STANDARD OPERATIVE POLICY

DEPARTMENT OF ORTHOPEDIC

HOSPITAL TENGKU AMPUAN AFZAN (HTAA), KUANTAN, PAHANG

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Orthopedic Clinic , Orthopedic Wards
and Orthopedic Operation Theatre

1.0 WAWASAN JABATAN ORTOPEDIK, HOSPITAL TENGKU AMPUAN AFZAN (HTAA)

Jabatan Orthopedik berazam dan berjanji akan memberi rawatan dalam bidang orthopedik kepada semua pesakit dan ahli keluarga mereka yang mempunyai masalah orthopedik berasaskan prinsip kerja dan wawasan Kementerian Kesihatan Malaysia.

Kami akan memberikan rawatan yang

- Adil dan saksama
- Cekap dan amanah
- Berteknologi terkini (mengikut kemampuan) dan sesuai
- Bersesuaian dengan persekitaran
- Berdasarkan keutamaan penyakit
- Berlandaskan etika professionalisma dan penyayang
- Melibatkan penyertaan pesakit dan ahli keluarga
- Berasaskan kecemerlangan ilmu yang terkini

Sistem ini juga mengutamakan:

- Kualiti dan Inovasi mutu kerja melalui program – program yang tersusun
- Promosi kesihatan untuk pencegahan dan juga untuk rawatan
- Hormat kepada kemuliaan insan
- Mengekalkan tanggungjawab individu
- Penjagaan dan penyelenggaran alatan perubatan yang bersistematik
- Penyertaan ahli keluarga dalam tanggungjawab bersama
- Penyaluran maklumat yang benar dan tepat kepada pesakit
- Keharmonian hubungan sesama kakitangan jabatan sentiasa terbaik
- Keselamatan dan kebajikan pesakit dan ahli keluarga terpelihara
- Keselamatan dan kebajikan kakitangan jabatan juga turut terpelihara

2. 0 MISI JABATAN ORTHOPEDIK, HTAA

Misi Jabatan Orthopedik, HTAA adalah melaksanakan perkhidmatan dengan berlandaskan ciri-ciri Budaya Korporat, Kementerian Kesihatan Malaysia iaitu Professionalisma, Perkhidmatan Penyayang dan Kerja Berpasukan.

3.0 OBJEKTIF JABATAN ORTHOPEDIK, HTAA

3.0.1. Objektif Umum

Untuk memberi perkhidmatan kesihatan dari aspek promosi pencegahan dan kuratif yang bersepadu kepada pesakit-pesakit serta mengamalkan taraf kesihatan yang optimal dengan mencegah dari penyakit-penyakit supaya membolehkan pesakit-pesakit hidup dalam fizikal, mental dan sosial yang baik dan sempurna.

3.0.2. Objektif Khusus

a. Menyelia Perkhidmatan Rawatan Pesakit Luar dan Dalam dengan cemerlang
b. Meninggikan daya pengeluaran dan menjamin nilai-nilai BUDAYA KERJA yang baik
c. Menerima dan merawat pesakit-pesakit daripada lain-lain institusi perubatan yang memerlukan rawatan khas atau rawatan daripada doktor dan pakar yang tidak boleh didapati dari institusi masing-masing
d. Berusaha dari masa ke semasa untuk memperbaiki mutu perkhidmatan hospital supaya akan mencapai taraf kesihatan yang lebih tinggi dan cekap
e. Menyediakan perkhidmatan pendidikan

5.0 POSITION DESCRIPTION AND DUTY

Descriptions of duty applies to both practicing consultants or specialists from both KKM and UIAM.

5.1 List of General Duty

5.1.1 Head of Department,
5.1.2 Consultant or Specialist In Charge of Ward and other various job delegation
5.1.3 Specialist or Clinical Specialist,
5.1.4 Medical Officers (M.O.)
5.1.5 Medical Officers (1st, 2nd and 3rd.) on call team
5.1.6 House Officers (HO) - modified flexi-hours shift duty
5.1.7 Head of Unit
5.1.8 Matron
5.1.9 Sister
5.1.10 Assistant Medical Officer
5.1.11 Nurses
5.1.12 Nurse In-Charge
5.1.13 Assistant for Medical Nursing (Attendant)

5.2. List of Specific Duty for Special Department Activity for Consultant or Specialist (assigned by HOD):

5.2.1 Lean Healthcare Committee
5.2.2 Safe Surgery Safe Life (SSSL)
5.2.3 Accreditation
5.2.4 JKKP
5.2.5 Drugs Committee
5.2.6 OT Committee (OT Manager)
5.2.7 KPI/NIA/QAP/H.S.I.
5.2.8 Budgeting (financial)
5.2.9 Wound-care Team
5.2.10 Wards Manager
5.2.11 HO Committee/Manager
5.2.12 Medical Advisory Committee
5.2.13 POMR and Morbidity/Mortality Unit
5.2.14 MO Manager
5.2.15 Clinic Manager
5.2.16 Research Manager
5.2.17 Case Mix
5.2.18 Lab Manager
5.2.19 Blood Transfusion Unit
5.2.20 Radiation Committee
5.2.21 Complaint Handling Unit (CHU)
5.2.22 Clinical Research Centre (CRC)
5.2.23 Infectious Control Unit
5.2.24 Departmental Sport Activity (DESA)

5.2.25 MyCPD
5.2.26 Incident Reporting
5.2.27 SKT and LNPT
5.2.28 Oncall Roster (Specialist)
5.2.29 Daycare Service and Surgery
5.2.30 Peripheral Hospitals – visiting specialists for clinic and OT
5.2.31 JK Khas Rekod Perubatan
5.2.32 Panel Jemaah Haji (Ortho)
5.2.33 JK Clinical Audit BHT

5.3 List of Specific Duty for Special Department Activity for MO:

5.3.1 Medical Officer in charge of Morbidity and Mortality
5.3.2 Medical Officer in charge of Accreditation
5.3.3 Medical Officer in charge of House Officer CME
5.3.4 Medical Officer in charge of Radiology Conference
5.3.5 Medical Officer in charge of Histopathology Conference
5.3.6 Medical Officer in charge of Department Statistic
5.3.7 Medical Officer in charge of Post Graduate CME
5.3.8 Medical Officer in charge of Quality Program

6.0 ORGANIZATION OF STAFF

6.1 Head of Department (HOD)

6.1.1 HOD is the overall Consultant In-Charge of Orthopedic Services in Hospital Tengku Ampuan Afzan (HTAA).

6.1.2 In an absence of HOD, the Consultant In-Charge shall be the next most senior Consultant or Specialist from KKM.

6.1.3 If none of the KKM Consultants or Specialist available, the Consultant on-call from UIAM will be responsible on that particular day.

6.2 Consultant In-Charge

6.2.1 Consultant In-Charge in the Department of Orthopedic HTAA will be appointed by the HOD based on the availability of hospital resource (operating time, clinic space and human resources) and experience of the consultant..

6.2.3 All other Consultants or Specialists or Trainees will be working directly under the supervision of the Consultant In-Charge with regards to their clinical services.

6.3 Head of Unit

6.3.1 Medical Officer In-Charge of Roster and others issues related to their function (Chief M.O.)

6.3.2 House Officer In-Charge of Flexi-hours schedule and others issues related to their function (Chief H.O.) in conjunction of Consultant or Specialist In-Charge HO

6.3.2 Matron (In-Charge of Overall Orthopedic Nursing Services),

6.3.3 Sisters (In-Charge of the each Orthopedic Wards, Orthopedic Clinic and Orthopedic Operation Theatre),

6.3.4 Assistant Medical Officer In-Charge of Orthopedic Out-Patient Services,

6.3.5 Assistant Medical Officer In-Charge Orthopedic Operation Theatre

6.3.6 Such duty and role shall be reviewed annually by the HOD

6.4 Staff Allocation

6.4.1 Allocation and placement of paramedics will be according to assignment done by the hospital authorities.

6.4.2 Medical Officers those have been assigned in Orthopedic Department will be periodically rotated, based on the prepared rotation list (approved by HOD)

6.5 On-Call List / Duty

6.5.1 Chief MO will be responsible in preparing the on-call list every month and chief HO will also be responsible in preparing the flexi-hours schedule for HO after discussion with Specialist In-Charge HO and both documents require final approval by HOD

6.5.2 The both documents shall be submitted a few days before the new months begin.

6.5.3 It shall be distributed to all the doctors and relevant units in the hospital.

6.5.6 A check list shall be maintained in the Orthopedic Clinic to ensure the complete delivery of the list.

6.5.6 For medical legal purpose, current and previous list shall be compiled in a file. Any change made to it, should be notified to the main list placed in the file at clinic.

