STANDARD OPERATING PROCEDURES

UROLOGY DEPARTMENT

PROJECT MANAGEMENT UNIT
Primary & Secondary Healthcare Department

DOCUMENT PREPARATION /APPROVAL AUTHORITIES:

Prepared By:	
Sr #	**Name**
1.	**Dr. Tariq Mahmood** MBBS, FCPS Urology Consultant Urologist Govt. Nawaz Sharif Yakki Gate Hospital Lahore
2.	**Dr. Ibtsam Ijaz** MBBS, MCPS Project Manager Technical, PMU, P&SHD Govt. of the Punjab

Reviewed By:	
Sr #	**Name**
1.	**Dr. Shafqat Ali** MBBS, DPH Senior Health Consultant Project Management Unit, P&SHD, Lahore
2.	**Dr. Sohail Khizar** Medical Superintendent DHQ Hospital Sheikhupura
3.	**Dr. Sabir Ashraf** Consultant Urologist DHQ Hospital Sheikhupura
4.	**Dr. Asad Ali Khan** Consultant Urologist DHQ Hospital Sheikhupura

Design & Formatting	
Sr #	**Name**
1.	**Mr. Imran Hameed** Project Management Unit P&SHD Govt. of the Punjab
2.	**Mr. Muhammad Saim Waris** Project Management Unit P&SHD Govt. of the Punjab

Please note that this is a first draft, and may be subject to revisions. All information and content in this Material is provided in good faith by Project Management Unit, Primary & Secondary Healthcare Department and is based on sources believed to be reliable and accurate at the time of development.

PROJECT MANAGEMENT UNIT
31-E/1, Shahra-e-Immam Hussain,
Qaddafi Stadium
Lahore

REVISION SHEET

Page #	Rev. #	Date	Reason of Change	Signature

Table of Contents

1. ABBREVIATIONS

AAC	Access, Assessment and Continuity of Care
ACLS	Advanced Cardiac Life Support
ADLS	Activities of Daily Life
APTT	Activated Partial Thromboplastin Time
ASA	American Society of Anesthesiologist
BP	Blood Pressure
BPP	Best Practice Principles
CMO	Causality Medical Officer
CN	Charge Nurse
CNIC	Computerized National Identity Card
COP	Care of Patient
CPR	Cardiopulmonary Resuscitation
CQI	Continuous Quality Improvement
DHQ	District Headquarter
DMS	Deputy Medical Superintendent
DOB	Date of Birth
DOR	Discharge on Request
DVT	Deep Venous Thrombosis
EAC	Equipment Audit Committee
ECG	Electrocardiography
EMO	Emergency Medical Officer
EMR	Electronic Medical Record
ER	Emergency Room
ETT	Endotracheal Tube
FAQs	Frequently Asked Questions
FBC	Full Blood Count
FCPS	Fellow of College of Physicians and Surgeons of Pakistan
FMS	Facility Management and Safety
GTN	Glyceryl trinitrate
HCE	Health Care Establishment
HCL	Hydrochloride
HCPs	Health Care Professionals
HIC	Hospital Infection Control
HIMS	Hospital Information Management System
HIV	Human Immunodeficiency Virus
HN	Head Nurse
HRM	Human Resource Management
ICU	Intensive Care Unit
ID	Identification
IMS	Information Management System
INR	International Normalized Ratio
IV	Intravenous
IVF	Intravenous Fluid

LAMA	Leave Against Medical Advice
LHV	Lady Health Visitor
LMA	Laryngeal Mask Airway
MBBS	Bachelor of Medicine and Bachelor of Surgery
Mg	milligram
Ml	Milliliters
mmol	milimoles
MO	Medical Officer
MOM	Management of Medication
MR	Medical Registration
MS	Medical Superintendent
MSDS	Minimum Service Delivery Standards
NPO	Nothing Per Oral
OPD	Outdoor Patient Department
OR	Operation Room
OT	Operation Theatre
OTA	Operation Theatre Assistant
P&SHD	Primary and Secondary Healthcare Department
PACU	Post Anaesthesia Care Unit
PCA	Patient Controlled Analgesia
PER	Performance Evaluation Report
PHC	Punjab Healthcare Commission
PMDC	Pakistan Medical and Dental Council
PMU	Project Management Unit
PPE	Personal Protective Equipment
PPM	Periodic Preventive Maintenance
PRE	Patient Rights and Education
PRN	As needed
PT	Prothrombin time
RN	Registered Nurse
SC	Subcutaneous
SHC&ME	Specialized Healthcare and Medical Education
SOPs	Standard Operating Procedures
THQ	Tehsil Headquarter
TIA	Transient Ischemic Attack
TURP	Trans-urethral Resection of Prostate
URS	Uretroscope
WMO	Women Medical Officer

2. PREFACE

The Government of Punjab is committed to the improvement of the Healthcare Services and has mandated the Punjab Healthcare Commission (PHC) to prepare and prescribe Minimum Service Delivery Standards (MSDS) for various categories of Healthcare Providers (HCPs), and to get the same implemented in all public and private healthcare establishments in Punjab, for grant of license without which no Healthcare Establishments (HCEs) can function. Primary and Secondary Healthcare Department (P&SHD) has been tasked with improving service delivery in the most extensive public healthcare infrastructure revamping in the province.

The goal of these Standard Operating Procedures (SOPs) is to involve more of the personnel working in District Headquarter Hospitals (DHQs) and Tehsil Headquarter Hospitals (THQs) of the P&SHD who have a special interest or expertise in Urology and have been leaders in Urology Departments at DHQs and THQs of P&SHD. The Government of Punjab has taken another revolutionary step to bifurcate the responsibilities of Health Department into P&SHD and the Specialized Healthcare and Medical Education Department (SHC&ME) for improvement of healthcare services at all levels. P&SHD is implementing multiple initiatives to improve the healthcare standards and ensuring compliance with the MSDS through a comprehensive revamping program.

MSDS for hospitals, prescribed by PHC and approved by the Government of Punjab, are the minimum set of standards that a hospital must comply with while providing healthcare services. The standards can only be complied with if the HCEs have proper infrastructure and material and human resources to provide the required care. Accordingly, the Project Management Unit (PMU) is currently reviewing and improving the facilities and human resources for the improvement of the services. Development of Urology Manual is a component of the larger effort in this regard.

The main aim of this manual is to update Urology services in all THQs and DHQs of Punjab according to the revamping program charted by the P&SHD, Government of Punjab. This manual will provide the structure to help the consultants effectively work together to enhance the quality of urology services in THQs and DHQs of Punjab in accordance with the revamping program conducted by PMU, P&SHD, and Government of Punjab. It contains all relevant SOPs regarding urological procedures exercised in DHQs and THQs of Punjab.

3. SCOPE

Urology is a surgical field involving the treatment of conditions related to the male and female urinary tract, and the male reproductive organs.

The standards of care provided in this manual will apply to all urology departments at DHQs and THQs of P&SHD across Punjab. All the Medical Superintendents (MSs) of these hospitals will receive a hard copy of the standards applicable to the Urology Department. All the staff will be cognizant of the care standards in operating departments they are expected to follow.

The aim of the manual for Urology Department is to provide quality of treatment, fostered in a culture of Continuous Quality Improvement (CQI) and Safe Practice for our patients and staff, with consultation processes incorporated into Urology Department's organizational structure.

The objective and aims of this manual are to

a) provide high quality holistic care based on Best Practice Principles (BPP)
b) utilize Urology Department's resources effectively and efficiently
c) achieve excellence in leadership and management which is consultative and supportive for all the staff
d) provide a comfortable, relaxed and safe environment conducive to patient care and recovery
e) maintain and upgrade professional competence of staff at all levels by providing in-service education and by encouraging staff participation in educational programs offered by other facilities
f) ensure all Urology Department staff are aware of their legal, moral and ethical responsibilities
g) Maintain ongoing evaluation and to monitor quality of care ensuring service excellence to the patient.

Revised SOPs may be added from time to time to keep up with international/ national standards for the conduct of safe urological surgeries to reduce morbidity and mortality.

4. LEGAL/ETHICAL CONSIDERATIONS

With the realization that urology deals with intimate details of patients, the goal of the Urology Department is to provide quality healthcare in a context which is culturally sensitive and is mindful of patients' rights and autonomy while being consistent with the principles of beneficence, non-maleficence and justice at the same time.

HCPs working in the Urology Department have a duty to offer treatment to patients, regardless of ethnicity, caste, creed, religion or sexuality. The only context in which an HCP may refuse treatment is if the patient is disruptive to hospital proceedings or verbally or physically harasses an HCP.

Consistent with the Pakistan Medical and Dental Council's (PMDC) Code of Ethics, patients will have a right to choose what to do with their medical information. They may request for copies of their medical information and will have the liberty to choose who to allow access to such information.

Female patients are entitled to be examined with a female HCP as a chaperone, assuming that an examination exclusively by a female specialist may not be possible due to staffing issues.

5. UROLOGY DEPARTMENT

4.1 Physical Settings

4.1.1 General

The physical setting of a ward is very closely correlated with the patient morbidity and mortality, lowering the likelihood of medical errors and facilitating an ethical environment for the healthcare setup. Easy access for patients is required in Urology Department, via stairs and ramps for wheelchairs and gurneys. Appropriate space leading to the ward is required for wheelchair and patient trolleys along with the porter service. Appropriate and distinctively visible signs will aid in guiding patients to the ward. The choice of the location of these signs should cater to the needs of individuals with poor vision. Area to examine the patient should be equipped with curtains so that the privacy may be ensured.

Fast and easy connections have to be established with the following:

1) Blood Bank
2) Main Pharmacy
3) Technical support services especially Biomedical Department.
4) Clinical Laboratory
5) Imaging Services

4.1.2 Urology department should consist of following functional areas:

1) Outdoor clinic
2) Indoor
3) Operation Theatre
4) Recovery Room
5) Intensive care Unit

4.2 Human Resources

4.2.1 Qualification Criteria

Job Title	**Urologist**
Qualification & Experience	1) FCPS or equivalent qualification recognized by PMDC 2) The person having MBBS and Postgraduate training in the relevant field 3) Valid registration with PMDC 4) Preference will be given to those with experience of working in A&E
BPS	18
Recruitment	Initial / Transfer
Position Type	Full Time
Jurisdiction	DHQ
Reports to	MS
Job Title	**Staff Nurse**
Qualification & Experience	1) Diploma in general nursing & Midwifery /BSN 2) Valid registration with PNC 3) Preference will be given to candidates with experience of working in Urology Department
BPS	17
Recruitment :	Initial / Transfer
Position Type :	Full Time
Jurisdiction	DHQ
Reports to	MS

4.3 Responsibility Matrix (Urologist)

4.3.1 General

1) Remains available on call after working hours.
2) Checks the punctuality of the staff attached to his/her section.
3) Checks the cleanliness and up-keep of the Department.
4) Ensures that responsible staff regularly up-keeps and maintains electro-medical equipment of the Department to ensure their functionality at all times.
5) Ensures that the responsible staff is regular in supply/replenishment of medicines and stores.
6) Ensures that the preparation and implementation of the duty roster for his/her Department is done regularly.
7) Provides technical assistance to the management for purchase of new equipment / instruments needed from time-to-time for the Department.
8) Checks that the subordinate staff performs their duties as per job description and executes all SOPs.
9) Writes objective and unbiased Performance Evaluation Reports (PERs) of subordinate staff.
10) Performs outreach duties to lower facilities as and when required.
11) Performs any other professional duty assigned by the MS.

4.3.2 Clinical

1) Overall in-charge of the Urology Department
2) Conducts Urology OPD with his team regularly on specified/notified days and time as per HCE policy
3) Reviews referrals by Medical Officers (MOs)/other specialists and from the lower facilities to establish diagnosis and proper management
4) Supervises and ensures preparation of OT list by the MO/Woman Medical Officer (WMO).
5) Plans and performs surgeries on specified days and time as per HCE policy
6) Performs emergency Urological surgeries/procedures on admitted patients as and when required
7) Writes post-operative notes and post-operative instructions of each case

8) Takes one planned round of the wards daily along with all the departmental doctors to review/follow-up on the old cases and examines in detail the newly admitted. The round is repeated with or without MO in charge of the ward, if so required, due to the condition of the patient.
9) Ensures that treatment prescribed is being administered to the patients
10) Attends the patients with Urology problems admitted in other wards as and when requested.
11) Explains the patients about the use and effects of prescribed drugs
12) Refers the patients to other specialists within the HCE and/or to higher level facilities if needed.

4.3.3 Preventive / Promotive

1) Ensures compliance of SOPs, particularly on Infection Control and Waste Management in the OPD and Urology Ward
2) Ensures that instruments and equipment being used in examinations and procedures are properly sterilized
3) Ensures that all staff participating in the procedures is physically well protected by wearing proper dress: gowns, masks, caps, gloves and shoes
4) Educates staff and patients on the prevention of common urinary tract diseases
5) Recommends physiotherapy and other rehabilitative measures to needy patients.

4.3.4 Training/Supervision

Trains medical, nursing and paramedical staff as per departmental and/or specialty requirements and protocols

4.4 Duty Rota

1) Monthly duty roster of the department will be submitted to the administration a week before the start of the month for information and approval.
2) The Urologist/Head of the Urology Department should make duty Rota, including duty in emergency, outdoor, indoor, minor OT and General OT. In the event that a doctor cannot attend the duty, the doctor will inform the immediate supervisor two days in advance so that appropriate measures may be taken to ensure that there is an HCP on duty.
3) The doctors on duty must be physically present in the ward during their duty hours.
4) The MO may leave the ward only after properly handing over the charge.

5) Doctors must communicate with each other at the time of change of duty i.e. they should handover the patient to next doctor on duty. The information should be accurate, complete, concise, current and confidential.

6. UROLOGY OUTDOOR

5.1 Purpose:

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

5.2 Responsibility:

Consultant Urologist, Duty Medical Officer, Charge Nurse/Dispenser

5.3 Procedure:

1) Outdoor will be conducted on all working days from 8 am to 2 pm where patients are seen on first come-first serve basis in morning shift except on Operation days as notified by MS.
2) Consultants and Medical Officers (MOs) with experience in urology will deliver outdoor services.
3) Consultants and MOs with experience in urology will be authorized to admit the patient in the ward after discussion with the Urologist, clearly charting out the diagnosis and treatment plan on the admission slip.
4) Contact details, diagnosis, examination findings and treatment offered to the patient will be recorded on OPD Register/HIMS.
5) Names and contact details of patients in need of elective surgery will be maintained on separate register present in OPD.
6) Patients in need of elective surgery will undergo serial laboratory investigations to document their fitness before appointment for surgery is issued.

7. ADMISSION IN UROLOGY WARD

6.1 Purpose:

1) To facilitate the process of accommodating the patient for subsequent management of health problems that threatens survival or impairment of normal body functions
2) To provide general guidelines on timely admission of patients in urology ward who need indoor care that is not possible to be rendered at home or as an outpatient.

6.2 Responsibility:

Admission officer, Consultant urologist, Duty Medical Officer, OPD Charge Nurse, Indoor Head Nurse

6.3 Procedure:

1) To admit the patient to the HCE, he/she must have:
   a. Unique Patient Identification Number.
   b. Written order from the admitting physician including diagnosis in OPD / ER card.
2) Physician or nurse directs the patient to admission office carrying respective file. The name of the patient, hospital number, age, CNIC number and diagnosis must be filled in the Admission Form; and the same will be entered in Admission Register/EMR.
3) There are no charges for admission in general wards including laboratory and radiological investigations. However, in case of admission in private rooms, Admission Officer will discuss the private room rates with patients or his/her relatives, after which the patient signs a Consent Form. One copy of CNIC must be attached with the Admission Form.
4) The Head Nurse in the concerned ward will be informed by the Admission Office staff to ensure the bed and/or room availability.
5) Except in case of an Emergency admission, no patients shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been recorded.
6) When there is a shortage of beds, patients shall be admitted to the Hospital according to the following priority list:
   a. Emergency
   b. Urgent
   c. Elective surgical procedure.
   d. Elective medical surgical investigation

7) After receiving the patient, the Head Nurse or Staff Nurse shall call the ward doctor on duty who will interview the patient for detailed history and physical examination.
8) HCPs shall abide by the Hospital Utilization Review Plan. The medical record should document the appropriateness and medical necessity for:
    a. Admission.
    b. Continued Stay
    c. Supportive Services
    d. Discharge Planning
9) When wards are full, patients will be triaged and emergency cases may be admitted to other disciplines' wards. Such patients must be checked regularly and full ward round may be conducted. Other disciplines may admit their overflow patients to urology wards but only after consultation with the Registrar on call. These patients must be returned to their respective wards as soon there is vacancy available.

8. UROLOGY INDOOR

7.1 Purpose:

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

7.2 Responsibility:

Consultant urologist, Duty Medical Officer, Indoor Head Nurse

7.3 Procedure:

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

1) History

Recording history involves the following steps:

a. Presenting Complaint

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

ii. night pain (associated with severity or malignancy)

iii. relieving and exacerbating factors (movements, positions)

b. Past Medical History

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

ii. For children, ask mothers about problems during pre-natal, natal, post-natal phases, and about development milestones

c. Systemic Review

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

d. Family History

e. Medication History

f. Allergies

g. Personal History

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

h. Social and Financial Status

i. Residence; living conditions

ii. Source of income; affording/non-affording

2) **Physical Examination:**

This includes;

a. Vitals
b. In general, physical examination; look for pallor, cyanosis, jaundice, clubbing, koilonychias, and thyroid etc.
c. Examination of the patient's inguinal region after ensuring consent and privacy of the patient
d. Perform Digital Rectal Examination when required using latex gloves and adequate lubrication
e. In systemic examination, look for co-morbidities

3) Pre-operative assessment will be done by an MO with experience in urology or by a Consultant Urologist.
4) General consent signed by the patient or on behalf of the patient who is admitted to the hospital, must be obtained at the time of admission.
5) Informed consent will be obtained from the patient and his/her relative which will be duly signed by the doctor or admitting physician who did pre-operative assessment. It shall be his responsibility to fully inform the patient and family, when indicated, of the nature, need and possible consequences or untoward effects of any procedures and to document such in the medical record.
6) Separate consent must be obtained for each of the following:
   a. Invasive procedures such as any type of surgery, biopsy, surgical incisions
   b. When anesthesia is in use
   c. Treatment of an unforeseen pathology which only becomes apparent during that surgery
   d. A diagnostic test which is invasive or which involves some risk to the patient
   e. High risk procedures
   f. Radiation or cobalt therapy
   g. Blood Transfusion
   h. Before administering high risk medication

7) Both the patient and the HCP shall sign a consent form affirming that the practitioner has informed the patient of the nature of the procedure or the surgery, and the patient understands and consents to it.
8) Medication on admission should be carefully charted using standard names and approved abbreviations with strength, dose, route of administration, frequency and duration.
9) Medicines shall be administered by authorized and trained staff permitted by law including doctors, nurses, dispensers etc.
10) Patient is identified by staff before administration of medicine; by asking the patient himself/herself; By verifying the Medical Register Number; by checking the identification band and verifying the details from drug prescription chart
11) Right drug, right dose, right route, and right time is verified from drug prescription chart before administration. Detail of medicine administered must be documented with name of drug, dose, and route, time with date and time. Nurse will affix the signature thereafter.
12) Handover at the end of the day, night, weekend, holiday period etc. is vital and must be done in person. This requires daily am and pm rounds with the nursing staff to ensure satisfactory progress of your patients. Out of hours, the on-call team must provide this level of care to the whole unit. Handover/takeover discussions must take place depending upon the condition of the patients etc.
13) Drugs and treatment regimens must be reviewed daily by pharmacist.
14) Patients on the list will be evaluated by Anesthesia Department one day before surgery.
15) Morning and evening rounds will be the responsibility of the Consultant.

Referred to Surgery bedhead ticket attached in ***Annexure-1***

7.4 Inpatient Consultation Request from Other Departments

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

consulting service attending. It will be the consulting attending physician responsibility to provide response in a timely fashion.

Referred to Medical consultation form attached in ***Annexure-2***

9. UROLOGY EMERGENCY

8.1 Purpose:

To establish a uniform system for assessment, management and disposition of urology patients from emergency.

8.2 Responsibility:

Consultant Urologist, CMO, EMO, Emergency staff Nurse

8.3 Procedure:

1) All patients will be accessed initially by Casualty Medical Officer (CMO)/ Emergency Medical Officer (EMO). This includes medical evaluation, diagnosis, recommended treatment and disposition of patient.
2) Systematic approach should be adopted in the assessment of the emergency case patients. Emergency Room (ER) personnel should consider that most dramatic injury might not always be the most serious case. Primary and secondary survey should be provided by the ER personnel to help identify and prioritize patient needs.
3) In case patient discharges from emergency, the patient must be issued specific, printed or legibly written after care/ instructions to visit urology OPD for follow-up.
4) In case patient needs specialized care, CMO/EMO on duty will contacts the consultant Urologist on telephone or through a written call. If required, He will physically attend the patient and assess the need for referral.
5) If the patient's clinical condition is serious and any delay in treatment may endanger her/his life, CMO/EMO on duty may refer the patient without consultant consent
6) Duly filled referral form will be provided to attendants/family explaining the clinical condition at referral, reasons for referral and name of hospital to whom he/she is being referred along with brief history, treatment provided in the emergency, investigations and reports.
7) CMO/ EMO on duty can decide whether or not the patient requires indoor admission in urology ward of DHQ hospital for further treatment.
8) If required, CMO/EMO on duty will contact the Consultant Urologist by telephone or through a written call. He will physically attend the patient and will assess the need for indoor admission or referral to tertiary car
9) Consultant Urologist must mention which clinical area the patient should be transferred to i.e. ward /ICU /OT.

10) After admission decision by the CMO/EMO/Consultant, the patient/attendants/family will be informed about the need and reasons for indoor admission.
11) In case of refusal for admission, a statement of refusal {Leave against Medical Advice (LAMA)} should be signed before discharging patients from emergency.
12) If patient's clinical condition is unstable, he/she must be stabilized clinically by providing initial treatment before indoor admission.
13) CMO/EMO on duty will initiate the admission process of the patient after advice from the consultant urologist and consent of patient/family.
14) CMO/EMO on duty will fill the admission request form and shall refer the patient to hospital reception for further process.
15) Complete admission orders including drug prescription will be written clearly by CMO/EMO on duty in consultation with admitting consultant urologist.
16) Nursing staff will carry out the initial lab, radiological and medication orders, and put ID band on the patient.
17) CMO/EMO will communicate with the Urology MO on duty in admitting Ward/ICU/and will inform him about the patient.
18) Nursing staff on duty in ER will communicate with the concerned nursing staff on duty in admitting Ward/ICU and will inform her about patient. ER nursing staff will hand over the complete patient documents to receiving nursing unit.
19) Paramedical/Nursing staff will accompany the patient and detailed handover of the patient will be given to the receiving staff.
20) No patient with urological injury should be shifted to the ward directly from Emergency Department without required intervention.

Referred to Emergency Treatment Card attached in ***Annexure-3***

10.OPERATION THEATER

9.1 Purpose:

The Main purpose of these guidelines is to ensure:

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

9.2 Responsibility:

Consultant Urologist, Duty Medical Officer, OT In charge, Anesthesiologist, Head Nurse

9.3 Procedure:

9.3.1 Pre-Operative Care

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

   Referred to Surgery bedhead ticket attached in ***Annexure-1***

3) Pre-Op investigations should not be ordered routinely. Pre-Op investigations should be tailored to the individual patient's needs and the surgery they are undergoing.
4) Following tests may be carried out as part of Pre-Op investigations:
   a. Plain Chest X Ray
   b. Twelve lead resting ECG
   c. Full Blood Count
   d. Coagulation Profile (PT, APTT, INR)
   e. Serum urea, creatinine, and electrolytes
   f. Random Serum glucose
   g. Urine Analysis
   h. Blood Gases
   i. Lung Function (Peak Expiratory Flow Rate, Forced vital capacity, and forced Expiratory volume)
   j. Pregnancy Test
   k. Sickle Cell Hemoglobin Test

l. Viral Markers Hepatitis B & C
m. Blood Grouping & Cross Matching

5) More investigations can be added depending upon the physical status of the patient. Clinicians need to be armed with only three or four key facts about patients in front of them;
   a. Age band
   b. Complexity of intended Surgery
   c. ASA Grade
   d. Nature of co-morbidity if ASA III
6) Elective and planned operation lists to be printed by 12 noon a day prior to the procedure (by the MO). Advise the theatre staff at the earliest of any special requirements e.g. equipment etc. Ensure timely availability of such requirements.
7) The surgical scrub nurse in the OT will be notified about any change in the list as soon as the decision has been made.
8) Emergency operations to be written up on the list outside theatre at the earliest and all relevant departments like X-ray be informed.
9) Patient should be admitted at least one night prior to the scheduled operation except for day case and emergency surgery.

