FOREWORD

As a world-class tertiary health institution, UPTH has produced its first edition of the Standard Operating Procedures (SOPs) in line with international best practices.

This document was produced to guide its staff in the discharge of their duties in a bid to provide good quality, equitable and efficient services to the good people of Nigeria.

It is therefore pertinent that every member of staff avails himself/herself of a copy of this document and complies strictly with the provisions of the stipulated guidelines contained in it.

My appreciation goes to all the Heads of Departments / Units, Members of the SOP Technical Committee and DCMAC (NHIS/SERVICOM)- Dr. Obianma N. Onya for the role they played in developing the maiden edition of the SOPs.

Prof. Henry A.A. Ugboma,

Chief Medical Director

PREFACE

An SOP is a set of guidelines or instructions one follows to complete a job or assignment in line with set organizational goals, while ensuring no adverse impact on client safety and the environment, and which meets regulatory compliance standards set by the management or any other regulatory body, and in a way that maximizes favourable outcomes.

Standard Operating Procedures for any organisation are of utmost importance. They provide the organisational workforce with predefined roles and expected actions which are easily identifiable in the event of service failure. Since an 'SOP' is a specific description of how to undertake a particular task, then it stands to reason that SOPs provide **detailed written instructions to achieve uniformity of the performance of specific functions. Where an SOP is in place, it is expected that procedures would be followed as described by all of the relevant members of staff referred to within the procedure**. If an SOP is not followed, this would be seen as a breach of process from the point of view of an audit (management).

UPTH is one of the first government health institutions to develop and implement the use of SOPs in a bid to ensure Quality Improvement in service delivery. The CMD, Prof. Henry Ugboma must be applauded for the achievement of this unprecedented feat and supporting the production of the MAIDEN EDITION of the Standard Operating Procedures of our beloved hospital.

Members of UPTH staff should endeavor to have access to the SOPs either in the form of hard or electronic copies accessed on the UPTH Website (www.upthng.com) or the UPTH mobile application downloadable from the Google Play store.

It is imperative to note that the SOPs are a living document subject to review at least annually to accommodate changes in policies, processes and practice that had not hitherto been reflected.

Dr. Obianma N. Onya

Chief Consultant Family Physician &

DCMAC (NHIS/SERVICOM)

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UPTH STANDARD OPERATING PROCEDURE FOR ACCIDENT & EMERGENCY DEPARTMENT

HEAD OF DEPARTMENT: DR PETER D. OKOH
DATE: 13/7/2018
SOP No.: 002
NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am

INTRODUCTION:

The Department of Accident & Emergency is the first port of call for all Surgical, Medical and Gynaecological emergencies arriving in the hospital. It is therefore the eye of the Hospital and its image. It is a centre where split second decisions and actions must be taken to avoid unnecessary loss of lives.
The Department has a 30-bed space capacity. Four of these beds are maintained at the reception area with attached resuscitative gadgets for the resuscitation of critically ill patients.

SCOPE:
Trauma and non-trauma related emergencies (medical or surgical)

PROTOCOL:

The major goal of the Accident &Emergency Department is to receive emergency cases, resuscitate &stabilize within the shortest possible time then refer to the various Specialist Departments/units for further management. Thus, the Department carries out mainly Primary survey/resuscitation. The Department has a theatre for the exploration of trauma injuries and suturing of wounds and also serves the Surgical departments for minor and sub-major cold surgical procedures.

The Accident/Emergency Department has a total of eighteen [18] doctors [3 Consultants and 15 medical officers],28 nurses [inclusive of 6 theatre nurses], ward maids [6]/Porters [4], Support Account/record/administrative staff [1 each] and 7 Casual staff [paid with the A&E revolving fund allocation].

PROTOCOL FOR EMERGENCY TRAUMA/MEDICAL CASES ARRIVING AT THE A&E DEPARTMENT

A	Reception/Quick assessment of Accident/Medical cases on arrival at the entrance of A/E.	Nursing staff	As soon as patient arrives.
B	Call for a trolley/Wheelchair for the conveyance of the patient.	Nursing staff/Porter	2minutes.
C	Patient seen by the Doctor and immediately transferred to the point of resuscitation and beginning of resuscitation/primary survey.	Doctors/Nurses	3 mins after arrival and until patient is stabilized.
D	Opening of card/Folder.	Account/Records unit assisted by relations.	During the stabilization of patient.
E	Patient's relatives counselled and informed of the extent of illness/injuries.	Doctors	After stabilization.
F	Secondary Survey/Referral of patients.	Doctors/Nurses	After stabilization.
G	Transfer to the theater of patients for wound suturing after preparation at the A&E Reception and informed consent obtained.	Doctors assisted by nurses and Porters	Patient with no major trauma: at most 25mins after arrival.
H	Stabilized/Referred cases are transferred to the A/E day-wards.	Nurses/Porters	As soon as patient is stable. enough to be moved.
I	Specialist units on call are promptly informed [if not on ground] of any referral.	Doctor	Within 30-60 minutes of being called. Time of referral to be documented.
J	Cleaning/Evacuation of used material.	Maids/Cleaners	Present at all times to ensure cleaning.

- Patients are brought in alive or dead for proper examination, documentation and possible resuscitation. Corpses should not stay more than 30 minutes in A&E.
- All patients-including those brought in dead- must get a folder except for those that may not eventually be admitted.
- If in need of admission, must be moved into the wards within 48 hours or discharged after being appropriately counselled.

PROTOCOL FOR STABILIZED PATIENTS IN THE A&E DAY WARDS

	PROCEDURES/TASK	FACILITATOR	TIME LAG
A	All referred Patients in the A&E day wards shall be attended to and vital signs monitored until transferred to the Specialist wards.	Doctors/Nurses	Within 48 hours
B	All referred Patients not admitted/transferred after 48hrs shall be transferred by the authorization of the A&E HOD to the Specialist wards.	HOD	After 48hrs of admission into the day ward.
C	Management of already seen cases by the Specialist units shall be the sole responsibility of such units.	Specialist units	

USE OF MATERIALS/CONSUMABLES

Dressing materials and drugs needed for the resuscitation of Emergency cases are constantly available in the Crash Cart. These Emergency drugs/materials are replaced by Patients/Relatives by direct purchase from the Hospital Pharmacy after prescriptions are made by the Doctors. There should be NO CASH COLLECTION FOR MATERIALS USED.

Cases of indigent or unknown accident victims shall be reported to the social welfare unit for assistance, and to the HOD. The supervising Consultant usually initiates the activation of the indigence process.

PAYMENT PROCEDURE

All payments are made either at the accounts section (if in possession of ATM) or at the banks. In both cases, electronic receipts are issued in triplicates. The A&E Account/Record officers are responsible for the recording and issuance of receipts. Reconciliation of all transactions are carried out on a daily basis by the Departmental project Accountant, the Chief Nursing Officer and the HOD or his designate.

The Project Account in conjunction with his/her team of account clerks are responsible for following up patients in the specialist wards to collect Casualty charges that were being owed until such patients were moved out of the department.

Patients for A&E theatre procedures shall be booked by the Theatre Matron or her designate, informed consent obtained from the patient and evidence of payments shown [stamped/signed teller by the bank]. All Patients admitted into the A&E wards [Reception inclusive] shall pay the appropriate fees. Patients on resuscitation and oxygen may pay extra charges as may be determined by Management.

RESPONSIBILITY SCHEDULE

a.) The HOD takes responsibility for any lapses in the functions of the department under his watch.
b.) Every other staff (including the doctors) takes responsibility for failure in his/her primary duties as enshrined in his/her job description.
c.) The Chief Nursing Officer in charge of A/E shall assist the HOD in the day to day activities of the nurses, maids and Porters in the Department. He or She shall therefore be the first to be held responsible for any lapses observed in the nursing duties in the A&E.
d.) To achieve the above goals [a, b&c], there is a clear job description and allotment of supervisory roles to Staff in the Department who in turn shall report to the Doctor on duty/Chief Nursing officer. These supervisory assignments include Laundry services, Wards/Environmental sanitations, repair of broken-down domestic

e.) facilities, inventory of departmental properties, reconciliation of departmental funds and academic/general departmental programs.

DEPARTMENTAL MEETINGS/ACADEMIC ACTIVITIES

a.) There is fortnightly [1st&3rd Fridays] mortality meetings, monthly [2nd Thursdays] clinical meetings and bimonthly general departmental meetings [3rd Thursdays].

b.) The Departmental Revolving Fund committee holds its meeting every 1st Tuesday of the month.

REVOLVING FUNDS/PROCUREMENT OF CONSUMABLES

As outlined in the SOP for Procurement & Stores.

STAFF TRAINING/MANPOWER

The A&E Department is not registered for residency training program. Currently, no resident is employed in the A&E. All A&E doctors with the exception of the HOD and the 2 Consultants are medical officers. Two of the Consultants are Family Physicians, while the HOD is a General Surgeon.

Seventy percent of these Medical officers have undergone the ATLS training. Recently, two doctors and two nurses attened the "Emergency Room Management of the trauma patient" ATLS training organized by the International Committee of the Red Cross [ICRC].

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

UPTH RECOMMENDED STANDARD OPERATING PROCEDURE FOR ALL THEATRES

CHAIRMAN THEATRE MANAGEMENT COMMITTEE:
PROF. PATRICK O. EGHWRUDJAKPOR
DATE: 12th November, 2018
SOP No: 002
NOTE: Work Starts by 8:00 am.All clinics and knife on skin (Surgery) starts by 9:00 am

INTRODUCTION

Operational guidelines describe the processes and procedures that staff in any organization follow when carrying out their work.

PURPOSE

To establish guidelines for Theatre use/operations with respect to the processes involved in cost effective, patient focused management in the University of Port Harcourt Teaching Hospital (UPTH).

RESPONSIBILITIES

The Theatre offers expert surgical care to patients booked by all surgical departments within the hospital. The theatre will give all-inclusive, uninterrupted and coordinated 24 hours surgical care to patients irrespective of age, sex and religion. The consultant surgeons, Resident doctors, Perioperative nurses, Anesthetists, Anesthetist technicians, Porters, Cleaners and all other theatre staff will work as a team to ensure the smooth running of the Theatre and to achieve patient-centered care.

ACCESSING SURGICAL CARE IN THE UPTH THEATRE SHOULD INVOLVE THE FOLLOWING FOR ELECTIVE CASES.

STEP	PROCEDURE	WHO IS RESPONSIBLE?	TIME
1	ADMISSION OF PATIENTS FOR SURGERY	RESIDENT DOCTORS/CONSULTANTS	2 DAYS BEFORE SURGERY
2	ANAESTHETIST REVIEW OF BOOKED PATIENT	RESIDENT DOCTORS/CONSULTANTS	24 HOURS BEFORE SURGERY
3	SURGICAL BOOKING OF PATIENTS SHOULD BE AFTER ANAESTHETIST REVIEW	RESIDENT DOCTORS/CONSULTANTS	BEFORE 12 NOON OF THE DAY PRECEEDING SURGERY
4	PATIENT TO MAKE ALL PAYMENTS	PRIMARY MANAGING TEAM	A DAY BEFORE SURGERY

5	SENDING FOR FIRST BOOKED CASE	ANAESTHETISTS GIVING THE ORDER, WHICH IS TO BE CARRIED OUT BY THE NURSES/PORTERS	8AM OF THE DAY OF SURGERY
6	BRINGING OF THE PATIENT TO THEATRE AFTER VERIFICATION OF PAYMENTS	NURSES/PORTERS	15 MINS
7	RECEIVING OF THE PATIENT IN THEATRE/ VITALS CHECK	NURSES	10 MINS
8	PAYMENT RECEIPT PRESENTATION TO THEATRE STAFF	NURSES/DOCTORS	5 MINS
9	WHEELING OF PATIENT INTO OPERATING ROOM	PORTERS/NURSES	5 MINS
10	KNIFE ON SKIN AFTER ADMINISTRATION OF ANAESTHESIA	SURGEONS	9AM PROMPT
11	REVERSING OF PATIENT FROM ANAESTHESIA WHEN INDICATED	ANAESTHETISTS	30-45 MINS
12	WHEELING OF PATIENT TO RECOVERING ROOM	NURSES/ANAESTHETISTS	5 MINS
13	MONITORING OF PATIENT IN THE RECOVERING ROOM UNTIL WHEN PATIENT IS FIT TO BE MOVED TO THE WARD	ANAESTHETISTS/NURSES	1 -2 HOURS
14	WHEELING OF PATIENT BACK TO THE WARD	PORTER/NURSES	10 -15 MINS
15	CLEANING OF THEATRE FOR THE NEXT CASE	CLEANERS	10-15 mins

EMERGENCIES

All emergencies should be given priority and managed accordingly. The hospital policy on assessing emergency services should be followed.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF ANAESTHESIOLOGY

NAME OF HEAD OF DEPARTMENT: DR O. T. ALAGBE-BRIGGS
SIGNATURE OF HEAD OF DEPARTMENT ……………………………
DATE: **20th July, 2018**
SOP No: 002
SOP TITLE: CLINICAL PATHWAYS IN THE PROVISION OF SAFE AND EFFICIENT ANAESTHESIA.
NOTE: Work Starts by 8:00 am.All clinics and knife on skin (Surgery) starts by 9:00 am

INTRODUCTION

The department of anaesthesiology is defined by the responsibility it shoulders which revolves around the prevention of pain and the total care of the patient before, during and after surgery, as well as intensive care of the critically ill. The relevance of our activities to humanity and especially to the surgical patient is enormous and drives the focus towards the various partnerships in global health that work towards the strengthening of health systems and universal health coverage.

PURPOSE

To outline the appropriate and safe anaesthetic/ monitoring techniques

- To define the anesthetic services provided in UPTH. This activity covers both emergency and elective surgical procedures
- To define the available resources that are required to provide these services within the confines of safety and efficiency

AIM

Anaesthesiology department is a service department that sub serves every segment of the hospital on a 24-hour basis.

The department ensures the following:

1. Patient Safety - our primary concern
2. Anesthetic services in partnership with surgeons and physicians to ensure a favorable outcome for our patients.

3. Prompt response to emergencies with an inherent aim of stabilizing and possibly transferring the very sick either to the operating room or to the intensive care unit.
4. Asafer perioperative environment forall patients undergoing anesthesia.
5. Elective cases are reviewed and accorded adequate attention
6. Facilitation of safe intra and inter-hospital transfers revolves around our responsibility.

SCOPE OF THE SERVICE

Coverage is 24 hours a day &seven days a week

COVERAGE

The following specialties / units are covered-

- Paediatrics
- Obstetrics and Gynaecology
- Orthopedics
- Accident and Emergency
- General surgery
- Plastic/ Burns
- Neurosurgery
- Urology
- Ophthalmology
- ENT
- Maxillofacial
- Cardiothoracic
- Laparoscopic Surgeries
- The activities include preanesthetic assessment and the provision of pain free perioperative periods.
- Admission of critically ill patients into the intensive care unit is facilitated.
- Education and support to anesthetists preparing for both the diploma and fellowship examinations
- Support to intensive care nurses and technicians working for the safety of patients
- Management of the recovery room

- Offsite administration of anaesthetic services to neuropsychiatry, radiology and pediatrics.
- Post-operative assessment and acute pain management of surgical patients.
- Management of the oxygen plant, production of oxygen to the entire hospital.

STAFFING

DESIGNATION	NO
Consultants	13
Residents	32
Medical Officers	04
Supernumerary Residents	06
Anesthetic Technicians	28
Nurses(ICU)	14
Admin Staff	04

INCLUSION CRITERIA

- All patients deemed fit for anaesthesia
- All patients requiring organ/ system support for admission in the ICU

EXCLUSION CRITERIA

- All patients deemed medically unfit at pre-assessmentvisit. These will require optimization and/or consultation
- Patients requiring care not provided at UPTH

WORK FLOW

All the staff are responsible to the head of department.

- There are 4-6 consultants on the theatre floor daily.
- The residents are grouped into consultant led teams.
- The residents consist of the registrars and senior registrars.
- Every surgical procedure is pre-operatively reviewed by the team members(consultants and residents) and a risk assessment and perioperative plan is made

- The anesthesia consultants often interface with the surgical consultants on all issues concerning the patient's perioperative management.
- The surgical checklist is used on every surgical procedure.
- The technicians are duly assigned theatre suites and are involved in the preoperative anesthetic equipment/theatre preparations on the day of surgery.

INFECTION CONTROL

- Strict infection control is undertaken by the department.
- Handwashing is mandatory before and after touching patients
- Pre-operative use of antibiotics for contaminated cases (or as instructed by the surgeon) is ensured

OPERATING HOURS

- All patients are seen and reviewed a day prior to surgery.
- Unit consultants are duly informed for every case that is booked.
- Laboratory investigations are requested on review
- ASARisk Classification is assigned
- Elective surgeries are scheduled from 8.30 am -4.00pm.

BIOMEDICAL ENGINEERING.

- For prompt maintenance of all anesthetic/theatre equipment, the works/bioengineering unit is engaged as an officer is posted to the theatre.

DOCUMENTATION

- The pre-anesthetic review is usually written in the respective patient file.
- All perioperative events are covered in the anesthetic charts.
- Critical incidents are reported and communicated to the head of department and intra / inter departmental morbidity / mortality reviews are organized for such incidences.

THEATRE FACILITIES

There are ten theatre suites.

- One anesthetic machine / suite
- One multiparameter monitor/suite
- One suction machine/suite
- Store for consumables
- Pharmacy
- Four bedded recovery room
- A pantry
- An autoclave room
- Office for the matron i/c with desktop and printer
- Two lounges (doctors/nurses) with 2 plasma tv sets
- A seminar room with teaching aids and equipment for telemedicine
- Four rest rooms

CONTIGENCY

- Casual leaves from every staff is granted by the head of department.
- Emergency defaults in equipment is reported through the head of department to the biomedical unit
- Major emergency purchases are channeled through the head of department to the chief medical director

AUDIT/ STORES DEPARTMENT

- These are actively involved with monitoring, auditing and taking inventory of departmental purchases/equipment in line with budgetary allocation.

RESPONSIBILITY

- The overall head of the department of anesthesiology takes full responsibility of all activities in the department and may delegate as is deemed fit.

ACCREDITATION PROCESSES
Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES
As outlined in the SOP for Procurement & Stores.

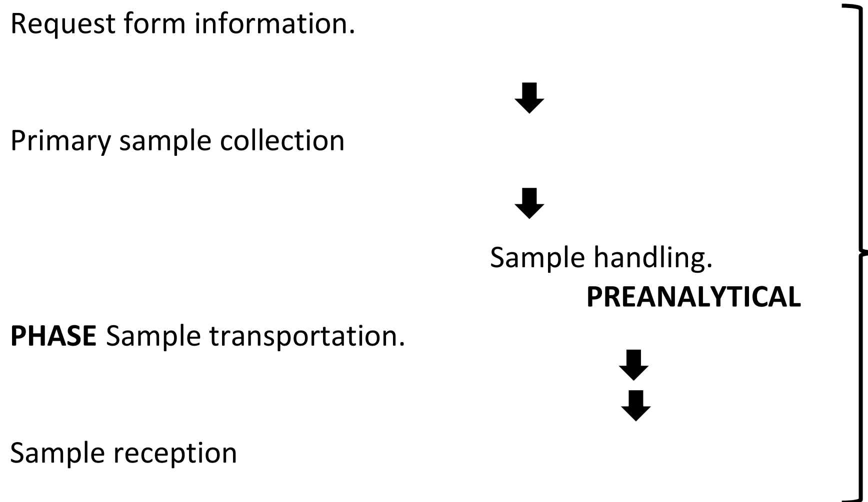
NB: Please Refer to Theatre SOPs for theatre management procedures.

DR. O.T. ALAGBE-BRIGGS
HEAD OF DEPARTMENT

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF ANATOMICAL PATHOLOGY

NAME & SIGNATURE OF HEAD OF DEPARTMENT: ……………………………………
DATE: 12TH JULY, 2018
SOP No: 002
SOP TITLE: **Preanalytical Variables.**
NOTE: Work Starts by 8:00 am.
INTRODUCTION

Adapting from the ISO, CAP, CLIA’s definition of a Clinical Laboratory, the Anatomical Pathology laboratory is the laboratory for the biological, cytological, pathological, genetic or other examination of materials derived from the human body for the purpose of providing information for diagnosis, management, prevention and treatment of disease in, or assessment of the health of, human beings, and which may provide a consultant advisory service covering relevant aspects of laboratory investigation including the interpretation of results and advise on further appropriate investigation (Prof Iroegbu K. C., lecture on Introduction to Quality Management System , 2018 February 09)



Preanalytical variables account for 32-75% of laboratory errors[1].

SPECTRUM OF SERVICES PROVIDED.

1. Histological diagnosis on all human tissue biopsy samples such as but not limited to incisional, excisional, whole organ, renal, liver and bone marrow biopsies.
2. Intraoperative consultation (frozen sections)
3. Immunohistochemistry assessment of hormone receptors on breast cancers, ER,PR HER 2 on breast cancer, lymphoma characterization etc.
4. Histopathological consultation in multidisciplinary patient management.
5. The Anatomical Pathology laboratory is responsible for the cytological examination of aspirated and exfoliated cells derived from the human body for the purpose of providing information for diagnosis, management, prevention and treatment of disease

SCOPE

This document contains instruction for all surgical and medical departments of the teaching hospital and all other hospitals. It is for surgeons, residents, house officers, nursing staff, medical laboratory staff etc. This document contains instructions on the processes involved in the collection, transport and handling of tissues, aspirates, smears, to the histopathology lab and cytology lab and also the receipt of bodies to the mortuary from the wards of UPTH, external

sources, management of the bodies, infection control, disposal of bodies, record keeping and quality improvement measures. These procedures apply to all designated staff in the Anatomical Pathology.

HISTOPATHOLOGY AND CYTOPATHOLOGY SERVICES

a. PROCEDURES FOR COLLECTION AND SUBMISSION OF ROUTINE HISTOPATHOLOGICAL INVESTIGATIONS

i. Ordering for a test begins with filling out of the Anatomical Pathology request form by the doctor of the patient. These request forms must be correctly filled out to include- name, age, sex, hospital number, managing consultant, preliminary diagnosis, date of request, etc.

UNIVERSITY OF PORT HARCOURT TEACHING HOSPITAL
HISTOPATHOLOGY REQUEST FORM

Name: (Surname, First name, Other name(s))	Patient's phone number:	Sex:	Age:	Ward / clinic:	Resident's name & phone number:

Hospital number:	Date of collection of specimen:	L.M.P.:	Consultant's name:	Lab number (for lab use only):	Date received at the Lab (for lab use only):

Clinical history: ...

Clinical /Provisional diagnosis: ...

Type of surgery/procedure performed and the indication for it: ...

Nature of specimen: ...

Any previous histological / Cytological diagnosis? (yes/ no): ...

If"yes" please state it: ...

Histology / Cytology number of previous report(s): ...

Date of current request: ___ Signature: port(s): ___

This is a patient referral and consultation form.

All spaces should be correctly filled.

In the clinical history segment, a summary of relevant clinical history, physical examination findings, intra-op findings, and other relevant laboratory investigation findings should be documented there for improved turnaround time.

ii. The patient/ relative brings the request form to the Anatomical Pathology Reception, adjacent to the Central Laboratory Specimen Collection Unit where the charges of the investigations are given,

payment made and receipts issued in triplicates (one for the patient, the second one to the accounts clerk andthird to the samples collection unit officer at the reception of the Anatomical Pathology department

iii. Patients covered by NHIS must present the NHIS cover paper before they can be attended to.

iv. Patients must be carefully selected and the best possible sample for accurate diagnosis be collected. As far as possible, avoid local heat damage form cautery to tissues.

v. Patients should be asked to provide containers with well-fitting lids that would contain the estimated size of the tissue to be removed. Tissues should not be crushed or squeezed into the containers. Syringes are NOT appropriate for tissue storage.

vi. After collecting the specimen, they should be placed in an appropriately sized plastic container after blood has been washed the tissue to prevent artefact formation.

vii. 10% Neutral buffered formalin should be put in the container in a ratio of 10:1(10 parts formalin, 1part tissue) **immediately** after removal for routine histopathological assessment. The volume of the formalin should be in the ratio of 10:1. Gauze should be placed at the bottom of heavy tissues. Cystic or fatty masses should have thick layer of formalin-soaked gauze placed on top of them to ensure proper immersion. Tissues should not be put into saline or disinfectants. ALL TISSUES REMOVED SHOULD BE SUBMITTED INTOTO.It is not in the best interest of the patient to divide tissues. This is not also in keeping with International Best Practices.

viii. The sample container should be well labelled on its body. The full name, age, hospital number, ward, nature of specimen with appropriate tagging, where necessary, name of consultant etc. should be on this label.

ix. Alaboratory number is given to each specimen bottle at the point of submission and the same number (as well as time of collection for each test requested) is written on the patient’s copy of the receipt to be used for the purpose of identification during collection of the report. Patient’s details and laboratory number are recorded in the departmental ledger (log book).

b. PRIMARY SAMPLE COLLECTION/HANDLING FOR FROZEN SECTION.

Intraoperative consultation aka frozen section is indicated to[2]:

- Establish the nature of a lesion: Is it benign or malignant, so as to decide the extent of the surgery.
- Establish the presence of a lesion.
- Confirm that the sample collected is representative or enough to make a diagnosis.
- Determine the organ of origin. This is applicable to organs that are difficult to recognize grossly e.g. parathyroid gland.
- Determine the adequacy of margins.
- Establish evidence of metastases of lymph nodes
- Acquire fresh tissues for special studies.
- Determine viability of possible resection margins.

The anatomical pathology department should be notified in writing for frozen section requests at **least 24 hours before** the procedure.

The sample should be placed in a sterile container and brought to the laboratory along with the request form.

c. TISSUE COLLECTION AND HANDLING FOR IMMUNOHISTOCHEMISTRY.

Samples for immunohistochemistry must be put in adequate amounts of neutral buffered formalin.

Fresh samples of formalin may be requested for.

Cold ischemic time, defined as the time from the removal of the tissue from the patient to the initiation of tissue fixation be shortened as much as possible, specifically, no more than 1 hour[3].

All large samples may be bread loafed.

Samples should be sent immediately into the laboratory as they should not be fixed for more than 48-72 hours.

d. CYTOLOGY

i. BODY FLUID COLLECTION/HANDLING.

The fluid should be collected in appropriate container and preserved with equal volume of 95% alcohol. These containers should be accurately labelled with the biodata of the patient. This label should be placed on the body of the container and not its cover.They should be sent for analysis as soon as possible.

ii. COLLECTION OF FNAC SAMPLES

FNAC samples are collected in our department. The mass should be palpable and discrete.

iii. COLLECTION OF CERVICAL SMEARS

For cervical smear, patient should be prepared by being advised on the following:

- Avoid intercourse, douching or vaginal medicines, creams or jellies or spermicides two days before a pap smear.
- The smear should not be conducted during menstrual period.

Upon completion of the request form, patient should be directed to our department where she shall be given a teller. When payment is completed, a Coplin jar containing 95% alcohol is given to her with labelled glass slides wrapped in paper.

The cervical smear should be taken by trained professionals and recommended guidelines should be followed.

It is imperative that the smeared slides be put into the alcohol containing Coplin jars **immediately** to prevent artefacts. The slides should not be air dried

e. SAMPLE TRANSPORTATION.

Unnecessary delays should be avoided. Ensure the container is well sealed and does not leak.

All samples should come with a well filled request form.

f.REPORT RECEIPT

The turn-around time for

i. Frozen section: 30 minutes
ii. Cytology specimen is 24-72 hours.
iii. Histopathology:14 days

g. RETRIEVAL OF TISSUE BLOCKS/SLIDES.

This may be required when there is a request for a second opinion or when the patient is being referred to another center for further treatment. In such cases, a requesting letter with the laboratory number should be addressed to the Head of department. Approval is usually immediately given.

Tissue blocks are usually kept for as long as there is adequate storage space.

Histology and cytology slides are kept for **10 years**

h. RETRIEVAL OF PREPARED SLIDES.

This may be required when there is a request for a second opinion or when the patient is being referred to another center for further treatment. In such cases, a requesting letter with the laboratory number should be addressed to the Head of department. Approval is usually immediately given.

i. **QUALITY IMPROVEMENT MEASURES**.

We are poised to continuous improvement. We are open to feedback and conduct surveys as scheduled.

j. RECORD KEEPING.

All log books and request forms are to be kept by the assistant director of laboratory services.

k. **INFORMATION MANAGEMENT**

All patients' records are kept confidential. All records are carefully kept with back up services available**.** They are available on request by authorized personnel.

l. **QUALITY IMPROVEMENT MEASURES**.

We are poised to continuous improvement. We are open to feedback and conduct surveys as scheduled.

m. RECORD KEEPING.

All log books and request forms are to be kept by the assistant director of laboratory services.

n. **INFORMATION MANAGEMENT**

All patients' records are kept confidential. All records are carefully kept with back up services available**.** They are available on request by authorized personnel.

MORTUARY SERVICES

The mortuary is an integral part of the hospital services as it deals with the preservation of dead bodies from within or without the hospital until collection by its family. The mortuary is also the site for port mortem examinations by Pathologists. Teaching of Resident doctors, medical students, anatomy students etc. also take place here.

RESPONSIBILITIES

Responsibilities	**Authorized staff name(s)**
Supervision of all the activities of the mortuary	Dr. Ajoro
Removal of bodies from the wards	
Reception of bodies and registration in the log book	
Suturing and embalming	
Cossetting	
Issuing of tellers and receipts	
Issuing gate pass	

RECEPTION OF BODIES FROM THE WARD

When there is notification of death by the ward assistant, the designated mortuary attendant would do the following within 30 minutes:

i. Receive the hospital folder of the deceased from the nurse assistant who makes the notification.
ii. The name, ward number, age of the deceased would be entered into the mortuary log book.
iii. The mortuary number would be assigned and name label prepared.
iv. The mortuary big and small card is also filled with the required information of the deceased
v. Payment for embalmment and initial storage fees is made and receipts issued.
vi. Safety and security should be top priorities. Appropriate Personal Protective Equipment (PPE) should always be used. Any safety concerns should be directed to the mortuary supervisor.
vii. After payment, the mortuary attendant then proceeds to the ward. He should introduce self to nursing staff on duty who would identify the deceased.
viii. Confirm all documentation are complete and accurate, signed, dated and timed and that the last offices checklist is complete.
ix. The name label should be placed on the deceased who is then removed and placed in the mortuary trolley. Medical paraphernalia on the deceased should be left in place.
x. The mortuary small card is also given to the relatives of the deceased
xi. The body is then transferred to the mortuary using appropriate, designated routes. Mortuary attendants are required to remove bodies in a courteous, sensitive and professional manner while ensuring uttermost respect for the dead.

RECEPTION OF BODIES FROM EXTERNAL SOURCES

All brought in dead corpses must first be taken to the Accident and Emergency (A&E) department for confirmation of death and circumstances of death. When cleared by the doctor on duty in the A and E for deposition in the mortuary, the

following is then done. Professionalism, empathy, and safety are utmost considerations.

i. The name, age, address of the deceased is entered into the mortuary log book by the personnel manning the reception.
ii. The account officer raises a teller for payment of embalmment fees and a deposit for storage fees. If it is brought in by security personnel, these steps are ignored
iii. After payment, the mortuary attendant should adorn appropriate PPE, then proceed to remove the body form the conveying vehicle using a trolley.

Personal effects of the deceases such as clothes, jewelry, wallets, braces etc should be carefully documented and handed over to the mortuary supervisor for safe keeping.

MANAGEMENT OF RECEIVED BODIES

Bodies may be stored in the refrigerator or embalmed using formaldehyde.

Before either, they are transferred to the receiving room. Clothes and medical paraphernalia should be well documented and then removed. Wounds should be examined and recorded by the pathology resident on call. These wounds should then be sutured. The body is then washed.

If body is for refrigeration, it is transferred to the appropriately labelled fridge cabinet for preservation.

If the body is for embalmment, an incision is made over the femoral vessels and the vein identified. The embalming fluid is put in through the femoral vein.

When fully infused the body is then transferred to the drying room. Then transferred to the appropriately labeled storage room in a clean, closed body bags with no leakage of fluids on rack.

COLLECTION OF BODIES

When the relatives or depositors request to remove the body. These steps are followed

i. The account clerk ensures all outstanding bills are settled. Then gate pass issued by the departmental secretary who re-verifies that all bills are paid and there is no order by the Police not to release the body.
ii. Locate and retrieve body from fridge or storage rack.
iii. If requested, the body may be cosseted by the mortuary attendants. Mortuary attendants should carry out the cleaning and cossetting unless otherwise indicated by for religious beliefs. In such situations, those who would clean should be adorned with appropriate PPE.
iv. The body may then be placed in the casket, if provided and transferred to the removal equipment.
v. Verify personal property being released on the personal property form
vi. The mortuary attendant and relatives should sign the body out on release log book
vii. Unidentified remains cannot be released.
viii. Photocopies of HOD acknowledged letters from the police that order that a body be not released, should be posted on the notice board. All staff on duty should ensure that these orders are obeyed.

DISPOSAL OF BODIES

Unclaimed bodies would be disposed after 2 years according to the state's protocol after advertisements are made in popular radio and television stations.

INFECTION CONTROL.

According to the concept of universal precautions, all human blood and human blood components, and other potentially infectious materials (OPIM) are treated and handled as if known to be infectious for HIV, HBV and other bloodborne pathogens. OPIM includes the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, anybody fluid

that is visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

Personal Protective Equipment

Personal protective equipment **(PPE)** shall be used to prevent skin and mucous membrane contact with blood and OPIM. These may include the use of gloves, N95 masks, protective eye wear, face shields, shoe covers, plastic aprons/gowns, hair bonnets, Tyvek suits and/or sleeves, cut resistant gloves, and laboratory coats. Additional PPE may be required depending on the particular case circumstances.

Hand Washing

Hands and other skin surfaces shall be washed with soap and water immediately after contact with blood or OPIM. Hands shall be washed each time gloves or other PPE are removed.

The mortuary supervisor and head of department should be notified when cases suspected to have died of hemorrhagic fever are to be deposited**.** All corpses confirmed to have died of notifiable Biosafety Level 4 diseases like Ebola should be kept in designated areas while awaiting the appropriate authorities in charge of their immediate burial.

All areas should be kept clean and rodent proof

QUALITY IMPROVEMENT MEASURES.

i. Perform financial audits monthly.
ii. Conduct an annual 'User' survey. User Survey reported Monthly over 12 months
iii. Hold regular meetings as listed in the Quality Manual.
iv. Raise CAPA (Corrective action/Preventive action) against all nonconformances and action them
v. Monitor free space against expected space.
vi. Measure % compliance against documented audit schedule

RECORD KEEPING.

i. All log books are to be kept by the mortuary supervisor. The mortuary card should also be safely kept in the designated shelves. Confidentiality should be respected
ii. These are vital documents for audit purposes.
iii. The duty roster is created monthly and should be signed by the head of department.
iv. The stock records for consumables should be checked and documented daily by the mortuary store keeper using the provided register. The protocol for requisition of reagents like formalin should be followed
v. The log book for all the equipment and materials used should be updated weekly.

MORTUARY SECURITY

The following items relate to Mortuary security:

i. All mortuary staff must enter and leave through the front door. Unauthorized personnel and relatives/corpse depositors should remain in the reception areas.
ii. The autopsy assistant should respond and meet with visitors in a timely manner.
iii. The back door and the garage door should be closed and locked when not in use.
iv. Within and outside the mortuary building should always be kept well lit.

TRAINING

All mortuary staff are expected to participate in Infection and Prevention control training once every year.

RECORD KEEPING.

All log books and request forms are to be kept by the assistant director of laboratory services.

INFORMATION MANAGEMENT

All patients' records are kept confidential. All records are carefully kept with back up services available**.** They are available on request by authorized personnel.

QUALITY IMPROVEMENT MEASURES.

We are poised to continuous improvement. We are open to feedback and conduct surveys as scheduled.

RECORD KEEPING.

All log books and request forms are to be kept by the assistant director of laboratory services.

INFORMATION MANAGEMENT

All patients' records are kept confidential. All records are carefully kept with back up services available**.** They are available on request by authorized personnel.

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

REVOLVING FUND MANAGEMENT/ PROCUREMENT PROCEDURE

Please refer to SOP for Procurement and Stores.

WRITTEN BY:DR EZINNE ERHIRHIE

REVIEWED BY:THE QUALITY CONTROL OFFICER (DR SOLOMON OBIOHA)
AUTHORISED BY: THE HEAD OF DEPARTMENT (DR ATHANASIUS B.P)

REFERENCES

1. Sumera N, Arshad M, Sadaruddin A. Preanalytical errors and their impact on tests in clinical laboratory practice.
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UPTH STANDARD OPERATING PROCEDURE FOR BURNS AND PLASTIC UNIT

DEPARTMENT: SURGERY
NAME OF HEAD OF DEPARTMENT: DR. BENJAMIN M. KEJEH
SIGNATURE OF HEAD OF DEPARTMENT ……………………………
DATE: **13th July, 2018**
SOP No: 002
NOTE: Work Starts by 8:00 am.All clinics and knife on skin (Surgery) starts by 9:00 am

SCOPE

A. OUT PATIENT CLINIC CARE – DOCTORS/NURSES

1. Patient pays and obtains a casenote from the Records Department.
2. Nurse checks vital signs.
3. Doctors ensure that every case note has a receipt of payment for registration before consultation.
4. Patient is seen by the Doctor: – Registrars /House Officers Clerk new patients and reviewed by the Consultant.
5. Old patients are seen by the Registrars and Senior Registrars and later a decision is taken in consultation with the Consultant.
6. The patient is reviewed by the Consultant and teaches Medical Students /Registrars.
7. After the review Patients are investigated, drugs are prescribed and an appointment written on the card – date, day and time.
8. Patients for admission are directed to meet the Nurses who arrange to take them to the wards.
9. Those booked for elective surgery on a later date are given appointment and informed on the day of admission and surgery.
10. Patients whose cases require further opinion from other Specialties are given referral letters to the respective Specialist.
11. All new patients and those booked for surgery are recorded in two different Notebooks.

B. ACCIDENT AND EMERGENCY (A/E) CARE – REGISTRAR/SENIOR REGISTRAR

1. The A/E Doctor refers a patient to Burns and Plastic Surgery and invites the Unit's Registrar.
2. The Unit Registrar clerks and examines the patient and invites the Senior Registrar.
3. If it is a Burns case with Total Body Surface Area (TBSA) 15%and above in an adult or 10% and above in a child, the patient is immediately admitted into the ward.
4. If it is deep burns or involving the face, joints or perineum; patient is admitted irrespective of the TBSA.
5. Chemical and Electrical Burns are also admitted without considering the TBSA involved.
6. Other non- burn trauma cases are reviewed;wound is either sutured in CasualtyTheatre and patient discharged with an appointment in the Outpatient Clinic in minor cases or admitted to the ward for further treatment.
7. More severe cases are taken to the main theatre from the A/E for surgery.
8. Duration of stay in A/E in 6 and 7 depends on availability of bed space.
9. Payment is made to the accounts clerk in Burns and Plastic Unit Revolving Fund.

C. ADMISSION PROCEDURE IN THE BURNS WARD - NURSES

1. The Ward Nurse is informed about a patient for admission from SOP or the A/E.
2. A bed is made and prepared for the patient.
3. Patient is brought to the ward by a Maid or a Porter.
4. The Nurse confirms that the admission has been documented by a Doctor in the Unit and the diagnosis clearly stated.
5. The Nurse collects the receipt of payment for admission.
6. The patient is admitted.
7. Vital signs are taken and she ensures that patient is stabilised.

8. Details of the patient are recorded in the admission and discharge register.
9. Patients and relations are educated about the disease condition, infection control, restriction of visitors, dietand what to expect.

D. PREPARING A PATIENT FOR THEATRE - DOCTOR

1. A decision is taken on the patient and the type of operation by the Consultant.
2. The procedure is categorised – minor, sub major, major or supermajor.
3. Investigations are done and results satisfactory.
4. The patient and relations are informed about the financial implication, possible complications and written consent obtained.
5. The patient is enlisted and the list is submitted to the Anaesthetist, Theatre, ward and other relevant offices.
6. Where specific challenges are anticipated, a letter is written to the Anaesthetist earlier detailing the challenges and if possible for the discussion on the available options.

E. DISCHARGE PROCEDURE – DOCTOR, NURSE AND ACCOUNTS CLERK

1. The Doctor documents the decision to discharge the patient and writes a discharge summary.
2. The Accounts Clerk makes the bill and patient pays.
3. The Nurse records the details of the receipt and amount paid.
4. The appointment date is written in the card and given to the patient.
5. Patient is advised to report before the appointment day if there is any deterioration in health.
6. Health education on the disease condition and preventive measures are explained to the patient and relations.

F. AT DEATH – DOCTOR, NURSE AND ACCOUNTS CLERK

1. The Nurse informs the Doctor.
2. Doctor certifies patient dead.
3. Relations are informed about the death by the Doctor.
4. Nurse does the ‘last office’ and the body is packed.
5. Mortuary is informed.
6. The Account Clerk makes the bill.
7. Death certificate is signed by the Doctor.
8. The certificate is handed to relations after the bill is paid by the Nurse.
9. Kind words and empathy is expressed to the relations.

G. ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

H. PROCUREMENT OF CONSUMABLES AND EQUIPMENT

As outlined in the SOP for Procurement & Stores

I. RESEARCH

This is an important part of our job.
Research is both at the Unit and individual Consultant’s levels.
There is no sponsored research work.

J. TRAINING

1. There is no sponsored external training.
2. Training is purely on individual level in Conferences and Updates both Local and International.
3. The Unit organises in-house Training sessions for the Staff especially Doctors and Nurses.

Thank you.

Dr. Benjamin M. KEJEH
Head, Burns and Plastic Surgery.

UPTH STANDARD OPERATING PROCEDURE FOR CATERING DEPARTMENT

NAME & SIGNATURE OF DIRECTOR OR HEAD OF DEPARTMENT:
Mrs. MARY BENNETT OKURU
DATE: 25TH MARCH, 2018
SOP No: 002
NOTE: Work Starts by 8:00 am.

INTRODUCTION

Catering Department is one of the earliest departments in the Hospital Services that provides Nutritional food for patients, staff, patients' relation and the Hospital community at large.

The standard of catering had improved over the years and is still improving as it is now recognized that the provision of an adequate diet is just as much as a part of the patient treatment, as careful nursing and skilled medical attention, the department works closely with the nursing staff in providing one of the most important objectives of hospital care, which is to get the patient better and back to their homes as soon as possible.

PURPOSE

To provide wholesome / good quality cooked food with minimum loss of nutritional value in a hygienic environment and presented to patient, guest, board members, examiners, students, patients relations, staff and the UPTH community at large.

There are four (4) units in the Catering Department

1. Staff on call
2. Patients
3. Pastry
4. Cafeteria sales

Processes involved in providing catering services for patients and staff.

There are four (4) processes involved in providing catering services for patients and staff in UPTH.

1. Through staff on call duty
2. Through cafeteria direct sales and departments/units outlets
3. Cooking for patients in wards and direct serving
4. Through offering catering services to all management and departmental meetings.

Each of these units are headed by a senior catering officer for efficiency

SCOPE

Catering services covers all the patients admitted into wards, doctors/staff on call

FUNCTIONS OF THE DEPARTMENT

Name	**Function**	**Remark**
1. PASTRY	Provide different types of snacks for the hospital	
2. CAFETERIA	Provide food for everyone in the hospital (patients, staff	

	and hospital community)	
3. PATIENTS	Provide food for patients	
4. STAFF ON CALL	Provide food for doctor/staff on call	

ROLES AND RESPONSIBILITIES OF VARIOUS STAFF DEPLOYED TO THE DEPARTMENT

Mary Bennett Okuru (Mrs)	Catering Administration
Mrs. FlorenceObuuofoulo (Catering officer)	Catering sales
Fyne Jaja	Patients services /
Mabel Mangete	Staff on call
Alice Dede	Pastry services
Higher Catering officers	Catering sales
Catering cooks	Food processing

PROCUREMENT OF RAW MATERIALS (FOOD ITEMS)

	Describe the procedure involved and category of staff responsible for it
1.Direct purchase from market	Senior catering officer goes to market for direct purchase of raw food stuff

MAINTENANCE OF COOKING UTENSILS

	Describe the process involved
VENDORS	Specialized vendors are hired to do maintenance of the cooking utensils/equipments used in the catering unit.

WASHING AND CLEANING

	Describe the process involved
Use of soap and sponge. Use of hand towels Use of serviette paper	Use of warm water and soap for washing and cleaning.

REPARATION OF FOOD

	Describe protocol
	1.Cooking methods: Boiling, roasting, grilling 2. Processing methods: Soaking, baking, roasting, frying, and sieving. Observe good hygiene by wearing

	Aprons and head caps or head tie, napkins and hand towels in pockets of staff cooking to ensure sweat does not drop in cooking food

QUALITY CONTROL OF COOKED FOOD

	Detail practice process including responsibilities, system and record keeping.
	a. Cooking time is considered to minimize nutrient6 loss. b. Standard measures are used to maintain portion control e.g. food scale, measuring cups, measuring spoon, measuring jugs, kitchen thermometer. c. Weight and height measures standard used. d. Hygienic and safe handling: Methods are employed especially during storage, preparation, cooking, serving and leftover management. **Record keeping done on daily:** i. Purchase ii. Sales iii. iv. Referral notes iv. v. Quantity of stock v. vi. Food servicing to patient

DISTRIBUTION OF COOKED FOOD

	Describe protocol
Done by catering cooks and other lower catering officers	Carries food to the ward with baskets and trolley.

CESSATION OF CATERING SERVICES TO PATIENT

	Describe protocol
Catering services are continuous for patient	Use of patients feedback questionnaires and direct interview with patients for food quality and satisfaction.

DEPARTMENTAL MEETINGS

The catering department holds its meetings every first Monday of every month.

STAFF TRAINING

External training organized by the Nigerian Hotels and Catering Institute

UPTH STANDARD OPERATING PROCEDURE FOR CENTRAL SAMPLES COLLECTION UNIT

PURPOSE:

To establish guidelines for submitting samples and paying for investigations at a central location in the laboratory section of the hospital.

INTRODUCTION

Laboratory services are key in optimal service delivery and cut across all clinical departments. As a direct consequence, a large volume of clients throng to the labs on a daily basis. However, the extant system of clients having to pay for & access laboratory services separately at each of the Pathology department is cumbersome, time consuming and frustrating for the clients whose ill health is already a source of concern to them.

In a bid to alleviate the suffering of our clients, reduce waiting time and increase client satisfaction, management has decided to establish a CENTRAL LABORATORY SAMPLE COLLECTION UNIT; the latter will include a phlebotomy section and another section for collection of other laboratory specimen. Clients will be attended to by Laboratory Scientists from the 4 Pathology departments. This will be in close proximity to the CENTRAL ACCOUNTS SECTION which will house accounts clerks from all the Pathology departments. In addition, central waiting area for the clients has been earmarked.

SCOPE

Processes/procedures involved in payment for laboratory investigations, submitting samples and collecting investigation results.

RESPONSIBILITIES

1. The Laboratory Scientists from the 4 Pathology departments will cross-check request forms and evidence of payment; collect, label and arrange samples for collection by N-Power staff every 30 minutes.
2. N-Power staff will collect the samples and submit to the various Pathology departments
3. Accounts clerks will check all the request forms and issue Tellers or receipts to clients. POS machines will be made available.

