OBJECTIVE OF THE NURSING SERVICE

The objectives of the Nursing Service are congruent to the vision, mission of Ospital ng Parañaque.

1. To establish, maintain and utilize standards of safe and ethical nursing practice.

2. To support the program of the Hospital to be the premier and compassionate healthcare provider, committed to providing quality services to the people of Parañaque.

3. To establish a systemic staffing, pattern of nursing personnel that can provide quality and safe nursing care to patient according to their skills level.

4. To coordinate with the hospital administrator, budget, supplies and property section in requisition of resources and funding for in-service training program and seminars.

5. To develop evaluation tools as means of providing information on staff performance, goal of care and in identifying needs for improvement.

6. To promote professional competencies by encouraging and providing opportunity for in-service training, formal studies and attendance to professional activities offered by outside agencies.

7. To provide training programs to trainee and newly hired personnel in order to widen their clinical experiences through actual exposure to different clinical areas under direct supervision of their highest staff.

8. To provide affiliating nursing and midwifery students an environment conducive to learning and provide them with related learning experience.

POSITION DESCRIPTION

CHIEF NURSE

1. Carries full administrative responsibilities and authority in planning, organizing, directing and controlling of the Nursing Service activities in the Hospital.
   1.1 Planning
   - Participate in formulating Hospital policies to develop and evaluate programs and services,
   - Lead and be responsible for development of the policies for the Nursing Service
   - Preparing budget proposal for the Nursing Division
   - Plan, implement and evaluate the staff development programs for different categories of nursing personnel.

   1.2 Organizing
   - Set-up organizational structure and identify groupings, roles and relationships.
   - Determine staffing requirements
   - Develop and maintain staffing patterns distribution in areas most needed
   - Develop position description, define qualifications and functions of personnel.

   1.3 Directing
   - Delineate line of authority, responsibility, accountability in terms of decision making and setting of regulations and procedures.
   - Direct the setting up of a system of control in records and reports for administrative use.
   - Utilize/ revise/ update policies and procedure
   - Promote harmonious relationship among the Nursing personnel and sub units.
   - Develop staff duties and knowledge through development programs

   1.4 Controlling
   - Review and revise performance measures for staff upgrading
   - Monitor and evaluate nursing care/ services for the improvement of nursing in relation to the total care of the patient
   - Recruit and recommend personnel for appointment, promotion or dismissal depending on the staffing needs of services.
2. Act as inter-agency liaison of the hospital as the need arises.
3. Make rounds to gain information on the problems and needs as presented by the client, family, the nurses and other health personnel.
4. Plan, direct and evaluate the time slots, areas and facilities for affiliating nursing schools/ colleges/ universities.
5. Recommend courses of actions/ activities related to placement, promotion and personnel discipline.
6. Carry out responsibilities delegated by the Chief of Hospital.

ASSISTANT CHIEF NURSE

1. Assists the Chief Nurse in the planning of over-all activities of the Nursing Service.
2. Assists in the formulation, revision, and implementation of hospital and nursing policies.
3. Assists in the budget preparation for equipment, supplies, physical facilities and personnel.
4. Makes general rounds to all wards and special departments noting down the needs and problems of patient, personnel and unit as a whole.
5. Checks and review a 24 hour report on the actual total number of patients' admissions, discharges, deaths, number treated, and number of surgery done.
6. Assists in planning and organizing continuous staff development program.
7. Assists in screening applicants for the nursing service,
8. Assists in maintaining discipline through proper counselling of nursing personnel.
9. Assists in budget preparation in the Nursing Service.
10. Assists in the preparation and evaluation of personnel performance rating.
11. Assists in performing CQI activities in the hospital.
12. Assume functions of the Chief Nurse in her absence.

NURSE SUPERVISOR

1. Assist the Head Nurses in planning, organizing, directing and controlling of over-all operation of the areas and reports to the Chief Nurse.
2. Identify and prioritize the Nursing Care required.
3. Supervise/ coordinate/ participate in staff development programs.
4. Establish an ambiance conducive to working human relationship as well as effective and efficient role modelling.
5. Recommend courses of actions/ activities related to placement, preservation and personnel disciplines.
6. Facilitate the gathering of information and reporting
    a. Daily supervisor's reports
    b. Progress of Nursing Care Program/ Plan of Care
    c. Mortality and Morbidity
    d. Incident report
    e. Status of staff, units, equipments, facilities, supplies and materials.
7. Evaluate and record the quantity and quality of services rendered by the Nursing personnel and possible individual teaching on the basis of findings.
8. Facilitate learning experiences for student nurses and on-the job training by providing the nursing facilities and learning modules.
9. Act as chairperson in the assigned committee.
10. Act in the capacity of the Chief Nurse, performs delegated duties and responsibilities in her absence.

HEAD NURSE

1. Assess and classify the over -all Nursing care needs of the client in each designated area.
2. Lead in the formulation of the general nursing care program based on the assessed client's needs/ priorities
3. Ensure the strict implementation of hospital policies, rules and regulations through interpretation of nursing personnel.
4. Schedule assignments of personnel, off duties, leave of absence and holidays taking into consideration special request and submit to the Chief Nurse.
5. Supervise, assess and evaluate the performance of the unit personnel and provides assistance when needed.
6. Coordinate needs for supplies, repairs, maintenance of equipment and submit to the Chief Nurse.
7. Coordinate and participate in staff development programs, research and orientation courses.
8. Assist in discharge planning, referral to other agencies and return to Out-patient department.
9. Counsel and guide personnel with their strengths and weaknesses and recommends disciplinary actions when needed.
10. Analyze unit problems with the staff and elevate to superiors those that cannot be solved at the unit level.
11. Coordinates with clinical instructors and participate in selecting learning experiences for student affiliates.
12. Submit regular reports on time.

2nd IN COMMAND

1. Act in the capacity of the Head Nurse and perform obligated duties and responsibilities in her absence

STAFF NURSES

1. Establish rapport with patient and family
2. Assess individual client needs for nursing care based on:
   a. Nursing history obtained
   b. Results of physical examination
   c. Analysis of the results of laboratory tests
3. Plan/ prioritize nursing care activities and program
   a. Establish priorities of nursing diagnosis
   b. Coordinate with health team members in planning for patient care
   c. Correlate nursing care plan with medical plan of care
   d. Select appropriate nursing intervention/ action
   e. Write nursing care plan
4. Institute nursing intervention relevant to overall plan of care
   a. Perform nursing procedure/ techniques accurately, completely and safely
   b. Provide health teaching for patient/family
   c. Execute legal orders of the physician relevant to the nursing needs, observes the correct rights in administering medicines

    d. Reassess patient to determine whether a re-modification of care plan is necessary
5. Evaluation of nursing intervention
    a. Monitor patient's status throughout tour of duty
    b. Evaluate the efficiency and effectiveness of nursing intervention rendered
    c. Document nursing intervention completely, accurately and on time
6. Conduct discharge planning with patient/family
7. Participate in nursing activities, program and research for the advancement of nursing practice and patient care

OPERATING ROOM NURSES

1. Provide pre-operative nursing care to patient
    a. Visit the patient a day prior to surgery
    b. Assess their emotional readiness for surgery
    c. Report and document any unusual observation
2. Receive patient for surgery and check for:
    a. Type, schedule of operation and surgeon
    b. Pre-op checklist
    c. Coordinate with surgeon any preference in instruments and supplies
3. Assist in positioning of patients on the OR table and preparation of the operative site.
4. Assist the surgeon skilfully as scrub nurse or circulating nurse.
5. Assume responsibility for correct sponge and instrument count.
6. Maintain accurate and complete record of the pre- and intra-op care given to the clients.
7. Report and record post-op vital signs and abnormality or untoward signs and symptoms.
8. Make proper endorsement of patient to staff nurse in the recovery unit.
9. Responsible for the maintenance of supplies, instruments, equipments and area cleanliness.

RECOVERY ROOM NURSES

1. Receive patient from OR Nurse for continuity of care.
2. Assess patient's condition, monitor vital signs, record and report any untoward signs and symptoms and/or complications
3. Provide nursing care needed while patient is under his/her care/
4. Reassure patient when consciousness is regained and orient patient from time to time and surroundings.
5. Endorse patient to incoming nurse or ward.
6. Responsible for the maintenance of supplies, equipments and area cleanliness.

MIDWIFE

1. Attend promptly upon patient's arrival to Labor/Delivery Room.
2. Obtain patient's obstetrical history and other pertinent data
3. Establish rapport for delivery process/coaching.
4. Document and monitor vital signs, FHT, identify and report significant deviation to resident physicians
5. Perform procedures such as:

a. Perennial prep, shaving and perennial washing
b. Emergency vaginal delivery
c. Newborn care

6. Assist the OB consultant/medical officer in performing vaginal delivery.
7. Perform other duties relevant to knowledge preparation and skills as designated and with supervision.
8. Encourage client to breast feed and initiate maternal bonding.
9. Accompany and endorse patient to DR/ Ward.
10. Responsible for the maintenance of supplies, instruments, equipments and area cleanliness.

NURSING ATTENDANT

1. Participate in the endorsement rounds.
2. Receive and endorse area articles, instruments and equipments. Report to the senior nurse any loss or breakage for proper action.
3. Monitor and record vital signs and report any significant deviation observed.
4. Assist the nurse in performing simple nursing procedures such as tepid sponge bath, enema, bed bath, etc. To patients.
5. Keep records of patient's intake and output of fluids.
6. Prepare beds for incoming patients; strip off and properly dispose soiled linen of discharged patients.
7. Distribute specimen bottles to patients; collect and bring down to the laboratory all properly labelled specimen containers.
8. Carry out clerical jobs in the absence of the unit clerk.
9. Monitor and charge oxygen consumption used by the patient.
10. Responsible for the maintenance of supplies, equipments and area cleanliness.

CENTRAL SUPPLY AND STERILIZATION UNIT

1. Request and maintain adequate stocks of supplies.
2. Prepare supplies for sterilization.
3. Dispose and control sterilized supplies.
4. Request for printing and arranging of risograph forms.
5. Control and monitor the outgoing and incoming supplies and equipments.
6. Conduct a regular inventory of equipments and supplies in all clinical areas.
7. Conduct a monthly inventory of all CSSU items and hospital clinical items.
8. Request and maintain adequate stocks of oxygen.
9. Ensure safety and security of the unit as well as the item in the unit.

DIVISIONAL SECRETARY

1. Makes records and relays telephone calls to the Chief Nurse and supervisor.
2. Relay messages of the Chief Nurse to different nursing areas.
3. Files, records and ensures security of all important documents.
4. Types and distributes memorandum, reports, written communications, schedule of duties and leave forms.
5. Records and reports absences, tardiness and leaves.

6. Coordinates with affiliating schools regarding affiliation fees of the students and other important communication.

CLINICAL CLERK

1. Maintenance of record
   a. Keep patient's charts in order at all times
   b. Record all admitted and discharged patients.
   c. Record and submit all discharged charts with final diagnosis to the record section.
   d. Submit and coordinate with accounting section regarding bills, SSS and Philhealth funds.
   e. Update area bulletin board.
2. Clerical activity
   a. Type various reports and communications.
   b. Prepare job requisition, job order and submit to appropriate section for proper action.
   c. Keep notation of DTR's requests, leave of absence, meetings, conferences and lectures.
   d. Check availability of supplies including charts forms.
   e. Answer and make telephone calls for purposes of information and clarifications.
   f. Bring written communication, referrals and messages to appropriate persons or department.
   g. Coordinate activities of the unit with other department for smooth functioning.
   h. Help in the cleanliness and orderliness of the unit.
3. Clinical activity
   a. Perform daily rounds in order to identify and report the following:
      - General cleanliness of the room
      - Patient and watcher's complaints
      - Compliance to visiting hours
   b. Submit OR proposals (elective)
   c. Submit laboratory requests and specimen.
   d. Assist the Nursing Aide and Utility Worker with the following:
      - Maintenance and monitoring of supplies and equipments
      - Setting-up equipments and packing of equipments
      - Charging of supplies used
   e. Facilitate the following:
      - Referrals
      - Ambulance conduction
      - Social service assistance
   f. Perform other duties relevant to knowledge and skills as designated under supervision.

UTILITY WORKER

1. Transport patients to and from different areas as directed.
2. Accompany patients in ambulance conduction and/or transfer to other hospital if needed.
3. Ensure safety of the environment through regular check-up and cleaning of all unit equipments and report to senior nurses all breakages and losses.
4. Deliver specimen like urine, stools etc. for examination to the laboratory.

5. Perform daily routine housekeeping activities in the unit. Participates with the housekeeping staff during general cleaning and fumigation of the area.
6. Assist in lifting, positioning, turning and dressing of patient.
7. Shave male patient for operation with supervision.
8. Pack linen supplies for sterilization.
9. Dispose soiled linen to Linen Section.
10. Operates autoclave machine and distribute sterilized item to the unit.
11. Check and maintain the availability of oxygen tank needed in the unit.

POLICY ON TRAINING PROGRAM OF NURSE TRAINEES

POLICY NO: NSO-001

DIVISION: NURSING SERVICE DIVISION

POLICY REVIEW DATE: July 12, 2016

Reviewed by:	**Reviewed by:**
Angeline L. Brillante, RN, MAN Assistant Chief Nurse	Arleen G. Herrera, RN, MAN OIC- Nursing Division
Reviewed by:	**Approved by:**
Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

This training program offers the newly graduate nurse (board certified) to widen their clinical experience through actual experiences to the different clinical areas with supervision by an official nurse educator.

COVERAGE:

This shall cover Nursing staff with supervisory levels.

RESPONSIBILITIES:

I. It shall be the responsibility of the Chief Nurse to oversee the implementation of this policy; to command order and obedience by trainees.
II. Responsibility of trainees to maintain a 100% attendance during the required training period, to comply and abide with all the rules and regulations set by this hospital.

POLICY:

I. This policy shall ensure that all trainees to comply with the requirements set for certificate awarding.
II. This policy shall regulate the movements of such trainees so as not to jeopardize the health condition of patients and the entire service as a whole.

PROCEDURE:

I. Trainees are accepted only after the completion of the requirements of the Nursing service with the recommendation from the City Hall approved by the Hospital Director who shall in turn forward it to the Chief Nurse for evaluation.

II. Qualified applicants must complete the following requirements prior to scheduling for written examination:
   1. Personal Data Sheet (PDS) with 2x2 pictures
   2. Application letter
   3. Board rating (photocopy)
   4. Transcript of record (photocopy)
   5. Diploma (photocopy)
   6. IV Therapy card (photocopy)
   7. Seminars/trainings attended (photocopy)
   8. PNA membership
   9. BLS certificate training

III. He/ she must pass the qualifying examination (written and oral) with a score of 85%.

IV. Trainees shall furnish this office a waiver of non-expectation for a job position after training.

V. They shall be expected to actively participate in all in-service training programs and nothing beyond the allowed practices of this Division.

VI. They shall be recommended if qualified to a vacant position. He/she must have undergone three (3) months training and exposure in all clinical areas, with a very satisfactory performance rating and must pass the pre-qualifying examination and interview.

VII. They shall work under the direct supervision/ monitoring of an official staff of this institution.

VIII. Grading system shall be followed to ensure training is comprehensive prior to issuance of certificate.

IX. No certificate of training will be issued for those who have not completed the required number of hours.

APPENDIX:

Official Undertaking for Nurse Trainee

DATE OF IMPLEMENTATION:

This policy has been implemented since 1986, revised 2006 and reviewed 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

OSPITAL NG PARAÑAQUE
0440 Quirino Ave. Bgy. La Huerta, Parañaque City

OFFICIAL UNDERTAKING

This is to confirm your appointment as a TRAINEE under the program of the Hospital _____from the division of _____.

It shall be expected of you to meet and comply with the general standards set by this institution but not limited to the following:

1.) Performance Rating ≥8.0-9.5 (Very Satisfactory) upon completion of training;
2.) Acceptable attendance record;
3.) Strict compliance with the hospital policies and rules of the Section/Division to which you are directly under;
4.) Maintain a harmonious relationship with peers and other health workers of this institution;
5.) Recognize hospital authority and the right of the patients;
6.) Subscribe to the norms of conduct of a good public servant and exemplify high ethical behaviour expected of your profession.

You shall be obliged to report for work with a minimum _____ hours a week or _____ hrs. in the course of your entire training period.

You are deemed and considered a trainee solely for the purpose of your career enhancement and to gain actual experience. As such, the Management is under no obligation to hire you as an employee upon termination of the training period. However, the Management shall be obliged to issue a valid certification of completed training as to credit number of hours for whatever legal purpose it may serve. In the event of grave misconduct and/or errors resulting from negligence, the Management shall have the prerogative to immediately terminate your training and oblige you to pay the equivalent remaining hours. No certification shall be issued to this effect.

_____
Name and Signature of Trainee

_____
Date and Time

Witness:

_____ _____
Name and Signature (Division Head) Date and Time

DR.EPHRAIM NEAL C. ORTEZA
Hospital Director

POLICY ON AREA ROTATIONAL PLAN

POLICY NO: NSO-002

DIVISION: NURSING SERVICE DIVISION

POLICY REVIEW DATE: July 12, 2016

Reviewed by:	**Reviewed by:**
Angeline L. Brillante, RN, MAN Assistant Chief Nurse	Arleen G. Herrera, RN, MAN OIC- Nursing Division
Reviewed by:	**Approved by:**
Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

This policy shall develop and hone skills and knowledge about the nature of work of those in this Division.

COVERAGE:

This shall cover Nursing Division in its entirety.

RESPONSIBILITIES:

I. It shall be the responsibility of the **Head of the Division** to oversee the implementation of this policy and to monitor its effectiveness corollary to the needs and trends in the management of this division; and to conduct periodic performance evaluation on those at the supervisory levels.

II. It shall be the responsibility of the **Nurse Supervisors** to act as go between in times when conflicts arises emanating from resistance to abide among his/her subordinates; to report relevant issues to the Division Head from time to time as needed.

III. It shall be the responsibility of **All Staff** under this division to abide with the guidelines incorporated into this policy with a good grasp and comprehension of the essentials and motives of such movements in the working plan.

POLICY:

I. This policy shall ensure that the conduct of motion for rotation of staff shall be orderly and discipline guided.
II. This policy shall enforce compliance by all with the guidelines incorporated into it to ensure the deliverance of quality nursing care and management.

PROCEDURE:

I. Rotation shall be as follows:
   Head Nurse – if need the arises
   Staff Nurse and Nursing Attendant – every six (6) months or if the need arises
II. Rotation shall be based on the performance evaluation of personnel as submitted by the designated rater to Chief Nurse
III. Rotation shall be done anytime if with manpower shortage of one area due to EL, SL and resignation of staff.
IV. Rotation may not proceed for all at the same time as those who would be responsible to orient and train the new rotators.

DATE OF IMPLEMENTATION:

This policy has been implemented since 1986, revised 2006 and reviewed 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

POLICY ON ON-CALL SCHEME (NURSE RELIEVER)

POLICY NO: NSO-003

DIVISION: NURSING SERVICE DIVISION

POLICY REVIEW DATE: July 12, 2016

Reviewed by:	**Reviewed by:**
Angeline L. Brillante, RN, MAN Assistant Chief Nurse	Arleen G. Herrera, RN, MAN OIC- Nursing Division
Reviewed by:	**Approved by:**
Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

I. To resolve "pull-out" from other clinical areas as well as extension of duty.
II. To cover manpower shortage in case of absences.

COVERAGE:

This shall cover Nurses in all clinical areas.

RESPONSIBILITIES:

I. It shall be the responsibility of the office of the Nursing Service Division to monitor the effectiveness of the policy.
II. It shall be the responsibility of the Supervisor on duty to inform the on call duty ahead of time.
III. It shall be the responsibility of the On-call staff to make him/her available on scheduled dates.

POLICY:

I. Under any circumstances that a staff nurse shall be absent, he/she shall inform the NSO two (2) hours prior to give time for the Nurse Supervisor to make arrangement. Failure to notify NSO on the specified time will mean absent without pay.
II. All ON CALL staff must be available at all times in case services shall be required.
III. ON CALL duty in each area shall be rotated among staff.

PROCEDURE:

I. Schedule submitted shall bear the name of the staff and days of ON CALL.
II. ON CALL staff shall be notified in cases of absences in their respective areas.
III. Replacement of extra off for staff that went on duty will be arranged in the next cycle of schedule.

APPENDIX:

On call slip form

DATE OF IMPLEMENTATION:

This policy has been implemented since 1986, revised 2006 and reviewed 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

ON CALL SLIP FORM

Nursing Service Division
ON CALL SLIP

Name: _____

Shift: _____

Date: _____

Nursing Supervisor Staff ON- CALL

_____ _____

POLICY ON FLEXI-TIME SCHEDULE

POLICY NO: NSO-004

DIVISION: NURSING SERVICE DIVISION

POLICY REVIEW DATE: July 12, 2016

Reviewed by:	**Reviewed by:**
Angeline L. Brillante, RN, MAN Assistant Chief Nurse	Arleen G. Herrera, RN, MAN OIC- Nursing Division
Reviewed by:	**Approved by:**
Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

To improve the staff attendance and minimize absences

COVERAGE:

This shall cover all Nursing Service Division Personnel

RESPONSIBILITIES:

I. It shall be the responsibility of the Chief Nurse and Supervisors to monitor implementation of this policy.
II. It shall be the responsibility of the Chief Nurse and Supervisors to approve requested off duties and avail of Flexi-time schedules without prejudice to performance of staff but to the best interest of the service.
III. It shall be the responsibility of the Nursing staff to abide with the procedures incorporated to this policy.

POLICY:

I. This policy shall enforce the orderliness in the processing of request off and in availing of the Flexi-time schedule.
II. This policy shall ensure that once such is availed both parties shall abide with the rules incorporated into it.
III. This policy shall enforce that the required number of working days in a month shall be satisfied as ruling by the Civil Service commission

PROCEDURE:

I. It shall be the responsibility of the Head Nurse of each area to prepare the schedule for the nursing staff for final approval of the Hospital Director.

II. Deadline for submission of written requests for consecutive OFF duties shall be every 5th and 20th of each month and upon the approval of the Head Nurse.

III. Request for exchange of duty maybe granted by the Nurse Supervisor if with valid reason only; documentation of signature by both parties shall be done. Failure to report by one (1) party, both will be marked as absent.

IV. Any changes on the approved schedule by the Hospital Director, notification slip must be accomplished and signed by both parties to be submitted to the Hospital Director for approval.

V. Flexi-time schedule are as follows:

9 days duty = 12 hours- 6 days/ 15days
10 days duty = 12 hours- 6 days } 15days
= 8 hours – 1 day
11 days =12 hours- 6 days }
= 8 hours – 2 days } 15 days
12 days = 12 hours- 8 days/ 15days

8 hours would mean 3 shifts/day
12 hours would mean 2 shifts/day

APPENDIX:

None

DATE OF IMPLEMENTATION:

This policy has been implemented since 1994, revised 2006 and reviewed 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

POLICY ON EXPANDED ROLE OF MIDWIVES

POLICY NO: NSO-005

DIVISION: NURSING SERVICE DIVISION

SECTION: DR/LR/ER/WARD

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Rosalie M. Rodriguez, RM DR- Head Midwife	Jean Ann T. Gabrinao, RN LR/DR Head Nurse	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

I. To maximize the skills utilization of Midwives
II. To enrich and develop new skills such as:
    a. High risk assessment and management
    b. Communication skills (written and verbal)
    c. Accomplish admission and discharge procedure with assistance with the NOD

COVERAGE: All Midwives

RESPONSIBILITIES:

I. It shall be the responsibility of all Midwives to perform duties in areas assigned.
II. It shall be the responsibility of all Midwives to join in the lecture or Ward/OPD for the implementation of breastfeeding, newborn screening program, and other related programs set by the hospital

POLICY:

I. Emergency Room

a. Do initial history taking and vital signs recording
b. They shall be responsible in monitoring the progress of labor and subsequent vital signs of all pregnant patients made to labor at ER while waiting to be admitted to the Labor/Delivery Room.
c. They are NOT allowed to do initial Internal Examination but may do subsequent I.E only upon direct order by the Resident Physician. If no doctor is around and

the need to perform an I.E is immediate, then they may be allowed to do the initial examination. It shall be incumbent upon the doctor to verify this examination once he/she becomes available.

d. The Medical Officer shall perform admitting I.E and verification of initial history recorded by the Midwife to ensure accurateness and completeness of data.
e. All pregnant patients shall be accompanied by the Midwife when admitted to the Delivery Room.

II. Delivery Room

a. Prepares admitted pregnant patient for delivery.
b. Assist doctors in case of spontaneous vaginal deliveries.
c. Monitors vital signs and progress of labor. Refer to doctor in charge if with untoward signs and symptoms and poor progress of labor.
d. Allowed to perform vaginal deliveries without assistance on multipara with prior assessment by doctors.
e. Allowed to perform ONLY right- medio-lateral episiotomy on primipara and secundi gravid at imminent stage of delivery. Repairs maybe started only after the evaluation of wound has been made by the doctor on duty.
f. ANY repair must be evaluated by the admitting doctor prior to transfer of patient to the OB Ward.

III. Obstetric Ward

a. Do vital signs monitoring on post-partum patients and their newborns. Report immediately to the Nurse on duty any untoward signs and symptoms.
b. Do lectures on breastfeeding and proper care of the newborn and umbilical care.
c. Report immediately to the Nurse on duty for any difficulties experienced by mothers regarding lactation within the first four hours after delivery. This is to prevent hypoglycaemic episodes on newborns.
d. Assist mothers and their newborn on proper positioning for better flow of breastmilk and stimulation of the sucking reflex.
e. Reinforce “No Feeding Bottles and Infant Formula” policy .

APPENDIX:

None

DATE OF IMPLEMENTATION:

This policy has been implemented since 2000, revised 2009 (NOI-014-08) and reviewed 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

POLICY ON IV THERAPY

POLICY:

I. This policy shall ensure that all Registered Nurses shall abide with the procedures incorporated into this policy.
II. All Staff Nurses shall be required to submit to the Nursing Office an updated IV Therapy License. (License is renewable every three (3) years.)
III. Non-renewal of IVT – No renewal of appointment and will be dropped from the plantilla.

PROCEDURE:

I. **Initiation of IV Therapy**
   a. Interpret the doctor's order for IV Therapy and check the following:
      - type and amount of solution, flow rate, and, if applicable, dose and frequency of medication to be incorporated
   b. Assess and identify:
      - Patients' level of communication, age, activity, clinical status, duration of therapy, condition of the vein, size of the cannula, and type of solution
   c. Prepare the IV equipment and check for is expiration date, the doctor's order, and the labeling device.
   d. Practice hand washing using soap and water.
   e. Site selection and preparation:
      - Start peripheral routine IV therapy in distal areas of the upper extremities.
      - Distend vein using a tourniquet 4-6 inches above the site selected.
      - Avoid previously-used veins, injured veins, and vein flexion.
      - Use an antiseptic solution (70% isopropyl alcohol) for skin preparation.

II. **Performing venipuncture and insertion of all types of needles available**
   a. Observe strict aseptic technique, irrigation of IV cannulas, check integrity of the product, and secure cannula sterility.
   b. Apply sterile dressing over all IV sites to cover the IV cannula entrance site.
   c. Anchoring of cannula and tubing to prevent movement of the cannula.
   d. Routine monitoring and regulation of the flow rate.

III. **Maintain documentation associated with the preparation, administration and termination of IV therapy**
   a. Label all solutions with date and time started, rate, medication additives, and the duration of therapy. Include the patient's name in labeling IV bottles.

b. Document on the patient chart (IV flow sheet) the date and time of insertion, type of solution, medication incorporated, series number of IV solution, and the rate of infusion, and must be signed by the nurse.

IV. **Administration of IV Medication**

a. Check for the doctor's order.
b. Determine any medication and solution incompatibilities and do corresponding correction in dilution prior to administration.
c. Explain the procedure of skin testing to the patient.
d. Observe aseptic technique in the preparation of medication.

V. **Monitoring IV Therapy**

a. The IV cannula should be gently palpated and inspected for redness, swelling, pain on IV site, and infiltration.
b. The cannula should be changed every 72 hours.

VI. **Termination of IV Therapy**

a. Check for the doctor's order.
b. Maintain aseptic technique and minimize trauma to patients.
c. Check for completeness of the catheter of the cannula after the removal.
d. Apply a sterile dressing over the IV site.
e. Document on the patient's chart.
f. Dispose IV cannula sets properly.

APPENDIX:

None.

DATE OF IMPLEMENTATION:

This policy has been implemented since 1998, with minor revisions in 2003 and 2009, and reviewed in 2011. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

STANDARD OPERATING PROCEDURE AT THE OUT PATIENT DEPARTMENT

POLICY NO: NSO -006

CLASSIFICATION: COMPREHENSIVE

DIVISION: NURSING SERVICE DIVISION

SECTION: OUT PATIENT DEPARTMENT

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Nimfa M. Vibar, RN OPD- Head Nurse	Juliet S. Condes, RN OPD Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

This policy aims to give medical assistance to non-urgent cases and referrals.

COVERAGE: OPD Section

OBJECTIVES:

This policy aims to give medical assistance to non-urgent cases and referrals.

RESPONSIBILITIES:

I. Medical Officers/ Consultants

- To examine patients, prescribed and instruct medication, recommend referrals, and admissions and issues medical certificates and clinical abstracts when needed.

II. Head Nurse

- Monitor implementation of policies; assists medical staff in some minor procedures and/ or examination.

III. OPD Staff Nurse - to assist the OPD doctor in performing examinations (e.g. specimen, internal exam etc.)

- responsible for IM injections (R.N.)
- wound dressing and suture removal

- instructing the proper administration of requests for laboratory, x-ray and ECG as ordered by Medical Officer.
- conduct mother's class

IV. Clerk/ Nursing Attendant

1. Maintenance Of Record

- control the release of OPD number and classify clients according to their needs.
- keep patient chart at all times.
- add new sheet to patients chart with every consultation.
- fill in heading of patient chart properly
- secure old chart when requested by doctor
- record and return patient chart to record section at the end of the day.

POLICY

I. This policy shall ensure the deliverance of quality services to all clients of whatever creed, race or status.

II. It shall enforce order and timeliness of delivery of services with proper referrals to various clinical departments as the need arises.

PROCEDURE:

I. All clients shall be instructed to secure OPD number at the OPD at 7:00a.m for new and 12:00 noon for p.m. For old patients that are to be seen at the consultants clinic will be directed to the consultants clinic for continuance of management.
Flow of activities refer to Flow Chart "A"

II. Clients schedule are as follows:
   a. All cases TTH – 8:00a.m – 12 noon
   b. OB/ Gyne cases (pregnant and non-pregnant)
      TTH – 1:00a.m – 5:00 pm
   c. Removal of suture
      MWF – 3:00 – 4:00pm.
   d. Lecture of Breastfeeding, Newborn Screening Test on OB days.
   e. OSCA prescription daily
      8:00a.m. – 4:00p.m

CONSULTANT CLINIC HOURS:

Monday:	OB/GYN	8:00am – 10:00am
AM	Pedia Surgery	8:00am – 12:00pm
	Dental	8:00am – 12:00pm
	ENT	8:00am – 12:00pm
	Pedia Nephro	8:00am – 12:00pm
PM	Pedia	1:00pm-4:00pm
	Surgery	1:00pm-5:00pm
	Ortho Surgeon	3:00pm-5:00pm

Tuesday:	Derma	8:00am – 10:00am
AM	Ortho Surgeon	9:00am-11:00am
	Dental	8:00am – 12:00pm
PM	Surgery	1:00pm-3:00pm
	Pulmo	2:00pm-4:00pm
	OB/Gyne	1:00pm-5:00pm
	Pedia	1:00pm-5:00pm
	IM- Infectious	3:00pm-5:00pm
Wednesday:	Medicine	8:00 – 10:30am
AM	OB/Gyne	9:00am-11:00am
	Surgery	8:00am – 12:00pm
	Cardio	8:00am – 12:00pm
	Urology	8:00am – 12:00pm
	Nephro	8:00am – 12:00pm
PM	Nuclear Med.	1:00pm-5:00pm
	Optha	1:00pm-4:00pm
	Ortho Surgeon	3:00pm-5:00pm
Thursday:	Derma	8:00am – 10:00am
AM	Ortho Surgeon	9:00am-11:00am
	Dental	8:00am – 12:00pm
PM	Surgery	1:00pm-5:00pm
	ENT	1:00pm-3:00pm
	Pulmo	2:00pm-4:00pm
	OB/Gyne	1:00pm-5:00pm
	Pedia	3:00pm-5:00pm
Friday:	Surgery	8:00 – 10:00am
AM	OB/Gyne	8:00am-12:00pm
	Endo	8:00am – 12:00pm
	Psychiatry	8:00am – 12:00pm
	Dental	8:00am – 12:00pm
PM	Optha	1:00pm-4:00pm
	Gastro	1:00pm-5:00pm
	Pedia	1:00pm-5:00pm
	Surgery	1:00pm-5:00pm

III. Patient shall be entertained on a First Come, First Serve basis through a numbering system.

IV. Medico-Legal cases not needing suturing shall follow the same procedure of securing chart and OPD number but will be prioritized alternately with senior citizen patients.

V. The following patients shall be immediately assessed and given certifications by the doctor:
   a. Inquests under custody of police and arresting barangay tanod for medical clearance.
   b. Children with their parents under custody of police or arresting officer.
   c. Children without their parents but assisted by our Medical Social Workers or City DSWD under custody of police or arresting officer.

VI. A policy on decking of Medical Specialist on out-patient duty shall be followed for patient assignments.

VII. Requirements of PNCU of OB patients:
   a. Primi-gravid/ Segundi
      - OPD check-up will start on the 32nd week of gestation.
      - Pink Card from LHC (Local Health Center) containing data on 4-5 PNCU, tetanus injection, lectures on breastfeeding and NBS testing, previously done laboratory exams or history of any infections.
      - Referral form by LHC physician to our OPD doctor
   b. Multipara (G5 onwards)
      - OPD check-up will start on the 32nd week of gestation.
      - Pink Card from LHC containing data on 4-5 PNCU, tetanus injection, lectures on breastfeeding and NBS testing, previously done laboratory exams or history of any infections.
      - Referral form by LHC physician to our OPD doctor
   c. All G2, G3 and G4 females shall be referred to their respective LHC for PNCU and delivery at the lying in near their place of residence.
   d. High risk patients beginning PNCU up to time of delivery will be done at our OPD.
      - All high risk OB females shall be referred to High Risk clinic for close evaluation by Medical Specialist.
      - Referrals from respective LHC (Lying- In Health Center) shall contain:
         d.1 reason for referral
         d.2 laboratory examination done/ requested
         d.3 medical treatment administered
      - Any such referral with urgency shall be entertained and referred to E.R physician for immediate care, if needed, even on days not dedicated for OB patients.

Instruction prior to Admission of Pregnant Females:

I. All pregnant females who have the intention to deliver in our institution shall be instructed and issued the list of items that shall be brought with them upon admission.

II. List of restricted items shall also be issued with signature by patient to signify understanding and compliance.

III. Verbal instructions to be made shall be incumbent upon your area to ensure only the approved items for entry will be brought.

IV. Signed consents/ waivers shall be attached to the patient's chart prior to endorsement to the E.R.

CONSULTANTS PROTOCOL ON RECEIVING AND ENDORSING ELECTIVE OPERATION

I. After evaluation of the OPD doctor the patient will be endorsed to the consultant's room for re-evaluation of the consultant on duty.