9.3.1.1 Night Prior To Surgery:

The Nurse shall;

1) Collect Reports of Medical Investigations
2) Take Vital Signs
3) Inform the Anesthetist on duty, if the patient has not yet been examined from OPD or ER.
4) Inform the MO on duty of the concerned department to further assess the patient and for further orders, if necessary.
5) Explain the procedures to be done to lessen anxiety and gain cooperation of the patient.
6) Assemble all supplies and equipment needed.
7) Keep the patient on Nothing per Oral (NPO) starting from 12:00 midnight unless the time is specified by attending doctor.
8) Administer enema, unless contra-indicated.

9) Advise and supervise the patient to take a bath with antiseptic soap (Special attention to be given to areas known to harbor many pathogens like hands and feet including nails, groin, perineum and buttocks, axillae).

9.3.1.2 Morning of Surgery

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

k. Patient voided freely or catheterized accordingly
l. Bowel preparation done
m. Artificial prosthesis such as dentures, contact lenses and hearing aids removed

Referred to Surgery bedhead ticket attached in ***Annexure-1***

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

9.3.2 Operation Theatre Care

1) All Pre-Operative Preparation must be carried out.
2) Safety of the patient must be considered prior to, during and after the operation.
3) Upon arrival to OR, the following should be checked
   a. Check if patient is wearing correct ID band
   b. Consent (should be properly filled and witnessed by the Surgeon and Anesthetist)
   c. Site of Operation clearly marked
   d. Laboratory investigations (any abnormal findings should be conveyed to the Surgeon)
   e. ECG results
   f. X-ray Film
   g. Ask patient if he/she has been on NPO post- midnight or when was the last meal eaten.
   h. Examine the site of operation to check if it is properly shaved and marked. Check for presence of nail polish, jewelry and dentures. Remove if found.
4) Patient will be prioritized according to age, severity of the disease and availability of the room.
5) Priority is given first to emergency cases and children. Septic case will be done at the last.
6) Infection control policy must be followed. Aseptic techniques should be strictly observed throughout the procedure.

7) Operation Theatre Assistant (OTA) must ensure that the operating area is clean, well-lighted and has good ventilation. He will check for safe functioning of the equipment. He will make sure that supplies are adequate and easily available.

8) Pre-induction re-evaluation will be carried out by Anesthesiologist on OT Table just before induction of anesthesia. When anesthesia must be provided on an urgent basis, the pre-anesthesia assessment may be performed following one another, or simultaneously and is documented separately**.**

   Referred to Surgery bedhead ticket attached in ***Annexure-1***

9) Identity of the patient must be ensured before the administration of anesthesia.

   The patient is identified:

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

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

    Time out Protocol

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

11) Immediate before surgery, the Consultant will also confirm patient's ID from ID band and file with medical record number, proposed procedure of surgery and the site of surgery. The Patient should have at least two corroborating patient identifiers as evidence to confirm identity.

    The patient's bed number should not be used as a patient identifier at hospital. Bed numbers are not person-specific identifiers, since patients can be moved from bed to bed

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

    *Referred to surgery bedhead ticket attached in **Annexure-1***

9.3.3 Post-Operative Care

9.3.3.1 Post-Operative Notes:

9.3.3.1.1 Operative Record:

Operative note must be documented in patient's medical records immediately following surgery. This note provides information about the procedure performed, postoperative diagnosis and status of the patient before shifting and shall be documented by the MO of the department and countersigned by urology department.

1) Date and Duration of Operation
2) Anatomical Site where surgery is undertaken
3) The name of the Operating Surgeon, Assistant including Scrub Nurse
4) Name of Prosthesis used
5) Details of the sutures used

6) Swab count
7) Detail instrument count
8) Preoperative and Postoperative Diagnosis
9) Name of Procedure and anesthesia given
10) Description of the Procedure
11) Intraoperative Findings
12) Estimated blood loss
13) Any Specimen removed
14) Condition of Patient after operation
15) Immediate Post-operative Instructions

9.3.3.1.2 Anesthetic Record

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

*Referred to Surgery bedhead ticket attached in **Annexure-1***

9.3.3.2 Post Op Care in PACU

1) Post-Anesthesia monitoring of vitals must be done in PACU till the patient completely recovers from anesthesia and shall be done by an Anesthetist. The following signs should be evaluated and their levels of stability should be verified with anesthesiologist.
   a. Blood Pressure
   b. Pulse Rate
   c. Respiratory Status
   d. Oxygen Saturation
   e. Hemodynamic status

f. Level of consciousness
g. Pain
h. Monitoring surgical site (s) for excessive bleeding, swelling, discharge, hematoma, redness etc.

2) Patient will be discharged from the recovery room after fulfilling the discharged criteria (for Aldreto score, refer to Anesthesia manual). If there is any doubt as to whether patient fulfills the criteria, or if there has been a problem during the recovery period, the Anesthetist who administered the anesthetics (or another Anesthetist with special duties in the recovery room) must access the patient. After medical assessment, patients who do not fulfil the discharge criteria must fulfil the discharge criteria before they are transferred to an ICU.

Referred to Surgery bedhead ticket attached in ***Annexure-1***

9.3.3.3 Post Op Care in Ward

9.3.3.3.1 First 24 Hours

1) After the patient is transferred from post-op recovery area, the nurse taking charge over his/her care should quickly assess the patient's overall condition and carefully read and follow the post-op instructions written by Urology Surgeon/Consultant and Anesthetist.
2) As a routine, the following parameters of patients who underwent general or spinal anesthesia are frequently monitored and assessed every 15 to 30 minutes depending upon the individual patient's condition during the first 24 hours, if required, in consultation with the on-call Consultant/MO
   a. Neurological, respiratory and circulatory status
   b. Any pain and nausea (any need of medication)
   c. Body temperature
   d. The status of incision, any drainage tubes
   e. Fluid intake and urine output.
3) It shall be ensured that patients and attendants are communicated the importance of the following information in post-op period
   a. Respiratory breathing exercises to prevent post-op chest problems

b. Mobility exercises for preventing blood clotting
c. Regulation and alleviation of pain to allow breathing and movement
d. Patients should may dry mouth after surgery which can be relieved with oral sponges dipped in ice water or lemon ginger mouth swabs

9.3.3.3.2 After 24 Hours

1) Routine monitoring continues but the frequency may be decreased (every4-8 hours if the patient is stable)
2) The patient mobility should be started depending upon patient's condition and Urology Surgeon and his team's decision
3) Patient should be monitored for any evidence of potential complications, such as deep vein thrombosis (DVT), Pulmonary embolism, wound dehiscence and paralytic ileus etc.
4) Patients and attendants should receive information regarding post-op care

9.3.3.3.3 Aftercare

1) Aftercare should ensure that the patients are comfortable either in the bed or chair, and their dressings are changed regularly and in time
2) Patients should be given the opportunity to ask questions and to learn exercises to be performed once they returned home
3) X-rays: It is usually recorded in the post-operative note.
4) Blood tests: PRN, FBCs of little value in first 48 hours
5) Interdisciplinary pain management
6) Ongoing communication and consultation with referring Surgeons and Physicians to ensure effective treatment and continuity of care
7) Education about risk factors and infection prevention

Referred to Surgery bedhead ticket attached in ***Annexure-1***

9.3.3.4 Handing Over of Post-operative Patient in PACU (Post-Anesthesia Care Unit) To Ward

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

Referred to Surgery bedhead ticket attached in ***Annexure-1***

11. INTENSIVE CARE UNIT (ICU)

10.1 Purpose:

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

10.2 Responsibility:

ICU In-charge, Consultant Urologist, Duty Medical Officer

10.3 Procedure:

1) Indoor or Emergency Patients of Urology Department who need critical care will be shifted to ICU Department with mutual discussion of Urology Consultant and the In-charge of ICU.
2) A brief endorsement (Doctor to Doctor and Nurse to Nurse) should be done prior to transfer.
3) Admission of patient in ICU should be under the name of the treating consultant.
4) All emergency situations are handled by ICU doctor in coordination with ICU Consultant and treating doctor for further management.
5) There should be an ICU doctor available 24 hours a day, seven days a weekin the unit.
6) Any changes in treatment/ procedure should be discussed first by the ICU doctor to the attending consultant except in case of emergency.
7) A Urology Consultant/Surgeon will visit that patient in ICU on daily basis. If the patient is stable then he will be admitted again in the ward. If the patient's condition will be worsening, the patient will be referred to tertiary care center nearby after mutual discussion of Urology Consultant and the In-charge of ICU.

12.INTERNAL TRANSFER OF PATIENTS

11.1 Purpose:

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

11.2 Responsibility:

Consultant Urologist, Duty Medical Officer, Nursing Supervisor

11.3 Procedure:

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

   *Referred to Internal Transfer form attached in **Annexure-** 4*

8) Receiving nurse should check for complete documents, physical condition of the patient, and personal belongings (if patient is unaccompanied by relative). He/she must clarify from endorsing nurse if in doubt of anything related to the patient management.

11.4 Special Considerations:

Transfer of patient from Isolation area.

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

13.PRESSURE ULCER

12.1 Purposes:

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

12.2 Responsibility:

Charge Nurse, Admitting consultant, Infection control Officer

12.3 Indications:

Following are the risk factors for developing pressure ulcer.

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

12.4 Procedure:

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

14.DISCHARGE PLANNING

13.1 Purpose:

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

13.2 Responsibility:

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

13.3 Procedure:

1) Discharge planning shall be initiated after admission needs assessment is completed.
2) The patient and his/her family shall be included in identifying realistic goals and all efforts shall be directed towards helping the patient to achieve these goals.
3) Discharge planning shall be a multi-disciplinary and inter-disciplinary team function.
4) The process must include mechanics to foster continuity of medical aftercare.
5) Attending Physician:
   a. Suggests plans for continued care and signs medical orders.
   b. Determines the appropriate length of stay and begins discharge planning as soon as possible.
   c. Involves the appropriate caregivers (e.g. nurses, physical therapist, nutritionist, social worker, etc.) as soon as possible.
   d. Provides direction, assistance, and support in the discharge planning process and activities.
   e. Communicates information to the patient and team members which will assist the professionals involved to benefit the patient.
   f. Identifies necessary appliances and supplies for home use.
   g. Writes discharge prescriptions and completes discharge order/instructions for the day.
6) Nursing Administration must:
   a. Ensure that discharge planning is a part of everyday care given by nursing staff.
   b. Consult with the Medical/Surgical Teams or the Primary Physician to ascertain a projected plan of care and communicate with all involved disciplines.
   c. Maintain communication with patient and his/her family as appropriate.
   d. Ensure that procedures are taught and that patient is counseled for better maintenance.
   e. Ensure that documentation of Discharge Plans is written on the Nursing Transfer
   f. Plan for patient and family education in preparation for discharge.
   g. Teach/demonstrate to patient or care provider measures, procedures and health instructions needed to be continued at home after discharge.
7) Nutritionists must:
   a. Make nutritional assessment.
   b. Instruct the patient and/or family in therapeutic dietary needs ordered by the physician.

c. Assist the patient in planning for his/her diet so that cultural and religious customs can be maintained.
d. Interpret how and when the patient can substitute cultural foods in therapeutic diets.

8) Physical Therapists must:
   a. Assess the patient to determine his/her physical, mental, vocational and social independence through treatment and education.
   b. Make an initial evaluation to assess the level of care and rehabilitation potential for every patient who is referred.
   c. Provide modalities as prescribed by the Physician.
   d. Take measures to prevent deformity.
   e. Teach patients and their families the exercises and skills needed to function effectively and independently within the limitations of their disability.
9) Social Workers must
   a. Assess the patient to determine his/her psychological and social needs
   b. Involved in the process of discharge planning as well as coordinating after-care services such as at-home care, follow-up appointments or finding the patient a rehabilitation facility, if needed.

Refer to Discharge Planning Form attached in ***Annexure-6***

15.DISCHARGE FROM UROLOGY DEPARTMENT

14.1 Purpose

To provide guidelines for discharge of patients from urology department to ensure continuity of care.

14.2 Responsibility

Consultant Urologist, Specialists, Duty Medical Officer, Head Nurse

14.2.1 Procedure

1) Consultant Urologist/ Specialist will take decisions and must document discharge orders/instruction in patient medical records.
2) Patient/attendants will be informed about discharge and discharge process will be discussed with patient and family.
3) Doctor will complete the Discharge Summary Form and hand it over to the patient after signatures.
4) The discharge summary must include
   a. Reason of admission
   b. Brief progress notes
   c. Significant clinical finding
   d. Final diagnosis and co-morbidities
   e. Significant findings of investigations done
   f. List of medications used during hospital stay
   g. Treatment advised
   h. Details of procedure, if performed any
   i. Date and Time of discharge
   j. Follow up instructions
   k. Follow up appointment
5) Before discharge, instructions regarding medication/side effects/precautions and restrictions on activities/diet must be given to the patient/ attendant in writing and explained verbally.
6) Remove the IV cannula, in-dwelling catheter etc.
7) Record must be maintained in admission register of Urology ward. Photocopy of discharge slip must be retained for medical record
8) Nursing staff will facilitate the transportation of the patient.

   Referred to Surgery bedhead ticket attached in ***Annexure-1***

16.REFERRAL TO OTHER HOSPITAL

15.1 Purpose

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

15.2 Responsibility

Consultant Urologist, Specialist, Duty Medical Officer, Staff Nurse.

15.2.1 Procedure

1) Medical Officer on duty will decide that the patient requires referral to tertiary care/specialized hospital for further treatment.
2) If patient's clinical condition is unstable ,he/she must be stabilized clinically by providing initial treatment before referral
3) The indications for referral may be
   a) Need of medical care is not available in DHQ hospital
   b) Patient's preference
4) Duty Medical Officer will contact the concerned admitting consultant on telephone or through a written call. If required Consultant will physically attend the patient and assess the need for referral.
5) If the patient's clinical condition is serious and any delay in treatment may endanger her/his life, Duty Medical Officer may refer the patient without Consultant's consent
6) Duty Medical Officer/Consultant will identify the facility where patient could/should be referred.
7) Patient/attendants/family will be informed about need and reasons for referral
8) Contact the referring facility and doctor on-duty if possible and inform him regarding patient needs.
9) Medical/Nursing /paramedical staff may accompany the patient if required
10) Referring Medical Officer/Consultant must ensure the continuity of care and patient safety during the transfer of patient.
11) Duly filled referral form is provided to attendants/family explaining the clinical condition at referral, reasons for referral and name of hospital to whom he/she is being referred along with brief history , treatment provided in urology department, investigations and reports
12) Clinical documentation must be completed as per HCE policy and must be available in referring facility.
13) Record must be maintained in referral register of DHQ hospital. Photocopy of referral form must be retained for medical record
14) Ambulance used must be equipped with necessary equipment for resuscitation and ambulance staff must be trained in Basic Life Support

*Referred to Referral Register attached in **Annexure-7***

17.DISCHARGE ON REQUEST/ LEAVE AGAINST MEDICAL ADVICE

16.1 Purpose:

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

16.2 Responsibility:

Consultant Urologist, DMS, Duty Medical Officer, Nursing staff,

16.3 Procedure:

16.3.1 DOR (Abbreviation):

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

16.3.2 LAMA:

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

*Referred to DOR and LAMA Consent Form attached in **Annexure-7***

18.DEATH IN THE UROLOGY DEPARTMENT

17.1 Purpose

Notification of the death of patient to his/her family and issuance of death certificate

17.2 Responsibility

Consultant urologist, Specialist, Duty Medical Officer, Nursing staff

17.3 Procedure

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

Referred to Death Record Register & Death Certificate attached in ***Annexure-8***

19.INFORMED CONSENT

18.1 Purpose:

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

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

18.2 Responsibility:

Consultant Urologist, specialist, Duty Medical Officer, DMS In charge, Nursing Staff,

18.3 Procedure:

1) Consent must be obtained from all patients coming to urology Department prior to initiation of any treatment. The procedures for which every patient should grant Informed Consent are listed below.
   a. Invasive procedures such as surgical incision, biopsy, cystoscopy, or paracentesis.
   b. When anesthesia is in use.
   c. High risk procedures such as arteriogram.
   d. Invasive therapeutic or diagnostic procedures
   e. Resuscitation
   f. Radiation or cobalt therapy.
   g. Blood Transfusion
   h. Administering high risk medication
2) Consent shall be written in patient's mother language.
3) If the patient is not competent to give consent, the substitute consent giver should sign the consent form. The substitute consent giver may be:
   a. A decision-maker duly appointed by the patient at such a time that he/she was not incompetent (was competent). Ideally this appointment will be in writing and witnessed.
   b. The legal guardian who may either be an individual or an agency can sign the consent document.
   c. An adult relative who has had substantial personal involvement with the patient in the preceding 12 months can sign the consent forms.

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

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

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

Referred to Surgery bedhead ticket attached in ***Annexure-1***

20.DOCTOR'S ORDER

19.1 Purpose

To provide guidelines in treatment/ management of patients.

19.2 Responsibility:

Consultant, Specialist, Duty Medical Officer, Staff Nurse

19.3 Procedure:

1) Written order should:
   a. Bear the date and time
   b. Include complete description or instruction with approved abbreviation.
   c. Be clear and legible
   d. Duly signed by the attending physician
2) Doctors' order should be read and reviewed by a registered nurse.
3) Orders that are not clear or doubtful should be clarified before being carried out.
4) Every order should be carried out immediately by the assigned nurse.
5) Check/countercheck and duly signed as the order is carried out by the nursing staff on the Round Order Form

   Refer to surgery bedhead ticket attached in ***Annexure-1***

6) Nurses must carry out and processes the order as required.
   a. Tick (☑) every order to ensure that it is done and nothing is left unnoticed.
   b. Transcribe or update orders to round order sheet, treatment sheet and medication card.
   c. Nurse executing the order should affix his/her name legibly with date and time.
7) Verbal/telephone order can only be given or received during emergency situation.
8) Verbal/Telephone orders:
   a. Should be received by any registered nurse who is directly responsible for the order.
   b. Should be transcribed and duly signed by the receiving nurse in a piece of paper, indicating the date, time, complete order and name of ordering physician.
   c. Confirm that the order is taken correctly by repeating/reading again the order to the doctor at the time of receiving.
   d. Should be signed by the ordering doctor with in a period of 24 hours.

9) The essential elements of a drug order are:
   a. Date and time the order is given
   b. Drug name (Generic or Trade)
   c. Dose of Drug
   d. Route of Administration
   e. Frequency and Duration of administration
   f. Any special instructions for withholding or adjusting dosage based on effectiveness or laboratory results
   g. Physician's name with signature or name in case of verbal order.

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

Refer to Doctor Order form attached in ***Annexure-10***

21.NURSING NOTES

20.1 Purpose:

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

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

20.2 Responsibility:

Staff Nurse, Nursing Supervisor

20.3 Procedure:

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

d. Preliminary observations made
Receiving Notes in surgery bedhead ticket ***Annexure-1***

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

10) Discharge notes should contain the following:
   a. Condition of the patient
   b. Health teachings given
   c. Instructions for take home medicines and diet.
   d. Follow up visit
   e. Mode of discharge
   f. Time of discharge
   g. Accompanying person
   h. If Discharge on request(DOR), it must be documented

11) Transfer-in notes should have
   a. General summary of the present condition.
   b. Specified notes about drains, or catheters attached, or on going IVF if any.
   c. Valuables or personal belongings if any.
   d. Specific instructions if any, x-ray films, medications or reports if present.
   e. Vital signs
   f. Mode of transfer
   g. Specific area where patient came from

12) Transfer-out notes should include.
   a. Condition of the patient at the time of transfer and area/unit to be transferred.
   b. Gadgets, drains or catheters and IVF if any.
   c. X-ray films, medications or reports if present.
   d. Valuables or personal belongings if any.
   e. Follow-ups to be done
      i. Referral
      ii. Procedure
      iii. Investigations done
   f. Mode of Transfer

13) Pre-op notes should include the complete preparation
   a. Physical
      i. Operation procedure to undergo
      ii. Site (skin preparation)
      iii. Bath given to/taken by patient
      iv. Change of gown/linen
   b. Physiological
      i. Bowel and bladder preparation done

ii. Pre-op medications given
iii. N.P.O. maintained
iv. Blood investigations
v. Number of units of blood kept ready
vi. X-ray, ECG results
vii. Vital signs and blood sugar if indicated
viii. Consultation done

c. Legal
   i. Consent filled and signed
d. Mode and time of transport to operating room.

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

Referred to Nursing Notes attached in ***Annexure-11***

22.CODE BLUE PROCEDURE

21.1 PURPOSE:

To sort or classify all in coming patients and to set priorities for care by performing safe, effective and efficient triage in order to reduce number of disabilities and complications.

Code Blue- the term used over the public address system to summon assistance for patients with impending or in cardiorespiratory arrest.

21.2 Responsibility:

Duty Medical Officer, Nursing staff, Code Blue team.

21.3 Equipments/Supplies:

1) Cardiac monitor with pulse oximeter.
2) Defibrillator.
3) Ambo bag.
4) Air ways
5) Laryngoscope
6) Air way maintaining equipment.(air way, LMA, ETT,etc).
7) Oxygen flow meter with Humidifier.
8) Suction Regulator with suction bottle and suction catheter.
9) Cardiac Board
10) Emergency Crash Cart with all medical supplies and emergency drugs.
11) For documentation (Patient files, Resuscitation form, Code Blue monitoring form).

21.4 Procedures:

1) All staff must be aware of how to call for code blue.
2) All members of the Code Blue Team should be present during the Code Blue.
3) Each member of the Code Blue Team should be aware of his/her responsibilities.
4) Code Blue announcement will be made by Charge Nurse or by the doctor who discovers the patient irresponsive. Announcement includes (department, bed number, gender, and floor or area).
5) Shift Supervisor will ensure emergency medications and equipment are inventoried and restocked on a weekly basis and immediately following a Code Blue (or an emergency kit may be ready in ICU, and after announcement of Code Blue, team member from ICU will reach the location with emergency kit). Code Blue must be announced for all the Department.
6) Duty Medical Officer shall
    a. Confirm that patient is:
        i) Unresponsive
        ii) No breathing
        iii) No pulse in carotid or femoral artery
    b. Call for Code Blue and state the exact location on Code Blue speakers.
    c. Position the patient in supine, remove pillows and put cardiac board at the back of the patient.
    d. Initiate one man CPR while waiting for the Code Blue Team to arrive.
        i) Open airway (head tilt-chin lift maneuver).
        ii) Assess for breathing (look, listen and feel) for 3-5 seconds.

iii) Give breathing (2 seconds each) with the aid of an ambo bag
iv) Prevent airway obstruction that maybe caused when the tongue falls back.
v) Use proper sized face and nose mask.
vi) Support the mask with left hand and compress the bag with right hand.
vii) Check carotid pulse (5-10 seconds).
viii) Locate the area (lower half of the sternum) and start giving compression and ventilation at 15:2 ratio.
ix) Check pulse after 1 minute, if no pulse is detected, continue CPR until the help arrives.

7) Nurse assigned for Crash Cart shall do the following:
   a. As soon as the Code Blue is announced by the operator, crash cart should be brought to the location of the Code Blue.
   b. Put the cardiac board at the back of the patient.
   c. Connect ambo bag to oxygen and apply to the patient.
   d. Assist in 2 rescuer CPR with 5:1 ratio until the Code Blue Team arrives.
   e. Connect patient to cardiac monitor.
   f. CPR will be continued by the Code Blue Team as soon as they arrive.
8) Assigned Nurse
   a. Will give a brief information to the Code Blue Team regarding the diagnosis and the condition of the patient prior to code blue.
   b. Will take blood pressure and do suction as needed.
9) Code Blue Team functions as follows:
   a. Anesthesiologist / ICU Specialist
      i) Continue ventilation (ambo bag).
      ii) Intubate if needed and maintain patient airway.
      iii) Establish and maintain IV access if none.
   b. ICU Nurse
      i) Assist the anesthesiologist/ Code leader in intubation.
      ii) Administer emergency medicines as per ACLS guidelines.
      c. Cardiologist
      i) Continue with cardiac massage.
      ii) Order emergency medicines.
      iii) Monitor cardiac status of the patient.
      iv) Apply external defibrillator if indicated with specified number of joules.
   d. Nursing Supervisor
      i) Nurse Supervisor will record, or delegate RN, to record the event on the CPR Form. The CPR Form will be placed in the patient record and a copy is forwarded to Quality Assurance Department.
      ii) Obtain additional equipment and help as necessary.
      iii) Assist the Code Blue team.
      iv) Clear the room of all personnel who are not included in the Code Blue team.
   e. Assigned Nurse
      i) Assist in the transfer of patient.
      ii) Endorse patient to receiving
   f. Biomedical Engineer remains on standby for any malfunction of the machine.

g. X-Ray Technician
h. Lab Technician
i. Security Guard
j. Support Staff (Ward Boy, Ward helper)

10) To continue Code Blue depending upon the patient's response to the treatment for at least 30-45 minutes.
11) As soon as the patient is stabilized, the patient is transferred to ICU after making necessary arrangements like bed availability, ventilator per order of cardiologist/anesthesiologist accompanied by the Code Blue Team.
    a. Document the following
        i) Time when Code Blue was announced.
        ii) Time CPR was initiated.
        iii) Time of arrival of the Code Blue Team and management done.
        iv) Medications given.
        v) Observations made.
        vi) Time of transfer and condition of patient upon transfer.
12) Following the use of cart, replace all used items and notify the pharmacy to arrange for the timely restocking of medications, to be ready for next use.
13) Do not forget to attach cardiac monitor and defibrillator for recharging.
14) Portable oxygen cylinder for refilling.

