducted under the programme at the State level. All these activities will ultimately result in effective implementation of the programme.

One of the mandatory requirements for certification is availability of the Standard Operating Procedures manual in the facility; therefore this SOP has been prepared and customized in the State's perspective for District Women Hospitals.

I appreciate the efforts of the officials of MoHFW - GoI and NHSRC, New Delhi who have provided detailed and elaborate checklists. Under the leadership of Shri Amit Kumar Ghosh, Mission Director-NHM, this SOP has been developed in collaboration with the specialists at State level and officials of SPMU. I would like to convey my special thanks to Dr. Madhu Sharma, General Manager-QA, Dr. Archana Verma, Deputy General Manager-QA, Dr. Sulbha Swaroop, Consultant-QA and Dr. Pankaj Kumar Grover, Fellow-NHSRC for putting their best efforts in preparing this manual.

I hope that the use of this SOP would help to standardize all the procedures and to build a sound and credible quality system in all the District Women Hospitals.

(Renu Jalote)

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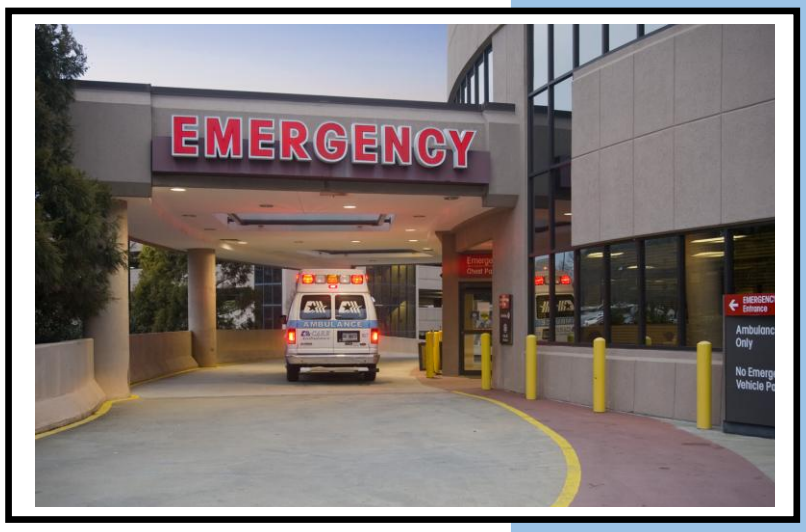
Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-1 Emergency Department



Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of Hospital Emergency

1. Provide immediate examination and admission if required, by EMO
2. Immediate management, treatment and relief to patient
3. Ensure availability of CEmOC services 24X7
4. Ensure transport for referral to higher facility 24X7
5. Ensure availability of trained skilled doctor and nursing staff
6. Proper handling of brought dead or died in emergency case as per protocol

SOP 1: Emergency Management

1. Purpose

To provide guideline instructions for the provision of immediate relief to and management of the patients arriving at the hospital with acute medical and surgical emergencies with rape cases, Gynaecological and Obstetrics emergencies etc without any discrimination

2. Scope:

Scope of services of the ED range from providing episodic, primary, acute (comprehensive) care to referrals.

3. Overall Responsibility:

Emergency: Emergency: SIC, EMO and supported by all hospital staff and doctors.

4. Standard Procedures

Sl. No	Activity	Responsibility	Reference Document/Record
4.1	**Service Provision** Emergency Department (ED) in the hospital offers comprehensive emergency care 24 hours a day. An attending Medical officer along with paramedical staffs in Emergency Department is on-duty in the ED 24 hours a day. If specialist consultant is required then medical officer refers the patient to Surgery, Orthopaedics, Obstetrics /Gynaecology, call them according to patient condition during OPD hours. Even medical officer call specialist in case of critical situation of patient, apart from OPD hours. Ambulance services are available 24*7 for transfer of patients. The charges are collected after receiving the patient from the site of incident. (as per govt. rules) Ramps are provided for patients Stretchers and wheelchairs are stored in the area immediately adjacent to the ambulance entrance and do not obstruct this entry. A waiting area, lavatories and telephones (on required basis) are provided for patients, families and individuals accompanying them. Unauthorized individuals are prohibited from entering the ED treatment area. The ED design maintains patient privacy without compromising patient care.	Medical Superintendent	Indian Public Health Standards
4.2	**Receiving Patients**: Patient is received in emergency, the attending doctor/ paramedical staff quickly attend to the patient without loss of time to assess the	Ward in-charge, ward boy, paramedical	Emergency Register

Sl. No	Activity	Responsibility	Reference Document/Record
	condition where needed and provide initial life support treatment. Initial treatment includes evaluation of patient's condition and initiation of management of case.	staff, Doctor	
4.3	**Shifting of the patients Labour Room to Indoor**		
4.3.1	The registration process of the patient is also initiated in the ED if the patients condition permits. In case of limb and life threatening situations the registration and consent process are postponed so as to facilitate the initiation of appropriate emergency care.	Emergency clerk	Emergency register
4.4	**Consent for Treatment**		
4.4.1	The Hospital requires consent for all invasive or therapeutic procedures. The general consent form is filled and signed either by the patient if possible or the patient representative if the patient is not is a state to give his consent. In case of a patient incapable of giving consent, it is taken from the patient representative or guardian.	Nursing Staff	Consent Form
4.4.2	Life-sustaining measures are not withheld for lack of formal consent if there is no time to obtain the consent for urgent procedures. The consent process is postponed and treatment is started immediately in such cases.	EMO	
4.4.3	Consent is required for elective blood transfusions that are not life threatening.	EMO/ Nursing staff	
4.5	**Patient Initial Screening Exam**		
	1. The initial assessment will be done by the ED EMO/ nurse for emergency patients. 2. The time frame for the initial assessment s measured, analyzed and corrective action shall be taken to reduce the time. 3. The Initial assessment will include ascertaining the level of consciousness, checking the blood pressure, Pulse, temperature, (Percentage of Oxygen in blood) Spo2, GRBS (growth receptor bound blood sugar) in case of diabetics or as per state guidelines. 4. The initial assessment will ascertain the condition of the patient whether stable or unstable and appropriate measures will be taken.	EMO/ Staff Nurse	Initial Assessment Sheet

Sl. No	Activity	Responsibility	Reference Document/Record
	5. Initial Assessment will include nutritional assessment of patient 6. Initial assessment by the medical officer will done 7. The initial assessment will result in documented plan of care.		
4.6	**Nursing Process in Emergency department** The ED nursing staff is the responsible person to oversee the functioning of the ED. The nursing staff provides all the medical and logistic support for patient care. As per the advice of the attending doctor, medication/dressing, condition monitoring is carried out. As per the need, and availability of the service, specialist may also be called to attend the patient. In case the patient is received as dead or dies during the course of treatment, the dead body is handed over to the attendant and certificate to this effect is issued indicating reasons.	Nursing Staff	
4.7	**Admission:** In case the patient's condition stabilizes or the first aid is provided, patient is discharged The patients are admitted on the basis of recommendation of doctor based on the patient's condition and need. The patient/attendants provide information regarding name, age, sex, date & time of arrival and informed consent is taken by the in-charge. Emergency registration no. is allotted to the patient in emergency department & entry is made in the emergency register. On transfer to the ward, the ER no. is entered in the IP register.	Emergency in-charge	Procedure for Patient Discharge Management Procedure for Patient Admission Informed Consent Emergency Slip, Emergency Register ()
4.8	**Transfer to the ward:** a) Patient's condition is observed in the observation room and life support treatment is provided to them. b) In case of cardiac patients, patients are transferred to the resuscitation room to handle the cardiac emergency. The room is equipped with the crash cart containing essential and emergency drugs, defibrillator, pulse oxymeter, cardiac monitor, ECG machine etc. c) Patients requiring minor surgical procedure are shifted to the procedure room (minor OT)	Doctor/ ward in-charge	

Sl. No	Activity	Responsibility	Reference Document/Record
	for carrying out X-Ray, plaster and pathological investigation. After providing the life support treatment and stabilizing patient's condition, the patient is shifted to the ward and entry is made in the Indoor Patient register. d) In case the services, essential for the treatment of the patient are not available in the hospital, patient is provided with the required first aid and condition explained to the attendant. Patient is referred to the alternate hospital and required support through ambulance for transfer of patient, is provided.		Indoor Register Procedure for Referral Management
4.9	**Maintenance of Medical Records (Registers and Documents maintained)**		
4.9.1	The following records are maintained in the ED: 1. List of Doctors on Duty and on call 2. Case files of patients attended in the ED 3. MLC register for medico legal cases 4. Drug Inventory Register 5. Controlled Drugs and Psychotropic Drugs Inventory 6. Brought Dead form 7. Death form	EMO/ Nurse on Duty	
4.10	**Diagnostic Services at Emergency**		
4.10.1	The ER of Hospital is equipped for undertaking all essential lab investigations and radiological work up for the patient; it collaborates with the laboratory and imaging department to provide such services on an emergency basis. After the necessary investigations are ordered, results are obtained from the laboratory by phone in cases urgency. When certain investigations like Blood Toxicology and Arterial Blood Gases which are not conducted at our in house laboratories are required, these tests are outsourced to outside laboratories.	Lab In charge/ X-ray In charge	
4.11	**Handling Medico-legal cases:** a) For MLC cases, police is informed after starting the treatment & entry is made in Police information book. Medico-legal record is maintained for cases under that category. b) In case the patient dies, or is received as dead, appropriate action is initiated towards	EMO/ Medical Superintendent	Police Information Book, MLC Register, Death Management

Sl. No	Activity	Responsibility	Reference Document/Record
	conducting the autopsy.		
4.12	**Brought in Dead**		
4.12.1	Take past history – HTN / DM / IHD etc., Look for / Ask about any suspicious signs: • Poisoning – Smell • Strangulation – Ligature mark around neck / abnormal sings • Any external injuries • Expose the body completely and look for any sings • Palpate the head and look for any hematoma, etc which may be missed. • If a female, ask history of married life and if it is less than 7 years register it as MLC, - it is mandatory.	EMO/ Staff Nurse	SOP for Management of Death
4.12.2	Register all brought dead cases as medico-legal case if death has occurred unexpectedly or from an unexplained cause. On arrival, the Emergency Medical officer should examine the patient thoroughly. He / She should go into the history in detail and look for signs of homicide, suicide, violence, external injuries to rule out any suspicious cause for the death. In case of female patient, marital history should be elicited and if EMO feels suspicious about cause of the death, Medico Legal Case has to be registered	EMO	
4.12.3	After complete examination and confirmation by clinical evaluation death & is confirmed, the individual should be declared as Brought in Dead (BID) and the accompanying relatives/friends must be explained and informed about the probable cause of death and to give only a Brought Dead Certificate until the cause of death is confirmed. The local police station should be informed immediately.	EMO	Brought Dead Certificate
4.13	**Death on Arrival**		
4.13.1	If a patient has sudden Cardio-Respiratory Arrest on arrival at the Emergency Room try to resuscitate the patients. Once death is confirmed the case should be treated as death on arrival, and necessary documentation should be done.	EMO	

Sl. No	Activity	Responsibility	Reference Document/Record
4.13.2	EMO should go into the detailed history of the patient and arrive at the probable cause of death. On the basis of this, death certificate should be issued and arrangements for release of the body are done.	EMO	
4.14	**Handling of Death & Release of Dead Body**		
4.14.1	Death of a patient is handled carefully with concern without complacency. Counselling of next of kin with empathy is importance. All help in shifting the body from the hospital & hand over to the next of kin. The dead body is released as soon as possible after completion of all formalities.	EMO & Nurses	
4.14.2	Acknowledgement for receipt of the body and the Death Certificate is obtained from Next of Kin/Legal representative and Handing-over of the body to patient's relatives' .it is ensured that hospital staff takes due care and concern in this respect. Due arrangements are made if preserving the body in the mortuary is found necessary. Security staffs of the hospital is present till the departure of the deceased and ensures orderliness in handing over the body to the next of kin.	EMO	
4.15	**Storage of Medicines in Emergency Department**		
4.15.1	All Emergency medications will be available 24 hrs in the ER.	Emergency Pharmacist & Emergency Nurses	
4.15.2	Medication inventory / Crash cart will be checked by the nurse on duty with each shift change, to detect shortage.	Nurses on duty	
4.15.3	Narcotic drugs will be kept in the narcotic box and will be under the supervision of the nurse in Charge. Narcotic drugs will be released only on the signed requisition of the Doctor/MO.		
4.15.4	Working condition of the ER equipment will be checked with each change in shift. Any Malfunction /non-functioning of the equipment will be brought to the notice of the nurse in charge and the Chief Emergency medical officer & complaint will be raised.	Nurse on duty	

Sl. No	Activity	Responsibility	Reference Document/Record
4.16	**Infection Control Measures:** Following infection control measures shall be followed in the hospital.		
4.16.1	**Hand Hygiene:** Adequate hand washing facility is available in all patient care areas. Elbow operated taps and washbasin and soap are available in service provider's room & in-patient care areas. If water facility is not available alcohol rub may be provided in patient care area. Scrub area is available in OT area with elbow operated or foot operated water tap facilities.	On duty doctor, staff nurse and all paramedic as well as housekeeping staff involved in patient care.	
4.16.2	**Aseptic technique:** Aseptic technique is followed strictly in OT as well as if the procedures are done outside OT.	OT I/C	
4.16.4	**Segregation of contaminated materials and instruments:** Contaminated pieces of linen, sputum cups, bedpans, instruments and biomedical waste are kept separately to avoid mixing with the clean ones.	Ward I/C	
4.16.6	**Disinfection:** Disinfection of equipment and furniture are carried out with bleaching powder solution. At least once a day or based on the procedure done/ contamination.	Housekeeping staff or General duty attendant	
4.16.7	**Sterilization practices:** The efficient CSSD ensures the supply of properly sterilized article to all users of the hospital. The unsterile items are stored separately from the sterile items.	Ward I/C or CSSD Incharge	
4.16.8	**Good housekeeping:** Cleaning of OT walls, floors, tables and fixtures are organized as per a schedule programme at pre-determined intervals and use of appropriate disinfectant is strongly advocated. (*Procedure 20, Hospital housekeeping & General Upkeep Management)* Biomedical waste are collected, segregated, transported, stored and disposed off as per BMW management & handling rule, 1998. (*Procedure 24, Hospital Waste Management)*	Housekeeping staff	Housekeeping Check list Biomedical waste Management & handling rule, 1998.
4.16.9	**Antibiotic policy:** Antibiotic policy is adopted to monitor and control involvement of organisms showing multi-drug resistance and to control the use of antibiotic policy in clinical practices	Infection Control Committee.	

Sl. No	Activity	Responsibility	Reference Document/Record
	Medical officers/microbiologist/pharmacist & nurses takes part in the preparation of antibiotic policy. Method: 1. Identification of relevant pathogens in exudates and body fluid collected from patients. 2. Sensitivity test done to determine the degree of sensitivity or resistance of pathogens isolated from patients to an appropriate range of antimicrobial drugs. 3. Sensitivity testing is the in-vitro testing of bacterial cultures with antibiotics to determine susceptibility of bacteria to antibiotic. 4. Antibiotic with higher efficacy, low side effects and less chances of anti microbial resistance, shall be used in the hospital.		
4.16. 10	**Soiled linens:** All soiled linen is considered potentially infected and treated accordingly.	Ward I/C and Laundry supervisor	
4.16. 11	**Use of PPEs** Use of personal protective equipment when handling blood, body substances, excretions and secretions; Using personal protective equipment provides a physical barrier between micro-organisms and the wearer. It offers protection by helping to prevent micro-organisms from: ➢ contaminated hands, eyes, clothing, hair and shoes; ➢ being transmitted to other patients and staff <u>Personal Protective Equipment includes</u>: · gloves; · protective eye wear (goggles); · mask; · apron; · gown; · boots/shoe covers; and · cap/hair cover	The entire healthcare worker involved in patient care and relatives of patient visiting isolation wards/ ICU.	
4.16. 12	**Prevention of injury with sharps** Precautions to be observed: • Needles should not be recapped, bent or broken by hand.		

Sl. No	Activity	Responsibility	Reference Document/Record
	• Disposable needles & other sharps should be discarded into puncture proof containers at the site of procedure • Sharps should not be passed from one HCW (Health Care Worker) to another. The person using the equipment should discard it. If necessary a tray can be used to transport sharps. • All sharps containers to be discarded when 3/4th full.		
4.17	**Disaster Management**		
4.17.1	Several types of hazards pose a threat to the hospital: 1. Internal disasters: fire, explosions, and hazardous material spills or releases. 2. Minor external disasters: incidents involving a small number of casualties. 3. Major external disasters: incidents involving a large number of casualties. 4. Disaster threats affecting the hospital or community (large or nearby fires, impending disasters, flooding, explosions, etc.). 5. Disasters in other communities.	EMO	
4.18	**General Considerations:**		
4.18.1	**Lines of Authority:** The following persons, in the order listed, will be in charge: 1. Chief Medical Superintendent 2. Medical Superintendents (Male & Female Wing) 3. Matron. 4. Nursing In charge on duty at time of disaster. 5. Emergency Room In charge		
4.18.2	**Communications:** A Command Centre will be set up at the Chief Medical Superintendent's office to handle and coordinate all internal communications. All department heads or their designee will report to this office and call as many of their employees as needed.		
4.18.3	The person In charge, when the disaster happens, will assign a staff to the communication system in the E.D. This clerical staff will answer all telephone calls from this		

Sl. No	Activity	Responsibility	Reference Document/Record
	station.		
4.18.4	The telephone shall be manned immediately at the HM office by an administrative staff but only for information purposes.		
4.18.5	At least one messenger will be assigned to the telephone operator to deliver messages, obtain casualty count from triage, etc.		
4.18.6	Person directing personnel pool shall send a runner (preferably a volunteer) to all departments to advise them of the type of disaster and number of victims and extent of injuries when this information is available.		
4.18.7	Nursing staff will be notified by the Nursing Head or designated persons. Department Heads will be notified by the Supervisor or designated staff. Department Heads will notify their key personnel.		
4.18.8	A "Visitor Control Centre" will be set up in the front lobby. Families of casualties will be instructed to wait there until notified of patient's condition. Normal visiting hours will be suspended during the disaster situation. A hospital staff member will update, educate and counsel the family members. A list of the visitor's names in association with the patient, they are inquiring about, should be kept. Volunteers may be needed to escort visitors within the facility.		
4.18.9	Telephone lines will be made available for outgoing and incoming calls. One line will be designated as the open line to the external Command Centre. The person in charge will designate assigned staff to monitor the phones.		
4.19	**Supplies and Equipment:** 1. Extra supplies will be obtained from store personnel through runners. 2. Outside supplies will be ordered by the store in charges and brought into the hospital.		
4.20	**Valuables and Clothing:** Large paper or plastic bags will be made available in the treatment Areas and the storeroom for patient's clothing and valuables which are properly tagged with identification		

Sl. No	Activity	Responsibility	Reference Document/Record
	no. and then reposition.		
4.21	**Public Communication Centre:** A communication centre for receiving outside calls and giving information to the press and relatives, shall be set up in PRO/ HM office.		
4.21	**Morgue Facilities:**		
4.21.1	Patients pronounced DOA (Death on arrival) will be tagged black.		
4.21.2	Bodies will be stored in a designated place by Security. Security Personnel will remain with bodies until removed by proper authority.		
4.21.3	After bodies have been identified, the information will be filed on the Disaster Tag and Medical Records notified as to the identification of the patient.		
4.21.4	The bodies will be handed over to the relatives after proper identification in presence of representatives from the police department. Bodies which remain unclaimed will be handed over to the police after following the required procedures		

5.0 Records

Sl.	Record Name	Record No.	Retention Period
1	Emergency register		
2	Consent		
3	Bed head tickets		
4	Emergency medicine stock register		
5	Death Register		
6	Emergency staff duty register		

6.0 Process Efficiency Criteria

Sl.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Referral	Emergency Referral Rate	
2	Initial Screening	Average time taken for initial Assessment	
3	Inventory	No of drug stock outs in the month	

7.0 Reference

1. IMC Code of Ethics 2000
2. Procedure for admission & Discharge
3. Guidelines for Hospital Emergency Preparedness Planning (GOI)

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-2 Out Patients Department

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of OPD

1. To enhance patients satisfaction in the area of time spent for examination in counseling (from existing 3 to 4)
2. Ensure promptness in drug distribution
3. Ensure availability of drugs in dispensary
4. Ensure proper signage's, directional arrow and information

SOP 2: Out Patient Department

1. Purpose:

- To ensure that all services to outpatients are coordinated so that they get the required care from service providers in the hospital.
- To respond to the need and expectations of the patients and to enhance patient satisfaction.

2. Scope:

- It covers the persons who visit the OPD facility (new and follow up patients) for treatment, investigation, consultation, check-up and immunization.

3. Responsibility:

- The registration clerks are responsible for issuing registration slip and providing consultation appointments.
- The OPD Nursing In-charge is responsible for monitoring the respective OPD unit functioning, maintaining necessary records and assisting the consultants.
- The Consultants are responsible for examination of the patients and for determining the line of management of the ailment / case thereof.

4. Standard Procedure:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	Hospital provides OPD services as mandated in minimum assured services by Indian Public Health Standards in respect of Gynecology and Obstetrics. All the maternal and Child Health Services are provided as per IPHS for District Hospitals and Operation Guidelines for Maternal & Child Health issued by MoHFW, Government of India. This Includes- 1. Antenatal Care including Management of High Risk Pregnancies referred form level 1 and 2 institutions 2. 24X7 services for Emergency Obstetric Care & New-born care 3. Emergency Care of Sick Children 4. Family Planning Services 5. Medical Termination of Pregnancy 6. Treatment of RTI/STI 7. Blood Storage Facility 8. Essential Laboratory Services 9. Referral Transport Services All services available in the Hospital are	SIC/ CMS	Indian Public Health Standards

Sl. No.	Activity	Responsibility	Reference Document/Record
	communicated through citizen charter & Enquiry Desk.		
	Antenatal Care		
	• **Registration and First ANC Visit-** • Any pregnant women requiring services during antenatal period visit hospital is registered at registration counter and OPD slip is issued to her. • Pregnancy is confirmed by conducting urine examination using pregnancy test kit (Nischay) • Last Menstrual Period (LMP) is recorded and Expected Date of Delivery (EDD) is calculated for pregnant woman. Pregnant Women's present and past history taken including any illness or complication during present & previous pregnancy.	Registration Clerk Medical Officer/ Staff Nurse/ ANM	OPD registration slip Mother & Child Protection Card
	Mother & Child Protection Card- • For each ANC registration, a Mother & Child Health Card is issued to pregnant women. • All the details including family identification, pregnancy records, institutional identification, next due date of ANC visit, findings of ANC examination and investigations, post natal care, care of baby, details of immunization, growth chart etc. is recorded on this card at different stages of ante and post natal care.	MO/ paramedical staff like staff nurse and ANM	Mother & Child Protection Card
	Schedule of Visit- 4 ANC visit of every registered pregnant woman is ensured as per following schedule **1st Visit-** Within 12 Weeks **2nd Visit –** Between 14- 26 Weeks **3rd Visit –** Between 28 -34 Weeks **4th Visit –** Between 36 Weeks and term. If a woman comes for registration later in her pregnancy, She is also icterus registered and care is provided according to gestational age	Medical Officer/ Staff Nurse/ ANM	Mother & Child Protection Card

Sl. No.	Activity	Responsibility	Reference Document/Record
	Antenatal Check-up • On each visit Patients history & complaints are taken and physical examination for weight, blood pressure, respiratory rate, pallor, oedema and icterus is done. • On each visit abdominal palpation for foetal growth, foetal lie and auscultation for foetal heart sound and breast examination is done according to the stage of pregnancy. • Laboratory test for Haemoglobin, urine albumin & urine sugar is done on each visit. • Tests for blood group and Rh factor, Syphilis (VDRL/RPR), HIV, blood sugar, malaria & Hepatitis B are also done for each pregnant woman. • Regular dose of Folic Acid is given 1st trimester onwards and Iron Folic Acid on subsequent trimester for at least 100 days. • First dose of Tetanus Toxoid injection (Inj. TT) is given as soon as possible after ANC registration. A second dose is given one month after the 1st dose. • At each ANC visit pregnant women is counselled for nutritional requirements, recognizing danger sign of pregnancy, birth preparedness, institutional delivery, arrangement of referral transport, breast feeding, family planning etc. • If the case is abortion procedure is done within the ambit of MTP act.	MO/ paramedical staff like staff nurse and ANM	SOP for Lab Investigation Guideline/ WI for Ante Natal Check-up & Examination Guidelines for pregnancy care and management of common obstetric complications by Medical Officer Guidelines for Antenatal care and skilled attendance at Birth by ANMs/LHVs/SNs
	Medical Termination of Pregnancy • If a pregnant woman during ANC is found to be requiring medical termination of Pregnancy they are preceded for same within the ambit of MTP Act 1972 as soon as possible.		