PROCEDURE

FOR AMBULANT CLIENTS:

1. Clients will be directed to the Central Waiting Area
2. Clients will be ushered to the CENTRAL ACCOUNTS SECTION in groups of 3 and payments made.
3. Clients will then proceed to the SAMPLES COLLECTION AREA
4. A dedicated Laboratory Scientist will sort out the laboratory request forms & evidence of payment and sort out the sequence of sample collection by the appropriate Laboratory Scientists
5. Samples will be collected, labelled and arranged appropriately.
6. Clients will be informed about investigation results collection date. The entire process should not take more than 10-15 minutes.
7. A desk officer will be assigned to issue investigation results on being shown evidence of payment in due course.
8. Please note: Clients for HVS/ Pap smear would be required to make payments at the CENTRAL ACCOUNTS SECTION but would be allowed to go to the Medical Microbiology department to have those investigations carried out.

FOR INPATIENT CLIENTS:

The Clients' relatives will undergo a similar process.

Dr. Obianma N. Onya

DCMAC (NHIS/SERVICOM)

UPTH STANDARD OPERATING PROCEDURE FOR CENTRAL STERILE SUPPLY DEPARTMENT (C.S.S.D)

NAME OF HEAD OF DEPARTMENT: ***Dr. (Mrs.) P. G. N. Harry***
SIGNATURE OF HEAD OF DEPARTMENT: ……………………………
DATE: 4th Sept., 2018
SOP No.: 002

NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) starts by 9:00 am

PURPOSE:

To establish guidelines for departmental operations with respect to Processes involved in ensuring that, medical devices/consumables are sterilized and delivered to various users in the hospital to ensure quality patient care in a quality-assured environment.

INTRODUCTION:

Each day several medical procedures are performed in ourhealth care facilities,like endoscopies, incisions, etc.The Central Sterile Supply Department (C.S.S.D) is a subset in the Nursing department whose sole function is to ensure that the equipment and materials used on patients are free of pathogens and are safe for patients' care.

Name of Head of Nursing Department: **Dr. (Mrs.) P.G.N.Harry.FCAI**

Name of Assistant Director of Nursing (A.D.N) in charge of C.S.S.D: **Ms. Amagboruju Victoria**.

SCOPE: It covers all the processes involved in sterilizing wide range of supplies, instruments, materials and subsequent use by health workers in the operating

theatre and also for other aseptic procedures in surgical, maternity and other wards of the hospital for quality patient care and for control/elimination of infection.

FUNCTIONS OF THE C.S.S.D:

- Collecting/issuing
- Inspection
- Decontamination
- Assembling
- Packing
- Sterilizing
- Storing

ROLES AND RESPONSIBILITIES OF VARIOUS STAFF DEPLOYED TO THE UNIT:

There are three categories of staff in the C.S.S.D.

S/No	Categories of staff	Total number
1	Nursing staff (CNO)	2
2	Autoclave operators	10
3	Health assistants	3

- The nursing staff is the head of the C.S.S.D, their roles are general supervision and inventory. The chief Nursing Officers report to the Assistant Director of Nursing (A.D.N), who now reports to the A.D.N.S.
- The Autoclave operators operate the autoclave and sterilizes the packs. The autoclave operators run shift duties; hence the C.S.S.D is covered 24 hours.
- The Health Assistant keeps the environment clean and tidy for hygienic hospital environment and infection control.

DAILY ACTIVITIES:

1. Collection of used packs from 8-10am for morning duties, 1:30-2pm for afternoon duties and 8:30pm for night duties. This is duly registered in a book and signed.
2. Issuing of sterile packs at the same period to various wards of the hospital according to their needs including main operating theatre.
3. Inspection of used packs, washing and decontamination.
4. Assembling/packing of decontaminated packs andlabeling.
5. Sterilization of packs depends on the quantity of packs available for autoclave, availability of light, availability of water and also on demand from the various wards of the hospital. Ideally, for morning duties 9am-12:30pm, for afternoon duty from 2pm-4:30pm and night duty from 9pm-12midnight. One way to know that a pack is properly sterilized is the change in the colour of the autoclave tape from milk to dark brown.
6. **Storing:** the sterile packs are then allowed to cool (30minutes) and it is then stored in a sterile area, ready to be issued to the different wards in the hospital according to the demand. Event or time related sterile storage is in use. Sterility period is 2 weeks after which if the packs are not used, it is re-autoclaved again.

The CSSD does not undertake the responsibility of distributing sterile packs to various units, rather it is the responsibility of the nurses/maids in the wards of the hospital to come and collect sterile packs from the staff in the C.S.S.D. It isalso the responsibilities of the theatre porter to bring used packs from the main theatre and also come for collection of sterile packs.

7. **Emergency services**: Possible only on demand from such a ward, availability of power and water supply. Unsterile packs are collected from staff of such a ward.
8. **Inventory management (List of Instruments):**
    a. List of instruments collected from various wards are entered into a record book.
    b. The list of sterile packs for issuing to various wards is also entered in a record book. These are the responsibilities of the Nurses and the autoclave operators.
    c. Blunt/worn out instruments are removed and kept for inventory purposes. Request for new instrument made through the Assistant Director of Nursing Services (A.D.N.S) and same provided by Management.
9. **Inventory Management(purchase of instrument):**The C.S.S.D does not purchase instruments/consumables.
10. **Funding:**The C.S.S.D is funded on monthly impress from the Assistant Director of Nursing (A.D.N.S) through the management.

PROCUREMENT PROCEDURE

Please refer to SOP for Procurement and Stores.

Dr. (Mrs.) P.G.N.Harry
D.N.S

UPTH STANDARD OPERATING PROCEDURE FOR CHEMICAL PATHOLOGY DEPARTMENT

NAME OF HEAD OF DEPARTMENT: ***Dr. Ehimen Phyllis ODUM***
SIGNATURE OF HEAD OF DEPARTMENT……………………………
DATE: **16th July, 2018**
SOP No: 002

NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am

1. PURPOSE:

To establish guidelines for:

- Sample collection and processing in the Department of Chemical Pathology.
- Running of Metabolic Clinic, ward rounds and responding to clinical consultations.

2. INTRODUCTION

The Department of Chemical Pathology offers routine laboratory, research and clinical services. The laboratory services involve the processing and running of samples for various Chemical Pathology investigations. Clinical services involve the care of patients with diverse metabolic conditions as outpatients.

3. SCOPE

3.1. **SECTION A: CHEMICAL PATHOLOGY INVESTIGATIONS**

The scope of investigations and services offered by the Department of Chemical Pathology include:

INVESTIGATION	SPECIMEN BOTTLE	TURN AROUND TIME (TAT)	RESPONSIBILITIES
Routine Investigations			

1. PLASMA GLUCOSE: Fasting, Random, OGTT, HbA1c	Fluoride Oxalate	1 to 2 hours	Medical Laboratory Scientists (MLS)
2. PLASMA ELECTROLYTES: Sodium,Potassium, Bicarbonate, Chloride, Calcium, Magnesium, Phosphate	Lithium Heparin	2 hours	MLS
3. RENAL FUNCTION TESTS: Plasma urea & creatinine, uric acid, creatinine clearance	Lithium Heparin	2 hours	MLS
4. PLASMA LIPID PROFILE: Total Cholesterol, HDL-C, Triglyceride	Lithium Heparin	2 hours	MLS
5. LIVER FUNCTION TESTS: • Plasma Bilirubin (Total & Conjugated), Albumin &Total Protein • Serum Enzymes (ALT, AST, ALP, GGT)	Lithium Heparin Plain Bottle	2 hours 2 hours	MLS
6. SERUM HORMONE ANALYSIS: • Thyroid Function Tests (TSH, T3, T4)	Plain Bottle	48 hours	MLS

• Reproductive Hormones (LH, FSH, Prolactin, Progesterone, Oestrogen, Testosterone) • Tumor markers (PSA)			
7. CSF ANALYSIS: • CSF Glucose • CSF Protein	Fluoride oxalate Plain Bottle	1 hour	MLS
Specialized Investigations			
1. Urine Toxicology Tests	Plain Bottle	1 hour	Resident Doctors
2. Serum electrophoresis	Plain Bottle	3 hours	Resident Doctors
3. Urine screening tests for Inborn Errors of Metabolism	Plain Bottle	1 hour	Resident Doctors
4. Gall stone/Renal stone analysis	Plain Bottle	5 hours	Resident Doctors
Emergency (CALL) Investigations			
1. Plasma and CSF Glucose (Fasting & Random)	Fluoride Oxalate	20 minutes	
2. CSF Protein	Plain Bottle	20 minutes	*MLS
3. Plasma Electrolyte Panel (Sodium, Potassium, Bicarbonate, Chloride)	Lithium Heparin	30 minutes	
4. Plasma Urea	Lithium Heparin	30 minutes	*Resident Doctors (Tuesdays & 3RD Weekends of the month)
5. Plasma Bilirubin (Total	Lithium	30	

& Conjugated)	Heparin	minutes	
Research Investigations	As required		*MLS *Resident Doctors

3.2. **SECTION B: CLINICAL CHEMICAL PATHOLOGY**

SECTION	SCHEDULE	RESPONSIBILITIES
1. Metabolic Clinic	Mondays:8AM to 4PM	Consultants & Resident Doctors
2. ClinicalConsultations	As required	Consultants & Resident Doctors
3. Clinical Meetings	Wednesdays: 12PM	Consultants & Resident Doctors
4. Ward Rounds	Fridaysor as required	Consultants & Resident Doctors
5. Calls	Daily	Consultants & Resident Doctors

4. PROCEDURES

4.1. PROTOCOL FOR LABORATORY INVESTIGATIONS

PROCEDURES FOR LABORATORY INVESTIGATIONS

a.) Ordering for a test begins with filling out a laboratory request form by the doctor of the patient. These request forms must be correctly filled out to include- name, age, sex, hospital number, managing consultant, preliminary diagnosis, date of request, etc.

b.) The patient/ relative brings the request form to the CENTRAL LABORATORY SAMPLES COLLECTION UNIT where the charges for investigations are given, payment made and receipts issued in triplicates (one for the patient, the second one to the accounts clerk and a third to the samples collection unit officer from the specified laboratory department.

c.) Patients covered by NHIS must present the NHIS cover paper before they can be attended to.

d.) At the reception section, the patient presents the request form and the receipt. The Medical Lab Scientists of the relevant laboratory

department who is manning the CENTRAL LABORATORY SAMPLES COLLECTION UNIT, collects the receipt and makes available the appropriate specimen bottle for the required test(s).

e.) Samples are then collected in the appropriate specimen bottles *(see 3.1 above)*.

f.) A laboratory number is given to each specimen bottle at the point of submission and the same number (as well as time of collection for each test requested) is written on the patient's copy of the receipt to be used for the purpose of identification during collection of the report. Patient's details and laboratory number are recorded in the departmental ledger (log book).

- ❖ Patients covered by NHIS must present the NHIS cover paper before they can be attended to.
- ❖ *Note that samples improperly collected or with accompanying improperly filled forms may be rejected.*
- ❖ Samples should be submitted in the appropriate specimen bottles.
- ❖ A laboratory number is given to each specimen bottle at the point of submission and the same number (as well as time of collection for each test requested) is written on the patient's copy of the receipt to be used for the purpose of identification during collection of the report. Patient's details and laboratory number are recorded in the departmental ledger (log book).
- ❖ Specimens are centrifuged and processed appropriately and arranged in a sample tray. Samples are analyzed respectively based on the requests,along with quality control samples.
- ❖ After analysis, the results are transcribed into the log book against the patient's name. The Chief Medical Laboratory Scientist (CMLS)/Assistant Director (AD) supervising each bench crosschecks and verifies the results and then transfers the figures along with the reference ranges to the request form. The Consultant Chemical Pathologist in charge of each unit then validates the results, comments on the report and it is then kept in the file for outgoing reports ready for the patient/relative to pick up. All laboratory records are strictly confidential.
- ❖ The patient/ relative returns to the CENTRAL SAMPLES COLLECTION UNIT to collect the reports of the ordered tests at

the expected turnaround time.
- Blood samples are usually discarded within 3 – 5 days as chemical pathology tests are best run on fresh samples.

4.2. **PROTOCOL FOR METABOLIC CLINIC**

Patients must open a hospital folder at the records department before they can be seen or reviewed by doctors.

1. Patients come to the clinic on referrals from other clinics or the general outpatient department.
2. Clinic days are Mondays and patients are reviewed by the Consultant Chemical Pathologists and Resident Doctors.
3. Any patient requiring admission will be admitted into the medical ward.
4. Follow up appointments are given on an individual basis.

Ward Rounds

1. Ward rounds are done for the in-patient care of those on admission.
2. Consultant ward rounds take place on Fridays and whenever consults are sent. Consults written to Chemical Pathologists will be attended to in a timely manner.
3. Residents do ward rounds within the week on Mondays-Thursdays.
4. Consultants and resident doctors are on call daily (from 4PM – 8AM on Weekdays, and 8AM – 8AM next day on weekends) to attend to patients in the ward or A/E, and to respond to consults sent in by other clinical departments.

4.3. **PROTOCOL FOR PROCUREMENT OF CONSUMABLES**

As outlined in the SOP for Procurement & Stores.

4.4. **PROTOCOL FOR ACCREDITATION**

Please refer to SOP for CS & T.

UPTH STANDARD OPERATING PROCEDURE FOR CHILD DENTAL HEALTH DEPARTMENT

NAME OF HEAD OF DEPARTMENT: ***Dr. Elfleda Aikins***
SIGNATURE OF HEAD OF DEPARTMENT ……………………………
DATE: **9th July, 2018**

NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am

PURPOSE:

To establish guidelines for departmental operations with respect to the processes involved in patient management in the clinical departments of UPTH.

INTRODUCTION

Workplace policies establish boundaries for acceptable behaviour and guidelines for best practices in work situations; in line with international best practices, Standard Operating Procedures have become imperative for **Quality Improvement** purposes, for ease of clinical audit, monitoring and research in accordance with hospital regulations/vision, MOH provisions and extant laws. SOPs are aimed at improving compliance with set tasks/duties for good quality, consistent and predictable outcomes, giving room for evaluation/re-evaluation and improvement of the processes to ensure better outcomes and greater efficiency.

SCOPE

The Department of Child Dental Health comprises of two units (specialties) namely Paediatric Dentistry and Orthodontics. The Paediatric Dentistry unit is concerned with managing all the dental needs of children up to the age of 16 years. The Orthodontic unit manages malocclusion and dentofacial anomalies for all patients regardless of age.

ACCESSING OUTPATIENT CARE

NEW PATIENTS

New patients are usually referred to the Department of Child Dental Health from the Department of Oral Diagnosis in the Dental Centre in the hospital. They may also be referred from other Departments within the hospital as well as outside of the hospital.

The patient upon presentation is initially clerked by a Dental student, house officer or registrar, after which the patient is presented to a Consultant. This process may take between 30 minutes to one hour.

Investigations which are usually in the form of intra oral or extra oral radiographs are taken after the appropriate fees are paid. Other investigations may be in the form of excisional biopsies which are carried out in the clinic and the sample sent to the Department of Oral Pathology Laboratory. Any other investigation deemed necessary may also be carried out and sent to the appropriate laboratory.

The patient is given a teller to pay at the pay point prior to the radiograph/investigations being taken. This may take 30 minutes or more depending on the number of people at the pay point.

The radiographs/Laboratory results are reviewed with the Consultant and a definitive diagnosis is arrived at.

The patient is then billed for the definitive treatment and payment made with a teller before any form of treatment is carried out.

The patient may be treated by a student supervised by a Senior Registrar or Consultant, a house officer, a resident doctor or the Consultant.

If the patient requires a cephalometric radiograph, this is taken outside of the hospital as the hospital does not have the machine yet. All other radiographs are taken in the hospital.

The patient may be treated immediately or given an appointment for the commencement of treatment.

This depends on the nature of the complaint and the patient load at the time.

Patients on appointment are attended to promptly on the day of appointment.

All patients must pay for their treatment before they are attended to.

To prevent cross infection in the clinic all instruments for patient care must be sterilized and all care givers must wear disposable hand gloves, face masks and ward coats while treating patients. After each patient the instruments must be washed and prepared for sterilization in the autoclave whilst the dental chair must be cleaned and swabbed with disinfectant.

At the end of the day the Dental Surgery Technicians must lock all the cupboards to ensure safe keeping of all instruments.

RETURNING PATIENTS

These patients are required to pay a consultation fee using a teller before they are attended to. This takes about 15 minutes.

The patient's case note is retrieved and the patient is clerked by a Dental student, house officer or resident doctor. The patient is then presented to the Consultant, a definitive diagnosis is arrived at after all necessary investigations (radiographs) have been taken and reviewed by the Consultant.

The patient is billed for the treatment and given a teller to pay at the pay point. After which he/she returns to the clinic to be treated.

These patients may also be given an appointment if necessary.

Standard precautions are observed for all patients.

DEPARTMENTAL LABORATORY

Appliances required by the patients are fabricated by the Dental Technologists. These appliances are prescribed by the Senior Registrar or the Consultant after which the patient is given a teller to pay at the pay point prior to the request being sent to the laboratory.

The appliances are then produced by the Dental Technologist within a maximum of two weeks. The Dental Surgery Technician is responsible for collecting these appliances from the laboratory and the Senior Registrar or Consultant then fit the appliance for the patient.

REFERRALS

Patients are referred to the appropriate Departments as deemed necessary. Referral letters are written and signed by the Consultant.

RECORD KEEPING

The Departmental Accountant records all tellers and monies generated in the Department on a daily basis.

All patients seen, treatments carried out and monies generated are recorded on a daily basis by the Dental Surgery Technicians and cross checked by the Chief Registrar. The Chief Registrar reports such to the Head of Department.

REVOLVING FUND MANAGEMENT

The Departmental Revolving Fund is headed by the Project Manager (Head of Department). Meetings are held every month for the effective running of the Department. Other persons present at the meetings include but are not limited to the following: Project Secretary, Chief Resident, Dental surgery technician and admin representative.

PURCHASE OF CONSUMABLES

Please refer to SOP for Procurement and Stores.

QUALITY ASSURANCE

Regular assessment of residents using qualitative and quantitative means such as mock examinations. Patients and staff satisfaction are currently assessed via random verbal assessment.

INFORMED CONSENT

Verbal / Written informed consent is obtained before a procedure is carried out on any patient.

INVOLVEMENT IN EMERGENCY CARE

Emergency cases are reviewed initially by the first on call who are the house officer and resident doctor.

Their findings may necessitate the Consultant on call being called to review and attend to the patient.

The patient may then be discharged home and reviewed in the outpatient clinic or admitted into the ward.

ISSUING OF MEDICAL REPORT

The patient will go through the procedure for accessing outpatient care and all fees must be paid. The report is written and sent to the record department for stamping before it is released to the patient.

POLICY TOWARDS NHIS PATIENTS

NHIS patients will be given treatment free provided the procedure is among those approved by NHIS. All NHIS patients will have to come with a referral from the NHIS Clinic and all the necessary forms for documentation and the claims.

The procedure is the same as described above.

RESPONSIBILITIES

1. Retrieving patients case notes...........Record officer

2. Issuing tellers / keeping accounts record...........Accountant

3.Clerking of patients..................Clinical Dental student, House officer, Resident Doctors, Consultant.

4.Taking of radiographs..........Dental Surgery Technician, house officer, resident doctors, Consultant

5. Treating patients.................Dental students (supervised), house officer, resident doctors, Consultant.

6. Assisting dental surgeons in treating patients.........Dental Surgery Technician.

7. Sterilization of instruments……………… Dental Surgery Technician

8. Fabrication of appliances…………………. Dental Technologist.

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

UPTH STANDARD OPERATING PROCEDURE FOR CLINICAL SERVICES & TRAINING UNIT

UPTH STANDARD OPERATING PROCEDURE FOR CLINICAL SERVICES & TRAINING UNIT

NAME, DESIGNATION & SIGNATURE OF HEAD OF UNIT: ***MRS VICTORIA MUBE***

DATE: 21st October, 2018

SOP No.: 002

SOP Title: Management of CS&T

1. **PURPOSE**
2. **INTRODUCTION**
3. **SCOPE**
4. **FUNCTIONS OF THE UNIT**

NAME	**MRS. VICTORIA MUBE**
PHONE NUMBER	08055416621

5. **ROLES AND RESPONSIBILITIES OF VARIOUS STAFF DEPLOYED TO THE UNIT**

See attached - appendix A

6. **EMPLOYMENT OF HOUSE OFFICERS/RESIDENT DOCTORS**

- Advertisement/sales of form and conduct of interviews
- Marking of scripts, selection and short listing of successful candidates done by Management
- Application forms of successful candidates will be sent to Establishment unit for further necessary action.

Category of staff responsible

All unit staff hands are on deck to achieve the set goal

7. POSTING OF HOUSE OFFICERS AND SUPERNUMERARY RESIDENTS

(a.) Posting of House officers:

Successful candidates are required to come for their four (4) clinical rotation posting every three (3) months.

After the 4 (four) clinical rotations, the house officers are cleared by their various departments and clearance form brought to CS&T for signing

Staff responsible:

Unit Head- Chief Administrative Officer (CS&T)

Principal Administrative Officer

(b.) Supernumerary Residents:

- All applications received by the unit
- Applications are processed only when applicants are seen
- Letter of willingness/offer of provisional appointment is issued stating the following conditions;

  - Evidence of release and sponsorship letter
  - Evidence of Primary Fellowship Exam for junior Residency
  - Evidence of Part l Fellowship Exam for senior Residency
  - Payment of annual bench fee of N150, 000 (One Hundred and Fifty Thousand naira)

- When all conditions are met, the supernumerary applicants are required to make the first payment of bench fees into UPTH TSA account, No. 0120504361018. Sterling bank.
- Bank tellers/remita print out exchanged for UPTH cash receipt at the Account/Finance department
- The duplicate of the receipt is attached to the approved application and sent to Establishment Unit for opening of file

- The file is then returned to the desk officer for the process of appointment letter stating some other conditions which include compulsory annual renewal of bench fees.
- The copies of the appointment letter are sent to the following;

  a) Chief Medical Director
  b) Chairman, MAC
  c) Director of Administration
  d) Deputy Director of Finance
  e) Chairman, Postgraduate Medical Committee
  f) HOD

Staff responsible:

Principle Administrative Officer

Senior Administrative Officer

8. **UPDATE COURSE ATTENDANCE BY RESIDENT DOCTORS, CONSULTANTS AND OTHER HOSPITAL STAFF**

- Applications are received by the unit, treated by the unit Head (CAO) and forwarded to the Desk officers for the issuance of Management decision.

  Staff responsible:

  PAO II and PAO III

9. **STUDY LEAVE WITH /WITHOUT PAY & BONDING**

- All applicants received by the unit
- An update of the applicants is requested for by the unit Head from the Desk officer
- An update is provided by the Desk officer taking into cognisance Rule Nos. 100224 and 100228 of the Public Service Rule and base his/her recommendation(s) to the Management.
- The Management will give approval or not based on the update provided by desk officer

- The staff (applicants) will be required to come for bonding if the approval is with pay, while bonding is not necessary if it is without pay
- The staff being bonded is expected to serve the hospital twice the duration of his/her training.

10. **SPONSORSHIP FOR TRAINING**

- All applications received by the unit
- Financial implications are provided/calculated by the desk officer, sent to the unit Head for onward action by the Management
- Whatever amount is approved by the Management will be communicated to the staff and Director, Finance will be requested to pay.

11. **MANAGEMENT OF SCHOOLS DIRECTLY AFFILIATED TO UPTH (CHO, SHIM, SCHOOL OF POST BASIC NURSING A&E, PAEDIATRICS, PERI-OPERATIVE AND MENTAL HEALTH, SCHOOL OF SOCIAL DEVELOPMENT AND OCCUPATIONAL THERAPY)**

- Advertisement is made
- During the interview process, the Head (CS&T) and her team partake in the supervision and set the current affairs/civil Services Rules questions and marked.
- Selection of successful candidates is done by the schools' board

12. **REVOLVING FUNDS MANAGEMENT**

- The Clinical Services & Training Unit which oversees the Revolving funds is being guided by the Rules and Regulations establishing the scheme, see attached – appendix B
- The CMD's representative, who is the unit Head nominates Secretaries for each Revolving Fund Committee
- The Secretaries call for meetings on the scheduled dates made by the unit
- Minutes of meeting, Tenders advertisements/Bids/Analysis, Job orders and Financial statements (monthly) provided by the Project Accountants are documented by the Secretaries.

13. DEPARTMENTAL ACCREDITATION VISITATION

PROCEDURE

1. HOD should notify the CMAC & the 3 DCMACs of previous accreditation outcome upon conclusion of the latter so that the requirements are subsequently prioritized and captured in the budget. To this effect, copies of the comments and checklist should be submitted to DCMAC (Due Process/Revolving Funds).
2. HOD should remind management 6 months ahead of time about impending accreditation visitation; accreditation checklist and observations/comments from previous accreditation visitations should be re-submitted to CMAC and DCMAC (Due Process/Revolving funds) for re-evaluation of needs.
3. DCMAC (Due Process/Revolving Funds) should ensure that purchases in the subsequent 5 months are made in line with accreditation requirements and brief the CMAC on the outcome.
4. HOD should send reminders to CMD, CMAC &the 3 DCMACs about accreditation visitation a month to the proposed visitation.
5. A copy of this reminder should be sent to the CS& T unit with which the HOD is expected to work closely to ensure proper co-ordination of accommodation, transport services, catering and accounts department (for agreed-upon honoraria and re-imbursement of transportation expenditure).

6. CMAC- in conjunction with the DCMACs, the HOD and all departmental Consultants- should arrange a mock accreditation, using the submitted checklist/previous comments as a guide.
7. Accreditation Itinerary and Departmental Profile should be ready a week before the proposed visitation and should be made available to all the departmental Consultants, the CS & T, the 3 DCMACs and the CMAC.
8. The HOD should be in constant communication with the CS & T unit to ensure the accreditation team is properly catered for throughout the duration of accreditation visitation.

14. OTHER RESPONSIBILITIES;

- Medical Advisory Committee Meeting
- Postgraduate Medical Committee
- Industrial Training

- Accommodation of House officers/Interns

Appendix A

CLINICAL SERVICES AND TRAINING (CS&T) DUTY ROSTER

CLINICAL SERVICES AND TRAINING DUTY ROSTER

S/N	NAME OF STAFF	DESIGNATION	JOB DESCRIPTION
1	Mrs. V.O.N Mube	CAO (CS&T)	All Administration Duties in Clinical Services and Training Unit and any other duty assigned to me by the Management
2	Soba Halliday	PAO (CS&T) I	Secretary – Medical Advisory Committee, House Officers Matters / Residents Doctors Matters, Supernumerary - Consultant Matters. Secretary To Revolving Funds Scheme - Obstetrics & Gynaecology; Haematology; Ophthalmology
3	TonyePriye-Cosmos	PAO (CS&T) II	House Officers' Posting, Verification of House Job, in-charge of House Officer's Quarter maters and Interns Accommodation Sponsorship/Study Leave for Staff and Administration of Bonds, Secretary to Revolving Fund Scheme - DRF, Radiology and Paediatrics.
4	Emmanuel Siyedukoma	PAO (CS&T) III	Resident Doctor's Sponsorships to updates and Fellowship Exams, Clinical Practicum,

			Observation Practice, Research Attachment and any other Duties as assigned to you. Secretary to Revolving Funds Scheme – Chemical Pathology, Accident & Emergency
5	Nse-Umoh	PAO (CS&T) IV	Training, Conference and Workshops and any other Duties as assigned to you. Secretary To Revolving Funds Scheme – Surgery and ENT.
6	WaribokoOdor	SAO (CS&T) I	Senior Staff Matters, Conveying of Approvals and any Other Duties Assigned to you. Secretary To Revolving Funds Scheme – Theatre / Theatre Users, Orthopaedics / Implant Orthopaedics
7	AbereOgali	SAO (CS&T) II	Residents Doctors Extension, Clinical Rotations / Postings; Clinical Practicum, Summer Vacation Practice and other duties assigned to you. Secretary To Revolving Funds Scheme – Anaesthesiology; Microbiology.
8	Ogundu-Wali Simeon A.	AO (CS&T) I	Secretary – Postgraduate Medical Committee and any other duty assigned to you. Secretary To Revolving Funds Scheme– Family Medicine; Works & Services.

9	Eddie Bereneghia	AO II (CS&T) [1]	Conveying of Approval and Assisting the *PAO III* on his duties. Secretary To Revolving Funds Scheme - Intensive Care Unit, Anatomical Pathology and Morbid Anatomy
10	Smart Karibi -Ethel	AO II (CS&T) [2]	Conveying of Approvals and assisting the *PAO III* on his duties. Secretary To Revolving Funds Scheme - Internal Medicine; Dentistry (Child Health) and Oxygen Plant.
11	Douglas Agba Friday	AO II (CS&T) [3]	In-charge of Nurses Matters. Secretary To Revolving Funds Scheme – NHIS and Community Medicine
12	Obomate Ephraim	AO II (CS&T) [4]	Processing of House Officers Forms (Verification and Posting), to assist *PAO II* in her duties. Secretary To Revolving Funds Scheme – Medical Records and Dentistry (Pathology).
13	Mrs. Queen Olumide C.	AO II (CS&T) [5]	To work with *CAO (CS&T)* on any duty assigned and Visitation matters. Secretary To Revolving Funds Scheme – Neuropsychiatry, Urology and Burns/Plastic.
14	OdiatorUle, S.	AO II (CS&T) [6]	To work with *PAO IV* on all

			matters. Secretary To Revolving Funds Scheme - Dentistry (Preventive); Physiotherapy and Haemodialysis
15	Ibituroko Douglas T.	AO II (CS&T) [7]	Industrial Training Matters to work with *CAO (CS&T)* as directed. Secretary To Revolving Funds Scheme - Dentistry (Restorative); Dentistry (Maxilo-facial); Catering & Dietetics
16	Boma Marcus	Snr. Conf. Sec. (CS&T)	Secretary To - Admin Officers at the C'MAC's wing.
17	Godwin Ibimie D.	Prog. Analyst	Secretary To Administrative Head (*CS&T)*, Accreditation Matters, and any Other Duties assigned.
18	Abubakar Aishat	CCO (CS&T) [1]	Clerical Duties
19	Samuel Rhoda	CCO (CS&T) [2]	Clerical Duties
20	Emeya Adline	CCO (CS&T) [3]	Clerical Duties
21	Odika Chamberlin	CCO (CS&T) [4]	Clerical Duties
22	AkaniChinedu	Chief Messenger	In the CAO's office

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF COMMUNITY MEDICINE

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *DAPRIM OGAJI*
DATE: 18th JULY, 2018
SOP No: 002

NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am

STANDARD OPERATING PROCEDURES IN THE VARIOUS UNITS IN THE DEPARTMENT

STANDARD OPERATING PROCEDURESIN WELL PERSON'S CLINIC

PURPOSE

To establish guidelines for unit operations with respect to the processes involved in patient management in the preventive medicine clinic.

RESPONSIBILITIES

The preventive medicine clinic is dedicated to promoting wellness and risk assessment forpreventable diseases/conditions. The entire health team works in synergy to ensure maximum client satisfaction.

SERVICE ACCESS

Step	Procedure	Staff Responsible	Time lag
1	Presentation at the preventive Medicine Clinic nurses' station	Ward maids and nurses	5 mins
2	Vitals check	Nurses	15
3	Waiting at the waiting hall		60-75 mins
4	Consultation /Completion of details in the Delphi risk assessment software/physical examination	Doctors	60-75mins
5	Presentation at nurses' station for further directives	Nurses	5-10 mins

6	Collection of required blood samples	Doctor/ Support staff	15mins

INVESTIGATIONS

These are requiredfor the adequate running of the clinic and include:

S/NO	Name of investigation	Staff responsible	Time lag
1	Urinalysis	Doctors	5 mins
2	Fasting blood sugar	Doctors	3mins
3	Lung function test	Doctors	5mins
4	Full blood count+ESR	Doctor	5mins
5	RVS	Doctors	3mins
6	Lipid profile	Doctor	3mins
7	Pap smear	Doctors	10mins
8	Prostate specific antigen	Doctor	3mins
9	Mammography	Radiology department	
10	ECG	Radiology department	

RETURN VISIT

This describes the processes for when the patient returns for review of outlined investigations. The procedure is as follows:

Step	Procedure	Staff responsible	Time lag
1	Presentation at the nurses' station	Nurses	5- 10mins
2	Waiting room	-	30-60 mins
3	Consultation with referral (if necessary)	Doctors	15-30 mins
4	Waiting room for further instruction	Nurses	5-10 mins

RELATIONSHIP WITH OTHER DEPARTMENTS

The preventive medicine clinic has a collaborative relationship with the Departments of Psychiatry, Ophthalmology, Physiotherapy, Radiology, Pharmacy, Haematology, Microbiology and Chemical Pathology. This is in form of referrals for further management or investigations as needed.

APPOINTMENTS

Patients seen in the Preventive Medicine Clinic may be given appointments for follow up of management or referred to other specialist clinics for care. Appointments vary depending on the case and could be from few days to 4 weeks.

DUTY ROSTER

The duty roster for the month is prepared by the chief resident (for doctors) and the matron in charge (for the nurses and ward maids). All rosters are placed on the notice board for every member of the department to see and soft copies are also sent to every member of the department.

REVOLVING FUND MANAGEMENT

PURCHASE OF CONSUMABLES

As outlined in the SOP for Procurement & Stores.

QUALITY ASSURANCE

Regular assessment of residents using qualitative and quantitative means such as mock examinations.

INFORMED CONSENT

Verbal informed consent is gotten from patients before carrying out any investigations/ procedure.

STANDARD OPERATING PROCEDURES IN DOTS CLINIC

DOTS Standard Operating Procedure

PRESUMPTIVE TB
From;
GOPD
ARV
Accident & Emergency
Referred in or Walk in

NURSES(20mins)
Receive Patients
Do Vitals
Enter Records
Do RVS

DOCTORS (between 30 - 45mins)
Welcome Patient warmly
Take a detailed History
Examine Patient
Fill out Investigation forms
Counsel Patient on cough etiquette and possible diagnosis

LABORATORY
(between 2 - 24hrs)
Gene Expert
AFB
Culture
CXR
ESR, others

NURSES (10mins)
Record Results
Counsel Patient

DOCOTORS
(10mins)
Refer appropriately
Release from DOTs Clinic

DOCTORS(30mins)
Prescribe Medications
Counsel on compliance
Confirm next appointment
Refer to a nearer facility if need be

+ve

LIAISON OFFICERS
(10mins)
Familiarize with patient
Clarify patient address
Plan Visit

NURSES (30mins)

Register and counsel patient

Dispense medication

Patient takes first dose in your presence

Give the next appointment

Home Visit

-
-
-

STANDARD OPERATING PROCEDURES (SOP) IN MDR-TB

SOP FOR PATIENT REFERRAL TO DR TB TREATMENT CENTER

All confirmed DR TB patients should be referred to DR TB treatment centre together with a relative, for initial commencement of care.

Steps	Actions
1.	• Guide patients and relations on all the available DR TB treatment centres for him/her to make choice • Educate patients on the duration of DR TB treatment and possible duration of stay at the treatment center (after first culture conversion) • Ask patient and relation to sign a written consent for assessing MDR TB care at the treatment center of his/her choice • Agree with the patient and relation on the date of movement to the treatment center
2.	• Confirm availability of bed space at the treatment center of patient's choice • If bed space is unavailable at center of choice, counsel patient on others available
3.	• If there is bed space, complete DR TB referral form for the

	patient. • Enclose the following investigation results and documents with the referral form as applicable (Xpert/MTB/RIF, Culture & DST, AFB microscopy, recent CXR, previous TB treatment card).
4.	• Educate patient and relative on infection control measures – cough etiquette, good cross-ventilation, household rearrangement etc. • Provide and demonstrate to patients and relatives how to use surgical mask • Counsel patient to use sputum mug. • Use dedicated vehicle for transport where possible.
5.	• Provide patients/relatives telephone number of the contact person at the treatment center.
6.	• Call patients'/relative's phone number to confirm arrival at the treatment center after 24 hours • Confirm arrival of patient, also from DR TB focal person at DR TB treatment center.

STANDARD OPERATING PROCEDURE FOR ENROLMENT OF MDR TB PATIENT ON TREATMENT

Steps	Actions
1.	• Review patient referral form and all enclosed documents • Educate patients/relatives on their expectations from the treatment center (feeding, visiting times, contact screening, infection control etc.) • Ask patients to sign written consent accepting care at the treatment center. • Educate patient on DR TB care (duration of treatment, range of duration of stay at treatment center, infection control, side effects of drugs and adherence)
2.	• Conduct base line investigations if not included with the

	referral. 1. Chest x-ray 2. Sputum/culture/DST 3. U&E, Creatinine, Liver function test, FBC/diffs, TFTs, FBS 4. HIV 5. Pregnancy test 6. Urinalysis 7. Audiometric analysis 8. Visual acuity
3.	• Assign drugs regimen and dosage based on weight • Prepare and institute ART for HIV positive clients
4.	• Open and complete an MDR TB treatment card, patient ID card (hand card) and MDR TB treatment register
5.	• Provide patient with items for infection control (surgical mask and sputum mug)

STANDARD OPERATING PROCEDURES IN STI CLINIC

PRE-CONSULTATION [NEW CLIENT]	• GATHER [Greet, Ask, Tell, Help, Explain & Return] • Ask client to pay five hundred naira to the bank after collecting teller upstairs (birth certificate office) = 15 minutes • Clerking following guidelines= 15 minutes • Registration in the admission book • Counselling on STI, emphasis on HIV pre-test • Blood pressure check= 15 minutes • Send folder to Consulting room • Consultation= 20 minutes • Folder comes back to counselling room • More counselling based on diagnosis e.g. Genital warts • Encourage Clients to go for investigations • Carry out your procedure e.g. Painting with Podophylline • Pre and Post-test counselling for Podophylline painting • Registration in the daily visiting book • Filing of folder • Follow up • Contact Tracing • Monthly quarterly and annually statistics & review. • In all a new patient is expected to spend at least 1:30 minutes in the first visit.
PRE-CONSULTATION [OLD CLIENT]	• GATHER • Ask client to pay five hundred naira to the bank after collecting teller upstairs= 15 minutes • Get the folder • Blood pressure check • Send to Consulting room • Consultation= 15 minutes • Counsel as appropriate • Recording and filing of folder • Carry out necessary procedure • An old patient is expected to spend at least 30 minutes.

STANDARD OPERATING PROCEDURES IN OCCUPATIONAL MEDICINE UNIT

PURPOSE

To establish guidelines for unit operations with respect to the processes involved in patient management in the unit

RESPONSIBILITIES

The occupational medicine of Community Medicine aims gives comprehensive, continuous and coordinated care to patients and clients irrespective of age, sex and disease entity in the context of the work health and safety. The doctors, nurses all work in synergy to ensure the smooth running of the unit and to achieve maximum client satisfaction. Clinic runs every day from 8am – 4am

ACCESSING PATIENT CARE IN THE UNIT INVOLVES THE FOLLOWING

Step	Procedure	Who is Responsible?	Time lag
1	Open New folder or retrieve previous folder	Medical records unit	45mins/30 mins
2	Pay for consultation fee (N1,000)	Accounts unit	10-20 mins
3	Presentation at the occupational Medicine Clinic nurses' station	Ward maids and nurses	5 mins
4	Vitals check	Nurses	5-10 Min
5	Health Education	Nurses / Registrars	10- 20 mins While at the nurses' station
6	Consultation	Doctors	15-20 Min
7	Presentation to the Nurses for further directives	-	5Min

POINT OF CARE TESTING

These are the easily carried out investigations needed for the adequate running of the UNIT and include:

S/NO	Name of POCT	Who is responsible?	Time lag
1	Urinalysis	Doctors	2 mins
2	FBS/RBS	Doctors	2 mins
3	HBsAg	Doctors	5-10 mins
4	HCV Ab	Doctors	5 -10 mins
5	RVS	Doctors	5-10 mins
6	Pregnancy test	Doctors	5-10 mins

Other investigations as required will be done at the various departments

CONDUCTING A WALK-THROUGH SURVEY

This is done randomly at selected sites or department within the Hospital community to assess safety at the workplace. This is usually done without prior notice to the area visited. There is no time lag attached to each step and findings are communicated to the appropriate authorities

Step	Procedure	Who is responsible	Time Lag
1	Identification of hazard	Doctors	
2	Identify who is at risk	Doctors	
3	Evaluate risk and decide on precaution	Doctors	
4	Recording of findings	Doctors	
5	Review of risk assessment	Doctors	

ISSUING MEDICAL CERTIFICATES

The protocol of procuring medical certificate of fitness include

Steps	Procedure	Who is responsible?	Time lag
1	Open folder or retrieve old folder	Medical records	30-45 mins
2	Payment for consultation fee	Accounts unit	10-30mins
3	Vitals	Nurses	10-30 mins
4	Consultation	Doctors	10-30 mins
5	Doing requested investigations	Laboratory	Hrs to days
6	Presentation with results of investigations & review	Doctor	10-30 mins
7	Issuance of medical certificate as appropriate	Doctor+ Secretary To be countersigned by the unit consultant and a copy kept in the Department	20-90 ins

APPOINTMENTS

Clients from companies and firms wishing for routine or pre-employment medical evaluation can also be seen on appointments. Such requests must have gone through official lines and the companies registered with the hospital. Results of such examinations are kept confidential and can be discussed with the Medical representatives of such companies. The unit also will work with the NHIS clinic in the provision of such services to doctors within the hospital

REVOLVING FUND MANAGEMENT

The units revolving fund is headed by the unit consultant and the HOD. Meeting are proposed monthly for the effective running of the unit

PURCHASE OF CONSUMABLES

As outlined in the SOP for Procurement & Stores.

SUGGESTIONS/COMPLAINTS BOX/LINE

All complaint, queries and suggestions are fully entertained. There will be a complain box situated in front of the clinic or sent to 08113217788 which is the dedicated phone line for the unit

STANDARD OPERATING PROCEDURES IN FAMILY HEALTH CLINIC

Standard Operating Procedure

CLIENTS

From post natal ward, CHOP, CHEW, referred in or walk in

↓

NURSES(20mins)

Receive clients
Do Vitals
Enter Records
Maintain cold chain

→

NURSES/CHEWS(15mins)

Do anthropometry
Conducts Health/Nutrition education,
Triage & refers sick patients to the doctor

→

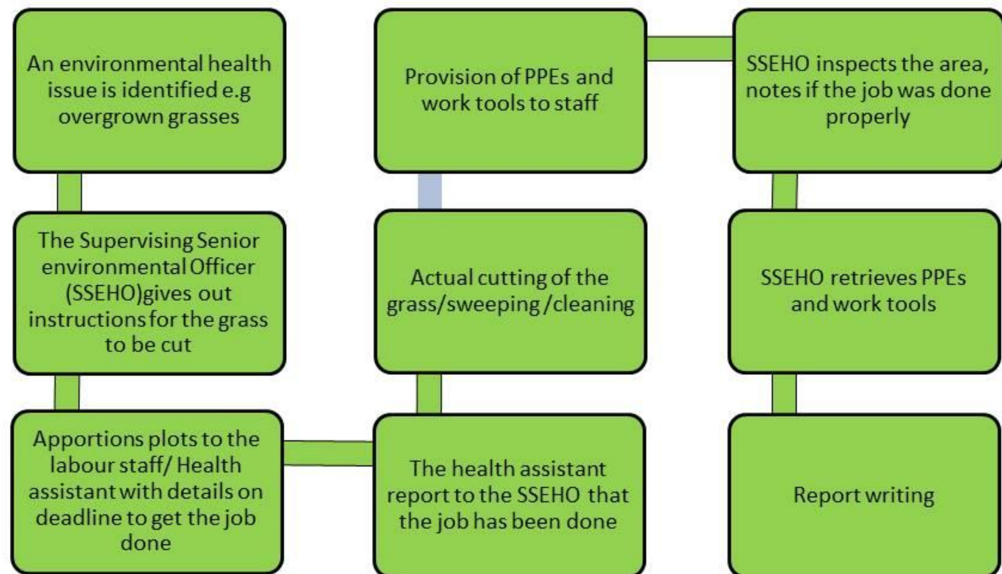
DOCTORS(30mins)
Welcome Patient warmly
Take a detailed History
Examine Patient
Fill out Investigation forms
Prescribe medications
Refers serious cases to Pediatricians

↓

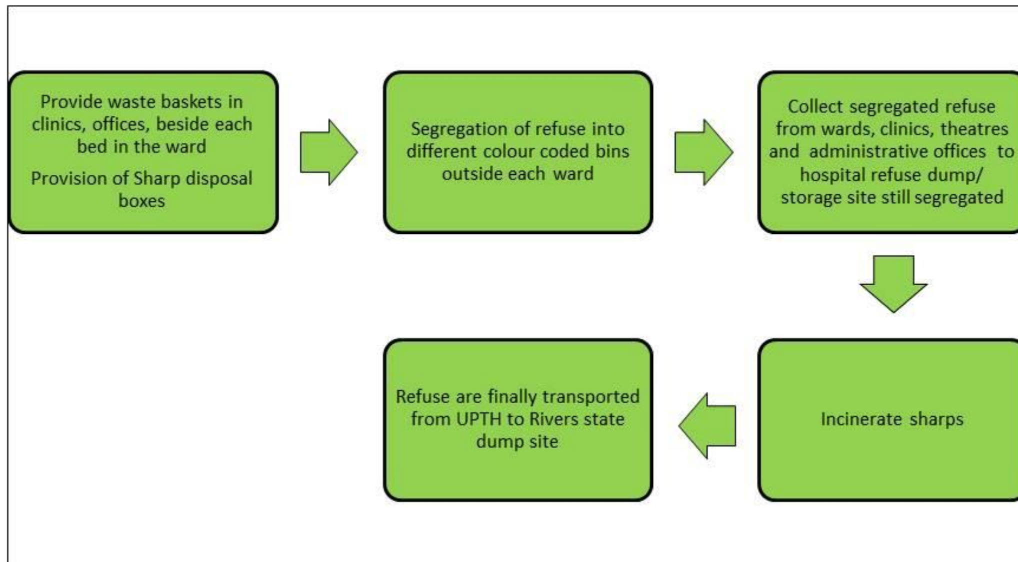
DOCTORS/NURSES/CHEWS(10mins)

Conducts immunization
Confirms next appointment

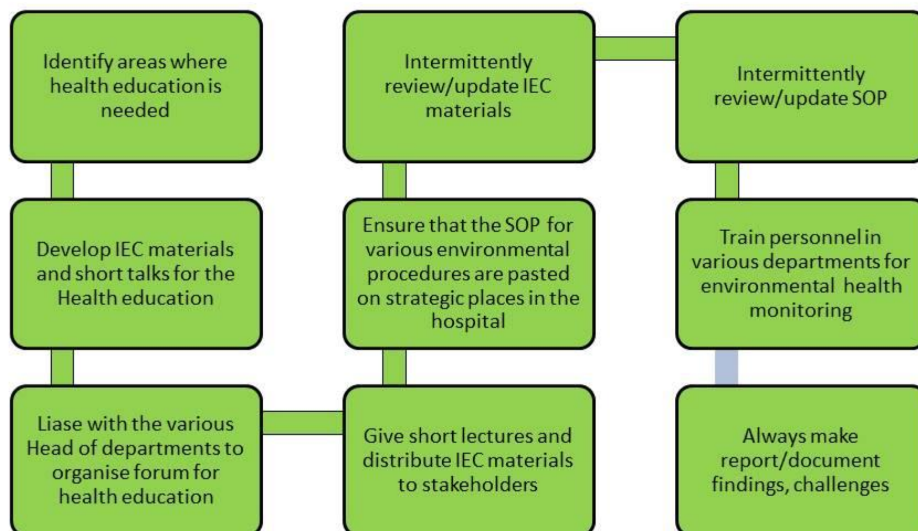
STANDARD OPERATING PROCEDURES IN ENVIRONMENTAL HEALTH UNIT



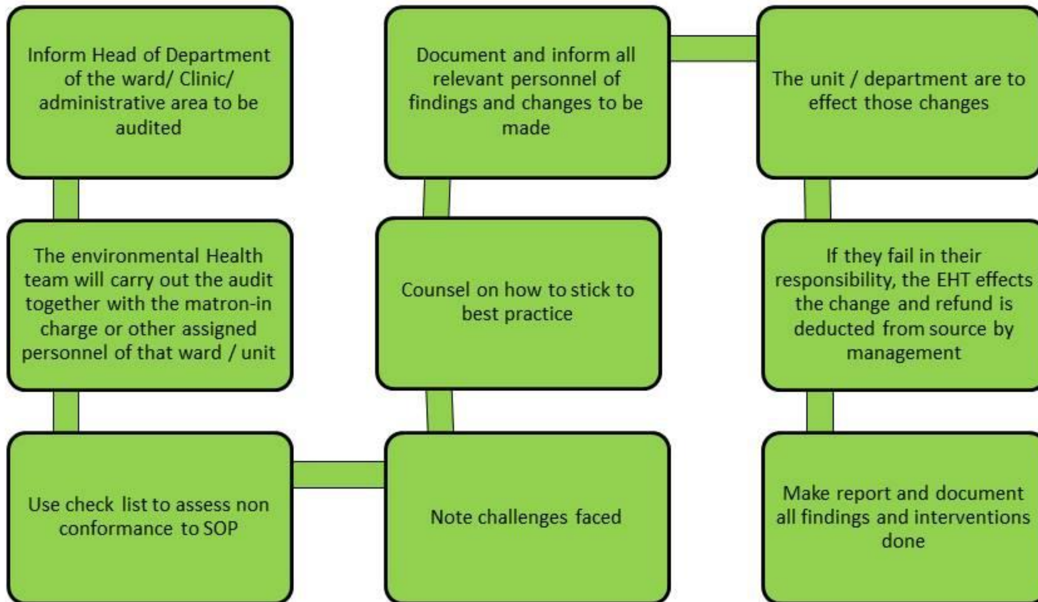
STANDARD OPERATING PROCEDURES
Refuse Collection and Disposal



STANDARD OPERATING PROCEDURES
Health Education



STANDARD OPERATING PROCEDURES
Environmental Health Audit



STANDARD OPERATING PROCEDURE IN PRIMARY HEALTH CENTRE, ALUU

PURPOSE

This document serves to define the general guidelines which will help achieve and maintain an acceptable standard of quality of health care, responsive and sensitive to the needs of the community.