6.5.7 Pass over round shall be conducted by Specialist and Medical Officer on-call and House Officer on duty for the particular flexi-hour (based on schedule)

6.6 Rotation Duty for the Ward / Clinic

6.6.1 An officer for each category (Chief MO and Chief HO) will be assigned to prepare a rotation list for both the medical officer and House officer for the ward duty.

6.7 Rotation of Consultant / Specialist for each Consultant In-Charge

6.7.1 An officer for each category (Chief MO and Chief HO) will be assigned to prepare a rotation list for both the Medical Officer and House Officer for the ward duty.

6.7.2 A minimal of one consultant or specialist is assigned to be in clinic on daily basis based on a roster prepared by Consultant In-Charge Clinic (Clinic Manager) to see patient in general orthopaedic clinic – 1 clinic 1 specialist concept

6.7.3 Every consultant and specialist either from KKM or UIAM has his/her own clinic session once or twice a week. This clinic preferably should be run by respective consultant and specialist him/herself but for some acceptable reason, a senior medical officer could run the clinic

6.8 Networking list

6.8.1 A list of networking visitation to district hospitals shall be prepared for the whole year by the Consultant or Specialist In-Charge Peripheral Hospital.

6.8.2 The list shall be made known and copies sent to the respected hospital.

6.9 Assignment of Duty for each Departmental Activity

6.9.1 For each departmental activity, a head of unit is assigned to oversee the continous running of their programme. A schedule (taqwin) has to be prepared for the whole year and compiled.

6.9.2 Past activity and attendance will be compiled in the files placed in respective division for future reference.

7.0 SCOPE OF SERVICES

7.1 In-patient Services

7.1.1 In-Patients Services shall be on 24 hours basis. On-call duty (for medical officer and paramedics) and shift duty (for House Officers and paramedics) list will be prepared by personals in-charge

7.1.2 The General Hospital Policy and In-Patient Policy shall be followed.

7.2 In-patient Services

7.2.1 Out-Patients Care is provided in Orthopedic Clinic HTAA

7.2.2 The General Hospital Policy and Out-Patient Policy shall be followed.

7.3 In-patient Services and In-patient Services in Networking Hospitals

7.3.1 Networking Hospitals namely Hospital Pekan, Hospital Sultan Haji Ahmad Shah (HoSHAS), Hospital Kuala Lipis and Hospital Muadzam Shah.

7.3.2 The in-patient services inclusive of doing operation and out-patient services are provided only for sub-speciality cases namely arthroplasty, paediatric and sport injury cases in HoSHAS and Hospital Kuala Lipis.

7.3.3 The in-patient and out-patient services are provided for general orthopaedic cases in Hospital Muadzam and Hospital Pekan.

7.3.3 The General Hospital Policy, In-patient and Out-patient Policy of respective networking hospital shall be followed.

7.4 Day Care Services

7.4.1 Day care services will be provided and the General Hospital Policy will be followed.

8.0 ORGANIZATION OF THE DEPARTMENT

8.1 Meeting

8.1.1 Mesyuarat Jabatan – Shall be held at least thrice a year
Chaired by HOD or Senior Consultant and members are all doctors (UIA & KKM), Head of Units and every category of staff.

8.1.2 Mesyuarat Pengurusan Ketua Unit (Peringkat Jabatan)
It shall be held monthly. Chaired by HOD or Senior Consultant and members consist of all the Head of Units. The secretariat shall be rotated among each of Head of Unit

8.1.3 Mesyuarat Peringkat Unit – Shall be held at least monthly
Chaired by Head of Unit and attended by members of each unit.

8.1.4 All minutes and attendance list shall be filed and maintained in accordance to hospital policy.

8.2 Departmental Activity

8.2.1 Individual in-charge of each activity will be nominated early of the year. The person will be responsible for organizing and record keeping. Itineraries and attendance list will always be maintained. The person in-charge is subjected to changes by HOD

8.3 CME

8.3.1 CME Activity both for the Medical officer and House officer will be conducted.

8.3.2 Activity includes House Officer CME, Journal/ Coffee Club and Business/ Grand Round

8.4 Surgical Audit

8.4.1 Surgical Audit for the department will be maintained and organized on daily, weekly or bi-weekly basis

8.4.2 Activity includes Morning Pass-Over (daily), Mortality and Morbidity Meeting (bi-weekly) and Cencus (weekly).

8.5 Continous Assessment

8.5.1 On-going assessment of the House Officers will be conducted twice during their posting.

8.5.2 The House Officer will be assessed based on their log book, viva session, senior medical officer and head of unit review.

8.5.3 On-going assessment for non-UIAM post-graduation students will be done by their respected consultant whom has been appointed by their university (external lecturer)

8.5.4 On-going assessment for UIAM post-graduation students will be done by their lecturers and respected consultant whom has been appointed by UIAM (external lecturer)

8.5.5 On-going assessment for other categories of staffs will be done by their respected head of units.

9.0 KKM and UIA

9.1 The Underlying Principles

9.1.1 All patients admitted to this hospital belong to KKM and KKM are liable to them.

9.1.2 HOD of the KKM is ultimately responsible for all the patients.

9.1.3 This responsibility will be shared by the appointed Consultant In-Charge through delegation of jobs by HOD.

9.1.4 All UIAM Consultants, Specialists and Trainees must adhere to the departmental, hospital and KKM Policy strictly.

9.1.5 As we are, they shall produce medical report of patient under their care if needed.

9.1.6 As we are, they are liable to write reports for failure to achieve any set of quality indicators such as KPI, NIA and etc.

9.1.7 If any of the Consultants, Specialists and Trainees fails to follow the departmental and hospital policy, they could be struck off and disallowed from practicing in the wards, on-call duty, Operating Room, Plaster of Paris (POP) Room, Treatment Room, out-patient services or anywhere in this department.

9.1.8 Specialist from both KKM and UIAM will work as a team to ensure delivery of all listed services in the Orthopedic Department, HTAA.

9.1.9 The KKM and UIAM are obligated for the training of officers posted in department during their orthopedic posting.

9.1.10 They are expected to participate in all department activities.

10.0 QUALITY ASSURANCE

10.1 KPI & NIA

10.1.1 KPI and NIA based on the KKM requirement will be maintained.

10.1.2 Every staff shall cooperate and participate with such programme such as Waiting Time Study, Patient Satisfaction Survey, Internal Audit and etc

10.1.4 Head of units are responsible to maintain the statistic and initiate a study if .required

10.2 Incidental Reporting

10.2.1 Every staff shall cooperate and participate in such programme.

11.0 ORGANIZATION OF PATIENTS / PATIENT OWNERSHIP

11.1 All patients admitted to this hospital belongs to KKM and KKM are liable to them.

11.2 HOD of the KKM is ultimately responsible for all the patients.

11.3 This responsibility will be shared by the appointed Consultant In-Charge.

11.4 Consultant In-Charge will be directly in charge to a group of patients who were admitted to the wards during their on call day and any new cases personally is referred to him/her.

11.6 He/ She is responsible in maintaining reasonable waiting time in the clinic, ensuring OT cancellation rate below the standard value set by KKM and always remain compliant to all the other KPI and NIA.

11.7 A system of patient ownership will be developed by the department and implemented by head of unit in the department.

12.0 DEPARTMENT CLINICAL SAFETY MEASURE

12.1 It is a process to counter check and supervising work of young staffs/officers by senior and more responsible staffs/officers.

12.2 Hierarchy -Every category of staff shall respect the hierarchy system. Immediate senior shall be consulted for any event of reasonable doubts or difficulty.

12.3 Result of any HPE result can be noted to HO but need to show and get countersign from senior medical officer, specialist or consultant.

12.4 Countersign all Lab results by the doctors before filing in the case notes

12.5 Screening all newly clerked patients in clinic and wards by the Medical Officer or Specialist In-Charge

12.6 Screening of the case notes of the defaulters and discharged patient from orthopaedic clinic

12.7 All urgent new and transferred-in-patient will be reviewed by doctors on duty within 15 minutes and all other patients (non-urgent cases) will be review within one hour.

12.8 All new patients shall be seen and reviewed by the specialist within 24 hours of admission

12.9 Countersign the prescription of drugs as required by the hospital policy

12.10 Countersign of certain radiological procedures as required by the hospital policy.

12.11 Countersign all the referral forms to a higher level of referral centres at least should be done by Medical Officer

12.12 Ward rounds will be done regularly by the doctors and sisters

13.0 OTHERS

13.1 Needle Prick Injury

13.1.1 All the staffs are advised to take precaution to avoid needle prick Injury.

13.1.2 All needle prick injury events shall be reported to the incident reporting unit, HTAA and an explanation letter shall be written to HOD.