Referred to CPR Form attached in ***Annexure-12***

23.CRASH CART

22.1 Purpose:

To provide necessary items needed for cardio-pulmonary resuscitation in the event of Code Blue.

Crash Cart - is a life-saving medical trolley equipped with all the necessary items and vital components of cardio-pulmonary resuscitation.

22.2 Responsibility:

Consultant, Duty Medical Officer, Nursing Supervisor, Nurse assigned for Crash Cart.

22.3 Procedure:

1) Crash Cart contents must be checked per Crash Cart list for completeness at the start of each shift daily and ensure that the following are available and are in good working condition
   a. Defibrillator - properly charged
   b. ECG monitor - loaded with ECG paper
   c. Required medicines - expiry date and quantity
   d. Supplies needed - expiry date and quantity
   e. Laryngoscope, penlight with batteries
   f. Portable O_2 Tank - filled with O_2
2) In the event of Code Blue, the nurse who checked the Crash Cart should be the one to attend.
3) All staff in the unit should be well oriented with the contents and use of Crash Cart.
4) Availability of adequate supply of emergency drugs, equipment and medical supplies is a must according to standard list.
5) Update crash cart of the required medicines. All expiring medicines should be returned to pharmacy 3 months prior to their expiry date.
6) All supplies and medicines must be used only for emergency cases.
7) All equipment should be functioning properly and medical supplies should be in proper order.
8) Defibrillator machine should always be plugged in AC Power and test load be done every shift.
9) Preventive maintenance should be carried out.
10) Checking must be done immediately after each Code Blue. Used items should be replaced.
11) Any medicines or items not available in the Crash Cart must be endorsed to the head nurse for immediate requisition and replacement.
12) Crash Cart should be cleaned and kept in usual order. Locations of medicines and lifesaving items should not be interchanged to avoid misguiding the staff and to locate easily when needed.
13) Instruments and equipment should be cleaned and disinfected after each use.
14) The Crash Cart should be kept in a place accessible for all and could be taken easily without any interference or difficulty.

Item	Suggested availability
Pocket mask with oxygen port	Immediate
Oxygen mask with reservoir	Immediate
Self-inflating bag with reservoir	Immediate
Clear face masks, sizes 3, 4, 5	Immediate
Oropharyngeal airways, sizes 2, 3, 4	Immediate
Nasopharyngeal airways, sizes 6, 7 (and lubrication)	Immediate
Portable suction (battery or manual) with Yankauer sucker and soft suction catheters	Immediate
Supraglottic airway device with syringes, lubrication and ties/tapes/scissors as appropriate	Immediate/Accessible
Oxygen cylinder (with key where necessary)	Immediate
Oxygen tubing	Immediate
Magill forceps	Immediate
Stethoscope	Immediate
Tracheal tubes, cuffed, sizes 6, 7, 8	Immediate/Accessible
Tracheal tube introducer (stylet)	Immediate/Accessible
Laryngoscope handles (x 2) and blades (size 3 and 4) Spare batteries for laryngoscope and spare bulbs (if applicable)	Immediate/Accessible
Syringes, lubrication and ties/tapes/scissors for tracheal tube	Immediate/Accessible
Waveform capnograph - with appropriate tubing and connector	Immediate/Accessible

Item	Suggested availability
Defibrillator Manual and/or automated external defibrillator Pacing function if needed.	Immediate
Adhesive defibrillator pads	Immediate
Razor	Immediate
ECG electrodes	Immediate
Intravenous cannulae (selection of sizes) and 2% chlorhexidine/alcohol wipes, tourniquets and cannula dressings	Immediate/Accessible
Adhesive tape	Immediate/Accessible
Intravenous infusion set	Immediate/Accessible
0.9% sodium chloride (1000 ml)	Immediate/Accessible
Selection of needles and syringes	Immediate/Accessible
Intra-osseous access device	Accessible
Central venous access - Seldinger kit, full barrier precautions (hat, mask, sterile gloves, gown) and skin preparation (2% chlorhexidine / alcohol)	Accessible
Ultrasound / echocardiography	Accessible

Item	Suggested availability
Clock/timer	Accessible
Gloves, aprons, eye protection	Immediate
Nasogastric tube	Accessible
Sharps container and clinical waste bag	Immediate
Large scissors	Accessible
2% chlorhexidine / alcohol wipes	Accessible
Blood sample tubes	Accessible
IV extension set	Accessible
Pressure bags for infusion	Accessible
Blood gas syringe	Accessible
Blood glucose analyser with appropriate strips	Immediate/Accessible
Drug labels	Accessible

CARDIAC ARREST DRUGS - FIRST LINE for intravenous use		
Item	**Suggested availability**	**Comments**
Adrenaline 1mg (= 10 ml 1:10,000) as a prefilled syringe x 3	Immediate	Number of syringes depends on access to further syringes. 1mg needed for each 4-5 min of CPR
Amiodarone 300mg as a prefilled syringe x 1	Accessible	First dose required after 3 defibrillation attempts

CARDIAC ARREST & PERI-ARREST DRUGS for intravenous use		
Item	**Suggested availability**	**Comments**
Adenosine 6 mg x 5	Accessible	
Atropine - 1mg x 3	Accessible	
Adrenaline 1mg (= 10 ml 1:10,000) prefilled syringe	Accessible	Further syringes should be accessible for prolonged resuscitation attempts
Amiodarone 300mg x 1	Accessible	If decision is made to give further doses of amiodarone
Calcium chloride 10 ml 10% x 1	Accessible	Calcium gluconate can be used as an alternative. Note: 10 ml 10% Calcium chloride = 6.8 mmol Ca2+ 10 ml 10% Calcium gluconate = 2.26 mmol Ca2+
Chlorphenamine 10 mg x 2	Accessible	Second-line treatment for anaphylaxis, can also be given intramuscularly
Hydrocortisone 100 mg x 2	Accessible	Second-line treatment for anaphylaxis, can also be given intramuscularly
Glucose for intravenous use	Immediate/Accessible	
20% lipid emulsion 500 ml	Accessible	For use in areas where large doses of local anaesthetic are used for regional blocks, according to Association of Anaesthetists Guidelines.
Lidocaine 100 mg x 1	Accessible	Inclusion to be determined locally
Magnesium sulphate (2 g = 8 mmol) x 1	Accessible	
Midazolam 5 mg in 5 ml x 1	Accessible	NPSA Alert
Naloxone 400 microgram x 5	Accessible	
Potassium chloride	Accessible	Formulation to be determined locally. Potassium chloride concentrate solutions. Patient safety alert. The National Patient Safety Agency. July 2002.
Sodium bicarbonate 8.4% or 1.26%	Accessible	Volume and concentration according to local policy

OTHER DRUGS		
Item	**Suggested availability**	**Comments**
Adrenaline 1mg (1 ml 1:1000)	Immediate	First-line treatment for anaphylaxis - 0.5 mg intramuscular injection in adults.
Aspirin 300 mg and other antithrombotic agents	Accessible	For acute coronary syndrome according to local policy
Furosemide 50 mg IV x 2	Accessible	
Flumazenil 0.5 mg IV x 2	Accessible	
Glucagon 1 mg IV x 1	Accessible	
GTN spray	Accessible	
Ipratropium bromide 500 microgram nebules x 2 (and nebuliser device)	Accessible	
Salbutamol 5mg nebules x 2 (and nebuliser device) and IV preparation for infusion	Accessible	
0.9% sodium chloride or Hartmann's solution 1000 ml x 2 cooled to 4°C	Accessible	For induction of therapeutic hypothermia as part of post-cardiorerspiratory arrest care

Reference:

1. *https://www.resus.org.uk/quality-standards/acute-care-equipment-and-drug-lists/*

24.PATIENT IDENTIFICATION

23.1 Purpose:

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

23.2 Responsibility:

DMS In charge, Consultant, Duty medical officer, Nursing Supervisor.

23.3 Procedure:

1) Every admitted patient should have an identification band (ID Band).

2) ID band is applied securely; neither tight nor loose.

   a. For adults, ,right wrist, unless contraindicated (as long as it is not interfering in the gadgets or treatment)

   b. Pediatric ,right wrist or right lower leg with the use of pediatric size ID band

3) ID band should bear the complete name and MR number of patient that should be clear and readable.

4) When administering patient care, identify patient by calling his/her name and compare with ID band applied.

5) Upon discharge, nursing staff will remove the ID band.

6) No discharged patient should be allowed to leave the hospital with ID band still attached to wrist or leg.

25.PREPARATION AND ADMINISTRATION OF ORAL AND PARENTERAL MEDICATION

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

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

Routes

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

24.1 Purpose:

To ensure patient and staff safety

24.2 Responsibility:

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

24.3 Equipment/ Supplies

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

24.4 Policy:

1) Preparation:
   a. Aseptic technique and proper procedure in handling and preparation of medication must be observed.
   b. Special precaution should be taken for the preparation of cytotoxic drugs.
   c. Follow standard drug calculation and measurement in preparing medications.
   d. Physician must be informed about the non-availability of the medicines and or if any substitute drug is issued.
   e. Never leave prepared medicine unattended.
   f. Any doubt about the doctor's order should be referred to HN/CN and the attending physician.
   g. The nurse must be aware of the pharmacological interactions of different drugs during preparation as follows:
      i) Drugs that are incompatible should not be given together.
      ii) Liquids or syrups should not be poured from one bottle to another.
      iii) Drugs that have changed color, odor, consistency; any expired and unlabeled bottle should never be given.
   h. Intrathecal medication will not be prepared during preparation of any other agent.
   i. Medicines should be prepared in properly lit medication preparation area.
2) Administration**:**
   a. Observe 6 rights in giving medication
      i) Right patient
      ii) Right medicine
      iii) Right dose
      iv) Right time
      v) Right route
      vi) Right documentation
   b. Observe and maintain patients' rights in giving medication
      i) The patient should be informed of drug name, purpose, action and potential undesired effects.
      ii) The patient may refuse a medication regardless of the consequences.
      iii) The patient may have qualified nurse or physician at hand to assess a drug history including allergies.
      iv) The patient has a right not to receive unnecessary medications.
      v) The patient may receive appropriate treatment in relation to drug therapy.
      vi) The patient may receive labelled medication safely without discomfort in accordance with 6 rights in drug administration.
   c. Medication should be administered by the qualified nurse who prepares it. The one giving the medicine must have a sound knowledge about the use, action, usual dose, and side-effects of drugs being administered.
   d. Before administration of medications, a registered nurse must make sure that prescription is valid, clear and legible. She can clearly read and understand the prescription and there is no confusion.
   e. If **prescription is not clear and legible** and nursing staff responsible for administration of medicine cannot understand it or have confusion regarding medicine orders, he/she should not administer the relevant medicines and should stop to avoid any errors.
   f. About medicines that cannot be administered/given for whatever reason, Head Nurse and attending physician should be notified.

g. About any error incurred during administration of medicine, Head Nurse and attending physician should be informed.
h. Verify and double check for high risk medications by independently comparing the Product contents in hand versus written orders by physicians.
i. Pre-aspirated medicine should be used immediately.
j. Never leave the patient until the medicine has been swallowed.
k. Self-administration of medication is not allowed in DHQ hospital. DHQ hospital also does not allow administration of patient's medication brought from outside the hospital.
l. Automatic cancellation of medicines, narcotics, controlled drugs and/or anticoagulants for patient who will undergo operation must be followed.

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

4) Storage
   a. Never leave a medicine cabinet or cart unlocked or unattended.
   b. Excess medicine or medicine refused by the patient should not be returned to stock cabinet or medicine cart.
   c. Any unused and/or left over medicine should be returned to the pharmacy as soon as patient is discharged.
   d. Separate storage for preparations for oral use and those for topical use is a must.
   e. Those medicines that require to be refrigerated must be kept in medicine refrigerator at required temperature of 2-8 degree centigrade.
   f. A system of stock rotation must be operated to ensure that there is no accumulation of old stocks (e.g. first in, first out).
   g. Regular stock checks should be carried out every shift daily.
   h. Medicines that will expire within 3 months should be returned to the pharmacy to be replaced by fresh stock.
   i. Multi-dose vials will be dated with date first used/the seal is broken and will expire at the earliest of the following dates:
      i) Multi-dose Injectable: 30 days
      ii) Allergy Clinic Preparations: 30 days
      iii) Multi-dose Ophthalmic Preparations for clinic use: 14 days
      iv) Nasal Preparations: 30 days
      v) Otic Drops: 30 days
      vi) Inhalation Solution: 7 days

24.5 Procedures:

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

ORAL

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

24.6 Parenteral

1) Intramuscular
   a. Place the prepared injectable medicine in the tray together with alcohol swab, band aid and small sharp container.
   b. Identify the patient carefully by:
      Asking his/her name
   c. Explain the purpose and action of each medication and the common expected side-effects.
   d. Select site for injection using anatomical land mark.
      i. Vastus Lateralis located in the anterior aspect of the thigh.
      ii. Ventrogluteal Muscles located deep and away from major blood vessels and nerves.
      iii. Dorsolateral Muscles muscles in the upper outer quadrant of the buttocks.
      iv. Deltoid Muscle located in the upper arm.
   e. After selecting appropriate site, wipe the site by using antiseptic swab.
   f. Hold syringe between thumb and forefinger in a dart like fashion.
   g. Pinch skin tightly. If irritating medicine, use Z track method.
   h. Inject needle quickly and firmly at 90 degrees angle. Then release skin.
   i. Grasp the lower end of the syringe with non-dominant hand and position dominant hand to the end of the plunger. Do not move the syringe.

j. Pull back the plunger to ascertain if needle is in a vein. If no blood appears, slowly inject the medication. If blood appears in the syringe, discard the medicine and prepare again to start a new procedure.
k. Quickly withdraw the needle while applying pressure on the antiseptic swab after the medicine is consumed.
l. Gently massage the site unless contraindicated.
m. Discard the uncapped needle and syringe in the sharp container.

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

3) Intradermal
a. Place the prepared injectable medicine in the tray together with the medication card, alcohol swab and small sharp container.
b. Identify the patient correctly by asking his/her name
c. Explain the procedure/reason why the drug is being given.
d. Provide privacy and assist patient in comfortable position
e. Select site for injection:
i. Extend elbow and support it to place forearm in flat surface.
ii. Inspect site for bruises, inflammation, lesion discoloration, edema, masses and tenderness.
iii. Forearm site should be 3-4 finger width below ante cubital space and one hand width above the wrist on inner aspect forearm.
f. Use antiseptic swab in a circular motion to clear skin at site.

g. While holding the swab with non-dominant hand, pull cap from needle.
h. With non-dominant hand, stretch the skin over site with forefinger and thumb.
i. Insert needle slowly at 5 -15 degrees angle, level-up, until resistance is felt; advance to no more than 1/8 inch below the skin. The middle tip should be seen through the skin.
j. Do not aspirate, slowly inject the medication until resistance will be felt. Note a small bleb, like a mosquito bite forming under the skin pressure.
k. Withdraw needle while applying antiseptic swab.
l. Do not massage the site.
m. Draw circle around the perimeter of injection site using black ink.
n. Dispose syringe with needle in the sharp container.
o. After 30 minutes, inform the physician to evaluate the result.

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

5) Assist patient to a comfortable position.
6) Observe closely for adverse reaction as the drug is administered and for several times thereafter.
7) Wash hands.
8) Dispose all supplies used.

24.7 Special Considerations:

1) Crush the tablet with mortar and pestle if medicine is to be given in powdered form.
2) Enteric-coated pills should not be crushed, since the purpose of coating is to delay absorption, thus preventing gastric irritation.
3) Tablets for buccal or sublingual administration should not be crushed.
4) Protect patient against aspiration by giving a tablet or capsule one at a time.

5) For intramuscular injection, solutions that are oily and viscous or those that contain suspended particles must be given through needles of larger diameter.
6) Drug that are injected subcutaneously should be non-irritating.
7) The volume of subcutaneous injection should be less than 2ml.
8) For drug known to be irritating or staining to the skin, a Z track injection method is advised. This method is used for injection of iron salts and for necrotizing or for highly irritating substances.
9) Providing truthful information when dealing with children is very important to gain cooperation.
10) Medium for IV injection must be isotonic solutions (saline of 5% Dextrose).
11) Rapid delivery of large volume of drug during IV injection can lead to embolism, pulmonary edema, elevated BP, or excessive pharmacological responses.
12) If diazepam or chlordiazepoxide HCl is given through IV push, flush with bacteriostatic water instead of saline to prevent drug precipitation due to incompatibility.
13) After heparin injection by SC route, do not rub or massage the site to avoid minute hemorrhage or bruises.
14) Streptomycin is not given during the first trimester of pregnancy to avoid staining of teeth of the fetus in later life.

26.NURSING ENDORSEMENT

25.1 Purpose:

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

25.2 Responsibility:

Duty Medical Officer, Head Nurse, Staff Nurse, Ward Boys

25.3 Procedure:

1) Face to face handover of patient must occur between nursing staff during shift changes in ward; i.e. morning, evening and night.
2) The responsible staff must provide essential information regarding the patient confidentially. It should be accurate, complete, concise, and current.
3) Endorsements should start on time attended by all incoming nurses. The time when shifts start is as follows:
    a. Morning shift - 7:00 AM - 7:30 AM,
    b. Evening shift - 1:30 PM – 2.00 PM
    c. Night shift – 7:30 PM – 8:00 PM.
4) Nursing endorsement should be given by Head Nurse.
5) All clarifications should be made during the time of endorsement.
6) Outgoing nurses should not leave the unit until all notes are completed and/or any question about patient have been answered.
7) Endorsement must be communicated in a language that is understood by all.
8) The following must be endorsed to the incoming shift:
    a. Total census
    b. Number of admissions/deaths
    c. Number of discharges
    d. Number of patients transferred to other departments
    e. Number of Referrals
9) Following must be discussed during handover between leaving and coming medical/nursing staff to ensure error-free transition.
    a. Patient's clinical details
    b. Provisional diagnosis and major problems
    c. Relevant co-morbid conditions
    d. Progress and important clinical events during the shift
    e. Any invasive procedures performed during the shift
    f. Important investigation results / pending results
    g. Current orders (especially any newly changed orders in medication, IV fluids, diet and activity level)

h. Changes in medical condition and response to medical therapy
    i. Probable plan of care for the next shift
    i) Consultant opinion
    ii) Discharge
    iii) Admission
    iv) Referral
j. Any significant interaction with family/relatives

25.4 Special Considerations:

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

27.VISITING RULES

26.1 Purpose:

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

26.2 Responsibility:

DMS in charge, Duty Medical Officer, Nursing Supervisor, Security guard

26.3 Procedure:

1) DMS in charge will have an overall responsibility of implementing visiting rules and recommending changes, if applicable.
2) Staff will:
   a. Explain rules and regulations to relatives and attendants in the Urology Department.
   b. Block unknown guest from entering the unit.
   c. Within reasonable limits, to ensure the safety and security of HCE staff, patients and the visitors
3) Security guard to be informed by the unit personnel, when needed.
4) Only one relative is allowed to be with the patient inside the unit.
5) A maximum of 2 persons are allowed to visit the patient at one time.
6) Children under 12 years of age are not allowed to visit the patient.
7) During treatment procedure, relative is allowed to be in the vicinity of the treatment room.
8) Visitors shall not
   a. smoke anywhere within hospital premises
   b. bring to the patient: medication of any type, linens, electrical devices etc.
   c. wander into any ward or floor other than the one occupied by their patient.
   d. take pictures inside the facility
9) Board with clear instructions should be displayed outside the unit by MS.
10) Security guard should make rounds along with the charge nurse after visiting hours to ensure that all visitors are out and persuade overstaying visitors to leave.
11) Flexibility to the policy on visiting rules may be applied for dying patients or patients in critical condition.

16.3.3 Visiting Days:

1) Daily

16.3.4 Visiting Hours:

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

28.EQUIPMENT

27.1 Essential Equipment

Serial No.	Name of Equipment
1	Pulse Oximeter
2	ECG Machine
3	Hand Disinfectant Dispenser System
4	X- Ray View Box
5	Mini and Micro Nephroscope Set
6	Headlight
7	Nephroscope
8	Suction Irrigation Set for Urology
9	Bipolar TURP Set
10	Flexible Cysto Nephro Fibro scope
11	Pneumatic Intracorporeal Lithotripter
12	URS Set 8 Fr
13	URS Set 6 Fr
14	Adult Cystoscope and Resectoscope
15	Ultra-Sonic Coagulation and Cutting Unit
16	Uroflow meter
17	Surgical Instruments Set

27.2 Department Preventive Maintenance Plan

1) Staff operating equipment will be trained in handling the equipment as per the manufacturer instruction manual. These manuals will be documented preventive maintenance plan for all equipment and machinery.
2) The hospital will develop a routine schedule of inspection and calibration of equipment based upon original equipment manufacturer guidelines.
3) These services can be provided through an in-house arrangement or alternatively through outsourcing.
4) The P&SHD will ensure that the record regarding purchase and maintenance of equipment and machinery is properly documented and maintained.
5) The Department will ensure that no equipment is non-functional by ensuring regular repairs, preventive maintenance, and provision of essential spares.

27.3 Equipment Inventory

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

27.4 Maintenance Schedule

1) After determining what is to be done, the frequency of the tasks required must be decided based on extent of use and the recommendation by the manufacturer's manual
2) An outline record card will be included with each schedule for recording measurement. The engineer should also note on the record card any item that needs to be replaced

27.5 Equipment Audit

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

29.SAFETY PRACTICES

28.1 Purpose:

These have been designated;

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

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

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

28.2 Responsibility:

Patients, Duty Medical Officers, Nursing staff, supporting staff

28.3 Procedure:

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

28.3.1 For Patients:

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

15) Ensure that wound drainage, IV cannula and the likes, are removed, unless indicated.
16) Every patient is accompanied by help desk officer and is assisted in wheelchair from the room to the hospital exit, if needed.

28.3.2 For Staff

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

28.4 Special Considerations:-

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

30.FALL PRECAUTIONS

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

29.1 Purpose:

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

29.2 Indications:

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

29.3 Procedure:

1) All patients at risk will be assessed for fall risk and evaluated immediately upon admission within a maximum of 3-4 hours after admission.
2) Registered Nurse will do the fall risk assessment by using the FALL RISK ASSESSMENT form attached in ***Annexure-13***
3) Following assessment by the nurse, if the patient is found to be at high risk for falls, the fall protocol will be initiated. The fall protocol consists of the following:
   a. Red placard will be placed as signage at foot part of bed.
   b. The patient will need assistance for transfers, ambulation and ADLs. The patient may not be left unattended in his/her room or bathroom while up or in a chair.
   c. The patient must be positioned in the bed with all side rails up in the position
   d. Beds will be kept in the lowest position at all times with brakes locked.
   e. Ensure that head and footboard of the bed is attached.
   f. Patients will be checked at least every 2 hours with the frequency being adjusted more frequently according to assessed patient needs.
   g. Patients at high risk will be placed in beds close to nurse's station to allow more frequent observation.

h. Patient and family will be educated regarding the fall prevention program. Education will be documented.
i. All patients will be instructed regarding their activity level.
j. Physical Therapy Department will be consulted for gait and/or strengthening exercises, if needed.
k. The status of the patients at risk for falls will be a routine part of the end of shift or transfer report.

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

31.MEDICAL RECORD KEEPING

30.1 Purpose:

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

30.2 Responsibility:

Consultants, Specialist, Duty Medical Officer, Nursing staff, Medical record review committee.

