PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

ANAESTHESIA		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 1** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ANAESTHESIA

SCOPE OF SERVICES

1. The PRIME SURGICAL CENTERS is a surgical center which provides services to include a variety of specialties. In addition to the anaesthesia service, support services include radiology and laboratory.
2. Techniques used include general anaesthesia, regional anaesthesia, monitored anaesthesia care (MAC), local infiltration and conscious sedation.

Patients appropriate for treatment at the short stay surgery center include physical status classification I & II.

AMERICAN SOCIETY OF ANAESTHESIOLOGISTS (ASA) PHYSICAL STATUS CLASSIFICATION:

1. **Class I**: The patient has no organic, physiologic, biochemical or psychiatric disturbance. The pathologic process for which operation is to be performed is localized and does not entail a systemic disturbance.
2. **Class II**: Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes. Patients with non or only slightly limiting organic heart disease, mild diabetes mellitus, essential hypertension or anaemia. Extremes of age, either the neonate or the octogenarian, even though no obvious systemic disease is present. Extreme obesity, chronic bronchitis, mild chronic obstructive airway disease, and patients with moderate smoking habits.
3. **Class III**: Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality. Severely limiting organic heart disease, severe diabetes mellitus with vascular complications, moderate to severe degrees of pulmonary insufficiency, angina pectoris or healed myocardial infarction.
4. **Class IV**: This classification is indicative of the patient with severe systemic disorder already life threatening, not always correctable by the operative procedure. Patients with organic heart disease showing marked signs of cardiac insufficiency, the anginal syndrome or active myocarditis, advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency.
5. **Class V**: The moribund patient who has little chance of survival but is submitted to an operation in desperation.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

EXPOSURE CONTROL PLAN MANUAL

PURPOSE OF EXPOSURE CONTROL PLAN AND DEFINITION OF TERMS		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 1** **Page: 1 of 2**
Effective Date: 11 April, 2013		

EXPOSURE CONTROL PLAN AND DEFINITION OF TERMS

PURPOSE

1. The key intent of the Exposure Control Plan is the protection of the employee at risk. Employees are at risk for acquiring infection and subsequent illness each time they are exposed to blood or other potentially infectious materials. The Prime Surgical Centers standard presumes that all human blood, bodily fluids and tissues are potentially infectious for Hepatitis B (HBV), human immunodeficiency virus (HIV), Hepatitis C (HCV) as well as other blood-borne diseases in the healthcare workplace.
2. The purpose of this Exposure Control Plan, therefore, is to minimize the healthcare worker's risk by eliminating or reducing employee exposure incidents to blood borne pathogens such as HBV and HIV, HCV.
3. This Exposure Control Plan establishes the Prime Surgical Centers policies and procedures for providing a safe workplace, by minimizing or eliminating occupational exposures to healthcare workers at risk.

DEFINITION OF TERMS

The terms used in this manual are defined as under:

1. **Blood** - Human blood, human blood components, and products made from human blood.
2. **Blood borne Pathogens** - Pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).
3. **Contaminated** - The presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.
4. **Contaminated Laundry** - Laundry that has been soiled with blood or other potentially infectious materials or may contain sharps.
5. **Contaminated Sharps** - Any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.
6. **Decontamination** - The use of physical or chemical means to remove, inactivate, or destroy blood borne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.
7. **Engineering Controls** - Controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the blood borne pathogens hazard from the workplace.
8. **Exposure Incident** - A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.
9. **Hand washing Facilities** - A facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines.
10. **Licensed Healthcare Professional -** A person whose legally permitted scope of practice allows him or her to independently perform the activities required by the section on Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.
11. **Needleless Systems** - A device that does not use needles for the collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established; the administration of medication or fluids; or any other procedure involving the potential for occupational exposure to

blood borne pathogens due to per-cutaneous injuries from contaminated sharps.

12. **Occupational Exposure** - Reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.
13. **Other Potentially Infectious Materials** - Human body fluids like semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.
14. **Parenteral** - Piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions.
15. **Personal Protective Equipment** - Specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts, or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.
16. **Regulated Waste** - Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.
17. **Sharps with Engineered Sharps Injury Protections** – A non-needle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medication or other fluids, with a built in safety feature or mechanism that effectively reduces the risk of an exposure incident.
18. **Source Individual** - Any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.
19. **Sterilize** - The use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.
20. **Universal Precautions** – An approach to infection control. According to the concept of universal precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, HCV and other blood borne pathogens.
21. **Work Practice Controls** – Controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two handed technique).

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

GENERAL NURSING ORIENTATION (GNO)		
Policy/Procedure Applies To	**All Nurses and O.T. /X-Ray Technicians**	**Policy/Procedure No: 1** **Page: 1 of 4**
Effective Date: 11 April, 2013		

GENERAL NURSING ORIENTATION (GNO)

POLICY STATEMENT

Guidelines are formulated for the orientation program for Nursing Department's personnel

DEFINITION

To ensure that newly employed Nursing Staff receive consistent information regarding Standards of Practice, Policies, Procedure and documentation to support practice and familiarize them with Prime Surgical's philosophy, vision, mission, values, goals and organizational Structure.

RESPONSIBILITIES

1. Nursing Superintendent:
   Responsible for revising the Policies & Procedures
2. Consultant Education:
   Responsible for formulating the policy & procedure and implementation of the Orientation Program
3. Operating theatre – Matron/ Unit Incharge:
   Responsible for disseminating the information contained in the policy & procedure and monitoring the staff for compliance
4. Staff Nurse /Technicians-Operating Theater Technicians (O.T.Technician)/X-Ray Technicians, etc.:
   Responsible for adherence to the policy

POLICY

1. All newly employed Nursing Personnel of Prime Surgical Center shall undergo General Nursing Orientation (GNO) before assuming his / her job position
2. All new employees must attend the General Orientation conducted by Human Resource or Administrative Head of Prime Surgical Center before being oriented to the Nursing Department
3. Orientation to the Nursing Department Personnel shall consist of but not limited to the following:
   a. Nursing Department organizational structure and scope of services
   b. Nursing Department philosophy, mission, vision and values
   c. Administration policies and procedures
   d. Service Provided
   e. Job description / performance expectation / yearly performance appraisal
   f. Physical resources
   g. Staffing / Scheduling
   h. Policies and Procedure
   i. Physical orientation or a tour to facility
   j. On-job orientation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

GENERAL NURSING ORIENTATION (GNO)		
Policy/Procedure Applies To	**All Nurses and O.T. /X-Ray Technicians**	**Policy/Procedure No: 1** **Page: 2 of 4**
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All Nurses of Prime Surgical shall attend the General Nursing Orientation (GNO) program at the earliest / possible opportunity

General Nursing Orientation consists of the following topics:

1. Customer Relations
2. Charting and Clinical documentation
3. Discharge planning
4. Absconding and Discharge Against Medical Advice
5. Nursing Process
6. Patient family education
7. Nursing Code of Ethics
8. Patient's Rights and Responsibilities.
9. Confidentiality and Privacy
10. Professional Conduct / Standards of Professional behavior
11. Professional Communication Skills
12. Management of Environment of Care
    a. Health Care Waste
    b. Responsibility of Nurses, Technician, Nursing Aides, OT Assistant and House Keeping
    c. Waste minimization
    d. Identification, Segregation, Packing, Color Coding, Labels & Signs,
    e. Transporting Waste
13. Personal Protection Equipment
14. Performance improvement
15. Prevention and Control of infection
16. Professional Caring
17. Pre, Intra & Post operative care
18. Safe medication administration
19. Medication Administration Certification Course
20. Medication Management and Use
21. High Alert Medication
22. Drug Calculation
23. Body Mechanics and safe patient handling
24. Fall prevention

25. CPR (Cardio –Pulmonary resuscitation as Basic Life Support)
26. Code (Blue) Management
27. Crash Cart Emergency medication
28. Defibrillator Test
29. Bed Making
30. Methodology for giving bed-pan/urinal
31. Perineal Care
32. Bathing
33. Pre, Intra and Post Operative Care
34. Uniform and Grooming
35. IV Therapy and Certification Course
36. Admission of Patient
37. Vital Parameters
38. Patient Transportation.
39. Disposal of Contaminated needle and Syringe
40. Sharp Injury
41. Nasogastric tube Insertion: Giving Medication and Removal
42. Urinary Catheterization
43. Gloving and Gowning.
44. Patient positioning in the OT and Procedure room

PROCEDURE

Upon reporting to Prime Surgical Nursing Section, the Nursing Superintendent shall introduce the new employee to the staff and facilities as well as to the rules of the department.

1. Subsequent orientation activities shall be in accordance with the established plan contained in the Nursing Administration Orientation Manual
2. The Nursing Superintendent & OT Matron shall assign a preceptor for a designated period of time or activity.
3. Clinical orientation for the Nurses, Technicians, OT Assistants and Nursing Aides shall commence after orientation to the Administrative Department's Orientation and preferably after completing the General Nursing Orientation.
    a. The Consultant for Nursing Education shall inform in writing or by telephone to the Nursing Superintendent / Operation Theater Matron prior to the Clinical Orientation. An orientation schedule shall be attached.
    b. Once clinical orientation starts, the schedule shall not be interrupted, unless otherwise requested by the Nursing Superintendent.

GENERAL NURSING ORIENTATION (GNO)		
Policy/Procedure Applies To	**All Nurses and O.T. /X-Ray Technicians**	**Policy/Procedure No: 1** **Page: 4 of 4**
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c. Upon completion of her / his clinical orientation, the Nurse shall submit a brief account of her / his orientation experience to the Consultant Educator.

d. Consultant Educator shall submit a checklist or a Report of each Nurses performance during the General Nursing orientation to Nursing Superintendent.

4. Clinical orientation for the Nurse shall consist of but not limited to the following :
   a. Physical facilities
   b. Department – specific policies, procedures and protocols
   c. Specialty core competencies / assessment check list / monitoring tool
   d. Patient care activities
5. The duration of the clinical orientation shall vary, but not to exceed 15 working days. He / She shall be given more time in his /her area of specialization.
6. On-job orientation of the Nurse shall consist of, but not limited to the following role functions:
   a. Assessing Patient needs, planning and implementing the care
   b. Documentation of the Patient care
7. On-job orientation of Nursing Aides and support staff shall focus on specific job expectations
8. The Nursing Superintendent and OT Matron shall initiate department orientation. Subsequent orientation activities may be delegated to on-board staff (preceptor) that is above or of the same level as the new employee.
9. The entire orientation period shall not exceed 45 days (1 ½ month) for the Nurses and one month for the Nurses and one month for the Nursing aides and support staff.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOUSEKEEPING MANUAL

HOUSEKEEPING AS FACILITY MANAGEMENT SYSTEM		
Policy/Procedure Applies To	**All Housekeeping Staff**	**Policy/Procedure No: 1** **Page: 1 of 1**
Effective Date: 11 April, 2013		

HOUSEKEEPING AS FACILITY MANAGEMENT SYSTEM

PURPOSE

1. Pleasant Work Environment
2. For comfort of patient , staff & visitors
3. Control and Prevent Hospital Infection.

The housekeeping services thus may be summarized as “All activities directed towards a clean, safe and comfortable environment”.

POLICY

1. Clean, remove waste and maintain – All floors, walls, ceiling, vestibular area, rooms, departments, gardens, public areas, toilets, terrace, external boundary.
2. Remove general furniture & specified items of aseptic furniture for maintenance and repair.
3. Clean, dust, maintain – drapes, curtain, blinds.
4. Check – fixtures, luminaries, fittings(electrical and sanitary)
5. Replenish- Utility supplies – Soap, toilet paper, towels.
6. Report – broken, missing hospital property to authority.
7. Report – deviations of area use – wrongly parked trolley, shoes, stacking of furniture.
8. Cleaning & maintenance of clean rooms, laboratories areas

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

INFECTION CONTROL		
Policy/Procedure Applies To	**All staff Nurses & OT Technicians**	**Policy/Procedure No: 1** **Page: 1 of 4**
Effective Date: 11 April, 2013		

INFECTION CONTROL

PURPOSE

The purpose of the Infection Control Policy is to outline the duties and responsibilities of nursing staff.

1. Each Nurse is expected to know how to perform all procedures necessary for the prevention and/or containment of infection.
2. The Prime Surgical Centers will provide a programme for all nurses during General Nursing Orientation (GNO) and yearly in-service. Consultant Nursing / Superintendent will be responsible for this activity.
3. Objectives for the program are:
   a. To provide optimum asepsis in Individual care,
   b. To provide an environment free of infections,
   c. To protect patients, personnel, and visitors against the risk of disease transmission,
   d. To participate effectively in infection control programs and surveillance monitoring activities as directed, requested, or required,
   e. To conduct and participate in planned regular in-service training and education programs for Infection Control.
   f. To conduct periodic risk analysis within the center and implement appropriate action plans to correct any identified opportunities for improvement.
   g. To identify and evaluate the occurrence of Healthcare Associated Infections (HAIs) and make recommendations for their reduction.
   h. To facilitate compliance with reporting requirements of the center to public health agencies.

POLICY

This policy is formulated for all Nursing staff on the process of Infection Control Practices to minimize the risk of infection associated with patient care practices through the application of principles of asepsis (both medical and surgical asepsis.)

DEFINITIONS OF TERMS

1. **Infection Control Practices** – Various measures applied to limit transfer and introduction of microorganisms into the body system through surgical, medical, and nursing procedures. These measures include:
   a. **Medical Asepsis of Clean Technique** – A practice to reduce the number of micro-organisms and prevent their spread from one place or person to another i.e. hand washing and skin antisepsis.
   b. **Surgical Asepsis or Sterile Technique** – A practice used to eliminate micro-organisms from the area or from an object e.g. Foley's catheter.
   c. **Sterile -** The absence of all living organisms.
   d. **Asepsis** – The exclusion of all micro-organisms which may cause infection.
   e. **Antisepsis** – Prevention of sepsis by preventing or inhibiting the growth of resident and transient microbes.
   f. **Standard precautions** - are practices that help to prevent the transmission of pathogens that might travel by means of blood or other body fluids and substances.

g. **Transmission-based precautions** - are precautions taken for persons with certain or suspected highly contagious illnesses. It includes three sets of precautions based on different ways diseases can spread:
   i. Airborne - Pathogens stay suspended in the air or dust becomes contaminated
   ii. By droplet - Pathogens are sent into the air when an infected person coughs, sneezes, or talks
   iii. By contact - Pathogens are passed between a person and an object or another person

h. **Airborne precautions** - are required for patient known or suspected to be infected by airborne pathogens (e.g. measles, chickenpox, tuberculosis).

i. **Droplet precautions** - are required for patient known or suspected to be infected by pathogens that travel in droplets, (e.g. scarlet fever, influenza, mumps, rubella, pertussis etc.).

j. **Contact precautions** - are required for patient known or suspected to be infected by pathogens that travel by direct contact (e.g. impetigo, herpes simplex).

k. **Contaminated** - The known or assumed presence of an infectious agent on a body surface, also on or in clothes, bedding, toys, surgical instruments or dressing, or on or in other inanimate articles or substances including water, milk or food.

l. **Disinfection**- The reduction in population of a disease producing micro-organism (but generally not resistant spores) usually by chemical germicides or heat.

m. **Infection**- Infection is the entry and multiplication of infectious agents in the tissues of a susceptible host. The results of infection may not be apparent and be detected only by antibody responses.

n. **Infection, hospital associated**- (Healthcare Acquired Infection) a hospital associated infection in a patient which was not apparent upon his/her admission but developed thereafter and when clinically diagnosed, did not appear to have been incubating at the time of admission.

POLICY

1. Nursing staff are to maintain appropriate work practices that are essential to the prevention, recognition, reporting, and management of the spread of disease or infection.
2. Nursing staff are expected to participate in infection control programs as outlined in Prime Surgical Centers policies and procedures, and standards of practice.
3. Nursing Staff will assist with surveillance monitoring activities as directed, requested, or required.
4. Nursing staff will maintain ongoing patient teaching and instruction of infection control measures based on the patient needs.
5. Nursing staff, having direct contact or the potential for contact with exposure to blood, body fluids, or other potentially infectious material of patient / staff, are expected to practice standard precautions according to policy on sharp injury (Refer to Hospital Infection Control Manual Policy and Procedure No. 5).
6. The fluid, blood, and moist body substances of patient's shall be treated as though they were contagious.
7. Standard Precautions will be utilized for all patients. These precautions will also serve to guide the care of patient who are merely suspected of having such illnesses.

INFECTION CONTROL		
Policy/Procedure Applies To	**All staff Nurses & OT Technicians**	**Policy/Procedure No: 1** **Page: 3 of 4**
Effective Date: 11 April, 2013		

PERTINENT CATEGORIES INVOLVING NURSING STAFF

1. Treatment of Nurses shall be done in accordance with Prime Surgical Centers policy:
   a. Nurses who become ill on duty shall report to their supervisors.
   a. Nurses who have an infection that pose a hazard to patient or other staff shall be cleared by a physician before being allowed to work.
   b. Prophylactic Therapy shall be provided for Nurses
   c. All level of nursing staff are offered Hepatitis B vaccine.
2. Protection measures for nursing staff working in the unit:
   a. Adequate hand washing facilities shall be available.
   b. Periodic in-service training programs to update infection control procedures shall be provided.
   c. Work area restrictions– no food or drink shall be kept or consumed near bio-hazardous substances such as laboratory counters, in treatment rooms, or specimen storage areas (refrigerators).

SPECIAL PRECAUTIONS

1. The moist blood and body substances of all patient, staff, and visitors shall be treated as though they were contagious. In all reasonably anticipated exposures to blood or other potentially infectious material, protective barriers and engineering controls shall be used.
2. Protective barriers (PPE - Personal Protective Equipment) such as gloves, masks, gowns, goggles, and caps are to be worn by a Nurse as the situation warrants for protection against a hazard. (General work clothes, e.g. uniforms, pants, shirts, or blouses are not intended to function as personal protective equipment protection against a hazard). (Refer to Hospital Infection Control Manual Policy and Procedure No. 7)
3. Gloves shall be worn in all cases when touching the moist body substances, mucous membranes, or non-intact skin of other persons; for performing venipunctures, finger sticks, and other invasive procedures; for handling items or surfaces visibly soiled with blood or other moist body substances.
4. Engineering controls are maintained in all locations of expected exposure and replaced on a regular schedule and as needed, e.g., sharps disposal containers, Safety Loc syringes, and Bag-Valve-Mask devices, Laboratory Specimen bags.
5. Transmission-Based (Isolation) Precautions shall be ordered by the attending physician in accordance with Prime Surgical Centers policy. All Nursing staff shall adhere to these precautions.

HAND HYGIENE POLICY

Hand hygiene is the single most effective practice in preventing the spread of infections. Refer to Hospital Infection Control Manual Policy and Procedure No. 4 for specific details.

EMPLOYEE EDUCATION PROGRAMS

1. All Nursing staff are to be oriented in the area of infection control (including Standard Precautions) at the time of General Nursing Orientation (GNO), and during Annual Infection Control Update.
2. In-service classes held as needed by the O T Matron or Nursing Superintendent
3. Content to be covered includes information concerning the kinds and characteristics of organisms most likely to be of concern, source of these organisms, practice of aseptic techniques, hand Washing, isolation, special procedures for care of patient with infectious disease, and the practice of

cleaning, disinfecting, and sterilization procedures.

4. The education program includes: Standard Precautions, Transmission-Based Precautions, infection control measures, practices and expectations, Prime Surgical Centers Blood Borne Pathogens Standard Exposure Control Plan including protective barriers and engineering controls.

NURSING ROLES AND RESPONSIBILITIES IN AN INFECTION CONTROL PROGRAM

General Infection Control Responsibilities of Nursing Staff:

1. Takes responsibility for all nursing functions essential to the prevention, recognition and management of infections.
2. Supports all hospital policies, practices, and procedures.
3. Attends to measures of medical asepsis, including hand washing and isolation/precaution techniques.
4. To be alert to signs of infection and make immediate reports.
5. Takes appropriate interim action upon signs of infectious diseases potentially hazardous to others.
6. Instructs patient in infection control procedures as per policy of Prime Surgical Centers.
7. Serves as a basic source of information on infections.
8. Protects patient against exposure to infection.
9. Instructs patient in matters of personal hygiene, aseptic techniques, etc.
10. Serves as a role model by practicing good personal hygiene.
11. Sanitation responsibility of Nursing Services.
    a. Waste or infective materials (e.g., secretions, excretions, body fluids, and tissues) shall be handled in accordance with Waste Management Disposal Policy. (Refer to Hospital Infection Control Manual Policy and Procedure No. 29)
    b. Infectious (contaminated) linen shall be handled in accordance with Nursing Policy and Procedure (Refer to Hospital Infection Control Manual Policy and Procedure No. 13) and Administrative Directive.
    c. In case of spills on him/her, the nurse must clean up immediately including changing uniform.
    d. General cleaning of the units shall be done in accordance with the procedures outlined in the Prime Surgical Centers Housekeeping Manual.
    e. Unit refrigerators must be cleaned weekly by nursing staff: (Refer to Nursing Manual Policy and Procedure No. 3-c-ii)

PRIME SURGICAL CENTERS

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NURSING MANUAL

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ANNEXURE
(Refer Customer Care and Billing Manual Policy and Procedure No. 1)

PATIENT REGISTRATION / VISIT DETAILS

(Please fill the form in CAPITAL LETTERS, Write NA if Not Applicable)

Please fill in the following details:

Patient Information		Date :	Time :
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Mast. ☐ Dr.		Last Name:	
First Name :		Second Name :	
Gender : ☐ Male ☐ Female		Marital Status : ☐ Married ☐ Single	
Full Residential Address			
City :	Pin Code :	Contact No. :	
Date of Birth :	Age :	Religion :	
Email Address :			
Occupation	☐ Business ☐ Salaried Professional ☐ Other (Please Specify)		
Business/Office Name :		Designation :	
Business/Office Address :			

Information of kin / relative
Name of relative:
Relation to patient:
Full Address:
Phone no.:
Name of Doctor you want to consult:
If referred by Doctor, specify Doctor Name & Address:

Billing Information	
Payment made by	☐ Self ☐ TPA / Insurance ☐ Corporate Account
	☐ Other (Please Specify):
TPA / Insurance No.:	

Signature of the Patient / Attendant: Relationship:

For Office Use Only

M.R. No.:

Name, Signature, Date & Time of the Customer Care Representative: .....

ANNEXURE I
(Refer to Housekeeping Manual Policy and Procedure No. 1)

PERIMETER

	Frequency				
AREA	**Daily**	**Weekly**	**Fortnightly**	**Mthly**	**Other**
Floor	X				
Front Gate Parking	X				
Garden	X				
Service Area	X				

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

POLICY AND PROCEDURE MANUALS		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 1** **Page: 1 of 1**
Effective Date: 11 April, 2013		

POLICY AND PROCEDURE MANUALS

PURPOSE

The policy and procedure manuals, for the Prime Surgical Centers, document the manner in which activities will be conducted and the principles upon which policies and procedures are based. The manuals are also designed to function as an informational tool to be used in orientation of new employees, continuing education and in-service programs.

POLICY

1. All policies and procedures will be approved by the Top Management before implementation.
2. Revisions or implementation of new policies or procedures will be made available to all personnel immediately upon approval and will be posted on bulletin board. Employees will be required to sign and date circulated material indicating review and understanding.
3. All policies and procedures will be reviewed and revised at least once each year.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

PROFESSIONAL CONDUCT AND STANDARDS OF PROFESSIONAL BEHAVIOUR		
Module Applies To	**All Nurses and Technicians**	**Module No: 1** **Page: 1 of 3**
Effective Date: 11 April, 2013		

PROFESSIONAL CONDUCT AND STANDARDS OF PROFESSIONAL BEHAVIOR

INTRODUCTION

At Prime Surgical we are committed to provide high quality, personalized care to our patients and their families. To achieve this a set of professional behavioural standards will require to be developed to establish a culture which supports our Center's core values of RESPECT in providing patient care, reliable service delivery, excellence in standard, safe & clean environment, patient –centered care, empowering each to do his/her best and interdisciplinary teamwork.

ATTITUDE/CODE OF CONDUCT

Patients are not an interruption to our work. They are the reason we are here.

1. Smiling is contagious—be friendly and respectful. Make eye contact.
2. " A smile cost nothing yet its worth"
3. Rudeness is unacceptable.
4. Come to work with a positive attitude. Do not let personal problems at home interfere your with job performance.
5. Staff is expected to be courteous, professional, and accountable.
6. Avoid making statements like "It's not my job."
7. If unable to meet a request, then find someone who can.
8. Treat every individual as if they are the most important person in our facility.
9. Never see any issue as a problem. It should be seen as an opportunity to resolve the issue.)
10. Personal conversations with other staff should not occur while in the presence of our patients/ their relations / visitors.

COMMITMENT TO CO-WORKERS

1. Be on time. When you are late for work, your co-workers must cover for you. Communicate unexpected delays to your supervisor and appropriate staff at the facility.
2. Every job is important. Treat your coworkers with respect and professionalism.
3. Offer to help others when possible. Cooperation is expected.
4. Avoid disciplining or criticizing fellow employees in the presence of others as well as patients.
5. Departmental issues should never be discussed in public areas.
6. Welcome new employees. Set an example of the cooperation expected in the work place by offering to help them get acclimatized to their new job.
7. It is not constructive to blame other departments when problems occur.
8. When confronted with a problem, see it as an opportunity to find a solution. Avoid spreading negative attitudes to others.

PERSONAL

1. All employees must demonstrate good hygiene, and project a neat, clean and professional appearance.
2. Adhere to the Prime Surgical Centers dress code policies (proper uniform/clothing, cosmetics, jewellery, scents, and perfume)

PROFESSIONAL CONDUCT AND STANDARDS OF PROFESSIONAL BEHAVIOUR		
Module Applies To	**All Nurses and Technicians**	**Module No: 1** **Page: 2 of 3**
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3. Prime Medical Centers ID card must be worn visibly.
4. Eating and drinking is strictly not permitted in nursing station and public places. Use only the designated places e.g. Nurse's Lounge.
5. Smoking is forbidden whilst you are in Prime Surgical Centers premises.
6. Uniform (complete or part) should not be worn in public places unless the employee is representing the Prime Surgical Centres (e.g. on escort duty)

DELIVERY OF CARE IN PROFESSIONAL MANNER

1. Be mindful of noise levels.
2. Prior to initiating patient care, wish patient, properly identify your name and your designation. And also properly identify patients by name and by checking their identification wristband.
3. Strive to provide prompt service.
4. Explain wait times to patients and families before they occur. Thank customers for waiting and apologize for delays.
5. Prior to leaving a patient's bedside, offer further assistance by asking, "Is there anything else I can do for you?"
6. Escort "lost" customers to their destination instead of pointing the way if possible.

CALL LIGHTS

1. Call lights should be answered immediately.
2. All nurses may answer a call light.

PRIVACY/CONFIDENTIALITY

1. Respect patient privacy when discussing medical matters.
2. Never discuss patient/visitor issues in public areas.
3. Give patients the opportunity to decide who should be present in the room when they are being interviewed.
4. Knock prior to entering patients' rooms.
5. Utilize doors/curtains/blankets as appropriate to ensure privacy
   (Explain to patients that this is being done for their privacy.).
6. Cover patients appropriately during transport.
7. Ask permission prior to removing blankets or garments.
8. Follow the Prime Surgical Centers' policy for release of information.
9. Patient's records must be confidential.
10. Those involved in patient care are to have access to patient information on a need-to-know basis.
11. Avoid display of patient information where the public has access.
12. Dispose of confidential information properly.
13. Utilize the shredder boxes if applicable.
14. Correctly sign in and out of computer terminals.

PROFESSIONAL CONDUCT AND STANDARDS OF PROFESSIONAL BEHAVIOUR		
Module Applies To	**All Nurses and Technicians**	**Module No: 1** **Page: 3 of 3**
Effective Date: 11 April, 2013		

TELEPHONE/E-MAIL ETIQUETTE

1. All Prime Surgical Centres' staff should be knowledgeable in the use of facility phones and their features. (See your supervisor if you need further training.)
2. Staff should feel comfortable answering any phone in Prime Surgical Centres.
3. Answer calls promptly (within three rings).
4. Identify your name and department along with a pleasant greeting.
5. Our tone transmits an unspoken message—speak with a smile.
6. Ask permission to place callers on hold. Give caller time to respond. Thank caller for holding when you return to them.
7. Provide caller with the full phone number prior to transferring them to another department. Be sure to speak with the staff member you are transferring them to prior to connecting them.
8. Offer further assistance to the caller upon completing the conversation.
9. When leaving a voice mail message, remember you are being recorded. Speak professionally and with respect for the person you are calling.
10. Personal cell phones should be turned off when working.
11. While calling Consultant or any other colleague of Prime Surgical Centers make sure that after appropriate greeting you find out whether that is a suitable time to continue speaking.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

SCHEDULING OF APPOINTMENTS		
Module Applies To	**Customer Care**	**Policy and Procedure No.: 1** **Page: 1 of 2**
Effective Date: 11 April, 2013		

SCHEDULING OF APPOINTMENTS

PURPOSE

To schedule the OPD appointments of Consultants so that both the Consultant and the patient are aware of the appointment time and to ensure a smooth flow and functioning of the OPD.

PROCEDURE

A patient may call in advance and book a phone appointment or he/she may walk-in for an OPD consultation. Preference will be given to patients who have booked a phone appointment with the Consultant. Walk-in patients will have to be adjusted as per the availability of time in between booked appointments and the urgency/criticality of the patient.

BOOKING A PHONE APPOINTMENT

When the patient calls to book an appointment with the Consultant the steps to be followed are:

1. In the system, go to OPD Phone Appointments. In the Appointment Booking Tab select the Date for which the appointment is to be booked. Also select the Unit, Department and the Consultant Name.
2. Select the time for which you need to book the appointment and double-click on it.
3. The Appointment Details tab will open.
   a. If the patient is an existing patient of Prime Surgical Centers, enter the MR number of the patient. The system will pull up the details of the patient.
   b. If an existing patient is not able to provide his MR number, search for it by clicking on [S]
      The search window will open wherein enter the patient details and search for the MR number.
   c. If the patient is new, take the first and last name of the patient along with his/her contact number (preferably a mobile number). These three are mandatory fields without which the appointment cannot be booked. Other details like middle name, date of birth, marital status, email, etc. should preferably be taken as well so that this will save time when registering the patient.
   d. The date of appointment, Consultant's name and appointment time will be preset as selected earlier.
   e. Click on OK to save the phone appointment.
4. An SMS will be automatically sent by the system to the patient and the Consultant informing them about the scheduled appointment.
5. Ask the patient if he would like us to forward registration form (refer Annexure to this policy) which he /she may complete at leisure at home and send it back through E-mail. This will decrease his /her waiting time for appointment.
6. Inform the patient to come half an hour earlier than the appointment time in order to complete the registration process / 15 minutes if registration is already completed and to take the vitals of the patient before consulting the Doctor.
7. Ask if the patient would need any assistance or has a special need of a wheelchair or stretcher. If yes, inform the security so that the wheelchair/stretcher can be kept ready.
8. If the patient is in need of an ambulance, provide the vendor's name and contact number to the patient so that the patient can arrange for the ambulance or take the responsibility of arranging the ambulance for the patient.

SCHEDULING OF APPOINTMENTS		
Module Applies To	**Customer Care**	**Policy and Procedure No.: 1** **Page: 2 of 2**
Effective Date: 11 April, 2013		

9. Inform the patient to get all his/her previous reports and/or films or medication details, if any for ease of consultation.
10. A day prior to appointment forward a SMS as gentle reminder for the same.

VIEWING THE PHONE APPOINTMENT LIST

In order to view the Phone Appointment List or to check the details of Phone Appointments:

In the system go to OPD Phone Appointments. In the Appointment List tab, you can view the appointments scheduled by Date, Unit, Department and/or Doctor.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

PRE ADMISSION MEDICATION LIST VERIFICATION AND ORDER FORM		
Module Applies To	**Consultant / Physician**	**Policy and Procedure No.: 2** **Page: 1 of 1**
Effective Date: 1 April, 2014		

PRE ADMISSION MEDICATION LIST VERIFICATION AND ORDER FORM

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OTC AND HERBAL MEDICATIONS

Source of Medication list: (check all used)

- ☐ Patient medication list
- ☐ Patient/Family recall
- ☐ Primary care physician list
- ☐ Previous discharge medication list

CIRCLE C to continue
OR
DC to discontinue

Medication History Recorded/Verified By: DR._____

Date Recorded:_____

MEDICATION NAME (WRITE LEGIBLY)	DOSE (mg, mcg)	ROUTE (PO, GT, SC, IV)	FREQUENCY	LAST DOSE DATE/TIME	**PHYSICIAN ORDER** Continue on Admission	**PHYSICIAN ORDER** COMPLETE On Discharge
1.					C DC	C DC
2.					C DC	C DC
3.					C DC	C DC
4.					C DC	C DC
5.					C DC	C DC
6.					C DC	C DC

Do not take off orders without Consultant signature

Consultant Signature: _____

Name: _____(Write in Capital Letters) **Date & Time**: _____

Reviewed and Transcribed

RMO Signature: _____

Name: _____(Write in Capital Letters) **Date & Time**: _____

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
Phone: - 020-39931000 Fax: - 020 39931020
Email: - customercare@primesurgical.in
Website: www.primesurgical.in

PRIME SURGICAL CENTERS

PRE ADMISSION MEDICATION LIST VERIFICATION AND ORDER FORM

MR No : IP No:
Name :
Age/Sex :
Comfort / Deluxe Bed No :
Admission Date :

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS <u>PRIOR TO ADMISSION</u> INCLUDING OTC AND HERBAL MEDICATIONS

Source of Medication list: (check all used)

- ☐ Patient medication list
- ☐ Patient/Family recall
- ☐ Primary care physician list
- ☐ Previous discharge medication list

CIRCLE C to continue OR DC to discontinue

Medication History Recorded/Verified By: DR._____

Date Recorded:_____

MEDICATION NAME (WRITE LEGIBLY)	DOSE (mg, mcg)	ROUTE (PO, GT, SC, IV)	FREQUENCY	LAST DOSE DATE/TIME	**PHYSICIAN ORDER** Continue on Admission	**PHYSICIAN ORDER** COMPLETE On Discharge
1.					C DC	C DC
2.					C DC	C DC
3.					C DC	C DC
4.					C DC	C DC
5.					C DC	C DC
6.					C DC	C DC
7.					C DC	C DC
8.					C DC	C DC
9.					C DC	C DC
10.					C DC	C DC
11.					C DC	C DC
12.					C DC	C DC

Do not take off orders without Consultant signature

Consultant Signature: _____

Name: _____(Write in Capital Letters) **Date & Time**: _____

Reviewed and Transcribed

RMO Signature: _____

Name: _____(Write in Capital Letters) **Date & Time**: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

ASEPSIS		
Policy/Procedure Applies To	**All Nurses & Surgical team**	**Policy/Procedure No: 2** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ASEPSIS

POLICY

1. Aseptic technique refers to the method by which the sterile members of the surgical team create and maintain a sterile field. All nursing staff must develop a surgical conscience.
2. It is the responsibility of all nursing personnel in the operating room / nursing unit on seeing a break in technique to notify immediately the responsible person to rectify the situation. Breaks in technique must be called to the attention of the individuals concerned, OT matron and /or Nursing Superintendent. An incident report may need to be filed if there is potential patient injury, staff injury, or willful noncompliance with aseptic practices, policy or procedure.
3. It is essential for the members of the nursing staff and surgical team to know:
   a. The common source of micro-organisms in an operating room.
   b. The means by which they reach the sterile field to contaminate it.
   c. How to prevent contamination of the sterile field.
   d. Use of antibiotic cannot replace the efficacy of the following sterile technique.
4. Sources of contamination:
   a. Members of the nursing and surgical team.
   b. The patient.
   c. All articles used in the wound and on the sterile setup.
   d. Dust in the air.
5. Monitoring and testing: (Refer to Nursing Manual Policy and Procedure No.)
   a. Indicators are used in all of the instrument packs.
   b. There are indicators that are utilized in each load and Immediate-use cycle in central services.
   c. Autoclaves are tested daily for efficiency and each load is documented.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

DETAILED SPECIFICATIONS FOR EQUIPMENT / MATERIAL		
Policy/Procedure Applies To	**All concerned Departments/ Executive Facility/ Consultant Bio-Medical Engineer**	**Policy/Procedure No: 2** **Page: 1 of 1**
Effective Date: 11 April, 2013		

DETAILED SPECIFICATIONS FOR EQUIPMENT / MATERIAL

PURPOSE

To specify the technical details (Qualitative Specifications) of equipment/material to be purchased.

PROCEDURE

Detailed specifications will be compiled for any equipment/material in consultation with concerned Consultant/Bio-Medical Engineer Consultant/Department Head as given in Annexure.

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

ANNEXURE
(Refer to Purchase and Maintenance Manual Policy and Procedure No. 2)

DETAILED SPECIFICATIONS FOR EQUIPMENT / MATERIAL

Prime Surgical Centers Pvt. Ltd., Pune.		
Sr. No.	Description	Qty.
	Name of Equipment/Material: Model: Make:	
1	Specifications:	
2	Accessories:	

Prepared By:

Name:

Signature:

Date:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

GUIDELINES FOR THE ETHICAL PRACTICE OF ANAESTHESIOLOGY		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 2** **Page: 1 of 2**
Effective Date: 11 April, 2013		

GUIDELINES FOR THE ETHICAL PRACTICE OF ANAESTHESIOLOGY

PURPOSE

To define guidelines for the ethical practice of anaesthesiology.

POLICY

The PRIME SURGICAL CENTERS Surgery Center adopts the ISA/ AAGBI Guidelines.

GUIDELINES

1. The Anaesthesiologist's relationship to patients and other physicians
   a. Anaesthesiology is a branch of medicine.
   b. Anaesthesiologists, like other physicians, should render service only to those patients who have consented to their services.
   c. An Anaesthesiologist must maintain the personal relationship which exists between physician and patient and must not permit any third party laymen or organization to interfere with the rendering of service in accordance with the standards of sound medical practice.
   d. If an Anaesthesiologist, either expressly or by implication, undertakes an obligation to a patient, he must discharge this responsibility. Anaesthesiologists should remain continuously and immediately available throughout the procedure for which responsibility is accepted. If Anaesthesiologist is to render only a portion of the anaesthesia care, either through medical direction or otherwise, the arrangement must be clearly explained to and understood by the patient. Patient deception is unethical, whether deliberate or not.
   e. An Anaesthesiologist may not delegate an accepted responsibility to another physician without prior consent of the patient. Patients should be informed that more than one physician may care for them.
2. The Anaesthesiologist's duties, responsibilities and relationship to the facility.
   a. Anaesthesiologists should be accorded the same clinical rights, limitations, responsibilities and privileges accorded to other members of the medical staff of the PRIME SURGICAL CENTERS. Anaesthesiologists must be permitted to conduct their medical practice with the same independence of medical judgment and responsibility (including, but not limited to, responsibility for matters of clinical privileges and standards for patient care) as the other members of the medical staff. Anaesthesia staff should have similar autonomy to that afforded to facility staff.
   b. The facility should provide the necessary equipment, drugs, and gases that a specialist in Anaesthesiology may require, in the manner and to the extent that such items are furnished for use by other physicians practicing in the facility.
3. The Anaesthesiologist's relationship to other non-physician personnel.
   a. Recognizes that the personal provision of anaesthesia care by the Anaesthesiologist must remain a desirable primary goal. It also believes that a proper concern for its members is the establishment of an acceptable environment within which medical direction of the anaesthesia care team may be carried out so as to provide better anaesthesia care for more patients.
   b. Neither the patient nor attending physician should be led to believe that an Anaesthesiologist will medically direct the administration of anaesthesia unless medical direction as defined above exists.

GUIDELINES FOR THE ETHICAL PRACTICE OF ANAESTHESIOLOGY		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 2** **Page: 2 of 2**
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c. Proper safeguards must be provided so that no exploitation of the patient, or of personnel whose activities are medically directed by the Anaesthesiologist, is permitted. It is emphasized that the Anaesthesiologist should assume responsibility for the medical direction of the anaesthesia care team so that all patients, to the extent possible, receive quality care.

d. Where an Anaesthesiologist medically directs a non-physician, such services are regarded as provided by the Anaesthesiologist. The Anaesthesiologist's responsibilities include:

   i. Pre-anaesthetic evaluation of the patient
   ii. Prescription of the anaesthesia plan
   iii. Personal participation in the most demanding procedures in this plan, especially those of induction and emergence during general anaesthesia.
   iv. Following the course of anaesthesia administration at frequent intervals.
   v. Remaining physically available for the immediate diagnosis and treatment of emergencies.
   vi. Providing indicated post-anaesthesia care.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune**.**

EXPOSURE CONTROL PLAN MANUAL

JOB CLASSIFICATIONS AND TASKS WITH OCCUPATIONAL EXPOSURE		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 2 Page: 1 of 3**
Effective Date: 11 April, 2013		

JOB CLASSIFICATIONS AND TASKS WITH OCCUPATIONAL EXPOSURE

PURPOSE

The Exposure Control Plan covers all employees who are at risk for occupational exposure to blood or bodily fluids. "Occupational exposure" carries the possibility of any "reasonably anticipated skin, eye, mucous membrane, or par-enteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties."

Job Classifications with Occupational Exposure

1. Surgeon
2. Scrub Nurse / First Assist
3. Allied Health Personnel

Category I

Tasks that involve the exposure to blood, bodily fluids, or tissues:

1. All procedures or other job-related tasks that involve an inherent potential for mucous membrane or skin contact with blood, bodily fluids, or splashes on these surfaces are Category I tasks.
2. Use of appropriate protective measures should be required for every employee engaged in category I tasks.

Job Classifications with Some Occupational Exposure

1. Circulating Nurse
2. Staff Nurse in Nursing Unit
3. Housekeeping Personnel
4. Phlebotomist
5. X-Ray Technician
6. Ancillary staff

Category II

Tasks that involve no exposure to blood, bodily fluids, or tissues, but employment may require performing unplanned tasks under Category I:

1. The normal work routine involves no exposure to blood, bodily fluids or tissues, but exposure or potential exposure may be required as a condition of employment.
2. Appropriate protective measures should be readily available to every employee engaged in Category II tasks.

Job Classifications with No Occupational Exposure

1. Business Office Personnel
3. Medical Records Personnel
4. Materials Management Staff
5. Ancillary Staff

Category III

Tasks that involve no exposure to blood, bodily fluids, or tissues, and Category I are not a condition of employment.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune**.**

EXPOSURE CONTROL PLAN MANUAL

JOB CLASSIFICATIONS AND TASKS WITH OCCUPATIONAL EXPOSURE		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 2** **Page: 2 of 3**
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The normal work routine involves no exposure to blood, bodily fluids, or tissues (although situations can be imagined or hypothesized under which anyone, anywhere might encounter potential exposure to bodily fluids). Persons who perform these duties are not called upon, as part of their employment, to perform or assist in emergency medical care or first aid or to be potentially exposed in some other way. Tasks that involve the handling of implements or utensils, use of public or shared bathroom facilities or telephone, and personal contacts such as handshaking are Category III tasks.

Tasks and Procedures: Occupational Exposure

The following is a list of tasks and procedures, not necessarily exhaustive, performed by surgical center employees where occupational exposure may occur:

1. Venipuncture
    a. Starting IVs
    b. Discontinuing IVs
2. Performing laboratory tests
    a. Hemoglobin
    b. Blood glucose
    c. Other tests
3. Insertion/removal of airways
    a. Nasal
    b. Oral
4. Intubation
5. Extubation
6. Suctioning
    a. Oral
    b. Nasopharyngeal
7. Care and disposal of body fluids
8. Handling soiled linen
9. Handling biomedical waste
10. Performing regional blocks
    a. IV regional
    b. Epidural
    c. Peripheral Nerve Blocks
11. Assisting with surgical procedures
12. Handling of contaminated instruments
13. Reinforcement or change of surgical dressings
14. Application of moist eye packs
15. Drains – activate or empty
    a. Hem vac
    b. Jackson-Pratt

JOB CLASSIFICATIONS AND TASKS WITH OCCUPATIONAL EXPOSURE		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 2** **Page: 3 of 3**
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16. Injections
    a. Intramuscular
    b. Intravenous
    c. Subcutaneous
17. Handling of contaminated equipment
    a. Emesis basins
    b. Needles
    c. Bedpans
    d. Suction equipment
18. Management of paediatric or uncooperative patients

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Bech House, Damle Path, Pune.

NURSING MANUAL

PHILOSOPHY OF NURSING DEPARTMENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 2** **Page: 1 of 2**
Effective Date: 11 April, 2013		

PHILOSOPHY OF NURSING DEPARTMENT

1. **Philosophy of Nursing** reflects Prime Surgical's Philosophy, Vision, Mission and Values. The Nursing department believes in creating a work climate for Nurses that nurtures and support clinical expertise, education, fostering the recruitment and retention of Nursing staff who demonstrate the highest integrity and competence.
2. **Vision**: To be internationally recognized as world class Minimally Invasive Surgical Centers through committed Nursing staff by creating a culture of lifelong learning that integrates evidence based practice and professional development.
3. **Mission**: Is to deliver the highest Quality of Nursing Care with utmost Compassion through effective leadership, the promotion of excellence in ongoing Service which provides ethical standards, technology and continuous quality improvement. To achieve this, a judicious mix of CARE (compassion, art, reliability and empathy) and SAVE (science, administration, value and efficiency) will be practiced by all nurses.
4. **Value Statement**: Excellent Nursing care based on continuous healing relationship. Professional caring is manifested by **SIX (6 C)** categories of Human Behavior to provide excellence in Nursing care by utilizing RESPECT
    1. **C**ompassion
    2. **C**ompetence
    3. **C**onfidence
    4. **C**onscience
    5. **C**ommitment
    6. **C**omportment

OBJECTIVES

1. To monitor compliance with and recommend changes, if any, in Prime Surgical Centers' Policy and Procedure.
2. To advocate organizational processes that allow for creativity in the development of alternative plans for achieving desired patient – centered, cost – effective outcome.
3. To monitor practice of all Nursing disciplines to ensure function within the scope of practice and the professional standards of practice.
4. To assist in the implementation of an effective, ongoing programme to measure, assess and improve the quality of care delivered to patients.
5. To ensure that patients and family are provided with appropriate information and reassurance prior to Surgical and Nursing interventions.
6. To ensure that patients and family are provided with appropriate health education so that there is confidence for all regarding home care.
7. To ensure that the patient's right of confidentiality, privacy, dignity and self-respect are maintained at all times.

PHILOSOPHY OF NURSING DEPARTMENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 2** **Page: 2 of 2**
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8. To ensure that documentation of patient care is done in accordance with the Nursing Standard Policies and Procedures.
9. To prepare to meet all crisis situations in a calm and therapeutic manner.
10. To provide leadership in critical thinking, conflict management, and problem solving.
11. To asses quality of patient care practices and care through data and provide feedback to improve outcomes.

FUNCTION

Patients may be admitted, assessed, and prepared to be transferred to the Operation Theater at the scheduled time for surgery. Surgery shall be performed in a safe and effective manner. The patient shall convalesce until stable and discharged home with a clear understanding of post-operative protocol.

POLICY

1. The Prime Surgical Centers will designate the Nursing Superintendent.
2. The clinical areas of the center will be supervised by a Nursing Superintendent.
3. The Nursing Superintendent will be responsible for ongoing assessment of patient needs for nursing care and will make sure that identified needs are addressed.
4. The Prime Surgical Centers will, at least annually, review the activities of the Nursing Superintendent.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE II
(Refer to Safety Manual Policy and Procedure No. 2)

PNEUMATIC PROBLEMS

Symptom	Problem	Solution
High-pressure leak test fails.	Controls are not set correctly.	Set the system switch to Standby and the auxiliary flowmeter to OFF.
	Incorrect cylinder connection (cylinder yokes).	Make sure that there is only one cylinder gasket, the gasket is in good condition, and the T-handle is tight.
	Incorrect cylinder connection (DIN connection.)	Make sure the nut is tight.
Low-pressure leak test fails with a vaporizer on.	The vaporizer is not correctly installed.	Correctly install the vaporizer.
	The vaporizer filler is loose (fill port type vaporizer).	Tighten the filler.
	Vaporizer port o-rings (external) are damaged or not installed.	Install new o-rings.
	A vaporizer malfunction (the leak stops if you use a different vaporizer in the same position).	Send the vaporizer to a Datex-Ohmeda Service Center for repair.
	A port valve malfunction (the leak continues if you use a different vaporizer in the same manifold position).	Have an qualified service person repair the vaporizer manifold.
Low-pressure leak with a vaporizer OFF.	Anaesthesia machine problem.	Contact a qualified service representative.

CAUTION No repair should ever be attempted by anyone not having experience in the repair of devices of this nature.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

POLICY AND PROCEDURE: CONFLICTS		
Policy/Procedure Applies To	**All staff**	**Policy/Procedure No: 2** **Page: 1 of 1**
Effective Date: 11 April, 2013		

POLICY AND PROCEDURE: CONFLICTS

POLICY

In the event of conflict between two or more existing policies or procedures and/or local, State, or Central regulations, the document that prevails will be determined using the following criteria:

1. The document issued and current from the higher authority shall prevail, except;
2. When the lesser authority document meets the higher authority document but is more stringent, then the lesser authority document shall prevail.
3. The Administrative Head of the Center has the authority to designate the prevailing document in the event of any failure to agree by the involved parties seeking information.

Example:

The general authority is:

1. Central Government
2. State Government
3. Municipal Corporation
4. Corporate Office
5. Governing Board
6. Administration and personnel policies and procedures
7. Departmental policy and procedure manuals

Revised By:	**Signature:**
Revision Date:	
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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

PROFESSIONAL CARING MODEL		
Module Applies To	**All Nurses and Technicians**	**Module No: 2** **Page: 1 of 5**
Effective Date: 11 April, 2013		

PROFESSIONAL CARING MODEL

COMPETENCY STATEMENT

New hire is able to articulate the central themes of the professional caring model as it relates to nursing practice at PRIME SURGICAL CENTERS.

LEARNING OUTCOME

1. Identify the attributes of Professional Caring Model
2. Describe the professional caring model of PRIME SURGICAL CENTERS
3. Evaluate the impact of Professional Caring attributes in nursing practice
4. Value the importance of professional caring attributes relating to own professional experience

INTRODUCTION

Nursing is clearly an autonomous self growing profession and a distinct scientific discipline with many autonomous practice features. Nurses have a unique scope of practice and a unique body of knowledge including special expertise in areas.

Nursing is an integral part of health care profession and is one of the most in demand careers. Nursing is a caring based discipline and it is appropriate to specify the fundamental elements needed for professional practice.

Caring is a human trait. Care is the essence of nursing and the central, dominant, and unifying focus of nursing. Little girls care for their dolls; boys care for their trucks; parents care for their children; sons and daughters care for elderly parents; and nurses' care for the sick. The humanistic nature of nursing is reflected in the caring model. Caring is the central concept in the discipline of nursing.

REFLECTIVE QUESTIONS

1. What are the main reasons you have chosen a career in nursing? What motivated you to take up nursing as your career?
2. What do you see as essential personal qualities for nurses?

There appears to be two elements involved in professional caring: instrumental caring, which includes the required skills and knowledge, and expressive caring involving the emotional aspects of the relationship. Expressive caring changes nursing actions into caring. This could help to explain why some nurses are technically competent, but do not seem outwardly compassionate.

The root words of compassion can be separated into the words "passion" "to suffer" and com "with". Compassion requires the distinct ability to enter into the suffering of another. It is the process of entering into suffering and being a companion to others in their pain that is one of the aspects of nursing care that makes an exceptional nurse.

Compassion, or caring can be viewed as "nursing's most precious asset", a fundamental element of nursing care and as one of the strengths of the profession. Compassionate care is a key product of health care providers and is a vital aspect of good nursing care. It involves being close to patients and seeing their situation as more than a medical scenario and routine procedures.

Compassion is viewed as an integral part of dignity and nurses' compassion plays a major role in providing dignified care to patients. Compassionate care enables patients to remain independent and retain their dignity.

Ultimately, compassion impels and empowers people to not only acknowledge, but also act. This involves focusing on another person's needs and chaneling the emotion generated by their predicament into an active response.

Compassion is sensitivity to the pain and brokenness of the other.

To a patient who is suffering pain or illness nothing is more valuable to him than a bit of sympathy and compassion from a nurse. All that he requires is a smile, a few gentle words and to make him feel relaxed through a caring approach and a graceful demeanour.

A compassionate person can understand an experience from another's perspective.

Nurses portray compassion to their patients by spending time with them, listening to them, talking with them, gathering information and showing interest and concern for them, thereby developing an understanding of the patient's situation. Patients depend on the nurses caring for them to do for them what they are unable to do for themselves. They place their trust in their carers

By just having the 2 qualities of empathy and compassion the patients can feel more bonded and trusting to the nurse. Being compassionate is being caring, considerate, concerned and understanding.

Patients perception of a nurses skill are largely based on their interpersonal skills and caring practices rather than their technical skills according to a small study published in the journal Critical Care Nurse.

If a nurse has no compassion, any amount of competence or professional skill and obligation that she might display will not have optimal healing in a patient.

ROLE OF EMPATHY IN CLINICAL PRACTICE

An empathetic provider fulfils the patient's basic need to be understood and is vital to the establishment of a healthy provider- patient relationship. Empathy increases the feeling of being connected with another human. Empathy can contribute to feelings of increased self esteem for those to whom you extend it. Empathy states that you accept how your Patients and colleagues feel; and contribute to their trust that you genuinely accept them as they are. Your withholding of judgment or advice enhances this trust. Empathy can help our Patients move on to new feelings and change their behavior.

In a literature review done in up-to-date it stresses the importance of the receipt of honest, intelligible and timely information which is among the primary concerns of family members of patients. In addition they need support, comfort, proximity and reassurance.

Unfortunately evidence indicates that communication with health care providers often leaves much to be desired. Observational studies have found that communication issues with health care providers are the number one source of complaints among families of deceased patients with as many as 30% of family members feeling dissatisfied with communication thereby affecting the psychological outcomes of patients and family members.

COMPETENCE

Nursing profession combines both the science and art of caring. The science comes from the knowledge gained through education and ongoing professional development. The art comes from experience and by attending to a range of health care needs.

Nothing in nursing is stagnant. The need to continually expose ourselves to the latest trends and technologies in health care and medicine. It is required of a nurse to be **competent, assertive and strong** because at times we may have to challenge a provider Physician, for instance in the interest of what's best for the patient.

PROFESSIONAL CARING MODEL		
Module Applies To	**All Nurses and Technicians**	**Module No: 2** **Page: 3 of 5**
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A good nurse should be highly qualified and trained. A competent nurse has sound knowledge of the nursing profession with good professional skills and is always ready to learn more. Many have advance degrees/ advance certification in their specialties and many are active in their professional associations. They are critical thinkers who **value lifelong learning, specialty certification and professional development**.

Strive for continuous improvement in patient outcomes. Continually seek better ways to provide care. Question the routine and through research develop better ways to provide high quality patient care.

The quality of nursing care is determined by the completeness of the interchange of knowledge, attitudes and skills between the nurse and the patients. To be most helpful to our Patients we have to make sure that we solicit their knowledge become aware of their feelings and attitudes and take into account their strengths and limitations in caring for themselves. We have to display our professional competence in helping our Patients achieve their best possible health status.

The Indian States are working on upgrading level of competence in the region through credentialing, CNE's, license regulation etc. Encourage to have a sustained commitment to maintaining competence by developing the necessary knowledge, skill and judgment to meet the needs of a changing population and take ownership over maintaining competence. The PRIME SURGICAL CENTERS has therefore implemented competency validation and revalidation of all staff according to their scope of practice.

Nurses have a professional obligation to provide only care they are competent to deliver. To do otherwise puts patients at risk and could expose nurses to allegations of professional misconduct. So nurses are mandated to fulfill the competencies for all required procedures.

Certification in a specialty demonstrates professional competency, gives professional recognition to nurses. Certification benefits nurses, health care facilities and health care consumers.

In Prime Surgical centers Nurses are certified on Medical Administration, IV therapy, drug calculation, Nursing Process, Clinical Documentation, Basic Life Support and Code management.

CONFIDENCE

Confidence is defined as '...the quality, which fosters trusting relationships. A 'caring confidence' between the nurse and patient will encourage trust, truth, equity and respect without conditions, distortion, fear or powerlessness. If patients do not sense that the staff are being honest in their dealings with them they will not trust or believe in them. The basis of a patient making an informed decision is that the nurse was honest and gave truthful information; if they do not perceive honesty they cannot be sure they are making the right decision. Carers also need to trust in their own abilities; they have to have confidence in their own skills and judgments and know their limitations.

Good presence of mind is crucial in the nursing profession. In any critical condition or medical emergency in the absence of a physician, the nurse should be confident and take correct decisions.

The nurse should be a quick thinker. When a nurse notices something is not right with a patient they need to be able to make decisions quickly and put their plans into actions instantly.

Nursing is not the career for someone who needs time to think about a situation before responding, because even a fraction of a second can mean the difference between life and death. A confident nurse has sound judgment and maturity.

Nurses who possess SELF – CONFIDENCE are really confident of their skills and values and never act as a powerful person.

Broadly speaking there are 3 attributes of self confidence:

1. Belief in positive achievements
2. Persistence
3. Self awareness

Low self confidence makes others uncomfortable. For instance when we speak to a teacher, engineer / an architect or a lawyer if we feel that they are not confident we also tend to fear that they do not know what they are talking about.

Nurses must therefore exude a level of self confidence which promotes patient comfort and allows more autonomous practice to be built.

CONSCIENCE

A common metaphor for conscience is “the voice within,” one that pipes up when moral conflict arises and one must decide between good and bad, right and wrong. The assumption is that the voice somehow is infallible, and, when one has acted contrary to how the voice directs, the person may feel guilty.

Another common conception is that of two competing voices within the same individual. A familiar image is two small characters, one devilish and the other angelic, perched one on each shoulder whispering into a person’s ears and advising the person which route to take or to avoid.

Nurses perceived conscience to play a role in nursing actions involving both patients and families. Conscience guides nurses to act according to good values and restrict acts of poorer quality. Conscience can be a valuable tool in the provision of high quality care to patients and families.

Nurses considered conscience as an important component that influenced the manner in which they performed their professional duties. Nurses listen to the voice of their conscience and stand up for their ethical values.

Conscience obliged the nurses to do their duty for the sake of patients. They experienced an obligation to place their duties before themselves and their own needs.

I may be suffering from abdominal cramps or a headache but my conscience tells me to ignore it because I have to focus on the patient. My own person is not important at that moment. Thus conscience makes me feel that I’m here for the patient, nothing else.

Conscience makes nurses admit mistakes, acknowledge their shortcomings and attempt to correct them.

Nurses with conscience are aware of their responsibility for patients and hence provide the best possible care. When nursing interventions and their conscience were in agreement, this led to a feeling of satisfaction, while the opposite created a sense of dissatisfaction.

It happens that we forget things. We promise three things and then the phone rings and somebody else needs our attention and we forget what we promised. Nurses are asked to perform multiple complex tasks everyday.

Accuracy is the key to determine the success of a nurse’s performance.

1. Are medications & treatments done accurately?
2. Are orders taken from chart accurately?
3. Was accurate information given to patient & family?

It is important that nurses are accurate in the work they do. It is equally important that if an error is made it is honestly reported.

So a medication error should be reported immediately to the physician so counter measures can be implemented to protect the patient.

PROFESSIONAL CARING MODEL		
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The motto is **'To be concerned about protecting the patient safety and not yourself'**.

Covering up any errors of nursing is not only unethical, but in most situations is also illegal .Our conscience should tell us "Work diligently to promote patient safety."

COMMITMENT

To stay focused on patient's perceptions is what makes a good nurse. It is important for nurses to understand how patients describe quality nursing care. Commitment connotes responsibility and involvement to work for a common good that is health. It is possible to strengthen nurses commitment by improving the organization of work, arranging the work so that nurses can use their abilities in the optimal way, offering good possibilities for further development, ensuring opportunities for continuous professional training, increasing possibilities to influence the work.

Work-related factors for reduced commitment among nurse:

1. feeling that one's work is not meaningful or important
2. few possibilities for development
3. low level of influence
4. dissatisfaction with the ways one's own abilities were put into use
5. poor atmosphere at work
6. Low quality of leadership.

There is no question about it. Nursing is a tough job. To be a nurse a person needs endless dedication and a real belief that they are changing the world.

All nurses are accountable to take action in situations where Patient care is compromised and this includes identifying and addressing situations in which Patients could be left without needed care.

We can make a difference to lives entrusted to our care if we incorporate these C's of Caring in our day to day dealings with our patients.

ANNEXURE II
(Refer to Housekeeping Manual Policy and Procedure No. 1)

STILT PARKING

	Frequency				
AREA	**Daily**	**Weekly**	**Fortnightly**	**Mthly**	**Other**
Floor	X				
Windows	X		X		
Security Cabin	X				
Walls			X		
Toilets	X				

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

PURCHASE ORDER		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 3** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PURCHASE ORDER

PURPOSE

To bring in a disciplined and standardized approach to issuing purchase order.

PROCEDURE

After a decision is taken by the Administrative Head of the centre based on received quotation as per Quotation Calling Letter (refer Annexure I to this policy) with required specifications, Commercial Comparative chart will be prepared as per Annexure II and necessary Purchase Order issued as per format given in the Annexure III.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

ADMINISTRATION OF BLOOD AND BLOOD COMPONENTS GUIDELINES		
Module Applies To	**Resident Medical Officer / Nurses and Technicians**	**Policy and Procedure No.: 3** **Page: 1 of 5**
Effective Date: 1 April, 2014		

ADMINISTRATION OF BLOOD AND BLOOD COMPONENTS GUIDELINES

Only physicians can request transfusion of blood and blood components.

Blood and blood components should be prescribed on the order sheet and the Blood Bank Request form. Both the order and the Blood Bank request should be signed and dated by the requesting Physician.

The physician or a Staff Nurse with a validated competency only administers Blood and Blood components.

Complete cross-match for emergency transfusion requires thirty (30) minutes from the time blood is received in the blood bank laboratory.

In case of extreme emergency, uncross-matched blood may be released if the attending physician submits a signed request for uncross-matched blood.

The Blood Transfusion Consent Form (Refer to Annexure I) should be completed and signed by the patient.

A phlebotomist or a Staff Nurse collects Blood specimen for type and screen and/or a cross-match.

Collect 10 ml of venous blood in a plain 10ml vacutainer tube.

When blood bank confirms that the blood is ready, the Staff Nurse of the unit should request delivery at a specific time.

Blood and blood components should not be collected from the blood bank until the patient is properly prepared for transfusion and the assigned Staff Nurse or physician is ready to begin the transfusion.

Prior to collection of blood or blood components from the blood bank staff the assigned Staff Nurse will check the following:

1. The physician's order for transfusion (on the order sheet) including the type of blood or blood component, number of units requested, duration of the transfusion and any special requirements or medications requested.
2. Any special transfusion requirement such as a special blood filter
3. Any site restrictions.
4. Time limits.

Before collecting the blood from the blood bank staff, the Staff Nurse should assemble all the essential equipment needed for transfusion. These include:

1. Blood or blood components administration set with filter.
2. Intravenous catheter or intravenous needle, recommended gauge: 18, 19 or 20. Nothing smaller than 20 gauge needles should be used because they may lead to red cell hemolysis.
3. Normal saline intravenous fluid.
4. Tape and appropriate arm restraint device if necessary.

The appropriate tubing and filters when necessary will be hung with a bag of normal saline and set at a Keep Vein Open (KVO) rate. Tubing must be changed after every two (2) units or after four (4) hours of use whichever is less. All filters and infusion devices must be used according to the manufacturer's directions.

ADMINISTRATION OF BLOOD AND BLOOD COMPONENTS GUIDELINES		
Module Applies To	**Resident Medical Officer / Nurses and Technicians**	**Policy and Procedure No.: 3** **Page: 2 of 5**
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The Staff Nurse and the Blood Bank Staff should check the patient's identification data by verbally verifying the following information on the order sheet.

1. The patient's first and family name.
2. The patient's MR Number.
3. The patient's blood group (ABO group and Rhesus type).

Check the expiry date of the blood unit.

The Staff Nurse and the Blood Bank Staff should verify the identification of blood/blood components by checking the following information on the primary label on the bag or bags:

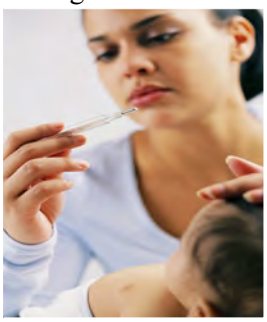
1. Type of component and number of units requested.
2. The donation number or numbers.
3. The blood group (ABO) and Rhesus (RH) Type.
4. Compatibility with the recipient.
5. Expiration date.

Staff Nurse will check the bag/bags for evidence of any leaks, clots or discoloration.

When the verification process has been completed, the Staff Nurse and the blood bank Staff sign the blood bank log book and sign on the back of the blood transfusion request form entering the date and the time.

Blood should be administered as soon as possible within thirty (30) minutes of the blood or blood components being issued to the unit.

Blood must be stored only in blood transfusion refrigerators and not in ward or domestic refrigerators.



The infusion must be started promptly after verification of the identification information, and a Staff Nurse must remain with the patient for the first fifteen (15) minutes for monitoring.

The patient must be assessed and baseline vital signs recorded before the transfusion starts. Vital signs should be taken and recorded in specific forms five (5) minutes after the blood reaches the IV site, then every fifteen (15) minutes for the first hour and there after every sixty (60) minutes until the infusion is completed.

The date and time the transfusion started and finished, the pre and post transfusion vital signs, the amount infused and whether or not any reaction was noted, must be recorded on the administration record and in the Nurse note.

Most transfusion reactions occur within the first fifteen (15) minutes of starting the infusion so the patient must be monitored very closely during this period.

Increased temperature is often the first sign. An increase in temperature > (of more than) 1 degree C associated with transfusion without any other explanation is considered a transfusion reaction. Other signs and symptoms will still apply.

The infusion of red cells requires close monitoring, especially, with elderly patients and those with a history of congestive heart failure or **other heart disease. Rapid administration of blood in these patients may lead to circulatory volume** overload. These patients should be observed for dyspnea, cough, rales and other vital-sign changes.

ADMINISTRATION OF BLOOD AND BLOOD COMPONENTS GUIDELINES		
Module Applies To	**Resident Medical Officer / Nurses and Technicians**	**Policy and Procedure No.: 3** **Page: 3 of 5**
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If no signs or symptoms of reaction occur after fifteen (15) minutes of transfusion, the rate may be adjusted. In most circumstances a unit of blood (Packed Red Blood Cells) should be infused in two (2) to three (3) hours depending on the patient's condition or Physician's orders. The maximum time for a transfusion is four (4) hours for blood and thirty (30) minutes for a therapeutic dose of platelets

When an uncomplicated blood transfusion is completed, the Staff Nurse should discard the blood bag and tubing in the Red plastic bag and dispose of the needle in a sharps box after burning.

Upon discontinuation/completion of transfusion and removal of the blood bag the Staff Nurse shall record the following on the Nurses note, Vital Parameters Record and Blood and Blood Component Transfusion Record (Refer to Annexure II to this policy).

1. Time the transfusion was discontinued/completed
2. The volume and blood component given
3. Vital signs on completion of transfusion.

Keep the patient's vein open unless there is a physician's order to the contrary.

Check with the physician if post transfusion laboratory tests are required such as hematocrit, HB, platelet count or coagulation surveys.

Continue to monitor the patient for at least twenty-four (24) hours after completion of the transfusion.

Transfused in-patients should be instructed to report any unusual symptoms to their assigned nurse so that any suspected transfusion reactions can be evaluated promptly.

Reactions to blood or blood components are varied and may be immunologic or non-immunologic and could be immediate or delayed.

The most serious immediate transfusion reactions are caused by intravascular hemolysis and can be fatal.

Signs and symptoms that may occur with impending or established transfusion reactions include:

1. Fever > 1 degree C with or without chills.
2. Shaking chills (rigors) with or without fever.
3. Pain at the infusion site or pain in the back, abdomen or flanks.
4. Pain or tightness in the chest
5. Blood pressure changes, usually acute hypertension or hypotension
6. Respiratory distress including dyspnoea, tachypnoea or hypoxia.
7. Skin changes including flushing, urticaria, localized or generalized oedema.
8. Nausea with or without vomiting
9. Acute onset of sepsis including fever, chills, hypotension.
10. Anaphylaxis.

ADMINISTRATION OF BLOOD AND BLOOD COMPONENTS GUIDELINES		
Module Applies To	**Resident Medical Officer / Nurses and Technicians**	**Policy and Procedure No.: 3** **Page: 4 of 5**
Effective Date: 1 April, 2014		

Delayed reactions may occur days to months after the transfusion.

The most common presenting signs of a delayed transfusion reaction are:

1. Fever
2. Declining haemoglobin
3. Mild jaundice

The immediate treatment response to all transfusion reactions is:

1. At the first sign of a transfusion reaction "STOP" the blood/blood component transfusion temporarily.
2. Keep the intravenous line open with new tubing and normal saline.
3. Notify the attending physician who should physically attend the patient for evaluation. Over the phone consultations are not acceptable.
4. Notify the Blood Bank immediately.
5. While the blood/blood component is still at the patient's bedside, the Staff Nurse performs a clerical check to determine if the patient received the correct blood/blood component unit.
6. Recheck the patient identity.
7. Check the blood unit number.
8. Check the ABO and Rh-type on the label of the bag/bags and Rh-type of the patient as recorded on the transfusion compatibility tag and verify ABO compatibility of the blood unit/units.
9. Check the bag for any evidence of haemolysis or change of colour.

If the physician decided this is a transfusion reaction, terminate the transfusion and collect the following samples from the patient:

1. 3ml blood sample in an EDTA tube.(Ethylene Diamine Tetra acetic Acid)
2. Clotted blood in plain tube (at least 5 ml)
3. The first voided urine specimen post reaction.
4. Two blood culture bottles.

Record all transfusion reaction information on Vital Parameters record, Blood and Blood Components Transfusion record and on Nurse Note.

Return the laboratory copy of the completed form; the post-transfusion specimens, report of post transfusion reaction and the blood/blood component bag including the IV (needle removed) administration set and all blood/blood components bags already transfuse if any, to the Blood Bank.

The patient's vital signs must continue to be monitored every one-two (1-2) hours or more often as indicated by the patient's condition or physician's order.

The Staff Nurse ensures that the transfusion reaction is appropriately documented in the patient's medical record and reported via incident Report to the Nursing Superintendent and Administrative Head of the Center.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

ADMINISTRATION OF BLOOD AND BLOOD COMPONENTS GUIDELINES		
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Approval Date:

ANNEXURE I
(Refer to Purchase and Maintenance Manual Policy and Procedure No. 3)

QUOTATION CALLING LETTER

Prime Surgical Centers Private Limited, Pune.

Beck House, Damle Path, Off Law College Road, Pune - 411004.

Quotation Calling Format

Ref. No.: 00/PSC/0000 - 00

Date : 00/00/0000

To,

M/s.

Address :

Contact Person :

Dear Sir,
Please forward us following details of your product as per our advertisement/letter/ telephonic discussion held on Dt. 00/00/0000

Sr.No.	Item Description	Company	Model	Rate in Rs.
1				
2				
3				
4				
5				

Please specify Technical details below :-

1	
2	
3	
4	
5	

Terms and Conditions :

Discount :

Taxes :

Octroi/ LBT :

Payment Terms :

Mode of Payment :

Delivery Schedule :

Warranty :

Installation Charges :

AMC & CMC :

ANNEXURE I
(Refer to Nursing Manual II Policy and Procedure No. 3)

BLOOD / BLOOD COMPONENTS TRANSFUSION CONSENT FORM

Blood Transfusion is a life-saving procedure, prescribed by the Doctor. Blood can be given "whole" but more often a Red component or combination or apheresis is transfused. Among these the most common components are:

- Whole Human Blood
- Concentrated Red Blood Cells
- Human Plasma
- Fresh Frozen Plasma
- Platelet Concentrate
- Cryo precipitate

1. I agree to the administration of blood and /or components in the interest of proper medical care.
2. I have been informed of transfusion options available which may include banked blood (allogeneic) provided by voluntary or replacement (relatives) donor.
3. I have been informed that despite careful screening of anti-HIV I/II, anti-HCV, HBsAG, syphilis and malarial parasite, in the donated blood, in accordance with the Government of India Gazette Notification No. G.S.R 245 (E) dated 05.04.99 issued by the Ministry of Health and Family Welfare, as amended from time to time, there are rare instances of life threatening infection such as AIDS, Hepatitis and other viruses or diseases as yet unknown. I understand that there is no practical way to eliminate all risk. I also understand that unpredictable reactions may occur, which include, but are not limited to, fever, rash and shortness of breath, shock and in rare occasions death.
4. I understand that Prime Surgical Centers does not have its own blood bank. The blood and/or blood components, being transfused to me/my patient is being supplied by a registered blood bank and the blood bank is responsible for the mandatory tests and other compatibility tests that are required by the prevailing law.
5. Expected benefits of the transfusion may include minimizing shock, minimizing brain and other organ damage, hastening recovery and replacing blood loss. However, I understand that there is no guarantee and / or assurance offered as to the expected benefits.
6. The Doctor has explained my prognosis and the risks of not undergoing the blood transfusion procedure. I also understand that the blood transfusion procedure may/may not improve my condition.
7. I have had the opportunity to ask question about transfusion, alternate forms of treatment, risk of non-treatment, the procedure to be used and the relative risks and hazards involved and I believe that I have sufficient knowledge to make an informed decision.
8. The Doctor has explained to me that if immediate, life threatening events occur during the blood transfusion procedure, the same will be treated to the best of his judgment.
9. I also agree that the blood transfusion administered on me shall be subject to Indian Laws and the Courts at Maharashtra, India only shall have the sole and exclusive jurisdiction in case of any dispute that may arise of any nature whatsoever.
10. The contents of the above mentioned form have been read over and explained to the patient/relative in the language known to him/her.

AUTHORISATION OF PATIENT

I acknowledge that I have had the opportunity to discuss the blood transfusion procedure, as stated earlier, and therefore give consent to this procedure.

Patient Name …… Witness Name ……

Patient Signature …… Witness Signature ……

Date & Time…… Date & Time……

PATIENT REPRESENTATIVE/SURROGATE

The patient is unable to give consent because……. and

I ……. (name and relationship to patient), therefore give consent for the patient.

I acknowledge that I have had the opportunity to discuss the blood transfusion procedure, as stated earlier, and therefore give consent to this procedure.

Patient Representative/Surrogate Name & Relationship ……

Signature …… Date & Time……

Tel. No.: ……

REFUSAL OF CONSENT TO TRANSFUSION OF BLOOD / BLOOD COMPONENTS

I, ……., do refuse to consent to the transfusion of Blood and/or Blood Components described in this consent form. The risks attendant to my refusal have been fully explained to me, and I hereby release the Prime Surgical Centers, its nurses and employees, together with all physicians in any way with me as a patient, from liability for respecting and following my express wishes and direction.

Patient or Responsible Person Name ……..

Relationship to Patient ……. Date & Time……

Witness Name ……. Witness Signature …….

Date & Time……

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
Phone: - 020-39931000 Fax: - 020 39931020
Email: - customercare@primesurgical.in
Website: www.primesurgical.in

PRIME SURGICAL CENTERS

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

BLOOD / BLOOD COMPONENTS TRANSFUSION CONSENT FORM

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- Human Plasma
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- Cryo precipitate

1. I agree to the administration of blood and /or components in the interest of proper medical care.
2. I have been informed of transfusion options available which may include banked blood (allogeneic) provided by voluntary or replacement (relatives) donor.
3. I have been informed that despite careful screening of anti-HIV I/II, anti-HCV, HBsAG, syphilis and malarial parasite, in the donated blood, in accordance with the Government of India Gazette Notification No. G.S.R 245 (E) dated 05.04.99 issued by the Ministry of Health and Family Welfare, as amended from time to time, there are rare instances of life threatening infection such as AIDS, Hepatitis and other viruses or diseases as yet unknown. I understand that there is no practical way to eliminate all risk. I also understand that unpredictable reactions may occur, which include, but are not limited to, fever, rash and shortness of breath, shock and in rare occasions death.
4. I understand that Prime Surgical Centers does not have its own blood bank. The blood and/or blood components, being transfused to me/my patient is being supplied by a registered blood bank and the blood bank is responsible for the mandatory tests and other compatibility tests that are required by the prevailing law.
5. Expected benefits of the transfusion may include minimizing shock, minimizing brain and other organ damage, hastening recovery and replacing blood loss. However, I understand that there is no guarantee and / or assurance offered as to the expected benefits.
6. The Doctor has explained my prognosis and the risks of not undergoing the blood transfusion procedure. I also understand that the blood transfusion procedure may/may not improve my condition.
7. I have had the opportunity to ask question about transfusion, alternate forms of treatment, risk of non-treatment, the procedure to be used and the relative risks and hazards involved and I believe that I have sufficient knowledge to make an informed decision.
8. The Doctor has explained to me that if immediate, life threatening events occur during the blood transfusion procedure, the same will be treated to the best of his judgment.
9. I also agree that the blood transfusion administered on me shall be subject to Indian Laws and the Courts at Maharashtra, India only shall have the sole and exclusive jurisdiction in case of any dispute that may arise of any nature whatsoever.
10. The contents of the above mentioned form have been read over and explained to the patient/relative in the language known to him/her.

AUTHORISATION OF PATIENT

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Patient Name …… Witness Name ……

Patient Signature …… Witness Signature ……

Date & Time…… Date & Time……

PATIENT REPRESENTATIVE/SURROGATE

The patient is unable to give consent because……. and

I …….. (name and relationship to patient), therefore give consent for the patient.

I acknowledge that I have had the opportunity to discuss the blood transfusion procedure, as stated earlier, and therefore give consent to this procedure.

Patient Representative/Surrogate Name & Relationship ……

Signature …… Date & Time……

Tel. No.: ……

REFUSAL OF CONSENT TO TRANSFUSION OF BLOOD / BLOOD COMPONENTS

I, ……., do refuse to consent to the transfusion of Blood and/or Blood Components described in this consent form. The risks attendant to my refusal have been fully explained to me, and I hereby release the Prime Surgical Centers, its nurses and employees, together with all physicians in any way with me as a patient, from liability for respecting and following my express wishes and direction.

Patient or Responsible Person Name ……..

Relationship to Patient …… Date & Time……

Witness Name …… Witness Signature ……

Date & Time……

ANNEXURE II
(Refer to Nursing Manual II Policy and Procedure No. 3)

BLOOD AND BLOOD COMPONENT TRANSFUSION RECORD

BLOOD GROUP:

BLOOD GROUP:

PRE TRANSFUSION STATUS	**IN CASE OF REACTION**
HIV : HBsAG : HCV : VDRL : Malaria :	1. STOP TRANSFUSION. 2. MAINTAIN IV LINE WITH NORMAL SALINE. 3. CHECK VITALS. 4. TAKE BLOOD SAMPLE FOR CROSS MATCHING. 5. INFORM DOCTOR. 6. SEND THE BAG WITH TRANSFUSION NOTE TO BLOOD BANK.

BLOOD GROUP :

Sr. No.	Blood Bag No.	Blood and Blood Component	Blood Component Volume	Date of Collection	Date of Expiry	Date & Time of Starting	Sign of Staff Nurse - Starting	Date & Time of Completing	Sign of Staff Nurse - Completing	Adverse Effects /Reaction with time, if any	Signature of Doctor
1.											
2.											
3.											
4.											

BLOOD TRANSFUSION RECORD MOUNT SHEET	
PASTE LABEL FROM BLOOD BAG ON THIS SIDE OF SHEET ONLY	PASTE LABEL FROM BLOOD BAG ON THIS SIDE OF SHEET ONLY
PASTE LABEL FROM BLOOD BAG ON THIS SIDE OF SHEET ONLY	PASTE LABEL FROM BLOOD BAG ON THIS SIDE OF SHEET ONLY

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
Phone: - 020-39931000 Fax: - 020 39931020
Email: - customercare@primesurgical.in
Website: www.primesurgical.in

PRIME SURGICAL CENTERS

BLOOD AND BLOOD COMPONENT TRANSFUSION RECORD

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

BLOOD GROUP:

PRE TRANSFUSION STATUS	**IN CASE OF REACTION**
HIV : HBsAG : HCV : VDRL : Malaria :	1. STOP TRANSFUSION. 2. MAINTAIN IV LINE WITH NORMAL SALINE. 3. CHECK VITALS. 4. TAKE BLOOD SAMPLE FOR CROSS MATCHING. 5. INFORM DOCTOR. 6. SEND THE BAG WITH TRANSFUSION NOTE TO BLOOD BANK.

Sr. No.	Blood Bag No.	Blood and Blood Component	Blood Component Volume	Date of Collection	Date of Expiry	Date & Time of Starting	Sign of Staff Nurse - Starting	Date & Time of Completing	Signof Staff Nurse - Completing	Adverse Effects /Reaction with time, if any	Signature of Doctor
1.											
2.											
3.											
4.											

BLOOD TRANSFUSION RECORD MOUNT SHEET	
PASTE LABEL FROM BLOOD BAG ON THIS SIDE OF SHEET ONLY	PASTE LABEL FROM BLOOD BAG ON THIS SIDE OF SHEET ONLY
PASTE LABEL FROM BLOOD BAG ON THIS SIDE OF SHEET ONLY	PASTE LABEL FROM BLOOD BAG ON THIS SIDE OF SHEET ONLY

ANNEXURE III
(Refer to Purchase and Maintenance Manual Policy and Procedure No. 3)

Purchase Order

Date : 00/00/0000

To,

M/s. _____

Address : _____

_____

Sub: Supply of _____

Ref: 1) Your Quotation No. _____ Dt._____

2) Subsequent Negotiation held at Prime Surgical Centers Pvt. Ltd., Pune.

Dear Sir,

With reference to your Quotation and subsequent negotiation with Prime Surgical Centers Pvt. Ltd. Pune. We are pleased to place our firm order for supply of _____ for Prime Surgical Centers Pvt. Ltd., Pune on the following terms and conditions.

1) Total Price : _____

2) Taxes : _____

3) Octroi : _____

4) Delivery : At Prime Surgical Centers Pvt. Ltd., Beck House, Damle Path, Off Law College Road, Pune 411001. By _____ Between 10 a.m. to 4 p. m. except Sundays.

5) Price Inclusion : Packing, Forwarding, Transportation, Loading, Unloading, Installation & Commissioning of Equipment at Prime Surgical Centers Pvt. Ltd., Pune.

6) Supply of above machine should be of the exact quality, grade, company as per attached detailed specifications.

7) Payment Terms: _____ % Advance i.e. Rs. _____ along with purchase order by Cheque No. _____ Dt. _____ Drawn on _____

Cheque will be issued on receipt of Order Acceptance Copy at Prime Office. Balance _____ **%** payment of Rs. _____ **will be made** on Delivery and Installation on COD basis. Please forward receipt of the said amount duly stamped.

8) In case of breakage, damage in transit you will have to replace your entire machine by new one at your cost.

9) The order will be terminated without any notice if the supply is found of inferior quality, substitute of other company than the one specified in quotation & purchase order. No compensation will be paid for termination of order in this situation. The decision of the Prime Surgical Centers Pvt. Ltd., Pune will be final.

10) In case the machine is found to be faulty, substandard etc. you will be liable to replace the whole unit at your cost as per our Purchase Order & quotation.

11) Warranty: _____ years against manufacturing defects from the date of Installation & satisfactory working of it will be given. After expiry of warranty period whether to enter in AMC / CMC will be decided by Prime Surgical Centers Pvt. Ltd.

12) Maintenance Schedule Sheet in details should be submitted at the time of supply. Failure to do this will attract delay in balance payment.

13) No escalation in the price will be given / allowed.

14) Kindly return the enclosed Order Acceptance Letter before supply of the machine duly signed and stamped by you.

15) Installation charges: Inclusive in the total cost.

16) In case of any dispute the same will be subject to the jurisdiction of the competent court at Pune.

Thanking you,

Pune.

Date: - 00/00/0000

Yours Sincerely,

Authorized Signatory

Prime Surgical Centers Pvt. Ltd,

Pune.

Purchase Order

PONo : PO Date :

Supplier Name :

Phone : Fax :

Mobile No : Email Id :

Dear Sir ,

Please Supply the following material in accordance with Terms & Conditions stipulated herein & acknowledge.

Code	Item Name	Qty	Unit	Price	Disc %	Tax %	Net Amount

Delivery :
Schedule :
Tax Nature :
Octroi :
Freight :

Total Amount :
Disc Amount :
Tax Amount :
Freight Amount :
Octroi Amount :
Other Taxes Amt :
Net Amount :
Currency : Rs

Term Of Payment :
Warranty :
Mode Of Payment :
Terms & Conditions :
Remark :

Please mention PO Number, Code,Material Description as per our PO and Tax invoice,Tin Number, VAT % and VAT Amount on your Bill.

Prepared By

Authorized Signature

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

TABLE OF CONTENTS

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

TABLE OF CONTENTS

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

1) **General Anesthesia:**
   a) **Result Expected:** Total unconscious state, Placement of a Tube in Windpipe
   b) **Techniques:** Medicine is injected in the bloodstream, breathed into the lungs or other routes
   c) **Risk:** Mouth or Throat Pain, Hoarseness, Injury to Mouth or Teeth, Injury to Blood Vessel
   d) **Remote Risk:** Pneumonia, Cardiac Arrest. Reaction, Awareness under Anesthesia

2) **Spinal / Epidural Anesthesia / Analgesia:**
   a) **Result Expected:** Temporary decreased or lost feeling and or movement to lower part of body
   b) **Techniques:** Medicine injected through a needle / catheter in the Spinal Canal or outside the Spinal Canal
   c) **Risk:** Headache, Backache, Persistent weakness, Numbness, Residual Pain
   d) **Remote Risk:** Injury to blood vessels, Infection of brain and its covering (Meninges), Convulsions, Sudden cardiac arrest.

3) **Nerve Block:**
   a) **Result Expected:** Temporary Decreased or lost feeling and or movement of specific limb or area.
   b) **Techniques:** Medicine injected through a needle / catheter near nerve.
   c) **Risk:** Persistent Weakness, Numbness, Residual Pain.
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4) **IV Regional Anesthesia:**
   a) **Result Expected:** Temporary decreased or lost feeling and or movement.
   b) **Techniques:** Medicine injected into veins of arms or leg while using tourniquet.
   c) **Risk:** Persistent Weakness, Numbness, Residual Pain.
   e) **Remote Risk:** Injury to blood vessels, Convulsions, Infection, Sudden Cardiac arrest.

5) **Monitored Anesthesia Care:**
   a) **Result Expected:** With or without Sedation.
   b) Remote Risk: Reaction

If life threatening event occurs patient may need Intensive Care Unit management. The Operation Theatre & ICU are well equipped to handle all complications. I have informed the doctor of all my previous illness, allergies, drug reactions, surgical procedures and all other facts relevant to my treatment. I acknowledged that doctor has explained above anesthesia details. I give consent for anesthesia after understanding all possible outcomes and risk involved. Anesthesia we are capable of managing the complications, but that may be a need for ICU, In such event we take the responsibility of shifting the patient to the nearby ICU.

I have understood the above:

ANNEXURE I
(Refer to Housekeeping Policy and Procedure Manual No. 3)

GUIDELINES – TERMINAL DISINFECTION

1. All furniture – thoroughly scrubbed – chemical disinfection mechanical friction
2. Wheels & casters of furniture & equipment – cleaned & kept free of debris
3. Spotlights & tracks cleaned
4. Wall mounted / ceiling mounted equipment cleaned

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

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I have understood the above:

5. Kick buckets & waste receptacles – cleaned & disinfected – sterilized sanitized
6. Scrub sinks – thoroughly cleaned daily
7. Spray heads of faucets & soap dispensers – disassembled & thoroughly cleaned
8. Reusable brushes – brush dispenser – removed, refilled & sterilized
9. Door of cabinets & OR – cleaned around handles, push plates etc.
10. Floors – machine scrubbed daily, solution picked with wet vacuum
11. Mops – if used – clean mop head used for each room & discarded in laundry hamper
12. Transportation & utility carts - cleaned daily – especially wheels & casters
13. Cleaning equipment – disassembled & cleaned with detergent - germicide

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

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Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

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I have understood the above:

Signature and Name of Patient:

ANNEXURE II
(Refer to Housekeeping Policy and Procedure No. 3)

Signature and Name of Witness: Signature and Name of Doctor:

GUIDELINES – WEEKLY CLEANING ROUTINE

1. Air conditioning grills – vacuumed
2. Shelves in cabinet – cleaned at least weekly
3. Autoclave interiors – cleaned weekly

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

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I have understood the above:

Signature and Name of Patient:

Signature and Name of Witness:

Signature and Name of Doctor:

4. Wall & ceiling – cleaned according to routine
5. Microbiological sampling – routine
6. Weekly check of steam sterilizers / daily check for ethylene oxide sterilizers using live spore preparations
7. Monthly random checks of floors and furniture using live spore preparations to determine effectiveness of housekeeping

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

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I have understood the above:

Signature and Name of Patient:

Signature and Name of Witness: Signature and Name of Doctor:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

EXPOSURE CONTROL PLAN MANUAL

METHODS OF COMPLIANCE: ENGINEERING AND WORK PRACTICE CONTROLS		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 3** **Page: 1 of 2**
Effective Date: 11 April, 2013		

METHODS OF COMPLIANCE: ENGINEERING AND WORK PRACTICE CONTROLS

GENERAL CONSIDERATIONS

Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

ENGINEERING AND WORK PRACTICE CONTROLS

1. Work practice controls mean controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).
2. Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the blood borne pathogens hazard from the workplace.

Prime Surgical Centers will adopt the following safe work practices to help minimize the opportunity for employee exposure to blood borne pathogens:

1. **HANDWASHING**
   a. Employees will wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment. (Refer Hospital Infection Control Policy and Procedure No. 4).
   b. Employees will be provided with appropriate antiseptic hand cleanser and alcohol dispensing units, in conjunction with clean paper towels if hand washing facilities are not readily available.
2. **CONTACT WITH MUCOUS MEMBRANES**

   Employees will wash their hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.
3. **FOOD, DRINK, CIGARETTES AND COSMETICS**
   a. Employees will be prohibited from eating, drinking, smoking, applying cosmetics and handling contact lenses in work areas where there is a reasonable likelihood of occupational exposure.
   b. Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials are present.
4. **CONTAMINATED NEEDLES/SHARPS**
   a. Contaminated needles and other contaminated sharps shall not be bent, recapped.
   b. Needle Burners provided at all nursing station will be used.
   c. Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:
      i. Puncture resistant
      ii. Labeled with the biohazard symbol or colour-coded (red containers)
      iii. Leak proof on the sides and bottom

METHODS OF COMPLIANCE: ENGINEERING AND WORK PRACTICE CONTROLS		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 3** **Page: 2 of 2**
Effective Date: 11 April, 2013		

5. **SPECIMENS**

Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping.

a. Label specimen containers that leave the facility with the biohazard symbol.

b. When universal precautions are utilized in the handling of specimens within the facility, labelling the containers is not necessary as long as the containers are easily recognized as containing specimens.

c. Utilize a secondary container if outside contamination of the primary container occurs. The second container must prevent leakage during handling, processing, storage, transport, or shipping, and be labeled.

d. If the specimen could puncture the primary container, place the primary container within a puncture-resistant and labeled secondary container.

e. Examine and decontaminate (if necessary and/or feasible) any equipment which may become contaminated with blood or other potentially infectious materials, prior to servicing or shipping. Attach to the equipment a biohazard label indicating which portion is contaminated.

ANNEXURE I
(Refer to Nursing Manual Policy and Procedure No. 3)

NURSES PROGRESS NOTES

MR No : IP No.
Name :
Age/Sex :
Comfort / Deluxe Bed No :
Admission Date :

Diagnosis :- .....

Date	Time	Focus	Nurse's Note	Name & Signature

Date	Time	Focus	Nurse's Note	Name & Signature

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

NURSING DOCUMENTATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 3** **Page: 1 of 10**
Effective Date: 11 April, 2013		

NURSING DOCUMENTATION

COMPETENCY STATEMENT

New hire demonstrates understanding of generic Prime Surgical Centers documentation policies.

OBJECTIVES

1. Discuss the purpose of clinical documentation
2. Differentiate between right and Wrong practices in clinical documentation
3. Apply the concept of Data-Action-Response (DAR) in documenting patient care information in nurses progress note
4. Explain the terminology associated with Occurrence-Variance-Accidents (OVA)
5. Apply the concept of nursing process in identifying patient problems and needs from a given case scenario
6. Use nursing process as guide in determining patient's centered outcome in a given case scenario.

INTRODUCTION

Documentation is any written or electronically generated information about a client that describes the care or service provided to that patient. Through documentation, nurses communicate their observations, decisions and actions and outcomes of these actions for patients. Documentation is accurate account of what occurred and when it occurred.

Nursing documentation should be based on the components of the nursing process. Nursing documentation's most important function is to communicate patient healthcare information to all other healthcare interdisciplinary team members in a clear, concise manner.

In the 19th century, Florence Nightingale stressed the importance of nurses to gather patient information in a clear concise manner, and to utilize it to provide the best quality of care to the patients.

1. **COMMUNICATION**

   Documentation is fundamentally communication that reflects the client's perspective on her/his health and well-being, the care provided and, the effect of care. Effective documentation allows nurses and other care providers to communicate about the care provided and to assist clients to make future care decisions. Clear, complete and accurate documentation in a client health record provides a reliable, permanent record of information. All health care providers need ongoing access to client information to provide safe, effective care and treatment.

2. **CONTINUITY OF CARE**

   Continuity of care is effectively demonstrated when care is documented. Coordination of the care is very important for good continuity of care. Coordination of care is displayed when the different parts of the care -- care on different days, care by different caregivers, and care from various departments -- are harmonized into the whole patient care.

3. **QUALITY IMPROVEMENT**

   The quality of care a client receives is reflected in the quality of the documentation of the care as the health care records as are being used as an indicator of the standard of care given to an individual client.

   Documentation serve as a basis for evaluation of the quality and appropriateness of care provided by

comparing documented information with established standards of care.

Information from the health record is often used to evaluate professional practice during quality improvement processes, such as performance reviews, chart audits, accreditation, legislated inspections and board reviews. Individual nurses can use outcome information or information from a critical incident to reflect on their practice and make needed changes based on the evidence. Clear, complete and accurate documentation facilitates the evaluation of the client's progress toward desired outcomes. It also enables nurses to identify and address areas that need improvement.

4. **RESEARCH**

   Health records can be a valuable source of data for health research. From a nursing perspective health records can be used to assess nursing interventions and evaluate client outcomes, as well as to identify care and documentation issues. Accurately recorded information is essential to provide accurate research data. Through research, nurses can improve nursing practice

5. **ACCOUNTABILITY**

   The health record demonstrates nurses' accountability and gives credit to nurses for their professional practice. It is used to determine responsibility and resolve questions or concerns about the provision of care.

6. **REIMBURSEMENT**

   Documentation justifies the cost and length of hospital stay

7. **RESOURCE MANAGEMENT AND COST CONTROL**

   Workload or client classification systems are best derived as byproducts of client documentation.

8. **EDUCATION**

   Documentation provides a comprehensive view of patient' illness; It serve as an educational tool that shows patterns of illness.

9. **LEGAL PROTECTION**

   Documentation provides a legal record of care provided and may used as evidence in the court .A good documentation will defend in a malpractice suit.

10. **LEGISLATIVE REQUIREMENT**

    To comply with legal, regulatory and institutional requirements

PRINCIPLES OF EFFECTIVE DOCUMENTATION

Effective charting should show evidence of the following:

1. Initial assessment and reassessments: what did you observe on initial encounter with patient, as well as subsequent encounters? How was the patient before and after nursing interventions?
2. Status of client / patient problems: what signs and symptoms are present?
3. Interventions and nursing care performed: what did you do to meet the patient's needs?
4. The response or outcome of care: what results did you observe?
5. Specific attention given to safety: what did you do to ensure safety of the patient?
6. The patient's ability to manage care needs after discharge: what did you observe in relation to patient managing his / her own care?

NURSING DOCUMENTATION		
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Right practices in documentation:

1. Never document a body system abnormality without elaboration.

   For Example: Possible spinal cord injury, it's vital to note the details. Over a period of time, the deficit may worsen and with each assessment, the severity should be noted (such as numbness versus inability to move).
2. Always document the patient's baseline mental status (if known).

GUIDELINES FOR RECORDING THE NURSING DATA BASE

1. Follow policies and procedures for documenting correctly.

   Designed to meet legal and regulatory requirements
2. Use black ink and write or print legibly
   a. Easy to understand
   b. Help to remind one of care given years in case of litigation
   c. Sloppy or illegible notes indicate sloppy care
3. Complete the data base as soon as possible

   Delayed or late documentation may result in omissions and errors which could be interpreted as substandard care. If one needs to leave the unit before completing documentation, make sure the most important information is charted before leaving the unit, e.g. vital signs, medication and allergies.
4. Avoid making value judgments, chart objectively

   Record subjective data by using direct quotes
5. Avoid terms that have a negative connotation

   “drunk” or “disagreeable” may be interpreted as one having a negative attitude
6. Keep all information confidential

   Inaccurate or unrecorded information and breach of confidentiality are reasons for legal action against health care providers.
7. Keep it short
   a. Record the facts
   b. Be specific about the problems at hand
8. If an inference is made, support it with evidence
9. If a mistake is made or wrong entry, correct it without covering up the original words
   a. Draw a line through the original words, write “error” and enter initials
   b. Covering up an error is regarded as malpractice
10. If the patient chooses not to answer a question, record “chooses not to answer”

    If information is obtained from a significant other, e.g. Family member and it is felt to be pertinent to the care of the patient, record the name and relationship of the person to the patient, e.g. “Wife states he’s allergic to morphine”.

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11. Symbols and Abbreviations
    a. Only Prime Surgical Centers approved symbols and abbreviations to be used in the medical records documentation
    b. Diagnoses may not be abbreviated in the:
        i. Consent form
        ii. Operative record
        iii. Transfer/ Discharge / Death Summary
        iv. Medical Report
        v. Consultation Report
        vi. Death certificate
        vii. Medical certificate
    c. Drug names shall not be abbreviated, use generic name
12. Only approved medical record forms and formats required by Prime Surgical Centers to be used.

    Each page in the patient's medical record shall include at least the patient's name and MR number or sticker label and name of the unit
13. Completion of Medical Records
    a. Physicians are responsible for accurate, adequate and complete documentation within specified timeframe according to the Completion of Medical Records by the Medical Staff By-Laws.
    b. Nurses and allied healthcare providers are responsible to complete their documentation on the appropriate forms according to Prime Surgical Centers Policies
14. Medical Record Ownership
    a. All Patient's medical record are the property of Prime Surgical Centers.
    b. Patient's have the right to access them upon request
15. Signing off documentation
    a. Physicians' name (first and last name), professional designation, stamp and date to be entered upon completion of documentation.
    b. Medical Students and Residents to sign off all entries made in the medical record by printing their first and last name, date of entry and countersigned by the attending Physician.
    c. Nurses and Allied Healthcare providers to signoff their entries with signature and designation.

MNEMONICS USED FOR DOCUMENTATION

DAR (Data Action Response)

Document

1. Data observed
2. Action performed
3. Response of the patient

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FOCUS CHARTING

The term focus was coined to encourage nurses to view the client's status from a positive perspective rather than the negative focus in problem charting. The system uses Data, Action, and Response (DAR) in documenting nurse's progress notes. With this system of documentation, the nurse identifies a focus based on client concerns or behaviors determined during assessment

FOCUS

Stated as nursing diagnosis which includes actual and potential.

IN THIS SYSTEM ASSESSMENT, CARE PROVIDED AND THE OUTCOME ARE ORGANIZED UNDER DATA, ACTION AND RESPONSE

Data- Subjective and/or objective information that support the stated focus. This category reflects the assessment phase of the nursing process.

Action- Describes the implementation of nursing interventions, such as medication, treatment, calls to the physician, and patient teaching. This category reflects the implementation phases of the nursing process.

Response-Description of client's response to medical and nursing care which reflects the evaluation phase of the nursing process

DATE	TIME	SPECIAL NOTATION	NURSES NOTES
20nd Mar 2013	0800H	Ineffective airway clearance related to inflammatory lung disease as evidenced by, crackles, tachypnoea, frequent Productive cough and desaturation.	D - Tachypnoeic, RR-36cpm ,with frequent productive cough,SaO2-90% crackles on auscultation ----------
			A - Chest physio done .Airway cleared by tracheal and Oropharyngeal suctioning. Positioned in propped up position. Fluid intake increased to 2liters for 24 hours----------S Kulkarni SN
			R - Clear patent airway, smooth and regular respiration .SaO2-96%-
			----------S Kulkarni SN

NURSING PROCESS

The nursing process is a problem-solving approach that enables the nurse to provide care in an organized scientific manner. The goal of the nursing process is to alleviate, minimize, or prevent actual or potential health problems. The nursing process can be applied in any interaction that involves a nurse and a patient.

1. Heart of Nursing Process
    a. Knowledge (what to, Why to)

b. Skills (how to)
c. Attitude (willing to, able to)

2. Steps in nursing process
   a. Assessment
   b. Nursing Diagnosis
   c. Planning
   d. Implementation
   e. Evaluation

ASSESSMENT

Assessment is an establishment of a database for a specific patient. It is the most critical step in Data collection & analysis.

The following are the activities in assessment phase:

1. **Collecting and Examining Data**-Gathering information about the patient from:
   a. Patient (Primary source)
   b. Patient's family/friend (Secondary source)
   c. Nursing records
   d. Medical records
2. **Identifying Subjective and Objective Data**
   a. S-S: Subjective Data are Stated
   Subjective data list includes:
      i. Patient's complaints
      ii. Description of patients support system
      iii. Behavioural and nonverbal messages
      iv. Patient's awareness of her / his own
         - Abilities/disabilities
         - Disease process
         - Prognosis
         - Health care needs
         - Available resources

   b. O-O: Objective Data are Observable
   Objective data list includes:
      i. Physical assessment including vital signs
      ii. Observation of the patient's support system in action
      iii. Chart information including laboratory and test results
3. **Validating Data -** Verifying data to make sure information is accurate and factual.
   Techniques
   a. Recheck your own data (e.g., take a patient's blood pressure in the opposite arm or 10 minutes later)

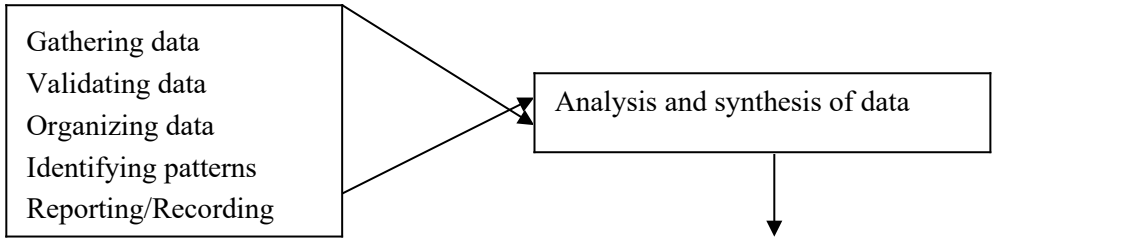
b. Look for factors (Check someone who has an elevated temperature and no other symptoms has just had a hot cup of tea)
c. Ask someone else (Ask more experienced nurse to recheck a blood pressure when you are not sure)
d. Always double check information
e. Compare your subjective and objective data
f. Clarify Patient/Family statements

4. **Organizing Data -** Clustering facts into groups of information that help you to identify patterns of health or illness.
5. **Reporting and Recording Data -** Reporting and recording data to expedite treatment; recording assessment findings to communicate current status.

NURSING DIAGNOSIS

Nursing diagnosis is the statement of a patient's problem derived from the systematic collection of data and its analysis.

Assessment



Subjective Data + Objective Data = **Nursing Diagnosis**

Rules for writing diagnostic statements

1. Actual Nursing Diagnosis - Use three part statement
   a. R - Human Response to illness
   b. E - Etiology
   c. D - Evidence of the diagnosis (defining characteristic)

   E.g.: Fluid volume excess related to inflammatory renal disease as evidenced by puffiness of the face, periorbital edema, decreased urine output and proteinuria
2. High risk nursing diagnosis-Use two part statement

   A risk or possible diagnosis written as a two part statement, when there are no defining Characteristics

   E.g. High risk for impaired skin integrity due to excessive diaphoresis

PLANNING

The planning phase of the Nursing Process involves the development of a nursing care plan for the patient's based on the nursing diagnosis. The nursing care plan is a communication tool used by Nurses to care for their patients.

Planning Involves the following activities:

1. Setting priorities
2. Establishing expected outcome
3. Determining nursing interventions
4. Recording the plan of care

Assigning priority to the nursing diagnosis

1. Life threatening
2. Actual before potential
3. Most stressful

Specifying expected outcome

Goals - Written statement of expected behaviour or outcome, which is to be achieved within a defined period of time

1. Patient – centered
2. Measurable
3. Observable

Elements in an expected outcome

1. Who
2. Behaviour
3. Criteria
4. Time frame

E.g. Patient will maintain normal bowel elimination pattern as evidenced by having bowel movement everyday

Short term goal-Achieved within 24 hrs.

E.g. Patient will demonstrate effective use of incentive Spiro meter within 24 hours of use

Long term goal- discharge goal

E.g. Patient will achieve optimal lung expansion with adequate ventilation upon discharge

FORMULATING NURSING INTERVENTIONS

1. Nursing interventions are activities performed by a nurse to:
    a. Monitor health status
    b. Prevent, resolve or control a problem
    c. Assist with activities of daily living
    d. Promote optimum health and independence
2. Guidelines
    a. Individualize the interventions that would work for a particular patient.
    b. Write nursing interventions in present tense.
    c. Intervention should be indicate what to assess, what to do, what to teach and what to document
    d. Identify interdependent interventions
    e. Consider patient preferences and limitations

IMPLEMENTATION

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Implementation is the actual performance of the nursing interventions identified in the care plan. The implementations are coordinated with other members of the health care team who have direct care of the patient.

Performing nursing interventions include the following:

1. Directly performing activity for someone
2. Assisting people to perform the activity for themselves
3. Teaching people about their healthcare
4. Monitoring for potential complications or problems

EVALUATION OF OUTCOME ACHIEVEMENT

Evaluation is an ongoing process that enables the nurse to determine what progress the patient has made in meeting the goals for care. The outcome criteria provide measures for determining outcomes of care.

Evaluation of an individual plan of care involves the following activities:

1. Evaluating outcome achievement
2. Identifying the variable or factors affecting outcome achievement
3. Deciding whether to continue, modify or terminate the plan

Continuing modifying or terminating the plan

NARRATIVE CHARTING

The nurse may be asked to chart in chronological order the events that occur including the gathering of information using a sentence structure that describes the nursing observations or assessments, treatments and patient's response, etc. Narrative charting is time consuming, so legibility is extremely important if the notes are to be understood by those reading them.

CONCLUSION

Nursing is a profession based on scientific study and rationale, and documentation should reflect that. Evidence Based Practice and Critical Thinking should be the basis for nursing interventions and should be the basis for the care that to be given to patients. Documentation should reflect the nursing process and utilize critical thinking skills in providing the best quality of care that reaches the maximum of Prime Surgical Centers nursing standards of care.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

NURSING DOCUMENTATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 3** **Page: 10 of 10**
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Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

NURSING DOCUMENTATION AND NURSING PROCESS GUIDELINES		
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NURSING DOCUMENTATION AND NURSING PROCESS GUIDELINES

POLICY STATEMENT

New Nurses demonstrate understanding of generic Prime Surgical Centers documentation guidelines.

DEFINITION

Documentation is any written or electronically generated information about a patient that describes the care or service provided to him/her. Through documentation, nurses communicate their observations, decisions and actions and outcomes of these actions for patients. Documentation is accurate account of what occurred and when it occurred.

1. Nursing documentation should be based on the components of the nursing process.
2. Nursing documentation's most important function is to communicate patient healthcare information to all other healthcare interdisciplinary team members in a clear and concise manner.

PURPOSE

1. **COMMUNICATION**

   Documentation is fundamentally communication that reflects the patient's perspective on her/his health and well-being, the care provided and, the effect of care. Effective documentation allows nurses and other care providers to communicate about the care provided and to assist patient's to make future care decisions. Clear, complete and accurate documentation in a patient's health record provides a reliable, permanent record of information. All health care providers need ongoing access to patient's information to provide safe, effective care and treatment

2. **CONTINUITY OF CARE**

   Continuity of care is effectively demonstrated when care is documented. Coordination of the care is very important for good continuity of care. Coordination of care is displayed when the different parts of the care -- care on different days, care by different caregivers, and care from various departments -- are harmonized into the whole patient care.

3. **QUALITY IMPROVEMENT**

   Documentation serve as a basis for evaluation of the quality and appropriateness of care provided by comparing documented information with established standards of care.

4. **RESEARCH**

   Health records can be a valuable source of data for health research.

5. **ACCOUNTABILITY**

   The health record demonstrates nurses' accountability and gives credit to nurses for their professional practice.

6. **REIMBURSEMENT**

   Documentation justifies the cost and length of hospital stay.

7. **RESOURCE MANAGEMENT AND COST CONTROL**

   Workload or patient's classification systems are best derived as bye products of patient's documentation.

8. **EDUCATION**

   Documentation provides a comprehensive view of patient' illness; It serve as an educational tool that shows patterns of illness.

9. **LEGAL PROTECTION**

   Documentation provides a legal record of care provided and may be used as evidence in the court of law. A good documentation will defend in a malpractice suit. “WRITTEN RECORDS SPEAK FOR THEMSELVES”.

10. **LEGISLATIVE REQUIREMENT**

    To comply with legal, regulatory and institutional requirements

PRINCIPLES OF EFFECTIVE DOCUMENTATION

1. Initial assessment and reassessments.
2. Status of patient/s problems.
3. Interventions and nursing care performed.
4. The response or outcome of care.
5. Specific attention given to safety.
6. The patient’s ability to manage care needs after discharge.
7. Patient/Family education.

RIGHT PRACTICES IN DOCUMENTATION

1. Never document a body system abnormality without elaboration.

   For Example: Possible spinal cord injury, it's vital to note the details. Over a period of time, the deficit may worsen and with each assessment, the severity should be noted (such as numbness versus inability to move).
2. Always document the patient’s baseline mental status (if known).

GUIDELINES FOR RECORDING THE NURSING DATA BASE

1. **Follow policies and procedures for documenting correctly**

   Designed to meet legal and regulatory requirements

2. **Use black ink and write or print legibly**

   a. Easy to understand
   b. Help to remind one of care given years in case of litigation
   c. Sloppy or illegible notes indicate sloppy care

3. **Complete the data base as soon as possible**

   Delayed or late documentation may result in omissions and errors which could be interpreted as substandard care. If one needs to leave the unit before completing documentation, make sure the most important information is charted before leaving the unit, e.g. vital signs, medication and allergies.

4. **Avoid making value judgments, chart objectively**

   Record subjective data by using direct quotes

5. **Avoid terms that have a negative connotation**

   "drunk" or "disagreeable" may be interpreted as one having a negative attitude

6. **Keep all information confidential**

   Inaccurate or unrecorded information and breach of confidentiality are reasons for legal action against health care providers.

7. **Keep it short**

   a. Record the facts
   b. Be specific about the problems at hand

8. **If an inference is made, support it with evidence**

9. **If a mistake is made or wrong entry, correct it without covering up the original words**

   a. Draw a line through the original words, write "error" and enter initials
   b. Covering up an error is regarded as malpractice

10. **If the patient chooses not to answer a question, record "chooses not to answer".**
    If the information is obtained from family/friend, record it so.

11. **Symbols and Abbreviations**

    a. Only Prime Surgical Centers approved symbols and abbreviations to be used in the medical records documentation
    b. Diagnosis may not be abbreviated in the:
       i. Consent form
       ii. Operative record
       iii. Transfer/ Discharge / Death Summary
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    c. Drug names shall not be abbreviated, use generic name.

12. **Only approved medical record forms and formats required by Prime Surgical Centers to be used**

    Each page in the medical record shall include at least the name and MR number or sticker label and name of the unit

13. **Completion of Medical Records**

    Nurses and technicians are responsible to complete their documentation on the appropriate forms according to policies of Prime Surgical Centers.

14. **Signing off documentation**

    a. Physicians' name (first and last name), professional designation, stamp, date and time to be entered upon completion of documentation.

    b. Resident Doctors to sign off all entries made in the medical record by printing their first and last name, date of entry and countersigned by the attending Physician.

    c. Nurses and technicians to sign off their entries with signature, name, date and time.

15. **Focus Charting**

    The term focus was coined to encourage nurses to view the patient's status from a positive perspective rather than the negative focus in problem charting. The system uses Data, Action, and Response (DAR) in documenting nurse's progress notes (refer to Annexure I to this policy). With this system of documentation, the nurse identifies a focus based on patient's concerns or behaviour determined during assessment

    a. **FOCUS**

    Stated as problem or nursing diagnosis which includes actual and potential problems

    b. **DAR** (Data Action Response) can be documented as:

    i. **Data Observed** - Assessment of Objective and Subjective data

    ii. **Action Performed** - Describes the implementation of nursing interventions, such as medication, treatment, calls to the physician, and patient teaching. This category reflects the implementation phases of the nursing process.

    iii. **Response of the Patient** -Description of patient's response to medical and nursing care which reflects the evaluation phase of the nursing process

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			R - Clear patent airway, smooth and regular respiration .SaO2-96%-
			----------S Kulkarni SN

16. **Documentation – Do's and Don'ts of Charting**

    Refer Annexure II to this policy.

NURSING PROCESS

The nursing process is a problem-solving approach that enables the nurse to provide care in an organized scientific manner. The goal of the nursing process is to alleviate, minimize, or prevent actual or potential health problems. The nursing process can be applied in any interaction that involves a nurse and a patient.

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    a. Knowledge (what to, Why to)
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2. Steps in nursing process
    a. Assessment
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ASSESSMENT

Assessment is an establishment of a database for a specific patient. It is the most critical step in Data collection & analysis.

The following are the activities in assessment phase:

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        iv. Patient's awareness of her / his own
            - Abilities/disabilities
            - Disease process
            - Prognosis
            - Health care needs
            - Available resources

b. O-O: Objective Data are Observable

Objective data list includes:

i. Physical assessment including vital signs

ii. Observation of the patient's support system in action

iii. Chart information including laboratory and test results

3. **Validating Data -** Verifying data to make sure information is accurate and factual.
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NURSING DIAGNOSIS

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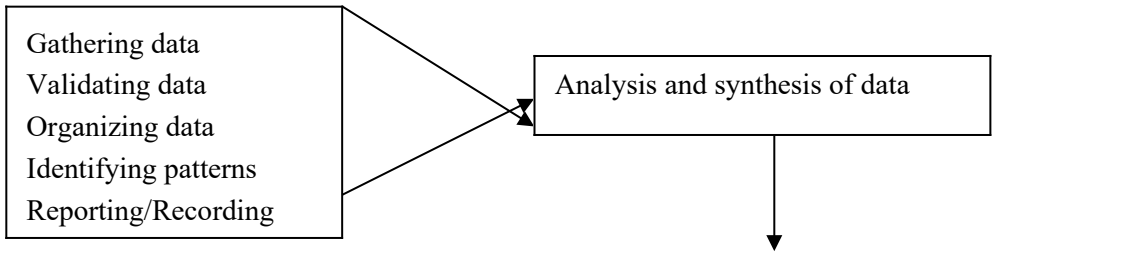
Assessment



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NURSING DOCUMENTATION AND NURSING PROCESS GUIDELINES		
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PLANNING

The planning phase of the Nursing Process involves the development of a nursing care plan for the patient's based on the nursing diagnosis. The nursing care plan is a communication tool used by Nurses to care for their patients.

Planning Involves the following activities:

1. Setting priorities
2. Establishing expected outcome
3. Determining nursing interventions
4. Recording the plan of care

Assigning priority to the nursing diagnosis

Specifying expected outcome

Goals - Written statement of expected behaviour or outcome, which is to be achieved within a defined period of time

1. Patient –centered
2. Measurable
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Elements in an expected outcome

1. Who
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E.g. Patient will maintain normal bowel elimination pattern as evidenced by having bowel movement everyday

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   b. Write nursing interventions in present tense.
   c. Intervention should be indicate what to assess, what to do, what to teach and what to document

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e. Consider patient preferences and limitations

IMPLEMENTATION

Implementation is the actual performance of the nursing interventions identified in the care plan. The implementations are coordinated with other members of the health care team who have direct care of the patient.

Performing nursing interventions include the following:

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4. Monitoring for potential complications or problems

EVALUATION OF OUTCOME ACHIEVEMENT

Evaluation is an ongoing process that enables the nurse to determine what progress the patient has made in meeting the goals for care. The outcome criteria provide measures for determining outcomes of care.

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2. Identifying the variable or factors affecting outcome achievement
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CONCLUSION

Nursing is a profession based on scientific study and rationale, and documentation should reflect that. Evidence Based Practice and Critical Thinking should be the basis for nursing interventions and should be the basis for the care that to be given to patients. Documentation should reflect the nursing process and utilize critical thinking skills in providing the best quality of care that reaches the maximum of Prime Surgical Centers nursing standards of care.

ANNEXURE II
(Refer to Nursing Manual Policy and Procedure No. 3)

NURSING DOCUMENTATION – DO'S AND DON'TS OF CHARTING

DO'S

1. Check that you have the correct chart before you begin writing.
2. Make sure all documentation has the correct patient sticker or details.
3. Make sure your documentation reflects the nursing process and your professional capabilities.
4. Write legibly.
5. Write in black for normal documentation and red for highlighting unusual events/allergy in permanent ink.
6. Chart the time you gave a medication, the administration route and the patient's response.
7. Chart precautions or preventive measures used, such as bed rails.
8. Record each phone call to a Physician, including the exact time, message and response.
9. Chart patient care at the time you provide it.
10. Chart important data as soon as it happens.
11. If you remember an important point after you've completed your documentation, chart the information with a notation that it's a "late entry". Include the date and time of the late entry.
12. Document often enough to tell the whole story.
13. Eliminate bias – don't use language that suggests a negative attitude towards the patient. Document the behaviour only and not your patient personally.
14. Keep the chart intact – do not remove pages.
15. Chart significant situations – changing conditions, results of tests and procedures, laboratory results, as well as codes and procedures.
16. Chart complete assessment data.
17. Document all discharge instructions.
18. Use neutral language.

DON'TS

1. Chart a symptom, such as "complains of pain", without also charting what you did about it.
2. Alter a patient's record – this is a criminal offense.
3. Use shorthand or abbreviations that aren't widely accepted.
4. Write imprecise descriptions, such as "bed soaked" or "a large amount".
5. Chart what someone else said, heard, felt, or smelled unless the information is critical. In that case, use quotations and attribute the remarks appropriately.
6. Chart care ahead of time – something may happen and you may be unable to actually give the care you've charted. Charting care that you haven't done is considered fraud.
7. Add information at a later date without indicating that you did so.
8. Leave blank spaces
9. Omit information.
10. Destroy records.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

OUT PATIENT DEPARTMENT (OPD) REGISTRATION / FOLLOW-UP AND VITALS CHECK-UP		
Module Applies To	**Customer Care / OPD Nurse / Security**	**Policy and Procedure No.: 3** **Page: 1 of 1**
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OUT PATIENT DEPARTMENT (OPD) REGISTRATION / FOLLOW-UP AND VITALS CHECK-UP

PURPOSE

To ensure completion of the registration / follow-up consultation process with a view to enhance patient experience and satisfaction.

PROCEDURE

1. If a patient has made a special request for a wheelchair or stretcher, ensure that it is provided once he/she enters Prime Surgical Centers premises. Ensure that the patient is handled with empathy and with all measures of safety and care. (Refer Nursing Manual Policy and Procedure No. 9). Under all circumstances all due courtesies will be extended to patients and their relatives.
2. Register the patient if he/she is coming for the first time for consultation or if the registration is has not been done earlier.
3. Get the registration form filled from the patient and enter the details in the system. If the patient has taken a phone appointment, some of his/her details would have already been entered in the system. These details can be pulled up in the system by selecting the “From Appointment” selection box.
4. On registration, an MR (Medical Record) number (unique identification number) will be generated for the patient.
5. If an Existing patient has come for a follow-up consultation, pull up the patient’s details in the system via the MR number.
6. Mark the visit of the patient by selecting the Department and the Consultant the patient desires to see.
7. Collect the Registration and/or OPD Consultation fees from the patient.

   The one-time Registration fee is Rs. 100. The First OPD Consultation charge is Rs. 500 and thereafter it is Rs. 350 for Follow-up OPD Consultation.

   Take two copies of the receipt. One copy is to be given to the patient. The second copy is to be handed over to the Accounts department, at the end of the day while depositing the total amount collected for the day.
8. Mention the patient details on the OPD Card (Refer Nursing Manual Policy and Procedure No. 25 Annexure II).
9. File the OPD card in the folder before handing it over to the patient.
10. Guide the patient to the Vitals Room where the patient’s vitals will be checked and this will be documented along with the patient’s past history on the OPD card and the system by the OPD Nurse. (Refer Nursing Manual Policy and Procedure No. 21)
11. The patient file will then be handed over to the patient for consultation and retention by him/her.
12. Ask the patient to be seated and await his/her turn to meet the Consultant.
13. The names of the patients who have come for OPD visit will be displayed on the leader board. Call out the respective patient’s token number (from the system) when it’s his/her time to visit the Consultant. Guide the patient to the Consultant’s OPD room i.e. room 01 / 02 / 03 or 04.

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PRIME SURGICAL CENTERS

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GENERAL MANUAL

PRIME PHILOSOPHY: ALWAYS REMEMBER		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 3** **Page: 1 of 1**
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PRIME PHILOSOPHY: ALWAYS REMEMBER

1. The most prized possession	Integrity
2. The most beautiful attire	Smile
3. The two most power filled words	" I Can"
4. The most contagious sprit	Enthusiasm
5. The most satisfying work	Helping others
6. The greatest joy	Giving
7. The greatest "shot in the arm"	Encouragement
8. The greatest asset	Faith
9. The greatest loss	Loss of self - respect
10. The ugliest personality trait	Selfishness
11. The greatest problem to overcome	Fear
12. The most crippling failure disease	Excuses
13. The most powerful force in life	Love
14. The most effective sleeping pill	Peace of mind
15. The most destructive habit	Worry

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PRIME SURGICAL CENTERS

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HOSPITAL INFECTION CONTROL MANUAL

PRINCIPLES OF STERILE TECHNIQUE		
Policy/Procedure Applies To	**All Nurses & OT Technicians**	**Policy/Procedure No: 3** **Page: 1 of 3**
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PRINCIPLES OF STERILE TECHNIQUE

The principles of sterile technique are applied in various ways. If the principle itself is understood, the application of it becomes obvious.

1. All articles to be used in an operation are sterilized previously. Articles such as packs, basins, and sponges are obtained from the sterile stock supply.
2. Scrub nurses touch only sterile articles. Circulating nurses touch only nonsterile articles. All supplies for the sterile team members reach them by means of the circulating nurse through sterile wrapped packages.
3. If in doubt about the sterility of anything, consider it NOT sterile.
    a. If a sterile package is found on the floor.
    b. If you are uncertain about the autoclave.
    c. If a nonsurgically clean person brushes close to a sterile table and vice versa.
4. The circulating nurse should avoid reaching over a sterile field, and the scrub nurse should avoid reaching over a nonsterile field.
    a. The scrub nurse sets basins or glasses to be filled at the edge of the sterile table. The circulating nurse stands near this edge of the table to fill it.
    b. The circulating nurse stands at a distance from the sterile field to adjust the light over it.
    c. The surgeon turns away from the sterile field to have perspiration wiped from his brow.
    d. The scrub nurse drapes a nonsterile table toward her first.
5. Tables are sterile only at table level.
    a. Linen or sutures falling over table edge are discarded. The scrub nurse does not touch the part hanging below table level.
    b. When the circulating nurse uncovers a sterile table, she is careful that the bottom edge of the sheet is not drawn up to the table level where it might contaminate the sterile contents.
    c. When the scrub nurse drapes a table, she is careful as she unfolds them that the part of the drape which drops down below the table surface is not brought up to table level again.
6. Gowns are considered sterile only from table level to shoulder level in front and the sleeves.
    a. Nurses and doctors gown and glove without touching the outside of the gown and gloves with the bare hand.
    b. They are careful not to touch the hand towels on their shirts while drying their hands.
7. Scrub nurses keep well within the sterile areas. Allow a wide margin of safety when passing nonsterile areas and follow back to back unless for passing.
8. Nonsterile persons keep away from the sterile areas. They allow a wide margin of safety when passing sterile areas and follow the rule for passing. Nonsterile persons face a sterile area when passing it so they can be sure they have not touched it.
9. Sterile persons keep contact with sterile areas to a minimum.
10. Moisture may cause contamination.
    a. Sterile packages are placed in dry areas.
    b. If a sterile package becomes damp or wet, it is resterilized or discarded.

PRINCIPLES OF STERILE TECHNIQUE		
Policy/Procedure Applies To	**All Nurses & OT Technicians**	**Policy/Procedure No: 3** **Page: 2 of 3**
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c. Wet ampoules from a bactericidal solution are placed on sterile area on a towel which absorbs the moisture.

d. Drapes are placed on a dry field.

e. If a solution soaks through a sterile area to a nonsterile one, the wet area is covered with another drape.

f. A towel is placed at the bottom of an instrument tray before placing the instruments in it to absorb the moisture and permit the tray to be set on a sterile table.

g. Linen packages from the sterilizer are permitted to cool before being put on shelves to prevent their becoming damp from steam condensation when in contact with a cold shelf.

11. When bacteria cannot be eliminated from a field, they must be kept to a minimum.

10. Skin cannot be sterilized. The skin of the patient is a source of potential contamination in every operation. However, this does not obviate the necessity for strict aseptic technique. Defences within the tissue and body as a whole usually can overcome these relatively few organisms. Also, the hands and arms of the members of the sterile team can be a source of contamination. All possible means are used to keep bacteria to a minimum and prevent any of them from gaining entrance to the wound.

a. The patient's skin of the operative area is given a preliminary clipping and scrub.

b. In draping, all the skin area is covered except the site of incision.

c. All doctors and scrub nurses scrub their hands and arms.

d. Nurses and doctors gown and glove without touching the outside of the gown and gloves with the bare hand.

e. They are careful not to touch the hand towels on their shirts while drying their hands.

f. The knife used for the skin incision is removed from the sterile field.

g. After the skin incision is made, skin towels cover all skin in cases where it is possible. Compromise is sometimes necessary.

h. If a glove is punctured during the operation, it is changed at once.

i. If the glove is pricked by a needle or instrument, the glove is changed at once and the needle or instrument is discarded from the sterile field.

11. Some areas cannot be scrubbed. When the operative field includes the mouth, nose, throat or sinus, the number of bacteria present is great. Various parts of the body usually are able to prevent infection from bacteria that normally inhabit those parts. However, an endeavor is made to reduce the number of bacteria that are present at these areas and to prevent scattering of the inevitable ones.

a. As much of the operative area is cleaned as can be and the surrounding skin is scrubbed. For example, the nose and face are prepared prior to submucous resection.

b. Surgeons make an effort to use a sponge only once for sponging, then discard.

12. The air is contaminated by dust and droplets.

a. Masks are worn over the nose and mouth. They fit snugly.

b. Talking is kept to a minimum.

c. Main corridors are considered contaminated.

d. Doors from corridors into operating rooms are kept closed.

e. Sterile trays without wrappers are not carried through corridors.

PRINCIPLES OF STERILE TECHNIQUE		
Policy/Procedure Applies To	**All Nurses & OT Technicians**	**Policy/Procedure No: 3** **Page: 3 of 3**
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f. Members of the sterile team remain in the operating room if waiting with gloved hand clothed with sterile towel.

g. If necessary to go out into corridor, the gown and gloves are changed upon returning to room.

h. All cleaning is damp cleaning. It is thoroughly done each morning before the day's schedule.

i. Lights over the operating table are cleaned. Check to see that this is done.

j. Floors are wet-mopped between each case and at the end of the day by housekeeping.

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PRIME SURGICAL CENTERS

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SAFETY MANUAL

SAFE USE OF ELECTRICAL EQUIPMENT		
Policy/Procedure Applies To	**All nurses**	**Policy/Procedure No: 3** **Page: 1 of 1**
Effective Date: 11 April, 2013		

SAFE USE OF ELECTRICAL EQUIPMENT

POLICY

All electrical equipment must be used in a safe and orderly fashion. All electrical wires on equipment must be in a good and proper order, have no frayed ends or uncovered wires, broken plugs, etc. Any observation of this should be reported to the Nursing Superintendent and Executive Facility immediately, and repairs undertaken on priority.

PROCEDURE

1. Only standard and ISI approved electrical plugs should be put in any electrical outlet.
2. All electrical outlets in the operating room(s) must be hospital grade and be checked for proper polarity and adequate grounding. All equipment fittings shall be hospital grade.
3. Always grasp electrical wiring on the plug head itself when pulling a plug out of a receptacle to avoid breaking the wire. Never pull on the wire itself.
4. Any evidence of shorting of equipment should be reported immediately to the surgeon and the O.T. Matron for O.T. and Nursing Superintendent for nursing units. Executive Facility and Electrician will however be kept in loop irrespective of any area.

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SAFETY MANUAL

SAFE USE OF ELECTRICAL EQUIPMENT		
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ANNEXURE III
(Refer to Housekeeping Manual Policy and Procedure No. 1)

SERVICE STILT

	Frequency				
AREA	**Daily**	**Weekly**	**Fortnightly**	**Mthly**	**Other**
Floor	X				
Walls		X			
AC Control Panel	X		X		
Electric Control Panel 1,2,3			X		
Store Room1,2			X		
UPS Room			X		
Air Handling Unit			X		
Generator Panel			X		
Generator		X			
Transformer Room			X		

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOUSEKEEPING MANUAL

DAILY HOUSEKEEPING SERVICES IN OPERATION THEATER / PROCEDURE ROOM		
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DAILY HOUSEKEEPING SERVICES IN OPERATION THEATER / PROCEDURE ROOM

PROCEDURE

1. **Cleaning prior to the first procedure of the day**
   a. Flat surfaces of tables, equipment and overhead lamps must be damp dusted with a clean cloth that has been moistened with a detergent germicide or disinfectant.2% Ecosheild
   b. Damp cleaning with detergent germicide moistened, lint free cloth all counter surfaces in the soiled receiving and clean work areas.
2. **Cleaning between cases**
   a. All used paper and trash put in plastic bag hamper in room. All used linen is placed in BLACK laundry hamper in room. At the end of the case, bags are tied and taken to soiled holding area and put in large plastic trash and/or laundry bins.
   b. All knife blades, needles and sharps placed in sharp Box in Nursing Station.
   c. When these sharp Boxes are 2/3rd full, they are sealed and placed in biohazard trash.
   d. Dirty instruments are taken to washing area in C.S.S.D. and decontamination process completed.
   e. Check both wall suctions. Discard if soiled.
   f. Wipe down all OR equipment and furniture in the room. Special equipment is then returned to proper storage area.
   g. Walls are spot cleaned with Ecoshield 5% germicidal solution.
   h. Floors are mopped with germicidal solution 1% sodium Hypochorite, whereas, the walls with 5% Ecoshield. Mop solution and mop head are changed daily and more frequently as needed.
3. **Cleaning suction equipment**
   a. Suction bottles are to be cleaned with hot water and then filled with hot soapy Water for 30 minutes and rinsed. Dry the bottle and return to the storage area.
   b. Disposable bottle has to be disposed off in red bags as biohazard waste.
   c. Suction stand is wiped down with tuberculocidal disinfectant of 5% Ecoshield.
4. **Cleaning OT lights:**
   a. Cleaned every morning and during terminal cleaning every afternoon.
   b. The dome surface and arm are cleaned with Ecoshield germicidal solution and the reflector is cleaned with alcohol.
5. **Cleaning equipment before storing**
   a. Any equipment taken outside of the OT is cleaned with germicidal solution [5% Ecoshield] and returned to proper storage area.
   b. Equipment used in the room is wiped down with germicidal solution [5% Ecoshield] at the end of the case and returned to proper storage area.

DAILY HOUSEKEEPING SERVICES IN OPERATION THEATER / PROCEDURE ROOM		
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6. C-arm Unit:

a. If C-arm unit is kept in store, it must be wiped down with germicidal solution [5% Ecoshield] before taking it in to the O.T. and the wheels to be sprayed with Baciliocide spray at OT door and then taken in.

b. After the use in OT, it is then wiped and sprayed as in #1 again and returned to storage area.

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PRIME SURGICAL CENTERS

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SAFETY MANUAL

ELECTROSURGICAL UNIT (ESU) - SAFETY		
Policy/Procedure Applies To	**All Nurses and O.T.Technicians**	**Policy/Procedure No: 4** **Page: 1 of 1**
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ELECTROSURGICAL UNIT (ESU) SAFETY

POLICY

All personnel will follow safety guidelines in order to reduce the potential for injury to the patients, surgeons and employees who use cautery equipment. Also Refer to Nursing Manual Policy and Procedure No. 86

PROCEDURE

1. Peri-operative personnel will be instructed in the proper operation, care and handling of the ESU during their orientation period. Return demonstration after instruction must be documented for the peri-operative employee.
2. The ESU must be inspected before each use and checked and certified for its functionality/safety once every six (6) months by the Biomedical Consultant.
3. Damaged or malfunctioning ESUs must be removed immediately and reported to the Executive Facility.
4. The identification/serial number of the ESU is to be documented on the O.R. record.
5. To prevent injury, patients will be instructed to remove all jewellery before their surgical procedure.
6. The grounding pad is not needed for a bipolar unit.
7. If used, the grounding pad must:
   a. Be the appropriate size for an infant, child or adult.
   b. Be placed on a clean, dry skin surface over a large muscle mass.
   c. Be placed as close to the surgical area as possible.
   d. Must not be placed over bony prominences, scar tissue, hairy surfaces, pressure points or skin over an implanted metal prosthesis.
8. Skin integrity must be inspected and documented before and after ESU use.
9. Patients with a pacemaker must have continuous ECG monitoring during ESU use.
10. Patients with an automatic implanted cardioverter defibrillator (AICD) must have the device de-activated before their surgical procedure when an ESU is used.

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PRIME SURGICAL CENTERS

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NURSING MANUAL II

GUIDELINE FOR SURGICAL AND MEDICAL EMERGENCIES		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses / Technicians**	**Policy/Procedure No: 4** **Page: 1 of 32**
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GUIDELINE FOR SURGICAL AND MEDICAL EMERGENCIES

The guidelines are intended as a guide to assist Resident Medical Officers (RMO) and all Nurses and technicians to manage and initiate treatment of serious conditions. There may be more than one approach to each of these problems; however, this guideline describes safe methods for handling these serious and stressful situations.

1. ACUTE AIRWAY OBSTRUCTION

Immediate management

Attend patient and make rapid assessment.

If patient unconscious/severe respiratory distress/respiratory arrest

1. Tell nursing staff to call Code Blue then move to head end of bed.
2. Perform triple manoeuvre – chin lift, jaw thrust, head tilt.
3. Clear mouth – suction secretions, sweep out foreign body from pharynx.

If it is an acute obstruction and the above fail, then definitive airway is required.

If mechanically obstructed

Surgical airway

1. Cricothyroidotomy
2. Tracheostomy

If acute neck haematoma

Open neck wound down to and including the deep fascial sutures.

If still obstructed and trachea on view attempt to incise and insert endotracheal tube.

If not mechanical

Bag and mask patient with oxygen using Guedel airway.

These manoeuvres can maintain an airway until help arrives.

Once more experienced staff is available the patient requires intubation and insertion of an endotracheal tube.

If unable to intubate, can try to insert laryngeal mask but if this does not secure airway:

Surgical airway

1. Cricothyroidotomy
2. Tracheostomy

GUIDELINE FOR SURGICAL AND MEDICAL EMERGENCIES		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses / Technicians**	**Policy/Procedure No: 4** **Page: 2 of 32**
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Clinical History

1. Basic information about patient
2. Events resulting in obstruction
3. Recent drug administration/operation

Points for consideration - Call for help early

1. An airway is required by any means possible
2. Choice depends on the cause as illustrated in ‘immediate intern management’
3. Suction and simple airway manoeuvres may be enough to establish an airway especially in a patient with secretions or a tracheostomy
4. Ideally intubation and advanced airway management should be performed by highly experienced staff
5. If simple airway measures are unsuccessful then a definitive airway is required
6. Intubation can be attempted but in mechanical obstruction is unlikely to be successful
7. A surgical airway is definitive
8. First line is cricothyroidotomy
9. A tracheostomy may be performed if there is sufficient time and adequate staff is readily available
10. Don’t confuse stridor (fixed airway noise on inspiration) with wheeze (fixed airway noise on expiration)

2. ACUTE ANAPHYLAXIS

Immediate management

Attend patient and make rapid assessment.

Patient unconscious

1. Tell nursing staff to call Code Blue then move to head end of bed.
2. Perform triple manoeuvre – chin lift, jaw thrust, head tilt.
3. Bag and mask patient with oxygen. (Be careful with instrumenting an airway in anaphylaxis – can make it worse. Secure airway with bag and mask.)
4. When help arrives obtain IV access, send off blood tests.
5. Give IV adrenaline one ampoule and 500 ml Gelofusine stat.

Patient conscious

1. Tell nursing staff to call code MET.
   Then:
2. Give oxygen by mask.
3. Get crash trolley, obtain IV access and send off blood tests (FBE, U&E, LFT, CRP).

Patient normotensive

1. Give 300 micrograms adrenaline S/C or IM.
2. Give 500 ml Gelofusine stat.

Help should arrive by now.

Patient hypotensive

Give IV adrenaline 50 micrograms bolus and repeat every two to three minutes.

If the patient has known anaphylaxis, an Epi-Pen (subcutaneous adrenaline pen) may be available for use in an emergency.

Clinical History

1. Rapid onset inability to breathe
2. Collapse
3. Known allergy/allergies
4. Recent administration (drug, tape, procedure)
5. Family history
6. Asthmatic

GUIDELINE FOR SURGICAL AND MEDICAL EMERGENCIES		
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Suspect the diagnosis when there are two or more of:

1. Itch, urticaria
2. Angio-oedema
3. Upper airway swelling
4. Wheeze
5. Hypotension

Management

Airway

1. Patient may require intubation if progressing to angio-oedema and respiratory arrest; however, this may be very difficult due to oedema and laryngeal spasm (the anaesthetists and surgeons can address this)
2. In this setting 5 mg nebulised adrenaline may be helpful
3. If intubation impossible and patient in extremis, surgical airway may be required. Hopefully early definitive management can prevent deterioration to the point of requiring intubation

Breathing

Oxygen by mask

Circulation

1. IV access and fluid resuscitation
2. IV adrenaline one ampoule as required to stabilize cardiovascular system

Other

1. Transfer patient to ICU for observation and further management
2. If intubated, leave ventilated until spasm and oedema settles
3. Consider using IV steroids (hydrocortisone) to settle inflammation
4. Identify underlying cause and ensure allergy clearly documented
5. Consider allergy testing and referral to immunologist
6. Provide patient education and appropriate documentation
7. Consider organizing Epi-Pen (subcutaneous adrenaline pen)

GUIDELINE FOR SURGICAL AND MEDICAL EMERGENCIES		
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3. ACUTE EXTERNAL HAEMORRHAGE – VASCULAR SURGERY, PENETRATING TRAUMA

Immediate management

Attend patient and make rapid assessment.

If large volume haemorrhage, call MET code.

Airway

Secure.

Breathing

1. Give oxygen by mask.
2. Ensure no pneumothorax (if penetrating trauma).
3. If pneumothorax present, patient needs urgent chest tube (call code MET while organising chest tube setup).

Circulation

1. Elevate bleeding site.
2. Put pressure focally over site of bleeding.
3. Obtain IV access (X–Match lost blood volume + extra two units), (FBE, U&E, LFT, INR).
4. Fluid resuscitate – 500 ml Gelofusine stat, followed by N. Saline 1 L stat.
5. Reverse reversible clotting abnormality.

Assessment

Clinical history.

Other

1. Call surgical registrar and unit registrar.
2. Nil orally.
3. Notify ICU about patient.

Clinical History

1. Reason for bleeding
   a. Trauma/stabbing
   b. Post-surgery (nature of surgery)
2. Site and estimate of blood loss
3. Penetrating trauma – site/implement/direction/force
4. General symptoms related to possible organs injured

5. History of reversible clotting abnormality (for example, Warfarin therapy or other blood thinning agents)

Management

Airway/breathing

Circulation

1. Pressure over bleeding point
   Bandage (+/- pressure dressing)
2. IV access and resuscitation
   a. Gelofusine
   b. Crystalloid
   c. Blood
3. X-Match and book theatre

Assessment of injury, mechanism and possible injuries

Surgical exploration

1. Tourniquet for limb bleeding
2. Extend wounds and assess injured/devitalised structures
3. Proximal and distal control for bleeding major vessels
4. Conservative debridement devitalised tissues
5. Second look and exploration 24–48 hours
6. Reconstruction
   a. Primary
   b. Secondary

Other

1. Rehabilitation
2. Counselling for trauma

Techniques for resuscitation

1. Multiple large bore IV cannulas (>16 G)
2. Increase height of IV pole
3. Infusion pumps/Imed pumps
4. Rapid volume infuser
5. Use crystalloid, colloid or blood once available (especially after 1.5 L of fluid resuscitation)

*For large volume resuscitation, consider warming fluids

GUIDELINE FOR SURGICAL AND MEDICAL EMERGENCIES		
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4. AIR EMBOLISM – CENTRAL LINE DISRUPTION

Immediate management

Attend patient and make rapid assessment.

If patient unconscious/severe respiratory distress/arrest

1. Tell nursing staff to call Code Blue then move to head end of bed.
2. Triple manoeuvre – chin lift, jaw thrust, head tilt.
3. Bag and mask patient with oxygen.
4. Start CPR if arrested.

Patient conscious/mild distress

1. Stop central line infusion/clamp line.
2. Give 100% oxygen by mask and place patient in trendelenburg position (head down).
3. If patient increasingly distressed:
    a. Rotate to left hand side with right side facing upwards (left lateral position). (Traps air at apex of ventricle).
    b. Ask nursing staff to call MET code.
4. Get crash trolley, obtain IV access and send off blood tests.
5. Notify unit registrar, ICU registrar and anaesthetist on call.

Clinical History

1. Incident following Central Venous Catheter (CVC) line manipulation
2. Chest pain
3. Shortness of Breath (SOB)
4. Palpitations
5. Neurosensory symptoms
6. Events preceding related to CVC line
7. Reason for CVC line
8. Cause for hospitalisation

Management

Immediate cardiorespiratory support and resuscitation

1. Check CVC line while CVC clamped:
    a. Moved/dislodged
    b. Attempt to aspirate air through CVC (never inject)

(The catheter may have to be advanced to achieve this. Catheter advancement should only be performed in a monitored environment and using sterile technique)

2. In cardiovascular collapse:
   a. External cardiac compression may expel air from the pulmonary outflow tract into the pulmonary circulation re-establishing pulmonary flow.
   b. Support the right heart with IV fluids and beta-adrenergic agents.
3. Admit patient to ICU
4. Consider hyperbaric oxygen therapy (liaise with appropriate facility)

Remember there are more common causes for acute Shortness of Breath (SOB) in a patient with a central line: for example, pneumothorax, pulmonary embolus, acute pulmonary oedema, sputum retention and anaphylaxis. Initial assessment should be aimed at ruling out these other causes and then, if they are not present, considering the possibility of air embolus.

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5. ASPIRATION

Immediate management

Attend patient and make rapid assessment.

If patient unconscious/severe respiratory distress/respiratory arrest

1. Tell nursing staff to call Code Blue then move to head end of bed.
2. Perform triple manoeuvre – chin lift, jaw thrust, head tilt.
3. Clear mouth – suction secretions, vomitus.
4. Insert Guedel airway/nasopharyngeal airway and administer oxygen.
5. Bag and mask patient until help arrives.
6. Intubate and insert cuffed Endotracheal Tube (ETT).

If patient conscious

1. Clear airway of secretions with suction or by turning patient on their side.
2. Perform basic airway manoeuvres to assist patient in obtaining a clear airway.
3. Administer oxygen by mask to maintain oxygen saturations.
4. Perform continuous pulse oximetry.
5. Carry out rapid clinical assessment.
6. Insert IV line and take set routine blood tests, including ABGs.
7. Inform unit registrar of events.

Other options to be considered

1. Insert nasopharyngeal airway.
2. Attempt to suction lungs.
3. Endotracheal intubation/flexible bronchoscopy.
4. Direct tracheal suction.

Clinical History

1. Basic information about patient – reason for admission, medical problems
2. Events surrounding incident
   a. Sudden shortness of breath (SOB)/cough
   b. Vomiting
3. Recent drug administration/operation

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Management

1. Consider ICU admission if high oxygen demands or if unstable
2. IV antibiotics
   a. Ceftriaxone and metronidazole
   b. Imipenem and vancomycin
3. NGT if has bowel obstruction
4. Respiratory support

   Bi-Level Positive Air Pressure (BiPAP), Continuous Positive Air Pressure (CPAP), intubation and ventilation

In setting of ARDS:

There is a role for steroids – IV hydrocortisone (would be decided in conjunction with ICU and medical staff)

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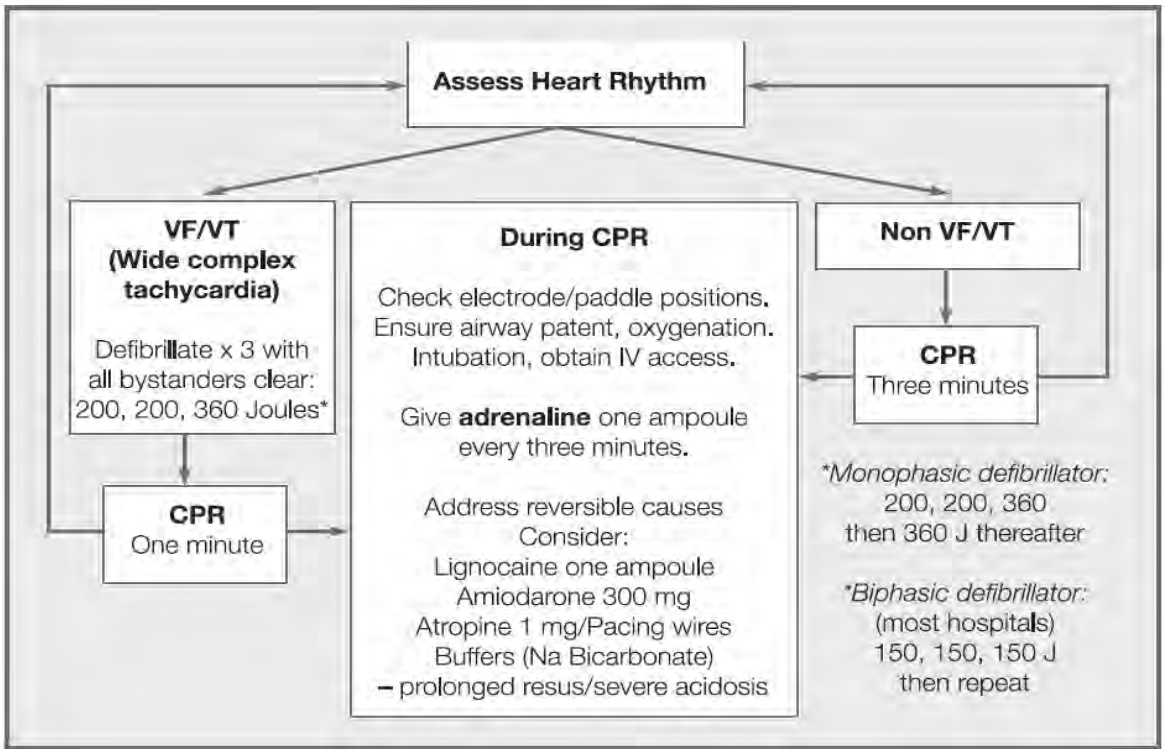
6. CARDIAC ARREST

Immediate management

1. Attend patient and make rapid assessment.
2. Tell nursing staff to call Code Blue then move to head end of bed after removing headboard.
3. Perform triple manoeuvre – chin lift, jaw thrust, head tilt.
4. Clear mouth – suction secretions, vomitus using Yanker Sucker.
5. Insert Guedel airway/nasopharyngeal airway and administer oxygen via bag and mask (found in crash trolley).
6. Check for pulse – if absent begin cardiopulmonary resuscitation.
   (Single operator [two breaths for every 15 compressions]; two or more operators [one breath for every five compressions])
7. Simultaneously place contact paddles on patient from defibrillator and cardiac monitor.



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7. METABOLIC DISTURBANCES – HYPOCALCAEMIA, HYPOGLYCAEMIA, HYPERGLYCAEMIA

A. Hypocalcaemia

Immediate management

Suspect diagnosis.

1. Obtain IV access and basic blood tests (including serum calcium).
2. Administer 20 ml of 10% calcium gluconate.
3. May need to administer magnesium together with calcium.
4. Recheck serum calcium levels in four hours or if symptoms return.

Clinical History

1. Recent neck surgery, below causes
2. Tingling around hands, feet, mouth

Investigations

1. Check renal function
2. PTH level
3. Amylase +/- Ranson's criteria if in setting of pancreatitis, notify surgical registrar as could be a sign of worsening pancreatitis

Management

1. Notify appropriate medical staff (registrar)
2. Consider ICU review if pancreatitis
3. Medical referral if in setting of renal failure or non-surgical cause

B. Hypoglycaemia

Immediate management

If conscious

1. Check BSL – finger prick.
2. If alert and not fasting, administer oral glucose solution and Lucozade.

If unconscious

1. Airway/breathing/circulation (ABC).
2. Check BSL – finger prick.
3. Obtain IV access and send off basic blood tests.
4. Administer 25 g of 50% Dextrose. Patient should wake up on end of needle.

5. Consider continuing with 10 per cent Dextrose infusion.

Check BSLs frequently (30 minutely, then hourly if stabilising).

Clinical History

1. Diabetic, insulinoma
2. Recent change to insulin regimen
3. Fasting
4. Anxiety, tremor
5. Palpitations
6. Fatigue

Management

1. Endocrine referral
2. Check HbA1c
3. Organise diabetic educator
4. Liaise with anaesthetist if fasting for surgery

C. Hyperglycaemia

Hyperglycaemia can be divided into:

Diabetic ketoacidosis (DKA)

Hyperosmolar non-ketotic-coma (HONKC)

Diabetic ketoacidosis (DKA)

1. Occurs in Type I diabetes mellitus
2. Results in insulin deficiency with absolute or relative increase in glucagon

Immediate management – DKA

If conscious:

1. Check BSL – finger prick.
2. Obtain IV access and send off basic blood tests (U&E, glucose, ketones, FBE).
3. ABG
   a. Metabolic acidosis
   b. Anion gap (HCO_3^- <10 mmol/L).
4. Dipstick urine
   Ketonuria.

5. IV fluids
   a. 1 L N saline over 30 minutes
   b. 1 L N. saline over one hour
   c. Then reassess fluid status.
6. Strict fluid balance chart
   +/- IDC (catheter) to monitor urine output.

Once the diagnosis of DKA has been established, seek advice from senior medical staff, including endocrinology team.

7. Start insulin infusion
   (Actrapid – short acting)
   100 units Insulin in 100 mls N. Saline (one unit = 1 ml).
   Infusion protocol

Blood Sugar Level (BSL)	
<7.0	Cease infusion and recheck BSL in one hour
7.1–9.0	1 ml/hour
9.1–11.0	2 ml/hour
11.1–13.0	3 ml/hour
13.1–15.0	4 ml/hour
15.1–17.0	5 ml/hour
17.1–20.0	6 ml/hour
>20.1	Call help

8. Once BSL <15.0 start 5% dextrose IV at 10/24 rate.
9. Potassium replacement.

Potassium	
K<4.5	30 mmol into IV fluid

10. Repeat Urea and Electrolyte or venous gases to assess potassium.
    Further replacement may be needed.

If unconscious:

1. Do above plus ABC.
2. Notify ICU.
3. Management may include bicarbonate replacement in ICU for severe acidosis.

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Clinical History – DKA

1. Diabetic, past history, recent stress
2. Compliance, last insulin dose
3. Polyuria, polydipsia, LOW
4. Nausea, vomiting
5. Blurred vision, cramps
6. Abdominal pain

Management

1. Cease insulin infusion when:
   a. pH normal
   b. BSL normal, <7.0
   c. Normal bicarbonate
   d. Conscious and able to resume normal diet and insulin
   (Ketones may still be present in urine for 48 hours)
2. Find precipitating factors
3. Diabetic education
4. Refer to appropriate medical staff – endocrinology unit

Hyperosmolar non-ketotic-coma (HONKC)

1. Occurs in elderly Type II diabetics
2. Causes sustained osmotic diuresis causing profound dehydration when patients are unable to drink sufficient water to replace urinary losses

Immediate management – HONKC

If conscious:

1. Check BSL – finger prick.
2. Obtain IV access and send off basic blood tests (Urea and Electrolyte, glucose, FBE).
3. IV fluids need to be administered with care due to age and concurrent cardiac illness.
   Aim for 2–3 L's in first two hours if able to tolerate volume.
   Inform medical team and ICU early because patient may need invasive monitoring.
4. Strict fl uid balance chart +/- IDC (catheter) to monitor urine output.
5. Start insulin infusion
   (Actrapid – short acting)
   100 units Insulin in 100 mls N. Saline (one unit = 1 ml).

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If unconscious:

1. Do above plus ABC.
2. Notify ICU.

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8. POST-OPERATIVE NECK HAEMORRHAGE FROM THYROID/CAROTID/EAR NOSE THROAT SURGERY

Immediate management

Attend patient and make rapid assessment.

If patient unconscious/severe respiratory distress/STRIDOR/respiratory arrest

1. Tell nursing staff to call Code Blue then move to head end of bed.
2. Perform triple manoeuvre – chin lift, jaw thrust, head tilt.
3. Clear mouth – suction secretions.

   If the airway is compromised then the priority is the establishment of a patent airway by either intubation or creation of a surgical airway. Control of haemorrhage is a secondary priority once an airway is established.

   As a matter of urgency, in the ward, cut the sutures from the wound down to and including the deeper fascial sutures.

   Scoop out any blood clot.

   This should release the pressure against the trachea and relieve the upper respiratory tract obstruction.

   If still obstructed and trachea on view, attempt to incise and insert endotracheal tube.

Neck haemorrhage without airway obstruction

1. Call Code Blue.
2. Assess airway.
3. Assess breathing.

   If stable, put direct pressure over the bleeding point.

   This may compromise the patient's airway. If this occurs the patient needs intubation or a surgical airway to allow control of the bleeding.
4. Give oxygen by mask and sit patient up.
5. Transfer to theatre for control of haemorrhage and resuture of wound.

Clinical History

1. Basic information about patient
   a. Nature of past surgery
   b. History of event
2. Neck swelling or pain
3. Shortness of Breath (SOB)

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Management

1. Patient should be urgently transferred to theatre
2. Intubate patient to achieve patent airway
3. Explore or re-explore wound
4. Identify and ligate bleeding points
5. Need for drain tube

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9. PULMONARY EMBOLUS

Immediate management

Attend patient and make rapid assessment.

If patient unconscious/arrested or in severe respiratory distress

1. Tell nursing staff to call Code Blue then move to head end of bed.
2. Perform triple manoeuvre – chin lift, jaw thrust, head tilt.
3. Clear mouth – suction secretions.
4. Insert Guedel airway and bag and mask.
5. Check pulse and if arrested start CPR.

If patient conscious

1. Administer oxygen by mask to maintain oxygen saturations.
2. Perform continuous pulse oximetry.
3. Obtain IV access and send off basic blood tests.
4. ABG.
5. Organise urgent Chest X-ray (CXR).
6. Liaise with senior medical staff – unit registrar and/or medical registrar.

Clinical History

1. Basic information about patient
2. Shortness of Breath (SOB)
3. Pleuritic chest pain
4. Haemoptysis

Management

1. Definitive investigations to confirm diagnosis
2. Anticoagulation. Choices are:
    a. Heparin infusion
    b. Therapeutic dose Clexane
3. If massive pulmonary embolism (PE) with signs of right heart strain, consider:
    a. Thrombolytics to dissolve clot
    b. Urgent sternotomy, cardiopulmonary bypass and surgical embolectomy

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10. PULMONARY OEDEMA

Immediate management

Attend patient and make rapid assessment.

If patient unconscious/arrest

1. Tell nursing staff to call Code Blue then move to head end of bed.
2. Perform triple manoeuvre – chin lift, jaw thrust, head tilt.
3. Clear mouth – suction secretions.
4. Insert Guedel airway and bag and mask.
5. Check pulse and if arrested start CPR.

If patient conscious/pre-arrest

1. Call Code Blue.
2. Oxygen by mask, continuous pulse oximetry.
3. Sit patient up.
4. Obtain IV trolley and insert IV line while taking blood.
5. Give IV morphine 5 mg.
6. Give IV frusemide 40 mg (if patient on regular dose of frusemide then double it; if frusemide naive you can give 20 mg).
7. ECG – look for any ECG changes of ischaemia.
8. Notify senior medical staff if not present already (medical registrar/ICU registrar).
9. Consider non-invasive ventilation (Continuous Positive Air Pressure - CPAP).

Clinical History

1. Basic information about patient
2. Shortness of breath (SOB)
3. Shortness of Breath on Exertion (SOBOE)
4. Chest pain
5. Symptoms of Congestive Cardiac Failure - CCF [Paroxysmal nocturnal dyspnoea (PND), swelling of ankles (SOA), orthopnoea]
6. History of Ischaemic heart disease (IHD), past Acute myocardial infarction (AMI)
7. Fluid balance

Management – Depends on cause

1. Above management plus further morphine/frusemide as required to produce a diuresis
2. Nitrates [50 mg – 25 mg GTN (glyceryl trinitrate) patch]

As long as no history of aortic stenosis, and patient has good BP >110 systolic

3. Maintain oxygen delivery by maintaining oxygen saturations:
   a. By mask
   b. Non-invasive ventilation [Continuous positive airway pressure (CPAP)]
   c. Intubation and ventilation
4. If patient fails to make a prompt response then should be transferred to ICU for invasive monitoring:
   a. Central venous line
   b. Arterial line
5. Insert indwelling catheter for accurate measurement of fluid balance
6. Commence fluid balance chart +/- daily patient weights
7. Identify and treat underlying cause

11. TENSION PNEUMOTHORAX

Immediate management

Attend patient and make rapid assessment.

If patient unconscious/arrest

1. Tell nursing staff to call Code Blue then move to end of bed.
2. Perform triple manoeuvre – chin lift, jaw thrust, head tilt.
3. Clear mouth – suction secretions.
4. Insert Guedel airway and bag and mask.
5. Check pulse and if arrested start CPR.

If conscious/severe respiratory distress/help arrives

Assess patient – oxygen saturations, PR, BP

1. Tracheal deviation
2. Reduced chest movement
3. Hyper-resonance to percussion
4. Decreased breath sounds

} Tension Pneumothorax

Tension pneumothorax (TP)

1. Call Code Blue.
2. Needle pleurocentesis
   Insert wide bore IV needle into second intercostal (IC) space in mid-clavicular line.
   The tension will be relieved instantly but the patient needs an urgent chest tube.
3. Oxygen by mask.
4. Notify surgical registrar/ICU registrar urgently regarding need for chest tube.
5. Organise chest tube and chest tube tray as a matter of priority with nursing/medical staff (but do not leave patient unless help has arrived).
6. If patient deteriorates again (saturations begin to fall) then insert second IV needle into second intercostal (IC) space.
7. Insert chest tube and place on 10 cm continuous underwater suction.
8. Obtain post insertion Chest X-ray (CXR).

Clinical History

1. Basic information about patient
2. Sudden onset sharp pleuritic chest pain with shortness of breath (SOB)

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Management

1. Insertion of a chest tube as described above
2. Continued air leak through pneumothorax may require thoracoscopy/thoracotomy

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12. ACUTE BOWEL OBSTRUCTION

Immediate management

Targeted history and examination

1. Obtain IV access and commence IV fluid resuscitation.
   Aim to replace estimated fluid lost and maintenance fluids.
2. Basic set bloods - Full Blood Examination (FBE), Urea and Electrolytes (U&E), International Normalized Ratio (INR).
3. Nil orally.
4. Anti-emetics (Maxalon 10–20 mg IV QID / Ondansetron 2–4 mg IV bid).
5. Basic definitive investigations – plain X-rays.
6. Insert nasogastric tube (NGT) if patient vomiting (place on free drainage and four-hourly aspirations).
7. Contact surgical registrar and unit registrar.

Clinical History

1. General patient features
2. Colicky central abdominal pain
3. Abdominal distension
4. Absolute constipation (flatus and faeces)
5. Vomiting
6. PHx abdominal surgery

Management

Small-bowel obstruction (SBO)

Initial treatment – trial conservative management

1. Nasogastric Tube (NGT)
2. IV fluid therapy
3. Nil orally

If NGT drainage becomes faeculent or ongoing obstruction:

1. Surgical exploration and repair

Note: An SBO in the setting of a hernia is a surgical emergency requiring urgent operative repair.

Large-bowel obstruction (LBO)

'Never let the sun set twice on an acute large bowel obstruction.'

1. IV fluid therapy
2. Nil orally
3. First line imaging

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The key to management of LBO is to establish a likely diagnosis and then decompress the large bowel

4. Second line imaging
5. Surgical decompression and bowel resection
6. Rigid sigmoidoscopic decompression (if sigmoid volvulus)
7. Limited period of observation if suspecting pseudo-obstruction

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13. ACUTE GASTRIC DISTENSION

Immediate management

Targeted history and examination and suspect diagnosis.

1. Nil orally.
2. Obtain IV access and commence IV fluids.
3. Administer anti-emetic medication:
   Maxalon 20 mg IV
   Ondansetron 2–4 mg IV.
4. Simple investigations if diagnosis unclear.
5. Insert NGT
   (Place on free drainage and four-hourly aspirations).
6. Contact surgical registrar and unit registrar.

Clinical History

1. General patient features
2. Nausea
3. Colicky upper abdominal pain
4. Abdominal distension
5. Past History
   a. Recent surgery
   b. Head injury
   c. Last meal
6. Vomiting (late symptom)

Management

Identify risk factors and correct reversible factors

NGT insertion is definitive and allows decompression of the stomach; it also reduces the risks of aspiration from acute gastric distension

Prevention

1. NGT insertion for treatment of SBO
2. Critical review of medication charts by parent units
3. Suspicion in cases of head injury or altered conscious state
4. Correct metabolic abnormalities
5. Cautious resumption of oral intake post general anaesthetic and abdominal operations
6. Ensure adequate period of fasting prior to general anaesthetic

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14. ACUTE MENTAL CONFUSION AND/OR EPILEPSY

Immediate management

Epilepsy

1. Clear environment from around patient to prevent injury.
2. If possible, patient can be placed in left lateral position.
   (Do not force patient into this position if the fi t will not allow).
3. Suction any vomitus from airway.
4. Ask nursing staff to get help of other medical staff/call Medical Emergency Team.
5. Give oxygen by mask.
6. Obtain IV access with nursing assistance, send off basic blood tests and measure bedside blood sugar level.
   If hypoglycaemic:
   a. Administer 50 ml 50% Dextrose IV.
   b. Continue until patient stops fitting and able to eat.
   c. Give oral glucose.
7. Administer:
   Diazepam 5 mg IV (rectal route can be used if delay in obtaining IV access).
8. If seizure continues, administer further dose:
   Diazepam 5 mg IV.
9. If seizure continues, call Medical Emergency Team and administer clonazepam 1 mg IV until fitting stops.
10. Load with antiepileptic – phenytoin 300 mg loading dose, followed by further dose 300 mg six hours later.

Delirium

1. Nurse patient in moderately lit, quiet environment with close supervision.
2. Investigate and treat underlying cause.
3. Rationalise medications.
4. Haloperidol 0.5 mg IM/IV can be used for agitation in these patients.

Clinical History – Delirium

1. Consciousness
   a. Fluctuates throughout the day
   b. Typically worse in late afternoon/night
   c. Impaired over hours to days
2. Disorientation

3. Behaviour disturbance
   a. Inactivity/quiet
   b. Hyperactivity/agitation
4. Thinking
   Slow and muddled
5. Perception
   Disturbed with delusional features
6. Mood disturbance
7. Memory impairment

Clinical History – Epilepsy

1. Seizure
2. Head trauma
3. Headache, vomiting, fever

Management

Delirium

1. Appropriate investigations
2. Treatment of the underlying cause
3. Observation over several days
4. Most deliriums will resolve with time

Epilepsy

1. Specialist referral for further investigation
2. May require commencement of antiepileptic medications (for example, phenytoin) or adjustment to current medications
3. Assess compliance in long term epileptics or recent medication changes for drug interactions
4. Consider MRI/lumbar puncture
5. Give advice about driving and operating heavy machinery

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15. ACUTE SPINAL COMPRESSION

Immediate management

Suspect the diagnosis. Any patient complaining of upper or lower limb neurological symptoms needs to have acute spinal cord compression ruled out.

Thorough history and examination, including full neurological examination

1. Obtain IV access and commence gentle IV fluids.
2. Send off basic blood tests.
3. Analgesia for back pain.
4. Strict rest in bed and spinal precautions.
5. Notify unit registrar and surgical registrar and discuss findings.
6. Organise urgent MRI (CT) scan.

Clinical History

1. Back pain
2. Neurological symptoms
   a. Weakness arms, legs
   b. Numbness arms/buttocks/legs
3. Bladder and bowel dysfunction
   a. Incontinence
   b. Urinary retention
4. Trauma
5. Known cancer/myeloma
6. Recent spinal/epidural

Management

Urgent neurosurgical evaluation is required

1. Urgent spinal decompression – laminectomy
2. Resection of tumour or disc prolapse
3. Corticosteroids (dexamethasone) have an urgent role in limiting cord oedema (use following discussion with neurosurgery)

Other considerations

1. Consider radiotherapy for known metastasis to the spine
2. Treatment of myeloma/TB

3. Pressure care if sensory disturbance
4. Indwelling catheter (IDC) for urinary retention
5. Specimen cultures if evidence fever/sepsis
6. Cauda equine syndrome will give Lower motor neurone (LMN) signs in the lower limbs

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16. SHOCK

Immediate management

Attend patient and make rapid assessment.

Airway

Secure.

Breathing

Oxygen by mask.

Circulation (PR, BP, periphery – warm/cool)

1. Put pressure focally over site of bleeding.
2. Elevate the foot of the bed.
3. Stop any epidural infusions.
4. Obtain IV access [X-Match lost blood volume + extra two units, Full Blood Examination (FBE), Urea and Electrolytes (U&E), International Normalized Ratio (INR), Liver function tests (LFT)].
5. Fluid resuscitation – 500 ml Gelofusine stat, followed by N. Saline 1 L stat.

Assessment

1. Clinical history.
2. Underlying cause of shock.

Reassessment

1. BP, PR, periphery, consciousness.
2. Responding to treatment.
3. Call surgical consultant.
4. Nil orally.
5. Notify ICU about patient.

Clinical History

1. Disorientation
2. Dizziness
3. Cold
4. History of trauma
5. Obvious blood loss (quantify)

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Management

Depends on the cause.

Hypovolaemia

1. IV fluids therapy
2. Blood if blood loss
3. Correct cause of hypovolaemia

Sepsis

1. IV fluid therapy
2. Cultures – blood, urine, sputum
3. Commence broad spectrum antibiotics
4. Identify cause of sepsis

Neurogenic

1. IV fluid therapy
2. Neurological assessment and investigation
3. Specialist referral
4. Maintain circulating volume

Iatrogenic

1. Cease epidural/drugs
2. IV fluid therapy
3. Correct and treat underlying cause

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

HAND CLEANSING AND HAND HYGIENE		
Policy/Procedure Applies To	**All Nurses/Technicians/Surgeons/Physician/ Anaesthesiologist/ Housekeeping Staff/ Nursing Aides**	**Policy/Procedure No: 4** **Page: 1 of 8**
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HAND CLEANSING AND HAND HYGIENE

PURPOSE

To provide appropriate guidelines for hand cleansing, the first line of defense against infection, and a primary method of preventing cross-contamination of infectious diseases.

To reduce the number of organisms on the skin and to prevent the spread of infections through direct patient contact.

SCOPE

All staff in patient-care activities.

POLICY

Frequent hand hygiene and hand cleansing will be conducted as critical element in the infection control and prevention program.

All Prime Surgical Center staff involved in patient care shall perform proper hand hygiene to prevent the spread of infectious diseases. (Wearing gloves shall not be a substitute for proper hand hygiene.)

HANDWASHING INDICATIONS

With the exception of urgent situations in which hand washing cannot be done, personnel should always wash their hands:

1. When coming on duty
2. Between all patient contacts
3. Before performing invasive procedures
4. After removing gloves
5. Before medication preparation
6. After touching inanimate objects that are likely to be contaminated with pathogenic micro-organisms, such as urine-measuring devices and secretion collection apparatuses
7. Before eating
8. After personal use of the toilet
9. When hands are soiled, including after sneezing, coughing or blowing your nose
10. Before and after touching wounds

HAND CLEANSING AND HAND HYGIENE		
Policy/Procedure Applies To	**All Nurses/Technicians/Surgeons/Physician/ Anaesthesiologist/ Housekeeping Staff/ Nursing Aides**	**Policy/Procedure No: 4** **Page: 2 of 8**
Effective Date: 11 April, 2013		

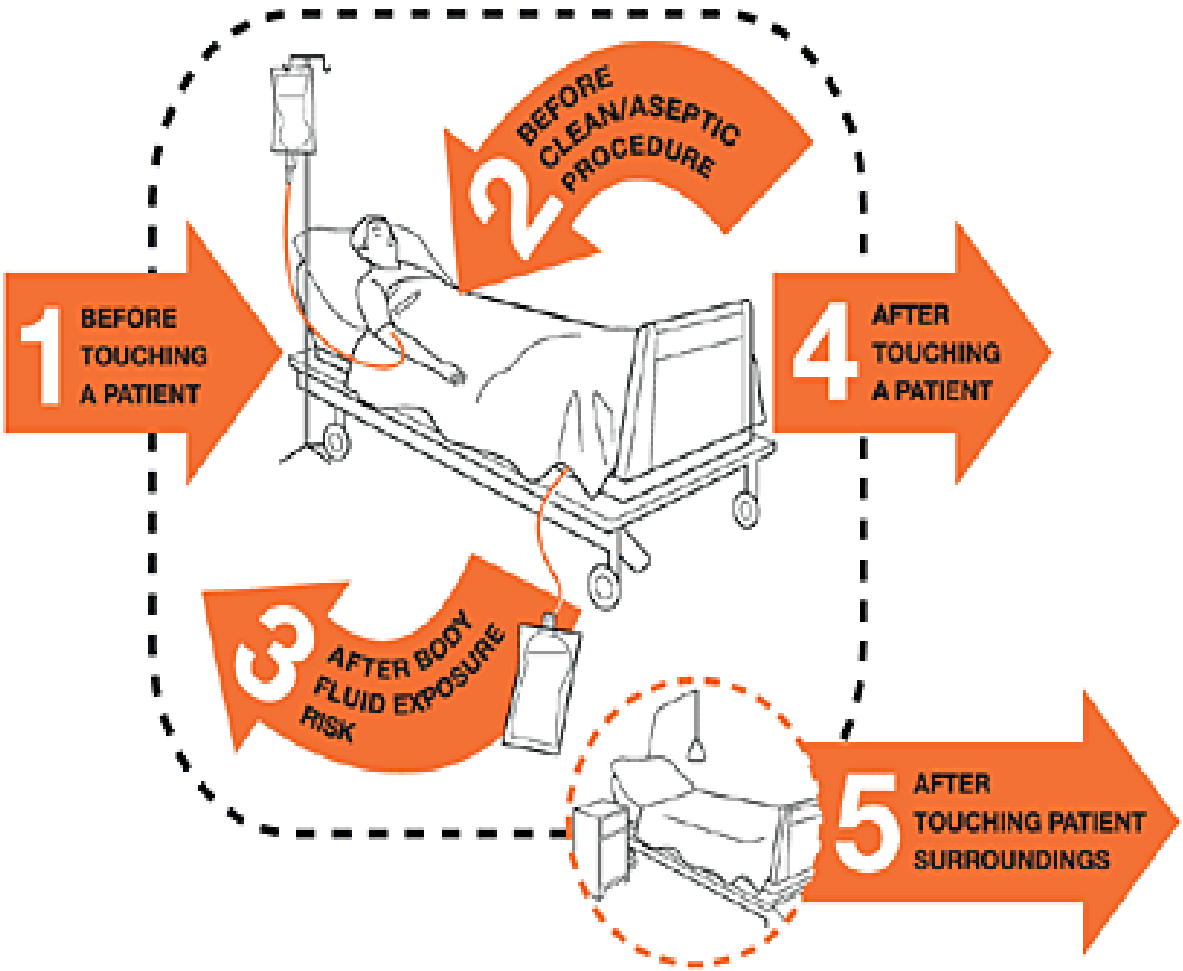
PROCEDURE

1. Wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water before and after any procedures.
2. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands. Decontaminate hands before having direct contact with patients
3. Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter.
4. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure.
5. Decontaminate hands after contact with a Individual's intact skin (e.g., when taking a pulse or blood pressure, and lifting a Individual).
6. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled.
7. Decontaminate hands if moving from a contaminated-body site to a clean-body site during Individual care.
8. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the Individual.
9. Decontaminate hands after removing gloves.
10. Wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water before eating and after using a restroom.

HAND CLEANSING AND HAND HYGIENE		
Policy/Procedure Applies To	**All Nurses/Technicians/Surgeons/Physician/ Anaesthesiologist/ Housekeeping Staff/ Nursing Aides**	**Policy/Procedure No: 4** **Page: 3 of 8**
Effective Date: 11 April, 2013		

HAND WASHING

Hand hygiene is a single most important factor for infection control. Wash hands before and after patient contact and use of toilets. Follow “Standard Precautions” in Prime Surgical Centers.



HAND CLEANSING AND HAND HYGIENE		
Policy/Procedure Applies To	**All Nurses/Technicians/Surgeons/Physician/ Anaesthesiologist/ Housekeeping Staff/ Nursing Aides**	**Policy/Procedure No: 4** **Page: 4 of 8**
Effective Date: 11 April, 2013		

PROCEDURE

1. Hand-Cleansing Technique (Soap and Water)

ACTION	RATIONAL
1. Turn on faucet; adjust temperature of water and rinse hands.	Rinsing dilutes contaminating organisms.
2. Apply soap from soap dispenser and lather hands and wrists, using friction for at least 15 seconds. Clean under nails and between fingers	Friction helps dislodge bacteria and soil. Spend one-half to one minute on each hand, depending on degree of contamination.
3. Rinse under running water holding hands in a downward position. Dry with hand dryers / tissue papers.	Use as needed to dry hands
4. Turn off water faucet with a clean dry pa-per towel.	Faucets are contaminated.

HAND CLEANSING AND HAND HYGIENE		
Policy/Procedure Applies To	**All Nurses/Technicians/Surgeons/Physician/ Anaesthesiologist/ Housekeeping Staff/ Nursing Aides**	**Policy/Procedure No: 4** **Page: 5 of 8**
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Hand Hygiene Technique with soap and water: Duration of the entire procedure 40-60 seconds

HAND CLEANSING AND HAND HYGIENE		
Policy/Procedure Applies To	**All Nurses/Technicians/Surgeons/Physician/ Anaesthesiologist/ Housekeeping Staff/ Nursing Aides**	**Policy/Procedure No: 4** **Page: 6 of 8**
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2. Hand-Antisepsis Technique (Alcohol-Based Hand Rub)

ACTION	RATIONAL
1. Apply product to palm of one hand.	Follow manufacturer guidelines regarding the amount of product to use
2. Rub hands together, covering all surfaces of hands and fingers until hands are dry. (approximately 15-25 seconds)	

Alcohol-based Formula: Duration of the entire procedure 20-30 seconds

HAND CLEANSING AND HAND HYGIENE		
Policy/Procedure Applies To	**All Nurses/Technicians/Surgeons/Physician/ Anaesthesiologist/ Housekeeping Staff/ Nursing Aides**	**Policy/Procedure No: 4** **Page: 7 of 8**
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3. Hand-hygiene technique

a. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Follow the manufacturer's recommendations regarding the volume of product to use.

b. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers.

c. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis.

4. Hand antisepsis (Surgical)

a. Remove rings, watches, and bracelets before beginning the hand scrub.

b. Remove debris from underneath fingernails using a nail cleaner under running water.

c. Surgical hand antisepsis using either an antimicrobial soap or an alcohol-based hand rub with persistent activity is recommended before donning sterile gloves when performing surgical procedures.

d. When performing surgical hand antisepsis using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2--6 minutes.

e. When using an alcohol-based surgical hand-scrub product with persistent activity, follow the manufacturer's instructions. Before applying the alcohol solution, pre wash hands and forearms with a non-antimicrobial soap and dry hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry thoroughly before donning sterile gloves.

5. Other Aspects of Hand Hygiene

a. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non intact skin could occur.

b. Remove gloves after caring for a Individual. Do not wear the same pair of gloves for the care of more than one Individual, and do not wash gloves between uses with different Individuals.

c. Change gloves during Individual care if moving from a contaminated body site to a clean body site.

6. Precautions (Soap and Water)

Always Wash from area of least contamination to area of greatest contamination. Faucet handles and doorknobs are considered contaminated. Hand lotions should be used to prevent excessive drying of the skin as intact skin is the first line of defense against invasion of organisms.

HAND CLEANSING AND HAND HYGIENE		
Policy/Procedure Applies To	**All Nurses/Technicians/Surgeons/Physician/ Anaesthesiologist/ Housekeeping Staff/ Nursing Aides**	**Policy/Procedure No: 4** **Page: 8 of 8**
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7. Precautions (Alcohol Based Hand Rub)

a. Frequent use of alcohol-based formulations for hand antisepsis can cause drying of the skin unless moisturizer or other skin-conditioning agents are added to the formulations.

b. Even well-tolerated alcohol hand rubs containing emollients may cause a transient stinging sensation at the site of any broken skin (e.g., cuts and abrasions). Alcohol-based hand-rub preparations with strong fragrances may be poorly tolerated by people with respiratory allergies. Allergic contact dermatitis or contact urticaria syndrome caused by hypersensitivity to alcohol or to various additives present in certain alcohol hand rubs occurs only rarely.

c. Alcohols are flammable. Alcohol-based hand rubs should be stored away from high temperatures or flames. It is emphasized that hands should be rubbed together after application of alcohol-based products until all the alcohol has evaporated.

ANNEXURE IV
(Refer to Housekeeping Manual Policy and Procedure No. 1)

MEDICAL GASES PLANT

	Frequency				
AREA	**Daily**	**Weekly**	**Fortnightly**	**Mthly**	**Other**
Floor	X				
Walls		X			
Windows		X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

EXPOSURE CONTROL PLAN MANUAL

METHODS OF COMPLIANCE: PERSONAL PROTECTIVE EQUIPMENT		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 4** **Page: 1 of 1**
Effective Date: 11 April, 2013		

METHODS OF COMPLIANCE: PERSONAL PROTECTIVE EQUIPMENT

(Also Refer Hospital Infection Control Manual Policy and Procedure No. 7)

Prime Surgical Centers will provide personal protective equipment at no cost to employees at risk of occupational exposure.

GEAR

The surgical center shall provide "appropriate" personal protective equipment not necessarily limited to such items as:

1. Gloves
2. Gowns
3. Face shields
4. Masks
5. Eye protection
6. Resuscitation bags
7. Other ventilation devices

Personal protective equipment is considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or to reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

USE

The surgical center shall ensure that the employee uses appropriate personal protective equipment during all potential exposures. Under rare and extraordinary circumstances, the employee may temporarily and briefly decline to use the protective equipment if in his or her professional judgement its use in specific instance would prevent the delivery of health care or public safety services or would pose an increased hazard to the safety of worker or co-worker. In such cases, the circumstances must be investigated and documented to determine whether changes can be made to prevent similar occurrences in the future.

ACCESSIBILITY

Ensure that appropriate personal protective equipment in the correct sizes is readily available in all work areas or is issued to employees.

CLEANING

Clean, launder and dispose of personal protective equipment at no cost to the employee.

1. Repair or replace personal protective equipment when needed to maintain in good working condition, at no cost to the employee.
2. If a garment is penetrated by blood or other potentially infectious materials, the employee will be encouraged to remove the garment immediately or as soon as feasible. All personal protective equipment will be removed prior to leaving the work area.
3. After personal protective equipment is removed, it will be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Bech House, Damle Path, Pune.

NURSING MANUAL

NURSES UNIFORM AND GROOMING		
Policy/Procedure Applies To	**All Nurses/ Technicians**	**Policy/Procedure No: 4** **Page: 1 of 3**
Effective Date: 11 April, 2013		

NURSES UNIFORM AND GROOMING

PURPOSE

The aim is to maintain a professional standard of Uniform & grooming to ensure presenting a positive image to patients and their relations/visitors, and to reduce the possibility of accident or transmission of infection.

POLICY

1. To promote and maintain a professional standard of Nurses Uniform appropriately, keep clothing in good repair, and maintain good personal hygiene standards.
2. To provide a safe work environment; promote a competent and professional image; encourage the public trust and confidence; and be appropriate with respect to job duties and work setting.
3. Nursing Superintendent and OT Matron are responsible to monitor and enforce the dress standards in their area(s) and may determine if other items such as footwear, jewellery, or clothing interfere with the reasonable performance of a nurse's duties or with the therapeutic environment.
4. Violations are subject to corrective and/or disciplinary actions in accordance with Prime Surgical Centers rules and regulations
    a. Nurses who violate the dress and grooming standards can expect to be sent home to correct the problem. Nurses sent home are not reimbursed for the time away from the work place.
    b. Nurses are encouraged to wear proper uniform suitable and appropriate for their job and the task in which they are involved e.g. (Operation Theatre)
    c. All Nurses shall wear uniforms designed by the Prime Surgical Centers.
    d. Nurses shall adhere to the acceptable standards of dress and grooming as well as maintain a professional standard of cleanliness and personal hygiene while coming on duty and going off duty.

PROCEDURES

1. Nursing Superintendent, OT Matron and Charge Nurse are responsible for administering and enforcing this policy.
2. Nurses are expected to maintain a professional standard of cleanliness and personal hygiene. Any fragrance or odor that is extreme or offensive is prohibited. Nurses may have sensitivity or allergic reactions to fragrances and unpleasant odors; therefore, Nursing Superintendent, OT Matron and Charge Nurse shall address any issues regarding sensitivity or allergic reactions to fragrances or unpleasant odors on a case-by-case basis.
3. Dress and Attire
    a. Uniforms

        Nurses shall display a neat, professional, fully dressed appearance in public while wearing the Prime Surgical Centers uniform. Uniforms shall not be worn during non-duty hours in a casual, unprofessional manner

NURSES UNIFORM AND GROOMING		
Policy/Procedure Applies To	**All Nurses/ Technicians**	**Policy/Procedure No: 4** **Page: 2 of 3**
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b. Name Pin / Identity Card

i. An Identity Card must be worn by all nurses when in the Prime Surgical Centers premises.

ii. The Identity Card will have first and last name, Photograph, employee ID number, the designation, Blood Group, Hospital No. and the logo of Prime Surgical Centers.

c. Shoes

i. Plain Black leather or vinyl shoes and low or medium heels are to be worn with the uniform.

ii. Shoes must have closed toes and heels must have proper grip for safety.

iii. White socks or hose must be worn with the uniform shoes.

d. Jewellery

i. A plain watch with a second hand is required.

ii. Wedding bands may be worn. Earrings must be small (no larger than six mm), bead-like, and one each ear (no dangling or over-sized earrings shall be worn.)

iii. Ornate hair accessories are not to be worn with the uniform.

e. Tattoos

i. Tattoos are to be concealed/ not to be visible.

ii. Equipment

iii. Pen with black and red ink, and bandage scissors are to be carried as appropriate for the clinical setting.

4. Grooming

"Well-Groomed," with regard to nails, cut short and well manicured. Hair, beards, mustaches, or sideburns, is defined as hair that is clean, neatly combed or brushed, does not present a ragged or unkempt appearance.

No smoking or chewing tobacco, paan or gum and spitting in the Prime Surgical Centers premises.

Strongly scented body products must not be worn due to potential patient allergic responses.

a. Female Nurses/Technicians

i. Hair

Nurses shall wear their hair in a well-groomed manner. Hair shall not extend below the bottom of the uniform collar. Hair shall be cut or pinned close to the sides, top, and back of the head with a net to achieve this standard. Hair color shall be of a natural shade such as brown or black and may not be an unnatural shade.

ii. Fingernails

Fingernails shall not extend more than one-quarter inch beyond the tip of the finger & well manicured. Coloured nail polish or mehandi is not allowed while on duty.

iii. Makeup

Makeup shall not be extreme in nature.

NURSES UNIFORM AND GROOMING		
Policy/Procedure Applies To	**All Nurses/ Technicians**	**Policy/Procedure No: 4** **Page: 3 of 3**
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b. Male Nurses/Technicians

i. Hair

Male Nurses shall wear their hair in a well-groomed manner. Hair shall be blocked or tapered, trimmed off the ears, and close to the sides, top, and back of the head. Hair shall not extend below the top of the uniform collar. Hair color shall be of a natural shade such as brown, or black and may not be an unnatural shade.

ii. Beards

Beards are prohibited. The only exception is in case of religious practice. In such case, the length of the facial hair shall not exceed one-quarter of an inch.

iii. Moustaches

Moustaches are permitted. However, the mustache shall be neatly trimmed and shall not extend over the top lip or vertically or horizontally beyond the corner of the mouth where the lips join. Handlebar moustaches are prohibited.

iv. Sideburns

Sideburns are permitted; however, the sideburns shall be neatly trimmed and shall not extend below the middle of the ear.

v. Fingernails

Fingernails shall not extend more than one-quarter inch beyond the tip of the finger.

c. Inappropriate Attire

Attire that is not considered appropriate or compatible while coming to and going off duty from Prime Surgical Centers includes, but is not limited to, the following:

i. Females

- Dresses or skirts shorter than knee length.
- Shorts of any length
- Blouse and sari or any attire considered to be see-through, exposing the midriff, shoulder or any portion of a feminine undergarments
- Flip-flops or shower shoes
- Brightly coloured or patterned undergarments are not to be worn with the uniform.

ii. Males

- Shorts
- Sweat suits, wind suits, or the pants of any such suit.
- Flip-flops or shower shoes
- Earrings of any kind.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

ORDER ACCEPTANCE LETTER		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 4** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ORDER ACCEPTANCE LETTER

PURPOSE

To ensure supply of ordered equipment is as per Technical specifications, decided price and schedule.