Sl. No.	Activity	Responsibility	Reference Document/Record
	A consent is taken from pregnant woman in form C prescribed under MTP Act.		
	Radio diagnosis during pregnancy –Ultrasonography- • Ultrasonography of pregnant women if required is performed during ANC visits. The reason for performing Ultrasound must be covered under any of the 23 indication prescribed in PC & PNDT Act 1994. • A declaration is taken on form F from doctor as well as from pregnant woman. **X-Ray-** • X-ray of pregnant woman is avoided, it is allowed only if approved by radiologist or physician who overweighs the benefit against risk of performing X-ray. • Pregnancy status of woman of child bearing age is confirmed before performing the procedure by radiographer. A notice for this purpose is displayed at X-Ray room. Lead shield is provided if X-ray procedure is performed on pregnant woman.		
	Management of High Risk Pregnancy • If any signs of high risk pregnancy is identified during ANC visits the case is referred to in house Obstetrician /Gynaecologist and treatment is started as per Standard Treatment Guidelines as early as possible. • All the high risk pregnancy cases coming from referring facilities are directly sent to in-house obstetrician & gynaecologist for management. • If the management cannot be done at the facility, patient is referred to Medical College / Tertiary Care Hospital.		

Sl. No.	Activity	Responsibility	Reference Document/Record
4.2	**Display of Information-**Information regarding OPD clinics, available, doctors and their timings, room no. and directional signage's for clinics are displayed at the entrance and other relevant locations.	Hospital Manager	
4.3	OPD CONSULTATION PROCESS		
4.3.1	After the patient is registered, registration number is generated at registration counter, the patient is directed to the doctor for OPD consultation.	Receptionist at the Registration Desk	OPD slip
4.3.2	Patient is directed to different OPDs by registration clerk based on his assessment of the patient is requirement. If he/she is not sure patient is directed to general OPD clinic where doctors screen the patient and refer to specialist if required	Help Desk Staff/ Volunteer	
4.3.3	**Patient Calling System -** Patient waits outside concerned doctor's room for his/her turn. Patient is called by Doctors/attendant as per his/her turn on the basis of "first come first examine" basis. If clinic caters to both male and female patient a definite turn is fixed for female and old patient. Two patients are not allowed at one time in clinic. For clinics having heavy patient load manual / electronic calling system is implemented. Attendant/Guard is provided on priority basis for such clinics to manage crowd. For any critical patient needing urgent attention queue can be bypassed for providing services on priority basis.	Duty staff	
4.3.4	**Receiving the patient in clinic-** Doctor/Attendant greets the patient and guides him to sit on patient stool/chair by his side. No consultation should be given to Patient while standing. If patient is accompanied by Relatives / attendant as per hospital policy they are also offered seats. But if patient wants to take consultation alone and Doctor also feels that it is necessary he can ask other	Medical Officer/ Specialist	

Sl. No.	Activity	Responsibility	Reference Document/Record
	person to wait outside.		
4.3.5	**History Taking-** Doctor reads the referral documents / other treatment related documents if provided by the patient. Doctor takes the history including the present problem, past medical history, family history, occupational history, habits like smoking & alcohol, allergies, drugs and other treatment history and other bodily systems that are not covered in present complaints. In case of complaint of pain details including site, radiation, severity, time course, aggravating factors, relieving factors and associated symptoms are asked as required. Doctor notes down the relevant history on the OPD slip	Medical Officer/ Specialist	OPD Slip
4.3.6	**Physical Examination-** Examination table with footsteps and screens for privacy have been provided in the clinics. Daylight is preferred over artificial light for examination. A female attendant / nurse /relative is required to accompany the female patient at a time of examination, in case the examining doctor is male. While doing examination of private parts it is essential. Doctor takes a verbal consent before examining the patient. Physical examination including examination of temperature, pulse is done as required. Doctors notes down the relevant findings of examination on the OPD slip.	Medical Officer/ Specialist	OPD Slip
4.3.7	**Risk Assessment & Differential Diagnosis-** Based on data gathered for History and Physical examination, severity of problem is assessed. Differential diagnosis is given on the basis of collected information. If patient requires some urgent treatment / procedure, same is arranged at OPD or patient is shifted to emergency/ OT/ Dressing Room/ Injection room as required. If the patient requires admission he/she and accompanying person is informed	Medical Officer/ Specialist	Procedure for Patient registration, admission and discharge Procedure for Referral Management

Sl. No.	Activity	Responsibility	Reference Document/Record
	and patient is shifted to ward. If patient requires such interventions / consultation which are not available in the hospital patient is referred to higher centre.		
4.3.8	**Investigations** In case laboratory/ radiology investigations are required to be performed, investigation requisition form is filled by the doctor/ OPD attendant. Only those investigations which are not available in hospital and essential for arriving at the diagnosis are prescribed from outside. After the investigation patient come back to OPD for the consultation. Final Diagnosis is arrived on the basis of investigation reports and clinical findings.	Medical Officer/ Specialist	
4.3.9	**Prescription-** Doctor prescribes the drugs/ procedures after arriving or provisional diagnosis/final diagnosis. If required drugs are part of essential drug list and available in the hospital pharmacy they are prescribed in generic name & patient is directed to collect it from OPD dispensary. If required drugs are not part of essential drug list/not available at hospital in house pharmacy, they are prescribed in generic name and patient is directed to generic drugstore/ Pharmacy, if available in the Hospital. In exceptional conditions only, when required drugs are not available in in-house Pharmacy, It is brought to the notice of the facility In charge who take further action to locally procure the drugs. Doctor mentions his /her name, initials, date & registration no. on the prescription. A stamp for the same has to be prepared for the same.	Medical Officer/ Specialist	OPD Slip/ Prescription Procedure for Pharmacy Management
4.4	**Drug Dispensing** If medicines are prescribed, the patient goes to the pharmacy to collect it.		Procedure for Pharmacy
4.5	**Follow Up** Cases where follow up visit is required the same is mentioned in the OPD slip	Medical Officer/ Specialist	OPD Slip

Sl. No.	Activity	Responsibility	Reference Document/Record
	and the patient / relatives are informed by the doctor about the date and time.		
4.6	Nursing Process in OPD		
4.6.1	Dresser/ Nurses on duty perform dressing as per Medical officer's advice. They enter the details in dressing room register. Patients are advised by dressing personal for next dressing if doctor prescribes the same.	Dresser/ Nurses on duty	Dressing register
4.6.2	Nurses on duty generates an immunization card and immunizes the patient and details are entered in the Immunization card and immunization register	Nurses	Immunization Card Immunization register
4.6.3	Injections as instructed by the treating doctor are administered by the Nursing staff.	Nurses	Injection Register
4.7	**Patient Privacy and Confidentiality-** Patient's privacy should be maintained during all OPD procedures including consultation, examination, counseling and procedures like injection and dressing. Screens and curtains have been provided at all such areas of OPD. Information and records pertaining to diagnosis and treatment of patients are not shared with anybody except clinical staff involved in treatment.		
4.8	**Duty Roster –** A duty roster is prepared weekly for deputation of Doctors and Nurses in OPD. Information of Doctors availability is updated as per the roster. In case of non-availability of any Doctor alternate arrangements are made if possible. If Clinic remains unattended information is displayed on the notice board.	Medical Superintendent/ Hospital Manager	Duty Roster
4.9	**Punctuality, Dress Code and Identity** Hospital manager monitors that all the doctors are present at their clinic at scheduled time. Any Discrepancy is reported to Medical Superintendent who takes corrective action in this regard. Same measures are also taken for Nursing and support staff. All the staff wear their respective uniform/Apron	Medical Superintendent/ Hospital Manager	

Sl. No.	Activity	Responsibility	Reference Document/Record
	with name plate/ I-Card.		
4.10	**Disable Friendly OPD** Ramps with handrails have been provided at entrance and for other elevated area. Wheelchairs / Trolleys have been provided on entrance/ reception. Disable friendly toilets with handrail and two ways swing doors have been provided at OPD.	Medical Superintendent/ Hospital Manager	
4.11	**Hand Hygiene-** Doctor/Nurse staff wash hands between examining two patients with soap following the steps and duration. Alternately alcohol based hand rub is used for the same. Hand washing facilities with running water and soap/ Hand rub have been made available at all point of use.	Medical Officer/ Specialist	
4.12	**Clinic Management –** Hospital Manager ensures that all necessary instruments/ equipment/furniture/consumables including patient stool, thermometer. BP apparatus, examination table, other examination equipment, hand washing facility, X-ray View box, examination gloves, screens and curtains are available in the clinic before start of day. Any deficiency is noted and discussed with medical superintendent for corrective action.	Hospital Manger	
4.13	**Patient Amenities-** Patient amenities like safe drinking water, adequate chairs in waiting area, clean toilets, fan and air cooling/heating are made available as stipulated in IPHS and monitored for their functionality and adequacy on regular basis. A May I Help You Desk has been provided at OPD with dedicated staff.	Hospital Manager /Medical Superintendent.	
4.14	**Prohibition of Smoking-** Smoking is prohibited in OPD as well as other areas of Hospitals under Prohibition of Smoking in Public Places rules 2008. A 60 by 30 cm board saying, "No Smoking Area – Smoking Here is an Offence" is prominently displayed at	Hospital Superintendent/ Hospital Manager	Prohibition of Smoking in Public Places rules 2008.

Sl. No.	Activity	Responsibility	Reference Document/Record
	each entrance, floors, staircases, entrance of the lifts and at conspicuous place(s) inside. Name of the person to whom a complaint may be made is prominently displayed. Any person found smoking is fined Rs. 200 as per the provision of rules. Medical superintendent or Hospital manager is authorized to collect this fine against receipt/ challan.		Format for receipt/Challan for fine
4.15	**Administrative and Non clinical work at OPD** Administrative work like attestation of certificates and issue of medical certificates are not entertained in the OPD timing, Medical representatives from pharmaceutical companies are not entertained in OPD timing. Notice for the same is displayed at the OPD**.**	Hospital Manager/ Medical Officer/	
	Immunization • The hospital immunization facility under universal immunization programme for children/ new born/ neonates which includes all vaccines e.g. OPV, DOT, TT, BCG, Measles etc. and register is maintained in the department by Sister In-Charge. • Details of immunization given are entered on immunization card. • Auto disable syringes are used for immunization. • Any serious adverse event following immunization such as death, hospitalization, disability and other serious events that are thought to be related with immunization are immediately reported to MS by Phone. • Other Serious AEFIs such as anaphylaxis, TSS, AFP, encephalopathy, sepsis, event occurring in cluster are reported to district immunization officer within the prescribed time in a prescribed format. • All the serious AEFI (Adverse Effects Following Immunization)	Immunization Nurse/ ANM	Universal Immunization programme Mother and Child Protection Card

Sl. No.	Activity	Responsibility	Reference Document/Record
	cases are investigated by appropriate authorities and corrective action is taken. ✓ After each immunization parents are informed about- ✓ What vaccine is given and it prevents what. ✓ What are minor side effects and how to deal with them? • When to come for next visit • To keep Mother and Child Protection card safe and bring it on next visit.		
4.16	Patient Satisfaction Survey		
4.16.1	**Sample Size** Sample size for patient satisfaction survey is calculated on the basis of case load of previous three months.	Hospital Manager	Sample Size calculator.
4.16.2	**Data Collection** Patient feedback is taken on OPD Patient Satisfaction format printed in local language on continuous basis. For illiterate patients, Enquiry counter personnel or any other designated staff takes the interview and records the feedback on the form. When collecting the feedback it is ensured that all categories of patients e.g. Male, female, BPL, Old age and revisit patients get representation	Hospital Manager/ Enquiry Counter Personnel	OPD Feedback format
4.17	**Monitoring of waiting times-** Waiting time for registration, consultation, investigations, pharmacy and consultation time are monitored through time motion study and data is analyzed on monthly basis. Processes having long waiting time and causing patient dissatisfaction are discussed in management review meeting and corrective and preventive actions is taken after arriving on root cause.	Hospital Manager	
	Infection Prevention		
4.4.1	**Hand Hygiene:** Adequate hand washing facility is	On duty doctor, staff nurse and all paramedic as well as	

Sl. No.	Activity	Responsibility	Reference Document/Record
	available in all patient care areas. Elbow operated taps and washbasin and soap are available in service provider's room & in-patient care areas. If water facility is not available alcohol rub may be provided in patient care area. Scrub area is available in OT area with elbow operated or foot operated water tap facilities.	housekeeping staff involved in patient care.	

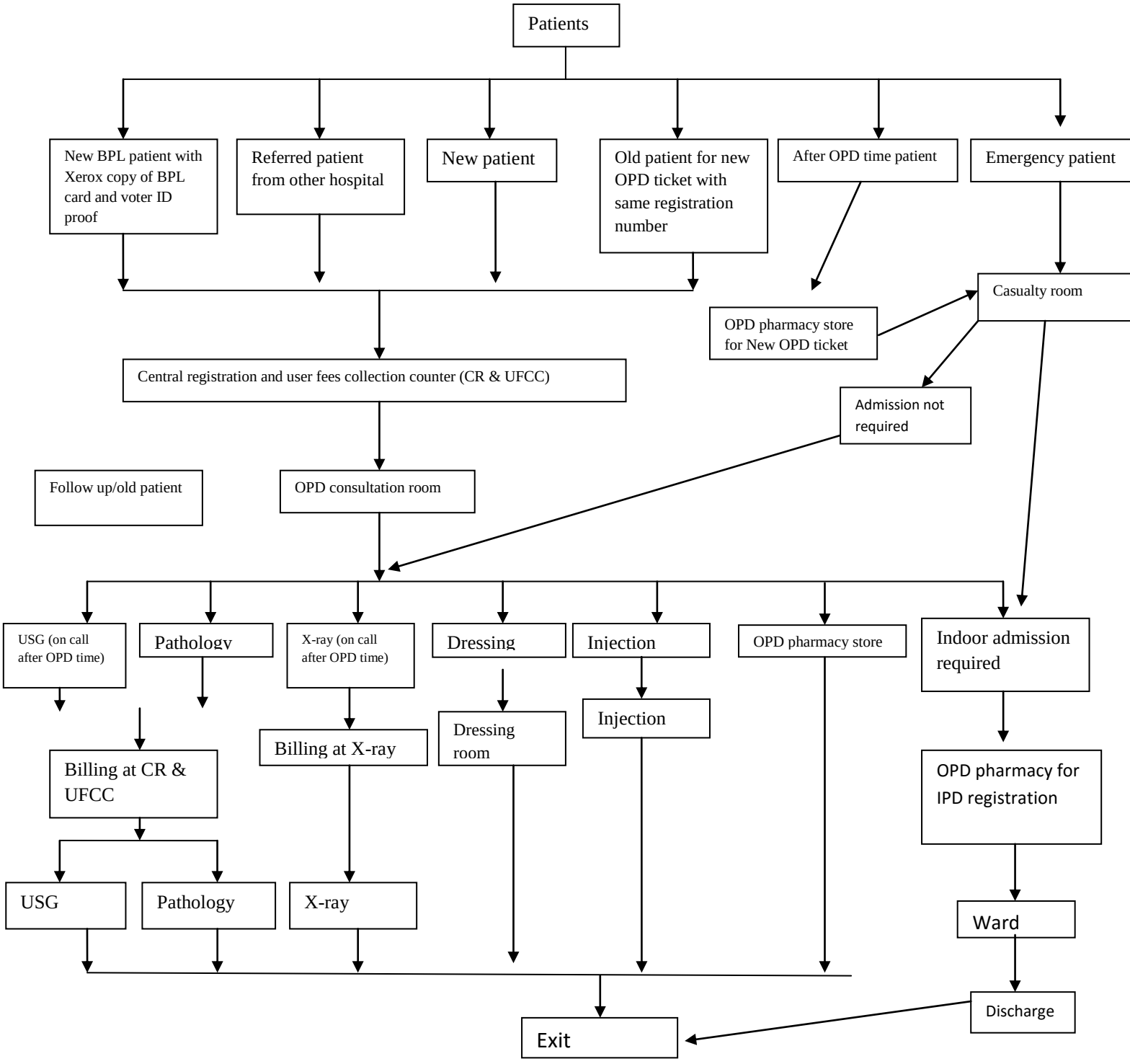
5. Records-

Sl.	Name of Records	Record No.	Minimum Retention Period
01	Immunization register		
02	Doctor's OPD Register		
03	Dressing room register		
04	Injection Register		

6. Process Efficiency Criteria

Sr. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Service Provision	Proportion of OPD Services Available IPHS	
2	Consultation	Consultation Time	
3	Consultation	OPD Patients per Doctor	
4	Prescription	Proportion of drugs prescribed from outside.	
5	Patient Information	Patient Right & Information Score	
6	Equity	Proportion of BPL OPD Patients	
7	Follow Up	Proportion of Old patient Visit	
8	Patient Satisfaction	Patient Satisfaction Score for OPD	

Process Mapping of OPD



7. Reference Documents

1. Code of Medical Ethics Regulation 2002
2. Prohibition of Smoking in Public Places rules 2008
3. Persons with Disability Act 1995
4. Indian Public Health Standards
5. Standard Treatment Guidelines issued by state & Government of India
6. Procedure for Referral
7. Procedure for Patient Admission
8. Procedure for Pharmacy
9. Procedure of Diagnostic Services

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-3 Labour Room

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of Labour Room

1. To further improve hygiene and cleanliness in LR as per IP & BMW management protocols
2. Ensure use of Personal Protection Equipment during all procedures
3. Ensure availability of all emergency drugs in the emergency tray
4. Maintain sterilized equipment 7 trays
5. Ensure fully equipped new born care corner with skilled doctor and nursing staff for management

SOP 3: Labour Room

1. Purpose:

To develop a system for ensuring care of pregnant women from antenatal to postnatal period and also address the needs of the new born. It includes a comprehensive approach to reduce maternal, neonatal, infant and less than 5 mortality and protect them from likely health risks they may face.

2. Scope:

It covers pregnant woman during the period, from day of her registration for first ANC to 42 days post-delivery & new born and child up to 5 years.

3. Responsible person:

In charge of hospital, Service Provider in OBG Department, Paediatrician, Medical officer and staff nurse/ANM.

4. Procedure:

Management of High risk patients

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1.1	**Management of 1st stage of labour:** • The patient is informed about the condition, counselling is done and consent is taken by the nurse in-charge and medical officer. • A partograph is established by staff nurse. • Monitoring & charting of uterine contraction, Foetal heart rate, emergency signs, cervical dilation, BP, temperature and Pulse is done on periodic basis depending upon low/ high risk pregnancy and progress is updated in partograph. • In any condition of unsatisfactory progress of labour due to prolonged latent phase, non-progress of labour, prolonged active phase, foetal distress, cephalo-pelvic disproportion, obstruction, mal-presentation, mal-position, prolonged expulsive phase, the obstetrician is called in for further management. • Decision about induction or augmentation of labour, vacuum extraction, forceps delivery , Craniotomy or C-Section after care full assessment of patient and procedure is performed as per standard EmOC guidelines • Paediatrician & Anaesthetist is alerted of anticipated surgery and newborn complications. • OT In charge is also alerted for	Medical Officer/ gynaecologist. Nurse in-charge	Simplified Partograph

Sl. No.	Activity	Responsibility	Reference Document/Record
	preparedness of Operation Theatre in case surgery is required.		
4.1.2	**Management of 2nd stage of labour:** Uterine contraction, FHR, Perineal thinning & Bulging, visible decent of foetal head during contraction and presence of any sign of emergency is monitored on periodic basis depending upon the low or high risk pregnancy. Episiotomy is performed if required. In case of shoulder dystocia obstetrician is called in for further management. Delivery of baby and time of delivery is noted. Cord is tied and cut with a sterile blade after 2-3 minutes of delivery. Immediate newborn care is given. If newborn does not cry in 30 seconds newborn resuscitation is started.	Nurse in-charge	Guideline for pregnancy care and management of obstetric complications for MO.
4.2.3	**Management of 3rd stage of labour:** Inj. Oxytocin or Misoprostol is administered. Controlled cord traction is done for assisted expulsion of placenta. Uterine massage is given to prevent PPH If there is retained placenta or PPH it is managed as per standard protocols. BP, Pulse, Temperature, vaginal bleeding is monitored periodically for one hours. In case the child delivered is dead, then the body is handed over to relatives and record is maintained in death register as still birth.	Medical Officer/ gynaecologist. Nurse in-charge	Labour Register Birth register WI for Active Management of 3rd Stage of Pregnancy WI for PPH New born death registered.
	Trays to be kept in Labour room		
	1.**Delivery tray:** Gloves, scissor, artery forceps, cord clamp, sponge holding forceps, urinary catheter, bowl for antiseptic lotion, gauze pieces and cotton swabs, speculum, sanitary pads,		

Sl. No.	Activity	Responsibility	Reference Document/Record
	Kidney tray. 2. **Episiotomy tray:** Inj. Xylocaine 2%, 10 ml disposable syringe with needle, episiotomy scissor, kidney tray, artery forceps, Allis forceps, sponge holding forceps, toothed forceps, needle holder, needle (round body and cutting), chromic catgut no. 0, gauze pieces, cotton swabs, antiseptic lotion, thumb forceps, gloves. 3.**Baby tray:** Two pre-warmed towels/sheets for wrapping the baby, cotton swabs, mucus extractor, bag & mask, sterilized thread for cord/cord clamp, Nasogastric Tube and gloves Inj. Vitamin K, needle and syringe. (Baby should be received in a Pre-warmed towel. Do not use metallic tray.) **4. Medicine tray*:** Inj. Oxytocin (to be kept in fridge), Cap Ampicillin 500 mg, Tab Metronidazole 400 mg, Tab Paracetamol, Tab Ibuprofen, Tab B complex, IV fluids, Tab. Misoprostol 200 micrograms, Inj. Gentamycin, Vit K, Inj. Betamethasone, Ringer lactate, Normal Saline, Inj. Hydrazaline, Tab. Nifedepin, Inj. Methyldopa, magnifying glass. **(* Nevirapin and other HIV drugs only for ICTC and ART Centers)** 5. **Emergency drug tray:**** Inj. Oxytocin (to be kept in fridge), Inj. Magsulf 50%, Inj. Calcium gluconate-10%, Inj. Dexamethasone, Inj. Ampicillin, Inj. Gentamicin, Inj. Metronidazole, Inj. Lignocaine-2%, Inj. Adrenaline, Inj. Hydrocortisone Succinate, Inj. Diazepam, Inj. Pheneramine maleate , Inj. Carboprost, Inj. Fortwin, Inj. Phenergan, Ringer lactate, normal saline, Betamexthazon Inj. Hydrazaline, Nefidepin, Methyldopa, IV sets with 16-gauge needle at least two,		

Sl. No.	Activity	Responsibility	Reference Document/Record
	controlled suction catheter, mouth gag, IV Cannula, vials for Drug collection Ceftriaxone (3rd generation cephalosporins) - For L3 facility. **(** – only for L2, L3 facilities)** 6. **MVA/ EVA tray:** Gloves, speculum, anterior vaginal wall retractor, posterior vaginal wall retractor, sponge holding forceps, MVA syringe and cannulas, MTP cannulas, small bowl of antiseptic lotion, sanitary pads, pads /cotton swabs, disposable syringe and needle, misoprostol tablet, sterilized gauze/pads, urinary Catheter. 7. **PPIUCD tray*****– PPIUCD Insertion Forceps, Cu IUCD 380A/ Cu IUCD 375 in a Sterile package. **(*** – only for L3 facilities with PPIUCD trained provider)**		
4.1.4	**Immediate Postpartum Care-** • Assessment is done for contraction of uterus, bleeding and for vaginal/ perineal tear. • Sanitary Pad is placed under the buttock to collect the blood. Assessment of blood loss is done by counting the blood soak pads. • Vitals are monitored at periodic intervals. • Mother and newborn is kept together. Breast feeding is encouraged**.** • Birth Companion is asked to stay with the mother. She was instructed to call for help in case of any danger sign. • Weight of new born is measured. • Information of mother and new born is recorded in labour register**.** Newborn and Mother is given identification tags.	MO/ Obstetrician/ Staff Nurse / Labor Room Companion	Guideline for pregnancy care and management of obstetrics complications for MO. Labor Room Register
4.1.5	**Essential Care of New Born**	Staff Nurse	WI for Immediate

