STANDARD OPERATING PROCEDURES OBSTETRICS AND GYNAECOLOGY

Frontier Medical &DentalCollege, Abbottabad

DOCUMENT PREPARATION /APPROVAL AUTHORITIES:

Prepared By:	
Sr #	**Name**
1.	**PROFESSOR Brig Rtd Mamoona Mushtaq** Shaheena Jameel Teaching Hospital HOD Obs&Gynae Department FMDC
2.	Professor Surrya Yasmeen MBBS,DGO,FCPS **Incharge Unit 2 SJTH mFMDC**

Reviewed By:	
1.	**Dr Fareeda Pervaiz** BDS, Master Medical Education HOD Medical Education Department FMDC

Design & Formatting	
1.	**Mr Ayaz** Project Management Unit HR Department FMDC
2.	**Mr Usama** Project Management Unit

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1 ABBREVIATIONS

AAC	Access, Assessment and continuity of care
ABC	Airway Breathing Circulation
ABGs	Arterial blood Gases
ACLS	Advanced Cardiac Life Support
ADLs	Activities of Daily Life
AM	Ante meridiem
Anti-HCV	Antibody to Hepatitis C virus
APD	Acid Peptic Disease
APH	Antepartum Hemorrhage
APTT	Activated Partial Thromboplastin Time
ARDS	Acute Respiratory Distress Syndrome
ASA	American Society of Anesthesiologists
ASM	Aseptic Measures
AVD	Assisted Vaginal Delivery
BHU	Basic Health Unit
BLS	Basic Life Support
BMI	Body Mass Index
BP	Blood Pressure
BPP	Biophysical Profile
BSF	Blood Sugar Fasting
BSR	Blood Sugar Random
CBC	Complete Blood Count
CCF	Congestive Cardiac Failure

CCU	Coronary Care Unit
cm	centimeter
CMO	Chief Medical Officer
CN	Charge Nurse
CNIC	Computerized national Identification Card
CNS	Central Nervous System
CO2	Carbon Dioxide
COP	Care of Patient
COPD	Chronic obstructive pulmonary disease
CPR	Cardiopulmonary Resuscitation
CQI	Continuous quality Improvement
CRF	Chronic Renal Failure
CRP	C-Reactive Protein
CS	Cesarean Section
CSE	Combined Spinal Epidural
CTG	Cardiotocography
CUE	Complete Urine Examination
CVA	Cerebrovascular Accident
CVP	Central Venous Pressure
CVS	Cardiovascular System
D.O.A	Date of Admission
D.O.O	Date of operation
D/T given	date and time given
DHQ	District Head quarter
DM	Diabetes Mellitus
DMS	Deputy Medical Suprintendent
DOB	Date of Birth
DOR	Discharge on Request
DTP	Drug Therapy problem
DVT	Deep Venous Thrombosis
EAC	Equipment Audit Committee
ECG	Electrocardiography
EDD	Estimated Date of Delivery
EMO	Emergency Medical Officer
EMONC	Emergency Obstetric and Newborn care
ENC	Emergency Neonatal Care
ER	Emergency Room
ETCO2	End Tidal Carbon Dioxide
ETT	Endotracheal Tube
EUA	Examination under Anesthesia
FCPS	Fellow of College of Physicians and Surgeons of Pakistan
FFP	Fresh Frozen Plazma
FHR	Fetal Heart Rate
FHR	Fetal Heart Rate
FHS	Fetal Heart Sound
FM	Fetal Movement

FMS	Facility Management and Saftey
FP	family Planning
FRCOG	Fellow of Royal College of Obstetricians and Gynecologists
FSE	Fetal Scalp Electrode
GA	General Anesthesia
GCS	Glasgow Coma Scale
GDM	Gestational Diabetes Mellitus
GIT	Gastrointestinal System
GPE	General Physical Examination
H/O	History of
Hb	Hemoglobin
HbsAg	Hepatitis B surface Antigen
HCE	Health Care Establishment
HCl	Hydrochloride
HCO3	Bicarbonate
HCP	Heathcare Provider
HCT	Hematocrit
HIC	Hospital Infection Control
HIMS	Health Information Management System
HIV	Human Immunodeficiency Virus
HN	Head Nurse
HOD	Head of Department
HRM	Human Resource Management
HTN	Hypertension
HVS	High Vaginal Swab
ICN	Infection Control Nurse
ICP	Intracranial Pressure
ICU	Intensive Care Unit
ID	Identification
IHD	Ischemic Heart Disease
IM	Intramuscular
IMNCI	Integrated Management of childhood illnesses
IMPAC	Integrated Management of Pregnancy and Child Birth
IMS	Information Management System
INR	International Normalized Ratio
IUCD	Intrauterine Contraceptive Device
IV	Intravenous
JD	Job Description
JVP	Jugular Venous pulse
Kg	Kilogram
LAMA	Leave against medical advice
LFT	Liver Function Test
LHV	Lady Health Visitor
LHW	Lady Health Worker
LMP	Last Menstrual Period
LOC	Loss of consciousness

LOR	Loss of Resistance
LR	Labor room
LSCS	Lower Segment Cesarean Section
MAP	Mean Arterial Pressure
MBBS	Bachelor of Medicine and Surgery
MCH	Mother and Child Health
MCPS	Member of College of Physicians and Surgeons of Pakistan
MG SO4	Magnesium Sulphate
MI	Myocardial Infarction
ml	mililitre
MLC	Medicolegal cases
MO	Medical Officer
MOM	Management of Medication
MR	Medical Record
MRCOG	Member of Royal College of Obstetricians and Gynecologists
MSDS	Minimum Service Delivery Standard
N2O	Nitrous oxide
NG	Nasogastric
NICU	Neonatal Intensive care unit
NPO	Nothing Per Oral
NVD	Normal Vaginal Delivery
O2	Oxygen
OPD	Outpatient Department
OT	Operation Theatre
OTA	Operation Theatre Assistant
P&SHD	Primary and Secondary Health Department
PACO2	Partial Pressure of Carbon Diaoxide
PACU	Post Anesthesia Care Unit
PAO2	Partial Pressure of Oxygen in Arterial Blood
PCA	Patient controlled Analgesia
PER	Performance Evaluation Report
PG	Primigravida
PH	Potential Hydrogen
PHC	Punjab Healthcare Commission
PICU	Pediatric Intensive Care Unit
PIH	Pregnancy Induced Hypertension
Plt	Platelets
PM	Post meridiem
PMDC	Pakistan Medical and Dental Council
PMU	Project Management unit
PPE	Personal Protective Equipment
PPH	Post Partum Hemorrhage
PPM	Planned Preventive Maintenance
P-PROM	Pre-term Premature Rupture of Membranes
PRE	Patient Right and Education
PROM	Premature Rupture of Membranes

PT	Prothrombin Time
PV	Per Vaginal
R/R	Respiratory Rate
RBCs	Red Blood Cells
RFT	Renal Function Test
Rh factor	Rhesus Factor
RHC	Rural Health Centre
RHD	Rheumatic Heart Disease
RN	Registered Nurse
RPOC	Retained Product of conception
SC	Subcutaneous
SEARO	South East Asia Regional office
SGOT	Seum glutamic-oxaloacetic transferase
SGPT	Seum glutamic-pyruvic transferase
SNIC	Smart national identification card
SOP	Standard Operating Procedure
SPO2	Oxygen Saturation
SSI	Surgical Site Infection
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SVD	Simple Vaginal Record
TB	Tuberculosis
THQ	Tehsil Head Quarter
TIA	Transient Ischemic Attack
TLC	Total Leucocyte Count
TPN	Total Parenteral Nutrition
UPT	Urine Pregnancy Test
URTI	Upper Respirartory Tract Infection
USG	Ultrasonography
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
WBC	White Blood Count
WHO	World Health Organization
WMO	Women Medical Officer

2 PREFACE

The Government of Khyber Pakhtoon Khah is committed to the improve the Healthcare Services in accordance with Minimum Service Delivery Standards (MSDS) laid down by KPK Healthcare Commission. The goal of these Standard Operating Procedures (SOPs) is to involve staff working in obs and Gynae Hospitals under the administrative control of FMDC is implementing multiple initiatives to improve the healthcare standards .

MSDS for hospitals, prescribed by KPKHC and approved by the Government of KPK, are the minimum set of standards that a hospital must comply with while providing healthcare services. The standards can

only be complied with if the HCEs have proper infrastructure and material and human resources to provide the required care.. Development of Obstetrics and Gyne Manual is a component of the larger effort in this regard. The main aim of this manual is to enhance the quality of Obs and Gyne services in secondary health facilities of KPK. This manual will be a helpful resource and guide in everyday practice of Obstetrics and Gynecology.

Obstetrics and Gynecology is a practical subject. There are a lot of effort and management required in maintaining an Obstetrics and Gyne unit. This manual throws light on working of a Gyne unit. It encompasses physical setting and organizational plan of Gynae ward. It also highlights general and specialized standard operative procedures. It gives knowledge about equipment and their maintenance, safety guidelines, medical record management and how continuous quality control in ensured.

3 SCOPE

Obstetrics and Gynecology is a medical specialty that encompasses the two subspecialties of Obstetrics (covering pregnancy, child birth and postpartum period) and Gynecology (covering the health of the female reproductive system). Our scope for Maternity Services across Primary and Secondary Health setup is for them to become safer, more personalized, kinder, professional and more family friendly, where every women has access to information and enables her to make decisions about her care, and where she and her baby can access support that is centered on individual needs and circumstances.

The standards of care provided in this manual will apply to Obs & Gyne department at SJTH . The manual of the Obstetrics and Gynecology Department provide standard guidelines for departmental workflow and safe practices for patients and staff fostered in a culture of Continuous Quality Improvement (CQI). Revised SOPs may be added from time to time to keep up with international/ national standards for the conduct of safe medical practices to reduce morbidity and mortality.

4 LEGAL AND ETHICAL CONSIDERATION

4.1 MEDICAL ETHICS

Medical ethics is the application of the core principles of bioethics to medical and healthcare decisions.

1) Respect for autonomy; patient have autonomy of thought and action when making decisions regarding health care procedures. In order for a patient to give informed consent, She must understands all benefits, risk and alternatives of the procedure.
2) Beneficence requires that the procedures be provided with the intent of patient benefit.
3) Non- maleficence requires that a procedure does not harm the patient
4) Justice – HCP must consider fair distribution of resources, competing needs, rights and obligations and potential conflicts with established legislation.

4.2 LEGAL CONSIDERATIONS

Primary and Secondary Healthcare Department expects healthcare staff to:

1) Respect the rights and dignity of all individuals.
2) Comply with the laws and regulations governing the practice of obstetrics and gyne in the country in which they practice.
3) Provide honest, competent and accountable professional services.
4) Promote patient safety and quality standards.
5) Provide quality health care services.
6) Provide accurate information to patients and the community about maternity and women reproductive health services.
7) Contribute to the planning and development of services which address the health needs of the community.
8) Establish and maintain with the patient, an ongoing collaborative process of decision making that exists throughout the provision of services.

9) The Healthcare Providers shall not release patient information to a third party without consent of the patient or legal authorization.

5 DEPARTMENT

5.1 PHYSICAL SETTING

1) Obs & Gyne Department should be easily accessible for general public. It is located close to parking area , having a separate entrance.
2) Access to Obs & Gyne is ensured by both stairs and ramps, clearly designed for patient arrival and departure. The pathways facilitate free movement of patient's trolley, stretcher etc.
3) Adequate space for wheelchairs and patient trolleys has been ensured. The availability of porter service are ensured.
4) Effective and standard signage for the guidance of patients is ensured. Fast and easy connections have been established with the following:

1) Blood bank
2) Clinical Laboratory
3) Imaging services
4) Pharmacy
5) Emergency Department

5.1.1 THE FUNCTIONAL AREAS OF OBS & GYNE DEPARTMENT

1) Emergency
    a. Triage Area
    b. Resuscitation room
    c. Emergency ward
    d. Procedure Room
2) Outdoor Clinic
    a. Antenatal Clinic
    b. Gynecological OPD
3) Indoor
    a. Obstetrics
        i. Antenatal ward
        ii. Stage -1
        iii. Labor room
        iv. Postnatal ward
        v. Eclampsia Room
    a. Gynecology
        i. Pre-operative ward
        ii. Post-operative ward
4) Operation Theatre 5) Recovery Room
6) Doctor's office
7) Nurses office

5.2 HUMAN RESOURCE

5.2.1 QUALIFICATION CRITERIA

Job Title	Gynecologist
Senior & Gynaecologist/Professor Qualification Experience	1) MBBS qualified physician with FCPS(OBs & Gyne)/MRCOG/FRCOG/American Board certification in OBs & Gyne or any other equivalent degree, or 2) MBBS qualified physician with MCPS and 2 years post qualification experience, or 3) MBBS qualified physician with 2 years diploma in OBs & Gyne with 2 years post qualification experience, 4) Valid registration with PMDC
BPS	18 -20
Recruitment	Initial / Transfer
Position Type	Full Time
Jurisdiction	DHQ/THQ
Reports to	MS
Job Title	**Women Medical Officer**
Qualification Experience &	1) MBBS Graduate from a recognized Medical College 2) Valid registration with PMDC 3) Preference will be given to candidates experience of working in with Obs & Gyne Department
BPS	17
Recruitment :	Initial / Transfer
Position Type :	Full Time
Jurisdiction	DHQ/THQ
Reports to	Gynecologist & MS

5.2.2 RESPONSIBILITY MATRIX (GYNECOLOGIST)

He/She shall

5.2.2.1 GENERAL

1) Be self-motivated and aware of current trends in the field
2) Be able to work in a multi-cultural environment
3) Abide by the code of Medical Ethics and rules and regulations of the Medical Staff and those specific to the department.
4) Participate in the on-call duties as required by the department.
5) Share workload in her specialty during the absence of her colleagues.

6) Ensure the staff punctuality.
7) Ensure the cleanliness of the Department.
8) Ensure the regular maintenance of biomedical and non-biomedical equipment.
9) Ensure the regular supply/replenishment of medicines.
10) Ensure the availability of medicines and functional equipment for emergencies at all times.
11) Provide technical assistance for purchase of new equipment / instruments needed from time-to-time in the Department.
12) Participate in the forward planning, and further development of the department.
13) Ensure the compliance of Minimum Service Delivery Standards.
14) Allocate duties to other specialists/doctors from within the defined framework of particular JDs
15) Conduct evaluation based on achievements against set targets.
16) Write objective and unbiased Performance Evaluation Reports (PERs) of subordinate staff.
17) Inform MS about the matters which need his/her attention.
18) Ensure complete record of departmental statistics and report to the MS.
19) Perform outreach duties to the primary healthcare facilities and community services as and when required.
20) Participate in hospital committees meetings as requested.
21) Participate in disaster management inside the hospital, when indicated.
22) Perform other applicable tasks and duties assigned by MS within the capacity of her knowledge, skills and abilities, within the hospital and/ or affiliated medical facilities.

5.2.2.2 **CLINICAL**

1) Senior Gynecologist shall be the Head of the Obstetrics & Gynecology Department or as assigned by MS.
2) Conduct antenatal and Gyne OPD with her team regularly on specified/notified days and time as per HCE policy.
3) Exercise the highest possible standards of patient care according to her clinical privileges and available resources.
4) Supervise and ensure preparation of OT list by the Woman Medical Officer (WMO).
5) Plan and perform elective surgeries on specified days and time as per HCE policy.
6) Perform emergency gynecological/obstetrics surgeries on patients admitted through A&E Department
7) Conduct complicated deliveries herself or under supervision.
8) Ensure post- delivery, post-natal, neonatal care, advice on family planning, dietary advice and post-operative care of patients in ward.
9) Write post-operative notes and post-operative instructions after each procedure.
10) Take daily round of the wards along with duty WMOs and staff Nurse for detail followup of the admitted patients.
11) Ensure that treatment prescribed is being administered to the patients.
12) Attend the patients with Gynecological problems admitted in other wards as and when requested.
13) Explain the patients about the use and effects of prescribed drugs.
14) Refer the patients to other specialists within the HCE and/or to higher level facilities if needed.
15) Review referrals from other specialists and from the lower health facilities to establish diagnosis and proper management.
16) Participate actively in approved research projects.

5.2.2.3 PREVENTIVE / PROMOTIVE

1) Ensure compliance of SOPs, particularly on Infection Control and Waste Management in the OPD, labor room, wards, operation theatres, pre and post-operative wards.
2) Ensure the sterilization of equipment and surgical instruments.
3) Ensure that all staff participating in the procedures is physically well protected by wearing proper dress: gowns, masks, caps, gloves and shoes.
4) Educate staff and patients on the prevention of UTI and STIs
5) Advice mothers on family planning and child spacing during antenatal visits.
6) Participate in the establishment and conduct of medical camps pertaining to MCH and FP activities
7) Recommend dietary, physical therapy and other rehabilitative measures to women in the post-natal and post-operative period for early return to normal life.

5.2.2.4 CAPACITY BUILDING

1) Train WMOs, LHVs, LHWs, Midwives, Nursing and paramedical staff as per departmental and/or specialty requirements and protocols.
2) Be involved in capacity building program for the staff at BHUs and RHCs, including periodic visits by the qualified staff to facilitate antenatal services in peripheral settings.
3) These trainings should include, but not limited to
    a. Emergency Obstetric and Neonatal Care (EmONC)
    b. Emergency Neonatal Care (ENC)
    c. Integrated Management of Neonatal and Childhood Illnesses (IMNCI)
    d. Integrated Management of Pregnancy and Child Birth (IMPAC)
    e. FP Surgical and Counselling
    f. Client Centeredness
    g. Basic Life Support (BLS)
    h. Advanced Cardiac Life Support (ACLS)
    i. General First Aid
    j. Correct and appropriate use of Biomedical Equipment

5.2.3 RESPONSIBILITY MATRIX (WOMEN MEDICAL OFFICER/MEDICAL OFFICER)

He/She shall

5.2.3.1 GENERAL

1) Be self-motivated and aware of current trends in the field
2) Be able to work in a multi-cultural environment
3) Deal calmly, with tact and diplomacy to patient and staff alike.
4) Abide by the code of Medical Ethics and rules and regulations of the Medical Staff and those specific to the department.
5) Share workload in her specialty during the absence of her colleagues.
6) Work on the compliance of Minimum Service Delivery Standards.
7) Perform outreach duties to the primary healthcare facilities and community services as and when required.
8) Participate in hospital committees meetings as requested.
9) Participate in disaster management inside the hospital, when indicated.
10) Perform other applicable tasks and duties assigned by HOD and MS within the capacity of her knowledge, skills and abilities, within the hospital and/ or other public health facilities.