13.1.3 Hospital Needle Prick Injury Protocol shall be strictly followed

13.2 Infection Control

13.2.1 All staff is required to practice hand-washing before and after every procedure

13.2.2 All staff is required to practice hand-washing before and after examination every patients

13.2.3 Other guidelines regarding Infection Control shall be strictly followed

13.3 Discharge Summary

13.3.1 Discharge summary must be completed upon the patients discharged.

13.3.2 All summary must be countersigned by medical officer.

13.3.3 Adequate medication, memo, appointment, special instruction and Medical Certificate (M.C.) are supplied.

13.3.4 Diagnosis must be correct according to ICD 10.

13.4 Death Summary

13.4.1 Death summary must be completed when the patient died before the case note despatched.

13.4.2 Cause of death must be appropriately according to ICD 10.

13.5 Medical Reports

13.5.1 All specialist / medical Officer actively working in the department have to write medical report.

13.5.2 Medical report with no monetary benefits such as police report will be rotated among all specialist / medical officer.

13.5.3 All medical report shall be completed within 10 days

13.5.4 Doctors who is failed to adhere to NIA standard of 10 days completion of medical report have write an explanation letters.

13.5.5 All patients' document / case notes will be the responsibility of the assigned doctor. Police report has to be filed if any of the document / case notes is missing.

13.5.6 Consultant / specialist from KKM and UIAM will produce medical report for patient under their care as requested by the hospital authority within a respectable period of time.

13.6 Claims (Tuntutan Perjalanan and EKLWB)

13.6.1 Completed claim forms for claims of previous month must be submitted by the 5th day of the new month.(or earlier if coincidentally associated with long holidays)

13.6.2 If delayed, no guarantee that the claim forms will be processed and subjected to consideration from HOD, Hospital Director, KKM and MOF

13.6.3 The privilege to claim may be lost if the claim is delayed by more than two months.

13.7 Leave

13.7.1 Leave application shall be planned ahead before the on-call list is out.

13.7.2 Application of leave after the list is out shall not disrupt the on call list unless in urgent situation.

13.7.3 Doctors are encouraged to finish off their annual leave before year end by planning ahead.

13.7.4 Accumulated leave cannot be taken at the end of their service (before transfer) unless there are available staff and with the exception of termination of service.

13.7.5 Leave for the doctors should be approved by both Specialist In-Charge and HOD before going for leave.

13.7.6 Leave for the nursing staff should be approved by both the sisters and matron in-charge before going for leave.

13.7.7 Leave for the Assistant Medical Officer should be approved by both Senior AMO (head of Unit) and HOD before going for leave.

13.7.8 Leave for the Pembantu Tadbir (PT) and Personal Assistant should be approved by HOD before going for leave.

13.7.9 The leave form should be submitted and signed by the respective officers in-charge preferably a week before going for leave unless an emergency leave.

13.7.10 If an emergency leave is to be taken for any reason, he/ she needs to get approval from the respective officers in-charge, may be by phone. Once he/ she come back to work, the leave form is required to be filled and submitted for record.

13.8 Statistics

13.8.1 Maintaining of statistics and returns is the responsibility of Head of Unit and by persons in-charge of each departmental activity.

13.9 Credentialling and privileging

13.9.1 All categories of staff should be credentialed by the hospital board (KKM and UIAM staffs)

13.9.2 Log Book shall be maintained by the respective staff both hard and soft copies

13.9.3 All doctors with the exception of HO should be licensed to practice

13.9.4 They are responsible for acquiring the MMC registration and the renewal of annual practicing certificate (APC).

13.9.5 Rule and regulation of Credentialing and Priveliging application and renewal procedure will always adhere to HTAA policy

13.10 Attitude and Conduct

13.10.1 Doctors should sign an undertaken (Akujanji) to follow the MMC ethics code

13.10.2 The paramedics should adhere to hospital policy and their professional code of conduct.

13.11 CME and CPD

13.11.1 The Orthopaedic Department shall organize CME activity for the member of staff.

13.11.2 Their participation shall be properly documented and maintained.

13.11.3 Every category of staff will be identified for general and special training if there is a need to improve service.

13.11.4 Every staff is required to maintain and submit their CPD report every quarterly. This has be done online and maintained in hard copy.

13.12 Standard of Care

13.12.1 Shall follow the qualification of the staff and in accordance to the CPG developed by the Ministry of Health.

13.13 Usage of Drugs and Consumables

13.13.1 The usage of drugs in the form of antibiotic and medications shall follow the department, hospital and KKM guidelines.

13.13.2 The usage of expensive consumables are subjected to the guidelines by the department.

13.13.3 All local purchase form shall be filled by a requesting specialist and approved by HOD or senior consultant appointed by him/ her before submitting to Bahagian Kewangan, HTAA

13.14 Orientation Programme

13.14.1 A structured orientation programme should be prepared and introduced to new staff into each unit of the department. Check list of what to-do and what to-see during orientation period as well as attendance will be maintained.

13.14.2 Orientation programme should be tailored specifically for orthopaedic department and should complementary to the Hospital Orientation Programme.

STANDARD OPERATIVE POLICY

IN-PATIENT CARE

DEPARTMENT OF ORTHOPAEDIC HOSPITAL TENGKU AMPUAN AFZAN

(FROM 2014 ONWARD)

5.0 ORGANIZATIONAL STRUCTURE

- HOD is responsible for the overall service and clinical care provided in the surgical ward.

- There will be Consultant In-Charge with at least one specialist in-charge in each ward for handling all aspect of In-patient Care Services.

- In the absence of the Consultant In-Charge, specialist on- call should be consulted.

- The Matron shall be in charge of nursing service in which includes monitoring nursing quality and identifying nursing training needs and problems.

- The sister is the manager of each ward. She is directly in charge in day to day operation of the ward ensuring smooth operation in- terms of clinical nursing care, ward supply and maintaining structural entity. She also responsible for the maintaining patients record and ward statistical compilation

- The sister will be assisted in every shift duty by the appointed staff-nurse who will assume her responsibility to a lesser degree when she is not around.

- The sister will always cooperate with Matron, Specialist In-Charge, Consultant In-Charge and HOD to ensure that all categories of staff in adhere to their work process, department and hospital policy.

- The sister will conduct and chair a meeting with the nursing team at least every month and she will participate in the Mesyuarat Pengurusan Ketua-Ketua Unit every month.

6.0 Ward Structure

- The ward shall be divided into acute bed, sub-acute surgical bed, non-acute and isolation room.

- Criteria of admission in each category should strictly depended on Priority of Care

- All avenues to organize the bed elsewhere in the hospital should be exhausted before any bed can be added.

- A patient requiring isolation bed (e. g MRO infection) should be admitted to the isolation room. Exception for the patient requiring acute care and monitoring

7.0 Organisation of Bed

- Prior to all admission the bed shall be identified and prepared.

- Elective admission for surgery and procedures, the usage of bed shall be expected.

- If no bed available, it is the duty of the staff nurse in-charge or the sister in-charge or on-call (after office hours) to organize the bed. The discussion with Matron in-charge or on-call (after office hours) should be done if necessary to smoothen the service.

- This shall be done with consultation with the Medical Officer or Specialist In-Charge / On Call to ensure only appropriate patient will be send out if needed to do so.

8.0 Admission

- Patient may be admitted via the A+E, specialist clinic, Day Care, Health clinics or transferred in from another hospital or another ward.

- Patient can only be accepted for admission or transferred-in only after being reviewed by the Medical Officer on-call (in consultation with the respective specialist on-call) and has agreed to accept the referrals and accept the patient to be admitted or transferred in..

- In case of elective admission, the patient must have a properly filled admission form. The patient should be admitted directly into the ward.

- Upon admission patients and their next of kin will be orientated once in regards to the facilities and regulations of the hospital. A check list will be provided for references.

- The process of registration should be conducted appropriately based MOH requirement.

- Each patient should be counselled regarding the hospital payment system at appropriate time. The system may change subjected to government regulation.

9.0 Care in the ward

- The assignment of the bed for the patient should be in consultation with the medical officer on-call when necessary.

- The bed assignment should follow the criteria for Priority of Care.

- Upon admission, transfer in and return from a procedure or surgery, initial vitals signs should be taken and documented in the chart by the nurse. Any abnormality should be noted to doctors and appropriate action shall be taken.

- House Officer / Medical Officer on-call / in-charge shall be immediately informed of the admission / transfer-in by the nurse in-charge.

- Admitted or transferred-in patient shall be seen and initially assessed by a doctor within 15 minutes.

- The patient should be thoroughly clerked and reviewed within 60 minutes of admission.

- Ill patient and unstable patients should be seen immediately by a doctor.

- Hospital and KKM protocol regarding transfer of ill patient must be strictly adhered to.