II. After re-evaluation of the consultant, the patient will be instructed by the Consultant to complete the necessary requirements prior to surgery such as:

a. CP clearance
   a.1. Adult patient - 35 y.o. and above
   a.2 Pediatric patient - 18 y.o. and below
b. notification for OR
c. admitting orders
d. consent for operation
e. list of medicine and supplies needed for the surgery

III. The patient will be asked to call the consultant's clinic the day before the surgery if there is an available bed. If there is a vacancy, he will be asked to go back and will be endorsed by the OPD Nurse to ER floor.

Consultation Protocol:

1. Medical Specialist shall have assigned day/days of clinic for follow up and check up.
3. Patient shall secure record or give their card to consultant's clinic clerk for retrieval of record.
4. Patient shall be seen on a "first come first serve basis."
3. All records shall be recorded by the clerk and forwarded to the records section.

APPENDIX: Flow chart
Patient flow charts, General I, II, III, OB cases uncomplicated (G1 & G2)

DATE OF IMPLEMENTATION

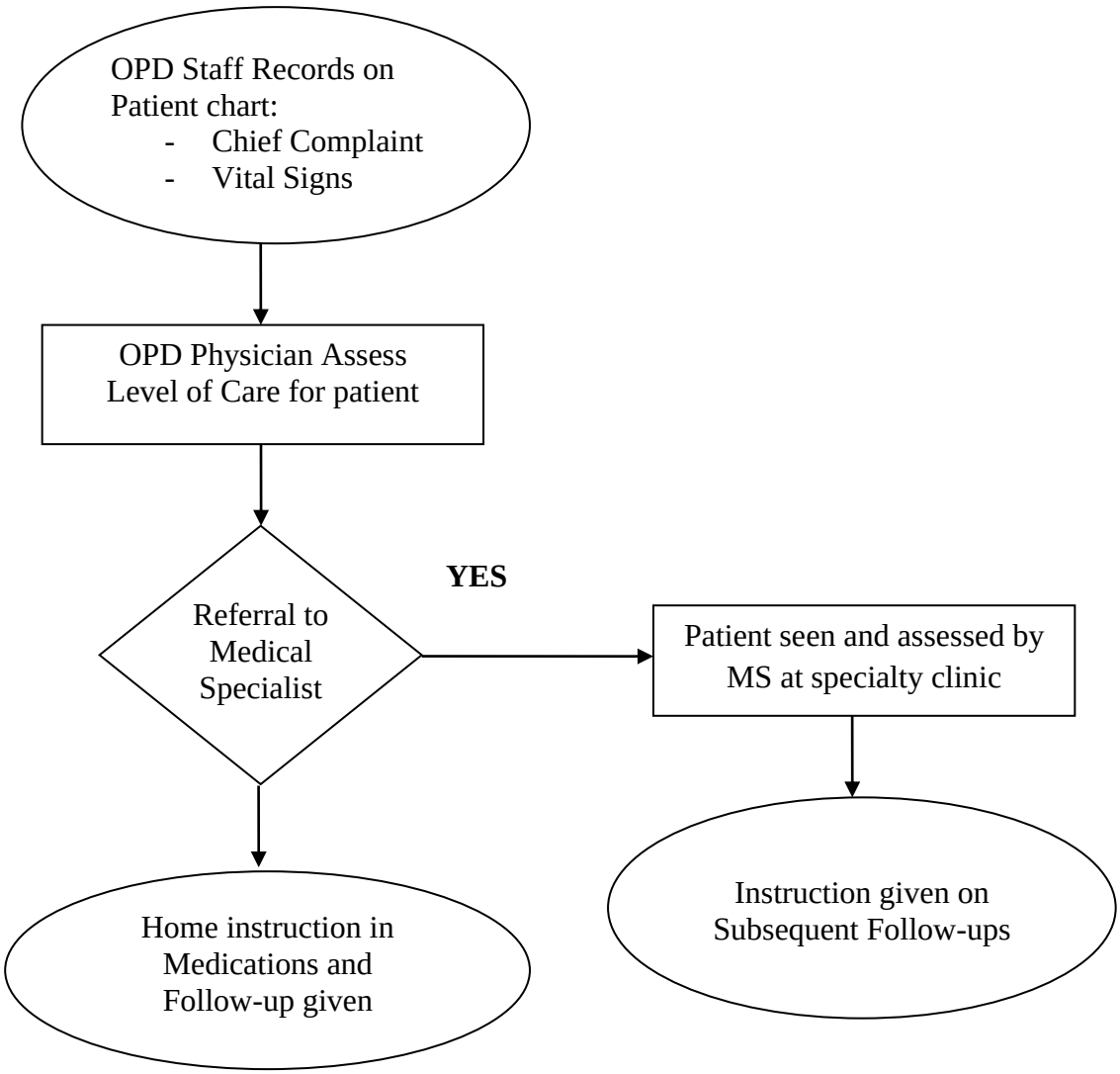
This part of the policy has been implemented since 1978; however revision has been issued 1994, 1998, 2001, and 2003. Reviewed 2006, 2011, 2016 this policy will continue to be implemented as rewritten.

SCHEDULE OF POLICY REVIEW

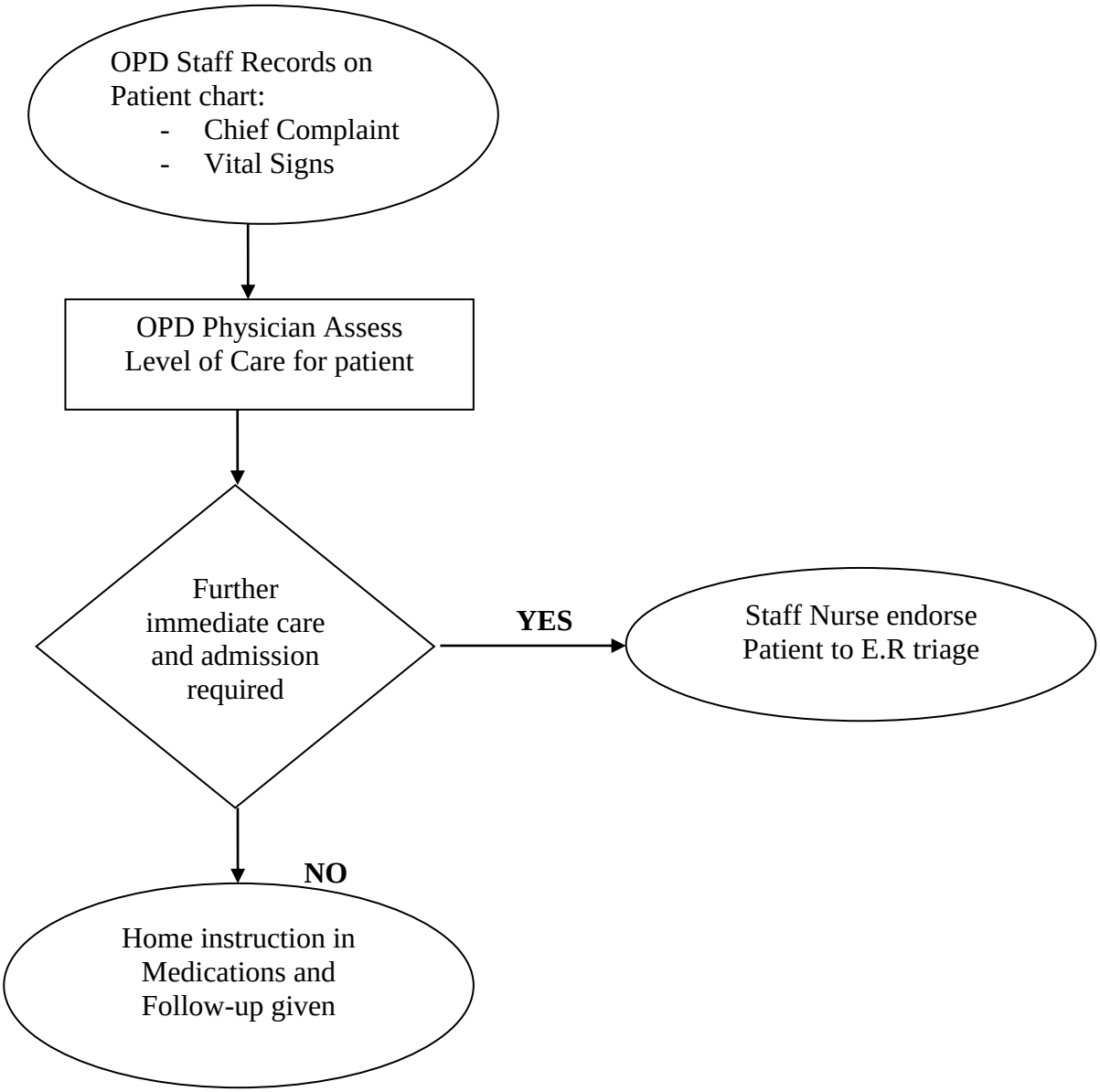
This policy shall be reviewed every three years (3) or as deemed necessary.

PATIENT FLOW CHART

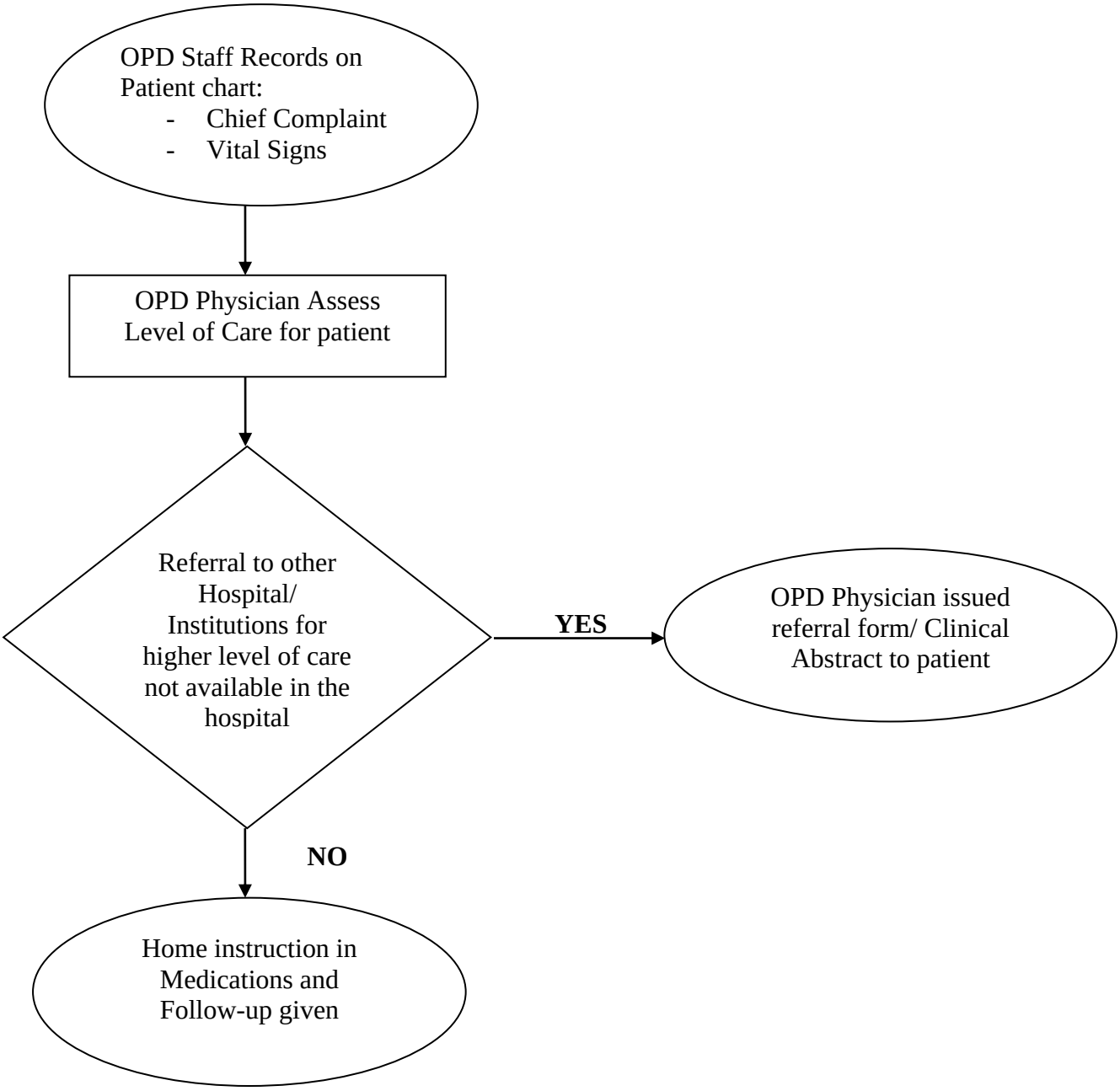
I. General



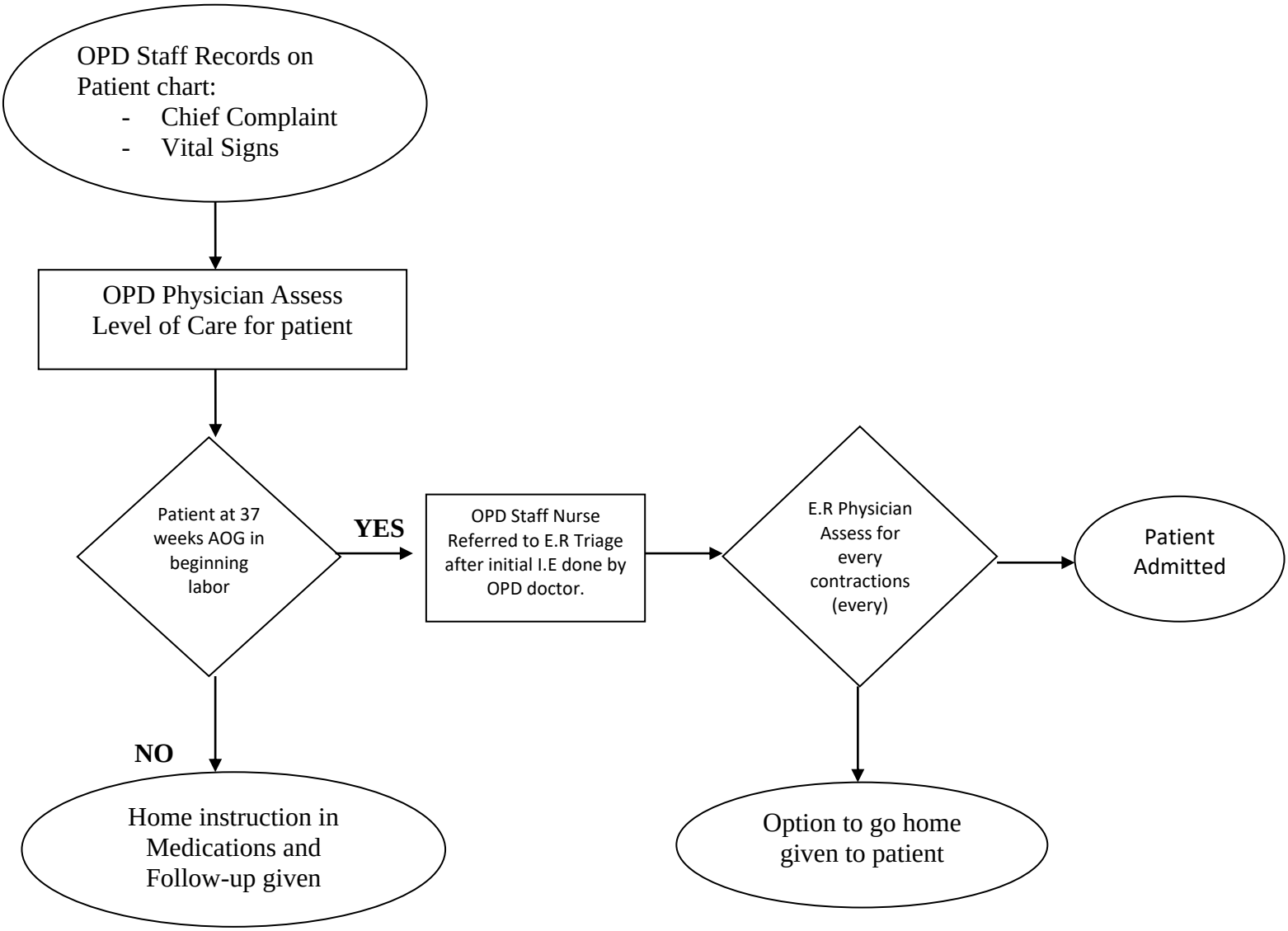
II.


OPD Staff Records on Patient chart:
- Chief Complaint
- Vital Signs
OPD Physician Assess Level of Care for patient
Further immediate care and admission required
YES
Staff Nurse endorse Patient to E.R triage
NO
Home instruction in Medications and Follow-up given

III.


OPD Staff Records on Patient chart:
- Chief Complaint
- Vital Signs
OPD Physician Assess Level of Care for patient
Referral to other Hospital/ Institutions for higher level of care not available in the hospital
YES
OPD Physician issued referral form/ Clinical Abstract to patient
NO
Home instruction in Medications and Follow-up given

III. OB CASES uncomplicated (G1 and G2)



STANDARD OPERATING PROCEDURES
AT THE EMERGENCY ROOM

POLICY NO: NSO-007

DIVISION: NURSING SERVICE DIVISION

SECTION: EMERGENCY ROOM

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Aleli T. Ortega, RN ER- Head Nurse	Concepcion A. Lacson, RN ER Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES: This policy aims to define the structured guidelines of this Section and the adjoining area of the Hydration- Observation.

COVERAGE: This policy shall cover the Medical and Nursing Division specifically the stated area of concern.

REPONSIBILITIES:

I. It shall be the responsibility of the **Head of this Section** to monitor the effectiveness of this policy; to exercise supervision over all those under him/her; to affect readiness of staff in response to any emergency and to coordinate with the various authorities of this hospital if needed for immediate execution of services.

II. It shall be the responsibility of the **Medical Officers** to abide with the guidelines incorporated into this policy to minimize conflicts and confusion; to refer all difficult and admitted cases to Medical Specialists in charge and to coordinate referrals of patients as needed.

III. It shall be the responsibility of the **Medical Social Service Section** to classify all patients prior to admission, whenever available.

IV. It shall be the responsibility of the **Staff Nurse** to prioritize patient care to patients; carry out doctor's order promptly and administration of medications and nursing management.

V. It shall be the responsibility of the **Nursing Attendant** to assist ER nurse in taking vital signs of all incoming patients, do monitoring of vital signs as ordered by doctors, to assist the nurse in all procedures to be done.

VI. It shall be the responsibility of the **Institutional Worker** to ensure regular check-up of all hospital equipment and instruments within the unit, ensure availability of these items and report to Head Nurse any breakages and losses and they will be held liable for any losses. All equipment must be cleaned after each use and kept clean at the end of the shift. Maintain cleanliness of the area and to assist the staff in some procedures to be done.

VII. It shall be the responsibility of the **Clerk on duty** to do recording of all patients examined, admitted, and transferred. She shall return charts of non-admitted patients to the Medical Records.

POLICY:

I. This policy shall enforce the proper procedures to facilitate the timeliness of admitting patients from this section to the Ward;

II. This policy shall enforce compliance by all to the guidelines incorporated into it to institute order and quality of delivered services.

PROCEDURE:

I. Upon consultation patient must be given initial assessment by the triage nurse and doctor to medical and nursing care to be instituted. Vital signs taken and ER physician is notified. If urgency is foreseen, emphasis is made to the physician, date, time and nursing management noted on the side of the chart.

II. In emergency cases, triage form must be accomplished and provided for documentation of the management rendered to patient while waiting for the relatives to secure patient chart. Patient who seeks consultation to ER but later advised by ER doctor for transfer shall be logged at the emergency transfer logbook and must be reported daily to the Chief of Hospital.

III. Relatives are given ER slip and made to secure patient record at the Admitting area.

IV. Nursing management done shall follow the same for all cases seen at this section:

A. Vital signs taken include: blood pressure, height, and weight, heart rate and respiratory rate. All instituted measures MUST be done with specific orders/ instructions from the ER physician to serve justification.

B. All admitted cases shall be classified by the social worker on duty. In the absence of Social Worker, patient who wishes to be under Private Classification shall sign a waiver in the presence of the SHO. Later in the morning all patient in the ward will be coded by the Social worker on duty.

C. All patients treated as Out Patients shall have clearance from the clinical areas (Laboratory/ ECG, Radiology and Pharmacy) prior to discharge.

D. Follow up instructions shall be given based on details of procedures done with discharge instructions properly signed by the discharging MD/Nurse and the patient/relatives.
E. All requests shall bear patients' middle name and the date of birth for PhilHealth purposes.
F. Every procedure should be explained with consent secured prior to commencement.

V. Strictly no visitors allowed; only one watcher per patient.

VI. Procedures to follow if patient is for admission:

A. ER Nurse shall notify Ward of admission and proceed to accomplish the checklist necessary for such: Kardex, OPD record, admission record, admission consent, informed consent for procedures, complete history and physical examination and the physician's order sheet, nurses notes, wrist tag prior to endorsement.
B. Additional requirements are attached for surgical cases. OR proposal, consent, pre-op checklist, signed by ER NOD, blood clearance from the SW, consent and requests for blood transfusion if needed. Consent shall be signed by the patient, if or legal age and conscious or by an adult relative if minor and unconscious patient. Any of the relatives or companion will sign as witness.
C. All admitted cases shall be classified by the Social Worker on duty whenever one is available. All private patients will sign a waiver in the office of the Social Worker or in the absence of the later; will be done by the SHO.
D. All STAT examinations MUST be done prior to transfer to Ward all x-ray to be performed prior to transfer, whenever possible. Routine examination (lab, ECG) to be done at the Ward.
E. Unused supplies and other remaining medications, unaccomplished procedures/ medication due to non-availability must be endorsed properly to receiving nurse.
F. All patients hooked with 2nd IVF even if for observation shall be considered and admission and therefore shall follow the same.
G. Patient MUST have stable vital signs and consent of ER physician prior to transfer to another area.
H. Receiving area MUST readily accept admissions to be done as bedside endorsement. Delay in acceptance shall not exceed more than 20 minutes from time of call by ER nurse unless the Nurse Supervisor shall deem justified. Endorsement shall be made before 5:30 am/pm to 6:30 am/pm.
I. Classification of Newborn admission: a) Non-institutional delivery where baby is separated from the placenta: Admitted with record from Admitting Section and separate registry number from mother. Prepare necessary documentation for Newborn record, to include Dubowitz/ballards scoring) Newborn delivered within
J. The hospital premises/ ER delivery: accomplish newborn record with case number assigned by the Delivery Room staff nurse, and history of parturition. Newborn delivered outside the hospital shall receive cord care at the ER to be done by the midwife.

K. Direct admission to OR and DR shall have notification of admission prior to transfer. OB patient must be advised to wear underwear while transporting to DR to be accompanied by ER nurse. Skin preparation for surgery 1. Elective surgery at the ward. 2. Emergency operation "Stat" cases shall be done in the emergency room.

VII. Patients for transfer to another institution for definite management shall follow different set of guidelines:

A. ER physician shall upon decision issue a Referral Letter to the patient and/or relative and reason for referral shall be indicated in the patient's chart. Patient and/or relative shall sign a waiver for transfer.

B. Ambulance conduction must be accompanied by ROD and Nurse at all times. All transfers shall be properly communicated by the attending MO to the receiving healthcare facility. If doctor is unavailable Nurse Supervisor to do proper documentation. Stabilization of vital signs shall precede each transfer. Charge ticket for use of ambulance shall also be secured.

C. Difficult cases MUST be referred by attending Medical Officer to Medical Specialist in charge prior to transfer and documented on the chart.

D. Ambulance MUST be furnished by drivers with full tank of Oxygen and functioning gauge prior to conduction. Trip tickets shall be processed by the same.

VIII. All patients seen in this Section shall be recorded into separate logbooks and disposition indicated.

IX. Nurse Supervisor shall be informed at any time when complicated or difficult cases are beyond decision by the ER staff.

APPENDIX: Emergency Room Flow Chart

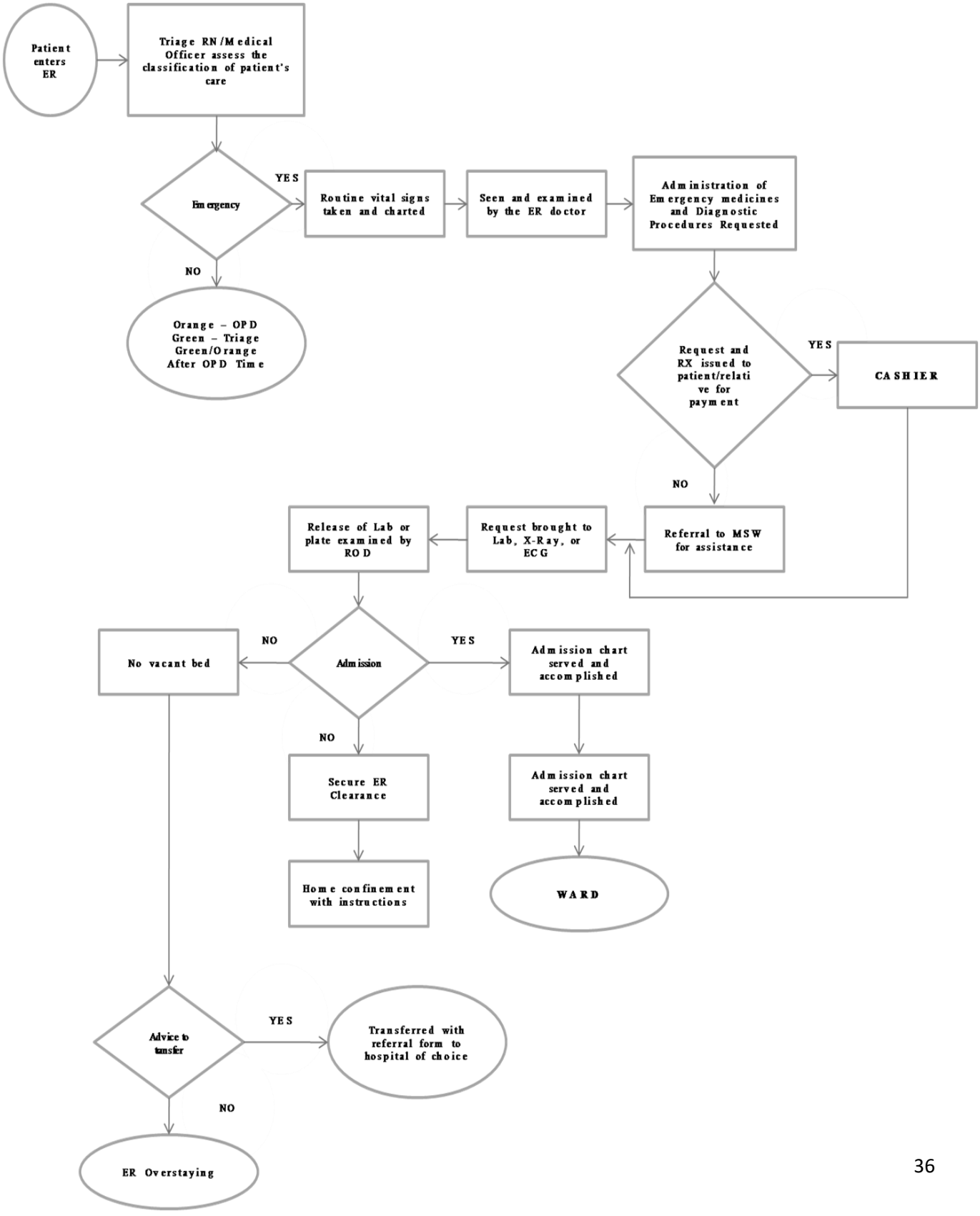
DATE OF IMPLEMENTATION:

This part of the policy has been in implementation since 1978; however revision has been issued since 1994, 1998, 2001, and 2003 with minor revision 2006, reviewed 2011, 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be reviewed every three (3) years or as deemed necessary.

EMERGENCY ROOM FLOWCHART



STANDARD OPERATING PROCEDURES
AT THE HYDRATION- OBSERVATION SECTION

POLICY NO: NSO-008

DIVISION: NURSING SERVICE DIVISION

SECTION: EMERGENCY ROOM

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Aleli T. Ortega, RN ER- Head Nurse	Concepcion A. Lacson, RN ER Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES: This policy aims to provide working guidelines on admission to this area.

COVERAGE: This policy shall cover all staff of this section only.

REPONSIBILITY:

I. It shall be the responsibility of the Head of this Section to monitor the effectiveness of this policy and to ensure that all abide with the guidelines incorporated into it.

POLICY: This policy shall ensure that criteria set for the admittance to this section be complied with by all professional staff.

PROCEDURE:

I. All cases admitted to this area shall follow the strict criteria to minimize cross infection and contamination.

- Dehydration of moderate to severe type, due to a gastrointestinal pathology of whatever age. Any infectious case with diarrhea as a secondary problem IS NOT admissible to this area.
- Patients brought in by public/private organizations or individual doing Good Samaritan unaccompanied by any relative may be admitted to this area if with

doctor's order. Proper coordination of staff with the Social Worker for location of relatives or for transfer to an institution when care has been completed.

I. Admission procedures shall be the same as in other areas.

II. Clearance for charges prior to discharge shall be undertaken by Charge Nurse and completion of chart is a MUST.

III. Emergency transfers from this area to another hospital for further treatment shall be similarly processed as in any case stipulated in discharge policy requiring clearance slip

IV. Transients to their area (not a primary diarrheal case requiring hydration) shall be allowed to stay for not more than 2 days.

- Medical Officer shall re-assess patient's status on a daily basis to ensure efficiency of isolation and prevention of cross-infection
- Staff nurse shall ensure proper steps for control of cross-infection, if case is communicable.

V. Policy on visiting hours shall be strictly implemented. Likewise, only one watcher per patient shall be monitored.

VI. Staff Nurse shall regularly educate patients and watcher on proper hand washing and waste segregation and disposal.

APPENDIX:

None.

DATE OF IMPLEMENTATION:

This part of the policy has been in implementation since 1978, however revision has been issued since 1994, 1998, 2001, 2003 with minor revision 2006, reviewed 2011, 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be reviewed every three (3) years or as deemed necessary.

CLEARANCE FOR DISCHARGE
Emergency Room/Ward

In order to maintain assurance of the security and privacy of our patients; The following policies and procedures shall likewise serve as counter measures against patient absconding and unpaid charges.

1. **Clearance Slip** shall be issued by the Charge Nurse once the following items in the checklist has been complied with:
   a. OR number encoded
   b. Bed and side table inspected by the IW and/ or NA for wastes
   c. Linen (beddings an gown) properly disposed by IW
   d. Signature of MSW, if code D
   e. Signature of CWU
   f. Patient wrist tag surrendered
2. Clearance accomplished in duplicate copies (one copy for the CWU at the ground floor and one copy retained in the chart for auditing purposes).
3. Security assigned at Wards shall always include the patient's wrist tag in their routine inspection. If and when prescribed tag is not available, staff nurse shall improvise one. Security shall be required to inspect the OB ward only in the presence of the staff nurse.
4. All patients shall dress into the hospital gown prior to endorsement into the wards and maintained in such until time of discharge.
5. Security team shall be authorized to confiscate the street clothes brought in for the patient. Confiscated items shall be surrendered to the Nurse's station and returned only when the watcher goes home.
6. The surety shall allow entry of street clothes for the patient only upon issuance of clearance pass from the Charge Nurse.
7. Strictly one (1) watcher per patient only shall be allowed at any given time. Children 14 years old and below are not allowed to be inside the wards. If ever, they will be made to seat at the waiting area only.
8. Strict observance of the visiting hours should be enforced. Only 2 visitors per patient shall be allowed at any given time except at the Isolation Ward.
9. OB Ward patients may be allowed to entertain visitors only after 8 hours after vaginal delivery and 36 hours after CS. Staff Nurse shall be required to evaluate their patients prior allowing them to stand or walk towards the Nurse Station II where she may talk with her visitors.
10. Visitors for OB patients shall be required by the Security to have clearance pass from the charge nurse.

APPENDIX:

ER Clearance for discharge

DATE OF IMPLEMENTATION:

This part of the policy has been in implementation since 1978, however revision has been issued since 1994, 1998, 2001, 2003 with minor revision 2006, reviewed 2011 and 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be reviewed every three (3) years or as deemed necessary.

ER Clearance for Discharge

OSPITAL NG PARAÑAQUE
E.R TRANSFER SLIP/ CLEARNCE

NAME: _____ DATE : _____

ITEM	QTY	AMOUNT
PHARMACY		
LABORATORY		
X-RAY		
BILLING		
CACHIER		

PREPARED BY: _____ HOSPITAL # : _____

POLICY ON HOSPITAL OPERATIONAL TRIAGE SYSTEM (H.O.T.S)

POLICY NO: ER-009

DIVISION: NURSING SERVICE DIVISION

SECTION: E.R TRIAGE

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Dennis S. Reyes, RN Triage- Head Nurse	Concepcion A. Lacson, RN ER Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES: This policy shall aim to:

a. Provide an effective and accurate distinction between those patients who have immediate medical and nursing needs from those who can safely wait without compromising their health;
b. Make speedy clinical assessment of each patient based on accepted levels of evaluation to reduce emergency room waiting time;
c. Determine if patient is appropriate for a given level of care and to ensure that hospital resources are utilized effectively.
d. Manage and treat cases that will lessen ER census and provide faster disposition of the patient.

COVERAGE: This policy shall cover the medical, nursing, admitting and security staff of the Emergency Room.

RESPONSIBILITIES:

I. It shall be the responsibility of the **Overall Team Leader** (Triage Physician) to ensure the efficiency of this policy. He shall determine in conjunctions with the hospital's admitting staff, what beds are available for optimal utilization of resources in order to provide safe care to all patients. He shall either refer patients for admission to ER physician on patients needing admission or from other physicians taking care of patients from other floors who can be transferred because they no longer need that level of care. He shall manage some cases under the management of the Triage Department and elevate cases initially managed but no improvement noted.

II. It shall be the responsibility of the **Triage Head Nurse** to supervise directly the Nursing Team. He shall monitor and evaluates effectively of the various guidelines into the working policy of the HOTS hand in hand with the Overall Triage Team Leader.

III. It shall be the responsibility of the Triage Nurse to evaluate patient's condition as well as any changes, and shall determine their priority for admission to the Emergency Room and also for initial treatment at the triage area. He/she shall provide accurate triage coding/ category and overshoot the overcrowding of patients in the waiting area. He/she may ask for the charge nurse or Supervisor to reassess the situation.

IV. It shall be the responsibility of the **Admitting Staff** to constantly update the ER/Triage physician of availability of beds for optimal utilization of resources to avert overcrowding at the emergency Room.

V. It shall be the responsibility of the hospital **Security Staff** to assist the Triage Nurse in maintaining the peaceful and orderly flow of patients in waiting and treatment areas. He shall ensure the safety of all staff in the area at all times.

PROCEDURE:

I. Upon consultation, the Triage Nurse shall assess briefly the patient.

II. The Triage nurse documents the reason of visit, current medications taken and all allergies of the patient. He/she shall record on the appropriate Triage form the following vital signs of the patient:
   a. Level of Consciousness (i.e. critical/stable/potentially stable)
   b. Pulse Rate
   c. Breathing (Respiratory Rate)
   d. Skin Temperature
   e. Blood Pressure Pain Scale

III. Triage Nurse categorizes the case and tags patient chart using the five (5) Levels of Priority:

CODE - denotes patient who has suffered from cardiac arrest outside of the hospital or someone whose vital signs crash within the Emergency Department. This category also includes people with gunshot wound with possible vital organ involvement and/or altered or absent vital signs.

