FHOK - FamilyCARE Medical Centres & MATERNITIES

Standard Operating Procedures (SOPs)

2017

FAMILY HEALTH OPTIONS KENYA
Your Health, Our Concern

IPPF International Planned Parenthood Federation

FHOK,s Vision, Mission and Core Values

FHOK's Vision: All people exercising their Sexual and Reproductive Health Rights and accessing quality health services.

FHOK's Mission: To provide quality, comprehensive and integrated SRH information and services to all; with special focus on young people, marginalized and the underserved.

FHOK's Core Values:

1. **Non-discrimination.**
   FHOK seeks to dignify every person regardless of race, gender, creed, economic or health status and age. FHOK treat people equally and also seek to understand people's differences and points of view without compromising our core mission.

2. **Integrity.**
   FHOK shows impartiality, fairness and honesty while upholding the highest ethical standards when providing SRH services.

3. **Quality Service.**
   FHOK maintains a high level of knowledge, skills and standards as we provide SRH services to clients. We maintain confidentiality whilst upholding the highest standards of service.

4. **Team Work.**
   Everyone contributes fully to the activities of the team to address shared challenges through common effort.

5. **Innovation.**
   FHOK always works to find sustainable solutions in a changing environment through creativity and innovations.

Our Rallying Cry; ***Your Health Our Concern!***

FORWARD

This Standard Operating Procedures Manual, to be referred to as **"Family Health Options Kenya (FHOK's) – Family Care Medical Centres & Maternities, Standard Operating Procedures (SOPs) Manual"** shall come into effect from 31st January 2017, and will remain in effect until further notice.

The terms and conditions in this manual will be updated periodically and may be changed at any time. All changes to this manual require to be approved by the FHOK's National Executive Committee.

It is the policy of Family Health Options Kenya to ensure that healthcare services delivered by the organization through the various approaches and strategies adopted are in line with Standard Operating Procedures as outlined in this policy document.

This document is a milestone in the delivery of health care services by FHOK as it provides a well-coordinated and clear mechanism in which staff working in FHOK's health care facilities and programmes should apply in their day to day functions.

The document has been developed in a participatory way with input of service providers, management, programme staff and other staff working in FHOK's programmes and projects. The guidelines also borrows from the existing guidelines of the Ministry of Health, World Health Organization (WHO) and International Planned Parenthood Federation (IPPF) where relevant.

In this regard, I would like to thank the Executive Director, Mr. Edward Marienga, and SMT, for providing overall leadership during the development process of the SOPs, the Director of Clinical Services, Mr. Amos Simpano, for coordinating the team and the technical input received from different sources, all the Medical Centre Managers and other FHOK staff who participated in the workshops and forums to develop or review the SOPs and particularly Dr. Jimmy Wawire and his Nairobi West clinic team that gave lots of inputs using practical experiences of their 24 hours facility. I also acknowledge the technical contribution from the Laboratory and Pharmacy departments given through their respective heads, Mr. Kennedy Ongubo and Mr. Fanuel Ojoi respective fully.

The guidelines are henceforth intended to guide healthcare workers and the management of FHOK in delivering the quality services to all our clients and contribute to the achievement of FHOK's vision and mission statements.

Rophus Mwamburi
Chairperson, National Executive Committee (NEC)

1st January 2017.
Nairobi, Kenya

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ABREVIATIONS

AIDS	Acquired Immuno- Deficiency Syndrome
B.N.F	British National Formulary
B.P	British Pharmacopeia
DDA	Dangerous Drugs Act
ED	Executive Director
eCMIS	Electronic Clinic Management information System
DCS	Director Clinical Services
FCMC	Family Care Medical Centre
FHOK	Family Health Options Kenya
GRN	Goods Received Note
HCW	Health Care Workers
HODs	Head of Departments
ICU	Intensive Care Unit
IV	Intravenous
LPO	Local Purchase Order
MCM	Medical Centre Manager
MDR	Multi-Drug Resistance
MCH	Maternal Child Health
MoH	Ministry of Health
MOU	Memorandum of Understanding
OPD	Out-patient Department
PHN	Patient Hospital Number
SOPs	Standard Operation Procedures
NGO	Non-Governmental Organization
SARS	Severe Acute Respiratory Syndrome
SRH	Sexual Reproductive Health
TB	Tuberculocis
HIV	Human Immune Virus
QOC	Quality of Care

