POLICY ON OBSTETRIC AND GYNECOLOGY UNIT

POLICY NO: NSO-017

DIVISION: Nursing Service

SECTION: Obstetric and Gynecology Unit

POLICY REVIEWED DATE: July 12, 2016

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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