Sl. No.	Activity	Responsibility	Reference Document/Record
	Essential new born care is given including maintaining body temperature, maintaining airway & breathing, care of cord and eyes, Breast Feeding.		Newborn Care WI for Preventing Hypothermia
4.1.6	**Neonatal Resuscitation** **The APGAR Score** is calculated at 1st and 5th minute after birth. Resuscitation may be required in following condition- If APGAR score is < 7 then immediate resuscitation is started. Neonatal resuscitation is discontinued only after 10 minutes of resuscitation if there is no sign of life. Prognosis of newborn is discussed with parents before discontinuing resuscitation. All cases of still birth are also given resuscitation for at least for 10 minutes. Paediatrician & SNCU in charge is intimated for the further management.	MO/ Paediatrician/ Staff Nurse	APGAR Score Criteria WI for Neonatal Resuscitation
4.2	**C-Section Surgery-** 24X7 availability of obstetrician or Medical Officer Trained in EmOC is ensured. Non availability of obstetrician for procedure is immediately informed to Hospital Superintendent/ Hospital Manager so alternative arrangement can be made**.**	Obstetrician/ Hospital Superintendent/ Hospital Manager	
4.2.1	**Preoperative Care-** **Preparing Operation Theatre** • Clean Operation theatre (after every procedure) • Ensure availability of necessary supplies and equipment including oxygen cylinder and drugs. • Ensure availability working condition of emergency equipment. • Ensure adequate supply of theatre dress for anticipated members of surgical team. • Ensure of sterile supply and that	OT In charge/ OT Nurse/ OT Attendant	SOP for OT & CSSD Management

Sl. No.	Activity	Responsibility	Reference Document/Record
	they are not beyond expiry. • Ensure availability of clean linen.		
4.2.2	**Preparing Women for Surgical Procedure-** • Procedure to be performed and its purpose is explained to the woman. If the woman is unconscious, it is explained to her family. • Informed consent for the procedure is obtained from the women. • Woman's medical history is reviewed and checked for any possible allergies. • Blood sample is sent for haemoglobin or haematocrit, RH type and screen. Arrange Blood when needed. • Area around the proposed incision site is washed with soap and water, if necessary. • Woman's pubic hair is not shaved as this increases the risk of wound infection. The hair may be trimmed, if necessary. • Vital signs are monitored and recorded. (Blood pressure, pulse, respiratory rate and temperature). • Premedication appropriate for the anaesthesia is administered. • Catheterize if necessary and monitor urine output. • Relevant information is passed on to other members of the team (doctor/midwife, nurse, anaesthetist, assistant and others).	OT In charge/ Obstetrician/ OT Nurse/ Anaesthetist	SOP for OT Management
4.2.3	**Intra Operative Care** • **Position-**Woman is placed in a position that is appropriate for the procedure to allow: optimum exposure of the operative site, access for the anaesthetist, access for the nurse to take vital signs and monitor IV drugs and infusions, safety of the woman by preventing injuries and	OT Incharge/ Obstetrician/ OT Nurse/ Anaesthetist	SOP for OT Management

Sl. No.	Activity	Responsibility	Reference Document/Record
	maintaining circulation, maintenance of the woman's dignity and modesty. • **Surgical Scrub-** Surgical Scrub is done as per standard Guidelines. • **Preparing Incision Site**- Part preparation is done as per guidelines. • Woman is monitored for vital signs throughout the surgery and findings are recorded. • Antibiotics and analgesics are given as per requirement. • Incision, handling of tissue, haemostasis, handling of instruments and sharps, draining, suturing and dressing is done as per standard EmOC Protocols.		
4.5.4	**Post-Operative Care-** • Woman is placed in recovery position. • Vitals signs are monitored every 15 minutes first hour and every 30 minutes next hour. • Assessment of consciousness level is done every 15 min until women is alert. • Clear airway and ventilation is ensured. • Transfusion is given if necessary • If vital signs become unstable or hematocrait continues to fall despite transfusion, woman is returned to OT as bleeding may be the cause. • Management of gastro intestinal functions, dressing & wound care, pain management, bladder care, administration of antibiotics, suture removal, management of fever, and ambulation done as per standard EmOC guidelines.	OT In charge/ Obstetrician/ OT Nurse/ Anaesthetist	SOP for OT Management
4.3	**Inpatient Care**		
4.3.1	**Post Natal Inpatient Care of Mothers** After delivery, mother is shifted to	Staff Nurse	SOP for IPD Management

Sl. No.	Activity	Responsibility	Reference Document/Record
	the maternity ward for post-natal care • Vital of mothers and baby are monitored regularly. • Medication is administered when required and prescribed by the doctor. • The patient is encouraged for taking normal diet, plenty of fluids and to start breast feeding the child within 1/2 hour of delivery.		
4.6.2	**Post Natal Inpatient care of New Born** • After delivery, new born not needing special care should be shifted to the postnatal ward along with mother. • Postnatal ward is kept warm (25°C). New Born is kept with mother on the same bed. • Mother is encouraged for breast feeding the baby within 1/2 hr. of delivery. Postnatal new born care includes review of labour and birth records, communication with mother, examination of baby, assessment of breastfeeding, cord care, skin & eye care, administration of Vit. K, immunization of the baby with BCG, OPV-0, Hepatitis B (HB-1) and follow-up.		IMNCI Manual Guidelines for antenatal care and skilled birth attendance at Birth
4.3.3	**Shifting of Newborn to SNCU** If the new born has any of the following conditions He/She is shifted to new born care unit • Birth weight < 1500 gms, • Major congenital malformation • Severe Birth Injury • Severe Respiratory Distress • PPV≥ 5 Minutes • Needing Chest Compression or drugs • Any other indication decided by paediatrician. • New born is kept under	MO/ Staff Nurse/ Paediatrician	IMNCI Manual

Sl. No.	Activity	Responsibility	Reference Document/Record
	closed observation • Birth Weight 1500-1800 gms. • Vigorous babies with fast breathing		
4.3.4	**Discharge of Patient** Discharge is done after delivery, depending upon the mother's condition but not less than 48 hours for normal delivery. Discharge slip is prepared by the M.O. and entry is made in the discharge register by ward in-charge. Mother is briefed about postpartum care and hygiene, nutrition for self & Newborn, Exclusive breastfeeding follow-up advice, keeping baby warm, complete immunization of newborn post-partum visits, family planning. She is also counselled about the danger signs that should be immediately reported to the hospital about herself and the new born.	Medical officer/ gynaecologist Nurse in-charge	Discharge slip Antenatal Care and Skilled Birth Attendance at Birth
4.4	**Payment to beneficiaries** The payment under JSY is provided to the beneficiaries after 48 hour of stay in the hospital after delivery The schedule of payment is informed to beneficiary by authorized personnel	Hospital Superintendent Clerk	JSY Scheme JSY Register
4.5	**Postnatal care after discharge-** Postnatal Care is provided through MCH/ Obstetrics & Gynaecology clinic Mothers referred to the hospital by ASHA/ANM for postpartum complications like PPH and puerperal sepsis, severe anaemia etc. are assessed in OPD Clinic/ Emergency and admitted in the hospital, if required.	MO/ Obstetrician	
4.6	**Immunization** • The hospital immunization facility under universal immunization programme for children/new born/neonates which includes all vaccines e.g.	Immunization Nurse/ ANM	Universal Immunization programme

Sl. No.	Activity	Responsibility	Reference Document/Record
	OPV, DPT, TT, BCG, Measles etc. and follow-up register is maintained in the department by Sister In-Charge. • Details of immunization given are entered on Mother and child protection card. • Auto disabled syringes are used for immunization. • Any serious adverse event following immunization such as death, Hospitalization, disability and other serious events that are thought to be related with immunization are immediately reported to MS by Phone. • Other Serious AEFIs such as anaphylaxis, encephalopathy, sepsis, TSS, AFP, event occurring in cluster, are reported to district immunization officer within the prescribed time in prescribed format. • All the serious AEFI are investigated by appropriate authorities and corrective action is taken. ✓ After each immunization parents are informed about- ✓ What vaccine is given and it prevents what. ✓ What are minor side effects and how to deal with them? • To keep mother and child protection card safe and bring it on next visit.		Mother and Child Protection Card
4.7	**Counselling for the family Planning**		
	• The patient is referred from Obstetrics & Gynaecology clinic / MCH Clinic and other consultation rooms to the counselling centre (if any) of hospital or counselled in PP clinic • The clerk enters patient's details in the register and asks the	MO/ PP Centre In charge	Family planning registers.

Sl. No.	Activity	Responsibility	Reference Document/Record
	patient to fill consent form • The MO explains the couple on importance of family planning and the various permanent (NSV, Vasectomy, Female sterilization, Tubectomy) and temporary methods of family planning (Intrauterine Devices, Condoms)		
4.8	**Integrated Management of Neonatal & Childhood Sickness** Patients under age of 2 months are classified as sick young infants and patients under 5 year of age are classified as sick child. Their management is done as per Integrated Management Neonatal and Childhood Illness approach. This Includes • Urgent Referral Services at facility (Pink) • Urgent Referral Facility at Out Patient Department(Pink) • Treatment Facility at OPD (yellow) • Home Management (green)	MO	IMNCI Guidelines
4.9	**Emergency Triage Assessment & Treatment-** Any sick young infant or child received in hospital is promptly attended and standard ETAT procedure followed for management.	MO/ Paediatrician/ Nursing Staff	WI- Steps in Management of Sick young Infants and Children.
4.9.1	**Triage-** Triage of all young infants and children is done in the following categories as soon as they arrive in the hospital. -those Emergency signs (E) requiring Emergency Treatment - those Priority Signs (P) requiring rapid assessment and action - Non urgent (N) cases those can wait Triage is done by assessing Airway, Breathing, Circulation, Coma, Convulsion and Dehydration (ABCD). If no emergency sign is seen than priority signs are looked for.	MO/ Paediatrician/ Nursing Staff	WI- Triage

Sl. No.	Activity	Responsibility	Reference Document/Record
4.9.2	**Assessment & Management of Emergency Signs-** Assessment and management of Emergency signs is done as per standard F-IMNCI Protocols. If any signs of hypothermia or hypoglycaemia are noticed, management is done simultaneously. **This includes -** Assessment for breathing, central cyanosis and severe respiratory distress is done and Basic Life Support is given if required. Assessment & treatment of shock, coma and convulsions, severe dehydration and Hypoglycaemia and Hypothermia.	MO/ Paediatrician/ Nursing Staff	WI Basic life support Management of WI Shock in a child without SAM, Coma & Convulsion, WI for Assessment & Management of severe dehydration, Hypothermia Hypoglycaemia,
4.10	**Facility based care of Sick Young Infant** This includes fluid management, Management of Hypoglycaemia, Post resuscitation care of Asphyxiated newborn, management of septicaemia, meningitis, diarrhoea, tetanus neonatorum, Jaundice and monitoring of sick young infant.	MO/ Paediatrician/ Nursing Staff	Management of sick young infants Checklist for Monitoring of Young Infants Guidelines for management of Neonatal Jaundice
4.10.1	**Management of Low birth Weight Neonates** All low birth weight newborns are to be given Vit. K intramuscular at birth. Neonates with birth weight less than 1800 gms are admitted in the hospital. Normal body temperature of neonate is maintained through Kangaroo Mother care or through radiant warmer/ incubator as advised by the paediatrician. Fluids and nutrition is provided as per birth weight or gestation of the neonate.	MO/ Paediatrician/ Nursing Staff	WI for modes of providing fluid and feeding. Feeding Volumes and rates of rates of increments in LBW. Indication of Discharge of LBW neonates.
4.10.2	**Referral and Transport of Neonates-** If management of newborn cannot be done at the hospital either due to lack of facilities (neonatal care unit) or due to need of tertiary care management, neonate is referred to	MO/ Paediatrician/ Nursing Staff	

Sl. No.	Activity	Responsibility	Reference Document/Record
	higher centre which should be given prior information about the referral. Neonate is stabilized with respect to temperature, airway, breathing, circulation and blood sugar. A doctor/nurse/health worker is arranged for accompanying the neonate to receiving hospital, if possible. Parents/attendants of newborn are communicated about the condition of new born sympathetically and instructions are given for care of newborn during transport. A referral note is prepared and given to attendants describing condition of new born, reason for referral and treatment given.		
4.11	**Facility Based care of Sick Child**		
4.11.1	**Children Presenting with cough or difficult breathing –** Careful assessment of patient is done to arrive at a diagnosis that may be due to respiratory or non respiratory causes. Once a diagnosis is established management is done as per standard treatment guidelines.	MO/ Paediatrician/ Nursing Staff	Treatment for very severe and severe Pneumonia Management of Acute Asthma
4.11.2	**Management of Children presenting diarrhoea** Assessment of child is done and case is classified as acute/persistent diarrhoea or dysentery. Following cases are admitted in the hospital- ➢ Children with severe dehydration ➢ Children with SAM ➢ Children with Co- Morbid Condition An ORT corner is provided in the hospital for day care stay of mothers & children during Oral Rehydration Therapy.	MO/ Paediatrician/ Nursing Staff	Classification and management of Dehydration
4.11.3	**Management of children presenting with fever** Initial assessment of children is done and cause of fever is identified according to fever with/without	MO/ Paediatrician/ Nursing Staff	WI Management of severe and complicated malaria

Sl. No.	Activity	Responsibility	Reference Document/Record
	localized signs or rashes and symptoms. Diagnostic tests are done to confirm the cause. Cases are managed as per standards treatment guidelines**.**		
4.11.4	**Management of Children with severe Acute Malnutrition-** Initial assessment of children done and admitted in hospital if- ➢ Weight for Height/length is <-3 Z Score of median of WHO child growth standards ➢ Bipedal Oedema Cases are managed as per standard treatment guidelines.	MO/ Paediatrician/ Nursing Staff	Management of Severe Malnutrition in Hospital. General Treatment of Malnutrition
4.11.5	**Infection Control –** Standard Infection Control Measures are taken to prevent hospital acquired infections and safe work environment to service providers. These measures broadly include. • Strict adherence to standard hand washing Practices • Use of personal protective equipment when handling blood, body substances, excretions and secretions • Appropriate handling of patient care equipment and soiled linen • Prevention of needle stick /sharp injuries • Environmental cleaning and spills-management • Appropriate handling of Biomedical Waste Regular culture for surveillance of infection prone areas like labour room, OT and SNCU is done to insure safe patient care environment.	Infection Control Nurse/ Staff Nurse/MO/Obstetrician	SOP for Hospital Infection Control SOP for Hospital Waste Management SOP for Housekeeping Management Infection Control Measures in Normal & C-section Deliveries
4.12	**Environmental Cleaning and Processing of equipment in Labor Room-** External foot wear are not allowed in the labour room. It is mandatory to wear dedicated labour room slippers before entering the labour room. After every procedure all working surfaces are disinfected.	Housekeeping Staff/ Hospital Manager	Guidelines for Environment Cleaning & Disinfection in Labor Room Guidelines for processing of equipment, surgical

Sl. No.	Activity	Responsibility	Reference Document/Record
	Only staff that is required for procedures is allowed in labour room. Traffic in labour room is kept minimal.		gloves and other Items in Labor Room
4.13	**Rights & Dignity of pregnant women** • Simple and clear language is used while communicating with pregnant women. • Pregnant woman is informed about the status of her health and supported to understand options and make decisions. • Woman is made to feel as comfortable as possible when receiving services. • Before any examination, permission is taken from pregnant women and procedure is explained to her. • During the examination, privacy of patient is maintained. Screens and curtains are provided in examination area and it is ensured that woman is protected from view of other people. • Consent of pregnant women is taken before discussing with her family or parents. • Confidential information about pregnant women is never discussed with other staff members or outside the facility. • Informed consent is taken before any invasive procedure. • Any pregnant woman with HIV is not denied services. Her HIV status is kept confidential except to people who are involved in care.	MO/ Staff Nurse/ Other service Providers	
4.13	**Monitoring & Quality Control**		
4.13.1	**Maternal Death Review** All maternal deaths occurring in the hospital, including abortion and ectopic gestation related deaths, in pregnant women and mothers within 42 days of delivery are informed	Treating MO, FNO, DNO	FMDR Format Maternal Death Review Guidebook

Sl. No.	Activity	Responsibility	Reference Document/Record
	immediately by treating doctor to facility nodal officer. The facility nodal officer at the hospital informs the District Nodal Officer (DNO) and subsequently to State Nodal Officer within 24 hours. Facility nodal officer should fill the primary informant format and sent it to (DNO) Maternal death is immediately investigated by medical officer treating the mother using facility based maternal death review format and submit it in triplicate to FNO within 24 hours. A facility Maternal Death Review committee is constituted as per MDR guidelines which reviews all maternal deaths in monthly review meeting and suggest corrective action to improve the quality of care. Minutes of review meeting along with case summary are sent to district nodal officer.		
4.13.2	**Quality Assurance of Referral Services-** Each woman who is referred to the district hospital is given a standard referral slip. This referral slip is sent back to the referring facility with the woman or the person who brought her after writing the outcome of referral on it. Both the district hospital and the referring facility keep a record of all referrals as a quality assurance mechanism	Medical Superintendent	

5. Records:

Sl. No.	Name of Records	Record No.	Minimum Retention Period
1	Admission Register		
2	Labour Room Register		
4	Antenatal/ Postnatal Register		
5	MTP Register		
6	Interval & PPIUCD Register		
7	OT Register		
8	Family Planning Register		
9	Maternal Death Record/ Register		

10	Lab Register		
11	Referral In/ Out Register		
12	MCP Card		
13	Bed Head Ticket		
14	Discharge Slip		
15	Referral slip		
16	Partograph		

6. Process Efficiency Criteria:

Sr. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/ Target
1	Clinical Care	Maternal Mortality Rate	
2	Clinical Care	Newborn Mortality Rate	
3	EOC Services	C-Section Rate	
4	EOC Services	No. of deliveries conducted in the night	
5	Antenatal Care	Proportion of mothers provided four or more ANCs	
6	Intra partum Care	Labour Room Score	
7	Antenatal Care	Door to drug time for antenatal visit	
8	Intra partum Care	Proportion of deliveries for which partograph established.	
9	New born Care	No. of new born resuscitated	
10	JSY	Percentage of mothers leaving hospitals within 48 hours.	

7. Reference Documents

1. Guideline for pregnancy care and management of obstetrics complications for MO-MoHFW
2. SBA Guidelines for Antenatal Care and Skilled Attendance at Birth- MoHFW
3. Operational Guidelines on Maternal & Newborn Health - MoHFW
4. Facility Based IMNCI- Participant Manual- MoHFW
5. Infection Control Practices in Emergency Obstetric Care –Engender Health
6. Infection Prevention Guidelines- JHPIEGO
7. Immunization Hand Book for Medical Officers- MoHFW
8. Managing complication in Pregnancy and Child Birth- WHO
9. Maternal Death Review Guidebook – MoHFW
10. Operational Guidelines for JSSK
11. Procedure for Admission Discharge Management
12. Procedure for Referral Management
13. Procedure for Diagnostic Management
14. MTP Act 1972
15. PC & PNDT Act 1994
16. Procedure for Blood Bank
17. Procedure for Operation Theatre Management
18. Procedure for Indoor Management
19. Procedure for Infection Control
20. Procedure for Biomedical Waste Management

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-4 Maternity Ward

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of Maternity Ward

1. **To ensure proper signages, directional arrows and proper IEC.**
2. **To ensure adequate stock and supply of drugs in the Maternity ward.**
3. **To ensure proper and prompt drug distribution.**
4. **To improve hygiene and cleanliness in ward as per IP & BMW management protocols**
5. **To ensure use of Personal Protection Equipments during all procedures**
6. **To maintain privacy confidentiality & dignity of client/ patient and empathetic & courteous behavior of the staff**

SOP 4: Maternity Ward

1. **Purpose:**
   - To establish, implement & maintain a system for patient admission in order to provide IPD services under JSY and JSSK offered by the hospital.
   - To provide guideline instructions for General Nursing care with the aim that needs and expectations of patients are honoured.
   - To enhance patient satisfaction.
2. **Scope:**
   It covers all indoor patients under JSY & JSSK.
3. **Responsibility:**
   Doctor, Matron, Nursing In-charge and Ward In-Charge, Housekeeping supervisor.
4. **Procedure:**

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	**Admission**		
4.1.1	**Admission Advise** Patient visits the OPD/emergency for doctor's consultation. Depending upon the assessment, the doctor on duty advises admission (in writing on the OPD Slip)	Treating Doctor	OPD Slip , Patient Registration no. Doctor's Instruction for admission
4.1.2	**Inpatient Registration-** Inpatient registration and allocation of beds is done as per the procedure	Registration Clerk	SOP for Patient Registration, Admission & Discharge Management, Bed Head Ticket.
4.2	**Shifting of Patient to concerned Ward** Stable Patient is shifted to the concerned inpatient facilities accompanied by an attendant. Stretcher/wheel chair/Trolley are used for shifting of patient as required. Critical patients who reach emergency are first assessed and primary treatment is given once stabilized, the patient is shifted to the ward. In case the patient has to be transferred to ICU/OT Wards he/she is preferably accompanied by a doctor /Nurse.	On duty Sister In charge	
4.3	**Patient warding in -** The ward nurse receives the patient. Ward Aaya / Ward boy /Attendant hand over admission slip or Bed Head Ticket (BHT) to the Sister in-charge. Wards nurse confirms the identity of the	On duty Sister In charge	Registration Slip IPD register

Sl. No.	Activity	Responsibility	Reference Document/Record
	patient. Ward nurse reviews the admission notes /instructions and acts on any urgent instructions by admitting doctor. Ward Nurse records the patient details in the patient admission/discharge register.		
4.4	**Bed Allotment** Bed is allocated to the patient and the bed number is recorded in BHT and admission register. Patient is oriented about the layout of ward with instructions on how to call the nurse in case of emergency. A cupboard/ bed side locker is allotted to the patient. In case of non availability of bed the ward nurse makes alternate arrangement for additional cots.	Sister In charge	
4.5	**Patient Property –** Valuables like jewellery, mobile and cash is handover to the patient relatives. Patient is instructed not to keep any valuables with them.		
4.6	**Consent** Consent is signed by all the patients admitted in the ward. In case patient is illiterate then the thumb impression of the patient is taken which is witnessed by a neutral person.	Sister In charge	Consent Format
4.7	**Initial Assessment-** Once patient is settled in the ward, nurse conducts a nursing need assessment. She calls the duty doctor who conducts the initial assessment if it is not done at emergency/OPD of the patient records the findings/ directions in the BHT.	Doctor/on Duty Ward Nurse	BHT
4.8	**Priority of treatment –** If an admission is done from the OPD on or from causality on urgent basis life saving treatment/ procedures supersedes any documentation work.	Doctor/on Duty Ward Nurse	
4.9	**Orphan/ *'Lawaris'* Patients –** Orphan patients not having any accompanier/ relative are specially monitored. Efforts are made to appoint some local NGOs/ volunteers who can take care of non clinical needs of these patients. Names of all such patients are reported to local police.	Doctor/on Duty Ward Nurse	

Sl. No.	Activity	Responsibility	Reference Document/Record
4.10	**People living with HIV/AIDS** Confidentiality of such patient is be maintained in all cases. Patient is not isolated/segregated. Beds / BHT of such patients are not labelled marked which denotes their HIV positive status. Status of such patients is not discussed with anybody who is not involved in direct care of patient.	Doctor/on Duty Ward Nurse	
4.11	**Inpatient Care**		
4.11.1	**Post Natal Inpatient Care of Mothers** After delivery, mother is shifted to the labour ward for post-natal care • Maternal health is monitored and every step shall be taken to improve well being and good health of mother & new born. • Medication is administered when required and prescribed by the doctor. • The patient is encouraged for taking normal diet, plenty of fluids and start breast feeding the child.	Staff Nurse	SOP for IPD Management
4.11.2	**Post Natal Inpatient care of New Born** After delivery; all new born not needing special care shifted to the Labour ward with mother for postnatal care and Postnatal ward is kept warm (25°C). New Born is kept with mother on the same bed right from the birth. Mother is encouraged to breast feed baby within 1/2 hr. of delivery. Postnatal new born care includes review of labour and birth records, communication with mother, examination of baby, assessment of breastfeeding, cord care, skin & eye care, administration of Vit. K, counselling of mother, immunization BCG, OPV-0, Hepatitis B (HB-1) and follow-up.	Nurse on duty	F. IMNCI Manual Guidelines for antenatal care and skilled birth attendance at Birth
4.11.3	**Shifting of Newborn to SNCU** If the new born has any of the following conditions He/She is shifted to new born care unit birth weight < 1500 gms Major congenital malformation Severe Birth Injury Severe Respiratory Distress PPV≥ 5 Minutes Needing Chest Compression or drugs	MO/Staff Nurse/ Paediatrician	F. IMNCI Manual