30.3 Procedure:

1) Systematic documentation of a single patient's history and care across time in urology department is mandatory and it is primary responsibility of all healthcare providers i.e. Consultants/ Specialists, doctors, nurses, etc.
2) Medical record of a particular patient is confidential and his/her right to privacy must be respected at all times
3) Medical records must be maintained for every individual who receives care in urology department.
4) Patient file containing all the medical records will remain in the custody of nursing staff during the entire stay of patient in DHQ hospital.
5) Every authorized person shall request the nursing staff on duty for patient's file to endorse his/her entry.
6) The author of entry in medical records is identified through signatures, names and designation.
7) The author of entry must make sure that every entry fulfills the following criteria
   a. Date of entry
   b. Time of entry
   c. Authenticated by his/her legible name ,signature and designation
8) After the discharge/death/referral /admission of patient, nursing staff on duty shall complete the medical record in all aspects and hand it over to Medical Record Section
9) Medical record must contain
   a. Medical Record Number along with patient bio-data, date and time of admission,
   b. Duly signed informed written consent for procedure/ anesthesia by authorized personnel
   c. A complete History and Physical Examination shall be recorded at all times and should be completed within 24 hours of admission.
   d. A Provisional or working diagnosis must be stated at the end of the completed History and Physical Examination.
   e. Plan of care
   f. All orders for investigation and treatment shall be in writing on the appropriate Physician's Order Sheet, and authenticated by the ordering physician.
   g. If the order is verbal (including by telephone). It also shall be entered on the Physician's Order Sheet, and signed by the Nurse to whom it was dictated. She should specify the name and title of the physician who dictated the order. Physician shall countersign the order as soon as possible but not later than 24 hours.

h. All progress notes must include the patient's Subjective symptoms; the Objective findings, the consultant's current Assessment, and further management Plan (i.e. SOAP).
i. If consultation is requested by a physician as outpatient/inpatient, the consulted physician shall record his or her considered opinion and recommendations on the consultation form. This report shall be authenticated.
j. Chronological details of treatment/procedure/investigations done during entire stay of patient in hospital.
k. Patient disposition, transfer to the ward, ICU or other department, with time of disposition.
l. Discharge/ LAMA/Referral/Death Certificate

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

*Referred to Surgery bedhead ticket attached in **Annexure-1***

32.STATISTICAL RECORDS

31.1 Purpose:

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

31.2 Responsibility:

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

31.3 Procedure:

1) Details of all patients admitted in Urology Department must be documented in record register which will include patient demographic data, date & time of admission, diagnosis along with disposition details.
2) There should be a separate record register for LAMA and referral cases.
3) All expired cases in urology department must be documented in death record register.
4) There should be record maintained for duty replacements of medical and paramedical staff inside the unit.
5) Daily generated waste in unit may be entered in waste record register.
6) Evidences of trainings conducted for staff must be maintained in training file.
7) There should be a separate file for equipment used in department with their inventory list, service history record, PPM record, inspection checklists.
8) Nursing supervisor and DMS Incharge will be responsible for assembling, archiving and retrieving of all these records.

Referred to Patient Record Register attached in ***Annexure-14***

33.INFECTION CONTROL

32.1 Purpose:

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

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

32.2 Responsibility:

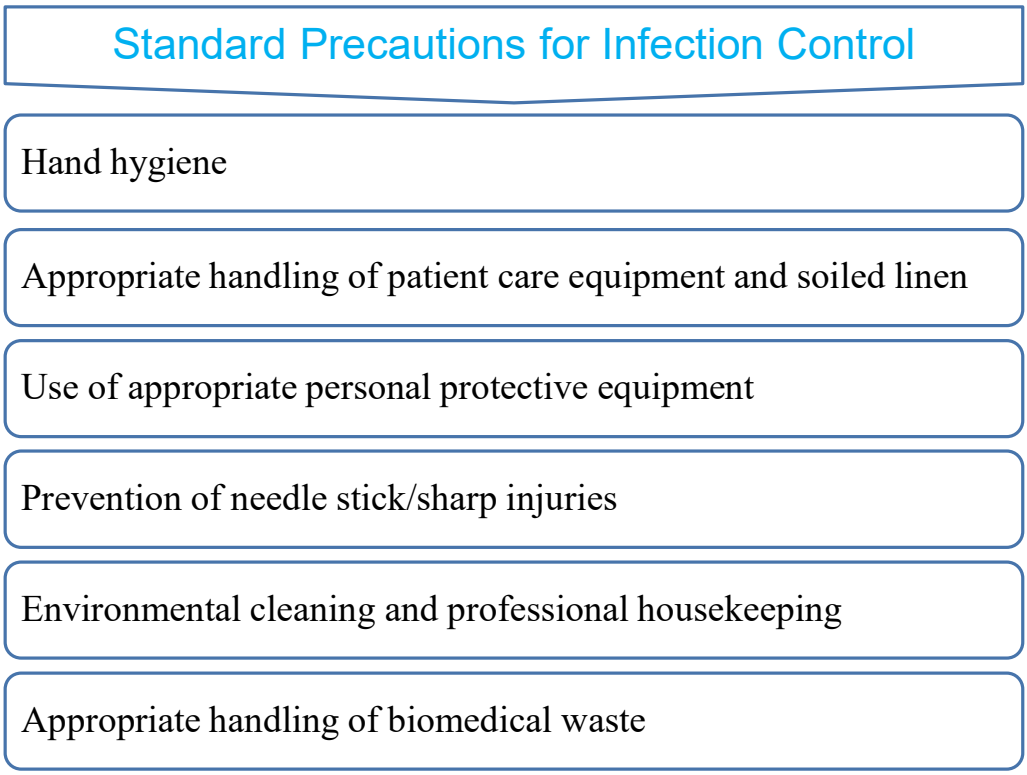
ICN, Consultant, Specialist, Duty Medical Officer Nursing supervisor, DMS Incharge.

32.3 Protocols:

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

1) Ensuring hand hygiene
2) By promoting the use of appropriate PPE while handling patient's blood, body fluids, excretions and secretions.
3) Ensuring prevention of needle stick/sharp injuries
4) By ensuring environmental cleaning and professional housekeeping
5) Through appropriate handling of biomedical waste
6) Through appropriate handling of patient care equipment and soiled linenand by ensuring all reusable equipment is cleaned and reprocessed/sterilized.
7) By reducing the number of visitors/attendants in A&E
8) Through education for visitors on the importance of hand hygiene
9) By controlling rodents, pests and other vectors.

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

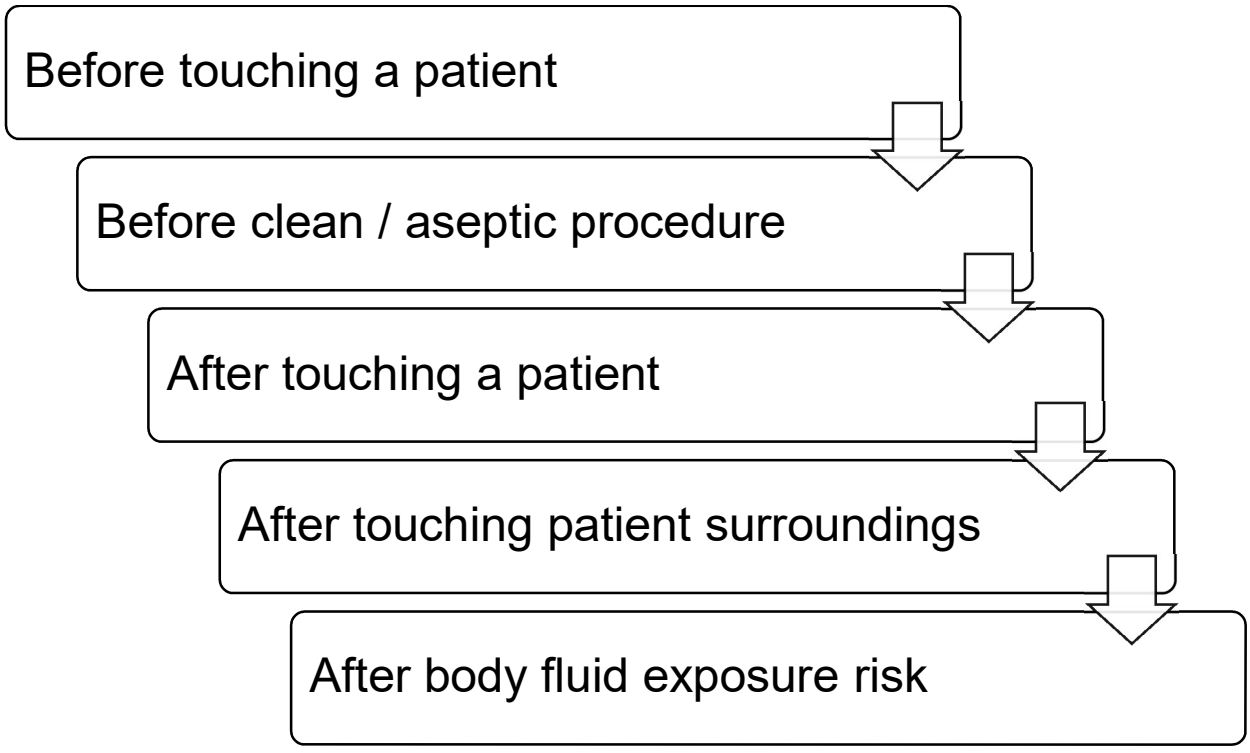


32.4 Procedure:

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

11) Clean and disinfect surface areas of beds and tables with 70% Isopropyl alcohol and bleaching solution.
12) Needles and sharps should be disposed only in a specified sharp container (puncture resistant, leak proof)
13) Place linens soaked with blood and body fluids in a separate yellow bag properly labeled. (if contaminated with Hep B, C , HIV, then in red bag properly labelled)
14) Nursing Supervisor
    a. Assists with the infection control officers in the formulation, review, and revision of infection control policies and procedures.
    b. Ensures all nursing staffs comply with the established infection control policies and procedures.
    c. Provides information, orientation, and continuing education program regarding infection control of nursing staffs in coordination with the infection control committee.
    d. Serves as a resource person for support personnel, patients, and families regarding infection control.

ESSENTIALS OF HAND HYGIENE



34.CONTINUOUS QUALITY IMPROVEMENT:

33.1 Purpose:

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

33.2 Responsibility:

MS, DMS Quality Control, Quality Assurance Officer, DMS Incharge A&E, Nursing Supervisor A&E

33.3 Procedure:

1) The CQI Committee comprises of the following individuals:
   a. MS of the HCE,
   b. Medical Consultant
   c. Surgical Consultant
   d. DMS Quality Control
   e. Quality Assurance Officer
2) All quality improvement efforts in unit are guided by following MSDS from MSDS reference manual of PHC.
   a. Access, Assessment and continuity of care AAC(lab and radiological services provided to urology patients)
   b. COP 1. Emergency services
   c. COP 2. Blood bank services provided to urology patients
   d. COP 4. and COP 5 for patients undergoing surgeries.
   e. Management of medication MOM
   f. Patient Rights and Education PRE
   g. Hospital Infection Control HIC
   h. Facility Management and Safety FMS
   i. Human Resource Management HRM
   j. Information Management System IMS
3) In addition to these, the Urology department participates in the required MSDS quality monitors for:
   a. Appropriate patient assessment with plan of care including treatment course and its documentation in medical record (Surgery bedhead ticket).
   b. Laboratory and radiology safety and quality control programs (including defined SOPs, implementation, documented training on SOPs, and training on occupational health and safety SOPs, external validation)
   c. Monitoring of invasive procedures and adverse events like wrong patient, wrong site, wrong surgery, return to operating room within 24 hours and re admission within 24 hours.
   d. Monitoring of adverse drug reactions
   e. Use of anesthesia and any adverse outcome like unplanned ventilation following anesthesia.

f. Use of blood and blood products and any adverse outcome like transfusion reactions.
g. Review of medical records to ensure availability, content and use of medical records.
h. Risk management and surveillance, defined sentinel events and after that control and prevention of such events that affect the safety of patients, family and staff.

4) These functions are overseen by key committees, including, but not limited to,
   a. Infection control Committee
   b. Blood Bank Committee
   c. Operation theatre Management Committee
   d. Medical Record Review Committee.
   e. Medication Usage and Evaluation Committee
   f. Continuous Quality Improvement Committee.
5) Once in a month CQI meeting will be held and all relevant information derived from quality improvement activities shall be shared to administration and concerned area of problem ,so that action can be taken at the right level to solve identified problems and to avoid duplication of effort.
6) Minutes of meeting will include defined agenda, issues discussed, conclusion/ recommendation, target date for action plan and the responsible person.
7) Documentation of review meeting shall be maintained in a confidential file by consultant Urologist. (*Refer to CQI Manual for further details)*

35.FAQs

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

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

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

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

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

34.3 Can resident doctors document operating reports?

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

34.4 Can staff smoke at DHQ Hospital?

DHQ Hospital's clean air policy provides a safe and healthy environment for patients, visitors and employees free of smoke. Smoking is prohibited with in the premises of the hospital.

34.5 What Is Patient confidentiality?

Confidentiality is one of the core duties of medical practice. It requires health care providers to keep a patient's personal health information private unless consent to release the information is provided by the patient.

34.6 Why is the door to the treatment area always locked?

It is important for the HCE staff to limit exit and entry into the operation theatre, to ensure the safety of patients and staff.

36.RELATED DOCUMENTS

35.1 Annexure -1 Surgery Bedhead Ticket

Government of the Punjab

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL

SURGERY BEDHEAD TICKET

Patient Name		Father / Husband Name		MR No.	
CNIC / SNIC	☐☐☐☐☐–☐☐☐☐☐☐☐–☐	Age		Gender	☐M ☐F ☐T
Mobile No		Address			
Date of Admission: ..... / ..... /		Time of Admission : ..... : ..... AM/PM		☐ MLC *(In Case of MLC, Mention MLC. No/Document No.)*	
Received Through: ☐OPD ☐ER ☐WARD		☐ Referred Case *(Mention Referral Facility)*		Medical Officer:	

رضامندی فارم منجانب مریضاں ولواحقین مع قواعد وضوابط ہسپتال

1- میں علاج کی غرض سے ہسپتال ہذا میں آیا/ آئی ہوں۔ اس سلسلے میں معائنے/ تشخیص کے لیے درکار کاروائی اور داخلے کی اجازت دیتا/دیتی ہوں اور یہ کہ اس دوران کسی بھی قسم کی پیچیدگی پیش آنے کی صورت میں ہسپتال کا عملہ یا ڈاکٹر ہرگز ذمہ دار نہیں ہوں گے۔

2- مجھے علاج کے مکمل تخمینے کے بارے میں بتادیا گیا ہے اور یہ بھی بتادیا گیا ہے کہ اگر علاج میں کوئی تبدیلی درکار ہوئی تو اخراجات میں بھی تبدیلی ہوسکتی ہے۔

3- مجھے معلوم ہے کہ تمام میڈیکل ریکارڈ کو قانون کے مطابق صیغہ راز میں رکھا جائے گا۔ تاہم میں ہسپتال انتظامیہ کو اجازت دیتا / دیتی ہوں کہ میری صحت سے متعلق معلومات مندرجہ ذیل اداروں کو فراہم کی جاسکتی ہیں۔

(الف) وہ ادارے اور انشورنس کمپنی جو میرے علاج معالجے کی ادائیگی کے ذمہ دار ہیں۔

(ب) آڈیٹر یا ایجنسیاں جن کی خدمات ادائیگی کنندگان یا میری انشورنس کمپنی نے حاصل کر رکھی ہیں۔ تاکہ علاج پر اُٹھنے والے اخراجات کی صحیح طور پر پڑتال کی جاسکے۔

(ج) ایسی تمام ایجنسیاں اور ادارے جو صحت کی سہولیات میں بہتری کی غرض سے سروے کرتے ہیں۔

4- ہسپتال کا عملہ صرف میرے/مریض کے علاج کا ذمہ دار ہے اور صرف اس پر توجہ دے گا۔ اگر میری غفلت لاپرواہی یا کوتاہی کی وجہ سے میری کوئی قیمتی چیز چوری یا گم ہوجاتی ہے تو اس صورت میں ہسپتال کے عملے کو الزام نہیں دوں گا/ گی۔

5- میں ہسپتال کے قوانین کی پابندی کروں گا/ گی اور عملے کے ساتھ تعاون کروں گا/ گی اور ہسپتال میں قیام کے دوران مندرجہ ذیل قواعد وضوابط کا پابند رہوں گا/ گی۔

- میں اپنی قیمتی اشیا بالخصوص سونا، نقدی، موبائل وغیرہ کی حفاظت خود کروں گا/ گی اور مشتبہ افراد سے ہوشیار رہوں گا/ گی۔
- میں نہ ہی کسی دوسرے سے کوئی چیز لے کر کھاؤں گا/ گی اور نہ ہی ہسپتال کی حدود میں کوئی آتش گیر مادہ، اسلحہ وغیرہ لے کر آؤں گا/ گی۔ نیز یہ کہ کوئی غیر قانونی کام نہیں کروں گا/ گی۔
- 12 سال سے کم عمر بچوں کو ہسپتال کے وارڈ میں یا مین گیٹ سے اندر نہیں لاؤں گا/ گی۔

میں نے مندرجہ بالا نکات سن/ پڑھ کر سمجھ لئے ہیں اور میں اپنے دستخط سے اس بات کی تائید کرتا/ کرتی ہوں کہ میں ہسپتال کے تمام اصول وضوابط کو ملحوظ خاطر رکھوں گا/ گی اور ان کی پابندی کروں گا/ گی۔

نام مریض/قریبی رشتہ دار:_____ ایم آر نمبر_____

قریبی رشتہ دار کی صورت میں

عمر:_____ ٹیلی فون:_____

شناختی کارڈ نمبر:_____

پتہ:_____

دستخط:_____ نشان انگوٹھا

نام ڈاکٹر_____ دستخط ڈاکٹر_____

تاریخ_____ وقت_____

نام سٹاف نرس_____ دستخط سٹاف نرس_____

تاریخ_____ وقت_____

مریض کے قریبی رشتہ دار کی عدم موجودگی کی صورت میں ڈیوٹی پر موجود ڈاکٹر مریض کی، حالت کے پیش نظر فوراً اس کا علاج شروع کریں اور مریض کے قریبی رشتہ دار کے آنے پر ان سے فارم پر دستخط کروائیں۔

دستخط ڈیوٹی میڈیکل آفیسر_____

دستخط ڈیوٹی ایڈیشنل میڈیکل سپرنٹنڈنٹ_____

MULTIDISCIPLINARY PLAN OF CARE

Date	Time	Plan of Care	Name,Signature & ID No.	Specialty Notification	Treating Doctor
..... / ..... /	..... : ..... AM/PM	Diagnosis ☐ Active ☐ Under Observation ☐ Conservative ☐ Other_____			
..... / ..... /	..... : ..... AM/PM				
..... / ..... /	..... : ..... AM/PM				
..... / ..... /	..... : ..... AM/PM				
..... / ..... /	..... : ..... AM/PM				
..... / ..... /	..... : ..... AM/PM				

SCREENING FOR NUTRITIONAL NEEDS

Malnourished	☐ Yes	☐ No	Refer to Nutritionist	☐ Yes	☐ No

RECEIVING NOTES

Receiving Date ..... / ..... /		Receiving Time ..... : ..... AM/PM		Unit	Ward No.	Bed No.
Vitals	BP	Pulse	Temp	R/R	BSL	SpO_2%
Drains				Dressing		
Nurse Name & Signature		Hospital ID		Date ..... / ..... /	Time	..... : ..... AM/PM

1

Presenting Complaint

History of Presenting Complaint

CURRENT MEDICATION

Drug Allergies ☐ No ☐ Yes *(If Yes, to What):* _____

Please enlist any medication that the patient is already taking which includes prescription medication, vitamins and supplements etc.

Serial No	Name of Drug & Strength	Dose	Route	Frequency	Duration
1					
2					
3					
4					
5					

PERSONAL HISTORY

Marital Status: ☐ Unmarried ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other.....

☐ Any Birth Problems? *(Specify)* | ☐ Any Disability *(If Yes, What & for How Long?)* _____

Where was Patient Born & Raised? | Education: ☐ No Education ☐ High school ☐ College ☐ Advanced Degree

Occupational History:

Substance Addiction | Smoking/Alcohol/Other | Using Since and Frequency

FAMILY HISTORY	IF LIVING						IF DECEASED	
	DM	HTN	IHD	Asthma	TB	Other	Age	Cause
Father								
Mother								
Siblings								
Children								

PAST MEDICAL HISTORY

☐ Diabetes Mellitus ☐ Tuberculosis ☐ HTN ☐ Hyperlipidemia ☐ Hepatitis ☐ Stroke

☐ APD ☐ IHD ☐ COPD ☐ Other

GENERAL PHYSICAL EXAMINATION

☐ Pallor ☐ Jaundice ☐ Dehydrated ☐ Cyanosis ○ Central ○ Peripheral ☐ Goiter

☐ Koilonychias ☐ Clubbing ☐ Toxic or Distressed ☐ Malar Rash ☐ Palmar Erythema

Birth Marks

☐ Nevi
☐ Hemangioma
☐ Other

Breast

☐ Right ☐ Left

Scar

Size _____
Shape _____
Location _____
☐ Hypertrophic ☐ Dehisce
☐ Atrophic ☐ Healed
☐ Stretch Marks ☐ Keloid
☐ Tenderness

Edema

☐ Edema
○ Pitting
○ Non-pitting
○ Dependant
○ Independant

JVP

☐ Normal
☐ Raised
☐ Waves
☐ Hepato Jugular Reflux

Lymph Nodes

Number _____
Site _____
Size _____
Palpable _____
Tenderness _____
Mobility _____
Consistency _____

HEENT

Eyes, Ears, Nose, Mouth and Throat

SYSTEMIC EXAMINATION

CARDIOVASCULAR SYSTEM

☐ Chest Tenderness	☐ Palpitations	☐ Dyspnoea → ○ Rest ○ Exertion		☐ Orthopnoea
Radial Pulse	Rate	Rhythm: ☐ Regular ☐ Irregular	Volume: ☐ Normal ☐ Weak ☐ Bounding	
Character	☐ Radial	☐ Radio Radial Delay	☐ Radio Femoral Delay	☐ JVP.....cm
Blood Pressure	Supine / Sitting Systolic / Diastolic	Standing: Systolic / Diastolic		☐ Postural Hypotension
Apex Beat	Location	Character ☐ Tapping ☐ Thrill		☐ Left Parasternal Heave
Venous Pulsations	☐ Neck Veins	☐ Pericardial Friction Rub		☐ Exocardial Sounds
	☐ Bruit	☐ Varicose Veins	☐ Capillary Pulsation	☐ Intermittent Claudication

Auscultation	Murmur		Others	Peripheral Pulses		
	Systolic	Diastolic		Area	Right	Left
☐ S1	☐ Mid Ejection	☐ Early	Condition of Vessel wall	Carotid	☐	☐
☐ S2	☐ Pan	☐ Mid		Femoral	☐	☐
☐ S3				Popliteal	☐	☐
☐ S4	☐ Late	☐ Late		Dorsalis Pedis	☐	☐

Others

RESPIRATORY SYSTEM

☐ Dyspnoea	☐ Tachypnoea	☐ Use of Accessory Muscles	☐ Orthopnoea	☐ Running Nose
☐ Cough (If Yes) ☐ Dry ☐ Productive	Colour → ☐ White ☐ Yellow ☐ Green		☐ Cyanosis (If Yes)	○ Central ○ Peripheral
Inspection	☐ Symmetrical	☐ Asymmetrical (If Chest is Asymmetrical)		
☐ Pigeon ☐ Flail ☐ Dum Bell	☐ Kypho-scoliosis	☐ Flat Chest ☐ Funnel	☐ Barrel	☐ Other
Transverse Diameter: ..... Inspiration ...../..... Expiration .....cm (At the level of Nipples during Inspiration / Expiration)				R/R Breaths/min
☐ Protrusion of Chest (If Yes)	☐ Unilateral	☐ Bilateral	☐ Hollowing of Chest (Where?)	
Breathing Pattern	☐ Abdomino-thoracic	☐ Thoraco-abdominal	Mediastinal Shift	☐ Central ☐ Left ☐ Right
Palpation	Tender Spot.....	Swelling.....	Trachea.....	
			Vocal Fremitus: ☐ – ☐ ↑ ☐ ↓	
Percussion	☐ Normal	☐ Dull ☐ Stony Dull	☐ Resonant	☐ Hyper Resonant
Auscultation	Breathing → ☐ Vesicular ☐ Bronchial		Additional Sounds	☐ Wheeze or Stridor ☐ Pleural Rub

Others

CENTRAL NERVOUS SYSTEM

☐ Headaches	☐ Dizziness	☐ Fainting or Loss of Consciousness	☐ Numbness or Tingling	☐ Memory Loss

Orientation	Behavior	Speech	Level of Consciousness	
Oriented ☐ Yes ☐ No If No, Disoriented to: ☐ Time ☐ Place ☐ Person ☐ Other.....	☐ Appropriate / Cooperative ☐ Anxious ☐ Agitated ☐ Violent ☐ Withdrawn/Quite ☐ Other.....	☐ Normal ☐ Slurred ☐ Aphasic ☐ Stammering ☐ With Artificial Airway ☐ Dysarthria ☐ Spastic ☐ Other.....	☐ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unconscious ☐ Drowsy ☐ Lethargy	Glasgow Coma Scale ☐ Eye Response ☐ Verbal Response ☐ Motor Response ☐ Total _____/15