CRITICAL - denotes a patient with stable vital signs who is exhibiting symptoms or who gives a history that clearly delineates life threatening condition. This might be a patient with chest pain, shortness of breath and profuse sweating (diaphoresis). May include people who have history of vomiting of blood, multiple traumas with head injury, or gunshot or stab wound, diabetic with respiratory distress, skin rashes with respiratory distress, increase BP with weakness, facial asymmetry, and severe dehydration.

URGENT - Represents patients with serious condition requiring medical intervention within two (2) hours. Doctors should see the patient within the hour and patient not made to wait for hours. These are patients with abdominal pain, high fever and/or productive cough,

deep lacerations (3cm and above) with bleeding under control, closed fracture with deformity, and so on. If made to wait due to overwhelming cases, the Triage Nurse shall be obliged to monitor such patients for changes in symptoms with vital signs at least every hour. Patient should be lying on a stretcher and not sitting on the chair, increased BP (symptomatic), VA with head injury (as vomiting), and moderate dehydration.

NON-URGENT DISABLED - The non-urgent disabled individuals, unable to walk or remain in a chair, and those for whom Triage Nurse determines that up to four (4) hours wait is clinically acceptable. The nurse places these people on a stretcher for comfort and safety. Sometimes the disability relates to the presenting problem, such as herniated disc causing severe low back pain. With others, disability does not seem related as in dislodged feeding tube, or bladder urine draining tube, increased BP (asymptomatic, ambulatory), VA with head injury (ambulatory), fever below 39 °C (moderate/ low grade fever), mild dehydration, laceration (2-3cm).

AMBULATORY - This group of patients make up the majority of the waiting room population. Those that do not need emergency care which may include cold, toothaches, headaches, bumps, bruises, abrasions, small lacerations, skin rashes, diarrhea without dehydration, and so on.

IV. Triage Nurse shall alert the Triage/ ER Physician about the patient's condition as to the levels of priority. He/she shall ask the relative of the patient to secure a record at the admitting section.

V. Triage/ER Physician shall let patients know their treatment priority once they are triaged. After proper evaluation, decision on manner of disposition (admission to ward, discharge with home instruction or transfer) must be swift so as patients do not suffer through long waiting time.

VI. Triage Nurse shall direct patient flow according to priority levels. He/she shall keep track of the amount and classification of treated patients.

VII. Triage Nurse shall ask the assistance of the security staff to ensure that patients know their destinations instead of allowing them to wander of as valuable time is lost attempting to locate patients and/or relatives for procedures or instructions.

VIII. The Triage action officer must always be available for the patients and relatives to allay their worries and anxieties and solve problems concerning treatment, procedures and handle complaints.

IMPORTANT REMINDERS:

a. Listen to your patient's chief complaint. If in doubt, ask or validate.
b. Do not refuse patient or send them away. Be aware of the risk management.
c. Always be a patient advocate. Keep in mind their rights and privacy.
d. Keenly observe the non-verbal and verbal presentation. Develop clinical eye and ears for hidden symptoms by gathering patient history.

OPD Endorsement:

a. After OPD hours, the OPD Nurse shall endorse all the patients and their charts that were untreated with complete vital signs.
b. In case OPD will transfer patient at triage during OPD hours, the OPD Nurse shall accompany the patient with the latest V/S and endorse it to the triage nurse.

Emergency Transfer:

In case of walk –in patient for emergency transfer, after the assessment of the Triage doctor, the triage staff will provide the temporary OPD chart and obtain the initial vital signs and necessary information, secure patient's signature and bring the chart to the admitting section for recording.

OB Cases:

All OB cases with prenatal check up at the OPD will not require triaging. The triage nurse should endorse the patient at the ER. Only walk-in patients will be triaged before endorsing to the ER Staff.

Medico-legal Cases:

Medical clearance for inquest, self-inflicted, sexual abuse, alcoholic intoxication, labor incidents, vehicular accidents are considered medico-legal cases. The Triage Nurse must ask the patient/relative to secure chart at the admitting section for medico-legal chart/form.

Clinical Cases under the Management of the Triage team:

1. All cases of fever without episode of convulsion in adults and children.
2. Rise in blood pressure without accompanying symptoms of bleeding, chest pain and diaphoresis.
3. Ambulatory and/or wheelchair-borne patients in pain (acute or chronic) with stable vital signs (**Code GREEN**)
4. Consultations coded **ORANGE** before and after OPD hours to include change in foley catheter or injections with proper doctor's prescription.
5. Diarrhea with mild to moderate cases of dehydration.
6. Insect or animal bites with no signs of compromise in vital signs.
7. Consultations of head injury with stable vital signs and no open wounds.
8. Allergic reactions to food or drugs with stable vital signs.
9. Newborn delivered in lying0in with proper referral for antibiotic prescription due to TMS.
10. Acute attacks of respiratory wheezing with mild rise in respiratory rate and BP.

NOTE: In the above cases, ancillary procedures shall be minimized as it will always a STAT procedure and cost will be higher. Requests shall be issued if preferred to be done at our institution on OPD basis; if on ordinary days, refer procedures to the nearest health center.

Cases for Management of the ER Physician:

1. All consultations under code **YELLOW** , **RED** and **BLUE.**
2. All Obstetric and gynecologic cases.
3. All open wounds with or without fractures requiring suturing.
4. All cases of convulsion with or without fever.
5. Cases of acute abdomen with unstable vital signs.

6. Consultations initially managed by the Triage Physician but no improvement noted in terms of:
    - Lowering of BP after 2 doses of Clonidine and/or intramuscular antihypertensive
    - No marked improvement in Pain Scale
    - Progression of dyspnea despite 2-3 cycles of nebulisation
    - State of dehydration requiring further management e.g intravenous fluid administration

** Patients shall be endorsed by Triage Physician to the ER Physician: if admission is entertained but no vacancy in the Ward. Triage Physician may opt to do referral of the patient to another institution provided that vital signs are stable.

APPENDIX:

HOTS Flow Chart

DATE OF IMPLEMENTATION:

This policy has been implemented since 2009, revised 2011 reviewed 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

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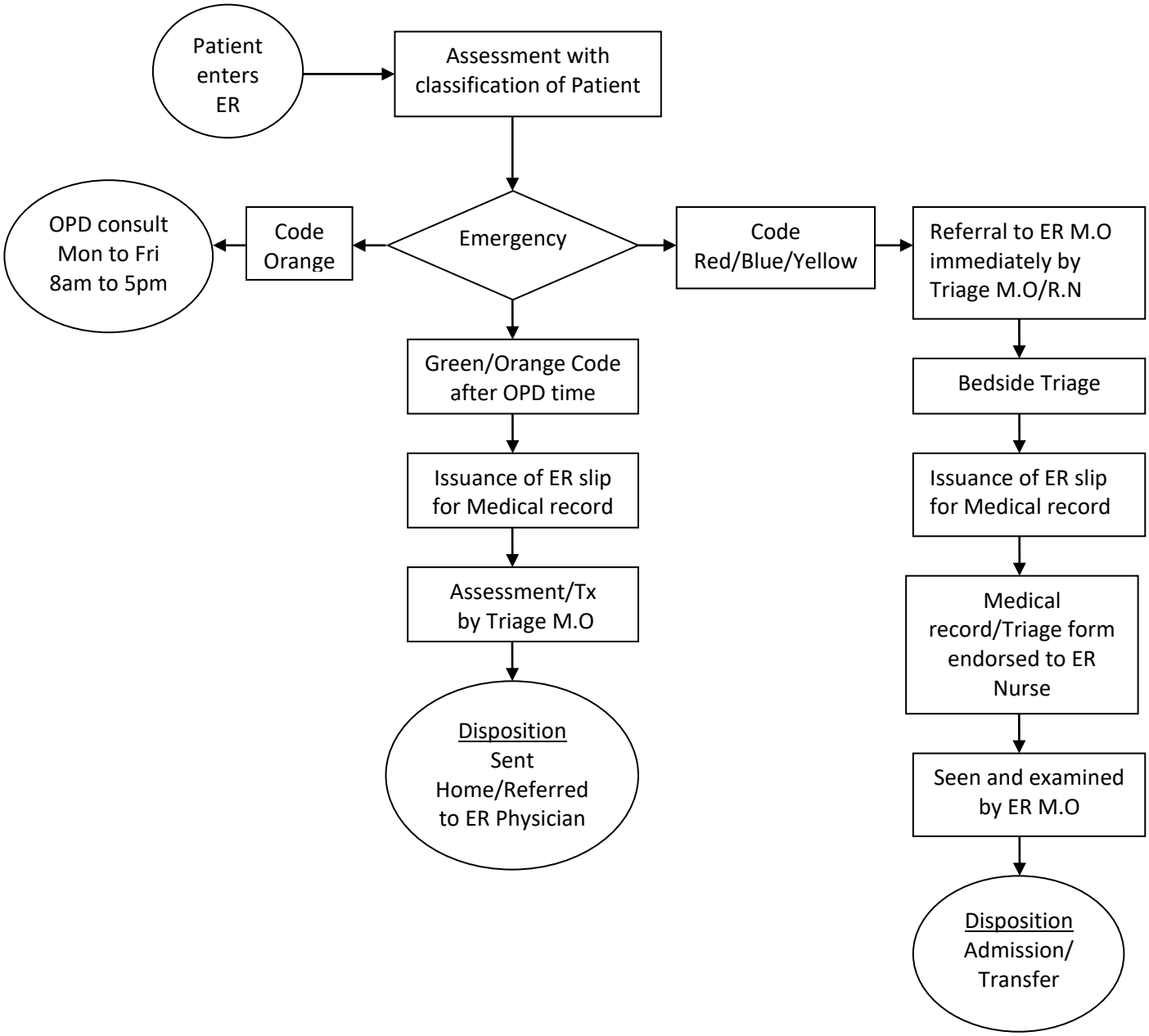
HOTS FLOWCHART
(Hospital Operational Triage System)



POLICY ON ADMISSION AND DISCHARGE
AT MEDICAL/ SURGICAL WARD

POLICY NO: NSO - 010

DIVISION: NURSING SERVICE DIVISION

SECTION: MEDICAL SURGICAL WARD

POLICY REVIEWED: July 12, 2016

Reviewed by:		
Arnaldo S. Cortes, RN MS Ward- Head Nurse	Nestor O. Beato, RN Ward Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

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OBJECTIVES: This policy defines the standard flow of admission and discharge in the medical and surgical unit regardless of cases to their designated room.

VISION: A nursing section dedicated in attaining excellent healthcare and recognized in giving quality medical and surgical care.

MISSION:

1. To improve and sustain the health of our fellow Paraqueños, by ensuring them with rational use and access to a safe, effective, good quality and affordable healthcare.
2. To promote and provide health services that is appropriate, equitable and sustainable by utilizing suitably qualified and motivated staff that is committed to excellence and professionalism.

Specific Objectives:

1. Instill the right attitude by proper education regarding laudable behaviour that will provide a positive atmosphere among staff and customers.

2. Strict adherence to the standard of care in accordance to the set policy of the local/international nursing administrators.

3. Proper coordination with all the concerned personnel from top to bottom regarding the use of hospital resources.

4. Apply the standard performance appraisal that will determine strength and weaknesses of the staff and develop their competencies in the process.

COVERAGE: All hospital employees, medical and non-medical, and students who have contact with patients in the Medical-Surgical floor.

I. Duties and Responsibilities:

It shall be the responsibility of the Medical and Nursing staff to abide with the procedure incorporated to this policy.

Head Nurse

1. Supervise, assess and evaluate the activities of the medical and surgical team.
2. Conduct orientation of the newly hired employees.
3. Schedule shifts for the nurses and assign duties to them.
4. Orient staff of this policy and to monitor the general activities in the unit.
5. Develop anticipated solutions to problems regarding health needs that may arise.
6. Assist in discharge planning, referral to other agencies and return to Out-Patient department.
7. Counsel guide personnel with their strengths and weaknesses and recommends disciplinary actions when needed.
8. Analyze unit problems with the staff and elevate to superiors those that cannot be solved in the unit level.
9. When the need arises, he may carry out professional nursing duties as a staff nurse on the floor.

Assistant Head Nurse

Supervises over the work of the nursing staff, support them and assume the responsibilities of the Head Nurse in the absence of the latter.

Medical Staff Nurse

1. Provide medications and injections as prescribed by the doctor.
2. Administer Intravenous Fluids and oxygen, if required.
3. Do the initial vital signs or as need arises like BP, Temperature, and Pulse etc. record and update the doctor including medical information.

4. Provide frequent patient evaluations including performing essential procedures.
5. Refer any changes in patient's status or untoward reaction to the doctor.
6. Monitor, analyse and record urine and stool output.
7. Assist doctors during rounds and treatment and caries out instructions properly.
8. Prepare the patient for various procedures like Ultra Sound, ECG, CT SCAN, MRI, Endoscopy, etc.
9. Provide general nursing care to all patients.
10. Give psychological support to the patient and family members. Educate patient and family about the disease and other laboratory procedures needed.
11. Record all care information in concisely, accurately and completely in a timely manner on patients nurses notes.
12. Participate in service nurse education programmes conducted by the hospital.
13. Inform patient and relatives in proper feeding as ordered by the doctor.
14. Responsible in maintenance of supplies, instruments, equipments and area cleanliness.

Surgical Staff Nurse:

1. Prepare the patient and equipments for various procedures and assist the Surgeon.
2. Provide Oxygen therapy and secretion suctions if needed.
3. Monitor any untoward reactions of patient and report to the surgeon.
4. Provide basic bedside care for Pre and Post surgical patients.
5. Use universal aseptic techniques during wound care and dressings.
6. Provide psychological support to the patient and relatives and educate how to manage their wound/injury.
7. Make proper endorsement of patient to staff in the Operating Room.
8. Perform the responsibilities of the medical ward nurse as stated in their duties and responsibilities.

Nursing Attendant:

1. Participate in endorsement rounds.
2. Taking and recoding vital signs and keep record of patient’s intake and output.
3. Properly dispose used linens of discharged patients and prepare the room for newly admitted patients.
4. Assist in changing in to patient’s hospital gown.
5. Help patients get in and out of bed
6. Receive and endorse area supplies, instruments and equipments and report any loss or breakage for proper action.
7. Monitor and charge oxygen consumption used by the patient.
8. Carry out clerical jobs in absence of the unit clerk.
9. Assist the nurse in performing simple nursing procedures (TSB, enema, bed bath,cleaning of wounds)

10. Collect specimens including sputum, stool, and urine and send it for medical analysis to laboratory.
11. Maintain the area's cleanliness.

UTILITY WORKER

1. Provide patients with help walking and moving in and out of bed.
2. Transport patient to treatment units using wheelchair or stretcher.
3. Accompany patients in ambulance conduction or transfer to hospital of choice.
4. Assist in turning or to reposition bedridden patients alone or with assistance to prevent bedsores.
5. Restrain patients if necessary.
6. Deliver specimens like urine/stool etc. for examination to the laboratory.
7. Assist in shaving male patients with supervision.
8. Properly dispose used linens of discharged patients and prepare the room for newly admitted patients.
9. Check and maintain the availability of oxygen tank needed in the unit.
10. Ensure safety of the environment through regular rounds and cleaning of all equipment and report any loss or breakage for proper action.

CLINICAL CLERK

1. Perform clerical duties such as processing documents and maintenance of record.
2. Keep patients chart in order
3. Record all admitted and discharged patients
4. Record and submit all discharged patients documents with final diagnosis to the record section; if with NO final diagnosis is noted, submit the record to the medical officer for completion.
5. Submit and coordinate patient's record to accounting office for proper billing.
6. Update the area bulletin board.
7. Prepare and submit requisition for job order for proper action
8. Keeps the staff's DTR, leave of absence, record of meetings and lectures.
9. Answer and make telephone calls.
10. Bring written communications and referrals to appropriate department.
11. Help in cleanliness and orderliness of the unit.
12. Record minutes of the meetings.

POLICY: This policy shall enforce compliance by all with the guidelines incorporated into it to institute order and quality delivered services.

II. Procedure on Admission:

Routine Admission Procedures

A. **From Emergency Room**

1. Each admitted case must have a confirmed designated room and bed assignment.
2. Do bedside endorsement, ER/WARD nurse.
3. Check for completeness of patient chart and patient classification entered by Social Worker.
4. Carry out doctor's order promptly.
5. Notify dietary for patient nutritional requirements.
6. Follow-up referral to the attending physician thru Medical Officer.
7. Elective cases procedure scheduling:

Chart from the emergency room endorse to ward with the following:

- Consent signed by the patient's relative as witness.
- OR proposal approved by the Medical Director, Chief of Clinics in his absence.
- Check date of surgery, CP clearance for patient 35 years old and above and pediatric clearance for patient 18 years and below.
- Consent for Blood Transfusion signed by the patient/patient's relatives.

For elective surgical cases notification of anaesthesiologist and surgical consultant and accomplishment of pre-anesthesia form must be done by the admitting medical officer.

B. **To the Operating Room (the night prior to surgery up to the day of operation)**

a. For elective surgery:

1. Begin the preparation based on the checklist form prior to surgery.
2. Check the Surgeon and Anesthesiologist's order a night prior to surgery and give the necessary medications and final preparations (if any).
3. Coordinate with the operating room to validate the schedule of operation and if visit prior to surgery has been made.
4. Follow up the anesthesiologist order to the resident on duty if the pre-anesthetic order has not been made.
5. Check the vital signs prior to admission to the operating room and report to the medical officer on duty for any abnormality.
6. Check again the doctors order if there is any medications to be given before endorsing the patient to the operating room nurse.
7. Validate the preparation made with the checklist form.
8. Do bedside endorsement, WARD/OR nurse.

b. For STAT operation:

1. Begin the preparation based on the checklist form prior to surgery.
2. Inform the anaesthesiologist thru medical officer for her availability.
3. Check the vital signs prior to admission to the operating room and report to the medical officer on duty for any abnormality.
4. Inform the operating room nurse through phone call prior to transporting the patient to the operating room.
5. Accompany the utility worker in transporting the patient to the operating room. Bed rails must be up at all times. The patient shall be covered with a blanket for warmth and privacy.

From Operating Room

a. Post-operative patient

1. OR/RR notify ward of the admission.
2. Check for completeness of patient record anaesthesiologist disposition.
3. Ward N.A. prepares bed and the necessary equipments needed for the incoming post-op patient.
4. Routine check of completeness of chart and bedside endorsement done.
5. Check dressing, patency of IV line, Foley catheter, and NGT and/or Thoracic tubes.
6. Monitor and report any signs of complication.

III. Discharge Routine

a. Upon order of may go home (MGH) by Attending Physician/Resident Doctor
b. Patient record shall be completed prior to submission for billing.
1.Routine May Go Home order on patient's chart
- Final Diagnosis (ICD 10) and procedure done fully accomplished.
-Change in dressing done by staff nurse , health home instruction sheet issued to patient and/or family.

1. If discharge against doctor's order, secure waiver for HAMA and attach to chart, noted by MD with the signature of both nurse and doctor.
2. Billing section issues payment order to relative of patient; Re-billing of MGH patient chart must be done if patient overstays.
3. Clearance issued by cashier upon payment of hospital bill and/ or professional fees.
4. Ward U.W. inspects bedside table and patient's bed for any uncollected wastes or personal belongings. If cleared the charge nurse, home instruction is given in triplicate. The latter issues clearance slip with Official receipt stamped to the security staff, linen staff and admitting staff along with the clearance.
5. Patient's tag inspected by security staff along with the clearance slip.

IV. Documentation

a. Chart should be arranged according to the required chart arrangement.

b. Write legibly and avoid erasures; the use of correction fluid is discouraged.

c. Indicate the number (#) of IVF on the Doctor's order in pencil, to check the accuracy of IVF infused. The one asking for to follow is responsible to #IVF at Doctors order sheet.

d. Medication sheet must be signed by NOD for any medication administered, place "o" mark if not given and indicate the reason at the nurses notes.

Indicate if increase or decreased in dosage and frequency, discontinued, shifted, completed, consumed or refused. Write the date when transcribed in the medication sheet.

e. Record IVF infused, separate sheet for main line/side drip or B.T, I & O, vital signs on TPR sheet; write monitoring in a separate sheet.

f. Laboratory results should be arranged according to date; recent one is on top, same as with the other results. For hgb, hct, platelet monitoring use separate sheet. All results shall be signed by Medical Officer/Medical Specialist date and time relayed.

g. Any procedure to be done must be properly explained and secure consent from the patient of legal age, for minors, parents or guardian, witness on the consent form must be signed by the relatives. Indicate date and time when the consent was secured.

h. Request for laboratory, x-ray and etc. must have a complete data indicate the middle name and date of birth of the patient.

i. Upon discharge check for patient admission record for final diagnosis and disposition; must be filled-up by the Attending Doctor or Medical Officer when discharge order was made.

j. Discharge summary/instruction sheet must be in duplicate with signature of the patient, nurse and the discharging doctor, one will be given to the patient and one will be attached to the patient chart.

k. Refusal to procedure and management (HAMA) must be reported immediately to the Attending Physician thru the MOD. A written waiver must be secured.

l. Admission, and discharges must be recorded on the logbook indicate the age, date, time, case of the patient for Phil health requirement and purposes.

m. Prepare for 24 hours floor census and submit to the supervisor on duty 12:00 midnight

n. Follow coded ink charting, Am-blue, PM-black and Night- red

o. Carry out doctors order promptly; check each line according to the acronym CARED; write a blocking line indicating it was carried out, countersign, indicate date and time it was carried out; use TRODAT.

p. Outgoing Nurse endorse Doctor's Order done during the shift to incoming Nurse, the latter then sign/TRODAT with the date that he/she received the endorsement.

q. Comply on the policy on documentation and charting

V. Endorsement

1. All staff must be in the area 15 minutes before the endorsement time.

2. Prior to ward rounds, a 15 minutes pre-conference endorsement at the nurse's station
3. All staff must not leave the area without the incoming shift. In case of absences, inform the Nurse Supervisor/Coordinator for the staffing arrangement.
4. Incoming Nurses will not receive the area if unclean. Maintain area cleanliness at all times.
5 Every endorsement outgoing nurse must endorse the patient's cardex and patient chart, incoming nurse must review the cardex prior to ward round, chart auditing must be done routinely.

VI. Procedures on Isolation Room:

1. Standard Precautions shall be used in the care of all patients taking into consideration the use of proper PPE and following universal precautions on communicable diseases.

2. Patients with known or suspected communicable diseases will be placed on the appropriate type of Isolation Precautions on admission to the hospital.

3. Proper signs/labels must be posted on the specified rooms and type of Standard Precautions must be included.

4. Hospital personnel should instruct all visitors about what type of precaution to be taken while visiting patients who are admitted.

5. Upon patient discharge, both used and unused items must be disposed properly and hospital equipment must be disinfected.
6. No watcher No admission unless "pulot" patients but with proper coordination with the social service; for private patients one watcher is allowed; serious patient – 2 watchers
7. No bed reservation at Ward, it should be channeled to Admitting section.

APPENDIX:

Ward Discharge Flow Chart
Discharged Patients Record Flow Chart
Flowchart of record of Discharged Patient

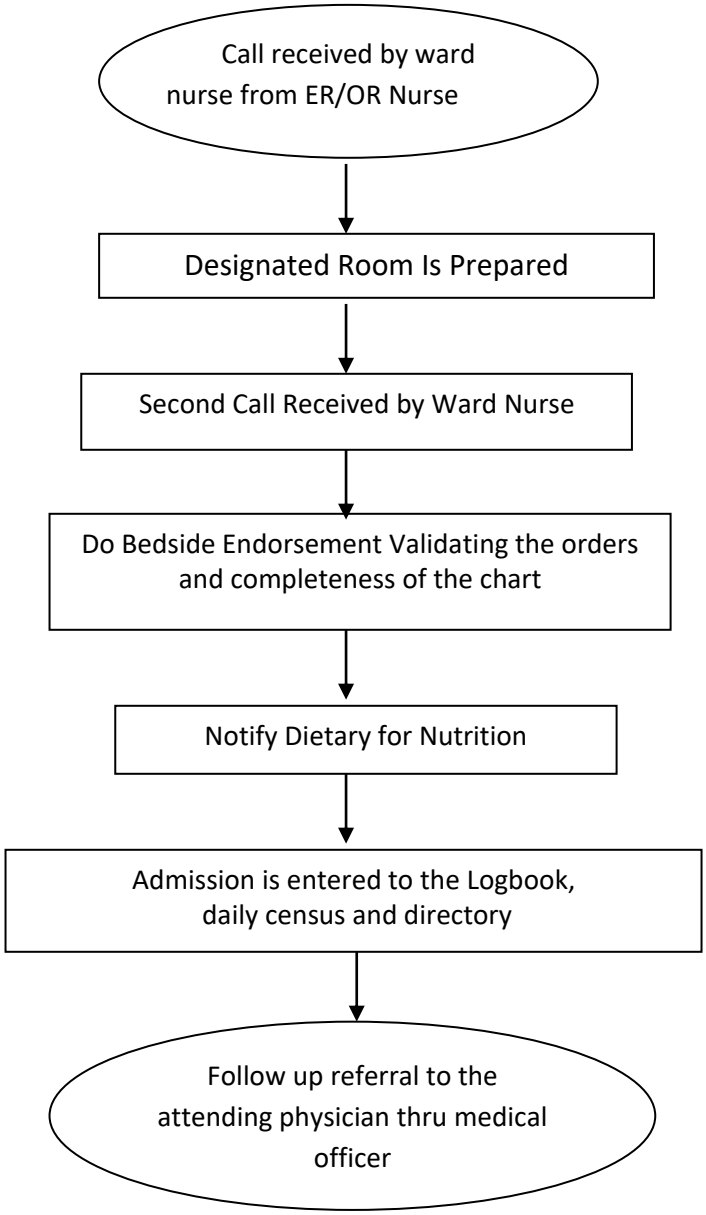
DATE OF IMPLEMENTATION:

This policy has been implemented since 2009, revised 2011 reviewed 2016. This policy will continue to be implemented as rewritten.

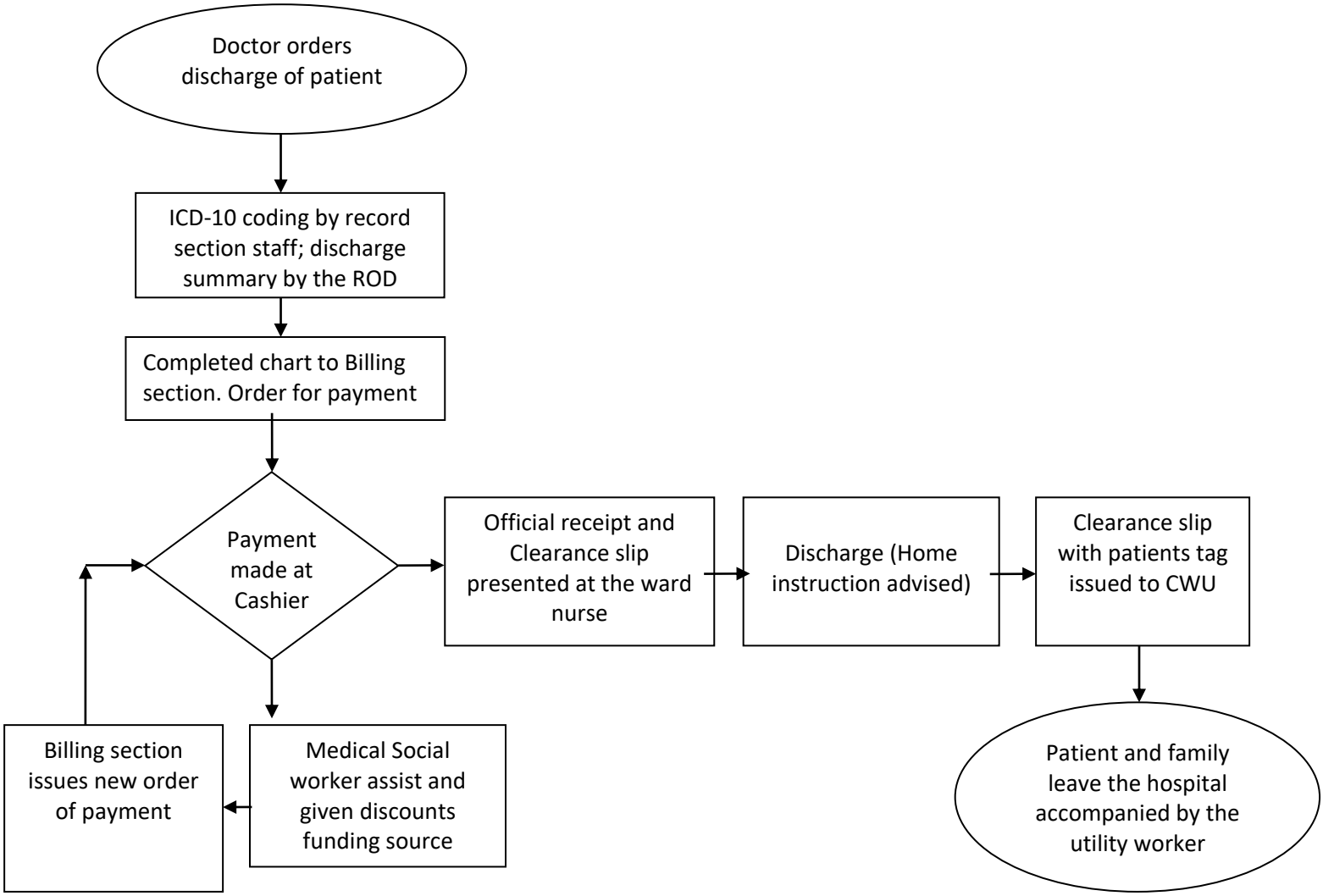
SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

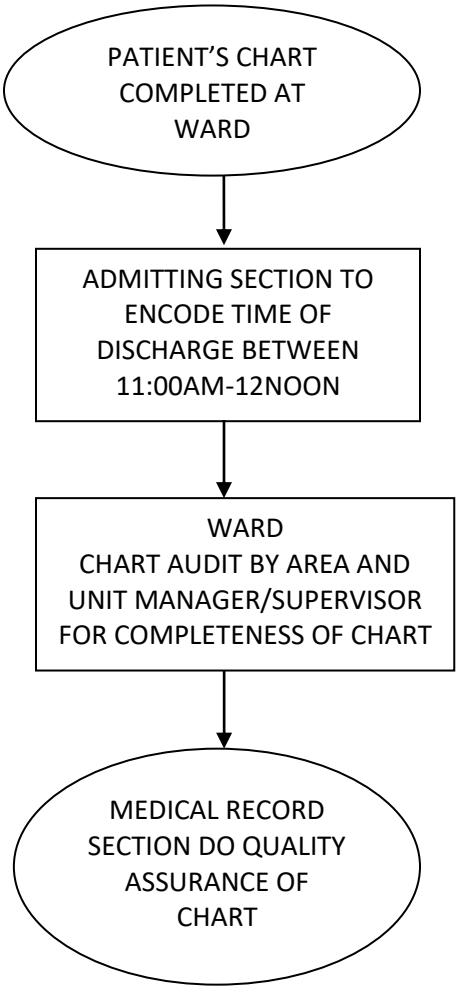
Admission Flowchart



Discharge Flowchart



FLOWCHART OF RECORD OF DISCHARGED PATIENT



Definition of terms:

Excellent- Possessing outstanding quality or superior merit; remarkably good

Laudable- Deserving praise, praiseworthy, commendable

Appraisal- The act of estimating or judging the nature and value of something or someone. An estimate or considered an opinion of the nature, quality, importance, etc.

Standard- A level of quality, achievement, etc., that is considered acceptable or desirable

ECG- is a test that checks for problems with the electrical activity of your heart. An EKG translates the heart's electrical activity into line tracings on paper. The spikes and dips in the line tracings are called waves. a medical device use to determine the activity of the heart.

CT SCAN -The abbreviated term for computed or computerized axial tomography. The test may involve injecting a radioactive contrast into the body. Computers are used to scan for radiation and create cross-sectional images of internal organs.

MRI- The abbreviated term for magnetic resonance imaging. MRI uses a large circular magnet and radio waves to generate signals from atoms in the body. These signals are used to construct images of internal structures.

Endoscopy- Examination of organs accessible to observation through an endoscope passed through the mouth.

Aseptic- Free from infection or septic material.

ELECTIVE- Surgery carried out at a time convenient to client and surgeon. The opposite of emergency surgery.

TRODAT- is a juxtaposition of the syllables TRO and DAT. "TRO" stands for Trolitul plastic previously used for stamp manufacture. "DAT" is the abbreviation for date stamp. It is a self-inking stamps with a built-in stamp pad

Cardex- is a form used by a nurse to record a patient's details in a manner that allows for easy retrieval of the information

Infirmary- health care institution providing patient treatment by specialized staff and equipment.

Pulot- An individual without permanent housing who may live on the streets; stay in a shelter, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.

Spill over- An instance of overflowing or spreading into another area.

Flowchart- A diagram of the sequence of movements or actions of people or things involved in a complex system or activity

Parturation- the action or process of giving birth to offspring

Abbreviations:

DTR- Daily Time Record
CP Clearance- Cardio-Pulmonary Clearance
QA- Quality Assurance
OD- Once a day
PE- Physical Examination
NA- Nursing Attendant
MGH- May Go Home
NGT- Naso-Gastric Tube
HAMA- Home Against Medical Advise
MD- Medical Director
CWU- Civilian Watcher's Unit
IVF- Intravenous Fluid
BT- Blood Transfusion
I & O- Intake and Output
HGB- Hemoglobin
HCT- Hematocrit
MOD- Medical Officer on Duty
CBC- Complete Blood Count
PPE- Personal Protective Equipment
UA- Urinalysis
CARED- Carried; Administered; Requested; Endorsed; Done

CHART ARRANGEMENT

Optional:

Hgt monitoring/ Weighing OD/ Abdominal girth OD

1. ADMISSION AND DISCHARGE RECORD
2. CONCURRENT PATIENT CHART AUDIT FORM
3. CONSENT FOR HOSPITAL CARE AND MANAGEMENT
4. MEDICATION SHEET OR TREATMENT SHEET
5. IVF SHEET
6. VITAL SIGNS/ NEURO VS MONITORING SHEET
7. DOCTOR'S ORDER
8. HISTORY AND PE
9. DOCTOR'S PROGRESS REPORT
10. NURSES NOTES
11. LABORATORY WORK UPS
12. PARTURITION RECORD (OB CASE)
13. OR RECORD (AUTHORIZATION FOR SURGICAL TREATMENT, ANESTHESIA RECORD AND TECHNIQUE OF OPERATION)
14. OTHER PERTINENT RECORDS –OPS CHART, PREVIOUS ADMISSION CHART AND OTHERS

POLICY ON ADMISSION AND DISCHARGES AT PEDIATRIC WARD

POLICY NO: NSO-011

DIVISION: NURSING SERVICE DIVISION

SECTION: PEDIATRIC WARD

POLICY REVIEWED DATE: **JULY12, 2016**

Reviewed by:		
Melliza B. Muyot, RN Pedia Ward- Head Nurse	Nestor O. Beato, RN Ward Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES: This policy defines the standard flow of admissions and discharge in the pediatric ward

COVERAGE: This policy shall be adopted by all Nursing ward staff assigned to this area

VISION: WILL BE A PREMIER LEADER IN PROVIDING SPECIALTY HEALTH CARE FOR CHILDREN AS WELL- KNOWN BY OUR:

- Quality of care
- Service excellence
- Innovation
- Multidisciplinary approach
- Family focus
- Outstanding personnel

MISSION: Provide quality, compassionate and family - centered care to the pediatric client ranging from 28 days old to 18 years of age.

