ASSIGNMENT ON ADMINISTRATION AND MANAGEMENT OF OBSTETRICAL AND GYNAECOLOGICAL UNIT

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SUBMITTED ON – 20/7/2015

DESIGN AND LAYOUT OF OBSTETRICS AND GYNAECOLOGICAL NURSING

INTRODUCTION
The Obstetric Unit is a discreet Unit providing facilities for the safe prenatal care, delivery and postnatal care of mothers and their babies. Within the unit, patients with specific needs will be taken into consideration through the creation of dedicated zones:

- Mothers having normal deliveries
- Mothers suffering from antenatal or postnatal complications, requiring acute maternity care
- Babies requiring minimal care
- Babies requiring care for complications arising from medium risk factors
- Babies requiring care for severe complications, in anticipation of a transfer to a Neonatal Unit of a higher delineation.

It is expected the Obstetric Unit, including the nursery, will be managed as one unit.

**PLANNING THE LAYOUT FOR AN OBSTETRICS AND GYNAECOLOGICAL UNIT**

**Planning model:**

Obstetrics consists of the following processes:

- Labour
- Delivery/ Birthing
- Recovery
- Postnatal (or Post-Partum)
- Separate from these 4 processes, the baby infant nurseries

A traditional Obstetrical model is based on the patient being moved between areas dedicated to the individual processes. The preferred design for an Obstetric Unit however, particularly for smaller birthing centres, includes a number of self contained rooms fitted out to perform several of the processes, without the patient having to move according to the following:

- The design model combining labour, delivery and recovery in one room will be referred to as an LDR model. The patient is only moved from this room in case of complications (to the Caesarean section delivery room) or after recovery, to an in-patient room.
- The design model combining all four processes will be referred to as LDRP model. Here the patient remains in one room for her entire stay.

Larger birthing centres may adopt a more traditional model where dedicated maternity inpatient beds are provided, combined with a separate birthing suite. If the birthing centre does not provide a standalone Special Care Nursery or Neonatal Intensive Care Unit, a Level 1 nursery may be provided.

**Functional areas:**

The Obstetric Unit consists of the following functional areas:
- Reception and arrival area including provisions for visitors and administrative activities
- Inpatient areas for general mother care and for acute care (both antenatal and postnatal)
- Birthing areas
- Neonatal Nursery area – General Care Nursery area
- Shared support and staff areas including facilities that can be shared between zones or Units.
- The Obstetric Unit will require rapid access to Operating Unit for emergency Caesarean Section deliveries; the Operational Policy will determine the requirement for Operating facilities located within the Birthing Area.

RECEPTION AREA:

The reception is the receiving hub of the unit and should therefore ensure the security of the entire department through access control, duress alarm buttons as a minimum and baby tagging as a preferred option. Mothers, their supporters and members of the public will need to have good access to public phones and separate male/female toilet facilities, prayer rooms (a minimum of 1 prayer room per sex, per floor) and waiting areas. A separate waiting area for families should be provided too, preferably with a small play area for children. Considering the substantial volume of flowers and gifts delivered to the unit, secure holding space should be provided adjacent the reception.

The reception may be used for the registration of expectant mothers; alternatively this can occur within the maternity ambulatory care area. Good access from reception to the nursing administration offices and education areas is beneficial.

INPATIENT AREA:

The inpatient area shall cater for both antenatal and postnatal patients. Although the unit described under this section is based on 24 patient beds – preferably only single rooms, for acute care and mother care – the bed numbers and mix will ultimately be determined by specific service conditions such as patient demographics, operational policies, cultural issues etc.

Mother care areas shall be designed to suit mothers and babies who are well whereas the acute care area shall cater for antenatal patients, postnatal patients with complications or simply for mothers recovering from Caesarean sections.

Patient rooms shall be grouped together in zones corresponding to their different levels of dependency. The more relaxed environment of mother care rooms can be located further away from the staff observation posts and the support areas whereas the more clinical acute care rooms shall be located to allow for effective staff observation and ease of access from the support areas.

NURSERY AREA:
A Level 1 nursery (General Care) could be provided as a supplementary area to the maternity inpatient area, under a level 3 or 4 Obstetrics Unit. The general care nursery will provide for the general care of healthy babies, such as:

- Feeding the baby
- Bathing, changing and weighing the baby
- Allowing the baby to sleep during the day in blacked out conditions
- Provide education to staff and parents
- Phototherapy
- Short term care, including the provision of assisted ventilation, for babies who suffer from complications and while they are waiting to be transferred to a neonatal intensive care unit/facility.

SHARED SUPPORT AND STAFF AREA:

Like elsewhere in the facility, sharing space, equipment and staffing should be promoted, both within the unit and with other units. Within the unit sharing of staff stations, support and waiting areas should be possible between the different zones. Toilet facilities, prayer rooms and educational spaces could be shared with other units. Obviously, where spaces are shared, the size should be increased proportionally.

OPERATING ROOM/S AND SUPPORT FACILITIES

If provided within the Obstetric Unit, Operating Room and support rooms shall have:

- Operating Room to comply with Standard Components – Operating Room, General; provision should be made for twin baby resuscitation areas within the operating room
- Scrub-up/ Gowning Bay to comply with Standard Components Scrub-up/ Gowning, 6 m2
- Clean-up Room
- Two Patient Bed Bays for Recovery for each Operating Room, to comply with Standard Components Patient Bay, Recovery Stage 1.

The time taken to travel to the Operating Room from the Birthing area ideally should not exceed three minutes. An assessment of the distance between the Birthing area and the Operating Rooms should be done taking into consideration the average speed of travel and whether lifts are involved including any delays associated with lift travel.

Functional Relationships:

EXTERNAL:
The Obstetric Unit shall be located and designed to prohibit non-related traffic through the unit. When Birthing and Operating Rooms are in close proximity, access and service arrangements shall be such that neither staff nor patients need to travel through one area to reach the other.

It is highly desirable that, if an Intensive Care facility is to be provided for Obstetric use, it should be located as near as possible to the Obstetric Unit.

The unit should be in close proximity to:

- short term parking/drop off bay for dropping off expectant mothers
- hospital car parking and public transport access points
- ambulance transport parking bay
- helipad

INTERNAL:

The entrance to the unit shall provide direct access to the reception area. Adjacent reception separate waiting areas are required for males, females and families. From there, direct access to assessment/consultation/examination, nursery, inpatient and birthing areas shall be provided.

Direct access to a climate controlled internal garden or courtyard for mothers and their supporters would be beneficial.

**DESIGN OF AN OBSTETRICS AND GYNAECOLOGICAL NURSING**

**General:**

The Obstetric Unit shall be located and designed to prohibit non-related traffic through the unit. When Birthing and Operating Rooms are in close proximity, access and service arrangements shall be such that neither staff nor patients need to travel through one area to reach the other. It is highly desirable that, if an Intensive Care facility is to be provided for Obstetric use, then it be located as near as possible to the Obstetric Unit.

**Environmental Considerations:**

**NATURAL LIGHT**

Essential to all patient rooms (mothers and babies).

**PRIVACY**

Privacy is essential for both the assessment and birthing rooms. Avoid direct views into the room from the outside, both through the windows and through the door – i.e. do not provide viewing panels and a privacy curtain should be allowed for. Furthermore, the foot end of the bed should be facing away from the door or the access point.

**ACOUSTICS**
Within the nursery, sound absorption and insulation techniques should be applied to soften the noise created by crying babies and their support equipment. This however should not impede the quality of observation or ease of access between staff/support areas and the nursery.

Similar techniques should be applied to the birthing rooms, allowing mothers to give birth without disturbing other patients.

The unit in general should be isolated from disturbing sounds of traffic and sirens of ambulances, either through its strategic location or through applying sound absorption and insulation techniques.

**Safety and Security:**

The number of access points to the unit should be minimised. All entries should be under direct control of staff and while the daytime access is to be via the reception area, afterhours access should give direct access to the birthing area. As a minimum, this entry point should be fitted out with video intercom and remote access hardware, allowing for 24 hours access for expectant mothers, support persons of patients in the In-patient area or parents of neonates.

All entry points should also be controlled through an Access Control System – a combination of reed switches, electric strike/magnetic locks and card readers. Card readers should be provided on both sides of these entry points and these only should be deactivated in case of an emergency.

To increase the safety of newborns even further, the use of electronic tagging should be promoted. This involves a combination of the infant wearing a tag around the ankle and sensor panels located at every access point to the unit (and perhaps the entire hospital).

All reception areas and staff stations to have duress alarm buttons in obscure but easily accessible locations.

Where lifting devices are used for the baths within the birthing rooms, special attention should be given to the storage and handling of this equipment.

To ensure the correct milk is provided to the right infant, breast milk storage freezers and fridges should be lockable or located within a lockable formula room with access restricted to staff only or to mothers under staff supervision.

**Finishes:**
A homely, non-clinical ambience is preferred for the nursery and birthing rooms. Medical equipment and services should be easily accessible but concealed behind built in joinery or screens.

Colours should be chosen carefully to avoid an adverse impact on the skin colour of patients and neonates, particularly of jaundiced babies.

**Building Service Requirements:**

**LIGHTING**

All High Dependency Care areas such as birthing suites (including bathroom/ensuite), birthing/assessment rooms, nurseries and areas for the examination/resuscitation and bathing of babies are to have dimmable colour-corrected lighting.

**HVAC**

The birthing rooms and nurseries should be serviced by individual HVAC systems, allowing raising the temperature quickly to 25-27 degrees Celsius when a baby is born. The temperature control devices should be located within the room and should only be accessible to the staff.

**COMMUNICATIONS**

All new phone, data and staff/emergency call systems should be compatible with hospital wide systems already in use. Annunciator panels should be located in strategic points within the hospital circulation area and should be of the “non-scrolling” type, allowing all calls to be displayed at the same time. The audible signal of these call systems should be controllable to ensure minimal disturbance to patients at night.

**Infection Control:**

Each birthing room should have a scrub basin. Each patient room should have a hand basin. Each pair of isolation rooms should have a hand basin outside.

Each nursery should have a hand basin at the point of entry, both for staff and parents. Within the nursery, minimum 1 hand basin should be provided per 6 cots and the distance between any point in the nursery to the closest basin should not exceed 6 metres.

The placenta is to be treated as contaminated waste and should be disposed of according to the correct waste management policy. Disposal using placental macerators is not appropriate and should be avoided. Freezer storage should be provided within the unit to allow for collection by the family, for cultural reasons.
COMPONENTS OF THE OBSTETRICS AND GYNAECLOGICAL UNIT
**General:**

The Obstetric Unit will contain a combination of Standard Components and Non-Standard Components. Provide Standard Components to comply with details in the Standard Components described in these Guidelines. Refer also to Standard Components Room Data Sheets and Room Layout Sheets.

**Non Standard Components:**

**BATHING / EXAMINATION ROOM**

This room is primarily used to teach parents baby bathing techniques and to examine the infant. Provide purpose-built baby baths for occupational health and safety reasons. Portable baths or bassinets may be used for demonstration purposes, generally within the patient room.

*Location and Relationships*

The Bathing/ Examination room may be provided as part of a nursery or a maternity inpatient unit.

*Considerations*

The room will require:

- Bench with inbuilt baby bath; consideration should be given to the bench height and the mounting of baby baths to ensure ease of access for staff and mothers
- Warm water supply to baby baths and sinks; controlled temperature range
- Overhead heating to baby bathing area (in addition to air conditioning to prevent babies becoming cold)
- Storage space for baby linen
- Baby scales and measuring equipment
- Lighting level in the bathing/ exam area to permit the examination of baby skin tones

**STAFFING OF OBSTETRICS AND GYNAECOLOGICAL UNIT**
**DEFINITION**

Staffing is the systematic approach to the problem of selecting, training, motivating and retaining professional and non-professional personnel in any organization. It involves manpower planning to have the right person in the right place.

**PHILOSOPHY**

Components of the staffing process as a control system include a staffing study, a master staffing plan, a scheduling plan, and a nursing management information system.

**ELEMENTS**

- Quality of patient care to be delivered and its measurement.
- Characteristics and care requirements of patients.
- Prediction of the supply of nurse power required for components.
- Logistics of the staffing program pattern and its control.
- Evaluation of the quality of care desired, thereby measuring the success of the staffing itself.

**PHILOSOPHY OF STAFFING IN NURSING**

1. Nurse administrators of a hospital nursing department might adopt the following philosophy.
2. Nurse administrators believe that it is possible to match employee's knowledge and skills to patient care needs in a manner that optimizes job satisfaction and care quality.
3. Nurse administrators believe that the technical and humanistic care needs of critically ill patients are complex that all aspects of that care should be provided by professional nurses.
4. Nurse administrative believe that the health teaching and rehabilitation needs of chronically ill patients are so complex that direct care for chronically ill patients should be provided by professional and technical nurses.
5. Should believe that believe that patient assessment, work quantification and job analysis should be used to determine the number of personnel in each category to be assigned to care for patients of each type (such as coronary care, renal failure, etc.).
6. Should believe that a master staffing plan and policies to implement the plan in all units should be developed centrally by the nursing heads and staff of the hospital.
7. Should the staffing plan should be administrated at the unit level by the head nurse, so that can change based on unit workload and workflow.

**OBJECTIVES OF STAFFING IN NURSING**

A. Provide an all professional nurse staff in critical care units, operating rooms, labor, delivery unit, emergency room.
B. Provide sufficient staff to permit a 1:1 nurse-patient ratio for each shift in every critical care unit.
C. Staff the general medical, surgical, Obstetrics and gynaecology, paediatric and psychiatric units to achieve a 2:1 professional –practical nurse ratio.
D. Provide sufficient nursing staff in general medical, surgical, Obstetric, paediatric and psychiatric units to permit a 1:5 nurse-patient ratio on a day and after noon shifts and 1:10 nurse–patient ratio on the night shift.