SECTION ONE:

CLINICAL STANDARD OPERATING PROCEDURES

1.0. Background

Family Health Options Kenya (FHOK) is a dynamic not-for-profit, national Non-Governmental Organisation (NGO) with a strong grassroots network. The organization plays a pioneering role in offering sustainable, innovative and Comprehensive Sexual and Reproductive Health (SRH) services in response to health and Socio-economic needs of all Kenyans. FHOK is committed to providing quality services and championing Sexual and Reproductive Health and Rights and the empowerment of young people to exercise and enjoy these rights. The organization embraces gender sensitivity and collaboration in providing Sexual Reproductive Health information and services. In particular, the organization is well respected for integrating HIV and Sexual and Reproductive Health and Rights, Cervical Cancer services and Reproductive Health and as being a centre of excellence in providing capacity building in SRH.

FHOK focuses on 5 programmatic areas that include Access, HIV/AIDS, Adolescents and youth, Advocacy and Safe Abortion. The above service delivery intervention are supported by various cross cutting strategies which includes governance, partnerships, institutional capacity building, resource mobilization, knowledge management and institutional sustainability. FHOK runs 17 clinics branded as FHOK-Family Care Medical Centres (FCMC) that are spread across the country. The clinics are located in Kakamega, Kisumu, Homa Bay, Eldoret , Nakuru, Phoenix House (Nairobi), Nairobi West (Family Health Plaza), Kibera, Eastleigh, Jerusalem (Nairobi), Thika, Nyeri, Meru, Isiolo, Kitengela, Mombasa and Malindi. Four of the clinics i.e Jerusalem, Eldoret, Nairobi West and Nyeri are maternities with in-patient & delivery services. The clinics provide a whole range of clinical services including full range family planning services, HIV and AIDS and curative services among others.

FHOK also run 9 model youth friendly services centers located in Kakamega, Bondo, Kisumu, Eldoret, Nakuru, Easteligh in Nairobi, Meru, Mombasa and Malindi. The youth centres provide a whole package of SRHR information and youth friendly services, enhancement of youth livelihoods, edutainment and talent development among others.

In order for FHOK to serve her clients better, there is need to have comprehensive Standard Operating Procedures to guide the day to day delivery of services in its health care facilities.

1.1. Out-Patient Department Standard Operating Procedures

The guidelines below apply to non-emergency out-patient cases seen by clinicians or nursing staff.

1. All clients or patients should register and pay at the reception then queued to the appropriate service provider through the Electronic Clinic Management Information System (eCMIS). The client or patient should then be directed to the designated service provider's consultation room.

2. All clients/patients should be attended to within the stipulated waiting time detailed in the FHOK -Family Care Medical Centres and Maternities (FCMC) Service Charter.

3. Clients/Patients preferring to be accompanied or chaperoned during their time with the service provider should be accommodated. All service providers should inform the clients/patients about this option.

4. In case there is need for a procedure to be done, written consent should always be obtained after the procedure has been clearly explained and client or patient has understood.

5. All clients/patients needing procedure should first pay at the reception before the procedure is done. This also applies to laboratory tests, kits and commodities needed from the pharmacy for the procedure.

6. All procedures should be well documented both in the eCMIS and in the OPD procedure file in minor theatre immediately after the procedure.

7. In case the service provider would like to request tests that are not available, he/she should advise the client/patient on where the same can be done with minimal inconvenience. Appropriate requests should then be written and given to the client/patient.

8. In case the client/patient needs admission, the appropriate documentation should be done and the client/patient accompanied to the ward.

9. All clients/patients needing referral for specialist consultation/investigations i.e laboratory, imaging, should be informed so and given all the options available or asked if they have any preferred specialist they would like to be referred to. Appropriate referral documents should be written and referral procedure followed.

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10. All staff in the OPD must abide by the terms of FCMC Code of Conduct and Standards.

11. All visiting consultants wishing to see clients/patients at FCMC should abide by the terms of their MoU.

1.2. Admission and In-Patient Standard Operating Procedures

Below are the procedure and guidelines on admission and management of in-patients.

1. The admitting clinician should call to brief the in-patient in-charge of the intended admission.

2. The patient should be accompanied to the ward by the clinician with all the appropriate documentation. In the case where the patient has been sent by the consultant accompanied, detailed documentation should be made available or the consultant should be contacted to give instructions.