PROCEDURE

Executive Facility will ensure that Order Acceptance Letter (refer Annexure to this policy) is attached with the purchase order and either handed over to the supplier personally or sent by post, as the case may be. The supplier must submit the Order Acceptance Letter either personally or through post, duly signed, dated & stamped.
Cheque for advance amount, if any, will only be issued after receipt of above document.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
Refer to Purchase and Maintenance Manual Policy and Procedure No.4

Order Acceptance Letter
(To be returned by Supplier duly signed before supply)

Date: 00/00/0000

To,
Prime Surgical Centers Pvt. Ltd,
Beck House, Damle Path,
Off Law College Road,
Pune - 411 004.

Dear Sir,

I/we received your P.O. No. **000/PSC/0000 - 00** Dt. **00.00.0000.** We have read the terms & conditions of your purchase order and I/we agree to supply the material as per the specifications, terms & conditions of purchase order & quotation.

Thanking you,

Yours faithfully,

Sign:

Name:

Place:

Date:

Company's Seal:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

OUT PATIENT DEPARTMENT (OPD) CONSULTATION ADVICE		
Module Applies To	**Customer Care, OPD Nurse / Radiology/Pathology/Pharmacy**	**Policy and Procedure No.: 4** **Page: 1 of 2**
Effective Date: 11 April, 2013		

OUT PATIENT DEPARTMENT (OPD) CONSULTATION ADVICE

PURPOSE

The customer care executive will assist and guide the patient as per the advice given by the Consultant which may be prescriptions, investigations and/or surgery/procedure.

PROCEDURE

Medication

If medication has been prescribed, direct the patient to the pharmacy i.e. Apollo Pharmacy located in the OPD. Patient will be advised to collect medicines on payment directly to pharmacy. Advice for follow-up, if any, will be explained.

Investigations

If the Consultant has advised any investigations to the patient assist the patient accordingly.

1. Prime Surgical Centers has outsourced the Pathology Services to Golwilkar Metropolis. For any Laboratory Investigations like blood, urine, etc. advice the patient if the tests have to be done on an empty stomach.
   a. If so, give the total estimate of the investigations cost to the patient and schedule an appointment for the patient as per his/her convenience.
   b. If the patient can do the tests immediately, take the payment for the tests. Take three copies of the bill, one for the patient, one for the Accounts department and one for the Laboratory on the authority of which they will conduct the tests. Guide the patient to the Laboratory room.
   c. Inform the patient when he/she can collect the report/s.
2. The Radiology Investigations like Ultrasound and X-Ray are done in-house.

   For certain investigations some special instructions are to be given, the same may be handed over to the patient for necessary compliance.

   If the patient has been advised an Ultrasound Sonography Test, schedule an appointment with the Radiologist and provide the total cost of the test to the patient.

   If the patient has been advised an X-Ray, provide the total cost of the X-ray to the patient.

   Prior to sending the patient to the USG / Radiology room, collect the payment for the respective investigation. Take three copies of the bill, one for the patient, one for the Accounts department and one for the USG/Radiology Department on the basis of which they will conduct the X-Ray/USG. Guide the patient to the USG / Radiology room. Inform the patient when he/she can collect the film/s and report/s.
3. ECG is conducted in-house. If the patient is advised ECG, inform the OPD Nurse so that he/she can take the ECG of the patient. Again as stated earlier, take the payment in advance.
4. For 2D Echo schedule an appointment of the patient with the cardiologist.
5. For Magnetic Resonance Imaging (MRI) test or CT Scan test, provide the patient with details of Poona Diagnostic Services with whom Prime Surgical Centers has a tie-up for MRI scans/CT scans. Schedule an appointment for the patient with Poona Diagnostic Services. Also fill in details of the patient in the ‘Authorization for MRI/CT Scan at Poona Diagnostic Services/Omega Scan’ form (refer Annexure to this policy) and ask the patient to hand it over to Poona Diagnostics. Maintain a record of such cases for future reporting purposes. If the patient needs ambulance for conveyance,

OUT PATIENT DEPARTMENT (OPD) CONSULTATION ADVICE		
Module Applies To	**Customer Care, OPD Nurse / Radiology/Pathology/Pharmacy**	**Policy and Procedure No.: 4** **Page: 2 of 2**
Effective Date: 11 April, 2013		

request Poona Diagnostics for arranging the same. For certain investigations some special instructions are to be given, the same may be handed over to the patient for necessary compliance.

6. Schedule the next appointment with the Consultant in order to show the results of the investigations to the Consultant.

Physiotherapy

If physiotherapy sessions have been suggested by the Consultant, schedule an appointment of the patient with the Physiotherapist.

Surgery/Procedure

If the Consultant has suggested surgery/procedure to the patient:

1. Confirm the name of the surgery/procedure.
2. If any implant is needed for the surgery, inform the OT Matron and Pharmacy so that they can co-ordinate with the Consultant for the arrangement of the implant.
3. Confirm if the surgery/procedure is to be done on OP (Out-Patient) basis or IP (In-Patient) basis.
4. Confirm if the patient has insurance to determine whether the patient can avail cashless facility or whether he will be self-paying.
5. Depending on the above, determine the estimated cost of surgery/procedure (as agreed by either the Consultant or the Administrative Head of the Center) and explain it to the patient. (Also refer Customer Care and Billing Manual Policy and Procedure No. 5)
6. Confirm if a Pre-Anaesthesia Check-up is required for the surgery/procedure. If required, explain the Pre-Anaesthesia Check-up requirement to the patient and also the investigations that are needed to be completed before the Check-up along with the estimated cost of it. (Also refer Customer Care and Billing Manual Policy and Procedure No. 6)

The patient will then decide if he/she wants to go ahead with the surgery and inform Customer Care accordingly.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

PATIENT SAFETY GOALS		
Module Applies To	**All Nurses and Technicians**	**Module No: 4** **Page: 1 of 7**
Effective Date: 11 April, 2013		

PATIENT SAFETY GOALS

OBJECTIVES

1. Outline the purpose and benefits of the safety process.
2. Define standard of care.
3. Explain the Patient Safety Goals (PSG) as laid down by World Health Organisation and Prime Surgical Centres Policies.

INTRODUCTION

Prime Medical Centres adopted the vision "To become a nationally recognised centre of Health care excellence". In order to achieve this vision the organization required nationally recognised health care standards to ensure that the standards are implemented and met.

To achieve the standards of health care set out by NABH, Prime Surgical Centres developed policies and procedures to guide the Nursing employees who in turn have to implement the policies and procedures to ensure and maintain the standards of care required to achieve national recognition.

DEFINITIONS

Standard of Care

This is a statement that defines the performance expectations, Policies / Procedures, guidelines and Protocol that must be in place for the Nursing Department to provide safe and high – quality care, treatment and service.

Types of standards

1. Patient centered Prime Surgical Centers standards:
   a. Prime Surgical Centers' Patient safety Goals
   b. Access to Care & Continuity of Care
   c. Assessment of Patients
   d. Care of Patients
   e. Anaesthesia & Surgical Care
   f. Medication Management Use
   g. Patient & Family Education
2. Health care organization management standards
   a. Prevention & Control Of Infections
   b. Leadership & Direction
   c. Facility Management & Safety
   d. Staff qualifications & Education
   e. Management Of Communication Information

PATIENT SAFETY GOALS		
Module Applies To	**All Nurses and Technicians**	**Module No: 4** **Page: 2 of 7**
Effective Date: 11 April, 2013		

PATIENT SAFETY GOALS

The purpose of the Patient Safety Goal is to:

1. Promote specific improvements in patient safety.
2. Highlight problematic areas in health care and describe evidence- and expert-based solutions to these problems.
3. Delivery of safe, high-quality health care

NINE IMPORTANT PATIENT SAFETY GOALS

1. **Look-Alike, Sound-Alike Medication Names**
2. **Patient Identification**
3. **Communication – Improve Effective Communication**
4. **Performance of Correct Procedure at Correct Body Site**
5. **Control of Concentrated Electrolyte Solutions**
6. **Assuring Medication Accuracy at Transitions in Care**
7. **Avoiding Catheter and Tubing Mis-Connections**
8. **Single Use of Injection Devices**
9. **Improved Hand Hygiene to Prevent Health Care-Associated Infection (HAI)**

1. LOOK-ALIKE, SOUND-ALIKE MEDICATION NAMES

Many drug names look or sound like other drug names. Contributing to this confusion are illegible handwriting, incomplete knowledge of drug names, newly available products, similar packaging or labelling, similar clinical use, similar strengths, dosage forms, frequency of administration.

There are many Look-Alike, Sound-Alike (LASA) combinations that could potentially result in medication errors. (Refer to Nursing Manual Policy and Procedure No. 36)

Medication orders and prescriptions that include both the brand name and non-proprietary name, dosage form, strength, directions, and the indication for use can be helpful in differentiating Look-Alike, Sound-Alike medication names. (Refer to Nursing Manual Policy and Procedure No. 37)

LASA medications; to alert users:

1. Tall Man lettering
2. Separation
   Eg. HydrOXYzine & HydrALAzine
   ZanTAC & ZyrTEC

Improve the Safety of Medication, High-Alert Medications

When medications are part of the patient treatment plan, appropriate management is critical to ensuring patient safety.

A frequently cited medication safety issue is the unintentional administration of concentrated electrolytes. Errors can occur when staffs are not properly oriented to the patient care unit.

The most effective means to reduce or to eliminate these occurrences is to develop a process for managing high-alert medications.

High-Alert Medications : "High-Alert medications; are drugs that bear a heightened risk of causing significant patient harm when they are used in error." "High-alert medications are those medications involved in a high percentage of errors and/or sentinel events, medications that carry a higher risk for adverse outcomes, as well as look-alike/sound-alike medications"

High alert medications are highlighted red to their labels and storage shelves in pharmacy Nursing Station and Operation Theater.

2. PATIENT IDENTIFICATION - IDENTIFY PATIENTS CORRECTLY

Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. Patients may be sedated, disoriented, or not fully alert; may change beds, rooms, or locations within the hospital; may have sensory disabilities; or may be subject to other situations that may lead to errors in correct identification.

All patients should be identified at time of:

1. Registration, Admission, Transfer, Discharge
2. Before administering medications,
3. Blood or blood products administration
4. Before taking blood and other specimens,
5. Prior to treatments, interventions and invasive procedures.

Patient identification

1. All inpatients should have an Identification band. Outpatients are not required to wear an Identification band unless they are admitted.
2. **Two identifiers** are used to identify each patient:
   a. Patient's name **and**
   b. Medical Record number
3. Compare identifiers to information on Patient Medical Record to make sure they are exactly the same.
4. **Do not proceed** if there is doubt about the correct identity of the patient. Notify your Supervisor.
   a. **Never** use a room or bed number as an identifier.
   b. Label Blood and other specimens in front of the patient.
5. In case of life threatening emergency, patient identification should be attempted but the patient's life should be saved.
6. The assigned nurse is accountable for the removal of the patient identity band once all discharge process is finalized

PATIENT SAFETY GOALS		
Module Applies To	**All Nurses and Technicians**	**Module No: 4** **Page: 4 of 7**
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3. COMMUNICATION - IMPROVE EFFECTIVE COMMUNICATION

Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces errors and results in improved patient safety. Communication can be electronic, verbal, or written.

The most error-prone communications are patient care orders given verbally and those given over the telephone. Another error-prone communication is the reporting back of critical test results, such as the clinical laboratory telephoning the patient care unit to report the results of a STAT test.

Improve Effective Communication

1. Verbal and telephone orders shall be utilized only in situations where any delay in writing the order prior to its being carried out could cause patient harm or have a possible negative outcome.
2. No verbal or telephone orders shall be accepted when the physician is physically present in the unit unless the situation is life threatening.
3. Emergency verbal and telephone orders can also be accepted from physician who is present but due to his / her involvement in a patient care procedure or treatment is unable to write the order by her/himself.

Process of Receiving Verbal and Telephone Orders

1. Write down the order immediately by the receiving staff on the physician order sheet.
2. Read back to the physician for verification of accuracy.
3. Sign, date with time by the staff receiving the order.
4. Staff receiving the verbal/telephone order should clearly write in the Physician order sheet indicating it as T.O (Telephone order) or V.O (Verbal order) with the name, and title of the Physician who prescribed the verbal or telephone order.
5. All orders for treatment or diagnostic tests should be written accurately, legibly, and completely.
6. **Do Not Use** abbreviations in documenting verbal/ telephone orders.
7. Verbal and telephone order shall be reviewed and countersigned by the Physician or another Physician member of the team caring for the patient as soon as possible within **twenty four (24) hours** of the verbal or telephone order being given.

4. PERFORMANCE OF CORRECT PROCEDURE AT CORRECT BODY SITE

Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery

Those procedures that investigate and/or treat diseases or disorders of the human body through cutting, removing, altering, or insertion of diagnostic/therapeutic scopes. The purpose of this standard is to eliminate wrong-site, wrong-patient, and wrong-procedure surgery.

Verification Process Involves

1. Pre-Operative verification process

   The pre-operative/pre-procedure checks and verification includes:

   a. Patient identity, using two-identifiers on ID band, is verified matched with relevant documentation on the consent, and on the medical record information.

b. Patient should be involved in the process through verbalization, full name, procedure, and site (if applicable), and information from patient should match the medical record data;
c. Current History and physical examination should be present.
d. Valid Consent form (s) signed and dated.
e. Radiological and sonographic images should be available and correctly identified for the patient;
f. Laboratory results should be available and correctly identified for the patient;
g. Any other test results as ordered by the physician should be correctly identified for the patient;
h. Site should be correctly marked.

2. Marking the surgical or procedure site.
3. Time Out that is held immediately before starting the operation or procedure.

   Use a 'time out' with the entire unit team, surgical team, or diagnostic studies **team just before starting the surgery or procedure** to verify:

   a. correct patient identity
   b. correct procedure
   c. correct site
   d. correct side
   e. correct documents, theatre list, special equipment and films presented
   f. the correct way
   g. completed multidisciplinary checklist

5. CONTROL OF CONCENTRATED ELECTROLYTE SOLUTIONS

Concentrated electrolyte solutions that are used for injection are dangerous which comes under High Alert Medication e.g. Potassium chloride injection (KCl), Sodium chloride more than 0.9 conc. Injection (NaCl), Magnesium Sulphate injection (Mg SO4), Conc. Ringer lactate injection, etc. (Refer to Nursing Manual Policy and Procedure No. 37). Electrolytes bear a heightened risk of causing significant patient harm, when they are used in error. (Refer to Nursing Manual Policy and Procedure No. 36)

1. In Prime Surgical Centers, concentrated electrolytes shall be considered as high-alert medications
2. The amount of any approved concentrated electrolyte should be limited to the smallest safe supply and kept in a segregated area.
   a. Potassium chloride
   b. Potassium phosphate
   c. Saline solutions that are greater than 0.9%
   d. 50% magnesium sulphate.
3. The storage of concentrated electrolytes should not be allowed in patient care units
4. If the IV admixture is not a standard strength, prediluted IV electrolyte solution may be stocked or only keep the minimum needed quantity electrolyte injection.

PATIENT SAFETY GOALS		
Module Applies To	**All Nurses and Technicians**	**Module No: 4** **Page: 6 of 7**
Effective Date: 11 April, 2013		

6. ASSURING MEDICATION ACCURACY AT TRANSITIONS IN CARE

Errors are common as medications are procured, prescribed, dispensed, administered, and monitored but, they occur most frequently during the prescribing and administering actions. Medication errors occur most commonly at transitions. Medication reconciliation is a process designed to prevent medication errors at patient transition points. Prime Surgical Centers assures creation of the most complete and accurate list of all medications the patient is currently taking-also called the “home” medication list. Compare the list against the admission and discharge orders when writing medication orders and communicate the list to the patient and his/her family whenever the patient is discharged. (Refer Nursing Manual Policy and Procedure No. 19)

5. AVOIDING CATHETER AND TUBING MIS-CONNECTIONS

The design of tubing, catheters, and syringes currently in use is such that it is possible to inadvertently cause patient harm through connecting the wrong syringes and tubing and then delivering medication or fluids through an unintended wrong route. Care givers need to give meticulous attention to detail when administering medications and feedings (i.e., the right route of administration), and when connecting devices to patients (i.e., using the right connection/tubing).

6. SINGLE USE OF INJECTION DEVICES

Prime Surgical Centers prohibits the reuse of needles. Periodic training will be conducted for all staff involved in direct patient care for infection control principles and safe needle disposal practices (Refer to Hospital Infection Control Manual Policy and Procedure No. 5). Education of patients and families regarding transmission of blood borne pathogens will be an ongoing process while admitted to Prime Surgical Centers.

7. IMPROVED HAND HYGIENE TO PREVENT HEALTH CARE-ASSOCIATED INFECTION (HAI)

Reduce the Risk of Healthcare Associated Infections

Indications for hand washing and hand antisepsis:

1. Hand washing:
   a. When hands are dirty or contaminated with visible material or soiled with blood or other body fluids, or if exposure to potential spore- forming organisms (e.g. C. difficile) is strongly suspected or proven.
   b. After using the toilet; after changing diapers or cleaning up a patient who has used the toilet.
   c. Before eating.
   d. After blowing your nose, coughing or sneezing.
   e. When caring for patient with diarrhea or suspected exposure to Clostridium difficile; Bacillus anthracis (Anthrax).
   f. After touching an animal or animal waste.
   g. After touching garbage.

2. Hand rubbing:

   If hands are not visibly soiled but are contaminated, use an alcohol-based hand rub for decontamination. Such situations include:

   a. Before and after having direct contact with patients;

   b. Before donning gloves for an invasive procedure (i.e. starting an IV and inserting a Foley catheter);

   c. After contact with a patient's intact skin (i.e. taking a blood pressure, lifting patient);

   d. After contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings;

   e. After moving from a contaminated body site before moving to a clean body site during same patient care;

   f. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.

   g. After removing gloves.

Hand Washing

Types:

1. Social hand wash
2. Hygienic hand wash
3. Surgical hand wash / Scrub

Prime Surgical Damle Path, LLP
Beck House, Damle Path
Off Law College Road
Pune 411004, India
www.primesurgical.in

Authorization for MRI /CT Scan at Poona Diagnostic Services/Omega Scan

Prime Surgical Centers MR No.: _____ Date: _____

Patient Name: _____

Age/Sex: _____ Contact No.: _____

MRI / CT Scan Details:

_____

_____

_____

Appointment Date and Time: _____

Remark: _____

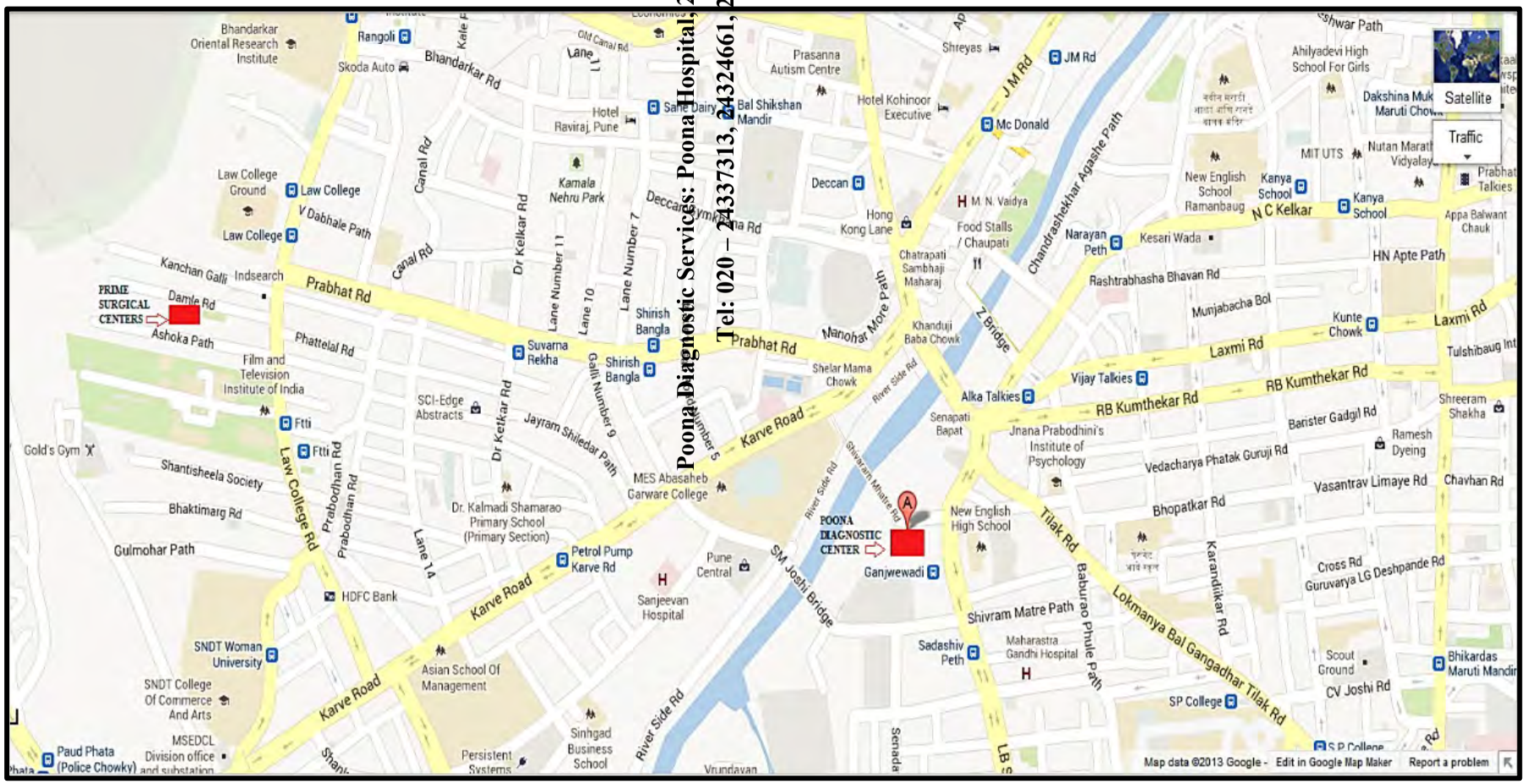
_____

We authorize the above patient to utilize the services of Poona Diagnostic Center/Omega Scan on payment for the above mentioned MRI/CT Scan.

Authorized Signatory
Prime Surgical Centers

Poona Diagnostic Services: Poona Hospital, 27 Sadashiv Peth, Pune-411030

Tel: 020 – 24337313, 24324661, 24331706 Ext. 1140



ANNEXURE
(Refer Customer Care and Billing Manual Policy and Procedure No. 4)

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Pune 411004, India
www.primesurgical.in

PRIME
SURGICAL CENTERS

Authorization for MRI /CT Scan at Poona Diagnostic Services/Omega Scan

Prime Surgical Centers MR No.: _____ Date: _____

Patient Name: _____

Age/Sex: _____ Contact No.: _____

MRI / CT Scan Details:

_____

_____

_____

Appointment Date and Time: _____

Remark: _____

_____

We authorize the above patient to utilize the services of Poona Diagnostic Center/Omega Scan on payment for the above mentioned MRI/CT Scan.

Authorized Signatory
Prime Surgical Centers

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

PRIME PHILOSOPHY: IMPORTANT WORDS TO REMEMBER		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 4** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PRIME PHILOSOPHY: IMPORTANT WORDS TO REMEMBER

1.	The most selfish “One” letter word	- I	-	Avoid it
2.	The most “satisfying “Two” letter word	- WE	-	Use it
3.	The most poisonous “Three” letter word	- EGO	-	Kill it
4.	The most used “Four” letter word	- LOVE	-	Value it
5.	The most pleasing “Five” letter word	- SMILE	-	Keep it
6.	The fastest spreading “Six” letter word	- RUMOUR	-	Ignore it
7.	The hardest working “Seven” letter word	- SUCCESS	-	Achieve it
8.	The most enviable “Eight” letter word	- JEALOUSY	-	Distance it
9.	The most powerful “Nine” letter word	- KNOWLEDGE	-	Acquire it

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

RESPONSIBILITIES OF ANAESTHESIA SERVICE		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 4** **Page: 1 of 2**
Effective Date: 11 April, 2013		

RESPONSIBILITIES OF ANAESTHESIA SERVICE

GENERAL INFORMATION

1. The anaesthesia service will provide information regarding the current credentials of all anaesthesia staff. Clinical privileges are approved for all anaesthesia staff by the Administrative Head of Prime Surgical Centers.
2. The anaesthesia service is responsible for assuring that it is consistent with patient needs and conforming to current anaesthesia practice. This is consistent with the implementation of an effective system for monitoring and evaluating the quality and appropriateness of anaesthesia care provided by individuals of the anaesthesia staff.
3. A representative of the anaesthesia service participates on appropriate committees as requested.

RELATIONSHIPS

1. The anaesthesia service is responsible to the Administrative Head of Prime Surgical Centers.
2. The anaesthesia service head will designate an individual to supervise physicians and non-physician staff assigned to the service.

QUALIFICATIONS

All anaesthesia staff must be approved members of the medical staff with appropriate clinical privileges approved by the Administrative Head of Prime Surgical Centers.

STANDARD I: Anaesthesia staff assigned to the facility demonstrates clinical competence and skills appropriate for types of clinical privileges approved.

Criteria:

1. Performs in accordance with adopted standards and approved policies and procedures.
2. Participates as a team member in support of the total peri-anaesthesia process.
3. Cooperates with physician and non-physician staff in implementing and monitoring programs.

STANDARD II: Demonstrates understanding and commitment to the Quality Assurance Program as adopted by the facility.

Criteria:

1. Supports the adopted plan and programs.
2. Supports risk management and enforces programs that are directed to patient and employee safety.

STANDARD III: Recommends the type and amount of physical resources necessary for support of anaesthesia services and for providing any necessary resuscitation measures.

Criteria:

1. Provides appropriate staff to adequately cover the surgical schedule.
2. Recommends budget items in accordance with needs to provide appropriate patient care.

STANDARD IV: Demonstrates commitment to enforcement of compliance with standards of professional performance of all physicians and non-physician anaesthesia staff.

Criteria:

RESPONSIBILITIES OF ANAESTHESIA SERVICE		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 4** **Page: 2 of 2**
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1. Investigates any breach of quality care of ethics that is reported and takes appropriate action.
2. Reviews the performance of anaesthesia staff and quality profiles for reappointment by the Administrative Head of Prime Surgical Centers.

STANDARD V: Demonstrate commitment to enforcement of the approved Medical Staff Bylaws, and policies and procedures**.**

Criteria:

1. Provides guidance regarding medical policies of the facility to enhance patient care.
2. Reviews activities to determine adherence to facility policies and procedures and other adopted standards.
3. Develops and implements, in cooperation with the administrator, methods to meet the recommended practices and requirements of regulatory and accrediting agencies.

STANDARD VI: Develops guidelines for anaesthesia safety.

Criteria:

1. Provides guidance as to required availability of safety devices as appropriate to scope of service including, but not necessarily limited to, oxygen analyzers, pressure and disconnect alarms, pin-index safety system, and oxygen pressure interlock systems.

STANDARD VII: Determines that requirements for continuing education are enforced for all individuals who provide anaesthesia services.

Criteria:

1. Provides information as to in-service training provided.
2. Upon request, provides in-services for all facility personnel based in part on the results of the monitoring and evaluation of anaesthesia care.

STANDARD VIII: Demonstrates acceptance of accountability for the quality and efficiency of anaesthesia services at the PRIME SURGICAL CENTERS.

Criteria:

1. Provides liaison between anaesthesia staff and medical staff.
2. Provides a mechanism for communication of opinions, concerns, and grievances of the medical staff to the anaesthesia service.
3. Participates in meetings and committees, as appropriate, to maintain communication.

STANDARD IX: An Anaesthesiologist will remain in the facility until all patients have recovered from anaesthesia (medically discharged). In order to objectively assess anaesthetic recovery, refer to the scoring system in Anaesthesia Manual Policy and Procedure No.15.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

SAFETY MANUAL

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

PRODUCT EVALUATION		
Policy/Procedure Applies To	**Nursing Superintendent / Executive Facility**	**Policy/Procedure No: 5** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PRODUCT EVALUATION

PURPOSE

To ensure that changes in products purchased are cost effective and promote good patient care.

SCOPE

All Center personnel

POLICY

With the introduction of a new product or change from one supplier to another for the same product, a periodic evaluation will take place and be documented before use of the new product or change is implemented.

PROCEDURE

1. When a new product is introduced:
   a. The Nursing Superintendent/Executive Facility will assign a person in the appropriate area to be responsible for evaluation and completion of the Product Evaluation Form.
   b. When the evaluation and form are completed it is returned to the Nursing Superintendent/Executive Facility.
2. The Nursing Superintendent/Executive Facility will make recommendation in writing and send it with a copy of the Product Evaluation Form, as per Annexure to this policy, to the Administrative Head of the Center.
3. Once the new product is approved and before it is put into use in the facility the product will be in serviced to all appropriate personnel.

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Revision Date:	
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ANNEXURE
(Refer to Purchase and Maintenance Manual Policy and Procedure No. 5)

PRODUCT EVALUATION

Product_____

Manufacturer_____

Date_____ Number of items received_____

Will product result in:

Easier procedure	_____yes	_____no	_____unchanged
Safer procedure	_____yes	_____no	_____unchanged
Better patient care	_____yes	_____no	_____unchanged
Reduced cost	_____yes	_____no	_____unchanged
Improved packaging	_____yes	_____no	_____unchanged
Improved storage	_____yes	_____no	_____unchanged

Comments:
Advantages _____

_____

Disadvantages_____

_____

Comparison with current product_____

_____

Evaluation_____

_____

Evaluation conducted by

_____ _____

_____ _____

_____ _____

_____ _____

Reviewer Date

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

ANAESTHESIA SERVICE RULES AND REGULATIONS		
Policy/Procedure Applies To	**Anaesthesiologists and Surgeons**	**Policy/Procedure No: 5** **Page: 1 of 4**
Effective Date: 11 April, 2013		

ANAESTHESIA SERVICE RULES AND REGULATIONS

PURPOSE

1. To identify specific rules and regulations for the anaesthesia service at the PRIME SURGICAL CENTERS.
2. To determine that the rules and regulations of the anaesthesia service are compatible with the rules and regulations of the medical staff at the PRIME SURGICAL CENTERS.

RULES AND REGULATIONS

1. Patient eligibility for elective procedures
   a. Due to the limited scope of surgical cases performed at the facility, patients scheduled for elective surgical procedures routinely meet the American Society of Anaesthesiologists (ASA) physical status classification I, II, or III as follows:

   Class I: The patient has no organic, physiologic, biochemical or psychiatric disturbance. The pathologic process for which operation is to be performed is localized and does not entail a systemic disturbance.

   Class II: Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes. Patients with non or only slightly limiting organic heart disease, mild diabetes mellitus, essential hypertension or anemia. Extremes of age, either the neonate or the octogenarian, even though no obvious systemic disease is present. Extreme obesity, chronic bronchitis, mild chronic obstructive airway disease, and patients with moderate smoking habits.

   Class III: Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality. Severely limiting organic heart disease, severe diabetes mellitus with vascular complications, moderate to severe degrees of pulmonary insufficiency, angina pectoris or healed myocardial infarction.

   Class IV: This classification is indicative of the patient with severe systemic disorder already life threatening, not always correctable by the operative procedure. Patients with organic heart disease showing marked signs of cardiac insufficiency, the anginal syndrome or active myocarditis, advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency.

   Class V: The moribund patient who has little chance of survival but is submitted to an operation in desperation.

   b. Emergency Operation

      Any patient in one of the above classes who is operated upon as an emergency is considered to be in a poor physical condition. The letter “E” is placed beside the numerical classification. Patients must be free from respiratory infection and asthmatic patients must be in remission.
2. Rules applicable to short stay surgery patients
   a. The patient and/or significant other must understand and agree with the concept of short stay surgery/anaesthesia, be willing and able to accept associated responsibilities and to follow instructions. In addition, the family situation and household environment must be conducive to a successful outcome.

b. Appropriate patient selection and adequate preparation and instruction are of paramount importance. The success of short stay surgical care is dependent upon full understanding and cooperation of all parties involved. (Patient, family, surgeon, anaesthesia staff and facility personnel).

3. Preoperative testing

   Requirements for preoperative testing procedures (e.g. laboratory, ECG, and x-ray) will be in compliance with the policies of Prime Surgical Centers, and in accordance with the appropriate assessment of the patient.

4. Preoperative assessment
   a. History, physical and medical clearance. It is the operating surgeon's responsibility to see that a complete and signed history and physical and medical clearance are present on the medical record.
   b. Pre-anaesthesia evaluation
      i. Anaesthesia staff will review the medical record to determine the medical status of the patient, develop a plan of care and acquaint the patient or the responsible adult with the proposed plan.
      ii. Anaesthesia staff will discuss the anaesthesia with patient or responsible adult, obtain patient's previous anaesthetic history and inform and reassure patient about anticipated anaesthesia. Written consent will be obtained.
      iii. After preoperative assessment, anaesthesia staff will order tests that may be required to adequately assess the patient. The attending physician will be advised as appropriate.

5. Anaesthetic management
   a. Techniques will be at the discretion and mutual agreement of the surgeon and anaesthesia staff and may include local infiltration or regional block with intravenous sedation and/or monitored anaesthesia care or general anaesthesia.
   b. Anaesthesia staff will be in attendance at all times when intravenous sedation with monitored anaesthesia care is requested by the surgeon.
   c. All patients will have an IV access line started, ECG, blood pressure and oxygen saturation of the blood monitored and recorded. Emergency drugs, airway management equipment and a defibrillator will be available at all times. Patients under general anaesthesia will have capnography performed. The ability to monitor body temperature will be available. An intra operative anaesthesia record will be maintained for each case.

6. Postoperative monitoring
   a. All patients receiving intravenous sedation or monitored anaesthesia care or general anaesthesia will be admitted to Nursing Unit.
   b. All patients receiving intravenous sedation, monitored anaesthesia care or general anaesthesia shall be evaluated by Anaesthesiologist prior to discharge.
   c. Patients who have received intravenous, monitored anaesthesia care or general anaesthesia will be discharged from the Prime Surgical Centers only after a clearance is given by the Anaesthesiologist.
   d. Patients who receive monitored anaesthesia care with any type of sedation or general anaesthesia must be discharged to the company of a responsible adult.

ANAESTHESIA SERVICE RULES AND REGULATIONS		
Policy/Procedure Applies To	**Anaesthesiologists and Surgeons**	**Policy/Procedure No: 5** **Page: 3 of 4**
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7. Local anaesthesia or conscious sedation not monitored by anaesthesia staff
   a. If local anaesthesia or sedation is administered by the attending Surgeon without monitoring by anaesthesia staff, only preoperative tests deemed necessary by the Surgeon are required.
   b. The administration of a local anaesthetic and any sedative medications ordered by the attending Surgeon, without monitoring by anaesthesia staff, shall be the sole responsibility of the Surgeon who is CPR qualified.
8. Safety regulations

Safe anaesthesia practice depends on a fundamental knowledge of anatomy, physiology, pharmacology and the effects of surgery and anaesthesia agents or techniques on a given patient. In addition, safe anaesthesia practice depends on the immediate availability of specialized equipment for the induction and maintenance of the anaesthesia state, as well as during the patient's recovery from the effects of anaesthesia.

Therefore:

1. Only individuals with specified anaesthesia privileges shall administer anaesthetics.
2. No anaesthesia state shall be induced without an adequate number of personnel immediately available in the event of complications.
3. Patients shall be positively identified and consent for surgery and anaesthesia verified prior to going to the OR.
4. The surgeon must be in the Surgery Center proper before inducing a general anaesthetic. (This does not preclude taking the patient to the OR and preparing the patient for induction of anaesthesia).
5. The following minimum equipment shall be prepared prior to taking the patient to the OR:
   a. An anaesthesia gas machine with continuous regulated low pressure alarmed oxygen supply and appropriate inhalation agents capable of delivering positive airway pressure as necessary.
   b. An assortment of masks, airways, and endotracheal tubes suited to the patient's age.
   c. An assortment of laryngoscope blades suited to the patient's age with spare light bulbs and batteries immediately available.
   d. A suitable assortment of intravenous cannulas, administration sets and IV fluids.
   e. A suction apparatus with a suitable assortment of catheters, tonsil tip suctions and stomach tubes.
   f. Monitors to include ECG, BP, Temperature, Pulse Oxymeter, and Pre-cordial or Oesophageal Stethoscope as appropriate.
   g. Anaesthetic agents, supplies and equipment necessary for the planned anaesthetic management and anticipated contingencies.
   h. An emergency cart centrally located and suitably stocked as per policy.
6. No clinically flammable or explosive anaesthetic or preparation agents are to be used in Prime Surgical Centers.
7. No electrical equipment shall be used unless specifically designed for patient use. In all cases proper instructions on its use including connections to the power source and patient should be available with the unit.

ANAESTHESIA SERVICE RULES AND REGULATIONS		
Policy/Procedure Applies To	**Anaesthesiologists and Surgeons**	**Policy/Procedure No: 5** **Page: 4 of 4**
Effective Date: 11 April, 2013		

8. Temperature in the OR should be established to optimize the comfort of all personnel as well as the patient. In instances where patient hypothermia may be anticipated, provisions for supplementary heat or heat loss control should be made. (For example, warming pads or extra blankets).
9. In the event of general electrical power failure, a delay of as much as ten seconds may occur before the startup of the emergency generator system.

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

ANNEXURE

(Refer Customer Care and Billing Manual Policy and Procedure No. 5)

ESTIMATE FOR SURGERY

Date of Estimate :

Name of Patient :

Gender : Age :

Email Address :

Phone Number :

Patient Category :

Procedure Name :

Routine Length of Stay :

Name of surgeon :

Accommodation Category		
Approx. Estimate in Rs.		

Terms and Conditions:

Package Inclusions:

1. Surgeon & Anesthesiologist's fees
2. Hospital stay as defined above
3. OT Charges for standard procedure
4. Diagnostics upto 3 % of package amount post-surgery
5. Medicines and disposables upto 15% of package amount

Package Exclusions:

1. Specialty and Surgical Consultation Fees, if required.
2. Pre-Anaesthesia Investigations and Check-up required for the surgery
3. Pre-operative fitness evaluation by Physician
4. Diagnostics exceeding 3 % of package amount
5. Pharmacy exceeding 15% of package amount
6. Cost of Implants, Knee supports/braces to be paid at actuals
7. Charges for treatment of unforeseen complications, extended stay
8. Charges not paid by insurance.
9. Medicines advised upon discharge are not part of the package.
10. Medical Certificate and CD, if required, will be charged extra.

This is the approximate estimate for the surgery. Actual cost of treatment will be known at the time of discharge.

For spine surgeries requiring multi-level surgery, the package cost will rise by 10% for every additional level.

The packages do not cover the management of existing co-morbidities / ailments and conditions not related to the surgery. In case of high rise, the package cost will rise by 10%.

In bio hazard cases universal precautions set will be charged additionally.

The hospital does not accept any responsibility for verbal estimates.

Estimates are valid for 15 days only and the package rates are subject to revision without notice.

Payment Terms:

1. **Full amount at the time of admission to be paid** either in cash, by DD or credit / debit card.
2. The break - up of the package is not available.

Estimate given by:
Name:

Signature:
Date:

Estimate received by:
Name:
Relationship with Patient:
Signature:
Date:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

ESTIMATE FOR THE SURGERY / PROCEDURE		
Module Applies To	**Customer Care**	**Policy and Procedure No.: 5** **Page: 1 of 2**
Effective Date: 11 April, 2013		

ESTIMATE FOR THE SURGERY / PROCEDURE

PURPOSE

Once a patient is advised surgery or procedure by the Consultant, the patient should know the estimated cost of the surgery/procedure so that the patient can make arrangements for the funds or inform the insurance company for cashless facility or for reimbursement claim.

PROCEDURE

On advice of surgery/procedure by the Consultant:

1. Confirm the name of the surgery/procedure with the Consultant.
2. Confirm if any implants would be needed for the surgery and the approximate cost of the implant.
3. Confirm if the patient has insurance to determine whether the patient can avail cashless facility or whether he will be self-paying.
4. Depending on the above, determine the estimated cost of surgery/procedure.
5. Confirm this estimate with the Consultant and with the Administrative Head of the Center.
    a. If the Consultant and the Administrative Head are not in agreement with the estimate, this will be discussed by them and an estimate will be agreed upon.
    b. If both the Consultant and the Administrative Head have agreed with the estimate, document it in the Estimate for Surgery form.
    c. In the event an estimate is arrived at between the Reference Doctor and Marketing Head, the same will be conveyed to the Administrative Head/CEO and informed to customer care post approval. The customer care will stick to this estimate.
6. Fill in all the details in the Estimate for Surgery form (refer to Annexure to this policy). The customer care executive giving the estimate to the patient should put in his/her name, signature and date on which the Estimate was given to the patient.
7. At the same time maintain a record of the Estimate for future reference and analysis.
8. Give the Estimate to the patient to read and understand.
9. Explain the Estimate to the patient so that it is clearly understood by the patient and there is no ambiguity or misunderstanding later.
10. Take the patient's signature along with name and date on the estimate. If the estimate is given to the patient's relative mention the relationship between the two.
11. File the estimate for reference so that the patient is not able to deny knowledge of the estimated cost given to him/her before the surgery.
12. Confirm the approximate date of the surgery/procedure.
13. If a Pre-Anaesthesia Check-up is required for the surgery/procedure, refer to Customer Care and Billing Manual Policy and Procedure No. 6

ESTIMATE FOR THE SURGERY / PROCEDURE		
Module Applies To	**Customer Care**	**Policy and Procedure No.: 5** **Page: 2 of 2**
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14. If the patient is fit to go ahead with the surgery, confirm the date of the surgery/procedure in agreement with the Consultant and patient and Anaesthesiologist if required. Also refer to Customer Care and Billing Manual Policy and Procedure No. 7

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MANUAL

FALL PREVENTION		
Module Applies To	**All Nurses and Technicians**	**Module No: 5** **Page: 1 of 3**
Effective Date: 11 April, 2013		

FALL PREVENTION

COMPETENCY STATEMENT

New hire demonstrates understanding of Prime Surgical Centres Patient Safety and Fall Prevention Policies and Protocol.

LEARNING OUTCOME

1. Identify risk factors associated with fall & fall related injuries.
2. Apply the knowledge of fall risk assessment.
3. Devise a plan of care for a patient with fall risk.

INTRODUCTION

Preventing falls among patients in healthcare settings requires a multifaceted approach, and the recognition, evaluation and prevention of patient falls are significant challenges. The purpose of this program is to educate nurses regarding, assessment, recognition and prevention of patient fall and injuries.

DEFINITIONS

1. **FALL**

   An untoward event, which results in the patient or a body part of the patient coming to rest on the ground or other surface lower than the patient.

2. **NEAR FALL**

   A sudden loss of balance that does not result in a fall or other injury. This can include a person who slips, stumbles or trips but is able to regain control prior to falling.

3. **AN UNWITNESSED FALL**

   Occurs when a patient is found on the floor and neither the patient nor anyone else knows how he or she got there.

4. **FALL PREVENTION AND MANAGEMENT**

   A process intended to prompt clinical staff (Nurses, physicians, rehabilitation therapists and others) to consider a systematic Assessment for determining patients' risk for falling and to recommend intervention.

FALL PREVENTION		
Module Applies To	**All Nurses and Technicians**	**Module No: 5** **Page: 2 of 3**
Effective Date: 11 April, 2013		

STAFF NURSE'S RESPONSIBILITIES

1. Initiate admission assessment of the patient within the first hour of admission and complete the nursing assessment within 2 hours including the fall risk assessment.
2. Perform continued reassessment of risk during the patient's hospitalization, i.e., whenever there is a clinical status change, and routinely on each shift.
3. Initiate fall prevention measures.
4. Communicate fall risk to other healthcare providers and document same on the Nurse's Sheet Flow Sheet, and also verbally communicate during hand over.
5. Document assessment, reassessment and response to the fall prevention interventions.
6. Educate the patient and family on risk for falls and fall prevention precautions.
7. Ensure safe and therapeutic environment

Other healthcare providers shall be responsible for compliance with fall prevention interventions when caring for a patient at risk. They shall report their continued care and safety observation to the patient's assigned nurse. Safety concerns shall also be documented in the medical record as part of each discipline's ongoing reassessment and progress note.

PATIENTS WHO ARE AT RISK FOR FALL

The following criteria are utilized to determine the patient's risk for falls. If any of these are present, the patient should be considered "risk for falls."

1. Ages below 3, and above 65
2. History of syncope or seizures
3. Recent history of a fall
4. Psychological problem(s)
5. Neurological deficit
6. Drug or alcohol withdrawal
7. Newly commenced medication: sedative/anti-hypertensive
8. Use of Narcotics or diuretics
9. Post-operative procedure/condition – sedated or anesthetized
10. Unstable gait or limb weakness
11. Paralysis, Hemiplegia or Stroke
12. Use of walker, cane or crutches
13. Postural hypotension
14. Poor Vision
15. Bowel or bladder urgency/incontinence
16. Patient unable to understand or use Nurse Call system

FALL PREVENTION		
Module Applies To	**All Nurses and Technicians**	**Module No: 5** **Page: 3 of 3**
Effective Date: 11 April, 2013		

FALL PREVENTION GUIDELINES

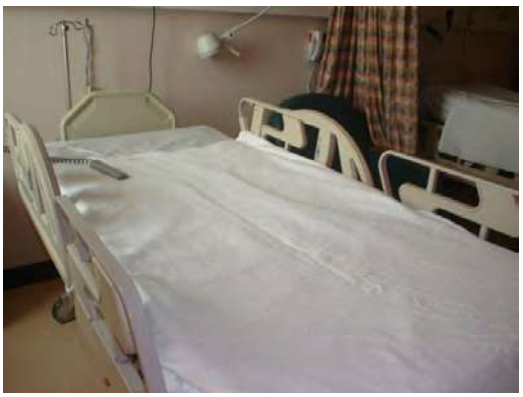
An admission and discharge planning assessment should be performed on all patients by an assigned Staff Nurse who uses the falls risk criteria on the Nursing Admission Assessment Record to determine the patient's degree of risk for falls. Reassessment of patient's risk for a fall should be completed and documented on every shift reassessment and whenever one of the criteria becomes applicable.

An individual patient, who upon admission is identified as being at high risk for falls, Fall Prevention Protocol to be initiated by the Nurse.

Fall prevention intervention should be in the patient's individualized plan of care. The problem should be updated to include the patient's potential for fall or injury. Fall prevention initiatives should be noted in the nursing documentation.

FALL PREVENTION MEASURES

The fall prevention measures should be as follows:



1. Three (3) side-rails raised when no procedure is being performed (at least the top of side rails must be up).
2. Bed in low position, unless a procedure is being performed.
3. Wheels of the bed should be locked, unless it is being moved.
4. Chair/wheel-chair bound patients should be secured with a seat belt. Wheel chair should be considered for transient patients with a weakness.
5. A functioning call-bell should be within easy reach of the patient, with prompt response from assigned nurse when the alarm sounds.

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Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOUSEKEEPING MANUAL

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

EXPOSURE CONTROL PLAN MANUAL

METHODS OF COMPLIANCE: WHEN TO USE PROTECTIVE GEAR		
Policy/Procedure Applies To	**All Staff involved with patient care**	**Policy/Procedure No: 5** **Page: 1 of 1**
Effective Date: 11 April, 2013		

METHODS OF COMPLIANCE: WHEN TO USE SPECIFIC PROTECTIVE GEAR

1. GLOVES
   a. Gloves will be worn when the employee has reasonable potential for the hands to have contact with blood (e.g. starting IVs), other potentially infectious materials, mucous membranes, non-intact skin, and when handling or touching contaminated items or surfaces.
   b. Single use (disposable) gloves will be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.
   c. Single use gloves will not be washed or decontaminated for re-use.
   d. Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, if they show signs of cracking, peeling, tearing, being punctured, or show other evidence of deterioration such that their integrity is compromised, they must be discarded.
2. MASKS, EYE PROTECTION, FACE SHIELDS

   Whenever splashes, spray, splatter, or droplets of blood or other potentially infectious materials may be generated, and eye, nose, or mouth contamination can be reasonably anticipated, masks, in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields will be worn.
3. GOWNS, APRONS, OTHER PROTECTIVE BODY CLOTHING

   Appropriate protective clothing such as gowns, aprons or similar outer garments will be worn in occupational exposure situations. The type of garment worn will depend on the nature of the task and degree of exposure anticipated.
4. SURGICAL CAPS OR SHOE COVERS

   In situations when gross contamination can be reasonably anticipated (i.e. orthopedic surgery), surgical caps or hoods and/or shoe covers or boots will be worn.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

PRIVACY OFFICER		
Policy/Procedure Applies To	**Administrative Head of the Center/Nursing Superintendent**	**Policy/Procedure No: 5** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PRIVACY OFFICER

POLICY

The Administrative Head of the Center will also be the Privacy Officer with regard to all patient privacy issues

HANDLING OF PATIENT PRIVACY ISSUES

POLICY

Any issues that may arise regarding patient privacy are to be addressed by the Privacy Officer of the organization. If the Privacy Officer is unavailable, the issue is to be managed by the Nursing Superintendent.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

SAFETY MANUAL

RADIATION SAFETY		
Policy/Procedure Applies To	**All X–Ray & OT staff**	**Policy/Procedure No: 5** **Page: 1 of 2**
Effective Date: 11 April, 2013		

RADIATION SAFETY

POLICY

Patients and personnel in the vicinity of radiographic examination areas shall be protected from unnecessary exposure to radiation.

PROCEDURE

1. Patient precautions
   a. A lead shield must be placed on the abdomen of all patients, especially those who are known to be pregnant.
   b. A lead shield shall be placed on patient gonads whenever possible.
   c. Whenever possible, a thyroid collar shall be placed on patients undergoing x-ray of the upper extremity, trunk, or head.
2. Personnel precautions

   jj
   In instances where patient safety is not compromised, non-scrubbed personnel may step outside the room during an x-ray.

   kkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkk
   Scrubbed personnel and non-scrubbed personnel who cannot leave the room must wear a lead apron and distance themselves as far as practical from the radiation source
3. Monitoring
   a. Dosimeters

      All personnel in the operating room who may be exposed to radiation will be provided with monitoring badges. Badges are to be worn on chest or waist and will be evaluated by approved testing agency on monthly basis.
   a. Documentation

      Any x-ray procedure performed in the operating room must be documented in the patient's record.

      Nursing interventions taken to protect patients from radiation exposure must be documented by the circulating nurse in the patient record.
4. Lead Aprons

   Lead aprons must be hung on apron racks. They are not to be folded. Only lead aprons that are intact and have been radiographically tested shall be used. Aprons should be radiographically tested every six months.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

SAFETY MANUAL

RADIATION SAFETY		
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PRIME SURGICAL CENTERS

Bech House, Damle Path, Pune.

NURSING MANUAL

ROLE AND RESPONSIBILITIES OF UNIT NURSES		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 5** **Page: 1 of 2**
Effective Date: 11 April, 2013		

ROLE AND RESPONSIBILITIES OF UNIT NURSES

1. The nurses will comply with all the nursing policies, procedures, philosophies, goals, and objectives of Prime Surgical Centers.
2. Implement and coordinate nursing interventions for pre and post operative patients.
3. Nurse shall have the following competencies:
   a. Implement aseptic technique
   b. Proper positioning techniques, pre and post operative care, IV procedures and medication administration.
   c. Recognize emergency situations and assist in corrective actions.
4. Maintain cheerful, poised, professional demeanor at all time.
5. Monitor and provide safe, neat and clean surgical environment.
6. Organize and prioritize assignments, duties and responsibilities.
7. Coordinate planned nursing care with other health care team members.
8. Proper preparation and planning of supplies, medications, equipment, and instruments used to attain optimal patient care and cost-efficiency.
9. Check all emergency equipments and crash cart daily in all shifts.
10. Able to accept and give direction.
11. Identify, analyze and implement effective problem-solving.
12. Utilize effective communication and interpersonal relationship skills.
13. Provide pre and post operative patient care and education for patient and family.
14. Delegate duties to nursing aides and House Keeping staff that are within their scope of practice and will supervise, monitor and educate such activities.
15. Maintenance of proper and appropriate nursing records.
16. Document pre and post operative care and patient family education in appropriate record. - Nurse's Note (Refer to Nursing Manual Policy and Procedure No. 28, 94 and 19 respectively)
17. Guidelines for documenting pre and post operative care.
    a. Pre-operative documentation should address, but is not restricted to:
       i. Pre admission patient family education.
       ii. History and physical assessments
       iii. Surgical, medical and anaesthetic history
       iv. Medication Management (Medication history, specific instructions for diabetes control, anti-coagulation therapy, hypertension control, etc.)
       v. Skin Condition
       vi. Preparation – skin, colour etc.

ROLE AND RESPONSIBILITIES OF UNIT NURSES		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 5** **Page: 2 of 2**
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vii. Site marking

viii. Informed consent

ix. Preparation / administration of medications (pre-operative medication and prophylactic anti-biotics)

x. Pain – acute and chronic

xi. Medication administered and patient response

For details Refer to Nursing Manual Policy and Procedure No. 28.

b. Post-Operative documentation should address, but is not restricted to:

i. Primary assessment of airway, breathing and circulation (ABC)

ii. Secondary full assessments, as appropriate for patient and procedure performed

iii. Medication administered and patient response.

iv. Intake and output for overall fluid balances (if needed).

v. On-going pain assessments.

vi. Post operative nausea and vomiting management.

vii. Post operative incision / puncture site management.

viii. Discharge planning.

ix. Postoperative patient / family teaching related to anaesthetic and invasive / non-invasive operative procedure performed.

For details Refer to Nursing Manual Policy and Procedure No. 92 and 107.

18. Display initiative, flexibility, and adaptability with a professional approach.

19. Show initiative for self-development and continuing education.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

SHARP INJURY AND LOG		
Policy/Procedure Applies To	**All Nursing Staff**	**Policy/Procedure No: 5** **Page: 1 of 3**
Effective Date: 11 April, 2013		

SHARP INJURY AND LOG

PURPOSE

1. The aim is to prevent/minimize the risk of exposure to blood borne viruses (BBV).
2. To promote awareness of each healthcare workers responsibility in the safe management of sharps and occupational exposure.
3. To provide a framework for the education of nursing staff in the safe handling of sharps.

DEFINITION

Sharp injuries are wounds caused by needle or any sharp object that accidentally puncture the skin. These injuries can occur at any time when staff use, dissemble or dispose of needle.

(Exposure of mucous membrane to blood and body fluids can occur during splashes or droplets of the fluids during some procedure.)

PROTOCOL

1. **IMMEDIATE ACTION**
   a. Do not Panic
   b. Skin sites and wounds that have been in contact with blood /body fluid or wound sustained at the time of sharp injury should be immediately washed with soap and plenty of water (do not scrub)
   c. Do not squeeze the site of injury. Allow free flowing of blood from the site. (do not suck the wound)
   d. Apply band-aid or water proof dressing.
   e. Rinse mucous membrane with warm water.
2. **REPORTING**
   a. Inform Operation Theatre Matron / Nursing Superintendent.
   b. Report immediately to physician /staff doctor on duty
   c. Complete incident reporting in the Sharp Injury Log Form (Refer Annexure to this policy)
   d. A register to be maintained by the Nursing Superintendent on this account for Sharp Injury data maintenance.
3. **POST EXPOSURE PROPHYLAXISIS**

   Evaluation of source and Nurse

   Initiate investigation as to the cause of the incident, risk assessment and management according to the policy of Prime Surgical Centers.
4. **FOLLOW UP OF THE NURSE**
   a. Regular follow up of Nurse is mandatory by serological investigations for HIV, HBsAg and HCV.
   b. Follow up at 6 weeks, 3 months and 6 months from the date of injury.

c. Follow up reports have to be informed to the Nursing Superintendent regularly which has to be recorded in the "Sharp Injury data maintenance" register.

5. **EVALUATING THE CIRCUMSTANCES SURROUNDING AN EXPOSURE INCIDENT**

The Nursing Superintendent will review the circumstances of all exposure incidents to determine:

a. Engineering controls in use at the time
b. Work practices followed
c. A description of the device being used (including type and brand)
d. Failure of controls
e. Personal Protective equipment (PPE) that was used at the time of the exposure
f. Incident (gloves, eye shields, etc.)
g. Location of the incident (OT, Procedure Room, Nursing Unit, OPD)
h. Procedure being performed when the incident occurred
i. Training of the Nursing staff.

PREVENTION

1. Proper knowledge of disposal of sharps and other biomedical waste.
2. Understand the risk involved in Sharp Injury.
3. Remember to use safety devices for personal protection.
4. Implementation of standard / universal precaution (stated below)
5. Ask for assistance if needed.
6. Importance of Hepatitis B Vaccination (0, 1,6mths) and booster after 5yrs.
7. Sharp box to be placed close to procedure area.
8. Avoid overfilling of the sharp container (to be sealed when 2/3 full).
9. Make use of injection trays.
10. Avoid recapping
11. Dispose of needle in to Sharp box after burning the needle.

STANDARD / UNIVERSAL PRECAUTIONS

1. **Body Substances**: Blood, Vaginal secretion, Semen, mucus, pus, fluids like CSF, amniotic, pleural, peritoneal, synovial fluids etc.
2. Wash the hands before and after all patient or specimen contact.
3. Handle the blood and body fluid of all patients as potentially infectious.
4. Wear gloves for potential contact with blood and body fluids.
5. Wear masks and protective eyewear for the procedures that are likely to generate droplets of blood or body fluid.

SHARP INJURY AND LOG		
Policy/Procedure Applies To	**All Nursing Staff**	**Policy/Procedure No: 5** **Page: 3 of 3**
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6. Wear Personal Protective Equipment (PPE) like gowns, gloves, mask and goggles during procedures that are likely to generate splashes of blood and body fluids.
7. Wear mask when in contact with patient having TB and other respiratory infections.
8. Place the burned needles and other sharps in Sharp Box. **Do not recap the needles**.
9. Handle all linen which is contaminated with blood and / or body fluids as infectious and dispose off appropriately as per Hospital Infection Control Manual Policy and Procedure No. 13 and 14
10. Use yellow coded bags for disposal of infectious waste.

SHARP INJURY LOG (Refer to Annexure to this policy)

The Prime Surgical Centers (Nursing Superintendent) will establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps for Nursing department. The information in the sharps injury log will be recorded and maintained in such manner as to protect the confidentiality of the injured staff. The sharps injury log will contain, at a minimum:

1. The type and brand of device involved in the incident,
2. The department or work area where the exposure incident occurred,
3. An explanation of how the incident occurred.

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ANNEXURE
(Refer to Hospital Infection Control Manual Policy and Procedure No. 5)

SHARP INJURIES LOG

A. Date of Incident:_____ Staff : ☐ Nurse ☐ OT Tech ☐ H K ☐ Other (Specify)

Name: _____

1. Type of Device Involved:
   a. IV Access Device
   b. Vacuum Tube Blood Collection System / phlebotomy device
   c. Needle / Syringe
   d. IV Medication Delivery System
   e. Lancet
   f. Surgical Scalpel
   g. Suture Needle
   h. Surgical Trocar
   i. Other Surgical Sharp

   Brand: _____ Safety Device ☐ or Conventional Device ☐
2. Did the device being used have engineered sharps injury protection?

   ☐ Yes ☐ No ☐ Do Not Know

   Was the protective mechanism activated?

   ☐ Yes – fully ☐ Yes – partially ☐ No

   Did the exposure incident occur?

   ☐ Before ☐ During ☐ After activation
3. Location of Incident

   ☐ Nursing Unit ☐ Operating Theatre
   ☐ OPD ☐ Procedure Room
   ☐ Treatment Room
   ☐ Other (Specify): _____
4. Explanation of how the incident occurred:

_____

_____

_____

B. First Aid Given: ☐ None ☐ Non-prescription Medication
☐ Tetanus Immunization ☐ Cleaning, Flushing, Soaking Wound

C. Medical Treatment Given: ☐ None ☐ HBV Vaccine
☐ HIV Prophylaxis ☐ Other: _____

Initiated By
(Name and Signature)
Date & Time:

Received By
(Name and Signature)
Date & Time:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

SURGICAL EMERGENCY MANAGEMENT – STANDARD OPERATING PROCEDURE		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 5** **Page: 1 of 2**
Effective Date: 01 April, 2014		

SURGICAL EMERGENCY MANAGEMENT – STANDARD OPERATING PROCEDURE

CONDITIONS

1. Bleeding more than 300 ml from surgical site.
   (Drains, Foleys catheter, Abdominal bleeding, Haematoma, Pain >8)
2. Loss of sensation (limb) and numbness
3. Loss of consciousness
4. Change of vital parameters
5. Urine output <50ml /hour

MANAGEMENT

1. Provide comfortable position
2. Check level of consciousness :
   a. if conscious:
      check the vitals
   b. if not conscious:
      i. activate code blue
      ii. attach monitor and bring crash cart
      iii. inform Resident Medical Officer (RMO)
3. Observe parameters
   a. Pulse: Tachycardia HR > 100b/m
      Inform Consultant/ Anaesthesiologist.
   b. Blood pressure:
      i. hypertension > 150 sys : inform RMO
      ii. hypotension < 90 sys : start IV fluids with ringer lactate (RL) and normal saline (NS)
   c. Respiration Rate (RR)
      i. >26 : inform RMO
      ii. <14 : start oxygen, inform RMO
   d. SPO2 < 85% : start 4 litres of oxygen
   e. Pain Score > 6
      i. Inform RMO
      ii. Start analgesics immediately and work up for the case.
      Analgesics : injection Tramadol 50mg. diluted in 100 ml normal saline (NS) followed by injection Ondansetron (Emset) over 30 min as per RMO order.
   f. Temperature > 102° F
      i. Cold sponge
      ii. Inform RMO
      iii. Give injection Paracetamol 1gm. IV

SURGICAL EMERGENCY MANAGEMENT – STANDARD OPERATING PROCEDURE		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 5** **Page: 2 of 2**
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4. Variations in vitals: Inform the Consultant and Anaesthesiologist immediately
   a. Monitor to be kept on the opposite side of IV pole
   b. Start IV, assess and provide inotropic support [injection Dopa, noradrenaline infusion as per RMO order for BP) and give oxygen support.
   c. If patient requires invasive or non-invasive ventilation assist RMO / Consultant to intubate patient and start ventilation.
   d. If transferring patient to another hospital arrange for cardiac ambulance from nearest hospitals.

      Poona hospital no.: 66096000

      Dinanath Mangeshkar hospital no: 40151000

      Sahyadri hospital no.: 25403000

      Ratna hospital no.: 25651037

      Joshi hospital no: 25673144
   e. Prior to shifting patient:
      i. Take ECG of the patient
      ii. Arrange PCV, if needed, from Jankalyan Blood Bank (Tel. no.: 24449527, 7350002460)
   f. Handle the patient safely and shift him/her to the ambulance. An Intensivist /Paramedic who accompany the ambulance should accompany the patient.

      If Intensivist /Paramedic is not available, then the RMO/Nursing Staff should accompany the patient to the transfer hospital and hand over the patient to the ICU / CCU staff.
   g. Hand over original reports to patients and relatives. Do not give Medical Records file to patient and relatives.
   h. The respective staff and RMO will fill in the Incident Report and the Cardiopulmonary Resuscitation (CPR) report form if CPR is given.

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ANNEXURE V
(Refer to Housekeeping Manual Policy and Procedure No. 1)

TWO-WHEELER PARKING

	Frequency				
AREA	**Daily**	**Weekly**	**Fortnightly**	**Mthly**	**Other**
Floor	X				
Walls		X			
Roofing			X		
Top of Roofing			X		

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

GOODS RECEIVED NOTE (GRN)		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 6** **Page: 1 of 2**
Effective Date: 11 April, 2013		

STEPS TO BE FOLLOWED FOR GOODS RECEIVED NOTE (GRN)

Sr. No.	Steps to be followed for GRN	Responsibility
1	Material received to stores with Invoice.	Supplier
2	Check the material physically as per Invoice.	Executive Facility
3	In case of Equipment unload the material upto the location/Department.	Supplier and Executive Facility
4	Check the Quality, Quantity, Rate, Tax, Discount if any as per Purchase Order.	Executive Facility
5	In case of technical approval contact and involve concern department.	User Department
6	Put a stamp of Goods Received and sign. On Supplier's Copy, Stores Copy.	Executive Facility
7	GRN is to be made as per Purchase Order in the system for quantity received.	Executive Facility
8	Take signature of center head on the Invoice. (pass for payment)	Executive Facility
9	Submit the bill to the Accounts Department for payment.	Executive Facility

GOODS RECEIVED NOTE (GRN)		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 6** **Page: 2 of 2**
Effective Date: 11 April, 2013		

FORMAT OF GOODS RECEIVED NOTE (GRN)

GOODS RECEIVED NOTE

PO. No. : **GRNPOCR0000002**

Supplier Name :

Phone No :

Fax No :

Mobile No :

Email Id :

Dear Sir ,

Please Supply the following material in accordance with Terms & Conditions stipulated herein & acknowledge.

Sr.No	Item Name	Rec. Qty	F Qty	Batch Code	MRP	Price	Conv.	VAT%	Amount
1									
2									
3									

Total Amount
Discount
Sch.Discount
Tax 4 %
Tax 12.5 %
Remark **Tax Amount**
Net Amount

Store Incharge **Prepared By**

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE VI
(Refer to Housekeeping Manual Policy and Procedure No. 1)

CUSTOMER CARE AND WAITING AREA

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
Glass Doors and Partitions	X			
Prime Surgical Centers Logo Sign Board	X			
Token Display Screen	X			
A/C baffles		X		
Chairs	X			
Tables	X			
Sofa Sets	X			
Work Table	X			
Personal Computers and Keyboards	X			
Telephones	X			
Printer	X			
Luminaries		X		
Electrical outlets, Switch plates	X			
Empty Waste Bins	X			
Boards	X			

PRIME SURGICAL CENTERS

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EXPOSURE CONTROL PLAN MANUAL

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Beck House, Damle Path, Pune.

SAFETY MANUAL

LASER SAFETY POLICY		
Policy/Procedure Applies To	**O.T. Technicians**	**Policy/Procedure No: 6** **Page: 1 of 1**
Effective Date: 11 April, 2013		

LASER SAFETY POLICY

POLICY

To ensure the optimum safety for patients and facility staff members, Prime Surgical Centers staff shall be made familiar with and follow all safety precautions in relation to any laser used by this facility. The Laser Safety Checklist shall be used for all laser surgical procedures as a guide for proper operation of the laser equipment.

PROCEDURE

1. The laser shall be operated ONLY under the direction of a physician trained in the operation and use of the surgical laser equipment.
2. Adjustment of the controls and performance of procedures not specified by the laser manufacturer shall NEVER be attempted.
3. NEVER look directly into the carbon dioxide or HeNe laser light source or scattered laser light from reflective surfaces, as severe eye damage could occur.
4. Except during actual treatment, the system must always be in STANDBY mode.
5. The laser equipment shall undergo regular calibration and testing to ensure proper function.
6. Protective eyewear shall be worn by all staff members who are directly involved in assisting or performing laser surgical procedures.

The Laser Safety Procedure Guide (refer Annexure to this policy) shall be followed for all laser surgical procedures.

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ANNEXURE
(Refer to Safety Manual Policy and Procedure No. 6)

LASER SAFETY PROCEDURE GUIDE

LUMENIS

VERSACUT TISSUE MORCELLATOR QUICK REFERENCE GUIDE

Read the entire VersaCut operator manual before attempting to operate the VersaCut Tissue Morcellator. These instructions are intended only as a supplemental guide to the operator manual.

PREOPERATIVE INSTRUCTIONS

1. Sterilize the hand piece, blade set, and endoscopic adapter, according to the instructions detailed in the Maintenance section of the VersaCut operator manual.

   NOTE

   Since blades and handpieces must be sterilized after use, purchase of a second handpiece and additional blades will eliminate waiting if surgeries are scheduled back to back. Additional sterile blade sets will also be useful if the active set seizes during surgery.
2. Verify that the VersaCut control unit power switch is in the O(off) position. If necessary, connect the main power cable to the control unit, ensuring that the correct voltage displays in the voltage window. Plug the main power cable into the wall socket.
3. Attach the outer blade to the VersaCut handpiece. Attach the inner blade to the handpiece.
4. Connect sterile aspiration tubing to the barbed connector at the proximal end of the inner blade. Attaché the tubing to the aspiration pump, as detailed in the Operation section of the VersaCut operator manual.
5. If used, connect the endoscope adapter to the outer blade.

INTRAOPERATIVE INSTRUCTIONS

1. Insert the handpiece power plug into the receptacle on the control unit.
2. Insert the footswitch power plug into the receptacle on the control unit.
3. Turn the control unit power switch to the I (on) position.
4. Set the morcellation rate.
5. Set the aspiration rate.

   WARNING

   This instrument should only be used under direct or endoscopic visualization.

   CAUTION

   This instrument is intended for use in a fluid environment. Do not activate morcellation while the blade set is in air. Doing so may jam and irreparably damage the blade set. If the blade set becomes jammed, discard and replace with a sterile blade set.
6. Position the blade tips in the center of the treatment site, then slowly depress the footswitch to activate aspiration. Morcellate the target tissue as it is suctioned into the blade tips.

   WARNING

   Any tissue in contact with the instrument’s blade tips when morcellation is activated will be morcellated. Ensure that only target tissue is in contact with the blade tips.

7. Continue until all target tissue is morcellated and aspirated out of patient.

   CAUTION

   Direct contact of the blade tips with metal instruments can damage the blade set. If contact occurs, stop using the instrument immediately, and examine the blade set carefully for evidence of cracks or fractures, if there is any doubt about the condition of the blade set, discard and replace with a sterile blade set.

POSTOPERATIVE INSTRUCTIONS

1. Turn the control unit power switch to the ⭘ (off) position.
2. Remove the blade set from the treatment site.
3. Disconnect the handpiece power plug from the control unit.
4. Disconnect the aspiration tubing from the inner blade and aspiration pump, then discard.
5. If used, remove the endoscope adapter from the outer blade.
6. Remove the outer blade from the handpiece.
7. Wipe the outer surface of the inner blade with a soft gauze cloth to ensure that it is clean of any tissue or debris.
8. Holding the barb connector, rotate the inner blade counterclockwise, and remove the blade from the handpiece.
9. Clean and sterilize the handpiece, blade set, and endoscope adapter, as instructed in the maintenance section of the VersaCut operator manual.

VERSAPULSE POWERSUITE QUICK REFERENCE GUIDE

Read and comprehend the entire VersaPulse PowerSuite operator manual and the appropriate delivery system instruction guide before attempting to operate the laser. These instructions are intended as a supplemental guide to the laser operator manual and delivery system instruction guide.

PREPARATION AND SYSTEM TURN-ON

1. Move the laser and all necessary equipment to the treatment room.
2. Turn off the main electrical service (wall circuit breaker).
3. Verify that the laser main power circuit breaker is in the off (down0 position.
4. Ensure that the laser components, including the footswitch, external door interlock plug, and remote control, if used, are properly connected to the laser.
5. Ensure that the delivery system is properly connected to the laser.
6. Post the “Laser in Use” warning sign outside the treatment room door.
7. Verify that all persons in the treatment room are wearing the appropriate laser safety eyewear.turn on the main electrical service (wall circuit breaker).
8. Place the laser main power circuit breaker in the on (up) position.
9. Insert the key into the key switch, and rotate the key to the “ || ” (start) position; hold for one full second, and release the key. Upon release, the spring-loaded key rotates to the “ | ” (on) position.

   A laser self-test and warm-up begin. The self-test and warm-up take approximately one minute. As internal tests are performed, self-test pass/fail messages display on the control screen. When the self-test is successfully completed, the default treatment settings display on both the control screen and remote control, and “Laser emission” displays on the control screen to alert the user that laser energy is available.
10. Verify the aiming beam integrity as instructed in the “Aiming Beam Verification” section of the laser operator manual.

    WARNING

    Verifying the aiming beam integrity is extremely important for the safe operation of your laser equipment. Do not use the laser or delivery system if the aiming beam is not visible. Operating the laser without the aiming beam may result in laser exposure to nontarget tissue and possible injury.

INTRAOPERATIVE INSTRUCTIONS

1. Set the treatment values for the desired wavelength, as instructed in the “Setting Treatment Values” section of the laser operator manual. Do not exceed the maximum energy or power settings for your delivery system, as specified in the instruction guide which accompanied that device.
2. If using a single-pedal footswitch with the Dual Wavelength laser, verify that the desired wavelength appears in the HO/ND display. If using a dual-pedal footswitch with the Dual Wavelength laser, verify that your foot is on the appropriate pedal for the desired wavelength.
3. Position the aiming beam on the target tissue.
4. Place the laser in ready mode.
5. Depress the footswitch to deliver the treatment beam. “Treat Ho” or “Treat Nd” displays on the Dual Wavelength control screen; “Treatment” displays on the Holmium control screen.
6. If surgery is interrupted, place the laser in standby mode to disable the footswitch.

POSTOPERATIVE INSTRUCTIONS

1. Place the laser in standby mode
2. Turn the laser key switch to the “ ⏻ ” (off) position. Remove the key to prevent unauthorized use of the laser.
3. Place the laser main power circuit breaker in the off (down) position.
4. If the laser is configured with a removable wall plug, turn off the main electrical service (wall circuit breaker), and remove the main power plug from the wall receptacle. Wrap the power cable around the cable wrap.
5. Remove the footswitch plug from the laser. Insert the footswitch cable into the footswitch housing, and place the footswitch on the footswitch storage mounts.
6. If the remote control was used, remove the remote control plug from the laser. Place the remote control in the storage area on top of the laser, above the fiber receptacle.
7. Disconnect the external door interlock, if used.
8. Disconnect the delivery system from the laser. If the delivery system is single-use, discard it; if multiple-use, prepare the delivery system for reuse as instructed in the appropriate delivery system instruction guide.
9. Clean the external surfaces of the laser, as needed.

HOLMIUM AVERAGE POWER TABLES

The following table shows the holmium average power, in watts, at various energy and rate settings.

NOTE

The maximum pulse rate setting varies according to laser model. See the "Specifications" section in the laser operator manual for the available pulse rate settings for your laser model.

Because the fill range of laser power is always available with the Nd:YAG wavelength, no corresponding Nd:YAG power table is necessary.

For 100 watt holmium systems operating in countries with an electric supply of 220 VAC / 50 Hz – refer to the Addendum in the operator's manual.

Energy (Joules) \ Pulse Rate (pulses/second)	5	6	8	10	15	20	25	30	35	40	45	50
0,2	1,0	1,2	1,6	2,0	3,0	4,0	5,0	6,0	7,0	8,0	9,0	10,0
0,3	1,5	1,8	2,4	3,0	4,5	6,0	7,5	9,0	10,5	12,0	13,5	15,0
0,4	2,0	2,4	3,2	4,0	6,0	8,0	10,0	12,0	14,0	16,0	18,0	20,0
0,5	2,5	3,0	4,0	5,0	7,5	10,0	12,5	15,0	17,5	20,0	22,5	25,0
0,6	3,0	3,6	4,8	6,0	9,0	12,0	15,0	18,0	21,0	24,0	27,0	30,0
0,8	4,0	4,8	6,4	8,0	12,0	16,0	20,0	24,0	28,0	32,0	36,0	40,0
1,0	5,0	6,0	8,0	10,0	15,0	20,0	25,0	30,0	35,0	40,0	45,0	50,0
1,2	6,0	7,2	9,6	12,0	18,0	24,0	30,0	36,0	42,0	48,0	54,0	60,0
1,4	7,0	8,4	11,2	14,0	21,0	28,0	35,0	42,0	49,0	56,0	63,0	70,0
1,5	7,5	9,0	12,0	15,0	22,5	30,0	37,5	45,0	52,5	60,0	67,5	75,0
1,6	8,0	9,6	12,8	16,0	24,0	32,0	40,0	48,0	56,0	64,0	72,0	80,0
1,8	9,0	10,8	14,4	18,0	27,0	36,0	45,0	54,0	63,0	72,0	81,0	90,0
2,0	10,0	12,0	16,0	20,0	30,0	40,0	50,0	60,0	70,0	80,0	90,0	100,0
2,2	11,0	13,2	17,6	22,0	33,0	44,0	55,0	66,0	77,0	88,0		
2,4	12,0	14,4	19,2	24,0	36,0	48,0	60,0	72,0	84,0	96,0		
2,5	12,5	15,0	20,0	25,0	37,5	50,0	62,5	75,0	87,5	100,0		
2,6	13,0	15,6	20,8	26,0	39,0	52,0	65,0	78,0				
2,7	13,5	16,2	21,6	27,0	40,5	54,0	67,5					
2,8	14,0	16,8	22,4	28,0	42,0	56,0	70,0					
3,0	15,0	18,0	24,0	30,0	45,0	60,0	75,0					
3,2	16,0	19,2	25,6	32,0	48,0	64,0	80,0					
3,5	17,5	21,0	28,0	35,0	52,5	70,0						

Holmium average power table — 100 watt systems

VERSACUT TISSUE MORCELLATOR ACCESSORIES AND REPLACEMENT PARTS

VersaCut Tissue Morcellator System Vacuum pump system for rapid endoscopic removal of tissue. Uses reusable, reciprocating blades. Activated with a foot pedal. 1. Works on all soft tissue regardless of composition. 2. Morcellates approximately 5 grams of tissue per minute. 3. Compatible with nephroscopes with ≥ 5mm working channel. Includes one control box, one handpiece, two blade sets, two pieces of sterile tubing, one sterilization tray, and one package each of 3 long cleaning brushes, 3 short cleaning brushes and 3 endoscope adapters.
VersaCut Control Box (with foot pedal) Allows precise adjustment of suction and morcellation speed.
VersaCut Handpiece (reusable) Ergonomically designed for right or left hand use.
VersaCut Blade Set (reusable) Inner and outer blades with limited reuse of approximately 2 to 8 times.
Sterile Tubing (single use, pack of 1) Designed for use with the control box and handpiece. Facilitates suction and retrieval of morcellated tissue for histology.
VersaCut Endoscope Adapter Kit (reusable, pack of 3) Snaps on blades to accommodate varying endoscope lengths.
VersaCut Steam Sterilization Tray Used for sterilizing handpiece and blade sets.
Long Cleaning Brushes (pack of 3) Ensures thorough removal of blade debris prior to sterilization.
Short Cleaning Brushes (pack of 3) Enables thorough removal of blade debris prior to sterilization.
Replacement Power Cable (230 V) Main power cable. Connects the VersaCut control box to the wall power. Hospital grade power plug required.
Replacement Power Cable (110 / 115 V) Main power cable. Connects the VersaCut control box to the wall power.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

MEDICAL EMERGENCY MANAGEMENT – STANDARD OPERATING PROCEDURE		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 6** **Page: 1 of 2**
Effective Date: 01 April, 2014		

MEDICAL EMERGENCY MANAGEMENT - STANDARD OPERATING PROCEDURE

CONDITIONS

1. Hypoglycemia / Hyperglycemia
2. Allergic reactions
3. Local anaesthesia toxicity
4. Acute asthmatic attack
5. Local anaesthetic reactions
6. Hypotension / Hypertension
7. Bradycardia / Tachycardia
8. Hypoxia
9. Acute coronary syndrome (ACS)
10. Seizure
11. Syncope (fainting)
12. Narcotic overdose
13. Drug toxicity
14. Unconsciousness
15. Fluids and electrolytes imbalance
16. Urinary retention

SIGNS AND SYMPTOMS

1. Itching, oedema, erythema of skin
2. Urticaria
3. Wheezing, bronchospasm, weak pulse, fall in BP.
4. Loss of consciousness
5. Tightness in chest
6. Cyanosis, Tachycardia
7. Light headedness, Dizziness
8. Changes in vision and speech
9. Confusion, Seizures, Tachypnoea, Bradycardia, Apnoea.
10. Palpitations, restlessness, chest pain
11. Uncontrolled muscle movement
12. Feeling of warmth, skin pale and moist
13. Pulse - Rapid initially then gets slow and weak
14. Cold extremities
15. Severe headache
16. Vomiting
17. Poly urea
18. Excessive thirst

MEDICAL EMERGENCY MANAGEMENT – STANDARD OPERATING PROCEDURE		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 6** **Page: 2 of 2**
Effective Date: 01 April, 2014		

MANAGEMENT

1. Provide comfortable position to the patient
2. Discontinue all sources of allergy causing substances
3. Call Consultant, Anaesthesiologist, Physician/Cardiologist
4. Check for all vital parameters
5. Administer oxygen
6. If severe respiratory depression, establish IV access
7. Assess and support airway, breathing and circulations (CPR if needed)
8. Follow Consultant order
9. If patient requires invasive or non-invasive ventilation assist RMO / Consultant to intubate patient and start ventilation.
10. If transferring patient to another hospital arrange for cardiac ambulance from nearest hospital

    Poona hospital no.: 66096000

    Dinanath Mangeshkar hospital no: 40151000

    Sahyadri hospital no.: 25403000

    Ratna hospital no.: 25651037

    Joshi hospital no: 25673144
11. Take ECG if the physician advices
12. Handle the patient safely and shift him/her to the ambulance. An Intensivist /Paramedic who accompany the ambulance should accompany the patient.

    If Intensivist /Paramedic is not available, then the RMO/Nursing Staff should accompany the patient to the transfer hospital and hand over the patient to the ICU / CCU staff.
13. Hand over original reports to patients and relatives. Do not give Medical Records file to patient and relatives.
14. The respective staff and RMO will fill in the Incident Report and the Cardiopulmonary Resuscitation (CPR) report form if CPR is given.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

EXPOSURE CONTROL PLAN MANUAL

METHODS OF COMPLIANCE: BLOOD OR OTHER BODY FLUID SPILLS		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 6** **Page: 1 of 1**
Effective Date: 11 April, 2013		

METHODS OF COMPLIANCE: BLOOD OR OTHER BODY FLUID SPILLS

PURPOSE

To appropriately contain and disinfect spills of blood or other body fluids.

POLICY

All members of the healthcare team will manage spills of blood or other body fluids according to facility procedure.

PROCEDURE

SPILL RESPONSE MATERIALS

The basic spill response materials will be available to respond to spills, as follows:

1. Utility gloves and medical examination gloves.
2. Face protection (eye wear and mask, or full face shield)
3. Plastic apron or other similar article
4. Shoe covers
5. Concentrated disinfectant (chlorine bleach)
6. A container for constituting and applying 10% bleach solution
7. A dust pan/brush, forceps, tongs or other mechanical device to pick up sharps or broken glass.
8. Package of paper towels or other suitable absorbent material
9. Biohazard bags for the collection of contaminated spill clean-up items

BLOOD SPILL CLEANING PROCEDURE

1. Minimize traffic in the spill area.
2. Don personal protective equipment, including suitable gloves, plastic apron, face shield or goggles and fluid repellent mask, and shoe covers.
3. Collect any sharp objects with forceps or other mechanical device and place in a sharps container. Do not use your hands for this purpose.
4. Contain and absorb the spill with paper towels or disinfectant-soaked paper towels and place in a biohazard bag.
5. Using disinfectant, clean the spill site of all visible blood.
6. Spray the spill site with 10% household bleach and allow air-drying for 15 minutes.
7. After the 15 minute contact time, wipe the area down with disinfectant-soaked paper towels. Discard all disposable materials used to decontaminate the spill into a biohazard bag. Decontaminate any reusable items with disinfectant.
8. Send contaminated cleaning articles for reprocessing or disposes.
9. Remove and dispose of personal protective equipment.
10. Wash your hands.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PRE ANAESTHESIA CARE		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 6** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PRE ANAESTHESIA CARE

PURPOSE

1. To provide guidelines for evaluating patients for anaesthesia care using consistent criteria.
2. To determine that all information and data is available and reviewed before that patient is pre-medicated in preparation for surgery.

POLICY

1. Patients who receive general, regional or monitored intravenous sedation will be evaluated by anaesthesia staff to determine their fitness for surgery and anaesthesia scheduled, formulate an anaesthesia plan and obtain the patient's consent to the plan.
2. The development of an appropriate plan of anaesthesia care is based upon:
   a. Reviewing the medical record
   b. Information to be reviewed includes:
      i. Previous surgical procedures and their anaesthesia course.
      ii. Allergies.
      iii. Present medications and dosage.
      iv. Family history of high fever or death associated with anaesthesia.
      v. Lung disease present including smoking history.
      vi. Heart disease or circulatory disease present.
      vii. Patient or family history of bleeding.
      viii. Contact lenses, dentures, LMP.
      ix. Surgical procedure to be performed, including expected and unexpected adverse events.
      x. Anaesthetic plan including expected outcome and possible complications associated with various medications and techniques
   c. Examination includes:
      i. Auscultation of heart.
      ii. Auscultation of lungs.
      iii. Pupil reaction is noted.
      iv. Other tests or examinations are performed as determined by the individual's medical history.
      v. Patients are classified according to the ASA classification system
   d. Obtaining and/or reviewing tests and consultations necessary to provide appropriate anaesthesia care.
   e. Determining the appropriate prescription of pre-operative medications as necessary to provide correct anaesthesia care.
3. The responsible physician (Anaesthesiologist) will verify that the pre-anaesthesia evaluation is properly performed and documented on the patient's medical record.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PRE ANAESTHESIA CARE		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 6** **Page: 1 of 1**
Effective Date: 11 April, 2013		

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      v. Patients are classified according to the ASA classification system
   d. Obtaining and/or reviewing tests and consultations necessary to provide appropriate anaesthesia care.
   e. Determining the appropriate prescription of pre-operative medications as necessary to provide correct anaesthesia care.
3. The responsible physician (Anaesthesiologist) will verify that the pre-anaesthesia evaluation is properly performed and documented on the patient's medical record.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

PRE-ANAESTHESIA / PRE-OPERATIVE CHECK-UP		
Module Applies To	**Customer Care/ OPD Nurse / Anaesthesiologist**	**Policy and Procedure No.: 6** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PRE-ANAESTHESIA / PRE-OPERATIVE CHECK-UP

PURPOSE

1. To ensure that the pre-anaesthesia / pre-operative check-up is done by the Anaesthesiologist before the surgery/procedure so that the fitness and the precautions to be taken before, during and after the surgery/procedure can be determined and documented at the appropriate place of medical records.
2. To ensure that after examination of patient by the Anaesthesiologist, he/she is informed in detail regarding the advantages of the type of anaesthesia to be used with its associated risks, a first step for bonding with the patient.

PROCEDURE

If a pre-anaesthesia / pre-operative check-up is required for the surgery/procedure, the Consultant or the Anaesthesiologist will fill-out the Pre-Anaesthesia / Pre-Operative Investigations slip (refer to Annexure to this policy) which will determine the investigations that need to be done by the patient.

Check if the patient has done any investigations.

1. If the patient needs to complete the Pre-Anaesthesia Check-up investigations, guide the patient according to the Investigations procedure stated in Customer Care and Billing Manual Policy and Procedure No 4.
2. If the patient has all the laboratory reports and films schedule an appointment with the Anaesthesiologist.
3. Validity of investigations done in the past will be for 3 months.

Prepare the IPD file of the patient. For the contents of the IPD file refer Nursing Manual Policy and Procedure No. 25.

Give the Medical History Declaration form to the patient so that the patient can fill in all the details and attach it to the IPD file.

Attach all the investigation reports along with imaging films to the IPD file.

Once the Anaesthesiologist has checked the patient, hand over the completed Pre-Operative Instructions sheet and the Anaesthesia Information sheet to the patient. Maintain a copy of the completed Pre-Operative Instructions sheet and attach it to patient's IPD file.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer Customer Care and Billing Manual Policy and Procedure No. 6)

PRE-ANAESTHESIA / PRE-OPERATIVE INVESTIGATIONS

Patient Name: _____

Consultant/Anaesthesiologist Name: _____

_____

A Pre-Anaesthesia Check-up is done before every surgery/procedure, for which the list of investigations required to be done by the patient before the check-up are:

1. ☐ Blood Sugar – Random ☐ Blood Sugar – Fasting + PP
2. ☐ BT & CT
3. ☐ Electrolytes
4. ☐ HBsAG
5. ☐ Hemogram (CBC)
6. ☐ HIV Combo
7. ☐ Prothrombin Time (PT INR)
8. ☐ Urea
9. ☐ Urine Routine ☐ Urine Microscopy
10. ☐ ECG
11. ☐ Chest X-Ray (PA)
12. Any Other Investigations: _____

_____

_____

We request the patient to complete the required investigations and submit all the reports and films before the date of the scheduled surgery.

Consultant/Anaesthesiologist Signature: _____

Date and Time: _____

PRIME SURGICAL CENTERS

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NURSING MANUAL

ROLE AND RESPONSIBILITIES OF THE SCRUB NURSE		
Policy/Procedure Applies To	**All O.T Nurses**	**Policy/Procedure No: 6** **Page: 1 of 3**
Effective Date: 11 April, 2013		

ROLE AND RESPONSIBILITIES OF THE SCRUB NURSE

DEFINITION

A Scrub Nurse works in the sterile area of surgery. He/she scrubs and dons sterile mask and clothing before entering Operating Room.

SCOPE

Operating Theater Nurse.

PURPOSE

1. The Scrub Nurse must have a thorough understanding of how to prepare and arrange instruments and supplies in the sterile field and how to assist the surgeon by providing the sterile instruments and supplies required.
2. Scrub Nurse maintains the sanitation of the operating area making sure everything stays sterile.

POLICY

1. Implement principles of aseptic technique.
2. Check physician preference card, identify and select instruments and equipment necessary for each surgical procedures.
3. Implement all the sterilization methods of choice and care required for special equipment and instruments necessary for surgical procedure.
4. Assist the surgeon competently during the operative procedure by anticipating his/ her needs and placing the necessary sterile equipment, supplies and sutures into his/her hands.
   a. By anticipating surgeon's needs, expedite the procedure, thereby minimizing the patient's exposure to infection and anxiety.
   b. To know various types of sutures and needles and where they are to be used.
   c. To know various types of special equipment for surgery.
   d. Assists in the sterile gowning and gloving of the surgeon and his or her assistant.
5. Is responsible for the maintenance of an orderly surgical field. He or she must keep the instrument table neat so that supplies can be handed quickly and efficiently.
6. Prevents injury to the patient by removing heavy or sharp instruments from the operative site as soon as the surgeon has finished using them.
7. Prevents contamination of the surgical field by the strict practice of aseptic technique.
8. Prevents the possible contamination of team members by blood-borne pathogens by following Universal Precautions / standard precaution set by the Prime Surgical Centers Hospital Infection Control Manual Policy and Procedure.
9. Is constantly alert to any intra operative dangers to the patient.

ROLE AND RESPONSIBILITIES OF THE SCRUB NURSE		
Policy/Procedure Applies To	**All O.T Nurses**	**Policy/Procedure No: 6** **Page: 2 of 3**
Effective Date: 11 April, 2013		

10. Takes part in sponge, needle, and instrument counts, as needed. All of these items must be accounted for during the procedure. Counts the items before, during, and after surgery to ensure that they are not left in the wound. The count is done in an orderly way and is performed using accepted technique.
11. Accepts and properly identifies any medications or solutions and does so in a prescribed manner.
12. Properly identifies and preserves specimens received during surgery. The technician is responsible for maintaining the specimens in a prescribed manner so that the material can be subsequently examined by the pathologist.
13. At the end of the procedure, assembles all instruments and supplies and prepares them for decontamination and resterilization and assists in the safe clean-up of the operating suite following Universal Precautions / Standard Precaution and policy on Prime Surgical Centers Hospital Infection Control Manual Policy and Procedure.
14. Recognize emergency situations and institute established procedure for the specific situation.

ROLE AND RESPONSIBILITIES OF THE SCRUB NURSE

1. Receive the assignment and ask questions about any operation that is unfamiliar to him/her.
   a. Know procedure, check physician's preference card and other written procedures.
   b. Obtain help if needed.
2. Prepare the room for surgery.
   a. Go to the room assigned and assist the circulating nurse in checking equipment.
   b. Assist with the initial cleaning of the room.
   c. Have the correct setup in the assigned room.
   d. Know the time the case is scheduled and be ready.
   e. Open gown and gloves before scrubbing.
   f. Scrub according to procedure and don gown and gloves.
   g. Begin setting up case scheduled. Check for proper instruments, prepare sutures, and check all equipment.
   h. Prepare and test special equipment.
   i. Drape microscope, if drape is requested by surgeon, as applicable.
3. While the patient is being prepared by the circulating nurse:
   a. Complete setting up
   b. Gown and glove the surgeon(s).
4. After the patient is pronounced ready for surgery by the Anaesthesiologist, prepare the patient for surgery:
   a. Assist the surgeon with draping
   b. Move Mayo stand and instrument tables into place.

c. Hand suction and cautery ends to circulator to attach when necessary.

d. Confirm medication and expiration date with circulator before drawing up into syringe; label all medications on sterile field.

5. During the surgery:

   a. Anticipate the surgeon's needs and provide the necessary equipment, sutures and supplies throughout the procedure. When handling instruments, do so in a firm manner so that they can readily be grasped by the surgeon in position for use.

   b. Guard the sterility of the instruments and the operating field and try to prevent sterile drapes from becoming wet.

   c. Assist the surgeon by tissue retraction, suture cutting, fluid evacuation or sponging the wound when needed

   d. Avoid tension-creating situations. Remember that much criticism is due to the tension and strain. Do not answer back or try to make excuses or explanations during the case.

6. While the surgical wound is being closed:

   a. Perform counts as required according to policy.

   b. Have supplies ready for the dressing before they are needed. A wet and dry sponge is on your Mayo for use before dressing is applied.

7. At the completion of the surgical case:

   a. Assist the surgeon with the dressing.

   b. Check drapes for instruments and return them to dirty table.

   c. Remove dirty drapes; place in plastic bag.

   d. Remove knife blades and discard in sharp containers.

   e. Open soiled instruments and separate from any instruments not used. Irrigate suction or cannulas. Take to soiled clean-up and prepare for re-sterilization.

   f. Assist with clean-up procedure according to work load.

   g. Return clean supplies, surgeon's preference cards, etc. (special supplies, medications, and sutures) to their proper place.

   h. Assist circulating nurse to transfer patient to stretcher as necessary.

   i. Assist with room changeover and opening setup for next case.

8. At the end of the procedure assemble all equipments:

   a. Assist in putting away unused supplies

   b. Restock room and prepare it for the next day.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

SANITARY ENVIRONMENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 6** **Page: 1 of 1**
Effective Date: 11 April, 2013		

SANITARY ENVIRONMENT

PURPOSE

To maintain a clean sanitary and sterile environment in the Operating Theater and Nursing Units.

POLICY:

1. The center will maintain air flow patterns required to assure sanitary conditions in all sterile areas.
   a. Air flow in Operating Theaters will be positive.
   b. Regular maintenance of air handling system in the center will be provided
   c. All filters will be changed at manufactures' recommended intervals.
2. All surfaces will be cleaned and disinfected regularly per cleaning protocols (Refer to Housekeeping Manual Policy and Procedure No. 3 and 4).
3. All food storage areas will be properly maintained for cleanliness.
4. All regulated and non-regulated waste will be disposed of in a safe manner and in accordance with laid down policy (Refer to Hospital Infection Control Manual Policy and Procedure No. 29).
5. The center will maintain a pest control contract with licensed pest control provider.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

STAFF REQUIREMENTS		
Policy/Procedure Applies To	**Anaesthesiologist / Resident Medical Officer / Nursing Superintendent**	**Policy/Procedure No: 6** **Page: 1 of 1**
Effective Date: 11 April, 2013		

STAFF REQUIREMENTS

POLICY

1. Medical Staff
   a. Anaesthesiologist will be available at the facility in time to adequately evaluate patients to have standby Anaesthesia before surgery.
   b. All members of the medical staff must agree to abide by the policies of the Center.
   c. All Anaesthesia will be administered by the Anaesthesiologist while local anaesthesia may be administered by the attending Consultant.
   d. An Anaesthesiologist shall remain in the Center during anesthesia and post-anesthesia recovery until all patients are alert. Thereafter, care will be taken by a Resident Medical Officer round the Clock.
2. Nursing and Resident Medical Officer
   a. At least one (1) Staff Nurse / Resident Medical Officer shall always be in the Nursing Unit round the Clock.
   b. Sufficient qualified Staff Nurses / Resident Medical Officers shall be available to provide quality nursing care to each patient from admission through discharge.
   c. A Staff Nurse / Resident Medical Officer shall always be free to respond to any emergency whenever there is a patient in the Center.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

EMPLOYEE IDENTIFICATION		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 7** **Page: 1 of 1**
Effective Date: 11 April, 2013		

EMPLOYEE IDENTIFICATION

POLICY

All Prime Surgical Centers employees will, during duty hours, wear name tags with their departments/designations as a means of public identification.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

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GENERAL MANUAL

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EXPOSURE CONTROL PLAN MANUAL

METHODS OF COMPLIANCE: HOUSEKEEPING PRACTICES		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 7** **Page: 1 of 1**
Effective Date: 11 April, 2013		

METHODS OF COMPLIANCE: HOUSEKEEPING PRACTICES

The workplace will be maintained in a clean and sanitary condition. The following practices will be followed:

1. Establish and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.
2. Clean and decontaminate all equipment and environmental and working surfaces after contact with blood or other potentially infectious materials.
3. Decontaminate all contaminated work surfaces with an appropriate disinfectant after completion of procedures.
4. Decontaminate surfaces as soon as feasible when overt contamination has occurred or after any blood spill or other spill of potentially infectious materials.
5. Decontaminate at the end of the work shift if the surface may have become contaminated since the last cleaning.
6. Remove and replace protective coverings such as plastic wrap or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, as soon as feasible when they become overtly contaminated or at the end of the work shift if they may have become contaminated since the last cleaning.
7. Inspect and decontaminate on a regularly scheduled basis all bins, pails, cans, and similar receptacles intended for reuse with a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials. If visible contamination has occurred, clean and decontaminate immediately or as soon as feasible.
8. Pick up and clean broken glassware which may be contaminated with a mechanical device (i.e., brush and dust pan), not directly with the hands.
9. Do not store or process reusable sharps that are contaminated with blood or other infectious materials in a manner that requires employees to reach by hand into containers where the sharps have been placed.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

PATIENT FAMILY EDUCATION AND DISCHARGE PLANNING		
Module Applies To	**All Nurses and Technicians**	**Module No: 7** **Page: 1 of 7**
Effective Date: 11 April, 2013		

PATIENT FAMILY EDUCATION AND DISCHARGE PLANNING

DEFINITIONS

Patient and Family Education: The process of influencing patient behavior and producing the changes in knowledge, attitudes and skills necessary to maintain or improve health.

Continuity of Care: The coordinate of treatment, care and services received by a patient over time and across multiple healthcare providers.

GOALS OF A PATIENT/FAMILY EDUCATION PROGRAM

1. Reduce Patient/family's anxiety
2. Increase patient Participation in health decisions
3. Provide patient with Current and accurate information and hospital services.
4. To prepare patient /family knowledge services provided and cost related to these services
5. Prepare patients diagnostic and invasive procedures

PATIENT FAMILY EDUCATION PROCESS

There are five steps in the education process:

1. Assessment
2. Planning
3. Implementation
4. Evaluation
5. Documentation

ASSESSMENT

The health care provider should assess:

1. Patient /family or significant others readiness prior to education to be provided
2. Learning needs ,abilities ,willingness and readiness, motivation and morale
3. Beliefs and values , including culture and religion
4. Language ,literacy and /or education level and learning preferences
5. Physical , cognitive and emotional abilities and limitations , including vision and hearing deficits
6. Financial implications of care choices and decisions

PLANNING

1. Develop individualized teaching plan
2. Formulate learning outcomes (results)
3. Organize teaching content (areas for Health Education)
4. Determine teaching priorities to organize teaching time
5. Choose teaching method (one-to-one or group teaching) and
6. Tools (pamphlets, handouts) Area for health education

IMPLEMENTATION

Education should be provided in manner that:

1. Facilitates understandable and simple plan
2. Encourages participation in decision making
3. Increases patient potential to follow the therapeutic health care options
4. Maximizes care skills
5. Increase coping ability
6. Enhances the understanding of their responsibility in continuing

Tips in Implementation:

1. Choosing an Appropriate Teaching Method: Choose the method that is appropriate for the content and for the learning style E.g.: (One-to-one or group teaching)
2. Teaching techniques as:
   a. Lecture, discussion
   b. Demonstration, practice and return demonstration
   c. Role-Play
3. Teaching Tools:
   a. Printed materials e.g., leaflets, pamphlets, posters and flip charts
   b. Audiocassettes
   c. TV programs
   d. Anatomical models

EVALUATION

1. Determine patient's learning progress during and after teaching
2. Compare results of evaluation with learning outcomes
3. Use good and right judgment
4. Identify barriers that have prevented learning from occurring
5. Measurement of the extent to which the patient has met the learning objectives
6. Indication of any need to clarify, correct, or review information
7. Notation of objectives that are not clear
8. Documentation of shortcomings in the process, (specifically ill content, format, activities, and media)
9. Identification of barriers that have prevented learning from occurring

Evaluation method/tools include:

1. Return demonstration
2. Oral and written tests
3. Interview
4. Checklists
5. Anecdotal notes
6. Physiological measurements

DOCUMENTATION

On the "Patient/Family Teaching Record" document:

1. Topics taught should be documented using keys and/or codes provided in the education record
2. Date and time of teaching
3. Learning needs, procedure, topic/disease
4. Learner
5. Method
6. Barriers to learning
7. Outcome code
8. Date teaching completed
9. Signature/Title
10. Remarks if any Comments

BARRIERS TO PATIENT/FAMILY EDUCATION INCLUDE

1. Emotional barriers and motivations
2. Religious and cultural differences
3. Educational level and individual learning styles
4. Language variations
5. Degree of illness

6. Financial constraints and implications of care choices
7. Willingness to learn
8. Physical and cognitive limitations, e.g, weakness, pain, disorientation; IQ and learning difficulties
9. Preferences and readiness to learn

MEASURES TO OVERCOME BARRIERS INCLUDE

1. For lack of time
   a. Teach while giving care
   b. Explain one part at time
   c. Allow patient to learn and practice in session
2. For an unwilling learner
   a. Inform physician
   b. Try later with a new approach
   c. Arrange for required teaching on discharge
   d. Work towards compliance
   e. Getting patient's reaction to teaching plan
   f. Limit number of tasks you expect of a patient at a give time
   g. Encourage active participation
   h. Allow more time for practice
   i. Consider rewards

EFFECTIVE WAYS OF PATIENT EDUCATION INCLUDE

a. Get and Keep your patients attention
b. Stick to the basic
c. Make the most of your time
d. Reinforcement is therapy
e. Testing your patients understanding

DISCHARGE PLANNING PROCESS

DEFINITIONS

Discharge: The point at which a patient leaves the hospital and either returns home or is transferred to another facility such as one for rehabilitation or to a nursing home care.

(Discharge involves the medical instructions that the patient will need to fully recover)

Discharge Planning: An interdisciplinary process involving patient, significant other/care giver, physicians, nurses, case managers, social workers, and other healthcare providers as necessary. It starts on admission and considers the patient's needs after the hospital stay, which may include a discharge risk assessment to identify those patients for who discharge planning is more critical.

Continuity of Care: The coordination of treatment, care and services received by a patient over time and across multiple healths care providers

Follow-Up: A systematic process of obtaining accurate information on a patient's health, vital status,

and progression of disease

DISCHARGE PLANNING PROCEDURE

1. During the initial nursing assessment, the anticipated needs for discharge should be assessed
2. Discharge risk assessment be completed within 24 hours of admission to the inpatient unit
3. Discharge needs should be identified
4. Discharge plans developed collaboratively with the patient and/or family representative, legal or surrogate guardian as appropriate to the patient and his/her needs, and with the physician and other healthcare providers
5. The discharge need and discharge plan should be documented on the Plan of Care and updated according to re-assessment information and patient's changing condition
6. The Nursing Superintendent should keep the health care team, including the patient and family representative, legal or surrogate guardian and/or significant other, informed of the discharge planning and progression
7. The need for support services and/or continuing medical services should be considered as part of the discharge process
8. The type of support services needed and the availability of such services should be considered Home Care and Health Center services
9. Readiness for discharge should be evaluated by the multidisciplinary team in collaboration with the patient and his/her family representative
10. The physician should write the anticipated Discharge order preferably 24 hours prior to the planned discharge. In short stay cases it must be written at least 2 hours before discharge.

DISCHARGE INSTRUCTIONS

1. The multidisciplinary team should write the discharge instructions and provide the patient and/or family representative with a verbal explanation and a written copy of the discharge instruction
2. Discharge instructions should be provided in an understandable manner and must be appropriate to the patient's condition
3. Discharge instructions should include how, when, where, and what to do in case of Emergency
4. The patient and/or family representative could obtain urgent care, treatment and services, and the need for any follow-up care
5. A copy of the discharge instructions is placed in the medical records

DISCHARGE SUMMARY

Should be prepared by a qualified staff and should include the following:

1. Reason for admission
2. Significant physical and other findings
3. Significant diagnosis and co-modalities
4. Diagnosis and therapeutic procedures performed
5. Significant medication and other treatments

6. Patient's condition at time of discharge
7. Listing of all discharge medication to be taken at home including herbals and over the counter drugs.
8. Any follow-up instruction or appointment date and times
9. The discharge summary should be dated and stamped with Physician identification
10. The patient or family representative should sign on the Discharge Summary as evidence of receipt
11. Patients who require outpatient follow-up should be given an appointment card with all details clearly written on it
12. The original of the Discharge instructions should be given to the patient and a copy kept in the patient's medical record

DISCHARGE DOCUMENTATION

a. It should reflect discharge planning and progress from admission to discharge
b. It reflect involvement of all persons participate in process
c. It should utilize a common source document
d. It should show that information has been provided
e. Activities are documented as they occur and summarized
f. It reflect inter disciplinary and interagency referral, which state the date and source of referral, action take and initiative plan for referral
g. Documentation should reflect the effectiveness of discharge planning

PRIME SURGICAL CENTERS

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NURSING EDUCATION AND TRAINING MODULES

PATIENT FAMILY EDUCATION AND DISCHARGE PLANNING		
Module Applies To	**All Nurses and Technicians**	**Module No: 7** **Page: 7 of 7**
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ANAESTHESIA MANUAL

PRE SEDATION CARE		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 7** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PRE SEDATION CARE

PURPOSE

1. To provide guidelines for evaluating patients for conscious sedation using consistent criteria.
2. To determine that all information is available and reviewed before the patient is sedated in preparation for the procedure.

POLICY

1. Patients who receive conscious sedation will be evaluated to determine their fitness for the scheduled procedure in the outpatient setting.
2. The development of an appropriate plan of conscious sedation is based upon:
   a. Reviewing the medical record
   b. Interviewing and examining the patient to
      i. Discuss the medical history, previous sedation experiences and drug therapy.\
      ii. Assess those aspects of the physical condition that might affect decisions regarding perioperative risk and management.
   c. Obtaining and/or reviewing tests and consultations necessary to the conduct of sedation.
   d. Determining the appropriate prescription of preoperative medications as necessary to the conduct of sedation.
3. The attending Anaesthesiologist will verify that the pre-sedation evaluation is properly performed and documented on the patient's medical record.

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ANAESTHESIA MANUAL

PRE SEDATION CARE		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 7** **Page: 1 of 1**
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PRIME SURGICAL CENTERS

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NURSING MANUAL II

PROTOCOL FOR RECEIVING PATIENTS FROM THE OPERATION THEATER		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 7** **Page: 1 of 1**
Effective Date: 01 April, 2014		

PROTOCOL FOR RECEIVING PATIENTS FROM THE OPERATION THEATER

Check rooms before nurse goes to OT to receive patients from the OT

1. Oxygen mask ready for administering oxygen.
2. Monitor (Cardiac Monitor B-20) ready to attach to patient, on standby.
3. Alarms adjusted not silenced.
4. Bed locked.
5. IV stands, Kidney tray, Gauze pieces ready
6. Trolley for shifting must have an oxygen cylinder and mask ready for use (cylinder open and checked for O2)
7. Pulse-oximeter to be attached and monitor the patient while shifting. Administer oxygen at 4 litres if oxygen saturation falls below 94%.

Once patient reaches the room

1. Patient's relatives to be requested to wait outside.
2. Room door to be closed
3. Lock the trolley and check that the bed is locked and shift the patient
4. Attach the monitors and check vitals are stable. Assess the patient.
5. Check post-op orders with the Anaesthesiologist and implement
6. Call the patient's relative in the room.
7. Give necessary post-op instructions to patient and relative.
8. Mandatory 15 min. vitals record to be maintained alternatively by Resident Medical Officer (RMO) and nurses. This ensures that the patient is seen by RMO/nurse every 15 min.
9. Inform the Anaesthesiologist and Consultant immediately if any change in assessments/vitals.
10. Inform status to the Anaesthesiologist and Consultant at 3 hours from receiving patient.

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PRIME SURGICAL CENTERS

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PURCHASE AND MAINTENANCE MANUAL

PURCHASE AND STORES STATIONERY FORMATS		
Policy/Procedure Applies To	**Purchase and Stores Department**	**Policy/Procedure No: 7** **Page: 1 of 5**
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LINEN REGISTER

Sr. No.	Code No.	Item Description	O.P.D.	O.T.	1st Floor Deluxe Ward	2nd Floor Comfort Ward	Radiology	TOTAL
1		Apron White						
2		Bath Towel						
3		Bed Sheet Cream Colour						
4		Bed Sheet White Colour						
5		Big Sheet Green						
6		Blanket						
7		Cap						
8		Draw Sheet White Colour						
9		Gown						
10		Hand Napkin						
11		Mask						
12		Medium Sheet Green						
13		O.T. Shirt						
14		O.T. Trouser						
15		Patient Shirt						
16		Patient Trouser						
17		Pillow Cover Cream Colour						
18		Pillow Cover White Colour						
19		Pillow Inner Cover						
20		Small Sheet Green						
21		Surgeon Shirt						
22		Surgeon Trouser						

LINEN BOOK

Prime Surgical Damle Path, LLP					
Beck House, Damle Path,					
Off Law College Road,					
Pune 411004.					
Linen Book					
Department :					
Date :					
Sr.No.	**Code No.**	**Item Description**	**Qty. Given for Washing**	**Qty. Received after Washing**	**Balance Qty.**
1		Apron White			
2		Bath Towel			
3		Bed Sheet Cream Colour			
4		Bed Sheet White Colour			
5		Big Sheet Green			
6		Blanket			
7		Cap			
8		Draw Sheet White Colour			
9		Gown			
10		Hand Napkin			
11		Mask			
12		Medium Sheet Green			
13		O.T. Shirt			
14		O.T. Trouser			
15		Patient Shirt			
16		Patient Trouser			
17		Pillow Cover Cream Colour			
18		Pillow Cover White Colour			
19		Pillow Inner Cover			
20		Small Sheet Green			
21		Surgeon Shirt			
22		Surgeon Trouser			
(Linen Issued By)			(Linen Received By)		

LINEN GATE PASS

Prime Surgical Damle Path, LLP

Beck House, Damle Path,
Off Law College Road,
Pune - 411004.

Linen Gate Pass

Date :
Time :

Please allow M/s. ----------
to pass out with dirty linen for washing and return back.

Total linen - Nos.

(Authorized by) (Received by)

PURCHASE AND STORES STATIONERY FORMATS		
Policy/Procedure Applies To	**Purchase and Stores Department**	**Policy/Procedure No: 7** **Page: 4 of 5**
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RETURNABLE / NON-RETURNABLE

Prime Surgical Damle Path, LLP

Beck House, Damle Path,
Off Law College Road,
Pune - 411004.

Returnable / Non-Returnable Gate Pass

Date :
Time :

Please allow Mr. ----------of ---------- to pass out with following material.
Contact No.

SR.NO.	ITEM DESCRIPTION	QUANTITY ISSUED	UOM	REMARKS
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

(Prepared By) (Authorized By) (Received By)

PRIME SURGICAL CENTERS

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PURCHASE AND MAINTENANCE MANUAL

PURCHASE AND STORES STATIONERY FORMATS		
Policy/Procedure Applies To	**Purchase and Stores Department**	**Policy/Procedure No: 7** **Page: 5 of 5**
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PURCHASE REQUISITION SLIP

Prime Surgical Damle Path, LLP			
Back House, Damle Path, Off Law College Road,			
Pune 411004.			
Purchase Requisition Slip			
Name Of Indentor :			Purchase Requisition Slip No.:
Department :			Date :
Sr.No.	**Item Description**	**Quantity**	**Remark**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Justification for Purchase :-

Indented By **Sanctioned / Not Sanctioned** **Facility Executive**

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Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

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CUSTOMER CARE AND BILLING MANUAL

SCHEDULING OF SURGERY / PROCEDURE		
Module Applies To	**Customer Care**	**Policy and Procedure No.: 7** **Page: 1 of 1**
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SCHEDULING OF SURGERY / PROCEDURE

A surgery/procedure is scheduled after taking into consideration:

1. Surgeon's availability
2. Anaesthesiologist availability
3. Availability of Operating Room
4. Availability of OT equipment
5. Availability of OT staff and Nursing staff
6. Bed availability
7. Completion of required investigations and availability of investigation reports/films.
8. Completion of Pre-Anaesthesia Check-up of the patient by the Anaesthesiologist, if required
9. Availability of implants/medication, if required for the surgery
10. Patient's fitness for surgery

If the patient is fit for surgery and if all the above conditions are met, schedule the surgery/procedure on the date as decided by the Surgeon and patient. Book the OT and inform all individuals/departments concerned. Also refer to Customer Care and Billing Manual Policy and Procedure No. 8

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)		
Policy/Procedure Applies To	**All Nurses & Staff involved in Surgical Care**	**Policy/Procedure No: 7** **Page: 1 of 6**
Effective Date: 11 April, 2013		

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

(GOWN, MASK, GLOVES, GOGGLES AND FACE SHIELD)

PURPOSE

To prevent contamination and to provide guidelines on use of barriers to prevent the spread of infectious materials.

POLICY

Nursing personnel shall use the Standard and Transmission Base Precautions for the care of all individuals. All nursing staff shall follow the guidelines for gowning, masking, and gloving from the Centers for Disease Control (CDC). Gowns and masks shall be removed and replaced if contamination occurs. Staff is required to wear masks to protect mucus membranes of the mouth and nose, and gowns to protect soiling of clothing during procedures and individual care activities that are likely to pose exposure to body and blood fluids.

PROCEDURE

1. Sequence for donning Personal Protective Equipment
   a. Gown first
   b. Mask
   c. Goggles or face shield
   d. Gloves over the gown cuffs

   Combination of PPE will affect sequence- be practical.
2. Sequence for removing Personal Protective Equipment
   a. Gloves
   b. Face shield or goggles
   c. Gown
   d. Mask

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)		
Policy/Procedure Applies To	**All Nurses & Staff involved in Surgical Care**	**Policy/Procedure No: 7** **Page: 2 of 6**
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GOWNING

ACTION	RATIONALE
1. Select the right size of gown for you	
2. Put gown on with opening at back, slipping one arm at a time into sleeves.	Touch only the inside of the gown.
3. Overlap gown at back to completely cover clothing.	
4. Secure the gown at the neck and waist by fastening the ties.	Remove and replace gown if contamination occurs.

REMOVING GOWN

ACTION	RATIONALE
1. Wash hands. Refer to Hospital Infection Control Manual Policy and Procedure No. 4	To avoid transfer of microorganism to other individuals or the environment.
2. Unfasten tie at neck first then at waist.	The neck is considered clean and should be handled with clean hands only.
3. Slip hands into sleeves carefully pulling off gown.	Remove gown with care to prevent contaminating clothing, keeping inside of gown clean. Only clean part of the gown should be visible.
4. Fold the gown towards inside and roll into a bundle.	Shaking causes spread of organisms into the air.
5. Discard into waste or linen Container as appropriate. If contaminated place in biohazard Container.	
6. Wash hands again.	

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)		
Policy/Procedure Applies To	**All Nurses & Staff involved in Surgical Care**	**Policy/Procedure No: 7** **Page: 3 of 6**
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MASKING

1. **TWO TYPES OF MASKS**
   a. The "PARTICULATE RESPIRATORY MASK" is used to block airborne organisms from entering the respiratory tract. The "Particulate Respiratory Mask" shall be used for caring for an individual in respiratory isolation or individual with infectious tuberculosis.
   b. The regular mask is used to protect face from splashes of blood or body fluids.
2. **PRECAUTIONS**
   a. Use mask once only.
   b. Wash hands before and after masking
   c. Do not dangle around neck or place in pocket, because organisms continue to multiply on mask.
   d. Do not touch mask during use.
3. PROCEDURE

ACTION	RATIONALE
1. Place the mask over mouth, nose and chin.	Use appropriate mask for the situation. Adjust the mask to fit.
2. Change mask if it gets moist.	Organisms freely pass through wet surfaces.
3. Wash hands before removing mask	
4. Remove mask by handling the ties starting with the bottom to the top ties. And discard in the appropriate waste container when leaving the room.	Masks used by individuals in isolation room should be disposed of as biohazardous waste. Masks worn by healthy staff may be disposed of in a regular waste container in the isolation room.
5. Wash hands after removing mask	

For "Particulate Respiratory Mask" (PRM) follow manufacturer's instructions for donning and removing the device.

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)		
Policy/Procedure Applies To	**All Nurses & Staff involved in Surgical Care**	**Policy/Procedure No: 7** **Page: 4 of 6**
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GLOVING

1. Use gloves only one time and discard properly.
2. Change gloves after use on each Individual and discard them.
3. Wash hands before and after using gloves.

PROCEDURE

ACTION	RATIONALE
1. Select the size of glove that best fits you.	
2. Insert each hand into appropriate glove.	Insert each hand into appropriate glove.
3. If wearing an isolation gown, tuck the gown cuffs securely under each glove	This provides a continuous barrier protection for skin
4. Remove gloves (1) by grasping the outside of the opposite glove near the wrist.	This prevents contamination
5. Remove gloves (2) by sliding one or two fingers of ungloved hand under the wrist of the remaining glove.	
6. Discard gloves after use in biohazardous waste container if contaminated with fluid blood or moist body substances.	Regular trash container should be used for unsoiled gloves.
7. Wash hands after removing gloves	

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)		
Policy/Procedure Applies To	**All Nurses & Staff involved in Surgical Care**	**Policy/Procedure No: 7** **Page: 5 of 6**
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GOGGLES AND FACE SHIELD

Goggles are used to provide barrier protection for eyes

1. **PRECAUTIONS**
   a. Goggles should fit snugly over and around eyes.
   b. Personal glasses are not a substitute for goggles.
2. PROCEDURE

ACTION	RATIONALE
1. Position goggles over eyes and secure to the head using ear pieces or headband.	
2. Position face shield over face and secure on brow with headband	
3. Adjust to fit comfortable	Goggles should feel snug but not tight
4. To Remove goggles and face shield:	
5. Grasp ear or head pieces with hands	
6. Lift away from face	
7. Discard them in appropriate waste receptacle.	

USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)		
Policy/Procedure Applies To	**All Nurses & Staff involved in Surgical Care**	**Policy/Procedure No: 7** **Page: 6 of 6**
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KEY POINTS OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

1. Don it before you have any contact with Individual.
2. Once you have PPE on, use it carefully to prevent spreading contamination
3. When you have completed your tasks, remove the PPE carefully and discard appropriately.
4. Then immediately perform hand hygiene before going to the next Individual.

PPE FOR STANDARD PRECAUTIONS

1. Standard Precautions
   a. Previously called Universal Precautions
   b. Assumes blood and body fluids of any Individual could be infectious
   c. Recommends PPE and other infection control practices to prevent transmission of common infectious agents.
2. Under Standard Precautions
   a. Gloves - shall be used when touching blood, body fluids, secretions, excretions, or contaminated items and for touching mucous membranes and no intact skin.
   b. Gown - shall be used during procedures and Individual care activities when contact of clothing and/or exposed skin with blood, body fluids, secretions, or excretions is anticipated.
   c. Mask and goggles - or a face shield shall be used during Individual care activities that are likely to generate splashes and sprays of blood, body fluids, secretions or excretions.

PPE FOR EXPANDED PRECAUTIONS

Expanded Precautions (formerly called Transmission-Based Precaution), which sometimes are used in addition to standard precautions, include:

1. Contact Precautions- Gown and gloves for contact with Individual or environmental care (e.g., medical equipment, environment surfaces)
2. Droplet Precautions- Surgical masks within 3 feet of Individual.
3. Airborne Infection Isolation - Particulate respirator. Negative pressure isolation room are also required.

ANNEXURE VII
(Refer to Housekeeping Manual Policy and Procedure No. 1)

VITALS ROOM

	Frequency				
AREA	**Daily**	**Weekly**	**Fortnightly**	**Mthly**	**Other**
Floor	X				
Walls		X			
Door and Handle	X				
Dressing Trolley	X				
Counter Top	X				
Telephone	X				
Chair	X				
Multipara Monitor	X				
Empty Waste Bins	X				
Wooden Cabinet and Cupboard	X				
Computer, Keyboard, CPU	X				
Foot Step	X				
Weighing Machine	X				
Luminaries		X			
Electrical Outlet/ Switch Plates	X				

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

ANAESTHESIA DOCUMENTATION OF MEDICAL RECORD		
Policy/Procedure Applies To	**Anaesthesiologists and All O.T./Staff Nurses**	**Policy/Procedure No: 8** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ANAESTHESIA DOCUMENTATION OF MEDICAL RECORD

PURPOSE

To provide documentation regarding anaesthesia during each anaesthesia care.

POLICY

The medical record for each patient receiving anaesthesia care will contain Anaesthesiology service documentation.

1. **Preoperative**
   a. History of:
      i. Previous anaesthesias.
      ii. Family history regarding anaesthesia
      iii. Allergies
      iv. Medications
      v. Last fluid or food intake
   b. Systems review
   c. Review of objective data (laboratory, ECG, X-Ray, etc.).
   d. Determination of physical status. (Documentation of preoperative evaluation should be consistent with physical status designation.).
   e. Anaesthesia plan for proposed operation.
   f. ASA classification (risk factor)
2. **Intraoperative**
   a. The dosage of all drugs and agents employed
   b. The type and amount of all fluids administered
   c. Evidence of monitoring the patient
   d. Description of technique(s) employed
   e. Record of unusual events during anaesthesia
   f. Status of patient at conclusion of surgery
3. **Postoperative**
   a. Evaluation of status of patient on admission and discharge from nursing unit.
   b. Record of vital parameters.
   c. Record of IV fluids administered.
   d. Record of drugs administered.
   e. Record of unusual events or postoperative complications including documentation of management.
   f. Discharge instructions duly signed by Resident Medical Officer/Anaesthesiologist.

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CUSTOMER CARE AND BILLING MANUAL

BOOKING OF OPERATION THEATER		
Module Applies To	**Customer Care**	**Policy and Procedure No.: 8** **Page: 1 of 1**
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BOOKING OF OPERATION THEATER

PROCEDURE

In the system-

Pull up the patient details via MR number.

Mark a Visit of the patient.

Go to the Medical records section of OPD.

1. Select the patient for whom the Operating Room is to be booked.
2. Go to the 'Services' tab and select the name of the surgery and click Add. The surgery would then be ordered for the patient.

Next go to Operation Theater Reservation.

1. Select the date on which the patient's visit is marked.
2. The patient's name will be displayed under OT Ordered.
3. Select the date on which the Operating Room is to be booked for the surgery/procedure.
4. Confirm with the OT Matron as to which Operating Room is to be booked.
5. Select the time slot of the surgery/procedure.
6. Select the Service ordered, Surgeon, Anaesthesiologist, OT Staff and save it.
7. An SMS template will automatically be generated for the OT being booked. Select the Consultants and the Staff members to whom the SMS is to be sent.

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ANNEXURE VIII
(Refer to Housekeeping Manual Policy and Procedure No. 1)

BUSINESS AND ADMINISTRATIVE OFFICES

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
Glass Partitions and Glass Doors	X			
Windows and Seals	X			
Roller Blinds and Doors	X			
A/C baffles		X		
Work Tables/Cabinets/Drawers	X			
Computers	X			
Telephone	X			
Luminaries		X		
Electrical Outlets/ Switch Plates	X			
Cupboards	X			
Empty Waste Bins	X			

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HOSPITAL INFECTION CONTROL MANUAL

EYE PROTECTION		
Policy/Procedure Applies To	**OT & Procedure Room Nurses & Technicians**	**Policy/Procedure No: 8** **Page: 1 of 1**
Effective Date: 11 April, 2013		

EYE PROTECTION

POLICY

1. Eye protection devices are available for personnel to wear during surgery. This applies to both nursing staff and physicians.(Universal Precautions)
2. All personnel should wear goggles to avoid eye contact with secretions and/or fluids during surgery, patient care, disinfecting or cleaning procedures.

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PRIME SURGICAL CENTERS

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NURSING MANUAL II

INTENSIVE CARE UNIT (ICU) / HIGH DEPENDENCY UNIT (HDU)		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 8** **Page: 1 of 4**
Effective Date: 01 April, 2014		

INTENSIVE CARE UNIT (ICU) / HIGH DEPENDENCY UNIT (HDU)

PURPOSE

1. All patients will receive a comprehensive health assessment of major body systems upon arrival to the ICU/HDU.
2. All patients will receive care guided by the assessment data.

POLICY

1. On admission to ICU/HDU, hand-off report will be given by the Staff Nurse from the OT or unit to the ICU/HDU Nurse. This can be prior to or upon patient arrival in the ICU/HDU and will include the peri-operative condition and the surgical/anesthetic course.
2. The transferring unit Nurse shall remain in the ICU/HDU until the ICU/HDU Nurse accepts responsibility for the nursing care of the patient.
3. The patient shall be observed and monitored by methods appropriate to the patient's condition. Particular attention shall be given to monitoring oxygenation, ventilation, circulation, level of consciousness, temperature and other vital parameters.
4. A comprehensive health assessment of major body systems will be done with priority, as appropriate:
   a. vascular access
   b. ECG monitoring, as needed
   c. infusing solutions and medications
   d. pain level and comfort, including nausea / vomiting
   e. temperature / thermoregulation
   f. tissue perfusion / skin condition and dressings
   g. pulse checks: e.g., radial arterial, femoral dorsal pedalis, and posterior tibialis
   h. sensory and motor function
   i. laboratory values
   j. disabilities
   k. age-specific considerations
   l. religious / cultural considerations
   m. other special needs as identified through report.
5. General medical supervision and coordination of patient care in the ICU/HDU is the responsibility of Resident Medical Officer (RMO) and Anesthesiologist. Patients who have not received anesthesia are the responsibility of the Resident Medical Officer (RMO) and Surgeon who has performed the procedure.
6. Anesthesiologist has primary responsibility to respond in urgent or emergent situations for patients in ICU/HDU who have received anesthesia services and develop complications or need resuscitation.

7. Intensive Nursing care is provided to all patients. Standards of care are consistent for all services unless otherwise specified. Practice concerns are addressed through the ICU/HDU Coordinating staff with Nursing Superintendent and Administrative Head of Prime Surgical Centers.
8. The standards of ICU/HDU is written for the purposes of planning, organizing, implementing, controlling and evaluating the ICU/HDU staff. The Nursing Superintendent is responsible for administrative concerns with guidance from the Administrative Head of the Center, as needed.
9. The ICU/HDU Nurse in collaboration with nursing personnel and members of other disciplines, engages in the following activities:
    a. Provides guidance for and supervision of new employee to the unit
    b. Coordinates nursing services with the services of other health care disciplines.
    c. Evaluates the quality and appropriateness of care.

ROLES AND RESPONSIBILITIES OF ICU/HDU NURSE

1. Maintains and demonstrates clinical competence.
2. Acquires, maintains current knowledge in clinical and administrative practice.
3. Collaborates with surgeons and all disciplines at all level in the development, implementation, and evaluation of patient care.
4. Monitors compliance with and recommends changes to ensure compliance with Prime Surgical Centers Nursing standards and Nursing Policies and Procedures.
5. Demonstrates knowledge of legal aspects of patient care and nursing practice.
6. Assists in the implementation of an effective, ongoing program to measure, assess and improve the quality of care delivered to patients.
7. Well – versed in Prime Surgical Centers Policies and Procedures, Nursing standards, and/or Nursing Policies/ Procedures
8. Demonstrates working knowledge of resource consumption by monitoring appropriate use of supplies.
9. Maintains knowledge base related to customer service and customer satisfaction. Practices effective communication and customer service skills with all customer groups. Develops and maintains collegial relationships with physicians and other departments within Prime Surgical Centers.
10. General Responsibilities:
    a. Reports to work in proper uniform or attire.
    b. Leaves for meal break on time and returns on time.
    c. Varies work schedule to meet the needs of the department.
    d. Strictly adheres to Prime Surgical Centers attendance/tardiness policies 100% of the time.
11. Adheres to Prime Surgical Centers standards and Nursing policy and procedure 100% of the time. Maintains confidentiality regarding patient/employee/facility/ Prime Surgical Centers information 100% of the time.

INTENSIVE CARE UNIT (ICU) / HIGH DEPENDENCY UNIT (HDU)		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 8** **Page: 3 of 4**
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12. Assists all patients, family members, physicians, visitors and employees in a professional and courteous manner.
    a. Extends special attention and sensitivity to all patients, visitors, physicians, and fellow employees.
    b. Demonstrates respect and cooperation in all staff relationships, and a genuine willingness to prevent or resolve inter – personal conflicts.
13. Strictly adheres to Standard Precautions by adhering to the usage of personal protective equipment while handling blood or body fluids.
14. Washes hands and other skin surfaces with soap and water thoroughly and immediately if contaminated with blood or other body fluids and before and after patient contact.
15. Disposes of sharps in puncture resistant needle boxes.
16. Ensures that healthcare workers who participate in invasive procedures must routinely use appropriate barriers precautions. Wear gloves, goggles, and surgical masks for all invasive procedures.
17. Ensures that all specimens of blood and body fluids are put in a well – constructed container with a secure lid to prevent leaking during transport. Specimen containers should be placed in bio-hazardous coded plastic bag for transport.
18. Adheres to isolation procedures and techniques at all times as applicable.
19. Demonstrates adequate knowledge of Safety Policies and Procedures, the use of MSDS (Material Safety Data Sheets), hazardous material procedures, and Safety Codes.
20. Enhances Patient Care potential through utilization and appreciation of clinical managerial skills and knowledge
    a. Patients and family are provided with appropriate information and reassurance prior to medical and nursing interventions.
    b. Patients and family are provided with appropriate health education.
    c. The patient's physical and psychosocial needs are met with minimum delay.
    d. Medications and therapies are administered in a safe, timely and effective manner.
    e. The patient's right of confidentiality, privacy, dignity and self-respect are maintained at all times.
    f. Documentation of patient care is done in accordance with the Nursing Standard Policies and Procedures of Prime Surgical Centers.
21. Staff Nurse is prepared to meet all crisis situations in a calm therapeutic manner:
    a. Knows the emergency/crash cart status and location at all times. Adheres to standards for checking and replenishing the crash cart when assigned.
    b. Identifies emergency drugs and their location on the emergency/crash cart. Knows their use side effects.
    c. Identifies equipment and explains its proper use and application.
    d. Initiates CPR/Code Management correctly and without delay.
    e. Accurately document events in Nurses Notes, Incident Report and CPR Report forms.

INTENSIVE CARE UNIT (ICU) / HIGH DEPENDENCY UNIT (HDU)		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 8** **Page: 4 of 4**
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PROTOCOL FOR RECEIVING PATIENTS FROM THE OPERATION THEATER (OT)

Check rooms before Nurse goes to OT to receive patients from the OT

1. Oxygen mask ready for administering oxygen.
2. Monitor (Cardiac Monitor B-20) ready to attach to patient, on standby.
3. Alarms adjusted not silenced.
4. Bed locked.
5. IV stands, Kidney tray, Gauze pieces ready
6. Trolley for shifting must have an oxygen cylinder and mask ready for use (cylinder open and checked for O2)
7. Pulse-oximeter to be attached and monitor the patient while shifting. Administer oxygen at 4 litres if oxygen saturation falls below 94%.

Once patient reaches the room

1. Patient's relatives to be requested to wait outside.
2. Room door to be closed
3. Lock the trolley and check that the bed is locked and shift the patient
4. Attach the monitors and check vitals are stable. Assess the patient.
5. Check post-op orders with the Anaesthesiologist and implement
6. Call the patient's relative in the room.
7. Give necessary post-op instructions to patient and relative.
8. Mandatory 15 min. vitals record to be maintained alternatively by Resident Medical Officer (RMO) and Nurses. This ensures that the patient is seen by RMO/Nurse every 15 min.
9. Inform the Anaesthesiologist and Consultant immediately if any change in assessments/vitals.
10. Inform status to the Anaesthesiologist and Consultant at 3 hours from receiving patient and at 8:00 am and 8:00 pm thereafter till discharge.

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PRIME SURGICAL CENTERS

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EXPOSURE CONTROL PLAN MANUAL

METHODS OF COMPLIANCE: REGULATED WASTE		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 8** **Page: 1 of 1**
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METHODS OF COMPLIANCE: REGULATED WASTE

(Refer to Hospital Infection Control Manual Policy and Procedure No. 29 and Exposure Control Manual Policy and Procedure No. 6)

Contaminated Sharps

1. Discard contaminated sharps immediately or as soon as feasible in containers that are:
   a. Closable
   b. Puncture resistant
   c. Labeled with biohazard symbol or according to color-coding system
   d. leak proof on the sides and bottom
2. Sharps containers will also have these additional characteristics:
   a. Be easily accessible to staff
   b. Located as close as possible to the work area where used
   c. Maintained upright
   d. Containers are emptied when 2/3 full.
   e. Containers are either wall mounted or otherwise stabilized
3. When moving contaminated sharps containers, containers will be closed prior to removal or replacement to prevent spillage and placed in a secondary container if leakage is possible. Containers will be closable, constructed to prevent leakage.
4. Reusable containers will not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of a per-cutaneous injury.

Other Regulated Waste

1. Other regulated waste will be placed in containers which are closable, constructed to prevent leakage and closed prior to removal to prevent spillage or protrusion of contents.
2. If outside contamination of the regulated waste containers occurs, it will be placed in a second container which meets the same design requirements as the primary container.
3. Disposal of all regulated waste will be in accordance with all applicable state and local regulations.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

PATIENT SAFETY: NINE LIFE-SAVING PATIENT SAFETY SOLUTIONS		
Policy/Procedure Applies To	**All Nurses/Staff**	**Policy/Procedure No: 8** **Page: 1 of 3**
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PATIENT SAFETY: NINE LIFE-SAVING PATIENT SAFETY SOLUTIONS

1. **Look-Alike, Sound-Alike Medication Names**

   Many drug names look or sound like other drug names. Contributing to this confusion are illegible handwriting, incomplete knowledge of drug names, newly available products, similar packaging or labelling, similar clinical use, similar strengths, dosage forms, frequency of administration.

   There are many Look-Alike, Sound-Alike (LASA) combinations that could potentially result in medication errors. (Refer to Nursing Manual Policy and Procedure No. 36)

   Medication orders and prescriptions that include both the brand name and non-proprietary name, dosage form, strength, directions, and the indication for use can be helpful in differentiating Look-Alike, Sound-Alike medication names. (Refer to Nursing Manual Policy and Procedure No. 37)

2. **Patient Identification**

   The widespread and continuing failures to correctly identify patients often leads to medication, transfusion, testing errors and wrong person procedures. The recommendations place emphasis on methods for verifying patient identity, including patient involvement in this process. Prime Surgical Centers will use two patient identifiers – Patient's Name and MR No./Date of Birth. The patient's room number/location is **not** to be used as an identifier. (Refer to Nursing Manual Policy and Procedure No. 9)

3. **Communication During Patient Hand-Overs**

   Gaps in hand-over (or hand-off) communication between patient care units and care teams, can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm for the patient. The recommendations for improving patient hand-overs include using protocols or checklist for communicating critical information; providing opportunities for staff to ask and resolve questions during the hand-over; and involving patients and families in the hand-over process. Follow the Nursing Manual Policy and Procedure Numbers 64 and 9

4. **Performance of Correct Procedure at Correct Body Site**

   Incorrect information and communication is a major contributing factor for errors in the Operating Room. To prevent errors rely on the conduct of a preoperative verification process; marking of the operative site by the surgeon who will do the procedure; and having the team involved in the procedure take a "time out" immediately before starting the procedure to confirm patient identity, procedure, and operative site.

5. **Control of Concentrated Electrolyte Solutions**

   Concentrated electrolyte solutions that are used for injection are dangerous which comes under High Alert Medication e.g. Potassium chloride injection (KCl), Sodium chloride more than 0.9 conc. Injection (NaCl), Magnesium Sulphate injection (Mg SO4), Conc. Ringer lactate injection, etc. (Refer to Nursing Manual Policy and Procedure No. 37). Electrolytes bear a heightened risk of causing significant patient harm, when they are used in error. (Refer to Nursing Manual Policy and Procedure No. 36)

6. **Assuring Medication Accuracy at Transitions in Care**

   Errors are common as medications are procured, prescribed, dispensed, administered, and monitored but, they occur most frequently during the prescribing and administering actions. Medication errors occur most commonly at transitions. Medication reconciliation is a process designed to prevent medication errors at patient transition points. Prime Surgical Centers assures creation of the most complete and accurate list of all medications the patient is currently taking-also called the "home" medication list. Compare the list against the admission and discharge orders when writing medication orders and communicate the list to the patient and his/her family whenever the patient is discharged. (Refer Nursing Manual Policy and Procedure No. 19)

7. **Avoiding Catheter and Tubing Mis-Connections**

   The design of tubing, catheters, and syringes currently in use is such that it is possible to inadvertently cause patient harm through connecting the wrong syringes and tubing and then delivering medication or fluids through an unintended wrong route. Care givers need to give meticulous attention to detail when administering medications and feedings (i.e., the right route of administration), and when connecting devices to patients (i.e., using the right connection/tubing).

8. **Single Use of Injection Devices**

   Prime Surgical Centers prohibits the reuse of needles. Periodic training will be conducted for all staff involved in direct patient care for infection control principles and safe needle disposal practices (Refer to Hospital Infection Control Manual Policy and Procedure No. 5). Education of patients and families regarding transmission of blood borne pathogens will be an ongoing process while admitted to Prime Surgical Centers.

9. **Improved Hand Hygiene to Prevent Health Care-Associated Infection (HAI)**

   Protocol as under to be followed:

   a. Hand washing

   b. Use of hand rubs

   c. Universal precautions where indicated

   Hand washing is the single most important factor for Infection Control:

   Five indications of Hand Hygiene by WHO to be implemented by all staff:

   a. Before touching the patient

   b. Before clean/aseptic procedure of patient

   c. After patient body fluid exposure risk

   d. After touching a patient

   e. After touching patient surroundings

   Follow "**Standard Precautions**" in the Center as per Hospital Infection Control Manual Policy & Procedure No. 4

PATIENT SAFETY: NINE LIFE-SAVING PATIENT SAFETY SOLUTIONS		
Policy/Procedure Applies To	**All Nurses/Staff**	**Policy/Procedure No: 8** **Page: 3 of 3**
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Prime Surgical Centers will ensure alcohol-based hand-rubs are readily available at points of patient care; access to a safe, continuous water supply at all taps/faucets; staff education on correct hand hygiene techniques; use of hand hygiene reminders in the workplace; and measurement of hand hygiene compliance through observational monitoring and other techniques.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

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Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

SAFE PATIENT HANDLING		
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SAFE PATIENT HANDLING

COMPETENCY STATEMENT

All Nurses demonstrates understanding of the principles of ergonomics and body mechanic.

LEARNING OUTCOME

1. Identify risk factors of patient handling task to care givers.
2. Identify safe handling technique from a video demo.
3. Identify safe body mechanics for maintaining balance and stability while performing patient handling task.
4. Apply the knowledge of principles of safe handling.
5. Differentiate between the right and wrong practices of patient handling from a video presentation.
6. Outline the strategies to modify risk factors and prevent injuries
7. Patient handling and movement tasks are physically demanding, performed under unfavorable conditions, and are often unpredictable in nature. Patients offer multiple challenges including variations in size, physical disabilities, cognitive function, level of cooperation, and fluctuations in condition. As a load to be lifted, they lack the convenience of handles, even distribution of weight, and have been known to become combative during the lift process. Shockingly, the cumulative weight lifted by a nurse in one typical 8-hour shift is equivalent to 1.8 tons. Further, many patient lifts are accomplished in awkward positions such as bending or reaching over beds or chairs while the nurse's back is flexed.

Nursing personnel are consistently listed as one of the top ten occupations for work-related musculoskeletal disorders.

DEFINITIONS

1. **Ergonomics**: Ergonomics is the science that plans and designs for human use – designing the job to fit the workers. It deals with the consideration of human characteristics, expectations, and behaviours in the design of the things people use in their work and everyday lives.
2. **Musculoskeletal injury (MSI)**: An injury or disorder of the muscles, tendons, joints, nerves, blood vessels or related soft tissue, including a sprain, strain or inflammation.
3. **Handling Tasks**: Patient handling tasks that have a high-risk of musculoskeletal injury for staff performing the tasks. These include but are not limited to transferring tasks, lifting tasks, repositioning tasks, bathing heavy patients in bed, making occupied beds, dressing heavy patients, turning heavy patients in bed, and tasks with long duration. Any patient requiring greater than minimal assist is considered to be high risk for the purposes of this guideline.
4. **High-risk Patient Care Areas**: Inpatient hospital units with a high proportion of dependent patients requiring assistance with patient handling tasks and activities of daily living. Designation is based on the dependency level of patients and the frequency with which patients are encouraged to be out of bed.
5. **Manual Lifting**: Lifting, transferring, repositioning, and moving patients using a caregiver’s body strength without the use of lifting equipment/aids to reduce forces on the caregiver’s musculoskeletal structure.

6. **Mechanical Patient Lifting Equipment**: Equipment used to lift, transfer, reposition, and move patients. Examples include portable base and ceiling track mounted full body sling lifts, stand assist lifts, and mechanical lateral transfer aids.

SYMPTOMS OF MUSCULOSKELETAL DISORDERS

1. Early stage: pain may disappear after a rest away from work
2. Intermediate stage: body part aches and feels weak soon after starting work and lasts until well after finished work
3. Advanced stage: body part aches and feels weak even at rest; sleep is affected; light tasks are difficult on days off
4. Tingling or numbness
5. Fatigue
6. Weakness
7. Signs include redness and swelling, loss of full or normal joint movement.

PURPOSE OF ERGONOMIC APPROACHES

1. Design jobs and job tasks to fit people rather than expecting people to adapt to poor work designs
2. Achieve a proper match between the worker and their job by understanding and incorporating the limits of people
3. Take into account that when job demands exceed the limits of workers, there are problems

RISK FACTORS CONTRIBUTING TO INJURIES

1. Traits of the Nurse
2. Traits of the Patient
3. The Environment
4. Patient Care Tasks

NURSING TASKS WHICH CONTRIBUTE MOST TO A RISK FOR INJURY

1. Transfer of a patient from bed to a chair or chair to toilet.
2. Lifting a patient up in bed or a chair.
3. Repositioning a patient from side to side
4. Making an occupied bed
5. Undressing a patient
6. Feeding a patient
7. Transfer from bed to stretcher
8. Weighing a patient
9. Applying anti embolism stockings
10. Transferring a patient off the unit
11. Feeding bed ridden patients
12. Bathing a patient in bed
13. Lifting a patient to the head of the bed

UNITS AT HIGH RISK OF BACK AND OTHER INJURIES TO CAREGIVERS HAVE THE FOLLOWING CHARACTERISTICS

1. History of frequent injuries in the past
2. High proportion of dependent patients
3. Lack of use of lifting equipment in good function
4. Low staffing levels

FIVE STEP PROCESS IN PATIENT HANDLING

1. Identifying and assessing potential risk factors
   a. **Environment** - flooring, obstacles, space, equipment, potentially confusing wall/floor patterns, distance to be moved, lighting, noise, temperature
   b. **Organization** - education and training, availability of assistance, workload, work flow
   c. **Equipment** - availability, cleanliness and condition, appropriateness to task,
   d. Compatibility with environment, adequate caregiver training in equipment use, patient comfort and safety levels
   e. **Caregiver** - skills, education & training, fitness and physical capabilities, medical & emotional status, clothing and accessories, physical force, posture, repetition, duration, contact stress, psychosocial stresses
   f. **Patient** - care plan (checklist, pictogram) available with current handling procedures, communication level, cognitive status, behavioral and emotional status (history of violence or other current risk factors), medical status, physical and sensory status, clothing, assistive devices, ability to assist identifying and assessing potential risk factors
2. Deciding on the appropriate patient handling technique:
   a. Check care plan & history of previous incidents
   b. Consider risk assessment results and match with care plan
   c. Consider facility patient handling policies and procedures
   d. provide maximum patient independence
   e. Determine appropriate patient handling technique.
3. Preparing for the patient handling task
   a. Preparing the environment
   b. Preparing the assistant(s)
   c. Preparing the equipment
   d. Preparing the care giver
   e. Preparing the patient
4. Performing the patient handling task.
5. Evaluating the completed patient handling task.

SAFE PATIENT HANDLING		
Module Applies To	**All Nurses and Technicians**	**Module No: 8** **Page: 4 of 6**
Effective Date: 11 April, 2013		

PRINCIPLES OF PATIENT SAFE HANDLING

1. Preparation
   a. Which task
   b. Which patient
   c. Which equipment
   d. Which environment
   e. Choosing a safe strategy
   f. Preparing the equipment and workplace
   g. Determining what kind of help is necessary
   h. Ask for help if necessary and wait
2. Positioning
   a. Feet apart
   b. Feet oriented in a way to facilitate the movement
   c. Back not twisted
   d. Back not slouched
   e. Knees bent
3. Gripping
   a. Narrow contact
   b. Surrounding arms
   c. Firm and soft gripping
   d. Block slippery points
   e. Patient participation
4. Movement
   a. Bring only the necessary help to the patient and communicate with her
   b. Respect natural movements
   c. Roll, glide, pivot the patient instead of lifting
   d. Use strength of legs or own body weight when physical help is necessary
   e. Do movements one at a time
   f. Pull the patient instead of pushing him/her
   g. Distribute and balance the weight in a symmetrical way

SAFE PATIENT HANDLING		
Module Applies To	**All Nurses and Technicians**	**Module No: 8** **Page: 5 of 6**
Effective Date: 11 April, 2013		

MOVEMENTS FOR PHYSICAL HELP

1. Movements of the care person
   a. Back – forward weight transfer
   b. Lateral weight transfer (on the side)
   c. Counterweight with support
   d. Back-forward transfer and counterweight combined
   e. Counterweight in diagonal with a knee in the bed
2. Movements of the patient
   a. ROLL
   b. GLIDE
   c. PIVOT

GENERAL PRECAUTIONS FOR PATIENT HANDLING TASKS:

1. Take responsibility for knowing how equipment works and its availability
2. Assess the client and the environment, using the Assessment Criteria and Care Plan.
3. Select the appropriate algorithm.
4. Gather the appropriate equipment and other staff members needed.
5. Organize the physical environment and the equipment to ensure safe completion of the task. This includes locking the wheels of the bed or chair, putting the bed/stretcher at the correct height, removing clutter, and making sure any mobile equipment is charged.
6. Procedures with two or more caregivers require communication and coordination. Make sure your team members know their role.
7. Position yourself using the principles of body mechanics
8. Coach the patient. Tell the patient what action you plan and expect from them. Show them what to do, and then help them move through the activity.

USE OF ASSISTIVE DEVICES

1. Use of a Transfer Board or Trapeze Bar
2. Use of friction reducing device
3. Use of a Transfer Belt or Gait Belt
4. Use of Mechanical Hoist Lifter

STRATEGIES TO MODIFY RISK FACTORS AND PREVENT INJURIES

1. Back exercises
2. Stress management
3. Weight reduction
4. Blood pressure control
5. Warm up exercises
6. Think in terms of anti-lifting, not correct lifting
7. Promote patient independence

8. Modify the Work Environment
9. Modify Work Organization

IMPROVING QUALITY OF CARE THROUGH PRACTICE OF ERGONOMICS

1. Increased patient comfort, security, and dignity during lifts and transfers
2. Enhanced patient safety during transfers as evidenced by decrease in patient falls, skin tears, or abrasions
3. Promotion of patient movement and independence
4. Enhance toileting outcomes and increase in continence
5. Improved quality of life for patients

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

STAFF MEETINGS		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 8** **Page: 1 of 1**
Effective Date: 11 April, 2013		

STAFF MEETINGS

PURPOSE

To ensure that at least once each quarter a time is available to establish a formal atmosphere to allow for communication between personnel to discuss problems, make suggestions and explore new ideas.

SCOPE

All facility personnel.

POLICY

1. The Nursing Superintendent / OT Matron will call a meeting of all their respective personnel to discuss new equipment, policies or procedures and to review those already existing. Opportunity will be given to air new ideas, answer questions, etc.
2. The periodicity of the meetings may be fortnightly initially for three (3) months, then monthly for the next (3) months and then quarterly.
3. Meetings will be called when the schedule allows that the majority of personnel will be able to attend. Some meetings will be designated mandatory.
4. An agenda will be posted in advance of the meetings and all staff will have an opportunity to submit agenda items.
5. Minutes will be circulated for one (1) week signed by the respective managers and filed in the appropriate manual.
6. Those who are unable to attend a meeting must review the minutes with signature and date and confer with their manager or administrator for further information.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

SAFETY MANUAL

SUCTIONING EQUIPMENT		
Policy/Procedure Applies To	**All nurses**	**Policy/Procedure No: 8** **Page: 1 of 1**
Effective Date: 11 April, 2013		

SUCTIONING EQUIPMENT

POLICY

All Nurses are responsible for the correct functioning of the suction system. The Nurse shall familiarize himself/herself with the suction system and be aware of how it performs.

PROCEDURE

1. Every case is to be treated as a "dirty" case, using Universal Precautions, including the proper use of protective barrier apparatus.
2. Following a dirty case, the suction bottles containing aspirate (plus and/or germicide) shall be emptied.
3. A disinfecting agent as specified by the Prime Surgical Centers from time to time shall then be used to clean the suction bottle followed by thorough washing with a germicide, rinsing and sterilization.
4. The disposable suction unit shall be placed in the red bags for infectious waste.
5. The suction racks and regulator shall be wiped down with a germicidal solution.

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Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

WATER TESTING SCHEDULE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 8** **Page: 1 of 1**
Effective Date: 11 April, 2013		

WATER TESTING SCHEDULE

INTRODUCTION

As a part of providing quality based services at Prime Surgical Centers following procedure will be followed for ensuring that quality water is provided to all persons at all times.

RESPONSIBILITY

Executive Facility will be responsible for ensuring testing of water and maintaining appropriate records. Prime Surgical Centers has decided to use services of Polytest Laboratories for carrying out physical, chemical and microbiological testing of water.

MONTHLY

Sites for sample collection

1. Overhead tank
2. Pantries
3. Staff Lounge
4. O. T. Complex
5. Water fountains on Ist & IInd floor.

METHODOLOGY

Samples of water will be collected in sterile bottles under aseptic conditions, labeled & sealed before forwarding it to laboratory, As a routine the tap water will be allowed to flow for 15 seconds before collection is made.

CONCLUSION

Quality water provision to clientele of Prime Surgical Centers, shows its commitment to provide over all best services. Executive Facility will initiate immediate corrective action in case of any abnormal reports and simultaneously bring it to the notice of higher administrative authorities of the centre.

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Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

DRAIN CARE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 9** **Page: 1 of 1**
Effective Date: 01 April, 2014		

DRAIN CARE

PROCEDURE

The Romovac Drain works as a Negative Pressure Closed Suction system. It consists of the drain tubing that is connected to 1 or 2 drains, a clamp and the collection chamber or canister.

To empty the drain,

Step 1: First wash hands and wear clean gloves.



Step 2: Clamp the tubing to prevent spilling of the fluid in the tubing.

Step 3: Unscrew the connector of the tubing from collection chamber by rotating in an anticlockwise manner.

Step 4: Empty the contents of the drain in a measuring flask. (An empty IV fluid bottle with the top cut off is also suitable for the purpose.)

DATE	TIME	OUTPUT (ml)

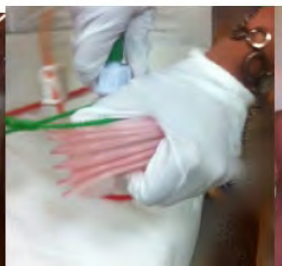
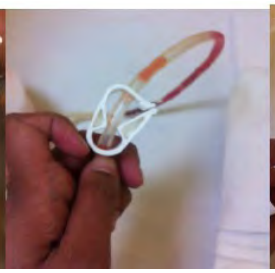
Step 5: Record the output along with the date and time of measurement.

Step 6: To charge the drain, the canister needs to be compressed. It is held in compression with one hand, while the other hand screws on the tubing connector, by rotation in a clockwise manner.

Step 7: Open the clamp.

Step 8: Ensure that the canister is in the compressed position and there are no kinks or clots in the system.

Step 9: Place the collection chamber in a dependent position by the patient's bedside.


Note: If the patient is taking the drain home, educate the patient and give the Drain Care Patient Instruction Sheet (Refer to Annexure)

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE

(Refer to Nursing Manual II Policy and Procedure No. 9)

DRAIN CARE PATIENT INSTRUCTION SHEET

PROCEDURE

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Step 6: To charge the drain, the canister needs to be compressed. It is held in compression with one hand, while the other hand screws on the tubing connector, by rotation in a clockwise manner.

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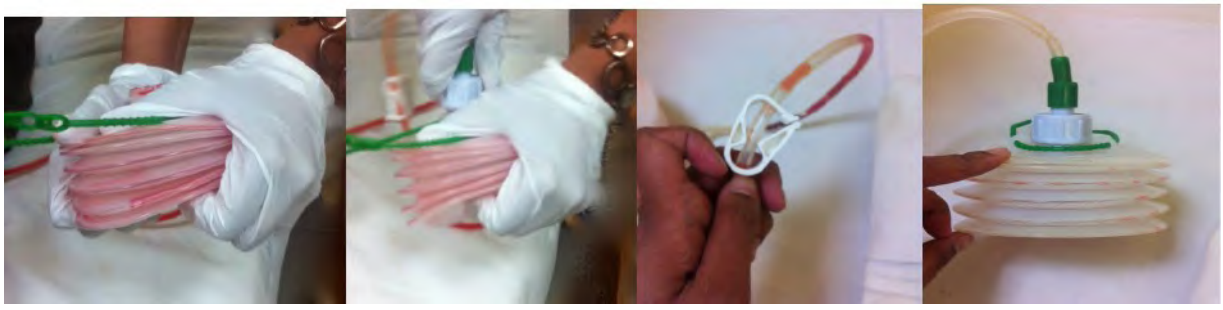
Step 8: Ensure that the canister is in the compressed position and there are no kinks or clots in the system.

Step 9: Place the collection chamber in a dependent position by the patient's bedside.



Please Turn Over

RECORD THE OUTPUT ALONG WITH THE DATE AND TIME OF MEASUREMENT

DATE	TIME	OUTPUT (ml)	DATE	TIME	OUTPUT (ml)

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
Phone: - 020-39931000 Fax: - 020 39931020
Email: - customercare@primesurgical.in
Website: www.primesurgical.in

PRIME SURGICAL CENTERS

DRAIN CARE PATIENT

INSTRUCTION SHEET

PROCEDURE

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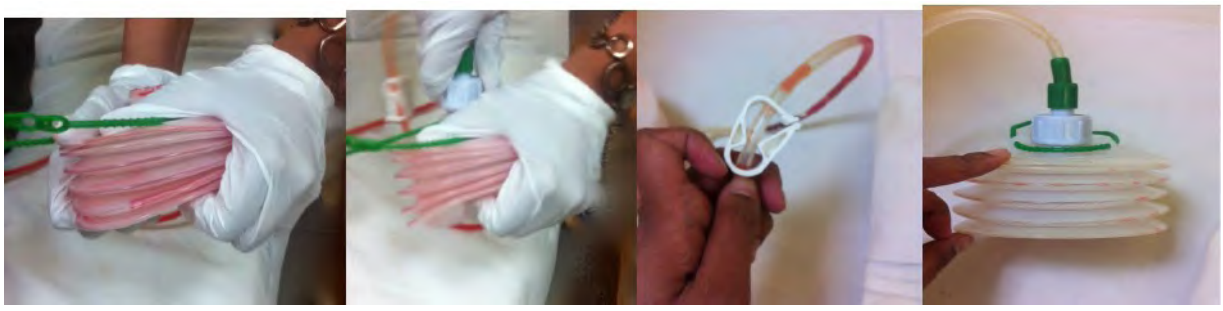

Please Turn Over

RECORD THE OUTPUT ALONG WITH THE DATE AND TIME OF MEASUREMENT

DATE	TIME	OUTPUT (ml)

DATE	TIME	OUTPUT (ml)

ANNEXURE I
(Refer to General Manual Policy and Procedure No. 9)

BUSINESS OFFICE STAFF MEETING

TOPIC: _____

SPEAKER: _____

DATE: _____

TIME: _____

(Include inservice starting time and inservice ending time)

PRESENT

(Name)	(Signature)
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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

TABLE OF CONTENTS

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

ENDOCARDITIS PROPHYLAXIS		
Policy/Procedure Applies To	**Anaesthesiologists and Staff Nurses**	**Policy/Procedure No: 9** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ENDOCARDITIS PROPHYLAXIS

PURPOSE

To ensure Endo-carditis prophylaxis.

POLICY

It is the policy of Prime Surgical Centers to have available a standard prophylactic regimen as recommended for dental, oral or upper respiratory tract, genitourinary or gastrointestinal procedures in adult patients at risk.

"At risk" patients are defined as any patient who has an organic cardiac lesion, such as mitral valve prolapse, valvular disease, or rheumatic heart disease. According to recommendations of the American Heart Association, the only patients with mitral valve prolapse who should receive antibiotic prophylaxis are those with valvular regurgitation. Recommended medications, dosage, and timing are given according to the physician's orders. With the discharge instructions, a prescription should be given for the remaining antibiotic regimen, if ordered, and the importance of completing the antibiotic course for preventing endocarditis should be stressed.

"At risk" patients may also be defined as those patients who have previously been identified by their medical doctor and were told that they should engage in the antibiotic regimen prior to certain procedures.

In the event that this specific group of "at risk" patients have failed to follow the standard prophylactic regimen prior to the procedure and it becomes known to staff of Prime Surgical Centers, they will give the appropriate dose according to the Anaesthesiologist's orders.

Revised by:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

ENDOCARDITIS PROPHYLAXIS		
Policy/Procedure Applies To	**Anaesthesiologists and Staff Nurses**	**Policy/Procedure No: 9** **Page: 1 of 1**
Effective Date: 11 April, 2013		

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Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

SAFETY MANUAL

EQUIPMENT MAINTENANCE		
Policy/Procedure Applies To	**All Nurses / Executive facility**	**Policy/Procedure No: 9** **Page: 1 of 1**
Effective Date: 11 April, 2013		

EQUIPMENT MAINTENANCE

POLICY

Each piece of operating room and nursing unit equipment shall be checked prior to any procedures commencing. This it to ensure proper operation of the equipment and reduce the possibility of malfunction and/or injury to patients or staff during any procedure or the recovery period. Same procedure will be followed for any dropped/mishandled equipment.

PROCEDURE

1. The designated O.R. staff/Nursing staff in nursing unit will check each piece of equipment to be used during the day by turning on the apparatus and checking to see that the functions of the unit work properly. With some machinery, it may not be possible for the equipment to run through all of its functions, but the safety of the machinery should be able to be determined by this exercise.
2. The designated O.R. staff/Nursing staff in nursing unit will document that this check took place.
3. Obvious hazards are reported. Any suspect equipment is immediately pulled from service until cleared.
4. A bio-medical Engineer (consultant) will check piece of equipment and perform electrical safety checks (preventive maintenance or PM) twice annually and attach labels to the equipment to verify these checks.
5. Documentation of these checks shall be kept by the Prime Surgical Centers for entire life of equipment. Executive Facility will be responsible for this activity.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE II
(Refer to General Manual Policy and Procedure No. 9)

GENERAL STAFF MEETING

TOPIC: _____

SPEAKER: _____

DATE: _____

TIME: _____

(Include inservice starting time and inservice ending time)

PRESENT

(Name and Unit)	(Signature)
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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

IN-PATIENT DEPARTMENT (IPD) FILE		
Module Applies To	**Customer Care / Staff Nurse**	**Policy and Procedure No.: 9** **Page: 1 of 1**
Effective Date: 11 April, 2013		

IN-PATIENT DEPARTMENT (IPD) FILE

PURPOSE

To handover a completed patient information file to the In-Patient Department before a surgery/procedure.

PROCEDURE

The In-Patient file should contain all the documents relating to the patient's case history, diagnosis, surgical and anaesthesia consent forms, bills, etc. For details refer to Nursing Manual Policy and Procedure No. 25.

Once the file is prepared, the OPD Nurse or the Customer Care Executive who has prepared the file will sign on the Pre-Operative Documentation Checklist and hand over the file to the Staff Nurse before or at the time of admission of the patient.

A handband (identity) for the patient will also be handed over to the Staff Nurse. The handbands are in two colours – red and grey. The red coloured handband is for patients who have any allergies and the grey coloured one is for those who don't have any allergies.

Make an entry in the Patient Handover Book and take signature of the Nursing Staff accepting the file, to keep a record of IPD file handover.

The Staff Nurse will check the contents of the file and confirm whether all the documentation as mentioned on the Pre-Operative Documentation Checklist is a part of the file.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

MEDICATION CALCULATIONS		
Module Applies To	**All Nurses and Technicians**	**Module No: 9** **Page: 1 of 17**
Effective Date: 11 April, 2013		

MEDICATION CALCULATIONS

COMPETENCY STATEMENT

New hire is able to confidently and competently calculate medication measurements as prescribed in utilizing various formulas/methods for medications via various routes of administration.

LEARNING OUTCOME

1. Make conversions within the metric system.
2. Utilize various formulas for calculating doses, temperatures, ratio's & proportions.
3. Utilize various formulas for calculating infusion rates.

CONVERSIONS BETWEEN METRIC UNITS

Because the metric system is based on the decimal system, conversions between one metric system unit and another can be done by moving the decimal point. The number of places to move the decimal point depends on the equivalent.

In health care, each unit of measure in common use for purposes of medication administration differs by 1,000. In the metric system the most common terms used are the gram, liter, microgram, milligram, milliliter, centimeter and kilogram. To convert or make a conversion means to change from one form to another. This conversion can be simply changing a measure to its equivalent in the same system. Changing from grams to milligrams illustrates a metric measure changed to another metric measure. Each metric unit in common use differs from the next by a factor of 1,000. Metric conversions can therefore be made by dividing or multiplying by 1,000. Knowledge concerning the size of a unit is important when converting by moving the decimal, because this determines whether division or multiplication is necessary to make the conversion.

Nurses often make conversions within the metric system when administering medications; for example, g to mg.

To make conversions within the metric system, remember the common conversion factors:
(1 kg = 1,000 g, 1 g = 1,000 mg; 1 mg = 1,000 mcg and 1 L = 1,000 mL) and the following rules:

1. To convert a **smaller** unit to a **larger** one, **divide** by moving the decimal point **three places to the left.**

   Example 1: 100 mL = _____ L (conversion factor 1,000 mL = 1 L)
   (smaller) (larger)

   100 mL = .100 = 0.1 L (placing zero in front of the decimal is important)

   Example 2: 50 mg = _____ g (conversion factor 1,000 mg = 1 g)
   (smaller) (larger)

   50 mg = .050 = 0.05 g (Placing zero in front of the decimal is important.)

2. To convert a **larger** unit to a **smaller** one, **multiply** by moving the decimal **three places to the right.**

Example 1: 0.75 g = _____ mg (conversion factor 1 g = 1,000 mg)
(larger) (smaller)

0.75 g = 0.750 = 750 mg

Example 2: 0.04 kg = _____ g (conversion factor 1 kg = 1,000 g)
(larger) (smaller)

0.04 kg = 0.040 = 40 g

SELF-EVALUATION AND CALCULATION PRACTICE

Convert the following metric measures by moving the decimal.

1.	300 mg	= _____	g	11.	529 mg	= _____	g
2.	6 mg	= _____	mcg	12.	645 mcg	= _____	mg
3.	0.7 L	= _____	mL	13.	347 L	= _____	mL
4.	180 mcg	= _____	mg	14.	238 g	= _____	mcg
5.	0.02 mg	= _____	mcg	15.	3,500 mL	= _____	L
6.	4.5 L	= _____	mL	16.	0.04 kg	= _____	g
7.	4.2 g	= _____	mg	17.	658 kg	= _____	g
8.	0.9 g	= _____	mg	18.	51 mL	= _____	L
9.	3,250 mL	= _____	L	19.	1.6 mg	= _____	mcg
10.	42 g	= _____	kg	20.	28 mL	= _____	L

Points to Remember

1. The liter and the gram are the basic units used for medication administration.
2. Conversion factors must be memorized to do conversions. The common conversion factors in the metric system are 1 kg = 1,000 g, 1 g = 1,000 mg, 1 mg = 1,000 mcg and
   1 L = 1,000 mL (mL is the correct term to use in relation to volume, instead of cc).
3. Express answers using the following rules of the metric system:
   a. Fractional parts are expressed as a decimal.
   b. Place a zero in front of the decimal point when it is not preceded by a whole number.
   c. Omit unnecessary zeros to avoid misreading of a value.
   d. The abbreviation for a measure is placed after the quantity.
4. Converting common metric units used in medication administration from one unit to another is done by moving the decimal point three places.
5. Answers should be stated with the unit of measure as a label.
6. Values greater than 1,000 should be written with a comma.

Think Critically to Avoid Drug Calculation Errors

Do not rely solely on formulas when calculating doses to be administered. Use critical thinking skills such as considering what the answer should be, reasoning, problem solving and finding rational justification for your answer. Formulas should be used as a tool for validating the dose you THINK should be given.

FORMULAS FOR CALCULATING DOSES

FORMULA: 1

When the dose desired and the dose on hand are in different systems, convert them to the same system before using the formulas. We can write the first formula as:

$$\frac{\mathbf{D}}{\mathbf{H}} \times \mathbf{Q} = x$$

where:

D = The dose desired, or what the physician has ordered, including the weights.
For example: mg, g,.

H = The dose strength available, what is on hand, or the weight of the drug on the label, including the weights. For example: mg, g,.

Q = The quantity or the unit of measure that contains the dose that is available. In other words the number of tablets, capsules, milliliters, etc., that contains the available dosage. “Q” is labeled accordingly as tablet, capsule, milliliter, etc.

When solving a problem that involves solid forms of medication (e.g.,tabs, caps), Q is always 1 and can be eliminated from the equation. **For consistency and to avoid chances of error when Q is not 1, always include Q even with tablet and capsule problems.** When solving problems for medications in solution, the amount for Q varies and must always be included.

x = The unknown, the dose you are looking for, the dosage you are going to administer, how many mL, tab, etc. you will give.

Note: It is important to note that the unknown "*x"* and "Q" will always be stated in the same unit of measure. It is critical that the formula is always set up with all of the terms in the formula labeled with the correct units of measure.

FORMULA: 2

The second formula is a ratio-proportion; the terms in the proportion are labeled differently and set up as a fraction. We can write it as:

$$\frac{\mathbf{DW}}{\mathbf{SW}} = \frac{\mathbf{DV}}{\mathbf{SV}}$$

where:

DW = **Dose weight** – The dose desired, or what the doctor has ordered, including the weights. For example; mg, g,.

SW = **Stock weight** – The dose strength available, what is on hand, or the weight of the drug on the label, including the weights. For example; mg, g,.

DV = **Dose volume** – The unknown, the dose you are looking for, the dose you are going to administer – *x* is used to represent this value. The number of mL, tab, caps, etc. *x* is always labeled.

SV = **Stock volume** – The quantity of unit of measure that contains the dose available. For solid forms of medication (tabs, caps) the SV is always 1 (for example, 1 tab, 1 caps). For medications in solution the amount for SV varies. To avoid errors in calculation always include the SV even if the value is 1.

STEPS FOR USING THESE FORMULAS

Either of the formulas presented may be used to calculate a dose to administer. The nurse should choose a formula and use it consistently. Regardless of which formula is used, remember the steps for using the formula.

1. Memorize the formula, or verify the formula from a resource.
2. Place the information from the problem into the formula in the correct position, with all terms in the formula labeled correctly.
3. Make sure all measures are in the same units and system of measure or a conversion must be done before calculating the dose.

4. Think logically and consider what a reasonable amount would be to administer.
5. Calculate your answer.
6. Label all answers – tabs, caps, mL, etc.

Now we will look at sample problems illustrating the use of the formulas.

Example: *Order: 0.375 mg p.o. of a drug. The tablets available are labeled 0.25 mg.*

Solution: The dose 0.375 mg is desired, the dose strength available is 0.25 mg per tablet. No conversion is necessary. What is desired is in the same system and unit of measure as what you have on hand.

➔**Formula Setup**

$$\frac{D}{H} \times Q = x$$

The desired (D) is 0.375 mg. You have on hand (H) 0.25 mg per (Q) 1 tablet. The label on *x* is tablet. Notice the label on *x* is always the same as Q.

$$\frac{\text{(D) } 0.375 \text{ mg}}{\text{(H) } 0.25 \text{ mg}} \times \text{(Q) } 1 \text{ tab} = x \text{ tab}$$

$$\frac{0.375}{0.25} \times 1 = x$$

$$\frac{0.375}{0.25} = x$$

OR

$$\frac{DW}{SW} = \frac{DV}{SV}$$

The desired (DW) is 0.375 mg. You have on hand (SW) 0.25 mg per (SV) 1 tablet. The label on *x* is tablet (DV). Notice the label on *x* is always the same as SV.

$$\frac{\text{(DW) } 0.375 \text{ mg}}{\text{(SW) } 0.25 \text{ mg}} = \frac{\text{(DV) } x \text{ tab}}{\text{(SV) } 1 \text{ tab}}$$

$$0.25 \times (x) = 0.375 \times 1$$

$$\frac{0.25\,x}{0.25} = \frac{0.375}{0.25} \qquad \frac{0.375}{0.25} = x$$

Answer: ***x*** **= 1.5 tabs, or 1 ½ tabs (Because 0.375 is larger than 0.25 mg, you will need more than 1 tab to administer 0.375 mg.) Note: Although 1.5 tabs is the same as 1 ½ tabs, for administration purposes it would be best to state is as 1 ½ tabs.**

Example: *Order: 7,000 U I.M. of a drug. The drug is available 10,000 U in 2 mL.*

Solution:

$$\frac{\text{(D) } 7{,}000 \text{ U}}{\text{(H) } 10{,}000 \text{ U}} \times \text{(Q) } 2 \text{ mL} = x \text{ mL}$$

$$\frac{7{,}000}{10{,}000} \times 2 = x$$

$$\frac{14{,}000}{10{,}000} = x$$

Note: Omitting Q here could result in an error. A liquid medication is involved; Q must be included.

OR

$$\frac{\text{(DW) } 7{,}000 \text{ U}}{\text{(SW) } 10{,}000 \text{ U}} = \frac{\text{(DV) } x \text{ mL}}{\text{(SV) } 2 \text{ mL}}$$

$$10{,}000 \times (x) = 7{,}000 \times 2$$

$$\frac{10{,}000x}{10{,}000} = \frac{14{,}000}{10{,}000} \qquad \frac{14{,}000}{10{,}000} = x$$

Note: SV here is 2 mL and is important to include, because with liquid medications this can vary.

Answer: ***x*** **= 1.4 mL. (because 7,000 U x 2 is more than 10,000 U, it will take more than 1 mL to administer the dose.)**

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RULES FOR DIFFERENT UNITS OR SYSTEMS OF MEASURE

Whenever the desired amount and the dose on hand are in different units or systems of measure, follow these steps:

1. Choose the identified equivalent.
2. Convert what is ordered to the same units or system of measure as what is available on hand by using one of the methods presented in the chapter on converting.
3. Use the formula: $\frac{D}{H} \times Q = x$ **or** $\frac{DW}{SW} = \frac{DV}{SV}$ to calculate the dose to administer

SELF EVALUATION CALCULATION PRACTICE

Calculate the following problems using one of the formulas presented.

1. Order: 0.4 mg p.o.

   Available: Tablets labeled 0.2 mg. _____

2. Order: 0.75 g p.o.

   Available: Capsules labeled 250 mg. _____

3. Order: 90 mg p.o.

   Available: Tablets labeled 60 mg. _____

4. Order: 7.5 mg p.o.

   Available: Tablets labeled 2.5 mg. _____

5. Order: 0.05 mg p.o.

   Available: Tablets labeled 25 mcg. _____

6. Order: 0.4 mg p.o.

   Available: Tablets labeled 200 mcg. _____

7. Order: 1,000 mg p.o.

   Available: Tablets labeled 500 mg. _____

8. Order: 0.6 g p.o.

   Available: Capsules labeled 600 mg. _____

Calculate the following in mL; round to the nearest tenth where indicated.

9. Order: 10 mg s.c.

   Available: 15 mg per mL. _____

10. Order: 400 mg p.o.

    Available: Oral solution labeled 200 mg/5 mL. _____

11. Order: 15 mEq p.o.

    Available: Oral solution labeled 20 mEq/10 mL. _____

12. Order: 125 mg p.o.

    Available: Oral solution labeled 250 mg/5 mL. _____

13. Order: 0.025 mg p.o.

    Available: Oral solution labeled 0.05 mg/5 mL. _____

14. Order: 375 mg p.o.

    Available: Oral solution labeled 125 mg/5 mL. _____

USE OF RATIO-PROPORTION IN DOSE CALCULATION

Ratio-proportion is useful and easy to use in dose calculation, because it is often necessary to find only one unknown quantity.

For example, suppose you had a medication with a dose strength of 50 mg in 1 mL and the physician orders a dose of 25 mg. A ratio-proportion may be used to solve this.

The known ratio is 50 mg: 1 mL and *x* represents the unknown number of mL that would contain 25 mg. Therefore, to set this problem up in a ratio-proportion, the known ratio (50 mg: 1 mL) is stated first, then the unknown ratio (25 mg: *x* mL).

The known ratio is what you have **available**, or the information on the drug label.

It is important to remember when stating ratios that the units of measure should be stated in the same sequence (in the example, mg : mL = mg : mL).

Example: 50 mg : 1 mL = 25 mg : *x* mL

(known) (unknown)

Solution: To solve for *x* use the principles presented in Chapter 4 on ratio-proportion

50 : 1 mL = 25 mg : *x* mL

$50x$ = product of extremes

25 = product of means

$50x = 25$ is the equation

$\frac{50x}{50} = \frac{25}{50}$ (Divide both sides by 50, the number in front of *x*.)

x = **0.5 mL**

IMPORTANT POINTS WHEN CALCULATING DOSES USING RATIO-PROPORTION

1. Make sure all terms are in the same unit and system of measure before calculating. If they are not, a conversion will be necessary before calculating the dose. Conversions can be made by changing what is ordered to the units in which the medication is available or by changing what is available to the units in which the medication is ordered. Try to be consistent as to how you make conversions. It is usual to convert what is ordered to the same unit and system of measure you have available.

2. Before calculating the dose, make a mental estimate of the approximate and reasonable answer.

3. Set up the proportion, labeling all terms in proportion. This includes *x*. State the known ratio first (what is available or on the drug label).

4. Make sure the terms of the ratios are stated in the same sequence.

5. Label the value you obtain for *x* (for example, mL, tabs).

Let's use ratio-proportion to solve some more problems.

Example: *Order: 40 mg p.o. of a drug. Available: 20 mg tablets.*
How many tablets will you administer ?

Solution: 20 mg : 1 tab = 40 mg : x tab

(known) (unknown)

$$\frac{20x}{20} = \frac{40}{20}$$

x **= 2 tablets**

Note: When setting up the ratios, follow the sequence in stating the terms for both.

For example, mg : tab = mg : tab

This proportion could also be stated as a fraction and solved by cross multiplication.

Known Unknown

$$\frac{20\text{mg}}{1\text{ tab}} = \frac{40\text{ mg}}{x\text{ tab}}$$

Here the unknown is stated as the first fraction and the unknown as the second.

Example: *Order: 1g p.o. of an antibiotic. Available: 500 capsules.*
How many capsules will you give?

Solution: Notice the dose ordered is a different unit from what is available. Proceed first by changing the units of measure so they are the same.

After making the conversion, set up the problem and calculate the dose to be given. In this example the conversion required is within the same system (metric).

In this example g is converted to mg by using the equivalent 1,000 mg = 1 g. After making the conversion of 1 g to 1,000 mg, the ratio is stated as follows:

500 mg : 1 cap = 1,000 mg : *x* cap

(known) (unknown)

x **= 2 capsules**

An alternate method of solving might be to convert mg to g. In doing this, 500 mg would be converted to g using the same equivalent: 1,000 mg = 1 g. However, decimals are common when measures are changed from smaller to larger in the metric system: 500 mg = 0.5 g. Even though converting the mg to g would net the same final answer, *conversions that net decimals are often the source of calculation errors*. Therefore, if possible, avoid conversions that require their use. As a rule, it is best to convert to the measure stated on the drug label. Doing this consistently can prevent confusion. As with the other examples, this proportion could be stated as a fraction as well.

POINTS TO REMEMBER

1. When stating ratios, the known ratio is stated first. The known ratio is what is available, on hand, or the information obtained from the drug label.
2. The unknown ratio is stated second. The unknown ratio is the dose desired, or what the physician has ordered.
3. The terms of the ratios in a proportion must be written in the same sequence of measurement.
4. Label all terms of the ratios in the proportion, including x.
5. When conversion of units is required, it is usually easier to convert to the unit of measure on the drug label, or what the medication is available in. A problem cannot be solved if the units of measurement are not the same.
6. Estimate the answer.
7. Label all answers obtained.
8. A proportion may be stated in horizontal fashion or as a fraction.
9. Double check all work.
10. Be consistent in how ratios are stated and conversions are done.
11. An error in the set up of the ratio proportion can cause an error in calculation.

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CALCULATION FOR PRACTICE

Answer the following problems by indicating whether you need less than 1 tablet or more than 1 tablet.

1. A client is to receive 1.25 mg of a drug. The tablets available are 0.625 mg.

   How many tablets do you need? _____

2. A client is to receive 10 mg of a drug. The tablets available are 20 mg.

   How many tablets do you need? _____

3. A client is to receive 100 mg of a drug. The tablets available are 50 mg.

   How many tablets do you need? _____

Solve the following problems using ratio-proportion calculations. Express your answer to the nearest tenth where indicated and include the units of measure in the answer.

4. Order: 7.5 mg p.o. of a drug.

   Available: Tablets labeled 5 mg. _____

5. Order: 0.25 mg I.M. of a drug.

   Available: 0.5 mg per mL. _____

6. Order: 100 mg p.o. of a liquid medication.

   Available: 125 mg per 5 mL. _____

7. Order: 20 mEq I.V. of a drug.

   Available: 40 mEq per 10 mL. _____

8. Order: 5,000 U s.c. of a drug.

   Available: 10,000 U per mL. _____

9. Order: 50 mg I.M. of a drug.

   Available: 80 mg per 2 mL. _____

10. Order: 0.5 g p.o. of an antibiotic.

    Available: Capsules labeled 250 mg. _____

11. Order: 400 mg p.o. of a liquid medication.

    Available: 125 mg per 5 mL. _____

12. Order: 50 mg I.M. of a drug.

    Available: 80 mg per mL. _____

13. Order: 0.24 g p.o. of a liquid medication.

    Available: 80 mg per 7.5 mL. _____

14. Order: 20 g p.o. of a liquid medication.

    Available: 10 g per 15 mL. _____

15. Order: 0.125 mg I.M. of a drug.

    Available: 0.5 mg per 2 mL. _____

16. Order: 0.75 mg I.M. of a drug.

    Available: 0.25 mg per mL. _____

FORMULAS FOR CONVERTING BETWEEN FAHRENHEIT & CELSIUS SCALES

1. To convert from Celsius to Fahrenheit, multiply by 1.8 and add 32.

$$^{o}F = 1.8\,(^{o}C) + 32$$

or

$$^{o}F = 9/5\,(^{o}C) + 32$$

Example: *Convert 37.5° C to ° F*

° F	=	(1.8) x 37.5 + 32		° F	=	9/5 x 37.5 + 32
° F	=	67.5 + 32	or	° F	=	67.5 + 32
° F	**=**	**99.5°**		**° F**	**=**	**99.5°**

Your preference between these formulas is based on whether you find it easier to work with decimals or fractions.

2. To convert from Fahrenheit to Celsius, subtract 32 and divide by 1.8.

$$^{o}C = \frac{^{o}F - 32}{1.8} \quad \text{or} \quad ^{o}C = (^{o}F - 32) \div \frac{9}{5}$$

Example: *Convert 68° F to ° C*

° C	=	$\frac{68 - 32}{1.8}$		° C	=	$(68 - 32) \div \frac{9}{5}$
° C	=	$\frac{36}{1.8}$	or	° C	=	$36 \div \frac{9}{5}$
				° C	=	$(36) \times \frac{5}{9}$
° C	**=**	**20°**		**° C**	**=**	**20°**

When converting between Fahrenheit and Celsius, if necessary carry the math process to hundredths and round to tenths.

FORMULAS FOR INTRAVENOUS FLOW RATE CALCULATIONS (Two Methods)

Two Step

Step 1 - Amount of fluid divided by hours to administer = ml/hr

Step 2 - $\frac{\text{ml/hr x gtts/ml(IV set)}}{\text{60 min}}$ = gtts/min

One Step

$$\frac{\text{amount of fluid x drops/milliliter (IV set) (drop factor)}}{\text{hours to administer x minutes/hour (60)}}$$

Example: 1000 ml over 8 hrs
IV set = 15 gtts/ml

Two Step

Step 1 - $\frac{1000}{8} = 125$

Step 2 - $\frac{125 \times 15}{60}$ = 31.25 (31 gtts/min)

One Step

$$\frac{1000 \times 15}{8 \text{ hrs} \times 60} = \frac{15{,}000}{480} = 31.25 \text{ (31gtts/min)}$$

Drop factor - IV tubing has a drip chamber that is used to count drops (gtts) per minute. Each tubing is labeled with the number of drops per milliliter (drop factor).

Macrodrop Tubing - has a drop factor of 10, 15 or 20 gtts/ml (drops per milliliter).

MicrodropTubing - has a drop factor of 60 gtts/ml.

Advanced Calculations: How to Calculate Continuous Infusions

A. mg/min (For example - Lidocaine, Pronestyl)

$$\frac{\text{Solution ml} \times 60 \text{ min/hr} \times \text{mg/min}}{\text{Drug mg}} = \text{ml/hr}$$

B. mcg/min (For example - Nitroglycerin)

$$\frac{\text{Solution ml} \times 60 \text{ min/hr} \times \text{mcg/min}}{\text{Drug mcg}} = \text{ml/hr}$$

C. mcg/kg/min (For example - Dopamine, Dobutamine, Nipride, etc.)

$$\frac{\text{Solution ml}}{\text{Drug mcg}} \times 60 \text{ min/hr} \times \text{kg} \times \text{mcg/kg/min} = \text{ml/hr}$$

Example: Dopamine 200 mg/50 ml D_5W to start at 6 mcg/kg/min.
Patient's weight is 90 kgs.

$$\frac{50 \text{ ml}}{200{,}000 \text{ mcg}} \times 60 \text{ min} \times 90 \times 6 \text{ mcg/kg/min} = 8.1 \text{ ml/hr}$$

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Calculation Practice

1. Dopamine 400 mg in 250 ml D5W to infuse at 5 mcg/kg/min. The patient's weight is 200 pounds. How many ml/hour would this be on an infusion pump?
2. A Dopamine drip (400mg in 250 ml of IV fluid) is infusing on your 80 kg patient at 20 ml/hour. How many mcg/kg/min are infusing for this patient?
3. A Nitroglycerin drip is ordered for your patient to control his chest pain. The concentration is 100 mg in 250 ml D5W. The order is to begin the infusion at 20 mcg/min. What is the rate you would begin the infusion on the infusion pump?
4. A Nitroglycerin drip (100mg in 250 ml D5W) is infusing on your patient at 28 ml/hour on the infusion pump. How many mcg/min is your patient receiving?
5. A procainamide drip is ordered (2gms in 250 ml D5W) to infuse at 4 mg/min. The patient weighs 165 pounds. Calculate the drip rate in ml/hour for which the infusion pump will be set at.
6. A Lidocaine drip is infusion on your 90 kg patient at 22 ml/hour. The Lidocaine concentration is 2 grams in 250 ml of D5W. How many mg/min is your patient receiving?

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

EXPOSURE CONTROL PLAN MANUAL

METHODS OF COMPLIANCE: LAUNDRY PRACTICES		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 9** **Page: 1 of 1**
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METHODS OF COMPLIANCE: LAUNDRY PRACTICES

(Refer Hospital Infection Control Manual Policy and Procedure No. 13 and 15)

1. Contaminated laundry will be handled as little as possible with a minimum of agitation.
2. Contaminated laundry will be bagged at the location where it was used and will not be sorted or rinsed in the location of use.
3. Contaminated laundry will be placed and transported in bags labeled with the biohazard symbol. If universal precautions are used in the handling of soiled laundry within the facility, it is sufficient if it allows all employees to recognize the containers as requiring compliance with universal precautions.
4. When contaminated laundry is wet and presents a reasonable likelihood of soaking or leakage from the bag or container, the laundry will be placed and transported in bags or containers which prevent leakage of fluids to the exterior.
5. All employees who have contact with contaminated laundry will wear gloves and other appropriate personal protective equipment.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE III
(Refer to General Manual Policy and Procedure No. 9)

NURSING STAFF MEETING

TOPIC: _____

SPEAKER:_____

DATE:_____

TIME:_____

(Include inservice starting time and inservice ending time)

PRESENT

(Name and Unit)	(Signature)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
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AGENDA:

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

PATIENT SAFETY		
Policy/Procedure Applies To	**All Staff involved in Patient Care Activities**	**Policy/Procedure No: 9** **Page: 1 of 5**
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PATIENT SAFETY

PURPOSE

To provide guidelines so that safety measures are observed and given priority in patient care.