- All the initial investigation ordered should be taken by the doctor concern.

- All the relevant investigation form / medication order should be immediately signed.

- The newly admitted patient should be seen at least once within 24 hours by a specialist / consultant on-call.

- All examination and procedure on a patient of different sex shall be chaperoned by another staff.

- Privacy of patient should be maintained and curtain should be drawn down at all times during examination or procedures.

- All procedures should be done in the procedures room.

10.0 Investigations Form

- Histo-pathology request, tumour markers, Viral study request, G x M should be completely filled up and properly labelled by the requesting doctors.

- All other investigation form should be filled up and countersigned by the doctor.

- Lab results should be countersigned by a doctor before filing up.

11.0 Consent

- Proper informed consent should be taken from the patient. A brief duration of time shall be given for consideration before consent is taken. In elderly well orientated patient, he/ she can give consent and the next of kin shall also be informed. However, in elderly but not orientated patient, informed consent shall be taken from his/her next of kin.

- In high risk surgery, inform of high risk consent shall be taken from both the patient and the next of kin. Their signatures shall be recorded in the consent form and case note

- A list of potential complication shall be recorded in the case notes.

- In dire emergency, orthopaedic procedure for saving life in unconscious patient with no relative around, the hospital director and the specialist in- charge/on-call shall authorize the procedure to be carried out by both of them signing the consent form.

- Consent form should be completely filled up by the respective doctors.

- All consent taken by the house officer should be countersigned by the Medical Officer / Specialist In-Charge.

- The translator (if needed) and witness must also place their signature onto the form.

12.0 Preparation for the orthopaedic operation and procedures

- All preparation for operation and procedures shall be prepared based on the latest guideline prepared by the respective specialty and subspecialty.

13.0 Meals

- The patients shall receive 4 meals a day.

- The meal shall be prepared and plated in the kitchen then transported to the ward in trolleys and serve by the staff.

- All used crookery and cutlery shall be transported to the kitchen for washing.

14.0 Monitoring of patient: Vitals sign monitoring

- The doctor are expected to record the frequency of vital monitoring required and it should be of a reasonable frequency.

- The qualified nurse is expected to document correctly the parameters in the observation charts and placed their initials.

- All observation by the a non qualified person shall be verified by a qualified nurse who will place his / her initial.

- Any abnormality of vital signs documented (e.g. PR > 100/min, Systolic pressure < 90 mmHg, SPO2 < 95, low urine output), doctors on duty or on-call should be immediately informed and the action should be promptly taken and documented.

- A doctor should review and assess patient and double check the findings at least once of any abnormality reported by a nurse.

15.0 Patients movement monitoring

- All staffs in the ward are responsible and should be aware of the patient movement in and out of the ward.

- The staff nurse in-charge / Sister are responsible for the unwarranted incident e.g. fall in the toilet.

- All the staff should be aware of any treatment the patient received in the ward.

- Any form of treatment not conform to the condition of the patient should be reported to the sister and doctor in-charge.

- A patient who is absconded should be reported to the police after all efforts to trace them failed. Police report is done after 24 hours of abscond.

- Incapacitated, elderly and weak patients should not be allowed to go to bathroom or anywhere on their own.

16.0 Patients transfer

- Transfer of patient to any other site or centres should follow the guidelines prepared by the hospital and KKM.

17.0 Ward Round

- Doctors in charge of the ward will conduct a normal ward round to see all patients. All patients shall be reviewed by respective HO, MO and Specialist or Consultant.

- The sister of the ward is expected to be actively involved and conducting passing over ward round during shifting over of staff nurses duty.

- When she is not on duty and unable to attend passing over, the nurse in-charge or senior nurse is expected to head the nursing round. The round must be conducted daily.

- Periodically, the matron as the overall in-charge of the nursing unit is expected to conduct and monitor the nursing round.

- The patients in acute and sub-acute cubicles will be reviewed at least 3 times a day by medical officer and house officer. The other patients will suffice with two reviews per day.

- A specialist or consultant on-call should conduct ward round at least once after office hour preferably night round. All patients should be seen by a specialist on-call within 24 hour of admission.

18.0 Doctors on-call

- On-call schedule for all categories of doctor should be prepared and distributed to the ward and the operators by the doctor in-charge in advance.

- Scope of duty – *please refer to the on-call duty list*

19.0 Documentation

- Clerking of cases by doctors should be thorough and all treatment modalities commenced should be properly documented in the patient's case notes and prescription slip.

- Similarly, the nurses shall record the response to those orders by treating doctors in the patient case notes and monitoring charts. Time of doctor has been informed of any abnormality shall also be documented.

- Every staff should chart date and time of entry or documentation and identify themselves with a personal official name seal.

20.0 D.I.L. issues

- Once D.I.L. is issued by a doctor, D.I.L. should be informed to patient next of kin and it should be documented and a signature of acknowledgement documented in the BHT.

- D.I.L. should be periodically informed and explained to next of kin until patient has passed away.

21.0 Death

- The next of kin shall be informed immediately of the patient death in the ward. The cadaver shall be sent to the mortuary within an hour for release to next of kin or post mortem.

- A cadaver shall be transported on a cadaver trolley to the mortuary by the mortuary attendants.

22.0 Notification of diseases

- All notifiable diseases must be notified to health officer through the medical record department by the respective disciplines doctors.

- Notification procedure should be strictly complied with the rules and regulations stated in the Act such as timing and type of form.

23.0 Records

- The sisters or assistant medical officers in charge of wards, clinic and orthopaedic OT shall be responsible for maintaining all record of services provided by the Orthopaedic Department and readily provide the necessary statistics or returns to the record office.

- In wards, a daily midnight census of patients shall be carried out.

24.0 Discharges

- All potential discharges shall be identified a day before by the doctors in-charge when they do his/her normal ward round (planned discharge)

- The patients should be informed of the possible discharge.

- All discharge summaries must be done the night before discharge by the doctor.

- All discharges should be completed before noon.

- Upon discharge, nurse in-charge must ensure that the patient has the appropriate next appointment date and time in their appointment card, dressing slip, medications slip, medical certificate leave, memo and any special instruction where necessary.

- No leave of absence shall be granted at any time.

- Patient who insists to be discharged against medical advice has a right to do so and can only be permitted to go after signing the AOR form.

- Upon discharge, patient's case notes must be returned to the record office within 72 hours.

25.0 Bill

- All patients shall be charged according to the Fees (medical) Order/ Act 1982.

- Any patient who cannot afford payment should be referred to the sister in-charge the ward for further work up.

26.0 Referral

- All referral to other hospital (inter-hospital referral) must be liaised with medical officer on-call of receiving hospital.

- All referral from other hospital (inter-hospital referral) must be liaised also with medical officer on-call and need to discuss with specialist in-charge, if necessary.

- The name of referring Specialist and Consultant should be included in the referral letter whether to or from other hospitals.

- All referral from the other department (inter-departmental referral) shall be reviewed by the medical officer only.

- All referrals must be informed to and discussed with the specialist on-call.

STANDARD OPERATIVE POLICY

OUT-PATIENTS SERVICES

DEPARTMENT OF ORTHOPAEDIC HOSPITAL TENGKU AMPUAN AFZAN (FROM 2014 ONWARD)

5.0 Organization Structure

- The overall responsibility of service and clinical care lies with the Head of Department (HOD)

5.1 Consultant In-Charge

- HOD shall appoint a Consultant In-charge to assure services provided at clinic run smoothly. Consultant In-charge will set up a schedule for specialists to have their clinic session.

- He/ She should ensure the clinic start on time, settling dispute, ensure adequate doctors to run the clinic.

- He/ She or available specialist at clinic should be consulted for any clinical doubts by the attending doctors.

- He/ She are also responsible for screening and review of all new cases patient's notes and the audit is done periodically. This duty can also be delegated to other specialist or senior medical officers.

- He/ She are responsible for countersigning of documents and investigations form whenever applied. This duty can also be delegated to other specialist or senior medical officers.

- A minimum of two medical officers and two house officers should run the clinic.

5.2 Nursing Sister

- The Sister in-charge of clinic is responsible to maintain adequate number of nurses to run and provide chaperone in the clinic rooms.

- She is required to maintain the waiting area for comfort to the patients and relatives.

- She is also required to provide special area for mother to breast feed her child.

- Abundant of reading material should be provided

- She is responsible for the smooth running of the clinic together with senior AMO

- She will be assisted by nurses, assistant nurses and attendants.

6.0 Structure of the Orthopaedic Clinic

6.1 Clinic session

- There will be 7 session per week lasting from 0900H to 1300H on Monday until Friday and 0900H to 1700H on Monday and Wednesday, seeing averagely 100-150 patients per day

6.2 Calling system

- The patients in the Orthopaedic Clinic are divided into 5 categories namely New, Priority, General and Subspecialty cases. The calling system will be distinctly differentiated each of them through a numerical calling system.