RESPONSIBILITIES:

I. It shall be the responsibility of the **MEDICAL NURSING STAFF** to abide with procedures incorporated into this policy

II. It shall be the responsibility **Head Nurse** (UNIT MANAGER)

a. Orient staff of this policy and to monitor the general activities in the unit
b. Maintain accurate implementation of total nursing care
c. Establish the trust of newly admitted patient and orient them to their surroundings
d. Develop anticipated solutions to problems regarding health needs that may arise
e. Supervises, assesses and evaluates the performance of the unit personnel, provides assistance when needed
f. Coordinates/participates in staff development program research and orientation courses

g. Assure strict implementation of hospital policies, rules and regulations through interpretation/orientation of nursing personnel

III. It shall be the responsibility **Assistant Head Nurse** to supervises over the work of the nursing staff, support and assume the responsibilities of the head nurse in the absence of the latter.

IV. It shall be the responsibility of the **Staff Nurse** to:

a. Accept and do bedside endorsement of any paediatric case from the Emergency room
b. Prepares and administers and record prescribed medications and report adverse reaction to medications or treatments.
c. Help patient to be comfortable and cooperative with examinations/procedures
d. Assist physicians in treating patients during examination, treatment and procedures
e. Provides education, information and support to the patient's family
f. Records all care information concisely ,accurately and completely in a timely manner in the appropriate format and on the appropriate forms
g. Carry out doctor's order legally with promptness
h. Ensure correct diet feeding
i. Evaluate and record the effectiveness of treatment and patient's comfort.
j. Maintain protective measures based on patient's safety
k. Document patient progress through careful record keeping, notifying doctors in the event of any changes in a patient's situation

V. It shall be the responsibility **Nursing Aide** to:

a. Prepare beds for admission.
b. Prepare and assist doctors in wound dressing.
c. Monitor, record, and report vital signs and any anticipated problems.
d. Collect and properly label specimen and deliver it with the corresponding request.
e. Follow proper procedure for lifting and moving patient
f. Observe patient's physical, mental and emotional conditions.
g. Help dress and groom patients. Check supplies and perform clerical task as needed.
h. Receives and endorse ward, articles, instruments and equipments. Reports to the senior nurse any losses/breakages for proper action
i. Monitor and charge oxygen consumption used by patient

VI**.** It shall be the responsibility of the **Ward Clerk** to:

a. Records all admitted and discharged patients
b. Check chart forms for completeness
c. Receive patients and watcher complaints
d. Coordinate activities of patient to different unit as need arises.

e. Assisting NA and UW in monitoring relevant duties as designated
f. Record and submit all discharged with final diagnosis to the record section.
g. Submit and coordinate with accounting section regarding bills and Physician's professional fee.

VII. It shall be the responsibility of the **Utility Worker** to:

a. Assist patient in lifting, turning, positioning, and dressings of patients
b. Check availability of oxygen for patient's use
c. Transport of patients from Emergency room
d. Accompanies patient for conduction and transfer to other hospitals as needed
e. Performs daily routine housekeeping activities in the unit. Participates with the housekeeping staff during general cleaning and fumigation of the area.
f. Ensure safety of environment through regular check-up of IV stands, stretcher and other equipments
g. Clean equipments after each use and maintains them clean during his tour of duty
h. Used vials shall be disposed in a proper container and forwarded to the pharmacy for final disposal every morning shift
i Ensures safety and security of the unit as well as all the items in the unit

PROCEDURE:

I. Routine Admission Procedures
1. Each admitted case must have a confirmed designated room and bed assignment
2. Do bedside endorsement,ER/Ward nurse.
3. Check for completeness of patient chart and patient classification entered by the social worker
4. Carry out doctor's order promptly
5. Notify dietary for patient nutritional requirements
6. Follow-up referral to the attending physician thru the medical officer.

II. Discharge Procedures
1. Upon order of may go home (MGH) by attending physician/Resident Doctor
2. Patient record to be completed prior to submission for billing
3. Billing section issues order of payment to patient's relative: Re-billing of MGH patient's chart must be done for overstaying patient.
4. Clearance issued by cashier upon payment of hospital bill and/or professional fees.
5. Ward U.W. inspects bedside table and patient's bed for any uncollected wastes or personal belongings
6. If cleared with the nurse in charge, official receipt stamped and signed.
7. Clearance slip and home instruction is given in duplicate, one copy will be given to the patient and another copy retained in patient's chart.
8. Patient's tag inspected by security staff along with clearance slip.

III. Documentation

a. Chart should be arranged according to the required chart arrangement, with complete patient's data
b. Write legibly and avoid erasures; the use of correction fluid is discouraged.
c. Indicate the number (#) of IVF on the Doctor's order in pencil, to check the accuracy of IVF infused. The one asking for to follow is responsible to #IVF at Doctors order sheet.
d. Medication sheet must be signed by NOD for any medication administered. Indicate if discontinued, shifted, completed, consumed or refused meds must be documented at the nurse's notes.
e. Record IVF infused, I & O, vital signs on TPR sheet; write monitoring in a separate sheet.
f. Laboratory results should be arranged according to date; recent one is on top, same as with the other results. For hgb, hct, platelet monitoring use separate sheet.
g. Any procedure to be done must be properly explained and secure consent from the patient of legal age, for minors, parents or guardian, witness on the consent form must be signed by the relatives. Indicate date and time when the consent was secured.
h. Request for lab, x-ray and etc. must have a complete data indicate the middle name and date of birth of the patient.
i. Upon discharge check for patient admission record for final diagnosis and disposition; must be filled-up by the Attending Doctor or Medical Officer when discharge order was made.
j. Refusal to procedure and management (HAMA) must be reported immediately to the Attending Physician thru the MOD. A written waiver must be secured.
k. Admission, and discharges must be recorded on the logbook indicate the age, date, time, case of the patient for Phil health requirement and purposes.
l. Prepare for 24 hours floor census and submit to the supervisor on duty 12:00 midnight
m . Follow color coded ink charting, Am-blue, PM-black and Night-red
n. Carry out doctors order promptly; check each line; write a blocking line indicating it was carried out, countersign, indicate date and time it was carried out; use TRODAT.

IV. Endorsement

1. All staff must be in the area 15 minutes before the endorsement time.

2. 15minutes pre-conference endorsement at the nurse's station, prior to ward rounds.

3. All staff must not leave the area without the incoming shift. In case of absences, inform the Nurse Supervisor/Coordinator for the staffing arrangement.

4. Incoming Nurses will not receive the area if unclean. Maintain area cleanliness at all times.

5. No watcher No admission unless "pulot" patients; for private patients one watcher is allowed; serious patient – 2 watchers

6. No bed reservation at Ward, it should be channelled to Admitting Section to avoid breaking the "first come first serve basis" rule at ER with regards to admission. Furthermore, ICU reservation will also not be allowed since ER is our priority unless the case at ER warrants ICU admission.

DATE OF IMPLEMENTATION:

This policy has been implemented since 2009, revised 2011 reviewed 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

OPERATING ROOM AND POST ANESTHESIA RECOVERY ROOM

POLICY NO: NSO -012

DIVISION: NURSING SERVICE DIVISION

SECTION: OPERATING ROOM

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Charles Rae Lindaya, RN OR- Head Nurse	Aida M. Landicho, RN OR Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES: This policy shall aim to provide the standard operating procedure which shall be observed to deliver quality health care services.

COVERAGE: This covers all the medical and nursing staff of the Operating Room and Recovery Room

RESPONSIBILITIES:

I. It shall be the responsibility of the **Medical and the Nursing staff** to abide with the procedures incorporated into this policy.

II. It shall be the responsibility of the **Head Nurse** to orient her staff and other personnel working in the unit to the policy, job description and monitor the activities in the unit.

III. It shall be the responsibility of the **Scrub Nurse** to:
   a. Check the supplies, equipments, medicines and instruments available for surgical procedures.
   b. Preparation of OR prior to surgery.
   c. Assisting in the set-up and performance of the cases.
   d. Opening of sterile packs and instruments according to sterile techniques.
   e. Preparing sterile field including sponges, needles and instrument count.
   f. Work directly with the surgeon within the sterile field
   g. Clean-up of OR following surgery.
   h. Updating surgeon's preference cards and instruments list.
   i. Clean and pack instruments used.

IV. It shall be the responsibility of the **Circulating Nurse** to :
   a. Prepares the patient for surgery.

b. Obtains and opens package for the "sterile" person to remove the sterile contents during the surgical procedure.
c. Keeps written accounts of the surgical procedure.
d. Answers questions about patient during surgery.
e. Maintains required log and paper works.
f. Forward specimen to laboratory with patient's relative.

V. It shall be the responsibility of the **Recovery Room Nurse** to:
a. Take care of the patient until they fully regain consciousness and recovered from anesthesia.
b. Observe and report the condition of patient for any signs of post-op complication.
c. Routine administration of medicines.
d. Refer for disposition of anethesiologist prior to room transfer.

VI. It shall be the responsibility of the **OR transporter** to:
a. Transport patient from the Operating Room accompanied by the RR Nurse.
b. Maintenance of area cleanliness,
c. Pack linens for autoclaving, forward all used linen to linen department.
d. Check all equipments used and maintain cleanliness during tour of duty.

POLICY:

I. This policy shall enforce that all abide to ensure order and eliminate conflicts among staff of this section and those of other divisions.

II. This policy shall ensure the timeliness and accuracy of delivered health services to the best interest of the patient and the institution.

PROCEDURE:

I. All hospital staff must change their street clothes into clean scrub suit when entering and assisting in operations. RR Nurses and transporter shall wear gown when transporting patient out of the area.

II. Any specimen for histopath should be brought to the laboratory by the OR Staff with patient's relatives. Surgical Pathology/ Cytology request form in duplicate copies should be properly filled-up with patient's complete data including the properly labelled specimen, indicating its location and laterality. A brief clinical history should also be written, including previous operation/s, biopsy and anciallary results. Receiving laboratory staff and patient's relatives should sign the OR specimen logbook.

III. Nurse should utilize endorsement logbook for stocks and specimens. Outgoing staff must not leave the area without the incoming staff. All staff on duty should be responsible in keeping the area clean at all times.

IV. Unreplaced supplies shall not be accepted by incoming charge nurse to ensure availability of stocks.

V. Document and report any loss of instrument or breakage of equipment with written justification for replacement to the Head of this section who shall do immediate reporting to the Chief Nurse.

VI. Soiled linens shall be double checked by staff after each operation for any infectious waste prior to collection by linen staff.

VII. The area shall maintain at least 20 patient gowns, linens and major packs in a day; but when supply runs low, request must be made for additional linen before 9pm.

VIII. Scheduling of operation:

a. Proposal for elective operation should be submitted not later than 5pm a day prior to date of the procedure with complete data and approval by the Chief of Hospital. A **NO proposal NO surgery policy** is for strict implementation. The Chief of Clinics may sign the proposal when the COH is unavailable.
b. For emergency OR, indicate the pre-operative diagnosis in the OR proposal slip and the SHO shall sign the proposal.
c. All patients for **Elective MAJOR** operation should be admitted not later than 12midnight of the day prior to scheduled operation, otherwise no acceptance of the procedure.
d. No OPD cases will be accepted by OR after 5pm.
e. The patient, surgeon, anaesthesiologist and the assist Medical Officer should be in the operating room 30 minutes before the proposed time of the operation. A grace period of two (2) hours shall be allowed for the delay in the arrival of the surgeon and anaesthesiologist. Beyond this waiting time:
   -Emergency Case: MO to call next on duty Medical Specialist who can make it and proceed with the operation
   -Elective Case: Surgical MS to make a new proposal for the reset of the OR to not later than two(2) days from original date of OR.
f. Patient shall stay in the RR while waiting for the procedure to commence and monitored for complication. If the date is reset, the patient is transferred back to ward.
g. All schedules of operation for the following day shall be posted in the OR bulletin not later than 5pm. Copies of the schedule shall be distributed to ER, Ward and Chief Nurse.
h. Elective Operation (Major/Minor)
   8am- 5pm - Monday to Friday
   8am- 12pm - Saturday
   Sunday – General cleaning and disinfection of the area
i. No scheduling of elective operations on holidays
j. Emergency cases anytime

IX. Pre-operative Routine
a. Skin preparation and pre-operative medications
   1.Elective Cases – Ward Nurses
   2.Emergency Cases - ER/ Ward Nurses
b. Check for OR pre-operative checklist signed by Ward/ER Nurse and by receiving OR Nurse for complete pre-operative preparation before putting the patient on the OR table.
c. Prepare all forms for OR documentation
d. Invest a minute for time out prior to induction of anesthesia to accomplish the Surgical Safety Checklist (with Nurse, Anesthesiologist, and Surgeon)

X. Intraoperative Routine
a. Field of operation shall be prepared by the surgeon assistant if available or the OR Nurse
b. Surgical preparation with Betadine scrub and antiseptic Cutasept. Follow the correct technique in skin preparation.
c. Perform sterile hand scrubbing, gowning, and gloving technique.
d. OR team assist the surgeon
e. Assurance of correct counting

XI. Post- operative Routine

a. Application of wound dressing, check vital signs, report any signs of bleeding
b. Accomplish the following documents prior to Recovery Room and Ward Transfer: OR Record, Nurses Notes, Instrument Count Sheet, Two (2) copies of Anesthesia Record, OR Technique and hospital charges.

XLL. Post- Anesthesia Recovery Room Routine

a. Check and prepare supplies and equipments for the coming of patient from the Operating Room.
b. Accomplish Recovery Record. The following information should be documented prior to discharge of patient:
    1. Time the patient is received in the RR and time of transfer to ward.
    2. Monitor the level of consciousness and the condition of the patient. Time, amount of infusion and medication given.
    3. Information concerning changes in vital signs if any
    4. Complication and management administered.
c. Close monitoring of vital signs every 15minutes for 2 hours, every 30minutes for 2 hours then hourly, including O2 Saturation until stable.
d. Record I & O accurately; refer immediately for urine output less than 30cc.
e. Discharge patient from RR when fully recovered from anesthesia.
    1. General Anesthesia – fully awake, vital signs stable
    2. Spinal Anesthesia – can flex both knees
f. Anaesthesiologist should not leave the patient prior to transfer to ward od ROD to check patient and make order for trans-out.
g. Inform ward staff 15minutes prior to ward transfer and inform them of the necessary appliances to prepare for the patient's needs.

XLLL. Area Endorsement

a. All staff should not leave the area without the incoming duty. Inform the Nurse Supervisor on duty if situation is compromised.
b. Area cleanliness should be maintained at all times. Blood should be disposed in a separate sink provided.

APPENDIX:

- Operating Room Flow chart
- Recovery room Flow Chart
- Authorization for Surgical Treatment
- Pre-anesthetic Record
- Instrument Count Sheet
- Record of Operation
- Anesthesia Record
- OR Charge Ticket
- OR Record of Nurse
- Recovery Room Record

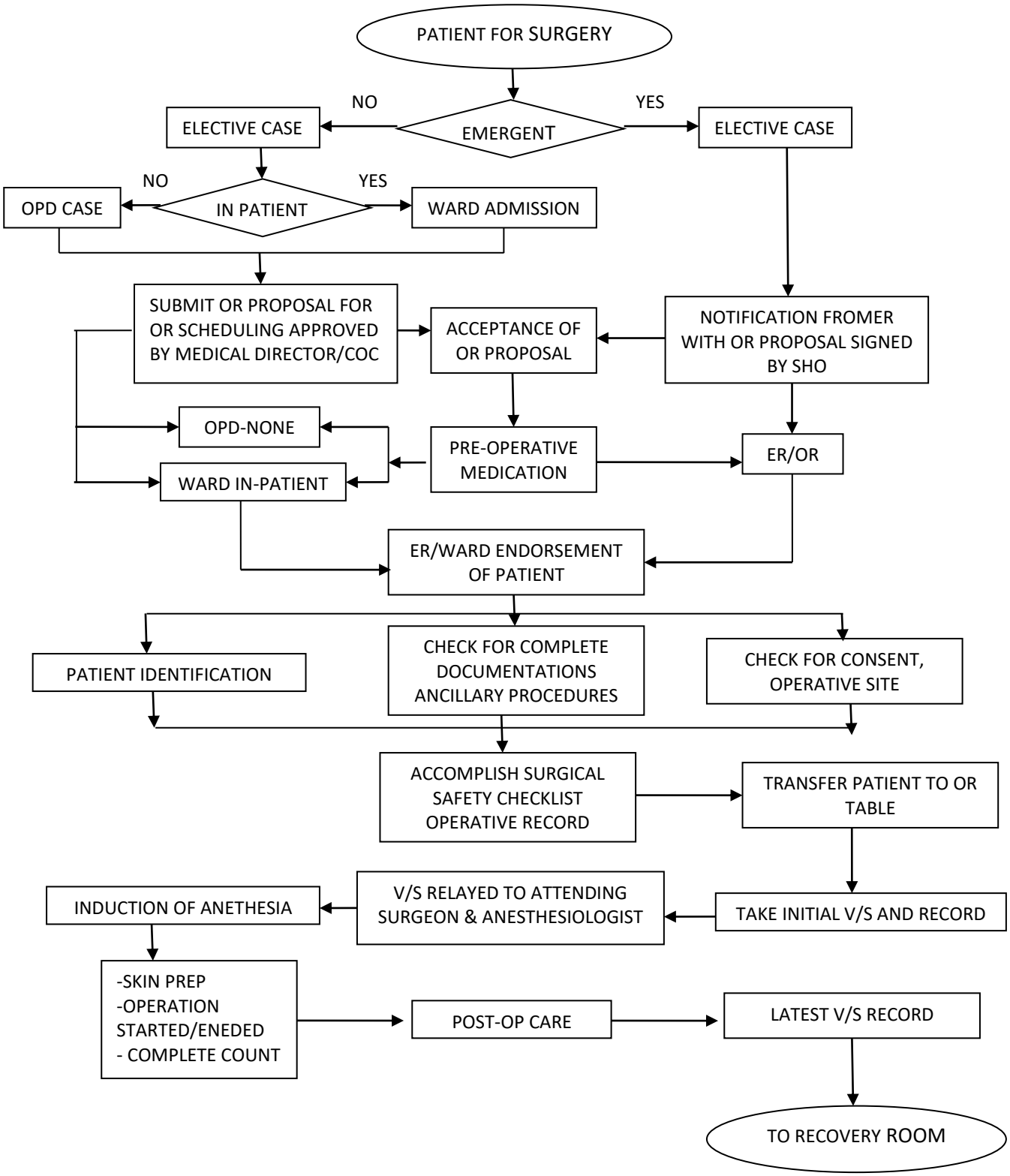
DATE OF IMPLEMENTATION:

This policy has been implemented since 1978, however, minor revision has been made 1994, 1998, 2001, 2003, 2006, 2011 and reviewed 2016.

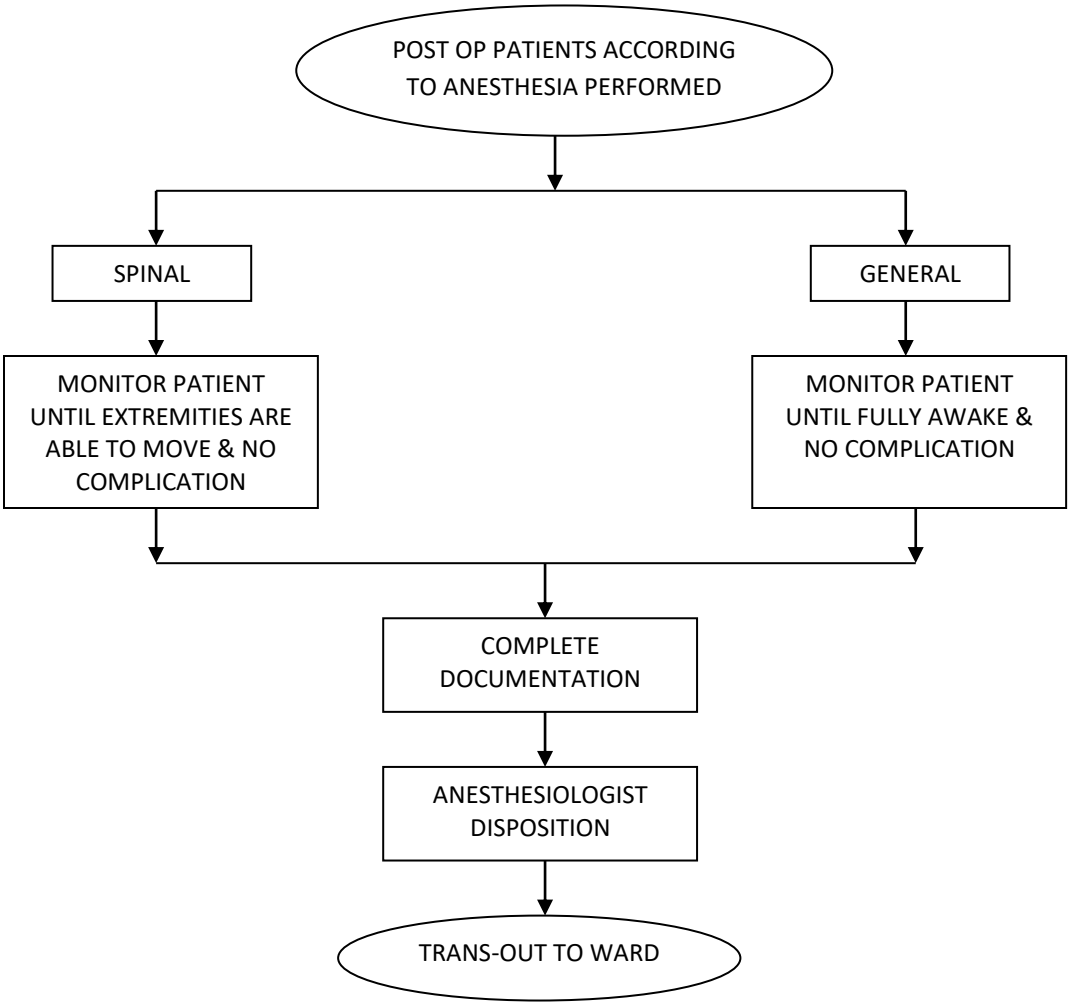
SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary

OPERATING ROOM FLOW CHART



RECOVERY ROOM FLOWCHART



Authorization for Surgical Treatment

OSPITAL NG PARAÑAQUE

Quirino Avenue. La Huerta, Parañaque City.
Tel-825-4902 Email – Ospitalngparanaque@yahoo.com

AUTHORIZATION FOR SURGICAL TREATMENT

NAME (LAST, FIRST, MIDDLE)	SEX	AGE	HOSPITAL NO.

1. I, THE UNDERSIGNED, A PATIENT IN Florencio V. Bernabe Sr. Memorial Hospital, HEREBY AUTHORIZE DR. _____ , AND (WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS) TO ADMINISTER SUCH TREATMENT AS IS NECESSARY, AND TO PERFORM THE FOLLOWING OPERATION(S) _____ AND SUCH ADDITIONAL OPERATIONS
   (STATE NAME OF OPERATION(S) AND/OR PROCEDURES)
   OR PROCEDURES AS ARE CONSIDERED THERAPEUTICALLY NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SAID OPERATIONS.
2. I FURTHER AUTHORIZE THE ADMINISTRATION OF SUCH ANESTHETICS AS ARE CONSIDERED NECESSARY OR DESIRABLE WITH THE EXCEPTION OF _____
   (STATE NONE OR NAME OF ANESTHETIC)
3. I AUTHORIZE THAT ANY SPECIMENS , TISSUES , OR PARTS REMOVED FROM THE PATIENT MAYBE DISPOSED OF IN ACCORDANCE WITH THE HOSPITAL'S ESTABLISHED PRACTICE.
4. THE NATURE AND PURPOSE OF THE OPERATION, THE RISKS INVOLVED, AND THE POSSIBILITY OF COMPLICATIONS HAVE BEEN EXPLAINED TO ME BY DR. _____ , I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.
5. I CERTIFY THAT I HAVE READ HIS CONSENT AND/OR THAT IT HAS BEEN EXPLAINED TO ME IN MY DIALECT. I FURTHER CERTIFY THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED BEFORE I AFFIXED MY SIGNATURE.

_____ SIGNATURE OF WITNESS

_____ SIGNATURE OF PATIENT

_____ DATE AND TIME

AUTHORIZATION MUST BE SIGNED BY THE PATIENT OR BY THE NEAREST RELATIVE IN THE CASE OF A MINOR OR WHEN PATIENT IS PHYSICALLY OR MENTALLY INCOMPETENT

PATIENT IS A MINOR_____YEARS OF AGE

PATIENT IS UNABLE TO SIGN BECAUSE _____

_____ SIGNATURE OF WITNESS

_____ SIGNATURE OF PATIENT'S REPRESENTATIVE

_____ DATE

_____ RELATIONSHIP TO PATIENT

A-2

OSPITAL NG PARAÑAQUE

PRE-ANESTHETIC ASSESSMENT

SURNAME :_____ GIVEN NAME : _____ MIDDLE NAME : _____	AGE : _____ SEX : F( ) M( )	HOSPITAL NO : _____ WARD/RM : _____ DATE:_____
OPERATION :	**SURGEON:**	

PATIENT INFORMATION Please answer the following questions **Yes** or **No**	**MEDICAL OFFICER ASSESSMENT** Weight:
Have you had anesthesia for operations previously?	Physical Status
Did you have any problem ?	
Have you ever suffered from: Heart attack	Hb_____ ECG_____ CXR_____Biochem_____
High blood pressure	
Stroke	Others:_____
Angina	_____
Chronic Lung Disease	Significant History:_____
Asthma	_____
Hepatitis	Physical Examinations:_____
Kidney Disease	Pre-operative instructions:_____
Diabetes	_____
Epilepsy	Pre-medications:_____
Rheumatic fever	_____
Other disease (describe)	_____ Nurse Signature:
What drugs do you take?	_____ Special Instructions:_____
Do you have any allergies?	_____ _____
Could you be pregnant?	_____
Signature of Patient / Parent / Guardian	Signature of Medical Officer

OSPITAL NG PARAÑAQUE
INSTRUMENT COUNT

DATE: _____

NAME OF PATIENT: _____ HOSP. NO. _____
AGE: _____ CASE NO._____
OPERATION PERFORMED: _____

INSTRUMENTS	NO.	1ST COUNT	2ND COUNT	FINAL COUNTING
ALLIS				
KELLY STRAIGHT				
KELLY CURVE				
MOSQUITO CURVE				
TOWEL CLIPS				
ARMY NAVY				
BOBCOCK				
MIXTER				
TISSUE /THUMB				
BLADE HOLDER				
NEEDLE HOLDER				
OCHSNER CURVE				
OCHSNER STRAIGHT				
PEON CURVE				
DEAVER				
LONG THUMB				
MALLEABLE				
OS 4 X 8				
MAYO CURVE				
NURSE SCISSORS				
METZ				
ADDITIONAL				

_____ _____
SCRUB NURSE SIGNATURE CIRCULATING NURSE SIGNATURE

Record of Operation

Record of Operation

Record of Operation

POLICY ON REQUISITION OF SUPPLIES
STANDARD OPERATING PROCEDURES

POLICY NO: NSO- 013

DIVISION: NURSING SERVICE DIVISION

SECTION: CENTRAL SUPPLIES AND STERILIZATION UNIT (CSSU)

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Nimfa Vibar, RN CSSU- Head Nurse	Juliet S.Condes, RN CSSU- Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES: Preservation of medical equipments and supplies needed by the Nursing Department

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COVERAGE: This policy shall cover all Sections under this division.

RESPONSIBILITIES:

Head Nurse:

To supervise and monitor the proper implementation of this policy.

Clerk:

a. Assemble, clean, store and maintain equipments, instruments and supplies.
b. Responsible for the requisition of medical and office supplies and forms needed by each clinical area and nursing office.
c. Store and dispense medical and office to all clinical areas.
d. Responsible for packing and sterilization of medical supplies
e. Perform regular inventory of equipments and instruments allocated to different clinical areas.
f. Accomplish monthly consumption report of each area.
g. Monitor continuous availability of oxygen to all areas.

h. Responsible for the replenishment of supplies to different areas on the date and time scheduled.

POLICY:

I. This policy shall enhance efficiency in monitoring and maintaining continuous supplies within this division at all times.
II. This policy shall ensure that all instruments and equipments stored in this area MUST be in top shape at any time when needed by the different sections and/or condemn them, if ever beyond repair.

PROCEDURE:

I. All forms must be requested at 2-10 shifts.
II. Requested materials, equipments or instruments MUST be verified as to kind, number and in good condition prior to signing out.
III. At the end of the shift, borrowed articles no longer in use are to be returned in proper order and number. All borrowed instruments and/or equipment must be returned in a clean state before the end of each shift.
IV. All returned instruments and/or equipments MUST be inspected thoroughly by the CCSU staff prior to signing of returned by the borrower.
V. No trainees/ nursing student shall be allowed to borrow instruments and/or equipments.
VI. Monitoring of supplies consumption
    a. Requisition slip must be accomplished and approved by the Head of the Division prior to the issuance of supplies for accounting and recording purposes.
    b. All clinical areas must submit their monthly, quarterly and annual report of supplies consumption to their section for proper accounting. This section shall in turn submit a corresponding overall report to the Chief Nurse.
VII. Inventory of equipments and instruments in every clinical area.
    a. Regularly done every end of the month by this section.
    b. All serviceable equipments and instruments must be reported to the Property and Supply office.
    c. Loss or breakage of any instruments or equipment not reported shall be accountable to area or staff for replacement. If report of loss or breakage is found to be unjustified, replacement shall still be made.

DATE OF IMPLEMENTATION:

This policy has been implemented since 1978, however, minor revision has been made 1994, 1998, 2001, 2003, 2006, 2011 and reviewed 2016.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary

POLICY ON REPLACEMENT OF SUPPLIES AND MEDICINES

POLICY NO: NSO-013

DIVISION: NURSING SERVICE DIVISION

SECTION: CENTRAL SUPPLIES AND STERILIZATION UNIT (CSSU)
PHARMACY

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Nimfa Vibar, RN CSSU- Head Nurse	Juliet S. Condes, RN CSSU-Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES: To develop an efficient method of replenishment of hospital supplies and Medicines in all clinical areas anytime when needed.

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COVERAGE: This policy shall cover this area alone.

RESPONSIBILITIES:

I. It shall be the responsibility of the **Head** to monitor the effectiveness of this policy to ensure the levels of medicines and supplies are at level far from description.
II. It shall be the responsibility of the **Staff** of this section to abide with the rules incorporated into this policy at all times.

POLICY:

I. This policy shall enforce that all abide with the guidelines incorporated into it.
II. This policy shall ensure that all emergent cases treated in the area shall be given the necessary quality service required regardless of creed or status.

PROCEDURE:

I. Incoming staff for each shift at start of duty shall check and verify on the level of medicines, oxygen and hospital supplies endorsed by the outgoing. If tally is not met, the outgoing staff shall have to replace unaccounted items.
II. Each medicine and/or supply used shall be charged accordingly to user, charge ticket must be in duplicate copies, 1 copy will be forwarded to CSSU/Pharmacy, and one

copy will be left in the area for replenishment purposes. It shall be the responsibility of the Charge Nurse to ensure that all items are charged and replenished.

III. Oxygen consumption tag on each tank shall be attached to record the name of the user and the amount used per patient. This shall be the responsibility of the Clerk or the Nursing Attendant. Charging will be done every after shift.

IV. Area transporter shall check at the start of his shift the oxygen levels of each tank and to replenish such tanks if necessary. He shall likewise, be responsible to check the levels of sterile water in each humidifier. Cleaning and soaking shall also be done by the same.

V. Each admission shall be charged with new oxygen cannula at ER when patient requires oxygen inhalation. Any condition requiring oxygen inhalation during their stay at the ward will be charged the same manner. Soaked appliances must be limited only to situation where supplies are low or unavailable.

VI. All consumption, issuance and return of medicines and supplies shall be properly documented into a separate logbook.

VII. Schedule of replenishment must be observed at all times.

Area	**Pharmacy**	**CCSU**
ER	Everyday	Every Shift
Triage	Everyday	Everyday
ICU	Everyday	Everyday
OB Ward	Everyday	Everyday
MS Ward	Everyday	Wednesday/Friday
Pedia Ward	Everyday	Monday/ Thursday
OR/DR	Everyday	Tuesday/ Saturday
NICU	Everyday	Monday/ Friday

APPENDIX:

None

DATE OF IMPLEMENTATION:

This policy has been implemented since 1978, however, minor revision has been made 1994, 1998, 2001, 2003, 2006, 2011 and reviewed 2016.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

POLICY ON STERILIZATION AND OPERATION OF AUTOCLAVE MACHINE

POLICY NO: NSO-014

DIVISION: NURSING SERVICE DIVISION

SECTION: OPERATING ROOM

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Charles Rae G. Lindaya, RN OR- Head Nurse	Aida M. Landicho, RN OR- Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

I. To provide a systematic system of sterilization of all hospital supplies and items used for surgery.
II. To minimize if not, eliminate prevalence of infection especially in clinical areas.

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COVERAGE: This policy shall cover Operating Room Nurses and I.W under this Division.

RESPONSIBILITIES:

I. It shall be the responsibility of the utility worker and Operating Room Nurses to do autoclaving and/or the OR transporter in his place.
II. Personnel involved must be educated in the sterilization process principles and machine operation.
III. Responsible for cleaning, packing, sterilization and storage of sterile supplies.
IV. Responsible for the maintenance of the machine and report for malfunctioning
V. Responsible for the collection of all items for sterilization

POLICY:

For Sterilization

1. All reusable items shall be cleaned after use or prior to sterilizations.
2. Instruments and supplies shall be wrapped, packed properly.
3. Articles for sterilization shall be arranged so that all surfaces are exposed to the sterilization agent for the prescribed time, temperature and humidity.

For Machine Operation

1. Only authorized personnel are allowed to operate the machine.
2. Check for the level of water and the condition of the machine before running the sterilization machine.
3. Follow the operating instruction for machine operation.
4. Always check chamber and filter inside after every sterilization.
5. Make requests for repair as soon as breakdown is noted. Submit this report to Chief Nurse for notation then directed to the office of the Hospital Director.
6. Operation of the autoclave machine will only be once a day on a scheduled time.

PROCEDURE:

I. Collect and record items for sterilization; use checklist.

II. Check all items if properly packed and upon completion of sterilization, check for sterilization indicator.

III. Follow operating instruction of the machine:

a. Before operating sterilizer, always check water level in the generator. To fill water, open all valves, except the drain valve. NEVER allow water to fall below the bottom of glass gauge or red line indicator.

b. Start with all valve closed, except the upper and lower valves of the water level, glass gauge should be kept open. (close ONLT in case of emergency if glass gauge breaks when operating)

c. Place materials in sterilizing chamber taking care to distribute the load evenly so that steam will circulate freely and penetrate the packs. Close autoclave door by hand tightening. Unnecessary tightening will shorten the life of the rubber gasket.

d. When jacket gauge reaches 20lbs/in pressure, current will be cut-off automatically and the heater pilot light will switch off

e. Open steam supply valve.

f. The jacket and chamber gauges will equally rise to 20lbs/in pressure and the heater pilot light will automatically on and off at an interval of 2-3lbs/in pressure. Begin timing from 20-30 minutes for complete sterilization period. Thermometer gauge will register approximately 250-255°F

g. Switch to “OFF”

h. Close steam supply valve. Open exhaust valve to release pressure inside the chamber. Leave pressure inside the jacket in preparation for the next sterilization or to easily dry dressing.

i. When chamber gauge drops to “0” open autoclave door approximately ½ inch beyond door collar. Leave door in this position within 5-10 minutes for further dry dressing.

j. Open the door widely and see to it that your proper temp. Tube sterilization indicator inserted between each pack is totally deep red in color showing that you have completed your sterilization or autoclave tape lines turn black.

k. After the sterilization period has been completed, lower starting switch to “OFF”. Level all valves exactly as they were, allowing the sterilizer to cool down gradually. Do not open the door until the chamber gauge indicates zero pressure.

l. Always clean autoclave chamber and filter inside after every sterilization.

m. Always drain water from boiler once a month after sterilization with pressure inside the jacket and chamber so as to discharge all dirt and hard water. Be sure to turn the switch to “OFF”.