3. Registration, bed allocation and any payments to be made should be organized by the receiving in-patient staff member. The patient/next of kin accompanying the patient should be informed clearly of all the charges and fees to be expected.

4. Management should be instituted as soon as the patient is settled in. The specialist consultant should be called to review the patient if the admitting clinician has indicated so.

5. Daily reviews should be conducted for all admitted patients by either the clinician on duty or the consultant. In case of emergency the clinician or admitting consultant should be alerted.

6. In the referrals or transfer of admitted patients, the clinician/consultant in discussion with relatives should assess condition of patient and make timely referral and make proper documentation of referral process or procedure. (refer SOP 1.6)

7. Billing updates should be given to the patient /next of kin daily and any questions fielded and answered to their satisfaction.

8. Discharge summaries should be well written by the clinician or consultant at the time of discharging the patient or client and records properly stored.

9. All payments for the bills should be handled by the accounts department at facility.

1.3. Labor Ward Standard Operating Procedures

The guidelines below apply to all mothers admitted to the labor ward in any stage of labor.

1. After admission, initial assessment should be conducted by the mid-wife on duty. If labor is confirmed a Partograph chart should be started, clinician on duty informed and consultant on call informed. Routine labor ward tests (urinalysis, haemogram) should be ordered as well as any other tests the clinician or consultant may deem necessary.

2. The mother should be monitored keenly using the Partograph. The consultant on call should conduct at least one review and should be informed to do any other subsequent reviews as soon as any abnormalities are noted.

3. All complications and emergencies should be managed with the help of the clinician on duty as the consultant on call's arrival is awaited. The appropriate protocols should be followed to the latter. Preparations for theatre should be instituted whenever a complication is detected in case an emergency Caesarean Section will be required. Algorithm charts on all common complications and emergencies should be prominently displayed in the labor ward.

4. After delivery the mother should be transferred to the post-natal ward and rooming in done. Any complications affecting the new born should be handled by the service providers and the consultant pediatrician should be called to review the baby.

5. Nursing care for both mother and baby should be provided and FCMCs' nursing care procedures and protocols in line with the guidelines of the Nursing Council of Kenya.

1.4. Theatre Standard Operating Procedures

1. A theatre list should be prepared by the in-patient nurse in-charge the day before the scheduled procedure for all elective surgery cases. This is to enable adequate preparation by theatre staff.

2. Written consent must be obtained from all patients scheduled for surgery. In case the patient is unable to sign the consent or he/she is a minor, the next of kin or guardian must do so on their behalf. The consent covers administration of anesthesia, surgery and blood transfusion.

3. The in-patient in-charge, anesthetist and operating surgeon should make sure pre-

operation patient preparations are done in good time. This includes investigations, fasting instructions, pre-medication and operation site preparation (shaving, marking etc.). Pre-operation reviews by the anesthetist and the operating surgeon should also be conducted before the patient is moved to theatre.

4. The anesthetist shall be responsible for the following in the operating theatre;
   - Checking the anesthetic machine, oxygen supply, monitors, laryngoscope andsuction machine.
   - Proper labelling of all anesthetic medication.
   - Availability of stand-by oxygen supply, Ambu-bag, emergency drugs and defibrillator.
   - Setting of IV lines and administration of IV fluids, blood and medication.
   - Setting monitors
   - Pre-medication
   - Induction, maintenance, monitoring and reversal of anesthesia.
   - Patient monitoring, documentation during immediate post-operative recovery period for at least one hour
   - Writing of detailed anesthesia notes and records and post-operation instructions

5. The operating surgeon and the assistant should ensure proper instrument, swab, packs and gauze counts during the operation.

6. The operating surgeon should write detailed operation notes including post-operation instructions. He/she is also responsible for recording any procedure performed in the main theatre book.

7. The operating surgeon should conduct post-operation review and put in place adequate mechanisms for dealing with any emergency e.g. bleeding in the post-operation period.

8. The operating surgeon should ensure all specimens are well labelled and should follow-up with the lab after the operation.