- New case is defined as newly referred patient with a new referral letter. The patient could be previously defaulted patient but suddenly re-present to the clinic with new orthopaedic problem

- General cases are all the other cases that can be safely managed by clinical specialist or senior medical officers.

- Priority cases are cases that involve elderly more than 65, mother with infants, patients bed bound, wheel chair bound, referral cases accompanied by a nurse from other hospital, significantly handicapped patients, prisoner and blood donor.

- However it is emphasized that patients should be called in accordance of their appointment

6.3 Registration

- All patients seen in the Orthopaedic Clinic shall be registered.

- Registration counter should be opened by 0800H. Each patient must be allotted an appointment card and patient's records.

- Every patient must have a correct appointment date before coming to the clinic (visit by appointment, not a walk-in)

- Every new patient must be accompanied by a proper referral letter or memo.

- Fee should be charged according to the Hospital and KKM guidelines.

6.4 Appointment System

- Appointment should be given and based on a staggered appointment system, of which each patient is given a specific time to come to clinic and each of them is allocated approximately 10 - 15 minutes of clinically consultation

- The patient must comply with the appointment time and date given to avoid over-crowding in clinic.

- All appointment shall be recorded.

- Details such as personal data, diagnosis, date of request and patient telephone number should be documented

- An appointment can be given directly by doctors after every visit or via a phone (communication between medical staff), a personal visit or from a list of request from the ward

- Appointment should be prioritized according to severity of the orthopaedic problem. If necessary, the referral can be screened by medical officer

- Urgent patient shall be given an appointment within a week.

- No-urgent appointment given as per available appointment date but shall not exceeded one month.

- Ill patient whether with or without appointment should be assessed by consultant in-charge of clinic or available specialist in clinic. The patient can also be reviewed by a medical officer in-charge of the clinic and if not available by medical officer on-call.

- If necessary, the ill patient should be sent by trolley or wheelchair or transported by ambulance to the Emergency Department and must be accompanied by a doctor.

6.5 New Cases

- Minimum of ten (10) new cases are allocated to each Sub-speciality clinic every week.

- A further 10 cases would be follow up cases for each consultant. This amount may increase depends on amount of workloads namely number of cases (new and follow up cases). Currently, about 20-30 patients will be coming to see each consultant on every clinic session.

- All appointment shall be recorded.

- Details such as personal data, diagnosis, date of request and patient telephone number should be documented

- General clinic, averagely 20-30 new cases will attend.

6.6 Follow up cases

- An appointment shall be given based on the duration requested by the attending doctor.

- An appointment (date and time) should be given appropriately with adequate amount of medication and if necessary sick leave is supplied.

- A master list of appointment system shall be developed to ensure the running of staggered appointment system

6.7 Defaulter patients

- A patient that default appointment (defaulter) should be given new appointment as per available appointment provided he has the previous appointment card.

- The patient should be last seen within 1 years otherwise is required to produce new referral letter / memo

6.8 Change of an appointment

- Patient should be given right to change their appointment.

- The new appointment should be reasonable to appointment available and medication supply

- Otherwise an effort should be made to give the extra supply of medication

- Any additional of sick leaves for the patient but be recorded in the case note

6.9 Chaperone

- All physical examination or procedure done on the patients of different sex should be chaperoned by another staff

7.0 Referrals system

- Referral to another hospital must use the appropriate form and based on guidelines of referrals
- All referrals should be done by medical officer and must also include the name of the Consultant or Specialist in-charge of the patient
- All referral letter or memo done by HO should be counterchecked and countersigned by respective MO
- All patients who has been referred back to the local health centre must at least have a memo

8.0 Notifications of Disease

- All notifiable diseases must be notified to health officer through the medical record department by the respective disciplines doctors.
- Notification procedure should be strictly complied with the rules and regulations stated in the Act such as timing and type of form.

9.0 Documentation

- The appointment card must be appropriately maintain to include relevant investigation results
- Summary of disease and treatment must be written in the appointment card
- Proper documentation are expected in the Orthopaedic Clinic continuation sheet
- Time, date, patient complains, clinical progress, tolerance to drugs, surgery and other important information should be documented by the doctors in the card.
- The nurse in-charge and the team are expected to properly maintain the results in the record
- Any documentation must be signed and stamped by attending doctors. The name seal must include full name, certification and MMC number.

10.0 Maintaining records

- The medical records should be return to the record office in good state for safe keeping
- They should be retrieved and prepared for the next appointment at least a week in advance
- The card cannot be brought out of the Orthopaedic Clinic without permission of the clinic sister or staff nurse in-charge and it must be properly documented
- Missing medical records must be reported to the police
- Before the expected appointment, the medical records shall be adequately prepared. The blood investigations, X Rays, ECG, the HPE reports etc shall be readily available before the patient comes for visit. The results will be properly maintain e.g. a book for HPE received and Blood results filing system
- Monthly census should be sent regularly to the record office and a copy kept in the clinic for reference

11.0 Quality

- The Orthopaedic Clinic is expected to participate in Hospital Quality Assessment done periodically to assess waiting time, patient satisfaction and in other quality programs.

12.0 Waiting time

- Consultant In-Charge must ensure that KPI and NIA for clinic can be achieved without fail.
- Any failure, SIQ report must be sent to quality unit, HTAA
- A proper record is maintain of the previous achievement

13.0 Clinical safe guard

- All HPE results shall be countersigned by the HOD or appointed specialist before they are filed up. Senior medical officer may review the result but required to discuss with respective specialist for further management.

- All abnormal investigations results shall be countersigned by a medical officer in the clinic

- All new cases shall be screened by Consultant In-Charge or available specialist in the clinic. This duty can also be delegated to senior MO.

- Any patient who are not happy with any consultation should be advised to have a second consultation or opinion with another specialist/consultant or HOD soon on the available appointment date, preferably on the same day

14.0 Appointment for elective surgery

- The appointment should be maintained in an appropriate appointment book with relevant details.

- Cases should be discussed with specialist or Consultant in-charge of patient.

- The patients should be worked up for the surgery and referral to medical team or other relevant team should be made and opinion sought before the date of surgery.

- Informed consent should be taken 24 hours before operation.

- All patient requires any form of anesthesia other than local must be referred to the pre-anesthetic clinic within at least one month from the date of surgery

15.0 Discharge

- Patients can only be discharged from the clinic after all the investigations report reviewed and signed by medical officer

- Patients appointment card should be completed with the summary of disease and treatment

16.0 Plaster of Paris Application

16.1 MANUAL MANIPULATION &REDUCTION OF CLOSE FRACTURES & DISLOCATIONS

Activity	Work Process	Standard	Requirement
1. Receive instructions	Read instruction.	Written instruction as given by doctor	BHT/ prescription
2. Registration	Registration patient	Register patient particulars in the procedure registration book	Procedure registration book
3. Assessment/ Examination	1. Confirm fracture / dislocation site / side. 2. Assess deformity of the limb. 3. Check condition of wound of any. 4. Check circulation 5. Check Sensation & movement of the limb	Review X-Ray Observe aseptic technique when necessary	X-Ray -AP view -lateral
4. Prepare equipments	Prepare equipment, medication and lotions.	Prepare as required for the procedure	POP Trolley Basin of Water Limb support cotton & gauze Adhesive plaster Dressing set Syringes Sedation Spirit swab Sofratulle Flavine Lotion Apron Arm Sling Collor&cuff Splint

5. Prepare patient	1. Check correct patient 2. Explain to patient relative/ parents the procedure to be carried out 3. Check consent 4. Confirm with patient the affected limb 5. Place patient in a comfortable position 6. Place linen protector under the injured limb	Correct patient and site & side to be treats At all time be courtenous, kind and gentle Valid consent	Consent form Linen
6. Perform Procedure	1. Give sedation 2. With the help of an assistant hold the affected limb carefully 3. Manipulate fracture / dislocation 4. Dress and bandage the wound if any 5. Apply POP /splint/slab strapping 6. Clean the affected limb 7. Mark window if necessary 8. Check X-ray (post reduction)	Sedation to be given Intra Venous by Doctor . Wait until patient is fully sedated. Apply POP according to PANDUAN PRAKTIKAL PEMASANGAN PLASTER KAST (KKM). Acceptable position (post reduction)	POP trolley Basin of water Limb support cotton & gauze Sedations Syringe Spitits swab Tourniquet Gauze Adhesive plaster X-ray film(post reduction) -AP view -lateral
7.Observation	1. Observe and record circulation 2. Refer to doctor if any complication arises	Observe circulation and sensation for at least an hour (out-patient)	Circulation chart
8. Health Education	1. Care the wound if any 2. Encourage movement of extremities 3. Care of POP / splint /slab / strapping 4. Advise patient return to Orthopaedic Out-patient Clinic/ Emergency Department immediately if develops :	To observe aseptic technique Advise slip must be given to the patient	Sterile dressing set Adhesive Plaster Scissors advice slip