5.2.3.2 CLINICAL

1) Exercise the highest possible standards of patient care according to her clinical privileges and available resources.
2) Carry out full range of inpatient and outpatient clinical duties in Obstetrics & Gynecology in accordance with individually approved clinical privileges.
3) Prepare OT list and notify the OT Incharge a day prior to OT day.
4) Take ward rounds along with staff Nurse for detail follow-up of the admitted patients.
5) Ensure that treatment prescribed is being administered to the patients.
6) Report and discuss unusual findings, complications or alterations in the management plan, or need of referral with the consultant/ senior specialist.
7) Attend the patients with Gynecological problems admitted in other wards as and when requested.
8) Explain the patients about the use and effects of prescribed drugs.
9) Explain the patients about discharge medications and instructions along with follow-up appointment.
10) Participate in and/ or actively support approved research projects.

5.2.3.3 PREVENTIVE / PROMOTIVE

1) Follow SOPs, particularly on Infection Control and Waste Management in the department.
2) Check the sterilization of equipment and surgical instruments.
3) Use Proper PPE during patient medical and Surgical Care.
4) Educate patients on the prevention of common gynecological diseases.
5) Send the patients for dietary, physical therapy and other rehabilitative measures on the recommendations of Gynecologist.

5.2.3.4 CAPACITY BUILDING

1) Participate in Training Programs related to skill development, Quality assurance and continuing medical education.
2) Be committed for learning and training in pursuance of a career in Obs & Gynae.

5.2.4 DUTY ROTA

1) Duty roster has the cover of consultants. Monthly duty roster of the department made by HOD OBs & Gyne will be submitted to the administration a week before the start of the month for information and approval.
2) Duty roster shall cover the following areas: duties at following different places.
    a. OPD Duty Roster
    b. Indoor Duty Roster
    c. Emergency Duty Roster
    d. 24/7 on-call Roster of Consultants
3) In the event that a doctor cannot attend the duty, the doctor will inform the immediate supervisor two days in advance so that appropriate measures may be taken to ensure that there is an HCP on duty.
4) The roster of on-call Anesthetist must also be displayed in the department for emergency surgeries.
5) The doctors on duty must be physically present in the ward during their duty hours.
6) The doctor may leave the ward only after properly handing over the charge.
7) Doctors must communicate with each other at the time of change of duty i.e. they should handover the patient to next doctor on duty. The information should be accurate, complete, concise, current and confidential.

6 GYNECOLOGY OUTPATIENT WORK PROCESS

6.1 PURPOSE

To provide a high quality, patient focused, outpatient service, delivering a professional and caring service.

6.2 RESPONSIBILITY

Consultant Gynecologist, Duty Women Medical Officer, Charge Nurse/Dispenser

6.3 PROCEDURE

1) Outdoor will be conducted on all working days from 8 am to 2 pm where patients are seen on first come-first serve basis in morning shift except on Operation days as notified by MS.
2) Consultant Gynecologist and WMOs with experience in obs & gyne will deliver outdoor services.
3) Obstetrics patients shall be categorized as low risk and high risk pregnancy. Low risk patients may be evaluated first by WMOs and shall be planned by consultants for management and treatment.
4) All high risk obstetrics patients and patients with gynecological diseases shall be evaluated and planned by consultant Gynecologist for management and treatment.
5) Consultant Gynecologist and WMOs with experience in Obs & Gyne will be authorized to admit the patient in the ward after discussion with the Gynecologist, clearly charting out the diagnosis and treatment plan on the admission slip.
6) Contact details, diagnosis, examination findings and treatment offered to the patient will be recorded on OPD Register/HIMS.
7) Names and contact details of patients in need of elective surgery will be maintained on separate register present in OPD.
8) Patients in need of elective surgery will undergo serial laboratory investigations to document their fitness before appointment for surgery is issued.

7 OBS & GYNE EMERGENCY WORK PROCESS

7.1 PURPOSE

To establish a uniform system for assessment, management and disposition of obstetrical and gyne emergency patients.

7.2 RESPONSIBILITY

Consultant Gynecologist, CMO, Duty WMO, Duty staff Nurse

7.3 PROCEDURE

1) Patients will be accessed initially by Casualty Medical Officer (CMO)/ Emergency Medical Officer (EMO).
2) As Gyne patient needs specialized care, CMO/EMO on duty will contacts the duty WMO of Gyne department and immediately refer the patient to OBS & Gyne Department.
3) Patients in active labor or acute emergency will be referred directly to the OBS & Gyne department without prior evaluation in ER.
4) Duty WMO will initially assess the patient. In case patient needs surgical intervention, doctor will contact the on-call consultant Gynecologist and prepare the patient for emergency procedure.
5) If specialized care is required, on-call Consultant Gynecologist will physically attend the patient and assess whether the patient can be treated at DHQ / THQ hospitals or there is need of referral to tertiary care hospital.
6) If the patient's clinical condition is serious and any delay in treatment may endanger her/his life, WMO on duty may refer the patient after consulting the on-call gynecologist on telephone.

7) Duly filled referral form will be provided to attendants/family explaining the clinical condition at referral, reasons for referral and name of hospital to whom she is being referred along with brief history, treatment provided in the emergency, investigations and reports.
8) In case of admission, the patient/attendants/family will be informed about the need and reasons for indoor admission.
9) In case of refusal for admission, a statement of refusal {Leave against Medical Advice (LAMA)} should be signed before discharging patients from Gyne Emergency.
10) In case patient discharges from emergency, the patient must be issued specific, printed or legibly written after care/ instructions to visit Obs & Gyne OPD for follow-up.

8 ADMISSION IN OBSTETRICS & GYNE INPATIENT DEPARTMENT

8.1 PURPOSE

To provide general guidelines on timely admission of pregnant women and patients with gynecological diseases in ward who need indoor care that is not possible to be rendered at home or as an outpatient.

8.2 RESPONSIBILITY

Admission officer, Consultant Gynecologist, Duty WMO, OPD/ER Charge Nurse, Indoor Head Nurse

8.3 PROCEDURE

1) **Obstetric Patients** shall be admitted as day case management and for elective cesarean section.
    a. Patient who is in labor will be sent immediately by ER/OPD staff Nurse to the Stage1/Labor room for further management.
    b. WMO on duty shall be notified upon arrival of the patient in Labor Room.
2) **Gynecological Patients** shall be admitted in ward from OPD for evaluation and surgical management, if required.
3) To admit the patient to the HCE, he/she must have:
    a. Unique Patient Identification Number.
    b. Written order from the admitting Gynecologist including diagnosis in OPD / ER card.
4) Duty WMO will initiate the admission process of the patient after advice from the consultant Gynecologist and consent of patient/family.
5) Duty WMO will fill the admission request form and shall refer the patient to hospital reception for further process.
6) The name of the patient, hospital number, age, CNIC number and diagnosis must be filled in the Admission Form; and the same will be entered in Admission Register/HIMS.
7) Complete admission orders including drug prescription will be written clearly by admitting consultant or duty WMO in consultation with admitting consultant Gynecologist.
8) ER/OPD Staff Nurse will communicate with the concerned nursing staff on duty in admitting Ward/ICU and will inform her about patient. ER/OPD Staff Nurse will hand over the complete patient documents to receiving nursing unit.
9) Paramedical/Nursing staff will accompany the patient and detail handover of the patient will be given to the receiving staff.

10) There are no charges for admission in general wards including laboratory and radiological investigations. However, in case of admission in private rooms, Admission Officer will discuss the private room rates with patients or her relatives, after which the patient signs a Consent Form. One copy of CNIC must be attached with the Admission Form.
11) The Head Nurse in the concerned ward will be informed by the Admission Office staff to ensure the bed and/or room availability.
12) Except in case of an Emergency admission, no patients shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been recorded.
13) When there is a shortage of beds, patients shall be admitted to the Hospital according to the following priority list:
    a. Emergency
    b. Urgent
    c. Elective surgical procedure.
    d. Elective medical surgical investigation
14) After receiving the patient, the Head Nurse or Staff Nurse shall call the WMO on duty who will interview the patient for detailed history and physical examination.
15) HCPs shall abide by the Hospital Utilization Review Plan. The medical record should document the appropriateness and medical necessity for:
    a. Admission.
    b. Continued Stay
    c. Supportive Services
    d. Discharge Planning

9 PATIENT IDENTIFICATION

9.1 PURPOSE:

To establish guidelines for proper identification of patients which will ensure safety of patient at all times.

9.2 RESPONSIBILITY:

DMS In charge, Consultant Gynecologist, Duty WMO, Nursing Supervisor.

9.3 PROCEDURE:

1) Every admitted patient should have an identification band (ID Band).
2) ID band is applied securely; neither tight nor loose.
    a. Right wrist, unless contraindicated (as long as it is not interfering in the gadgets or treatment)
3) ID band should bear the complete name and MR number of patient that should be clear and readable.
4) When administering patient care, identify patient by calling her name and compare with ID band applied.
5) Upon discharge, nursing staff will remove the ID band.
6) No discharged patient should be allowed to leave the hospital with ID band still attached to wrist.

10 GYNECOLOGY INPATIENT WORK PROCESS

10.1 PURPOSE

To provide guideline instructions for further observation, treatment or management of the admitted patients.

10.2 RESPONSIBILITY

Consultant Gynecologist, Duty WMO, Indoor Head Nurse

10.3 PROCEDURE

1) All admitted patients will be interviewed for detailed history. They will be put through systemic examinations and required laboratory investigations. The findings must be recorded in medical records within 24 hours of admission. The admitting HCP must countersign the history and physical examination report prepared by the duty WMO.

2) **History**

Recording history involves the following steps:

a. Presenting Complaint

i. Whether the complaint is urinary or genital; infectious or noninfectious; acute or chronic; congenital or acquired

ii. Pain lower abdomen, severity, intensity

iii. relieving and exacerbating factors (movements, positions)

b. Past Medical History

i. Ask about co-morbidities; previous trauma, surgery or hospital admissions; medication reconciliation

c. Systemic Review

i. Look for co-morbidities and associated disorders to assist with the differential diagnosis

d. Obstetrical History

i. Ask for conception history either natural or assisted
ii. Ask for number of pregnancies, alive issues, number of abortions.
iii. Ask for any Twin Pregnancy iv. Ask for mode of delivery (NVD/AVD/CS).
v. In case of C-section, ask for indication. vi. Ask for any Pre-Term Delivery.
vii. Ask for average Birth weight of babies
viii. Ask for any Still Birth, Early Neonatal Death
ix. Ask for any obstetrical complication like (PIH, Pre-Eclampsia, Eclampsia, GDM, Obstructed Labor, Placenta Previa, Placental Abruption etc)

e. Gynecological History

i. Ask for the menstrual history.
ii. Ask for marital history
iii. Ask for coital history
iv. Ask for gynecological diseases.

f. Family History

g. Medication History

h. Allergies

i. Personal History

i. Record if the patient is a tobacco user or alcoholic

h. Social and Financial Status

i. Residence; living conditions

ii. Source of income; affording/non-affording

2) Physical Examination:

This includes;

a. Vitals

b. In general, physical examination; look for pallor, cyanosis, jaundice, clubbing, koilonychias, and thyroid etc.

c. Examination of the Abdomen and Pelvic/ Genital region after ensuring consent and privacy of the patient.

d. Perform per Vaginal and Per Speculum Examination, when required using latex gloves and adequate lubrication.

e. In systemic examination, look for co-morbidities.

3) Pre-operative assessment will be done by duty WMO or by a Consultant Gynecologist.

4) General consent signed by the patient or on behalf of the patient who is admitted to the hospital, must be obtained at the time of admission.

5) Informed consent will be obtained from the patient and his/her relative which will be duly signed by the doctor or admitting doctor who did pre-operative assessment. It shall be his responsibility to fully inform the patient and family, when indicated, of the nature, need and possible consequences or untoward effects of any procedures and to document such in the medical record.

6) Separate consent must be obtained for each of the following:
   a. Invasive procedures such as any type of surgery, biopsy, surgical incisions
   b. When anesthesia is in use
   c. Treatment of an unforeseen pathology which only becomes apparent during that surgery
   d. A diagnostic test which is invasive or which involves some risk to the patient
   e. High risk procedures
   f. Radiation or cobalt therapy
   g. Blood Transfusion
   h. Before administering high risk medication

7) Both the patient and the doctor shall sign a consent form affirming that the practitioner has informed the patient of the nature of the procedure or the surgery, and the patient understands and consents to it.

8) Nursing staff will carry out the initial lab, radiological and medication orders, and put ID band on the patient.

9) Medication on admission should be carefully charted using standard names and approved abbreviations with strength, dose, and route of administration, frequency and duration.

10) Medicines shall be administered by authorized and trained staff permitted by law including doctors, nurses, dispensers etc.

11) Patient is identified by staff before administration of medicine; by asking the patient himself/herself; By verifying the Medical Register Number; by checking the identification band and verifying the details from drug prescription chart

12) Right drug, right dose, right route, and right time is verified from drug prescription chart before administration. Detail of medicine administered must be documented with name of drug, dose, and route, time with date and time. Nurse will affix the signature thereafter.

13) Handover at the end of the day, night, weekend, holiday period etc. is vital and must be done in person. This requires daily am and pm rounds with the nursing staff to ensure satisfactory progress of your patients. Out of hours, the on-call Consultants must provide this level of care to the whole unit. Handover/takeover discussions must take place depending upon the condition of the patients etc.

14) Drugs and treatment regimens must be reviewed daily by pharmacist.

15) Patients on the list will be evaluated by Anesthesia Department one day before surgery.

16) Morning and evening rounds will be the responsibility of the Consultant.

Referred to Gynecology (Elective Surgery) bedhead ticket attached in ***Annexure-1***

11 OBSTETRICS INPATIENT WORK PROCESS

11.1 PURPOSE

1) To provide immediate care to the patient ensuring comfort and maintaining maternal and fetal well-being.
2) To provide guideline instructions for further observation, treatment or management of the admitted patients.

11.2 RESPONSIBILITY

Consultant Gynecologist, Duty WMO, Indoor Head Nurse

11.3 PROCEDURE

1) Patient who is in labor or admitted for elective C-Section/procedure will be sent by ER/OPD staff Nurse to the Pre-Natal Ward for further management.

2) WMO on duty shall be notified upon arrival of the patient.

3) General consent signed by the patient or on behalf of the patient who is admitted to the hospital, must be obtained at the time of admission.

4) Jewelries and valuables shall be removed and given to the relatives.

5) Allow the patient to void.

6) Apply identification band.

7) Explain the procedure to be done.

8) Keep the patient on bed in a comfortable position, provide privacy.

9) Patients will be interviewed for detailed history. They will be put through systemic examinations and required laboratory investigations. The findings must be recorded in medical records within 24 hours of admission. The admitting doctor must countersign the history and physical examination report prepared by the duty WMO.

10) **History**

Recording history involves the following steps:

a. Presenting Complaint

i. Ask for Labor pains, PV leaking, vaginal bleeding,
ii. Ask for duration of pains, frequency and intensity
iii. Ask for fetal movements iv. In case of PV leaking, ask for color, amount of discharge and since when started.

b. History of Presenting Complaint

i. Ask for Gravida, Para, Abortions ii. Ask for LMP
iii. Calculate EDD
iv. Calculate Gestational age by dates and by early ultrasound scan
v. Ask about mode of last delivery
vi. Ask for age of last born child
vii. Ask for any complication in the current pregnancy like GDM, PIH, Threatened abortion, Cervical cerclage, antepartum bleeding, hyperemesis gravidum, anemia etc
viii. Ask for conception either natural or assisted
ix. Ask for any blood transfusion or parenteral iron therapy

c. Past Medical History

i. Ask about co-morbidities; previous trauma, surgery or hospital admissions; medication reconciliation

d. Systemic Review

i. Look for co-morbidities and associated disorders to assist with the differential diagnosis

d. Obstetrical History

i. Ask for conception history either natural or assisted
ii. Ask for number of pregnancies, alive issues, number of abortions. iii. Ask for any Twin Pregnancy iv. Ask for mode of delivery (NVD/AVD/CS).
v. In case of C-section, ask for indication. vi. Ask for any Pre-Term Delivery.
vii. Ask for average Birth weight of babies
viii. Ask for any Still Birth, Early Neonatal Death
ix. Ask for any obstetrical complication like (PIH, Pre-Eclampsia, Eclampsia, GDM, Obstructed Labor, Placenta Previa, Placental Abruption etc)

e. Gynecological History

i. Ask for the menstrual history.
ii. Ask for marital history
iii. Ask for coital history
iv. Ask for gynecological diseases.

f. Family History

g. Medication History

h. Allergies

i. Personal History

i. Record if the patient is a tobacco user or alcoholic

j. Social and Financial Status

i. Residence; living conditions
ii. Source of income; affording/non-affording **11) Physical Examination:**

a. Check the height and weight.
b. Wash hands, and check vital signs.
c. Palpate the position and locate fetal heart and attach the CTG machine to the patient.

Monitor for uterine activity and FHR.

i. Write the following data on CTG Report
   - Name of patient
   - MR No
   - Date and time of Admission
   - Gravida, Para, Abortions
   - Gestational age
   - Report Interpretation ○ Baseline Fetal Heart Rate ○ Baseline variability
     ○ Response of the Fetal heart to uterine Contractions

 Duty Doctor name and signature

d. Do GPE; look for pallor, cyanosis, jaundice, clubbing, koilonychias, and thyroid etc.
e. Perform Examination of the Abdomen and Pelvic/ Genital region after ensuring consent and privacy of the patient.
   i. Per Abdominal Examination of Obstetrical Patient, Look for
      - Fundal Height
      - Lie of Fetus
      - Presenting Part
      - Amount of Liquor
      - Estimated Fetal weight
      - Fetal heart Sounds
f. Perform per Vaginal and Per Speculum Examination, when required using latex gloves and adequate lubrication.
   i. Per Vaginal Examination of Obstetric Patient, Look for
      - Cervical dilatation
      - Effacement of Cervix
      - Consistency of Cervix
      - Fetal Presentation and Station
      - Status of Membranes (intact, leaking or ruptured)
      - Color of Liquor

12) Place the patient in left lateral position if indicated to avoid supine hypotension.
13) Give kleen enema.
14) Help the patient to go to the toilet.
15) Assist the patient to go back on bed, place in comfortable position.
16) Insert IV cannula and start prescribed medication and IV fluid as ordered by the doctor.
17) Medication on admission should be carefully charted using standard names and approved abbreviations with strength, dose, and route of administration, frequency and duration.
18) Medicines shall be administered by authorized and trained staff permitted by law including doctors, nurses, dispensers etc.
19) Patient is identified by staff before administration of medicine; by asking the patient himself/herself; By verifying the Medical Registration Number; by checking the identification band and verifying the details from drug prescription chart
20) Right drug, right dose, right route, and right time is verified from drug prescription chart before administration. Detail of medicine administered must be documented with name of drug, dose, and route, time with date and time. Nurse will affix the signature thereafter.
21) Laboring Patient
    a. Observe the patient for progress of labor and notify the doctor for any failure to progress.
    b. Provide information regarding progress of labor to the patient and family member.

c. Provide psychological and emotional support to the patient and family.
d. If failure to progress, and signs of fetal distress indicate the need of emergency intervention, WMO shall inform the on-call consultant Gynecologist and prepare the patient for emergency procedure, if indicated.