9. The in-patient in charge and theatre technician shall be responsible for the following in theatre;
   - Maintenance of theatre cleanliness and waste disposal
   - Observation of proper theatre attire by all theatre users
   - Observation of proper scrubbing-in technique and maintenance of sterile areas for operations
   - CSSD
   - Maintenance of equipment and organizing for repairs and replacement

- Theatre supplies
- Theatre should be cleaned immediately after every procedure and ready for next.
- The Anaesthetist should monitor the patient after surgery for at least 1 hour. There should be proper documentation on the management of patient at this stage.

1.5. Emergency Preparedness and Handling Standard Operating Procedures

1. Ambulant or Ambulance-borne patients should be received at the reception and the OPD, nurse and clinician alerted.
2. Nurse and/or clinician on duty should conduct initial assessment, triage and classification of the patients as follows;

- **Priority I**-Life threatening, needing immediate attention(loss of consciousness,
  severe airway compromise, shock, severe chest pain, seizure, head trauma, chest trauma, obstetric emergency)
- **Priority II**-No immediate threat to life but requiring definitive treatment(severe limb injuries, abdominal trauma, penetrating abdominal injuries, lacerations, high fever, altered mentation, acute exacerbation of chronic conditions e.g. diabetes, severe pain, extensive burns, dyspnea, severe dehydration, poisoning, acute intoxication)
- **Priority III**-Ambulatory patients with non-life threatening conditions.

Priority I and II patients should be moved to the **OPD recovery/Observation room for resuscitation and stabilization.** This should be done by the clinician on duty assisted by 2 nursing staff and 2 nurse assistants. Additional help should be requested if deemed necessary. **Priority III** patients should be seen in the **OPD consultation rooms designated for this.**

3. After initial resuscitation and stabilization the patients should be classified for transfer, admission, observation or discharge and appropriate procedures instituted.
4. BLS and ALS algorithms flow charts should be clearly displayed in the resuscitation room.
5. Patients' relatives and those accompanying or visiting them should be kept updated.

1.5.1. Standard Emergency Tray/Bag

Equipment

1. Ambu-Bag and masks (adult and Paediatric)

2. Oropharyngeal Airways (000,00,0,1,2,3,4)

Medicine (appropriate dosage/quantities)

1. Inj. Adrenaline (1:1000)
2. Inj. Chlopheniramine
3. Atropine
4. Sodium Bicarbonate
5. Dobutamine/Dopamine
6. Diazepam
7. Furosemide
8. Hydralazine
9. Potassium Chloride
10. Salbutamol/Ipratropium Solution
11. Oxytocin
12. Normal Saline
13. 50% Dextrose
14. Sterile water for injection
15. Hydrocortisone
16. Ketamine
17. Magnesium Sulphate
18. Naloxole

There should be a checklist for the tray and Centre Manager or assigned clinician to;

(a). Replace drugs daily or immediately after use
(b). Check expiry dates weekly

Consumables

1. IV cannulas (18,22,24)
2. IV Infusion set
3. Syringes (2ml, 5ml, 10ml,20ml)
4. Needles
5. Gauze
6. Sutures (absorbable/non-absorbable)
7. Crepe Bandage
8. Gloves (clean/sterile)
9. Strapping

Each of the following locations to have at least one Standard Emergency Tray;

Maternities

1. OPD Consultation Room 3
2. OPD Observation/Recovery Room
3. Minor Theatre
4. Maternity
5. Main Theatre

Smaller facilities

1. Procedure/theatre
2. Designated Consultation
3. Pharmacy

The following equipment to be located at a central point with ease of access;

1. ECG Machine-OPD Observation/Recovery Room
2. SPO2 monitor-OPD Observation/Recovery Room, Maternity, Main Theatre
3. Defibrillator-Maternity or OPD Recovery Room
4. Laryngoscope and Endo-tracheal Tubes-Main Theatre
5. Oxygen- OPD Observation/Recovery Room, Maternity, Main Theatre
6. Nebulizer- OPD Observation/Recovery Room, Maternity.

1.6. Transfer and Referral Standard Operating Procedures

After the decision by the attending clinician for the transfer of a patient has been made, steps outlined below should be followed to guide the process. The patient and relatives ought to be informed about all the extra charges arising from the use of the ambulance.