NORMS OF STAFFING

Norms- Norms are standards that guide, control, and regulate individuals and communities. For planning nursing manpower we have to follow some norms. The nursing norms are recommended by various committees, such as; the Nursing Man Power Committee, the Highpower Committee, Dr. Bajaj Committee, and the staff inspection committee, TNAI and INC. The norms has been recommended taking into account the workload projected in the wards and the other areas of the hospital. All the above committees and the staff inspection unit recommended the norms for optimum nurse-patient ratio. Such as 1:3 for Non Teaching Hospital and 1:5 for the Teaching Hospital. The Staff Inspection Unit (S.I.U.) is the unit which has recommended the nursing norms in the year 1991-92. As per this S.I.U. norm the present nurse-patient ratio is based and practiced in all central government hospitals. Recommendations of S.I.U:

1. The norms for providing staff nurses and nursing sisters in Government hospital is given in annexure to this report. The norm has been recommended taking into account the workload projected in the wards and the other areas of the hospital.

2. The posts of nursing sisters and staff nurses have been clubbed together for calculating the staff entitlement for performing nursing care work which the staff nurse will continue to perform even after she is promoted to the existing scale of nursing sister.

3. Out of the entitlement worked out on the basis of the norms, 30% posts may be sanctioned as nursing sister. This would further improve the existing ratio of 1 nursing sister to 3.6 staff nurses fixed by the government in settlement with the Delhi nurse union in may 1990.

4. The assistant nursing superintendent are recommended in the ratio of 1 ANS to every 4.5 nursing sisters. The ANS will perform the duty presently performed by nursing sisters and perform duty in shift also.

5. The posts of Deputy Nursing Superintendent may continue at the level of 1 DNS per every 7.5 ANS

6. There will be a post of Nursing Superintendent for every hospital having 250 or beds.

7. There will be a post of 1 Chief Nursing Officer for every hospital having 500 or more beds.

8. It is recommended that 45% posts added for the area of 365 days working including 10% leave reserve (maternity leave, earned leave, and days off as nurses are entitled for 8 days off per month and 3 National Holidays per year when doing 3 shift duties).

Most of the hospital today is following the S.I.U.norms. In this the post of the Nursing Sisters and the Staff Nurses has been clubbed together and the work of the ward sister is remained same as staff nurse even after promotion. The Assistant Nursing Superintendent and the Deputy Nursing Superintendent have to do the duty of one category below of their rank.
DESCRIPTION OF MIDWIFERY, NURSING AND SUPPORT STAFF UTILISED WITHIN THE MATERNITY SERVICE

Specialist Roles:

- Safeguarding Vulnerable
- Perinatal Mental Health
- Infant feeding
- Antenatal and Newborn Screening
- Practice Development Midwife
- Risk Management
- Audit

Team Leaders:

- Antenatal Inpatients, DAU, Triage
- Labour Ward
- Postnatal Ward
- Antenatal Clinic
- Co-located Birthing Unit

Midwifery Managers:

- Head of Midwifery/Nursing
- Lead Midwife: Labour Ward and Birthing Unit, Inpatient Services
- Lead Midwife: Community, Standalones, ANC

Midwifery Roles:

It is recognised that, regardless of place of birth, midwives will provide care for women and their babies. Midwives work throughout all areas of the maternity service and rotate to all sites as part of their contract of employment.

Nurses and Staffing of Obstetric Theatres

- Nurses working at the main theatres, Obstetric Theatres and support midwives in providing care to women and their babies in the operative setting.
- Nurses provide a full theatre and recovery service for women who have had operative interventions either under regional or general anaesthetic in the Obstetric Theatres.
- Additionally midwives provide direct midwifery support and care in the obstetric theatre and recovery areas.
- There are no nurses employed within the postnatal area of the service

Support Workers

- The maternity service utilises maternity care assistants within the hospital setting, at the standalone midwifery-led units and within the community. Maternity care
assistants are available 24 hours a day within the hospital and work within the community.

- Maternity Care assistants also provide on call cover at the stand alone units in line with the lone worker policy
- Healthcare assistants are also employed within the hospital setting working 24 hours a day, 7 days a week supporting trained healthcare professionals.

Administrative Staff

- The maternity service is supported throughout by administrative assistants, personal assistants and ward clerks

Student Midwives and Return to Practice Midwives

The maternity service also offers clinical placements for student midwives and return to practice midwives.

Others

The care needs of women whilst pregnant can be diverse and demanding. The provision of the appropriate care to these women can only be provided when the staff caring for them has the appropriate skills.

Midwifery Supervision

- Provides an essential role within the Maternity Service. The supervision of midwives is a statutory responsibility that provides a mechanism for support and guidance to every midwife
- The role of the Supervisor of Midwives (SOM) is to protect the public and support midwifery practice by actively promoting safe standards of care.
- The ratio of supervisor to supervisee recommended by the Nursing and Midwifery Council (NMC) is no more than 15 midwives to 1 SOM.
- Within MEHT there has been a yearly increase over the last three years in the number of midwives being trained as SOMs and the current ratio is 1:17, with a further 2 student supervisors due to complete their training in early 2013. This will ensure ratios of 1:15 are met.

Required Staffing Levels for Midwifery and Support Staff within the Maternity Service

Midwives are the most senior professionals at the majority of all births and are the main providers of antenatal and postnatal care, minimum safe staffing levels of midwives and support workers are often difficult to calculate due the fluctuation of activity and patterns of care within the maternity service. Thus, appropriate staffing levels are calculated using the recommendations for overall levels within each part of the service, combined with the recommendations from Safer Childbirth which are inputted into a financial model for baseline funded staffing ratios for each ward area. This is then balanced against calculated
patterns of activity based on the birth rate and case mix of women using the service. These baseline funded staffing levels are reviewed as part of the annual audit of staffing within the service and adjusted accordingly in relation to the birth rate and changes in models of care. On the whole, determining staffing levels in both the acute and community settings is dependent on service design, the types of buildings and facilities being used, the geographical and demographic circumstances locally, the birth rate, case mix and associated activity generated, as well as the models of care and individual midwives capacity and capability.

**STAFFING FORMULA**

ONE METHOD FOR DETERMINING THE NURSING STAFF OF A HOSPITAL:

Example: analysis of how the days are used;

- Days in the year: 365
- Days off 1 day/week: 52
- Casual leave: 12
- Privilege leave: 30
- 1 Saturday/month: 12
- Public holidays: 18
- Sick leave: 8
- Total number working days: 132
- Total working days per year: 233

1. The average number of sick/maternity leave days taken can be obtained from administrative records.

Example: to show the amount of nursing time available in a hospital with 20 nurses and 100 patients i.e. ratio of 1:5

1 nurse = 233 working days per year

20 nurse = 233 x 20 = 4660 working days per year

To complete the number of nurses available per day, divided 4660 by the number of days in the year. 4660/365=12.8 rounded off to 13. If the 13 nurses, each work an eight-hour day, they may be assigned as follows.

Day shift 6
Evening shift  4
Night shift  3

13

**STAFFING IN HOSPITAL AND COMMUNITY SETTING:**

Staffing is of deep concerned to the nurse managers in the hospital or community to provide standard patient care to carry out all the functions allocated to the nursing personnel.

Factors affecting staffing in hospital and community

1. **Quality and quantity of nursing personnel**
   This factor depends upon appropriate education or training provided to the nursing personnel for the kind of service they are being prepared for, i.e. professional, skill, routine or ancilliary work. The nurse has to perform direct care, supervisory, teaching and administrative functions.

2. **Utilization**
   Utilization means that the nursing personnel must be assigned work in such a way that his/her knowledge and skill learnt are best used for the purpose he/she was educated or trained. In addition the nurse has to maintain a positive attitude towards nursing work and the people he/she serves. Many studies revealed that nurses are overladen with work, lack in supportive, stimulative, challenging or encouraging environment to work in.

3. **Patients condition**
   Acutely ill :- where the life saving is the priority or bed ridden is the condition which might require 8-10 hours per patient (HPD), the nurse patient ratio may be 1:1, 2:1, 3:1.
   Moderately ill :- requires to be assisted in meeting his human needs conducive to faster recovery and rehabilitation. The nurse patient ratio may be 1:3, 1:5
   Mild ill :- patient has minimum dependency as he is able to take care of himself for the most of biological needs. The nurse patient ratio may be 1:6, 1:10.

4. **Fluctuation of workload**
   The workload is never constant and varies on day to day.

5. **Number of medical staff**
   Staffing of nurses still become complicated with increase of medical staff especially consultants, more of eounds, diagnostic investigations, orders of the doctors and personality difference.

**Staffing in hospital**

a) Chief Nursing Officer 1 per 500 beds.
b) Nursing Superintendent 1 per 400 beds.
c) Deputy nursing superintendent 1:200 beds.
d) Assistant Nursing Superintendent. 1:100
f) Staff nurses for wards: 1:3.
g) For nurses OPD and Emergency etc. 1: 100 patients.
h) For Intensive Care Unit 1:1.
h) For operation Theatre, Labour room 1:25.

According to Levine 3.5 hours nursing are is required in 24 hrs(hours per patient per day HPD). HPD can be 8-10 hrs for acutely ill patients or it can be as low as 1-2 hours for ambulatory patients.

e.g. in a mixed ward of 30 patients, then the no. of nursing personnels required are
30 patients X 3.5 hrs = 105 hrs
If each nurse give 8 hrs of care daily then
105 hrs ÷ 8 = 13 nurses

**Staffing in community**

a) 1 ANM for 2500 population.
b) 1 ANM for 1500 population for hilly areas.
c) 1 Health Supervisor for 7500 population.
d) 1 Public Health Nurse For 1 PHC.
e) 1 Public Health Nursing Officer for 1CHC.
f) District Public Health Nursing Officers-2 for each district

**Staffing pattern according to the Indian Nursing Council (relaxed till 2012)**

**Collegiate programme-A**

Qualifications and experience of teachers of college of nursing-

1. Professor-cum-Principal
   - Masters Degree in Nursing
   - Total 10 years of experience with minimum of 5 years of teaching experience

2. Professor-cum- Vice Principal
   - Masters Degree in Nursing
   - Total 10 years of experience with minimum of 5 years in teaching

3. Reader/Associate Professor
   - Masters Degree in Nursing
   - Total 7 years of experience with minimum of 3 years in teaching

4. Lecturer
   - Masters Degree in Nursing with 3 years of experience.

5. Tutor/Clinical Instructor
   - M.Sc.(N) or B.Sc. (N) with 1 year experience or Basic B.Sc. (N) with post basic diploma in clinical specialty

**For B.Sc and M.Sc nursing:**

Annual intake of 60 students for B.Sc (N) and 25 for M.Sc (N) programme

<table>
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<tr>
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<th>B.Sc (N)</th>
<th>M.Sc (N)</th>
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<tr>
<td>Professor cum principal</td>
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<td></td>
</tr>
<tr>
<td>Professor cum vice principal</td>
<td>1</td>
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One in each speciality and all the M.Sc (N) qualified teaching faculty will participate in both programmes.

Teacher-student ratio = 1:10

**GNM and B.Sc. (N) with 60 annual intake in each programme**

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<th>Admission capacity</th>
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<td><strong>Annual intake</strong></td>
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<tr>
<td>Professor cum principal</td>
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<tr>
<td>Reader/Associate professor</td>
<td>1</td>
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<tr>
<td>Lecturer</td>
<td>2</td>
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<tr>
<td>Tutor/clinical instructor</td>
<td>19</td>
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<tr>
<td><strong>Total</strong></td>
<td>24</td>
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</table>

**Basic B.Sc (N)**

Teacher student ratio= 1:10 (All nursing faculty including Principal and Vice principal)

Two M.Sc (N) qualified teaching faculty to start college of nursing for proposed less than or equal to 60 students and 4 M.Sc (N) qualified teaching faculty for proposed 61 to 100 students and by fourth year they should have 5 and 7 M.Sc (N) qualified teaching faculty respectively, preferably with one in each specialty.

Part time teachers and external teachers:
1. Microbiology  
2. Bio-chemistry  
4. Bio-physic  
5. Psychology  
6. Nutrition  
7. English  
8. Computer  
9. Hindi/Any other language  
10. Any other- clinical discipliners  
11. Physical education

The above teachers should have post graduate qualification with teaching experience in respective area

**School of nursing-B**

Qualification of teaching staff-

<table>
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<th>No.</th>
<th>Position</th>
<th>Qualification</th>
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<tbody>
<tr>
<td>1</td>
<td>Professor cum principal</td>
<td>M.Sc. (N) with 3 years of teaching experience or B.Sc.(N) basic or post basic with 5 years of teaching experience.</td>
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<td>2</td>
<td>Professor cum vice principal</td>
<td>M.Sc. (N) or B.Sc. (N) (Basic)/Post basic with 3 years of teaching experience.</td>
</tr>
<tr>
<td>3</td>
<td>Tutor/clinical instructor</td>
<td>M.Sc. (N) or B.Sc. (N) (Basic) / Post basic or diploma in nursing education and Administration with two years of professional experience.</td>
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For School of nursing with 60 students i.e. an annual intake of 20 students:

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<tr>
<td>Principal</td>
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<tr>
<td>Vice-principal</td>
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<tr>
<td>Tutor</td>
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<tr>
<td>Additional tutor for interns</td>
<td>1</td>
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<td>Total</td>
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</table>
Obstetric Service Design and Equipment Criteria.