POLICY

1. Key areas that help to protect the safety of patient who are receiving care in Prime Surgical Centers are:
   a. Identify patient correctly. (Refer to Nursing Manual Policy and Procedure No. 8)
   b. Effective staff communication. (Refer to Nursing Manual Policy and Procedure No. 3 and 8)
   c. Use medicines safely. (Refer to Nursing Manual Policy and Procedure No. 8)
   d. Prevent health care-related infection. (Refer to Hospital Infection Control Manual)
   e. Checking of all life-saving/support bio-medical equipment for safety (Refer to Safety Manual Policy and Procedure No. 2, 4 and 8)
   f. Prevent errors in Surgery or during procedures in the unit or diagnostic areas. (Refer to Nursing Manual Policy and Procedure No. 28)
   g. Prevent patient from falling. (Refer to Nursing Manual Policy and Procedure No. 67, 68 and 69)
   h. Transporting Patients. (Refer to Nursing Manual Policy and Procedure No. 69)
   i. Positioning and Transporting Anaesthetized patients. (Refer to Nursing Manual Policy and Procedure No. 92 and Anaesthesia Manual Policy and Procedure No. 17)
   j. Lifting unconscious patients. (Refer to Procedure No. 9 of this policy)
2. Application of safety measures regarding patient care will be monitored consistently and reviewed frequently for comprehensiveness.
3. It is the responsibility of every member of the staff, physicians and employees to observe and report any breach of safety policies and procedures so that accidents will be prevented.
4. All nursing/nursing aide/housekeeping staff will be trained to use correct Body Mechanics for moving/lifting patients to prevent injury to self or patient. (Refer to Nursing Manual Policy and Procedure No. 75). As part of on-going Quality Assurance Programme, the Nursing Superintendent will monitor such injuries and ensure that specific unit holds reinforcing training programme for correct body mechanics.

PROCEDURE

The elements of the patient safety program to be implemented and documented are as follows:

1. Patient identification
   a. Patients will be identified upon admission by a tagging system that cannot be lost or accidentally removed.
   b. Identifying information will remain on patient until discharge.

c. Identifying information will include (minimum):

i. Patient's full name, sex, age and medical records no. (MR No.)

ii. Procedure

iii. Surgeon

iv. Allergies

d. Each staff member before administering any clinical care will check identification wristband and if the patient is responsive will verbally verify patient's identity before proceeding with above care.

2. Effective communication by the following

a. Write down complete verbal/telephone orders, test results in patient chart.

b. Follow the policy and procedure on verbal / telephone order. (Refer to Nursing Manual Policy and Procedure No. 64)

c. Document all communication clearly and in a timely way with legible hand writing.

d. Do not use abbreviation and symbols except for internationally accepted ones.

e. Standardized approach of handing / taking over patient by Nurses will be followed as under:

i. Use of SBAR (Situation, Background, Assessment and Recommendation) technique (Refer Annexure to this Policy)

ii. Repeat and read back system with sufficient time for communication between two nurses or nurse and consultant without interruption.

iii. Use of laid down check list.

3. Utilize Safety Manual Policy and Procedure for medicines / blood / blood products for the following

a. Medication administration. (Refer to Nursing Manual Policy and Procedure No. 35)

b. Medication check list Nursing Unit.

i. All medications will be monitored at least daily.

ii. All medications will be checked for refrigeration, safety hazards, environment, emergency equipment and medications.

iii. All medication cabinets will be cleaned at least daily or more often when needed.

iv. A medication checklist will be completed for Nursing Station on a weekly basis. The original will be kept on the cabinet.

v. Medication checklists will be kept on file for a minimum of one year in an easily accessible manner.

vi. Please refer to the Policy on High Alert Medication and Protocol of Medication Management and Use. (Refer to Nursing Manual Policy and Procedure No. 37)

c. Medication Refrigeration Safety.

A refrigerator checklist will be completed for each refrigerator located in a patient care unit.

i. All medication refrigerators in patient care units and Operation Theater will be monitored on a daily basis for a temperature range between 16 to 20 degrees Celsius and log to be maintained.

- The freezer compartment of medication refrigerators will not used for medication.
- All medication refrigerator freezers will have a sign on them indicating they are not being used.
- All medication refrigerators will be connected at all times to an emergency back-up power source.
- If the refrigerator temperature is not in desired range, the contents will be removed and placed in alternate refrigerator with appropriate temperature. The faulty refrigerator will be removed from service and tagged to indicate that it is not working and intimation forwarded to the Nursing Superintendent and Executive Facility immediately.

ii. All refrigerators in patient care units and Operation Theater will be cleaned at least weekly or more often as needed. At the time of defrosting (in case automatic defrosting facility is not incorporated) alternate arrangement will be laid down in writing by Nursing Superintendent.

iii. All refrigerators in patient care units will have contents checked for proper storage and labelling at least monthly.

iv. A refrigerator checklist will be completed monthly for each refrigerator in patient care units and Operation Theater and signed by the concerned nurse. The same will be checked by the Nursing Superintendent on a periodic basis,i.e.,monthly.

v. Refrigerator checklists will be kept on file for a minimum of one year in an easily accessible manner.

d. Blood and Blood products administration

e. Collection of Blood and other specimens for clinical testing. (Refer to Nursing Manual Policy and Procedure No. 38)

4. Reduce the risk of healthcare associated infection.

a. Follow infection control policy. (Refer to Hospital Infection Control Manual)

b. Report infection.

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5. Preventing Errors in Surgery or Procedures (Refer to Nursing Manual Policy and Procedure No. 28, 80 and 81)
   a. Correct patient / site procedure
      i. Ensure multidisciplinary checklist is completed before procedure and surgery (Refer to Nursing Manual Policy and Procedure No. 28 and 81)
      ii. Use 2 identifiers and match all documents. (Refer to Nursing Manual Policy and Procedure No. 8)
      iii. Ensure multidisciplinary time out checklist is complete before Procedure / surgery begins. (Refer to Nursing Manual Policy and Procedure No. 80)
   b. Precautions for Intubation / Extubation

      If general anaesthesia is administered, the nurse will not leave room during intubation or extubation. The patient may need guarding to prevent injury to himself and/or anaesthesia staff may require assistance. One person will be readily available to assist with intubation. (i.e. a second anesthesia staff or a Circulating Nurse.)
6. Protection from falls (Refer to Nursing Manual Policy Procedure No. 67, 68 and 69)
   a. Use appropriate Safety measures
   b. Vertigo may result at any time and from a number of causes. Patients are not to be left alone.
   c. Side rails must be utilized at all times even when patients are observed / transported and to be documented. Safety restraint straps are to be utilized during the entire time patient is in OT.
   d. If patient is transferred from stretcher or from operating table to stretcher, the following precautions are observed:
      i. Operating table and stretcher wheels are locked.
      ii. Space between stretcher and operating table is minimal.
      iii. It is necessary to have a minimum of two people when transferring, one on each side of operating table and stretcher.
7. Transporting patients (Refer to Nursing Manual Policy Procedure No. 69).
   a. Position patient's arms and legs inside rails to prevent damage on door frames or wall projections.
   b. Side rails up and locked.
   c. If patient is awake explain the transfer procedure.

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Effective Date: 11 April, 2013		

8. Positioning and transporting anaesthetized patients (Refer to Nursing Manual Policy Procedure No. 92 and Anaesthesia Manual Policy Procedure No. 17)
    a. When positioning patient after anaesthesia has been given, Anaesthesiologist will tell circulating nurse when patient can be safely positioned. The anaesthesia staff guards endo-tracheal tube, protects patient's neck and head, and prevents kinking of tubes. If support personnel are helping turn or move patient, make sure they are aware of dangers in premature moving and how to position properly. Anaesthesiologist will direct and coordinate all major moving or turning activities. Any activity that may potentially affect airway maintenance requires consent of Anaesthesiologist prior to initiation.
    b. Moving of anaesthetized patient must be done gently and slowly. Circulatory depression can also occur when turning into or out of Trendelenburg position. Make corrections slowly and by degrees.
9. Lifting unconscious patients
    a. Anaesthesia staff guards head and neck from injury. Do not allow arms or legs to dangle.
    b. Arms are splinted or supported.
    c. Move slowly by degrees.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 9)

SBAR (Situation, Background, Assessment and Recommendation)

S - Situation

What is the situation that you are talking about?

1. Identity self, unit, patient, room number.
2. Briefly state the problem, what is it, when it happened/ started and how severe.

B - Background

Pertinent background information related to the situation, to include:

1. Date of Admission, admitting diagnosis.
2. List of current medication, allergies and IV fluids.
3. Most recent vital signs.
4. Laboratory results, provide date and time of test and result of previous test for comparison.
5. Other clinical information.

A - Assessment

What is your assessment of the situation?

R - Recommendation

What is your recommendation or what do you want? E.g. Patient needs to be seen now.

ANNEXURE IX
(Refer to Housekeeping Manual Policy and Procedure No. 1)

PHARMACY

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
Glass Partitions	X			
Counter Tops	X			
A/C baffles		X		
Chairs	X			
Shelves			X	
Refrigerator	X			
Luminaries		X		
Electrical Outlets/Switch Plates	X			
Empty Waste Bins	X			

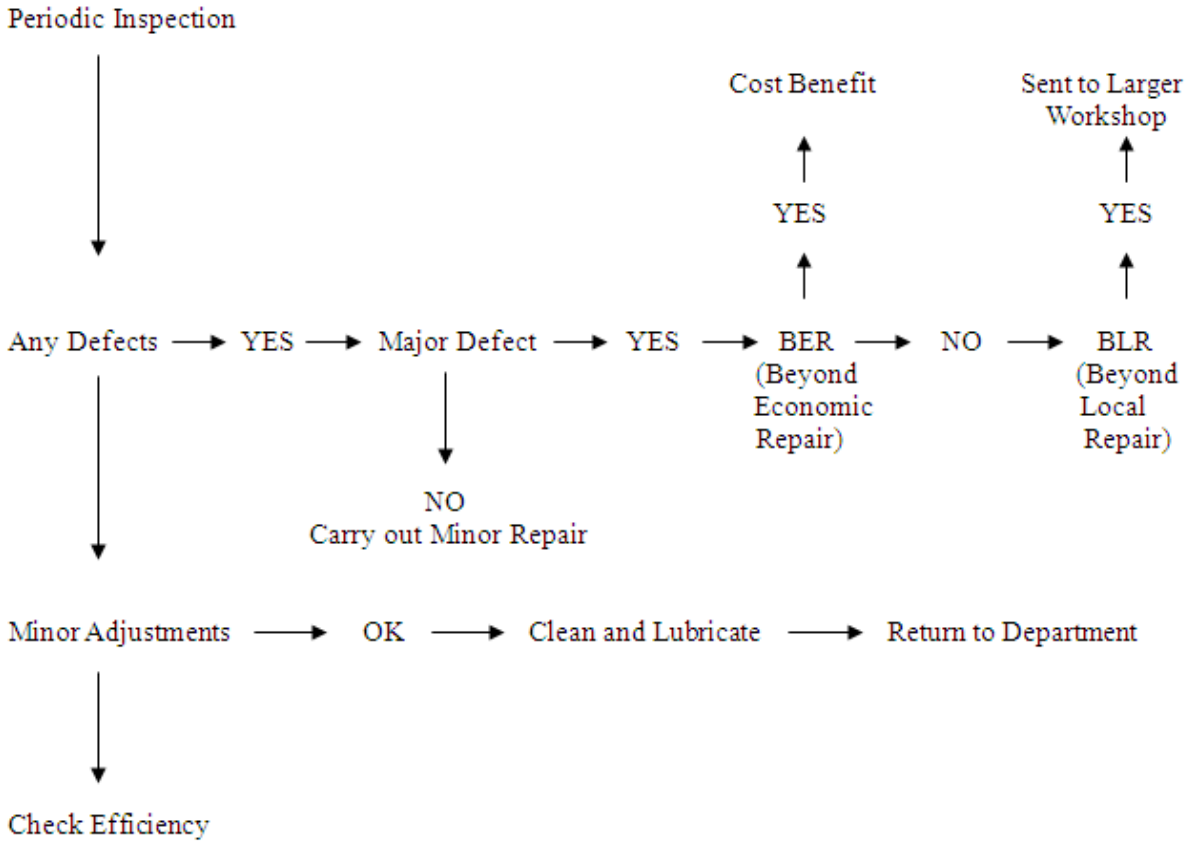
PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

PREVENTIVE MAINTENANCE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 9** **Page: 1 of 1**
Effective Date: 11 April, 2013		

DIAGRAMMATIC FLOW CHART OF PREVENTIVE MAINTENANCE



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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

PREVENTIVE MAINTENANCE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 9** **Page: 1 of 1**
Effective Date: 11 April, 2013		

DIAGRAMMATIC FLOW CHART OF PREVENTIVE MAINTENANCE

Periodic Inspection

Cost Benefit — Sent to Larger Workshop

YES — YES

Any Defects · YES · Major Defect · YES · BER (Beyond Economic Repair) · NO · BLR (Beyond Local Repair)

NO
Carry out Minor Repair

Minor Adjustments · OK · Clean and Lubricate · Return to Department

Check Efficiency

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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

RESPONSIBILITIES OF INFECTION CONTROL OFFICER		
Policy/Procedure Applies To	**Nursing Superintendent**	**Policy/Procedure No: 9** **Page: 1 of 1**
Effective Date: 11 April, 2013		

RESPONSIBILITIES OF INFECTION CONTROL OFFICER

PURPOSE

Success of any Infection Control Program will depend on nominating a suitable person as Infection Control Officer and laying down his/her responsibilities.

POLICY

Nursing Superintendent of Prime Surgical Centers will be the Infection Control Officer.

RESPONSIBILITIES

1. Identification of infection trends
2. Reports communicable diseases to applicable public health agencies
3. Reviews patient related cultures
4. Reviews and monitors sterilization and disinfection processes
5. Formulates or revises policies and procedures to decrease the risk of infection
6. Interacts with personnel to increase the effective application of Infection Control policies and recommendations
7. Conducts staff education regarding Infection Control and related performance improvement strategies
8. Designs and conducts department surveillance monitoring
9. Monitors effective implementation of Universal Precautions
10. Reports patient and employee infections of epidemiologic significance and conducts surveillance as needed

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Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

STAFF MEETING FORMS		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 9** **Page: 1 of 1**
Effective Date: 11 April, 2013		

STAFF MEETING FORMS

1. Business Office Staff Meeting Form (Refer Annexure I to this policy)
2. General Staff Meeting Form (Refer Annexure II to this policy)
3. Nursing Staff Meeting Form (Refer Annexure III to this policy)

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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

ADMISSION OF PATIENT		
Module Applies To	**Customer Care/ All Nurses**	**Policy and Procedure No.: 10** **Page: 1 of 2**
Effective Date: 11 April, 2013		

ADMISSION OF PATIENT

PURPOSE

To admit the patient in Prime Surgical Centers for surgery / procedure as suggested by the Consultant.

(Also refer to Nursing Manual Policy and Procedure No. 26)

PROCEDURE

A patient will be admitted if the following conditions are met:

1. OT is available
2. Bed is available (as per patient's preference or depending upon the surgery package i.e. either in Comfort Ward or Deluxe Ward)

When the patient comes for admission confirm with the respective ward whether bed is ready. Also intimate the respective ward that the patient is getting admitted. If yes, complete the admission process in the system. If bed is not ready, request the patient to wait in the OPD till the time the bed is ready.

Payment

For details regarding mode of payment and other payment details refer to Customer Care and Billing Manual Policy and Procedure No. 13.

1. **Self - Paying**

   Take the advance payment of the surgery package from the patient and file the receipt in the patient file. Maintain one copy of the receipt with the patient's signature with us to be handed over to the Accounts department.

   If the patient does a part payment, fill the patient payment guarantee form and get it signed by the patient/patient's relative who can guarantee the payment before the discharge of the patient from Prime Surgical Centers. Attach it to the patient file.

2. **Cashless**

   Attach the Pre-Authorization Form of the TPA/Company to the patient file.

To admit a patient the following steps need to completed in the system:

1. Under the In Patient tab go to the Reception tab. Here select the Admission tab.
2. The Patient Admission Details form will open up.
3. Under the Registration Details enter the MR number to pull up the details of the patient.
4. Under the Admissions Details tab select the Bed Category and the Bed number. Add the patient kin information and save the details.
5. A Patient Registration and Admission form will be generated. Take two prints of the form and attach them to the patient file. One will be a part of the MRD file and one will be attached to the patient file that will be given to the patient at the time of discharge.

ADMISSION OF PATIENT		
Module Applies To	**Customer Care/ All Nurses**	**Policy and Procedure No.: 10** **Page: 2 of 2**
Effective Date: 11 April, 2013		

Check if the patient file is complete with all the relevant investigation reports and films. Refer to Nursing Manual Policy and Procedure No. 25 and Customer Care and Billing Manual Policy and Procedure No. 9.

Give the Attendant's pass to the patient's relative and inform them that only one relative will be allowed to be with the patient at one time. Take the patient/relative's sign on the Attendant's register.

On completion of the above, guide the patient to the respective Comfort or Deluxe Wing.

Handover the patient file to the Staff Nurse.

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

BREAST SURGERY PRE-OPERATIVE ORDERS		
Module Applies To	**Consultant**	**Policy and Procedure No.: 10** **Page: 1 of 1**
Effective Date: 1 April, 2014		

BREAST SURGERY PRE-OPERATIVE ORDERS

Date of Surgery: _____

Diagnosis: _____

_____

Procedure Scheduled: _____

Allergies: _____

1. Place IV on arm opposite to side of breast surgery.
2. Ensure NBM status after _____ OR ○ NA
3. Antibiotics:

   Send antibiotic checked below with the patient to the OT. Infusion to be started in OT.

   - o IV Cefazolin 1 g (If patient weight ≤ 80 kg)

   OR

   - o IV Cefazolin 2 g (If patient weight > 80 kg)

   OR

   - o IV Clindamycin 600 mg (If patient is allergic to Penicillin or Cephalosporin)

4. Ensure that side of surgery is marked by surgeon prior to transfer to the OT
5. Ensure that patient consent form is complete and signed before transfer to the OT
6. Send patient's mammogram and ultrasound films with patient to OT
7. Patient to void /urinate just before transfer to the OT

Other Orders:

_____

Name:

Signature:

Date and Time:

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
Phone: - 020-39931000 Fax: - 020 39931020
Email: - customercare@primesurgical.in
Website: www.primesurgical.in

BREAST SURGERY
PRE-OPERATIVE ORDERS

Name :

Age/Sex :

Comfort / Deluxe Bed No :

Admission Date :

Date of Surgery: _____

Diagnosis:

_____

_____

Procedure Scheduled: _____

Allergies: _____

1. Place IV on arm opposite to side of breast surgery.
2. Ensure NBM status after _____ OR ○ NA
3. Antibiotics:

   Send antibiotic checked below with the patient to the OT. Infusion to be started in OT.

   - IV Cefazolin 1 g (If patient weight ≤ 80 kg)

   OR

   - IV Cefazolin 2 g (If patient weight > 80 kg)

   OR

   - IV Clindamycin 600 mg (If patient is allergic to Penicillin or Cephalosporin)

4. Ensure that side of surgery is marked by surgeon prior to transfer to the OT
5. Ensure that patient consent form is complete and signed before transfer to the OT
6. Send patient's mammogram and ultrasound films with patient to OT
7. Patient to void /urinate just before transfer to the OT

Other Orders:

_____

_____

_____

_____

Name:

Signature:

Date and Time:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

DETERMINING HEALTHCARE ACQUIRED INFECTION (HAI)		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 10** **Page: 1 of 2**
Effective Date: 11 April, 2013		

DETERMINING HEALTHCARE ACQUIRED INFECTION (HAI)

DEFINITION

Healthcare Acquired Infection (HAI) manifests in patients in whom infection was not present or incubating at the time of admission.

When the incubation period is unknown, an infection is called HAI if it develops at any time following admission and is related to the surgical event. An infection present on admission can be classified as HAI, only if it is directly related to or the residual of a previous admission. All infections that fail to satisfy these requirements are classified as community acquired.

The term "Healthcare Acquired Infection" will include potentially preventable infections as well as some infections that may be regarded as inevitable.

POLICY

If infection is suspected upon postop examination, it is requested cultures be performed immediately to identify organisms and determine sensitivity.

Data will be collected to investigate the circumstance to determine if contamination occurred and to determine if infection is HAI.

GUIDELINES

Application of specific guidelines requires that the clinical and laboratory data be reliable. There must be a high degree of certainty as to when the clinical manifestations of the infection in question had their onset. Additionally, when the diagnosis of infection depends on microbiological identification of organisms, colony counts, or other laboratory procedures, it is essential that these procedures be reliably performed on adequately collected and promptly delivered specimens.

1. Skin and subcutaneous infections
   a. Surgical wound infections: Any surgical wound which drains purulent material, with or without a positive culture, is considered to be the site of a Healthcare Acquired Infection. The source of the organisms, whether endogenous or exogenous is not considered.
   b. Other cutaneous infections: Any purulent material in skin or subcutaneous tissue first developing after admission is regarded as indicating a Healthcare Acquired Infection whether or not a culture is positive, negative, or has not been taken.
2. Other sites of infection
   a. Any culture documented bacteremia that develops in a patient who was not admitted with evidence of bacteremia is regarded as a Healthcare Acquired Infection, unless the organism has been judged to be a contaminant. Such Healthcare Acquired Infection bacteremias may occur in the absence of recognized underlying infections, or originate from a site of Healthcare Acquired Infection, or from manipulation of a site which was infected at the time of the patient's admission (e.g. catheters, drains, incision and drainage, etc.)

DETERMINING HEALTHCARE ACQUIRED INFECTION (HAI)		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 10** **Page: 2 of 2**
Effective Date: 11 April, 2013		

b. Intravenous catheters and needles: Purulent drainage from site of an intravenous catheter or needle is regarded as Healthcare Acquired Infection, even if no cultures are obtained. Inflammation of such sites, without purulent material or strong clinical evidence cellulitis is not regarded as an infection unless a positive culture of fifteen (15) colonies is obtained from the catheter tip or from aspirates of tissue fluid and a positive blood culture is obtained. All culture results should be correlated with other clinical data.

c. Many other possible sites of Healthcare Acquired Infection must sometimes be considered. Application of the general principles outlined above, however, will generally make classification of these infections possible. It must be reemphasized that clinical impressions/diagnosis (if available) always supersedes laboratory or radiological data.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

SAFETY MANUAL

EMERGENCY BACKUP SYSTEM AND POWER FAILURE, EMERGENCY LIGHTING SYSTEM		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 10** **Page: 1 of 1**
Effective Date: 11 April, 2013		

EMERGENCY BACKUP SYSTEM AND POWER FAILURE, EMERGENCY LIGHTING SYSTEM

POLICY

The Prime Surgical Centers is equipped with an emergency backup power system. In the event of a power failure, the system will automatically start and provide electricity to all necessary support systems within 10 seconds.

PROCEDURE

1. The power system will be checked on a regular basis – monthly, at a minimum, by throwing the transfer switch. Readings will be taken from the control gauges on the generator, recorded and records maintained. The generator automatically tests on a weekly basis.
2. All security and supervisory staff will be instructed in the manual operation of the generator, so in the event the power system does not automatically start when there is a power failure, it can be started manually.
3. The Maharashtra State Electricity Distribution Company Ltd. (MSEDCL) will be notified of the outage. Their contact phone no. is 020 25655307/7875728885.
4. No surgery will begin while on emergency power till details of outage is checked by Executive Facility and permission given.
5. Every component of the emergency lighting system will be tested on a monthly basis. This monthly test will last for at least 30 seconds. There will also be an annual test of the emergency lighting system that will occur for at least 90 minutes. All components of the emergency lighting system must be fully operational during the length of the test.
6. Written records of all tests, visual inspections and maintenance reports must be kept on file and available for inspections by Executive Facility.
7. Exit signs will be visually inspected on a monthly basis for proper illumination.

MAINTENANCE

1. The emergency generator will have preventive maintenance performed through a contract service. Records of all service will be maintained by the Executive Facility.
2. If smoke does not clear within 5 seconds of starting during the monthly test, a yearly load bank test will be performed. The load bank will have a duration of not less than 2 hours, but will continue until the exhaust is clear of black smoke.

REPORTING

Any occurrence involving the emergency power system will be reported in the Performance Improvement summary, quarterly, to the Administrative Head of the Center.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

1) **General Anesthesia:**
   a) **Result Expected:** Total unconscious state, Placement of a Tube in Windpipe
   b) **Techniques:** Medicine is injected in the bloodstream, breathed into the lungs or other routes
   c) **Risk:** Mouth or Throat Pain, Hoarseness, Injury to Mouth or Teeth, Injury to Blood Vessel
   d) **Remote Risk:** Pneumonia, Cardiac Arrest. Reaction, Awareness under Anesthesia

2) **Spinal / Epidural Anesthesia / Analgesia:**
   a) **Result Expected:** Temporary decreased or lost feeling and or movement to lower part of body
   b) **Techniques:** Medicine injected through a needle / catheter in the Spinal Canal or outside the Spinal Canal
   c) **Risk:** Headache, Backache, Persistent weakness, Numbness, Residual Pain
   d) **Remote Risk:** Injury to blood vessels, Infection of brain and its covering (Meninges), Convulsions, Sudden cardiac arrest.

3) **Nerve Block:**
   a) **Result Expected:** Temporary Decreased or lost feeling and or movement of specific limb or area.
   b) **Techniques:** Medicine injected through a needle / catheter near nerve.
   c) **Risk:** Persistent Weakness, Numbness, Residual Pain.
   d) **Remote Risk:** Injury to blood vessels, Convulsions, Infection, Sudden Cardiac arrest.

4) **IV Regional Anesthesia:**
   a) **Result Expected:** Temporary decreased or lost feeling and or movement.
   b) **Techniques:** Medicine injected into veins of arms or leg while using tourniquet.
   c) **Risk:** Persistent Weakness, Numbness, Residual Pain.
   e) **Remote Risk:** Injury to blood vessels, Convulsions, Infection, Sudden Cardiac arrest.

5) **Monitored Anesthesia Care:**
   a) **Result Expected:** With or without Sedation.
   b) Remote Risk: Reaction

If life threatening event occurs patient may need Intensive Care Unit management. The Operation Theatre & ICU are well equipped to handle all complications. I have informed the doctor of all my previous illness, allergies, drug reactions, surgical procedures and all other facts relevant to my treatment. I acknowledged that doctor has explained above anesthesia details. I give consent for anesthesia after understanding all possible outcomes and risk involved. Anesthesia we are capable of managing the complications, but that may be a need for ICU, In such event we take the responsibility of shifting the patient to the nearby ICU.

I have understood the above:

ANNEXURE I
(Refers to Exposure Control Plan Manual Policy and Procedure No. 10)

HEPATITIS B DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself.

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

1) **General Anesthesia:**
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2) **Spinal / Epidural Anesthesia / Analgesia:**
   a) **Result Expected:** Temporary decreased or lost feeling and or movement to lower part of body
   b) **Techniques:** Medicine injected through a needle / catheter in the Spinal Canal or outside the Spinal Canal
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   b) **Techniques:** Medicine injected into veins of arms or leg while using tourniquet.
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5) **Monitored Anesthesia Care:**
   a) **Result Expected:** With or without Sedation.
   b) Remote Risk: Reaction

If life threatening event occurs patient may need Intensive Care Unit management. The Operation Theatre & ICU are well equipped to handle all complications. I have informed the doctor of all my previous illness, allergies, drug reactions, surgical procedures and all other facts relevant to my treatment. I acknowledged that doctor has explained above anesthesia details. I give consent for anesthesia after understanding all possible outcomes and risk involved. Anesthesia we are capable of managing the complications, but that may be a need for ICU, In such event we take the responsibility of shifting the patient to the nearby ICU.

I have understood the above:

However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____

Employee Signature & Name

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

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   - **a) Result Expected:** Total unconscious state, Placement of a Tube in Windpipe
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If life threatening event occurs patient may need Intensive Care Unit management. The Operation Theatre & ICU are well equipped to handle all complications. I have informed the doctor of all my previous illness, allergies, drug reactions, surgical procedures and all other facts relevant to my treatment. I acknowledged that doctor has explained above anesthesia details. I give consent for anesthesia after understanding all possible outcomes and risk involved. Anesthesia we are capable of managing the complications, but that may be a need for ICU, In such event we take the responsibility of shifting the patient to the nearby ICU.

I have understood the above:

Date: _____ Place: _____

_____

Administrative Head of Center Signature & Name

Date: _____ Place: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

EXPOSURE CONTROL PLAN MANUAL

HEPATITIS B VACCINATION		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 10** **Page: 1 of 1**
Effective Date: 11 April, 2013		

HEPATITIS B VACCINATION

GENERAL CONSIDERATIONS

1. Prime Surgical Centers is responsible for making the Hepatitis B vaccine and vaccination series available to all employees who have occupational exposure. Likewise, it will have a duty to provide post- exposure evaluation and follow-up to all employees who have had an exposure occurrence.
2. The surgical center shall ensure that all medical evaluations and procedures including the Hepatitis B vaccine and vaccination series as well as post-exposure evaluation and follow-up, including prophylaxis are:
   a. Made available at no cost to the employee.
   b. Made available to the employee at a reasonable time and place
   c. Performed by or under the supervision of a licensed physician.

HEPATITIS B VACCINATION PROTOCOL

1. The Hepatitis B vaccination will be available to employees with occupational exposure within 10 working days of initial hire, after the employee has received training on the following information:
   a. Efficacy of the vaccine
   b. Safety of the vaccine
   c. Method of administration
   d. Benefits associated with vaccination
   e. Awareness/acknowledgement of free vaccine and vaccination series
2. The surgical center is exempt from providing the hepatitis B vaccine to employees under the following conditions:
   a. If the employee demonstrates that he/she has previously received the complete hepatitis B vaccination series
   b. If documentation of antibody testing has revealed that the employee is immune
   c. If the vaccine is contraindicated for medical reasons

EMPLOYEE DECLINES - If the employee initially declines the hepatitis B vaccination, but at a later date while still covered under the standard, decides to accept the vaccination, the surgical center will make the hepatitis B vaccination available at that time.

DECLINATION STATEMENT - Any employee who decides against receiving the vaccination offered by the employer must sign statement as per Annexure -I.

ACCEPTANCE/CONSENT FORM - Any employee who agrees to accept the vaccine and follow-up testing and/or pre-screening vaccine and follow-up testing must read and sign as per Annexure – II. Alternatively, the surgical center may provide its own consent form.

BOOSTERS - Any future booster dose(s) of the hepatitis B vaccine recommended by the manufacturer will be made available to the employee at no cost.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

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2) **Spinal / Epidural Anesthesia / Analgesia:**
   - **a) Result Expected:** Temporary decreased or lost feeling and or movement to lower part of body
   - **b) Techniques:** Medicine injected through a needle / catheter in the Spinal Canal or outside the Spinal Canal
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4) **IV Regional Anesthesia:**
   - a) **Result Expected:** Temporary decreased or lost feeling and or movement.
   - b) **Techniques:** Medicine injected into veins of arms or leg while using tourniquet.
   - c) **Risk:** Persistent Weakness, Numbness, Residual Pain.
   - e) **Remote Risk:** Injury to blood vessels, Convulsions, Infection, Sudden Cardiac arrest.

5) **Monitored Anesthesia Care:**
   - a) **Result Expected:** With or without Sedation.
   - **b) Remote Risk:** Reaction

If life threatening event occurs patient may need Intensive Care Unit management. The Operation Theatre & ICU are well equipped to handle all complications. I have informed the doctor of all my previous illness, allergies, drug reactions, surgical procedures and all other facts relevant to my treatment. I acknowledged that doctor has explained above anesthesia details. I give consent for anesthesia after understanding all possible outcomes and risk involved. Anesthesia we are capable of managing the complications, but that may be a need for ICU, In such event we take the responsibility of shifting the patient to the nearby ICU.

I have understood the above:

ANNEXURE II
(Refer to Exposure Control Plan Manual Policy and Procedure No. 10)

HEPATITIS B VACCINATION AND FOLLOW-UP TESTING CONSENT

For the protection of our employees, we are offering HBV vaccination to all employees who are exposed to blood or other potentially infectious materials. A center representative will provide information and answer any questions you might have regarding the efficacy, safety, method of administration and benefits of being vaccinated.

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

1) **General Anesthesia:**
   - **a) Result Expected:** Total unconscious state, Placement of a Tube in Windpipe
   - **b) Techniques:** Medicine is injected in the bloodstream, breathed into the lungs or other routes
   - **c) Risk:** Mouth or Throat Pain, Hoarseness, Injury to Mouth or Teeth, Injury to Blood Vessel
   - **d) Remote Risk:** Pneumonia, Cardiac Arrest. Reaction, Awareness under Anesthesia

2) **Spinal / Epidural Anesthesia / Analgesia:**
   - **a) Result Expected:** Temporary decreased or lost feeling and or movement to lower part of body
   - **b) Techniques:** Medicine injected through a needle / catheter in the Spinal Canal or outside the Spinal Canal
   - **c) Risk:** Headache, Backache, Persistent weakness, Numbness, Residual Pain
   - **d) Remote Risk:** Injury to blood vessels, Infection of brain and its covering (Meninges), Convulsions, Sudden cardiac arrest.

3) **Nerve Block:**
   - a) **Result Expected:** Temporary Decreased or lost feeling and or movement of specific limb or area.
   - b) **Techniques:** Medicine injected through a needle / catheter near nerve.
   - c) **Risk:** Persistent Weakness, Numbness, Residual Pain.
   - d) **Remote Risk:** Injury to blood vessels, Convulsions, Infection, Sudden Cardiac arrest.

4) **IV Regional Anesthesia:**
   - a) **Result Expected:** Temporary decreased or lost feeling and or movement.
   - b) **Techniques:** Medicine injected into veins of arms or leg while using tourniquet.
   - c) **Risk:** Persistent Weakness, Numbness, Residual Pain.
   - e) **Remote Risk:** Injury to blood vessels, Convulsions, Infection, Sudden Cardiac arrest.

5) **Monitored Anesthesia Care:**
   - a) **Result Expected:** With or without Sedation.
   - **b) Remote Risk:** Reaction

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I have understood the above:

In accordance with the Blood-borne Pathogens Standard, this vaccine will be offered at no cost to the employee. You have the ability to decide whether or not you want vaccine.

Please indicate your choice as under. Please return this consent with your signature and date to your immediate supervisor.

I want ☐ / do not want ☐ to receive vaccine.

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

1) **General Anesthesia:**
   a) **Result Expected:** Total unconscious state, Placement of a Tube in Windpipe
   b) **Techniques:** Medicine is injected in the bloodstream, breathed into the lungs or other routes
   c) **Risk:** Mouth or Throat Pain, Hoarseness, Injury to Mouth or Teeth, Injury to Blood Vessel
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I have understood the above:

_____ _____

_____
Signature & Name of Employee

Place: _____

Date and time: _____

Registration No: **Date:_____**

Name of the Patient: _____ Age: _____Sex: _____

Procedure Explanation: The doctor has explained that I need to undergo (Surgery) _____ as I am suffering from (Surgical Condition) _____ The treatment requires one / Combination of the following anesthesia procedure / s. (Please tick the appropriate box.)

1) **General Anesthesia:**
   - **a) Result Expected:** Total unconscious state, Placement of a Tube in Windpipe
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I have understood the above:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

INCIDENT REPORT		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 10** **Page: 1 of 5**
Effective Date: 11 April, 2013		

INCIDENT REPORT

PURPOSE

1. To outline the procedures to be used in making Incident Reports and define what constitutes an incident reportable
2. To report and document events that have an adverse effect on safety, care and treatment of patient served by the Prime Surgical Centers.
3. To monitor the appropriateness and effectiveness of follow-up actions to minimize and/or prevent a recurrence of similar incidents.
4. To provide data analysis for continuous quality improvement activities.

DEFINITIONS

1. **INCIDENT**: An event or circumstance, which results in an unintended or unnecessary harm to a person, whether he or she is a patient, employee, contractor or visitor. An incident may include an event that results in a complaint about treatment, care or service, loss or damage to Prime Surgical Centers property or personal property.
2. **NEAR MISS**: An event or situation that could have resulted in an accident, injury, or illness, but did not, either by chance or through timely intervention. Circumstances that had potential to cause harm/damage or negligible damage.
3. **OCCURENCE**: An event that results in a loss to a third party due to bodily injury, or property damage or destruction.
4. **VARIANCE**: A difference between what is expected and what actually occurs; an event that departs from expectations; an act contrary to a usual rule.
5. **ACCIDENT**: An unplanned, unexpected, and undesirable event, which occurs suddenly and results in damage, injury or harm.

   Although human error is commonly the final event before the incident or accident happens, a faulty process or system is almost always the root cause that permits or compounds the harm and should be the focus of improvement.
6. **NEGLIGENCE:** The act of omission in the treatment or care of a patient by any of the healthcare professional, which deviates from the accepted standard of care.
   a. **SEVERITY LEVEL 1, Negligible:** Events/error that can cause no negative consequences or no erroneous output.
   b. **SEVERITY LEVEL 2, Minor Harm/ Damage:** Events/error results in minor harm or damage where first aid treatment only is needed and no further intervention is required.
   c. **SEVERITY LEVEL 3, Moderate Harm/Damage:** Events/error results in moderate harm/damage that necessitates hospitalization and required treatment.
   d. **SEVERITY LEVEL 4, Serious Harm/Damage:** Events/error results in serious harm or damage requiring hospitalization for intensive treatment and invasive procedure that hinders a return to work.

e. **SEVERITY LEVEL 5, Sentinel:** Events/error or catastrophic that results in unexpected death and/or major permanent loss of function.

7. **SENTINEL EVENT:** Any unexpected event which involves death or serious physical or psychological injury or risk to patient or employee example suicide of the patient, infant abduction, significant adverse drug reaction, and adverse transfusion reactions.

POLICY

1. An Incident Report shall be completed for:
   a. Any occurrence which is either physically or psychologically harmful to Patients
   b. Any occurrence which is inconsistent with the patient's expected behavior / conditions
   c. An occurrence which adversely affects or has the potential of adversely affecting the operations of the Prime Surgical Centers
   d. All medication errors, fall, procedure / surgical errors etc.
   e. Unusual occurrences
2. An Incident Report is to be initiated by the employee who witnesses, discovers, or has firsthand knowledge of the incident.
3. An immediate assessment of the Patient shall be made as clinically indicated, by a Staff Nurse
4. The Staff Nurse will be responsible for ensuring that Physician/Surgeon and Nursing Superintendent are promptly notified and all components and requirements of the incident / occurrence report are dealt with in an expedient manner.
5. The Nursing Superintendent will ensure the Incident Report is written in an objective, legible and coherent manner, and that the necessary components of writing an Incident Report are addressed.
6. The original copy of Incident report shall be reviewed by the Unit Surgeon / Anaesthesiologist, Nursing Superintendent/ Executive Facility/ Executive Assistant as the case may be, and forwarded to Administrative Head of Prime Surgical Center no later than 24 hours after the date of the incident.
7. A Post-Incident Critique will be conducted for each incident. The recording of the Post Incident Critique needs to be documented on the reverse side of the Incident Report but not on the patient's file.
8. Incident Report duly commented by all intermediaries as in # 6 above will be discussed in Quality Assurance Committee's monthly meeting.

GENERAL INFORMATION

An incident is any event that is not consistent with the routine of the unit or routine care of a Patient. The Patient or staff may be at risk when anything unusual occurs in a health care area. Examples of incidents include Patient falls, accidental needle-stick injuries, medication administration errors, accidental deletion of ordered therapies, and carelessness in performance of a procedure/surgery that leads to injury or a potential risk for Patient's injury. Reporting of incidents helps the identification of high-risk trends in nursing care or daily unit operations that warrant correction. Incident reports are an important part of a unit's quality improvement program. It is used for monitoring and tracking.

When an incident occurs, the nursing staff involved in the incident or the staff member who witnessed the occurrence completes the incident report. The report is completed even though an injury does not

occur or is not apparent. The nursing staff member observing the incident will take steps to remove the patient from risk and write the report describing details of the incident. A physician will examine the patient to determine whether an injury has been sustained. The nursing staff documents only an objective description of what happened and follow-up care that occurred.

Documentation of the Incident Report should be clear, concise, and legible. Printing legibly prevents misinterpretation. Accurate and complete description of what had occurred also assists the staff to develop a baseline data for comparison, and also promotes future planning and protection of patient, care, environment, and security issues. The following questions should be answered while documenting:

INCIDENT REPORT CHECKLIST

Answer all the following questions: WHO? WHAT? WHEN? WHERE? HOW?

1. **WHO?** Are all the patients directly involved in the incident accurately identified? Patient(s), staff, visitors involved; how many staff members were required to assist; witnesses
    a. Who committed the incident?
    b. Who was involved in the incident?
    c. Who was the victim?
    d. Who discovered the incident?
    e. Who wrote the report?
2. **WHAT?** Is there an accurate description of what happened during the incident? Exactly what occurred; include Patient's statements as well as actions. Was there property damage, injuries? Was there a clear and present danger?
    a. What happened?
    b. What objects were used during the incident?
    c. What time did the incident occur?
    d. What contraband was used during the incident?
    e. What injuries occurred?
    f. What first aid or treatment was administered to the injuries?
    g. What immediate actions did staff take?
    h. What further actions or follow-up was required?
3. **WHEN?** Are the time(s) and date(s) included? Record time per 24-Hour clock and also record general activity milieu where incident occurred, e.g. before breakfast, after visitor left, etc.
    a. When did the incident occur?
    b. When was the incident discovered?
    c. When were the appropriate parties notified?

4. **WHERE?** Is the location of the incident and the immediate area adequately described? Identify the

specific location and any additional circumstances, e.g. dim lighting, wet floor, secluded area, etc.

a. Where did the incident occur?

b. Where were the items used in the incident discovered?

c. Where were the items used in the incident obtained?

5. **HOW?** Is there a description of how the incident started, progressed, and ended? Address how incident took place in a chronological order. How did staff intervene?

6. **WHY?** Review incident. Talk with Patient and staff to determine activating event or action; note contributing factors. An Incident Report should be written in common ordinary language, objectively and limited to what has been directly observed.

   a. Indicate who was notified

   b. The name of all involved Patient(s) shall be used on the Incident Report. Do not use their names in the Incident Documents. Use only patient registration number for identification in the Incident Documents. DO NOT label Incident Document / Nurses notes as “Incident Report”.

   c. The staff nurse is responsible for ensuring that the incident has been assessed/ brought to the attention of the physician for comments and signature when applicable and report to nursing superintendent.

   d. The Nursing Superintendent shall check for completeness, approved coding, and that adequate information is provided to describe the incident.

   e. The investigation/finding(s) portion of the form (reverse side) shall be completed by the Nursing Superintendent and forwarded to the Administrative head of the centers no later than 24 hours for information / necessary action.

GUIDELINES FOR FILLING OUT AN INCIDENT REPORT

1. The Incident Report Form (Refer to Annexure to this policy) is used.
2. The staff member, who witnessed the incident, finds the error, or who found the Patient at the time of the incident files the report prior to the end of his or her shift.
3. The staff member describes specifically what happened in concise, objective terms. Do not interpret or attempt to explain the cause of the incident. Record the details of the incident in objective terms. Describe exactly what you saw or heard. For example, unless you saw a Patient fall, it is advisable to write, “Found Patient on floor”.
4. The staff member describes objectively the Patient’s condition when the incident was discovered. Use your senses (e.g. what did you see, here, or smell)
5. Use concise phrases and you make your sentences as short as possible.
6. Use exact quotes to record the Patient’s description of the occurrence whenever possible.
7. Document a physical assessment of the Patient, with particular attention to any injuries that resulted. Include set of Vital Signs and pain rating assessment. If no injury resulted, this should be clearly documented.
8. Any measures taken by nursing staff, physician, or other staff at the time of the incident are reported.
9. The incident is reported to the Staff Nurse, Physician, the Nursing Superintendent and the report is

submitted as soon as possible to the Administrative Head of the Center.

10. Do not admit to liability or blame. No staff member is blamed in an incident.
11. Do not include explanation as to how the incident could be avoided in the future. However, do verbally share your suggestion for changes with your staff, Nursing Superintendent and Administrative head of Prime Surgical Center. (Refer to Annexure to this policy)

ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 10)

INCIDENT REPORT

Unit :

Patient Identification Data

MR / Emp. No.				Date		Time		Bed No. / Dept:	
Name of the Party Involved				Last			First		
Sex	M / F	Age		Yr / mths	Physician / HOD				
Date of Occurrence						Time of Occurrence			

Identification	Emergency ☐	Outpatient ☐	Inpatient ☐	Employee

Place of Occurrence

EMERGENCY	DIAGNOSTICS		UNIT
OPERATION THEATRE	X-Ray ☐	Endoscopy ☐	1st Floor
OR1 ☐	Ultrasound ☐		2nd Floor
OR2 ☐			OPD
OR3 ☐			Other
OR4 ☐			
Procedure Room ☐			

EVENT / OCCURRENCE – It is essential to tick as many parameters as needed to fully explain the nature & extent of the incident occurrence

A. ANAESTHESIA / SURGERY	B. COMMUNICATION RELATED
Complications of Anaesthesia	☐ **Order / Results**
☐ Intubation related	☐ Delay in Lab / Radiology Test Results
☐ Accidental ex-tubation	☐ Physician Order not followed
☐ Surgery / Operating Room	☐ Lab. Specimen improperly prepared
☐ Sponge count	☐ Lab. Requisition improperly prepared
☐ Wrong Patient / Wrong Site - Side	☐ Specimen container Improperly Labeled
☐ Wound Infection	☐ Other
☐ Unplanned Organ repair / removal	☐ **Physician Related**
☐ Acute MI within 48hrs. of Surgery	☐ Physician not notified as required
☐ Hemorrhage during / Post procedure	☐ Unable to contact Physician
☐ CNS complications	☐ Delay arrival of Physician / Consultant
☐ Aspiration	☐ Inappropriate response from Physician
☐ Sponge, Instrument, Needle left in-situ	☐ Patient complaints about Physician
☐ Retained Foreign Body removal	☐ **Consent Related**
☐ Death in OT / within 48 hrs	☐ Consent not obtained / document
☐ Unplanned return to ward / OT	☐ Inadequate consent
☐ Others	☐ Other

C. SAFETY FALLS RELATED	D. DIAGNOSIS & TREATMENT RELATED
Complications of Anaesthesia	☐ Diagnosis Related
☐ Patient fall from – bed, stretcher, etc.	☐ Failure to adequately diagnose & treat
☐ Self inflicted injury	☐ Abnormal diagnosis
☐ Pt. protection precautions not followed	☐ Delayed diagnosis
☐ Assault on Patient / employee	☐ Management of Care
☐ Needle – prick injury	☐ Delay in starting treatment
☐ Hazardous material spillage	☐ Consultant did not respond timely
☐ Other safety related issues	☐ Patient not seen by doctor
E. DRUG / IV / BLOOD RELATED	☐ Repeat blood sample withdrawal
☐ Blood and Blood Product	☐ Unexpected death
☐ Varriance in use of blood & products	☐ Patient Transfer / Transport related
☐ Transfusion Deferred	☐ Method of transfer / papers incomplete
☐ Transfusion stopped due to reaction	☐ Incomplete / No. info. Of Pt. transferred
☐ Hb.<8, or HCT>24 or Blood Loss <560ml	☐ Delay in arrival of transport boys
☐ Platelets for Platelet count >30,000	☐ others
☐ RhIG not given Patient Rh Negative	**F. COMPLAINTS RELATED**
☐ Drug review / Medication Variance	☐ Patients Leaves against medical advice
☐ Medication errors/Prescription/Transcription/Dispenser	☐ Patient Absconded / left without info. Patient complaints
☐ Verification in count of controlled drugs	☐ Complaints regarding admission
☐ Drug given to pt. with known allergy	☐ Complaints regarding room readiness
☐ Wrong drug given	☐ Complaints in regarding relation to doctors
☐ Inappropriate dosage of drug	☐ Complaints regarding to nursing
☐ Drug not given on time	☐ Complaints regarding billing
☐ Adverse drug reaction	☐ Complaints housekeeping services
☐ Others	☐ Complaints regarding food services
G. FOLLOW UP TREATMENT	☐ Complaints regarding maintenance
☐ Patient did not return for advice follow up	☐ Complaints regarding noise levels
☐ Investigation ordered not done	☐ Employee Complaints
☐ Investigation done, result not brought.	☐ Physician
☐ Treatment advised not taken	☐ Executive
H. EQUIPMENT RELATED	☐ Housekeeping
☐ Equipment not available	☐ Maintenance
☐ Equipment malfunctioned / failed	☐ Food and beverage
☐ Equip. Available, no knowledge to use it	☐ Security
☐ Others	☐ Others
I. MISCELLANEOUS	
☐ Security related	
☐ Theft of personal property	
☐ Assault on Patient / Staff	
☐ IT related problems / Lack of response	
☐ Others	

NOTIFICATION OF ACTION		Attending Physician informed	Yes ☐ No ☐
Event document on Chart	Yes ☐ No ☐	Family / Relatives notified	Yes ☐ No ☐
Seen by Attending Physician	Yes ☐ No ☐	Emergency Physician	Yes ☐ No ☐
Others – NAME _____		Time Called _____	Time Attended _____
SUPERVISOR COMMENTS			
SEVERITY SCORE		☐ No harm / No treatment	
Insignificant harm / minimal treatment		☐ Significant physical intervention / residual effect possible	
Major or extensive intervention / residual effect		☐ Major potentially life threatening disability or other residual	
Death imminent / predictable		☐ Resultant Death	

Do not write in the space below	**QUALITY MANAGEMENT ACTION**
Name	Signature Date

Follow up Comments -	

Name	Signature	Date

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

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GENERAL MANUAL

MANAGEMENT OF CONFLICT		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 10** **Page: 1 of 3**
Effective Date: 11 April, 2013		

MANAGEMENT OF CONFLICT

A certain amount of conflict is beneficial to any organisation, e.g., conflict creates tension that leads to change and innovation. It is also believed that during conflict situations members of a group tend to close ranks thereby promoting group cohesiveness. Conflict in a health care facility affects quality of patient care as confirmed by many studies which found higher quality care where Physicians and Nurses had a greater understanding of each other's work, problem and needs.

Thus while conflict may foster institutional innovation and progress the welfare of the individual patient is served more effectively by institutional harmony and stability. It is therefore, felt that controlling conflict is an important goal for Prime Surgical Centers.

Potential for conflict in a health care facility is due to the wide range of specialized personnel gathered together in one work group, e.g. Administrator-Medical staff conflict, Personal -Departmental conflict; Administrator -Consumer conflict, etc.

DEFINITION

It is measure of power where ground rules are spelled out and the winner in a conflict situation clearly emerges.

NATURE OF CONFLICT

1. **Individual Conflict**

   This is usually manifested as a person-role conflict and involves a situation in which the individual feels incompatible with the role he/she occupies. Individual values, capabilities and administrative style can contribute to this conflict. Introverts, emotionally sensitive people and individuals who are strongly achievement oriented (no promotional opportunities without more education) usually are candidates for this conflict.

2. **Interpersonal conflict**

   It broadly includes:

   a. Interpersonal disagreements over substantive issues, such as policies and practices.

   b. Interpersonal antagonism, that is, the more personal and emotional differences that arise between independent human beings.

   An individual's role in the health care facility can have a major effect on the conflict to which he/she is subjected. Past experiences and characteristics usually help in coping up with “role conflict”. Role conflict is the simultaneous occurrence of two or more role sending’s such that compliance with one would make more difficult compliance with the other, e.g. Nurse caught between multiple lines of authority and physicians.

   “Role ambiguity” and “role overload” may contribute to role-conflict. Role ambiguity is uncertainty about the way one's work is evaluated by superiors and about scope of responsibility, opportunities for advancement and expectations of others for job performance. Related to role ambiguity is role overload, in which the incumbent has too many tasks to perform.

3. **Group conflict**

Inherent characteristics of health care facility e.g. interdependence, specialization and heterogenecity of personnel and levels of authority are co-related positively with conflict. In health care facility power and status are not centered in the same individuals. This is a basic source of administration-medical staff conflict and Nurses status vis-a-vis nonphysicians, Medical Director status vis-a-vis non physician CEO.

It is important to understand the power is the maximum ability of a person or group to influence individuals or groups. Basis of power is derived from legitimacy, control of rewards and sanctions including money, expertise, personal liking and coercion. Hospital administrator usually has all above.

Germane to the discussion of inter group conflict is the concept of territory. When group such as administrative personnel, medical staff or newly created technical assistants begin to encroach what was once the exclusive territory of the specialist, conflict can be expected. One way to reduce inter group conflict in such cases is to increase the zone of indifference, i.e., through participation in decision-making, improved communication, or change in status etc.

4. **Patient hospital conflict**

In earlier days patients had faith in professional's ability to what was best for them. Increased commercialization / Industrialization, however has changed the complete scenario. More and more patients feel today that the health care providers are lacking in the art of communication, compassion and empathy so essential for establishing a bond of doctor-patient relationship.

5. **Mitigation of conflict**

To develop a positive attitude and environment at Prime Surgical Centers none of the common general management approaches like eliminating the opposition / transferring / firing, reorganization of departments or elimination etc., development of bureaucratic rationality with its resulting policies, rules and procedures, bargaining, third party arbitration, use of bribes, under the table payments will be used as a technique for mitigation of conflict.

Win-win strategies which basically focus on the problem (which should be considered as an opportunity to give positive connotation) or issue rather than the parties involved, be they individuals, groups or institutions. Following steps will be used invariably by all concerned:-

a. Focus on the problem rather than on themselves.

b. Look for facts

c. Avoid self-oriented behaviour

d. Not trade, vote or use averages in conflict situation.

All administrators will therefore, need to develop 3 competencies to facilitate conflict mitigation.

a. To develop a style of mitigation that is compatible with the manager and situation.

b. Need to clarify messages, the ability to understand and clarify the meaning behind words.

c. Utilization of problem solving approach. It involves an initial investigation, selection of a meeting site, problem identification, consideration of various situations, implementation and finally evaluation

Problem solving strategy conveys three things to involved parties:-

a. I want a solution which achieves your and my goals and is acceptable to both of us.

b. It is our collective responsibility to be open and honest about facts, opinions and feelings.

c. I will control the process by which we arrive at agreement but will not dictate content.

DECISION MODEL FOR DIAGNOSING & MITIGATING CONFLICT

Conflict participants	Some sources	Some tentative approaches to mitigation
Hospital – client	Goal displacement Inadequate communication	Comprehensive institutional goal setting Public Relations programme.
Individual role	Role conflict Role ambiguity	Management by objectives Job descriptions, organization manuals.
Inter-personal	Disagreement Antagonism	Creative problem – solving Constructive confrontation
Administration – Medical staff	Balance of power Status	Participative management Training in team sensitivity training.
Nursing -Administration	Unfulfilled expectations status	Participative management Training in team sensitivity training.

PRIME SURGICAL CENTERS

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NURSING EDUCATION AND TRAINING MODULES

MEDICATION ADMINISTRATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 10** **Page: 1 of 12**
Effective Date: 11 April, 2013		

MEDICATION ADMINISTRATION

INTRODUCTION

Medication safety is the responsibility of every healthcare professional who are involved in medication related procedures which includes prescribing, dispensing, administering and monitoring patients after medication administration. Medication administration is one of the many high risk tasks that can lead to devastating consequences for the patient and for the healthcare professional's career. Following safe medication administration practices results in positive patient care outcomes .Knowledge about our medication administration policy guides the nurses to ensure patient safety while administering medications to their assigned patients

Writing medical orders

A history of medication response, allergies, sensitivities and any substance abuse should be correctly assessed and recorded by the Physician or Nurse during the initial assessment process or history and physical examination. Patients, family, caregivers and next of kin should be educated about medications they are receiving, such as, name of medication, reason, frequency, and possible side effects.

Before giving the medication, the patient must be positively identified by checking his/ her identification band and asking the patient to state his/ her name (if possible). The health care provider administering the medication should stay with the patient until the dose has been taken.

All medications should be properly labelled & nurses shall not prescribe any medication.

All medical orders shall be written on a physician order sheet.

Medical orders on designated order sheets written by qualified physicians should be considered valid to be carried out by Nurses.

Physician Order Sheet should be used for all orders other than medication orders, and should be completed only by Physicians.

Any change in the medication dose, route or frequency should be written as a new prescription.. Order date should indicate the date when the new prescription is written.

A valid medication order should be in the prescribing physician's legible handwriting in English and should clearly indicate the following:

1. The date and time the order was written.
2. Patient's full name and hospital identification number.
3. The name of the drug (preferably both generic and trade name)
4. Dose of the drug in milligrams, micrograms etc.
5. Route of drug administration.
6. The frequency of the dose
7. A PRN prescription has to include:
   a. Reason (e.g. for pain or elevated blood pressure)
   b. Timeframe (e.g. 4 hourly)
   c. Specific parameters (e.g. pain exceeding VAS Score of 30 or blood pressure exceeding 150 / 90)
8. The prescribing physician's full name (per surgery center stamp) and signature.

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When the patient goes to the Operating Theatre all existing medications should be stopped and new orders prescribed post operatively

The Staff Nurse will notify if the patient is on NPO (Nil per Orally)

From the date of order, the following intervals will be used to automatically discontinue the medication unless a new order is written.

1. Antibiotics Injection 3 days
2. Oral Antibiotics 7 days
3. Anticoagulants Injection 3 days
4. Anticoagulants Oral 7 days
5. Analgesics 5 days

Standing Orders / Protocols for medication administration must be approved and signed by the Administrative Head of prime Surgical Center and dated.

It is the nurses' right and responsibility to question and to refuse to carry out any drug order in the following condition:

1. Contraindicated due to drug incompatibility
2. Inappropriate to the patient's condition
3. Known allergy to the medication
4. Inappropriate for age and weight
5. Illegible or any part of the physician's order is a concern i.e. dosage, route etc.

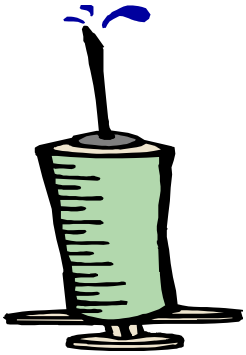
ADMINISTRATION OF MEDICATION

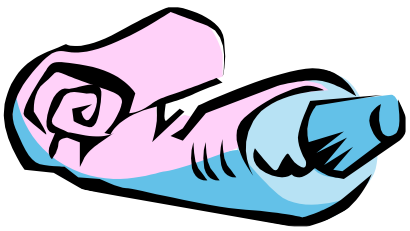
Three (3) conditions should be met before medication is legally administered:

1. The medication order must be valid
2. The health care staff must have validated competence.
3. The indications, contraindications, action and side effects of the drug to be administered are known.

Nurses may administer drugs through the following route / methods

1. Topical
2. Ophthalmic, Otic, Nasal
3. Oral and Nasogastric
4. Sublingual
5. Inhalation
6. Intradermal
7. Subcutaneous
8. Intramuscular
9. Intravenous
10. Vaginal and rectal





Nurses shall not administer medications via the following routes or methods:

1. Intra-cardiac (directly into the myocardium)
2. Intra-pericardial (pericardial sac)

3. Intraosseous
4. Intrathecal
5. Intraarticular

All medication administration by any route shall be safely and correctly performed by staff consistent with the seven rights of medication administration:

1. Right patient
2. Right medications
3. Right dose
4. Right route
5. Right time
6. Patient's right to refuse
7. Right to patient and family education.

1. Administration to the Right Patient

Once a nurse is prepared to administer a drug, the patient's identification band (ID band) is checked against the Medication order Sheet and the patient is asked to state his or her full name if possible

There will be situations when patients are confused or unresponsive. The nurse then compares the medical record number on the Medication Order Sheet with the patient's ID band. If the patient is a child, parents or legal guardians can be used to identify the child. The practice of checking patients' identification is invaluable in preventing errors, especially when caring for multiple patients. It is also essential even after caring for the same patient for several days. If a patient questions the practice of identification verification, explain that this is a routine practice for making sure patients receive the correct medication.

2. Administering the Right Medication

The nurse should always review the Medication Order Sheet (MOS) prior to preparing and administering the medication – when in doubt regarding the Generic or Trade name, a pharmacology reference book should be sought. Antibiotics in particular have many trade names which are similar.

3. Administering the Right Dose

Drug calculations should always be double-checked and independently. When in doubt, another nurse or resident doctor should be brought in to re-check the calculations. Wrong calculations in pediatric or Geriatric nursing can result in a drug error which is 10 fold and could therefore prove fatal.

Appropriate measuring devices should also be used when preparing medications to avoid dose related errors whilst infusion pumps if required should always be checked to ensure correct functioning – an infusion pump can only be as accurate as it is set.

4. Administering by the Right Route

The prescriber's order must designate a route of administration. If the route of administration is missing or if the specified route is not the recommended route, the nurse must consult the prescriber immediately. When an injection is administered, the nurse must use only preparations intended for parenteral use. Injection of a liquid intended for oral use can produce local complications, such as sterile abscess, or fatal systemic effects. Medication companies label parenteral medication "for injectable use

only".

5. Administering a Drug at the Right Time

Each hospital has routine time schedules for medications ordered at standard intervals. For example, medications to be given tid (three times a day) may be routinely scheduled for 0800H, 1400H and 2000H, or 0900H, 1300H and 1900H, depending on physician's instructions. A drug may also be ordered q8h (every 8 hours), which is also three times a day, however, the medication ordered q8h needs to be given around the clock to maintain adequate therapeutic blood levels. All routinely ordered medications should be given within 30 minutes before or after the scheduled time.

The military 24 hour clock is routinely used in Prime Surgical Centers when prescribing and documenting treatments.

A medication may also be ordered for special circumstances. A preoperative medication may be ordered "stat" (to be given immediately); or "on call", which means the operating room or treatment area will notify the nurse when it is the appropriate time. A drug may be ordered AC (before meals) or PC (after meals).

Some medications require the nurse's clinical judgment in determining the right administration time. A medication that is ordered prn (pro re nata) is intended to be given according to circumstances or when needed. For example, when a prn analgesic is ordered "q3-4h prn" the nurse needs to assess the characteristics and severity of the pain to determine when to administer within the 3 – 4 hour time span or longer.

6. Patient has a Right to Refuse

In addition to the six rights of medications, a **client has the right to refuse medications**. When this occurs the nurse needs to document the refusal correctly and make appropriate persons aware of the refusal. The right to refuse may be denied to the client who has a mental illness.

It is extremely important for nurses to check frequently for side-effects relating to medications and to listen carefully to client's complaints. The reason for the refusal of medications should be carefully analyzed and documented in all cases. Education of the client and a reassuring therapeutic relationship can assist in diminishing a client's refusal.

7. Right to be Educated

Another important right has to do with educating the client. **All patients have a right to be educated regarding the medication they are taking.**

All medications administered to patients shall be recorded in the Medication Order Sheet or appropriate ones in the Nurse's Note.

The Standard Medication Timing as recommended by the Prime Surgical Center should be followed as

far as possible.

Once Daily	***0800H***
Twice daily	0800H – 2000H
Three times daily	**0800H – 1300H – 2000H**
Four times daily	0800H – 1200H – 1800H – 2200H
Every 6 hours	0600H – 1200H – 1800H – 2400H
Every 8 hours	0600H – 1400H – 2200H
Every 4 hours	0800H – 1200H – 1600H –2000H –2400H– 0400H
At bed time	2000H or 2100H
Every 12 hours	0600H – 1800H

Medications may be given 30 minutes before or after the scheduled time, with the following exception:

1. Stat orders
2. Pre-operative drugs drugs within one hour
3. Ante and post cibum medication (Before and after meals)
4. Antibiotics should be given one hour after induction of anaesthesia
5. Febrile Neutropenia patient's order is considered as stat order even if not specified
6. Cardio-toxic drugs (to be given within 15 min. before or after the specified time.)

Nurses should not store any drug in a syringe to administer at a later time or date. The appropriate time to administer oral medications after an NPO (Nil Per Orum) order should be specified by the Physician.

Intravenous medications administered intermittently via capped vascular access ports should be flushed with 3 to 6 ml of compatible IV fluid or heparin lock before and after medication administration.

Continuous intravenous (IV) medication administration requires special assessment, monitoring and interpretations. Intravenous infusion medications are to be administered preferably through a programmable infusion pump.

Medications such as IV push through cannula should be performed only by a competent medical staff or a certified staff Nurse.

If a patient has discharge order the medication should be given until the patient physically leaves the unit.

If a patient refuses to take a prescribed medication or if the Staff nurse omits to administer a medication, the following actions should be taken:

1. The incident should be documented.
2. The Physician and the Nursing Superintendent should be notified.
3. The Nurse should complete an Incident Report if the outcome is likely to have serious potential or actual consequences on the patient.

Procedure for Preventing Medication Errors:

1. All professional handling medications should exercise the "check 3 times and 7 rights system".
2. All medication to be prepared by a qualified Staff Nurse.
3. Check the calculation and the preparation.
4. The Staff Nurse should be well versed & certified in Medication administration including calculation of drug by Prime Surgical Centers.

Physician Verbal / Telephone Orders:

Verbal / telephone orders should be limited to situations where immediate written communication is not feasible like:

1. In emergency situations (could cause patient harm or have a possible negative outcome).
2. Physicians busy with another task and cannot attend to the patient.

No verbal / telephone orders should be accepted when the physician is physically present in the unit unless the situation is life threatening.

Verbal / telephone orders are immediately written by the staff receiving the order. The verbal / telephone order is read back to the physician for verification of accuracy.

The name and designation of the physician who prescribed the verbal / telephone order must be recorded by the nurse who received the order on to the physician's order sheet.

Verbal / telephone orders are entered into the patient's physician's order sheet, signed and dated by the staff receiving the order.

Verbal / telephone orders are reviewed and countersigned by the physician or another physician member of the team caring for the patient as soon as possible but within twenty four (24) hours.

Abbreviations shall not be used in documenting verbal/ telephone orders.

The content of verbal / telephone medication order should be clearly communicated.

1. The name of the drug is confirmed by spelling if needed.
2. Doses should be dictated in alphabetical letters e.g. fifty (50) milligrams five zero milligrams, and when writing the order, the dose maybe written in numerical format.
3. Route and frequency are provided without abbreviation. (i. e. 1 tab. tid – should be verbally communicated as give one tablet orally three times daily.) When writing the verbal / telephone order standard approved abbreviations are used.

Telephone and verbal orders will not be accepted for:

1. Chemotherapeutic agent
2. Investigational drugs
3. "Do Not Resuscitate "
4. Withdrawing life support, i.e., mechanical ventilation

Patient and Family Education.

The assigned Nurse should teach the patient and/or family, caregiver or next of kin utilizing proper education tools regarding:

1. Medication
2. Mechanism of action
3. Preparation and administration
4. Schedule of self-administration
5. Side effects
6. Precautions and Conditions for notification of the health care team.

The patient should be observed and supervised when preparing and self administering as necessary before the discharge from the Center.

Patient and family education should be documented in the Nurses Notes or Teaching Record as

applicable.

High Alert Medications

Are those medications involved in a high percentage of errors and / or sentinel events, medications that carry a higher risk for adverse outcomes, as well as look-alike/ sound-alike medications.

Look-Alike and Sound-Alike Medications (LASA): Medications that can look alike (presentation, strength, appearance and name) or sound like (pronunciation) other medications leading to avoidable mix-ups.

Tall Man Lettering – a system in which part of a drug's name is written in upper case letters to help distinguish LASA medications from one another in order to avoid medication errors e.g. on storage shelves.

Concentrated electrolytes shall be considered as **high-alert** medications

Prime Surgical Centers has developed Guidelines on LASA and High Alert medication to avoid errors.

The storage of concentrated electrolytes should not be allowed in patient care units).

If supplied as a concentrated electrolyte, it should be labeled in **red- High-alert** and with direction must be diluted before use.

Storage of high alert medications, rather than concentrated electrolyte, stocks in the patient care units should be limited and clinically justified as determined by evidence and professional practice, and actions are taken to prevent inadvertent administration in those areas.

Narcotic and Controlled Drug Administration, Storage, Maintenance, and Accountability

Controlled substances are stored in a separate locked compartment storage unit, double locked with access limited to approved personnel (Staff nurse and Physician).

All controlled substances obtained from the controlled drug cabinet are recorded on the narcotic sheet. Documentation must be clearly legible with all applicable information provided.

The dose recorded on the narcotic sheet must match the dose recorded on the Medication Administration Record and the Nurses Progress Notes or any other applicable forms.

All narcotic and controlled drug prescriptions should be verified prior to administering the first dose to the patient. Narcotic Shift Inventory Logbook is the only document to be used for documenting the narcotic inventory. The incoming and outgoing Staff nurses will check all narcotics together and sign in the logbook.

Medications removed from the controlled drug cabinet must have a separate documented physician’s order for each dose that is registered in the narcotic sheet.

Narcotic drugs and other restricted substances may only be administered upon a valid written order/ prescription of a licensed physician.

Only one controlled narcotic drug should be prescribed in each prescription.

Parenteral narcotic and controlled drug prescription is valid only for a single dose administration.

Oral drug prescription can be used for multiple doses as per ordered frequency and it is valid only for 24 hours.

The intravenous administration of narcotic drugs by Staff Nurses maybe carried out in emergency situation and / or in critical situation

The expiry of narcotic and controlled drugs unit stock must be checked at least monthly by In-charge nurses and replaced two months before expiry.

The narcotic drug key must be attached to a separate key ring and carried "on the person" Nurse In-charge.

The narcotic key must not be taken out off the unit.

If the narcotic drug key is lost or mislaid inside the unit the matter must be reported immediately to the Nursing Superintendent

An Incident Report to be completed. The narcotic drug cupboard lock and key must be changed if the key is mislaid within the unit for more than one hour.

Administration of Blood and Blood Components

Only physicians can request transfusion of blood and blood components.

Blood and blood components should be prescribed on the order sheet and the Blood Bank Request form. Both the order and the Blood Bank request should be signed and dated by the requesting Physician.

The physician or a Staff Nurse with a validated competency only administers Blood and Blood components.

Complete cross-match for emergency transfusion requires thirty (30) minutes from the time blood is received in the blood bank laboratory.

In case of extreme emergency, uncross-matched blood may be released if the attending physician submits a signed request for uncross-matched blood.

A phlebotomist or a Staff Nurse collects Blood specimen for type and screen and/or a cross-mach.

Collect 10 ml of venous blood in a plain 10ml vacutainer tube.

When blood bank confirms that the blood is ready, the Staff Nurse of the unit collect blood and administer the transfusion.

Blood and blood components should not be collected from the blood bank until the patient is properly prepared for transfusion and the assigned Staff Nurse or physician is ready to begin the transfusion.

Prior to collection of blood or blood components from the blood bank staff the assigned Staff Nurse will check the following:

1. The physician's order for transfusion (on the order sheet) including the type of blood or blood component, number of units requested, duration of the transfusion and any special requirements or medications requested.
2. Any special transfusion requirement such as a special blood filter
3. Any site restrictions.
4. Time limits.

Before collecting the blood from the blood bank, the Staff Nurse should assemble all the essential equipment needed for transfusion. These include:

1. Blood or blood components administration set with filter.
2. Intravenous catheter or intravenous needle, recommended gauge: 18, 19 or 20. Nothing smaller than 20 gauge needles should be used because they may lead to red cell hemolysis.
3. Normal saline intravenous fluid.
4. Tape and appropriate arm restraint device if necessary.

The appropriate tubing and filters when necessary will be hung with a bag of normal saline and set at a Keep Vein Open (KVO) rate. Tubing must be changed after every two (2) units or after four (4) hours of use whichever is less. All filters and infusion devices must be used according to the manufacturer's directions.

The Staff Nurse and the Blood Bank Staff should check the patient's identification data by verbally verifying the following information on the order sheet.

1. The patient's first and family name.
2. The patient's MR Number.
3. The patient's blood group (ABO group and Rhesus type).

Check expiry date of blood unit.

The Staff Nurse and the Blood Bank Staff should verify the identification of blood/blood components by checking the following information on the primary label on the bag or bags:

1. Type of component and number of units requested.
2. The donation number or numbers.
3. The blood group (ABO) and Rhesus (RH) Type.
4. Compatibility with the recipient.
5. Expiration date.

Staff Nurse will check the bag/bags for evidence of any leaks, clots or discoloration.

When the verification process has been completed, the Staff Nurse and the blood bank Staff sign the blood bank log book and sign on the back of the blood transfusion request form entering the date and the time.

Blood should be administered as soon as possible within thirty (30) minutes of the blood or blood components being issued to the unit.

Blood must be stored only in blood transfusion refrigerators and not in ward or domestic refrigerators.

The infusion must be started promptly after verification of the identification information, and a Staff Nurse must remain with the patient for the first fifteen (15) minutes for monitoring.

The patient must be assessed and baseline vital signs recorded before the transfusion starts. Vital signs should be taken five (5) minutes after the blood reaches the IV site, then every fifteen (15) minutes for the first hour and there after every sixty (60) minutes until the infusion is completed.

The date and time the transfusion started and finished, the pre and post transfusion vital signs, the amount infused and whether or not any reaction was noted, must be recorded on the administration record and in the Nurse note.

Most transfusion reactions occur within the first fifteen (15) minutes of starting the infusion so the patient must be monitored very closely during this period.

Increased temperature is often the first sign. An increase in temperature > (of more than)1C associated with transfusion without any other explanation is considered a transfusion reaction. Other signs and symptoms will still apply.

The infusion of red cells requires close monitoring, especially, with elderly patients and those with a history of congestive heart failure or **other heart disease. Rapid administration of blood in these patients may lead to circulatory volume** overload. These patients should be observed for dyspnea,

cough, rales and other vital-sign changes.

If no signs or symptoms of reaction occur after fifteen (15) minutes of transfusion, the rate may be adjusted. In most circumstances a unit of blood should be infused in two (2) to three (3) hours depending on the patient's condition or Physician's orders. The maximum time for a transfusion is four (4) hours for blood and thirty (30) minutes for a therapeutic dose of platelets

When an uncomplicated blood transfusion is completed, the Staff Nurse should discard the blood bag and tubing in the Red plastic bag and dispose of the needle in a sharps box after burning

Upon discontinuation/completion of transfusion and removal of the blood bag the Staff Nurse shall record the following on the Administration Record: and Nurses note.

1. Time the transfusion was discontinued/completed
2. The volume and blood component given
3. Vital signs on completion of transfusion.

Keep the patient's vein open unless there is a physician's order to the contrary.

Check with the physician if post transfusion laboratory tests are required such as hematocrit, HB, platelet count or coagulation surveys.

Continue to monitor the patient for at least twenty-four (24) hours after completion of the transfusion.

Transfused in-patients should be instructed to report any unusual symptoms to their assigned nurse so that any suspected transfusion reactions can be evaluated promptly.

Reactions to blood or blood components are varied and may be immunologic or non-immunologic and could be immediate or delayed.

The most serious immediate transfusion reactions are caused by intravascular hemolysis and can be fatal.

Signs and symptoms that may occur with impending or established transfusion reactions include:

1. Fever > 1 C with or without chills.
2. Shaking chills (rigors) with or without fever.
3. Pain at the infusion site or pain in the back, abdomen or flanks.
4. Pain or tightness in the chest
5. Blood pressure changes, usually acute hypertension or hypotension
6. Respiratory distress including dyspnoea, tachypnoea or hypoxia.
7. Skin changes including flushing, urticaria, localized or generalized oedema.
8. Nausea with or without vomiting
9. Acute onset of sepsis including fever, chills, hypotension.
10. Anaphylaxis.

Delayed reactions may occur days to months after the transfusion.

The most common presenting signs of a delayed transfusion reaction are:

1. Fever

2. Declining haemoglobin
3. Mild jaundice

The immediate treatment response to all transfusion reactions is:

1. At the first sign of a transfusion reaction "STOP" the blood/blood component transfusion temporarily.
2. Keep the intravenous line open with fresh tubing and normal saline.
3. Notify the attending physician who should physically attend the patient for evaluation. Over the phone consultations are not acceptable.
4. Notify the Blood Bank immediately.
5. While the blood/blood component is still at the patient's bedside, the Staff Nurse performs a clerical check to determine if the patient received the correct blood/blood component unit.
6. Recheck the patient identity.
7. Check the unit number.
8. Check the ABO and Rh-type on the label of the bag/bags and Rh-type of the patient as recorded on the transfusion compatibility tag and verify ABO compatibility of the unit/units.
9. Check the bag for any evidence of haemolysis or change of colour.

If the physician decided this is a transfusion reaction, terminate the transfusion and collect the following samples from the patient:

1. 3ml blood sample in an EDTA tube.(Ethylene Diamine Tetra acetic Acid)
2. Clotted blood in plain tube (at least 5 ml)
3. The first voided urine specimen post reaction.
4. Two blood culture bottles.

Record all transfusion reaction information on administration record and on Nurse Note.

Return the laboratory copy of the completed form; the post-transfusion specimens and the blood/blood component bag including the IV (needle removed) administration set and all blood/blood components bags already transfuse if any, to the Blood Bank.

The patient's vital signs must continue to be monitored every four (4) hours or more often as indicated by the patient's condition or physician's order.

The Staff Nurse ensures that the transfusion reaction is appropriately documented in the patient's medical record and reported via incident Report to the Nursing Superintendent and Administrative Head of the Center.

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Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

NIL PER ORALLY STATUS (NPO) STATUS		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 10** **Page: 1 of 1**
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NIL PER ORALLY (NPO) STATUS

POLICY

The NPO status for the PRIME SURGICAL CENTERS is determined by Anaesthesiologist.

PROCEDURE - NPO STATUS:

1. Patients having surgery:

   General anaesthesia patients: NPO after midnight

   Exception: Surgery scheduled at 11:00 am or later may have clear liquids only by 7:00 am.
2. Pain management patients:

   No diet restrictions. (Note: No alcohol for twenty four (24) hours P.O.)

   Exception: For General Anaesthesia is used, NPO after midnight and if procedure scheduled at 11:00 am or later, may have clear liquids only by 7:00 am.
3. Laser patients:

   No diet restrictions.
4. Endoscopy patients

   NPO after midnight except for Consultant's specific instructions (i.e., prep)
5. While above plan indicates only general NPO status, the Anaesthesiologist will indicate NPO status on case to case basis. (Refer Annexure VIII of Nursing Manual Policy and Procedure No. 25)

Note: Clear liquids include water, black coffee, clear juices, i.e., apple or cranberry. No citrus. No milk.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

NIL PER ORALLY STATUS (NPO) STATUS		
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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

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ANNEXURE X
(Refer to Housekeeping Manual Policy and Procedure No. 1)

USG / X-RAY/ PATHOLOGY ROOM

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
Windows with Seals	X			
Counter Tops	X			
A/C baffles		X		
Chairs	X			
Cabinets	X			
Shelves & Drawers	X			
Luminaries		X		
Electrical Outlets, Switch plates	X			
Empty Waste Bins	X			
Sink	X			
Examination Couch (USG)	X			
X-Ray Table and Stand (X-Ray Room)	X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

WHEELCHAIR MAINTENANCE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 10** **Page: 1 of 2**
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WHEELCHAIR MAINTENANCE

PURPOSE

Wheelchairs are very much like any other specialist vehicle in that regular maintenance/servicing will prevent its untimely and inconvenient breakdowns, keep repair cost down and extend its life. This is so essential to provide uninterrupted quality patient care. Largely many of the checks can be done by in house staff as per the checklist. In cases where this activity cannot be done rough in house mechanism, services of a qualified maintenance contractor will be utilised.

RESPONSIBILITY

In house maintenance activity will be monitored/supervised by Executive Facility.

CHECKLIST

Sr. No.	Periodicity	Activity	What to do
1	Daily	Cleaning	Wipe a chair with a damp cloth.
2	Weekly	a. Check your wheels to ensure that spokes are intact, rims are not bent & that wheels are parallel to one another. b. Apply breaks and check that tyres are held firmly in place, and the breaks are easy to put on/off. c. Check the axle housing is free from dirt, hair and mud. d. Axles should slide through. No squeaking, catching or excessive side to side motion should be present when rolling. Axles collect dirt easily and need to be kept clean to ensure smooth propelling. e. Check castors for any wobbling, alignment or excessive play. The castors are as susceptible to dirt as axles and need to be locked after in the same f. Manner. Make sure that castors do not have hair, orgrit	Contact maintenance contractor Tighten bracket so that brakes are held firmly to the frame in the correct position. Wipe the axles with a clean cloth that has ten drops of oil on it. Appropriate is any penetrating lubricant. Also try and clean the axle Rousing and round the bearing, then lubricant with oil. Pick out dirt with tweezers or take the spindle out clean it & then replace it. Lubricate the castor Rousing bearings. If it is still not free, contact maintenance

WHEELCHAIR MAINTENANCE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 10** **Page: 2 of 2**
Effective Date: 11 April, 2013		

		g. Make sure that top of the rousing is parallel with the floor.	contractor. Use a spirit level to check that housing is parallel.
3	Monthly	a. Check for loose nuts & bolts. Make sure that they are secure. b. Check for cracks, splets, large dents in the frame for ensuring safety of patient. c. Check that any removable parts, such as leg rest or back rest. Can be easily removed and replaced. Make sure that parts lock in place securely. d. Check for splits, cracks, bulging or loss of tread of tyres	Tighten to hand tight or as specified in manual. Replace nuts and bolts with those of the same grade or strength rating. If you find any of these DO NOT USE. Contact Maintenance Contractor immediately. If parts are not locking, try lubricating. If this is unsuccessful contact Maintenance Contractor Replace tyres when worn. It is better to replace both tyres at once so that, the Wheel Chair moves smoothly.
4	Annually	In case of folding chair, check that it opens and closes easily.	Lubricate the folding mechanise, is necessary. Lubricate all pivot joints and ball bearings (To be done by Maintenance Contractor)

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

SAFETY MANUAL

ANTI TERRORISM		
Policy/Procedure Applies To	**All staff**	**Policy/Procedure No: 11** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ANTI-TERRORISM

POLICY

There shall be a standardized procedure for responding to terrorism threats. The Nursing and Administrative staff shall be aware of these procedures.

PROCEDURE

The following procedure will be performed in the event of a terrorism threat.

1. The operator/receptionist will immediately call 100 and notify law enforcement of the nature of the threat.
2. The senior most staff of Prime Surgical Centers on the spot at that particular time will assume all responsibility for directing activities.
3. All exterior doors will be immediately locked, allowing no access to the facility.
4. Keep calm and reassure the patients and their families that they are safe.
5. All procedures should be terminated as soon as it is safe to do so.
6. When procedures are complete, all gases must be turned off.
7. When authorities arrive, the person as stated in Serial No. 2 above will carry out all required activities to assure the safety of the patients and the staff.
8. No one will leave the building until the authorities give the all clear which will then be announced by the Administrative Head of the Center/Nursing Superintendent/Senior most staff of Prime Surgical Center.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer to Hospital Infection Control Manual Policy and Procedure No. 11)

MR No.:	IP No.:
Name:	
Age/Sex:	
Comfort/Deluxe Bed No.:	
Admission Date:	

BREAK-IN-TECHNIQUE/SURGICAL WOUND CLASSIFICATION

Description of Incident: _____

_____

_____

_____

Staff Members Involved:_____

_____

Was Culture Taken in OR? ☐ Yes ☐ No

Results:_____

SURGICAL PROCEDURE CLASSIFICATION:

Class II: Clean contaminated: Infection discovered but contained.
Class III: Contaminated, acute inflammation with pus formation, break in aseptic technique.
Class IV: Dirty

WERE ANY OF THE FOLLOWING CONDITIONS PRESENT POSTOPERATIVELY?

Temperature Elevation: _____Yes _____ No
Purulent Drainage: _____ Yes _____ No
Wound Infection: _____ Yes _____No
Other, describe: _____

FORM COMPLETED BY:

Name: _____
Date and Time: _____
Signature:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

BREAST SURGERY POST-OPERATIVE ORDERS		
Module Applies To	**Consultant**	**Policy and Procedure No.: 11** **Page: 1 of 2**
Effective Date: 1 April, 2014		

BREAST SURGERY POST-OPERATIVE ORDERS

Date of Surgery: _____

Procedure Performed: _____

Allergies: _____

1. Transfer to _____ when meets criteria.
2. Vitals: TPR/BP
   Every 15 minutes for the first 3 hours after surgery
   then every 1 hour for 3 hours
   then every 6 hours thereafter
   Notify surgeon if: HR< 60 or > 140, BP systolic < 100 or > 150, Temp > 101F.
3. Diet: NBM until _____ then start liquid diet.
   Advance as tolerated to ☐ Soft diet ☐ Regular diet ☐ Diabetic diet
4. IV Fluids:
   ☐ IV _____ at _____ ml/hr ☐ Stop IV fluids when adequate oral intake
   ☐ No IV fluids
5. Analgesics:
   Intravenous
   ☐ IV Paracetamol (Perfalgan) 1 g every 8 hours for _____ doses
   ☐ IV Tramadol Hydrochloride (Tramadol) 50 mg slow IV (over 2 -3 minutes) every 12 hours if needed for breakthrough pain.

   Oral
   ☐ Tab Diclofenac (Voveran) 50 mg every 12 hours
   Or
   ☐ Tab Dynapar (Diclofenac 50mg + Paracetamol 500 mg) every 12 hours
   ❖ Total Paracetamol intake to not exceed 4 g over 24 hours
6. Antacid:
   ☐ Tab Ranitidine (Rantac) 150 mg every 12 hours
   Or
   ☐ IV Pantoprazole (Pantocid) 40 mg daily
7. Anti-nausea/ Anti-emetic:
   ☐ IV Ondansetron (Emecet) 4 mg every 6 hours as needed for nausea.

8. Diabetic Patients:
   - ☐ Accucheck on arrival from OT
   - ☐ Accucheck every 4 hours when NBM ☐ Before meals and before bedtime
   - ☐ Glucose control per physician consulted.
9. Drain Care:

   First 6 hours after surgery: Observe output in drain collection chamber every 1 hour
   Thereafter: Empty drain every 6 hours and record output
   Notify surgeon if you note any of the following:
   a. Drain output exceeding 100 cc /hr
   b. No output or clotting in the tubing
   c. Change in drain content from serous (clear) to frank fresh blood (hemorrhagic)

   Teach drain-care to patient/ care-giver. Provide drain care instruction sheet to patient.
10. Wound Care:

    First 6 hours after surgery: Check surgical site every 2 hours.
    Thereafter: Check surgical site every 6 hours.
    Notify surgeon if you note any of the following:
    a. Bleeding
    b. Swelling/ Hematoma

11. Activity:
    - ☐ Keep head of bed elevated at 30 degrees when in bed.
    - ☐ Once awake, encourage patient to sit up in bed.
    - ☐ Walk with assistance. Secure drain to patient's side when walking.
12. Home Medications:

_____

_____

13. Other orders:
    - ☐ No IV sticks / BP cuffs on side of axillary dissection
    - ☐ Referral /Consult to _____ for

_____

_____

Name:

Signature:

Date and Time:

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
Phone: - 020-39931000 Fax: - 020 39931020
Email: - customercare@primesurgical.in
Website: www.primesurgical.in

BREAST SURGERY
POST-OPERATIVE ORDERS

Name :

Age/Sex :

Comfort / Deluxe Bed No :

Admission Date :

Date of Surgery: _____

Procedure Performed:

_____

Allergies: _____

1. Transfer to _____ when meets criteria.
2. Vitals: TPR/BP
   Every 15 minutes for the first 3 hours after surgery
   then every 1 hour for 3 hours
   then every 6 hours thereafter
   Notify surgeon if: HR< 60 or > 140, BP systolic < 100 or > 150, Temp > 101F.
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4. IV Fluids:
   ☐ IV _____ at _____ ml/hr ☐ Stop IV fluids when adequate oral intake
   ☐ No IV fluids
5. Analgesics:
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   ☐ IV Paracetamol (Perfalgan) 1 g every 8 hours for _____ doses
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   Oral
   ☐ Tab Diclofenac (Voveran) 50 mg every 12 hours
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   ❖ Total Paracetamol intake to not exceed 4 g over 24 hours
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   ☐ IV Pantoprazole (Pantocid) 40 mg daily
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   Notify surgeon if you note any of the following:
   a. Drain output exceeding 100 cc /hr
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    Notify surgeon if you note any of the following:
    a. Bleeding
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11. Activity:
    - ☐ Keep head of bed elevated at 30 degrees when in bed.
    - ☐ Once awake, encourage patient to sit up in bed.
    - ☐ Walk with assistance. Secure drain to patient's side when walking.
12. Home Medications:

_____

_____

_____

_____

13. Other orders:
    - ☐ No IV sticks / BP cuffs on side of axillary dissection
    - ☐ Referral /Consult to _____ for

_____

_____

_____

_____

Name:

Signature:

Date and Time:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

CARDIOPULMONARY RESUSCITATION (CPR)		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 11** **Page: 1 of 4**
Effective Date: 11 April, 2013		

CARDIOPULMONARY RESUSCITATION (CPR)

PURPOSE

1. To establish a complete and efficient procedure so that CPR can be easily accomplished when indicated without delay or confusion.
2. CPR provides basic emergency life support until the medical help arrives for a sudden cardiac arrest patient.

SCOPE

All Prime Surgical Centers nursing personnel.

POLICY

All nursing services personnel shall maintain Cardiopulmonary Resuscitation (CPR) certification by Prime Surgical Centers.

1. CPR procedures will be made familiar to all nursing personnel through training and practice under the direction of a certified instructor. CPR/Code drill will take place every month whenever a new centre is started and thereafter on 3-monthly basis.
2. At least 1 nursing Personnel trained and knowledgeable in the indications for the techniques required in the use of adjunctive equipment and drugs will always be available
3. A copy of current standards and guidelines for cardiopulmonary resuscitation and emergency cardiac care will be used in formulation of procedures.

PROCEDURE

1. In the event of actual or suspected cardiac or respiratory arrest, the order of procedure will be immediately as follows:
   a. Give alert through emergency communication system. Generation of SMS through Hospital Information System.
   b. Record time and signal code and location.
   c. Initiate BLS until assistance is on site.
   d. When adjunctive equipment is available, begin ACLS procedures.
2. Notification of code.
   a. Upon notification of a CODE, call the Resident Doctor on duty/ Anaesthesiologist:
      i. Telephone **CODE BLUE** and name and the location to the Code Team.
      ii. Inform Operation Theater Matron and Code Team
      iii. Keep all telephone lines clear.
      iv. Notify **CODE BLUE CLEAR**.

b. Arrest in Nursing unit: **CODE BLUE** is announced when a patient is Unresponsive , Stops Breathing , is Pulseless, or has severe Hypotension.

Are you alright? If unresponsive Identify CODE BLUE

First Staff Nurse, who identifies code, will initiate CPR. Shout for help.

First person who responds to the code will bring the crash cart to the site and call the Resident Doctor on duty & Anaesthesiologist.

Attach monitors/ defibrillator, suction.

All other persons responding to the site assist as directed by Resident Doctor on duty/ Anaesthesiologist.

ACLS protocol to be resumed as soon as Resident Doctor on duty/ Anaesthesiologist arrive.

3. Performance of basic CPR:

a. **Circulation**

i. Check carotid pulse not less than 5 seconds and not more than 10 seconds.

ii. If pulse is absent, start chest compressions.

iii. Use cardiac board or floor/ locked trolley.

iv. Elevate the legs.

v. Compression: Ventilation ratio should be 30:2

vi. Chest compressions rate should be at least 100/min, with a compression depth of at least 5cm/2inches with complete chest recoil to allow the heart to fill completely before next compression.

b. **Airway**

Open the airway by tilting the head backwards by applying gentle pressure to forehead, jaw lift.

c. **Breathing**: Ventilate the patient

i. If no respiration, ventilate the patient with AMBU bag.

ii. Each rescue breath to be given over 1 second.

iii. Give sufficient tidal volume to produce visible chest rise.

d. **Early Defibrillation** when indicated by the patient's condition will be performed by certified personnel under the direction of the Resident Doctor on duty/Anaesthesiologist.

e. Secure an IV line

f. Use drugs as indicated from diagnosis of patient condition (prepare drugs)

4. Arrest in operating room with anaesthesia personnel present

a. Anaesthesiologist notifies Surgeon that patient has a cardiac arrest or is in eminent danger of cardiac arrest.

b. Surgeon stops surgery and will be available for closed chest cardiac massage.

c. Proceed to ACLS

d. Identify the rhythm. Start Defibrillation

e. Intubation if not done.

f. IV adrenaline, vasopressin, Atropine, Cardiorone according to the rhythm

g. Send blood for testing to find out cause of arrest(5H, 5Ts)

h. Circulating nurse:

i. Note time of arrest.

ii. Immediately activate emergency alarm.

iii. Ask for any help available.

iv. Assist Anaesthesiologist.

v. Prepare routine drugs (Adrenaline, atropine, cardiorone)

vi. Assign personnel to:

- Record times, drugs and treatment on CPR report.
- Assist with closed chest cardiac massage.

i. Scrub nurse:

i. Protect operative site as possible.

- Warm packs
- Sterile towels

ii. Remain sterile unless priority demands otherwise. (CPR always demands priority).

iii. Assist as necessary.

5. Arrest in operating room without anaesthesia personnel present, i.e., local procedure.

a. Circulating nurse informs surgeon of impending cardiopulmonary complications.

i. Attaches monitor leads - note time.

ii. Closed chest compressions to be initiated as soon as possible.

iii. Establishes airway.

iv. Secure a IV line if not present.

b. Scrub nurse:

i. Press emergency call for help.

ii. Prepare drugs.

iii. Chart on CPR report.

c. Surgeon available for closed chest compressions.

Circulating nurse may perform closed chest compressions to relieve surgeon to intubate patient, if necessary.

CARDIOPULMONARY RESUSCITATION (CPR)		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 11** **Page: 4 of 4**
Effective Date: 11 April, 2013		

Overview of CODE Team Members/Responsibilities

RESPONSIBILITY	**CODE TEAM**
Team Leader-Anaesthesiologist	Anaesthesiologist / Surgeon/RMO
Ventilation-Nurse / Physician	Nursing Superintendent / OT Matron
Compression-Nurse / Physician	Operation Theatre - Matron
Monitor, defibrillation- Nurse & Physician	Unit Nurse / Physician
IV insertion-Nurse / Physician	RMO / Physician
Medications-Nurse / Physician	Housekeeping
Documentation- Nurse / Physician	
Communication-OT Matron / Nursing Superintendent	

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 11)

CARDIOPULMONARY RESUSCITATION (CPR) GUIDELINES

1. Patient unresponsive or monitor shows flat line or dropping saturation or falling blood pressure.
2. If patient not connected to monitor, start monitoring.
3. Person who has observed above will stay with the patient and feel pulse and shout for help.
4. Person who responds to help will call the Anaesthesiologist/Duty Doctor and mobilize emergency equipment and drugs i.e. Crash Cart.
5. If no pulse, initiate Cardio-pulmonary resuscitation as specified. (Refer Nursing Manual Policy and Procedure No. 11)

ANNEXURE XI
(Refer to Housekeeping Manual Policy and Procedure No. 1)

CORRIDORS OR STAIRWELLS

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		As needed
A/C baffles and top of cabinets		X		
Door Frames	X			
Door Handles	X			
Fire Extinguisher	X			
Fire Cabinets	X			
Stair Cases	X			
Windows	X			
Empty Waste Bins	X			
Luminaries		X		
Electrical Outlet/ Switch Plates	X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

INTRAVENOUS THERAPY		
Module Applies To	**All Nurses and Technicians**	**Module No: 11** **Page: 1 of 24**
Effective Date: 11 April, 2013		

INTRAVENOUS THERAPY

COMPETENCY STATEMENT

Demonstrate competence in safe administration of Intravenous infusions (Continuous, intermittent infusions, and I.V Push) in compliance with policy of Prime Surgical Centres and manufacture guidelines and infection control guidelines in simulated setting.

LEARNING OUTCOME

1. Identify the purposes of I.V therapy
2. Differentiate between various I.V infusions according to the osmolarity
3. Identify the suitable veins for I.V puncture
4. Apply the knowledge of specific nursing considerations in managing patients with I.V additives
5. Calculate flow rate in drops per minute using varied drop factor tubes
6. Calculate flow rate in millilitres per hours.
7. Use appropriate devices for I.V therapy while administering I.V infusion procedure
8. Verify the I.V order
9. Determine appropriate site for I.V infusion
10. Perform safe I.V cannula insertion procedure
11. Administer I.V infusion in compliance with the Prime Surgical Centres infection control guidelines
12. Administer medication by I.V push in compliance with Prime Surgical Centres guidelines on medication administration

INTRODUCTION

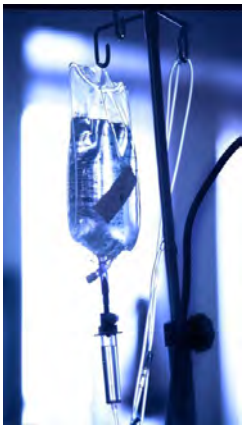
One of the routine tasks of a nurse is to manage Intravenous Therapy. Intravenous infusions may be administered either continuously or intermittently. Peripheral IV therapy however is the most common method used.

Continuous IV therapy involves administration of prescribed fluids over a period of time.

Intermittent IV therapy involves the administration of a solution over short periods at specified intervals (e.g. administration of medications intravenously).

The method of administration depends on the following factors:

1. Purpose and duration of therapy
2. Patient's condition, age and health history



Uses of IV Therapy include:

1. Restore and maintain fluid and electrolyte balance
2. Administration of drugs
3. Transfusion of blood and blood products
4. Parenteral nutrition

INTRAVENOUS THERAPY		
Module Applies To	**All Nurses and Technicians**	**Module No: 11** **Page: 2 of 24**
Effective Date: 11 April, 2013		

Advantages of IV Therapy are:

1. Easy access to veins
2. Rapid administration of solutions, blood and medication
3. Allows continuous or intermittent administration of drugs
4. Produces rapid systemic changes
5. Easy to monitor due to visibility

Disadvantages of IV Therapy are:

IV therapy is an invasive vascular procedure posing some risks to the recipient, which include:

1. Infection
2. Bleeding

Rapid administration of IV drugs may result in:

1. Irreversible adverse effects such as:
   a. Hearing loss
   b. Bone marrow depression
   c. Renal or heart adverse effect
2. Limited time use – up to 4 weeks
3. More expensive than oral, subcutaneous or intramuscular administration.

Components of an IV Therapy Order

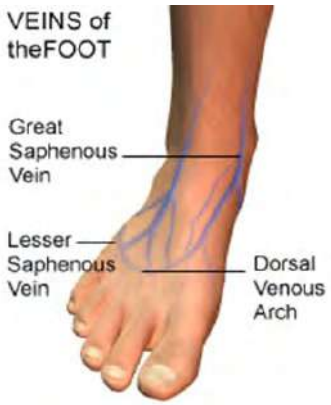
The IV therapy order should specify the following:

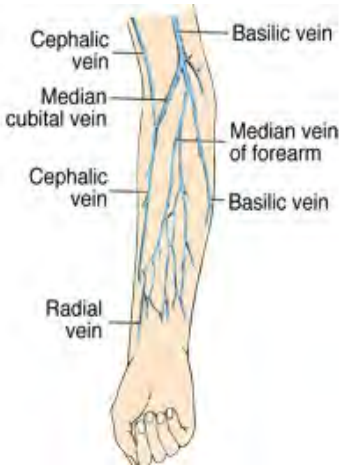
1. Date and time of the order
2. Type and amount of the solution / medication
3. Any additives and their concentration, e.g. 10 mEq potassium chloride in 500 ml D5W (Dextrose 5% in water)
4. Rate or volume of the infusion
5. Physicians' signature and stamp

It is the nurse's responsibility to ensure that the order is legible, correct and complete before the Physician leaves the patient's bedside.

Comparison of Venepuncture Sites

Veins	Advantages	Disadvantages
Metacarpal Veins	1. Easily accessible 2. Lie flat on back of hand 3. In adult and older child, bones of hand act as splint	1. Wrist movement decreased unless a short cannula is used 2. Insertion more painful due to many nerve endings in hands 3. Site becomes phlebetic easily
Cephalic Vein	1. Large vein excellent for venepuncture 2. Readily accepts large – gauge cannula 3. Does not impair mobility	1. Proximity to elbow may decrease joint movement 2. Veins tend to roll during insertion
Median Antebrachial Vein	1. Vein holds winged needles well 2. A last resort when no other means available	1. Many nerve endings in mid anterior arm, resulting in painful venepuncture or infiltration damage 2. Infiltration occurs easily
Basilic Vein	1. Will take a large – gauge cannula easily 2. Straight strong vein suitable for large – gauge venepuncture devices	1. Uncomfortable position for patient during insertion 2. Penetration of dermal layer of skin causing pain 3. Vein tends to roll during insertion
Antecubital Veins	1. Large veins facilitate drawing blood 2. Often visible and palpable in children when other veins won't dilate 3. May be used in an emergency or as last resort 4. Is less painful area for venepuncture	1. Difficult to splint elbow area with arm board 2. Median cephalic vein crosses in front of brachial artery 3. Veins may be small or scarred if blood has been taken repeatedly from this site
Great Saphenous Vein	1. Large vein excellent for venepuncture	1. Circulation of lower leg may be impaired 2. Walking difficult with devise in place 3. Increase risk of deep vein thrombosis

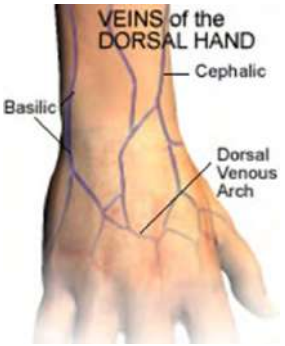




Peripheral IV Sites

When choosing peripheral IV site, consider the following:

1. Location of the vein
2. Purpose of infusion
3. Duration of the therapy
4. Cooperation needed by the patient
5. Patients preference, when possible



Successful IV therapy depends on selecting the best vein.

Select a vein in the non-dominant hand or arm.

Never select a vein on an oedematous hand, arm or foot.

Rotate venepuncture access sites.

Always choose a site that is most distal and move upwards.

Selecting Equipment for Initiating IV Therapy

In preparation for IV Therapy, obtain ordered IV solution; choose appropriate administration set, filter, infusion pump or volume controller (if needed) and venepuncture device.

IV Solutions are prescribed to maintain or replace fluid balance. Three basic types of solutions: isotonic, hypotonic and hypertonic solutions.

Isotonic Solutions possesses similar osmolality as serum and other body fluids, and therefore stays within the vascular system. It is useful for treating hypotension from hypovolemia.

Hypotonic Solutions osmolality is lower than serum, and when administered into the body causes the body fluids and electrolytes to shift out of the blood vessels into the surrounding interstitial spaces, where osmolality is higher.

Indications for hypotonic solutions are:

1. Rehydrating body cell in the case of diuretic therapy
2. Hyperglycaemic conditions such as diabetic ketoacidosis

Hypertonic Solutions have a higher osmolality than serum, thus when administered to the body it causes fluid and electrolytes to move out of the cells and interstitial space into the intravascular system raising osmolality.

Quick Guide to IV Solutions

Solution	Nursing Considerations
Isotonic	
• **Lactated Ringer's / Ringer's** (275mOsm/litre) • **0.9% Sodium Chloride (Normal Saline)** (308 mOsm /litre) • **(Dextrose 5% in water)** (260 mOsm / litre)	• Expand intravascular compartment • Monitor closely for fluid overload – especially in patients with hypertension and congestive cardiac failure • Liver converts lactate to bicarbonate, therefore do not give Lactated Ringer's solution if patient's blood pH exceeds 7.5 • Do not give lactated Ringer's solution if patient has liver disease • Avoid giving (Dextrose 5% in water) for prolonged periods to patient at risk for increased intracranial pressure (ICP), as it acts like a hypotonic solution.
Hypotonic	
• **0.45% Saline** (154 mOsm /litre) • **0.33% Saline** (103 mOsm / litre) • **Dextrose 2.5% in water** (126 mOsm / litre)	• **Administer cautiously**. These solutions cause sudden shift from blood vessels into cells resulting in cardiovascular collapse due to intravascular fluid depletion and increased intracranial pressure from fluid shift into brain cells • Do not give hypotonic solutions to patient at risk for raised intracranial pressure from cerebrovascular accident, head trauma or neurosurgery • Do not give hypotonic solutions to patients at risk for third space fluid shifts (abnormal fluid shifts into interstitial compartment or body cavity) such as patients suffering from burns, trauma, or low serum protein levels from malnutrition or liver disease
Hypertonic	
• **Dextrose 5% in 0.45% saline** (406 mOsm /litre) • **Dextrose 5% in normal saline** (560 mOsm /litre) • **Dextrose 5% in lactated Ringer's** (575 mOsm / litre)	• Monitor closely for fluid overload – these solutions expand intravascular compartment • Do not give to patients that have a condition that causes cellular dehydration, such as diabetic ketoacidosis – these solutions pull fluid from intracellular spaces • Do not give to patient's with impaired heart or kidney functions – the system cannot handle extra fluid

Administration Sets

Three major administration sets are available; basic, add-A-line and volume control. Depending on the type of IV therapy, supplemental equipment such as flow regulator, a T-connector, IV loop and extension tubing is available.

Selection of sets depends on the following:

1. Rate and type of infusion
2. Type of solution container
3. Need for mechanical flow control device or not
4. Flow rate the set is gauged to produce
5. Nature of IV solution
6. More viscous the solution, the larger the drops, thus fewer drops per millilitre

Administration sets come in two types of drip systems – macrodrip and microdrip. Macrodrip set delivers solution in large quantities at rapid rates. Microdrip set delivers smaller amount of solution with each drop. It is used in paediatrics and for adults requiring small or closely regulated amounts of IV solution.

Basic Sets

Basic IV administration sets consist of a piercing spike, a drop orifice, a drip chamber, one or more y-site injection ports, a roller clamp, and a luer-lock adapter or slip-lock needle adapter. They are used to deliver any IV solution or to infuse solutions through an intermittent infusion device. A secondary injection port permits separate or simultaneous infusion of two solutions.

Add-A-line Sets

A patient requiring intermittent secondary infusion will have an Add-A-line administration set added through a y-site to deliver the solution. A back check valve prevents the backflow of the secondary solution into the primary solution. The primary solution hangs lower than the secondary solution, thus once secondary solution infused the primary solution continues.

Volume - Control Sets

These are used mainly in paediatrics, delivering small, precise amounts of fluids and medication from a volume-controlled chamber. Also called burette sets. Calibrated in millilitres, they can be attached to the top of the IV tubing just above the drip chamber. They are available with or without an in line filter. They can also be attached directly to the venepuncture device or to a secondary infusion into a Y-site of a primary IV administration set.

Filters

An in-line filter is located in the fluid pathway between the IV tubing and the venepuncture device. An add-on filter is added to the distal end of the IV tubing. Both types of filters remove pathogens and particles to reduce the risk of infection and phlebitis. Filters also help air from entering the patient's circulation by venting it through the filter housing.

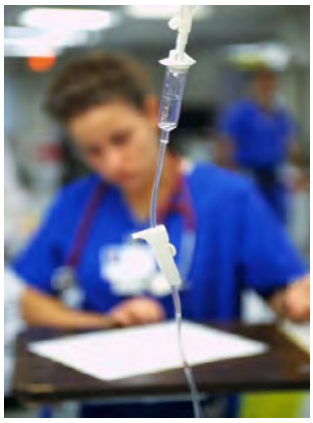
Filters are used in the following circumstances:

1. For immune suppressed patients
2. When administering total parenteral nutrition
3. When using additives such as medications – antibiotics
4. When risk for phlebitis is high

Avoid filters when administering solutions with large particles that may clog the filter, e.g. suspensions, emulsions and high-molecular-volume plasma expanders such as Dextran, as well as when administering 5mg or less of a drug as the filter may absorb it.

Change filter according to manufacturer's recommendations.

Volume-Controllers and Pumps



These are electronic infusion devices which deliver IV solutions 95 – 98% accuracy. They also indicate when the infusion is completed, as well as detecting infusion problems, such as;

1. Air in the line
2. Low battery
3. Machine malfunctions
4. Occlusion
5. Inability to deliver at the set rate.

Depending on the problem the device may shut off, sound or flash an alarm or switch to keep the vein open rate.

IV Infusion Pumps

IV infusion pumps apply pressure to the infusion to maintain the preset flow rate. They help when patient activity increases venous back pressure. They save time by eliminating the need for counting the drops and adjusting the flow rates. They also offer safety benefits, such as controlled flow rates reduce the risk of fluid overload. Any increase in pressure caused by coughing, sneezing, crying or straining does not affect the flow rate, as the pressure generated by the pump exceeds maximum venous pressure. They reduce the risk of air embolism by sound or flashing an alarm or stop infusion when IV container is empty. The disadvantages of the infusion pumps are they are expensive and the pressure they exert increases the risk of undetected infiltration.

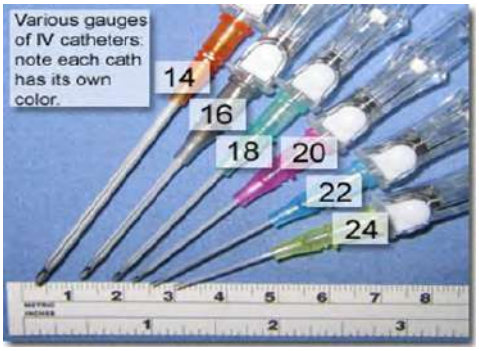
Venepuncture Devices

According to international standards of IV therapy, one should select the venepuncture device with the shortest length and smallest diameter that allows for proper administration of the therapy. Selecting of the venepuncture device depends on the following factors:

1. Length of time the device will stay in place
2. Type of therapy and the procedure or surgery to be performed
3. Patient's activity level and age
4. Type of solution to be administered
5. Types of veins available

Comparison of Venepuncture Devices

Device	Purpose	Advantage	Disadvantage
Winged Infusion Device	1. Short term therapy for any cooperative adult patient 2. Therapy of any duration for paediatric patient 3. Geriatric patient with sclerotic or fragile veins	1. Easiest venepuncture device to insert 2. Ideal for IV push drugs	1. May easily infiltrate if steel winged infusion device used
Over-the-needle Catheter	1. Long term therapy for active or agitated patient	1. Inadvertent puncture of vein less likely than with a needle 2. More comfortable for patient once in place 3. Contains radiopaque material for easy identification on X-ray	1. More difficult to insert than other devices
Through-the-needle Catheter	1. Long term therapy for the active or agitated patient	1. Inadvertent puncture of vein less likely than with a needle 2. More comfortable for patient once in place 3. Contains radiopaque material for easy identification on X-ray	1. Leaking at site may occur especially in geriatric patient 2. If needle guard not used catheter may be severed



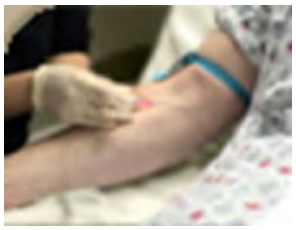
Nurse's Guide to Needle and Catheter Gauges

Gauge	Uses	Nursing Considerations
16	• Adolescent and adults • Major surgery • Trauma • Whenever large amounts of fluids are to be infused	• Painful insertion • Requires large vein
18	• Older children, adolescents and adults • Administration of blood and blood products and other viscous infusions	• Painful insertion • Requires large vein
20	• Children, adolescents and adults • Suitable for most IV infusions	• Commonly used
22	• Infants, toddlers, children, adolescents and adults, especially geriatric patients • Suitable for most IV infusions	• Easier to insert in small, thin, fragile veins • Slower flow rates must be used • More difficult to insert into tough skin
24, 26	• Neonates, infants, toddlers, school-age children, adolescents, and adults, especially geriatric patients • Suitable for most infusions, but flow rate is slower	• For extremely small veins – small veins of fingers or veins of inner arms in geriatric patients • May be difficult to insert into tough skin

Preparation to Commence IV Therapy

Before gathering the required equipment, check Physician order for the type of solution and flow rate.

Equipment Required for IV Therapy



1. Intravenous solution containers
2. Administration sets/flow rates
3. IV stands
4. Tourniquet or BP cuff
5. IV needles or catheters
6. Tape and site dressing materials
7. Label for IV infusion
8. Antiseptic solution (alcohol / Betadine) to cleanse skin

Selection of IV Equipment

1. Check the physician's orders. Pay particular attention to the type of fluid and solution concentration, and to the infusion rate. Many abbreviations are used; some of the most common are:
   a. 5% Dextrose in water: D5W
   b. 5% Dextrose in normal saline: D5N/S
   c. half-strength normal saline: ½ N/S
   d. Lactated Ringer's: LR

   If you do not understand the orders, be sure to ask.
2. Wash hands.
3. Select the ordered solution. Carefully check the order and the label to be certain that you have the correct solution. Also check the expiration date. Finally, check the clarity; any cloudiness or particulate matter could indicate that the solution is not suitable for use and should be returned to its source.
4. Select an infusion set, considering the amount of fluid to be administered and the rate. If a very slow rate is needed; a microdrip set will provide more accurate regulation. If medications are to be given; a set with multiple injection ports may be needed. For an infant or child, using a controlled-volume set (Buretrol or soluset) is usually routine. Using a Controlled-volume set allows for more accurate delivery of IV solutions.
5. Attach a time label to the container. On the label write the approximate time the solution level should reach each mark on the container.
6. If there is a great deal of equipment around the patient, an extension tubing to lengthen the IV line may be needed. Make sure that an IV stand is available. Also, have an armboard available; you often do not know whether you will need an armboard until after the IV is in place. A tray is usually set up with equipment for starting the IV.

Assembling the IV Equipment

1. Open the package containing the tubing. Be sure to maintain the sterility of the connectors. If the connectors are covered with plastic caps, leave the plastic caps in place until you are ready to connect the tubing. Check the drop factor of the tubing.
2. Open the entry area of the fluid container according to the manufacturer's direction. There should be evidence that the container was sealed, which certified sterility. Be careful that you do not contaminate the entry port.
3. Follow the manufacturer's directions about cleaning the entry port with an alcohol swab. Most fluid containers are sealed so that the entry area is sterile and does not need to be cleaned.
4. Close the regulator on the tubing.
5. Insert the tubing into the fluid container through the correct entry port.
6. Invert the bottle with the tubing hanging down. It is convenient to be able to hang the bottle on a hook stand at this time.
7. For a flexible plastic drip chamber, squeeze the chamber to fill it half full with fluid. A rigid drip chamber usually fills when the container is inverted.

8. Hold the end of the tubing over a basin or waste container. Open the regulator gradually and allow the tubing to fill. If the end of the tubing is tightly capped, that cap must be loosened to allow the tugging to fill. Replace the cap when the tubing is full. Be sure that all large bubbles are eliminated. Very tiny bubbles that do not together constitute a large bubble are not dangerous, so do not be alarmed if a small bubble is inadvertently administered.

Performing Venepuncture

Performing the venepuncture requires preparation of the patient, dilatation of the chosen vein, preparation of the venepuncture site and insertion of the cannula (intravascular) device. Once the infusion is commenced, the IV placement must be secured with tape and transparent dressing. Finally the procedure is to be documented in the patient's medical record / nurses notes.

Preparation of Patient

Prior to commencing IV therapy approach the patient and identify patient using two patient identifiers.

Prepare patient physically and psychologically by explaining the procedure to the patient, reasons for need for infusion and answer questions that the patient may ask.

To some patients, the knowledge that they are about to receive intravenous fluids is threatening. Certain patients feel the procedure implies serious illness; others are frightened by the threat of pain, discomfort, and immobility. Previous experience can help make the patient less apprehensive, assuming the experience was a good one. For other patients, however, the memories of problems related to the IV make the impending experience truly frightening.

Tell the patient that a venepuncture can cause discomfort for a few seconds, but there should be no discomfort while the solution is flowing.

Provide any scheduled care prior to the IV to minimize movement of the affected limb during the procedure since moving the limb afterwards could dislodge the needle.

Check the patient's gown to make sure that it can be removed over the IV apparatus if necessary.

Preparing the Venepuncture Site

The site chosen will vary depending upon the patient's age, the infusion time, the type of solution used, and the condition of the veins. The larger veins of the forearm, in contrast to the metacarpal veins of the hand, are used for infusions that need to be given rapidly, for solutions that are hypertonic, highly acidic or alkaline, or that contain irritating medications.

It is best to start low in the vein (in the hand or forearm). Then, if unsuccessful or if the IV comes out at a later time, a vein proximal to or higher than the first one is chosen. A site where there is bifurcation may be easier to enter if entered from below. Compare the length of the device to be used with the available vein. Given a choice, it is preferable not to use the dominant hand or arm, and also better to change sides with subsequent IVs. Choices are often limited by the diagnosis, the condition of the patient's veins, and the presence of additional equipment.

Select the vein by looking, palpating, and attempting to distend any veins in the area. A clearly visible vein that can be palpated and that has a straight section for entry is required. Veins that are not visible but are palpable can be used.

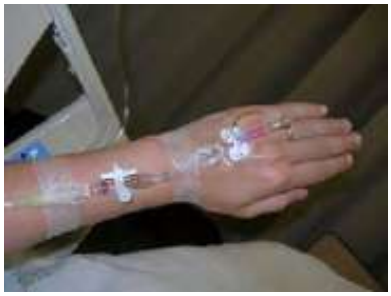
The administration of a local anaesthetic cream or patch may be required for children prior to inserting the venepuncture device.

Performing the Venepuncture

1. Wash hands. Starting an IV is a sterile procedure for which the hands must be clean. To protect oneself, put on clean gloves.

   Note: The latest Infection Control policy requires gloving whenever venepuncture is done.
2. Ensure that you are in a comfortable position to perform procedure. In order to start an IV, it is equally important to be in a comfortable position as it is for the patient. The position chosen in order to be comfortable may be a chair at the bedside. Some nurses put the bed in high position and stand; others put the bed in low position and kneel on a towel, still others sit on the bed.
3. Locate a vein in which to start the IV. Examine both forearms and select a site to begin. Place a tourniquet a few inches above the selected area, ask the patient to open and close his or her fist.
4. Clean the area thoroughly. Start from the entry point moving with a circular motion away from it, cleaning the skin thoroughly at and around the selected vein. If the area is especially hairy, shave or clip the hairs before commencing to attempt to start the IV, both for aseptic reasons and to prevent the tape from pulling. Clean the area with an alcohol swab after it has been shaved or clipped. Try not to touch the area after it has been cleaned.
5. Insert the needle. Using the thumb of the non dominant hand, gently retract the skin away from the site. Holding the needle at about a 45° angle, with the bevel up, pierce the skin immediately beside the selected vein. When the needle is through the skin decrease the angle until it is almost parallel with the skin, and enter the vein. When blood comes back into the tubing or syringe or flashback chamber (depending on the device used), insert the needle or catheter almost the full length of the needle. Follow the package instructions for the use of any other device.
6. Release the tourniquet. Holding the needle or other device steadily with the dominant hand, release the tourniquet with the other hand. Apply gentle pressure with index finger of non-dominant hand 1 ¼ inches above site.
7. Connect the tubing to the IV tube and initiate the flow. Remove the protective cap from the IV tubing (maintaining sterile technique), connect it securely to the needle, and open the regulator to initiate the flow. This should be done quickly to prevent the patient's blood from clotting and clogging the needle.
8. Tape the needle securely and dress the site according to the following procedure:
   a. Place a small amount of an antiseptic ointment (betadine is commonly used) at the needle site.
   b. With ¼ inch adhesive tape (after checking for patient allergy), tape the needle in place using a chevron configuration.
   c. Tape the needle and tubing in place, using paper tape (if available – it is usually less traumatic to the patient' skin), and make a loop near the point of entry. This helps prevent the weight of the tubing from pulling the needle out of place.
   d. A sterile transparent dressing (Tegaderm) is placed over the insertion site. This dressing is not replaced routinely, only when soiled or loose off the skin.
   e. Label the insertion site with the date and time of insertion, and the nurse's initials: as per Prime Surgical Centers policy.
   f. Tape the armboard in place, if necessary.

9. Adjust the flow rate. The physician will have ordered a specific amount of fluid to be administered over a certain period of time. Calculation of the flow rate may be required if a volume control pump is not used. The flow rate may be based on the number of drops per millilitre administered by the equipment being used. The nurse will calculate the flow rate, however the nurse must be able to determine the rate of flow when IV gets "ahead" or "behind." Application of narrow strips or paper calibrated according to the number of hours the IV is to run (time label), is useful in assisting the nurse to monitor flow of IV infusion; the nurse adds specific times appropriate for the individual.
10. Dispose of the equipment.
11. Remove gloves.
12. Wash hands.
13. Teach the patient how to protect the IV:
    a. Avoid sudden twisting or turning movements of the arm with the infusion.
    b. Avoid stretching or placing tension on the tubing.
    c. Try to keep the tubing from dangling below the level of the needle.



    d. Notify the nurse if he or she notices a sudden change in the flow rate, the solution container becoming nearly empty, blood in the IV tubing, or discomfort at the IV site.
    e. Nurses may need to show patients how to ambulate safely, if they are allowed to do so, with a portable IV stand.
14. Chart the IV. Document the commencement of IV infusion in the nurses' progress notes, patient flow chart and intake and output chart. Include the time the IV was started, the type of fluid, any additives, where the IV was started, and by whom. A patient receiving an IV is usually on intake and output chart.

Routine Care of the IV Infusion

After the IV has been started, the nurse must continue to monitor and maintain the infusion and prevent complications from occurring.

At the commencement of each shift during the handover / endorsement period the incoming nurse and the outgoing nurse together must check the IV site for any signs of infiltration, infection, pain or swelling and document findings in the nurse's notes. Thereafter the nurse on duty throughout her / his shift should monitor the infusion site and dressing, and the infusion flow rate.

Wash hands and wear gloves before touching the infusion.

Regulating Flow Rate

An important nursing function for an IV infusion is to regulate the flow rate of the solution. The physician usually describes in the IV order how long an infusion should last, e.g., 3000 ml over 24 hours. It is then a nursing responsibility to calculate the correct flow rate and regulate the infusion. Problems can result from incorrectly regulated infusions.

Milliliters per hour

This calculation is made by dividing the total infusion volume by the total time in hours.

$$\textbf{Milliliters per hour} = \frac{\text{Total infusion volume}}{\text{Time of infusion in hours}}$$

Example: If the requirement is 1000 ml in 8 hours, the calculation is:

$$\frac{1000}{8} = 125 \text{ ml per hour}$$

Hourly checks are required by nursing personnel to ensure that the correct number of ml has infused. Some nurses put a strip of adhesive tape on the IV container with the exact times for the infusion or the amount to be infused hourly.

Drops per minute

The number of drops per minute (gtts/min) are calculated as follows:

Multiply the milliliters per hour by the drip factor and divide by the number of minutes.

Example: IV to infuse at 125 cc/hr per IV set with drip factor of 15.

$$\text{Gtts/min} = \frac{\text{mls/hr } \mathbf{X} \text{ Drop Factor}}{60}$$

$$\frac{125 \times 15}{60} = = 31 \text{ gtts/min.}$$

The infusion rate can then be established by adjusting the clamp on the tubing and counting the drops in the drip chamber. Meters and similar devices are also available that can be set to regulate the flow. Some of these systems have alarms that are triggered when there is a change in the flow rate.

IV Pumps

Infusion pumps assist to control the IV flow rate. The nurse sets the pump to deliver a set volume at a set rate. Since they pump against pressure gradients, a constant infusion rate and volume can be maintained even with fluctuations in the patient's venous pressure. Remember that the pump is only as effective as the nurse operating it. Do not expect the pump to be a substitute for nursing skills. The nurse must still check the patient regularly for complications, such as infiltration or infection. The machine may not work properly all the time. Read and understand the manufacturer's instructions.

Changing the Fluid Container and Tubing

According to Prime Surgical Centres Infection Control guidelines it is recommend that all IV tubing's and dressings be changed every 48 hours to decrease the incidence of phlebitis at the site. Containers are changed every 24 hours.

Routine Assessment

The nurse must make a systematic check of the entire infusion each time she or he is at the patient's bedside. Most IVs are checked hourly, or every 30 minutes in a paediatric or critical care setting. Review the entire system for obvious problems.

1. Check the container.
    a. Note the date and time.
    b. Is it the correct solution?
    c. Which number bottle is it?
    d. What time will it be finished?
2. Check the drip chamber.
    a. Is it dripping?
    b. Is there flow?
    c. Is the rate correct?
3. Check the tubing over its entire length for kinks or obstructions.
4. Check the date and time on the tubing. If not dated, assume it needs to be changed.
5. Check the site for signs of phlebitis or infiltration:
    a. Colour.
    b. Skin temperature.
    c. Pain
    d. Swelling
    e. Use the phlebitis and infiltration scale to determine the degree of phlebitis or infiltration.

Phlebitis Scale		
Intravenous (IV) site appears healthy	**0**	No signs of phlebitis – observe cannula
ONE of the following signs is evident: • Slight pain near IV site • Slight redness near IV site	**1**	Possibly first signs of phlebitis – observe cannula
TWO of the following signs are evident: • Pain at IV site • Erythema • Swelling	**2**	Early stage of phlebitis – resite cannula
ALL of the following signs are evident: • Erythema • Induration	**3**	Medium stage of phlebitis – resite cannula, consider treatment

ALL of the following signs are evident and extensive: • Pain along path of cannula • Erythema • Induration • Palpable venous cord	**4**	Advanced stage of phlebitis or the start of thrombophlebitis – resite cannula, consider treatment
ALL of the following signs are evident and extensive: • Pain along path of cannula • Erythema • Induration • Palpable venous cord • Pyrexia	**5**	Advanced stage of thrombophlebitis – initiate treatment, resite cannula

Grade	Clinical criteria
0	No symptoms
1	Skin blanched Oedema 2.5cm in any direction Cool to touch With or without pain
2	Skin blanched Oedema 2.5-15cm in any direction Cool to touch With or without pain
3	Skin blanched, translucent Gross oedema 15cm in any direction Cool to touch Mild to moderate pain Possible numbness
4	Skin blanched, translucent Skin tight, leaking Skin discoloured, bruised, swollen Gross oedema 15cm in any direction Deep pitting tissue oedema Circulatory impairment Moderate to severe pain Infiltration of any amount of blood product, irritant or vesicant

6. If an armboard is in use, remove it periodically to move the extremity or to examine for skin irritation or circulatory impairment. Then, replace.
7. Document findings and assessment in nursing progress notes and assessment flow sheet.

Administering Intravenous Medications

Because IV medications directly enter the patient's bloodstream, they are appropriate when a rapid effect is required. (e.g. in a life-threatening situation such as cardiac arrest.) The IV route is also used when medications are too irritating to tissues to be given by other routes (e.g. Levophed for acute hypotension) or when an IV line is already established and you want to avoid the discomfort of other parenteral routes.

There are, however, potential hazards in giving IV medications: infections and rapid, severe reactions to the medication. To prevent infection, sterile procedures are used during all aspects of IV medication techniques.

To safeguard against severe reactions, the nurse must carefully assess the patient for early signs of a reaction such as:

1. Noisy respirations.
2. Changes in pulse rate.
3. Chills.
4. Nausea.
5. Headache.
6. Specific adverse effects of the particular medication.

If any of these signs occur, discontinue the medication and notify the physician or responsible nurse.

Intravenous medications are given in a variety of ways. In Prime Surgical Centres all intravenous medications are prepared by the Unit Nurses.

The various methods used to administer IV medication include the following:

1. IV bottles or bags.
2. Volume-controlled in-line administration sets.
3. Additive sets (secondary or piggyback sets).
4. Direct IV push (bolus), via venepuncture, a port in an established IV line, or an intermittent infusion set (Heparin lock or trap).

There are three peripheral IV routes: bolus injection, intermittent and continuous infusion, and each have inherent risks. The rationale for route choice is based on knowledge of the medicine and its therapeutic effect. The patient, circumstances and equipment need to be considered. Peripheral route choice requires competent practice and effective clinical judgement to reduce risk and ensure safe practice.

When considering the peripheral IV route, administration factors such as compliance, absorption and rate of medicine administration are also important.

Compliance The peripheral IV route ensures the prescribed medicine concentration is achieved rapidly. It overcomes any nil-by-mouth or fasting requirements, and may also overcome a patient's refusal to take oral medication.

Absorption One hundred per cent bioavailability is achieved as the medicine is administered directly into the circulation and avoids the need for absorption; problems with malabsorption or medicine inactivation by the gut are also avoided.

Rate of medicine administration once injected, there is no recall. The risks of speed shock, anaphylaxis, extravasation, infiltration and fluid overload with large-volume rapid infusions are factors to be considered, taking into account time, cost and increased risk of infection.

Table 1 **Rationale for Peripheral Intravenous Route**	
Bolus injection	1. Quick response needed 2. High blood concentration required 3. Patient is fluid overloaded 4. Medicine is not chemically stable in a solution
Intermittent infusion	1. High blood concentration required 2. Patient is fluid overloaded 3. Medicine not chemically stable for continuous route, for example, benzylpenicillin 4. Reduces risk of adverse reactions, for example, bolus antibiotics
Continuous infusion	1. Constant blood level required 2. Constant effect required

Nurse's Role in Commencing IV Medication

It is the nurse's responsibility to do the following when administering IV medications in any form:

1. Check physicians prescription
2. Identify patient using 2 patient identifiers
3. Check the medication label against the physicians' prescription
4. If more than one medication is added, the compatibility of the drugs and solutions being mixed is determined. An incompatibility is an undesired chemical reaction between a drug and an infusion, or between two or more drugs.
5. Wash hands and put on gloves.
6. Check IV site for redness, tenderness, oedema or leakage. If any signs of complications, change IV site before administering medication.
7. Attach the piggyback bag or bottle with medication to the secondary line / tubing, maintaining sterile / aseptic technique
8. Monitor rate of flow of both primary and secondary infusion lines
9. Document administration of medication in medication profile and in nurses' progress notes. Document any adverse effect or reaction as well as any treatment given.

IV Push

An IV push is the intravenous administration of a medication that cannot be diluted or that is needed in an emergency. Some drugs are also administered this way to achieve maximum effect. It is important to remember that the medication is administered rapidly with an IV push and this could be dangerous for the patient.

A IV push can be administered into the existing intravenous apparatus through an injection port and through an intermittent infusion set (Heparin lock) when the patient does not have an IV running but does have a Heparin lock in place. The Heparin lock is used primarily for patients who require regular intermittent IV medication but not the fluid volume of an IV infusion. The set usually consists of a butterfly needle attached to a plastic tube with a sealed injection tip. It is called a Heparin lock because

small amounts of Heparin are injected into it to maintain its potency. The infusion set is generally inserted in a patient's arm or hand.

Note: Some institutions are now using med-locks instead of Heparin locks for intermittent IV infusions. These are flushed with 1-2 ml of NaC1 solution before and after mediation administration.

Assembling the Equipment

Wash hands using a surgical hand wash before gathering the following equipment:

1. The correct sterile medication.
2. Antiseptic swabs.
3. A sterile syringe and sterile needle of the appropriate size for the volume of medication.
4. A syringe and needle with a Heparin solution if an intermittent infusion set is used. Many agencies advocate using 100 units of Heparin per ml of saline solution.

IV Push into an Existing IV

1. Identify an injection port nearest the patient.
2. Clean the port with an antiseptic swab.
3. If the medication is not compatible with the primary infusion, flush the primary line with a sterile saline solution before giving the bolus.
4. Stop the IV flow by closing the clamp.
5. While holding the port steady, insert the needle in the port.
6. Draw back on the plunger to withdraw some blood. This ensures that the IV needle is in the vein.
7. Inject the medication at the correct rate (specific to each medication), withdraw the needle, reopen the clamp, and re-establish the IV infusion at the correct rate.

IV Push into an Intermittent Infusion Set

1. Swab the injection port with an antiseptic swab.
2. Insert the needle with the medication into the port.
3. Withdraw the plunger slightly. If blood does not return into the syringe, move the needle a little in case it is lodged against the wall of the vein. If blood still does not return in to the syringe, inject a little sterile saline and watch for any swelling or burning. If there is evidence that the fluid is flowing into the tissue, do not inject the medication, remove and start in a different site.
4. When the set is in the vein, inject the medication into the set at the recommended rate specified for the medication.
5. Withdraw the needle. Clean the port again.
6. Insert the Heparin syringe and inject the Heparin or Normal Saline slowly into the set. After the injection of Heparin or Normal Saline, the set is ready for the next infusion of medication. See Incompatible Medications below for information on what to do if a medication is incompatible with Heparin.

Incompatible Medications

If the drug is to be administered with the primary solution or with the Heparin is incompatible for an intermittent infusion set, precautions must be taken. In general, follow these steps:

1. Prepare the medication to be administered as directed.
2. Prepare two syringes with normal saline.
3. Establish that the IV is in the vein (get blood return).
4. Use one syringe of normal saline to flush the IV tubing (insert needle at secondary port) or intermittent infusion set.
5. Administer medication.
6. Use the second syringe of normal saline to again flush the IV tubing or intermittent infusion set.
7. Restart the primary IV or inject Heparin if using the intermittent infusion set.

Complications of IV Infusions

The nurse needs to check the patient regularly for problems related to the infusion. Common complications are phlebitis, fluid infiltration, obstructions and circulatory overload.

Phlebitis

Phlebitis, an inflammation of the vein, can be present with or without a clot in the vein. When there is a clot, it is technically thrombophlebitis. In actual practice, the two terms are used interchangeably. Phlebitis is characterized by redness, warmth, pain, and swelling at the IV site. It seems to occur more rapidly when plastic rather than metal needles are used, when electrolytes (especially potassium) are in the solution, and when antibiotics are being administered through the IV. This is due to direct irritation of the vessel. Changing the dressing and tubing every 48 hours seems to decrease the incidence of phlebitis, which suggests that microorganisms also play a role in its development.

When phlebitis occurs, the best course of action is to discontinue the IV and use warm moist packs on the site to relieve the discomfort. When an IV is critical, or when there is just a small amount of fluid left, the IV may be continued at a slow rate. Observe carefully for any increase in redness or swelling.

Infiltration

Infiltration is cause by the leaking of IV fluid into the surrounding tissue. Pallor, swelling, coolness, pain at the site, and usually a diminished IV flow rate are all indications of infiltration. It occurs more frequently with metal needles that have become dislodged and have penetrated a vein wall. It also can occur around a plastic needle that has been in place for a period of time. An infiltrated IV must be discontinued.

Obstructions

Obstructions are indicated by a decrease in flow rate or the complete cessation of fluid flow. Obstructions can be caused by a clot forming over the needle lumen, particulate matter clogging the filters, the lumen of the needle being positioned against the wall of the vein, kinking or pressure on the tubing, or a position of the arm that occludes the vessel proximal to the IV site. Locate the source of the obstruction and correct it (See Table 2).

Circulatory Overload

Circulatory overload occurs when the circulatory system contains more fluid than normal. A significant increase in the usual adult circulatory volume about six litres of blood, can cause circulatory overload, possibly resulting in pulmonary oedema and cardiac failure. The clinical signs of cardiac failure are dyspnoea, reduced urine output, oedema, weak and rapid pulse, and shallow and rapid respiration. Pulmonary oedema is recognized by dyspnoea, cough, and frothy sputum. Careful monitoring of the patient's intake and output can help to prevent circulatory overload.

Mistaken Arterial Puncture

1. The phlebotomy needle may be inserted into arteries instead of veins. This occurs most commonly in the antecubital fossa, with the catheter entering the brachial artery instead of the median cubital or basilic vein.
2. Arterial cannulation is distinguished by arterial flow (pumping) of blood, which will also be a bright scarlet color if he patient is not hypoxic.
3. Phlebotomy may still be performed in the event of arterial puncture. Pressure should be placed over the site for 5 to 10 minutes, longer if patient has a coagulopathy.

Table 2
Complications of Intravenous Therapy

Complication	Assessment Data	Nursing Actions
Infiltration of IV Solution	1. Infusion rate slows or stops completely. 2. Swelling, hardness, and pain around the needle site. 3. A feeling of coldness around the injection site. 4. When the bottle is lowered below the level of the needle, blood fails to return into the tubing (into a reliable sign in presence of hypotension) 5. Signs of tissue necrosis (with irritating solutions or Vasoconstriction drugs)	1. Stop the infusion Immediately 2. Elevate the arm and apply warm towels to the swollen area to aid absorption and reduce discomfort 3. If necessary, restart the infusion at another site.
Thrombophlebitis	1. Pain along the vein. 2. Area of redness and swelling around the affected vein	1. Stop infusion. 2. If necessary, restart the infusion at another site. 3. Apply warm moist compresses. 4. Do not massage or rub the affected limb.

Pyrogenic Reaction	1. Symptoms generally appear 30 minutes after the injection is started. 2. Temperature elevation and chills. 3. Headache. 4. Nausea and vomiting 5. Circulatory collapse.	1. Immediately stop infusion. 2. Check vital signs. 3. Notify physician. 4. Save IV solution so that it can be examined for pathogens. 5. Do not give any solution that is cloudy.
Speed Shock	1. Pounding headache. 2. Hypertension with possible loss of consciousness. 3. Rapid pulse. 4. Apprehension. 5. Chills. 6. Dyspnoea.	1. Stop or slow infusion, depending upon the severity of the symptoms 2. Check vital signs, neurologic and pulmonary functions. 3. Notify physician.
Air Embolism	1. The main problem here is sudden vascular collapse due to occlusion of vessel by embolism. As a result, tissues which are normally supplied with blood by the involved vessel will not receive adequate oxygen. Signs are: a. Cyanosis b. Low blood pressure, c. Tachycardia d. Rise in venous pressure.	1. Check vital signs. 2. Administer oxygen. 3. To prevent this complication: a. Make certain that air does not enter arterial or central venous catheters. b. Secure all IV connectors with adhesive tape. c. Have the patient perform a Valsalva manoeuvre or place the patient's head below heart level while changing the tubing on the central venous lines.
Circulatory Overload	1. Weight gain 2. Pitting oedema 3. Pulmonary oedema. 4. Ascites 5. Distension of neck veins 6. Apprehension 7. Rales 8. Dyspnoea.	1. Notify physician 2. Put the patient in semi Fowler's position 3. Administer oxygen. 4. Administer diuretics. 5. Restrict sodium. 6. Weigh patient daily. 7. Strict monitoring of IV 8. Record and evaluate intake and output. 9. Postural blood pressure and measurements.
Drug Reaction	1. Cardiac arrhythmias. 2. Nausea 3. Vomiting. 4. Rashes. 5. Renal failure	1. Slow or stop the infusion, depending upon the severity of the symptoms. 2. Check the vital signs, neurologic and pulmonary

	6. Anaphylaxsis (Penicillin and related antibiotics, Aspirin, NSAIDS) a. Hives b. Urticaria c. Swelling of the lips, tongue or face.	functions. 3. Notify physician.

Patients most at risk of phlebitis, infiltration and extravasation are

1. Older people
2. Neonates and very young children
3. Confused patients, or patients with dementia
4. Patients with a communication problem, for example, stroke or unconsciousness
5. Patients with diabetes, cancer, peripheral vascular disease, Raynaud's phenomenon (causing arterial spasm, may compromise peripheral circulation and reduce venous flow), superior vena cava syndromes (elevated venous pressure may predispose the patient to leakage at the intravenous (IV) site), and patients with blood abnormalities or circulatory problems.
6. Patients who have had repeated IV infusion and or injections (these may thrombose vessels and limit the number of accessible veins). This could also apply to patients with substance misuse problems.)

Discontinuing and IV Therapy

Steps for Discontinuing an IV

1. Check the orders. It is very upsetting to patients and staff to have an IV discontinued by mistake.
2. Wash hands.
3. Gather the necessary equipment: a 2 x 2 sterile gauze square and a Band-Aid type bandage.
4. Check the patient's identity using 2 patient identifiers.
5. Explain the procedure to the patient. Tell him/her that this should not cause discomfort.
6. Don clean gloves.
7. Carefully remove the tape and dressing.
8. Shut off the IV flow.
9. Hold the 2 x 2 gauze above the entry site. Be ready to exert pressure as soon as the needle is out, but do not exert pressure on the site while pulling the needle out. This compresses the vein wall between the needle and the swab and can damage the vein.
10. Remove the needle by pulling straight out in line with the vein. Check needle or catheter to be sure it is intact.
11. Immediately put pressure on the site.
12. Raise the patient's arm above his or her head for about one minute. Hold it there until the bleeding is controlled.
13. Put a band aid over the site.
14. Remove all the equipment. Be sure to note the volume of fluid remaining in the container in order to

record intake accurately.

15. Remove gloves and wash hands.
16. Chart, including intake, and note if needle or catheter is intact.

Documentation

It is important to chart carefully after IV care and monitoring are done. The charting must include the exact time started and stopped, and the exact content in detail. Careful records of fluid quantities must be recorded often on the intake and output worksheet, to facilitate assessing the patient's fluid balance. The patient's response is also noted.

According to Prime Surgical Centres Medication Administration Policy, the nurse is to document on the patient's medication profile when IV medication and IV therapy discontinued.

It is suggested that numbering of each vaculitre is done sequentially, to facilitate accuracy in administration and record-keeping.

When complete tubing is changed or when the IV site is redressed, a notation is made in the nurse's progress notes.

While an IV therapy is in place, assessment data must be recorded, such as signs of infection and/or infiltration. Even if no problems are noted, evidence that assessment has been done is required. All items checked should be noted.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

MAINTENANCE LOG BOOK FORMATS		
Policy/Procedure Applies To	**OT Matron & Ward In-charge**	**Policy/Procedure No: 11** **Page: 1 of 1**
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ALL ELECTRICAL MAINTENANCE LOG BOOK

Date	Area	Engineering Problem	Electrical Problem	Sign of OT Matron

ALL EQUIPMENT MAINTENANCE LOG BOOK - OT

Date	Complaints & Name of Equipment	Informed Person Name & Time	OT Person Name & Time	Action Taken	Repair Date & Time	Company Person Name & Sign	OT Person Name & Sign	Remark / Result

ALL EQUIPMENT MAINTENANCE LOG BOOK - WARD

Date	Complaints & Name of Equipment	Informed Person Name & Time	Ward Person Name & Time	Action Taken	Repair Date & Time	Company Person Name & Sign	Ward Person Name & Sign	Remark / Result

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

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Effective Date: 11 April, 2013		

PAEDIATRIC PATIENT IN NURSING UNIT

PURPOSE

To promote safe and quality care of the paediatric patients in the Nursing unit by defining the difference in their care from adult patients and to promote understanding of the patient and the family.

POLICY

1. Children will be treated with special care and understanding in the Nursing Unit, as many times they cannot or do not understand what is happening to them.
2. Considerations will be given to the paediatric patient for being subjected to painful or frightening procedures, being separated from parents and fear of the unknown, all of which can cause the child to increased anxiety.

PROCEDURE

1. Special equipment
   a. Small and medium size blood pressure cuffs.
   b. Laryngoscope with paediatric blade and paediatric endotracheal tube.
   c. Paediatric airways and paediatric ambu bag.
   d. Paediatric/geriatric defibrillator paddles.
   e. Micro drip Buretrols for IV infusions.
   f. #22 and #23 catheters for starting IV's.
2. Monitor the patency of child's airway immediately upon arrival to the Nursing Unit; count respirations and document frequently, at least every fifteen (15) minutes. Apply pulse oximeter probe and document results. If irritating, remove and reapply for further monitor.
3. Monitor pulse and document frequently, at least every fifteen (15) minutes, while in the Nursing Unit initially or as per instructions of Anaesthesiologist.
4. Blood pressure is measured on all paediatric patients over twelve (12) years of age, regardless of surgical procedures, and on any age when instructed by the Anaesthesiologist or Surgeon.
5. Temperature will be monitored.
6. Start oxygen on all children using 40% aerosol mist.
7. Monitor IV infusions; secure IV as necessary. Never tape all the way around an extremity. If child is extremely restless, IV may be secured with a loose dressing.
8. Examine operative site and document findings.
9. Note and document level of consciousness.
10. Report any unusual responses or occurrences to the Resident Medical Officer/Anaesthesiologist and document in nurse's notes. Signs and symptoms to watch for are:
    a. Cyanosis, pallor, rash hives or any mottled appearance.
    b. Cold, clammy skin, diaphoresis (excessive perspiration).
    c. Obstructed airway, stridor and/or laryngeal spasm.
    d. Decreasing level of consciousness.
    e. Alterations in blood pressure.

PAEDIATRIC PATIENT IN NURSING UNIT		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 11** **Page: 2 of 2**
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f. Allergic reactions to medications.

g. Plugged catheters due to blood clots.

11. Attempt to give intramuscular injections before the child awakens from anaesthesia to prevent hurting or frightening child.
12. Children may be discharged from the Nursing Unit when they are awake and alert, vital signs are stable and there are no signs of bleeding from the operative site and no signs of covert bleeding. Aldrete score must be nine (9) or ten (10).
    a. Document and record observations of operative site.
    b. Be sure child is neat, face washed and changed to street clothes.
13. Safety
    a. Never leave any child unattended; constant contact may be appropriate; bedside attendance is required.
    b. Leave side rails up at all times. Prevent child from harming himself by staying near the head of the bed. Children can easily hit their head against the side rails. Prevent arms and legs from becoming caught in side rails or between side rails and mattress. Pad side rails if child is extremely restless.
    c. Provide appropriate personnel to protect the restless patient from injury. Avoid excessively limiting restraints unless absolutely necessary as it can tend to increase combativeness and increase fear.
    d. Confirm that all extremities are inside stretcher during transportation.
14. Psychological support
    a. Treat all children with understanding, love and acceptance.
    b. Allow one person for direct conversation as this allows rapport building and decreases stimulus. This individual can talk to them in a soft, soothing voice and explain everything that he/she is doing.
    c. If deemed appropriate by caregivers, that it is necessary for child's well-being, allow parents to be in nursing unit with the child as he/she awakens.
    d. Very small children may be cradled in the nurse's arms and rocked when it is no longer necessary that they lie on the stretcher.
    e. Keep them covered and clothed; make every effort to make them feel secure.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PAEDIATRIC PATIENT IN NURSING UNIT		
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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

PHYSICIAN PRIVILEGES		
Policy/Procedure Applies To	**Administrative Head of the Center / Customer Care**	**Policy/Procedure No: 11** **Page: 1 of 1**
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PHYSICIAN PRIVILEGES

PURPOSE

To ensure that physicians scheduling procedures have been approved for privileges, according to procedure, by the Top Management of Prime Surgical Centers.

POLICY

A list will be maintained at the Customer Care desk indicating which Consultants have been approved and the specific discipline/procedures for which privileges have been granted.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

EXPOSURE CONTROL PLAN MANUAL

POST EXPOSURE EVALUATION AND FOLLOW UP PROTOCOL		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 11** **Page: 1 of 2**
Effective Date: 11 April, 2013		

POST EXPOSURE EVALUATION AND FOLLOW-UP PROTOCOL

If an employee reports an exposure incident, the surgical center shall conduct the following measures on behalf of the affected employee:

MEDICAL EVALUATION

1. Make immediately available to the exposed employee a confidential medical evaluation and follow-up provided by the center, to include at a minimum, the following elements:
   a. Initiation of an Exposure Incident Form, following the steps outlined on the form as per annexure to this policy.
   b. Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred.
   c. Identification and documentation of the source individual, unless that identification is not possible, or is prohibited by state or local law.
   d. Testing of the source individual's blood as soon as possible and after consent is obtained in order to determine HBV, HCV and HIV infectivity. If consent is not obtained, Prime Surgical Centers shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.
   e. Repeat testing is not needed if the source individual is already known to be infected with HBV or HIV or HCV.
   f. Results of the HIV, HBV and HCV tests will be given to the Administrative head of the center and kept confidential.
   g. Results of the source individual's testing will be made available to the exposed employee. All applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual will be available.
2. Collect and test the exposed worker’s blood for HBV, HCV and HIV serological status, at no cost to the employee.
   a. Exposed worker will be sent to an appropriate hospital for counseling and testing of blood, preferably within 6 hours, after necessary consent is obtained.
   b. Preserve the blood sample for 90 days, if the employee consents to baseline blood collection but does not give consent at that time for HIV serologic testing. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing will be done as soon as feasible.

INFORMATION TO PROVIDE TO EMPLOYEE

Provide the employee after an exposure incident with the following information

1. Complete description of the exposed employee's duties as they relate to the exposure incident
2. Details of Antiretroviral Therapy for prevention of HIV infection following occupational exposure to HIV

POST EXPOSURE EVALUATION AND FOLLOW UP PROTOCOL		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 11** **Page: 2 of 2**
Effective Date: 11 April, 2013		

PROCEDURES FOR EVALUATING THE CIRCUMSTANCES SURROUNDING AN EXPOSURE INCIDENT

A committee consisting of Administrative Head of the Center, Anaesthesiologist & Nursing Superintendent will review the circumstances of all exposure incidents to determine:

1. Engineering controls in use at the time
2. Work practices followed
3. A description of the device being used (including type and brand)
4. Failure of controls
5. Protective equipment or clothing that was used at the time of the exposure
6. Incident (gloves, eye shields, etc.)
7. Location of the incident (OR, Nursing Unit etc)
8. Procedure being performed when the incident occurred
9. Employees training

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

SURGICAL WOUND CLASSIFICATION		
Policy/Procedure Applies To	**All OT Nurses**	**Policy/Procedure No: 11** **Page: 1 of 2**
Effective Date: 11 April, 2013		

SURGICAL WOUND CLASSIFICATION

PURPOSE

To monitor aseptic technique in the operating room and monitor adherence to set criteria for patient admission.

POLICY

After any procedure in which break in technique is observed, a Break-in-Technique/Surgical Wound Classification (Refer to Annexure to this policy) will be completed by the Circulating Nurse as instructed by the Surgeon.

Surgical wound classification record is maintained for quarterly review by QA Committee.

CLASSIFICATION

Class I - Clean

Non-traumatic undetected operative wounds in which no inflammation is encountered, there is no break in technique, and neither the respiratory, alimentary or genitourinary tracts nor the oropharyngeal cavities are entered. Clean wounds are those that are elective, primary closed and undrained.

Class II - Clean Contamination

Non-traumatic wounds in which minor break in technique occurred or in which gastrointestinal, genitourinary or respirator tracks were entered under controlled conditions and without unusual contamination. Includes entrance into the genitourinary tract in the presence of infected urine and those wounds mechanically drained.

Class III - Contamination

Any open, fresh traumatic wound from a relatively clean source, or an operative wound in which there is a major break in technique, gross spillable from the gastrointestinal tract, or entrance into genitourinary tract in the presence of infected urine, including incisions encountering acute, non-purulent inflammation.

Class IV - Dirty

Traumatic wound from a dirty source, or with delayed treatment, fecal contamination, foreign body, or retained devitalized tissue. Also includes operative wounds in which acute bacterial inflammation or a perforated viscus is encountered, or in which clean tissue is transacted to gain access to a collection of pus. This classification suggests that organisms causing postoperative infection are present in the operative field before operation.

PROCEDURE

1. The Break-in-Technique/Surgical Wound Classification will be filled out by circulating nurse during procedure as per Annexure to this policy. (Class II, III and IV procedures only)
2. Classification of wound will be established by surgeon and circulating nurse at completion of procedure.

SURGICAL WOUND CLASSIFICATION		
Policy/Procedure Applies To	**All OT Nurses**	**Policy/Procedure No: 11** **Page: 2 of 2**
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3. Classification records will be filed with the O.T. Matron and follow-up information will be obtained from the clinical record.
4. At regular intervals, the O.T. Matron will review cases and results of any postoperative complications and report to the Nursing Superintendent /Administrative Head of the Center who will in turn present it in the QA Committee.
5. Appropriate steps will be taken to find the cause and remedy.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

UPDATION OF IPD BILLING		
Module Applies To	**Customer Care**	**Policy and Procedure No.: 11** **Page: 1 of 1**
Effective Date: 11 April, 2013		

UPDATION OF IPD BILLING

PURPOSE

To keep the IPD Bill updated in order to ensure a smooth and quick discharge.

PROCEDURE

After surgery the ward will receive the IPD patient file from the OT. Take the charge slip and the Doctor Visit form from the patient file.

The surgery name is mentioned by the Surgeon on the charge slip. If the surgery name is different from what was mentioned in the Estimate, confirm it with the Surgeon and accordingly add the surgery name in the IPD Bill.

As per the package, add the Surgeon fees, Anaesthesiologist fees, OT charges, Room charges, Assistant Surgeon fees (if applicable).

The pharmacy will provide the OT pharmacy bill. Add this as well to the bill.

Add any other investigations done.

Also add food and beverages charges of the patient's relative/s, if any.

If the Surgeon and/or Anaesthesiologist who have performed the surgery, visit the patient on the same day of the surgery, this visit is marked as free. If they visit on any day after the day of surgery and if they have signed on the Doctor Visit form, add this visit to the bill. As these visits are not a part of the package, the patient will have to bear the charges.

If the length of stay gets extended, provide a draft bill to the patient/relative so that they are aware of the charges and make arrangement for the same. Take the patient/relative's signature on the draft bill.

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

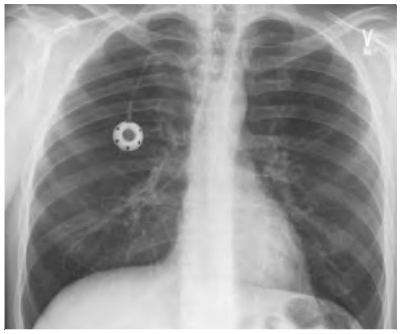
CHEMOTHERAPY PORT USE - PROTOCOL		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 12** **Page: 1 of 4**
Effective Date: 01 April, 2014		

CHEMOTHERAPY PORT USE - PROTOCOL

1. PRIOR TO FIRST TIME USE OF THE CHEMO PORT

Ensure that the physician has verified the position of the port on post op chest X-ray and an order for use of the port is placed in the chart.

Figure 1. X ray showing port placement.



2. ACCESSING THE PORT

a. Assemble supplies: 20 G Port Needle (Non coring Huber needle), IV placement tray, Sterile gauze, 100 ml NS, Tegaderm (adhesive transparent) dressing, IV tubing, chlorhexidine /alcohol for skin prep.

b. Explain the procedure to the patient.

c. Perform hand hygiene.

d. Locate and expose site of the port. Feel the flat part (diaphragm) of the port. Ensure that there is no redness or swelling of the site. If present, report these signs to the physician and do not use port.

e. Wear sterile gloves.

f. Connect the connector on the catheter of the needle to this to a 10 ml syringe filled with normal saline and place this on sterile surface/ tray

g. Prepare the skin over the port and a 10 x 10 cm area around the port with chlorhexidine/ alcohol based solution. Allow to air dry.

h. Uncover the tip of the Needle.

CHEMOTHERAPY PORT USE - PROTOCOL		
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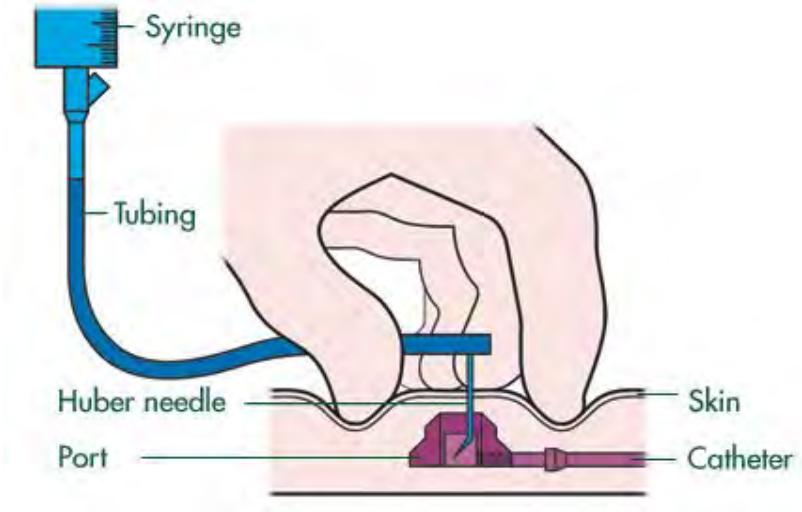
i. Hold the port steady under the skin with one hand and insert the needle to penetrate the diaphragm of the port perpendicular to the skin (exactly at 90 degrees). Figure 2.



j. Aspirate a small amount of blood to verify placement into the port and flush the saline into the port. (Notify physician, if blood cannot be aspirated or there is resistance to flushing the port).

k. Clamp the port while the last 1ml is still infusing, to generate positive pressure and avoid backflow into the catheter. (Figure 3.)

l. Ensure that no swelling develops around the port site.

m. Place a sterile gauze to support the part of the needle outside the skin, under the butterfly flanges.

n. Place a Tegaderm dressing to hold the needle in position.

o. After connecting the IV line to the 100 ml NS bottle, prime the bottle (removing the bubbles from the tubing) and connect the IV line to the connector on the needle.

p. Ensure that the NS infuses freely and that no swelling develops around the port. Keep this line open on slow drip.

q. Commence Further IV therapy / Medications per orders of the physician

3. ADMINISTERING IV MEDICATIONS THROUGH PORT

a. Perform hand hygiene.

b. Clean medication side port of the needle with an alcohol swab.

c. Administer medication as directed.

d. Flush the port with 10 ml saline after the medication bolus or between 2 different IV therapies.

4. LOCKING THE PORT & REMOVING NEEDLE

a. Assemble supplies: 5 ml vial of Heparin (1000 units/ ml), Kidney basin, sterile gauze, micro-pore tape.

CHEMOTHERAPY PORT USE - PROTOCOL		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 12** **Page: 3 of 4**
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b. Draw 1 ml of Heparin (1000 Units/ ml) and 9 ml of saline in a 10 ml syringe
c. Flush port with the Heparinized Saline mixture above (do not use dilute heplock solution). Clamp port while the last ml is still being injected. (Fig 3)

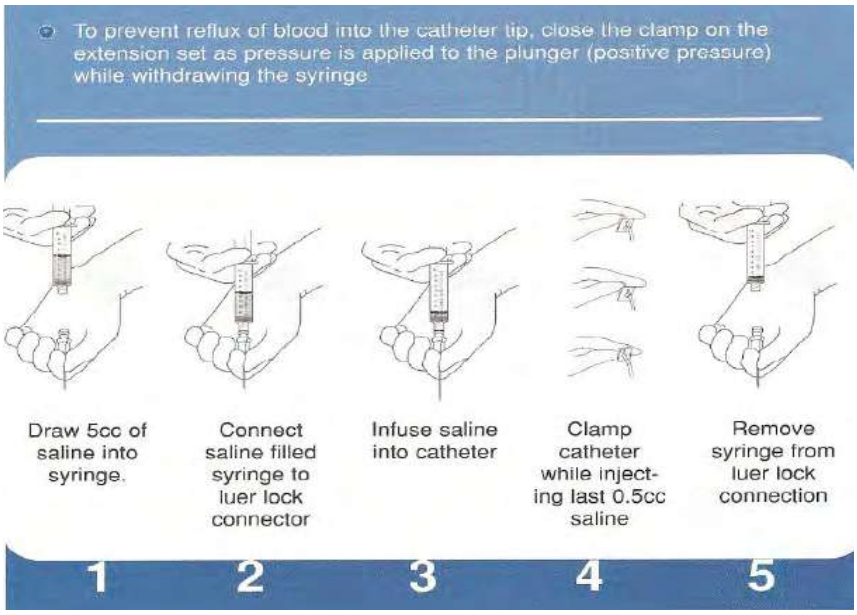

Figure 3: Positive Pressure Method of flushing port. (Use 10ml instead of 5ml shown)

d. Wear gloves for protection
e. Remove dressing around port circumferentially until only the needle is in contact with the skin
f. Withdraw the needle out of the port at an angle perpendicular (90 degree) to the skin, without bending or turning.
g. Hold mild pressure with gauze if oozing noted.
h. Place small gauze and tape dressing.
i. Dispose the needle per sharp disposal protocol

5. DRAWING BLOOD FROM PORT

The port should only be used for blood draws on inpatients where the port has already been accessed. The procedure should only be performed personnel. The port should not be used for routine out-patient lab draws.

a. Follow steps a - i described above in Accessing the Port.
b. Supplies: 10 ml syringes x 2 with NS flush. 10 ml syringes for the blood draw.
c. Wear sterile gloves and clean the surface of the 3 way with an alcohol swab.
d. Connect the 10 ml syringe to port needle or 3 way and aspirate 10 ml blood.

CHEMOTHERAPY PORT USE - PROTOCOL		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 12** **Page: 4 of 4**
Effective Date: 01 April, 2014		

e. Discard this first 10 ml of blood

f. Draw the required amount of blood in 10 ml syringes.

g. Immediately flush the port with 20 ml of NS. Use push-pause method when flushing to create turbulence and remove all blood from the system. Do not connect the port to an IV drip without flushing as it will not rid the port of all the blood. (If blood remains in the port, it will clot off).

h. Flush with 10 ml of heparinized saline (1 ml of 1000 Units/ ml Heparin in 10 ml NS). The catheter should be clamped while the last ml is in process of being infused (to create positive pressure) Refer to positive pressure method in part D.

i. Remove needle if no further therapy is planned per instructions in Part D

- ❖ A new port needle should be used every 72 hours.
- ❖ The port should be flushed every 4 weeks when not in use.

PATIENT INSTRUCTIONS FOR PORT CARE

(Refer Annexure to this policy)

ANNEXURE
(Refer to Nursing Manual II Policy and Procedure No. 12)

PATIENT INSTRUCTIONS FOR PORT CARE

1. **Dressing**: If you have just had a port placed, you may have a small dressing over the surgical incision. This can be removed in 2 days. If you have a small white steri-strip dressing or skin glue under this, you can leave it in place; this will come off with time.
2. **Skin and Site Care**: Do not apply any lotions/ ointments/ medications over the port site. You can clean this area gently with soap water when bathing/ showering. Do not fidget with or handle the port or catheter you may feel under the skin.
3. **Port Flushing**: When the port is not being used, your infusion team should flush it regularly every 4 weeks. If the port is not regularly flushed it may clot off.
4. **Use of the Port**: Only your oncology team of doctors and nurses should use the port. Special needles are used for the port and only persons trained in accessing the port should use it. Lab technicians can draw blood from arm veins (and not the port) to avoid incorrect use of the port and risk of port infection.
5. **Alarm Signs**: High fevers, (101 F or more), redness of the skin, swelling or pain around the port, can be signs of infection of the port. Arm pain and swelling on the side of the port can be sign of vein clotting or deep vein thrombosis. Report any such findings to your doctors urgently.
6. **Port Removal**: Once your oncologist has determined that the port is no longer needed, discuss removal of the port with your surgeon. If the port is not in use or is malfunctioning, it can pose an infection risk and should not be left in the body. Port removal is usually a simple procedure done under local anesthesia.
7. **Device Information**: The device label is provided in the space below. If you undergo an MRI in the future, you may be asked if the device is MRI- compatible. The port you have is MRI compatible unless you were provided information that says otherwise.

Affix Label of Implanted Device in this space.   Date Placed:

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
Phone: - 020-39931000 Fax: - 020 39931020
Email: - customercare@primesurgical.in
Website: www.primesurgical.in

PRIME SURGICAL CENTERS

PATIENT INSTRUCTIONS FOR PORT CARE

1. **Dressing**: If you have just had a port placed, you may have a small dressing over the surgical incision. This can be removed in 2 days. If you have a small white steri-strip dressing or skin glue under this, you can leave it in place; this will come off with time.
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Affix Label of Implanted Device in this space.   Date Placed:

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Beck House, Damle Path, Pune.

SAFETY MANUAL

BOMB THREAT PROCEDURE		
Policy/Procedure Applies To	**All staff**	**Policy/Procedure No: 12** **Page: 1 of 1**
Effective Date: 11 April, 2013		

BOMB THREAT PROCEDURE

POLICY

There shall be a standardized procedure for responding to a bomb threat. Nursing and administrative staff shall be aware of these procedures.

PROCEDURE

As most bomb threats are received via telephone, the following procedures shall be followed.

1. Upon receiving a bomb threat, immediately notify the staff, patients and police on Tele No. 100 and try to remember the following items listed below:
   a. Determine the caller's age, sex, and race
   b. Time of the call
   c. Exact words used
   d. Time the bomb will explode
   e. Where is the bomb?
   f. What does it look like?
   g. Why did he place the bomb?
   h. Special characteristics of the voice, i.e. accent, slang, etc.
   i. Background noise.
2. On receipt of a Bomb threat person who has received the call will inform Executive Facility in order that assistance on a search may be implemented with a minimum of lost time. Simultaneously Executive Facility will inform police control room on 100 and also higher administrative authorities of Prime Surgical Centers.

Time is most important and all searches must be conducted immediately upon the notification of a bomb threat. The area of immediate concern will be the patient areas. Reports must be made in a timely fashion in order that a proper evaluation of the threat can be made.

If a bomb or suspicious package is located, clear the area. When the police department personnel arrive on the scene, they will be directed to the suspected area by the staff.

Evacuation: The decision to evacuate shall be made only after a considered evaluation has been made by the Police authorities to evacuate the Surgery Center. The staff personnel will ensure that patients are handled and evacuated in the manner which affords the patient the greatest protection.

Preventive measures: It is very important that the staff be continuously aware of the various people in their respective areas. If a stranger is noted in the area, find out who he or she is and what his or her business is in the area.

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Revision Date:	
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PRIME SURGICAL CENTERS

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NURSING MANUAL

CARDIOPULMONARY RESUSCITATION (CPR) EMERGENCY EQUIPMENT		
Policy/Procedure Applies To	**OT & Procedure Room Nurses & Technicians**	**Policy/Procedure No: 12** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CARDIOPULMONARY RESUSCITATION (CPR) EMERGENCY EQUIPMENT

PURPOSE

To provide emergency life support equipment and drugs for immediate availability.

POLICY

1. Only physicians and personnel who are ACLS certified may direct use of adjunct equipment in the treatment of cardiopulmonary emergency.
2. The following adjunct equipment will be available and maintained to function properly:
   a. Equipment to monitor and record
      i. ECG
      ii. Blood pressure
      iii. Temperature
      iv. Oxygenation of blood
   b. Equipment for defibrillation
   c. Equipment to aspirate and establish an airway
   d. Equipment for pulmonary resuscitation and support
   e. Equipment to open an airway
3. The crash cart and equipment will be inspected each day and after each use for proper inventory and proper function of equipment (Refer Nursing Manual Policy and Procedure No. 13).

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PRIME SURGICAL CENTERS

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CUSTOMER CARE AND BILLING MANUAL

DISCHARGE OF PATIENT		
Module Applies To	**Customer Care / Staff Nurse / Resident Medical Officer**	**Policy and Procedure No.: 12** **Page: 1 of 1**
Effective Date: 11 April, 2013		

DISCHARGE OF PATIENT

Also refer Nursing Manual Policy and Procedure No. 109, 110 and 111

PROCEDURE

Once the Consultant confirms the discharge of a patient the same will be communicated to the Customer Services, Billing department and the Pharmacy.

If any implant is used for the patient, this will be paid by the patient directly to Pharmacy.

The Customer Services and Billing department will:

1. Enter the details mentioned in the Charge Slip and Doctor Visit charges in the system so that it can be added to the final billing of the patient. File the Charge Slip and Doctor Visit Charges for future record.
2. Add the Ward and OT pharmacy bill charges.
3. Add any other charges as may be applicable.
4. Take a print of the Draft bill and once the patient is in agreement with it, obtain the patient's signature on it.
5. Take any pending payment from the patient and make the Final bill of the patient. Also make the IPD Settlement bill. Take two copies of the bills – take signature on one copy to be handed over to the Accounts department and file the other copies to the patient file.
6. Inform the RMO (Resident Medical Officer) that patient is ready to be discharged. The RMO will print the Discharge Summary and attach it to the patient file. The RMO will then discharge the patient from the system. An SMS about the patient's discharge will be sent to all those concerned.
7. At the time of discharge, the RMO in consultation with the Surgeon will schedule a post-op consultation appointment for the patient with the Surgeon.

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PRIME SURGICAL CENTERS

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PURCHASE AND MAINTENANCE MANUAL

FACILITY DEPARTMENT - DAILY CHECKLIST		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 12** **Page: 1 of 1**
Effective Date: 11 April, 2013		

FACILITY DEPARTMENT - DAILY CHECK LIST

Date: - _____

1.	MSDEL : PF Factor & Meter reading recorded	Yes / No
2.	DG Set : Diesel & Oil Level checked	Yes / No
3.	DG Battery Voltage & Distilled Water Level checked	Yes / No
4.	DG Manual Starting done	Yes / No
5.	Diesel Stock in hand Level checked	Yes / No
6.	UPS Battery Voltage recorded	Yes / No
7.	UPS Input /Output Voltage recorded	Yes / No
8.	Electrical Gadgets like Switches, Lamps, Fans checked	Yes / No
9.	Water level of Ground floor water tank recorded	Yes / No
10.	Plumbing : Taps, Flush, Leakage are checked	Yes / No
11.	Liquid Soap & Tissues are filled in each dispenser	Yes / No
12.	Hourly Cleaning Schedule is followed	Yes / No
13.	Bio Medical Waste bags are sealed and proper Bar code is put on bag	Yes / No
14.	Other Waste is taken out of premises on daily basis	Yes / No
15.	Elevator both the Lifts are cleaned & working properly	Yes / No
16.	Elevator License displayed properly	Yes / No
17.	Security Daily Attendance checked	Yes / No
18.	Inward/Outward Register maintained on daily basis	Yes / No
19.	Daily round of Oxygen Bank for checking of O2 & Nitrous Level	Yes / No
20.	Incident Report maintained	Yes / No
21.	Laundry - daily feedback from wards	Yes / No
22.	Washing quality, press, balance linen checked	Yes / No
23.	Gas Cylinder Stocks	Yes / No
24.	Check of CCTV and Fire Sensors/Alarm System	Yes / No
25.	Recording of CCTV Camera	Yes / No

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

MEDICAL ETHICS: FOUR PRINCIPLES AND SCOPE		
Policy/Procedure Applies To	**All Doctors / Nurses**	**Policy/Procedure No: 12** **Page: 1 of 2**
Effective Date: 11 April, 2013		

MEDICAL ETHICS: FOUR PRINCIPLES AND SCOPE

PURPOSE

To provide a simple, accessible and culturally neutral approach to thinking about ethical issues in health care. It offers a common basic moral analytical framework and a common, basic moral language. These principles can help Doctors and other health care workers to make decisions when reflecting on moral issues that arise at work. The approach is based on four common, basic prima- facie moral commitments-respect for autonomy, beneficence, non-maleficence and justice-plus concern for their scope of application. “Prima-facie” means that principle is binding unless it conflicts with another moral principle-if it does we have to choose between them.

RESPECT FOR AUTONOMY

Autonomy -literally, self rule but probably better described as deliberated self rule – is a special attribute of all moral agents, it involves:

1. Respect for wishes of others
2. Obtaining informed consent before carrying out any surgical procedure.
3. Promise of confidentiality, so that the patient is able to divulge highly private and sensitive information essential to provide optimal health care.
4. Avoiding description regarding patient's diagnosed illness.
5. Good communication which mainly means listening (and not just with ears) as well as telling (and not just with lips or word processor) and is usually necessary for giving patients adequate information about any proposed intervention and finding out whether he/she wants it. Most patients want more and not less information and want to participate in deciding their medical care. Beneficence and Non-maleficence

Whenever we try to help others we inevitably risk harming them; health care workers, who committed to helping others, must therefore consider above principles together and aim at producing net benefit over harm, i.e. remembering traditional Hippocratic moral obligation to provide net medical benefit to patients with minimal harm.

To achieve these moral objectives range of prima facie obligations involve:-

1. Rigorous and effective education and training both before and during professional lives.
2. Respecting patient's autonomy for that constitutes benefit for one patient may be harm for another.
3. Clear understanding risk and probability while assessing harm and benefit.
4. Obtaining empirical information about harms and benefits which may result from proposed intervention. This information is based on effective medical research.
5. Empowering – that is, doing things to help patients to be in more control of their health and health care. It combines two moral obligations of beneficence and respect for autonomy.

MEDICAL ETHICS: FOUR PRINCIPLES AND SCOPE		
Policy/Procedure Applies To	**All Doctors / Nurses**	**Policy/Procedure No: 12** **Page: 2 of 2**
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JUSTICE

It is often regarded as being synonymous with fairness and can be the moral obligation to act on the basis of fair adjudication between competing claims.

It can be:-

1. Distributive justice that is fair distribution of scarce resources.
2. Rights based justice that is respect for people rights.
3. Legal justice that is respect for morally accepted laws.

As Aristotle argued long ago, justice is more than mere equality – people can be treated unjustly, even if they are treated equally. It is difficult to decide on merits of "good for all v/s best for few". Similar moral conflicts arise in the context of rights based and legal justice. To resolve this dilemma health care worker should distinguish between following views:-

1. Personal views
2. Organizational views
3. Profession's views.
4. Society's views as expected in law and practice.

For personal decision making all health care workers of Prime Surgical Centers in this context will do well to remember :-

1. Personal preferences or prejudices have no role in case there is no moral basis or justification.
2. That is not your role to punish a patient e.g. withholding antibiotics to patients who do not give up smoking.
3. Not to waste resources e.g. if a cheaper drug is likely to produce as much benefit as a more expensive one then prescribe the cheaper one. Cost and opportunity cost are moral issues and central to distributive justice.
4. Respect patient's rights, e.g. a patient's lifestyle for refusing to provide sickness certificate if he / she is unable to work.
5. Obey morally acceptable laws, e.g. if a law is enacted through a democratic political system and hence one that fundamentally respects autonomy-which represents conflicting views within its population and makes law on the basis certain common moral values that reflect the four principles than the law is morally acceptable, and prima facie one is morally required to obey it.

For organizational, professional and societal decisions role of health care workers of Prime Surgical Centers regarding taking decisions about justice should only be as a member.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

METHODS TO ELIMINATE SOURCES OF CONTAMINATION		
Policy/Procedure Applies To	**All Staff involved in the Patient/Surgical Care**	**Policy/Procedure No: 12** **Page: 1 of 2**
Effective Date: 11 April, 2013		

METHODS TO ELIMINATE SOURCES OF CONTAMINATION

PURPOSE

Aseptic technique is the process of controlling the mode and eliminating the source of contamination.

GUIDELINES

1. Patient
   a. Microbes cannot always be eliminated from the field and must be kept to a minimum. All possible means are used to keep these bacteria to a minimum and to prevent any cross contamination.
   b. Each patient is a potential contaminate of the operating room.
      i. All items used for one patient must be properly cleaned and re-sterilized before being used for another patient.
      ii. All disposable items must be discarded after first use. (Exceptions will be items approved for re-sterilization by the manufacturer.)
      iii. Skin cannot be sterilized. The patient's skin is a source of potential contamination in every operation. Proper procedure for skin prep is important.
         - Patient should wash operative area as instructed prior to admission for surgery.
         - Skin prep is performed per physician's order.
         - After antiseptic prep solution is applied in the operating room, all skin is covered with sterile drapes except operative site.
2. Members of the operating team

   Personnel preparation
   a. Personal cleanliness is essential for all the members of the surgical team.
   b. Fingernails must be kept short at all times. Polish and false fingernails are not permitted.
   c. Surgical team members with respiratory ailments or skin conditions may not scrub due to potential for high bacteria counts. Personnel found to have infectious conditions will not be permitted in operating room.
   d. All personnel will scrub or thoroughly wash hands when first reporting for duty and immediately after handling patients.
   e. Persons assisting is sterile field must wear a sterile gown and gloves after completing surgical scrub. (Refer to Nursing Manual Policy and Procedure No. 4 and 73)
   f. Hair of personnel must be covered completely with clean caps or hoods.
   g. Masks must be effective filters and worn covering both nose and mouth snugly. Masks are changed between cases and when contaminated by fluid or moisture.
   h. Will use designated slippers as laid down by the management.
   i. All personnel entering the operating suite must wear clean OR attire.
   j. OR attire will not be worn outside of the facility. All personnel leaving the building must change clothes before re-entering the semi-restricted/restricted area.

METHODS TO ELIMINATE SOURCES OF CONTAMINATION		
Policy/Procedure Applies To	**All Staff involved in the Patient/Surgical Care**	**Policy/Procedure No: 12** **Page: 2 of 2**
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3. Air particles - Operating room environment

   Microbes are carried from one place to another on dust particles, other objects and people's hands. Air itself is considered a source of contamination since it contains dust particles and droplets.

   a. Motion in the operating room is kept to a minimum.
   b. Talking and laughing is discouraged during a procedure.
   c. Sneezing and coughing are avoided. If you must sneeze or cough, do so directly into mask. Do not turn head, as droplets can escape through side of mask. Change mask as quickly as possible.
   d. Doors to corridors into the operating rooms are kept closed.
   e. Traffic through the operating room suite is kept to a minimum.
   f. Handle linen gently to avoid shaking lint into room and disturbing the air around sterile areas.
   g. Main corridors are considered contaminated areas.
   h. Laundry hampers kept in the operating room should be changed between cases. Other laundry hampers should have lids.
   i. Damp dusting is done between cases when necessary.
   j. Floors are considered contaminated and cross-contaminated. Operating room floors are to be mopped with germicidal solution between procedures as necessary and cleaned thoroughly at the end of the day. Floors are never dry swept.
   k. Air conditioning must be operational at all times in the operating room.

4. Other personnel or visitors in operating room

   a. Only authorized personnel may enter operating room suite.
   b. Anyone entering an operating room must be properly attired in OR clothes, cap, mask and slippers.
   c. It is the responsibility of the entire OR team to observe visitors and other personnel to prevent or report contamination. Circulating nurse is to observe visitor at all times to protect the sterile field.

5. Eliminate the potential for contamination

   Any containers that are deemed refillable shall not be “topped off.” The container shall be emptied of its contents, rinsed out with water and bleach and then refilled. Examples of such products are hand soap, betadine, etc.

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ANAESTHESIA MANUAL

MONITORED ANAESTHESIA CARE		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 12** **Page: 1 of 1**
Effective Date: 11 April, 2013		

MONITORED ANAESTHESIA CARE

PURPOSE

To provide definition of services rendered for monitored anaesthesia care.

DEFINITION

The phrase "monitored anaesthesia care" refers to instances in which anaesthesia staff has been called upon to provide specific anaesthesia services to a particular patient undergoing a planned procedure, in connection with which a patient receives local anaesthesia or, in some cases no anaesthesia at all. In such a case, the anaesthesia staff is providing specific services to the patient and is in control of the patient's nonsurgical medical care, including the responsibility of monitoring patient's vital parameters, and is available to administer anaesthesia or provide other medical care as appropriate.

SERVICES

1. Services will be requested by the operating surgeon and be made known to the patient in accordance with accepted procedures of the facility.
   a. Services shall include:
      i. Performance of a pre-anaesthetic examination and evaluation.
      ii. Anaesthesia plan.
      iii. Personal participation in, or medical direction of, the entire plan of care.
      iv. Continuous physical presence of anaesthesia staff.
      v. Approximate presence or (in the case of medical direction) availability of the supervising physician for diagnosis or treatment of emergencies.
   b. All facility regulations pertaining to anaesthesia services will be observed, and all the usual services performed by anaesthesia staff will be furnished, including but not limited to:
      i. Usual non-invasive cardio circulatory and respiratory monitoring.
      ii. Oxygen administration, when indicated.
      iii. Intravenous administration of sedatives, tranquilizers, anti-emetics, narcotics, analgesics, beta-blockers, vasopressors, bronchodilators, anti-hypertensives, or other pharmacologic therapy as may be required in the judgement of the anaesthesia staff.

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ANNEXURE XII
(Refer to Housekeeping Manual Policy and Procedure No. 1)

PANTRY

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
Windows and Seals /Roller Blind	X			
Door & Handle	X			
Luminaries		X		
Electrical Outlet/ Switch Plates	X			
A/C baffles and top of cabinets		X		
Counter tops	X			
Shelves and drawers	X			
Microwave	X			
Refrigerator		X		
Sink	X			
Gas Tubing	X			
Empty Waste Bins	X			
Fill soap dispensers	X			

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EXPOSURE CONTROL PLAN MANUAL

RECORDKEEPING: EMPLOYEE MEDICAL RECORDS		
Policy/Procedure Applies To	**Nursing Superintendent and O.T. Matron**	**Policy/Procedure No: 12** **Page: 1 of 1**
Effective Date: 11 April, 2013		

RECORDKEEPING: EMPLOYEE MEDICAL RECORDS

1. The Prime Surgical Centers will be responsible for establishing and maintaining an accurate record for each employee with occupational exposure. The employee's record shall include the following information:
   a. Name
   b. A copy of the vaccination status and dates
   c. A copy of all results of examinations, medical testing, and follow-up procedures regarding the post-exposure evaluation
   d. A copy of the Exposure Incident Record
2. All employee medical records:
   a. Will be kept confidential
   b. Will not be disclosed or reported without the employee's written consent to any person within or outside the workplace except as required by rule or may be required by law.
3. Employee medical records will be maintained for at least the duration of employment plus 30 years.

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PRIME SURGICAL CENTERS

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NURSING EDUCATION AND TRAINING MODULES

URINARY CATHETERIZATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 12** **Page: 1 of 3**
Effective Date: 11 April, 2013		

URINARY CATHETERIZATION

PURPOSE

The purpose of urinary catheterization is to facilitate urinary drainage when medically necessary. Urinary catheters should be evaluated everyday for need and removed promptly when no longer necessary.

INDICATIONS

1. Urinary retention including obstruction and neurogenic bladder: the patient is unable to pass urine because of an enlarged prostate, blood clots or an edematous scrotum/penis or unable to empty the bladder because of neurologic disease / medication effect.
2. Short perioperative use in selected surgeries (less than 24 hours) and for urologic Studies or surgery on contiguous structures.
3. Output measurements in the Intensive Care Units.
4. Assist healing of perineal and sacral wounds in incontinent patients to avoid further deterioration of wound and skin.
5. Required immobilization for trauma or surgery.
6. Hospice/comfort care or palliative care, if requested by patient
7. Chronic indwelling urinary catheter on admission.

BACKGROUND

Urinary catheterization is the aseptic process of inserting a sterile hollow pliable tube into the urethra to facilitate urine drainage into a closed bag system. The urinary tract is the most common site of hospital-acquired infections accounting for approximately 40% of hospital infections. The intent of this class is not only to give guidance for urinary catheter maintenance techniques, but also will assist in the prevention of catheter-associated urinary tract infections (CAUTI).

GUIDELINES

1. General

Urinary catheters should be inserted only when medically necessary and should be evaluated daily for need. Urinary catheters should not be used solely for the convenience healthcare workers. Document alternative methods for bladder elimination prior to insertion of indwelling catheter.

Alternative methods include:

1. Programmed toileting, which consists of placing the patient on the bedpan or commode every 2-4 hours while awake.
2. Utilizing a bladder scan machine for suspected urinary retention.

Urinary catheters should be placed only under the direction of a physician order. However, if the patient's nurse does not deem the urinary catheter meets the indications for placement, the patient's nurse should question need.

2. Insertion/Application

a. Indwelling, straight, and suprapubic urinary catheters should be inserted using aseptic technique and sterile equipment.

Sterile gloves, drape, and sponges; an appropriate antiseptic solution for periurethral cleaning

and a single-use packet of lubricant jelly should be used for insertion.

b. The smallest bore catheter possible should be utilized to minimize urethral trauma and irritation.

Caude catheters may be placed by nursing staff based on urology orders.

c. Indwelling catheters should be properly secured after insertion to prevent movement and urethral trauma.

d. Patients who perform self-catheterization at home should be encouraged to continue performing this procedure while in the hospital.

i. Patients performing self-catheterization should utilize a clean technique.

ii. Nursing personnel should evaluate the patient's performance and reinforce positive behaviors.

3. Maintenance

a. Standard Precautions: Use gloves when manipulating the catheter site and drainage system and practice hand hygiene before and after.

b. A sterile, continuously closed drainage system should be maintained for indwelling and suprapubic catheter systems.

c. The catheter and drainage tubing should not be disconnected unless the catheter can only be irrigated manually or if new tubing needs to be attached.

d. If there are breaks in aseptic technique, disconnection of tubing, or leakage from the bag; the drainage system should be replaced. The catheter-tubing junction should be disinfected before connecting to the new drainage system. If the catheter becomes contaminated, the catheter should also be replaced.

e. Drainage bags should always be placed below the level of the patient's bladder to facilitate drainage and prevent stasis of fluid.

f. Urine in drainage bags should be emptied at least once each shift using a container designated for that patient only. Care must be taken to keep the outlet valve from becoming contaminated. Use gloves and practice hand hygiene before and after handling the drainage device.

g. Patients with urinary catheters will have intake and output (I&O) recorded. However, urinary catheters are not to be inserted simply to monitor outputs with the exception of the intensive care units. Make use of other means to monitor outputs in the incontinent patient, such as daily weights.

4. Catheter Change

a. Catheters of post-op urology patients should only be changed or removed with urology's approval.

b. Catheter change: The interval between catheter changes should be determined by the individual patient's needs. Indications for change may include: mechanical dysfunction or blockage of the urinary catheter system, and contamination of the closed system.

c. Indwelling catheters should not be changed at arbitrary fixed intervals.

5. Meatal Care

Meatal Care: Cleansing the meatal surface during daily bathing is appropriate.

URINARY CATHETERIZATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 12** **Page: 3 of 3**
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6. Specimen Collection

a. Small volume urine specimens should be obtained by inserting a sterile needle/syringe into a disinfected sampling port and aspirating the urine. Attempt obtaining the urine cultures prior to starting antibiotics for patients with suspected urinary tract infections.

b. Regular microbiological monitoring of catheterized patients is not recommended.

c. The patient with an indwelling catheter should be monitored for signs of catheter-associated urinary tract infection such as fever, chills, or suprapubic pain.