SCOPE

These procedural guidelines apply to all UPTH Aluu Primary Health Center personnel/Staff as his/her specific job requires. It involves the various departments which include: – General Outpatients Department (GOPD); Maternal and Child Health including Family Planning, Immunization; Pharmacy; Medical Records; Laboratory; and General Maintenance Department. This document outlines the minimum requirements.

RESPONSIBILITIES

It is the responsibility of all personnel/staff - Doctors, Nurses/Midwifes, Pharmacist, Medical records Officer, Medical Laboratory Scientist as well as Security Personnel, Health Attendants and General Maintenance Staff to follow the procedures and guidelines outlined specifically for each of them in the standard operating procedure (SOP-002).

GENERAL OUTPATIENT DEPARTMENT (GOPD)

General Out Patient Department runs 8:00am to 4pm every week day

Service Access

i. **Clients and their attendants are to be received and treated in a respectful manner**

   a. Registrationis to be completed promptly for all clients, a new folder should be opened if necessary or an old folder retrieved.
   b. The time the client arrives should be documented.

ii. **Clients are to be seen in order of priority**

   a. The time of arrival recorded during registration process is used to prioritize clients

b. The time of treatment should be noted
c. Prioritize extremely sick clients/emergencies first; those of extreme ages (elderly and babies) second and then others.
d. Emergency cases are to be seen immediately (at least within ten minutes) and those of extreme ages within 30 minutes.
e. Clients not among c and d above are to be seen on a first - come first - serve basis
f. Waiting time should not be more than one hour

iii. **Clients needing referrals (Emergencies and Others)**

a. Cases needing referral should be sent University of Port Harcourt Teaching Hospital (UPTH).
b. The referral directory must be documented
c. There should be identification of type of clients who need to be referred
d. Referral forms must be filled to provide sufficient information to allow continuity of care.

iv. **Client Care and Treatment**

a. The privacy and confidentiality of clients should be ensured during consultation and examination
b. Consultations and examination are to be done one by one in privacy- Behind closed doors, behind the screens.
c. Doctors are to ensure confidentiality at all times during consultation and examination
d. Examinations and any intervention are carried out only in the presence of a chaperone if need be

v. **Client should receive appropriate assessment and diagnosis**

a. Basic assessment should be undertaken and includes temperature, pulse, blood pressure, also weight and height if need be and should be recorded appropriately
b. A client history should be taken and documented together with the clinical examination results
c. Basic assessment for children under 5 must include weight, height, immunization status, temperature, level of consciousness and symptom identification

d. Diagnostic tests are ordered to support a provisional diagnosis if found necessary during initial assessment

e. Clients should be given an opportunity to express their concerns and the doctor listens carefully to what they say
f. Care and Treatment is Planned, Managed and followed up
g. The Doctor should explain to the client the diagnosis, desired results, care management and follow up
h. The doctor ensures he takes feedback from the client to make sure the client understands the message communicated
i. Referrals to other services are to be made when required and documented accordingly
j. Appointments for future care are made if applicable and are documented

MATERNAL AND CHILD HEALTH DEPARTMENT

Maternity services are managed by the Medical Doctors, Nurses or midwife

Birthing services have 24 hours – on – call cover

1. **Antenatal Care** – Visit Days are Tuesdays and Wednesdays

   a. Every pregnant woman presenting should be registered irrespective of her gestational age and care should be given to her according to gestational age
   b. At registration of pregnancy, the following History should be taken

      - ✓ Bio-Data
      - ✓ Medical History
      - ✓ Obstetric History
      - ✓ Gynaecological History

   c. Ensure to do a general examination, abdominal exam, breast examination, examination of the uterus and contents; check the weight, height, blood pressure

d. A minimum of 8 antenatal check-up (if pregnancy is registered in the first trimester) is required.
e. Laboratory investigation should be done – urinalysis for protein and sugars, hemoglobin estimation, VDRL, blood grouping, genotype, HIV, HbSAg, HCV
f. Malaria prophylaxis should be given at quickening and 1 month after
g. Iron and folic acid supplementation should be given during the antenatal care and post-natal period
h. High – Risk pregnancies should be identified and there should be appropriate and prompt referral
i. Counseling should be done

- ✓ On Rest and diet
- ✓ Birth preparedness and complication readiness
- ✓ Labour signs
- ✓ Danger signs of labour
- ✓ Initiation of breast feeding
- ✓ Exclusive breast feeding for 6 months
- ✓ Demand feeding
- ✓ Supplementary feeding at 6 months
- ✓ Contraception
- ✓ Advise on institutional deliveries
- ✓ Post - natal care and hygiene
- ✓ Care of newborn
- ✓ Registration of birth

2. **Care During Delivery (Intra-Natal Care)**

a. Normal deliveries should be managed accordingly
b. Manually remove the placenta
c. Manage labour using partogram
d. Active management of 3rd stage of labour should be done
e. Pre-referral management (obstetric first-aid) in obstetric emergencies when required
f. There must be appropriate and prompt referral for cases needing specialist care
g. Repair episiotomy and tears when required

h. Zero-day immunization – BCG, OPV0, Hepatitis B should be given
i. Clients should stay a minimum of 48 hours after delivery

3. Post-Natal Care

Newborn Care

a. Resuscitate – administration of oxygen, airway suctioning
b. Management of neonatal hypothermia through provision warmth-radiant warmer/Kangaroo Mother care
c. Weigh the neonate
d. Early initiation of breast feeding within 30 minutes of birth
e. Prompt referral of any neonate if required
f. Educating mothers on cord care
g. Post – Natal visit for the client's 6 weeks after delivery
h.

Child Health

All children under 5 who attend the facility should have

a. Their temperatures checked
b. Their weight and height taken and plotted correctly on their growth monitoring chart
c. Mid Upper Arm Circumference (MUAC) recorded
d. Immunization status should be checked according to the card and missing immunization are given as needed
e. Counsel mothers on exclusive breast feeding for 6 months and appropriate and adequate complementary feeding from 6 months of age while continually breast feeding
f. Routine and Emergency care of sick children including integrated management of Neonatal and childhood illnesses (IMNCI) strategy
g. There should be prompt referral of sick children requiring specialist care
h. Prevention and control of routine childhood disease—diarrhea, malnutrition etc.

Immunization

Immunization days at UPTH Aluu Primary Health Centre are Tuesdays and Thursdays

IMMUNIZATION SCHEDULE

Vaccine/ Supplement	Age	Minimum interval between doses	Route of Administration	Dose	Vaccination Site
Bacillus Calmette Guerin (BCG)	At birth or as soon as possible		Intradermal	0.05ml	Upper left arm
Hepatitis B Vaccine (HBV)	At birth, within 24hours after birth		Intramuscular	0.5ml	Outer part of right thigh
Oral Polio Vaccine (OPV)	At birth, 6, 10 and 14 weeks	4 weeks	Oral	2 drops	Mouth
Pentavalent Vaccine DPT, Hep B, Hib	At 6, 10 and 14 weeks	4 weeks	Intramuscular	0.5ml	Outer part of left thigh
Pneumococcal Conjugate Vaccine (PCV)	At 6, 10 and 14 weeks	4 weeks	Intramuscular	0.5ml	Outer part of right thigh
Inactivated Polio Vaccine	At 14 weeks		Intramuscular	0.5ml	Outer part of right thigh (2.5cm away from PCV site)
Rotavirus Vaccine	At 6 and 10 weeks	4 weeks	Oral	1.5ml	Mouth

Measles Vaccine	At 9 months		Subcutaneous	0.5ml	Upper left arm
Yellow Fever Vaccine	At 9 months		Subcutaneous	0.5ml	Upper right arm
Vitamin A*	At 9 and 15 months	6 months	Oral	100,000 IU 200,000 IU	Mouth

*supplement

a. All children needing immunization should have

- ✓ Their temperatures checked
- ✓ Weight and height should be taken and plotted on the growth monitoring chart
- ✓ Mid upper arm circumference (MUAC) should be recorded.
- ✓ Health education should be given to parents while awaiting immunization for their children
- ✓ A new immunization card should be collected for those who previously didn't have.
- ✓ Immunization should be given according as per guidelines of national Programme on Immunization.
- ✓ The immunization status of each child should be checked according to the card; also missing immunization should be given as needed.
- ✓ Possible adverse effects following immunization should be looked out for and treated accordingly if need be.

<u>FAMILY PLANNING DEPARTMENT</u>

Family Planning Clinic runs on Mondays, Wednesdays & Fridays from 8am - 2pm.

a. Clients should be received courteously and the following 6 steps followed:

G - Greet client respectfully

A - Ask about their family planning needs

- ✓ A brief history should be taken

- ✓ Clients should have a pregnancy test and urinalysis done.
- ✓ The weight should be checked.

T - Tell them about contraception options e.g.

- ✓ Condoms (both male &female)
- ✓ Oral pills
- ✓ Injectables
- ✓ Sub-dermal implants
- ✓ Intrauterine contraceptive devices (IUCD)

H - Help them decide

E - Explain and demonstrate use of method

R - They could return or you could refer if required

b. **Clients could return or you could refer if required**.

- ✓ Referral and follow up services are to be given to eligible couples adopting permanent methods (bilateral tubal ligation/vasectomy)
- ✓ Identify side effects of the methods, give treatment on the spot for side effects & minor complaints and refer when required.

c. Infection prevention should be enhanced and it entails

- ✓ Hand washing
- ✓ High level disinfection or sterilization of instruments that touch mucous membranes or broken skin.
- ✓ The use of sterile gloves at all times
- ✓ Disposal of single use equipment safely using a 'sharps' box.

PHARMACY DEPARTMENT

The pharmacy unit seeks to promote the availability, safety and effective use of pharmaceutical products in collaboration with other health care professionals.

MEDICATION AND VACCINATION MANAGEMENT

a. The pharmacy is opened 8:00am – 4pm every weekday
b. Headed by the pharmacist

1. All prescriptions should be legible and duly signed by a doctor, clearly stating the doctor's name and include the following:

    - ✓ Name
    - ✓ Age
    - ✓ Sex
    - ✓ Doses, frequency, durations and timing.
    - ✓ Strength of medications

2. The client should be provided with written and verbal information on the presented medicine including

    - ✓ The cost if applicable
    - ✓ The potential benefits and adverse effects and
    - ✓ The risks of ignoring instructions, including not completing the prescribed course of medicine

3. The client should be instructed about the medication, the amount of medication to take, what time of the day it should be taken and for how long it should be taken
4. Ensure the client understands the instruction
5. Essential drugs and supplies are to be available at all times during open hours

Essential drug list should be at the pharmacy

a. Stock keeping should be clearly assigned to one or more responsible staff members
b. Stock cards should be up to date and correspond to physical stock
c. There should be stock for at least two months of the essential drugs and emergency drugs in accordance with government approved lists
d. There should be a documented process for checking dates of expiry and for using earliest expiring drugs first.
e. No expired drugs should be in stock and there should be a documented process in place for separating, discarding and disposing of expired drugs

f. Monthly utilization rates of essentials drugs are calculated and an appropriate system put in place to prevent stock-outs

6. Stock is stored to ensure that medication is kept safe
7. Medicines are stored in shelves with: -

   a. Protection from the adverse effects of light, dampness and temperature extremes
   b. Freedom from rodents and insects
   c. Adequate ventilation should be ensured

8. Adequate and secure storage facilities should be locked

   a. Flammable and/or hazardous material should be stored in a suitable metal cupboard
   b. The refrigerator should be used solely for drugs

LABORATORY DEPARTMENT

The medical laboratory is opened weekdays between 8:00am-4:00pm

It is manned by the medical laboratory scientist

1. For an investigation to be done:

   a. A requisition form is to be filled and should include the following:

      i. Client information – full name, age, sex, contact numbers
      ii. Registration number and a provision for laboratory number
      iii. Test required
      iv. Type of sample
      v. Relevant clinical findings
      vi. Probable diagnosis
      vii. Sample collection time
      viii. Name of sample collector

   b. Lab staff should follow and communicate to clients, verbally and if possible in writing, procedures for the client's preparation for test
   c. Samples collected are labeled with the client's name, UPTH Aluu PHC centre registrations number plus laboratory ID number, and date and time of collection
   d. Urgent samples should be identified

e. The laboratory register should be entered and should contain the following:

   i. Date and time of receipt by the laboratory
   ii. UPTH Aluu PHC registration number; plus, laboratory ID number
   iii. Client's full name
   iv. Age and gender
   v. Identification of samples source e.g. blood, tissue, urine
   vi. Name of the test
   vii. Test results
   viii. Name of technologist who performed test
   ix. Date and time of reporting result

f. Laboratory registers should be readily accessible to laboratory staff
g. Result are recorded on the reporting/result form
h. All persons must be protected from potential hazards in the laboratory

   i. Only authorized personnel should be allowed into the laboratory
   ii. Universal precautions should be observed. They Include:

      - ✓ Wash hands before and after all patient/specimen contact
      - ✓ Handle blood of all patients as potentially infectious
      - ✓ Always use gloves for contact with blood / body fluids
      - ✓ Place used syringes in puncture proof container
      - ✓ Do not recap or manipulate needles
      - ✓ Wear protective eye–wear/mask if splash/splatter of blood/body fluids is possible
      - ✓ Wear gowns and aprons when splash with blood / body fluids is expected
      - ✓ Lab staff should not use mouth pipette
      - ✓ When there is any breach in skin, seal it with strongly water proof adhesive tape
      - ✓ Ward coats must be worn always

i. In the event of an accidental exposure and / or occupational illness it should be reported and clearly documented.
j. In the event of a needle stick injury

- ✓ Encourage the wound to bleed ideally by holding it under running water
- ✓ Wash the wound using running water and plenty of soap
- ✓ Don't scrub the wound while you're washing it
- ✓ Don't suck the wound
- ✓ Blood splatter in the eyes - wash eyes under running water

2. General Laboratory Procedures

a. Cleanliness of the laboratory must be maintained
b. Glassware and equipment should be kept clean
c. Microscopes should be maintained and handled properly
d. Equipment should be sterilized as required

3. Laboratory Investigations Routinely carried out include:

a. Hb estimation
b. Blood sugar
c. Blood grouping
d. Rapid diagnostic test for typhoid
e. Rapid diagnostic test for malaria
f. Urinalysis
g. Rapid test for pregnancy

MEDICAL RECORDS DEPARTMENT

The records departmentopens 8am to 4pm, Monday to Friday.

The medical records officer is in charge of keeping the records of the health centre

a. Clients' registers are used to collect data for management and statistical purpose
b. Unauthorized access and use of client records should be restricted
c. The contents of client records are filed in a numerical order with the client's name and identification on the outside of the record
d. Client records should be secured inside a cardboard folder, filed on a daily basis, stored safely and securely in accessible cabinets or shelves and available when needed
e. Entries in the client's record -

- ✓ Should be made only by authorized persons
- ✓ Should be legible, dated and timely

- ✓ Should be signed with name and designation
- ✓ Should Include the time of relevant events

f. The daily Out Patients Department register, health facility daily general attendance register must be entered in with client's information daily

g. Basic written information in the registers should include

- ✓ Dates
- ✓ ID number
- ✓ Client demographic data
- ✓ Diagnosis
- ✓ Treatment
- ✓ Follow up

h. At the end of the month, the health facility Monthly Summary Form should be filled

i. There should be a review of a representative sample (batch check) of client records for completeness and legibility of entries and contents at least quarterly

GENERAL MAINTENANCE DEPARTMENT

Comprising of Works, Security, Sanitation and House Keeping

1. Housekeeping services include:

a. Mopping
b. Dusting
c. Sanitation of toilets and bathrooms
d. Laundry
e. Housekeeping staff should use PPE (gloves, shoes and mask)
f. Floors of all departments should be mopped every day
g. Floors should be mopped after every procedure that involves spills on the floor
h. Furniture should be dusted everyday
i. Cobwebs should be removed from the ceilings and walls periodically
j. Bed sheets /pillows cases should be changed everyday
k. Floor of bathrooms is to be cleaned with detergent once a day
l. Toilets should be cleaned once a day with disinfectant solution
m. Bed pans should also be washed and disinfected by phenol

n. Curtains should be changed once in 15 days and sent for laundry

2. Security

At least 2 security men should be in place running two (2) shifts

3. Works

a. Generators should be serviced periodically
b. There should be documented process of purchasing and procuring fuel
c. Generator should only be handled by authorized personnel
d. Light bulbs should be changed as the need arises
e. Physical built environment of the facility should be maintained at all times

ACCOUNTS DEPARTMENT

This is manned by the accountant/cashier.

PROCEDURES

a. All procedures, services and transactions are billed by either a revenue officer or the originating cost center (department), listing the cost items
b. The accountants crosscheck the billing, accepts payment and issues two of the triplicate receipts to the client and retains a copy
c. Services are only rendered at the various service points upon presentation of the payment receipt from the accounts
d. Keeps up to date financial records
e. Remits all finances to appropriate accounts
f. And other services that will be mandated by the supervising consultant

MANAGEMENT OF PATIENT FLOW IN GOPD AND MATERNITY

Patient arrival at the Hospital

Follow up/subsequent visitor

First time visitor

Record retrieval and

Card issuance and

Waiting area of General Outpatient Clinic

Assigned number, vital sign checks and health education by

Physician Consultation

Laboratory/radiology – review, scheduling,

Pharmacy – review, costing

Referral to other specialists

Payment for service

Conduct of investigations

Receipt of medications

Receipt of specialist service

DEPARTURE

TIME SCHEDULES

Step	Procedure	Who is Responsible?	Time lag
1	Open New folder or retrieve previous folder	Medical records unit	45mins/30 mins
2	Pay for consultation fee	Accounts unit	10-20 mins
3	Vitals check	Nurses	30-60 mins
4	Health Education	Nurses	10- 20 mins While at the waiting hall
5	Waiting at the waiting hall	-	1-20 mins
6	Consultation	Doctors	10-30 mins
7	Presentation at nurses' station for further directives	Nurses	5-30 mins
8	Urinalysis	Lab Scientist	2 mins
9	FBS/RBS	Lab Scientist	2 mins
10	HBsAg	Lab Scientist	5-10 mins
11	HCV Ab	Lab Scientist	5 -10 mins
12	RVS	Lab Scientist	5-10 mins
13	Pregnancy test	Lab Scientist	5-10 mins
14	Getting drugs from the Pharmacy	Pharmacist	5 mins
15	Payment for service (each request)	Cashier	5 mins

DUTY ROSTER

The duty roster for the month is done by the chief resident (for resident doctors and honorary consultants) and the matron in charge (for the nurses and ward maids). The chief resident also prepares the roster for whole department academic presentations. The most senior resident and chief nursing officer in each unit prepared meetings and training schedules for their unit. It is expected that each unit have a session between the unit consultant and the residents; a unit's academic presentation; a general meeting of all staff in the unit every month. All rosters are placed on the notice board for every member of the department to see and soft copies are also sent to every member of the department.

REVOLVING FUND MANAGEMENT

The department's revolving fund is headed by the HOD who is the project manager. Whenever the funds available are limited, the HOD request the Project Secretary (from administration) to call a meeting involving the project manager, project accountant, project secretary, chief resident and Assistant Director of Nursing in charge of the Department. The priorities for the various units are discussed and approvals are made with respect to the fund available. There is no fixed time for this meeting and it is hoped that when the release of fund by management to the department improves, we would be able to call for the broader due-process meeting as required by the status.

PURCHASE OF CONSUMABLES

As outlined in the SOP for Procurement & Stores.

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

QUALITY ASSURANCE

Each resident in the department has a pathway that is used to regularly assess their progress. The resident is also attached to a consultant as his/her trainer and they are also quarterly mock examination for the residents. Routine monitoring of processes and procedures is carried out by the various practice administrators assigned to the units. Deviations from the SOPs as well as report from period patient experiences/satisfaction surveys are handled administratively.

INFORMED CONSENT

Verbal informed consent is obtained from all patients before carrying out any procedure on them.

UPTH STANDARD OPERATING PROCEDURE FOR

DIETETICS DEPARTMENT

NAME & SIGNATURE OF DIRECTOR OR HEAD OF DEPARTMENT:

Mrs ODAZIE ECHEFU

DATE: 23RD JULY, 2018
SOP No: 002
SOP Title: Processes involved in providing catering services for patients and staff.

NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) starts by 9:00 am
PURPOSE
To establish a system for providing dietary services to all patients and staff
SCOPE
It covers all the patients admitted into wards or observational beds except patients
Advised Nothing by Mouth. Also covers staff on call or during special functions.

FUNCTIONS OF THE DEPARTMENT

Name	Function	Remark
Ward round on medical nutrition therapy	Dietitians	**Echefu O.** **Mbah O.** **Nwafor S.**
Dietary counselling	Dietitians	;; ;;
Nutrition Education	Dietitians N-Power Nutritionist	
Food demonstration	Dietitians N-power Nutritionist	
Food processing	Diet cooks Corp members	
Bread making	Baker Corp members	
Diet shop sales	N-power Nutritionist Corp member	
Dietary administration	HOD	

ROLES AND RESPONSIBILITIES OF VARIOUS STAFF DEPLOYED TO THE DEPARTMENT

Nil	Authorised staff **enter name(s).**
Nil	Authorised staff **enter name(s).**
Nil	Authorised staff **enter name(s).**
Nil	Authorised staff **enter names(s).**
Nil	Describe system.

DIETARY ADVICE

	Describe the procedure involved and category of staff responsible for it	
	Assessment **Nutritional Diagnosis** **Nutrition intervention** **Prognosis.**	**Dietitians** **Interns.**

DIETARY PRESCRIPTION

	Describe the procedure involved and category of staff responsible for it
Type of Diet	Personal data Diagnosis Caloric requirement Culture Religion Socio Economic status

PROCUREMENT OF RAW MATERIALS(FOOD ITEMS)

	Describe the procedure involved and category of

	staff responsible for it
1.Direct purchase from market	Tigernuts,wheat flour,soy beans,vegetables, etc.
2.Return on sales supply.	Coconut oil,spices,sesame seeds etc.

MAINTENANCE OF COOKING UTENSILS

	Describe the process involved
Washing cleaning mopping	

WASHING AND CLEANING

	Describe the process involved
Use of soap and sponge. Use of hand towels Use of serviette paper	

PREPARATION OF FOOD

	Describe protocol
	1.Cooking methods: Boiling, roasting, grilling 2. Processing methods: Soaking, dehauling, roasting, milling, and sieving.

QUALITY CONTROL OF COOKED FOOD

	Detail practice process including responsibilities, system and record keeping.
	a.Cooking time is considered to minimize nutrient6 loss. b.Standard measures are used to maintain portion control e.g. food scale, measuring cups, measuring spoon, measuring jugs, kitchen thermometer.

	c.Weight and height measures standard used. d.Hygienic and safe handling: Methods are employed especially during storage,preparation,cooking, serving and leftover management. e.Record keeping done on daily: i. Purchase ii. Sales iii. Dietary counselling iv. Referral notes v. Quantity of stock

DISTRIBUTION OF COOKED FOOD

	Describe protocol
Done by diet cooks	Carries food to the ward with baskets and trolley.

CESSATION OF DIETARY SERVICES TO PATIENT

	Describe protocol
Dietary services are continuous until death	Monthly reviews done

UPTH STANDARD OPERATING PROCEDURES FOR UNODC/FMOH MODEL DRUG REHABILITATION TREATMENT CENTRE

HEAD OF UNIT: ***PROF. P.C. STANLEY***

PREPARED BY: ***DR NKPORBU A.K.***

SOP No: 002
NOTE: Work Starts by 8:00 am.All clinics and knife on skin (Surgery) starts by 9:00 am
STANDARD OPERATING PROCEDURES (SOP)
Activity 1: Out-patient Clinic
Activity 2: Admission Procedures
Activity 3: In-patient Treatment/Rehabilitation
Activity 4: Psychotherapeutic Procedures
Activity 6: Discharge Procedures

Purpose: To clarify the procedures to follow by doctors, nurses, social workers and psychologists working at the Model Drug Treatment Centre (MDTC) while attending to Clients.

Goal: In managing Clients at the MDTC, University of Port Harcourt Teaching Hospital (UPTH), practitioners should provide an organized and evidence-based care to Clients, reduce variability and ensue a disciplined approach using the available resources.

Scope: This SOP applies to all staff involved in the clinical management of Clients at the Model Drug Treatment Centre (MDTC).

Activity 1: Out-Patient Clinic

Standard Procedure	**Supporting Information/Explanation**
Clinic starts by 8.00am on specified day: 2 days in the week – Mondays and Wednesdays	To ensure that the best evaluation that will lead to the right diagnosis is made
The clinic is headed by a Consultant assisted by Senior Registrars and Registrars	
All new cases must be reviewed by the Consultant	
Time/Duty Roaster must be pasted in the clinic and the MDTC	To allow all clinical staff become aware of their duty schedule
Consultant’s review will recommend	

further care for the Clients - Necessary investigations - Out-patient care - In-patient care - Brief psychosocial intervention	
Individual support	
All new cases must first complete the hospital registration including payments and be observed by nurses on duty before being seen by the doctors	To satisfy preliminary stages and observations and for the hospital to keep appropriate record.
Substance used disorders with psychiatric or medical emergencies will have to be managed in the Psychiatry Wards first before being transferred to the Drug Unit when they are **STABLE** and **MOTIVATED**	to avoid admitting client with underlying and co-morbid disorders that may interfere with recovery or cause disruption in management and rehabilitation or constitute a nuisance for the Residents of the MDTC
Admission can either come through the Clinic, Psychiatric Wards or through direct referral to the MDTC	To make admission processes flexible
Client that requireonly brief psychological or psychosocial intervention or any other form of psychotherapy must be attended to during the clinic time and subsequent visits may be scheduled by the clinical Psychologists/Social Workers	To avoid any gap or delay in treatment

Activity 2: Admission Procedure

Admission must be properly documented by the doctor – time, date, and name of patient on all the pages of documentation	To ensure proper documentation
Clients or his relatives or guardian must sign the consent form	Ensure commitment and social support and to avoid abandonment
The attending doctor must obtain all the necessary information from the	Update bio-data and clinical information

clients and/or his or her relatives	
The attending nurses must complete and record the vital signs assessment of the client	To ensure proper clinical care
The attending nurses must conduct a thorough check of the items of the clients includingpersonal effects andclothing currently worn and items brought by the relatives before admitting the Clients or accepting their items into the Drug Wards. The check will also be done regularly including all times items are brought by relatives. Already prepared food items brought by relatives for the Clients are not allowed.	To prevent drugs(even hidden in food used to cook food) and/or dangerous items being smuggled into the Drug Wards
All electronic and communicating gadgets must be taken away from clients for the period of their stay and can only be given to allow passage of very important information and for that purpose alone	To monitor external communication. To reduce/curb unnecessary stress

Activity 3: In-patient Treatment/Rehabilitation

The doctor continues to lead the team of clinical care.	To ensure best and highly specialized team care.
There will be Consultants, Senior Registrars, as well as Registrars ward rounds.Nurses, Pharmacist, Clinical psychologists and Social Workers are to join the Consultant's and Senior Registrar's ward round.	To ensure adequate maximal case and delivery of the best care using team approach.
The Registrars conduct a pre-consultant ward round on the day of the round.	To update all relevant information regarding Clients and to ensure proper care for the Client
The Senior Registrars and Registrars ensure that instructions from the Consultant's Ward round including investigations, drug and psychological treatments are diligently and swiftly	To provide a form of monitoring and evaluation of care for the Clients

carried out.	
The Nurses administer the medications and the Senior Registrars and Registrars Ensure that the medications are given correctly both in dosing and frequently. All intravenous medication must be administered by the doctors.	Ensure delivery of highly specialized care.
The Consultants' Ward rounds days are Tuesdays for team A and Thursdays for Team B	
In case of any emergency the registrars on call should be called first and this can extend to the Consultant on call if need be	To maintain appropriate communication link
The Client will commence the appropriate vocation/occupation rehabilitation as soon as he or she is well motivated for that.	

Activity 4: Psychotherapy/Social Work

The clinical Psychologists will administer the different psychotherapeutic procedures prescribed by the Doctor/Team	To ensure psychotherapy is given appropriately.
Supportive psychotherapy should be done at least twice a week for each indicated Client while other specialized psychotherapy can be done once a week	To ensure regular care

Activity 5: Discharge Procedure

Discharge must be done by the managing Consultant	To ensure proper order
The care note of the client can then be taken to the Finance Officer for assessment	For Hospital Revenue

UPTH STANDARD OPERATING PROCEDURE FOR
EAR NOSE AND THROAT SURGERY DEPARTMENT

NAME & SIGNATURE OF HEAD OF UNIT: ***DR ONOTAI L.O***
DATE: 19TH JULY, 2018
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics and knife on skin start by 9:00 am
INTRODUCTION

Ear, Nose and Throat surgery also known as otorhinolaryngology is a surgical specialty which deals with diseases of the ear, nose and throat and related structures of head and neck.

PURPOSE

To establish guidelines for ENT departmental operations with respect to the processes involved in cost effective, patient focused management in the clinical departments of University of Port Harcourt Teaching Hospital (UPTH).

RESPONSIBILITIES

The department of **EAR NOSE AND THROAT SURGERY** offers expert care to patients referred either from other clinical departments within the hospital or from outside the hospital. The department gives all-inclusive, uninterrupted and coordinated care to patients irrespective of age, sex and religion. The consultants, Resident doctors, speech Therapist/Audiologist, nurses and ward maids all work as a team to ensure the smooth running of the department to achieve patient centred care.

ACCESSING PATIENT CARE IN THE DEPARTMENT INVOLVES THE FOLLOWING

Step	Procedure	Who is Responsible?	Time lag
1	Open New folder or retrieve previous folder	Medical records unit	45mins/30 mins
2	Pay consultation fee first visit (N1,000), follow up N800.00	Accounts / Payment at the bank	15-20 mins
3	Presentation at the ENT outpatient nursing station.	Ward maids and nurses	10 mins

4	Checking of Vital signs	Nurses	10-20 mins
5	Health Education	Nurses	10- 20 mins While at the waiting hall
6	Sorting of patients	Consultants/Residents	10 – 15 mins While patients are still at the waiting hall
7	Waiting at the waiting hall	-	30-60 mins
8	Consultation	Consultants and Residents	10-20 mins per patient
9	Presentation at nurses' station for further directives	Nurses	5-10 mins

PROCEDURE ROOMS

The department has 3 rooms used for procedures such as Pure Tone Audiometry, Speech therapy and for others (wound care, syringing of the ears, antra lavage, aural dressing, removal of foreign bodies from the ear and nose in cooperating patients etc).

Step	Procedure	Who is responsible?	Time lag
1	Receipt collection by patient	Account unit	5-10 mins
2	Payment at the bank by patient (for those with cash)	Sterling bank	15-20 mins
3	Receipt of payment taken to the procedure room by patient	-	5 mins
4	Relevant procedure done: Syringing Antral Lavage Pure tone	Doctors/Nurses/Speech therapist/Audiologist	10-45 mins (depending on the procedure)

	Audiogram/Speech therapy Indirect Laryngoscopy. Foreign body Removals		

WARDS

There are two wards that cater for children, males and females. Within the female/children wards lies the treatment room

S/NO	Wards admission	Who is responsible?	Time lag
1	Male	Doctors/Nurses	10-15 mins
2	Female/Children	Doctors/Nurses	10-15 mins

ADMISSION PROTOCOL

The doctors admit patient, the account officer issues teller for payment of admission deposit. Patient makes payment in the bank. Confirmation of payment by the nurse on duty. Patient is then given a bed space to occupy.

DISCHARGE PROTOCOL

Patient discharged by doctor. Discharge summary written by doctor. Preparation of bill account officer. Payment of bill at the bank. Confirmation of payment by the nurse on duty. Patient allowed to go home.

THEATRE

The department has only 2 days in a week to operate in only one theatre space provided for us. The operating days are MONDAY AND WEDNESDAY. However, emergencies can be done in the main theatre in agreement with the Anaesthetic team on call.

Step	Procedure	Who is responsible?	Time lag
1	Booking of the patient for surgery	Consultants/Residents	5-10 mins
2	Payment at the bank	Patient	15-20 mins
3	Sending for the booked patient after the Anaesthetist has reviewed in the ward	Consultants Anaesthetist/Residents	5- 10mins
4	Bringing of the patient to theatre after payment in the bank	Nurses/Porters	15-20 mins
5	Payment receipt presentation to the theatre nurses	patient	2-5 mins
6	Receiving of the patient in theatre/ Vitals check	Nurses	5-10 mins
7	Confirmation of payment receipts before wheeling patient into operating room	Doctors	2-5 mins
8	Wheeling of patient into operating room	Nurses/Porters	5 – 10 mins
9	Anaesthesia administration/ Surgical Procedure	Doctors/Nurses/ Anaesthetic Technicians	Ranges from 30 mins to 3 hours depending on the procedure carried out
10	Recovery of patient	Doctors/Nurses	10-30 mins

RELATIONSHIP WITH A&E/ CHEW

The department of ENT Surgery covers both thedepartments ofAccident and Emergency and CHEW from 4pm to 8am. The doctors take the calls in the form of First on call (Registrars), second on call (Senior Registrars) and third on call (Consultants). A copy of the Department call duty roster is placed on the notice board of A&E and CHEW.

RELATIONSHIP WITH ICU/SCBU

We attend to patients that need our services in the ICU/SCBU. In some cases, we admit our patients straight into the ICU from theatre. Doctors call also cover the ICU and Special Care baby Unit.

RELATIONSHIP WITH NHIS

The department sees all NHIS patients referred to her using NHIS approved tariff. Regrettably, the patients bill is not been serviced either by management or NHIS Providers.

MANAGEMENT OF PATIENTS IN THE ENT OUT PATIENT CLINICS

The ENT Surgery department runs a heavy outpatient clinic from Monday to Thursday. Friday is reserved for Ground rounds and for both speech therapy clinic and minor procedures. Majority of the patients are managed within the department. If/when the need arises for referral (according to laid down criteria stipulated in internationally-recognized clinical practice guidelines), they are referred to appropriate specialties and subsequently, the patients return to the department for follow up and further expert management.

PATIENTS APPOINTMENTS

Patients seen in the ENT outpatient Clinics/wards may be given appointments for follow up of management or referred to other specialist clinics for care. Duration of appointments vary depending on the case and could be from 1 week to 1 year.

MANAGEMENT OF THE ENT REVOLVING FUND

The membership of the Revolving fund is as constituted by management. The HOD is the project Manager, there is a Project Secretary and Project Accountant and other members. Funds for running of the department is from the monthly money released by management after passing through Due Process Committee. It fluctuates between 30% and 45% of total money made in the previous month. There are months that the stipend was not released. For maintenance of equipment and repair of faulty electrical appliances, the department involves the hospital maintenance department. For the purchase of consumables, the department carry out

direct purchase through the Chief Resident of the department, Head of the nurses in the ward and outpatient clinics. Items are purchased as the need arises. The method is cheap and simple, no mark up of prices and no delay in purchasing of these consumables. The HOD oversee the purchase items. Revolving Fund meetings are held every 3rd Wednesday of the month for effective running of the department.

ACCREDITATION

Please refer to SOP for CS & T.

ISSUING MEDICAL REPORTS FOR OUR PATIENTS

The protocol of writing medical report for our patients follow due process. It includes

Steps	Procedure	Who is responsible?	Time lag
1	Open folder or retrieve old folder	Medical records	20-30 mins
2	Payment for consultation fee	Accounts unit	10-30mins
3	Vitals check	Nurses	10-20 mins
4	Consultation	Doctors	10-30 mins
5	Doing requested investigations if required	Laboratory / Radiological	Hrs to days
6	Presentation with results of investigations & review	Doctor	10-30 mins
7	Issuance of medical report as appropriate	Doctor+ departmental Secretary (types the letter) Letter is signed either for or by the	30 mins-1hr mins

		Consultant in charge of the patient. Finally, it is stamped after registration with the records department.	

DUTY ROSTER/CALL DUTY ROSTER

The call duty roster for the month is done by the chief resident (for doctors). This has to be approved by the HOD before display. The Matron in charge (for the nurses and ward maids) does the duty roster for the nurses and ward maids. The chief resident also prepares the roster for academic presentations. All rosters are placed on the notice board for every member of the department to see and soft copies are also sent to every member of the department through the departmental WhatsApp group. Call duty rosters are sent to the office of the CMAC and various notice boards as stipulated by the hospital management. The house officer and the first on call who is usually a Registrar sleep in the departmental call room.

ISSUING OF DEATH CERTIFICATES

The doctor who certified the patient death usually issues the death certificate. The certificate is available within the department. The details to be filled are already as outlined in the prepared certificate. The hospital stamp is then affixed after the doctor has signed the certificate.

QUALITY ASSURANCE

Residents are assessed regularly during clinic and ward rounds by the consultants. Mock examinations are conducted for Residents to assess their competence in the management of Patients.

INFORMED CONSENT

Verbal informed consent is gotten from patients before carrying-out the point of care investigations while written informed consent is gotten before a surgical procedure is carried out on the patient.

PROCUREMENT OF EQUIPMENT & CONSUMABLES

As outlined in the SOP for Procurement & Stores.

ACCREDITATION

Please refer to SOP for CS & T.

REVOLVING FUND MANAGEMENT

As outlined in the SOP for Procurement & Stores.

THEATRE MANAGEMENT

As outlined in the theatre SOP.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF FAMILY MEDICINE UNIT: NHIS

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *DR ADJUGAH JOSHUA UVIEROGHENE*
DATE: 15TH July 2018
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am

PURPOSE

To outline the processes involved in accessing healthcare services in the NHIS UNIT of UPTH.

RESPONSIBILITY

1. **NATIONAL HEALTH INSURANCE SCHEME (NHIS) CLINIC**

   The NHIS Clinic is a unit under Family Medicine department and therefore is also a gateway for all NHIS patients to get access to the entire healthcare system and offers comprehensive, continuous and coordinated health care irrespective of age, sex or disease entity. The work ethics is to achieve maximum patient satisfaction within the shortest possible time and it involves the interplay of Doctors, Nurses, Maids, Admin/Clerical staff, pharmacist and accountants.

   The NHIS UNIT provides primary care services and coordinates the secondary/tertiary healthcare services within UPTH.

2. **FEDERAL SECRETARIAT STAFF/NHIS CLINIC**
   This is an extension of UPTH NHIS UNIT domiciled at the Federal secretariat complex along Aba road, Port Harcourt. It is directly under the supervision of UPTH NHIS UNIT.
3. **LIFESTYLE MEDICINE CLINIC**
   This is a specialized clinic domiciled in the UPTH NHIS UNIT, which specifically sees to the health and wellbeing of all UPTH staff. It is operational on Wednesday from 8am to 2pm. It is an appointment clinic that attend to those whose birthday falls within the week.

   Plans are underway to expand its services to cater for all patients accessing care in UPTH in need of its services.

4. ACCESS TO LIFESTYLE MEDICINE CLINIC

Step	Procedure	Staff Responsible	Time lag
1	Registration at the preventive Lifestyle Medicine Clinic nurses' station	Ward maids and nurses	5 mins
2	Vitals check including weight, height, BMI	Nurses	15
3	Waiting at the waiting hall/Health talks/demonstrations		60-75 mins
4	Consultation /Completion of Lifestyle Medicine Questionnaire& other follow up questionnaires.	Doctors	60-75mins
5	Presentation at nurses' station for further directives (including follow up appointments)	Nurses	5-10 mins
6	Referral to laboratory, radiology, pharmacy, dieticians, physiotherapists (which ever applicable)	Doctor/ Support staff	30mins

5. ACCESING PATIENTS CARE IN THE NHIS UNIT

STEP	PROCEDURE	OFFICER	WAITING TIME
1a	New patient (both primary and secondary referral) need clearance to get a folder	Admin officer	2 minutes
2a	Take folder clearance to NHIS record and get a folder. The folder/patient appointment is registered into the Electronic Health Record (EHR)	Record officer	15 minutes
3a	Vital signs recording by the Nurses at the Nurses' station. The folders move to the consulting rooms.	Nurses	2 minutes

STEP	PROCEDURE	OFFICER	WAITING TIME
4a	Medical consultation with three possible outcomes: -Drugs at the pharmacy -Investigations/procedures at the laboratory, radiology or ECG etc. -Referral to secondary/tertiary health care	Doctors	5 minutes
1b	Follow-up patient: submit appointment card at the Record section.	Record officer	2 minutes
2b	Folders are retrieved and entered into EHR for that day's medical consultation. Then passed to the Nurses' station for observation. -Those for secondary/tertiary care follow-up are referred to their respective specialist clinics by the Doctor. Then collect their consultation slip from the admin officer. -Those for primary care follow-up, consult the NHIS UNIT physicians.	Record officer Doctor Doctor	3 minutes 3 minutes 5 minutes
3b	Same for 3a and 4a above	As in 3a/4a	As in 3a/4a
1c	Old patient accessing care for a new medical complaint: Submit appointment card at the NHIS Record	Record officer	2 minutes
2c	Folder retrieved and entered into the EHR for that day's medical consultation.	Record officer	3 minutes
3c	Same for 3a and 4a above	As in 3a/4a	As in 3a/4a

6. PHARMACY (Primary care level)

STEP	PROCEDURE	OFFICER	WAITING TIME
1	Take drug prescription for clearance	Admin officer	2 minutes
2	NHIS UN IT pharmacy for costing and payment of 10% cost of drug bills (not applicable to TISHIP and military officers).	Pharmacist	3 minutes
3	Get teller for the 10% payment	Pharmacist	1 minute
4	Payment at Sterling bank payment point in UPTH	Bank official	20 minutes
5	Get your drugs at the NHIS UNIT pharmacy after payment.	Pharmacist	3 minutes

7. PHAMACY (Secondary/tertiary care level)

STEP	PROCEDURE	OFFICER	WAITING TIME
1	Need an authorization code from the HMO, but it is usually covered by the authorization code for the initial referral	Admin officer/HMO rep in UPTH.	2 minutes
2	The processes then continued as it is for pharmacy (primary care level above)	Same as (2) above	Same as (2) above

8. LABORATORY/RADIOLOGY/ECG

STEP	PROCEDURE	OFFICER	WAITING TIME
1	The required slips for any of these investigations are printed out from the EHR (for primary/secondary /tertiary levels of care) and attached to the request forms.	Doctor and/or Admin officer	1 minute
2	Pre-authorization code from the HMO (not applicable to capitated investigations)	Admin officer/HMO rep in UPTH	2 minutes
3	Proceed for the respective investigations	As applicable.	Not available

9. REFERRAL FOR SECONDARY/TERTIARY LEVELS OF CARE (TWO-WAY REFFERAL)

STEP	PROCEDURE	OFFICER	WAITING TIME
1	The required referral form is printed out from the HER	Doctor	1 minute
2	Pre- authorization code is sought from the HMO	Admin officer	2 minutes
3	Then the printing of the consultation slip from the HER is then proceed on the referral	Admin officer	2 minutes
4	Subsequent follow-up, the patient must pass through the NHIS UNIT for proper documentation (retrieve folder and entered it into EHR) before going to the specialist clinics as it is in 1b and 2b.	Record officer/ Doctor/ /Admin officer	5 minutes

10. PROCEDURE/SURGERY

STEP	PROCEDURE	OFFICER	WAITING TIME
1	The required slip for the procedure, admission or surgery must be printed out from the EHR. Note that all patients at secondary/tertiary care level must come for this activity before a prescribed procedure is done. (In A&E the procedure can go on but documentation at the NHIS UNIT must be done within 48hrs).	Doctor/Admin officer	1 minute
2	Pre- authorization code from the HMO	Admin officer/HMO rep in UPTH.	2 minutes

11. INJECTION/DRESSING ROOM

STEP	PROCEDURE	OFFICER	WATING TIME
1	Get requisite papers from NHIS UNIT for identification/documentation (no cash or bank payment).	Admin officer	1 minutes
2	Procedure done at the Family Medicine dept. dressing room	Nurses	5 minutes

12. EMERGENCY SERVICES ON PUBLIC HOLIDAY, WEEKEND AND AFTERNOON 4 PM OF THE WORKING WEEK

NHIS clients can access medical care in Accident & Emergency (A & E) department

a. Requirements are any means of identification as an NHIS enrollee using the NHIS number or contacting the client HMO for authorization.
b. Family medicine/NHIS Doctors are on call in A & E.
c. NHIS UNIT admin/clerical/record staff are also in A & E on shift duty
d. Pharmaceutical prescriptions for emergency cases or patients on ward admission can be gotten from the A & E pharmacy, but they must present the requisite NHIS slips/papers for identification/authorization/documentation.
e. FOR UNIPORT TERTIARY INSTITUTION HEALTH INSURANCE SCHEME (TISHIP)**:** They may or may not come with referral or authorization code. But once they are identified as UNIPORT students, they are given emergency medical care. However, they must provide the referral letter, authorization code and their personal UNIPORT GREEN CARD within 24 hours or before admission into the wards or before discharge from the hospital.