1. The attending clinician should fill and sign the referral/transfer form. He should also note any special considerations that should be made during the transfer e.g. appropriate level of staff to accompany the patient, vital signs monitoring, use of oxygen, special positioning of the patient, fluids and or medication to be administered etc.
2. The nursing officer in-charge should notify the ambulance staff to ensure transportation readiness. He/she should also obtain expected/estimated arrival time at the receiving facility from the ambulance staff.
3. The nursing officer in-charge should contact the receiving facility detailing the patient's particulars, expected condition on arrival and estimated time of arrival.

4. The attending clinician and/or the nursing officer in-charge should brief the accompanying staff on the following;
   - Patient history and current condition
   - Reasons for referral
   - Receiving facility
   - Receiving facility contact person
   - Special considerations during transfer and possible interventions that may be necessary
5. After arrival at the receiving facility, the patient should be handed over to the designated person with all the accompanying documentation including any medication administered during transportation of the patient. A verbal report should also be submitted and appropriate patient handover documentation signed.
6. On returning, the following documentation should be submitted and appropriately filed;
   - Vehicle work-ticket
   - Patient handover form signed by the designated person from the receiving facility
   - A report by accompanying staff detailing all the medications or consumables used to facilitate replacement.
7. Ambulance staff is responsible for maintenance of all equipment, ensuring of timely repairs and replacement and ensuring all consumable are available as per the ambulance check-list.
8. Where a facility has no ambulance and in need of services, you can collaborate with County Ambulance or have a signed MOU with any other ambulance services provider

1.7. Care after Death Guidelines

The following guidelines should be followed while handling any mortality that occurs in the hospital premises.

1. Immediately after patient has been confirmed dead, screen the bed and inform relatives.
2. The care giver or clinician should communicate the death to the family in a professional
   manner and offer support. If not skilled in doing so he/she should seek assistance from a more qualified person.
3. All information pertaining to the circumstances surrounding the patient's death should be clearly explained to the family and all the questions answered. This information should preferably be communicated by the primary care giver at the time of death of the patient.

4. The body of the deceased should be moved to a single room/waiting room where personal care and last office procedures can be performed in privacy and dignity. The family should be allowed to view the body, though infection prevention procedures should be observed.
5. The facility in-charge should inform the DCS and or the ED to be aware
6. Transfer to the mortuary should be arranged within 8 hours.
7. Facility staff ensures that they support relatives during transfer of body from facility to hearse.
8. Body should be moved from facility to the hearse through special exit points not in view of other clients.
9. In case the body has stayed beyond 8 hours before relatives could collect it, the in-charge of facility will inform the police to collect the body and transfer to mortuary.

1.7.1. Documentation

1. Fact of death verification should be done by a clinician. All aspects of care to the deceased in the period preceding death should be well documented. The date, time of death, name, qualifications and signature of the clinician should also be documented.
2. The in-patient in-charge should update and organizes all aspects of care and medical documentation and identify and inform all professionals involved.
3. A case summary of the care of the deceased up to the time of death in hospital should be written by the primary care clinician, and a copy should remain in the patient's file.
4. The death registration form should be duly filled by the primary care clinician.
5. Anyone other than the police, collecting a body from FHOK's facility should sign consent from the relevant authorized relative/next of kin.

1.7.2. Audit

A mortality audit and review committee comprising the Hospital Management Team, the relevant consultants and clinical staff on duty should sit to conduct an audit in all the following cases;

1. Maternal mortality
2. Newborn mortality.
3. Mortality during or after a procedure.
4. Unexpected mortality in relation to the deceased's clinical progression during care.
5. Mortality with unknown or no obvious cause of death.
6. Mortality where the deceased's family raise queries relating to mismanagement or negligence.

Audit deliberations and decisions should be well documented using the audit tool and appropriately shared with the relevant parties that may request for it.

1.7.3. Post-Mortem

Cases of death involving the below listed should be referred to the appropriate pathologist for post-mortem.

1. Unknown or no obvious cause of death
2. Death caused by violence, trauma or physical injury whether intentional or otherwise
3. Death caused by poisoning
4. Death caused by intentional self-harm
5. Death caused by neglect or failure of care
6. Death that occurs while in custody or state detention.
7. Any other as the situation may neceessitate

In case the relatives want to conduct a private post-mortem, in-charge of facility ensures that the FHOK's Pathologist participate in the Post-Mortem.

