NURSING SERVICES MANUAL AIIMS, New Delhi

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All India Institute of Medical Sciences

New Delhi, India

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From The Director's Desk

It gives me a great pride and joy in presenting the Nursing Services Manual for All India Institute of Medical Sciences, New Delhi.

Knowledge gained through education has been the driving force for progress of mankind. This coupled with human experience has helped to provide quality care. The workforce of nurses is an extremely vital component of healthcare and they act as direct interface between the hospital and patients. Working in a large tertiary care institute places several demands upon them for efficient discharge of their responsibilities.

This manual provides guidance to all the issues encompassing job responsibilities, code of conduct, nursing organization, leave rules, ward management and information on various aspects of nursing services.

I am sure that this manual will provide a fresh and engaging perspective on the aforementioned subjects for all the nursing manpower.

Dr. Randeep Guleria
Director
All India Institute of Medical Sciences
New Delhi

From The Medical Superintendent's Desk

Greetings!

I am honored to be able to write the foreword for Nursing Services manual, AIIMS. The excellent writing and contents of the manual cover issues applicable to various facets of nursing services, which are commonly faced in healthcare settings.

AIIMS Hospital has the legacy of keeping highest standards of Nursing Care. Indeed, on any given day, nursing professionals handles a wide array of responsibilities ranging from patient care, ward management, human resources, facilities management, as well as attendants' management This manual is aimed at standardizing the administrative policies & procedures with respect to nursing services, assisting in training new staff and having information readily available to the nursing fraternity.

I congratulate the nursing in-service education team of AIIMS for their commitment and effort for bringing out this manual.

Dr. D.K. Sharma
Medical Superintendent
All India Institute of Medical Sciences
New Delhi

From The Chief Nursing Officer's Desk

Nursing services forms an integral part of any health care facility. Nursing task force is considered the backbone of patient care. This Nursing Services Manual aims at providing a positive resource to nurses, so that they can significantly improve the quality, wellbeing and safety for patients working in one of the largest tertiary care institution.

My congratulations to Nursing In-Service Education (NIE) Team, Hospital for successfully taking out the 1st edition of Nursing Services Manual. I also congratulate NIE Educators at entire institute for their contribution in making this manual a knowledge resource.

This manual will be helpful for nursing professionals working at various patient care facilities and will also assist in training new staff. It will provide key information about the Nursing Services in an easy-to-use and practical manner.

Ms. Kamlesh Chandelia
Chief Nursing Officer
All India Institute of Medical Sciences
New Delhi

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Chapter 1

NURSING PROFESSION- AN OVERVIEW

INTRODUCTION:

Nursing profession is considered a caring profession. To begin with, it was an art and a vocation; now it is considered a scientific profession.

EFFECTIVE NURSING:

Effective nursing is based on nursing process which is an organized and systematic approach to nursing care that prioritizes patient's assessment and management.

Entire nursing process consists of four phases:-

- ASSESSMENT- It is not only initial but integral, ongoing component of the whole nursing process.
- PLANNING AND IMPLEMENTATION- In this phase, the nurse formulates and implements the care.
- EVALUATION- This phase decides whether the action taken has met the identified needs or not. This is the final step of care and it also reviews the whole care plan. A comprehensive and Quality care is possible only with the evaluation phase of nursing process.

Core Values In Delivering Patient Care:

* Treating patient with honesty and respect.
* Developing good partnership between patient and the care givers.
* Alleviating pain and suffering.

* Providing clean and safe environment.
* Protecting comfort and well being.
* Protecting the rights of patients as well as addressing the spiritual and cultural needs.
* Involving the staff in planning and decision making
* Efficient and effective team work
* Effective communication and understanding between the team
* Supporting staff to reach their full potential.
* Positive reinforcement.
* Recognizing achievement at all levels in the organization.

Reference:

- *Brunner & Suddarth's, Text book of Medical and surgical Nursing, Vol.1*
- *Potter Perry, Fundamentals of Nursing, 6th edition*

Chapter 2

NURSING SERVICES AT AIIMS

INTRODUCTION

Nursing service is an integral part of AIIMS, which aims at high quality nursing care to the patients and community. The professional nurses work in an environment that encourages professionalism and expertise in providing comprehensive patient care with the members of allied disciplines in the hospital.

The hierarchy of nursing services at AIIMS is as per following organization chart:

ORGANISATION OF NURSING SERVICES AT AIIMS

CHIEF NURSING OFFICER

|

NURSING SUPDT

|

DY. NURSING SUPDT.

|

ASSTT.NURSING SUPDT.

|

Senior Nursing Officer -CLINICAL SUPERVISOR

|

Nursing Officer ----STUDENT NURSE

MANPOWER NORMS FOR NURSING:

In order to provide effective nursing care in AIIMS, New Delhi, SIU Norms (Ministry of Finance, Department of Expenditure, Govt of India, Year 1991-1992) are being followed in clinical areas and are as follows**;**

- 01 Senior Nursing Officer for 3.6 Nursing Officers.
- 01 ANS for 4.5 Senior Nursing Officers.
- 01 DNS for 7.5 ANS.
- 01 Nursing Supdt for 250-500 beds.
- 01 CNO for 500 or more beds.

Chapter 3

JOB RESPONSIBILITIES OF NURSING PROFESSIONALS

NURSING OFFICER

Nursing Officer is directly responsible to Senior Nursing Officer (Ward In-Charge) for total nursing care of the patient assigned to him/her

1) **DIRECT PATIENT CARE**

1. Admission and discharge of the patients
2. To maintain the personal hygiene of the patients, including bathing, care of mouth, back, nails, hair etc.
3. Care of pressures points as needed.
4. To assist the patient in elimination, offering and removing the bed pans and Urinals.
5. Bed making.
6. Assist in feeding the weak and debilitated patients.
7. Writing of diet sheet, Supervision and distribution of diets.
8. Assist in physiotherapy, ambulation and rehabilitation.
9. Carry-out patient's teaching and demonstration according to the need.
10. Counseling the patients, and relatives.
11. Care of the dying and dead.

12. Administration of Medicines and Injections to the patients.

13. Assist in administration of intravenous injections, infusion and Transfusion.

14. Observing, recording and reporting of vital signs e.g. T.P.R. and Blood pressure.

15. Carry out technical procedures, such as Naso-gastric intubation, Gastric Gavage and Lavage, Oxygen Therapy, Dressing and Irrigation, Enema, Catheterization hot and cold applications, suction etc.

16. Collecting, labeling and dispatch of specimens.

17. Preparation for and assistance in clinical tests and medical/surgical procedures.

18. Urine testing for sugar, and albumin.

19. Observation, recording and reporting of all procedures and tests.

20. Escorting serious patients to and from the department/ wards for investigations.

2) **WARD MANAGEMENT**

1. Handing over and taking over charge of patients, and ward inventory in each shift.

2. Maintenance of therapeutic environment in the ward.

3. Keeping the ward clean and tidy.

4. Routine care and cleaning of dressing trolleys, cupboards apparatus, mackintosh etc.

5. Care of clean and soiled linen.

6. Disinfection of linen, beds, floor and bed pans, and fumigation of rooms etc.
7. Preparation of room, trolleys, and sets for procedures.
8. Preparation of surgical supplies.
9. Maintaining interpersonal relationship with patients, relatives and health team members.
10. Orientation of new staff/students.
11. Demonstration and guidance to student nurses.
12. Participation in staff education and staff meetings.
13. Participation in professional activities.
14. Demonstration and supervision of domestic staff.
15. Report about the medico-legal cases if any admitted in the ward. To keep the senior nursing officials informed of the happenings / in the ward like fire, absconding patients, theft etc.
16. Any other duty that may be assigned by Senior Nursing Officer from time to time.

SENIOR NURSING OFFICER

The Senior Nursing Officer is responsible to the Assistant Nursing Superintendent or the total care of patients in the wards and supervision of the Nursing Officer, student nurses and Domestic staff. She would also be assisted by Nursing Officer, Clinical and Domestic staff. The main aim of the Senior Nursing Officer should be to foster team spirit in her area of works as a team leader.

1) **NURSING CARE OF PATIENTS**

1. Assess the total needs of patients and prepare plan of nursing care.
2. Admission and discharge of patients.
3. Demonstrate and carry out efficient nursing care, taking care of personal comfort and toilet of patients, administration of drugs and treatment, observation and recording of vital parameters.
4. Supervise patients diet.
5. Attending rounds with Medical/Nursing personnel.
6. Assist Medical staff in examination of patients and treatment.
7. Participate and help with clinical investigations/ procedures.
8. Demonstrate and carry out preoperative and post-operative care of patients.
9. Maintenance of patient's records.
10. Care of patient's personal effects in accordance with hospital rules.
11. Giving and receiving reports.
12. Follow prescribed rules in case of accident or death of a patient.
13. Give information and health education to patients and their attendants.
14. Intimation to nursing supervisors of any emergency or unusual occurrence in the ward.

2) **WARD MANAGEMENT**

1. Handing over and takeover charge of patients at the end of the shift.
2. Assignment of work to nursing Officer and domestic staff.
3. Co-ordinate and facilitate work of other staff, e.g. physical therapist, social worker, dietitian, voluntary worker etc.
4. Maintaining good inter personal relationship among all categories of staff and with patients and their relatives.
5. Maintain cleanliness of ward, its annexes and environments. Proper upkeep and repairs of linen and ward equipment.
6. Make indents for drugs, surgical supplies, stores and issue.
7. Keep custody of dangerous drugs and record of their administration.
8. Daily check of emergency drugs and life savings equipments.
9. Maintenance of stock registers, inventories.
10. Investigate complaints if any.

3) **TEACHING AND SUPERVISION**

1. Orientation of new staff and student nurses.
2. Participate in service education of nursing personnel and attend staff meetings.
3. Impart planned and incidental teaching.
4. Supervise Nursing officer and student nurses.
5. Supervise domestic staff.
6. Consult and co-operate with nursing tutor in arranging clinical teaching.
7. Perform any other duty as may be specified from time to time.

Chapter 4

CODE OF CONDUCT FOR NURSING PROFESSIONALS

The purpose of the Code of Conduct is to guide nurses in their day-to-day practice and help them to understand their professional responsibilities in caring for patients in a safe, ethical and effective way.