REVOLVING FUND MANAGEMENT:

It is supervised by a team of 12 persons under the chairmanship of the NHIS UNIT HEAD. The revolving meeting is held once monthly (second Tuesday of every month)

REVENUE

The revenue is in two dimensions from the HMO:

(a.) Monthly capitation

(b.) Fee- for service (FFS) following bill submitted to the HMO for secondary/tertiary services for NHIS clients. For the improvement of FFS, there is an NHIS ward patient monitoring team.

All payment goes into the UPTH TSA account with the CBN.

PURCHASE OF CONSUMABLES

As outlined in the SOP for Procurement & Stores.

ACCREDITATION PROCESSES

Please refer to SOP for CS&T.

QUALITY ASSURANCE

This is maintained, monitored and improved upon by

(a.) Opinions of NHIS clients/users by the use of a suggestion box option.

(b.) Periodic NHIS patients' satisfaction survey.

(c.) Periodic sensitization seminars for staff, patients and NHIS enrollees by the NHIS UNIT, HMO and NHIS regulators

RENEWAL OF NHIS CONTRACTUAL AGREEMENT:

There is a periodic renewal of NHIS contractual agreement with UPTH which covers both the primary care level and all the various secondary/tertiary care levels offered within UPTH. In addition, there is periodic payment of UPTH indemnity insurance as an NHIS accredited center.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF FAMILY MEDICINE

NAME & SIGNATURE OF HEAD OF UNIT: *DR NDUKWU G.U*

DATE: 12TH JULY, 2018

SOP No: 002

NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am.

PURPOSE

To establish guidelines for departmental operations with respect to the processes involved in patient management in the clinical departments of UPTH.

RESPONSIBILITIES

The department of Family Medicine is the first port of call of most patients in UPTH and gives comprehensive, continuous and coordinated care to patients irrespective of age, sex and disease entity in the context of the family and society. The doctors, nurses and wardmaids all work in synergy to ensure the smooth running of the department and to achieve maximum patient satisfaction.

Step	Procedure	Who is Responsible?	Time lag
1	Payment for/opening new folder & consultation fee (N 1,000) or retrieval of previous folder	Medical records/Accounts unit	20-40 mins
2	Presentation at the Family Medicine Clinic nurses' station	Ward maids and nurses	5 mins
3	Vitals check	Nurses	30-60 mins
4	Health Education	Nurses	10- 20 mins While at the waiting hall
5	Sorting of patients	Doctors	10 – 15 mins While at the waiting hall

7	Waiting at the waiting hall	-	30-60 mins
8	Consultation	Doctors	10-30 mins
9	Presentation at nurses' station for further directives	Nurses	5-30 mins

DRESSING ROOM

The dressing room is used for patients' wound care

Step	**Procedure**	**Who is responsible?**	**Time lag**
1	Receipt collection	Account unit	10-20 mins
2	Payment at the bank (if paying cash)	Sterling bank	10-20 mins
3	Receipt of payment taken to the dressing room	-	5 mins
4	Relevant dressing done	Nurses	20-45 mins

POINT OF CARE TESTING

These are the easily carried out investigations needed for the adequate running of the department and include:

S/NO	**Name of POCT**	**Who is responsible?**	**Time lag**
1	Urinalysis	Doctors	2 mins
2	FBS/RBS	Doctors	2 mins
3	HbsAg	Doctors	5-10 mins
4	HCV Ab	Doctors	5 -10 mins
5	RVS	Doctors	5-10 mins
6	Pregnancy test	Doctors	5-10 mins

USE OF OBSERVATION ROOM

The room is used to keep not too critically sick patients but who still require some minutes to hours of observation before allowing home. The procedure for use includes:

Step	Procedure	Who is responsible?	Time lag
1	Consultation	Doctors	10-30mins
2	Presentation at the nurses' station	Nurses	5- 10mins
3	Receipt for payment for use of the room	Account unit	5-20 mins
4	Payment at the bank	Sterling bank	5-20 mins

5	Payment receipt presentation to the nurses	Patient	2-5 mins
6	Admission for observation as stated in consultation	Nurses	1hr – 3hrs

USE OF PROCEDURE ROOM

This room is used for simple day procedures such as in-growing toe nail removal and Incision and Drainage of abscesses. The protocol for use of the room include:

Step	Procedure	Who is responsible	Time Lag
1	Consultation	Doctors	10-30 mins
2	Presentation at the nurses ’station	Nurses	5-10 mins
3	Teller for payment for procedure	Account unit	5-20 mins
4	Payment at the bank	Sterling bank	5-20 mins
5	Receipt of payment’s presentation	Nurses	2-5 mins
6	Actual procedure done	Doctors	20-60 mins

RELATIONSHIP WITH A&E AND NHIS

The department of Family Medicine covers the Accident and Emergency from 4pm to 8am and is tasked with rendering care to NHIS patients during this time. It is responsible for the 24-hour coverage of the NHIS clinic in terms of service provision. The doctors take the calls in the form of First on call (Registrars), second on call (Senior Registrars) and third on call (Consultants).

MANAGEMENT OF PATIENTS IN THE DEPARTMENT

The vast majority are managed within the department. If/when the need arises for referral (according to laid down criteria stipulated in internationally-recognized clinical practice guidelines), they are referred to appropriate specialties and subsequently, the patients return to the department for follow up and management of any other medical condition that they may present with (co-ordination of care).

APPOINTMENTS

Patients seen in the Family Medicine Clinic may be given appointments for follow up of management or referred to other specialist clinics for care. Appointments vary depending on the case and could be from few days to 4 weeks.

REFERRALS TO AND FROM OTHER DEPARTMENTS

Referral from the Family Medicine Clinic is a two- way system, which means that after treatment in the clinic in which the patient is referred, the patient should come back to the Family Medicine Clinic for further follow up. Referrals from other departments are also honoured by Family Medicine department.

Step	Procedure	Who is responsible?	Time lag
1	Consultation	Doctors	10-30 mins
2	Presentation to the nurses'station	Nurses	5-20 mins
3	Directions to clinic referred to	Nurses / ward maids	10-30 mins
4	Presentation andreception + appointment scheduling at the clinic referred to	Nurses of the clinic referred to	20-30 mins

Patients referred to the department from other departments are also seen. They are usually seen on the day of referral except they get to the department later than 6pm. The procedure includes:

Step	Procedure	Who is responsible?	Time lag
1	Presentation at the nurses' station	Nurses	2-5 mins
2	Teller for payment for consultation	Account unit	5-20mins
3	Payment at the bank	Sterling bank	5-20 mins
4	Teller presentation and registration	Nurses	5-20 mins
5	Consultation	Doctors	10-30 mins

ISSUING MEDICAL CERTIFICATES

The protocol of procuring medical certificate of fitness include

Steps	Procedure	Who is responsible?	Time lag
1	Open folder or retrieve old folder	Medical records	30-45 mins
2	Payment for consultation fee	Accounts unit	10-30mins
3	Vitals	Nurses	10-30 mins
4	Consultation	Doctors	10-30 mins
5	Doing requested investigations	Laboratory	Hrs to days

6	Presentation with results of investigations & review	Doctor	10-30 mins
7	Issuance of medical certificate as appropriate	Doctor+ Secretary To be countersigned by the HOD.	20-90 mins

DUTY ROSTER

The duty roster for the month is done by the chief resident(for doctors) and the matron in charge (for the nurses and ward maids). The chief resident also prepares the roster for academic presentations, running of the Point of care testing side labs and call duty rosters. All rosters are placed on the notice board for every member of the department to see and soft copies are also sent to every member of the department.

REVOLVING FUND MANAGEMENT/ PROCUREMENT OF EQUIPMENT & CONSUMABLES

As outlined in the SOP for Procurement & Stores.

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

QUALITY ASSURANCE

Regular assessment of residents using qualitative and quantitative means such as mock examinations. Patients and staff satisfaction are also assessed using satisfaction questionnaires.

INFORMED CONSENT

Verbal informed consent is gotten from patients before carrying out the point of care tests while written informed consents are gotten before a procedure is carried out on the patient.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF FINANCE

NAME & SIGNATURE OF DIRECTOR OF FINANCE: *MR. PAUL L. OKPALO*
DATE: 19/11/19
SOP No: 002
PURPOSE

To establish a procedure for the book keeping function of Account preparation and Finance methods followed in the Hospital

NOTE: Work Starts by 8:00 am.All clinics and knife on skin (Surgery) starts by 9:00 am

INTRODUCTION

FUNCTIONS OF THE DEPARTMENT

1. Ensuring compliance with Financial Regulations and the Accounting code by all staff in the Department **2**. Ensuring adequate supervision of the disbursement of funds and proper monitoring and accounting for revenue. **3**. Advising the accounting officer on all financial matters as well as the more technical provisions of these Regulations and other Treasury and Finance Circulars. **4**.Maintaining proper accounting records Ensuring prompt rendition of all returns to the Consolidated Revenue Fund. **5**.Compiling and defending of the budget proposals and ensuring effective budgeting control by matching/comparing budgeted figures with actual Expenditure or revenue as the case may be and advise the Accounting Officer appropriately	The Accountable Officer**:** **Mr. Paul L. Okpalo**

Assisting the Head of Department in ensuring the carrying out of the above listed functions. Supervising the different Unit heads to create a synergy in the functions of the Department and general administration within the department.	**Mr B. F. Okatubo**

ROLES AND RESPONSIBILITIES OF VARIOUS STAFF DEPLOYED TO THE DEPARTMENT

Adequately supervising Accounts staff under their Revolving Funds as to ensure proper recording of all transactions	All Project Accountants
Compiling and preparing budget proposals in conjunction with the Head of Department	Mr Suo Atedoghu
Preparation of Salaries and allowances of all staff of the hospital in consultation with the Head of Department	Mrs F. A. Fente
1.Collation and preparation of bills for payment to staff, suppliers and contractors. **2**.Uploading of authorized and processed payments for review and final approval by the relevant officers	Mrs Y. Benebo

CASH MANAGEMENT

Not applicable as we operate a cashless system	

RECEIPT OF USER CHARGES AND ISSUE OF RECEIPTS

1.Patient approaches the Revenue clerk with request form for service required. 2. Revenue Clerk looks up the appropriate charge for service and issues a teller for payment, to the patient who pays the amount stated into the bank 3. Patient comes back with stamped bank teller and Revenue Clerk collects duplicate copy and attaches triplicate copy to request form and asks patient to	

go receive service	

DAILY WEEKLY /MONTHLY RECONCILIATION OF MONEY COLLECTED FROM PATIENTS

Duplicate copies of tellers are checked against Cash Registers for each Revenue Clerk. Reconcile Cash register of takings with bank records of transactions on a daily basis	

RECEIPT OF BILLS FROM PROCUREMENT /STORES DEPARTMENT FOR PAYMENT TO ALL SUPPLIERS AND CONTRACTORS

Bills are submitted to Stores or Procurement Department, from where they are forwarded either to the Chief Medical Director or the Project Manager of the as the case may be for approval and payment	

BANKING ACTIVITIES

Nothing significant apart from reconciliation of statements as we operate a cashless system	

HANDLING OF VOUCHERS

After necessary approval for a payment has been gotten, bill is attached to voucher and sent to Internal Audit Department to ensure that relevant approvals and regulations have been complied with and then returned for payment	

PAYMENT/ FILLING OF INCOME TAX

Payment of Income Tax deducted is done simultaneously with the payment of salaries automatically	

ACCOUNTANT PAYROLL SHEET AND PAYMENT OF SALARY ARREARS

Salaries and arrears are not paid locally. They are done centrally by IPPIS at Abuja	

PAYMENT OF STAFF SALARIES

Payments done by IPPIS	

PREPARATION OF ANNUAL ACCOUNTS

Collation / analysis of closing balances of various ledgers for accounts preparation. Drawing up a trial balance to ensure correct posting, classification and recording of transactions. Preparation of final accounts for external auditors to audit	**Accountant in charge of Final Accounts/Budgets**

BUDGET PREPARATION

Budget are prepared in accordance with the details of Call Circulars from the Budget Office of the Federation for each year. Each MDA is then required to adhere to the details stated in the Call circular	

RECORDS

Duty roster	**Project Accountant**
Day Book	
Reconciliation report	**Reconciliation of Cash Book balance and Bank statement balance**
Pay bill register	

PROCUREMENT OF EQUIPMENT & CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURE FOR GENERAL ADMINISTRATION DEPARTMENT

NAME OF DIRECTOR OF ADMINISTRATION: ***Mr. Akie Opuene Hart***
DATE: **30th July, 2018**
SOP No: 002
SOP Title: Processes involved in General Administration
PURPOSE:

The development of a descriptive documentary instrument which serves as a system for navigation of major operation of administrative department as pertains to the performance of its functions as the executioner of the management decision and policy implementation. This extends to all employees working under the purview of the hospital including both permanent and outsourced staff.

INTRODUCTION:

The SOP is a narrative instrument comprising rules, practices, protocols, guidelines and the modus operandi of administrative department.

SCOPE:

It covers all administrative procedures in the hospital including those aimed at managing the human resources development of the staff serving in the hospital in a systematic way to ensure effective utilization of resources to realize organizational goals. Keeping all correspondence to ensure the smooth running of bureaucracy of project and implementation of decisions.

THE FUNCTIONS OF ADMINISTRATIVE DEPARTMENT ARE AS FOLLOWS:

Accountable Officer (AO)	The accountable is: Mr. Akie Opuene Hart. Address: UPTH. Phone No.: 08034517960.
Functions of administrative Department	i. Policy implementation ii. Directing of staff activity iii. Formulation of methodology or mechanism on implementation of policies.

CATEGORIES OF STAFF AND THEIR FUNCTIONS:

Junior Staff	Responsible for opening, register of files, handling of mails and any other duties assigned to them from time to time.
Senior Staff	Responsible for supervising the junior ones, treat files, handling of mails and any other official duties assigned to them from time to time.
Principal Officer	Monitors and supervises both the junior and senior staff. They also treat files, handling of mails and any other official duties assigned to them from time to time.
Management Staff	Responsible for decision making, planning, directing, coordinating and monitoring the duties of staff.

CONTRACT/OUTSOURCING:

Contract job	If a temporary job and terms are stated in the contract document.
Outsourcing	To outsource means to give certain job to external body for a period of time.

LOAN INTRODUCTION:

Loan Introduction	This is an avenue to help staff financially.
Procedure	i. Application of loan introduction be written by an interested staff. ii. The Management gives a letter of loan introduction to the interested staff. iii. The Bank gives a loan application form to be filled.

MANPOWER PLANNING/ RECRUITMENT:

Man-Power Planning	This is an attempt to forecast how many and what kind of staff should be engaged in the future. And what extends this demand is likely to be met. ManpowerPlanning helps the management in making decisions in the following areas: i. Recruitment ii. Avoidance of redundancies iii. Training etc.
Recruitment/selection	PSR 020201 states that recruitment is the filling of vacancies by the appointment of persons not already in the Civil Service of the Federal Republic OF Nigeria. Selection is assessing the candidate by various means and making a choice followed by an offer of employment.

PROCEDURE:

Junior Staff Recruitment	According to PSR 020103 appointment to junior post shall be conducted by junior staff committee.
Other Forms of Recruitment.	i. Advertisement ii. application iii. Examination iv. interview

STAFF REPLACEMENT:

Staff Replacement	Staff replacement is the existence of vacancy in the department/units within the organization due to retirement, sack, transfer etc. Hence, a staff is appointed to occupy the vacant post.

PROMOTION/APPOINTMENT:

Promotion	This is a move of an employee to job within the company which has greater importance and usually higher pay. This is done as at and when due subject to availability of vacancy and possession of requisite qualification in the scheme of service and approved manpower project.
Types of Appointment	The following appointment are given: i. Direct Appointment ii. Trainee iii. Appointment on probation in a pensionable post. iv. Acting Appointment.

EVALUATION:

Evaluation	This is to ascertain the capability and efficiency of staff in performing duties assigned to them. It also x-rays their attitude to work. It serves as a medium for promotion.
Procedure	APER. This is done by the various head of units/departments.

INDUCTION/ORIENTATION PROGRAMME FOR NEWLY EMPLOYED PERSONNEL:

Induction/orientation	This is a period of familiarizing the newly employed with the working environment. It is also a way of giving them knowledge of how things are done in the organization.
Process	It is done by those assigned. However, it has not been recently done in UPTH.

INFORMATION ON TERMS OF EMPLOYMENT:

terms of employment	PSR 020202 states the type of employment: i. Direct employment. ii. Trainee. iii. On probation in a pensionable post iv. On non-pensionable contract to a non-pensionable post for a specified period. v. Acting appointment.
Process	i. Advertisement ii. Application iii. Examination iv. Interview

PREPARATION OF CONFIDENTIAL REPORT FOR PERMANENT STAFF:

Process	Done through the APER forms and their assessment. This is to issue APER forms to staff to fill.

DISCIPLINARY ACTION:

Misconduct	PSR030301 clearly stated that misconduct is an act of wrong doing or an improper behavior which is inimical to the image of the service. There could be misconduct and serious misconduct. Examples of misconducts are: i. Immoral behavior ii. Foul language iii. Battery iv. Negligence v. Dishonesty vi. Insubordination vii. Lateness etc.

Serious Misconduct	Serious misconduct PSR030401 states that serious misconduct is a specific act of very serious wrong doing and improper behavior. Example are: i. Falsification of records ii. Suppression of records iii. Withholding of files iv. Conviction on criminal charge v. Absence from duty without leave vi. Corruption vii. Bribery viii. Engaging in partisan political activities ix. Misappropriation etc.
Process	a.) Notify the officer b.) Investigate the matter c.) Giving access to exculpate himself d.) Panel of enquiry e.) Report of the enquiry to be sent to commission f.) suspension g.) Deferment of salary h.) Dismissal. See PSR 030305, 030403

STAFF FILE MOVEMENT:

Staff File Movement	This is within 48 hours.
Process	Registration of file by clerks and signing for it.

STAFF APPLICATION ROUTING:

Staff Application Routing	This is through individual staff's HOD to higher authority.
process	To be routed properly or accordingly.

STAFF MAIL MOVEMENT:

Staff Mail Movement	This is within 48 hours.
Process	Files are treated in 48 hours

ANNUAL MEDICAL CHECK-UP AND VACCINATION FOR STAFF:

Annual medical check-up and vaccination for staff:	This is done periodically.

TYPES OF AWARDS/REWARDS FOR STAFF:

Awards/Rewards for Staff	Awards are given to motivate staff. PSR150102 clearly stated that the recipient of such awards must be considered the best on basis of outstanding performance.
Types of Awards	The types of awards are; i. Certificate. ii. Medals. iii. Gifts of cash or kind. Besides an officer who has served for a minimum of 15, 25 and 35 years with a good record of service could be given a certificate of merit.
Procedure	The CMD inaugurate a committee to handle the selection of deserving officers from nomination list.

STAFF PERSONAL RECORDS:

Staff Personal Records	Records must be completed accordingly and not to be tampered with.

STAFF PENSION MANAGEMENT:

Staff Pension Management	Retired staff is properly taken care of by the pension fund administrators (PFA) as established by the Federal Government.
Process	Staff must go for verification and letters of

	retirement issued as at and when due after assessment

TRAINING ASSESSMENT:

Training	This is concern with a deliberate and systematic way to develop and improve a capacity profile; a pattern of skill, knowledge and attitude required by an individual to accomplish a task. It is one of the functions of administrative department. Training are done as at and when due subject to availability of funds. Assessment of training needs are done as at and when due.
Types of Training	i. Induction ii. Career Development iii. On-The-Job Training iv. Departmental Training etc.

STAFF PENSION MANAGEMENT:

Staff Pension Management	Retired staff is properly taken care of by the pension fund administrators (PFA).
Process	Staff must go for verification and letters of retirement issued as at and when due after assessment.

STAFF DISMISSAL:

Staff Dismissal	In line with PSR 030407 the ultimate penalty for serious misconduct is dismissal. An officer who is dismissed forfeits all his claims to retiring benefits.
Process	i. Notify officer by writing. ii. Investigate the issue. iii. Panel of enquiring. iv. Reports of enquiring to the commission. v. A decision is taken.

DEATH OF STAFF:

Death of staff	PSR 070402 States that when a pensionable officer dies it is the duty of the management to provide the following
Procedure	(1) cost of burial expenses including; preparation of the body, settlement of the mortuary bills and provision of coffin/casket subject to the maximum amount; (a) GL01-06 #100,000.00 (b) GL07-14 #200,000.00 (C) GL15-17 #300,000.00 (d) Consolidated #500.000.00 (2) Payment to the family of the deceased cost of one full page advertisement in one National News Paper for the publication of obituary at prevailing rates. (3) Transportation of the corpse to the officer’s home at reasonable cost. Entitlement due to dead staff are supposed to be paid to his or her next of kin.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF HAEMATOLOGY & BLOOD TRANSFUSION

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *DR. KALADADA KORUBO*
DATE: 12TH July 2018
SOP No: 002
NOTE: Work starts at 8am. Clinics start at 9am.

1. PURPOSE:

To establish guidelines for;

1. Sample collection and processing for in the department of haematology and blood transfusion.
2. Requests for Blood transfusion/ blood banking
3. Running of Haematology Clinics, Day care, ward rounds and responding to clinical consultations

2. INTRODUCTION

The department of haematology and blood transfusion offers laboratory, blood banking and clinical services. The laboratory services involve the processing and running of samples for various haematological investigations while the blood bank is involved in safe blood donation, blood banking and dispatch of blood for transfusion. Clinical services on the other hand involves the care of patients with diverse haematological conditions both as outpatients and in the wards.

3. SCOPE

3.1 SECTION A: HAEMATOLOGY INVESTIGATIONS

The scope of investigations and services offered by the department of haematology include;

INVESTIGATION	SAMPLE BOTTLE	T.A.T.	RESPONSIBILITY
1. **Routine Haematology**			
a. Packed cell volume	EDTA	1 Hour	MLS
b. Full blood count i. Red cell count	EDTA	24 Hours	MLS

ii. Haemoglobin concentration			
iii. Packed cell volume			
iv. Red cell indices (mean cell volume-MCV; mean cell haemoglobin- MCH; mean corpuscular haemoglobin concentration- MCHC, red cell distribution width- RDW)			
v. White cell count (total)			
vi. Differential white cell count			
vii. Platelet count			
viii. Reticulocyte count			
c. Peripheral Blood Film (PBF)	EDTA	72 Hours	Doctors
d. Erythrocyte sedimentation rate (ESR)	EDTA	24 Hours	MLS
e. Haemoglobin electrophoresis (genotype)	EDTA	48 Hours	MLS
2. **Coagulation**			
a. Clotting time	Serum	24 Hours	MLS
b. Prothrombin Time (PT)	Sodium Citrate	72 Hrs (Manual) 24 Hrs (Automated)	*MLS- (Manual) *Doctors (Auto-mated)
c. Activated partial thromboplastin time (APTT)			
3. HIV Lab/ Research			
a. HIV	Serum	24 Hours	MLS
b. CD4 Count	EDTA	48 Hours	MLS
c. Hepatitis B (HBsAg)	Serum	24 Hours	MLS
d. Hepatitis C (HCV)	Serum	24 Hours	MLS

e. Syphillis (VDRL)	Serum	24 Hours	MLS
4. Specialized Tests/ Procedures			
a. Bone marrow aspiration	N/A	72 Hours	Doctors
b. Bone marrow trephine biopsy	N/A	(*Histopathology)	Doctors

TAT- Turnaround time; MLS- Medical Laboratory Scientists

3.2 SECTION B: BLOOD BANKING

1. INVESTIGATIONS	SAMPLE BOTTLE	TAT	RESPONSIBILITIES
a. Blood grouping	EDTA	1 Hour	*MLS *Resident Doctors (on Tuesdays & 3rd Weekends of the month)
b. Packed cell volume	EDTA	1 Hour	
c. Screening- HIV, HBsAG, HCV, VDRL	Serum	3 Hours	
d. Full Crossmatch	EDTA & Serum	3 Hours	
e. Direct antiglobulin test	EDTA & Serum	24 Hours	
f. Antibody screening	EDTA & Serum	24 Hours	
2. Blood banking/ storage	Blood Bags	30 Days (Storage)	
3. Blood dispatch	N/A	When required	
4. Blood Component Therapy • Apheresis platelets • Platelet rich plasma • Fresh plasma	Blood Bags	Same day (On Request)	Resident Doctors

3.3 SECTION C: CLINICAL HAEMATOLOGY

SECTION	SCHEDULE	RESPONSIBILITIES
1. Day care	Mon-Friday	Doctors

	8AM – 4PM	
2. Haematology Clinic	Thursdays 8AM – 4 PM	Doctors
3. Ward rounds	Mondays 10AM (Consultants) Tuesday – Friday 10AM (Residents)	Doctors
4. Accident and Emergency	*As required*	Doctors
5. Clinical Consultations/ Referrals	*As required*	Doctors
6. Daily Ward Cover/ On Call	Daily Weekdays 4PM – 8AM Weekends 8AM – 8AM Next day	Doctors

4. PROCEDURES

4.1 PROCEDURES FOR LABORATORY INVESTIGATIONS

1. Ordering for a test begins with filling out a laboratory request form by the doctor of the patient. These request forms must be correctly filled out to include- name, age, sex, hospital number, managing consultant, preliminary diagnosis, date of request, etc.
2. All *full blood count* requiring *peripheral blood film report* must be clearly stated on the form which should be written as "BLOOD FILM- ATTENTION HAEMATOLOGIST".
3. The patient/ relative brings the request form to the CENTRAL SAMPLES COLLECTION UNIT- ACCOUNTS SECTION, where the tests/ procedures ordered will be costed.
4. Payment must be made before any procedure can be carried out.
5. Patients covered by NHIS must present the NHIS cover paper before they can be attended to.
6. The respective sample bottle for each test will be given based on ordered tests.
7. Samples in the laboratory are received in 2 ways
    a. Patients come directly to the CENTRAL SAMPLES COLLECTION UNIT for sample collection

b. Samples are collected in the wards/ clinics and transported to the CENTRAL SAMPLES COLLECTION UNIT.
   i. All samples should reach the laboratory within one hour maximum after collection. On no account should samples that have stayed overnight in the wards be sent for analysis as these yields wrong results due to denaturing of cells.
   ii. Samples should be collected in a manner to prevent clot formation during the process of collection as this can yield errors in analysis.
   iii. *Note that samples collected with accompanying improperly filled forms may be rejected.*

8. Samples should be submitted to the CENTRAL SAMPLES COLLECTION UNIT in the appropriate specimen bottles *(see 3.1 and 3.2 above)*.
9. A copy of the teller/receipt containing a laboratory number will be given to the person submitting the sample as this is required for collection of result (time of collection will be made known for each test requested).
10. Samples are run respectively based on the requests.
11. Bone Marrow Aspiration/ Trephine Biopsy
    a. Patients who require a bone marrow aspiration or trephine biopsy after payment either come to the Day care for the procedure (on outpatient basis); or the haematologists perform the procedure in the wards (if patients is on admission).
    b. Bone marrow aspirates are reported by the haematologists.
    c. The bone marrow core biopsy sample will be transferred to the histopathologists for their own tissue processing and report.
12. The patient/ relative returns to the CENTRAL SAMPLES COLLECTION UNIT to collect the reports of the ordered tests at the expected turnaround time.
13. Blood samples are usually discarded within 3 – 5 days as haematology tests are best run on fresh samples.
14. All records of results will be documented in the different departmental ledgers as applied.
15. All laboratory records are strictly confidential.

4.2 PROCEDURES FOR BLOOD BANK

1. A request for blood grouping and crossmatch is made by the doctor.
2. Payment is made just as 4.1 above.
3. Donor interview and counselling will be performed for each prospective donor.
4. Samples are collected from both the patient and the prospective donor.
5. Initial testing will be assessment of donor's sample for PCV and blood group compatibility.
6. Both donor and patient will be screened for HIV, HBsAg, HCV and VDRL.
7. A compatibility test (full crossmatch) will be carried out.
8. Donors that satisfy all criteria will be bled.
9. Blood collected from the donor will be properly labelled, given a blood bag number and registered and a blood slip of this record will be given to the patient/ relative.
10. At the time of transfusion, the doctor brings the blood slip to the blood bank to collect the blood for the patient (dispatch).
11. To avoid blood wastage, the blood bank operates a first-in, first-out policy.
12. In the event that blood components/ products are requested, steps 1-8 will be carried out.
    a. If apheresis is to be performed on the donor, this will be done in the Haematology Day care by the resident doctors.
    b. If cold centrifuge is to be used to prepare the blood components, this will be done at the resident's laboratory after bleeding the prospective donors.
13. If a patient does not have a donor, blood can be sourced for from the zonal blood transfusion centre (Military Hospital). HOWEVER, EACH UNIT SOURCED FROM OUTSIDE WILL STILL UNDERGO THE SAME PROCESSES OF STEPS 5 – 7 and 9 – 11 above.

4.3 PROCEDURES FOR CLINICAL HAEMATOLOGY

Patients must open a hospital folder at the records department before they can be seen or reviewed by doctors.

A. Presentation via Accident & Emergency (A&E)

1. Emergency cases usually present through the Accident and Emergency.
2. Consults when received will be immediately attended to by the doctor on call. Further review will be done during ward rounds by both residents and consultants.

3. Patients from the A&E are then transferred to the Medical Wards for further care.
4. Discharge of patients from the ward is done as required, based on patient's clinical condition.
5. Follow up visits after discharge is during the Thursday Haematology Clinics.

B. Presentation via Haematology Clinic

1. Patients come to the clinic on referrals from other clinics or the general outpatient department.
2. Clinic days are Thursdays, patients are reviewed by the haematologists.
3. Any patient requiring admission will be admitted into the medical ward.
4. Follow up appointments are given on an individual basis.

C. Presentation via Day care

1. Already registered haematology patients who require Day care services access the Day care between 8am to 4pm on Mondays – Fridays (excluding Public Holidays).
2. Day care services include; rehydration and pain relief for sickle cell anaemia patients, chemotherapy for patients with haematological malignancies, blood transfusion, bone marrow aspiration and trephine biopsy procedures, management of haematological disorders in patients who are clinically stable and do not require admission.
3. In the event that a patient is not clinically fit to be handled in the Daycare or to go home at the time of work closing, the patient will be transferred to the A&E or the Wards.

D. Ward Rounds

1. Ward rounds are done for the in-patient care of those on admission.
2. Consultant ward rounds take place on Mondays.
3. Residents do daily ward rounds within the week on Tuesdays- Fridays.
4. Consults written to haematologists will be attended to in a timely manner.
5. A resident doctor is on call daily (from 4PM – 8AM on Weekdays, and 8AM – 8AM next day on weekends) to attend to patients in the ward or A/E, and to respond to consults sent in by other clinical departments.

4.3 SOP FOR BLOOD TRANSFUSION

1. RESPONSIBILITY OF THE DOCTOR

i. Takes the decision to transfuse patient.
ii. Informs/counsels patients on benefits/risks of blood transfusion.
iii. Fills out blood transfusion form; gives clear directives to lab stating the indication, urgency, number of units required, name of doctor and Consultant in charge.
iv. Ensures that 100mg of hydrocortisone and 50 mg of promethazine are prescribed and available.
v. When blood is ready, doctor sends for it, cross checks to make sure it's for the patient then warms it up for 10-15 minutes under running tap water then transfuses within 30 minutes-1hour or return it to the blood bank not later than 1 hour after collection if transfusion is deferred for any reason.
vi. Doctor further counsels and obtains informed written consent from patient.
vii. Doctor sets up the blood, writes Transfusion Order (should include time of onset of transfusion, type of blood products to be transfused, how long it will last, what the nurses should do in the event of a transfusion reaction etc).
viii. Doctor should be within reach of the patient in the first 30 minutes to handle possible immediate transfusion reactions.
ix. Doctor should from time to time review the patient and document his transfusion experience

2. RESPONSIBILITY OF THE LABORATORY

i. On receiving the blood sample, the lab attendants will liaise with the patient's relative to get required blood product.
ii. The attendant follows the instructions on the request form and provides required blood product.
iii. The attendant informs the requesting ward when the blood is ready and ensures that it dispenses the right blood product when the nurse or ward assistant comes to fetch it. It is not the responsibility of the patient's relatives to take the blood to the ward.

3. RESPONSIBILITY OF THE NURSE

i. Nurse counsels patients on blood transfusion.
ii. Nurse informs the doctor that blood is ready and on the doctor's request, she or the ward assistant goes to the lab to collect the blood.
iii. She follows the Transfusion Order and monitors the blood from the beginning to the end. She calls the attention of a doctor if she suspects an adverse reaction.
iv. Counsels patient at the end of the transfusion
v. She ensures that the empty blood bag is not discarded until 12 hours after transfusion.

4. RESPONSIBILITY OF THE PATIENT

i. The patient's relatives transport the blood sample to the blood bank.
ii. The relatives liaise with the lab to provide the required blood product.
iii. Patient and his relatives should co-operate with the medical team to ensure blood is made available for a timely, smooth and risk-free transfusion.
iv. in emergency situations/indigent patients, the doctor could make arrangements for the provision of blood.

ACCREDITATION

Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS & CONSUMABLES

As outlined in the SOP for Procurement & Stores.

SOP Prepared by;

UPTH STANDARD OPERATING PROCEDURE FOR INFORMATION AND COMMUNICATION TECHNOLOGY UNIT

NAME & SIGNATURE OF HEAD OF UNIT: ***MR OJU OGOLO***
DATE: 14/8/18
SOP No: 002
NOTE: Work Starts by 8:00 am.
INTRODUCTION

The Information and Communication Technology unit of UPTH is setup to handle all ICT infrastructures and every other information and communication technology related investment made by Federal Government through the Federal Ministry of Health and implemented by the Nigerian Communication Commission.

SCOPE OF JOB IN THE INFORMATION AND COMMUNICATION TECHNOLOGY UNIT

The Hospital Information and Communication Technology unit is responsible for the following:

1. To handle the building and updating of the Hospital website
2. Administration of the hospital network
3. Carry out basic computer training/ workshop for members of staff
4. Carry out maintenance / repairs of all I.C.T. equipments and infrastructural facilities within the Hospital
5. Identification of specification and configuration of system required for various job description and specialization.
6. Implementation and running of all hospital-based software management systems
7. Spearheading the implementation and running of the Hospital digitization process which includes (digital file room, digital records system).

FUNCTION OF THE I.C.T. DEPARTMENT

1. Organize a planned routine systems inspection, making recommendations based on current system status and also reducing systems down time.
2. Organize maintenance/ repairs services for all computers within the hospital.

3. Administration of all Networks used in the hospital
4. Administration/ reactivation of all hospital phone lines.
5. Manage all deployed I.C.T. gadgets within the Hospital.

STAFF RESPONSIBILITY IN THE I.C.T. UNIT

Currently there are just two (2) personnel running the hospital I.C.T. unit in the Hospital which is grossly inadequate for an I.C.T. unit of a highly esteemed establishment to function optimally.

1. **Mr.OjuOgolo**

- ➢ Responsible for the running of the hospital server room and smart class room
- ➢ In-charge of the Hospital NCC-E Health network platform and its administration
- ➢ Organizing basic computer training for staff/ webinar services
- ➢ In charge of all maintenance and repairs of computers and other ICT gadgets within the hospital.

2. **Mr. Tari Roman Jackson**

- ❖ Website designer in charge of building and updating the Hospital website
- ❖ Running security programme on the Hospital website
- ❖ Organizes basic computer training for staff within the Hospital.

COMMERCIALIZATION / BILLING PROCESS FOR I.C.T. SERVICES

1. All funds to be realized from the I.C.T. services should be paid into an account recommended by the Hospital management.
2. All funds for specific service delivery to be rendered should be paid to the officer who is supposed to execute the job.
3. I suggest that all staff who requested for training in I.C.T. related topics must give their consent to direct withdrawing of fund from the IPPIS platform.

STAFF STRENGTH OF THE UNIT

Currently, the I.C.T. unit is short staffed as a result its impact might not really be felt that much but there is need to incorporate the services of

1. A Network Administrator
2. Programmer
3. A Database Manager
4. Information Security Expert
5. Other technicians/I.C.T. support staff.

PROCEDURES FOR APPLICATION FOR I.C.T. MATTERS

- All computer purchase, maintenance and repairs application should pass through the I.C.T. unit for proper advice because we have experienced instances where computer purchase is done directly with vendors, after the supply has been made, we at the I.C.T.unit will now be called upon to conduct installation and configurations which for us at the I.C.T. unit is totally wrong but we still respond accordingly.
- There are also several instances where defective and sometimes obsolete device that does not meet required specification in our work environment are also procured.

CONFIDENTIALITY / SECURITY

1. The hospital Networks access codes should be known to only members approved by management
2. Members in the I.C.T. unit are solely responsible for the smooth running of all Job description within their jurisdiction.

RECOMMENDATIONS

1. Much attention should be given to the UPTH I.C.T. unit to strengthen it
2. Since I.C.T. is the direction the world is moving to, so I.C.T. projects should be implemented for advancement of the Hospital as soon as it is possible.
3. All schools runned by the Hospital Management benefitting or using the I.C.T. unit infrastructure should be paying a particular sum of money for use by the I.C.T. unit to maintain the I.C.T. infrastructure

within the hospital and such fund can be deducted from whatever percentage of money the students are paying for I.C.T. services to the schools.

4. Since the hospital is a nonprofit making establishment, we can request for price slashing of services from vendors we partner with in I.C.T. projects externally.
5. We can also partner with multi-national companies like Agip, Elf, NDDC, Total e.t.c. for public private partnership and branding such project with sponsors name on it.

PROCUREMENT OF EQUIPMENT & CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF INTERNAL MEDICINE
UNIT: HEMODIALYSIS

NAME & SIGNATURE OF HEAD OF UNIT: *DR. R. I. OKO-JAJA*
DATE: 19TH JULY, 2018
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am.

PROCESSES AND PROCEDURES INVOLVED IN OUT-PATIENT CARE

(i) Clerking of Patients in MOP Clinic and Renal Clinic, as well as prior to every hemodialysis procedure – conducted by Renal Unit House Officer or Registrar, or rarely Unit Senior Registrar
(ii) Clinical Review of Patients in Out-Patient Clinics, culminating in Review of current drug prescriptions and further clinical laboratory investigations/requests (if indicated)
(iii) Education and Counselling (including Psychological Support) of Patients, as relating to illness
(iv) Scheduling of next clinic appointment.

Each process/procedure as outlined above will be conducted by the consulting/attending doctor/physician, but may be subsequently reviewed by a senior colleague.

INVOLVEMENT IN EMERGENCY CARE

Every physician member of the Unit is involved in attending to patients who present in the Accident and Emergency Department on dedicated call-duty days/periods.
The Unit's first-on-call is usually the Registrar and House Officer working as a 2-man team. This method permits the relatively inexperienced House Officer to play active roles in support of the Unit Registrar who has the main responsibility in the care of ill patients at first contact with the Unit.
The Registrar (and the House Officer) clerk the ill patient and institute immediate resuscitative measures.
However, this is not always the case: in the case of a severely-ill patient, the Unit's Senior Registrar may be drafted to "see first".

The Unit's Senior Registrar is soon called up by the Registrar to (join in the care of the ill patient) review the entire clinical processes already undertaken/performed by the Registrar. This clinical review is

comprehensive and covers the clerking, clinical examination, formulation of differential diagnoses, the admitting diagnosis (or a summary of clinical problems) and review of laboratory investigations and drug prescription.

Patient may be discharged home, or temporarily admitted into the Accident & Emergency Department by the Unit's Senior Registrar, awaiting review by the Unit Consultant. The Unit Consultant subsequently reviews.

All admitted patients are encouraged to be admitted into the appropriate medical wards within 36 hours. Management of patient's ill-health continues while on the ward.

ADMISSION INTO WARDS

The decision to admit into the wards is made by the Unit Consultant, and sometimes by the Unit Senior Registrar (with the knowledge and permission of the Unit Consultant).

DISCHARGE PROTOCOL

Patient discharge from the wards follows satisfactory improvement of patient's wellbeing with treatment.

Decision to discharge an admitted from the ward is the prerogative of the Unit Consultant. The discharge is usually supervised by the Senior Registrar.

Discharge summaries and drug prescription(s) at discharges are written by Unit House Officer closely supervised by the Unit Registrar. An outpatient clinic appointment (date) is chosen and communicated to patient.

The House Officer submits the patient's case file to the Ward Matron/Head Nurse for administrative processing of the discharge.

PATIENT SAMPLE COLLECTION

All patients' samples are considered as infective. (Every sample collection requires strict observance of strict procedures or protocols). Therefore, optimal precautionary measures must be undertaken by all attending doctors.

Patient sample collection is supervised by the Senior Registrar or/and Registrar.

Generally, collection of samples is carried out by the House Officer and Registrar in the Unit.

In the case of a difficult-to-collect sample, the Unit Consultant (or Senior Registrar) performs the sample collecting procedure, watched and supported by his/her junior colleagues.

Collected samples are promptly/immediately submitted to the appropriate laboratories for processing.

RELEASE OF LABORATORY AND IMAGING RESULTS

This is governed by rules set out by the specific laboratory.

The laboratory results are signed out to the Unit House Officer by the individual laboratories.

ISSUING OF MEDICAL REPORTS

This is governed by the rules prescribed by the Hospital Management.

A medical report is usually written and signed by any member of the Unit, for and on behalf the Unit Consultant.

POLICY TOWARDS NHIS PATIENTS

Hemodialysis service in UPTH operates on a "cash-and-carry" basis. Hence, most patients requiring hemodialysis were in the past unsuccessful in accessing hemodialysis care, except for a few who had made a financial deposit to cover their treatment costs.

REFERRALS

Referrals are made to other specialist clinical units, as routine in appropriate cases within UPTH.

Referrals to outside centres are in cases of kidney organ transplant (a service we are not offering), or in cases of those requiring hemodialysis care when our machine are dysfunctional (such as this present time).

THE HEMODIALYSIS PROCEDURE

This is a complex clinical procedure employing biophysical processes to effect dialysis of blood under aseptic conditions.

In a simple description, blood in the human body is from a low-pressure large-caliber vessel (a vein) into an initial large bore tubing which leads into a system of small calibertubing (arranged in a canister called the Dialyzer)such that the direction of blood flow is against the direction of flow of the dialysate.

This simulates the "counter-current flow mechanism" which operates in the natural human kidney. (The blood is anticoagulated as it leaves the human body into the tubing).

The hemodialysis procedure is conducted under a strict set of guidelines so as to minimize or completely prevent injury to the patient. A hemodialysis prescription made after an initial clerking and clinical examination is closely adhered to.

RESPONSIBILITIES OF SPECIFIC CATEGORIES OF STAFF IN THE UNIT

(i) Doctors:

The Unit's doctors attend to the patient at presentation at the Renal Clinic/Hemodialysis Unit. They (House Officer, Registrar and sometimes the Senior Registrar conducts the clerking and clinical examination and makes a diagnosis (with all identified clinical complications). A hemodialysis prescription is then made.

Patient is subsequently prepared, cannulated and connected to the hemodialysis machine.

The machine (sterilized at a previous time or date) is primed and appropriately calibrated. The blood and dialysate flow rates are adjusted then reviewed at appropriate time intervals in order to achieve set objectives.

Other responsibilities are as detailed in the Head of Department's submission.

(ii) Nurses: The nurses in the Unit are made of Specialist Dialysis Nurses and General-Duty Nurses. The nurse cares for the patient whether on the wards on admission, or during hemodialysis.

REVOLVING FUND MANAGEMENT & PROCUREMENT OF CONSUMABLES

As outlined in the SOP for Procurement & Stores.

ACCREDITATION PROTOCOL

Please refer to SOP for CS & T.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF INTERNAL MEDICINE

HEAD OF DEPARTMENT: ***DR. PC EMEM-CHIOMA***
PREPARED BY: ***DR. EMMANUEL OBAZEE***
DATE: 13/9/18
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am.

INTRODUCTION (PREAMBLE)

The department of Internal Medicine is one of the major clinical services and training departments in the hospital. It is generally acknowledged for the quality of service and training it renders.

The Department gained its first full accreditation in 1987 for the training of resident doctors; between 1987 and 2017 the department has trained a lot of house officers, and resident doctors.

The postgraduate programs are accredited by the West African College of Physicians and National Postgraduate Medical College of Nigeria. The success of the accreditation exercise is a prerequisite in achieving the global mission and vision of the department in developing subspecialty internal Medicine practice to globally comparable standards, thus putting the hospital on the global map as a regional and national centre for excellence.

MEDICAL OUT PATIENT CLINIC (MOPC)

The MOPC is the point of care where new patients refer from within and outside the department of Internal Medicine are seen. It is also an avenue to follow-up patient discharged from the medical ward after been assessed stable by managing consultant.

MEDICAL OUT PATIENT ACTIVITIES

S/N	ACTIVITY	RESPONSIBLE PERSON	TIME LAG
1.	Opening of patient folder	Medical Record	30 mins
2.	Assessing patient vital sign	Nurses	10 mins
3.	Distribution of patient folder to specific specialty	Nurses	Immediately after vital sign assessment

4.	Patients are required to wait to see their specific doctor (Specialty)	Nurses	30 min
5.	Consultation with the patient	Consultant/ Senior Registrar/Junior Registrar	45 mins
6.	Patient is given next appointment at the end of consultation.	Medical doctor in charge	Immediately

MEDICAL EMERGENCY

The department of Internal Medicine operates a 24 hours emergency service by a dedicated medicine team on call headed by a consultant who manages all medical emergency irrespective of he's specialty.

Patient is however referred to specific specialty at the end of the 24 hours call for specialty care/ management.

EMERGENCY ACTIVITY

S/N	ACTIVITY	RESPONSIBLE PERSON	TIME LAG
1.	Opening of folder	Medicine record	5mins
2.	Vital sign assessment	Nursing	10mins
3.	Commencement of emergency treatment	Medical team on call	Immediately
4.	Refer to specific specialty	Medical team on call	End of call period
5.	Admission into medical ward	Medical team on call	As soon as patient pays admission deposit and availability of bed space.

INPATIENT WARD ROUND

Patient admitted into medical wards are seen every day by respective specialty, also during weekend by medical team on call.

The team comprises of the unit consultant, Senior Registrar, Junior Registrar, Unit house Officer and the Ward Nurses.

ACTIVITIES DURING MEDICAL WARD ROUND

S/N	ACTIVITY	RESPONSIBLE PERSON	TIME LAG
1.	Provision of patient folder	Nurses	
2.	Provision of result, continuation sheets	Nurses	During ward round
3.	Pre-consultant ward round	Senior Registrar/ Junior Registrar	20 mins per patient
4.	Consultant ward round	Unit Consultant	20 mins per patient

SIDE LABORATORY

The medical teams have a side laboratory where urgent simple investigations are done.