7. Irrigation

a. Avoid irrigation unless there is an obstruction in the catheter.

b. Closed continuous and/or manual irrigation should only be done if ordered by a physician.

c. If irrigation is necessary to prevent obstruction due to bleeding, a manual method of irrigation should be utilized.

d. If the catheter is obstructed, obtain an order for relieving the obstruction. Relieving the obstruction should be done aseptically.

i. If the system is opened to irrigate the urinary catheter, disconnect the urinary catheter from the drainage system and disinfect the site with alcohol. Use a bladder irrigation kit and complete the procedure. Use gloves and practice hand hygiene before and after the procedure. Clean both ends of the urinary catheter with alcohol and reconnect the urinary catheter to the drainage system. If there is need for multiple irrigations, then consider changing the urinary catheter to a 3-way catheter (obtain recommendations from physician).

ii. Consider a 3 –way catheter when either continuous irrigation is required or frequent irrigation. The 3-way catheter has one port is to inflate the balloon and keep the catheter in the bladder; the second port is to instill irrigating solution into the bladder; the third port allows urine and solution to empty out of the bladder. If done aseptically, the system sterility is maintained because the system is a closed system.

e. If clots are present, irrigate until clear using sterile normal saline.

8. Responsible Persons

Only persons (e.g., nursing staff, family members, or patients themselves) who know the correct technique of aseptic insertion and maintenance of the catheter should handle catheters. Healthcare workers and others who take care of catheters should be given periodic education and training, stressing the correct techniques and potential complications of urinary catheterization.

PRIME SURGICAL CENTERS

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NURSING MANUAL II

CANCER CHEMOTHERAPY - DEFINITIONS		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 13** **Page: 1 of 2**
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CANCER CHEMOTHERAPY – DEFINITIONS

Cancer Chemotherapy	The use of antineoplastic medications to promote tumor cell destruction by interfering with cellular function and reproduction. A single drug or combination of drugs used for the treatment of cancer. The cancer chemotherapy drugs may or may not be cytotoxic. Supportive treatments, used to help ameliorate adverse effects of the cancer treatment or the disease.
Cancer Chemotherapy Regimen	A drug or combination of chemotherapy drugs, with predetermined relative or absolute doses, schedule of administration, and often with recommended supportive therapy (e.g. antiemetic, hydration).
Closed System Device	A drug transfer device which mechanically prohibits the transfer of environmental contaminants into the system and the escape of hazardous drug or vapour concentrations outside the system.
Cytotoxic	A drug possessing a specific destructive action on certain cells. Used commonly in referring to antineoplastic drugs that selectively kill dividing cells. Cytotoxic drugs are associated with specific occupational risk concerns.
Extravasation	The leakage of a drug into the subcutaneous tissue which may cause pain, necrosis and / or sloughing of tissue.
Vesicant	A chemotherapeutic agent that can cause blister formation and / or causing tissue destruction and pain upon extravasation.
Decontamination	The process of the removal of all visible dust, soil, and other foreign material, usually done using water and detergents, or enzymatic products along with physical action such as brushing, in order to render an object safe for handling.
Hazardous Medication	Drugs used for the systemic therapy of cancer, identifying which agents must be handled as hazardous drugs, and which do not necessarily require the precautions of handling hazardous agents.

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NURSING MANUAL II

CANCER CHEMOTHERAPY - DEFINITIONS		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 13** **Page: 2 of 2**
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Personal Protective Equipment (PPE)	Equipment designated for personnel to wear during administration of cancer chemotherapy, and other activities where physical exposure to cytotoxic agents and/or waste is a risk. PPE may include a gown, goggles, mask, gloves (sterile disposable, powder-free non-latex gloves).
Systemic Therapy	Systemic Therapy is the use of drugs that spread throughout the body to eliminate cancer cells. Systemic therapy includes cancer chemotherapy, hormone therapy, immunotherapy or biological agents, vaccine and supportive care drugs, and includes drugs given by any route, including oral. These drugs are also used for non-cancer treatment.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

CARDIOPULMONARY RESUSCITATION: EMERGENCY (CRASH) CART MAINTENANCE WITH MEDICATION CHECKLIST		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 13** **Page: 1 of 2**
Effective Date: 11 April, 2013		

CARDIOPULMONARY RESUSCITATION: EMERGENCY (CRASH) CART MAINTENANCE WITH MEDICATION CHECKLIST

PURPOSE

1. This policy is formulated for the Prime Surgical Centers Nurses, for the maintenance, checking and stocking the Emergency Cart and its related bags.
2. To have equipment and supplies readily available in case of a medical emergency within the security area of the hospital.
3. To provide guidelines for managing the equipment and drugs used in medical emergencies.

DEFINITION

Emergency Cart – A set of trays on a wheeled cart that is used in Hospital Units. It contains all the basic equipment necessary for Advanced Cardiac Life Support (ACLS) or Advanced Life Support (ALS). These include a defibrillator, intravenous emergency medications plus a variety of medical supplies needed in emergency situations.

POLICY

1. A nursing staff nearest to a medical emergency will respond to the event with the emergency cart. Each unit will have access to Crash cart with an Automated External Defibrillator (AED), emergency drugs, O2, suction and other medical supplies. The location of the cart will be fixed by Nursing Superintendent that Staff Nurse on duty is able to access and move it easily.
2. Nursing Superintendent will ensure that all Nurses are trained in CPR (Cardio Pulmonary Resuscitation) and in possession of necessary certificate. (Refer to Nursing Manual Policy and Procedure No. 18)
3. All nursing staff will be current in CPR certification.
4. Only staff which have been trained and certified to use medical equipment shall do so.
5. All Nursing services personnel who provide patient care are expected to maintain basic cardiac life support certification by Prime Surgical Centers.

PROCEDURE

The Staff Nurse of each unit and OT Technicians will be responsible to ensure that all emergency equipment is maintained and operational.

1. The Emergency Cart should not be kept sealed/or locked.
2. Whenever discrepancies are observed during checking, it should be notified to the Nursing Superintendent in writing.
3. The Emergency Cart should be checked and cleaned after each use. This should be documented on the daily checklist.
4. OT Matron and Nursing Superintendent should check the Emergency Cart randomly weekly and affix the signature with date and time.

CARDIOPULMONARY RESUSCITATION: EMERGENCY (CRASH) CART MAINTENANCE WITH MEDICATION CHECKLIST		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 13** **Page: 2 of 2**
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5. Administrative head of the Center should check the Emergency Cart randomly at least twice a month and affix the signature with date and time.
6. All the drawers should be checked on each shift and documented on the daily checklist.
7. The defibrillator should be checked strictly as per manufacturer's instructions, including the energy selected and frequency of checking and documented.
8. There should be a correlation between the last check number documented on the daily checklist and the item on the cart.
9. Any discrepancy in numbers, which are not documented, should be the accountability of the Staff Nurse on duty. An occurrence, variance and accident (OVA) / or an incident report should be completed.
10. The waste bin should be emptied after each use.
11. The checklist should be completed fully by check mark (√) for individual items and any missing items should be replaced by the Staff Nurse / Nursing Superintendent. Broken or missing items should be referred to the OT Matron, Staff Nurse or Nursing Superintendent.
12. Each item on the emergency cart should be checked for expiry during the daily check. This includes medications, which should be returned to the Pharmacy two months prior to expiry for immediate replacement.
13. The expiry dates of the medications should be written in pencil in the allocated column and revised whenever they are exchanged.
14. Whenever an emergency medication is used in an emergency situation, the same will be made good through a requisition from Pharmacy.
15. The Emergency Cart Checklist will be as per Annexure I for all Nursing Stations located in OPD and Nursing Units. For each Operating/Procedure Room, it will be as per Annexure II.

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PRIME SURGICAL CENTERS

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NURSING EDUCATION AND TRAINING MODULES

CODE MANAGEMENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 13** **Page: 1 of 2**
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CODE MANAGEMENT

COMPETENCY STATEMENT

Newly hired nurses are able to respond effectively to the various codes in Prime Surgical Centres facilities, as per the following Prime Surgical Centres Policies:

LEARNING OUTCOME

1. Identify the various safety / emergency codes used in Prime Surgical Centers facilities.
2. Explain the purpose of using codes in relation to safety matters in the healthcare environment
3. Identify and define all the codes

INTRODUCTION

It is the responsibility of all Prime Surgical Centers staff to ensure that all patients are cared for in a safe and non-threatening environment. All staff has a duty to know and respond to the various security / safety codes. Code management is a coded system that is used by the employees of the facility to deal with various emergency situations without alerting the public and patients thus preventing panic and unnecessary injury. The various codes used in health facilities include:

1. Code Blue – Adult resuscitation (Refer to Nursing Manual Policy and Procedure No. 11)
2. Code White – Infant / Neonate resuscitation
3. Code Red – Activating Fire Alarm
4. Code Orange – Dealing with a Bomb threat
5. Code Pink – Infant / Child Abduction

It is imperative that all staff in all Prime Surgical Centers have an understanding and are able to respond appropriately for Code Blue.

Code Blue is discussed in a separate presentation incorporating Basic Life Support.

In this section Code Red is discussed.

CODE RED

Any suspicious event which causes smoke or fire, or activation of fire alarm, eg exiting from an emergency exit, must be reported to the Control Room of the respective facility. The Control Room will notify the Fire & Safety Officer on duty who will investigate and further inform staff of the next action to take.

Code Red is activated in the event of an uncontrolled fire. Announced by the Fire & Safety Officer, to the unit staff, of which one will notify Communication on their respective emergency number.

Communication will announce Code Red activated three (3) times and the area affected. The Fire & Safety Officer will inform Control Room, who will send Safety staff to assist the Nursing Staff.

Nursing staff must know where the fire alarm activation box is located in their units, as well as where the fire extinguishers are located. Nursing staff are also expected to know which type of fire extinguisher to use according to the type of fire which will be demonstrated by Safety Staff.

CODE MANAGEMENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 13** **Page: 2 of 2**
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Nursing staff must also know where the emergency Oxygen shut off points are located in their units, as these need to be switched off in the event of a fire.

Each unit has its own evacuation equipment and it is the duty of all nursing staff to know where this equipment is stored and also how to use this equipment.

All staff are to attend at least one fire drill per year.

It is mandatory for all staff to attend annual reorientation of the Prime Surgical Centers Fire & Safety procedure. Evidence of this is to be documented in the personnel file.

CONCLUSION

All nurses in Prime Surgical Centers have a responsibility and are duty bound to provide and ensure a safe environment for our patients. It is therefore imperative that nurse is vigilant and observant in order to prevent any emergency situations or events from occurring.

PRIME SURGICAL CENTERS

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PURCHASE AND MAINTENANCE MANUAL

FACILITY DEPARTMENT - PREVENTIVE MAINTENANCE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 13** **Page: 1 of 4**
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ELECTRICAL

Sr. No.	Description	Company Name	Make	Sr. No.	Capacity	Minium Stock Level	Points for Daily Checking	Schedule	Company Name	Contact Person & Contact No.	AMC Period
1	**MSEB**				11000 Volts 13.12 Amp 3 Phase 250 KVA	N.A.	Voltage Reading Note down, PF recorded. Meter reading.	Daily	MSEB Deccan Office	On Duty Person - 78757 28885	N.A.
2	**D.G. SET**	Kirlosker Cummins	Powarica	2746	140 KVA (Tank 200 Ltrs.) Consumption 20 Ltrs. Per hour	100 Ltrs.	Diesel & Oil Level, Battery, Manual Starting.	Daily	Trident Services Pvt.Ltd.	Landline - 020 25671243/44 Mr.Rahul Jadhav - 98509 08165 Mr.Avinash Kulkarni - 98505 50121	01.01.2013 to 31.03.2013
3	**UPS**	Ador UPS	Ador Power Ace	13812	60 KVA Back up time ½ Hrs. on full load	N.A.	Battery Reading	Daily	Presently in Warranty	Mr.Muley - 98504 78373 Mr.Anil - 90110 08752	UPS & Battery Under Warranty from 01.04.2013 to 31.03.2015
4	**Project Contractor**	Adarsh Electricals								Mr.Deshmukh - 98201 86551	

WATER

Sr. No.	Description	Qty.	Capacity	Minium Stock Level	Points for Daily Checking	Agency Name	Schedule	Contact Person & Contact No.
1	**Ground Floor Tank**	1	20000 Ltrs.	10000 Ltrs.	Water Level Indicator	Water Tank Cleaning - Bapu's Cleaning Services	Twice in a year	020 - 2542 0068/70 98220 95992
2	**Overhead Tank**	2	10000 Ltrs. Each	5000 Ltrs.	Water Level Indicator	Water Testing - Polytest Laboratories	Yearly (In the month of September)	020 - 2447 1767
3	**Water Tanker**		10000 Ltrs. Each			Balaji Water Tanker	As per requirement	93250 07571
						Rohit Water Tanker	As per requirement	98509 56754

PEST CONTROL

Sr. No.	Description	Company Name	Points for Checking	Schedule	Contact Person & Contact No.	Contract Period
1	**Pest Control**	Pest Control India	Pest Control schedule is followed by Company as per agreement.	Weekly	Landline - 020 2545 5511/ 2025 5656 Mr. Amol Pawar - 99211 90701	20.05.2013 to 19.05.2014

PRIME SURGICAL CENTERS

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PURCHASE AND MAINTENANCE MANUAL

FACILITY DEPARTMENT - PREVENTIVE MAINTENANCE		
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WASTE MANAGEMENT

Sr. No.	Description	Company Name	Points for Daily Checking	Schedule	Contact Person & Contact No.
1	**Bio Medical Waste**	Passco Environmental Solutions Pvt.Ltd.	All bags are handed over to Passcco daily between 02:30 pm to 3 :30 pm	Daily	Mr.Chandrakant - 83088 10364
2	**Other Waste**	Pune Municipal Corporation	Daily cleaning is done and taken out of premises.	Daily	Mrs.Shobha Vetal

ELEVATOR

Sr. No.	Description	Company Name	Make	Capacity	Points for Checking	Schedule	Contact Person & Contact No.	AMC Period
1	**Patient Elevator**	SKY Elevator	**Sky**	12 Persons (1 Ton)	Cleaning,Electrical Gadgets checking. License is displayed inside the lift.	Daily	Mr. Shantaram Uttekar - 84216 24154 Mr. Sunil Yenpure - 98814 17711 Ms. Manjushree - 77559 28025 Mr. Hivre - 97666 11477	Under Warranty
2	**Visitor Elevator**	OTIS Elevator	OTIS	8 Persons (544 Kg.)	Cleaning,Electrical Gadgets checking. License is displayed inside the lift.	Daily	Mr. Deepak Patil - 95525 91060 Mr.Sunil - 99231 72746	AMC

HOUSE KEEPING

Sr. No.	Company Name	Manpower	Strength	Duty Timing	Responsibility	Monitoring Person	Contact Person & Contact No.	Contract Period
1	**Rare Hospitality Services Pvt.Ltd.**	Supervisor	1	08:00 am to 04:00pm	As described in agreement / manual	Nursing Superintendent & Facility Executive	Ms. Shiba Khan (GM Operations) 99209 72255 / 98202 54422	01.03.2013 to 28.02.2014
2	**Rare Hospitality Services Pvt.Ltd.**	House Keeping Male House Keeping Female General Duty Attendant - Male General Duty Attendant - Female Pantry Boy Electrician Gardner	4 3 4 3 2 1 1	Shift Duties	As described in agreement / manual	Nursing Superintendent & Facility Executive	On site Supervisor Mr. Jaideep Shankar 81498 72938	
		Total	**19**					

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PURCHASE AND MAINTENANCE MANUAL

FACILITY DEPARTMENT - PREVENTIVE MAINTENANCE		
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KEYS

Sr. No.	Description	Policy	Responsible Person
1	**Locker Keys**	One set of keys will be given to each staff for their locker/Drawer.	Individual Staff
2	**Duplicate Keys**	All the Duplicate keys are with Security. In case any staff lost his/her keys, duplicate key will be issued against written application of his/her and sanctioned by Unit Head.	Security

PARKING

Sr. No.	Description	Policy	Responsible Person
1	**Parking Ground Floor**	3 Parking slots are for Prime & 2 for Beck India each side. Right side parking slot will be reserved for CEO,Vice President,VIP and left side parking will be used for Doctor's.	Security Incharge & Guard
2	**Parking Garden Area**	Doctor's and Visitors car will be parked in Garden area parking.	Security Incharge & Guard
3	**Parking Front Road Side**	Visitor's parking.	Security Incharge & Guard

CATERING

Sr. No.	Company Name	Schedule	Policy	Responsibility	Contact Person & Contact No.
1	**Khushbu Snacks**	Daily	Patient will get Breakfast, Lunch, Evening tea & Dinner during their stay at Center.Daily patient count will be informed to the food supply agency.	Ward Incharge / On Duty Brother,Sister	Mr. Katrela - 98233 64365
2	**Khushbu Snacks**	Monthly	Register will be maintained by ward for the food supply during month. Monthly bill checking done by WardIncharge,signed by Nursing Superintendent and put up for passing to the Unit Head.	Ward Incharge & Nursing Supdt.	Mr. Katrela - 98233 64365
3	**Khushbu Snacks**	As per requirement	For VIP Patients food services will be provided by this vendor.	Ward Incharge / On Duty Brother,Sister	Mr. Katrela - 98233 64365

FACILITY DEPARTMENT - PREVENTIVE MAINTENANCE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 13** **Page: 4 of 4**
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LAUNDRY

Sr. No.	Company Name	Schedule	Policy	Responsibility	Contact Person & Contact No.
1	**Clothespa**	Daily	Dirty Linen will be handed over to vendor daily between 02:30 pm - 05:00 pm Washed linen will be supplied by vendor to OT/wards/Dept. next day. Daily transaction will be recorded in the Linen Book.	OT/ Ward Incharge / On Duty Sister	Clothespa Mr.Desai 98229 88811
2	**Clothespa**	Daily	Checking,inspection of linen will be done at O.T./ward level.	OT/ Ward Incharge / On Duty Sister	
3	**Clothespa**	Monthly	Monthly bill checking and put up for passing to the Unit Head.	Facility Executive.	

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ANNEXURE
(Refer to Hospital Infection and Control Manual Policy and Procedure No. 13)

FLOW CHART FOR INFECTIOUS / SOILED LINEN AND CLOTHING IN OT/COMFORT/DELUXE NURSING UNITS

O.T.1/2/3/4/5/ Comfort/Deluxe Nursing Units

Corridor

Patient Elevator

Dirty Linen Prime Laundry (Located On Ground Floor)

Outside Laundry

O.T.1/2/3/4/5/ Comfort/Deluxe Nursing Units

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

HANDLING INFECTIOUS OR SOILED LINEN AND CLOTHING		
Policy/Procedure Applies To	**All Nurses and Housekeeping staff**	**Policy/Procedure No: 13** **Page: 1 of 3**
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HANDLING INFECTIOUS OR SOILED LINEN AND CLOTHING

PURPOSE

The primary objective of this policy is to provide guidelines toward minimizing the risk of disease transmission during the handling of infectious or soiled linen and clothing.

POLICY

1. The proper care and handling of infectious, soiled linen and clothing are the responsibility of all nursing and housekeeping staff of each unit.
2. Standard Precautions shall be followed for any linen or clothing grossly contaminated with blood, body fluids or other potentially infectious materials.
3. Linen or clothing contaminated with blood or other potentially infectious materials shall be carefully gathered with a minimum of disturbance. These articles will be placed initially into a water-soluble bag, and then placed into a yellow plastic bag. To minimize the risk of cross-contamination, this double bagging process will take place at the location of the infectious article then transported to the designated infectious linen area.
4. Hand Cleansing & Hand Hygiene Procedures (Refer to Hospital Infection Control Manual Policy and Procedure No. 4) shall be followed prior to handling soiled or infected linen or clothing.
5. Linen Hamper and Soiled Laundry Carts shall be tightly closed when not in use.
6. The Soiled Laundry Cart shall be emptied at least daily even when the cart is not full.
7. To reduce the risk of cross-contamination Nursing staff will establish ongoing health teaching measures to discourage patient from sharing their linen, clothing, or shoes. This teaching shall be documented on Family Education Record.
8. Linen Hamper and Soiled Laundry Cart should not be over stuffed and should only be filled up to two-thirds full. If unit Soiled Laundry Cart is filled to two-thirds full, empty soiled laundry bags into other Soiled Laundry Cart that is not two-thirds full.
9. Do not stuff soiled laundry bags (not to weigh more than 18 kilo grams / 40 pounds).

PROTOCOL FOR HANDLING SOILED LINEN AND CLOTHING

PROCEDURE

ACTION	RATIONALE
1. Place soiled linen in plastic lined Hamper bags.	Do not fill more than two-thirds full or it will be difficult to remove it from hamper.
2. When bags are two-thirds full, wheel hamper to soiled linen area in unit.	
3. Remove bag and place directly into the soiled laundry cart.	Wear gloves to minimize risk of cross contamination.
4. If needed, cleanse Hamper with germicidal detergent solution.	A general – purpose germicidal detergent is available in all units.
5. Insert new bag through the top and fold over the outside rim to form a cuff. Close Hamper lid.	

HANDLING INFECTIOUS OR SOILED LINEN AND CLOTHING		
Policy/Procedure Applies To	**All Nurses and Housekeeping staff**	**Policy/Procedure No: 13** **Page: 2 of 3**
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PROTOCOL FOR HANDLING OF INFECTIOUS LINEN AND CLOTHING

PROCEDURE

ACTION	RATIONALE
1. Place a yellow plastic bag in the Hamper then place a water-soluble bag inside the yellow plastic bag.	The Nurse will assign responsibility for bagging and removal of Infectious Linen and Clothing.
2. Roll Hamper to area where infectious linen / clothing is to be collected.	
3. Wearing disposable gloves, staff will carefully place the infected articles in a clear water soluble bag and tie securely with the tape.	Remove disposable gloves prior to tying bag. Do not tie knot with end of bag. Discard used gloves in regular trash.
4. Securely close the yellow plastic bag, eliminating as much air as possible.	Eliminating the air prevents the bag from rupturing when other (heavy) laundry is put on top of it.
5. The staff bagging the infectious laundry shall mark the outer yellow plastic bag with their unit number e.g. Comfort /Deluxe /O.R.1/2/3/4/ Procedure Room, etc. and date.	
6. The bag is then taken to the soiled linen room of the unit and placed in the unit's Soiled Laundry Cart.	

PROTOCOL FOR HANDLING OF THE SOILED LAUNDRY CART

1. Place Soiled Linen Bags from Hamper into Soiled Laundry Cart.
2. Replace lid. If lid becomes damaged, replace immediately.
3. Roll Soiled Laundry Cart, to Soiled Linen Room of particular unit. Empty laundry cart at least daily (Full or not) or as often as necessary.

PROCEDURE

ACTION	RATIONALE
1. If needed, remove soiled material (from soiled laundry cart) by cleaning with detergent germicidal solution at least daily or whenever soiling occurs.	Cleansers are available in all units for general purpose cleaning.
2. Place Soiled Laundry Cart for monthly steam cleaning.	

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HOSPITAL INFECTION CONTROL MANUAL

HANDLING INFECTIOUS OR SOILED LINEN AND CLOTHING		
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PRECAUTIONS

1. Any clean linen accidentally dropped on the floor is considered soiled and must be placed in the soiled linen hamper.
2. Soiled laundry is not to be sorted and must be handled with caution to prevent the spread of airborne infection
3. Bags of soiled laundry must be placed directly from the Linen Hamper into the Soiled Laundry Cart.
4. Laundry bags with self-contained covers will be used in the linen Hamper.
5. Linen and clothing contaminated with blood and/or body fluid shall be considered infectious and double-bagged in accordance with Infection Control protocols.

FLOW CHART

The flow chart for Linen has been attached as Annexure to this policy.

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PRIME SURGICAL CENTERS

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ANAESTHESIA MANUAL

INTRAOPERATIVE MONITORING		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 13** **Page: 1 of 2**
Effective Date: 11 April, 2013		

INTRAOPERATIVE MONITORING

PURPOSE

To provide guidelines for safe, efficient monitoring of patients receiving all levels of anaesthesia.
To determine that monitoring activities remain in accordance with ASA standards for basic intraoperative monitoring.

POLICY

1. Qualified anaesthesia staff will be continuously present in the operating room throughout the administration of all general anaesthesia, regional anaesthesia and monitored anaesthesia care to monitor and provide anaesthesia care.
2. During all anaesthesias, the patient's oxygenation, ventilation, circulation and temperature will be continually evaluated.*
   a. Oxygenation
      i. The objective is to provide adequate oxygen concentration in the inspired gas and blood during all types of anaesthesias.
      ii. Inspired gas: Should general anaesthesia be required using an anaesthesia machine, the concentration of oxygen in the patient's breathing system will be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.
      iii. Blood oxygenation: During all anaesthesias, adequate illumination and exposure of the patient is necessary to assess colour. While this and other qualitative clinical signs may be adequate, qualitative clinical signs may be adequate, quantitative methods such as pulse oximetry will be used.
   b. Ventilation
      i. The objective is to provide for adequate ventilation of the patient during administration of all types of anaesthesias.
      ii. The adequacy of ventilation for each patient will be continually evaluated. While qualitative clinical signs such as chest movement and auscultation of breath sounds may be adequate during monitored anaesthesia care, quantitative monitoring of the C02 content and/or volume of expired gas is encouraged during general anaesthesia. Capnography will be performed if patients receive general anaesthesia.
      iii. During general anaesthesia, once the endotracheal tube is inserted, its correct positioning in the trachea must be verified by clinical assessment. End-tidal C02 analysis will be used from the time of tube placement throughout the procedure until extubation.
      iv. Should controlled ventilation become necessary, there will be, in continuous use, a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.
      v. During regional anaesthesia and monitored anaesthesia care, the adequacy of ventilation will be evaluated, at least, by continual observation of qualitative clinical signs.

INTRAOPERATIVE MONITORING		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 13** **Page: 2 of 2**
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c. Circulation

i. The objective is to provide the adequacy of the patient's circulatory function during all types of anaesthesias.

ii. Every patient receiving anaesthesia will have the electrocardiogram continuously displayed from the beginning of anaesthesia until time of transfer.

iii. Every patient receiving anaesthesia will have arterial blood pressure and heart rate monitored and evaluated at least every five minutes.

iv. If general anaesthesia is administered, the patient will have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse; auscultation of heart sounds: monitoring ultra-sound peripheral pulse monitoring: or pulse plethysmography or oximetry.

d. Temperature

i. The objective is to aid in the maintenance of appropriate body temperature during all anaesthetics.

ii. There will be readily available a means to continuously measure the patient's temperature. When changes in body temperature are intended, anticipated or suspected, the temperature will be measured.

*Continually is defined as repeated regularly and frequently in steady rapid succession, whereas continuous means prolonged without any interruption at any time.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

MODE OF PAYMENT		
Module Applies To	**Customer Care**	**Policy and Procedure No.: 13** **Page: 1 of 1**
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MODE OF PAYMENT

The mode of payment accepted is as follows:

OPD

1. Cash
2. Debit / Credit Card

   We accept all cards except American Express. If payment is made by a debit or credit card, print out the settlement receipt at the end of the day. Attach this receipt to the collection report that is handed over to the Accounts department at the end of the day.

IPD

1. Cash
2. Debit / Credit Card
3. Demand Draft

   Patient can pay the advance (estimated cost of the surgery) by demand draft. The demand draft is to be drawn on Prime Surgical Damle Path, LLP.
4. Cheque

   Cheque can be accepted only under exceptional cases, with prior approval of the Administrative Head of the Center.

   If a patient wants to make cheque payment for the estimated package cost of the surgery, then the cheque should be deposited with Prime Surgical Centers at least a week in advance so that it gets cleared before the date of admission.

   The cheque is to be drawn on Prime Surgical Damle Path, LLP.
5. Bank Transfer
   a. Direct Bank Deposit – The patient can make a direct cash deposit at the bank, in Prime Surgical Centers' account. In such a case provide the Account Name and Number.
   b. Online Bank Transfer – If a patient wants to do an online bank transfer provide the Account Name and Number, Bank Name and Branch Address and RTGS/NEFT IFSC code.
6. Cashless Facility

   If we have a tie –up with the insurance company or TPA with which the patient has the insurance policy, we can provide cashless facility to the patient. Refer to Customer Care and Billing Manual Policy and Procedure No.15 for further details.

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ANNEXURE XIII
(Refer to Housekeeping Manual Policy and Procedure No. 1)

NURSING STATION

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
A/C baffles		X		
Counter tops	X			
Nurse's Call Bell Displayer	X			
Cabinets	X			
Cabinet Top		X		
Cupboards/Chairs	X			
Shelves	X			
Computer	X			
Telephone	X			
Luminaries		X		
Electrical outlets/ Switch Plates	X			
Empty Waste Bins	X			

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GENERAL MANUAL

PATIENT CHARGES		
Policy/Procedure Applies To	**Customer Care / All Nurses / Billing**	**Policy/Procedure No: 13** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PATIENT CHARGES

PURPOSE

To ensure that every patient is charged a fair and equitable fee for services rendered.

SCOPE

Accounting and nursing personnel

POLICY

1. Every patient at the time of his surgical appointment will be charged by procedure code a predetermined fee for services rendered.
2. Periodic cost analysis studies may be rendered to determine the equitability of the system.
3. Additional fees may be incurred on an individual basis for specialized prosthetic devices or implants.

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EXPOSURE CONTROL PLAN MANUAL

RECORDKEEPING: SHARP INJURY LOG		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No: 13** **Page: 1 of 1**
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RECORDKEEPING: SHARP INJURY LOG

(Also Refer to Hospital Infection Control Manual Policy and Procedure No. 5)

The facility will establish and maintain a sharps injury log for the recording of per-cutaneous injuries from contaminated sharps. The information in the sharps injury log will be recorded and maintained in such a manner as to protect the confidentiality of the injured employee.
The sharps injury log will contain, at a minimum:

1. The type and brand of device involved in the incident.
2. The department or work area where the exposure incident occurred, and
3. An explanation of how the incident occurred.

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NURSING MANUAL II

CANCER CHEMOTHERAPY - LIST OF HAZARDOUS AGENTS		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 14** **Page: 1 of 3**
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CANCER CHEMOTHERAPY - LIST OF HAZARDOUS AGENTS

Hazardous Medications

Medications that are known or suspected to cause adverse health effects from exposures in the workplace. They include:

1. Antineoplastic and chemotherapy medications used for cancer and other diseases.
2. Medications to treat auto immune diseases like arthritis
3. Antiviral medications, hormones, some bioengineered medication & other miscellaneous medications.

Hazardous drugs include those drugs that exhibit one or more of the following characteristics in animals or humans:

1. Carcinogenicity
2. Teratogenicity or other developmental toxicity
3. Reproductive toxicity
4. Organ toxicity at low doses
5. Genotoxicity

Potential risks to health care workers

Working with or near hazardous medications in health care settings can potentially cause:

1. Sore throat, Cough
2. Dizziness
3. Head ache
4. Diarrhoea, Nausea / vomiting
5. Skin rashes
6. Infertility
7. Miscarriage
8. Birth defects
9. Organ toxicities
10. Leukemia or other cancers

PRIME SURGICAL CENTERS

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NURSING MANUAL II

CANCER CHEMOTHERAPY - LIST OF HAZARDOUS AGENTS		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 14** **Page: 2 of 3**
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CYTOTOXIC HAZARDOUS MEDICATIONS		NON-CYTOTOXIC HAZARDOUS MEDICATIONS	
Altretamine	IDArubicin	Acitretin	Iloprost
Amsacrine	Ifosfamide	Aldesleukin	Imatinib
Arsenic	Irinotecan	Alitretinoin	Interferons
Asparaginase	Lenalidomide	Anastrazole	ISOtretinoin
azaCITIDine	Lomustine	Ambrisentan	Leflunomide
azaTHIOprine	Mechlorethamine	Bacillus Calmette Guerin	Letrozole
Bleomycin	Melphalan	(bladder instillation only)	Leuprolide
Bortezomib	Mercaptopurine	Bexarotene	Megestrol
Busulfan	Methotrexate	Bicalutamide	Methacholine
Capecitabine	MitoMYcin	Bosentan	MethylTESTOSTERone
CARBOplatin	MitoXANtrone	Buserelin	Mifepristone
Carmustine	Nelarabine	Cetrorelix	Misoprostol
Chlorambucil	Oxaliplatin	Choriogonadotropin alfa	Mitotane
CISplatin	PACLitaxel	Cidofovir	Mycophenolate mofetil
Cladribine	Pegasparaginase	ClomiPHENE	Nafarelin
Clofarabine	PEMEtrexed	Colchicine	Nilutamide
Cyclophosphamide	Pentostatin	cycloSPORINE	Oxandrolone
Cytarabine	Procarbazine	Cyproterone	Pentamidine (Aerosol only)
Dacarbazine	Raltitrexed	Dienestrol	Podofilox
DACTINomycin	SORAfenib	Dinoprostone	Podophyllum resin
DAUNOrubicin	Streptozocin	Dutasteride	Raloxifene
Dexrazoxane	SUNItinib	Erlotinib	Ribavirin
DOCEtaxel	Temozolomide	Everolimus	Sirolimus
DOXOrubicin	Temsirolimus	Exemestane	Tacrolimus
Epirubicin	Teniposide	Finasteride	Tamoxifen
Estramustine	Thalidomide	Fluoxymesterone	

CYTOTOXIC HAZARDOUS MEDICATIONS	NON-CYTOTOXIC HAZARDOUS MEDICATIONS

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NURSING MANUAL II

CANCER CHEMOTHERAPY - LIST OF HAZARDOUS AGENTS		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 14** **Page: 3 of 3**
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The following groups of products are not listed on the Cytotoxic and Non-Cytotoxic Hazardous Medications list, but may require handling precautions for safe administration.

a. Salts, pegylated and liposomal drugs: only the parent compound is listed, handle all derivatives of a hazardous drug the same as the parent compound.

b. Radioactive pharmaceuticals: nuclear medicine has policies and procedure for safe handling of radioactivepharmaceuticals. These products are generally not handled by pharmacy.

c. Chemicals / raw powders: follow the MSDS (Material Safety Data Sheet) for safe handling precautions.

1. Bacillus Calmette Guerin (BCG), when used for bladder instillation, should be prepared following the instructions provided with the closed system reconstitution kit.

2. "Dissolve and dose" may be considered as a method of oral administration when a liquid preparation is required.

Etoposide	Thioguanine	Flutamide	Testosterone
Floxuridine	Thiotepa	Foscarnet	Tretinoin
Fluctosine	Topotecan	Fulvestrant	Trifluridine
Fludarabine	ValGANciclovir	Gamrelix	Triptorelin
Fluorouracil	Valrubicin	Gefitinib	
Ganciclovir	VinBLAStine	Goserelin	
Gemcitabine	VinCRIStine		
Gemtuzumab ozogamicin	Vindesine		
Hydroxyurea	Vinorelbine		

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NURSING MANUAL

CARDIOPULMONARY RESUSCITATION: USE OF AMBU BAG RESUSCITATION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 14** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CARDIOPULMONARY RESUSCITATION: USE OF AMBU BAG RESUSCITATION

PROCEDURE

1. Tilt patient's head back, making sure airway is clear.
2. Press mask firmly over nose and mouth.
3. Squeeze bag release.
    a. Squeeze bag with enough pressure to raise chest, thereby inflating lungs.
    b. Remember a child does not need as much pressure to inflate lungs. A lung can be ruptured with too much pressure.
4. Release bag and allow patient to exhale. Bag will refill for next inflation of lungs.
5. Repeat above procedure 18-20 times per minute for adults until normal breathing is restored.
6. Always keep Ambu Resuscitator fully assembled with bag, valves and mask together and in working order.

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GENERAL MANUAL

CONFIDENTIALITY: PATIENTS		
Policy/Procedure Applies To	**All Staff involved with Patient Care**	**Policy/Procedure No: 14** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CONFIDENTIALITY: PATIENTS

POLICY

1. It is the obligation of each employee, member of the medical staff and administration to protect the confidentiality of any private information which may be acquired from a patient or from any source about a patient. The trust that is built in an employee/patient relationship would be broken by disclosure of confidential information. Information also includes the medical record.
2. Knowledge which is gained in a nurse/patient relationship may be essential in planning the patient's care. When this is the case the nurse must use judgment to avoid improper disclosure. The nurse discloses only that information which is relevant to the patient's welfare. The privacy rights of the patient must always be a paramount consideration in any decision to disclose information.
3. In a patient centered environment, certain activities and procedures are accepted as routine. Despite this, care shall be taken to assure that the patient's physical privacy always be protected by appropriate screening and draping as a demonstration of the employee's appreciation of the patient as an individual.
4. Telephone information may be given to physicians and health care providers for treatment in medical emergencies or for continuity of care. Proper procedure as outlined in the Medical Records Section must be followed.
5. Information requested by telephone regarding a patient being treated at the Center that day is also considered confidential (name, operation, condition, laboratory work, weight, etc.). You should not even acknowledge over the telephone that a patient is here having surgery unless the identity is ascertained. Employees are instructed to obtain a phone number from the caller for the patient or family member to call them back.

   EXCEPTION: If a patient's family member, friend or driver leaves the Center during the surgery and calls to determine if the patient is ready to be picked up, the call should be transferred to the Staff Nurse in concerned nursing unit. He/she will be responsible for determining if this information can be relayed to the caller.

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PRIME SURGICAL CENTERS

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CUSTOMER CARE AND BILLING MANUAL

DAILY COLLECTION		
Module Applies To	**Customer Care**	**Policy and Procedure No.: 14** **Page: 1 of 1**
Effective Date: 11 April, 2013		

DAILY COLLECTION

PURPOSE

To maintain a record of the daily collection and handing over to the Accounts Department on a daily basis.

PROCEDURE

A copy of all the bills will be maintained with the Customer Care to be handed over to the Accounts Department at the end of the day/next day.

Handover all the cash collected for the day.

If payment has been made by demand draft or cheque, hand these over to the Accounts department.

If the payment has been made by card, the card settlement bill should also be given to the Accounts Department.

Take two prints of the detailed Collection Report for the day. The total cash collected for the day should tally with the Collection Report for the day.

Prepare the Daily Collection Report (refer Annexure to this policy). The Cash Report will state the total billing for the day for OPD and IPD and the mode of payment.

Handover the Collection Report, Receipts, Cash Report, Card Settlement Bills, DD, Cheque and the cash to the Accounts department and take the signature of the accountant on the Cash/Collection Register.

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ANNEXURE XIV
(Refer to Housekeeping Manual Policy and Procedure No. 1)

DELUXE WING

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls	X			As needed
Windows and Seals	X			
Roller Blinds	X			
Fan		X		
Cupboard	X			
Patients Bed (Mattress, Pillow)	X			
Bedside Locker	X			
Tables /Chairs/Sofa sets	X			
Luminaries		X		
Electrical Outlet / Switch Plates	X			
Doors and Handles	X			
Television/Telephone	X			
Central panel	X			
Nurse’s Call Bell	X			

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HOSPITAL INFECTION CONTROL MANUAL

HANDLING CLEAN LINEN AND CLOTHING		
Policy/Procedure Applies To	**OT & Procedure Room Nurses & Technicians**	**Policy/Procedure No: 14** **Page: 1 of 1**
Effective Date: 11 April, 2013		

HANDLING CLEAN LINEN AND CLOTHING

PURPOSE

The primary objective of this policy is to provide guidelines toward minimizing the risk of disease transmission while handling clean linen and clothing.

POLICY

1. Clean linen shall not be placed on the floor or stored on shelves less than 15cm above the floor.
2. Linen and clothing rooms shall be locked at all times unless nursing staff is present.

PROTOCOL FOR HANDLING CLEAN LAUNDRY

PROCEDURE

ACTION	RATIONALE
1. Pick up clean laundry from the laundry.	Will be delivered in a plastic lined cart.
2. Before placing clean linen and/or clothing on the shelves make sure they are clean.	Use detergent germicidal solution for cleaning if needed. A general purpose germicidal detergent is available in all units.
3. Store on appropriate shelves (use naphthalene balls) in the clean linen area of unit.	

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ANAESTHESIA MANUAL

INTRAOPERATIVE MONITORING DURING SEDATION		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 14** **Page: 1 of 1**
Effective Date: 11 April, 2013		

INTRAOPERATIVE MONITORING DURING SEDATION

PURPOSE

1. To provide guidelines for safe effective monitoring in compliance with current medical practice.
2. To determine that monitoring activities remain in accordance with standards for basic intra operative monitoring.

POLICY

1. Qualified staff will be continuously present in the operating or procedure room throughout the conduct of all administration of conscious sedation.
2. During all sedation, the patient's oxygenation, ventilation, circulation and temperature will be continually evaluated.
   a. Oxygenation
      i. The objective is to provide adequate oxygen to the patient and maintain a patent airway.
      ii. Blood oxygenation: During the procedure, adequate illumination and exposure of the patient is necessary to assess colour. While this and other quantitative methods such as pulse oximetry will be used.
   b. Ventilation
      i. The objective is to provide for ventilation of the patient during administration of all types of sedation.
      ii. The adequacy of ventilation for each patient will be continually evaluated by qualitative clinical signs such as chest movement and auscultation of breath sounds.
   c. Circulation
      i. The objective is to ensure the adequacy of the patient's circulatory function during all types of sedation.
      ii. Every patient receiving conscious sedation will have the electrocardiogram continuously displayed from the beginning of sedation until transfer to Nursing Unit.
      iii. Every patient receiving conscious sedation will have arterial blood pressure and heart rate monitored and evaluated at least every five minutes.
   d. Temperature
      i. The objective is to aid in the maintenance of appropriate body temperature during all conscious sedation.
      ii. Every patient receiving conscious sedation will have a baseline temperature recorded prior to sedation and PRN based on assessment throughout the treatment.

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PURCHASE AND MAINTENANCE MANUAL

MEDICAL GASES PIPELINE SYSTEM (MGPS)		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 14** **Page: 1 of 1**
Effective Date: 11 April, 2013		

MEDICAL GASES PIPELINE SYSTEM (MGPS)

OXYGEN CONTROL SYSTEM

1. The Oxygen control system has two manifolds named as left bank & right bank manifold. Always either left or right bank of semiautomatic oxygen panel is in running condition & other bank is in reserve condition. When one side of the bank is empty, i.e. Oxygen pressure of that bank is below 5 Kg/CM2, the indicator light of empty bank will indicate,& buzzer will give sound, that empty cylinders need replacement by filled cylinders. Also pressure gauge of empty bank will indicate pressure below 5 kg./CM2. The control system however will automatically change the bank & Oxygen supply will be continued without interruption. Follow cylinder replacement procedure as mentioned below.
2. In case both the sides of cylinders are empty, the valve situated at your right side in pipe line of outlet of Oxygen control panel should be closed and valve located at Emergency manifold pipe line should be opened. Please ensure that the cylinders valves are in open condition.
3. How to open the Cylinder
   a. The 7 M3 cylinder, normally called as Jumbo cylinder is used.
   b. The cylinder should be opened with key very gently.
   c. Please do not open with jerk & complete opening of cylinder valve, in one jerk, will damage the diaphragm of pressure regulator valve inside the Oxygen panel.
4. How to replace empty Cylinders, by filled cylinders.
   a. Use spanner size 28 for opening the pig tail connection hex. Coupling nut
   b. Shift the cylinder to the empty cylinder area.
   c. Shift the cylinder from filled cylinder area to the required Oxygen manifold.
   d. Fit the filled cylinder in place of empty cylinder location of manifold, by ensuring that coupling nut is engaged, rotating clockwise by hand at least first 2 to 3 full threads. Further tightening can be done by using the 28 size spanner. After fitting the cylinder to the pigtail, open the cylinder, as per the procedure mentioned above.
5. There are no operations/adjustment involved in Oxygen panel & should never be opened by unauthorised person.
6. Please maintain a daily logbook of filled cylinders connected to manifold. Each cylinders Sr. no. should be recorded while receipt of filled cylinder & return of empty cylinder.

(Refer Annexure for the Oxygen Plant Layout of Prime Surgical Centers)

NITROUS OXIDE CONTROL SYSTEM

This is manual control system. Two cylinder manifold is connected to the main N2O Line. Only one cylinder is opened by cylinder key and connected to the main line. Other cylinder is kept as reserve/standby, (cylinder valve closed position), duly connected to the manifold.

When N2O pressure falls below 4.2 Kg/CM2, indicated by OT alarm system, the reserve cylinder valve should be opened & running cylinder valve should closed, and empty cylinder should be replaced with filled cylinder.

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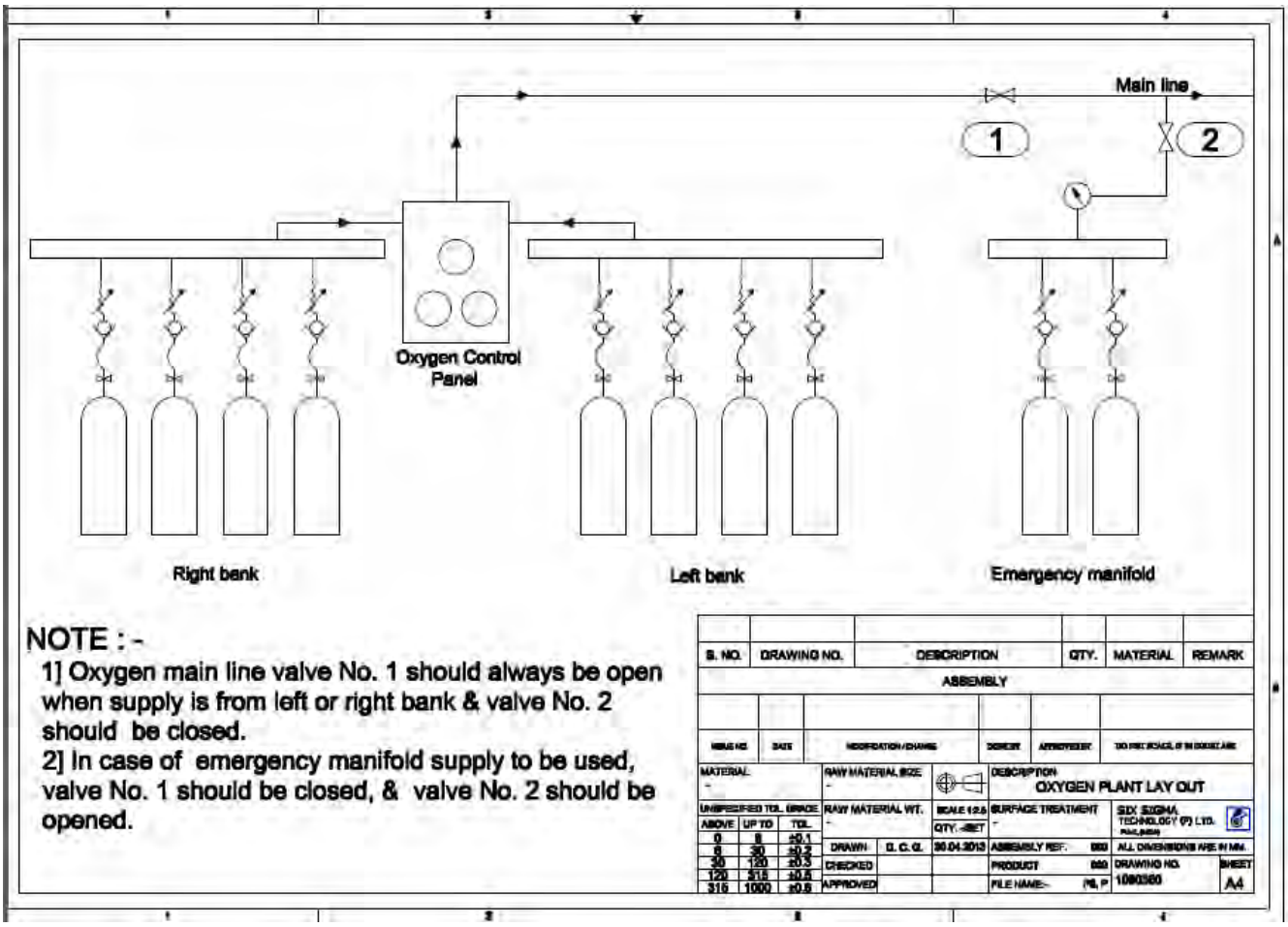
ANNEXURE
(Refer to Purchase and Maintenance Manual Policy and Procedure No. 14)

OXYGEN PLANT LAYOUT



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EXPOSURE CONTROL PLAN MANUAL

RECORDKEEPING: TRAINING RECORDS		
Policy/Procedure Applies To	**Nursing Superintendent**	**Policy/Procedure No: 14** **Page: 1 of 1**
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RECORDKEEPING: TRAINING RECORDS

1. Records of all training programs in which employees participate will be maintained.
2. Document the date of the training session, summary of the training program, name(s) of person(s) conducting the training.
3. Maintain all training records for three years from the date on which the training occurred.
4. All training records will be made available upon request to authorized personnel.

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NURSING EDUCATION AND TRAINING MODULES

SHARP INJURY		
Module Applies To	**All Nurses and Technicians**	**Module No: 14** **Page: 1 of 5**
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SHARP INJURY

PURPOSE

1. The aim is to prevent/minimize the risk of exposure to blood borne viruses (BBV).
2. To promote awareness of each healthcare workers responsibility in the safe management of sharps and occupational exposure.
3. To provide a framework for the education of nursing staff in the safe handling of sharps.

DEFINITION

Sharp injuries are wounds caused by needle or any sharp object that accidentally puncture the skin. These injuries can occur at any time when staff use, dissemble or dispose of needle.

(Exposure of mucous membrane to blood and body fluids can occur during splashes or droplets of the fluids during some procedure.)

SAFE HANDLING OF SHARPS

The most efficient method of BBV transmission in Health Care is by percutaneous exposure to infected blood. Many percutaneous injuries are preventable. Such injuries may occur while hollow bore needles are being prepared for disposal, e.g. whilst attempting to re-sheath a needle manually after venepuncture. Implementation of the following procedures for the safe handling and disposal of sharps will reduce the risks:

1. Avoid the use of sharps if possible.
2. All staff who handle sharps should be immunised against Hepatitis B.
3. Sharp containers in use must comply with National Standards.
4. Sharp containers must be assembled correctly with identification label signed including the name of nursing unit/department, facility, hospital, date and signature.
5. Sharp containers should be available at the point of use, including drug, crash cart trolleys and within a tray device with room for an integral container or wall mounted.
6. When transporting a used syringe (e.g. arterial blood sampling) remove the needle using a removal device and attach a blind hub prior to transportation.

It is the user's responsibility to dispose of used sharps as soon as possible after use.

SAFE DISPOSAL OF SHARPS

1. Inspect the refuse bag before removal / transport in case of inappropriate disposal of sharps
2. Never discard needles / syringes / sharps in a polythene bag
3. Discard sharps at the point of use into a sharps container after burning/cutting and immediately following use
4. Sharps such as small quantities of broken glass, drug vials, razors, blades etc. must be carefully disposed of into approved sharps containers
5. Never attempt to decant contents of small sharps containers into larger containers

6. Never dispose of sharps in containers used for storage of other wastes, or place used sharps containers in clinical waste bags
7. Never leave sharps lying around
8. Never insert fingers / hand past the level of the lid
9. Ensure Sharp containers are free from protruding sharps
10. Sharp containers should not be filled above the fill line. Replace when ¾ full
11. Once full the container aperture is locked, tagged and identification label signed
12. The person locking the sharps container must tag the Sharps container

SAFE HANDLING OF SHARPS

1. Do not pass sharps from hand to hand. Use kidney dish / tray.
2. When using sharps during a procedure, ensure that they do not become obscured by dressings, paper towelling or drapes etc.
3. Ask for assistance when taking blood / giving injections to uncooperative or confused patients.

Do not dispose of sharps with other clinical waste.

STORAGE

1. Ensure Sharp containers are located / positioned / stored appropriately off the floor.
2. Ensure Sharp containers are located / stored safely, away from the public and out of reach of children.
3. Sharp containers must be stored in a locked holding area while awaiting collection for disposal.
4. Sharp containers awaiting removal by a contractor should be stored in a secure, protected area.

TRANSPORT

1. Transport a sharps container by the handle and away from the body.
2. Sharp containers must be transported and placed in an upright position. Handle carefully.
3. Personnel involved in the removal of Sharp containers for disposal must wear heavy duty gloves and protective clothing.
4. If a sharp object is found, protect self, remove item carefully and place into a sharps container. **Do not physically handle a sharp object, use a dustpan to manipulate the sharp instead.**
5. The designated person responsible for the removal / disposal of Sharp containers must ensure sharp containers are **tagged**, sealed / locked before removal for disposal.
6. If there is a breach in the system, inform the department head.

SHARP INJURY		
Module Applies To	**All Nurses and Technicians**	**Module No: 14** **Page: 3 of 5**
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EDUCATION AND TRAINING

1. Heads of Disciplines /Heads of Departments / Supervisors should be aware of the action required following an inoculation injury.
2. All Health Care Workers should be conversant with the location of the safe handling and disposal of sharps policy.
3. Health Care Workers should attend education and training at orientation and yearly thereafter. Each Head of Department / Head of Discipline should have a record of staff training.
4. Ensure Standard Precautions poster is available in each clinical area for the management of sharps / inoculation injury.

MEASURES TO REDUCE RISKS DURING SURGICAL PROCEDURES

1. Most percutaneous injuries in the operating theatre or during procedures are caused by sharp suture needles.
2. Double gloving does not “prevent” sharps injury, but has been shown to effect up to a six-fold decrease in inner glove puncture. In the event of percutaneous injury, the volume of blood transmitted may also be reduced due to the enhanced wiping effect of two layers of glove.
3. The use of blunt-tipped needles can further reduce the incidence of glove puncture and percutaneous injury. Although unsuitable for suturing skin and bowel, they can be used effectively for all other components of abdominal closure. For skin and bowel closure, stapling devices are a safer alternative to sharp suture needles.
4. In order to minimise the risk of injury, the tasks of each member of the surgical team should be outlined. Specific hazards and measures to reduce the risks from these should be identified for each team member and should be reviewed periodically.

REDUCING THE RISK OF PERCUTANEOUS EXPOSURE: METHODS, PROCEDURES AND EQUIPMENT

The following measures may reduce the risk of percutaneous exposure and should be considered where practicable:

1. Have no more than one person working in an open wound/body cavity at any time (unless essential to the safe and successful outcome of an operation);
2. Use a “hands-free” technique where the same sharp instrument is not touched by more than one person at the same time, avoid hand to hand passing of sharp instruments during an operation;
3. Assure safer passage of necessary sharp needles and instruments via a “neutral zone”, announce when a sharp instrument or needle is placed there. The “neutral zone” may be a tray, kidney basin or an identified area in the operative field.
4. Ensure that scalpels and sharp needles are not left exposed in the operative field, but always removed promptly by the scrub nurse having been deposited in the neutral zone by the operator or assistant;
5. Use instruments rather than fingers for retraction, and for holding tissues while suturing;
6. Use instruments to handle needles and to remove scalpel blades;

7. Direct sharp needles and instruments away from own non-dominant, or assistant's hand;
8. Remove sharp suture needles before tying suture; tie suture with instruments rather than fingers. Alternative equipment and procedure should be considered where practicable:
9. Eliminate any unnecessary use of sharp instruments and needles, e.g. by appropriate substitution of electrocautery, blunt-tipped needles and stapling devices;
10. Opt for alternative less invasive surgical procedures where practicable and effective;
11. Avoid scalpel injuries associated with assembly/disassembly, by using scalpels which are either disposable, have retractable blades or which incorporate a blade release device;
12. Avoid the use of sharp clips for surgical drapes; blunt clips are available as are disposable drapes incorporating self-adhesive operating film;
13. Consider double gloving with a larger pair of gloves innermost for optimum comfort.

REDUCING RISK OF BLOOD-SKIN CONTACT

The following measures may reduce the risk of blood-skin contact and should be considered:

1. If a glove puncture is suspected or recognised, rescrub if possible and reglove as soon as safety permits;
2. Change gloves regularly if performing, or assisting with a prolonged surgical procedure even if no glove puncture is suspected or recognised;
3. Wear protective clothing for body, eyes and face according to risk assessment;
4. Choose waterproof gowns, or wear a surgical gown with waterproof cuffs and sleeves and a plastic apron underneath if blood contact and therefore "strike-through" is considered a risk – such as procedures anticipated to involve high blood loss;
5. If legs or feet may be contaminated, ensure that impermeable gown/apron covers legs and wear impermeable footwear.
6. Wear protective headwear and surgical mask. Male health care workers should consider wearing hoods rather than caps to protect freshly shaven cheeks and necks;
7. Ensure that all blood is cleansed from a patient's skin at the end of an operation before patient leaves theatre;
8. Remove protective clothing including footwear on leaving the contaminated area. All contaminated reusable protective clothing, including footwear, should be subjected to cleaning and disinfection or sterilisation, with appropriate precautions for those undertaking it. Footwear should be adequately decontaminated after use.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

SHARP INJURY		
Module Applies To	**All Nurses and Technicians**	**Module No: 14** **Page: 5 of 5**
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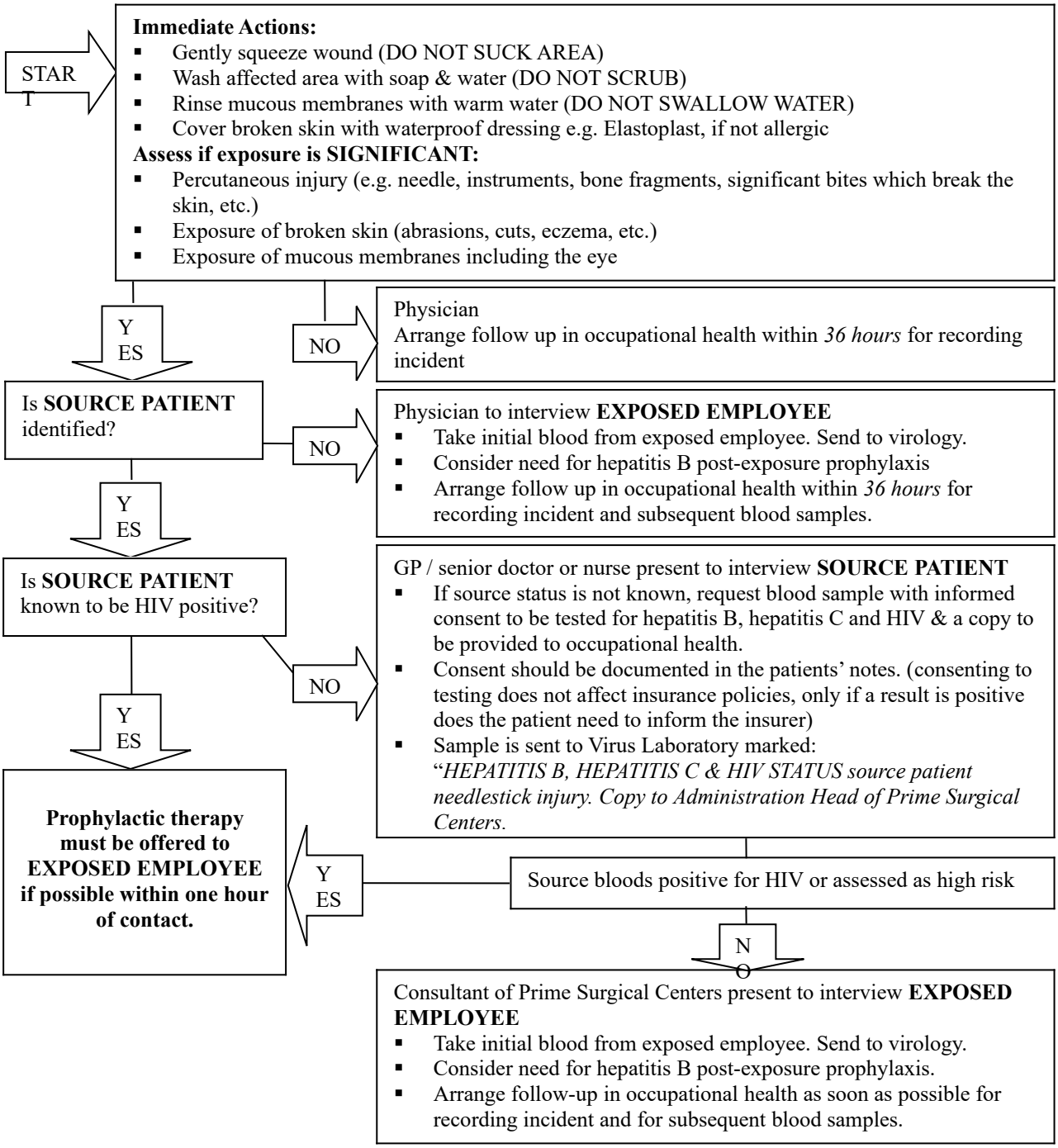
MANAGEMENT OF OCCUPATIONAL EXPOSURE TO BLOOD-BORNE VIRUSES



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NURSING MANUAL

CARDIOPULMONARY RESUSCITATION: EXTERNAL DEFIBRILLATION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 15** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CARDIOPULMONARY RESUSCITATION: EXTERNAL DEFIBRILLATION

PURPOSE

To terminate ventricular fibrillation by the delivery of an electric shock, of brief duration, to the chest wall. Ventricular fibrillation is total disorganization of ventricular activity. The purpose of defibrillation is to convert to effective cardiac contractions.

POLICY

1. When a patient's condition indicates ventricular fibrillation by rapid loss of consciousness, cessation of pulse, verified by monitor or electrocardiogram, the external defibrillator will be available. Staff Nurse will assist the Physician.

2. The physician present will specify the energy level setting and apply or delegate ACLS certified personnel to apply the paddles and discharge the current. The nurse present is responsible for having the defibrillator available and ready as directed.

PERTINENT FACTS

This procedure involves high voltage hazards to the patient and to personnel. When the physician determines the appropriate energy required, the energy level is then set on the defibrillator. When the discharge button is pressed, the patient receives immediately the current level that is set on the machine.

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ANNEXURE XV
(Refer to Housekeeping Manual Policy and Procedure No. 1)

COMFORT WING

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		As needed
Windows and Seals	X			
Roller Blinds	X			
Control Panel	X			
Nurse's Call Bell	X			
Cupboard	X			
Patients Bed	X			
Bedside Locker	X			
Stool	X			
Luminaries		X		
Electrical Outlet/ Switch Plates	X			
Cubicle Curtains		X		
Fans		X		

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EXPOSURE CONTROL PLAN MANUAL

COMMUNICATION OF HAZARDS		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No:15** **Page: 1 of 1**
Effective Date: 11 April, 2013		

COMMUNICATION OF HAZARDS

LABELS

1. Warning labels will be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material. Other containers used to store, transport or ship blood or other potentially infectious materials will also be labeled except when:
   a. Red bags or red containers are used
   b. Containers of blood, blood products, or blood components are labeled with their contents and have been released for transfusion and other clinical uses
   c. Individual containers of blood or other potentially infectious materials are placed in a labeled container during storage, transport, shipment or disposal
2. Labels will include the biohazard symbol.
3. Labels will be fluorescent orange or orange-red with lettering in a contrasting color.
4. Labels will be firmly affixed to the container in a method that prevents their loss or unintentional removal.
5. Red bags or red containers may be substituted for labels.
6. Labels required for contaminated equipment will be in accordance with these guidelines and will also state which parts of the equipment are contaminated.
7. Regulated waste that has been decontaminated is exempt from labeling or the color-coding system.

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NURSING EDUCATION AND TRAINING MODULES

INTRAVENOUS THERAPY SKILL COMPETENCY CHECKLIST		
Module Applies To	**All Nurses and Technicians**	**Module No: 15** **Page: 1 of 3**
Effective Date: 11 April, 2013		

INTRAVENOUS THERAPY SKILL COMPETENCY CHECKLIST

1. Verify physician order for IV Administration
   a. Name of the fluids
   b. Dose
   c. Frequency
   d. Date
   e. Time of order and physicians signature.

2. Assemble appropriate supplies:
   a. IV catheter of proper type, size, length.
   b. IV fluids prescribed
   c. IV administration set according to the flow rate/ syringe with 3-4ml NaCl for flushing
   d. Alcohol / povidine iodine/ chloraxidine swabs
   e. Sterile gauze
   f. Transparent semipermeable dressing (tegaderm) Or Easy Fix.
   g. Unsterile gloves.

3. Identify patient using two identifiers
   a. Introduce yourself ask the patient his/her name.
   b. Check of ID bracelet.

4. Confirm any allergy history for
   a. Medications
   b. Iodine
   c. Chlorhexidine
   d. Latex and tape.

5. Explain the procedure to the Patient and assess extremities for appropriate placement of IV insertion:
   a. Select the most distal site of the extremity
   b. Avoid area of flexion
   c. Use non dominant Hand/arm
   d. Choose site located above the previous insertion sites

6. Identify contraindications for an insertion including:
   a. Dialysis access site
   b. History of mastectomy
   c. History of trauma or impaired venous drainage to extremity
   d. Prior history of IV complication
   e. Frail, fragile, phlebotic, infiltrated or bruised vein.

7. Assess patient's previous or perceived experience with IV therapy.

8. Perform hand hygiene.

9. Apply tourniquet *(*above proposed insertion site).

INTRAVENOUS THERAPY SKILL COMPETENCY CHECKLIST		
Module Applies To	**All Nurses and Technicians**	**Module No: 15** **Page: 2 of 3**
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10. Check for radial pulse.

11. Identify accessible vein for venipuncture.

12. Don gloves.

13. Recheck to make sure all equipments are accessible.

14. Prepare the area with Chlorhexidine / Alcohol:
    a. Cleans using circular motion from the puncture site to outward for 30 seconds.
    b. Allow to dry.
    c. If allergic to Chlorhexidine use the Povidine iodine prep or Alcohol;
    d. Allow to dry
    e. Follow with alcohol wipe if Chlorhexidine or Povidine is used.

15. Prior to venipuncture hold the catheter hub and rotate barrel 360 degrees

16. Perform venipuncture:
    a. Draw skin below the insertion site taut using the non-dominant hand.
    b. Puncture skin parallel to the path of vein with the bevel up and needle at 15- 30 degree angle.
    c. Observe for blood return in catheter hub holding the devise stable
    d. Advance catheter several millimeters to ensure catheter entrance into vein until the hub rest at insertion site.
    e. Release tourniquet.
    f. Apply digital pressure beyond the catheter tip.
    g. Gently stabilize and anchor catheter hub with Easy Fix.

17. Remove stylet from catheter and dispose of in to sharp box after burning.

18. Attach primed IV bag / syringe with 2-3ml NaCl to Catheter hub.

19. Initiate proper IV flow rate or flush with NaCl.

20. Assess for signs of infilteration.

21. Apply Easy Fix /Tegaderm (transparent semipermeable dressing) & anchor hub
.
22. Label dressing with date, gauge and your initials.

23. Tape loop securely.

24. Discard supplies in appropriate container.

25. Remove the Gloves and wash hand.

26. Label IV bag including the name and amount of solution, flow rate in ml per hour and drops per minute, additives if added, date and time and the signature of the Nurse.

INTRAVENOUS THERAPY SKILL COMPETENCY CHECKLIST		
Module Applies To	**All Nurses and Technicians**	**Module No: 15** **Page: 3 of 3**
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27. Document IV administration in the Patient's Medical Record. Include:
    a. Date
    b. Time
    c. Number of attempts
    d. Site
    e. Gauge
    f. Rate of solution or flush
    g. Problem encountered by the Patient
    h. Site assessment
    i. Signature of the nurse.

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ANAESTHESIA MANUAL

ONE LEVEL OF CARE FOR IV CONCIOUS SEDATION		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 15** **Page: 1 of 3**
Effective Date: 11 April, 2013		

ONE LEVEL OF CARE FOR IV CONSCIOUS SEDATION

PURPOSE

To establish guidelines for all departments to follow when administering IV conscious sedation.

DEFINITION

Intravenous conscious sedation is the administration of pharmacologic agents to provide a minimally depressed level of consciousness yet allow the patient to independently and continuously maintain an airway and respond to physical stimulation and verbal commands. The purpose of intravenous conscious sedation is to enhance the patient's comfort during therapeutic procedures.

LOCATIONS

Conscious sedation may be conducted in the following areas providing that appropriate monitoring can be accomplished:

1. Operating room
2. Endoscopy department

1. ESSENTIAL EQUIPMENT AND SUPPLIES

a. Required monitoring equipment includes:
   i. ECG monitor
   ii. SpO2 monitor
   iii. BP monitor, preferably automatic
b. Oxygen supply must be available.
c. Suction with fully assembled system, preferably wall suction but portable suction acceptable.
d. Crash cart immediately accessible to every location where IV sedation is administered.
e. IV access
f. PAR scoring. It is recommended that the following be incorporated into all recovery forms for consistency.

ONE LEVEL OF CARE FOR IV CONCIOUS SEDATION		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 15** **Page: 2 of 3**
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DISCHARGE CRITERIA

PAR SCORE		TIME	IN	15	30	45	60	75	OUT
ACTIVITY Able to move voluntarily or on command	4 extremities 2 extremities 0 extremities	2 1 0							
RESPIRATION Able to deep breathe and cough freely Dyspnoea shallow or limited breathing Apnoeic		2 1 0							
CIRCULATION BP +/- 20mm of pre-anaesthesia level BP +/- 21-49mm of pre-anaesthesia level BP +/- 50mm of pre-anaesthesia level		2 1 0							
CONSCIOUSNESS Fully aware Arousable on calling Not responding		2 1 0							
O2 SATURATION Able to maintain SpO2 □ 92% on room air Needs supplemental O2 to maintain SpO2 □ 90% SpO2 □ 90% with supplemental O2		2 1 0							

Once the patient has reached a combined score of eight (8) to ten (10), and the Anaesthesiologist deems the patient medically dischargeable (street ready), the Anaesthesiologist may leave the facility. An Anaesthesiologist will be on call each day. The Anaesthesiologist's name, home or office phone number will be posted in the patient care areas. The Anaesthesiologist's response time to the facility in case of an emergency must be less than thirty (30) minutes.

Patients may be discharged home after meeting the following discharge criteria:

1. Alert and oriented
2. Vital parameters are stable
3. No emesis, nausea mild if present
4. Ambulating without dizziness
5. Pain controllable with oral analgesics

ONE LEVEL OF CARE FOR IV CONCIOUS SEDATION		
Policy/Procedure Applies To	**Anaesthesiologists**	**Policy/Procedure No: 15** **Page: 3 of 3**
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2. RECOMMENDED DRUG DOSAGE GUIDELINES FOR NURSE ADMINISTRATION

Medications utilized will include the following narcotic analgesics and sedative hypnotics. Achieving an optimal balance between patient comfort and safety requires careful titration of sedative and analgesic drugs. Drugs should be given only on the order of a physician.

GUIDELINES

1. Not recommended for patients under age fifteen (15) or less than forty(40) kg weight, except upon order of Anaesthesiologist or attending physician.
2. Individualize dosing based on but not limited to age, general health and concomitant medications.
3. Titrate via small increments to desired effect.
4. Administer doses slowly.
5. Wait minimum of 2-10 minutes depending on drug to fully evaluate effects.
6. Be aware of and comply with manufacturer's directives.

Versed On order of Anaesthesiologist or Attending Physician

Initial dose: 0.5mg - 1.0mg over 2-3 minutes
Should not exceed 2.5mg over minimum 5 minute period.

Morphine On order of Anaesthesiologist or Attending Physician

Initial dose: 1-2mg slowly every 5 minutes
Additional dose: On order of Anaesthesiologist or attending physician
Should not exceed 10mg in 60 minutes.

Fentanyl On order from Anaesthesiologist.

Initial dose: Up to 20mg over 1-2 minutes
Give no more except by order of Anaesthesiologist.

3. EVALUATION

It is the responsibility of the nurse to notify the Resident Medical Officer/Anaesthesiologist immediately of any adverse reaction and changes in the patient's condition. Specific discharge criteria may be waived off by the order of the Anaesthesiologist.

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CUSTOMER CARE AND BILLING MANUAL

INSURANCE PATIENT GUIDELINES / PLANNED CASES		
Module Applies To	**Customer Care / TPA**	**Policy and Procedure No.: 15** **Page: 1 of 3**
Effective Date: 11 April, 2013		

INSURANCE PATIENT GUIDELINES / PLANNED CASES

PURPOSE

To provide cashless hospitalization for insured patients without a direct payment for required treatment.

The assigned TPA will mediate between the healthcare service provider (hospital) and the insurance Company and settle the bills on behalf of the insured customer.

SCOPE OF SERVICES

TPA / Customer care

PROCEDURE

1. Whenever the insured patient advised to undergo surgery by a treating doctor then he or she should contact to customer care department at earliest for smooth cashless processing and to get pre-approval done.(3-4 days before admission)

   Phone No. 020 39931000

   Email – customercare@primesurgical.in
2. Customer care department should ask following details and forward the details to the TPA department.
   a. Name of insurance company
   b. Name of TPA/corporate
3. TPA / Customer care department will issue respective Insurance / TPA pre-authorization forms to the patient.
4. Patient will fill up his details on Insurance / TPA pre-authorization form and the remaining part is to be filled by a consultant /RMO with correct clinical history of the insured patient & Estimation is done by TPA executive as per guidelines.
5. Patient has to submit the duly filled Insurance / TPA pre-authorization forms enclosing following documents at TPA help desk (3-4 days before admission).
   a. Insurance company /TPA card
   b. Valid photo ID card
   c. Valid Photo ID address Proof
   d. Relevant investigation reports
6. TPA / customer care department will forward the Insurance/ TPA pre-authorization form along with above mentioned Documents to respective Insurance/TPA immediately to get early approval through mail or Fax
7. In case of approval / rejection - status has to be informed to patient before admission.
8. Prior to discharge, Final bill along with Discharge summary has to forwarded to insurance /TPA.
9. Once the final approval is received from Insurance/TPA then discharge the patient with terms and conditions on Final approval.

INSURANCE PATIENT GUIDELINES / PLANNED CASES		
Module Applies To	**Customer Care / TPA**	**Policy and Procedure No.: 15** **Page: 2 of 3**
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10. Non –Payable items, copayment amount, any amount not payable by Insurance /TPA has to be collected from the patient with duly signed by the patient on Final bill.

NOTE - Insurance approval and final discharge procedure takes minimum 4 to 6 Hours from Insurance / TPA.

Documents to be handed over to patient before discharge

1. Original discharge summary
2. Xerox copies of all In-house Laboratory test reports
3. Original bill copy of patients final bill
4. Paid receipt if any
5. USG film and X-ray film not to hand over to patient as it is required for claim submission.

Documents handed over to Insurance/TPA after final billing and discharge

1. Insurance pre-authorization claim form along with all approval copies, original investigation reports and films.
2. Discharge summary of patient with pharmacy bills in original

Reimbursement Procedure for Insurance /TPA

Documents to be handed over to patient before discharge –

1. Discharge summary of the patient
2. Pharmacy bills, investigation reports and films in original.
3. Detailed bill breakup as per package.

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CUSTOMER CARE AND BILLING MANUAL

INSURANCE PATIENT GUIDELINES / PLANNED CASES		
Module Applies To	**Customer Care / TPA**	**Policy and Procedure No.: 15** **Page: 3 of 3**
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PRIME SURGICAL CENTERS

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GENERAL MANUAL

PATIENT SELECTION		
Policy/Procedure Applies To	**All Consultants**	**Policy/Procedure No: 15** **Page: 1 of 2**
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PATIENT SELECTION

POLICY

The Consultant usually determines where a procedure will be done, but many factors may influence his/her decision. Adequate protection against the insult of surgery and anaesthesia must be provided to assure that all patients are cared for in a safe manner.

FACTORS INFLUENCING PATIENT SELECTION

1. Medical Appropriateness:
   a. Type of procedure
   b. Health status of patient
   c. Surgeon's judgment
   d. Anaesthesiologist’s judgment - ASA status classification
2. Technological Advances
   a. Modern technique that permit more rapid recovery and early discharge.
   b. Advances in instrumentation and therapeutic interventions.
   c. Development of anesthetic agents and other drugs that facilitate rapid and uncomplicated recovery and enable a safe course in the home environment.
3. Community Standards
   a. Influence of standards of medical practice accepted within the community.
   b. Influence of third party payers to encourage the short stay surgical setting.
   c. Consumer awareness of advanced technology.
4. Safety Concerns
   a. Potential for complications low.
   b. Adequate home support or alternate care source available.
5. Legal Considerations

   Assurance that physicians on staff are appropriately credentialed.
6. Appropriateness of Procedure
   a. Regular review of acceptable procedures.
   a. Review of safety and effectiveness of new services.
   b. Available resources and personnel.
7. Nursing Input
   a. Nursing assessment
   b. Concerns regarding the patient's day of surgery course and home care.
   c. Identifying and discussing areas of concern via quality assurance meetings.
8. Contra-indications for Short Stay Surgery
   a. No home support system.
   b. Inability of patient/family to understand proper self care.
   c. Extreme anxiety or emotional instability that may cause security or safety concerns.
   d. High probability of more extensive surgery.

PATIENT SELECTION		
Policy/Procedure Applies To	**All Consultants**	**Policy/Procedure No: 15** **Page: 2 of 2**
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e. History of postoperative complications.
f. Acute ingestion of intoxicating substances or acute stage of withdrawal.

9. Not Acceptable for Admission
   a. Patients having an infection that would require isolation and additional professional help in surgical or recovery services.
   b. Patients who have been exposed to infectious disease during the incubation period.
   c. Long stay probability patients

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NURSING MANUAL II

ROLES AND RESPONSIBILITIES OF CHEMOTHERAPY NURSE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 15** **Page: 1 of 2**
Effective Date: 01 April, 2014		

ROLES AND RESPONSIBILITIES OF CHEMOTHERAPY NURSE

PURPOSE

The cancer chemotherapy nurse practices at a high level of autonomy and accountability in collaboration with Oncologists, Consultants, Surgeons, Counselors, Dietitians and Physiotherapists to provide a continuum of patient care for prevention, early detection, diagnosis, treatment, follow-up, palliation, bereavement and survivorship.

SCOPE

To provide a range of clinical nursing services to cancer patients and their families, so that the patient needs are met and excellence in nursing practice is promoted.

RESPONSIBILITIES

In addition to the staff nurse job description, key chemotherapy nurse functions include:

1. Maintain a current knowledge base of chemotherapy / oncology patient care.
2. Use a systematic process of assessment, diagnosis, planning, implementation and evaluation of patient care.
3. Coordinate and support the continuity of care for patients and families through collaboration with multi-disciplinary team members.
4. Preparation and administration of chemo therapeutic drugs according to the guideline provided.
5. Management of patients with malignancy, receiving cytotoxic chemotherapy by demonstrating knowledge of drug administration and drug toxicity.
6. Educates patients and families about the disease, diagnostic procedures, treatment symptoms and self-care measures.
7. Maintains competence in advance nursing procedures and delegated medical acts e.g. maintenance of central venous access devise/lines, etc.
8. Coordination of oncology clinic and OPD visits including assessment of pre visit documentation and lab work, interpretation and implementation of therapeutic orders and arrangement of appropriate follow up including referrals.
9. Communicates with patients and families in between OPD / treatment visits in order to follow up on education and support provided during visits. Assesses and intervenes with new problems or concerns as they arise.

ROLES AND RESPONSIBILITIES OF CHEMOTHERAPY NURSE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 15** **Page: 2 of 2**
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10. Demonstrates ability to work independently on all cancer chemotherapy preparation, administration, documentation, patient education and disposal of used items. (Refer to Nursing Manual policy and procedure no. 29)
11. Identifies and pursues own learning needs. Attends and participates inservices and other continuing education activities and / or oncology / chemotherapy related topics / seminars / workshops etc.

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SAFETY MANUAL

SECURITY		
Policy/Procedure Applies To	**All staff**	**Policy/Procedure No: 15** **Page: 1 of 1**
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SECURITY

POLICY

The Executive facility is responsible for ensuring that the facility is secure after each surgical day.

PROCEDURE

1. The number of people with access to the facility shall be kept to a minimum. Only those employees requiring access to the Center will be issued keys. The Executive facility is responsible for all keys/authorization.
2. Emergency assistance can be summoned by calling the front desk from any phone, or dialling 100 for fire or police assistance. In addition, direct emergency numbers are included on the Emergency Phone List.
3. During hours of non-operation, security is provided by a monitored security system and security guards.
4. Internal fire security is based on a system of smoke detectors and fire alarms (both smoke and heat sensors) which are monitored 24 hours daily.

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HOSPITAL INFECTION CONTROL MANUAL

SOILED LINEN HANDLING		
Policy/Procedure Applies To	**OT & Procedure Room Nurses & Technicians**	**Policy/Procedure No: 15** **Page: 1 of 1**
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SOILED LINEN HANDLING

PURPOSE

To maintain a clean environment by proper removal and processing of soiled linen.

POLICY

All soiled linen will be removed and handled in a manner designed to prevent cross-contamination.

PROCEDURE

1. All used or contaminated linen will be placed in linen hampers located in each area. To avoid contamination of employee's clothing, soiled linen is never held against the body. Linen is never thrown on the floor or shaken in the air.
2. When linen is removed from item, (e.g. instrument tray, stretcher), linen piece is folded into itself with all loose ends carefully contained and then it's placed in appropriate linen hamper or removed to linen holding area in a hamper liner.
3. All used OR apparel or patient gowns will be placed in designated hampers in the dressing areas to be removed to the soiled holding area as necessary.
4. Any unused piece of linen falling to the floor or becoming wet is considered contaminated and must be laundered again.
5. When sorting linen for processing, gloves must be worn and care should be taken not to contaminate uniforms. Should this occur, the employee will change clothes and wash hands thoroughly.

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PURCHASE AND MAINTENANCE MANUAL

VACUUM PUMP MAINTENANCE SCHEDULE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 15** **Page: 1 of 1**
Effective Date: 11 April, 2013		

INGERSOLL RAND VACUUM PUMP MAINTENANCE SCHEDULE

Sr. No.	Maintenance Check	× Weekly ×× Monthly ××× Quarterly	Remarks
1	Crankcase oil level	x	
2	Drain Air receiver	x	
3	Check belt wear & Tension	xx	
4	Blow off cylinder fins	xx	
5	Blow off intercooler fins	xx	
6	Clean vacuum filter element	xx	
7	Change crankcase oil	xxx	
8	Check & tighten bolts	xxx	
9	Check & record motor current at 600 mm. of vacuum	xxx	

Weekly Maintenance schedule record

Week no.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
Schedule date/ mait.date													
Week No.	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**
Schedule date/ mait.date													
Week No.	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**
Schedule date/ mait.date													
Week No.	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**	**50**	**51**	**52**
Schedule date/ mait.date													

Monthly Maintenance schedule record

Week no.	**1**	**5**	**9**	**13**	**17**	**21**	**25**	**29**	**33**	**37**	**41**	**45**	**49**
Schedule date/ mait.date													

Quarterly Maintenance schedule record

Week no.	**13**	**25**	**37**	**49**
Schedule date/ mait.date				

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

CUSTOMER CARE AND BILLING MANUAL

FOREIGN NATIONALS REGISTRATION PROCEDURE		
Policy/Procedure Applies To	**Customer Care & Billing Executive**	**Policy/Procedure No: 16** **Page: 1 of 5**
Effective Date: 11 April, 2013		

FOREIGN NATIONALS REGISTRATION PROCEDURE

PROTOCOL

All foreigners (including foreigners of Indian origin) visiting India on Student Visa, Medical Visa, Research Visa and Employment Visa are required to get themselves registered with the Foreigners Regional Registration Officer (FRRO)/ Foreigners Registration Officer (FRO) through website.

PURPOSE

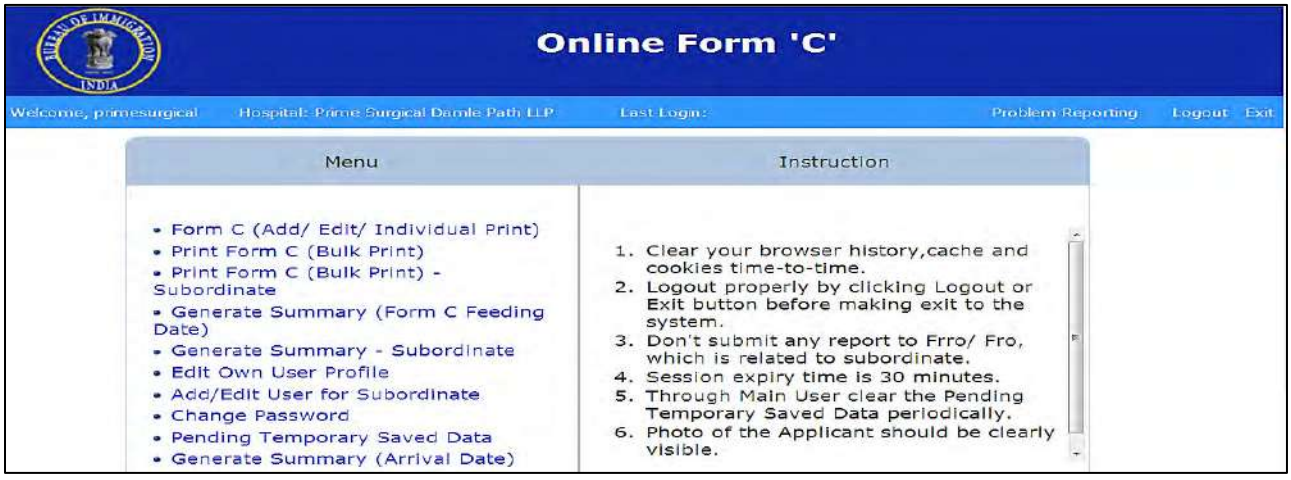
To safeguard the Center from improper registration of Foreign Nationals & to follow FRO department's protocol.

PROCEDURE

1. Supporting documents required for the Registration
   a. If the first point of contact is in Prime Surgical Center:
      i. The "Arrival Report of Foreigner in Hospital" Form (refer to Annexure I to this policy) has to be filled by the patient/attendant.
      ii. 1 photocopy of original valid passport and Visa (photo page, page indicating validity, page bearing arrival stamp of Indian Immigration).
   b. If the first point of contact is other Hospital/Hotel/Residence:
      i. The "Arrival Report of Foreigner in Hospital" Form (refer to Annexure I to this policy) has to be filled by the patient/attendant.
      ii. 1 photocopy of already submitted Form C by other Hospital/Hotel/Residence.
2. Guidelines for online filing of Form C:

The Customer Care executive needs to apply online from the website: http://www.indianfrro.gov.in/frro/FormC/login.jsp.

Enter User ID and Password and Authentication code.



Select the 1st link – Form C (Add/Edit/Individual Print).

FOREIGN NATIONALS REGISTRATION PROCEDURE		
Policy/Procedure Applies To	**Customer Care & Billing Executive**	**Policy/Procedure No: 16** **Page: 2 of 5**
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The Online Form C will open up with details of Prime Surgical Centers.

The session expiry timeout is of 30 minutes, hence the form needs to be filled in quickly else all the data entered will be lost and it has to be fed in again.

The following process should be followed:

a) Before filling the information online, keep the scanned copy of the patient's passport size photograph ready.

Scan the patient's photograph which is on his/her passport.

Select the face of the photograph; crop the photograph accordingly and save it.

Re-open it in Paint brush format, and adjust the photograph and save it in such a way that the total size of the photograph is below 50KB. If size is above 50KB, the website will not accept the photograph.

Save the photograph in JPEG/JPG format only as other formats are not accepted by the website.

b) In Personal Details section:

i. For uploading photo, click “Browse” for file selection & click "Upload File" after selecting the photograph.

ii. Fill Surname, Given Name and Sex

iii. Fill Date of Birth (Date Format to be filled in as per the Passport)

(Date of Birth Format on the online form is as follows: If MM/YYYY is chosen, then the Date is set as DD/MM/YYYY. If YYYY is chosen, then Date is set as MM/DD/YYYY)

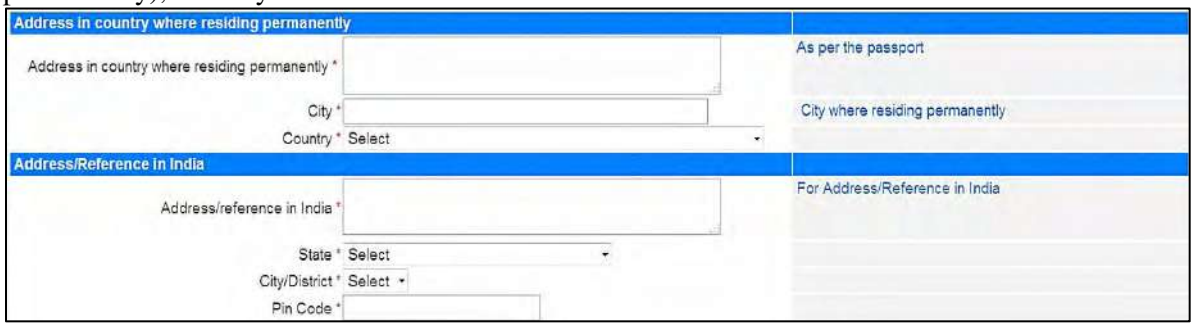
iv. Fill Age [If on the passport Date of Birth is not given, only the age of the person is given then fill in the Age. The Year of Birth gets automatically calculated and date is set as 01/01/YYYY, If AGE is less than One year it will show as 0(zero)]

v. Fill Special Category (Choose Others always for General Category)

vi. Fill Nationality.

c) In Address in country where residing permanently section:

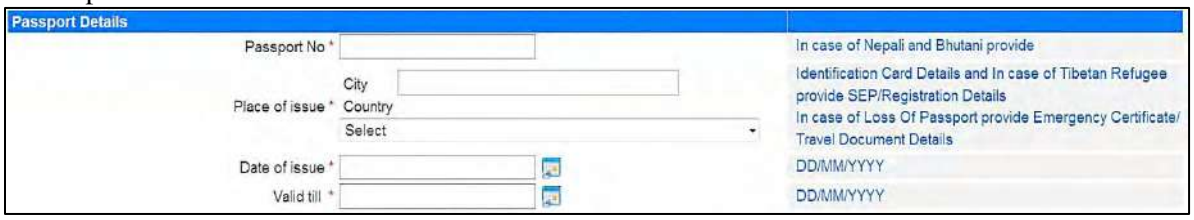
Fill Address in country where residing permanently (As per the passport), City (City where residing permanently), Country.



d) In Address/Reference in India section:

Fill Address/Reference in India, State, City/District, Pin Code.

e) In Passport Details section:



i. Fill Passport No. (In case of Nepali & Bhutani provide Identification Card Details and In case of Tibetan Refugee provide SEP/Registration Details. In case of Loss Of Passport provide Emergency Certificate/Travel Document Details)

ii. Place of issue City, Country

iii. Date of issue (DD/MM/YYYY)

iv. Valid till (DD/MM/YYYY)

FOREIGN NATIONALS REGISTRATION PROCEDURE		
Policy/Procedure Applies To	**Customer Care & Billing Executive**	**Policy/Procedure No: 16** **Page: 4 of 5**
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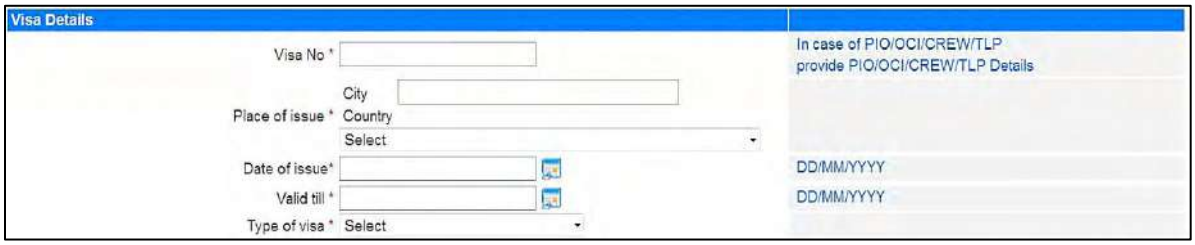
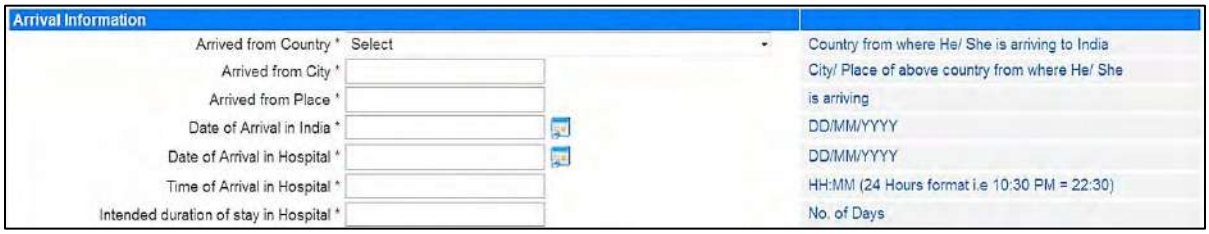
f) In Visa Details section:



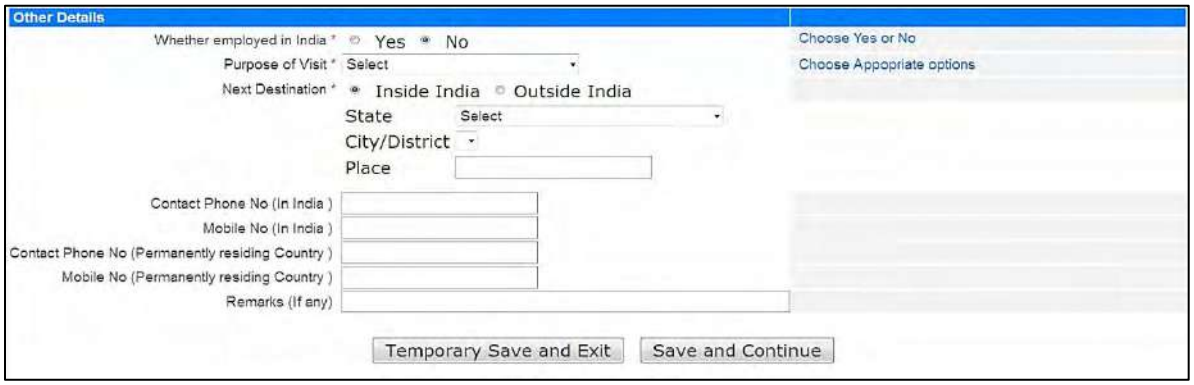
i. Fill Visa No. (In case of PIO/OCI/CREW/TLP, provide PIO/OCI/CREW/TLP Details)
ii. Place of issue City, Country
iii. Date of issue (DD/MM/YYYY), Valid till (DD/MM/YYYY)
iv. Type of Visa.

g) In Arrival Information section:



i. Fill Arrived from Country (Country from where He/ She is arriving to India)
ii. Arrived from City (City/ Place of above country from where He/ She has arrived)
iii. Arrived from Place (is arriving)
iv. Date of Arrival in India (DD/MM/YYYY)
v. Date of Arrival in Hospital (DD/MM/YYYY)
vi. Time of Arrival in Hospital [HH:MM (24 Hours format i.e. 10:30 PM = 22:30)]
vii. Intended duration of stay in Hospital (No. of Days).

h) In Other Details section:



i. Whether employed in India (choose Yes/No)
ii. Purpose of visit (Choose appropriate option)
iii. Next Destination (Inside/Outside India, State, City/District, Place)
iv. Contact Phone No (in India & permanently residing country)
v. Mobile No (in India & permanently residing country)
vi. Remarks (if any).

i) Your full information will be saved permanently and no further changes can be made, if you click Save and Continue button to Submit the form.

Partial information will be temporarily saved, if you click Temporary Save and Exit button.

You can continue entering the remaining information later using the Application ID.

If you click Logout or Exit without doing either of that, your information will be lost.

j) If you have already filled the form and if you want to view or print the form, please type your Application ID in the top right side column of the web page.

k) Keep record of original printed form, patient's Passport & Visa photocopies & other Hospital/Hotel/Residence photocopy of Form C (if any). These documents can be demanded by FRO department (if required).

3. The flow chart of Foreign Nationals Registration Procedure is attached as Annexure II to this policy.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

SAFE HANDLING AND PREPARATION OF CANCER CHEMOTHERAPY		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 16** **Page: 1 of 5**
Effective Date: 01 April, 2014		

SAFE HANDLING AND PREPARATION OF CANCER CHEMOTHERAPY

Parenteral antineoplastic and cytotoxic medications shall be prepared and disposed of according to recommended practices to protect staff and the environment. Antineoplastic agents shall be administered only by persons trained in the safe use of such agents. Chemotherapeutic waste shall be properly contained, labeled, transported, and disposed of, to reduce the risk of environmental or personal exposure. Chemotherapy shall only be prepared by Nurses with appropriate training on administration of cytotoxic / antineoplatics.

PURPOSE

1. To provide Nurses and Resident Medical Officer's (RMO's) with guidelines for the safe handling of cytotoxic drugs during preparation of chemotherapy.
2. To promote safety in handling parenteral antineoplastic and cytotoxic medications to reduce the risk of environmental or personal exposure to chemotherapeutic waste.

POLICY

1. The Chemotherapy Nurse (trained in chemotherapy administration) should administer chemotherapy and is accountable for all aspects of chemotherapy administration. The Nurse should be knowledgeable in the following:
   a. Appropriate chemotherapy dosage (following the Body Surface Area calculation of the doctor)
   b. Proper procedures for drug preparation and handling
   c. Alternate methods of drug delivery i.e. vascular access devices and ambulatory infusion pumps
   d. Precautions of chemotherapeutic administration, sensitivity reactions, contraindication and drug compatibility
   e. Chemotherapy extravasations management
   f. Chemotherapy spillage management
2. Chemotherapy is prepared in the Chemotherapy Preparation Area. Cytotoxic chemotherapy drugs are not prepared in patient care rooms or other areas outside the chemotherapy preparation area.
3. Each chemotherapy drug will be prepared with the proper diluent(s) for reconstitution and/or admixture, and given within the appropriate expiry date and time, as indicated in the Suggested Methods for Administration of Chemotherapy Drugs (refer to Annexure) or as per consultant order.
4. All cancer chemotherapy drugs used for treatment of cancer patients are prepared and dispensed by Resident Medical Officer or Staff Nurse optimizing safety, efficiency and economical use of chemotherapeutic agents.
5. Nursing staff with Chemotherapy Preparation Training satisfactorily demonstrate their knowledge of and adherence to all required procedures through a 'Cancer Chemotherapy Preparation' training program. Nurses are reassessed regularly.
6. All staff involved with handling cancer chemotherapy drugs regularly review Prime Surgical Centers policies and procedures for the safe handling of these agents.

SAFE HANDLING AND PREPARATION OF CANCER CHEMOTHERAPY		
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7. All chemotherapy drugs are ordered by a Consultant Oncologist. Any chemotherapy orders written by an Oncologist Specialist Doctor must be co-signed by the Consultant Oncologist. No verbal orders for chemotherapy should be given or taken. Chemotherapy orders should be written according to the following guidelines:
   a. The order should be written clearly and without abbreviations or acronyms except on protocol forms.
   b. Generic name of drugs shall be used.
   c. Any dose modification requires a new written order. The original order shall not be crossed out, erased or tampered with in any manner.
   d. The total dose should be indicated along with the administration route, IV fluids and amount and length of time of the injection or infusion.
   e. Multiday regimens should specify the dose per m^2 /day, dose per/day and number of days of therapy. This information should be followed by the diluents, route and length of time of the injection or infusion.
   f. The distinction should be clearly indicated if one drug in a combination is to be given for 1 day only.
8. The Staff Nurse / Resident Medical Officer verifies the medication order against the treatment protocol, the patient's medication administration sheet and the patient's file prior to dispensing cancer chemotherapy drugs.
9. The Staff Nurse prepares labels, using a standardized format as given below. The labels are verified by the Resident Medical Officer along with the Nurse prior to dispensing cancer chemotherapy drugs.

   Labeling
   a. MR number and Patient name
   b. Bottle or bag sequence name
   c. Name and amount of drug (s) added
   d. Name and amount of admixture solution
   e. Final total volume of admixture
   f. Prescribed flow rate (in milliliters per hour)
   g. Date and time of scheduled administration
   h. Date and time of preparation
   i. Expiration date
   j. Initials of person who prepared / checked IV admixture
10. The Resident Medical Officer / Staff Nurse perform an independent check of the final drug against the drug label and a copy of the verified consultant's order. The drug check is performed at the time the drug is prepared.

SAFE HANDLING AND PREPARATION OF CANCER CHEMOTHERAPY		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 16** **Page: 3 of 5**
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11. The Staff Nurse ensures the safe handling and distribution of cytotoxic drugs. The List of Hazardous Agents identifies those drugs which require safe handling precautions, and those for which precautions are not required, but may still be practiced. Cytotoxic agents are handled in a manner to ensure:
    a. The safety of personnel
    b. The accuracy and appropriateness of the drug and dose
    c. Protection of the patient regarding sterility of the parenteral agent
    d. Protection of the environment
    e. Minimization of exposure and undue hazards to others including nursing staff, housekeeping, allied health staff, visitors and patients.
12. Parenteral cancer chemotherapy drug admixtures are prepared in a Class II Biological Safety Cabinet (BSC) located in the Chemotherapy Preparation Area. The BSC meets current technical standards. Class II Type A cabinets are a minimum requirement and Class II Type B cabinets which are exhausted to the outside are used whenever feasible. The BSC should be equipped with a continuous monitoring device to allow confirmation of adequate airflow and cabinet performance.
    a. A horizontal laminar flow cabinet is not used to prepare cytotoxic chemotherapy.
    b. Due to the possibility of cross contamination, biologicals (e.g. BCG - Bacillus Calmette–Guérin) and cytotoxic drugs should not be prepared in the same BSC. If a biological agent is prepared in the same BSC used for cytotoxic drugs, there will be procedures for disinfection and decontamination of the BSC after each use of biologic agents are prepared in the BSC.
13. Parenteral cancer chemotherapy drugs are prepared using appropriate equipment to ensure product sterility and optimal protection for the health care worker.
    a. Sterile disposable equipment is used for all cancer chemotherapy drugs and doses.
    b. Luer-Lock devices are used, where available.
    c. If possible, closed system devices should be used for preparation and administration of cancer chemotherapy and other occupationally hazardous drugs.
14. Staff Nurse to follow best practice procedures, to ensure safety in the preparation and handling of cytotoxic agents.
    a. Protective equipment is used and protective clothing will be worn to prevent personnel exposure and to maintain product sterility.
    b. An eye wash station or wash basin is immediately accessible to the chemotherapy preparation area.
    c. Properly trained personnel dispose of cancer chemotherapy drugs and contaminated equipment.
    d. Employees who are pregnant, attempting to conceive or father a child, or are breast feeding may opt to be transferred to comparable duties, that do not involve handling cytotoxic drugs.
15. Cytotoxic preparation involves specific techniques to ensure the integrity of the product and personnel safety.
16. Personnel follow best practice procedures for the identification, containment, collection, segregated storage, and disposal or removal of cytotoxic waste materials. Cytotoxic drug waste is disposed of in accordance with the Waste Management policy of Prime Surgical Centers (refer to Hospital Infection Control Manual Policy and Procedure no. 29) for the handling of hazardous and toxic waste.

SAFE HANDLING AND PREPARATION OF CANCER CHEMOTHERAPY		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 16** **Page: 4 of 5**
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17. Properly trained personnel follow established policies and procedures immediately for spill management and clean up procedures. (Refer Exposure Control Manual Policy and Procedure no. 6)
    a. Spill kits, containing all materials and equipment necessary to clean a spill, are available and readily accessible at each area where hazardous drugs are handled.
    b. All individuals who routinely handle cytotoxic drugs are trained in proper spill management and cleanup procedures.
    c. The circumstances and handling of spills are documented and reported according to Prime Surgical Centers policies and procedures. (Refer to Nursing Manual Policy and Procedure no. 10)

PROCEDURE

Recommended practices for preparing and disposing of parenteral antineoplastic medications:

1. The Prime Surgical Centers administration shall ensure that nursing staff engaged in the preparation of parenteral antineoplastic and cytotoxic medications are properly trained and equipped to perform their duties.
2. Parenteral antineoplastic and cytotoxic agents shall only be prepared in a Class II Vertical Laminar Flow Hood or Biological Safety Cabinet.
    a. The Vertical Laminar Air Flow Hood or Biological Safety Cabinet surface shall be covered with plastic backed absorbent paper to reduce the dispersion of droplets and spills and to facilitate clean up.
    b. The plastic backed absorbent paper covering the Laminar Air Flow Hood or Biological Safety Cabinet shall be replaced after any overt spills.
    c. After completing the medication preparation, a disposable towel with seventy (70) percent alcohol shall be used to wipe down the interior of the Laminar Air Flow Hood or Biological Safety Cabinet.
3. Staff who prepare chemotherapeutics shall wear:
    a. Two pairs of non-powdered surgical gloves while preparing the medication. Fresh gloves shall be used when beginning any new task.
    b. A protective disposable surgical gown made of lint-free, low-permeability fabric with a solid front and long sleeves with tight-fitting elastic cuffs. Staff Nurse shall immediately replace overtly contaminated outer protective garments.
    c. A protective eye shield or splash goggles.
4. Have two Nurses or a Resident Medical Officer (RMO) and a Nurse double-check the preparation and administration of chemotherapy. If there is any doubt on the written order, the Nurse must verify with the Resident Medical Officer (RMO) or consultant who prescribed the chemotherapy.
5. If there is an order to infuse a different solution in combination with a drug, check with consultant to ensure compatibility.
6. Prior to chemotherapy administration, the Nurse must make sure that chemotherapy consent was signed and that the patient was well educated of the chemotherapy protocol to receive.
7. The Nurse must check the following parameters prior to chemotherapy administration. Routinely, the Nurse confirms that the patient's hemoglobin level, white blood cell count, absolute neutrophil/ granulocyte count (ANC/AGC), and platelet count are within acceptable ranges. (Certain chemotherapy

SAFE HANDLING AND PREPARATION OF CANCER CHEMOTHERAPY		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 16** **Page: 5 of 5**
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drugs require particular parameters e.g. doxorubicin requires Multiple Gated Acquisition (MUGA) scan or echocardiogram, liver function test should be evaluated before 5-flourouracil and renal function test before Cisplatin administration.)

8. Chemotherapy drugs are prepared by chemotherapy trained Nurse whose signature is affixed on the labeled container.
9. The Nurse administering the chemotherapy medication is to assure that the Seven Rights in medication administration is observed i.e. right patient, right medication, right dosage, right route, right time, right frequency and right education and documentation.
10. A Nurse who is pregnant or who is suspected pregnant and breastfeeding Nurses must not administer chemotherapy or care for a patient receiving chemotherapy. Nurses who are attempting pregnancy should minimize exposure to chemotherapy agents through use of appropriate protective equipment which should minimize, if not totally eliminate, potential risks.
11. Nurses are educated about chemical spillage management and disposal of contaminated materials including patient excreta. The Nurse administering chemotherapy is required to wear Personal Protective Equipment (PPE). Chemotherapy medications should not be left on patient's bedside.
12. An emergency chemotherapy spill kit to be readily available in the unit. (Refer Exposure Control Manual Policy and Procedure no. 6)
13. Complete blood count and urine analysis should be done annually on all employees who handle cytotoxic drugs. Any employee with abnormalities in the C.B.C should be referred to the consultant for evaluation.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer to Nursing Manual II Policy and Procedure No. 16)

SUGGESTED METHODS FOR ADMINISTRATION OF CHEMOTHERAPY DRUGS

Note:

1. The CADD (Continuous Ambulatory Drug Delivery) pump or any device approved by Prime Surgical Centers.
2. NS = Normal Saline
3. D5W = Dextrose 5% in water

DRUG	METHOD OF ADMINISTRATION
Aldesleukin (Interleukin – 2)	1. Each vial (1.3 mg) should be reconstituted with 1.2 ml of SWI. 2. During reconstitution, syringe and needle be directed at the side of the vial and the contents gently swirled to avoid excess foaming. Do not shake. 3. For IV administration, dilute further in 50 mL bag of D5W; infuse over 15 minutes. 4. Final concentration of drug should be 30 - 70µg/mL. 5. Drug delivery is more consistent when diluted in PVC container rather than non PVC container. 6. In-line filter should not be used when administering aldesleukin. 7. Do not freeze. Recommended premedication: 1. Antipyretics such as acetaminophen or NSAID's 2. Meperidine to control rigors 3. H2-blockers for GI irritation or bleeding 4. Antiemetics and anti-diarrheals should be given as indicated 5. Consider antibiotic prophylaxis in patients with indwelling intravenous lines
Altretamine	Oral
Amifostine	1. Mix in 100mL minibag; Infuse over 15 minutes. 2. Patient must be supine during infusion; measure blood pressure throughout infusion.
Amsacrine	1. Dilute only with supplied lactic acid diluent. 2. Dilute further with 500mL bag (5% Dextrose; <u>do not dilute</u> with Normal Saline); Infuse over 60-90 minutes. 3. Incompatible with any solution containing chloride ions. 4. For i.v. infusion only.
Anastrozole	Oral
Asparaginase	1. Reconstitute with Sterile Water for Injection – do not shake. 2. Given as an IM injection (preferred route). 3. If given intravenously then dilute further in 100mL minibag or slow push through side arm of free flowing IV (5% Dextrose, Normal Saline); Infuse over at least 30 minutes.

DRUG	METHOD OF ADMINISTRATION
BCG (Bacillus Calmette–Guérin)	1. Handle as infectious material - contains live mycobacteria. Check the expiry date of the product carefully. Note that if stored between 2 and 8° C a new expiry date of 6 months from the start of storage at this temperature supersedes the printed expiry date. 2. Reconstitute with sterile non-preserved diluent provided and dilute further to a total volume of 50mL with sterile saline. Use immediately after reconstitution. 3. Do not expose to direct sunlight and minimize exposure to any light. 4. For intravesical use only. Instillation into the bladder (through an indwelling catheter); held in the bladder for as long as possible up to 2 hours with frequent body positioning (to coat inner surface of bladder). 5. All urine voided for up to 6 hours after installation should be disinfected with hypochlorite solution.
Bicalutamide	Oral
Bleomycin	1. If the patient is known to have hypersensitivity to other drugs, the first dose may be preceded by 1mg test dose given in sidearm of running IV and 30 minutes observation for hypersensitivity. 2. Reconstitute in 1-5mls sterile water for injection. Bacteriostatic water for injection or normal saline for injection. 3. Full dose mixed in 50mL minibag (NS); Infuse over 10-15 minutes. 4. May be given by direct IV push over 5-10 minutes, followed by a Saline flush, if no IV line has been set up. 5. For intrapleural administration, infuse 50-100mls, via an indwelling thoracostomy tube after drainage. Frequent repositioning of patient. Drain after 4 hours.
Bortezomib	Administered as a **3- to 5-second** IV push followed by a standard saline flush; no central line is required.
Busereli	1. Nasal spray and subcutaneous injection. 2. Subcutaneous: rotate sites
Busulfan	Oral
Capecitabine	1. Oral 2. Clinical studies performed with capecitabine administered 30 minutes after food. Administering capecitabine on an empty stomach may result in slightly higher exposure and thus toxicity.
Carboplatin	1. Mix in 50mL to 250mL bag (D5W or NS); Infuse over 15 to 60 minutes. 2. Incompatible with sets, needles or syringes containing aluminum - leads to precipitation and loss of potency.
Carmustine (BCNU)	1. Reconstitute with the supplied diluent. 2. Mix in 250-500mL polyolefin bag/glass bottle (D5W, NS). Use non-PVC (poly-vinyl chloride) tubing. 3. Infuse over 60 minutes or longer (faster infusion, if tolerated). 4. Extra IV fluid (up to 750mL) may be run at same time by piggyback, to reduce vein irritation. 5. May be mixed in 500mL bag (NS) and infused through main IV line, with an additional 250 mL NS co-infused through a piggyback line (more IV fluid if ordered by Consultant). 6. Should be protected from light and must be refrigerated (2-8°C).

DRUG	METHOD OF ADMINISTRATION
Cisplatin **All Doses**	1. Ensure good urinary output during chemotherapy visit; Patient should void at least once during chemotherapy visit. 2. Blood pressure should be taken before and after chemotherapy. 3. Additional hydration may be ordered for hypovolemic patients. 4. Hydration and diuresis for patients with pre-existing renal, cardiac, or diabetic history at discretion of Consultant. 5. Oral hydration with 8 glasses of fluid per day (for 1-2 days) is strongly encouraged; if nausea and vomiting prevent oral hydration, the patient may need to return for more IV hydration.
Cisplatin **Doses <50mg/m²** (Sample Hydration Protocols)	1. Prehydration: a. 250mL NS; Infuse over 30 minutes, or b. 500mL NS over 60 minutes 2. Infusion: a. Infuse in 100-250mL bag (NS) over 15-60 minutes b. May add 10G Mannitol with Cisplatin 3. Post-hydration: a. 100-250mL NS, or b. 500mL NS with10Meq KCL
Cisplatin **Doses ³ 50mg/m²** (Sample Hydration Protocols)	1. Prehydration: a. 500-1000mL NS with 10 Meq KCL over 2 hours; b. May add 20-40mg of Furosemide or 10G Mannitol c. May add 20-40mg Furosemide 2. Infusion: a. in 250-500mL NS over 60 minutes b. Give 50G Mannitol (concurrently with Cisplatin or split with pre and post hydration) unless Furosemide given with prehydration. 3. Post-hydration: a. 1000mL NS with 20Meq KCL (2g Magnesium Sulfate may also be added) over 1 hour b. May give magnisium glucoheptonate (100mg/ml) 30ml PO QID x 4 days 4. For inpatient administration: May prehydrate with 1-2L (NS, 2/3:1/3) over 8-12 hours; post-hydrate with 1-1.5L of IV fluid
Chlorambucil	Oral
Cladribine	1. Continuous infusion; can be given by ambulatory infusion with CADD (Continuous Ambulatory Drug Delivery) pump – benzyl alcohol diluent should be used. 2. May mix in 250-500mL NS and administer over 2 hours each day. 3. Do not mix with D5W (results in increased degradation of cladribine). 4. Do not admix with other drugs. 5. Protect from light and store at 2-8°C.

DRUG	METHOD OF ADMINISTRATION
Cyclophosphamide	1. Smaller doses (<500mg) may be given by direct IV push, followed by a Normal Saline flush, if no IV line has been set up. 2. May mix doses < or = 1000mg in 50mL minibag (Normal Saline); Infuse over 10-15 minutes. 3. Doses >1000mg may be mixed in 100mL minibag Normal Saline; Infuse over 20-30 minutes. 4. Doses >2000mg may be mixed in 250mL bag (Normal Saline); Infuse over 20-30 minutes. 5. Larger doses of drug should be given with larger total fluid volumes to the patient; patients receiving doses >1000mg should receive at least 500-750mL total fluid, either as oral or IV hydration. 6. Oral hydration is strongly encouraged; for PO cyclophosphamide: 8-10 (8oz) glasses of fluid per day; for IV cyclophosphamide: 2-3 L of fluid/day; poorly hydrated patients may need more IV hydration. Inadequate total hydration may result in dose-related hemorrhagic cystitis. Patients should be encouraged to empty their bladder frequently to minimise dwell times. 7. Consider usage of mesna with very high dose therapy of cyclophosphamide (>1g/m²).
Cyclophosphamide Oral	Oral tablets should be administered as a single dose in the morning with or without food.
Cyproterone Injection	300 mg as intramuscular injection every week; in orchiectomized patients: 300 mg IM every 2 weeks.
Cytarabine	1. May be given as IM or SC injection. 2. Do not use benzyl alcohol diluent with high dose cytarabine. 3. May be mixed in 50-100mL minibag (Normal Saline); Infuse over approximately 15 minutes. 4. Larger doses may be mixed in 250mL bag (Normal Saline); Infuse over 15 minutes. 5. May be given by direct IV push, followed by a Normal Saline flush, if no IV line has been set up. 6. Continuous infusion using CADD infusion pump, or similar device; Infuse through central venous access device. 7. Incompatible with heparin, insulin, methotrexate, fluorouracil , penicillin and methyl-prednisolone .
Dacarbazine	1. May be given by slow infusion through sidearm of free-flowing IV (D5W, NS, or 2/3: 1/3). 2. May be mixed in 250-500mL bag (NS) and infused through main IV line or central venous access device, with an additional 250mL NS run at same time by piggyback, to reduce vein irritation (more IV fluid if ordered by physician). 3. Infuse over 30 to 120 minutes. 4. **Protect from light.**

DRUG	METHOD OF ADMINISTRATION
Dactinomycin	1. Slow push through sidearm of free flowing IV (5% Dextrose or Normal Saline). 2. May be mixed in 50 mL minibag (Normal Saline); Infuse over 10-15 minutes. 3. May be filtered out by in-line filters; do not use these filters. 4. Reconstitute dactinomycin by adding 1.1 mL of sterile water for injection (without preservative) using aseptic precautions. 5. Dactinomycin is extremely corrosive to soft tissue and precautions should be observed. 6. Protect from light
Daunorubicin	1. Slow push through sidearm of free flowing IV (D5W, NS or 2/3:1/3); Give 4mg (2mL) per minute. 2. May be mixed in 50mL minibag (D5W, NS); Infuse through sidearm of free flowing IV over 10-15 minutes. 3. Slow down injection rate if erythematous streaking occurs. 4. Do not use if solution turns blue or purple.
Dexamethasone Oral	Oral
Dexrazoxane	1. Should be reconstituted with the diluent provided, Sodium Lactate. 2. Should be given approximately 30 minutes before anthracycline administration. 3. May be given undiluted as an IV bolus or as a rapid IV drip infusion (from an empty viaflex PVC bag) or may be given diluted in 50-100mL NS or D5W, infused over 15 minutes. 4. The diluted solution is only stable for 6 hours in room temperature.
Diethylstilbestrol	1. Oral 2. IV Infusion in 250-500mL (D5W or NS) slowly (1-2mL/min) for first 10-15 minutes then remainder over 1 hour.
Docetaxel	1. ALWAYS premedicate with Dexamethasone. 2. Mix in 250mL D5W or NS to a maximum concentration of 0.3-0.9mg/mL; Infuse through main IV line over 1 hour. 3. Use **non-PVC** equipment. 4. To minimize hypersensitivity reactions, docetaxel infusion should be started at a slow rate, then increased incrementally to planned rate e.g. infuse at an 8 hourly rate for 5minutes, then at a 4 hourly rate for 5 minutes , then at a 2 hourly rate for 5 minutes, then finally, resume at the 1 hourly infusion rate.

DRUG	METHOD OF ADMINISTRATION
Doxorubicin	1. Slow push through sidearm of free flowing IV (0.9% Sodium Chloride Injection or 5% Dextrose); Give 2 to 4mg (1-2mL) per minute. 2. Doses < or = 100mg may be mixed in 50mL minibag (D5W), doses >100mg may be mixed in 100mL minibag (D5W); Infuse through sidearm of free flowing IV over 10-30 minutes. 3. Do not admix with other drugs unless data are available; precipitates with fluorouracil and heparin. 4. Slow down injection rate if erythematous streaking occurs. 5. If any signs or symptoms of extravasation occur, the injection or infusion should be immediately terminated and restarted in another vein. 6. Protect from light.
Doxorubicin & Vincristne Infusion Admixture	1. May be diluted in NS for continuous infusion via central venous access device over 24hr ;Continuous infusion using an ambulatory infusion pump for periods over 1 day via central venous access device 2. Stable at room temperature for 7 days in NS at concentrations: doxorubicin 1.4 to 2.37 mg/ml and vincristine 0.033 to 0.05 mg/ml
Doxorubicin Liposomal	1. For dose < 90mg, dilute drug in 250mL D5W 2. For dose = 90mg, dilute drug in 500mL D5W 3. To minimize the risk of infusion reactions, the initial dose is administered at a rate no greater than 1 mg/minute. If no infusion reaction is observed, subsequent infusions may be administered over a 60-minute and 30-minutes period for ovarian cancer patients and Kaposi's sarcoma patients, respectively. 4. Avoid Extravasation 5. Do not administer as a bolus injection or undiluted solution 6. Liposomal doxorubicin must not be given by the intramuscular or subcutaneous route.
Epirubicin	1. Slow push through sidearm of free flowing IV (D5W, NS); Give 10mg(5mL) per minute. 2. Doses < or = 100mg may be mixed in 50mL minibag (D5W), doses >100mg may be mixed in 100mL minibag (D5W); Infuse through sidearm of free flowing IV over 10-20 minutes. 3. Do not admix with other drugs. 4. Protect from light.
Erlotinib	1. Oral 2. Should be administered at least one hour before or two hours after meal.
Estramustine	1. Oral 2. Capsules should be taken on an empty stomach (1 hour before or 2 hours after a meal). 3. Must not be taken with milk, milk products or drugs that contain calcium, magnesium or other polyvalent ions which may impair the absorption of estramustine.

DRUG	METHOD OF ADMINISTRATION
Etoposide	1. Maximum diluted concentration of 0.4 mg/mL 2. All premixed bag(s) should be attached to (0.22 micron) in-line filter. 3. Precipitation is unpredictable, depending on concentration, time after dilution, presence of crystallization nuclei, agitation, contact with incompatible surfaces and other factors. 4. Monitor solutions for precipitation before and during administration. 5. Dilute doses < or = 100 mg in 250 mL NS or D5W, doses >100 mg to < or = 200 mg in 500 mL, and doses >200 mg in 1000 mL 6. Larger volumes may be used for prehydration for Cisplatin or Ifosfamide dose. 7. Infuse over 30 to 60 minutes; Adjust rate if blood pressure drops. Etoposide should not be given by rapid i.v. injection. 8. May observe patient for 30 minutes after dose, to watch for hypotension.
Etoposide Oral	1. Oral 2. Capsules should be taken on empty stomach.
Exemestane	Oral
Fludarabine	1. Oral. Tablets should not be broken, crushed or chewed. 2. Intravenous: Mix in 50mL minibag (Normal Saline); Give over 15-30 minutes. Do not admix with other drugs.
Fluorouracil	1. Slow push through sidearm of free flowing IV (D5W, NS). 2. May be given by direct IV push, followed by a NS flush, if no IV line has been set up. 3. May be mixed in 50ml minibag (NS or D5W); infuse over 15 min.
Fluorouracil Infusion	1. Continuous infusion using CADD infusion pump, or similar device. 2. Infuse through central venous access device, if available 3. Infuse through patent peripheral venous catheter, if infusion for only 3-5 days; Inspect peripheral infusion sites daily and replace if evidence of irritation or extravasation. 4. Protect from light. 5. Incompatible with doxorubicin, epirubicin, diazepam, methotrexate and cytarabine; line must be flushed prior to administration of these agents.
Fluoxymesterone	Oral
Flutamide	Oral
Fulvestrant	Intramuscular injection
Gefitinib	1. Oral 2. May be administered with or without food.

DRUG	METHOD OF ADMINISTRATION
Gemcitabine	1. Mix drug in 250mL (NS); Infuse over 30 minutes through free-flowing IV. 2. May further dilute with normal saline to concentrations as low as 0.1mg/mL. 3. Stability data done by Trissel et al. has shown that the reconstituted solution is stable for 35 days at room temperature, but may crystallize upon refrigeration. 4. Diluted solution at concentrations of 0.1 to 10mg/mL in D5W or NS is stable for 35 days at room temperature or refrigerated temperature.
Gleevec	1. Oral, once daily with a meal and a large glass of water to reduce gastric irritation. 2. Total daily doses of 800mg should be given as 400mg twice daily.
Goserelin	Subcutaneous injection.
Hydrocortisone	Oral
Hydroxyurea	Oral
Idarubicin	1. Intravenous: a. Slow push through sidearm of free flowing IV (D5W, NS); Give over 10-15 minutes. b. Doses may be mixed in 50mL minibag (D5W); Infuse through sidearm of free flowing IV over 10-20 minutes. c. Slow down injection rate if erythematous streaking occurs. d. When admixed with heparin, precipitation may occur. 2. Oral: a. Oral b. Available as 5, 10 and 25 mg capsules. c. Swallow whole with water; should not be chewed. d. May be taken with or without food.
Ifosfamide	1. Bolus dose of Mesna before Ifosfamide infusion; Mesna admixed in Ifosfamide solution; followed by 2 doses of Mesna by IV bolus or PO, see Mesna. 2. May mix doses < or = 2000mg in 100mL bag (NS); Infuse over 30-60 minutes. 3. May mix doses >2000mg in 500-1000mL bag (NS); Infuse over 2-4hours. 4. May be admixed with Mesna solution, when Mesna given by an infusion started before Ifosfamide. 5. Oral hydration is strongly encouraged; poorly hydrated patients may need more IV hydration. 6. Inadequate total hydration may result in dose-related hemorrhagic cystitis.
Ifosfamide and Mesna Infusion Admixture	May be diluted in larger volumes for continuous infusion over 6-24 hours; May be infused using a CADD ambulatory infusion pump over longer periods.

DRUG	METHOD OF ADMINISTRATION
Interferon Alfa	1. Subcutaneous. 2. For IV administration mix in 100mL bag of NS; Infuse over 30 minutes. 3. May give acetaminophen 500mg-1000mg 30min prior administration to alleviate Flu-like symptoms. 4. Avoid IM use with thrombocytopenia.
Irinotecan	1. Mix in 500mL bag (D5W); Infuse over 90 minutes. 2. Do not refrigerate admixtures in NS (may result in precipitation). 3. Refrigerated admixtures in D5W, when protected from light, are stable up to 48 hours. 4. Freezing irinotecan and admixtures of irinotecan may result in precipitation of the drug and should be avoided. 5. Do not admix with other drugs. 6. Protect from light.
Letrozole	Oral
Leucovorin	1. Doses < or = to100mg may be given by IV push through sidearm of free flowing IV (5% Dextrose, Normal Saline), the injection must not exceed 160mg/min of leucovorin (due to calcium content). 2. May be mixed in 50mL minibag (doses >100mg) or 100mL minibag (doses >500mg) or in 100mL fluid in graduated administration set (5% Dextrose, Normal Saline); Give over 15 minutes. 3. Continuous infusion using CADD pump or similar device. 4. Cryodesiccated powder reconstituted with Bacteriostatic Water for Injection containing benzyl alcohol should only be used at doses below 10 mg/m^2 5. Leucovorin should not be mixed in the same infusion as 5-fluorouracil as a precipitate may form.
Leuprolide	1. Intramuscular injection. 2. Vary injection site. 3. Dilute with supplied diluent. 4. Use within 24 hours.
Levamisole	Oral
Liposomal Daunorubicin	Mix in 100mL empty minibag with D5W in a 1:1 ratio with the volume of the drug dose; infuse over 1 hour.
Lomustine	Oral

DRUG	METHOD OF ADMINISTRATION
Liposomal Doxorubicin	1. For dose < 90mg, dilute drug in 250mL D5W. 2. For dose = 90mg, dilute drug in 500mL D5W. 3. To minimize the risk of infusion reactions, the initial dose is administered at a rate no greater than 1 mg/minute. If no infusion reaction is observed, subsequent infusions may be administered over a 60-minute and 30-minutes period for ovarian cancer patients and Kaposi's sarcoma patients, respectively. 4. Avoid Extravasation. 5. Do not administer as a bolus injection or undiluted solution. 6. Liposomal doxorubicin must not be given by the intramuscular or subcutaneous route.
Mechlorethamine	1. Solution should be prepared immediately prior to administration. 2. Slow push through sidearm of free flowing IV (NS); Give 1mg/1mL per minute.
Medroxyprogres-terone	1. Oral 2. Intramuscular injections 3. Medroxyprogesterone is not for IV use.
Megestrol	Oral
Melphalan Oral	1. Oral 2. Take on an empty stomach.
Melphalan	1. Slow push through sidearm of free flowing IV (NS). 2. May mix in 100mL bag (NS); Infuse over 15-30 minutes. 3. Perfusion duration should not exceed 1 hour. 4. Should be administered within 50 minutes of reconstitution. Reconstituted product is stable for 2 hours at 30°C. Precipitate forms if refrigerated.
Mercaptopurine	Oral
Mesna	1. May be diluted in 50-100mL of diluent and given over a few minutes. 2. May be diluted in larger volumes for continuous infusion over 6-24 hours; May be infused using a CADD ambulatory infusion pump over longer periods. 3. May be given as IV push through side arm of free-flowing IV. 4. May be infused concurrently with Ifosfamide. 5. Incompatible in solution with cisplatin. 6. IV solution may be given PO; may be mixed with juice, or milk to mask unpleasant taste.
Mithramycin	Slow push through sidearm of free flowing IV (NS)
Mitomycin	1. Slow push through sidearm of free flowing IV (NS); Give 1.5mg/3mL per minute. 2. Doses may be mixed in 50mL minibag (NS); Infuse through sidearm of free flowing IV over 10-30 minutes.

DRUG	METHOD OF ADMINISTRATION
Methotrexate	1. Preserved formulation contains benzyl alcohol and should not be used for intrathecal intraventricular or high dose treatment. 2. Do not admix with araC, 5FU, prednisolone, KCI or other drugs unless compatibility are available. 3. Slow push through sidearm of free flowing IV (D5W, NS). 4. May be given by IM or direct IV push, followed by a NS IV flush, if no IV line has been set up. 5. Doses from >100mg may be mixed in 50-100mL minibag (NS); Infuse over 30-60 minutes. 6. Doses from 250-500mg may be mixed in 500mL bag (NS); Infuse over 1-2 hours. 7. Doses from >500mg may be mixed in 1000mL bag (NS); Infuse over 2-4 hours. 8. May be given as Intrathecal injection; use unpreserved solution or mix in unpreserved diluent using strict aseptic technique.
Methotrexate (High-Dose >1g/m²)	Alkalinize and hydration: example: 1. Hydrate with NS at 100-125mL/hour, starting 6 to 12 hours before Methotrexate; measure urine output (>60 mL/hour). 2. Alkalinize urine, starting 6-12 hours before Methotrexate, with Sodium Bicarbonate 50mmol in alternating litres of IV hydration fluid (or in each litre); maintain urine pH > 7.0 (may also give Sodium Bicarbonate 100mg/m² PO q6h). 3. Continue hydration and alkalinization for 24 hours after completion of Methotrexate infusion. 4. Leucovorin rescue to start 24 hours after Methotrexate dosing finished; continue until serum levels drop below toxic range (<0.05µmol/L).
Methotrexate Oral	Oral
Mitotane	1. Oral 2. Should not be taken with a fatty meal. 3. Consider steroid replacement.
Mitoxantrone	1. Doses may be mixed in 100mL minibag (NS); Infuse through sidearm of free flowing IV over 10-15 minutes. 2. Slow push through sidearm of free flowing IV; Give 4mg/2mL per minute. 3. Mitoxantrone should not be mixed in the same infusion with heparin since a precipitate may form. 4. Do not admix with other drugs. 5. Do not freeze.
Nilutamide	Oral

DRUG	METHOD OF ADMINISTRATION
Octreotide	1. Sandostatin: subcutaneous 2. Sandostatin LAR (long acting): may only be administered by deep intragluteal injection. 3. Patients switching over to the long-acting injection may need to continue to receive SC (subcutaneous) octreotide for approximately 2 weeks, and some individuals may need additional rescue SC octreotide for up to 2 to 3 months because of the time required to reach steady state octreotide levels as the drug is slowlu released from the microspheres. 4. Protect ampoules and vials from light.
Oxaliplatin	1. May be mixed in 250-500 mL bag (D5W only - not NS or alkaline solutions, and should not be mixed with fluorouracil) and given by slow infusion. 2. Infuse over 120 minutes (2 hours) . Increasing infusion time to 360 minutes (6 hours) may decrease acute toxicity such as pharyngolaryngeal dysesthesia. 3. Infusion may be given at the same time as Leucovorin in separate bags using a Y-site (not in the same bag). May not be administered with fluorouracil.
Paclitaxel	1. Use non-PVC equipment, including 0.22 micron in-line filter; Infuse over 3 hours. 2. Prefilled in 500-1000mL bag (Normal Saline or 5% Dextrose-dilution concentration 0.3-1.2 mg/mL). 3. May be given as 24 hour infusion-mix in 1000mL bag and use non-PVC equipment and in-line filter; given as inpatient or using CADD pump.
Pemetrexed	Mix drug in 100mL (NS); infuse over 10 minutes through free flowing IV.
Porfimer	1. Direct intravenous: preferred route, over 3-5 minutes 40-50 hours prior to laser light delivery. Reconstitute powder with D5W to a final concentration of 2.5 mg/mL. **Do not** reconstitute with **normal saline** solutions since this will result in precipitation. 2. Refer to package insert for details regarding photo activation.
Prednisone	Oral
Procarbazine	Oral
Raltitrexed	1. Mix drug in 100mL (NS, D5W); Infues over 15 minutes. 2. Do not admix with other drugs.

DRUG	METHOD OF ADMINISTRATION
Rituxan	1. Rituximab infusions should be administered in a setting where the emergency cart is immediately available, and under the close supervision of someone experienced and capable of dealing with severe infusion-related reactions. 2. DO NOT administer as an **I.V. push or bolus**. 3. Do not admix with other drugs. 4. Administer rituximab through a dedicated line. Infusion rates: 1. First infusion: initial rate of 50 mg/h, then escalate rate in 50 mg/h increments every 30 minutes, to a maximum of 400 mg/h. 2. Subsequent infusions: initial rate of 100 mg/h, then escalate rate in 100 mg/h increments every 30 minutes, to a maximum of 400 mg/h as tolerated. 3. Consider a slower infusion rate for patients with high bulk disease who are at a higher risk of tumour lysis syndrome and infusion related reactions.
Streptozocin	1. Mix in 100-250 mL bag (NS or D5W); Infuse over 30 to 60 minutes. 2. Dilute drug volume to 50mL with NS; infuse over 10-15 minutes through rapid free-flowing IV. 3. Incompatible with allopurinol, aztreonam or piperacillin / tazobactam.
Tamoxifen	Oral
Temozolomide	1. Oral 2. Temozolomide should be administered in the fasting state, at least one hour before a meal. Capsules must not be opened or chewed, but are to be swallowed whole with a glass of water. 3. If vomiting occurs after the dose is administered, a second dose should not be administered.
Teniposide	1. May mix in 250mL bag (doses < or = 100mg) or 500mL bag (doses>100mg) (NS); Infuse over 1-2 hours (adjust infusion time for blood pressure response) 2. Use non-DEHP (Di-2-Ethylhexyl Phthalate) container and administration sets. 3. To avoid the possibility of hypotensive reactions, teniposide should not be administered by bolus injection or rapid infusion. 4. Care should be taken to ensure that teniposide infusions are given IV with indwelling catheter in proper position prior to infusion as extravasation, necrosis and/or thrombophlebitis may result with improper administration.
Thalidomide	1. Oral 2. Contents of capsules can be mixed with semi-solid food, but must be ingested immediately. 3. Thalidomide should be administered at bedtime to minimize adverse effects such as dizziness and somnolence.
Thioguanine	Oral

DRUG	METHOD OF ADMINISTRATION
Thiotepa	1. Solutions should be filtered through a 0.22 micron filter prior to administration. Filtering does not alter potency. Solution that remains **opaque or precipitate** after filtration **should not be used**. 2. Push through sidearm of free flowing IV (NS, D5W). 3. May mix in 50mL minibag (NS, D5W); Infuse over 15 minutes.
Topotecan	1. Mix in 50mL-100mL minibag, (NS or D5W); Infuse over 30 minutes. 2. Final concentration should be 20mcg-500mcg/mL. 3. Use immediately after reconstitution or store in a refrigerator for up to 24 hours.
Trastuzumab	1. Mix in 250 mL bag NS; **Do not use D5W. Do not shake.** 2. May be infused over 90 minutes as loading dose or over 30 minutes as maintenance dose or 90 minutes as maintenance dose 3. **DO NOT ADMINISTER AS AN IV PUSH OR BOLUS.** 4. Should not be mixed or diluted with other drugs. 5. Herceptin infusions should not be administered or mixed with Dextrose solutions. 6. Do not freeze the reconstituted solution.
Tretinoin	1. Oral 2. Should be administered with food.
Vinblastine	1. Quick push through sidearm of free flowing IV (D5W, NS); Inject over 1 minute. Do not admix with solutions that will change pH (lactate containing solutions). 2. May mix in 50mL minibag (NS or D5W); Infuse over 20-30 minutes.
Vincristine	1. Push through sidearm of free flowing IV (D5W, NS); Inject over at least 1 minute. 2. May be given by direct IV push, followed by a NS flush, if no IV line has been set up. 3. May limit dose to 2mg for selected regimens. 4. May mix in 50mL minibag (NS or D5W); Infuse over 15 minutes.
Vinorelbine	1. Mix in 50mL minibag (D5W, NS) to a final concentration 0.5-2mg/mL; Infuse over 6-10 minutes through free-flowing IV. 2. May push (at final concentration of 1.5 - 3mg/ml) through sidearm of free flowing IV (NS); Inject over 6-10 minutes. 3. After administration is completed, flush IV line with 200 to 300ml NS or D5W. 4. Vinorelbine should be administered only via the IV route.
Zoledronic Acid	1. Must not be mixed with calcium containing solutions. 2. Mix in 100mL solution (D5W or NS) and infuse over 15 minutes. 3. Should be administered as a single intravenous solution in a line separate from all other drugs. 4. Dehydrated patients must be adequately rehydrated prior to treatment with zoledromic acid.

Note: These methods are suggested chemotherapy administration, follow individual Consultant for their preference.

ANNEXURE I
(Refer Customer Care and Billing Manual Policy and Procedure No. 16)

ONLINE FORM C

ARRIVAL REPORT OF FOREIGNER IN HOSPITAL

Personal Details:

Photo: (Take/Scan Photograph and upload the same. Size should be < 50 KB)

Surname:_____

Given Name:_____

Sex: Male/Female/Transgender Date of Birth: _____

Special Category: PIO/OCI/Loss of Passport/Newly Born/Refugee/Emergency Transit/OTHERS

Nationality: _____

Note: In case of Nepali and Bhutani provide, Identification Card Details and In case of Tibetan Refugee, provide SEP/Registration Details. In case of Loss Of Passport provide Emergency Certificate/Travel Document Details.

Address in Country where Residing Permanently:

_____

City:_____ Country:_____

Contact Phone No. (Permanently Residing Country):_____

Mobile No. (Permanently Residing Country): _____

Address/Reference in India:

Full Name:_____

Address:_____

State:_____ City:_____ Pin Code:_____

Contact Phone No. (in India):_____

Mobile No.(in India):_____

Passport Details:

Passport No:_____

Place of Issue: City:_____ Country:_____

Date of Issue:_____ Vaild Till:_____

Visa Details

Visa No:_____

Place of Issue: City:_____ Country:_____

Date of Issue:_____ Vaild Till:_____

Type of Visa: Business/Tourist etc. _____

Note: In case of PIO/OCI/CREW/TLP, provide PIO/OCI/CREW/TLP Details

Arrival Information

Arrived from Country:_____ Arrived from City:_____

Arrived from Place:_____ Date of Arrival in India:_____

Date of Arrival in Hotel/Residence: _____

Time of Arrival in Hotel/Residence: _____(HH:MM)

Intended Duration of Stay in Hotel/Residence:_____ (No. of Days)

Other Details

Whether employed in India: Yes/No

(If Yes) Office Name: _____

Address: _____

Purpose of Visit:_____

Next Destination**: Inside India**: Place:_____

State:_____ City/District:_____

OR

Outside India: Place:_____

Country: _____ City:_____

Remarks (If any):_____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

CARDIOPULMONARY RESUSCITATION: DEFIBRILLATOR TEST		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 16** **Page: 1 of 2**
Effective Date: 11 April, 2013		

CARDIOPULMONARY RESUSCITATION: DEFIBRILLATOR TEST

PURPOSE

To determine and document every week that the defibrillator is functioning properly.

SCOPE

Staff Nurse assigned to run check every week.

POLICY

The defibrillator will be tested on the Defibrillator Test Load every week. A log will be maintained to document the proper function with time, date and signature of the Nurse who conducts the test (Refer Annexure to this policy). If the unit indicates improper function, request the concerned vendor for maintenance/repairs through Nursing Superintendent and Executive facility.

PROCEDURE

Every Week

Test every shock delivery method that is used with your HeartStart XL. To perform the Weekly Check:

1. If you are using **external paddles**, make sure the paddles and paddle tray are thoroughly clean, there is no debris or residue (including all conductive material) on the electrode surfaces of the paddles and tray, and paddles are fully seated in their holders.
2. If you are using **multifunction electrode pads**, attach a 50 ohm test load to the end of the pads patient cable. **The Pacing function can *only* be tested when using the patient (hands free) cable for external pads.**
3. Turn the HeartStart XL off.
4. Unplug the AC power cord.
5. While pressing (Strip), turn the Energy Select knob to **Manual On** or **AED On** to start the test.
6. Follow the prompts on the display to proceed with the check.
7. After the XL has completed printing out the weekly check results, turn off the device and reconnect it to AC power.

To verify performance of either **switched or switchless internal paddles**:

1. Use the sterile defibrillator paddle test device to perform this test.
2. Connect the internal paddles to the defibrillator.
3. Turn the Energy Select knob to Manual and select 2 Joules.
4. Place the paddles on the test device.
5. Press **CHARGE**.

CARDIOPULMONARY RESUSCITATION: DEFIBRILLATOR TEST		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 16** **Page: 2 of 2**
Effective Date: 11 April, 2013		

6. Press the Shock button on the right handle (switched paddles) or on the defibrillator (switchless paddles).
7. Verify the measurement or indicator on the test device.
8. Follow the test device requirements for completion of the test.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

COMPRESSOR MAINTENANCE SCHEDULE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 16** **Page: 1 of 2**
Effective Date: 11 April, 2013		

ANEST IWATA COMPRESSOR MAINTENANCE SCHEDULE

Sr. No.	**Inspection Item**	**× Weekly ×× Monthly ××× Yearly**	**Remarks**
1	Drain Air Receiver	×	During Operation
2	Check safety Valve operation	×	Lift its stem at about max. pressure & check that it blows off.
3	Abnormal vibration or sound	×	Check compressor floor level, If still abnormal do maintenance.
4	Looseness of bolts, nuts or screws	××	Tighten by proper tool
5	Belt tension & damage	××	Remove belt guard & check. **Check the belt tension** Push center of span softly & adjust so that belt is deflated about 15 mm. If loose, slide motor and adjust. If belt is worn out, or damaged, replace.
6	Air Intake filter	××	Remove dirt by blowing air. If too dirty replace filter element.
7	Compressor air leaks	×××	Leave it max. pressure for 30 minutes. Check if pressure drop is within 15% from max. Pressure. If it is more than 15% inspect & repair.
8	Breather filter	×××	

Weekly Maintenance schedule record

Week no.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
Schedule date/ mait.date													
Week No.	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**
Schedule date/ mait.date													
Week No.	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**
Schedule date/ mait.date													
Week No.	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**	**50**	**51**	**52**
Schedule date/ mait.date													

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

PURCHASE AND MAINTENANCE MANUAL

COMPRESSOR MAINTENANCE SCHEDULE		
Policy/Procedure Applies To	**Executive Facility**	**Policy/Procedure No: 16** **Page: 2 of 2**
Effective Date: 11 April, 2013		

Monthly Maintenance schedule record

Week no.	**1**	**5**	**9**	**13**	**17**	**21**	**25**	**29**	**33**	**37**	**41**	**45**	**49**
Schedule date/ mait.date													

Quarterly Maintenance schedule record

Week no.	**13**	**25**	**37**	**49**
Schedule date/ mait.date				

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

EXPOSURE CONTROL PLAN MANUAL

EMPLOYEE TRAINING		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No:16 Page: 1 of 2**
Effective Date: 11 April, 2013		

EMPLOYEE TRAINING

BASIS OF TRAINING PROGRAM

The Prime Surgical Centers will provide all employees at risk for occupational exposure with a training program, at no cost to the employee and during working hours.

1. Training will be conducted as follows:
   a. At the time of initial employment
   b. On an annual basis thereafter
2. Employees who have received previous training on blood borne pathogen information need to be updated on new information included in this standard.
3. Additional training will be provided when changes involving a modification of tasks or procedures affect the employee's occupational exposure.
4. Materials appropriate in content and vocabulary to the educational level, literacy and language of employees will be used.
5. The person conducting the training will be knowledgeable in the subject matter outlined in the elements of the training program and to any additional training needs identified by the surgical center.

COMPONENTS OF THE TRAINING PROGRAM

A comprehensive training program conducted by a knowledgeable person in the subject matter as it relates to the workplace, will contain the following components:

1. Copy/explanation of the Blood borne Pathogen Standard
2. General explanation of epidemiology and symptoms of blood borne diseases
3. Modes of transmission of blood borne pathogens C
4. Copy/explanation of the Prime Surgical Centers Exposure Control Plan
5. Methods for recognizing tasks and other activities that may involve exposure to blood or other potentially infectious materials
6. Effective methods (and their limitations) to reduce exposure, including appropriate engineering controls, work practices, and personal protective equipment
7. Information on types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment
8. Explanation of basis for selection of personal protective equipment
9. Information on the hepatitis B vaccine including:
   a. Efficacy
   b. Safety
   c. Method of administration
   d. Benefits with vaccination
   e. Acknowledgement of free vaccination
10. Emergency procedures and notifications involving blood or other potentially infectious materials (e.g., large spills of potentially infectious material)
11. Explanation of the Prime Surgical Centers exposure incident reporting protocol and medical follow-up available

EMPLOYEE TRAINING		
Policy/Procedure Applies To	**All staff involved in Patient care**	**Policy/Procedure No:16 Page: 2 of 2**
Effective Date: 11 April, 2013		

12. Post-exposure evaluation and follow-up subsequent to an exposure incident.
13. Explanation of labels system in place
14. Opportunity for question and answer session

ANNUAL EVALUATION

The Exposure Control Plan will be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure. The review and update of such plans will reflect changes in technology that eliminate or reduce exposure to blood borne pathogens and document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.

Nursing Superintendent shall obtain inputs from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and shall document the inputs in the Exposure Control Plan.

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Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

SAFETY MANUAL

FIRE DRILL		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 16** **Page: 1 of 3**
Effective Date: 11 April, 2013		

FIRE DRILL

POLICY

A fire drill will be held quarterly (every three months) by Executive Facility and there shall be written documentation that the fire drill was held and who participated. The simulated location of the fire drill will be changed to practice procedures for all contingencies. All employees will be aware of their responsibilities during a fire emergency and will be aware of the locations of fire extinguishers and how the fire alarm system functions.

PROCEDURE

1. **Initial actions in the Fire Area**

   In the event of a fire, the acronym **RACE** will be used to implement procedures.

   a. Rescue or remove all patients in immediate danger.

   b. Activate the fire alarm if not automatically initiated while directing someone to alert others by sending Code F SMS and the location of the fire. The Customer Care Executives/Duty Doctor will call the Fire Department on Tele No. 020 25468373/101 when the code F is initiated.

   c. Contain the fire by closing all doors to isolate the fire area. Clear all corridors of carts and equipment. Roll carts to any nearby room so that evacuation, if necessary will not be impeded.

      ***Note** - Medical gas is to be turned off only upon approval of the Anaesthesiologist or upon request of the responding fire department.

   d. Extinguish the fire by using fire extinguisher, if the fire is small.

2. **Removing patients**

   The fire department will give the orders for a total building evacuation should it become necessary. Staff in the various areas will make a systematic search of all rooms to ensure all are evacuated from the facility. The following steps are to be taken if total building evacuation is necessary:

   a. Patients nearest to the fire area are to be evacuated first through the nearest exit. Patients will be ambulated to the outdoors via the nearest and safest escape route. Those patients who must be evacuated by wheelchair or stretcher will be evacuated through entrances with sidewalks to the parking area.

   b. Ambulatory patients and visitors will be expected to remove themselves from the center with directions from employees.

RESPONSIBILITIES

3. **Duties of the Non-nursing personnel**

   a. Alert all employees again of the fire by using the intercom system.

   b. Return all records to the storage cabinet and secure.

   c. File all computer data, store any disks in the fireproof cabinets (if available), then close the cabinet. Secure all medical records in their fire proof cabinet.

FIRE DRILL		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 16** **Page: 2 of 3**
Effective Date: 11 April, 2013		

4. **Duties of the nursing personnel if fire is not in your area.**
   a. **Remain calm and help others.**
   b. In assigned area, close all doors and shut off all oxygen and nitrous oxide valves in the area. (If in the operating room, check with Anaesthesiologist before shutting off gas valves)
   c. Assure that all corridors and exits are cleared of possible obstructions.
   d. Turn off electrical equipment that is not absolutely needed.
5. **Nursing Superintendent's responsibility**
   a. Assist in moving all patients from the area of danger and out of the center if necessary.
   a. Verify all patients, visitors and employees are accounted for.
   b. Assist the Fire Department as necessary.
   c. Give the order for all clear when verified by the Fire Department. Reset the fire alarm system.

FIRE DRILLS

1. A test of the fire plan will be held at least once each quarter (every three months). Drills are intended to put into practice the actions that one would take in an actual fire and refine and improve them. All staff will participate during fire drills.
2. Records of the drills and employee response will be maintained by Executive Facility. Deficiencies discovered during drills will be discussed at the next staff meeting. Minutes of the meeting will be disseminated to all employees.

SPECIFIC FIRE INFORMATION

1. Fire Types: How to distinguish one type of fire from another. The following are the three basic types of fires:
   a. Class A: Fire that consists of ordinary combustible materials such as paper, wood, cloth, etc.
   b. Class B: Fires that consist of flammable liquids, oil, grease, oil base paints and flammable gases. The flashpoint is the lowest temperature at which a liquid forms a vapor that can be ignited.
   c. Class C: Fires that involve energized electrical equipment.
2. Fire Extinguishers
   a. Using the Appropriate Fire Extinguisher. There is one type of fire extinguisher within the facility, an ABC, or dry chemical extinguisher.
   b. Operating an Extinguisher. Utilize the acronym PASS to operate a fire extinguisher.

      Pull pin

      Aim at the base of the fire

      Squeeze lever or handle

      Sweep agent at the base of the flames

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

SAFETY MANUAL

FIRE DRILL		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 16** **Page: 3 of 3**
Effective Date: 11 April, 2013		

FIRE DETECTION AND NOTIFICATION DEVICES USED WITHIN THE FACILITY

1. Manual Fire Alarm Station

   Operation: Pull handle down and the alarm will sound and a fire signal will be transmitted to the appropriate monitoring organization.

   Locations: Throughout the building (see evacuation plan).

2. Smoke Detectors:

   Operation: When smoke enters the detector, an automatic circuit causes the fire alarm bells to ring or activate and a fire signal is sent through the notification network.

   Locations: Throughout the building.

FIRE SAFETY TRAINING

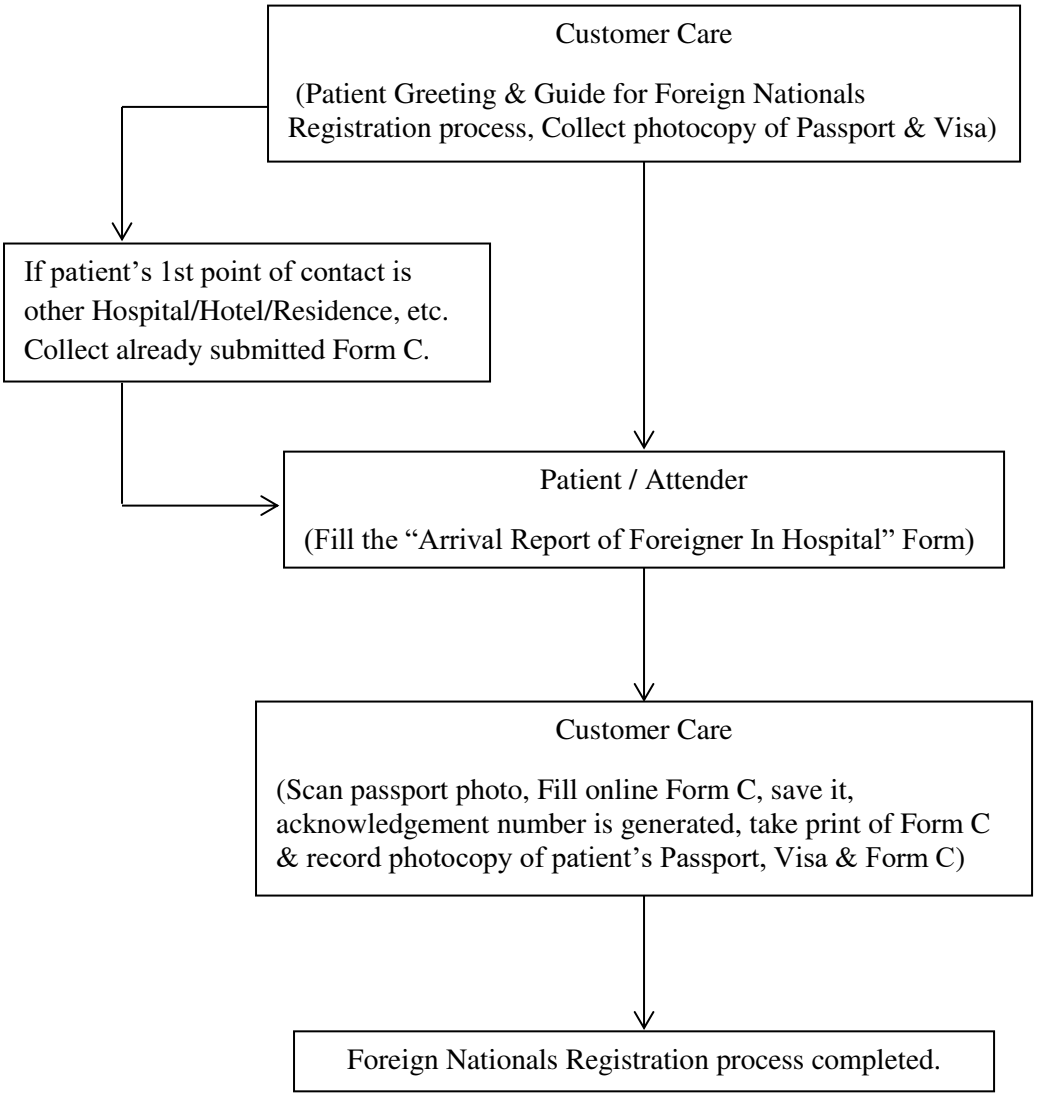
Each employee is required to receive an initial orientation training to familiarize him / herself with the fire plan. Management is required to provide specific training to employees upon assignment to their work area.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE II

(Refer Customer Care and Billing Manual Policy and Procedure No. 16)

Flow Chart of Foreign Nationals Registration Procedure



ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 16)

HEARTSTART XL WEEKLY CHECKLIST

Perform a "Weekly Check" to verify the HeartStart XL monitor/defibrillator is functioning properly and necessary supplies/accessories are present and ready for use. Write the month, date and time of the weekly check. Place a check mark in the box as you check each item in the list below or write NA if not applicable. The person performing the check should also write his/her name and signature to indicate the check was performed for that week.

Device Name or Serial Number: _____

Nursing Unit / OR: _____

Month: _____

Date					
Time					
Weekly system check completely					
Defibrillator – clean, clear of objects and no damage					
Cables/connectors – present and inspected					
Paddles/Therapy cable – present and inspected					
Pads* – present and sufficient supply					
Monitoring electrodes* – present and sufficient supply					
Charged batteries – one in device, Battery Charge LED is green, and at least one spare					
AC power cord plugged in and AC Power LED is green					
Printer paper – present and sufficient supply					
Data card – present and at least one spare (if applicable)					
SpO_2 sensor – present and inspected (if applicable)					
Name					
Signature					

* Check expiry dates on multifunction defibrillator electrode pads and monitoring electrodes every month. Replace them if the expiry date has passed.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: INSERTION OF AN INTRAVENOUS CANNULA		
Module Applies To	**All Nurses and Technicians**	**Module No: 16** **Page: 1 of 6**
Effective Date: 11 April, 2013		

Name: _____ Unit:_____ Date: _____

Frequency

1. Rarely observed or never done
2. Rarely done (<6 x a year)
3. Occasionally done (1 – 2 x a month)
4. Frequently done (daily or weekly)

Experience

1. None
2. Limited
3. Moderate
4. Proficient

Validation Method

1. = Cognitive: Tests, verbalize action/steps
2. = Psychomotor: Demonstrates skill in lab. simulated setting
3. = Psychomotor: demonstrates skill in clinical setting
4. = Affective: Demonstrates appropriate behavior/attitude

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			1. Verbalizes cognitive knowledge about insertion of an Intravenous Cannula.	1. Lists the indications for insertion of an Intravenous Cannula. ▪ Administration of medications in bolus or continuous / intermittent infusions ▪ Administration of fluids and Electrolytes for patients with electrolyte imbalances, malnutrition, shock, trauma, sepsis, surgery, endocrine disorders, cardiovascular disease and cancer, etc. ▪ Administration of Blood and Blood products. ▪ For diagnostic procedures. 2. Lists the most commonly used veins for peripheral IV Cannula insertion ▪ Cephalic ▪ Basilic ▪ Median veins in the lower arm ▪ Metacarpal veins in the dorsum of the hand							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: INSERTION OF AN INTRAVENOUS CANNULA		
Module Applies To	**All Nurses and Technicians**	**Module No: 16** **Page: 2 of 6**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
				3. Verbalizes the factors which help to maintain the IV therapy longer. ▪ Select the most distal site of the extremity ▪ Use smallest gauge catheter appropriate to vein size and prescribed therapy ▪ Avoid areas of flexion such as antecubital fossa and the wrist ▪ Use the non dominant hand ▪ Choose the sites that are located above previous insertion sites and sites that are phlebitic, infiltrated or bruised. 4. Describes the most commonly used types of IV catheter used for a peripheral intravenous insertion. ▪ over the needle, plastic catheter in different sizes (24g to 16g) for short term IV therapy ▪ The winged infusion set or "butterfly" for less than 24 hours. 5. Lists the complications associated with the insertion of a peripheral IV cannula. a. <u>Local</u> ▪ Phlebitis ▪ Thrombo phlebitis ▪ Infiltration ▪ Catheter occlusion							

Note: Must be psychomotor validation

COMPETENCY: INSERTION OF AN INTRAVENOUS CANNULA		
Module Applies To	**All Nurses and Technicians**	**Module No: 16** **Page: 3 of 6**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
				b. Systemic ▪ Septicemia ▪ Thrombo embolism ▪ Embolism ▪ Circulatory overload ▪ Speed shock ▪ Allergic/anaphylactic reactions							
			2. Demonstrates technical and psychomotor skills in insertion of an Intravenous Cannula.	1. Checks the physician order for the following : ▪ Name, dose, frequency and route of the medication or IV fluid ▪ Date and time of order ▪ Physician's signature and stamp 2. Assesses the patient for the following before insertion of IV cannula ▪ Current anticoagulation / thrombolytic therapy or blood dyscrasiasis ▪ Allergy history (eg. lidocaine, antiseptic solutions, adhesives) ▪ History of Mastectomy, fistula, shunt, neurovascular injury, cellulites and thrombosis ▪ Patient's age, size, skin condition and anatomy of venous system 3. Assembles necessary supplies ▪ IV catheter of appropriate type, size and length ▪ IV fluids / medications as prescribed with IV administration set and short extension tubing attached and primed							

COMPETENCY: INSERTION OF AN INTRAVENOUS CANNULA		
Module Applies To	**All Nurses and Technicians**	**Module No: 16** **Page: 4 of 6**
Effective Date: 11 April, 2013		

				▪ Tourniquet, Kidney basin ▪ Alcohol swabs ▪ square gauze – sterile ▪ Easy fix / transparent semipermeable dressing ▪ Unsterile gloves ▪ syringe with 3 to 5ml of Normal Saline 4. Prepares the patient for insertion of an intravenous cannula ▪ Ensures that the patient and family understand pre-procedural teaching ▪ Positions the patient in a supine position with the head slightly elevated and arms at side ▪ Extends the patient's upper extremity to form a straight line from the shoulder to the wrist 5. Washes hands 6. Selects appropriate venipuncture site starting with the most distal branch of the vein selected. Palpates for suitability of vein. 7. Utilize a comfortable position and good lighting 8. Dons unsterile gloves 9. Cleanses the selected venipuncture site with alcohol swab using circular motion from the center outwards 10. Applies tourniquet on extremity without contaminating disinfected area.							

COMPETENCY: INSERTION OF AN INTRAVENOUS CANNULA		
Module Applies To	**All Nurses and Technicians**	**Module No: 16** **Page: 5 of 6**
Effective Date: 11 April, 2013		

				11. Draws the skin just below the insertion site taut, using the thumb of the non-dominant hand 12. Punctures the skin parallel to the path of the vein with the bevel up and needle at a 15 degree angle without palpating disinfected area again. 13. Advances the needle until blood is observed in the catheter hub or tubing of winged infusion set. Holding the device stable, advances the catheter into the vein until hub rests at insertion site 14. Releases tourniquet 15. Places a sterile 4x4 gauze pad under the catheter hub, uses pressure just above the puncture site, removes the stylet and disposes into the kidney basin. 16. Connects primed IV administration set or syringe with Normal Saline to catheter hub 17. Initiates proper IV flow rate or flushes with 3ml of Normal Saline. Assesses for signs of infiltration 18. Secures the catheter with Easy fix / transparent semipermeable dressing 19. Discards supplies in appropriate container according to policy. 20. Removes gloves 23. Labels dressing with date, time, gauge no. and initials and on the IV bag according to policy.							

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: INSERTION OF AN INTRAVENOUS CANNULA		
Module Applies To	**All Nurses and Technicians**	**Module No: 16** **Page: 6 of 6**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
				24. Washes hands before documentation							
			3. Provides patient / family education.	1. Explains the following : ▪ The purpose ▪ Steps of procedure ▪ Role of the patient ▪ Expected pain ▪ Signs and symptoms that should be reported to the Nurse (pain, edema, tenderness, erythema) 2. Answers the questions as they arise and reinforces information as needed.							
			4. Documents the procedure	1. Documents the following on Critical Care flow sheet / Nurse's Note ▪ Patient and family education ▪ Known allergies ▪ Date and time of procedure ▪ Catheter type, gauge and length ▪ Location of peripheral IV insertion ▪ Problems encountered during or after procedure and nursing interventions ▪ Patient tolerance of procedure ▪ Assessment of insertion site.							

Note: Must be psychomotor validation

_____ _____ _____

Validator Signature **Designation** **Date**

Preceptor code: **A- Preceptor** **B- OT Matron** **C- Nursing Superintendant**

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

INTER DISCIPLINARY CONSULTATION		
Policy/Procedure Applies To	**Administrative Head of the Center/All Consultants**	**Policy/Procedure No: 16** **Page: 1 of 1**
Effective Date: 11 April, 2013		

INTER DISCIPLINARY CONSULTATION

POLICY

1. The attending Consultant will be primarily responsible for requesting consultation when indicated and for calling a qualified consultant.
2. A consultant shall be qualified to give an opinion in the field in which his opinion is sought.
3. The status of the consultant will be determined by the Administrative Head of the Center on the basis of the individual's training, experience and competence.
4. Consultants who are not members of the medical staff or the Center may attend patients upon the request of the attending Consultant and with the concurrence of the Administrative Head of the Center.
5. Such Visiting Consultants may, with the approval of the attending Consultant, write orders.
6. Consultations shall show evidence of a review of the patient's record by the Consultant, pertinent findings on examination of the patient and the consultant's opinions and recommendations.
7. The report of consultation shall be made a part of the patient's medical record.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

MONITORING OF PATIENTS RECEIVING IV CONSCIOUS SEDATION		
Policy/Procedure Applies To	**Anaesthesiologists and O.T.Nurses**	**Policy/Procedure No: 16** **Page: 1 of 1**
Effective Date: 11 April, 2013		

MONITORING OF PATIENTS RECEIVING IV CONSCIOUS SEDATION

RATIONALE

To provide guidelines for monitoring the patient receiving IV sedation. All patients receiving IV sedation will be monitored with automatic blood pressure cuff, cardiac monitor, and pulse oximeter.

POLICY STATEMENT

To provide consistent nursing care for all patients receiving IV sedation during a procedure.

PROCEDURE

1. Each patient will be monitored for reaction to drugs and for behavioural and physiological changes.
2. The nurse will be able to recognize cardiac arrhythmias, changes in patient's condition and report the findings to the Anaesthesiologist.
3. The nurse will be able to recognize normal and abnormal reactions to drugs used during the procedure.
4. The nurse will have second suction available for all procedures.
5. An IV per protocol will be started unless otherwise ordered by the Anaesthesiologist.
6. The nurse will be familiar with the function and interpretation of the monitoring equipment, cardiac monitor, and automatic blood pressure cuff and pulse oximeter.
7. Documentation on the nursing record will be an accurate reflection of care rendered.
8. The nurse will record vital parameters prior to administration of IV sedation, five minutes after sedation and a minimum of every fifteen (15) minutes during procedure and every fifteen (15) minutes post procedure.
9. The nurse will keep an ongoing record of the amount of IV sedation used and time given on nursing record.
10. The monitoring will include, but not be limited to, the following nurse activities:
    a. Blood pressure, pulse, respiration, cardiac monitor, and oxygen saturation via pulse oximetry.
    b. Initiate 02 when warranted.
    c. Protection of patient privacy at all times.
    d. Ongoing emotional and psychological support should be given.
11. Previous allergic reactions will be documented.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

MONITORING OF PATIENTS RECEIVING IV CONSCIOUS SEDATION		
Policy/Procedure Applies To	**Anaesthesiologists and O.T.Nurses**	**Policy/Procedure No: 16** **Page: 1 of 1**
Effective Date: 11 April, 2013		

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Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

PERSONNEL LAUNDRY		
Policy/Procedure Applies To	**All Nurses & Surgical team and Housekeeping staff**	**Policy/Procedure No: 16** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PERSONNEL LAUNDRY

PURPOSE

To maintain a clean environment by proper removal and processing of soiled laundry and personnel laundry.

POLICY

1. All Nursing, Surgical team, and Housekeeping staff are to bring laundered uniform and scrubs into facility and change prior to duty
2. All Nursing, Surgical Team and House Keeping personnel cannot wear uniforms/scrubs while coming for work or going home after work
3. If scrubs become soiled by body fluids or blood, they must be sent out to commercial laundry to ensure they are disinfected and free of vegetative pathogens.

PROCEDURE

Surgical Team staff will bring clean laundered scrubs and change prior to duty. If scrubs become soiled by body fluids or blood should be removed and sent out to a commercial laundry to ensure they are disinfected and free of vegetative pathogens (i.e., hygienically clean). According to the Centers for Disease Control and Prevention guidelines, Laundering cycles consist of flush, main wash, bleaching, rinsing.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE XVI
(Refer to Housekeeping Manual Policy and Procedure No. 1)

STAFF LOUNGE

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls	X			
A/C baffles and top of cabinets		X		
Table and chairs	X			
Luminaries		X		
Electrical Outlets	X			
Cabinets	X			
Chairs/Tables/Sofa Sets	X			
Telephone	X			
Drawers	X			
Microwave	X			
Refrigerator		X		
Windows and Seals	X			
Television	X			
Sink	X			
Empty Waste Bins	X			
Fill soap dispensers	X			
Fans		X		
Water Cooler	X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune**.**

GENERAL MANUAL

ANCILLARY SERVICES		
Policy/Procedure Applies To	**Customer Care and All Nurses**	**Policy/Procedure No: 17** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ANCILLARY SERVICES

PURPOSE

To provide direction as to which ancillary services will render support services to the facility and to indicate how communication will be conducted with those agencies.

POLICY

1. Laboratory services will be provided by NABL accredited Golwilkar Metropolis Health Services, Pune. A Phlebotomist will collect all laboratory samples and send it to the Laboratory. The results will be forwarded through hard and soft copy (pdf file).
2. Stat blood gases will be done at above laboratory.
3. Jankalyan Sahakari Blood Bank (contact number 24449527) will provide blood products on request.
4. CT and MRI services will be provided by Poona Diagnostic Services, Pune and Omega MRI Centre, Pune respectively. The patients if so desire will be taken in an Ambulance by them and dropped back at Prime Surgical Centers.
5. Patients will be given proper forms and orders during their clinical pre operative visit.
6. Documentation of test results will be placed in the file by Customer Care Staff.
7. Emergency services/transfer will be provided, on call, by Shree Datta Ambulance Services (Contact information: Mr. Patil – 9850336567 / 9922468467 / 9860464374).
8. Pharmacy services will be provided by Apollo Pharmacy located within the premises of OPD.

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Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

CANCER CHEMOTHERAPY ADMINISTRATION SKILL CHECK LIST		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 17** **Page: 1 of 1**
Effective Date: 01 April, 2014		

CANCER CHEMOTHERAPY ADMINISTRATION SKILL CHECK LIST

PRIOR TO ADMINISTRATION

1. Co-ordinates time of administration with pharmacy and others as needed.
2. Verifies that consent for treatment is signed.
3. Checks that laboratory values are within acceptable parameters and reports results to Consultant as needed.
4. Verifies that original order is transcribed correctly by Resident Medical Officer.
5. Checks chemotherapy order (protocol) for drug, dose, schedule, time and route.
6. Verifies that patient education, premedication, prehydration and other preparations are completed.

ADMINISTRATION

1. Compares original order to transcribed drug.
2. Verifies patient identification.
3. Applies gloves, mask, gown and uses safe-handling precautions.
4. Verifies adequacy of venous access and appropriate IV-site selection.
5. Checks IV line patency and flushes line with 5-10ml NS (normal saline).
6. Demonstrates safe administration:
   a. Checks patency every 3-5 hours
   b. Ensures proper rate of administration.
   c. Flushes between drugs.
7. Demonstrates appropriate monitoring/observation for specific acute drug effects.
8. Takes appropriate action in the event of extravasation and stop IV, informs Consultant.
9. Takes appropriate action in the event of hypersensitivity reaction.

AFTER ADMINISTRATION

1. Flushes line with at least 5-10 ml NS (normal saline).
2. Appropriately removes device or flushes / maintains VAD (vascular access device) / Central line.
3. Disposes of chemotherapy waste according to Prime Surgical Centers Nursing Manual Policy and Procedure No. 29.
4. Documents medications, education and patient response.
5. Communicates post-treatment considerations to patient, family members and appropriate personnel.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

CARDIOPULMONARY RESUSCITATION REPORT FORM		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 17** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CARDIOPULMONARY RESUSCITATION REPORT FORM

PURPOSE

To provide a guideline for recording data as to activities during a **CODE BLUE** procedure and to use that information for recording on the chart and for evaluation by Administrative Office

SCOPE

All Nursing Personnel.

POLICY

A Cardiopulmonary Resuscitation Report Form (Refer Annexure to this policy) will be completed during any **CODE BLUE** procedure which is carried out, no matter what the cause.

PROCEDURE

1. Cardiopulmonary Resuscitation Report Forms are kept in the back of the Defibrillator Checklist clipboard.
2. When the crash cart is taken to a Code Blue, the nurse in charge should note the time and assign someone to record pertinent information on the report form.
3. When the Code Blue is over, the form should be completed (except for the space marked "Outcome") and signed by the nurse and the physician.
4. The form is not placed on the chart. One (1) copy of the form should be kept on file in the Nurse Superintendent's office for review at a staff meeting. The original should be given to the administrator who will complete the "Outcome" portion.
5. The form will be reviewed by the Administrator for any recommendations given in writing to the Nurse Superintendent.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE

(Refer to Nursing Manual Policy and Procedure No. 17)

CARDIOPULMONARY RESUSCITATION REPORT FORM

PATIENT NAME: _____

DATE: _____ TIME: _____ A.M P.M

MR No: IP No:
Age/Sex:
Comfort/Deluxe Bed No:
OR 1 / 2 / 3 / 4 :

CARDIAC ARREST

1. TYPE	2. SUSPECTED CAUSE		3. RECOGNIZED BY	4. HOW RECOGNIZED
□ STANDSTILL	□ MYOCARDIAL INFARCTION	□ HEAMORRHAGE	□ NURSE	□ NO PULSE
□ VENTRICULAR TACHYCARDIA	□ PULMONARY OEDEMA	□ ANAESTHESIA	□ PHYSICIAN	□ NO RESPIRATION
□ CIRCULATORY COLLAPSE	□ PULMONARY EMBOLISM	□ DRUG	□ NURSING AIDE	□ DILATED PUPILS
□ UNKNOWN	□ RESPIRATORY ARREST	□ UNKNOWN	□ ALARM	□ AGONAL GASP
	□ OTHER		□ OTHER	□ ALARM

6. RESUSCITATION STARTED BY	7. METHOD OF ARTIFICIAL VENTILATION	8. METHOD OF ARTIFICIAL CIRCULATION
□ NURSE □ PHYSICIAN	□ BAG / MASK	□ EXTERNAL (CLOSED)
□ ANAESTHESIOLOGIST □ NURSING AIDE	□ BAG / ENDO TUBE	□ MANUAL
□ OTHER _____	□ OESOPHAGEAL AIRWAY	□ MECHANICAL
	□ MECHANICAL VENTILATOR	
WITHIN _____ MINUTES	TYPE _____	

9. DURATION	10. SYSTOLIC BLOOD PRESSURE DURING RESUSCITATION	11. DEFIBRILLATION AC EXTENSION (NO. OF SHOCKS)
□ MANUAL □ MECHANICAL □ BOTH	□ PALPABLE PULSE □ NOT PALPABLE	□ 50 □ 100 □ 150
	□ RECORDED (MMHG)	□ 200 □ 300 □ 400
	□ 50 □ 60 □ 70 □ 80 □ 90 □ 100	

MIN	3	5	12	15	20	30	40	MORE
NIBP								
CIRC.								

12. RESTORED			13. REVERTED TO
YES	NO		
□	□	PALPABLE PULSE	□ VENTRICULAR FIBRILLATION
□	□	SPONTANEOUS BREATHING	□ CARDIAC STANDSTILL
□	□	CONSCIOUSNESS	□ CARDIOVASCULAR COLLAPSE
□	□	RHYTHMIC ECG	

DRUG	DOSE /ROUTE
EPINEPHRINE	
CALCIUM	
NA CO3(50 CC/44 CAECQ)	

REASON FOR STOPPING			PROCEDURE UNSUCCESSFUL
YES	NO		□ NO RESPONSE
□	□	CIRCULATION RESTORED	□ EQUIPMENT SUPPLY PROBLEMS
□	□	RESPIRATION RESTORED	□ OTHER _____

PROCEDURE INAPPROPRIATE □

□ TERMINAL DISEASE □ DELAY IN STARTING

□ OTHER _____

REMARKS:

OUTCOME

□ LEFT CENTER ALIVE AT_____HRS AFTER CPR

□ EXPIRED AT_____HRS AFTER CPR

CAUSE OF DEATH _____

_____

AUTOPSY □ YES □ NO

AUTOPSY FINDING _____

_____

Additional comments and/or suggestions:

CONSULTING DOCTOR'S

SIGNATURE: _____

NAME:_____

DATE & TIME: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: GOWNING AND GLOVING		
Module Applies To	**All Nurses and Technicians**	**Module No: 17** **Page: 1 of 6**
Effective Date: 11 April, 2013		

Name: _____ Unit:_____ Date: _____

Frequency

1. Rarely observed or never done
2. Rarely done (<6 x a year)
3. Occasionally done (1 – 2 x a month)
4. Frequently done (daily or weekly)

Experience

1. None
2. Limited
3. Moderate
4. Proficient

Validation Method

1. = Cognitive: Tests, verbalize action/steps
2. = Psychomotor: Demonstrates skill in lab. simulated setting
3. = Psychomotor: Demonstrates skill in clinical setting
4. = Affective: Demonstrates appropriate behavior/attitude

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
			1. Verbalizes knowledge of gowning and gloving.	1. Identifies importance of gowning and gloving. ▪ Provides a bacterial barrier between the patient and the healthcare worker and between sterile and un-sterile areas. ▪ Prevents microorganisms from hands and clothing from being transferred to the patient's wound during surgery. ▪ Maintains sterile area.						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: GOWNING AND GLOVING		
Module Applies To	**All Nurses and Technicians**	**Module No: 17** **Page: 2 of 6**
Effective Date: 11 April, 2013		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up	Plan	Preceptor
					Method	Code	Date		Date	Method
				2. Identifies the considered sterile and un-sterile areas of the gown. ▪ Sterile gowns are considered sterile only in front from chest to waist level and at the sleeves from 2 inches above the elbow to the cuff. ▪ The neckline, shoulders, areas under the arm, the cuffs and back are considered un sterile. 3. States the barrier quality of the gown. ▪ Clean and dry ▪ Free from holes and fraying ▪ Free from tear and puncture. 4. Lists the hazardous effects of the gloves powder. ▪ Potential for skin allergy ▪ Powder fallout from hands and gloves will provide a convenient vehicle for dissemination of microorganisms through out the operating room						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: GOWNING AND GLOVING		
Module Applies To	**All Nurses and Technicians**	**Module No: 17** **Page: 3 of 6**
Effective Date: 11 April, 2013		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
			2. Demonstrates techniques in surgical self-gowning.	1. Scrubs hands, opens the hand towel and dries the hands avoiding contamination of gown packages from dripping water. 2. Grasps the sterile gown at the neckline with both hands. 3. Holds the gown away from the body and allow it to unfold with the inside towards the wearer. 4. Slips both hands in to the open armholes, keeping the hands at shoulder level and away from the body. 5. Pushes the hands and forearms in to the sleeves of the gown, advancing the hands only to the proximal edge of the cuff if the closed gloving technique will be used. If the open gloving technique will be used, advances the hands completely through the cuffs of the gown. 6. Secures the gown ties with the help of the circulating nurse.						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: GOWNING AND GLOVING		
Module Applies To	**All Nurses and Technicians**	**Module No: 17** **Page: 4 of 6**
Effective Date: 11 April, 2013		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up	Plan	Preceptor
					Method	Code	Date		Date	Method
			3. Performs closed gloving techniques	1. Lifts right glove by grasping it through fabric or sleeve by left hand. 2. Places glove with palm down along forearm of right hand, with thumb and fingers pointing toward elbow. 3. Lies glove cuff over gown wristlet. 4. Draws the cuff back into wrist, directs fingers in to their cots in glove and adjust glove to hand. 5. Positions remaining glove on opposite sleeve in same fashion by gloved hand. Draws second glove on to hand, and pulls cuff in to place. 6. Adjust fingers of gloves and wipes with wet gauze sponge to remove any powder that maybe on them.						
			4.Demonstrates open gloving technique.	1. Lifts right glove with the left hand from inner glove wrapper by placing thumb and index finger of opposite hand on fold of averted cuff at a point in line with glove's palm and pulls glove over hand, leaving cuff turned back.						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: GOWNING AND GLOVING		
Module Applies To	**All Nurses and Technicians**	**Module No: 17** **Page: 5 of 6**
Effective Date: 11 April, 2013		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up	Plan	Preceptor
					Method	Code	Date		Date	Method
				2. Takes second glove with the right hand from inner glove wrapper by placing right gloved fingers under everted cuff. 3. Introduces free hand into glove and draws it over cuff of gown and upper part of wristlet by slightly rotating arm externally and internally adjusting fingers in to glove cots. 4. Draws right glove cuff over cuff of the gown and upper part of wristlet.						
			5. Demonstrates assisted gowning procedure.	1. Grasps the sterile gown at the neckline with both hands. 2. Holds the gown away from the body and allow it to unfold. 3. Opened armholes are turned toward the individual who is to be gowned. 4. Cuffs the neck and shoulder area of the gown to protect the gloved hands. 5. Holds the gown until the person's hand and forearms are in the sleeves of the gown. The circulating nurse assists in pulling the gown onto the shoulders, adjusting the back and tying the tapes.						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: GOWNING AND GLOVING		
Module Applies To	**All Nurses and Technicians**	**Module No: 17** **Page: 6 of 6**
Effective Date: 11 April, 2013		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
			6. Demonstrates procedure in gloving another person.	1. Grasps the glove under the everted cuff. 2. Turns the palm of the glove toward the ungloved individual's hand with the thumb of the glove directly opposed to the thumb of the person's hand. 3. Stretches the cuff to open the glove using thumbs and fingers. The ungloved individual can then insert his/her hand into the glove. 4. Repeats procedure for the other hand.						

Note: Must be psychomotor validation

_____ _____

Validator Signature **Designation**

Preceptor code: **A- Preceptor** **B- OT Matron** **C- Nursing Superintendant**

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

POST ANAESTHESIA CARE		
Policy/Procedure Applies To	**All Staff Nurses and Resident Medical Officers**	**Policy/Procedure No: 17** **Page: 1 of 1**
Effective Date: 11 April, 2013		

POST-ANAESTHESIA CARE

PURPOSE

To establish guidelines for responsibilities of Anaesthesia staff regarding post-anaesthesia care to patients.

POLICY

1. All patients will receive appropriate post anaesthesia management in the Nursing Unit.
   a. The medical aspects of care in the Nursing Unit shall be governed by policies and procedures which have been reviewed and approved by Head of Anaesthesiology Services.
   b. Staffing will be directly related to patient requirements.
2. A patient transported to the Nursing Unit will be accompanied by a member of the surgical Nursing care team who is knowledgeable about the patient's condition. The patient will be continually evaluated and treated during transport with monitoring and support appropriate to the patient's condition. Handing/taking over of patient will be carried out between nursing staff of O.T. and Nursing Unit in transfer area as per laid down policy (Refer Nursing Manual Policy and Procedure No. 92). In exceptional circumstances based on case to case an Anaesthesiologist may accompany the patient to the Nursing Unit.
3. Upon arrival in the Nursing unit, the patient will be re-evaluated (Refer Nursing Manual Policy and Procedure No. 92).
   a. The patient’s status on arrival in the Nursing unit will be documented.
   b. Information concerning the preoperative condition and the surgical/anaesthesia course will be rechecked.
4. The patient's condition will be evaluated continually in the Nursing unit.
   a. The patient will be observed and monitored by methods appropriate to the patient's medical condition. Particular attention will be given to monitoring oxygenation, ventilation and circulation. Quantitative methods will be used when deemed necessary.
   b. An accurate written report of the post-anaesthesia period will be maintained. Use of an appropriate Nursing unit scoring system is used on admission, at appropriate intervals prior to discharge, and at the time of discharge.
   c. General medical supervision and coordination of patient care in the Nursing unit will be the responsibility of Resident Medical Officers/ Anaesthesia staff.
5. There will be a physician available at all times who has the capability of managing complications and providing cardiopulmonary resuscitation for patients in the Nursing unit until the last patient is medically discharged (street ready).
6. A physician is responsible for the discharge of the patient from the Nursing unit and from the facility (Refer to Nursing Manual Policy and Procedure No.107). Discharge criteria are approved by Anaesthesia staff and/or medical staff (Refer Nursing Manual Policy and Procedure No.106).

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

POST ANAESTHESIA CARE		
Policy/Procedure Applies To	**All Staff Nurses and Resident Medical Officers**	**Policy/Procedure No: 17** **Page: 1 of 1**
Effective Date: 11 April, 2013		

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Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

PROCESSING OF CONTAMINATED ANAESTHESIA EQUIPMENT		
Policy/Procedure Applies To	**OT & Procedure Room Nurses & OT Technicians**	**Policy/Procedure No: 17** **Page: 1 of 2**
Effective Date: 11 April, 2013		

PROCESSING OF CONTAMINATED ANAESTHESIA EQUIPMENT

PURPOSE

1. To prevent cross contamination between patients during the administration of anaesthetic agents.
2. To provide guidelines for methods of decontamination acceptable for reusable anaesthesia equipment.

POLICY

1. The entire anaesthesia equipment system should be terminally cleaned and reusable components either high-level disinfected (5% sodium hypochorite for twenty[20] minutes) or sterilized. Single use components will be discarded after use.
2. All reusable equipment will be disinfected between each patient's use. Items in direct contact with patient's mouth and nose secretions will be subjected to high-level chemical disinfection immediately after use.
3. In the event of treatment of a patient with recognized infectious disease, single use items will be used to the extent possible and all discarded with infectious waste. Reusable items will be sterilized.

DEFINITION OF HIGH-LEVEL DISINFECTION

1. Some disinfection procedures are capable of producing sterility if they are continued long enough to kill all but resistant bacterial spores, they are called high-level disinfection processes.
2. Intact mucous membrane are generally resistant to infection by common bacterial spores but not by many other organisms such as viruses and tubercle bacilli; it is “less critical” that objects touching mucous membranes be sterile, although these require a disinfection process that kills all but resistant bacterial spores.
3. Objects contaminated with virulent organisms, such as hepatitis viruses, Shigella, or multiply-resistant gram-negative bacilli, may require disinfection even if their use would normally dictate only cleaning.
4. Tubercle bacilli and poliocoxsackie, echo and rhino viruses are resistant to most germicidal agents and require high-level disinfection if they are to be reliably eliminated from reusable object.
5. High-level disinfection can be accomplished by hot water pasteurization or liquid chemicals.