Sl. No.	Activity	Responsibility	Reference Document/Record
	Any other indication decided by paediatrician. New born is kept under closed observation Birth Weight 1500-1800 gms Vigorous babies with fast breathing		
4.11.4	**Discharge of Patient** Discharge is done after delivery, depending upon the mother's condition but not before 48 hours in case of normal delivery Discharge slip is prepared by the M.O. and entry is made in the discharge register by ward in-charge. Mother is briefed about postpartum care and hygiene, nutrition for self & Newborn, Exclusive breastfeeding follow-up advice, keeping baby warm, complete immunization of newborn, post partum visits, family planning. She is also counselled about the danger signs related to herself and the newborn that should immediately reported to the hospital.	Medical officer/ gynaecologist Nurse In-charge	Discharge slip Antenatal Care and Skilled Birth Attendance at Birth
4.12	**Payment to beneficiaries** The payment under JSY is provided to the beneficiaries after 48 hour of stay in the hospital after delivery. The schedule of payment is informed to beneficiary by authorized personnel	Hospital Superintendent Clerk	JSY Scheme JSY Register
4.13	**Postnatal care after discharge-** Postnatal Care is provided through MCH/ Obstetrics & Gynaecology clinic Mothers referred to hospital for postnatal visits by ASHA/ANM for postpartum complications like PPH and puerperal sepsis, severe anaemia are assessed in OPD Clinic/ Emergency and admitted in the hospital if required**.**	MO/ Obstetrician	
5	**JSY and JSSK**		
	In hospital, for pregnant women JSY and JSSK Yojana is present in which following are the Free Entitlements for pregnant women: ▪ Free and cashless delivery ▪ Free C-Section ▪ Free drugs and consumables ▪ Free diagnostics ▪ Free diet during stay in the health institutions		

Sl. No.	Activity	Responsibility	Reference Document/Record
	▪ Free provision of blood ▪ Exemption from user charges ▪ Free transport from home to health institutions ▪ Free transport between facilities in case of referral ▪ Free drop back from Institutions to home **The following are the Free Entitlements for Sick newborns till 30 days after birth. This has now been expanded to cover sick infants**: • Free treatment • Free drugs and consumables • Free diagnostics • Free provision of blood • Exemption from user charges • Free Transport from Home to Health Institutions • Free Transport between facilities in case of referral • Free drop Back from Institutions to home		
6	**Infection Control**		
	Responsibility of IC nurse: • To ensure proper infection control measures. • To identify problems in implementation of infection control polices and provide solutions. • To monitor the following practices on daily basis: a) Bio Medical Waste. b) Autoclave log book in OT. c) Linen segregation is done or not (dirty and contaminated). d) Hand washing. e) Sharp disposal in wards. f) Use of needle cutter. g) Preparation of Hypochlorite solution • To provide training of paramedical staff including nurses and housekeeping staff.	**Chairperson infection control team**	

Sl. No.	Activity	Responsibility	Reference Document/Record
	Meeting of Infection Control Committee The infection control Committee meets once in a month and otherwise as necessary. Incharge of Infection Control Team keeps the Management Review Team updated on the status of Infection in the Hospital.		Minutes of meeting
	Food Handlers Screening of food handlers is done **biannually.** Samples include nasal swabs and stool samples. Records to be maintained by Kitchen Incharge.	Kitchen I/C and Lab attendant	
	Drinking Water Bacteriological surveillance shall be done **monthly** from govt. recognized water testing laboratory. Records maintained by Pathology Department.	Sanitary Inspector/ Maintained supervisor and Lab attendant	
	Staff health plan: To control spread of infection from staff to patient or to protect staff from occupational hazards annual medical checkup of staff should be done also vaccination for Hepatitis B/any other immunization required is provided to all staff members.	Hospital infection control committee	
	Hand Hygiene: Adequate hand washing facility is available in all patient care areas. Elbow operated taps, washbasin and soap are available in service provider's room & in the in-patient care areas. If water facility is not available alcohol rub may be provided in patient care area. Scrub area is available outside the OT with elbow operated or foot operated water tap facilities.	On duty doctor, staff nurse and all paramedic as well as housekeeping staff involved in patient care.	
	Disinfection: Disinfection of equipment and furniture is carried out with bleaching powder solution at least once a day or as required.	Housekeeping staff or General duty attendant	
	Good housekeeping: Cleaning of OT walls, floors, tables and fixtures are organized as per a schedule programme at pre-determined intervals and use of appropriate disinfectant is strongly advocated. (*Procedure 20, Hospital housekeeping & General Upkeep Management)*	Housekeeping staff	Housekeeping Check list Biomedical waste Management & handling rule, 1998.

Sl. No.	Activity	Responsibility	Reference Document/Record
	Biomedical waste is collected, segregated, transported, stored and disposed off as per BMW management & handling rule, 1998. *(Procedure 24, Hospital Waste Management)*		
	Antibiotic policy: Antibiotic policy is adopted to monitor and control irrational use of antibiotics leading to multi-drug resistance and to promote the use of antibiotic policy in clinical practice. Method: • Identification of relevant pathogens in exudates and body fluid collected from patients. • Sensitivity test is done to determine the degree of sensitivity or resistance of pathogens. • Antibiotic with higher efficacy, low side effect and less chances of anti-microbial resistant shall be used in the hospital.	Infection Control Committee.	
	Soiled linens: All soiled linen is considered potentially infected and treated accordingly.	Ward I/C and Laundry supervisor	
	Use of Personal Protective Equipment's Use of personal protective equipment when handling blood, body substances, excretions and secretions; Using personal protective equipment provides a physical service provider between micro-organisms and the wearer. It offers protection from: ➢ Contaminated hands, eyes, clothing, hair and shoes; ➢ Cross infections Personal Protective Equipment includes: · Gloves; · Protective eye wear (goggles); · Mask; · Apron; · Gown; · Boots/shoe covers; and · Cap/hair cover	The entire healthcare worker involved in patient care and relatives of patient visiting isolation wards/ ICU.	
	Protection against injury with sharps Precautions to be observed: • Needles should not be recapped, bent or broken by hand. • Disposable needles & other		

Sl. No.	Activity	Responsibility	Reference Document/Record
	sharps should be discarded into puncture proof containers • Sharps should not be passed from one HCW (Health Care Worker) to another by hand. If necessary a tray can be used to transport sharps. • All sharps containers to be discarded when 3/4^{ths} full.		
	Infection Control Audit The infection control audit shall be carried out on a regular basis. Timely actions shall be taken against the observations raised during the audit. The Infection Control team members shall conduct inspection periodically. Records are maintained by head of infection control team.	Infection Control Committee.	Infection Control Audit Check list

5. Records:

Sl. No.	Name of Records	Record No.	Minimum Retention Period
1	Immunization Register		
2	Birth Register		
3	Still Birth Register		

6. Process Efficiency Criteria:

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Clinical Care	Maternal Mortality Rate	
2	Clinical Care	Newborn Mortality Rate	
3	EOC Services	C-Section Rate	
4	EOC Services	No. of deliveries conducted in the night	
5	Antenatal Care	Proportion of mothers provided four or more ANCs	
6	Intra partum	Labour Room Score	
7	Antenatal Care	Door to drug time for antenatal visit	
8	Intra partum Care	Percentage of deliveries for which partograph is prepared.	
9	New born Care	No. of new born resuscitated	
10	JSY	Percentage of mothers leaving hospitals within 48 hours.	

7. Reference Documents

1. Guideline for pregnancy care and management of obstetrics complications for MO- MoHFW
2. SBA Guidelines for Antenatal Care and Skilled Attendance at Birth- MoHFW
3. Operational Guidelines on Maternal & Newborn Health - MoHFW
4. Facility Based IMNCI- Participant Manual- MoHFW
5. Infection Control Practices in Emergency Obstetric Care –Engender Health
6. Infection Prevention Guidelines- JHPIEGO
7. Immunization Hand Book for Medical Officers- MoHFW
8. Managing complication in Pregnancy and Child Birth- WHO
9. Maternal Death Review Guidebook – MoHFW
10. Operational Guidelines for JSSK
11. Procedure for admission Discharge Management
12. Biomedical waste Management & handling rule, 1998
13. Infection Management & Environment Plan (IMEP) Guidelines – MoHFW
14. Practical Guidelines for Infection Control in Health Care Facilities – WHO

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-5 SNCU

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of Sick New Born Care Unit (SNCU)

1. Manage Specific conditions- Post Asphyxia, Sepsis, (Pneumonia & Meningitis), Tetanus Neonatorum, Neonatal Jaundice
2. Measures to reduce deaths in SNCU
3. Enhancing the skill of the staff by bed side CME
4. Follow the protocol for step-down of Newborn
5. Ensure proper fire safety by regular check up for electrical connections and wiring etc

SOP 5: Sick Newborn Care Unit

1. Purpose:

- Neonatal mortality contributes to about two thirds of infant deaths. There is an increasing need to focus on newborn care and survival for significant reduction in IMR.
- Strengthening the care of sick, premature, low birth weight newborns right from birth through the neonatal period.
- To provide all required services to in born as well as out born neonates referred to SNCU.
- To respond to the need and expectations of the attendants.

2. Scope:

To provide Intensive care services to sick new born babies both in-born and out-born.

3. Responsibility:

Pediatrician on duty/sister in-charge

- To receive the potential high risk sick new born referred from OT, LR and maternity ward (in born) or referred from other health facilities.
- To pay immediate attention, assessment, immediate management.
- It is the responsibility of pediatrician on duty at SNCU to attend the call from emergency for acutely sick new born baby.
- To provide immediate intensive care to acutely sick newborn and the treatment record should be mentioned in Bed Head Ticket.
- Triage management of Sick Inborn & Out-born Neonate
- Shifting of baby to step-down is sole responsibility of SNCU team
- To take decision for transferring the severely sick New Born to higher level
- To follow all quality parameters

4. Standard Procedure:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	**SNCU**		
4.1.1	**Admission:** **Criteria for shifting new born to the SNCU.** • **Below 28 weeks of gestation** • **Weight <1800gms** • **34 weeks baby** **Emergency advice** If the transfer of the Neonate is required, the ambulance is sent from NGH to the NBSU of DH. The mother of the neonate will stay	Treating Doctor, Nurse.	In-patient Admission Register / BHT

in the SNCU. If the mother is admitted in the Postnatal Unit, then after discharge the mother will go to the SNCU.

The neonates (**< 28 days**) from the community can also be admitted in the SNCU.

<u>Criteria for babies to be admitted in SNCU</u>

a) Criteria for babies to be admitted in SNCU for inborn babies:

1. Infants who are born prior to 34 weeks gestation
2. Infants weighing 1800 grams at birth (regardless of gestational age).

*(*Neonates weighing less than 1.2 Kg should be referred to the higher centre after proper stabilization)*

3. Infants with an APGAR score of < 6 at 1 min and evidence of birth asphyxia or delayed cry after 5 minutes. (i.e. slow gasping respiration or no respiration at 1 minute).
4. After prolonged Resuscitation that is after using Bag and mask or Bag and tube.
5. Persistent respiratory Distress.
6. Shock or CRT > 3 seconds
7. Central cyanosis
8. Vomiting ---especially bile stained
9. Neonates with surgical problems should also be referred after stabilizing.
10. Any infant who is felt to be at risk by the nursing staff or Doctor
11. Any infant with a birth weight of <1800 grams & /or <34 weeks must be admitted to the SNCU for a minimum of 24 hours.
12. Transfer from Neonatal ward due to need for close monitoring or any deterioration in the condition of the Neonate.

b) **Admission criteria in SNCU for any baby < 28 days from the community**

1. Delayed cry after 5 minutes

	2.Respiratory distress with Tachypnea, grunt , Chest indrawing or central cyanosis 3. Central cyanosis or spells 4. Vomiting esp. Bile stained 5. Abdominal distension 6. Suspected sepsis but child unstable 7. Unstable Babies with congenital abnormality requiring investigation 8. Jaundice requiring Exchange transfusion 9.Neonates in shock (CRT > 3 seconds, poor skin colour , cold extremities, weak pulses and mottled skin) 10. Fits including subtle signs (refer to neonatal convulsion for details) 11. Low birth weight < 1800 gm or unstable baby. 12. Severe Asphyxia, RDS or is satisfying the above criteria of admission to SNCU. c) **Criteria for Transfer to Step Down:** a. Babies whose respiratory distress is improving and no longer require oxygen supplementation to maintain saturation b. Babies on antibiotics for completion of duration of therapy c. Low birth weight babies (< 1800 gms) who are otherwise stable(for adequate weight gain) d. Babies with jaundice requiring phototherapy but otherwise stable e. Babies admitted for any condition but are now thermo-dynamically and haemo-dynamically stable. **d) Criteria for transfer to Maternity ward**: a. Babies who satisfy the criteria for transfer to step down ward but cannot be accommodated due to want of space in the Step down ward and whose mother is available for stay with the baby b. Babies who are comparatively less sick but need observation. Such babies shall be transferred to SNCU if their condition does not improve at the Maternity ward		

5.1.2	**Providing continuous monitoring:** The doctors & nurses are always present in the SNCU for providing care to the neonates admitted in SNCU	Treating Doctor / On duty Nursing Staffs.	
5.1.3	**Documentation:** The documentation in the Nursing services starts with the initiation of the Inpatient case sheet and end with the making of the Discharge slip of the patient at the time of discharge of the patients. **Documentation includes:** • Bed Head Ticket • Admission Register • General Medication Order • Patient Hand over register • Discharge Register • Death Register • Call Book for Superintendent, Medical Officer, Ward Master, Nursing Superintendent etc. • Transfer out Register	Ward In-charge	Bed Head Ticket Admission Register General Medication Order Patient Hand over register Discharge Register Death Register Call Book for Superintendent, Medical Officer, Ward Master, Nursing Superintendent etc. Transfer out Register .
5.1.4	**Infection Control –** Standard Infection Control Measures are taken to ensure prevent hospital acquired infections and safe work environment to service providers. These measures broadly includes – Strict adherence to standard hand washing Practices • Use of personal protective equipment when handling blood, body substances, excretions and secretions • Appropriate handling of patient care equipment and soiled linen • Prevention of needle prick /sharp injuries • Environmental cleaning and spill-management • Appropriate handling of Biomedical Waste • Regular culture surveillance of infection prone area like SNCU is done to insure safe patient care environment.		

5.1.5	**Environmental Cleaning -** External foot wears are not allowed in the SNCU. It is mandatory to wear dedicated SNCU sleepers before entering the labour room. Mask and cap should be used by Drs & Nursing Staff. The shoe caps, mask and cap should be provided to mother if she is entering in the critical SNCU room. After every procedure all working surfaces are disinfected. Only doctor & staff are allowed while performing the procedure in SNCU. Traffic in SNCU is kept minimal**.**		
5.1.6	**Diagnostic tests in SNCU-** ***Availability of at the point of care:*** Serum billirubin, Plasma glucose, Serum Creatnine, Complete Blood Count, Platelet, C reactive protein, Prothrombin time, Arterial Blood Gas analysis with PH measurement analysis.		
5.1.7	**Key Protocols:** 1) Assessment and treatment of new borns with emergency signs 2) Triage of sick new born(in SNCU & EMERGENCY) 3) Grading and management of hypothermia 4) Expression of breast milk 5) Assisted feeding of low birth weight neonates 6) IV fluid therapy for new born 7) Management of hypoglycemia 8) Assessment and management of jaundice in newborn babies 9) Assessment and management of respiratory distress 10) Assessment of neonatal sepsis 11) Administration of commonly used drugs 12) Resuscitation algorithm 13) Management of newborn with seizures 14) Administration of Dopamine in a newborn with hemodynamic compromise 15) Identifying intrauterine growth retardation in new born 16) Assessing gestation of new born baby- expanded new ballard score		

	17) Housekeeping protocol 18) Breastfeeding		
5.1.8	**Safety and Security** 1) Check for fixtures and furniture like cupboards, cabinets, and heavy equipments , hanging objects are properly fastened and secured 2) Switch Boards, other electrical installations are intact and does not have temporary connections and loosely hanging wires 3) Mechanism for periodic check / test of all electrical installation by competent electrical Engineer 4) Dedicated earthling pit system to be available 5) Earth resistance should be measured twice in a year and recorded 6) Power boards are marked as per phase 7) Floors of the SNCU are even and non slippery 8) Windows/ventilators in the SNCU are intact and sealed		
5.1.9	**Discharge:** **<u>DISCHARGE POLICY FROM SNCU</u>** 1) All acute problems should have been resolved or no longer active. 2) Baby is accepting breast feeding or spoon feeds well. 3) Adequate weight gain for 3 consecutive days. 4) Mother should be confident for managing the baby. 5) At discharge the baby weight should be more than 1.5 kg. 6) Counselling of parents for Retinopathy of Prematurity if weight < 1800 gm and esp. in children < 32 weeks 7) Proper mention of Date, time and day for follow up not generalization to come after a week) 8) A pre discharge physical examination including Weight, Head Circumference and length	Treating Doctor, Nurse	Discharge Summary / Discharge Register

	to done. 9) Medications demonstrated as the dose, drug, duration and method of administration to mother. 10) Emergency phone number of the facility to be given to parents. 11) Various problems, investigations and course during hospital stay should be properly noted. At the time of discharge the discharge advice is obtained from the doctor of SNCU. The Nursing staff on duty explains the treatment details and the follow up of the Medications that the neonate will have to continue even after getting discharged.		
5.1.10	**Transportation and referral** • In the district hospitals with provision of a functional /affordable transport for sick neonates • It should be linked to a transport service that reaches within 30 minutes and transport patient to referral centre. • Monitor care during transport. • Communication contact with the vehicle driver directly or routed through a call centre. • The ambulance service should be free of cost at the time of need. • An assured referral facility linkage is a facility which provides management of complications including surgical emergencies and blood transfusion and which agrees to provide these services on a cashless basis to any patient referred from the referring facility. This may be a public hospital or an accredited private hospital through a public-private partnership arrangement. • The effort should be to have a network of referral centres within one or two hours of any facility providing Sick New Born Care.		

Reference Documents:

1. MTP Act 1972
2. PC & PNDT Act 1994
3. Procedure for Blood Bank
4. Procedure for Operation Theatre Management
5. Procedure for indoor management
6. Procedure for Infection Control
7. Procedure for biomedical waste management
8. Procedure for admission Discharge Management
9. State Protocol for SNCU
10. FBNC Manual
11. Standard Maternal Newborn Toolkit

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-6 Operation Theatre / Central Sterile Supply Department / Theatre Sterile Supply Unit

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of OT/CSSD/TSSU

1. To manage Operation Theatre for quality patient care.
2. To ensure use of Personal Protection Equipment during all procedures by all staff posted in OT.
3. To follow all OT protocols and procedures to ensure OT aseptic and environment including regular fumigation.
4. To maintain schedule of surgery as per priorities and seriousness of the case.
5. To ensure segregation of waste generated after every procedure.

SOP 6: OT/CSSD/TSSU

1. Scope:

The scope of this procedure covers the patients selected for surgical procedures

2. Purpose:

The purpose of this procedure is to develop a system for managing Operation Theatre for quality patient care.

3. Responsibility:

Operation Theatre In charge:

a) To schedule surgeries as per priorities and seriousness of cases.
b) To develop and maintain OT and environmental cleanliness practices mentioned in the Infection Control and Hygiene procedures.
c) To formulate the OT protocols and procedures.
d) To provide assistance to Nurse In-charge of OT for routine supervision of above mentioned issues.

OT Assistant:

a) To book & schedule cases to be performed in OT and preparing the OT list for the next day.
b) To ensure that all the instruments / linen are autoclaved / sterilized.
c) To perform routine Check & proper functioning of equipment with the help of Checklist.
d) To ensure that infected cases are taken at the end of the list of surgeries for the OT,
e) To ensure that OT is fumigated; instruments / equipment are disinfected and cleaned when infected cases are operated.

Staff Nurses:

a) To receive & hand over the patient along with case file, diagnostic reports duly filled and signed by concerned doctor.
b) To facilitate the patients in filling the consent form with full signature, date and time.
c) To prepare the patient 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 / equipments.
e) To assist the gynecologist/doctor during the entire process of operation/insertion
f) To ensure the availability of cross-matched whole blood units before the commencement of operation and same is recorded.

Sweeper:

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

4. Standard Procedures

Sl. No.	Activity	Responsibility	Reference Document/Record
	Schedule of Surgery		
1	The surgeon informs the OT technician through an OT Call Register for OT booking. This slip include the date and type of surgery to be performed.	OT Technician/ Surgeon	OT call register
2	The OT Technician records the request in the OT Booking Register In case of any clash in schedule or non-availability he informs the concerned surgeon.	OT technician	OT booking register
3	He forwards the details of the OT bookings to the OT In charge and Anesthetist.	OT Technician	
4	Operating List (for the next day is consolidated at about 3.00 P.M. in the afternoon of the previous day by the OT technician and the same is approved & exhibited on the notice Board of the theatre. Issued by the OT In-Charge and prominently	OT In charge	Operating list
5	Emergency cases are accorded priority by the OT In-Charge of Operation Theatre. This may require rescheduling of planned surgeries which is intimated to the concerned authorities.	OT In charge	
	Pre-operative Procedure		
1	Surgeon gives written pre operative instructions to ward nurse e.g. Nil orally, enema etc.)	Staff Nurse	
2	Physical Preparations (Shaving of site, enema, bath, dress, valuables / jewellery) is done	Staff Nurse	
3	Staff nurse receives the patient sent from the ward and transfers him / her to the pre-operative area with the assistance of the attendant.	Staff Nurse	
4	Written Consent for Surgery is obtained from the patient / patient's relatives.	Staff Nurse	Consent
5	Staff nurse conducts the following pre-operative checks. □□ Medication □□ Patient Identification □□ Case Record and Investigation Reports / Films □□ I.V. Fluids □□ Blood Requirement □□ Prophylactic Antibiotics (If prescribed)	Staff Nurse	Preoperative Checklist
	Pre-operative Anesthetic Checks		

Sl. No.	Activity	Responsibility	Reference Document/Record
1	A pre-operative evaluation of the patient is done by the anesthetist for all cases posted and admitted for surgery a day prior to the surgery. In case the patient is not deemed fit for surgery, the Surgeon and Nursing In-Charge for OT is informed through the ward nurses. In emergency case pre anesthesia check up is done in emergency/OT.	Anaesthetist	PAC form
2	After receiving of the patient at the OT the anaesthetist verifies the identity of the patient against details provided in the case sheet with the patient and the OT nurse and does a quick evaluation of the patient's vitals and records the same in the case sheet.	Anaesthetist	Case Sheet
In Process Checks during Surgery			
1	The Scrub Nurse controls the number of sponges on the table. At the commencement and the closure of the surgical incision, the scrubbed nurse counts the sponges and satisfies herself that these are correct & informs the surgeon accordingly.	Scrub Nurse	
2	The surgeon verifies himself that all swabs have been counted for, before the closure of the surgical incision. In case of any discrepancy in the number of swabs, the surgeon records this fact on the case sheet of the patient and informs the Civil surgeon/ Deputy medical superintendent.	Surgeon	Case Sheet
3	The surgeon keeps the scrubbed nurse informed of the location of swabs in the operational field to Facilitate her counting. After the first count has been taken, the scrubbed nurse and the surgeon, Carefully check the number of swabs still in use. Before the closure of the incision a final count is to be done.	Surgeon	Scrub Nurse
4	The scrub nurse checks all the instruments on the operating table and the hemostat clamps Immediately before the operation. Under the supervision of the surgeon the scrub nurse checks the instruments and hemostat clamps again before the closure of the surgical incision	Scrub nurse	
5	The scrubbed nurse counts all the needles on the table before the commencement of the operation. As a rule, the scrubbed nurse does not part with the second needle till the first is returned to her by the surgeon. In the event of more	Scrub nurse	