1.8. Infection Prevention and Control and Waste Disposal Guidelines

All staff are responsible for infection prevention and control in their respective areas of work. The department heads with the assistance of members of the infection prevention and control committee are responsible for ensuring compliance to the guidelines below.

1.8.1. Standard Precautions

Wash or decontaminate hands:

1. After handling any blood, body fluids, secretions, excretions and contaminated items.
2. Between contact with different patients.
3. Between tasks and procedures on the same patient to prevent cross contamination.
4. Between different body sites.
5. Immediately after removing gloves.

Personal protective equipment should be used by:

1. Health care workers who provide direct care to patients and who work in situations where they may have contact with blood, body fluids, excretions or secretions.
2. Support staff including medical aides, cleaners, and laundry staff in situations where they may have contact with blood, body fluids, secretions and excretions.
3. Laboratory staff, who handle patient specimens.
4. Family members who provide care to patients and are in a situation where they may have contact with blood, body fluids, secretions and excretions.

Patient care equipment

1. Handle patient care equipment soiled with blood, body fluids secretions or excretions with care in order to prevent exposure to skin and mucous membranes, clothing and the environment.
2. Ensure all reusable equipment are decontaminated, cleaned and reprocessed appropriately before being used on another patient.

Linen handling

1. Handle, transport and process used linen that is soiled with blood, body fluids, secretions or excretions with care to ensure that there is no leaking of fluid.

Prevention of needle stick/sharps injuries

1. Take care to prevent injuries when using needles, scalpels and other sharp instruments or equipment.
2. Place used disposable syringes and needles, scalpel blades and other sharp items in a puncture resistant container with a lid that closes and is located close to the area in which the item is used.
3. Take extra care when cleaning sharp reusable instruments or equipment.
4. Never recap or bend needles.

1.8. 2. Transmission Based Precautions

Airborne Precautions

1. Implement standard precautions as outlined above.
2. Place patient in a single room that has a monitored negative airflow pressure, and is often referred to as a "negative pressure room". The air should be discharged to the outdoors or specially filtered before it is circulated to other areas of the health care facility.
3. Keep doors closed.
4. Anyone who enters the room must wear a special, high filtration, particulate respirator (e.g. N 95) mask.
5. Limit the movement and transport of the patient from the room for essential purposes only. If transport is necessary, minimize dispersal of droplet nuclei by masking the patient with a surgical mask.
6. It is important to keep the patient in a room with adequate ventilation.

Droplet precautions

1. Implement standard precautions.

2. Place patient in a single room (or in a room with another patient infected by the same pathogen).
3. Wear a surgical mask when working within 1-2 meters of the patient.
4. Place a surgical mask on the patient if transport is necessary.
5. Special air handling and ventilation are not required to prevent droplet transmission of infection.

Contact Precautions

1. Implement standard precautions.
2. Place patient in a single room (or in a room with another patient infected by the same pathogen). Consider the epidemiology of the disease and the patient population when determining patient placement.
3. Wear clean, non-sterile gloves when entering the room.
4. Wear a clean, non-sterile gown when entering the room if substantial contact with the patient, environmental surfaces or items in the patient's room is anticipated.
5. Limit the movement and transport of the patient from the room. Patients should be moved for essential purposes only. If transportation is required, use precautions to minimize the risk of transmission.

1.8. 3. Patient Placement and Transportation

Appropriate or selective placement of patients is important in preventing the transmission of infections in the hospital setting. General principles in relation to the placement of patients include the following:

1. In open plan wards, there should be adequate spacing between each bed to reduce the risk of cross contamination/infection occurring from direct or indirect contact or droplet transmission. Optimum spacing between beds is 1-2 meters.
2. Single rooms reduce the risk of transmission of infection from the source patient to others by reducing direct or indirect contact transmission. Where possible, single rooms should have the hand washing, toilet and bathroom facilities.
3. Single rooms used for isolation purposes may include an anteroom to support the use of personal protective equipment.
4. For infection control purposes, if single rooms are not available, or if there is a shortage of single rooms, patients infected or colonized by the same organism can be cohorted (sharing of room/s).
5. When cohorting is used during outbreaks these room/s should be in a well-defined area (a designated room or designated ward), which can be clearly segregated from other patient care areas in the health care facility used for non-infected/colonized patients.
6. Limiting the movement and transport of patients from the isolation room/area for

essential purposes only will reduce the opportunities for transmission of micro-organisms in other areas of the hospital.