A. Renovation or construction of a hospital's obstetric unit shall be consistent with all health care facilities.
B. Delivery rooms, LDR/LDRP rooms and nurseries shall be equipped to provide emergency resuscitation for mothers and infants.
C. Equipment and supplies shall be assigned for exclusive use in the obstetric and newborn units.
D. The same equipment and supplies required for the labor room and delivery room shall be available for use in the LDR/LDRP rooms during periods of labor, delivery, and recovery.
E. Sterilizing equipment shall be available in the obstetric unit or in a central sterilizing department. Flash sterilizing equipment or sterile supplies and instruments shall be provided in the obstetric unit.
F. Daily monitoring is required of the stock of necessary equipment in the labor, delivery, and recovery rooms (LDR) and labor, delivery, recovery and postpartum (LDRP) rooms and nursery.
G. The hospital shall provide the following equipment in the labor, delivery and recovery rooms and, except where noted, in the LDR/LDRP rooms:

1. **Labor rooms**
   - A labor or birthing bed with adjustable side rails.
   - Adjustable lighting adequate for the examination of patients.
   - An emergency signal and intercommunication system.
   - A sphygmomanometer, stethoscope and fetoscope or doppler.
   - Fetal monitoring equipment with internal and external attachments.
   - Mechanical infusion equipment.
   - Wall-mounted oxygen and suction outlets.
   - Storage equipment.
   - Sterile equipment for emergency delivery to include at least one clamp and suction bulb.
   - Neonatal resuscitation cart.

2. **Delivery rooms**
   - A delivery room table that allows variation in positions for delivery. This equipment is not required for the LDR/LDRP rooms.
   - Adequate lighting for vaginal deliveries or cesarean deliveries.
   - Sterile instruments, equipment, and supplies to include sterile uterine packs for vaginal deliveries or cesarean deliveries, episiotomies or laceration repairs, postpartum sterilizations and cesarean hysterectomies.
   - Continuous in-wall oxygen source and suction outlets for both mother and infant.
   - Equipment for inhalation and regional anesthesia. This equipment is not required for LDR/LDRP rooms.
   - A heated, temperature-controlled infant examination and resuscitation unit.
   - An emergency call system.
   - Plastic pharyngeal airways, adult and newborn sizes.
   - Laryngoscope and endo tracheal tubes, adult and newborn sizes.
   - A self-inflating bag with manometer and adult and newborn masks that can deliver 100% oxygen.
   - Separate cardiopulmonary crash carts for mothers and infants.
   - Sphygmomanometer.
   - Cardiac monitor. This equipment is not required for the LDR/LDRP rooms.
   - Gavage tubes.
   - Umbilical vessel catheterization trays. This equipment is not required for LDR/LDRP rooms.
   - Equipment that provides a source of continuous suction for aspiration of the pharynx and stomach.
   - Stethoscope.
   - Fetoscope.
Intravenous solutions and equipment.
Wall clock with a second hand.
Heated bassinets equipped with oxygen and transport incubator.
Neonatal resuscitation cart.

3. Recovery rooms.
- Beds with side rails.
- Adequate lighting.
- Bedside stands, over bed tables, or fixed shelving.
- An emergency call signal.
- Equipment necessary for a complete physical examination.
- Accessible oxygen and suction equipment

GENERAL REQUIREMENTS FOR ALL OBSTETRIC DEPARTMENTS

a) The temperature and humidity in the nurseries and in the delivery suite shall be maintained at a level best suited for the protection of mothers and infants as recommended by the Guidelines for Perinatal Care. Chilling of the neonate shall be avoided; a non-stable neonate shall, immediately after birth, be placed in a radiant heat source that is ready to receive the infant and that allows access for resuscitation efforts. The radiant heat source shall comply with the recommendations of the Guidelines for Perinatal Care. When the neonate has been stabilized, if the mother wishes to hold her newborn, a radiant heater or pre-warmed blankets shall be available to keep the neonate warm. Stable infants shall be placed, and remain, in direct skin-to-skin contact with their mother immediately after delivery to optimally support infant breastfeeding and to promote mother/infant bonding. Personnel shall be available who are trained to use the equipment to maintain a neutral thermal environment for the neonate. For general temperature and humidity requirements, see Section 250.2480(d)(1). In general, a temperature between 72 degrees and 76 degrees and relative humidity between 35% and 60% are acceptable.

b) Linens and Laundry: Linens shall be cleaned and disinfected in compliance with the Guidelines for Perinatal Care.

1) Nursery linens shall be washed separately from other hospital linens.
2) No new unlaundered garments shall be used in the nursery.

c) Sterilizing equipment: Sterilizing equipment may be provided in the obstetric department or in a central sterilizing unit, provided that flash sterilizing equipment or adequate sterile supplies and instruments are provided in the obstetric department.

d) Accommodations and Facilities for Obstetric Patients

1. The hospital shall identify specific rooms and beds, adjacent when possible to other
a. Obstetric facilities, as obstetric rooms and beds. These rooms and beds shall be used exclusively for obstetric patients or for combined obstetric and clean gynecological service beds.

2. Patient rooms and beds that are adjacent to another nursing unit may be used for clean a. cases as part of the adjacent nursing unit. A corridor partition with doors is recommended to provide a separation between the obstetric beds and facilities and the non-obstetric rooms. The doors shall be kept closed except when in active use as a passageway.

3. Facilities shall be available for the immediate isolation of all patients in whom an infectious condition inimical to the safety of other obstetric and neonatal patients exist.

4. Labor rooms shall be convenient to the delivery rooms and shall have facilities for examination and preparation of patients. Each room used for labor, delivery and postpartum shall include a bathroom equipped with a toilet and a shower. The bathroom also shall include a sink, unless a sink is located in the patient room. The bathroom shall be directly accessible from the patient room without going through the corridor.

5. Delivery rooms shall be equipped and staffed to provide emergency resuscitation for infants pursuant to the recommendation of the American Academy of Pediatrics and ACOG and shall comply with the American Academy of Pediatrics/American Heart Association's American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) of Pediatric and Neonatal Patients: Neonatal Resuscitation Guidelines.

6. If only one delivery room is available and in use, one labor room shall be arranged as an emergency delivery room and shall have a minimum clear floor area of 180 square feet.

7. The patient shall be kept under close observation until her condition is stabilized following delivery. Observations at established time intervals shall be recorded in the patient's medical record. A recovery area shall be provided. Emergency equipment and supplies shall be available for use in the recovery area.

e) Accommodations and Facilities for Infants

1) Level I nurseries:

A. A clean nursery or nurseries shall be provided, near the mothers' rooms, with adequate lighting and ventilation. A minimum of 30 square feet of floor area for each bassinet and 3 feet between bassinets shall be provided. Equipment shall be provided to prevent direct draft on the infants. Individual nursery rooms shall have a capacity of six to eight neonates or 12 to 16 neonates. The normal newborn infant care area in a smaller hospital
shall limit room size to eight neonates, with a minimum of two rooms available to permit cohorting in the presence of infection.

B. Bassinets equipped to provide for the medical examination of the newborn infant and for the storage of necessary supplies and equipment shall be provided in a number to exceed obstetric beds by at least 20% to accommodate multiple births, extended stay, and fluctuating patient loads. Bassinets shall be separated by a minimum of 3 feet, measuring from the edge of one bassinet to the edge of the adjacent one.

C. A glass observation window shall be provided through which infants may be viewed.

D. Resuscitation equipment should be available in the nursery at all times.

E. Each nursery shall have necessary equipment immediately available to stabilize the Sick infant prior to transfer.

Equipment shall consist of:

- A heat source capable of maintaining the core temperature of even the smallest infant at 98 degrees (an incubator, or preferably a radiant heat source);
- ii) Equipment with the ability to monitor bedside blood sugar;
- iii) A resuscitation tray containing equipment pursuant to the American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) of Pediatric and Neonatal Patients: Neonatal Resuscitation Guidelines; and
- iv) Equipment for delivery of 100% oxygen concentration, and the ability to measure delivered oxygen in fractional inspired concentrations (FI O$_2$) pursuant to AAP recommendations. The oxygen analyzer shall be calibrated and serviced according to the manufacturer's instructions at least monthly by the hospital's respiratory therapy department or other responsible personnel trained to perform the task.

F) Consultation and Referral Protocols shall comply with the Regionalized Perinatal Health Care Code.

2) **Level II and Level III nurseries** shall comply with the Regionalized Perinatal Health Care Code. Cribs shall be separated by 4 to 6 feet to allow for ease of movement of additional personnel, and to allow space for additional equipment used in care of infants in these areas. New buildings or additions or material alterations to existing buildings that affect the Level II with Extended Neonatal Capabilities nursery shall provide at least 70 square feet of space for each infant.

- 2) A Level III nursery shall provide 80 to 100 square feet of space for each infant.
- 3) Facilities shall be available for the immediate isolation of all newborn infants who have or are suspected of having an infectious disease.
4) When an infectious condition exists or is suspected of existing, the infant shall be isolated in accordance with policies and procedures established and approved by the hospital and consistent with recommended procedures of the Guidelines for Perinatal Care and the Control of Communicable Diseases Code.

f) The personnel requirements and recommendations set forth in Subpart D apply to the operation of the obstetric department, in addition to the following:

Each hospital shall have a staffing plan for nursing personnel providing care for obstetric and neonatal patients.

i. Nursing supervision by a registered nurse shall be provided for the entire 24-hour period for each occupied unit of the obstetric and neonatal services. This nurse shall have education and experience in obstetric and neonatal nursing.

ii. At least one registered nurse trained in obstetric and nursery care shall be assigned to the care of mothers and infants at all times. To prepare for an unexpected delivery, at least one registered nurse or LPN trained to give care to newborn infants shall be assigned at all times to the nursery with duties restricted to the care of the infants. Infants shall never be left unattended.

iii. A registered nurse shall be in attendance at all deliveries and shall be available to monitor the mother's general condition and that of the fetus during labor, for at least two hours after delivery, and longer if complications occur.

iv. Nursing personnel providing care for obstetric and other patients shall be instructed on a continuing basis in the proper technique to prevent cross-infection. When it is necessary for the same nurse to care for both obstetric and non-obstetric patients in the gynecologic unit, proper technique shall be followed.

v. Obstetric and neonatal department nurses providing input to the hospital's nursing care committee.

Temporary relief from outside the obstetric and neonatal division by qualified personnel shall be permitted as necessary according to appropriate infection control policy.
INTRODUCTION

Infection control is the discipline concerned with preventing nosocomial or healthcare-associated infection, a practical (rather than academic) sub-discipline of epidemiology. It is an essential, though often under recognized and under supported, part of the infrastructure of health care. Infection control and hospital epidemiology are akin to public health practice, practiced within the confines of a particular health-care delivery system rather than directed at society as a whole.

Infection control addresses factors related to the spread of infections within the healthcare setting (whether patient-to-patient, from patients to staff and from staff to patients, or among-staff), including prevention (via hand hygiene/hand washing, cleaning/disinfection/sterilization, vaccination, surveillance), monitoring/investigation of demonstrated or suspected spread of infection within a particular health-care setting (surveillance and outbreak investigation), and management (interruption of outbreaks). It is on this basis that the common title being adopted within health care is "infection prevention and control."

OBJECTIVES

Management of health-care waste is an integral part of hospital hygiene and infection control. Health-care waste should be considered as a reservoir of pathogenic microorganisms, which can cause contamination and give rise to infection. If waste is inadequately managed, these microorganisms can be transmitted by direct contact, in the air, or by a variety of vectors. Infectious waste contributes in this way to the risk of nosocomial infections, putting the health of hospital personnel, and patients, at risk.

EPIDEMIOLOGY OF NOSOCOMIAL INFECTIONS

Nosocomial infections known also as hospital-acquired infections, hospital-associated infections, and hospital infections are infections that are not present in the patient at the time of admission to hospital but develop during the course of the stay in hospital. There are two forms:
Endogenous infection, self-infection, or auto-infection.
The causative agent of the infection is present in the patient at the time of admission to hospital but there are no signs of infection. The infection develops during the stay in hospital as a result of the patient have altered resistance.

Cross-contamination followed by cross-infection.
During the stay in hospital the patient comes into contact with new infective agents, becomes contaminated, and subsequently develops an infection.

While there is no clinically significant difference between the endogenous self-infection and the exogenous cross-infection, the distinction is important from the standpoint of epidemiology and prevention. Healthy people are naturally contaminated. Faeces contain about 10^13 bacteria per gram, and the number of microorganisms on skin varies between 100 and 10000 per cm². Many species of microorganisms live

HOSPITAL HYGIENE AND INFECTION CONTROL

Microorganisms that penetrate the skin or the mucous membrane barrier reach subcutaneous tissue, muscles, bones, and body cavities (e.g. peritoneal cavity, pleural cavity, bladder), which are normally sterile (i.e. contain no detectable organisms). If a general or local reaction to this contamination develops, with clinical symptoms, there is an infection.

THE TRANSITION FROM CONTAMINATION TO INFECTION

Whether or not a tissue will develop an infection after contamination depends upon the interaction between the contaminating organisms and the host. Healthy individuals have a normal general resistance to infection. Patients with underlying disease, newborn babies, and the elderly have less resistance and will probably develop an infection after contamination. Health-care workers are thus less likely to become infected than patients.

Local resistance of the tissue to infection also plays an important role: the skin and the mucous membranes act as barriers in contact with the environment. Infection may follow when these barriers are breached. Local resistance may also be overcome by the long-term presence of an irritant, such as a cannula or catheter; the likelihood of infection increases daily in a patient with an indwelling catheter. The most important determinants of infection, however, are the nature and number of the contaminating organisms. Microorganisms range from the completely innocuous to the extremely pathogenic: the former will never cause an infection, even in immune compromised individuals, while the latter will cause an infection in any case of contamination. A classification of conventional, conditional, and opportunistic pathogens.
When only a few organisms are present on or in a tissue, an infection will not necessarily develop. However, when a critical number is exceeded, it is very likely that the tissue will become infected. For every type of microorganism, the minimal infective dose can be determined; this is the lowest number of bacteria, viruses, or fungi that cause the first clinical signs of infection in a healthy individual. For most causative agents of nosocomial infections, the minimal infective dose is relatively high. For Klebsiella and Serratia spp. and other Enterobacteriaceae, for example, it is more than 100,000, but for hepatitis B virus it is less than 10.