Principles

1. **Respect for the Dignity of the person**

- Nurses respect each person as a unique individual.
- Nurses respect and defend the dignity of every stage of human life.
- Nurses respect and maintain their own dignity and that of patients in their professional practice. They believe that this respect is mutual with patients.
- Nurses respect all people equally without discriminating on the grounds of age, gender, race, religion, civil status, family status, sexual orientation, disability (physical, mental or intellectual)

2. **Professional Responsibility and Accountability**

- Nurses are expected to show high standards of professional behaviour.
- Nurses are professionally responsible and accountable for their practice, attitudes and actions; including inactions and omissions.

- Nurses recognise the relationship between professional responsibility and accountability, and their professional integrity.
- Nurses advocate for patients' rights.
- Nurses recognise their role in the appropriate management of health care resources.

3. **Quality of Practice**

- Nurses who are competent, safety-conscious and who act with kindness and compassion, provide safe, high-quality care.
- Nurses make sure that the health care environment is safe for themselves, their patients and their colleagues.
- Nurses aim to give the highest quality of care to all people in their professional care.
- Nurses use evidence-based knowledge and apply best practice standards in their work.

4. **Trust and Confidentiality**

- Trust is a core professional value in nurses' and midwives' relationships with patients and colleagues.
- Confidentiality and honesty form the basis of a trusting relationship between the nurse or midwife and the patient. Patients have a right to expect that their personal information remains private.
- Nurses and midwives exercise professional judgment and responsibility in circumstances where a patient's confidential information must be shared.

5. **Collaboration with others**

- Professional relationships with colleagues are based on mutual respect and trust.

- Nurses and midwives share responsibility with colleagues for providing safe, quality health care. They work together to achieve the best possible outcomes for patients.
- Nurses and midwives recognise that effective and consistent documentation is an integral part of their practice and a reflection of the standard of an individual's professional practice. They support the ethical management of the documentation and communication of care.
- Nurses and midwives recognise their role in delegating care appropriately and in providing supervision.

Expected Conduct/ Etiquettes while on Duty:

1) All the nurses are expected to perform their tasks as per the duties assigned by the nurse in charge.
2) A nurse is expected to be punctual in attendance and duty timings. In case she/he is late for any genuine reason, then the same should be informed to the ANS telephonically at the earliest and later in writing as well.
3) Nurses are liable to be transferred from one Patient Care Area to another and they must accept the decision of the Nursing Superintendent. In case of any genuine reasons for inability to accept the transfer, the same would have to be stated in writing to the Nursing Superintendent.
4) In case a nurse wants a transfer, the same request should be addressed to the Nursing Superintendent in writing.
5) Nurses should not accept and/or demand any gifts in cash or kind from patients or their relatives or Pharmaceutical/ any other firms.
6) All patient information and other hospital information are to be considered confidential and should not be communicated in any form to any unauthorized staff/person.
7) All nurses shall register with the Delhi Nursing Council for practice in the institution.

8) As employees of the hospital, nurses are strictly prohibited from giving any medicine to any person except to those it is ordered to be given by the treating doctor to the patients
9) Prior intimation about daily duties of the Nursing staff will be appropriately notified, in the duty schedule. Any changes in the duty would require prior written request and approval of the ANS.
10) The nursing staff should ensure that effective patient care is being provided in the hospital.
11) On duty, nurses should be in station and be attentive at all times.
12) Sleeping during duty hours is prohibited.

Reference:

- *American Nurses Association (ANA), (2001), Code of Ethics for Nurses, American Nurses Association, Washington, D.C.*

- *Code of Ethics & Professional Conduct, Indian Nursing Council*

Chapter 5

DUTY TIMINGS AT AIIMS FOR NURSING PROFESSIONALS

Duty Timings In Ward Block /IPC

Pattern	Duty Time	Privileges
A **Straight Shift**	08.00 AM - 4.00 PM 08.30 AM – 4.30 PM 09.00 AM – 5.00 PM 10.00 AM - 6.00 PM 11.00 AM – 7.00 PM	½ Day Off on Saturday Sunday Holiday Off on all Gazette. holidays National Holidays/year - 03 Restricted holidays/year – 02 Casual leave – 08
B **03 Shift duties**	**Morning Shift**: 07. 30 am – 02.00 pm **Evening Shift**: 01.30 pm – 08.30 pm **Night Shift**: 08.00 pm – 08. 00 am	Monthly 08 offs National Holidays/year- 03 Casual leave – 10

Duty Timings In Operation Theatre

Pattern	Duty Time	Privileges
A **Straight Shift**	Reference ward block pattern **"A"**	Reference ward block pattern **"A"**
B	**Morning Shift**: 07. 30 am – 03.30 pm	Monthly 08 offs National

03 Shift duties	**Evening Shift**: 03.00 pm – 09.30 pm **Night Shift**: 09.00 pm – 08. 00 am	Holidays/year- 03 Casual leave – 10

Duties of Different Categories of Nursing Staff In Ward Block

Nursing officer	**Pattern A + B**
Senior Nursing Officer	**Pattern A + B**
Asst. Nursing Supdt.	**Pattern A + B**

Duties of Different Categories of Nursing Staff in Operation Theatre

Nursing officer	**Pattern A + B**
Senior Nursing Officer	**Pattern A + B**
Asst. Nursing Supdt.	**Pattern A**

Reference::
Circular dated 28.05.2009; Director Office;AIIMS;Dy No:001537

Chapter 6

DRESS CODE

1. **UNIFORM COLOR:**
   Dark Blue for all nursing personnel up to ANS HR
   Light blue for DNS, Nsg. Suptndt. and Chief Nursing officer

2. **SHOES:**
   Black leather shoes/ Sandals with or without buckles.
   (Maximum heel 1.5 inch allowed)

3. **SOCKS:**
   Natural skin color

4. **COAT/APRON**
   Half sleeves white color for nursing officers, senior nursing officers and ANS(UG)
   Three fourth sleeves white color for ANS (HR), DNS, NS and CNO

5. **SWEATER:**
   Black for Nursing officer, Senior nursing officers and ANS
   White for DNS, NS and CNO

6. **HAIRPINS/ HAIR BAND**: Black

7. **TYPE OF APPAREL**:
   Salwar & Kamezfor nursing officers, senior nursing officers (UG) Saree with blouse for Senior nursing officers (HR), ANS, DNS, NS and CNO

8. **FOR MALE NURSES**:
   Navy blue Formal trousers and light blue shirts half sleeve in summer and full sleeve in winter

9. DESIGNATION PLATE:

- Black base with white color letter for nursing officers, senior nursing officers (UG)
- White base with black color letter for Senior nursing officer (HR) and ANS (UG)
- Maroon base with white color letter for ANS (HR)
- Golden base with Black letter for DNS, NS and CNO

Professional Dress-up and Personal Hygiene

1. Functionality and Grooming

1.1 Nurses must be able to bend, stoop, reach and lift in the course of patient care.

1.2 Grooming is important for a nurse.

1.3 Wrinkled uniforms, scuffed shoes or dirty fingernails do not present an image that inspires confidence in the patient.

2. Infection Control

2.1 Finger nails should be clipped, no nail paints allowed.

2.2 Rings should be limited or removed for the same reason.

2.3 Nursing uniforms are frequently subject to spills and stains and should be laundered regularly.

3. Personal Hygiene

3.1 The nurse is expected to maintain cleanliness.

3.2 Maintain proper hair cleanliness.

3.3 Women's hair should be tied up tidily with black clips and pins.

3.4 Men's hair should be well groomed.

3.5 Men's beard should be properly trimmed and maintained.

3.6 Personal hygiene should be maintained.

3.7Wear clean, properly ironed uniform.

Chapter 7

LEAVE RULES

- **Leave Rules**: Booked leave application, permission letters, NOC etc. should be sent at least 20 days prior to the CNO office. No leave without the proper sanctioning will be allowed to be availed.
- **Short leave/Emergency leave** cannot extend beyond 10 days and for this leave application should be sent to CNO office two days prior to proceeding for leave.
- Only 30% of the sanctioned nursing strength can be given leave at a time.
- For absenteeism, verbal report is valid for only 24 hours. Beyond that period, written leave has to be submitted by the employee. Otherwise, absent report in writing to be sent to the CNO office by the ANS**. (***Reference: vide circular dated 10.04.2018 No.F.20 -10/2018-Estt.I)*
- In morning shift duties, half day casual leave (afternoon) starts from 11.30 am and not before that. **During evening and night duties no half days/CL/ Earned Leave is allowed. Only medical leave can be taken in emergency.**
- When OFFs are arranged for going outstation by any nursing personnel, an undertaking for the same should be taken by the ANS of the ward. Further, after returning from leave, the **ANS should deploy them only on morning shift** and not on evening and night shifts.
- Joining should always be taken in the forenoon only

- **<u>Study Leave</u>**

1. All eligible nurses will be issued “NOC” by the administration subject to their fulfilling eligibility criteria**.** *(vide Circular dated 02.03.2107; No F.58/UN(pt)/2016-Estt-(H.))*

- The employee must have satisfactorily completed probation and rendered at least five years of regular continuous service.(including probation period)
- Permission is granted to study only in Institutes of national importance or PGIMER, RAK, NIMHANS and AIIMS

ALL COMMUNICATION FOR AVAILING ANY KIND OF LEAVE SHOULD ALWAYS BE THROUGH PROPER CHANNEL

Chapter 8

ADMISSION, DISCHARGE & MISC. WARD PROCEDURES

WARD MANAGEMENT: GENERAL REQUIREMENTS

- The Nurse should know her ward thoroughly with detailed knowledge of the activities, equipment status, ward procedures etc. He/She must be completely aware of the hospital policies and their implications on the ward operations and the interrelated departments of the hospital.
- Nursing staff should follow the nursing procedure manual for any standard procedure.
- The nurses should be familiar with the department/unit, ward/OT procedures, equipment functioning, furniture and fixtures, types of cases admitted -their criticality and level of care etc.
- The nurse in-charge is to make a schedule of activities/assignments on a daily basis, to be followed by the other nurses.
- The nurse should not leave the station until and unless the next duty nurse has reported to duty and the new nurse being briefed.
- Orientation of all new nursing staff by ANS is required to guide and instruct them with the policies of the ward management, duty structuring, routine for emergencies, familiarize with the equipment, supplies, store and medicines of the ward.
- The New staff should be assigned to a senior staff nurse for one week to become familiar with the functioning of the ward.

- All the medicines and other items indented are to be maintained in a log book, which would enable pilferage check.

ADMISSION OF A PATIENT

Admission in the ward is either from Out Patient Department or Emergency Service and directly in special cases.