	4.1 swelling 4.2 severe pain 4.3 numbness 4.4 change in colour of extremities 4.5 broken POP /slab 4.6 fever 4.7 foul smell		
9. Documentation	Record in the procedure book. Record in patient's BHT Fill billing code	Entries to be legible, signed & dated	Procedure book . Patient's BHT

16.2 APPLICATION OF PLASTER CAST

ACTIVITY	WORK PROCESS	STANDARD	REQUIREMENTS
1. Receive instructions	read instruction	written instruction as given by doctor	bht/prescription slip
2. Registration	register patient	register patient particulars in procedure registration book	procedure registration book
3.Assesment/ Examination	1.Confirm fracture /disclocation / affected limb / site&side 2.Assess deformity of the limb 3.Check condition of wounds if any 4.Checks circulation 5.Check sensation & movement of the limb	review xray observation aseptic technique when necessary	xray -xray -lateral
4. Prepare equipments	Prepare equipment / medication / lotions	prepare as required for the procedure	pop trolley basin of water limb support cotton & gau
5. Prepare patient	1.Check correct patient 2.Explain to patient/relatives/parents the procedure to be carried out 3.Check consents 4.Confirm with patient's the affected limb 5.Place patient in comfortable position 6.Place linen protector under the injured limb	correct patient and site & side to be treats at all times be courteous,kind and gentle valid consent	

ACTIVITY	WORK PROCESS	STANDARD	REQUIREMENTS
6. Perform procedure	1. With the help of an assistant hold the affected limb carefully 2. Dress and bandage the wound any 3. Apply plaster cast 4. Mark window if necessary 5. Check x-ray (post reduction)	Sedation to be given intravenous by a doctor Wait until patient is fully sedated observe aseptic technique when necessary apply pop according to panduan praktikal pemasangan plaster kast(kkm) acceptable position(post reduction)	pop trollry basin of water limb support softratulle flavine lotion apron consent from linen adhesive [plaster dressing set sedatives xray -ap view -lateral(post reduction)
7. Observation	1. Observe and record circulation 2. Refer to doctor if any complication arises	observe circulation and sensation of distal part of the limb for at least an hour (out-patient)	circulation chart
8. Health education	1. Care of the wound if any 2.Encourage movement of extremities 3. Care of plaster cast 4. Advise patient to return to orthopaedic out patient clinic/emergency deparment immediately if develops: 4.1 swelling 4.2 severe pain 4.3 numbness 4.4 change in color of extremities 4.5 broken pop 4.6 fever 4.7foul smell	observe aseptic technique when necessary. Advice slip must be given to the patient	
9. Documentation	Record in the procedure book. Record in patients bht. Fill billing code	enteries to be legible,signed &dated	procedure book patient's bht

16.3 APPLICATION OF PLASTER SLAB

Activity	Work Process	Standart	Requirement
1. Receive instructions	Read instruction.	Written instruction as given by doctor	BHT/ prescription
2. Registration	Registration patient	Register patient particulars in the procedure registration book	Procedure registration book
3. Assessment/ Examination	1. Confirm fracture / dislocation /site /side. 2. Assess deformity of the limb. 3. Check condition of wound of any. 4. Check circulation 5. Check Sensation & movement of the limb	Review X-Ray Observe aseptic technique when necessary	X-Ray -AP view -lateral Circulation chart
4. Prepare equipments	Prepare equipment, medication and lotions.	Prepare as required for the procedure	POP Trolley Basin of Water Limb support cotton & gauze Adhesive plaster Dressing set Sedation Spirit swab Sofratulle Flavine Lotion Apron Scissors Linen Consent
5. Prepare patient	1. Explain to patient / relatives / parents the procedure to be carried out 2. Check consent 3. Confirm with patient the affected limb 4. Place patient in a comfortable position 5. Place linen protector under the injured limb	At all time be courteous kind and gentle. Validity of consent	

6. Perform Procedure	1. Dress and bandage wound id any 2. Apply plaster slab 3. Mark window if necessary	Sedation to be given Intra Venous by Doctor . Wait until patient is fully sedated. Apply POP according to PANDUAN PRAKTIKAL PEMASANGAN PLASTER KAST (KKM). Acceptable position (post reduction)	POP trolley Basin of water Limb support cotton & gauze Sedations Syringe Spitits swab Tourniquet Gauze Adhesive plaster
7.Observation	1. Observe and record circulation 2. Refer to doctor if any complication arises	Observe circulation and sensation for at least an hour (out-patient)	Circulation chart
8. Health Education	1. Care the wound if any 2. Encourage movement of extremities 3. Care of POP / splint / slab / strapping 4. Advise patient return to Orthopaedic Out-patient Clinic/ Emergency Department immediately if develops : 4.1 swelling 4.2 severe pain 4.3 numbness 4.4 change in colour of extremities 4.5 broken POP /slab 4.6 fever 4.7 foul smell	To observe aseptic technique Advise slip must be given to the patient	Sterile dressing set Adhesive Plaster Scissors advice slip
9. Documentation	Record in the procedure book. Record in patient's BHT Fill billing code	Entries to be legible, signed & dated	Procedure book . Patient's BHT

16.4 OPEN WEDGING OF PLASTER CAST

Activity	Work Process	Standart	Requirement
1. Receive instructions	Read instruction.	Written instruction as given by doctor in BHT/ prescription slip	BHT/ prescription slip
2. Registration	Registration patient	Register patient particulars in the procedure registration book	Procedure registration book
3. Assessment/ Examination	1. Confirm site / side and angulation of fracture. 2. Check for integrity of plaster cast. 3. Check for rotational angulation. 4. Check for amount correction needed.	Review X-Ray Duration of injury (ideally after 3 weeks when the fracture is sticky)	X-Ray -AP view -lateral
4. Prepare equipments	Prepare equipment, medication and lotions.	Prepare as required for the procedure	POP Trolley Basin of Water Limb support cotton & gauze Adhesive plaster Dressing set Syringes Sedation Spirit swab Sofratulle Flavine Lotion Apron Linen
5. Prepare patient	1. Explain to patient relatives / parents the procedure to be carried out 2. Confirm with patient the affected limb 3. Place patient in a comfortable position 4. Place linen protector under the injured limb 5. With help of an assistant, hold and position the limb as required. 6. Give sedation if required.	At all time be courteous kind and gentle.	
6. Perform Procedure	Review x-ray Draw lines along the longitudinal axis of the proximal and distal fragment. Measure the angle of the deformity	Used goniometer Cut ¾ of the circumference of POP. Angulation should be correct	x-ray -AP view -lateral (post wedging) Goniometer Plaster Marker Wedge

	Mark and cut the POP at the level of the fracture. Correct the angulation, insert the wedge according to the angle deformity. Reinforce the wedge with padding and plaster. Send for post wedging x-ray.		
7.Observation	1. Observe the circulation and sensation. 2. Take necessary action if complication arises	Record obcervation for circulation (in patien) Avoid doing wedging near joints, loose POP, soft POP. Do not open window at wedging area and vice – versa.	Circulation chart
8. Health Education	1. Care the wound if any 2. Encourage movement of extremities 3. Care of Plaster cast. 4. Advise patient to return to Clinic / Emergency Department immediately if develops : 4.1 swelling 4.2 severe pain 4.3 numbness 4.4 change in colour of extremities 4.5 fever 4.6 broken plaster cast 4.7 foul smell	To observe aseptic technique Advise slip must be given to the patient	Advice slip
9. Documentation	Record in the procedure book.	Entries to be legible, signed & dated	Procedure book . Patient's BHT

16.5 REMOVAL OF PLASTER CAST

Activity	Work Process	Standart	Requirement
1. Receive instructions	Read instruction.	Written instruction in BHT/ prescription slip	Patient's BHT/ prescription slip
2. Registration	Registration patient	Register patient particulars in the procedure registration book	Procedure registration book
3. Prepare equipments	Prepare equipment, medication and lotions.	Prepare as required for the procedure	POP cutter/saw Shears Spreader POP knife Lister scissors Adhesive plaster Dressing set Linen x-ray -AP view -lateral
4. Prepare patient	1. Explain to patient relatives / parents the procedure. 2. Confirm with patient the affected limb 3. Place patient in a comfortable position 4. Place linen protector under the injured limb 5. Hold and position the limb.	At all time be courteous kind and gentle. Refer to instruction and x-ray	
5. Perform Procedure	Cut the plaster with PIOP cutter/saw using the correct technique. Refer to Doctor if any of the following complications is present: 1. pressure ulcer, 2. stiffness of the joint, 3. allergies, 4. circulation or 5. nerve impairment.	Refer to PANDUAN PRAKTIKAL PEMASANGAN PLASTER KAS (KKM) PAGE 14 PARA 4.5	
6. Health Education	care of the wound if any. Teach crutch walking. Encourage exercise. Follow up clinic.	To observe aseptic technique Advise slip must be given to the patient	Advice slip
7. Documentation	Record in the procedure book. Record in patien BHT.	Entries to be legible, signed & dated	Procedure book . Patient's BHT