THE SOURCES OF INFECTION

In a health-care facility, the sources of infection, and of the preceding contamination, may be the personnel, the patients, or the inanimate environment. The hospital environment can be contaminated with pathogens. Salmonella or Shigella spp., Escherichia coli, or other pathogens maybe present in the food and cause an outbreak of disease just as they can in a community outside the hospital. If the water distribution system breaks down, waterborne infections may develop.

THE ROUTES OF TRANSMISSION

Microorganisms can be transmitted from their source to a new host through direct or indirect contact, in the air, or by vectors. Vector-borne transmission is typical of countries in which insects, arthropods, and other parasites are widespread. These become contaminated by contact with excreta or secretions from an infected patient and transmit the infective organisms mechanically to other patients. Airborne transmission occurs only with microorganisms that are dispersed into the air and that are characterized by a low minimal infective dose. Only a few bacteria and viruses are present in expired air, and these are dispersed in large numbers only as a result of sneezing or coughing.

Direct contact between patients does not usually occur in health-care facilities, but an infected health-care worker can touch a patient and directly transmit a large number of microorganisms to the new host. The most frequent route of transmission, however, is indirect contact. The infected patient touches and contaminates an object, an instrument, or a surface. Subsequent contact between that item and another patient is likely to contaminate the second individual who may then develop an infection. During general care and/or medical treatment, the hands of health-care workers often come into close contact with patients. The hands of the clinical personnel are thus the most frequent vehicles for nosocomial infections. Transmission by this route is much more common than vector borne or air borne disease.
Aseptic technique is a key component of all invasive medical procedures. Similarly, infection control measures are most effective when Standard Precautions (health care) are applied because undiagnosed infection is common. Infections can be avoided by boosting our immune system with the help of antibacterial foods and herbs.

Hand hygiene

Independent studies by Ignaz Semmelweis in 1847 in Vienna and Oliver Wendell Holmes, Sr. in 1843 in Boston established a link between the hands of health care workers and the spread of hospital-acquired disease. The U.S. Centers for Disease Control and Prevention (CDC) state that “It is well documented that the most important measure for preventing the spread of pathogens is effective hand washing.” In the developed world, hand washing is mandatory in most health care settings and required by many different regulators.

In the United States, OSHA standards require that employers must provide readily accessible hand washing facilities, and must ensure that employees wash hands and any other skin with soap and water or flush mucous membranes with water as soon as feasible after contact with blood or other potentially infectious materials (OPIM).

DRYING

Drying is an essential part of the hand hygiene process. In November 2008, a non-peer-reviewed study was presented to the European Tissue Symposium by the University of Westminster, London, comparing the bacteria levels present after the use of paper towels, warm air hand dryers, and modern jet-air hand dryers. Of those three methods, only paper towels reduced the total number of bacteria on hands, with "through-air dried" towels the most effective.

The presenters also carried out tests to establish whether there was the potential for cross-contamination of other washroom users and the washroom environment as a result of each type of drying method. They found that:

- The jet air dryer, which blows air out of the unit at claimed speeds of 400 mph, was capable of blowing micro-organisms from the hands and the unit and potentially contaminating other washroom users and the washroom environment up to 2 metres away.
• Use of a warm air hand dryer spread micro-organisms up to 0.25 metres from the dryer

• Paper towels showed no significant spread of micro-organisms.

In 2005, in a study conducted by TUV Produkt und Umwelt, different hand drying methods were evaluated. The following changes in the bacterial count after drying the hands were observed:

<table>
<thead>
<tr>
<th>Drying method</th>
<th>Effect on bacterial count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper towels and roll</td>
<td>Decrease of 24%</td>
</tr>
<tr>
<td>Hot-air drier</td>
<td>Increase of 117%</td>
</tr>
</tbody>
</table>

**Sterilization**

Sterilization is a process intended to kill all microorganisms and is the highest level of microbial kill that is possible. Sterilizers may be heat only, steam, or liquid chemical. Effectiveness of the sterilizer (e.g., a steam autoclave) is determined in three ways. First, mechanical indicators and gauges on the machine itself indicate proper operation of the machine. Second, heat sensitive indicators or tape on the sterilizing bags change color which indicate proper levels of heat or steam. And, third (most importantly) is biological testing in which a microorganism that is highly heat and chemical resistant (often the bacterial endospore) is selected as the standard challenge. If the process kills this microorganism, the sterilizer is considered to be effective. It should be noted that in order to be effective, instruments must be cleaned; otherwise the debris may form a protective barrier, shielding the microbes from the lethal process. Similarly care must be taken after sterilization to ensure sterile instruments do not become contaminated prior to use.

Sterilization, if performed properly, is an effective way of preventing bacteria from spreading. It should be used for the cleaning of the medical instruments or gloves, and basically any type of medical item that comes into contact with the bloodstream and sterile tissues.
There are four main ways in which such items can be sterilized: *autoclave* (by using high-pressure *steam*), dry *heat* (in an oven), by using chemical sterilants such as glutaraldehydes or *formaldehyde* solutions or by *radiation*.

The first two are the most used methods of sterilizations mainly because of their accessibility and availability. Steam sterilization is one of the most effective types of sterilizations, if done correctly which is often hard to achieve. Instruments that are used in *health care facilities* are usually sterilized with this method. The general rule in this case is that in order to perform an effective sterilization, the steam must get into contact with all the surfaces that are meant to be disinfected. On the other hand, dry heat sterilization, which is performed with the help of an oven, is also an accessible type of sterilization, although it can only be used to disinfect instruments that are made of *metal* or *glass*. The very high temperatures needed to perform sterilization in this way are able to melt the instruments that are not made of glass or metal.

Steam sterilization is done at a temperature of 121 C (250 F) with a pressure of 106 k Pa (15 lbs/in2). In these conditions, unwrapped items must be sterilized for 20 minutes, and wrapped items for 30 minutes. The time is counted once the temperature that is needed has been reached. Steam sterilization requires four conditions in order to be efficient: adequate contact, sufficiently high temperature, correct time and sufficient *moisture*. Sterilization using steam can also be done at a temperature of 132 C (270 F), at a double pressure. Dry heat sterilization is performed at 170 C (340 F) for one hour or two hours at a temperature of 160 C (320 F). Dry heat sterilization can also be performed at 121 C, for at least 16 hours. [1]

Chemical sterilization, also referred to as cold sterilization, can be used to sterilize instruments that cannot normally be disinfected through the other two processes described above. The items sterilized with cold sterilization are usually those that can be damaged by regular sterilization. Commonly, glutaraldehydes and formaldehyde are used in this process, but in different ways. When using the first type of disinfectant, the instruments are soaked in a 2-4% solution for at least 10 hours while a solution of 8% formaldehyde will sterilize the items in 24 hours or more. Chemical sterilization is generally more expensive than steam sterilization and therefore it is used for instruments that cannot be disinfected otherwise. After the instruments have been soaked in the chemical solutions, they are mandatory to be rinsed with sterile water which will remove the residues from the *disinfectants*. This is the reason why *needles* and *syringes* are not sterilized in this way, as the residues left by the chemical...
solution that has been used to disinfect them cannot be washed off with water and they may interfere with the administered treatment. Although formaldehyde is less expensive than glutaraldehydes, it is also more irritating to the eyes, skin and respiratory tract and is classified as a potential carcinogen.

Other sterilization methods exist, though their efficiency is still controversial. These methods include gas, UV, gas plasma, and chemical sterilization with agents such as peroxyacetic acid or paraformaldehyde.

**CLEANING**

Infections can be prevented from occurring in homes as well. In order to reduce their chances to contract an infection, individuals are recommended to maintain a good hygiene by washing their hands after every contact with questionable areas or bodily fluids and by disposing of garbage at regular intervals to prevent germs from growing.

**DISINFECTION**

Disinfection uses liquid chemicals on surfaces and at room temperature to kill disease causing microorganisms. Ultraviolet light has also been used to disinfect the rooms of patients infected with *Clostridium difficile* after discharge. Disinfection is less effective than sterilization because it does not kill bacterial endospores.

**PERSONAL PROTECTIVE EQUIPMENT**

**DISPOSABLE PPE**

*Personal protective equipment (PPE)* is specialized clothing or equipment worn by a worker for protection against a hazard. The hazard in a health care setting is exposure to blood, saliva, or other bodily fluids or aerosols that may carry infectious materials such as *Hepatitis C*, HIV, or other blood borne or bodily fluid pathogen. PPE prevents contact with a potentially infectious material by creating a physical barrier between the potential infectious material and the healthcare worker.

The United States Occupational Safety and Health Administration (OSHA) requires the use of *Personal protective equipment (PPE)* by workers to guard against blood borne pathogens if there is a reasonably anticipated exposure to blood or other potentially infectious materials.
Components of PPE include gloves, gowns, bonnets, shoe covers, face shields, CPR masks, goggles, surgical masks, and respirators. How many components are used and how the components are used is often determined by regulations or the infection control protocol of the facility in question. Many or most of these items are disposable to avoid carrying infectious materials from one patient to another patient and to avoid difficult or costly disinfection. In the US, OSHA requires the immediate removal and disinfection or disposal of a worker's PPE prior to leaving the work area where exposure to infectious material took place.

ANTIMICROBIAL SURFACES

Microorganisms are known to survive on non-antimicrobial in animate ‘touch’ surfaces (e.g., bedrails, over-the-bed trays, call buttons, bathroom hardware, etc.) for extended periods of time. This can be especially troublesome in hospital environments where patients with immuno deficiencies are at enhanced risk for contracting nosocomial infections.

Antimicrobial copper-alloy touch surfaces

Products made with antimicrobial copper alloy (brasses, bronzes, cupronickel, copper-nickel-zinc, and others) surfaces destroy a wide range of microorganisms in a short period of time. The United States Environmental Protection Agency has approved the registration of 355 different antimicrobial copper alloys and one synthetic copper-infused hard surface that kill E.coli O157:H7, methicillin-resistant Staphylococcus aureus (MRSA), Staphylococcus, Enterobacter aerogenes, and Pseudomonas aeruginosa in less than 2 hours of contact. Other investigations have demonstrated the efficacy of antimicrobial copper alloys to destroy Clostridium difficile, influenza A virus, adenovirus, and fungi. Antimicrobial copper alloys are being installed in healthcare facilities in the U.K., Ireland, Japan, Korea, France, Denmark, and Brazil. The synthetic hard surface is being installed in the United States as well as in Israel.

VACCINATION OF HEALTH CARE WORKERS

Health care workers may be exposed to certain infections in the course of their work. Vaccines are available to provide some protection to workers in a healthcare setting. Depending on regulation, recommendation, the specific work function, or personal preference, healthcare workers or first responders may receive vaccinations for hepatitis.
Influenza; measles, mumps and rubella; Tetanus, diphtheria, pertussis; N. meningitidis; and varicella. In general, vaccines do not guarantee complete protection from disease, and there is potential for adverse effects from receiving the vaccine.

**POST-EXPOSURE PROPHYLAXIS**

In some cases where vaccines do not exist, post-exposure prophylaxis is another method of protecting the health care worker exposed to a life-threatening infectious disease. For example, the viral particles for HIV-AIDS can be precipitated out of the blood through the use of an antibody injection if given within four hours of a significant exposure.

**SURVEILLANCE FOR INFECTIONS**

Surveillance is the act of infection investigation using the CDC definitions. Determining the presence of a hospital acquired infection requires an infection control practitioner (ICP) to review a patient's chart and see if the patient had the signs and symptom of an infection. Surveillance definitions exist for infections of the bloodstream, urinary tract, pneumonia, surgical sites and gastroenteritis.

Surveillance traditionally involved significant manual data assessment and entry in order to assess preventative actions such as isolation of patients with an infectious disease. Increasingly, computerized software solutions are becoming available that assess incoming risk messages from microbiology and other online sources. By reducing the need for data entry, software can reduce the data workload of ICPs, freeing them to concentrate on clinical surveillance.

As of 1998, approximately one third of healthcare acquired infections were preventable. Surveillance and preventative activities are increasingly a priority for hospital staff. The Study on the Efficacy of Nosocomial Infection Control (SENIC) project by the U.S. CDC found in the 1970s that hospitals reduced their nosocomial infection rates by approximately 32 per cent by focusing on surveillance activities and prevention efforts.

**ISOLATION**

In the health care context, isolation refers to various physical measures taken to interrupt nosocomial spread of contagious diseases. Various forms of isolation exist, and are applied depending on the type of infection and agent involved, to address the likelihood of spread via airborne particles or droplets, by direct skin contact, or via contact with body fluid.
ESSENTIALS OF THE STANDARD PRECAUTIONS TO BE USED IN THE CARE OF ALL PATIENTS

A. Hand washing
• Wash hands after touching blood, secretions, excretions and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between patient contacts.
• Use a plain soap for routine hand washing.
• Use an antimicrobial agent for specific circumstances.

B. Gloves
• Wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin.

C. Mask, eye protection, face shield
• Wear a mask and eye protection or a face shield during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

D. Gown
• Wear a gown during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.

E. Patient-care equipment
• Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately.

F. Environmental control
• Ensure that the hospital has adequate procedures for the routine care, cleaning, and disinfection of environmental surfaces.

G. Linen
• Handle used linen, soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, and that avoids transfer of microorganisms to other patients and environments.