22) Elective or Emergency C-section

a. Pre-operative assessment will be done by duty WMO or by a Consultant Gynecologist in elective or emergency procedure. ii. Notification to Pediatrician and Anesthetist is a must and should be provided with complete data of the patient.

iii. Patient should be NPO at least 6 hours prior to surgery if to be done under general anesthesia (except in emergency cases).

iv. Informed consent will be obtained from the patient and his/her relative which will be duly signed by the doctor or admitting doctor who did pre-operative assessment. It shall be his responsibility to fully inform the patient and family, when indicated, of the nature, need and possible consequences or untoward effects of any procedures and to document such in the medical record.

23) Separate consent must be obtained for each of the following:

a. Invasive procedures such as any type of surgery, biopsy, surgical incisions
b. When anesthesia is in use
c. Treatment of an unforeseen pathology which only becomes apparent during that surgery
d. A diagnostic test which is invasive or which involves some risk to the patient
e. High risk procedures
f. Radiation or cobalt therapy
g. Blood Transfusion
h. Before administering high risk medication

17) Both the patient and the doctor shall sign a consent form affirming that the doctor has informed the patient of the nature of the procedure or the surgery, and the patient understands and consents to it.

18) Handover at the end of the day, night, weekend, holiday period etc. is vital and must be done in person. This requires daily am and pm rounds with the nursing staff to ensure satisfactory progress of your patients. Out of hours, the on-call Consultants must provide this level of care to the whole unit. Handover/takeover discussions must take place depending upon the condition of the patients etc.

19) Drugs and treatment regimens must be reviewed daily by pharmacist.

20) Patients on the list will be evaluated by Anesthesia Department one day before surgery. 21) Morning and evening rounds will be the responsibility of the Consultant.

Referred to Gynecology (Elective Surgery) bedhead ticket attached in ***Annexure-1***

Referred to Gynecology (Normal Labor) bedhead ticket attached in ***Annexure-2***

Referred to Gynecology (Labor to C-Section) bedhead ticket attached in ***Annexure-3***

12 INPATIENT CONSULTATION REQUEST FROM OTHER DEPARTMENTS

12.1 PURPOSE

To provide guidelines for prompt patient evaluation requested from other speciality.

12.2 RESPONSIBILITY

Consultant Gynecologist, Duty WMO, Duty Nurse

12.3 PROCEDURE

1) Requests for consultation from the any other department require prompt patient evaluation.
2) Consultations should be provided within a reasonable time frame, as determined by patient condition. The following timeframes are guidelines for reasonable response times to any consultation request.
   a. **Emergent** (defined as immediate life-threatening illness) within 10 minutes
   b. **Urgent** (defined as potentially life or limb-threatening) within 60 minutes
   c. **Routine** (defined as requiring prompt evaluation but not life or limb-threatening) within 2 hours.
3) Requests for consultation from a Healthcare provider may not be declined unless in mutually agreed upon circumstances between the Gynecologist and the referring HCP, where this formal request is no longer required (e.g. the wrong service was called, change of patient status etc.).
4) The HCP placing the consultation request will document the reasoning on the consultation request form. The HCP will also place a phone call to the Gynecologist.
5) Consultations will be completed in a timely fashion. A consultation is considered complete when:
   a. the consulting service provides the HCP a final written or verbal plan and/or
   b. documented summary of recommendations immediately available to the referring consultant/ MO
6) Formal documentation of consultations shall be placed in the medical record in keeping with the documentation requirements of the MSDS.
7) Inpatient consultation should only be requested in situations where the consultation may impact the patient's hospital care. Many non-acute problems are best handled by outpatient consultation following hospital discharge (for example, patient has chronic back pain or needs a routine gynecologic exam or pap smear)
8) If the consulting service provider shall not respond within time frames appropriate to a patient's condition, or if the consulting service workup and evaluation seem prolonged, the attending healthcare provider will contact the consulting service provider. It will be the consulting doctor responsibility to provide response in a timely fashion.

*Referred to Medical consultation form attached in **Annexure-4***

13 OBS & GYNE OT WORK PROCESS

13.1 PURPOSE

The Main purpose of these guidelines is to ensure:

1) Appropriate Pre-operative assessment and patient preparation
2) Adequate Preparation for anesthesia and surgical procedures
3) Observation of asepsis and principles of sterile technique are adhered to 4) Appropriate Post-operative care

13.2 RESPONSIBILITY

Consultant Gynecologist, Duty WMO, OT In charge, Anesthesiologist, Head Nurse

13.3 PROCEDURE

13.3.1 PRE-OPERATIVE CARE

1) Patient should be admitted at least one night prior to the scheduled operation except for day case and emergency surgery.
2) All patients scheduled for surgery must have pre-operative assessment performed by Consultant Gynecologist.

   Referred to Gynecology (Elective Surgery) bedhead ticket attached in ***Annexure-1***

   Referred to Gynecology (Labor to C-Section) bedhead ticket attached in ***Annexure-3***

3) Pre-Op investigations should not be ordered routinely. Pre-Op investigations should be tailored to the individual patient's needs and the surgery they are undergoing.
4) Following tests may be carried out as part of Pre-Op investigations:
   a. Plain Chest X Ray
   b. Twelve lead resting ECG
   c. Full Blood Count
   d. Coagulation Profile (PT, APTT, INR)
   e. Serum urea, creatinine, and electrolytes
   f. Random Serum glucose
   g. Urine Analysis
   h. Blood Gases
   i. Lung Function (Peak Expiratory Flow Rate, Forced vital capacity, and forced Expiratory volume)
   j. Pregnancy Test
   k. Sickle Cell Hemoglobin Test
   l. Viral Markers Hepatitis B & C
   m. Blood Grouping & Cross Matching
5) Blood Pint should be arranged one day before surgery, if required.
6) More investigations can be added depending upon the physical status of the patient. Clinicians need to be armed with only three or four key facts about patients in front of them;
   a. Age band
   b. Complexity of intended Surgery
   c. ASA Grade
   d. Nature of co-morbidity if ASA III
7) Elective and planned operation lists to be printed by 12 noon a day prior to the procedure (by the WMO). Advise the OT staff at the earliest of any special requirements e.g. equipment etc. Ensure timely availability of such requirements.
8) The surgical scrub nurse in the OT will be notified about any change in the list as soon as the decision has been made.
9) Emergency operations to be written up on the list outside theatre at the earliest and all relevant departments like X-ray be informed.

13.3.1.1 **NIGHT PRIOR TO SURGERY** The Nurse shall;

1) Collect Reports of Medical Investigations
2) Take Vital Signs

3) Inform the Anesthetist on duty, if the patient has not yet been examined from OPD or ER. 4) Check the fitness from Anesthesia Department in case of Hypertensive and Diabetes etc.
5) Inform the WMO on duty of the concerned department to further assess the patient and for further orders, if necessary.
6) Explain the procedures to be done to lessen anxiety and gain cooperation of the patient.
7) Assemble all supplies and equipment needed.
8) Keep the patient on Nothing per Oral (NPO) starting from 12:00 midnight unless the time is specified by attending doctor.
9) Administer enema at 6.00 pm, 12.00 am and 6.00 am, unless contra-indicated.
10) Tab Dulcolex 4 stat peroral at 6.00 pm
11) Advise and supervise the patient to take a bath with antiseptic soap (Special attention to be given to areas known to harbor many pathogens like hands and feet including nails, groin, perineum and buttocks, axillae).

13.3.1.2 **MORNING OF SURGERY**

1) Advise the patient to wash the area of the body to be operated upon. If patient is unable to move, wash the site of operation and its surrounding area with soap and water, and dry it.
2) Shave the patient according to the site of operation.
    a. Shaving should be done 1-2 hours before going to OT.
    b. Get verbal consent from the patient. If the patient is unconscious, inform the relatives.
    c. Assess skin site for rash and abrasion.
    d. Take extra caution to avoid cuts and epidermal damage.
3) Use sterile gauze to swab the operation site with skin disinfectant for 2 minutes.
4) Provide OT dress with disposable surgical cap and mask.
5) Let the patient void immediately before going to operation room. Use urinary Bladder catheterization for bed ridden patients
6) Take vital signs and give pre-medications as ordered.
    a. Pre-operative antibiotic test dose 30 min before surgery.
    b. Check BSL and omit morning dose of insulin.
    c. Give morning dose antihypertensive with sip of water.
7) All patients scheduled for operation should have a completely accomplished Pre-Op checklist which must be completed and signed by the Ward Nurse. Pre-Op checklist serves as a basis for the evaluation of the completeness of necessary requirements needed for the patient to undergo surgical operations. The following are the key Pre-Op markers; a. The operation to be done.
    b. The operating Gynecologist.
    c. The site of surgery shaved, cleaned and properly marked.
    d. Presence of ID band (should be placed on the wrist of non-operative side of the body).
    e. Pre-operative assessment by anesthesiologist to include history, physical examination, ASA risk assessment, lab investigations, pre-medications and necessary consultations.
    f. Informed consent for planned procedure and proposed anesthesia type.
    g. Laboratory, radiological results for immediate reference, consultations and referral forms available in patient's file.
    h. Patient is placed on NPO.
    i. Blood pints with cross-matching done arranged.
    j. Undergarments, jewelry, nail-polish, lipstick, hairpins removed.
    k. Patient voided freely or catheterized accordingly.
    l. Bowel preparation done.

m. Artificial prosthesis such as dentures, contact lenses and hearing aids removed. *Referred to Gynecology (Elective Surgery) bedhead ticket attached in* ***Annexure-1***

Referred to Gynecology (Labor to C-Section) bedhead ticket attached in ***Annexure-3***

8) Allergies and any positive result for HIV and Hepatitis test should be noted and conveyed to the operating surgeon and should be verbally endorsed to OR Nurse.
9) Raise bed-side rails and keep the bed locked to ensure safety during transfer.
10) The assigned nurse will accompany the patient to operation theatre staff along with complete file, X ray films, investigation records, medication (if any).
11) If the ID band is required to be removed, it is recommended to be placed with the patient chart in order to be immediately replaced on the wrist at the end of the procedure, or a new ID band is obtained and placed with the patient chart for immediate placement on the wrist.

13.3.2 Operation Theatre Care

1) All Pre-Operative Preparation must be carried out.
2) Safety of the patient must be considered prior to, during and after the operation.
3) Upon arrival to OR, the following should be checked
    a. Check if patient is wearing correct ID band.
    b. Consent (should be properly filled and witnessed by the Surgeon and Anesthetist).
    c. Site of Operation clearly marked.
    d. Laboratory investigations (any abnormal findings should be conveyed to the Surgeon).
    e. ECG results.
    f. X-ray Film.
    g. Ask patient if he/she has been on NPO post- midnight or when was the last meal eaten.
    h. Examine the site of operation to check if it is properly shaved and marked. Check for presence of nail polish, jewelry and dentures. Remove if found.
4) Patient will be prioritized according to age, severity of the disease and availability of the room.
5) Priority is given first to emergency cases and children. Septic case will be done at the last.
6) Infection control policy must be followed. Aseptic techniques should be strictly observed throughout the procedure.
7) Operation Theatre Assistant (OTA) must ensure that the operating area is clean, welllighted and has good ventilation. He will check for safe functioning of the equipment. He will make sure that supplies are adequate and easily available.
8) Pre-induction re-evaluation will be carried out by Anesthesiologist on OT Table just before induction of anesthesia. When anesthesia must be provided on an urgent basis, the pre-anesthesia assessment may be performed following one another, or simultaneously and is documented separately**.**

Referred to Gynecology (Elective Surgery) bedhead ticket attached in ***Annexure-1*** *Referred to Gynecology (Labor to C-Section) bedhead ticket attached in* ***Annexure-3*** 9) Identity of the patient must be ensured before the administration of anesthesia.

The patient is identified:

a. By asking his name and father name / husband name.
b. By confirming his name from operation list.
c. By confirming from patient file.
d. By confirming from patient tag.
e. By confirming from surgical team.

10) In order to ensure patient safety, care shall be taken and “Time Out” protocols shall be used to prevent adverse events like wrong patient, wrong surgery, and wrong site.

Time out Protocol

a. Confirming identification of the patient.
b. Checking and confirmation of consent by the patient.
c. Checking the correctness of procedures or surgery to be performed.
d. Ascertaining of the correct site for surgery or other invasive procedures as applicable.
e. Verification that diagnostic images (relevant tests results) are available and are correct as applicable

11) Immediate before surgery, the Consultant Gynecologist will also confirm patient's ID from ID band and file with medical record number, proposed procedure of surgery and the site of surgery. The Patient should have at least two corroborating patient identifiers as evidence to confirm identity.
The patient's bed number should not be used as a patient identifier at hospital. Bed numbers are not person-specific identifiers, since patients can be moved from bed to bed. ***Referred to Specific WHO Surgical Safety Checklist For Maternity Cases Only ANNEX-05***

12) All procedures will be performed by Consultant Gynecologist and he/she will be assisted by duty WMO.
13) Specimen should be sent for histopathology, if any.
14) Procedures requiring image intensifier and traction table will not be performed till their availability and the presence of trained staff.
15) The following parameters need to be monitored and recorded on the **Monitoring Sheet** by Anesthesiologist.
    a. Heart Rate
    b. Cardiac Rhythm
    c. Respiratory Rate
    d. Arterial Blood Pressure
    e. Oxygen Saturation
    f. End Tidal CO2
    g. Airway security and Patency
    h. Level of Anesthesia
    i. Evaluation of circulatory function
    j. Temperature (in case clinically significant changes in body temperature are intended, anticipated or suspected)

Referred to Gynecology (Elective Surgery) bedhead ticket attached in ***Annexure-1***
Referred to Gynecology (Labor to C-Section) bedhead ticket attached in ***Annexure-3***

13.3.3 POST-OPERATIVE CARE

13.3.3.1 POST-OPERATIVE NOTES:

13.3.3.1.1 OPERATIVE RECORD: Operative note must be documented in patient's medical records immediately following surgery. This note provides information about the procedure performed, postoperative diagnosis and status of the patient before shifting and shall be documented by the operating Surgeon and WMO who assist the procedure.

1) Date and Duration of Operation
2) Anatomical Site where surgery is undertaken
3) The name of the Operating Surgeon, Assistant including Scrub Nurse
4) Name of Prosthesis used
5) Details of the sutures used
6) Swab count
7) Detail instrument count
8) Preoperative and Postoperative Diagnosis

9) Name of Procedure and anesthesia given
10) Description of the Procedure
11) Intraoperative Findings
12) Estimated blood loss
13) Any Specimen removed
14) Condition of Patient after operation
15) Immediate Post-operative Instructions
16) In case of C-Section, Baby notes contain following:
    a. Gender of Baby
    b. Baby weight
    c. Apgar Score
    d. Date and Time of Birth

13.3.3.1.2 ANESTHETIC RECORD

1) Date and duration of anesthesia
2) Operation performed
3) Name of the Anesthetist, Anesthesia Assistant
4) Post-op assessment by Anesthetist
5) Drugs and doses given during anesthesia and route of administration
6) Monitoring data
7) Intravenous fluid therapy
8) Post-anesthetic instructions
9) Any complications or incidents during anesthesia
10) Signature of the Anesthetist and Anesthesia Assistant

*Referred to Gynecology (Elective Surgery) bedhead ticket attached in **Annexure-1***

*Referred to Gynecology (Labor to C-Section) bedhead ticket attached in **Annexure-3***

13.3.3.1.3 POST OP CARE IN PACU (IMMEDIATE POST-OPERATIVE MANAGEMENT)

1) Post-Anesthesia monitoring of vitals must be done in PACU till the patient completely recovers from anesthesia and shall be done by an Anesthetist. The following signs should be evaluated and their levels of stability should be verified with anesthesiologist.
    a. Blood Pressure
    b. Pulse Rate
    c. Respiratory Status
    d. Oxygen Saturation
    e. Hemodynamic status
    f. Level of consciousness
    g. Pain
    h. Monitoring surgical site (s) for excessive bleeding, swelling, discharge, hematoma, redness etc..
2) Patient will be discharged from the recovery room after fulfilling the discharged criteria (for Aldreto score, refer to Anesthesia manual). If there is any doubt as to whether patient fulfills the criteria, or if there has been a problem during the recovery period, the Anesthetist who administered the anesthetics (or another Anesthetist with special duties in the recovery room) must access the patient. After medical assessment, patients who do not fulfil the discharge criteria must fulfil the discharge criteria before they are transferred to an ICU.

*Referred to Gynecology (Elective Surgery) bedhead ticket attached in **Annexure-1***

Referred to Gynecology (Labor to C-Section) bedhead ticket attached in ***Annexure-3***

13.3.3.2 **POST OP CARE IN WARD**

13.3.3.2.1 FIRST 24 HOURS

1) After the patient is transferred from post-op recovery area, the nurse taking charge over her care should quickly assess the patient's overall condition and carefully read and follow the post-op instructions written by Consultant Gynecologist and Anesthetist.
2) As a routine, the following parameters of patients who underwent general or spinal anesthesia are frequently monitored and assessed every 15 to 30 minutes depending upon the individual patient's condition during the first 24 hours, if required, in consultation with the on-call Consultant/WMO
    a. Ensure air way, breathing and circulation
    b. Keep patient pain free with adequate analgesia.
    c. Anti-emetic for nausea.
    d. Monitor vitals, oxygen saturation, fluid intake, urine output, status of incision, any drainage tubes, dressing.
    e. Ensure adequate fluid management and IV antibiotics.
3) It shall be ensured that patients and attendants shall be communicated the importance of the following information in post-op period
    a. Respiratory breathing exercises to prevent post-op chest problems.
    b. Mobility exercises for preventing blood clotting.
    c. Regulation and alleviation of pain to allow breathing and movement.
    d. Patients may complain of dry mouth after surgery which can be relieved with oral sponges dipped in ice water or lemon ginger mouth swabs.
4) First Post-OP Day
    a. Allow oral fluids (if gut sounds are audible).
    b. Encourage mobilization.
    c. Early removal of Foley's catheter.
    d. Monitor for complications
        i. Phlebitius ii. Embolism

9.3.1.1.1 AFTER 24 HOURS

1) Routine monitoring shall be continue but the frequency may be decreased (every4-8 hours if the patient is stable). 2) On 2nd Post-Operative day :
    a. Allow oral semi- Solids
    b. Hold I/V fluids
    c. Send post- operative labs (Complete Blood Count and complete urine examination)
    d. Risk assessment for DVT
    e. Wound care
3) On 3rd Post-Operative day :
    a. Start Oral anti-biotics
    b. Patient should be monitored for any evidence of potential complications, such as deep vein thrombosis (DVT), pulmonary embolism, PPH, wound infection, wound dehiscence and paralytic ileus etc.
4) Patients and attendants should receive information regarding post-op care.
5) Discharge the patient on 3rd post-operative day, if no complications.