Cranial Nerves		Observations to be Made	Right	Left
I Olfactory		Smell, Anosmia, Parosmia, Hallucination		
II- Optic	Visual Acuity	Far & Near		
	Visual Fields	Black & White (Grey Scale) / Colour		
	Fundus	On Fundoscopy		
III - IV - VI Oculomotor, Trochlear & Abducens		i) Movement of Eye Ball ii) Pupils, Size, Shape, Equality, Accommodation Reflex iii) Reaction to Light (Light Reflex Cr. 2,3), Consensual Reflex. iv) Strabismus, Paralytic, Concomitant Diplopia.		
V-Trigeminal		Sensory Part-Corneal & Conjunctival Reflex, Sensation in 3 Divisions. Motor part - Muscles of Mastication, Movements of Jaw, Clenching of Teeth & Jaw Jerk.		
VII-Facial		Judgment whether the lesion is in UMN or LMN Frowning, Closing of Eye, Naso-Labial Fold, Angle of Mouth, Whistling out, Blowing Cheeks, Showing of Teeth, Taste on Anterior 2/3 of Tongue, and Facial Expression		
VIII- Vestibulocochlear		Hearing, Rinne's test, Weber's test & Vertigo		
IX- Glossopharyngeal		Taste on Posterior 1/3 of Tongue, Tickling of Pharynx Reflex (Gag Reflex)		
X-Vagus nerve		Movement of Palate during Phonation (Ah-test), Nasal Twang, Hoarseness		
XI-Accessory		Power of Sternocleidomastoid, and Trapezius		
XII-Hypoglossal		Tongue position, Deviation, Movements of Tongue (Comparison and Power), Wasting, and Fasciculation of Tongue		

Gait				
	☐ Normal	☐ Sensory	☐ Neuropathic / High-stepping	☐ Hemiplegic ☐ Choreiform
	☐ Diplegic/Spastic		☐ Myopathic/Waddling	☐ Parkinsonian/Festinant ☐ Drunken

SENSORY FUNCTION	INTACT	NOT INTACT		UPPER LIMB (R)	UPPER LIMB (L)	LOWER LIMB (R)	LOWER LIMB (L)
Fine Touch	☐	☐	Bulk				
Crude Touch	☐	☐	Tone				
Temperature	☐	☐	Power				
Position	☐	☐	**Reflexes**	Right		Left	
Vibration	☐	☐	Biceps				
Pain	☐	☐	Triceps				
Motor Function			Supinator				
☐ Normal ☐ Involuntary Movement			Abdominal				
☐ Neck Stiffness			Knee				
☐ Kernig's Sign			Ankle				
☐ Brudzinski's Sign			Plantar				
☐ Straight Leg Raising			Babinski				
☐ Others.....			Clonus				

GASTRO INTESTINAL SYSTEM

Alternative Route	☐ Gastrostomy ☐ Jejunostomy	☐ Naso-Gastric	☐ Orogastric ☐ TPN	☐ Other.....................
☐ Heart Burn / Epigastric Pain	☐ Abd. Pain..........................	☐ Nausea	☐ Vomiting	
☐ Chronic Constipation	☐ Diarrhoea	☐ Dysentery	☐ Dysphagia	
Bowel Consistency	☐ Formed ☐ Semi-formed ☐ Watery	☐ Hard ☐ Mucus ☐ Blood	Bowel Frequency.........	
Inspection	☐ Normal ☐ Distended	☐ Scaphoid	☐ Sunken	
	☐ Striae ☐ Pigmentation	☐ Dilated Veins	☐ Other	
Palpation	☐ Soft ☐ Rigid	☐ Tender	☐ Rebound Tenderness	
	☐ Palpable Masses	☐ Organomegaly		
Percussion	☐ Shifting Dullness	☐ Fluid Thrill		
Auscultation	Bowel Sounds ☐ Normoactive	☐ Hyper Peristalsis	☐ Hypo Peristalsis	☐ Absent
	☐ Liver Bruit	☐ Renal Bruit		

HERNIA

Type	Location	Reducibility	Cough Impulse Test	Other
☐ Inguinal ○Direct ○Indirect	☐Bilateral ☐ Unilateral➔ ☐L ☐R	☐Reducible ☐Irreducible ☐Strangulated	☐ +ve ☐-ve	
☐ Femoral	☐Bilateral ☐ Unilateral➔ ☐L ☐R	☐Reducible ☐Irreducible ☐Strangulated	☐ +ve ☐-ve	
☐ Umbilical	☐Bilateral ☐ Unilateral➔ ☐L ☐R	☐Reducible ☐Irreducible ☐Strangulated	☐ +ve ☐-ve	
☐ Surgical	☐Bilateral ☐ Unilateral➔ ☐L ☐R	☐Reducible ☐Irreducible ☐Strangulated	☐ +ve ☐-ve	

RECTAL

☐ Fissures	☐ Hemorrhoids	☐Prolapse	☐Perianal Abscess
☐ Abnormal Masses	☐ Anal Warts	☐ Anal Tags	Others
Digital Rectal Examination Findings	☐ Performed ☐ Not Performed *(Document positive findings below)*		

UROGENITAL SYSTEM

If unable to void	☐ Continent ☐ Incontinent ☐ Bed Wetting	**Urine** ☐ Clear ☐ Colour.............	☐ Cloudy ☐ Sediment			
Voiding Aid	☐ Diapers ☐ Sanitary Pads ☐ Urosheath	☐ Supra Pubic Catheter ☐ Other............	Voiding Amount: ☐ Sufficient ☐ Not Sufficient			
Bladder	☐ Distended bladder ☐ Pain	☐ Burning Micturition	☐ Hematuria			
	☐ Anuria ☐ Dysuria	☐ Foley's Catheter Size.............Date Inserted ....dd... / ....mm.. / .....yy..	☐ Others			
☐ Genital Abnormality *(If Yes ,Mention details)*..						
Male	☐Normal	☐Hydrocele	☐Varicocele	☐Circumcised	☐Sign of Inflammation	☐Other
Female	☐Perforate Hymen	☐Clitoromegaly	☐Bartholin Cyst	☐Cystocele	☐Cystourethrocele	☐Rectocele ☐Other
	☐Vaginal Bleeding	☐Vaginal Discharge *(If Yes, Then)*	Color………....... Odour............….. Amount…......…....Consistency…….........			
Others:						

MUSCULO SKELETAL

Range of Movement	Weakness / Paralysis	Contractures	Doformities	Fractures	Ambulatory Devices
☐Passive ☐ Restricted Limb: ………………	Location	Location	Location	☐Cast ☐Splint	Type: …….. ☐With Patient ☐At Home
Back ☐Sacral Dimple	☐Kyphosis	☐Lordosis	☐Scoliosis	☐Other...	
Joints ☐Mobile	☐Swelling	☐Tender *(If Yes, then Specify)*			
Gait ☐In Toeing	☐Out Toeing	☐Bow legs	☐Knock knee	☐Limp	
Others:					

OBSTETRIC & GYNECOLOGICAL

Menstruating	☐No ☐Yes *(If Yes, then)* Age of Menarche...	Last Menstrual Period	
Menstrual Cycle	☐Regular ☐Irregular Duration of Menstrual Cycle………………..Days	Contraceptive Use	☐No ☐Yes (If Yes, then Type)
Menstrual Loss	☐Scanty ☐Moderate ☐Excessive Pads Used.........../Day	PAP Smear Findings	
☐Dysmenorrhea	○Before Onset ○0-2 Days of Menses ○After Menses		
☐Dyspareunia	○Superficial ○Deep		
G__P__A___	Last Born child……… (Month/years) No. of living children……..	☐ Complication during Pregnancy	
Has Patient Reached Menopause ?	☐No ☐Yes What Age?......................................	....	

INTEGUMENTARY SYSTEM

Skin	Skin Color	Skin Turgor	Hair / Scalp
☐ Rash ☐ Scar (S) ☐ Diaphoretic	☐ Normal ☐ Pale ☐ Flushed	☐Adequate ☐Poor ☐Dry	☐ Clean ☐ Lice ☐ Flakes
☐Petechiae ☐ Echymosed ☐ Bruises	☐ Cyanotic ☐ Jaundiced	☐Moist ☐Cool ☐Warm	☐ Wound ☐ Lesion
☐Pressure Sores ☐Nodules/Bumps	☐ Mottled ☐ Other..................	☐Other..	☐ Other..
☐ Others.............			

4

DOCTOR FIRST ORDER SHEET

Diagnosis	Differential Diagnosis (If Any)

Treatment Advised

Investigation

Dr. Name		Signature & ID		Date	...../...../.....	Time	..... : .....AM/PM

اجازت نامہ برائے بے ہوشی / جسم کا سن کرنا

مجھے / ہمیں بتایا گیا ہے کہ مجھے / میرے مریض کو بغرض علاج بے ہوش کرنے یا جسم کے کسی حصے کو سن کرنے کی ضرورت ہے۔ ڈاکٹر صاحبان نے مجھے/ہمیں بے ہوشی / جسم کو سن کرنے کی ضرورت، متبادل طریقہ علاج _____ اور پیچیدگیوں _____ کے بارے میں وضاحت سے بتا دیا ہے جس میں دانت ٹوٹنا، سانس کا رکنا، خون کی نالیوں میں خون جمنا، ہوا یا بچہ دانی کے پانی کا خود بخود پھیپھڑوں میں چلے جانا حتی کہ موت بھی شامل ہے۔ مجھے /ہمیں یہ بھی بتایا گیا ہے کہ آپریشن کے بعد سانس قدرتی طور پر بحال نہ ہونے کی صورت میں مجھے / میرے مریض کو سانس دلانے کے لیے مصنوعی مشین کی مدد بھی لی جا سکتی ہے۔ میں ان تمام خدشات کے باوجود اپنے / اپنے مریض کو بے ہوش / جسم کے حصے کو سن کرنے کی اجازت دیتا / دیتی ہوں۔ میں مطمئن ہوں کہ میرا / میرے مریض کا علاج قابل ڈاکٹر / سرجن / اینستھیٹسٹ سرانجام دیں گے۔ مجھے ڈاکٹروں کی صلاحیت، قابلیت اور خلوص پر مکمل اعتماد ہے اور میں بے ہوشی / / جسم کے سن کرنے کے دوران پیش آنے والی کسی بھی پیچیدگی کی صورت میں ہسپتال انتظامیہ، متعلقہ ڈاکٹر یا طبی عملے کے کسی فرد کو قصور وار نہیں ٹھہراوں گا / گی اور کسی قسم کی قانونی کاروائی عمل میں نہیں لاوں گا / گی۔ مجھے بتا دیا گیا ہے کہ آپریشن سے پہلے میں اپنے / اپنے مریض کو بے ہوش / جسم کے کسی حصے کو سن کرنے کے طریقے سے مطمئن نہ ہونے کی صورت میں آپریشن سے انکار کر سکتا / سکتی ہوں اور یہ حق مجھے اس فارم پر دستخط کرنے کے بعد بھی حاصل ہو گا۔ مندرجہ بالا تحریر مجھے / میرے مریض کو پڑھ کر سنا دی گئی ہے اور اجازت کے ثبوت کے طور پر میں نے دستخط اور نشان انگوٹھا ثبت کر دیے ہیں۔

اینستھیٹسٹ / ایم او اینستھیٹیز یا کا بیان: میں نے مریض کو بے ہوش کرنے سے پہلے اس کا بغور معائنہ کر لیا ہے اور بے ہوشی سے پہلے میں نے مریض کو آسان زبان میں بے ہوشی کی ضرورت کے مطابق ٹیسٹ بھی ، تجویز کر دیے ہیں۔ مریض نے مخصوص طریقہ کار اور ممکنہ پیچیدگیوں پر اطمینان کا اظہار کیا ہے / نہیں کیا ہے۔ میں نے فراہم کردہ معلومات کی ایک قابل توثیق کاپی مریض کے طبی ریکارڈ میں رکھ دی ہے۔ میں مریض کے علاج کے سلسلے میں اپنی تمام ذمہ داریاں پوری ذہانت اور محنت سے ادا کروں گا اور مریض کے علاج کے سلسلے میں میرا ہر فیصلہ / مشورہ صرف اور صرف مریض کی بہتری اور اسکی صحت کے لیے ہو گا۔

نام مریض/قریبی رشتہ دار: _____ ایم آر نمبر _____

قریبی رشتہ دار کی صورت میں

عمر: _____ ٹیلی فون: _____

شناختی کارڈ نمبر: _____

پتہ: _____

دستخط: _____ نشان انگوٹھا

نام ڈاکٹر _____ دستخط ڈاکٹر _____

تاریخ _____ وقت _____

نام سٹاف نرس _____ دستخط سٹاف نرس _____

تاریخ _____ وقت _____

مریض کے قریبی رشتہ دار کی عدم موجودگی کی صورت میں ڈیوٹی پر موجود ڈاکٹر مریض کی، حالت کے پیش نظر فوراً اس کا علاج شروع کریں اور مریض کے قریبی رشتہ دار کے آنے پر ان سے فارم پر دستخط کروائیں۔

دستخط ڈپٹی میڈیکل سپرنٹنڈنٹ _____

ڈیوٹی میڈیکل آفیسر _____

اجازت نامہ برائے آپریشن

مجھے/ میرے مریض کو بغرض علاج آپریشن کی ضرورت ہے۔ متعلقہ ڈاکٹر نے مجھے / ہمیں تجویز کردہ آپریشن _____ ، متبادل طریقہ علاج _____ اور اس کے فوائد و نقصانات، خدشات اور پیچیدگیوں _____ کے بارے میں وضاحت سے بتا دیا ہے اور یہ بھی بتا دیا ہے کہ آپریشن / علاج کے نتائج کی کوئی ضمانت نہیں۔ میں ان تمام خدشات کے باوجود اپنے/ اپنے مریض کے آپریشن کی اجازت دیتا / دیتی ہوں۔ میں اجازت دیتا / دیتی ہوں کہ آپریشن / معائنہ کے دوران لی جانے والی تصاویر اور خون یا ٹشو کے نمونے تعلیمی مقاصد کے لیے استعمال کیے جا سکتے ہیں جن کی تفصیلات صیغہ راز میں رکھی جائیں گی جسے ضرورت کے بعد احتیاط سے ضائع کر دیا جائے گا۔ میں اجازت دیتا / دیتی ہوں کہ اگر علاج کے دوران میرا خون عملے کے کسی فرد پر گر جاتا ہے تو متعدی بیماری کے ٹیسٹ کے لیے میرے خون کا نمونہ لیا جا سکتا ہے جسکی رپورٹ بھی مجھے ہسپتال کی جانب سے فراہم کی جائے گی۔ مجھے / ہمیں ڈاکٹروں کی صلاحیت، قابلیت اور خلوص پر مکمل اعتماد ہے اور آپریشن کے دوران پیش آنے والی کسی بھی پیچیدگی کی صورت میں ہسپتال انتظامیہ ، متعلقہ ڈاکٹر یا طبی عملے کے کسی فرد کو قصور وار نہیں ٹھہراوں گا / گی اور کسی قسم کی قانونی کاروائی عمل میں نہیں لاوں گا / گی۔ مجھے/ ہمیں بتا دیا گیا ہے کہ آپریشن سے پہلے میں اپنے / اپنے مریض کے علاج کے طریقے سے مطمئن نہ ہونے کی صورت میں آپریشن سے انکار کر سکتا / سکتی ہوں اور یہ حق مجھے اس فارم پر دستخط کرنے کے بعد بھی حاصل ہو گا۔ مندرجہ بالا تحریر مجھے / میرے مریض کو پڑھ کر سنا دی گئی ہے اور اجازت کے ثبوت کے طور پر دستخط اور نشان انگوٹھا ثبت کر دیے ہیں۔

سرجن کا بیان: میں نے مریض اور اس کے رشتہ داروں کو آپریشن اور اس کے متبادل طریقہ کار کے فوائد، خدشات، پیچیدگیوں اور ممکنہ خطرناک نتائج سے آگاہ کر دیا ہے۔ میں نے مریض کے آپریشن سے متعلق اس کے تمام سوالات کے موثر جوابات دے دیے ہیں اور ضرورت کے مطابق ٹیسٹ بھی تجویز کر دیے ہیں۔ مریض نے مخصوص طریقہ کار اور پیچیدگیوں پر اطمینان کا اظہار کیا ہے / نہیں کیا ہے۔ میں نے فراہم کردہ معلومات کی ایک قابل توثیق کاپی مریض کے طبی ریکارڈ میں رکھ دی ہے۔ میں مریض کے علاج کے سلسلے میں اپنی تمام ذمہ داریاں پوری ذہانت اور محنت سے ادا کروں گا اور مریض کے علاج کے سلسلے میں میرا ہر فیصلہ / مشورہ صرف اور صرف مریض کی بہتری اور اسکی صحت کے لیے ہو گا۔

نام مریض/قریبی رشتہ دار: _____ ایم آر نمبر _____

قریبی رشتہ دار کی صورت میں

عمر: _____ ٹیلی فون: _____

شناختی کارڈ نمبر: _____

پتہ: _____

دستخط: _____ نشان انگوٹھا

نام ڈاکٹر _____ دستخط ڈاکٹر _____

تاریخ _____ وقت _____

نام سٹاف نرس _____ دستخط سٹاف نرس _____

تاریخ _____ وقت _____

مریض کے قریبی رشتہ دار کی عدم موجودگی کی صورت میں ڈیوٹی پر موجود ڈاکٹر مریض کی، حالت کے پیش نظر فوراً اس کا علاج شروع کریں اور مریض کے قریبی رشتہ دار کے آنے پر ان سے فارم پر دستخط کروائیں۔

دستخط ڈپٹی میڈیکل سپرنٹنڈنٹ _____

ڈیوٹی میڈیکل آفیسر _____

زبان کی عدم فہمی کی صورت میں ترجمان کا اقرار: میں نے ڈاکٹر اور مریض کے درمیان گفتگو کا ترجمہ اپنی اہلیت کے مطابق کر دیا ہے

نام ترجمان _____

دستخط ترجمان _____ تاریخ _____

PRE-OPERATIVE ANAESTHESIA ASSESSMENT

Name:	Age:	Gender: ☐M ☐F ☐T	MR. No.	Weight:	Anesthesia Assessment Date dd/mm/yy
Department:	Unit:	Ward No.	Bed No	Emergency/Elective	Date of Surgery dd/mm/yy

Surgeon: Planned Surgery:

Medical History

Family History of Anaesthesia Complication

Diagnosis

Surgical History

Drug History

Known Allergies

Vitals BP_____ Pulse _____ Temp _____ R/R _____

Operative Site Verification ☐R ☐L ☐N/A

Systemic			(Encircla Relevant)
	☐ Dyspnea I II III IV		
	☐ Angina I II III IV		
☐ MI	☐ IHD	☐ HTN	☐ CCF
☐ Pace Maker	☐ RHD	☐ Dysrhythmia	☐ TB
☐ Asthma	☐ Recent URTI	☐ Productive Cough	☐ Orthopnea
☐ Valve Disease	☐ Gag Reflex	☐ Pneumonia	☐ COPD
☐ Cirrhosis	☐ Bowel Obst.	☐ Hepatitis	☐ Hiatal Hernia
☐ APD	☐ Thyroid	☐ Diabetes Mellitus	☐ CRF
☐ Seizures	☐ CVA/ Storke/TIAs	☐ Neuromuscular	☐ Paralysis
☐ Paresthesia	☐ Headache/↑ICP	☐ Pregnancy	☐ Anemia
☐ Immuno Suppressed	☐ Sickle Cell Disease	☐ Cancer/ Chemotherapy	☐ Recent Steroids
☐ Tobacco Use (..... Packs/Day)		☐ Other	

ASA Status	I	II	III	IV	V	E	Scoring

Significant Investigations

ECG

CXR

USG

Other

Hb	Platelet	WBC	Blood Group
Na	K	Cl	HCO_3
BSF	BSR	Hepatitis B/C	HIV
PT	APTT	INR	Bilirubin
Urea	Creatinine	SGOT	SGPT
Other			

Auscultation

S1	S2
S3	S4
Murmur	

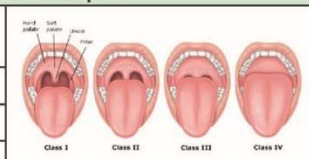
Mallampatti

Teeth

Dentures ☐Yes ☐No

Jaw Movement

Neck Movement



Theromental Distance ☐ >6.5 ☐ <6.5

Mandibular Protrusion ☐ A ☐ B ☐ C

Atlantoocscipital Ext. ☐ >90 ☐ <90

Mouth Opening (Finger) ☐ 1 ☐ 2 ☐ 3

Skeleta Review

Any Deformity: Y/N
Infection: Y/N
Previous Surgery: Y/N
Pain: Y/N
Other_____

Anticipated Risks

_____
_____
_____
_____

Anesthetic History

Previous Exposure: ☐YES ☐NO

Detail:

Complication (If Any:)

Pre-Operative Order

☐ Pass I/V Cannula ☐ Provide Hospital Dress / Theatre Gown
☐ Marked Operation Site & Side_____
☐ Shave & Prepare the Area_____
☐ N.P.O from _____ AM/PM
☐ Arrange _____ Pints of Blood.
☐ Send all Investigations to the Operation Theater
☐ Send Patient to Operation Theatre at _____ AM/PM
☐ Any Other Specific Order: _____
_____

Current Medications

Pre Anaesthesia Orders (Medication & Fluids)

Blood Required	Blood Ordered	Blood Group	X-Match	Whole Blood/ FFP / Platelet

Dr. Name & Sign	Designation	Hosp. ID	Date & Time:
			dd/mm/yy ..... : ..... AM/PM

PROPOSED ANAESTHESIA PLAN			PRE OP WARD CHECKLIST		
Type Of Anaesthesia: ☐GA ☐Regional			Identity of Patient Confirmed / ID Band Applied	☐ Yes ☐ No	
General Anaesthesia			Planned Operation Time Confirmed	☐ Yes ☐ No	
Airway Management: ☐Oral ☐LMA ☐Cannula			Operation Side / Site Mark (If Applicable)	☐ Yes ☐ No	
☐Intubation ☐Ventilator	Gases: O_2_____/L N_2O_____/L		Pre-Anaesthesia Assessment done by Anaesthetist	☐ Yes ☐ No	
O_2 Inhalation: ☐Face Mask ☐Nasal Cannula ☐Via Tracheostomy			Consent for Anesthesia, Surgery & Blood Transfusion Taken	☐ Yes ☐ No	
Inj Propofol / Ketamine_____mg	Inj. Succinyl Choline____mg		NPO Since_____hrs.	☐ Yes ☐ No	
Maintenance:			Blood Arranged_____pints	☐ Yes No	
			IV Cannula	☐ Yes ☐ No	
Regional Anaesthesia: ☐ Spinal ☐Epidural ☐ Combined Spinal Epidural			Vitals Stable	☐ Yes ☐ No	
Needle Size: Approach: Level:			All Reports Have Been Received / Sent	☐ Yes ☐ No	
Drugs Infiltrated:			Patient in Hospital Dress / Theatre Gown	☐ Yes ☐ No	
Pre-Anaesthesia Orders (Medication & Fluids):			Area for Surgery Shaved	☐ Yes ☐ No	
			Pre Op Orders Carried Out	☐ Yes ☐ No	
			Pre Op Medication Administered	☐ Yes ☐ No	
Monitoring Plan:			Bladder Care Done (If Applicable)	☐ Yes ☐ No	
			Bowel Preparation Done (If Applicable)	☐ Yes ☐ No	
Post Anaesthesia Care Plan:			The Following are Removed: ☐ Jewelries ☐ Dentures		
			☐ Prosthesis ☐Nail Polish ☐Lipstick ☐Hair Pins		
			☐ Hearing Aid☐ Glasses & Lenses ☐_____		
Anesthetist Name, Signature & Stamp	Hosp.ID	Date & Time	Nurse Name, Signature & Stamp	Hospital ID	Date & Time

ANESTHESIA PRE-INDUCTION RE-EVALUATION				PRE OPERATION CHECKLIST (SIGN IN)			
Identity of Patient Confirmed / ID Band Applied		☐Yes ☐ No		Time Received in OT _____:_____AM / PM			
Patient Conscious		☐ Yes ☐ No		Identity of Patient Confirmed		☐Yes ☐ No	
Anesthesia Assessment Review		☐ Yes ☐ No		ID Band Applied		☐Yes ☐ No	
ASA Status		☐ Yes ☐ No		Planned Operation Time Confirmed		☐Yes ☐ No	
B.P:	Pulse:			Operation Side / Site Mark (If Applicable)		☐Yes ☐ No	
R/R:	Temp:			Consent for Anesthesia, Surgery & Blood Transfusion Taken		☐Yes ☐ No	
Operative Site: ☐ Right ☐ Left		☐N/A		NPO Since hrs.		☐ Yes ☐ No	
NPO Since hrs.		☐ Yes ☐ No		Blood Arranged pints		☐ Yes ☐ No	
Any Known Allergy		☐ Yes ☐ No		IV Cannula		☐Yes ☐ No	
Drugs Reviews		☐ Yes ☐ No		Anesthesia Machine, Equipment's, Implants & Medication Ready		☐Yes ☐ No	
Difficult Air Way / Aspiration Risk		☐ Yes ☐ No		Pulse Oximeter Attached to Patient & Functioing		☐Yes ☐ No	
Does the Patient have a Risk of > 500 ml Blood Loss		☐ Yes ☐ No		Any Known Allergy		☐Yes ☐ No	
DM, HTN, Co-Morbidity Reviewed		☐ Yes ☐ No		Difficult Air Way / Aspiration Risk		☐Yes ☐ No	
Anesthesia Plan Reviewed		☐ Yes ☐ No		Does the Patient have a Risk of > 500 ml Blood Loss		☐Yes ☐ No	
Any Specialist Consultation		☐ Yes ☐ No		All Reports have Been Received		☐Yes ☐ No	
Any Change in Anesthesia Plan		☐ Yes ☐ No		Patient in Hospital Dress / Theatre Gown		☐Yes ☐ No	
If (Yes), Cause of Change in Anesthesia Plan				Area for Surgery Shaved		☐Yes ☐ No	
_____				Pre Op Orders Carried out		☐Yes ☐ No	
Modification in Anesthesia Plan				Pre Op Medication Administered		☐Yes ☐ No	
				Provisional Diagnosis			
Anesthetist Name, Signature & Stamp	Hosp.ID	Date & Time		Surgeon Name, Signature & Stamp	Hospital ID	Date & Time	

INTRA-OPERATIVE ANAESTHESIA SHEET

Name		Age	Gender	Weight	Date
MR. No.	Unit	Ward No.	Bed No.	Blood Group	Given Time
Diagnosis	Surgery	Anesthetist	Surgeon	Pre Medication	
Time	Entry.....:..... Am/Pm	Induction.....:..... Am/Pm	Incision.....:..... Am/Pm	Closure.....:..... Am/Pm	Reversal.....:..... Am/Pm

Preoperative Condition ASA I II III IV V E

☐ I.V Line Maintained

Monitors Applied

☐ $ETCO_2$ ☐ SPO_2 ☐ Pulse Oximeter ☐ ECG ☐ BP

☐ Others.....