DATE OF IMPLEMENTATION:

This policy has been implemented since 2003, with minor revision 2006, reviewed 2011 and 2016.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

DELIVERY ROOM/LABOR ROOM
STANDARD OPERATING PROCEDURE

POLICY NO: NSO-015

DIVISION: NURSING SERVICE DIVISION

SECTION: DELIVERY ROOM/ LABOR ROOM

POLICY REVIEW DATE: May 22, 2014

Reviewed by:		
Rosalie M. Rodriguez, RM DR- Head Midwife	Jean Ann T. Gabrinao, RN DR- Head Nurse	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

I. To encourage women to have constant labor and birthing companions of their choice.
II. To advise women to walk and move about during labor, if desired, and to assume the positions of their choice while giving birth, unless a restriction is specifically required for a complication and the reason is explained to the mother (not using invasive procedure)
III. To define the standard operating procedures in the area for compliance and implementation.
IV. To foster better mother-child relationship.

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COVERAGE:

All medical and non-medical personnel of the hospital, patients and their significant others.

RESPONSIBILITIES:

1. It shall be the responsibility of the **Head Nurse** to orient her staff with regard to this policy and to monitor the general activities in the unit.
2. It shall be the responsibility of all **Staff** of this section to observe and follow set standard operating procedures as written in this policy.
3. It shall be the responsibility of the DR/LR Nurses/ Midwives to:
    a. Closely monitor vital signs, FHT, and progress of labor
    b. DR Nurses perform IV insertion and administers medication

c. Properly document progress of labor and refer for any untoward signs and symptoms
d. Assist the doctor in the performance of vaginal deliveries.
e. Perform newborn care
f. Render health teaching and assist in early initiation of breastfeeding

POLICY:

1. To require that all shall abide with the guidelines incorporated into this policy.
2. This policy shall ensure timeliness and accuracy in the deliverance of only the best and quality service afforded by this institution.
3. To enforce the timeliness of release of any procedure done.

PROCEDURES:

1. LABOR ROOM ADMISSION

a. Primi Gravida/Segundi in active labor with 8 cm cervical dilatation and 6 cm cervical dilatation for multi-para.
b. High risk pregnancies in labor, for induction or augmentation of labor.

Considered high risk are the following:

- Elderly Primi-Gravida (35 years old and above)
  young Primi-Gravida (15 years old and below)
- Toxemia of pregnancy (pre-eclampsia and eclampsia)
- Pre-maturity and Post maturity
- Early Rupture of Membrane (EROM),
  Premature Rupture of Membrane (PROM)
- Multiple gestation
- Malpresentation (Frank breech), footling, shoulder and face presentation
- Polyhyramnios and oligohyramnios
- Intrauterine Fetal Growth Retardation (IUGR)
- Patients with moderate vaginal bleeding (e.g low lying placenta or placenta previa marginalis)

c. All pregnant patients with oxytocin drip regardless of the internal examination except for the blighted ovum, missed abortion and intra-uterine fetal death

Note:
LR maybe used for delayed CS, only that OR staff will be the one responsible for the patient.

d. Change street clothes to hospital gown.
e. Check patency of IVF/IV site
f. Monitor and record vital signs, FHT and progress of labor, refer to MO/MS for any signs of abnormalities:
-FHT of:

- LOW RISK patients – recorded every 15 minutes
- HIGH RISK patients - recorded every 5 minutes

Note: separate sheet provided for this purpose must be used.

Normal FHT: 120 -160 bpm

- Uterine contractions and blood pressure recorded every 30 minutes on the same monitoring sheet. (Normal BP <140/90 mmHg and 3-5 contractions every 30 minutes in < 90 seconds)

g. Transport patient to delivery room at 9 cm cervical dilatation and notify MO/MS

2. DELIVERY ROOM ADMISSION

a. Primi gravid and Segundi gravid client in active labor, 9 cm to fully dilated cervix.
b. Multi-para client, in active labor, 8 cm cervical dilatation.
c. Muliti-para client, BOW ruptured:
   - Change patient street clothes to hospital gown before entering Delivery Room
   - False teeth, nail polish, jewelries must be removed
   - Check for patient's record for complete laboratory results (CBC, blood typing, Hbs Ag, Ultrasound and other relevant data)
   - IVF insertion, monitoring of vital signs and FHT
d. For placental extraction but with IVF before admission

3. INTR-UTERINE DELIVERIES ROUTINE
   a. Check vital signs and FHT.
   b. Client should not be left unattended while on the DR table.
   c. Vaginal delivery must be attended by the Resident Doctor or by the Attending Physician.
   d. In case of emergency vaginal deliveries, the Nurse/Midwife attends to the delivery and may perform a right-media-lateral episiotomy and immediately inform the MO/MS. Repair shall be done only when verbal consent of the physician is given
   e. All patients whose deliveries are not directly supervised by the MO on duty MUST undergo I.E and/or rectal examination by the consenting physician prior to transfer of patients to ward.

4. POST-PARTUM ROUTINE
   a. Check vital signs, record and report signs of bleeding, uterine atony and abnormalities
   b. Perineal washing and application of adult diaper prior to ward transfer.
   c. ID wrist band for mother and baby should contain the following data:
      -Name of mother
      - Sex of baby
      - Date and time delivered
      - Type of delivery
      - Attending Physician
   d. Routine maternal boding should be done immediately after delivery of the newborn and to encourage mothers to breastfeed their babies while in the ward
   e.All post-partum patients must be assessed by the doctor prior to order for transfer to ward.
   f. Internal Exam by NOD/MO/MS prior to ward transfer.

5. ESSENTIAL NEWBORN CARE (DOH AO 2009-0025)
   This Administrative Order (AO) outlines specific policies and principles for health care providers with regards to the prescribed systematic implementation of interventions that

address health risks known to lead to preventable neonatal deaths. This AO is consistent with AO No. 2008-2009 on implementing Health Reforms for Rapid Reduction of Maternal and Newborn Mortality and support all DOH initiatives and programs for newborn and child health.

a. Within the first 30 seconds

Objective: Dry and provide warmth to the newborn and to prevent hypothermia

- Put on double gloves just before delivery.
- Use a clean, dry cloth to thoroughly dry the newborn by wiping the eyes, face, head, front and back, arms and legs.
- Remove wet cloth.
- Do a quick check of newborn's breathing while drying.
- Do not put the newborn on a cold or wet surface.
- Do not bathe the newborn earlier than 6 hours of life.
- If the newborn must be separated from his/her mother, put him/her on a warm surface, in a safe place close to the mother.

b. **After thorough drying**

Objective: Facilitate bonding between the mother and her newborn through skin-to-skin contact to reduce likelihood of infection and hypoglycaemia.

- Place the newborn prone on the mother's abdomen or chest, skin to skin.
- Cover the newborn's back with a blanket and head with a bonnet.
- Place the identification band on the ankle.
- Do not separate the newborn from the mother, as long as the newborn does not exhibit severe chest in-drawing, gasping or apnea and the mother does not need urgent medical/surgical stabilization e.g emergency hysterectomy.
- Do not wipeoff vernix if present

Check for multiple births as soon as newborn is securely positioned on the mother. Palpitate the mother's abdomen to check for a second baby or multiple births. If there is a second baby (or more), get help. De;liver the second newborn. Manage like the first baby.

c. While on skin-to-skin contact (up to 3 minutes post delivery)

Objective: reduce the incidence of anemia in term newborns and intraventricular hemorrhage in pre-term newborn by delaying or non-immediate cord clamping.

- Remove the first set of gloves immediately prior to cord clamping.
- Clamp and cut the cord after cord pulsation have stopped (typically at 1-3 minutes). Do not milk the cord towards the newborn.
  -Put ties tightly around the cord at 2 cm and 5 cm from the newborn's abdomen.
  -Cut between ties with sterile instrument.
  -Observe for oozing blood.
- After cord clamping, ensure 10 IU Oxytocin IM is given to the mother. Follow the protocol in PCPNC.

d. **Within 90 minutes of age**
Objective: Facilitate the newborn's early initiation to breastfeeding and transfer of colostrums through support and initiation of breastfeeding.

- Leave the newborn on the mother's chest in skin-to-skin contact. Health workers should not touch the newborn unless there is a medical indication.
- Observe the newborn. Advice the mother to start feeding the newborn once the newborn starts to show feeding cues (e.g opening of mouth, tonguing, licking, rooting). Make verbal suggestions to the mother to encourage her newborn to move toward the breast e.g nudging.
- Counsel on positioning and attachment. When the newborn is ready, advise the mother to position and attach her newborn.
- Advise the mother not throw away the colostrums.
- If the attachment or suckling is not good, try again and reassess.
- A small amount of breastmilk may be expressed before starting breastfeeding to soften the nipple area so that it is easier for the newborn to attach.

To prevent **opthalmia neonatorum** through proper eye care, administer erythromycin or tetracycline ointment or 2.5% povidone-iodine drops to both eyes after the newborn has located the breast. Do not wash away the eye antimicrobial.

6. NON-IMMEDIATE INTERVENTIONS

These interventions are usually given within 6 hours after birth, and should never be made to compete with the time-bound interventions.

a. Give Vitamin K prophylaxis
- Inject a single dose of Vitamin K 1mg IM (if parents decline intramuscular injections, offer oral Vitamin K as a 2nd line.

b. Inject Hepatitis B and BCG vaccinations
- Inject Hepatitis B vaccination IM and BCG intradermally.

c. Examine the newborn. Check for birth injuries, malformations or defects
- Weigh the newborn and record
- Look for possible birth injury and/ or malformation
- Refer for special treatment and/or evaluation if available
- If the newborn has feeding difficulties because of the injury/malformation, help the mother to breastfeed. If not successful, teach her alternative feeding methods.

d. Cord care
- Wash hands.
- Fold diaper below stump. Keep cord stump loosely covered with clean clothes.
- If stump is soiled, wash it with clean water and soap. Dry it thoroughly with clean cloth.
- Explain to the mother that she should seek care if umbilicus is red or draining with pus.
- Teach the mother to treat local umbilical infection three times a day.

7. NEWBORN RESUSCITATION
    a. Start resuscitation if the newborn is not breathing or is gasping after 30 seconds of drying or before 30 seconds of drying if the newborn is completely floppy and not breathing.
    b. Cut and clamp the cord immediately.
    c. Call for help.
    d. Transfer newborn to a dry, clean and warm surface. Keep the newborn wrapped or under a heat source if available.
    e. Inform the mother that the newborn needs help to breath.

8. ADDITIONAL CARE FOR A SMALL BABY OR TWIN

    If a newborn is preterm, 1-2 months early or weighing 1500-2499 g (or visibly small where a scale is not available)

    a. If the newborn is delivered 2 months earlier or weighs < 1500 g, refer to a specialized hospital.
    b. For a visibly small newborn born >1 month early;
        - Teach the mother how to keep the small newborn warm in skin-to-skin contact via Kangaroo Mother Care (KMC). Start KMC when:
            - The newborn is able to breathe on its own (no apneic episodes)
            - The newborn is free of life-threatening disease or malformations.
        - Provide extra blankets for the mother and the newborn, bonnet, mittens, and socks.
        - If the mother cannot keep the newborn skin-to-skin because of complications wrap the newborn in a clean, dry, warm cloth and place in a cot. Cover with a blanket. Use a radiant warm if the room is not warm or if the baby is small.
        - Give special support for breastfeeding: encourage the mother to breastfeed every 2 hours.
        - Weigh the newborn daily.
        - When the mother and newborn are separated, or if the newborn is not sucking effectively, use alternative feeding methods.

9. UNNECCESARY PROCEDURES
    a. Routine suctioning
    b. Early bathing/ washing
    c. Footprinting
    d. Giving sugar water, formula or other prelacteals and use the bottles or pacifiers
    e. Application of alcohol, medicine and other substances on the cord stump and bandaging the cord stump or abdomen.

10. DOCUMENTATION
    a. Check for complete patient record, including laboratory request and results (CBC, blood typing, HbsAg during endorsement)
    b. Accomplish Delivery Room and Newborn record and signed by the Attending Physician and Nurse on Duty.

11. ENDORSEMENT
    a. Inform the ward staff 5-10 minutes before sending the patient out from the delivery room.
    b. All staff should not leave the area without the proper endorsement to the incoming staff.
    c. Soiled linens should be sent to the linen section for linen replacement.
    d. Maintain cleanliness and orderliness of the area.

APPENDIX:

Summary of Parturition
Labor Record
Birth Practices Checklist
Client Survey on Breastfeeding

DATE OF IMPLEMENTATION:

This policy has been implemented since 1978, however, minor revision has been made 1994, 1998, 2001, 2003, 2006, 2011 and reviewed May 22, 2014.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary

INTENSIVE CARE UNIT
STANDARD OPERATING PROCEDURE

POLICY NO: NSO-

DIVISION: NURSING SERVICE DIVISION

SECTION: INTENSIVE CARE UNIT

POLICY REVIEW DATE:

Reviewed by:		
ICU – Head Nurse	ICU- Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

I. Provide multidisciplinary patient care on a concentrated and continuous basis.
II. Provide a multidisciplinary approach / plan to patient care which includes input from all relevant healthcare professionals.
III. Provide quality nursing care based upon the nursing process of assessment that includes biophysical, environmental, educational and psychological needs of the patient and family, planning, intervention and evaluation.
IV. Assign, orient and maintain a highly qualified professional staff, competent to provide individualized, concentrated care and to provide for the continuity of care.
V. Ensure that standards for professional nursing practice are implemented, evaluated and monitored.
VI. Provide for and participate in relevant studies that investigate problems and provide opportunities to improve patient care.

COVERAGE:

The Intensive Care is open for all health professionals involved in intensive care medicine.

RESPONSIBILITIES:

1. It shall be the responsibility of the **Head Nurse** to manage overall operations in the unit including administrative responsibilities, setting and maintaining patient care standards, and facilitating staff development and quality monitoring.
2. All ICU staff must have a variety of professional experience as well as specialized training in the field of critical care nursing.
   - All Critical Care Nurses should have a certificate in ACLS training
3. There should be at least 2 ICU nurses in every shift. A 1:3 bed at anytime is applied. Staffing ratio is adjusted according to patient acuity.
4. It shall be the responsibility of all **Staff** of this section to observe and follow set standard operating procedures as written in this policy.
5. Facilitate and monitor the workflow, ensuring patient care standards are maintained.
6. Assessing a patient's condition and planning and implementing patient care plans.
7. Ensuring that ventilator, monitors and other types of medical equipment function properly.
8. Assisting physicians in performing procedures.
9. Administering intravenous fluids and medications.
10. Observing and recording patient vital signs.
11. Collaborating with fellow members of the critical care team
12. Responding to life-saving situations, using nursing standards and protocols for treatment
13. Providing education and support to patient families.

POLICY:

I. ADMISSIONS:

All admissions should be discussed as soon as possible with the Attending Physician. The decision whether to admit the patient at the ICU rests on the Attending Physician after having been cleared from PTB as evidenced by chest x-ray readings and AFB results. The ICU nurse should be consulted by the ER Nurse regarding the availability of beds. The Attending Physician and other referring physicians shall be notified of all admissions by the ER resident on duty prior to transfer of patient to the ICU.

II. TRANSFER OUT OF ICU:

Patients should be assessed by the Attending Physician prior to transfer to other areas. Confirmation and reservation for the availability of bed for the patient to be trans out should be done to facilitate process of transfer. There should be a clear written doctor's order indicating for such transfer, detailing updated patient's status and ongoing care plan. For transfer of patients to other hospital, the patient must be coordinated or endorsed to the receiving institution prior to leaving the ICU.

III. ORDERS:

All orders in the ICU must be written in the chart, including date and time of the order. The physician writing the order should also verbally notify the ICU nurse of the order and discuss its implications. In very urgent situations such as cardiac arrest or impending respiratory or cardiac arrest, verbal orders may be given. These should later be transcribed to the chart and signed by the physician.

IV. NOTES:

1. Admission:

   An admission history, physical examination, assessment and plan of management and problem list must be written for each patient. The resident on duty is responsible for this. The ICU nurse should make use of the prescribed nurses' notes in FDAR format.

2. Procedures:

   All procedures must be documented in the progress notes. The note should include all pertinent data such as date, time, anesthesia, compliance with practice guidelines (see below), difficulties in procedure.

   - All arterial lines
   - All central lines, including Swan-Ganz catheters, triple lumens, TPN catheters
   - All intubations
   - All chest tubes
   - All pacemakers
   - All cardioversions
   - All sampling of body fluids (e.g thoracenthesis, paracenthesis, lumbar puncture, etc.)

3. All patients in the ICU must have at least one progress note written daily.

4. Discharges out of the Hospital and Deaths

   A summary must be written as soon as possible by the resident on duty for all patients who expired in the ICU, who are transferred to another hospital, or who are to be discharged home.

   For patients who expired in the ICU, a note describing the circumstances and management at the time of death must also be written.

   The resident on duty at the time of death must notify the next of kin, attending physician, and referring physician (if any).

POLICY ON HIGH RISK PREGNANCY UNIT (HRPU)

I. All patients needing Obstetrical and Gynecological care seen at the ER and OPD clinic shall be referred to the Consultant on duty who will manage/ decide on the patient's condition and referral to other specialty when the need arises.

II. CRITERIA FOR ADMISSION ON HIGH RISK UNIT

The following patients are to be admitted at the HRPU:

1. Pregnant women with medical complications such as uncontrolled hypertension, asthma in exacerbation, heart disease, maternal metabolic disease (uncontrolled diabetes mellitus, thyroid diseases), psychiatric patients.
2. Infectious disease (HIV, toxoplasmosis, fever of unknown origin, etc.)
3. Poor obstetrical History
   a. Preterm – 35 weeks and below by early ultrasound
      -cervical dilatation of less than/ eaual to 4 cms
      -incompetent cervix
   b. Preterm Premature Rupture of Membrane
4. Obstetrical complications- placenta previa, oligohydramnios, fetal growth restriction, multiple gestation, trauma or surgical complications

III. Perinatology is a subspecialty of OB/Gyne that focuses on the specialized and advance care of high risk pregnant women. It aims to provide the highest quality care and improve the outcome for both mother and fetus.

IV. POSTPARTUM GUIDELINES

1. All postpartum patients will be monitored at the recovery room and transferred to the ward once stable.
2. All postpartum mothers with hypertension and/or placed on Nicardipine drip shall be monitored at the ICU for 24 hours unless cleared by the Attending Physician or Internist to be sent to ward.
3. Postpartum patients with co-morbids (hypertensive emergencies, thyroid storm, cardiac problems, postpartum hemorrhage) shall be brought to the ICU for close monitoring if need arises.

DATE OF IMPLEMENTATION:

This policy has been implemented since June 25, 2015

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary

POLICY ON OBSTETRIC AND GYNECOLOGY UNIT

POLICY NO: NSO-017

DIVISION: Nursing Service

SECTION: Obstetric and Gynecology Unit

POLICY REVIEWED DATE: July 12, 2016

Reviewed by:		
Elizabeth B. Cantorna RN Ob-Gyn- Head Nurse	Nestor O. Beato, RN OBW- Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES: To establish a system and set responsibilities for OB/Gynecology and Newborn admissions according to patient's requirements and best utilization of available resources.

COVERAGE: This policy shall be adopted by all medical and non medical employees, patients and their relatives and all those who will avail of the services of the department/hospital.

RESPONSIBILITIES:

It shall be the responsibility of the Medical and Ob/Gyne Nursing staff to abide with the procedure incorporated to this policy.

I. HEADNURSE

a. Orient her staff to this policy and to monitor the general activities in the unit.

b. Maintain accurate implementation of total nursing care.

c. Establish trust of newly admitted patient and orient them to its surrounding.
d. Develop anticipated solutions to problems regarding health needs that may arise.
e. Assess and classify the overall Nursing care needs of the client in each designated area.

f. Ensure strict implementation of the general nursing care program based on the assessed client need/ priorities.
g. Ensure the strict implementation of the hospital policies, rules and regulations through interpretation of nursing personnel.
h. Schedule assignments of personnel, off duties, leave of absence and holidays taking into consideration special request and submit to the Chief Nurse.
i. Supervise, assess and evaluate the performance of the unit personnel and provides assistance when needed.
j. Coordinate needs for supplies, repairs, maintenance of equipments and submit to the Chief Nurse.
k. Coordinate and participate in staff development programs, research and orientation courses.
l. Assist in discharge planning, referral to other agencies and return to Out-Patient department.
m. Counsel/ guide personnel with their strengths and weaknesses and recommends disciplinary actions when needed.
n. Analyze unit problems with the staff and elevate to superiors those that cannot be solved at the unit level.
o. Coordinate with clinical instructors and participate in selecting Learning experiences for student affiliates.
p. Submit regular reports on time.

II. ASSISSTANT HEAD NURSE

a. Supervises over the work of the nursing staff, support them and assumes the responsibilities of the head nurse in the absence of the latter.

III. STAFF NURSE

a. Carry out doctors orders with the appropriate diagnosis and laboratory test, evaluate and record the results.
b. Administers prescribed medications administration of medications using 10 R's such as Oral, SC, IV routes and record changes and response of the patient.
c. Develop skill and knowledge in using various medical devices such as Electronic fetal monitors, defibrillators, suction pumps and other Gyne unit instruments.
d. Assist Obstetricians and Gynecologists in various procedures related to delivery; post partum, C-section, newborn care etc.
e. Provide health teaching and educate patients and families regarding breastfeeding (8pm-9pm), newborn care, C-Section care, newborn screening, and other therapeutic procedures.
f. Follow all policies and protocols of the hospital with limited variations.
g. Maintain skills and knowledge by participating various nurse education programs, seminars, staff meetings, workshops, and other online nurse education programs.
h. Perform professional nursing care to the patients admitted in the obstetrics and Gynecology unit.

i. Assess and document various clinical conditions and vital signs of the patient.
j. Accept and do bedside endorsements of any case from different areas such as ER, OR, DR, NICU.
k. Attend promptly to patient's needs and problems on a system of priority.
l. Maintain protective measures based on patients safety.
m. Establish trust and rapport to patient for familiarization.
n. Evaluate total patients comfort which includes physically, emotionally and comfort.
o. Monitor vital signs as needed for rechecking.
p. Recognize and evaluate principles of cephalo-caudal assessment.
q. Ensuring correct diet feedings.
r. Carry out of legality of doctor's order with promptness.

IV. NURSING AIDE

a. Participates in the endorsement rounds.
b. Receive and endorse area articles, instruments and equipments. Report to the senior nurse any loss breakage for proper action.
c. Assist the nurse with newly admitted and discharge client.
d. Prepares beds for admission
e. Assist nurses with wound dressing
f. Monitor, record and report vital signs or any anticipated problems
g. Collect properly labeled specimen to laboratory.
h. Assist the nurse in performing simple nursing procedures such as tepid sponge bath ,enema, bed bath etc to clients,
i. Keep records of client intake and output of fluids and reports to the nurse assigned to the patient.
j. Prepare beds for incoming clients; strip off and properly dispose soiled linen of discharged patients.
k. Carry out clerical jobs in the absence of the unit clerk.
l. Monitor and charge oxygen consumption used by patient.
m. Monitor the maintenance of supplies, instruments, equipments and area cleanliness.

V. WARD CLERK

a. Records all admitted and discharged clients.
b. Check charts forms for auditing. Keep patients charts in order at all times.
c. Collect Patient Satisfaction form.

c. Coordinates activities of patients to different unit as need arises. (i. e. checks schedule of patients for X-ray, UTZ, facilitates referrals etc.)
d. Assisting NA and UW in monitoring relevant duties as designated.
e. Check availability of supplies including chart forms.
f. Answer and make the telephone calls for purposes of information.
g. Prepare job requisition job order and submit to appropriate section for proper action.
h. Bring written communication, referrals and messages to appropriate person or department.

i. Attend meetings for proper guidance.
j. Record minutes of the meeting.
k. Update the area bulletin board.

VI. UTILITY WORKER

a. Assist patient in lifting, turning and positioning.
b. Assist in the transport of patients from ER, OR, DR. Check availability of oxygen for patient's use.
c. Assist the nurse for conduction and transfer of patient to other hospital as needed.
d. Restrain and strap combatant patient.
e. Ensure safety of the environment through regular check up and cleaning of all unit equipments and report to senior nurses all breakages and losses.
f. Deliver specimens like urine, stool etc. For examination to the laboratory.
g. Perform daily routine housekeeping activities in the unit.
h. Participates with the housekeeping staff during general cleaning and fumigation of the area.

POLICY: This policy shall enforce compliance by all, with the guidelines incorporated into it to institute order and quality of delivered services.

PROCEDURE:

I. Routine Admission Procedures

A. From Emergency Room.

1. ER NOD informs the Ob-Gyne ward of admission.
2. Each admitted case must have a confirmed designated room assignment.
3. Do bedside endorsement ER and OB/Gyne Ward nurse.
4. Placed patient according to case diagnosis and accompany patient in her room.
5. Check for complete patient chart and patient classification by Social Worker.
6. Carry out doctor's order promptly.
7. Follow-up dietary for patient nutritional requirements.
8. Follow-up referral to the attending physician thru ROD
9. Check for Blood clearance and consent for elective surgery.
10. Elective cases procedure scheduling: Chart from the Emergency Room endorsed to ward with the following:
    a. Consent signed by the patient witnessed by relatives. If patient is a minor or incapacitated, the immediate relative will sign the consent.
    b. OR proposal approved by the Hospital Director or Chief of Clinics in his absence.
    c. Check date of surgery, CP clearance for patient 35 years old above and pediatric clearance.
    d. Blood Clearance signed by the social service staff.
    e. For elective surgical cases notification of anesthesiologist, and surgical consultant and accomplishment of pre –anesthesia form must be done by the admitting medical officer.

B. **To the Operating Room (the night prior to surgery up to the day of operation)**

1. Begin the preparation based on the checklist form prior to surgery.
2. Check the surgeon and the anesthesiologist's order a night prior to surgery and give the necessary medications and final preparations, if any. Check again the doctors order if there is any medications to be given before endorsing the patient to the operating room nurse.
3. Coordinate with the operating room staff to validate the schedule of operation and if visit prior to surgery has been made by OR staff.
4. Follow up the anesthesiologist order to the ROD/SHO if the pre-anesthetic order has not been made.
5. Check vital signs prior bringing the patient to the operating room and report to the ROD/SHO for any abnormality.
6. Validate the preparation made with the checklist form.
7. Do bedside endorsement,OB-Gyne WARD/OR nurse.

C. For STAT operation:

1. Inform OR of the STAT operation
2. Begin the preparation based on the checklist form prior to surgery.
3. Inform the anesthesiologist thru medical officer for her availability.
4. Check vital signs prior bringing the patient to the operating room and report to the medical officer on duty for any abnormality.
5. Inform the operating room nurse prior to transporting the patient to the operating room.
6. The nurse accompanies the utility worker in transporting the patient to the operating room. Bed rails must be up at all times. The patient shall be covered with a blanket for warmth and privacy.
7. Inform OR if STAT operation has been cancelled.

D. **From DR and OR/RR**

I. **Post partum patient**

1. Upon notification of admission, bed should be prepared and the necessary equipments needed, prior to patient transfer. **.**
2. Rooming-in is encouraged in line with the Baby Friendly Hospital concept. All roomed-in babies should be asses by the ROD/SHO, prior to transfer.
3. For roomed-in baby, check for mother and baby's tag and the sex of the baby. (should have the same data on the tag)
4. Vital signs monitoring, record and report any signs of vaginal bleeding, uterine atony and any untoward signs and symptoms

5. Newborn assessment should be done, record and report any signs of respiratory distress, poor suck, umbilical cord bleeding and other abnormal assessment. To be brought to NICU and be admitted separately.

II. **Post-operative patient**

1. OR/RR shall notify OB/Gyne ward of the admission
2. Ward N.A. prepares bed and necessary equipments needed for the incoming post –op patient.
3. Check vital signs and operative site and report any signs of complication.
4. Check for completeness of the chart and bed side endorsement should be done.
5. Monitor any signs of complication and report immediately to medical officer on duty.

III. OB Ward to Neonatal Ward:

1. When births of preterm or sick babies are anticipated/ planned, NICU should be informed so that there is place for the baby, especially when ventilation may be needed. Information shall be given by the caring OB Nurse to the receiving nurse .
2. When babies develop feeding difficulty, fever or jaundice, Medical officer shall be inform immediately and carry out doctors order.
3. When babies are transferred to Neonatal ward, form must be filled and baby escorted by OB ward nurse.

II. Discharge Procedures

a. Upon order of may go home (MGH) by Attending Physician/Resident Doctor. Patient record shall be completed prior to submission for billing.
    1. Routine "May Go Home" order on patients chart must be written by AP/MO

c. For OB patient, post C/S, post partum and D & C patient, vaginal internal examination should be done, screen for HAMA patient prior to discharge and documented into the chart by Ward Medical Officer.
d. NB Assessment has been done by Ward Medical Officer with complete physical examination, and should be documented in the chart.
e. Final diagnosis (ICD10) and procedure done fully accomplished.
f. Change of dressing done by staff nurse and discharge summary worksheet given to patient and /or family.
g. Discharge instruction must be done to all patient as to:
    i. Health teaching and home medication
    ii. Newborn screening and breastfeeding instruction.

iii. Follow-up check-up instruction in Health Center or Ospital ng Paranaque - Out patient department or to their attending physician.

h. Stamped at the back of patient official receipt for ward clearance.

2. If discharge against doctor's order, secure waiver for HAMA and attach to chart, noted by MD with signature.
3. Billing Section issues payment order to relative of patient; Re-billing of MGH patient chart must be done if patient overstays.
4. Clearance issued by cashier upon payment of hospital bill and /or professional fees.
5. Ward U.W. inspects bedside table and patient's bed for any uncollected wastes or personal belongings. If cleared with the charge nurse, home instruction is given in duplicate. The later issues clearance slip with Official Receipt stamped to the security staff. Another copy retained in patient chart.
6. Patient's tag inspected by security staff along with clearance slip.

III. Documentation

Chart should be arranged according to the required chart arrangement, complete with patient's data.

a. Write legibly and without erasures, nor superimposition.
b. Indicate the number (#) of IVF on the Doctor's order in pencil, to check the accuracy of IVF infused. The one asking for to follow is responsible to #IVF at Doctors order sheet.
c. Medication sheet must be signed by NOD for any medication administered,. place 0 mark if not given and indicate the reason at the nurses note. Indicate if discontinued, shifted, completed, consumed or refused, increase or decrease and indicate the date.
d. Record IVF infused, I & O, vital signs on TPR sheet for monitoring write in a separate sheet.
e. Laboratory results should be arranged according to date; recent one is on top, same as with the other results. For hgb, hct, platelet monitoring use separate sheet.
f. Any diagnostic or invasive procedure to be done must be properly explained and secure consent from the patient of legal age and for minors, parents or guardian. Witness on the consent form must be signed by the relatives. Indicate date and time as to when the consent was secured.
g. Request for lab, x-ray and etc. must have a complete data indicate the middle name and date of birth of the patient.
h. Upon discharge check for patient admission record for final diagnosis and disposition; must be filled-up by the Attending Doctor or Medical Officer when discharge order was made.
i. Refusal to procedure and management (HAMA) must be reported immediately to the Attending Physician thru the MOD. A written waiver must be secured and signed.

j. Admission, and discharges must be recorded on the logbook indicating the age, date, time, case of the patient for Phil health requirement and purposes.
k. Prepare for 24 hours floor census and submit to the supervisor on duty 12:00 midnight
l. Follow coded ink charting, Am-blue, PM-black and Night- red
m. Carry out doctors order promptly; check each line according to the acronym CARED; write a blocking line indicating it was carried out, countersign, indicate date and time it was carried out with complete printed name and signature.
n. Outgoing Nurse endorse Doctor's order done during the shift to incoming Nurse, the later then sign with date that he/she received the endorsement.
o. Comply on the policy on documentation and charting.

IV. Endorsement

1. All staff must be in the area 15 minutes before the endorsement time.
2. 15 minutes pre-conference endorsement at the nurse's station, prior to ward rounds.
3. All staff must not leave the area without the incoming shift. In case of absences, inform the Nurse Supervisor/Coordinator for the staffing arrangement.
4. Incoming Nurses will not receive the area if unclean. Maintain area cleanliness at all times.
5. During endorsement out going nurse must endorse the patient's cardex and the patient chart to incoming nurses. Incoming nurses must review the cardex prior to ward round. Chart auditing must be done routinely.
6. Watchers or visitors are not allowed inside the OB-GYNE ward. Visiting hours of OB patient. Normal Spontaneous Delivery: after 8 hours ; C/S: after 36 hours
7. No bed reservation at Ward, it should be channelled to the Admitting Section.

CODE OF CONDUCT

1. All the nurses are expected to perform their tasks as per the duties assigned
2. by the nurse in charge.
3. A nurse is expected to be punctual in attendance and duty timings. In case she/he is late for any genuine reason then the same should be presented to the nurse in charge in writing.
4. Nurses are liable to be transferred from one ward to another and must accept the decision of the nursing superintendent. In case of any genuine reasons for not accepting the transfer, the same would have to be stated in writing to the nursing superintendent. In case a nurse wants a transfer, the same would have to be addressed to the nursing superintendent in writing.
5. Nurses should not accept and/or demand any gifts in cash or kind from clients or their relatives.

6. All patient information and other hospital information are to be considered confidential and should not be communicated in any form to any unauthorized staff/person.
7. As employees of the hospital, nurses are strictly prohibited from giving any medicine to any person except to those it is ordered to be given by the treating doctor to the clients.
8. Prior intimation about daily duties of the Nursing staff will be appropriately notified, in the duty schedule. Any changes in the duty would require prior written request and approval of the nurse in charge.
9. The admitting nurse must carry out all the ward formalities promptly and courteously, as this is perhaps could be the first contact for the client and their family with the hospital.
10. The nursing staff should ensure that effective client care is being provided in the hospital. Clients look for security, skilful care, clean and hygienic environment and staff should understand them.
11. Good nursing practice should be followed 24 hour schedule of nursing care from the time of admission to discharge.
12. At the time of discharge the nursing staff should educate the client regarding the post operative instructions and care they need to take at home.
13. On duty, nurses should be in station and be attentive all the time. Sleeping during duty hours is prohibited.

DRESS CODE

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

EQUIPMENT MAINTENANCE

1. Ensure that all equipments are in good working condition and are providing the correct information/data.
2. All equipment should be handled by the nurses and/or technicians and no other unauthorized person should be allowed to handle any of the equipments.
3. All required materials for the functioning of the equipment should be requisitioned on a regular basis and inventory records for the same should be maintained.
4. Nurse in-charge should inform the Bio-Medical/Maintenance engineer, if the required periodic/annual maintenance of any equipment has not been carried out.

RECORD KEEPING:

Appropriate records are to be maintained

1. Inventory of drugs – emergency cart.
2. Bed occupancy of the ward. (Date and Time of admission and discharge, Name and Case of clients, with the name of the treating physician/consultant).