Sl. No.	Activity	Responsibility	Reference Document/Record
	than one needle being in use at the same time, the scrubbed nurse takes care to see that all the needles are returned to her. The scrubbed nurse makes a count of the needles before the closures of the surgical incision. In the event of any discrepancy, the surgeon is informed promptly.		
Post Operative Care of the Patient			
1	Post operation the patient is shifted to the Recovery Room or Post-Operative Ward and thereafter Supervised by concerned specialist.	Ward Nurses	
2	A provisional Surgery Note containing the details of the surgery is prepared by the surgeon with his/her Signature before the patient is transferred out of OT complex.	Surgeon	Surgery Note
3	Detailed post operative care instructions are Documented in the case sheet by the surgeon.	Surgeon	Case Sheet
4	The anesthetist orders the transfer of the patient from recovery room to the ward after verifying her progress.	Anesthetist	
5	Anesthetist supervises the Post Operative Patient in the Post Operative Ward (in case patient was transferred to Post Operative Ward) for the progress.	Anesthetist	
Operation Theater Asepsis and Environment Management			
1	The staff nurse conducts daily checks of the Cleanliness of the OT. She ensures that all areas found soiled are again cleaned under her supervision.	Staff nurse	
2	The staff nurse ensures that OT surfaces, tables and instruments are scrubbed with disinfectant agents on a daily basis.	Staff Nurse	
3	Staff nurse / OT Incharge ensures that the OT is fumigated on a weekly basis and / or after each biohazard case. The details of the fumigation will be recorded in the Fumigation Register.	OT Incharge	Fumigation Record Register
4	All personnel entering the OT will wear OT gowns /dress including footwear and undergo proper scrubbing procedure to ensure sterility of the clean areas.		
OT Documentation			
1	The details regarding Anesthesia are noted in the Anesthesia Register**.**	Anaesthetist	Anaesthesia register
2	Anesthetist notes down all the drugs and consumables, which are used during the surgery in Operation theatre	Anaesthetist	Operation theater Indent Register.
3	OT Nurse In-charge records the details of each	OT Nurse In-	Gynaecology Surgery

Sl. No.	Activity	Responsibility	Reference Document/Record
	surgery performed	charge	Registers
4	OT Nurse In-Charge prepares a monthly statement of surgeries performed and submits the same to the OT in charge & CMS	OT Nurse In charge	
5	Staff Nurses maintains the Psychotropic and Narcotics Drugs Register of statutory requirements.	Staff Nurse	Psychotropic & Narcotics register
6	Staff Nurses maintains the inventory of OT Consumables and medicines.	Staff Nurse	Inventory Register
7	Pharmacists will maintain the records of the nonfunctional /damaged equipment and informs OT me /C and the Stores I /C. They update the same in the Dead Inventory Register**.**	Pharmacist	Dead Inventory register
Central Sterile Supply Department			
1	**Receipt and Issue of Packs**: Receipt of items from various point of generation from 9.00 am to 1.00 pm. Issue of sterile packs from the CSSD from 3.00 pm to 6.00 pm. However in departments like OT, ICU, Emergency Department etc is exempted from the above mentioned time dimensions since it is difficult to restrict their activity within specific time limit due to the emergency nature of care provided by them.	CSSD Assistant	CSSD Receipt & Issue Register
General Cleaning of the Department			
1	The general working area of the CSSD is mopped everyday including the following area within the CSSD environment. By • Packing area • Sterile packs Storing • Contamination area and sluice room	Housekeeping staff	
General treatment of Items before Sterilization			
1	The items to be sterilized at the Central Sterile Supply Department are washed with detergent, sorted and packed at the respective point of generation (Wards, ICUs, Emergency Department, OTs, and OPDs etc).	CSSD Assistant	
2	The Housekeeping staff is responsible for transporting the prepared packs from the point of generation to the Central Sterile Supply Department.	Housekeeping Staff	
3	OT linen is sent directly to the laundry for cleaning. The laundry washed linen are received, packed & forwarded to the CSSD for sterilization.	Laundry Staff	

Sl. No.	Activity	Responsibility	Reference Document/Record
Return of Unutilized Packs:			
	In case the packs which are sterilized in the CSSD remains unutilized in the respective user departments for a period of 72 hours, the same are returned to the CSSD department for resterilization.	Respective Departments	
Maintenance and Calibration of Equipments			
	Maintenance of the equipment is done as per the annual maintenance contract (AMC) entered into with the vendor of the respective CSSD equipments.	Biomedical Equipment Engineering &Maintenance Department of the hospital.	AMC Agency
2	All equipment used in the department are appropriately calibrated at periodic intervals to ascertain whether they are performing at the expected level and a record of the same is documented in the department as well as with the of Hospital Manager.	Respective department/ concerned clerk in the administrative Department	Calibration Agency
Recall Procedure :			
1	Whenever a breakdown in the sterilization system is noted all packs sterilized by the faulty machine is immediately called back from the respective areas The packs called back are sent for re-sterilization using a proper machine**.**	CSSD Technician	Recall Register

5. Reference Records

Sl.No.	Record	Name Record No.	Retention Period
1	OT call register		
2	OT booking register		
3	Operating list		
4	Fumigation Record Register		
5	Anaesthesia register		
6	Operation theatre Indent register		
7	Surgery register for OB&G		
8	Psychotropic and Narcotic drugs register		
9	Dead Inventory register		

6. Process Efficiency Criteria

Sl.No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Infection Control	Surgical Site Infection rate	
2	Schedule	Surgery Cancellation Rate	
3	Utilization	OT Utilization Rate	
4	Outcome	Major Surgeries per doctor	

7. Reference Documents

1. WHO Surgical Safety Checklist
2. Procedure for Hospital Infection Control
3. Surgical Care at District Hospital

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-7 Post Partum Centre

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of Post Partum Centre

1. To display the available post partum services including family planning
2. To display 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. To Follow all Infection Prevention & Bio Medical Waste management protocols & procedures
6. To Increase PPIUCD user rate by 1% from existing rate

SOP 7: Post Partum Centre

1. Scope:

All patients requiring post partum care including Family Planning services

2. Purpose:

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

3. Responsibility:

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 as well,
   - Services for spacing & Limiting methods,
   - Counseling for abortion, (1^{st} & 2^{nd} trimester abortion 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 provide information in the form of leaflets, wall writing, posters etc.
e) To ensure display of the services & the entitlements available in the department. (e.g. Compensation for family planning indemnity scheme, FP services, FP Insurance Scheme).
f) To maintain the privacy, confidentiality & dignity of the client/patient & related information.
g) To ensure that the staff is empathetic and courteous.
h) To update staff's knowledge about reproductive rights of the clients.

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

a) Is responsible to schedule the cases to be performed in PPC OT.
b) Ensures to provide autoclaved / sterilized instruments and linen
c) Performs routine Check & recording of proper functioning of equipment with the help of checklist, later on 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.

- **Staff Nurse:**

a) To receive & hand over the patient along with case file, diagnostic reports duly filled and signed by concerned doctor.
b) To facilitate the patients in filling the consent form with full signature, date & time.
c) To prepare the patient 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

- **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 segregate 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	Facility has Post operative / Post partum ward		

5. Standard Procedures

Sl. No.	Activity	Responsibility	Reference Document/Record
I.	**Family planning spacing methods**		
	- Cafeteria approach for assisting client in decision making - Counseling for FP in ANC, PNC ward by counselors. - Informed about the advantages of spacing methods - Informed choice & take consent before treatment and procedures. - In case of abortion informed consent on prescribed form 'C' for abortion - Client is informed about the availability of free services, free drugs, consumables and contraceptives.	Doctor on Duty & PPC Incharge	PPC Register
	Condom: Available free of cost in any govt. health facility, provides protection from RTI/STI.		
	Oral contraceptive Pills: Oral contraceptive pills contain hormones and are one of the most important and reliable methods of		

Sl. No.	Activity	Responsibility	Reference Document/Record
	contraception. 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. The pills are to be consumed daily at the same time		
	Intra Uterine Contraceptive Device- CuT (IUCDs) have been used by women in India for decades for spacing pregnancies. In some of the health facilities, it has also been provided to women in the immediate postpartum period. ***POLICY*** - The CuT-380A is approved for immediate postpartum insertion as a method of contraception. - The PPIUCD must be placed after counseling and obtaining a written informed consent by the woman. - The PPIUCD can be placed immediately following delivery of the placenta, during cesarean section or within 48 hours following childbirth. - The IUCD must be inserted only by a trained service provider. - PPIUCD insertion must be done in a healthcare facility that provides delivery services and has acceptable standards of infection prevention**.** The usual timings are: **Immediate Postpartum:** - ***Post placental***: Insertion within 10 minutes after expulsion of the placenta following a vaginal delivery on the same delivery table. - ***Intra cesarean:*** Insertion that takes place during a cesarean	Doctor on Duty & PPC Incharge	

Sl. No.	Activity	Responsibility	Reference Document/Record
	delivery, after removal of the placenta and before closure of the uterine incision. - Within 48 hours after delivery: Insertion within 48 hours of delivery and prior to discharge from the postpartum ward. - ***Post abortion:*** Insertion following an abortion, if there is no infection, bleeding or any other contraindications. - ***Extended Postpartum/Interval:*** Insertion any time after 6 weeks postpartum. The IUCD should **NOT** be inserted from 48 hours to 6 weeks following delivery because there is an increased risk of infection and expulsion.		
	Emergency Contraceptive Pills Women can use within the first few days after unprotected intercourse to prevent an unwanted pregnancy. EC is not a regular FP method and is intended for "emergency use" only. **Emergency Contraception** can be used - After voluntary sexual act without contraceptive protection - Incorrect or inconsistent use of regular contraceptive methods: - Failure to take oral contraceptives for more than 3 days, being late for contraceptive injection - In case of contraceptive failure - Expulsion of an intrauterine device and, - Slippage/ leakage/ breakage of condom		

Sl. No.	Activity	Responsibility	Reference Document/Record
	Methods of Emergency Contraception All the hormonal oral contraceptive pills (combined as well as single) in varying doses and IUCDs can be used for EC. The following methods are in use: - Progesterone only pill (LNG). - Combined oral contraceptive containing Ethyl Estradiol and Levonorgestrol - Copper releasing IUCD CuT 380-A		
II.	**Family Planning Limiting Methods**		
	Laparoscopic tubal Ligation: When to perform – - After menstruation, within 7 days - After 42 days of delivery, - After abortion/ MTP (up to 12 weeks) within 7 days, if no infection/ complication. Anesthesia : Local Anesthesia Steps: - Laparoscope is inserted through the small nick given near the naval of woman, tubes are seen and 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. - Analgesics and antibiotics are provided. Woman is allowed to take rest for a day or two, bath after 24 hours, follow up visit is necessary after one week. As absorbable stitch material is used hence no need of removal of stitch. **Mini-Lap tubal Ligation:** When to perform – ▪ After menstruation, ▪ After delivery within 7 days, ▪ After abortion within 7 days,	Trained gynecologist performs the surgery. Staff nurse assists.	

Sl. No.	Activity	Responsibility	Reference Document/Record
	if no complications / infections. Anesthesia : Local Anesthesia Steps: ▪ Small incision is given in the lower abdomen, through which fallopian tubes are visualized pull out, tied up and cut one by one. Abdomen is stitched ▪ Analgesics and antibiotics are provided. Woman is allowed to take rest for a day or two, bath after 24 hour, follow up visit is necessary after one week for removal of stitches.		
	3. Schedule of FP Limiting Surgery, MTP, D & C		
a)	The doctors counsels the client regarding FP services and if the client is ready then sends her to PPC along with the OPD slip mentioning the date and type of surgery to be performed.	PPC OT I/C staff nurse	OPD ticket, OT register
b)	The OT nurse records the request in the PPC **OT Register** In case of non-availability of OT, she informs the concerned doctor.	OT sister or staff nurse	OT register
c)	She forwards the details of the client to the OT Incharge (doctor)	PPC OT staff nurse	
	1. Pre-operative Procedure		
a.	Surgeon gives written pre operative instructions to ward nurse.	Staff Nurse	
b.	Part Preparation (Shaving of site, 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
5	Staff nurse conducts the following pre-operative checks. ➢ Medications as per prescription ➢ Clients Identification ➢ Case Record and Investigation Reports / Films ➢ I.V. Fluids	Staff Nurse	Preoperative Checklist

Sl. No.	Activity	Responsibility	Reference Document/Record
	➢ Blood Requirements ➢ Prophylactic Antibiotics (If prescribed)		
	2. 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. In emergency cases pre-operative check up is done in Emergency/OT by the doctor, accordingly the notes to be 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 The OT nurse does a quick evaluation of the patient's vitals and records the same.	Anesthetist	Case Sheet
	3. **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. 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
c.	The surgeon helps the scrub nurse informed of the location of swabs in the operational field and facilitates her in counting. - After the first count has been taken, the scrub nurse and the surgeon carefully check the number of swabs still in use. - Before the closure of the incision a final count is to be done	Surgeon	PPC register & Case sheet

Sl. No.	Activity	Responsibility	Reference Document/Record
d.	The scrub nurse checks all the instruments on the operating table and the hemostat clamps immediately before the operation. - Under the supervision of the surgeon the scrub nurse checks the instruments and hemostat clamps again before the closure of the surgical incision	Scrub nurse	PPC register & Case sheet
e.	The scrub nurse counts all the needles on the table before the commencement of the operation. 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. 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.	Scrub nurse	PPC register & Case sheet
	4. Post Operative Care of the Patient		
a.	Post operation, the patient is shifted to the Recovery Room or Post Operative Ward and thereafter supervised by concerned doctor	Ward Nurses	PPC-OT register & Case sheet
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-OT 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-OT register & Case sheet
e.	Surgeon supervises the Patient in the Post Operative Ward for the progress.	Surgeon	
	5. Operation Theatre Asepsis and Environment Management		
a.	The staff nurse conducts daily checks of the Cleanliness of the OT. She ensures that all areas found soiled are	Staff nurse	PPC-OT register & Case sheet

Sl. No.	Activity	Responsibility	Reference Document/Record
	again cleaned under her Supervision.		
b.	She ensures that OT surfaces, tables and instruments are scrubbed with disinfectant agents on a daily basis.	Staff Nurse	
c.	She ensures that the OT is Fumigated Carbolized/ on a weekly basis and / or after each biohazard case. The details of the fumigation are recorded in the **Fumigation Register**.	OT Incharge	Fumigation Record Register
d.	All personnel entering the OT should wear OT gowns /dress including footwear and undergo proper scrubbing procedure to ensure sterility of the area.		
6. **OT Documentation**			
a.	The details of Anaesthesia are noted in the Anaesthesia Register	Anesthetist	Anaesthesia register
b.	Anesthetist notes down all the drugs and consumables, which are used during the surgery in Operation theatre	Anesthetist	Operation theater Indent Register.
c.	OT Nurse In-charge records the details of each Surgery/procedures performed	OT Nurse In-charge	Gynecology/PPC Surgery Registers
d.	OT Nurse In-Charge prepares a monthly statement of surgeries performed and submits the same to the OT in charge/ CMS.	OT Nurse In charge	
e.	Staff Nurse maintains the Psychotropic and Narcotic Drugs Register as per statutory requirements.	Staff Nurse	Psychotropic & Narcotics register
f.	Staff Nurse maintains the inventory of OT consumables and medicines.	Staff Nurse	Inventory Register
g.	Pharmacist maintains the records of the nonfunctional /damaged equipment and informs OT I/C and the Store I/C. They update the same in the Dead Inventory Register**.**	Pharmacist	Dead Inventory register
7. **CSSD (Central Sterile Supply Department)**			
	Receipt and Issue of Packs: Receipt of items from various point of generation from 9.00 am to 1.00 pm. Issue of sterile packs from the CSSD from 3.00 pm to 6.00 pm. However the departments like OT,	CSSD Assistant	CSSD Receipt & Issue Register

Sl. No.	Activity	Responsibility	Reference Document/Record
	ICU, emergency etc. are exempted from the above mentioned time line.		
8.	**General Cleaning of the Department**		
	The general working area of the CSSD is mopped everyday including : • Packing area • Sterile packs Storing area • Contamination area and sluice room	Housekeeping staff	
9.	**Generation of Items for Sterilization**		
a.	The items to be sterilized at the Central Sterile Supply Department are washed with detergent, sorted and packed at the respective point of generation PPC-OT, PPC minor OT, PPC Wards, etc).	CSSD Assistant	
b.	The Housekeeping staff is responsible for transporting the prepared packs from the point of generation to the Sterile Supply unit	Housekeeping Staff	
c.	OT linen is send directly to the laundry for cleaning. The laundry washed linen are received, packed & forwarded to the CSSD for sterilization.	Laundry Staff	
10.	**Return of Unutilized Packs:**		
	In case the packs which are sterilized in the CSSD remains unutilized in the respective user departments for a period of 72 hours, the same are returned to the CSSD department for resterilization.	Respective Departments	
11.	**Maintenance and Calibration of Equipment's**		
a.	Maintenance of the equipment are done as per the annual maintenance contract (AMC) entered into with the vendor of the respective CSSD equipment.	Biomedical Equipment Engineering & Maintenance Department of the hospital.	AMC Agency
b.	All equipment used in the department are appropriately calibrated at periodic intervals to ascertain whether they are performing at the expected level and a record of the same is documented in the department as well as with the Hospital Manager	Respective department/concerned clerk in Administrative Department	Calibration Agency

Sl. No.	Activity	Responsibility	Reference Document/Record
12. **Recall Procedure :**			
	Whenever a breakdown in the sterilization system is noted, all packs sterilized by the faulty machine are immediately called back from the respective areas and sent for re sterilization using a proper machine.	CSSD Technician	Recall Register

6. Reference Records

Sl. No.	Record	Name Record No.	Retention Period
1	OT call register		
2	OT booking register		
3	Operating list		
4	Fumigation Record Register		
5	Anaesthesia register		
6	Operation theatre Indent register		
7	Surgery register for FP, MTP, D & C		
8	Psychotropic and Narcotics register		
9	Dead Inventory register		

7. Process Efficiency Criteria

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Infection Control	Surgical Site Infection rate	
2	Scheduling	Surgery Cancellation Rate	
3	Utilization	OT Utilization Rate	

8. Reference Documents

1. WHO Surgical Safety Checklist
2. Procedure for Hospital Infection Control
3. Surgical Care at District Hospital

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SOP-8 Laboratory Department

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of Laboratory Services

1. To cater all patient care areas of the hospital round the clock
2. To follow all Infection Prevention & Bio-Medical Waste management protocols
3. To reduce waiting time of the patient for obtaining sample & providing report in committed time
4. To provide all free diagnostic services under JSSK
5. To have culture sensitivity testing in hospital lab

SOP 8: Laboratory Services

1. Purpose:

To provide all kind of available diagnostic services to patients.

2. Scope:

It covers all patient care areas of hospital.

3. Responsibility:

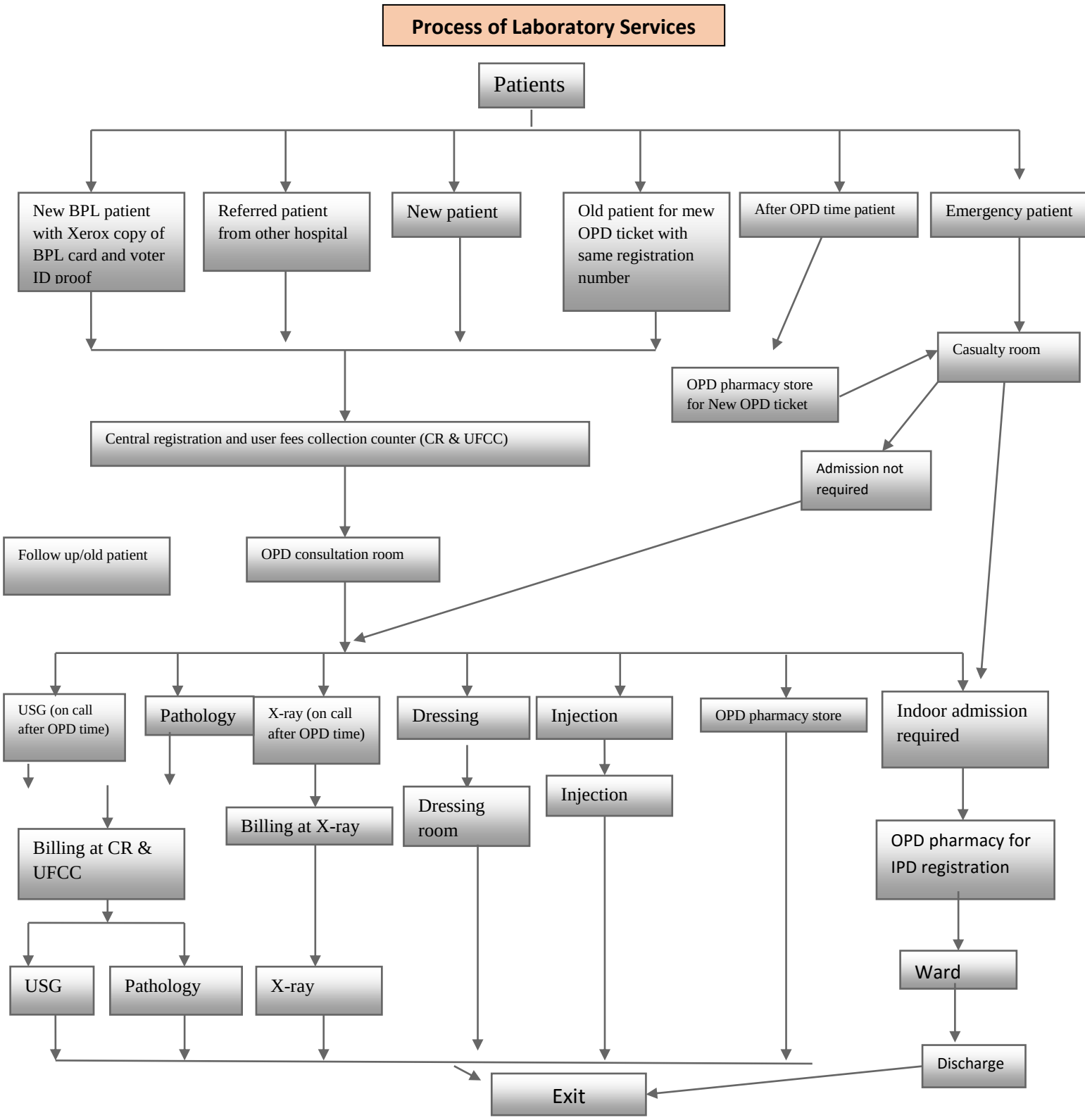
The Pathologist/Lab technician treating physician shall be responsible for prescribing, diagnosis and further treatment based on reports.

4. Procedures:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	**Laboratory services**		
A.	**Out Patient Services:** The Physician prescribe the various investigations on the Investigation request slip. The Lab technician enters the request received, in the lab. Collection Register and allots a Lab / Hospital registration number. The Lab technician collects the sample, puts a label and transports it to testing area of the lab Patients are intimated about the time for collection of report The Lab technician segregates the specimens according to various testing areas and starts testing the samples. The Lab Technician records the details of the samples received in the respective registers.	Lab technician Lab technician	Lab investigation requisition form Lab register Haematology register, biochemistry register, special test register
B.	**In patient services** The lab technician /nurse shall collect the samples of the patients admitted in the ward and send it to the lab with request form and the patient details are labelled on the sample test tube / container. The lab technician records all the details of the samples received in the respective registers	Lab technician/ nurse on duty	Haematology register, biochemistry register, special test register
C.	**Reporting** The Lab Technician records the reports and gets it approved by the lab Incharge/ Pathologist and issues the reports to patient /treating physician.	Lab technician	
D.	**Samples that are sent outside the facility:** The lab-in charge records the details of the samples and patient in the reference patient lab register If the samples are sent outside, lab technician	Lab technician	

Sl. No.	Activity	Responsibility	Reference Document/Record
	records the reports when available.		
E.	**Stock Maintaining & Monitoring:** A stock register shall be maintained for the items and wherever required re-order shall be maintained in the stock register itself. List of the items required shall be well informed to the administrative department through indent.		
4.2	**Infection Control :** Following infection control measures shall be followed in the hospital.		
A.	**Staff health plan:** To control spread of infection from staff to patient or to protect staff from occupational hazards annual medical check-up of staff should be done and required vaccination is provided to all members.	Hospital Infection Control Committee	
B.	**Hand Hygiene:** Adequate hand washing facility should be available in all patient care areas. Elbow operated taps and washbasin and soaps are available in service provider's room & in-patient care areas. If water facility is not available alcohol rub may be provided in patient care area. Scrub area should have elbow/foot operated water taps.	On duty doctor, staff nurse and all paramedic as well as house keeping staff involved in patient care.	
C.	**Aseptic techniques:** Aseptic techniques are followed strictly.	OT I/C	
D.	**Segregation of contaminated materials and instruments:** Contaminated pieces of linen, sputum cups, bedpans, instruments & biomedical waste are kept separately to avoid mixing with the clean ones.	Ward I/C	
E.	**Disinfection:** Disinfection of equipment and furniture's are carried out with bleaching powder solution**.** At least once a day or as required.	Housekeeping staff or General duty attendant	
F.	**Sterilization practices:** The efficient CSSD ensures the supply of properly sterilized articles to all users of the hospital. The unsterile items are stored separately.	Ward I/C or CSSD In-charge	
G.	**Good housekeeping:** Cleaning of OT walls, floors, tables and fixtures are organized as per a schedule programme at pre-determined intervals and use of appropriate disinfectant is strongly advocated. (*Procedure 20, Hospital housekeeping & General Upkeep Management)*	Housekeeping staff	Housekeeping Check list Biomedical waste

Sl. No.	Activity	Responsibility	Reference Document/Record
	Biomedical waste are collected, segregated, transported, stored and disposed off as per BMW management & handling rule, 1998. *(Procedure 24, Hospital Waste Management)*		Management & handling rule, 1998.