1. Admission is given to those patients who fulfill the criteria for admission.
2. It is advised by the doctor of concerned dept/unit and the admission slip is given by the senior resident of the concerned unit. For private ward admission, the admission slip is given by Officer In charge Private Ward.
3. The patient should be instructed to present the admission slip to the clerk at the Central Admission Office. The Central Admission Office directs the patient to the ward where he or she is to be admitted.
4. The admission is then made in the admission Office after paying advance hospitalization charges for 10 days.[Rs35/ - + Rs.25/-, admission Charge/ day charge and Rs.60/- for short admission. The admission office generates a “face-sheet” of the patient[1]
5. For short admission under day care hematology, only Rs.35/- is charged and admission charge of Rs.25/- is exempted

Criteria for General Ward admissions:

(a) Patients seen in general OPD, who are sick enough or have a diagnostic problem needing detailed investigations, are admitted directly.

(b) Patients seen in speciality clinics, being run under the purview of general disciplines, needing admission may also be admitted in general wards under the unit-on-call for that day of the week.

(c) Patients presenting in the casualty with acute and serious illness needing hospitalization can also be admitted in general wards.

Admission Procedure for the Emergency Wards:

1. There are three emergency wards:

   C-6, D-6 and New Emergency Ward (specified Beds) for emergency admission only from casualty. The CMO, in consultation with the Senior Resident of the unit-on-call, decides on the admission.

2. The CMO fills in the admission slip and directs the patient to the Central Admission Office for generating the Face Sheet for admission, as described above.

3. Respective departments should shift their patient from emergency wards within 48 hours failing which their routine OPD admissions will be blocked by the Duty Officer.

4. Several patients are referred from casualty to other Govt Hospitals for lack of availability of beds in one hospital. However, some cases such as intubated patient, follow up case of AIIMS or EHS patient, any serious condition likely to deteriorate further on his way to another hospital, are not referred/transferred and are given admission on priority.

5. The Duty Officer coordinates their admission going through the hospital ward census, which he/she receives at 8.30 p.m. daily.

However, it is the responsibility of the unit (to whom the patient belongs) to transfer the case back to their own ward at the earliest so that admission of other units does not suffer the next day.

Admission procedure for the private ward:

1. Generally, Private Wards admissions are “Elective” admissions of patients, who can afford to pay the charges.
2. A consultant advises the admission of the patient to the private wards on the OPD card.
3. These patients are registered and kept on a waiting list. When a room falls vacant, they are informed about the vacancy by post or by telephone and are advised to report on a particular date and time.
4. Patients being admitted in private ward will have to pay an advance for10 days charges, at the time of admission i.e. :
    - For ‘B’ Class Rooms Rs.22,200/-[Rs.20,000/- Room rent advance of 10 days and Rs.2,000/- Diet charges advance of 10 days]
    - For ‘A’ Class Rooms Rs. 32,200/-[Rs.30,000/- Room rent advance of 10 days and Rs. 2,000/- Diet charges advance of 10 days]

As the private ward patients are admitted as and when a vacancy arises, it is generally not possible to co-ordinate it with the admission day of the unit to which the consultant belongs.

FOR EHS:

1. There are separate but limited number of EHS beds available in AB-7, AB-6, D-1.New private ground floor also has dedicated rooms for EHS patients. Senior officials (pay level 10 & above) are admitted on other private ward rooms as well.
2. An EHS patient needing hospitalization is referred to the relevant general or specialty department for consultation.
3. From there the patient is admitted on EHS beds. If no EHS bed is available the patient may be admitted on the emergency ward beds or even on regular ward beds.
4. However, these patients must immediately be transferred to the EHS beds as soon as they fall vacant.
5. In no case should an EHS beneficiary be sent to other hospitals without the permission of the Medical Superintendent.
6. Duty officer in control room should be contacted for allotment of EHS beds. These earmarked beds are under the control of Duty Officer in control room.
7. Various departments have earmarked EHS beds in their own departments. EHS patient should get first preference in departmental EHS bed

Criteria for Short Admission:

1. Protocol to be followed when a patient admitted in AIIMS hospital as a ‘Short admission’ patient.

NURSES' RESPONSIBILITIES:

1. Nursing officer in charge on duty provides the bed to the patient on presentation of the admission papers (face sheet) provided that the patient is physically present in the hospital premises
2. The admission sheet should have: Name, age & sex, address, consent signature of patient if conscious and major or the relative if patient is not in a condition to sign or in case of minor.
3. Patient is received. Weight, height and vital signs are checked.
4. History about present illness, past medical history, drug history and any drug allergy is obtained.
5. Patient and the family are oriented to the ward.
6. Admission is informed to the resident doctor of concerned department/unit.
7. Whenever a foreigner reports for treatment in the hospital, he/she may be advised to get registered himself/herself with FRRO, Delhi FRRO concerned. The particulars of the foreign national admitted in the ward should be filled in the prescribed C-Form and sent to MRD.

DISCHARGE OF A PATIENT

1) Discharge is planned by the unit doctors once the patient fulfils the criteria.
2) Patient and the family is explained prior to actual discharge.

3) Private Ward patients may also be discharged by 12:00 noon or patients have to pay charges for that day also. Sister Incharge Private Ward should also be informed of discharge of paying patients well in advance to enable her to get the bills cleared in time.

4) Special care is taken for discharge of EHS patients. Ambulance service is available for discharged EHS patients (if so required) for transport to residence, which is available only till 8:30 p.m. EHS patients should preferably be discharged from wards during the morning and afternoon hours.

5) A detailed discharge summary is prepared by the resident doctor that includes the history, various investigations done in the hospital, the treatment given, the medicines advised and the recommendations for the follow up.

6) The nurse has to check the various bills and to ensure that the patient has cleared the entire bill.

7) All the investigations, reports, OPD card(s) and imaging studies to be handed over to the patient during discharge and receiving of the same to be mentioned number wise at the back of the face sheet.

8) Health education is given about the discharge medicines, diet and the follow up.

9) Once the patient has left, bed is shown as vacated in the computer and the discharged patient cannot be shifted on a virtual bed.

10) The Vacant bed is cleaned and disinfected and kept ready for the new patient.

11) Ensure that the actual date of discharge in the discharge summary and the TPR sheet (Nurses chart) should be the same.

12) As per the guidelines of MCI, all the files of discharge/ death/ Abscond/ LAMA patients must be handed over to the MRD staff within 48 Hours(Working Days)

13) Further, if any obstetric and Gynae department patient has been registered under 'JSSK' and later on takes a private ward bed, the nurse on duty should convert the payment category of mother and Newborn from the MRD on the very same day or latest by the next working day.

TRANSFER OF PATIENT

1) A patient can be transferred from one ward to another ward or from one centre to another centre.

2) Transfer order is written by the resident doctor in the instruction book.

3) Transfer notes is printed out through CPRS which contains patient details and the treatment.

4) Information is given to staff in the counter of the ward to which the patient is to be transferred.

5) Patient and the attendant are explained about the transfer.

6) General condition and the vitals of the patient is checked and recorded before transferring.

7) If the patient is on oxygen, ventilator or sick, the resident doctor of concerned unit has to accompany the patient.

8) Once the patient has been transferred, it is entered in the computer.

9) Once the patient has been transferred (after being entered in the computer) to any other center of AIIMS, a new center specific CR. No is generated while the UHID No. remains the same.

LAMA

1) It is Leaving or Left Against Medical Advice. It is also called Discharge Against Medical Advice (DAMA)

2) The patient has the right to leave the ward if he /she is not satisfied with the care.

3) In that case, patient is counseled and is allowed to leave.

4) The resident has to get the signature from the patient/ relative in the face sheet that he is leaving against advice.

5) The resident is supposed to write the notes and fill the face sheet discharge column as LAMA.

6) The nurse's record should have the proper documentation of the general condition, vitals and the other appropriate observations of the patient.

7) The nurse must ensure that the file is collected properly and dispatched. No document should be ordinarily given to the patient. However if the patient/attendant insists on getting a discharge summary/treatment summary given during the period of hospitalization, such a summary can be given by the concerned resident doctor specifically endorsing on it(in bold letters) the fact that the patient is leaving against medical advice.

8) If the patient is terminally ill or on ventilator staff must ensure that the patient is shifted in ambulance safely with oxygen and other necessary equipments.

9) Once the patient has left, the details are entered in the computer and the bed is shown as vacated.

ABSCOND REPORT

1) Abscond report is a legal document stating that the patient is missing from his/her bed in the ward.

2) When the patient is not found on his/ her bed for more than four hours, it must be informed to the unit duty doctor.

3) If the patient is absent for more than 12 hours a detailed report about the patient and the time since he is missing is mentioned and is declared as absconded.

4) The abscond report is written by the doctor and the copies are sent to Duty Officer, Security officer, CNO and Medical Record Department.

5) In case of MLC cases, it is very important to inform the police officer about the abscond report.

6) A copy of abscond report is attached to the file and dispatched.

7) The bed is shown as vacated in computer as absconded.

PATIENT CARE AFTER DEATH

1. Two sets of the e -Death Certificates should be prepared and signed by the Resident doctor (Senior or Junior) concerned.
2. In the case of M.L.C., the death certificate should be marked M.L.C. at the top and the MLC information slip be filled up by the Sister-in-charge/Staff Nurse on duty and sent to the Police Officer in the Casualty, for further necessary action.
3. Appropriate care and packing of dead body is to be followed according to the protocol given in the infection control manual
4. An adhesive plaster bearing the name of the patient in indelible ink is put on the right wrist, chest and on the sheet of the deceased.
5. The other copies of the 'Death Slip' with rest of the papers of the Death Certificate are sent to the Central Admission Office. The staff in CAO completes the 'Death Register' from the Death Certificate.
6. The CAO will issue the 'death slip' to the relative of the deceased after stamping 'The Body may be released' and obtain the signature of the relative/ friend in the Death

Register. Then the dead body can be handed over to the family with a copy of the 'Death Slip'.

7. If the body is to be kept in mortuary, the staff in mortuary will handover to the relatives of the deceased the dead body along with the death slip which was sent to them earlier, in exchange of the death slip from the CAO, keeping this as an acknowledgement from the relative(s).
8. In case the body is sent to the mortuary and the next of kin/relatives are not present. Then with the help of details on the death information slip the Central Admission Office informs the relatives/next of kin by telephone. On their arrival the body is handed over to them from the mortuary, the procedure for this being the same as described above.
9. Dispatch the file to MRD within 48 hours

Chapter 9

HANDING AND TAKING OVER

INTRODUCTION:

For maintaining the continuity of care and improving the quality of care, effective inter-shift information communication is important. Handover error can endanger patient safety. A nursing handover occurs when one nurse hands over the responsibility of care for a patient to another nurse. When a nurse hands over responsibility of care to another nurse there is an opportunity for error if all the important medical information is not shared thoroughly and efficiently.