9.3.1.1.2 AFTERCARE

1) Aftercare should ensure that the patients are comfortable either in the bed or chair, and their dressings are changed regularly and in time

2) Patients should be given the opportunity to ask questions and to learn exercises to be performed once they returned home
3) Interdisciplinary pain management
4) Ongoing communication and consultation with referring Gynecologist and Doctor to ensure effective treatment and continuity of care
5) Education about risk factors and infection prevention

13.3.3.3 HANDING OVER OF POST-OPERATIVE PATIENT IN PACU (POST-ANESTHESIA CARE UNIT) TO WARD

1) Patient should be transferred to the ward Staff accompanied by a suitably trained member of staff.
2) He will endorse patient to receiving nurse with patient file containing pre and post op investigations, anaesthetic record, recovery note, prescription charts and specimens (if any). The recovery nurse must ensure that full clinical details are conveyed to the ward nurse with particular emphasis on problems and syringe pump setting (if in place).

13.3.3.4 PATIENT RECEIVING PROTOCOL

1) Duty Ward Nurse shall:
   a. Check the identity of the patient.
   b. Check the admission status, diagnosis and operation notes.
   c. Check condition of patient whether satisfactory, serious or critical.
   d. Check vitals, Pulse, B.P, Temperature, Respiratory rate.
   e. Check specific instruction regarding
      i. Diet (Clear liquids, semi solids and solids
      ii. Foley's catheter (urine output monitoring)
      iii. Drain iv. Ant embolic care
      v. Medications prescribed.

*Referred to Gynecology (Elective Surgery) bedhead ticket attached in **Annexure-1***

*Referred to Gynecology (Labor to C-Section) bedhead ticket attached in **Annexure-3***

14 INTENSIVE CARE UNIT (ICU)

14.1 PURPOSE

1) To provide definitive guidelines on the process of admitting patients to the unit 2) To provide health care that is not possible to be rendered in the general unit.
3) To provide comprehensive monitoring of patient condition and cares.
4) To prevent deterioration before more definitive treatment can be given.

14.2 RESPONSIBILITY

ICU In-charge, Consultant Gynecologist, Duty WMO

14.3 PROCEDURE

1) Indoor or Emergency Patients of Obs & Gyne Department who need critical care will be shifted to ICU Department with mutual discussion of Consultant Gynecologist and the Incharge of ICU.
2) A brief endorsement (Doctor to Doctor and Nurse to Nurse) should be done prior to transfer.
3) Admission of patient in ICU should be under the name of the treating consultant.
4) All emergency situations are handled by ICU doctor in coordination with ICU Consultant and treating doctor for further management.
5) There should be an ICU doctor available 24 hours a day, seven days a week in the unit.
6) Any changes in treatment/ procedure should be discussed first by the ICU doctor to the attending consultant except in case of emergency.

7) Consultant Gynecologist will visit that patient in ICU on daily basis. If the patient is stable then he will be admitted again in the ward. If the patient's condition will be worsening, the patient will be referred to tertiary care center nearby after mutual discussion of Consultant Gynecologist and the In-charge of ICU.

15 INTERNAL TRANSFER OF PATIENTS

15.1 PURPOSE

1) For continuity of care
2) For further medical/nursing observation and management.

15.2 RESPONSIBILITY

Consultant Gynecologist, Duty Medical Officer, Nursing Supervisor

15.3 PROCEDURE

1) Duty Women Medical Officer must:
   a. Instruct the nursing staff on duty to shift the patient to concerned unit.
   b. Explain the clinical condition and reason of transfer to attendant in detail and shall document it in the file of the patient mentioning the name and relation of attendant.
   c. Communicate with the duty doctor of concerned unit
   d. Inform the duty doctor about the patients and patient's clinical condition so that receiving unit can make necessary arrangement.
2) Staff Nurse on duty shall communicate with the staff nurse of the concerned unit and will inform him/her about the patients' clinical condition so that receiving unit can make necessary arrangements.
3) Before shifting the patient, the Staff Nurse will ensure that
   a. A bed is available in the shifting unit
   b. Patient's Medical Record is completed till date
   c. Duty WMO has endorsed his/her shifting notes in patient file.
   d. Staff Nurse on duty has endorsed his/her shifting notes in patient's file
   e. In emergency situation, documentation could be done later.
   f. Family/attendants have been informed about shifting and destination of patient.
4) Shifting must be accompanied by a close relative.
5) Safety measures should be followed.
6) Transport patient by wheelchair, stretcher or bed, according to her condition.
7) Proper documentation should be followed. Complete and accurate endorsement to the receiving nurses should be done.

   *Referred to Internal Transfer form attached in **Annexure-** 6*
8) Receiving nurse should check for complete documents, physical condition of the patient, and personal belongings (if patient is unaccompanied by relative). She must clarify from endorsing nurse if in doubt of anything related to the patient management.

15.4 SPECIAL CONSIDERATIONS:

Transfer of patient from Isolation area.

1) To General Ward/Room/ ICU
   a. Give the patient a full bath.
   b. Gown and linens should be changed.
   c. Dressing (if there is) should be done.

d. Instruct the staff to bring the bed to transfer the patient from isolation bed.

2) **For Procedure**
   a. Patient with airborne/droplet infection should wear mask.
   b. Instruct the housekeeper to clean the bed or prepare a clean bed to transfer the patient.
   c. Change the linens/gown if soiled.
3) Ensure that the staff who are transferring patient from isolation area should wear protective apparel according to type of infection the patient is suffering from.
4) Transfer the patient with specific precautions.
5) The movements of patients under isolation should be limited, and when transported appropriate barriers should be used.
6) The personnel in the receiving unit should be informed and of the precautions to be taken.
7) Educate the patient in which ways she can help in preventing the spread of infectious microorganism while she is out of the room.

16 PRESSURE ULCER

16.1 PURPOSE

1) Identify those patients who are at risk for pressure ulcer.
2) Know the extent of pressure ulcer.
3) Develop an individualized nursing care plan for patient with impaired skin integrity.
4) Promote evaluation program for pressure ulcers by establishing timetable assessment.

16.2 RESPONSIBILITY

Charge Nurse, Admitting consultant, Infection control Officer

16.3 INDICATIONS:

Following are the risk factors for developing pressure ulcer.

1) Immobility especially immobility of the hips and/or buttocks
2) Inability to feel pain, anesthesia, neurologic damage
3) Incontinence of urine or feces: moisture causes maceration of skin
4) Skin condition of elderly, Thin skin
5) Poor nutrition, Anemia and/or malnutrition can result in skin damage 6) Infections, Bacteria may colonize and/or infect damaged or macerated skin.

16.4 PROCEDURE

1) When a patient has a pressure ulcer, or is at risk of developing one, the patient will be assessed for pressure ulcers.
2) Braden Scale must be completed within 8 hours to identify patient at risk for pressure ulcer**.** ***Annexure-7***
3) Patients with pressure ulcer on admission, or acquired during hospitalization, initial/weekly ulcer assessment form must be completed.
4) Each pressure ulcer is documented on a separate pressure ulcer assessment form.
5) Notify the Admitting Consultant, Nutritionist, Head Nurse, Infection Control Nurse, Nursing Supervisor if patient has a pressure ulcer. Obtain Doctor Order and carry out necessary intervention.
6) Document findings, actions and outcomes in the nursing notes.
7) Acquired pressure ulcer after hospital admission requires an incident report.
8) Section 1 Braden scale is accomplished by scoring system (1-4) based on the risk assessment tool for predicting pressure ulcer.
9) Total score is then computed.
10) If Braden Scale is less than 16 (<16), nurse initiates appropriate intervention according to pressure ulcer intervention guidelines.
11) Section II: This specify the exact lesion size and location of the pressure ulcer. Encircle the number according to the area affected.
12) Section III Initial/daily Pressure Ulcer

17 DISCHARGE PLANNING

17.1 PURPOSE:

1) To define standards for collaborative planning which prepares the patient and her family for discharge from hospital and care at home.

17.2 Responsibility:

Admitting Gynecologist, Staff Nurse, Social worker, Nutritionist, Physiotherapist

17.3 Procedure:

1) Discharge planning shall be initiated after admission needs assessment is completed.
2) The patient and his/her family shall be included in identifying realistic goals and all efforts shall be directed towards helping the patient to achieve these goals.
3) Discharge planning shall be a multi-disciplinary and inter-disciplinary team function.
4) The process must include mechanics to foster continuity of medical aftercare.
5) Attending Doctor shall:
    a. Suggest plans for continued care and sign medical orders.
    b. Determine the appropriate length of stay and begin discharge planning as soon as possible.
    c. Involve the appropriate caregivers (e.g. nurses, physical therapist, nutritionist, social worker, etc.) as soon as possible.
    d. Provide direction, assistance, and support in the discharge planning process and activities.
    e. Communicate information to the patient and team members which will assist the professionals involved to benefit the patient.
    f. Identify necessary appliances and supplies for home use.
    g. Write discharge prescriptions and complete discharge order/instructions for the day. 6) Nursing Administration must:
    a. Ensure that discharge planning is a part of everyday care given by nursing staff.
    b. Consult with the treating Gynecologist and team of Healthcare providers to ascertain a projected plan of care and communicate with all involved disciplines.
    c. Maintain communication with patient and her family as appropriate.
    d. Ensure that procedures are taught and that patient is counseled for better care.
    e. Ensure that documentation of Discharge Plans is written on the Nursing Notes.
    f. Plan for patient and family education in preparation for discharge.
    g. Teach/demonstrate to patient or care provider measures, procedures and health instructions needed to be continued at home after discharge.
7) Nutritionists must:
    a. Make nutritional assessment.
    b. Instruct the patient and/or family in therapeutic dietary needs ordered by the treating Gynecologist.
    c. Assist the patient in planning for her diet so that cultural and religious customs can be maintained.
    d. Interpret how and when the patient can substitute cultural foods in therapeutic diets.
8) Physical Therapists must:
    a. Assess the patient to determine her physical, mental, vocational and social independence through treatment and education.
    b. Make an initial evaluation to assess the level of care and rehabilitation potential for every patient who is referred.
    c. Provide modalities as prescribed by the Treating doctor.
    d. Take measures to prevent deformity.
    e. Teach patients and their families the exercises and skills needed to function effectively and independently within the limitations of their disability.
9) Social Workers must
    a. Assess the patient to determine her psychological and social needs.

b. Involved in the process of discharge planning as well as coordinating after-care services such as at-home care, follow-up appointments or finding the patient a rehabilitation facility, if needed.

Refer to Discharge Planning Form attached in ***Annexure-8***

18 DISCHARGE FROM OBS & GYNE DEPARTMENT

18.1 PURPOSE

To provide guidelines for discharge of patients from Obs & Gyne department to ensure continuity of care.

18.2 RESPONSIBILITY

Consultant Gynecologist, Duty Women Medical Officer, Head Nurse

18.3 PROCEDURE

1) Consultant Gynecologist will take decisions and must document discharge orders/instruction in patient medical records.
2) Patient/attendants will be informed about discharge and discharge process will be discussed with patient and family.
3) Doctor will complete the Discharge Summary Form and hand it over to the patient after signatures.
4) The discharge summary must include
    a. Reason of admission
    b. Brief progress notes
    c. Significant clinical finding
    d. Final diagnosis and co-morbidities
    e. Significant findings of investigations done
    f. List of medications used during hospital stay
    g. Treatment advised
    h. Details of procedure, if performed any
    i. For Post-natal Patients, Baby Notes must include:
        i. Gender of baby
        ii. Alive Status
        iii. Birth Weight
        iv. Apgar Score
    j. Post-operative care instructions (like breast feeding) immunization of baby, cord care, diet, self-hygiene and self-care
    k. Date and Time of discharge
    l. Follow up instructions
    m. Follow up appointment
5) Before discharge, instructions regarding medication/side effects/precautions and restrictions on activities/diet must be given to the patient/ attendant in writing and explained verbally.
6) Signs and symptoms of post-operative problem (Excessive bleeding, pain, leg pain, fever, foul smelling vaginal discharge, chest infection, urinary tract infection) must also be explained in detail.
7) In case of any associated medical problem there should be a referral letter attached with discharge slip.
8) Remove the IV cannula, in-dwelling catheter etc.
9) Record must be maintained in record register of Obs & Gyne Department. Photocopy of discharge slip must be retained for medical record
10) Nursing staff will facilitate the transportation of the patient.

*Referred to Gynecology (Elective Surgery) bedhead ticket attached in **Annexure-1** Referred to Gynecology (Normal Labor) bedhead ticket attached in **Annexure-2***

18.4 FOLLOW UPS

1) Patient of vaginal delivery should have follow up visit at 4-6 weeks.
2) Patients of caesarean section should have follow up visit at 7-10 days for removal of stitches and next visit should be between 4-6 weeks.
3) All gynecological post- op patients should have 1st follow up visit at 7-10 days for removal of stitches and assessment of histopathology report of specimen.
4) 2nd follow up visit shall be planned at 4-6 weeks.
5) All gynecological patients with medical treatment shall be reviewed after 3 months
6) Certain issues should be discussed on follow up
    a. Contraception
    b. Plan for next pregnancy
    c. Women with medical problems should have pre pregnancy counseling 7) All patients who need future follow ups should come again.
8) Rest of patients should be discontinue for follow ups.
9) Head Nurse shall maintain a record register for follow-up appointment.
10) Patients with reports of histopathology showing malignancies shall be referred to oncology unit.

19 REFERRAL TO OTHER HOSPITAL

19.1 PURPOSE

Timely referral of patients who need more complex and specialized care to a tertiary care hospital

19.2 RESPONSIBILITY

Consultant Gynecologist, Duty WMO, Staff Nurse.

19.3 PROCEDURE

1) Duty WMO will decide that the patient requires referral to tertiary care/specialized hospital for further treatment.
2) If patient's clinical condition is unstable ,he/she must be stabilized clinically by providing initial treatment before referral
3) The indications for referral may be
    a) Need of medical care is not available in DHQ/THQ hospital
    b) Patient's preference
4) Duty WMO will contact the Consultant Gynecologist on telephone or through a written call. If required Consultant will physically attend the patient and assess the need for referral.
5) If the patient's clinical condition is serious and any delay in treatment may endanger her life, Duty WMO may refer the patient without Consultant's consent
6) Duty WMO/Consultant Gynecologist will identify the facility where patient could/should be referred.
7) Patient/attendants/family will be informed about need and reasons for referral
8) Contact the referring facility and doctor on-duty if possible and inform him regarding patient needs.
9) Medical/Nursing /paramedical staff may accompany the patient if required.
10) Referring WMO/Consultant Gynecologist must ensure the continuity of care and patient safety during the transfer of patient.
11) Duly filled referral form shall be provided to attendants/family explaining the clinical condition at referral, reasons for referral and name of hospital to whom she is being referred along with brief history, treatment provided in Obs & Gyne department, investigations and reports.

12) Clinical documentation must be completed as per HCE policy and must be available in referring facility.
13) Record must be maintained in referral register of DHQ/THQ hospital and on-line referral system of Primary & Secondary Health Department. Photocopy of referral form must be retained for medical record.
14) Ambulance used must be equipped with necessary equipment for resuscitation and ambulance staff must be trained in Basic Life Support

*Referred to Referral Register and Form attached in **Annexure-9***

20 DISCHARGE ON REQUEST/ LEAVE AGAINST MEDICAL ADVICE

20.1 PURPOSE

To establish guidelines in discharging patient from obs & gyne department against doctor's advice. This policy will protect treating doctor or hospital from any unexpected lawsuits.

20.2 RESPONSIBILITY

Consultant Gynecologist, DMS, Duty WMO, Nursing staff,

20.3 PROCEDURE

20.3.1 DISCHARGE ON REQUEST

1) If a patient expresses a desire to leave the hospital against medical advice, notify the attending physician of patient's desire to refuse or withdraw treatment.
2) The attending physician or duty WMO will discuss the reason with the patient and must explain the potential consequences of discharge on request. Reasonable efforts should be made to address any issues presented as reasons for DOR decision.
3) The discussion should be documented in medical record and include the following. a. The Patient diagnosis
   b. Reason for the patient's DOR decision
   c. Discharge instructions and follow up appointment
4) Patient should be advised to fill up and sign the DOR Consent Form which is countersigned by the Consultant Gynecologist/ Duty WMO.
5) Doctor will complete the discharge summary form (refer to discharge policy) and hand it over to the patient after signature. One copy must be kept in record. 6) Remove the I/V cannula, ID band , indwelling catheter etc 7) Nursing staff will assist the patient in leaving.

16.3.1 LAMA

1) In case the patient leaves the hospital without information, fill the Quality Assurance Leave against Medical Advice notification and submit it to the nursing supervisor and CQI committee with attached patient treatment card.
2) LAMA date and time must be noted in medical records. Nursing staff will sign and Duty Medical Officer will countersign it. DMS must also be informed.
3) Record must be maintained in LAMA register of DHQ hospital

*Referred to DOR and LAMA Consent Form attached in **Annexure-10***

21 DEATH IN THE OB & GYNE DEPARTMENT

21.1 PURPOSE

Notification of the death of patient to her family and issuance of death certificate.

21.2 Responsibility

Consultant Gynecologist, Duty WMO, Nursing staff

21.3 Procedure

1) If a patient dies during treatment in the Obs & gyne ward/ ICU, WMO on duty will confirm death by observing respiration, auscultation, palpate carotid pulse, check pupil and corneal reflex.
2) Duty WMO will declare the death of patient. He will inform the family/attendants and counsel them if needed.
3) WMO must document complete clinical information on progress notes.
4) WMO will issue the death certificate as per hospital policy.
5) Handing over of dead body to relatives by taking their CNIC and signatures upon receiving.
6) Record must be maintained in death register of DHQ/THQ hospital.

Referred to Death Record Register & Death Certificate attached in ***Annexure-11***

22 INFORMED CONSENT

22.1 INFORMED CONSENT

Permission granted in full knowledge of proposed treatment, procedure or act of care with possible risks and benefits. Informed Consent is given by a patient to a doctor.

22.2 PURPOSE

To establish guidelines in securing Informed Consent from patient and/or family in order to protect patient against unsanctioned practice and to protect hospital against claims of negligence.

22.3 RESPONSIBILITY

Consultant Gynecologist, Duty WMO, DMS In charge, Nursing Staff,

22.4 PROCEDURE

1) Consent must be obtained from all patients coming to obs & gyne Department prior to initiation of any treatment. The procedures for which every patient should grant Informed Consent are listed below.
    a. Invasive procedures such as surgical incision, biopsy, cystoscopy, or paracentesis. b. When anesthesia is in use.
    c. High risk procedures such as arteriogram.
    d. Invasive therapeutic or diagnostic procedures
    e. Resuscitation
    f. Radiation or cobalt therapy.
    g. Blood Transfusion
    h. Administering high risk medication
2) Consent shall be written in patient's mother language.
3) If the patient is not competent to give consent, the substitute consent giver should sign the consent form. The substitute consent giver may be:
    a. A decision-maker duly appointed by the patient at such a time that she was not incompetent (was competent). Ideally this appointment will be in writing and witnessed.

b. The legal guardian who may either be an individual or an agency can sign the consent document.
c. An adult relative who has had substantial personal involvement with the patient in the preceding 12 months can sign the consent forms.