5.Records:

Sl. No.	Record	Record No.	Minimum Retention Period
1	Collection Register (IP/OP)		
2	Biochemistry Register		
3	Haematology Register		
4	Special Tests Register		

6. Process Efficiency Criteria:

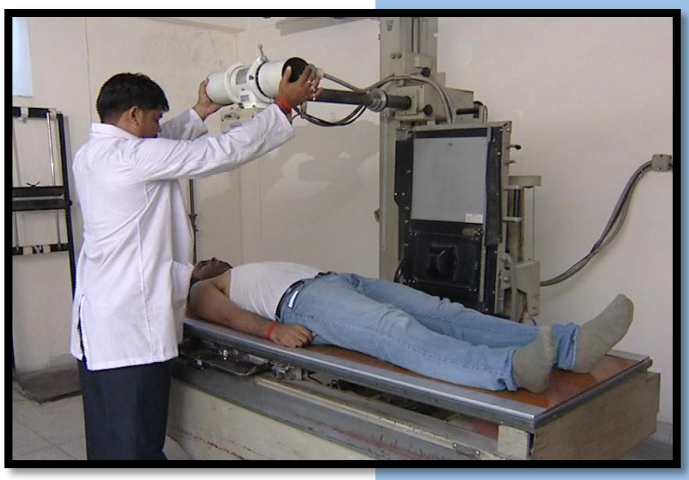
Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Routine Testing	Turn Around Time	
2	Utilization	Lab test done per indoor patient	
3	Emergency Testing	Turn Around Time	
4	Proficiency	Z score in external validation	

7. Reference Documents

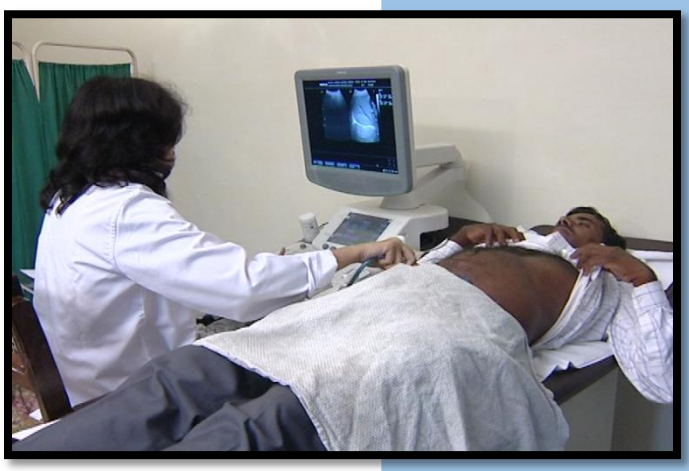
1. The Bio-Medical Waste (Management and Handling) Rules,1998
2. ISO 15189: 2007 - Medical Laboratories Particular Requirements for Quality & Competence
3. Guidelines for Good Clinical Laboratory Practice –ICMR
4. Manual on Quality Assurance for Laboratory Diagnosis of Malaria – NVBDCP
5. Guidelines for Standard Operating Procedures for Haematology – WHO

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-9 Radiology Department



X-Ray



USG

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of Radiology Department

1. **To cover all patient care areas of hospital**
2. **Ensure availability of round the clock services**
3. **USG room/space will be in accordance with PCPNDT-Act**
4. **Patient and employee safety measures will be followed as per Atomic Energy Regulation Board (AERB) rules & regulations**
5. **Confidentiality of the report will be maintain.**

SOP 9: Radiology Department

1. Purpose:

To provide all kind of available diagnostic services to patients.

2. Scope:

It covers all patient care areas of hospital.

3. Responsibility:

The Medical Officer / Physician shall be responsible for prescribing, diagnosis and further treatment based on reports.

4. Procedures:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	**Radiology Department**		
4.1.1	**Arrival of Patients in Radiology department:** Patients arrive in the department with radiology requisition slip given by the treating doctor		Radiology Request
4.1.2	**Explaining the Procedure to Patient & Recording of Patient details** All the details of the patient (like name, age, procedure requested for etc) are entered in diagnostic register. Staff nurse informs the patient about the procedure and the duration.	Staff Nurse/ Technician	Diagnostic Register
4.1.3	**Radiation Protection** Confirm about the pregnancy status of female patients of child bearing age and provide her lead shield as per AERB norms. All the technician/workers dealing with radiation exposure are provided with TLD badges which are compulsory to be worn during working hours.	Radiology technician	
4.1.4	**Preparation of the patient** Consent is taken from patient or relatives before procedure. Clean patient gown is provided to patient to prepare for procedure Patients are requested to remove all the jewellery and accessories before investigation.	Staff nurse/ technician	Consent form
4.1.5	**Processing & Drying of films** After exposure, film is processed & dried and once ready, it is kept for reporting.		

4.1.6	**Turn Around time for reports** The report is sent to the concerned doctor/ department directly, if patient is admitted in IPD and through patient/relative if patient is visiting in OPD/ as per turnaround time**.** In case of an emergency report, the radiologist will see the film and give a verbal report to the treating physician. If the patient is referred or wants to go to some other hospital (on request or against medical advice), efforts and made to generate the reports on priority basis.	Radiologist	X-Ray Report
4.1.7	**Maintenance of Record:** The record such as Requisition slips, Radiology Register, File of X-ray, Maintenance Record of X-ray Machine, consent form of patient is maintained by the staff nurse.	Radiologist/ Staff Nurse	List of Records
4.1.8	**Inventory Management** Inventory of following items is maintained at all the time in sufficient no. • Linen • Cassettes • Lead Apron • Gloves • Chemicals • X-ray films As per daily OPD/IPD load, stock of the above items is maintained. It is ensured that these items are available in adequate number at all time. Based on lead time of procurement, minimum stock and average consumption the indent is sent to store in time.	Staff nurse	List of Items in the department with minimum quantity in Stock Register
4.2	**Ultra Sonography**		
4.2.1	The treating physician/ medical officers shall prescribe for the USG scan specifying the details of the type of investigation to be done in USG requisition slip.	Medical Officer	Requisition Slip
4.2.2	The staff nurse enters details of the patient in the USG Register.	Staff nurse	
4.2.3	Staff nurse explains & instructs the patient about pre requisite for USG	Staff nurse	USG Appointment register
4.2.4	Patient arrives at the department complying with all instructions for preparation (as per appointment), and duty sister forwards the patient scan details to the radiologist/ sonologist	Staff nurse	
4.2.5	Staff nurse assists the patient and prepares her/him for USG	Staff nurse	

4.2.6	The radiologist writes down the findings.	Radiologist	
4.2.7	The staff nurse shall clean the patient's exposed body part after finishing the scan and tell the patient to wait in the waiting area for the report.	Staff nurse	
4.2.8	The report is prepared by radiologist and it is handed over to the patient	Radiologist and staff nurse	
4.2.9	In case of pregnancy, PC-PNDT form is filled before the scan.	Radiologist	PNDT form

5. Records:

Sl. No.	Record	Record No.	Minimum Retention Period
1	X-ray Nominal Register		
2	X-Ray Film Stock Register		
3	Ultrasound Scan Register		
4	Ultrasound Film Stock Register		

6. Process Efficiency Criteria:

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/ Standard/Target
1	Routine Testing	Turn Around Time	
2	Utilization	Lab test done per indoor patient	
3	Emergency Testing	Turn Around Time	
4	X-Ray Film Processes	Percentage of films wasted	
5	X-Ray reporting	Turn Around Time	
6	Proficiency	Z score in external validation	

7. Reference Documents

1. PC & PNDT Act 1996
2. Atomic Energy Act 1962, AERB guidelines
3. The Bio-Medical Waste (Management and Handling) Rules,1998
4. ISO 15189: 2007 - Medical Laboratories Particular Requirements for Quality & Competence
5. Guidelines for Good Clinical Laboratory Practice –ICMR.

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-10 Pharmacy Department

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of Pharmacy Department

1. To ensure free drugs to all patients including JSSK beneficiaries
2. Will maintain 45 minutes registration to drug time (as the time motion study done) & try to improve upon it.
3. To ensure the patients receive appropriate medicine as per their clinical need
4. To avoid situation of 'Stock out' of drug & Equipments.
5. To ensure the procurement as per 'State Drug Policy'.

SOP 10: Pharmacy Department

1. Purpose:

To establish a system for:

- Effective and efficient management of pharmacy services in the hospital including storage and dispensing of drugs.
- To ensure that patients receive medicines appropriate to their clinical needs, in doses that meet their individual requirements, for an adequate period of time.
- To ensure the selection, purchase, control, storage, dispensing and distribution of pharmaceutical items as per need of women & Child and it should be in compliance with 'State Drug Policy'.

2. Scope:

It covers all women and child related needs

3. Responsibility:

Chief Pharmacist and Pharmacists

4. Procedure:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	Based on EDL (Essential Drug list) of state, Drug and Therapeutic Committee develops "Drug Formulary" appropriate to Hospital needs and scope of services. A copy of the formulary is available at Pharmacy and with all treating Physicians and departments.	Drug and Therapeutic committee MS/Pharmacist	Drug Formulary.
4.2	**<u>Receipt of Drugs</u>** Drugs are received in the hospital through DHS/CMSD based on the requirement of the hospital. The drugs are supplied on as and when available through DHS based on supplies from supplier. At times, the drugs are received in the central store and the same are collected by the Chief Pharmacist / In-charge Store. The drugs received are identified and their quantity checked. The drugs are received through acknowledgement on the counter slip. The items & quantity received are entered in the stock register. The drugs not received are noted and intimated to Hospital Incharge especially the emergency drugs. A list is also prepared for the drugs received as damaged or expired. Such drugs are segregated and a detailed note put up through hospital Incharge to DHS.	Chief Pharmacist / Store In-Charge	Challan or Related documents Stock Register Shortage note List of damaged & expired medicines

Sl. No.	Activity	Responsibility	Reference Document/Record
4.3	**Storage of Drugs** • Stock is arranged neatly in **alphabetical** order with name facing the front. • Products of similar name and different strength are stored separately. • Heavy items are stored in lower shelves. • Fragile items are not stored at the edges of the shelves. • Near expiry drugs are segregated and stored separately. • Items requiring refrigeration are stored appropriately. • Temperature book is maintained for monitoring of the temperature of refrigerator. • Look alike and sound alike drugs are stored separately. • Medications that are considered light-sensitive, as labelled by their respective manufacturers, will be stored in closed drawers.	Chief Pharmacist	Stock Register
4.4	**Disposal of Drugs** Record of drugs expired during the month is maintained in the Expired medicine register. Expired drugs & damaged drugs are disposed off as per the state guidelines of the hospital and the record of disposal are maintained in Expired Medicine Register. (i.e. date, quantity of expired drug etc)	Chief Pharmacist	Expired Drug Register List of drugs disposed off
4.5	**Supply of drugs** Drugs are supplied to the dispensary/ ward/ emergency/ NICU/SNCU etc. as per the Indent and keeps the duly signed Indent from the employee who receives the drug The intimation for the replenishment of drugs is given to the Hospital in charge.	Chief Pharmacist	Voucher/ Indent Signed Indent
4.6	**At Store** Drugs are issued to the dispensary against duly filled Indent form which is collected from the pharmacist or In-charge. The record of issued drugs is maintained in the daily expense/drug issue register at the store. A list of available drugs is prepared & intimated to the doctors. The list is periodically updated **At Dispensary** List of available and non-available drugs are displayed outside the dispensary.	Chief Pharmacist Pharmacist	Indent Form, Daily Expense. Drug Issue Register List of available drugs/ Updated stock of essential drug list Stock Register at dispensary

Sl. No.	Activity	Responsibility	Reference Document/Record
	Record of drug is maintained at the dispensary stock register along with the name, quantity, date of manufacture and expiry etc. Received drugs are kept in the marked location/slots for ease of identification. The strips of drug is cut into the small ones and kept in marked boxes ready for dispensing. The drugs which are to be kept in controlled temperature, either kept in dispensary store or in store in controlled condition.		
4.7	**Dispensing of Drugs** The patient visits the pharmacy to receive the prescribed medicine along with the Registration slip. The pharmacist at the dispensary records registration number, name of drugs issued to the patient, quantity of drug issued etc. in the dispensary register. Drugs which are not available are informed to store Patient is informed of the method of taking the medicine.	Pharmacist	Registration Slip, Dispensary Register
4.8	**Local Purchase:** Life saving medicines/ emergency medicines required for day to day functioning can be purchased from local vendors selected by open tendering system after approval from MS and chairperson RKS.		
4.9	Hospital has a functional Drug and Therapeutic Committee comprising of: 1. SiC/CMS/Head of Institution, 2. Pharmacist 3. HODs 4. Matron.	MS	MOM.

5. Records:

Sl. No.	Name of Records	Record No.	Minimum Retention Period
1	Stock Register		
2	Daily Expense /Drug Issue Register		
3	Expired Drug Register		
4	Dispensary Register		
5	Available Drug List		

6. Process Efficiency Criteria:

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
A	Service provision	Proportion of drugs available against EDL	
B	Dispensing	Waiting time at pharmacy counter	

7. Reference Documents

1. State Essential Drug List
2. IPHS drug list.
3. State Guidelines for disposal of expired drugs.

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-11 Auxiliary Service Departments

Laundry

Kitchen/Dietary Department

Medical Record

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of Auxiliary Service Departments

1. To ensure free dietary services to all patients including JSSK & JSY beneficiaries.
2. To ensure that the food is stored and cooked in hygienic conditions and undergoes quality check every day.
3. To ensure clean & timely supply of linen
4. To minimize inventory loss
5. To ensure infection prevention practices for disinfection of soiled linen before washing
6. To Maintain hospital medical record in a systemic way so that they may be readily retrievable
7. To ensure proper Management of Medical Record and hospital statistics.

SOP 11: Auxiliary Service Departments

Dietary Department/Kitchen

1. Purpose: To establish a system for providing dietary services to all patients including JSY & JSSK beneficiaries.

2. Scope : It covers all the patients admitted in IPD or observational beds except patients advised Nothing By Mouth.

3. Responsibility:
a) Overall – Superintendent in Chief/ CMS
b) Specific – Outsourced Agency/ Kitchen I/C

4. Procedure:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	**Dietary advice** The doctor/ dietician advise diet as per the nutritional requirement of patient.	Doctor/Dietician	Bed Head Ticket/ Diet Chart
4.2	**Calculation of number of Diet:** The concerned nurse at the IPD calculates the dietary requirement of the patient in the diet register and sends it to the kitchen in-charge.	Nursing In-charge	Diet Register
4.3	**Procurement of Raw Material:** • Approved Diet Menu is available in the hospital and with the kitchen in-charge. • On the basis of Diet menu & no. of diet to be prepared, the concerned person at the kitchen purchases the raw material under the supervision of the nursing In-charge. • The inventory of perishable & non-perishable items in the kitchen is properly maintained by the cook. Vegetables are purchased on daily basis.	Concerned Nurse	Diet Menu Diet Register
4.4	**Upkeep of Utensils, Stove etc.** • Utensils are kept ready neat, clean & dry. • Stove and gas cylinder are always kept in clean and working environment. • Stove in running condition is kept ready for use.	Kitchen In-charge / Cook	
4.5	**Washing and Cleaning** Vegetables are washed with clean water and cut on clean and hygienic surface.	Cook	
4.6	**Preparation of Food** The food is prepared by the cook in the		

	hospital kitchen two times a day in a hygienic environment wearing gloves, caps and kitchen gown.	Cook	
4.7	**Quality Check of Cooked Food** • The quality of the food is first checked by the cook. • The nurse In-charge / Doctor on duty checks the quality of food. • Nurse In-charge takes feedback from the in-patents and prepares monthly quality report, and submits it to the CMS.	Cook Doctor On-Duty /Nurse In-Charge	Monthly Report on Quality of food
4.8	**Distribution of Cooked Food** The concerned person distributes the food to the admitted patients at the definite time twice a day with the intimation of concerned nurse.	Helper	Diet Register
4.9	**Feedback on Cooked Food** Feedback is taken from the IPD patient and reported to the nurses.	Concerned Nurse	Diet register
4.10	**Cessation of Dietary Services to patient** When the patient is discharged or referred, the concerned nurse updates the diet register and informs the concerned person accordingly.	Concerned doctor	Discharge Slip

5. Records

Sl. No.	Name of Records	Record No.	Minimum Retention Period
1	Diet Register		
2	Kitchen Report		

6. **Process Efficiency Criteria:**

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Quality Check	➢ Quality check is done under the supervision of the Nurse In-charge every time the diet is supplied ➢ Weekly check of housekeeping of Kitchen with respect to hygiene by the deputed officer.	
2	Kitchen/Diet Report	➢ The diet report on monthly basis shall be submitted to MS/Health Manager.	

7. Reference

- State guideline for Dietary services.

Laundry Department

1. Scope :

This applies to the management of hospital linen ensuring adequate cleaning of the linen for better hygienic hospital environment and infection control.

2. Purpose

To provide:

- Clean and timely supply of linen
- Minimize of inventory loss
- Clean linen to every patient admitted in the hospital.

3. Responsibility:

The smooth functioning of the laundry is the responsibility of the:

- Laundry Supervisor
- Hospital Manager
- Nursing In-charge
- Dhobi/Washer man

4. Type:

- In-house/Outsourced
- Mechanized / Hand wash
- Capacity
- Linen: Bed, Body, OT, Staff

5. Procedure:

Sl. No.	Activity	Responsibility	Reference Document/Record
5.1	**Service Provision**		
5.1.1	Laundry activities are operated through contracted service provider, whose staff cleans the hospital linen. The service provider serves as per the guidelines laid in the contract. Hospital Management is responsible to handle & manage contractors and maintain a copy of their contract for reference & records.	Laundry Supervisor, Matron	Contract Agreement with Outsourced Agency
5.2	**Daily Activities**		
5.2.1	**Change of Linen** • Once daily in morning. • Whenever it gets soiled with vomiting, faeces, blood spills, urine etc • When a new patient comes.	Staff Nurse/ ANM/ Trainee/Ward Attendant	Work Instructions for Bed Making
5.2.2	**Sorting and Storing of used Linen** Soiled and Infected Linen is segregated from dirty Used linen and stored in a specified area (dirty utility area).	Ward Attendant/ House Keeping Staff	Work instructions for Sorting & Handling of Infected Linen

Sl. No.	Activity	Responsibility	Reference Document/Record
5.2.3	**Disinfection of Soiled/ Infected Linen** Soiled linen is disinfected by soaking it into 1% Sodium Hypochlorite solution for one hour before sending it to laundry.	Ward Attendant/ Housekeeping Staff	
5.2.4	**Collection of Used/ Soiled Linen** Dirty linen is collected between 8:30-9:30 am daily from Wards, OPD, ICU, Labour room, Emergency OT Linen is collected daily between 8.00-8.30 am	Outsourced Laundry Staff	
5.2.5	**Sorting of Linen in OT** All OT Linen (e.g. surgical drapes, gowns, wrappers) used in a procedure are considered infectious even if there is no visible stain. All used linen is collected in **Disposal Zone** of OT.	OT Technician/ Attendant	IMEP guideline
5.2.5	**Counting of Collected Linen-** Counting of collected linen is done by laundry staff in presence of nursing in charge. Details of collected items are entered in Laundry register counter signed by nursing In-charge.	Laundry Staff/ Nursing In charge	Laundry Register
5.2.6	**Transporting Dirty Linen** 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.	Laundry Staff/ Dhobi	
5.2.7	**Washing and Drying of Linen** Washing , drying, Mending and Ironing of Linen done in designated place as per work instructions	Outsourced Laundry Staff	
5.2.8	**Receipt of Washed Linen** After washing of linen, the packed linens are delivered in the hospital. The quality and quantity of the linen is checked. The laundry register is signed by nursing in-charge and member of the outsourced agency.	Nursing In-charge / Hospital Manager	Laundry Register
	Storage and Issue of washed Linen : The packed and washed linen is stored at identified place The linen is sent to the respective wards according to demand.	Nursing In-charge	Laundry Register
5.3	**Inventory Management**		
5.3.1	**Sets of linen:** ***Hospital has 5 sets of linen per bed*** 1.One set which will be used 2. One set ready for use is kept in the ward	Hospital Manger/ Medical	

Sl. No.	Activity	Responsibility	Reference Document/Record
	3. One set being processed in the laundry 4. One set in transit to be delivered or to be received in the ward 5. One set for holidays and weekends	Superintendent	
5.3.2	**List of Linen** Hospital Manger maintains a list of Linen that consist of broadly a. Bed linen b. Body linen c. Operation theatre linen d. Staff linen e. Department/service linen.	Hospital Manager	List of Linen
5.3.3	**Condemnation of Linen** Condemnation committee meets in every three month to inspect items sorted for condemnation and recommends their replacement. Condemned bed sheets may be used as dusters, Mops by housekeeping staff	Hospital Manger/ Medical Superintendent	Condemnation Policy of the Hospital
5.3.4	**Purchase of New Linen** Purchase of new linen is done according to need and procedures of procurement.	Hospital Manger/ Medical Superintendent	SOP for Procurement and Outsourcing Management
5.3.5	**Pilferage of Linen** • No patient is allowed to take linen with them at the time of discharge. • Security Guard and Ward attendants keep vigil on movement of patients so that pilferage of Linen can be avoided • Linen are stored in lock and key and change is given at change of shift**.**	Security Guard/ Nursing Staff/ Ward Attendant	
5.4	**Quality Control**		
5.4.1	Hospital manager checks the quality of laundered linen once a week and reports to Medical Superintendent accordingly.	Hospital Manager	Weekly Report
5.4.2	Nursing in charge reports receipt of less linen, delay in delivery, dirty or torn linen on a daily basis.	Nursing In charge	
5.4.3	If any discrepancy is found in the services of outsourced agency, amount is deducted as per TOR of Contract.	Medical Superintendent/ Hospital; Manager	Contract Document
5.4.4	Work instructions for sorting and washing of Linen are displayed at point of use.	Hospital Manager	

6. Reference Record

Sl. No.	Name of Records	Record No.	Minimum Retention Period
1	Laundry Register		
2	Linen Stock Register		

7. Process Efficiency Criteria:

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Availability	Linen Index	

8. Reference Documents

- Contract Agreement with Outsourced Agency
- Procurement and Outsourcing Management
- IMEP Guideline: Ministry of Health and family Welfare, Govt. Of India.

Medical Record Department

1. Purpose:

To provide guidelines/ instructions & process of Data and Information of Hospital Statistics and Medical Records with the aims that

- Hospital Statistics and Medical Records are readily retrievable
- Feedback loop is established for continuous improvements of Health Indicators.

2. Scope: It covers all patient Medical records and Statistics in the hospital.

3. Responsibility: Superintendent in Chief / CMS

4. Procedure:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1.1	**Objective:** ❖ To develop good Medical Records containing sufficient data written in sequence of events to justify the diagnosis, treatment and end result. ❖ To keep them under safe custody and make them readily available as and when required for • The Patient. • The Doctor • Hospital Administrators. • Medico Legal Purposes. • External Reporting.		
4.1.2	**For Patient** • Serves to document the clinical history & treatment. • Serves to avoid repetition of diagnostic and therapeutic measures. • Assists in continuity of Care in future. • Serves as evidence in Medico-legal Cases. • Serves necessary certification for employment purposes.		
4.1.3	**For the Doctor** • Assures quality and adequacy of diagnostic and therapeutic measures undertaken. • Serves as an assurance of continuity of medical care. • Evaluates Medical Practices. • Protects in litigation.		