Always:

- Keep on tips the important lab results.
- Organize transmission of information.
- Focus on medical and nursing needs of the patient.
- Communicate effectively

Using checklist for handing over and shift change can prevent missing of important information.

Points to Remember:

- Patient particulars
- Diagnosis/ surgery done
- Advanced diagnosis
- Short history
- Post- op day (if applicable)
- Medications/ antibiotic day
- Any allergies
- Oxygen
- External devices

- Lab investigations
- Nutrition/ Intake Output
- Ambulation
- Pending procedures
- Documents
- Payments

Handing over and change of shift should be recorded and details discussed critically

Handing/Taking over Protocol:

- Detail handing and taking over of the unit/ward should be done by the staff on duty and the patient should be handed over at the bedside.
- The senior most nursing officer of the outgoing team should lead the handover.
- Doctor's order should be carried out before handing over to the incoming staff.
- Outgoing staff should communicate information accurately, succinctly and professionally.
- All incoming staff should attend taking over responsibility.
- **The incoming staff should check all drugs and ensure that articles and emergency equipment are functional in every shift.**
- Check that all the bedside charts are complete prior to handover.
- Allow the patient to seek clarification, and ask question and confirm information.
- Confidentiality should be maintained at all time. Sensitive information should be shared within professionals only.

- During handover, incoming staff should undertake a safety check of the patient's environment.
- Ensure patient care is continued without any lapses during handing taking process.
- The staff on duty is/are solely accountable and answerable for any events/ activities that occur during their duty time.

Key Points:

- Suction, oxygen, or other equipments are in working condition and easily accessible.
- Dressings, drain, intravenous fluids, and infusion pumps are secure and correct.
- Handing and taking over of the articles should be done in every shift by the nurses before taking over of the patients.
- All basic articles should be checked for functionality.
- Sign on the inventory book/assignment book after taking over.

Chapter 10

RECORD KEEPING

Introduction:

- A record is a permanent written communication that documents information relevant to a client's health care management.
- Clinical record keeping is an integral component in good professional practice and the delivery of quality healthcare.
- Regardless of the form of the records (*i.e.* electronic or paper), good clinical record keeping should enable continuity of care and should enhance communication between different healthcare professionals.
- Nurses are subject to increasing scrutiny regarding their record-keeping.

Purpose of documentation:

- Legal documentation
- Reimbursement& Insurance Claims
- Patient care analysis

Appropriate records are to be maintained for the department functioning in the areas of:

- Inventory of drugs – emergency.
- Bed occupancy of the ward.
- Maintain a log book for recording the breakdown of any equipment (the data required would be equipment name, company name, if on maintenance contract (yes/no), time/date of failure, time/date of equipment made functional, reported to whom).
- Record has to be maintained, if the equipment is borrowed by any department or service area and when it has been returned.
- Other records for management purposes should be maintained like:

Complete Patient File should contain:

1)	Face-sheet	-	MR-1
2)	Discharge summary or death form	-	MR-2
3)	Patient history	-	MR-3
4)	Progress record	-	MR-4
5)	Doctor orders	-	MR-5
6)	Intake out-put chart	-	MR-6
7)	Consent and operation notes	-	MR-7
8)	Anesthesia records		
9)	Nurses daily record	-	MR-8
10)	Consultation record	-	MR-9
11)	Temperature chart	-	MR-10

How to improve record-keeping:

- Get into the habit of using factual, consistent, accurate, objective and unambiguous patient information;
- Use your senses to record what you did, such as 'I heard', 'felt', 'saw', and so on;
- Use quotation marks where necessary, such as when you are recording what has been said to you;
- Ensure there is a reasoned rationale (evidence) for any decision recorded,
- Ensure notes are accurately dated, timed, and signed, with the name printed alongside the entry (initials should be avoided);
- Follow the SMART model (Specific, Measurable, Achievable, Realistic and Time-based) or similar when planning care;

- Write up notes as soon as possible after an event and, by law, within 24 hours, making clear any subsequent alterations or additions;
- Document any objections you may have to the care that has been given;
- Timing, legible, permanence, correct spelling and grammar
- Sequence, appropriateness and completeness.
- Do not include jargon, meaningless phrases (for example 'slept well'), irrelevant speculation, and offensive subjective statements;
- Confidentiality of the patient and hospital records to be maintained.

Records Maintenance Period at AIIMS

• Stock Register	--	20 years
• Drug Indent Books	--	5 years
• Drug Account Books	–	5 years
• Indent Books (Non-consumable)	–	20 years
• Indent Books (Consumable)	–	5 years
• Treatment Books	–	5 years
• Doctors Order Books	–	5 years
• Daily Drugs Books	–	5 years
• Report Books	–	5 years
• Loss & Breakage Books	–	5 years
• Repair Books	–	5 years
• Blood Bank Books	–	5 years
• Specimen Books	–	5 years

Chapter 11

HOSPITAL INFECTION CONTROL PROGRAMME AT AIIMS

AIIMS Hospital has a well-defined Hospital Infection Prevention & Control Programme which is managed by Hospital infection Control Committee (HICC)

HOSPITAL INFECTION CONTROL COMMITTEE (HICC) COMPOSITION

Chairman: Medical Superintendent

Members:

- Heads of Clinical Departments
- Chief of Centers
- Superintending Engineer
- Infection Control Nurse
- Engineering Services

Member Secretary: Faculty member from Department of Hospital Administration

HICC CORE GROUP

From within the HICC, a core group has been formed on the lines of Infection Control Team to look after the surveillance activities and handling day to day problems. It also implements the educational and training programmes for the hospital staff.

The Department of Microbiology is responsible for monitoring of healthcare associated infections and anti-microbial resistance,

disinfection and sterilization as well as surveillance activities in which they are assisted by the Infection Control Nurses.

Infection Control Nurses: Six experienced nurses are appointed full time on this position in main AIIMS Hospital and their functions are described below.

FUNCTIONS OF INFECTION CONTROL NURSES

1. Regular visits to all wards and high risk units to monitor infection control practices.
2. Recording details of patients with healthcare associated infections
3. Collection of samples from different areas of the hospital for monitoring disinfection, sterilization and air quality and sending them to the lab.
4. Daily visit to microbiology laboratory to ascertain results of samples collected for surveillance and to liaise between microbiology department and clinical departments.
5. Compilation of ward wise, discipline wise and procedure wise statistics for HCAI.
6. Monitoring and supervision of infection among hospital staff.
7. Training of nursing aides and paramedical personnel on correct hygiene practices and techniques.

REFER HOSPITAL INFECTION CONTROL MANUAL

- https://www.aiims.edu/en/component/content/article/236-notices/miscellaneous/ 10158-aiims-infection-control-manual.html

Chapter 12

WORKPLACE VIOLENCE IN HEALTHCARE SETTINGS

The National Institute for Occupational Safety and Health defines workplace violence *as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty*." Enforcement activities typically focus on physical assaults or threats that result or can result in serious physical harm. However, many people who study this issue and the workplace prevention programs highlighted include verbal violence—threats, verbal abuse, hostility, harassment, and the like—which can cause significant psychological trauma and stress, even if no physical injury takes place. Verbal assaults can also escalate to physical violence.

In hospitals and other healthcare settings, possible sources of violence include patients, visitors, intruders, and even coworkers. Examples include verbal threats or physical attacks by patients, a distraught family member who may be abusive or even become a gang violence in the emergency department, a domestic dispute that spills over into the workplace, or coworker bullying.

Workplace violence risk factors vary by healthcare setting, but common factors include the following:

Patient, Client and Setting-Related Risk Factors

a. Working directly with people who have a history of violence, abuse drugs or alcohol, gang members, and relatives of patients or clients;
b. Transporting patients and clients;
c. Working alone in a facility or in patients' homes;
d. Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident;
e. Poorly lit corridors, rooms, parking lots and other areas;
f. Lack of means of emergency communication;

g. Prevalence of firearms, knives and other weapons among patients and their families and friends; and
h. Working in neighborhoods with high crime rates.

Organizational Risk Factors

a. Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff;
b. Working when understaffed—especially during mealtimes and visiting hours;
c. High worker turnover;
d. Inadequate security and mental health personnel on site;

Healthcare facilities can reduce workplace violence by following comprehensive workplace violence prevention programme.

An effective programme includes five key components:

a. Management commitment and worker participation
b. Worksite analysis and hazard identification
c. Hazard prevention and control
d. Safety and health training
e. Recordkeeping and program evaluation

A workplace violence prevention programme can also fit effectively into a broader safety and health management system, and it can help our facility enhance employee and patient safety, improve the quality of patient care, and promote constructive labor-management relations.

Reference:

- *Occupational Safety and Health Administration (OSHA). 2015. Guidelines for preventing workplace violence for healthcare and social service workers. No. 3148-04R.*

Chapter 13

SEXUAL HARASSMENT AT WORKPLACE

"No woman shall be subjected to sexual harassment at any workplace."

The Sexual Harassment of Women at Workplace, (Prevention, Prohibition and Redressal) Act, 2013, is an act to provide protection against sexual harassment of women at workplace and for the prevention and redressal of complaints of sexual harassment and for matters connected therewith or incidental thereto.

It is the right of every woman to be safe and secure at workplace environment irrespective of her age or employment/work status. Hence, the right of all women working or visiting any workplace whether in the capacity of regular, temporary, adhoc, or daily wages basis is protected under the Act.

It also includes persons working on a voluntary basis, co-worker, contract worker, probationer, trainee, and apprentice or called by any other such name.

Few Definitions:

Workplace is defined as "any place visited by the employee arising out of or during the course of employment, including transportation provided by the employer for undertaking such a journey."

As per this definition, a workplace covers both the organised and un-organised sectors.

An Aggrieved Woman means- in relation to a workplace, a woman of any age who is employed or not and who alleges to have been subjected to any act of sexual harassment by the respondent.

A Respondent means a person against whom the aggrieved woman has made a complaint

What constitutes Sexual Harassment at Workplace?