3. Maintain a log book for recording the breakdown of any equipment (the data required would be equipment name, company name, if on maintenance contract (yes/no), time/date of failure, time/date of equipment made functional, reported to whom).
4. Record has to be maintained, if the equipment is borrowed by any department or service area and when it has been returned.
5. Other records for management purposes should be maintained like:
    a. NBS
        Logbook I –Data base of all patients screened
        Logbook II-logbook of positive cases
    b. BCG
    c. Consultants Attendance Logbook (Ward rounds – timings).
    d. Out Going Chart
    e. Pharmacy / labs/xray/other diagnostic procedures
    f. Endorsement logbook which provide inputs to the nursing superintendent any other records to be maintained for the better functioning of Ward/department.
    g. Ensure that all the clinical records are being maintained appropriately by the respective treating doctors.

APPENDIX:

None

DATE OF IMPLEMENTATION:

This policy has been implemented since 1978, however, minor revision has been made 1994, 1998, 2001, 2003, 2006, 2011 and reviewed 2016.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary

POLICY ON HUMAN MILK BANKING

POLICY NO: NSO- 018

DIVISION: Nursing Service

SECTION: Obstetric and Gynecology Unit

POLICY REVIEWED DATE: July 12, 2016

Reviewed by:		
Elizabeth B. Cantorna RN OB-Gyn- Head Nurse	Nestor O. Beato, RN OBW- Nurse Supervisor	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez,MD OIC- Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES: To describe the steps to follow when assisting mothers in collecting, storing, transporting and thawing of human breast milk.

POLICY : It is the policy of our Institution that the human breast milk shall be handled and administered according to a safe and standardized process.

PROCEDURE:

A. Exposure of human milk in the hospital.

1. Human milk is expressed using a hospital-grade electric breast pump.
2. Mothers should be provided with pumping kits suitable for double breast pumping. Each mother will be instructed in the correct use of the pump; including now to clean the pumping kit between uses.
3. Mothers will be provided with single use, clean milk storage containers by unit staff.
4. Mothers will receive instructions on correct hygiene (hand washing and care of nipples and breast) while pumping. Mothers should be discouraged from using any nipple treatments (creams and ointments) that may affect milk quality and or be harmful to the infant. Mothers may be instructed to use their own milk as a lubricant.
5. The Unit Manager, Area Staff are responsible for the routing cleaning and disinfecting of a hospital-owned breast pumps. Pumps should be cleaned each day following the

manufacturer's instructions for use of cleaning products. Users should be reminded to wash their hands before and after using the breast pump.

B. STORAGE

1. Our hospital's patient care staff should follow Standard Precautions when handling expressed milk.
2. Human milk may be stored on the hospital's designated refrigerator unit/freezer for that purpose only. It should never be stored with employee foods/medications.
3. Human milk should be stored in hard plastic containers intended for single use should not be larger than 8-ounces volume.
4. Each container must be labeled with patient's name, medical record number, date and time expressed; date and time thawed and any additives. If frozen in a general freezer: expiration is in 3 months; if frozen in a deep freezer; expiration is in 6 months.
5. Milk intended for use within 24-48 hour period should be refrigerated. Any other milk should be placed in the freezer for longer storage. Milk stored at 4 C (40 F) in a refrigerator is good for 48 hours.
6. Human milk containing any supplements or additives can be refrigerated for 24 hours.
7. Human milk that has been refrigerated up to 24 hours can be frozen; milk refrigerated >24 hours cannot be frozen.
8. Human milk that has been thawed or partially thawed cannot be frozen and must be used within 24 hours.
9. Human milk containing supplements or additives cannot be frozen.
10. Daily monitoring of expressed milk's expiration dates must be checked. Expired milk must be discarded immediately.

C. TRANSPORTATION

1. An insulated container with freezer gel pack should be used to transport fresh or frozen breast milk.

D. THAWING

1. Patient care staff should use Standard Precautions when handling breast milk.
2. Verify and identify of human milk by matching before breast milk is administered to a patient, 2-unique patient identifiers (patient's name and medical record number or date of birth) on the patient's identification bracelet with the same information on the human milk label. Checking can be done by 2 Registered Nurses and patient's parent.
   (1)Check expiration date; use the oldest milk first according to expiration date.
3. There are two acceptable methods for thawing and/or warming human milk.
   a) Warm water basin:

      1) Fill a basin belonging to the patient with lukewarm water, not hot or boiling water. Do not use a "common basin" to warm milk for multiple patients. DO NOT thaw breast milk at room temperature, in the refrigerator, or in the microwave. If not fed to patient, breast milk is refrigerated after thawing.

2) Place the milk container(s) in the basin; making sure the water level does not touch the lid of the container(s). The milk container may be placed in a vinyl glove or plastic bag to protect the label from getting wet.
3))Keep the basin on a counter or stable surface while thawing the milk; do not place the basin in the sink. Do not thaw milk under running water in a sink

Temperature approved breast milk warmer can be used instead of the previous thawing procedure.

b) Human Milk Warmer:

(1)See Manufacturers Guidelines for Usage.

4. Swirl the milk container(s) periodically to distribute the milk components.
5. Instruct parents/family members in the correct procedure for thawing breast milk for use in the hospital and at home.
6. Milk should not be warmed beyond 122°F. to prevent destruction of enzymes and natural immune factors present in the milk.
7. Only RN's may add supplements/additives to human breast milk.
8. If the volume of milk to be fortified is > 60 ml, mix in a plastic container. If the volume is < 60 ml, use a nursette. Label container with the Connecticut Children's human milk label with the patient name, Medical record number, date/time milk was thawed, date/time prepared, contents/list of supplements added and expiration based on whether the milk was fresh or frozen.
9. Place any unused thawed breast milk in the refrigerator labeled with patient Identification label, (as above) and the date/time thawed. Use within 24 hours.

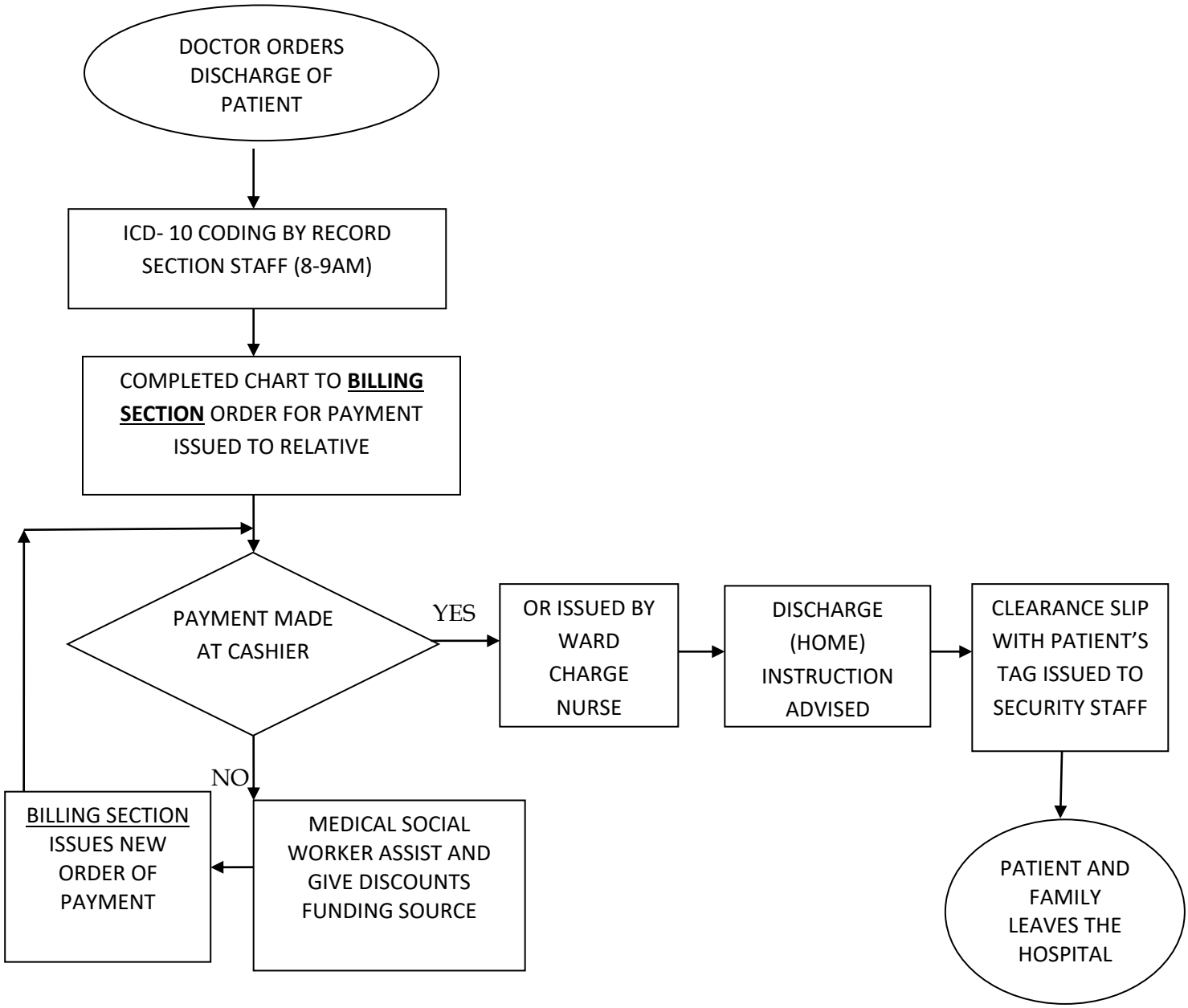
E. DOCUMENTATION:

1) Record medication additives in the medication administration record
2) Record nutritional additives/supplements on the flow sheet with the description of the feeding.

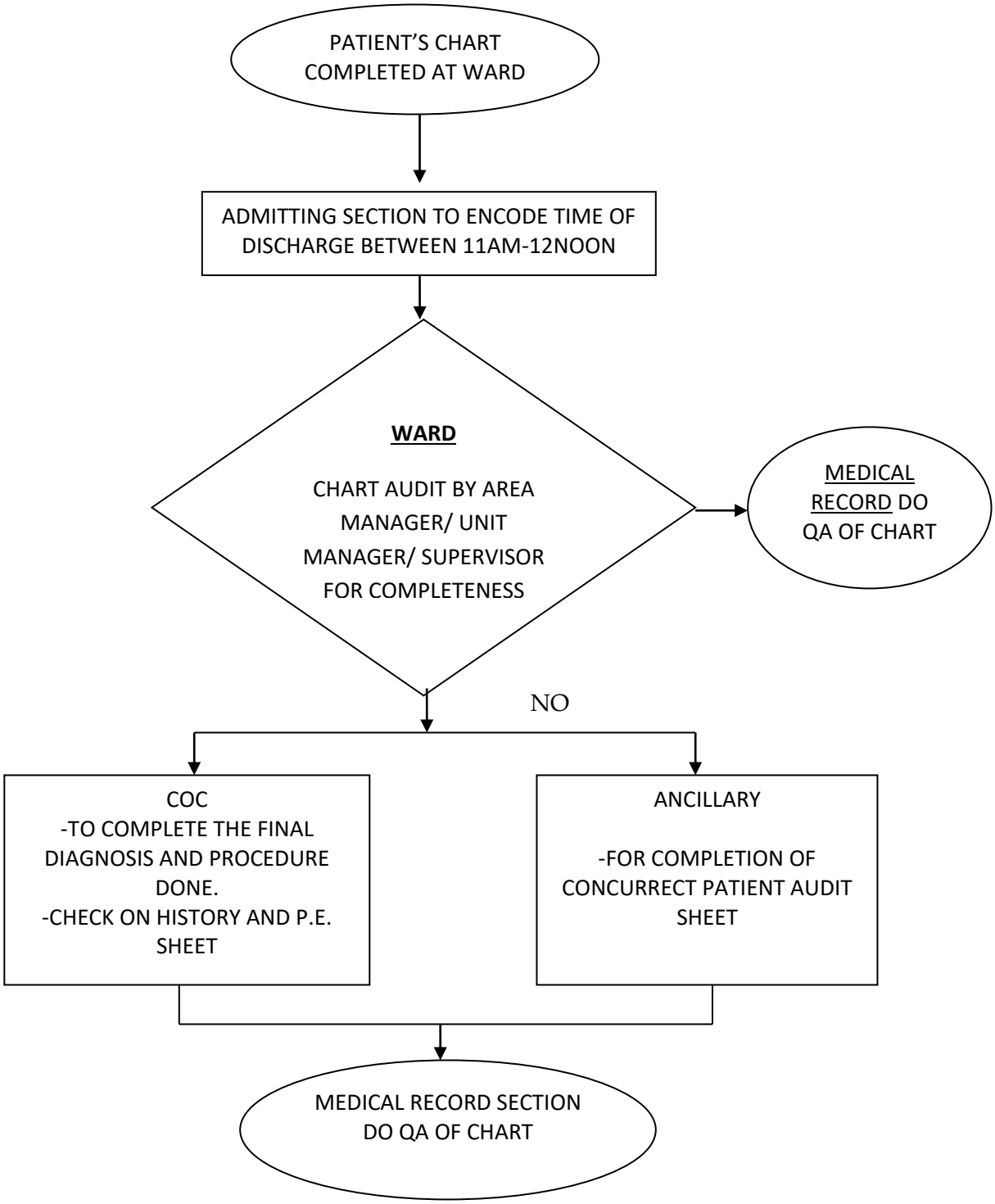
APPENDIX:

Flow Chart for Discharge of Admitted Patients
Flow Chart of Record of Discharged Patient
Flow Chart of Admission to NICU
Ob/Gyne Unit Discharge Flow Chart
Discharged Patients Record Flow Chart

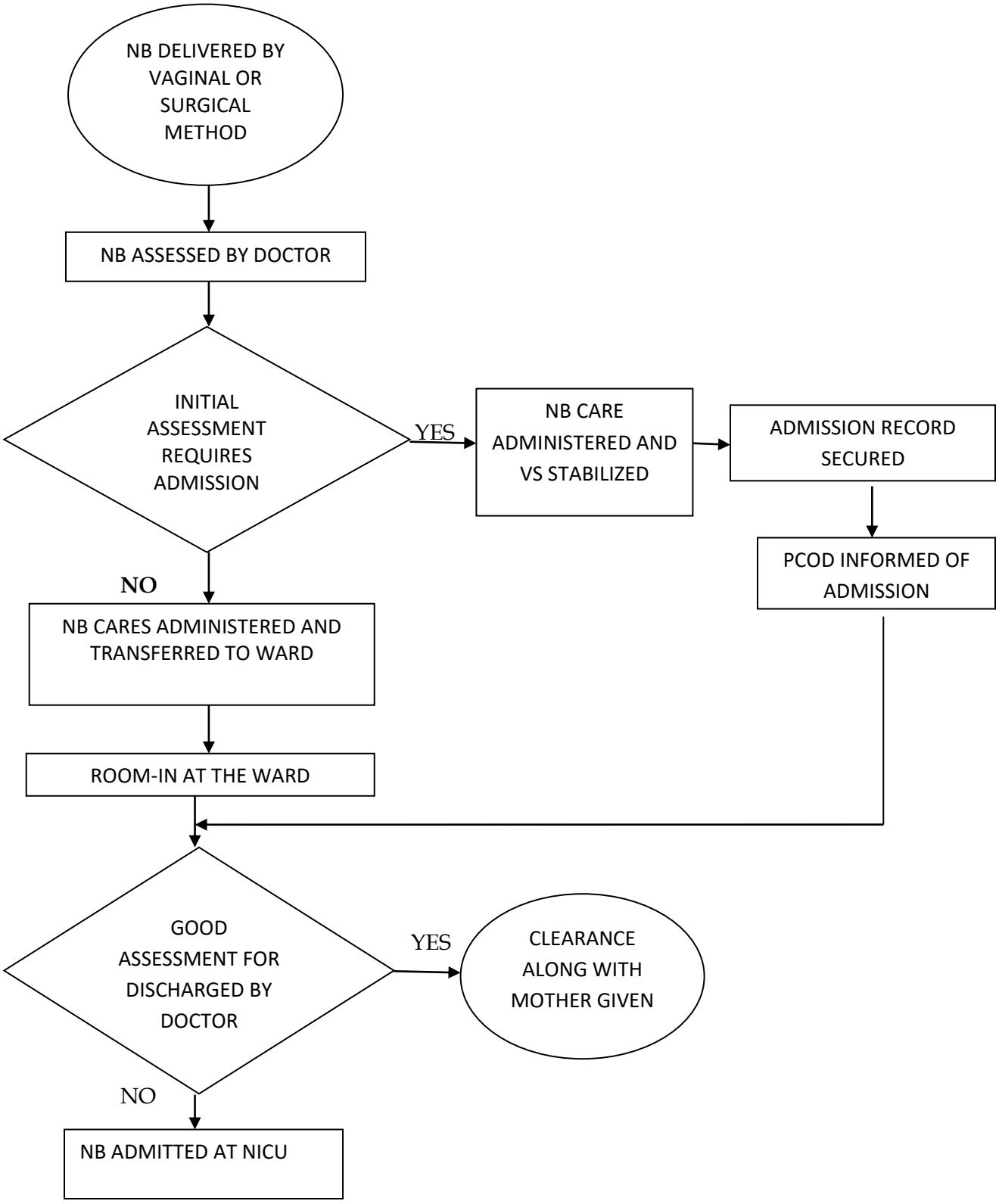
FLOWCHART FOR DISCHARGE OF ADMITTED PATIENTS



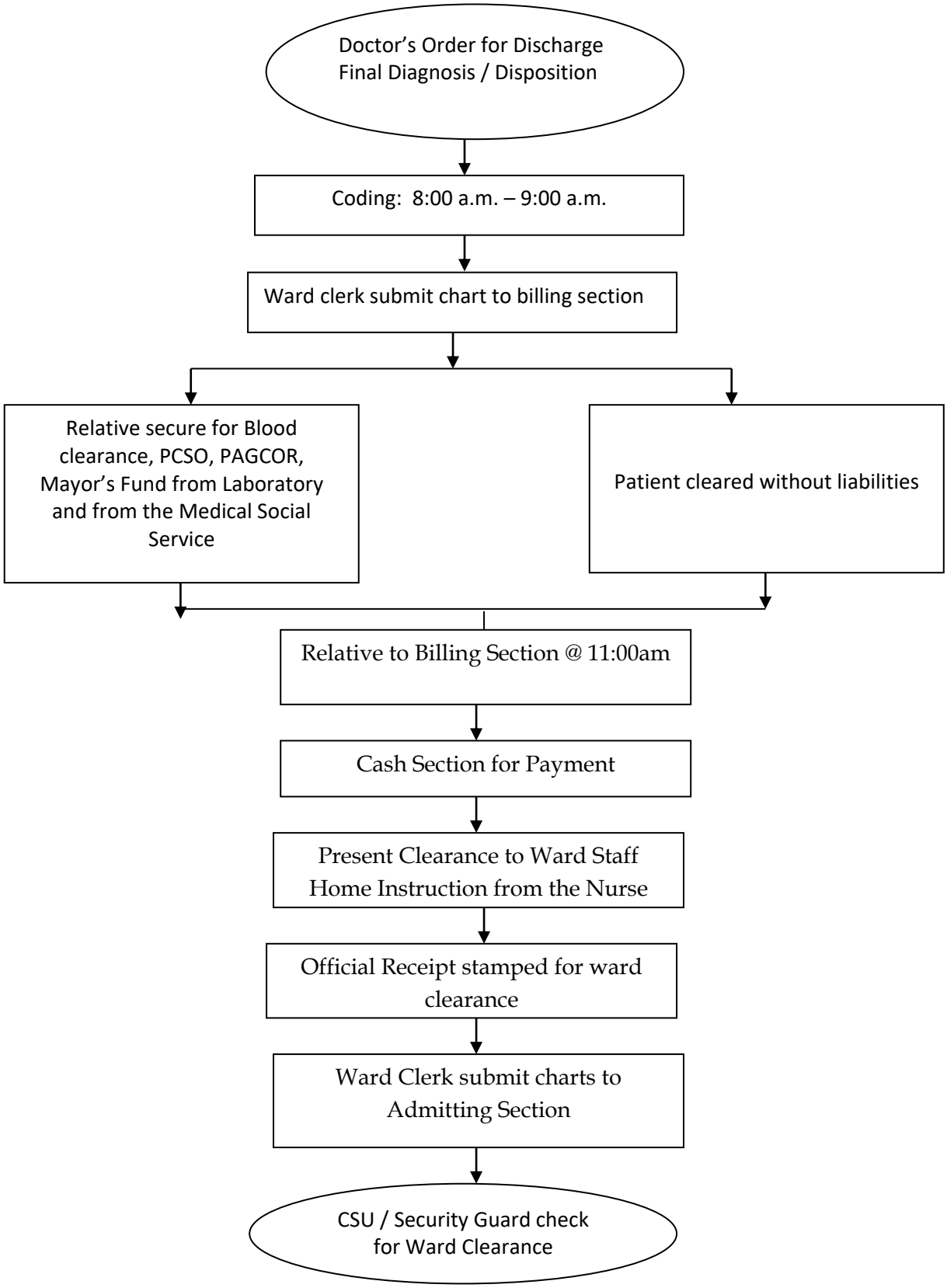
FLOWCHART OF RECORD OF DISCHARGED PATIENT



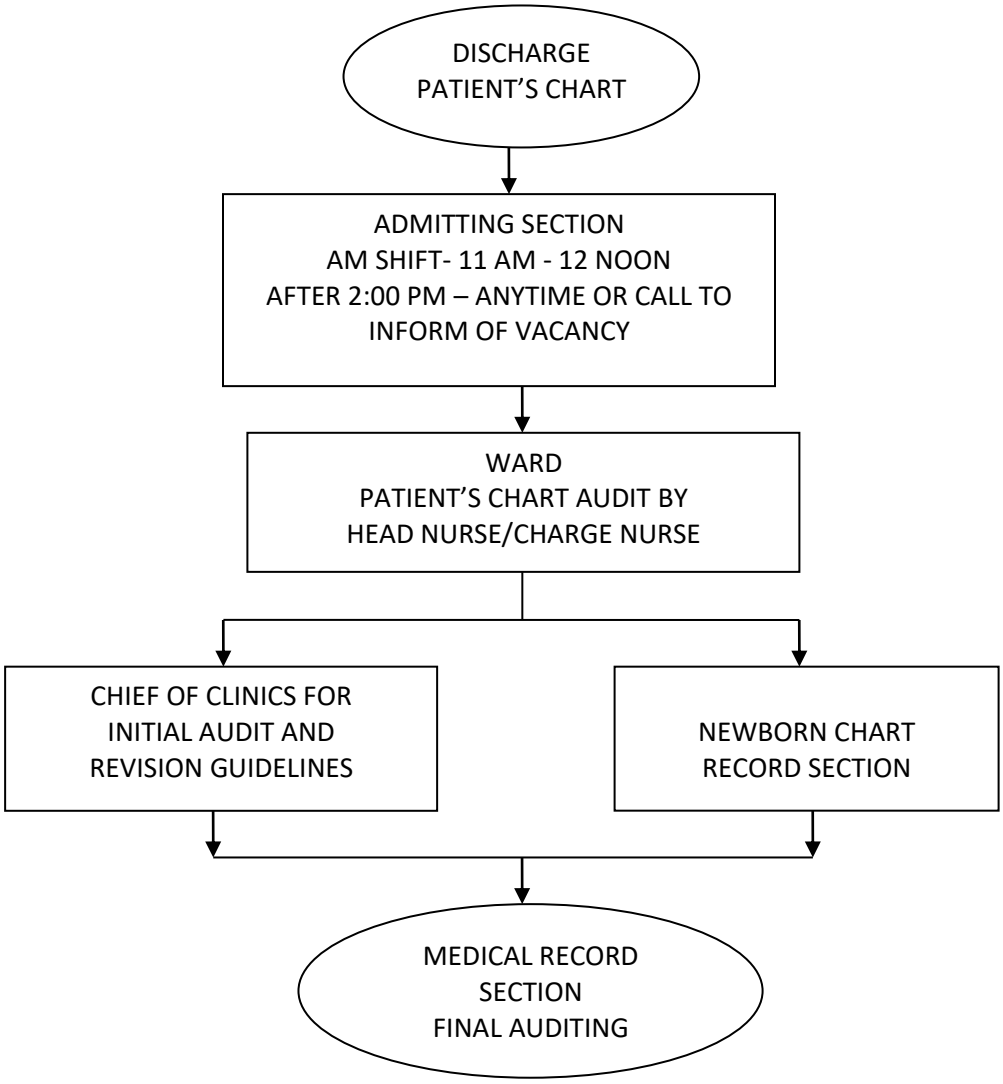
FLOWCHART OF ADMISSION TO NICU



OB/GYNE WARD DISCHARGE FLOW CHART



DISCHARGED PATIENT'S RECORD FLOW CHART



POLICY ON NEWBORN SCREENING

POLICY NO. : NSO-019

DIVISION: NURSING SERVICE DIVISION

SECTION: NICU/OB/GYN WARD/OPD

POLICY REVIEWED DATE: FEBRUARY 21, 2015

Reviewed by:			
Elizabeth B. Cantorna, RN OB-Gyn Head nurse	Nestor O. Beato, RN Nursing Supervisor	Angeline Brillante RN, MAN Asst. Chief Nurse	Arleen G. Herrera RN MAN OIC- Nursing Division
Noted by:			Approved by:
Dra. Juana Sinena Loren Head OB-Gyn Department	Dr. Alexander Salazar Head Pediatric Department	Dra. Lea Grace M. Vasquez Chief Of Clinics	Ephraim Neil Orteza MD MHA Hospital Director

OBJECTIVES:

I. To educate patients in the importance and advantage of Newborn screening test.

II. Provides the opportunity for early treatment of diseases that can be diagnosed before the symptoms appear, this providing affected newborn the chance to grow and develop normally.

COVERAGE:

This policy will cover this division, the medical and ancillary division.

RESPONSIBILITIES:

I. In compliance to Republic Act No. 9288 otherwise known as "Newborn Screening Act of 2004", our institution shall implement its program guidelines for all newborn delivered in our institution.

II. COMPOSITION & RESPONSIBILITIES OF HOSPITAL NEWBORN SCREENING TEAM

Hospital Coordinators:

a. Attend regular meetings of hospital coordinators
b. Information dissemination
c. Coordinator of the project
   - Implementation of NBS in the hospital
   - ensure screening of patients
   - receive and disseminate information
   - ensure prompt recall of positive screened patients and recommendation for confirmatory test and management

Consultant Staff:

a. parental education and consent
b. prompt patient recall of patients with positive result for repeat sample (by telephone, mailing system, home visit)
c. diagnosis and management

Resident Staff:

a. assist coordinators in implementing newborn screening
b. assist coordinators and consultants in obtaining consent

Nursing Staff (OPD, OBGYN Ward, NICU)

a. assist physician in implementing newborn screening
b. information dissemination
c. administrative record keeping

LABORATORY STAFF

Test Performed
Screening for the following:

1. Congenital Hypothyroidism
2. Congenital Adrenal Hyoperplasia
3. Phenylketunoria
4. Galactosemia
5. Homicystenuria
6. Glucose 6 Phosphate Deficiency

Responsibilities

- Performance of tests
- Analysis of results
- Coordination with international counterparts for transfer of technology
- Quality assurance
- Training

POLICY

I. All hospital staff must be aware of the implementation of Newborn Screening Test in our institution.

II. Medical and nursing staff shall begin the education classes focusing in the right of every newborn to service and feel healthy development as normal individual

Guidelines for NBS test:

a. Newborn screening is ideally done immediately after 24 hours from birth to not more than 14 days old. Aged 21 days old is still acceptable but is to be discouraged as to be able to catch the disease at its early stage and to reinforce treatment if needed.

b. All information required in the filter card must be fully and properly filled-up by the nurses at the NICU or the Ward if still admitted or by the OPD Nurse if in outpatient basis.

c. NBS testing fee shall be incorporated into the bill of the mother amounting to Php 600.00

d. Results are available by 7 - 14 working days from the time samples are received at the NSC.

e.Positive NBS results are relayed to the parents immediately by the health facility. Please ensure that the address and phone number you will provide to the health facility are correct.

The following system must be observed:

1. OB/GYN Ward and NICU section forward NBS charge ticket to the billing section
2. For paid NBS fee, parents shall be instructed by the OB-GYN Ward/NICU nurse for the test/scheduling.
3. For unpaid NBS fee due to financial constraint. Refusal to the test, the billing section shall indicate the reason on the charge ticket and return back to OB-GYN Ward/NICU section. The nurse will still have to encourage the parents on the importance of Newborn screening.
4. Parents who will refuse to have their child undergo NBS must sign a dissent form in duplicate; one copy will be retained in the patient chart and shall form part of the permanent record of the child and the other copy to be forwarded to the nursing office.
5. Any patient referral coming from the health centers shall be accepted initially until they are able to set up their own membership into the program.
6. Walk-in patient shall be accepted if qualified.
7. The laboratory section shall accommodate all qualified candidates only in the afternoon from 1pm-5pm. If still admitted, the Med tech shall proceed to Ward, if on Outpatient basis, shall perform at the Laboratory area with detailed explanation of the procedure to the patient.
8. “No receipt, no kit” policy shall be reinforce while no subsidy has yet been approved.
9. All result shall be followed up by the NBS coordinators at the NBS Center of the NIH (National Institute of Health, UP-PGH)
10. All patient who turned out positive to any of the test shall recalled through mail or home visit by the NBS coordinators and initially referred to the Pediatric Consultants for assessment. If any further confirmatory test is needed, parents of these Newborns shall be referred back

to the NSC-NIH for further testing.

11. Parents of the Newborn are advised to follow-up results after 2 weeks; unclaimed result will be notified by person and be mailed after.
12. Monitoring and evaluation of the implementation of the program shall be made by our NBS coordinators. Reports of monthly census shall be submitted by the same to NSC-NIH thru fax. Reports must be in duplicate. One (1) for NBS coordinator file and one to the Chief of Hospital for her file.
13. Babies on TPN for more than a week, request NBS after seven (7) days and had 24 hours Lactose (milk) intake.

APPENDIX

1. NBS test instruction/request
2. NBS flow of operation
3. Dissent form

IMPLEMENTATION DATE

This policy has been implemented since 2005, with minor revision August 2011
-DOH Memorandum December 16, 2006 NB test fee
-NOI 017-11 August 15, 2011

SCHEDULE FOR POLICY REVIEW

This policy shall be reviewed every three (3) years or as deemed necessary.

OSPITAL NG PARANAQUE
NEWBORN SCREENING TEST REQUEST/INSTRUCTION

OSPITAL NG PARANAQUE
NEWBORN SCREENING TEST REQUEST/INSTRUCTION

NAME:_____ DATE/TIME OF BIRTH_____ SEX:_____

AOG:_____WT. in Gms._____FEEDING:_____ UNIT:_____

ATTENDING PRACTITIONER: _____

MOTHER'S NAME: _____

ADDRESS/CONTACT#:_____

_____

NEWBORN SCREENING TEST INSTRUCTION:

_____

ACTUAL DISCHARGE DATE & TIME:_____

_____ _____

Signature of the Discharging Nurse
Giving instruction & Designation

Signature of Patient/Relative/Others
Taking Patient Home/Transfer

OSPITAL NG PARANAQUE

WAIVER ON NEWBORN SCREENING

DATE: _____

Ako po ang ina ni Bb. _____ na
Nangangako na ibabalik ang aking anak para sumailalim sa Newborn Screening Test ng hindi lalagpas ng _____(2 linggo mula ng petsa ng kapanganakan)
Petsa

_____
Pangalan at Lagda ng Ina

_____
Witness
(NARS)

NEWBORN SCREENING FLOW OF OPERATIONS

NBS Flow of Operation

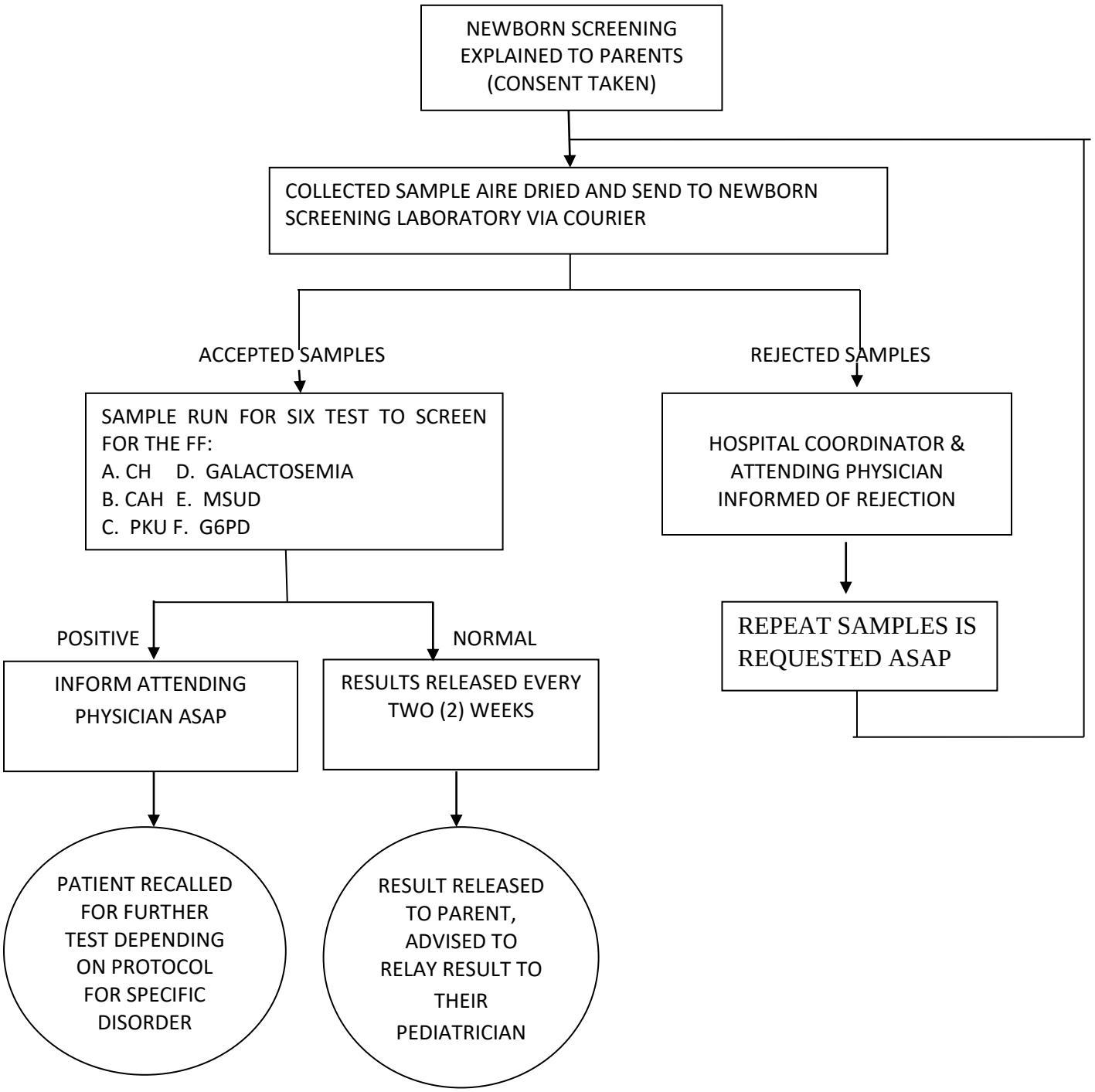
Motivating the parents

↓

Collecting Blood Samples

↓

Handling & Transporting Samples



POLICY ON BREASTFEEDING

POLICY NO. **: COM - 001**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMPREHENSIVE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE **:** May 2014

Reviewed By:		
Arleen G. Herrera, RN, MAN OIC-Nursing Division	Angeline L. Brillante, RN,MAN Asst. Chief Nurse	Juana Sinena-Loren, MD HEAD-OB-Gyne Dept.
Reviewed By:	**Noted By:**	**Approved By:**
Ma. Rima G. Apelo, MD HEAD-Pediatric Dept	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

- To encourage, protect and support the practice of breastfeeding.
- It shall create an environment where basic physical, emotional and psychological needs of mothers and infants are fulfilled through the practice of rooming-in and breastfeeding.