PROCEDURE

1. Single use items will be discarded immediately after use:
   a. Single use endotracheal tubes
   b. Esophageal stethoscopes
   c. Levine tubes
   d. Single use masks
   e. Monitoring electrodes
   f. Needles and syringes
   g. Regional block trays (local infiltration)
   h. Suction catheters
   i. Airways
   j. Breathing circuits

PROCESSING OF CONTAMINATED ANAESTHESIA EQUIPMENT		
Policy/Procedure Applies To	**OT & Procedure Room Nurses & OT Technicians**	**Policy/Procedure No: 17** **Page: 2 of 2**
Effective Date: 11 April, 2013		

2. Grossly contaminated single use items will be discarded in accordance with policy of Prime Surgical Centers regarding biohazardous waste.
3. Reusable metal equipment (e.g. laryngoscope blades, Magill forceps, stylettes) is to be sterilized or subjected to high-level chemical disinfection immediately after each use.
4. Reusable objects must be thoroughly cleaned before processing because organic material (e.g. blood and protein) inactivate disinfectants and protect microorganisms from disinfection and sterilization.
5. High-level disinfection of reusable equipment must be soaked for the time recommended by the manufacturer. Tubing must be completely filled for disinfection.
6. Criteria for the selection of an appropriate cleaning or disinfecting agent should include, but are not limited to, the following:
    a. The physical removal (cleaning process) of microbes may be adequate, or the inactivation of microbes (disinfection) may be desired.
    b. The cleaning agent should be safe, effective, and compatible with the surfaces cleaned and soil loads involved.
    c. The disinfectant, when used, should be:
        i. Compatible with the cleaning agent.
        ii. Safe for use by personnel and with the equipment.
        iii. Effective against the microbial population involved considering inactivation of disinfectant by extraneous factors such as organic debris, water hardness, and pH.
        iv. Free from harmful residues.
    d. Recommended agents
        i. Iodophor - use only a product approved for disinfection by the EPA.
        ii. Glutaraldehyde (a 2% solution has been customary used for high-level disinfection)
7. Objects disinfected with liquid chemicals for cleaning purposes only, must be rinsed in sterile water (or water containing at least 10 mg/liter free residual chlorine, e.g. a fresh 1:5000 dilution of a household bleach that is 5.25% hypochlorite solution) to remove possibly toxic or irritating residues.
8. Cleaning anaesthesia machines
    a. The exterior surfaces of anaesthesia machines, instruments attached to and kept on them, and equipment carts will be thoroughly cleaned with an appropriate agent at least every twenty four (24) hours and when visibly contaminated.
    b. Absorbers will be cleaned when C02 absorbent is changed, paying particular attention to accumulated absorbent dust

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE XVII
(Refer to Housekeeping Manual Policy and Procedure No. 1)

TOILETS

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
Fixtures and showers	X			
Tap in working condition	X			
Nurse's Call Bell	X			
Luminaries		X		
Electrical Outlet/ Switch Plates	X			
Wash Basin	X			
Exhaust		X		
Slide Door	X			
Empty Waste Bins	X			
Fill Soap Dispensers	X			
Flush & Health Faucet	X			
Fill Toilet Paper	X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

MEDICAL RECORDS REQUIREMENTS		
Policy/Procedure Applies To	**All Nurses / Medical Records Department**	**Policy/Procedure No: 18** **Page: 1 of 2**
Effective Date: 11 April, 2013		

MEDICAL RECORDS REQUIREMENTS

1. GENERAL

a. The attending Consultant assisted by a Resident Medical Officer shall be responsible for the preparation of a complete and legible medical record of each patient. Its content shall be pertinent and current. The record shall include identification date, complaint, personal history, family history if pertinent, a history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services and provisional diagnosis, medical or surgical treatment (specifically operative procedure with any complications) condition on discharge, summary or discharge note and post-operative diagnosis.

b. All clinical entries in the patient's medical record shall be accurately dated and authenticated (signed and stamped).

c. In all instances the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

d. Use of Symbols / abbreviations will not be permitted.

e. Written consent from the patient is required for release of the medical information to persons not otherwise authorized to receive this information (Refer Annexure I to this policy)

f. Records may be removed from the Center's jurisdiction and safekeeping only in accordance with a court order subpoena or statute.

g. All records are the property of the Center. Unauthorized removal of charts from the Center is grounds for disciplinary action.

h. In cases of readmission of a patient, all pertinent previous records shall be available for use of the attending Consultant.

i. Free access to all medical records of all patients shall be afforded to members of the medical staff for bona fide studies and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects shall be approved by the Administrative Head of the Center.

j. A medical record shall not be permanently filed until it is completed by the Concerned Consultant.

k. All orders for treatment shall be in writing in the Physician Order Sheet. An order shall be considered to be in writing if dictated to a nurse and signed by the attending surgeon. Orders dictated over a telephone shall be signed by the person to whom dictated with the name of the physician, per his or her own name. The attending Consultant shall sign such orders within 24 hours (Refer Nursing Manual Policy and Procedure No. 64).

l. Pathology reports, when appropriate as specified in policies and procedures, will be signed by the pathologist and become a permanent part of the record.

2. HISTORY AND PHYSICAL EXAMINATION

a. A complete admission history and physical examination with a provisional diagnosis shall be recorded prior to admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. (Refer to Annexure II to this policy)

b. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled unless the attending Consultant states in writing that such delay would be detrimental to the patient.

MEDICAL RECORDS REQUIREMENTS		
Policy/Procedure Applies To	**All Nurses / Medical Records Department**	**Policy/Procedure No: 18** **Page: 2 of 2**
Effective Date: 11 April, 2013		

3. PROGRESS NOTES

Pertinent progress notes, as per Annexure III to this policy, shall be recorded at the time of observation sufficient to permit continuity of care and transferability. They will be signed and dated with name of the Consultant.

4. OPERATIVE REPORTS

a. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique (Also refer Nursing Manual Policy and Procedure no. 81).

b. Operative reports shall be written immediately following surgery and the report promptly signed by the surgeon with date and time, and made a part of the patient's current medical record.

c. Anaesthesia Record duly signed and dated with the name of Anaesthesiologist (Also refer to Nursing Manual Policy and Procedure no. 25 and 81).

d. Anaesthesia Summary duly signed by the Anaesthesiologist with name, date and time as per Annexure IV

5. ORDERS

a. Routine orders when applicable to a given patient shall be reproduced in detail on the order sheet of the patient's record. (Also refer Nursing Manual Policy and Procedure no. 35).

b. Orders shall be dated, signed, stamped and counter signed by the attending Consultant.

6. DISCHARGE SUMMARY

a. A final diagnosis shall be recorded in full without the use of symbols and abbreviations and dated, signed and stamped by the Resident Medical Officer at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order. This will have to be counter signed/ stamped by the attending Consultant.

b. A discharge note shall be written as part of the physician progress notes as per Annexure V.

c. All discharge notes shall be authenticated by a Resident Medical Officer (Also refer Nursing Manual Policy and Procedure No.109).

7. RECORD COMPLETION

a. The patient's medical record shall be completed at the time of discharge including progress notes, final diagnosis and written or dictated discharge note.

b. If a record remains incomplete for 72 hours after being placed in the Consultant's incomplete chart file after discharge, it shall be considered delinquent. Administrative Head of the center will be informed in writing for further necessary action.

c. Incomplete records will remain in a stated place in the medical record department.

8. DELINQUENT MEDICAL RECORDS

a. A system for monitoring delinquent medical records will be developed and followed.

b. A deficiency listing of Consultants, Resident Medical Officers and Nurses with incomplete charts will be developed and monitored.

c. The deficiency listing will be reviewed by the Administrative head of the center and Concerned persons with trends for deficiencies will be contacted

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE I
(Refer to General Manual Policy and Procedure No. 18)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, hereby authorize the release of medical, psychiatric, alcohol and /or drug abuse, HIV testing, and / or AIDS information as described below:

Patient's Name: _____
(First Name) (Father's/Husband's Name) (Surname)

Date of Birth: _____

Date of Request: _____

from the Prime Surgical Centers.

Please send the following information to:

Facility/Physician: _____

Address: _____

City, State, Pin-code: _____

_____ Entire Record _____ History and Physical

_____ Report of Operations _____ X-Ray Reports

_____ Laboratory Reports _____ Pathology Reports

Other Reports: _____

_____

_____ _____
Patient signature Date

Or

_____ _____
Legal guardian signature Date

_____ _____
Witness signature Date

ANNEXURE II
(Refer to General Manual Policy and Procedure No. 18)

IPD HISTORY SHEET

MR No.:
Name:
Age / Sex:
Bed No.:
Date:

Chief Complaints:
History of present illness:
Past History:
Family History:
Personal History:
Treatment History:
General Examination: Pulse: Blood Pressure: Temperature: Respiration Rate: Other relevant findings:

Systemic Examination: CVS: RS: CNS: P/A:
Local Examination:
Provisional Diagnosis:
Investigations Done:
Investigations Advised:

Name and Signature: _____

Date and Time: _____

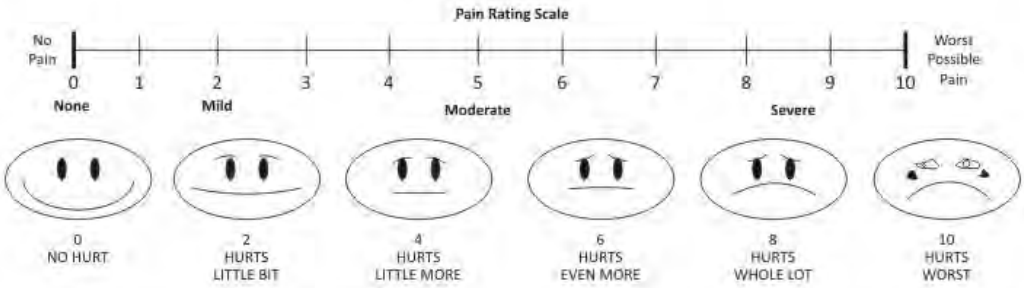
ANNEXURE III
(Refer to General Manual Policy and Procedure No. 18)

PROGRESS SHEET

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Diagnosis :- .....

Consultant Name :- .....



Date Time	Clinical Notes	Signature

Date Time	Clinical Notes	Signature

ANNEXURE IV
(Refer to General Manual Policy and Procedure No. 18)

ANAESTHESIA SUMMARY

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Name of Procedure:-

Name of Anaesthesiologist:-

ASA grade 1 2 3 4 5 E

Co-morbidities:

Anaesthesia Administered:

- General anaesthesia
- Spinal anaesthesia
- Epidural anaesthesia
- Nerve block
- Monitor anaesthesia care

INTRAOPERATIVE :

Adverse incidents / Complications:

Recovery phase : Hemodynamics

PONV

Pain relief

Full Recovery From Anaesthesia (Time) :

Precautions on Discharge :

Name & Signature of Anaesthesiologist, Date & Time :-

ANNEXURE IV
(Refer to General Manual Policy and Procedure No. 18)

ANAESTHESIA SUMMARY

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Name of Procedure:-

Name of Anaesthesiologist:-

ASA grade 1 2 3 4 5 E

Co-morbidities:

Anaesthesia Administered:

- General anaesthesia
- Spinal anaesthesia
- Epidural anaesthesia
- Nerve block
- Monitor anaesthesia care

INTRAOPERATIVE :

Adverse incidents / Complications:

Recovery phase : Hemodynamics

PONV

Pain relief

Full Recovery From Anaesthesia (Time) :

Precautions on Discharge :

Name & Signature of Anaesthesiologist, Date & Time :-

ANNEXURE V
(Refer to General Manual Policy and Procedure No. 18)

DISCHARGE NOTIFICATION / INSTRUCTION

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Diagnosis : - .....

.....

Date and time of discharge : - ..... at ..... am/pm.

Instructions : - .....

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Signature of the consultant:- .....

Name of the Consultant : - .....

Date and Time: - .....

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

CARDIOPULMONARY RESUSCITATION (CPR) CERTIFICATION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 18** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CARDIOPULMONARY RESUSCITATION (CPR) CERTIFICATION

PURPOSE

CPR provides basic emergency life support until the medical help arrives for a sudden cardiac arrest patient.

POLICY

All nursing services personnel who provide patient care are expected to maintain basic cardiac life support certification by Prime Surgical Centers (Refer to Annexure to this policy).

PROCEDURE

1. All nursing services personnel are proficient in and certify annually in basic CPR.

   All nursing services personnel who cannot physically perform CPR are expected to maintain the didactic (written) portion of basic cardiac life support certification.

2. Nursing services personnel initiates cardiopulmonary resuscitation when required according to the assessment of the victims/ patients.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 18)

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL NURSING ORIENTATION (GNO)
CERTIFICATE – CARDIOPULMONARY RESUSCITATION

This is to certify that Staff / Operation Theater Nurse _____ has completed the required course in Cardiopulmonary Resuscitation including theory and practical.

This Staff / OT Nurse has been directly supervised in performing the following Procedures:

1. To keep guidelines in mind for starting CPR
2. Emergency (Crash) Cart maintenance with medication checklist
3. Use of Ambu Bag resuscitation
4. Maintenance and use of Emergency Equipment for CPR
5. Use of External Defibrillation for CPR
6. How to generate CODE BLUE
7. Performance of Basic CPR
8. Documentation: Initiation of CPR report form

Return Demonstration: (Performed on mannequin)

Consultant Educator: _____ Date: _____

Written evidence of the above education, examination and demonstration shall be documented upon successful initial training (Certification). Recertification will occur annually to include: 1) Completion of required course in theory and practice, and 2) Return demonstration on mannequin. Certification Records and a reference list of certified Nurses will be maintained by the Nursing Superintendent in the Nursing Office.

Re-certifications:

_____ Preceptor Date: _____

_____ OT Matron / Nursing Superintendent Date: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

DISPOSAL OF CONTAMINATED SYRINGES AND NEEDLES		
Policy/Procedure Applies To	**All Nursing and Housekeeping Staff**	**Policy/Procedure No: 18** **Page: 1 of 2**
Effective Date: 11 April, 2013		

DISPOSAL OF CONTAMINATED SYRINGES AND NEEDLES

PURPOSE

1. To uphold infection control regulations through proper disposal of contaminated syringes and needles.
2. To promote awareness to Nursing Staff in order to decrease the number of injuries.
3. Alleviate the possibilities of infection development.
4. To Provide guidance about the correct use & disposal of needle & other sharp items at Prime Surgical Centers

GENERAL INFORMATION

Sharp wastes are devices having acute rigid corners, edges, or protuberances capable of cutting or piercing including, but not limited to all of the following:

1. Needles
2. Blades
3. Syringe
4. Broken glass items, e.g. vials.

These items will be disposed of within the sharp box located in the unit. The sharps box is a red impermeable plastic, box-type container with a round-flanged opening. The flanged opening contains a white cuff through which the assembled needle and other identified sharps are placed. When the container is two-thirds full the round white cap is attached to the flang and pressed down until the cap securely snaps into place. Once the cap snaps into place, the cap cannot be removed. Do not seal this cap until ready to dispose of the container.

POLICY

1. Nursing staff having direct contact or the potential for contact with exposure to blood from sharps are expected to practice Standard Precautions according to the Hospital Infection Control Manual Policy and Procedure No. 5
2. All nursing staff shall be knowledgeable to practice the safe disposal of used syringes, needles and other sharps.
3. The nursing staff administering the injection or withdrawing blood is responsible for the safe and proper disposal of needle, syringe, or vacutainer following its use.
4. In all reasonably anticipated exposures to blood or other potentially infectious material, Personal Protective Equipment (PPE) shall be used.
5. The sharps box is utilized for safe disposal of used and contaminated needles after burning.
6. Syringes and vacutainers will be disposed off by putting it in to a red plastic bag.
7. If an injection or other use of sharps must be performed in a room, the sharp box and the needle burner shall be taken to the room for safe storage before disposal in red plastic bag.

DISPOSAL OF CONTAMINATED SYRINGES AND NEEDLES		
Policy/Procedure Applies To	**All Nursing and Housekeeping Staff**	**Policy/Procedure No: 18** **Page: 2 of 2**
Effective Date: 11 April, 2013		

8. Needles shall be burned and disposed of directly into the sharps container without recapping
9. No item is to be removed from the sharp box.
10. The sharps box must be replaced when two-thirds full.

PROCEDURE

1. After injection, burn the needle and remove from the syringe.
2. Place burnt needle in to sharp box and syringe in to Red plastic bag for disposal.
3. When the sharp box is 2/3 full seal the box. Do not press down.
4. Prior to disposal, staff must ensure the lid is locked.
5. Store the sharp box and red plastic bag of syringes safely until it is taken for disposal.
6. Take sharps box and Red plastic bag of syringes to Biohazardous Waste within 24 hours of closure.

PRECAUTIONS

1. Used needles must not be recapped, bent, or broken, removed from safety locking disposable syringes, or otherwise manipulated by hand as accidental puncture may occur.
2. Needles used to withdraw medication is to be removed from the syringe and placed immediately in the sharp box after burning the needle.
3. Do not place fingers in the opening of sharp box or shake as needle stick injury may result.
4. Do not shake a sharps container in an attempt to make protruding needles settle into the box. (A needle may be dislodged by shaking and fly through the air.)
5. Keep the sharp box stabilized so contents will not spill.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 18** **Page: 1 of 5**
Effective Date: 01 April, 2014		

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION

DEFINITION

Vesicants

Drugs which are capable of causing pain, inflammation and blistering of the local skin, underlying tissues and structures, leading to tissue death and necrosis.

Exfoliants

Drugs which are capable of causing inflammation and shedding of the skin, but less likely to cause tissue death.

Irritants

Drugs which are capable of causing inflammation, irritation or pain at site of infilteration, but rarely cause tissue breakdown.

Inflammitants

Drugs which are capable of causing mild to moderate inflammation in local tissues

Neutrals

Inert or neutral compounds that do not cause inflammation or damage.

CONTENTS OF CYTOTOXIC EXTRAVASATION KIT

Please keep the cytotoxic extravasation kit ready in the unit in case of extravasation emergency.

1. Disposable Gloves
2. 5ml Syringe with subcutaneous needle
3. Hyaluronidase 1,500 units injection (1 ampoule)
4. Hydrocortisone 1% cream – labelled with directions for use
5. Sterile water for injection 1 x 10ml
6. Dimethyl sulfoxide (DMSO) 98% solution 1 x 10ml bottle with applicator
7. Hot Pack
8. Cold Pack

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 18** **Page: 2 of 5**
Effective Date: 01 April, 2014		

CLASSIFICATION OF CYTOTOXIC DRUGS ACCORDING TO EXTRAVASATION RISK

Classification of cytotoxic drugs according to their potential to cause serious necrosis when administered outside of the vein, known as extravasation or infiltration.

Vesicants Group 1	Exfoliants Group 2	Irritants Group 3	Inflammitants Group 4
Amsacrine	Cisplatin	Bendamustine	Fluorouracil
Cabazitaxel	Liposomal Daunorubicin	Carboplatin	Methotrexate
Carmustine	Docetaxel	Dexrazoxane	Raltitrexed
Dacarbazine	Liposomal Doxorubicin	Etoposide	
Dactinomycin	Mitoxantrone	Irinotecan	
Daunorubicin	Oxaliplatin		
Doxorubicin	Topotecan		
Epirubicin			
Idarubicin			
Mitomycin			
Paclitaxel			
Streptozocin			
Treosulfan			
Vinblastine			
Vincristine			
Vindesine			
Vinflunine			
Vinorelbine			

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 18** **Page: 3 of 5**
Effective Date: 01 April, 2014		

IMMEDIATE MANAGEMENT OF EXTRAVASATION

Please follow the below mentioned treatment modalities (Consultant should be contacted immediately)

Sr. No.	Drug	Cold /Warm Pack	Treatment
1.	Amsacrine	Cold	Hydrocortisone cream
2.	Bendamustine	Cold	Hydrocortisone cream
3.	Bleomycin	None	No antidote
4.	Cabazitaxel	Warm	Hyaluronidase
5.	Carboplatin	Cold	Hydrocortisone cream
6.	Carmustine	Cold	Hydrocortisone cream
7.	Cisplatin	Cold	Hydrocortisone cream
8.	Cladribine	None	No antidote
9.	Cyclophosphamide	None	No antidote
10.	Cytarabine	None	No antidote
11.	Dacarbazine	Cold	Hydrocortisone cream
12.	Dactinomycin	Cold	Dimethyl Sulfoxide (DMSO)
13.	Daunorubicin	Cold	Dimethyl Sulfoxide (DMSO)
14.	Docetaxel	Warm	Hyaluronidase
15.	Doxorubicin	Cold	Dimethyl Sulfoxide (DMSO)
16.	Epirubicin	Cold	Dimethyl Sulfoxide (DMSO)
17.	Eribulin	None	No antidote
18.	Etoposide	Cold	Hydrocortisone cream
19.	Fluorouracil	Cold	Hydrocortisone cream
20.	Gemcitabine	None	No antidote
21.	Idarubicin	Cold	Dimethyl Sulfoxide (DMSO)
22.	Ifosfamide	None	No antidote
23.	Irinotecan	Cold	Hydrocortisone cream
24.	Liposomal, Daunorubicin	Cold	Dimethyl Sulfoxide (DMSO)

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 18** **Page: 4 of 5**
Effective Date: 01 April, 2014		

Sr. No.	Drug	Cold /Warm Pack	Treatment
25.	Liposomal, Doxorubicin	Cold	Dimethyl Sulfoxide (DMSO)
26.	Melphalan	None	No antidote
27.	Methotrexate	Cold	Hydrocortisone cream
28.	Mitomycin	Cold	Dimethyl Sulfoxide (DMSO)
29.	Mitoxantrone	Cold	Dimethyl Sulfoxide (DMSO)
30.	Oxaliplatin	Warm	Hyaluronidase
31.	Paclitaxel	Warm	Hyaluronidase
32.	Pemetrexed	None	No antidote
33.	Pentostatin	None	No antidote
34.	Raltitrexed	Cold	Hydrocortisone cream
35.	Streptozocin	Cold	Hydrocortisone cream
36.	Topotecan	Cold	Hydrocortisone cream
37.	Treosulfan	Cold	Hydrocortisone cream
38.	Vinblastine	Warm	Hyaluronidase
39.	Vincristine	Warm	Hyaluronidase
40.	Vindesine	Warm	Hyaluronidase
41.	Vinflunine	Warm	Hyaluronidase
42.	Vinorelbine	Warm	Hyaluronidase

If an extravasation occurs please contact the Consultant for appropriate management.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses**	**Policy/Procedure No: 18** **Page: 5 of 5**
Effective Date: 01 April, 2014		

Cytotoxics requiring WARM PACK	**Cytotoxics requiring COLD PACK**
Inject 1500 iu hyaluronidase (in 1ml WFI) via pincushion s/c injections in 0.1 – 0.2ml volumes around the site THEN Apply a warm pack to aid absorption of hyaluronidase Warm pack to remain in situ for 2-4 hours after initial management	**Cold pack + hydrocortisone cream** Apply cold pack for 15-20 minutes 3-4 times a day for up to 3 days. Apply hydrocortisone 1% cream tds, as long as redness persists. Once opened, cream must be labelled with patient details. **OR** **Cold pack + dimethyl sulfoxide (DMSO)*** (see NOTES below for details)

↓

ELEVATE THE LIMB

↓

Urgent assessment by Oncologist / Haematologist

↓

Document the incident by completing Prime Surgical Centers incident form and in Nurses Note

NOTES:

*** Use of 98% dimethyl sulfoxide (DMSO)**

1. DMSO should be applied within 10 – 25 minutes of the extravasation occurring.
2. Draw around area of extravasation with indelible pen. Then, a thin layer of 98% DMSO solution should be applied topically to the extravasated area using the applicator provided. Contact with good skin should be minimised, as there are some reports associating DMSO with blistering of the skin. Once DMSO dries, apply 1% hydrocortisone cream and 30 minutes of cold compression. This process (DMSO, hydrocortisone cream, cold compression) should be repeated as above every 2 hours for the first 24 hours.
3. After 24 hours of the above, for the next 7 days, 98% DMSO should be applied every 6 hours alternating with 6 hourly applications of 1% hydrocortisone cream, so that a preparation is being applied every 3 hours overall.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**All Nurses / Resident Medical Officers**	**Policy/Procedure No:** **Page: 1 of 5**
Effective Date: 01 April, 2014		

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION

DEFINITION

Vesicants

Drugs which are capable of causing pain, inflammation and blistering of the local skin, underlying tissues and structures, leading to tissue death and necrosis.

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Drugs which are capable of causing mild to moderate inflammation in local tissues

Neutrals

Inert or neutral compounds that do not cause inflammation or damage.

CONTENTS OF CYTOTOXIC EXTRAVASATION KIT

Please keep the cytotoxic extravasation kit ready in the unit in case of extravasation emergency.

1. Disposable Gloves
2. 5ml Syringe with subcutaneous needle
3. Hyaluronidase 1,500 units injection (1 ampoule)
4. Hydrocortisone 1% cream – labelled with directions for use
5. Sterile water for injection 1 x 10ml
6. Dimethyl sulfoxide (DMSO) 98% solution 1 x 10ml bottle with applicator
7. Hot Pack
8. Cold Pack

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**All Nurses / Resident Medical Officers**	**Policy/Procedure No:** **Page: 2 of 5**
Effective Date: 01 April, 2014		

CLASSIFICATION OF CYTOTOXIC DRUGS ACCORDING TO EXTRAVASATION RISK

Classification of cytotoxic drugs according to their potential to cause serious necrosis when administered outside of the vein, known as extravasation or infiltration.

Vesicants Group 1	Exfoliants Group 2	Irritants Group 3	Inflammitants Group 4	Neutrals Group 5
Amsacrine	Cisplatin	Bendamustine	Fluorouracil	Alemtuzumab
Cabazitaxel	Liposomal Daunorubicin	Carboplatin	Methotrexate	Asparaginase
Carmustine	Docetaxel	Dexrazoxane	Raltitrexed	Bevacizumab
Dacarbazine	Liposomal Doxorubicin	Etoposide		Bleomycin
Dactinomycin	Mitoxantrone	Irinotecan		Bortezomib
Daunorubicin	Oxaliplatin			Cetuximab
Doxorubicin	Topotecan			Cladribine
Epirubicin				Cyclophosphamide
Idarubicin				Cytarabine
Mitomycin				Eribulin
Paclitaxel				Fludarabine
Streptozocin				Gemcitabine
Treosulfan				Ifosfamide
Vinblastine				Ipilimumab
Vincristine				Melphalan
Vindesine				Pemetrexed
Vinflunine				Pentostatin
Vinorelbine				Rituximab
				Trastuzumab

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**All Nurses / Resident Medical Officers**	**Policy/Procedure No:** **Page: 3 of 5**
Effective Date: 01 April, 2014		

IMMEDIATE MANAGEMENT OF EXTRAVASATION

Sr. No.	Drug	Cold /Warm Pack	Treatment
1.	Amsacrine	Cold	Hydrocortisone cream
2.	Bendamustine	Cold	Hydrocortisone cream
3.	Bleomycin	None	No antidote
4.	Bortezomib	None	No antidote
5.	Cabazitaxel	Warm	Hyaluronidase
6.	Carboplatin	Cold	Hydrocortisone cream
7.	Carmustine	Cold	Hydrocortisone cream
8.	Cisplatin	Cold	Hydrocortisone cream
9.	Cladribine	None	No antidote
10.	Cyclophosphamide	None	No antidote
11.	Cytarabine	None	No antidote
12.	Dacarbazine	Cold	Hydrocortisone cream
13.	Dactinomycin	Cold	DMSO
14.	Daunorubicin	Cold	DMSO
15.	Docetaxel	Warm	Hyaluronidase
16.	Doxorubicin	Cold	DMSO
17.	Epirubicin	Cold	DMSO
18.	Eribulin	None	No antidote
19.	Etoposide	Cold	Hydrocortisone cream
20.	Fludarabine	None	No antidote
21.	Fluorouracil	Cold	Hydrocortisone cream
22.	Gemcitabine	None	No antidote
23.	Idarubicin	Cold	DMSO
24.	Ifosfamide	None	No antidote
25.	Irinotecan	Cold	Hydrocortisone cream
26.	Liposomal, Daunorubicin	Cold	DMSO

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**All Nurses / Resident Medical Officers**	**Policy/Procedure No:** **Page: 4 of 5**
Effective Date: 01 April, 2014		

Sr. No.	Drug	Cold /Warm Pack	Treatment
27.	Liposomal, Doxorubicin	Cold	DMSO
28.	Melphalan	None	No antidote
29.	Methotrexate	Cold	Hydrocortisone cream
30.	Mitomycin	Cold	DMSO
31.	Mitoxantrone	Cold	DMSO
32.	Oxaliplatin	Warm	Hyaluronidase
33.	Paclitaxel	Warm	Hyaluronidase
34.	Pemetrexed	None	No antidote
35.	Pentostatin	None	No antidote
36.	Raltitrexed	Cold	Hydrocortisone cream
37.	Streptozocin	Cold	Hydrocortisone cream
38.	Topotecan	Cold	Hydrocortisone cream
39.	Treosulfan	Cold	Hydrocortisone cream
40.	Vinblastine	Warm	Hyaluronidase
41.	Vincristine	Warm	Hyaluronidase
42.	Vindesine	Warm	Hyaluronidase
43.	Vinflunine	Warm	Hyaluronidase
44.	Vinorelbine	Warm	Hyaluronidase

If an extravasation occurs please contact the Consultant for appropriate management.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

GUIDELINES FOR PREVENTION AND MANAGEMENT OF CHEMOTHERAPY EXTRAVASATION		
Policy/Procedure Applies To	**All Nurses / Resident Medical Officers**	**Policy/Procedure No:** **Page: 5 of 5**
Effective Date: 01 April, 2014		

Cytotoxics requiring WARM PACK	**Cytotoxics requiring COLD PACK**
Inject 1500 iu hyaluronidase (in 1ml WFI) via pincushion s/c injections in 0.1 – 0.2ml volumes around the site THEN Apply a warm pack to aid absorption of hyaluronidase Warm pack to remain in situ for 2-4 hours after initial management	**Cold pack + hydrocortisone cream** Apply cold pack for 15-20 minutes 3-4 times a day for up to 3 days. Apply hydrocortisone 1% cream tds, as long as redness persists. Once opened, cream must be labelled with patient details. **OR** **Cold pack + dimethyl sulfoxide (DMSO)*** (see NOTES below for details)

↓

ELEVATE THE LIMB

↓

Urgent assessment by Oncologist / Haematologist

↓

Document the incident by completing Prime Surgical Centers incident form and extravasation record form. File copies in patient's health record.

NOTES:

*** Use of 98% dimethyl sulfoxide (DMSO)**

1. DMSO should be applied within 10 – 25 minutes of the extravasation occurring.
2. Draw around area of extravasation with indelible pen. Then, a thin layer of 98% DMSO solution should be applied topically to the extravasated area using the applicator provided. Contact with good skin should be minimised, as there are some reports associating DMSO with blistering of the skin. Once DMSO dries, apply 1% hydrocortisone cream and 30 minutes of cold compression. This process (DMSO, hydrocortisone cream, cold compression) should be repeated as above every 2 hours for the first 24 hours.
3. After 24 hours of the above, for the next 7 days, 98% DMSO should be applied every 6 hours alternating with 6 hourly applications of 1% hydrocortisone cream, so that a preparation is being applied every 3 hours overall.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE XVIII
(Refer to Housekeeping Manual Policy and Procedure No. 1)

MALE AND FEMALE DRESSING ROOM

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
A/C baffles and top of lockers		X		
Uniform Cupboard	X			
Lockers	X			
Chairs	X			
Luminaries		X		
Electrical Outlet/ Switch Plates	X			
Empty Waste Bins	X			
Empty Laundry Hamper	X			
Shoes Stand	X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: OPENING STERILE PACKAGES		
Module Applies To	**All Nurses and Technicians**	**Module No: 18** **Page: 1 of 5**
Effective Date: 11 April, 2013		

Name_____ Unit_____ Date_____

Frequency

1. Rarely observed or never done
2. Rarely done (<6 x a year)
3. Occasionally done (1 – 2 x a month)
4. Frequently done (daily or weekly)

Experience

1. None
2. Limited
3. Moderate
4. Proficient

Validation Method

1. = Cognitive: Tests, verbalize action/steps
2. = Psychomotor: Demonstrates skill in lab. simulated setting
3. = Psychomotor: Demonstrates skill in clinical setting
4. = Affective: Demonstrates appropriate behavior/attitude

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
			1. Discusses pre-requisite knowledge regarding the technique of opening sterile packages.	1. Defines sterile packages. ▪ Supplies linens and instruments wrapped in papers, linens or in metal and plastic instrument boxes rendered free of micro-organisms by sterilization. 2. Enumerates the indicators of sterility. ▪ Chemical strips and tapes, autoclave tapes and tube tests that changes color on exposure to sterilization ▪ Manufacture's stamps on packages of dates of sterilization and expiration. ▪ Indicator strip line in the pouch papers which changes color when exposed to steam or gas.						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: OPENING STERILE PACKAGES		
Module Applies To	**All Nurses and Technicians**	**Module No: 18** **Page: 2 of 5**
Effective Date: 11 April, 2013		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up	Plan	Preceptor
					Method	Code	Date		Date	Method
				3. Verbalizes the principles behind sterile packaging. ▪ Edges of anything that encloses sterile contents are considered unsterile. ▪ Maintain a margin of safety which is the area inside the sterile wrapper considered sterile one (1) inch from the edges of the wrappers. ▪ Never tear edges of packages and do not slide contents over the edges of the flap on peel –open packages. ▪ Sterile items are opened into the sterile field or handed over to a sterile person. ▪ Any doubt on sterility of any item is considered unsterile or contaminated. ▪ Packages with holes, tears are not sterile ▪ Wet packages are considered contaminated and unsterile						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: OPENING STERILE PACKAGES		
Module Applies To	**All Nurses and Technicians**	**Module No: 18** **Page: 3 of 5**
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SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
				4. States the indications of sterile packaging. ▪ For use in surgical procedures ▪ Prevent infection ▪ Keep items sterile until time of use ▪ Aseptic purposes.						
			2. Performs the technique of opening sterile packages.	1. Opens sterile packages/supplies. ▪ Checks for the date of sterilization is stamped on the outer packages; ensures it is not outdated/expired. ▪ Checks for package integrity for tears water marks and cover lids of metal box instruments are tightly closed and no leakage. ▪ Opens, rigid instrument container by lifting lid straight up, then tilt it back towards self. Scrub person opens the inner wrapper (if inner wrapper is between tray and container) and lifts the inner tray out by handles on the ends of the tray. ▪ Removes tape from packages wrapped in paper, cotton muslin/linen and non woven materials. ▪ Checks chemical indicator to be certain that an item have been exposed to a						

Note: Must be psychomotor validation

COMPETENCY: OPENING STERILE PACKAGES		
Module Applies To	**All Nurses and Technicians**	**Module No: 18** **Page: 4 of 5**
Effective Date: 11 April, 2013		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
				sterilization process. eg. tube test, autoclave tapes, chemical strips ▪ Opens drape packs, instrument sets, gown packs and basin set, so inside of each inner wrapper becomes the sterile table cover. The wrapper amply cover the entire table surface. ▪ Circulating person or unsterile person opens top flap away from self, then turns the sides under. Ends of flaps are secured in hand so flaps do not dangle loosely. The last flap is pulled towards the person opening the package, there by exposing package contents away from non sterile hand. ▪ Pulls open downward, edges of peel –open packages and lifts upward the contents of sterile package and hand over to sterile person or flips it open on to the sterile field. ▪ Sterile person lifts sterile contents from packages by reaching down and lifting items straight up, holding elbows high. 2. Maintains a sterile transfer of supplies to sterile table ▪ Opens packages such as gloves, sponges, sutures etc by touching only the outside of the outer wrapper.						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: OPENING STERILE PACKAGES		
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SELF ASSESSMENT

Freq	Exp	Area	Competency	Standard	Preceptor Validation			Follow-Up	Plan	Preceptor
					Method	Code	Date		Date	Method
				▪ Avoids reaching over sterile contents and sterile table. ▪ Opens gowns and gloves for the scrub person on the mayo stand or small table. ▪ Discards or uses contents of opened sterile bottles. Does not recap bottles as pouring edges are contaminated by the caps.						
			3. Establishes a positive interpersonal relationship with colleagues	▪ Speaks in a modulated voice and uses respectable language eg. Please, thanks ▪ Considers, accepts and follows suggestions or corrections as part of learning process. ▪ Accomplishes work assignments and cooperates with surgical team. ▪ Shows interest and initiative by taking notes and asking questions related to work assignments.						

_____ _____

Validator Signature **Designation**

Note: Must be psychomotor validation

Preceptor code: A- Preceptor B- OT Matron C- Nursing Superintendant

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PATIENT CARE AFTER ANAESTHESIA		
Policy/Procedure Applies To	**All Staff Nurses / Resident Medical Officers**	**Policy/Procedure No: 18** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PATIENT CARE AFTER ANAESTHESIA

PURPOSE

To assist the patient in achieving a smooth transition from the unconscious to conscious state in a quiet, reassuring atmosphere.

POLICY

1. Oxygen will be routinely applied on all patients transferred back to the Nursing Unit after General Anaesthesia unless otherwise ordered by Anaesthesiologist. Oxygen may be administered at 4L per nasal cannula, 6L per face mask, if appropriate, or 6L for face tent. This may be removed once the patient is awake and able to take deep breaths spontaneously.
2. All intake and output for the post operative period will be measured and recorded.
   a. Urine.
      i. Catheterized patients: Drainage bag will be emptied on arrival and the amount of urine from surgery recorded.
      ii. Drainage bag will again be emptied before removal and the amount recorded.
   b. Other output

      Will be recorded as designated on post operative record.
3. Patients are to be visually monitored or attended by nursing staff at all times.
4. If the patient is thrashing about while recovering from General Anaesthesia, pad the side rails of the stretcher. Stay near and comfort the patient by talking softly and touching patient reassuringly. Restraints should be a last resort and only used for the patient's safety and upon written order of the operating Surgeon or Anaesthesiologist
5. Vital parameters will be taken and recorded every fifteen (15) minutes by Resident Medical Officer as well as the Nurse independently on alternate basis for first 3 hours. The Anaesthesiologist will be informed immediately in case of any change/s in vital parameters. Inform the Anaesthesiologist in case patient remains uneventful after 3 hours of surgery. Temperatures will be taken every half hour if less than 96 degrees and more than 99 degrees.
6. The head of the bed will remain flat until the patient becomes responsive. Once responsive, the head of the bed may be raised gradually every fifteen (15) minutes to a Fowler's position. Frequent monitoring of vital parameters will determine the patient's tolerance to the position change.
7. Bed rails are to be raised at all times.
8. Discharging patients

   Patient must be in stable condition and recovered from anaesthesia with reflexes intact.
   Patients will be discharged by a physician's orders. (Refer to Nursing Manual Policy and Procedure No.107 and 108).

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

END OF LIFE CARE (LAST OFFICES), SUDDEN OR UNEXPECTED DEATH		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses / OT Matron / Nursing Superintendent**	**Policy/Procedure No: 19** **Page: 1 of 10**
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END OF LIFE CARE (LAST OFFICES), SUDDEN OR UNEXPECTED DEATH

PURPOSE

1. To ensure that the deceased person is handled with dignity.
2. To free the dead body from drains and invasive lines.
3. To render the dead body clean from secretion, blood and other body excretion.
4. To dress the surgical incision.

POLICY

1. Each individual shall be allowed to die with dignity, respect and humanity.
2. Each individual shall be allowed to die with minimal pain.
3. The hygienic and physiologic needs of the dying are great importance and shall not be neglected.
4. Whenever possible, the patient's attendants must be informed about the patient's critical condition and a regular update given by the doctor on duty.
5. The doctor informs death of the patient to his/her relatives.
6. The Nurse must give / offer the attendant or next of kin the opportunity to see the dead, without disturbing other patients in unit.
7. The body will be handed over to security with two carbon copies of death notification forms.
8. Documentation and billing will be done without delay.

   The documentation will include the following:

   a. Death Notification : Three Forms
   b. Hospital Death Notification
   c. Form – 2 (Gurmukhi)
   d. Form – 4 (English cause of death) 2 copies
   e. Nurses notes, all Vitals and Medication Administration and Flow Sheets to be completed.
9. The patient's room or cubicle is thoroughly cleaned, carbonized and all waste disposed of as per Prime Surgical Centers policy.

Points to Remember

1. Prior to last office consult the family before the body is handed over.
2. Accord respect for religious beliefs.
3. Ensure all documentation is done in legible handwriting (including the carbon copies).

END OF LIFE CARE (LAST OFFICES), SUDDEN OR UNEXPECTED DEATH		
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PROCEDURE

The following procedure will be carried out after the Consultant's certification of death:

1. The care of the patient's body after death will be maintained with the same dignity as in life.
2. The body must not be handled unnecessarily. Details of last offices will vary according to patients/client's cultural background and religious practices.
3. Protective clothing gloves and aprons must be worn, according to the Hospital Infection Control Policy as necessary.
4. Straighten the body as rigor mortis occurs 2-4 hours after death. Place client/patient on his/her back and remove pillows. Align limbs in natural position with arms at his/her side.
5. Remove any mechanical aids, such as splints.
6. Seal all leaking wounds drain sites etc. with a firm dressing pad and waterproof tape. It is possible for wounds, intravenous infusion sites, etc. to leak profusely after death.
7. Close patient's eyes by applying light pressure to eyelids for 30 seconds.
8. Wash patient following procedure for bed bathing. If necessary, carefully shave male patient.
9. False teeth should be placed in the person's mouth if possible / practicable.
10. Close the mouth and support the jaw by placing pillow on the chest underneath jaw to ensure the mouth remains closed.
11. Place clean sheet under the client/patient.
12. Remove all jewellery in the presence of a witness unless instructed otherwise by next of kin/relatives. Any jewellery remaining on client/patient should be recorded on notification label and documented in the patient's notes.
13. Dress the patient/client in a shroud. Wrap the body loosely in a large sheet ensuring the face and feet are covered. Secure sheet with adhesive tape. Place second sheet on top of shroud.
14. Complete client/patient identification label and attach to wrist and ankle.
15. Throughout the procedure the client/patient must remain covered in order to preserve dignity and privacy.
16. Arrange for transfer of client/patient to appropriate facility.

INFORM NEXT OF KIN

1. If the next of kin is not present at the time of death, the Resident Medical Officer on duty must inform them.
2. Bereaved relations require sensitive and compassionate approaches, as a range of emotions may be expressed at the news of death.
3. Relatives should be given clear information about collecting the death certificate and the patient's/client's belongings.

END OF LIFE CARE (LAST OFFICES), SUDDEN OR UNEXPECTED DEATH		
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SUDDEN OR UNEXPECTED DEATH

POLICY IN THE EVENT OF A SUDDEN OR UNEXPECTED DEATH

Death is classed as sudden or unexpected in the following circumstances:

1. Death which has occurred within 24 hours of admission.
2. Death following post-operative or post-invasive procedures.
3. Death as a result of untoward incident, fall or drug error.
4. Death where there is any suspicious or foul play.

In the event of sudden death the Resident Medical Officer and the Consultant attending the patient will contact the police (Kothrud - 020-25391515, 25391010, 25447427; Deccan Gymkhana- 020- 25675005; Prabhat Road – 18002009000) to ask them to attend. He will also contact the coroner to inform him that a post-mortem may be required.

In the event of sudden death, the client/patient must not be moved or tampered with until such time as the Resident Medical Officer and the patient's Consultant, has attended to confirm death and complete relevant paperwork.

If a service user is unconscious and not breathing the ambulance service should be called and resuscitation attempts should continue until a Resident Medical Officer / Consultant makes the decision to discontinue resuscitation.

PROCEDURE FOR SUDDEN OR UNEXPECTED DEATH

Every attempt should be made not to disturb the area surrounding the body of the deceased and all evidence must be retained, the area should be sealed off from view to others in the vicinity.

The police must be informed.

A member of staff should stay with the body until the police arrive and assume responsibility for the body.

In the event of an unexpected death it is the responsibility of the police to inform the relatives. The Resident Medical Officer / Consultant **must** clarify with the police that the relatives have been informed.

In the event of an unexpected death, the body of the deceased will be removed to the Coroner. It is the responsibility of the police to liaise with the Coroner. Out of hours the police will act on behalf of the Coroner and arrange for the removal of the body.

If the death occurs between 9am and 5pm on a weekday the person in charge of the unit/ Resident Medical Officer must ensure that the following Prime Surgical Centers personnel are informed immediately:

1. Unit In-charge
2. Responsible Consultant
3. Nursing Superintendent
4. Customer Services, Billing and Medical Records
5. Housekeeping Department
6. Administrative Head of Prime Surgical Centers

Unit staff must complete the Incident Report form (Refer to Nursing Manual Policy and Procedure No. 10)

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If the death occurs outside office hours the person in charge of the unit/ Resident Medical Officer must alert the following Prime Surgical Centers personnel (Telephone numbers available in the Prime Surgical Centers directory)

1. Respective Consultant
2. Nursing Superintendent
3. Administrative Head of Prime Surgical Centers
4. Housekeeping, Customer Service, Billing and Medical Records
5. Administrative Head of Prime Surgical Centers must contact the Pune Municipal Corporation (at the earliest possible time after the death)

Staff involved in the resuscitation attempt must provide a clear and accurate record of every intervention used (Refer to Nursing Manual Policy and Procedure No. 11 on CPR). Each member of staff on shift should be given the opportunity to write down everything they can remember about the events surrounding the death.

In preparation for the Coroner's request for the original medical records, all medical records should be photocopied. If the medical records are very lengthy consideration should be given to limiting the photocopying to the relevant sections of the medical records. All pages should be stamped with Prime Surgical Centers Registration No. Stamp and initiated by the Administrative Head of the Center).

The unit in-charge/nursing Superintendent and all senior managers should ensure that every effort is made to support (which may involve counseling, spiritual or religious support) unit staff.

Unit staff must complete the Incident Report form (Refer to Nursing Manual Policy and Procedure No. 10)

CONTACT WITH THE RELATIVES

Following the initial contact by the police, the Consultant or the Administrative Head of Prime Surgical Centers must contact the relatives to inform the relatives what actions are being taken by Prime Surgical Centers following the sudden death.

Any personal property of the deceased must be returned at an appropriate time in accordance with the wishes of the family. A list of items must be included. Nursing Superintendent must ensure that the return of the deceased property is conducted in a respectful and sensitive manner.

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GUIDELINES FOR LAST OFFICES/DEATH

Required Items

1. Bowl, soap, towel and two face cloths.
2. Razor (electric or disposable), comb, nail scissors
3. Equipment for oral toilet including equipment for cleaning dentures.
4. Identification labels x 2.
5. Documents required by law or Prime Surgical Centers policy, e.g. notification of death cards.
6. Shroud of patients personal clothing: nightdress, pyjamas, clothes previously requested by the patient; or clothes which may comply with family / cultural wishes. (Mortuary prefers patients to be in shroud.)
7. Plastic Body bag if required (i.e. in event of actual or potential leakage of bodily fluids and/or infectious disease) and labels for the body defining the nature of the disease/infection.
8. Tape
9. Gauze, tape dressings and bandages if wounds present.
10. Valuables or property check list.
11. Plastic bags for clinical and household waste.

END OF LIFE CARE (LAST OFFICES), SUDDEN OR UNEXPECTED DEATH		
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PROCEDURE

ACTION	RATIONALE
Confirmation of death must be written by the Attending Consultant. Confirmation of death must be recorded in a patient's medical and nursing records.	
Inform and offer support to relatives and / or next of kin.	To ensure relevant individuals are aware of patient's death.
Inform other patients.	Other patients are often aware that a death is expected or has occurred. It is important to inform them when someone dies so that they can be offered support and reassurance, and to answer any questions sensitively, so as to allay misconceptions and fears.
Put on gloves and apron.	To reduce risk of contamination with body fluids, and to reduce risk of cross-infection. Protective clothing, for example gloves and an apron, must be worn for carrying out last offices.
Lay the patient on his/her back with the Assistance of two Nurses or housekeeping staff (adhering to Safe Handling of Patient policy). Support the jaw by placing a pillow or rolled up towel on the chest underneath the jaw. Remove any mechanical aids such as cannulas, electrodes, Ryles tubes, heel pads, etc. Straighten limbs.	To maintain the patients dignity and for future management of the body, as rigor mortis occurs 2 – 6 hours after death
Close the patient's eyes by applying light pressure to the eyelids for 30 seconds.	To maintain patient dignity and for aesthetic reasons. Closure of eyes will also provide tissue protection in case of corneal donation.
Drain the bladder by pressing on the lower abdomen.	Because the body can continue to excrete fluids after death.
Pack orifices with gauze if fluid secretion continues or is anticipated. If excessive leaking of bodily fluids occurs, consider suctioning.	Leaking orifices pose a health hazard to staff and relatives coming into contact with the body. Aspirate before removing Ryles tube and suction.

END OF LIFE CARE (LAST OFFICES), SUDDEN OR UNEXPECTED DEATH		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses / OT Matron / Nursing Superintendent**	**Policy/Procedure No: 19 Page: 7 of 10**
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ACTION	RATIONALE
Exuding wounds should be covered with clean absorbent dressing and secured with an occlusive dressing.	The dressing will absorb any leakage from the wound site. Open wounds pose a health hazard to staff coming into contact with the body. If a post mortem is required existing dressing should be left insitu and covered.
Remove drainage tubes etc., unless otherwise stated. Open drainage sites may need to be sealed with an occlusive dressing.	Open drainage sites pose a health hazard to staff coming into contact with the body. If a post mortem is required drainage tubes etc., should be left insitu.
Wash the patient unless requested not to do so for religious or cultural reasons. Shave a male patient. It may be important to family or carers to assist with the washing, to continue to provide the care given in the period before the death.	For hygienic and aesthetic reasons. It is an expression of respect and affection, part of the process of adjusting to loss and expressing grief.
Clean patient's mouth with a glycerine lemon stick to remove any debris and secretions. Clean dentures and replace them in the mouth if possible.	For hygienic and aesthetic reasons. To maintain privacy and dignity.
Remove all jewellery, in the presence of another Nurse, unless requested by the patient's family to do otherwise. Jewellery remaining on the patient should be documented on the 'notification of death' form. Record the jewellery and other valuables in the patient's valuable checklist and store the items according to Prime Surgical Centers policy.	To meet with legal requirements and partner / relatives wishes. According to Prime Surgical Centers policy no valuables are kept with the patient.
Dress the patient in personal clothing or a shroud, depending on relatives' wishes.	For cultural or religious reasons and to meet with family's wishes.
Label one wrist and one ankle with an identification label. Complete any documents such as notification of death forms. Copies of such forms are usually required. Tape one securely to shroud.	To ensure correct and any easy identification of the body in case sending the body to the mortuary.
Wrap the body in a mortuary sheet, ensuring that the face and feet are covered and that all limbs are held securely in position.	To avoid possible damage to the body during transfer and to prevent distress to colleagues e.g. portering staff.
Secure the sheet with tape.	Pins must not be used, as they are a health and safety hazard to staff and others.

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ACTION	RATIONALE
Place the body in a body bag if leakage of body fluids is a problem or is anticipated, or if the patient has certain infectious diseases.	Actual or potential leakage of fluid, whether infection is present or not, poses a health hazard to all those who come into contact with the deceased patient. The sheet will absorb excess fluid.
Tape the second notification of death form to the outside of the sheet or hand over to the patient's relatives and Pune Municipal Corporation.	For the ease of identification of the body in the mortuary or for notification to Pune Municipal Corporation.
Request the portering staff remove the body from the unit and transport to the mortuary or home.	Decomposition occurs rapidly, particularly in hot weather and in overheated rooms. Many pathogenic organisms survive for some time after death and so decomposition of the body may pose a health and safety hazard for those handling the body. Autolysis and growth of bacteria are delayed if the body is cooled. (Advice the relatives regarding this).
Screen off area where removal of the body will occur.	Avoid causing unnecessary distress to other patients, relatives and staff.
Remove gloves and apron. Dispose of equipment according to Prime Surgical Centers, Hospital Infection Control policy, and wash hands.	To minimize risk of cross infection and contamination.
Record all details and actions within the nursing documentation & Incident Report	To record the time of death, names of those present, and names of those informed.
Transfer property, patient records etc. to the appropriate administrative department (Medical Records Department/ Pune Municipal Corporation).	

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INFECTION PREVENTION & CONTROL FOR SUSPECTED INFECTIOUS CASES

Prime Surgical Centers Guidelines on the precautions to be taken with the bodies of those who have died with a known or suspected infection.

1. **INTRODUCTION**

   The measures taken or advised to control the perceived hazards are often insensitively applied. The indiscriminate use of body bags may cause needless anxiety for the bereaved family, friends and also among the Center staff.

   The safety of all persons who may come in contact with a body associated with an infection must always be given high priority. There should be a balance between what is required for safety and the sensitivity and dignity of the bereaved.

   Not all cases of infection will have been identified before death and for this reason it is strongly recommended that high standards are adopted for the handling of all bodies.

2. **SPREAD OF INFECTION**

   Organisms in a dead body are unlikely to infect healthy people with intact skin, but there are other ways they may be spread.

   a. Needlestick injuries with a contaminated instrument or sharp fragment of bone.
   b. Contaminated aerosols or splashes from body openings or wounds.
   c. Aerosol from lungs, e.g. tubercle bacilli when condensation could possibly be forced out through the mouth.
   d. Intestinal pathogens from anal and oral orifices.
   e. Through and from abrasions, wounds and sores on the skin.
   f. Splashes or aerosols onto the conjunctivae.

   The risks of infection are not high (and no more than in life) and are usually prevented by the use of appropriate PPE (Personal Protective Equipment).

   If a risk of infection is known or suspected, appropriate procedures need to be followed. (Refer Annexure I to this policy).

3. **COMMUNICATION**

   If a person has died with a known or suspected infection, it is essential and a legal responsibility, that all persons who may be involved in handling the body are informed of the potential risk of infection. They should be told of the risks but not the specific diagnosis as this remains confidential, even after death. The persons who need to know include:

   Medical and Nursing staff, housekeeping, mortuary staff and the bereaved relatives.

   It is important that good liaison is maintained between staff in the units, housekeeping , microbiology and histopathology laboratories and mortuary departments.

   Co-ordinating of viewing, hygienic and ritual body preparation and then bagging of the deceased should be done in the unit.

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4. **LAST OFFICES**

The most final act of care for a patient is that of laying out. It is necessary to be mindful of any infection risks and the precautions necessary to protect others.

Mortuary staff must be informed if the patient was receiving specific infection control nursing other than for antibiotic resistant organisms or protective isolation. Use a Biohazard label.

Nursing staff performing the last offices must follow the same working practices as when the patient was alive as stated in the Infection Prevention & Control Good Practices Policy.

When preparing the body consideration must be given to control the loss of blood and or body fluids. Last offices should therefore include:

a. Check identification band is on wrist.
b. Cleaning the body of any soiling and body fluids, including nasal and oral cleansing also putting in cleaned dentures.
c. Observing the body for wounds and puncture sites and applying waterproof pressure dressings wherever practicable.
d. If the death is to be referred to the coroner, newly introduced drains, intravenous lines, catheters, etc. must be left in situ. Tubing must be clamped or drainage bags attached to prevent syphoning.
e. Plugging the mouth and nostrils, if necessary, to prevent discharges, e.g. in cases of severe abdominal obstruction.
f. Emptying the bladder, if necessary, by applying pressure to the abdomen.

BODY BAGS

A risk assessment must be made on the infectivity of the body prior to leaving the unit.

A body bag must be used prior to transfer of the body to the mortuary or home where there is:

1. A high risk of infection. (Refer Annexure I)
2. Uncontrollable loss of blood or body fluids.
3. No known medical history.

Whenever body bags are used a biohazard label must be attached to the body bag and the body and the accompanying Notification Form (Form 4 – Medical Certification of Cause of Death) Refer Annexure II for the mortuary staff.

Ensure that the relevant form is completed and placed in a sealed envelope (to ensure confidentiality) for the attention of the mortuary staff.

Ensure the zip closure is left at the head end of the bag.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE I
(Refer to Nursing Manual II Policy and Procedure No. 19)

GUIDELINES FOR HANDLING CADAVERS WITH INFECTIONS

Infection	Body Bag	Category of Risk	Viewing	Hygienic Preparation
Anthrax	Yes	HR	No	Yes
Chickenpox/shingles	No	L	Yes	Yes
Cholera	Yes	M	Yes	Yes
Cryptosporidiosis	No	L	Yes	Yes
Dermatophytosis	No	L	Yes	Yes
Diphtheria	Yes	M	Yes	Yes
Dysentery	Yes	M	Yes	Yes
Acute encephalitis	No	L	Yes	Yes
Food poisoning	No	M	Yes	Yes
Hemorrhagic fever with renal syndrome	No	M	Yes	Yes
Hepatitis A	No	M	Yes	No
Hepatitis B, C, and non-A, non-B	Yes	H	Yes	No
HIV/AIDS	Yes	M	Yes	Yes
Influenza types A, B and C	No	H	Yes	Yes
Legionellosis	No	L	Yes	Yes
Leprosy	No	L	Yes	Yes
Leptospirosis (Weil's Disease)	No	M	Yes	Yes
Lyme Disease	No	L	Yes	Yes
Malaria	No	M	Yes	Yes
Measles	No	L	Yes	Yes
Meningitis (except meningococcal)	No	L	Yes	Yes
Meningococcal septicemia (with or without meningitis)	Yes	M	Yes	Yes

L = Low Risk M = Medium Risk H = High Risk HR = High (Rare)

Definitions
Bagging: Placing the body in a plastic body bag.
Viewing: Allowing the bereaved to see, touch and spend time with the body before disposal
Hygienic Preparation: Cleaning and tidying the body so it presents a suitable appearance for viewing (an alternative to embalming).

NB. The advice given in specific cases may be varied if the Consultant Microbiologist/ Consultant in Communicable Disease Control decide it is appropriate after assessing the risks.

Infection	Body Bag	Category of Risk	Viewing	Hygienic Preparation
Methicillin resistant Staphylococcal Aureus (MRSA)	No	L	Yes	Yes
Mumps	No	L	Yes	Yes
Ophthalmia neonatorum	No	L	Yes	Yes
Orf	No	L	Yes	Yes
Paratyphoid Fever	Yes	M	Yes	Yes
Plague	Yes	HR	No	No
Acute poliomyelitis	No	M	Yes	Yes
Psittacosis	No	L	Yes	Yes
Q Fever	No	M	Yes	Yes
Rabies	Yes	HR	No	No
Relapsing Fever	Yes	M	Yes	Yes
Rubella	No	L	Yes	Yes
Scarlet Fever	Yes	M	Yes	Yes
Smallpox	Yes	HR	No	No
Streptococcal Invasive Group A	Yes	H	No	No
Tetanus	No	L	Yes	Yes
Transmissible spongiform encephalopathies (eg Creutzfeldt-Jakob Disease)	Yes	H	Yes	Yes
Tuberculosis	Yes	M	Yes	Yes
Typhoid Fever	Yes	M	Yes	Yes
Typhus	Yes	M	Yes	Yes
Viral Haemorrhagic Fever	Yes	HR	No	No
Whooping Cough	No	L	Yes	Yes
Yellow Fever	Yes	HR	No	No

L = Low Risk M = Medium Risk H = High Risk HR = High (Rare)

Definitions

Bagging: Placing the body in a plastic body bag.

Viewing: Allowing the bereaved to see, touch and spend time with the body before disposal

Hygienic Preparation: Cleaning and tidying the body so it presents a suitable appearance for viewing (an alternative to embalming).

NB. The advice given in specific cases may be varied if the Consultant Microbiologist/ Consultant in Communicable Disease Control decide it is appropriate after assessing the risks.

OTHER CONDITIONS REQUIRING BODY BAG AND WITH RESTRICTION OF CONTACT (EXCEPT TOUCHING FACE), BUT SHOULD NOT BE REMOVED FROM BAG INCLUDE:		
▪ Death in dialysis unit ▪ Known intravenous drug misuser ▪ Severe secondary infection	▪ Gangrenous limbs & infected amputation sites ▪ Large pressure sores ▪ Leakage & discharge of body fluids likely	▪ Post mortem ▪ Incipient decomposition

ANNEXURE II
(Refer to Nursing Manual II Policy and Procedure No. 19)

MMDM 1092 (1000 pads of 100 pgs) 8-11 Birth-Death

PUNE MUNICIPAL CORPORATION

MEDICAL CERTIFICATION OF CAUSE OF DEATH

(For institutional deaths. Not to be used for still births.)

FORM NO. 4 (See Rule 7)

To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital ..... I hereby certify that the person whose particulars are given below died in the hospital in Ward No. ..... on ..... at ..... A.M./P.M.

NAME OF DECEASED

Sex		Age at Death: If 1 year or more, age in Years	If less than 1 year, age in Months	If less than 1 month, age in Days	If less than 1 day, age in Hours	For use of Statistical Office
M	F					

CAUSE OF DEATH

		Interval between on set & death approx.
1. Immediate cause : State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc.	(a) Due to (or as a consequences of)	
Antecedent cause : Morbid conditions, if any giving rise to the above cause, stating underlying conditions last.	(b) Due to (or as a consequences of)	
2. Other significant conditions contributing to the death but not related to the disease or conditions causing it.	(c)	

Manner of Death : (How did the injury occur ?)

1. Natural 2. Accident 3. Suicide 4. Homicide 5. Pending investigation

If deceased was a female, was the death associated with pregnancy ? 1. Yes 2. No

If Yes, was there a delivery ? 1. Yes 2. No

Name and Signature of the Medical Attendant certifying the cause of death

Date of verification

SEE REVERSE FOR INSTRUCTIONS

(To be detached and handed over to the relative of the deceased.)

Certified that Shri / Smt. / Kum. ..... son / wife / daughter of Shri ..... R/O ..... was admitted to this hospital on ..... and expired on ..... at ..... A.M./P.M.

Doctor : .....

Medical Superintendent : .....

Name of the Hospital : .....

MEDICAL CERTIFICATE OF CAUSE OF DEATH

Directions for completing the Form.

Name of Deceased : To be given in full. Do not use initials. If deceased is an infant, not yet named at time of death, write 'Son of' (S/O) or 'Daughter of' (D/O), followed by names of mother and father.

Age at Death : If the deceased was over 1 year of age, give age in completed years. If the deceased was below 1 year of age, give age in months and If below 1 month give age in completed number of days and if below one day, in hours.

Cause of Death : This part of the form should always be completed by the attending physician personally.

The certificate of cause of death is divided into two parts, 1 and 2. Part 1 is again divided into three parts, lines (a), (b), (c). If a single morbid condition completely explains the deaths, then this will be written on line (a) of Part 1 and nothing more need be written in the rest of Part 1 or Part 2. For example, smallpox, lobar pneumonia, cardiac beriberi are sufficient cause of death and usually nothing more is needed.

Often, however, a number of morbid conditions will have been present at death and the doctor must then complete the certificate in the proper manner so that the correct underlying cause will be tabulated. First, enter in Part 1 (a) the immediate cause of death. This does not mean the mode of dying. e.g. heart failure, respiratory failure, etc. These terms should not appear on the certificate at all since they are modes of dying and not causes of death. Next consider whether the immediate cause is a complication or delayed result of some other cause. If so, enter the antecedent cause in Part 1, line (b). Sometimes there will be three stages in the course of events leading to death. If so, line (c) will be completed. The underlying cause to be tabulated is always written last in Part 1.

Morbid conditions or injuries may be present which were not directly related to the chain of events causing death but which contributed in some way to the fatal outcome. Sometimes the doctor finds it difficult to decide, especially for infant deaths, which of several independent conditions was the primary cause of death; but only one cause can be tabulated, so the doctor must decide. If the other diseases are not effects of the underlying cause, they are entered in Part 2.

Do not write two or more conditions on a single line. Please write the names of the diseases (in full) in the certificates as legible as possible to avoid the risk of their being misread.

Onset : Complete the column for interval between onset and death whenever possible, even if very approximately, e.g. 'form birth' several years.

Accidental or violent deaths : Both the external cause and the nature of the injury are needed and should be stated. The doctor or hospital should always be able to describe the injury, stating the part of the body injured, and should give the external cause in full when this is shown. For example : (a) Hypostatic pneumonia, (b) Fracture of neck of femur, (c) fall from ladder at home.

Maternal deaths : Be sure to answer the questions of pregnancy and delivery. This information is needed for all women of child-bearing age, even though the pregnancy may have had nothing to do with the death.

Old age or senility : Old age (or senility) should be not given as a cause of death if a more specific cause is known. If old age was contributory factor, it should be entered in Part 2. For example : (a) Chronic bronchitis, II old age.

Completeness of information : A complete case history is not wanted, but if the information is available enough details should be given to enable the underlying cause to be property classified. For example : Anaemia - Give type of anaemia, if known. Neoplasms - indicate whether benign or malignant and site with site of primary neoplasm, whenever possible. Heart disease - describe the condition specifically, if congestive heart failure, chronic on pulmonale, etc are mentioned, give the antecedent conditions. Tetanus - describe the antecedent injury, if known. Operation - state the condition for which the operation was performed. Dysentry - specify whether bacillary, amoeble, etc, if known. Complications of pregnancy or delivery - describe the complication specifically. Tuberculosis - give organs affected.

Symptomatic statement : Convulsion, diarrhoea, fever, ascites, jaundice, debility etc. are symptoms which may be due to any one of a number of different conditions. Sometimes nothing nore is know, but whenever possible, give the disease which caused the symptom.

Manner of Death : Deaths not due to external cause should be identified as 'Natural'. If the cause of death is known, but it is not known whether it was the result of an accident suicide or homicide and is subject to further investigation, the cause of death should invariably be filled in and the manner of death should be shown as 'Pending investigation'.

[illegible] महानगरपालिका **49301** (नियम क्र. ५ पाहा)

[illegible] माहिती या भागाची माहिती मृत्यू नोंदवही रकाने संबोधण्यात यावी.

माहिती देणाऱ्याने खालील रकाने भरावेत.

मृत्यू दिनांक : दिनांक [ ][ ] महिना [ ][ ] वर्ष [ ][ ][ ][ ]

मृताचे संपूर्ण नाव : .....

मृत व्यक्तीचे लिंग : ☐ पुरुष ☐ स्त्री

मृत व्यक्तीचे वय : [ ]

(जर मृत व्यक्ती १ वर्षापेक्षा जास्त वयाची असेल तर वय पूर्ण वर्षात लिहावे. जर वय १ वर्षापेक्षा कमी असेल तर वय महिन्यांमध्ये लिहावे. जर वय १ महिन्यापेक्षा कमी असेल तर वय दिवसांत लिहावे व १ दिवसापेक्षा कमी वय असेल तर वय तासांत लिहावे.)

आईचे पूर्ण नाव : .....

वडिलांचे / पतीचे पूर्ण नाव : .....

मयत व्यक्तीचा मृत्यूसमयीचा पत्ता : .....

मयत व्यक्तीचा कायमचा पत्ता : .....

मृत्यूचे ठिकाण : (खाली नमूद केलेल्या अ, ब किंवा क पैकी एकामध्ये संपूर्ण माहिती भरण्यात यावी. उदा. हॉस्पिटल / घर / इतर ठिकाणी जेथे जन्म झाला असेल ते ठिकाण.)

अ. रुग्णालय / संस्थेचे नाव व पत्ता : .....

ब. घर (घराचा टपालाचा पत्ता) : .....

क. इतर : .....

माहिती देणाऱ्याचे नाव व पत्ता : .....

दिनांक माहिती देणाऱ्याची सही / डाव्या हाताचा अंगठा

रकाने भरावयाची माहिती

णी क्रमांक : ..... नोंदणी दिनांक : .....

णी संस्थेचे नाव : .....

/शहर : ..... जिल्हा : .....

: ..... प्रमाणपत्र दिल्याचा दिनांक : .....

धकाचे नाव, सही व शिक्का :

कऱ्याचा पत्ता :

पुणे महानगरपालिका **49301** मुद्रांक मु. १४८७ (५०×२ [illegible] पुस्तके) १-११

मृत्यू अहवाल : सांख्यिकी माहिती या भागाची माहिती कापून पुढील संकलनासाठी पं.स./न.पा./मनपा/कॉ. [illegible] यात यावी.

माहिती देणाऱ्याने, खालील रकाने भरावेत.

टीप : ☐ योग्य त्या ठिकाणी ☑ खूण करावी.

११. मृत व्यक्तीचे नेहमीचे राहण्याचे ठिकाण :
(हे ठिकाण मृत्यूच्या ठिकाणापेक्षा वेगळे असू शकेल.)

अ. गाव / शहराचे नाव : .....

ब. गाव आहे का शहर आहे : ☐ गाव ☐ शहर

क. जिल्ह्याचे नाव : .....

ड. राज्याचे नाव : .....

१२. कुटुंबाचा धर्म : ☐ हिंदू ☐ मुस्लिम ☐ ख्रिश्चन

☐ इतर धर्म (धर्माचे नाव लिहावे) : .....

१३. मृत व्यक्तीचा व्यवसाय / नोकरी :
(जर नसेल तर तसे लिहावे)

१४. मृत्यूपूर्वी घेतलेल्या वैद्यकीय सेवेचा प्रकार :

☐ वैद्यकीय संस्था

☐ याव्यतिरिक्त इतर वैद्यकीय सेवा

☐ वैद्यकीय सेवा घेतलेली नाही

१५. मृत्यूचे कारण वैद्यकीयदृष्ट्या प्रमाणित आहे का ?

☐ होय ☐ नाही

१६. रोगाचे नाव किंवा मृत्यूचे नेमके कारण :
(वैद्यकीयदृष्ट्या प्रमाणित आहे किंवा नाही याच्याशी संबंधित नाही.)

.....

१७. मृत व्यक्ती स्त्री असेल व मृत्यू गरोदरपणी, प्रसुतीच्यावेळी किंवा प्रसुतीनंतर ६ आठवड्यांत झाला तरच रकाना माहिती भरावी :

.....

१८. सिगारेट, विडी किंवा तत्सम पदार्थाचे व्यसन होते का ?

☐ होय ☐ नाही असल्यास किती वर्षे [ ]

१९. तंबाखू खाण्याचे व्यसन होते का ?

☐ होय ☐ नाही असल्यास किती वर्षे [ ]

२०. सुपारी किंवा पानमसाला खाण्याचे व्यसन होते का ?

☐ होय ☐ नाही असल्यास किती वर्षे [ ]

२१. दारू किंवा तत्सम उत्तेजक पदार्थाचे व्यसन होते का ?

☐ होय ☐ नाही असल्यास किती वर्षे [ ]

(नमूद रकाने पूर्ण भरून झाल्यावर, डावीकडील स्तंभात माहिती देणाऱ्याने सही करावी.)

निबंधकाने भरावयाची माहिती

ठिकाण	नाव	कोड नं. (जनगणना)
जिल्हा		
तालुका		
गाव / शहर		
नोंदणी संस्था		

नोंदणी क्रमांक : ..... नोंदणी दिनांक : .....

मृत्यूचा दिनांक : ..... मृताचे वय : .....

लिंग : ☐ पुरुष ☐ स्त्री

मृत्यूचे ठिकाण : ☐ हॉस्पिटल ☐ घर ☐ इतर

निबंधकाचे नाव, सही व शिक्का :

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune

GENERAL MANUAL

CHART REVIEW OF SURGICAL SPECIMENS		
Policy/Procedure Applies To	**Nursing Superintendent**	**Policy/Procedure No: 19** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CHART REVIEW OF SURGICAL SPECIMENS

PURPOSE

To provide a mechanism for the determination of the appropriateness of surgical treatment through the periodic assessment of surgical specimens.

POLICY

At least once every month charts containing pathology reports will be reviewed by the QA committee for initial 6 months and thereafter on quarterly basis.

PROCEDURE

1. Staff to review, utilizing the developed criteria/form.
2. Pre and post surgical diagnosis will be compared with the pathology report.
3. Discrepancies will be reported to the QA Committee and subsequently the Management Committee for review. Repeated discrepancies would require punitive action against the offending surgeon.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE XIX
(Refer to Housekeeping Manual Policy and Procedure No. 1)

CLEAN UTILITY ROOM

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
A/C baffles		X		
Doors and Push Plates	X			
Counter Tops	X			
Shelves and Drawers/ Racks	X			
Refrigerator		X		
Sink	X			
Empty Waste Bins	X			
Fill Soap Dispensers	X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

EDUCATION OF PATIENTS AND FAMILIES		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 19** **Page: 1 of 2**
Effective Date: 11 April, 2013		

EDUCATION OF PATIENTS AND FAMILIES

POLICY

1. The Nursing staff will assist the patient and relatives family in gaining the knowledge and skills needed to meet the patient's ongoing health care needs.
2. Assessment of patient's learning needs, abilities, preferences, and readiness to learn will be documented on the Patient and Family Teaching Record. Education will be specific to the patient's relevant health care needs and provided in ways understandable to the patient and family. The education will be provided in a timely, efficient, caring and respectful manner.
3. Education shall be addressed as part of the multidisciplinary plan of care.
4. Patients who are potential for drug-food interaction will be identified and counselled of such possible interactions prior to discharge. Education will be provided by the staff nurse to patients who are placed on the following medications during hospitalization:
    a. Insulin
    b. Oral hypoglycemics
    c. Phenytoin (Dilantin) -- if patient on continuous tube feeds
    d. Sucralfate (Acarp)
    e. Tetracycline
    f. Metronidazole (Flagyl)
    g. Warfarin
    h. Eption
    i. Cefprizone
    j. Glycomet
    k. Taxim-O
    l. Amoxicillin
    m. Ampicillin
    n. Azithromycin
    o. Doxycyclin
    p. Lenofloxacin
    q. Augmentin
    r. Crocin
    s. Combiflam
    t. Ibuprofen

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

EDUCATION OF PATIENTS AND FAMILIES		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 19** **Page: 2 of 2**
Effective Date: 11 April, 2013		

PROCEDURE

1. Patient's educational needs pertaining to self-care will be assessed, mutually identified and prioritized, and documented on the Patient and Family Teaching Record at the beginning of the visit/admission. Factors affecting learning will be documented in the designated portion of the Patient and Family Teaching Record.
2. Education will include instruction in the specific knowledge and/or skills needed by the patient and/or when appropriate his/her family to meet the patient's ongoing health care needs, including:
   a. Diagnosis
   b. Patient's rights and responsibilities
   c. Safe and effective use of medication, if any
   d. Safe and effective use of medical equipment, if any
   a. Instruction on potential drug-food interactions and counselling on modified diets, as appropriate
   e. When and how to obtain further treatment, if needed
3. Provide patient and family education in a manner that:
   a. Facilitates the patient's and family understanding of the health status, health care options selected
   b. Encourages participation in decision-making about health care options
   c. Maximizes care skills
   d. Increases the patient/ family ability to cope with the patient's health status/prognosis/outcome.
   e. Increases patient/ family potential to follow the therapeutic health care options
   f. Enhances the patient/ family role in continuing care and promoting a healthy lifestyle
4. Resources shall be selected based on patient/ family needs and shall include, but not be restricted to, didactic information, approved brochures and printed materials.

   Education provided will be documented in the Patient and Family Teaching Record (nursing) and/or in the progress note section of the medical record and/or in the Discharge Instructions. (Education may also be documented in the electronic equivalent of any of these documents in unit specific computer system/software.
5. Adapt the education to appropriate age, culture, and language, and individualize for the specific patient/ family.
6. Patient/ family response to education will be documented on the Patient and Family Education Record (Refer Annexure to this policy) or progress notes as a means to assure needed reinforcement or to identify Patient / family not receptive to education.
7. A copy of discharge instructions to be given to the patient and/or his/her family.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PATIENT CARE AFTER LOCAL ANAESTHESIA		
Policy/Procedure Applies To	**All Staff Nurses**	**Policy/Procedure No: 19** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PATIENT CARE AFTER LOCAL ANAESTHESIA

PURPOSE

To provide guidelines for monitoring the condition of patients after local anaesthesia.

POLICY

Patients receiving only local infiltration (no sedation) will be monitored in respective Nursing Unit

PROCEDURE

1. Assess patient: airway, breathing, circulation and level of consciousness. Document and report any negative findings to the Anaesthesiologist.
2. Record vital signs at appropriate intervals. Use appropriate monitoring. Administer oxygen if ordered.
3. Examine surgical site/dressing for bleeding, hematoma and swelling. Document and report any negative findings to the Resident Medical Officer.
4. Examine IV site for signs of infiltration.
5. Position patient as appropriate.
6. Offer fluids by mouth to patient.
7. Dangle patient at side of bed. If stable, assist out of bed.
8. Assist patient to dress and walk to bathroom.
9. Discontinue IV and provide oral fluids as ordered.
10. Explain instructions and prescriptions to patient and family member, if available.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PATIENT CARE AFTER LOCAL ANAESTHESIA		
Policy/Procedure Applies To	**All Staff Nurses**	**Policy/Procedure No: 19** **Page: 1 of 1**
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Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: POST-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 19** **Page: 1 of 8**
Effective Date: 11 April, 2013		

Name: _____ Unit : _____ Date: _____

Frequency

1. Rarely observed or never done
2. Rarely done (<6 x a year)
3. Occasionally done (1-2 x a month)
4. Frequently done (daily or weekly)

Experience

1. None
2. Limited
3. Moderate
4. Proficient

Validation Method

1. = Cognitive: Tests, verbalizes action/steps
2. = Psychomotor: Demonstrates skill in lab. simulated setting
3. = Psychomotor: Demonstrates skill in clinical setting
4. = Affective: Demonstrates appropriate behavior/attitude

SELF–ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			1. Demonstrates skills in receiving a clear and complete report from the Recovery Room nurse.	1. Identifies the patient by the Identification Band. 2. Obtains/reviews operative data from the Recovery Room nurse. ▪ Type of exact surgery/procedure ▪ Type of anesthesia received. ▪ Name of Surgeon/s. ▪ Name of Anesthetist. ▪ Type of surgical dressing, drains, indwelling catheter if any ▪ Medication received intra-operatively and in the Recovery Room. ▪ Vital signs and level of consciousness. ▪ Intravenous lines and fluids, any blood transfusion received.							

Note: Must be psychomotor validation

				▪ Surgeon's post-operative orders. 3. Obtains a briefing on problems encountered intra-operatively and in the Recovery Room. 4. Assesses patient's level of consciousness by determining the patient's best response to stimulation: ▪ Eye opening ▪ Motor response ▪ Verbal response 5. Checks operative site for drains, status of dressing, bleeding 6. Inspects the IV insertion site for erythema, induration, tenderness or infiltration.						
			2. Demonstrates knowledge and skills in providing immediate post-operative care for patient.	1. Transfers and positions the patient comfortably in bed. Initiates fall prevention Protocol: ▪ Side rails up ▪ Bed is in low position ▪ Call button is within the reach of the patient and in good working condition.							

Note: Must be psychomotor validation

COMPETENCY: POST-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 19** **Page: 3 of 8**
Effective Date: 11 April, 2013		

SELF–ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation	Follow-up Plan	Preceptor Validation

Note: Must be psychomotor validation

			.	2. Monitors vital signs (blood pressure, pulse rate, respiratory rate and temperature) level of consciousness every 15 minutes for the first hour, then every 30 minutes for the next two hours then every hour for the next 4 hours. 3. Assists patient in deep breathing exercises and use of incentive spirometer if needed. 4. Checks patency of Intravenous lines and fluids every 2 hours. 5. Follows Surgeon's specific guidelines for positioning. 6. Records the amount of drainage accurately and reports excessive blood loss promptly. 7. Monitors and records intake and output for fluid balance and replacement. 8. Checks patency of Intravenous lines and fluids every 2 hours. 9. Checks patency of Intravenous lines and fluids every 2 hours.	Method	Code	Date		Date	Method	Date

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: POST-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 19** **Page: 5 of 8**
Effective Date: 11 April, 2013		

Note: Must be psychomotor validation

COMPETENCY: POST-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 19** **Page: 6 of 8**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
				10. Checks patency of Intravenous lines and fluids every 2 hours. 11. Follows Surgeon's specific guidelines for positioning. 12. Records the amount of drainage accurately and reports excessive blood loss promptly. 13. Monitors and records intake and output for fluid balance and replacement. 14. Observes for any signs of blood transfusion reaction if blood has been given. 15. Observes and reports signs and symptoms of post-operative complications: ▪ Bleeding ▪ Hematoma formation- (severe pain beneath the dressing). ▪ Infection- fever, presence of pus/discharges, severe pain ▪ Swelling around wound site increased output from the drains.							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: POST-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 19** **Page: 7 of 8**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			3. Provides appropriate patient/family teaching.	1. Explains the following important points: ▪ Diet modification ▪ Nothing by mouth until fully awake then can gradually resume regular diet with Surgeon's order. 2. Reinforces the following pre-operative teaching: ▪ Reason for semi-recumbent position - to promote deep breathing. ▪ Signs and symptoms to observe and report. ▪ Hematoma formation- severe pain beneath the dressing. ▪ Infection- fever, discharges, swelling and redness, severe discomfort. ▪ Pain, swelling in lower leg muscles ▪ Importance of easily mobilization to prevent post surgical complications.							

Note: Must be psychomotor validation

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NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: POST-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 19** **Page: 8 of 8**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			4. Documents pertinent data. .	1. Documents in the Nurse's Notes and Kardex the following: ▪ Positioning of patient. ▪ Vital signs- Assessment/Reassessment ▪ Level of consciousness. ▪ Wounds status, dressings and drains. ▪ Patient/family teaching provided ▪ Patient/family's response to treatment and nursing interventions. 2. Documents medication/IV fluids in the Medication Administration Record.							

_____ _____

Validator Signature **Designation**

Preceptor code: **A- Preceptor** **B- OT Matron** **C- Nursing Superintendant**

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

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HOSPITAL INFECTION CONTROL MANUAL

TERMINAL PROCESSING OF INSTRUMENTS		
Policy/Procedure Applies To	**All OT/Procedure Nurses/ OT and CSSD Technicians**	**Policy/Procedure No: 19** **Page: 1 of 1**
Effective Date: 11 April, 2013		

TERMINAL PROCESSING OF INSTRUMENTS

PURPOSE

To provide guidelines for examining instruments for defects and administration appropriate care before repackaging for sterilization or storage.

POLICY

1. Instruments used for a surgical procedure will be subjected to a decontamination procedure before processing through cleanup procedure prior to repackaging and storage.
2. Instruments will be inspected for damage or defects after each day's use and not stored or replaced in set if defective or damaged.
3. Instruments will be subjected to appropriate care procedures before replacement in set for repackaging or storage.

PROCEDURE

1. Following initial decontamination, process instruments in the ultrasonic cleaner or manually.
   a. Follow manufacturer's written instructions for detergent selection and proper use, care and maintenance of the ultrasonic cleaner.
   b. Follow manufacturer's written instructions when placing dissimilar metals in the ultrasonic cleaner.
   c. Powered surgical instruments and air hoses should not be placed in the ultrasonic cleaner.
   d. Instruments will be rinsed and drained after ultrasonic cleaning.
2. Stain remover will be used as needed per manufacturer's recommendations. Instrument polish will not be used as it may remove protective finish of instrument.
3. Powered surgical instruments and accessories and instruments with movable parts should be lubricated according to manufacturer's written instructions.
4. Inspect instruments for cleanliness, proper function and alignment and freedom from defects and prepare for storage and/or sterilization following the cleaning process. Defective or damaged instruments will be given to the OT Nurse with a written description of damage.
5. Instruments must be thoroughly dried before storage.
6. Delicate and sharp instruments should be protected according to the manufacturer's written instructions.
7. Before decontamination or sterilization, instruments with removable parts should be disassembled.
8. Terminal sterilization of all instruments including air powered instruments will be based on manufacturer's recommendations.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

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NURSING MANUAL II

COMPETENCY: POST-EPIDURAL ANESTHESIA, CARE OF PATIENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 1 of 5**
Effective Date: 15 February, 2014		

Name:_____ Unit:_____ Date:_____

Frequency

1. Rarely observed or never done setting
2. Rarely done (< 6x a year)
3. Occasionally done (1-2 x a month)
4. Frequently done (daily or weekly)

Experience

1. None
2. Limited
3. Moderate
4. Proficient

Validation Method

1. = Cognitive: Tests, verbalize actions/steps
2. = Psychomotor: Demonstrates skill in lab. Simulated setti
3. = Psychomotor: Demonstrates skill in clinical setting
4. = Affective: Demonstrates appropriate behavior/attitude

SELF ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
			A. Verbalizes knowledge of Epidural Anesthesia	1.Defines epidural anesthesia - Injection of local anesthetic agent into the epidural space of the spinal column. 2. Identifies the approaches of epidural anesthesia. a. Lumbar approach – peridural block b. Caudal approach – epidural and sacral block. 3. Lists the uses of Epidural Anesthesia. a. Anorectal procedures b. Vaginal & perioral procedures c. Labor & delivery d. During and after caesarian section e. Control pain in patient with intractable or prolonged pain (e.g. Terminal malignancies) f. Lower extremities procedure						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

COMPETENCY: POST-EPIDURAL ANESTHESIA, CARE OF PATIENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 2 of 5**
Effective Date: 15 February, 2014		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
				4. Identifies the anesthetic agents used for Epidural Anesthesia in PSC a. Bupivacaine HCL (Marcaine 0.25%-0.5%- 0.75% b. Lidocaine HCL (Xylocaine 2%) 5. States the advantages and disadvantages of Epidural anesthesia Advantages: a. Lesser degree of hypertension b. No spinal cord injury c. Less head ache d. Patient can be ambulated. Disadvantages: a. More complicated procedure (needs high skill) b. Time consuming (patient should be cooperative) c. Potential for infection d. Slow induction (analgesia will take 20 minutes to 45 minutes)						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

COMPETENCY: POST-EPIDURAL ANESTHESIA, CARE OF PATIENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 3 of 5**
Effective Date: 15 February, 2014		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
				6. Identifies the complications of Epidural Anesthesia. a. Minor complication: ▪ Intra vascular injection. ▪ Tingling of the fingers ▪ Numbness of fingers b. Major complications: ▪ C.N.S. Toxicity – convulsion ▪ Cardiac toxicity ▪ Accidental dural puncture resulting to severe headache ▪ Total spinal anesthesia (accidental puncture of the dura) ▪ Blood vessel puncture and hematoma ▪ Profound hypotension ▪ Backache –repeated puncture of same site ▪ Transient or permanent paralysis ▪ Local anesthetic toxicity ▪ Nerve & spinal injury ▪ Failure of procedure (segmental block or failed block)						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

COMPETENCY: POST-EPIDURAL ANESTHESIA, CARE OF PATIENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 4 of 5**
Effective Date: 15 February, 2014		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
			B. Demonstrates psychomotor skills in caring for a patient post Epidural Anesthesia	1. Monitors vital signs: ▪ blood pressure ▪ pulse rate ▪ respiratory rate ▪ O_2 saturation 2. Evaluates patients response to epidural anesthesia. a. Degree of sensation and reflexes of lower extremities b. Presence or absence of movements 3. Maintains supine position with head elevated on one pillow or 15 degree elevations of the head of bed or according to Physicians order 4. Maintains patient safety by: a. stays with the patient b. side rails up c. provides pillows or jelly pads on sides of extremities to prevent mechanical injury. 5. Creates a calm and quiet environment a. Minimizes noise around the patient b. Provides a low beam light c. Limits discussion or conversation to patient care related issues						

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

COMPETENCY: POST-EPIDURAL ANESTHESIA, CARE OF PATIENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 5 of 5**
Effective Date: 15 February, 2014		

SELF ASSESSMENT

Freq	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-Up Plan		Preceptor
					Method	Code	Date		Date	Method
				6. Provides privacy : a. Drawing the curtain around the bed or close the door b. Covering the patient with bed sheet. c. Restrict visitors 7. Document in appropriate forms: a. Any reaction manifested ▪ allergies ▪ headache ▪ nausea and vomiting b. Response to epidural anesthesia : ▪ degree of sensation ▪ absence or presence of sensation						
			C. Provides patients education on Epidural anesthesia	1. Instructs the patients on the following: a. Importance of coughing and deep breathing exercises. b. To report to the nurse unusual reactions.						

Note: Must be psychomotor validation

_____ _____

Validator Signature **Designation**

Preceptor code: **A- Preceptor** **B- OT Matron** **C- Nursing Superintendant**

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

DECONTAMINATION OF INSTRUMENTS		
Policy/Procedure Applies To	**Operation Theatre Nurses**	**Policy/Procedure No: 20** **Page: 1 of 2**
Effective Date: 11 April, 2013		

DECONTAMINATION OF INSTRUMENTS

PURPOSE

To provide guidelines for the removal of gross contaminates (e.g. blood, tissue, etc.) and decrease the bioburden. To determine that items handled in the sterile, clean work area are free of infectious material in order to prevent cross infection to patients and to protect personnel.

POLICY

1. Instruments used for invasive procedures are considered contaminated and will be processed through a decontamination procedure prior to handling, repackaging or reprocessing for use or storage.
2. Appropriate personal protective equipment will be worn at all time when handling contaminated instruments.
3. Soiled instruments will be cleaned immediately at the point of use to prevent blood and other substances from drying on the surface or in the crevices.
4. Instruments will be processed in the same manner whether considered contaminated or infected.
5. If an instrument is found to be defective or damaged during a surgical procedure, it will be decontaminated and removed from the instrument tray.

PROCEDURE

1. During the surgical procedure, instruments will be kept free of debris and gross contamination by wiping instruments with a sponge moistened with sterile solution. Instruments with lumens should be kept patent by irrigating with sterile solution.
2. Immediately after completion of surgical procedure, instruments will be decontaminated.
3. Initial decontamination may be achieved by manual cleaning.
    a. Personnel will wear personal protective equipment.
    b. Instruments will be submerged in warm water with appropriate detergent and cleaned while submerged.
    c. Instruments will then be sterilized by high level disinfection with ultrasonic machine or autoclave.
    d. Instruments with lumens and cannulas should be flushed with appropriate detergent and followed by flushing with water.
4. Powered surgical instruments will be immediately decontaminated after use.
    a. Powered surgical instruments and air hose should not be immersed in water or placed in the automated cleaner. Inspect hoses and cords for damage or wear.
    b. Air hoses of powered surgical instruments should remain attached to the hand piece during cleaning.
    c. Cleaning will be done with an appropriate agent.

DECONTAMINATION OF INSTRUMENTS		
Policy/Procedure Applies To	**Operation Theatre Nurses**	**Policy/Procedure No: 20** **Page: 2 of 2**
Effective Date: 11 April, 2013		

d. Rinse all traces of cleaning solution from the powered surgical instrument; wipe the air hose with a clean damp cloth; remove excess water from the instrument; and dry the outside with a lint-free towel.

e. Immediate-use sterilization is based on manufacturer recommendations for powered surgical instruments.

(Methods of decontamination should be compatible with the manufacturer's written instructions.)

5. Flowchart for Instruments (contaminated and decontaminated) is attached as Annexure.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE XX
(Refer to Housekeeping Manual Policy and Procedure No. 1)

DIRTY UTILITY

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
Shelves and drawers	X			
Sink and counter tops	X			
Bed Pan	X			
Urinals	X			
Kidney Tray	X			
Empty Waste Beans	X			
Fill Soap Dispensers	X			
Commode	X			
Empty Laundry Hamper	X			
Luminaries		X		
Electrical Outlet/ Switch Plates	X			
Exhaust	X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

EQUIPMENT, FURNITURE, LINEN FOR EACH CONSULTING ROOM - OPD		
Policy/Procedure Applies To	**All OPD Nurses**	**Policy/Procedure No: 20** **Page: 1 of 1**
Effective Date: 11 April, 2013		

EQUIPMENT, FURNITURE, LINEN FOR EACH CONSULTING ROOM - OPD

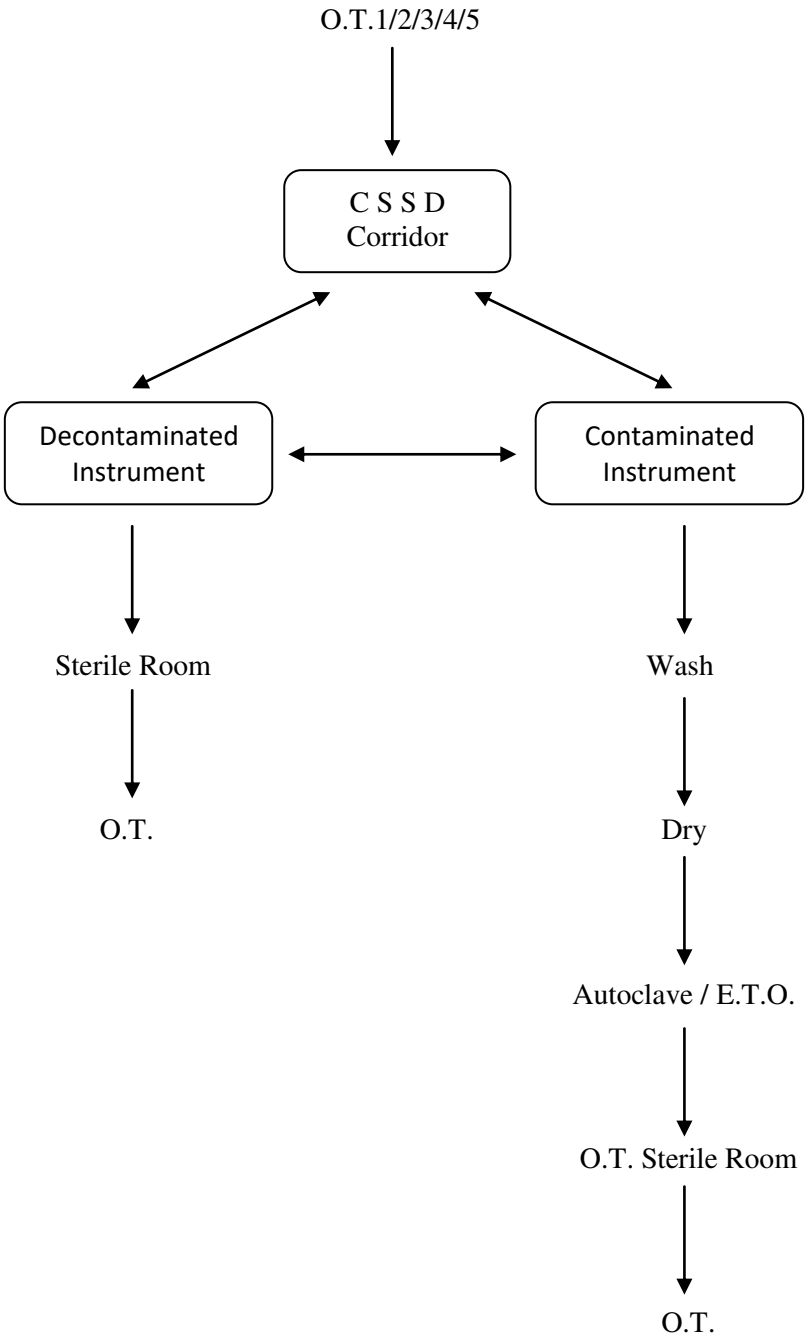
1. The following equipment and supplies will be available in the Consulting Room at all times.
   a. Four Bed-sheets, 1 Pillow, 4 Pillow covers, 4 Draw sheets and 3 Towels.
   b. Consultant Chair and Table, Patient's Stool/Couch-1, Relative's Chairs-2 and Examination Couch-1.
   c. Stationery cupboard
   d. Voice / data communication
   e. Telephone Directory – internal numbers and important local numbers
   f. Prescription Pad
   g. OPD Papers
   h. Pens, Pencils, Eraser and Stapler
   i. Viewing Box
   j. Sphygmomanometer
   k. Tongue Depressors
   l. Soap dispenser and towels
   m. Practice Formulary
   n. Examination Tray – Tuning Fork, Hammer, Cotton, Pins and Gloves.
   o. Kidney Tray, Dressing Trolley
   p. Stethoscope, Hammer, Tuning Fork, Cotton, Pins
   q. Torch (battery operated)
   r. Hand Sanitizer – 1, Dryer – 1
   s. Tissue with holder
   t. Proctoscope - 1 and Dressing Trolley-1 in the 1st Consulting Room only.
   u. Blinds for windows.
   v. Privacy curtain – 1 for examination couch.
2. The staff nurse on duty will check the standardized inventory every day and certify by affixing signature, name, date & time.
3. The Staff Nurse will be responsible for restocking the Consulting Room daily.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE

(Refer to Hospital Infection and Control Manual Policy and Procedure No. 20)

FLOW CHART FOR INSTRUMENTS



PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

POST SEDATION CARE		
Policy/Procedure Applies To	**All Staff Nurses and Resident Medical Officers**	**Policy/Procedure No: 20** **Page: 1 of 1**
Effective Date: 11 April, 2013		

POST SEDATION CARE

PURPOSE

To provide guidelines for staff responsibilities regarding safe and efficient post sedation care.

POLICY

1. All patients will receive appropriate post sedation management in the Nursing Unit.
2. A patient transported to the Nursing Unit will be accompanied by a member of the intraoperative team who is knowledgeable about the patient's condition. The patient will be continually evaluated and treated during transport with monitoring and support appropriate to the patient's condition (Refer Anaesthesia Manual Policy and Procedure No. 17).
3. Upon arrival in the Nursing Unit, the patient will be re-evaluated and documented.
   a. The patient status on arrival.
   b. Information concerning the preoperative condition and the procedural/sedation course
4. The patient's condition will be evaluated continually in the Nursing Unit.
   a. The patient will be observed and monitored by methods appropriate to the patient's medical condition. Particular attention will be given to monitoring oxygenation, ventilation and circulation.
   b. An accurate written report of the post-sedation period will be maintained. Pain Score will be recorded at appropriate intervals prior to discharge, and at the time of discharge.
   c. General medical supervision and coordination of patient care in the Nursing Unit will be the responsibility of the Resident Medical Officer.
5. There will be a Resident Medical Officer available at all times who has a capability of managing complications and providing cardiopulmonary resuscitation for patients in the Nursing Unit.
6. Resident Medical Officer will be responsible for the discharge of the patient from Nursing Unit of Prime Surgical Centers under Instructions of the Anaesthesiologist.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: PRE-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 1 of 5**
Effective Date: 11 April, 2013		

Name: _____ Unit : _____ Date: _____

Frequency

1. Rarely observed or never done
2. Rarely done (<6 x a year)
3. Occasionally done (1-2 x a month)
4. Frequently done (daily or weekly)

Experience

1. None
2. Limited
3. Moderate
4. Proficient

Validation Method

1. = Cognitive: Tests, verbalizes action/steps
2. = Psychomotor: Demonstrates skill in lab. simulated setting
3. = Psychomotor: Demonstrates skill in clinical setting
4. = Affective: Demonstrates appropriate behavior/attitude

SELF–ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			1. Verbalizes knowledge about Surgical procedure performed.	1. Defines the surgical procedure that, this patient is having 2. List of general post operative complications: ▪ Infecting ▪ Atelectasis ▪ Deep Vein Thrombosis ▪ Pain ▪ Nausea / Vomiting ▪ Bleeding ▪ Paralytic Illness							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: PRE-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 2 of 5**
Effective Date: 11 April, 2013		

SELF–ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			2. Demonstrates skills in providing pre-operative nursing care	1. Completes pre-operative assessment: ▪ Nursing History ▪ Physical Examination ▪ Nutritional Status ▪ Clinical/Diagnostic Examinations: ▪ Blood test (CBC) ▪ Serum Electrolyte ▪ Chest X-ray and ECG for 40 years old and above with any medical/cardiac related problems. ▪ Blood typing and cross matching (with Packed Red Blood Cell reservation). ▪ Patient's level of understanding of his/her condition. 2. Assesses patient/family's understanding of planned surgery. 3. Acts as witness to Surgeon in obtaining written, informed consent from the patient or guardian. 4. Checks that the operative site is clipped as per each Surgeon orders. Completes the pre-operative checklist: ▪ Consent for operation- checks validity ▪ Latest vital signs							

Note: Must be psychomotor validation

COMPETENCY: PRE-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 3 of 5**
Effective Date: 11 April, 2013		

SELF–ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			3. Provides appropriate patient / family teaching.	▪ Time of administration of pre-operative medications ▪ Patient's weight in kilogram ▪ Time of fasting started ▪ Availability of results of clinical/diagnostic investigations ▪ Special pre-operative preparation ▪ Others (emptying of bladder, bath, dentures, jewelries, Operating Theatre Cap, Identification Band, Bracelet) 1. Instructs patient/family on the following pre-operative activities: ▪ Nothing by mouth from 12 midnight. ▪ Pre-operative medications and their effect. 2. Instructs patient on the following post-operative activities: ▪ Turning, deep breathing and coughing exercises. ▪ Active/passive leg exercises ▪ Use of incentive spirometer ▪ Activity restriction- if applicable. ▪ Diet modification ▪ Early, gradual ambulation							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: PRE-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 4 of 5**
Effective Date: 11 April, 2013		

SELF–ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			4. Documents pertinent data.	▪ Reportable signs and symptoms to observe: • Bleeding • Excessive pain around wound site. • Pain and swelling of the lower limbs. 1. Documents in the Nurse's Notes the following: ▪ Laboratory/diagnostic investigations done. ▪ Preparation of operative site. ▪ Patient/family teaching provided. ▪ Patient/family's response to care and teaching provided. ▪ Comprehensive patient assessment- History/Physical exam./Nutritional status. 2. Documents the pre- operative medications/IV fluids in Medication Administration Record. 3. Documents assessment of operative site in Nursing Admission Assessment.							

_____ _____

Validator Signature **Designation**

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

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NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: PRE-OPERATIVE CARE		
Module Applies To	**All Nurses and Technicians**	**Module No: 20** **Page: 5 of 5**
Effective Date: 11 April, 2013		

Preceptor code: **A- Preceptor** **B- OT Matron** **C- Nursing Superintendant**

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

TRANSFER OF PATIENTS TO ACUTE CARE FACILITY		
Policy/Procedure Applies To	**Consultant / Anaesthesiologist, Nursing Superintendent**	**Policy/Procedure No: 20** **Page: 1 of 1**
Effective Date: 11 April, 2013		

TRANSFER OF PATIENTS TO ACUTE CARE FACILITY

POLICY

1. Patient transfers shall be made by BLS or ACLS transport to a hospital with which the Prime Surgical Centers has a transfer agreement, in case of need for acute care facility.
2. Patients shall be transferred only on order of the attending Consultant or Anaesthesiologist accompanied by a Doctor and Nurse depending on Clinical merits.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

BLADDER IRRIGATION CHART AND BLOOD SUGAR LEVEL CHART		
Module Applies To	**All Nurses**	**Policy and Procedure No.: 21** **Page: 1 of 2**
Effective Date: 1 April, 2014		

BLADDER IRRIGATION CHART

DATE	IRRIGATION FLUID WITH QUANTITY	START TIME & INITIAL	COMPLETED TIME & INITIAL	TOTAL IRRIGATION OUTPUT & COLOUR	ACTUAL URINE OUTPUT	SIGN

BLADDER IRRIGATION CHART AND BLOOD SUGAR LEVEL CHART		
Module Applies To	**All Nurses**	**Policy and Procedure No.: 21** **Page: 2 of 2**
Effective Date: 1 April, 2014		

BLOOD SUGAR LEVEL CHART

DATE	TIME	BSL (mg/dl)	ADVICE GIVEN	SIGN

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
Phone: - 020-39931000 Fax: - 020 39931020
Email: - customercare@primesurgical.in
Website: www.primesurgical.in

PRIME
SURGICAL CENTERS

MR No :   IP No.
Name :
Age/Sex :
Comfort / Deluxe Bed No :
Admission Date :

BLADDER IRRIGATION CHART

DATE	IRRIGATION FLUID WITH QUANTITY	START TIME & INITIAL	COMPLETED TIME & INITIAL	TOTAL IRRIGATION OUTPUT & COLOUR	ACTUAL URINE OUTPUT	SIGN

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
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Email: - customercare@primesurgical.in
Website: www.primesurgical.in

PRIME
SURGICAL CENTERS

MR No :   IP No.
Name :
Age/Sex :
Comfort / Deluxe Bed No :
Admission Date :

BLOOD SUGAR LEVEL CHART

DATE	TIME	BSL (mg/dl)	ADVICE GIVEN	SIGN

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

FLOW PATTERN FOR CLEAN AND SOILED UTILITY AREAS		
Policy/Procedure Applies To	**O.T. & Procedure Room Nurses & O.T. Technicians**	**Policy/Procedure No: 21** **Page: 1 of 1**
Effective Date: 11 April, 2013		

FLOW PATTERN FOR CLEAN AND SOILED UTILITY AREAS

PURPOSE

To maintain a flow of soiled to clean with proper cleaning procedures maintained to prevent cross contamination of clean work areas.

POLICY

Equipment, instruments, soiled disposable and non-disposable linen and containers of body waste or fluids will be treated as biohazardous waste and never deposited in clean utility rooms. Only items surgically clean or sterile may be placed or stored in clean utility rooms or sterile storage areas.

PROCEDURE

1. When procedure or treatment is complete, all biohazardous waste items will be consolidated and removed to a soiled utility or decontamination room immediately.
   a. Contaminated suction fluids will be sealed in vacuum containers and deposited with biohazardous waste for appropriate disposal or flushed into an isolated system, if available. A treated consolidation product will be used when feasible.
   b. Instruments are cleaned of gross contamination in the Operating Theatre and then processed. Only after decontamination items can be stored in clean work area or sterile storage.
   c. Equipment is cleaned of gross contamination, wiped with germicide solution (1% Sodium Hypochlorite) and returned to proper storage area.
   d. Designated biohazardous contaminated disposables will be deposited in approved waste holding containers to be removed according to biohazardous service contract.
   e. Soiled non disposable linen will be placed in appropriate container to be sent to the soiled holding area for removal to laundry as per service (Refer Hospital Infection Control Manual Policy and Procedure No. 15)
2. Items not contaminated or sterile items not used in a procedure or treatment may be taken directly to a clean work area to be prepared for reprocessing.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PAIN MANAGEMENT (EPIDURAL INJECTIONS)		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 21** **Page: 1 of 2**
Effective Date: 11 April, 2013		

PAIN MANAGEMENT (EPIDURAL INJECTIONS)

PURPOSE

To provide quality nursing care and assist physician in administering medications via epidural injections.

POLICY

All patients admitted for epidural steroid injections will be monitored and the proper aseptic technique maintained.

PROCEDURE	RATIONALE
1. Assemble required items and medications per physician's preference.	
2. Identify patient, introduce self and explain procedure to patient.	Patient safety, ensure cooperation and decrease patient's anxiety.
3. Obtain baseline vital signs, temperature, pulse, respiration, oxygen saturation (SpO2).	Continue monitoring cardiac status to observe any arrhythmias. Monitor Oxygen (SpO2) saturation if Diprivan is used.
4. Requirements: a. Informed consent b. Nothing Per Oral for A.M. case. Nothing Per Oral after light breakfast if scheduled for afternoon. c. It is recommended that aspirin/blood thinners be stopped one (1) week prior to procedure. Must notify physician if not complied with by the patient.	Patient safety If Diprivan is used.
5. Assist patient into position desired by physician: a. Sitting on edge of bed with feet on stool. b. Position patient in lateral recumbent position with back on edge of bed. i. Arch back ii. Flex knees lightly against abdomen iii. Flex neck forward in chest.	This position widens interspinous spaces and promotes entry into epidural space.
6. Help patient to maintain desired position during procedure by providing support behind head and knees and keep "up" shoulder from falling forward. Stand on side of bed patient is facing.	Support helps to prevent sudden movement and resultant trauma.

PAIN MANAGEMENT (EPIDURAL INJECTIONS)		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 21** **Page: 2 of 2**
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PROCEDURE	RATIONALE
7. Physician will clean and prepare skin site and drape per Center protocol.	Prevents infection.
8. Support patient and monitor status during needle insertion and throughout procedure.	The patient will feel pressure as epidural needle is inserted. Pain may radiate down legs or hips.
9. Clean area and apply Band-Aid to puncture site after needle is withdrawn.	
10. Obtain post procedure vital signs: pulse, respiration, blood pressure and SpO2(if Diprivan is used).	
11. Assist patient in repositioning self to supine/sitting position.	
12. Discharge patient as per physician's orders.	

ANNEXURE XXI
(Refer to Housekeeping Manual Policy and Procedure No. 1)

PATIENT FAMILY LOUNGE AND CORRIDOR

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls		X		
A/C baffles		X		
Windows and Seals	X			
Counter Tops	X			
Tables and Chairs	X			
Sofa Sets	X			
Luminaries		X		
Electric Outlets/Switch Plates	X			
Empty Waste Bins	X			
Shoe Rack	X			
Patients Family Lockers	X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

PATIENT SATISFACTION QUESTIONNAIRE		
Policy/Procedure Applies To	**All Nursing Staff, Nursing Unit, Resident Medical Officers, Customer Care**	**Policy/Procedure No: 21** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PATIENT SATISFACTION QUESTIONNAIRE

PURPOSE

To provide a mechanism for evaluating patient's perception of care and treatment in the facility and to provide a method to measure patient satisfaction and to identify potential or existing problems.

POLICY

A Patient Satisfaction Questionnaire (refer Annexures to this policy) will be provided to each patient. Nursing Superintendent or Customer Care will encourage each patient to complete and return the questionnaire. The importance of honest replies will be stressed with emphasis upon the benefits to the facility and personnel.

PROCEDURE

1. Keep questionnaires available in OPD/discharge area.
2. Patient Satisfaction Questionnaire will be explained to patient and family as part of discharge instructions.
   a. Explain the purpose of the questionnaire.
   b. Explain that patient name and date of procedure are optional.
   c. Encourage patient and family to be honest with criticism.
   d. Encourage the patient to return the questionnaire as soon as possible.
3. Returned questionnaires will be reviewed and pertinent data compiled by the executive assigned by Medical Administrator.
4. Analysis of questionnaire reports will be forwarded to the Administrator and included in monthly Management Committee Meeting.
5. Results will be shared with facility personnel.
6. If the patient is identified, the problem is to be addressed through the patient grievance procedure.
7. Nursing Superintendent will implement plan for solving any problem requiring immediate attention.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer to General Manual Policy and Procedure No. 21)

PATIENT SATISFACTION QUESTIONNAIRE - OPD

Please complete the form and drop it in the drop – box (suggestion box)

1. **What influenced you most to choose the Prime Surgical Centers?**

☐ Doctor/Surgeon ☐ Location ☐ Advertisement
☐ Friend/Relative/Colleague ☐ Brochure/Website Other: _____

2. **First Impression**

	Excellent	Good	Average	Poor	Not Applicable
Appointment booking process					
Information given prior to arrival					
Overall impression					
Comment (if any):					

3. **On Arrival**

	Excellent	Good	Average	Poor	Not Applicable
Parking Facility					
Security Staff					
Directions to appropriate floor					
Front Office/Reception					
Greetings on arrival					
Promptness of attention					
Waiting room comfort					
Overall impression					
Comment (if any):					

4. **Facilities and Amenities**

	Excellent	Good	Average	Poor	Not Applicable
Information and Sign Board					
Laboratory and Pharmacy					
Newspapers/magazines in waiting lounge					
Conditions of restrooms/waiting area					
Overall impression					
Comment (if any):					

5. Consultant Care

How efficiently were you seen?

Within 0-5 min ☐ 5-10 min ☐ 10-20 min ☐ 20-25 min ☐ 30 min + ☐

	Excellent	Good	Average	Poor	Not Applicable
Explanation for the condition and treatment options					
Involvement in decision making about your care					
Overall consultant care					
Comment (if any):					

6. Radiology / Ultra Sonography-

How efficiently were you seen?

Within 0-5 min ☐ 5-10 min ☐ 10-20 min ☐ 20-25 min ☐ 30 min + ☐

	Excellent	Good	Average	Poor	Not Applicable
Explanation of procedure					
Time & attention given					
Cleanliness & hygiene					
Overall care					
Comment (if any): listening					

7. Overall Comments & Suggestions

8. If you would like us to contact you please include your details below. (Optional)

Name	
Address	
Telephone	
E-mail	

9. Please let us know if you agree for use of your comments on our website.

☐ YES ☐ NO

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: SAFE MOVING/HANDLING OF PATIENTS		
Module Applies To	**All Nurses and Technicians**	**Module No: 21** **Page: 1 of 4**
Effective Date: 11 April, 2013		

Name: _____ Unit:_____ Date: _____

Frequency

1. Rarely observed or never done
2. Rarely done (<6 x a year)
3. Occasionally done (1 – 2 x a month)
4. Frequently done (daily or weekly)

Experience

1. None
2. Limited
3. Moderate
4. Proficient

Validation Method

1. = Cognitive: Tests, verbalize action/steps
2. = Psychomotor: Demonstrates skill in lab. simulated setting
3. = Psychomotor: demonstrates skill in clinical setting
4. = Affective: Demonstrates appropriate behavior/attitude

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			1. Verbalizes pre-requisite knowledge necessary for safe patient handling.	1. Explains the reasons of planned patient moving ▪ Prevents accidents and injuries ▪ Provides safety for patients and staff 2. Lists the basic requirements for safe patient handling. ▪ Always get assistance if necessary ▪ Use devices/aides if available ▪ Use pre-planning ▪ Narrow contact ▪ Surrounding, firm grip ▪ Roll, glide, pivot : no lifting ▪ Pulling motion : no pushing							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: SAFE MOVING/HANDLING OF PATIENTS		
Module Applies To	**All Nurses and Technicians**	**Module No: 21** **Page: 2 of 4**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
				▪ Block slippery points ▪ Use body weight for transfer movements							
			2. Demonstrates pre-planning.	1. Performs the following necessary steps before attempting to handle a patient. ▪ Gets assistance if necessary ▪ Gathers aides/devices if necessary and available ▪ Plans best way to move patient ▪ Prepares the environment ▪ Coordinates with the assisting person ▪ Explains clearly and concisely to patient what he/she must do ▪ Decides on a starting code word.							
			3. Demonstrates basic principles of patient handling.	1. Shows positioning techniques ▪ feet : wide stance : angled toward direction of movement ▪ knees : bent ▪ back : straight : no twisting							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: SAFE MOVING/HANDLING OF PATIENTS		
Module Applies To	**All Nurses and Technicians**	**Module No: 21** **Page: 3 of 4**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
				2. Shows gripping techniques ▪ Narrow contact ▪ Surrounding arms ▪ Firm, solid grip ▪ Finds or creates handles ▪ blocks slippery points 3. Shows movement techniques ▪ Synchronization between helpers ▪ Synchronization between helpers and patients ▪ Uses body weight for transfer movement ▪ Provides only necessary help and respects natural movement ▪ Uses pre-arranged starting code word ▪ Rolls, glides or pivots instead of lifting ▪ Uses pulling motion instead of pushing ▪ Moves patient step by step but in a flowing movement ▪ Distributes and balances weight for patient and helper							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: SAFE MOVING/HANDLING OF PATIENTS		
Module Applies To	**All Nurses and Technicians**	**Module No: 21** **Page: 4 of 4**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			4. Evaluates procedure	1. Assesses the following : ▪ Patient comfort throughout move and afterwards ▪ Result of move i.e. desired position achieved ▪ Effect of move on staff and need for further movement ▪ Additional staff or aides/devices required							
			5. Documents relevant data.	1. Documents the following in the Nurses' Notes ▪ Type of moving done ▪ Doctor's order checked – if required ▪ Result of moving ▪ Adverse effects ▪ How often moving to be repeated.							

_____ _____

Validator Signature **Designation**

Note: Must be psychomotor validation

Preceptor code: **A- Preceptor** **B- OT Matron** **C- Nursing Superintendant**

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

VITAL PARAMETERS		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 21** **Page: 1 of 4**
Effective Date: 11 April, 2013		

VITAL PARAMETERS

DEFINITION

Temperature, pulse, respiration, blood pressure, body weight and pain assessment together comprise a set of Vital Parameters. These are considered Vital because they are indispensable indicators of a patient's current state of health. Even when individual seems to be in a state of high -level wellness, it is often important to assess the Vital Parameters as a means to establish baseline data with which to judge the significance of any future deviations from what appears to be the characteristic or normal.

POLICY

The taking of Vital Parameters consists of obtaining the temperature, pulse, respiration, blood pressure, body weight, and Pain Assessment. Verbal and written description will be presented and communicated in this sequential order (TPR, BP, body weight and Pain Assessment). Height will also be recorded along with these vital parameters once only at the time of OPD (Out Patient Department) Consultation. (Refer to Nursing Manual Policy and Procedure No. 22).

1. Nursing personnel are expected to know the normal range of each vital sign. During the shift, whenever there is a question about the well being of any patient, the taking of Vital Parameters is to be accomplished as often as deemed necessary. A physician’s order is not required. The assessing of Vital Parameters becomes a required part of the overall picture when assessing an individual's condition. It is used to establish trends and make comparison of changes in condition.
2. Nursing staff shall obtain and document a full set of vital parameter in Out Patient Department (OPD), on admission, pre/ post operatively and on discharge. It will also be recorded when need arises as under:
    a. Patient who complain of feeling ill before calling to the attention of Consultant.
    b. Before and after surgery or invasive diagnostic procedures
    c. While on medications that alter cardiovascular, respiratory or temperature control status (e.g. antihypertensives, digitalis, antipyretics, cardiotonics, bronchodilators etc.)
    d. Within one hour after administration of a PRN (Pro Re Nata means whenever needed) medication given specifically for its effect on Vital Parameters.
    e. Throughout a medical emergency.
    f. Immediately after a fall take a complete set of Vital Parameters including orthostatic Blood Pressure readings
3. Nursing staff are expected to exercise clinical judgment and take Vital Parameters as warranted by the patient's condition.
4. Vital Parameters on admission shall be recorded on the Initial Screening Assessment and Vital Parameters Record.
5. All abnormal Vital Parameters or deviation from the patient's normal baseline are to be reported to the Consultant.

6. All the patients will be assessed for pain. When pain is an identified problem, individualized pain management goal will be established and regular assessments will take place until the problem is resolved. Pain assessment includes: location and intensity; but in most cases should include other dimensions such as psychological and spiritual distress.
7. Under the new standards, an individual has the right to appropriate pain assessment and management.

PROCEDURE

1. **Temperature**

All patients will have a temperature recorded (Axilla) on admission, intra-operatively, on discharge and whenever needed in Celsius unit.

2. **Pulse**

Pulse will be taken and recorded on all patients upon admission intra-operatively on discharge and whenever needed. Radial pulse is appropriate unless contra-indicated. Count the pulse for one minute.

3. **Respiration**

Respiratory rate is taken on all patients upon admission intra-operatively, on discharge and whenever needed. Count for 1 minute

4. **Blood Pressure**

All patients will have a blood pressure taken and recorded upon admission.

5. **Body Height**

For details Refer Nursing Manual Policy and Procedure No. 22.

6. **Pain Assessment**

Pain is to be assessed and treated promptly, effectively and for as long as the pain persists. Pain assessment is performed in a manner that is appropriate to the patient. The pain assessment shall be noted in the patient chart in a manner consistent with other Vital Parameters.

Pain Intensity Rating Scales

Use of a pain scale lets the patient describe pain in a way that is meaningful to the patient

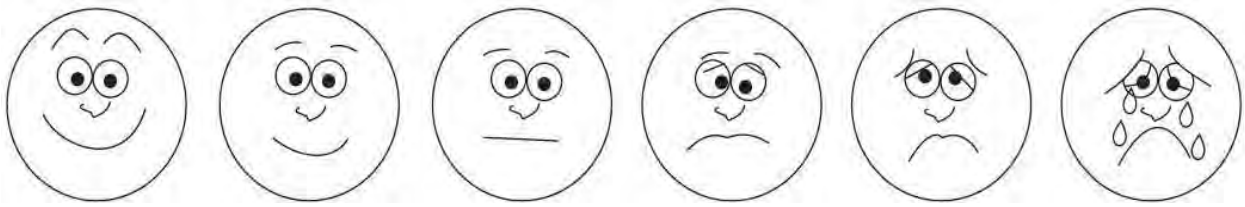
The scale helps the patient to quantify their current levels of pain.

No Pain	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it can be**

It is now required that all health care staff record pain assessment each time Vital Parameters are recorded for a patient. Using the zero-to-ten pain assessment scale a recording of pain e.g. 2/10 is acceptable. The Staff Nurse is required to take appropriate action based on deviations from normal.

If pain is rated more that 4/10 or is unacceptable to the individual, notify physician.

Progress notes should clearly delineate the plan and rationale for the pain treatment.



0	2	4	6	8	10
Very happy, no hurt	**Hurts just a little bit**	**Hurts a little more**	**Hurts even more**	**Hurts a whole lot**	**Hurts as much as you can imagine (don't have to be crying to feel this much pain)**

VITAL PARAMETERS		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 21** **Page: 4 of 4**
Effective Date: 11 April, 2013		

GUIDELINE FOR MONITORING VITAL PARAMETERS

All patient Vital Parameters will be monitored at the minimum as follows:

Adult: BP, P, R

Upon arrival and every shift / or as per Physician order.

Adult: Temperature

Upon arrival and every shift & as per Prime Surgical Centers policy on routine Vital Parameters Repeat every thirty (30) minutes if below thirty five (35 C) degrees celsius or above thirty eight (38 C) degrees celsius

Pain Assessment

Upon arrival: Pain will be assessed by the Nursing staff using the standard 1 to 10 scale/ visual analogue

1. Repeat regularly during the stay and prior to discharge.
2. Pain must be controlled using PO (Per Oral) medications prior to discharge.
3. Pain assessment for discharge is performed by the Anaesthesiologist

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

HEIGHT AND WEIGHT ASSESSMENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 22** **Page: 1 of 4**
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HEIGHT AND WEIGHT ASSESSMENT

PURPOSE

1. To ensure and maintain a professional standard in measuring height and weight.
2. To provide the patient undergoing surgery a proper physical assessment that includes height and weight.

POLICY

1. Accuracy is important in obtaining height and weight measurements to assess health status and recording the data. Accurate weighing and measuring have three critical components:
   a. Technique – standardized and appropriate technique for each measure must be utilized
   b. Equipment – must be calibrated and accurate (for details refer manufacturer's instructions)
   c. Trained measurers – measures should be performed by a trained staff
2. Set up measurement stations with all the appropriate equipment
3. Check accuracy of the scales
4. Prepare the patient for measurement
5. Measure height and weight in rotational order
6. Perform the steps of the weight and height measurement correctly
7. Record manually
8. Apply appropriate confidentiality measures

PROCEDURE

MEASURING HEIGHT

1. Have the patient remove shoes, hat, hair ornaments and buns.
2. Have the patient stand on the footplate or uncarpeted floor with back against stadiometer rule
3. Have the patient bring legs together (in contact at some point, whatever touches first)
4. Ensure patient's legs are straight, arms are at sides, and shoulders are relaxed
5. Ensure the back of the patient's body touches/has contact with the stadiometer at some point, preferably with heels, buttocks, upper back and head touching the measuring surface.

HEIGHT AND WEIGHT ASSESSMENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 22** **Page: 2 of 4**
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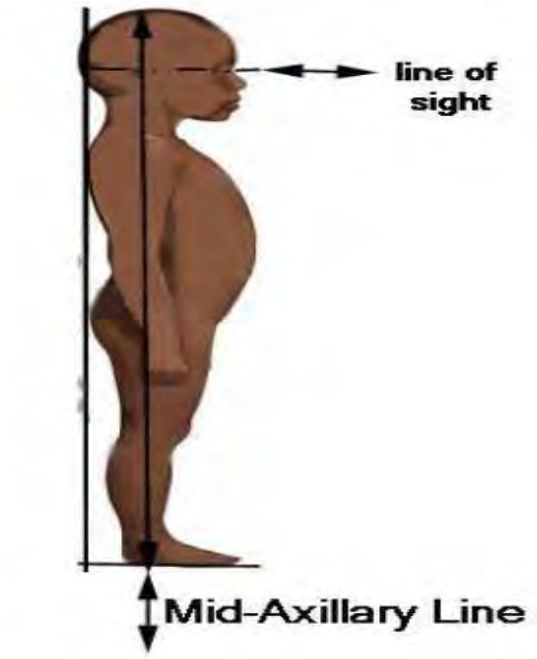
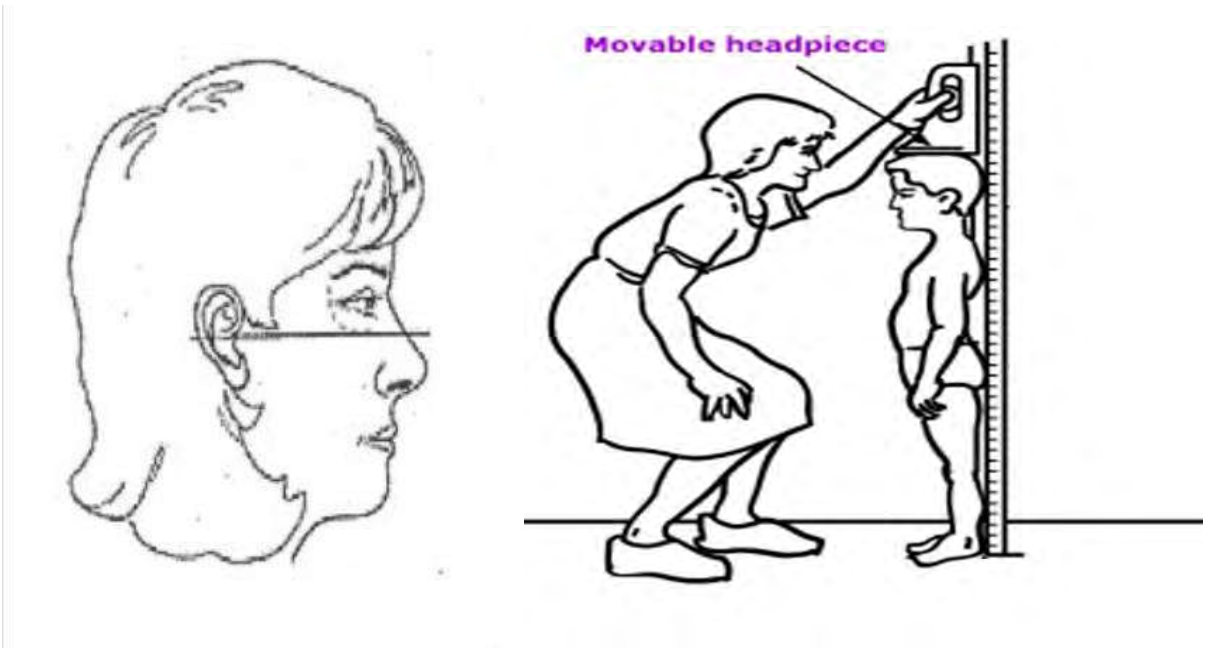
6. Ensure that the patient's body is in a straight line (mid-axillary line parallel to the stadiometer), see Figure #1

   Figure #1 Mid-axillary Line



7. Assure the head is in the appropriate position (Frankfort plane) see Figure #2

   Figure #2 Frankfort Horizontal Plane



8. Lower the headpiece until it touches the crown of the head firmly, compressing the hair
9. Position yourself so that your eyes are parallel with the head piece and read the measurement to the nearest 0.1 cm, make note of the first measurement
10. Move the headboard away, check the posture, and remeasure the height.
11. Measurements should agree within 1 cm or remeasure and select the average of the two measures that agree the most.
12. Immediately record the results in the patient's documents.

MEASURING WEIGHT

1. Set the scale at zero reading
2. Have the patient remove shoes, heavy outer clothing (jacket, sweater) and empty pockets (cell phones, iPods)
3. Have the patient step on the scale platform, facing away from the scale read out, with both feet on the platform, and remain still with arms hanging naturally at side and looking forward
4. Read the weight value to the nearest 0.1 (1/10) kilogram
5. Have the patient step off the scale and take a second measurement, repeating the steps above (measurements should agree within 0.1 kilogram; if not, remeasure until this standard is met)
6. For confidentiality and to avoid stigma or harassment, do not call out weight value
7. Record the weight value immediately in the patient's documents.

GUIDELINE

WEIGHT MEASUREMENT

1. Turn on the scale to "zero" .
2. If the readout is more than 250 gms off the standard weight, change the batteries. Then place the standard weight on the scale again. If it is still off by more than 250 gms, do not use this scale.
3. If scale is accurate, begin assessments
4. Ask the patient to remove extra layers of clothing, jewellary, and any items in his/her pockets
5. Ask the patient to step on the scale backwards (for confidentiality)
6. Ensure that the body weight is evenly distributed between both feet
7. Arms hang freely by the sides of the body, palms toward thighs
8. Head is up and facing straight ahead
9. Weight is recorded

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

HEIGHT AND WEIGHT ASSESSMENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 22** **Page: 4 of 4**
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HEIGHT MEASUREMENT

1. Patient stands with back against the board
2. Body weight is evenly distributed on both feet
3. Arms hang freely by the sides of the body, palms facing the thighs
4. Legs are placed together, bringing knees or ankles together
5. Patient stands erect; head is up and facing straight ahead
6. Verify body position front and left
7. Position head in Frankfort Horizontal Plane
8. Patient inhales deeply holding his/her breath WITHOUT moving head or body
9. Bring headpiece down onto the upper most point on the head; compress the hair
10. Patient is told to let breath out
11. Height is recorded

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE XXII
(Refer to Housekeeping Manual Policy and Procedure No. 1)

OPERATION THEATER COMPLEX

CSSD

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls	X			
A/C baffles		X		
Windows And Seals	X			
Luminaries		X		
Electric Outlet/Switch Plates	X			
All Equipment	X			Clean by Technician

EQUIPMENT ROOM

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls	X			
A/C baffles		X		
Cupboard and Table	X			
Doors and Push Plates	X			

STERILE ROOM

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls	X			
A/C baffles		X		
Cupboards/Counter Tops	X			
Racks/ Pass-by Box	X			
Refrigerator		X		
Doors and Push Plates	X			

SCRUB AREAS

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls	X			
A/C baffles		X		
Scrub sink and ledges	X			
Fill soap dispensers	X			
Luminaries		X		
Electrical Outlet	X			

OPERATING ROOM

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls	X			
A/C baffles			X	
Central Pendent	X			
Luminaries		X		
Electric Outlet/ Switch Plates	X			
X-Ray View Box	X			
Instrument Trolley and Wheel	X			
Count Board/ Roller	X			
Stool/ Chairs and Wheels	X			
Keep Empty Bins As per Colour Code	X			
IV Stand	X			
Suction Bottels/Tubings/Wheel	X			
All Equipment: Laser, C-Arm, Anaesthesia Machine, Video Trolley and All Accessories, Cautery Machine	X			Clean by Technician

PROCEDURE ROOM

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Floor	X			
Walls	X			
Doors and Windows	X			
A/C baffles		X		
Counter tops	X			
Storage cabinets	X			
Tables, stands, chairs and stools	X			
Wheels on Furniture	X			
Anaesthesia cart	X			
Central Panel	X			
Sink	X			
X-ray View Box	X			
Floor buckets	X			
Empty Waste Bins	X			

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PAIN MANAGEMENT (LUMBAR SYMPATHETIC BLOCK)		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 22** **Page: 1 of 2**
Effective Date: 11 April, 2013		

PAIN MANAGEMENT (LUMBAR SYMPATHETIC BLOCK)

PURPOSE

To provide quality nursing care and assist physician in administering medications via lumbar sympathetic block.

POLICY

All patients admitted for lumbar sympathetic block will be monitored and the proper aseptic technique maintained.

PROCEDURE	RATIONALE
1. Assemble required items and medications per physician's preference.	
2. Identify patient, introduce self and explain procedure to patient.	Patient safety, ensure cooperation and decrease patient's anxiety.
3. Obtain baseline vital signs (temperature, pulse, respirations, oxygen saturation (SpO2).	Continue monitoring cardiac status to observe any arrhythmias. Monitor O2 saturation (SpO2) if Diprivan is used.
4. Start IV or Hep Lock	A patient line must be maintained for emergency drugs if necessary.
5. Requirements: a. Informed consent b. Nothing Per Oral for A.M. case. Nothing Per Oral after light breakfast if scheduled for afternoon. c. It is recommended that aspirin/blood thinners be stopped one (1) week prior to procedure. Must notify physician if not complied by the patient.	Patient safety If Diprivan is used.
6. Assist the patient into position desired by the physician. Patient is to be prone with two (2) pillows under the abdomen.	
7. Support patient and monitor status during needle insertion and throughout procedure.	
8. Clean area and apply Band-Aid to puncture site after needle is withdrawn.	
9. Obtain post procedure vital signs: temperature, pulse, respiration, blood pressure and oxygen saturation (if Diprivan is used).	

PAIN MANAGEMENT (LUMBAR SYMPATHETIC BLOCK)		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 22** **Page: 2 of 2**
Effective Date: 11 April, 2013		

PROCEDURE	RATIONALE
10. Assist patient in repositioning self to supine position.	
11. Discharge patient as per physician's orders.	

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE I
(Refer to General Manual Policy and Procedure No. 22)

PATIENT GRIEVANCE ANALYSIS SHEET

Date/Chart	Grievance	Responsible Party	Handled By	Remarks

ANNEXURE II
(Refer to General Manual Policy and Procedure No. 22)

PATIENT GRIEVANCE REPORT FORM

Names of persons involved:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Name of person filling out form:_____

Date of grievance:_____

Source of grievance:_____

With reference to person involved in grievance:

Age_____ Sex_____ Preop_____ Postop_____

OR_____ Other location_____ Diagnosis_____

Brief description of patient grievance to include area, equipment, treatment, drug, procedure involved, and parts of body affected. Do not mention names of individuals in this section.

_____

_____

_____

_____

Corrective action if applicable:

_____

_____

_____

_____

Date of report:_____

Signature, Name and Designation:_____

Date of review by Nursing Superintendent:_____

Signature of Nursing Superintendent:_____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

PATIENT GRIEVANCES		
Policy/Procedure Applies To	**Nursing Superintendent, Executive Assistant, Executive Facility and Executive Finance**	**Policy/Procedure No: 22** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PATIENT GRIEVANCES

POLICY

Any patient grievance including those generated from patient satisfaction reply forms will be reviewed and analyzed. A grievance is any complaint relating to patient care or the quality of services.

PROCEDURE

1. In the event of a patient grievance, every effort will be made to contact the patient to explore, clarify, and resolve the grievance.
2. These grievances will be reviewed, summarized and analyzed by Nursing Superintendent assisted by Executive Assistant, Executive Facility and Executive Finance. (Refer Annexure I to this policy)
3. The tabulated results are presented to the Quality Assurance Committee and the Management Committee for discussion and/or recommendation after they are seen by the Administrative Head of the Center.
4. All patient grievance forms will be retained by the Executive Assistant. (Refer Annexure II to this policy).

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

STERLIZATION METHODS		
Policy/Procedure Applies To	**All O.T. Nurses / O.T. / CSSD Technicians**	**Policy/Procedure No: 22** **Page: 1 of 2**
Effective Date: 11 April, 2013		

STERILIZATION METHODS

PURPOSE

To provide guidelines for compliance with standards for processing supplies and equipment for use in the operative field during a surgical procedure.

POLICY

All equipment and supplies will be rendered sterile by steam sterilization or high-level chemical disinfection prior to use in operative field.

PROCEDURE

1. **Steam Sterilization:** Steam under pressure is the most effective and most commonly used method for rendering instruments and supplies sterile. Its efficiency depends on the penetration of packs by saturated steam at a specified temperature for a specified period of time.
    a. Steam sterilization should be used for heat and moisture stable items.
    b. Items should be disassembled, thoroughly cleaned, rinsed, and wiped or air dried.
    c. Items should be positioned in sterilizer to enhance air removal, allow free circulation and penetration of steam and to prevent excessive condensation.
    d. The time-temperature settings recommended by the manufacturer should be followed.
2. **Immediate Use Sterilization:** Immediate Use Sterilization is appropriate only in an emergency situation such as an immediate need for an individual item (e.g. a dropped instrument) and there is no alternative. Individual items, instrument trays or instrument sets should be sterilized only if all the following conditions are met:
    a. There is an urgent need for the items.
    b. Work practices provide appropriate time for proper cleaning and decontamination, inspection and arrangement of instruments into appropriate sterilizing trays or containers prior to sterilization.
    c. The physical layout of department or work area ensures direct delivery of sterilized items to the point of use (e.g. the sterilizer opens into the procedure area).
    d. Procedures are developed and followed for aseptic handling and personnel safety during transfer of the sterilized items from the sterilizer to the using area.
        i. Only clean, unwrapped instruments should be sterilized.
        ii. Specialty instrumentation or devices (e.g. drills) require different exposure times.
        iii. Follow manufacturer's recommendations for the device.
        iv. Implantable items should never be sterilized using immediate use methodology.
        v. Inspect recording device to ensure appropriate exposure time and temperature following each cycle.
        vi. Transfer item in a manner that maintains sterility.
        vii. Follow the manufacturer’s recommendations for proper temperature and time to achieve sterilization.

STERLIZATION METHODS		
Policy/Procedure Applies To	**All O.T. Nurses / O.T. / CSSD Technicians**	**Policy/Procedure No: 22** **Page: 2 of 2**
Effective Date: 11 April, 2013		

NOTE

1. Cannulated instrumentation should be freely irrigated immediately prior to Immediate-use sterilization.
2. Stand clear of door opening slowly to allow steam to escape out and up, away from user.

3. **Chemical Disinfection:** Chemical Disinfection differs from sterilization by its power to kill spores and is divided into three levels: high, intermediate and low. A high-level disinfectant can be sporicidal as well as bacteriocidal and virucidal if contact time is sufficient. An intermediate-level disinfectant is not sporicidal, but will kill the more resistant bacteria and viruses. A low-level disinfectant is not sporicidal and will kill only less resistant bacteria and viruses.

   A high-level disinfectant should be used if an item is to be disinfected rather than sterilized.

   a. The manufacturer's written instructions should be followed.
   b. Items to be disinfected should be thoroughly cleaned, rinsed and as dry as possible to avoid interference with the disinfecting process or dilution of the disinfectant.
   c. All surfaces of the items, including lumens and channels, should be in contact with disinfectant solution for recommended exposure time.
   d. The disinfectant process should occur prior to storage and immediately prior to use.
   e. Prior to use, items should be aseptically removed from the disinfectant, rinsed thoroughly with sterile water and dried in a manner which minimizes the risk of contamination.
   f. An expiry date, determined according to manufacturer's written recommendations, should be marked on the container of the disinfectant solution currently in use.
   g. High-level disinfectant contact with skin, mucous membrane and eyes should be avoided and solutions should be kept covered and used in a well ventilated area.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

SUCTION EQUIPMENT CLEANING - PROTOCOL		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 22** **Page: 1 of 2**
Effective Date: 01 April, 2014		

SUCTION EQUIPMENT CLEANING - PROTOCOL

PROTOCOL

Suction machines are to be cleaned and disinfected and stored in the designated area between uses.

PURPOSE

The purpose of this procedure is to reduce the incidence of cross-contamination and infection in the facility.

These procedures are offered as a resource for use by staff as they attempt to determine how best to achieve the goal of providing each patient with appropriate health care.

REQUIRED ITEMS

1. Soap
2. Warm water
3. Hospital disinfectant- 1% Sodium Hypochlorite
4. Bottle brush
5. Personal protective equipment

PROCEDURE

1. Wash and dry hands and put on gloves.
2. **Cleansing suction machines at the end of each shift when used by a single patient:**
   a. Empty contents of the suction canister.
   b. Rinse suction jar with warm water and empty it out.
   c. Suction clean water through the suction tubing. If there is mucous build-up in the tubes, replace before re-using.
   d. The suction catheter shall be replaced very 24 hours.
3. **Disinfecting suction machines between use by different patients:**
   a. Empty contents of suction canister.
   b. Rinse canister with warm water and liquid detergent and empty.
   c. Fill suction canister half full with liquid detergent and water and scrub the inside and outside with the bottle brush.
   d. Soak the suction canister and lid in disinfectant solution for one hour.
   e. Clean the exterior of the suction machine with 10% alcohol and a clean cloth.
   f. Remove equipment from soaking solution and rinse well with clean water.
   g. Turn upside down on a clean towel and let dry completely. Equipment must be completely dry before reassembling.

SUCTION EQUIPMENT CLEANING - PROTOCOL		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 22** **Page: 2 of 2**
Effective Date: 01 April, 2014		

h. Replace plastic tubing with a new package of disposable tubing.

i. Cover cleaned and dry machine and canister with a clean plastic bag and store in designated area.

j. Never cover a machine with a plastic bag until it has been properly cleaned and disinfected.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: URINARY BLADDER CATHETERIZATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 22** **Page: 1 of 6**
Effective Date: 11 April, 2013		

Name: _____ Unit:_____ Date: _____

Frequency

1. Rarely observed or never done
2. Rarely done (<6 x a year)
3. Occasionally done (1 – 2 x a month)
4. Frequently done (daily or weekly)

Experience

1. None
2. Limited
3. Moderate
4. Proficient

Validation Method

1. = Cognitive: Tests, verbalize action/steps
2. = Psychomotor: Demonstrates skill in lab. simulated setting
3. = Psychomotor: Demonstrates skill in clinical setting
4. = Affective: Demonstrates appropriate behavior/attitude

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			1. Verbalizes the cognitive knowledge regarding catheterization	1. Defines Urinary Bladder Catheterization ▪ The introduction of a catheter through the urethra into the bladder for the purpose of draining urine. 2. States the indication for catheterization ▪ To relieve acute or chronic urinary retention ▪ To obtain uncontaminated urine specimen for culture and sensitivity ▪ To empty the bladder before, during or after surgery and before certain diagnostic examinations ▪ To measure the amount of PVR (Post-void Residual Volume) urine in the bladder							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: URINARY BLADDER CATHETERIZATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 22** **Page: 2 of 6**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
				3. Differentiates between 2 types of catheters and its uses ▪ Intermittent or straight catheter – used to drain the bladder for short periods ▪ Indwelling urinary catheter for gradual decompression of an over distended bladder							
			2.Demonstrates skill in preparation before catheterizing	1. Prepares all required equipment for Urinary Catheterization 2. Ensures that a physician's written order is obtained 3. Obtains a urological history before catheterizing a male patient. eg. renal or other types of cancer ▪ urological disorders ▪ urologic or renal surgery ▪ polycystic kidney disease 4. Complies with the policy : ▪ Catheterization of female is done by female physician / nurse ▪ Catheterization of male is done by male physician / nurse							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: URINARY BLADDER CATHETERIZATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 22** **Page: 3 of 6**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			3. Demonstrates skills in catheterization of **female** patient.	1. Inserts urinary catheter for a female patient ▪ Maintains strict aseptic technique ▪ Provides privacy by screening bed and exposing genital area only ▪ Washes hand before and after procedure ▪ Dons sterile gloves ▪ Separates vaginal fold with fingers of non-dominant hand and cleanse perineal area with soap and water ▪ Lubricates tip of catheter with lubricant jelly ▪ Holds catheter in dominant hand and using non-dominant hand to keep vaginal folds open, clean labial folds using cotton balls, moving from above the meatus down towards the rectum using downward strokes ▪ Inserts catheter into urethra (about 3 inches) until urine begins flowing ▪ Inflates the balloon according to manufacturer's recommendations							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: URINARY BLADDER CATHETERIZATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 22** **Page: 4 of 6**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
				▪ Tugs gently on the catheter after balloon is inflated to feel resistance – attach to drainage system and secure to upper thigh with Velcro leg strap or tape ▪ Cleans perineal area. Makes patient comfortable after washing hands	Method	Code	Date		Date	Method	Date
			4. Demonstrates skill in catheterization of **male** patient.	1. Inserts urinary catheter for a male patient ▪ Maintains strict aseptic technique ▪ Provides privacy ▪ Washes hands pre and post procedure ▪ Dons sterile gloves ▪ Washes and rinses end of penis using soap and water (Pull back foreskin if not circumcised) ▪ Holds penis with slight upward tension perpendicular to patient's body. Gently insert the tip of syringe with lubricant into urethra and instill 10 cc of lubricant							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: URINARY BLADDER CATHETERIZATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 22** **Page: 5 of 6**
Effective Date: 11 April, 2013		

SELF-ASSESSMENT

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
				▪ Inserts catheter into urethra (7 – 10 inches) until urine begins flowing – if met with resistance, do not force catheter ▪ Inflates balloon as per manufacturer's orders and gently pull back catheter into place – connect to drainage bag ▪ Secures catheter to upper thigh / lower abdomen ▪ Cleans area, washes hands and makes patient comfortable							
			5. Provides patient / family education	1. Instructs the patient as follows : ▪ reasons and expectations of the procedure ▪ potentials complications (eg. urinary tract infection, septicaemia, urethral erosion, epidimitis) ▪ care of the catheter							

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY: URINARY BLADDER CATHETERIZATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 22** **Page: 6 of 6**
Effective Date: 11 April, 2013		

Freq.	Exp.	Area	Competency	Standard	Preceptor Validation			Follow-up Plan		Preceptor Validation	
					Method	Code	Date		Date	Method	Date
			6. Documentation of all relevant data	1. Documents in the Nurses' Progress Notes ▪ Date / time of catheterization ▪ Physician / nurse who inserted the catheter ▪ Size of catheter inserted ▪ Difficulties experienced ▪ Amount of urine drained and appearance of urine ▪ Patient / family education provided 2. All entries and signatures to be legible.							

_____ _____

Validator Signature **Designation**

Preceptor code: **A- Preceptor** **B- OT Matron** **C- Nursing Superintendant**

Note: Must be psychomotor validation

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

PROTOCOL FOR DISPOSAL OF HUMAN TISSUE / ANATOMICAL REMAINS / WASTE		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses / OT Matron / Technicians**	**Policy/Procedure No: 23** **Page: 1 of 2**
Effective Date: 01 April, 2014		

PROTOCOL FOR DISPOSAL OF HUMAN TISSUE / ANATOMICAL REMAINS / WASTE

Anatomical waste is defined for the purposes of this procedure as a 'recognizable' body part, tissue or organ arising from healthcare activities, excluding that which is generated post-mortem.

PROTOCOL

Staff must ensure that all human tissue removed during any operative procedure is disposed of in an ethical and respectful manner.

Staff must confirm with the surgeon that the tissue in question is for disposal only and not required for specimens or histopath.

Any tissue for disposal should be kept separate until the operative procedure is complete and all counts have been carried out.

The tissue may then be placed securely in a rigid yellow clinical waste bin or bag for incineration. Care must be taken with any tissue containing sharp penetrative items such as bone fragments. Staff must wear appropriate personal protective equipment when dealing with tissue for disposal.

Larger items, such as amputated limbs, should be placed directly into a rigid yellow bin or bag. The bin or bag should be sealed and labeled clearly with the Theatre of origin, date and case number.

The OT Matron should arrange for removal of the bin or bag to a secure area awaiting collection for incineration.

The waste shall be collected no less than daily and shall be removed from the site within 24 hours.

Table 1 describes examples of the clinical wastes that are included by this definition.

Table 1: Defining Anatomical Waste

Description of Anatomical Waste	**Anatomical** YES/NO
Limbs (whole or Part)	YES
Whole or Part Fingers, Toes, Ears, Eyes or other appendages (part = any single item ≥ 5% of the total mass of the item whole)	YES
Whole or Part Bones (part = any single item ≥ 5% of the total mass of the item whole)	YES
Whole or Part Organs (part = any single item ≥ 5% of the total mass of the item whole)	YES
Skin / Muscle (when individual pieces are greater than approximately 4 cm^2/cm^3)	YES

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

PROTOCOL FOR DISPOSAL OF HUMAN TISSUE / ANATOMICAL REMAINS / WASTE		
Policy/Procedure Applies To	**Resident Medical Officers / All Nurses / OT Matron / Technicians**	**Policy/Procedure No: 23 Page: 2 of 2**
Effective Date: 01 April, 2014		

Description of Anatomical Waste	**Anatomical** YES/NO
Teeth	NO
Finger-nails/Toe-nails	NO
Hair	NO
Blood soaked swabs, dressings etc. containing traces of human tissue e.g. wound repair, blood vessels or fragment of bone	NO

Transporting Anatomical Waste

Contact the contractor (PASSCO) collecting anatomical waste for Incineration.

All transportation trolleys or bags used to contain Anatomical Waste must be filled with care to ensure that the mixture with any other waste does not occur. Trolleys or bags must remain closed, locked and must be accompanied by a completed label that describes the waste in accordance with the Pune Municipal Corporation (PMC) regulations.

Table 2 describes the color code packaging required to ensure healthcare wastes receive appropriate treatment.

Table 2: The Classification of Clinical Waste for Packaging and Treatment

Description of the waste	**Treatment / Packaging**
'INCINERATION ONLY' waste from Operating Theatres such as: 1. Recognizable Anatomical Waste 2. Frozen tissue waste e.g. Placentas 3. Profusion Waste 4. Any apparatus partly or wholly made of metal that is contaminated with blood or other infectious materials including tools, implanted medical devices, plates, screws, etc. (not destined for CSSD returns) 5. Any substance or material potentially or knowingly contaminated with TSE/CID (Transmissible Spongiform Encephalopathy / Clinical Infectious Diseases)	'INCINERATION ONLY' **ALL YELLOW BAGS** **OR** **ALL YELLOW RIGID CONTAIINERS / SHARPS BOXES**

An Informed Consent for Disposal of Anatomical Remains form (Refer to Annexure to this policy) must be completed.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer to Nursing Manual II Policy and Procedure No. 23)

INFORMED CONSENT FOR DISPOSAL OF ANATOMICAL REMAINS

Date: _____

Procedure to be performed: _____

Procedure performed by: _____

Information / Explanation for Consent briefed by:

Signature of the Doctor: _____

Name of the Doctor: _____

Date: _____ Time: _____

We have been explained the Medical problems of the patient in the language we understand. We have been explained the treatment options and the risks involved with and without treatment/ intervention procedure. We understand that the limb / toes / fingers or other anatomical remains will be disposed off by Prime Surgical Centers as per PMC rules and regulations.

	Witness / Interpreter	**Patient / Relative / Guardian in case patient is Minor / Is Unconscious / Is suffering from Unsoundness of mind**
Signature / Thumbprint	_____	_____
Name	_____	_____
		Relationship to the Patient
		_____

PS: You are welcome to discuss any of the points mentioned above with the doctors attending on you before signing of the informed consent.

Prime Surgical Damle Path, LLP
Beck House, Damle Path, Off Law College Road, Pune 411004
Phone: - 020-39931000 Fax: - 020 39931020
Email: - customercare@primesurgical.in
Website: www.primesurgical.in

PRIME SURGICAL CENTERS

MR No :
Name :
Age/Sex :
Date :

INFORMED CONSENT FOR DISPOSAL OF ANATOMICAL REMAINS

Date: _____

Procedure to be performed: _____

Procedure performed by: _____

Information / Explanation for Consent briefed by:

Signature of the Doctor: _____

Name of the Doctor: _____

Date: _____ Time: _____

We have been explained the Medical problems of the patient in the language we understand. We have been explained the treatment options and the risks involved with and without treatment/ intervention procedure. We understand that the limb / toes / fingers or other anatomical remains will be disposed off by Prime Surgical Centers as per PMC rules and regulations.

	Witness / Interpreter	**Patient / Relative / Guardian in case patient is Minor / Is Unconscious / Is suffering from Unsoundness of mind**
Signature / Thumbprint	_____	_____
Name	_____	_____
		Relationship to the Patient
		_____

PS: You are welcome to discuss any of the points mentioned above with the doctors attending on you before signing of the informed consent.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

ARRIVAL TIME FOR PATIENTS		
Policy/Procedure Applies To	**All Nurses / Customer Care Executives**	**Policy/Procedure No: 23** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ARRIVAL TIME FOR PATIENTS

POLICY

1. For OPD Consultations (first visit) patient will be requested to come 30 minutes before the appointment time.
2. Patients should arrive at the Prime Surgical Centers Two (2) hours prior to their scheduled surgery time, unless specified otherwise.
3. Exception to the above policy will be based on the following criteria for admission of patient on the previous day between 8 to 9 p.m.:
   a. Any surgery posted before 7 a.m.
   b. Surgery time greater than 2 hours requiring General Anaesthesia.
   c. Age of patient more than 60 years.
   d. Associated co-morbidities like Hypertension/Diabetes/Ischemic heart Disease.
   e. Pre-anaesthesia check up not done or completed.
4. Pain Clinic patients may arrive 30 minutes before scheduled procedure time.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE II
(Refer to General Manual Policy and Procedure No. 23)

To,

_____

_____

_____

_____

Dear Sir/Madam,

At Prime Surgical Centers we are concerned about the well-being of our patients and therefore we had tried to contact you on three different occasions without success.

We hope that you are doing well and following your Doctor's advice including medications. In case you have any query or suggestion, please feel free to contact us on telephone number +91 20 3993-1000 Between 9:00am to 5:00pm Monday to Friday.

Wishing you all the best.

Regards,
Customer Care Executive
Prime Surgical Damle Path LLP

ANNEXURE I

(Refer General Manual Policy and Procedure No. 23)

POST-DISCHARGE FOLLOW-UP CALL

MR No: ……. Name of Surgeon: ……..

Patient Name: ……

Date of Admission: …… Date of Discharge:……

Date of Follow-up Call: / / 20

Call Successful? Yes No Left Message with ……

☐ Wrong number ☐ Disconnected ☐ No Answer

2nd Call: …… 3rd Call: ……

Greeting,

You were recently admitted for ……

surgery at Prime Surgical Centres. I am Dr…….. and I have called to find out how you are doing and to see if there is anything we can help you with. Is this a good time to talk?

1. Was there pain in the post operative period? **Y/N** …….
   Was it effectively treated? **Y/N** …….
2. At the time of discharge did you get the Post-operative instructions sheet? **Y/N** …….
   Did you understand all the instructions? **Y/N** …….
3. Were you able to get all the prescriptions? **Y/N** …….
   Are you taking your medication(s) as per the time schedule? **Y/N** …….
4. Are you facing any problem? **Y/N** …….

(Problem)……

……

(Action)……

……

5. Do you have any Questions/ Comments/Suggestions

……

……

……

……

6. What is Satisfaction score on 1- 5 scale?

5 - Excellent	4 - Very Good	3 - Good	2 - Average	1 - Poor

Thank you for speaking with me today. If you have any questions, please call me on 020 3993 1000

For Customer Care: ……

……

Doctor Name, Signature, Date & Time: ……

Customer Care Exe. Name, Signature, Date & Time: ……

If call unsuccessful, Follow-up Letter sent by ☐ Post ☐ Courier ☐ Email on (date)……

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

FOLLOW–UP TELEPHONE CALLS		
Policy/Procedure Applies To	**Resident Medical Officers and Customer Care Executives**	**Policy/Procedure No: 23** **Page: 1 of 1**
Effective Date: 11 April, 2013		

FOLLOW-UP TELEPHONE CALLS

PURPOSE

To determine patient's condition after returning home to reinforce instructions and to show our concern for discharged patients. It will help the Center to build a long term relationship with the patient.

POLICY

An attempt will be made to contact every discharged patient by telephone within three (3) business days. The Post-Discharge Follow-up Call form (refer Annexure I) will be used for the follow-up phone call script and to document the information received from the patient. Unsuccessful attempts to contact the patient will be documented and a written communication sent through e-mail/courier/post (refer Annexure II).

PROCEDURE

1. Telephone patient within 3 business days after procedure. Continue to call for a minimum of two (2) successive business days if patient is not reached initially.
   a. Document telephone follow-up in the Post-Discharge Follow-up Call form.
   b. Record all relevant information as given by the patient.
   c. Note details of person giving information if other than the patient.
   d. File the form in the Post-Discharge Feedback File.
2. If the information given indicates a complication or a pending complication, notify the surgeon/Anaesthesiologist immediately and follow-up prescribed action.
   a. Document any further action taken.
   b. Follow-up and document treatment results of any complication.
   c. Forward documentation to Administrative Head of the Center.
3. If the patient has any administrative query mention it on the Post-Discharge Follow-up Call form. Ask the patient to either call the customer care department or handover the details to the customer care department with name, signature, date and time, for further action.
4. If the patient cannot be reached, handover patient details to the customer care department who will send a communication (refer to Annexure II) through e-mail/courier/post.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

ORIENTATION CHECKLIST - GENERAL		
Policy/Procedure Applies To	**ALL NURSES & TECHNICIANS**	**Policy/Procedure No: 23** **Page: 1 of 2**
Effective Date: 11 April, 2013		

ORIENTATION CHECKLIST - GENERAL

PROCEDURE

1. Use the attached checklist for the general orientation.
2. The verify column is for preceptor verification initials

	DATE Instruct	VERIFY		DATE Complete	COMMENTS
General Orientation Information Sheet					
1. Philosophy					
2. Confidentiality					
3. Entry into Building					
4. Employee Parking					
5. Locker Assignment					
6. Working Hours					
7. Time Clock					
8. Communication Book					
9. Payroll Procedure					
10. Personal Phone Calls					
11. Time Off Request Book					
12. Time Schedule					
13. Vacation, Holidays, Personal Days					
14. Savings, Retirement, Life					
15. Health Plan					
16. Illness and Tardiness					
17. Dress and Behavior Code, Smoking Policy					
18. Breaks and Lunch					
19. Orientation and Skills Checklist					
20. Organization Chart					
21. Job Description					
22. Annual Performance Appraisal Form					
23. Employee Communication Form					
24. Disaster/ Fire Plan, Location of Exits, Extinguishers and Alarms					

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

ORIENTATION CHECKLIST - GENERAL		
Policy/Procedure Applies To	**ALL NURSES & TECHNICIANS**	**Policy/Procedure No: 23** **Page: 2 of 2**
Effective Date: 11 April, 2013		

	DATE Instruct	VERIFY		DATE Complete	COMMENTS
25. Right to Know Manual/ Hazard Communication					
26. Best Demonstrated Practices					
27. Incidence Report					
28. Alarms					
29. Emergency Plan, Code Procedures					
30. Location of Crash Cart and Emergency Equipment					
31. Use of Copy Machine and Fax Machine					
32. Phone and Intercom System					
33. Telephone Etiquette					
34. Tour of the Physical Layout – Nursing Unit					
a. Clean and Dirty Utility Room					
b. Linen Storage					
c. Nursing Station					
d. High Alert Medication Cupboard					
35. Demonstration of Patient Flow					
36. Policy and Procedure Manuals/ Explanation/ Location					
37. Skills Checklist Applicable for Position					
38. Exposure Control Plan					
39. Employee Handbook					

ORIENTEE: _____

PRECEPTOR: _____

DATE: _____

Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PAIN MANAGEMENT (TRIGGER POINT INJECTION)		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 23** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PAIN MANAGEMENT (TRIGGER POINT INJECTION)

PURPOSE

To provide quality nursing care and assist physician in administering medications via trigger point injections.

POLICY

All patients admitted for trigger point injections will be monitored and the proper aseptic technique maintained.

PROCEDURE	RATIONALE
1. Assemble required items and medications per physician's preference.	
2. Identify patient, introduce self and explain procedure to patient.	Patient safety, ensure cooperation and decrease patient's anxiety.
3. Obtain baseline vital signs: temperature, pulse, respiration& blood pressure.	
4. Requirements: a. Informed consent b. It is recommended that aspirin/blood thinners be stopped one (1) week prior to procedure. Must notify physician if not complied by the patient.	Patient safety
5. Assist patient into position desired by physician dependent on site of injection.	
6. Physician will prepare skin site for injection.	Prevents infection
7. Support patient and monitor status during needle insertion and throughout procedure.	
8. Clean area and apply Band-Aid to puncture site after needle is withdrawn.	
9. Obtain post procedure vital signs: temperature, pulse, respirations & blood pressure.	
10. Assist patient in repositioning self to supine position.	
11. Discharge patient as per physician's orders.	

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PAIN MANAGEMENT (TRIGGER POINT INJECTION)		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 23** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PAIN MANAGEMENT (TRIGGER POINT INJECTION)

PURPOSE

To provide quality nursing care and assist physician in administering medications via trigger point injections.

POLICY

All patients admitted for trigger point injections will be monitored and the proper aseptic technique maintained.

PROCEDURE	RATIONALE
1. Assemble required items and medications per physician's preference.	
2. Identify patient, introduce self and explain procedure to patient.	Patient safety, ensure cooperation and decrease patient's anxiety.
3. Obtain baseline vital signs: temperature, pulse, respiration& blood pressure.	
4. Requirements: a. Informed consent b. It is recommended that aspirin/blood thinners be stopped one (1) week prior to procedure. Must notify physician if not complied by the patient.	Patient safety
5. Assist patient into position desired by physician dependent on site of injection.	
6. Physician will prepare skin site for injection.	Prevents infection
7. Support patient and monitor status during needle insertion and throughout procedure.	
8. Clean area and apply Band-Aid to puncture site after needle is withdrawn.	
9. Obtain post procedure vital signs: temperature, pulse, respirations & blood pressure.	
10. Assist patient in repositioning self to supine position.	
11. Discharge patient as per physician's orders.	

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE XXIII
(Refer to Housekeeping Manual Policy and Procedure No. 1)

PARAPET/BALCONY

	Frequency			
AREA	**Daily**	**Weekly**	**Mthly**	**Other**
Wing A – First and Second Floor			X	
Wing B – First and Second Floor			X	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

RECALL POLICY IN THE EVENT OF STERILIZED GOODS BEING CONTAMINATED		
Policy/Procedure Applies To	**O.T. & Procedure Room CSSD Staff**	**Policy/Procedure No: 23** **Page: 1 of 1**
Effective Date: 11 April, 2013		

RECALL POLICY IN THE EVENT OF STERILIZED GOODS BEING CONTAMINATED

POLICY

This policy applies when contamination of sterilized goods occurs due to H_2O contamination, rips or tears in wraps, or improper sterilized temperature.

1. Those items involved will be removed from the shelf and resterilized.
2. If the physician must be notified for a case involved:
   a. Notify Nursing Superintendent, OT Matron, and Administrative
   b. Head of the Center
   c. Notify Surgeon
   d. Notify CSSD staff.
3. Recall in the event of contaminated manufacturer's goods is as follows:
   a. Notify Nursing Superintendent and OT Matron
   b. Refer to Log Implant Book
   c. Notify Administrative Head of the center.
   d. Notify Surgeon involved
   e. Notify CSSD Staff.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

CLEANING OF CUBICLE CURTAINS		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 24** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CLEANING OF CUBICLE CURTAINS

PURPOSE

To maintain a clean environment by proper removal and processing of soiled drapes.

POLICY

Privacy curtains should be cleaned once a day in the morning and on as required basis if there is visible dust or soiling is present. They should be washed every Quarter and record maintained for the same by the concerned nurse in nursing unit and OPD.

PROCEDURE

Housekeeping staff / Nursing aides will remove these curtains and wash with soap and water.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST - OPERATION THEATER		
Module Applies To	**All OT Nurses and Technicians**	**Module No: 24** **Page: 1 of 5**
Effective Date: 11 April, 2013		

COMPETENCY CHECKLIST - OPERATION THEATER

PROCEDURE

1. Use the attached checklist for Operation Theater orientation.
2. The verify column is for preceptor verification initials.

	DATE Reviewed	VERIFY		DATE Complete	COMMENTS
PERIOPERATIVE ORIENTATION:					
1. EMERGENCY & GENERAL EQUIPMENT					
a. O_2					
b. Crash Cart					
c. Defibrillator					
d. Stretchers					
e. Lumenis Laser 100Watt					
f. Pathology Lab (Golwilkar Lab)					
g. Warmers					
h. Warming Blanket					
i. Monitors					
j. Anesthesia cart					
k. Phones					
l. Medication Room					
2. CHARTING FORMS					
a. Pre-op and Intra-op orders					
b. Intra-operative charts					
c. Pre-operative Checklist					
d. Post-operative Checklist					
e. Implant Logs					
f. Sterilization Logs					
i. Autoclave					
ii. Cidex / E.T.O					
g. Specimen forms and logs					
h. Progress Notes					

COMPETENCY CHECKLIST - OPERATION THEATER		
Module Applies To	**All OT Nurses and Technicians**	**Module No: 24** **Page: 2 of 5**
Effective Date: 11 April, 2013		

	DATE Reviewed	VERIFY		DATE Complete	COMMENTS
i. Lens re-ordering forms					
j. Surgical and Anaesthesia consents					
3. GENERAL OT					
a. Suctions					
b. Overhead lights					
c. Electro cautery					
d. Light sources & headlights					
e. Anaesthesia cart and monitors					
f. Nitrous controls					
g. Autoclave					
h. Cidex soaks					
i. General supply cabinets (OR & Anes.)					
j. Sutures					
k. Ultrasonic cleaner					
l. Warming cabinets					
m. O.T tables					
n. Positioning aides					
o. Scrub sinks					
p. Scrubbing					
q. Gowning & gloving					
r. Back table set-up					
s. Draping					
t. Decontamination of instruments					
u. Instrumentations:					
i. Minor tray					
ii. Specialty trays					
iii. Plastic tray					
v. Surgical counts (sponges, sharps, instruments)					

COMPETENCY CHECKLIST - OPERATION THEATER		
Module Applies To	**All OT Nurses and Technicians**	**Module No: 24** **Page: 3 of 5**
Effective Date: 11 April, 2013		

	DATE Reviewed	VERIFY		DATE Complete	COMMENTS
w. Surgical preps					
x. Decontamination/ soil workroom					
y. CSSD					
z. Equipment Room					
aa. Janitor's closet					
bb. Linen cart and storage					
cc. Trash disposal (general and bio-hazard)					
dd. PPE location (Personal Protective Equipment)					
ee. Policy, Procedure & equipment manuals					
ff. Room prep for cases					
gg. Medications					
hh. Pre-op assessment of patient					
ii. Post-operative report					
4. QA PROGRAM					
a. Incidence Report					
b. Infection Control					
5. PLASTIC					
a. Bi-polar coagulators					
b. Light sources					
c. Elmed cautery					
d. Lipo suction (Grams, Medical) -					
i. Cannulas					
e. Lighted retractor with cord					
6. ORTHOPEDIC / SPINE					
a. Video cart					
b. Intelijet for knees					
c. Davol Hydroflex for shoulders					
d. Tourniquets (ATS & Zimmer)					

COMPETENCY CHECKLIST - OPERATION THEATER		
Module Applies To	**All OT Nurses and Technicians**	**Module No: 24** **Page: 4 of 5**
Effective Date: 11 April, 2013		

	DATE Reviewed	VERIFY		DATE Complete	COMMENTS
e. Drills, saws, inserters					
f. Stryker command					
g. Positioning Aides					
i. Knee holder					
ii. Hand table					
iii. Shoulder positioner (Schlein)					
h. C-Arm					
i. Arthro wand					
j. Mitek Vapor					
k. Cast cart					
l. Dyonic shaver					
m. Knee & shoulder scopes					
n. Fragment sets					
o. Orthopedic extras					
7. ENDOSCOPY					
a. Video carts					
b. Valleylab					
c. Karl Storz light source					
d. Printer					
e. Video monitor					
f. Scopes					
g. Scope cleaner/decontamination (Unitrol)					
h. Specimens					

Key: N/O – no opportunity to demonstrate

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST - OPERATION THEATER		
Module Applies To	**All OT Nurses and Technicians**	**Module No: 24** **Page: 5 of 5**
Effective Date: 11 April, 2013		

STATEMENT OF COMPLETION

I have:

1. completed the General Orientation & OR Orientation.
2. reviewed the Orientation List with the preceptor/OT Matron/Administrative Head of the Center.
3. had all my questions answered that are pertinent to this orientation.
4. an understanding and working knowledge of all that was covered in this Orientation.
5. an understanding of the purpose, content and location of procedure manuals.

Orientee: _____

Signature Printed or Typed Name of Orientee

Date: _____

Preceptor: _____

Signature Printed or Typed Name of Preceptor

Date: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

MEDICAL RECORD QUALITY REVIEW TOOL		
Module Applies To	**Resident Medical Officer, All Nurses, Auditor**	**Module No: 24** **Page: 1 of 4**
Effective Date: 01 April, 2014		

MEDICAL RECORD QUALITY REVIEW TOOL

	DOCUMENTATION REQUIREMENTS	File 1			File 2			File 3			File 4			File 5		
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
AOP 1	Initial Nursing assessments are completed within the first 1 hour after the patient's admission as an inpatient.															
AOP 2	Initial Medical assessments are completed within the first 2 hours after the patient's admission as an inpatient.															
AOP 3	The assessment includes:	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	1 – Physical															
	2 – Social															
	3 – Psychological															
	4 – Health History															
AOP 4	Patient's Nursing needs are identified from the initial assessments and are recorded															
AOP 5	Patient's Medical needs are identified from the initial assessments and are recorded															
AOP 6	Nursing Assessment findings are documented in the patient's record and readily available to those responsible for the patient's care.															
AOP 7	Medical Assessment findings are documented in the patient's record and readily available to those responsible for the patient's care.															
AOP 8	Medical assessment documented prior to surgery															
AOP 9	Patients are reassessed at intervals appropriate to their condition; plan of care and individual needs or according to Prime Surgical Centers policies and procedures.															
AOP 10	Nutritional screening done and documented															
AOP 11	Functional assessment done and documented															
AOP 12	Patient is assessed for pain															

AOP - Assessment of Patients

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

MEDICAL RECORD QUALITY REVIEW TOOL		
Module Applies To	**Resident Medical Officer, All Nurses, Auditor**	**Module No: 24** **Page: 2 of 4**
Effective Date: 01 April, 2014		

	DOCUMENTATION REQUIREMENTS	File 1			File 2			File 3			File 4			File 5		
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
AOP 13	If identified, a comprehensive assessment is performed:															
	1 – Appropriate to the patient's age															
	2 – Measures pain intensity															
	3 – Measures quality such as character, frequency, location & duration															
	4 – Appropriate intervention given in time															
	5 – Reassessment after intervention was done as per policy															
	6 – Patient's response to pain management was documented															
AOP 14	Dying patients and their families are assessed / reassessed according to their individualized needs and documented															
ACC 1	Patient's readiness for discharge is determined by relevant criteria or indications.															
COP 1	The care provided to each patient is planned and written in the patient's record within 24 hours of admission by	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	1 – Physician															
	2 – Nurse															
	3 – Other healthcare professionals															
COP 2	The care planned is reviewed and verified by the responsible physician with a notation in the progress notes.															
PFR 1	Informed consent is obtained before	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	1 – Any surgery or invasive procedure															
	2 – Before anesthesia (including moderate & deep sedation)															
	3 – Administration of blood and blood products															
	4 - Other high-risk treatments and procedures															
IPSG 1	"MULTIDISCIPLINARY TIME OUT CHECK LIST" completed before the surgery/procedure															

ACC - Access to Care & Continuity of Care COP - Care of Patients PFR - Patient & Family Rights IPSG - International Patient Safety Goals

MEDICAL RECORD QUALITY REVIEW TOOL		
Module Applies To	**Resident Medical Officer, All Nurses, Auditor**	**Module No: 24** **Page: 3 of 4**
Effective Date: 01 April, 2014		

	DOCUMENTATION REQUIREMENTS	File 1			File 2			File 3			File 4			File 5		
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
PFE 1	Patient's educational needs are assessed and recorded. Educational assessment includes:															
	1 - Patient's and family's belief and values															
	2 – Their literacy, educational level & language															
	3 – Emotional barriers and motivations															
	4 – Physical and cognitive limitations															
	5 – Patient's willingness to receive information															
PFE 2	Patient and family education includes the following (when appropriate)	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
	1 – Safe & effective use of medication															
	2 - Safe & effective use of medical equipment															
	3 - Potential interaction between medications and food															
	4 – Diet and nutrition															
	5 – Pain management															
	6 - Rehabilitation techniques															
IPSG 2	Fall prevention measures are implemented to reduce fall risk for those associated to be at risk.															
MMU 1	Medication orders are complete as per policy															
MMU 2	Medications prescribed and administered are written in the patient's record															
MCI 1	1 - The Prime Surgical Centers staff uses standardized diagnosis codes, procedure codes, symbols, abbreviations, and definitions															
	2 – Do not use abbreviations are not used															
MCI 2	Every medical record entry must indicate the name of the person writing it, signature, date and time (according to Prime Surgical Centers policy)															
	1 –Writer / Signature (person writing in the file)															
	2 – Date															
	3 – Time															

PFE - Patient & Family Education MMU - Medication Management & Use MCI - Management of Communication & Information

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

MEDICAL RECORD QUALITY REVIEW TOOL		
Module Applies To	**Resident Medical Officer, All Nurses, Auditor**	**Module No: 24** **Page: 4 of 4**
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REMARKS	
MEDICAL RECORD# 1 (Prime Surgical Centers Record):-	Date: Time: Name: Signature:
MEDICAL RECORD# 2 (Patient's Record):-	Date: Time: Name: Signature:
REVIEWER 1:-	Date: Time: Name: Signature:
REVIEWER 2:-	Date: Time: Name: Signature:
ADMINISTRATIVE HEAD of the CENTER:-	Date: Time: Name: Signature:

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

PAIN MANAGEMENT (STELLATE GANGLION BLOCK)		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 24** **Page: 1 of 2**
Effective Date: 11 April, 2013		

PAIN MANAGEMENT (STELLATE GANGLION BLOCK)

PURPOSE

To provide quality nursing care and assist physician in administering medications via stellate ganglion block.

POLICY

All patients admitted for stellate ganglion block will be monitored and proper aseptic technique maintained.

PROCEDURE	RATIONALE
1. Assemble required items and medications per physician's preference.	
2. Identify patient, introduce self, and explain procedure to patient.	Patient safety, ensure cooperation and decrease patient's anxiety.
3. Place patient on cardiac monitor. Obtain baseline vital signs (Pulse, Temperature, Respiration, Blood Pressure and Oxygen Saturation). Place temperature strip to affected extremity and obtain baseline vital signs.	Continue monitoring cardiac status to observe any arrhythmias. Monitor 02 Saturation (SpO2) if sedation used.
4. Start IV.	A life line must be maintained for emergency drugs if necessary.
5. Requirements: a. Informed consent b. Nothing Per Oral if AM case. Nothing Per Oral after clear liquid breakfast for afternoon use.	Patient safety If Diprivan is used.
6. Assist patient into position desired by physician.	
7. Help patient to maintain desired position during procedure. Support head as instructed by Anaesthesiologist.	
8. Area is prepped for injection by physician.	Prevents infection.
9. Monitor patient's status during needle insertion and throughout procedure.	Patient will feel pressure as needle is inserted. May feel pain radiating to shoulder or arm.
10. Raise head of bed to upright position if requested.	Stellate ganglion block is performed at level C6. Elevation of head will cause medication to go to C7 which is where stellate ganglion is located.

PAIN MANAGEMENT (STELLATE GANGLION BLOCK)		
Policy/Procedure Applies To	**Anaesthesiologist**	**Policy/Procedure No: 24** **Page: 2 of 2**
Effective Date: 11 April, 2013		

PROCEDURE	RATIONALE
11. Clean area and apply Band-Aid to puncture site after needle is withdrawn.	
12. Monitor vital signs and effect of treatment: seizures, ptosis, hoarseness, respiratory distress. Check and record temperature changes to affected extremity.	Sympathetic blockade will cause vasodilatation and subsequent increase in temperature of extremity.
13. Discharge patient as per physician's orders.	

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

PATIENT VALUABLES		
Policy/Procedure Applies To	**All Nurses / Customer Care Executives**	**Policy/Procedure No: 24** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PATIENT VALUABLES

POLICY

1. All patients will be instructed to leave all valuables at home. Any valuables brought to the Prime Surgical Centers will be given to a family member and signature obtained in the acknowledgement sheet.
2. Personal items such as eyeglasses, dentures, medications, etc. will be kept in the patient's cabinet.
3. Location of valuables should be documented within the contents of the nurse's notes.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

QUALITY ASSURANCE PROGRAM		
Policy/Procedure Applies To	**All staff involved in patient care**	**Policy/Procedure No: 24** **Page: 1 of 5**
Effective Date: 11 April, 2013		

QUALITY ASSURANCE PROGRAM

INTRODUCTION

The staff at the PRIME SURGICAL CENTERS is committed to creating and maintaining an environment for high quality health care in the short stay surgical setting (Refer to Nursing Manual Policy and Procedure No. 26). To that end, this Quality Assurance Plan has been established. The Quality Assurance (QA) Program shall define the following elements: authority and responsibility; philosophy; goals and purpose; Quality Assurance Committee, customers, quality and service indicators; problem-solving tools; and appraisal.

In this plan we have defined in concrete terms what "quality" means to The Center. Attributes of quality care relevant to the ambulatory surgical setting can be defined and measured. Having said this, we also realize that quality health care carries with it certain intangible aspects. These aspects are difficult if not impossible to measure. We believe those intangible aspects most likely have to do with competent and caring staff who emanate a sense of dedication, confidence in their abilities, as well as genuine caring for the patients and physicians they are serving. The Center strives to create this special kind of atmosphere as well as score high marks on the measurable components.

AUTHORITY AND RESPONSIBILITY

The Management Committee of the Center will be ultimately responsible for the quality of care rendered in the facility. The Management Committee will delegate authority to the Administrative Head of the Center to execute the quality program. The administrator will be empowered to delegate responsibilities for implementation of the program to designated staff members, who will be charged with making the quality program happen. Staff members involved in the quality process are accountable to the Administrative Head of the Center. For this purpose he/she will form a QA Committee which will consist of minimum 5 members to be nominated by him/her. Administrative Head of the Center will be the Chairman of this committee.

The Management Committee shall receive reports of the quality activities and findings from the QA Committee. Reports will include meeting minutes, variances, infection control findings, safety audits, patient satisfaction results, etc.

All employees shall be informed of and have input into The Center's quality activities via staff meetings, bulletin board notices, and through other avenues as appropriate.

PHILOSOPHY

The QA process is based on several fundamental premises. The core principles include:

1. Focus on customer satisfaction i.e., surgeons, patients and their relatives, and staff.
2. Establishment of clinical and administrative standards of care
3. Comprehensive credentialing of physicians and staff
4. Implementation of Best Demonstrated Practices (BDP) concepts
5. Collection of measurable and actionable data on key quality and service indicators
6. On-going assessment, evaluation, and management of quality data integration with risk management
7. Team-oriented approach to problem solving
8. Committee structure that supports the QA process

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

QUALITY ASSURANCE PROGRAM		
Policy/Procedure Applies To	**All staff involved in patient care**	**Policy/Procedure No: 24** **Page: 2 of 5**
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GOALS/ PURPOSE

The goal of the QA program is to continuously improve the quality and calibre of service to customers. Perfection, although desirable, is most likely unrealistic the majority of the time. However, it is realistic and doable to strive for and to achieve continuous assurance in our clinical and service indicators -to keep getting a little bit better in the processes that contribute to the overall experience perceived by each of our customer groups. It is for this purpose that the QA program exists.

Information gathered through the quality assurance process is utilized in decisions regarding physician reappointments and employee performance evaluations.

CONFIDENTIALITY

Confidentiality of all QA patient data and Center documents shall be strictly upheld. Processes in place for specific departments are addressed in the related manual (i.e., medical records, incident reporting etc.).

QUALITY ASSURANCE COMMITTEE

The QA Committee will be composed of minimum 5 members from the management team and staff members from each area of the Center to be constituted by Administrative Head of the Center, e.g.: Administrative head of the center (Chairman), Anaesthesiologist, Radiologist, Representative of Golwilkar Metropolis Laboratory and Apollo Pharmacy, Nursing Superintendent, and any others as deemed necessary. With total representation, input is thus gained from each area of service in the surgical center. The QA Committee shall meet at a minimum on a monthly basis for initial 6 months and thereafter, on quarterly basis / more often if desired. An agenda shall be followed to ensure that all attributes of quality and center performance are covered.

Minutes shall be documented of each meeting and maintained in a confidential manner. The minutes and any relevant supporting documentation shall be transmitted to the Management Committee.

CUSTOMERS

A customer is anyone who is dependent on the Center for meeting their needs. The primary customers at the Center are Surgeons, Anaesthesiologists, Patients, Staff, and outside surveyors (i.e. State, TPA, Accreditation, etc.) The QA program shall only monitor and study processes that are important to our customers, both external and internal. Customer needs shall be pinpointed through internal center mechanisms.

QUALITY/ RISK MANAGEMENT INDICATORS AND OUTCOMES

Data are collected on an ongoing basis on the following quality and service indicators - indicators that reflect on various facets and degrees of quality care and where risk may occur:

1. Patient questionnaire results
2. Surgeon satisfaction survey results
3. Medical record audit results
4. Peer review issues and results (medical and nursing)
5. Deaths (within one (1) week of surgery)
6. Direct admissions for any reason
7. Admissions within seventy two (72) hours for procedure -related complications

8. Confirmed post-op surgical wound infections
9. Incorrect extremity operated on
10. Patient burns of any kind
11. Employee variances
12. Any other variances identified through the risk management program
13. Staff input on the important aspects of care for each respective clinical area – OPD/ Nursing Units/ Operating Theater
14. Other, miscellaneous (Exit interactions, Discharge Follow up and so on)

Variance reports shall be generated whenever an unexpected outcome or deviation from normal operations occurs, including but not limited to the above. The report is directed to the Administrative Head of the Center who will coordinate all quality and risk data.

The Center recognizes the concept that "you can't manage what you can't measure." Measurement of the above indicators provides a benchmark against which to determine current and future performance. By knowing where we stand on the clinical outcomes and service components, we are in a better position to manage the information until resolution and opportunities can be achieved.

Chart audits are routinely conducted as another means to determine the overall quality of care and charting. Chart audits also help to identify any discrepancies, which are followed up by a designated staff member and reported to the QA Committee.

Additionally, we recognize that the main source of quality deficiencies lies in problems in systemic processes, not the failure of people to do the work as instructed. To this end, special studies shall be conducted regarding issues felt to be worthy of deeper investigation and understanding, as identified by the Center's QA Committee. Studies shall encompass clinical, administrative, and cost of care issues.

The results of the risk management program shall be utilized in the quality program. Corrective actions are evaluated on a timely basis by follow-up studies in some cases, by monitoring recurring variances, by observing patterns and by conducting random audits. Issues identified through risk management are reviewed with an eye to prevention of similar variances to the extent possible.

PROBLEM-SOLVING TOOLS

The Center shall use a variety of problem solving mechanisms to improve the care. Such mechanisms include but are not limited to: old fashioned chart review (based on objective criteria); data gathering and follow-up of variances; tissue review criteria; infection control worksheets; customer/supplier alignments; team approach utilizing FADE wheel systematically (F-ocus, A-nalyze, D-evelop, E-xecute); brainstorming; cost-benefit analysis; action plans, etc. The method of investigation shall be suited to the nature of the problem.

The Administrative Head of the center and Nursing Superintendent and other staff members will be involved in the problem-solving process. Solutions to problems may include staff education, policy changes, equipment and supply recommendations, etc. Recommendations for solutions are made by the QA Committee which is empowered to implement changes. Certain solutions may require approval of Management Committee. Decisions regarding changes are communicated to the staff by way of staff meetings, communications books, notices, and word of mouth.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

QUALITY ASSURANCE PROGRAM		
Policy/Procedure Applies To	**All staff involved in patient care**	**Policy/Procedure No: 24** **Page: 4 of 5**
Effective Date: 11 April, 2013		

UTILIZATION REVIEW AND QUALITY ASSURANCE (PEER REVIEW)

Utilization review is a function of quality assurance and is a continuing process established to increase efficiency and economy while maintaining safety, convenience and satisfaction for the patient. All physicians, nurses and other personnel influence the performance of the facility. Documentation of performance will be determined by prospective, concurrent and retrospective analysis. The QA Committee will recommend to the Administrative Head of the center and Nursing Superintendent and the Management Committee changes in any aspect of the functions of the facility or the physicians using the facility, which can improve performance.

1. **Retrospective Analysis**

   A retrospective analysis to document the performance of the facility will be carried out using the following reports:

   a. Surgical procedures performed
   b. Personnel utilized
   c. Equipment and supply expenditures
   d. Operating time
   e. Turnover time
   f. Patient satisfaction questionnaire
   g. Outcome
      i. infections
      ii. hospitalization
      iii. unsatisfactory result of surgery or anaesthesia
      iv. recovery time

2. **Concurrent Analysis**

   A concurrent analysis will record observations by facility personnel or as to efficiency, effectiveness, safety and comfort. These reports will be requisitioned by the Administrative Head of the center and Nursing Superintendent, or their designees, and summarized in a report to the Utilization Review and QA Committee.

3. **Prospective Analysis**

   a. Regulations have been prepared which are subject to frequent review and revision. They are designed to provide security and comfort for the patient, efficiency of utilization of the facility and safety for facility personnel. These regulations include:
      i. Authorized list of operative procedures and criteria.
      ii. Annual review by the Credential Committee of Surgeon's and Anaesthesiologist's qualifications including licensure, hospital appointment, and malpractice insurance coverage.
      iii. Provision for written patient post-op instructions by Surgeon, Nurses, and Anaesthesiologist.
      iv. Preparation of standard and written procedures for use of steam to avoid injury to personnel or inadequate sterilization.
      v. Review by QA Committee of disaster plans. These include fire regulations and procedures for bomb threats or other potential disaster.
   b. Requirements for selection and preparation of the patient by the Surgeon.

c. Responsibility of Anaesthesiologist for evaluation, preparation, administration of anaesthesia, post anaesthetic care and discharge have been written.

d. The duties and responsibilities of nursing personnel before, during and after surgery have been provided.

e. Regulations concerning the health status of personnel which might affect the patient's outcome have been prepared and will be enforced.

4. Fiscal Accountability

The facility is committed to providing safe service at a reasonable charge to the patients. Efficient use of physical facilities, equipment, supplies and personnel are the goal of the facility, under the guidance of the Administrative Head of the center. The Quality Assurance Committee will review policies, procedures and practices to advise methods for assurance and will report this recommendation to the Management Committee.

APPRAISAL

The QA program shall be reviewed on an annual basis. The plan shall evolve as the Center grows and shall be adjusted to accommodate for changes in services and scope of practice.

SUMMARY

In essence, the QA plan is a road map to help get to the destination of the best possible medical and nursing care. Chief goal is to constantly and faithfully be responsive to and satisfy the needs of all the customers. The Center desires to be distinguished for its superior service to all customer groups, both internal and external.

ANNEXURE II
(Refer to Nursing Manual Policy and Procedure No. 25)

OPD CARD

MR No :

Name :

Age/Sex :

Consultant : _____

Vitals : Temperature _____ Pulse _____ Respiration _____ Blood Pressure _____

Height _____ Weight _____ Pain _____

Complaints :

Past History :

Family History :

Clinical Findings :

Provisional Diagnosis :

Advised :

Advised (Continued) :

MR No :

Name :

Age/Sex :

Name & Signature of Consultant

ANNEXURE III
(Refer to Nursing Manual Policy and Procedure No. 25)

INFORMED CONSENT FOR SURGERIES / INVASIVE PROCEDURE

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

INSTRUCTION : This consent form should be signed by patient if an adult :by a parent/guardian if the patient is a minor (below 18 years) : by spouse, adult children, parents, adult brother or sisters, adult grandchildren, other relatives, close friend (in this order of priority), if the patient lacks the ability to make an informed decision .

1. I hereby authorize the performance of the following operation(s), procedures(s)

   (Hereafter referred to as procedures) : (Use no abbreviation / Avoid technical terms).

Procedure Name .....

Diagnosis .....

Patient Name .....

2. I have been advised of the benefits and the reason for the procedure(s) as indicated by the clinical observation and or diagnostics performed. I recognise that in the practice of medicine no guarantees can be made regarding the likelihood of success or outcome of the stated procedures/operations as these have side effects ,complications and undefined outcomes. Potential benefits are as follows:

   ---

3. I have been adviced of the following existing alternatives in treatment and prognosis if the proposed procedures is not done which are listed as follows:

   ---

4. I authorize Dr. ---------- and the assistant and associates as may be selected by him/her to perform full/any part of the procedures on myself/ the patient. I have been advised and agree that any member of this team may perform any part of the procedures according to his/her stage of training and ability, if in the opinion of the above named doctor the experience and capability of the assistants and associates justifies such a decision.

5. I have been advised that major risks involved in the above procedures are as under:-

   ---

   ---

6. As with any procedure, i am aware that risks such as allergic reaction, infection, shock, any organ failure, postoperative bleeding or any other complication, paralysis, etc. may arise necessitating attention. Therefore, in addition to consenting to the performance of the particular procedures, i also consent and authorize for procedures of above and/or other unforeseeable event which may occur.