"Sexual Harassment" includes anyone or more of the following unwelcome acts or behaviour, (Whether directly or by implication), namely:

1. Physical contact or advances;
2. A demand or request for sexual favors;
3. Making sexually colored remarks;
4. Showing pornography;
5. Any other unwelcome physical, verbal or non-verbal conduct of a sexual nature

The following circumstances if occur or are connected with any act or behaviour of sexual harassment may also amount to sexual harassment:-

1. Implied or explicit promise of preferential treatment or threat of detrimental treatment in her employment.
2. Implied or explicit threat about present or future employment status
3. Interference with work or creating an intimidating or offensive/ hostile work environment for her.
4. Humiliating treatment likely to affect her health and safety.

Complaints Committee/s

The Act provides for two kinds of complaint mechanisms:

1. Local Complaints Committee (LCC): Every district has a LCC for establishments with less than ten workers or if the complaint is against the employer himself.

2. Internal Complaints Committee (ICC): Every workplace has to have an ICC with at least one-half of the total members nominated be women.

The Internal Complaint Committee shall have the same powers as are vested in a civil court under the Code of Civil Procedures, 908 when trying a suit for:

1. Summoning and enforcing the attendance of any person and examining him on oath
2. Requiring the discovery and production of documents and any other matter which may be prescribed.

COMPLAINT AND INQUIRY PROCEDURE

Any aggrieved woman may make a complaint within a period of three months from the date of incident and in case of a series of incidents, within a period of three months from the date of last incident to the Internal Complaint Committee.

The time limit may be extended by the committee if they are satisfied of the circumstances which prevented the woman from filing a complaint within the said period.

The complaint should be in writing and all reasonable assistance to file the complaint in writing should be made by the committee.

Where the aggrieved woman is unable to make a complaint (due to physical or mental incapacity or death or otherwise), her legal heir or such other person as may be prescribed may make a complaint.

The notice to the respondent is to be given within seven days of receiving copy of the complaint.

The inquiry should be completed within a period of ninety days

The inquiry is made in accordance with the provisions of the service rules applicable to the respondent.

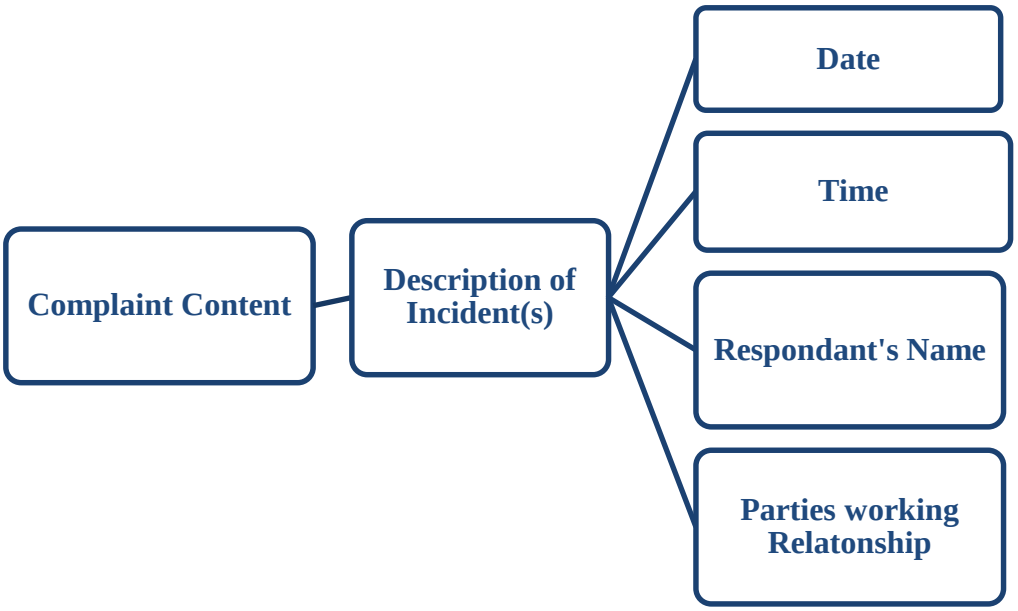
During the inquiry, the ICC on basis of written request:

1. Transfer the aggrieved woman or the respondent to any other workplace or
2. Grant leave to the aggrieved woman up to a period of three months (in addition to leave she would be otherwise entitled)

The report is submitted to the employer on completion of inquiry within ten days from the day of completion of the inquiry and report to be made available to the concerned parties.

Where the Internal Committee arrives at the conclusion that the allegation is malicious and forged or misleading documents have been produced, or any witness has given false evidence it may recommend to the employer to take action against as per the service rules.

WHAT SHOULD THE COMPLAINT CONTAIN?



REDRESSAL MECHANISM:

An appeal to the court or tribunal in accordance with the provision of the service rules applicable to the said person may be made.

The appeal should be made within ninety days of the recommendations

WHAT CAN A COMPLAINANT EXPECT?

A trained, ***skilled*** and ***competent*** Complaints Committee, a time bound process, information, confidentiality, assurance of non-retaliation, counseling or other enabling support where needed and assistance if the complainant opts for criminal proceedings.

RIGHTS OF THE COMPLAINANT

- An empathetic attitude from the Complaints Committee so that she can state her grievance in a fearless environment
- A copy of the statement along with all the evidence and a list of witnesses submitted by the Respondent
- Keeping her identity confidential throughout the process.
- In case of fear of intimidation from the respondent, her statement can be recorded in absence of the respondent
- Right to appeal, in case, not satisfied with the recommendations/ findings of the Complaints Committee

RIGHTS OF THE RESPONDENT

- A patient hearing to present his case in a non-biased manner
- A copy of the statement along with all the evidence and a list of witnesses and complainant
- Confidentiality of identity throughout the process
- Right to appeal

Committee at AIIMS:

- An **Internal Complaint Committee for Sexual Harassment of women at workplace (ICCSHWW)** exists at AIIMS.
- For any other grievance apart from harassment of sexual nature are addressed by the **women grievance cell** of the institute

Women's helpline Number at AIIMS

011-26593333

011-26594444

Control Room

011-26593308

AIIMS, New Delhi committed towards the safe workplace.

Reference:

- *Handbook on sexual harassment of women at workplace (Prevention, Prohibition and Redressal) Act, 2013. Ministry of Women & Child Development, Government of India)*
- *Protocol for Sexual Assault Victims: https://www.aiims.edu/en/forensic-patient-care/sexual-assault-accused-medicolegal-examination-1.html*

Chapter 14

DISASTER MANAGEMENT

INTRODUCTION:

Disaster is any occurrence that causes ecology disruption, loss of human life and deterioration of health services on a scale sufficient to warrant an extraordinary response from the community or area. Disaster occurs suddenly and unexpectedly, disrupting normal life and infrastructure of social services including health care systems. For this reason a country's health system and public health infrastructure must be organized and kept ready to act in any emergency situation as well as under normal condition.

DEFINITION OF DISASTER

Disaster is defined as "any occurrence that causes damage, ecological disruption, loss of human life, deterioration of health and health services, on a scale sufficient to warrant an extraordinary response from outside the affected community or area." (WHO)

Disaster Plan of AIIMS Hospital

Disaster Committee:

The following officers of AIIMS hospital will form the Disaster Committee under the chairmanship, Hospital Management Board.

- Prof & Head, Deptt. Of Orthopaedics
- Prof. In charge, Accident& Emergency Services
- Prof. & Head, Deptt. of Surgery
- Prof. & Head, Deptt. of Medicine

Prof.& Head, Deptt. of Forensic Medicine

Prof. & Head, Deptt. of Neuro Surgery

Prof.& Head, Deptt. of Anaesthesiology

Prof. & Head, Deptt. of Radio-diagnosis

The Nursing Superintendent

Officer In charge of all Supportive Hospital Services

Prof.& Head, Deptt. of Gastroenterology

Secretary, Hospital Management Board

Types of Disasters Expected:

Vehicular accidents and aircraft emergencies Bullet and Blast injuries

Collapse of a building Fire Food poisoning – Gastro Enteritis

Any other like drowning etc.

HQ for Disaster plan coordination:

Control Room: Room No 12, Tel: 26862663, 26593308 round the clock

MS Office, Tel: 26594700, 26861389

Information and Communication:

Receiving information at Radio Telephone Desk which is already established in all the conference areas

One Hot lines from Police HQ in the Control Room

Direct arrival of casualty without any prior intimation Details to be ascertained on the Hot lines are

Time and place of occurrence Nature of accident Approximate number of causalities Source of information Authenticity

Activating the Plan:

On receipt of information from authentic source the Duty Officer will activate the plan and inform the MS, Chairman, HMB and Security Officer Reception Centre

For moderate load : The present Casualty OPD will function as the reception area

For heavy load : Main hall of ground floor OPD will be converted into reception area

Police and Security personnel of AIIMS will act as Traffic Controllers directing the patient and relatives to the respective reception centres

First Aid and Sorting : Triage

For Moderate Load : Existing casualty Medical Team will function for First aid and sorting

For heavy Load : The centre will manned by 4 teams each consisting of :

One General Surgeon

One Orthopaedic Surgeon

One Physician

One Anaesthetist

Two Sisters

Two Nursing Orderlies

One sweeper

A team of two Stretcher Bearers each having one stretcher

The responsibilities of First Aid Centre will be

Quick sorting of causalities into

Priority one : Needing immediate resuscitation

Priority two : Immediate surgery

Priority Three : Needing first-aid & possible surgery

Priority Four: Needing only first-aid

Action : Priority one will be attended to in Casualty and if need arises will be sent to AB-VIII, ICU

Priority two will be transferred immediately to casualty OT and MOT

Priority three will be given first-aid and admitted if bed is available or transferred to other hospital

Priority four will be given first-aid and discharged home.

The area marked for holding ward: Corridors AB & D wing, first floor Brought in dead or those who may die while receiving/resuscitation will be segregated. Temporary morgue for keeping dead bodies will be created in the long verandah opposite the mechanical laundry. Necessary identification and handing over of bodies to the relative after medico legal clearance will be done in this area. This will function under care of the Department of Forensic Medicine.