The sequence of priority is: Spouse, Father, Mother, Brother, Sister

d. Friends cannot give or withhold consent for the performance of an emergency medical treatment/procedure

4) An intervention should be initiated without consent when an emergency situation exists. Where all the following criteria are fulfilled, consent is not required for emergency treatment
   a. There is immediate threat to life or health.
   b. Treatment cannot be delayed.
   c. The patient is not capable of giving consent.
   d. For minors, the person legally capable of consenting on behalf of the minor is not available.
5) The clinical circumstances that necessitated emergency procedure without a signed consent should be documented in the progress note by Duty WMO.
6) If the patient's emergent need for blood and blood components does not permit obtaining consent, the transfusion should proceed without delay and the clinical circumstances that necessitated emergency transfusion without a signed consent should be documented in the progress note by WMO on duty.
7) If the consent is obtained by telephone, two nurses should monitor the call and sign the form which will be signed later by the patient's legal representative on arrival at the hospital. The call may be recorded on an electronic device if possible.
8) On duty doctor or nurse must document the fact that all attempts were made to contact a substitute consent giver in the medical record of the patient.
9) Unit nurse is responsible to ensure that consent is completely filled up with correct data 10) Duly signed by the patient, witnessed by a relative and treating doctor.

22.5 AN EXAMPLE CASE OF EXPLAINING BENEFITS AND RISKS TO PATIENTS FOR A CAESAREAN SECTION:

22.5.1 THE INTENDED BENEFITS OF C-SECTION:

These include delivery of baby/ babies through a cut in the abdomen and uterus (womb) in a situation where the risks of vaginal delivery are more than those of a caesarean section operation

22.5.2 SERIOUS RISKS OF C-SECTION:

1) Emergency hysterectomy, 7-8 women in every 1000(uncommon)
2) Need for further surgery at a later date, 5 women in every 1000 (uncommon)
3) Admission to intensive care unit, 9 women in every 1000 (uncommon)
4) Increased risk of a tear in the womb in future pregnancies, 2-7 women in every 1000 (uncommon)
5) Developing a blood clot, 4-16 women in every 10000 (rare)
6) Stillbirth in future pregnancies, 1-4 women in every 1000 (uncommon)
7) In a future pregnancy, the placenta covers the entrance to the womb (placenta Previa), 4-8 women in every 1000 (uncommon)
8) Injury to the urinary system, 1 woman in every 1000 (rare)
9) Death, approximately 1 woman in every 12000 (very rare)

22.5.3 FREQUENT RISKS OF C-SECTION

1) Common: persistent wound and abdominal discomfort, repeat caesarean section in subsequent pregnancies, readmission to hospital, minor cut to the baby's skin 2) **Uncommon:** hemorrhage, infection

22.5.4 ANY EXTRA PROCEDURES WHICH MAY BECOME NECESSARY DURING THE PROCEDURE

1) Blood transfusion
2) Other procedure (please specify) hysterectomy, repair to damaged organs

Referred to Gynecology (Elective Surgery) bedhead ticket attached in ***Annexure-1***
Referred to Gynecology (Normal Labor) bedhead ticket attached in ***Annexure-2***
Referred to Gynecology (Labor to C-Section) bedhead ticket attached in ***Annexure-3***

23 DOCTOR'S ORDER

23.1 PURPOSE

To provide guidelines in treatment/ management of patients.

23.2 RESPONSIBILITY

Consultant Gynaecologist, Duty WMO, Staff Nurse

23.3 PROCEDURE

1) Written order should:

   a. Bear the date and time
   b. Include complete description or instruction with approved abbreviation.
   c. Be clear and legible
   d. Duly signed by the attending doctor

2) Doctors' order should be read and reviewed by a registered nurse.

3) Orders that are not clear or doubtful should be clarified before being carried out.

4) Every order should be carried out immediately by the assigned nurse.

5) Check/countercheck and duly signed as the order is carried out by the nursing staff on the Round Order Form

Referred to Gynecology (Elective Surgery) bedhead ticket attached in ***Annexure-1***

Referred to Gynecology (Normal Labor) bedhead ticket attached in ***Annexure-2*** 6)

Nurses must carry out and processes the order as required.

   a. Tick (☑) every order to ensure that it is done and nothing is left unnoticed.
   b. Transcribe or update orders to round order sheet, treatment sheet and medication card.
   c. Nurse executing the order should affix his/her name legibly with date and time.

7) Verbal/telephone order can only be given or received during emergency situation.

8) Verbal/Telephone orders:

   a. Should be received by any registered nurse who is directly responsible for the order.
   b. Should be transcribed and duly signed by the receiving nurse in a piece of paper, indicating the date, time, complete order and name of ordering physician.
   c. Confirm that the order is taken correctly by repeating/reading again the order to the doctor at the time of receiving.
   d. Should be signed by the ordering doctor with in a period of 24 hours.

9) The essential elements of a drug order are:

   a. Date and time the order is given
   b. Drug name (Generic or Trade)
   c. Dose of Drug

d. Route of Administration
e. Frequency and Duration of administration
f. Any special instructions for withholding or adjusting dosage based on effectiveness or laboratory results
g. Doctor's name with signature or name in case of verbal order.

10) When a component is missing from the drug order, the order is incomplete. A registered nurse should not administer the medication until clarification is obtained.

Refer to Doctor Order form attached in ***Annexure-12***

24 NURSING NOTES

24.1 PURPOSE

To create a systematic, clear and concise written accounts on nursing documentation of all the patient care management.

1) Means of communication among health personnel.
2) Serves as legal document.
3) Serves as a basis in determining prognosis.
4) For continuity of care.
5) For future reference in education and research.
6) For Clinical audit

24.2 RESPONSIBILITY

Staff Nurse, Nursing Supervisor

24.3 PROCEDURE

1) All entries should be clearly and legibly written in blue or black ink.
2) Follow approved hospital abbreviation.
3) Never chart/record ahead of time and for anyone else.
4) Follow error policy as:
   a. Draw a single line through the incorrect entry
   b. Draw a Parenthesis ( ) around the incorrect entry, and write error above the line. c. Write the correct entry.
   d. Never erase a wrong entry by using white corrector, scratching or pasting.
5) Entries should be in chronological order according to the right sequence of time of occurrence.
   a. Put the correct time.
   b. Each significant entry should be having a time, duly signed by the staff with his/her complete name and Hospital ID number.
6) All documentation should be counter-checked by the HN/CN before closing the patient medical record.
7) When a nurse is carrying out any procedure or going for rounds with the doctor in the absence of the assigned nurse, the attending nurse will be the one to record the observations and outcomes of the procedure, followed by a detailed endorsement to the assigned nurse upon her arrival.
8) Should not skip lines between entries or leave space before the signature. If any, draw a single line across and sign.
9) Admission notes should include:
   a. Age, sex,
   b. Mode of admission and routine admission care rendered.
   c. Chief complaints (not diagnosis)
   d. Preliminary observations made

   Receiving Notes in Gynaecology (Elective Surgery) bedhead ticket ***Annexure-1***
   Receiving Notes in Gynaecology (Normal Labor) bedhead ticket ***Annexure-2***
   Receiving Notes in Gynaecology (Labor to C-Section) bedhead ticket ***Annexure-3***

   e. Initial vital signs
   f. Accompanying relatives or person, if any

g. Admitting physician

10) Discharge notes should contain the following:
    a. Condition of the patient
    b. Health teachings given
    c. Instructions for take home medicines and diet.
    d. Follow up visit
    e. Mode of discharge
    f. Time of discharge
    g. Accompanying person
    h. If Discharge on request (DOR), it must be documented
11) Transfer-in notes should have
    a. General summary of the present condition.
    b. Specified notes about drains, or catheters attached, or on going IV Fluids if any.
    c. Valuables or personal belongings if any.
    d. Specific instructions if any, x-ray films, medications or reports if present. e. Vital signs
        f. Mode of transfer
        g. Specific area where patient came from

12) Transfer-out notes should include.
    a. Condition of the patient at the time of transfer and area/unit to be transferred.
    b. Gadgets, drains or catheters and IV Fluids if any.
    c. X-ray films, medications or reports if present.
    d. Valuables or personal belongings if any.
    e. Follow-ups to be done
        i. Referral
        ii. Procedure
        iii. Investigations done
    f. Mode of Transfer
13) Pre-op notes should include the complete preparation
    a. Physical
        i. Operation procedure to undergo
        ii. Site (skin preparation)
        iii. Bath given to/taken by patient
        iv. Change of gown/linen
    b. Physiological
        i. Bowel and bladder preparation done ii. Pre-op medications given
        iii. N.P.O. maintained
        iv. Blood investigations
        v. Number of units of blood kept ready
        vi. X-ray, ECG results
        vii. Vital signs and blood sugar if indicated
        viii. Consultation done
    c. Legal
        i. Consent filled and signed
    d. Mode and time of transport to operating room.
14) Post-op notes should consist of:
    a. Surgery done

b. Type of anaesthesia given
c. Name of surgeon
d. Condition of patient
e. Observation made
f. Level of consciousness
g. Drains/catheters if any
h. Dressing
i. IV Fluids or blood transfusion on going
j. Vital signs
k. 4 Post-op orders if any
l. Specific instructions given by the area staff

*Referred to Nursing Notes attached in **Annexure-13***

25 NURSING ENDORSEMENT

25.1 PURPOSE

1) To provide as a baseline for comparison and indicate the kind of care to be anticipated on the next shift.
2) To identify priorities to which incoming staff must attend.
3) To give basic identifying information about each patient - name, bed number, bed designation, current diagnosis, etc.
4) To give a summary of each newly admitted patient, including her diagnosis, age, plan of therapy, and general condition.
5) To report patients who have been transferred or discharged.

25.2 RESPONSIBILITY

Duty WMO, Head Nurse, Staff Nurse, Ward Boys

25.3 PROCEDURE

1) Face to face handover of patient must occur between nursing staff during shift changes in ward; i.e. morning, evening and night.
2) The responsible staff must provide essential information regarding the patient confidentially. It should be accurate, complete, concise, and current.
3) Endorsements should start on time attended by all incoming nurses. The time when shifts start is as follows:
    a. Morning shift - 7:30 AM – 8.00 AM,
    b. Evening shift - 1:30 PM – 2.00 PM
    c. Night shift – 7:30 PM – 8:00 PM.
4) Nursing endorsement should be given by Head Nurse.
5) All clarifications should be made during the time of endorsement.
6) Outgoing nurses should not leave the unit until all notes are completed and/or any question about patient have been answered.
7) Endorsement must be communicated in a language that is understood by all.
8) The following must be endorsed to the incoming shift:
    a. Total census

b. Number of admissions/deaths
c. Number of discharges
d. Number of patients transferred to other departments
e. Number of Referrals

9) Following must be discussed during handover between leaving and coming medical/nursing staff to ensure error-free transition.
   a. Patient's clinical details
   b. Provisional diagnosis and major problems
   c. Relevant co-morbid conditions
   d. Progress and important clinical events during the shift
   e. Any invasive procedures performed during the shift
   f. Important investigation results / pending results
   g. Current orders (especially any newly changed orders in medication, IV fluids, diet and activity level)
   h. Changes in medical condition and response to medical therapy
   i. Probable plan of care for the next shift
      i) Consultant opinion ii) Discharge iii) Admission iv) Referral
   j. Any significant interaction with family/relatives

25.4 SPECIAL CONSIDERATIONS:

1) Unprofessional and judgmental comments about the patient must be avoided, as this could pre-dispose incoming nurses to view and respond to patient negatively.
2) Any conflict that happened between nurses during endorsement must be settled by the Head Nurse.

26 SPECIALIZED SOPS

26.1 MANAGEMENT OF LABOUR

1) Admit the patient.
2) Assess the patient clinically at time of admission.
3) Review all previous record.
4) Label her as low risk or high risk patient.
5) Do CTG.
6) Send certain investigations like.
    a. Blood group +Rh factor
    b. CBC
    c. HbsAg, Anti HCV
    d. BSR
7) Send the patient for USG if indicated.
8) Maintain partogram.
9) FHR monitoring every 15 minutes during 1st stage of labor.
10) If required > Augmentation of labor by syntocinon infusion.
11) Repeat pelvic exam, every 3 or 4 hours if not indicated earlier.
12) Ensure repeated emptying of bladder.
13) Give psychological support to patient.
14) Allow only clear fluids like water.
15) Place the patient in Lithotomy position, once she is fully dilated, drape the patient, empty the bladder.
16) Give local anesthesia at Episiotomy site.
17) Give 5 units of syntocinon I/V at delivery of anterior shoulder.
18) Hand over the baby to pediatrician
19) Wait for placental delivery till 30 minutes by Brand's Andrew method 20) Take cord blood for grouping and Rh factor if mother is Rh –ve 21) Monitor for primary PPH and look for any genital tract injury.
22) Stitch episiotomy in 3 layers.
23) Do Per rectal examination after stitching.
24) Encourage breast feeding.
25) Ask for early emptying of bladder.
26) Discharge after 6-8 hours if post partum period uneventful.

26.2 PRE-LABOUR RUPTURE OF MEMBRANES AT TERM

1) Admit the patient.
2) Take relevant history, examination and necessary investigations.
3) Do not carry out a speculum examination if it is certain that the membranes have ruptured.
4) If uncertain, do sterile speculum examination, avoid PV (digital vaginal examination) in the absence of contractions.
5) Induction of labour after 24 hours if labor pains not started.
6) Until the induction is started or if expectant management beyond 24 hours is chosen by woman.
7) Do not offer lower vaginal swabs and C- reactive protein.
8) To detect infection, record her temperature every 4 hours.
9) Report immediately any change in colour or smell of vaginal fluid.

10) If labour has not started 24 hours after rupture of membranes, advise to stay in hospital for at least 12 hours after birth.
11) Monitor the Baby born with pre labour rupture of membranes at term for first 12 hours of life (1 h, 2 h, 6 h, 12 h).
12) If there are no signs of infection, do not give antibiotics to either woman or baby even if membranes ruptured over 24 hours.
13) If there is evidence of infection, prescribe full course of broad spectrum I/V antibiotics.

26.3 PRE TERM PREMATURE RUPTURE OF MEMBRANES

1) Complicates only 2% of pregnancies and is associated with 40% of pre-term.
2) Associated with significant neonatal morbidity and mortality.
3) Admit the patient.
4) Take detail history, examination (pulse, temperature, abdominal tenderness, C reactive protein, fetal heart rate) and investigations (CBC, CUE, HVS, Obs USG) 5) Do Sterile per- speculum examination.
6) If pooling of amniotic fluid observed, do not perform any diagnostic test.
7) If amniotic fluid positive, give treatment.
8) Offer woman with PROM, injectable antibiotics for first 24 hours then oral erythromycin 250 mg 4 times a day for 10 days or until woman is in established labor.
9) If women cannot tolerate or there are contraindications to erythromycin, consider oral penicillin for 10 days.
10) Give maternal corticosteroids from 24 weeks to 35+6 weeks.

26.4 IDENTIFYING INFECTION IN WOMEN WITH PRE-PROM

1) Do combine clinical assessment and diagnostic assessment (CRP, TLC count and measurement of fetal heart rate using CTG) to diagnose intrauterine infection.
2) Do not use any of the following in isolation to confirm or exclude intrauterine infection in P-PROM.
3) Maternal pyrexia, offensive vaginal discharge and fetal Tachycardia indicates chorioamnionitis.
4) Delivery should be considered at 34 weeks if everything goes normal.
5) If a woman wants to go home, it is reasonable to keep her for 48 hours before making a decision.
6) Give verbal and written information to take regular temperature recordings at home every 4 to 8 hours, Colour and odor of vaginal discharge and fetal movements.

26.5 ANTEPARTUM HAEMORHAGE

1) It is defined as vaginal bleeding after 20 weeks of pregnancy till before the delivery of the baby.
2) Call for help for senior Obstetricians, Anesthetists and Hematologists.
3) Assess the condition of patient, take vitals, BP, pulse.
4) Assess amount of blood loss.
5) Secure two I/v lines (with wide bore cannula 16 gauge).
6) Obtain blood for CBC, coagulation profile and cross match 6 units of the blood.
7) Restore blood volume with I/V fluids
    a. Start one haemaccel and one ringer lactate
    b. Start blood transfusion as soon as possible
8) Monitor and maintain hourly urine output of at least 30ml per hour.
9) Avoid digital and per speculum exam of vagina until placenta Previa ruled out on USG.

26.5.1 IN CASE OF PLACENTAL ABRUPTION

1) Bleeding associated with;
    a. Intermittent or constant abdominal pain.
    b. Fainting attack.
    c. Patient in shock.
    d. Decrease or absent fetal movements.
    e. Tense/ tender abdomen and uterus.
    f. Signs of Fetal distress or absent fetal heart sounds.
2) If fetus is alive and viable, proceed for emergency C. section after stabilization of patient.
3) Ask for help of neonatologist.
4) If fetus dead, counsel the patient and relatives. Give psychological and emotional support to the patient.
5) Do Bishop scoring induce labour according to Bishop Score.
6) Do artificial rupture of membranes early.
7) Correct coagulopathy by fresh blood transfusion and fresh frozen plasma.
8) Monitor renal functions and coagulation profile. 9) If marginal abruption and Fetus is premature:
    a. Watch, bleeding will settle spontaneously
    b. Continue CTG monitoring
    c. If CTG is reactive and biophysical Profile 10/10 or 8/10 with adequate liquor
    d. Give steroid cover and manage conservatively.
10) If patient is bleeding heavily and it does not stop spontaneously:
    a. Shift patient immediately for emergency C. Section regardless of gestational age.
    b. C-Section shall be performed by Consultant Gynecologist in presence of consultant Anesthetist and Consultant Pediatrician.
    c. Shift baby to nursery.
    d. Volume replacement by crystalloids or colloids and by blood transfusion.
    e. Monitor intake and output preferably by securing CVP line.
    f. Shift patient to intensive care unit for intensive care for 24 hours.
    g. Estimate blood loss and replace by blood transfusion.
    h. Monitor for post-partum hemorrhage and continue to monitor mother closely during postnatal period.
11) If fetus is premature, bleeding is mild and stops spontaneously.
    a. Keep patient admitted.
    b. Give steroid cover (Inj. Dexamethasone 12mg I/M 2 DOSES, 12 HOUR APART)
    c. Hb% should be > 12 gm/dl, correct anemia by:
        i. Blood transfusion, in case of major placenta Previa
        ii. I/V iron therapy in minor degree placenta Previa.
    d. Ascertain type of placenta Previa and rule out placenta Accreta.
    e. Keep 4-6 units of blood arranged.
12) In case patient bleeds heavily, proceed for C. Section.
13) If patient remain bleeding free or there are small episodes of bleeding, plan for elective LSCS at 37 weeks.