16.6 APPLICATION OF SKIN TRACTION

Activity	Work Process	Standart	Requirement
1. Receive instructions	Read instruction.	Written instruction in BHT/ prescription slip by doctor	Patient'sBHT/ prescription slip
2. Registration	Registration patient	Register patient particulars in the procedure registration book	Procedure registration book
3. Assessment/ Examination	1. Check for wound. 2. Check for dermatitis, varicose veins, ischaemic limb or insente limb. 3. Ask patien for history of diabetes. 4. Ask patien for history of plaster allergy. 5. Comfirm the site & side for fraction.	Do not apply over an open wound Contraindicated in dermatitis, varicose veins, ischaemic limb or insente limb. Use cautiously in diabetes Contraindication for patient's with plaster allergy.	X-Ray if any
4. Prepare equipments	Prepare equipment, medication and lotions.	Prepare as required for the procedure	Skin traction kit Crepe bandage Felt Thomas splint Bohler's braun Frame Weight & hanger Buck extension scissor Adhesive plaster Cotton wool Bed blocks Linen protector Shaving set Pillow.
5. Prepare patient	1. Explain to patient relatives / parents the procedure to be carried out 2. Confirm with patient the affected limb 3. Place patient in a comfortable position 4. Place linen protector under the injured limb 5. With help of an assistant, hold and position the limb as required. 6. Give sedation if required.	At all time be courteous kind and gentle.	
6. Perform Procedure	Begin procedur with help of an assistant. Hold the injured limb with care.	Begin bandaging at distal end. Avoid Achilles tendon (for lower	Skin traction kit Crepe bandage Felt Thomas splint

	Protect bony prominences. Apply skin traction and bandage. Begin bandaging Fix a Thomas splint to the affected limb and bandage if required. Tie the traction cord to the weight running over a pulley / extension buck. Placed a pillow under the injured limb if required.	limb). Fix skin traction and bandage neatly. At all time courteous, kind and gentle Maintain principle of traction. 1. position 2. counter traction 3. friction 4. continous traction 5. line of pull	Bohler's braun Frame Weight & hanger Buck extension scissor Adhesive plaster Cotton wool Bed blocks Linen protector Shaving set Pillow.
7. Health Education	1. Personal hygiene. 2. Psychological support. 3. Care of the skin traction.	Do not middle with the bandage. Keep the weight always hanging free. Do active/ passive exersice of the affected limb. Do not scratch over traction area. Inform the staff if any problem.	Advice slip
9. Documentation	Record procedure. Record in patient BHT Fill billing code.	Entries to be legible, signed & dated	Procedure book . Patient's BHT

PRECAUTIONS:
1. Do not apply over an open wound
2. Contraindicated in dermatitis, varicose veins, ischaemic limb or insente limb.
3. Use cautiously in diabetes
4. Contraindication for patient's with plaster allergy.

Maintain principle of traction.
1. position
2. counter traction
3. friction
4. continous traction
5. line of pull

16.7 APPLICATION OF SKELETAL TRACTION

Activity	Work Process	Standart	Requirement
1. Receive instructions	Read instruction.	Written instruction as given by doctor in BHT/ prescription slip	BHT/ prescription slip
2. Registration	Registration patient	Register patient particulars in the procedure registration book	Procedure registration book
3. Prepare equipments	Prepare equipment.	Prepare as required for the procedure	Bohler's braun Frame Bohler's stirrup/ Thomas splint. Traction cord Crepe bandage Weight Sling Safety pin Padding material traction appliances Scissors. Linen protector
4. Prepare patient	Place patient in a supine position. Explain to patient relatives / parents the procedure to be carried out. Place linen protector under the injured limb.	At all time be courteous kind and gentle.	
5. Perform Procedure	Fix Bohler's Stirrup on to Steinmann Pin. Placed the injured limb over the Bohler's Braun Frame or Thomas splint. Fix traction cord to the Bohler's Stirrup and connect it to the weight over a pulley. Pad and bandage the affected limb. Cover the sharp end of Steinmann Pin.	Weight not to exceed 1/10 of body weight. Prevent patient from injury.	
6. Health Education	Care the wound. Personal hygiene. Psychological support. Care of the skeletal traction.	Observe aseptic technique. Do not meddle bandage. Keep the weight always hanging free. Active exercise of	Advice slip

		the affected limb. Inform the staff if any problem.	
7. Documentation	Record in the procedure book. Record in patien BHT.	Entries to be legible, signed & dated	Procedure book . Patient's BHT

PRECAUTIONS
Maintain principle of traction.
1. position
2. counter traction
3. friction
4. continous traction
5. line of pul

16.8 APPLICATION OF TOURNIQUE

Activity	Work Process	Standard	Requirement
1. Receive instructions	Read instruction.	Receive Instruction From Doctor	Patient's BHT/
2. Assessment/ Examination	Rule out contraindication for tourniquet application	Ensure no leakage of air to maintain the required pressure. Contraindicated in ischemic limb. Exsanguination contraindicated in: Infection, tumour and thrombosis	
3. Prepare equipments	Prepare Tourniquet unit and cuff.	Test to ensure tourniquet unit is functional and in good condition.	
4. Prepare patient	Place patient in required position	Patient's position according to the type of surgery as required by surgeon.	
5. Perform	Apply orthoban and suitable size	Suggested pressure	Tourniquet Unit Cuffs- various sizes.

Procedure	cuff. Elevate the affected limb. Exsanguinate limb with Esmarch bandage if required. Inflate cuff to the recommended pressure. Set the tourniquet starting time. Inform anesthetist time of inflation. Inform operating surgeon at appropriate intervals. After completion of surgery, deflate and remove cuff. Check blood circulation of the affected limb.	: <u>For upper limb</u> Systolic + (50 to 75 mmHg) <u>For lower limb</u> Systolic x 2 Alert operating surgeon at appropriate intervals.	Orthoban Esmarch Bandage Timer
6. Documentation	Record name, time of inflation, deflation and pressure applied in the specific notes.	Entries to be legible, signed & dated	Patient's record

PRECAUTIONS:

Ensure no leakage of air to maintain the required pressure.
Contraindicated in ischaemic limb.
Exsanguination caontraindicated in :
Infection, tumour and thrombosis

16.9 REMOVAL OF EXTERNAL FIXATOR

Activity	Work Process	Standard	Requirement
1. Receive instructions	Read instruction.	Written instruction as given by doctor	Patient's BHT/ prescription slip
2. Registration	Register patient.	Register patient in the procedure registration book	Procedure registration book
3.Assessment/ examination	Review X-ray. Check deformity of limb Check condition of wound	Deformities of the limb, condition of wound & any pin tract infection to be noted to doctor.	X-ray -AP view -lateral
4. Prepare equipments	Prepare equipment	Prepare equipment as required for the procedure.	Open Wrench, Allen Key, Socket wrench pliers, T-Handle, Dressing Set, Sterile Gauze, Adhesive Plaster, Povidone Iodine, Sedation, C&S Bottle, Sterile Swab, Pathological Lab, Form, Linen
5. Prepare patient	Place patient in a comfortable position. Explain to patient relatives/ parents the procedure to be carried out. Place linen protector under the injured limb.	At all times be courteous, kind and gentle	
5. erform procedure	Begin procedure with help of an assistant. Hold the injured limb with care. Clean the affected area and surrounding skin. Take Swab for C&S if required. Use T-Handle to remove Schan'z pin with proper technique. Dress the wound. Rest patient in comfortable position	At all time be courteous, kind and gentle. For the removal of Halo Vest apply cervical collar before removal. Sedation if necessary Observe aseptic technique. Use appropriate appliances Refer to doctors if	Open Wrench, Allen Key, Socket wrench pliers, T-Handle, Dressing Set, Sterile Gauze, Adhesive Plaster, Povidone Iodine, Sedation, C&S Bottle, Sterile Swab, Pathological Lab, Form, Linen

		there is any complication.	
7. Observation	Care of the wound. Teach Crutch walking. Follow up clinic. Exercise the affected limb.	To observe aseptic technique Advice slip must be given to patient's	Advice slip Crutch
8. Documentation	Record in the procedure book. Record in patient BHT. Fill billing code.	Entries to be legible, Signed & dated.	Procedure book Patient's BHT

16.10 REMOVAL OF KIRCHNER WIRE

Activity	Work Process	Standard	Requirement
1. Receive instructions	Read instruction.	Read Written instruction as given by doctor	Patient's BHT/ prescription slip
2. Registration	Register patient.	Register patient in the procedure registration book	Procedure registration book
3.Assessment/ examination	Review X-ray. Check deformity of limb Check condition of wound & any pin tract infection.	Any Deformities of the limb, sepsis of the wound & any pin tract infection to be noted to doctor.	X-ray film
4. Prepare equipments	Prepare equipment	Prepare equipment and drugs as required for the procedure.	Pliers, T-Handle with chuck & Key, Dressing Set, Adhesive Plaster, Antiseptic Lotion, Swab, C&S Bottle, Pathological Lab Form, Linen, sedative
5. Prepare patient	Place patient in a comfortable position. Explain to patient relatives/ parents the procedure to be carried out. Place linen protector under the injured limb.	At all times be courteous, kind and gentle. Sedation to be given if necessary.	