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1.4	**For Hospital Administrator/ SiC & CMS** • To document the type and quantity of work undertaken and accomplished. • To evaluate proficiency of Medical Staff for administrative and clinical purposes. • To evaluate the services of the hospital in terms of accepted norms and standards. • To serve as an Administrative record and Performance. • To assist in futures Programmes for Planning and developments of hospital.		
4.1.5	**For Medico Legal Purposes, it serves** • As a documentary evidence • To dispose of claims of the Insurances. • Malpractice Suits. • Authorization for operation etc. signed document for consent for operation will prove that the Patient /Relative have allowed the performance of such Procedure. • Criminal cases –as a Potential Document		
4.1.6	**Development of Hospital Performance Statistics** Statistical and epidemiological Data are needed to implement and manage medical care planning and to obtain Health Indicators to monitor and evaluate their effectiveness for Hospital Management as follows: • Bed Occupancy Rate • Average No. of Out Patients • Average No. of Admissions • Sex wise Admissions • Average Length of Stay of Patients. • Gross and Net Death Rate. • Number of Types of Operations performed (Major & Minor) • Number of X-ray / C.T. Scan, Ultra Sound etc. • Laboratory Tests. • Information about Institution Deaths (Deaths occurring over 48 hrs.) • Total Number of Babies born in a		

Sl. No.	Activity	Responsibility	Reference Document/Record
	hospital. • Daily Census of the Hospital etc.		
4.1.7	**Reporting to State Authorities** • To submit the Diagnostic Reports to departments under the ambit of Health & Family welfare department. • Daily / weekly / monthly Malaria and Dengue Fever cases to the CMO. • Notifiable diseases are reported immediately to control room to Chief Medical Officer • Morbidity / Mortality Statistics to the D.H.S. and when required by the Directorate of Health and Family Welfare.		
4.2	**Process of Creating Medical Records**		
4.2.1	Medical Record contains different sections for recording the information as • Identification Section • Medical Section • Nurses Section	Doctors & Nurses	
4.2.2	**Identification** The following particulars are provided at Admission counter by the Patient / Relatives. • Name of Patient • Father's / Husband's Name • Age & Sex • Occupation • Permanent / Emergency Address. • Telephone / Mobile Numbers • Nationality • Religion • Medico Legal Case if any.		
4.2.3	**Medical Section** The Medical Section is filled up by the Attending Doctor in the BHT. The notes include- • Initial diagnosis Record Sheet • History Record Form • Reasons for Admission • Physical Examination Record Form • Progress And Treatment Record (including operation notes) Form • Consultation Record Forms (special)		

Sl. No.	Activity	Responsibility	Reference Document/Record
	• Different Investigations Report Forms **In Special cases-** Consent Forms, Operation Record Form. A summary is given in case of Discharged – cured, LAMA, Discharge on request or Death. A copy of the same is preserved in the patient medical record. • In case of death, Medical certification of cause of death form is to be filled up by the attending Doctor. • A copy of the death certificate is preserved in the patient's medical record file.		
4.2.4	**Nurses In-charge** The Nurse in-charge should record the following: • Medication Record Forms • T.P.R. Chart. • Intake and Output Record Form. • Diet sheet	Nurses	Medication Record Form, T.P.R. Chart. Intake and Output Record Form, Diet sheet Discharge summary
4.3	**Medical Record from Admission to Discharge**		
4.3.1	A complete medical record of the patient from admission to discharge is maintained.		
4.3.2	• Admission request form is filled by the treating doctor. • The general inpatient case sheet/IPD booklet for patients is prepared at the time of admission at admission counters. • All data pertaining to the patient stay in the hospital and care provided are preserved in the patient's bed head ticket/IPD booklet by the nursing staff.		
4.3.3	Nursing Staff gets the discharge summary prepared from the Doctor.		
4.3.4	In case the patient is transferred or referred to another hospital the medical record contains information regarding reason and the name of the hospital where the patient is being transferred		
4.3.5	After discharge the medical record is checked for its completeness and duty ward nurse sends it to MR department.		
4.4	**Midnight Census:**		
4.4.1	Ward Census Reports from each ward is	Ward Nurse	Mid Night Census

Sl. No.	Activity	Responsibility	Reference Document/Record
	generated by nursing staff at night duty. The reports are submitted individually to the Emergency Medical Officer/ Nurse superintendent.		report
4.4.2	The record clerk collects the data from the Emergency Department/ nurse superintendent office the next morning and compiles the same for preparing the census report. The census report is submitted to the I/C of hospital on a regular basis.		
4.5	**Confidentiality and Integrity of Record**		
4.5.1	The hospital identifies its responsibility as custodian of medical records and observes the following procedures to maintain its confidentiality, security and integrity		
4.5.2	Patient is the owner of his medical record and no form of it would be made available to any third party without written authorization from the patient.		
4.5.3	**Retrieval / Accessibility of Medical Record:** • Maintains records. • Hands over the records as & when required by I/C of hospital for administrative purposes. • Physician / Surgeon for follow up purposes by getting permission from I/C of hospital. • Records required for Medico Legal Cases in the Court of Law by the Doctor • For Follow up of In-patients by the Doctors • Patient's relatives will require a written authorization from the patient for obtaining information from the medical records. However such information would not be given in original, a Xerox of the same would be handed over and signatures taken in specific format.		Medical record requisition slip
4.5.4	• If loss or tampering of patient's medical record data is reported, the medical record clerk would immediately inform the same to the Deputy I/C of hospital for appropriate action.	Medical record clerk	

Sl. No.	Activity	Responsibility	Reference Document/Record
	• S/He would form an internal committee under the Deputy I/C of hospital and would hold the enquiry in reality and would submit the report to I/C of hospital as per the committee's finding for further action. • In case the internal committee confirms any sort of negligence or discrepancy on part of any hospital employee, I/C of hospital would inform the same to higher authorities of the Health and Family Welfare Department for further action.		
4.5.5	The Medical Record Department is responsible for proper storage, retrieval and maintenance of confidentiality and security of the record.		
4.5.6	At the end of the day medical record clerk is responsible to lock the department in the presence of a security staff. The key is handed over to the MS office. There after the security department is made responsible for the protection of the medical record room.		
4.6	**Retention Policy** :		
4.6.1	The Department is responsible for consolidation of all Forms belonging to the patient for storage in a manner with the help of Admission Number, which is assigned at the time of Admission. These records are stored in the Medical Record Departments.		
4.7	**Security Policy**		
4.7.1	**Security of record:** • Access to Medical Records Department is limited to only the person who is authorized. • In case any record is issued to any designated individual as per the retrieval policy; the same is recorded in the outgoing patient record entry register for accountability. • No form of record is issued to any person without proper authorization from the designated authorities. • During non-working hours the security staff in responsible for safety of the		

Sl. No.	Activity	Responsibility	Reference Document/Record
	department		
4.7.2	At the end of the designated retention period the medical record clerk will seek written approval from the designated hospital authority, the medical records will be destroyed by the MR department.	Medical Record Clerk	
4.8	Hospital statistics like Infant and Maternal Mortality etc. to be documented and reported. Reporting of all the details to be done as per hospital and State Govt. norms.		

5. Records:

Sl. No.	Record Name	Record Number	Retention Period
1.	Mid Night Census register		
2.	Death Register		
3	LAMA Register		
4	Record Issue Register		

6. Process Efficiency Criteria:

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Medical Audit	No. of cases audited	
2	Death Audit	Proportion of deaths occurred in hospitals audited.	
3	Retrieval	Retrieval time of for medical records	

7. Reference Documents:

1. Medical Record Manual –WHO
2. Internal Statistical Classification of Diseases and Related Health Problem (ICD-10) – WHO

Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP-12 General Administration

Quality Assurance Team
Veerangna Awanti Bai Mahila Chikitsalaya, Lucknow

Objectives of General Administration

1. **The hospital maintenance & upkeep services will ensure Cleanliness, Sanitation & Environmental hygienic conditions in Indoor and Outdoor including hospital campus**
2. **Ensure an effective IP & BMW Management System**
3. **Ensure enhancement in Patient/Client and Employees Satisfaction (study through PSS/ESS)**
4. **Functional District Hospital Quality Assurance team will ensure periodic internal assessment of all the 12 departments for improvement**

SOP 12: Hospital Administration

Hospital Maintenance & Upkeep

1. Purpose:

To provide process, instructions and methodology for Management of House Keeping with the aim that

- Cleanliness is maintained
- Infection is controlled
- Customer Satisfaction is enhanced

2. Scope

The scope of the housekeeping services is to ensure cleaning of all internal and external areas of the hospital. It also includes:

- Sanitation and hygiene
- Odour control
- Waste disposal
- Pests, Rodents and Animal control
- Environmental Hygiene
- Infection Control

3. Responsibility:

a) Overall – Hospital Manager

b) Responsibility lies with the Matron along with a team to ensure standards in housekeeping.

4. Procedure:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	**Service Provision** Housekeeping service in the hospital is outsourced to an external agency which has deployed adequate numbers of housekeeping staffs (as per contract) in the hospital for the general upkeep and cleanliness.	Medical Superintendent	Contract between the hospital and the Outsourced agency
4. 2	**Duty Roster** The Duty roster for the in-house housekeeping staff is maintained by the Hospital Manager to maintain the cleanliness and hygiene in the hospital	Hospital Manger	Attendance register, Duty roster
4.3	**Duty Roster (out Sourced)** Housekeeping staff is available in the hospital 24*7 on the rotation basis.	Housekeeping Supervisor	Duty Roster
4.4	**Housekeeping Procedures-**		
4.4.1	• The floor is cleaned weekly. • Detergent and copious amounts of water shall be used during one cleaning.	Housekeeping Staff	Housekeeping Check list

Sl. No.	Activity	Responsibility	Reference Document/Record
	• Mopping of the floor is done with the Phenyl and water. • The mopping is always done in one direction.		
4.4.2	• The walls are washed with a brush, using detergent and water. • High dusting is done with a wet mop. • Fans and lights are cleaned with soap and water. • All work surfaces are disinfected by wiping with Bacilllocid / Carbolic Acid • Cupboards, shelves, beds, lockers, IV stands, stools and other fixture cleaned with detergent and water.	Housekeeping Staff	
4.4.3	Curtains are changed periodically or whenever soiled. These curtains are sent for regular laundering.	Housekeeping Staff	
4.4.4	• Patient's bed is cleaned every week with detergent and water. 1% hypochlorite is used when soiled with blood or body fluids. • The waste is collected, category wise from the wards, OT, LR all the departments and store them at identified location.	Housekeeping Staff	
4.4.5	**Miscellaneous items** Kidney tray, bed pans, urinals etc to be cleaned with detergent and water and disinfected with Phenyl.		
4.5	**Housekeeping Process for Operation Theatre:**		
4.5.1	**Before the start of the 1st case** Wipe all equipment, furniture, room lights, suction points, OT table, surgical light reflectors, other light fittings, slabs etc with soap solution.	Housekeeping Staff	
4.5.2	After each case: The operation theatre is cleaned –OT table and floor. In case of a spill, treat it according to the protocol.	Housekeeping Staff	
4.5.3	**Environment**. • Wipe used equipment, furniture, Operating table etc., with detergent and water. If there is a blood spill, disinfect with sodium hypochlorite before	Housekeeping Staff	

Sl. No.	Activity	Responsibility	Reference Document/Record
	wiping. • Empty and clean suction bottles and tubing with disinfectant		
4.5.4	**After the last case** The same procedures as mentioned above are followed and in addition the following are carried out. • Wipe over-head lights, cabinets, waste receptacles, equipment, and furniture with 0.5% Bacilllocid. • Wash floor and wet mop with liquid soap and then remove water and wet mop with Phenyl. • Clean the storage shelves scrub & clean sluice room. • Collect all the waste category wise in the specific colour coded bags, and keep them in the Bio medical waste storage site/location from where they will be collected by the outsourced agency.	Housekeeping Staff	
4.5.5	**Weekly Cleaning Procedure** • Remove all portable equipment. • Wipe lights and other fixtures with detergent. • Clean doors, hinges, facings, glass inserts with a cloth moistened with detergent. • Wipe down walls with clean cloth, mop with detergent. • Scrub floor using detergent and water .Use Phenyl to mop it finally. • Stainless steel surfaces – clean with detergent, rinse & clean with warm water. • Wash (clean) and dry all furniture and equipment (OT table, suction holders, foot & sitting stools, IV poles, basin stands, X-ray view boxes, hamper stands, all tables in the room, holes to oxygen tank, kick buckets and holder, and wall cupboards) • After washing floors, allow disinfectant solution to remain on the floor for 5	Housekeeping Staff	

Sl. No.	Activity	Responsibility	Reference Document/Record
	minutes to ensure destruction of bacteria.		
4.6	**Housekeeping Procedure for Isolation Room:**		
4.6.1	**Cleaning procedure for isolation room:** • Linen shall be stripped from the bed and shall be soaked for 1 hour in 1% sodium hypochlorite and then sent to the laundry. • All other articles like IV stands and furniture shall be cleaned with detergent and disinfected with phenyl. • Walls shall be cleaned with detergent and disinfectant with Bacilllocid solution. • The bathrooms shall be cleaned with detergent and disinfectant	Housekeeping Staff	
4.6.2	**At discharge (terminal disinfection):** • The pillows and mattresses are to be cleaned with detergent, disinfectant with 1% sodium hypochlorite and dried in sunlight for 24 hours. • Bed sheets, curtains, gowns and dusters must be removed, soaked in 1% sodium hypochlorite for one hour and then sent to laundry. • After disinfection, wash the room, wall, window, doors, bathroom, sink and furniture with soap solution after doing thorough high dusting in that cubicle. • Soak bed pan, urinal, kidney basin in bacillocid solution for 1 hour, wash with detergent and dry it under sunlight. • Bath basins, multi-bin, bucket, jugs, mugs are washed with soap solution and dried in sunlight. • Rubber sheets (Mackintosh) are to be cleaned with bacillocid, dried, powdered and replaced.	Housekeeping Staff	
4.7	**Housekeeping Process for Toilets and Bathrooms**		
4.7.1	• The floor of bathrooms is to be cleaned with a broom and detergent once a day and then disinfectant solution. • Toilets are cleaned with a brush using a detergent Disinfection with Phenyl is	Housekeeping Staff	Checklist

Sl. No.	Activity	Responsibility	Reference Document/Record
	done. Stain removal using Hydrochloric acid may be used. • Wash basins are cleaned with detergent powder every morning.		
4.7.2	• Spill management for blood and mercury (Refer annexure for SOP Hospital Waste Management).	Housekeeping Staff	BMW guideline
4.8	**Record keeping** • Check list of the cleaning process shall be maintained. • The waste generated shall be entered in the BMW register.	Housekeeping Staff	Housekeeping Cleaning Checklist BMW Generation Record Register
4.9	**Periodical Check** Periodical check by hospital manger/Matron/deputed officer shall be done and housekeeping check list shall be signed.	Hospital Manager	Housekeeping Cleaning Checklist

5. Reference Records

Sl. No.	Record Name	Record No.	Retention Period
1	Attendance register		
2	Duty Roaster		
3	Cleaning checklist		
4	Bio-Medical waste Register		

6. Process Efficiency Criteria

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Cleaning	Hygiene Score	

7. Reference Documents:

- IMEP guidelines : Ministry of Health and Family Welfare, Govt. of India
- Hospital waste Management
- Out Patient Management
- In patient Management
- Emergency and disaster Management
- OT and CSSD Management

Hospital Infrastructure and Equipment Maintenance Management

1. Purpose:

Establish and implement a procedure for of systematic maintenance of equipment & infrastructure so as to ensure effective provision of services in the hospital.

2. Scope:

It covers all the equipment essential for operation of the services, infrastructure and equipment.

3. Responsibility:

Maintenance of Equipment- Medical Superintendent/ Hospital Manager
Maintenance & development of Infrastructure - Medical Superintendent.

4. Procedure:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	**Infrastructure Development**		
4.1.1	Renovation and up-gradation of the hospital building and premises including high cost equipment is undertaken/ procured as per the State Govt. norms.	Medical Superintendent	
4.2	**Infrastructure Maintenance**		
4.2.1	The civil annual preventive maintenance includes the following: • Cleaning of the terraces of the hospital • Proper weeding should be there • Repair of plasters, fixing window glass panes, water proofing measures to handle leakage, seepage and drainage. • Ensuring that all patient care areas are free from Fungus –if fungal growth is noticed than anti-fungal paints is applied. • Fencing of every new construction and maintenance activities to reduce pollution of patient care areas. • Lubrication of all the hinges of doors and windows for smooth movement. • Prevent collection and blockage of water within the premises of the hospital to prevent breeding	Engineering Maintenance Staff	Report/ Proposal

Sl. No.	Activity	Responsibility	Reference Document/Record
	ground for mosquitoes. • Annual Pest Control measures are undertaken to ensure rodent and pest free environments. • Maintenance of Hospital Landscape, including gardens and other green areas. • Ensure proper ventilation and lighting of patient care areas and other work stations.		
4.2.2	• All major areas to undergo preventive maintenance. • Necessary estimates and technical specifications are drawn with the help of Contractors/PWD/maintenance department of the hospital. • The plan is sent for approval and for necessary budgetary sanction to the Rogi Kalyan Samiti (RKS) or to the relevant Government Authorities depending upon the size of estimated budget for the activity. • While the smaller projects are handled at the level of RKS, bigger projects need approval at the level of the State and District Health Societies /department. • Post sanctions, tendering process is initiated. • The TOR for the job clearly defines the deliverables with specifications, timelines for completion of scheduled task and defines penalties clauses for non-completion /unsatisfactory work done, so that progress of the project is monitored suitably.	MS/ Finance Head /Maintenance Head/ Hospital Manger	Report/ Proposal Tender notice Signed agreement
4.2.3	• Cleaning drains, removal of debris and Plumbing are a continuous activity and is planned by the plumber and civil engineering staff on a daily basis during their regular Rounds of the patient care areas	MS/ Maintenance staff	

Sl. No.	Activity	Responsibility	Reference Document/Record
	and hospital campus. • The electrical maintenance staff plans their activities during their regular rounds in the patient care areas • The required items are indented by the civil and electrical maintenance staff. • The required items are either supplied by the stores or procured from the local market with due approval from the MR depending upon the availability of budgetary provisions for the sanctioned heads.		
4.2.4	• A Complaint Book shall be maintained by all departments and wards. • In case of any event besides the regular maintenance, a complaint shall be sent to the maintenance department by the concerned Departmental Head. • All repair works that are initiated should define the timelines for the completion of the job with due approval from the Engineering Department Head or the MR/ supervisor designated by MR and intimates the same to the complainer. • The progress of the job is monitored based on the timeliness of the completion of the complaint received and the level of satisfaction of the complainer. • No repair and maintenance job is considered complete till a completion certificate is received from the complaining departmental supervisor/in-charge.	Department heads / Maintenance staff	Maintenance book
4.3	**Process of preventive and breakdown maintenance of installed bio medical equipment & furniture**		
4.3.1	• Procurement Incharge with the help of department heads, looks	MS of hospital	Equipment Maintenance Register

Sl. No.	Activity	Responsibility	Reference Document/Record
	after the overall maintenance of the equipment. • A **master list of equipment with the approved agencies for maintenance** is maintained centrally in one file along with the valid contracts • At the time of procurement, the equipments are being procured with CMC/AMC. • For equipment not being covered under AMC / CMC, maintenance Plan is prepared. • Maintenance Plan will contain Annual Maintenance Schedules. • In case vendors do not provide maintenance services, request would be sent to parties interested in undertaking such exercises. • A list of Calibration service will be made annually. • Necessary Budgetary estimates will be made annually for these maintenance works and due sanction sought. • All departments should necessarily display the various lists described above along with their Calibration /maintenance status. • The procurement Incharge and Department Heads shall work in close Coordination to see that Calibration and Maintenance work are carried out as per the scheduled plan.		
4.4	**Process of preventive and breakdown maintenance of utilities :**		
4.4.1	All the fire fighting equipment whether ABC powder based or the conventional one is inspected for its specified standard pressure once in every six months.	Maintenance In-charge	
4.4.2	All the signage's along with citizen charter are updated from time to time and check of maintenance every six monthly.	Maintenance in-charge and hospital manager.	

5. Records:

Sl. No.	Name of Records	Record No.	Minimum Retention Period
1	Case file containing Breakdown Report, Proposal, approval letter, tender/quotation, agreement, offer letter NOC etc.		
2	Equipment Maintenance Register		
3	Equipment history record		
4	AMC record.		
5	Calibration record		

6. Process Efficiency Criteria:

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	AMC	% of equipment covered under AMC	
2	Repair	Turn around time for repair	
3	Maintenance	Downtime for critical equipment	

7. Reference Documents

- State Govt. Guideline for maintenance of equipment and infrastructure

Hospital Security and Safety Management

1. Purpose:

- To ensure safety and security of the Hospital building, equipment, patients and staff.
- To provide safe and assuring environment in the hospital premises for efficient delivery of healthcare services and review for improvement.

2. Scope :

This covers all infrastructure & services provided by hospitals which have direct bearing on security and safety such as

- Infrastructure & hospital property
- Control & flow of visitors
- Safety of Patients, visitors and service providers.

3. Responsibility:

A) Security- Hospital Manager and Security Personnel are responsible for effective implementation of the process.

B) Safety- Medical Superintendent/Hospital Manger/ Departmental In charge and all staff.

4. Procedure:

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1	**Security**		
4.1.1	**Planning the requirements for Infrastructure Security** Requirements are identified for resources needed for safety and security of Hospital infrastructure and environment & sent to District Health Society /M.S.	Medical Superintendent / Hospital Manager	
4.1.3	**Allocation / Posting of Security Staff at various points** • Security staff is positioned at different entry gates or strategic places in the hospital such as at Patient Registration, OPD, Wards and Labor room, OT, Emergency, ICU, Nursery, Parking and Mortuary etc. • Special duties are also assigned for VIPs based on the information received. • 24X7 security guards are available in hospital.	Security Staff	

Sl. No.	Activity	Responsibility	Reference Document/Record
4.1.4	**Control of Incoming & Outgoing Items** All purchased items when received in hospital, are checked by security guard at Security Gate and then are allowed to move in hospital stores. Same process is followed before moving any item out. A Gate Pass System (in Triplicate) is used for outgoing and incoming items. ***For goods/Articles going out :*** 1. Guard at hospital Gate. 2. User (Along with goods/articles). 3. Hospital/ Office copy. ***Any articles/goods coming in :*** 1. One copy along with goods/Articles 2. One copy with Guard at HOSPITAL 3. Office copy. All Passes are countersigned by Pharmacist /Accountant/ MS /Hospital Manager.	Security In charge/Indenter/In charge stores/User section	
4.1.5	**Keys Control** A key records register with details of keys and department concerned is maintained with details of Keys Issue, and Keys returned.	Hospital Manager.	Keys Register.
4.1.6	**Restricted visiting Hours:** Visiting Hours for attendants and visitors are fixed and displayed in the Hospital: Morning: 9:00 am – 10:00 am. Evening: 4:00 pm- 6:00 pm Two Visitor passes are issued for all the patients admitted in the Hospital. • One is for attendants requiring stay along with the patient at night, and • One pass for visitors visiting other than visiting hours. Attendants are allowed Entry only after producing the relevant Pass.	Security Guard/Duty Nurse	
4.1.7	**Fire Safety and Its controls** • The Hospital obtains NOC of Fire Safety from the Fire Department and an annual request is sent to the department for appraisal of the Building and fire safety measures. • The hospital has been declared 'No Smoking' zone. • Fire extinguishers and sand buckets are placed at different marked	Hospital Manager/ Fire Safety Officer	Layout of hospital indicating Fire extinguisher / Sand bucket , Fire Extinguisher file

Sl. No.	Activity	Responsibility	Reference Document/Record
	points throughout the hospital. A Hospital layout indicating fire extinguisher / sand bucket is also kept/ displayed in the hospital premises • Hospital Layout with fire exit plan is also displayed. • Fire exit is marked in the hospital for exit during fire. • In collaboration with Fire Department, Fire Training and Fire drills are held at periodic intervals. All employees are provided adequate training on Fire Safety. They are informed about the fire evacuation procedures including fire exits located in their work places. • Checking and testing of Fire extinguishers and its refilling is maintained. • A list of all fire devices is maintained for effective control.		
4.1.8	**Training to Security Personnel** Training on security related issues such as queue management, crowd control, etc. and use of fire extinguisher, sand bucket are conducted as per the need on approval of Facility In charge	Training In charge	Training File
4.2	**Safety**		
4.2.1	**Hospital Safety Committee:** The Hospital Safety Committee is a multidisciplinary committee consisting of five members. It is constituted by Head of RKS. It meets at least two times in a year or when required, to evaluate the various safety aspects of the hospital. The Committee undertakes detail analysis of the ongoing monitoring activities and gives its feedback on the same. The Committee submits its report in the meeting of Rogi Kalyan Samiti conducted for the hospital.	Medical Superintendent	List of Hospital Safety Committee Members
4.2.2	**Evaluation of Hospital Activities with respect to Safety** The Hospital Safety Committee evaluates the ongoing monitoring activities on various	Hospital Safety Committee	

Sl. No.	Activity	Responsibility	Reference Document/Record
	aspects of the following problems: 1. Injuries to patients/ visitors 2. Property damage. 3. Occupational illnesses and injuries to staff 4. Hazardous materials and waste spills, exposures, and other related incidents 5. Security incidents involving patients, staff, and visitors in the hospital 6. Fire-safety management problems, deficiencies, and failures. 7. Utility systems management problems, failures, or user errors. 8. Staff mobilization during Weather Emergencies, and natural disasters.		
4.2.3	**Hazard recognition:** Departmental Heads and Hospital Manager identifies hazards within their specific area of control. The same is notified to the appropriate hospital authorities for immediate corrective actions. Audits are undertaken on a periodical basis to identify the measures taken to prevent/reduce the impact of the potential hazards	Departmental heads/Hospital manager	
4.2.4	**Safety Inspection and Records** The hospital undertakes periodic inspection of the safety precautions. These inspections are conducted at least twice a year or when required.. The reports of the safety inspections are reviewed by the hospital's safety committee and the same is submitted to RKS as and when required. The safety Inspection records are maintained with respective departmental authorities The Hospital Safety Committee may require periodic assessment of the following safety aspects: 1. Infection control for e.g. hand hygiene, cleaning, disinfection, sterilization. 2. Patient safety 3. Electrical/Fire safety for e.g. open wiring, fire extinguishers, fire mock drill etc. 4. Biological and chemical hazards 5. Personal Protective Equipment status. 6. Building safety for e.g. seepage, broken	Hospital Safety Committee	Hospital Safety Inspection Records

Sl. No.	Activity	Responsibility	Reference Document/Record
	windows etc. 7. Hospital security Each inspection report records pertinent safety management violations, noncompliance items, and observe deficiencies. Employees directly involved in the use or operation of the facilities or function being inspected is to participate in the inspection process. Corrective and preventive measures are undertaken and implemented.		
4.2.5	**Electrical Safety** The hospital undertakes the following measures to ensure Electrical Safety: • Inspection of the power outlets throughout the hospital at defined frequency & SOS. • Trip Switches are located in different parts of the hospital to prevent short circuits. • Inspection of wires to ensures that they are in appropriate conditions, at defined frequency.. • Electrical equipment not required during the night is switched off. • Areas around electrical switchboards are kept clear for a distance of at least 1 meter. • Suitable fire extinguishers are located adjacent to electrical switchboards.	Maintenance Staff/ Electricity Department	
4.2.6	**Biological Hazards** The Hospital identifies primary causes for biological hazards which are: ➢ Infectious Sharp Objects ➢ Blood and Body fluid spill ➢ Biomedical Waste ➢ Hospital Acquired Infections Biological Hazards are prevented and managed as per Standard Procedures for Hospital Infection Controls.	Hospital Infection Control Committee	SOP for Hospital Infection Control
4.2.7	**Laboratory Safety** Standard precautions like personal protective equipment (PPE), safety devices and proper decontamination and disposal of biohazard us wastes are the Laboratory Safety Policy specifies in details the safety	Laboratory Staff	SOP for Laboratory Services

Sl. No.	Activity	Responsibility	Reference Document/Record
	measures undertaken by the hospitals		
4.2.8	**Staff Safety:** All staff including out sourced staff goes through periodic health check-up. All staff is vaccinated against TT and Hepatitis-B. Adequate PPE are provided to all categories of staff. Radiographers are provided with lead aprons and TLD batches which are evaluated periodically at BARC or its designated laboratory.	MS/state Health department.	