☐ GENERAL ANAESTHESIA

Airway

☐ Oral ☐ LMA ☐ Nasal

☐ Intubation ☐ Oral ☐ Nasal ☐ Cuffed ☐ Un-Cuffed Size.....

☐ Ventilator

O_2 Inhalation ☐ Facemask ☐ Nasal Cannula ☐ Via Tracheostomy

Gases

O_2 L

N_2 O L

Sevoflurane

Iso Flurane

Reversal & Extubation:

Time Reversal Started..... : ..... AM/PM

Extubation Time: ..... : ..... AM/PM

☐ IF REGIONAL ANESTHESIA

☐ Spinal ☐ Epidural ☐ Combined Spinal Epidural (CSE)

ASM: ☐ NO ☐ Yes **Needle:** Gauge: Type:

Approach: ☐ Median ☐ Para Median

Position of Patient: ☐ Sitting ☐ Lateral

Level: ☐ L2-3 ☐ L3-4 ☐ L4-5 **No of Attempts:**

Drugs: Skin Infiltration:

Intrathecal:

Epidural:

LOR_____cm. Epidural Catheter Fixed at_____cm

Level Acheived:

POSITION OF PATIENT DURING SURGERY ☐ Supine ☐ Prone

☐ Trendelenburg ☐ Lithotomy ☐ Lateral

☐ Other

Eye Protection: ☐ Saline ☐ Goggles

☐ Ointment ☐ Pads ☐ Tape

Course of Anesthesia: ☐ Uneventful

ADVERSE ANAESTHESIA EVENTS

Any Adverse Anesthesia Event ☐ No ☐ Yes, (If Yes Then Specify)

☐ Unplanned Ventilator Support (Bag Mask Ventilation)

☐ Emesis with Suspected Aspiration ☐ Oxygen Saturation <90% for 5 minutes or more

☐ Code Blue Performed ☐ Unplanned Admission of ICU

☐ Reversal Agent Given for LOC<4 ☐ Emesis with Suspected Aspiration

☐ Bradycardia ☐ Death

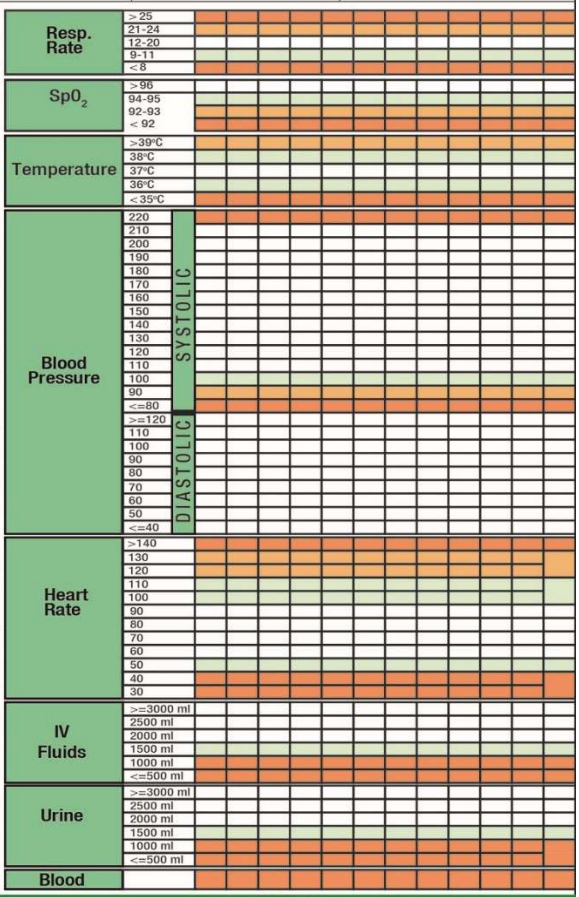
☐ Prologed Mental or Physical Impairment Resulting from the Sedation of the Procedure

☐ Hypotension Requiring Intervention (i.e. Trendelenburg. IV fluids)

☐ Other

IMMEDIATE POST ANESTHESIA STATUS IN OT

BP	Pulse	R/R
Airway	SPO2	Consciousness
Pain		Temp



Medication

Medicine	Ordered by	Given by	Time

Controlled Drugs

Drug Name	Issued	Used	Returned	Provider
Morphine				
Fentanyl				
Pethidin				
Dormicum				Witness
Thiopental				

Remarks:

Name of Anesthetist		Sign & Stamp		Date	...dd/...mm/...yy...	Time	..... : ..... AM/PM

8

OPERATING NOTES

Name	Age	Gender	MR No.	D.O.A:...dd../.mm../..yy..
Admission Via: ☐ Emergency ☐ OPD	Ward No.	Bed No.	Operation Time	D.O.O:...dd../.mm../..yy..

Surgical Safety Checklist Before Skin Incision (Time Out)		
Time Started: ..... : .....AM/PM	Time End: ..... : .....AM/PM	
☐ Confirm all Team members have Introduced Themselves by Name and Role & Team Include		
☐ Surgeon	☐ Assistant Surgeon	☐ Anesthetist
☐ Scrub Nurse	☐ Circulating Nurse	☐ Technician
☐ Confirm Patient Name, Procedure, Incision Site & Side		
☐ Antibiotic Prophylactic being given within last 60 minutes		
☐ Is Essential Imagining Displayed?		

Pre Op Diagnosis	
Procedure	
Anaesthesia Given	
Post-Op Diagnos is	
Surgery Elective / Planned	
Anesthetist	
Surgeon	
Assistant	
Nurse	

Anticipated Critical Events
To Surgeon
☐ What are Critical or Non-routine Steps
☐ How long will the Case Take
☐ What is Anticipated Blood Loss?
To Anesthetist:
☐ Are there any Patient Specific Anesthesia Related Concerns?
To Nurse
☐ Has Sterilization of Equipment Been Confirmed
☐ Are there any Equipment Related Issues/Concerns
Anatomical Site Surgery Performed:
Incision:
Procedure Details:
Wound Closure:

Findings	
Disease Nature & Extent of Disease	
Any Unexpected Pathology	
Specimen Test	
Condition of Patient after Operation	

Sign Out
Nurse Verbally Confirms with the Team
☐ The Name of the Procedure
☐ Completion of Instrument, Sponge and Needle Counts
☐ Specimen Labelling (Read Specimen Labels Aloud, Including Patient Name)
☐ Whether there are any Equipment Problems to be Addressed
Intra OP Estimated Blood Loss:
Intra OP IV Fluid / Blood transfusion:
Intra OP Urine Ouput:
Surgeon, Anaesthethist and Nurse
☐ What are key Concerns for Recovery and Mangement of this Patient?

Sutures		Drains		Prothesis	
				Type	Serial No.

Name, Signature, Stamp & ID of Surgeon	Date & Time	Name, Signature, Stamp & ID of Scrub Nurse	Date & Time

POST OP INSTRUCTION

Transfer Patient to ☐ ICU ☐ Bed/Room ☐ Ward

FIRST 24 HOURS	☐ Monitor Neurological, Respiratory and Circulatory Status	
	☐ Monitor Fluid Intake / Urine Output	
	☐ Monitor and Control Pain, Nausea	
	☐ Monitor Body Temperature	
	☐ Monitor Status of Incision/ Drainage Tubes	
	☐ Ensure Respiratory Exercises	
	☐ Ensure Movement/ Sequence Compression Devices	
	☐ Oral Sponges for Dry Mouth	
	☐ NPO After Operation Should be	
AFTER 24 HOURS	☐ Routine Monitoring Frequency	
	☐ Limited Oral Intake	
	☐ Ensure Respiratory Exercise	
	☐ Monitor Complications like DVT, Paralytic Ileus, Pulomonary Embolism, Wound Dehiscence	
AFTER CARE	☐ Re-Dressing Change Frequency	
	☐	

Doctor Name | Sign & ID | Date .....dd...../.....mm...../.....yy.. | Time ..... : ..... AM/PM

POST ANESTHESIA CARE UNIT

Name of Patient: | Age: | Gender: ☐M ☐F ☐T | MR No:

Post-Operative Anesthesia Cover Required for: _____ Hours.

Time of Arrival in Recovery: ..... : .....AM / PM | Time of Discharge from Recovery: ..... : .....AM / PM

☐ Oxygen Inhalation: | ☐ Check Vitals every:

Investigation: ☐ Hb + HCT _____ ☐ Serum Electrolytes _____ ☐ ABGs _____ ☐ ECG Monitor _____

☐ Other _____

Anesthetist Notes (Post Op Advice)

☐ Prop up	☐ NPO _____	☐ O_2 Inhalation _____	Handing Over Statement			
			BP	Pulse	Temp	R/R	SPO2
			Date:.....dd...../.....mm...../.....yy.....		Time:..... : ..... AM/PM		
Patient Condition on Shifting	☐ Fully Awake		☐ Drowsy		☐ Easily Arousable		

Medication and Fluid Administration Record

Drug	Dose	Route	Frequency	Advised by	Time Given	Administered by

Vital Records

Date	Time	GCS	Temp	Pulse/Min	B.P	R/R	SPO_2	Pain Score	Intake		Output			Name Sign & ID
									IV	Oral	Urine	Drain	Gastric Secretions	

Shifting Notes

Patient to be shifted when Aldreto's Score is More than 8

Circulation	☐ Blood Pressure 50% of Pre-Anesthesia Level	☐ Blood Pressure+20-50% of Pre-Anesthesia Level	☐ Blood Pressure 20% of Pre-Anesthesia Level	Total
Respiratory	☐ Apnea	☐ Dysponea, Shallow or Limited Breating	☐ Able to Breath and Cough Freely	
Color	☐ Cyanotic	☐ Pale, Dusky, Blotchy, Jaundice, Other	☐ Pink	
Activity	☐ Able to Move Zero Extremities on Command	☐ Able to Move Two Extremities on Command	☐ Able to Move for Extremities on Command	
Consciousness	☐ Not Responding	☐ Arousable on Calling	☐ Fully Awake	

Anesthetist Name Sign, ID & Stamp	Date: ...../...../.....	Time: ..... : ..... AM/PM
Recovery Room Nurse Name Sign, ID & Stamp	Date: ...dd.../...mm.../...yy...	Time: ..... : ..... AM/PM

PATIENT RECEIVING FROM OPERATION THEATER IN ICU / WARD / ROOM

BP	Pulse	R/R	Temp.	GCS	CVP	Pain

Receiving Protocal			Status of Drains	
Document Received	☐ Yes	☐ No	NG	
IV Line Intact	☐ Yes	☐ No	Foleys	
Biopsy Specimen	☐ Sent	☐ Not Sent	T.Tube	
Blood Transfusion	☐ Advised	☐ Not Advised	Drain 1	
Operation Notes & Post Op Orders Check	☐ Yes	☐ No	Drain 2	
Fluid Balance:			Chest Tube	
Ward Nurse Name		Sign & ID	Reveiving Date	...../...../..... Time .....:..... AM/PM

DIAGNOSTIC INVESTIGATION

Lab Test (Mention Date)	Values	Lab Test (Mention Date)	Values	Lab Test (Mention Date)	Values

Test	Order Date	Expected Date	Reports Date	Dr. Signature
USG				
Report				
CXR / Abd.X-Ray				
Report				
Echo / ECG				
Report				
Misc.				
Report				

اجازت نامہ برائے انتقال خون/اجزائے خون

میں بحیثیت مریض/مریض کا قریبی رشتہ دار تصدیق کرتا/کرتی ہوں کہ مجھے/میرے مریض کو درکار خون/خون کے اجزاء کے انتقال کے بارے میں آگاہ کردیا گیا ہے۔ متعلقہ ڈاکٹر نے مجھے انتقال خون کے فوائد ونقصانات کے بارے میں آگاہ کردیا ہے اور اس بارے میں میرے خدشات دور کردیے ہیں۔ مجھے یہ بھی بتا دیا گیا ہے کہ اس طریقہ علاج کے علاوہ اس کا کوئی اور متبادل علاج نہیں ہے۔ مجھے اس بات کا ادراک ہے کہ خون یا اجزائے خون کے تمام ٹیسٹ ہونے کے باوجود خون کے ری ایکشن، ہیپاٹائٹس، ایڈز اور آتشک جیسی بیماریوں کے منتقل ہونے کا خطرہ باقی رہتا ہے۔ میں نے مندرجہ بالا بیان مکمل طور پر سمجھ لیا ہے اور میں انتقال خون کی اجازت دیتا/دیتی ہوں۔

نام مریض/قریبی رشتہ دار _____ ایم آر نمبر _____

قریبی رشتہ دار کی صورت میں

عمر _____ ٹیلی فون نمبر _____

شناختی کارڈ نمبر _____

پتہ _____

دستخط _____ نشان انگوٹھا

نام ڈاکٹر _____ دستخط ڈاکٹر _____

تاریخ _____ وقت _____

NEWS CHART

Patient Name:	MR No.	Age:	Gender: ☐M ☐F ☐T
Diagnosis:	Ward No.	Bed No.	Unit:

NEWS KEY 0 1 2 3 | Date of Birth: dd/mm/yy | Date of Admission: dd/mm/yy | Time of Admission: : AM/PM

DATE			
TIME			
RESP. RATE	>25		3
	21-24		2
	12-20		
	9-11		1
	<8		3
SpO_2	>96		
	94-95		1
	92-93		2
	< 92		3
INSPIRED O2%	☐Y		2
TEMPERATURE	>39°C		2
	38°C		1
	37°C		
	36°C		1
	<35°C		3
BLOOD PRESSURE (SYSTOLIC)	220		3
	210		
	200		
	190		
	180		
	170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		1
	90		2
	<=80		3
BLOOD PRESSURE (DIASTOLIC)	>=120		
	110		
	100		
	90		
	80		
	70		
	60		
	50		
	<=40		
HEART RATE	>140		3
	130		2
	120		
	110		1
	100		
	90		
	80		
	70		
	60		
	50		1
	40		3
	30		
LEVEL OF CONSCIOUSNESS	Alert		
	V / P/U		3
BLOOD GLUCOSE			
TOTAL NEWS SCORE			
Abnormal Parameter	Pain Score	0-No Pain / 1-Mild Pain / 2-Moderate Pain / 3-Severe Pain / 4-Very Severe Pain	
	Urine Output		
	Monitoring Frequency		

ESCALATION PLAN

New / Scale	Monitoring Frequency	Clinical Response
0	Minimum 12 Hourly	Routine Monitoring
Total 1-4	4-6 Hourly	Routine Monitoring
Total 5 or More or 3 in One Parameter	1 Hourly	Doctor must Reassess the Patient and based on Assessment Shift to Intensive Care
Total 7 or More	Monitor Attached (Continuously)	1- Shift to Intensive Care 2- Consultant must Reassess the Patient

MEDICATION	Name:			Age:	Weight	MR No.
	Unit:	Ward No.	Bed No.	Date of Admission: ....dd.... / ....mm.... / ....yy....	Time of Admission: .... : .... AM/PM	
	Allergies			Previous Medication:		

Sr. No.	Drug Name & Strength:										(____ mm ____ yy)					
	Dose	Route	Date		Date		Date		Date		Date		Date		Date	
			Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial
	Frequency	Duration														
	Instruction															
	Drug Name & Strength:										(____ mm ____ yy)					
	Dose	Route	Date		Date		Date		Date		Date		Date		Date	
			Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial
	Frequency	Duration														
	Instruction															
	Drug Name & Strength:										(____ mm ____ yy)					
	Dose	Route	Date		Date		Date		Date		Date		Date		Date	
			Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial
	Frequency	Duration														
	Instruction															
	Drug Name & Strength:										(____ mm ____ yy)					
	Dose	Route	Date		Date		Date		Date		Date		Date		Date	
			Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial
	Frequency	Duration														
	Instruction															
	Drug Name & Strength:										(____ mm ____ yy)					
	Dose	Route	Date		Date		Date		Date		Date		Date		Date	
			Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial	Time	Name & Initial
	Frequency	Duration														
	Instruction															

13

ONLY ONCE MEDICATION							MEDICATION TO BE GIVEN AT BED TIME						
Drug & Strength	Dose	Route	D/T Given	Instruction	Dr.Name & Sign	Nurse Name & Sign	Drug & Strength	Dose	Route	D/T Given	Instruction	Dr.Name & Sign	Nurse Name & Sign

Patient Name: Ward No: Bed No: MR No:

Round Orders

Orders Given		Orders	Carried By		Verified by Doctor Name & Signature
Date	Time		Time	Nurse Name, Signature & ID	
..... / ..... /	__:__ AM/PM		____:____ AM/PM		
..... / ..... /	__:__ AM/PM		____:____ AM/PM		
..... / ..... /	__:__ AM/PM		____:____ AM/PM		
..... / ..... /	__:__ AM/PM		____:____ AM/PM		
..... / ..... /	__:__ AM/PM		____:____ AM/PM		
..... / ..... /	__:__ AM/PM		____:____ AM/PM		
..... / ..... /	__:__ AM/PM		____:____ AM/PM		
..... / ..... /	__:__ AM/PM		____:____ AM/PM		
..... / ..... /	__:__ AM/PM		____:____ AM/PM		
..... / ..... /	__:__ AM/PM		____:____ AM/PM		

Pharmacist Review Sheet

Pharmacist Recommendation			Doctor Recommendation	
DTP No:	Date	Follow Up Date	Date	Make Changes as recommended ☐ Yes ☐ No
DTP Detail			Comment / Revision	
Proposed Solution with Alternative			Doctor Name, Sign / ID	
Pharmacist Follow Up			Pharmacist Name, Sign / ID	

OUTCOME SUMMARY / IMPORTANT NOTES

☐ Discharge ☐ DOR ☐ Referral ☐ LAMA ☐ Expired *(In case of Referral / Expired Please Specify):*..

Condition on Discharge ☐ Satisfactory ☐ Fair ☐ Poor *(In case of Poor / Fair Please specify)*..

DISCHARGE CHECKLIST

☐ Discharge Order	☐ Completion of Forms	☐ Provision of Documents and Prescription to Patient
☐ Follow-up Appointment		☐ Arrangement of Discharge Medication
☐ Patient's Valuables are Returned to Family		☐ Assist the Patient to Leave Hospital Safely
☐ Update Patient Record Register		☐ Patient's File Return to Medical Record Department
☐ Removal of ID Band & IV Cannula		

I have checked the file thoroughly and found that all documentation in the file has been completed before the discharge of the patient.

Head Nurse		Doctor	
Name:	Sign & ID:	Name:	Sign & ID:
Date: .... / ...... /	Time: .... : .... AM/PM	Date: .... / ...... /	Time: .... : .... AM/PM

14

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL

SURGERY BEDHEAD TICKET

☐ DISCHARGE FORM ☐ REFERRAL FORM

Patient Name		Father/Husband Name		MR No	
CNIC/SNIC	☐☐☐☐☐-☐☐☐☐☐☐☐-☐	Age		Gender	☐ M ☐F ☐T
Mobile No		Address			
Date of Admission: ...dd.../...mm.../...yy...		Time of Admission: ..... : ..... AM/PM		MLC *(In case of MLC, mention DOC. No./MLC. No.):*	

Presenting Complaint

Concomitant Disease ☐ DM ☐HTN ☐ Asthma ☐ IHD ☐Tuberculosis ☐Hepatits ☐ Other

Significant Examination Findings

Diagnostic Investigations Significant Results

Final Diagnosis **Additional Diagnosis**

MEDICATION GIVEN

1.	2.
3.	4.