Definition of Terms:

- **Age of gestation –** the length of time the fetus is inside the mother's womb
- **Bottlefeeding –** the method of feeding an infant using a bottle with artificial nipples, the contents of which can be any type of fluid.
- **Breastfeeding –** the method of feeding an infant directly from the human breast.
- **Breastmilk –** the human milk from a mother.
- **Expressed Breastmilk –** the human milk which has been extracted from the breast by hand or by breast pump. It can be fed to an infant using a dropper, a nasogastric tube, a cup and spoon or a bottle.

- **Formula feeding –** the feeding of a new born with infant formula usually by bottlefeeding. It is also called artificial feeding.

- **Health institution –** are hospitals, health infirmaries, health centers, lying-in or puericulture centers with obstetrical and pediatric service.

- **Health personnel –** are professionals and workers who manage and/or administer the entire operations of health institutions and/or who are involve in providing maternal and Child health services.

- **Infants –** a child within zero (0) to twelve (12) months of age.

- **Infant formula –** the breastmilk substitute formulated industrially in accordance with applicable Codex Alimentarius standards, to satisfy the normal nutritional requirements of infants up to six (6) months of age, and opted to their physiological characteristics.

- **Lactation management –** the general care of a mother-infant nursing couple during the other's prenatal, immediate postpartum and postnatal periods. It deals with educating and providing knowledge and information to pregnant and lactating mothers on the advantages of breastfeeding, the physiology of lactation, the establishment and maintenance of lactation, the proper care of the breast and nipples and such other matters that would contribute to successful breastfeeding.
- **Low birth weight infant –** a newborn weighing less than two thousand five hundred grams at birth.

- **Mother's milk –** the breastmilk from the newborn's own mother.

- **Rooming-**in – the practice of placing the newborn in the same room as the mother right after delivery up to discharge to facilitate mother-infant bonding and to initiate breastfeeding. The infant may either share the mother's bed or be placed in a crib beside the mother.

POLICY:

1. Exclusive breastfeeding shall be implemented for all newborns delivered at Ospital Ng Parañaque.

2. Rooming-in shall be strictly implemented for all newborns delivered **EXCEPT** those with medical contraindication(s) to rooming-in.

3. Early and continuous mother-infant bonding shall be implemented in all newborns delivered at Ospital Ng Parañaque unless medical contraindication is present.

4. Demand or baby-led feeding shall be practiced in all newborns who are exclusively breastfeed unless medical contraindication is present.

5. The hospital shall create a Lactation and Breastfeeding Committee with the following functions:

    - To provide training in Lactation Management for hospital staff and other health care workers.
    - To evaluate and monitor the implementation of breastfeeding policies.
    - To manage problems related to breastfeeding.
    - To assist mothers in breastmilk expression
    - To disseminate information related to breastfeeding or benefits of breastmilk through visual aids, lectures, demonstrations.
    - To formulate a breastfeeding policy that addresses the 10 steps to successful breastfeeding as well as HIV (+) mothers and infant feeding.

6. The hospital shall prohibit promotion and/or distribution of breastmilk substitutes inside its premises.

7. Purchase of infant formula and other related products shall be prohibited, unless with medical indication.

8. The hospital shall confiscate infant formula, bottlefeeding paraphernalia, teats or pacifiers found in its premises.

9. Display of non-human milk products and other breastmilk substitutes or advertisements of these products within the hospital premises shall be prohibited.

10. Physicians and paramedical staff of Ospital Ng Parañaque shall not be allowed to accept samples of non-human milk or similar products nor give such products to pregnant women, mothers and members of their families.
11. Counseling of mother(s) and her companion(s) on the benefits of breastfeeding and dangers of not breastfeeding or not giving breastmilk to infants under 6 months of age shall be conducted during the first prenatal visit and shall be re-enforced at every visit.

12. Postpartum mothers shall be given written instructions on how and where to get help with feeding their infants prior to discharge.

13. Early outpatient follow-up shall be implemented for postpartum mothers and their babies 3 – 4 days after discharge and after one week in order to ensure continued breastfeeding.

14. HIV positive (+) mothers shall receive counseling on breastfeeding benefits, risk of not breastfeeding and appropriate feeding options that is **affordable, feasible, acceptable, safe and sustainable (AFASS)**

15. Privacy of the HIV (+) mother shall be strictly imp[lemented.

16. Mother-friendly care practices shall be implemented in all pregnant women seeking hospitalization at Ospital Ng Parañaque unless specific complication(s) is/are anticipated.

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

POLICY ON TRAINING OF HEALTH CARE STAFF ON LACTATION AND BREASTFEEDING

POLICY NO. **: COM - 002**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMMITTEE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE **:** May 2014

Reviewed By:		
Arleen G. Herrera, RN, MAN OIC-Nursing Division	Angeline L. Brillante, RN,MAN Asst. Chief Nurse	Juana Sinena-Loren, MD HEAD-OB-Gyne Dept.
Reviewed By:	Noted By:	Approved By:
Ma. Rima G. Apelo, MD HEAD-Pediatric Dept	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVE:

- That every staff member will confidently support mothers with early and exclusive breastfeeding, and that this facility moves towards achieving Baby-friendly hospital.

POLICY:

1. Train all health care staff in skills necessary to implement the policy.

2. All nursing staff especially those involved in the care of mother and infants shall undergo training in lactation, neonatal care and breastfeeding management.

3. New staff shall be trained upon entrance of duty.

4. All training seminars must be documented, including **TIME-IN** and **TIME-OUT** of every participant.

5. Inform all health care workers and employees of the hospital that, the Global Strategy is supported by national policies, laws and programs to promote, protect and support breastfeeding, and protect the rights of working women to maternity protection.

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

POLICY ON COMMUNICATION ABOUT THE BENEFIT AND MANAGEMENT OF BREASTFEEDING

POLICY NO. **: COM - 003**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMMITTEE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE **:** May 2014

Reviewed By:		
Arleen G. Herrera, RN, MAN OIC-Nursing Division	Angeline L. Brillante, RN,MAN Asst. Chief Nurse	Juana Sinena-Loren, MD HEAD-OB-Gyne Dept.
Reviewed By:	Noted By:	Approved By:
Ma. Rima G. Apelo, MD HEAD-Pediatric Dept	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVE:

- To ensure consistent, effective care for mothers and babies.
- To provide a standard of practice that can be measured.

POLICY:

1. Require all pregnant mothers and their husband to attend mother's class on breastfeeding (Tuesday & Thursday @ 12:00 Noon – 1:00 P.M.) at the lobby of OSPAR and at 8:00 P.M. at the OB-Gyne Ward.

   They will be informed about:
   a. Hospital policy on breastfeeding and rooming-in its strict enforcement at all times whether the patient is private or charity.
   b. Benefits of breastfeeding.
   c. Importance of adequate diet during pregnancy.
   d. Proper management of mothers and newborn during lactation.
2. In the event that there are pregnant women who have not attended mothers class seminar but who are about to deliver, personnel concerned shall inform such women of the breastfeeding and rooming-in policies at the soonest possible time upon admission to the hospital.

3. Posting of instructional/demonstrative materials relevant to breastfeeding in strategic places of the hospital.

4. Videos presentation on breastfeeding education during mother's class.

5. All health facility materials will promote breastfeeding as the normal and optimal way to care for a baby.

How can a pregnant woman prepare for breastfeeding?

1. During pregnancy, women should eat an extra meal a day for adequate weight gain to support fetal growth and future lactation and take iron/folate supplement.
2. During lactation, women should eat the equivalent of an additional nutritionally balanced meal a day. She needs also high dose vitamin A supplements within one month after delivery to build stor4es and to improve the vitamin A content of breastmilk.
3. Pregnant women should prepare their breast and nipples, use the **Hoffman's maneuver.** This is a simple stretching exercise that pulls the skin back and away from the nipple with fingertips. For those with no nipple problems, the expectant mother can prepare her breasts during the last six weeks of pregnancy. She can pull the nipple gently in all directions, grasp the nipples with two fingers and pull and roll them back and forth and gently massage her breast.

Advantages of exclusive breastfeeding for mothers.

1. Physiological benefits
    - Breastfeeding promotes uterine involution, decreases risk of postpartum hemorrhage and increases period of postpartum anovulation (having periods without ovulation).
    - Mothers can also practice natural child spacing since breastfeeding delays ovulation. This is called Lactation Amenorrhea Method (LAM). A lactating woman has at least 98% protection from pregnancy for six (6) months when she remains without her period (ammenorrheic) and fully or nearly fully breastfeeds.
    - Breastfeeding also decreases the risk of breast cancer, ovarian cancer and hip and bone fractures.
    - Breastfeeding also makes it easier for night feeds.
2. Psychological Benefit
    - Breastfeeding promotes attachment between the mother and child, increases self-esteem to mothers and allows daily rest for mothers. It is important for the optimal health and development of the baby. Breastmilk provides every single essential nutrient in the development of the babyand the bonding element (mother's thoughts, emotions and vibration) that helps mother and baby to bond for life.

3. Financial Benefits
    - Breastfeeding can save as much as P2000 a month when compared to using other milks.
    - Reduces time lost from work. Mothers do not have to absent themselves from work because breastfed babies are less likely to get sick.

- Reduces cost for medicines for sick baby because breastfed infants do not get sick easily.

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

POLICY ON THE INITIATION OF BREASTFEEDING WITHIN HALF HOUR OF BIRTH

POLICY NO. **: COM - 004**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMMITTEE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE **:** May 2014

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Arleen G. Herrera, RN, MAN OIC-Nursing Division	Angeline L. Brillante, RN,MAN Asst. Chief Nurse	Juana Sinena-Loren, MD HEAD-OB-Gyne Dept.
Reviewed By:	Noted By:	Approved By:
Ma. Rima G. Apelo, MD HEAD-Pediatric Dept	Lea Grace Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVE:

- **ESSENTIAL NEWBORN CARE (DOH AO 2009-0025)** – this Administrative Order (AO) outlines specific policies and principles for health care providers with regard the prescribed systematic implementation of interventions that address health risk known to lead to preventable neonatal deaths. This AO is consistent with AO No. 2008-2009 on implementing Health Reforms for Rapid Reduction of Maternal and Newborn Mortality and support all DOH initiatives and programs for newborn and child health.

POLICY:

A.Within the first 30 seconds

Objective: Dry and provide warmth to the newborn and prevent hypothermia

- Put on double gloves just before delivery.
- Use a clean, dry cloth to **thoroughly** dry the newborn by wiping the eyes, face, head, front and back, arms and legs.
- Remove the wet cloth.
- Do a quick check of newborn's breathing while drying.
- Do not put the newborn on a cold or wet surface.

- Do not bathe the newborn earlier than 6 hours of life.
- If the newborn **must** be separated from his/her mother, put him/her on a warm surface, in a safe place close to the mother.

B.After thorough drying

Objective: Facilitate bonding between the mother and her newborn through skin-to-skin contact to reduce likelihood of infection and hypoglycemia

- Place the newborn prone on the mother's abdomen or chest, skin-to-skin.
- Cover the newborn's back with a blanket and head with a bonnet.
- Place the identification band on the ankle.
- Do not separate the newborn from the mother, as long as the newborn does not exhibit severe chest in-drawing, gasping or apnea and the mother does not need urgent medical/surgical stabilization e.g. emergency hysterectomy.
- Do not wipe off vernix if present.

Check for multiple births as soon as newborn is securely positioned on the mother. Palpate the mother's abdomen to check for a second baby or multiple births. If there is a second baby (or more), get help. Deliver the second newborn. Manage like the first baby.

C. While on skin-to-skin contact (up to 3 minutes post-delivery)

Objective: Reduce the incidence of anemia in term newborns and intraventricular hemorrhage in pre-term newborn by delaying or non-immediate cord clamping.

- Remove the first set of gloves immediately prior to cord clamping.
- Clamp and cut the cord after cord pulsation have stopped (typically at 1 to 3 minutes). Do not milk the cord towards the newborn.
    a. Put ties tightly around the cord at 2 cm and 5 cm from the newborn's abdomen.
    b. Cut between ties with sterile instrument.
    c. Observe for oozing blood.
- After cord clamping, ensure 10 IU Oxytocin IM is given to the mother. Follow other protocol per PCPNC.

D.Within 90 minutes of age

Objective: Facilitate the newborn's early initiation to breastfeeding and transfer of colostrums through support and initiation of breastfeeding

- Leave the newborn on the mother's chest in skin-to-skin contact. Health workers should not touch the newborn unless there is a medical indication.

- Observe the newborn. Advice the mother to start feeding the newborn once the newborn shows feeding cues (e.g. opening of mouth, tonguing, licking, rooting). Make verbal suggestions to the mother to encourage her newborn to move toward the breast e.g. nudging.
- Counsel on positioning and attachment. When the newborn is ready, advise the mother to position and attach her newborn.
- Advise the mother not to throw away the colostrums.
- If the attachment or suckling is not good, try again and reassess.
- A small amount of breast milk may be expressed before starting breastfeeding to soften the nipple area so that it is easier for the newborn to attach.

To prevent ophthalmia neonatorum through proper eye care, administer erythromycin or tetracycline ointment or 2.5% povidone-iodine drops to both eyes after the newborn has located the breast. Do not wash away the eye antimicrobial.

E.NON-IMMEDIATE INTERVENTIONS – These interventions are usually given within 6 hours after birth, and should never be made to compete with the time-bound interventions.

b. **Give Vitamin K prophylaxis**
   - Inject a single dose of Vitamin K 1 mg IM (if parents decline intramuscular injections, offer oral vitamin K as a 2nd line).

c. **Inject Hepatitis B and BCG vaccinations**
   - Inject hepatitis B vaccine IM and BCG intradermally.

d. **Examine the newborn. Check for birth injuries, malformations or defects.**
   - Weigh the newborn and record
   - Look for possible birth injury and/or malformation.
   - Refer for special treatment and/or evaluation if available.
   - If the newborn has feeding difficulties because of the injury/malformation, help the mother to breastfeed. If not successful, teach her alternative feeding methods.

e. **Cord Care**
   - Wash hands
   - Fold diaper below stump. Keep cord stump loosely covered with clean clothes.
   - If stump is soiled, wash it with clean water and soap. Dry it thoroughly with clean cloth.
   - Explain to the mother that she should seek care if the umbilicus is red or draining pus.
   - Teach the mother to treat local umbilical infection three times a day.

F.NEWBORN RESUSCITATION

a. Start resuscitation if the newborn is not breathing or is gasping after 30 seconds of drying or before 30 seconds of drying if the newborn is completely floppy and not breathing.
b. Clamp and cut the cord immediately.
c. Call for help.
d. Transfer the newborn to a dry, clean and warm surface. Keep the newborn wrapped or under a heat source if available.
e. Inform the mother that the newborn needs help to breath.

G.ADDITIONAL CARE FOR A SMALL BABY OR TWIN – if a newborn is preterm, 1 – 2 months early or weighing 1,500 – 2,499 g (or visibly small where a scale is not available).

a. If the newborn is delivered 2 months earlier or weighs < 1500 g, refer to a specialized hospital.
b. For a visibly small newborn or a newborn born >1 month early;

-Teach the mother how to keep the small newborn warm in skin-to-skin contact via Kangaroo Mother Care (KMC). Start kangaroo mother care when;

- The newborn is able to breathe on its own (no apneic episodes).
  The newborn is free of life-threatening disease or malformations.

-Provide extra blankets for the mother and the newborn, plus bonnet, mittens and socks for the newborn.

- If the mother cannot keep the newborn skin-to-skin because of complications wrap the newborn in a clean, dry, warm cloth and place in a cot. Cover with a blanket. Use a radiant warmer if the room is not warm or the baby is small.

- Give special support for breastfeeding: Encourage the mother to breastfeed every 2 – 3 hours.

-Weigh the newborn daily.

-When the mother and newborn are separated, or if the newborn is not sucking effectively, use alternative feeding methods.

H.UNNECCESSARY PROCEDURES

A. Routine suctioning
B. Early bathing/washing

C. Footprinting
D. Giving sugar water, formula or other prelacteals and the use of bottles or pacifiers.
E. Application of alcohol, medicine and other substances on the cord stump and bandaging the cord stump or abdomen.

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

POLICY ON HOW TO BREASTFEED AND MAINTAIN LACTATION EVEN IF THEY SHOULD BE SEPARATED FROM THEIR INFANTS

POLICY NO. **: COM - 005**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMMITTEE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE **:** May 2014

Reviewed By:		
Arleen G. Herrera, RN, MAN OIC-Nursing Division	Angeline L. Brillante, RN,MAN Asst. Chief Nurse	Juana Sinena-Loren, MD HEAD-OB-Gyne Dept.
Reviewed By:	Noted By:	Approved By:
Ma. Rima G. Apelo, MD HEAD-Pediatric Dept	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVE:

To be able to know the advantages and disadvantages of Breastfeeding through proper motivation, mother's class and health teaching.

POLICY:

1. Breastfeeding is preferred and encouraged since we are a Baby Friendly Hospital affiliated.

2. The infant is burped well then should be placed on his right side for easy gastric emptying or in prone position after feeding.

3. Surrogate expressed breast milk is given in the absence of breast milk from the mother.

4. Use of sterilized containers for expressed breast milk is necessary.
    a. **Feeding on a normal babies**
        - Colostrums and breast milk must be given to all neonates who can tolerate oral feeding by direct manner.
        - The baby should be permitted to suck at the breast frequently or as demanded.

- Mother should wake their babies for breastfeeding if they sleep more than 3 hours.

b. **Feeding on preterm babies**

- Preterm (32 – 34 weeks gestation) and low birth weight whose sucking and swallowing mechanisms are not fully developed can be given through OGT feeding. Immediately 1 – 2ml of colostrums is given every 1 – 2 hours of life and may be given 5ml/day. However, unstable preterm is placed on NPO.
- With stabilization of vital signs and gestational age 32 – 34 weeks, breast milk by syringes or breastfeeding can be initiated.
- Asphyxiated babies generally cannot be fed 24 – 96 hours depending on the severity of complications.

c. **Feeding on babies with Hyperbilirubinemia**

- Mothers are allowed to breastfed or continue through expressed breast milk by tube or cup at NICU while the infant is on phototherapy.

Feedings are given more frequent to prevent water loss and dehydration brought by phototherapy.

BREASTFEEDING TECHNIQUES:

1. Put the baby to the breast immediately after birth and allow baby to remain with the mother.
2. Mother could either sit or lie down when breastfeeding. The position while breastfeeding should not make the mother feel tired.
3. Mother should hold the baby close enough to her body, supporting the baby's neck and shoulder.
4. Mother could place the nipple on the baby's cheek. This will make the baby turn and look for the nipple and grasp it by the mouth.
5. Mother could help the baby get enough milk by placing the baby's lower lip toward the base of the areola. This assures that the nipple is at the center of the baby's mouth.

Mother should offer both breast to the baby one after the other at each feeding time, allowing the baby to suckle on each breast for about 5 – 15 minutes. For the next feeding time, mother should start feeding on the breast last used by the baby.

6. If the baby is satisfied after feeding from only one breast, mother should express the milk from the other breast. She should start feeding on this breast at the next feeding. This will ensure equal suckling and emptying of both breasts.
7. Breastfeed frequently, as often as the baby wants, day and night. The signs when the baby is hungry are:
    - When baby turns towards the breast and searches for the nipple
    - licking movements
    - Flexing arms
    - Clenching fists
    - Tensing body

- Kicking legs
- Crying

8. Continue breastfeeding even if the mother or the baby becomes ill. Sick mothers need to rest and drink plenty of fluids top help her recover. If the mother does not get better, she should consult a health worker and say that she is breastfeeding. If the baby has diarrhea or fever, the mother should continue to exclusively breastfeed and frequently to avoid dehydration and malnutrition.

HOW WORKING MOTHERS CONTINUE TO BREASTFEED THEIR BABY

- Mothers can continue breastfeeding even when they have to return to work.
- Working mothers can breastfeed her baby before leaving for work, after returning from work, at night and day-off or on weekends.
- While at work, mothers can express their milk to relieve pain due to full breasts to ensure continuous milk production and prevent breasts from drying up.
- While the mother is away, the expressed breastmilk can be fed to the baby using a clean cup.

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

POLICY ON NEWBORN INFANT NO FOOD & DRINK OTHER THAN BREASTMILK, UNLESS MEDICALLY INDICATED

POLICY NO. **: COM - 006**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMMITTEE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE **:** May 2014

Reviewed By:	Reviewed By:	Reviewed By:
Arleen G. Herrera, RN, MAN OIC-Nursing Division	Angeline L. Brillante, RN,MAN Asst. Chief Nurse	Juana Sinena-Loren, MD HEAD-OB-Gyne Dept.
Reviewed By:	Noted By:	Approved By:
Ma. Rima G. Apelo, MD HEAD-Pediatric Dept	Lea Grace Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVE:

Breastmilk is the best food since it contains essential nutrients completely suitable for the infant's needs.
It is also nature's first immunization, enabling the infant to fight potential serious infection.

POLICY:

1. What does **BREASTFEEDING TSEK** means?

    - **"Tama"** by immediate skin-to-skin contact between mother and baby after birth, and initiation of breastfeeding within the first hour of life.
    - **"Sapat"** by encouraging and assuring mothers that little breastmilk is enough for the first week and that frequent breastfeeding ensures continuous breastmilk supply to respond to the increasing needs of the baby.
    - **"EKsklusibo"** by giving only breastmilk and no other liquid to the baby for the first six(6) months. Breastmilk has all the other and nutrients that the baby needs for the first six (6) months after which the baby should be given appropriate complementary foods while continuing breastfeeding.

2. What is the importance of **BREASTFEEDING TSEK?**

    - Babies who were not breastfed in the first 6 months of their lives are 25 times more likely to die than those who experienced exclusive breastfeeding from the time they were born.

- The timing of initiation of breastfeeding is important as there is a higher risk of death among infants with longer delay in the initiation of breastfeeding.
- Hospitalized low birth weight infants who were fed with formula milk had 4 times the incidence of serious illness compared to those infants who were breasted.
- There is a 2 – 4 fold increase in neonatal mortality rate (NMR) in not receiving colostrums. There is a 5 – 13% decrease in NMR with exclusive breastfeeding
- Breastfeeding not only saves babies from death, but also provides long-term benefits. Breastfed babies do better in school cognitive tests by as much as 4.9 points. There is a positive association of breastfeeding with educational attainment.

3. What are **the advantages of exclusive breastfeeding** for the baby?
    - The human milk is naturally designed for human consumption. It is nutritionally superior to any alternatives, bacteriologically safe and always fresh.
    - Breastfeeding **promotes proper jaw, teeth, and speech development.**
    - **Suckling at the breast is comforting** to fussy, overtired, ill or hurt baby.
    - It also **promotes bonding.**
    - **Provides protection against infection** – breast milk reduces the risk of acute infection such as diarrhea, pneumonia, ear infection, influenza, meningitis and urinary tract infections.
    - **Protect against illnesses** – it protects against chronic disease in children such as allergies, diabetes, ulcerative colitis and Chron's disease. Breastfeeding promotes child development and is associated with lower risk factors for cardiovascular disease including high blood pressure and obesity in later life.
    - **Protects from allergies** – breastfed babies are exposed to fewer allergens in the first hour of life and the first feedings of colostrums literally 'seal the gut' (the porous lining of the intestine), providing a barrier to the absorption of allergy-producing agents. Both colostrums and mother's mature milk are rich in antibodies, providing the baby the benefit of being immune for about 6 months of age.
    - **Enhances intelligence** – human breast milk enhances brain development and improves cognitive development.
4. Why do exclusive breastfed babies **need no additional water?**
    - Healthy infants need about 80-100 ml of water per kilogram of body weight in the first week of life and increases to 140-160 ml per kilogram between 3-6 months of age. The water requirements of the infant are all available from breast milk.
    - Eight-eight (88)% of breast milk is made-up of water. Even though a newborn gets little water in colostrums, no additional water is needed because a baby is born with extra water. The breastmilk with higher water content is usually available in mothers about the third or fourth day from birth.
    - Breast milk is also low in solutes or dissolved substances such as sodium, potassium, nitrogen and chloride. Thus, less water is needed to flush out these solutes. With less solutes, the baby's kidneys which are still immature are not overworked.

MILK BANKING

It is the policy of our institution that the human breast milk shall be handled and administered according to a safe and standardized process.

Procedure:

A. Exposure of human milk in the hospital.
   a. Human milk is expressed using a hospital-grade electric breast pump.
   b. Mothers should be provided with pumping kits suitable for double breast pumping. Each mother will be instructed in the correct use of the pump, including how to clean the pumping kit between uses.
   c. Mothers will be provided with single use, clean milk storage containers by unit staff.
   d. Mothers will receive instructions on correct hygiene (hand washing and care of nipples and breast) while pumping. Mothers should be discouraged from using any nipple treatments (creams and ointments) that may affect milk quality and or be harmful to the infant. Mothers may be instructed to use their own as a lubricant.
   e. The Unit Manager, Area Staff are responsible for the routine cleaning and disinfecting of a hospital-owned breast pumps. Pumps should be cleaned each day following the manufacturer's instructions for use of cleaning products. Users should be reminded to wash their hands before and after using the breast pump.

B. Storage
   a. Our hospital's patient care staff should follow Standard Precautions when handling expressed milk.
   b. Human milk may be stored on the hospital's designated refrigerator unit/freezer for that purpose only. It should never be stored with employee foods/medications.
   c. Human milk should be stored in hard plastic containers intended for single use should not be larger than 8-ounces volume.
   d. Each container must be labeled with patient's name, medical record number, date and time expressed, date and time thawed and any additives.

      If frozen in a general freezer: expiration is in 3 months

      If frozen in a deep freezer: expiration is in 6 months
   e. Milk intended for use within 24-48 hour period should be refrigerated. Any other milk should be placed in the freezer for longer storage. Milk stored at 4^0C (40^OF) in a refrigerator is good for 48 hours.
   f. Human milk containing any supplements or additives can be refrigerated for 24 hours.
   g. Human milk that has been refrigerated up to 24 hours can be frozen; milk refrigerated >24 hours cannot be frozen.

h. Human milk that has been thawed or partially thawed cannot be frozen and must be used within 24 hours.
i. Human milk containing supplements or additives cannot be frozen.
j. Daily monitoring of expressed milk expiration dates must be checked. Expired milk must be discarded immediately.

C. Transportation
   a. An insulated container with freezer gel pack should be used to transport fresh or frozen breast milk.

D. Thawing
   a. Patient care staff should use Standard Precautions when handling breast milk.
   b. Verify and identify of human milk by matching before breast milk is administered to a patient, 2-unique patient identifiers (patient's name and medical record number or date of birth) on the patient's identification bracelet with the same information on the human milk label. Checking can be done by 2 Registered Nurses and patient's parent.

      NOTE: Check expiration date; use the oldest milk first according to expiration date.
   c. There are two acceptable methods for thawing and/or warming human milk.
      i. Warm water basin
         1. Fill a basin belonging to the patient with lukewarm water, not hot or boiling water. DO NOT use a "common basin" to warm milk for multiple patients. DO NOT thaw breast milk at room temperature, in the refrigerator, or in the microwave. If NOT fed to patient, breast milk is refrigerated after thawing.
         2. Place the milk container(s) in the basin, making sure the water level does not touch the lid of the container(s). The milk container may be placed in a vinyl glove or plastic bag to protect the label from getting wet.
         3. Keep the basin on a counter or stable surface while thawing the milk, DO NOT place the basin in the sink. DO NOT thaw milk under running water in a sink.

            NOTE: Temperature approved breast milk warmer can be used instead of the previous thawing procedure.
      ii. Human Milk Warmer
         1. See Manufacturers Guidelines for Usage.
   d. Swirl the milk container(s) periodically to distribute the milk components.
   e. Instruct parents/family members in the correct procedure for thawing breast milk for use in the hospital and at home.
   f. Milk should not be warmed beyond 122^0F to prevent destruction of enzymes and natural immune factors present in the milk.
   g. Only RN's may add supplements/additives to human breast milk.

h. If the volume of milk to be fortified is >60 ml, mix in a plastic container. If the volume is <60 ml, use a nursette. Label container with the Connecticut Children's human milk label with the patient name, medical record number, date/time milk was thawed, date/time prepared, contents/list of supplements added and expiration based on whether the milk was fresh or frozen.
i. Place any unused thawed breast milk in the refrigerator labeled with patient identification label (as above) and the date/time thawed. Use within 24 hours.

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

POLICY ON ROOMING-IN

POLICY NO. **: COM - 007**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMMITTEE
SECTION **:** LACTATION AND BREASTFEEDING
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Reviewed By:		
Arleen G. Herrera, RN, MAN OIC-Nursing Division	Angeline L. Brillante, RN,MAN Asst. Chief Nurse	Juana Sinena-Loren, MD HEAD-OB-Gyne Dept.
Reviewed By:	Noted By:	Approved By:
Ma. Rima G. Apelo, MD HEAD-Pediatric Dept	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVE:

- To promote a wellness model of maternity care that will improve birth practices.
- To support every baby the best start in life by creating a health care environment that support breastfeeding as the norm.
- To foster a closer mother-baby relationship.

POLICY:

1. **For vaginal deliveries (NSD) –** the following newborn infants shall be put to the breast of the mother immediately after birth and forthwith roomed-in within thirty (30) minutes.
    - All well infants regardless of age gestation and delivered without complication shall be given to their mother to hold and caress immediately after birth.
    - Infants with low birth weights but who can suck, should also be given to the mother immediately.
    - Infants shall be roomed-in with their mothers within 30 minutes to 1 hour after delivery.
    - The NICU staff shall assist the mother to initiate breastfeeding in the delivery room by latching on.
2. **For Caesarian Section deliveries:**
    - Infants delivered by caesarian section shall be roomed-in and breastfed within three (3) to four (4) hours after birth **(RA No. 7600 Sec. 6)**
    - The NICU staff shall assist the mother to initiate breastfeeding.
3. **For complicated births (sick baby, sick mothers or both sick)**

- Infants shall be roomed-in as soon as medical condition permits. If the baby is staying in the unit, the mother must breastfeed directly or will feed with expressed breast milk.
- Newborn shall not be given pre-lacteal feeds such as sterile water, glucose water or milk formula since breast milk can provide their needs.
- Supplemental feedings are accepted only on medical conditions such as inborn errors of metabolism (Galactosemia, Phenylketonuria, MSUD), very low birth weights (below 1000g), preterm newborns (below 32 weeks gestation).

4. **For mothers with illnesses:**
    - Mothers with common breast problems such as breast engorgement, sore nipples and mastitis are still encouraged to continue to breastfeed their babies.
    - Mothers with mild to moderate medical conditions may still continue to breastfeed directly or give EBM by dropper or cup.

❖ **Exemption from rooming in and breastfeeding policies include those who are seriously ill such as mothers with eclampsia, CHD class IV, severe infection or diabetes, taking medications contraindicated to breastfeeding such as anti-cancer drugs, mothers with psychotic problems and other conditions which do not permit the said policies.**

❖ **Exemptions – infants whose conditions do not permit rooming-in and breastfeeding as determined by the attending physician, and infants whose mothers are either:**
    - Serious ill
    - Taking medications contraindicated to breastfeeding
    - Violent psychosis
    - Whose conditions do not permit breastfeeding and rooming-in as determined by the attending physician

Shall be exempted from the provisions of Section 5,6 and 7: Provided, that these infants shall be fed expressed breastmilk or wet-nursed as may determined by the attending physician. (RA 7600 Sec.8)

❖ **Right of the Mother to Breastfeed(RA 7600 Sec. 9)** – it shall be the mother's right to breastfeed her child who equally has the right to her breastmilk. **Bottlefeeding** shall be allowed only after the mother has been informed by the attending health personnel of the advantages of breastfeeding and the proper techniques of the infant formula feeding and the mother has opted in writing to adopt infant formula feeding for her infant.

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

POLICY TO ENCOURAGE BREASTFEEDING ON DEMAND

POLICY NO. **: COM - 008**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMMITTEE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE: May 2014

Reviewed By:		
Arleen G. Herrera, RN, MAN OIC-Nursing Division	Angeline L. Brillante, RN,MAN Asst. Chief Nurse	Juana Sinena-Loren, MD HEAD-OB-Gyne Dept.
Reviewed By:	Noted By:	Approved By:
Ma. Rima G. Apelo, MD HEAD-Pediatric Dept	Lea Grace Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVE:

- For better nutritional needs.

POLICY:

1. **A baby needs to be fed on demand.**
    - In the first two days of life, babies need only to be fed 2 4 times a day.
    - From about the third day onward, the baby starts to feed more often or about 10 – 20 feeding in 24 hours.
    - On the second week or so, most babies settle into routine of their own and feed 5 – 10 times a day.
    - From the third week onward, the number of feedings decreases to about one feeding every 3 – 4 hours.
    - A mother should offer her breast to the baby often.
2. **Babies are content with breastmilk alone**
   Breastmilk is adequate when the baby:
    - Is satisfied after 15 – 20 minutes of feeding
    - Falls asleep right away after each feeding and sleeps for about 3 – 4 hours

- Gains weight satisfactorily, i.e. about ½ kilogram every month for the first six (6) months such that birth weight will be doubled by about the sixth (6^{th}) month, and tripled by the first year.
- Urinates about six (6) times a day.

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

NO ARTIFICIAL TEATS OR PACIFIER TO BREASTFEEDING INFANTS

POLICY NO. **: COM - 009**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMPREHENSIVE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE **:** May 2014

Reviewed By:		
Arleen G. Herrera, RN, MAN OIC-Nursing Division	Angeline L. Brillante, RN,MAN Asst. Chief Nurse	Juana Sinena-Loren, MD HEAD-OB-Gyne Dept.
Reviewed By:	Noted By:	Approved By:
Ma. Rima G. Apelo, MD HEAD-Pediatric Dept	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVE:

- To promote, protect and support breastfeeding practices.

POLICY:

1. Sterile water or glucose should **not be given** to infants on pre-lacteal between feedings.

2. **No milk formula or any breast milk substitutes** should be given, unless with a narrative written report and a waiver.

3. **No artificial teats or pacifiers** (dummies or soothers) should be given to breastfeeding babies.
4. Complimentary food in addition to or in placed of breast milk should be given by dropper or small cup in the following condition:

    - Infants with inborn errors of metabolism
    - Those with increased insensible water loss such as during phototherapy
    - Very low birth weight and preterm below 32 weeks of gestation
    - Severe prematurity, severe hypoglycemia not responsive to increase breastfeeding
    - Infants whose mothers are taking medications which may cause harm

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

POLICY ON REFERRAL SYSTEM

POLICY NO. **: COM - 0010**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMPREHENSIVE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE: May 2014

Reviewed By:		
Angeline L. Brillante, RN, MAN Asst. Chief Nurse	Arleen G. Herrera, RN, MAN OIC-Nursing Division	Ma. Rima G. Apelo, MD HEAD-Pediatric
Reviewed By:	Noted By:	Approved By:
Juana Sinena-Lotren, MD HEAD-OB-Gyne	Lea Grace Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

- To inform mothers the availability of follow-up and support after discharge.
- For sustaining breastfeeding for the second year or longer.