5. Records

Sl.No.	Record Name	Record No.	Retention Period
1	Duty Roster Of Security Personnel		
2	Attendance Register		
3	Safety Inspection Report & Their Action		
4	Details of Fire Extinguisher & maintenance		
5	Accident Report file		

6. Process Efficiency Criteria

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Patient Safety	Patient Safety Score	
2	Mock Drills	No. of fire mock drills conducted in year	
3	Security	No. of incidences of pilferage/theft in the year	

7. Reference:

1. IP & BMW management Act
2. Fire Safety rules
3. Housekeeping in the public health Facilities guidelines
4. AERB rules

ANNEXURE

A. ADVERSE DRUG REACTION/SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

(The from shall be filled in case of any adverse drug reaction or suspected adverse drug reaction and shall be sent to administrator/Hospital Safety Committee. The reporting shall as soon as possible after occurrence of reaction and after the corrective measures.)

Patient Information			
Name		**IPD No**	
Doctor Incharge		**CR No.**	
Date of Admission		**Sex**	
Room No		**Height /Weight**	

Suspected Medicine						
S. No.	**Name & Brand or generic name.**	**Manufacturer (if Known)**	**Batch No /Lot No.**	**Date of Expiry**	**Route Used**	**Reason for use or Prescribed for**

Visual Inspection of Vial : Intact/Turbidity/fungal Growth/Sedimentation (Circle the appropriate)
Remarks:

Suspected Adverse Reaction	
Date of reaction started	
Date of Recovery	
Describe reaction or problem	

Seriousness of Reaction

- ☐ **Death**
- ☐ **Life Threatening**
- ☐ **Hospitalization-initial or prolonged**
- ☐ **Disability**
- ☐ **Congenital Anomaly**
- ☐ **Required intervention to prevent permanent impairment/damage**
- ☐ **Other (specify)**

Outcomes

- ☐ **Fatal**
- ☐ **Continuing**
- ☐ **Unknown**
- ☐ **Recovering**
- ☐ **Recovered**
- ☐ **Other (specify)**

Cause of reaction	
Wrong drug to wrong patient	
Wrong dose	
Wrong route	
Wrong rate of administration	
Other	
Not a medication error	

Reported by (Doctor on Duty)	
Name of Doctor: ..... **Date of Reporting.....** **Signature .....**	

Does the reaction abated after stopping drug or reducing dose – Yes / No

Action Taken after Reaction		
Relevant Test /Laboratory Data including date		
Culture of Medicine	**Date of Sending culture**	**Report(Findings)**
Bacterial Culture		
Fungal Culture		
Note : If two or more then two Drug Reaction noted with same batch no. Then culture should be sent		
Drug Formulary Committee Remarks		
Final Decision		
Signature..... **Head Drug Formulary Committee** **Name.....** **Date .....**		

B. Blood Transfusion Reaction Report

(To be used for investigation of suspected reactions to blood products)

Patient Name:

Hospital

Ward:.....Patient ID:.....

Please complete form and forward with appropriate blood specimens and used pack to the ..... Hospital Blood Bank.

Date:.....	Clinical Diagnosis:
Product Transfused:.....	Time Commenced:.....
Donation (pack) number:.....	Volume Transfused:.....ml

Clerical Check (please circle)

Patient ID correct	Blood pack correct	Blood Transfusion Record correct
Yes / No	Yes / No	Yes / No

Temperature in the 24 hours prior to transfusion: (Please tick) FEBRILE ☐ AFEBRILE ☐

Vital Signs	Time	Temperature	Respiratory Rate	B.P.	Pulse Rate
Pre Reaction					
Post Reaction					

Signs and Symptoms – Please Tick

Fever ☐	Lower Back pain ☐	Skin Pallor ☐
Chills ☐	Chest pain ☐	Dark Urine ☐
Nausea / Vomiting ☐	Anxiety ☐	Dyspnoea ☐
Hives / Itching ☐	Headache ☐	Bleeding from wound or IV site ☐
Others ☐		

Please document any blood products given in previous 12 hours:

Donor Unit Number	Product Type	Date	Time Units		Volume	Reaction

Reviewing Doctors:

Signature:

Name:..... Date:.....

C. ACCIDENT/ INCIDENT REPORT

Document FACT only (NOT opinion)

Write LEGIBLY
Serious injury/ death must be reported immediately to the concerned authority at …….

1	Name & Address : Age: Sex: M/F Time: Location: Tel (R) Tel (M) E-mail (please tick) Patient ☐ Healthcare worker ☐ Visitors ☐
2	Type of accident/ incident severity **Clinical:** Needle Stick ☐ Injury ☐ Mercury Spill **Non Clinical :** Loss of valuable Items
3	Details of Accident/ Incident (Equipment) Equipment model Removed form service ☐ N ☐
4	Accident/Incident reported to: Name : Designation: Date & time: Signature
5	Subsequent action: To be completed by Line Manager on duty at the time of incident

D. List of Sentinel Events

Followings are the Sentinel Events identified and defined by the Hospital.

1. Wrong Surgery on wrong Part.
2. Adverse Drug Reaction.
3. Mismatched Blood Transfusion.
4. Baby Charring in NICU.
5. Gangrene of the Limb of the Baby.
6. Aspiration Pneumonia.
7. Displacement of Joint due to Mal positioning by the Staff.
8. Occupational Hazards.
9. Bed Sore.
10. Hospital acquired infection.
11. Fall from Bed.
12. Stick Injury (Needle stick injury)

E. Mission and Vision of Hospital

दृष्टिकोण एवं उद्देश्य

दृष्टिकोण :

चिकित्सालय में आने वाले समस्त रोगियों को गुणवत्तापरक उत्कृष्ट पेशंट/क्लाइंट केंद्रित सेवायें प्रदान करना तथा गुणवत्ता के क्षेत्र में प्रदेश में महत्तवपूर्ण अग्रणिय स्थान प्राप्त करके 'मॉडल महिला चिकित्सालय' का स्तर प्राप्त करना। हमारे दृष्टिकोण सें 'स्वस्थ मॉ एवं नवजात–सम्पन्न भवष्यि' की नीवं है।

उद्धेश्यः

1. चिकित्सालय में आने वाले समस्त रोगियों को आधुनिक तकनीकियों के माध्यम से गुणवत्तापरक उत्कृष्ट 'प्रजनन मातृ, नवजात शिशु, बाल स्वास्थ्य तथा किशोरी स्वास्थ्य' (आर0एम0एन0सी0एच0ए0) सेवायें प्रदान करना।

2. रोगी के स्वास्थ्य सुधार एवं संतुष्टि स्तर में निंरतर सुधार करने की प्रतिबद्धताः

   - वर्तमान रोगी संतुष्टी (ओ0पी0डी0 3 को बढाकर 3.5 स्तर प्राप्त करना)।
   - सभी कर्मचारियों को प्रशिक्षित एवं निर्देशित करना।
   - चिकित्सालय का वर्तमान लामा रेट 5.07 को घटाकर 4.8 पर लाना है।
   - जननी सुंरक्षा योजना के अन्तर्गत डिस्चार्ज से पहले प्रसूता को भुगतान करने का वर्तमान स्तर 93.28 से बढाकर 95 प्रतिशत लाना है।

अस्पताल प्रबन्धन

Vision & Mission

Vision:

To be recognized as leader in quality, patient-centered, cost effective healthcare services. Our motto is "Healthy mother & new born - Wealthy future".

Mission:

- To provide Special Gynecological & Obstetrics services using state of art Technology.
- Committed to improve health and satisfaction level of our patients by ensuring continuous improvement by:
  - Training of all categories of staff
  - Latest treatment technologies
- To develop as a leading referral centre for Gynecological & Obstetrics Patients.

Hospital Management

F. Mission and Vision of Sick Newborn Care Unit

दृष्टिकोण एवं उद्देश्य

दृष्टिकोण :

चिकित्सालय में आने वाले समस्त शिशु रोगियों को गुणवत्तापरक उत्कृष्ट सेवायें प्रदान करना तथा गुणवत्ता के क्षेत्र में प्रदेश में महत्तवपूर्ण स्थान प्राप्त कर चिकित्सा सेवाओं को अत्याधिक सुविधाजनक बनाना।

उद्धेश्यः

1. चिकित्सालय में आने वाले समस्त शिशुओं को आधुनिक तकनीकियों के माध्यम से गुणवत्तापरक उत्कृष्ट सेवायें प्रदान करना।
2. रोगी के स्वास्थ्य सुधार एवं संतुष्टि स्तर में निंरतर सुधार करने की प्रतिबद्धताः
   - सभी कर्मचारियों को प्रशिक्षित एवं निर्देशित करना।
   - अत्याधुनिक रोगोपचार तकनीकों का उपयोग करना।
3. शिशुओं के लिए रेफरल संस्थान के रूप में स्थापित होना।

अस्पताल प्रबन्धन

Vision & Mission

Vision:

To be recognized as leader in quality, patient-centered, cost effective healthcare working towards Healthy patients Wealthy future.

Mission :

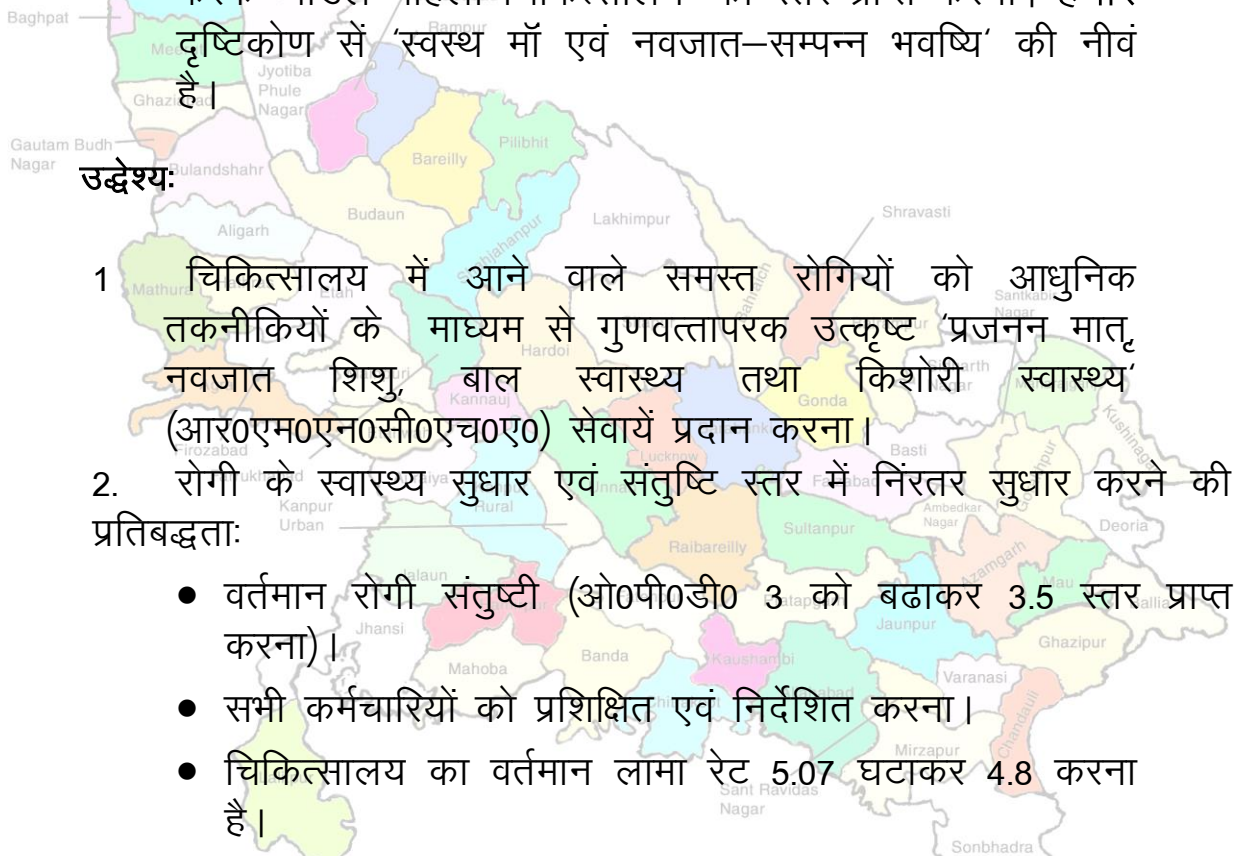
- To provide Special Gynecological & Obstetrics services using state of art Technology.
- Committed to improve health and satisfaction level of our patients by ensuring continuous improvement by:
  - Training of all categories of staff
  - Latest treatment technologies
- To develop as a leading pediatric referral centre.

Hospital Management

G. दृष्टिकोण एवं उद्देश्य

दृष्टिकोण :

चिकित्सालय में आने वाले समस्त रोगियों को गुणवत्तापरक उत्कृष्ट पेशंट/क्लाइंट केंद्रित सेवायें प्रदान करना तथा गुणवत्ता के क्षेत्र में प्रदेश में महत्तवपूर्ण अग्रणिय स्थान प्राप्त करके 'मॉडल महिला चिकित्सालय' का स्तर प्राप्त करना। हमारे दृष्टिकोण सें 'स्वस्थ मॉ एवं नवजात–सम्पन्न भवष्यि' की नीवं है।



उद्धेश्यः

1 चिकित्सालय में आने वाले समस्त रोगियों को आधुनिक तकनीकियों के माध्यम से गुणवत्तापरक उत्कृष्ट 'प्रजनन मात्, नवजात शिशु, बाल स्वास्थ्य तथा किशोरी स्वास्थ्य' (आर0एम0एन0सी0एच0ए0) सेवायें प्रदान करना।

2. रोगी के स्वास्थ्य सुधार एवं संतुष्टि स्तर में निंरतर सुधार करने की प्रतिबद्धताः

- वर्तमान रोगी संतुष्टी (ओ0पी0डी0 3 को बढाकर 3.5 स्तर प्राप्त करना)।
- सभी कर्मचारियों को प्रशिक्षित एवं निर्देशित करना।
- चिकित्सालय का वर्तमान लामा रेट 5.07 घटाकर 4.8 करना है।
- जननी सुंरक्षा योजना के अन्तर्गत डिस्चार्ज से पहले प्रसूता को भुगतान करने का वर्तमान स्तर 93.28 से बढाकर 95 प्रतिशत लाना है।

H. NEEDLE STICK INJURY FORM

Sr. No.	Parameters		Remarks
1.	**Name of Health Care Worker (HCW)**		
2.	**Name of the Unit & Department**		
3.	**Date and Time of Needle Stick/Sharp Injury**		
4.	**Date and Time of Reporting to ICN**		
5.	**Site of Injury**		
6.	**Nature of Injury**	Needle Prick /Sharp Cut/Lacerations/Splash of Fluids / Splattered Glass/Others(Please specify)	
7.	**Source of Injury (If Available)**		
8.	**Action taken on site**		
9.	**Pre-exposure Prophylaxis given**	Yes/No	
10.	**Date Time & Type of Vaccination**		
11.	**Whether vaccination taken after exposure**	Yes/No	
12.	**If taken after exposure Date Time and Type of Vaccination**		
13.	**If not taken after exposure reasons for the same**		
14.	**Test Results after exposure with method used.**		

Filled By:_____ Submitted to:_____

Action Taken_____

I. बाहय रोगी फीडबैक

प्रिय रोगी,

आपने अपना बहुमूल्य समय इस चिकित्सालय में अपने रिश्तेदारों/परिवारजनों के इलाज हेतु दिया। हमारा आपसे विनम्र अनुरोध है कि आपने कीमती सुझाव इस चिकित्सालय में दी जाने वाली सुविधाओं के परिप्रेक्ष्य में हमें बतायें जिससे यहां पर आपकों उपलब्ध करायी जाने वाली चिकित्सीय सुविधाओं को और अधिक बेहतर बनाने में हमें सहायता मिल सके।

कृप्या उचित खाने में सही (✓) का चिन्ह लगायें।

क0 सं0	विषेषतायें	खराब	उचित	अच्छा	बहुत अच्छा	सबसे अच्छा	टिप्पणी
1	चिकित्सालय में दी जाने वाली सुविधाओं की उचित जानकारी दियें जाने के सम्बन्ध में।						
2	पंजीकरण पटल पर प्रतीक्षा के समय के सम्बध में।	30 मिनट से अधिक	10–30 मिनट	5–10 मिनट	5 मिनट के अन्दर	तत्काल	
3	चिकित्सालय कार्मिकों के आचरण एवं व्यवहार के सम्बन्ध में।						
4	ओ0पी0डी0 एवं शौचालय की साफ–सफाई के सम्बन्ध में।						
5	चिकित्सकों का आचरण एवं बोलचाल तथा व्यवहार के सम्बन्ध में।						
6	चिकित्सकों द्वारा परीक्षण के दौरान एवं उनसे प्राप्त होने वाली सलाह के सम्बन्ध में।						
7	प्रयोगशाला एवं एक्स–रे की उपलब्धता के सम्बन्ध में।						
8	औषधि वितरण पटल पर औषधि की तत्काल उपलब्धता के सम्बन्ध में।						
9	चिकित्सालय में औषधियों की उपलब्धता के सम्बन्ध में।						
10	चिकित्सालय में आप द्वारा बिताये गये समय के बाद आप कितने सन्तुष्ट रहे।						

आपके सुझाव–

दिनांकः–.....ओ0पी0डी0रसीद सं0ः–.....नामः–.....

J. भर्ती रोगी फीडबैक

प्रिय रोगी,

आपने अपना बहुमूल्य समय इस चिकित्सालय में अपने रिश्तेदारों/परिवारजनों के इलाज हेतु दिया। हमारा आपसे विनम्र अनुरोध है कि आपने कीमती सुझाव इस चिकित्सालय में दी जाने वाली सुविधाओं के परिप्रेक्ष्य में हमें बतायें जिससे यहां पर आपकों उपलब्ध करायी जाने वाली चिकित्सीय सुविधाओं को और अधिक बेहतर बनाने में हमें सहायता मिल सके।

कृप्या उचित/सन्तुष्टिजनक खाने [✓] का चिन्ह लगायें।

क0 सं0	विषेषतायें	खराब	उचित	अच्छा	बहुत अच्छा	सबसे अच्छा	टिप्पणी
1	पंजीकरण एवं भर्ती पटल पर सूचनायें उपलब्ध कराने के सम्बन्ध में।						
2	पंजीकरण एवं भर्ती पटल पर प्रतीक्षा करने के सम्बन्ध में।	30 मिनट से अधिक	10–30 मिनट	5–10 मिनट	5 मिनट के अन्दर	तत्काल	
3	पंजीकरण एवं भर्ती पटल पर कार्मिकों का आचरण एवं व्यवहार।						
4	निरावेशित करने की प्रक्रिया के समय पर आपकी सन्तुष्टि।						
5	भर्ती कक्ष की साफ–सफाई के सम्बन्ध में।						
6	स्नानागार एवं शौचालय की साफ–सफाई के सम्बन्ध में।						
7	बिस्तर की चादरों एवं तकियों के कवर की साफ–सफाई के सम्बन्ध में।						
8	चिकित्सालय परिसर एवं नालियों की साफ–सफाई के सम्बन्ध में।						
9	चिकित्सकों द्वारा नियमित ध्यान दिये जाने के सम्बन्ध में।						
10	चिकित्सकों का आचरण एवं बोलचाल तथा व्यवहार के सम्बन्ध में।						
11	चिकित्सकों द्वारा परीक्षण एवं उनसे प्राप्त होने वाली सलाह के सम्बन्ध में।						
12	भर्ती कक्ष में उपचारिका द्वारा तत्काल प्रतिकिया किये जाने के सम्बन्ध में						
13	चिकित्सालय भर्ती कक्ष में उपचारिका द्वारा समय–2 पर निरीक्षण किये जाने के सम्बन्ध में।						
14	उपचारिका का आचरण एवं बोलचााल तथा व्यवहार के सम्बन्ध में।						
15	कक्ष सेवक/सेविका की उपलब्धता, आचरण, तत्परता के सम्बन्ध में।						
16	सभी निर्धारित औषधियां चिकित्सालय आपूर्ति द्वारा उपलब्ध कराये जाने के सम्बन्ध में।						
17	चिकित्सक का ज्ञान आपकी जानकारी में है इस सम्बन्ध में।						
18	चिकित्सालय में निदान सेवा मुहैया होने के सम्बन्ध में।						
19	समय से भोजन की आपूर्ति के सम्बन्ध में।						
20	रोगी के रूप में बिताये गये समय के दौरान आपकी सन्तुष्टि के सम्बन्ध में।						

आपका महत्वपूर्ण सुझावः–

दिनांकः–.....आई0पी0डी0रसीद संख्या0ः–..... कक्ष संख्या.....

.नामः–.....

K. Prescription Audit

IP/OP number.

_____

Name of patient written with IP/OP number	1	2	3	4	5	6	7	8	9	10
Medication written in capital letter										
Medication orders are clear and easily readable										
Medication orders have date and time mentioned										
Medication orders have route mentioned										
Medication orders have dosage mentioned (not required for single dose)										
Medication orders have frequency mentioned										
Prescription/Medication order is signed										
Prescription/Medication order is named										
Whether the drug is relevant to the disease/condition?										
Any drugs or combination of drugs which cause drug-drug interaction										

Date- **Signature of the Auditor**