H. Occupational health and blood borne pathogens
• Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices.
• Use ventilation devices as an alternative to mouth-to-mouth resuscitation methods.

I. Place of care of the patient
• Place a patient who contaminates the environment or who does not assist in maintaining appropriate hygiene in an isolated (or separate) room.

J. Environmental cleaning
• Use adequate procedures for the routine cleaning and disinfection of environmental and other frequently touched surfaces.

K. Waste disposal
• Ensure safe waste management.
• Treat waste contaminated with blood, body fluids, secretions and excretions as clinical waste, in accordance with local regulations.
• Human tissues and laboratory waste that is directly associated with specimen processing should also be treated as clinical waste.
• Discard single use items properly

QUALITY ASSURANCE IN NURSING

INTRODUCTION:
Health care quality is in the eye of the beholder. In this, the primary goal is to secure the health care. It refers to the actual delivery of care from the point of patients first signaling a desire to be considered for potential treatment.

**DEFINITION-**

Quality assurance is a programme adopted by an institution that is designed to promote the best possible care. (Delaughery)

Quality assurance is the process of achieving excellence in the service rendered to every client.

“Quality assurance is a process in which achievable and describable levels of quality are described, the extent to which there level are achieved is measured, and action to enable them to be reached is taken.”

**PRINCIPLES OF QUALITY ASSURANCE**

Managers need to be committed to quality management. All employees must be involved in quality improvement. The goal of quality management is to provide a system in which workers can function effectively. The focus quality management is on improving the system. Every agency has internal and external customers. Customers define quality. Decision must be based on facts.

**GOALS OF QUALITY ASSURANCE**

- Evidenced of nursing accountability for services rendered and compliances with standard of practice.
- A defined mechanism to identify, measures and resolves, clinical issues related to practice.
- A defined mechanism of evaluating quality indicators, collecting data, developing corrective action and accessing outcomes.

**COMPONENTS OF QUALITY ASSURANCE PLAN**

- Documented quality system
- Organization
- Review of quality system operation
- Planning
- Work instruction
- Records
Corrective action
Control of design activities
Documentation and change control
Control of inspection, measuring and test equipment
Control of purchased material
Purchaser supplied material
Completed item inspection and test
Sampling procedure
Control of non conforming material
Indication of inspection status
Protection and preservation of product quality
Training

FACTORS INFLUENCING QUALITY MANAGEMENT

- Good organization structure/function
- Good quality staff
- Continuing professional development
- Continuing structure/functional performance evaluation
- Learning from failures and moving from low quality to high quality organization

GUIDELINES FOR QUALITY CONTROL

1. Quality improvement must not be a fad; it must be a long term continuous effort. There are always opportunities for improvement
2. While top management commitment is of vital importance, everybody in an organization, from top to bottom, must be committed to quality
3. Most quality problems requires the co-operation and co-ordination of many functional departments, production design testing, engineering, manufacturing, marketing and so on
4. Ideas and suggestions for quality improvement can come from many, often unexpected, sources.
5. Quality control should be done at crucial steps in the operation process
6. A quality improvement plan is not enough. Provision must make for its implementation.

IMPLEMENTATION OF QUALITY ASSURANCE IN NURSING

Quality improvement is the commitment and approach used to continuously improve every process in every part of an organization, with the intent of making and exceeding customer expectations and outcomes.

A. POLICY AND PLANNING
1. Involvement of nurses and midwives in health policy formulation and programme planning.
2. Strategic planning for nursing and midwifery workforce management has an integral part of human resource planning and health system development.

B. EDUCATION TRAINING AND DEVELOPMENT
- Coordination between education and service
- Student recruitment
- Competency-based education
- Multidisciplinary education
- Life-long learning culture
- Continuing education system

C. DEVELOPMENT AND UTILIZATION
- Appropriate skill mix and competencies
- Relevant nursing and midwifery infrastructure
- Effective leadership and management
- Good working conditions and efficiently organized work
- Technical supervision system
- Career advancement opportunities
- Incentive system
- Job satisfaction

D. REGULATIONS

The enforcement of regulations for nurses/midwives is uneven across the region despite the extensive evidence based now available on the impact of strengthen regulations, and best practice approaches to regulations.

E. EVIDENCE BASED DECISION MAKING

The information system available in the countries of the regions is limited. The shortage of nurses and midwives to some extent is one of the causes of inequity in health of the population in the region. The weakness in all components of the workforce management mentioned above how contributed to this problem.

APPROACHES TO QUALITY ASSURANCE

Methods for measuring performance:

As nursing care is delivered within a frame work of independent relationships with physicians and a multiplicity of other health care personnel. The most commonly used methods of nursing care are task analysis and quality control.
Measuring actual performance:

It is an ongoing repetitive process with the actual frequency dependant on the type of activity being measured. It is better to clarify the purpose of the measurement and to measure performance on a continuous basis.

Comparing results of performance with standards and objectives and identifying strengths and areas for correction:

- The standards and objectives and methods of measurement have been set, if performance matches standards and objectives, managers may assume that things are under control if performance is a contrary to standards and objectives, action is necessary.
- Acting to reinforce strengths or success and taking corrective action as necessary:
- Positive aspects needed to be identified in order that they may be translated into encouragement and motivation for the nursing members involved in achieving them.

FACTORS AFFECTING QUALITY ASSURANCE IN NURSING CARE

1. Lack of resources: Insufficient resources, infrastructure, equipment, money for recurring expenses and staff make it impossible for output of a certain quality.
2. Personnel problem: Lack of trained, skilled and motivated employees, staff in discipline etc. affects the quality of care.
3. Unreasonable patients and attendants: Illness, anxiety absence of immediate response to treatment, unreasonable and unco-operative attitude which in turn affects the quality care.
4. Improper maintenance: Building equipment requires proper, maintenance for efficient use.
5. Absence of well-informed populace: To improve quality nursing care, it is necessary that the people become knowledgeable and assert their rights to quality care.
6. Absence of accreditation laws: There is no organization strictly empowered legislation to lay down standards for nursing & medical care so as to regulate the quality of care.
7. Inspect hospitals and ensure that basic requirements are met: Enquire into major incidence of negligence and take action against health professional involved in malpractices.
8. Lack of incident review procedures: During a patient’s hospitalization several incidents may occur which have a bearing on the treatment and the patient’s final recovery.
10. Lack of good hospital information system: A good management information system is essential for the appraisal of quality care.
11. Absence of conducting patient satisfaction surveys: Surveys to be carried out through questionnaires, interviews etc. by social worker, hospital management trainees and consultant groups.
12. Lack of nursing care records: Nurses should use the problem oriented record system or use nursing process while recording the care given.
13. Miscellaneous: Lack of good supervision absence of knowledge about the philosophy of nursing care, lack of policy & administrative manual lack of procedure manual, substandard education and training, inadequate quality and number of professionals, lack of evaluation techniques, lack of co-ordination between and within departments, lack of written job descriptions and job specifications, lack of in service and continuing educational programmes.

DEVELOPMENT OF A QUALITY ASSURANCE PROGRAM

This programme is a carefully planned, phased process, or it may be implemented in one step as part of a fundamental organizational change.

Foster Commitment o Quality:

This process must continue throughout the life of a project and at all levels of the organization. Commitment can be done through awareness- raising seminars, special planning meetings, or one-to- one discussion with an organizations leader

Conduct a Preliminary Review of Quality- Related Activities:-

It is important to conduct an initial review of the organization and to develop a general description of the existing system.

Develop the Purpose and Vision for the Quality Assurance Effort:

Purpose is to build consensus between managers and to set boundaries for the quality assurance effort. The vision will help the staff to understand how their day-to day wok relates to quality improvement.

Determine level and scope of initial Quality Assurance Activities:
It depend on the resources available, the implementation time frame and the receptivity of management and program staff to the idea of quality assurance. The effort can be implemented at national, regional and district level or within a single health facility.

**Assign responsibility for Quality Assurance:**

An Existing committee or management body will take on responsibility for quality assurance, integrating it into the general management structure.

**Allocate resources for quality assurance**

Local resources must be allocated to quality assurance programme to become a permanent part of a health care organization. It may depend on outside technical and financial assistance.

**Develop a written quality Assurance plan**

This plan is a written document that describes the programme objectives and scope, defines lines of responsibility and authority, and puts forth implementation strategies. The plan help the staffs to relate quality, goals and objectives to their routine activities.

**Critical Management System:**

Quality assurance efforts will focus three critical management system: Supervision, training and management information systems.

**Disseminate Quality Assurance Experience:**

Dissemination strategy should be devised to share experience inside and outside the organization. Conferences which conduct at local, regional, national & international level will reinforce success encourage dialogue and creativity.

**Manage Change:**

A careful, phased approach to change is required and an open and trusting environment must be cultivated.

**ELEMENTS OF QUALITY**
 ROLE OF A NURSE

A nursing administrator has to develop a formalized quality programme.

1. Review organizational, personnel and environment.
2. Focus on standards of nursing care and methods of delivering nursing care.
3. Focus on the outcome of care

STANDARDS IN MIDWIFERY PRACTICE

Midwifery practice as conducted by certified nurse-midwives (CNMs) and certified midwives (CMs) is the independent management of women's health care, focusing particularly on pregnancy, childbirth, the post partum period, care of the newborn, and the family planning and gynecologic needs of women. The CNM and CM practice within a health care system that provides for consultation, collaborative management, or referral, as indicated by the health status of the client. CNMs and CMs practice in accord with the Standards for the Practice of Midwifery, as defined by the American College of Nurse-Midwives (ACNM).

Purposes of standards

- To give direction and provide guidelines for performance of nursing care
- To provide a baseline for evaluating quality of nursing care, ranging from excellent care to unsafe care
- To help to improve quality of nursing care, increase effectiveness of care and improve efficiency
- To improve documentation of nursing care provided
- Help to determine the degree to which standards of nursing care should be maintained and take necessary action time
- To help supervisors to guide nursing staff to improve performance
- To help to improve the decision making and device alternative system for delivering nursing care
- It may help justify demands for resources association or improvement
- To help to clarify nurses area of accountability
- To help to decrease the costs of nursing care of eliminating non essential nursing tasks
- Motivate nurses to achieve excellence

**USES AND ADVANTAGES OF STANDARDS**

- They improve efficiency and lead to better utilization of resources
- They improve staff utilization and staff motivation
- They can be used to assess the practical aspects of both basic and post basic education and training
- They demonstrate quality provision and act as a benchmark to monitor quality performance

**APPROACHES**

1. Centralized approach/national approach
2. Decentralized or local approach
3. Combined approach
   1) Centralized approach/national approach

   It relies on the centre taking a lead, making all the decisions and initiating all the activities. For this approach to be effective there should be an effective management system

2) Decentralized or local approach

   This approach is when the centre takes the leading making the policy decisions to use midwifery standards, as a major component of quality assurance

3) Combined approach

   The central and the national level remains responsible for the over all implementation of the midwifery standards; but uses local demonstration sites to try them out, to learn lessons on how they can be implemented elsewhere, and what adaptations are required to meet them specific to the country situations

**STANDARDS DEVELOPMENT CYCLE**

Step 1 : define and agree

Step 2: select who should be involved

Step 3: gather information

Step 4: draft standards
Step 5: test the standards

Step 6: communicate the standards

- Implementation of standards
- Monitor compliance on structure standards and process standards

STANDARDS FOR THE PRACTICE OF MIDWIFERY

STANDARD I

MIDWIFERY CARE IS PROVIDED BY QUALIFIED PRACTITIONERS The midwife:

1. Is certified by the ACNM designated certifying agent.
2. Shows evidence of continuing competency as required by the ACNM designated certifying agent.
3. Is in compliance with the legal requirements of the jurisdiction where the midwifery practice occurs.

STANDARD II

MIDWIFERY CARE OCCURS IN A SAFE ENVIRONMENT WITHIN THE CONTEXT OF THE FAMILY, COMMUNITY, AND A SYSTEM OF HEALTH CARE. The midwife:

1. Demonstrates knowledge of and utilizes federal and state regulations that apply to the practice environment and infection control.
2. Demonstrates a safe mechanism for obtaining medical consultation, collaboration, and referral.
3. Uses community services as needed.
4. Demonstrates knowledge of the medical, psychosocial, economic, cultural, and family factors that affect care.
5. Demonstrates appropriate techniques for emergency management including arrangements for emergency transportation.
6. Promotes involvement of support persons in the practice setting.
STANDARD III

MIDWIFERY CARE SUPPORTS INDIVIDUAL RIGHTS AND SELF-DETERMINATION WITHIN BOUNDARIES OF SAFETY The midwife:

2. Provides clients with a description of the scope of midwifery services and information regarding the client's rights and responsibilities.
3. Provides clients with information regarding, and/or referral to, other providers and services when requested or when care required is not within the midwife's scope of practice.
4. Provides clients with information regarding health care decisions and the state of the science regarding these choices to allow for informed decision-making.

STANDARD IV

MIDWIFERY CARE IS COMPRISED OF KNOWLEDGE, SKILLS, AND JUDGMENTS THAT FOSTER THE DELIVERY OF SAFE, SATISFYING, AND CULTURALLY COMPETENT CARE. The midwife:

1. Collects and assesses client care data, develops and implements an individualized plan of management, and evaluates outcome of care.
2. Demonstrates the clinical skills and judgments described in the ACNM Core Competencies for Basic Midwifery Practice.
3. Practices in accord with the ACNM Standards for the Practice of Midwifery.
4. Practices in accord with service/practice guidelines that meet the requirements of the particular institution or practice setting.