7. Blood Or The Blood Products: I have been informed that despite careful screening in accordance with national and international regulations there are instances of transmitting of infections such as HIV, HEPATITIS and other viruses or diseases as yet unknown for which screening tests do not exist .I also understand that unpredictable reactions may occur which include but are not limited to fever, rash and shortness of breath ,shock and in rare cases death.

   Expected benefits of the transfusion may include minimizing shock, brain and other damage, hastening recovery and limiting blood loss. However, I understand that there are no guarantees offered as to the expected benefit of the transfusion.

8. **Photography :** I consent to the photography or televising of the procedure to be performed for the purpose of advancing medical education; or its publications in scientific journal provided my /the patient identify is not revealed by the pictures or descriptions accompanying texts.

   In an effort to further medical science and education, I permit the presence of an observer/trainee as may be authorized by prime surgical centers as per its rule/regulations.

AUTHORISATION OF PATIENT:

I acknowledge that i have had an opportunity to discuss this procedure, as stated, with my surgeon/physician or his / her designate, therefore give consent to this procedure.

Patient name & signature ---------- Date & Time ----------

Tel. No.

PATIENT REPRESENTATIVE / SURROGATE

The patient is unable to give consent because----------and I ----------
---------- (name/relationship to the patient), therefore give consent for the patient.

I acknowledge that I have had an opportunity to discuss this procedure, as stated, with treating surgeon/physician or his/her designate, therefore give consent to this procedure.

Patient representative/surrogate name & signature

Date & Time :-

Tel. No.

Witness name & Signature :

Date & Time

Tel. No.

Surgeon/Physician name & Signature

Date & Time

ANNEXURE IV
(Refer to Nursing Manual Policy and Procedure No. 25)

MEDICAL HISTORY DECLARATION

MR No :
Name :
Age/Sex :
Date :

This questionnaire is designed to assist the Anaesthesiologist who will be taking care of you to know more about your state of health.

Please answer the questions as accurately as possible:-

Blood Group if known:-
Name of operation:-
Referring Doctor:-

Have you ever had or do you have now : (Yes/No/Not Applicable-Y/N/NA)

High/Low blood pressure		Frequent headaches	
Chest pain,palpitation,sweating		Fall / Head injury	
Anaemia,Blood disorder/Prolonged bleeding		Trouble with balance	
Blood transfusion		Epilepsy or Fits	
Frequent colds, sore throat		Depression / Psychiatric Problem	
Chronic cough? , Blood in the sputum.		Jaundice / stomach Ulcers	
Asthma, Lung Problem		Kidney trouble/Urine Trouble	
Shortness of Breath while walking climbing stairs, lying down		Frequent Fever / Malaria.	
Tuberculosis		Weight loss	
Diabetes		Arthritis, Joint Pains	
Fainting, Dizzy Spells		Back Pain/Sciatica	
Vomiting, Acidity, Motion Sickness, Constipation.		For Women Married / Single? Pregnant? No of children.	
Snoring		Last Menstrual Period	

Have you ever had: (Y/N/NA)

Allergies		Surgery	
Injuries		Anaesthesia	
Hospital Treatment		Anaesthesia Complication	
Blood Transfusion		Mitral Valve prolapse	

Have you ever used any of these: (If yes, Number of days, Months, And years/N/NA)

Cough syrups		Blood thinners Antiplatetlet, Aspirin, Clopigard.	
Pain killers		Nasal Drop	
Sleeping tablets		Anti epileptic Drug	
Steroids		Birth control pills	
Any Anti- hypertensive drug		Antibiotic	
Others		Anti-Diabetic Drug	

To What Extent Do You Use, if (Y/N/NA)

Alcohol		Narcotic Drug	
Tobacco /Cigarette smoking		other	

Do You Have (Y/N/NA):-

Dentures/Crown/Bridge		Contact Lenses	
Hearing Aid		Pace Maker	
Investigations in last 6 months:-			
Hospital Admission:-			

Any other information you would like to give:-

I solemnly declare that the above information is true and complete and I have not withheld any information.

Further, I personally stand fully responsible for any complication that may arise in the above information being proved incorrect.

_____

Name & Signature of patient / Parent / Guardian, Date & Time

_____

Counter signature of Anaesthesiologist. Name, Date & Time:-

ANNEXURE V
(Refer to Nursing Manual Policy and Procedure No. 25)

PRE - OPERATIVE EVALUATION

DISCIPLINE : SPINE/ORTHO/GENERAL/PLASTIC/URO/GYNAEC

OPERATION PLANNED :

SURGEON :

PRE-ANAESTHETIC ASSESSMENT BY :

MR No :

Name :

Age/Sex :

Date :

Day Surgery : Yes / No

PST 139 GEN 007

PRESENT COMPLAINTS :

PAST MED. HISTORY & MEDICATION :

PAST SURG. & ANAES. HISTORY :

H/O DRUG ALLERGY : Yes / No

Alcohol Tobacco Cigarette

EXAMINATION :

Pulse : BP : SPO_2 :

CVS :

RS :

P/A :

CNS :

Spine :

AIRWAY ASSESSMENT : **Normal** ☐ **Difficult** ☐

MALLAMPATTI GRADE 1 2 3 4

THYROMENTAL DISTANCE > 6.5 / 6.5 / < 6.5

OBESITY NECK TRISMUS TEETH

OTHERS

LAB RESULTS:

Hb ..... Na+ ..... PT ..... URINE:

PCV ..... K+ ..... IMR ..... Prot .....

Plts ..... Cl- ..... APTT ..... Sugar .....

WBC ..... Urea ..... Blood Sugar ..... Acetone ...

Cr ..... HIV .....

ECG ..... HbsAg .....

X-ray .....

2DEcho .....

OTHER INVESTIGATIONS :

PRE OPERATIVE MEDICATION :

ASA GRADE : 1 2 3 4 5 E

ANAESTHESIA PLAN :
ALTERNATIVE PLAN :

Name of Anaesthesiologist : Signature

POST - OP INSTRUCTIONS :

NBM - WATER _____ **AM/PM**
LIQUIDS _____ **AM/PM**
SOLIDS _____ **AM/ PM**

POSITIONS - SUPINE HEAD UP OTHERS
OXYGEN SUPPLEMENTATION : NO YES
I V FLUIDS -

ANALGESICS -

PONV MEDICATION -

OTHERS -

NAME, SIGNATURE, DATE & TIME OF ANAESTHESIOLOGIST

Time	PULSE	BP	SpO_2	I V DRUGS	I V FLUIDS	COMMENTS	NAME & SIGN. OF NURSE

INTRAOPERATIVE RECORD

Consent Checked Y / N **NBM From**

SURGERY	ANAESTHESIOLOGIST	SURGEON	POSITION	DURATION (ANAES)	DURATION (SURG.)	ANAES. TYPE

ANAESTHESIA RECORD

HOUR	30	30	30	30	30	30	30	30	30
EMESET									
GLYCOPYROLATE									
MIDAZ									
FENTANYL									
FORTWIN									
RANITIDINE									
REGLAN									
EPHEDRINE									
PENTOTHAL									
KETAMINE									
PROPOFOL									
DEXETOMIDINE									
SCOLINE									
ATRACURIUM									
VECURIONIUM									
NEOSTIGMINE									
ATROPINE									
N_2O									
O_2									
AIR									
RL									
DNS									
SpO_2									
$EtCO_2$									
ECG									
220									
200									
190									
180									
170									
160									
150									
140									
●Pulse 130									
∧ Diast BP 120									
110									
∨ Syst BP 100									
90									
80									
70									
60									
50									
40									
30									
20									
10									
0									

INDUCTION

IV / INHAL

LARYNX : CORMACK LEHANE

1 2 3 4

ETT SIZE

ORAL / NASAL

CUFF Y / N

INFLATED WITH ..... ML

PACK Y / N

LMA / COPA

SIZE & TYPE

CUFF ..... ml AIR

MAINTENANCE :

AIR / O_2 / N_2O / SEVO ..... %

REVERSAL WITH :

MYOPYROLATE :

NEOSTIGMINE ..... MG + GLCOPYROLATE ..... MG

SUCTION DONE : Y / N

REVERSAL : COMPLETE / INCOMPLETE

EXTUBATION : Y / N

SPONTANEOUS BREATHING : Y / N

TONE : GOOD / POOR

CONSCIOUSNESS : AWAKE / AROUSABLE / DRAWSY

COLOUR : PINK / PALE / CYANOSED

NAUSEA : Y / N VOMITTING : Y / N

PERIPHERIES : WARM / COLD

SHIVERING : Y / N

SIGNATURE :

RESPIRATION

CIRCUIT :

SPON / ASSIST / CONTROL / VENTI

MODE: VC / PC / SIMV+PS / PS

RR: ..... /MIN

T.V:..... ML

PEEP:

MEAN AIRWAY PRESSURE -

SPINAL / EPIDURAL / OTHER

POSITION -

PAINTING -

APPROACH -

SPACE -

NEEDLE GAUGE & TYPE -

DRUG & VOLUME

ADDITIVES

CATHETER

TOP UP DOSE

TIME DRUG & VOLUME

TOTAL INTAKE

URINE OUTPUT :

BLOOD LOSS :

TOTAL OUTPUT :

VITALS ON SHIFTING

PULSE: ..... BEATS PER MIN

BP: ..... MM OF HG

SPO_2 ..... %

PAIN SCORE:

COMMENTS:

ANNEXURE IX
(Refer to Nursing Manual Policy and Procedure No. 25)

PATIENT'S RESPONSIBILITIES

1. To maintain healthy habits & take responsibility for health.
2. To be respectful to Doctors and medical staff.
3. To be honest with Doctor & disclose family / medical history.
4. To do best to comply with Doctor's treatment plan.
5. If not happy, to inform the Doctor.
6. Will do homework to participate intelligently in medical care.
7. Will not ask for padded bills and false certificates.
8. Will understand prescribed medicines.
9. Will be punctual for appointments.
10. Will pay bills on time.
11. Will have realistic expectations from Doctor's treatment.
12. Will report fraud and wrongdoing.
13. To treat the Center staff and fellow patients with respect.
14. To keep all old medical records in sequential order and to show treating Doctor on as required basis.
15. To provide medical Insurance Card, if requiring admission and paying through Insurance.
16. To follow rules and regulations of Prime Surgical Centers.
17. To take care of own valuables / personal belongings.
18. To comply with no smoking, pan / gutkha, chewing policy in the centers.
19. To be considerate to others for privacy, noise level and safety.

PATIENT'S RIGHTS

1. To receive considerate and compassionate care respecting personal, psycho social, spiritual, cultural and religious beliefs.
2. To be heard till satisfied.
3. To receive all relevant information about professionals involved in the patient care.
4. To receive prompt and reasonable response to any request for services within the capacity of Prime Surgical Centers.
5. To receive reasonable safety / security environment.
6. To receive complete privacy regarding medical care programme and physical dignity.
7. To receive confidentiality of all communications and records.
8. To receive complete information on diagnosis, treatment and medicines, i.e., participate in development and implementation of plan of medical care.
9. To receive / understand various treatment options from the treating Doctor for selection of best option.
10. To receive pain assessment and it's appropriate management.
11. To know if Prime Surgical Center has relationship with outside parties that may influence treatment and care.
12. To receive a legible prescription with dosage and do's and don’ts for each prescribed medicine.
13. To receive information of rules and regulations of the Prime Surgical Center.
14. To receive the same level medical care, irrespective of the category of nursing unit admitted to.
15. Refuse to participate in human experimentation, research, project affecting care or treatment.

16. To refuse treatment. However, this decision will be at patient's own risk.
17. Option of seeking second opinion on disease / treatment from panel of Doctors of Prime Surgical Centers.
18. To receive details of person to be contacted in case of any issue / grievance / suggestion.
19. To receive details of bill.
20. To receive copies of medical records. Cost to be borne by the patient.
21. To receive information about continuing / planning of medical care needs at the time of leaving Prime Surgical Center.

DOCTORS CODE OF PRACTICE

1. Will schedule appointments to allow the necessary time to see patient with minimal waiting & listen to without interruption.
2. Will encourage patient to bring a friend or relative into the examining room.
3. Will facilitate getting the medical and hospital records, and provide with copies of test result
4. Will explain prognosis and further diagnostic activity and treatment in simple terms, which can be understood by the patient.
5. Will prescribe therapy and discuss diagnostic, treatment and medication options, to allow to make a well informed decision.
6. Will inform of qualifications to perform the proposed diagnostic measures of treatments.
7. Will inform of organizations, support groups, websites and publications that can assist Patient.
8. Will not proceed until patient is satisfied and understands the benefits and risks of each alternative and have agreement on a particular course of action.

Name, Signature, Date & Time of Patient / Relative

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

CLEANING BLOOD PRESSURE CUFFS AND STETHOSCOPES		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 25** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CLEANING BLOOD PRESSURE CUFFS AND STETHOSCOPES

PURPOSE

To provide guidelines for appropriate cleaning of equipment used for monitoring vital signs.

POLICY

Disinfection of blood pressure cuffs and stethoscopes is necessary if in contact with open sores, drainage, etc.

PROCEDURE

1. Routine cleaning

   While wearing gloves, apply disinfectant solution on blood pressure cuff and stethoscope, allow 20 minutes contact time and wipe dry.
2. Cleaning after contamination with blood or body fluid
   a. While wearing gloves, completely dismantle equipment.
   b. Soak in a high-level disinfectant (5% sodium Hypochlorite) for 20 minutes
   c. Rinse thoroughly with water.
   d. Allow to dry completely.
   e. Reassemble item and test for proper working order.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

INSERVICE EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST – ALL OT TEHNICIANS		
Module Applies To	**All OT TECHNICIANS**	**Module No: 25** **Page: 1 of 2**
Effective Date: 11 April, 2013		

COMPETENCY CHECKLIST – All Operation Theater Technicians.

PROCEDURE

1. Use the attached checklist for orientation of All OT Technicians.
2. The verify column is for preceptor verification initials.

	DATE Instruct	VERIFY		DATE Complete	COMMENTS
1. EQUIPMENT AND ITS CARE:					
a. Crash Cart					
b. Non-invasive BP Monitor					
c. Pulse Oximeter/Suction.					
d. Laser 100 watt.					
e. Medical Gases Panel (Mask, Re-breathers, Non-rebreathers, Nebulizers)					
f. Stretchers/Wheelchairs.					
g. Glucometer					
h. Room prep for cases					
i. Care & storage of scopes.					
j. Portable Oxygen; Suction					
k. Defibrillator					
l. ECG/ BP Monitors					
m. Bair Hugger					
n Arthro wand/Vapr/Shaver/Stryker.					
O Decontamination of instruments					
P Care of all equipment & Instruments.					
q. PPE location (Personal Protective Equipment)					
r. Knee & shoulder supports.					
2. SUPPLIES:					
a. Equipment Storage					
b. Central Supply/ Sterile Supply					
c. Airway Cleaning					
d. Cleaning Solutions					
e. IV Tray					
f. Waste Disposal					

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

INSERVICE EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST – ALL OT TEHNICIANS		
Module Applies To	**All OT TECHNICIANS**	**Module No: 25** **Page: 2 of 2**
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	DATE Instruct	VERIFY		DATE Complete	COMMENTS
g. CSSD.					
h.Stocking Area					

3. PATIENT PROCEDURES:					
a. Bed making					
b. Giving of bed pan/urinal					
c. Airway Maintenance					
d. Transportation of Patient					
4. PHASE II					
a. Privacy					
5. POLICY/ PROCEDURE MANUALS (Read and Understand)					

6. LOCATION OF REFERENCE MANUALS					
7. INSERVICE / EDUCATION OPPORTUNITIES					
8. QA PROGRAM:					
a. Incidence Report					
b. Infection Control					
c. Hazardous Material					
9. INTRODUCTION TO ALL MEMBERS OF ANAESTHESIA CARE TEAM					

STATEMENT OF COMPLETION

I have:

1. Completed the General Orientation Checklist for Pre-op in Nursing Unit.
2. Reviewed the Orientation List with the preceptor/Nursing Superintendent/Administrative Head of the Center
3. had all my questions answered that are pertinent to this orientation.
4. An understanding and working knowledge of all that was covered in this Orientation.
5. An understanding of the purpose, content and location of procedure manuals.

ORIENTEE: _____

PRECEPTOR: _____

DATE: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

DISCHARGE CRITERIA FOR PATIENTS RECEIVING IV CONSCIOUS SEDATION		
Policy/Procedure Applies To	**All Staff Nurses**	**Policy/Procedure No: 25** **Page: 1 of 1**
Effective Date: 11 April, 2013		

DISCHARGE CRITERIA FOR PATIENTS RECEIVING IV CONSCIOUS SEDATION

DISCHARGE CRITERIA (Refer to Nursing Manual Policy and Procedure No. 107)

1. Vital Parameters stable. Consultant informed.
2. Alert, oriented, no dizziness.
3. No nausea/vomiting.
4. Dressing checked/drain checked/blood loss acceptable.
5. Accepting fluids
6. Accepting solids
7. Pain score acceptable 0-3
8. Last pain medication
9. Able to ambulate
10. Urine voided
11. Responsible relative present
12. Patient given and explained discharge instructions
13. Patient has received all investigation + discharge card

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

QUALITY ASSURANCE STUDY FORM		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 25** **Page: 1 of 1**
Effective Date: 11 April, 2013		

QUALITY ASSURANCE STUDY FORM

PURPOSE

The Quality Assurance Study Form reviews the findings of the formal investigational process of an identified problem. This documentation ensures that the goals of the study are being carried out.

SCOPE

All Center personnel

POLICY

The results of quality assurance studies will be documented monthly for initial 6 months and thereafter, quarterly and submitted to the Quality Assurance Committee.

PROCEDURE

The following elements will be addressed. Follow the five-step process.

1. What important problem or concern in the care of the patient was identified?
2. How were the frequency, severity and source of suspected problems or concerns evaluated?
3. What corrective measures were implemented to resolve the problem?
4. Action taken.
5. How was the problem re-evaluated to determine whether corrective measures were successful?
6. How were the results reported to appropriate personnel, the Administrative Head of the center, Quality Assurance Committee and Management Committee?

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

QUALITY CONTROL LOG - DEFIBRILLATOR		
Module Applies To	**All Nurses, Nursing Superintendent, OT Matron**	**Module No: 25** **Page: 1 of 1**
Effective Date: 01 April, 2014		

QUALITY CONTROL LOG - DEFIBRILLATOR

Month:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
Visual check (each shift)																
Power check (each shift)																
Defibrillator check paddles (each shift)																
Defibrillator check Multifunction Cable (each shift)																
Pacer check (if applicable each shift)																
Full check (6 monthly)																
SIGNATURE																

Month:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
Visual check (each shift)																
Power check (each shift)																
Defibrillator check paddles (each shift)																
Defibrillator check Multifunction Cable (each shift)																
Pacer check (if applicable each shift)																
Full check (6 monthly)																
SIGNATURE																

Month:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
Visual check (each shift)																
Power check (each shift)																
Defibrillator check paddles (each shift)																
Defibrillator check Multifunction Cable (each shift)																
Pacer check (if applicable each shift)																
Full check (6 monthly)																
SIGNATURE																

Codes: ✓ = Passed Test / check   X = Failed Test / check, reported to Bio-Engineering for evaluation   —— = Machine out of unit

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

ADMISSION OF PATIENT		
Policy/Procedure Applies To	**All Nurses / Customer Care Executives**	**Policy/Procedure No: 26** **Page: 1 of 2**
Effective Date: 11 April, 2013		

ADMISSION OF PATIENT

PURPOSE

Establish an initial relationship with the patient to promote a feeling of confidence and security, to enable nursing staff to identify the needs of the patients and also the Admission unit staff to identify the patient properly and check that information is properly documented which will match the patient's nursing care needs with available nursing resources.

SCOPE

All Nursing and Customer Care Executives.

DEFINITION

Admission: involves a patient staying at **Prime Surgical Centers** when surgery is needed. Admission may be Elective or Emergent.

Short stay unit: A nursing unit which will accommodate and treat from 12 to 72 Hrs.

POLICY

1. Patients shall be admitted to the Center for treatment without regard to race, colour, religion, sex or national origin. The Center shall accept patients for care and treatment on a short term basis i.e. 12 to 72 hours.
2. Patients having surgery under local anaesthesia with no sedation are permitted to be admitted/ discharged without being accompanied by “responsible individual" with their Surgeon's or Anaesthesiologist's permission.
3. The parents or legal guardian of paediatric patients must remain at the Center while the individual is being treated.
4. Every patient of the Center shall be admitted to and remain under the care of a member of the medical staff. All Consultants shall be governed by the official admitting policy of the Center.
5. No patient shall be admitted to the Center until a provisional diagnosis or valid reason for admission has been stated.
6. A member of the medical staff (Resident Medical Officer/Surgeon/Anaesthesiologist) shall be responsible for the medical care and treatment of each patient in the Center, for the prompt completeness and accuracy of the medical record, for any necessary special instructions and for transmitting reports of the condition of the patient.
7. The Customer Care staff will admit patients on the basis of elective admissions involving all services.
8. The admitting Consultant shall be held responsible for giving such information to assure the protection of the patient from self harm.
9. A patient scheduled for Surgery will be admitted in normal circumstances on the date of scheduled surgery after fulfilling Clinical / Insurance / Payment administrative criteria.

   (Refer to Nursing Manual Policy and Procedure No. 23 and 25).

ADMISSION OF PATIENT		
Policy/Procedure Applies To	**All Nurses / Customer Care Executives**	**Policy/Procedure No: 26** **Page: 2 of 2**
Effective Date: 11 April, 2013		

10. If there is a significant delay in admission/management (care/treatment) or patient is placed on waiting list, the following information should be provided to the patient/patient's relation by the surgeon and or nurse/customer care executive and documented in the appropriate form.
    a. Reason for delay/ wait.
    b. How long the delay/ waiting list will be.
    c. Alternative approaches based on clinical needs.

PROCEDURE

1. Prepare the bed, environment and equipment in advance as per the check list given in the Annexure to this policy. Completion / authentication of the check list will now mean that the vacant bed is ready for service.
2. The nurse should receive and greet the Patient and his/her relative at the entrance of lounge of Nursing Unit and obtain admission documents.
3. The nurse to escort the patient and relative to the allotted bed/room, give orientation about important facilities in the room/cubicle, and make the patient comfortable. Request him/her to bath, if not already done at home, and change clothes.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

CLEANING OF ARTHROSCOPES AND LAPAROSCOPES		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 26** **Page: 1 of 1**
Effective Date: 11 April, 2013		

CLEANING OF ARTHROSCOPES AND LAPAROSCOPES

PROCEDURE

In order to render the above free from all bacteria:

1. Disassemble all instruments on a clean towel. Stopcocks must be taken apart and gaskets removed. Always handle telescopes by eyepiece.
2. Thoroughly clean in enzymatic solution (Cidezyme for 20 minutes) making sure to clean small channels and holes. Plastic basins should be used to avoid scratching. Disinfect scopes in Glutarldehyde solution per manufacturer recommendations. Do not allow telescopes or any instruments to remain in any solution or sterile water for more than thirty (30) minutes.
3. Rinse well with gentle agitation to remove the disinfection solution. It is recommended to separate and rinse very thoroughly with agitation. If all Glutaraldehydes residue is not removed it can cause sparking or shocks.
4. Dry thoroughly, taking care to remove all water from channels and holes. Electrical cords and cables should not be soaked.
5. Lubricate stopcocks with one drop of lubricant after each use. All parts held together with screws, joints and moving parts should be lubricated weekly.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST - ENDOSCOPY		
Module Applies To	**All OT Nurses and Technicians**	**Module No: 26** **Page: 1 of 3**
Effective Date: 11 April, 2013		

COMPETENCY CHECKLIST - ENDOSCOPY

PROCEDURE

1. Use the attached checklist for orientation of endoscopy nurses/technicians.
2. The verify column is for preceptor verification initials.

	DATE Instruct	VERIFY		DATE Complete	COMMENTS
1. Tour of Endoscopy Room					
2. Equipment a. Blood pressure monitor					
b. ECG Monitor					
c. Pulse Oximeter					
d. Bovie/Bicap II/Heater Probe					
e. Karl Storz Light Source					
f. Karl Storz Scopes-EGD & Accessories					
g. Karl Storz Scopes-Colon & Accessories					
h. Washing Procedures					
i. Balloon dilators					
j. Savory dilators					
k. Bougies					
3. Supplies: a. Location of room supplies					
b. Review of supplies - stock (in-house)					
4. Medications: a. Narcotics					
b. Tranquilizers					
c. Hurricaine Spray					
d. 1:10 Epi / NACL 9cc					
5. Specimens: a. Cytology					
b. Biopsy					
c. Polyp					
d. Location & review of supplies & related paperwork					

COMPETENCY CHECKLIST - ENDOSCOPY		
Module Applies To	**All OT Nurses and Technicians**	**Module No: 26** **Page: 2 of 3**
Effective Date: 11 April, 2013		

6. Charts, Charting & related paperwork a. Review of charts					
b. Order of charts					
c. Review of instruction sheet					
d. Infection control					
e. Policy and procedures					
7. Patient Care a. Connecting monitors					
b. Drug allergies					
c. EGD - Hurricaine Spray					
d. Abdomen check - colon and flex					
e. Transfer to Nursing Unit and report					
f. Observation during procedure					
8. Procedures					
EGD					
EGD with biopsy					
Colonoscopy					
Colonoscopy with biopsy					
Colonoscopy with polypectomy					
Flexible Sigmoidoscopy					
Dilations					
PEGS PRN					
Injection Therapy PRN					
9. Scope Care					
Leak Testing					
Hand washing					
Unitrol					
Storing Scopes					
Repair of Scopes					

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST - ENDOSCOPY		
Module Applies To	**All OT Nurses and Technicians**	**Module No: 26** **Page: 3 of 3**
Effective Date: 11 April, 2013		

STATEMENT OF COMPLETION

I have:

1. completed the General Orientation Endoscopy.
2. reviewed the Orientation List with the preceptor/ OT Matron/ Nursing Superintendent/ Administrative Head of the Center
3. had all my questions answered that are pertinent to this orientation.
4. an understanding and working knowledge of all that was covered in this Orientation.
5. an understanding of the purpose, content and location of procedure manuals.

ORIENTEE: _____

PRECEPTOR: _____

DATE: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

COMPONENTS OF ORIENTATION PROGRAM		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 26** **Page: 1 of 1**
Effective Date: 11 April, 2013		

COMPONENTS OF ORIENTATION PROGRAM

POLICY

1. Job Description

   The job description is presented to each new employee during orientation. It contains a position summary, reporting relationships, qualifications, physical demands, standards of care and criteria for evaluation. It is the basis by which employees will be evaluated at probationary and annual performance reviews.

2. Goals and Objectives of the Orientation Program

   This policy explains the goals, objectives and structure of the orientation program delineating the role and responsibilities of both the Prime Surgical Centers and the employee.

3. General Orientation/Job Specific Orientation Checklists

   a. The orientation checklists ensure that the employee has mastered certain skills before going on to independent practice.

   b. The checklists will become a part of the personnel record.

4. Clinical Skills Checklists

   a. The purpose of the Clinical Skills Checklist is to assist the employee to acquire knowledge of the various area-specific tasks and associated nursing responsibilities.

   b. A planned work experience provides a definite knowledge base upon which the employee can develop clinical expertise.

5. Orientation Evaluation

   a. The orientation evaluation identifies employees' opinions about the strong and weak points of the orientation program.

   b. Results are analysed and form the basis for any change in the orientation program that might be necessary.

6. Performance Review and Development

   Copies of the Performance Appraisal Forms and Clinical Skills Evaluation Checklists will be provided at time of orientation to familiarize the employee with the review process and expectations for their specific job description.

7. Policy and Procedure Manuals

   a. This is a comprehensive list of all policy and procedure manuals at the Prime Surgical Centers in the General Orientation Checklist.

   b. All employees must be familiar with the general contents and location of the material contained in the various volumes.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

IV CONSCIOUS SEDATIONS/ANALGESIA STUDY PACKET FOR NURSE COMPETENCIES		
Policy/Procedure Applies To	**All Staff and O.T. Nurses**	**Policy/Procedure No: 26** **Page: 1 of 12**
Effective Date: 11 April, 2013		

IV CONSCIOUS SEDATIONS/ANALGESIA STUDY PACKET FOR NURSE COMPETENCIES

IV CONSCIOUS SEDATION/ANALGESIA

1. IV conscious sedation is produced by the administration of pharmacological agents.
2. A patient under conscious sedation has a depressed level of consciousness, but retains the ability to independently and continuously maintain a patent airway and respond appropriately to physical stimulation and/or verbal command. It is used for the management of patients for short-term therapeutic, diagnostic or surgical procedures.

OBJECTIVES

1. Alteration of mood
2. Maintenance of consciousness
3. Cooperation of patient
4. Elevation of pain threshold
5. Minimal variation of vital signs
6. Some degree of amnesia which is dependent upon medication

DESIRABLE EFFECTS

1. Relaxed patient
2. Cooperative patient
3. Diminished verbal communication
4. Initiation of slurred speech
5. Arousable sleep
6. Rapid, safe return to ambulation and/or normal pre-procedural state.

UNDESIRABLE EFFECTS

1. Agitation
2. Combativeness
3. Severely slurred speech
4. Unarousable sleep
5. Respiratory depression
6. Hypotension
7. Apnoea
8. Dizziness
9. Significant tachycardia, or bradycardia

IV CONSCIOUS SEDATIONS/ANALGESIA STUDY PACKET FOR NURSE COMPETENCIES		
Policy/Procedure Applies To	**All Staff and O.T. Nurses**	**Policy/Procedure No: 26** **Page: 2 of 12**
Effective Date: 11 April, 2013		

CONTRAINDICATIONS

1. Inexperienced/untrained staff
2. Pregnancy
3. Significant hepatic dysfunction
4. Thyroid dysfunction
5. Adrenal dysfunction
6. Patients on MAOIs or tricyclic antidepressants
7. Known allergies to IV Conscious Sedation medications

PRE-PROCEDURE ASSESSMENT OF PATIENT SHOULD INCLUDE:

1. Physical and baseline assessment parameters, i.e., level of consciousness, anxiety level, vital parameters, temperature, and sensory deficits.
2. Current medications, drug allergies
3. Concurrent medical problems
4. History of substance abuse
5. Chief complaint
6. Communication ability

The above data allows the nurse to identify patient risk factors during the pre-procedure phase.

DURING PROCEDURE, NURSE IS RESPONSIBLE FOR:

1. Continually assess IV
2. Immediate availability of oxygen delivery
3. Monitoring parameters, i.e., respiration, 02 saturation, blood pressure, pulse, level of consciousness, skin condition
4. Documentation of patient response
5. Provide emotional support
6. Observe for and report any changes to the Resident Medical Officer/Anaesthesiologist, such as: restlessness, cyanosis, pallor, flushing, diaphoresis, nausea.
7. Document data every five (5) to fifteen (15) minutes throughout the procedure.

IDENTIFY PATIENT PROBLEMS DURING THE PROCEDURE.

1. Low O2 saturation
2. Continuous IV access
3. Allergic reaction medication

ASSESSMENT FACTORS

ASSESSMENT FACTORS FOR LOW O2 SATURATION	ASSESS	INTERVENTIONS
1. Shivering	1. Restlessness	1. Notify Resident Medical Officer/ Anaesthesiologist
2. Restlessness	2. Agitation	2. Request patient to take slow deep breaths
3. Hypothermia	3. Irritability	3. Start O_2 at rate specified by physician. May titrate according to O_2 saturation level - keep above 90%
4. Peripheral vascular disease	4. Euphoria	
5. Vasoconstrictive drugs	5. Cool, pale skin	
6. Nail polish	6. Initial increase in pulse and systolic pressure	
7. Sensor displacement		

SIGNS OF ALLERGIC REACTION TO MEDICATION

SIGNS OF ALLERGIC REACTION TO MEDICATION	INTERVENTION
1. Rash	1. Notify Resident Medical Officer / Anaesthesiologist
2. Redness	2. Initiate O2 therapy as directed by the Resident Medical Officer / Anaesthesiologist.
3. Itching	3. Prepare to administer the following drugs as directed by physician: a. Benadryl b. Decadron c. Epinephrine d. IV fluids
4. Hives	4. Know where to get an emergency tracheostomy set
5. Oedema especially around eyes, mouth and tongue	
6. Bronchoconstrictor	
7. Respiratory distress	
8. Hypotension	
9. Syncope	
10. Respiratory and/or cardiac arrest	

COMMONLY ADMINISTERED MEDICATIONS

Benzodiazepines	Midazolom
	Ativan (Lorazepam)
	Valium (Diazepam)
Narcotics	Fentanyl
Reversal Agents	Narcan
	Romazicon
Miscellaneous	Chloral Hydrate

DPT IM
BENZODIAZEPINES

MIDAZOLAM

Action: Short-acting benzodiazepine central nervous system depressant

Onset: Three (3) to five (5) minutes.

Duration: Approximately five (5) minutes, gradually declining over next thirty (30) to forty (40) minutes. Effects may last as long as six (6) hours.

Nursing implications:

Monitor and assess vital signs and O2 Sat. Monitor for early signs of underventilation.

Individualize dosage.

Oxygen, suction and resuscitation equipment must be nearby. Know how to use.

Must be skilled at managing airway and ventilation support.

Evaluate response and observe for allergic reactions.

May impair memory of perioperative events. Reinforce patient teaching with written discharge instructions in presence of accompanying adult

Treatment of overdose:

Monitor and assess vital signs, O2 Sat.

Maintain patent airway and support ventilation with O2.

Hypotension - IV fluids, judicious use of vasopressors.

Other supportive measures as indicated.

REFERENCE A: CHART FOR MIDAZOLAM

BENZODIAZEPINES - MIDAZOLAM

DRUG/ROUTE	INITIAL DOSE	EVALUATION INTERVAL	SPECIAL CONSIDERATIONS
Adults	< 2.5 mg or 0.35mg/kg <1 mg	2 minutes	Dilute to 1 mg/ml. Slow IV over 2-3 minutes (max 1 mg/min). Consider decreasing initial dose by 30-50% if used in combination with narcotics.
Geriatric or debilitated patients		2 minutes	See above
Pediatrics		2 minutes	See above
Adults	7.5-15 mg	15-30 minutes	See above
Paediatrics	0.3-0.5 mg	15-30 minutes	See above
MIDAZOLOM INTRANASAL	0.2-0.3 mg/kg	10-15 minutes	See above

REFERENCE B: CHART FOR ATAVAN IV AND VALIUM IV

BENZODIAZEPINES - ATAVAN

DRUG/ROUTE	INITIAL DOSE	EVALUATION INTERVAL	SPECIAL CONSIDERATIONS
Adults	2 - 4 mg or 0.44 mg/kg	5 minutes	Slow IV over 2-5 minutes (max 2mg/min)
Geriatric or debilitated patients	1 -2 mg or 50% of regular dose	5 minutes	See above
Paediatrics	0.05 - 0.1 mg/kg	5 minutes	See above
VALUM (DIAZEPAM)			
Adults	5 - 10 mg or 0.05-0.01 mg/kg	5 minutes	< 5mg/min
Geriatric or debilitated patients	1-2 mg or 50% of regular dose	5 minutes	Use with caution in the elderly
Paediatrics	0.05 - 0.2 mg/kg	5 minutes	(Children over 2-3 min) Rapid injection may result in respiratory depression or hypertension.

MORPHINE

Action: A potent narcotic analgesic with principal pharmacological effects on the CNS and GI tract

Onset: One (1) to three (3) minutes

Duration: Four (4) hours

Nursing implications:

Monitor and assess vital signs and O_2 Sat

Observe for early signs of respiratory depression, suppression of cough reflex

Individualize dose

Oxygen, suction and resuscitation equipment must be nearby. Know how to use

Must be skilled at managing airway and ventilation support

Evaluate response and observe for allergic reaction, respiratory depression, hypertension, arrhythmias, nausea and vomiting

Avoid in patients with known seizure disorders

Avoid in patients with gall bladder disease

Treatment of overdose:

Monitor and assess vital signs, O_2 Sat

Maintain patent airway and support ventilation with O_2

Narcotic antagonist - Narcan

IV fluids

Vasopressors if needed

Other supportive measures as indicated

REFERENCE C: CHART FOR MORPHINE

NARCOTIC (OPIATE) AGENT

DRUG / ROUTE	INITIAL DOSE	EVALUATION INTERVAL	ADDITIONAL DOSES (INCREMENTAL)	SPECIAL CONSIDERATIONS
MORPHINE IV				
Adults	2-5 mg or 0.5-1 mg/kg	5 minutes	2 mg (25-33% of initial dose) Usual effective dose is < 20 mg	Slow IV over 5min (hypertension due to histamine release may occur).
Geriatric or debilitated patients	50 - 70% of normal dose	5 minutes	25-33% of initial dose	See above
Pediatrics	0.05 - 0.1 mg	5 minutes		See above
Infants	0.025 - 0.05 mg/kg	5 minutes	0.05 mg/kg	See above

FENTANYL (SUBLIMAZE)

Action: A potent narcotic analgesic

Onset: One (1) to three (3) minutes for onset of sedative effect; onset of analgesia may not be noted for several minutes

Duration: Thirty (30) to sixty (60) minutes for analgesic effect

Dosage: Up to 20 mcg IV

May repeat every ten (10) minutes x2

Further dose by order of Anaesthesiologist

Dilute to 10 mcg 1 ml

Administer slowly over one (1) to two (2) minutes

Individualize dosing according to, but not limited to, age, general health, and concomitant medications

Titrate to desired effect

Wait five (5) to ten (10) minutes to evaluate effect

* 0.1mg is equivalent to 10 mg Morphine

Nursing implications:

Monitor and assess vital signs and O_2 Sat

Monitor for early signs of underventilation

Duration of respiratory depression may be longer than one (1) hour

Individualize dosage

Oxygen, suction and resuscitation equipment must be nearby. Know how to use.

Must be skilled at managing airway and ventilation support

Evaluate response and observe for allergic reactions - rash, urticaria, CNS changes, decreased LOC, respiratory dysfunction/depression

Treatment of overdose:

Monitor and assess vital signs, O_2 Sat

Maintain patent airway and support ventilation with O_2

Narcotic antagonist - Narcan

IV fluids, vasopressors if needed

Other supportive measures as indicated

REVERSAL AGENTS

NARCAN (NALOXONE HCL)

Dosage: Upon order of Anaesthesiologist

Small increments of 0.1 - 0.2 mg

Administer at two (2) to three (3) minute intervals into an infusing IV line

Max dosage should not exceed 0.4 mg

Potential adverse reactions of Narcan:

Excitement

Hypotension, hypertension

Cardiac arrhythmias

Seizures

Draphosis

Nausea/vomiting

REFERENCE D: CHART FOR REVERSAL AGENTS

REVERSAL AGENTS

DRUG / ROUTE	INITIAL DOSE	EVALUATION INTERVAL	ADDITIONAL DOSES (INCREMENTAL)	SPECIAL CONSIDERATIONS
NARCAN IM/SQ/IV (NALOXONE)				
Adults	0.1 - 0.2 mg	5 - 15 seconds IV	May repeat q 2-3 minutes until desired level of reversal is reached.	IV over 30 seconds repeat doses may be required within 1 to 2 hr intervals depending on the type and time interval since last administration of narcotic.
Paediatrics	0.01 - 0.1 mg/kg	5 - 15 seconds IV	May repeat q 2-3 minutes until desired level of reversal is reached.	Abrupt reversal of narcotic depression may result in the following: Nausea, HR, BP, tremors, seizures, cardiac arrest.
ROMAZICON IV (FLUMAZENIL)				
Adults	0.2 mg	1 minute	0.2 mg at 1 minute intervals to max of 1 mg or 3 mg in 1 hour	IV over 15-30 sec
Paediatrics < 20 kg	0.01 mg/kg to max of 0.2 mg	1 minute	0.005 mg/kg at 1 min intervals to max of 1 mg	Monitor for a minimum of 120 min: vital signs and SaO2 q 15 min X 2, then q 30 min X 3.
Paediatrics > 20 kg	0.2 mg	1 minute	0.005 mg/kg at 1 min interval to max of 1mg 0r 3 mg in 1 hour	Contraindicated in patients physically dependent on Benzodiazepines, patients with known or suspected head trauma. Adverse side effects: seizures, headache, agitation.

MISCELLANEOUS
Chloral Hydrate
DPT
REFERENCE E: CHART FOR MISCELLANEOUS

DRUG / ROUTE	INITIAL DOSE	EVALUATION INTERVAL	ADDITIONAL DOSES (INCREMENTAL)	SPECIAL CONSIDERATIONS
CHLORAL HYDRATE				
Adults Oral	500 - 1000 mg	30 - 60 minutes	25-50% of initial dose (usual effective dose < 2000 mg)	Irritating to mucous membranes, may cause laryngospasm if aspirated; paradoxical excitation.
Paediatrics Oral	50-75 mg/kg (2000 mg max)	30 - 60 minutes	Usual effective dose < 120 mg/kg	Irritation to mucous membranes, may cause laryngospasm if aspirated; paradoxical excitation.
Adult and Paediatric Rectal	same	30 - 60 minutes	same	See above
DPT IM PHENERGAN				
Paediatrics	(D) 2 mg/kg 1M (P) 1mg/kg 1M (T) 1 mg/kg 1M	10-15 minutes		Cyanotic heart disease: (D) 1.2 mg/kg (P) 0.3 mg/kg (T) 0.3 mg/kg

NARCOTIC SIDE EFFECTS INCLUDE

1. Respiratory
2. Hypotension
3. Cough suppression
4. Euphoria, dysphoria
5. Hypersensitivity, allergic reactions
6. Nausea/vomiting
7. Biliary colic
8. Muscle rigidity

TREATMENT OF NARCOTIC OVERDOSE INCLUDES

1. Patent airway
2. Support of ventilation
3. Vasopressors if needed
4. O2
5. IV fluid therapy
6. Narcan
7. CPR

COMPLICATIONS

1. Dyspoenea
   a. Notify Resident Medical Officer/Anaesthesiologist
   b. Open airway using heat tilt/chin lift method
   c. Administer O2 as directed by the Resident Medical Officer/Anaesthesiologist.
   d. Support ventilation with AMBU bag as needed
   e. If indicated and ordered by the Resident Medical Officer/Anaesthesiologist, administer narcotic antagonist such as Narcan.
2. Symptomatic bradycardia or hypotension
   a. Reposition patient in modified Trendelenburg if indicated
   b. Administer fluid therapy, atropine, and vasopressor as directed by the Resident Medical Officer/Anaesthesiologist.
3. Code/arrest
   a. Initiate general supportive measures; patent airway, CPR
   b. Activate emergency system
4. Seizures
   a. Protect patient from injury
   b. Midazolom as directed by Anaesthesiologist

IV CONSCIOUS SEDATIONS/ANALGESIA STUDY PACKET FOR NURSE COMPETENCIES		
Policy/Procedure Applies To	**All Staff and O.T. Nurses**	**Policy/Procedure No: 26** **Page: 12 of 12**
Effective Date: 11 April, 2013		

REVIEW OF OXYGEN THERAPY

Oxygen therapy - highest priority

1. Patent airway
   a. Most frequent cause for airway obstruction is the tongue
   b. Use head-tilt/chin-lift
2. Oxygen delivery via
   a. Nasal cannula
   b. Non rebreathing mask
   c. AMBU bag
3. Oxygen saturation
   a. Normal reading: 95-100%
   b. Mild hypoxemia 89-94.5%
   c. Severe hypoxemia: Less than 75%

*** Note if relying on observation of signs and symptoms of cyanosis, usually not observed until Sp O_2 falls below 75%.**

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

QUALITY CONTROL LOG - MEDICATION REFRIGERATOR TEMPERATURE		
Module Applies To	**All Nurses, Nursing Superintendent, OT Matron**	**Module No: 26** **Page: 1 of 2**
Effective Date: 01 April, 2014		

QUALITY CONTROL LOG - MEDICATION REFRIGERATOR TEMPERATURE

Range: 2 – 8^{0}C

Year _____

Day	JANUARY			FEBRUARY			MARCH			APRIL			MAY			JUNE		
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Action Codes: 1. None 2. Adjusted Temp ↑ 3. Adjusted Temp ↓ 4. Maintenance Called 5. Cleaned 6. Defrosted / Cleaned

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

QUALITY CONTROL LOG - MEDICATION REFRIGERATOR TEMPERATURE		
Module Applies To	**All Nurses, Nursing Superintendent, OT Matron**	**Module No: 26** **Page: 2 of 2**
Effective Date: 01 April, 2014		

QUALITY CONTROL LOG - MEDICATION REFRIGERATOR TEMPERATURE

Range: 2 – 8^{0}C

Year _____

Day	JULY			AUGUST			SEPTEMBER			OCTOBER			NOVEMBER			DECEMBER		
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Action Codes: 1. None 2. Adjusted Temp ↑ 3. Adjusted Temp ↓ 4. Maintenance Called 5. Cleaned 6. Defrosted / Cleaned

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST - PAIN MANAGEMENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 27** **Page: 1 of 3**
Effective Date: 11 April, 2013		

COMPETENCY CHECKLIST - PAIN MANAGEMENT

PROCEDURE

1. Use the attached checklist for orientation of Pain Management for nurses and technicians.
2. The verify column is for preceptor verification initials.

	DATE Instruct	VERIFY		DATE Complete	COMMENTS
1. EQUIPMENT AND ITS CARE:					
a. Non-invasive BP Monitor					
b. Pulse Oximeter					
c. Suction					
d. Oxygen (includes Mask, Tents, Re-breathers, Non-rebreathers, Nebulizers)					
e. Stretchers					
f. Glucometer					
g. Wheelchairs					
h. Portable Oxygen; Portable Suction					
i. Defibrillator					
j. ECG/ BP Monitors					
2. SUPPLIES:					
a. Anesthesia Shelves					
b. Equipment Storage					
c. Central Supply					
d. Cleaning Solutions					
e. IV Tray					
f. Waste Disposal					
g. Stocking Area					
h. Set-up of Nursing Unit in Morning					
i. Closing of Nursing Unit at night					
j. Set up of Nursing Unit for procedure use					

COMPETENCY CHECKLIST - PAIN MANAGEMENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 27** **Page: 2 of 3**
Effective Date: 11 April, 2013		

3. MEDICATIONS:					
a. Medications					
b. Med Prep					
c. Standing Orders (Draw up, Label and Administer)					
4. CHARTING LEGALITIES/ ACCURACY/ ERRORS:					
a. Order of Chart					
b. Finding orders, Transcribing/Signing off					
c. Charting, Writing Notes					
i. Admission Assessment					
▪ Vital Signs					
▪ Airway Status					
▪ Observation of Patient					
▪ Observation of Procedure					
▪ Level of Response & Alertness					
ii. Record IV Therapy					
iii. Record Medications					
iv. Write Verbal Orders on Doctor's Orders Sheet					
v. Discharge Instructions					
d. Filling Out Post-Op Instruction Sheet					
5. PATIENT PROCEDURES:					
a. Admission of Patient (Assessment)					
b. Airway Maintenance					
c. Care of IV Meds Patient					
d. Standing Orders in Nursing Unit					
6. PHASE II					
a. Privacy					
b. Management of:					
i. Pain Control (ensure safety/comfort)					
ii. Nausea and Vomiting					

COMPETENCY CHECKLIST - PAIN MANAGEMENT		
Module Applies To	**All Nurses and Technicians**	**Module No: 27** **Page: 3 of 3**
Effective Date: 11 April, 2013		

c. Preparation for Discharge					
i. Patient Teaching					
ii. Assessment of Procedure					
7. POLICY/ PROCEDURE MANUALS (Read and Understand)					
8. LOCATION OF REFERENCE MANUALS					
9. INSERVICE/EDUCATION OPPORTUNITIES					
10. QA PROGRAM:					
a. Incidence Report					
b. Infection Control					
c. Hazardous Material					
11. POST-PROCEDURE PHONE CALLS:					
a. Documentation					
b. Follow-Up					
12. INTRODUCTION TO ALL MEMBERS OF ANESTHESIA CARE TEAM					
13. PAIN MANAGEMENT PATIENTS					

STATEMENT OF COMPLETION

I have:

1. completed the General Orientation to Pain Management.
2. reviewed the Orientation List with the preceptor/ OT Matron/ Nursing Superintendent/ Administrative Head of the Center
3. had all my questions answered that are pertinent to this orientation.
4. an understanding and working knowledge of all that was covered in this Orientation.
5. an understanding of the purpose, content and location of procedure manuals.

ORIENTEE: _____

PRECEPTOR: _____

DATE: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

COMPETENCY STATEMENTS FOR THE NURSE MANAGING THE CARE OF THE PATIENT RECEIVING IV CONSCIOUS SEDATION		
Policy/Procedure Applies To	**All O.T. Nurses**	**Policy/Procedure No: 27** **Page: 1 of 1**
Effective Date: 11 April, 2013		

COMPETENCY STATEMENTS FOR THE NURSE MANAGING THE CARE OF THE PATIENT RECEIVING IV CONSCIOUS SEDATION

Name_____Date_____

The Nurse should be able to:		**Sign/Date**
_____1.	Define IV conscious sedation	_____
_____2.	Express the objectives and desired effects Of conscious sedation	_____
_____3.	For each medication administered The nurse should be able to identify the Following: a. Initial dose b. Administration technique c. Total dosage d. Potential adverse reaction e. Appropriate antagonist	_____
_____4.	Assess the total patient care requirements prior to, during IV conscious sedation, and during recovery phase. Physiologic measurement should include, but are not limited to: a. Respiratory rate b. Oxygen saturation c. Cardiac rate and rhythm d. Blood pressure e. Level of consciousness	_____
_____5.	Demonstrate documentation of patient's Response and the monitoring parameters collected.	_____
_____6.	Understand the principles of oxygen delivery, respiratory physiology, transport and uptake.	_____
_____7.	Demonstrate the ability to use oxygen delivery devices	_____
_____8.	Demonstrates skill in airway management resuscitation.	_____

Date exam taken_____Score_____Pass_____Fail_____
(Passing score is 80% of competency exam)

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

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HOSPITAL INFECTION CONTROL MANUAL

LEAK TESTING		
Policy/Procedure Applies To	**OT & Procedure Room Nurses**	**Policy/Procedure No: 27** **Page: 1 of 1**
Effective Date: 11 April, 2013		

LEAK TESTING

Leak testing will be done on all scopes after each procedure to ensure there are no defects.

1. Prior to cleaning, attach adaptor to leak tester and immerse scope under water in a basin filled with clean tap water.
2. Connect adaptor to the ETO port of instrument.
3. Press the on button on the MU-1 Leak Tester. The distal end of the scope will be pressurized. Check for a leak by observing for constant bubbles coming from the scope.
4. Completely articulate the scope via the knob to bend the distal portion of the scope to confirm the integrity of the distal end of the scope.
5. After the test is complete, turn off the on/off button and wait approximately 30 seconds for the distal tip to de-pressurize. Then disconnect and continue to disinfect the scope.
6. If a leak is confirmed, scope is removed from use and sent for repair.

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

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GENERAL MANUAL

ORIENTATION PROGRAM FOR NEW EMPLOYEE		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 27** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ORIENTATION PROGRAM FOR NEW EMPLOYEE

POLICY

1. Goals
    a. To familiarize the new employee with Prime Surgical Centers policies and procedures with special emphasis on those specifically for his/her clinical/work area.
    b. To ensure that the new employee demonstrates competence in performing assignments and can perform the required skills of his/her job description.
    c. To evaluate existing skills and to ensure that all new employees are familiar with equipment and can demonstrate its proper use.
2. Objectives
    a. To assist the new staff member in gaining an understanding of the philosophy and objectives of Prime Surgical Centers through a planned introduction.
    b. To properly orient employee to the Prime Surgical Centers physical layout as well as policies and procedures.
    c. To assist a new employee to adjust to his new environment and make him/her fully understand his/her job.
    d. To create pride in Prime Surgical Centers and in the job and thus reduce turnover and absenteeism.
    e. To identify specific needs of each new employee.
    f. To enable the new employee to function competently and safely in the performance of assigned responsibilities.
    g. To allow the employees to have documentation of instruction received by the employee.
3. Policy
    a. Employees will receive an individualized, planned and coordinated orientation program. The length of the orientation program depends on the individual program and the amount and type of his/her experience and shall be completed within thirty (30) to ninety (90) days of employment.
    b. A preceptor model will be employed in the orientation of all new employees.

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Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

QUALITY CONTROL LOG - O2 CYLINDER, O2 REGULATOR, O2 FLOWMETER, SUCTION REGULATOR		
Module Applies To	**All Nurses, Nursing Superintendent, OT Matron**	**Module No: 27** **Page: 1 of 1**
Effective Date: 01 April, 2014		

QUALITY CONTROL LOG - O2 CYLINDER, O2 REGULATOR, O2 FLOWMETER, SUCTION REGULATOR

Date	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**		**11**		**12**		**13**		**14**		**15**		**16**	
O2 Cylinder	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
Stored upright out of direct sun																																
Key available																																
>1/2 full																																
Requested replacement																																
Action																																
Signature																																

Date	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**		**11**		**12**		**13**		**14**		**15**		**16**	
O2 Regulator	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
Well fitting																																
Gauge working																																
Action																																
Signature																																

Date	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**		**11**		**12**		**13**		**14**		**15**		**16**	
O2 Flowmeter	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
Casing intact																																
Wall fitting intact																																
Nipple available																																
Flow meter functioning																																
Action																																
Signature																																

Date	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**		**11**		**12**		**13**		**14**		**15**		**16**	
Suction Regulator	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
Casing intact																																
Wall fitting intact																																
Pressure meter functioning																																
Action																																
Signature																																

Action Codes: 1. None 2. Replaced 3. Maintenance Required 4. Condemned

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

VERIFICATION OF SURGICAL SITE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 27** **Page: 1 of 2**
Effective Date: 11 April, 2013		

VERIFICATION OF SURGICAL SITE

PURPOSE

To identify and document the surgical site prior to surgery and to assure appropriate care is given by the physician and the nursing staff as the patient progresses through the surgical process.

SCOPE

All surgical patients.

POLICY

1. The verification of the site and side of the procedure is obtained by questioning the patient in a way that requires a descriptive response from the patient and/or family. Care must be taken to avoid increasing the patient's anxiety.
2. Physician will initial correct site immediately prior to the procedure.
3. The records that will reflect the planned procedures are:
    a. Surgical schedule
    b. Surgical and Anaesthesia consent
    c. Physician's orders
4. The verification of the site and side of the procedure is to be recorded on the following:
    a. Surgical checklist except in an emergency
    b. Operation Theater record
    c. Anaesthesia record.

RESPONSIBILITY

1. The surgeon schedules the procedure, appropriately including site and side, obtains an informed consent including site and side, and verifies the site and side immediately prior to the surgical procedure.
2. Each nurse assigned to the patient from admission to surgery verifies the consent with the patient and/or family and documents verification on the Pre-operative Checklist and/or nurses notes.
3. Anaesthesia personnel interview the patient as to the side and site of the procedure. Documentation is made on their record.

PROCEDURE

1. The surgical procedure will be scheduled by the Consultant. Customer Care Executive will schedule the surgery after checking all variables like O.R. / bed / manpower / equipment availability.
2. The schedule of a surgical procedure shall be as exact as possible and include site and side (left or right)
3. The Consultant's progress notes should reflect the surgical procedure planned and include both site and side of the procedure.

VERIFICATION OF SURGICAL SITE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 27** **Page: 2 of 2**
Effective Date: 11 April, 2013		

4. The signed surgical and anaesthesia consent for the patient shall include the exact procedure and include site and side.
5. The nurse caring for the patient pre-operatively shall verify the signed surgical and anaesthesia consent form with the patient and/or family; and document the agreement with regards to the consent, side and site. In the case of an unresponsive patient, verification may be done with the family.
    a. If there is a discrepancy, the Administrative Head of the centre and the Consultant should be notified immediately.
    b. Surgeon and Anaesthesiologist will be informed of discrepancies and resolution.
6. Using a skin marker the correct operative site will be marked with the Surgeon's initials.
7. The circulating nurse will verify the surgical and anaesthesia consent with the patient as to the site and side and document on the Operation Theater record as part of the pre-operative assessment of the patient.
8. Anaesthesiologist assessing the patient pre-operatively will verify the surgical procedure including site and side (left or right) documenting on the anaesthesia record.
9. The surgeon on his visit with the patient immediately prior to the procedure will verify the procedure including site and side. Any variance with documentation will be addressed at this time if it has not been previously clarified.
10. If the same personnel are not following the patient throughout the process, the patient will be asked to identify the procedure site and side prior to induction of anaesthesia.

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

ANAESTHESIA MANUAL

COMPETENCY EXAMINATION FOR NURSE MANAGING THE CARE OF A PATIENT RECEIVING IV CONSCIOUS SEDATION		
Policy/Procedure Applies To	**All O.T. Nurses**	**Policy/Procedure No: 28** **Page: 1 of 3**
Effective Date: 11 April, 2013		

COMPETENCY EXAMINATION FOR NURSE MANAGING THE CARE OF A PATIENT RECEIVING IV CONSCIOUS SEDATION (IVCS)

1. Must have a current BLS certification.
2. Define IV conscious sedation.
3. List three (3) objectives of IVCS.
   1. _____
   2. _____
   3. _____
4. List three (3) desired effects of IVCS.
   1. _____
   2. _____
   3. _____
5. List three (3) contraindications for IVCS.
   1. _____
   2. _____
   3. _____
6. Give at least three (3) pre-procedure assessment parameters.
   1. _____
   2. _____
   3. _____
7. How often monitoring parameters should be documented during the procedure?
8. List the five (5) monitoring parameters the Nurse will use:
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____
9. During the procedure the Nurse should: (circle 2)
   a. Ask patient about history of substance abuse
   b. Continually assess IV status
   c. Leave patient unattended
   d. Ensure immediate availability of oxygen delivery
   e. All of above

COMPETENCY EXAMINATION FOR NURSE MANAGING THE CARE OF A PATIENT RECEIVING IV CONSCIOUS SEDATION		
Policy/Procedure Applies To	**All O.T. Nurses**	**Policy/Procedure No: 28** **Page: 2 of 3**
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10. List at least four (4) signs of allergic reaction to medication.
    1. _____
    2. _____
    3. _____
    4. _____

11. You notice that the patient is shivering, restless and the O2 Saturation is 92%. You should initiate the following: (circle 3)
    a. Notify Resident Medical Officer/Anaesthesiologist
    b. Instruct patient to take slow deep breath
    c. Administer O_2 as directed
    d. Instruct patient not to move and tighten security straps

12. List at least three (3) complications of IVCS.
    1. _____
    2. _____
    3. _____

13. List parameters for O2 Saturation.
    Connect with line_____

14. Signs and symptoms of cyanosis are not usually observed until Sp O2 falls below 75%.
    _____True _____False

15. List the benzodiazepine used for IVCS.
    _____

16. List the three (3) common narcotics used for IVCS.
    1. _____
    2. _____
    3. _____

17. Narcan is the antagonist for
18. Midazolom should be administered in a bolus. _____True _____False
19. List four (4) side effects of narcotics.
    1. _____
    2. _____
    3. _____
    4. _____

COMPETENCY EXAMINATION FOR NURSE MANAGING THE CARE OF A PATIENT RECEIVING IV CONSCIOUS SEDATION		
Policy/Procedure Applies To	**All O.T. Nurses**	**Policy/Procedure No: 28** **Page: 3 of 3**
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20. Name four (4) treatment modalities for narcotic overdose.
    1. _____
    2. _____
    3. _____
    4. _____
21. State corresponding P O2 for Sp O2 of 75%

    _____

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

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NURSING EDUCATION AND TRAINING MODULES

ORIENTATION EVALUATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 28** **Page: 1 of 2**
Effective Date: 11 April, 2013		

ORIENTATION EVALUATION

PROCEDURE

Please use the following form to rate your orientation.

ORIENTATION EVALUATION

ORIENTEE:_____DATE_____

Please rate your orientation according to the rating score in the following manner. Your candid and sincere evaluation will be valuable in developing and improving the operating room orientation.

RATING SCALE:
1. Seldom
2. Occasionally
3. Often

LEARNING ENVIRONMENT:

1	2	3	a.	Provides an "open environment" conducive to asking questions or practicing new techniques without feeling threatened.
1	2	3	b.	Provides an atmosphere promoting individual initiative and problem solving.
1	2	3	c.	Provides experience stimulating to learning.
1	2	3	d.	Provides an atmosphere of moral support, cooperation and assistance without promoting dependency.

CLINICAL EXPERIENCE:

1	2	3	a.	Allowed sufficient time to learn basic instrument sets.
1	2	3	b.	Allowed sufficient time for diverse experiences through different surgical procedures.
1	2	3	c.	Allowed sufficient instruction/independent study time to cover theoretical basis.
1	2	3	d.	Provided individual experiences during which theoretical content could be related to the clinical setting.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

ORIENTATION EVALUATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 28** **Page: 2 of 2**
Effective Date: 11 April, 2013		

INSTRUCTIONAL GUIDANCE:

1 2 3 a. Presented material in organized manner.

1 2 3 b. Demonstrated technical knowledge and experience.

1 2 3 c. Offered assistance and support in attempting new procedures.

1 2 3 d. Management was available for guidance or consultation.

SUGGESTIONS FOR IMPROVEMENT:

Name and Signature: _____

Date: _____

PRIME SURGICAL CENTERS

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GENERAL MANUAL

ORIENTATION OF NEW EMPLOYEE		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 28** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ORIENTATION OF NEW EMPLOYEE

PROCEDURE

STANDARD ONE

The orientation program will be carefully planned and designed as to meet the individual learning needs of each new employee.

Criteria

1. A preceptor will be assigned to the employee and will identify individual needs. An individualized orientation program is planned using the orientation schedule and skills checklist as guidelines.
2. The orientation checklists and experience monitors are reviewed. The employee is responsible for seeking out learning experiences on the various checklists. The checklists will be reviewed with the employee at the end of the orientation and become a part of the employee's personnel file.

STANDARD TWO

A preceptor model will be utilized to provide support and supervision to each new employee.

Criteria

1. During orientation the new employee is under the supervision of a designated preceptor.
2. The preceptor is responsible for planning and evaluating learning experience provided.

STANDARD THREE

The length of orientation is flexible and is planned to meet the individual needs of each employee.

Criteria

1. The program is designed to be completed within thirty (30) to ninety (90) days.
2. The skills and policy procedures checklists must be completed and reviewed by new employees and preceptor and must be completed prior to the end of the provisional period.
3. If some areas are pending, orientation may be extended a designated time.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE I
(Refer to Nursing Manual Policy and Procedure No. 28)

PRE-OPERATIVE CHECKLIST NURSING UNIT

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Pre-Op Diagnosis :-				
Allergies :-				
Operation / Procedure Name :-				
Surgeon Name :-		**Anaesthesiologist Name :-**		
Fasting Since :-	**Solid :-**	**Liquid :-**	**Weight :-**	**Language(s) Spoken :-**

CHECKLIST	NURSING UNIT		
	YES	NO	N/A
Patient Correctly identified (I D Band)			
Patient Guardian Present / Relative			
Physical side, Left, Right, Bilateral, N/A			
Vital Parameters BP:- Pulse:- Respiration:- Temp:- Pain:-			
Bath/Hair Wash taken			
Nail polish/Lipstick removed			
Ornament removed			
Denture/ prosthesis/Hearing aid removed			
Under garment removed			
Loose Teeth			
Pre-operative assessment			
Pathology Laboratory study completed/Report available			
Radiology Studies identify side/site if applicable			
Medical history declaration, Surgical & Anaesthesia consent form Completed			
E C G Completed			
Other test completed			
Blood Arranged			
Skin Preparation			
I/V Site Time			
Catheterization			
Urine voided			
Enema			
Ryle's tube to be inserted			
Antibiotic			

Pre Medication Chart :-

Time	Medication Details	Dosage	Route	Prescribed by

Name & Signature of Nurse, Date & Time :-

Counter Signature of Doctor, Date & Time :-

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

PRE-OPERATIVE RECORD / PROTOCOL		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 28** **Page: 1 of 2**
Effective Date: 11 April, 2013		

PRE-OPERATIVE RECORD / PROTOCOL

PROCEDURE

Nurse in the Nursing Unit will ensure the following before moving a Patient to the Operation Theater and complete the Pre-Operative Checklist as per Annexure to this policy.

1. Identification: Patient must be properly identified. Have patient state name, verify that ID band is in place, check ID band with chart, ask patient to verify that ID band information is correct
2. Presence of Patient's guardian / relative.
3. Lab Data/ Blood: Note if lab record is checked or not required, and if blood was ordered and available.
4. X-rays: Note if patient arrived with x-rays and report.
5. Note: If ECG was done (□) and interpreted (□).
6. Consents: Consent for Surgery and Anaesthesia must be properly completed, signed and witnessed. (Refer to Nursing Manual Policy and Procedure No. 25)
7. Medical History Declaration Form: It must be completed by patient, parent or legal guardian and reviewed by nurse of respective nursing unit and Anaesthesiologist. (Refer to Nursing Manual Policy and Procedure No. 25)
8. Bath: Bath taken with Salvon soap.
9. Record Patient's Weight.
10. Record vital parameters.
11. Orientation/Impairments: Note any impairments or limitations and if patient is or is not alert and oriented.
12. Prostheses: Note the presence or absence of any dentures, contact lens, crowns, hearing aids, glasses. Retain sensory aids to encourage adequate communication for as long as possible.
13. Loose/chipped teeth: Note if patient has any loose or chipped teeth.
14. NPO (nothing per oral) Status: Note last intake. Any variance from policy should be brought to the attention of the Anaesthesiologist, Surgeon, or Staff.
15. Note LMP if appropriate
16. Record Pregnancy Test, if appropriate, as done (□). Note that copy has been placed on chart (□).
17. Allergies: Indicate if patient has any allergies to medications in Red and list these in appropriate area and place a red tape in front of the Patient's file.
18. Skin preparation/ Clipping of hair done.
19. Verification of Surgical Site: Surgical site will be marked by physician prior to procedure when appropriate. (Refer to Nursing Manual Policy and Procedure No. 27).
20. History and Physical: History and physical must be on chart prior to surgery.
21. Record Results of pre-operative investigations profile ordered by the surgeon/physician

PRE-OPERATIVE RECORD / PROTOCOL		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 28** **Page: 2 of 2**
Effective Date: 11 April, 2013		

22. Patient's latest prescriptions available.
23. IV site/ time
24. Ryle's tube to be inserted or not.
25. Pre-medication chart.
26. Pre-Op Teaching: Inform patient of the procedures taking place in the pre-op area, and of what to expect after surgery.
27. Voiding: All patients should void prior to surgery. If patient is unable to void, so indicate.

Any discrepancy / deviation will be brought to the notice of Anaesthesiologist before moving the patient to the Operation Theater.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

REPORTING AND INVESTIGATING POST-OPERATIVE INFECTION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 28** **Page: 1 of 2**
Effective Date: 11 April, 2013		

REPORTING AND INVESTIGATING POST-OPERATIVE INFECTION

PURPOSE

To identify necessary steps for investigation and analysis of the infection occurrence and to identify the cause and appropriate preventive measure.

POLICY

If infection is determined to be Healthcare Acquired Infection, investigation and follow-up will be done by facility personnel and findings will be reported to the Administrative Head of the Center / Quality Assurance Committee and the Surgeon.

Several components will be dealt with concurrently during investigation of an occurrence: confirmed diagnosis, persons and situation involved and source.

PROCEDURE

1. When postoperative information is reported by the surgeon, the facility person responsible for surveillance of postoperative information will initiate investigation.
2. Data sources for investigation:
    a. Review microbiology laboratory data.
    b. Review surgery records for break in technique
    c. Review sterilization records.
    d. Review quality management records for possible similarity with other Healthcare Acquired Infection to identify trends or patterns.
    e. Surgical Wound Problem Analysis Form (Refer to Annexure to this policy)
3. Considerations in reviewing data sources.
    a. Establish the existence of an infection occurrence.
        i. Verify diagnosis.
        ii. Consider reliability of reporting sources.
        iii. Review laboratory results vs. clinical results.
    b. Orient occurrence as to time, place and person by:
        i. Reviewing factors impacting case (e.g. postop follow-up).
        ii. Concentrating coincidence in multiple occurrences.
        iii. Assembling results of (non-statistical) collateral investigation.
    c. Search for source of infection.
    d. Seek further facts until an array is found which matches deductions and is inconsistent with all others.
    e. Base conclusions upon all pertinent evidence, not relying upon any single circumstance by itself.
    f. Analyze facts, identify probable cause, formulate plan to solve problem, and set time- frame to review results.

REPORTING AND INVESTIGATING POST-OPERATIVE INFECTION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 28** **Page: 2 of 2**
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4. Document Surgical Wound Problem Analysis Form as given in Annexure to this policy.
5. Institute corrective measures.
6. Draft a report to the QA Committee and Surgeon.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer to Hospital Infection Control Manual Policy and Procedure No. 28)

SURGICAL WOUND PROBLEM ANALYSIS FORM

PROBLEM IDENTIFIED:

FINDINGS:

Reported By: _____

Date of Procedure: _____ Start Time: _____ End Time: _____

Date Reported: _____

Patient Name: _____

MR No.: _____I.P. No.: _____ Comfort/Deluxe Bed No.: _____

OR Room No.: _____

Surgeon: _____

Preoperative Diagnosis: _____

Pre-existing Infection? (Includes Systemic): _____

Diabetes? _____

Other Identified Risk Factors?: _____

Operative Procedure: _____

Total Operative Time: _____

Circulating Nurse: _____

Scrub Nurse: _____

Surgical Assistants: _____

Culture: Intra-Op: _____Post Discharge: _____

Organism Identified?: _____

Attest Results: _____

Antibiotic Therapy:

Preop: _____

Intraop: _____

Postop: _____

Post Discharge: _____

Tourniquet Time: _____

Type of Skin Prep Used: _____

Preoperative Temperature: _____

Surgical Wound Class: _____

Method of Sterilization of Equipment/Instruments: _____

DISCUSSION WITH SURGEON ON:_____(Date)

REPORTED TO INFECTION CONTROL OFFICER ON: _____ (Date)

_____ (Name) _____ (Signature)

RECOMMENDATION OF INFECTION CONTROL OFFICER: _____

FOLLOW-UP: _____

Seen by Administrative Head of the Center on _____ (Date)

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

ANNUAL COMPETENCY CHECKLIST – O.T. TECHNICIAN		
Module Applies To	**O.T. Technician**	**Module No: 29** **Page: 1 of 6**
Effective Date: 11 April, 2013		

ANNUAL COMPETENCY CHECKLIST – O.T. TECHNICIAN

PROCEDURE

1. Use the attached checklist for both orientation and annual competency assessment of surgical technicians.
2. The verify column is for preceptor verification initials.

	DATE Instruct	VERIFY		DATE Complete	COMMENTS
1. **Pre-Operative & Post-Operative Area (Nursing Unit):**					
a. Demonstrates Location and functional use:					
i. O2					
ii. Crash Cart					
iii. Latex Allergy box					
iv. Monitors					
v. Lab					
vi. Medication room					
vii. Manuals					
viii. Stretchers					
ix. Patient Recliners					
x. Blanket Warmer					
xi. Phones					
xii. Linen Carts					
xiii. Doctor's preference sheets					
xiv. Assignment & communication boards					
xv. Computers					
2. **Endoscopy Suite**					
a. Tour of Endoscopy Suite					
b. Equipment: - Demonstrates knowledge and care of:					
i. Blood Pressure monitor					
ii. ECG Monitor					
iii. Pulse Oximeter					
iv. Bovie/Bicap II					
v. Karl Storz Light Source					
vi. Karl Storz Scopes-EGD & Accessories					
vii. Karl Storz Scopes-Colon & Accessories					
viii. Washing Procedures					
ix. Balloon dilators					

ANNUAL COMPETENCY CHECKLIST – O.T. TECHNICIAN		
Module Applies To	**O.T. Technician**	**Module No: 29** **Page: 2 of 6**
Effective Date: 11 April, 2013		

	DATE Instruct	VERIFY		DATE Complete	COMMENTS
x. Savory dilators					
xi. Snares					
xii. Biopsy Forceps					
xiii. Bougies					
c. Supplies:-Maintains par levels and restock as necessary.					
i. Location of room supplies					
ii. Review of supplies-stock (in house)					
d. Specimens: - Staff/OT Nurse					
i. Cytology					
ii. Biopsy					
iii. Polyp					
iv. Location & review of supplies & related paperwork					
e. Procedures – Staff/OT Nurse					
i. EGD					
ii. EGD with biopsy					
iii. Colonoscopy					
iv. Colonoscopy with biopsy					
v. Colonscopy with polypectomy					
vi. Flexible Sigmoidoscopy					
vii. Dilatations					
viii. PEGS					
ix. Injection Therapy					
f. Scope Care-Demonstrates knowledge and care of:					
i. Leak Testing					
ii. Hand Washing					
iii. Unitrol					
iv. Steris Processor					
v. Storing Scopes					
vi. Repair of Scopes					
g. Patient Care					
i. Assist in transport to Procedure Room					
ii. Assist in transport to Nursing Unit					

ANNUAL COMPETENCY CHECKLIST – O.T. TECHNICIAN		
Module Applies To	**O.T. Technician**	**Module No: 29** **Page: 3 of 6**
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3. **Soiled Work Room**					
a. Demonstrates knowledge of care & operation of all equipment & supplies:					
i. Autoclave					
ii. Indicator strips					
iii. Attest					
iv. Cleaning Supplies					
v. Bio-Hazard Waste Disposal					
vi. Cidex (Glutaraldehyde)					
vii. Instrument Decontamination					
viii. Hopper					
ix. Garbage (disposal)					
x. Chemical Cleaners					
xi. Unitrol					
4. **OR Equipment**					
a. Demonstrates knowledge of care and operation of:					
i. OT Table					
ii. Mayfield Neuro Headrest					
iii. Schlein Shoulder Immobilizer					
iv. Stirrups (Candy Cane)					
v. Hand Table					
vi. Lights					
vii. Anesthesia Cart & Monitors					
viii. Suction Units					
ix. Nitrogen Gauges/Hoses					
x. Bovie (Valley Lab)					
xi. Prep Stands					
xii. Patient Roller (Transfer)					
xiii. Tourniquet - Intelligent 2001					
xiv. Video Monitors, Camera					
xv. Hummer-Ent (Stryker)					
xvi. Headlight					
xvii. Insufflator					
xviii. C-Arm					
xix. Bipolar					
xx. Autoclave with Log					
xxi. Ultrasonic					
xxii. Cidex (OPA) Tray					
xxiii. Stryker Command Drill					
xxiv. Arthroscopy Shaver					

ANNUAL COMPETENCY CHECKLIST – O.T. TECHNICIAN		
Module Applies To	**O.T. Technician**	**Module No: 29** **Page: 4 of 6**
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5. **Central Supply**					
a. Demonstrates knowledge and operation of the following:					
i. Autoclave (All cycles)					
ii. Instrument Trays – All					
iii. Peel Packs					
iv. Wrapped Instruments					
v. Location of Processed Instruments					
vi. Miscellaneous supplies/Restocking					
vii. Pulling cases					
6. **Procedure Preparation and Closure**					
a. Demonstrates knowledge and skills of:					
i. Pulling Cases					
ii. Room set up					
▪ Morning prep of room					
▪ Each case set up					
▪ Turnover					
▪ End of day closure					
iii. Instrumentation					
▪ Assembles all needed instruments					
▪ Pre-test ▪ equipment prior to case					
▪ Assures proper sterilization via Autoclave/Cidex					
▪ Reports defective equipment					
▪ Documents sterilization					
▪ Disassembles and decontaminates					
▪ Reassembles instrument trays					
iv. Surgical Hand scrub					
v. Gowning and gloving – Scrub					
vi. Gowning and gloving – Doctor					
vii. Maintains aseptic technique					
viii. Instrument and sponge counts					
ix. Prepping of patient					
x. Draping for specific cases					
xi. Backtable and mayo set-up					
xii. Dressings and drains					
xiii. Specimen Handling					

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

ANNUAL COMPETENCY CHECKLIST – O.T. TECHNICIAN		
Module Applies To	**O.T. Technician**	**Module No: 29** **Page: 5 of 6**
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7. **Specific Procedures: Demonstrates knowledge of skills and instrumentation. Follows aseptic technique. Assists and anticipates needs of surgeon.**					
a. Orthopedic					
i. Arthroscopy					
▪ Shoulder					
▪ Knee					
ii. Carpal Tunnel Release					
iii. Ganglion Cyst					
iv. Hand surgery (others)					
v. Hardware (Insertion or Removal)					
vi. Bony cyst excisions					
vii. Cast application / removal					
b. Spine					
i. Laser Assisted Foraminoplasty					
ii. Laser Assisted Disc Surgery					
iii. Laminectomy					
iv. Discectomy					
v. Cervical discectomy					
vi. Laminectomy and Fusion					
vii. Facet Block					
viii. Facet Denervation					
ix. Root Block + Radiculogram					
x. Discogram and Probing for Pain					
xi. Sympathetic Block					
xii. Endoscopic Disc Replacement					
xiii. Endoscopic Fusion					
xiv. Endoscopic Bone Grafting					
xv. Root Block / Nerve Block					
xvi. Percutaneous Fusion					
xvii. Endoscopic Cervical Discectomy					
xviii. Traditional Spine Procedure					
xix. Instrumented Fusion					
xx. Traumatic Spine Vertebroplasty					
c. Plastics					
xxi. Augmentation Mammoplasty					
xxii. Mastopexy					
xxiii. Breast Reduction/Reconstruction					
xxiv. Liposuction					
xxv. Abdominoplasty					
xxvi. Rhytidectomy					

ANNUAL COMPETENCY CHECKLIST – O.T. TECHNICIAN		
Module Applies To	**O.T. Technician**	**Module No: 29** **Page: 6 of 6**
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xxvii. Rhinoplasty					
xxviii. Scar Revisions					
xxix. Blepharoplasty					
xxx. Brow Lift					
xxxi. Excision of skin cancers					
▪ Basal Cell					
▪ Squamous Cell					
▪ Melanoma					
xxxii. Grafting & reconstructive skin transfer					
xxxiii. Frozen sections					
d. Urology					
i. Cystoscopy					
ii. Vasectomy					
iii. T.U.R.P					
iv. T.U.R.B.T.					
v. Hydrocelectomy					
vi. Orchidectomy					
8. **Miscellaneous**					
a. Assist in the following:					
i. Restocking supplies (storeroom)					
ii. Specimen handling					
iii. Assigned duties					
▪ Charts					
▪ Quality Control					
iv. Maintains surgeon's preference cards					

EMPLOYEE: _____

PRECEPTOR: _____

ADMINISTRATIVE HEAD OF THE CENTER: _____

DATE: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

ORIENTATION - PRECEPTOR PROGRAM		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 29** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ORIENTATION - PRECEPTOR PROGRAM

POLICY

1. Orientation of all new employees will utilize a preceptor model of education. A preceptor will be assigned to the new employee by the Administrative Head of the Center according to the specific job classification.
2. During the orientation period the preceptor and employee will complete the general and/or job specific checklists and the specific components are signed off as accomplished. Then upon final completion all completed checklists will be reviewed by the Administrative Head of the Center and become part of the employee's personnel file.
3. Preceptors will be either Consultants or experienced staff members who:
   a. Have interest and ability in the teaching of adults.
   b. Are role models in their specific job classification
   c. Can facilitate the new employees' socialization into the work group.
   d. Are able to evaluate a co-worker's performance and assist in formulating plans to acquire or improve job performance.
   e. Possess good oral and written communication skills.
   f. Maintain current knowledge pertinent to his/her job classification and actively seek opportunities to improve his/her knowledge and skills.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

HOSPITAL INFECTION CONTROL MANUAL

WASTE MANAGEMENT		
Policy/Procedure Applies To	**All Nurses & Technicians, Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 29** **Page: 1 of 6**
Effective Date: 11 April, 2013		

WASTE MANAGEMENT

POLICY STATEMENT

Aims to provide for a system for management of all potentially infectious and hazardous wastes in accordance with the Bio-Medical Waste (Management and Handling) Rules 1998.

PURPOSE

1. Give clear direction about the segregation, storage, handling, transportation and disposal of waste.
2. Dispose of infectious wastes in a manner that poses minimal potential hazard to the environment or public.
3. Prevent staff injuries from exposure to contaminated wastes and sharps.
4. Properly define, handling, transporting and disposing infectious waste, and ensure safety of Healthcare Workers, Housekeeping Staff, and the general public and cost reduction.

DEFINITIONS

1. Non-Hazardous Waste: (General Waste)

Are general domestic type waste from offices, public areas, stores, catering areas, rest rooms, floor sweepings, pantries and kitchen wastes (e.g. news papers, letters, documents, cardboard containers, metal cans, etc.)

2. Hazardous Waste: (Infectious, toxic and clinical)

Refers to that portion of bio-medical waste which has a potential to cause hazards to health and life of human beings. Generally the areas generating this type of waste includes nursing unit, treatment room, nursing station, operation theatres**,** medical stores, pharmacy, OPDs' injection rooms, procedure rooms / endoscopy rooms, x-ray room, etc. They include the following:

a. Sharp Wastes

These are the wastes that contain sharp items such as sharps, intravenous needles, Pasteur pipettes, blood vials, glass vials and needles, scalpels, lancets, sutures, razors, broken glass or any other sharp objects that cut or sting the body.

b. Wastes from Human blood and blood products and body fluids

This includes human blood or blood components (serum or plasma). Containers with free flowing blood or blood components or discarded saturated material containing free flowing blood, blood component and body fluids, surgical dressings, swabs etc from treatment areas and operating theatres soiled with blood and/or body fluid, blood or body fluid contaminated supplies from isolation rooms.

c. All types of blood contaminated tubing

Blood drip sets, dialysis, infusion devices, drainage bags and tubing, pacemakers, etc.

d. Pathogenic Organic Waste

These are the wastes that contain bacteria, viruses, parasites & fungi in quantities or at concentrations sufficient for causing disease for individuals liable to infection. They include the remains of viral cultures, surgery wastes, isolation section wastes and the wastes of renal dialysis procedures made to patients with infectious diseases.

WASTE MANAGEMENT		
Policy/Procedure Applies To	**All Nurses & Technicians, Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 29** **Page: 2 of 6**
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e. Pathological waste

Include wastes with fragment of tissues and organs, non-viable fetuses, blood and body fluids removed at surgery, autopsy, animal corpses, animal organs or other medical procedures or specimens, and body fluids and their containers.

f. Contaminated equipment

Shall include used, discarded air filters of biological safety cabinets and vacuum pumps extract fans serving isolation room.

g. Waste-Treatment Units

These are the facilities in which the operations of changing biological, chemical or physical properties of Healthcare Waste are carried out for elimination of their danger, so that they can be safe in connection with environment and health.

PROCEDURE

1. All Nursing and Housekeeping Staff of Prime Surgical Centers must comply with this policy.
2. It is the responsibility of the Housekeeping Staff to provide the appropriate color coded bags and labels for collection of wastes. All containers of infectious waste must be color coded or have a biohazard label. (Refer Annexure I to this policy.)
3. Any spillage of clinical waste (e.g. content of yellow bag) must be dealt with immediately as per Exposure Control Manual Policy and Procedure No. 6
4. Nursing Superintendent will be responsible for monitoring the implementation of this policy.
5. The Prime Surgical Centers administration shall provide temporary storage area for Infectious Waste within the center. The TEMPORARY STORAGE areas shall have the following provisions:
   a. To provide a special location for storage within the facility so as to be a collection center for the health care infectious wastes produced by the center.
   b. These wastes must be filled in closed and secured containers or plastic bags prior to storage.
   c. The storage location should be appropriate and cause no pollution or harm against the human health or environment.
   d. The storage location must be in a well-sealed location and equipped with materials that protect the building against water leakage, rain, spread of bad smells and the access of rodents, insects, strays, and with a concrete floor resistant, and withstand washing, cleaning, and equipped with proper sanitary means.
   e. The storage place should be run by competent trained personnel specialized (Housekeeping) in handling Infectious wastes.
   f. Storage location should be equipped with proper lighting and ventilation.
   g. Storage location should be equipped with hand washing sink.
   h. Storage time for infectious wastes should not be more than 24 hours.
   i. Storage location should be accessible for storage, transport and cleaning.
   j. Storage location should be distant from other food storages, kitchens / pantry, cafeteria / canteen where food is prepared.
   k. Access to storage location is restricted to authorized personnel.

WASTE MANAGEMENT		
Policy/Procedure Applies To	**All Nurses & Technicians, Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 29** **Page: 3 of 6**
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l. Legible stickers should be placed on the storage locations that state the location and contents.

m. The location should be equipped with necessary cleaning materials for use in cleaning the center frequently, in case of emergency and when wastes spill.

HANDLING OF WASTE

1. In order to prevent inappropriate disposal, infectious waste should be segregated from non-risk (domestic waste). Clear information, instruction and training about identifying specific categories of waste should be provided to Nursing and Housekeeping Staff.
2. There should be foot/pedal operated garbage bin in every examining room or any room patient is cared for.
3. Identification, segregation and packaging of waste should be done at the point and time of origin by generator of that waste.
4. All waste bags must be labeled with the department's name and the date that the bag was left for collection. (Refer Annexure I to this policy.) Flow chart for Waste Management for OT/Comfort/ Deluxe Nursing Units is as shown at Annexure II.
5. Correct **colour coded** bags must be used to segregate wastes.

LABELS, SIGNS AND TAGS

1. Warning labels should be affixed to containers refrigerators and freezers containing blood and to containers used to transport them.
2. These labels should be with lettering or symbols in a contrasting colour similar to the labels used by the PASSCO Environmental Solutions Pvt. Ltd.
3. The labels should be affixed to the container by adhesive or other method that prevents their
4. Loss or unintentional removal.
5. The labels shall be used to signify and identify equipment, containers, rooms that contain or
6. Suspected to contain infectious microorganisms.
7. Required tag shall be affixed to the packaging of all contaminated materials being forwarded to
8. The Autoclave Waste Plant for treatment indicating the point of generation and the actual pick-up date to be done by the Housekeeping Staff under the supervision of the Unit Nursing Staff.
9. Waste bags shall be packed three fourth full or as required and securely closed by tying the top of each bag.

SEGREGATION OF WASTE

1. Segregation and packaging of waste should be done at the point and time of generation in waste bags and boxes according to the colour code and labeling scheme.
2. Yellow bags with contaminated clinical waste should not be mixed with black bag or red bag
3. Double bagging is recommended when the weight/mass of the waste warrants added packing strength. Infectious waste shall be packed in single bags only.

WASTE MANAGEMENT		
Policy/Procedure Applies To	**All Nurses & Technicians, Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 29** **Page: 4 of 6**
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DISPOSABLES

1. The contents of vomit bowls, and sputum pots should be flushed into the sluice or water Closet
2. Body fluid drains should be placed in yellow plastic bag
3. For used Intravenous set, discard by tying the tube around the empty plastic bag and place in the
4. Red bag – no cutting. If the IV tubing is connected to glass, cut the IV tubing by retaining the spike inside the bottle and discard in the rigid container for empty bottles.

STORAGE OF WASTE

1. Yellow bags awaiting collection must be separated from non-clinical waste bags and collected twice daily.
2. Wastes should not be allowed to accumulate in corridors, Nursing Unit, Operation Theatre, Procedure Room and OPD or other unsuitable places.
3. A protected central waste storage facility should be provided to maintain waste and prevent odour.
4. Temporary holding storage in Prime Surgical Centers will be provided as appropriate.
5. Waste will be held temporarily till pick-up time in closed containers in designated area.
6. Waste containers, trolleys in patient units intended for infectious waste should be designed with a foot-operated cover, sited away from public view to prevent it from being abused.
7. Domestic waste storage area must be separated from infectious waste areas.
8. Anybody entering the waste storage room shall, without exception, wear the required protective equipment.

PATIENT ROOMS

1. Each patient care room should have garbage can/dustbin lined with black bag for collecting domestic waste.
2. Patient with Communicable Disease will have garbage lined with yellow bag for Infectious Waste.
3. Nursing station in each unit will have domestic garbage bins and cans for infectious waste.
4. Infectious Waste will be collected by PASSCO Environmental Solutions Pvt. Ltd.
5. Number of domestic or Infectious Waste bins / cans should be liberal and enough depending on the quantity of waste generated in the area.

TREATMENT OF WASTE

1. All Non-risk or domestic waste should be placed in black bag.
2. Infectious waste to be placed in Yellow bags.
3. Sharp placed in Red sharp box.
4. Pathological wastes should be disposed according to the waste disposal policy of PASSCO Environmental Solutions Pvt. Ltd.:

   For example:

   a. Blood and body fluid removed at surgery should be decanted and flushed to sewer.
   b. Sharps should be placed in Red sharp box which must be securely closed when three quarter full and sent to PASSCO Environmental Solutions Pvt. Ltd. for incineration.

WASTE MANAGEMENT		
Policy/Procedure Applies To	**All Nurses & Technicians, Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 29** **Page: 5 of 6**
Effective Date: 11 April, 2013		

c. All types of blood contaminated tubing should be placed in Red Bags and sent to PASSCO Environmental Solutions Pvt. Ltd.

d. Nursing Superintendent should educate all Nursing and Housekeeping staff on the appropriate handling of infectious waste.

POINTS TO REMEMBER FOR WASTE MANAGEMENT AT PRIME SURGICAL CENTERS

1. Do segregate waste at point of generation to:
   a. Infectious
   b. Non-Infectious/Garbage
   c. Sharps/Needles.
2. Do collect waste in color coded containers/bags :
   a. Yellow – Infectious waste for incineration.
   b. Black – Garbage for dumping in municipal bin.
   c. Blue (inner perforated) – Sharps/needles.
3. Do decontaminate all sharps and plastic waste by chemical/autoclave.
4. Do shred plastic waste (cut all tubing into pieces by scissors).
5. Do use syringe and needle/burner destroyer.
6. Do incinerate blood soaked dressings/body parts etc.
7. Do cover waste collection containers.
8. Do transport through covered trolleys/wheel barrows.
9. Do provide Personal Protective Equipment (PPE) (mask, gloves, plastic aprons, gum boots to transporters and handlers).
10. Do immunize all waste handlers.

DO'S AND DON'T'S FOR CHEMICAL TREATMENT

1. Do apply chemical treatment to infected sharp and plastic waste.
2. Do use 1% sodium hypochlorite or equivalent disinfectant. Proper concentration is essential.
3. Do ensure all surfaces come in contact with chemical (including lumen).
4. Do let the contact time be at least 20 minutes.
5. Do change chemical solutions frequently (with every shift).
6. Do handle with gloves and mask. Wear apron and boots if splashing is expected.
7. Don't chemically treat if the waste can be incinerated.

DONT'S FOR HANDING AND DISPOSAL OF WASTE GENERATED AT PRIME SURGICAL CENTERS

1. Don't mix the infectious with non-infectious waste.
2. Don't throw sharps in the trash or into non-puncture proof containers.
3. Don't recap the needle or bend or break needles by hand.
4. Don't fill the waste container more than 3/4th of capacity.
5. Don't allow unauthorized persons access to waste collection/storage areas.

WASTE MANAGEMENT		
Policy/Procedure Applies To	**All Nurses & Technicians, Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 29** **Page: 6 of 6**
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6. Don't use open buckets for infectious waste or sharps.
7. Don't incinerate plastic waste.
8. Don't chemically treat if the waste can be incinerated.

TRAINING ON HOSPITAL WASTE MANAGEMENT

In order to be able to comprehend and implement the Bio-Medical Waste (Management and Handling) Rules' 1998, it is mandatory to provide training to all categories of staff (i.e. resident doctors, nurses, paramedical and Housekeeping staff, patient and their attendants, and canteen staff) on operation of Bio-Medical Waste treatment facilities. Before the training is carried out the training needs to be identified. It should be interactive and should include awareness sessions, demonstrations and behavioral science inputs. It should definitely include the following:

1. Awareness of different categories of waste and potential hazard
2. Waste minimization, reduction in use of disposables
3. Segregation policy
4. Proper and safe handling of sharps
5. Use of protective gear
6. Colour coding of containers
7. Appropriate treatment of waste
8. Management of spills and accidents
9. Occupational health.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE II
(Refer to Hospital Infection Control Manual Policy and Procedure No. 29)

WASTE MANAGEMENT FLOW CHART FOR OT/COMFORT/DELUXE NURSING UNITS

O.T.1/2/3/4/5/ Comfort/Deluxe Nursing Units

C S S D Corridor (Colour Coded Bag)

Patient Elevator

Garbage Room (Located On Ground Floor)

Disposal by PASSCO

ANNEXURE I
(Refer to Hospital Infection Control Manual Policy and Procedure No. 29)

WASTE MANAGEMENT

TYPE OF WASTE	COLOR CODED BAG
Domestic Waste	**Black** Bag
Infectious Waste	**Yellow** bag labeled with the **Universal Biohazard sign**
Sharps (needles, ampoules, etc.)	**Red Sharp Box** with the **Universal Biohazard sign**
Needles, Contaminated Sharps with Cytotoxic Agents	**Red** leak-proof sharp container with **Cytotoxic Hazard** label
Pathological Waste	**Yellow** bag
Contaminated Solid Metal	**Yellow Sharp Box** with the **Universal Biohazard sign**
Instrument	
Contaminated IV/Blood Bags, Plastic Tubing, Catheter, Urine Bag, Rubber Wastes, etc.	**Red** bag
Used Vials	**White** bag

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

ORIENTATION CHECKLIST - GENERAL		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 30** **Page: 1 of 3**
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ORIENTATION CHECKLIST - GENERAL

PROCEDURE

1. Use the attached checklist for the general orientation.
2. The verify column is for preceptor verification initials.

	DATE Instruct	VERIFY		DATE Complete	COMMENTS
General Orientation Information Sheet					
1. Philosophy					
2. Confidentiality					
3. Entry into Building					
4. Employee Parking					
5. Locker Assignment					
6. Working Hours					
7. Time Clock					
8. Communication Book					
9. Payroll Procedure					
10. Personal Phone Calls					
11. Time Off Request Book					
12. Time Schedule					
13. Vacation, Holidays, Personal Days					
14. Savings, Retirement, Life					
15. Health Plan					
16. Illness and Tardiness					
17. Dress and Behavior Code, Smoking Policy					
18. Breaks and Lunch					
19. Orientation and Skills Checklist					
20. Organization Chart					
21. Job Description					
22. Annual Performance Appraisal Form					

ORIENTATION CHECKLIST - GENERAL		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 30** **Page: 2 of 3**
Effective Date: 11 April, 2013		

	DATE Instruct	VERIFY		DATE Complete	COMMENTS
23. Employee Communication Form					
24. Disaster/ Fire Plan, Location of Exits, Extinguishers and Alarms					
25. Right to Know Manual/ Hazard Communication					
26. Best Demonstrated Practices					
27. Incidence Report					
28. Alarms					
29. Emergency Plan, Code Procedures					
30. Location of Crash Cart and Emergency Equipment					
31. Use of Copy Machine and Fax Machine					
32. Phone and Intercom System					
33. Telephone Etiquette					
34. Tour of the Physical Layout – Nursing Unit					
a. Clean and Dirty Utility Room					
b. Linen Storage					
c. Nursing Station					
d. High Alert Medication Cupboard					
35. Demonstration of Patient Flow					
36. Policy and Procedure Manuals/ Explanation/ Location					
37. Skills Checklist Applicable for Position					
38. Exposure Control Plan					
39. Employee Handbook					

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

ORIENTATION CHECKLIST - GENERAL		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 30** **Page: 3 of 3**
Effective Date: 11 April, 2013		

ORIENTEE: _____

PRECEPTOR: _____

NURSING SUPERINTENDENT: _____

DATE: _____

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

ANNUAL COMPETENCY CHECKLIST: CLINICAL SKILLS – STAFF NURSE / OT NURSE		
Module Applies To	**Staff / OT Nurse**	**Module No: 31** **Page: 1 of 9**
Effective Date: 11 April, 2013		

ANNUAL COMPETENCY CHECKLIST: CLINICAL SKILLS – STAFF NURSE / OT NURSE

		Instruction		
	Competent	**Req'd**	**Complete**	**Comments**
1. PATIENT ASSESSMENT AND CARE				
a. Respiratory				
i. Airway Management (chin lift, jaw thrust)				
ii. Signs & Symptoms Airway Obstruction				
iii. Insertion Oral Airway				
iv. Insertion Nasal Airway				
v. Proper Suctioning Pharynx				
vi. Use of Ambu Bag				
vii. Assessment of Respirations - Rate, Depth, Exchange & Breath Sounds				
viii. Exhibits General Understanding of Signs & Symptoms of:				
▪ Laryngospasm				
▪ Pulmonary Oedema				
▪ Pneumothorax				
▪ Acute Respiratory Arrest				
▪ Bronchospasm				
▪ Aspiration				
▪ Residual Muscle Paralysis				
▪ Post Intubation Croup				
▪ Hypoxemia				
ix. Removal Oral Airway				
x. Removal Nasal Airway				
xi. Care of Patient with Compromised Airway				

	Competent	Instruction Req'd	Complete	Comments
xii. General Knowledge & Classification of Anesthesia Agents & Side Effects (Refer Anaesthesia Manual Policy and Procedure No. 26)				
▪ Induction Agents				
• Pentothal				
• Propofol				
• Ketamine				
▪ Muscle Relaxants				
• Succinylcholine				
• Vecuronium				
• Atracurium				
▪ Reversal Agents				
• Myopyrolate				
• Neostigmine				
▪ Glycopyrolate				
xiii. General Knowledge & Understanding of Respiratory Drugs (See pharmacological reference in Unit)				
▪ Aminophylline				
▪ Steroids				
• Decadron				
• Hydrocurtisone				
• Methylprednisolone				
▪ Inhalers				
• Salmetrol				
• Veloilin				
b. Circulation				
i. Non-invasive BP Monitor				
ii. Use of Oximeter				
c. Neurological				

ANNUAL COMPETENCY CHECKLIST: CLINICAL SKILLS – STAFF NURSE / OT NURSE		
Module Applies To	**Staff / OT Nurse**	**Module No: 31** **Page: 3 of 9**
Effective Date: 11 April, 2013		

	Competent	Instruction Req'd	Complete	Comments
i. Pupil Size and Response to Light				
ii. Level of Consciousness				
iii. Reflexes (Gag, Corneal, Babinski)				
iv. Motor Movement				
v. Recognition of Signs and Symptoms of Neurological Decline				
d. Vascular				
i. Pulses				
▪ Dorsalis Pedis				
▪ Popliteal				
▪ Femoral				
▪ Posterior Tibial				
▪ Radial				
▪ Ulnar				
ii. Neck Veins				
iii. Color, Sensation, Movement Checks				
e. Cardiac				
i. Recognition of Cardiac Rhythms & Appropriate Responses:				
▪ NSR				
▪ Tachycardia				
▪ Bradycardia				
▪ Heart Block				
▪ Atrial Fibrillation				
ii. Correct ECG Electrode Placement				
iii. Correct "Backpack" ECG Electrode				
iv. Cardiopulmonary Resuscitation (CPR) Certified				
v. Knowledge of Crash Cart/ Defibrillator				

ANNUAL COMPETENCY CHECKLIST: CLINICAL SKILLS – STAFF NURSE / OT NURSE		
Module Applies To	**Staff / OT Nurse**	**Module No: 31** **Page: 4 of 9**
Effective Date: 11 April, 2013		

	Competent	Instruction Req'd	Complete	Comments
vi. General Knowledge & Understanding of Cardiac Drugs (See pharmacological reference in Unit)				
▪ Epinephrine				
▪ Dopamine				
▪ Lidocaine				
▪ Atropine				
▪ Metaprolol				
▪ Ephedrine				
▪ Verapamil				
▪ Propranolol				
▪ Labetalol				
▪ Phenytoin				
▪ Isoprenaline				
▪ Fosphenytoin				
▪ Frusemide				
vii. Preparation/Testing & Usage of:				
▪ Life Pack & Monitor/ Defibrillator				
f. Physical Assessment				
i. Observation of Operative Site				
▪ Assessment of Drains (Hemovac, etc.)				
▪ Application of Ice Pack				
▪ Application of Immobilizer/Brace				
▪ Assessment of Operative Site				
ii. Observation of Intravenous Line				
▪ Assessment of IV Site				
▪ Proper Administration of IV Fluids & Use with Other Medications				

ANNUAL COMPETENCY CHECKLIST: CLINICAL SKILLS – STAFF NURSE / OT NURSE		
Module Applies To	**Staff / OT Nurse**	**Module No: 31** **Page: 5 of 9**
Effective Date: 11 April, 2013		

	Instruction			
	Competent	**Req'd**	**Complete**	**Comments**
• Adult				
▪ Proper Administration of IV Antibiotics				
▪ General Knowledge & Understanding of Following Drugs (See pharmacological reference in Unit)				
• Penicillin				
• Ampicillin				
• Cefuroxime				
• Doxycycline				
• Gentamycin				
• Vancomycin				
• Cefotaxim				
• Ceftriaxone				
iii. Assessment and Management of Post Operative Pain and Nausea				
▪ General Knowledge & Understanding of Following Drugs (Refer Anaesthesia Manual Policy and Procedure No. 26)				
• Fentanyl				
• Phenergan				
• Regian				
• Aspirin				
• Ibuprofen				
• Tramadol				
iv. Assessment and Management of Hypotension				
▪ General Knowledge & Understanding of Following Drugs (Refer Anaesthesia Manual Policy and Procedure No. 26)				
• Ephedrine				
▪ Trendelenburg Position				
▪ IV Fluid Management				
v. Assessment and Management of Patient in Emergence from Anesthesia:				

ANNUAL COMPETENCY CHECKLIST: CLINICAL SKILLS – STAFF NURSE / OT NURSE		
Module Applies To	**Staff / OT Nurse**	**Module No: 31** **Page: 6 of 9**
Effective Date: 11 April, 2013		

	Instruction			
	Competent	**Req'd**	**Complete**	**Comments**
▪ Assessment and Care of IV Meds				
• GA Inhalation vs IV vs MAC				
▪ General Knowledge & Understanding of Alternate Anesthesia Drugs (Refer Anaesthesia Manual Policy and Procedure No. 26)				
• Midazolam				
• Naloxone				
• Benadryl				
vi. Assessment and Management of Hypertension				
▪ General Knowledge & Proper Administration of Following Drug (Refer Anaesthesia Manual Policy and Procedure No. 26)				
• Labetalol				
▪ Reverse Trendelenburg				
vii. Recognition & Appropriate Responses to:				
▪ Allergic Reactions				
▪ Seizure				
viii. Assessment and Management of Diabetic Patient				
▪ Monitoring Blood Sugar				
▪ Carrying out of Appropriate Orders				
ix. Assessment & Management of Epidural Anesthesia/Spinal Anesthesia Patient				
▪ Removal of Epidural Catheter				
▪ Assessment of Sensation and Movement				
x. General Knowledge of Malignant Hyperthermia				
xi. Care of Patients with:				
▪ Axillary Blocks				
▪ IV Regional Blocks				

ANNUAL COMPETENCY CHECKLIST: CLINICAL SKILLS – STAFF NURSE / OT NURSE		
Module Applies To	**Staff / OT Nurse**	**Module No: 31** **Page: 7 of 9**
Effective Date: 11 April, 2013		

	Competent	Instruction Req'd	Complete	Comments
g. Provide Safety for Patient				
i. Side Rails (Refer Nursing Manual Policy and Procedure No. 69)				
ii. Restraints (Refer Nursing Manual Policy and Procedure No. 75)				
iii. Never Leave Patient Unattended				
iv. Disposal of Sharps Property				
v. Follow Universal Precautions (Refer Hospital Infection Control Manual Policy and Procedure No. 7 and 29)				
2. NURSING TECHNIQUES				
a. Management and Care of Nasogastric Tube				
i. Proper Insertion				
ii. Check Position and Anchor				
iii. Irrigation				
iv. Removal				
b. Management and Care of Foley Catheter				
i. Proper Insertion				
ii. Irrigation				
iii. Removal				
c. IV Therapy				
i. Proper Insertion of IV Catheter				
ii. Proper Administration of IV Fluids				
iii. Proper and Safe Administration of Medications				
d. Proper Administration of Blood and Blood Products				
i. Checking and Hanging				
ii. Signs and Symptoms of Blood Reaction				
iii. Administration of Rhogam				
e. Intramuscular Injections & SQ				

ANNUAL COMPETENCY CHECKLIST: CLINICAL SKILLS – STAFF NURSE / OT NURSE		
Module Applies To	**Staff / OT Nurse**	**Module No: 31** **Page: 8 of 9**
Effective Date: 11 April, 2013		

	Competent	Instruction Req'd	Complete	Comments
f. Isolation Techniques				
g. Post-Operative Teaching				
h. Transfer to Hospital				
i. Discharge				
j. Code Management				
3. PRE-OPERATIVE RESPONSIBILITIES				
a. Pre-Operative Teaching				
i. Interviewing Patient				
ii. Pre-Operative Instruction				
iii. Pre-Operative Lab, ECG, CXR as applicable				
iv. Protocol for Reporting Abnormal Test				
v. Obtaining Test Results Prior to Surgery				
vi. Check for Allergies				
b. Preparation of Patient for Surgery				
i. Chart Reviewed for Surgical Consent and Appropriate Lab Studies				
ii. Hemoglobin (if not done)				
iii. NPO Status Confirmed				
iv. IV as applicable				
v. IV Piggyback Antibiotics Prepared				
vi. Surgical Preps as Ordered by Surgeon				
vii. Pre-Op Orders				
viii. History and Physical				
ix. Operating Room Consent				
x. Proper Patient Identification				
xi. Vital Signs				

ANNUAL COMPETENCY CHECKLIST: CLINICAL SKILLS – STAFF NURSE / OT NURSE		
Module Applies To	**Staff / OT Nurse**	**Module No: 31** **Page: 9 of 9**
Effective Date: 11 April, 2013		

			Instruction	
	Competent	**Req'd**	**Complete**	**Comments**
xii. Completion of Pre-Op Checklist				
xiii. Skin Preparation				
xiv. Draping, Positioning				
4. MISCELLANEOUS EQUIPMENT AND USE				
a. Blanket Warmer				
b. PCA Pump				
c. Glucometer				
d. Countable items				
e. Setting up & maintaining sterile field				
f. Cleaning room & equipment				

EMPLOYEE: _____
(Signature)

PRECEPTOR: _____
(Signature)

NURSING SUERINTENDENT / ADMINISTRATIVE HEAD OF THE CENTER:

_____
(Signature)

DATE: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

BED MAKING: CLOSED OR EMPTY BED		
Policy/Procedure Applies To	**All Nurses/Nursing Aides/ House Keeping Staff**	**Policy/Procedure No: 31 Page: 1 of 3**
Effective Date: 11 April, 2013		

BED MAKING: CLOSED OR EMPTY BED

CLOSED BED

It is important to remember that a clean, comfortable bed has a positive effect on the patient's physical and mental well-being.

PROCEDURE

PREPARATION

1. Assemble your equipment on a linen trolley near the bed
    a. Mattress cover, if used
    b. Bottom sheet
    c. Cotton and plastic draw sheets (or disposable bed protector)
    d. Top sheet
    e. Blanket
    f. Bedspread (if used)
    g. Pillowcase
    h. Pillow
    i. Pillow protector, if used
2. Place linen trolley near the bed.
3. For patient's relation – Couch, 2 Sheets, 1 Pillow, 1 Pillow Cover

STEPS

1. Wash your hands.
2. Put the pillow on the linen trolley.
3. Stack the bed linen on the linen trolley in the order in which you will use them: First things to be used on top, last things to be used on the bottom.
4. Adjust the bed on the highest horizontal position for comfort while you work
5. Push the mattress to the head of the bed until it touches the headboard.
6. Fold the bottom sheet length-wise and place it on the bed:
    a. Place the center fold of the sheet in the center of the mattress from head to foot.
    b. Place the large hem to the head of the bed.
    c. Put the small hem at the foot of the bed, even with the edge of the mattress.
7. Open the sheet. It should now hang evenly the same distance over each side of the bed. The rough edges of the hem should now face down toward the mattress and away from the patient.
8. Tuck the sheet (at least 18 inches) smoothly and tightly under the head of the mattress.

BED MAKING: CLOSED OR EMPTY BED		
Policy/Procedure Applies To	**All Nurses/Nursing Aides/ House Keeping Staff**	**Policy/Procedure No: 31 Page: 2 of 3**
Effective Date: 11 April, 2013		

9. To make a mitered corner:
    a. Pick up the edge of the sheet at the side of the bed (12 inches) from the head of the mattress
    b. Place the triangle (the folded corner) on the top of the mattress
    c. Tuck the hanging portion of the sheet under the mattress
    d. While you hold the fold at the edge of the mattress, bring the triangle down over the side of the mattress.
    e. Tuck the sheet under the mattress from the head to foot. Start at the head and pull toward the foot end of the bed.
10. Stand and work entirely on one side of the bed until that side is finished.
11. Fold the half and place the plastic draw sheet 14 inches down from the head of the bed. Tuck it in. Be sure each piece of linen is straight and even as you tuck it in.
12. Cover the plastic draw sheet with the cotton draw sheet and tuck it in.
13. Fold the top sheet length-wise and place it on the bed.
    a. Place the center fold on the center of the bed from the head to foot.
    b. Put the large hem at the head end of the bed, even with the top edge of the Mattress.
    c. Open the sheet, with the rough edge of the hem up, fanfolding half to the center of the bed.
    d. Tightly tuck the sheet under at the foot of the bed.
    e. Make a mitered corner at the foot end of the bed
    f. Do not tuck in at the side of the bed.
14. Fold the blanket lengthwise and place on the bed.
    a. Place the center fold of the blanket in the center of the bed from head to foot.
    b. Place the upper hem 6 inches from the top edge of the mattress.
    c. Open the blanket.
    d. Tuck it under the foot end tightly.
    e. Make a mitered corner at the foot end of the bed.
    f. Do not tuck in at the sides of the bed.
15. Fold the bedspread lengthwise and place it on the bed.
    a. Place the center fold of the center of the bed from head to foot.
    b. Place the upper hem even with head edge of the mattress.
    c. Have the rough edge down.
    d. Open the spread.
    e. Tuck it under the foot end of the bed tightly.
    f. Make a mitered corner at the foot end of the bed.

BED MAKING: CLOSED OR EMPTY BED		
Policy/Procedure Applies To	**All Nurses/Nursing Aides/ House Keeping Staff**	**Policy/Procedure No: 31**
Effective Date: 11 April, 2013		

g. Do not tuck in at the sides of the bed.

16. Now go to the other side of the bed. Start with the bottom sheet:
    a. Pull the sheet tight to get rid of all wrinkles.
    b. Miter the top corner
    c. Pull the plastic draw sheet tight and tuck it in.
    d. Pull the cotton draw sheet tight and tuck it in.
    e. Straighten out the top sheet, making a mitered corner at the foot end of the bed.
    f. Miter the corner of the blanket.
    g. Miter the corner of the bed-spread.
17. To make the cuff:
    a. Fold the top hem of the spread under the top hem of the blanket.
    b. Fold the top hem of the sheet back over the edge of the spread and the blanket to form a cuff.
    c. The hemmed side of the sheet must be on the underside so that it does not come in contact with the patient.
18. To put the pillowcase on the pillow:
    a. Hold the pillowcase at the center of the end seam.
    b. With your hand outside the case back over your hand
    c. Grasp the pillow through the case at the center of one end of the pillow
    d. Fit the corner of the pillow into the seamless corner of the case.
    e. Bring the case down over the pillow.
    f. Fold the extra material from the side seam under the pillow.
    g. Place the pillow on the bed with the open end away from the door.
19. Adjust bed to its lowest horizontal position.

FOLLOW-UP

1. Bag and dispose of soiled linen in the laundry hamper.
2. Wash your hands.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

ORIENTATION CHECKLIST – BUSINESS OFFICE		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 31** **Page: 1 of 2**
Effective Date: 11 April, 2013		

ORIENTATION CHECKLIST – BUSINESS OFFICE

PROCEDURE

1. Use the attached checklist for Business Office orientation.
2. The verify column is for preceptor verification initials.

		DATE Instruct	VERIFY		DATE Complete	COMMENTS
1.	Equipment: postage machine, copy machine, fax, credit card machine					
2.	Telephone system					
3.	Supplies: office, other					
4.	General task of clean-up					
5.	Review of job description & evaluation form					

		DATE Instruct	VERIFY		DATE Complete	COMMENTS
1.	Introduction to staff					
2.	Philosophy					
3.	Tour of building					
4.	Benefits / pay review					
5.	Time Sheet / time schedules					
6.	Review of policy / procedures manuals					
7.	Equipment: Postage machine, copy					
8	Disaster Plan Codes.					
9.	Telephone system					
10.	Supplies: Office, other.					
11.	General task of clean-up					
12.	Parking					
13.	Review of job description and evaluation					

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

GENERAL MANUAL

ORIENTATION CHECKLIST – BUSINESS OFFICE		
Policy/Procedure Applies To	**All Staff**	**Policy/Procedure No: 31** **Page: 2 of 2**
Effective Date: 11 April, 2013		

STATEMENT OF COMPLETION

I have:

1. completed the General Orientation and Business Office Orientation..
2. reviewed the Orientation List with the preceptor/ Administrative Head of the Center
3. had all my questions answered that are pertinent to this orientation.
4. an understanding and working knowledge of all that was covered in this Orientation.
5. an understanding of the purpose, content and location of procedure manuals.

ORIENTEE: _____

PRECEPTOR: _____

DATE: _____

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

ANNUAL COMPETENCY STATEMENT REGARDING PATIENT ASSESSMENT FOR THE OPERATING THEATER NURSE		
Module Applies To	**OT Nurse**	**Module No: 32** **Page: 1 of 1**
Effective Date: 11 April, 2013		

ANNUAL COMPETENCY STATEMENT REGARDING PATIENT ASSESSMENT FOR THE OPERATING THEATER NURSE

PURPOSE

Continual assessment of all components of care of the surgical patient.

Validation consists of observation and review of individual nurse's documentation accuracy.

PERFORMANCE CRITERIA

1. Performs preoperative assessment of the physiologic status of the patient, noting condition of the patient's skin, determining the patient's level of mobility, noting any abnormalities such as injuries or a chipped tooth, verifying allergies, and identifying any sensory aids and/or prosthetic devices and removing only if necessary. Also assesses patient's orientation prior to surgery.
2. Performs assessment of the psychosocial status of the patient by eliciting the patient's knowledge and understanding of the impending surgical procedure. Also identifies the patient's philosophical and religious beliefs and cultural practices relevant to the planning of his/her perioperative care.
3. Verifies the operative site.
4. Performs assessment of patient's anxiety related to surgery and other impediments to learning such as sensory deficits or language barrier.
5. Verifies informed consent and refers medical questions/concerns to the surgeon or appropriate surgical team member.
6. Explains perioperative events related to the surgical procedure before they occur.
7. Provides physical safety for the patient to include:
    a. Correct sponge, instrument and needle/sharp count
    b. Proper positioning of the patient
    c. Maintaining aseptic controlled environment.
8. Performs a final assessment of the patient's condition prior to the patient being transported from the operating theater to the respective nursing unit and makes notation of where the patient is being discharged and who is accompanying the patient.

_____ _____

Nurse's Name Date

_____ _____

Evaluator's Name Date

Competency statement was met: _____

Competency statement was not met: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

BED MAKING: OPEN, FANFOLDED OR EMPTY BED		
Policy/Procedure Applies To	**All Nurses/Nursing Aides/ Housekeeping Staff**	**Policy/Procedure No: 32** **Page: 1 of 1**
Effective Date: 11 April, 2013		

BED MAKING: OPEN, FANFOLDED OR EMPTY BED

The open bed is made exactly like the closed bed except the top sheets are fanfolded to the foot end of the bed.

PROCEDURE

PREPARATION

1. Assemble the equipment for making a closed bed
2. Wash the hands and make the closed bed.

STEPS

1. Grasp the cuff of the beding in both hands
2. Fanfold to the foot end of the bed
3. Fold the bedding back on itself toward the head of the bed. The edge of the cuff must meet the fold.
4. Smoothen the hanging sheets on each side neatly into the folds you have made
5. Wash your hands.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

ANNUAL COMPETENCY STATEMENT FOR STAFF NURSES: CLINICAL SKILLS INSERT FOR STAFF NURSES		
Manual Applies To	**Staff Nurse**	**Manual No: 33** **Page: 1 of 2**
Effective Date: 11 April, 2013		

ANNUAL COMPETENCY STATEMENT FOR STAFF NURSES: CLINICAL SKILLS INSERT FOR STAFF NURSES

Employee Name: _____

PERFORMANCE REVIEW FACTORS

	Excellent **G**ood **A**verage **F**air **P**oor	**E**	**G**	**A**	**F**	**P**
1.	Assesses adult respiratory status by demonstrating skills such as airway management, airway insertion/ removal, oxygen administration, care of the intubated patient, etc.	☐	☐	☐	☐	☐
2.	Recognizes and appropriately intervenes in conditions causing respiratory compromise such as pulmonary edema, laryngospasm, aspiration, etc.	☐	☐	☐	☐	☐
3.	Understands effects of anesthetic agents on recovering patient; Understands actions, dosages, side effects of respiratory drugs used in OT.	☐	☐	☐	☐	☐
4.	Assesses circulatory status by properly taking pulses, including peripheral, and demonstrating correct use of non-invasive BP monitor and oximeter.	☐	☐	☐	☐	☐
5.	Understands extent of neuro assessment and performs adequately. Recognizes significant neurologic changes.	☐	☐	☐	☐	☐
6,	Takes an ECG and correctly interprets cardiac rhythms. Responds appropriately to arrhythmias.	☐	☐	☐	☐	☐
7.	Understands action, dosages, side effects of major cardiac drugs used in OT and Nursing Unit.	☐	☐	☐	☐	☐
8.	Maintains knowledge of content of crash cart and use of defibrillator. Participates appropriately during codes.	☐	☐	☐	☐	☐
9.	Understands action, dosages, side effects of major drugs used in adult patients for: antibiotic therapy, pain, nausea, treatment of hypo/hypertension. Includes knowledge of alternate anesthesia drugs.	☐	☐	☐	☐	☐
10.	Performs adequate physical assessment by observing operative site, IV fluid administration, care of drains, dressings, etc.	☐	☐	☐	☐	☐
11.	Recognizes and appropriately responds to clinical needs of patients with conditions such as diabetes, seizures, allergic reactions.	☐	☐	☐	☐	☐
12.	Demonstrates skill In care of patients after axillary and IV regional blocks, and epidural anesthesia.	☐	☐	☐	☐	☐
13.	Ensures pattered safety by demonstrating awareness of environmental factors such as side rails, etc., and infection control practices such as universal precautions.	☐	☐	☐	☐	☐
14.	Exhibits technical skill in fundamental nursing care such as management of: Foley catheter, IV therapy, crystalloids, medication administration.	☐	☐	☐	☐	☐

15.	Understands and can articulate components of patient discharge including discharge criteria, post-op teaching, and transfer to hospital.	☐	☐	☐	☐	☐
16.	Conducts thorough pre-op assessment including such components as patient interview, pre-op tests, reporting abnormal results, consent, pattered teaching, etc.	☐	☐	☐	☐	☐
17.	Prepares patient for surgery according to physician and/or standing orders.	☐	☐	☐	☐	☐

Reviewed By: _____

Date: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

BED MAKING: THE OCCUPIED BED		
Policy/Procedure Applies To	**All Nurses/Nursing Aides/ House Keeping Staff**	**Policy/Procedure No: 33 Page: 1 of 3**
Effective Date: 11 April, 2013		

BED MAKING: THE OCCUPIED BED

The occupied bed is made when the patient is not able or not permitted to get out of bed. The most important part of making an occupied bed is to get the sheets smooth and tight under the patient so that there will be no wrinkles to rub against the patient skin.

PROCEDURE

PREPARATION

1. Assemble equipments in the order in which it will be used and place on a linen trolley near the bed:
   a. Two large sheets
   b. One plastic draw sheet
   c. One cotton draw sheet
   d. Disposable or reusable bed protectors
   e. Two blankets (1 optional)
   f. Pillowcase
   g. One bedspread
   h. Laundry hamper.
2. Introduce yourself and identify the patient by checking the identification bracelet.
3. Explain the procedure.
4. Provide privacy for the patient.

STEPS

1. Wash your hands.
2. Lower the backrest and knee rest until the bed is flat. Raise the bed to a comfortable working height and lock in place. Keep side rails up to provide safety.
3. Loosen all the sheets around the entire bed.
4. Take the bedspread and blanket off the bed and fold them and keep them over the linen trolley, leaving the patient covered only with the top sheet.
5. Cover the patient with the blanket by placing it over the top sheet without exposing the patient; remove the top sheet from under the blanket.
6. Raise the bedside rail on the opposite side of your working position and lock it.
7. Ask the patient to turn onto his/her side toward the side rail. Help the patient to turn. The patient is now on the far side of the bed.
8. Adjust the pillow for the patient.
9. Fold the cotton draw sheet toward the patient and touch it against his/her back.
10. Raise the plastic draw sheet (if it is clean) over the blanket and the patient.

BED MAKING: THE OCCUPIED BED		
Policy/Procedure Applies To	**All Nurses/Nursing Aides/ House Keeping Staff**	**Policy/Procedure No: 33** **Page: 2 of 3**
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11. Fold the bottom sheet toward the patient and tuck it against his/her back.
12. Take the large clean sheet and fold it in half length wise. Do not permit the sheet to touch the floor or your uniform.
13. Place the sheet on the bed, still folded, with the fold running along the middle of the mattress. The small hem end of the sheet should be even with the foot edge of the mattress. Fold the top half of the sheet toward the patient. Tuck the folds against her back, below the plastic draw sheet.
14. Miter the corner at the head of the mattress, Tuck in the clean bottom sheet on your side from head to foot end of the mattress
15. Pull the plastic draw sheet towards you, over the clean bottom sheet, and tuck in.
16. Place the clean cotton draw sheet over the plastic sheet, folded in half. Fold the top half toward the patient, tucking the fold under back as you did with the bottom sheet. Tuck the draw sheet under the mattress.
17. Raise the bedside rail on your side of the bed and lock in place.
18. Go to the opposite side of the bed.
19. Lower the bedside rail. Ask the patient or help him/her, to roll over the “hump” onto the clean sheets away from you.
20. Remove the old bottom sheet and cotton draw sheet from the bed. Pull the fresh bottom sheet toward the edge of the bed. Tuck it under the mattress at the head of the bed and make a mitered corner. Then tuck the bottom sheet under the mattress from the head to the foot, pulling firmly to remove any wrinkles.
21. Pull the plastic draw sheet and clean cotton draw sheet toward you, one at a time. Tuck the draw sheets under the mattress along the side.
22. Be sure to pull all the sheets tight as you tuck them in for a tight foundation.
23. Have the patient turn on his/her back, loosening the blanket as the patient turns.
24. Change the pillowcase and place the pillow under the patient's head.
25. Spread the clean top sheet over the blanket with the wide hem to the top. The middle of the sheet should run along the middle of the bed. The wide hem should be even with the head edge of the mattress. Remove the blanket, moving toward the foot of the bed, without exposing the patient.
26. Tuck the clean top sheet under the mattress at the foot end of the bed. Make sure you leave enough room for the patient to move feet freely. Miter the corners of the sheet.
27. Spread the blanket over the top sheet. Be sure the middle of the blanket runs along the middle of the bed. The blanket should be high enough to cover the patient's shoulders.
28. Tuck the blanket in at the foot end of bed. Make sure you leave enough room for the patient to move the feet freely. Miter the corners of the sheet.
29. Spread the blanket over the top sheet. The blanket should be high enough to cover the patient's shoulders.
30. Tuck the blanket in at the foot end of the bed. Make a mitered corner with the blanket.
31. Place the spread on the bed in the same way. Make a mitered corner with the spread.

BED MAKING: THE OCCUPIED BED		
Policy/Procedure Applies To	**All Nurses/Nursing Aides/ House Keeping Staff**	**Policy/Procedure No: 33 Page: 3 of 3**
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32. Go to the other side of the bed and pull the top sheet, blanket, and spread over and straighten. Turn the top covers back and miter the top sheet; then miter the blanket and then miter the spread. Be sure the top covers are loose enough for the patient to move feet.
33. To make the cuff:
    a. Fold the top hem edge of the spread over and under the top hem of the blanket.
    b. Fold the top hem of the top sheet back over the edge of the spread and blanket to form a cuff. The rough edge of the hem of the sheet must be turned down so the patient does not come in contact with it.
34. Raise the backrest and knee rest to suit the patient, if this is allowed.
35. Make the patient comfortable and confirm, replace the call light.
36. Lower the bed to a position of safety for the patient.
37. Raise the side rails for patient safety.
38. Bag and dispose of used linen in the laundry hamper.
39. Wash your hands.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

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BED MAKING: POST-OPERATIVE OR SURGICAL BED		
Policy/Procedure Applies To	**All Nurses/Nursing Aides/ House Keeping Staff**	**Policy/Procedure No: 34** **Page: 1 of 1**
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BED MAKING: POST-OPERATIVE OR SURGICAL BED

The post-operative bed is also called the surgical, operation theatre or recovery bed. The surgical bed is used for patients returning from surgery. Blankets may be necessary due to cold surgical environment.

PROCEDURE

PREPARATION

1. Assemble equipment for making a closed bed with the additional blankets.
2. Wash your hands.

STEPS

1. Adjust bed to its highest horizontal, comfortable working position. Lock the bed in place. Strip all used linen from the bed and place in the laundry bag.
2. Make the bottom part of the bed. Follow the instructions for making a closed bed.
3. Spread one blanket across the bed, on top of the draw sheet and bottom sheet. The bottom end of the blanket should be even with the foot end of mattress. Tuck the edge under the mattress on your side of the bed.
4. Go to the other side of the bed. Tuck the blanket under the mattress.
5. Spread the second blanket across the bed. The upper edge should be about 6 inches from the head end of the bed. This blanket gives the patient extra warmth
6. Put the top sheet and the spread on the bed. Do this the same way as when making the closed bed, but do not tuck them in at the foot end of the bed. Instead, all the bedding at the foot end should be folded back on the bed so the folded edge is even with the foot end of the mattress.
7. Make the cuff the as for the open bed, except you fold the blanket over the cuff
8. Go to the side of the bed where the stretcher will be in place.
9. Grasp the top bedding at the side with both hands. Fold the bedding across the bed so the folded edge is even with the far side of the mattress. Again, fold the bedding to the edge so it is twice folded.
10. Put the pillow into the pillow case. Put the pillow upright against the headboard. Place it so as to protect the patient from hitting his or her head on the headboard during the transfer procedure.
11. Move the bedside table, chair and any other furniture out of the way to make room for the stretcher.
12. Remove everything from the bedside table except a box of tissues and an emesis basin.
13. Position the surgical bed to match stretcher height.
14. Wash your hands.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE II
(Refer to Nursing Education and Training Modules No. 34)

EVALUATION OF GENERAL NURSING ORIENTATION

Date: _____

Name: _____

Department: _____

Title: _____

Please answer the following questions.

1. In your opinion, the Introductory Session: (circle your choice)

   a1. was too short a2. too long a3. just right

   b1. was not helpful b2. somewhat helpful b3. very helpful

   c1. should be totally changed c2. change some parts b3. leave it the same

   d. what would you change?

   Suggestion: _____

2. In your opinion, General New Nurse Orientation: (circle your choice)

   a1. was too short a2. too long a3. just right

   b1. was not helpful b2. somewhat helpful b3. very helpful

   c1. should be totally changed c2. change some parts c3. leave it the same

   d. what would you change?

   Suggestion: _____

3. In your opinion, your Orientation:

Strongly Agree	*Agree*	*Neutral*	*Disagree*	*Strongly Disagree*
5	4	3	2	1

   _____ Was well organized and helpful?

   _____ Covered sufficient information to get you started?

   _____ Familiarized you with equipment used in your work place?

   _____ Taught you all of the Prime Surgical Centers standard & skills needed in your work place?

Comments:

_____

_____

_____

_____

4. In your opinion, do you feel that orientation has prepared you with the clinical skills necessary to perform your duties as a staff nurse in your work place? (circle one)

Strongly Agree	*Agree*	*Neutral*	*Disagree*	*Strongly Disagree*
5	4	3	2	1

Comments:

_____

_____

_____

_____

5. After you completed orientation did you feel prepared to begin your own practice in your department?

☐ Yes, Definitely ☐ Somewhat Prepared ☐ Not Ready at All

ANNEXURE I

(Refer to Nursing Education and Training Modules No. 34)

INSERVICE ATTENDANCE FORM

TOPIC: _____

SPEAKER: _____

DATE: _____

TIME: _____ Total Time _____

(Include inservice starting time and ending time)

PRESENT

(Name)	(Signature)

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

INSERVICE EDUCATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 34** **Page: 1 of 2**
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INSERVICE EDUCATION

PURPOSE

To provide all personnel information on new procedures, products and equipment being introduced for use in Prime Surgical Centers. To ensure that all personnel are properly informed as to the use and application of all equipment and supplies.

SCOPE

All ambulatory surgical center personnel.

POLICY

1. New products and equipment will not be available for use until all persons have demonstrated familiarity with its function and application. Inservices will also be held at intervals on existing equipment not frequently used in order to update the knowledge of personnel.
2. When new equipment or products are purchased the administrator will schedule an inservice with the sales representative as quickly as possible to include all personnel and surgeons whenever possible.
3. A certain number of inservice sessions will be devoted to review of policies and procedures to keep personnel current and to aid in revision. Inservices will be held at least monthly.
4. At least one inservice/quarter will address quality improvement/risk management. Programs in infection control, fire and safety, code management will be held at least annually.
5. An Inservice Education Program is provided at Prime Surgical Centers utilizing a variety of following sources:
    a. Lectures presented by the Physicians, Nursing Superintendent, Educator and Administration Head of the Center.
    b. Videotapes or cassettes.
    c. Presentations on new products or equipment from companies providing these products.
    d. Articles taken from professional journals.
    e. Presentations from members of the staff.
6. Attendance Records (Refer to Annexure I to this policy) shall be kept of all inservices provided in the Center and shall contain as a minimum the title of the offering to include a description of the material presented, attendance record (name of the speaker, name and signature of all attendees, handout, etc.) and length of time of the inservice. Attendance Records to be filed in the Inservice Manual.
7. Those not attending the inservice must review the minutes and confer with manager for further information. This “self study” shall be documented.
8. The Nursing Superintendent or his/her delegate will organize and schedule inservices. He/she will formulate an annual calendar to include mandatory or required inservices as well as those that would be considered pertinent to staff. Staff are encouraged to present ideas to their charge nurse for consideration.

INSERVICE EDUCATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 34** **Page: 2 of 2**
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9. Each staff member will be responsible for arranging a minimum of four (4) inservice program annually.
10. Staff members are encouraged to pursue educational activities that would increase their skills and competence in their jobs, i.e., ACLS for OT Staff.
11. Inservices such as Risk Management, Hazard Communication Policy, Fire/Disaster, Laser Safety and HIV AIDS update are provided by the facility and are mandatory.
12. An Evaluation of Nursing Orientation Form to be distributed to the participants for their feedback. (Refer Annexure II to this policy)

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

DOCUMENTATION - TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 35** **Page: 1 of 2**
Effective Date: 11 April, 2013		

DOCUMENTATION – TEST

Name: _____ Date: _____

Designation: _____ Unit: _____

Please select the correct answer by encircling the alphabet

1. Under which circumstance is it acceptable practice for the nurse to document a nursing activity before it is carried out?
   a. When the activity is routine(e.g., raising the bedrails)
   b. When the activity occurs at regular intervals (e.g., turning the client in bed)
   c. When the activity is to be carried out immediately (e.g., a stat medication)
   d. It is never acceptable

2. The primary purpose of the evaluating phase of the care planning process is to determine whether the...
   a. Desired outcomes have been met.
   b. Nursing activities have been carried out
   c. Nursing activities were effective
   d. Client's condition has changed.

3. Which action should the nurse take when a mistake in recording has occurred?
   a. Draw a line through the mistake.
   b. Draw a line through it, and write error above the entry and sign.
   c. Draw a line through it and write mistaken entry above it.
   d. Draw a line through the mistake and write mistaken entry and your initials above it.

4. DAR means?
   a. Data, Action & Assessment.
   b. Data, Alteration & Response.
   c. Deviation, Alteration & Reassessment.
   d. Data, Action & Response.

DOCUMENTATION - TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 35** **Page: 2 of 2**
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5. Use the following situation & complete nurses note utilizing DAR format:

   Mr. Sudhir Dar 47 years old is admitted to nursing unit with Rt. Ankle pain. According to him the pain is continuous since 1 hour, aching in nature, with mild relief when leg is kept elevated on a pillow. Rt. Ankle is swollen with redness, warm to touch. Patient is on TAB MUSCADOL 2 PO TID for his pain. He is a known case of DM on Insulin (MONOTARD) 10 IU am. He is an accountant working in a private company. He is depressed as he is unhappy with the job. The pain intensity was assessed; pain score was 6 on a scale of 10. He was given 2 MUSCADOL tablet at 10:00 hrs after the food. At 12:00 hrs pain was reassessed and it showed 5 on a scale of 10, injection VOLTAREN 75 mg IM was given as per the physician order.

Use DAR and organize the relevant data under Data, Action, and Result

DATE	SPECIAL NOTATION	NURSES NOTES

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

MEDICATION ADMINISTRATION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 35** **Page: 1 of 4**
Effective Date: 11 April, 2013		

MEDICATION ADMINISTRATION

PURPOSE

Medications are administered to patients using a systematic method to minimize medication errors and protect the safety of the Patient. This provides for the security of the drugs by preventing unauthorized access.

SCOPE

All Staff Nurse certified in Administration of Medication by Prime Surgical Centers.

POLICY

1. A physician's order, as per Annexure to this policy, is required before any medication may be administered which is legible and accurate.
   a. Name of medication
   b. Form – oral solid unless otherwise specified.
   c. Dose - using metric system.
   d. Route – oral, sub lingual, suppositories, intra dermal, SQ, Trans-dermal patch, IV, Etc.
   e. Frequency – two times daily, etc.
   f. Duration - x 1 day x 2 doses,(bid) etc.
   g. All PRN (Pro re nata-when required) orders require a minimum number of hours between doses.
   h. SOS (Si Opus Sit – repeat once if urgent)
   i. Stat (Statim-at once/immediately)
2. Check the following "Seven (7) Rights" as guide to the administration of medications:
   a. The right patient
   b. The right drug
   c. The right dose
   d. The right route
   e. The right time
   f. The right to refuse
   g. The right to patient family education
3. Be sure the medications are given to the right patient. Accurately identify the patient by two identifiers, viz. Identity band and asking the patient to state his name.
4. Check allergy
5. Never administer a drug unless he/she has satisfied all the requirements pertaining to the drug use. If there is any doubt regarding a drug dosage or route of administration, it should not be administrate until the prescription is verified.

6. Give medicines at the specified time and read the label three (3) times.
    a. Read label on medication container before removing container from shelf or drawer.
    b. Read label again before taking medicine from container.
    c. Read label again before returning container to its place.
7. Medications are never left unattended.
    a. Only authorized personnel are allowed in the medication rooms.
    b. Medication cupboards and medication rooms are kept locked at all times when unattended.
8. Never give a medicine someone else has prepared.

    Never chart a medication as given unless the Nurse who prepared and administered. If the drug is administered by the physician, the nurse assisting in the administration documents the drug as given by the physician with complete name of the physician.
9. Standing Post Operative Protocol may be used for administration of certain medications, oxygen and intravenous fluids.
10. If the patient refused to take the medication, inform the physician and document in the nurse's note or on the administration chart.
11. Documentation should include medicine, method, dosage, time given and nurse's signature, time and date.
    a. Charting errors:
        i. Draw a clear line across incorrect data in black ink taking care that what has written in incorrect data is clearly visible. The word "Error" is written, also in ink. The corrected material then follows. The error and signature of person making the correction should always be included.
        ii. Any alteration and the use of "white out"/ "Black Out" is not acceptable.
12. Adverse drug reaction must be reported to the physician immediately and documented on the record.
13. Any incidents / events relating to medications should be reported to physician and Nursing Superintendent immediately.
14. If a multi-dose drug vial is opened the bottle must be marked to show the expiration date which occurs twenty eight (28) days after the vial is opened.
15. Single dose vials must be used and discarded according to the policy.
16. Emergency medication
    a. Emergency Medication should be available in all clinical areas in an emergency cart
    b. A checking system ensures that the cart and medications are current and in place (Refer Nursing Manual Policy and Procedure No. 13)
17. Administration of drugs in the Operating Theater.
    a. Any drug that the surgeon uses in the operative suite, such as antibiotic or local anaesthetic, is recorded by the circulating nurse and by the surgeon in the operative note.

b. The drug is checked by the Scrub Nurse and Circulating Nurse, or the Circulating Nurse with the Anaesthesiologist or Surgeon, before it is transferred to the sterile field.

c. The scrub nurse repeats the name of the drug to the surgeon when passing it.

The scrub nurse may have more than one drug on the instrument table. Each drug must be correctly identified on the table. (Refer to Nursing Manual Policy and Procedure No. 83)

PROCEDURE

1. Medications are prepared for administration in a designated area by a designated Staff Nurse
   a. Medications may be prepared in the medication area for distribution and administration for one patient or several patients prior to administering the medications.
   b. Controlled substances must be prepared in single doses and administered as soon as possible after preparation.
2. Preparation of medication includes the following:
   a. Transcription of Medication Orders according to nursing policies.
   b. Check the patient's medication record to determine which medications are due for administration.
   c. The name of the drug, the dosage, route, and time are carefully noted.
   d. Identify the patient and ask for the allergies
3. The appropriate medication container is removed from the medication cupboard.
   a. The label of the container is read three times: before preparing, while withdrawing the medication, and before returning the container to the cupboard.
   b. Stock medication that is ordered for patient use has the expiration date circled in red and this date is checked before each administration.
4. Medications are prepared for one patient at a time.
   a. Aseptic technique is used when preparing medications for administration.
   b. When all medications for a specific patient have been prepared, the medication record is reviewed to validate that the correct patient, correct medication, correct dosage, correct route, and correct time have been observed.
   c. The prepared medication is placed in the appropriate holder until the medication is given to the patient.
   d. Only the Staff Nurse preparing the medications is in the medication room/area while medications are being prepared.
   e. The Staff Nurse who prepared the medications must administer the medication to the patient.
5. Administer the medication to the correct patient.
   a. Check the patient's mouth to make certain the oral medications were swallowed.

b. If the nurse suspects an adverse drug reaction, he/she calls the on-call physician to report it.

   i. Monitor patient for reaction.

   ii. If reaction does occur, discontinue medication, assess the patient, notify Anaesthesiologist and/or attending physician immediately; treat reaction as ordered; document occurrence in Incident Report form and Nurse's Note.

   iii. For patients who are on narcotic or analgesic Post-Operatively, should stay for an additional thirty (30) minutes or at the discretion of the Anaesthesiologist or Physician.

6. Document administration by entering full signature, name, date and time in the appropriate place on the medication record and Nurse's Note.

   a. Document controlled drugs on the Controlled Drug Record Sheet as well as on the patient medication record /Nurse's Note.

   b. Document Stat (Statim-at once/immediately), PRN (Pro re nata-when required)/ SOS (Si Opus Sit – repeat once if urgent) and single dose in the appropriate place on the medication record and / Nurse's Note.

7. The nurse leaving the shift checks to make sure all medications given and the documents are complete with name, signature, date and time.

8. In case a patient refuses medication the Staff Nurse will document the medication refusal on the Medications record / nurse's note and report to physician

9. The Staff Nurse is responsible to report and document desired therapeutic responses and side effects on patients.

10. All Nursing staff are required to demonstrate competency in medication administration.

11. All nursing staff who administer medications are required to attend and obtain certificate of medication administration course during Orientation and training at Prime Surgical Centers.

ANNEXURE

(Refer to Nursing Manual Policy and Procedure No. 35)

PHYSICIAN ORDER SHEET
MEDICATION

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

TO BE FILLED BY DOCTORS																				
DRUG ORDER																				
SR. NO.	DRUG NAME Oral / Injection / IV	DOSE	ROUTE	FREQ	SIGN OF DR.	D1				D2				D3				REMARKS		
	NON-DRUG ORDER																			

TO BE FILLED BY DOCTORS																	
DRUG ORDER																	
SR. NO.	DRUG NAME Oral / Injection / IV	DOSE	ROUTE	FREQ	SIGN OF DR.	D4				D5				D6				REMARKS
	NON-DRUG ORDER																	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

DRUG CALCULATION TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 36** **Page: 1 of 5**
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DRUG CALCULATION TEST

Name:_____

Designation:_____ Unit:_____ Date:_____

Please answer the questions below. Show the Calculation or Formula on the right side (space provided). Use a calculator.

1. You have to give 20 mg. of Buscopan. The available dosage strength is 10mg. / tablet. How many tablet/s will you give?
   a. 1.0
   b. 2.0
   c. 3.0
   d. 4.0

2. Digoxin 125 mcg is ordered once daily. Only 0.25mg tablets are available. How many tablets are needed for the daily dose?
   a. 0.5
   b. 1.0
   c. 1.5
   d. 2.0

3. Pethidine 75 mg IM is ordered for your patient. The available concentration is 100 mg/2 mL. How many mL will you give?
   a. 0.5
   b. 1.0
   c. 1.5
   d. 2.0

4. 100 mg of Ibuprofen is ordered; available solution contains 20 mg/mL. How many mL will you administer?
   a. 3.0
   b. 4.0
   c. 5.0
   d. 6.0

5. Rocephine 2 gr. is ordered; available medication is powder and 1 vial contains 1gr. and diluted in 10 mL. How many mL will you give?
   a. 10.0
   b. 15.0
   c. 20.0
   d. 25.0

6. A Paracetamol syrup P.O. is ordered for a child who has fever, the order was to administer 20 mg / Kg. The child weighs 15 kg and the drug concentration is each 5 mL contains 120 mg. Then how many mL you will give to that child?
   a. 10.2
   b. 11.3
   c. 12.5
   d. 13.2

7. The physician orders an IV infusion of normal saline 2000 mL to be infused daily. The IV tubing that you are using delivers 15gtt/min. What is the correct flow rate in gtt/min.?
   a. 21.0
   b. 25.0
   c. 30.0
   d. 33.0

8. 50 cc solution of normal saline with 100 units of insulin is infusing at 2 mL per hour. How many units of insulin is the patient receiving each hour?
   a. 3.0
   b. 3.5
   c. 4.0
   d. 4.5

9. A patient has an intravenous infusion in place. 1.5 L of 0.9% sodium chloride is to last for 12 hours. Then how many mL per hour the patient is receiving?
   a. 75.0
   b. 100.0
   c. 125.0
   d. 150.0

10. You have an order to transfuse one unit whole blood (350 mL) over 3 hours. The IV tubing that you are using delivers 10 gtt / min. What is the correct flow rate in gtt/min.?
    a. 15.0
    b. 19.0
    c. 25.0
    d. 33.0

DRUG CALCULATION TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 36** **Page: 3 of 5**
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11. A Cloralhydrate syrup P.O. is ordered for a child, the order was to administer 20 mg / Kg. The child weighs 12 kg and the drug concentration is each 1 mL contains 100 mg. Then how many mL you will give to that child?
    a. 2.0
    b. 2.4
    c. 3.0
    d. 5.0

12. A patient, admitted with a head injury, has an order for NS 0.9 % at 60 mL/hour. The IV tubing has a drip factor of 20gtt/mL. What is the correct flow rate for this patient in gtt/min.?
    a. 15.0
    b. 20.0
    c. 22.0
    d. 25.0

13. 1000cc solution of D5W with 20,000 units of Heparin is infusing at rate of 20 mL/hour. How many units of Heparin is the patient receiving each hour?
    a. 300
    b. 400
    c. 450
    d. 500

14. You have an order to transfuse one unit fresh frozen plasma (150mL) over 30 minutes. The IV tubing that you are using delivers 10 gtt / min. What is the correct flow rate in gtt/min.?
    a. 30.0
    b. 40.0
    c. 50.0
    d. 55.0

15. The 10 am medications scheduled for your patient include Keflex 1.5 G in 50 mL of a 5% Dextrose solution. According to the pharmacy, this preparation should be administered in thirty minutes. The IV tubing on your unit delivers 15 gtt. per milliliter. What is the correct flow rate in drops per minute?
    a. 20.0
    b. 22.0
    c. 25.0
    d. 28.0

DRUG CALCULATION TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 36** **Page: 4 of 5**
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16. A client weighing 50 kg is receiving Dobutamine infusion of 5 Mcg/kg/min., if the dilution is Dobutamine 250 mg in 500 mL D5W, then how many mL/hr your patient should receive?

    a. 20.0

    b. 25.0

    c. 30.0

    d. 35.0

17. Your 120 kg client is currently receiving an infusion of Dopamine of 10 Mcg/kg/min. Your medication dilution is 200 mg Dopamine in 50 mL N/S 0.9 % solution, then how many mL/hr your patient should receive?

    a. 15.0

    b. 18.0

    c. 22.0

    d. 25.0

18. A patient is receiving nitroglycerin 50 mg in 250 mL D5W. The order is to infuse 50 Mcg/min. How many mL/hr. would be needed to deliver this amount?

    a. 10.0

    b. 15.0

    c. 20.0

    d. 25.0

19. A Procainamide drip is ordered (2gms in 250 cc D5W) to infuse at 4 mg/min. Calculate the flow rate in cc/hour for which the infusion pump will be set at.

    a. 30.0

    b. 32.0

    c. 35.0

    d. 40.0

20. A physician ordered Heparin 1200 units / hour I.V. infusion for your patient, the Heparin was prepared in a syringe pump with concentration of 25000 units in 50 mL normal saline. Calculate how many mL/hr your patient should receive?

    a. 2.1

    b. 2.2

    c. 2.3

    d. 2.4

21. Your 89 kg client is currently receiving an infusion of Dopamine of 6 Mcg/kg/min. Your medication dilution is 200 mg Dopamine in 50 mL N/S 0.9 % solution, then how many mL/hr. your patient should receive?
    a. 8.0
    b. 10.0
    c. 12.0
    d. 14.0

22. A client weighing 101 kg is receiving Dobutamine infusion of 7 Mcg/kg/min., if the dilution is Dobutamine 250 mg in 100 mL D5W, then how many mL/hr. your patient should receive?
    a. 15.0
    b. 17.0
    c. 20.0
    d. 22.0

23. A patient is receiving Lidocaine drip 2 mg/min., if the drug concentration is 2 gr. In 500 mL of fluid, then how many mL/hr. your patient should receive?
    a. 15.0
    b. 20.0
    c. 25.0
    d. 30.0

24. A Nitroglycerin drip is ordered for your patient who weighs 90 kg to control his chest pain. The concentration is 100 mg in 250 cc D5W. The order is to begin the infusion at 17 mcg / min. What is the rate you would begin the infusion on the infusion pump in mL/hr.?
    a. 2.1
    b. 2.2
    c. 2.3
    d. 2.5

25. A physician ordered Heparin 1600 units / hour I.V. infusion for your patient, the Heparin was prepared in a syringe pump with concentration of 25000 units in 50 mL normal saline. Calculate how many mL/hr. your patient should receive?
    a. 3.0
    b. 3.1
    c. 3.2
    d. 3.3

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

MEDICATION MANAGEMENT AND USE (PROTOCOL)		
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MEDICATION MANAGEMENT AND USE (PROTOCOL)

PURPOSE

To reduce medical errors in Prime Surgical Centers.

POLICY

1. Medication orders are to be written clearly in the physician's order sheet. (Refer to General Manual Policy and Procedure No.)
2. Start and discontinuation order of any drug should have name, signature, date and time.
   (Doctors need to cancel the medication administration orders in the medication chart to discontinue the medicine usage.)
3. Any wrong entry has to be crossed out with a single line and word "error" being boldly written and authenticated by signature, name, date and time.
4. Effect of the medication is to be documented in the progress note.
5. Medications are administrated at standard times other than stat orders.
6. Self medication and medication from outside are not encouraged in the center.
7. Never leave medicines unattended in the open. Keep them safe in bedside cabinets.
8. Label all open in-use vials and re-fill syringes.
9. All medication error to be reported (Medication error form).
10. All ADR (Adverse Drug Reactions) need to be reported in ADR form for clinical audit.
11. All orders (including diet and nursing) stand cancelled when patient undergo surgery or is transferred out of Operation Theater. All order including dietary order need to be written afresh in the situation.

REQUIRED ELEMENTS OF A COMPLETE PRESCRIPTION ORDER

1. Patient identification details (Patient name and MR No. and I.P. No.)
2. Patient Age
3. Patient Sex
4. Prescribing Doctor's Name, Signature, Date and Time.
5. Provisional diagnosis / Final Diagnosis
6. All the medications prescribed to be in clear handwriting preferably by using CAPITAL LETTERS, avoid using abbreviations or use only approved abbreviations
7. Dose, Route and Frequency (standardized times are followed unless otherwise specified)
8. Formulation and Medication's Name
9. SOS orders with indications that in which conditions medication is to be administered
10. Look-alike / Sound-alike medications are to be prescribed by mentioning both Generic and Brand name.

11. Preferably medications to be prescribed by using both Generic name and Brand Name. e.g. Fosphenytoin and Inj. Fosolin
12. Special Dilution for required IV infusions or preparation instructions with infusion rate
13. Un-approved and unauthorized abbreviations shall not be used.
14. Special instructions to be used whenever required:
    a. Hold Dose or Order
    b. Status STAT or NOW otherwise the order is assumed to be routine
    c. Ask before administration (with physician name)
    d. Medication to be given for specified durations only

AUTOMATIC STOP MEDICATION ORDERS

Medication orders discussed below are automatically stopped after their validity

1. Routine orders of in-Patient are valid for 3 days only
2. Stat orders are valid only for single dose only
3. Narcotic Drug orders are valid for time period mentioned by doctor on DRUG CHART and Narcotic request book (whichever falls earlier)
4. High alert medication orders are valid for single day only

MEDICATION MANAGEMENT AND USE (PROTOCOL)		
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LIST OF APPROVED ABBREVIATIONS (PRIME SURGICAL CENTERS)

1.	**od**	Once a day
2.	**BID**	Two times a day
3.	**TID**	Three times a day
4.	**QID**	Four times a day
5.	**SOS**	When necessary (one dose)
6.	**PRN**	When necessary
7.	**ml**	Milliliter
8.	**MG**	Milligram
9.	**µg**	Microgram
10.	**IV**	Intravenous
11.	**IM**	Intramuscular
12.	**HS**	Every night
13.	**PO**	Oral
14.	**RT**	By Ryles Tube
15.	**TAB**	Tablet
16.	**INJ**	Injection
17.	**AMP**	Ampoule
18.	**MCG**	Microgram
19.	**QD**	Every day
20.	**SL**	Sublingual
21.	**SC**	Subcutaneous
22.	**DC**	Discontinue

Do NOT use trailing zeros (zero after decimal point) – e.g. 4.0 can be misinterpreted as 40, use leading zero (zero before decimal) for e.g. 0.4

Give space between medicine name and its unit e.g. Inderal40 mg (incorrect) → **Inderal 40 mg (correct)**

MEDICATION MANAGEMENT AND USE (PROTOCOL)		
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DO NOT USE ABBREVIATION FOR MEDICATION NAMES

E.g. Dangerous (medication names) or dose designation NOT TO BE USED in medical record.

Abbreviation/ Dose Expression	**Intended meaning**	**Misinterpretation**	**Correction**
D/C	Discharge discontinues	Premature discontinuation of medication when D/C (intend) to mean 'discharge' has been misinterpreted as 'discontinued' when followed by a list of drugs.	Use 'discharge ' and 'discontinue'
AZT	Zidovudline (RETROVIR)	Azathioprine	Use the complete spelling for drug names
HCL	Hydrochloric Acid	Potassium chloride (The 'H' is misinterpreted as 'K')	Use the complete spelling for drug names
HCT	Hydrocortisone	Hydrochlorothiazide	Use the complete spelling for drug names
HCTZ	Hydrochlorothiazide	Hydrocortisone (seen as HCT 250 mg)	Use the complete spelling for drug names
MgSO4	Magnesium sulphate	Morphine sulphate	Use the complete spelling for drug names
MSO4	Morphine sulfate	Magnesium sulphate	Use the complete spelling for drug names
MTX	Methotrexate	Mitoxantrone	Use the complete spelling for drug names
TAC	Triamcinolone	Tetracaine, ADRENALINE, cocaine	Use the complete spelling for drug names
ZnSO4	Zinc sulphate	Morphine sulphate	Use the complete spelling for drug names

MEDICATION MANAGEMENT AND USE (PROTOCOL)		
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Medication errors can occur at any stage of medication administration.

These are the following:

1. Ordering (Prescription errors) : wrong dose, wrong choice of drug,
2. Transcribing (Prescription /indenting errors): wrong frequency of drug administration, missed dose because medication is not transcribed,
3. Dispensing: drug not sent in time to be administered as per prescription, delay in administration , wrong drug dispensed, wrong dose dispensed
4. Administering: wrong dose of drug administered, wrong technique used to administer the drug, and wrong time
5. Monitoring: not documenting the effects of the given medication

Outside medication / Patient in-brought medication / Sample medication

Outside medication / patient in brought medication/ Sample medication are not allowed to be administered at Prime Surgical Centers.

Sample medications are not allowed in Store / Sale at Prime Surgical Centers.

Drug Formulary

A list of medications (Drug Formulary) approved by the Consultants / Administration of Prime Surgical Centers will be stocked by the Pharmacy.

Non-formulary drugs and new drugs if required in specific conditions are to be provided by pharmacy for specific patient use only after approval from management.

STORAGE PRACTICE

1. Store all the medications at secure place.
2. Do not store any medications on the floors.
3. Store al the medications by proper labeling.
4. Use scientific methods for storing Look-alike, sound –alike and spell-alike medications.
5. Follow manufacture guidelines for storage. E.g. TallMAN Labeling

   CapfluNIL 10 MG

   CapfluVIR 75 MG

Store High alert / High Risk mediation with proper labeling for e.g.

CAUTION:	**HIGH ALERT MEDICATION**
CAUTION:	**HIGH RISK MEDICATION**

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

DRUG CALCULATION POST-TEST		
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DRUG CALCULATION POST-TEST

Name:_____

Designation:_____ Unit:_____ Date:_____

Please answer the questions below. Show the Calculation or Formula on the right side (space provided). Use a calculator.

1. Calculate the volume per hour (mL/h) that you need to deliver if a patient is prescribed an infusion. The volume of the infusion is 500 mL over an 8 hour period.
   a. 62.5
   b. 55.0
   c. 65.2
   d. 75.2

2. You have to run an infusion of 500 mL Dextrose/Saline over the next 3 hrs. How many drops per minutes will the infusion be set if you are using a giving set of 20 drops/mL.
   a. 45.0
   b. 50.0
   c. 55.0
   d. 60.0

3. Your patient is prescribed Lasix 80 mg IV stat this morning. The available dose is 10 mg/mL. How many mL will you draw up?
   a. 5.0
   b. 8.0
   c. 12.0
   d. 14.0

4. The doctor orders a volume of 250 mL to be infused at 30 mL/hr. You start this infusion at 12 noon. At what time will this infusion be complete?
   a. 8:30 pm
   b. 9:00 pm
   c. 9:30 pm
   d. 10:00 pm

5. You patient had Hartman's 1000 mL started at 12 noon in the theatre recovery. This was to run for 6 hours. When he returned to the unit at 14:30 there was 650 mL remaining in the bag. Is the infusion running on time?
   a. On time
   b. No (Fast)
   c. No (Slow)

6. Calculate the flow rate (in drops per minute) which is necessary to deliver 2 liters in 16 hours with a drop factor of 20 drops/mL.
   a. 35.0
   b. 38.0
   c. 40.0
   d. 42.0

7. Your Patient is prescribed Heparin of 23000 units over 24 hrs. You hold a stock of Heparin which comes in 5000 units/mL. What volume in mL of Heparin will you draw up?
   a. 4.5
   b. 4.9
   c. 5.3
   d. 5.9

8. In order to improve the renal perfusion the doctors have prescribed an infusion of Dopamine to be titrated at 3 mcg/kg/min. Your patient's weight this morning is 85 kg. How many micrograms will your patient receive each minute?
   a. 200
   b. 255
   c. 285
   d. 300

9. The order is for 200 mg. The label reads 250 mg /5 mL. You would give _____mL(s).
   a. 4.0
   b. 5.0
   c. 7.0
   d. 10.0

DRUG CALCULATION POST-TEST		
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10. To restrict fluid overload for a patient (Wt = 50 Kg) you are asked to mix 300 mg of Dopamine in 100 mL of 5% Dextrose Water. How many mL will your patient be receiving each hour if the doctor order is 3 Mcg/kg/min.?
    a. 1.0
    b. 2.0
    c. 3.0
    d. 4.0

11. Your patient is written up for IV Metronidazole 500 mg every 8 hrs. This comes pre-packed in 100 mL bag (Metronidazole 500 mg/100 mL). The MIMS suggest that this drug should be administered at a rate of 5 mL/min. Over what period of time will you administer the Metronidazole?
    a. 10.0
    b. 15.0
    c. 20.0
    d. 25.0

12. The doctors have ordered an infusion of 1500 mL of 5% Dextrose to be given at the rate of 50 drops per minute. Assuming a drop factor of 20 drops per mL, how many hours will it take for this infusion to complete?
    a. 05.0
    b. 10.0
    c. 15.0
    d. 20.0

13. A 34 kg child is ordered Erythromycin 40mg/kg/day, with 4 doses per day. How many mg per dose he should take?
    a. 300
    b. 340
    c. 360
    d. 370

DRUG CALCULATION POST-TEST		
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14. Calculate the volume in mL of Diamorphine you would need to draw up from stock available in 10 mcg per 2 mL of solution, to give the ordered dose of 1.5 mcg.
    a. 0.1
    b. 0.2
    c. 0.3
    d. 0.4

15. The order is for 60mg. The label reads 60 mg/2 mL. You would give _____mL.
    a. 1.0
    b. 2.0
    c. 3.0
    d. 4.0

16. The order is for 1000 mL of I.V. solution to be infused at 125 mL/hr. You would infuse the solution for _____ hours.
    a. 2.0
    b. 5.0
    c. 8.0
    d. 12.0

17. The order is for 6000 mL of IV solution to run over a 24 hour period. The drop factor of the I.V tubing is 10 gtt. /mL. You would infuse _____gtt. /min.
    a. 32.0
    b. 42.0
    c. 52.0
    d. 62.0

18. Your patient weighs 75 kg and you are ordered to infuse 250 mg Dobutamine in 500 mL N/S at 10 mcg/kg/min. How many milligrams of Dobutamine will infuse per hour?
    a. 45.0
    b. 50.0
    c. 55.0
    d. 60.0

19. The order is: KCl 30 mEq PO Bid pc. Available: KCl 45 mEq/15 mL. How many mL of KCl should you administer?
    a. 5.0
    b. 10.0
    c. 15.0
    d. 20.0

20. The order is for 25 mg. The label reads 75 mg/mL. How many mL would you give?
    a. 0.22
    b. 0.33
    c. 0.44
    d. 0.55

21. The order is for 1.5 gm. The label reads 1 tablet equals 3 g How many tablet (s) would you give?
    a. 0.5
    b. 1.0
    c. 1.5
    d. 2.0

22. The order is for 400mcg of Thyroxin. The label reads 0.2 mg tablets. How many tablets would you give?
    a. 1.0
    b. 2.0
    c. 3.0
    d. 4.0

23. The order is Penicillin G 1.2 million units IM daily. Available: Penicillin G 9 million units/1 mL. How many mL will you give?
    a. 0.10
    b. 0.11
    c. 0.12
    d. 0.13

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Correct answers

1.	62.5 mL/hr.
2.	56 gtt/min
3.	8 mL
4.	8:20 pm
5.	No (Slow)
6.	42 gtt/min
7.	4.6 mL
8.	255 mcg/min
9.	3 mL/hr
10.	20 min
11.	10 hr's
12.	340 mg per dose
13.	0.3 mL
14.	4 mL
15.	2mL
16.	8 hr's
17.	42 gtt/min.
18.	45 mg/hr.
19.	10 mL
20.	0.33 mL
21.	0.5 tablet
22.	2 tablets
23.	0.13 mL

PRIME SURGICAL CENTERS

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HIGH ALERT MEDICATIONS INCLUDING LOOK-ALIKE AND SOUND-ALIKE MEDICATIONS (LASA)		
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HIGH ALERT MEDICATIONS INCLUDING LOOK-ALIKE AND SOUND-ALIKE MEDICATIONS (LASA)

POLICY STATEMENT

This policy is formulated for Prime Surgical Centers Healthcare Providers to establish safe medication practices for High Alert medications throughout all clinical areas in order to protect patients from medication errors or significant adverse reactions resulting from the use of the High Alert medications.

DEFINITIONS

1. **Brand Name** – A distinctive name identifying a pharmaceutical product. A standardized pharmaceutical product from a single company may have different trade names in different countries or be supplied from different manufacturers with different brand names
2. **High-Alert Medications** – Are those medications involved in a high percentage of errors and / or sentinel events, medications that carry a higher risk for adverse outcomes, as well as look-alike/ sound-alike medications. Suggested list of high-alert medications is given as Annexure I.

CONCENTRATED ELECTROLYTES

1. Magnesium Sulfate 50 % or more concentration
2. Potassium Chloride 2 mmol/ml or more concentration
3. Potassium Phosphate 3 mmol/ml or more concentration
4. Sodium Chloride hypertonic (greater than 0.9%)

Look-Alike and Sound-Alike Medications (LASA) –

Medications that can look alike (presentation, strength, appearance and name) or sound alike (pronunciation) leading to avoidable mix-ups.

Tall Man Lettering –

A system in which part of a drug's name is written in upper case letters to help distinguish LASA medications from one another in order to avoid medication errors e.g. on storage shelves.

PROCEDURE / PROCESS

1. In Prime Surgical Centers, concentrated electrolytes shall be considered as **high-alert** Medications
2. Prime Surgical Centers shall be responsible to develop and get approval of their own High-alert Medications list including (LASA) specific to their services and establish risk reduction strategies to avoid errors. Suggested list of LASA is given as Annexure II.
3. Administrative Head of the Center will approve the list.
4. The storage of concentrated electrolytes should not be allowed in patient care units in Prime Surgical Centers.

5. A pre-diluted IV electrolyte solution may be stocked in the Nursing Station.
6. If the IV Admixture Pharmacy is not operating twenty four hours a day (24 hrs), seven days a week (7days) and the electrolyte is not available as a premixed solution, the patient care unit may stock the minimum needed quantity of concentrated electrolyte injection but only if there is no practical and safer alternative.
7. A concentrated electrolyte should be labeled in **red "High-alert"** and with direction "must be diluted before use".
8. When concentrated electrolytes are stocked in the Nursing Station, it should be dispensed by Pharmacy (its own delivery bag, not containing any other item). They must be segregated from other floor stock and clearly labeled and stored in a manner that has restricted access.
9. Storage of High Alert medications, other than concentrated electrolyte in the Nursing Station should be limited.
10. Stocks of High Alert medications, except LASA, should be identified by **Red Color** labels and the storage shelves in pharmacy and all clinical areas.
11. TallMan lettering or distinctive color flag or separation should be used in labeling the storage shelves of LASA medications to alert users.
12. Physicians, nurses and Pharmacist should be educated about the management and use of High Alert medication through in-service education.

Look Alike, Sound Alike Medication (LASA) Protocol

1. It is the most common cause of medication error. Due to thousands of drugs in the market, many drug names look or sound like other drug names. The contributing factors in these errors are as follows:

   a. Illegible handwriting
   b. Incomplete knowledge of drug names (new products)
   c. Similar packaging or labeling
   d. Similar clinical use
   e. Similar strengths, dosage, frequency of administration

2. Managing the risks associated with LASA medications:

   a. Annually reviewing the LASA medication used
   b. Minimize the use of verbal and telephone orders
   c. Emphasize the need to carefully read the label each time a medication is accessed
   d. Emphasize the need to check the purpose of the medication on the prescription/order and prior to administering the medication, check for an active diagnosis that matches the purpose/indication.
   e. Include both the generic name and the brand name of the medication on medication orders and labels.

f. Avoid confusion or misrepresentation caused by illegible prescriptions or medication orders by:

   i. Printing of drug names and dosages

   ii. Emphasize drug name differences using bold / Tallman lettering

g. Store problem medications in separate locations or in non-alphabetical order, such as bin number and on shelves. Avoid storage of look-alike medications at one place.

h. Use techniques such as bold letters and color differences to reduce the confusion associated with the use of LASA names on labels, storage bins, shelves, computer screens and medication administration records.

i. Provide patients and their caregivers with written medication information, including indication, generic, brand names and potential side effects.

Taxonomy of Patient Safety

There are a number of terms and definitions used in the context of patient safety.

Some of the definitions are given below.

1. **Safety:** Freedom from Hazard
2. **Hazard:** A circumstance, agent or action that can lead to or increase risk.
3. **Circumstance:** Any factor connected with or influencing an event, agent or person(s).
4. **Event:** Something that happens to or involves a patient.
5. **Adverse Event:** Defined as an injury caused by medication management rather than by the underlying disease or condition of the patient
6. **Patient Safety:** It is defined as the freedom from accidental injury due to medical care or from medical error.
7. **Healthcare Associated Harm:** Harm arising from or associated with plans or actions taken during the provision of healthcare rather than an underlying disease or injury.
8. **Patient Safety Incident:** An event or circumstance which could have resulted or did result, in unnecessary harm to the patient.
9. **Error:** Failure to carry out a planned action as intended or application of an incorrect plan.
10. **Violation:** Deliberate deviation from an operating procedure, standard or rules.
11. **Risk:** The probability that an incident will occur.
12. **Harm:** Impairment of structure or function of the body and / or any deleterious effect arising thereof.
13. **Injury:** Damage to the tissues caused by an agent or circumstance.
14. **Disability:** Any type of impairment of body structure or function, activity limitation and / or restriction of participation in society, associated with past or present harm.
15. **Near Miss:** An incident that did not cause harm.

HIGH ALERT MEDICATIONS INCLUDING LOOK-ALIKE AND SOUND-ALIKE MEDICATIONS (LASA)		
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16. **System Failure:** A fault, breakdown or dysfunction within an organization's operational methods, process or infrastructure.
17. **System Improvement:** The result or outcome of the culture, processes and structures that are directed towards the prevention of system failure and improvement of safety and quality.
18. **Sentinel Event:** An unexpected occurrence, involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome.
19. **Hazardous Condition:** Any set of circumstances (exclusive of the patient or the condition for which the patient is being treated) that significantly increase the likelihood of a serious adverse outcome.
20. **Patient Safety Solutions:** It is defined as any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of healthcare.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE II
(Refer to Nursing Manual Policy and Procedure No. 37)

LIST OF LOOK-ALIKE AND SOUND-ALIKE (LASA) MEDICATION

DRUG NAME		CONFUSED DRUG NAME	
AMILOride	[Midamor]	**AMLO**dipine	[Acedip]
Bu**PRO**Pion	[Bupron]	Bu**SPIR**one	[Buspar]
Di**FLU**can	[Fluoconazole]	Di**PRI**van	[Propofol]
Do**PAM**ine	[Cardopa]	Do**BUT**amine	[Dobutrex]
Es**MOL**ol	[Brevibioc]	Es**MER**on	[Rocuronium]
Epi**NEPH**rine	[Adrenalin]	Ephe**D**rine	[Alergin]
Flu**OXE**Tine	[Alpradon]	Flu**PHEN**azine	[Modecate]
Gli**BENC**lamide	[Glucovance, Glucomet]	Gli**MEP**Iride	[Amaryl]
Hydr**OXY**zine	[Atarax]	Hydr**ALAZ**ine	[Apresoline]
Huma**LOG**	[Insulin Lispro]	Humu**LIN**	[Insulin Reg]
Lami**SIL**	[Tervina]	Lami**CTAL**	[Lamotrigine]
Peni**CILLIN**	**[**Bacampicillin**]**	Peni**CILLAMINE**	[D. Penamine]
Tacro**LIMUS**	[Prograf]	Siro**LIMUS**	[Rapamycin]
Zan**TAC**	[Ranitidine]	Zyr**TEC**	

SAFETY MEASURE: Use **TALL**man letters and Store separately.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

FEMALE URETHRAL CATHETERIZATION – POST TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 38** **Page: 1 of 2**
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FEMALE URETHRAL CATHETERISATION - POST TEST

Name: _____ Date: _____

Designation: _____ Unit: _____

(Select the best answer and encircle the corresponding alphabet)

1. A reason for female urinary catheterization is :
   a. Monitoring urinary out put
   b. Urodynamic investigations
   c. Instillation of cyto-toxic drugs
   d. All of the above

2. What percentage of catheterized patient develops a urinary tract infection?
   a. 1-4
   b. 2-6
   c. 13
   d. 20-30

3. How long is the female catheter?
   a. 20-26 cm
   b. 14 cm
   c. 40-45 cm
   d. 50 cm

4. Polytetrafluoroethylene-coated catheters usually have a lifespan of :
   a. 7 days
   b. 21 days
   c. 28 days
   d. 84 days

5. A local anaesthetic suitable to aid catheter insertion is:
   a. Chlorohexadine
   b. Lidocaine
   c. Hydrophilic polymer
   d. 0.9%sodium chloride

FEMALE URETHRAL CATHETERIZATION – POST TEST		
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6. Equipment required for catheterization includes:
   a. Good lighting
   b. Appropriate urinary catheter
   c. Cleansing solution
   d. All of the above

7. A benefit of using a catheter valve is:
   a. Maintenance of blood supply to the bladder Wall
   b. It cannot be used for short term catheterization
   c. Reduce bacterial colonisation
   d. It allows the bladder to contract

8. A catheter of 40-50 cm may be used to catheterize:
   a. Female
   b. Children
   c. Male
   d. Infants

9. Why catheters might be unsuitable for use on confused patients?
   a. They may pull the catheter out causing trauma
   b. They have impaired bladder sensation
   c. They have renal impairment
   d. They have haematuria

10. What procedure might be useful if the urethral orifice cannot be easily identified?
    a. Suprapubic catheterization
    b. Vaginal Insertion
    c. Digital guidance
    d. Intermittent self-catheterization

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PHLEBOTOMY BY STAFF NURSES		
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PHLEBOTOMY BY STAFF NURSES

PURPOSE

To provide guidelines to obtain blood sample for clinical laboratory testing.

DEFINITIONS

Phlebotomy -refers medical intervention in which the removal of blood is performed for the Laboratory investigations.

POLICY

1. Phlebotomy is a medical intervention and requires a physician's order
2. Phlebotomy can be performed by a qualified staff Nurse after IV therapy certification from Prime
3. Surgical Center.

PROCEDURE

1. REQUIRED ITEMS
    a. Disposable gloves
    b. Tourniquet
    c. Syringe 10 cc. and 21X1 needle or vacutainer and adapter with 21X1 multiple sample needle.
    d. Vacutainer Tubes
    e. Proper laboratory investigation requisition slips correctly, legibly and completely filled out.
    f. Alcohol sponges.
    g. Clean dry cotton balls.
    h. Paper tape.

ACTION	RATIONALE
1. Introduce self and explain the procedure to patient	To obtain cooperation; it will lessen fear and resistance.
2. Perform hand hygiene. Wear exam gloves while performing the procedure. Communicate with the patient throughout the procedure	Prevent self/patient contamination during procedure.
3. Select site for venipuncture. Inspect both arms to find and use the best vein.	Ante-cubital fossa is usually best site. Be sure patient is comfortable and well supported, either sitting or lying down.

PHLEBOTOMY BY STAFF NURSES		
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4. Assemble syringe and needle/vacutainer. Ensure proper lighting of the room	Syringe is preferable for fragile, collapsible veins. If using an adapter, assemble necessary tubes in an accessible location. Nurse makes herself comfortable during the procedure by sitting on a chair. Have spare tubes in case a tube with no vacuum is encountered. **Note:** A tube may be introduced onto the needle inside the adapter, but only up to the line on the adapter; going further will penetrate the stopper and destroy the vacuum.
5. Lightly apply tourniquet half way between shoulder and elbow. Do not leave on for more than 2 min.	Use light to moderate pressure to distend veins enough to permit visualization or palpation.
6. Lightly palpate vein with fingertip. Keep the arm flat and extended.	
7. Prepare the puncture site by rubbing vigorously in a 2-3 inch radius with 70% isopropyl alcohol. Allow alcohol to dry	Disinfect puncture site.
8. Remove needle guard. Turn needle so that bevel is facing upward.	
9. Anchor skin and vein below puncture site with free thumb.	Prevent vein from rolling or sliding away from needle.
10. Align syringe/adapter with vein and puncture skin and vein with a smooth, gentle motion.	Do not go all the way through the vein. When using a syringe, blood will appear in the neck of the syringe when the vein is entered.
11. If using a syringe, withdraw the plunger smoothly. If using an adapter, brace the adapter with your holding hand and push the vacutainer tube onto the vacutainer needle with your free hand. Fill additional tubes as needed.	Pulling too hard on a syringe plunger will hemolyze the blood. Be careful not to move the needle when pushing or pulling Vacutainer tubes on and off.
12. When sufficient blood has been collected, remove the tourniquet. Withdraw the syringe/adapter and needle from the puncture site. Place a clean, dry cotton ball over the puncture site and apply pressure for at least one minute.	Remove the vacutainer tube from the adapter needle before withdrawing the needle from the vein; otherwise several drops of blood are likely to drip out of the needle. Note: Applying pressure to puncture site with an alcohol soaked cotton ball actually lengthens the clotting process. Inadequate pressure will lead to bleeding and/or bruising and/or hematoma.
13. If using syringe, puncture the top(s) of the required tube(s) with the needle and allow the tubes to fill via vacuum.	

14. Dispose of needle using established Hospital Infection Control Manual Policy & Procedure No. 18 **Note:** do not recap.	Prevent self-contamination with Individual's blood
15. Gently invert 8-10 times to mix the blood and the anticoagulant.	Vigorous mixing or shaking will hemolyze the blood.
16. Inspect puncture site; if indicated, apply clean, dry cotton ball and tape in place or use Band Aid	Prevent delayed bleeding.
17. Label specimen tubes with Patient's full name, ID number, MR No., I.P. No., Bed No., date, and initials of staff who drew the blood.	Proper identification of specimen. Initial has to be verified by full name.

Note: If after 3 attempts you are unable to obtain a blood specimen, notify physician for assistance.

DOCUMENTATION

1. Document the patient's data, blood drawn and site drawn from, test ordered, time, date and when sent to the Laboratory.
2. Document the patient's response to the procedure.
3. Sign and affix name of staff completing note.

TRANSPORTATION OF LABORATORY SAMPLES

Since the laboratory services have been outsourced by Prime Surgical Centers, it will be the responsibility of the outsourced agency, in present context Metropolis Golwilkar Laboratory to transport various samples and make available the results at mutually appointed time. Concerned nursing units will however be responsible to hand over samples where drawn by nurses to the outsourced agency's representative.

PRIME SURGICAL CENTERS

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NURSING MANUAL

INTRAVENOUS THERAPY		
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INTRAVENOUS THERAPY

DEFINITION

Intravenous infusion is the introduction of fluid/electrolyte and/or medication directly into a vein. It is used to hydrate tissue, give nourishment, restore volume, and to administer medication.

PURPOSE

To provide the patient undergoing surgery with a safe, sterile intravenous route. As an adjunct to anaesthesia for medication administration and hemodynamic support.

To ensure that an established procedure on IV bolus / push, Heparin Lock (Saline caps), continuous & intermittent IV medication.

SCOPE

All Nurses certified in IV therapy by Prime Surgical Centers.

POLICY

1. All adult patients receiving general or local standby anaesthesia will have an intravenous access route started in the nursing unit by the nursing staff or Anaesthesiologist prior to surgery.
2. Patients receiving local anaesthesia may have an intravenous infusion or a heparin reseal started prior to surgery at the request of the surgeon.
3. Nurses who have completed an intravenous therapy course may start an intravenous infusion, adjust drip rates, and do IV therapy as ordered by the physician.
    a. Ensure that Physician's order is legible, accurate and complete before starting IV which will include the following
        i. Date and time of the order
        ii. Type and amount of solution and medication
        iii. Additives and the concentration
        iv. Rate or volume of the infusion
        v. Physician’s signature, stamp and date
    b. Nurses administers intravenous medication via Heparin Lock (Saline caps) IV bolus/ push, piggyback, continuous or intermittent IV therapy as ordered by the physician.
    c. When intravenous medications are required the Nurse is responsible for mixing the appropriate medication with the appropriate solution for administration to the patient.

    When the Nurse mixes Potassium Chloride (KCL) in the IV, the dosage must be double checked with another nurse /physician prior to mixing it in the solution.

INTRAVENOUS THERAPY		
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4. The intravenous tubing, including add-on devices, is replaced no more frequently than at 72-hour intervals, unless clinically indicated.
5. The IV dressing is replaced when the catheter is removed or replaced, or when the dressing becomes damp, loosened, or soiled. Dressings are replaced more frequently in diaphoretic patients.
6. All Nurses utilize IV Skill Competency Checklist Criteria (Refer to Nursing Manual Policy and Procedure No. 49)

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NURSING EDUCATION AND TRAINING MODULES

INTRAVENOUS THERAPY: POST TEST FOR CERTIFICATION		
Module Applies To	**All Nurses and Technicians**	**Module No: 39** **Page: 1 of 4**
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INTRAVENOUS THERAPY- POST TEST FOR CERTIFICATION

Name: _____ Date: _____

Designation: _____ Unit: _____

Instructions: Select the best / correct answer and circle the letter.
Only one answer to each question.

1. Which of the following is not a purpose of IV therapy?
   a. To maintain fluid and electrolyte balance
   b. To provide parenteral nutrition
   c. To administer medication
   d. To provide enteral nutrition

2. An advantage of IV therapy is
   a. Rapid administration of solutions and medication
   b. Gradual systemic changes
   c. Difficult to access
   d. Limited time use

3. Rapid administration of IV drugs may result in
   a. Reversible adverse effects
   b. No adverse effect
   c. Irreversible adverse effects
   d. Some adverse effect

4. When teaching a patient about IV therapy, which instruction would be most appropriate?
   a. Expect the IV fluid to feel warm at first
   b. Anticipate slight discomfort throughout the infusion
   c. Plan to keep the arm immobilized during IV therapy
   d. Call the nurse if the alarm sounds during the infusion

5. When selecting a site for IV therapy, why should one avoid using a vein on the inner arm?
   a. The vein would be small and thick-walled
   b. This site is prone to bruising and phlebitis
   c. Use of this site would interfere with blood sampling
   d. Use of this site could compromise circulation to the hand

6. When palpating a patient's arm or hand for a suitable vein, the most suitable vein for Venepuncture should feel:
   a. Elastic and flat
   b. Firm and round
   c. Engorged and hard
   d. Elastic and puffy

7. Which type of IV solution pulls fluid and electrolytes from the intracellular compartments into the intravascular compartment?
   a. Isotonic
   b. Hypertonic
   c. Isobaric
   d. Hypotonic

8. Which of the following solutions is Hypotonic?
   a. Dextrose 5% in Lactated Ringer's solution
   b. Dextrose 5% in 0.9% Sodium Chloride
   c. 0.9% Sodium Chloride (Normal Saline)
   d. 0.45% Saline

9. Which technique is **not** helpful in distending a vein?
   a. Applying a tourniquet tightly enough to trap venous blood
   b. Flicking the skin over the vein with your forefinger
   c. Having the patient make a tight fist several times
   d. Apply a cold pack

10. What is the best way to apply a transparent dressing to an IV site?
    a. Cover the cannula and hub with the dressing
    b. Cover the insertion site and tubing with the dressing
    c. Stretch the dressing over the catheter and hub
    d. Tape it down securely, using a chevron or similar pattern

11. When documenting the insertion of venepuncture device that you have just completed, you do not need to include which of the following data?
    a. Number of the solution container
    b. Type of venepuncture device
    c. Prescribing Physicians name
    d. Your name

INTRAVENOUS THERAPY: POST TEST FOR CERTIFICATION		
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12. Anil Deshpande, age 49, is about to be discharged with an intermittent infusion device and will be receiving IV therapy at home. Which information should you teach him before discharge?
    a. How to use an infusion pump
    b. How to recognise extravasation
    c. How to flush his infusion device
    d. All of the above

13. The Physician has just ordered Ranitidine IV for Mohan Apte, age 64, who is already receiving Dextrose 5% In Lactated Ringer's solution. You realize that the drug is not compatible with the solution that is running. What should you do?
    a. Ask the Physician to prescribe a different drug
    b. Add a filter to the line and administer the drug
    c. Dilute the drug and administer it with the solution
    d. Give bolus injection

14. Shobha Kulkarni, age 70, requires Gentamicin IV through an intermittent infusion device. When should you flush the device?
    a. Before administering the drug
    b. While administering the drug
    c. After administering the drug
    d. Before and after administering the drug.

15. While making rounds in the unit, you assess Susheela Kale, age 76, and notice that her IV is infusing slowly, even after you open the flow regulator all the way. Which of the following factors would not affect the patient's IV flow rate?
    a. Type of administration set
    b. Viscosity of the IV fluid
    c. Length of the venepuncture device
    d. Height of the IV solution container

16. You are assessing Mahesh Pathan, age 58, who is receiving Dextrose 5% in Lactated Ringer's solution by IV to treat dehydration. Your assessment reveals increased blood pressure, neck vein distension, an increased difference between her fluid intake and urine output, and crackles on lung auscultation. What complication of IV therapy should you be alert for?
    a. Septicaemia
    b. Air embolism
    c. Allergic reaction
    d. Circulatory overload

INTRAVENOUS THERAPY: POST TEST FOR CERTIFICATION		
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17. During IV therapy, Ryan Tellis, age 56, develops a fever and chills for no apparent reason. What should you suspect is causing his signs and symptoms?
    a. Nerve damage
    b. Systemic infection
    c. vasovagal reaction
    d. Circulatory overload

18. You have just discontinued IV therapy for Richard Thomas, age 52. When documenting this procedure, which information does not need to be included?
    a. Physicians name
    b. Condition of site
    c. Time and date of removal
    d. Reason for discontinuing therapy

Circle either true or false for the following statements:

19. The IV route is not the preferred route for administering drugs in an emergency

    ☐ True ☐ False

20. When discontinuing an infusion, you should maintain aseptic technique and use an alcohol pad to clean the site.

    ☐ True ☐ False

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NURSING MANUAL

INTRAVENOUS THERAPY: VENIPUNCTURE AND IV INFUSION PROCEDURE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 40** **Page: 1 of 3**
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INTRAVENOUS THERAPY: VENIPUNCTURE AND IV INFUSION PROCEDURE

REQUIRED ITEMS

1. IV Tray with antiseptic solution (Alcohol/Betadine)
2. Prescribed IV Solution
3. Tourniquet
4. IV Catheter/needle
5. Tape / site dressing / Easy fix
6. Label for IV Infusion
7. Administration sets / IV tubing.
8. Disposable gloves
9. IV Stand

ACTION	RATIONALE
1. Perform hand hygiene	Good medical asepsis will help prevent contamination during IV procedure.
2. Assemble required items	To expedite the procedure.
3. Approach and identify patient. Introduce yourself if not already done earlier and explain the procedure and rational for venipuncture.	To elicit patient cooperation and reduce apprehension.
4. Ensure that light is adequate to perform the procedure.	To provide optimum environment.
5. The nurse uses a comfortable position to perform procedure, may be by sitting on a chair at the bedside.	In order to start an IV, it is equally important to be in a comfortable position as it is for the patient.
6. Wash hand and put on disposable gloves. Select IV site as distal as feasible. Do not hesitate to examine both arms carefully, or to switch from one arm to the other before attempting a venipuncture.	To prevent contamination of hands by blood. Veins below an infiltrated or phlebetic site may not be usable if they lead into the network of the affected vein.
7. Apply tourniquet above selected site in a slip knot on a single bone.	To ensure proper distention of the vein.
8. Ask patient to open and close his hand repeatedly, then to relax entire extremity.	To facilitate visibility and palpation of the vein.

INTRAVENOUS THERAPY: VENIPUNCTURE AND IV INFUSION PROCEDURE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 40** **Page: 2 of 3**
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9. Cleanse skin with an antimicrobial skin preparation such as Alcohol / Betadine. Start cleaning the area from the entry point moving with a circular motion away from it, cleaning the skin thoroughly at and around the selected vein.	To remove contaminating bacteria on the skin as much as possible. If the area is hairy, clip the hairs before commencing to attempt to start the IV, both for aseptic reasons and to prevent the tape from pulling.
10. Insert the IV Catheter Using the thumb of the non dominant hand, gently retract the skin away from the site. Holding the needle at about a 45° angle, with the bevel up, pierce the skin immediately beside the selected vein. When the needle is through the skin decrease the angle until it is almost parallel with the skin, and enter the vein.	When blood comes back into the tubing or syringe or flashback chamber (depending on the device used), insert the needle or catheter almost the full length (Follow the package instructions for the use of any other device.)
11. Release the tourniquet. Holding the needle or other device steadily with the dominant hand, release the tourniquet with the other hand. Apply gentle pressure with index finger of nondominant hand 1 ¼ inches above site.	
12. Anchor the cannula and insertion site securely with Easy fix.	
13. Connect the tubing to the IV tube and initiate the flow. Remove the protective cap from the IV tubing (maintaining sterile technique), connect it securely to the needle, and open the regulator to initiate the flow.	This should be done quickly to prevent the patient's blood from clotting and clogging the needle.
14. Adjust the flow rate.	
15. Label the insertion site with: a. Date and Time b. Gauge number. Label the IV Tubing with date and time. Label the IV Bag with: a. Date and Time b. Name and Amount of the solution c. In case of additive and the concentration, rate of infusion (per hour and drops per minute) d. Completion time e. Signature of the nurse	

INTRAVENOUS THERAPY: VENIPUNCTURE AND IV INFUSION PROCEDURE		
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16. Dispose off the equipment according to Infection Control (Refer Hospital Infection Control Manual Policy and Procedure No. 29)	
17. Remove gloves	
18. Wash hands	
19. Teach the patient how to protect the IV	According to patient family teaching protocol.
20. Documentation according to Prime Surgical Centers policy	

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NURSING EDUCATION AND TRAINING MODULES

MEDICAL ADMINISTRATION - TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 40** **Page: 1 of 3**
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MEDICAL ADMINISTRATION - TEST

Name: _____ Date: _____

Designation: _____ Unit: _____

1. Answer the following questions by placing (T) for True statements and (F) for False statements.
   a. If the medication order is illegible or inappropriate to the patient's condition, nurses have the right to refuse to carry out the drug order. ---
   b. Patient's allergies to be written in black ink on the space provided. ---
   c. Only one controlled narcotic drug should be prescribed in each prescription. ---
   d. The expiry of narcotic and controlled drugs floor stock must be checked at least monthly. ---
   e. In order to prevent medication error, all professional handling medications should exercise the "check 3 times and 7 rights system". ---
   f. Any unused medication should be stored for later use or to be used for other patient. ---
   g. Any medication error must be reported as soon as recognized to minimize the possible negative outcome. ---

Please select the correct answer by encircling the alphabet:

2. In case of physician verbal / telephone orders:
   a. Verbal / telephone orders are immediately written by the staff receiving the order and must be carried out after read back.
   b. Verbal / telephone orders are immediately written by the staff receiving the order and is read back to the physician for verification of accuracy.
   c. Verbal / telephone orders are immediately written by the staff receiving the order, read back to the physician for verification of accuracy, sign and dated by the staff receiving the order.
   d. Verbal / telephone orders are immediately written by the staff receiving the order, read back to the physician for verification of accuracy, sign and dated by the staff receiving the order and to be countersigned by the physician within 24 hour.