Additional Bed Space:

In addition to the area marked on first floor, AB-1 & D-1 extra bed space will be created as follows:

Utilisation all pre-operative beds in AB-7

Any vacant beds will be requisitioned by the MS for this purpose

By discharging following categories of patients

Convalescing patients needing only nursing care

Elective surgical cases

Patients who can have domiciliary care or OPD advise

Ward side rooms and Seminar rooms of the wards may have to be used temporarily

Linen Stores:

A room in D wing, (SF 1) room 1st floor is earmarked for this purpose following stores will be transferred to that room from the stores

- Mattress – 40
- Bed Sheets - 120
- Blankets – 80
- Pillows and cover - 60
- Patient clothing female- 30
- Patient clothing male - 30
- IV Stand – 60
- O2 cylinder - 20

Drugs and Equipment:

The Medical and Surgical Stores Officer will be called at once to open the store. As an immediate measure the buffer stock earmarked in casualty will be utilised. All essential drugs will be stocked in the medical stores and issued on orders of MS, DMS, Duty Officer. Dressing material and items of surgical stores are similarly kept in reserve. A dozen emergency trays containing life saving drugs will be kept ready in medical stores. For first few hours and for immediate use the drugs will be requisitioned from emergency stock lying with sister I/C of Casualty.

Approximately 400 bottles of Crystalloids are kept available by the Crystalloids store. I/C stores will be at once sent for reporting on duty.

Emergency Blood Bank:

Efforts shall be made for blood of all the available groups to the stocked in plenty. Volunteers and Voluntary Organisation will be approached to donate as much blood as possible.

Staff:

Medical Staff : In addition to members of regular clinical units the faculty members of para and preclinical discipline will be asked to render help to assist the clinical staff in managing the causalities. The duty

roster of regular consultants and standby doctors is to be made available in control room.

Nursing Staff : A pool of nursing staff will be created by the Nursing Supdt. So that nursing staff is available at short notice. This pool should be out of nurses staying in the hostel for operational reasons. Duty roster will be sent to the duty officer by Sanitary Supdt.

Volunteers:

Volunteers will be invited by the coordinated efforts of Faculty I/C HospAdmn and two MHA residents, if necessary Documentation Centres

For small load of casualty; documentation shall be done at the casualty OPD itself

For large load of casualty; it is to be established in ground floor OPD at the central registration office

of OPD. The staff working at registration counter and nursing staff will be utilised for documentation and identification volunteers may also be used for this purpose

Hospital Security:

Security of staff, patients and hospital building and equipment being of paramount importance, during such disasters, the security officer has been requested to tune up and organise the security arrangements for this purpose

Food Service:

Supply of nourishment to the patients and emergency duty staff will start immediately by the staff of the dietary services under direct supervision of Head of the Department of Dietetics or Dietician-in-charge of Kitchen. Most of the patient for first 24-48 hrs will be using only liquid or semi solids. By then efforts can made supply of proper meals.

Information Services:

Faculty of Hospital Administration will function as information officer and all information to press, radio and other media, individuals,

organisations, government or otherwise will be issued by him. He will get prior clearance from competent authorities before issue of such information.

Engineering and Maintenance Service:

The engineers will make sure that water and electricity is made available without interruption. All the standby electric power generators will be regularly checked, inspected and maintained in excellent serviceable condition.

Discharge Procedure:

After appropriate treatment the casualties fit to be discharged shall be discharged to go home or to other hospital for convalescence. For all cases discharged the destination will be noted by the hospitals and police informed.

Success of Plan:

Disaster is an emergency situation. Timely help of every individual is needed to make this plan a success to reduce the Mortality and Morbidity. In such state of affairs the individual and personnel consideration take low priority in the face of duty to the profession for sake of amelioration of human suffering.

PRINCIPLES OF DISASTER NURSING

Nurses have very important role in disaster management. Team must understand the disaster plans at their workplace and community and will participate in disaster drills.

1. Rapid assessment of the situation and of nursing care needs. Triage and initiation of life-saving measures first.
2. The selected use of essential nursing interventions and the elimination of nonessential nursing activities.

3. Adaptation of necessary nursing skills to disaster and other emergencies. The nurse must use imagination and resourcefulness in dealing with a lack of supplies, equipment, and personnel.
4. Evaluation of the environment and the mitigation or removal of any health hazards.
5. Prevention of further injury or illness.
6. Leadership in coordinating patient triage, care, and transport during times of crisis.
7. The teaching, supervision, and utilization of auxiliary medical personnel and volunteers.
8. Provision of understanding, compassion, and emotional support to all victims and their families.

Chapter 15

FIRE SAFETY IN HOSPITAL

What is Fire

Fire is rapid oxidation of a fuel evolving heat, particulates, gases and non-ionizing radiation.

Types of Fire

Class of Fire	Type of Fire	Type of Extinguisher	Extinguisher Identification	Symbol
A	Ordinary combustibles: wood, paper, rubber, fabrics, and many plastics	Water, Dry Powder, Halon		
B	Flammable Liquids and Gases: gasoline, oils, paint, lacquer, and tar	Carbon Dioxide, Dry Powder Halon		
C	Fires involving Live Electrical Equipment	Carbon Dioxide, Dry Powder Halon		
D	Combustible Metals or Combustible Metal Alloys	Special Agents		
K	Fires in Cooking Appliances that involve Combustible Cooking Media: Vegetable or Animal Oils and Fats			

Type of Fire Extinguishers

All fire extinguishers operate in the same way, which can easily be remembered with another acronym, **P.A.S.S.**, which stands for:

P – Pull the pin in the nozzle of the extinguisher;

A – Aim the nozzle at the base of the fire;

S – Squeeze the handle; and

S – Sweep from side to side, covering the fire.

What to do in case of Fire

Everyone has a role and responsibility in the event of a fire emergency, which may involve the rescue of residents and others, assisting with moving them to safety, sounding the alarm, or just staying out of the way of firefighters and other designated emergency response personnel. All healthcare staff should know the following:

- Their facility's Fire Emergency Plan;
- The location of pull/call boxes;
- The location of and how to use a fire extinguisher;

- Places of safe refuge; and
- Evacuation procedures.

If a fire occurs, there will be confusion, excitement, and nervousness. To help staff prepare, providers should routinely conduct fire safety training and practice drills using different scenarios. An easy acronym to help staff retain the information is **R.A.C.E.**, which stands for **Rescue, Alert/Alarm, Confine/Contain, and Extinguish/Evacuate**. Each of these steps should be accomplished while responding to a fire emergency at any location throughout the building.

Role of Nursing Officers:

1. To get trained in fire safety (A detailed fire safety manual is available)
2. To be alert in case of fire and inform the appropriate authority
3. To prevent any possible source of fire at their work place
4. In case of small fire help in extinguishing of the fire and evacuation of patients
5. Senior nursing officer to train the new joined nursing officer or transferred nursing officer of all the fire plan of their ward.

It is important for staff to remember the following:

- Never use elevators to evacuate a fire area.
- Evacuate people closest to danger first, then ambulatory residents, followed by non-ambulatory residents, and lastly, critical residents on life support (because they are not in immediate danger and will need more time and care).
- If possible, move resident charts with the resident.

All staff members should know the primary and secondary safe areas and route of evacuation according to the facility's fire plan, which should be openly displayed.

FIRE CONTROL ROOMS & PHONE NOs.

- Main Hospital / CNC - 26593333/4444
- RPCOS- 26594427
- BRAIRCH - 29575047
- CDER - 26542307
- JPNATC – 26731130

Chapter 16

NURSING IN-SERVICE EDUCATION

INTRODUCTION:

Education plays an important role in achieving organizational goals through a combination of organizational and the workforce interests. Nowadays, training is an essential factor contributing to greater efficiency of the staff and organizations.

In-service training of nurses plays an indispensable role in improving the quality of inpatient care. Need to enhance the effectiveness of in-service training of nurses is an inevitable requirement. The empowering education can facilitate occupational tasks and achieving greater mastery of professional skills among the nurses.

In addition to the theoretical knowledge, vocational training should enhance the technical capacity and quality of services, leading to innovation. Training programs must be organized in such a way that they enhance the beneficial capabilities of nurses. One of the main features of in-service training is applicability of theory knowledge to practical in every nursing procedure.

Nurses play an important role in improving health standards. Hence, they need to be updated about theoretical and practical knowledge in this field. In fact, in-service training serves to update the staff's occupational knowledge and professional skills and improve the best practices for fulfilling various tasks and responsibilities. Another important aspects concerning the in-service training of the nursing staff is their active participation in such programs which leads to effective learning and development in their field of work.

A well structured in-service education program has been initiated since January 2011. Initially it started with twice a week class of one

hour each, which was later on increased to thrice in a week. Two classes in a week are conducted for the bedside nurses (Nursing Officer and Senior Nursing Officer),where as one class in a week is for senior nurses (Sister In-charges and above).

The Goal of nursing in service programme is to empower nurses by maximizing their knowledge base, licensure needs through various modalities like:

- Conferences
- Workshops
- Training Programme
- Weekly Classes
- Quiz
- Role play
- Group Discussion
- Quality Improvement Initiative
- Research
- Public Awareness Programme
- School Health programme
- Development of Various Nursing Modules and SOP's

NURSING IN-SERVICE EDUCATION ACTIVITIES

I. Clinical Teachings

Clinical teaching is provided with an objective of upgrading standard of nursing care and solving practical issues in the area itself. This initiative was started w.e.f 1st January 2015, with an active participation of bedside nurses and supervisory nursing personnel of the clinical areas. From August 2018 onwards clinical teaching handed over to ANS In Charge of the respective wards.

II. **In Service Education Weekly Classes**

Weekly update lectures arranged for nursing personnel on various ward management related topics.

Classes for CNO/NS/DNS/ANS/SNO HR:

- Safe Staffing
- Hepatic Disorders
- Stroke
- Cardiac Emergencies I
- Cardiac Emergencies II
- Acute Kidney Injuries
- Respiratory Emergencies
- SIU & Staffing
- Corona Virus
- Overview of Malignancies

Classes for Senior Nursing Officers/Nursing Officers

- Management of Patients on Ventilator
- Hepatic Disorders
- Stroke
- Cardiac Emergencies I
- Cardiac Emergencies II
- Acute Kidney Injuries
- Respiratory Emergencies
- SIU & Staffing
- Corona Virus
- Overview of Malignancies

III. **Conferences and workshops:**

- Annual **NURSICON** Conference
- Critical care Nursing Update for bedside nursing personnel.
- Mental Health At Workplace for Senior Nursing Officers
- Soft Skills& Communication workshops for nurses.
- Workshops with hands on training for the Pediatric, Intensive care unit and Emergency Nurses.