The side laboratory is within the medical ward for easy access.

SIDE LABORATORY ACTIVITY

S/N	INVESTIGATION	RESPONSIBLE PERSON	TIME LAG
1.	FAST/ RANDOM BLOOD GLUCOSE	MANAGING TEAM	10 mins
2.	URINALYSIS	MANAGING TEAM	10 mins
3.	FASTING LIPID PROFILE	MANAGING TEAM	10 mins
	ECG	MANAGING TEAM	20 mins
5	GLYCOSYLATED HAEMOGLOBIN	MANAGING TEAM	10 mins
6	LUNG FUNCTION TEST	RESPIRATORY UNIT.	30 mins

DICHARGE PROTOCOL

A patient is discharged from the medical ward when he/ she is stable and are recorded fit for discharged by the managing consultant. A discharged summary of treatment is written by the unit senior Registrar, vetted by the unit consultant who signed the discharged form before patient is allowed home to be seen in the medical out-patient clinic.

DEATH OF PATIENT

S/N	ACTIVITY	RESPONSIBLE PERSON	TIME LAG
1.	The death of the patient is confirmed and certified after resuscitation	Managing unit or the medical unit on call	30mins
2.	Following death certification, the relative is notified immediately and cause of death explained to the relative	Managing unit or medical unit on call	10mins
3.	Death occurring within 24 hours of presentation in the accident and emergency or admission into the ward should be treated as corona case. The head of department should be aware of such case and autopsy requested to know the possible cause of death.	Managing unit	As soon as possible
4.	Following confirmation of death by the medical team on call or primary managing unit, the nurse on duty is instructed to prepare the corpse to be transferred to the mortuary.	Managing unit or medical unit on call	10min
5.	The death Certificate is given to the next of kin with a proof of identification.	Managing unit/medical records	As soon as next of kin make request

REVOLVING FUND MANAGEMENT & PROCUREMENT OF CONSUMABLES

As outlined in the SOP for Procurement & Stores.

ACCREDITATION PROTOCOL

Please refer to SOP for CS & T.

PROPOSED UPTH STANDARD OPERATING PROCEDURE FOR INTRAMURAL PRACTICE

BY DR OBIANMA N. ONYA (DCMAC (NHIS/SERVICOM)
DATE: 19/09/18
SOP No: 002

PURPOSE:

To establish guidelines for intramural private practice for medical and dental Consultants within the service of UPTH using the hospital facilities on the basis of an income-sharing arrangement.

INTRODUCTION

As outlined above.

SCOPE

Processes/procedures involved in a**ccessing outpatient care**, **emergency care**, laboratory/imaging services and **referrals** (whichever is applicable). This would be done on the basis of an MOU between the Hospital management and the medical and dental Consultants in UPTH employ, duly registered to administer private service within the confines of the hospital.

DEFINITION

Registered Intramural Care Provider:

A Consultant staff of UPTH who purchases an Intramural Care Provider Registration Form, signs an MOU with UPTH and is issued an identification card with his name, photograph, phone number and code on it.

Care Co-ordinator:

The registered Family Physician who co-ordinates the care of the patient

Referring Doctor:

A registered Consultant who refers his private patient to another Consultant for expert management under the intramural arrangement. The

referring Doctor could also be the Care Co-ordinator or the Admitting Doctor

Admitting Doctor:

A registered Consultant who is directly responsible for the management of the client on either outpatient or inpatient basis (or both) the client; could be the Care Co-ordinator.

Co-Care Doctor:

Refers to another Consultant whose expertise is subsequently sought mainly by the admitting doctor or with his consent, by the Care Co-ordinator for the effective and comprehensive management of an index patient.

RESPONSIBILITIES

Care Co-ordinator:

1. Verifies that patient has paid the necessary bills and obtained the PINK FOLDER.
2. Contacts the Admitting Doctor to notify about the presence of the private patient, and clarify (if necessary) the management plan for the patient.
3. Interphases with the Admitting Doctor to ensures patient promptly receives prescribed services
4. Co-ordinates the billing process
5. Makes input into patient management as may be required. This should be done in consonance with the Admitting Doctor who is primarily responsible for managing the patient.
6. Generally co-ordinates patient management including referrals (where necessary).
7. Manages patients (Consultations/procedures) when requested to.
8. Gives feedback to the Referring Doctor on Request.

Referring Doctor:

1. Links the patient to the Admitting Doctor (through Care Co-ordinator)
2. Refers patient to labs/imaging/pharmacy & other registered Consultants (as appropriate) through the Care Co-ordinator.

3. Gets feedback from the Admitting Doctor through the Care Co-ordinator.

<u>**Admitting Doctor**</u>:

1. Ensures Care Co-ordinator is informed.
2. Informs referring doctor about his decision to admit.
3. Manages the patient on admission.
4. May seek the expert services of yet another Consultant through the "Care Co-ordinator" (if different from the "Admitting Doctor" (consultation/procedure). The Care Co-ordinator should be informed.

<u>**Dedicated Accounts and Records Staff**</u>**:**

Domiciled in the same place. Dedicated computers with relevant software should be made available to bill patients, issue receipts and PINK FOLDERS and keep relevant records. POS should be made available, and generated print outs should serve as evidence of payment (deposit) for services to be accessed. A dedicated ward maid may be inundated with the task of ensuring that services paid for are obtained. There should also be a mechanism for verifying the print-out at the point of service.

Outlets will be at:

1. Family Medicine Department
2. Paediatrics
3. Accident and Emergency
4. Dental Centre

<u>**Dedicated nurses**</u>:

To promptly and politely attend to patients and accompany them to the various places they are referred to so as to ensure services are fast-tracked.

<u>**Dedicated Trained Maids:**</u>

Run errands such as collecting sample bottles, retrieve investigation results, carry folders around, undertake pay-point services when patient presents to the hospital unaccompanied etc.

PROCEDURES

Registration of Doctors as Intramural Practice Providers:

Eligibility: All Consultants working at UPTH.

Procedure:

1. Purchase Intramural Care Provider Registration Form for N40, 000 only. This is renewable annually.
2. Fill Registration Form
3. User code is generated and identification card issued bearing code, passport photograph doctor's name and phone number.
4. An MOU is prepared by the legal unit and signed by the parties involved.
5. A list of registered Intramural Practice Providers is generated and made available to Care Co-ordinators (registered Family Physicians).

Accessing Care by Prospective Patients Referred to UPTH by their Private Doctors:

A. First time visit:

1. Dedicated Accounts Clerk and Records Officer domiciled in the same place promptly take the bio data and name and code of registered Referring and Admitting Doctors (if different).
2. Makea stipulated down payment (deposit) which would include Consultation/folder fees.
3. Obtain receipt and pink folder
4. To be attended to by a registered Care Co-ordinator (Family Physician on duty)
5. Care Co-ordinator arranges for patient to be attended to by registered Admitting Doctor.

The entire process should take approximately 10 minutes.

In the event that the patient is to be co-managed with another registered Consultant,

1. The Care Co-ordinator will arrange for patient to be attended to by Co-Care Doctor on the advice of the Admitting Doctor.

2. The Care Co-ordinator is expected to get feedback from the Admitting and Co-Care Doctor with regards to the line of management and the cost implications. This also applies to all the service points at which the patient accesses care (laboratory/imaging/pharmacy etc.)

B. Subsequent visits:

1. Give name and code of registered Admitting Doctor
2. Pay a stipulated deposit which would exclude folder fees.
3. Obtain receipt and pink folder
4. To be attended to by a registered care co-ordinator (Family Physician on duty)
5. Care Co-ordinator arranges for patient to be attended to by registered Admitting Doctor.

The entire process should take approximately 8 minutes.

Accessing Care by Walk-in Patients Desiring Fast-Track Services (not referred by any doctor):

A. First time visit:

1. Pay a stipulated deposit which will include Consultation/folder fees.
2. Obtain receipt and pink folder
3. Consultation by a registered Care Co-ordinator (Family Physician on duty that day) who may also be the Admitting Doctor if he plays an active and significant role in the actual clinical management of the patient.
4. If referral is required, either an Admitting Doctor or a Co-Care Doctor is contacted by the Care Co-ordinator
5. Care Co-ordinator arranges for procedures, follow up, laboratory/imaging services where necessary.
6. The Care-Co-ordinator obtains feedback from all the parties involved in the clinical management of the patient.

B. Subsequent visits:

1. Give name and code of registered referring doctor (or care-co-ordinator)
2. Pay a stipulated deposit.
3. Obtain receipt and pink folder

4. Consultation by a registered Care Co-ordinator (Family Physician on duty that day) who could also be the Admitting Doctor if he plays an active and significant role in the actual clinical management of the patient.
5. If referral is required, the Care Co-ordinator arranges for either an Admitting Doctoror a Co-Care Doctor to attend to the patient (depending on the extent of his involvement in the clinical management of the patient).
6. The Care Co-ordinator, arranges for procedures, follow up, laboratory/imaging/pharmaceutical services where necessary.
7. The Care-Co-ordinator obtains feedback from all the parties involved in the clinical management of the patient.

Emergency Services

Shall follow the SOPs for Accident and Emergency but will be co-ordinated by the Care Co-ordinator who should be informed in order to make the necessary bills.

Billing:

1. Initial Deposit

   An initial deposit of N200,000 should be made by the patient from which subsequent deductions shall be made for services rendered.

2. Initial and subsequent Consultations

   N 10,000; N 5,000-hospital, N5,000- Admitting Doctor (who performs the stipulated service). Folder fee- N 5,000.

3. Referral-

   Attracts a consultation fee of N10,000; N5,000-hospital, N5,000 to registered Co-Care Doctor patient was referred to.

4. Laboratory/Imaging services- 2x the normal bill;

   50%-Hospital
   10%- Departmental revolving fund
   5% - Care co-ordinator
   15%- Admitting Doctor
   30% -Radiologist/ Pathologist doing the procedure.

Note: If the referring doctor is a pathologist/radiologist doing the procedures in his department, he/she is eligible to get the 45% of the total bill earmarked for the "referring doctor" in his department. If the referring doctor is also a care-co-ordinator, he's entitled to a total of 20% (5+15%) of the total bill.

5. <u>Admissions into Private Wards-2x the normal bill:</u>

   50%- Hospital
   5%- Departmental revolving fund
   5%- Care co-ordinator
   40%- Admitting doctor (attending to the patient)

6. <u>Procedures requiring anaesthesia-2x the normal bill;</u>
   45% -Hospital
   5% -Referring Doctor
   10% -Theatre revolving fund
   30%- Registered Admitting Doctor (doing the procedure)
   5%- Care Co-ordinator
   5%- Anaesthetist
   If referred for a procedure by the Admitting Doctor, the Co-Care Doctor to whom the patient is referred to is entitled to 20% (out of

   which those assisting in the procedure will be remunerated), while the Admitting Doctor (not doing the procedure) gets 10%. (20%+10%=30%)

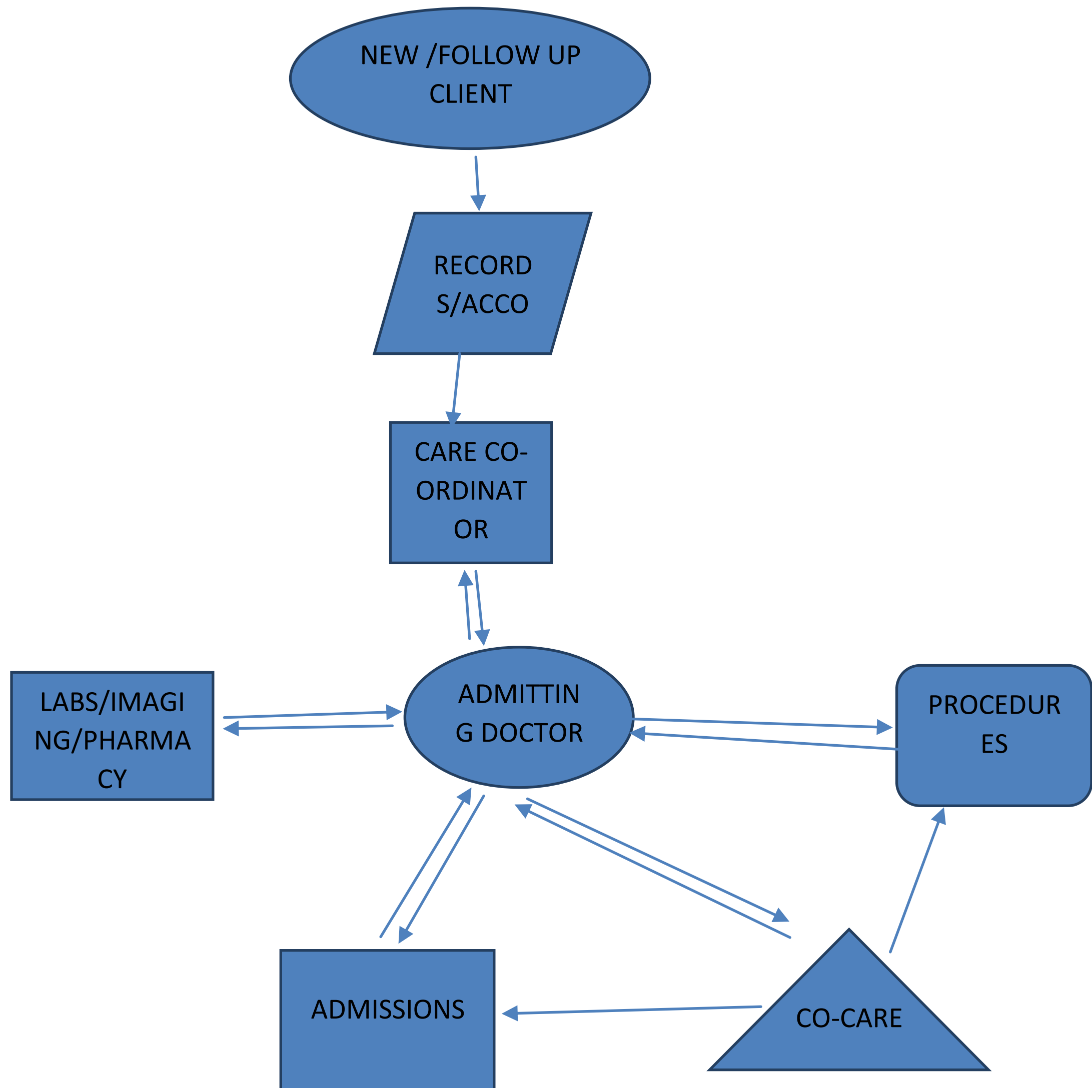
7. <u>Procedures not requiring anaesthesia- 2x the normal bill;</u>

   45%- Hospital
   5%- Referring Doctor
   5%- Departmental revolving fund
   5%-Care-co-ordinator
   40%- Registered Admitting Doctor (doing the procedure). Out of this, those assisting in the procedure would be remunerated.

Note:

1. If referred for a procedure, the Co-Care Doctor is entitled to 25% while the Admitting Doctor (primarily responsible for the management but not doing the procedure) gets 15%.
2. The care co-ordinator gets percentages of the total bills for admissions, labs/imaging and procedures.
3. In the event that the care co-ordinator (Family Physician) initially introduces patients to the intramural private practice arrangement, does consultations, procedures or admissions apart from co-ordinating care, he/she will be entitled to the percentage of the total bill earmarked for the "Referring and/or Admittingdoctor" (which ever is applicable).
4. The dedicated accounts clerks, nurses and records staff and maids shall be staff of UPTH who will receive an "Intramural Care" allowance in addition to their salaries at the end of each month which shall be decided upon by UPTH management.

FLOW CHART:



UPTH STANDARD OPERATING PROCEDURE FOR LAUNDRY DEPARTMENT

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *MR OKPORO FRIDAY*

DATE: 11TH July 2018

SOP No: 002

SOP Title: Processes involved in providing laundry services for patients and staff.

NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am

PURPOSE:

Processes involved in management of hospital linen; ensuring adequate cleaning of the linen for hygienic hospital environment and infection control.

INTRODUCTION

SCOPE

It covers all laundry services including provision of clean linen and timely supply of linen and reduction of inventory loss.

FUNCTIONS OF THE DEPARTMENT

1) Collection of dirty linens from the various wards and departments
2) Return of cleaned linens

ROLES AND RESPONSIBILITIES OF VARIOUS STAFF DEPLOYED TO THE DEPARTMENT

Every member of the laundry department is involved with the above functions.

S/NO	STAFF TYPE	NAME
1	STAFF	OKPORO FRIDAY (HOD)
2	STAFF	OTUOKPON GOSPEL (ASST HOD)
3	STAFF	AKINDA INNOCENT
4	CASUAL STAFF	SUNDAY OHAKA
5	CASUAL STAFF	OROKE U. KARO JESHUA
6	CASUAL STAFF	CONFIDENCE NWIWA
7	CASUAL STAFF	LEKPOA NAANA
8	CASUAL STAFF	SUNNY S. IGBENEGBARA
9	CASUAL STAFF	GIFT JOSHUA

SERVICE PROVISION

	Describe the procedure involved and category of staff responsible for it
1) Daily collection of dirty linens (2 hrs)	**All members of the laundry team are involved in the processes.**
2) Sorting according to degree of soiling (1 hr)	
3) Pre-washing of linen (5 mins)	
4) Washing of linens (30 mins)	
5) Spinning (10 mins)	
6) Drying (25 mins)	
7) Ironing and folding (3 hrs)	
8) Classifying according to ward/department	
9) Return of clean linens	

DAILY ACTIVITIES (CHANGING OF LINEN)

Nurses duty

DAILY ACTIVITIES

Sorting and storing of used linen.

	Describe the procedure involved and category of staff responsible for it
1) According to ward/ departments	**All members of the laundry team are involved in the processes.**
2) According to degree of soiling	
3) According to Infectious and non-infectious	

DAILY ACTIVITIES

Collection of soiled/infected linen.

	Describe the process involved
1) Pre-labelled by the various departments/wards	**All members of the laundry team are involved in the processes.**
2) Washed separately	
3) Packaged for return to the wards/departments	

DAILY ACTIVITIES

Disinfection of used/soiled linen.

	Describe the process involved
1) Use of bleach	**All members of the laundry team are**

2) Use of Izal	**involved in the processes.**

DAILY ACTIVITIES (SORTING OF LINEN IN THE OPERATING THEATRE)

The linens from the theatre are already prelabelled and sorted out by the nurses.

DAILY ACTIVITIES

Counting of collected linen.

	Detail practice process including responsibilities, time lag and record keeping
1) Linens are counted in the presence of either the nurse or the ward maid	**All members of the laundry team are involved in the processes.**
2) The number of linens counted are then recorded	
3) The recording is counter signed by the nurses	
4) The linens are then taken to the laundry for cleaning.	

DAILY ACTIVITIES

Transporting of dirty linen.

	Describe protocol including time lag
1) Trolley is used to transport the dirty linen to the laundry (2 hrs)	**All members of the laundry team are involved in the processes.**
2) A different trolley is used to transport the cleaned linens back to the different wards/	

departments (2 hrs)	

DAILY ACTIVITIES

Washing and drying of dirty linen.

	Describe protocol including time lag
1) Pre-washing and washing of dirty linen is done with an industrial washing machine(35mins)	**All members of the laundry team are involved in the processes.**
2) Drying is done with an industrial dryer (35mins)	

RECEIPT OF WASHED LINEN

	Describe protocol including time lag
1) The washed linens are counted by the receiving nurse/ward maid.	**All members of the laundry team are involved in the processes.**
2) The number received is recorded	
3) Crosschecking of number received with number given out initially	
4) Signing by the receiving nurse/ward maid.	

STORAGE AND ISSUE OF WASHED LINEN

	Describe protocol including time lag
1) Washed linens are usually returned on the same day	**All members of the laundry team are involved in the processes.**
2) If not returned for any reason, they are stored in the counters in the department.	
3) Sent at the next feasible time.	

EMERGENCY SERVICES

	Describe protocol
1) Possible only with water and power supply	**All members of the laundry team are involved in the processes.**
2) Dirty linens are collected from such a department and counted as usual	
3) Returned in 90minutes to the department/ward from which it was received.	

INVENTORY MANAGEMENT

List of linen

	Describe protocol
1) The list of linens collected are entered into the record book	**All members of the laundry team are involved in the processes.**
2) The list of washed linens for returns are also entered in a record book	

INVENTORY MANAGEMENT:

Condemnation of linen

	Describe protocol
Condemnation of linens are done only in collaboration with the nurses and must be signed and countersigned.	**All members of the laundry team are involved in the processes.**
No condemnation of linen occurs by the laundry department alone.	

INVENTORY MANAGEMENT (PURCHASE OF LINEN):

The laundry department does not purchase linen.

PILFERAGE

	Describe protocol
1) The measures of registration and recording has eliminated pilferage.	**All members of the laundry team are involved in the processes.**
2) Those in any shift in which linens can't be accounted for are liable to replace such.	

QUALITY CONTROL

	Describe protocol
1) Lectures for new comers to the department	**All members of the laundry team are involved in the processes.**
2) Two weekly training and retraining to achieve best laundry practises.	

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURES FOR DEPARTMENT OF MEDICAL MICROBIOLOGY AND PARASITOLOGY

PREPARED BY: *DR EMEKA EYIDIA*
REVIEWED BY: *DR IGUNMA JEREMIAH*
REVIEWED BY: *DR. ALEX-WELE MARY A.*
AUTHORISED BY: *DR AWOPEJU A. TEMITAYO.*
DATE: 11TH July 2018
SOP No: 002
SOP Title: Accessing laboratory care in the department of medical microbiology and parasitology.

NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am

PREAMBLE:

The department runs a **24-hour service**, **7 days a week**.

RECEPTION SERVICES:

Routine sample collection commences daily at 8.00am and ends at 3.00pm.

Issuing of sample containers commences at 8.00am and stops at 2.00pm. Thereafter, all samples for which specimen containers have already been issued will be received and processed.

Call duty commences by 3.00pm and ends at 8.00 am the following day on week days while 24 hours call duty services run on weekends and public holidays.

During that period, specimen containers will be issued and received for emergency samples only.

EMERGENCY SAMPLES

The following are considered as emergency samples:

f.) Urine for analysis
g.) Urine microscopy, culture and sensitivity for pregnant women
h.) Cerebrospinal fluid for analysis and culture
i.) Venous blood for malaria parasitaemia
j.) Blood culture

k.) Body fluids and aspirates from newly admitted patients (those admitted within 24hours) before commencement of antimicrobials.

REQUEST FORM

l.) For Inpatients (Wards) and outpatients (Clinics):Microbiology request forms are completed by the attending physician in the wards and clinics and given to patient or patient care giver to forward to the microbiology laboratory.

m.) All request forms must be properly completed with clinical details **(incomplete and/or improperly filled request forms will likely be rejected).**

n.) Completed microbiology request forms are brought to the CENTRAL SAMPLES COLLECTION UNIT then caregivers are educated and prepared on how to proceed thereafter.

o.) This should take an average of 5 to 10 minutes per patient.

PAYMENT

p.) The requested investigation is costed and a teller given by departmental cashier at the CENTRAL SAMPLES COLLECTION UNIT. This should take an average of 5 minutes per patient.

q.) Patient or caregiver proceeds to nearest certified bank pay-point to pay for the requested investigation.

r.) Stamped teller/receipt from the pay-point is returned to departmental cashier as proof of payment.

s.) Sample container is then given to patient.

SAMPLE COLLECTION

t.) A phlebotomist in the CENTRAL SAMPLES COLLECTION UNIT will be responsible for collection of venous blood for all requested tests as appropriate. Estimated waiting time for each patient is about 15 minutes.

u.) High vaginal swab (HVS), Intracervical swab (ICS) and Urethral swabs (US) are collected by Clinical Microbiology Team on duty. High vaginal swab (HVS) and intracervical swab (ICS) collection are done using sterile speculae and sterile cotton wool swab sticks.

Estimated waiting time per patient is about 30 minutes.

v.) Skin snips and scrapings for fungal elements are collected by the Technical Team. Estimated waiting time per patient is about 15 minutes.

w.) For in-patients, sample is collected by the attending physician.

x.) Venous blood collection for children is done in the paediatric outpatient clinic/wards by attending physician.

y.) For those on admission, vaginal/intracervical swabs should be collected by the patients' managing team in the ward while outpatients are expected to have their specimens collected in the department.

z.) For urine culture specimen, mid-stream urine sample is collected at least four (4) hours after last void.

aa.) Other urine samples accepted are catheter tube urine and suprapubic tap urine.

bb.) Sputum collection management is done at the TB reference laboratory. Appropriate instructions are given at that point.

cc.) **Appropriate asepsis is observed for all specimens collected as required.**

DUTY ROSTER

dd.) Duty roster for Medical Laboratory Scientists is prepared by the Assistant Director of Medical Laboratory Science (ADMLS) and approved by the HOD.

ee.) Duty roster for Residents and Consultants is prepared by the Chief Resident/Consultant and approved by the HOD.

ff.) Duty rosters for Laboratory Scientists include bench call duty, routine bench duty, molecular laboratory and tuberculosis reference laboratory.

gg.) Duty rosters for Residents and Consultants include specialized bench and clinical duties including molecular laboratory duty, tuberculosis reference laboratory bench duty, STI/ARV clinic, infection control rounds, clinical consult duty as well as bench and clinical call duties.

WEEKEND DUTIES

hh.) The department provides 24-hours coverage during weekends.

ii.) The call duty for the technical unit is covered by both a junior Medical Laboratory Scientist (MLS) and supervised by a Senior Technical staff, Chief Medical Laboratory Scientist (CMLS).

jj.) The call duty for the Clinical Unit is covered by Resident Doctors and supervised by Consultants.

ACCIDENT AND EMERGENCY

kk.) Microbiology Department does not have a staff on duty in the Accident and Emergency Department (A & E), however, the call duty roster with the telephone numbers of staff on duty in the laboratory are placed in the Accident and Emergency Department.

ll.) Samples from the A & E are collected by attending physicians.

mm.) The microbiology staff on call is alerted when necessary, prior to sample collection, especially when there is suspicion of a Viral Haemorrhagic fever (VHF) or uncommon pathogen.

nn.) Collected samples are brought to the microbiology laboratory by patient caregivers, except for highly virulent/pathogenic organisms as mentioned.

NATIONAL HEALTH INSURANCE SCHEME (NHIS) PATIENTS

oo.) Patients under the NHIS are attended to as outlined above, however they are not required to pay for the services.

pp.) After completing requested investigations, the cost is documented and forwarded to NHIS office for reconciliation and payment.

INVESTIGATIONS AND TURN-AROUND TIME

TIME	SAMPLE
Within 2 hours urgent	CSF microscopy, malaria parasite test,
	Urinalysis, semen microscopy
24 hours	Routine microscopy - Urinalysis - HVS microscopy - Sputum AFB - Serological test - Pregnancy test

48 -72 hours Routine cultures

- Urine m/c/s
- ICS m/c/s
- Wound m/c/s
- Sputum m/c/s

COLLECTION OF RESULTS

qq.) Results of microbiology investigations are collected at the CENTRAL SAMPLES COLLECTION UNIT by patients or patient caregivers after presenting the duplicate teller/receipt issued to them when the sample was submitted. This should take an average of 5 to 10 minutes/ patient

rr.) For emergency samples such as cerebrospinal fluid, a preliminary report is communicated to the attending physician and same is done for urgent urinalysis and urgent malaria parasite tests.

ss.) Preliminary reports of microbial growth on blood culture are also communicated to clinicians.

REVOLVING FUND

➢ The Microbiology Revolving Fund (MRF) is properly constituted with the HOD as the project manager. Others members include a project accountant and a project secretary, all ADMLS, all consultants and the Chief Resident.

ACCREDITATION

Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURE FOR
MEDICAL RECORDS DEPARTMENTS
MEDICAL RECORDS

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *MR SAMPSON C. JAJA*

DATE: 17TH JULY 2018

SOP No: 002

SOP Title: Processes Involved in Medical Record Keeping and Retrieval for Patients and Staff.

NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am

PURPOSE

Efficient access to patient's records; for planning, audit, research, teaching, medico-legal purposes, communication between physicians and improved care.

SCOPE

It covers all medical records units in the hospital.

ROLES AND RESPONSIBILITIES OF VARIOUS STAFF DEPLOYED TO THE DEPARTMENT

S/N	STAFF	RESPONSIBILITY
1	HEAD OF DEPARTMENT	OVERSEAS THE ACTIVITIES IN THE DEPARTMENT
2	PROJECT ACCOUNTANTANT	PREPARES THE BUDGET CORDINATES FINANCE
3	STATISTICIANS	COLLECTIONS AND PREPARATION OF THE HOSPITAL DATA.
4	RECORD PERSONNEL	REGISTRATION OF NEW PATIENTS AND SORTING OF FOLDERS

RECORD GENERATION (PROCESS OF DEVELOPING MEDICAL RECORDS)

S/N	ACTIVITIES	STAFF RESPONSIBLE	TIME LAG
1	COLLECTION OF DEMOGRAPHIC DATA / INFORMATION FROM PATIENTS BY.	RECORD PERSONNEL	2-5MINUTES
2	PAYMENT FOR FOLDER & COLLECTION OF RECEIPTAND FOLDER BY PATIENTS	ACCOUNT CLERK	10-15 MINUTES
3	PAYMENT AT THE BANK & COLLECTION OF RECEIPT (if paying cash)	STERLING BANK	30-45 MINUTES
4	TRANSPORTATION OF FOLDER TO THE CLINIC	WARD MAID	3-5MINUTES

RECORD STORAGE / FILLING

S/N	ACTIVITIES	STAFF RESPONSIBLE
1	FOLDERS FROM THE CLINIC SENT TO THE FILING ROOM IN ALPHABETICAL ORDER	RECORD RECRSONNEL ON DUTY
2	FOLDERS COLLECTED FROM THE WARD AND FILLED IN THE FILLING ROOM	RECORD PERSONNEL

RECORD RETRIEVAL

S/N	ACTIVITIES	STAFF RESPONSIBLE	TIME LAG
1	APPOINTMENT CARDS ARE COLLECTED FROM THE PATIENTS AS THE COME	RECORD PERSONNEL	2-3MINUTES
2	THE FOLDERS ARE SORTED OUT WITH THE APPOINTMENT CARDS	RECORD PERSONNEL	3-5MINUTES
3	FOLDERS SENT TO THE CLINICS	WARD MAID	5-8MINUTES

OUTPATIENT RECORDS: APPOINTMENTS

APPOINTMENT IS DONE BY DOCTORS AND NURSES IN THE CLINIC

CANCER REGISTERS

PROPER REGISTER NOT YET SET UP AS MEDICAL RECORD IS NOT INVOLVED

STD, ANC RGISTERS

S/N	ACTIVITIES	STAFF RESPONSIBLE
1	STD CLINIC FOLDERS ARE FILLED AND RETRIEVED IN THE DEPARTMENT	RECORD PERSONNEL POSTED THERE
2	ANC FOLDERS ARE TRANSFERED TO ANC ON	RECORD PERSONNEL

	BOOKING	
3	AT TERM THE FOLDERS ARE SENT THE LABOUR WARD	RECORD PERSONNEL

IN-PATIENT RECORDS: ADMISSION AND DISCHARGE REGISTERS

S/N	ACTIVITIES	STAFF RESPONSIBLE
1	ADMISSION AND DISCHARGE REGISTER IS KEPT AND UP DATED IN THE WARD	NURSES
2	ON DISCHARGE THE FOLDERS ARE PICKED UP AND RECORDED	RECORD PERSONNEL

IN-PATIENT RECORDS: CENSUS SUMMARY

S/N	ACTIVITIES	STAFF RESPONSIBLE
1	DATA EXTRACTED FROM THE NURSES REGISTERS IN THE WARD	STATISTICIANS

IN-PATIENT RECORDS: OPERATION AND DELIVERY REGISTERS

S/N	ACTIVITIES	STAFF RESPONSIBLE
1	THE OPERATION REGISTERS ARE KEPT AND MAINTAINED IN THE THEATRE	THEATRE NURSES
2	DELIVERY REGISTERS ARE KEPT AND MAINTAINED IN THE LABOUR WARD	NURSES
3	DATA EXTRACTED FROM THE REGISTERS DAILY	RECORD STATISTICIANS

EMERGENCY SERVICES

S/N	ACTIVITIES	STAFF RESPONSIBLE	TIME LAG
1	DERMOGRAPHIC DATA COLLECTED	RECORD PERSONNEL IN EMERGENCY	2-3MINUTES
2	PATIENT RELATION IS DIRECTED TO THE ACCOUNT TO MAKE THE PAYMENT	ACCOUNT CLERK	3-5MINUTES
2	RETURNS TO COLLECT THE FOLDERS WITH THE TELLER.	RECORD PERSONNEL	1-2MINUTES

POSTING OF RECORDS STAFF TO VARIOUS DEPARTMENTS

S/N	ACTIVITIES	STAFF	HOW OFTEN
1	POSTING OF STAFF TO VARIOUS DEPARTMENTS	HOD	WEEKLY

PROCUREMENT OF CONSUMABLES / PRINTING OF FORMS, CARDS AND FOLDERS

S/N	ACTIVITIES	STAFF	HOW OFTEN
1	FOLDERS ARE PRINTED THROUGH THE CONTRACTORS	PROJECT ACCOUNTANT	MONTHLY
2	CARDS, FORMS AND STATIONARIES	DIFFERENT DEPARTMENTS	??

DISTRIBUTION OF FORMS, CARDS, FOLDERS AND OTHER CONSUMABLES

THE FOLDERS SUPPLIED BY THE CONTRACTOR AND DISBURSED BY THE HEALTH RECORD PERSONNEL

PREVENTING "OUT OF STOCK SYNDROME"

OUT OF STOCK SYNDROME CAN BE PREVENTED BY EMPOWERING THE DEPATMENT OF MEDICAL RECORD TO PRINT ALL THE STATIONARIES DIRECTLY

THIS IS POSSIBLE IF THE DEPARTMENT ARE EMPOWERED TO SOURCE FOR A PRINTER

BILLING OF VARIOUS CATEGORIES OF PATIENTS

BILLING IS DONE IN THE WARD BY THE ACCOUNT OFFICERS IN CONJUCTION WITH THE NURSES

QUALITY CONTROL

S/N	ACTIVITIES	STAFF RESPONSIBLE	HOW OFTEN
1	ROUTINE CHECK ON DIFFERENT STATIONS TO THE ACTIVITIES	HOD /ASSISTANT HOD	DAILY
2	DEPARTMENTAL MEETINGS	HOD AND STAFF	MONTLY
3	FEEDBACK ARE GOTTEN FROM THE PATIENTS THROUGH THE SUGGESTION BOX IN THE DEPATMENT	ALL STAFF	DAILY

REVOLVING FUND

THE REVOLVING FUND HOLD REGULAR MEETING WHERE PROJECT ACCOUNTANT DRAWS THE BUDGET THAT IS PRESNTED TO THE MANAGEMENT FOR APPROVAL

CODING AND INDEXING (ICD-10)

S/N	ACTIVITIES	STAFF
1	CODING AND INDEXING	TRAINED STAFF

REPORT WRITING AND HOSPITAL PERFORMANCE STATISTICS

PREPARED BY THE MEDICAL RECORD PERSONNEL TRAINED AND POSTED TO THE STATISTIC SECTION

TRAINING

S/N	ACTIVITIES	STAFF RESPONSIBLE
1	ORIENTATION IS ORGANISED FOR NEWLY EMPLOYED STAFF	SENIOR STAFF
2	POSTING AND REPOSTING TO DIFFERENT DEPARTMENTS	SENIOR STAFF

ELECTRONIC MEDICAL RECORDS IN NHIS:

S/N	ACTIVITIES	STAFF RESPONSIBLE	TIME LAG
1	SEMIELECTRONIC RECORD INVOLING FOLDER	RECORD PERSONNEL	3-5MINUTES

SECURITY POLICY (CONFIDENTIALITY)

THE FOLDERS ARE NEVER HANDLED BY THE PATIENT OR PATIENT RELATION TO MAINTAIN CONFIDENTIALITY
MEDICAL RECORD PERSONNEL DO NOT REVEAL INFORMATION CONTAINED IN THE FOLDER WITHOUT DUE PROCESS

REPORTING OF NOTIFIABLE DISEASES

THE NOTIFIABLE DISEASE DISEASES SUCH AS LASSER, EBOLA ARE REPOED TO THE MINISTRY OF HEALTH WHEN DIAGNOSES ARE MADE. THE STATISTICS UNIT PREPARES THE DOCUMENT THAT IS SIGNED BY THE HEAD OF DEPARTMENT BEFORE IT WILL BE SENT TO THE MINISTRY OF HEALTH

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF MEDICAL SOCIAL WORK SERVICES

NAME & SIGNATURE OF HEAD OF UNIT: *TENDE WILFRED*

DATE: 19/08/18

SOP No: 002

NOTE: Work Starts by 8:00 am.

INTRODUCTION

The medical Social worker plays a vital role in the provision of comprehensive health care because of their pivotal functions and holistic perspective on the range of physical, emotional, environmental, and cultural factors that have an impact on the well-being of individuals, families, and communities. As part of the health care team we provide assessment and appropriate interventions to aid the patient in achieving optimum recovery/rehabilitation and quality of life by:

1. Assisting ill or disabled patient to maintain, regain, or attain a mode of living that is satisfactory to them and helps them to make a socially positive contribution to their communities.
2. Ensuring the availability of and the accessibility to efficient and appropriate social work services in all wards of the hospitals, and other service areas.
3. Establishing effective and consistent relationships with NGO, donor agencies and individual philanthropist for support to indigent patient.

SCOPE

Our scope of practice as social workers entails the assessment, diagnosis, treatment and evaluation of individual, interpersonal and societal problems to assist individuals, families, groups, communities and organizations to achieve optimum psychosocial and social functioning.

Our scope of practice encompasses two major sub-groupings:

1. Direct patient services which include clinical social work and health related social services, which are offered to individuals, groups,

families, and communities. These services include inpatient and outpatient treatment as well as field contacts and follow-up.

2. Indirect patient services include documentation activities, patient/ staff case conferences and referrals to and placements in other agencies as well as consultation to other agencies.

PROCEDURES

Medical Social Work Process Flow:

1. Client Intake or Referral

The referral process provides for the initial entry of clients into the social work services delivery system by determining the need for those services. The referral system consists of the following criteria:

- Date of the referral and information identifying the client such as name, sex, date of birth, folder number, and address.
- The source for the referral should be identified as being a client requesting services, a referral by another health professional, a result of high-risk screening for social work services, or the result of social work case-finding.
- The presenting problem(s) will be stated; including the health condition and status, the psychosocial problem(s) related to the health condition or status, and other perceived or potential problems.
- Services that are being requested should be appropriate in that they require social work interventions, health/disease prevention strategies, collaborative services, or health team services.

2.Psychosocial Assessments

- The assessment process leads to an overall assessment (diagnosis) that encompasses the social worker's analysis of the data gathered, including an estimate of the client's coping strengths and limitations at the present time and the interrelationships of health status and pertinent social/family variables.
- The overall assessment is based upon the social worker's estimate of the problem as shared with the client and other health care

providers involved and tested against the client's own expectations and view of the problem(s)

- The client's psychosocial assessments results must be completed and entered into the patient folder in a timely manner by the social worker who is assigned to the case.

3.Intervention Plan

- An appropriate intervention plan is developed for each client based on the psychosocial assessment data obtained by the social workers in charge.
- Identification of specific objectives and tasks for client and other health care providers if necessary.
- Timeframes for achievement of the objectives and for periodic review of plan are given.
- The plan allows for a joint monitoring of the helping process for the client and is subject to change as new needs become apparent or new information becomes available.

4.Termination and Evaluation

Arrangements for termination of treatment are clearly delineated and are included in the treatment plans for each client. Follow-up services and patient satisfaction are evaluated on an ongoing basis in order to identify problems and areas of concern and needs.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

TENDE WILFRED
Head of Department MSSD

SOCIAL WORK SERVICES FLOW CHART

CLIENT INTAKE OR REFERRALS

CLIENT REQUESTING SERVICES

SOCIAL WORKERS CASE FINDINGS

CONSULTS FROM OTHER HEALTH PROFESSIONALS

PSYCHOSOCIAL ASSESSMENT

SOCIAL INVESTIGATION

DIAGNOSIS/ANALYSIS OF DATA

SOCIAL REPORT

INTERVENTION PLAN

COUNSELING

RECONCILIATION

REHABILITATION

REPATRIATION

FOLLOW UP

FINANCIAL

HEALTH ASSISTANCE

EDU

TERMINATION & EVALUATION

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF NEUROPSYCHIATRY

NAME & SIGNATURE OF HEAD OF DEPARTMENT:
OKEAFOR CHUKWUMA U
DATE: 17TH July 2018
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am.
PURPOSE

To establish guidelines for departmental operations with respect to the processes involved in patient management in the clinical departments of UPTH.

RESPONSIBILITIES

The Department of Neuropsychiatry is a specialist department that offers mental health and neuropsychiatric care to patients in the University of Port Harcourt Teaching Hospital on referral and emergency basis.The team comprises of Consultants, Resident Doctors, Clinical Psychologist, Nurses, Social Workers, Ward maids and Security officers.

CARE PATHWAY IN THE DEPARTMENT OF NEUROPSYCHIATRY

Step	Procedure	Who is Responsible?	Time lag
1	Presentation of Referral Document (for new patients)	Nurses/Doctors	10-15mins
2	Opening of folder/Retrieval of folder	Medical Records	20-35mins
5	Teller for payment for consultation (N1,000 for New patients and N500 for old patients) /Admission (32,000)	Account unit	5-20mins
6	Payment at the bank	Sterling bank	5-20 mins
7	E-receipt presentation and registration	Nurses	5-20 mins
8	Presentation at the Neuropsychiatry Clinic nurses' station and Vital Checks	Nurses	10-15 mins

9	Waiting at the waiting hall	-	30-60 mins
10	Consultation (Old Patients)	Doctors	20-30 mins
11	Consultation (New Patients)	Doctors	1hour 30 minutes
12	Presentation at nurses' station for further directives	Nurses	5-10 mins

SIDEINVESTIGATIONS

These are investigations which are easily carried out in clinic or wards to enable quick decisions on patient care

S/NO	Investigation	Who is responsible?	Time lag
1	Urinalysis	Doctors	2 mins
2	FBS/RBS	Doctors	5 mins
3	Urine Toxicology	Nurses/Doctors	5 mins

PATIENT CARE

Patients are managed in the clinics and wards. Patients are managed by the particular team in clinic or "on call" on the day of patient's first arrival to the hospital. The teams are led by consultant(s) in the unit.

ADMISSIONS

Patients are admitted via the clinic, the accident and emergency unit or referral from another ward or any other specialist referral. The patient is received by a doctor who documents on the clinical status of the patient and indication for admission. The nurse on duty ensures that requirements for admissions are met. Patients are then managed and discharged as directed by the managing team. The admission deposit for the wards is N32,000.00.

FOLLOW-UP

Patients in the clinic are followed-up for optimal care. The frequency of follow-up depends on the condition of the patient and clinical judgement of the managing team.

REFERRALS TO OTHER DEPARTMENTS/CENTRES

Patient could be referred to other clinical and ancillary departments of the hospital to access care as the need arises.

DUTY ROSTER

The duty roster for the month is prepared by the chief resident (for doctors) and the matron in charge (for the nurses and ward maids). The chief resident also prepares the roster for academic presentations, running of the Point of care testing side labs and call duty rosters under the supervision of the HOD.

REVOLVING FUND MANAGEMENT

The department's revolving fund is headed by the HOD, the project accountant and other statutory members. The revolving fund meetings are on monthlybasis.

PURCHASE OF CONSUMABLES

As outlined in the SOP for Procurement & Works Department.

INFORMED CONSENT

Informed consent is gotten from patients and or relatives for admission and electroconvulsive therapy.

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

QUALITY ASSURANCE

Staff satisfaction is assessed by regularly interactions with staff during the departmental meetings. Managing units also regularly interact with patients in the wards and clinics regarding services rendered.

UPTH STANDARD OPERATING PROCEDURE FOR NURSING DEPARTMENT

NAME & SIGNATURE OF HOD: ***Dr. (Mrs.)P.G. N. Harry***
DATE: 20th September, 2018
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am.
PURPOSE: To establish guidelines for developmental operations with respect to patient.

INTRODUCTION:

The nursing department is made up of four units namely: Clinical area, in-service education unit, School of Post Basic Nursing (SPBNS) and Community Health Units. Each of this unit performs their peculiar functions.

SCOPE:

The scope encompasses all the wards and clinics.

FUNCTIONS OF NURSING SERVICES:

- Overview of the nursing department.
- Provision of leadership
- Implementation of hospital policies.
- Implementation of disciplinary actions.
- Ensuring corrective measures.
- Ensuring that the wards/clinics are duly staffed.
- Liaising with other departments.
- Ensuring that all nursing procedures are carried out at when due.
- Mediating between management and the department.
- Ensuring staff to improve educationally.
- Ensuring managerial/professional role within the medical facilities.
- Supervising all nurses.
- Budgeting and decision making.
- Doing periodic assessment of nurses on daily basis as the nursing procedures are carried out and annually with the used of the Aper (annual performance evaluation report) form.

Just to mention but a few.

A.D.N.S Nursing Admin. Office phone no.:

08038754661

ROLE AND RESPONSIBILITIES OF VARIOUS CADRES OF NURSES:

- The accountable officer CNO or the most senior on duty heads the shift. Daily report given to the ADNS in the morning by the CNO in the nursing admin. Office.
- The CNO or any senior nurse on duty heads the shift.
- The number of nurses per shift varies according to the ward; ideally it is one nurse to 5 patients in the other wards but in the intensive care unit, one nurse to one patient and a circulating nurse. When the number of nurses per shift is not met, the standard of care of patient may become compromised.

ADMISSION OF PATIENTS:

Admission of patients into various wards within thirty (30) minutes. Patient is accompanied by the nurse and the transferring ward health attendant/assistant.

- Admission procedures to be done in various wards immediately the patient is admitted.
- Rendering of nursing care as at when due.

NURSING CARE OF THE PATIENT:

All categories of nurses are involved in all patient care in the entire shift.

INTRA-DEPARTMENTAL TRANSFER OF NURSES:

Periodic transfer of all nurses within the wards of UPTH with special consideration to area of specializatione.g. peri op, pediatric, psychiatric, etc.

DRUG ADMINISTRATION PROCEDURE AND TIME:

Duly done by the nurse assigned to carry out the procedure.
Medication time:
TDS -10am,2pm,6pm
BD -10am, 6pm.

QID -10am, 2pm,6pm,10pm.
12hrly -6am,6pm.
Daily -10am
Nocte -10pm
Adequate documentation and record keeping is ensured.
Parenteral therapy:

As per no.10 above.

ARRANGEMENT FOR BLOOD INVESTIGATION:

Ensuring that patients go for their investigation depending on the condition of the patient as ordered by the Doctor within (15) fifteen minutes.

ACTIVITIES DURING DOCTORS WARD ROUNDS:

Assigned nurse on duty to join in ward round.

PRE-OPERATIVE CARE OF PATIENTS:

- Rendering of pre-operative nursing care and ensuring that the operation check list is properly filled and the instruction on it accurately followed.
- Vital signs taking.
- Administration of pre-medications
- bed bath
- Other required nursing care.