3. Physician verbal / telephone orders will not be accepted for:
   a. Chemotherapeutic agent
   b. Investigational drugs
   c. DNR
   d. All of the above

4. How long after blood and blood component have been issued to the unit should it be administered?
   a. 15 minutes
   b. 30 minutes
   c. 45 minutes
   d. 60 minutes

MEDICAL ADMINISTRATION - TEST		
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5. You are the nurse assigned for Ms. Rana ,Case of post appendectomy .You have started one unit of PRBC at 1100H as Ms Rana's Hb was 8mg/dl .At 1115H Ms. Rana complained of fever and temp is 38C

   State your actions below:

6. You dropped a an ampoule of inj Pethidine while taking out from the narcotic cabinet

   State your actions below:

MEDICAL ADMINISTRATION - TEST		
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7. How do you manage if patient develops an adverse drug reactions?
   State your actions below

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NURSING MANUAL

INTRAVENOUS THERAPY: INSERTING A WINGED-TIP NEEDLE OR BUTTERFLY NEEDLE PROCEDURE		
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INTRAVENOUS THERAPY: INSERTING A WINGED-TIP NEEDLE OR BUTTERFLY NEEDLE PROCEDURE

PROCEDURE

1. Select a winged-tip needle (a 20 to 22 gauge needle is adequate for an adult). (Winged tip needles are used in short term therapy with adults and elderly Individuals who have small fragile veins.)
2. Carefully affix end of IV administration tubing to end of winged-tip needle. Remove sterile cover from needle. Run fluid through needle.
3. Hold needle by its wings.
4. Anchor vein by placing your thumb below the patient's vein and gently stretching the skin by pulling down distally.
5. With bevel of needle up, enter Individual's skin at an angle. Use either of these methods:
   a. Enter skin at an angle either next to or alongside the vein. Flatten angle once needle is under skin and enter vein from the side.
   b. Enter skin and vein in one smooth motion from above. You will feel a gentle "pop" or release as the needle enters the vein. Observe for flashback of blood in needle tubing.
6. Advance needle carefully through the course of the vein
7. Release tourniquet.
8. Open clamp on IV tubing and observe drip chamber.
   (Fluid should flow easily, and there should be no sudden swelling around IV site.)
9. Reduce flow rate to keep open until you have taped the needle and tubing in place.
10. Cover site with sterile two-by-two inch strips or transparent semi-permeable adhesive dressing.
11. Tape winged-tip needle and tubing to patient's skin.
12. Set drip rate.
13. Document according to Prime Surgical Center's policy (Refer to Nursing Manual Policy and Procedure No. 3).

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NURSING EDUCATION AND TRAINING MODULES

NURSING PROCESS - TEST		
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NURSING PROCESS - TEST

Name: _____ Date: _____

Designation: _____ Unit: _____

1. Classify the following data as subjective (S) or objective (O) and identify as primary (P) or secondary (S) source data.
   a. You read in the medical record that the client's blood pressure is 130/75mmHg._____ _____
   b. The Patient's husband says she has difficulty swallowing food. _____ _____
   c. You observe the client is pale. _____ _____
   d. Ravi states: "I can't sleep". _____ _____
   e. Nursing progress notes state that: 'the client has rapid & shallow breathing' _____ _____
   f. You auscultate wheezes in the client's left lung. _____ _____

2. Identify which of the following data should be validated (V).
   a. The client tells you that he is not anxious about his scheduled operation today. He is lying quietly in bed with no obvious muscle tension. His hands are still and his skin appears warm and dry. _____
   b. The client says: "On a scale of 1 to 10, the pain is 10. The worst I can imagine". Less than 5 minutes ago, you observed the client talking on the telephone in a normal tone of voice and laughing. _____
   c. The client claims that he does not smoke cigarettes. You observe that his teeth and fingers are brown stained. _____
   d. The mother states that her son eats a lot of food. You observe that the child is thin and small for his age. _____

3. Match the diagnostic label with the defining characteristics
   a. ineffective airway clearance
   b. ineffective breathing patterns
   c. sensory/perceptual alterations
   d. impaired swallowing

____ Coughing, choking, or gagging: food falls from the mouth; drooling

____ Orthopnea, use of accessory muscles to breathe, dyspnea, shortness of breath, nasal flaring

____ Restlessness, poor concentration, visual distortions, irritability, change in usual response to stimuli

____ Diminished breath sounds, ineffective cough, cyanosis, changes in respiratory rate & rhythm

4. Write a nursing diagnostic statement for each of the following:

   a. Patient is obese, undernourished and demonstrates limited knowledge regarding what foods contribute to a healthy diet.

   b. Patient is 83 years old, frail, underweight, immobilized and with 'paper thin' skin.

   c. Patient is an uncontrolled diabetic with complications including diminished peripheral circulation.

   d. Patient is very anxious and stressed re her current health status; she is crying continuously and unable to listen to what any of the health professionals have to say about her condition and proposed treatment. Client states that they have always been easily stressed and they have been prescribed medication in the past to reduce their stress levels and anxiety.

5. Identify which of the following outcomes are measurable (M).

   a. Will be progressively less anxious. _____

   b. Will eat fruit at least 3 times per day. _____

   c. Body temperature will be < 38oC within 24hrs. _____

   d. Will explain the importance of exercise. _____

   e. Blood pressure will return to normal. _____

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NURSING MANUAL

INTRAVENOUS THERAPY: INSERTING HEPARIN LOCK FLUSH (SALINE CAPS) PROCEDURE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 42** **Page: 1 of 2**
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INTRAVENOUS THERAPY: INSERTING HEPARIN LOCK FLUSH (SALINE CAPS) PROCEDURE

DEFINITION

An intermittent infusion set (heparin lock/saline lock) is an indwelling reservoir in the vein for intermittent infusion therapy when continuous infusion therapy is not indicated. Periodic injections of heparin flush solution into the device keep the needle or catheter patent.

REQUIRED ITEMS

1. Male Adaptor Plug/Heparin Lock
2. Antimicrobial preparation (7% alcohol swab/povidone-iodine / Betadine)
3. Tape and gauze
4. Heparin lock flush solution as ordered by physician
5. Syringe for heparin/saline solution.
6. 5ml safety syringe for 3ml normal saline
7. Disposable gloves

PREPARATION OF REQUIRED ITEMS AND PATIENT

When continuous infusion therapy has been discontinued/not indicated and there is a need for intermittent infusion therapy for a patient who has an indwelling over-the needle catheter, a male adaptor plug may be inserted into the catheter to convert it to a heparin lock/saline lock.

ACTION	RATIONALE
1. Check the physician's order.	To determine proper authority to initiate heparin lock/saline lock, and medication.
2. Follow steps as per serial no. 1-5 of Procedure on Venipuncture and IV Infusion Procedure (Refer to Nursing Manual Policy and Procedure No. 40)	
3. Perform hand hygiene and put on gloves.	Medical asepsis.
4. Clean top of the 3-way stop lock or adaptor with antimicrobial.	
5. Allow to dry completely.	
6. Attach saline syringe to adaptor and open the clamp.	
7. Inject 3ml saline and disconnect the syringe.	
8. Flush the catheter with prescribed amount of heparin solution.	
9. Inject Heparin flush solution slowly and disconnect syringe.	

INTRAVENOUS THERAPY: INSERTING HEPARIN LOCK FLUSH (SALINE CAPS) PROCEDURE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 42** **Page: 2 of 2**
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10. Clamp the 3-way adaptor	
11. Dispose of items used according to Hospital Infection Control Manual Policy and Procedure no. 29	
12. Wash hands and document the procedure.	

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NURSING EDUCATION AND TRAINING MODULES

PATIENT SAFETY GOALS – POST TEST		
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PATIENT SAFETY GOAL – POST TEST

Name: _____ Date: _____

Designation: _____ Unit: _____

Circle the correct answer.

1. Correct patient identification must be done before:
   a. Administering medication
   b. Administering blood and blood products
   c. Collection of blood or other specimens
   d. Taking a patient out of bed
      i. a, b, c.
      ii. a, b, d.
      iii. a, b, c, d,
      iv. d.

2. When receiving a telephone order or result:
   a. Write it down on a piece of paper
   b. Write it in the patient's chart
   c. Read back and confirm the order or result
   d. Throw the paper away
      i. a, b, c, d.
      ii. b, c.
      iii. a, d.
      iv. a, c, d.

3. "Time out" is a process to:
   a. Ensure correct patient identity
   b. Ensure correct procedure, site and side
   c. Is time consuming and unnecessary
   d. Involve the multidisciplinary team
      i. a, b, c
      ii. b, c, d.
      iii. a, b, d.
      iv. a, d.

PATIENT SAFETY GOALS – POST TEST		
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4. Which of the following is **not** a Patient Safety Goal?
   a. Identify patients correctly
   b. Reduce the risk of patient harm resulting from falls
   c. Improve effective communication
   d. Ensuring correct diagnosis

5. Which of the following is **not** a component of identifying patient correctly?
   a. Complete name
   b. Bed number
   c. MR number
   d. All of the above

6. Who is authorized to give a telephone order?
   a. Nurse
   b. Physician
   c. Pharmacist
   d. Respiratory Therapist

7. Which of the following is **not** a component of the process of a telephone order?
   a. Write down the order and document that it has been confirmed
   b. Repeat the order back
   c. Telling another nurse that you have just taken a telephone order
   d. Confirmation of the order by the order giver

8. Which of the following is **not** a high alert medication?
   a. Potassium chloride
   b. 0.9% sodium chloride
   c. 50% Magnesium Sulphate
   d. Potassium phosphate

9. Who may mark a surgical or procedure site?
   a. Nurses
   b. The person who is capable of performing the procedure
   c. Physiotherapists
   d. All of the above

PATIENT SAFETY GOALS – POST TEST		
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10. When should the 'time out' be conducted?
    a. While obtaining informed consent
    b. While marking the site
    c. Just before the start of the surgery or procedure
    d. During pre-anaesthesia checks

11. **Where** should a 'time out' procedure be conducted?
    a. At the patient's bedside on the ward just before starting an invasive procedure
    b. Just before starting surgery in the Operating Theatre
    c. Just before conducting a radiological examination
    d. All of the above

12. When should you wash your hands?
    a. Before every patient contact
    b. When the hands are visibly soiled
    c. Before wearing clean gloves
    d. All of the above

13. Who is responsible for reducing the risk of patient harm resulting from falls?
    a. Hospital Executive Director
    b. Nurses
    c. Housekeeping staff
    d. All hospital employees

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

PATIENT SAFETY GOALS – POST TEST		
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State True (T) or False (F)

14. Two patient identifiers include patient's name and Medical Record Number. True False

15. The Physician who gave a telephonic order does not need to sign, date and stamp the order within 24 hours. True False

16. Look-alike, sound-alike medications must be identified by using TaLLmAn lettering. True False

17. Concentrated electrolytes are potentially harmful and therefore are allowed to be kept in the unit. True False

18. In order to reduce the risk for healthcare associated infections it is not necessary to wash hands between patients or procedures. True False

19. Contact with blood and body fluids requires nurses to wear gloves. True False

20. Fall risk criteria from the age of 3 to 70 years requires nurses to initiate the Fall Prevention Protocol. True False

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NURSING EDUCATION AND TRAINING MODULES

PROFESSIONAL CARING TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 43** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PROFESSIONAL CARING TEST

Name: _____ Date: _____

Designation: _____ Unit: _____

LET'S PLAY A WORD GAME: FIND OUT THE APPROPRIATE "C"

Please write the correct term in the blanks.

1. A nurse feels lazy to report on time for duty. Later she feels that what she is doing is not right and rushes to be on time. _____,she possesses the right knowledge, attitude and skills required to work in her clinical setting._____

2. My patient was crying in pain. I just got to her, held her hands and comforted her. _____

3. I feel comfortable when I take decisions _____

4. I want all nurses to be dedicated to their jobs. _____

5. I put my plans into actions non hesitantly _____

6. When a nursing aide reports to me that he has had a terrible night and indirectly meant to have a change in his area of assignment, I gave him a lighter assignment _____

7. I can assist in the endotracheal intubation and lead the Code Blue Team _____

8. I need to have certifications in my specialty to demonstrate my professional _____

9. I reported a medication error immediately to the physician _____

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NURSING EDUCATION AND TRAINING MODULES

SAFE PATIENT HANDLING - TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 44** **Page: 1 of 2**
Effective Date: 11 April, 2013		

SAFE PATIENT HANDLING - TEST

Name: _____ Date: _____

Designation: _____ Unit: _____

Please select the correct answer by encircling the alphabet

1. Ergonomics means:
   a. Making changes to the job to fit the worker
   b. Making changes to the worker to fit the job
   c. Making workers work harder at their jobs
   d. Selecting stronger workers for the job

2. The goal of the patient ergonomics is to:
   a. Slow down your work
   b. Help you feel and work better
   c. Increase your workload
   d. Make patients recover faster

3. Which of the following patient care tasks involve heavy lifting?
   a. Charting
   b. Talking with the patient
   c. Transferring an immobile patient
   d. Giving medications

4. Which of the following is a work environment factor that can reduce safety both for patient and caregiver?
   a. Caregiver educational level
   b. Uneven work spaces
   c. Patient BMI index
   d. No lift policy

5. While bending forward, you spend 30 minutes feeding a patient on bed rest. What is (are) the musculoskeletal risk factor(s) in this situation?
   a. Pushing/pulling
   b. Awkward posture
   c. Long duration
   d. Heavy lifting

SAFE PATIENT HANDLING - TEST		
Module Applies To	**All Nurses and Technicians**	**Module No: 44** **Page: 2 of 2**
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6. The purpose of assessing tasks and surroundings for risk factors is to
   a. Take steps to protect yourself
   b. Slow down your work pace
   c. Delay care to the patients
   d. Distribute the workload to staff

7. If you had to transfer a totally dependent patient from a nonadjustable stretcher to a nonadjustable bed of different heights, what is the best step you could take to reduce the environment risk factor?
   a. Use a friction reducing device when transferring
   b. Use a wide base of support when transferring.
   c. Coach the patient to make the transfer unaided.
   d. Use a wheel chair to transfer the patient.

8. A staff nurse asks you to help her perform a lift you feel is unsafe, what would be your best response?
   a. "I`m busy caring for another patient, but I will help find someone to assist.
   b. "What does the safe lifting algorithm say we need to move the patient?"
   c. "Let me check if I am allowed to help lift this patient."
   d. "Tell me how you would like me to assist you with moving the patient"

9. Why are mechanical aides needed for a patient handling?
   a. Nurses do not have sufficient training using proper body mechanics.
   b. Manual lifting techniques are not sufficient to protect nurses from injury.
   c. Body mechanics algorithm is too complicated and difficult to understand.
   d. Nursing staff levels have declined in most institutions in recent years.

10. Which of the following is Environment potential risk factors can be identified through your assessment?
    a. Flooring, obstacles and lighting, noise, temperature
    b. Skills, education & staff training
    c. Availability of assistance, workload, work flow.
    d. All of the above

PRIME SURGICAL CENTERS

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NURSING MANUAL

INTRAVENOUS THERAPY: SITE OBSERVATION AND PRECAUTIONS		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 45** **Page: 1 of 1**
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INTRAVENOUS THERAPY: SITE OBSERVATION AND PRECAUTIONS

ACTION	RATIONALE
1. Observe site. If needle has not entered vein correctly, the area at the needle site will begin to bulge and become discoloured by a collection of blood and fluid in the subcutaneous space. If this occurs, close the clamp on the tubing. Remove the needle quickly and apply firm external pressure over the area with a dry sterile sponge. Re-attempt above the first site or if necessary in the opposite arm.	Assure a successful venipuncture was made.
2. If venipuncture is unsuccessful after 2-3 attempts, request assistance from another certified Staff Nurse and notify the physician.	
3. Apply arm board if venipuncture site is near a joint or if additional support is needed. Do not apply constrictive tape above the I.V. insertion site.	Immobilize the area as necessary to prevent the needle from being dislodged.
4. Assist the Individual to a comfortable position.	
5. Check the I.V. every hour for pain, infiltration, inflammation, and proper rate of flow (air vent open, no kinks in tubing, proper operation of I.V. Controller).	

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 46)

INTAKE / OUTPUT CHART

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Consultant Name :- **Diagnosis :-**

DATE TIME	ORAL INTAKE		I.V. INTAKE					OUTPUT					SIGN
	TYPES OF DIET	AMOUNT	I.V.FLUID NAME	Drop/ Mt.	START	FINISH	AMOUNT	URINE	STOOL	EMESIS	RTA	DRAIN	
Morning Shift													
Sub Total													
Evening Shift													
Sub Total													
Night Shift													
Sub Total													
TOTAL INTAKE _____ ML								TOTAL OUTPUT _____ ML					

Consultant Name :- **Diagnosis :-**

DATE TIME	ORAL INTAKE		I.V. INTAKE					OUTPUT					SIGN
	TYPES OF DIET	AMOUNT	I.V.FLUID NAME	Drop/ Mt.	START	FINISH	AMOUNT	URINE	STOOL	EMESIS	RTA	DRAIN	
Morning Shift													
Sub Total													
Evening Shift													
Sub Total													
Night Shift													
Sub Total													

TOTAL INTAKE _____ ML TOTAL OUTPUT _____ ML

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NURSING MANUAL

INTRAVENOUS THERAPY: PATIENT EDUCATION AND DOCUMENTATION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 46** **Page: 1 of 1**
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INTRAVENOUS THERAPY: PATIENT EDUCATION AND DOCUMENTATION

1. Teach the patient how to protect the IV:
   a. Avoid sudden twisting or turning movements of the arm with the infusion.
   b. Avoid stretching or placing tension on the tubing.
   c. Try to keep the tubing from dangling below the bevel of the needle.
   d. Notify the nurse if he or she notices a sudden change in the flow rate, the solution container becoming nearly empty, blood in the IV tubing, or discomfort at the IV site.
   e. Nurses may need to show patients how to ambulate safely, if they are allowed to do so, with a portable IV stand.
2. Documentation
   a. Document the commencement of IV infusion in the nurses' progress notes, patient flow chart and intake and output chart (Refer Annexure to this policy). Include the time the IV was started, the type of fluid, any additives, where the IV was started, and by whom.
   b. At the commencement of each shift during the handover / endorsement period the incoming nurse and the outgoing nurse together must check the IV site for any signs of infiltration, infection, pain or swelling and document findings in the nurse's notes.
   c. The nurse on duty throughout her / his shift should monitor the infusion site and dressing, and the infusion flow rate.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

INTRAVENOUS THERAPY: STEPS OF DISCONTINUING AN IV		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 47** **Page: 1 of 1**
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INTRAVENOUS THERAPY: STEPS OF DISCONTINUING AN IV

Check the orders. It is very upsetting to patients and staff to have an IV discontinued by mistake.

1. Wash hands.
2. Gather the necessary equipment: a 2 x 2 sterile gauze square and a Band-Aid type bandage.
3. Check the patient's identity using 2 patient identifiers.
4. Explain the procedure to the patient. Tell him/her that this should not cause discomfort.
5. Don clean gloves.
6. Carefully remove the tape and dressing.
7. Shut off the IV flow.
8. Hold the 2 x 2 gauze above the entry site. Be ready to exert pressure as soon as the needle is out, but do not exert pressure on the site while pulling the needle out. This compresses the vein wall between the needle and the swab and can damage the vein.
9. Remove the needle by pulling straight out in line with the vein. Check needle or catheter to be sure it is intact.
10. Immediately put pressure on the site.
11. Raise the patient's arm above his or her head for about one minute. Hold it there until the bleeding is controlled.
12. Put a Band-aid type bandage over the site.
13. Remove all the equipment. Be sure to note the volume of fluid remaining in the container in order to record intake accurately.
14. Remove gloves and wash hands.
15. Chart, including intake, and nurses note if needle or catheter is intact.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

IV SKILL COMPETENCY CHECKLIST		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 48** **Page: 1 of 3**
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IV SKILL COMPETENCY CHECKLIST

1. Verify physician order for IV Administration
    a. Name of the fluids
    b. Dose
    c. Frequency
    d. Date
    e. Time of order and physician's signature.
2. Assemble appropriate supplies
    a. IV catheter of proper type, size, length
    b. IV fluids prescribed
    c. IV administration set according to the flow rate / syringe with 3-4ml Na Cl 0.9 % (Normal Saline) for flushing
    d. Alcohol/povidine, iodine/ chlorhexidine swabs,
    e. Sterile gauze,
    f. Tegaderm/Elastic Adhesive Bandage,
    g. Unsterile gloves.
3. Introduce self and confirm identity by
    a. Checking of Identity Band.
    b. Asking patient his / her name.
4. Confirm any allergy history for
    a. Medications
    b. Iodine
    c. Chlorhexidine
    d. Latex and tape.
5. Assess extremities for appropriate placement of IV insertion:
    a. Select the most distal site of the extremity
    b. Avoid area of flexion
    c. Use non dominant Hand/arm
    d. Choose site located above the previous insertion sites
6. Identify contraindications for an insertion including:
    a. Dialysis access site
    b. History of mastectomy

c. History of trauma or impaired venous drainage to extremity

d. Prior history of IV complication

e. Frail, fragile, phlebotic, infilterated or bruised vein.

7. Assess patient's previous or perceived experience with IV therapy
8. Ensure adequate light and use a comfortable position to perform the procedure.
9. Perform hand hygiene (Refer to Hospital Infection Control Manual Policy and Procedure No. 4)
10. Apply tourniquet above proposed insertion site (on a single bone).
11. Check for radial pulse.
12. Identify accessible vein for venipuncture
13. Don gloves.
14. Recheck to make sure all equipments are accessible.
15. Prepare the area with alcohol swab/chlorhexidine:
    a. Clean using circular motion from the puncture site to outward for 30 seconds.
    b. Allow to dry.
    c. If allergic to chlorhexidine/Provodine iodine prep, use alcohol.
    d. Allow to dry.
    e. Follow with alcohol wipe.
16. Prior to venipuncture hold the catheter hub and rotate barrel 360 degrees
17. Perform venipuncture:
    a. Draw skin below the insertion site taut using the non dominant hand.
    b. Puncture skin parallel to the path of vein with the bevel up and needle at 45o degree angle.
    c. Observe for blood return in catheter hub holding the devise stable,
    d. Advance catheter several millimeters to insure catheter entrance into vein until the hub rest at insertion site.
    e. Release tourniquet.
    f. Apply digital pressure beyond the catheter tip
    g. Gently stabilize catheter hub placing a sterile gauze under the hub.
18. Remove stylet from catheter and dispose it into kidney dish.
19. Attach primed IV bag / syringe with 2-3ml NaCl 0.9 % (Normal Saline) to catheter hub.
20. Initiate proper IV flow rate or flush with NaCl 0.9 % (Normal Saline.)
21. Assess for signs of infilteration.
22. Apply Tegaderm/Elastic Adhesive Bandage dressing & anchor hub with tape strip.
23. Label dressing with date, gauge and your initials.

IV SKILL COMPETENCY CHECKLIST		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 48** **Page: 3 of 3**
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24. Tape loop securely.
25. Discard supplies in appropriate container.
26. Burn needle and discard into Sharp Box.
27. Remove the gloves and wash hand.
28. Label IV bag (Refer to Nursing Manual Policy and Procedure No 40).
29. Document IV administration in the patient's medical record:
    a. Date
    b. Time
    c. Number of attempts
    d. Site
    e. Gauge
    f. Rate of solution or flush
    g. Problem encountered or faced by the patient/nurse (if so report to Nursing Superintendent / Surgeon)
    h. Site assessment
    i. Signature of the nurse.

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

INTRAVENOUS THERAPY CERTIFICATION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 49** **Page: 1 of 2**
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INTRAVENOUS THERAPY CERTIFICATION

PURPOSE

Staff Nurse who start and care for Intravenous therapy, complete a certification class by Prime Surgical Centers to assure competency in care of Intravenous therapy.

RESPONSIBILITY

Staff Nurses who have a current Prime Surgical Centers approved certification of proficiency are authorized to perform the below enumerated intravenous procedures in the policy.

POLICY

1. Staff Nurses are trained in starting Intravenous therapy and in troubleshooting any Intravenous therapy problems. The training includes the following classes:
   a. Protective IV Catheter
   b. Butterfly Needle
   c. Venipuncture Procedure
   d. Withdrawing Blood samples for Lab test.
   e. Intravenous Administration of Fluids and medications
   f. Heparin Lock Insertion for Intermittent Infusion therapy
   g. Administration of Admixture IV solution
   h. Starting, discontinuing and caring for IV's.
   i. Documentation
2. When a patient requires insertion of an IV, the Staff Nurse who is trained in intravenous therapy starts the IV.
3. When a patient is receiving IV therapy, trained Staff Nurse is responsible for care of the IV and delivery of the prescribed IV fluids and medications.
4. If problems with the IV occur, the trained Staff Nurse troubleshoots the problems and corrects them.
5. Staff Nurses who are trained in infusion therapy, discontinue IV’s when there is an order to discontinue the IV therapy.
6. The Staff Nurse will attend Intravenous Procedures classes consisting of theory and practice, which will lead to development of proficiency / competency in these procedures. On successful result of theory and practical examination of Intravenous Therapy procedures a certificate as per Annexure to this policy will be issued. For this purpose IV Skill Competency Checklist will be used (Refer to Nursing Manual Policy and Procedure 48)

INTRAVENOUS THERAPY CERTIFICATION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 49** **Page: 2 of 2**
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Initial certification will include:

a. Completion of required course in theory and practice during GNO (General Nursing Orientation)

b. Demonstration on simulated arm.

c. One supervised I.V. start under the supervision of certified Staff Nurse / Charge Nurse / OT Matron/ Preceptor

Annual re-certification will include:

a. Completion of required course in theory & practical.

b. Return demonstration on simulated arm.

7. Documentation of Intravenous therapy Certification will be maintained by Nursing Superintendent.
8. Intravenous Therapy Certificate attached as Annexure to this policy.

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 49)

PRIME SURGICAL CENTERS

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GENERAL NURSING ORIENTATION (GNO)
CERTIFICATE - INTRAVENOUS THERAPY PROFICIENCY

This is to certify that Staff / Operation Theater Nurse _____ has completed the required course in Intravenous Therapy Proficiency including theory and practical.

This Staff / OT Nurse has been directly supervised in performing the following Procedures.

1. Protective IV Catheter
2. Butterfly Needle
3. Venipuncture Procedure
4. Withdrawing Blood samples for Lab test.
5. Intravenous Administration of Fluids and medications
6. Heparin Lock Insertion for Intermittent Infusion therapy
7. Administration of Admixture IV solution
8. Starting, discontinuing and caring for IV's.
9. Documentation

Return Demonstration: (Performed on simulated arm)

Consultant Educator: _____ Date: _____

Written evidence of the above education, examination and demonstration shall be documented upon successful initial training (Certification). Recertification will occur annually to include: 1) Completion of required course in theory and practice, and 2) Return demonstration on simulated arm. Certification Records and a reference list of certified Nurses will be maintained by the Nursing Superintendent in the Nursing Office.

Re-certifications:

_____ Preceptor Date: _____

_____ OT Matron / Nursing Superintendent Date: _____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

URINARY CATHETERIZATION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 50** **Page: 1 of 2**
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URINARY CATHETERIZATION

PURPOSE

The purpose of urinary catheterization is to facilitate urinary drainage when medically necessary. Urinary catheters should be evaluated everyday for need and removed promptly when no longer necessary.

Urinary Catheters are deemed medically necessary for the following reasons:

1. To obtain sterile urine specimens for diagnostic laboratory procedures
2. Urinary retention including obstruction and neurogenic bladder (the patient is unable to pass urine because of an enlarged prostate, blood clots or an edematous scrotum/penis or unable to empty the bladder because of neurologic disease / medication effect.)
3. To instill medication or irrigate the bladder.
4. Short preoperative use in selected surgeries (less than 24 hours) and for urological Studies or surgery on contiguous structures.
5. Output measurements in the Nursing Care Units.
6. Assist healing of perineal and sacral wounds in incontinent patients to avoid further deterioration of wound and skin.

GENERAL INFORMATION

A physician's order is required for all types of catheterization or external (condom) catheter. The physician's order must specify the catheter and balloon size. In and Out catheterizations and instillation of medications are performed by nursing staff or by the physician.

POLICY

1. Urinary Catheterization will be performed only when a physician determines that there is a specific and adequate medical indication.
2. Indwelling Urethral Catheters will be used for a limited duration as much as possible and only after careful consideration of the alternative methods of management.
3. All nurses providing Urethral Catheter care will be educated in the epidemiology of and infection prevention and control procedures for preventing urinary tract infections.
4. The smallest bore catheter possible should be utilized to minimize urethral trauma and irritation.
5. Utilize standard precautions: Practice hand hygiene before and after the procedure (Refer Hospital Infection Control Manual Policy and Procedure No. 4). Use gloves when manipulating the catheter site and drainage system.
6. Indwelling catheters should be properly secured after insertion to prevent movement and urethral trauma.
7. A sterile, continuously closed drainage system should be maintained for indwelling and suprapubic catheter system.

URINARY CATHETERIZATION		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 50** **Page: 2 of 2**
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8. Disconnect tubing, if there are breaks in aseptic technique. If the bag leaks, drainage system should be replaced.
9. Drainage bags should always be placed below the level of the patient's bladder to facilitate drainage and prevent stasis of fluid.
10. Patients with urinary catheters will have intake and output (I&O) recorded.
11. The patient with an indwelling catheter should be monitored for signs of catheter-associated urinary tract infection such as fever, chills, or suprapubic pain.
12. Catheters of post-op urology patients should only be changed or removed with urologist's approval.
13. Closed continuous and/or manual irrigation should only be done if ordered by a physician. Avoid irrigation unless there is an obstruction in the catheter.
14. Hand washing before and after procedure to be done according to policy.

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Revision Date:	
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URINARY CATHETERIZATION: CATHETERIZATION OF MALE PATIENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 51** **Page: 1 of 3**
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URINARY CATHETERIZATION: CATHETERIZATION OF MALE PATIENT

Required Items

1. Foley's catheter (size specified)
2. Sterile gravity drainage set with bag
3. Appropriate size syringe and sterile normal saline solution
4. Washcloth, towel, soap and water
5. Sterile cotton tip applicators
6. Intake & Output sheet
7. Safety syringe 2cc and #22 needle (for specimen collection)
8. External tube clamp (for specimen collection)
9. Sterile disposable catheterization tray containing:
    a. Ureteral catheter, 14-18 French
    b. Antiseptic prep solution, 50ml
    c. 2 pair sterile gloves
    d. Specimen containers
    e. Waterproof underpad
    f. Waterproof tray
    g. 5 large absorbent cotton balls
    h. Sterile water soluble lubricant package
    i. Sterile drape
10. Adhesive tape
11. Larger syringe and sterile saline if large balloon catheter is used
12. Clear plastic bags for medical waste
13. Sterile urine specimen container, with data label and Laboratory slip.

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NURSING MANUAL

URINARY CATHETERIZATION: CATHETERIZATION OF MALE PATIENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 51** **Page: 2 of 3**
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PROCEDURE

ACTION	RATIONALE
1. Review physician's orders and allergies	To determine if catheter size or type has been specified. If the patient has allergies to Betadine and/or Latex, consult with the physician for alternatives
2. Wash hands before and after procedure	To prevent cross contamination
3. Explain procedure and the purpose to the patient	To elicit cooperation and minimize anxiety and discomfort
4. Screen the bed or close door	Assure the patient his respect, dignity, and privacy
5. Prepare a work area. Adjust light as needed to provide visualization	Poor lighting is a major cause of contamination
6. Place the patient in a horizontal recumbent position with hips firmly supported	Position allows exposure of genital area. Gravity will aid flow of urine when bladder is higher than end of the catheter
7. Cover the patient's chest and drape.	Embarrassment and low temperatures can cause the patient to become tense, making introduction of the catheter more difficult.
8. Arrange equipment to avoid contamination of sterile items. Open sterile catheterization tray	Equipment is arranged inside tray in order of use to increase the speed of performance
9. Expose genitalia and retract prepuce if present. Picking up sterile underpad corners, lay pad under the penis and on the top of the scrotum across upper thighs.	Provides clean working area and reduces chance of introducing bacteria into urinary tract.
10. Put on sterile gloves; prepare contents of the tray by lubricating the catheter tip 2.5 to 5 cms.	Keep everything within the tray to maintain sterility
11. Open packet of swab sticks. Hold penis with foreskin retracted, using the disinfectant swab sticks as ordered cleanse glans from meatus outward. Discard swabsticks repeat cleansing.	Using the swab sticks will keep one gloved hand sterile to handle the catheter. Use one downward stroke. **Do not** cleanse with a circular motion.
12. Place collection basin between patient's legs on the towel. Holding the penis directly behind the glans with thumb and forefinger, apply gentle tension and raise the penis vertical to the body.	Keep the channel of urethra straight to allow easier passage of the catheter.

URINARY CATHETERIZATION: CATHETERIZATION OF MALE PATIENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 51** **Page: 3 of 3**
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ACTION	RATIONALE
13. Hold the lubricated catheter 5 to 7.5 cms from the tip and insert the tip into the meatus. When reaching the sphincter ask the patient to take deep breaths and lower the penis slightly. Continue inserting the catheter, into the urethra 15 to 17.5 cms or until urine begins to flow	Be gentle as trauma to the urethra or bladder may result in cystisis. Do not force catheter entry. Deep breaths will help the patient to relax. Lowering the penis slightly helps straighten the urethra, which aids in easier passage of the catheter. The most common causes of difficult catheterization are sphincter spasm and inadequate lubrication of the catheter. In either case, if undue difficulty in passing catheter into bladder is encountered, stop procedure and notify the physician.
14. Collect urine specimen for Lab as ordered. Allow some urine to flow into the collection container first, then into the sterile specimen bottle. Finish emptying the bladder into the collection container.	Letting urine flow prior to collecting the specimen will minimize the amount of organisms introduced from the catheter insertion in the specimen. The amount of urine is measured for recording on the Intake and Output sheet.
15. If more than 1000cc is obtained, clamp catheter for 15 minutes before allowing urine flow to continue.	Prevent possibility of shock
16. Upon taping the catheter to the thigh, avoid exerting tension on the urethra.	
17. Replace prepuce back into natural position	Prevents constriction of the glans, which could result in swelling
18. Wash hands	
19. Record amount of urine on the Intake & Output (I & O) sheet	
20. Encourage patient with unrestricted fluid intake to increase intake to at least 3000 ml per day	This will help flush the urinary system and reduce sediment formation

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URINARY CATHETERIZATION: CATHETERIZATION OF FEMALE PATIENT		
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URINARY CATHETERIZATION: CATHETERIZATION OF FEMALE PATIENT

PROCEDURE

ACTION	RATIONALE
1. Review physician's orders & Allergies	Ensure procedure is valid
2. Wash hands before procedure. (Refer to Hospital Infection Control Manual Policy and Procedure No. 4)	To prevent cross contamination
3. Follow policy "Catheterization of Male Patient", regarding instructions for insertion of a catheter. (Refer Nursing Policy and Procedure Manual No. 51 Procedure Serial No. 3-8)	
4. Place disposable water proof underpad below patient's buttocks and thighs.	To prevent soiling of bedding if leakage occurs.
5. Open all equipment using aseptic technique	
6. Put on sterile gloves	Prevent cross-infection during procedure.
7. Place sterile drape across thighs	To create a sterile area.
8. Expose genitalia and start cleaning process.	
9. Using sterile cotton swabs, separate labia minora so that the urethral orifice can be identified.	This provides access to the urethral orifice to prevent labial contamination of the catheter during insertion. One hand to maintain separation until procedure is completed.
10. Clean the labia majora and minora separately from anterior to posterior, inner to outer, in single downward strokes, one swipe per swab, clean around the urethral orifice and discard the swabs.	Inadequate preparation is a cause of infection.
11. Place a small amount of sterile soluble lubricant on to the sterile field.	Catheter being inserted has adequate surface lubrication to avoid urethral friction.
12. Place the catheter in sterile water proof tray between the patient's legs.	To provide container into which urine can drain.
13. Introduce the tip of the catheter gently into the urethral orifice, after lubrication. Slowly advance the catheter up the urethra.	To prevent trauma during insertion. During insertion the urethra is being dilated and prevents risk of trauma.
14. Once urine commences, advance catheter to 6-8 cms.	To ensure adequate length of catheter has been inserted.
15. Use syringe filled with sterile water and inject into small side tube to fill balloon.	Do not over inflate the balloon

URINARY CATHETERIZATION: CATHETERIZATION OF FEMALE PATIENT		
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16. Give gentle pull on catheter to be sure the balloon is inflated and will hold the catheter in place	The balloon lies in the neck of the bladder and keeps the catheter in place
17. Keeping the end of the catheter and the end of the drainage tube sterile, connect catheter to the gravity drainage set.	A retention catheter may be allowed to drain or may be clamped off with periodic release to develop bladder control.
18. Initial emptying of the bladder after catheterization should be limited to 1000ml. Clamp catheter for 15 minutes if more urine than this.	Complete emptying of a full bladder may cause spasms, cramping, discomfort and shock. (collection container only holds a volume of 1100ml)
19. Tape the catheter securely to the thigh, but without exerting tension or pull on the urethra	Tension on the catheter exerts pressure on the neck of the bladder causing a painful straining to urinate. Tubing is not to be compressed by the weight of the patient's buttocks or thigh.
20. Ensure that the vulval area is dry.	To prevent dampness which may cause soreness or irritation to the skin.
21. Dress patient and make comfortable.	Patient is no longer exposed and is comfortable.
22. Dispose of all used equipment as per waste management policy.	The treatment area is left clean and dry.
23. Wash hands after procedure as per policy.	To prevent cross contamination
24. Educate patient on catheter care and management, including using and changing the drainage system.	Patient can be independent and self-caring.
25. Measure amount of urine drained and document its appearance.	To measure bladder volume of contained urine, and record its appearance, clear, cloudy, blood-stained, etc.

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URINARY CATHETERIZATION: PLACEMENT OF BALLOON		
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URINARY CATHETERIZATION: PLACEMENT OF BALLOON

(Follow steps as outlined in Nursing Manual Policy and Procedure No. 51 - Procedure Serial No. 1-8)

ACTION	RATIONALE
1. Use syringe filled with sterile water and inject into small side tube to fill balloon at catheter tip.	To inflate balloon and retain catheter in place.
2. Gently pull on catheter to assure balloon placement.	
3. Retain catheter in place as ordered. Notify the physician if pain, swelling, redness or changes in urine characteristics occurs.	
4. Each shift; assess the catheter for any problems of drainage or signs of infection. Check the urine drainage for mucus, blood clots, sediment, and turbidity. Pinch the catheter between two fingers to determine if the lumen contains any material.	Record findings in the Nurse's Note. Notify the physician if any of these conditions exist. This may warrant obtaining a urine specimen
5. Inspect the catheter at the entrance of the urinary meatus for encrusted material and supportive drainage. Also inspect the tissue around the meatus for irritation or swelling.	
6. Once within 24 hours clean the catheter. Put on procedure gloves. Then use a sterile gauze pad or cotton-tipped applicator saturated with antiseptic soap to clean the outside of the catheter and the tissue around the meatus. Observe sterile technique at all times. Apply Betadine ointment daily round the urinary meatus.	To avoid contaminating the urinary tract, always clean by wiping away from, never toward, the urinary meatus. Do not pull on the catheter while cleaning, this can injure the urethra and the bladder wall and expose a section of the catheter that was inside the urithra, so that when the catheter is released, the newly contaminated section will reenter the urethra.
7. Catheter should be changed as per orders	
8. Empty bag through the bottom vent into a gravity collection container.	
9. Never elevate the drainage bag to the bladder level or use catheter plugs.	If the drainage bag is elevated above the bladder it increases the incidence of infection and can damage the bladder wall and urethra.

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URINARY CATHETERIZATION: PLACEMENT OF CONDOM CATHETER		
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URINARY CATHETERIZATION: PLACEMENT OF CONDOM CATHETER

Required Items

1. Self adhesive external urinary catheter of appropriate size
2. Gravity collection bag
3. Sterile Gloves
4. Adhesive tape
5. Clear plastic bag for medical waste

PROCEDURE

ACTION	RATIONALE
1. Review physician's orders	To ensure correct catheter is obtained. Catheters containing no latex are available for patients with a known latex sensitivity
2. Gather supplies and inform the patient of the procedure. Select a proper sized catheter per Central Supply instructions.	
3. Provide privacy for the patient.	
4. Wash Hands and Put on gloves (Refer to Hospital Infection Control Manual Policy and Procedure No. 4)	
5. Follow manufacturer's instructions for application of lubricant to shaft of penis.	Do not use on irritated or compromised skin
6. Place inner flap of the condom against glans.	If the patient is uncircumcised, the foreskin should remain in the natural position
7. Unroll the condom catheter up the shaft of the penis with as little wrinkling as possible	To prevent leaking
8. Gently squeeze the condom catheter to properly seal the adhesive sheath to the skin	To ensure a proper fit and prevent leaking
9. Discard plastic collar	Some brands do not have a collar. Do not push the plastic collar onto the penis.

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URINARY CATHETERIZATION: REMOVAL OF CONDOM CATHETER		
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URINARY CATHETERIZATION: REMOVAL OF CONDOM CATHETER

PROCEDURE

1. Explain the procedure to the patient. Put gloves on after following Hospital Infection Control Manual Policy and Procedure No. 4
2. Condom catheter and gravity collection bag should be changed at a maximum of every 3 days, per orders. Nursing staff should assess the skin integrity of the penis after each condom removal and document assessment
3. Slowly unroll catheter down the shaft of the penis
4. Discard the used catheter and collection bag as management of waste. (Refer Hospital Infection Control Manual Policy and Procedure No. 29)

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URINARY CATHETERIZATION: PLACEMENT AND CARE OF GRAVITY COLLECTION SET AND LEG BAG		
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URINARY CATHETERIZATION: PLACEMENT AND CARE OF GRAVITY COLLECTION SET AND LEG BAG

Required Items

1. Leg bag and straps (for day time use)
2. Gravity collection bag (for night time use)
3. Gloves
4. Adhesive tape
5. Clear plastic bag for medical waste

PROCEDURE

ACTION	RATIONALE
1. Gather supplies and inform the patient of the procedure.	
2. Provide privacy for the patient	
3. Keeping the end of the catheter sterile remove the protective covering from the tip of the drainage tube.	
4. Clean the tip of the catheter with an alcohol sponge, wiping away from the opening to avoid contaminating the tube.	
5. If using a gravity drainage set connect the catheter	
6. If using a leg bag, place the bag on the patient's calf or thigh. Fasten the straps securely.	Almost all leg bags have a valve in the drainage tube that prevents urine reflux into the bladder, urge the patient to keep the drainage bag lower than his bladder at all times because urine in the bag is a perfect growth medium for bacteria. Caution the patient not to go to bed or take long naps while wearing the leg bag. Encourage the patient to empty the bag when it's only half full. Instruct the patient to periodically inspect the catheter and drainage tube for kinking or compression.
7. Discard at a maximum of 7 days, each time the catheter is changed and/or as ordered.	

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URINARY CATHETERIZATION: SPECIMENS FOR CULTURE AND SENSITIVITY		
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URINARY CATHETERIZATION: SPECIMENS FOR CULTURE AND SENSITIVITY

Required Items

1. Safety Syringe 2cc with #22 needle
2. Sterile alcohol sponge
3. External tube clamp
4. Procedure gloves
5. Sterile urine specimen container, with label (patient's data)
6. Laboratory Slip data and marked for culture- Cath. Specimen

PROCEDURE

ACTION	RATIONALE
1. Wash hands before and after procedure (Refer to Hospital Infection Control Manual Policy and Procedure No. 4)	To prevent cross contamination
2. Put on gloves	To prevent cross contamination
3. Apply clamp to drain tube just beyond catheter connection for about five (5) minutes prior to collecting specimen.	To allow urine to collect in catheter
4. Using alcohol sponge, clean the area of catheter between the connecting tip and side arm	To prevent introduction of contamination into catheter or urine specimen
5. Insert sterile needle into the catheter and aspirate 2ml of urine	Be careful to avoid entering the lumen of the side arm
6. Withdraw needle and place urine in culture container. Cap container aseptically and label. Send to Lab immediately or refrigerate for Lab pickup.	Protect specimen from outside contamination that would confuse identification of organisms causing bladder infection and give false positive results of cultures.
7. Secure needle in protective sheath and dispose of needle in sharps container	To prevent cross contamination and accidental injuries

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URINARY CATHETERIZATION: REMOVAL OF RETENTION CATHETER		
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URINARY CATHETERIZATION: REMOVAL OF RETENTION CATHETER

PROCEDURE

ACTION	RATIONALE
1. Review physician's orders	
2. Wash hands before and after procedure. (Refer to Hospital Infection Control Manual Policy and Procedure No. 4)	Prevent cross contamination
3. Wear sterile gloves during procedure	Prevent cross contamination
4. To remove a retention catheter, withdraw the fluid with a syringe or cut off the end of the side arm. The fluid in the balloon will drain out and the catheter will slide out easily.	Be sure the balloon is emptied before the catheter is withdrawn.
5. If the balloon does not empty or the catheter does not come out easily, notify the physician	Prevent trauma to the urethra
6. Discard catheter and other disposable equipment as per policy on waste disposal management (Refer to Hospital Infection Control Manual Policy and Procedure No. 29)	Beware of contaminated articles
7. Clean reusable equipment and return to Central Supply	Central Supply sterilizes equipment

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URINARY CATHETERIZATION: CONTINUING CARE / MAINTENANCE OF CATHETER		
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URINARY CATHETERIZATION: CONTINUING CARE / MAINTENANCE OF CATHETER

PROCEDURE

ACTION	RATIONALE
1. Wash hands before and after procedure (Refer to Hospital Infection Control Manual Policy and Procedure No. 4)	To prevent cross contamination
2. Apply Betadine Ointment daily around the urinary meatus	An indwelling catheter is a route for bacterial infection and a source of irritation to delicate tissues
3. Observe sterile techniques at all times. At entry into the drainage system is preceded by thoroughly cleansing the connection to be opened with an alcohol sponge.	Make every effort to prevent bacterial contamination and infection of the bladder.
4. Never elevate the drainage bag to bladder level	Avoid back flows of urine
5. Empty the bag through the bottom vent into an appropriate container to measure urine output, or to collect specimens for chemical analysis.	Do not use uro-meteres and other special containers to measure hourly output, as none has a completely closed system.
6. When the patient is out of the bed catheter ad tubing is taped securely to the thigh, without exerting pull on the urethra. There is no need to disconnect the drainage set.	Prevent traction on the catheter tubing. Prevent risking infection unnecessarily.
7. The catheter is to be checked frequently to determine that it has not been displaced and is flowing freely.	Avoid urethral trauma and urinary tract infection.
8. Irrigation of the catheter is done only with a physician's order	
9. Change retention catheter upon written orders of a physician	Replacement ensures patency, reduced odor, and helps prevent contamination and growth of organisms in the urethra. Avoid any unnecessary disconnection of the drain system.
10. Never use catheter plugs. Use an external clamp to occlude the catheter or drainage tube for bladder training or other purposes.	To prevent contamination leave the catheter connected to the drainage system even when the catheter is clamped.

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URINARY CATHETERIZATION: COMPLICATIONS, INFECTION CONTROL & DOCUMENTATION		
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URINARY CATHETERIZATION: COMPLICATIONS, INFECTION CONTROL & DOCUMENTATION

1. COMPLICATIONS

COMPLICATIONS	ACTION
1. Urethritis: some mucopurulent discharge from the meatus is to be expected. This can be minimized by daily cleaning.	Notify the physician of any discharge, fever or tenderness.
2. Voiding around the catheter: is indicative of an obstruction, mal-position of the catheter or severe bladder spasm	Notify the physician unless the problem is readily found and corrected. This may require a change of catheter.
3. Urinary tract infection: cloudy urine, flank pain or fever can be indicative of an invasive infection or obstruction in the catheter system or the upper urinary tract. Bacteremia may occur with urinary tract infections; these symptoms include fever, often with chills, hyperventilation, hypotension and prostration.	Notify the physician immediately if such symptoms are apparent.
4. Accidental removal of inflated catheter balloon: requires careful attention. This can be complicated by bacteremia, severe bleeding or urethral rupture with extravasation.	Notify the physician immediately.

2. INFECTION CONTROL

a. Prevention of urinary tract infection is vital to the catheterization procedure. Meticulous hand washing is essential. Strict adherence to sterile technique during the procedure is also necessary. Cleansing the area around the meatus must be done in a downward motion on the male to avoid contamination of the urinary meatus. When connecting the drainage bag to the catheter, the ends of both tubes should not be touched any closer than five (5) cms from the end.

b. Daily catheter care is essential. If the system is closed, it will not be accessed from the outside. If the system is open, it may be accessed. Opening of the system is discouraged and should be preceded by cleaning both ends of the tubing with a bactericide agent.

3. DOCUMENTATION

a. In the Nurses & flow sheets Notes, the person performing the procedure will record the time, procedure, appearance of urine, condition of catheter, specimens sent to the laboratory, bladder irrigations, catheter care, instillation of medication and any complications that occur. Include the patient's reaction and tolerance to the procedure.

b. In the Daily Care Flow Sheet, record the amount of urinary output every eight (8) hours and every twenty-four (24) hours.

c. Patient family teaching.

URINARY CATHETERIZATION: COMPLICATIONS, INFECTION CONTROL & DOCUMENTATION		
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4. GENERAL INFORMATION

All instructions apply to the insertion of the retention catheter. Retention (Foley's Catheter) comes in various sizes and types with various size balloons. The physician's order must specify the catheter and balloon size. The 5ml balloon is used routinely while the 30ml balloon is used principally after prostatic surgery. A three-way Foley's Catheter (with additional side arm and channel opening into the bladder) is available for continuous bladder irrigation. The connection between the catheter and the tubing is never broken, except when absolutely necessary to remove clots obstructing drainage. Irrigations are done under absolutely sterile conditions.

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URINARY CATHETERIZATION: PROTOCOL FOR CARE OF URINARY DRAINAGE BAGS		
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URINARY CATHETERIZATION: PROTOCOL FOR CARE OF URINARY DRAINAGE BAGS

1. When a patient uses a urinary leg bag during ambulation and a urinary down drain bag when in bed, the following care is taken when changing from one bag to the other:
2. The urinary bag attached to the catheter is carefully removed and the other urinary bag connecting point is cleansed with alcohol and attached to the catheter.
3. The used urinary bag is emptied of urine and is then cleansed with a 1:10 ratio of household bleach and water.
    a. The household bleach must be maintained by the Staff Nurse in a locked area and in small quantities and labeled.
    b. The bag is filled with approximately 200 ml of the household bleach and water mixture and then shaken for approximately 1 minute.
    c. The bleach is not mixed with water until immediately prior to use.
    d. The mixture is drained from the urinary bag and the connecting points are covered with the appropriate caps to maintain cleanliness.
4. The cleaned urinary bag is stored until it is re-connected to the patient's catheter
5. When a new urinary bag is first used, the date of implementation is marked on the bag with a felt marker. Urinary bags are changed at least every 30 days or when no longer viable due to leakage.

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ORDERS FOR TREATMENT		
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ORDERS FOR TREATMENT

POLICY

1. All orders for treatment shall be in writing.
   a. Verbal orders shall not be accepted or carried out until transcribed.
   b. An order shall be considered in writing if dictated to a professionally licensed individual such as Nurse / Doctor.
   c. All orders dictated over the telephone shall be signed by the person accepting the order.
   d. The name of the person dictating the order shall be recorded by the person accepting the order.
   e. The concerned Consultant shall authenticate such orders within Twenty Four (24) hours of the order.
2. The physician's order must be written clearly, legibly and completely which include complete patient identification. Orders which are illegible or improperly written will not be carried out until rewritten.
   a. Date & Time
   b. Name and dose of the drug
   c. The Route
   d. Prescribing Physician's full name, designation, signature, date and time.
3. Each patient admitted to the Center shall have specific admission orders provided by the admitting Consultant.

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VERBAL ORDERS/TELEPHONE ORDERS		
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VERBAL ORDERS/TELEPHONE ORDERS

PURPOSE

To promote the proper transcription, interpretation and administration of orders.

POLICY

1. Verbal orders/Telephone orders will be limited to Emergency Situations only.
2. A nurse may take a verbal order for medications or treatment. Verbal orders must be signed by the Consultant within twenty four (24) hours after the event. (Refer General Manual Policy and Procedure No.)

PROCEDURE

1. When taking a verbal order, the nurse is to repeat the physician's name for clarification and affirmation.
2. Take order and repeat aloud to verify order is correct.
3. Write order on physician's order sheet or on surgical flow sheet and sign as follows:

   V/O physician's name/nurse's name
4. Date and time of the order.
5. Document date and time of completion after carrying out orders.
6. Obtain the Consultant's full name and signature upon his arrival in the facility not later than twenty four (24) hours and include date and time the order was signed.
7. Verbal orders must be obtained directly from ordering Consultant.

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MOVING A PATIENT UP IN BED WITH THE PATIENT'S HELP		
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MOVING A PATIENT UP IN BED WITH THE PATIENT'S HELP

PROCEDURE

PREPARATION

1. Wash your hands.
2. Identify the patient by checking the identification band.
3. Ask visitors to step out of the room.
4. Identify yourself if not already done earlier and explain the purpose for it.
5. Tell the patient that you are going to move him up in bed.
6. Provide privacy for the patient.
7. Lock the wheels on the bed.
8. Raise the height of the bed to a comfortable working position.
9. Lower the backrest and footrest.

STEPS

1. Remove the pillow from under the patient's head. Put the pillow at the top of the bed against the head board. This will protect the patient's head from hitting the headboard.
2. Put the side rails in the up position on the far side of the bed.
3. Put one hand under the patient's shoulder. Put your other hand under the patient's hip. Provide assistance to the weaker side of the patient.
4. Ask the patient to bend his knees and brace his feet firmly on the mattress.
5. Have your feet hip width apart. The foot closest to the head of the bed should be pointed in that direction.
6. Bend your knees. Maintain the natural curves in your back.
7. Bend your body from your hips and pivot slightly toward the head of the bed.
8. At the signal, “one, two, three” have the patient push toward head of bed with his hands and feet.
9. At the same time, help the patient to move toward the head of the bed by sliding the patient with your hands and arms, as you shift weight from back foot to foot closest to head of the bed.
10. Replace the pillow under the patient's head and shoulders.

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FOLLOW-UP

1. Make the patient comfortable and confirm the same.
2. Lower the bed to a position of safety for the patient.
3. Raise the side rails for patient safety.
4. Place the call light within easy reach of the patient.
5. Wash your hands.

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MOVING A PATIENT FROM THE BED TO A STRETCHER		
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MOVING A PATIENT FROM THE BED TO A STRETCHER

PREPARATION

1. Assemble your equipment:
   a. Stretcher (check & confirm its mobility, locking mechanism etc.)
   b. Sheet or blanket
2. Ask two other assistant to help. The two of you should work in unison to move the patient from the bed to a stretcher.
3. Wash your hands.
4. Identify the patient by checking the identification bracelet.
5. Identify yourself if not done earlier and purpose for it.
6. Tell the patient you are going to move him from the bed to a stretcher and purpose for it.
7. Ask visitors to step out of the room.
8. Provide privacy for the patient.

STEPS

1. Loosen the top sheets.
2. Cover the patient with a blanket or sheet. Remove the top sheets without exposing the patient.
3. Move the stretcher next to the bed.
4. Raise the bed so that it is at the same height as the stretcher. Lock the wheels on the bed.
5. Lock the wheels on the stretcher.
6. Stand on the far side of the bed, using your body to hold the bed in place.
7. Your partner will stand on the far side of the stretcher, using his/her body to hold the stretcher in place.
8. Position your legs so that one is in front of the other, bend your knees and maintain the natural curves in your back.
9. At the signal, “one, two, three” push, pull and slide the patient on roller board/scoop from the bed to the stretcher, while shifting your weight from the front leg to the back leg (if you are the assistant positioned on stretcher side) or from the back leg to the front leg (if you are the assistant positioned on bed side). Use a pull (turning) sheet whenever possible.

MOVING A PATIENT FROM THE BED TO A STRETCHER		
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10. Support the patient's head and feet, keeping the body covered with a loose blanket or sheet.
11. Fasten the stretcher straps around the patient at the hips and shoulders, if provided.
12. Put the side rails of the stretcher in the up position for the patient's safety.
13. Wash your hands

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NURSING MANUAL

MOVING A PATIENT FROM A STRETCHER TO THE BED		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 68** **Page: 1 of 2**
Effective Date: 11 April, 2013		

MOVING A PATIENT FROM A STRETCHER TO THE BED

PREPARATION

1. Assemble your equipment:
   a. Stretcher (check & confirm its mobility, locking mechanism etc.)
   b. Sheet or blanket
2. Ask two other assistants to help you. You should work in unison to move the patient from the bed to a stretcher.
3. Wash hands.
4. Identify the patient by checking the identification bracelet.
5. Identify yourself if not done earlier and purpose for it.
6. Tell the patient you are going to move him from the stretcher to a bed.
7. Ask visitors to step out of the room.
8. Provide privacy for the patient.
9. Lock the wheels on the bed.
10. Fan-fold the top sheet to the bottom of the bed.
11. Bring the stretcher next to the bed.
12. Raise the bed so that it is level with the stretcher.
13. Lock the wheels on the stretcher.

STEPS

1. Two assistants stand by the far side of the bed, using their bodies to hold the bed in place.
2. The other two assistants stand by the far side of the stretcher, using their bodies to hold the stretcher in place.
3. Open the stretcher straps.
4. Bend your knees, maintaining the natural curves in your back, and position your legs so that one is in front of the other.
5. At the signal, “one, two, three” slide the patient from the stretcher to the bed. Use a pull sheet whenever possible.
6. Keep the patient covered with a loose blanket or sheet and support the head and feet.

MOVING A PATIENT FROM A STRETCHER TO THE BED		
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FOLLOW-UP

1. Make the patient as comfortable as possible and confirm.
2. Replace the top sheets, removing the blanket without exposing the patient.
3. Lower the bed to a position of safety for the patient.
4. Raise the side rails for patient safety.
5. Place the call light within easy reach of the patient.
6. Wash your hands.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

TRANSFERRING OF PATIENTS		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 69** **Page: 1 of 1**
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TRANSFERRING OF PATIENTS

PROCEDURE

1. If patient is able to move:
   a. Make sure bed and trolley are at the same height and both are locked.
   b. Have a person to secure bed on one side and another to secure stretcher before patient begins to move and then unlock the stretcher trolley.
   c. Ensure Patient's modesty is not compromised.
   d. Make certain patient is positioned properly.
   e. If patient has an IV:
      i. Be sure tubing is not tangled or kinked.
      ii. Secure IV container to IV pole on stretcher.
   f. If patient has an in-dwelling catheter:
      i. Be sure tension is not placed on catheter during the move.
      ii. Check for position and be certain tubing is not tangled or kinked after move.
   g. Always move stretcher with restraint strap attached over thighs or side rails up.

2. If patient is unable to move:
   a. Observe all rules of procedure as if patient were able to move except that instead of patient moving himself/herself transfer patient from the bed to trolley by means of scoop/roller board and put side rails up. Unlock trolley before transportation.
   b. Additional considerations include:
      i. Patient’s inability to control extremities.
      ii. Patient’s state of consciousness.
   c. Enlist all help necessary to move patients safely and ensure good body mechanics to protect employees as well as patients.

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NURSING MANUAL

RECEIVING THE PATIENT BY OPERATION THEATER NURSE		
Policy/Procedure Applies To	**Operation Theater Nurse**	**Policy/Procedure No: 70** **Page: 1 of 1**
Effective Date: 11 April, 2013		

RECEIVING THE PATIENT BY OPERATION THEATER NURSE

PURPOSE

To ensure proper identity of the patient and that all information is available to document the patient's condition before beginning the procedure. To obtain any information pertinent to the care of the patient while in the Operating Theatre.

SCOPE

The Staff Nurse assigned to circulate in the Operating Room during the patient's surgical procedure.

POLICY

The patient will be identified and chart reviewed by the Circulating Nurse in transfer area of Operation Theater. Verification of Surgical and Anaesthesia consents and operative site must be confirmed according to established policy. (Refer Nursing Manual Policy and Procedure No. 25 and 27)

PROCEDURE

Identify the patient/review chart:

1. Ask the patient's name.
2. Check identification band against the patient's verbal response and the chart.
3. Ask the patient to identify the procedure to be done and the operative site.
4. Check for completeness of ordered investigations.
5. Check the procedure on the consent form against the operating room schedule.
6. Check to see that all jewellery is removed.
7. Question the patient as follows:
    a. Time of last food or drink.
    b. Any known allergies.
    c. Presence of prosthetics and remove as necessary.
8. Take the patient to the Operating Room and position on the Operating Room table.
9. Counter check Pre operative checklist.

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ANNEXURE I
(Refer to Nursing Manual Policy and Procedure No. 71)

CHECKLIST OPERATING ROOM [O.R.] 1/2/3/4 FOR NEXT DAY SCHEDULE (FIRST CASE)

Sr. No.	Responsibility	YES	NO	NA
	HOUSKEEPING OR CLEANING WITH BACILLOCIDE 2% (20ml IN 1 Liter)			
1	Floor Wall			
2	OR Door & Its Handle			
3	Windows			
4	OR Light, Switch Plates			
5	X –Ray View Box			
6	OR Table & Its Attachments & Pendent Cleaning			
7	Foot Step			
8	I.V. Stand			
9	Instrument Trolley & Wheels			
10	Patient Trolley (Cushion, Wheels, Side Rail)			
11	Count Board			
12	Roller/Shifter			
13	Suction Bottles, Tubings, Wheels			
14	Stool, Chairs & Wheels			
15	Beans As Per Colour Code			
	O.R. TECHNICIAN (Checked & found functional)			
1	Anaesthesia Machine			
2	Multipara Monitor			
3	Cautery Machine			
4	C-Arm Machine			
5	Suction Machine			
6	Laser Machine			
7	Syringe Pump			
8	Tourniquet			
9	Defibrillator			
10	Video Trolley With All Accessories			
11	Lithoclast Machine			
12	Flexible Endoscopes			
13	Extension Board And Spy Guard			
14	OR Light			

Sr. No.	Responsibility	YES	NO	NA
15	X – Ray View Box			
16	Crash Cart			
17	Patient Warmer			
18	OR Tables And Attachments			
	O.R. NURSES			
1	Instrument Sets As Per Surgery			
2	Special Instruments As Per Surgeon's Requirement			
3	Linen And Gown Packs			
4	**DRESSING TROLLEY - :**			
a	Cleansing Solutions (Spirit, Betadin, Hydrogen Peroxide,			
b	Betascrub, Ether, Tr. Iodine, Tr. Benzoin, Sterlium) Dressing Material			
c	Tailor Scissor			
d	Micropore, Dynaplast.			
e	Adhesive Tapes			
5	**CONSUMABLES - :**			
a	All Disposables			
b	Sutures			
c	Medications			
d	Specimen Container (All Sizes) & Swabs Sticks In Each OR			
e	Culture Swab sticks In Each OR			
f	OR Documents, Forms, Registers Etc			

Remarks (Mentioned details of items found non-functional)

Name & Signature of Nurse, Date & Time:- .....

ANNEXURE III
(Refer to Nursing Manual Policy and Procedure No. 71)

CHECKLIST OR 1/2/3/4 FOR O.T. TECHNICIAN BEFORE SURGERY

Sr. No.	NAME OF THE ITEM / EQUIPEMNT (Checked & Found Functioned)	YES	NO	NA
1	**Anaesthesia machine**			
	- Anaesthesia drugs as per check list			
	- Laryngoscope			
	- E.T tubes			
	- Air syringe			
	- Airway			
	- Throat pack			
	- Stylet			
	- Bougie			
	- Flexi / Trupti laryngoscope blade			
	- Bain circuit with Ambu bag			
	- Ventilator tubing			
	- Anaesthesia face mask			
	- Nitrous Oxide, Oxygen, air, central pendant, soda Lime, Sevoflurane, Isoflurane			
2	**Multipara monitor**			
	- B.P cuff and cable			
	- Pulse oximeter including probe			
	- E.C.G cable and ETCO2 module			
3	**Cautery machine**			
	- Cautery cable			
	- Patient plate			
	- Foot paddles			
4	**'C'-arm machine**			
5	**Suction Machine**			
	- Vacuum Pressure			
	- Suction Tubing			
	- Suction Bottles			
6	Syringe pump kept charging			
7	Tourniquet machine			
8	Defibrillator charged			
9	Laparoscopic camera(VIDEO TROLLEY)			
10	Laparoscopic light source cable			
11	CO2 insufflators			
12	Lithoclast machine			
13	All types of endoscopes e.g. gastroscope ,colonoscope			
14	Extension board or spikegaurd			
15	O.T. light			
16	Crash cart trolley			
17	Lumenis Laser			
18	Patient warmer			
19	X-ray view board			
20	**O.T Table**			

Sr. No.	NAME OF THE ITEM / EQUIPEMNT	YES	NO	NA
	- Attachment as per surgery checked			
21	**Miscellaneous** items			
	- Foot step			
	- I.V stand			
	- Patient shifter			
	- Bolster			
22	A/C switch ON ½ hour before surgery			

Remarks : (Mention in details items found non-functioned)

Name & Signature of technician, Date& Time:- .....

ANNEXURE II
(Refer to Nursing Manual Policy and Procedure No. 71)

OPERATING ROOM (O R) 1/2/3/4 CHECKLIST FOR NEXT CASE

MR No :
Name :
Age/Sex :
Comfort / Deluxe Bed No :
Date :

Sr. No.	Responsibility	YES	NO	NA
	HOUSKEEPING			
1	OR Cleaning (Bacillocide 0.5%/For Blood Spillage Use 1% Sodium Hypochloride)			
2	Keep Beans In Place As Per Colour Code			
3	Clean Suction Bottles, Cautery Machine.			
4	Clean The Scrub Station			
	OR TECHNICIAN			
1	Anesthesia Machine			
2	Suction Machine			
3	OR Tables And Attachments			
4	Cautery Machine			
	OR NURSES			
1	Instrument Sets As Per Surgery			
2	Special Instruments As Per Surgeon's Requirement			
3	Linen And Gown Packs			
4	**Dressing Trolley - :**			
a	Cleansing Solutions (Spirit, Betadin, Sterilium)			
b	Dressing Material			
5	**CONSUMABLES - :**			
a	All Disposables			
b	Sutures			
c	Medications			
d	Keep Specimen Bottles & Swabs Sticks In Each OR			

Name & Signature of Nurse, Date & Time:- .....

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NURSING MANUAL

PRE-SURGERY OPERATING THEATRE PREPARATION		
Policy/Procedure Applies To	**Operation Theatre Nurses**	**Policy/Procedure No: 71** **Page: 1 of 2**
Effective Date: 11 April, 2013		

PRE-SURGERY OPERATING THEATRE PREPARATION

PURPOSE

1. To provide a safe environment with least possible number of microorganisms before the patient is wheeled in to the operating room
2. To Ensure that all equipment is in proper working order.

POLICY

1. The Circulating Nurse should check the operating room schedule the day before surgery
2. The operating room Nurse should be in the assigned room long enough to prepare for the surgical procedure. Centralized sterile supply department should be notified of any special equipment and / or instruments that may be needed for the case that are not readily available.
3. Personal cleanliness is extremely important for the operating room staff
    a. Don a clean, cotton scrub suit & a mask before entering the restricted areas.
    b. Before the preparation of the operating room, the Circulating Nurse should wash his / her hands thoroughly and don a surgical cap. (Refer to Hospital Infection Control Manual Policy and Procedure No. 4)
4. Ensure Damp dusting of the operating theatre is done by the housekeeping. OT matron will monitor this activity.
5. Consult with the Scrub Nurse on the arrangement of the furniture & equipment needed for the surgical procedure.
6. Check equipment, arrange furniture, and restock supplies.
    a. Wet vacuum the floor using 1% sodium hypochlorite
    b. Set up the equipment and check each item for proper functioning.

PROCEDURE

1. Damp dusting should be done before the first scheduled incision of the day
2. Start with the tallest equipment and work down since this method helps the settling of airborne microorganisms.
3. Damp dust the operating room overhead light first, then the operating table.
    a. Switch on the overhead light to ensure proper functioning.
    b. Check the operating table for proper working order.
    c. Check the suction machine, the electrosurgical unit, and other pieces of equipment in the operating room whether or not they are to be used.
    d. Line the kick buckets with plastic bags of appropriate color.
    e. Check the supply cabinets for stock. Restock, if necessary.

PRE-SURGERY OPERATING THEATRE PREPARATION		
Policy/Procedure Applies To	**Operation Theatre Nurses**	**Policy/Procedure No: 71** **Page: 2 of 2**
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4. Place sterile goods on the tables or stands where they will be used to avoid having to move them from one place to another.
   a. The linen or drape pack on the large instrument table (back table).
   b. The gown pack on the prep table.
   c. The Mayo tray on the Mayo stand.
   d. The sterile basin set into the ring stand.
   e. The prep set placed on the prep table.
   f. The instrument set on a ring stand or table.
5. Put sterile packages that the scrub will not need immediately
6. Do not place sterile supplies on the operating table
7. While opening the sterile supplies integrity of every package will be checked for tears, punctures, watermarks, expiration date, and the sterilization indicator.
8. Open the packs and sets in the order in which the scrub will need them.
   a. Remove the tape from the packages
   b. After opening the pack containing the scrub's gown, open the basin set, the linen pack, the prep set, and the instrument set.
9. Detailed check lists for the Operating Room ready for the first case of the day, after a case is finished and ready for the next case, action to be taken by O.T. Technician, are given as Annexure I, II and III respectively and required to be followed strictly by all concerned.

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NURSING MANUAL

GLOVE CASES		
Policy/Procedure Applies To	**OT & Procedure Room Nurses**	**Policy/Procedure No: 72** **Page: 1 of 1**
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GLOVE CASES

The following cases may be classified as glove cases. Glove cases are defined as procedures in which scrub and gowning are not necessary for personnel unless otherwise specified by surgeon.

1. Myringotomy
2. Endoscopy cases
3. Closed reductions
4. Cast applications
5. Local excision (at the discretion of the physician)

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NURSING MANUAL

SURGICAL HAND SCRUBBING AND DRYING TECHNIQUE		
Policy/Procedure Applies To	**All members of Surgical Team**	**Policy/Procedure No: 73** **Page: 1 of 4**
Effective Date: 11 April, 2013		

SURGICAL HAND SCRUBBING AND DRYING TECHNIQUE

SCOPE

All members of surgical team.

PURPOSE

Skin is a major potential source of microbial contamination in the surgical environment. Although scrubbed members of the surgical team wear sterile gloves, the skin of their hands and forearms should be cleaned preoperatively to reduce the number of micro-organisms in the event of glove tears. The purpose of the surgical hand scrub is to remove debris and transient micro-organisms from the nails, hands and forearms; reduce the resident microbial count to a minimum; and inhibit rapid rebound growth of micro-organisms.

POLICY

All members of the surgical team will complete the surgical hand scrub using aseptic technique in order to mechanically and chemically reduce microbial flora on the skin of hands and forearms in the event of glove failure.

PROCEDURE

1. PREPARATION OF SURGICAL HAND SCRUB

ACTION	RATIONALE
1. Rings, watches and bracelets should be removed before beginning the surgical hand scrub.	During hand washing, rings, watches and bracelets may harbour or protect micro-organisms from removal. Allergic skin reactions may occur as a result of a scrub agent or a glove powder accumulating under the jewellery.
2. Fingernails must be kept short, clean and healthy.	The subungual region harbours the majority of micro-organisms found on the hand. The risk of tearing gloves increases if fingernails extend past the fingertips.
3. Skin on hands and arms should be intact.	Breaks in skin integrity and open lesions increase the risk of patient and surgical team member infection. Cuts, abrasions, exudative lesions and hangnails tend to ooze serum, which may contain pathogens. Broken skin permits micro-organisms to enter the various layers of skin, providing deeper microbial breeding grounds.
4. If timed scrub technique is used, a clock should be visible for the timed scrub.	Standard timing is necessary for effective preparation of the surgical team's hands and arms.
5. An effective antimicrobial surgical hand scrub agent Micro Shield PVP 10% approved by Prime Surgical Centers should be used for	An antimicrobial agents kills micro-organisms and reduces the level further by its residual effect, but can be inactivated by organic material.

all surgical hand scrubs. The agent should be used according to the manufacturer's instructions.	Efficacy of the agents depends on its proper use.
6. The selected antimicrobial hand scrub agent should: a. Significantly reduce selected micro-organisms on intact skin b. Contain a non-irritating antimicrobial preparation c. Be broad spectrum d. Be fast acting e. Have a residual effect	Organisms reproduce in the moist environment of gloves, and gloves frequently become damaged during procedures; therefore, persistent chemical activity is desirable to suppress microbial growth. No agent is ideal in every situation. Agents should be selected based on these factors and their acceptability to the surgical team for their consistent use according to the manufacturer's direction.
7. A non medicated soap scrub followed by application of an alcohol-based hand cleanser may be used.	The primary action of cleansing with soap is the mechanical removal of transient organisms. Vigorous rubbing with enough alcohol-based hand cleanser to cover the hands and forearms completely has been shown to be an effective method of antisepsis.
8. Micro Shield PVP containers should be discarded when empty.	

2. SURGICAL HAND SCRUB

ACTION	RATIONALE
1. The hand scrub procedure should be utilized by all personnel working in the OT/Procedure Room according to this policy/procedure.	A standardised surgical hand scrub procedure establishes a single standard of care. Although the skin can never be rendered sterile, it can be made surgically clean by reducing the number of micro-organisms.
2. The hands and forearms are thoroughly moistened and washed using Micro Shield PVP 10% agent and rinsed before beginning the surgical scrub procedure.	A short, pre-scrub wash loosens surface debris and transient micro-organisms.
3. The water is of a comfortable temperature and steady flow.	Setting the temperature and flow of the water before beginning the surgical hand scrub prevents cross-contamination.
4. The hands should be held higher than the elbows and away from surgical attire. Rinsing is performed from fingertips to elbows, using water flow and not hands. Do not shake hands vigorously to dispel water from hands and arms.	Hands and forearms are held higher than the elbows and out from the surgical attire to prevent contamination and to allow water to run from the cleanest area down the arm. Water droplets dispersed by shaking can contaminate surrounding attire or supplies.

SURGICAL HAND SCRUBBING AND DRYING TECHNIQUE		
Policy/Procedure Applies To	**All members of Surgical Team**	**Policy/Procedure No: 73** **Page: 3 of 4**
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5. Care should be taken to avoid splashing water onto surgical attire.	A sterile gown cannot be put on over damp surgical attire without risk of resultant contamination of the gown by strike-through moisture.
6. Micro Shield PVP 10% should be applied with friction to the wet hands and forearms.	The principle action of hand washing is mechanical-vigorous rubbing that produces friction, which removes dirt, transient microorganisms, and some resident microorganisms.
7. Fingers, hands, and arms should be visualized as having four sides; each side must be scrubbed effectively.	The surgical scrub is effective only if all surfaces are exposed to mechanical cleaning and chemical antisepsis.
8. Nails and subungual areas, and only nail and subungual areas, should be brushed	The majority of flora on the hands is found under and around the fingernails. Brushing other areas of the hands and arms has been shown to abrade the skin surface detrimentally.
9. Timed Technique: Scrub hands for at least two minutes. Break the process into three stages: a. wash hands and arms as far as elbows b. wash hands and arms but not as far as the elbow c. wash hands and only two-thirds of forearm	Optimal length of scrub time is not known, but recent studies suggest scrubbing for at least two minutes is as effective at reducing bacterial colony counts as the traditional ten minute scrub. Longer scrubs lead to a greater number of skin problems among staff and discourage compliance.
10. Counted Stroke Technique: The digits, hands, forearms, and arms are divided into four planes a. Each plane requires 10 strokes with the scrub sponge. b. The digits have 4 planes and each digit will have a total of 40 strokes. c. The dorsal and palm of the hand will have a total of 30 strokes. d. The forearm has 4 planes and it will have a total of 40 strokes. e. The elbow has 4 planes and it will have a total of 40 strokes. f. The arm 5 cm above the elbow has 4 planes and it will have a total of 40 strokes. g. The counted stroke technique will be completed on the right and left side.	

SURGICAL HAND SCRUBBING AND DRYING TECHNIQUE		
Policy/Procedure Applies To	**All members of Surgical Team**	**Policy/Procedure No: 73** **Page: 4 of 4**
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11. Hands and forearms should be blotted dry starting with the fingertips and proceeding to elbows with a sterile cloth or disposable towel before donning sterile gown or gloves.	Rubbing skin to dry it will further disturb skin cells. The fingertip to elbow process completed on one hand and using another portion of the sterile towel (or another sterile towel) to dry the other hand preserves the hands as the cleanest area.

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NURSING MANUAL

PATIENT POSITIONING IN THE OPERATION THEATER AND PROCEDURE ROOM		
Policy/Procedure Applies To	**OT & Procedure Room Nurses & Technicians**	**Policy/Procedure No: 74** **Page: 1 of 6**
Effective Date: 11 April, 2013		

PATIENT POSITIONING IN THE OPERATION THEATER AND PROCEDURE ROOM

PURPOSE

1. The proper positioning of the patient on the table is one of the most important steps of the operative procedure which will affect the welfare of the patient. Always remember to keep the patient as comfortable as possible, regardless of whether he is awake or asleep.
2. During anaesthesia the patient is unable to take care of his needs and we must act on his behalf at all times. This is one of the most important responsibilities of the nurses in the operating room.

SCOPE

1. The choice of position is determined by each individual Surgeon and Anaesthesiologist.
2. The Circulating Nurse / O.T.Technician is responsible for placing patient in correct position under the direction of the Anaesthesiologist. Extremities are to be padded and protected as per individual needs.
3. The Anaesthesiologist assists Circulating Nurse in positioning and overseeing procedure.
4. In difficult cases or where more detailed positioning is needed or where patient is extremely obese, the Surgeon himself will position patient with the help of Circulating Nurse and/or Anaesthesiologist.

GENERAL INFORMATION

1. Factors affecting type of positioning:
    a. Site of patient's operation
    b. Age and size of patient.
    c. Presence of pain upon moving.
    d. Skin Condition.
    e. Nutritional Status.
    f. Type of anaesthetic agent and anaesthesia used.
    g. Underlying physical limitations and/or impairment.
    h. Normal Range of movement.
    i. Back problem or deformities.
    j. Pre-existing medical conditions.
    k. Previous surgeries and complications.
    l. Implants e.g. total joint prosthesis.
    m. Special Considerations:
        i. Handle patient's blanket and gown gently to avoid throwing lint and bacteria into the air which could settle on sterile tables.
        ii. Table should be placed so that operative area is well illuminated.
        iii. Treat patient as individual.
            - Reassure patient and explain everything you plan to do.
            - Help alleviate his fears.
            - Always try to make patient comfortable.
            - If local Anaesthesia is used, remember patient can hear any conversation.

- Instill confidence by being friendly, firm, unexcitable, well organized and by working with assurance.
- Protect him from exciting factors, such as clattering of instruments. If discussion of procedure is necessary, do so out of patient's hearing.

2. Purpose of a good positioning:
   a. To allow free respiration.
      i. To prevent hypoxia.
      ii. To aid induction of inhalation anaesthesia.
      iii. To provide maximum safety for the patient.
   b. To free circulation.
      i. To permit free flow of intravenous solution.
      ii. To help maintain blood pressure.
      iii. To prevent pressure injury, stasis and post-operative circulatory disturbances. It is an established fact that smudging of blood, which occurs when the circulation is poor, predisposes thrombus formation.
   c. To prevent pressure on any nerves & muscle which may cause tingling, numbness, tenderness, paralysis or nerve & muscle trauma.
   d. To support hand and feet for preventing hand/foot drop.
   e. To prevent skin injury due to intensity and duration of pressure.
   f. To prevent undue post-operative discomfort.
      i. If patient's head is extended for a long time he may suffer more discomfort from resulting "stiff neck" than from actual surgery.
      ii. Avoid strain on muscles of limbs and body.
   g. To provide accessibility to the operative area.
      i. Permits surgeon to reach affected area as conveniently as possible.
      ii. Patient must be stabilized so he maintains position throughout surgery.

      To ensure protection from falls after sedation - Vertigo may result from pre-op medication. Patient should not be left alone when on operating room table.
3. When transferring patient from stretcher bed to operating room table, make sure:
   a. Table is locked.
   b. Space between cart and table is at a minimum.
   c. It is necessary to have two people when transferring, one on opposite side of table.
4. When patient ambulates to operating room:
   a. Have patient stand close to table.
   b. Sit first, then swing legs to foot section.
   c. Slowly lower head of table until patient is in proper operative position.
5. Further protective measures:
   a. When moving stretcher through doorway, patient's arms must be at sides to protect them with side rails up.

b. Any moving of patient must be done gently and slowly. Turning the patient too quickly from prone to dorsal or vice versa can cause circulatory depression. This can also occur when turning into or out of Trendelenburg position. Lower table gradually and by degrees.

c. When positioning patient the Anaesthesiologist should tell the Circulating Nurse when patient can be safely positioned.

6. Table Attachments
   a. Leg holders, which include handling straps that suspend the ankles and padded foot and calf support.
   b. Shoulder supports, which may be necessary to secure patients in a steep head-down tilt position.
   c. Skull clamps to provide maximum stability of the positioned head
   d. Arm boards, which may be contoured to cradle the patient's arm and protect the biceps, elbows and forearms
   e. Additional upper extremity support systems, which are designed to support the upper arm, forearm, wrist and / or hand
   f. Lateral positioning bars and posts.
7. Pads and Positioning Devices
   a. Arm pads: Arm pads redistribute pressure from pressure points to a larger surface area. They include ulnar nerve protectors and variety of larger pads that cushion the whole arm.
   b. Donuts: Donut-shaped head pads are designed to protect and cradle the patient's head. Smaller donuts may be used to cradle other parts of the anatomy.
   c. Rolls: Full and half-round positioning devices are used to lift certain areas of the body off the mattress, restoring more physiological alignment and relieving down-side pressure points.
   d. Heel Cups/mini positioners: Heel cups are appropriate for any procedure that is lengthy and involves pressure at the patient's heel area. A slit in back of the cup secures the patient's Achilles tendon. Heel cups can be used in multiples to provide quick, easy protection of any bony prominence or potential high-pressure area.
   e. Egg-crate foam: A convoluted foam mattress overlay (egg-crate foam) is effective in reducing pressure only if it is made of thick, dense foam that resists compression.
   f. Vacuum bean bags: Vacuum bags contain tiny plastic pellets. They are molded to the shape of the positioned patient and then the contained air is evacuated, stiffening the bag to help hold the patient in place.
8. Secure Devices: Restraining straps are justified for most operations to prevent patients from falling off the table, but such straps must be used with care.
9. Choosing Positioning Devices
   a. Availability in a variety of sizes and shapes
   b. Durability (if not disposable)
   c. Ability to conform to the patient's body, distributing pressure evenly without any "bottoming out" effect.
   d. Ability to maintain a normal capillary interface pressure of 32 mm Hg or less
   e. Resistance to moisture and microorganisms
   f. Radiolucency
   g. Fire resistance

h. Non allergenicity
i. Ease of use
j. Ease of cleaning/disinfection (if not disposable)
k. Ease of storage, handling and retrieval
l. Cost effectiveness

BASIC SURGICAL POSITIONS

Most surgical procedures are performed with the patient in some variation of one of the following four positions:

1. Supine (face-up)
2. Head-up tilt
3. Head-down tilt (formerly known as Trendelenburg)
4. Lithotomy (Face-up, with the legs elevated and hips abducted)
5. Lateral (on the side)
6. Prone (face-down)

PROCEDURE

1. Supine-Local
   a. Pillow under head.
   b. Safety strap across upper leg.
   c. Snuggle arms on armboard, at side or across chest, depending on procedure and patient comfort.
2. Supine-General
   a. Armboard under arms
   b. Legs uncrossed.
   c. Safety strap across upper legs snugly.
   d. Cover patient with blanket.
3. Prone-Local
   a. Armboard under arms.
   b. Pillow under chest.
   c. Cover patient with blanket.
   d. Safety strap across upper posterior leg snugly.
4. Prone-General
   a. Patient asleep on cart.
   b. Patient intubated under general anaesthesia.
   c. Patient turned onto blanket rolls or chest bolsters.
   d. Both arms positioned on arm boards. May need blanket or sheet to support arm. Axillary area free. No pressure on brachial plexus.
   e. Assist Anaesthesiologist in positioning head. May need blankets and sheets for support.
   f. Legs padded with blanket or pillow to assure toes will dangle freely.
   g. Check and eliminate pressure points.

h. Apply safety strap snugly over posterior upper legs.
i. Make sure emergency cart is outside room at all times in the event of an emergency situation.
j. May be put on table in jack-knife position.

5. Lithotomy-Local
   a. Have stirrups and straps ready on one side of table.
   b. Ask patient to sit on the table on the side without stirrups.
   c. Position patient so that the buttocks are on edge of table cut-out (almost feels like sitting in a hole).
   d. Cover patient with blanket.
   e. Arms may be folded across chest or on armboard at side, depending on procedure and comfort of patient.
   f. Put feet into stirrups.
   g. Keep exposure on patient to a minimum.
   h. Remove padding, crank down foot portion of table.
6. Lithotomy-General
   a. Have stirrups and straps ready on one side of table.
   b. Ask patient to sit on the table on the side without stirrups.
   c. Position patient so that the buttocks are on edge of table cut-out (almost feels like sitting in a hole).
   d. Cover patient with blanket.
   e. Arms may be folded across chest or on armboard at side, depending on procedure and comfort of patient.
   f. Patient induced.
   g. Put feet into stirrups.
   h. Keep exposure on patient to minimum.
   i. Remove padding, crank down foot portion of table.
7. Lateral-Local
   a. Give patient pillow for head.
   b. Have patient become as comfortable as possible.
   c. May give blanket or pillow to put between knees.
   d. Cover patient with blanket or sheet.
   e. Apply safety strap snugly across upper legs or put side rails up of the cart on your opposite side.
8. Lateral-General
   a. Armboard under arms
   b. Legs uncrossed.
   c. Safety strap across upper legs snugly.
   d. Cover patient with blanket.
   e. After intubation with adequate lifting, help turn patient to appropriate side.
   f. Assist Anaesthesiologist with positioning of head. May need extra blanket or sheet.

PATIENT POSITIONING IN THE OPERATION THEATER AND PROCEDURE ROOM		
Policy/Procedure Applies To	**OT & Procedure Room Nurses & Technicians**	**Policy/Procedure No: 74** **Page: 6 of 6**
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g. Place blanket or pillow between knees. Lower leg should be flexed. Upper leg should be straight.

h. Check for and eliminate pressure points.

i. Lower arm on armboard.

j. Upper arm may be on padded mayo or pillow or flexed and positioned by Anaesthesiologist.

Note: Soft patient restraint straps may be used to secure arm or arms on armboards. They are to be wrapped around and tied loosely but secure.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

BODY MECHANICS, POSITIONING AND DRAPING THE PATIENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 75** **Page: 1 of 3**
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BODY MECHANICS, POSITIONING AND DRAPING THE PATIENT

GUIDELINES

1. When an action requires physical effort, try to use the largest muscles or group of muscles possible. For example, use both hands rather than one hand to pickup an object.
2. Use good posture. Keep your body aligned in front of your work. Maintain the natural curves in your back, keeping ears, shoulders and hips in vertical alignment. Bend your knees. Keep your weight balanced evenly on both feet.
3. Keep your feet slightly more than hip width apart to give you a broad base of support and good balance.
4. Position your body close to the load being lifted.
5. When you have to move a heavy object, push it or roll it rather than lift and carry.
6. Use your arms to support the object. Keep your arms in a fixed position with elbows close to your sides. The muscles of your legs not the muscles of your back and arms should do the job of lifting.
7. When you are doing work such as giving a back rub, making a corner on a bed or moving the patient, align your body in the direction of your work. Avoid twisting at the waist. Always turn or pivot with your feet or shift your weight from one foot to the other.
8. When you lift an object
    a. Squat close to the load.
    b. Maintain the natural curves in you back
    c. Grip the object firmly
    d. Hold the load close to your body.
    e. Keep your arms fixed and close to your sides.
    f. Lift by pushing up with your strong leg muscles (avoid lifting load with arms to chest and then standing)
9. Ask for assistance if you think you may not be able to lift the load yourself.
10. Lift smoothly; don't jerk. Always count “one, two, three” when working with another person or say “ready” and “go” so that you work in unison. Do this with both the patient and with other health care workers.
11. When you want to change the direction of movement:
    a. Pivot (turn) feet
    b. Use short steps.
    c. Turn your whole body using your feet to avoid twisting your back and neck.

BODY MECHANICS, POSITIONING AND DRAPING THE PATIENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 75** **Page: 2 of 3**
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POSITIONING AND DRAPING THE PATIENT

Draping covers a patient's entire body or parts of the body with a sheet, blanket or other material. Draping is usually done during the physical examination of the patient and during surgery. A drape is the actual cover used to provide privacy during an examination or an operation.

1. Horizontal Recumbent Position (Supine Position)

   In the supine position, the draping covers the entire body. The patient lies on his/her back with the legs together and extended or with the knees bent slightly to relax the muscles of the abdomen. A pillow is placed under the patient's head; the drape is spread loosely over the patient's body

2. Dorsal Recumbent Position

   In the dorsal recumbent position, the patient's legs are separated, the knees are bent, and the soles of the feet are flat on the bed, Drape the female patient by putting a sheet, folded once, across her chest. Put a second sheet crosswise over her legs loosely so that the perineal region (the area of the body between the thighs) can be exposed for examination

3. Fowler's Position

   Fowler's Position is also called the high Fowler's Position. The patient is partly sitting with the back rest of the bed at a 45 degree – 90 degree angle. The knees are slightly bent. For the semi Fowler's Position the incline is less than the Fowler's Position. The head of the bed is raised 30 degree - 45 degree and the patient's knees are slightly bent.

4. Knee-Chest Position

   In the Knee-Chest Position, the patient rests on the knees and chest. The head is turned to one side with the cheek on a pillow. The patient's arms are extended slightly, bent at the elbows. Although the arms help support the patient, the main body weight is supported by the knees and chest. The knees are bent so that they are at right angles to the thighs. Draping is done with two sheets, one for the upper part of the body and one for the lower part. This position is used in rectal and vaginal examinations.

5. Side-Laying Positions

   Side-Laying Positions are positions of comfort to relieve pressure points. Pillows are used to provide support and prevent skin breakdown

6. Trendelenburg's Position

   In Trendelenburg's Position, the draping covers the entire body. The patient's head is low; the body is on an incline, carefully supported to prevent the patient from slipping out of position or being injured. This position is used for postural drainage, prolapsed cord situations and so on.

7. Reverse Trendelenburg

   In reserve Trendelenburg position, the patient's body is on an incline so that the feet are lower than the head. Again, the body is completely draped

BODY MECHANICS, POSITIONING AND DRAPING THE PATIENT		
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8. Dorsal Lithotomy Position

   The Dorsal Lithotomy Position is the same as the dorsal recumbent position, except that the patient's legs are well separated and the knees are bent more. This position is used often for examination of the bladder, vagina, rectum and perineum. If an examination table is being used, the patient's feet are sometimes placed in stirrups.

9. Prone Position

   In the Prone Position, the patient lies on the abdomen with the arms at the sides or bent at the elbows. The patient's head is turned to the side.

10. Left Sims's Position

    Sims's Position is also called the semi prone position. The patient lies on the left side. The patient's cheek is resting on a small pillow that is placed under the head. The right knee is bent against the patient's abdomen. The left knee is also bent, but not as much. The left arm is placed behind the body and the right arm rests in a way that is comfortable for the patient. This position is used for rectal examinations and enemas. Draping covers the entire body.

11. Left Lateral Position

    In the Left Lateral Position, the patient lies on the left side. The hips are closer to the edge of the bed than the shoulders. The knees are bent, one more than the other.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

GOWNING AND GLOVING		
Policy/Procedure Applies To	**Surgical Team and Other participants in Operation Theatre**	**Policy/Procedure No: 76** **Page: 1 of 3**
Effective Date: 11 April, 2013		

GOWNING AND GLOVING

PURPOSE

To allow Operation Theatre Nurses and Surgical Team to participate in surgical procedures while maintaining asepsis.

POLICY

All Operation Theatre Nurses and Surgical Team will don sterile gown and gloves in order to participate at the sterile field.

PROCEDURE

1. Closed glove and gowning technique

a. This technique is used for initial gowning and gloving. If during this procedure gown and/or gloves must be changed, open method must be used.

b. Facts to remember:

i. Care must be taken to avoid contamination of outstretched sleeves while donning gown.

ii. The back of the gown is non-sterile after being donned.

iii. Only the front of the gown between waist and chest region is considered sterile.

iv. Wet sleeves or a part of the gown which is wet is no longer sterile.

v. The outside of the gown must not be touched with ungloved hand.

vi. A torn gown or one with holes must be removed by circulating nurse.

c. Gowning procedure

i. Using sterile technique, open gown and glove package to allow for donning without contamination. Place on surface away from traffic pattern, i.e. Mayo stand, prep stand, never on open back table

ii. After thoroughly drying hands (Refer Nursing Manual Policy and Procedure No. 73), pick up gown without touching glove packet.

iii. Lift gown directly upward, avoiding edge of wrapper and drop bottom of gown gently, making sure it does not touch anything unsterile. If top of gown should be dropped downward inadvertently, discard gown. (Never correct a piece of linen once the wrong end has been dropped.)

iv. Slip hands into armholes and extend hands sideways. Do not put hands through cuff of gown. Do not let hand go closer than 2.5cm from edge of cuff.

v. Allow Circulating Nurse/Technician to pull gown over the shoulders from inside, grasp ties and tie at the waist.

d. Gloving procedure

i. Open glove packet being careful not to touch edges of wrapper.

ii. Pick up glove by grasping cuff with gown covered hand.

iii. Place glove on sleeve of gown with thumb down and fingers of glove extending up arm.

iv. Grasp under cuff of glove and with opposite hand, pull upper cuff of glove over cuff of gown.

v. Work fingers through gown cuff into glove by slowly pulling gown and glove at same time.

GOWNING AND GLOVING		
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2. Gowning and gloving surgeon

a. Procedure for gowning surgeon

i. When surgeon is ready to be gowned, grasp gown at upper third and while being careful to hold high and avoiding any unsterile object, drop bottom of gown.

ii. Keep hands on outside of gown and under a protective cuff made at neck area and back edges, keep cuff ends toward you to protect gloves while gowning.

iii. Offer inside of gown to surgeon and he will slip his arms into it.

iv. Release gown and pull sleeves of gown down with steady pull.

v. Be careful strings of gown do not flip back to unsterile back and then hit your gloves or front of gown.

b. Procedure for gloving surgeon

i. Grasp the right glove firmly with fingers under the turned back cuff.

ii. Hold palm of glove toward surgeon.

iii. Surgeon will plunge hand into glove. Release glove as cuff goes over his gown.

iv. Repeat procedure for the next glove.

3. Open glove technique

a. This technique is used if gloves become contaminated during procedure.

b. Facts to remember

i. Pick up left glove with right hand at folded edge of cuff. This is optional, if right glove is put on first, reverse steps.

ii. Insert left hand into glove and draw on, leaving cuff turned well down over hand.

iii. Slip fingers of left glove under turned back cuff of right glove, pick it up and step back from field.

iv. Insert right hand into right glove and pull it on, leaving cuff turned well down over hand.

v. Turn over a pleat on right cuff of gown and hold it with left thumb. With fingers on left hand, pull cuff of right glove over cuff on gown and sleeve.

vi. Repeat for left cuff.

4. Re-gowning and gloving during procedure

When removing gown, to prevent contamination, the nurse must not allow the strings or outside of gown to touch arms or hands. Gown is removed first, then the gloves. Remove gloves, observing "hand-to-hand and glove technique"

GOWNING AND GLOVING		
Policy/Procedure Applies To	**Surgical Team and Other participants in Operation Theatre**	**Policy/Procedure No: 76** **Page: 3 of 3**
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5. Use of powder in Operation Theatre

a. Powder should not be used in Operation Theatre.

b. Ordinary talcum powder has been found to be dangerous in a wound because it causes adhesions or granulomas.

c. Powder released into the air becomes part of dust and bacteria and will cause contamination.

d. Powder that falls from hands is no longer sterile and could cause contamination.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

SKIN PREPARATION (PRE–OPERATIVE)		
Policy/Procedure Applies To	**All Staff involved in providing Aseptic Care**	**Policy/Procedure No: 77** **Page: 1 of 2**
Effective Date: 11 April, 2013		

SKIN PREPARATION (PRE-OPERATIVE)

OBJECTIVE

To remove soil and microorganisms from the skin prior to surgery to sub-pathogenic amounts with the least amount of tissue irritation and inhibit their rapid rebound growth.

SCOPE

All Staff involved in providing Aseptic Care

PROCEDURE

1. Assemble all needed supplies.
2. Position patient for procedure.
3. Expose site and adjust overhead light. Check prep site for unwanted hair. Clip as necessary, if not already done.
4. Check chart for drug sensitivities.
5. Wash hands as per policy.
6. Don sterile gloves and place sterile towels at the scrub site to prevent pooling of antimicrobial solution.
7. Begin washing with an antimicrobial agent in a circular motion, starting at the incision site.
8. Repeat process with clean sponges for three to five minutes.
9. Dry prepared area.
10. Antiseptic paint may be applied immediately after the scrub preparation.
11. Specific areas:
    a. Abdomen - use cotton tip applicators to clean umbilicus.
    b. Elevated limbs – prepare most elevated point first rather than incision site.
    c. Anus - prepare surrounding area, i.e. buttocks, perineum or lower back, depending on position first. Prepare anus last.
    d. Vagina - begin preparing a few centimeters above vulva. Extend to include thighs and pubis. Prep inside vagina with sponge and forceps gently in a circular motion. Last, wash vulva and anus. Discard sponge. (Do not back track with sponge. Start at cleanest area and prep to most contaminated area).
    e. Eye - refer to specific procedure.

SKIN PREPARATION (PRE–OPERATIVE)		
Policy/Procedure Applies To	**All Staff involved in providing Aseptic Care**	**Policy/Procedure No: 77** **Page: 2 of 2**
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DOCUMENTATION OF SKIN PREPARATION

The documentation of skin preparation must include:

1. Pre-operative and post-operative skin condition (i.e., rashes, abrasions, skin eruptions)
2. Hair removal (i.e. method, time)
3. The antimicrobial solutions used.
4. Name of person performing skin preparation.
5. Any allergic reaction encountered.

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NURSING MANUAL

DRAPING FOR SURGICAL PROCEDURE		
Policy/Procedure Applies To	**All OT Nurses / Technicians**	**Policy/Procedure No: 78** **Page: 1 of 2**
Effective Date: 11 April, 2013		

DRAPING FOR SURGICAL PROCEDURE

PURPOSE

To create and maintain an adequate sterile field during the operation.

POLICY

The patient positioned on the operating room table shall be covered with sterile drapes in a manner which will isolate the surgical site and provide an effective bacterial barrier.

General Comments

Draping techniques are directed at containing the bacteria and preventing their migration to the surgical wound by creating and maintaining a sterile field.

PROCEDURE

1. **Guidelines**
   a. Patient draping is a joint medico-nursing responsibility. The areas of and about the surgical site as well as certain surgical equipment for use at the sterile field must be draped.
   b. When sterility is in doubt, consider the article contaminated. There is no gray zone; the article in question should be removed from the field.
   c. Gowned and gloved members must protect and maintain their scrubbed status, i.e., activities must be technique wise.
      i. Be aware of defined areas of sterility and maintain a safe distance from non sterile areas.
      ii. Touch only sterile equipment.
      iii. Do not lean over non sterile area.
      iv. In handling drapes, always protect the gloved hand within a fold (cuff) of the drape
   d. Draping activities must be slow and deliberate.
      i. Allow adequate time for draping procedures.
      ii. Keep all drapes folded until positioned.
      iii. Avoid over handling of drapes.
      iv. Draping components must be positioned slowly to avoid producing air currents and dispersing potential contaminants.
   e. Draping must be done as per functional requirement.
      i. In order to be an effective barrier, drapes must be devoid of defects (tears, holes, etc.)
      ii. Once a drape is positioned, do not reposition it; either reinforce the drape or discard it and position a new drape.
      iii. Draping components must adequately cover the prescribed areas, no more, no less.
2. **Draping the back table**

   The back table has an impervious plastic like sheet bonded to the underside so that once the drape is opened on the table it is virtually fluid and moisture proof.
   a. Personnel opening packs must wear mask.
   b. Remove the impervious outer plastic bag following the instruction on the label.
   c. Place pack in the center of the back table with arrow pointing toward self.

d. Grasp the outside of the table drape with minimal handling and open the drape laterally.

e. Standing at the front of the table, grasp the edges of the cuff and open toward self carefully draping over the edges of the table. Maintain a safe distance between the scrub dress and sterile drapes.

f. Move to the other side of the table and open toward self. The table is draped and the pack contents are exposed.

3. **Draping the Mayo stand.**

The Mayo stand cover resembles a long pillow case. The inner side of the Mayo stand cover is reinforced with an impervious plastic like sheeting creating a fluid proof drape.

a. The scrub nurse slides both hands, palms down, into the cuffs. (Cuffs are labeled with anatomical directions).

b. Keeping the hands protected within the generous cuff, slide the cover over the Mayo stand. The length of the cover is folded to facilitate gradual unfolding. Do not allow the closed end of the Mayo cover to fall below the waist level.

c. Continue sliding the cover over the stand until the open end extends downward over the vertical portion of the Mayo stand.

d. Tuck pleat the excess width. The circulating nurse may adjust the lower margins of the free hanging portion of the drape.

e. At the completion of the procedure, the Mayo stand cover may be used to collect all disposable contaminants.

4. **Draping components.**

a. **Towels** are used to outline the operative site as adjuncts for other areas and equipment. The folded edge of the towel is placed toward the line of incision.

b. **Drape sheets** are available in a variety of sizes and provide flexibility as components of the draping system. They are positioned to delineate the operative site. Once positioned, the drape sheet is opened laterally or longitudinally and toward the head and foot of the operating room table or toward either side.

c. **Laparotomy sheets** are also available in a variety of sizes and apertures to provide for flexible and specialized draping. These sheets are folded so that the aperture is positioned; it is opened laterally toward the foot and head of the operating room table.

d. **Split sheets** are specialty draping components in which one end of the sheet is split to form tails. Split sheets are valuable for draping body parts that do not lend themselves to fenestrated sheets such as the head and extremities. The tails are opened to circumvent the operative site and the other end is opened toward the opposite end of the operating room table.

e. **Plastic drapes** are made of plastic material which adheres to the incision area. The incision is made directly into or through the drape.

f. For laser procedures, cover drapes around surgical site with moist cloth towels.

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NURSING MANUAL

OPENING STERILE PACKAGES		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 79** **Page: 1 of 1**
Effective Date: 11 April, 2013		

OPENING STERILE PACKAGES

PURPOSE

To provide guidelines for proper monitoring and handling of sterile supplies used in a surgical procedure.

POLICY

The opening of sterile supplies shall adhere to a "technique-wise" procedure.

PROCEDURE

1. **Inspection**
   a. Check package for holes, tears, indications of exposure to liquids.
   b. Check sterilizer tape for sterility indicator. (Diagonal stripes should have turned if conditions for sterility have been met).
   c. Check expiry date, when appropriate.
2. **Wrapped packages**
   a. Holding package in left hand, open each flap, being careful not to contaminate inner wrapper.
   b. Do not let folds snap back.
   c. With other hand, hold three ends together under hand and sterile package. This will enclose hand.
   d. Hand package to scrubbed personnel or deposit carefully at the edge of sterile draped table.
3. **Peel pack envelopes**
   a. Place thumbs on inside of split open edges, pull down evenly and gently.
   b. Drop on sterile surface or allow scrubbed personnel to remove inner package.
   c. Check for a chemical strip which has been exposed to steam

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NURSING MANUAL

INTRA-OPERATIVE CHECKLIST		
Policy/Procedure Applies To	**OT Nurses/Procedure Room/Technicians**	**Policy/Procedure No: 80** **Page: 1 of 1**
Effective Date: 11 April, 2013		

INTRA-OPERATIVE CHECKLIST

OBJECTIVE

To ensure that all aspects of patient care are correct prior to beginning the procedure.

PERFORMED BY

Circulating Nurse

PROCEDURE

1. Surgeon and Circulating Nurse review the Intra-Operative Checklist prior to beginning procedure.
2. Circulating Nurse signs the Intra-Operative Checklist which becomes part of the medical record.

FORMAT

The format is attached as Annexure to this policy.

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ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 80)

INTRA-OP CHECK LIST

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Sr. No.	Description	Operationg Room No. 1	2	3	4
1	Confirm all team members have introduced themselves by name & Role		☐		
2	Patient has confirmed ☐ Identity ☐ Site ☐ Procedure ☐ Consent		☐		
3	Site Marked / Not Applicable		☐		
4	Anaesthesia safety check completed		☐		
5	Essential imaging displayed X-Ray, CT, MRI, and USG.		☐		
6	Surgeon, Anaethesiologist & Nurse verbally Confirm Patient Procedure Site ☐ Consent ☐		☐		
7	All Equipment Working		☐		
8	Assistant (If needed)		☐		
9	Skin Preparation		☐		
10	Verify that instrument, needle, swabs* counts are correct Before Surgery ☐ After Surgery ☐		☐		
11	Sterilization indicator have been confirmed		☐		
12	Special Equipment (If needed) Any other		☐		

* ONLY APPLICABLE FOR OPEN CASES

Name & Signature of Circulating Nurse, Date Time :- .....

Counter Signature of Anesthesiologist, Nurse, Date Time :- .....

ANNEXURE I
(Refer to Nursing Manual Policy and Procedure No. 81)

ANAESTHESIA RECORD FOR SHORT DURATION CASES

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

WEIGHT BL. GROUP

PRE-OP DIAGNOSIS :					
PROCEDURE					
ANAESTHESIOLOGIST :			SURGEON :		
DURATION :			POSITION :		
ANAESTHESIA : GA / SA / EA / LA / MAC			ASA- 1 2 3 4 5 E		
PT. RISK FACTORS : 1. 2. 3. 4. 5.			**PRE-OP MEDICATION :**		
PRE INDUCTION PARAMETERS :			P-	/min.	BP - /mmHg
CVS -	RS.	SpO_2- %	STARVATION	Hrs.	CONSENT Y / N
PRE-OP IV DRUGS : Sedation : Others :					

INDUCTION	**INTUBATION** Y / N	**MAINTENANCE**	**REVERSAL**
(Specify agent) INH / IV Muscle Relaxant	Tube No. Type - Oral / Nasal cuff- Y / N Pack - Y / N Larynx - Air Entry	Circuit - N2O - L/min O2 - L/min Air - L/min Iso / Sevo IV agent Pav / Vec / Atrac / Roc / Soc	Neo mg Atropine mg Glyco mg
LMA			
Mask			

SPINAL / EPIDURAL	**REGIONAL**	**EPIDURAL DOSES**
Position - Painting - Space - Needle - Catheter - Approach - Drug - Level - Spine -	Painting - Approach - Drug & Vol. Complications	Time Drug & Volume

POST - OP PARAMETERS -	P -	/ min.	BP -		mmHg
Respn -	Reflexes -	Y / N	Tone - Poor / Good		
Awake / Arousable / Unconsc	Extubation -	Y / N	T- Piece / Mech-Ventilation		

SHIFTED TO :
LEVEL OF ANAESTHESIA (in case of Spinal / Epidural) -
EPIDURAL CATHETER REMOVED - Y / N TIP INTACT - Y / N
POST - OP ANALGESIA :

TIME AM / PM	PULSE / min	BP MmHg	SPO2 %			DRUGS	

TOTAL INPUT

CRYST

COLLOID

BLOOD

TOTAL OUTPUT

BLOOD LOSS

POST - OP ORDERS :

1) NBM

2) Position

3) IV Fluids

ANAESTHESIA COMMENTS :

Name of Anaesthesiologist :

Signature :

Date & Time :

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NURSING MANUAL

INTRA-OPERATIVE RECORD		
Policy/Procedure Applies To	**OT Nurses/Procedure Room/Technicians**	**Policy/Procedure No: 81** **Page: 1 of 2**
Effective Date: 11 April, 2013		

INTRA-OPERATIVE RECORD

PURPOSE

To provide documentation of patient care during the intra-operative period.

POLICY

1. During the course of the intra-operative period, nursing care data and observations will be documented appropriately.
2. Each blank must be completed or indicated not applicable (N.A).
3. Anaesthesia Record will be the responsibility of the Anaesthesiologist and later on attached as Intra operative record duly signed with name, date and time. (Refer to Nursing Manual Policy and Procedure No. 25 for long term Anaesthesia Administration and Annexure I to this policy on Short term Anaesthesia Administration)
4. Operation Notes will be the responsibility of the Operating Surgeon. It will include account of findings at surgery as well as details of surgical technique. It will be written immediately following surgery and signed by the Surgeon with name, signature, date and time (Refer Annexure II to this policy). It will be attached as intra-operative record. (Also Refer General Manual Policy and Procedure No.)

PROCEDURE

1. After receiving report of pertinent information from the pre-operative staff, the circulating nurse will document appropriate information on the intra-operative record.
2. Record the following information:
   a. Patient identification, verification of signed consent, allergies, skin condition.
   b. Document verification of surgical site in nurse's notes.
   c. Describe positioning of patient to include safety padding (Refer to Nursing Manual Policy and Procedure No. 74) and Security measures.
   d. Describe ground pad placement if present, condition of skin before application, equipment type and settings.
   e. Record skin preparation solution. (Refer to Nursing Manual Policy and Procedure No. 77)
   f. Time surgery begins.
   g. Enter complete information regarding pre-op and post-op diagnosis, procedure performed, name and credentials of surgical team, medications administered (including local anaesthetic drugs), and information regarding any prosthesis or implant, and any special equipment used.
   h. Tourniquet data if used to include location, padding if used laterally, pressure setting, time up, time down, condition of site pre and post application and any problems encountered.
   i. Document specimens taken according to type, number and source.
   j. Document catheter placement and urine output as appropriate.

INTRA-OPERATIVE RECORD		
Policy/Procedure Applies To	**OT Nurses/Procedure Room/Technicians**	**Policy/Procedure No: 81** **Page: 2 of 2**
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k. Document type and location of dressings, drains or packing.

l. Document and sign for counts performed. (Refer to Nursing Manual Policy and Procedure No. 82)

m. Document any unusual outcomes or complications.

n. Time that surgery is completed.

Note: Throughout the Surgical Procedure, the Circulating nurse will ensure the checking and cross checking of above details from Surgeon / Anaesthesiologist / Scrub Nurse as applicable.

3. Anaesthesia record maintained by the Anaesthesiologist duly signed with name, date and time will be incorporated in intra-operative record.

FORMAT: The intra-operative record format is attached as Annexure III to this policy.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE III
(Refer to Nursing Manual Policy and Procedure No. 81)

INTRA-OPERATIVE RECORD

MR No :	IP No:
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Date	OR Room	Pt. Identified	Time in	Proc.Start	Proc.End	Time Out	Wound Class
		☐ Verbal ☐ ID BAND ☐ Parent ☐ Guardian					

Procedure / Side Verified : ☐ Right ☐ Left ☐ Bilateral ☐ Consents ☐ Surgeon ☐ Circulating ☐ Scrub ☐ Anaesthesiologist

☐ **Allergies :-**

Anaesthesiologist Name :-

Anaesthesia ☐ General ☐ MAC ☐ Local ☐ SAB ☐ Spinal ☐ Reg. Block ☐ EA

Surgeon Name :- **Assistant Name :-**

Scrub Name :- **Circulating Name :-**

Pre-op Diagnosis :-

Operative Procedure :-

Patient Position : ☐ Supine ☐ Prone ☐ Lateral ☐ L ☐ R ☐ Padded arm board ☐ L ☐ R ☐ Arm at Side ☐ L ☐ R ☐ Safety Strap ☐ Beach Chair ☐ Other

Skin Preparation : ☐ Betadine ☐ Dura prep ☐ Alcohol ☐ Other

Thermia Measures : ☐ Bair Hugger ☐ Warm Blanket ☐ Other

Cautery : ☐ Monopolar ☐ Bipolar Unit ☐ Coag ☐ Cut ☐ Blend ☐ Pad Placement

Tourniquet :- ☐ RA ☐ LA ☐ RL ☐ LL Applied By :-
Inflated Time :- Deflated Time :-
Total Time :-

Irrigation :- ☐ Normal Saline ☐ Lactated Ringer ☐ Antibiotic Added

COUNT BY : ☐ **Scrub** ☐ **Circulating**

Swab Count :- ☐ **Correct** ☐ **Incorrect**
Needle Count :- ☐ **Correct** ☐ **Incorrect**
Instruments Count :- ☐ **Correct** ☐ **Incorrect**

Types of dressing :- ☐ **Staples** ☐ **Suture**

Drain - Type :- _____
Site :- _____
Packing - Type :- _____
Site :- _____

Specimens :- Histopathology :- _____
Culture :- _____
Any Other :- _____

Nurse's Note : _____

Intra-op Total intake : **Intra-op total Output :-**

Transferred with :-

Name & Signature of Circulating Nurse, Date & Time :-

Counter Signature of Surgeon, Name, Date & Time :-

ANNEXURE II
(Refer to Nursing Manual Policy and Procedure No. 81)

OPERATION NOTES

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Date of Operation	Time Started	Time Completed	Duration in Hour	OR NO 1 / 2 / 3 / 4

Pre Operative Diagnosis :

Post Operative Diagnosis :

Type of Operative Wound	Clean ☐	Clean Contaminated ☐	Contaminated ☐	Dirty ☐
General Anaesthesia ☐	Spinal Anaesthesia ☐	Epidural Anaesthesia ☐	Monitored Anaesthesia ☐	Anaesthesia / Local ☐
Surgeon	Assistant	Anaesthesiologist	Scrub Nurse	Technicians

Counts :- ☐ **Correct** ☐ **Incorrect**

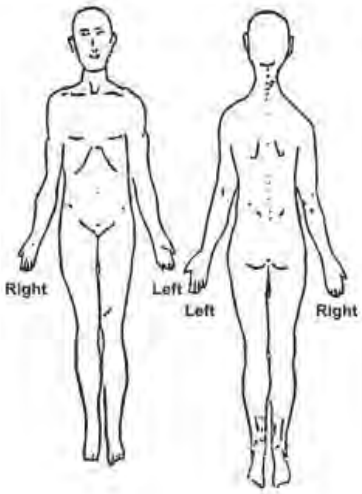
Emergency ☐ Yes ☐ No **Specimen Sent to Pathology :** ☐ Yes ☐ No

Name of the procedure(Indicate side of operation):-

Incision :

Findings :

PROCEDURE/OPERATION NOTES



CLOSURE :

DRAINAGE :

ESTIMATED BLOOD LOSS :

URINE OUTPUT :

NATURE OF SPECIMEN SENT :

POST OPERATIVE CONDITION :

POST OPERATIVE ORDERS :

Signature of the surgeon Date & Time:-	Signature of the Scrub Nurse Date & Time:-
Name of the surgeon Date & Time:-	Name of the Scrub Nurse Date & Time:-

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

SURGICAL COUNTS		
Policy/Procedure Applies To	**OT Nurses / Technicians**	**Policy/Procedure No: 82** **Page: 1 of 2**
Effective Date: 11 April, 2013		

SURGICAL COUNTS

PURPOSE

To provide guidelines for accountability for sponges, sharps and instruments used during surgical procedures. The implementation of accurate count procedure helps ensure patient safety.

SCOPE

All circulating nurses and scrub personnel

POLICY

1. Counting Sponges
   a. Sponges should be counted on all procedures. Sponges include gauze pads, cottonoids, peanuts, dissectors, laparotomy sponges, etc. used.
   b. Subsequent sponge counts should be taken:
      i. of additional sponges added to the sterile field,
      ii. before closure of any deep or large incision or body cavity,
      iii. at the time of permanent relief of scrub and/or circulating person(s), and
      iv. immediately before completion of the surgical procedure.
   c. Sponges should be counted audibly with the scrub person and circulating nurse concurrently viewing each sponge as it is counted.
   d. All sponges used during a surgical procedure should be x-ray detectable.
   e. All counted sponges should remain within the operating room and/or sterile field unless intentionally used as packing. If the patient leaves the operating room with this packing in place, the number and type of sponges retained as packing should be documented on the intra-operative record and an incident report be written accordingly.
   f. ONLY non x-ray detectable sponges should be used as dressings.
   g. Used sponges should be contained and confined. Soiled sponges should be handled with instruments and/or gloved hands only, never with bare hands.
   h. To avoid potential incorrect counts on subsequent procedure, all sponges should be accounted for and properly disposed off before preparing the room for the next patient.
2. Counting Sharps
   a. Sharps should be counted on all procedures. Sharps include suture needles, scalpel blades, hypodermic needles, electrosurgical needles and blades, safety pins, etc.
   b. Subsequent sharp counts should be taken:
      i. of additional sharps added to the sterile field,
      ii. before closure of the deep or large incision or body cavity,
      iii. at the time of permanent relief of scrub and/or circulating persons, and
      iv. immediately before completion of the surgical procedure
   c. Sharps should be counted audibly with the scrub person and circulating nurse concurrently viewing each sharp as it is counted.
   d. Suture needles should be counted according to the number marked on the outer package and verified when the package is opened.
   e. All counted sharps should remain within the operating room and/or sterile field.

SURGICAL COUNTS		
Policy/Procedure Applies To	**OT Nurses / Technicians**	**Policy/Procedure No: 82** **Page: 2 of 2**
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f. Sharps broken during a procedure should be accounted for in their entirety.

g. Sharps should be contained in puncture resistant, impervious containers and confined to ensure proper safe disposal as per laid down policy.

h. To avoid potential incorrect counts on subsequent procedures, all sharps should be accounted for and properly disposed of before preparing the room for the next patient.

3. Counting Instruments

a. Instruments should be counted on procedures in which the potential of entering a body cavity exists. Instruments mean surgical tools or devices to perform a specific function such as cutting, dissecting, grasping, holding, retracting, or suturing. Standardization of instrument sets with the minimum types and numbers of instruments in the set should be established.

b. An initial instrument count should be taken on applicable surgical procedures.

c. Subsequent instrument counts should be taken

i. of additional instruments added to the sterile field,

ii. before closure of a cavity or incision that might contain an instrument.

iii. at the time of permanent relief of scrub and/or circulating person(s), and

iv. at the completion of the surgical procedure

d. Instruments should be counted concurrently in the operating room by the scrub person and the circulating nurse.

e. All counted instruments should remain within the operating room and/or sterile field.

f. Instruments disassembled or broken during a procedure should be accounted for in their entirety.

g. Instruments should be contained and confirmed in impervious containers before decontamination.

h. To avoid potential incorrect counts on subsequent procedures, all instruments should be accounted for before preparing the room for the next patient.

4. Documentation

Sponge, sharps and instrument counts should be documented, as per Annexure, and the same will also be recorded in the patient's intra-operative record.

a. If count discrepancies occur:

i. all attempts should be made to find the missing item and rectify the discrepancy, then

ii. report incident to Operation Theater Matron, Surgeon and Nursing Superintendent as soon as discrepancy.

iii. X-ray to determine if lost item is on the patient (if applicable),

iv. document count discrepancy on OR record,

v. write an Incident Report (Refer to Nursing Manual Policy and Procedure No. 10).

b. Count sheets shall be kept with the Incident Report in the event of a discrepancy. If no discrepancy is present, count sheets do not need to be saved.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 82)

SWAB COUNT SPONGE RECORD

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Procedure Name :- .....

Surgeon Name :- ..... Asst. Surgeon Name :- .....

Scrub Nurse :- ..... Circulating Nurse :- .....

Count Item	First Count	Added	Total	Final
Sponges 30 x 30 "R/O				
Sponges 15 x 15 "R/O				
Gauze 4 x 4 "R/O				
Peanuts				
Instrument				
Needles				
Syringes				
Blade				
Rubber				
Neuro Patty				

Particulars of tubes inside :- .....

.....

Surgeon informed that above counts are correct :- .....

Name & Signature of Surgeon Date & Time .....

Name & Signature of Scrub Nurse Date & Time .....

Name & Signature of Circulating Nurse Date & Time .....

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

BLANKET/SOLUTION WARMER		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 84** **Page: 1 of 1**
Effective Date: 11 April, 2013		

BLANKET/SOLUTION WARMER

PURPOSE

There is a blanket/solution warmer in the OR substerile room for the purpose of warming blankets for patient's comfort and to warm solutions if needed.

POLICY

1. Optimum temperature for solution is 40.5 degrees Celsius.
2. Optimum temperature for blankets is 48.8 degrees Celsius.
3. A check of the temperature will be done daily and recorded in log book.
4. No IV fluids are to be warmed in these warmers.
    a. For warming IV fluids, wrap bags or bottles in a warm blanket (outside of the blanket warmer) prior to administration.
    b. Microwave ovens shall not be used to warm IV fluids.

PROCEDURE

1. IV fluid stored in the fluid warmer will be kept at 37.7 degrees Celsius.
2. IV fluid in the warmer will be removed from the warmer on the 10th, 20th and the 30th of each month (the 28th in the month of February) A Log sheet will be completed indicated that all IV fluids have been removed, dated and timed and signed by the staff nurse who completes this task.
3. All IV fluids that are prepared in the warmer will be dated with a "previously warmed, remove by" sticker. The remove by date will be the 10th, 20th and 30th of the month, whichever date is soonest. These removed IV fluids will be brought to the medication room in the Operation Theatre so that they can be used for patient care.
4. Fresh IV fluids that have not been previously placed in a warmer will be used to restock the warmer.
5. Mannitol for IV administration will be kept in a locked box in a upper compartment of the warmer in the Operation Theatre. This compartment will be set for 37.7 degrees Celsius. On the 10th, 20th and 30th of each month all Mannitol in the warmer will be discarded and replaced with new Mannitol. The log sheet will indicate when this was completed and by which staff member.
6. All Mannitol that is placed in the warmer will be dated with a "previously warmed, remove by" sticker. The remove by date will be the 10th, 20th and 30th of the month, whichever date is earliest.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

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NURSING POLICY AND PROCEDURE MANUAL

C-ARM: STAFF SAFETY		
Policy/Procedure Applies To	**All OT Nurses & Technicians**	**Policy/Procedure No: 85** **Page: 1 of 1**
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C-ARM: STAFF SAFETY

POLICY

Personnel who are pregnant or suspicious of being so are encouraged not to participate in radiation exposure cases. If personnel are present during these x-ray cases, proper lead aprons must be worn and exposure should be at a minimum.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

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NURSING MANUAL

PULSE OXIMETRY MONITORING		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 87** **Page: 1 of 1**
Effective Date: 11 April, 2013		

PULSE OXIMETRY MONITORING

POLICY

Pulse oximetry is a noninvasive method for determining the oxygen saturation of hemoglobin in the blood. It is sensitive to changes in blood oxygen content and can signal a hypoxic event before clinical signs appear. It is a simple noninvasive mode of monitoring which provides a continuous display, visual and audible.

A 95% to 100% oxygen saturation is considered normal in an adult breathing room air.

1. **Following general anaesthesia.**

   Patients admitted to Nursing Unit following procedures in which anaesthesia, with or without sedation, have been used will be placed on appropriate oxygen therapy upon arrival and monitored via oximetry. Oximetry will be continued for a period of time after discontinuing oxygen therapy to assess the patient's response. If the oxygen saturation remains between 95% -100% (unless precluded by an existing condition), oxygen therapy may remain off and oximetry monitoring may be discontinued.

2. **Following local anaesthesia / spinal / regional**

   Patients admitted to Nursing Unit following procedures in which local anaesthesia has been used, without supplemental sedation, do not require oxygen therapy and/or oximetry monitoring unless indicated and/or at the discretion of the Anaesthesiologist and/or Surgeon.

Revised By:	**Signature:**
Revision Date:	
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Approval Date:	

PRIME SURGICAL CENTERS

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NURSING MANUAL

SUCTIONING: NASOPHARYNGEAL		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 88** **Page: 1 of 2**
Effective Date: 11 April, 2013		

SUCTIONING: NASOPHARYNGEAL

PURPOSE

To remove secretions from nasopharyngeal passage from an unconscious/conscious patient by means of a suction catheter to maintain a patent airway, promote pulmonary gas exchange and help prevent infections caused by accumulated secretions.

SCOPE

All Staff Nurses.

POLICY

1. Nasopharyngeal suctioning will be performed on all unconscious patients to avoid aspiration of secretions or when cough reflex is absent and/or when patient is unable to bring up secretions on his/her own.
2. Staff Nurse will assist physician in insertion, maintenance, removal and suction of a nasopharyngeal airway.
3. Staff Nurse may perform suction and maintenance of nasopharyngeal airway.

REQUIRED ITEMS

1. Oxygen – to supply 100 %
2. Mask
3. Wall suction set-up
4. Plastic connecting tube
5. Nasopharyngeal airway of appropriate catheter size. Adults, # 12 or 14 French
6. Sterile water / water soluble lubricant
7. Clean Gloves
8. Stethoscope
9. Suction Catheter
10. Sterile normal saline

PROCEDURE

1. ASSISTING IN INSERTION

a. Evaluate patient for level of consciousness
b. Wash Hand and put on Gloves
c. Slightly extend the patient's neck (chin lift or jaw thrust maneuver) and raise the end of the patient's nose.
d. Handover to physician the lubricated catheter with the water-soluble lubricant / sterile water
e. Assist physician to verify tube's placement. Look for chest movement, listen for breath sounds and feel for air movement.
f. Assist the physician to oxygenate with 100% oxygen (mask) for 10-20 seconds prior to (and after) suctioning
g. Instruct the patient to cough and deep breath prior to suctioning.
h. Provide humidification as required.

SUCTIONING: NASOPHARYNGEAL		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 88** **Page: 2 of 2**
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i. Observe the patient and Re-oxygenate.
j. Discard catheter, tubing and gloves as per Waste Management Policy.
k. Wash Hands and documents the procedure in Nurse's Note.

2. SUCTIONING

a. Set the suction gauge of 80-120 mmHg
b. Put on clean gloves after hand wash.
c. Choose a suction catheter about one half the diameter of the airway and lubricate the tip with normal saline.
d. Advance the catheter without applying suction about one inch beyond the tip of the airway or less if the patient begins to cough. Suctioning further than this is considered a sterile procedure so as to decrease the incidence of hospital-acquired pneumonia. (An assistant may be necessary to stabilize the airway during suctioning.)
e. Withdraw the catheter while applying suction for no more than 10 seconds.
f. Rinse the suction catheter with sterile normal saline and repeat as necessary.
g. Discard the suction catheter, gloves and used items as per waste management disposal policy.
h. Wash hands as per laid down policy.

3. DOCUMENTATION

a. Note date and time of initial insertion and by whom
b. Respiratory assessment before and following insertion
c. Date and time of removal of airway
d. Adverse reactions to procedure and associated nursing interventions
e. Size of airway inserted
f. Skin color
g. Oxygen percentage if used
h. Condition of patient's nares / mucous membranes
i. Patient tolerance of procedure

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

MONITORING OF TEMPERATURE AND HUMIDITY IN THE OPERATION THEATER		
Policy/Procedure Applies To	**OT & Procedure Room Nurses**	**Policy/Procedure No: 89** **Page: 1 of 1**
Effective Date: 11 April, 2013		

MONITORING OF TEMPERATURE AND HUMIDITY IN THE OPERATION THEATER

POLICY

Monitoring of temperature and humidity will be performed daily. For this purpose each Operation Room will be fitted with a Thermometer measuring Temperature and Humidity.

PROCEUDRE

1. A log sheet will be completed in the master log book.
2. Recommended Temperature: (20-230 Celsius)
3. Recommended Humidity: 20-60%
4. Should the temperature and/or humidity not be in the desired range, the following steps should be taken:
   a. If your humidity starts to drift up, say from 55-65% and climbing you can raise the temperature in the room to compensate for the dehumidification that needs to happen. Inform Electrician and Executive Facility.
   b. If humidity starts to drift down, 55-45% and dropping. You can lower your temperature to get the humidity to rise to keep room operational. Inform Electrician and Executive Facility.
   c. If you find that the temperature and humidity are both rising together, you need to check to see if the HVAC (Heating Ventilation and Air Conditioning) system is running. These do not rise together unless the unit is off, chiller or compressors are off and fans are still running. Inform Electrician and Executive Facility.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE I
(Refer to Nursing Manual Policy and Procedure No. 90)

LATEX ALLERGY EDUCATIONAL MATERIAL

Frequently contain LATEX	**Examples of LATEX-SAFE alternatives/barriers**
Anaesthesia, ventilator circuits, bags	Neoprene (Anaesthesia Associates, Ohmeda adult), well-washed systems
Band Aids	Active Strips (3-M Latex in package), Snippy Band (Quantasia), Readi-Bandages
Bed protectors (washable rubbers)	Disposable underpads
Blood pressure cuff, tubing	Cleen Cuff (Vital Signs), over clothing or stockinette
Bulb syringe	PVC (Davol) Medline, Rusch
Casts: Delta-Lite Conformable (J&J)	Scotchcast soft cast, Delta-Lite S, Fiberglass, Fabric (J&J), Caraglas ultra
Catheters, condom	Clear Advantage (Mentor), Silicone (Coloplast, Rochester), Prosysnl (Convatec)
Catheters, indwelling	Silicone
Catheters, leg bags, drainage systems	Velcro, nylon, PVC Bard systems
Catheters, straight, coude	Bard, Coloplast, Mentor, RobNel
Catheters, urodynamics	Bard, Cook
Catheters, rectal pressure	Cook
Dressings: moleskin, Dyna-flex (J&J) Action Wrap, Coban (3M0, BDF Elastoplast	Duoderm (Squibb), Reston foam (3M), Opsite, Venigard, Comfeel ,Xerofoam (Sherwood), PinCare Bioclusive, Montgomery straps (J&J), Webrill (Kendall), Selopor, Opraflex (Iohmann) Note: Steri-strips, Tegaderm, Tegasorb (3M) have latex in package.
Elastic wrap: ACE, Esmarch, Zimmer, Dyna-flex, Elastikon (J&J)	Adban Adhesive Elastic Bandage, Xmark (Avcot) Comprilan (Jobst), Conco all cotton elastic bandages/Esmark (DeRoyal) Cover skin with cotton barrier under wrap.
Electrode bulbs, pads, grounding	Baxter, Dantec EB\MG, Conmed, ValleyLab, Vermont Med
Endotracheal tubes, airways	Berman, Mallinckrodt, Polamedco, Portex, Rusch, Sheridan, Shiley
Enemas, Ready-to-use (Fleet-latex valve)	Glycerin, BabyLax (Fleet), Theravac, Bowel Management Tube (MIC) cone irrigation set (Convatec)
G-tubes, buttons	Silicone (Bard, MIC Stomate) Rusch
Gloves, sterile, clean, surgical	Vinyl, neoprene, polymer gloves: Allergard (J&J), dermaprene (Ansell), Neolon, SensiCare, Tru-touch (B-D), Nitrex, Tactyl 1,2 (Smart Practice), Duraprene, Triflex (Baxter)

Frequently contain LATEX	**Examples of LATEX-SAFE alternatives/barriers**
IV access; injection ports, Y-sites, bags buretrol ports, PRN adaptors Needleless systems	Cover Y-sites and do not puncture; Use stopcocks for meds. Flush tubing. Do not puncture bag ports to add meds. Polymer injection caps (Braun). Abbot nitroglycerin tubing: Walrus, Gemini (IMED), some Baxter systems, Baxter buretrols, Braun burettes, SAFSITE (Braun), Clave, Abbott needleless systems
OR masks, hats, shoe covers	Replace elastic bands with twill tape ties
Oxygen masks, cannulas	Remove elastic bands, check content of valves
Medication vial stoppers	Eli Lilly, Fujisawa; if not certain, remove stopper
Penrose drains	Jackson-Pratt, Zimmer Hemovac
Pulse oximeters	Certain Oxisensor (Nellcor), cover digit with Tegaderm
Reflex hammers	Cover with baggie
Respirators - tb (3M 9970)	Advantage (MSA), HEPA-Tech (Uvex)
Resuscitators, manual	Silicone: PMR 2 (Puriton Bennett) SPUR (Ambu), Vital Blue, Respironics, Laerdal, Armstrong, Rusch
Stethoscope tubing	PVC tubing, cover with stockinette or ScopeCoat
Suction tubing	PVC (Davol, Laerdal, Mallinckrodt, Superior, Yankauer), Medline, Ballard
Syringes, disposable	Draw up medication in syringe right before use; Abboject, Abbott PCA, Norm-Ject (air-tite), certain 1cc, 60cc syringes & reusable glass (BD), Terumo syringes, Epi-Pen
Tapes, adhesive, porous, pink Waterproof (3M)	Dermaclear, Dermicel, Waterproof (J&J), Durapore, Microfoam, Micropore, Transpore (3M), Mastisol liquid adhesive
Tourniquet	Children's Med Ventures, Grafco, VelcroPedic, X-Tourn straps (Avcor)
Theraband, Therastrip, Theratube	Cover with cloth, exercise putty (Rolyan)
Tubing, sheeting	Plastic tubing - Tygon LR-40 (Norton), elastic thread, sheets (JPS Elastomerics)
Vascular stockings (Jobst)	Compriform Custom (Jobst)
Art supplies, paints, glue, erasers	Elmers (school glue, Glue-All, GluColors, Carpenters Wood Glue, Sno-Drift Paste), FaberCastel art erasers, Crayola products (except for rubber stamps, erasers), Liquitex paints, Silly Putty
Balloons	Mylar balloons
Balls: Koosh balls, tennis balls, bowling balls	PVC (Hedstrom Sports Ball)
Carpet backing, rubber gym floors, basement sealant	Provide barrier, cloth or mat

Frequently contain LATEX	**Examples of LATEX-SAFE alternatives/barriers**
Clothes, applique on tees, elastic on socks, underwear, soles on sneakers, sandals	Cover elastic with cloth (Decent Exposures - covered elastic), Nolatex Industries neoprene
Condoms, contraceptive diaphragm	Polyurethana (Avanti), female condom (Reality)
Crutches, tips, axillary pads, hand grips	Cover with cloth, tape
Dental rubber bands, root canal material	Wire springs, dental sealant (Delton)
Diapers, incontinence pads, rubber pants	Huggies, First Quality, Gold Seal, Tranquility, Drypers, Attends (some)
Food handled with latex gloves (Note: associated allergies to kiwi, banana, avocado, and other fruits)	Synthetic gloves for food handling
Feeding nipples	Silicone (Gerber, Evenflo, MAM), some Ross, Mead Johnson nipples
Handles on racquets, tools	Vinyl, leather handles, or cover with cloth or tape
Infant toothbrush-massager	Soft bristle brush or cloth
Kitchen cleaning gloves	PVC MYPLEX (Magla) cotton liners (Allerderm)
Newspring, ads, coupons dusted with latex	
Pacificers	Plastic, silicone, vinyl (Binky, Gerber, Infa, Kip, MAM, Children Medical Ventures)
Toys - Stretch Armstrong; old Barbies	Jurassic Park figures (Kenner), 1993 Barbie, Disney dolls (Mattel) many toys by Fisher Price, Little Tikes, Playschool, Discovery, Trolls (Norfin)
Rubber bands	String
Water toys and equipment, thongs, masks, bathing suits, caps, scuba gear, goggles	PVC, plastic
Wheelchair cushions, tires	Jay, ROHO cushions, cover seats, use leather gloves
Zippered plastic storage bags	Waxed paper, plain plastic bags

ANNEXURE II
(Refer to Nursing Manual Policy and Procedure No. 90)

LATEX ALLERGY KIT

A latex allergy kit shall be maintained containing basic items for use in the pre-operative care of patients with actual or suspected latex allergy. This kit will contain the following items:

1. 3-way stop cock x2
2. Assorted tapes, paper and plastic
3. Non-latex tourniquets (strips of vinyl gloves)
4. Silicone Foley catheter 16fr
5. Assorted plastic masks (4 sizes)
6. Adult breathing circuit and bag - Neoprene
7. 4" Kling, 4" cast padding (2 each)
8. Feeding tubes 2 - 8fr, 2 5fr, vessel loops x2
9. CO2 tubing x 1
10. Assorted sterile glass syringes 10cc, 5cc (3 each), 20cc (2 each)
11. Allergy alert bracelets market “Latex Allergy” in red lettering x4
12. Salem sumps x2, Jackson Pratt x1
13. Mini infusion set x2
14. Assorted non-latex gloves - 8, 7½, 7 (4 of each); 6½ x1
15. All cotton elastic bandage - 6", 4" (2 of each sterile; 1 of each nonsterile)
16. One can opener to open vials
17. Latex allergy nursing checklists x6
18. List of latex containing products and substitutes
19. Latex allergy signs x4

ANNEXURE III
(Refer to Nursing Manual Policy and Procedure No. 90)

LATEX ALLERGY NURSING CHECKLIST

PRE-OPERATIVE

1. Identify if patient has a latex allergy.
2. Assure that patient has a visible latex allergy band on.
3. Assure that chart is clearly documented stating that a latex allergy is present.
4. Obtain necessary latex free supplies from latex allergy kit.
5. Latex-free gloves should be worn for any patient care/contact (un-sterile boxes of latex gloves should be removed from the room).
6. Assure that all members of the health care team are aware of the latex allergy (OR nurse, Anaesthesiologist, etc.).

INTRA- OPERATIVE

1. Hang sign on OR door to identify latex allergy.
2. Place latex allergy kit outside OR door.
3. Place all latex items away from patient if possible.
4. Use non-latex items from latex allergy kit to substitute for latex products.
5. No rubber medication stoppers should be punctured with a needle. Remove rubber stoppers to draw up medications.
6. A three-way stop cock should be used as an injection port for medications in place of IV rubber ports. Tape all ports on IV tubing and bags to prevent accidental usage.
7. Medications should not be used unless drawn up fresh prior to use.
8. Wrap webril around arm and/or leg to prevent blood pressure cuff tubing and/or tourniquet cuff tubing from coming in contact with the patient's skin.
9. Use a silicone Foley if a catheter is ordered for procedure.
10. Assess the sterile field/backtable with the scrub nurse to assure a latex free setup. Scrub nurse must change gloves after removing latex containing items from field.

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Beck House, Damle Path, Pune.

NURSING MANUAL

POST ANAESTHESIA RECOVERY SCORE		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 91** **Page: 1 of 2**
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POST ANAESTHESIA RECOVERY SCORE

POLICY

1. **Aldrete Scoring System** is used to evaluate recovery after anaesthesia and is used as part of the transfer and discharge evaluation. A score of 8-10 should be met for transfer, unless otherwise indicated by the Anaesthesiologist responsible for transfer of the patient.

   a. Activity
      i. Able to move four (4) extremities voluntarily or on command. **Score 2**
      ii. Able to move two (2) extremities voluntarily or on command. **Score 1**
      iii. Able to move no (0) extremities voluntarily or on command. **Score 0**

   b. Respiration
      i. Ability to take a deep breath and cough. **Score 2**
      ii. Respiratory effort limited (i.e., splinting) or dyspnea is apparent. **Score 1**
      iii. No spontaneous respiratory effort. **Score 0**

   c. Circulation (Arterial blood pressure is measured by sphygmomanometer, cuff and stethoscope.)
      i. Blood pressure plus (+) or minus (-) 20 % of the pre-anaesthetic level. **Score 2**
      ii. Blood pressure plus (+) or minus (-) 20% to 50% of the pre-anaesthetic level. **Score 1**
      iii. Blood pressure plus (+) or minus (-) 50% of the pre-anaesthetic level. **Score 0**

      NOTE: Great difference in diastolic blood pressure should be noted.

   d. Consciousness
      i. Full alertness with ability to answer question. **Score 2**
      ii. Patient aroused by calling his name. **Score 1**
      iii. Auditory stimuli fails to illicit any response. **Score 0**

   e. Color
      i. Pink, normal. **Score 2**
      ii. Pale, dusky. **Score 1**
      iii. Cyanotic. **Score 0**

PROCEDURE

Record patient's score on post operative record by the Nursing Unit, Staff Nurse and update as appropriate.

1. If patient has a score of less than eight (8) patient will remain in Operation Theater until that score is reached.
2. If the patient has not achieved a score of eight (8), nine (9), or ten (10) within an acceptable period of time (approximately one (1) hour), notify the Anaesthesiologist to evaluate the patient's condition.
3. Document score every 30 minutes

POST ANAESTHESIA RECOVERY SCORE		
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2. **Pain Intensity Rating Scales:**
   Use of a pain scale lets the patient describe pain in a way that is meaningful to the patient

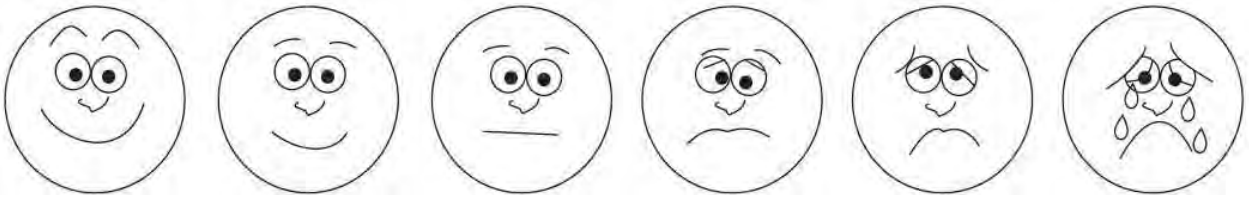
   Visual Analog Scale (VAS)

   a. 0-10 Numeric Pain Rating Scale

   The scale helps the patient to quantify their current levels of pain.

No Pain	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it can be (Worst possible pain)**

   b. Wong – Baker Faces Pain Scale



0	2	4	6	8	10
Very happy, no hurt	**Hurts just a little bit**	**Hurts a little more**	**Hurts even More**	**Hurts a whole lot**	**Hurts as much as you can Imagine (don't have to be crying to feel this much pain)**

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Revision Date:	
Approved By:	**Signature:**
Approval Date:	

ANNEXURE I
(Refer to Nursing Manual Policy and Procedure No. 92)

POST-OP CHECK LIST

MR No. :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Date :	

Allergies :-
Procedure :-
Type of Anesthesia :- ☐ General ☐ Spinal ☐ Epidural ☐ MAC ☐ Block ☐ TIVA
Time Out :-

Sr. No.	Description	YES	NO	NA
1	Pain scale	☐	☐	☐
2	Central Venous Pressure Line	☐	☐	☐
3	Ryle's tube	☐	☐	☐
4	Endo tracheal tube	☐	☐	☐
5	Drains	☐	☐	☐
6	Medical records including all reports (Lab,x-ray,operation notes etc)	☐	☐	☐
7	Epidural catheter Present	☐	☐	☐
8	Intake & Output chart recorded	☐	☐	☐
9	Foley's Catheter Present	☐	☐	☐
10	TED Stocking Given	☐	☐	☐
11	Received Post-op Instructions.	☐	☐	☐
12	Any other	☐	☐	☐

Nurse's Notes :- _____

_____

_____

_____

Name & Signature of Circulating Nurse, Date & Time :- .....

Counter Signature of Anesthesiologist, Nurse, Date & Time :- .....

Signature of Nursing Unit Nurse receiving the patient, Name, Date & Time :- .....

Counter Signature of Resident Doctor, Name, Date & Time :- .....

PRIME SURGICAL CENTERS

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NURSING MANUAL

TRANSFER OF POST OPERATIVE PATIENT TO NURSING UNIT		
Policy/Procedure Applies To	**All Nurses/Technicians and Nursing Assistants**	**Policy/Procedure No: 92** **Page: 1 of 2**
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TRANSFER OF POST OPERATIVE PATIENT TO NURSING UNIT

POLICY

1. All patients who receive general, regional or Local / Nerve Block anaesthesia will be transferred back to Nursing Unit after it is Certified from Anaesthesiologist that patient is ready for transfer.
2. Operation Theater Nurse to evaluate the following before transferring the patient to nursing unit.
   a. Adequate respiratory function.
   b. Stable vital signs Temperature, Pulse, Respiration, and Blood Pressure.
   c. Level of consciousness.
   d. Condition of surgical site.
   e. Comfort.
3. Before the Nurse proceeds to transfer the area of O.T to receive any post-operative case, she will ensure the following:
   a. Mask to be kept ready for administering oxygen.
   b. Monitor to be kept ready on standby mode (if indicated earlier by the Anaesthesiologist).
   c. Alarms adjusted and not silenced.
   d. Bed to be kept in a locked position.
   e. IV stands, kidney tray and gauze pieces to be kept ready.
   f. Trolley for transportation must have an oxygen cylinder and mask ready for use (check cylinder for level of oxygen and keep it open for any emergency use).
4. While transporting a patient who has been given IV sedation from O.T., the accompanying O.T Nurse will ensure that oxygen is administered at 4 litres of oxygen if saturation falls below 94%. To ensure this oxygen saturation monitoring will be done continuously.
5. These patients will be handed/taken over by O.T. Nurse and Nurse of Nursing Unit in the transfer area of O.T. After verbal briefing on salient parameters (unusual and/or important occurrences or orders) post-operative checklist and post-operative instructions duly signed with date and time will be handed over to Nurse of Nursing Unit who will acknowledge it by her signature, date and time. (Refer to Annexure I and II)
6. On arrival in the Nursing Unit the Nurse will assess the patient as per post-operative checklist and post-operative instructions. (Refer to Anaesthesia Manual Policy and Procedure No. 18)

PROCEDURE

1. Patient's relatives to be requested to wait in the lounge.
2. Room door to be closed/bay curtains drawn to provide privacy to the patient.
3. Patient carrying trolley to be brought at the same height as bed and locked.
4. Bed to be locked before shifting the patient.

TRANSFER OF POST OPERATIVE PATIENT TO NURSING UNIT		
Policy/Procedure Applies To	**All Nurses/Technicians and Nursing Assistants**	**Policy/Procedure No: 92** **Page: 2 of 2**
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5. Patient to be shifted as per policy laid down on shifting (Refer Nursing Manual Policy and Procedure No. 69 and Anaesthesia Manual Policy and Procedure No. 17 and 18)
6. Assist patient to a comfortable position as per surgery done.
7. Side rails of the bed to be kept in raised position.
8. Attach the monitors if so indicated by the Anaesthesiologist.
9. Assess and maintain airway, if indicated.
10. Check post-operative instructions in details.
11. Record vital parameters including oxygen saturation.
12. Start oxygen if indicated.
13. The Nurse may need to hold patient's chin to assist in ventilation until the patient is alert and reactive and capable of maintaining adequate ventilation on his/her own.
14. Check operative site, dressings.
15. Provide warm blankets as needed.
16. Note presence of IV and amount remaining as well as amount infused, and check site.
17. Administer any medications required or ordered.
18. Document initial assessment.
19. Call the patient's relatives in the room/bay and explain necessary post-operative instructions. The relative will be permitted to stay in the room/bay as per laid down policy of Prime Surgical Centers
20. Vital parameters will be checked and recorded every 15 minutes alternatively by the Resident Medical Officer and Nurse for first three hours post-operatively.
21. During this time, any significant change in vital parameters will be informed to the Anaesthesiologist immediately by the Resident Medical Officer/Nurse.
22. In case the patient's vital parameters remain uneventful after three hours post-operatively, the Anaesthesiologist to be informed about the status.

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Revision Date:	
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TRANSFER OF POST OPERATIVE PATIENT TO NURSING UNIT – LOCAL ANAESTHESIA		
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TRANSFER OF POST OPERATIVE PATIENT TO NURSING UNIT – LOCAL ANAESTHESIA

POLICY

1. Patients who receive local anaesthesia may be transferred to nursing unit post operatively.
2. These patients will be accompanied by the circulating nurse. They may be accompanied by a Staff Nurse or Technician. A verbal report will be given to the receiving staff nurse in nursing unit.

PROCEDURE

1. Apply oxygen as appropriate.
2. Apply monitors as appropriate.
3. Observe and record vital functions and vital signs every five (5) minutes until stable.
4. Notify physician of any deviation from normal parameters.
5. Check operative site. Report unusual or excessive drainage to the physician.
6. Provide warm blankets as needed.
7. Position as appropriate, including elevation of extremities as ordered.
8. Apply ice if ordered.
9. Apply any podiatric shoes if indicated.
10. Note presence of IV. Check site (if applicable).
11. Administer any medications required/ordered.
12. Document initial and ongoing assessments as well as vital signs.
13. Offer ice chips or fluids as appropriate.

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ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 94)

HOURLY CLINICAL CHART

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Time	Temperature °C	Pulse (Rate Per Minute)	Respiratory (Rate / Minute)	BP (mmHg)	Name & Signature
8 AM					
9 AM					
10 AM					
11 AM					
12 NOON					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
12 Midnight					
1 AM					
2 AM					

Time	Temperature °C	Pulse (Rate Per Minute)	Respiratory (Rate / Minute)	BP (mmHg)	Name & Signature
3 AM					
4 AM					
5 AM					
6 AM					
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
12 NOON					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
12 Midnight					
1 AM					
2 AM					
3 AM					
4 AM					

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POST OPERATIVE DOCUMENTATION OF MEDICAL RECORD		
Policy/Procedure Applies To	**All Staff Nurses/Resident Medical Officers**	**Policy/Procedure No: 94** **Page: 1 of 2**
Effective Date: 11 April, 2013		

POST OPERATIVE DOCUMENTATION OF MEDICAL RECORD

PURPOSE

To provide guidelines for documenting post operative information and observations.

POLICY

All patients will be observed post operatively and, observations and data documented appropriately.

PROCEDURE

1. After receiving report regarding the patient's condition from anaesthesia from Operating Room Nurse (during handing/taking over in transfer area of Operation Theater), observe for general stability and orientation, patent airway, give oxygen when ordered, and record vital parameters.
2. Record the following information.
   a. Time received back (from Operating Room) at the Nursing unit.
   b. Vital parameters as per hourly clinical chart (refer Annexure to this policy) unless indicated otherwise by the Surgeon/Anaesthesiologist
   c. Allergy information (record in each designated area)
   d. Airway
      i. Presence of an airway or endotracheal tube will be documented in nurse's notes.
      ii. Patient will be observed very closely until he/she no longer requires airway support. Document nurse's notes with the removal time of the airway as well as the return of the patient's reflexes.
   e. Observe patient for any abnormal breathing pattern and report any unexpected observations to the Resident Medical Officer/Anaesthesiologist immediately.
   f. Level of consciousness and orientation
      i. Patients who have received a local anaesthesia may have received medication for sedation. Therefore, the level of consciousness must be monitored.
      ii. If a patient receives general anaesthesia, the time patient regains consciousness will be documented on the post operative record.
      iii. Degree of orientation must be compared with pre operative observations. Deviations will be reported to the Resident Medical Officer/Anaesthesiologist.
   g. Intravenous solutions

      The amounts of IV fluid/s to be given will be noted on the post operative record and a separate Intake and Output Chart also maintained.
   h. Intake and output
      i. All intake and output will be recorded in the designated area of the post operative record.
      ii. Unusual or unexpected observations regarding intake or output are to be brought to the attention of the Resident Medical Officer/Anaesthesiologist.

POST OPERATIVE DOCUMENTATION OF MEDICAL RECORD		
Policy/Procedure Applies To	**All Staff Nurses/Resident Medical Officers**	**Policy/Procedure No: 94** **Page: 2 of 2**
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i. Dressings

The condition of the surgical dressing will be noted and documented in the nurse's notes.

j. Medication

i. Indicate drug, amount, route, time and by whom given, as indicated on record.

ii. Document injection site in the nurse's notes.

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NURSING MANUAL

PAIN MANAGEMENT (PATIENT CARE)		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 95** **Page: 1 of 4**
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PAIN MANAGEMENT (PATIENT CARE)

1. Pain management procedures may be done in the Nursing Unit or Operation Theater.
2. Patients may be scheduled and admitted for procedures (i.e., epidural injection, stellate ganglion block, lumbar sympathetic block), for consultation with the physician, or for consultation and procedure.
3. Patients are admitted, monitored and discharged according to procedure.
4. Patients are given pre-admission instructions using the standard pre-operative interview format.
5. The Prime Surgical Centers has specific forms for the pain management chart. These include informed consent, procedural record and post procedure instructions.
6. Pre-operative lab studies are not required unless by specific order of the physician.
7. Patients admitted and having pain management procedures with the exception of trigger points, are not permitted to drive for twelve (12) to twenty four (24) hours.

Pain Intensity Rating Scales:

Use of a pain scale lets the patient describe pain in a way that is meaningful to the patient

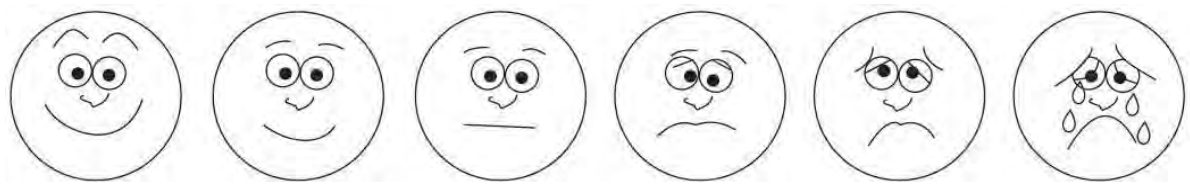
Visual Analog Scale (VAS)

1. 0-10 Numeric Pain Rating Scale

The scale helps the patient to quantify their current levels of pain.

No Pain	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it can be (Worst possible pain)**

2. Wong – Baker Faces Pain Scale



0	2	4	6	8	10
Very happy, no hurt	**Hurts just a little bit**	**Hurts a little more**	**Hurts even more**	**Hurts a whole lot**	**Hurts as much as you can imagine (don't have to be crying to feel this much pain)**

Nonverbal Pain Assessment

Items *	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown	Facial grimacing.	
Body language	Completely Relaxed	Partially Relaxed Tense. Distressed pacing - slower Fidgeting.	Not Relaxed Tense – clenched jaw Distressed pacing - faster Fidgeting - repetitive	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
			Total**	

*** Five-item observational tool - see the description of each item below.**

Breathing

1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional laboured breathing is characterized by episodic bursts of harsh, difficult or wearing respirations.
3. Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. Noisy laboured breathing is characterized by negative sounding respirations on inspiration or expiration. They may be loud, gurgling, or wheezing. They appear strenuous or wearing.
5. Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. Cheyne-Stokes respirations are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative vocalization

1. None is characterized by speech or vocalization that has a neutral or pleasant quality.
2. Occasional moan or groan is characterized by mournful or murmuring sounds, wails or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic or caustic tone.
4. Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. Loud moaning or groaning is characterized by mournful or murmuring sounds, wails or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial expression

1. Smiling is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
4. Frown is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

PAIN MANAGEMENT (PATIENT CARE)		
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Body language

1. Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. Tense is characterized by a strained, apprehensive or worried appearance. The jaw may be clenched (exclude any contractures).
3. Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. Fidgeting is characterized by restless movement. Squirming about or wiggling in the chair may occur. Repetitive touching, tugging or rubbing body parts can also be observed.
5. Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible.
6. Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance.
8. Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape.
9. Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. No need to console is characterized by a sense of well being. The person appears content.
2. Distracted or reassured by voice or touch is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction with no indication that the person is at all distressed.
3. Unable to console, distract or reassure is characterized by the inability to sooth the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

****Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain**
(0="no pain" to 10="severe pain").

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PAIN PROTOCOLS FOR POST OPERATIVE PAIN		
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PAIN PROTOCOLS FOR POST OPERATIVE PAIN

Assess Visual Analog Score (VAS)

If VAS score more than 4 Administer injectable analgesics.

1. **NSAIDs: Exclude contraindications for NSAIDs (Asthma, Renal disease)**

   Pediatric Patients - only under Anaesthesiologist's orders

   a. **Injection Paracetamol 1 gm / 100 ml (contraindicated in liver disease)**

      Adult Patient: 1 gm Intravenous (IV) in 15 minutes

      Max dose not to exceed 4 grams / day

   b. **Injection Diclofenac Sodium 75 mg / ml**

      Intravenous (IV) 75 mg in 100 ml Normal Saline (NS) over 30 minutes

      Max dose 150 mg / day

      Or

   c. **Injection Ketorolac** 30 mg / ml
      Intravenous (IV) Bolus 30 mg in 100 ml Normal Saline (NS) in 10 minutes.
      30mg three times a day Intramuscular (IM) / Intravenous (IV) **Max Dose 120 mg/ day**

      Adults > 60 yrs

      Intravenous (IV) Bolus 10 mg in 100 ml Normal Saline (NS) in 10 minutes

      10-30 mg Two times a day. **Max Dose 60 mg / day**

2. **NON- NSAID DRUGS**

   Injection Tramadol 50 mg / ml 1 ml / 2ml amp (Antiemetic to be administered)

   Adult Patient: 50 mg diluted in 100 ml Normal Saline (NS) over 15 minutes.

   Max daily dose 600 mg

If VAS score > 5 Inform Anaesthesiologist.

3. **OPIOIDS: Before Opioid administration Vital Signs to be monitored.**

   a. **Inj Fortwin 30mg/ml**

      Adult patient: 15 mg diluted in 10ml Normal Saline(NS) over 10 mins.

      INFORM ANAESTHESIOLOGIST IF:

      i. Sedation Score More Than 2
      ii. Respiratory Rate < 8 / Minute.
      iii. Nausea And Vomiting
      iv. Itching
      v. Blood Pressure is less than 90 Systolic

b. Inj Fortwin 30mg & Inj Phenargan 25mg can be given intramuscularly if sedation is also desired.

Injectable Opioids to be given strictly under Anaesthesiologist Guidance

Epidural analgesia protocols as prescribed by Anaesthesiologist.

Analgesics Patches: Follow the instructions by the Anaesthesiologist.

1. Diclofenac Sodium Patch: NUPATCH 100mg/200mg :as advised by Consultant
   Dose: Once a day
   To be labelled with details like date& time of application, site of application ,name of the person applying it.
2. Fentanyl Patch: DURAGESIC 12mcg/hour, 25mcg/hour, 50 mcg/hour,75mcg/hour, 100mcg/hour for 72 hours
3. Buprenorphine (Buvalor) 5/10/20 mcg Transdermal patch for 7 days.

INFORM ANAESTHESIOLOGIST IF:

1. Sedation Score More Than 2
2. Respiratory Rate < 8 / Minute.
3. Nausea And Vomiting
4. Itching
5. Blood Pressure is less than 90 Systolic

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POST OPERATIVE VISITS IN NURSING UNIT BY FAMILY MEMBERS		
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POST OPERATIVE VISITS IN NURSING UNIT BY FAMILY MEMBERS

POLICY

1. Not more than two (2) family members will be permitted to visit a patient during post- operative phase in Nursing Unit at one time. This restriction may be waived off in special circumstances at the discretion of the Administrative Head of the Center.
2. Visitors may be restricted if:
   a. They do not follow nurse's directions.
   b. The patient declines to have visitors.
   c. They are disruptive.
   d. They appear to be ill.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

NOURISHMENTS		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 98** **Page: 1 of 1**
Effective Date: 11 April, 2013		

NOURISHMENTS

SCOPE

Nursing staff

PURPOSE

To provide fresh and safe food for patient nourishments.

POLICY

1. All nourishments served to patients will be commercially prepared.
2. The Nursing Superintendent will ensure that all nourishments are stored in the Pantry using proper sanitation, temperature, light, moisture, ventilation and security.
3. Non-refrigerated stock is discarded as per expiry or recommended by the manufacturer for each item.
4. Refrigerated stock is dated and discarded as recommended by the manufacturer. Refrigerator temperature should be maintained below 4 degrees Celsius. Freezer temperature should be maintained at 0 degree Celsius or below.
5. Refrigerators/freezers containing patient nourishments should be kept cleaned once a week.
6. Patients will be assessed prior to offering any nourishment. Assessments will include patient's alertness, ability to swallow and chew and presence of any nausea. Nourishments will be held until any nausea passes.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

OFFERING THE BEDPAN		
Policy/Procedure Applies To	**All Nurses / Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 99** **Page: 1 of 3**
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OFFERING THE BEDPAN

GUIDELINES

Some patients are unable to get out of bed to use the bathroom. For those patients urinal and a bedpan are required. It is used by a patient whose surgery or injuries don't allow the patient sufficient movement to utilize a toilet for urination and defecation.

Wear gloves whenever handling a bedpan or urinal. Always cover the bedpan and remove it from the patient's bedside to the bathroom as quickly as possible.

PROCEDURE

REQUIRED ITEMS

(To be kept on the Bedside Table/Trolley)

1. Bedpan and cover
2. Toilet tissue roll
3. Wash basin with warm water
4. Soap
5. Hand towel
6. Talcum Powder
7. Disposable bed protector
8. Disposable gloves

STEPS

1. Identify the patient by checking the identification wrist band and asking the name of the patient
2. Ask the patient if he/she would like to use the bedpan & explain the procedure
3. Provide privacy for the patient.
4. Raise the bed to a comfortable working position.
5. Wash your hands and put on gloves.
6. Take the bedpan out of the designated place.
7. Fold back the top sheets so that they are out of the way.
8. Raise the patient's gown, but keep the lower part of his/her body covered.
9. Ask the patient to bend his/her knees and put his/her feet flat on the mattress, if he/she is able.
10. Then ask the patient to raise her hips. If necessary, help the patient to raise her buttocks by slipping your hand under the lower part of her back. Place the protective pad and then bedpan in position with the seat of the bedpan (smooth round rim) under the buttocks.

OFFERING THE BEDPAN		
Policy/Procedure Applies To	**All Nurses / Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 99** **Page: 2 of 3**
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11. Sometimes the patient is unable to lift his/ her buttocks to get on or off the bedpan. In this case, turn the patient on his/her side with his/her back to you. Put the bedpan against the buttocks. Then turn the patient onto the bedpan
12. Replace the covers over the patient. (Assist the patient to roll over onto the bedpan if necessary)
13. Raise the backrest and a knee rest, if allowed, so the patient is in a sitting position (Raise patient to a comfortable sitting position)
14. Put toilet tissue and the call light where the patient can reach them easily.
15. Ask the patient to signal when finished.
16. Raise the side rails on the up position.
17. Dispose of gloves and wash your hands. Leave the room to give the patient privacy, if condition allows.
18. When the patient signals, return to the room.
19. Wash your hands and put on gloves.
20. Help the patient to raise his/her hips so you can remove the bedpan.
21. Cover the bedpan immediately with a disposable pad or a paper towel if no cover is available.
22. Help the patient if he/she is unable to clean himself / herself. Turn the patient on his / her side. Clean the anal area with toilet tissue or warm washcloth, if necessary.
23. Take the bedpan to the patient's bathroom for Deluxe wing/Dirty Utility area in Comfort wing.
24. If a specimen is required, collect it at this time. Measure the urine if the patient is on intake and output.
25. Check the excreta (feces or urine) for abnormal (unusual) appearance.
26. Empty the bedpan into the patient's toilet/dirty utility area commode.
27. Wash with 1% Sodium Hypochlorite Solution and air dry it.
28. Put the clean bedpan and cover back into designated place / dirty utility room.
29. Help the patient to wash his/her hands in the basin of water.

OFFERING THE BEDPAN		
Policy/Procedure Applies To	**All Nurses / Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 99** **Page: 3 of 3**
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FOLLOW-UP

1. Dispose of your gloves and wash your hands.
2. Make the patient comfortable and replace the call light. Lower the backrest as necessary.
3. Lower the bed to a position of safety for the patient.
4. Raise the side rails.
5. Document the following in Nurse's Note and / Intake & Output chart:
   a. Patient has urinated or defecated.
   b. Specimen was collected or not
   c. Patient tolerance to the procedure.
   d. Any unusual observations.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

OFFERING PORTABLE / BEDSIDE COMMODE		
Policy/Procedure Applies To	**All Nurses / Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 100** **Page: 1 of 2**
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OFFERING PORTABLE / BEDSIDE COMMODE

PROCEDURE

PREPARATION

1. Assemble required items on the bedside table:
    a. Portable bedside commode next to the bed
    b. Toilet tissue
    c. Basin of warm water
    d. Soap (Portable bedside commode)
    e. Towel
    f. Disposable gloves
2. Identify the patient by checking the identification wrist band.
3. Explain the procedure and assist him onto the bedside commode.
4. Provide privacy for the patient.
5. Keep the call light, where the patient can reach easily.
6. Ask the patient to signal when finished.
7. Wash your hands and put on gloves.
8. Help the patient clean himself.
9. Assist the patient back to bed.
10. Close the cover on the commode.
11. Help the patient to wash his hands in the basin of water.
12. Make the patient comfortable and make him sit over the commode.
13. Check the excreta (feces or urine) for abnormal (unusual) appearance.
14. Measure output if patient is on intake and output. If a specimen is required, collect if at this time
15. Empty the commode into the toilet.
16. Clean the commode with 1% Sodium Hypochlorite and dry it and store it in dirty utility room or in the patient's toilet.
17. Dispose of your gloves and wash your hands.

OFFERING PORTABLE / BEDSIDE COMMODE		
Policy/Procedure Applies To	**All Nurses / Nursing Aides and Housekeeping Staff**	**Policy/Procedure No: 100** **Page: 2 of 2**
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18. Lower the bed to a position of safety for the patient.
19. Raise the side rails when ordered or appropriate for patient safety.
20. Place the call light within easy reach of the patient.
21. Document the following in Nurses Note and intake & output chart:
    a. Patient has voided or defecated.
    b. Specimen was collected or not.
    c. The patient tolerance to the procedure.
    d. Any unusual observations.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

OFFERING THE URINAL		
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OFFERING THE URINAL

PREPARATION

1. Assemble required items
   a. Urinal and cover
   b. Basin with warm water
   c. Soap
   d. Towel
   e. Disposable gloves
2. Identify the patient by checking the identification wrist band and ask the name of the patient.
3. Ask the patient if he would like to use the urinal.
4. Provide privacy for the patient.
5. Wash your hands and put on gloves.

STEPS

1. Give the urinal to the patient.
2. Place the call light within easy reach.
3. Ask the patient to signal when finished.
4. Leave the room to give the patient privacy, if condition allows.
5. When the patient signals, return to the room.
6. Cover the urinal and take it to the patient's bathroom.
7. Check the urinal for abnormal (unusual) appearance.
8. Measure the urine if the patient is on intake and output. Collect a specimen at this time, if required.
9. Empty the urinal in to the toilet & clean with 1% Sodium Hypochlorite & air dry it.
10. Put the clean urinal back in the patient's bathroom / dirty utility room.
11. Remove the gloves and wash your hands.
12. Help the patient to wash his hands in the basin of water.

OFFERING THE URINAL		
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FOLLOW-UP

1. Make the patient comfortable and place the call light.
2. Lower the bed to a position of safety for the patient.
3. Raise the side rails when ordered or appropriate for patient safety.
4. Document the following in Nurses Note and intake & output chart:
    a. Patient has urinated.
    b. Specimen was collected.
    c. Patient tolerance the procedure
    d. Any unusual observations.

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

BATHING THE PATIENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 102** **Page: 1 of 1**
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BATHING THE PATIENT

GUIDELINES

1. A complete bed bath is given as part of the morning care. After the bath, the hair is combed, the dress is changed and the occupied bed is made.
2. Use good body mechanics, keep your feet separated. Stand firmly, bend your knees and keep your back straight.
3. Raise the patient's bed to a comfortable working position with the side rails up on the far side of the bed.
4. Change the water during the bed bath as necessary. For example, change the water whenever it becomes soapy, dirty or cold.
5. Only one part of the body is washed at a time. Wash, rinse and dry each part or area very well. Then cover it right away with the bath blanket.
6. Soap has a drying effect on the patient's skin. Be sure to rinse off all the soap.
7. When you are not using the soap, keep it in the soap dish instead of the basin. In this way, the water will not dissolve the soap and get too soapy.
8. Putting the patient's hands and feet into the water makes the patient feel relaxed.
9. Observe the condition of the patient's skin when you are giving the bath. Report any redness, rashes, broken skin or tender places you see on the patient's body.
10. Put the lotion on your hands and rub your hands together to warm it up.
11. Deodorant should be used if the patient asks for it. It should be applied after the bath has been completed and before the clean gown is put on.
12. Check the patient's gown and bed linens for personal items or valuables and return them to the patient before putting the gown in the laundry hamper.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

BATHING THE PATIENT: PARTIAL BED BATH		
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BATHING THE PATIENT: PARTIAL BED BATH

PROCEDURE

REQUIRED ITEMS

(To be kept on the Bedside Table/Trolley)

1. Soap and soap dish / shower gel
2. Washcloth
3. Wash basin
4. Face and bath towels
5. Talcum powder, if required
6. Clean Dress
7. Blanket
8. Lotion for back rub (body lotion)
9. Comb and hair brush.
10. Disposable laundry hamper for dirty linen
11. Clean bed linen, stacked on the chair in order of use, if the bed is to be made following the bed bath.
12. Disposable gloves

STEPS

1. Introduce yourself and identify the patient by checking the identification band and explain the procedure.
2. Provide privacy for the patient.
3. Raise the bed to a comfortable working height.
4. Wash your hands and put on gloves.
5. Assist the patient with oral hygiene.
6. Offer the bedpan or urinal or assist patient to bathroom.
7. Place the laundry bag on a chair near the bed.
8. Pull out all the bedding from under the mattress. Leave it hanging loosely at all four sides of the bed.
9. Take the regular blanket off the bed. Fold it loosely over the linen trolley, leaving the patient covered with the top sheet.
10. Place the blanket over the top sheet. Remove the top sheet from underneath without uncovering the patient. Slide the sheet out from under the blanket and leave fan-folded at foot end of the bed.
11. Take out the patient's dress, keeping him/her covered with the blanket. Put the dress into the laundry hamper.

BATHING THE PATIENT: PARTIAL BED BATH		
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12. Fill the wash basin two-third full of warm water.
13. Wash the area of the body as in bed bath.
14. Put a clean dress without exposing him/her.
15. Raise the side rails for patient safety.
16. Place the call light in its proper place.
17. Clean and return your equipment to its proper place. Discharge disposable equipment.
18. Wipe off the bedside table. Discard used linen in the laundry hamper as per laid down policy.
19. Wash both hands as per laid down policy.

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PRIME SURGICAL CENTERS

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NURSING MANUAL

PERINEAL CARE: MALE PATIENT		
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PERINEAL CARE: MALE PATIENT

Perineal care is specific care given to the perineum or perineal area (the external genitalia and rectal area) during the daily bath and after voiding or defecating. Cleansing is always done anterior to posterior (front to back).

Perineal care provides cleanliness and comfort for both the male and female patient. It helps to prevent irritation and infection.

PROCEDURE

REQUIRED ITEMS

1. Blanket
2. Bedpan and cover or urinal and cover
3. Soap
4. Basin with warm water
5. Disposable gloves
6. Disposable bed protector
7. Washcloth and towel
8. Disposable laundry hamper for dirty linen

STEPS

1. Introduce yourself and identify the patient by checking the identification band.
2. Explain the procedure
3. Provide privacy for the patient.
4. Provide safety with the side rail up on the opposite side of the bed.
5. Lower the side rail on the side nearest you.
6. Wash Hands
7. Position the patient on his back or in a side-lying position.
8. Remove the blanket and place on a linen trolley to use after the perineal care.
9. Cover the patient with blanket taken from prepared tray.
10. Do not to expose the patient, slide the sheet out from under the bath blanket and leave fan folded at the foot of the bed.
11. Ask the patient to raise his hips, and then slide the bed protector under him.
12. Ask the patient to flex his knees and separate his legs. If the patient is on his side use a pillow or folded bath blanket between the knees to separate the legs comfortably and to allow easier access to the perineal area.
13. Slide down the blanket to expose the perineal area only, keeping the legs covered.
14. Put on gloves.
15. Wet the wash cloth in the basin, form it in to a mitt and add a small amount of soap.
16. Grasp the penis gently in one hand and apply soap with the wash cloth. Start at the meatus and wash in a circular motion down to the base on each side of the penis.
17. Uncircumcised patients require that the foreskin be pulled gently down to expose the end of the penis, which can then be washed.

PERINEAL CARE: MALE PATIENT		
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18. Wash the scrotum, lifting it to wash the perineum.
19. Rinse the wash cloth, using the mitt to rinse the area washed. More than one rinse or wash, may be necessary to clean the area thoroughly.
20. Dry the area with the towel. Place the foreskin back in position for the uncircumcised patient.
21. Turn the patient on his side away from you, and flex the knee of his upper leg slightly, if this is permitted depending on his restrictions.
22. Wet the washcloth, form into a mitt and apply soap.
23. Wash the anal area, using gentle front (perineum) to back (coccyx) strokes.
24. Rinse carefully as before. Repeat the wash and rinse if necessary.
25. Dry gently.
26. Reposition patient on his back.
27. Remove the protective pad from the bed and dispose of it.
28. Dispose of gloves and wash your hands.
29. Pull the sheet over the top of the blanket. Slide the blanket out from under the sheet. Bag and discard in laundry hamper.
30. Place the blanket back on the patient. Tuck in as required.

FOLLOW-UP

1. Empty the basin of water, clean place in proper storage. Dispose of wash cloth and towel. Dispose of gloves and wash hands.
2. Document the procedure. Remember to document any redness, sores, rashes, swelling, bleeding, discharge or discomfort the patient may have in that area.

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NURSING MANUAL

PERINEAL CARE: FEMALE PATIENT		
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PERINEAL CARE: FEMALE PATIENT

REQUIRED ITEMS

1. Blanket
2. Bedpan and cover
3. Soap
4. Basin with warm water
5. Disposable gloves
6. Disposable bed protector
7. Wash cloth and towel
8. Disposable laundry hamper for dirty linen

STEPS

1. Identify the patient by checking the identification band and introduce yourself if not already done earlier.
2. Explain the procedure.
3. Provide privacy for the patient.
4. Provide safety with the side rail up on the opposite side of the bed.
5. Lower the side rail on the side nearest you.
6. Wash Hands
7. Position the patient on his/her back (a side-lying position is also used)
8. Remove the blankets and place on a linen trolley for use after perineal care.
9. Cover the patient with blanket from the prepared tray.
10. Do not expose the patient, slide the sheet out from under the blanket and leave fan folded at the foot end of the bed.
11. Ask the patient to raise her hips, and then slide the bed protector under her.
12. Ask patient to flex her knees and separate her legs. If the patient is on her side use a pillow or folded blanket between the knees to separate the legs comfortably and to allow easier access to the perineal area.
13. Slide down the blanket to expose the perineal area only, keeping the legs covered.
14. Put on gloves.
15. Wet the wash cloth in the basin, form it in to a mitt and add a small amount of soap.
16. Separate the vulva with one hand.
17. To wash gently:
    a. Using the mitt, stroke the outer labia once from top downward to the perineum.
    b. Rinse the washcloth and repeat this one stroke to rinse the area.
    c. Using the soaped mitt, stroke the other outer labia once from top, downward to the perineum.
    d. Rinse the washcloth and repeat this one stroke
    e. Repeat the above steps for both inner labia.

PERINEAL CARE: FEMALE PATIENT		
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f. Separate the labia with one hand.
g. Wash and rinse with the same one downward stroke.

18. Rinse the wash cloth, using the mitt to rinse the area washed.
19. More than one rinse or wash, may be necessary to clean the area thoroughly.
20. Dry the area with the towel.
21. Turn the patient on his/her side away from you, and flex the knee of his/her upper leg slightly.
22. Wet the washcloth, form into a mitt and apply soap.
23. Wash the anal area, using gentle front (perineum) to back (coccyx) strokes.
24. Rinse carefully as before. Repeat the wash and rinse if necessary.
25. Dry gently.
26. Reposition patient on her back.
27. Remove the protective pad from the bed and dispose of it.
28. Dispose of gloves and wash your hands.
29. Pull the sheet over the top of the blanket. Slide the blanket out from under the sheet. Bag and discard in laundry hamper.
30. Place the blanket back on the patient. Tuck in as required.

FOLLOW-UP

1. Empty the basin of water, clean & place in proper storage. Dispose of wash cloth and towel. Wash your hands.
2. Document the procedure and if any redness, sores, rashes, swelling, bleeding, discharge or discomfort the patient may have in that area

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NURSING MANUAL

VOIDING PRIOR TO DISCHARGE		
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VOIDING PRIOR TO DISCHARGE

POLICY

Patients having the following procedures must void prior to discharge unless otherwise ordered or indicated by the physician:

1. Spinal anaesthesia
2. Haemorrhoidectomy
3. Laparoscopy
4. Urology procedures

Patients should be encouraged to walk to the bathroom, if appropriate and void prior to discharge. Unless amount of output is specifically indicated or required, there is no need to measure urine output.

Voiding may be documented as up to bathroom with assistance and voided.

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NURSING MANUAL

DOCUMENTATION: DISCHARGE CRITERIA		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 107** **Page: 1 of 1**
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DOCUMENTATION: DISCHARGE CRITERIA

POLICY

1. The Discharge summary reflects the entire discharge planning process and the progress from admission to discharge.
   a. Activities are documented as they occur and summarized.
   b. Documentation should show information which is specific to Patient's need.
2. The nurse, as a member of the multidisciplinary treatment team, is an active part of patient discharge planning.
   a. In preparation for discharge, the patient's continuing care needs are assessed.
   b. The nurse completes the nursing discharge summary upon discharge of the patient.
3. The Discharge Summary is prepared along with the approved discharge criteria to (Annexure attached) document the patient's readiness for discharge from the Prime Surgical Centers. Criteria are to be checked as appropriate in case of any narrative to be included and it should be written in Nurse's Note.
4. "Post-operative Teaching" will be imparted by the concerned Nurse of Nursing Unit (Refer Nursing Manual Policy and Procedure No. 100)
5. Note if any prescriptions were given to the patient. A copy of these is to remain on the medical record marked "Copy".
6. The Consultant or Anaesthesiologist has to indicate the name, date and time while discharging the patient.
8. A check at "Discharge Criteria Met" indicates that all discharge criteria for this patient have been met.
9. Document how patient was discharged, i.e., Escorted to Car and Released to relative.
10. Note discharge time and include signature of Staff Nurse discharging patient.
11. Discharge comments by and signatures of the consultant discharging the patient are documented in the appropriate area.

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ANNEXURE
(Refer to Nursing Manual Policy and Procedure No. 107)

DISCHARGE CRITERIA

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Sr. No.	Details	Time	Comment	
			Yes	No
1	Vital Parameters stable, Consultant informed.			
2	Alert, oriented, no dizziness.			
3	No nausea/vomiting.			
4	Dressing checked/drain checked/blood loss acceptable.			
5	Accepting fluids			
6	Accepting solids			
7	Pain score acceptable: 0-3			
8	Last pain medication given			
9	Able to ambulate			
10	Urine voided			
11	Responsible relative present			
12	Patient given and explained discharge instructions			
13	Patient has received all investigations report / films and discharge card			

Name & Signature of Nurse, Date Time :- .....

PRIME SURGICAL CENTERS

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NURSING MANUAL

POST-OPERATIVE DISCHARGE INSTRUCTIONS: AFTER SURGERY INSTRUCTIONS		
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POST-OPERATIVE DISCHARGE INSTRUCTIONS: AFTER SURGERY INSTRUCTIONS

PURPOSE

To ensure that the patient and family fully understand their responsibilities, limitations and possible signs of complication and what action to take. When the patient and family know what to expect, observe for and what to do, anxiety is reduced.

SCOPE

All Nurses.

POLICY

1. Individual post-operative discharge instructions will be given to the patient prior to discharge and photostat copy attached to medical records.
2. Discharge instructions cover the period immediately following the procedure to the first post-operative visit.

Every patient will receive a list of written instructions. Written instructions will be carefully reviewed and verbalized by Staff Nurse with the patient and his/her family.

PROCEDURE

Post-operative instruction before discharge of the Patient:

1. Before the patient who had residual sensory or motor blockade is discharged home, the duration of the blockade must be explained. The patient must receive written or verbal instructions, about his/her condition until normal sensation returns.
2. Patient should be discharged home with a supply of appropriate analgesic and advised not to drive, drink alcohol, operate machinery or cook until the following day.
3. In the event of any problem, the patient should be informed of where help or advice can be found including contact telephone number.
4. These instructions should be given in the presence of the responsible family member\ caregiver or next of kin who is to escort and care for the patient.
5. Give the appropriate list of instructions to the person accompanying patient.
6. Review each instruction with patient and the person accompanying him/her.
7. Give ample opportunity for questions.
8. Demonstrate any procedure to be performed.
9. Be sure patient is aware of signs of complication and to call treating consultant for advice.
10. The staff shall sign off the instruction sheet after completing it and patient or his/her family member shall sign after listening to instructions.
11. If no family is with the patient (i.e., taxi driver only), so indicate on the form.
12. For details refer Annexure to this Policy.

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ANNEXURE
(Refers to Nursing Manual Policy and Procedure No. 108)

POST-OPERATIVE DISCHARGE INSTRUCTIONS
(To be given to patient on discharge)

1. ACTIVITY
You might feel a little sleepy for the next 24 hours. This may be due to the medicine you received for anaesthesia/sedation.

2. YOU SHOULD NOT FOR THE NEXT 24 HOURS
- Drive a car or operate machinery or power tools.
- Engage in strenuous activity.
- Drink any alcoholic beverages including beer.
- Make any important decisions or sign legal document**.**

3. EXPLAINED THE DIET ☐ **Yes** ☐ **No** ☐ **NA**

4. EXPLAINED MEDICATION AND DISCHARGE SUMMARY ☐ **Yes** ☐ **No** ☐ **NA**

5. WHEN TO CALL THE DOCTOR ON TELEPHONE OR MOBILE NUMBER *
- **Persistent** nausea and vomiting.
- A fever over 101 degrees orally.
- Pain not relieved by pain medication.
- Any bleeding or unexpected drainage from wound.
- Extreme redness or swelling around the incision.

6. PRESCRIPTIONS GIVEN _____

_____

7. ADDITIONAL INSTRUCTIONS (if any) _____

_____

_____

8. MEDICINE/SUPPLIES GIVEN ☐ **Yes** ☐ **No** ☐ **NA**

* Between 9:00am to 5:00pm:
Prime Surgical Centers – 020-3993 1000

Between 5:00pm to 9:00am:
Dr (Mrs) Pratibha Kane – 9822090771
Dr (Mrs) Neha Banwat – 9970024442
Dr (Mrs) Samruddha Kulkarni – 9850134424
Dr Sameer Sabat - 8055933975

I have received all documents and medicine/supplies and understood the above instructions.

_____ _____

Name & Signature of patient/patient's relation
Date& Time:
Telephone No:

Nurse Signature
Date & Time:

ANNEXURE
(Refers to Nursing Manual Policy and Procedure No. 109)

DISCHARGE SUMMARY

MR No :	IP No.
Name :	
Age/Sex :	
Comfort / Deluxe Bed No :	
Admission Date :	

Date of Discharge : _____

Consultant In charge: Dr. _____

Diagnosis : 1. _____

2. _____

3. _____

Brief Summary : _____

_____

_____

_____

_____

_____

_____

Investigations : _____

Hb (gm/dl)- _____ WBC- _____ /mm^3 Platelets- _____

Blood Group _____ BSl _____ gm/dl- S. Creatinine _____ B. Urea- _____

BUN _____ Serum Electrolytes: S. Na+: _____ S.K.+: _____

Urine: (Routine)- _____

(Microscopy)- _____

ECG: _____

X-Ray: _____

USG: _____

CT Scan : _____

_____

MRI : _____

_____

Hospital Course & Treatment : _____

_____

_____

_____

_____

_____

Anaesthesia Summary :

Consultant Anaesthesiologist : Dr. _____

ASA GRADE : 1 2 3 4 5 E

Anaesthesia Administered : ☐ General Anaesthesia ☐ Spinal Anaesthesia

☐ Epidural Anaesthesia ☐ Monitored Anaesthesia Care ☐ Regional Block

Adverse Anaesthesia Events if any : _____

_____

Advice on Discharge : _____

_____

_____

_____

Date :

Name & Signature of RMO / Consultant

ANNEXURE
(Refers to Nursing Manual Policy and Procedure No. 111)

Letter No: _____ Date: _____

To,
The Senior Police Inspector
Prabhat Road, Erandwana,
Deccan Gymkhana,
Pune-411004

Dear Sir,

ABSCONDING PATIENT REPORT

Mr. / Ms. _____, aged _____years,

Male / Female, having MR No_____, who was admitted to Comfort/Deluxe Bed

No._____ at Prime Surgical Centers, Pune on _____, has left the

premises of Prime Surgical Centers, Pune, without informing anyone on _____

at approximately _____a.m. / p. m.

I have contacted the person, whose details are given as contact in Medical Records, to inform / locate whereabouts of absconding patient.

After making all reasonable efforts to locate the absconding patient, a complaint with your Police Station is being lodged vide above quoted letter.

Thanking you.