Chapter 17

NURSING INFORMATICS AT AIIMS

All India Institute of Medical Sciences, New Delhi is a medical college and research institute at New Delhi, India.. The hospital ensures to provide affordable health care for the poorest of patients without compromising the quality.

For the clarity and credibility of the work progressing in AIIMS and to be in accordance with the current information age it has been imperative to adopt and adapt to the latest technology developments to achieve high quality care. AIIMS being premier medical institute and supreme temple of learning in India has sought effective and latest technology to provide standardized health care. As a major thrust towards computerization, hospital information system and electronic medical record were implemented in AIIMS

The successful implementation of the AIIMS e-Hospital Project and the AIIMS OPD Transformation Project, transformed AIIMS to India's fully digital public hospital. This has benefited lakhs of patients and relatives visiting AIIMS, reducing the average waiting time of patients and increasing the transparency and accountability in the functioning of public sector healthcare institutions and which is most marked in the delivery of emergency services as well as out-patient (OPD) services.

This which required proper planning by stake holders and a core team of officials collaborated cordially and constructively for the planning and implementation of e hospital modules at AIIMS.

MODULES OPERATIONAL AT AIIMS

The modules were developed and customised by NIC based on the requirements of AIIMS.These modules were organized in two sections are as follows:

- e-Hospital modules
- In-house modules

e-Hospital modules

- OPD Appointment Module
- IPD (Admission/Discharge/Transfer) Module
- Laboratory Module
- Billing Module
- Dietary Module
- Laundry Module
- Inventory Module
- e-Blood Bank (BOTS module)

In-house modules

- e-MLC((Snomed Integrated)
- Patient Display system (Snomed Integrated)
- Quality Assurance module
- Vitals entry (Snomed Integrated)
- e-OT list
- e-birth module (Snomed Integrated)
- e-death note (NDRI) (Snomed Integrated)
- e-Roster

NURSING INFORMATICS SPECIALIST (NIS)

Nursing Informatics specialist was started in AIIMS with a mission of digitalisation of AIIMS .

Functions and roles of NIS

The three major functions of nursing informatics specialist are coordination, patient care, education & research.

Role of NIS in digitalisation caters to various areas which include direction in developing various programmes along with developers, training to all staff, coordinating with the implementation of software and emergency nurse coordinator providing assistance to patients 24X7.In addition to the above said, the following assignments are also being entrusted to NIS roles:

1. Prepare, educate and provide technical support to end users /staff when a new application is integrated into the healthcare workflow
2. Proactively assist users (faculty members, doctors, nurses and staff) for all IT related issues at their end, and if necessary with the help of computer facility.
3. Interaction with the end users for IT related issues, sorting the issues, if necessary in coordination with computer facility

    i. In case of configuration issues: Configuring the templates, configure mappings wherever applicable. Creating new user Ids/Roles, transfer/change of roles and mappings.
    ii. In case of error /bugs: Bringing this into notice of the concerned officers of computer facility for rectification and follow- up with them until the issue is resolved
    iii. In case of new user requirements: Bringing this into the notice of Prof-in charge computer facility for their approval and follow up the same.
    iv. For hardware/network issues: lodging the complaint at help desk and follow up until the issue is satisfactorily resolved.

Chapter 18

DISCIPLINARY PROCEEDINGS

Introduction: Every Government servant shall at all time, maintain absolute integrity, decorum of conduct and devotion to duty and shall not commit any act which amounts to personal immorality or failure to discharge duties properly.

A Government servant is expected to discharge his duties sincerely and observe utmost discipline of conduct. Any omission or commission in due discharge of his duties will warrant disciplinary action against him as per the provisions of the CCS (Classification, Control and Appeal) Rules, 1965.

CCS (CCA) Rules, 1965 basically form part of the reward and punishment sub-system under personnel management system of organization. It provides a mechanism for dealing with erring employees whose behavior does not conform to the prescribed organizational norms – either by express provision or by necessary implications.

The rules cover the following aspects:

a) What penalties can be imposed on an erring employee? (Rule 11)
b) Who imposes these penalties? (Rule 12 and 13)
c) What is the procedure to be followed for imposing these penalties? (Rule 14, 15, 16, 18, 19, etc.)
d) What remedies are available to the employee after a penalty has been imposed? (Rule 22 to 29A)
e) Issues which are incidental to the above. (Rule 10 [i.e suspension which is a step in aid for conducting inquiry], 31 to 35, etc.)

Complaint: Vigilance Manual (2017 Ed) defines complaint as a piece of statement or information containing details about offences alleged to have been committed under the Prevention of Corruption Act,1988, or malpractice/ misconducts under Conduct Rules governing specified categories of public servants.

Anonymous or pseudonymous complaints: When the complaint is done anonymously or with the name of some person other than the actual complainant, usually no action is taken in these cases.

False complaint: If a complaint is found to be malicious, vexatious or unfounded, departmental or criminal action as necessary may be initiated against the author of false complaints.

Preliminary investigation, also known as Fact Finding Inquiry, is the process of checking the veracity of a complaint and if the complaint is true, to collect evidence in support of the charge. It may be carried out departmentally or by police as the situation warranted.

Possible actions on the Preliminary Investigation report are as under:

a) **Closure of the case**: In case the investigation report indicates that no misconduct has been committed, the case may be closed.
b) **Action against false complaints**: If it is found that complaint was malicious, vexatious or unfounded departmental or criminal action may be initiated against the complainant
c) **Administrative action**: This includes issue of warning, clarification to the decision making authorities, etc.
d) Minor Penalty Proceedings
e) Major penalty proceedings
f) Criminal prosecution

SUSPENSION (Rule 10 of CCS (CCA) Rules, 1965)

Suspension is a temporary deprivation of office. The contract of service is not terminated. However, the Govt. servant placed under suspension is not allowed to discharge the functions of his office

during the period of his suspension. It is not a penalty under the CCS (CCA) Rules, 1965. It is only an intermediate step. However, it visits the Government servant with civil consequences. An appeal lies against the order of suspension (under Rule 23(i)) and the employee is entitled to receive subsistence allowance during the period of suspension.

Rule 10(1): As per rule 10(1) a government servant may be placed under suspensionunder the following situations:

I. Where a disciplinary proceeding is contemplated or is pending; or
II. Where in the opinion of the competent authority, he has engaged himself in activities prejudicial to the interest of the security of the State; or
III. Where a case against him in respect of any criminal offence is under investigation, inquiry or trial;
IV. When Government servant is involved in dowry death case

Deemed suspension: Deemed suspension is a case when a Government Servant is considered to be under suspension without a conscious decision of any of the authorities i.e. the rules create a legal fiction in which though no actual order is issued it is deemed to have been passed by operation of the legal fiction. Such a suspension is deemed to have arisen consequent to the happening of certain events. Nevertheless an order is required to be passed by the competent authority

Rule 10(2)

During the service period, a person is deemed to have been placed under suspension in the following cases:-

1. From the date of detention in custody (whether on criminal charge or otherwise) for a period exceeding 48 hours.
2. From the date of conviction for an offence leading to imprisonment for a period exceeding 48 hours if he is not forthwith dismissed or removed or compulsorily retired

consequent upon such conviction. (48 hours will be computed from the commencement of the imprisonment).

Government servant to intimate his/her arrest/conviction:
Although the Police Authorities will send prompt intimation of arrest and/or release on bail etc., of a Government servant to the latter's official superior as soon as possible after the arrest and/ or release indicating the circumstances of the arrest etc., but it is also the duty of the Government servant who may be arrested, or convicted, for any reason to intimate promptly the fact of his arrest/conviction and circumstances connected therewith to his official superior even though she/he might have been released on bail. Failure to do so will render him liable to disciplinary action on this ground alone.

Revocation of the order of suspension and the Review Committee.
Rule 10(5): The general rule is that an order of suspension made or deemed to have been made may at any time be modified or revoked by the competent authority.
Rule 10(6): An order of suspension made or deemed to have been made will not be valid after a period of 90 days unless it is extended after review by the Review Committee constituted. This review has to be done before expiry of ninety days from the effective date of suspension. If it is decided to further continue the suspension, it shall not be continued beyond 180 days at a time. After 180 days, the review has to be done again.
On the conclusion of the disciplinary proceedings, if a minor penalty is imposed, suspension is regarded as unjustified and full pay and allowances and other consequential benefits are given to him/her and the period of suspension is treated as duty.

Subsistence allowance: A Government servant placed under suspension or deemed suspension is not entitled to salary but is entitled to draw for the first three months subsistence allowance at an amount equal to leave salary during half pay or half average payplus dearness allowance as admissible on such amount (i.e. pro-rata) but

CCA and HRA as admissible to him before suspension. The matter is regulated by the provisions of F.R.53. The order for subsistence allowance is usually passed simultaneously with the order of suspension or as early as possible to avoid hardship to the concerned Government servant**.**

Review of Subsistence Allowance: If the period of suspension exceeds 3 months, the amount of subsistence allowance may be increased or decreased up to a maximum of 50% of the amount being drawn by him during the first three months, depending on whether the reasons for continued suspension are attributable directly or indirectly to the Government servant.

PENALTIES:

The following penalties may, for good and sufficient reasons and as hereinafter provided, be imposed on a Government servant, namely:-

Minor Penalties -

(i). **Censure**: An order of "Censure" is a formal and public act intended to convey that the person concerned has been guilty of some blameworthy act or omission for which it has been found necessary to award him a formal punishment, and nothing can amount to a "censure" unless it is intended to be such a formal punishment and imposed for "good and sufficient reason" after following the prescribed procedure. A record of the punishment so imposed is kept on the officer's confidential roll and the fact that he has been 'censured' will have its bearing on the assessment of his merit or suitability for promotion to higher posts.

There may be occasions, on the other hand, when a superior officer may find it necessary to criticize adversely the work of an officer working under (e.g. point out negligence, carelessness, lack of thoroughness, delay etc.) or he may call for an explanation for some act or omission and taking all circumstance into consideration, it may be felt that, while the matter is not serious enough to justify the imposition of the formal punishment of 'censure' it calls for some informal action

such as the communication of a written warning, admonition or reprimand, if the circumstances justify it, a mention may also be made of such a warning etc., in the officer's confidential roll; however, the mere fact that it is so mentioned in the character roll does not convert the warning etc. into "censure". Although such comments, remarks, warning etc., also would have the effect of making it apparent or known to the person concerned that he has done something blame-worthy and, to some extent, may also effect the assessment of his merit and suitability for promotion, they do not amount to the imposition of the penalty of 'Censure' because it was not intended that any formal punishment should be inflicted.