26.6 POST PARTUM HAEMORRAHGE

1) It is defined as loss of more than 500 ml or more from the genital tract within 24 hours of the child birth (Severe >1000ml, shock).
2) Call for help.
3) A, B, C position flat, keep her warm.
4) Pass two wide bore cannula (14G).
5) Give oxygen (10-15L).
6) Take blood sample for CBC, clotting profile, RFTs, LFTs and blood cross match for 4-6 pints of blood.
7) Until blood is available, infuse 2 Lt of crystalloids and 1.5 Lt of colloid.
8) If blood is available give blood and blood products.
9) Bimanual uterine compression (rubbing up the fundus) to stimulate contraction.
10) Ensure bladder is empty, pass Foleys catheter.
11) Take High risk consent and explain the situation to relatives.

26.6.1 UTERINE ATONY

1) Syntocinon 5 units IV stat.
2) Syntocinon infusion, 40 units in 500 ml Hartmann's solution at 125 ml per hour.
3) PG2α 0.25mg IM repeated after 15 minutes total 8 doses.
4) Misoprostol 1000µg rectally.
5) If bleeding persists, shift the patient to OT.
6) Perform Examination under anesthesia to rule out any local injury. Uterine cavity should be empty.
7) Balloon tamponade.
8) If failed perform emergency laparotomy >> B-lynch >> uterine artery ligation >> hysterectomy.

26.6.2 PERINEAL TEARS 1)

Perform EUA.

2) Stitch under anesthesia and good light.
3) Do Per rectal examination after repair to ensure that sutures have not been inadvertently inserted through ano-rectal mucosa.
4) Give broad-spectrum antibiotic.
5) Give laxatives for stool-softening.
6) Allow fluid and semi-solid diet in early post-operative period as per advice of Consultant Gynecologist.

26.6.3 RETAINED PLACENTA

1) Manual removal of placenta under GA.
2) Give antibiotics for 7 days.
3) Monitor vitals, intake output.
4) Repeat investigations (CBC, coagulation profile, RFTs, LFTs).
5) Results interpretation
   a. Hb >8gdl
   b. Plt > 75X109L
   c. PT, APTT <1.5X mean control
   d. Fibrinogen >1gdl
6) If clotting disorder, give warm fresh blood, FFP, platelet concentrate.

26.7 MISCARRIAGE

1) Miscarriage is diagnosed when fetal pole is >7mm with no fetal heart pulsation or there is a gestational sac with diameter >20-25 mm with no obvious yolk sac.

26.7.1 THREATENED MISCARRIAGE

1) Advise woman with vaginal bleeding and a confirmed intrauterine pregnancy with fetal heart that;
   a. If bleeding gets worse or persists beyond 14 days, patient should return for further assessment.
   b. If bleeding stops, she should start or continue routine antenatal care.

26.7.2 MISSED AND INCOMPLETE MISCARRIAGE

26.7.2.1 EXPECTANT MANAGEMENT

1) For 7-14 days as the first line management if there is no history of >>> risk of hemorrhage (late first trimester), previous traumatic experience (still birth, miscarriage or APH), coagulopathies, evidence of infection
2) Give all women oral and written information what do expect throughout the process, advice on pain relief and when to get help in an emergency.
3) Resolution of bleeding and pain indicate that the miscarriage has completed during 7-14 days.
4) Advise UPT (urine pregnancy test) after 3 weeks.
5) Offer repeat scan if bleeding and pain not started or persisting or increasing.
6) Discuss medical or surgical options.

26.7.2.2 MEDICAL MANAGEMENT

1) 800 microgram misoprostol orally or vaginally
2) For incomplete, 600 microgram if there is no heavy bleeding or infection.
3) Give pain relief and anti-emetics. 4) Advise UPT after 3 weeks.

26.7.2.3 SURGICAL MANAGEMENT 1)

Manual vacuum aspiration

2) Evacuation and curettage

26.8 SEPTIC INDUCED ABORTION

1) Admit the patient
2) Assess the condition of patient
3) If stable;
   a. Do abdominal examination to check signs of peritonitis.
   b. Per speculum and bimanual pelvic examination.
   c. Take HVS culture and sensitivity.
   d. Save I/V line.
   e. Start triple regime antibiotic after sending blood culture and sensitivity.
   f. Maintain hydration status.
   g. Get detail abdominopelvic USG for abdominopelvic collection and RPOCs.
   h. If RPOCs, evacuation of uterine cavity after 24 hours of antibiotic therapy.
   i. Rule out uterine perforation.
   j. If abdominopelvic collection of pus or blood, or signs of gut injury then exploratory laparotomy.

26.9 MANAGEMENT PROTOCOL FOR PATIENT WITH DIC

26.9.1 PURPOSE

1) To manage the underlying disorder in order to remove the initiating stimulus depending upon the specific condition

2) To maintain circulating blood volume. 3) To replace clotting factor and RBCs.

26.9.2 PROCEDURE

1) Call for help of Physician, Hematologist and Anesthetist.
2) Blood grouping and cross matching to arrange at least 6 units of blood 3) Following laboratory test should be done:
   a. Complete blood count with platelets count
   b. PT/ APTT + INR, Serum, Fibrinogen, Conc. + D. Dimers
4) Start prompt and adequate fluid replacement by crystalloids or colloids to maintain circulatory blood volume.
5) Blood and Blood products should be given as soon as available.
6) FFPs + stored RBCs can be given as it provides all the necessary component as in fresh whole blood apart from platelets, till fresh blood is available.
7) If there is persistent bleeding + platelet count is very low 50000, platelet concentrate should be given.
8) Repeat coagulation study every hourly and give replacement accordingly.

26.10 IMPENDING ECLAMPSIA

1) If BP > 160/ 110mmHg (MAP=> 125mmHg).
2) Protein urea ++ on dipstick or more than 1g in 24 hours (in absence of UTI).
3) Symptoms
   a. Severe headache
   b. Epigastric pain
   c. Blurring of vision
   d. Altered consciousness
4) Signs
   a. Hyper reflexia
   b. Epigastric tenderness

26.10.1 MANAGEMENT

1) Admit the patient.
2) Inform Consultant on duty / on call immediately.
3) Maternal surveillance by close monitoring of BP every 15 minutes, urine albumin, urine output by passing indwelling catheter.
4) Send investigations CBC, LFTs, RFTs, serum electrolytes, BSL, coagulation profile, urine C/E and repeat after 24 hours.
5) Strict fluid balance to avoid pulmonary edema or ARDS (not more than 2 liter per 24 hours).
6) Fetal surveillance by clinical examination, CTG and BPP.
7) Control BP by hydralazine 5mg bolus every 10 to 15 minutes until BP is controlled, i.e. 130/90 (max. dose 20mg).
8) Give Mgso4 prophylaxis.
9) Monitor BP every 15 minutes.
10) High risk consent after relatives counseling.
11) Consider delivery after stabilization.
12) Mode of delivery depends on gestational age, fetal maturity and Bishop scoring.

26.11 CLAMPSIA

26.11.1 DEFINITION

1) Any woman with convulsions during pregnancy or in the first 10 days postpartum, together with at least two of the following features within 24 hours of the convulsion(s). a. Hypertension.
   b. Proteinuria (at least 1+ or > 0.3gm in 24 hours collection).
   c. Raised plasma alanine aminotransferase concentration >42 IU/L or an increased plasma aspartate aminotransferase concentration > 42IU/L.

26.11.2 MANAGEMENT

1) Admit the patient.
2) Call for help.
3) Put her in left lateral position.
4) Check ABC.
5) Pass airway.
6) Give oxygen inhalation.
7) Pass IV line.
8) 4gm loading dose of Mg SO4 IV over 15 minutes, then continuous infusion 1gm/ hour for 24 hours after the last fit (maintenance dose).**Or** 5mg MgSO4 by deep IM injection into alternate buttock every four hours, 24 hours after delivery or last fit.
9) Send CBC, Serum Electrolytes, RFTs, LFTs, clotting profile and save serum.
10) Check BP.
11) Pass indwelling catheter.
12) 1 team member should monitor vitals, intake, output, chest auscultation, reflexes.
13) Confirm fetal heart rate.
14) If fetus is alive, steroid cover should be administered carefully.
15) Do Bishop scoring and induce the patient if no contraindications to vaginal delivery.
16) At time of delivery, pediatric team should be alert.
17) If fits still persist, diazepam will be needed and call anesthetic to intubate.
18) If fits continue, GA with muscle relaxation is needed during C-section.
19) After delivery, patient should be in high dependency care for 72 hours but risk of Eclampsia is up to 10 days.

26.11.3 SPECIAL CONSIDERATIONS

1) In case arrangements for care of Eclampsia patients are not available, Patient shall be referred to the tertiary care hospital after initial stabilization.

26.12 MANAGEMENT OF SHOCK

1) Assess the patient.
2) If BP un-recordable, call for help.
3) Check airway, breathing and circulation.
4) Raise foot end of the bed.
5) I.V access with 2 wide bore cannula.
6) Give 100% O2.
7) Take blood for (CBC, LFTs, RFTs, serum electrolytes, coagulation profile and arrange 4 units of fresh blood. 8) Pass Foley's catheter.

26.13 BASIC LIFE SUPPORT (REFERRED TO EMERGENCY MANUAL FOR CODE BLUE POLICY)

1) **Duty WMO shall**
   a. Confirm that patient is:
      i. Unresponsive

ii. No breathing

iii. No pulse in carotid or femoral artery

b. Call for Code Blue and state the exact location on Code Blue speakers.

c. Position the patient in supine, remove pillows and put cardiac board at the back of the patient.

d. Initiate one man CPR while waiting for the Code Blue Team to arrive.

i. Open airway (head tilt-chin lift maneuver).

ii. Assess for breathing (look, listen and feel) for 3-5 seconds. iii. Give breathing (2 seconds each) with the aid of an ambo bag iv. Prevent airway obstruction that maybe caused when the tongue falls back.

v. Use proper sized face and nose mask.

vi. Support the mask with left hand and compress the bag with right hand. vii. Check carotid pulse (5-10 seconds). viii. Locate the area (lower half of the sternum) and start giving compression and ventilation at 15:2 ratio.

ix. Check pulse after 1 minute, if no pulse is detected, continue CPR until the help arrives.

2) **Nurse assigned for Crash Cart shall do the following:**

a. As soon as the Code Blue is announced by the operator, crash cart should be brought to the location of the Code Blue.

b. Put the cardiac board at the back of the patient.

c. Connect ambo bag to oxygen and apply to the patient.

d. Assist in 2 rescuer CPR with 5:1 ratio until the Code Blue Team arrives.

e. Connect patient to cardiac monitor.

f. CPR will be continued by the Code Blue Team as soon as they arrive.

3) **Assigned Nurse**

a. Will give a brief information to the Code Blue Team regarding the diagnosis and the condition of the patient prior to code blue.

b. Will take blood pressure and do suction as needed. 4) **Code Blue Team functions as follows:**

a. Anesthesiologist / ICU Specialist

i. Continue ventilation (ambo bag).

ii. Intubate if needed and maintain patient airway.

iii. Establish and maintain IV access if none.

b. ICU Nurse

i. Assist the anesthesiologist/ Code leader in intubation.

ii. Administer emergency medicines as per ACLS guidelines.

c. Cardiologist

i. Continue with cardiac massage. ii. Order emergency medicines. iii. Monitor cardiac status of the patient.

iv. Apply external defibrillator if indicated with specified number of joules.

d. Nursing Supervisor

i. Nurse Supervisor will record, or delegate RN, to record the event on the CPR Form. The CPR Form will be placed in the patient record and a copy is forwarded to Quality Assurance Department. ii. Obtain additional equipment and help as necessary.

iii. Assist the Code Blue team.

iv. Clear the room of all personnel who are not included in the Code Blue team.

e. Assigned Nurse

i. Assist in the transfer of patient.

ii. Endorse patient to receiving

f. Biomedical Engineer remains on standby for any malfunction of the machine. g. X-Ray Technician

h. Lab Technician

i. Security Guard

j. Support Staff (Ward Boy, Ward helper)

5) To continue Code Blue depending upon the patient's response to the treatment for at least 30-45 minutes.
6) As soon as the patient is stabilized, the patient is transferred to ICU after making necessary arrangements like bed availability, ventilator per order of cardiologist/anesthesiologist accompanied by the Code Blue Team.
   a. Document the following
      i. Time when Code Blue was announced.
      ii. Time CPR was initiated. iii. Time of arrival of the Code Blue Team and management done. iv. Medications given.
      v. Observations made.
      vi. Time of transfer and condition of patient upon transfer.
7) Following the use of cart, replace all used items and notify the pharmacy to arrange for the timely restocking of medications, to be ready for next use.
8) Do not forget to attach cardiac monitor and defibrillator for recharging and portable oxygen cylinder for refilling.
9) In Pregnant women if gestational age is more than 20 weeks, do Perimortem caesarean section, aiming to deliver in 4-5 minutes, if no response to CPR.

Referred to CPR Form attached in ***Annexure-14***

27 PREPARATION AND ADMINISTRATION OF ORAL AND PARENTERAL MEDICATION

Medication Preparation - is one of the nursing functions of setting the medicines ready for administration. The process involves accurate dosage, calculation, measurement and proper handling of medicines.

Medication Administration - is an act of giving the medicines according to the route, drug preparation and safety of the patient.

Routes

1) **Oral**
   a. Oral
   b. Sublingual
   c. Buccal
2) **Parenteral**
   a. Subcutaneous
   b. Intramuscular
   c. Intravenous
   d. Intradermal
   e. Intrathecal
   f. Intra articular

27.1 PURPOSE

To ensure patient and staff safety

27.2 RESPONSIBILITY

Pharmacist, Staff Nurses, LHVs, Trained Midwife and Medical Staff (EMO, CMO, MO, Consultants, Specialists, Anesthesiologist)

27.3 EQUIPMENT/ SUPPLIES

1) Prescribed medicine
2) Medication tray
3) Syringe and needle of different size
4) Medication cups
5) Sterile gauze
6) Alcohol swabs, band aids, tongue depressor
7) Disposable gloves, blue pads
8) Scissor
9) Saline solution, Sterile water
10) Sharp disposal container
11) Razor (if needed)
12) Water soluble lubricant
13) Tissues Mortar and pestle
14) Butterfly needle
15) Stethoscope
16) Sphygmomanometer
17) Thermometer

27.4 POLICY

1) Preparation:
    a. Aseptic technique and proper procedure in handling and preparation of medication must be observed.
    b. Special precaution should be taken for the preparation of cytotoxic drugs.
    c. Follow standard drug calculation and measurement in preparing medications.
    d. Doctor must be informed about the non-availability of the medicines and or if any substitute drug is issued.
    e. Never leave prepared medicine unattended.
    f. Any doubt about the doctor's order should be referred to HN/CN and the attending doctor.
    g. The nurse must be aware of the pharmacological interactions of different drugs during preparation as follows:
        i) Drugs that are incompatible should not be given together.
        ii) Liquids or syrups should not be poured from one bottle to another. iii) Drugs that have changed color, odor, consistency; any expired and unlabeled bottle should never be given.
    h. Intrathecal medication will not be prepared during preparation of any other agent.
    i. Medicines should be prepared in properly lit medication preparation area.
2) Administration**:**
    a. Observe 6 rights in giving medication
        i) Right patient ii) Right medicine iii) Right dose
        iv) Right time

v) Right route vi) Right documentation

b. Observe and maintain patients' rights in giving medication
   i) The patient should be informed of drug name, purpose, action and potential undesired effects.
   ii) The patient may refuse a medication regardless of the consequences.
   iii) The patient may have qualified nurse or physician at hand to assess a drug history including allergies.
   iv) The patient has a right not to receive unnecessary medications.
   v) The patient may receive appropriate treatment in relation to drug therapy.
   vi) The patient may receive labelled medication safely without discomfort in accordance with 6 rights in drug administration.
c. Medication should be administered by the qualified nurse who prepares it. The one giving the medicine must have a sound knowledge about the use, action, usual dose, and side-effects of drugs being administered.
d. Before administration of medications, a registered nurse must make sure that prescription is valid, clear and legible. She can clearly read and understand the prescription and there is no confusion.
e. If **prescription is not clear and legible** and nursing staff responsible for administration of medicine cannot understand it or have confusion regarding medicine orders, he/she should not administer the relevant medicines and should stop to avoid any errors.
f. About medicines that cannot be administered/given for whatever reason, Head Nurse and attending physician should be notified.
g. About any error incurred during administration of medicine, Head Nurse and attending physician should be informed.
h. Verify and double check for high risk medications by independently comparing the Product contents in hand versus written orders by physicians.
i. Pre-aspirated medicine should be used immediately.
j. Never leave the patient until the medicine has been swallowed.
k. Self-administration of medication is not allowed in DHQ/THQ hospital. DHQ/THQ hospital also does not allow administration of patient's medication brought from outside the hospital.
l. Automatic cancellation of medicines, narcotics, controlled drugs and/or anticoagulants for patient who will undergo operation must be followed.

3) Labeling:

a. Prepared medications must be labelled immediately upon preparation prior to preparation of second drug, as this is particularly important for administration of medication in OT during anesthesia, Neonatal, and ICU.
b. No prepared drug should be left unlabeled.
c. Medicines must be labelled clearly and legibly.
d. Label should contain
   i) Patient name and second identifier (MR No, CNIC, DOB, etc.) ii) Full generic name of drug iii) Date and time of preparation iv) Date of administration
   v) Route of administration vi) Total dose to be given, vii) Total volume required to administer this dosage, viii) Date and time of expiration when not for immediate use.

4) Storage

a. Never leave a medicine cabinet or cart unlocked or unattended.

b. Excess medicine or medicine refused by the patient should not be returned to stock cabinet or medicine cart.
c. Any unused and/or left over medicine should be returned to the pharmacy as soon as patient is discharged.
d. Separate storage for preparations for oral use and those for topical use is a must.
e. Those medicines that require to be refrigerated must be kept in medicine refrigerator at required temperature of 2-8 degree centigrade.
f. A system of stock rotation must be operated to ensure that there is no accumulation of old stocks (e.g. first in, first out).
g. Regular stock checks should be carried out every shift daily.
h. Medicines that will expire within 3 months should be returned to the pharmacy to be replaced by fresh stock.
i. Multi-dose vials will be dated with date first used/the seal is broken and will expire at the earliest of the following dates:
i) Multi-dose Injectable: 30 days ii) Allergy Clinic Preparations: 30 days
iii) Multi-dose Ophthalmic Preparations for clinic use: 14 days iv) Nasal Preparations: 30 days v) Otic Drops: 30 days vi) Inhalation Solution: 7 days

27.5 PROCEDURES:

1) Wash hands before the procedure and wear gloves if necessary.
2) Prepare the needed equipment and supplies.
3) Calculate correct drug dose and double check calculation.
4) Preparation:

ORAL

1) Tablet/Capsule
a. Pour required amount into bottle cap and transfer to medication cup without touching with fingers.
b. Package tablet/capsule to be placed directly into medicine cup without removing the wrapper.
c. Place all tablets/capsules given at the same time in one cup except for those requiring pre-administration assessment (pulse rate or blood pressure).
d. Take the prepared or measured medicine in the medication tray to the patient.
e. Identify the patient by asking his/her name.
f. Explain the purpose and action of medicine and the common side-effects. Observe necessary precautions.
g. Assist patient in a sitting position if not contraindicated.
h. Offer water with the medicine.
i. Stay with the patient until he/she swallows the medicine. For sublingual administration, instruct the patient to place the medicine under the tongue and not to swallow.
j. Dispose used medicine cup in appropriate container.
k. Wash hands.