Procedure Done | Outcome

Type of Anaesthesia Given

Amount of Transfused Blood

In Case of Any Complications During Hospital Stay

Outcome / Response to Treatment

DISCHARGE NOTES *(In case of Discharge please fill this Section)*

☐ Discharge advised by Dr. ☐ DOR Date ..... / ..... / ..... Time..... : ..... Condition on Discharge: ☐Satisfactory ☐Fair ☐Poor

TREATMENT ADVISED

Sr. No	Medicine & Strength	Dose	Route	Frequency	Timing	Duration
					کھانے سے پہلے / کھانے کے بعد	
					کھانے سے پہلے / کھانے کے بعد	
					کھانے سے پہلے / کھانے کے بعد	
					کھانے سے پہلے / کھانے کے بعد	
					کھانے سے پہلے / کھانے کے بعد	

درج ذیل تاریخ کو ہسپتال ہذا کے درج ذیل ڈیپارٹمنٹ میں معائنہ کیلئے تشریف لائیے۔ تاریخ معائنہ : _____ ڈیپارٹمنٹ: _____

ہدایات برائے خوراک _____

_____

مندرجہ ذیل علامات ظاہر ہونے کی صورت میں دوبارہ ہسپتال سے رجوع کریں _____

_____

REFERRAL ☐ Yes ☐ No *(To be filled by Referring Doctor in case of Referral)*

Nature of Referral	☐ Emergency ☐ Non-Emergency	**Refer To:**	
Reason for Referral	☐ Patient / Attendant's Request ☐ Clinical Assessment ☐ MLC ☐ Other_____		
Condition on Referral	☐ Alert ☐ Respond to Verbal Command ☐ Unconscious ☐ Other_____		
Vitals on Referral	BP:	Pulse:	R/R:	Temp:
Any Drug Allergy		Date ...../...../.....		Time:..... : ..... AM/PM
Instructions to be Carried Out During Patient Transfer				Ambulance Call Time: ..... : ..... AM/PM
				Patient Departure Time ..... : ..... AM/PM
Discharge/Referral Prepared By (Doctor Name & Signature)		Date...../...../.....	Time..... :	Hospital Employee ID:

15

کیا آپ ہماری خدمات سے مطمئن ہیں؟

آپ کی رائے ہماری خدمات کو بہتر بنانے میں مددگار ثابت ہوسکتی ہے۔ آپ سے گزارش ہے کہ اپنے قیمتی وقت میں سے کچھ وقت نکال کر نیچے دیئے گئے سوالات کے جوابات دیجئے۔ ہر سوال کے سامنے ممکنہ جوابات دیئے گئے ہیں۔ ان میں سے موزوں ترین جواب پر نشان لگائیں۔

ہسپتال کا نام _____ یونٹ/وارڈ/او پی ڈی _____

مریض کا نام _____ ایم آر نمبر _____ موبائل نمبر _____

تاریخ داخلہ _____ تاریخ واپسی _____ پتہ _____

نمبر شمار	سوالات	بہت عمدہ	عمدہ	مناسب	غیر تسلی بخش
1	ہسپتال میں طبی سہولیات کی فراہمی کیسی ہے؟				
2	معالج کی تشخیص اور طریقہ علاج کیسا ہے؟				
3	ہسپتال کے ڈاکٹرز اور عملے کا رویہ کیسا ہے؟				
4	ہسپتال میں مفت ادویات کی فراہمی کی صورت حال کیسی ہے؟				
5	لیبارٹری میں ایکسرے، الٹراساونڈ اور دیگر ٹیسٹ کی سہولیات کیسی ہیں؟				
6	ہسپتال میں صفائی کے انتظامات کیسے ہیں؟				
7	ہسپتال کے پنکھے، ائیر کنڈیشنر، کولر اور ہیٹر کی کارکردگی کیسی ہے؟				
8	ہسپتال میں سیکورٹی اور پارکنگ کی سہولیات کیسی ہیں؟				

9 اگر آپ تشخیص اور علاج سے مطمئن نہیں ہیں تو اس کی وجہ بیان کریں؟

☐ توجہ کی عدم فراہمی ☐ علاج میں تاخیر

☐ عملے کی قابلیت میں کمی ☐ غیر مناسب طریقہ علاج ☐ دیگر _____

10 آپ کو ہسپتال میں طبی سہولیات کے حصول کیلئے کتنی دیر انتظار کرنا پڑا؟

☐ 30 منٹ یا کم ☐ 1 گھنٹہ ☐ ڈیڑھ گھنٹہ ☐ 2 گھنٹے یا زیادہ

11 آپ کو ان میں سے کس سہولت کے حصول کے لیے سب سے زیادہ انتظار کرنا پڑا؟

☐ رجسٹریشن سلپ حاصل کرنے میں ☐ ڈاکٹر سے چیک اپ کروانے میں

☐ لیبارٹری اور ریڈیالوجی کی سہولیات حاصل کرنے میں ☐ فارمیسی سے ادویات حاصل کرنے میں

12 ہسپتال کی کارکردگی کو بہتر بنانے کیلئے اپنی قیمتی رائے کا اظہار کریں۔

ہدایات برائے مریضاں

- تجویز کردہ ادویات صرف اور صرف مریض کے لیے ہیں جسے کوئی دوسرا شخص استعمال نہیں کرسکتا۔
- دوا ڈاکٹر کی ہدایات اور بتائے گئے طریقہ کار کے مطابق استعمال کریں۔
- ادویات مقررہ وقت کی پابندی کے ساتھ استعمال کریں۔
- طبیعت بہتر ہونے کے باوجود ادویات بند نہ کریں اور کورس مکمل کریں۔
- پانی ہمیشہ اُبال کر استعمال کریں۔
- نرم غذا کا استعمال کریں۔
- غذا میں قیمہ، دودھ، انڈہ اور پھل شامل کریں۔
- بازاری کھانے، چکنائی اور مصالحہ دار غذا سے پرہیز کریں۔
- ہلکی پھلکی چہل قدمی کریں۔
- سگریٹ اور تمباکو نوشی سے اجتناب کریں۔
- شوگر اور بلڈ پریشر کا باقاعدگی سے ریکارڈ رکھیں۔
- شوگر اور بلڈ پریشر کی ادویات ڈاکٹر کی ہدایات کے مطابق جاری رکھیں۔
- زخم کو روزانہ پایوڈین سے صاف کریں۔
- ڈاکٹر کی تجویز کردہ تاریخ پر دوبارہ معائنے/ ٹانکے کھلوانے کے لیئے لازمی تشریف لائیں۔

Government of the Punjab

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL

SURGERY BEDHEAD TICKET

☐ DISCHARGE FORM ☐ REFERRAL FORM

Patient Name		Father/Husband Name		MR No	
CNIC/SNIC	☐☐☐☐☐-☐☐☐☐☐☐☐-☐	Age		Gender	☐ M ☐F ☐T
Mobile No		Address			
Date of Admission: ...../...../.....		Time of Admission: ..... : ..... AM/PM		MLC *(In case of MLC, mention DOC. No./MLC. No.):*	

Presenting Complaint

Concomitant Disease ☐ DM ☐HTN ☐ Asthma ☐ IHD ☐Tuberculosis ☐Hepatits ☐ Other

Significant Examination Findings

Diagnostic Investigations Significant Results

Final Diagnosis **Additional Diagnosis**

MEDICATION GIVEN

1.	2.
3.	4.

Procedure Done Outcome

Type of Anaesthesia Given

Amount of Transfused Blood

In Case of Any Complications During Hospital Stay

Outcome / Response to Treatment

DISCHARGE NOTES *(In case of Discharge please fill this Section)*

☐ Discharge advised by Dr. ☐ DOR Date ..... / ..... / ..... Time..... : ..... Condition on Discharge: ☐Satisfactory ☐Fair ☐Poor

TREATMENT ADVISED

Sr. No	Medicine & Strength	Dose	Route	Frequency	Timing	Duration
					کھانے سے پہلے/ کھانے کے بعد	
					کھانے سے پہلے/ کھانے کے بعد	
					کھانے سے پہلے/ کھانے کے بعد	
					کھانے سے پہلے/ کھانے کے بعد	
					کھانے سے پہلے/ کھانے کے بعد	

درج ذیل تاریخ کو ہسپتال ہذا کے درج ذیل ڈیپارٹمنٹ میں معائنہ کیلئے تشریف لائیے۔ تاریخ معائنہ : _____ ڈیپارٹمنٹ: _____

ہدایات برائے خوراک _____

_____

مندرجہ ذیل علامات ظاہر ہونے کی صورت میں دوبارہ ہسپتال سے رجوع کریں _____

_____

REFERRAL ☐ Yes ☐ No *(To be filled by Referring Doctor in case of Referral)*

Nature of Referral	☐ Emergency ☐ Non-Emergency	**Refer To:**	
Reason for Referral	☐ Patient / Attendant's Request ☐ Clinical Assessment ☐ MLC ☐ Other_____		
Condition on Referral	☐ Alert ☐ Respond to Verbal Command ☐ Unconscious ☐ Other_____		
Vitals on Referral	BP: Pulse: R/R:		Temp:
Any Drug Allergy		Date ...../...../.....	Time:..... : ..... AM/PM
Instructions to be Carried Out During Patient Transfer			Ambulance Call Time: ..... : ..... AM/PM
			Patient Departure Time ..... : ..... AM/PM
Discharge/Referral Prepared By (Doctor Name & Signature)	Date...../...../.....	Time..... :	Hospital Employee ID:

18

35.2 Annexure -2 Medical Consultation Form

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT
DHQ / THQ HOSPITAL -

Patient Name:		Father / Husband Name:		MR No:
CNIC/SNIC: □□□□□ - □□□□□□□ - □			Age:	Gender: □ M □ F □ T
Ward No.	Bed No.	Unit	Diagnosis	

CONSULTATION FORM

Admission Date ………. / ………. / ……….		Consultation Date ………. / ………. / ……….	
To Consultant :		Specialty :	
From Consultant :		Specialty :	
Urgency	□ Emergency (within 30 minutes)	□ Urgent (within 5 hours)	□ Routine (within 24 hours)
Patient History:			

Treating Consultant Name, Signature & ID	Date & Time
	……….. / ……….. / ……….. ……….. : ………. AM/PM

Consulted Physician/ Surgeon Notes: ____________________

Examination & Finding: ____________________

Recommendations & Follow Up: ____________________

Please Consult me again if: ____________________

Consulted Physician/Surgeon s Signature & Stamp	Date & Time
	……….. / ……….. / ……….. ……….. : ………. AM/PM

35.3 Annexure -3 Emergency Treatment Card

Government of the Punjab

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL

EMERGENCY CARD

Patient Name | Father/Husband Name | MR No.

CNIC No. _____-_____-_____ Age _____ Gender ☐ M ☐ F ☐ T

Mobile No. _____ Address _____

☐ **MLC** *(In case of MLC, mention MLC No. / Document No.)* _____

Date of Admission	(..... dd /..... mm /..... yy.....)
Time of Admission	(..... : ..... AM / PM)
Date of Exit	(..... dd /..... mm /..... yy.....)
Time of Exit	(..... : ..... AM / PM)
Medical Officer:	
Consultant:	

میں اپنا/اپنے مریض کا داخلہ ایمرجنسی وارڈ میں کرواتا/کرواتی ہوں اور ہسپتال کے طبی عملے کو اپنے/اپنے مریض کے ہر قسم کے علاج اور اس کیلئے ضروری ٹیسٹ، پروسیجرز اور ادویات دینے کی اجازت دیتا/دیتی ہوں۔

نام مریض _____

نشان انگوٹھا _____ دستخط _____ نام رشتہ دار _____

Informed to:(In case the patient / relative is not available / incapacitated / unable to give consent)

دستخط سٹاف نرس _____ ڈپٹی/ایڈیشنل میڈیکل سپرنٹنڈنٹ _____ ایمرجنسی میڈیکل آفیسر _____

Diagnosis	Differential Diagnosis (If Any)	Receiving Notes
		Time Seen By Nurse ..... : ..... AM/PM By Doctor..... : ..... AM/PM

Mode of Arrival	Condition on Arrival	Triage Category	Vitals	
☐ Walk In	☐ Alert	☐ Resuscitation	BP	RBS
☐ Stretcher	☐ Verbal	☐ Emergency	Pulse	**Pain**
☐ Wheel Chair	☐ Unconscious	☐ Urgent	Temp	☐ Mild
☐ Public Service (Police/Rescue Team)	☐ Reacts to Painful stimuli	☐ Semi Urgent	R/R	☐ Moderate
	☐ Other	☐ Non Urgent	SpO_2	☐ Severe

Presenting Complaint _____

Brief History _____

Examination

- ☐ Head & Neck
- ☐ CNS
- ☐ CVS / Pulmonary
- ☐ GIT
- ☐ GUT
- ☐ Extremities
- ☐ Integumentary
- ☐ **Oedema:** *(If Yes)*
- ☐ Pitting
- ☐ Non-pitting
- ☐ Pedal
- ☐ Sacral

1

Previous Medical & Surgical History

Allergies ☐ No ☐ Yes _____

Immunization Status: _____

Previous Medication, (If Any)

Drug	Strength	Dose	Frequency	Duration

	HTN	IHD	DM	Asthma	Hep B/C	Other
Past Hx						
Family Hx						
Social Hx	☐ Alcohol ☐ Smoking ☐ IV Drug ☐ Other					

Any significant previous Surgical History _____

☐ Re-admission within 72 hours, (If Yes) ☐ Same Hospital ☐ Other Hospital _____

☐ If Specialist Care Required

Time Called:	..... : ..... AM/PM	Department:	Notes
Time Call Received:	..... : ..... AM/PM	Name of Doctor on call:	
Time Seen:	..... : ..... AM/PM	Dr. Signature / ID on call:	

Resuscitation Form *(In case CPR is performed, write treatment in this section)*

Resuscitation Required ☐ Yes ☐ No

Time of Arrest	Time Resuscitation Started	Time Resuscitation Ended	Total Duration of Resuscitation
..... : ..... AM/PM	..... : ..... AM/PM	..... : ..... AM/PM	

Resuscitation Team

Name	Signature	ID	Speciality

Outcome: ☐ Revived ☐ Expired ☐ Admitted ICU / Ward ☐ Referred

Drug	Strength	Dose	Route	Time	Signature
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	
				..... : ..... AM/PM	

Procedures	Details	Post Procedure Vitals				
		BP	Pulse	Temp	R/R	SpO2
Compressions						
Defibrillator						

Emergency Treatment Chart

Drug	Strength	Dose	Route	Time	Signature: Order by	Signature: Administered by
				..... : ..... AM/PM		
				..... : ..... AM/PM		
				..... : ..... AM/PM		
				..... : ..... AM/PM		
				..... : ..... AM/PM		
				..... : ..... AM/PM		

IV Fluids / Blood	Quantity	Time Started	Time Ended	Signature: Order by	Signature: Administered by
		..... : ..... AM/PM	..... : ..... AM/PM		
		..... : ..... AM/PM	..... : ..... AM/PM		
		..... : ..... AM/PM	..... : ..... AM/PM		
		..... : ..... AM/PM	..... : ..... AM/PM		

Others

2

Vitals

Parameter	Value	Score
Time		
Resp. Rate	≥ 25	3
	21-24	2
	12-20	
	9-11	1
	5-8	3
SpO_2	≥ 96	
	94-95	1
	92-93	2
	≤ 91	3
Inspired O_2.%	%	
Temp	39.1	2
	38	1
	37	
	36	
	≤35	1
		3
Blood Pressure (SYSTOLIC)	220	3
	210	
	200	
	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	1
	90	2
	≤80	3
Blood Pressure (DIASTOLIC)	≥120	
	110	
	100	
	90	
	80	
	70	
	60	
	50	
	≤40	
Heart Rate	140	3
	130	2
	120	
	110	1
	100	
	90	
	80	
	70	
	60	
	50	1
	40	3
	30	
Level of Consciousness	Alert	
	V /P / U	3
Blood Sugar		
TOTAL NEW SCORE		
Additional Parameters	Pain Score	
Urine Output		
Monitoring Frequency		
Initials		

Investigations Done, (If Any)

☐ **CBC**

Hb	ESR	TLC	PLT
P	L	M	E

☐ **LFTs**

☐ Bilirubin	☐ S/Protein
☐ ALT	☐ S/Albumin
☐ AST	

☐ **S/Electrolytes** ☐ **Blood Group**

☐ Na^{+1}	☐ K^{+1}	☐ Ca^{2+}	

☐ **RFTs**

☐ S/Urea	☐ S/Creatinine

☐ **CSF**

Protein	Sugar
TLC	RBCs
WBCs	

☐ **Urine C/E**

Sp. Gravity	pH	Protein	Sugar
RBCs	Cast	Pus Cells	Ketones

☐ **ABGs**

PH	PaO_2	$PaCO_2$
HCO_3	Base Excess	

☐ **Bleeding Profile** ☐ **B-HCG**

☐ PT	☐ APTT	

☐ **Cardiac Enzymes**

☐ CPK	☐ CK-MB	☐ Troponin	☐ LDH

☐ **Viral Markars**

☐ Hep B	☐ Hep C	☐ HIV	☐ Syphilis

☐ **X-Ray:** ____________________

☐ **CT Scan:** ____________________

☐ **USG:** ____________________

☐ **MRI:** ____________________

Procedures Done, (If Any)

☐ ETT	☐ Thrombolytic Therapy
☐ NG Tube/Gastric Suction	☐ Bladder Catheter
☐ IV Fluids	☐ OBS/Gynae Care
☐ Blood Transfusion	☐ Orthopaedic Care
☐ Nebulizer Therapy	☐ Wound Care
☐ Other	

Post Procedure Detail

(In case of any procedure done, record vitals in news chart with + sign in times row)

3

☐ Any complication during emergency stay:

Mode of Exit

☐ Discharge		☐ Advised by Doctor
☐ Referral	☐ Emergency ☐ Non-Emergency	☐ On Patient/Relative Request
Referred to:	☐ Known Drug Allergy	☐ Other_____
Hospital Name	Instructions for Patient Transfer:	Reason_____
	Ambulance Call Time: (..... : .....) AM/PM	
	Patient Departure Time: (..... : .....) AM/PM	
☐ Admission	☐ Medicine ☐ Surgery ☐ ICU ☐ Paeds ☐ Gynae	
	☐ Burn Unit ☐ Dialysis Unit ☐ Ortho ☐ Other	
☐ LAMA	*(in case of LAMA or DOR, please fill in the relevant box below)*	

LAMA

In case a patient leaves against medical Advice without informing record the patient details as soon as this comes to attention of the Duty Doctor.

Date of LAMA:_____

Time of LAMA:_____

Informed to staff on duty:_____

Staff's Name & Signature: _____ Doctor's Name & Signature: _____

DISCHARGE ON REQUEST (DOR) STATEMENT

ہمیں اپنے مریض کی حالت بارے آگاہ کر دیا گیا ہے۔ ہم اپنی مرضی سے ہسپتال سے چھٹی لے کے جانا چاہتے ہیں۔ مریض کی جان کو ہونے والے نقصان کے ہم خود ذمہ دار ہوں گے۔ ہمیں ہسپتال کے عملہ یا ڈاکٹر سے کوئی شکایت نہیں ہے۔

نام رشتہ دار/مریض:_____

نشان انگوٹھا: _____ تاریخ: _____ دستخط: _____

شناختی کارڈ:

					-								-	

Response to Treatment	☐ Improved	☐ Unchanged	☐ Deteriorated	☐ Other		
Patient Condition on Exit	☐ Alert	☐ Responds to Verbal Command		☐ Unconscious	☐ Other	
Patient Vitals on Exit	Pulse	BP	Temp	R/R	SpO2	☐ Stable ☐ Unstable

Treatment Advice

Medicine	Strength	Dose	Timing	Duration
ادویات	طاقت	خوراک	ہدایات اوراوقات	دورانیہ علاج
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ شام ☐ کھانے کے بعد	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ شام ☐ کھانے کے بعد	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ شام ☐ کھانے کے بعد	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ شام ☐ کھانے کے بعد	

ہدایات برائے دوبارہ معائنہ:

تاریخ معائنہ:_____ شعبہ:_____

عمومی ہدایات برائے مریضاں:_____

ہدایات برائے خوراک:_____

مندرجہ ذیل علامات ظاہر ہونے کی صورت میں دوبارہ ہسپتال سے رجوع کریں

Prepared BY:	Doctor Name:	Signature/ID:	Designation
	Date(.....dd...../ .....mm...../ .....yy.....)		Time (..... : ..... AM/PM)
Scanned BY:	Scanner Name:	Signature/ID:	Designation
	Date(.....dd...../ .....mm...../ .....yy.....)		Time (..... : ..... AM/PM)

4

Government of the Punjab

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL

EMERGENCY CARD

Admission | Discharge | Referral

Patient Name | Father/Husband Name | MR No.

CNIC No. _____-_____-_____ Age: _____ Gender: M F T

Mobile No. _____ Address _____

Triage: Resuscitation | Emergency | Urgent | Semi Urgent | Non Urgent

Date of Admission (dd /mm /yy)

Time of Admission (.....: ..... AM / PM)

Date of Exit (dd /mm /yy)

Time of Exit (.....: ..... AM / PM)

Presenting Complaint

Significant Clinical History & Examination Findings

Significant Investigations & Values

Diagnosis

Emergency Management

Drug	Strength	Dose	Route	Drug	Strength	Dose	Route

Procedures Undertaken (If Any)

☐ CPR	☐ IV Fluids	☐ Bladder Catheter	☐ Stable ☐ Unstable
☐ Defibrillator	☐ Blood Transfusion	☐ OBS/Gynae Care	
☐ ETT	☐ Nebulizer Therapy	☐ Orthopaedic Care	
☐ NG Tube/Gastric Suction	☐ Thrombolytic Therapy	☐ Wound Care	
☐ Other			

Post Procedure Detail

☐ Any Complication:

Emergency Exit Portal

☐ Admission ☐ Discharge ☐ Referral

☐ Advised by Doctor
☐ On Patient/Relative Request
☐ Other _____

Reason _____

Response to Treatment	☐ Improved	☐ Unchanged	☐ Deteriorated	☐ Other	
Patient Condition at Exit	☐ Alert	☐ Responds to Verbal Command		☐ Unconscious	☐ Other
Patient vitals at Exit	Pulse	BP	Temp	R/R	SpO2

Discharge Note (*In case of Discharge, please fill the following*)

Treatment Advice

Medicine	Strength	Dose	Instruction	Treatment course
ادویات	طاقت	خوراک	ہدایات اور اوقات	دورانیہ علاج
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	
			☐ کھانے سے پہلے ☐ صبح ☐ دوپہر ☐ کھانے کے بعد ☐ شام	

ہدایات برائے دوبارہ معائنہ: درج ذیل تاریخ کو ہسپتال ہذا کے درج ذیل شعبہ میں معائنہ کیلئے تشریف لائیں۔

تاریخ (................/................/................) شعبہ: ____________________

عمومی ہدایات برائے مریضاں:

____

____

ہدایات برائے خوراک: ____________________

مندرجہ ذیل علامات ظاہر ہونے کی صورت میں دوبارہ ہسپتال سے رجوع کریں: ____________________

____

Admission Note (*In case of Admission, please fill in the following*)

☐ ICU	☐ Burn Unit	☐ Dialysis Unit	☐ Medicine	☐ Surgery	☐ Ortho	☐ Paeds	☐ Gynae	☐ Other ________

Referral Note (*To be filled in by Referring Doctor, in case of Referral*)

Nature of Referral: ☐ Emergency ☐ Non-Emergency	Referred to:
Any Known Drug Allergies:	
Instructions to be carried out during patient transfer:	Ambulance Call Time: (............ :.............) AM/PM
	Patient Departure Time: (............ :.............) AM/PM
Treatment given during patient transfer *(To be filled in by PTS staff)*	Ambulance Staff Name
	Signature
	Designation

Referred Hospital Receiving Notes *(To be filled in by Receiving Doctor of Referred Hospital)*

Patient Arrival Time: (……..:………) AM/PM	Patient Condition: ☐ Stable ☐ Unstable ☐ Expired	
Receiving Doctor Name:	Signature/ID:	Designation:

Prepared BY:	Doctor Name:	Signature/ID:	Designation
	Date(.....dd......./ .....mm......./ .....yy.........)		Time (..................... : .... AM/PM)

Scanned BY:	Scanner Name:	Signature/ID:	Designation
	Date(.....dd......./ .....mm......./ .....yy.........)		Time (..................... : .... AM/PM)

ii

35.4 Annexure -4 Internal Patient Transfer Form

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL -

Patient Name:		Father / Husband Name:	MR No:
CNIC/SNIC: ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐		Age:	Gender: ☐ M ☐ F ☐ T
Ward No.	Bed No.	Unit	Diagnosis

INTERNAL PATIENT TRANSFER

Admission Date .... / .... /	Transfer Date .... / .... /	Transfer Time .... : .... AM/PM

Transfer From	☐ ER	☐ ICU	☐ CCU	☐ NICU	☐ PICU	☐ LR	☐ Ward
Transfer To	☐ ER	☐ ICU	☐ CCU	☐ NICU	☐ PICU	☐ LR	☐ Ward
	☐ Dialysis		☐ Medical Imaging				

Reasons of Admission	
Significant Finding	
Diagnosis	

DIAGNOSTIC PROCEDURES / INVESTIGATIONS

Procedure / Investigation	Results	Procedure / Investigation	Results

SIGNIFICANT MEDICATIONS USED

Medication Name	Dose	Last Dose Taken	Medication Name	Dose	Last Dose Taken

THERAPEUTIC PROCEDURES PERFORMED

Intervention	Outcome

Patient Condition at Transfer	☐ Good	☐ Fair	☐ Poor

REASON(S) FOR TRANSFER

Treating Consultant Name, Signature & ID	Date & Time	Endorsing Doctor Name, Signature & ID	Date & Time
	.... / .... / .... : ...... AM/PM		.... / .... / .... : .... AM/PM

Vital Signs	Pulse	Temp	BP	R/R	RBS	Weight	SPO2
GCS							

Endorsing Nurse Name, Signature & ID	Date & Time	Receiving Nurse Name, Signature & ID	Date & Time
	.... / .... / .... : ...... AM/PM		.... / .... / .... : .... AM/PM

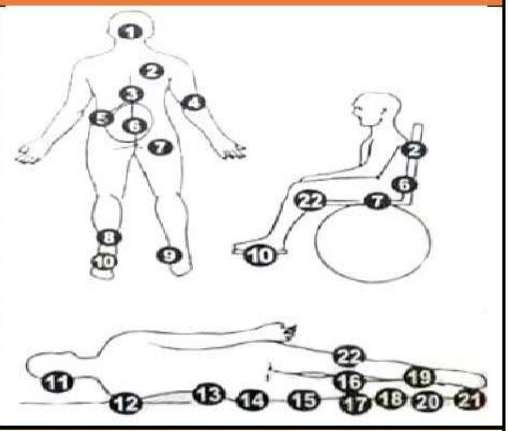
Receiving Doctor Name	Signature & ID	Date & Time
☐ Accepted Case ☐ Not Accepted Case Feedback & Comments: _		.... / .... / .... : .... AM/PM

35.5 Annexure-5 Patient at Risk for Pressure Ulcer

Name:	Age:	Sex: ☐ M ☐ F ☐ T	MR#

SECTION I														
RISK ASSESSMENT TOOL FOR PREDICTING PRESSURE ULCERS (REFER TO GUIDELINES)														
DATES:														
SENSORY PERCEPTION: Ability to respond meaningfully to pressure related discomfort.														
MOISTURE: Degree of which skin exposed to wetness and/or fluids.														
ACTIVITY: Degree of physical ability to work and bear weight.														
MOBILITY: Ability to change and control body position.														
NUTRITION: Usual food intake pattern														
FRICTION AND SHEARING:														
TOTAL SCORE														
NURSE NAME SIGN & ID														

Risk Factor			
☐ High Risk (11)	☐ Moderate (12 -14)	☐ Mild (15 -16)	☐ Not at Risl (>16)

SESCTION II		
Circle the effected site with Pressure Ulcer		
☐ Occipital bone	☐ Shoulder	
☐ Scapula	☐ Anterior Iliac Spine	
☐ Spinous process	☐ Trochanter	
☐ Elbow	☐ Thigh	
☐ Iliac Crest	☐ Medial Knee	
☐ Sacrum	☐ Lateral Knee	
☐ Ischium	☐ Lower Leg	
☐ Achilles Tendon	☐ Medical Malleolus	
☐ Heel	☐ Lateral Malleolus	
☐ Sole	☐ Lateral Malleolus	
☐ Ear	☐ Posterior Knee	
Date and time of completion / / : AM/PM		Counter Checked By: ☐ Head Nurse ☐ Charge Nurse
Nurse Name:	Sign & ID:	Name Sign & ID:

INITIAL / DAILY ULCER ASSESSMENT																
DESCRIPTORS	Initial	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day	Day
DATE:																
SIZE : (Length x Width)																
CITL																
EDGES ☐ Clear, Visible																
☐ Attached to the wound base																
☐ Fibrotic, scarred																
UNDERMINING:																
NECROTIC TISSUE:																
SLOUGH:																
ESCHAR:																
EXUDATE ☐ Serous																
☐ Serosanginous																
☐ Purulent																
GRANULATION																
☐ Healthy Granulation																
☐ Septic Granulation																
EPITHELILIZATION																
SURROUNDING SKIN:																
☐ Bright Red																
☐ Blanchable																
☐ Edematous																
☐ Indurated																
STAGE OF PRESSURE ULCER: As per scale																
NURSE'S SIGNATURE AND I.D. NO.																