(ii). Withholding of his/her promotion;

(iii). Recovery from pay of the whole or part of any pecuniary loss caused by him/her to the Government by negligence or breach of orders;

(iiia) Reduction to a lower stage in the time-scale of pay by one stage for a period not exceeding three years, without cumulative effect and not adversely affecting his/her pension.

(iv). Withholding of increments of pay;

Major Penalties –

(v). Same as provided for in clause (III) (a), reduction to a lower stage in the timescale of pay for a specified period, with further directions as to whether or not the Government servant will earn increments of pay during the period of such reduction and whether on the expiry of such period, the reduction will or will not have the effect of postponing the future increments of his pay;

(vi). Reduction to lower time-scale of pay, grade, post or Service for a period to be specified in the order of penalty, which shall be a bar to the promotion of the Government servant during such specified period to the time-scale of pay, grade, post or Service

from which he was reduced, with direction as to whether or not, on promotion on the expiry of the said specified period –

a) The period of reduction to time-scale of pay, grade, post or service shall operate to postpone future increments of his pay, and if so, to what extent; and

b) The Government servant shall regain his original seniority in the higher time scale of pay, grade, post or service;

(vii) Compulsory retirement;

(viii) Removal from service which shall not be a disqualification for future employment under the Government;

(ix) Dismissal from service which shall ordinarily be a disqualification for future employment under the Government.

Provided that, in every case in which the charge of possession of assets disproportionate to known-sources of income or the charge of acceptance from any person of any gratification, other than legal remuneration, as a motive or reward for doing or forbearing to do any official act is established, the penalty mentioned in clause (viii) or clause (ix) shall be imposed.

Provided further that in any exceptional case and for special reasons recorded in writing, any other penalty may be imposed.

Explanation: The following shall not amounted to a penalty within the meaning of this rule, namely:—

(i). withholding of increments of pay of a Government servant for his failure to pass any departmental examination in accordance with the rules or orders governing the Service to which he belongs or post which he holds or the terms of his appointment;

(ii). stoppage of a Government servant at the efficiency bar in the timescale of pay on the ground of his unfitness to cross the bar;

(iii). non-promotion of a Government servant, whether in a substantive or officiating capacity, after consideration of his case, to a Service, grade or post for promotion to which he is eligible;

(iv). reversion of a Government servant officiating in a higher Service, grade, or post to a lower Service, grade or post, on the ground that he is considered to be unsuitable for such higher Service, grade or post or on any administrative ground unconnected with his conduct;

(v). reversion of a Government servant, appointed on probation to any other Service, grade or post, to his permanent Service, grade or post during or at the end of the period of probation in accordance with the terms of his appointment or the rules and orders governing such probation;

(vi). replacement of the services of a Government servant whose services had been borrowed from a State Government or an authority under the control of a State Government, at the disposal of the State Government or the authority from which the services of such Government servant had been borrowed;

(vii). compulsory retirement of a Government servant in accordance with the provisions relating to his superannuation or retirement;

(viii). termination of the services—

a. of a Government servant appointed on probation, during or at the end of the period of his probation, in accordance with the terms of his appointment or the rules and orders governing such probation; or

b. of a temporary Government servant in accordance with the provisions of sub-rule (1) of rule 5 of the Central Civil Services (Temporary Service) Rules, 1965; or

c. of a Government servant, employed under an agreement, in accordance with the terms of such agreement.

(ix). Any compensation awarded on the recommendation of the Complaints Committee referred to in the proviso to sub-rule (2) of rule 14 and established in the Department of the Government of India for inquiring into any complaint of sexual harassment within the meaning of rule 3 C of the Central Civil Services (Conduct) Rules, 1964.

Common procedure for imposing penalties: following rule sections CCS (CCA) rules 1965 are followed for imposing penalties:

Rule 14- Procedure for imposing major penalties
Rule 15- Action on inquiry report
Rule 16- Procedure for imposing minor penalties
Rule 17 –Communication of orders
Rule 18- Common proceedings

Appeal: Government servant may prefer appeal as per the provisions of rule 22-25 of CCS (CCA) rules 1965 except in following orders against which no appeal lies

(i). Any order made by the President;
(ii). Any order of an interlocutory nature or of the nature of a step-in-aid of the final disposal of a disciplinary proceeding, other than an order of suspension;
(iii). Any order passed by an inquiring authority in the course of an inquiry under Rule 14.

Period of limitation of appeal:
No appeal preferred shall be entertained unless such appeal is preferred within a period of 45 days from the date on which a copy of the order appealed against is delivered to the appellant.
The Appellate authority may entertain the appeal after the expiry of the said period, if it is satisfied that the appellant had sufficient cause for not preferring the appeal in time.

FURTHER READING: Central Civil Services (Classification, Control and Appeal) Rules, 1965. *https://dopt.gov.in/ccs-cca-rules-1965*

Chapter 19

PATIENT SAFETY

Patient safety

The delivery of safe, high-quality patient care is of utmost importance to nurses. As nursing care spans all areas of care delivery, nurses are well placed to prevent harm to patients and improve the quality and safety of healthcare delivered across all settings. As such, nurses should be central to the design and operation of all health providers' patient safety systems and processes.

(Reference: International Council of Nurses https://www.icn.ch/nursing-policy/icn-strategic-priorities/patient-safety)

What is Patient Safety?

Patient Safety is a health care discipline that emerged with the evolving complexity in health care systems and the resulting rise of patient harm in health care facilities. It aims to prevent and reduce risks, errors and harm that occur to patients during provision of health care. A cornerstone of the discipline is continuous improvement based on learning from errors and adverse events

The Burden of harm

Many medical practices and risks associated with health care are emerging as major challenges for patient safety and contribute significantly to the burden of harm due to unsafe care. Below are some of the patient safety situations causing most concern.

1. **Medication errors** are a leading cause of injury and avoidable harm in health care systems: globally
2. **Health care-associated infections** occur in 7 and 10 out of every 100 hospitalized patients in high-income countries and low- and middle-income countries respectively
3. **Unsafe surgical care procedures** cause complications in up to 25% of patients. **Unsafe injections practices** in health care settings can transmit infections, including HIV and hepatitis B and C, and pose direct danger to patients and health care workers; **Diagnostic errors** occur in about 5% of adults in outpatient care settings, more than half of which have the potential to cause severe harm.
4. **Unsafe transfusion practices** expose patients to the risk of adverse transfusion reactions and the transmission of infections
5. **Radiation errors** involve overexposure to radiation and cases of wrong-patient and wrong-site identification
6. **Sepsis** is frequently not diagnosed early enough to save a patient's life. Because these infections are often resistant to antibiotics, they can rapidly lead to deteriorating clinical conditions
7. **Venous thromboembolism (blood clots)** is one of the most common and preventable causes of patient harm, contributing to one third of the complications attributed to hospitalization.

NURSING AS THE KEY TO IMPROVING QUALITY THROUGH PATIENT SAFETY

Nursing has clearly been concerned with defining and measuring quality long before the current national and State-level emphasis on quality improvement. Florence Nightingale analyzed mortality data among British troops in 1855 and accomplished significant reduction in mortality through organizational and hygienic practices.[14]She is

also credited with creating the world's first performance measures of hospitals in 1859.

Many have often viewed nursing's responsibility in patient safety in narrow aspects of patient care, for example, avoiding medication errors and preventing patient falls. While these dimensions of safety remain important within the nursing purview, the breadth and depth of patient safety and quality improvement are far greater. The most critical contribution of nursing to patient safety, in any setting, is the ability to coordinate and integrate the multiple aspects of quality within the care directly provided by nursing, and across the care delivered by others in the setting

promote safety!

(Reference: https://www.who.int/news-room/fact-sheets/detail/patient-safety)

WHO SURGICAL SAFETY CHECKLIST

(Ref.https://www.who.int/patientsafety/topics/safe-surgery/checklist/en/)

The WHO Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery. The 19-item checklist has gone on to show significant reduction in both morbidity and mortality and is now used by a majority of surgical providers around the world.

Surgical Safety Checklist

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

Before induction of anaesthesia

(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision

(with nurse, anaesthetist and surgeon)

- ☐ **Confirm all team members have introduced themselves by name and role.**
- ☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

Chapter 20

COVID-19: RESOURCES FOR NURSING OFFICERS

During the currently rapidly evolving pandemic of COVID-19, guidelines, recommendations and advisories are issued by hospital. These are available at following link:
https://covid.aiims.edu/

In addition, Hospital Infection Control Committee organises large no. of training programmes and created online learning resources for Capacity Building of Health Professionals. Resource material is available on following topics

- Infection Prevention & Control Guidelines
- Updated Infection Prevention & Control Guidelines
- Appropriate use of PPEs
- PPE- Donning & Doffing
- Hand hygiene
- Safe intubation
- PICC lines
- Arterial lines
- NP swab sampling
- Other Sample Packing and Transport
- Clinical Management Guidelines
- Dead Body Management

These Learning Resources are available at:
https://covid.aiims.edu/training/

COVID-19 Special Training Course for Nurses is available at:https://saral.aiims.edu/enrol/index.php?id=641

Appendix:

FORMAT FOR MEDICINE & EQUIPMENT AUDIT

****

Medicine & Equipment audit need to be done by different wards/ areas/ departments.

Medicine Audit (Format)

Area/ ward/ Department: _____

Nodal officer:_____

External audit team (Nodal Officer):_____

Date of external audit:_____

1. **Crash-cart:**
   a. Has the crash-cart checklist been maintained: Yes/ No
   b. Are the drugs located in designated places within crash-cart: Yes/ No
      If no, please elaborate:
   c. Any near expiry/ expired medicines in the crash cart: Yes/ No
      If yes, details:

Sl No.	Name of the drug	Date of expiry

2. **Medicine sub-store:**

Sl No.	Name of the drug	Date of expiry

Equipment audit (Format)

Area/ ward/ Department:_____

Date:_____

Nodal officer:_____

External audit team (Nodal Officer):_____

Date of external audit:_____

Sl No	Equipment	Quantity	Functional Status	Critical/ Non-critical	Date of installation	Under warranty/ CMC/ AMC	**Remarks (By external audit team)**

*Nodal officer of respective ward/ area/ department to arrange the equipment in descending order of criticality/ importance for functioning of ward/ area/ department and the respective columns to be prefilled in readiness.

The equipment will be physically assessed by the external audit team before filling the last column