POST –OPERATIVE CARE OF PATIENTS:
Rendering post-operative care i.e. regular vital signs, given medications/injections and other Nursing care.

ALERTING THE DOCTOR ON CALL:
Ensuring that the patients are promptly seen by the Doctor on call.

POLICY TOWARD NHIS PROMOTION:
Ensuring that all patients for NHIS are duly registered with NHIS.

DISCHARGE OF PATIENTS:
Ensuring that patients are duly prepared to go home on discharge after all the discharge procedures are carried out. Bills settled and take-home drugs collected.

ROOM PREPARATION AFTER DEATH/ DISCHARGE OF PATIENT:
The assigned Nurse ensures that the Morgue attendants are informed if there is death for evacuation after last office. The bed lockers, mackintosh, mattress and bed carbolized and aired.

MEDICINES AND CONSUMABLES STOCK REGISTER:
The nurse assigned ensures that the consumables for daily use are duly requested from the store as at when due, using ward SIV book for proper documentation.

PATIENT CASE REPORT WRITING:
Ward/matron's reports written on each shift namely: morning, afternoon and night shift. The compound matron on night duty aside handling over to the assistant Directors of Nursing and the chief nursing officer in the nursing admin office in the morning, also do the midnight statistics for the entire hospital.

SPECIALIZED NURSING CARE SERVICES:
As peculiar to Paediatric Nursing, pre-op Nursing, Psychiatric nursing, intensive care nursing, etc.

CLINICAL SUPPORT STAFF (HEALTH ASSISTANTS/ATTENDANTS):
These group of workers are directly under the nursing department. They wear maroon as their uniform.

- Assisting with varied duties depending on the unit/ward in which they are posted.
- Daily maintenance of cleanliness in various wards.
- Works as part of a team to deliver high-quality ethical and non-discriminating care to patients.
- Transfer of patients to various wards in company of the nurse.
- Collection of blood and retrieval of laboratory and imaging results.
- Performing any other duties as required.

Generally, there should be two health support staff per shift but where this is not possible, one health support staff can cover a shift. Generally, the duties of the health support staff center around keeping the hospital cleanby sweeping floors, cleaning windows, dusting furniture, getting rid of waste, removing medical waste from examination and surgery rooms, cleaning toilets and bathrooms.

ACCREDITATION
Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES
As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *DR. PREYE FEIBAI*
DATE: ……………………………..
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) starts by 9:00 am

INTRODUCTION

The Obstetrics and Gynaecology department is one of the four major clinical departments in the University of Port Harcourt Teaching Hospital (UPTH). It was the first clinical department to be accredited for the residency training program in the UPTH (1985).

The department has the following objectives

- To provide broad-based specialist care
- Promote medical education and training of resident doctors, undergraduate students and nurses
- Carry out groundbreaking research that would improve medical care in obstetrics and gynaecology
- Carry out health education of the public to improve maternal health.

PURPOSE

This document describes the regular recurring operations relevant to delivering quality services in view of our objectives, with the aim of carrying out these operations correctly, efficiently with quality output and uniformity of performance while reducing miscommunication and failure to comply with regulations.

OPERATIONS

The department runs the following clinics; the antenatal, postnatal, family planning, general gynaecology, Gynae oncology, and Assisted reproductive technology(ART) clinics. It has six wards; antenatal, postnatal, unbooked-lying-in, gynaecology, labour and unbookedlabour wards. It runs three theatre suites; one gynaecology theatre in the main theatre complex and

two obstetric theatres in the labour ward complex. There are procedure rooms, side laboratoryand a mannequin room.

FIRMS

The department operates the firm system run by specialist consultants in the following subspecialties;

FIRM A	FIRM B	FIRM C	FIRM D	FIRM E
FETOMATERNAL MEDICINE	REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY	INFECTIOUS DISEASES AND FETAL MEDICINE	REPRODUCTIVE HEALTH AND FERTILITY REGULATION	GYNAECOLOGICAL ONCOLOGY / UROGYNAECOLOGY
PROF. S. A. UZOIGWE	PROF. J. I. IKIMALO	PROF. C. I. AKANI	PROF. A. O. U. OKPANI	DR. N. M. INIMGBA
DR. N. C. ORAZULIKE	DR. P. O. FIEBAI	PROF. H. A. A. UGBOMA	PROF. C. E. ENYINDAH	DR. K. T. NYENGIDIKI
DR. D. S. ABAM	DR. V. K. ORIJI	DR. R. N. OGU	DR. J. D. OJULE	DR. G. BASSEY
DR. T. KASSO	DR. K. I. GREEN	DR. O. C. JOHN	DR. E. O. ORANU	DR. J. ALEGBELEYE
	DR. S. NYECHE	DR. M. ABBEY		

DAILY ACTIVITIES			
FIRMS	**CLINICS**	**CONSULTANT WARD ROUND**	**THEATRE**
A	MONDAYS	TUESDAYS	WEDNESDAYS
B	TUESDAYS	WEDNESDAYS	THURSDAYS
C	WEDNESDAYS	THURSDAYS	FRIDAYS
D	THURSDAYS	FRIDAYS	MONDAYS
E	FRIDAYS	MONDAYS	TUESDAYS

- Junior residents, senior residents, and medical interns rotate through these firms every 3-6 months under the supervision of consultants, gathering the necessary knowledge and essential clinical and surgical skills required for their training.

- Emergency obstetric cases are seen by the labour ward and unbooked labour ward teams under the supervision of a consultant seconded to the labour ward for the month between the hours of 8AM and 4PM on weekdays. Emergency gynaecology patients are seen by the unbooked labour ward team, between the hours of 8AM and 4PM on weekdays.
- The call hours of4PM to 8AM each weekday and 24 hours on the weekends are covered in turns by each of the firms. During these call hours, every patient who presents to the hospital for emergent or non-emergent specialist care is attended to by the team on call. The team on call each day is indicated on a duty roster prepared each month by the chief resident supervised by the HOD and circulated to the appropriate offices and departments in the hospital.

ANTENATAL CLINIC

STEP	**PROCEDURE**	**WHO IS RESPONSIBLE**	**TIME LAG**
1	Registration and Opening of Folder	Medical Records Department	About 30 minutes
2	Payment for Antenatal Registration	Accounts Department	About 5 to 15 minutes
3	Presentation at the Nurses Station Documentation of Antenatal Registration Summary	Nurses and Nurse Attendants	10 minutes
4	Observation of Vital Signs and Routine Urinalysis	Nurses	5-10 minutes
5	Performing of Clinic Side Laboratory (HIV status, and fasting/random blood glucose) tests	Medical Laboratory Scientist	10-15 minutes
6	Antenatal Health Talks	Nurses	15-20 minutes
7	Consultation; The patients are sorted out and a triage is done by the most Senior obstetrician, who distributes the Folders based on gestational age and any other existing factors. The folders are spread across the cadre.	Doctors	10 to 15minutes per consultation

	The House officers handle simple uncomplicated early booking mothers. The next appointment is scheduled after consultation.		
	The patients proceed to the Pharmacy for their routine and other medication.	Pharmacy Department	About 5 to 10 minutes

POSTNATAL CLINICS

The clinic usually runs for patientswho had their antenatal period and/or deliveries here in UPTH or referred from GOPD

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME LAG
1	Registration and Issuing of Post natal Card	Medical Records Department and Nurses	About 15-20 minutes
2	Payment for Post natal Consultation	Accounts Department	About 5 to 15 minutes
3	Observation of Vital Signs and Routine Urinalysis. Observation of the Baby's Vital Signs and Anthropometric parameters	Nurses	About 5-10 minutes
4	Consultation; The patients are sorted out and a triage is done by the most Senior obstetrician, who distributes the Folders based existing co-morbidities and the patients are seen, discharge or referred for further care	Doctors	15 to 20 minutes per consultation
5	The patients proceed to the Pharmacy for hermedication	Pharmacy Department	About 5 to 10 minutes

GYNAECOLOGY CLINIC

New patientsseenin the gynaecology clinic are referred from the GOPC. When they present at the gynaecology clinic there are either seen that day or given an appointment for a later date by the clinic nurses.

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME LAG
1	Opening of New Folders and Retrieval of Folder from Referral Units	Medical Records Department/Nurse Attendants	About 30 minutes
2	Payment for Gynaecological Consultation	Accounts Department	About 5 to 15 minutes
3	Presentation at the Nurses Station with Tellers and Observation of Vital Signs	Nurses	About 10 minutes
4	Consultation; The first time Patients are clerked by the House officers and Junior Residents. The patients are reviewed by the consultants. The patients on follow are seen by senior residents and Consultants. The patients are sent to the laboratory for investigations, pharmacy or admitted for in patient care, including surgeries.	Doctors	5 to 15minutes per consultation

SPECIALIST CLINICS

- The family planning clinic runs every weekday from 8AM-4PM. The consultants in the fertility control unit supervise its activities and specialist procedures are scheduled by the clinic nurses for the consultants onTuesdays. The family planning services are offered free to clients.
- The Assisted Conception clinic is open every weekday from 8AM to 4PM for enquires and procedures. The unit is supervised by consultants in Firm B
- The Gynae Oncology clinic holds every Friday between 1-4pm

ADMISSION IN ACCIDENT AND EMERGENCY

Patients with gynaecologic emergencies and unbooked obstetric emergencies less than 28 weeks of gestation are admitted at the Accident and Emergency department, where they are first attended to by the medical officers on duty. The emergency obstetrics and gynaecology team are then invited to see the patient, once the medical officer has determined that specialist care is required.

- The emergency team of the department must respond to the consult from A&E within one hour
- The patient is evaluated by the emergency team and a diagnosis is made and emergency treatment offered.
- The consultant in charge is informed and decisions on further care are clearly documented
- The patient must be discharged or transferred out of A&E within 48 hours
- Patients admitted into the ward are required to pay an admission deposit except in emergency cases where the patient is required to sign an undertaking to pay such fees within 24-48 hours
- All decisions on admission of any patient are taken by the consultant.

WARD ADMISSION

Patient admitted from the antenatal clinics are either admitted into the gynaecology ward, if the gestational age is less than 28 weeks or to the antenatal ward if gestational age is more than 28 weeks.Gynaecological patients are admitted into the gynaecological ward. Patients who present in labour or with complications following delivery are admitted intolabour ward.Patients who are in labour or have complications following delivery but did not receive antenatal care in UPTH are admitted into the unbooked labour ward

Step	Procedure	Who is Responsible?	Time lag
1	After consultation and documentation of admission instruction, patient proceeds to the nurses' desk for further directives.		5 minutes
2	Patient's details including diagnosis are recorded in nurses' Admissions register	Nurses	About 5-10 minutes
3	Patient proceeds to the ward where she has been admitted accompanied by an attendant who carries the case records of the patient. In the ward, the attendant hands over the patient and their folder to the duty nurse.	Ward maid	About 5-10 minutes
4	Patients is formally admitted	Nurses	10-15

	and directed to accounts department to make necessary payments		minutes
5	Collection of bank teller	Accounts Department	5 to 15 minutes
6	Payment at bank	Patient/Relatives	15 -30 minutes
7	Return of patient to ward to complete admission formalities		5 to 15 minutes

ADMISSIONS INTOLABOUR WARD

- Booked obstetrics patients after 28 weeks of gestation, present with their antenatal tracer card which is handed to the nurse on duty and the patient's folder is retrieved.
- The labour ward nurses/midwife examine the patient to make the diagnosis of labour and the patient is admitted into the labour ward.
- The nurse midwife indicates thepatient's time of presentation and admission by filling out the front page of the partogram including the vital signs of the patient
- The doctors on duty in the labour ward, attend to the patient and confirms that the patient is in labour.
- The consultant on duty in the labour ward or the consultant on call during call hours is informed about the patient
- The patient is commenced on petrographic monitoring if in active phase of labour
- Delivery is conducted by the midwives except in high risk pregnancies in which the residents and consultants either conduct or supervise such deliveries.

DISCHARGE

- Discharge from the wards should only follow a decision endorsed by the consultant in charge.
- A discharge summary including events and treatment received while on admission, duration of admission, and follow up appointment dates, are recorded in the case folder.
- The case folder is then submitted to the accounts department by the ward nurses and patient is allowed to leave the ward, only after payment of bills has been ascertained by the nurse in charge.

PROTOCOL FOR ELECTIVE OPERATIONS

Step	Procedure	Who is Responsible?	Time lag
1	Counseling	Doctors	30 minutes
2	Booking of theatre	Doctors	5-10 minutes
3	Patient is directed to the accounts department for payment for surgery	Nurses	10-20 minutes
5	Bank teller collection	Accounts Department	5-10 minutes
6	Payment at bank	Patient/Relatives	10 minutes to 30 minutes
7	Patient returns to ward and other preoperative preparations are completed before actual surgery	Nurses/Doctors	

PROTOCOL FOR REFERRALS

- Inter and intra-departmental referral of patients MUST be carried out at the level of the Consultant. Senior Residents may be mandated by a consultant to refer but this must be appropriately documented and signed on behalf of the consultant.
- All external referrals to the department must be managed by a consultant.
- A decision to refer a patient out of the hospital can only be taken by the managing Consultant and must be sanctioned by the Head of Department and the Hospital administration.

PROTOCOL FOR MEDICAL REPORTS AND CERTIFICATES

- ALL medical reports from the department MUST be signed by a consultant in charge of the patient. This must be appropriately documented in the patient's folder.
- Maternity leave certificates are issued by the Matron in charge of the antenatal clinic and documented in the patient's folder.
- External medical reports for ALL patients should be signed by a consultant who is advised to attach the Nigerian Medical Association Stamp as currently stipulated by law.

PROTOCOL FOR THE DEATH OF A PATIENT

- The managing Consultant must be made aware of the events leading to the demise of the patient
- The team that managed the patient up till the time of death must document a summary of events leading to the death of the patient in the patient’s folder and offer grief management to the patient’s relatives
- The team must fill the Death certificate which is handed over to the nurse on duty
- The nurses perform the last offices and the body is transferred to the mortuary with the consent of the relatives.
- The case summary and the patient’s folder must be submitted to the HOD within 24 hours of the event.
- The case summary is presented at the morning review if the event occurred during the call hours and all maternal mortalities are presented at the clinical meetings (Mortality review) on the last Tuesday of every month.
- The body leaves the hospital only after the patient’s bill made by the account’ unit has been paid.
- The death certificate is issued to the relatives by the nurses after payment of outstanding bills has been ascertained by the nurse.

PERINATAL MORTALITY

- The managing Consultant should be made aware of the events leading up to the perinatal death
- The team managing the patient at the time of the event should write a detailed summary of events leading up to the perinatal loss in the patient’s folder and institute grief management to the parents/relatives.

- If the baby has been delivered and the demise occurred while still under the care of the department, the baby’s corpse should be cleaned, well wrapped and handed over to the relatives in a humane fashion for appropriate disposal, except in the event of an epidemic of public health significance, where methods of disposal of human waste has been specified by Hospital management.
- The case should be presented at the morning review if the event occurred during the call hours or at the mortality review.

- The Head of Department should be made aware of the event and a summary of the event submitted to his office by the team who managed the patient.

PROTOCOL FOR PREOPERATIVE CARE

- The patient is admitted into the ward by the nurse after payment of admission deposit has been ascertained by the nurse except in emergency cases
- A bed is allocated and the patient’s vital signsare assessed at regular interval by the nurses
- The patient is reviewed by the managing team and booked for surgery
- All instructions as directed by the consultant are carried out by the doctors and nurses
- A signed informed consent is obtained supervised by the nurses
- The patient is encouraged to make the necessary payments for the surgery
- A list of cases for elective surgery is prepared by the managing team and submitted to the theatre nurses before 12noon on the day preceding the operation day and the list is distributed appropriately
- The anaesthetist in charge must review the patient at most the day before the surgery for all elective cases
- A checklist of items in preparation for surgery is filled by the nurses on the morning of the operation and the patient is tagged with an identification wristband. The nurse must confirm that all stipulated fees are paid before the patient can be wheeled to the theatre.
- The patient is transferred to the theatre on the day of the surgery by the theatre potter accompanied by the ward nurse who will hand over the patient to the theatre nurse.
- In **emergency cases**, a consult is submitted to the theatre nurses and the anesthetist in charge stating the name of the patient, ward, indication for the surgery, the procedure and the time for the procedure. The anesthetist must review the patient within 30minutes of receipt of the consult. The patient must sign an undertaking to pay all stipulated fees within 24 hours

PROTOCOL FOR POSTOPERATIVE CARE

- The surgeon writes the procedure notes with the postoperative instructions
- The surgeon must ensure that the correct surgical procedure was documented by the nurses
- The surgeon ensures all specimen for histopathologic analysis are sent and the pathology form filled correctly by the residents
- The patient's postoperative medications are prescribed by the doctors and issued to the relatives
- The ward nurses receive the patient from the theatre with the anaesthetist notes, the operation notes,and the theatre nurses' recovery chart.
- The ward nurses must confirm the patient's vital signs are stable before transferring the patient to the ward.
- The postoperative instructions are carried out by the nurses and doctors in the ward.

ACCREDITATION PROCEDURE

Please refer to SOP for CS & T.

PROCUREMENT OF CONSUMABLES

As outlined in the SOP for Procurement & Stores Department

NB: Refer to Theatre SOPs for theatre management procedures.

Dr. P. O. Fiebai/ Dr. G. Bassey

UPTH STANDARD OPERATING PROCEDURE FOR OPHTHALMOLOGY DEPARTMENT

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *DR AWOYESUKU E.A*
DATE: 13TH July 2018
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am
PURPOSE

To establish guidelines for departmental operations with respect to the processes involved in patient management in the clinical departments of UPTH.

RESPONSIBILITIES

The department of Ophthalmology is the first port of call of most patients with ophthalmic conditions and gives comprehensive, continuous and coordinated care to patients irrespective of age, sex and disease entity. The doctors, nurses and ward maids all work in synergy to ensure the smooth running of the department and to achieve maximum patient satisfaction. The department also runs sub specialized ophthalmology clinics in addition to general ophthalmology clinics and has an average turnover of 100 -150 patients daily.

CLINIC DAYS

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
8am to 4pm	General clinic	General clinic	Casualty clinic	General clinic	General clinic
	Pediatric ophthalmology	Glaucoma	Vitreo-retina	Theatre	Oculoplasty
	Theatre	Theatre	Neuro-ophthalmology		
			Anterior segment		
			Theatre GA		

ACCESSING PATIENT CARE IN THE DEPARTMENT INVOLVES THE FOLLOWING

Step	Procedure	Who is Responsible?	Time lag
1	Open New folder or retrieve previous folder	Medical records unit	45mins/30 mins
2	Pay for consultation fee (N1,000)	Accounts unit	10-20 mins
3	Visit nurses' station for number	Ward maids and nurses	10 mins
4	Vitals check	Nurses	30-60 mins
5	Health Education	Nurses	10- 20 mins While at the waiting hall
6	Sorting of patients	Doctors	10 – 15 mins While at the waiting hall
7	Waiting at the waiting hall	-	30-60 mins
8	Consultation	Doctors	10-30 mins
9	Presentation at nurses' station for further directives	Nurses	5-30 mins

TREATMENT ROOM

The dressing room is used dilatation, foreign body removal, epilation, dressing of minor injuries, irrigation

Step	Procedure	Who is responsible?	Time lag
1	Teller collection	Account unit	10-20 mins
2	Payment at the bank	Sterling bank	10-20 mins
3	Receipt of payment taken to the treatment room	-	5 mins
4	Relevant procedure done	Nurses	20-45 mins

USE OF MINOR OPERATION THEATRE

This room is used for simple day procedures such as Pterygium excision, Chalazion incision and drainage, the protocol for use of the room include:

Step	Procedure	Who is responsible	Time Lag
1	Consultation	Doctors	10-30 mins
2	Presentation at the nurses 'station	Nurses	5-10 mins
3	Teller for payment for procedure	Account unit	5-20 mins
4	Payment at the bank	Sterling bank	5-20 mins
5	Receipt of payment's presentation	Nurses	2-5 mins
6	Actual procedure done	Doctors	20-60 mins

Step	Optometry services	Who is responsible	Time lag
1	Referral for optometry services	Doctors	10-20mins
2	Issuance of tellerfor refraction and other services	cashier	5 mins
3	Payment	Sterling bank	10-30mins
4	Refraction/ orthoptic assessment/ low vision assessment	Optometrist/ Senior registrars	10-20 mins
5	Review and ordering of optometric services	Ophthalmologist (Doctors)	5 mins

MANAGEMENT OF PATIENTS IN THE DEPARTMENT

The vast majority are managed within the department. If/when the need arises for referral (according to laid down criteria stipulated in internationally-recognized clinical practice guidelines), they are referred to appropriate specialties and subsequently, the patients return to the department for follow up and management of any other medical condition that they may present with (co-ordination of care).

APPOINTMENTS

Patients seen in Ophthalmology clinic may be given appointments for follow up of management or referred to other specialist clinics for care. Appointments vary depending on the case and could be from few days to 4 weeks.

REFERRALS TO AND FROM OTHER DEPARTMENTS

Referral from other clinics to Ophthalmology are seen in the general ophthalmology clinic running same day while subspecialty referrals are seen in the appropriate clinic. Emergency consults are seen same day by the senior registrar attached to the consultant on call and the consultant informed to review patient within 24 hours. A casualty clinic also runs every Wednesday to see emergency cases and treatment is commenced immediately.

	Procedure	**Who is responsible?**	**Time lag**
	Consultation	Doctors	10-30 mins
	Presentation to the nurses' station	Nurses	5-20 mins
	Directions to clinic referred to	Nurses / ward maids	10-30 mins
	Presentation and reception + appointment scheduling at the clinic referred to	Nurses of the clinic referred to	20-30 mins

Patients referred to the department from other departments are also seen. They are usually seen on the day of referral except they get to the department later than 6pm. The procedure includes:

	Procedure	**Who is responsible?**	**Time lag**
	Presentation at the nurses' station	Nurses	2-5 mins
	Teller for payment for consultation	Account unit	5-20mins
	Payment at the bank	Sterling bank	5-20 mins
	Teller presentation and registration	Nurses	5-20 mins
	Consultation	Doctors	10-30 mins

DUTY ROSTER

The duty roster for the month is done by the chief resident(for doctors) and the matron in charge (for the nurses and ward maids). The chief resident also prepares the roster for academic presentations. All rosters are placed on the notice board for every member of the department to see and soft copies are also sent to every member of the department.

REVOLVING FUND MANAGEMENT

The department's revolving fund is headed by the HOD and the project accountant, 3 consultant staff, the clinic and ward matron-in- charge as well as the chief resident are members of the group. Revolving fund meetings hold once a month while verification / reconciliation of accounts hold every Monday between the HOD, chief resident and accountant.

PURCHASE OF CONSUMABLES

In line with the SOP for Procurement & Stores department.

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

COMMUNITY / OUTREACH

Primary Health Centre Ndele is used as our community / outreach clinic and is covered by an optometrist posted monthly while a senior resident is posted every 3 months. We offer first aid, optical and minor surgical services to the rural populace. An annual free cataract outreach program has been successfully arranged yearly with over 100 free surgeries done.

QUALITY ASSURANCE

Regular assessment of residents using qualitative and quantitative means such as mock examinations. Patients and staff satisfaction are also assessed using satisfaction questionnaires.

NB: Please Refer to Theatre SOPs for theatre management procedures.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF ORAL & MAXILLOFACIAL SURGERY [OMS]

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *AKADIRI O.A.*

DATE: 12TH July 2018

SOP No: 002

NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am.

RESPONSIBILITIES AND RESPONSIBLE PERSONNEL IN ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICES

RESPONSIBILITIES	PERSONNEL	DURATION
Accessing outpatient care	Medical Records Officer(s) for Dental centre Pay point personnel Designated Clinic Maid Dental Nurse/Dental Surgery Technician OMS Team on clinic schedule	1 hour
Emergency care at A&E	OMS Team on Call	Response within 30 minutes of receiving Consult
Admission into wards	Ward Matron & Nurses on duty	Within 30 minutes of notification
Discharge protocol	Consultant / Residents on duty/Ward nurses/ Account officers	1 hour
Appointments	Chief resident/designated resident & Dental nurse	-
Sample collection/specimen	House officers/Residents	-
Issuing of medical reports, certificates	Consultant/ Resident under the Consultant's	-

	authority	
Policy towards NHIS patients	OMS Team on duty	-
Referrals	Consultant in charge/Residents under the Consultant's authority	-

PROCEDURES FOR CLINICAL SERVICES AT THE DEPARTMENT OF ORAL & MAXILLOFACIAL SURGERY

A. Accessing outpatient care

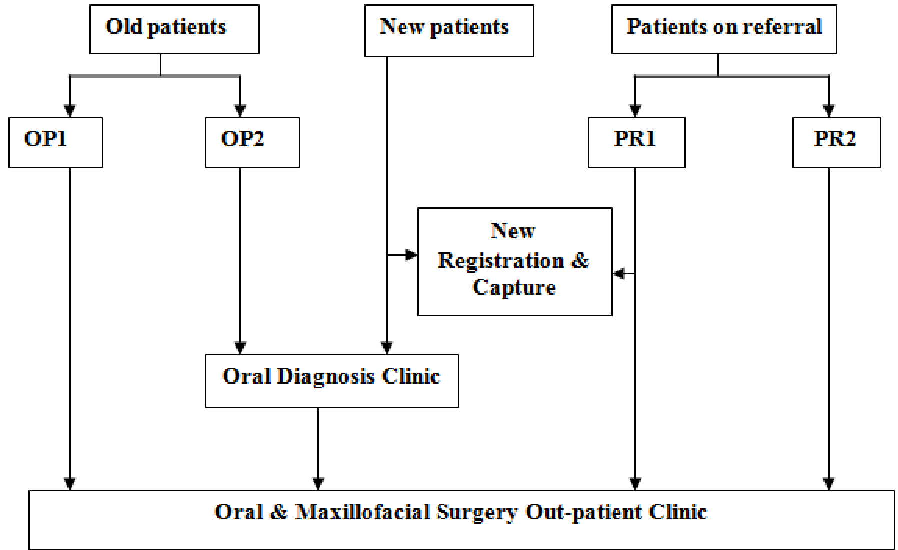
There are three streams of patients that access care in oral and maxillofacial surgery out-patient clinic, these are: new patients, old patients and patients on referral.

New patients: Patients visiting the OMS clinic on their own for the first time.

Old patients: Patients who have previously received OMS care in this hospital. There are two categories here; those coming for follow-up appointment (**OP1**) and those coming with fresh complaint after 6 months of the last visit (**OP2**).

Patients on referral: These are patients coming with a referral letter addressed to specific oral and maxillofacial surgeon or openly to the unit. There are two categories which are those from outside facility (**PR1**) and those from other units/departments in UPTH (**PR2**).

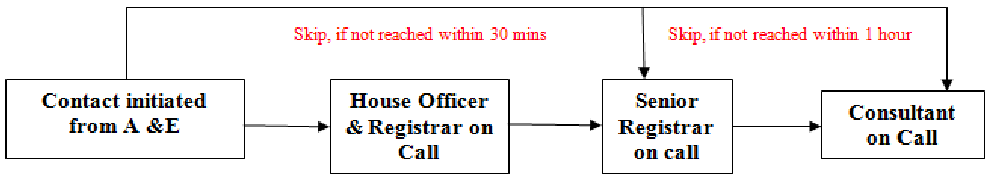
The procession of these patients to the point of care in OMS out-patient clinic is illustrated in the flow chart below:



Note that "**New patients**" and patients referred from outside facility (**PR1**) must go through registration and capture before proceeding to either Oral diagnosis clinic or directly to the OMS clinic respectively.

B. Emergency care at A&E

The OMS team shall provide emergency care at the A&E upon receiving a written consult or a phone call from appropriate personnel from the A & E. Our standard response time shall be within 30 minutes of contact (written or phone call). However, the timing may be affected by a number of unpredictable logistic challenges. Whatever be the case, life threatening emergency would be given the highest priority in terms of promptness of attention. The channel of consultation from the A&E is given below:



C. Admission into wards

Admission into the OMS ward shall be authorized only by a consultant or the chief resident with due clearance with the Consultant in charge of the patient. Patient shall be admitted either

from the outpatient clinic, A & E ward or via transfer from another ward in UPTH.

The admission process will include the issuance of teller for patient/relation to pay the admission deposit fee without which patient may not be accommodated on the ward. Special cases shall be treated with the discretion of authorized team members.

The nurses on duty shall receive patient, take and record vital signs and perform all other required nursing processes for admission. This shall be supervised by the Ward Matron.

A newly admitted patient must be fully clerked and documented by the OMS doctor on duty supervised by the Chief/Senior resident and reported to the Consultant in Charge.

Newly admitted patient must be reviewed by a consultant within 24 hours of admission.

Note however that OMS shall not admit multiply injured or systemically ill patients who require co-management with other specialty units for concerns of higher priority.

D. Minor and Major surgical procedures

Minor Surgery:

Patients who require minor surgery under LA (Local anaesthesia) shall be treated as a Day case in the Oral surgery clinic after obtaining informed consent which may be verbal or written depending on the complexity of the planned procedure.

After the procedure, patient shall be monitored to ensure adequate haemostasis and hemodynamic stability.

Patients who require prolonged monitoring shall be kept under observation for up to a maximum of 24 hours barring any unforeseen development.

Major surgery:

Patients who require major operation under GA (General anaesthesia) shall be managed through the following highlighted steps:

- Patient shall be given a specific date for admission preparatory for the surgery
- Patient shall also be given a list of pre-anaesthetic ancillary investigation plus any specifics relevant in an index case at least one week to scheduled surgery
- Patient presents results of all investigations at the last consultant clinic prior to surgery day for review and determination of the need or otherwise for additional tests/investigations.
- A shopping list which include all items and drugs patient must provide for surgery shall be given at the same time as above
- Patient shall be admitted early in the morning a day before the scheduled elective surgery
- Patients requiring control of certain systemic conditions e.g DM, Thyroid disease etc shall be admitted much earlier for review and input by relevant specialties.
- A operation list shall be drawn and copies delivered to the Theatre (Main & OMS Theatre), Anaesthesia department, OMS ward and ICU.
- In cases where special pre-anaesthetic preparation/consideration is required, an earlier consultation shall be made to the Consultant Anaesthesiologist in charge for prior review of patient
- Preoperative review shall be done on the afternoon preceding the day of surgery
- Patient shall be reviewed by the responsible/assigned anaesthesia team
- On the morning of surgery day, Patient shall be prepared by the nurses for transfer to the theatre
- Patients shall be called for and accessioned in the theatre by the perioperative nurses

- The perioperative nurses shall ensure adequate sterilization, selection and set-up of surgical instruments and special requests according to planned procedure
- Anaesthetic team shall take over patient to ensure propoer anaesthesia is delivered ready for the operation
- Surgical procedure shall ideally commence between 9 – 10 am (Knife-on-skin). The target shall be to complete the operation list for the day
- After proper post-anaesthetic recovery, patient shall be re-admitted to the OMS ward or the ICU depending on the evaluation and decision made by the anaesthesia and surgical team.
- Further nursing care on the ward shall be as obtained for every admitted patient and varies according to individual patient's needs.

E. Discharge protocol

A patient, upon discharge from admission, shall be given a bill covering the fees for all the services provided while on admission. S/He shall be required to make full payment before being released to go. Special cases shall be treated with discretion by authorized personnel and with necessary approval.

After settlement of bills, a discharge summary must be written by a doctor on duty and a copy given to the patient while a duplicate is kept in the patient's folder/. Also, a date must be given (written in the Out-patient Reference card – "Record's small card") by the doctor/nurse for the next follow up appointment.

F. Appointments

Follow up appointments, Surgery date and Admission date for pre-surgical work-up must be given and written in patient's reference card ("Records' small card") by designated personnel who could be a nurse, Dental surgery technician or House officer.

G. Sample collection/specimen

Collection of Samples for laboratory investigations and post-surgical specimen shall follow the following simple procedural steps:

- Explain indication, procedure and process to patient
- Patient gets teller to make payment and return with sample/specimen container
- Perform procedure (venipuncture, biopsy, swab, aspiration)
- Patient take sample to the laboratory
- Patient is given a review appointment
- Patient shall retrieve the result/report of investigation to present at the next appointment afterwards (This is expected to take from 24hrs – 2 weeks depending on the specific investigation)
- Result shall be documented in the case note and completed investigation filed in the case note.
- Further decisions on the use of results in patient management shall be taken or approved by the Consultant in charge.

H. Issuing of medical reports, certificates

Patients requiring medical reports, estimated bill for proposed service etc shall be required to make their request in writing addressed to the managing consultant. In response, the required report shall be written, and processed as laid down by the hospital management to ensure that the hospital seal and the doctor's stamp is affixed to every one of such reports.

Death certificate shall be issued upon confirmation of death, and shall be signed by the doctor who so confirmed.

I. Policy towards NHIS patients

Services to patients under the NHIS system shall follow the processes specified by the NHIS unit. No patient shall be treated under this arrangement unless due process is followed and necessary documents tendered.

J. Referrals

Patients shall be referred from OMS care to other clinical/service departments if in the opinion of the managing consultant, patient will benefit from inputs that might arise from such referral or the patient is better managed (taken over) by the recipient unit or department.

Referrals can also be addressed to outside facility; provided the required service is not available in UPTH.

All referral must be done with a properly endorsed written letter and all endorsement must be by or on behalf of the managing consultant with his authorization. A copy of the referral letter must be inserted in the patient's folder.

Beside outright referral, the OMS team may write a written consult to another unit within the hospital for the purpose of reviewing a patient under her care (both In-patient and out-patient) and will expect a written observation/advice from such department/unit either as documentation in the case file and/or as a separately written letter.

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS & CONSUMABLES

As outlined in the SOP for Procurement & Stores.

NB: For theatre management procedures, refer to theatre SOPs.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF ORAL PATHOLOGY & ORAL BIOLOGY

NAME & SIGNATURE OF HEAD OF DEPARTMENT:

Dr Omitola Olufemi Gbenga

DATE: 9TH July 2018

SOP No: 002

NOTE: Work Starts by 8:00 am.All clinics and knife on skin (Surgery) starts by 9:00 am

PURPOSE:

To establish guidelines for departmental operations with respect to the processes involved in patient management in the clinical departments of UPTH.

INTRODUCTION

Workplace policies establish boundaries for acceptable behaviour and guidelines for best practices in work situations; in line with international best practices, Standard Operating Procedures have become imperative for **Quality Improvement** purposes, for ease of clinical audit, monitoring and research in accordance with hospital regulations/vision, MOH provisions and extant laws. SOPs are aimed at improving compliance with set tasks/duties for good quality, consistent and predictable outcomes, giving room for evaluation/re-evaluation and improvement of the processes to ensure better outcomes and greater efficiency.

ACCESSING OUTPATIENT CARE

This can be for a fresh patient or old patient

For fresh patient

- The patient is register after payment for registration. This usually takes about 15-20 minutes. Referral letter is not mandatory for this registration.
- Patient proceeds to the vital signs table where the vital signs are taken and recorded in the case notes. This takes about 10 minutes

- The patient is given a teller to pay for consultation. Time depends on the number of people at the pay point but can take about 20-30 minutes.
- Then the patient is clerked by a clinical dental students or house officers or resident doctor after confirmation of payment.
- Patient is then presented to the Consultant in the clinic. This usually takes about 15-20 minutes. The differential diagnoses are drawn up and investigations to be done are listed.
- If the patient requires intra-oral radiograph this is taken after the payment of the necessary fee at the pay point. This takes about 30 minutes
- Patient is then referred to the appropriate Department in the Dental Centre for further management

For old patient (Old patients are registered patient that have not visited the Centre in the last 6 months).

- Case not is retrieved.
- Patient proceeds to the vital signs table where the vital signs are taken and recorded in the case note. This takes about 10 minutes
- The patient is given a teller to pay for consultation. Time depends on the number of people at the pay point but can take about 20-30 minutes.
- Then the patient is clerked by a clinical dental students or house officers or resident doctor after confirmation of payment.
- Patient is then presented to the Consultant in the clinic. This usually takes about 15-20 minutes. The differential diagnoses are drawn up and investigations to be done are listed.
- If the patient requires intra-oral radiograph this is taken after the payment of the necessary fee at the pay point. This takes about 30 minutes. The report is given to patient directly.
- Patient is then referred to the appropriate Department in the Dental Centre for further management

INVOLVEMENT IN EMERGENCY CARE AT THE ACCIDENT AND EMERGENCY DEPARTMENT

- Following the receipt of the request from the A&E Department unit, the first on call who is usually the resident doctor and house officer will review the patient.
- Depending on their finding, the Senior Registrar and the Consultant may be called in to review the patient.

- The patient may be discharge home and follow up treatment given in the outpatient clinic or admitted into the Oral and Maxillofacial Surgery ward.
- The patient management will then be taking over by the Oral and Maxillofacial Department.

PATIENT SAMPLE COLLECTION AND PROCESSING

- Patients for blood collection are sent to the phlebotomy unit for collection
- Patients for cytology/ smear are done in the outpatient clinic (Oral Diagnosis Clinic). This usually performed by the registrar in the unit or the senior registrar.
- Patient for oral biopsy procedure will be referred to the Oral and Maxillofacial Surgery Clinic where it will be performed and the sample send to the Oral Pathology Laboratory.
- In the Oral Pathology Laboratory, the sample is collected and registered after payment of the laboratory fee.
- The sample is processed in the laboratory. This usually takes about 1-2 weeks depending on whether it is soft or hard tissue.
- The slides are passed out of the laboratory and initially read by the registrar and then the senior registrar. The consultant will review all slides before they are passed out. The senior registrar and the consultant will sign the final report.
- The review and typing of result usual take about 1 week.

RELEASE OF LABORATORY RESULT

- The final result is returned to the laboratory where the patient can sign for a copy.
- The result is issued by the laboratory assistant after confirming patient paid for the procedure.

ISSUE OF MEDICAL REPORT/CERTIFICATE

- The patient will go through all the procedure for accessing outpatient care with the payment of all the prescribed fees.
- The report will be written by the registrar or senior registrar on behalf of the consultant.
- The final report will be sent to record department for stamping before it will be released to the patient.

POLICY TOWARD NHIS PATIENT

- NHIS patients will be given treatment free provided the procedure is among those approved by the regulatory body.

- Patients will have to come with a referral from the NHIS Clinic of the Hospital.
- They are also required to come with the necessary forms for proper documentation and claims.
- The procedure is similar to the described for accessing outpatient care.

RESPONSIBILITY

S/N	PROCEDURES	STAFF RESPONSIBLE
1	Registration of patient and retrieving patients case notes	Record officer
2	Taking vital signs	Dental surgery technicians (DST)
3	Issuing tellers/ Keeping account records	Account clerk/ Accountant
4	Clerking (History, examination, investigation)	Clinical dental student and Dental Surgeon (House officer, Registrar, Senior Registrar & Consultant).
5	Taking intra-oral radiographs/ Orthopanthomograph	DST, Clinical dental student and Dental Surgeon (House officer, Registrar, Senior Registrar & Consultant).
6	Taking oral smear/cytology	Dental Surgeon (House officer, Registrar, Senior Registrar & Consultant).
7	Registering Laboratory patients	Laboratory assistant
8	Processing laboratory samples	Medical laboratory scientist and Laboratory assistant
9	Reading of histopathology/cytopathology slides	Registrar, Senior Registrar & Consultant
10	Typing of patient reports (medical and laboratory)	Departmental secretary
11	Release of laboratory reports	Laboratory assistant

ACCREDITATION PROCESSES
Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES
As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF ORTHOPAEDICS AND TRAUMA

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *DR V.U.E. ADIELA*
PREPARED BY*:* *DR F. ORUPABO*
DATE: ……………………….
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am

PREAMBLE

The Department of Orthopaedics and Trauma consists of three units, with a staff structure comprising of Consultants, Senior Registrars, Registrars, House Officers, Nurses of various cadres, as well as other ancillary staff. Patients are admitted to the Orthopaedic wards, consisting of male, female, and children sections, via the Orthopaedic Outpatient clinic or through the accident and emergency department. Patients may also be transferred from other departments' in- patient wards. We also work closely with radiology department

PURPOSE

The Standard Operative Procedures are aimed at establishing guidelines for departmental operations with respect to the processes involved in patient management.

ORTHOPAEDIC OUTPATIENTS' CLINIC

Staff involved: doctors, nurses, plaster technicians, auxiliary staff.

- The orthopaedic outpatient department consists of consulting rooms, nurse's station, patient waiting area, plaster room, dressing room and pharmacy

- It is the first point of contact of most patients with the Department.
- Patients are referred from Family Medicine and other departments within UPTH, as well as from other health institutions.
- SOP for patient registration and payment has been established
- All new patients should be reviewed by the consultant
- List of minor procedures performed in the clinic and their cost, including cast application and removal

ADMISSIONS

- Patients are admitted to the wards under specific units and consultants after paying relevant deposits, from the outpatients' clinic and the Accident and Emergency unit
- Date of admission, managing team, consultant and provisional diagnosis must be recorded in the folder by the admitting team

SURGERIES

Staff involved: doctors, ward nurses, theatre nurses, auxiliary staff

Orthopaedic surgeries are carried out in the two orthopaedic suites in the main theatre, and also the A & E theatre for some emergencies. Collaboration with anaesthesia, radiology, laboratory, pharmacy and accounting departments.

Emergency surgery:

- Emergency surgeries are done as soon as practicable
- Patients may have to pay for external fixators and k-wires

Elective surgery:

- Patients booked for elective or definitive surgery are usually admitted from the outpatient's department or as emergencies from the A & E dept. after patient has been stabilised.
- Each unit operates once a week; however, we advocate extra surgery days for each unit during their call
- Necessary investigations should be carried out and informed consent signed before the day of the surgery
- Patients should pay for both pre- and post- operative radiographs prior to surgery
- Evidence of payment for ORF and TRF. The patients may have to procure their implants, these should be available for inspection and sterilization at least a day before surgery
- Operation list should get to theatre not later than 12 noon the previous day
- Nurses checklist

- Prophylactic antibiotics, DVT prophylaxis, post- operative analgesia protocol
- Post- operative notes should be properly filled; date and type of surgery and surgeon should be properly filled in the patient's folder

DISCHARGE PROTOCOL

Staff involved: consultants, residents, nurses, project accountant

- Decision to discharge is made by the consultant
- Before discharge, a discharge summary is prepared.
- A prepared discharge pro forma will aid in making sure relevant information is not omitted.A separate form for assessing nursing care may also be necessary
- Thereafter, the patient's folder is sent to the accounts department for assessment and payment.
- Date for follow-up of patients at the Outpatient Clinic is determined by the managing team.

DUTY ROSTER

Staff involved: Head of department, chief resident

- The duty roster and call rosterare prepared monthly by the chief resident with the approval of the HOD.
- Copies of the roster are sent to the A & E Department, other clinical departments and the main theatre. Copies are given to all unit heads and individualmembers of the Department and also placed on strategically located notice boards.

MANAGEMENT OF THE REVOLVING FUND AND PROCUREMENT OF CONSUMABLES

Staff involved: The head of department as Project Manager, all Consultants, a project accountant, project secretary, the chief resident, chief nursing officers in charge of all the wards, orthopaedic out patients' clinic and orthopaedic theatre, as well as a representative of hospital management

- Statutory meetings to be held once every month. Emergency meetings can however be held as the need arises.
- Procurement of consumables, implants, repair and replacement of equipment and instruments will be determined by the funds available.

DEATH OF A PATIENT

Staff involved: Doctors, Nurses, Clerks, Morgue attendants

In the event of death of any patient,

- A doctor is required to confirm same through standard procedures to establish no evidence of life.
- Certification of death protocol forms should be developed to prevent any lapses that could give rise to medicolegal issues.
- Relevant entries in the patient's folder including the time and cause of death, as well as the attempts made at resuscitation.
- Death certificates should be written which is deposited with the ward nurses for onward transmission to patient's relatives at the appropriate time.
- The morgue should be notified

ACADEMIC ACTIVITIES

- The academic roster for the department is prepared by the chief resident, approved by the HOD. It consists of unit presentations, clerking and clinical sessions, and an orthopaedic grand round

ACCREDITATION

Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

NB: Please Refer to Theatre SOPs for theatre management procedures.

UPTH STANDARD OPERATING PROCEDURE FOR PAEDIATRICS DEPARTMENT

NAME & SIGNATURE OF HOD: …………………………………………..
DATE: …………………………………………..
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am

INTRODUCTION:

Prepared by Consultants in Department of Pediatrics and Child Health, College of Health Sciences, University of Port Harcourt

Committee Composition:

- Prof. Barbara Otaigbe
- Dr. Peace Opara
- Dr. Iroro Yarhere

SCOPE:

- Develop a scheme of patient consultation and admission into the department
- Reduce the waiting time for consultation
- Triage and emergency care for critical patients
- Prevent leakages of revenues

PURPOSE:

To improve patient's consultation time and discharge from the clinics and wards
Improve the management of patients' conditions in the clinics and wards
Improve the image of the department

PROCEDURES:

<u>First time patient and follow up patient for out-patient and Consultant Pediatric (CP) clinic consultation:</u>

1. Obtain authentic identity folder from the Records unit within 10 minutes of arrival to the department
2. Direct patient to the nurses in the out-patient and CP clinics for vital signs and anthropometric measurement recording within 10 minutes of folder retrieval
3. Triaging will be done by the nurses for prioritization

4. Waiting time for consultations should not exceed 30 minutes for each patient
5. Bloodletting for investigations will be done within 10 minutes of processing with the laboratory

First time patient and follow up patient for Emergency room consultation:

It is the policy of the emergency room to admit, diagnose and treat any emergency within the first 24 hours without recourse to the patients' ability to pay for services or insurance coverage:

1. Nurses will triage patients according to codes and send to the physician for care
2. Patient in critical care is immediately taken to the treatment room and treatment procedure initiated within 5 minutes of arrival
3. Following diagnosis and stabilization, the patient is taken to the open ward for continued care
4. The first on-call will inform the second-on-call immediately and/or seek assistance
5. All procedures for diagnosis and treatment will be performed in the emergency room unless otherwise stated
6. Patients' dignity and honor shall be maintained at all times
7. Surgical patients shall be operated within 6 hours of diagnosis
8. There will be daily rounding of patients at 8:00 am with the physician in charge, senior resident and residents
9. Upon stabilization, patient shall be transferred to the children medical wards for continued care
10. Patients can be discharged following treatment from the emergency room

Protocols in the Children medical wards

1. Patients are admitted directly from the emergency room, CP or out-patient units
2. Nurses on duty arrange the beds and corners of patients before the patient arrives
3. There will be daily rounding of the patients in the wards at 8:00am
4. Patients' treatment and management plans shall be documented and updated daily
5. Intravenous medications shall be administered by the medical doctors
6. Oral and intramuscular medications shall be administered by the nurses
7. Written discharge summaries shall be made by the registrar on behalf of the managing consultant and signed off
8. All procedures will be carried out in the procedure rooms

Special Care Baby Unit

1. Patients are admitted directly from the labour wards, labour ward theaters, post-natal ward, and children emergency room
2. admission processes shall be completed within 30 minutes of patient's arrival
3. Patient shall be resuscitated on the resuscitaire and samples for investigation processed within 30 minutes of admission
4. There shall be daily rounding of patients and management plans documented and updated
5. Surgical patients shall be operated upon within 6 hours of diagnosis
6. Discharge summaries shall be written by the registrar on behalf of the consultant

Initial deposits and Discharge payment

For all cases, initial deposits shall be made to cover items used for resuscitation and emergency care.