Parenteral

1) Intramuscular
a. Place the prepared injectable medicine in the tray together with alcohol swab, band aid and small sharp container.
b. Identify the patient carefully by asking her name and check the same on ID band.

c. Explain the purpose and action of each medication and the common expected sideeffects.
d. Select site for injection using anatomical land mark.
    i. Vastus Lateralis located in the anterior aspect of the thigh.
    ii. Ventrogluteal Muscles located deep and away from major blood vessels and nerves.
    iii. Dorsolateral Muscles muscles in the upper outer quadrant of the buttocks. iv. Deltoid Muscle located in the upper arm.
e. After selecting appropriate site, wipe the site by using antiseptic swab.
f. Hold syringe between thumb and forefinger in a dart like fashion.
g. Pinch skin tightly. If irritating medicine, use Z track method.
h. Inject needle quickly and firmly at 90 degrees angle. Then release skin.
i. Grasp the lower end of the syringe with non-dominant hand and position dominant hand to the end of the plunger. Do not move the syringe.
j. Pull back the plunger to ascertain if needle is in a vein. If no blood appears, slowly inject the medication. If blood appears in the syringe, discard the medicine and prepare again to start a new procedure.
k. Quickly withdraw the needle while applying pressure on the antiseptic swab after the medicine is consumed.
l. Gently massage the site unless contraindicated.
m. Discard the uncapped needle and syringe in the sharp container.

2) Subcutaneous
a. Take the medication tray containing the syringe with prepared medicine, alcohol swab and small sharp container to the patient bed.
b. Identify the patient carefully by asking her full name.
c. Explain the purpose and action of each medication and the common expected sideeffects (if any).
d. Select the appropriate injection site. The most common site used are the outer aspect of abdomen, anterior aspect of the thigh, posterior aspect of the upper arm.
e. Assist patient in a comfortable position.
f. Clean site with antiseptic swab.
g. Remove cap from needle by pulling it straight off.
h. Hold syringe correctly between thumb and forefinger of dominant hand as in dart fashion.
i. For average size patient, spread skin tightly across injection site or grasp skin with non-dominant hand. For obese patient, grasp skin at site.
j. Inject needle firmly and quickly at 45 degrees or 90 degrees, then release skin if grasp.
k. Give the injection at a 90 degree angle, if you can grasp 2 inches of skin between your thumb and first finger, if you can grasp only 1 inch of skin, give the injection at a 45 degree angle.
l. Pull back the plunger of the syringe to check if the needle is not in the vein (optional). If no blood returns, inject the medicine slowly.
m. If blood appears, remove and prepare a new one.
n. Then withdraw the needle while applying alcohol swab gently above or over injection site.
o. Gently massage the site if not contraindicated.
p. Discard needle and syringe in sharp container.

3) Intradermal
a. Place the prepared injectable medicine in the tray together with the medication card, alcohol swab and small sharp container.

b. Identify the patient correctly by asking her name and check the same on ID band.
c. Explain the procedure/reason why the drug is being given.
d. Provide privacy and assist patient in comfortable position
e. Select site for injection:
    i. Extend elbow and support it to place forearm in flat surface. ii. Inspect site for bruises, inflammation, lesion discoloration, edema, masses and tenderness.
    iii. Forearm site should be 3-4 finger width below ante cubital space and one hand width above the wrist on inner aspect forearm.
f. Use antiseptic swab in a circular motion to clear skin at site.
g. While holding the swab with non-dominant hand, pull cap from needle.
h. With non-dominant hand, stretch the skin over site with forefinger and thumb.
i. Insert needle slowly at 5 -15 degrees angle, level-up, until resistance is felt; advance to no more than 1/8 inch below the skin. The middle tip should be seen through the skin.
j. Do not aspirate, slowly inject the medication until resistance will be felt. Note a small bleb, like a mosquito bite forming under the skin pressure.
k. Withdraw needle while applying antiseptic swab.
l. Do not massage the site.
m. Draw circle around the perimeter of injection site using black ink.
n. Dispose syringe with needle in the sharp container.
o. After 30 minutes, inform the physician to evaluate the result.

4) Intravenous
a. Place the prepared injectable medicine in the tray together with the alcohol swab, Band-Aid, disposable gloves, butterfly needle, tourniquet and small sharp container.
b. Identify the patient carefully by asking his/her name.
c. Explain the procedure, reason why the drug is being given and the expected common side-effects.
d. Ask for previous allergy for IV drug anaphylactic reaction.
e. Provide privacy. Assist patient in a comfortable position.
f. If there is an existing cannula or IV line, check the site for infiltration and phlebitis. Give prepared medicine slowly.
g. If there is no IV access, administer through butterfly needle.
h. Connect the syringe with medicine to the port of the butterfly tubing and push slowly the plunger to fill the tubing with medicine and to expel the air.
i. Select the site for the IV insertion.
j. Place the tourniquet 4-6 inches above the selected site, ask the patient to open and close her fist.
k. Clean the site with alcohol swab.
l. Inject the needle at an angle of 25-45 degrees and check for return flow.
m. Release the tourniquet and stabilize the needle with one hand.
n. When return flow is present, slowly inject the medicine.
o. Pinch the tubing after medicine is completely injected and replace the syringe with saline syringe and flush the tubing.
p. Place sterile gauze with alcohol swab over the insertion site and remove the needle.
q. Apply band aid over the site
r. Inspect the area for redness, pain, swelling, and edema.

5) Assist patient to a comfortable position.
6) Observe closely for adverse reaction as the drug is administered and for several times thereafter.

7) Wash hands.
8) Dispose all supplies used.

27.6 Special Considerations:

1) Crush the tablet with mortar and pestle if medicine is to be given in powdered form.
2) Enteric-coated pills should not be crushed, since the purpose of coating is to delay absorption, thus preventing gastric irritation.
3) Tablets for buccal or sublingual administration should not be crushed.
4) Protect patient against aspiration by giving a tablet or capsule one at a time.
5) For intramuscular injection, solutions that are oily and viscous or those that contain suspended particles must be given through needles of larger diameter.
6) Drug that are injected subcutaneously should be non-irritating.
7) The volume of subcutaneous injection should be less than 2ml.
8) For drug known to be irritating or staining to the skin, a Z track injection method is advised. This method is used for injection of iron salts and for necrotizing or for highly irritating substances.
9) Medium for IV injection must be isotonic solutions (saline of 5% Dextrose).
10) Rapid delivery of large volume of drug during IV injection can lead to embolism, pulmonary edema, elevated BP, or excessive pharmacological responses.
11) If diazepam or chlordiazepoxide HCl is given through IV push, flush with bacteriostatic water instead of saline to prevent drug precipitation due to incompatibility.
12) After heparin injection by SC route, do not rub or massage the site to avoid minute hemorrhage or bruises.
13) Antibiotics should be given after test dose. Antibiotic should be given slowly, if required in an infusion form. Keep watch and early recognition of Allergic reaction after giving antibiotic
14) Streptomycin is not given during the first trimester of pregnancy to avoid staining of teeth of the fetus in later life.

28 VISITING RULES

28.1 PURPOSE

1) To provide visiting guidelines for patients admitted in the unit.
2) To provide secure and healthful surroundings for patients, staff and visitors.
3) To satisfy the psycho-social needs of the patient.
4) To control the flow of visitors coming in and out of the unit.
5) To promote patient privacy during observation and treatment.
6) To prevent any hospital problem regarding infection control.

28.2 RESPONSIBILITY

DMS in charge, Duty WMO, Nursing Supervisor, Security guard

28.3 PROCEDURE

1) DMS in charge will have an overall responsibility of implementing visiting rules and recommending changes, if applicable.
2) Staff will:
    a. Explain rules and regulations to relatives and attendants in the Obs & Gyne Department.
    b. Block unknown guest from entering the unit.
    c. Within reasonable limits, to ensure the safety and security of HCE staff, patients and the visitors

1) Security guard to be informed by the unit personnel, when needed.
2) Only one relative is allowed to be with the patient inside the unit.
3) A maximum of 2 persons are allowed to visit the patient at one time.
4) Children under 12 years of age are not allowed to visit the patient.
5) During treatment procedure, relative is not allowed to be in the vicinity of the treatment room.
6) Visitors shall not
    a. Smoke anywhere within hospital premises
    b. Bring to the patient: medication of any type, linens, electrical devices etc.
    c. Wander into any ward or floor other than the one occupied by their patient.
    d. Take pictures inside the facility
7) Board with clear instructions should be displayed outside the unit by MS.
8) Security guard should make rounds along with the charge nurse after visiting hours to ensure that all visitors are out and persuade overstaying visitors to leave.
9) Flexibility to the policy on visiting rules may be applied for dying patients or patients in critical condition.

28.3.1 VISITING DAYS

1) Daily

28.3.2 VISITING HOURS

1) Morning: 6.00 AM – 7.00 AM 2)
Evening: 2.00 PM – 4.00 PM
3) Night: 6.00 PM—8.00 PM

29 EQUIPMENT

29.1 ESSENTIAL EQUIPMENT

29.1.1 OPD

1) Height and Weight machine
2) BP Apparatus
3) Stethoscope
4) Thermometer
5) Examination Couch
6) Examination Light
7) IUCD insertion/ removal set
8) Pap Smear Tray
9) Stitch Removal Tray
10) Dressing Tray
11) Examination Tray
    a. Sims speculum
    b. Cuscos speculum
    c. Sponge holding forceps
    d. Uterine sound
    e. Aeyrs spatula, slides, fixator
    f. Gloves
    g. Sherman curette
    h. Volsellum
    i. Scissors
    j. Tissue holding forceps
    k. Artery forceps

12) Fetoscope
13) Fetal Heart Sound Detector

29.1.2 WARD

1) Fetal Heart Sound Detector
2) CTG Machine
3) Ultrasound
4) Height and Weight machine
5) BP Apparatus
6) Stethoscope
7) Thermometer
8) Crash Cart
9) Examination Couch
10) Examination Light
11) Stitch Removal Tray
12) Dressing Tray
13) Examination Tray
    a. Sims speculum
    b. Cuscos speculum
    c. Sponge holding forceps
    d. Uterine sound
    e. Aeyrs spatula, slides, fixator
    f. Gloves
    g. Sherman curette
    h. Volsellum
    i. Scissors
    j. Tissue holding forceps
    k. Artery forceps

29.1.3 LABOR ROOM

1) Portable Light
2) Delivery Table
3) Suction Machine
4) Baby Warmer
5) Baby Weight Machine
6) Oxygen Cylinder
7) Neonatal Resuscitation Tray
8) Adult Resuscitation Tray
9) Delivery Set
10) Outlet Forceps
11) Manual Vacuum Extractor

29.1.4 OPERATION THEATRE

1) C-Section Set
2) Dilatation and Curette Set
3) Evacuation and Curette Set

4) Abdominal Hysterectomy Set
5) Vaginal Hysterectomy Set
6) Myomectomy Set
7) Laparoscope
8) Hysteroscope
9) Other Surgical instruments as required by Gynecologist for different obstetrical and Gynecological Procedures

29.2 MAINTENANCE OF EQUIPMENT

29.2.1 DEPARTMENT PERIODIC PREVENTIVE MAINTENANCE PLAN

1) Staff operating equipment will be trained in handling the equipment as per the manufacturer instruction manual.
2) The hospital will develop a routine schedule for inspection and calibration of equipment based upon original equipment manufacturer guidelines.
3) These services can be provided through an in-house arrangement or alternatively through outsourcing.
4) The P&SHD will ensure that the record regarding purchase and maintenance of equipment and machinery is properly documented and maintained.
5) An outline record card will be included with each schedule for recording measurement. The engineer should also note on the record card any item that needs to be replaced.
6) The Department will ensure that no equipment is non-functional by ensuring regular repairs, preventive maintenance, and provision of essential spares.
7) Equipment not working must be tagged "OUT OF ORDER"
8) Any work carried out by the biomedical technician or engineer should be recorded in Equipment History card as follows:
    a. Time spent for servicing.
    b. Description of service being carried out
    c. Status of equipment after servicing
    d. Name of the technician / engineer attended
    e. Date of equipment commissioned and break down during warranty period.

29.2.2 EQUIPMENT INVENTORY

1) All the relevant information about the equipment must be entered, including its installation location, record of repair and maintenance, and the manufacturer.
2) A reference number is given and written on a printed paper label, which is attached to each item. This number is recorded in a ledger of equipment with full identifying details.
3) All equipment in the hospital that is in the care of the department service workshop should be recorded on registers or cards as shown in the format of equipment service history form.

29.2.3 EQUIPMENT AUDIT

1) Equipment audit is the periodic evaluation of the quality of performance of the physiotherapy equipment by Equipment Audit Committee (EAC).
2) The EAC shall meet once every quarter of a year and will fill the maintenance of history sheet and log book of the equipment.

*Refer to Equipment Record and Maintenance attached at **ANNEX-15***

30 SAFETY PRACTICES

30.1 PURPOSE

These have been designated;

1) To prevent inadvertent or hazardous event from taking place.
2) To protect the patient from any harm during the course of hospitalization.
3) To caution patient, relative, and the staff of any hazardous events.
4) To urge the patient/healthcare providers to observe safety measures to avoid dangers when performing duties.

Safety security; freedom from danger, injury, damage, and harmful side-effects.

Precautions actions, words, or signs by which warning is given or taken before any inadvertent or hazardous event might takes place.

30.2 RESPONSIBILITY

Patients, Duty Women Medical Officers, Nursing staff, supporting staff

30.3 PROCEDURE

Safety precaution should be strictly observed at all times. It is the responsibility of every hospital employee. Patients and relatives are not excused from observing safety measures for their benefit.

30.3.1 FOR PATIENTS:

1) Bedside rails should always be on.
2) Safety belt is always applied in transporting patient by stretcher or wheelchair.
3) Prior explanation of the procedure/operation to be done is given to patient/relative.
4) Patient is always identified properly and correctly when dealing with her.
5) Written consent is obtained for a procedure/operation whenever necessary.
6) Observe fall precaution measures at all times and document them.
7) Assistance and support to patient is rendered whenever needed.
8) Sharps and blunt objects are not allowed especially to Psychiatrist patient.
9) Medicines are prepared and administered safely and correctly. Follow six rights in medication administration.
10) All medicines of any type are properly stored and labeled.
11) Medicines shall be administered by authorized and trained staff permitted by law including doctors, nurses, dispensers etc
12) Patient is identified by staff before administration of medicine by asking the patient himself/herself, MR no, by checking the identification band and verifying the details from drug prescription chart
13) Right drug, right dose, right route, and right time is verified from drug prescription chart before administration. Details of medicine administered must be documented with name of drug, dose, and route, time with date. Nurse will affix the signature thereafter.
14) Health teachings such as preventive maintenance; coping up with daily activities; proper ambulating techniques; instructions to take home medications; and follow-up appointment are given to every patient before discharge.
15) Ensure that wound drainage, IV cannula and the likes, are removed, unless indicated.
16) Every patient is accompanied by help desk officer and is assisted in wheelchair from the room to the hospital exit, if needed.

30.3.2 FOR STAFF

1) Observe infection control measures at all times.
2) Submit yourself for annual physical check-up, which is provided free of charge for all hospital employees. Priority is given to high-risk staff.
3) Immunization vaccination should be provided regularly, especially when there is an epidemic.
4) Medical investigations and treatment should be provided to staff exposed to healthhazards showing manifestations such as allergy, pain, or trauma as a result of injury, etc.
5) Needle stick injury policy should be strictly followed.
6) In Obstetrical and Gynecological procedures, face mask and eyewear are particularly important in preventing the mucocutaneous exposure and eye trauma that can be caused by the spray of blood and bone fragments that occur with frequent use of power tools.
7) Wear proper uniform and safety gadgets or devices as required.
8) Gowns with higher water and oil resistance and smaller pore size provide the most protection. Body exhaust suits can provide additional protection from droplet transmission.
9) Wear anti-static shoes as indicated when entering sterile areas.
10) Observe proper waste disposal.
11) Label the procedure.
12) Observe proper handling of cytotoxic.
13) Comprehensive orientation on safety should be given to staff that includes:
    a. Fire Safety training about how to use firefighting equipment and to evacuate patients safely in the event of fire.
    b. Infection Control.
    c. Cardio-Pulmonary Resuscitation (CPR).
    d. Proper operation of new machines and medical equipment.
14) Faulty machines, electrical wiring and connections should be labeled and sent immediately to the Maintenance Department for repair.
15) Do not insist on using defective machine. It can endanger lives.
16) Machines and electrical equipment should be properly labeled as to their voltage and safety warnings..
17) Plug machines and electrical equipment into the outlet according to the correct voltage.
18) Do not use an open wire to conduct electricity.
19) Do not insist on entering a restricted area where there are danger warning signs.

30.3.3 Special Considerations:-

1) Fire safety gadgets provided within the hospital vicinity are as follows:
    a. Fire Alarm
    b. Fire Extinguisher
    c. Fire Hose
    d. Smoke Detector
2) Each nursing care procedure has safety measures that must be strictly followed for patient and staff safety.

31 FALL PRECAUTIONS

Fall Precautions-: safety measures observed to protect and prevent patient from sustaining accidental fall.

31.1 PURPOSE

1) To make all staff and family members aware of the enforced precautionary measures.
2) To identify patients at risk of falls, initiate interventions to prevent falls and thus reduce the risk of injury due to falls.

31.2 INDICATIONS

1) Partial Paralysis
2) Loss of limb
3) Blindness
4) Deafness
5) Impaired mobility
6) Other physical limitation or impaired sensorium/ uncooperative patient
7) Confusion/disorientation
8) Sedation/anesthesia
9) Slow reaction time
10) Lack of coordination
11) History of syncope
12) Convulsion/seizures
13) Transient Ischemic Attack (TIA)
14) 70 years or older
15) Nocturia
16) Recent significant blood loss
17) Previous fall (date _____)

31.3 PROCEDURE

1) All patients at risk will be assessed for fall risk and evaluated immediately upon admission within a maximum of 3-4 hours after admission.
2) Registered Nurse will do the fall risk assessment by using the FALL RISK ASSESSMENT form attached in ***Annexure-16***
3) Following assessment by the nurse, if the patient is found to be at high risk for falls, the fall protocol will be initiated. The fall protocol consists of the following:
    a. Red placard will be placed as signage at foot part of bed.
    b. The patient will need assistance for transfers, ambulation and ADLs. The patient may not be left unattended in her room or bathroom while up or in a chair.
    c. The patient must be positioned in the bed with all side rails up in the position
    d. Beds will be kept in the lowest position at all times with brakes locked.
    e. Ensure that head and footboard of the bed is attached.
    f. Patients will be checked at least every 2 hours with the frequency being adjusted more frequently according to assessed patient needs.
    g. Patients at high risk will be placed in beds close to nurse's station to allow more frequent observation.
    h. Patient and family will be educated regarding the fall prevention program. Education will be documented.
    i. All patients will be instructed regarding their activity level.

j. Physical Therapy Department will be consulted for gait and/or strengthening exercises, if needed.
k. The status of the patients at risk for falls will be a routine part of the end of shift or transfer report.