POLICY:

1. **Before a mother leaves the hospital, she needs to:**
    - Be able to feed her baby
    - Understand the importance of exclusive breastfeeding for 6 months and continued breastfeeding after introduction of complementary foods to two years and beyond.
    - Be able to recognize that feeding is going well.
    - Find out how to get the on-going support that she needs.
2. **Primary Care and Community Health Workers**
    - Any time a health worker is in contact with a mother and young child, the health worker can help and support the mother in feeding and caring for her baby. If the health worker cannot do so themselves, they may be able to refer the mother to someone else who can provide support.
    - Community health workers are often nearer to families than are hospital-based health workers and may be able to spend more time with them.

- Community health centers can have “lactation clinics” which means that there are trained staff who will help a breastfeeding mother at the time that she contacts the clinic rather than waiting for an appointment.

Implementation Date:

This policy has been implemented since 1995, revised February 17, 2011, November 17, 2011 reviewed May 2, 2014, revised March 30, 2013

Schedule for Policy Review:

This policy shall be reviewed every three (3) years or as deemed necessary.

HOSPITAL POLICY ON BREASTFEEDING WITH MOTHERS WHO ARE HIV POSITIVE

POLICY NO. **: COM - 0011**
DIVISION **:** OB-GYNE, NICU, PEDIA
CLASSIFICATION **:** COMPREHENSIVE
SECTION **:** LACTATION AND BREASTFEEDING
POLICY REVIEWED DATE: May 2014

Reviewed By:		
Angeline L. Brillante, RN, MAN Asst. Chief Nurse	Arleen G. Herrera, RN, MAN OIC-Nursing Division	Ma. Rima G. Apelo, MD HEAD-Pediatric
Reviewed By:		**Approved By:**
Juana Sinena-Loren, MD HEAD-OB-Gyne	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

- To provide policies and guidelines on the prevention of mother to child transmission of HIV that shall be used by health care providers.
- To describe the different components of prevention of mother to child transmission (PMTCT) at all levels of health care.
- To define the roles and responsibilities of the different health care providers in the implementation of the PMTCT guidelines.

COVERAGE:

All hospital personnel, women and their partners.

RESPONSIBILITIES:

All hospital personnel should promote the policy on the prevention of mother to child transmission of HIV and serve as a guide for health care providers.

DEFINITION OF TERMS:

Antiretroviral ARV) – drugs that are given to people living with HIV infection in order to improve or maintain their immune function.

HIV Counseling and Testing – a confidential process that enables individuals to examine their knowledge and behavior in relation to their personal risks of acquiring or transmitting HIV. Counseling helps an individual decide on whether or not to undergo HIV testing and provides support to an individual receiving his or her test result.

Prevention of Mother to Child Transmission (PMTCT) – set of interventions with an aim of preventing the spread of HIV among infants and children.

POLICY:

1. All hospital staff shall be oriented on the **Prevention of Mother to Child Transmission (PMTCT)** of HIV policies.
2. All nursing staff especially those involve in the care of mother and infants shall be given basic and essential information on STI, HIV and AIDS including PMTCT.
3. Require all pregnant mothers and their husband to attend mother's class and give basic and essential information on STI, HIV and AIDS including PMTCT through either individual or group education. They shall also be given information on the availability of HIV counseling and testing services.
4. All pregnant women and those with complaints pertaining to the reproductive tract shall undergo risk assessment. The health service provider shall interview the client and ask the following question:
    a. Does client or partner have history of multiple sex partners?
    b. Does client or partner have or in the past suffered from symptoms of STI (genital tract symptoms such as dysuria, discharge or sores)?
    c. Does client or partner have history of injecting drugs?
    d. Does client or partner have history of undergoing voluntary HIV counseling and testing?
5. All women and partners identified with having one or more risk factors shall be offered HIV counseling and testing. For women who refused to undergo HIV testing, health care provider shall offer HIV test on her subsequent visits. Once the client has agreed to undergo the test, the principles of counseling and testing such as informed consent and confidentiality shall be observed at all times.
6. Women who tested HIV-negative shall be given counseling on risk reduction interventions, focusing mainly on how to maintain their HIV-negative status.
7. All women who tested positive shall receive counseling on available PMTCT services, including family planning options. Likewise, all partners of women infected with HIV shall be offered HIV counseling and testing.
8. All women and partners who tested positive for HIV shall be referred to the nearest treatment hub in order to access proper treatment and care such as antiretroviral (AVR) prophylaxis and treatment.

9. HIV infected pregnant women who are about to deliver should be referred and admitted to the nearest treatment hub. The attending physician should consider vaginal delivery if the following criteria are satisfied:
    a. HIV medications have been taken during pregnancy
    b. No previous uterine surgery or elective cesarean section
    c. No signs and symptoms of STI
    d. No indication of prolonged labor

    Cesarean section is recommended if vaginal delivery cannot be performed due to presence of contraindications. Cesarean section should be scheduled prior to the rupture of the membrane.
10. HIV infected pregnant women need **NOT** be isolated during labor and delivery because of their HIV status. Hospital staff must use standard precautions in all regardless of their status.
11. Counseling of HIV infected mothers should include information about the risk and benefits of exclusive breastfeeding and exclusive replacement feeding and guidance in selecting the most suitable option in their circumstances.

    Exclusive breastfeeding is recommended for HIV infected for the first six (6) months of life unless replacement feeding is acceptable, feasible, affordable sustainable and safe (AFASS) for them and their infants before that time. Mixed feeding must be avoided. Breastfeeding mothers of infants and young children who are known to be HIV infected should be strongly encouraged to continue breastfeeding with regular assessment of both mother and baby.
12. The hospital health care provider shall work in coordination with Local Health Department in the provision of treatment care and support for people living with HIV/AIDS and their families.

IMPLEMENTATION DATE:

This policy has been implemented since 2009 as **Administrative Order No. 2009-0016** by the Department of Health, revised and reviewed May 2, 2014

SCHEDULE FOR POLICY REVIEW

This policy shall be reviewed every three (3) years or as deemed necessary.

POLICY ON HEPA B AND BCG VACCINATION

POLICY NO: NSO --019

DIVISION: NURSING SERVICE DIVISION

SECTION: DR/ OB WARD/ OPD

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Jean Ann T. Gabrinao, RN DR- Head Nurse	Elizabeth B. Cantorna OB Ward – Head Nurse	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		**Approved by:**
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

. To reduce the incidence of Chronic Hepatitis B infection and respiratory diseases later in life.

COVERAGE: This policy will cover this Division and the Medical Division.

RESPONSIBILITIES:

I. It shall be the responsibility of the **DR staff t**o administer Hepa B vaccine prior to transfer of Newborn to the Ward.

II. It shall be the responsibility of the **OB Ward staff** to administer BCG vaccine to all infant at the OB Ward prior to discharge of Newborn

POLICY:

As part of the ongoing program of the Department of Health (DOH) and Philippine Health Insurance Company (PHIC), we are mandated that all Newborn be given an initial Hepa B vaccine and BCG vaccine prior to discharge from the hospital.

PROCEDURE:

I. All Newborn in the service ward shall undergo initial Hepa B and BCG vaccination for free prior to discharge.

II. The first dose of Hepatitis B vaccine shall be administered as soon as possible within 24 hours after birth. The subsequent 2 doses shall be given at the Health Center, the second dose on the 6th weeks and the 3rd dose on the 14th weeks.
III. All vaccines shall be kept in the refrigerator with the required cooling temperature and shall be monitored regularly with the use of temperature control gauge and graph.
IV. Administration of Hepa B and BCG vaccines shall be recorded and report submitted monthly to DOH (c/o Sto. Niño Health Center).
V. Fill-up discharge instruction and indicate the dates of the next vaccination at the Barangay Health Center
VI. All vaccines will be provided for FREE to all Newborn whether with Philhealth or none.
VII. Newborns delivered at the Emergency Room must also be given Hepa B vaccine prior to endorsement to OB Ward.
VIII. Vaccines are provided by DOH (c/o Sto. Niño Health Center) and it shall be the responsibility of the DR/NICU staff to maintain its availability at all times.

DATE OF IMPLEMENTATION:

This policy has been implemented since 2005, with minor revision 2006, reviewed 2011 and 2016.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

POLICY ON DOCUMENTATION

POLICY NO: NSO-021

DIVISION: NURSING SERVICE DIVISION

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Juliet S. Condes, RN CQI Committee Chair	Nestor O. Beato, RN QA- Committee Chair	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		Approved by:
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

I. To provide legal records that can be used to protect the patient, health professionals and health facilities that provide care.
II. To provide a way for a health team professionals to communicate with each other.
III. To provide data needed for effective interdisciplinary care and to ensure continuity of care.
IV. To furnish written record of quality care.
V. To provide a record of services rendered to the patient

RESPONSIBILITIES:

I. It shall be the responsibility of the Head of every Division, to orient all their staff with regard to this policy and to monitor the compliance.
II. It shall be the responsibility of all staff to follow set standard policy on documentation.

POLICY:

This policy shall enforce that all abide with the guidelines incorporated into it.

Legal guidelines in Documentation

DO's in Documentation:

1. Write legibly or present neatly, illegibly entries can cause misunderstanding leading to error.
2. Use permanent ink, the used of colored ink depends on hospital policy.

3. Write entries in constructive and chronological order as soon as case has been provided. Be factual and specific.
4. Give the date and time of every entry, sign your entry with your full signature. The signature clarifies who is responsible for the care.
5. Describe the care provided and the patient's response to it. Include the patient and family's response to health teaching.
6. Promptly document any changes in patient's condition and the action taken based on that change. Use patient and family quotes.
7. Chart only for yourself. Do not chart in advance as patient condition may change anytime.
8. Correct error promptly as these may lead to error in treatment. To correct an error, simply draw a line through that error and write the word "ERROR" above it. Sign your name and write the date and time this was done.
9. Review notation before signing them. This helps minimize the need for subsequent corrections or addenda.
10. Draw a line through an empty space at the end of an entry or at the bottom of the page.
11. Complete all boxes or blanks if forms are used. If no information is available or an item on the form is not applicable, indicate this in the box or blank so that it is clear that you didn't disregard the item.
12. Stick to the facts and choose your words carefully if a mishap occurs. Do not argue your case in the medical record. Defensive entries can damage the credibility of the entire record.
13. Use only hospital-approved abbreviations and symbols.

DONT's in Documentation:

1. Relying on memory. Facts may be forgotten or distorted with the passage of time.
2. Making retaliating remarks or critical comments regarding the patient or any member of the health team. These may be used against health team member for unprofessional conduct or poor quality care.
3. Erasing or applying correction fluid or crossing out words beyond recognition. It may seem to be an attempt to cover up incriminating evidence.
4. Leaving gaps or blanks spaces on narrative notes between entries and your signature. Another person may add incorrect data.
5. Using abbreviation except where they are clear and appear on the hospital's list of accepted abbreviation.
6. Using generalized empty phrase such as " Status unchanged" or " patient had a good day"

12 Rights in giving the medications:

1. Right Drug
2. Right patient
3. Right dosage
4. Right route
5. Right time and frequency
6. Right Expiration
7. Right Assessment

8. Right education and information (teach the patient about the drug he is taking)
9. Right to Refuse
10. Right documentation
11. Right Evaluation
12. Right Reason

COMMON ABBREVIATION GUIDE TO NURSES ON CHARTING

ABBREVIATION	STANDS FOR	MEANS
a.c.	antecebos	before food or meals
abd	abdomen	abdomen
amp	amperage	ampule
amt.	-	amount
ASAP	-	as soon as possible
b.i.d.	bis indie	two times a day
BMR	-	basal metabolic rate
B.P.	-	blood pressure
C	-	centigrade
CR	-	cardiac rate
Cap.	capsula	capsule
Cath	cathartic	catheter
DAT	-	diet as tolerated
ECG	-	electro cardiogram
I.Q.	-	intelligence quotient
I.U	-	international units
ID	-	intra dermal
IM	-	intra muscular

IV	-	intravenous
OD	on diem	once a day/daily
Inj.	Injection	injection
I&O	-	intake and output
KUB	-	kidney, ureter, bladder
Liq.	Liquor	liquid
Meq.	-	milliequivalent
N.I.H.	-	National Institute of Health
NPO	-	nothing per orem
O2 Sat	-	oxygen saturation
pc.	Post cibum	after meal
p.o.	per orem	by mouth
p.r.n.	pro re nata	according as circumstances require
q.h	quaque hora	every hour
q.2h	quaquesegunda hora	every 2 hours
q.3h	quaquetertia hora	every 3 hours
q.4h	quaquequarta hora	every 4 hours
q.i.d.	quarter in del	4 times a day
RR.	-	respiratory rate
r.b.c.	-	red blood cell
SC	sub cutem	under the skin, subcutaneously
Sig.	signa	write, signature
Sol.	Solution	solution, soluble
Stat.	statim	immediately
Supp.	Suppositorium	suppository
Syr.	Syrupus	syrup

TB	tubercle baccilus	tuberculosis
TID	tur in dei	3 times a day
Ugm	-	microgram
TPR	-	temperature, pulse, respiration
Tab.	Tablet	tablet
Tinct.	Tincture	tincture
v.d.	-	venereal diseases
v/s	-	vital signs
v/v	-	volume in volume
v/w	-	volume in weight
w.b.c.	-	white blood cell

Special Considerations:

1. The initial dose of newly ordered medications should be started as soon as drug is available unless a specified times for starting it is given. The next dose should be given according to standard practice.
2. Standing order medications and treatments are cancelled/discontinued under the following circumstances:
    a. When a patient goes to surgery, laboratory, delivery

STANDARD HOURS OF ADMINISTERING DRUGS:

OD - 8AM

BID - 8AM – 6PM

TID - 8AM – 1PM – 6PM

QID - 8AM – 12PM – 4PM – 8PM

AC - 30 minutes before meal

PC - one hour after meal

HS - 9PM or at bedtime

Q

Q2hrs - 8, 10, 12PM, 2, 4, 6, 8, round the clock

Q3hrs - 9, 12, 3, 6, 9, 12, (or depending upon the initial dose time)

Q4hrs - 8, 12, 4, 8, 12, round the clock

Q6hrs - 12, 6, 12, 6

Q8hrs - 8, 4, 12, - 8PM – 4AM

PRN - if necessary (no exact time, only indication)

Q12 - 12-12, 6-6, 8-8

ASAP - as soon as possible

NPO - nothing per orem

PROCEDURES:

App - appendectomy

D&C - dilatation and curettage

CS - caesarean section

BTL - bilateral tubal ligation

ORIF - open reduction internal fixation

Amp B/K - amputation below knee

Amp A/K - amputation above knee

Ex lap - exploratory laparotomy

DISEASES:

AF - atrial fibrillation

AGE - acute gastroenteritis

AIDS - acquired immunodeficiency syndrome

MI - myocardial infarction

ARF - acute respiratory failure

ARDS - acute respiratory distress syndrome

Ca - carcinoma

CAD -coronary artery disease

CAP -community acquired pneumonia

DIAGNOSTICS:

CXR - chest xray

AP/L - antero-posterio / lateral view

UTZ - ultrasound

CT/CAT SCAN- computer (axial) tomography scan

MRI - magnetic resonance imaging

ECG/EKG - electro cardiography

CBC - complete blood count

Hg - hemoglobin

Hct - hematocrit

WBC - white blood cell

BldChem - blood chemistry

BUN - blood urea nitrogen

Crea - creatinine

PT - Prothrombin time

PTT - partial thromboplastine time

CT/BT - clotting time/bleeding time

SGOT - serum glutamicoxalo-acetic acid

SGPT - serum glutamic pyruvic transaminase

TC - total cholesterol

TG - triglyceride

TPAG - total protein – albumin globulin ratio

C/S - culture and sensitivity

ABG - arterial blood gas

FWB - fresh whole blood

PRBC - packed red blood cell

HGT -hemogluco test

CBG - capillary blood glucose

UA - urinalysis

COLOR OF MEDICINE CARDS:

OD - white

BID - green

TID - yellow

QID - pink

PRN - red

Q6 - blue

Q12 - green

Q8 - orange

HS - yellow

STAT - red

Q4 - pink

ROUTE FOR ADMINISTRATION:

SL - sublingual

TIV - through intravenous

IM - intramuscular

SQ - subcutaneous

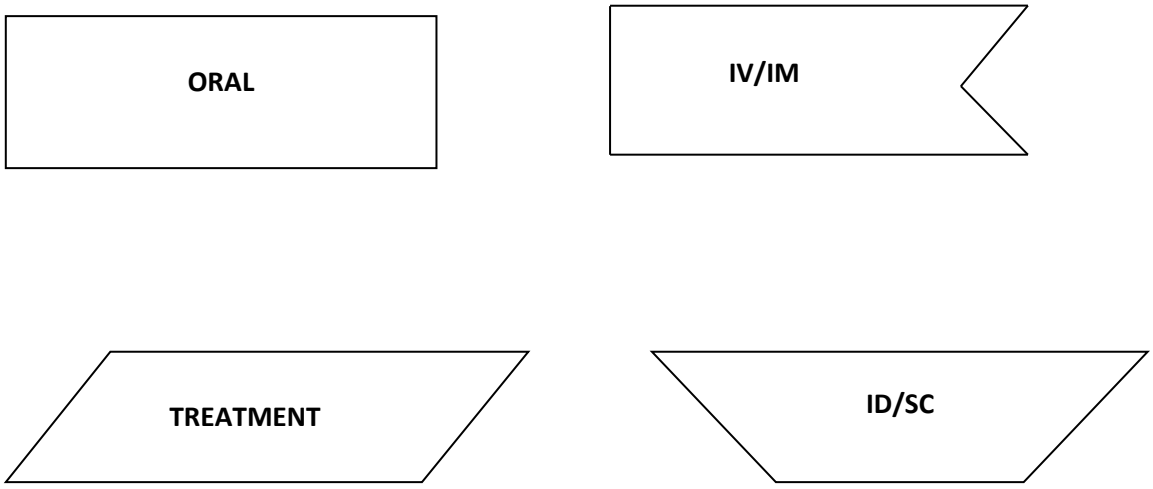
ID - intradermal

NGT - nasogastric tube

CATH - catheter

“U”/IU – international unit

SHAPES OF MEDICINE CARDS:



OBSOLETE TERM	REASON	SUGGESTED PHRASE
Conscious Coherent	Only for patients whose neurological status is affected and disoriented	Patient oriented to date, time and place
Vital signs taken	Vital signs are already written on the monitoring sheet	Document of you were not able to take vital signs and why
Afebrile	Temperature is included in the monitoring sheet, status can be deducted here	If the patient is febrile support it with subjective and objective cues Evaluate effectiveness of nursing intervention for fever, include element of time
Due meds given	Recording of medications given is on the medication sheet	Document medications that were not given and indicate the reason Document stat medications given, its indications and evaluate effectiveness
Seen at intervals	It is expected that we visit the patient at intervals	Visit patients frequently and assess for any complications
Needs attended	It is expected that we make	Enumerate measures done to make

Kept comfortable Kept undisturbed Kept safe	the patients comfortable during their hospital stay	the patient comfortable Verbalized needs must also be documented and referred to the doctors as necessary
Slept fairly Slept well Asleep the whole shift	Only noted if the patient is having sleeping difficulty	If the patient has difficulty sleeping, document subjective cues, interventions done and evaluation "Slept for approximately 5 hours as verbalized by the patient"
MGH	Not an accepted abbreviation	"Patient seen by DrGueco with discharge order given"
On DFA With fair/good appetite	DFA is not an accepted abbreviation Include a recording of the food intake if the appetite was affected by the illness	"Patient was able to eat half of the food that was served for lunch" Include the instruction given regarding the prescribed diet and the patient's compliance
No complaints made For further management	Do not document something that did not happen	
No pain		Note pain level and characteristics (PQRST) Evaluate patient's response to interventions done "Denies any pain at this time"
S.O.	Not an accepted abbreviation	If abbreviations are used they should be standardized throughout the agency Abbreviations must be consistent so that they mean the same thing to everyone reading the record

Forbidden Abbreviations

DO NOT USE	POTENTIAL PROBLEM	USE INSTEAD
U (Unit)	Mistaken for "0", "4" or "cc"	"unit"
IU (International Unit)	Mistaken for "IV" or "10"	"international unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod, EOD (every other day)	Mistaken for each other. Period after "Q" mistaken for "I" and the "O" mistaken for "I"	"daily" "every other day"
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium	"morphine sulfate" "magnesium sulfate"

	sulfate Mistaken for one another	
> greater than < less than	Misinterpreted as "7" or "L"	"greater than" "less than"
HS (half-strength) Hs (at bedtime, hour of sleep)	Mistaken as "bedtime Mistaken as "half strength"	"half strength" "bedtime"
SC, SO, sub (subcutaneous)	"SC" mistaken as "SL"; mistaken as "every", the "q" in "sub q" has been mistaken as "every"	"subcut" or "subcutaneously"
Abbreviations for drug names	Misinterpreted due to similar abbreviations	Write drug names in full
Trailing zero (X.0 mg)* Lack of leading zero (.Xmg)*	Decimal point is missed	Write X mg Write 0.X mg

Standards on Nursing Documentation

Standard I: Structural Data

The nurse documents structural data of each patient accurately and completely based on applicable laws and regulations, professional standards and institutional requirements.

Measurable Elements

1. There is an accurate and complete documentation of patients' structural data in all nursing and applicable forms which include but are not limited to the following:

    Patient's addressograph – name, age, gender, civil status, date of birth
    Registration number or admission number
    Date and time of admission and discharge
    Mode of admission/transport/discharge
    Admitted via: ambulatory, wheelchair, stretcher
    Admitted from: home, transferring hospital, care facility
    Attending physician and referring physician, if any
    Religion
    Languages spoken
    Advanced directive
    Health care insurance

Standard II: Clinical Data

The nurse documents essential clinical data of each patient accurately and completely based on individualized nursing care plan from admission to discharge in health care facility.

1. There is relevant/essential, accurate and complete nursing documentation of patients' clinical data in all appropriate forms from admission to discharge in health care facility which include but are not limited to the following:

Physical Assessment (head-to-toe)
Health history
Psychological, social, spiritual and economic evaluation
Actual and potential health problems and needs
Diagnostic and therapeutic intervention
Pharmacological management
Nursing interventions
Health teachings – patient and family
Patient's response and outcome
Preferences and idiosyncrasies

NURSING DOCUMENTATION:

FOCUS CHARTING SYSTEM

- It encourages using assessment data to evaluate patient care concerns
- It helps identify necessary revisions to the care plan as you document
- This works well in acute care setting and in areas where the same care and procedures are repeated frequently
-Focus charting is patient-centered rather than problem oriented and addresses the patient's strengths, concerns

A focus will identify a change in a patient's condition or behavior, such as disorientation to time, place and person.
A significant event in the patient's treatment/therapy, such as safety concerns, or initiation in focus charting you may write each focus as a nursing diagnosis, such as risk for infection or fluid volume deficit. However, the focus may also refer to:

Sign or symptom – chest pain, nape pain, etc
Patient behavior – inability to ambulate, altered ADLs
Acute changes in patient's condition – loss of consciousness, increased BP, pain
Significant event – surgery, transfer, etc
Blood transfusion

FOCUS PROBLEM

Abnormal lab results	Aspiration
Activity	Cardiovascular
Admission	Central line therapy
Airway impairment	Chest tubes

Allergic reaction

Anxiety

Confusion

Comfort

Constipation

Coping

CNS status

Dehydration

DNR/Therapeutic choices

Dialysis

Discharge

Enema

Elimination

Falls

Fatigue

Family dynamics/concerns

Fluid balance

Fever

GI/GU status

Health teaching

Hemorrhage/Bleeding

High risk/Suicidal

Hypotension

Hypertension

Hypothermia

Code

Cognitive impairment

Hyperthermia

Incontinence

Infection

Isolation

Mental/emotional status

Nausea/vomiting

Neurovascular

Musculoskeletal

Pain control

Physician/Visit/Assist/Notified

Physical status

Respiratory status

Restraints

Skin integrity/wound care

Spiritual interventions

Swallowing

Substance abuse

Teaching

Telemetry

Transfer

Vital signs

Wound care

ADVANTAGES

- Flexible, can be adapted to fit any clinical setting
- Centers on the nursing process
- Easy to find data on a particular problem
- Encourages regular documentation of patient's response to nursing and medical care
- Helps organize thoughts
- Helps identify areas in the care plan that needs revising

DISADVANTAGES

- Staff members who are familiar with other systems may need in-depth training
- Requires you to use many flow sheets and checklists
- Can be a narrative note if you neglect to include patient's response to interventions

FOCUS CHARTING SYSTEM

DATE/TIME	FOCUS	DATE, ACTION, RESPONSE
08-31-10 6AM	Ineffective airway clearance	D – "Hirap pa din akoilabasang phlegm ko", with severe cough, RR – 25 with rales upon auscultation on the left lung A – nebulization done, chest – physio therapy facilitated, deep breathing exercises advised, and increase in oral fluid intake advised
8AM	Fever	D – "Mainit pakiramdam ko" patient is warm to touch with a temperature of 39.6C A – PRN meds given Aeknil 2 amps IV, TSB facilitated and increase in oral fluid intake instructed
12PM	Hypertension	D – "Medyo nahihilo ako, mataas daw BP ko" patient is weak looking with a BP of 160/100 A – bed rest instructed, referred to Dr. Quijano with orders made, Catapres 75 mcg 1 tab SL given as stat meds, O2 inhalation maintained @2-3L/min
1PM	Fever	R – patient is no longer warm to touch, Temp 37
3PM	Hypertension	R – patient can now sit up on bed, BP 130/90
5PM	Ineffective airway clearance	R – patient verbalized that he can now easily spit out phlegm. Still with minimal rales on left lung RR 20.

DATE/TIME	FOCUS	DATA, ACTION, RESPONSE
08-31-10 9AM 10AM	Altered body temp/fever Fever	D – "4 days na ako may lagnat" came in to ER ambulatory, weak looking and warm to touch, with a temp of 38.5C A – sponge bath facilitated, referred to Dr, Quijano with admitting orders made and carried out, Aeknil 1cc IM given as stat meds, hooked to IVF with a gauge of 20, CBC w/ PC and BT done, soft diet and no dark colored food advised. R – patient is no longer warm to touch with a temp of 37.6C
DATE/TIME	FOCUS	DATA, ACTION, RESPONSE
Aug 16, 06 11AM	Discharge Planning	D – may go home as previously ordered by Dr. Quijano. Patient verbalized desire to go home, but still in due to financial constraints. A – availability of meds reinforced, and frequency advised, referred to social worker on duty for assistance R – discharged, with home meds instructions, follow up check up advised.

DOCTOR'S DOCUMENTATION:

PART OF THE MEDICATION ORDER (Doctor's Order)

1. Name of the client
2. Date and time when the order is written
3. Name of the drug to be administered
4. Dosage/frequency
5. Route by which the medication is o be administered and special derivatives about its administration
6. Time of administration
7. Signature of the person writing the order

DOCTOR'S PROGRESS NOTES:

I. S – subjective signs
II. O – objective signs
III. A – action
IV. P –plan

PATIENT CARE AUDIT

A. **Concurrent Audit –**is one in which patient care is observed and evaluated. It is given through:
    a. Review of patient's chart while patient is still in the hospital
    b. Observation of the staff as patient care is given
    c. Inspection of patient's and/or observation of effects of patient care where the focus is on the patient
B. **Retrospective Audit –**is one in which patient care is evaluated through:
    a. A review of discharged patients' charts
    b. Interviews conducted on discharged patients

USES OF IV THERAPY

- Restore and maintain fluid and electrolyte balance
- Provide medication and chemotherapeutic agents
- Transfuse blood and blood products
- Deliver parenteral nutrients and nutritional supplements

RISKS OF IV THERAPY

- Blood vessel damage
- Bleeding
- Infiltration (infusion of the IV solution into the surrounding tissue)
- Infection
- Overdose (response to IV drugs is more rapid)
- Incompatibility when drugs and IV solutions are mixed
- Allergic responses to infused substances

PURPOSES OF DOCUMENTATION

- Provides accurate description of care that can serve as legal protection
- Mechanism for recording and retrieving information
- Record for health care insurers of equipment and supplies used

FORMS USED IN THE DOCUMENTATION OF IV THERAPY

- Nurse's progress notes
- IV fluid sheet
- Medication sheet
- Blood transfusion sheet

DOCUMENTING INITIATION OF IV THERAPY:

- Size, length and type of device
- Name of the person who inserted the device

- Date and time
- Site location
- Type of solution
- Any additives
- Flow rate
- Use of an electronic infusion device/flow controller
- Patient teaching and evidence of patient understanding
- Number of attempts (both successful and unsuccessful)

LABEL THE DRESSING

- Date of insertion
- Gauge and length of venipuncture device
- Your initials

DOCUMENTING IV THERAPY MAINTENANCE

- Condition of the site
- Site care provided
- Dressing changes
- Tubing and solution changes
- Patient teaching and evidence of patient understanding

INFORMATION REQUIRED BEFORE IV DRUG ADMINISTRATION

- PATIENT – name, id tag, allergies, treatment chart
- DRUGS – name, dosage, frequency, side effects and expiration date

BLOOD TRANSFUSION

The introduction of whole blood or blood components into the bloodstream

PURPOSE OF BLOOD TRANSFUSION

- Restore and maintain blood volume
- Improve the oxygen-carrying capacity of the blood
- Replace deficient blood components and improve coagulation

CHECK, VERIFY AND INSPECT

- Check to make sure that an informed consent form was signed
- Double check patient's name, medical record number, ABO and Rh status, and the blood bank identification number against the label on the blood bag
- Check the date of extraction and expiration date

MONITORING A BLOOD TRANSFUSION

- Record the patient's vital signs before the transfusion, and every 15 minutes after
- Always have a sterile saline solution, an isotonic solution as a primary line along with the transfusion
- Act promptly if the patient develops wheezing and bronchospasm
- Stop the transfusion immediately, start the normal saline solution
- Check and document the patient's vital signs
- Call the doctor and initiate anaphylactic procedure
- If the patient develops a transfusion reaction, return the remaining blood with the blood transfusion form to the lab

TERMINATING THE TRANSFUSION

- Record the date and time of the transfusion
- Identification of the blood bag
- Type and amount of blood transfused
- Volume of normal saline transfused, status of the venous access device
- Patient's vital signs
- Signs and symptoms of a reaction (or the absence of signs and symptoms)
- How well the patient tolerated the procedure

SPECIMEN CARE

The term 'specimen handling' is meant to include identifying, collecting, labeling, preserving, storing, preparing for transport, documenting and communicating.

Specimen refers to blood, body fluids, tissue or other specimen type removed from the patient, implanted, or reinfused, including those sent for pathological or gross examination, culture and sensitivity, or other studies. Delivering a specimen to the pathology department involves many steps including:

- Correctly identifying the patient
- Correctly identifying and confirming the specimen by the surgical team
- Placing the specimen in an appropriate container and preservative
- Correctly labeling the specimen
- Completing the pathology requisition slip
- Transporting the specimen to the pathology department

Proper identification of the patient and item or tissue removed, the correct preservative, and specimen documentation are of primary importance in the care of the specimen.

IMPLEMENTATION DATE: This policy has been implemented since September 1, 2010 with minor revision 2011, 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW: The policy shall be reviewed every 3 years or as deemed necessary.

POLICY ON QUALITY ASSURANCE

POLICY NO: NSO- 022

DIVISION: NURSING SERVICE DIVISION

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Nestor O. Beato, RN QA- Committee Chair	Angeline L. Brillante, RN, MAN Assistant Chief Nurse	Arleen G. Herrera, RN, MAN OIC- Nursing Division
		Approved by:
Jefferson R. Pagsisihan, MD Hospital Administrator	Lea Grace Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

To demonstrate the efforts of the health care providers the best possible results and to ensure delivery of quality patient care. The Quality Assurance continues to identify, analyze and solve other problems.

SPECIFIC OBJECTIVES:

- Reduce errors and enhance quality
- Inspire more effective teamwork
- Increase employee motivation
- Build an attitude at problem prevention
- Increase problem-solving capability
- Improve inter-agency communication
- Develop harmonious worker-manager relationship
- Promote personal and leadership development
- Develop greater safety awareness

FUNCTIONS AND PROCEDURE OF THE NURSING QUALITY ASSURANCE:

The Quality Assurance Committee is composed of administrative, trained, organized employees within the nursing division who shared common work interest and problems.

- Conduct investigation on submitted incidental/ complaint reports
- Gather all personalities involved for inquiries with the committee and verify reports.
- Analyzes and solve related problems with guidelines from existing hospital policies.
- Recommend solutions (risk management) to the management.

- Assist the Chief Nurse in formulation, implementation, evaluation and revision of the nursing division policies and procedures.
- Periodic review of staff monitoring tools and performance appraisal.
- Collect and analyze patient's satisfaction survey.
- Continue to identify, analyze and recommend solution to the problem

COMMON QUALITY ASSURANCE ASSESSMENT INDICATORS

- Accidental injury or fall of the patient
- Error in the administration of medication and treatment
- Adverse effects of a treatment, procedure or medication
- Intravenous infiltration and related incidents
- Escape of patient
- Unethical behaviour/ conduct unbecoming of an employee or in the authority
- Malfunction or breakdown of equipment or medical devices
- Unscheduled admission or transfer to the intensive care unit
- Hospital acquired infection
- Neurological or physical defect not found upon admission
- Wrong procedure and/or procedure performed on wrong patient
- Unplanned return to the operating room during the same admission
- Any other occurrence not consistent with established clinical practices

DATE OF IMPLEMENTATION:

This policy has been implemented since 2015 .

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary

ACKNOWLEDGEMENT TO THE CONTRIBUTORS

CHIEF NURSES

Arleen G. Herrera - 2013 - present
Editha H. Carceler - 2004 - 2013
Ruth G. Lindaya - 2002 – 2004
Janet E. Pia - 1991 – 2002
Maria Veracel Cruz - 1989 – 1990
AnicetaLaceda - 1986 – 1988
ElenitaAbrecea - 1979 – 1986

ASSISTANT CHIEF NURSE

Angeline L. Brillante - Disease Surveillance

SUPERVISORS

Concepcion A. Lacson - Supplies and Equipments
Aida M. Landicho - Manpower Management
Juliet S. Condes - Continuous Quality Improvement
Nestor O. Beato - Quality Assurance
Marivic J. Rapada - Continuing Education
Annie Marie G. Marcial -
Georgina L. Rodriguez - Infection Control
Evelyn L. Palma - 2007- 2005
Felisa L. Maestro - 2004- 2014
Ruth G. Lindaya - 1994 – 2004
Priscilla T. Panganiban - 1987 – 2001
Flordeliza Nicolas - 1987 - 1993

HEAD NURSES

Melliza B. Muyot - Pediatric Ward

Arnaldo S. Cortes - Medical & Surgical Ward

Nimfa M. Vibar - Out-Patient Department/CSSU

Elizabeth B. Cantorna - OB/Gyne Ward

Frances Diane Concepcion - ICU

Lurleen R. Saberon - NICU

Charles Rae G. Lindaya - Operating Room

Jean Ann T. Gabrinao - Delivery Room

Rosalie M. Rodriguez - Delivery Room

Dennis S. Reyes - Triage

Aleli T. Ortega - Emergency Room

SPECIAL ACKNOWLEDGEMENT

MEDICAL DIRECTORS

1. Dr. Ephraim Neal C. Orteza - 2013 - Present
2. Dr. Renato M. Bernabe - 2010 – 2013
   - Hospital Director - 1978 - 1986
3. Dr. Ma. Loreleigh S. Obed - 2002 – 2010
4. Dr. Annabelle Valera - 1999 – 2002
5. Dr. Cecilio J. Salazar - 1995-1998
6. Dr. Jose Hernandez -1992 – 1995
7. Dr. Rodolfo Punzalan - 1991 – 1992
8. Dr. Arsenio Santiago - 1986 - 1991