STANDARD V

MIDWIFERY CARE IS BASED UPON KNOWLEDGE, SKILLS, AND JUDGMENTS WHICH ARE REFLECTED IN WRITTEN PRACTICE GUIDELINES AND ARE USED TO GUIDE THE SCOPE OF MIDWIFERY CARE AND SERVICES PROVIDED TO CLIENTS. The midwife:

1. Maintains written documentation of the parameters of service for independent and collaborative midwifery management and transfer of care when needed.
STANDARD VI

MIDWIFERY CARE IS DOCUMENTED IN A FORMAT THAT IS ACCESSIBLE AND COMPLETE. The midwife:

1. Uses records that facilitate communication of information to clients, consultants, and institutions.
2. Provides prompt and complete documentation of evaluation, course of management, and outcome of care.
3. Promotes a documentation system that provides for confidentiality and transmissibility of health records.
4. Maintains confidentiality in verbal and written communications.

STANDARD VII

MIDWIFERY CARE IS EVALUATED ACCORDING TO AN ESTABLISHED PROGRAM FOR QUALITY MANAGEMENT THAT INCLUDES A PLAN TO IDENTIFY AND RESOLVE PROBLEMS. The midwife:

1. Participates in a program of quality management for the evaluation of practice within the setting in which it occurs.
2. Provides for a systematic collection of practice data as part of a program of quality management.
3. Seeks consultation to review problems, including peer review of care.
4. Acts to resolve problems identified.

STANDARD VIII

MIDWIFERY PRACTICE MAY BE EXPANDED BEYOND THE ACNM CORE COMPETENCIES TO INCORPORATE NEW PROCEDURES THAT IMPROVE CARE FOR WOMEN AND THEIR FAMILIES. The midwife:

1. Identifies the need for a new procedure taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensures that there are no institutional, state, or federal statutes, regulations, or bylaws that would constrain the midwife from incorporation of the procedure into practice.
4. Identifies a mechanism for obtaining medical consultation, collaboration, and referral related to this procedure.

5. Maintains documentation of the process used to achieve the necessary knowledge, skills and ongoing competency of the expanded or new procedures.

PRINCIPLES OF NURSING PRACTICE

The Practice Standards for Midwives are clearly aligned with the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives 2014

The Five Principles of the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives 2014

Principle 1 Respect for the Dignity of the Person
Principle 2 Professional Responsibility and Accountability
Principle 3 Quality of Practice
Principle 4 Trust and Confidentiality
Principle 5 Collaboration with Others

STANDARDS FOR NURSING PRACTICE

Principle 1 Respect for the Dignity of the Person

Practice Standard 1:
Midwifery practice is underpinned by a philosophy that protects and promotes the safety and autonomy of the woman and respects her experiences, choices, priorities, beliefs and values.

Practice Standard 2:
Midwives practice in line with legislation and professional guidance and are responsible and accountable within their scope of midwifery practice. This encompasses the full range of activities of the midwife as set out in EC Directive 2005/36/EC and the adapted Definition of the Midwife International Confederation of Midwives 2011 (ICM) as adopted by the NMBI.

Practice Standard 3:
Midwives use comprehensive professional knowledge and skills to provide safe, competent, kind, compassionate and respectful care. Midwives keep up to date with midwifery practice by undertaking relevant continuing professional development.

Practice Standard 4:
Midwives work in equal partnership with the woman and her family and establish a relationship of trust and confidentiality.

Principle 5 Collaboration with Others

**Practice Standard 5:**

Midwives communicate and collaborate effectively with women, women’s families and with the multidisciplinary healthcare team.

**EXAMPLE OF ANTENATAL CARE STANDARD**

**Abdominal palpation**

**Aim:** to estimate gestational age, monitor fetal growth and accurately identify lie, presentation and position of the fetus
AUDIT IN OBSTETRICS

Audit is defined as the systematic and critical analysis of the quality of medical care.

NURSING AUDIT

It is a means by which nurses they can define standards from their point of view and describe the actual practice of nursing.

OBJECTIVE

Objective of carrying out an audit is to improve the quality of clinical care. It is done by changing and strengthening many aspects of hospital, practice and administration.

Audit could be medical where scrutiny is done over the work done by all health professionals including the doctors.

STRUCTURING AN AUDIT

Important aspect to organize an obstetric audit is motivation of all doctors, midwives and other health professionals. Proper documentation of facts and figures must be there. Audit should be kept confidential and is considered as an educational tool.

WHEN TO AUDIT

The audit should be done 3-6 months or 12 months after commencement; then

- At regular interval such as annually
- Or immediately when a major incident or problem occurs, or
- As soon as feasible when there is a complaint is raised by the community about the quality services
- When a new intervention related to the standard is implemented such as the use of some new technology or treatment or drug

HOW TO CONDUCT AUDIT

Audit should be pre arranged with the midwifery trained personnel. The auditor should go to the field/ unit where the midwifery trained personnel is working to observe the standard in practice in the local situation. This should be done over 2-3 days so that the auditor can observe the midwifery trained personnel in different situations.

Importance of carrying out an audit:

1. A well structured and efficient audit is based on scientific evidences with facts and figures
2. It can replace the out of date clinical practice with the better one
3. It can remove the disbelieving and diagnostic attitudes between hospital management and professionals and also amongst the professionals
4. It improves awareness between doctors and patients
5. It is an efficient educational tool
USE OF AUDIT RESULTS

After conducting the audit and depending up on the result, the decision will be made either to

- Continue with the standard since it is working effectively
- Take further specific action to strengthen the standard or correct deficiencies
- Revise the standard

LIMITATIONS

Unless the audit is simple one it requires lot of time staff commitment and technology

CLINICAL AUDIT

Clinical audit is about improving a better service for consumers. Practitioners are expected to measure and demonstrate the effectiveness of the care they provide and one way of assessing practice by clinical audit

Clinical audit is a continues process that involves identifying an area to be examined the collection of appropriate data and the introduction of changes in practice as a result of analysis of the data

Process of clinical audit

When embarking on a process of clinical audit for the first time, it is better to concentration on a small area of study, and one that is amenable to change. It is extremely important to define objectives at the start of any process of audit and how the results of the process might be used to influence practice

Example of audit checklist

- Evaluation of procedure on bed bath
- Date of evaluation
- Name of the patient
- Hospital number
- Date of admission
- Name of the student nurse

Fundamental steps in admission procedure

- Preparing the patients unit
- Explanation to the patient
- Action of bed bath
- Comfortable position to the patient
- Termination of the articles
- Recording and reporting

OBSERVATION CHECKLIST ON ADMISSION PROCEDURE
<table>
<thead>
<tr>
<th>SI NO</th>
<th>Area of observation</th>
<th>Done (1)</th>
<th>Not done (0)</th>
<th>remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preparation of patient unit articles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Wash basin with warm water</td>
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<tr>
<td></td>
<td>• Soap</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Wash cloth</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Towel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patients cloth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Explanation to the patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Explain the procedure to the patient or mother before starting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Action of bed bath</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>• Bringing the necessary equipment of the bedside locker</td>
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<tr>
<td></td>
<td>• Close the curtain or door of the bed</td>
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<tr>
<td></td>
<td>• Perform hand hygiene</td>
<td></td>
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<tr>
<td></td>
<td>• Loosen the patients gown</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Keep the towel under the head</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Fold the wash cloth like a mitt on the hand</td>
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<tr>
<td></td>
<td>• Wipe the face without soap</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bath the patients face neck and ears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Expose the far arm of the child and place the towel length wise under it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Using firm strokes wash the arm and axilla</td>
<td></td>
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<tr>
<td></td>
<td>• Place the folded towel on the bed next to the patients hand and put the basin on it</td>
<td></td>
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<tr>
<td></td>
<td>• Soak the patients hand on the basin. Wash rinse and dry the hand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Expose the nearer arm of the child and place the towel length wise under it</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Using farm strokes wash the nearer arm and axilla</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Place the folded towel on the bed next to the patients hand and put the basin on it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Soak the patients hand on the basin. Wash rinse and dry the hand</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Spread the towel across the patient’s chest</td>
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<tr>
<td></td>
<td>• Wash rinse and dry the child’s chest</td>
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<tr>
<td></td>
<td>• Place the towel over the patient’s chest</td>
<td></td>
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<tr>
<td></td>
<td>• Wash rinse and dry the abdomen</td>
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</tr>
<tr>
<td></td>
<td>• Place the towel under the far leg</td>
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<tr>
<td></td>
<td>• Wash rinse and dry the child’s leg from ankle to knee and knee to groin</td>
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<tr>
<td></td>
<td>• Fold the towel near the foot area and place</td>
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<td></td>
</tr>
</tbody>
</table>
- Fold the towel near the foot area and place the basin on it
- Place the child’s foot while supporting the child’s ankle and heel in hand and leg on arm
- Wash rinse and dry paying particular attention between the toes
- Assist the patient to take prone position
- Wash rinse and dry the patients back and buttocks area
- If not contraindicated give back rub
- Refill the basin with clear water
- Clean the perineal area
- Help the patient to put clean dress

4 Comfortable position to the patient: provide a comfortable position to the child

5 Termination of the articles
   - Discard the water of the basin
   - Wash the sponge cloth and basin
   - Spread the sponge cloth to dry it

6 Recording and reporting – record the significant observation on the patients chart

<table>
<thead>
<tr>
<th>Criteria for evaluation: poor = 0-23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average = 24-32</td>
</tr>
<tr>
<td>Good = 33-41</td>
</tr>
<tr>
<td>Excellent 42-48</td>
</tr>
</tbody>
</table>

Remark: the student nurse obtains a total score of 28 which is categorized as average necessary corrections given to the student nurse and advised to practice regularly.

Records
Rule 42 (UKCC1993) requires the midwife to keep detailed records which must be made as contemporaneously as is reasonable, in other words as near the event as possible. Records must be in a form acceptable to the employer and approved by the local supervising authority. A midwife in independent practice will discuss the format of her records with her supervisor of midwives.

Maternity units use a wide variety of records and notes, including those which are designed to be entered into a computer and others which are appropriate to the midwifery process or to varying styles of individualized care. All records that are made by a midwife and must be preserved for a period of not less than 25 years.

**Norms**

Norms are standards that govern and regulate individuals and communities. For planning nursing manpower we have to follow some norms. The nursing norms are recommended by various committees such as the nursing man power committee, the high power committee, dr. bajaj committee and the staff inspection committee, TNAI, and INC. The norms has been recommended taking into account the workload projected in the wards and the other areas of the hospital.

**Policies**

These are the general principles or directions, they are usually without the mandatory approach for addressing an issue, but might be considered mandatory in some NHS trusts. They are often set at national level such as the indications of success in the report changing child birth.

A policy is a general statement which in line with the organizational objectives intends to provide guidelines for decision making.

According to Terry, a policy is a verbal written or implied overall guide setting up the boundaries that supply the general limits and direction in which management actin will take place. Policies on the basis of their emergence are called originated, appealed, implied or imposed policies.

**Characteristics of good policies**

A good policy must have the following features:

- In order to help in achieving objectives policies must be in line with organizational goals and it should reflect the needs of those who will be affected by it.
- It must be comprehensive enough to cover a wide range of actions and leave room for judgment and interpretation as required by the specific situations.
- In order to avoid ambiguity every policy should be expressed in definite and precise words indicating as who is responsible for implementing it.
- It should be formulated by using a participative approach in order to ensure compliance by the people.
- It must maintain a responsible balance between stability and flexibility.
In order that a good standard nursing care be maintained, the nursing superintendent should develop written policies and procedures to serve as guides for nurses of the various units of the hospital. Important topics that should be incorporated are as follows:

1. Organization
2. Status and relationship
3. Responsibilities
4. Staffing patterns, shift pattern
5. Departmental functions
6. Requisitioning of supplies
7. Utilizations, care and maintenance of equipments
8. Patient admission procedures including communication with doctor
9. Nursing procedures
10. Coordination and domestic services
11. Handling of patients clothing and valuables
12. Dealing with verbal and telephonic orders by medical staff
13. Handling and controlling narcotics and dangerous drugs
14. Isolation techniques and communicable diseases
15. Control/prevention of hospital infection
16. Safety hospital hazards, accidents and fire
17. Care and maintenance of furnishings
18. Standards of temperature ventilation, lighting
19. Public relations release of patient information to others
20. Visiting hours dealing with patients
21. Health education of patients, briefing of relatives and visitors
22. Transfer of patients
23. Records and reports
24. Private nurse
25. Use of restraints
26. Discharge procedures including communication to business office and others
27. Procedure of patients leaving against medical advise
28. Procedure following death of patients.
PROTOCOLS

A protocol is a written system for managing care that should include a plan for audit of that care. Most protocols are binding on employees as they usually relate to the management of consumers with urgent, possibly life threatening conditions. A protocol may exist for the care of the women with ante partum haemorrhage but not for the care of the women in labor without complications. Balliere’s midwives dictionary describes a protocol as a multidisciplinary planned course of suggested action in relation to specific situations.