4) Reassessment must be performed for all patients at risk for fall. Following are the indications for reassessment:
   a. Every shift
   b. Following Procedural Sedation
   c. Medication effects, such as those anticipated with sedation or diuretics
   d. Immediate Postoperative (Within 48 hours post-surgery)
   e. Narcotic administration such as PCA or epidural analgesia
   f. Change in conscious level or mental status
   g. Changing in ambulation
   h. Transfer between Nursing unit/clinic
   i. Whenever there is a fall incident.
5) All falls will be documented and reported.
6) The environment will be kept clean and clutter-free all the times. Adequate lighting will be provided.
7) All wheeled equipment will be placed on a routine preventive maintenance program.
8) There will be a cooperative effort between the nursing staff and patient's family to ensure the safety of the patient. When present, assistance of family member may be required for patients found to be at high risk for falls.
9) Signage will be placed in patient wards to educate and inform patients, family and visitors of safety precautions.
10) Wet floor signs will be available in each unit for use in the event of a spill.

32 MEDICAL RECORD KEEPING

32.1 PURPOSE

To establish guidelines and the responsibilities of various disciplines who depend on the medical record as the primary tool for communicating information important to patient care.

32.2 RESPONSIBILITY

Consultants Gynecologist, Duty WMO, Nursing staff, Medical record review committee.

32.3 PROCEDURE

1) Systematic documentation of a single patient's history and care across time in Obs & Gyne department is mandatory and it is primary responsibility of all healthcare providers i.e. Consultants/ Specialists, doctors, nurses, etc.
2) Medical record of a particular patient is confidential and her right to privacy must be respected at all times
3) Medical records must be maintained for every individual who receives care in Obs & Gyne department.
4) Patient file containing all the medical records will remain in the custody of nursing staff during the entire stay of patient in DHQ/THQ hospital.
5) Every authorized person shall request the nursing staff on duty for patient's file to endorse his/her entry.
6) The author of entry in medical records is identified through signatures, names and designation.
7) The author of entry must make sure that every entry fulfills the following criteria a. Date of entry

b. Time of entry
c. Authenticated by his/her legible name ,signature and designation

8) After the discharge/death/referral /admission of patient, nursing staff on duty shall complete the medical record in all aspects and hand it over to Medical Record Section
9) Medical record must contain
   a. Medical Record Number along with patient bio-data, date and time of admission,
   b. Duly signed informed written consent for procedure/ anesthesia by authorized personnel
   c. A complete History and Physical Examination shall be recorded at all times and should be completed within 24 hours of admission.
   d. A Provisional or working diagnosis must be stated at the end of the completed History and Physical Examination.
   e. Plan of care
   f. All orders for investigation and treatment shall be in writing on the appropriate Physician's Order Sheet, and authenticated by the ordering physician.
   g. If the order is verbal (including by telephone). It also shall be entered on the Doctor's Order Sheet, and signed by the Nurse to whom it was dictated. She should specify the name and title of the Consultant Gynecologist who dictated the order. Consultant Gynecologist shall countersign the order as soon as possible but not later than 24 hours.
   h. All progress notes must include the patient's Subjective symptoms; the Objective findings, the consultant's current Assessment, and further management Plan (i.e. SOAP).
   i. If consultation is requested by a physician as outpatient/inpatient, the consulted physician shall record his or her considered opinion and recommendations on the consultation form. This report shall be authenticated.
   j. Chronological details of treatment/procedure/investigations done during entire stay of patient in hospital.
   k. Patient disposition, transfer to the ward, ICU or other department, with time of disposition.
   l. Discharge/ LAMA/Referral/Death Certificate

10) All entries must be legible, accurate, clinically relevant and authenticated.

*Referred to Gynecology (Elective Surgery) bedhead ticket attached in **Annexure-1***
*Referred to Gynecology (Normal Labor) bedhead ticket attached in **Annexure-2***
*Referred to Gynecology (Labor to C-Section) bedhead ticket attached in **Annexure-3***

33 STATISTICAL RECORDS

33.1 PURPOSE

To establish guidelines to maintain patient's statistical record, duties record of personnel, equipment records etc.

33.2 RESPONSIBILITY

DMS In charge/ Consultant Gynecologist, Nursing Supervisor, Quality Assurance Officer

33.3 PROCEDURE

1) Details of all patients admitted in Obs & Gyne Department must be documented in record register which will include patient demographic data, date & time of admission, diagnosis along with disposition details.

2) Obs & Gyne department must maintain the record of following:

a. Number of Normal Vaginal Deliveries
b. Number of Assisted Vaginal Deliveries
c. Number of Elective C-Section
d. Number of Emergency C-Section
e. Total number Number of live Births
    i. Full-Term Birth
    ii. Pre-Term Birth
f. Number of Still Births
g. Number of D & C
h. Number of Antenatal Visits
i. Number of Gynecological Procedures
j. Number of Discharge Patients
k. Number of DOR Cases
l. Number of LAMA cases
m. Number of referral
n. Number of Deaths

3) There should be record maintained for duty replacements of medical and paramedical staff inside the unit.
4) Daily generated waste in unit may be entered in waste record register.
5) Evidences of trainings conducted for staff must be maintained in training file.
6) There should be a separate file for equipment used in department with their inventory list, service history record, PPM record, inspection checklists.
7) Nursing supervisor and DMS Incharge will be responsible for assembling, archiving and retrieving of all these records.

Referred to Obs & Gyne Record Registers attached in ***Annexure-14***

34 INFECTION CONTROL

34.1 PURPOSE:

To establish guidelines and practices in the unit in conformity with the hospital- wide infection control program in order to:

1) Protect healthcare workers from blood borne infections.
2) Minimize, if not prevent infection, from patients having blood-borne viruses and pathogenic bacteria from recognized and unrecognized sources.
3) Implement isolation precaution for infections that are virulent or communicable hence, prevention of their transmission to other patients is attained.
4) Establish guidelines for vaccination against hepatitis B for susceptible patients.

34.2 RESPONSIBILITY

ICN, HOD, Consultant Gynecologist, Ward WMOs, Nursing supervisor, DMS Incharge.

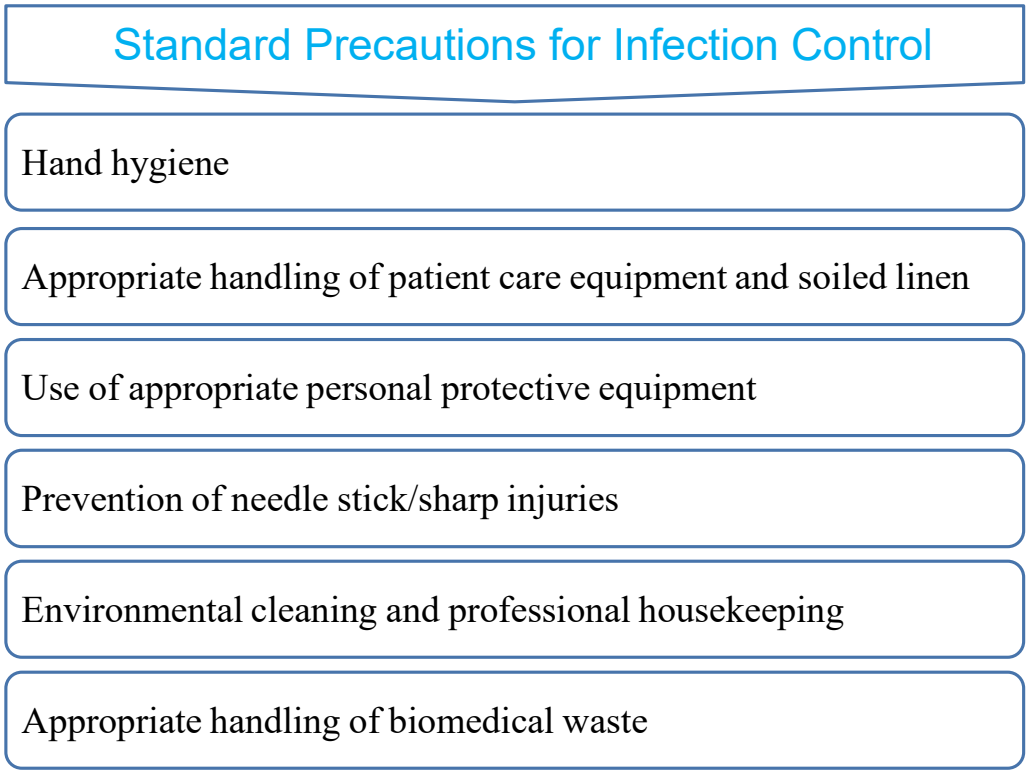
34.3 PROTOCOLS

Transmission of infections in healthcare facilities can be prevented by adopting following standard precautions and protocols

1) Ensuring hand hygiene 2) By promoting the use of appropriate PPE while handling patient's blood, body fluids, excretions and secretions.
3) Ensuring prevention of needle stick/sharp injuries

4) By ensuring environmental cleaning and professional housekeeping
5) Through appropriate handling of biomedical waste
6) Through appropriate handling of patient care equipment and soiled linen and by ensuring all reusable equipment is cleaned and reprocessed/sterilized.
7) By reducing the number of visitors/attendants in A&E
8) Through education for visitors on the importance of hand hygiene 9) By controlling rodents, pests and other vectors.

(Reference; Practical guidelines for infection control in healthcare facilities SEARO Regional Publication No. 41)



34.4 PROCEDURE

1) All staffs should perform proper hand washing techniques on following occasions: a. coming to duty
   b. before and after wearing gloves
   c. before and after patient contact
   d. after removal of gloves
2) All nursing staff and ward boys should wear a designated uniform.
3) All staff should comply with policy of wearing protective barriers in following events.
   a. In contact with blood or contaminated equipment.
   b. Touching body fluids, secretion, contaminated items or blood.
   c. Avoids touching surface with gloved hands that will be subsequently touched with ungloved hands.
4) Cleaning of blood spills should be done by bleaching chemical.
5) Keep number of personnel and conversation in the unit to a minimum.
6) Relatives should be limited to a minimum number.
7) Patients who appear unusually ill, especially with cough, should be isolated from other patients if possible.
8) Appropriate patient preparation should be done in accordance to infection control guidelines.

9) Comply with the infection control policies on cleaning and storage of equipment.

10) All disinfections and sterilization of all equipment used during procedures should be done in the Sterilization Unit.

11) Clean and disinfect surface areas of beds and tables with 70% Isopropyl alcohol and bleaching solution.

12) Needles and sharps should be disposed only in a specified sharp container (puncture resistant, leak proof)

13) Place linens soaked with blood and body fluids in a separate yellow bag properly labeled. (if contaminated with Hep B, C , HIV, then in red bag properly labelled)

14) Nursing Supervisor

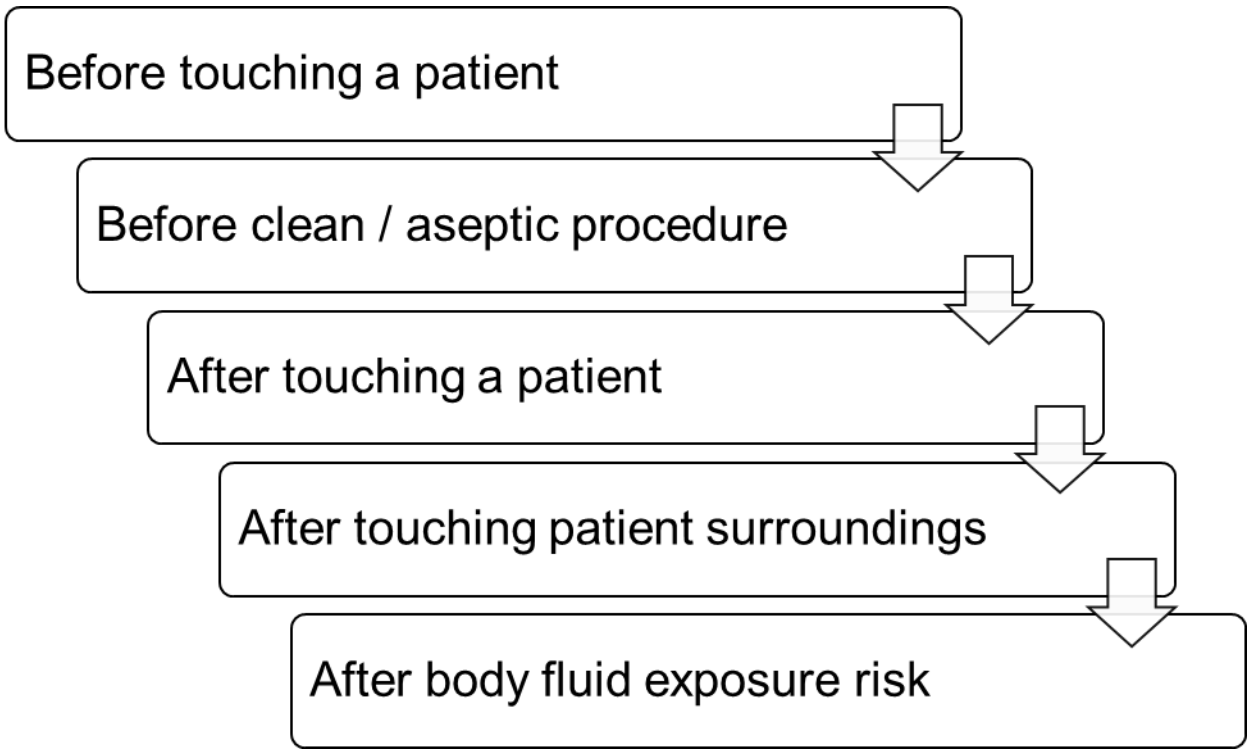
    a. Assists with the infection control officers in the formulation, review, and revision of infection control policies and procedures.

    b. Ensures all nursing staffs comply with the established infection control policies and procedures.

    c. Provides information, orientation, and continuing education program regarding infection control of nursing staffs in coordination with the infection control committee.

    d. Serves as a resource person for support personnel, patients, and families regarding infection control.

ESSENTIALS OF HAND HYGIENE



35 CONTINUOUS QUALITY IMPROVEMENT

35.1 PURPOSE

To establish an effective process which leads to measurable improvement in health care services provided to the patient by identifying factors affecting service quality.

35.2 RESPONSIBILITY

MS, Consultant Gynecologist, DMS Quality Control, Quality Assurance Officer, Nursing Supervisor

35.3 PROCEDURE

1) The CQI Committee comprises of the following individuals:
    a. MS of the HCE,
    b. Medical Consultant
    c. Surgical Consultant
    d. DMS Quality Control
    e. Quality Assurance Officer
2) All quality improvement efforts in unit are guided by following MSDS from MSDS reference manual of PHC.
    a. Access, Assessment and continuity of care AAC(lab and radiological services provided to urology patients)
    b. COP 1. Emergency services
    c. COP 2. Blood bank services provided to obs & gyne patients
    d. COP 4. and COP 5 for patients undergoing surgeries.
    e. Management of medication MOM
    f. Patient Rights and Education PRE
    g. Hospital Infection Control HIC
    h. Facility Management and Safety FMS
    i. Human Resource Management HRM
    j. Information Management System IMS
3) In addition to these, the Obs & gyne department participates in the required MSDS quality monitors for:
    a. Appropriate patient assessment with plan of care including treatment course and its documentation in medical record (Gyne bedhead ticket).
    b. Laboratory and radiology safety and quality control programs (including defined SOPs, implementation, documented training on SOPs, and training on occupational health and safety SOPs, external validation)
    c. Monitoring of invasive procedures and adverse events like wrong patient, wrong site, wrong surgery, return to operating room within 24 hours and re admission within 24 hours.
    d. Monitoring of adverse drug reactions
    e. Use of anesthesia and any adverse outcome like unplanned ventilation following anesthesia.
    f. Use of blood and blood products and any adverse outcome like transfusion reactions.
    g. Review of medical records to ensure availability, content and use of medical records.
    h. Risk management and surveillance, defined sentinel events and after that control and prevention of such events that affect the safety of patients, family and staff.
    i. Discuss the number of antenatal patients, normal deliveries, elective and emergency C-section, referred obstetric patients, still births, neonates admitted in nursery, SSI reported etc.
4) These functions are overseen by key committees, including, but not limited to,
    a. Infection control Committee
    b. Blood Bank Committee
    c. Operation theatre Management Committee

d. Medical Record Review Committee.
e. Medication Usage and Evaluation Committee
f. Continuous Quality Improvement Committee.

5) Once in a month CQI meeting will be held and all relevant information derived from quality improvement activities shall be shared to administration and concerned area of problem ,so that action can be taken at the right level to solve identified problems and to avoid duplication of effort.
6) Minutes of meeting will include defined agenda, issues discussed, conclusion/ recommendation, target date for action plan and the responsible person.
7) Documentation of review meeting shall be maintained in a confidential file by consultant Gynecologist.

(Refer to CQI Manual for further details)

36 FAQS

36.1 Are children of patients or their attendants allowed in General OPD and Inpatient ward?

It is not recommended for families to bring children under the age of 12 to visit with patients. However, if patients have no option but to keep children with them, it is under the assumption that the family will ensure strict discipline and good behavior of the child. If the family is unable to do so, the attendants may be asked to take the children outside the Department.

36.2 Are patients allowed to use their mobile phone to call relatives and friends?

This must be reviewed on a situational basis. Ideally, patients or their attendants should not use cellular devices while in the emergency department, operation theatre or ICU because of the risk that there will be interference of medical monitoring equipment. However, there may be circumstances where it is essential for patients or their attendants to contact friends or family, such as in instances of patient death. In general ward the use of mobile phones should be allowed, as long as their use does not affect the safety of patients or other people, patients' privacy and dignity, the operation of medical equipment.

It is recommended that the healthcare provider take a gentle approach while talking to patients requesting to use a cellular device, and explain the situation to patients, or request for attendants to take telephone calls outside.

36.3 Can Women Medical Officers document operating reports?

There is no regulation requiring the attending Gynecologist to physically document the services rendered or findings of a surgical procedure. WMOs can prepare the documentation for the attending Gynecologist, at his or her direction, but the attending Gynecologist needs to review, approve, and sign the dictated operative report, thereby validating that all of the information provided by the resident is accurate and complete.

36.4 What should Patients bring on their antenatal and gynecological checkups?

They will bring relevant medical records, scan reports and investigations performed, if any.