Upon discharge, nurses will list all items used and procedures done on the patient for the finance or accounts officer to make their bills.

Patients shall pay exact fees to the designated bank in the department

Upon sitting receipt of payment, nurses will escort the patient to the exit of the hospital.

Policy following death

Autopsies shall be performed on all deaths within 24 hours even on weekends. Informed written consents/accent shall be requested and obtained from the parents or care-givers before the corpse is taken from the wards.

All mortalities shall be discussed in the weekly morbidity and mortality reviews

This policy was abridged and prepared on the 10th of September 2018.

PURCHASE OF CONSUMABLES:

In line with the SOP for Procurement & Stores department.

ACCREDITATION PROCESSES:

Please refer to SOP for CS & T.

UPTH STANDARD OPERATING PROCEDURES FOR PALLIATIVE CARE UNIT

NAME & SIGNATURE OF HEAD OF UNIT: *NDUKWU GERALDINE*
DATE: ……………………………………
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics start by 9:00 am
PURPOSE: To establish guidelines for delivering appropriate palliative care services in UPTH.

RESPONSIBILITIES: Palliative care unit is a multidisciplinary approach to specialized medical and nursing care for people with life threatening illnesses, through the prevention and relief of suffering by means of early identification and impeccable assessment, with treatment of pain and other; physical, psychosocial and spiritual problems of a terminal diagnosis to improve quality of life for both the patient and their family/caregiver.

1. ASSESSING PATIENT CARE IN THE UNIT INVOLVES THE FOLLOWING

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME
i.	Open new folder or retrieve previous folder	Nurse	5mins
ii.	Presentation at the palliative care clinic nurse station	Nurse	5mins
iii.	Vital check	Nurse	15mins
iv.	Health education	Nurse	10:20mins
v.	Consultation	Doctor	30-45mins
vi.	Return to nurse's station for further directives	Nurses	30mins

2. **OBSERVATION /PROCEDURE ROOM:** Room used to keep patients who still require other forms of observations and treatment before allowing home. It involves.

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME
i.	Consultation	Doctors	30mins
ii.	Presentation at nurse station	Nurses	10mins
iii.	Admission for observation as stated in consultation (Pain management/mental and spiritual counseling, family conferencing etc.)	Nurse/ Doctor/chaplain	1-3hrs

3. **APPOINTMENTS:** Patients seen in the palliative care unit may be given appointments for follow up of management or referred to other specialist's clinic for co-management. Appointments vary depending on the case and could be from few daysto 4 weeks.

4. **REFERRALS TO AND FROM OTHER DEPARTMENTS:** Referrals from the palliative care unit is a two-way referral, which means that after treatment in the clinic in which the patient is referred, the patient should come back to the palliative care unit for further follow up care

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME
i.	Consultation	Doctors	20mins
ii.	Presentation at nurse station	Nurses	5mins
iii.	Directions to the clinic referred to	Nurse/ward maids	20mins
iv.	Presentation and reception appointment scheduling at the clinic referred to	Nurse of the clinic referred to	20min

Patients referred to the palliative unit from other departments are also seen. They are usually seen on the day of the referral except they get to the unit later than 4pm or 6pm.Procedure includes: -

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME
i.	Presentation at the nurse station	Nurses	5mins
ii.	Consultation	Doctors	30mins

5. **CONSULTATION FROM OTHER DEPARTMENTS:** Patient on admission is seen by the PCU team on receiving consult from the managing team.

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME
i.	Presentation of consult at nurse station reception	Nurse	5mins
ii.	Consultation visit	Doctors/Palliative team	30mins

Daily outpatient services at the palliative care unit and counseling at the center of the radio-oncology clinic

6. **STAFF MEETING:** This are done once every 2months for a duration of 2-3 hours, where the staff come together to discuss the welfare of the unit.

7. **SUPPORT GROUP MEETINGS:** This provides opportunity for patient, doctors and other specialists to come together and discuss, share personal experiences and interact. The purpose is also for sharing coping strategies about their illnesses in order to encourage, empower and uplift the patient. This last for about 3 hours and comes up once every month.

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME
1	Arrival and registration	Social worker	30mins
2	Introduction of topic and	Speaker and cancer	30-90mins

	sharing	survival	
3	Questions and interactions	Moderator	30-45mins
4	Refreshment and closing formalities	PCU team	15mins

8. **HOME BASED CARE (HOME VISIT):**The palliative care unit provides medical and supportive care for the patient and family at home. This is especially for the terminally ill patient that prefer to die at home, need hospice care or cannot afford hospital admission. Duration of visit is about 3-4 hours and should be weekly or monthly depending on patient's needs.

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME
1	Arrival at patient home	PCU team	30min -2hrs
2	Consultations	Doctor	30mins
3	Prescriptions and other needs	Doctor and PCU team	30- 90mins

9. **FAMILY CONFERENCE:** The palliative team, the patient and family relatives/carer come together to discuss about the illness, goals of care and plan care strategies to enhance the quality of care provided to patient and the family/carer.This takes 60-90mins.

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME
1	Arrival of family members and the PCU team at the venue.		
2	Discussion	Doctor moderates with the other team members	60-90mins

		participating.	
3	Conclusion and assigning of task	Doctor	20-30mins

10. **BEREAVEMENT SERVICES:** This is done by offering counseling and assistanceto the family of the deceased patient on how to bury their relation. The PCU team also helps the relation through the grieving period and also participates during the burial when it is possible.

STEP	PROCEDURE	WHO IS RESPONSIBLE	TIME
1	Breaking the new of death of patient to the family	Doctor or any member of the PCU team	30-60mins
2	Assisting with death certificate and other activities as regarding preserving the corpse.	Doctor/ PCU team	30mins
3	Attending burial and advice on any other issues.	PCU team	90-180mins

11. **ROUTINE TELEPHONE FOLLOW-UP**: Occasional phone call to patients, to check-up on their well-being.

12. **QUALITY ASSURANCES:** Regular assessment of staff of the unit using qualitative and quantitative means such as pre and post assessment examination. Patient and staff satisfaction are also assessed using satisfaction questionnaires.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF PHARMACY

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *VICTORIA E. UKWU*
DATE: 23RD July 2018
SOP No: 002
SOP Title: Management of Drugs in UPTH Pharmacy
NOTE: Work Starts by 8:00 am.

PURPOSE

Development of a descriptive documentary instrument which serves as a prototype template or system for navigation of key operations of Pharmacy Department with regards to the performance of its functions as the provider of essential medicines to patients and the hospital community.

INTRODUCTION

The SOP is a descriptive documentary instrument containing a set of rules, practices, protocols, procedures, guidelines and systems which constitutes the backbone of operations of the department involved in the performance of its functions as the engine room for the provision of essential medicines and controlled drugs.

It is a description of the functional organisation of the department with regards to the apportioning of responsibilities and the methods to be employed by officers responsible in performing their duties and functions.

It is also an expository to authorities and clients of the hospital seeking specialised services of the department on the channels to explore in order to access the services required.

SCOPE

These SOP elucidate the spectrum and channels of operations of the different units of the Pharmacy department and is subject to change or amendment in light of time and experience as may be dictated by laws governing ethical professional practice.

RESPONSIBLE PERSONS

Accountable Officer (AO)	The Accountable Officer is **Mrs Ebikemi Victoria Ukwu,** who is also the Head of Department and the project Manager of the Essential Drug Revolving Fund (EDRF). Address: Telephone Number:
Responsible Pharmacist	The responsible Pharmacist is **Pharm. (Mrs) Ebikemi Victoria Ukwu.** Address: Telephone Number:

RESPONSIBILITIES

Responsibilities are assigned to Heads of Pharmacy Units which form the components of the department. There are eighteen units/ subunits which are itemised below alongside their respective Heads/Subheads.

General Administration	Ebikemi Victoria Ukwu (Mrs). Ezenwanyi N-Chris (Mrs).
Paediatics Pharmacy	Ezenwanyi N-Chris (Mrs).
Accident and Emergency Pharmacy	Ibidun F. Dokubo (Mrs)
Surgery/Orthopaedic Pharmacy	Blessing I. Amadi.
Ophthalmology/ENT Pharmacy	Roseline O. Abumere (Mrs)
Lab/DIC/Theatre Pharmacy	Wilson Opoto InkoLaye
Family Medicine (GOPD) Pharmacy	TonyeOpuda (Miss)
O &G Pharmacy	Dr. (Mrs) NwamakaCookeygam
Drug Store	Onabanjo O. Ikumuyite Ibelema Green (Miss)
NHIS/FSSC Pharmacies	Joy Iniworikabo(Miss)
Internal Medicine Pharmacy I (MOPC I)	Chinyere Azunda (Mrs)

Internal Medicine Pharmacy II (MOPC II)/CEPU	Christopher Osuala. TarilateTemedie
ARV/MDRTB	OpualayeWariboko-West.

PROCUREMENT AND STOCK TAKING OF CONTROLLED DRUGS

The Central Medical Store (CMS), Oshodi makes a list of available stock and prices of controlled/ narcotic drugs and sends it to the hospital.	**Procedure involved**
The HOD of Pharmacy, through the CMD makes an order for the drugs subject to the needs of the department and the minimum order quantity using the hospital requisition document for controlled drugs.	
The HOD calculates the cost of requested drugs and remits same to CMS, Oshodi.	
The CMS, Oshodi acknowledges receipt of payment and despatches the drugs to the HOD of Pharmacy who receives them personally.	
The HOD of Pharmacy keeps records of the consumption of the drugs using some official record books. These records and books are sent periodically to the Director of Pharmaceutical Services (DPS) of the State who carries out checks to ascertain, confirm and countersign all records.	
The National Agency for Food and Drug Administration and Control (NAFDAC) pays frequent unscheduled visits to the department to take stock of the controlled drugs.	

7. Receipt of Controlled Drugs

The HOD of Pharmacy, Pharm. (Mrs) E.V. Ukwu accepts deliveries of controlled drugs from the CMS and keeps them in her custody for end-user units to request. In some cases, appropriate formulations of the drugs are not available but	**Specify names,of all who may accept delivery of CDs.**

needed in the hospital. In such cases, Active Pharmaceutical Ingredients (APIs) may be suppliedby the CMS (e.g. morphine powder instead of morphine injection or tablets). Such case scenario requires the attention of the formulation Pharmacist to transform the APIs to individualized end- user formulation such as liquid morphine. For this purpose, the HOD releases some of the drugs to Pharm. Wilson Opoto who is in charge of the compounding/ manufacturing laboratory.	
Unit Heads of Pharmacy may receive allocations of controlled drugs either from the manufacturing laboratory or directly from the HOD of Pharmacy depending on the needs of the units.	**Specify all locations and the process to be followed and also any process to be followed in the event of being unable to immediately access the correct drugs.**

SAFE STORAGE OF CONTROLLED DRUGS

Storage locations are: Drug Stores (Bulk Store, Active Drug Store) and all Satellite Pharmacy Units.	**Specify all storage locations.**
Storage Conditions: Humidity: relative humidity of 60% or lower. Temperature of storage space to be maintained between 15-25 degrees centigrade. A mercury thermometer fastened to the wall of the storage space makes monitoring of temperature possible. Thermolabile drugs to be stored in a refrigerator between 2- 8 degrees centigrade. Drugs should be stored in the dark so as to prevent deterioration of photolabile drugs (use of blinds) and lights should be switched off when the store or dispensary is not in use.	

SAFE STORAGE OF PRESCRIPTION STATIONERY

Storage location: DRF Bulk Store in a dry place protected from pests and destructive insects.	**Specify all locations and how storage is secured.**

PREVENTING EXPIRATION OF DRUGS

Prevention of expiration of drugs is achieved through various professional inventory practices such as: FIFO (First in, First out) LIFO (Last in, first out) depending on expiry date (FEFO- First to expire, First out).	**Describe the procedure involved and category of staff responsible for it**
Shifting stock from areas where they are less needed to areas or dispensaries where they are more needed. Frequent stock taking exercises.	
It is the duty of all staff especially the Pharmacists to be observant and contribute to prevention of expiration of drugs.	

DISPENSING

Pharmacist receives prescription from the patient and checks for the following: If it is written and signed by a medical doctor working in the institution; If there are prescription errors such as errors in dosage form, dose or regimen;	**Describe the process involved**

If there are detrimental drug interactions e.g. drug-drug, drug-food, drug-laboratory test interactions; If there are any issues or findings takes appropriate steps to correct anomaly in agreement with the prescriber or makes other pharmaceutical care intervention as may be appropriate; If there are no issues or issues arising corrected, he proceeds to cost the prescriptions. On costing the prescription, he sends the patient or caregiver to pay for prescribed drugs in the pay-point	
The patient after paying for the drugs comes back to the pharmacist to obtain his drugs. The pharmacist on sighting the payment documents (tellers and receipts), proceeds to dispense the prescriptions to the patient according to guidelines for Good Dispensing Practice (GDP).	
Patient is counselled by the Pharmacist on the use of his medications. Pharmacist makes necessary documentations.	
N.B. Prescriptions for narcotics should contain only narcotics or controlled drugs.	

COLLECTION AND DELIVERY OF CONTROLLED DRUGS

The HOD of Pharmacy collects controlled drugs personally from CMS, Oshodi.	**Detail practice process including responsibilities, system and record keeping.**
See section 7 for responsibilities, system and record keeping for controlled drugs	

BILLING

Prices of drugs are centrally determined from the	**Describe disposal**

drug store using the stipulated Percentage mark-up for the hospital	**protocol**
After stock checks, expired drugs are valued and documented.	
The expired stock is handed over to NAFDAC for boarding or destruction.	
The Hospital foots the bill for hiring of labour and transportation of the drugs to NAFDAC or NAFDAC specified site.	
Expired controlled drugs are withdrawn by NAFDAC for boarding.	

STOCK CHECKS

Stock checks are done as frequently as permissible within units.	**Detail practice process including frequency of checks.**
A major mid-year stock involving the departments of Pharmacy,Internal Audit and Accounts.	
A major end-of-year stock taking involving the departments of Pharmacy, Accounts and external Auditors.	

DESTRUCTION AND DISPOSAL OF CONTROLLED DRUGS

NAFDAC comes in to the department periodically to check records and stock of controlled drugs	**Describe disposal protocol**
Expired drugs are withdrawn by NAFDAC, disposed or boarded.	

POLICY TOWARDS NHIS DRUGS

The department makes plausible efforts to ensure that drugs listed in the NHIS working document are provided in NHIS Pharmacy.	**Describe disposal protocol**
The department is not under obligation to provide prescribed drugs not listed in the working document. Patient pays for such drugs.	

COMMUNICATION WITH CLINICAL DEPARTMENTS ON THEIR DRUG NEEDS AND AVAILABLE DRUGS IN THE PHARMACY

The department compiles drug bulletin from time to time and circulates to prescribers	**Describe protocol**
Units of Pharmacy inform prescribers working in their service departments of the need to prescribe more of some drugs to prevent their expiration.	

PROCUREMENT AND STOCKING OF HIGHLY SPECIALIZED DRUGS

Procurement of highly specialised is done by quarterly tendering except emergency cases.	**Describe protocol**

ADVERSE EVENTS AND PHARMACOVIGILANCE

Persons responsible (for reports):

Name	Role	Timescale
	Responsible person	
	Deputy	

TRAINING

	Detail practice process.

ACCREDITATION

Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS & CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF PHYSIOTHERAPY

NAME & SIGNATURE OF HEAD OF DEPARTMENT: …………………………………

DATE: …………………………………

SOP No: 002

NOTE: Work Starts by 8:00 am.

INTRODUCTION

The physiotherapy department of University of Port Harcourt Teaching hospital has five major units: Neurology/Medicine Physiotherapy, which has presently two sub units, Care of the elderly unit and neurology: Pediatrics physiotherapy has two sub units, Pediatric neurology Physiotherapy and Pediatric musculoskeletal Physiotherapy; Women's Health Physiotherapyhas two sub units, Antenatal and Post-natal Physiotherapy; Surgicalconditions in Physiotherapy has burns and Plastic Physiotherapy, Cardiopulmonary Physiotherapy and Pre and Post-Surgical Physiotherapy sub units ; Lastly, Orthopedic Physiotherapy has Trauma and Spine Physiotherapy. Also,there is custom split Making Workshop (For orthotic only).

CLINICAL OPERATIONS

This department provides the necessary training to meet the complete operation of spectrum of patients care responsibility involve in preventing disabilities and promoting restoration of functions to the physically

impaired.This includes; musculoskeletal and neuromuscular disorders that interfere with physical functions.

Our physiotherapy management includes; prescriptions of exercise therapy. This may include and is not limited to Physiotherapeutic exercises, Electrotherapy and Manual therapy.

ORGANIZATION

The department of Physiotherapy and Rehabilitation handles the inpatient (wards-patients) as well as the outpatient department for all Physiotherapyrelated conditions.

This department employs eighteen Physiotherapiststo provide super specialized therapy for the patients of physiotherapy University of Port Harcourt Teaching Hospital. The Physiotherapist are assigned to each of the ward patients and out patients in all five (5) major Physiotherapy units.

SERVICE STANDARDS

The physiotherapy department

1. Each patient referred will be attended to within 30mins after arrival in all units.
2. Physiotherapeutic assessment will be carried out by physiotherapist using appropriate, physiotherapeutic tools or instrument and outcome measure with medical radiological reports and laboratory results to arrive at Physiotherapy diagnosis.
3. Every patient will be assessed thoroughly on the first day of assessment.
4. The initial assessment done and physiotherapeutic treatment given will be documented immediately in the patient's folder.
5. Plan of care of treatment for each patient will be designed taking with consideration patient's level and their goals from Physiotherapy.
6. Goals, short term and/ or long term, will be set for each patient. This goal will be documented at the time of initial assessment therefore each patient will be re assessed or reviewed every one or two weeks depending on how many treatment sessions (at least six (6) treatment sessions) to assess their achievement of goals.
7. For the patients assess by our physiotherapy interns, each initial assessment and at least each treatment sessions each week will be supervised by respective physiotherapist.
8. Strictly, the policies of the University of Port Harcourt Teaching Hospital and guidelines will be followed in the Physiotherapy department in the wards and out patients' departments as well.
9. INPATIENTS: the length of treatment sessions is usually thirty to forty-five minutes and can be repeated at least two times a day according to the needs, for example, a patient with respiratory conditions may have more than two treatments daily.
   It is done in coordination with the medical and nursing team and it must be documented in the folder.
10. OUTPATIENT: Forty-five (45) to Sixty (60) minutes treatment sessions in the physiotherapy outpatients. Follow up of each case is mandatory. Physiotherapy sessions are delivered by professional physiotherapist who received training based on international standards as established by world confederation of physical therapy. The focus of physiotherapy department is to prevent impairment and restore functions in road traffic accident cases,

domestic accident, non-communicable diseases, fire disasters, work related musculoskeletal and neurological disorders and congenital, physical impairments and developmental delays.

CLINICAL ORGANIZATIONAL CHART

An organizational flow chart is included below

HEAD OF PHYSIOTHERAPY DEPARTMENT

Neurology/Medici
Pediatric
Orthopedic
Women's
Surger

OP
Neurolog
CEP
W
OP
W

Musculoskeletal
W
OP
Neurolog
W
OP

Trauma
W
OP
Spin
W
Out

Antenat
W
OP
Postnat
W
OP

Burns
&
W
OP
Per &
Post
Surgica
W
OP
Cardiopulmonary
W
OP

= WP - Ward Patients

= OP - Outpatients

Cases needing urgent medical or surgical interventions:
These are the inclusion criteria for referrals:

- Severe cardiovascular compromise
- immediate ICU intervention
- Immediate live saving medico-surgical procedure
- Cases needing the specialized surgery
- Cases requiring the devices like the customized orthotics

MOTOR NEURONE DISEASES

Cardio respiratory:
Cardiopulmonary diseases
Dyspnea
Airflow obstruction/mucus retention
Restrictive lung diseases etc.

PEADIATRICS

Birth defects;
Club foot
Spinal bifida
Down syndrome
Cleft lip and/ palate
Developmental delays (including the ones due to malnutrition) and cerebral palsy

OTHER NON-COMMUNICABLE DISEASES

DIABETES (foot ulcers, pain and limb amputation), cardiovascular diseases (hypertension), peripheral vascular diseases etc.

OTHERS

Referral for the specialized services:
Wound management
Prosthesis and orthotics
Corrective and reconstructive surgeries and specialized rehabilitation services.

ORTHOPEADIC/SURGERY

Post trauma/ surgery joint stiffness
Post trauma/surgery joint pain swelling
Post trauma/surgery muscle weakness
Stump management following
Burns
Head trauma- stabilized

Torticollis
Idiopathic scoliosis/ postural scoliosis
Ankylosing spondylitis

SPONDYLOLISTHESIS (Isthmic type and Post-surgical)

- Spondylitis
- Retrolysthesis
- Osteo arthritis
- Rheumatoid arthritis
- Septic arthritis
- Osteomyelitis
- Ligaments and tendon disorders
- TB spine after medical or Surgical management etc.

NEUROLOGICAL

Multiple sclerosis
Paralysis due to poliomyelitis
Post poliomyelitis syndrome
SCI medically and surgically stabilized
Neurological conditions due to meningitis, Parkinson's disease,
Muscular Dystrophy
Transverse myelitis, Multiple sclerosis.

WOMEN'S HEALTH PHYSIOTHERAPY

Others indications during pregnancy includes

- Pedal edema
- Leg cramps
- Pelvic organ prolapses
- Body aches and pains
- Carpal tunnel syndrome
- Recti abdominal diastasis
- Pubic symphysis dysfunction
- Hemi-plegia
- Hemiparesis
- Facial nerve palsy
- Sacroiliac joint dysfunction
- Tailbone pain

ACCREDITATION

Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores

OMOJUNIKANBI ALFRED
Ag. Head of Physiotherapy Dept.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF PREVENTIVE DENTISTRY

HEAD OF DEPARTMENT: *DR SOROYE MODUPEOLUWA OMOTUNDE*

DATE: 10/7/2018
SOP No.: 002
NOTE: Work Starts by 8:00 am. Clinics start by 9am.
PURPOSE
To establish guidelines with respect to the processes involved in patient management in the Department of Preventive Dentistry, UPTH.

INTRODUCTION

The Department of Preventive Dentistry consists of two units and an Annex;

- Periodontology unit
- Community Dentistry Unit with a Primary Oral healthcare outpost at Ahoada General hospital, Ahoada
- An annex at the Federal Secretariat, Rumuola.

The Department is concerned with the prevention of oral diseases as well as the diagnosis and management of the diseases of the supporting structures of the teeth.

The Department provides training for Resident doctors, Dental students, Nursing students, Community health students and industrial attachment for dental therapy students from the Institute of Dental Technology, Enugu. In addition, it provides training for Dental technicians and Dental Surgery assistants from the Schools of Dental Technology in Rivers and Bayelsa States

The Department provides Oral health education to patients in the out-patient clinics in the Hospital, does diet control programmes, plaque control programmes, smoking cessation programmes, and community and school outreaches.

The Department provides periodontal surgeries such as crown lengthening, gingivectony/gingivotomy, frenectomy/frenotomy, soft tissue and bone grafting, Guided Tissue Regeneration and gingival cosmetic surgeries to patients

SCOPE

Accessing Outpatient Care

This can be for a fresh or old patient

a.) Reception / Waiting period for Patients

PatientsareusuallyreferredtoPreventivedentistrydepartmentfromOraldiagnosisunitand other departments. Every patient referred to the Department of Preventive Dentistry must bereceivedpolitelyandseenwithintheshortestpossibletime,usuallynotmorethanten (10) minutes. Patients should be seen on first-come-first-servebasis.

b.) Attending to Patients in the Department

Every new and old patient must first be seen by a doctor and clerked.

Treatment is provided by the doctors and Consultants and where scaling and polishing is required; the therapist may be requested to perform the procedure.

Patients seen by house officers and students must be supervised by a Consultant or Resident Doctor in the absence of a Consultant

Residents must provide dental care under the guidance and directive of the supervising Consultant

d.) Payment for Treatment

Payment for treatment involves collection of payment slip from the department, teller from account clerk and final payment made at the pay point. Time depends on the number of people at the pay point but can take between 20-30 minutes.

On presentation of teller of payment, patient is then seated on the dental chair to receive treatment

e.) Treatment time

The treatment time varies depending on the type of treatment, approximately from 30 minutes for non-surgical treatment, to 2 hours for surgical treatment.

f.) Sterilisation of Used instrument

Topreventcross-infectionintheclinic,allinstrumentsforpatientcaremustbesterilisedand care giver must wear disposable hand gloves and ward coat while treating patient.

g.) Taking care of Instruments and locking of Departmental cupboard

At the close of work each day, the Dental Surgery Assistants (DSAs) must ensure all departmental instruments and equipment are safely kept and all lockers and cupboard securely locked

h.) Cleanup of the Clinic

In addition, the DSA must ensure that all dental units in the department are cleaned using disinfectant

RESPONSIBILITY

S/N	PROCEDURES	STAFF RESPONSIBLE
1	- Clerking (History, examination, investigation) - Treatmentplan - Treatment	Clinical dental student and Dental Surgeons (House officer, Registrar, Senior Registrar& Consultant).
2	- Scaling and Polishing/ Oral Hygiene Instructions (OHI)	Dental Students, Dental Surgeons and Dental therapists

3	- Cleaning of dentalchair - Setting up of instruments for examination andtreatment. - Sterilisation ofinstruments. - Post-operativeinstructions.	Dental Surgery Assistants

INVOLVEMENT IN EMERGENCY CARE AT THE ACCIDENT AND EMERGENCY DEPARTMENT

- Following the receipt of the request from the A&E Department, the resident doctor and house officer on call will first review the patient.
- Then the Senior Registrar and the Consultant will also review the patient.
- The patient may be discharged home or given follow up treatment at the outpatient clinic.

PATIENT SAMPLE COLLECTION AND PROCESSING

- Patients for blood collection are sent to the phlebotomy unit
- Surgical excision is done for patients with gingival enlargement in the clinic and the samples sent to the Oral Pathology Laboratory for histopathology. The result is received about 1 week later

ISSUE OF MEDICAL REPORT/CERTIFICATE

- The patient will go through all the procedures for accessing outpatient care with the payment of all the prescribed fees.
- The report will be written by the senior registrar with input from the consultant in charge.
- The final report will be sent to record department for stamping before it will be released to the patient.

POLICY TOWARD NHIS PATIENT

- NHIS patients will be given treatment free provided the procedure is among those approved by the regulatory body.
- Patients will have to come with a referral from the NHIS Clinic of the Hospital.
- They are also required to come with the necessary forms for proper documentation and claims.
- The procedure is similar to that described for accessing outpatient care.

MANAGEMENT OF REVOLVING FUND

The Head of Department shall be responsible for procurement through hospital certified contractors with the fund allocated to the department from the revolving fund.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

ACCREDITATION PROCESS AND STATUS

Please refer to SOP for CS & T.

UPTH STANDARD OPERATING PROCEDURE FOR PROCUREMENT/STORES DEPARTMENT

NAME & SIGNATURE OF HOD: ***TONYE OGOLO***
DATE: 10/7/2018
SOP No: 002
SOP Title: Process of Acquiring Goods and Services for The Hospital, Storing and Keeping Proper Records of Them Until They Are Needed by The User Departments
NOTE: Work Starts by 8:00 am.

INTRODUCTION

Just as the name implies, Procurement is the process of finding agreeing terms and acquiring goods, works and services from the external sources often via a tendering or competitive bidding process for the organization.

PROCUREMENT PROCESS:

Every procurement process begins with planning, and for each financial year, each procuring entity such as University of Port Harcourt Teaching Hospital shall establish a procurement planning committee according to public procurement Act 2007 section (21) and the procurement planning committee shall consist of:

(a) The accounting officer of the procuring entity or his representative who shall chair the committee
(b) A representative of;

1. The procurement unit of the procuring entity who shall be the secretary
2. The unit directly in requirement of the procurement.
3. The financial unit of the procuring entity
4. The planning research and statistic unit of the procuring entity
5. Technical personnel of the procuring entity with expertise in the subject matter for each particular procurement and
6. The legal unit of the procuring entity.

The duties of the planning committee are in two segments namely; Planning and implementation.

A. PLANNING:

Subject to regulation as may from time to time be made by the Bureau under the direction

Of the council, a procuring entity shall plan its procurement by: -

i. Preparing the needs assessment and evaluation
ii. Identifying the goods, works and services required.
iii. Carrying appropriate market and statistical surveys and on the basis prepare analysis of the cost implications of the proposed procurement.
iv. Integrating its procurement expenditure into its yearly budget.

B. Subject to regulation as may from time to time to made by the Bureau under the direction for the council, a procuring entity shall plan implementing its procurement plan.

i. Advertise and solicit for bids in adherence to the Procurement Act and guidelines.
ii. To invite two credible persons as observers in every procurement process, one person each representing a recognized;
iii. Private sector professional organization whose expertise is relevant to the particular goods or services being procured and
iv. Non-government organization working in transparency, accountability and anti-corruption areas, and the observers shall not intervene in the procurement process but shall have right to submit their observation report in any relevant agency or body including their own organization or associations.
v. Obtain approval of the approving authority before making award (Done by PTB)
vi. Resolve complaints and dispute if any
vii. Obtain certificate of No Objection where necessary.

APPROVAL AND AWARDS:

a. After Six weeks which is the duration of the advertisement done by the Secretary of the Planning committee, The

   Committee hands over to the Parastatals Tenders Board whose duty is to invite the bidders, open the Tender Box and awards the procurement of goods, works and services within the threshold set in the regulations.

b. In all case where there is a need for pre-qualification, the Chairman of the Tenders Board shall constitute a Technical evaluation sub-committee of the Tenders Board charged with the responsibility for the evaluation of bids which shall

be made up of **professional staff of the procuring entity and the Secretary of the Tenders Board who shall also be the Chairman of the Evaluation Sub-committee.**

c. Debrief the bid losers on request.

MEMBERSHIP OF THE PTB

The memberships of the Parastatals Tenders Board are as follows:

a.	The Chief Executive	-	Chairman
b.	Director of Administration	-	Member
c.	The Director of Finance	-	member
d.	HOD Works and Services	-	member
e.	Quantity Surveyor	-	member
f.	Legal Head	-	member
g.	HOD Procurement	-	secretary.

MEMBERS OF THE TECHNICAL SUB COMMITTTEE:

A.	Head of Procurement Unit	-	Chairman
B.	Head of Works and Services	-	Member
C.	Head of Quantity Surveyor	-	Member

SUPPLIES

After the award, supplies are made to the UPTH central stores in the presence of the Internal Auditor, Head of Stores Unit, and the User Department/Unit; before inviting the various Department/Units to come with their requisition books for collection.

Thanks.

T. G. OGOLO
HOD PROCUREMENT

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF RADIOLOGY

NAME & SIGNATURE OF HEAD OF DEPARTMENT: **Dr Ugboma EW**
DATE: 12/07/2018
SOP No: 002
NOTE: Work Starts by 8:00 am.
PURPOSE:
To establish guidelines for departmental operations with respect to the processes involved in patient management in the diagnostic department of UPTH. To provide comprehension high quality imaging service leading to the establishment and confirmation of clinical diagnosis

RESPONSIBILITIES:

The department of Radiology attend to the imaging needs of patients of UPTH who are referred from the various clinical departments of the hospital. It is a service department.

1) **ACCESSING PATIENT CARE IN THE DEPARTMENT INVOLVES THE FOLLOWING:**

Step	Procedure	Who is Responsible?	Time lag
1	Costing of the investigation to be done	Radiographers/	5-10 mins
2	Pay for investigation	Accounts unit	30-20 mins
3	Presentation for registration after payment	Accounts unit and nurses	5 - 10 mins
4	Directed to waiting area	Nurses	5-10 mins
5	waiting for the investigation to be done: Ultrasound scan X ray Specials	Radiologist/Radiographer	30- 60 mins 30-60 mins Ivu morning 30mins Other special studies 5-

			7hrs starts in the afternoon after 2pm
6	After investigation is done. Waiting for the result Typing of Ultrasound scan reports X ray/ specials	Doctors Doctors Typists	 30-40 min 3-5 days
7	Dispatch of Reports	Medical records - x ray Doctors uss	30-60 ins

- The printed but unreported film will be available within 30 minutes of completing the study. The final typed and signed report will be ready in 3-5 days.
- Printed films without typed and signed reports may be taken from the department but must be signed for by the attending doctor, patient or patient relative must sign for it. The film thereafter must be returned to the department for reporting and issuance of a signed report

2) **<u>VARIOUS IMAGING MODALITIES/RESPONSIBILITY</u>**

Step	Procedure	Who is responsible?
1	X RAYS	RADIOGRAPHERS /DOCTORS
2	ULTRASOUND SCAN	CONSULTANTS/REGISTRAS
3	CT/MRI	RADIOGRAPHERS/DOCTORS
4	INTERVENTIONAL STUDIES	DOCTORS/NURSES
5	Special studies- HSG, MCUG, IVU, ETC	DOCTORS/ RADIOGRAHERS

3) **REPORTING OF INVESTIGATIONS**

Step	**WRITING OF REPORTS**	**Who is responsible?**	**Time lag**
1	X RAYS	DOCTORS	**5-10MINS**
2	ULTRASOUND SCANS	DOCTORS	
3	DOPPLER STUDIES	DOCTORS	
4	MRI/CT	DOCTORS	
5	SPECIAL STUDIES	DOCTORS	

4) **RELATIONSHIP WITH NHIS**:

Department attends to the NHIS patients at all times.

NHIS patients must present stamped clearance for the requested study before it can be carried out.

5) **DUTY ROSTER**:

The duty roster for the month is done by the chief resident (for doctors) the matron in charge (for the nurses and ward maids) and the chief radiographers for the radiographers. The chief resident also prepares the roster for academic presentations. All rosters are placed on the notice board for every member of the department to see and soft copies are also sent to every member of the department.

6) **REVOLVING FUND MANAGEMENT**:

The department's revolving fund is headed by the HOD. Other members are the project accountant, senior consultants, the chief resident and chief radiographer. Meeting are held every 2ndWednesday of the month. A purchase committee for the PPP with IDC runs once a month and looks into consumables purchase by the PPP. Members of the committee are the HOD, chief radiographer, and members of IDC, project accountant, secretary, store chief and the matron.

7) **ACCREDITATION PROCESSES**:
Please refer to SOP for CS & T.

8) **REVOLVING FUND MANAGEMENT/ PROCUREMENT OF EQUIPMENTS & CONSUMABLES**
As outlined in the SOP for Procurement & Stores.

9) **IN-PATIENT CARE**
The department provides in- patient imaging care to patients on admission. It is done on request from the referring doctor.

10) **EMERGENCY SERVICES**:
The department runs a system where emergency cases are attended to as soon as they present in the department. Patients who are on admission or unstable must be accompanied to the department by a nurse.

Step	Emergency service	Who is responsible?	Time lag
1	X RAYS	RADIOGRAPHER/DOCTORS	**10-20MINS**
2	ULTRASOUND SCANS	DOCTORS	
3	DOPPLER STUDIES	DOCTORS	

11) **SERVICES OUTSIDE THE DEPARTMENT AND THEATRE**
When the services of staff of the department are required in theatre for any procedure (this includes ultrasound guided procedures and use of the C-arm) a consult should be sent to the department not less than 24hours before the planned surgery or procedure. A copy of the operation list must be sent to the department as soon as it is made. The appropriate fees should be paid and the teller handed over to the radiology accounts department. The staff of the assigned unit can then take part in the surgery or procedure.

- For services in the wards for non- mobile patients; the cost of the investigation must be paid for in the radiology department. Then the assigned staff can then proceed to the wards to carry out the investigation.
- NHIS patients must present the stamped clearance in the department for the requested investigation before the assigned unit will proceed to the wards or theatre.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF RESTORATIVE DENTISTRY

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *DR UMANAH A.U*

DATE: 21ST July 2018
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am

PURPOSE

To establish guidelines for departmental operations with respect to the processes involved in patient management in the clinical departments of UPTH.

RESPONSIBILITIES

The department of Restorative Dentistry is a specialized unit of Dentistry that is involved in providing fixed prosthesis, Removable partial and full dentures, endodontic procedures and tooth restoration. The Department receives patients referred to the Unit usually from the Oral Diagnosis Clinic and any of the other dental Specialities as well from outside the Teaching Hospital. Currently the Department has 3 subspecialties of Removable Prosthodontics and Implantology, Endodontics and Fixed Prosthodontics and Operative Dentistry. Beyond the Clinic, the Department has two Laboratories where Removable prosthesis and Fixed Prosthesis are fabricated. The Doctors, Dental Technologists, Dental SurgeryTechnicians (DST) and Laboratory Assistant interrelate in a seamless way to ensure efficient delivery of service to the Customers (Patients).

The Department is a speciality unit and thus does not see patients first hand. Patients are usually referred from the Oral diagnosis Unit of The Department of Oral Diagnosis and Oral Pathology as well as from other specialties of Dentistry specialties.

ACCESSING PATIENT CARE IN THE DEPARTMENT INVOLVES THE FOLLOWING

Step	**Procedure**	**Who is Responsible?**	**Time lag**
1	Open New folder or retrieve previous folder	Medical records unit	30 minutes
2	Pay for consultation fee (N500)	Accounts unit	10-20 mins
3	Presentation at the nurses' station / Assigning patient Case note to Doctors	DST	5-10minutes (based on availability of free doctor)
4	Consultation	Doctors	10-15 minutes
5	Investigations	Doctors/DST	10-15mins
6	Payment for treatment	Accounts Department	5-10 mins
7	Payment at Bank pay point	Bank account staff	15-30mins
8	Receipt of payment taken to the clinic	Patient	5 mins
7	Waiting at the waiting hall for treatment	-	10-20 mins
8	Treatment	Doctors	30mins-2 hour
9	Presentation at DST station for further directives (appointments,post-operative instructions)	DST	5-10 mins

REVIEW /SUBSEQUENT VISIT

Step	Procedure	Who is responsible?	Time lag
1	Retrieve case file	DST	10-20 mins
	Review	Doctor	5-10mins
	Collection of tellers	Accounts staff	5-10 mins

2	Payment at the bank	Sterling bank	10-20 mins
3	Receipt of payment taken to the Clinic	-	5 mins
4	Treatment	Doctor/DST	30mins-1hour

RELATIONSHIP WITH A&E AND NHIS

The department sees patients from the NHIS after such patients have been seen in the Department of Oral Diagnosis. Such Patients are thereafter examined and treatment outlined and patient sent back to NHIS for collection of code approving the treatment before such is carried out.

Patients from A&E will also be seen first by the Oral Diagnosis department before being referred to the department for treatment.

MANAGEMENT OF PATIENTS IN THE DEPARTMENT

Since the department is a specialty unit, patients referred to the units are usually given the DST who distributes them to the doctors (House officers and Residents). Simple cases are given to the students to clerk and manage under supervision. Challenging cases are managed by Senior Residents and Consultants. Referrals are made or other specialists are invited to review cases that would require co-management, this is usually well documented in patient folder. Outright referral to other units is documented in patient's file when patient chooses treatment option that is outside our jurisdiction and the patient sent to the referred department.

APPOINTMENTS

Patients seen in the Restorative Clinic may be given appointments for treatment if

1. Patient presented too late for the treatment to commence that day
2. If patient cannot afford the cost of treatment that day
3. If the specific specialist clinic of which patient requires is not that day.

   DST are responsible for documenting on patient Clinic appointment card the day, time and doctor name who the patient is scheduled to see as well as document on the clinic diary.

REFERRALS TO AND FROM OTHER DEPARTMENTS

Referral to other department will follow these steps;

Step	Procedure	Who is responsible?	Time lag
1	Consultation	Doctors	10-30 mins
2	Presentation to the DST	DST	5-10 mins
3	Directions to clinic referred to	DST	5 mins
4	Presentation and reception + appointment scheduling at the clinic referred to	Nurses of the clinic referred to	20-30 mins

Patients referred to the department from other departments are also seen. They are usually seen on the day of referral except they get to the department later than 3pm. The procedure includes:

Step	Procedure	Who is responsible?	Time lag
1	Presentation at the DST station	DST	2-5 mins
2	Teller for payment for consultation	Account unit	5-20mins
3	Payment at the bank	Sterling bank	5-20 mins
4	Teller presentation and registration	DST	5-20 mins
5	Consultation	Doctors	10-30 mins

DUTY ROSTER

The duty roster for the month is done by the chief resident(for doctors) and by the Head DST for the DSTs. The chief resident also prepares the roster for academic presentations. All rosters are placed on the notice board for every member of the department.

REVOLVING FUND MANAGEMENT

The department's revolving fund is headed by the HOD (Dr AU Umanah) and the project accountant is part of the group. Meeting are held every month for the effective running of the department.

PURCHASE OF CONSUMABLES

This is done in conjunction with the DEPUTY CHIEF RESIDENT and the DST in charge of consumables in the department. After compilation of desired consumables, the list is forwarded to the Project secretary who places an advert for bids. Thereafter, the bids are opened and selection of contractor(s) based on lowest reasonable prices to procure the material is done. Thereafter, supplied consumables is vetted and inspected by Audit/ Stores before being stored for departmental use.

QUALITY ASSURANCE

Regular assessment of residents using qualitative and quantitative means such as mock examinations. Patients and staff satisfaction are currently assessed via random verbal assessment. Questionnaires or examining satisfaction of service delivery is being developed.

INFORMED CONSENT

Verbal informed consent is gotten from patients before carrying out the point of care tests while written informed consents are gotten before a procedure is carried out on the patient.

STANDARD OPERATING PROCEDURES

The department of restorative dentistry comprises three major specialties namely;

1. Conservative dentistry/ Fixed Prosthodontics
2. Prosthodontics/ Removable Denture
3. Endodontics

There are areas of overlap in the 3 specialties' which would cause the standard operating procedures to be similar.

OPERATING PROCEDURES COMMON TO ALL UNITS

1. Use of lead apron and thyroid collar during exposure of any radiograph
2. Standard universal precautions of cross infection control
3. Pregnant women (especially during third trimester if treatment is absolutely necessary) should be treated while reclined at 45° to the horizontal plane.
4. Sterilization or disinfection of handpieces between patients and sterilization of all used instruments before use.
5. Adequate explanation of treatment plan, obtaining informed consent before undertaking treatment and proper documentation of treatment done with name and signature of dentist.
6. Proper supervision of dental students handling patients. All treatment plans must be approved by supervising dentist before been carried out.
7. Repeat procedures done due to departmental error should be done without charging patient.

CONSERVATIVE DENTISTRY

1. Use of rubber dam to prevent injuries to soft tissue and accidental ingestion of burs
2. Use of properly cooled handpieces to prevent burns
3. Proper documentation of all procedures planned and performed. Patient duly informed and consent obtained before treatment is carried out.

PROSTHODONTICS

1. Proper positioning of patients during impression making to prevent aspiration or ingestion of impression material
2. Patients to be given typed post denture insertion instructions
3. Proper filling of laboratory forms to prevent mismatch of patient's prosthesis
4. Proper matching of prosthesis to patient before placement in patient or before any adjustment is made on prosthesis.
5. Disinfection of impression materials and prosthesis fabricated before insertion in patient's mouth

ENDODONTICS

Due to the use of tiny operating instruments such as burs, reamers and files during endodontic treatment that can be aspirated, it is required that the following are done to prevent this.

1. Gold standard precaution: use of rubber dam as intraoral surgical drape
2. Proper positioning of patients to prevent ingestion or aspiration of instruments or irrigating fluids.
3. Attaching dental floss to the files and reamers to aid easy retrieval if ingested.
4. Use of 0.5 -2.5% concentration of sodium hypochlorite as irrigating fluid
5. Use of side venting irrigating needle to prevent irrigating fluid from entering periapical space and causing chemical injuries. where this is not readily available, use of minimal force during irrigation

STANDARD OPERATING PROCEDURE FOR APICECTOMY/SURGICAL ENDODONTICS:

<u>Operative management</u>

1. Drugs

There is no current evidence to support the use of peri/post-operative antibiotics, however post-operative antibiotics cover should be given when compliance with post-operative instructions is questionable.

Chlorhexidine mouthwash is used prior to surgery to reduce plaque accumulation and oral bacteria. Anxiolytics and analgesics preoperatively could be helpful in the management of post-operative pain.

2. Anaesthesia

Local anaesthesia should be the method of choice and cartridges should be properly examined for expiration dates, cracks and cloudiness. General anaesthesia would be indicated in cases where the size of the peri radicular lesion/cyst makes surgery in an outpatient conscious environment unsafe.

3. Magnification

The use of magnification with surgical loupes (3-4x) will be the standard of practice in this department however magnifying hand-held lens can also help.

4. Soft tissue management

Proper assessment of soft tissue prior to surgery should be carried out

5. Osteotomy and peri radicular curettage

The removal of bone, following an assessment of the root-length and its axis, should allow adequateaccess to the root end. Removal of soft tissue using curettes is necessary and mandatorily all lesions curreted should be stored in formalin and sent to Oral Pathology for Histology.

6. Root-end resection, preparation and filling. Resection of the root should be carried out as close to 90 degrees to the long axis of the tooth. Resect at least 3mm of root end with a rotating bur. Examine the resected root end the resected root surface under magnification forcracks, canal irregularities and ensure a smooth finish.

Remove all Gutta percha to a depth of 3-4mm with bur or ultrasonic diamond coated tip.

The prepared root-end should be adequately isolated and dry prior to filling. The material for filling is Mineral Trioxide Aggregate (MTA). Suture soft tissue back

7. Post-operative instructions and care

This would be the standard care pathway unless otherwise specified by the operator.

Assessment of outcome

The recommended clinical and radiographic follow-up required would be at: 1 month, 3 months, 6 months and1 year. Radiographic examination endeavours to achieve the same angulation as the preoperative radiograph.

INFECTION CONTROL SOP

INTRODUCTION

All dental personnel in operational settings are at risk of skin, eye, mucous membrane, or parenteral contact with blood or other infectious material during their normal work routine. Patients are also at risk of infections from aerosols or contaminated instruments or surfaces. There is therefore need for high level of infection control in the Department.

TRAINING

All personnel and students rotating through the department will receive initial training in general infection control and training in aseptic and sterilization techniques,

The following are to be strictly adhered to:

All dental staff are to wear personal protective equipment (PPE) to include gloves,clinical apparel, face masks and protective eyewear during patient care.

1) Clinical wear will beworn only in dental spaces and changed daily or more frequently when visibly soiled.
2) Change of masks aftereach patient where aerosols are produced or when visibly contaminated is required by all personnel.
3) Immunization status of all personnel in respect of Hepatitis B should be pursued and monitored.
4) No eating nor drinking by personnel in clinical spaces.
5) Hand Hygiene. The most important first step in infection control is hand hygiene before and after patient care.
6) Bar soap should not be used in the dental treatment room and hands should be dried withdisposable paper towels.
7) Dentists should wear sterile gloves for all invasive procedures; non-sterile exam gloves are acceptable for other procedures. Staff handling patients should remove gloves and wash hands prior to completing record entries
8) Dental delivery system water lines disinfection protocol must be instituted to prevent transmission of water borne pathogens.

Dental delivery system water lines should be flushed for one minute at the beginning of each day and for 30 seconds after each patient.