RH PROTOCOL IN COCs

<table>
<thead>
<tr>
<th>Client desires oral pills</th>
</tr>
</thead>
<tbody>
<tr>
<td>new client</td>
</tr>
<tr>
<td>Assess if pregnant</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

- For resupply after 3 months
- Taking if taking pills correctly
- Review instructions
- Ask if any side effects
- Review

History
- Heavy smoker
- History of blood clots
- Breast lump or breast cancer
- Unexplained vaginal bleeding
- Diabetes mellitus
- Active liver disease
- High BP
- Migraine head ache
- On rifampicin or antiepileptic drugs

Example

BP higher than 160/90
Normal

Provide method (3 cycles)

Give instructions on warning signs
  - Arrange follow up in three months
  - Tell client to come to health institution even

Abnormal

Carefully consider whether Oral contraceptives are appropriate for the client even though condition is abnormal

• A full physical exam is not necessary to administer oral contraceptives
• However if available or helpful in decision making, consider offering a general exam including – breast examination
  - Abdominal exam
  - P/S exam: cervical screening
  - P/V exam
  - Hemoglobin

When questions are asked about delays

• Listen and respond
• Acknowledge and apologize for the delay
• Briefly explain the reason for the delay, communicate a realistic and do not blame other departments or colleagues for the delay
• Confirm the patient understands of his or her plan of care
When questions are asked about treatment

- Listen and respond with empathy and concern
- Clarify the questions. Answer and the question confirm the patient understands of response

When patients verbalize that they are leaving without being seen

- Immediately communicate to the charge nurse that the patient if going LWBS. Patients leaves that the emergency department
- The charge nurse should evaluate the situation and intervene with the patient as appropriate
- Document the patient
- Intervention and the results

When patients verbalize that they are leaving against medical advice

- Immediately communicate to the in charge nurse and the physician that the patient is going to AM
- The physician should evaluate the situation and intervene with the patient as appropriate
- Document the patient intervention and the results and complete the appropriate forms

When patients use threats and it profanity

- If the patient uses profanity state the following: inorder for me to be able to help you to need to stop using profanity
- Immediately notify the charge nurse of situation
- Implement the security management plan as needed.

Identify patient who are at high risk for dissatisfaction

It is important to identify patients who may be high risk for dissatisfaction inorder to use proactive behaviors to keep the patients dissatisfaction from escalating to the point where the patient goes LWBS on AMA. Proactive behaviors on the part of emergency department staff may also prevent profanity. Keep in mind that the following patients are a high risk for dissatisfaction

1. Patients who have waited over 45 minutes in the lobby
2. Patients who have waited over 30 minutes to see a doctor
3. Patients who have spent over 3 hours in the emergency room
PROBLEM ORIENTED RECORD (POR)

It is organized around the patient’s problems. It consists of four components.

- **Database:** It consists of many parts such as demographic data, history and physical and nursing assessment data and pertinent family and social history.
- **The problem list:** It is the concise listing of problems that have been identified from the data base.
- **The plan of care:** It includes the physician’s orders and the nursing care plan for addressing the identified problems.
- **Progress notes:** It is organized according to the problem list.

COMMON RECORDS - KEEPING FORMS OR RECORDS IN HOSPITAL SETTING

Documentation forms vary by purpose, institution and unit. However regardless of the system or forms used nursing documentation reflects the nursing process. The most commonly used forms are:-

a) **Clinical records**
   - Patients clinical record is one of the important records in the hospital wards. It is knowledge of events in patients, illness and progress to recovery and care by the hospital personnel.
   - Information of events is recorded by doctors, nurses and paramedical staff.
   - The value of this record is both scientific and legal.
   - The record serves as evidence that the care is being intelligently managed.
   - A record of illness and treatment saves duplication of efforts in future care and helps in prompt treatment.
   - The clinical records serve a legal protection to the hospital medical officer and the nurse as recording sigs symptoms observations and the treatment of the patient at the time of their occurrence. The records are used in determining the hospital charges to the patient

b) **Concerning the staff**
   - Job description
   - Records of all staff members, educational qualifications experience and other details.
   - Leave records
   - Health record
   - Attendance register,
   - Confidential records

c) **Admission nursing data base**
   - It is completed at the time of admission. It may be used as a bench mark to monitor the change. It provides information about the support system of the client and helps forecast future needs.
- It contains critical information chief complaints or the reasons for admission vital signs, allergy information, current medications, ADL status, physical assessment data and discharge planning information

d) **Flow sheets and graphic records**
- It helps to document assessments and care that are performed frequently on a recurring schedule or as a part of unit routines. The simplest forms are organized with the time on one axis and the activities or patients assessment parameters on the other axis. This allows you to see the pattern of change. The flow chart used in long term care, check list and intake and output records

e) **Client education record.**
- Client teaching is an essential part of nursing interventions. Many hospitals have an educational record that identifies client’s level of knowledge related to diagnosis treatment and medications. The goal of client and family education is to improve health outcomes by promoting healthy behaviour and self care and involving the client and family care division.

f) **Acuity charting**
- It provides a method of determining the hours of care staff required for a given group of clients based on the type and number of nursing interventions required for each client. The acuity level determined by the nursing care allows clients to be rated in comparison with one another. For e.g. acuity system might rate clients from one to five. A client returning from surgery with assessments and interventions is rated as an acuity level one. On the same continuum, another client rating for discharge after a very successful surgery is rated as acuity level 5

g) **Medication record**
- It contains detailed information about the medications that have been prescribed for the client. The information varies by setting with significant differences between outpatient and inpatient facilities.

h) **Progress notes**
- It is used to document nursing interventions and the patient’s response to them.

i) **Kardex or patient care summary**

It is in the form of a folding card. It usually includes;

- Demographic data
- Medical diagnosis
- Medication or other allergies
- Diet and activity order
- Safety precautions
- Intravenous therapy orders
• A summary of medication ordered

j) **Integrated plans of care**
   • It is combined charting and care plan form

k) **Discharge summary**
   
   It is the last entry in the chart. It is completed when the patient is discharged from or transferred within the facility. It may be multidisciplinary document or each discipline may write a separate summary. A discharge summary contains the following data;
   
   • Time of departure
   • Method of transportation
   • Condition of the clients discharge
   • Name and relationship of person accompanying patients discharge
   • List of medications sent home with patients

l) **Occurrence reports**
   
   • It is a formal record of unusual occurrence or accident.

m) **Computerized charting**
   
   • Many health care institutions are adopting computerized patient record systems. The following are some helpful hints for charting on a computer;
     - Do not leave patient data displayed on a computer screen where others may view it
     - Follow the institutional protocol for correcting errors
     - Never leave a computer terminal unattended after have logged on
     - Never give the personal password or computer signature to anyone

**MAINTAINING OF RECORDS ACCORDING TO THE DIFFERENT WARD**

The association of womens obstetrical and neonatal nursing had developed guidelines to assist the nurse in identifying areas that need to be documental.

**Antenatal testing**

When caring for a patient undergoing antenatal fetal surveillance, documentation will need to include criteria specific to the type of testing utilized. The type of accelerations as well as any interventions needs to be recorded.

1. **Antenatal period**
   
   A. Antenatal examination and care
      • Bio demographic data
      • Socio economic history
      • Personal history
      • Dietary history
      • Family history
      • Medical and surgical history
      • Menstrual history
✓ Age at menarche
✓ Time gap between each menstruation period
✓ Regularity of period
✓ Amount and duration of blood flow
✓ Date of LMP

• Previous obstetrical history
• Physical examination
  ❖ General appearance
    ✓ State of health
    ✓ Gait
    ✓ Nutritional status
    ✓ Personal hygiene
    ✓ Neurological status
  ❖ Clinical examination
    ✓ Weight
    ✓ Height
  ❖ Vital signs
  ✓ Systemic examination
  ✓ Head
  ✓ Ears
  ✓ Nose
  ✓ Eye
  ✓ Oral cavity
  ✓ Neck
  ✓ Respiratory system
  ✓ Cardiovascular system
  ✓ Musculo skeletal system
  ✓ Abdomen
  ✓ Female breast
  ✓ Lymph nodes
  ✓ Skin
  ❖ Inspection of skin
    ✓ Colour
    ✓ Patches or lesions
    ✓ Itching scar
    ✓ Oedema scar
    ✓ Dehydration
    ✓ Cleanliness
  ❖ Palpation of skin
    ✓ Temperature
    ✓ Texture
    ✓ Oedema
    ✓ Dehydration

• Antenatal abdominal examination
  ❖ Inspection
    ✓ Contour of the abdominal wall
• Fetal movement
• Operation scar
• Striae gravidarum
• Linea nigra

❖ Palpation
• Girth of abdomen
• Fundal height
• Fundal palpation
• Lateral palpation
• Pelvic palpation
• Pawlik grip
• Position

❖ Auscultation

❖ P V examination
• General assessment of the pelvis
• Fetopelvic relationship
• Signs of onset of labor
• Dilatation and effacement of cervix
• Presence of show

❖ X ray/scan
• Present obstetrical history
  ✓ Date of last menstrual period, calculate EDD and week of gestation
  ✓ Attendance of antenatal clinic
  ✓ General health condition before pregnancy
  ✓ Problem/complication during pregnancy
  ✓ History of vaginal bleeding
  ✓ Time of quickening

❖ Antenatal examination
• Symptoms
• Physical signs
• Special examination
• Investigations
  • Complete blood count
  • Blood ABO grouping
  • Routine urine analysis
  • VDRL
  • Hepatitis B surface antigen
  • Ultrasonography
  • Fasting and post prandial blood sugar

2. Intranatal period
• History of the patient
  ✓ Name, age, gravida, parity
  ✓ Time of onset of labor
  ✓ Date of registration
  ✓ LMP
  ✓ EDD
MAINTAIN RECORD OR DOCUMENTATION OF LABOR

A comprehensive record of the progress of the labor must be evident. It is maintained by:

1) **Sample of labor progress note or observation sheet**
   Throughout the first stage of labor the midwife must record all events.

2) **Partograph**
   It is a composite graphical record of progress of labor. It can be assessed from the visual patterns of cervical dilatation and descent of the presenting part.
Record the following on the partograph,

1. Patient information
   ✓ Name
   ✓ Date and time of admission
   ✓ Gravida, para
   ✓ Time of rupture of membranes
   ✓ Hospital number
   ✓ Time of onset of labor
2. Fetal heart rate
3. Amniotic fluid
   State the state of membranes and if it ruptured record the color of amniotic fluid at every vaginal examination and time of rupture.
4. Cervical dilatation
   Subsequent cervical dilatation is plotted on the basis of the time of first cervical dilatation.
   Alert line: A line starts at 4cm of cervical dilatation to the point of expected full dilatation at the rate of 1cm per hour.
   Action line: Parallel and 4 hours to the right of the alert line.
5. Descent of the head or station of the head
   It is recorded as fifths of head palpable above the brim or head palpable above the symphysis pubis.
   ✷ At 5/5, the 5 parts of the head is palpable above the symphysis pubis.
   ✷ At 4/5, sinciput high and occiput easily felt just above the pelvic brim.
   ✷ At 2/5, sinciput felt and occiput just felt.
   ✷ At 0/5, head is palpable.
6. Hours
7. Time
8. Contractions
   The square in the vertical columns are shaded according to the duration and intensity
9. Oxytocin
10. Drugs given
11. Pulse
12. Blood pressure
13. Temperature
14. Protein, acetone and volume of urine
   Record urine volume, acetor and protein in the appropriate time.
• Vaginal examinations
  ✓ Effacement
  ✓ Cervix dilatation
  ✓ Presentation and position
  ✓ Station
  ✓ Membranes
  ✓ Pelvis
• Delivery notes
  ✓ Membranes ruptured at
  ✓ Membranes ruptured spontaneous/artificially
✓ Reason
✓ Exclusive contractions commenced at
✓ Baby born at
✓ Date
✓ Condition of baby when born
✓ Sex of the baby

- Immediate care of the baby at birth
  ✓ Observation
  ✓ Colour
  ✓ Respiration
  ✓ Anus patent
  ✓ Meconium passed or not
  ✓ Cleft palate
  ✓ Hair lip
  ✓ Spina bifida
  ✓ Talipes
  ✓ Weight of the baby
  ✓ Height of the baby
  ✓ Head circumference
  ✓ Chest circumference
  ✓ Cord ligation
  ✓ Cord care

- Delivery of placenta and membranes
  ✓ Methods
  ✓ Normal/manually
  ✓ Examination of placenta
  ✓ Weight of placenta
  ✓ Diameter
  ✓ Cord insertion
  ✓ Cord diameter
  ✓ Maternal surface
  ✓ Diameter
  ✓ Membranes complete/incomplete

**REPORTING**

A full report given in the morning before distribution of assignment and another time at the end of the shift of duty to the oncoming staff. It includes information about each patient's condition including problems and suggested methods of assisting him/her as well as his/her treatment and day-to-day progress. Most reports are done orally between the staff and certain reports need to be written. A report summarizes the services of the nurse and or the agency. Reports may be in the form of an analysis of some aspect of a service. Reports are usually written daily, weekly, monthly, and yearly. Giving a good report is an art. It is a skill that is developed by definite effort.

**DEFINITION**
Oral communication about a patient's status is called reporting.

OR

A report is a system of communication aimed at transferring essential information necessary for safe and holistic patient care.

**PURPOSES**

- To show the kind and amount of service rendered over a specified period.
- To illustrate progress in teaching goals.
- It acts as an aid in studying health conditions.
- It acts as an aid in studying health conditions.
- It acts as an aid in planning.
- To interpret the services to the public and to the other interested agencies.

**Value Of Good Reports**

- Good reports are time savers. They prevent duplication of work.
- Direct influence on the progress and even life of the patients.
- Provide a sense of security and confidence to the nurse in doing her work. Giving a good report is an art.

**ELEMENTS OF REPORT**

- **Timing**
  - Most pertinent time. An accident or change in a person's conditions are examples of reasons for immediate reporting.

- **Organization**
  - Important points are mentioned in a logical order and stand out from the explanatory and supporting statements.

- **Clarity**
  - Leaving no doubt of what happened, what was done, or what remains to be done.

- **Brevity**

- **Objectivity**

- **Correctness**

d. **Brevity**

Omit unnecessary words and statements for a clear, complete picture.

e. **Correctness**

Of all information to prevent serious mistakes in giving continued nursing care.

f. **Objectivity**

Presentation of facts, not personal feelings, to give a true picture.