NOTE: Check ☐ where applicable, Use separate from for each pressure ulcer

GLOSSARY

Crater	- A Circular area of depression surrounded by an elevated margin.
Devitalized Tissue	- Tissue that has died and therefore lost its physical property and biological Activity (Necrotic)
Epithelialization	- It is process of epidermal resurfacing and appears as pink or red skin.
Escher	- Thick, leathery, necrotic, devitalized tissue.
Exudate	- Any fluid that has been extruded from a tissue or its capillaries.
Granulation Tissue	- The growth of small blood vessels and connective tissue in full thickness wounds
	Healthy Granulation: Bright red not easily bleeds and clean.

BRADEN SCALE GUIDELINES

SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. Complete limited:** Unresponsive (does not moan, flinch, or grasp) to painful stimuli due to diminished level of consciousness or sedation, **OR** limited ability to feel pain over most of body surface.	**2. Very Limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited:** Responds to verbal commands but cannot always communicate discomfort or need to be repositioned, **OR** has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE Degree to which skin is exposed to wetness and/or body fluids	**1. Constantly moist:** Skin is wet, clammy almost constantly from perspiration, urine, etc. Dampness is detected every time patient is moved, turned, or repositioned.	**2. Moist:** Skin is often but bot always wet, clammy. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely moist:** Skin is usually dry, linen requires changing only at routine intervals.
ACTIVITY Degree of physical ability to work and bear weight	**1. Bedfast:** Confined to bed.	**2. Chair Fast:** Ability to walk is severely limited to non - existent. Cannot bear own weight and/or must be assisted into the chair or wheel chair. Ability to walk is severely limited to nonexistent. Cannot bear own weight and/or must be assisted into chair or wheel char.	**3. Walk Occasionally:** Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks frequently:** Walks outside the room at least twice a day and inside the room at least once every 2 hours during waking hours.
MOBILITY Ability to change and control body position	**1. Complete immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited:** Makes frequent tough slight changes in body or extremity position independently.	**4. No limitation:** Makes major and frequent changes in position without assistance.
NUTRITION Usual food intake pattern	**1. Very Poor:** Never eat a complete meal. Rarely eats more than ½ of any food offered. Eats 2 serving or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, **OR** is NPO (nothing by mouth) and/or maintained on clear liquids or IV fluids for more than 5 days.	**2. Probably Inadequate:** Rarely eats a complete meal and generally eats only about ½ of any fo od offered. Eats 2 serving or less of protein (meat or dairy products per day. Occasionally will take a dietary supplement, **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. Adequte:** Eats over half of most meals. Eats a total of four servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement of ordered **OR** is on a tube feeding or total parental nutrition (TPN) regimen, which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products daily. Occasionally eats between meals. Does not require nutritional supplement.
FRICTION AND SHEARING	**1. Problem:** Required moderate to maximum assistance in reposition. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with	**2. Potential Problem:** Moves freely or required minimum assistance. During a move skin probably slides – to some extent – against sheets, chari, restraints, or other devices. Maintains relatively good	**3. No apparent problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during repositioning. Maintains good position in chair or bed at all time.	

Directions for pressure Ulcer Assessment Form:	
1. Document the assessment Date.	4. When all the areas of the assessment are complete, add the number together and document the total in the section labeled "Total Score"
2. Choose the number of the description in each section that best describes the assessment of your patient	5. Determine prediction of risk according to the risk factor category range document in the form.
3. Document the selected assessment description n umber in the box under the date for each assessment category on the form.	6. Place your name in the section labeled "Name of Evaluation".

Annexure-6 Inter Disciplinary Discharge Planning Sheet & Discharge Form

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT
DHQ / THQ HOSPITAL -

Patient Name:		Father / Husband Name:		MR No:
CNIC/SNIC:			Age:	Gender: ☐ M ☐ F ☐ T
Ward No.	Bed No.	Unit	Diagnosis	

INTERDISCIPLINARY DISCHARGE PLANNING SHEET

THIS PART TO BE FILLED BY ATTENDING / TREATING PHYSICIAN WITHIN 1-2 DAYS OF ADMISSION	Yes	No
Is there identified carer to take care of the patient post discharge ? If No, Action Needed.....	☐	☐
Are patient and carer aware of the expected recovery path? If No, Action Needed.....	☐	☐
Are Patient and carer aware of likely changes to health status on discharge? If No, Specify action:	☐	☐
Do you expect the patient to be independently ambulating by the discharge date? If No will the patient be discharged home? It Yes are there management plans for ensuring patient safety? If No, specify action:.....	☐ ☐ ☐	☐ ☐ ☐
Does the carer live with the patient? Is the carer capable and prepare to assist the patient post discharge? If No, Specify actions:.....	☐ ☐	☐ ☐
Do you expect the patient to be independent with toileting, showering, dressing and personal ADL? If No specify actions:.....	☐	☐
THIS PART TO BE FILLED BY ASSIGNED NURSE ON THE DAY PRIOR TO DISCHARGE		
Information		
Are the patient and carer been provided with sufficient information on new / existing medications? If No document actions	☐	☐
Are the patient and carer been provided with information on support groups and self-help programs? No, is this information required? Yes, Document actions	☐ ☐	☐ ☐
Are the patient and carer been provided with emergency contacts to the treating doctor and hospital? If No document actions	☐	☐
Are, all discharge plans still in process? No, what remains to be done? Document actions	☐	☐
Medications		
Over all relevant medication information and supplies been provided? If No, what remains to be done? Document actions	☐	☐
Have patient and/or carer demonstrated their competence with medications? If No, what remains to be done? Document actions	☐	☐
Equipment		
Have all relevant equipment and home modifications been provided / organized? If No, what remains to be done? Document actions	☐	☐
Have the patient and/or carer demonstrated their competence with equipment? If No, what remains to be done? Document actions	☐	☐
THIS PART TO BE FILLED BY ATTENDING / TREATMENT PHYSICIAN ON THE DAY OF DISCHARGE		
Discharge Summary		
Has the discharge summary been given to the patient / carer? If No, is it appropriate to do so? If Yes, Document actions and instructions to the entitled person	☐ ☐	☐ ☐
Management at Home		
Have there been final discussions with patient and carer regarding short and long term issues of management at home post discharge? If No, conduct discussions as soon as possible. If Yes, do any further actions need to be taken? If Yes, document actions	☐ ☐ ☐	☐ ☐ ☐
Follow-up appointments		
Have appropriate follow-up appointments been made, e.g. medical specialist, outpatient clinics? If No, are they required? If Yes, document actions	☐ ☐	☐ ☐
Treating Doctor Name:	Date: ..... / ..... /	
Signature & ID:	Time: ..... : ..... AM/PM	

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT
DHQ / THQ HOSPITAL -

DISCHARGE FORM

Patient Name:	Father / Husband Name:	MR No:
CNIC/SNIC: | | | | | - | | | | | | | - | | Age:	Gender: ☐ M ☐ F ☐ T	
Mobile No:	Address:	
Date of Admission: ..dd.. / ..mm.. /..yy..	Time of Admission: ..... : ..... AM/PM	☐ MLC *(In case of MLC, Mention DOC. No./MLC. No.):* _____

Presenting Complaint:

Concomitant Diseases:	☐ DM	☐ HTN	☐ Asthma	☐ IHD	☐ Tuberculosis	☐ Hepatitis
	☐ Other					

Significant Examination Findings:

Diagnostic Investigations Significant Results _____

Final Diagnosis		Additional Diagnosis	

Medication Given	
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

PROCEDURE DONE :

OUTCOME:

Amount of Transfused Blood:	Type of Anaesthesia Given: _____

In case of any complications during hospital stay _____

Outcome / Response to Treatment _____

Discharge Notes

☐ Discharge advised by Dr. ☐ DOR Date of Discharge ..dd.. / ..mm.. / ..yy.. Condition on Discharge: ☐ Satisfactory ☐ Fair ☐ Poor

Treatment Advised

Sr. No	Medicine	Strength / Dose	Route	Frequency	Timing	Duration
					کھانے سے پہلے / کھانے سے بعد	
					کھانے سے پہلے / کھانے سے بعد	
					کھانے سے پہلے / کھانے سے بعد	
					کھانے سے پہلے / کھانے سے بعد	
					کھانے سے پہلے / کھانے سے بعد	
					کھانے سے پہلے / کھانے سے بعد	
					کھانے سے پہلے / کھانے سے بعد	

درج ذیل تاریخ کو ہسپتال ہذا کے درج ذیل ڈیپارٹمنٹ میں معائنہ کیلئے تشریف لائیے۔

تاریخ معائنہ : _____ ڈیپارٹمنٹ _____

ہدایات برائے خوراک _____

_____

_____

مندرجہ ذیل علامات ظاہر ہونے کی صورت میں دوبارہ ہسپتال سے رجوع کریں _____

_____

Discharge Prepared By (Doctor Name , Stamp & Signature)	Hospital Employee ID:

35.6 Annexure-7 Referral Register & DOR and LAMA Consent Form

REFERRAL REGISTER

S.No	Name	MR#	Age	Gender	CNIC	Address	Diagnosis	Treating Consultant	Date of Adminssion	Date of Refferal	Referred To	Cause of Referral	Remarks	Name Sign & ID

LAMA

In case a patient leaves against medical Advice without informing record the patient details as soon as this comes to attention of the Duty Doctor.

Date of LAMA: _____

Time of LAMA: _____

Informed to staff on duty: _____

Staff's Name & Signature: _____

Doctor's Name & Signature: _____

DISCHARGE ON REQUEST (DOR) STATEMENT

ہمیں اپنے مریض کی حالت بارے آگاہ کر دیا گیا ہے۔ ہم اپنی مرضی سے ہسپتال سے چھٹی لے کے جانا چاہتے ہیں۔ مریض کی جان کو ہونے والے نقصان کے ہم خود ذمہ دار ہوں گے۔ ہمیں ہسپتال کے عملہ یا ڈاکٹر سے کوئی شکایت نہیں ہے۔

نام رشتہ دار/مریض: _____

نشان انگوٹھا: _____ تاریخ: _____ دستخط: _____

شناختی کارڈ:

					-							-	

35.7 Annexure-8 Death Record Register & Death Register

DEATH RECORD REGISTER

S.No	Name	MR#	Age	Gender	CNIC	Address	Diagnosis	Treating Consultant	Date of Adminssion	Date of Expiry	Time of Expiry	Cause of Death	Body Handed Over To	Remarks	Name Sign & ID

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT
DHQ / THQ HOSPITAL -

DEATH CERTIFICATE

DECEDENT

Name:	Father/Husband Name:	Age:	Gender: ☐ M ☐ F ☐ T
Address:		City	District
CNIC		Date of Birth: (……../……../……..)	Date of Death: (……../……../……..)
Religion:	Marital Status:	Surviving Family Name:	Time of Death: …… : ……. AM/PM

NEXT OF KIN

Name:	Father/Husband Name:	Age:	Gender: ☐ M ☐ F ☐ T
Address:		City	District
CNIC		Date of Birth: (……../……../……..)	
Religion:	Marital Status:	Occupation:	

ADMISSION DIAGNOSIS

FINAL DIAGNOSIS

HOSPITAL COURSE OF TREATMENT & MANAGEMENT

PROCEDURE PERFORMED

SIGNIFICANT LAB FINDINGS

BRIEF SUMMARY OF FACTS SURROUNDING DEATH

CAUSE OF DEATH

Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	
DUE TO (OR AS A CONSEQUENCE OF) :	
Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST** b	
DUE TO (OR AS A CONSEQUENCE OF) :	
c	
DUE TO (OR AS A CONSEQUENCE OF) :	
d	

MANNER OF DEATH

☐ Natural ☐ Homicide ☐ Accident ☐ Suicide

☐ Pending Investigation ☐ Could not be determined

Was an autopsy performed? ☐ Yes ☐ No

Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

CERTIFIER *(Check only one box)*

☐ CERTIFYING PHYSICIAN *(Physician certifying cause of death when another physician has pronounced death)*
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ PRONOUNCING AND CERTIFYING PHYSICIAN *(Physician both pronouncing death and certifying to cause of death)*
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER/CORONER
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause (s) and manner as stated.

میں تصدیق کرتا/ کرتی ہوں کہ میں نے اپنے رشتہ دار/عزیز کی لاش ہسپتال ہذا سے وصول کر لی ہے اور ہسپتال کی جانب سے متوفی کے تمام اثاثہ جات ایمانداری کے ساتھ میرے حوالے کر دیے گئے ہیں۔

نام رشتہ دار _____ متوفی سے رشتہ _____

شناختی کارڈ نمبر _____ فون نمبر _____

پتہ _____

Name & Signature of Certifier:	PMDC No:	Date & Time ……. / ……. / ……. ……. : ……. AM/PM
Name and Signature of Pronouncing Physician:	PMDC No:	Date & Time ……. / ……. / ……. ……. : ……. AM/PM
Medical Superintendent Signature:	PMDC No:	Date filed ……. / ……. / …….

35.8 Annexure-10 Doctor Order Form

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL -

Patient Name:		Father / Husband Name:	MR No:
CNIC/SNIC: □□□□□ - □□□□□□□ - □		Age:	Gender: □ M □ F □ T
Ward No.	Bed No.	Unit	Diagnosis

DOCTOR ORDER SHEET			
DIAGNOSIS:		Additional DIAGNOSIS: *(IF ANY)*	
ALLERGIES			
TREATMENT ADVISED			
INVESTIGATION:			
Dr. Name	Signature & Stamp:	Date: dd / mm / yy	Time: ..... : ...... AM/PM
Nurse Name	Signature & Stamp:	Date: dd / mm / yy	Time: ..... : ...... AM/PM

35.9 Annexure-11 Nursing Notes

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL ------------------------

Patient Name:		Father / Husband Name:	MR No:
CNIC/SNIC: _ _ _ _ _ - _ _ _ _ _ _ _ - _		Age:	Gender: ☐ M ☐ F ☐ T
Ward No.	Bed No.	Unit	Diagnosis

NURSING NOTES

Date	Time	Notes:	Nurse Name , Signature & ID
Date	Time	Notes:	Nurse Name , Signature & ID
Date	Time	Notes:	Nurse Name , Signature & ID

35.10 Annexure-12 CPR Form

RESUSCITATION FORM

Name	Age:	Gender:	Bed No:	MR No:
Date: ..... / ..... /	Time of Code: ..... : ..... AM/PM	Time CPR Began:	Pre-Arrest Diagnosis:	
Patient Discovered by (First Rescuer):		Witnessed: ☐ Yes ☐ No		
Attending Physician:	Type of Arrest: ☐Respiratory ☐Cardiac ☐ False Code Blue ☐ Other _____			
Ventilation: ☐ Bag & Mask ☐ Endo tracheal Tube	☐ Intubated ☐ Successful ☐ Unsuccessful Intubated by: _____			

Time	Rhythm Pulse	Blood Pressure	Counter Shock	Epinephrine	Atropine	Xylocaine	Sodium Bicarb	Other Medication A	Other Medication B	Response to Treatment

IV Fluids & IV Medication Drip Concentration	Arterial Blood Gas Results:						
	Time	pH	PaCO2	PaO2	HCO3	Base Deficit	SpO_2

Defibrillator Usage: ☐ Yes ☐ No

S No.	Time	Joules	Synchronize	Type of Dysrhythmias	Outcome	Biomedical issues related to Defibrillator
1.			☐ Yes ☐ No			☐ Defibrillator is Not working well
2.			☐ Yes ☐ No			☐ Battery is Not working
3.			☐ Yes ☐ No			☐ Defibrillator is Not charged
4.			☐ Yes ☐ No			☐ ECG is Not working
5.			☐ Yes ☐ No			☐ Paddle is Not OK

CPR Outcome: ☐ Successful ☐unsuccessful	Time CPR Ended: ..... : ..... AM/PM	Total Duration of CPR .....

Outcome	❑ Revived	❑ Expired	❑ Admitted	❑ ICU/Ward	❑ Referred

Attending Physician Comment: _____

Name:	Signature & ID:	Date ...../...../..... Time: ..... : ..... AM/PM

TEAM LEADER COMMENT

Assessment	Intervention	Post Resuscitation Recommendation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name:	Signature & ID:	Date ...../...../..... Time: ..... : ..... AM/PM

ATTENDING CPR MEMBERS

Specialization	Name	Time Attending	Sign & ID
❑ Cardiologist			
❑ Anesthesiologist			
❑ ICU/NICU Specialist			
❑ Attending Physician			
❑ ICU/NICU Nurse			
❑ Nurse at the Site of Arrest			
❑Other			

35.11 Annexure-13 Fall Risk Assessment

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL -

Patient Name:		Father / Husband Name:		MR No:
CNIC/SNIC: □□□□□ - □□□□□□□ - □		Age:		Gender: □ M □ F □ T
Ward No.	Bed No.	Unit	Diagnosis	

FALL RISK ASSESSMENT

DIAGNSOSIS									
				DATE:					
	PARAMETER	SCORE	ASSESSMENT	TIME:					
MENTAL STATUS	A Level of Consciousness / Mental Status	0	Alert, Oriented, Reliable, Safety Awareness, or Comatose						
		2	Diminished, Safety Awareness						
		4	Poor Recall, Judgment, Safety Awareness						
MOBILITY / CONSTEMENT	B Ambulatory Status	0	Ambulatory / continent						
		2	Impaired Mobility / Continent (Assist with toileting) / with Urinary Catheter						
		4	Ambulatory / Incontinent						
	C Gait / Balance	**To assess the patient's Gait/Balance, observe him/her while standing on both feet without holding onto anything; Walk straight forward; walk through a doorway; make a turn. Score each area with 1, if condition is present and N/A if problem is not determined. Note: Score 0 if patient is normal after doing assessment of Gait / Balance.**							
		0	No Balance problem while standing						
		1	Problem while walking						
		1	Decreased Muscular Coordination						
		1	Change in gait pattern when walking through doorway						
		1	Jerking or unstable when making turn						
		1	Requires use of assistive devices (cane, walker, furniture, etc.)						
MEDICAL STATUS / HISTORY	D Vision Status	0	Adequate (with or without glasses)						
		2	Poor (with or without glasses)						
		4	Legitimate Blind						
	E Orthostatic Blood Pressure (Systolic)	0	No note drop between lying or sitting and standing						
		2	Drop **LESS THAN** 20mmHg between lying or sitting and standing						
		4	Drop **MORE THAN** 20mmHg between lying or sitting and standing						
	F Falls History (Immediately / Past 3 months)	0	No Falls in past 3 months						
		2	1-2 Falls in past 3 Months						
		4	3 or **MORE FALLS** in past 3 months						
	G Medications (if Total is greater than 2, may refer to physician for assessment)	**Respond below based on the following types medications: Anesthetics, Antihypertensive, Antiselzure, Benzodiazepines, Diuretics, Hypoglycemic, Narcotics, psychotropic, and Sedatives / Hypnotics, Laxatives**							
		0	NONE of these medication taken currently within 7 days						
		2	TAKES 1-2 of these medications currently and/or within 7 days						
		4	TAKES 3-4 of these medications currently and/or within 7 days						
		+1	If patient has had a change in medication and/or change in dosage in the past 5 days ---- Score 1 additional point						
	H Predisposing Diseases / Conditions	**Respond below based on the following predisposing conditions: Hypotension, Hypertension, Vertigo, CVA, Parkinson's Disease, Loss of Limb(s), Seizure, Arthritis, Osteoporosis, Fracture, Dementia, Anemia, Wandering, Anger, Diabetes, Guilin Barre' Syndrome, Myasthenia Gravis, COPD**							
		0	NON PRESENT						
		2	1-2 PRESENT						
		4	3 OR MORE PRESENT						
		+1	If patient's Age $\geq$ 60 Years old, Score 1 Additional Point						
RISK LEVEL	Low	0-5	Implement Standard Fall Precaution	TOTAL SCORE					
	Moderate	6-9	Implement Standard Fall Precaution and Moderate Risk Precaution	Nurse Name					
	High	$\geq$ 10	High Risk fall prevention interventions, plus standard and moderate fall precautions Precaution	Signature & ID					
				Date ....../....../...... Time: ...... : ...... AM/PM					

NURSING MEASURES

LOW RISK – STANDARD FALLS PRECAUTIONS & MODERATE RISK FALL PREVENTION INTERVENTION
☐ Patient Teaching – Orientation To Room, Call Bell, Fall Risk Medication Information, caution For Ambulation Following Sedation / Analgesia, Call For Assistance With Ambulation, Use Rubber Or Non-Slip Footwear To Prevent Slipping. ☐ Secure Call Bell, Phone And Bed Table Within Reach. ☐ Ensure Clothing Does Not Interfere With Mobility. ☐ Keep Bathroom Lights On, Floor Dry. ☐ Use Raised Toilet Seat Or Stool In The Shower As Necessary. ☐ Maintain Bed In The Lower Position, Ensure Wheels Locked. ☐ Use Safety Straps On Stretcher, Wheelchair While Transporting Patient. ☐ Identify As **Fall Risk** On Medical Record & **WHITE Placard** As A Signage At Foot-Part Of The Bed. ☐ Assist And / Or Supervise Ambulation. ☐ Monitor For Reversal Causes – Orthostatic Hypotension, Hydration & Blood Sugar. ☐ Move Patient Closer To Nursing Station. ☐ Add Round The Clock Lighting Such As Night Light at Room ☐ Hourly Safety Checks, Attending To The 4 P's Concerns Of The Patient. ☐ Regular Pain Assessment, Provide Lowest Dose Of Analgesia ☐ Raise Side Rails, Assess Patient After Visitors Leave To Ensure Safety Measures In Place. ☐ Patient, Families, Watcher Teachings – Calls For Assistance With Ambulation, Do Not Lower Side Rails Notify Nurse If Leaving The Patient.

HIGH RISK FALL PRESENTATION INTERVENTIONS (PLUS ALL LOW AND MODERATE RISK INTERVENTIONS)
☐ **RED Placard** As A Signage At Foot-Part Of The Bed. ☐ Raise Both Upper And Lower Side Rails & Apply Gap Protectors. ☐ Place Mattress On Floor, As Appropriate. ☐ Healthcare Providers Collaboratively Review Medication. ☐ Consult Physical Therapy For Gait And/or Strengthening Exercise If Needed. ☐ Initiate Constant Observation As Appropriate To Patient Need.

INDICATIONS FOR REASSESSMENT
☐ Every Shift. ☐ Following Procedural Sedation. ☐ Medication Effects, Such As Those Anticipated With Sedation Or Diuretics. ☐ Immediate Postoperative (Within 48 Hours Post Surgery) ☐ Narcotic Administration Such As PCA Or Epidural Analgesia. ☐ Change In Conscious Level Or Mental Status ☐ Changing In Ambulation ☐ Transfer Between Nursing Unit / Clinic ☐ After Whenever There Is A Fall Incident