9) Only sterilized or disinfected trays and instruments are used in treatment of patient. Difficult to disinfect items/areas (dental chair, light handles, x-ray tube heads, etc.) should be covered with plastic wrap or foil and these should be changed between patients. Clean and disinfect all contact surfaces, dental unit surfaces, and countertops with a high-level disinfectant.
10) Materials in tubes or syringes should be dispensed in unit doses when possible.
11) The use of Rubber dams should be wherever possible.
12) Needles should be recapped using a device made for the procedure or with the one-handed and disposed in appropriate sharps container.
13) High volume evacuation should be used during all procedures that create aerosols and it should be flushed with a quart of water and disinfectant at the end of each day

STERILIZATION/ DISINFECTION

1. Personnel will wear heavy puncture resistant gloves while handling and cleaning potentially contaminated items and immerse all reusable items in high level disinfectant before further handling. Autoclaving all instruments that can withstand heat. The instruments packs should be labelled with disclosing tapes for monitoring sterilization
2. Dry heat should be used to sterilize burs and other non-disposable cutting instruments.
3. Heat labile instruments should be sterilized using high level disinfectant.
4. Disinfection of dental chair headrest, hand-operated controls, switches, and handles is mandatory after each patient. Daily disinfection of counter tops, the dental light, X-ray apparatus and protective shield.

PROSTHETIC LABORATORY

Appliances, casts and impressions must be disinfected either prior to entering the lab, or in a designated, contaminated area in the lab itself.

SOLUTIONS FOR IRRIGATION

Irrigants should be discarded after 1 week of opening and if to be used for surgical procedures must be opened that day and not reused for surgical procedure thereafter.

INFECTIOUS WASTE DISPOSAL

Infectious, or regulated, waste is liquid or solid waste containingpathogens in sufficient numbers and virulence to cause infectious disease. Of interest todentistry are “sharps”, liquid or semi-liquid blood, dried blood, saliva and pathology specimen.

Infectious waste should be placed in dedicated appropriate containers labeled withthe universal biohazard logo. Contaminated sharps are placed in rigid, puncture resistant sharpcontainers labeled with the biohazard logo; and turned in to the medical department for disposal.

HAZARDOUS MATERIALS

1. Mercury Safety. Mercury spills require a specific cleanup technique and this should be well known to all unit staff. Amalgamators should be placed in stainless steel pans to catchmercury if a capsule break and the triturator cover should be closed during use. Leftoveramalgam should be placed in a closed metal container containing used x-raydeveloper and disposed properly.
2. Use of face masks and gloves while handling monomer liquid in laboratory and clinic spaces.
3. Non-disposal of dental stone or plaster through the wash hand sink

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURE FOR SECURITY DEPARTMENT

NAME & SIGNATURE OF CHIEF SECURITY OFFICER – *Mr Oba Ibinabo*

DATE: 11th July 2018

SOP No: 002

SOP Title: Processes involved in maintenance of hospital equipment and infrastructure

1. PURPOSE:

- To ensure safety and security of the Hospital building, equipment, patients and staff.
- To provide safe and assuring environment in the hospital premises for efficient deliveryof healthcare services and review for improvement.

2. SCOPE

It covers all the equipment essential for provision of clinical services, water supply, power generation and infrastructure.

3. FUNCTIONS OF THE DEPARTMENT

a) Protection of life and property in the institution
b) To ease traffic in the hospital
c) Providing directives for Man O'war

4. ROLES AND RESPONSIBILITIES OF VARIOUS STAFF DEPLOYED TO THE DEPARTMENT:

The members of staff in the department are 17 and include

S/NO	ROLE	NAME AND PHONE NO
1	Security	Mr Oba Ibinabo – 08038974792
2	"	Mr Zelde Monday – 08030912851
3	"	Miss Igoni Precious – 08037083035
4	"	Mr UwamEghuam – 08166984626
5	"	Mr Ogan L. Livingstone – 07064522323
6	"	Mr FubaraOgboada – 08064327347
7	"	Mr Sonime Samuel – 08025390062
8	"	Mr Opuiyo T. Jeremiah – 08063757865
9	"	Mr Ibibo A. Mitchel – 08037594552

10	"	Mr NgonimeAcheseemie – 08051095291
11	"	Mr IkaweFyneface – 08062290384
12	"	Mr Vincent Meallin – 07033479734
13	"	Mr IkeremaNwaditor – 09039482127
14	"	Mr EleruAmadi – 08064529449
15	"	Mr WizorGodpower – 08035787497
16	"	Mr Amah Kamalu – 08168771341
17	"	Mr Anthony Njika– 08066680108

5. CONTROL OF IN-COMING AND OUT-GOING ITEMS:

All members of the security involved.

1) Banner at the gate for registration of personal items brought into the hospital.
2) Items not previously registered will be cleared with proof of ownership
3) Outgoing hospital items/equipment will require a written approval from the HOD of the department and counter signed by the CSO

6. KEYS CONTROL:

keys are kept the security post at the reception of UPTH.

1) Register name, department of the keys
2) Department's staff (usually cleaners) sign for the key indicating name, signature and time of collection
3) Returned keys are also signed
4) Daily countersigning by security staff

7. RESTRICTED VISITING HOURS:

Visiting time is 4pm – 6pm.	**Describe the procedure involved and category of staff responsible for it**
1) Nurses announce when visiting time is over	**All members of the security department are responsible**
2) If there's any interference, the nearest security post is notified.	
Departments with security posts are: O&G, Psychiatry and A&E.	

8. **FIRE SAFETY AND ITS CONTROL:**

In case of fire outbreak:	**Describe the process involved and waiting time**
1) Alert Security head/unit closest(2-5mins)	**All members of the security department are responsible**
2) The fire service unit is informed (5 mins)	
3) Extinguishing fire (10-30mins)	

9. **HOSPITAL SAFETY COMMITTEE:**

NIL

10. **EVALUATION OF HOSPITAL ACTIVITIES WITH RESPECT TO SAFETY:**

	Describe the process and category of staff involved
1) Available number of security personnel doing their possible best	**All members of the security department**
2) Inadequate man power	
3) Inadequate equipmente.g. fire service truck	

12. HAZARD RECOGNITION AND NOTIFICATION:

1) realization/ identification of the hazard by the immediate unit	**Every member of the security department is involved**
2) Supervising unit alerts the HOD and /or Departmental Safety Manager, Works department Safety Unit	
3) CSO reviews	
4) calls Police unit if necessary	

11. SAFETY INSPECTION AND RECORDS:

Done by the fire service department.

12. ELECTRICAL SAFETY:

Done by the works and service department

13. BIOLOGICAL HAZARDS:

NIL

14. LABORATORY SAFETY:

NIL

15. PATIENT AND STAFF SAFETY:

	Describe protocol involved and categories of staff involved
1) Information from the wards/clinics/departments to the nearest security unit	All members of the security department are involved. The latter are rostered to various departments/units with their names & numbers submitted to the HOD & Chief Resident.
2) Dispatch of security to the relevant place	
3) Arrest of the situation	

16. RECORDS:

The following are adequately kept registers	**Detail practice process including responsibilities.**
1) Attendance register	All members of the security department are involved. Duty roster is kept at the reception.
2) Key movement records	
3) Vehicle movement records	
4) Personal property register	

17. EMERGENCY NUMBERS:

	Detail practice process including responsibilities.
08038974792	This is the CSO's number. He is

	called on at identification of any security hazard.

18. REGISTERS, VISITORS'TAGS & STAFF IDENTIFICATION CARDS

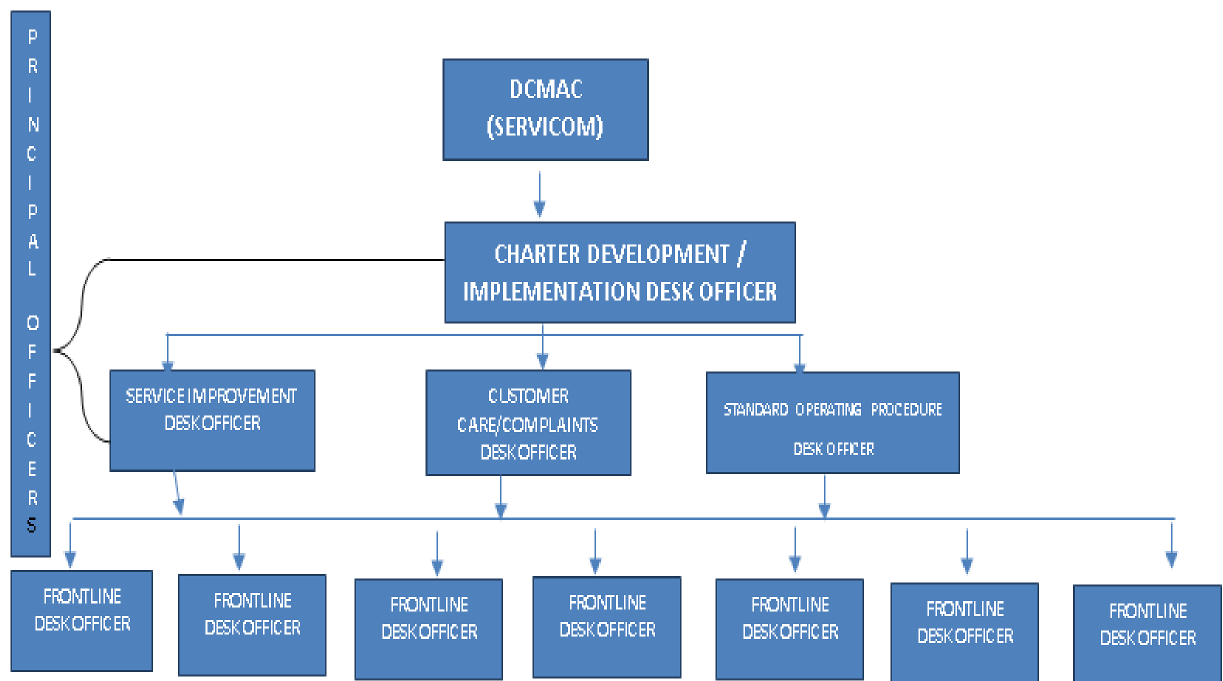
Security in the Wards	**Detail practice process including responsibilities.**
At least 2 security officers should be stationed at a security desk stationed outside 2 wards in close proximity	Their responsibility is to control and monitor entry of inpatients & external visitors in and out of wards. The latter should be searched for possession of lethal weapons, expected to fill their names in a register; stating the purpose of visit, time in & time out. On discharge, the security personnel should be shown the patients' copy of the Discharge Certificate and evidence of payment for all services rendered in order to prevent absconding of patients. Under no circumstances should the wards be without a security personnel at any point in time.
Visitors' Tags/Staff Identification Cards	Visitors' Tags should be issued to authorized visitors which should be worn at all times; all members of staff are expected to wear their ID cards around their necks while in hospital premises.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURES FOR SERVICOM UNIT

NAME & SIGNATURE OF HEAD OF UNIT: ***DR OBIANMA N. ONYA***
(SERVICOM NODAL OFFICER & DCMAC NHIS/SERVICOM)
DATE: 10/7/2018
SOP No: 002
SOP Title: THE PROCESSES INVOLVED IN ENSURING OPTIMAL SERVICE DELIVERY IN UPTH BY THE SERVICOM UNIT



INTRODUCTION

SERVICOM (Service Compact) is a Federal Government initiative that was established in 2004 to ensure optimal service delivery in all government Ministries, Departments and Agencies (MDAs). In line with this goal, the University of Port Harcourt Teaching Hospital has keyed into the objectives of SERVICOM, by ensuring that our clients (the patients) receive good quality, timely and efficient services whenever they access our facilities.

It is in view of the aforementioned objectives that the **SERVICOM Unit** of the University of Port Harcourt Teaching Hospital is saddled with the responsibility of ensuring that the hospital upholds the tenets of the **Patients' Bill of Rights**.

The SERVICOM Unit has put in place certain measures to actualize these objectives including developing and implementing the Standard Operating Procedures & SERVICOM Service Charter; ascertaining job descriptions (duties/tasks) of staff; regulating/monitoring and evaluating service delivery in the hospital by conducting Patient Satisfaction Surveys and other service improvement measures using relevant indicators.

It is also within its purview to continuously check duty rosters and attendance registers to curtail suboptimal service delivery in the hospital.

Below, is the SERVICOM Organogram of the University of Port Harcourt Teaching Hospital. It comprises Principal and Frontline SERVICOM Officers. The latter report to the former and the former report to the DCMAC (NHIS/SERVICOM) who is the **SERVICOM Nodal Officer in UPTH.**

PROTOCOLS:

The DCMAC (SERVICOM Nodal Officer):

- Is the head of the Parastatal SERVICOM Unit (PSU) in the hospital.
- Holds weekly meetings with all the Principal and Frontline SERVICOM Officers (the entire SERVICOM Unit).
- Attends to matters that require urgent attention and matters that cannot be handled peripherally (by SERVICOM Principal & Frontline officers).
- Is expected to respond to complaints within 10 working days.
- Is expected to report the progress of the resolution of the complaint within 15 working days, statutorily.
- Plans and reviews the strategies of the SERVICOM Unit.
- Reviews weekly reports submitted by the Charter Development /Implementation Desk Officer.
- Takes disciplinary actions against erring SERVICOM staff.
- Reports directly to the Chief Medical Director on SERVICOM matters and the SERVICOM Office Presidency (through the CMD) in line with the provisions of the SERVICOM guidelines with respect to the responsibilities of SERVICOM Nodal Officers in MDAs.

DUTIES OF THE PRINCIPAL AND FRONTLINE DESK OFFICERS

CHARTER DEVELOPMENT/IMPLEMENTATION DESK OFFICER:

- To guide the departments/Units and other service frontlines on Charter formulation and implementation.
- To monitor the implementation of Service Charter periodically.
- To coordinate and review the Charter in conjunction with the Service Improvement Desk Officer.
- Draws up the duty/leave rosters and is in charge of posting frontline desk officers to various departments after due consultation with the DCMAC.
- To periodically brief the DCMAC with regards to formulating and implementing the Service Charter.
- Reports to the DCMAC.
- To carry out any other function as may be assigned by the DCMAC in line with service delivery.

CUSTOMER CARE/COMPLAINTS DESK OFFICER:

- To oversee the reception areas of the hospital.
- To coordinate, produce and publicize the client care policy of the hospital.
- To produce and circulate client feedback form to customers.
- To collate, analyze and publicize comments by the clients.
- To ensure clients are aware of the hospital complaints procedure.
- To keep records of all complaints, comments, compliments and suggestions by customers.
- To periodically (quarterly) publicize a summary of complaints, as well as commendations and compliments received by action taken.
- Reports to the Charter Development/Implementation Desk Officer and the DCMAC.

SERVICE/QUALITY IMPROVEMENT DESK OFFICER:

- To ensure the promotion of quality assurance and best practices in hospital services delivery.
- To in conjunction of with the Charter Desk Officer monitor the implementation of the Hospital Service Charter.
- To carry out the Patient Satisfaction Surveys.

- To update the Service Delivery Improvement plans and actions of the hospital for further deliberation by the SERVICOM SOP Technical Committee.

- To carry out other function that may be assigned by the DCMAC with regards to quality improvement in service delivery.

STANDARD OPERATING PROCEDURES DESK OFFICER:

- To assist the DCMAC in collating the standard operating procedure drafts from departments /units.
- To liaise with the various departments for the purpose of the development and revision of the standard operating procedures.
- To liaise with the Service Improvement Desk Officer to see to it that the standard operating procedure is followed at all times.
- To report to the Charter Development/Implementation Desk Officer and the DCMAC.
- To carry out other function that may be assigned by the DCMAC with regards to development and review Standard Operating Procedures.

SERVICOM FRONTLINE DESK OFFICERS:

- To take complaints directly from the service outlets.
- To ensure that services do not fail at the service outlets.
- To intimate patients about the modus operandi of the hospital.
- To sensitize the clients (patients) on their rights and privileges.
- To address any enquiry bordering on service delivery that the clients may have.
- Reports to the principal SERVICOM Officers.
- To ensure that they issue aggrieved customers the complaints form after all efforts to solve the issue fail.

UPTH STANDARD OPERATING PROCEDURE FOR DEPARTMENT OF SURGERY

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *PROF. PATRICK O.* EGHWRUDJAKPOR
DATE: ……………………………………
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am
INTRODUCTION

The Department of Surgery is one of the major clinical departments of the University of Port Harcourt Teaching Hospital (UPTH). It was created with the twin goals of (a) producing well trained surgical manpower that possess the requisite skills and knowledge to practice their profession not only in Nigeria but also anywhere in the world and (b) providing high level surgical services in line with best practices.

To achieve these goals, the Department has a staff structure that includes Consultants, Senior Registrars, Registrars and House Officers. Apart from the consultants that are certified specialists, the others are doctors at different levels of training. At present the Department has specialists in all the major subspecialties of Surgery including: General Surgery; Paediatric Surgery; Orthopaedic Surgery; Urological Surgery; Burns, Plastic and Reconstructive Surgery; Cardiothoracic Surgery and Neurological Surgery.

PURPOSE

The Standard Operative Procedures are aimed at establishing guidelines for departmental operations with respect to the processes involved in patient management.

Management of surgical patients occurs at several levels. Within the department itself, inpatients are managed in the surgical wards; while patients that have been discharged for follow-up and all new patients are seen in the Surgery Outpatients' Clinic.

SURGERY OUTPATIENTS' CLINIC (SOP)

Patients seen in the SOP include those referred from Family Medicine and other departments within UPTH, those referred from other health institutions within and outside Port Harcourt, and old patients of the Department on follow-up. First time patients usually come with referral letters from the referring doctors.

ACCESSING PATIENT CARE IN THE SURGERY OUT PATIENTS' CLINIC

(Table 1)

All patients visiting the SOP are expected to go through the following processes:

TABLE 1

Step	Procedure	Who is Responsible?	Time lag
1	Registration and opening of folder	Medical Records Department	From 30minutes to 1 hour
2	Payment of consultation fee of one thousand naira only (N1,000)	Accounts Department	From 10 to 20 minutes
3	Presentation at the nurses' station	Nurses, ward maids and other attendants	5 to 10 minutes
4	Observation of vital signs androutine urine analysis	Nurses	15 minutes
5	Sorting of patients for distribution to the appropriate units and subspecialties to whom patients were referred	Nurses	10 to30 minutes
6	Patients stay in the waiting hallof clinic awaiting their turn for consultation with the appropriate specialists		15 minutes to 1 hour
7	Consultation. First time patients are usually clerked by a House	Doctors	10 to 30 minutes

	Officer or junior resident who then presents the case to the consultants for evaluations		
8	Patients returnto nurses' station after consultation with the doctors for further directives	Nurses	5 to 10 minutes

SURGERY OUTPATIENTS' DRESSING ROOM

Patients requiring wound dressing, suture removal or minor procedures are treated here. The time spent in the dressing room depends on the type of procedure involved (Table 2).

TABLE 2

Step	Procedure	Who is responsible?	Time lag
1	Teller collection	Accounts unit	10 to 20 minutes
2	Payment at the bank	Sterling bank	10 to 20 minutes
3	Receipt of payment taken to the clinic nurses	Patient	5 minutes
4	Relevant dressing done, stitches removed or procedure performed	Nurses or doctors	10 to 30 minutes

SIDE LABORATORY

Some simple investigations needed for the monitoring of the status of patients on admission are carried out in the side laboratory(Table 3).

TABLE 3

S/NO	Investigation	Who is responsible?	Time lag
1	Urinalysis	Doctors	10 minutes
2	Hb/PCV	Doctors	10 minutes
3	Electrolytes, Urea and Creatinine	Doctors	10 to 30 minutes

ACCIDENT AND EMERGENCY THEATRE

Day cases and relatively minor cases that do not require intense monitoring are operated upon here

ADMISSIONS

Patients are admitted to the Surgical Wards under specific units and consultants after paying relevant deposits. These include patients admitted from the Surgery Outpatients' clinic (commonly for elective surgeries), Accident and Emergency unit (usually emergencies, some of them after undergoing operation at the A&E theatre) and Children Emergency Ward. Patients being jointly managed with specialists in other clinical departments are also sometimes transferred to the surgical wards. Table 4 shows the processes involved inadmission from the Surgery Outpatients' clinic.

TABLE 4

Step	Procedure	Who is Responsible?	Time lag
1	After consultation, patient proceeds to the SOP nurses' desk for further directives.		3 minutes
2	Patient's details including diagnosis are recorded in nurses' Admissions register	Nurses	From 10 to 20 minutes
3	Patient proceeds to the ward to which admitted accompanied by an attendant who carries the case records of the patient. In the ward, the attendant hands over the patient and their folder to the	Ward maid	15 to 30 minutes

	duty nurse.		
4	Patients is formally admitted and directed to accounts department	Nurses	15 minutes
5	Collection of bank teller	Accounts unit	10 to 30 minutes
6	Payment at bank		15 minutes to 1 hour
7	Return of patient to ward to complete admission formalities		5 to 15 minutes

ELECTIVE OPERATIONS

Patients that are booked for elective operations are usually admitted a couple of days earlier. This is to enable the managing teams work them up and prepare them adequately for surgery. Every surgical unit has its own day for elective operations during the week. Emergency operations are done every day and any time. In general, emergency cases are not required to pay the statutory deposits before surgery. All major surgical procedures are performed by the consultant surgeon in charge of the case or very senior residents (with consultant supervision).

Table 5 shows the processes involved when a patient is scheduled for an elective operation.

TABLE 5

Step	Procedure	Who is Responsible?	Time lag
1	Counselling	Doctors	30 minutes
2	Booking of theatre	Doctors	30 minutes
3	Patient is directed to the accounts department for payment of deposit for surgery	Nurses	30 to 45 minutes
5	Bank teller collection	Accounts Department	10 to 30 minutes
6	Payment at bank		10 minutes to 30 minutes
7	Patient returns to ward and other preoperative preparations are completed before actual surgery		

DISCHARGE PROTOCOL

Before a patient is discharged by any surgical team, a discharge summary is prepared by the most junior member of the team. This summary is expected to contain significant events about the patient from the time of admission and all through the period of stay in hospital, including relevant investigations done, operations performed(including the findings, if any), other treatments given, the patient's clinical course, outcome of treatment, any complications and the general condition at the time of discharge. Thereafter, the patient's folder is sent to the accounts department by the nurses for computation of the bill accrued. Following settlement of the bill, the patient is allowed to go home after due counselling by the doctors in matters relating to the condition that caused him/her to be admitted.

FOLLOW UP/APPOINTMENTS

After discharge, patients are given appointment for follow-up in the Surgery Outpatients' Clinic at intervals determined by the managing teams. A typical appointment can vary from 1 week to 6 months depending on the patient's current status, the condition being managed and his/her progress. After a reasonable period of follow-up and when the managing team finally determines that there has been sufficient improvement and there is no longer need for scheduled visits, the patient is discharged from SOP.

DUTY ROSTER

The duty roster for Surgery is usually prepared monthly by the chief resident or his assistant. He is also responsible for preparing the time table for all academic activities in the department after due consultation with the Department's Clinical Director, Chairman of the Department's Education Committee or the Head of Department. Copies of the roster are sent to the A & E Department, other clinical departments and the main

theatre. Copies are given to all unit heads and individual members of the Department and also placed on strategically located notice boards.

MANAGEMENT OF SURGERY REVOLVING FUND AND PROCUREMENT OF CONSUMABLES

The department has a revolving fund which is managed by a Committee headed by the HOD as Project Manager. Other members of the Surgery Revolving Fund committee include a project accountant, project secretary, the chief resident, chief nursing officers in charge of all the surgical wards and surgery outpatients' clinic and a representative of hospital management. Statutory meetings are held once every month. Emergency meetings can however be held any time as the need arises. Procurement of consumables at the time of writing this report is by direct purchase, and is usually determined by the amount of available funds. However, there are plans to introduce the bidding system in the very near future.

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

DEATH OF A PATIENT

In the event of death of any patient, a doctor is required to confirm same through standard procedures to establish that there is no evidence of life. Thereafter he makes the relevant entries in the patient's folder including the time and cause of death, as well as the attempts made at resuscitation. Having confirmed the patient dead he then issues a death certificate which is deposited with the ward nurses for onward transmission to patient's relatives at the appropriate time.

The deceased patient is then screened off by the ward nurses. After a reasonable period of observation (at least 1 hour) the corpse is dressed by the nurses and mortuary attendants are invited to come and convey it to the mortuary.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

NB: Refer to Theatre SOPs for theatre management procedures.

UPTH STANDARD OPERATING PROCEDURE FOR

TRANSPORT UNIT

NAME & SIGNATURE OF TRANSPORT OFFICER: *IKPEAZU JOHNSON OBINNA*

DATE: 12/8/18
SOP No: 002
SOP Title: Processes involved in Maintenance of Hospital Vehicles and Transportation of Staff
NOTE: Work Starts by 8:00 am.
SCOPE

In vehicle maintenance, it is the office of the Transport Officer, who makes such requisition to Management for any vehicle maintenance. Management will give its approval for any such maintenance process to be carried out and two to three hospital Registered Auto-Mobile Contractors will submit their bill quotation after accessing the level of maintenance or repairs work to Management through the Transport Officer and Management will send it for vetting at the Works & Services Department and the Lowest Bidder will be given the approval for such maintenance repairs work.

As part of Management welfare package to staff, free transportation policy was introduced to Transport Staff from the hospital to Rumuokoro at close of work and even in the morning.

PURPOSE

The standard operating procedures is one important tool/means Management use to evaluate performance in different areas and to ascertain if the needed results achieved, followed Due Process without violating the constituted procedures.

INTRODUCTION

Transport as the name implies is the movement of humans and goods from one point to another. It is important in a daily activity because it enables trade between people to be easy and as a health institution, it enables the esteemed patients and staff to trade on health issues.

So, it is important when carrying out such activities that standard operating procedures should be adhered to.

FUNCTION OF THE DEPARTMENTS

- Rendering of Ambulance Services
- Transportation of Staff
- Maintenance of Hospital Vehicles
- Provision of fueling Official Vehicles
- Provision of Transportation services to Visitors visiting the hospital from outside the state
- Provision of Transportation to Management and Staff
- Transportation of Clinical Equipments and Materials when necessary
- Rendering Welfare Services to Staff during Events and other related matters
- Transportation of Patients from one point to the other when need arises

ROLES AND RESPONSIBILITIES OF VARIOUS STAFF DEPLOYED TO THE UNIT

There are two (2) main section in the Transport Unit, namely: The Ambulance section and the Pool Section.

THE AMBULANCE SECTION

There are six (6) drivers in the Ambulance Section and three (3) shift is been run (morning, afternoon and night) and a day-off. But presently due to the shortage of manpower, we try to manage what we have to ensure that adequate service is rendered.

THE POOL SECTION

This section has about ten (10) drivers and six (6) are attached to Principal Officers while the rest number are on stand-by for any Pool or Emergency duties.

PURCHASE OF VEHICLES

In the issue of car purchase, the end user makes a request or requisition to CMD. CMD will then authorize a tendering procedure for it through the "Parastatal Tender Board" (Procurement Unit) either through competitive or selective bidding before such award can be made for the purchase of any vehicle.

Staff responsible for such Committee of the Parastatal Tender Board are: -

- The Chief Medical Director
- Director of Administration
- HOD, Works & Services
- HOD, Store
- Head of Procurement Unit
- Deputy Director, Finance
- Legal Unit

LIST OF ALL VEHICLES

As at 3rd August, 2018, these are the list of vehicles under the watch of the Transport Unit *(see attached list).*

MAINTENANCE OF AMBULANCE AND OTHER VEHICLES

Ambulance and other vehicles of the hospital are maintained in the same process. In some rare cases, it can take a week or more and even days depending on the nature of damage or repairs work.

As stated earlier, this process is carried out by the Transport Officer in-charge in conjunction with Registered Auto-mobile Contractors of the hospital. Who after diagnosing the problem, forward such complain to Management through the Transport Officer and such bills are forwarded to Works & Services Department for vetting before such maintenance or repair works can be approved.

DUTY-ROSTER

As earlier stated that we run three (3) shifts at the Ambulance section and a day-off when manpower was available but presently we now run one shift of twenty-four hours and two (2) days off, so as to ensure adequate coverage of the Unit and rendered good services to the Public. While at the Pool Section, it is a daily affairs or activities that all drivers must report to duty except on the ground of Annual Leave or Excuse Duty and approval of Casual Leave *(see attached Duty-Roster for Ambulance Section)*.

VEHICLE LOG-BOOK WITH DETAILS OF THE DISTANCE TRAVELLED AND FUEL CONSUMED

In an institution like UPTH, where Transport plays a vital role, Vehicle Log-book is an important document that gives details of activities of movement of each vehicle and to get accurate details of affairs.

But here in UPTH, the practice is not effective maybe due to some financial constraint and no formal proposal to that effect from previous Management. But presently we have tried to introduce a format towards actualizing it base on the attached format but for us to achieve it, Management must be ready to provide constant fuelling of our Ambulances and other official vehicles. There must be a fueling process of Official Vehicles not the present system of quelling money to drivers to buy fuel *(please see attached Log-Book Format)*.

DEPLOYING AMBULANCES

There is an Emergency Response Committee (ERC), comprising various critical Units of the hospital. This Committee is headed by DR. ADIELE, an Orthopedic Surgeon, for any response activities which the transport unit is also part of the Committee.

For any emergency, there is always a stand-by Ambulance that takes care of such emergency. Even in distress calls, we go with our full team of professionals. Doctor, Nurse and a first aid kits is provided in any deployment of Ambulance for emergency.

DEPLOYING AMBULANCE IN CASE OF EMERGENCY OR DEPLOYING AMBULANCE FOR TRANSFER OF PATIENTS OUT OF THE HOSPITAL

The same process is followed. The professionals as stated earlier are there and the necessary first aid kits are provided, cross-checked before any deployment or repatriation of patient can take place with an Ambulance.

PRE-DEPARTURE CHECK FOR OXYGEN, ESSENTIAL EQUIPMENT AND DRUGS

This process is always carried out by Accident & Emergency Department. The Doctors and Nurses who are trained ensure that details report and other necessary items needed for such movement is intact. They ensure that first aid box kits are adequate before any movement or transfer of patients.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURES FOR
DEPARTMENT OF SURGERY
UNIT: UROLOGY

NAME & SIGNATURE OF HEAD OF DEPARTMENT: *DR O.N. EKEKE*
DATE: …………………………………
SOP No: 002
NOTE: Work Starts by 8:00 am. All clinics and knife on skin (Surgery) start by 9:00 am

INTRODUCTION

The Urology Division consists of two units, with a staff structure comprising of Consultants, Senior Registrars, Registrars, House Officers, Nurses of various cadres, as well as other non-medical staff. Patients are admitted to the Urology wards, consisting of male and female/children sections, via the Urology Outpatient clinic (Mondays at the Surgery Outpatient) or through the Accident and Emergency department.

Patients may also be transferred from the in- patient wards of other departments. We also have an outpatient procedure room for weekly urological procedures like urethral catheterization, prostate biopsy and ward endoscopy. There is also uroflowmetry facilities in our ward.

PURPOSE

The Standard Operative Procedures are aimed at establishing operational guidelines with respect to the processes involved in patient management.

Management of urological patients occurs at several levels. Within the department/division/units, in-patients are managed in the urology wards and other wards when to co-managing patients admitted by other teams. Patients that have been discharged for follow-up andall new patients are seen in the Urology Outpatients' Clinic on Mondays.

UROLOGY OUTPATIENTS' CLINIC (UOP)

Patients seen in the UOP include those referred from Family Medicine and other departments within UPTH, those referred from other health institutions within and outside Port Harcourt, and old patients of the department on follow-up. First time patients usually come with referral letters from the referring doctors.

ACCESSING PATIENT CARE IN THE SURGERY OUT PATIENTS' CLINIC

(Table 1)

All patients visiting the UOP are expected to go through the following processes:

TABLE 1

Step	Procedure	Who is Responsible?	Time lag
1	Registration and opening of folder	Medical Records Department	From 30minutes to 1 hour
2	Payment of consultation fee of one thousand naira only (N1,000)	Accounts Department	From 10 to 20 minutes
3	Presentation at the nurses' station	Nurses, ward maids and other attendants	5 to 10 minutes
4	Observation of vital signs androutine urine analysis	Nurses	25 minutes
5	Sorting of patients for distribution to the appropriate units and subspecialties to whom patients were referred	Nurses	10 to30 minutes
6	Patients stay in the waiting hallof clinic awaiting their turn for consultation with the appropriate specialists		15 minutes to 2 hour
7	Consultation. First time patients are usually clerked by a House Officer or junior resident who then presents the case to the	Doctors	10 to 30 minutes

	consultants for evaluations		
8	Patients returnto nurses' station after consultation with the doctors for further directives	Nurses	5 to 10 minutes

OUT-PATIENTS' DRESSING ROOM

Patients requiring wound dressing, suture removal or minor procedures are treated here. The time spent in the dressing room depends on the type of procedure involved (Table 2).

TABLE 2

Step	Procedure	Who is responsible?	Time lag
1	Teller collection	Accounts unit	10 to 20 minutes
2	Payment at the bank	Sterling bank	10 to 20 minutes
3	Receipt of payment taken to the clinic nurses	Patient	5 minutes
4	Relevant dressing done, stitches removed or procedure performed	Nurses or doctors	10 to 30 minutes

WARD PROCEDURES

Patients are seen on an outpatient basis every Thursday for urological procedures. These include urethral catheterization, prostate biopsy under caudal block, chemotherapy administration, uroflowmetry, ward endoscopy, outpatient wound dressing and stitch removal.Table 3 shows the processes involved in the outpatient procedure room.

TABLE 3

Step	Procedure	Who is responsible?	Time lag
1	Registration, identification of procedure and sorting of patients	Nurses	10 minutes
2	Retrieval of folders from medical records	Medical records department/ ward maids /nurses	10 to 45 minutes
3	Payment of procedure fee(depending on the procedure being done)	Accounts department	10 to 30 minutes
4	Vital signs measurements	Nurses	10 to 30 minutes
5	Patient in waiting area	Nurses	15 minutes to 2 hours
6	Patient counselling concerning specific procedure	Doctors	10 to 15 minutes
7	Procedure	Doctors	Depends on specific procedure
8	Post procedure observation, counselling and prescription	Doctors	15 minutes to 1 hour

ACCIDENT AND EMERGENCY THEATRE

Resuscitation of patients and emergency surgeries(minor and sub major) are performed here.

ADMISSIONS

Patients are admitted to the Urology Wards under specific units and consultants after paying relevant deposits. These include patients admittedfrom the Urology Outpatients' clinic (commonly for elective surgeries), Accident and Emergency unit (usually emergencies, some of them after undergoing operation at the A&E theatre), Children Emergency Ward and Special care baby unit. Patients being jointly managed with specialists in other clinical departments are also sometimes transferred to the surgical wards. Table 4 shows the processes involved inadmission from the Urology Outpatients' clinic.

TABLE 4

Step	Procedure	Who is Responsible?	Time lag
1	After consultation, patient proceeds to the UOP nurses' desk for further directives.		3 minutes
2	Patient's details including diagnosis are recorded in nurses' Admissions register	Nurses	From 10 to 20 minutes
3	Patient proceeds to the ward to which admitted accompanied by an attendant who carries the case records of the patient. In the ward, the attendant hands over the patient and their folder to the duty nurse.	Ward maid	15 to 30 minutes
4	Patients is formally admitted and directed to accounts department	Nurses	15 minutes
5	Collection of bank teller	Accounts unit	10 to 30 minutes
6	Payment at bank	Patient/ Relatives	15 minutes to 1 hour

ELECTIVE OPERATIONS

Patients that are booked for elective operations are usually admitted a couple of days earlier. This is to enable the managing teamswork them up and prepare them adequately for surgery. Urology operates on Tuesdays(main theatre) and alternate Thursdays(ENT Theatre) for elective operations during the week. Emergency operations are done every day and any time.

In general, emergency cases are not required to pay the statutory deposits before surgery. All major surgical procedures are performed by the consultant surgeon in charge of the case or senior residents(with consultant supervision).

Table 5 shows the processes involved when a patient is scheduled for an elective operation.

TABLE 5

Step	Procedure	Who is Responsible?	Time lag
1	Counselling	Doctors	30 minutes
2	Booking of theatre	Doctors	30 minutes
3	Patient is directed to the accounts department for payment of deposit for surgery	Nurses	30 to 45 minutes
5	Bank teller collection	Accounts Department	10 to 30 minutes
6	Payment at bank	Patient/Relative	10 minutes to 30 minutes
7	Patient returns to ward and other preoperative preparations are completed before actual surgery	Nurses/House Officer/Registrar	

DISCHARGE PROTOCOL

Before a patient is discharged by the urology team, the discharge is discussed with the patient and/or relative, and the discharge summary is prepared by the most junior member of the team. This summary is expected to contain significant events about the patient from the time of admission and all through the period of stay in hospital, including relevant investigations done, operations performed(including the findings, if any), other treatments given, the patient's clinical course, outcome of treatment, any complications and the general condition at the time of discharge. Thereafter, the patient's folder is sent to the accounts department by the nurses for computation of the bill accrued. Following settlement of the bill, the patient is allowed to go home after due counselling by the doctors on matters relating to the conditions that caused him/her to be admitted.

FOLLOW UP/APPOINTMENTS

After discharge, patients are given appointment for follow-up in the Urology Outpatients' Clinic at intervals determined by the managing teams. A typical appointment can vary from 1 week to 6 months depending on the patient's current status, the condition being managed and his/her progress. After a reasonable period of follow-up and when the managing team finally determines that there has been sufficient improvement and

there is no longer need for scheduled visits, the patient is discharged from UOP.

DEATH OF A PATIENT

In the event of death of any patient, a doctor is required to confirm same through standard procedures to establish that there is no evidence of life. He informs the managing consultant. Thereafter he makes the relevant entries in the patient's folder including the time and cause of death, as well as the attempts made at resuscitation. Having confirmed the patient dead, he then issues a death certificate which is deposited with the ward nurses for onward transmission to patient's relatives at the appropriate time.

The deceased patient is then screened off by the ward nurses. After a reasonable period of observation (at least 1 hour) the corpse is dressed by the nurses and mortuary attendants are invited to come and convey it to the mortuary.

MANAGEMENT OF SURGERY REVOLVING FUND AND PROCUREMENT OF CONSUMABLES

As outlined in the SOP for Procurement & Stores.

ACCREDITATION PROCESSES

Please refer to SOP for CS & T.

NB: Refer to Theatre SOPs for theatre management procedures.

UPTH STANDARD OPERATING PROCEDURE FOR WORKS DEPARTMENT

NAME & SIGNATURE OF HEAD OF DEPARTMENT:
ENGR. JOHNSON ATONPIRIKASIKI
DATE: 7th July 2018
SOP No: 002
SOP Tittle: Processes involved in maintenance of hospital equipment and infrastructure
NOTE: Work Starts by 8:00 am.All clinics and knife on skin (Surgery) starts by 9:00 am

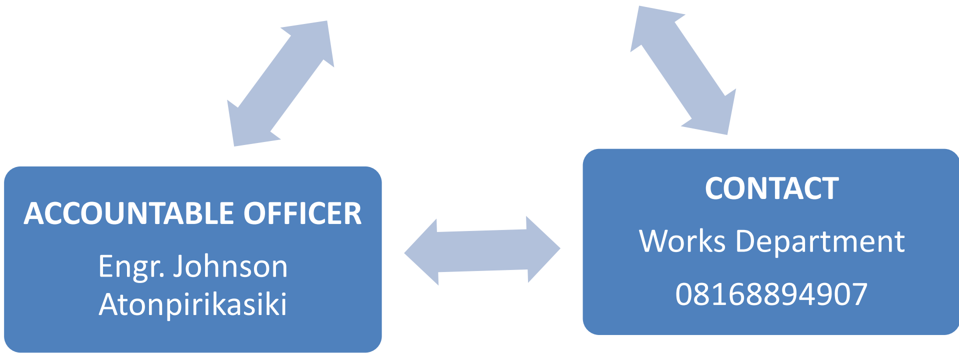
PURPOSE

Establish and implement a procedure for systematic maintenance of equipment & infrastructure so as to ensure effective provision of services in the hospital.

INTRODUCTION

SCOPE

It covers all the equipment essential for provision of clinical services, water supply, power generation and infrastructure.



UNITS UNDER THE DEPARTMENT

Bio-Engineering Unit	Engr. ObianineAtubori
Civil	Ordu Emmanuel
Mechanical	AnokwuruOnyemachi
Safety/Fire	Moses Tamuno
AC/Refrigeration	Mrs. DeebaOruwari
Water Treatment/Generator	Amada A.
Electrical	Ogan T.

INFRASTRUCTURE DEVELOPMENT

<table>
<tr><th>UNITS INVOLVED</th><th>DESCRIBE THE PROCEDURE INVOLVED</th></tr>
<tr><td>Civil</td><td rowspan="3">Recommendations are made for infrastructural decay and possible solution given to management for futuristic/immediate action</td></tr>
<tr><td>Mechanical (lift-operations)</td></tr>
<tr><td>Electrical</td></tr>
</table>

INFRASTRUCTURE MAINTENANCE

<table>
<tr><th>UNITS INVOLVED</th><th>DESCRIBE THE PROCEDURE INVOLVED</th></tr>
<tr><td>Civil</td><td rowspan="4">Job requests are usually raised from the reporting department and sent to the works department to effect repairs</td></tr>
<tr><td>Mechanical</td></tr>
<tr><td>Electrical</td></tr>
<tr><td>Utilities (Plumbing)</td></tr>
</table>

PROCESS OF PREVENTIVE AND BREAKDOWN MAINTENANCE OF INSTALLED BIO MEDICAL EQUIPMENT & FURNITURE

UNIT INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
Biomedical Engineering Unit	The Biomedical equipment technicians/engineers are involved in repairs/maintenance and calibrations of medical equipment. They are also inundated with the task of training end users namely, nurses, doctors, lab scientists etc. There should in addition be a maintenance officer assigned to every department who does routine preventive maintenance checks of departmental equipment.

PROCESS OF PREVENTIVE AND BREAKDOWN MAINTENANCE OF UTILITIES

UNITS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
Water/Plumbing	Job request/report of water leakages and electrical faults are being sent to the department and upon availability of funds repairs are made as soon as possible.
Electrical	

RECORD KEEPING.

UNITS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
All units	Every unit under the department keeps inventory of job done

PROCUREMENT OF WORKING MATERIALS.

UNITS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
All units	This is usually done by the personnel directly involved for the repairs after job estimates are being vetted by

	the HOD and in collaboration with the Central Procurement Unit of the Procurement and Stores Department.

BILLING

UNITS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
All units	Estimates raised for the repairs are sent to the department in need of our services as being vetted by the HOD

HOSPITAL POWER GENERATION

UNITS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
	This is usually being outsourced. We only have two of our staff as plant operators stationed at Aluu health centre.

ALTERNATIVE POWER GENERATION IN THE EVENT OF POWER OUTAGES

UNITS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
	The hospital on alternative power generation uses solar energy via inverters and being managed by the works and services electrical unit.

HOSPITAL WATER SUPPLY UNIT

UNITS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
Water treatment	The water supply operators are responsible for pumping and treatment of water supplied to the hospital for consumption

SUNDRY REPAIRS

UNITS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
All units	Repairs are done as requested by the departments in need usingour revolving fund.

OTHER ACTIVITIES (SPECIFY)

UNIT INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
Consultancy services on engineering-technical expertise to vendors/contractors	Personal contacts are made with the various units under the department.

EMERGENCY SERVICES

UNITS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
This is usually on areas of fire/electrical and equipment failure. Also, water supply leakages	The HOD calls on the staff on call duty.

SAFETY UNIT

PERSONS INVOLVED	DESCRIBE THE PROCEDURE INVOLVED
Departmental Safety Managers:	In every department, a member of staff should be nominated to function as Departmental Safety Managers. They are expected to do routine safety checks and ensure appropriate steps are taken in the event of a fire outbreak. Their training should be co-ordinated centrally by the Central Safety Unit of the Works department on a regular basis. The Departmental Safety Managers should in turn train

	their departmental their departmental staff. In addition, they are to ensure that an EMERGENCY numbers are boldly displayed in every department/unit.
PROVISION OF FIRE EXTINGUISHERS & SMOKE DETECTORS	These should be installed in every department/unit with “NO SMOKING” signs. The Works department will be responsible for the maintenance, servicing & replacement of spoilt fire extinguishers in the various departments/units.

PROCUREMENT OF EQUIPMENTS &CONSUMABLES

As outlined in the SOP for Procurement & Stores.

UPTH STANDARD OPERATING PROCEDURE (SOPs)
TECHNICAL COMMITTEE

Dr. Obianma Onya
DCMAC (NHIS/SERVICOM) &
Committee
(Chairman)

Dr. Charles Tobin-West
Community Medicine
(Member)

Dr. Joy Eminue
Child Dental Health
(Member)

Dr. Bamgboye
Restorative Dentistry
(Member)

Dr. Sampson Uzeugwu
Haematology
(Member)

Dr. Emmanuel Obazee
Internal Medicine
(Member)

Dr. Iboh Oghu
NHIS Clinic
(Member)

Dr. Godfrey Bassey
Obstetrics & Gynaecology
(Member)

Dr. Dick Williams
Accident & Emergency
(Member)

Dr. Belema Manuel
Radiology
(Member)

Dr. Edward Ikpae
Accident & Emergency
(Member)

Mr. Akie Hart
Director of Administration
(Member)

Dr. Tope Olamuyiwa
Palliatiave
(Member)

Dr. Job Otokwala
Anaesthesia
(Member)

Dr. Ovusike
Burns
(Member)

Dr. Obiora
Anatomical Pathology
(Member)

Dr. Solomon Elenwo
Surgery
(Member)

Dr. Furo Orupabo
Orthopaedics
(Member)

Dr. Chukwujekwu
Neuropsychiatry
(Member)

Dr. Alade
Preventive Dentistry
(Member)

Dr. A. K. Ovusike
Burns & Plastic
(Member)

Dr. Fred Allison
Chemical Pathology
(Member)

Dr. Iroro Yarhere
Paediatrics
(Member)

Dr. Affiong John
Family Medicine
(Member)

Dr. Bassey Fiebai
Ophthalmology
(Member)

Dr. Uju Ibekwe
Otorhynolaryngology
(Member)

Dr. C. A Iyogan
Oral Pathology (Member)

Dr. Alexwele Mary
Medical Microbiology
(Member)

Mr. Clifford Opusunju
Medical Social Welfare (Member)

Mr. Oba Ibinabo
CSO (Member)

Mrs. Patricia Harry
DNS (Member)

Mr. Fred Omojunikanbi
HOD, Physiotherapy
(Member)

Mr. Obinna I.J
HOD, Transport
(Member)

Mr. Friday
HOD, Laundry
(Member)

Mrs. Obuoforibo
HOD, Catering
(Member)

Mrs. Echefu Odazie
HOD, Dietetics
(Member)

Mrs. Victoria Mube
Head, Clinical Services & Training

Mr. Tamuno-Tonye Ogolo-
HOD Stores (Member)

Mr. Johnson A.
HOD Works & Services
(Member)

Mr. Okatubo
Accounts
(Member)

Mrs. Victoria Ukwu
Pharmacy
(Member)

Mrs. Mary Bennett Okuru
Catering
(Member)

CSSD representative