**TYPES OF REPORTS**

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<tr>
<th>ORAL REPORT</th>
<th>WRITTEN REPORT</th>
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a. **Oral Report**

Oral reports are given when information is required for immediate use. An oral report is made by nurse to another nurse who is supposed to relieve her. Staff nurses and students present oral reports to in charge nurse who in turn gives new orders, makes changes in assignments and conveys any other information needed by them to carry out their work. A definitive time and place to be arranged so that the reports can be given without interruption. A full report needs to be made at the time of each duty change.

**Reports between head nurse and her assistant:**

The assistant head nurse is to take over the management of the ward in the absence of the head nurse. It is advisable for the head nurse and her assistants to record memoranda of information on a notebook or on the notepad which they plan to report. ii) Reports between nurses who are assigned to bedside care on change of shift

Contents include change of condition of patients assigned to the nurses, treatments and medications, adaptations in method required by each patient, information about the patient as a person and his diagnosis. The reports may be given to relieving staff by going through care plan so that questions are asked and answered immediately.

**Reports of staff members to the in-change nurse :**

When the nurse is ready to go off duty the head nurse receives a concise report on each patient and also on incomplete assignments. They have to give report regarding changes in condition and results of treatment.

**Nurse in-charge report to the bedside nurse:**
The information to be given to bedside nurses mainly includes the changes in the condition of the patient. She should also communicate the information which she receives from her superior administrators.

**Reports of the head nurse to the administrative supervisor:**

The administrative supervisor needs to receive from the head nurse, overview of the ward in detail, to understand its problems and needs. She is told about the complaints of patients, visitors, doctors or members of the nursing staff as well as accident and errors.

**b. Written Report**

Reports are written when the information is to be used by several people or is more or less permanent value. A written report should show an awareness of thinking and time. It should concentrate on the past, present and future state of patient or the event. Description and conclusions of action that influence further planning and decision making are necessary. The number of reports will vary according to the size, type of the institution. They need to be reviewed and revised periodically.

- **a) Day, evening and night reports:**

  It is to provide means of transferring important information about the patients to the head nurse, the ward nurses, night nurses, nursing officer and the day and night supervisors.

- **b) Census report:**

  The daily census or the number of patients in the hospital at the midnight furnish are important source material for hospital statistics. It should be well understood by night supervisor that the census figure must be correct.

- **c) Interdepartmental reports:**

  Reports of the patient to be discharged are sent to the admitting officer, business office, information desk. Special charges drug, dressings or other equipments used by patient are reported to the business office. Reports on condition of danger list patients and others who are acutely ill may be sent to the director of the hospital, the director of the nursing.

- **d) Interagency reports:**

  Interagency report is essential when patient is discharged. In some hospitals, it can be done through telephone, but written report are more satisfactory. The interagency report should contain information about the treatment which the patient has undergone in hospital and which is to carried on at home or by some other agency.

- **e) 24 hour report:**

  Supervisory and nurse administration personnel need to be keep information about what is happening in and around all the patient care areas. It should give a good general picture of the
ward. Information should include the total number of patient, the name, diagnosis and condition of all seriously ill patient and all new admissions.

f) **Accident report:**

Many different kinds of accidents can occur in a hospital eg. Minor injury such as from hot water bottle. Most of them are minor in nature.

g) **Department reports:**

A variety of reports produced periodically in every faculty can give the manager a valuable departmental information. The information from reports enables a manager to evaluate performance of the unit and determine expenses compared to the budget.

### REPORTS USED IN HOSPITAL SETTING

- a. Change of shift reports.
- b. Transfer reports.
- c. Incident reports.
- d. Day, evening and night reports.
- e. Legal reports.
- f. Telephone reports.
- g. Telephone order.

#### a. Change of shift reports
A change of shift is a report given to all nurses on the next shift. Its purpose is to provide continuity of care of clients by providing the new care givers a quick summary of client needs and details of care to be given.

Key element of a change of shift:

- Follow a particular order (eg: follow room number in a hospital)
- Provide basic identifying information for each client (eg: name, room number, bed designation)
- For new clients, provide the reason for admission or medical diagnosis (or diagnoses), surgery (date), diagnostic tests, and therapies in past 24 hours.
- Includes significant change in client's condition and present information in order.
- Provide exact information.
- Report clients need for special emotional support.
- Include current nurse prescribed a physician prescribed order.
- Provide a summary of newly admitted clients, including diagnosis, age, general condition, plan of therapy and significant information about the clients support people.
- Report on client who has been transferred or discharge from the client.
- clearly state priorities of care and care that is due after the shifts begins.
- Be concise.

b. Transfer reports

Patient will be frequently be transferred from one unit to another to receive different levels of care. A transfer report involves communication of information about clients from the nurse on sending unit to the nurse or the receiving unit. When giving transfer request; nurse should include the following information:

- Client's name, age, primary doctor, and medical diagnosis.
- Summary of medical progress up to the time of transfer
- Current health status- physical and psychological.
- Current nursing diagnosis or problems and care plan
- Any critical assessment or interventions to be completed shortly.
- Needs for any special equipment, etc.

c. Incident reports

Nurses usually become involved in client relate incidents as some point in their careers. They must understand the purpose of incident reports and the correct way to report information. While incident reporting the following points to be kept in mind:

- The nurses who witness the incident or who found the client at the time of incident should file the report.
- The nurse describes in concise what happened specifically objective terms, etc.
- The nurse does not interpret or attempt to explain the cause of the incident.
- The nurse describes objectively the clients, condition when the incident was discovered.
• All measures taken by the nurse, other nurses, doctors at the time of incident are reported.
• No nurse is blamed in an incident report.
• The report is submitted as soon as possible to the appropriate authority.
• The nurse should never make photocopy of the incident report.

d. Legal reports

Incident reports and reports on client's accident, mistakes and complaints are legal in nature. These are times when a hospital is criticized for what is claimed to be negligence or poor care because of a condition that resulted in discomfort and perhaps serious harm to the patient or client. In such reports, the content is stated briefly and objectively giving all pertinent information. Accuracy, timeliness, completeness, and relevancy to the problems are maintained promptly while making such reports.

e. Telephone reports

Health professionals frequently report about a client by telephone. Nurses inform physician about a change in a client's condition; a radiologist reports the result of an X-ray study; a nurse may report to a nurse on another unit about a transferred client. The nurse receiving a telephone report should document the date and time, the name of the person giving the information, and the subject of the information received and designs the notation.

f. Telephone orders

Physicians often order a therapy (eg: a medication) for a client by telephone. Most agencies have specific policies about telephone orders. Many agencies allow only registered nurse to take telephone orders. While the physician gives the order, write it down and repeat it back to the physician to ensure accuracy. Question the physician about any order that is ambiguous, unusual (eg: an abnormally high dosage of a medication), or contraindicated by the clients condition. Then transcribe the order onto the physicians order sheet, indicating it as verbal order (VO) or telephone order (TO).

ROLE OF MIDWIFE IN RECORDING AND REPORTING

The nurse administrator should see that everybody is following common guidelines for recording information:-.

• Information recorded is true and complete.
• Entries should be legible and written in ink.
• Only facts should be recorded. Entries should be brief, accurate, legible and correctly spelt.
• If item error is made while writing, the nurse should not erase or overwrite, instead draw a single line over it and sign it. Then note it down correctly.
• Do not leave blank space in note.
• Always make chart for yourself and never for someone else. A nurse is accountable for information into the chart.
• Should be written in chronological order of date and time.
• Each page of record should be properly identified with identification data.
• The reports and records should be kept under safe custody.
• No individual sheet is separated from the complete record.
• Records should be kept in place, inaccessible to patients and visitors.
• No stranger is permitted to read the records.
• Records are not handed over. The Nurse administrator is legally and ethically obligated to keep in confidence all the informations provided in the records.
• All records to be handled carefully. Careless handling can destroy the records.
• Protection from loss.
• Filing should be done according to hospital system such as alphabetically, numerically with index cards and geographically.
• Assess periodically to determine the use of the record and re-examine for means of simplification.
• All records are identified with the biodata of the patients such as name, age, ward, bed no, O.P no, I.P no, diagnosis etc.

GYNAECOLOGY: EMERGENCY SERVICES STANDARDS OF PRACTICE AND SERVICE ORGANISATION

Introduction

Gynaecological emergencies can arise at any time of the day. The introduction of early pregnancy units (EPU) has led to an organized assessment of women with complications of early pregnancy, the most common cause of emergency assessment. Thus, most of these women are seen within working hours. However, some women have severe symptoms, which cannot wait until an EPU opens, and others have non-pregnancy related conditions.

As a result of the introduction of EPUs and following National Confidential Enquiry into Patient Outcome and Death recommendations, most gynaecological emergency surgery
should take place within the working day. This allows for better consultant availability for teaching and supervision of trainees. However, given that emergencies also arise out of hours, when trainees are likely to be the only doctors in the hospital, the need for consultant presence or distant supervision will always remain.

Waiting list targets for elective surgery create a priority for elective surgery, which is sometimes at opposition to the priority for emergency cases during daytime operating lists.

Standards for emergency gynaecology need to encompass all of these factors.

Purpose

Gynaecology is a major surgical specialty and it therefore follows that gynaecological emergencies are one of the most common indications for surgery. This document lays down the principles for service organisation and delivery of emergency gynaecology. These principles apply to units where patients with emergency gynaecological conditions are clinically assessed, investigated and treated.

STANDARDS

Many of the standards set out in this document are also supported by the RCOG working party report Standards in Gynaecology, published in June 2008.

4. Organisation of a high-quality emergency gynaecology service

The delivery of a high-quality emergency gynaecology service requires:

- Leadership – a lead senior clinical leader
- Organisation – a good infrastructure including sufficient theatre capacity and manpower
- Practice and training – adequate numbers and supervision of junior staff
- Managerial and patient focus on emergency gynaecology services.

Leadership

Each unit must have a named lead consultant who is responsible for the emergency gynaecological service.

This responsibility includes clinical organisation, standards of practice, governance and directing the most effective use of resources in the emergency gynaecology service.

This responsibility should be reflected by dedicated time in the named consultant’s job plan based on the size of the unit and its volume of activity. The named consultant should work within a team, including a senior nurse or matron and the directorate manager. They must hold quarterly multidisciplinary risk management meetings, including nurses, anaesthetists and theatre staff involved in the provision of the emergency gynaecological service.
Clinical reviews of difficult cases and root cause analyses of significant clinical incidents must take place regularly. The frequency of these meetings will depend upon the size and activity of the service but should be held at least monthly. These meetings should report through the departmental and Trust governance structures.

Organisation

There should be a policy stating at what point there must be direct consultant input into the management of emergency gynaecological cases. The consultant on-call must ensure that emergency patients are reviewed at least once every 24 hours, including at weekends. If the volume of activity is high, the service will require an appropriate level of presence from the consultant on-call.

It is essential that there is ready and timely access to the following:

Diagnostic support services – ultrasound, radiology including magnetic resonance imaging and computed tomography, haematology and biochemistry.

Operating theatres – there must be adequate theatre provision for gynaecological emergencies in working hours. Although surgical evacuation of the uterus for miscarriage is often seen as a minor procedure, the risks of delay should be recognised (infection and bleeding). In addition, it is appropriate that these women should expect timely and sensitive care at an emotionally vulnerable time. Clearly, in cases of medical emergency (for example, ruptured ectopic pregnancy with haemodynamic instability) the clinical features will determine the priority to be given in relation to other surgical emergencies.

Critical care facilities – complex cases may need access to a critical care facility (for example, severe ovarian hyperstimulation syndrome). Ideally, these facilities should be on the same hospital site. However, where this is not the case, an effective care pathway for ready access to a nearby critical care facility is essential. If patients are transferred to another site, the name of the consultant gynaecologist in charge should be clearly discussed and documented.

Specialist or tertiary level services – In a small number of emergencies, access to specialist or tertiary level services will be needed. Again, a robust care pathway must be in place for these women.

Psychological support services – some women may need psychological support. Suitable care pathways and services must be in place for those women who need extra support, especially following pregnancy loss.

Governance – a full range of governance systems and processes must be in place and working to identify and register risks associated with the emergency gynaecological service. Emergency gynaecological surgery must be the subject of regular audits of clinical processes and outcomes.

Practice and training
Guidelines must be in place for the most common emergencies and updated on a regular basis. Trainee doctors must be able to get advice and support from a senior doctor at all times. The level of support will depend on the trainee’s level of experience.

Training in the management of emergencies must be given priority. This must include operative skills. Modified Early Warning Score charts and scores should be used to assess patients. These charts enable an accurate assessment of the patients’ current state and to trigger action in patients who are deteriorating before they reach a critical point.

Procedures must be in place for the effective handover of care between the changing shifts of doctors. This must include an accurate assessment of the patient’s current condition and a suggested time for review by a gynaecologist (specialist registrar or above)

Patient focus

Patients’ views must be taken into account when developing emergency gynaecological services. Trusts have a variety of mechanisms for gathering patients’ views about services and these should be used to assess emergency gynaecological services.

Patient information leaflets should be available covering the common emergency gynaecological conditions. Good quality national leaflets are available, such as those produced by the RCOG. These should be supplemented by local information, such as where to find help (contact telephone numbers and so on), especially for those patients being managed in the outpatient setting.

Ward areas must be organised and equipped to maintain patient dignity at all times. This means ensuring complete privacy during consultations and examinations.

CONCLUSION

Obstetrics and Gynecology is the specialty that focuses on the treatment of women. Gynecology focuses on maternity care before birth, support pregnant and after treatment when gynaecologist is facing the general health of women. Both these two specialties obstetrics and gynecology clumped together because both involve in caring for women. Specialties are the maternal and prenatal care, where management obstetric high-risk pregnancy, as well as family planning and reproductive health, endocrinology, hormones, research on the reproductive system. As a unit it is essential to have effective management of the unit.

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