	Review X-Ray		
6. Perform procedure	Begin procedure with help of an assistant. Hold the injured limb with care. Clean the affected part. Take Swab for C&S if required. Use Pliers / T-Handle to pull the wires out. Dress wound. Rest patient in comfortable position	Observe aseptic technique. Refer to doctors if there is any complication.	Pliers, T-Handle with chuck & Key, Dressing Set, Adhesive Plaster, Antiseptic Lotion, Swab, C&S Bottle, Pathological Lab Form, Linen, sedative
7. Health Education	Care of the wound. Follow up clinic.	To observe aseptic technique Advice slip must be given to patient's	Advice slip
8. Documentation	Record in the procedure book. Record in patient BHT.	Entries to be legible, Signed & dated.	Procedure book Patient's BHT

16.11 MINOR SURGERY

Activity	Work Process	Standard	Requirement
1. Receive instructions	Read instruction. Verify minor surgery check list.	Read Written instruction as given by doctor	Patient's BHT/ prescription slip
2. Registration	Register patient.	Register the patient particulars in the procedure book	Procedure registration book
3.Assessment/ examination	Examine of the affected area	To observe excessive bleeding, excessive swelling, acute pain and other abnormalities	T&S Set, I &D Set Aspiration set Excision set Local Anaesthesia Syringes / needles

		To inform doctor if required	Sterile Glove Surgical mask Solution Normal saline Antiseptic Lotion Sterile Dressing Towel Adhesive Plaster Sutures Bandage Linen
4. Prepare equipments	Prepare equipment	Prepare equipment and drugs as required for the procedure.	
5. Prepare patient	Explain to patient the procedure to be carried out. Place patient in a comfortable position. Place a linen protector under the intended area.	At all times be courteous and kind.	
6. Perform procedure as Appendix 1	Set intravenous drip if required Clean the affected part and surrounding area with antiseptic lotion. Drape the area. Administer local anaesthesia. Perform minor surgery. Inform doctor if complication arises.	Observe aseptic technique. Local Anaesthesia to be given according to body weight. REFER TO APPROPRIATE PROCEDURE PROTOCOL.	Pliers, T-Handle with chuck & Key, Dressing Set, Adhesive Plaster, Antiseptic Lotion, Swab, C&S Bottle, Pathological Lab Form, Linen, sedative
7. Health Education	Care of the wound. Follow up clinic.	To observe aseptic technique Advice slip must be given to patient's	Advice slip Appointment card
8. Documentation	Record in the procedure book. Record in patient BHT. Fill billing code.	Entries to be legible, Signed & dated.	Procedure book Patient's BHT

PRECAUTIONS;

Avoid injecting into vessels

17.0 DRESSING ROOM PROCEDURE

17.1 PROPER ASEPTIC DRESSING PRACTICAL:

17.1.1 INTRODUCTION

- Wound dressing is one of the major nursing responsibilities.
- Aseptic technique is mandatory to minimize complications.
- Effective wound dressing promotes wound healing and lead to early discharge and thus save cost

17.1.2 OBJECTIVES

- To ensure nurses perform wound dressing using aseptic technique
- To assess the caring component during dressing
- To document wound findings after the procedure in the appropriate patient's records

17.1.3 STANDARD

- Nurses perform wound dressing using aseptic technique
- Nurses exhibit the caring component during dressing
- Nurses document wound findings in the appropriate

17.1.4 CRITERIA

STRUCTURE	PROCESS	OUTCOME
1. Screen / Procedure Room 2. Dressing trolley 3. Hand–washing facilities/hand rub 4. Relevant protective personal 5. Clinical waste bin 6. Domestic waste bin 7. Protective cover 8. Sterile dressing set 9. Sterile soft dressings 10. Cleansing agent 11. Adhesive tapes	1. Greet patient and introduce self 2. Perform pain assessmen (if indicated) 3. Administer analgesic (if indicated) 4. Place sterile dressing set on clean dry trolley 5. Inform patient and explain procedure 6. Provide privacy to the patient 7. Place patient in comfortable position	1. Dressing performed 2. adhering to principles of 3. aseptic technique 4. Patient is informed of the 5. progress of his / her 6. wound 7. Respect and comfort of 8. patient is maintained 9. Wound findings and its 10. progress are documented

12. Nursing Operating Procedure (N.O.P) /Manual of wound dressing 13. Copy of Standard Precautions by Ministry of Health is available 14. The nurse is competent in performing aseptic wound dressing 15. Nurse need to verify patient and verify type of dressing	8. Perform hand hygiene 9. Wear mask 10. Open outer layer of dressing set 11. Discard soiled dressing 12. Perform hand hygiene 13. Open inner layer of dressing set 14. Pour cleansing agent. Add soft dressings / supplementary 15. Perform hand hygiene 16. Wear sterile gloves (optional) 17. Perform dressing 18. Make patient comfortable after procedure	

17.1.5 DEFINITION OF OPERATIONAL TERMS

- Hand hygiene – include both hands washing with either plain or antiseptic - containing soap and water, or use of alcohol-base hand rub (WHO-2007)
- Sterile soft dressings – refer to sterile swab / gauze / gamgee
- Cleansing agent – refers to any lotion used to clean the wound
- Sterile field refers to the area within the sterile packaging, i.e. 1 inch around the working area be kept free of instruments
- Ensure body / any part of uniform of nurse does not touch sterile field
- Assessment of pain should be done prior to procedure and should include administration of analgesic if indicated
- Aseptic technique includes :
    - discard soiled forceps after use
    - keep forceps facing downwards and above waist line
    - no contact of forceps when transferring soft dressing from one hand to another

- correct technique of pouring of cleansing agent (no touching and spillage) and topping up of supplementary
- body/ any part of uniform of nurse must not touch sterile field
- does not cross sterile field at all times
- clean the skin area around wound thoroughly
- cover wound appropriately
- Pain assessment – use pain score format from KKM to assess pain

➢ Discard soiled dressing involves loosening dressing, removing soiled dressing, discard soiled dressing forceps and observing condition of wound

* ***Failure to comply with any of the above will be considered non-conformance to aseptic technique***

➢ Documentation of wound finding includes – wound size and depth, nature of wound-swelling, dirty, clean, slough, gangrene, healing process and nature of discharge – smell, color, serous, bloody, pus

17.1.6 COMPLIANCE OF ASEPTIC WOUND DRESSING AUDIT

Every step in the process must be performed

a) TECHNICAL

- Perform hand hygiene
- Wear musk
- Open outer layer of dressing set
- Perform hand hygiene
- Open inner layer of dressing set
- Pour cleansing agent
- Add soft dressings / supplementary
- Assess patient's pain threshold (observe/ask)
- Perform hand hygiene
- Wear sterile gloves (optional)
- Remove soiled dressing with forceps
- Discard used forceps into receiver
- Perform dressing
- Cover the wound with appropriate dressing
- Discard used dressing set
- Perform hand hygiene

b) ESSENCE OF CARE (SOFT SKILLS)

- Greet patient and introduce self
- Perform pain assessment (if indicated)
- Administer analgesic (if indicated). (Do not score if not indicated)
- Inform patient and explain procedure
- Provide privacy to the patient
- Place patient in a comfortable position before procedure
- Make patient comfortable after procedure - involves placing patient in a comfortable position and reassess pain

c) DOCUMENTATION

Documentation of wound finding includes :

- wound size and depth, healing process
- nature of wound-swelling, dirty, clean, slough, gangrene
- nature of discharge - smell, color, serous, bloody, pus