Signature of the Staff Nurse: _____

Name of the Staff Nurse: _____

Date: _____Time:_____

Countersigned By:

Signature of Doctor:_____

Name of Doctor: _____

Date: _____Time:_____

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

DISCHARGE FOR ABSCONDING PATIENT		
Policy/Procedure Applies To	**All Nurses**	**Policy/Procedure No: 111** **Page: 1 of 1**
Effective Date: 11 April, 2013		

DISCHARGE FOR ABSCONDING PATIENT

If a Patient leaves without the knowledge of hospital staff, it will be termed as absconding patient and the following procedure will be followed:

1. Upon noticing the Patient's absence from the Nursing Unit, the Nurse will contact the Consultant, Nursing Superintendent and the Administrative Head of the center.
2. Nursing Staff will call the contact person indicated in medical records to inform / locate the whereabouts.
3. If the Patient is not located / returns to the room within two hours after the initiation of the search, a complaint will be lodged with the local police station giving all necessary details as per Annexure of this policy.
4. The nurse will invariably note all pertinent information in patient's medical records and complete discharge procedure as Absconding Patient.
5. Complete the Incident Report and forward to Nursing Superintendent and Administrative Head of the Center.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL

VIDEOTAPING, RECORDING AND PHOTOGRAPHIC PROCEDURES		
Policy/Procedure Applies To	**All Nurses/ Administrator/ Surgeons/ Medical Records/ Anaesthesiologists**	**Policy/Procedure No: 112** **Page: 1 of 2**
Effective Date: 11 April, 2013		

VIDEOTAPING, RECORDING AND PHOTOGRAPHIC PROCEDURES

PURPOSE

The Prime Surgical Centers recognizes the therapeutic potential of videotaping patients involved in various center activities. In order to guarantee confidentiality, videotaping, recording, Photographic Procedures, etc., must be done under the guidelines of the following procedures. This policy also applies for audiotapes, still pictures, movies, or any similar form of recording.

POLICY

1. No Staff may make any photographic record of hospital buildings, grounds, units, or patients without prior approval from the center's Administrative Head.
2. Staff making videotapes for therapeutic purposes must make every effort to assure confidentiality to the patient(s) involved.
    a. No patient may be recorded without their knowledge and consent.
    b. Videotaping is defined as a treatment procedure, with appropriate consideration given to the indications and contra-indications of the procedure.
    c. After the recording is made, it becomes the property of the Center and may not be viewed by any individual not currently involved in the treatment of the patient. The tape may not leave the Prime Surgical Centers premises.
    d. No copies of the tape may be made without the written authorization of the Prime Surgical Centers administrator.

3. Exceptions to the viewer regulations may be given only by the Administrative Head of the Center.
    a. Exceptions may include clinical/educational presentations to appropriate groups.
    b. Exceptions are granted only after the patient has given informed consent for Videotaping/ Photography.
    c. Requests for viewings by individuals not employed by the Prime Surgical Centers require the administrator's signed approval.

PROCEDURE

The following guidelines shall be followed when videotaping / Photographic a procedure:

1. The request for videotaping / Photography should be made to the administrator's office when the procedure is scheduled.
2. When the surgeon arrives for a case, confirm with him/her that he/she intends to videotape the procedure.
3. Make sure the word 'video' / Photography is used when charting the procedure.

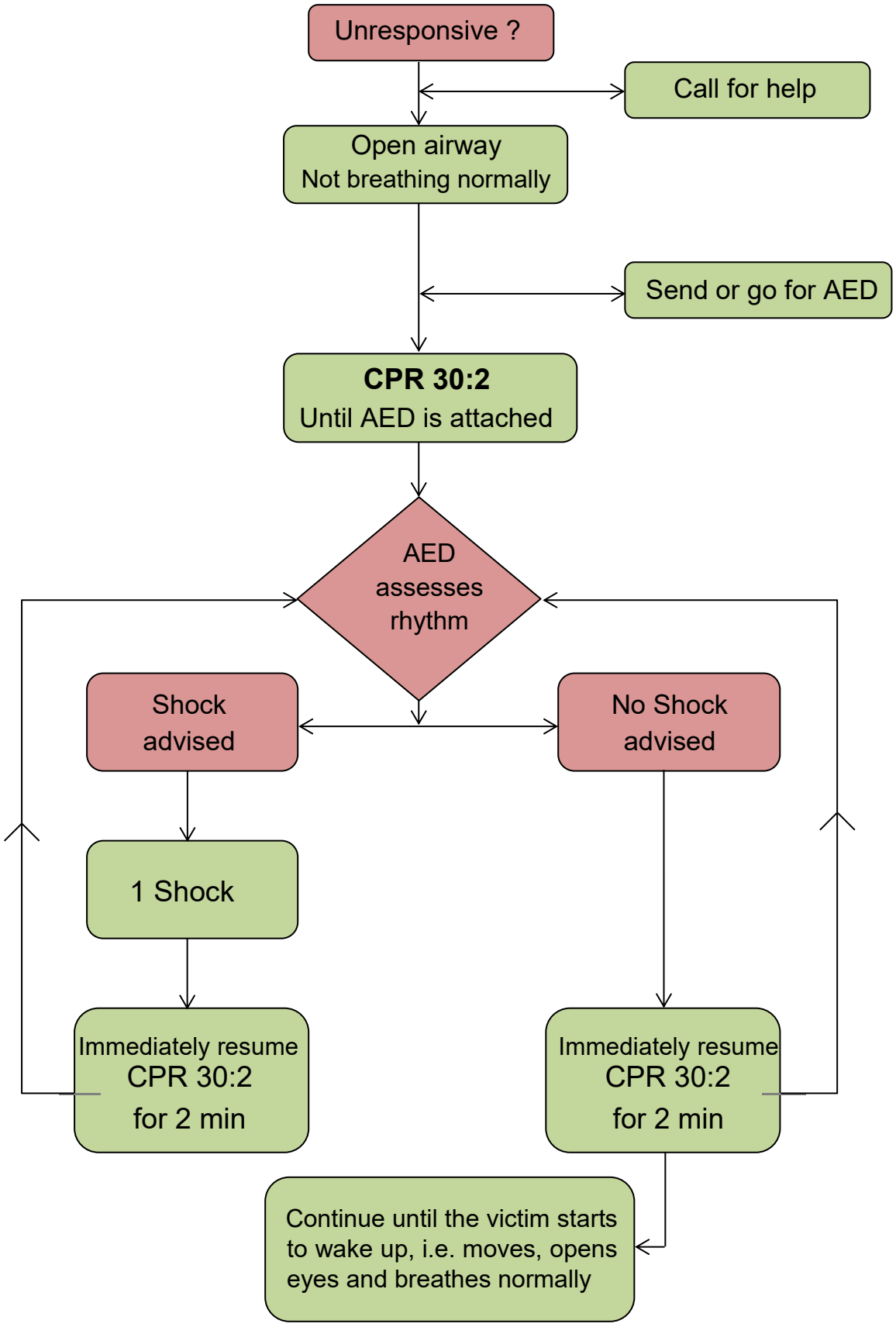
VIDEOTAPING, RECORDING AND PHOTOGRAPHIC PROCEDURES		
Policy/Procedure Applies To	**All Nurses/ Administrator/ Surgeons/ Medical Records/ Anaesthesiologists**	**Policy/Procedure No: 112** **Page: 2 of 2**
Effective Date: 11 April, 2013		

4. At the end of the procedure, rewind the tape, label tape / camera and give to Surgeon. Label tape with the following:
   a. Patient name
   b. Date
   c. Procedure
   d. Surgeon

5. Note on chart that tape / camera have been given to Surgeon and obtain signature with name, date and time.

Revised By:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

AED Algorithm



ANAESTHESIA MANUAL INDEX

ASSISTING A PATIENT TO USE THE WHEELCHAIR

PURPOSE

To ensure that the patient is handled with care and safety.

PROCEDURE

Assisting a patient to transfer into the wheelchair

1. Make sure that both the brakes are 'on', and the front casters are swiveled forwards.
2. Fold up both footplates and swing them to the sides and out of the way.
3. If possible, get another person to hold the handles of the wheelchair so that it will not move. If this is not possible then stand behind the chair and hold the handles yourself.
4. Ask the patient to stand, then with both hands on the front of the armrests, get them to lower him/herself onto the seat.
5. Swing the footrests to the front and fold down the footplates. If required, assist the patient to place their feet on the footplates, with their heels well back.
6. Lock the safety strap on.
7. Ensure that the patient's elbows are not sticking outside the wheelchair when going through doorways. Also ensure that their hands are on their laps and not hanging outside the chair where they can catch in the spokes.

Assisting a patient in transferring out of a wheelchair

1. Position the wheelchair in a position wherein the casters swivel forwards.
2. Make sure that both the brakes are on.
3. Fold up both footplates and swing them to the sides, out of the way.
4. Unlock the safety strap.
5. If possible, get another person to hold the handles of the wheelchair so that it will not move. If this is not possible then stand behind the chair and hold the handle yourself.
6. Ask the patient to move forwards on the seat.
7. Ask the patient to place both hands on the front of the armrests, then get them to lean forwards with their head and shoulders over their knees to give balance. From this position they should be able to push themselves to standing. Always encourage the patient to take their time with each step of the procedure.
8. Ask the patient to place both feet firmly on the ground, slightly apart and with one foot further back.

Assisting a patient in transferring sideways from a wheelchair to another form of seating

1. Place the wheelchair alongside, and at 45°, to the chair/toilet/bed/car that they wish to transfer to.
2. If possible position the wheelchair up slightly so that the front casters swivel forwards.
3. Ensure that both the brakes are on.
4. Fold up both footplates and swing them to the sides out of the way.
5. Remove the armrest on the side to which the patient is transferring.
6. If possible, get another person to hold the handles of the wheelchair so that it will not move. If this is not possible then stand behind the chair and hold the handles yourself.
7. Ask the patient to move forwards on the seat.
8. Ask the patient to place one hand on the remaining armrest and the other palm down, on a stable area of the surface they are transferring to.
9. Ask the patient to lean slightly forwards, push up and slide their bottom across to the other surface.

Negotiating kerbs

Whenever possible, it is best to avoid kerbs. Instead, always try to use dropped kerbs or ramps. If a kerb is unavoidable then the following precautions should be taken:

Pushing an occupied wheelchair down a kerb

It is safer to go down a kerb backwards. It requires less strength and gives a gentler ride. Care should, however, be taken due to the weight of the chair and also because the task involves stepping backwards into a road.

1. Practice with an empty wheelchair first.
2. Always keep the wheelchair user informed about what you are intending to do.
3. Make sure the road is clear, and then back the wheelchair to the edge of the kerb.
4. Ensure that the chair is lined up at 90° to the kerb.
5. Slowly roll the rear wheels down from the kerb and onto the road surface, making sure that both wheels touch down at the same time.
6. When the front casters are at the edge of the kerb, push down and forward on the tipping lever with your foot while gently pulling back on the handles and at the same time. This will balance the wheelchair and its occupant on the rear wheels. Do not tip the wheelchair back more than necessary.
7. Carefully pull the wheelchair further back into the road and, when the occupant's feet are clear of the kerb, gently lower the front to the road. Check that the road is clear before turning around and crossing.

Pushing an occupied wheelchair up a kerb

It is safer to go up a kerb forwards; it requires less strength and gives a gentler ride.

1. Practice with an empty wheelchair first.
2. Always tell the person in the wheelchair what you are about to do.
3. When the occupant's feet are nearly touching the kerb, push down and forwards on the tipping lever with your foot while gently pulling back on the handles and at the same time. This will balance the wheelchair and its occupant on the rear wheels.
4. When the front casters are just clear of the kerb, push the wheelchair forwards until the casters rest on the pavement. Do not tip the wheelchair back more than necessary.
5. Push the wheelchair forwards until the back wheels just touch the kerb and then lift up on the handles as you continue pushing forwards to place the rear wheels on the pavement. The occupant can help with this stage by pushing forwards on the handrims (if they are capable of doing so).

Changes made to existing manuals

Exposure control –pol 6

6. A container for constituting and applying 5.25% bleach solution

6. Spray the spill site with 5.25% household bleach and allow air-drying for 15 minutes.

Hospital infection control – pol 17

3. Reusable metal equipment (e.g. laryngoscope blades, Magill forceps, stylettes) is to be sterilized or subjected to 5% Cidex for 15 minutes immediately after each use.

7. Objects disinfected with liquid chemicals for cleaning purposes only, must be rinsed in sterile water (or 1% sodium hypochlorite solution) to remove possibly toxic or irritating residues.

Hospital infection control – pol 19

4. Inspect instruments for cleanliness, proper function and alignment and freedom from defects and prepare for storage and/or sterilization following the cleaning process. Defective or damaged instruments will be given to the OT Matron with a written description of damage.

Hospital infection control – pol 25

While wearing gloves, spray Bacillocid 20% or Ecoshield 5% disinfectant solution on blood pressure cuff and stethoscope, allow 20 minutes contact time and wipe dry.

Hospital infection control – pol 29 – page 5

c. Red – Sharps and needles

5. Do change chemical solutions frequently (with 24 hours).

Prime Surgical Centers

Competencies - Operation Theatre / Procedure Room

Name: _____ Designation:_____ Unit No.:_____

S.No	Competency	Frequency of Revalidation	Validation & Revalidation					
			First		Second		Third	
Initial Competencies (Months:1-3)			Date	Validated By	Date	Validated By	Date	Validated By
1	Cardiopulmonary Resuscitation-Adult	Every Year						
2	Care of Specimens Collected in OR	Every Year						
3	Creates and Maintains the Sterile Field	Every Year						
4	Electrosurgical Units (Monopolar & Bipolar)	Every Year						
5	Fall Prevention	Every Year						
6	Gowning & Gloving	Every Year						
7	Opening Sterile Packages	Every Year						
8	Oxygen Therapy-Care of Patient on	Every Year						
9	Safe Moving and Handling of Patients	Every Year						
10	Sharps & Needle Stick Injury	Every Year						
11	Surgical Scrub	Every Year						
12	Use of Glucometer	Every Year						
13	Care of Instruments & Equipment.	Every Year						
14	Defibrillation	Every Year						
15	Defibrillator Checking - Routine	Every Year						
16	Disposal of Sharps	Every Year						
17	Positioning of Surgical Patients in the OR	Every Year						
18	Sterility Assurance of Supply	Every Year						
19	Transfer of Patients from OT to ICU	Every Year						

ORINTEE: ----------

PRECEPTER :----------
DATE:

***Competencies to be revalidated when needed (i.e. if deficit identified)**

Prime Surgical Centers

Competencies - Operation Theatre / Procedure Room

Name: _____ Designation: _____ Unit No.:_____

S.No	Competency	Frequency of Revalidation	Validation & Revalidation					
			First		Second		Third	
Initial Competencies (Months:1-3)			Date	Validated By	Date	Validated By	Date	Validated By
1	Blood and Blood Products Administration	Every Year						
2	Cardiopulmonary Resuscitation-Adult	Every Year						
3	Care of Specimens Collected in OR	Every Year						
4	Care of Patients Under Conscious Sedation	Every Year						
5	Care of Patients Post Epidural Anesthesia	Every Year						
6	Care of Patients Post General Anesthesia	Every Year						
7	Care of Patients Post Spinal Anesthesia	Every Year						
8	Catheterization – Urinary Bladder	Every Year						
9	Charting and Documentation	Every Year						
10	Creates and Maintains the Sterile Field	Every Year						
11	Electrosurgical Units (Monopolar & Bipolar)	Every Year						
12	Fall Prevention	Every Year						
13	Gowning & Gloving	Every Year						
14	Insertion of Intravenous Cannula	Every two years						
15	Medication Administration	Every two years						
16	Opening Sterile Packages	Every Year						
17	Oxygen Therapy-Care of Patient on	Every Year						
18	Pain Assessment (VAS)	Every Year						
19	Safe Moving and Handling of Patients	Every Year						

***Competencies to be revalidated when needed (i.e. if deficit identified)**

Prime Surgical Centers

Competencies - Operation Theatre / Procedure Room

Name: _____ Designation:_____ Unit No.:_____

S.No	Competency	Frequency of Revalidation	Validation & Revalidation					
			First		Second		Third	
Initial Competencies (Months:1-3)			Date	Validated By	Date	Validated By	Date	Validated By
20	Sharps & Needle Stick Injury	Every Year						
21	Sponge, Sharps and Instruments Count	Every Year						
22	Surgical Scrub	Every Year						
23	Use of Glucometer	Every Year						
24	Blood Culture	Every Year						
25	Care of Instruments	Every Year						
26	Care of Patients Under Local Anesthesia	Every Year						
27	Defibrillation	Every Year						
28	Defibrillator Checking - Routine	Every Year						
29	Disposal of Sharps	Every Year						
30	Phlebotomy	Every Year						
31	Positioning of Surgical Patients in the OR	Every Year						
32	Sterility Assurance of Supply	Every Year						
33	Transfer of Patients from OT to ICU.	Every Year						

ORINTEE: ----------

PRECEPTER :----------

DATE: ----------

***Competencies to be revalidated when needed (i.e. if deficit identified)**

Prime Surgical Damle Path, LLP
Beck House, Damle Path
Off Law College Road
Pune 411004, India
www.primesurgical.in

CARDIOPULMONARY RESUSCITATION REPORT FORM

PRIME SURGICAL CENTERS

PATIENT NAME: _____

DATE: _____ TIME: _____ A.M P.M

MR No: IP No:
Age/Sex:
Comfort/Deluxe Bed No:
OR 1 / 2 / 3 / 4 :

CARDIAC ARREST

1. TYPE	2. SUSPECTED CAUSE		3. RECOGNIZED BY	4. HOW RECOGNIZED
□ STANDSTILL	□ MYOCARDIAL INFARCTION	□ HEAMORRHAGE	□ NURSE	□ NO PULSE
□ VENTRICULAR TACHYCARDIA	□ PULMONARY OEDEMA	□ ANAESTHESIA	□ PHYSICIAN	□ NO RESPIRATION
□ CIRCULATORY COLLAPSE	□ PULMONARY EMBOLISM	□ DRUG	□ NURSING AIDE	□ DILATED PUPILS
□ UNKNOWN	□ RESPIRATORY ARREST	□ UNKNOWN	□ ALARM	□ AGONAL GASP
	□ OTHER		□ OTHER	□ ALARM

6. RESUSCITATION STARTED BY	7. METHOD OF ARTIFICIAL VENTILATION	8. METHOD OF ARTIFICIAL CIRCULATION
□ NURSE □ PHYSICIAN	□ BAG / MASK	□ EXTERNAL (CLOSED)
□ ANAESTHESIOLOGIST □ NURSING AIDE	□ BAG / ENDO TUBE	□ MANUAL
□ OTHER _____	□ OESOPHAGEAL AIRWAY	□ MECHANICAL
	□ MECHANICAL VENTILATOR	
WITHIN _____ MINUTES	TYPE _____	

9. DURATION	10. SYSTOLIC BLOOD PRESSURE DURING RESUSCITATION	11. DEFIBRILLATION AC EXTENSION (NO. OF SHOCKS)
□ MANUAL □ MECHANICAL □ BOTH	□ PALPABLE PULSE □ NOT PALPABLE	□ 50 □ 100 □ 150
	□ RECORDED (MMHG)	□ 200 □ 300 □ 400
	□ 50 □ 60 □ 70 □ 80 □ 90 □ 100	

MIN	3	5	12	15	20	30	40	MORE
NIBP								
CIRC.								

12. RESTORED			13. REVERTED TO
YES	NO		
□	□	PALPABLE PULSE	□ VENTRICULAR FIBRILLATION
□	□	SPONTANEOUS BREATHING	□ CARDIAC STANDSTILL
□	□	CONSCIOUSNESS	□ CARDIOVASCULAR COLLAPSE
□	□	RHYTHMIC ECG	

DRUG	DOSE /ROUTE
EPINEPHRINE	
CALCIUM	
NA CO3(50 CC/44 CAECQ)	

REASON FOR STOPPING

YES NO

□ □ CIRCULATION RESTORED

□ □ RESPIRATION RESTORED

PROCEDURE UNSUCCESSFUL

□ NO RESPONSE

□ EQUIPMENT SUPPLY PROBLEMS

□ OTHER _____

PROCEDURE INAPPROPRIATE □

□ TERMINAL DISEASE □ DELAY IN STARTING

□ OTHER _____

REMARKS:

OUTCOME

□ LEFT CENTER ALIVE AT_____HRS AFTER CPR

□ EXPIRED AT_____HRS AFTER CPR

CAUSE OF DEATH _____

AUTOPSY □ YES □ NO

AUTOPSY FINDING _____

Additional comments and/or suggestions:

CONSULTING DOCTOR'S

SIGNATURE: _____

NAME:_____

DATE & TIME: _____

HOSPITAL INFECTION CONTROL MANUAL INDEX

28-Reporting and Investigating Post-Operative Infection
28-Reporting and Investigating Post-Operative Infection-Annexure
29-Waste Management
29-Waste Management-Annexure

HOUSEKEEPING MANUAL INDEX

Infection Control Manual

July 6

2012

AMBULATORY SURGERY CENTER

AMBULATORY SURGERY CENTER

TABLE OF CONTENTS:

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Infection Control Program	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 1	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

INFECTION CONTROL PROGRAM

SCOPE: All personnel

PURPOSE:

The Infection Control Program is a major component of the center's safety and performance improvement programs. Activities of the infection control program are appropriate to this center's geographic location, the volume of patients encountered, the patient populations served, the center's clinical focus, and number of employees.

POLICY:

The AMBULATORY Surgery Center will have an organized infection control program. Infections acquired in health care facilities or brought into health care facilities are potential hazards for patient, families, employees and physicians. Procedures will be implemented to prevent, identify, investigate and control potential infections and communicable diseases The Governing Body is the ultimate authority for the Infection Control program. The ongoing responsibility for the program is assigned by the Administrator to an individual who receives special training regarding Infection Control and the responsibilities of the position. The designated individual will be a member of the center's Quality Improvement/Patient Safety Committee and provide quarterly reports regarding the program activities, findings, and improvement strategies. Professional guidelines to be utilized in the implementation of the Infection Control Program: Evidence-based policies and procedures have been developed from CDC, APIC, and OSHA resources.

PROGRAM OBJECTIVES:

1. To conduct periodic risk analysis within the center and implement appropriate action plans to correct any identified opportunities for improvement.
2. To identify areas of potential exposure to infection for patients, staff, visitors, and contractors through direct observation, survey analysis and reports from healthcare workers.
3. To minimize the risk of and impact of exposure through effective infection control practices.

4. To identify and evaluate the occurrence of Healthcare Associated Infections (HAIs) and make recommendations for their reduction.

5. To maintain an awareness and working knowledge of guidelines and recommendations that are published by regulatory and accrediting agencies and professional organizations.

6. To keep well-informed of current information about the emergence of epidemics or new infections.

7. To provide liaison activities with Governing Body and administration, in the event of an outbreak.

8. To provide education in order to facilitate the creation of an environment in which consistent optimal standards of care can be achieved.

9. To collect, aggregate and analyze data for trends and to provide timely and effective intervention to reduce risk.

10. To facilitate compliance with reporting requirements of the center to public health agencies.

Surveillance

Surveillance is an active process to identify and analyze outcomes related to infection control, and includes:

1. Environmental surveillance to identify and correct practices found in the workplace
2. Preventive surveillance such as immunization of staff
3. Observation and documentation of sterilization and disinfection practices
4. Verification of education and training for staff
5. Conformity with safe sharps handling
6. Public Health reporting and monitoring of community trends
7. Postsurgical surveillance conducted through reports sent to physicians

Patient Care

1. Patient Assessment and Triage

   All patients will receive a pre-operative or pre-procedure assessment of current and past health history, including a symptom-based evaluation for current communicable disease. The ambulatory care setting does not provide for isolation rooms and therefore contact with patients who are potentially contagious must be limited.

2. Hand Hygiene

   Protocols for proper hand hygiene and surgical hand antisepsis are an essential element of the Program.

3. Laundry Services

Facility policies and procedures will outline the handling, processing, and storage of clean and dirty linen, as well as the use of disposable supplies.

4. Environment of Care

   Environmental factors reviewed as part of the Infection Control plan include work flow to prevent cross contamination, sterilization and reprocessing procedures and documentation, ventilation, temperature and humidity of rooms, appropriate ventilation and maintenance of systems (including measurement of air exchanges), housekeeping responsibilities, disinfection of surfaces between patients, cleaning schedules, and pest management.

Employee Health Program

The employee health program will integrate with the infection control program and will include providing employees the following:

1. Health screening
2. TB screening
3. Immunizations
4. Post exposure evaluation, testing and follow up

Education

Orientation and training regarding infection prevention and control will be conducted by the designated Infection Control person and will include the topics of hand hygiene, high level disinfection/sterilization, waste management procedures, and infection prevention practices. Information related to employee health will also be included**.**

Outbreak Investigation

Systems are in place to facilitate recognition of increases in infections as well as clusters and outbreaks.

Improvement Strategies

Monitoring of infection control measures will be conducted and variances will be reported for specific occurrences. Corrective and preventive measures for improvement will be undertaken immediately as needed.

Policies and Procedures/ Facility References

The following Infection Control policies and procedures will be maintained and made part of the facility's infection control plan:

1. Exposure Control Plan
2. Procedure for postoperative surveillance (report sent to physician)

3. Procedure for follow up on reported infections
4. Infection Control Best Practices pack
   Procedures for cleaning, disinfection and sterilization of rooms, equipment, and medical devices
5. Hand hygiene
6. Biohazardous waste management
7. Handling of linen
8. Mandatory reporting of communicable disease conditions
9. OR asepsis/operating room technique
10. Surgical hand scrub
11. Attire in the OR
12. Gowning and gloving
13. Employee health program
14. Monitoring the environment of care
15. Disaster preparedness
16. Orientation and training program/documentation of competencies
17. Policies addressing state-specific requirement

Program Evaluation

The Infection Control Plan and program will be reviewed at least annually and updated as needed (i.e., changes in services, risks)

REFERENCE:

Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Infection Control Coordinator Responsibilities	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 1	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

INFECTION CONTROL COORDINATOR RESPONSIBILITIES

AMBULATORY Surgery Center has a designated individual who will assume responsibility for the direction of the center's Infection Control Program. This person will be a Registered Nurse who will receive training specific to the responsibilities of the position. These responsibilities include, but are not limited to:

1. Identification of infection trends
2. Reporting of trends noted in infections to designated Employee Health nurse, if applicable
3. Reports communicable diseases to applicable public health agencies
4. Reviews patient related cultures
5. Reviews and monitors sterilization and disinfection processes
6. Formulates or revises policies and procedures to decrease the risk of infection
7. Interacts with personnel to increase the effective application of Infection Control policies and recommendations
8. Conducts staff education regarding Infection Control and related performance improvement strategies
9. Promotes compliance with APIC, OSHA, CDC, AAAHC and CMS standards related to Infection Control
10. Designs and conducts department surveillance monitoring
11. Monitors effective implementation of Universal Precautions
12. Compiles quarterly reports for Patient Safety, Quality Improvement Committee, Medical Executive Committee, and Governing Body
13. Reports patient and employee infections of epidemiologic significance and conducts surveillance as needed
14. Enters reports of confirmed infections to Management Company wide benchmarking.

Manual:	Infection Control	Subject:	Definitions	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 1a	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

DEFINITIONS

POLICY

To promote a safe, quality working environment by providing definitions of various terms to provide for better understanding and utilization of "clean" and "daily" terminology.

Antiseptic: A chemical compound that stops or inhibits the growth of micro-organisms.

Asepsis: The exclusion of all micro-organisms which may cause infection.

Clean: The absence of pathogenic organisms, visible matter and soil.

Communicability: In terms of an isolation period, communicability is that period of time during which the patient is infectious.

Communicable Disease: A communicable disease is an illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from a reservoir to a susceptible host, either directly, as from an infected person or animal, or indirectly though the agency of an intermediate plant or host, a vector or the inanimate environment.

Contact: Exposure to infection or contact in association with an infected person or his discharges (secretions or excretions).

> **Contact, direct**: Physical contact between a susceptible host and infected person or his discharges.
>
> **Contact, droplet nuclei**: The residues of evaporated droplets of moisture produced by coughing, sneezing, laughing, or talking, etc, which usually travel no more than three (3) feet; therefore, close association is required.
>
> **Contact, indirect:** Personal contact of a susceptible host with micro-organism through an intermediate, i.e. a doctor or instruments and dressings in the infected person's environment that have become contaminated

Contaminated: The known or assumed presence of an infectious agent on a body surface, also on or in clothes, bedding, toys, surgical instruments or dressing, or on or in other inanimate articles or substances including water, milk or food.

Disinfection: The reduction in population of a disease producing micro-organism (but generally not resistant spores) usually by chemical germicides or heat.

Infection: Infection is the entry and multiplication of infectious agents in the tissues of a susceptible host. The results of infection may not be apparent and be detected only by antibody responses.

Infection, endogenous: Infection from organisms normally resident in or on the person himself.

Infection, cross or cross contamination: Transmitted between persons with different pathogenic mere organisms.

Infection, exogenous: Infection resulting from contamination by a source outside the person.

Infection, hospital associated: (Healthcare Acquired Infection) a hospital associated infection in a patient which was not apparent upon his admission but developed thereafter and when clinically diagnosed, did not appear to have been incubating at the time of admission.

Infection, inapparent: An infection in a host without the occurrence of recognizable clinical signs or symptoms. Some inapparent infections are specifically identifiable by serological or skin tests.

Infection, new: Infections that appear at the new and different site, even if it is caused by the same organism or if new and different organisms appear in the cultures of the old infection.

Isolation: The separation of infected persons from susceptible persons in order to prevent the direct or indirect conveyance of the infectious agent. Selection of the appropriate isolation procedure is based on type and site of infection, pathogenic organism and mode of transmission.

Sterile: The absence of all living organisms.

Unclean: The usual collection of soil or matter in variable amounts resulting from occupancy of use.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Orientation and In-service	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 2	
Category:	Policy/ Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

ORIENTATION AND INSERVICE

PURPOSE
To provide documentation verifying that all personnel are familiar with infection control policies and procedures of the facility.

POLICY
There will be a comprehensive orientation program which includes infection control and which will be mandatory for each new employee.

In-services specifically regarding infection control issues will be scheduled at least twice each year.

PROCEDURE
A. Employee will document he/she has read and understands infection control policies and procedures. (*Bloodborne Pathogens Exposure Control Plan, Hazard Communication, Handling of Biohazardous Waste).*

B. Inservice all equipment, including use of sterilizer monitors and document employees and date of inservice including return demonstration by employees.

C. Document that housekeeping personnel have been oriented and inserviced regarding appropriate infection control issues, including exposure to blood borne pathogens.

Manual:	Infection Control	Subject:	Criteria for Patient Admission	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 3	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

CRITERIA FOR PATIENT ADMISSION

PURPOSE
To maintain and control potential infection producing situations.

POLICY
In accordance with the *Medical Staff Rules and Regulations*, patients not acceptable for admission to the facility are:

1. Those having an infection(s) that would require isolation and additional professional help in surgical or recovery room services.
2. Those who have been exposed to infectious disease during the incubation period.
3. Those exhibiting symptom(s) of tuberculosis which include the following:,
    a. unexpected weight loss
    b. productive cough
    c. cough for greater than three (3) weeks
    d. night sweats

PROCEDURE
A. Patients identified as having an infectious disease prior to admission will be discharged immediately with instructions to contact the primary physician.

B. During preoperative assessment, personnel will observe patient for potential infection problems and report and findings to surgeon.

C. Patient will be informed regarding signs of infection to report and method of reporting.

D. Precautionary measures appropriate to bloodborne pathogens will be practiced with all patients.

E. Patients identified as having an infectious condition while in the OR will be recovered and discharged directly from the operating room. The operating room will undergo terminal cleaning prior to admission of the next patient.

Manual:	Infection Control	Subject:	Determining Presence of Healthcare Acquired Infection	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 4	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

DETERMINING PRESENCE OF HEALTHCARE ACQUIRED INFECTION (HAI)

DEFINITION

Healthcare Acquired Infection (HAI) manifests in patients in whom infection was not present or incubating at the time of admission.

When the incubation period is unknown, an infection is called HAI if it develops at any time following admission and is related to the surgical event. An infection present on admission can be classified as HAI, only if it is directly related to or the residual of a previous admission. All infections that fail to satisfy these requirements are classified as community acquired.

The term "Healthcare Acquired Infection " will include potentially preventable infections as well as some infections that may be regarded as inevitable.

POLICY

If infection is suspected upon postop examination, it is requested cultures be performed immediately to identify organisms and determine sensitivity.

Data will be collected to investigate the circumstance to determine if contamination occurred and to determine if infection is HAI.

GUIDELINES

Application of specific guidelines requires that the clinical and laboratory data be reliable. There must be a high degree of certainty as to when the clinical manifestations of the infection in question had their onset. Additionally, when the diagnosis of infection depends on bacteriologic identification of organisms, colony counts, or other laboratory procedures, it is essential that these procedures be reliably performed on adequately collected and promptly delivered specimens.

A. Skin and subcutaneous infections

1. **Surgical wound infections**: Any surgical wound which drains purulent material, with or without a positive culture, is considered to be the site of a Healthcare Acquired Infection. The source of the organisms, whether endogenous or erogenous is not considered.

2. **Other cutaneous infections**: Any purulent material in skin or subcutaneous tissue first developing after admission is regarded as indicating a Healthcare Acquired Infection whether or not a culture is positive, negative, or has not been taken.

B. Other sites of infection

1. Any culture documented bacteremia that develops in a patient who was not admitted with evidence of bacteremia is regarded as a Healthcare Acquired Infection, unless the organism has been judged to be a contaminant. Such Healthcare Acquired Infection bacteremias may occur in the absence of recognized underlying infections, or originate from a site of Healthcare Acquired Infection, or from manipulation of a site which was infected at the time of the patient's admission (e.g. catheters, drains, incision and drainage, etc.)

2. Intravenous catheters and needles: Purulent drainage from site of an intravenous catheter or needle is regarded as Healthcare Acquired Infection infection, even if no cultures are obtained. Inflammation of such sites, without purulent material or strong clinical evidence cellulitis is not regarded as an infection unless a positive culture of fifteen (15) colonies is obtained from the catheter tip or from aspirates of tissue fluid and a positive blood culture is obtained. All culture results should be correlated with other clinical data.

3. Many other possible sites of Healthcare Acquired Infection infection must sometimes be considered. Application of the general principles outlined above, however, will generally make classification of these infections possible. It must be reemphasized that clinical impressions/diagnosis (if available) always supersedes laboratory or radiological data.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Reportable Communicable Diseases	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 5	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

REPORTABLE COMMUNICABLE DISEASES

PURPOSE
To provide guidelines for reporting events, observations or illness that may qualify as a reportable communicable disease.

POLICY
Immediately upon identification of potentially communicable disease as specified by the state health department, the ranking administrative person and medical director will be notified.

PROCEDURE
A. Objective observations will be documented in employee or patient's record.

B. Documentation will be reviewed by the nurse, administrator and medical director to determine appropriate action.

C. The ranking administrative person or medical director will proceed with appropriate notification action.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Reporting and Investigating Postoperative Infection	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 6	
Category:	Policy/ Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

REPORTING AND INVESTIGATING POSTOPERATIVE INFECTION

PURPOSE

To identify necessary steps for investigation and analysis of the infection occurrence and to identify the cause and appropriate preventive measure.

POLICY

The AMBULATORY Surgery Center will request that all physicians' office staff maintain the policy that each postoperative patient be observed for evidence of infection. Monthly/quarterly infection control forms will be sent to each office for completion.

If infection is determined to be Healthcare Acquired Infection , investigation and follow-up will be done by facility personnel and findings will be reported to the Medical Executive/QI Committee and the physician.

Several components will be dealt with concurrently during investigation of an occurrence: confirmed diagnosis, persons and situation involved and source.

PROCEDURE

A. When postoperative information is reported by physician's office, the facility person responsible for surveillance of postoperative information will initiate investigation.

B. Data sources for investigation:
   1. Review microbiology laboratory data.
   2. Review surgery records for break in technique
   3. Review sterilization records.
   4. Review quality management records for possible similarity with other Healthcare Acquired Infection to identify trends or patterns.
   5. *Surgical Wound Problem Analysis Form*

C. Considerations in reviewing data sources.
   1. Establish the existence of an infection occurrence.
      a. Verify diagnosis.
      b. Consider reliability of reporting sources.
      c. Review laboratory results vs. clinical results.

   2. Orient occurrence as to time, place and person by:
      a. Reviewing factors impacting case (e.g. postop follow-up).
      b. Concentrating coincidence in multiple occurrences.
      c. Assembling results of (non-statistical) collateral investigation.

   3. Search for source of infection.

   4. Seek further facts until an array is found which matches deductions and is inconsistent with all others.

   5. Base conclusions upon all pertinent evidence, not relying upon any single circumstance by itself.

   6. Analyze facts, identify probable cause, formulate plan to solve problem, and set time-frame to review results.

D. Document information in an *Infection Control Log*.

E. Institute corrective measures.

F. Draft a report to the Medical Executive/QI Committee and physician.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Reporting and Investigating Postoperative Infection-Surgical Wound Problem Analysis Form	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 6a	
Category:	Policy/ Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

SURGICAL WOUND PROBLEM ANALYSIS FORM

AMBULATORY SURGERY CENTER

SURGICAL WOUND PROBLEM ANALYSIS FORM

PROBLEM IDENTIFIED:
FINDINGS:

Reported by: _____
Date of Procedure: _____ Start Time: _____ End Time: _____
Date Reported: _____
Patient Name: _____
OR Room Number: _____
Physician: _____
Preoperative Diagnosis: _____
Preexisting Infection? (Includes Systemic): _____
Diabetes? _____
Other Identified Risk Factors?: _____
Operative Procedure: _____
Total Operative Time: _____
Circulating Nurse: _____
Scrub Nurse: _____
Surgical Assistants: _____
Culture: Intra-Op: _____ Post Discharge: _____
Organism Identified?: _____
Attest Results: _____
Antibiotic Therapy:
Preop: _____
Intraop: _____
Postop: _____
Post Discharge: _____
Tourniquet Time: _____
Type of Skin Prep Used: _____
Preoperative Temperature: _____
Surgical Wound Class: _____
Method of Sterilization of Equipment/Instruments: _____

DISCUSSION WITH PHYSICIAN ON: _____ (Date)

REPORTED TO INFECTION CONTROL CONSULTANT ON: _____ (Date)
RECOMMENDATION OF INFECTION CONTROL CONSULTANT: _____

FOLLOW-UP: _____

MEDICAL ADVISORY BOARD REVIEW DATE: _____
COMPLETED BY: _____ RN - INFECTION CONTROL COORDINATOR
DATE: _____

Manual:	Infection Control	Subject:	Surgical Wound Classification	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 7	
Category:	Policy/ Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

SURGICAL WOUND CLASSIFICATION

PURPOSE
To monitor aseptic technique in the operating room and monitor adherence to set criteria for patient admission.

POLICY
After any procedure in which break in technique is observed, a *Break-in-Technique/Surgical Wound Classification* will be completed.

Surgical wound classification record is maintained for quarterly review by Medical Executive/QI Committee.

CLASSIFICATION

Class I - Clean
Non-traumatic undetected operative wounds in which no inflammation is encountered, there is no break in technique, and neither the respiratory, alimentary or genitourinary tracts nor the oropharyngeal cavities are entered. Clean wounds are those that are elective, primary closed and undrained.

Class II - Clean Contamination
Non-traumatic wounds in which minor break in technique occurred or in which gastrointestinal, genitourinary or respirator tracks were entered under controlled conditions and without unusual contamination. Includes entrance into the genitourinary tract in the presence of infected urine and those wounds mechanically drained.

Class III - Contamination
Any open, fresh traumatic wound from a relatively clean source, or an operative wound in which there is a major break in technique, gross spillable from the gastrointestinal tract, or entrance into genitourinary tract in the presence of infected urine, including incisions encountering acute, non-purulent inflammation.

Class IV - Dirty
Traumatic wound from a dirty source, or with delayed treatment, fecal contamination, foreign body, or retained devitalized tissue. Also includes operative wounds in which acute bacterial inflammation or a perforated viscus is encountered, or in which clean tissue is transacted to gain access to a collection of pus. This classification suggests that organisms causing postoperative infection are present in the operative field before operation.

PROCEDURE

A. The *Break-in-Technique/Surgical Wound Classification* will be filled out by circulating nurse during procedure. (Class II, III and IV procedures only)

B. Classification of wound will be established by surgeon and circulating nurse at completion of procedure.

C. Classification records will be filed with the nurse manager and follow-up information will be obtained from the clinical record.

D. At regular intervals, the nurse manager will review cases and results of any postoperative complications and report to the Medical Executive/QI Committee.

E. Appropriate steps will be taken to find the cause and remedy.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Break-in-Technique/Surgical Wound Classification	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 7a	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

BREAK-IN-TECHNIQUE/SURGICAL WOUND CLASSIFICATION

AMBULATORY SURGERY CENTER

BREAK-IN-TECHNIQUE/SURGICAL WOUND CLASSIFICATION

Date: _____ Patient: _____ Chart #: _____

Description of Incident: _____

Staff Members Involved: _____ _____

Was Culture Taken in OR? _____ Yes _____ No
Results: _____

SURGICAL PROCEDURE CLASSIFICATION:

Class II: Clean contaminated: Infection discovered but contained.

Class III: Contaminated, acute inflammation with pus formation, break in aseptic technique.

Class IV: Dirty

WERE ANY OF THE FOLLOWING CONDITIONS PRESENT POSTOPERATIVELY?

Temperature Elevation:	_____ Yes	_____ No
Purulent Drainage:	_____ Yes	_____ No
Wound Infection:	_____ Yes	_____ No

Other, describe: _____

FORM COMPLETED BY: _____

Manual:	Infection Control	Subject:	Traffic Control in the Surgery Center	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 8	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

TRAFFIC CONTROL IN THE SURGERY CENTER

PURPOSE
To reduce the opportunity for cross-contamination and to eliminate unnecessary traffic and activity, maintaining a functional flow.

POLICY
A. The Surgery Center is divided into three areas that are defined by the activities in each area.

1. The **unrestricted area** includes a control point for the monitoring of the entrance of patients, personnel and materials and communicating information between the surgical suite and the rest of the surgery center.

2. The **semi-restricted** area includes the most peripheral support areas of the surgical suite which may include, but are not limited to, storage areas for clean and sterile supplies, work areas for storage and processing of instruments, and corridors to the restricted areas of the suite.

3. The **restricted area** is the area where surgical procedures are performed and unwrapped supplies and includes operating room, clean core and substerile areas.

B. Movement of personnel will be kept to a minimum while surgery is in progress.

1. Doors to the operating room will be closed except during movement of personnel and equipment.

C. The movement of clean and sterile supplies and equipment will be separated as much as possible from soiled equipment and waste by space, time or traffic patterns.

1. Supplies prepared for procedures outside the surgical suite will be transported to the operating room in closed packaging or covered carts.

2. Materials will be removed from external shipping cartons or uncovered in the unrestricted area before transfer into OR storage areas.

3. Soiled supplies, instruments, equipment for reprocessing, trash and soiled linen will be contained in a closed impervious system or an enclosed cart and will be transported along a planned route that avoids clean areas.

D. Only authorized personnel ate allow in surgical and treatment areas.

Manual:	Infection Control	Subject:	Monitoring of Refrigerator Temperatures	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 10	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

MONITORING OF REFRIGERATOR TEMPERATURES

POLICY

There will be monitoring of the refrigerator temperatures daily.

PROCEUDRE:

1. A log sheet will be completed in the master log book.

2. Refrigerator Temperatures
    a. Nourishment
        i. Refrigerator: 34º F- 41º F degrees.
        ii. Freezer: Below 32º F degrees
    b. Medication Refrigerator
        i. Refrigerator: 36° F to 46°F
        ii. Freezer: Below 32º F degrees

3. Should the temperature not be in the desired range, the contents will be removed and placed in a refrigerator that has the appropriate temperature. The refrigerator that is not functioning properly will be removed from service and tagged to indicate that it is not working.

Reference:
ICP Associates, Inc. Infection Prevention Manual for Ambulatory Care, 2009

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Monitoring of OR Humidity and Temperature	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 11	
Category:	Policy	Date: O:	7-19-2012	
		Revised		

MONITORING OF TEMPERATURE AND HUMIDITY IN THE OPERATING ROOM

POLICY
Monitoring of temperature and humidity will be performed daily.

PROCEUDRE:

1. A log sheet will be completed in the master log book.
2. Recommended Temperature: $68\text{-}73^0$ F($20\text{-}23^0$ C)
3. Recommended Humidity: 20-60%
4. Should the temperature and/or humidity not be in the desired range, the following steps should be taken:
    A. If your humidity starts to drift up, say from 55-65% and climbing you can raise the temperature in the room to compensate for the dehumidification that needs to happen. Call for service.
    B. If humidity starts to drift down, 55-45% and dropping. You can lower your temperature to get the humidity to raise to keep room operational... Call for service.
    C. If you find that the temperature and humidity are both rising together, you need to check to see if the HVAC system is running. These do not rise together unless the unit is off, chiller or compressors are off and fans are still running. Call for service.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Nourishments	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 12	
Category:	Policy	Date: O:	7-19-2012	
		Revised		

SCOPE:

Nursing staff

PURPOSE:

To provide fresh and safe food for patient nourishments.

POLICY:

All nourishments served to patients will be commercially prepared.

The center stores nourishments using proper sanitation, temperature, light, moisture, ventilation and security.

Non-refrigerated stock is rotated (1st in, 1st out) and discarded as recommended by the manufacturer for each item.

Refrigerated stock is dated and discarded as recommended by the manufacturer. Refrigerator temperature should be maintained between 34 – 41 degrees. Freezer temperature should be maintained 32 degrees or below.

Refrigerators/freezers containing patient nourishments should be kept cleaned (at least monthly and as needed).

Patients will be assessed prior to offering any nourishment. Assessments will include patient's alertness, ability to swallow and chew and presence of any nausea. Nourishments will be held until any nausea passes.

REFERENCES:

ICP Associates, Inc. Infection Prevention Manual for Ambulatory Care, 2009

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AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Toy Sanitation	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 13	
Category:	Policy	Date: O:	7-19-2012	
		Revised		

SCOPE:
All staff

PURPOSE:

To promote sanitation of toys used within the center.

POLICY:

The facility will select play toys that can be easily cleaned and disinfected.

Stuffed furry toys will not be provided if they will be shared. Stuffed toys will be sent home with the child to which it was provided.

Large stationary toys (e.g., climbing equipment) will be cleaned and disinfected at least weekly and whenever visibly soiled.

Toys that are likely to be mouthed will be rinsed with water after disinfection; alternatively they may be washed in a dishwasher.

Toys requiring cleaning and disinfection will be cleaned and disinfected immediately or stored in a designated labeled container separate from toys that are clean and ready for use.

REFERENCES:

CDC, ***Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*** *2007 (HICPAC), 2007; 1-219.*

Manual:	Infection Control	Subject:	Sanitary Environment	Approved by:
Section:	General Policies/ Procedures	Code:	IC - 11	
Category:	Policy	Date:	7 – 6 - 12	
		Revised:		

SANITARY ENVIRONMENT

PURPOSE

To maintain a clean sanitary and sterile environment in the operating rooms.

POLICY

1. The center will maintain air flow patterns required to assure sanitary conditions in all sterile areas.

    A. Air flow in OR's will be positive.

    B. Regular maintenance of air handling system in the center will be provided

    C. All filters will be changed at manufactures' recommended intervals.

2. All surfaces will be cleaned and disinfected regularly per cleaning protocols
3. All food storage areas will be properly maintained for cleanliness
4. All regulated and non-regulated waste will be disposed of in a safe manner and in accordance with protocols.
5. The center will maintain a pest control contract with licensed pest control provider.

Manual:	Infection Control	Subject:	Cubical Drape Cleaning	Approved by:
Section:	Employee Health	Code:	IC -AT - 12	
Category:	Policy/Procedure	Date:	7 – 6 - 12	
		Revised		

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Cubical Drape Cleaning

PURPOSE

To maintain a clean environment by proper removal and processing of soiled drapes.

POLICY

Privacy curtains should be cleaned any time there is visible dust or soil present and a minimum of once annually.

PROCEDURE

Privacy curtains should be removed and sent out to a commercial laundry to ensure they are disinfected and free of vegetative pathogens (ie, hygienically clean). According to the Centers for Disease Control and Prevention guidelines, Laundering cycles consist of flush, main wash, bleaching, rinsing.

Manual:	Infection Control	Subject:	Asepsis	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 1	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

ASEPSIS

POLICY

A. Aseptic technique refers to the method by which the sterile members of the operating team create and maintain a sterile field. The circulating nurse assists them and oversees traffic and remains alert for potential problems. All staff must develop a surgical conscience.

B. It is the responsibility of all personnel in the operating room on seeing a break in technique to notify immediately the responsible person to rectify the situation. Breaks in technique must be called to the attention of the individuals concerned and possibly the nurse manager. An occurrence report may need to be filed if there is potential patient injury, staff injury, or willful noncompliance with aseptic practices, policy or procedure.

C. It is essential for the members of the operating team to know:

1. The common source of micro-organisms in an operating room.
2. The means by which they reach the sterile field to contaminate it.
3. How to prevent contamination of the sterile field.
4. Antibiotics have not supplanted sterile technique.
5. Always react that sterile technique has been broken when there is any question.

D. Sources of contamination:

1. Members of the operating team.
2. The patient.
3. All articles used in the wound and on the sterile setup.
4. Dust in the air.

E. Monitoring and testing:

1. Indicators are used in all of the instrument packs.
2. There are indicators that are utilized in each load and Immediate-use cycle in central services.
3. Autoclaves are tested daily for efficiency and each load is documented.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Hand Hygiene and Handwashing	Approved by:
Section:	Aseptic Technique	Code:	IC - AT – 2	
Category:	Policy	Date: O:	7-6-2012	
		Revised		

SCOPE:
All staff

PURPOSE:
To reduce the number of organisms on the skin and to prevent the spread of infections through direct patient contact.

POLICY:
Frequent handwashing and hand hygiene will be conducted as a critical element in the infection control and prevention program.

Indications for handwashing and hand antisepsis:

1. Wash hands with soap and water when hands are visibly dirty or contaminated.

2. If hands are not visibly soiled, use an alcohol-based waterless antiseptic agent for routinely decontaminating hands in all other clinical situations

3. Decontaminate hands:

- After contact with a patient's intact skin (i.e. taking a pulse or blood pressure).
- After contact with body fluids or excretions, mucous membranes, non-intact skin or wound dressings, as long as hands are NOT visibly soiled.
- If moving from a contaminated body site to a clean body site during patient care.
- After contact with inanimate object(s) (including medical equipment) in the immediate vicinity of the patient.
- Decontaminate hands before donning sterile gloves when inserting a central intravenous catheter, insertion of urinary catheter or other invasive devices that do not require a surgical procedure.
- Before caring for patients with severe neutropenia or other forms of severe immunosuppression.
- After removal of gloves.

Artificial fingernails or extenders will NOT be allowed for staff who provide patient care. Natural nails must be kept less than ¼ inch long.

Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes and non-intact skin will occur. Remove gloves after caring for a patient. Do NOT wear the same pair of gloves for the care of more than one patient.

PROCEDURE:

1. Handwashing

A. Turn on faucet and adjust water temperature.

B. Procure soap from the soap dispenser using a paper towel or elbow to pump the cleanser into th hands.

C. Lather the hands to include area between fingers and wrist area with soap using friction on all surfaces for 10-15 seconds. Clean under nails and between fingers.

D. Rinse under running water holding hands in a downward position.

E. Dry hands with clean, dry paper towel. Use paper towel to turn off faucets.

F. To avoid contamination from hand lotions, every effort will be made to provide individu lotion packets or use dispensers that are not opened and refilled.

2. Hand Hygiene

A. Apply waterless antiseptic agent into palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. It should take 15-25 seconds for hands to dr

REFERENCES:

CDC, ***Guideline for Hand Hygiene in Healthcare Settings*** *MMWR, Oct. 25, 2002.*

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AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Methods to Eliminate Sources of Contamination	Approved by:
Section:	Aseptic Technique	Code:	IC - AT – 2a	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

METHODS TO ELIMINATE SOURCES OF CONTAMINATION

PURPOSE

Aseptic technique is the process of controlling the mode and eliminating the source of contamination.

GUIDELINES

A. Patient

1. Bacteria cannot always be eliminated from the field and must be kept to a minimum. All possible means are used to keep these bacteria to a minimum and to prevent any cross contamination.

2. Each patient is a potential contaminate of the operating room.
   a. All items used for one patient must be properly cleaned and re-sterilized before being used for another patient.

   b. All disposable items must be discarded after first use. (Exceptions will be items approved for re-sterilization by the manufacturer.)

   c. Skin cannot be sterilized. The patient's skin is a source of potential contamination in every operation. Proper procedure for skin prep is important.
      i) Patient should wash operative area as instructed prior to admission for surgery.
      ii.) Skin prep is performed per physician's order.

      iii.) After antiseptic prep solution is applied in the operating room, all skin is covered with sterile drapes except operative site.

B. Members of the operating team

1. Personnel preparation
   a. Personal cleanliness is essential for all the members of the surgical team.

b. Fingernails must be kept short at all times. Polish and false fingernails are not permitted.

c. Surgical team members with respiratory ailments or skin conditions may not scrub due to potential for high bacteria counts. Personnel found to have infectious conditions will not be permitted in operating room.

d. All personnel will scrub or thoroughly wash hands when first reporting for duty and immediately after handling patients.

e. Persons assisting is sterile field must wear a sterile gown and gloves after completing surgical scrub. (See policies on OR attire and surgical scrub and hand drying technique)

f Hair of personnel must be covered completely with clean caps or hoods.

g. Masks must be effective filters and worn covering both nose and mouth snugly. Masks are changed between cases and when contaminated by fluid or moisture.

h. Shoe covers must be worn or shoes worn in the operating room must be kept clean and not worn outside the facility.

i. All personnel entering the operating suite must wear clean OR attire.

j. OR attire will not be worn outside of the facility. All personnel leaving the building must change clothes before reentering the semi-restricted/restricted area.

C. Air particles - Operating room environment

1. Bacteria are carried from one place to another on dust particles, other objects and people's hands. Air itself is considered a source of contamination since it contains dust particles and droplets.

a. Motion in the operating room is kept to a minimum.

b. Talking and laughing is discouraged during a procedure.

c. Sneezing and coughing are avoided. If you must sneeze or cough, do so directly into mask. Do not turn head, as droplets can escape through side of mask. Change mask as quickly as possible.

d. Doors to corridors into the operating rooms are kept closed.

e. Traffic through the operating room suite is kept to a minimum.

f. Handle linen gently to avoid shaking lint into room and disturbing the air around sterile areas.

g. Main corridors are considered contaminated areas.

h. Laundry hampers kept in the operating room should be changed between cases. Other laundry hampers should have lids.

i. Damp dusting is done between cases when necessary.

j. Floors are considered contaminated and cross-contaminated. Operating room floors are to be mopped with germicidal solution between procedures as necessary and cleaned thoroughly at the end of the day. Floors are never dry swept.

k. Air conditioning must be operational at all times in the operating room.

D. Other personnel or visitors in operating room

1. Only authorized personnel may enter operating room suite.
2. Anyone entering an operating room must be properly attired in OR clothes, cap and mask.
3. It is the responsibility of the entire OR team to observe visitors and other personnel to prevent or report contamination. Circulating nurse is to observe visitor at all times to protect the sterile field.

E. Eliminate the potential for contamination

1. Any containers that are deemed refillable shall not be "topped off." The container shall be emptied of its contents, rinsed out with water and bleach and then refilled. Examples of such products are hand soap, hibiclens, betadine, etc.

Manual:	Infection Control	Subject:	Principles of Sterile Technique	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 3	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

PRINCIPLES OF STERILE TECHNIQUE

The principles of sterile technique are applied in various ways. If the principle itself is understood, the application of it becomes obvious.

A. All articles used in an operation have been sterilized previously. Articles such as packs, basins, and sponges are obtained from the sterile stock supply. Others such as instruments may be sterilized immediately preceding the operation and removed directly from the sterilizer to the sterile table.

B. Scrub nurses touch only sterile articles. Circulating nurses touch only nonsterile articles. All supplies for the sterile team members reach them by means of the circulating nurse through sterile wrapped packages.

C. If in doubt about the sterility of anything, consider it NOT sterile.
   1. If a sterile package is found on the floor.
   2. If you are uncertain about the autoclave.
   3. If a nonsurgically clean person brushes close to a sterile table and visa versa.

D. The circulating nurse should avoid reaching over a sterile field, and the scrub nurse should avoid reaching over a nonsterile field.
   1. The scrub nurse sets basins or glasses to be filled at the edge of the sterile table. The circulating nurse stands near this edge of the table to fill it.
   2. The circulating nurse stands at a distance from the sterile field to adjust the light over it.
   3. The surgeon turns away from the sterile field to have perspiration wiped from his brow.
   4. The scrub nurse drapes a nonsterile table toward her first.

E. Tables are sterile only at table level.
   1. Linen or suture falling over table edge are discarded. The scrub nurse does not touch the part hanging below table level.

2. When the circulating nurse uncovers a sterile table, she is careful that the bottom edge of the sheet is not drawn up to the table level where it might contaminate the sterile contents.
3. When the scrub nurse drapes a table, she is careful as she unfolds them that the part of the drape which drops down below the table surface is not brought up to table level again.

F. Gowns are considered sterile only from table level to shoulder level in front and the sleeves.
   1. Nurses and doctors gown and glove without touching the outside of the gown and gloves with the bare hand.
   2. They are careful not to touch the hand towels on their shirts while drying their hands.

G. Scrub nurses keep well within the sterile areas. Allow a wide margin of safety when passing nonsterile areas and follow back to back unless for passing.

H. Nonsterile persons keep away from the sterile areas. They allow a wide margin of safety when passing sterile areas and follow the rule for passing. Nonsterile persons face a sterile area when passing it so they can be sure they have not touched it.

I. Sterile persons keep contact with sterile areas to a minimum.

J. Moisture may cause contamination.

   1. Sterile packages are placed in dry areas.
   2. If a sterile package becomes damp or wet, it is resterilized or discarded.
   3. Wet ampoules from a bactericidal solution are placed on sterile area on a towel which absorbs the moisture.
   4. Drapes are placed on a dry field.
   5. If a solution soaks through a sterile area to a nonsterile one, the wet area is covered with another drape.
   6. A towel is placed at the bottom of an instrument tray before placing the instruments in it to absorb the moisture and permit the tray to be set on a sterile table.
   7. Linen packages from the sterilizer are permitted to cool before being put on shelves to prevent their becoming damp from steam condensation when in contact with a cold shelf.

K. When bacteria cannot be eliminated from a field, they must be kept to an irreducible minimum. It is recognized that perfect asepsis in an operative field is an ideal that can be approached only. It is not an absolute.

L. Skin cannot be sterilized. The skin of the patient is a source of potential contamination in every operation. However, this does not obviate the necessity for strict aseptic technique. Defenses within the tissue and body as a whole usually can overcome these relatively few organisms. Also, the hands and arms of the members of the sterile team can be a source of contamination. All possible means are used to keep bacteria to a minimum and prevent any of them from gaining entrance to the wound.

1. The patient's skin of the operative area is given a preliminary shave and scrub.
2. In draping, all the skin area is covered except the site of incision.
3. All doctors and scrub nurses scrub their hands and arms.
4. Nurses and doctors gown and glove without touching the outside of the gown and gloves with the bare hand.
5. They are careful not to touch the hand towels on their shirts while drying their hands.
6. The knife used for the skin incision is removed from the sterile field.
7. After the skin incision is made, skin towels cover all skin in cases where it is possible. Compromise is sometimes necessary.
8. If a glove is punctured during the operation, it is changed at once.
9. If the glove is pricked by a needle or instrument, the glove is changed at once and the needle or instrument is discarded from the sterile field.

M. Some areas cannot be scrubbed. When the operative field includes the mouth, nose, throat or sinus, the number of bacteria present is great. Various parts of the body usually are able to prevent infection from bacteria that normally inhabit those parts. However, an endeavor is made to reduce the number of bacteria that are present at these areas and to prevent scattering of the inevitable ones.

1. As much of the operative area is cleaned as can be and the surrounding skin is scrubbed. For example, the nose and face are prepared prior to submucous resection.
2. Surgeons make an effort to use a sponge only once for sponging, then discard.

N. The air is contaminated by dust and droplets.

1. Masks are worn over the nose and mouth. They fit snugly.
2. Talking is kept to a minimum.
3. Main corridors are considered contaminated.
4. Doors from corridors into operating rooms are kept closed.
5. Sterile trays without wrappers are not carried through corridors.
6. Members of the sterile team remain in the operating room if waiting with gloved hand clothed with sterile towel.
7. If necessary to go out into corridor, the gown and gloves are changed upon returning to room.
8. All dusting is damp dusting. It is thoroughly done each morning before the day's schedule. Lights over the operating table are dusted. Check to see that this is done.
9. Floors are wet-mopped between each case and at the end of the day by housekeeping.
10. Our air conditioning system is ideal. The air is exchanged and filtered as it is drawn through the system into the room.

Manual:	Infection Control	Subject:	Eye Protection	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 3a	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

EYE PROTECTION

POLICY

A. Eye protection devices are available for personnel to wear during surgery. This applies to both nursing staff and physicians.

B. All personnel should wear goggles to avoid eye contact with secretions and/or fluids during surgery, patient care, disinfecting or cleaning procedures.

Manual:	Infection Control	Subject:	Skin Cleansing Preparations	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 5	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

SKIN CLEANSING PREPARATIONS

PURPOSE

The purpose of skin preparation is to render the skin as free as possible from transient and resident microorganisms.

GUIDELINES

Skin cleansing preparations should be bacteriostatic and bactericidal to a wide variety of organisms. They should be harmless to skin and underlying tissues, either directly or through sensitization. The maintenance of asepsis does not depend on any single factor, but on a summation of good techniques with optimal facilities and environment.

Despite the relative merit and limited side effects of current antiseptic agents, sufficient disadvantages exist to indicate that the ideal product is not yet available.

A. Antiseptic Solutions

1. **Soaps**. Soap's value lies in its non-irritating detergent action, especially when washing is combined with mechanical friction, e.g., the use of a stiff brush and repeated motion. It appears to make little difference whether bar soap, liquid soap or tincture of green soap is used. More organisms, including staphylococci, have been noted following a soap scrub than before, indicating that resident flora has been freed. For adequate skin antisepsis the area must be thoroughly dried and an antiseptic must be applied subsequently.

2. **Hexachlorophene**. A bis-phenol, it is one of the few antiseptics which does not lose its potency when combined with soap (*Septisol; Phisohex*). It is bacteriostatic, disinfecting the skin slowly, due to a film of the agent left on the skin after washing. In order to achieve antisepsis, it is necessary to use hexachlorophene soap exclusively and frequently.

Some individuals appear to have a relatively resistant cutaneous flora: in those with sensitive flora, an occasional brief wash cannot be relied upon for antisepsis. Furthermore, hexachlorophene may demonstrate a "rebound", i.e. during succeeding days of non-use, there may be excessive regeneration of resident bacteria. The effectiveness of the hexachlorophene film may be lost by application of alcohol, such as aftershave lotion, perfume, etc. with prolonged use, some organisms, especially the Gram negatives such as E. Coli and S. Typhosa have demonstrated increased resistance to the agent. The bis-phenols also lose appreciable activity in the presence of organic matter (body fluids, pus, blood, etc.) and of the newer non-ionic detergents (*Tweens, Spans, Tritons,* etc.). Because of its slow action, hexachlorophene appears to have little valve in preparing either a patient's skin or surgeon's hands when used intermittently or occasionally as a single application. If used 3 or 4 times a day for several days, however, hexachlorophene appears to effectively degerm both the patient's skin and the hands of personnel. It may have a drying and/or pruritic effect on the skin of some persons.

3. **Alcohol** (liquid or foam). A 70% solution (by weight) of ethyl alcohol is a time-honored and effective skin antiseptic. Isopropyl alcohol is non-potable and degerms skin fully as well as ethyl alcohol. The bacteriocidal action of isopropyl alcohol increases with concentration, but so does its tendency to defat skin, so a 70% solution is recommended. The more prolonged the alcohol washing, the more effective. In addition, friction with a sponge or washcloth enhances the degerming action. The antiseptic properties of the alcohols are less effective than iodine, and slightly less than the iodophors, making them an adequate substitute in the rare case of iodine sensitivity.

4. **Iodine.** Iodine kills bacteria, viruses, fungi, and spores and remains the most effective antiseptic agent. A 1% solution with an equal amount of K-1 in 70% ethyl alcohol (by weight), effectively reduces bacterial flora within two minutes of application. Previously used iodine solutions were 2.5 to 7 times stronger and were probably ever more concentrated due to evaporation of the alcohol. These strong solutions were prone to cause burns. Inasmuch as iodine achieves its total effect within two minutes (approximately the time for drying), it should be removed with 70% alcohol to prevent any possibility of skin damage. Because of occasional allergy to Iodine, careful inquiry should be made before use. No interference with thyroid function studies have been noted when alcohol removal has been carried out. There are, overall, few patients in whom such studies might be required within the short period of exogenous iodine influence, so the problem is mostly a theoretical one.
5. **Iodophors**. *Betadine, Ioprep,* etc., are combinations of iodine with a carrier. Most are reported to contain 1% “available” iodine which is slowly released to become effective against organisms. They appear to be largely free from skin damage, allergic or toxic effects in sensitive patients, and reactivity with metals. They require about four minutes for effective results (approximate drying time) and therefore the final application should not be blotted dry or washed off in view of this lack of side effects, and because they are said to continue to slowly liberate iodine as long as their yellow color lasts. Iodophors appear to be superior to other kinds of skin

preps and are acceptable where skin irritation or sensitivity are feared. Iodophors have been combined with detergents which serve to clean the skin at the same time released iodine is acting. These scrub solutions, (e.g. *Betadine Scrub*) are reported to maximally degerm skin and maintain this state for at least two hours. These scrub solutions have been recommended preoperatively for scrubbing of both the surgeon's hands and the patient's skin.

Note: History of allergic reaction to iodine products preclude use of iodophor products. It is the responsibility of the operating physician to explore this history and determine appropriate measures.

6. **Chlorhexidine**. (*Hibiclens*) Chlorhexidine is an antiseptic antimicrobial skin cleanser.

7. Other agents approved and validated as effective for minimizing skin bacteria may be utilized for operative site preparation and/or personnel scrub.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Surgical Scrub and Hand Drying Technique	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 6	
Category:	Policy/ Procedure	Date: O:	7-18-201 Replaces IC AT-6 Surgical Scrub and hand drying Technique.	
		Revised	7-6-2012	

SCOPE:
All clinical staff

PURPOSE:
To outline the process for cleaning hands prior to surgery, using aseptic technique.

POLICY:
All members of the surgical team will complete the surgical hand scrub using aseptic technique in order to mechanically and chemically reduce microbial flora on the skin of hands and forearms in the event of glove failure.

PROCEDURE:

I. Preparation:
   A. Dress in complete surgical attire and remove all jewelry from hands and forearms.

   B. Check hands and forearms. They must be free of lesions and breaks in skin integrity.

   C. Keep arms level and well away from the body and hands up above elbow for duration of scrub.

   D. Remove brush from wrapper.

   E. Wet hands and forearms. Apply sufficient water to sponge part of brush and work up lather. Apply lather from fingertips to three inches above elbows.

   F. Clean nails with disposable nail cleaner under running water.

   G. Rinse hands and arms thoroughly.

II. Mechanical Scrub:

   A. Scrub hands and forearms with a disposable brush to two inches above the elbow

using the time scrub method. If you have not scrubbed for 24 hours you may do a three to five minute scrub and then use antiseptic foam for the following cases of the day.

B. Scrub the fingernails of the first hand. Then scrub each finger, starting with the thumb, using a brisk back and forth motion on all four planes.

Pay particular attention to each inter-digital space. Using the same technique, move down to the back, sides and palms of the hand.

C. Follow with second hand.

D. Scrub first arm from wrist to elbow.

E. Scrub second arm from wrist to elbow.

F. Discard brush into waste receptacle.

G. Rinse hands and arms thoroughly, keeping hands raised.

H. Turn off water using knee control.

I. Proceed into O.R. keeping hands and forearms up and out from scrub clothes.

III. Antiseptic Foam Scrub:

A. A three- to five-minute mechanical scrub must be done daily prior to initial use of antiseptic foam.

B. Using 3M Avagard, dispense one pump into the palm of one hand. Dip fingers of the opposite hand into the hand prep and work under fingernails. Spread remaining hand prep over the hand and up to just above the elbow.

C. Dispense one pump and repeat procedure with opposite hand.

D. Dispense final pump of hand prep into either hand and reapply to all aspects of both hands up to the wrists.

REFERENCES:

CDC, ***Guideline for Hand Hygiene in Healthcare Settings*** *MMWR, Oct. 25, 2002.*

Manual:	Infection Control	Subject:	Gowning and Gloving	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 7	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

GOWNING AND GLOVING

PURPOSE
To allow the members of the surgical team to participate in surgical procedures while maintaining asepsis.

POLICY
All members of the surgical team will don sterile gown and gloves in order to participate at the sterile field.

PROCEDURE
A. **Closed glove and gowning technique**

1. This technique is used for initial gowning and gloving. If during this procedure gown and/or gloves must be changed, open method must be used.

2. Facts to remember:
   a. Care must be taken to avoid contamination of outstretched sleeves while donning gown.
   b. The back of the gown is non-sterile after being donned.
   c. Only the front of the gown between waist and chest region is considered sterile.
   d. Wet sleeves or a part of the gown which is wet is no longer sterile.
   e. The outside of the gown must not be touched with ungloved hand.
   f. A torn gown or one with holes must be removed by circulating nurse.

3. Gowning procedure
   a. Using sterile technique, open gown and glove package to allow for donning without contamination. Place on surface away from traffic pattern, i.e. Mayo stand, prep stand, never on open back table.

b. After thoroughly drying hands (see drying procedure), pick up gown without touching glove packet.

c. Lift gown directly upward, avoiding edge of wrapper and drop bottom of gown gently, making sure it does not touch anything unsterile. If top of gown should be

dropped downward inadvertently, discard gown. (Never correct a piece of linen once the wrong end has been dropped.)

d. Slip hands into armholes and extend hands sideways. Do not put hands through cuff of gown. Do not let hand go closer than 1" from edge of cuff.

e. Allow circulating nurse to pull gown over the shoulders from inside, grasp ties and tie at the waist.

4. Gloving procedure
   a. Open glove packet being careful not to touch edges of wrapper.
   b. Pick up glove by grasping cuff with gown covered hand.
   c. Place glove on sleeve of gown with thumb down and fingers of glove extending up arm.
   d. Grasp under cuff of glove and with opposite hand, pull upper cuff of glove over cuff of gown.
   e. Work fingers through gown cuff into glove by slowly pulling gown and glove at same time.

B. **Gowning and gloving surgeon**

1. Procedure for gowning surgeon
   a. When surgeon is ready to be gowned, grasp gown at upper third and while being careful to hold high and avoiding any unsterile object, drop bottom of gown.
   b. Keep hands on outside of gown and under a protective cuff made at neck area and back edges, keep cuff ends toward you to protect gloves while gowning.
   c. Offer inside of gown to surgeon and he will slip his arms into it.
   d. Release gown and pull sleeves of gown down with steady pull.
   e. Be careful strings of gown do not flip back to unsterile back and then hit your gloves or front of gown.

2. Procedure for gloving surgeon
   a. Grasp the right glove firmly with fingers under the turned back cuff.
   b. Hold palm of glove toward surgeon.
   c. Surgeon will plunge hand into glove. Release glove as cuff goes over his gown.
   d. Repeat procedure for left glove.

C. **Open glove technique**

1. This technique is used if gloves become contaminated during procedure.

2. Facts to remember
   a. Pick up left glove with right hand at folded edge of cuff. This is optional, if right glove is put on first, reverse steps.
   b. Insert left hand into glove and draw on, leaving cuff turned well down over hand.

c. Slip fingers of left glove under turned back cuff of right glove, pick it up and step back from field.
d. Insert right hand into right glove and pull it on, leaving cuff turned well down over hand.
e. Turn over a pleat on right cuff of gown and hold it with left thumb. With fingers on left hand, pull cuff of right glove over cuff on gown and sleeve. Avoid touching gloved fingers to bare waist.
f. Repeat for left cuff.

D. **Re-gowning and gloving during procedure**

1. When removing gown, to prevent contamination, the nurse must not allow the strings or outside of gown to touch arms or hands. Gown is removed first, then gloves. Remove gloves, observing "hand-to-hand and glove technique"

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E. **Use of powder in OR**

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1. Powder should not be used in operating room.

2. Ordinary talcum powder has been found to be dangerous in a wound because it causes adhesions or granulomas.

3. Powder released into the air becomes part of dust and bacteria and will cause contamination.

4. Powder that falls from hands is no longer sterile and could cause contamination.

Manual:	Infection Control	Subject:	Opening Sterile Packages	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 8	
Category:	Policy/ Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

OPENING STERILE PACKAGES

PURPOSE
To provide guidelines for proper monitoring and handling of sterile supplies used in a surgical procedure.

POLICY
The opening of sterile supplies shall adhere to a "technique-wise" procedure.

PROCEDURE
A. Inspection
   1. Check package for holes, tears, indications of exposure to liquids.
   2. Check sterilizer tape for sterility indicator. (Diagonal stripes should have turned if conditions for sterility have been met).
   3. Check expiration date, when appropriate.

B. Wrapped packages
   1. Holding package in left hand, open each flap, being careful not to contaminate inner wrapper.
   2. Do not let folds snap back.
   3. With other hand, hold three ends together under hand and sterile package. This will enclose hand.
   4. Hand package to OR scrubbed personnel or deposit carefully at the edge of sterile draped table.

C. Peel pack envelopes
   1. Place thumbs on inside of split open edges, pull down evenly and gently.
   2. Drop on sterile surface or allow scrubbed personnel to remove inner package.
   3. Check for a chemical strip, and it has been exposed to steam

Manual:	Infection Control	Subject:	Draping for Surgical Procedure	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 9	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

DRAPING FOR SURGICAL PROCEDURE

PURPOSE
To establish and protect an adequate sterile field during the surgical procedure.

POLICY
The patient, positioned on the operating table, shall be covered with sterile drapes in a manner which will isolate the surgical site and provide an effective bacterial barrier. Only disposable drapes will be used at the facility.

Draping techniques are directed at containing the bacteria and preventing their migration to the surgical wound by creating and maintaining a sterile field.

PROCEDURE
A. General rules
   1. Patient draping is a joint medico-nursing responsibility. The areas of and about the surgical site, as well as certain surgical equipment for use at the sterile field, must be draped.

   2. When sterility is in doubt, consider the article contaminated. There is no gray zone; the article in question should be removed from the field.

   3. Gowned and gloved members must protect and maintain their scrubbed status, i.e. activities must be technique-wise.
      a. Be aware of defined areas of sterility and maintain a safe distance from non-sterile areas.
      b. Touch only sterile equipment.
      c. Do not lean over non-sterile areas.
      d. In handling drapes, **always** protect gloved hand within a fold (cuff) of the drape.

   4. Draping activities must be slow and deliberate.
      a. Allow adequate time for draping procedures.
      b. Keep all drapes folded until positioned.

c. Avoid overhandling of drapes.
d. Draping components must be positioned slowly to avoid producing air currents and dispersing potential contaminants.

5. Draping must be technique-wise with emphasis on functionalism.
   a. In order to be an effective barrier, drapes must be devoid of defects (tears, holes, etc.)
   b. Once a drape is positioned, **do not** reposition it; either reinforce the drape or discard it and position a new drape.
   c. Draping components must adequately cover the prescribed areas - no more, no less.

B. Draping the back table

1. The back table drape has an impervious plastic like sheet bonded to the underside, so that once the drape is opened on the table, it is virtually fluid and moisture proof.
   a. Remove the impervious outer plastic bag following the instructions on the label.
   b. Unfold as indicated.
   c. Maintain a safe distance between the OR apparel and sterile drapes.
   d. Always avoid reaching across open sterile fields.

C. Draping the Mayo stand

1. The Mayo stand cover resembles a long pillow case. The inner side of the Mayo stand cover is reinforced with an impervious plastic like sheeting, creating a fluid proof drape.
   a. The scrubbed personnel slides both hands, palms down, into the cuffs (Cuffs are labeled with anatomical directions).
   b. Keeping the hands protected within the generous cuff, slide the cover over the Mayo stand. The length of the cover is folded to facilitate gradual unfolding. **Do not** allow the closed end of the Mayo cover to fall below waist level.
   c. Continue sliding the cover over the stand until the open end extends downward over the vertical portion of the Mayo stand.
   d. Tuck pleat the excess width. The circulating nurse may adjust the lower margins of the free hanging portion of the drape.
   e. At the completion of the procedure, the Mayo stand cover may be used to collect all disposable contaminants.

D. Draping components

1. **Drape sheets** are available in a variety of sizes and provide flexibility as components of the draping system. They are positioned to delineate the operative site. Once positioned, the drape sheet is opened laterally or longitudinally and toward the head and foot of the operating table or toward either side.

2. **Split sheets** are specialty draping components in which one end of the sheet is split to form in which one end of the sheet is split to form tails. Split sheets are valuable for draping body parts that do not lend themselves to fenestrated sheets such as the head and extremities. The tails are opened to circumvent the operative site and the other end is opened toward the opposite end of the operating table.

3. **Plastic drapes** are made of plastic material which adheres to incision area. The incision is made directly into or through the drape.

Manual:	Infection Control	Subject:	Glove Cases	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 9a	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

GLOVE CASES

The following cases may be classified as glove cases. Glove cases are defined as procedures in which scrub and gowning are not necessary for personnel unless otherwise specified by surgeon.

1. Myringotomy
2. Endoscopy cases
3. Closed reductions
4. Cast applications
5. Local excision (at the discretion of the physician)
6. R.K.

Manual:	Infection Control	Subject:	Flow Pattern for Clean and Soiled Utility Areas	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 10	
Category:	Policy/ Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

FLOW PATTERN FOR CLEAN AND SOILED UTILITY AREAS

PURPOSE
To maintain a flow of soiled to clean with proper cleaning procedures maintained to prevent cross contamination of clean work areas.

POLICY
Equipment, instruments, soiled disposable and nondisposable linen and containers of body waste or fluids will be treated as biohazardous waste and never deposited in clean utility rooms. Only items surgically clean or sterile may be placed or stored in clean utility rooms or sterile storage areas.

PROCEDURE
A. When procedure or treatment is complete, all biohazardous waste items will be consolidated and removed to a soiled utility or decontamination room immediately.

1. Contaminated suction fluids will be sealed in vacuum containers and deposited with biohazardous waste for appropriate disposal or flushed into an isolated system, if available. A treated consolidation product will be used when feasible.
2. Instruments are cleaned of gross contamination in the operating room, then processed. Only after decontamination may items be stored in clean work area or sterile storage.
3. Equipment is cleaned of gross contamination, wiped with germicide solution and returned to proper storage area.
4. Designated biohazardous contaminated disposables will be deposited in approved waste holding containers to be removed according to biohazardous service contract.
5. Soiled nondisposable linen will be placed in appropriate container to be sent to the soiled holding area for removal to laundry as per service contract.

B. Items not contaminated or sterile items not used in a procedure or treatment may be taken directly to a clean work area to be prepared for reprocessing.

Manual:	Infection Control	Subject:	Soiled Linen Handling	Approved by:
Section:	Aseptic Technique	Code:	IC - AT - 11	
Category:	Policy/ Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

SOILED LINEN HANDLING

PURPOSE
To maintain a clean environment by proper removal and processing of soiled linen.

POLICY
All soiled linen will be removed and handled in a manner designed to prevent cross-contamination.

PROCEDURE
A. All used or contaminated linen will be placed in linen hampers located in each area. To avoid contamination of employee's clothing, soiled linen is never held against the body. Linen is never thrown on the floor or shaken in the air.

B. When linen is removed from item, (e.g. instrument tray, stretcher), linen piece is folded into itself with all loose ends carefully contained and then it's placed in appropriate linen hamper or removed to linen holding area in a hamper liner.

C. All used OR apparel or patient gowns will be placed in designated hampers in the dressing areas to be removed to the soiled holding area as necessary.

D. Any unused piece of linen falling to the floor or becoming wet is considered contaminated and must be laundered again.

E. When sorting linen for processing, gloves must be worn and care should be taken not to contaminate uniforms. Should this occur, the employee will change clothes and wash hands thoroughly.

Manual:	Infection Control	Subject:	Personnel Laundry	Approved by:
Section:	Employee Health	Code:	IC - AT - 12	
Category:	Policy/Procedure	Date:	7 – 6 - 12	
		Revised		

PERSONNEL LAUNDRY

PURPOSE

To maintain a clean environment by proper removal and processing of soiled laundry and personnel laundry.

POLICY

A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross-infection, is ensured through the provision of adequate space, equipment, supplies and personnel.

1. All OR staff is to bring laundered scrubs into facility and change prior to fist case.
2. OR personnel can not wear scrubs in from home.
3. If scrubs become soiled by body fluids or blood, they must be sent out to commercial laundry to ensure they are disinfected and free of vegetative pathogens.

PROCEDURE

OR personnel will bring clean laundered scrubs and change prior to first case. If scrubs become soiled by body fluids or blood should be removed and sent out to a commercial laundry to ensure they are disinfected and free of vegetative pathogens (i.e., hygienically clean). According to the Centers for Disease Control and Prevention guidelines, Laundering cycles consist of flush, main wash, bleaching, rinsing.

Manual:	Infection Control	Subject:	Employee Health	Approved by:
Section:	Employee Health	Code:	IC - E - 1	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

EMPLOYEE HEALTH

PURPOSE: To ensure employees are properly screened and/or vaccinated to be able to fulfill their responsibilities.

SCOPE: All personnel

PROCEDURE

A Testing done prior to employment through

1. Health survey
2. Drug screen (also event related testing performed)
3. TB testing
4. Hepatitis B vaccine optional

B. Completed annually at the Center:

1. TB testing

C. Completed as requested or required through

1. HIV/AIDS (per needlestick policy)

D. Workmen's Compensation handled by current facility worker's compensation carrier.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	TB Testing	Approved by:
Section:	Employee Health	Code:	IC - E - 2	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

EMPLOYEE HEALTH

TB TESTING

SCOPE

1. **New Employees**
   a. New employees will receive a tuberculin skin test unless they are pregnant, have a history of prior positive test, or have been vaccinated with BCG. Testing shall be done annually thereafter.
   b. The Mantoux technique using 5 I.U. PPD will be used.
   c. New employees with positive reactions (10 mm of induration) must receive further evaluation. A chest x-ray will be ordered, and the employee referred to a physician or the health department for follow-up, if necessary.
   d. New employees with reactions measuring 5–9 mm must be retested.
   e. All testing and other arrangements will be done through employee health/company care.

2. **Current Employee**
   a. Annual PPD tests will be required of patient care personnel.
   b. Employees with a history of a positive TB test will not receive chest x-rays routinely but only if symptoms of TB are evident. Such employees will receive a written description of the symptoms of TB.

ANNUAL TESTING

RESPONSIBILITY

Employee health nurse under the direction of the medical director.

PROCEDURE

1. Reviews employee's history and determines if test should be administered using the checklist.

2. Prepares testing material by drawing up 0.1 ml of 5 I.U. PPD in a tuberculin syringe. Ascertains no bubbles are left in syringe.

3. Selects area on employee’s arm to administer test.

4. Places employee's forearm, volar surface up, flat on a table to administer the test.

5. Grasps the syringe by the center of the barrel, turning the bevel upward.

6. Grasps forearm and exerts pressure downward to tighten skin.

7. Holds syringe horizontal to arm and inserts the tip of the needle just beneath the surface of the skin on the volar arm surface.

8. Injects 0.1 ml of PPD into employee's arm.

9. Instructs employee to return for reading of site in forty eight (48) to seventy two (72) hours.

10. Instructs employee not to cover injected site with dressing and that no local care is necessary.

11. Inspects injected site for induration upon employee's return.

12. Measures induration, if present, by drawing a line with a ball point pen to the point of induration and repeat this on the opposite side of the induration; then measure in millimeters between the marks. The diameter of the induration will be the result.

13. Records results in millimeters, if reactive, in employee's health file.

TB EXPOSURE STANDING ORDERS

Significant contact defined:
Ten (10) minutes face-to-face contact with patient coughing productively with positive AFB sputum smear.

Known previous negative TB test:

Do PPD test if six (6) months since last PPD.

Repeat in eight (8) to ten (10) weeks.

Known previous positive TB test:

Counsel employee regarding signs and symptoms of TB (see checklist).

Chest x-ray only if symptoms present.

Obtain signed checklist sheet from employee.

If conversion occurs or symptoms develop:

Refer employee to health department or physician for follow-up.

Sputum culture and smear.

Chest x-ray.

Other laboratory work as requested by the health department or physician.

Send letter to health department or physician with test results.

_____
Employee Signature

_____, M.D.
Medical Director

_____
Date

AMBULATORY SURGERY CENTER

TUBERCULIN SKIN TESTING PROCEDURE

PURPOSE
To assist in the control of mycobacterium tuberculosis infections in both patients and employees

EQUIPMENT
1. Well lighted area
2. ETOH wipes
3. Disposable tuberculin syringe
4. Disposable 27g. x 1/2 needle
5. 5 I.U. of intermediate PPD (Mantoux)
6. 2×2 gauze
7. Spirits of ammonia
8. Needle dispenser box
9. Ruler with millimeter increments

GUIDELINES
1. Complete checklist with employee prior to TB testing. Do not administer test to persons with history of past positive reaction to TB tests, history of tuberculosis infection, history of BCG vaccination, currently under treatment for tuberculosis or diagnosis of sarcoidosis.

2. Allow four (4) weeks to elapse after the administration of measles, mumps and/or rubella vaccine and the administration of the TB skin test to avoid false negative TB test readings.

3. To avoid false results in the interpretation of TB test results, allow thirty (30) days to elapse in the following instances before administering test:
   a. Severe or febrile illness
   b. Administration of adrenal corticosteroid hormones or immunosuppressive drugs
   c. Antibiotic therapy

4. The upper third of the volar surface of the forearm is the usual site for administering the test. Do not administer the test in an area where skin rash, eczema, psoriasis or abrasions are present.

5. A white elevated wheal approximately 6mm to 10mm in diameter is produced when the injection is properly administered. If this is not achieved, a second injection with another needle, syringe and dose of PPD may be given. Cleanse another site about one (1) inch below the first to administer the second dose.

6. The test should be read within forty eight (48) to seventy two (72) hours after it is administered. Only induration is significant and should be measured. Erythema or discoloration is not significant.

7. A TB test reading of 10mm or more of induration signifies a positive reaction.

AMBULATORY SURGERY CENTER

CHECKLIST PRIOR TO TB TESTING

Past positive reaction to TB test	_____Yes	_____No	_____Date
Current symptoms:			
Unexplained fever	_____Yes	_____No	
Chronic, productive cough	_____Yes	_____No	
Night sweats	_____Yes	_____No	
Unexplained weight loss	_____Yes	_____No	
General malaise	_____Yes	_____No	
History of TB infection	_____Yes	_____No	_____Date
BCG vaccination	_____Yes	_____No	_____Date
Under current treatment of TB	_____Yes	_____No	
Under current treatment of sarcoidosis	_____Yes	_____No	
Within the past four (4) weeks: measles, mumps, rubella vaccine	_____Yes	_____No	
Within the past thirty (30) days: severe or febrile illness	_____Yes	_____No	
Adrenal corticosteroid hormones or immunosuppressive drugs	_____Yes	_____No	
Antibiotic therapy	_____Yes	_____No	

Employee signature Date

TB TEST

Name_____Date_____

Date	**TB test Type/dose**	**Results (MM)**	**Site/route**	**Lot #**	**Signature**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

CHEST X-RAY RESULTS	**Date**	**Results**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referred to private physician _____Yes _____No _____Date

Referred to health department _____Yes _____No _____Date

Comments/follow-up:_____

AMBULATORY SURGERY CENTER

ADDENDUM A

INTERPRETATION OF POSITIVE REACTIONS

Positive reactions are classified as follows:

1. Equal to or greater than 5mm reaction
    1. Persons who have had close contact with a patient with infectious tuberculosis.
    2. Persons who have chest x-rays with fibrotic lesions likely to represent old healed tuberculosis.
    3. Persons with known or suspected HIV infection.
    4. IV drug users whose HIV status is unknown.
    5. Other population which have bean identified locally as having an increased prevalence of tuberculosis.

2. Equal to or greater than 10mm reaction
    1. Foreign born persons from high prevalence areas (such as Asia, Africa and Latin America).
    2. Intravenous drug users known to be HIV negative, sero-negative.
    3. Medically underserved, low income populations, including high risk racial or ethnic minority populations (especially blacks, hispanics and native Americans).
    4. Residents of long term care facilities.
    5. Persons with medical conditions which have been reported to increase the risk of tuberculosis, such as: silicosis, being 10% or more below ideal body weight, chronic renal failure, diabetes mellitus, high dose corticosteroid or other immunosuppressive therapy, some hematologic disorders (such as leukemias and lymphomas and other malignancies).

Manual:	Infection Control	Subject:	Absence due to Illness from Infectious or Communicable Disease	Approved by:
Section:	Employee Health	Code:	IC - E - 3	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised	7-6-12	

ABSENCE DUE TO ILLNESS FROM INFECTIOUS OR COMMUNICABLE DISEASE

PURPOSE
To protect patients and staff members from exposure to infectious and communicable disease.

POLICY
Any employee or physician who is absent due to illness or who demonstrates symptoms while on duty, will notify immediate supervisor or medical director or a description of the illness as soon as possible.

PROCEDURE
A. Staff members with conditions determined infectious will be given a medical leave of absence or will be transferred from areas involving patient contact.
   1. Temperature over 100º
   2. Vomiting or diarrhea
   3. Exudative lesions or rash

B. The staff member's supervisor will give a complete progress report to the examining physician.

C. Following an illness related to an infectious or communicable disease, a written statement that the staff member is no longer infectious must be presented to the immediate supervisor before staff member may return to work. A copy will be kept in the staff member's personnel file.

D. If the etiology of the disease is uncertain, a preliminary attempt will be made to determine if the illness is job related. If determined job related, all initial and subsequent reports, including a statement from the staff member, the physician and the supervisor, will be sent to the Workers' Compensation carrier.

Manual:	Infection Control	Subject:	Tuberculosis Infection Control Program	Approved by:
Section:	Employee Health	Code:	IC - E - 5	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

TUBERCULOSIS INFECTION CONTROL PROGRAM

POLICY

The Center shall not knowingly treat a patient with active infectious or laryngeal tuberculosis (TB). The purpose of this program is to minimize risks of transmission of TB to health care workers (HCWs), patients, and visitors. The program will address administrative controls, engineering controls, and respiratory protection. This type of facility will rely on administrative controls, unless it determines that such have failed to control TB infections.

PROCEDURES

I. RESPONSIBILITY

A. The Quality Improvement Committee shall be responsible for overseeing and executing the program.

B. The medical director and employee health nurse are involved in implementing the program.

II. IDENTIFICATION, EVALUATION, AND TREATMENT OF PATIENTS WHO HAVE TB

A. The proper screening of patients is considered critical to the success of this program.

1. The preoperative assessment contact by the perioperative nurses should include the following questions:
   a. History of TB disease - type of treatment received, evidence of being disease-free by three negative sputums.
   b. Recent exposure to active TB and if so, results of PPD.
   c. Persistent cough of > 3 weeks.
   d. Bloody sputum, night sweats, fever, weight or appetite loss.

2. The reviewing physician or anesthesiologist should verify such findings.

3. A higher index of suspicion should be held in those patients:
   a. Who may have a higher prevalence such as: 1) foreign born persons from Asia, Africa, the Caribbean, and Latin America; and 2) medically underserved such as some African-Americans, Hispanics, Asians, Pacific Islanders, American Indians, Alaskan Natives, homeless, current and former correctional facility inmates, alcoholics, injecting drug users, and the elderly.
   b. Who may have a higher risk of converting from latent non-infectious TB infection to active TB such as: those infected in the last two years, children under 4 years, patients with fibrotic lesions on chest x-ray, and certain medical conditions such as HIV, silicosis, gastrectomy, jejuno-ileal bypass, 10% below ideal body weight, chronic renal failure on dialysis, diabetes, immunosuppression, and leukemias.

B. If active TB disease is being considered in a patient, the procedure shall be delayed until diagnostic measures for identifying TB have been conducted in another health facility or the physicians office.

1. The attending staff physician will be notified regarding the consideration.

2. An appropriate site for a diagnostic work-up, not including the surgery center facility, will be determined.

3. If the patient is present in the facility, arrangements will be made for prompt discharge of the patient to home or to a facility with isolation capability. The Center will make immediate arrangements to prevent exposure including explaining to the patient their need to wear a surgical mask, and to cover mouth and nose when coughing or sneezing followed by immediate disposition of tissues.

4. Diagnostic measures include a medical history and physical examination, PPD skin test, chest x-ray, and microscopic examination and culture of sputum or other appropriate specimens.

5. If the diagnosis is positive for active TB, the state and county health departments should be notified by the patient's attending physician.

6. The procedure will not be performed at this surgical facility until the presence or absence of active TB is determined, and evidence of non-infectiousness of active TB after treatment is presented.

III. ENGINEERING CONTROLS

Since the policy of the Center is to not treat patients with active TB and the facility has recirculated air without HEPA filtration, and no isolation room, engineering controls will therefore not be relied upon to prevent TB exposure. The treatment rooms have a minimum of six (6) air changes an hour and positive pressure ventilation.

IV. RESPIRATORY PROTECTION

Since the policy of the Center is to not treat patients with active TB, the facility therefore has not developed a respiratory protection program

V. EDUCATION AND TRAINING OF HEALTH CARE WORKERS

A. All HCWs will be educated upon initial employment or as soon after this policy is adopted on the following points:

1. Transmission of TB and basic concepts of the disease including signs, symptoms, latent and active disease, possibility of reinfection.

2. Signs and symptoms of TB disease.

3. Potential for occupational exposure to TB in the Center based on the facility's risk assessment.

4. Principles and practices of TB infection control to be employed in the Center.

5. The purpose of the PPD skin testing program.
6. Preventive therapy principles for latent TB infection.

7. HCW's responsibilities regarding medical evaluation in the event of development of symptoms or PPD test conversion, and notification of the Center.

8. Principles of drug therapy of active TB.

9. HCWs responsibility to notify the Center if diagnosed with active TB so that an investigation can be initiated.

10. The Center's responsibilities regarding HCWs confidentiality rights.

11. Higher risks associated with TB infection in immuno-compromised persons.

12. Skin testing in HIV positive persons.

13. Efficacy and safety of BCG vaccinations.

14. The Center's policy for immuno-compromised HCWs regarding voluntary work reassignment, in keeping with the provisions of the ADA.

Note: An educational packet has been prepared for employee training.

VI. HCW COUNSELING, SCREENING, AND EVALUATION

A. Counseling HCWs regarding TB.

1. All HCWs should know if they have a medical condition or are receiving a medical treatment that may lead to severely impaired cell-mediated immunity. HCWs who may be at risk for HIV should be encouraged to voluntarily seek counseling and testing for HIV. Such knowledge will allow the HCW to seek appropriate preventive measures and to consider voluntary work reassignments.

2. All HCWs should be informed about the need to follow existing recommendations for infection control to minimize the risk for exposure to infectious agents.

B. Screening HCWs for active TB.

1. Any HCW who has a persistent cough (i.e. cough lasting = or > three weeks). especially in the presence of other signs or symptoms compatible with active TB (eg., weight loss, night sweats, bloody sputum, anorexia, or fever), should be evaluated promptly for TB.

2. The HCW should not return to the workplace until a diagnosis of TB has been excluded or until the HCW is on therapy and a determination has been made that the HCW is noninfectious.

C. Screening HCWs for Latent TB Infection

1. It is the policy of the Center to require a baseline PPD skin test at the time of employment. This includes those with a history of BCG vaccination. For employees who have not had a documented negative PPD test result during the preceding 12 month period, the baseline testing should employ the two-step method in order to detect boosting phenomena.

2. HCWs who have a documented history of a positive PPD test, adequate treatment of TB disease, or adequate preventive therapy for infection, should be exempt from further PPD screening, unless they develop signs or symptoms suggestive of TB. An annual TB assessment questionnaire will be administered to all such HCWs to determine the presence of any symptoms (Attachment B).

3. It is the policy of the Center that physicians and other personnel not paid by, but working in the facility more than thirty (30) hours per week, receive skin testing annually, initially. This shall be free of charge.

4. PPD-negative HCWs should undergo repeat PPD testing at regular intervals as determined by risk assessment. Initially such period will be annually. It is anticipated that if the conversions remain low, annual testing will be eliminated and a longer period or no routine repeat testing will be required.

5. All PPD tests should be administered, read, and interpreted in accordance with current guidelines by specified trained personnel. HCWs should be informed about the interpretation of both positive and negative PPD test results. Specifically, HCWs with indurations of 5-9 mm. in diameter should be advised that such results may be considered positive for HCWs who are contacts of persons with infectious TB or who have HIV infection or other causes of severe immunosuppression (See Attachment C Table S2-1, Summary of Interpretations of PPD).

6. PPD test results should be recorded confidentially in the HCWs employee health record or personnel file, and in an aggregate database of all HCW PPD test results. This database can be analyzed periodically to estimate the risk for acquiring new infection in the facility.

7. Records shall also be kept regarding HCW active TB and TB infection that progresses to disease within 5 years.

8. When transmission of TB is known to have occurred at the Center, a problem evaluation will be conducted as outlined in Section VIII. Any HCW should be tested whenever they have been exposed to a TB patient and proper precautions were not observed at the time of exposure.

D. Evaluation and Management of HCWs who have a positive PPD skin test results or active TB

1. Evaluation
   a. All HCWs with newly recognized positive PPD test results or PPD test conversions should be evaluated promptly for active TB. This should include a clinical examination and a chest x-ray. If the findings are compatible with active TB, additional tests should be performed. If symptoms compatible with TB are present, the HCW should be excluded from the workplace until either: a) a diagnosis of active TB is ruled out, or b) a diagnosis of active TB was established, the HCW is being treated and a determination has been made that the HCW is noninfectious. HCWs who do not have active TB should be evaluated for preventive therapy according to established guidelines.

   b. If a HCWs PPD test results converts to positive, a history of confirmed or suspected TB exposure should be sought in an attempt to determine the potential source. If such source is determined, the drug susceptibility pattern isolated from the source should be recorded in the HCW's medical record.

2. Routine and follow-up chest x-rays

   Routine chest x-rays are not required for asymptomatic, PPD negative HCWS. HCWs with positive PPD test results should have a chest x-ray as part of the initial evaluation of the PPD test. If negative, repeat chest x-rays are not needed unless symptoms develop that could be attributed to TB.

3. Workplace restrictions
   a. Active TB

   i. HCWs with pulmonary or laryngeal TB pose a risk to patients and other HCWs while they are infectious, and therefore they should be excluded from the workplace until they are noninfectious.
   ii. Before the HCW who has TB can return to the workplace, documentation should be provided that the HCW is receiving adequate therapy, the cough has resolved, and the HCW has three consecutive negative sputum smears collected on different days. Ongoing documentation should be provided that the HCW is on effective drug therapy and that the sputum AFB smears continue to be negative.

3. HCWs with active laryngeal or pulmonary TB who discontinue treatment before they are cured should be evaluated promptly for infectiousness.

4. HCWs who have TB at sites other than lung or larynx usually do not need to be excluded from the workplace if a diagnosis of concurrent pulmonary TB has been ruled out.

b. Latent TB infection

i. HCWs receiving preventive treatment for latent TB infection should not be restricted from their usual work activities.
ii. HCWs with latent TB infection who cannot take or who do not accept or complete a full course of preventive therapy should not be excluded from the workplace. Counseling will be provided regarding the risk for developing active TB with instructions to seek prompt medical evaluation if signs/symptoms develop.

VII. CONDUCTING A PROBLEM EVALUATION

A. An epidemiologic investigation may be indicated for several situations:
   1. The occurrence of PPD test conversions or active TB in HCWS.
   2. The occurrence of possible person-to-person transmission of TB.
   3. Situations in which patients or HCWs with active TB are not promptly identified and isolated, thus exposing other persons in the facility to TB.

B. The following general objectives for conducting an epidemiologic investigation are:

1. Determination of the likelihood that transmission of and infection with TB has occurred at the Center and resulted from occupational transmission.
2. Determination of the extent to which TB has been transmitted.
3. Identification of those persons who have been exposed and infected thus enabling those persons to receive an evaluation for TB infection and disease and if indicated, appropriate clinical management. The public health department should be notified immediately for consultation and to allow for investigation of community contacts who were not exposed at the Center.
4. Identification of factors that could have contributed to transmission and infection and to implement appropriate interventions.
5. Evaluation of the effectiveness of any interventions that have been implemented and to ensure that exposure to and transmission of TB have been terminated.

D. Investigating PPD Conversions in HCWs

The decision tree (Attachment D, Source: *MMWR* October 28, 1994) will be followed when PPD conversions occur in HCWS.

E. Investigating Cases of Active TB in HCWs

1. The case should be evaluated epidemiologically, in a manner similar to PPD test conversions in HCWs (see Attachment D), to determine the likelihood that it resulted from occupational transmission, and to identify possible causes and implement appropriate interventions if the evaluation suggests such transmission.

2. Contacts of the HCW who have had intense exposure to the HCW should be identified and evaluated for TB infection and disease. The state and county health departments should be notified immediately for consultation and to allow for investigation of community contacts who were not exposed at the Center.

F. Investigating Possible Patient to Patient Transmission of TB.

Any determination of active TB in a patient inadvertently treated at the Center should be investigated. Ascertain whether any other patients or HCWs could have been exposed. If so, these persons may need an evaluation for TB infection and disease. The state and county health departments should be consulted for this investigation.

G. Investigating Contacts of Patients and HCWs who have Infectious TB

If it is determined that a patient who has active pulmonary TB has received treatment at the Center or a HCW develops active TB:

1. Notify the state and county health department immediately to help in the epidemiology.
2. Identify other patients and HCWs who may have been exposed to the source patient. Interview all applicable personnel and the source patient. Review the patient's

medical record. Investigate the matter thoroughly as to who was involved, what happened, and where exposures occurred.

3. Administer PPD testing on the most intensely exposed HCWs and patients as soon as possible after the exposure has occurred. If transmission did occur to the most intensely exposed persons, then those persons with whom the individual had less contact should be evaluated. If the initial PPD test result is negative, a second test should be administered twelve (12) weeks after the exposure was terminated.

4. Those persons exposed to TB and who have either a PPD conversion or symptoms suggestive of TB should receive prompt clinical evaluation, and if indicated, chest x-ray and bacteriologic studies should be performed. Most persons who have evidence of newly acquired infection or active disease should be evaluated for preventive or curative therapy. Persons who have previously had positive PPD test results and who have been exposed to an infectious TB patient do not require a repeat PPD test or a chest x-ray unless they have symptoms suggestive of TB.

VIII. COORDINATION WITH PUBLIC HEALTH DEPARTMENT

A. As soon as a patient or HCW is known or suspected to have active TB, the patient or HCW should be reported to the state and county heath departments so that appropriate follow-up care can be arranged and a community contact investigation can be performed.

B. The confidentiality of the patient or HCW should be protected in accordance with state and local laws.

C. The Center will coordinate efforts with the health department in performing appropriate contact investigations on patient and HCWs who have active TB.

D. In accordance with state and local laws and regulations, results of all AFB positive sputum smears, cultures positive for TB, and drug susceptibility results on M. tuberculosis isolates should be reported to the public health department as soon as these results are available.

E. The public health department should be considered a resource to the Center in planning and implementing various aspects of the TB infection control plan.

SOURCE DOCUMENTS AND INDIVIDUALS

- "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities". 1994; MMWR. October 28, 1994, Volume 43, Number RR 13, pp. i - 132.

- Presentation by Gail Bennett, R.N., MSN, on "Tuberculosis" at FASA Annual Meeting, May 4-6, 1995

- Telephone call by Kenneth Richardson, M.D., Medical Director of Centrum Surgical Center, on the issue of respiratory protection with Alan Block, M.D. of the TB Elimination Section of the Centers for Disease Control, April 7, 1995. After a detailed discussion of the Center and its operations as well as the community incidence of TB, Dr. Block stated that a respiratory protection program was not necessary.

- Centers for Disease Control Fax Information Service, Various Documents on TB published from May to December 1994.

- Colorado State Department of Health - Department of Epidemiology, Tuberculosis.

- APIC News, Volume 14, Number 2, March/April 1995

- Hospital Employee Health, American Health Consultants, Volume 13, Number 12, December 1994.

- TB Monitor, American Health Consultants, Volume 1, Number 11, November 1994.

Manual:	Infection Control	Subject:	Housekeeping	Approved by:
Section:	Housekeeping	Code:	IC -H-1	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

HOUSEKEEPING

POLICY

PURPOSE

To maintain a safe environment for patients and personnel by decreasing or eliminating bacteria, preventing transmission of infectious organisms, controlling vermin and achieving an anesthetically pleasing operating room.

RESPONSIBILITY

The housekeeper contracted by the AMBULATORY Surgery Center and all employees are responsible for maintaining a safe, clean environment.

1. Housekeeping duties in the operating room are under the direct supervision of the nurse in charge. He/she carries responsibility of assignment for maintenance and sanitation needs.

2. Staff in each theater and/or staff assigned to housekeeping is responsible for cleaning rooms and equipment between cases and prior to first procedure of day.

3. Damp dusting is the only type of dusting allowed in the operating room. Brooms, non-treated dust mops and brushes are not to be used. Properly ventilated vacuums may be used.

4. All personnel are to use disposable rubber gloves during cleaning.

5. All heavy equipment such as x-ray machines, monitors etc., stored outside the operating room are to be damp dusted with disinfectant solution before entry into the operating room.
6. All trash and soiled linen is encased in specified bags after each procedure and as necessary in other areas, tied securely, and taken to the soiled holding room and placed in proper linen or trash disposal cart. Housekeeping will make routine disposal in dumpster.

Manual:	Infection Control	Subject:	Daily Room/Equipment Procedures	Approved by:
Section:	Housekeeping	Code:	IC - H - 3	
Category:	Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

HOUSEKEEPING

PROCEDURE

A. **Cleaning prior to the first procedure of the day:**

1. Flat surfaces of tables, equipment and overhead lamps must be damp dusted with a clean cloth that has been moistened with a detergent germicide or disinfectant. (70% alcohol is acceptable)

2. Damp dust with detergent germicide moistened, lint free cloth all counter surfaces in the soiled receiving and clean work areas.

B. **Cleaning between cases:**

1. All used paper and trash put in plastic bag hamper in room. All used linen is placed in laundry bag hamper in room. At the end of the case, bags are tied and taken to soiled holding area and put in large plastic trash and/or laundry bins.

2. All knife blades, needles and sharps placed in sharp container in room. When these sharp bottles are full, they are sealed and placed in biohazard trash.

3. Dirty instruments are taken to soiled workroom for washing and decontamination.

4. Check both wall suctions. Discard if soiled.

5. Wipe down all OR equipment and furniture in the room. Special equipment is then returned to proper storage area.

6. Walls are spot cleaned with germicidal solution.

7. Floors are mopped with germicidal solution starting at the walls, moving equipment and mopping to center of room. Mop solution and mop head are changed daily and more frequently as needed.

C. **Cleaning suction equipment:**

1. Suction bottles are capped shut and disposed of in red bags as biohazardous waste.
2. Suction stand is wiped down with tuberculocidal disinfectant.

D. **Cleaning OR lights:**
   1. Cleaned every morning and during terminal cleaning every afternoon.
   2. The dome surface and arm are cleaned with germicidal solution and the reflector is cleaned with alcohol.

E. **Cleaning equipment before storing:**
   1. Any equipment taken outside of the OR is cleaned with germicidal solution and returned to proper storage area.
   2. Equipment used in a room is wiped down with germicidal solution at the end of the case and returned to proper storage area.

F. **X-ray unit:**
   1. If X-ray unit goes to OR, it must be wiped down with germicidal solution at OR door and then taken in.
   2. After use in OR, it is then wiped with germicidal solution again and returned to storage area.

Manual:	Infection Control	Subject:	Cleaning of Stretchers/Recliners	Approved by:
Section:	Housekeeping	Code:	IC - H - 5	
Category:	Policy	Date: O:	3-10-96	
		Revised	7-6-2012	

CLEANING OF STRETCHERS/RECLINERS

PURPOSE
To prevent cross infection between patients.

SCOPE
All nursing personnel, CNA's, and/or any employees assigned to this area.

POLICY
Stretchers/recliners are cleaned between each patient's use with a hospital grade germicidal preparation.

PROCEDURE
Follow manufacturers' recommended guidelines to clean surface areas.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Cleaning of Stretchers/ Recliners	Approved by:
Section:	Housekeeping	Code:	IC - H - 7	
Category:	Procedure	Date: O:	3-10-96	
		Revised	7-6-2012	

CLEANING OF STRETCHERS/RECLINERS

PROCEDURE

A. **Stretchers:**
1. Strip stretcher of linens.
2. Wipe down mattress, side rails, bumper rail, lower shelf and IV pole with a germicidal preparation, using disposable wipe.
3. Allow to dry and apply clean linens.

B. **Recliners:**
1. Remove any linens.
2. Spray and wipe with a germicidal.
3. Allow to dry.

Manual:	Infection Control	Subject:	Endoscope reprocessing	Approved by:
Section:	Housekeeping	Code:	IC - H - 9	
Category:	Policy	Date: O:	6-15-96	
		Revised	7-6-2012	

Endoscope Reprocessing

Purpose

To ensure appropriate reprocessing of flexible endoscopes and accessories.

Policy and Procedure

Endoscopes are considered semi-critical devices on the Spaulding Scale and require, at a minimum, high-level disinfection with a FDA approved disinfectant.

Personnel performing reprocessing of flexible endoscopes shall demonstrate competency in the care and reprocessing of endoscopes and related equipment. Personnel shall also demonstrate competency in infection control and safe use of chemicals

Appropriate personal protective equipment must be worn.

All endoscopes shall be pre-cleaned according to the manufacturer's guidelines immediately following the procedure.

After each use, all endoscopes shall be disassembled and leak tested according to manufacturer's instructions.

All endoscopes and accessories will be thoroughly and properly cleaned with an enzymatic detergent prior to high-level disinfection and/or sterilization. Manufacturer's instructions for preparation and use of the enzymatic detergent shall be followed. The prepared detergent shall be discarded after each use. Appropriately sized brushes will be used for cleaning. All endoscopes will be properly rinsed after cleaning according to manufacturer guidelines.

Reprocessing for each endoscope shall be performed according to the manufacturer's instructions specific to that endoscope. An EPA-registered disinfectant solution will be utilized for all endoscopes and compatible accessories for high level disinfection and/or sterilization. Manufacturer instructions shall be followed in the preparation, testing and use of the disinfectant solution. Manufacturer guidelines for exposure time and temperature will be followed. Each

endoscope and it components shall be completely immersed in the disinfectant solution and all channels must be disinfected during reprocessing.

Following high-level disinfection, all endoscopes and accessories shall be rinsed and dried in accordance with manufacturer instructions.

When an automated processor is used in lieu of high-level disinfection, manufacturer's directions for processing shall be followed.

Disinfected and dried endoscopes shall be properly stored in a vertical position away from the reprocessing area in a location that will provide protection from contamination.

Reusable endoscopic accessories that break the mucosal barrier will be mechanically cleaned and sterilized after each patient use.

When a sterilizer is used, manufacturer's instructions for use shall be followed.

When automated processors and/or sterilizers are used, maintenance and repair shall be performed according to manufacturer instructions and shall be documented.

Personnel shall routinely inspect endoscopes and all related equipment and supplies for integrity, function, and cleanliness. Damaged or soiled endoscopes or accessories shall not be used.

Manual:	Infection Control	Subject:	Automated Cleaning and Sterilization-Endoscopes	Approved by:
Section:	Housekeeping	Code:	IC - H - 9a	
Category:	Procedure	Date: O:	6-15-96	
		Review/ Revised Date:	01-22-01 7/6/2012	

FLEXIBLE FIBEROPTIC ENDOSCOPE CLEANING AND STERILIZATION WITH AUTOMATED WASHER

CLEANING

Clean endoscope immediately after procedure in the following manner:

1. Wipe insertion tube with cleansing solution of enzomatic detergent.

2. Turn off air pump and remove air/water valve.

3. Insert blue air/water channel cleaning adapter. Turn on pump and alternately feed air/water for 10 seconds each.

4. Suction enzomatic detergent through the suction channel. Disconnect endoscope from the light source and take to cleaning area (sink). Perform Leak Test with leak tester.

5. Place endoscope into sink and gently wash all debris from the outside of the scope with enzymatic cleaner.

6. Remove all valves from the scope and place in washer/sterilizer inside round cleaning container.

7. Using a clean brush, brush all channels of the scope.

8. Once the endoscope is coiled, hook the three cleaning tubes to the perspective areas. One is hooked to the suction port, one is hooked to the water port, and one is hooked to the port at which biopsy forceps are pushed through.

9. When all hooked up, hold start button for a few seconds, add detergent and close lid.

10. When machine has completed the wash-sterilize cycles, push alcohol and air through machine and scope.

11. Remove the cleaning tubes and hang to dry.

12. Hot biopsy forceps are disposable and to be discarded when finished with procedure.

13. Snares are disposable and to be discarded when finished with the procedure. If to be reprocessed, follow guidelines furnished by processing company.

14. Cleaning brushes:
    a. Wash with enzomatic cleaner and disinfect in cidex solution for the recommended time per manufacture.
    b. Rinse and hand to dry

15. Mouth guards are either disposable or non-disposable types. Disposable bite blocks are to be discarded when finished with the procedure.
    Non-disposable bite blocks:
    a. Wash with enzomatic cleaner
    b. Rinse and soak in CIDEX Solution for recommended time per manufacturer.
    c. Rinse and set out to dry

16. Water bottles to be disinfected daily in Cidex.
    a. Rinse and dry

Manual:	Infection Control	Subject:	Manual Cleaning and Sterilization-Endoscopes	Approved by:
Section:	Housekeeping	Code:	IC - H - 9b	
Category:	Procedure	Date: O:	6-15-96	
		Review/ Revised Date:	01-22-01 7/6/2012	

ENDOSCOPE CLEANING - MANUAL METHOD

RATIONALE
Strict protocols of vigorous mechanical cleaning, disinfection and drying of the endoscopes and accessories are necessary to eliminate the risk of disease transmission.

POLICY STATEMENT
The following guidelines are for infection control safety of equipment:

1. Patient safety
   Endoscopes and accessories disinfected properly after each patient use.

2. Personnel safety while disinfecting equipment. The following should be worn:
   a. Double gloves
   b. Protective gown
   c. Goggles/shield
   d. Mask

PROCEDURE
Scope is cleaned and disinfected according to manufacturer's instructions: Olympus-*Nurses and Technicians Guide to OES*.

1. Immediately after scope is removed from patient, air/water valve should be removed and replaced with air/water cleaning valve to prevent clogging of channel. Leave scope connected to light source and suction pump. Operate air/water channel cleaning adapter to feed air and water alternately for at least ten (10) seconds. Turn off light source.

2. With 4x4 gauze soaked in detergent solution (Enzol) wipe off excess secretions from the insertion tube.

3. Place distal end of scope in Enzol and aspirate through suction channel for approximately ten (10) seconds. Alternate aspiration of Enzol and air several times.

Turn off suction pump and disconnect suction line from light guide connector section.

4. Take scope to cleaning room and place in designated sink. Immerse entire instrument in Enzol solution.

5. Remove air/water channel cleaning adapter, suction valve, biopsy valve, distal hood and C02 valve-(colonscopes only) and place with air/water valve in Enzol solution for separate cleaning. Thoroughly wash, brush, and rinse in clean water all accessories. Place in disinfectant, glutaraldehyde 2%, and soak per manufacturer recommended time.

6. Perform a leak test with the Olympus leak tester checking for any leaks or holes in the scope. Clean scope suction channel, universal cord suction channel and biopsy channel with special OES cleaning brush. Repeat brushing as often as necessary.

7. Clean insertion tube and control body carefully using gauze, and channel housing brushes with Enzol solution to remove all debris. Discard solution.

8. Attach all channel irrigators and immerse entire scope in disinfectant. Flush air/water and suction/instrument channels with disinfectant. Flush supplementary channels as necessary.

9. Soak scope in disinfectant as per manufacturer recommendations.

10. On completion of disinfection period, remove the scope and valves from the disinfectant. Rinse by immersing in clean water. Flush with water to remove disinfectant from all channels. Follow with alcohol flush and air.

11. Dry the scope by flushing with air via biopsy channel, suction, air channel ports. Then dry the outside of the scope with a soft towel.

12. Place distal end in alcohol and aspirate through suction channel at least ten (10) seconds.

13. Hang scope in cabinet on separate scope hanger. Attach ETO cap at end of day for aeration. Be sure to remove cap before patient examination.

Note: Precautions for staff shall be followed as outlined in the *Infection Control Manual*.

14. Accessories- Are Disposable

a. Bite Blocks
b. Biopsy forceps
c. Hot biopsy forceps and snares
d. Water bottles are cleaned and disinfected daily

15. Disinfectant (glutaraldehyde) is changed per manufacturer's recommendations. Check Cidex Solution daily with CIDEX test strip and document in Cidex Log Book. Cidex bins to be covered when not in use.

Manual:	Infection Control	Subject:	Leak Testing	Approved by:
Section:	Housekeeping	Code:	IC - H - 9c	
Category:	Procedure	Date: O:	6-15-96	
		Review/ Revised Date:	01-22-01 7/6/2012	

LEAK TESTING

Leak testing will be done on all scopes after each procedure to ensure there are no defects. Refer to technician's manufacturers guide.

1. Prior to cleaning, attach adaptor to leak tester and immerse scope under water in a basin filled with clean tap water.

2. Connect adaptor to the ETO port of instrument.

3. Press the on button on the MU-1 Leak Tester. The distal end of the scope will be pressurized. Check for a leak by observing for constant bubbles coming from the scope.

4. Completely articulate the scope via the knob to bend the distal portion of the scope to confirm the integrity of the distal end of the scope.

5. After the test is complete, turn off the on/off button and wait approximately 30 seconds for the distal tip to de-pressurize. Then disconnect and continue to disinfect the scope.

6. If a leak is confirmed, scope is removed from use and sent for repair.

Manual:	Infection Control	Subject:	Cleaning of Arthroscopes, Laparoscopes	Approved by:
Section:	Housekeeping	Code:	IC - H - 9d	
Category:	Procedure	Date: O:	6-15-96	
		Review/ Revised Date:	01-22-01 7-6-2012	

CLEANING OF ARTHROSCOPES AND LAPAROSCOPES

PROCEDURE

In order to render the above free from all bacteria:

1. Disassemble all instruments on a clean towel. Stopcocks must be taken apart and gaskets removed. Always handle telescopes by eyepiece.
2. Thoroughly clean in enzymatic solution making sure to clean small channels and holes. Plastic basins should be used to avoid scratching. Disinfect scopes in glutarldehyde solution per manufacturer recommendations. Do not allow telescopes or any instruments to remain in any solution or sterile water for more than thirty (30) minutes.
3. Rinse well with gentle agitation to remove the disinfection solution. It is recommended to separate and rinse very thoroughly with agitation. If all glutaraldehydes are not removed they can cause sparking or shocks.
4. Dry thoroughly, taking care to remove all water from channels and holes. Electrical cords and cables should not be soaked.
5. Lubricate stopcocks with one drop of lubricant after each use. All parts held together with screws, joints and moving parts should be lubricated weekly.

Manual:	Infection Control	Subject:	High Level Disinfection of Arthroscopes, Laparoscopes	Approved by:
Section:	Housekeeping	Code:	IC - H - 9f	
Category:	Procedure	Date: O:	6-15-96	
		Review/ Revised Date:	01-22-01 7/6/2012	

HIGH LEVEL DISINFECTION OF ARTHROSCOPES, LAPAROSCOPES AFTER BEING PROPERLY CLEANED

PROCEDURE

1. Properly clean scope prior to disinfection
2. Place scope in high level disinfection solution according to manufacturer's recommendations for soak time.
3. Thoroughly rinse scope before use according to manufacturer's recommendations.

Manual:	Infection Control	Subject:	Housekeeping Guidelines	Approved by:
Section:	Housekeeping	Code:	IC - H - 11	
Category:	Policy	Date: O:	3-10-96	
		Review/ Revised Date:	01-22-01 7-6-2012	

HOUSEKEEPING GUIDELINES

This list is not meant to be exclusive or all inclusive. It is to serve as a guide. Frequency of cleaning various areas is influenced greatly by degree and type of procedures. Therefore, cleaning intervals should be adjusted.

AMBULATORY SURGERY CENTER

HOUSEKEEPING GUIDELINES

Lobby/Waiting Area

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X					As needed
Windows and sills	X			X		
A/C baffles	X			X		
Seating	X			X		
Tables	X		X			
Coffee cart	X	X	X			
Empty trash containers	X		X			
Carpet/furniture	X					Semi-annually & as needed

Business and Administrative Offices

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X					As needed
Windows and sills	X			X		
A/C baffles and top of cabinets	X			X		
Counter tops	X	X	X			
Top of files	X		X			
Mouthpiece on telephone	X		X			
Empty trash containers	X		X			
Carpet	X		X			Semi-annually and as needed

Nursing Station

AMBULATORY SURGERY CENTER

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X					As needed
A/C baffles	X			X		
Counter tops	X	X	X			
Tops of files	X		X			
Mouthpiece on telephone	X		X			
Empty trash containers	X		X			

Staff Lounge

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X					As needed
A/C baffles and top of cabinets	X			X		
Table and chairs	X	X	X			
Counter tops	X	X	X			
Shelves		X		X		
Drawers		X		X		
Refrigerator top and shelves		X		X		
Sink	X	X	X			
Empty trash containers	X		X			
Fill soap dispensers	X		X			
Fill paper towels	X		X			

AMBULATORY SURGERY CENTER

Nourishment Station

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X					As needed
A/C baffles and top of cabinets	X			X		
Counter tops	X	X	X			
Shelves and drawers		X		X		
Refrigerator		X		X		
Sink	X	X	X			
Empty trash containers	X		X			
Fill soap dispensers	X		X			
Fill paper towels	X		X			

Male and Female Dressing Rooms

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X				X	
A/C baffles and top of lockers	X			X		
Uniform cupboard	X			X		
Lockers		X		X		
Chairs	X			X		
Empty trash containers	X		X			
Empty laundry hamper	X		X			

AMBULATORY SURGERY CENTER

Bathrooms

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X		X			
A/C baffles	X			X		
Fixtures and showers	X		X			
Empty trash containers	X		X			
Fill soap dispensers	X		X			
Fill paper towels	X		X			
Fill toilet paper	X		X			

Scrub Areas

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X	X	X			
Walls	X		X			
A/C baffles	X			X		
Scrub sink and ledges	X	X	X			
Caps and masks		X	X			
Empty trash containers	X		X			
Fill soap dispensers	X		X			
Fill paper towels	X		X			

AMBULATORY SURGERY CENTER

Staff Entrance, Linen, Clean Storage, Darkroom

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X			X		As needed
A/C baffles	X			X		
Shelves		X		X		
Cart tops and shelves		X		X		
Empty trash containers	X		X			

Preop/PACU/Med Prep

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X					As needed
Windows and sills	X			X		
A/C baffles	X			X		
Chairs and stretchers	X	X	X			Between patients and terminally
Cart top and shelves	X	X	X			
Cubicle curtains	X					As needed
Oxygen and vacuum apparatus		X	X			
Blood pressure cuffs		X		X		Between patients as needed
Empty trash containers	X		X			
Empty linen hamper	X		X			

AMBULATORY SURGERY CENTER

Operating Rooms and Endo Room

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X					As needed
Doors and push plates	X		X			
A/C baffles	X			X		
Counter tops	X		X			
Storage cabinets		X		X		
Tables, stands and stools		X	X			
Wheels on furniture	X			X		
Tables/stretchers/chairs		X	X			Between patients and terminally
Anesthesia cart		X	X			May be anesthesia personnel
Operating lights		X	X			
Equipment		X	X			thoroughly, after each use
Laundry hamper	X		X			
Floor buckets	X		X			
Empty trash containers	X		X			

AMBULATORY SURGERY CENTER

Clean Work Room and Substerile

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X			X		
A/C baffles	X			X		
Doors and push plates	X		X			
Shelves and drawers		X			X	
Sterile storage cupboards (inside and outside)		X			X	
Sink	X		X			
Empty trash containers	X		X			
Fill soap dispensers	X		X			

Soil Work Room

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X		X			
Walls	X					As needed
A/C baffles	X			X		
Shelves and drawers		X			X	
Sink and counter tops	X	X	X			
Clinical sinks	X		X			
Empty trash containers	X		X			
Fill soap dispensers	X		X			
Fill paper towels	X		X			

AMBULATORY SURGERY CENTER

Non-Sterile Storage and Equipment

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X			X		
Walls	X					As needed
A/C baffles	X			X		
Shelves	X			X		

Mechanical Rooms

	Responsible		*Frequency*			
AREA	***Hskpg Person***	***Nursing Person***	***Daily***	***Weekly***	***Mthly***	***Other***
Floor	X					As needed
Walls	X					As needed

Manual:	Infection Control	Subject:	Housekeeping Guidelines	Approved by:
Section:	Housekeeping	Code:	IC - H - 12	
Category:	Policy	Date: O:	7-18-2012	
		Review/ Revised Date:		

SCOPE:
All staff

PURPOSE:
To assure patient safety in use of ice and ice machines.

POLICY:

I. Ice machines that dispense ice directly into portable containers at the touch of a control provide a more sanitary method to store and obtain ice than use of ice chests.

II. Access to ice chests and machines should be limited.

III. All ice handlers should be taught the following precautions:

A. Perform hand hygiene before obtaining ice. Apply glove to hand used to scoop ice.
B. Hold scoop used with ice chest by handle; do not touch bowl surface with hands
C. Do not handle ice with hands
D. Do not return unused ice to an ice storage chest
E. Keep access doors to chests closed except when removing ice.

IV. Ice scoops used should be smooth and impervious and should be kept on an uncovered stainless steel, impervious plastic or fiberglass tray on top of the chest or in a mounted holder when not in use. The tray and the scoop should be run through a dishwasher daily.

V. Clean, disinfect, and maintain ice-storage chests on a regular basis.

A. Follow the manufacturer's instructions for cleaning.

B. Use an EPA-registered disinfectant suitable for use on ice machines, dispensers, or storage chests in accordance with label instructions.

C. If instructions and EPA-registered disinfectants suitable for use on ice machines are not available, use a general cleaning/disinfecting regimen.

D. Flush and clean ice machines and dispensers if they have not been disconnected

before anticipated lengthy water disruptions.

VI. Install proper air gaps where the condensate lines meet the waste lines.

VII. Conduct microbiologic sampling of ice, ice chests, and ice-making machines and dispensers where indicated during an epidemiologic investigation.

REFERENCES:

CDC Guidelines for Environmental Infection Control in Healthcare Facilities: Recommendations of CDC and the Healthcare Infection Control Practice Advisory Committee (HICPAC). MMWR 2003; 52 (No. RR-10).

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Manual:	Infection Control	Subject:	Decontamination of Instruments	Approved by:
Section:	Sterilization	Code:	IC - S - 1	
Category:	Policy/ Procedure	Date: O:	3-10-96	
		Review/ Revised Date:	01-22-01 7-6-2012	

DECONTAMINATION OF INSTRUMENTS

PURPOSE

To provide guidelines for the removal of gross contaminates (e.g. blood, tissue, etc.) and decrease the bioburden. To determine that items handled in the sterile, clean work area are free of infectious material in order to prevent cross infection to patients and to protect personnel.

POLICY

A. Instruments used for invasive procedures are considered contaminated and will be processed through a decontamination procedure prior to handling, repackaging or reprocessing for use or storage.

B. Appropriate personal protective equipment will be worn at all time when handling contaminated instruments.

C. Soiled instruments will be cleaned immediately at the point of use to prevent blood and other substances from drying on the surface or in the crevices.

D. Instruments will be processed in the same manner whether considered contaminated or infected.

E. If an instrument is found to be defective or damaged during a surgical procedure, it will be decontaminated and removed from the instrument tray.

PROCEDURE

A. During the surgical procedure, instruments will be kept free of debris and gross contamination by wiping instruments with a sponge moistened with sterile solution. Instruments with lumens should be kept patent by irrigating with sterile solution.

B Immediately after completion of surgical procedure, instruments will be decontaminated.

C. Initial decontamination may be achieved by manual cleaning.
   1. Manual decontamination.
      a. Personnel will wear personal protective equipment.
      b. Instruments will be submerged in warm water with appropriate detergent and cleaned while submerged.
      c. Instruments will then be sterilized by high level disinfection or autoclave.
      d. Instruments with lumens and cannulas should be flushed with appropriate detergent and followed by flushing with water.

D. Powered surgical instruments will be immediately decontaminated after use. Methods of decontamination should be compatible with the manufacturer's written instructions.
   1. Powered surgical instruments and air hose should not be immersed in water or placed in the automated cleaner.
   2. Inspect hoses and cords for damage or wear.
   3. Air hoses of powered surgical instruments should remain attached to the handpiece during cleaning.
   4. Cleaning will be done with an appropriate agent.
   5. Rinse all traces of cleaning solution from the powered surgical instrument; wipe the air hose with a clean damp cloth; remove excess water from the instrument; and dry the outside with a lint-free towel.
   6. Immediate-use sterilization is based on manufacturer recommendations for powered surgical instruments.

Manual:	Infection Control	Subject:	Terminal Processing of Instruments	Approved by:
Section:	Sterilization	Code:	IC - S - 2	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Review/ Revised Date:	01-22-01 7-6-2012	

TERMINAL PROCESSING OF INSTRUMENTS

PURPOSE
To provide guidelines for examining instruments for defects and administration appropriate care before repackaging for sterilization or storage.

POLICY
A. Instruments used for a surgical procedure will be subjected to a decontamination procedure before processing through cleanup procedure prior to repackaging and storage.

B. Instruments will be inspected for damage or defects after each day's use and not stored or replaced in set if defective or damaged.

C. Instruments will be subjected to appropriate care procedures before replacement in set for repackaging or storage.

PROCEDURE
A. Following initial decontamination, process instruments in the ultrasonic cleaner or manually.
   1. Follow manufacturer's written instructions for detergent selection and proper use, care and maintenance of the ultrasonic cleaner.
   2. Follow manufacturer's written instructions when placing dissimilar metals in the ultrasonic cleaner.
   3. Powered surgical instruments and air hoses should not be placed in the ultrasonic cleaner.
   4. Instruments will be rinsed and drained after ultrasonic cleaning.

B. Stain remover will be used as needed per manufacturer's recommendations. Instrument polish will not be used as it may remove protective finish of instrument.

C. Powered surgical instruments and accessories and instruments with movable parts should be lubricated according to manufacturer's written instructions.

D. Inspect instruments for cleanliness, proper function and alignment and freedom from defects and prepare for storage and/or sterilization following the cleaning process.
   1. Defective or damaged instruments will be given to the nurse manager with a written description of damage.

E. Instruments must be thoroughly dried before storage.

F. Delicate and sharp instruments should be protected according to the manufacturer's written instructions.

G. Before decontamination or sterilization, instruments with removable parts should be disassembled.

H. Terminal sterilization of all instruments including air powered instruments will be based on manufacturer's recommendations.

Manual:	Infection Control	Subject:	Sterilization Methods	Approved by:
Section:	Sterilization	Code:	IC - S - 3	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Review/ Revised Date:	01-22-01 7-6-2012	

STERILIZATION METHODS

PURPOSE
To provide guidelines for compliance with standards for processing supplies and equipment for use in the operative field during a surgical procedure.

POLICY
All equipment and supplies will be rendered sterile by steam sterilization or high-level chemical disinfection prior to use in operative field.

PROCEDURE
A. **Steam Sterilization**. Steam under pressure is the most effective and most commonly used method for rendering instruments and supplies sterile. Its efficiency depends on the penetration of packs by saturated steam at a specified temperature for a specified period of time.

1. Steam sterilization should be used for heat and moisture stable items.

2. Items should be disassembled, thoroughly cleaned, rinsed, and wiped or air dried.

3. Items should be positioned in sterilizer to enhance air removal, allow free circulation and penetration of steam and to prevent excessive condensation.

4. The time-temperature settings recommended by the manufacturer should be followed.

B. **Immediate Use Sterilization**. Immediate Use sterilization is appropriate only in an emergency situation such as an immediate need for an individual item (e.g. a dropped instrument) and there is no alternative. Individual items, instrument trays or instrument sets should be sterilized only if all the following conditions are met:

1. There is an urgent need for the items.

2. Work practices provide appropriate time for proper cleaning and decontamination, inspection and arrangement of instruments into appropriate sterilizing trays or containers prior to sterilization.

3. The physical layout of department or work area ensures direct delivery of sterilized items to the point of use (e.g. the sterilizer opens into the procedure area).

4. Procedures are developed and followed for aseptic handling and personnel safety during transfer of the sterilized items from the sterilizer to the using area.
   a. Only clean, unwrapped instruments should be sterilized.
   b. Specialty instrumentation or devices (e.g. drills) require different exposure times. Follow manufacturer's recommendations for the device.
   c. Implantable items should never be sterilized using immediate use methodology.
   d. Inspect recording device to ensure appropriate exposure time and temperature following each cycle.
   e. Transfer item in a manner that maintains sterility.
   f. Follow the manufacturer's recommendations for proper temperature and time to achieve sterilization.

Note:
1. Cannulated instrumentation should be freely irrigated immediately prior to Immediate-use sterilization.
2. Stand clear of door opening slowly to allow steam to escape out and up, away from user.

C. **Chemical Disinfection**. Chemical disinfection differs from sterilization by its power to kill spores and is divided into three levels: high, intermediate and low. A high-level disinfectant can be sporicidal as well as bacteriocidal and virucidal if contact time is sufficient. An intermediate-level disinfectant is not sporicidal, but will kill the more resistant bacteria and viruses. A low-level disinfectant is not sporicidal and will kill only less resistant bacteria and viruses.

A high-level disinfectant should be used if an item is to be disinfected rather than sterilized.

1. Products selected for disinfection should be registered with the EPA. The manufacturer's written instructions should be followed.

2. Items to be disinfected should be thoroughly cleaned, rinsed and as dry as possible to avoid interference with the disinfecting process or dilution of the disinfectant.

3. All surfaces of the items, including lumens and channels, should be in contact with disinfectant solution for recommended exposure time.

4. The disinfectant process should occur prior to storage and immediately prior to use.

5. Prior to use, items should be aseptically removed from the disinfectant, rinsed thoroughly with sterile water and dried in a manner which minimizes the risk of contamination.

6. An expiration date, determined according to manufacturer's written recommendations, should be marked on the container of the disinfectant solution currently in use.

7. High-level disinfectant contact with skin, mucous membrane and eyes should be avoided and solutions should be kept covered and used in a well ventilated area.

Manual:	Infection Control	Subject:	Resterilization of Disposables	Approved by:
Section:	Sterilization	Code:	IC - S - 3a	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Review/ Revised Date:	01-22-01 7-6-2012	

RESTERILIZATION OF DISPOSABLES

PURPOSE
To determine proper handling of resterilized disposable items for cost containment purposes.

POLICY
Disposable items that may be resterilized on a limited basis without changing the integrity of the item and which may be cleaned and sterilized adequately without jeopardizing patient care may be considered for reuse.

PROCEDURE

REPROCESSING PROTOCOLS
1. Reprocessing should be done by a third party or company engaged in the business of refurbishing/reprocessing medical items.
2. Check manufacturer's guidelines regarding reprocessing or reusing items. The information may be included in the package insert. If not, contact the manufacturer.
3. Establish reprocessing criteria regarding items that have been used on a patient.
4. Establish reprocessing criteria for items opened and removed from sterile package but not used.
5. Establish reprocessing criteria for items unused but have exceeded expiration dates or have been inadvertently contaminated.

RISK AND INSURANCE CONSIDERATIONS
1. Minimum insurance limits should be one ($1) million per occurrence and three ($3) million aggregate. However, a lower aggregate limit may be acceptable if there is excess liability coverage in the form of an umbrella policy in the amount of at least five ($5) million.
2. The reprocessing firm must warrant the form, function, and serviceability of the reprocessed item.
3. There must be a "hold harmless" and "indemnification" clause in the contract.

Note: Rationale for risk and insurance considerations is that if an instrument or piece of equipment is used against manufacturer's recommendations, the user accepts all liability for that item. If the agent reprocessing the instrument does not have adequate insurance coverage or does not warrant their work, the user retains the product liability.

ITEMS TO BE REPROCESSED

1. Each facility should critically examine the items that will be reprocessed and reused.
2. Items that may retain tissue/bone fragments and cannot easily be cleaned should be eliminated from consideration for reprocessing.
    a. Those items may include but not be limited to the following:
        - Drill bits or caps
        - Saw blades
        - Burrs
        - Trocars
        - Arthroscopic tissue cutters
3. Items that the manufacturer indicates may be reprocessed a number of times should not be reprocessed beyond that number.

INFECTION CONTROL - PERFORMANCE IMPROVEMENT

1. Postoperative/procedure complications, to include noscomial infections, should be tracked and trended comparing single use items and reprocessed items.
2. Identification of comparable or increased complication rates will be crucial to future consideration to continue or discontinue this practice.

Monitors should be established reviewing the efficacy and function of the reprocessed item.

Manual:	Infection Control	Subject:	Preparation of Equipment and Supplies for Sterilization	Approved by:
Section:	Sterilization	Code:	IC - S - 4	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Review/ Revised Date:	01-22-01 7-6-2012	

PREPARATION OF EQUIPMENT AND SUPPLIES FOR STERILIZATION

PURPOSE
To provide appropriate wrap or covering to preserve sterile shelf life of equipment, instruments and supplies.

POLICY
Stored instruments, equipment and supplies will be consistently wrapped appropriately, identified, load number documented and dated prior to sterilization.

GUIDELINES
A. **General packaging requirements**

1. Instrument sets do not exceed sixteen (16) pounds and are placed in trays with mesh or perforated bottoms.

2. Wrappers must be of adequate size to completely cover the item being sterilized and to provide a sterile field if it is necessary to open it on a table.

3. Items other than those in heat-sealed packages should be wrapped sequentially in two wrappers or bonded dual layer wrappers.

4. An internal chemical integrator is placed in that area of the package to be sterilized considered to be least accessible to penetration.

5. An external chemical indicator, such as heat sensitive tape, is clearly visible on every package to be sterilized.

6. Each double wrapped CSR wrapped item or pack processed in the sterilizer must be labeled with the following information:
   a. Name of item
   b. Date of sterilization
   c. Expiration date
   d. Initial of person preparing the pack
   e. Load number

7. All other items (peel packs, dust-covered packs), container systems
   a. Name of item
   b. Date of sterilization
   c. Initial of person preparing pack
   d. Load number
   e. "Sterile" label

PROCEDURE

A. **Instrument trays**

1. Instruments with "lock mechanism" or joint hinge are to be sterilized in the open position. Instruments with multiple or sliding parts are to be disassembled for sterilization.

2. Choose appropriate size of wrapper according to size of tray of instruments.

3. Wrap in single sheet twice, according to procedure.

4. Insert internal chemical indicator on tray where it is least accessible to penetration.

5. Secure according to type of packaging.

6. Affix label according to guidelines.

B. **Single instruments**

1. Choose appropriate size, see-through instrument pouch.

2. Insert instrument inside along with internal chemical indicator.

3. Seal according to type of packaging.

4. Affix label according to guidelines.

C. **Small sets of instruments**

` 1. Wrap in single wrapper according to size with internal chemical indicator placed in that area of the set considered to be least accessible to penetration.

2. Place in second wrapper.

3. Seal according to type of packaging

4. Affix label according to guidelines.

D. **Catheters and tubing**

1. After cleaning, pre-moisten lumen with distilled water.

2. Package and sterilize immediately.

Manual:	Infection Control	Subject:	Recall Policy in the Event of Sterilized Goods Being Contaminated	Approved by:
Section:	Sterilization	Code:	IC - S - 4a	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised	01-22-01 7-6-2012	

RECALL POLICY IN THE EVENT OF STERILIZED GOODS BEING CONTAMINATED

POLICY

This policy applies when contamination of sterilized goods due to H_2O contamination, rips or tears in wraps, or improper sterilized temperature occurs.

1. Those items involved will be removed from the shelf and resterilized.

2. If the physician must be notified for a case involved:
   a. Notify nurse manager and administrator
   b. Notify doctor's office
   c. Notify infection control

3. Recall in the event of contaminated manufacturer goods is as follows:
   a. Notify nurse manager
   b. Refer to *Log Implant Book*
   c. Notify administrator
   d. Notify physician involved
   e. Notify infection control

For sterilizer load identification, refer to *Daily Sterilizer Load Book.*

Manual:	Infection Control	Subject:	Shelf Life	Approved by:
Section:	Sterilization	Code:	IC - S - 5	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7-6-2012	

SHELF LIFE

PURPOSE

To provide guidelines for determining the status of sterility of prepacked items.

POLICY

A. Loss of sterility of package contents is considered event related and not time related and is dependent in part by the type of packaging used.

B. Event related factors include:
   1. Frequency and method of handling
   2. Storage area conditions such as location, space, open/closed shelving, temperature, humidity, dust, insects, flooding, vermin, etc.

PROCEDURE

A. Shelf life is according to the following guidelines or until discovery that integrity of packaging is compromised.
   1. Commercial - as printed on package. If not dated, package is sterile as long as package is intact.
   2. All other items are considered sterile indefinitely unless package integrity is questioned. Double peel packs are not required.
   3. Dust covers - indefinite.
   4. Items wrapped in two layers of CSR wrap (no dust cover) are sterile as long as package is intact and has not been compromised.
   5. Items placed in a closed container system have an indefinite shelf life as long as integrity of the container has not been compromised.

Manual:	Infection Control	Subject:	Loading Sterilizer	Approved by:
Section:	Sterilization	Code:	IC - S - 6	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7-6-2012	

LOADING STERILIZER

PURPOSE
To provide guidelines for loading the sterilizer in order to allow for free circulation and penetration throughout all portions of the load.

POLICY
A. The sterilizer load will be arranged in such a manner as to present the least possible resistance to the passage of steam through the packages.

B. In operating all sterilizers, the manufacturer's recommendations must be followed.

PROCEDURE
A. Wrapped articles must be arranged in the sterilizer so that they rest on the edge rather than flat side up. This is to permit prompt and complete permeation of the materials with the moisture and heat of the steam.

B. Packs should be resting on edge in loose contact with each other.

C. The upper layer is placed crosswise of the lower layer.

D All jars and other non-porous containers for dry materials should be loaded in the sterilizer to provide a horizontal path for the escape of air.

E. Rigid containers, regardless of method of sterilization used, will be placed flat on sterilizer shelves.
   1. Stacking must be in accordance with manufacturer's guidelines.
   2. If loads are mixed, containers should be placed on shelves below absorbent items.

Manual:	Infection Control	Subject:	Chemical and Biological Indicators	Approved by:
Section:	Sterilization	Code:	IC - S - 7	
Category:		Date: O:	3-10-96	
		Revised Date:	01-22-01	

CHEMICAL AND BIOLOGICAL INDICATORS
(Sterilizer Test, Failure and Recall)

PURPOSE
To monitor the sterilization process to detect failures in packaging, loading and/or sterilizer function. To document the efficacy of specific sterilization cycles.

POLICY
A. Chemical indicators will be used on each wrapped item to be sterilized and on all Immediate-useed instruments trays.

B. Biological Indicators (ATTEST) appropriate to type of load of sterilization method to be run in each sterilizer will be run daily prior to sterilizer use. They will be documented in log book. Results will be monitored and documented in log book.

PROCEDURE
A. Chemical indicators
   1. An external chemical indicator should be clearly visible on the outside of each package to be sterilized. Any marking will be done on the indicator tape to prevent bleeding of the ink into the package.

   2. An internal chemical indicator should also be used within each package or open tray to be sterilized. The indicator must be placed in that area of the package considered to be least accessible to penetration; this may or may not be the center of the pack. Peel pack items require an external indicator which is part of the package and an internal indicator must be present.

   3. Chemical indicator results should be interpreted according to manufacturer's written instructions and indicator reaction specifications.

   4. The indicators must be examined after sterilization and before use to make sure it indicates that the items have been exposed to sterilization.

5. If the indicator suggests inadequate sterilization, the contents of the package must not be used. The supervisor must be notified to investigate for possible malfunction of sterilizer equipment or improper preparation of item for sterilization.

B. Biological indicators

1. Biological indicator test packs should be used on the first load of wrapped hardgoods daily for Prevac cycles only. Immediate-use biological indicator should be used prior to the first load daily and results documented (Gravity Cycles use an attest in a peel pack for test pack). A rapid read out attest should be done on each sterilizer.

2. Measurements should be performed with a biological indicator that employs spores of established resistance in a known population.

3. Each load containing implantable objects should be monitored with a rapid readout biological indicator. These objects should not be used until the test is negative at one hour.

4. Prior to being exposed, the test pack must be identified with appropriate sterilizer number and load information. (Prevac cycles only). Gravity cycles: Attest in a peel pack for test pack are to be used and load and sterilizer number present.

5. The test pack should be placed in the area of the sterilizer that is most commonly used or will most challenge all sterilization parameters.
   a. On edge at the front bottom, near the door in a routinely loaded steam sterilizer.

6. A normal cycle must be run as specified by the sterilizer manufacturer.

7. Subsequent to being exposed to the sterilization cycle, the biological indicator is removed from the sterilized load and its identification noted. All biological indicators used in challenging the sterilization cycle and as controls must be accounted for after their use. These are discarded in a rigid, leakproof biohazard container.

8. The biological indicators must then be handled according to the manufacturer's instructions.

9. If the test is positive, the sterilizer should immediately be rechallenged for proper use and function.

10. If a sterilizer malfunction is discovered, all available items from the suspect load(s) should be recalled and reprocessed. The malfunctioning sterilizer will not be used until it has been serviced and successfully tested according to manufacturer's recommendations.

C. Chemical/biological indicators do not prove that items are sterile but that required parameters have been met.

Manual:	Infection Control	Subject:	Pre-vacuum Sterilizer Testing of Air Removal Systems	Approved by:
Section:	Sterilization	Code:	IC - S - 8	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7-6-2012	

PRE-VACUUM STERILIZER TESTING OF AIR REMOVAL SYSTEMS

PURPOSE
To test the proper removal of air from the chamber during the pre-vacuum stage.

POLICY
The air removal test will be performed daily prior to the first sterilization cycle.

PROCEDURE
A. The Dart/Bowie Dick evaluates the ability of pre-vacuum sterilizers to reduce air residuals effectively from chamber space. If air has not been sufficiently removed, steam will drive air back into the load, air pockets will develop and sterilizing conditions will not occur.

B. To perform the air removal test, if sterilizer is not already at operating temperature, bring unit up to operating conditions (270º - 274ºF) by running a preliminary nonprocessing cycle, four (4) minutes with no dry time.

C. Place the Dart/Bowie Dick horizontally at the bottom front of the sterilizer near the door, in an otherwise empty chamber.

D. Operate a standard pre-vacuum cycle (270ºF) with exposure time set for between three and one half (3.5) and four (4) minutes depending on manufacturer's recommendation). **For best results, exposure times should not exceed four (4) minutes: drying times do not affect results.**

E. Interpret results per manufacturer's instructions. **Note: A vacuum leak test must be done weekly per manufacturer recommendation.**

F. After interpreting the result, enter the date, sterilizer number and operator ID on the chart.

G. In the event of a failed Dart/Bowie Dick, a challenge study will be performed. If there is a second failure, the sterilizer must not be used until it is serviced.

H. If the challenge study is acceptable, a third verification study will be performed prior to use of the unit.

Manual:	Infection Control	Subject:	Sterilizer Records	Approved by:
Section:	Sterilization	Code:	IC - S - 9	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7-6-2012	

STERILIZER RECORDS

PURPOSE
To document monitoring process as it occurs to determine cycle parameters are met and to establish accountability.

POLICY
A. Pertinent information will be recorded and maintained for each sterilization cycle, routine and Immediate-use.

B. Documentation will be utilized to determine whether recalls are necessary, and the extent of recalls, should evidence subsequent to lot release, such as a positive biological indicator, suggest sterility problems.

PROCEDURE
A. Determine that supplies are available to provide continuity of recording throughout sterilization process.

B. The following information will be recorded and maintained for each sterilization cycle.
   1. Load
   2. General content of the lot or load (e.g. instrument packs, linen packs)
   3. Exposure time and temperature, if not provided on the recording chart
   4. Name or initials of the operator
   5. Results of biological testing, if applicable
   6. Response of chemical indicator placed in the biological indicator test pack, if applicable
   7. Results of leak testing, if applicable
   8. Any reports of inconclusive or nonresponsive chemical indicators found later in the load.

C. The time and temperature recording chart or tape, if applicable, will be dated and maintained and each cycle will be initialed.

D. A record of repairs and preventive maintenance will be maintained for each sterilizer.

Manual:	Infection Control	Subject:	Storage and Distribution of Disposable Supplies	Approved by:
Section:	Sterilization	Code:	IC - S - 10	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7-6-2012	

STORAGE AND DISTRIBUTION OF DISPOSABLE SUPPLIES

PURPOSE
To prevent introduction of contaminated material into clean storage areas.

POLICY
Traffic pattern is to be followed in the storage and distribution of sterile and non-sterile supplies.

PROCEDURE
A. Prior to distribution to clean or sterile storage areas, supplies must be removed from their shipping containers and transported to their designated area. No corrugated multi-layer cardboard containers will be allowed in the restricted area.

B. Supplies are then placed on shelves in the clean or sterile storage areas.

C. Each operating room and all patient areas are stocked from sterile supply area as needed each day.

D. Items not stocked in the sterile area include:
   1. Pillows
   2. Pillow cases and sheets
   3. Cleaning solutions

   The above items are stocked in preop, PACU or housekeeping storage area.

Manual:	Infection Control	Subject:	Cleaning Blood Pressure Cuffs and Stethoscopes	Approved by:
Section:	Sterilization	Code:	IC - S - 11	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7/6/2012	

CLEANING BLOOD PRESSURE CUFFS AND STETHOSCOPES

PURPOSE
To provide guidelines for appropriate cleaning of equipment used for monitoring vital signs.

POLICY
Disinfection of blood pressure cuffs and stethoscopes is necessary if in contact with open sores, drainage, etc.

PROCEDURE
A. Routine cleaning
   1. While wearing gloves, apply disinfectant solution on blood pressure cuff and stethoscope, allow appropriate contact time and wipe dry.

B. Cleaning after contamination with blood or body fluid
   1. While wearing gloves, completely dismantle equipment.
   2. Soak in a high-level disinfectant for the time recommended by manufacturer.
   3. Rinse thoroughly with water.
   4. Allow to dry completely.
   5. Reassemble item and test for proper working order.

Manual:	Infection Control	Subject:	Processing of Contaminated Anesthesia Equipment	Approved by:
Section:	Sterilization	Code:	IC - S - 12	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7-6-2012	

PROCESSING OF CONTAMINATED ANESTHESIA EQUIPMENT

PURPOSE

To prevent cross contamination between patients during the administration of anesthetic agents.

To provide guidelines for methods of decontamination acceptable for reusable anesthesia equipment.

POLICY

A. The entire anesthesia equipment system should be terminally cleaned and reusable components either high-level disinfected or sterilized. Single use components will be discarded after use.

B. All reusable equipment will be disinfected between each patient's use. Items in direct contact with patient's mouth and nose secretions will be subjected to high-level chemical disinfection immediately after use.

C. In the event of treatment of a patient with recognized infectious disease, single use items will be used to the extent possible and all discarded with infectious waste. Reusable items will be sterilized.

DEFINITION OF HIGH-LEVEL DISINFECTION

Some disinfection procedures are capable of producing sterility if they are continued long enough to kill all but resistant bacterial spores, they are called high-level disinfection processes.

Intact mucous membrane are generally resistant to infection by common bacterial spores but not by many other organisms such as viruses and tubercle bacilli; it is “less critical” that objects touching mucous membranes be sterile, although these require a disinfection process that kills all but resistant bacterial spores.

Objects contaminated with virulent organisms, such as hepatitis viruses, Shigelia, or multiply-resistant gram-negative bacilli, may require disinfection even if their use would normally dictate only cleaning.

Tubercle bacilli and poliocoxsackie, echo and rhino viruses are resistant to most germicidal agents and require high-level disinfection if they are to be reliably eliminated from reusable object.

High-level disinfection can be accomplished by hot water pasteurization or liquid chemicals.

PROCEDURE

A. Single use items will be discarded immediately after use:
   1. Single use endotracheal tubes
   2. Esophageal stethoscopes
   3. Levine tubes
   4. Single use masks
   5. Monitoring electrodes
   6. Needles and syringes
   7. Regional block trays (local infiltration)
   8. Suction catheters
   9. Airways
   10. Breathing circuits

B. Grossly contaminated single use items will be discarded in accordance with facility policy regarding biohazardous waste.

C. Reusable metal equipment (e.g. laryngoscope blades, Magill forceps, stylettes) is to be sterilized or subjected to high-level chemical disinfection immediately after each use.

D. Reusable objects must be thoroughly cleaned before processing because organic material (e.g. blood and protein) inactivate disinfectants and protect microorganisms from disinfection and sterilization.

E. High-level disinfection of reusable equipment must be soaked for the time recommended by the manufacturer. Tubing must be completely filled for disinfection.

F. Criteria for the selection of an appropriate cleaning or disinfecting agent should include, but are not limited to, the following:

1. The physical removal (cleaning process) of microbes may be adequate, or the inactivation of microbes (disinfection) may be desired.
2. The cleaning agent should be safe, effective, and compatible with the surfaces cleaned and soil loads involved.
3. The disinfectant, when used, should be:
    a. Compatible with the cleaning agent.
    b. Safe for use by personnel and with the equipment.
    c. Effective against the microbial population involved considering inactivation of disinfectant by extraneous factors such as organic debris, water hardness, and PH.
    d. Free from harmful residues.
4. Recommended agents
    a. Iodophor - use only a product approved for disinfection by the EPA.
    b. Glutaraldehyde (a 2% solution has been customary for high-level disinfection)

G. Objects disinfected with liquid chemicals for cleaning purposes only, must be rinsed in sterile water (or water containing at least 10 mg/liter free residual chlorine, e.g. a fresh 1:5000 dilution of a household bleach that is 5.25% hypochlorite solution) to remove possibly toxic or irritating residues.

H. Cleaning anesthesia machines

1. The exterior surfaces of anesthesia machines, instruments attached to and kept on them, and equipment carts will be thoroughly cleaned with an appropriate agent at least every twenty four (24) hours and when visibly contaminated.
2. Absorbers will be cleaned when C02 absorbent is changed, paying particular attention to accumulated absorbent dust.

Manual:	Infection Control	Subject:	Care of Carbon Dioxide Absorbing Granules Container	Approved by:
Section:	Sterilization	Code:	IC - S - 13	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01	

CARE OF CARBON DIOXIDE ABSORBING GRANULES CONTAINER

PURPOSE
To determine that carbon dioxide absorber unit does not present an opportunity for cross infection.

POLICY
If infectious respiratory condition is suspected, carbon dioxide absorbing granules will be replaced and system disinfected.

PROCEDURE
A. Dispose of used granules in container for biohazardous waste.

B. Disinfect system according to procedure.

C. Replace new canister.

D. Determine that system is free from air leaks.

Manual:	Infection Control	Subject:	Autoclave Start-Up Daily	Approved by:
Section:	Sterilization	Code:	IC - S - 17	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7/6/2012	

AUTOCLAVE START UP DAILY

PURPOSE
To ensure complete pre-sterilization care of the autoclave prior to use.

POLICY
Daily/routine start-up procedure will be followed to allow proper care of all sterilizers according to manufacturer's recommendations.

PROCEDURE
Refer to Manufactures Operating Instructions

Manual:	Infection Control	Subject:	Autoclave Load Record	Approved by:
Section:	Sterilization	Code:	IC - S - 18	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01	

AUTOCLAVE LOAD RECORD

POLICY
Accurate records will be maintained for all sterilization processes.

PROCEDURE
1. All items/trays for sterilization must be listed on the load sheet. All loads will have a load sheet that identifies the load number, autoclave number, sterilization dates and initial of operator. In case of recall, this will present a complete list of items to be pulled from circulation.

2. These load sheets, along with daily autoclave graphs will be kept for up to seven (7) years.

3. The Log sheets can be found in the clean work room and sub-sterile room.

Manual:	Infection Control	Subject:	Routine Maintenance and Cleaning of Steam Sterilizers	Approved by:
Section:	Sterilization	Code:	IC - S - 20	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7-6-2012	

ROUTINE MAINTENANCE AND CLEANING OF STEAM STERILIZERS

PURPOSE
Cleaning the steam sterilizers is necessary to keep the apparatus free from scale and rust.

POLICY
All sterilizers will be cleaned according to manufacturer's recommendations.

PROCEDURE
1 Allow the sterilizer to cool to room temperature by turning off power switch, steam, water supply and steam chamber.

2. Wash surface, interior, sterilizer door and gasket with a mild detergent using a soft brush or sponge. A specially prepared cleaning solution may be used. Never use abrasive cleaning compounds, wire brush or steel wool.

3. Rinse all surfaces with tap water using a sponge or wet cloth.

4. Dry all surfaces with lint-free cloth.

5. Cleaning of sterilizers should be done once weekly.

6. Remove drain trap from chamber drain hole and clean thoroughly.

7. The drain and steam trap should be flushed on a weekly basis using a mixture of sonic detergent and warm water as per the manufacturer's manual.

All routine and preventative maintenance will be completed by the service technician on a quarterly basis.

Manual:	Infection Control	Subject:	Biological Indicator Test Pack for Gravity and Prevac Sterilizers	Approved by:
Section:	Sterilization	Code:	IC - S - 21	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7-6-2012	

BIOLOGICAL INDICATOR TEST PACK FOR GRAVITY AND PREVAC STERILIZERS

PURPOSE
To provide a reproducible, well defined, easily constructed standardized challenge to test sterilizer performance.

POLICY
Biological indicator test packs will be assembled in the following manner for installation testing and routine weekly biological monitoring of both gravity displacement and prevacuum sterilizers, according to manufacturer's recommendations.

PROCEDURE
A. **Prevacuum sterilizer**

1. A commercially prepared steam test pack equivalent to a 16 towel pack with biological indicator will be placed in the sterilization with the first load of wrapped hard goods daily and processed with the load.
2. It will contain the following:
   a. A 1262 attest biological indicator
   b. A record keeping sheet with chemical indicator.

B. **Immediate Use sterilizer/Gravity**

1. Place a Attest(1261)/rapid readout(1291) biological indicators in a peel pack and in a Immediate-use tray with it representative of a typical load.

2. Run for traditional three (3) minute cycle.

3. Cool, crush and incubate rapid readout biological for one (1) hour and attest in 24 hours.

4. Read and record result.

Manual:	Infection Control	Subject:	Procedural Guide for Biological Monitoring	Approved by:
Section:	Sterilization	Code:	IC - S - 22	
Category:	Procedure	Date: O:	3-10-96	
		Revised Date:	01-22-01 7-6-2012	

PROCEDURAL GUIDE FOR BIOLOGICAL MONITORING

(Each vial contains spores of Bacillus Stearothermophilous)

PROCEDURE

1. Place sterilizer number and the date on the biological indicator vial cap and record same information on daily sterilization record form.

2. a. Place test pack for steam cycle to be challenged (gravity wrapped) over drain line.
   b. When cycle is complete and pack is cooled, remove biological indicator and label appropriately.

3. a. Immediate-use biological indicator - place in an open pan.
   b. Place peel pack over drain line.

4. After the biological indicator is cool, check the chemical indicator on the label for color change. Steam turns the indicator to dark brown or black. If the indicator is unchanged, sterilization conditions have <u>not</u> been met. Check sterilization procedures.

5. Activate the biological indicator by fully depressing cap so enclosed ampule is crushed and activation line is covered.

6. Invert vial and shake vigorously to assure complete mixture of contents, then return to upright position.

7. Place processed biological indicator in incubator (55°C)

8. Activate biological control indicator as in Step 5. Label with date and "control." Place control in same incubator as test indicator.

9. Document type of control, test indicator, date, time of incubation and initial of person documenting in log book.

10. The biological indicators for the Immediate Use sterilization cycles provide a high degree of read out reliability following twenty four (24) hours of incubation at 55°C.

11. Check biological indicators for growth at twenty four (24) and forty eight (48) hours. If the test indicators show turbidity and or change to yellow, sterility has **not** been achieved. If test indicator remains purple (Immediate-use) or red (wrapped), sterilization was achieved.

12. A rapid readout biological indicator will be used to monitor gravity displacement Immediate-use sterilizers and when an implantable must be sterilized. A result may be obtained after one (1) hour of incubation, but it must be incubated in the incubator specifically designed for this process.

13. Record results in daily sterilization record books following the minimum incubation time for each biological indicator. (Time out, date and initial.)

14. Dispose of processed indicators as you would other microbiological waste.

Note: Implantables should be withheld from service until sterility is verified.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Label Applicator Gun	Approved by:
Section:	Sterilization	Code:	IC - S - 23	
Category:	Policy/Procedure	Date: O:	3-10-96	
		Revised		

LABEL APPLICATOR GUN

PURPOSE
To clearly identify the sterilization date on all processed items sterilized by the Center.

POLICY
Every processed sterilized tray/package will be recorded on sterilization load sheet in order to identify each load number and contents.

PROCEDURE
Set the top line for:

1. Sterilizer number
2. Month
3. Day
4. Year
5. Load number

This information is necessary on each item as well as recorded on the sterilization load sheet for each sterilization cycle to identify load number and contents.

AMBULATORY SURGERY CENTER

Manual:	Infection Control	Subject:	Sterilizer cleaning	Approved by:
Section:	Sterilization	Code:	IC - S - 24	
Category:	Policy/Procedure	Date: O:	7-20-2012	
		Revised		

SCOPE:
All staff who routinely work with sterilization.

PURPOSE:
To insure complete sterilization of supplies used on a surgical procedure.

POLICY:
Sterilizers will be cleaned as per the recommended method and frequency as defined by the manufacturer.

PROCEDURE:

DAILY:
Check the plug screen strainer and remove lint and sediment from the pores with a brush.

MONTHLY:
The inside of the chamber should be washed with a mild detergent or special sterilizer cleaner at least once a month. Never use strong abrasive, steel wool, and the like. (Chamber should be cool before cleaning).

CARE OF CARRIAGE:
Surfaces should be washed with a mild detergent solution. Use a damp cloth. Begin at the top and work downward.

Manual:	Infection Control	Subject:	Sterrad NX Sterilizer	Approved by:
Section:	Sterilization	Code:	IC - S - 25	
Category:	Policy/Procedure	Date: O:	7-20-2012	
		Revised		

SCOPE:
Clinical staff involved with sterilization.

PURPOSE:
To provide guidelines for the operation of the Low Temperature Gas Plasma STERRAD® NX™ Sterilizer.

POLICY:
The STERRAD® NX™ Sterilization System will be operated in an efficient and effective manner following manufacturer guidelines.

1. The door must remain closed when the sterilizer is not in use.

2. Always check the display panel before starting a cycle. A message should appear indicating that the machine is ready to use.

3. If the "PLEASE INSERT NEW CASSETTE" message appears, insert a new STERRAD® NX™ Cassette before attempting to operate the sterilizer.

4. After the chamber has been properly loaded, close the door and:
   - Enter **Load Item Data**
   - Enter **Cycle Notes**, if desired
   - Select the desired cycle

5. The phases of the sterilization cycle are:
   - **Exposure 1** – Hydrogen peroxide solution is delivered from the cassette to the vaporizer, the pressure is reduced within the sterilization chamber and the vaporizer, water is removed from the solution and concentrated hydrogen peroxide is delivered to the chamber. Plasma is created in the chamber and the chamber is vented following the exposure.
   - **Exposure 2** – The stages of the Exposure 1 phase are repeated. The vent valve is opened and HEPA filtered air is admitted to the chamber, allowing the door to be opened.

6. At the end of the sterilization cycle:
   - A 10 second continuous audible alarm sounds, alerting the operator that the cycle is complete and items can be removed from the sterilizer.
   - The background of the screen turns green, indicating successful cycle completion.

- The printer prints a summary of the cycle parameters.
- Operator can then touch the "**Done icon**" to open the door
- Remove all of the sterilized items and close the door.

7. After the chamber has been properly loaded, close the door and:
   - Enter **Load Item Data**
   - Enter **Cycle Notes**, if desired
   - Select the desired cycle

8. Instrument trays and peel pouches can be labeled with ink or wax markers.

9. Trays must not contain materials manufactured from cellulose base or items such as cotton, paper, cardboard, linen, huck towels, gauze sponges, wood or foam, as these will absorb the hydrogen peroxide and cause cycle cancellation.

10. Count and content sheets can be taped to the outside of the packages after the sterilization process is completed.

11. Traditional paper load stickers may be used if applied at the end of the sterilization cycle. Stickers made from Tyvek® are compatible with the STERRAD® NX™ System.

12. Single use devices and implants should be processed according to written instructions from the original device manufacturers.

13. Do not put liquids or dead end lumens in the STERRAD® NX™ Sterilizer.

14. Vent caps designed for the EtO sterilization process should be placed on flexible endoscopes, following the recommendations from the endoscope manufacturer, prior to processing in the STERRAD® NX™ Sterilizer.

15. Instruments and devices labeled specifically for gravity sterilization should not be processed in the STERRAD® NX™ Sterilizer.

16. ASP recommends processing only lumens that conform to the dimensions that have been validated for the STERRAD® NX™ Sterilizer. Approved lumen dimensions are:

Standard Cycle

- Stainless steel lumens with inside diameter 1mm or larger, length 150mm or shorter
- Stainless steel lumens with inside diameter of 2mm or larger, length 400mm or shorter
- Polyethylene or Teflon® medical tubing with inside diameter of 1mm or larger, length 350mm or shorter

Advanced Cycle

- Stainless steel lumens with inside diameter of 1mm or larger, length of 500mm or shorter

- Single-channel flexible endoscopes with a polyethylene or Teflon® lumen, inside diameter of 1mm or larger and length of 850mm or shorter.

PROCEDURE:

1. Open door to access chamber.
2. Check the display panel. A message should appear stating "TOUCH SCREEN TO START" indicating that the machine is ready to use.
3. Place items to be sterilized inside the chamber.
4. Arrange the load so that trays are in a single layer and do not touch the walls, door or electrode of the sterilizer. The most effective sterilizer performance is achieved when the load contains a mixture of metal and plastic items.
5. The load should be placed in a way that does not occlude the hydrogen peroxide monitor which will lead to a cancelled cycle.
6. Ensure that the sterilizer chamber is not overloaded.
7. All peel-pouch packages should be placed on edge, if possible, with the opaque side of one pouch facing the transparent side of the next pouch.
8. Place the STERRAD® CycleSure® Biological Indicator (BI) inside the sterilizer chamber at the back of the lowest shelf with the Tyvek side facing upward. Ensure that the CycleSure (BI) is not obstructed.

Please refer to your STERRAD® NX™ User's Guide or call the ASP **Customer Care Center** for additional assistance.
Telephone Number 1-888-STERRAD

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST - OPERATION THEATER		
Module Applies To	**All OT Nurses**	**Module No: 24** **Page: 1 of 4**
Effective Date: 11 April, 2013		

COMPETENCY CHECKLIST - OPERATION THEATER

PROCEDURE

1. Use the attached checklist for Operation Theater orientation.
2. The verify column is for preceptor verification initials.

	DATE Reviewed	VERIFY		DATE Complete	COMMENTS
PERIOPERATIVE ORIENTATION:					
1. EMERGENCY & GENERAL EQUIPMENT					
a. O_2					
b. Crash Cart					
c. Defibrillator					
d. Stretchers					
e. Lumenis Laser 100Watt					
f. Pathology Lab (Golwilkar Lab)					
g. Warmers					
h. Warming Blanket					
i. Monitors					
j. Anesthesia cart					
k. Phones					
l. Medication Room					
2. CHARTING FORMS					
a. Pre-op and Intra-op orders					
b. Intra-operative charts					
c. Pre-operative Checklist					
d. Post-operative Checklist					
e. Implant Logs					
f. Sterilization Logs					
i. Autoclave					
ii. Cidex / E.T.O					
g. Specimen forms and logs					
h. Progress Notes					
i. Surgical and Anaesthesia consents					

PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST - OPERATION THEATER		
Module Applies To	**All OT Nurses**	**Module No: 24** **Page: 2 of 4**
Effective Date: 11 April, 2013		

	DATE Reviewed	VERIFY		DATE Complete	COMMENTS
3. GENERAL OT					
a. Suctions					
b. Overhead lights					
c. Electro cautery					
d. Light sources & headlights					
e. Anaesthesia cart and monitors					
f. Nitrous controls					
g. Autoclave					
h. Cidex soaks					
i. General supply cabinets (OR & Anes.)					
j. Sutures					
k. Ultrasonic cleaner					
l. Warming cabinets					
m. O.T tables					
n. Positioning aides					
o. Scrub sinks					
p. Scrubbing					
q. Gowning & gloving					
r. Back table set-up					
s. Draping					
t. Decontamination of instruments					
u. Instrumentations:					
i. Minor tray					
ii. Specialty trays					
iii. Plastic tray					
v. Surgical counts (sponges, sharps, instruments)					
w. Surgical preps					
x. Decontamination/ soil workroom					
y. CSSD					
z. Equipment Room					

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST - OPERATION THEATER		
Module Applies To	**All OT Nurses**	**Module No: 24** **Page: 3 of 4**
Effective Date: 11 April, 2013		

	DATE Reviewed	VERIFY		DATE Complete	COMMENTS
aa. Janitor's closet					
bb. Linen cart and storage					
cc. Trash disposal (general and bio-hazard)					
dd. PPE location (Personal Protective Equipment)					
ee. Policy, Procedure & equipment manuals					
ff. Room prep for cases					
gg. Medications					
hh. Pre-op assessment of patient					
ii. Post-operative report					
4. QA PROGRAM					
a. Incidence Report					
b. Infection Control					
5. PLASTIC					
a. Bi-polar coagulators					
b. Light sources					
c. Elmed cautery					
d. Liposuction (Grams, Medical) -					
i. Cannulas					
e. Lighted retractor with cord					
6. ORTHOPEDIC / SPINE					
a. Video cart					
b. Intelijet for knees					
c. Davol Hydroflex for shoulders					
d. Tourniquets (ATS & Zimmer)					
e. Drills, saws, inserters					
f. Stryker command					
g. Positioning Aides					
i. Knee holder					
ii. Hand table					

NURSING EDUCATION AND TRAINING MODULES

COMPETENCY CHECKLIST - OPERATION THEATER		
Module Applies To	**All OT Nurses**	**Module No: 24** **Page: 4 of 4**
Effective Date: 11 April, 2013		

	DATE Reviewed	VERIFY		DATE Complete	COMMENTS
iii. Shoulder positioner (Schlein)					
h. C-Arm					
i. Arthro wand					
j. Mitek Vapor					
k. Cast cart					
l. Dyonic shaver					
m. Knee & shoulder scopes					
n. Fragment sets					
o. Orthopedic extras					
7. ENDOSCOPY					
a. Video carts					
b. Valleylab					
c. Karl Storz light source					
d. Printer					
e. Video monitor					
f. Scopes					
g. Scope cleaner/decontamination (Unitrol)					
h. Specimens					

Key: N/O – no opportunity to demonstrate

STATEMENT OF COMPLETION

I have:

1. Completed the General Orientation & OR Orientation.
2. Reviewed the Orientation List with the preceptor/OT Matron/Administrative Head of the Center.
3. Had all my questions answered that are pertinent to this orientation.
4. An understanding and working knowledge of all that was covered in this Orientation.
5. An understanding of the purpose, content and location of procedure manuals.

Orientee: _____
Signature Printed or Typed Name of Orientee

Date:_____

Preceptor: _____
Signature Printed or Typed Name of Preceptor

Date: _____

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

NURSING MANUAL II

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PRIME SURGICAL CENTERS

Beck House, Damle Path, Pune.

STANDING AND EMERGENCY PHYSICIAN'S ORDERS		
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PHYSICIAN'S STANDING ORDERS

PURPOSE

To allow patient care and preparation for surgery or discharge to proceed without delay in waiting for the physician to write orders.

POLICY

1. Telephone orders must be presented to the physicians) for signature at the first opportunity. (The record is not complete until all signatures are entered.)

PROCEDURE

1. Always verify with the physician and document verification of any order questioned or which may not be appropriate due to new information available.
2. Check off the order carried out, enter date, time and initial.
3. Document in nurses notes the action taken to fulfill order.

STANDING AND EMERGENCY PHYSICIAN'S ORDERS

PATIENT NAME:_____DATE:_____

STANDING ADMISSION ORDERS:

1. Vital signs and room air oxygen saturation on admission. Continuous monitoring for patients receiving sedation.
2. IV LR 500 - 1000cc for patients receiving anesthesia. Heparin locks for patients having only local anesthesia.
3. Haemoglobin and dipstick urine as ordered. EKG protocol.
4. For diabetics on insulin:
   a. Blood glucose on admit.
   b. D5W 250cc IV piggyback.
   c. Give insulin per anaesthesiologist orders.
5. Other:_____

STANDING ORDERS FOR NURSING UNIT AND POSTOP HOLDING:

1. Oxygen until awake. Monitor with EKG, BP, oximeter.
2. Administer bolus IV fluids to replace deficit as indicated on anesthesia record, then slow to maintenance rate. Give additional fluids per orders from anesthesiologist. Record oxygen saturation at least once on admit to postop holding.
3. ANY PROBLEMS, APPLY OXYGEN AND CALL ANESTHESIOLOGIST.
4. HYPOTENSION: Lower head of bed and bolus IV up to 200cc in adults.
5. LARYNGOSPASM: Place oral airway and give gentle positive pressure with AMBU and oxygen. Notify anesthesiologist.
6. BRADYCARDIA WITH HYPOTENSION: Atropine 0.5mg IV; repeat until pulse >60 in patients >6 years of age to a maximum of 1mg. In patients <75 pounds, give 0.1mg IV, repeat until pulse >100 to a maximum of 0.5mg. PVCs (malignant or symptomatic): Lidocaine 50-100 mg IV; repeat x1 if needed.
7. Discharge from recovery room to postop holding when Aldrete score is 9 - 10.

STANDING AND EMERGENCY PHYSICIAN'S ORDERS		
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8. Chloroseptic lozenges P.O. PRN for sore throat.
9. For diabetics on insulin, check blood glucose prior to discharge and notify anesthesiologist of results.
10. P.O. fluids and solids as tolerated, progressive ambulation as tolerated.
11. PAIN MEDS: Fentanyl IV up to 3cc in □ to 1cc increments in adults.
12. For adults, May choose from the following: Tylenol 500mg 1-2 tabs P.O.; Roxicet 1-2 tabs P.O.; Tylenol with codeine 1-2 tabs P.O.
13. For patients under 75 pounds, Tylenol suppositories per package directions.
14. Nausea and vomiting: See that fluid deficit is met and that vital signs are normal.
15. For patients less than 75 pounds, call anesthesiologist.
16. Adults: One or more of Inapsine 1/8cc IV; Reglan 10-20mg IV; ephedrine 25mg I.M.; Anzimet 12.5 mg IV.
17. Follow discharge protocol until requirements met.
18. Other: _____

_____

_____

Anesthesiologist

Revised by:	**Signature:**
Revision Date:	
Approved By:	**Signature:**
Approval Date:	

SAFETY MANUAL INDEX

Prime Surgical Damle Path,LLP

Beck House,Damle Path,
Off Law College Road,
Pune 411004.

Linen Book **Date :**

Sr. No.	Code No.	Item Description	O.P.D.	O.T.	1st Floor Deluxe Ward	2nd Floor Comfort Ward	Radiology			TOTAL
1		Apron White								
2		Bath Towel								
3		Bed Sheet Cream Colour								
4		Bed Sheet White Colour								
5		Big Sheet Green								
6		Blanket								
7		Cap								
8		Draw Sheet White Colour								
9		Gown								
10		Hand Napkin								
11		Mask								
12		Medium Sheet Green								
13		O.T. Shirt								
14		O.T. Trouser								
15		Patient Shirt								
16		Patient Trouser								
17		Pillow Cover Cream Colour								
18		Pillow Cover White Colour								
19		Pillow Inner Cover								
20		Small Sheet Green								
21		Surgeon Shirt								
22		Surgeon Trouser								

Prime Surgical Damle Path,LLP

Beck House,Damle Path,

Off Law College Road,

Pune 411004.

Linen Book

Department :

Date :

Sr.No.	Code No.	Item Description	Qty. Given for Washing	Qty. Received after Washing	Balance Qty.
1		Apron White			
2		Bath Towel			
3		Bed Sheet Cream Colour			
4		Bed Sheet White Colour			
5		Big Sheet Green			
6		Blanket			
7		Cap			
8		Draw Sheet White Colour			
9		Gown			
10		Hand Napkin			
11		Mask			
12		Medium Sheet Green			
13		O.T. Shirt			
14		O.T. Trouser			
15		Patient Shirt			
16		Patient Trouser			
17		Pillow Cover Cream Colour			
18		Pillow Cover White Colour			
19		Pillow Inner Cover			
20		Small Sheet Green			
21		Surgeon Shirt			
22		Surgeon Trouser			

(Linen Issued By) (Linen Received By)

Prime Surgical Damle Path, LLP

Beck House,Damle Path,
Off Law College Road,
Pune - 411004.

Linen Gate Pass

Date :
Time :

Please allow M/s. ----------
to pass out with dirty linen for washing and return back.

Total linen - Nos.

(Authorized by) (Received by)

Prime Surgical Damle Path, LLP

Beck House, Damle Path,
Off Law College Road,
Pune - 411004.

Non Returnable Gate Pass

Date :
Time :

Please allow Mr. ----------of ---------- to pass out with following material.
Contact No.

SR.NO.	ITEM DESCRIPTION	QUANTITY ISSUED	UOM	REMARKS
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

(Prepared By) (Authorized By) (Received By)

Prime Surgical Damle Path, LLP

Back House,Damle Path, Off Law College Road,

Pune 411004.

Purchase Requisition Slip

Name Of Indentor : | Purchase Requisition Slip No.:

Department : | Date :

Sr.No.	Item Description	Quantity	Remark
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Justification for Purchase :-

Indented By **Sanctioned / Not Sanctioned** **Facility Executive**

Store Stationery Format

Prime Surgical Damle Path, LLP

Beck House, Damle Path,
Off Law College Road,
Pune - 411004.

Returnable Gate Pass

Date :
Time :

Please allow Mr. ----------of ---------- to pass out with following material.
Contact No.

SR.NO.	ITEM DESCRIPTION	QUANTITY ISSUED	UOM	REMARKS
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

(Prepared By) (Authorized By) (Received By)

Surgery Name:-

Surgeon Name:- Dr. ANAND JADHAV

Order Date	Sr. No.	Item Name	Order Qty.	RMO Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.
	1	Inj Perfalgan	3						
	2	Inj Pan 40	1						
	3	Inj Emset 2ml	2						
	4	Inj Dynaper	2						
	5	Inj Sufacef 750mg	2						
	6	Inj Fortwin	1						
	7	Inj Phenargan	1						
	8	Inj Omnikacin 500	3						
	9	Duoline Respules	5						
	10	Budecort Respules	5						
	11	Asthalin Respules	5						
	12	DNS 500ML	1						
	13	RL 500ML	1						
	14	NS 100ML	1						
	15		3						

Surgery Name:-

Surgeon Name:- Dr. ANAND JADHAV

Order Date	Sr. No.	Item Name	Order Qty.	RMO Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.

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Website: www.primesurgical.in

PRIME SURGICAL CENTERS

MR No :	IP No :
Name :	
Age/Sex :	
Comfort/Deluxe Bed No :	
Admission Date :	

PHARMACY REQUISITION
MEDICATION & CONSUMABLES

SPINE - MEDICATION

Surgery Name:-

Surgeon Name:-

Order Date	Sr. No.	Item Name	Order Qty.	RMO Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign
	1	Inj Perfalgan	3								
	2	Inj Pan 40	1								
	3	Inj Emset 2ml	2								
	4	Inj Dynaper	2								
	5	Inj Sufacef 750mg	2								
	6	Inj Fortwin	1								
	7	Inj Amikacin 500mg	2								
	8	Inj Phenargan	2								
	9	DNS 500 ML	1								
	10	RL 500 ML	1								
	11	NS 100 ML	1								
	12	CATH FLUSH	1								
	13	Tab Restyl 0.25									

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PHARMACY REQUISITION
MEDICATION & CONSUMABLES

SPINE - CONSUMABLES

Surgery Name:-

Surgeon Name:-

Order Date	Sr. No.	Item Name	Order Qty.	Nurse Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign
	1	Easy Fix	1								
	2	0 2 Mask Adult	1								
	3	Syr 10cc	4								
	4	Syr 5cc	3								
	5	Microtouch Gloves	2 pair								
	6	Distilled Water 10ml	5								
	7	Galant Blade	2								
	8	DC Alcohol Swab	2								
	9	Vasofix 20 G	1								
	10	Urine Bag	1								
	11	Softswab 10cm*10cm sterile	5								
	12	IV set	1								
	13	Needle 24 11/2"	1								
	14	3 way	1								
	15	Foleys catheter 16	1								

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PHARMACY REQUISITION
MEDICATION & CONSUMABLES

SPINE - MEDICATION

Surgery Name:-

Surgeon Name:-

Order Date	Sr. No.	Item Name	Order Qty.	RMO Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign

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PHARMACY REQUISITION
MEDICATION & CONSUMABLES

SPINE - CONSUMABLES

Surgery Name:-

Surgeon Name:-

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PHARMACY REQUISITION
MEDICATION & CONSUMABLES

UROLOGY - MEDICATION

Surgery Name:-

Surgeon Name:-

Order Date	Sr. No.	Item Name	Order Qty.	RMO Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign
	1	Inj Perfalgan	3								
	2	Inj Pantodac 40mg	1								
	3	Inj Emset 2ml	2								
	4	Inj Dynaper	2								
	5	Inj Fortwin	1								
	6	Inj Phenargan	2								
	7	Inj Tramazac	1								
	8	Inj Gentycin 80mg	4								
	9	Inj Monocef 1gm	2								
	10	DNS 500 ML	1								
	11	RL 500 ML	1								
	12	NS 100 ML	1								
	13	Dextrose 5%	1								
	14	NS 2 LIT	4								
	15	Cath flush	1								

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Admission Date :	

PHARMACY REQUISITION
MEDICATION & CONSUMABLES

UROLOGY - CONSUMABLES

Surgery Name:-

Surgeon Name:-

Order Date	Sr. No.	Item Name	Order Qty.	Nurse Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign
	1	O2 Mask Adult	1								
	2	Easy Fix	1								
	3	Syr 10cc	4								
	4	Syr 5cc	3								
	5	Microtouch Gloves	2 pair								
	6	Distilled Water 10ml	5								
	7	Easy Fix	1								
	8	DC Alcohol Swab	2								
	9	vasofix 20 G	1								
	10	Urine bag	1								
	11	Softswab 10cm*10cm sterile	5								
	12	IV set	1								
	13	Needle 24 11/2"	1								
	14	3 way	1								
	15	Foleys catheter 16	1								

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UROLOGY - CONSUMABLES

Surgery Name:-

Surgeon Name:-

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PHARMACY REQUISITION
MEDICATION & CONSUMABLES

ORTHOPEDICS - MEDICATION

Surgery Name:-

Surgeon Name:- Dr. Ashish Babhulkar

Order Date	Sr. No.	Item Name	Order Qty.	RMO Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign
	1	Inj Perfalgan	3								
	2	Inj Pan 40	1								
	3	Inj Emset 2ml	2								
	4	Inj Dynaper	2								
	5	Inj Sufacef 750mg	1								
	6	Inj Fortwin	1								
	7	Asthalin Respules	4								
	8	Budecort Respule	4								

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Admission Date :	

PHARMACY REQUISITION
MEDICATION & CONSUMABLES

ORTHOPEDICS - CONSUMABLES

Surgery Name:-

Surgeon Name:- Dr. Ashish Babhulkar

Order Date	Sr. No.	Item Name	Order Qty.	Nurse Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign
	1	DNS	1								
	2	Cathflush	1								
	3	Syr 10cc	2								
	4	Syr 5cc	3								
	5	Nonsterile Gloves 6.5	2								
	6	Nonsterile Gloves 7	1								
	7	Distilled Water 10ml	5								
	8	NS100ml	1								
	9	DC Alcohol Swab	2								
	10	Vasofix 20 G	1								
	11	RL 500ml	1								
	12	Gauze 4"	5								
	13	IV set	1								
	14	Needle 24 11/2"	1								
	15	3 way	1								
	16	Swaft swab	5								

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Age/Sex :	
Comfort/Deluxe Bed No :	
Admission Date :	

PHARMACY REQUISITION
MEDICATION & CONSUMABLES

ORTHOPEDICS - MEDICATION

Surgery Name:-

Surgeon Name:- Dr. Ashish Babhulkar

Order Date	Sr. No.	Item Name	Order Qty.	RMO Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign

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Admission Date :	

PHARMACY REQUISITION
MEDICATION & CONSUMABLES

ORTHOPEDICS - CONSUMABLES

Surgery Name:-

Surgeon Name:- Dr. Ashish Babhulkar

Order Date	Sr. No.	Item Name	Order Qty.	Nurse Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign

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PHARMACY REQUISITION
MEDICATION & CONSUMABLES

SPINE - MEDICATION

Surgery Name:-

Surgeon Name:-

Order Date	Sr. No.	Item Name	Order Qty.
	1	Inj Perfalgan	3
	2	Inj Pan 40	1
	3	Inj Emset 2n	2
	4	Inj Dynaper	2
	5	Inj Sufacef 7	2
	6	Inj Fortwin	1
	7	Inj Amikacin	2
	8	Inj Phenarga	2
	9	DNS 500 ML	1
	10	RL 500 ML	1
	11	NS 100 ML	1
	12	CATH FLUSH	1
	13	Tab Restyl 0.25	

PRIME
SURGICAL CENTERS

MR No :	IP No :
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Age/Sex :	
Comfort/Deluxe Bed No :	
Admission Date :	

RMO Sign	Issue Qty.	Issue Date	Nurse Sign	Used	Return Qty.	Return Date & Time	Pharma Sign