7. If transportation is required, suitable precautions should be taken to reduce the risk of transmission of microorganisms to other patients, health care workers or the hospital environment (surfaces or equipment). For example: when transporting a patient with pulmonary tuberculosis (open/active) placing a surgical mask on the patient while in transit is an appropriate precaution.

1.8. 4. Isolation Room

Preparation of the isolation room

1. Ensure additional precautions by indicating with appropriate signage on the door (for example, biohazard logo).
2. Place a log book at the entrance of the isolation room. All health care workers or visitors entering the isolation area must sign the log book.
3. Remove all non-essential furniture. The remaining furniture should be easy to clean and should not conceal or retain dirt or moisture, either within or around it.
4. Collect linen as needed.
5. Stock the hand basin with suitable supplies for hand washing.
6. Place appropriate waste bags in the room on a foot-operated bin.
7. Place a puncture-proof container for sharps in the room.
8. Keep the patient's personal belongings to a minimum. Keep water pitcher and cup, tissue wipes, and all items necessary for attending to personal hygiene within the patient's reach.
9. The patient should be allocated his/her own non-critical items of patient care equipment, e.g. stethoscope, thermometer and sphygmomanometers. Any item of patient care equipment that is required for other patients should be thoroughly cleaned and disinfected prior to use.
10. Set up a trolley outside the door to hold personal protective equipment.
11. A checklist may be useful to ensure all equipment is available.
12. Place appropriate container with a lid outside the door for equipment that requires disinfection and sterilization. Once equipment has been appropriately cleaned, it can be sent to the sterilizing service department.
13. Keep adequate equipment required for cleaning and disinfection inside the patient's room.

Cleaning the room

1. Scrupulous daily cleaning of the isolation unit is essential to prevent cross-infection.

Entering the room

2. Collect all equipment needed.
3. Sign the log book.
4. Wear personal protective equipment.
5. Enter the room and shut the door.

Attending the patient

1. Give careful instructions and explanations to patient and visitors so that they comply fully with the precautions.
2. Give the patient the same kind of respect that is given to other patients.
3. Be courteous and accepting. Do not convey any feelings of disgust or fear about the infection.
4. Teach the visitors and the patient how to observe safe and correct procedures in order to prevent spread of infection.
5. If the patient is a child, isolate the family caregiver in the same unit.

Catering

1. Serve food on disposable crockery to be eaten with disposable cutlery (if available).
2. Non-disposable crockery and cutlery should be washed using hot water (70C) and detergent, rinsed and dried.

Excreta

1. If there is no bedpan flusher/disinfector available in the isolation area, bedpans and urinals should be bagged in the isolation room, taken and emptied immediately and then washed in a bedpan washer/ hot boiling water, dried and returned immediately to the patient's room.
2. If sewage treatment systems are not available secretions and excretions should be disinfected prior to their discharge into sanitary sewage.
3. Reusable bedpans, urinals and sputum mugs should be decontaminated and cleaned with a neutral detergent then disinfected with an appropriate disinfectant, for example 5% sodium hypochlorite solution. Wash and dry to reuse.

Dressings

1. Discard waste material and dirty dressings in clinical (infectious) waste bag.

2. Keep used lotions/medications in the room and do not use for non-isolation patients.

Leaving the room

1. Remove personal protective equipment avoiding contact with blood, body fluids, secretions, excretions and other contaminants when leaving the patient care area.
2. Use alcohol-based hand-rub or wash hands.
3. Leave the room.
4. Once outside room use alcohol hand-rub again or wash hands. Wash hands using plain soap, antimicrobial agent or waterless antiseptic agent such as an alcohol-based hand gel.

1.8.5. Waste Management

1. Segregate clinical (infectious) waste from non-clinical waste in dedicated and appropriately labelled containers.

2. Transport waste in a dedicated trolley.

3. Store waste in specified areas with restricted access.

4. Collect and store sharps in sharps containers. Sharps containers should be made of plastic or metal and have a lid that can be closed. They should be marked with the appropriate label or logo, e.g. a biohazard symbol for clinical (infectious) waste.

5. Mark the storage areas with a biohazard symbol.

6. Ensure that the carts or trolleys used for the transport of segregated waste collection are not used for any other purpose and should be cleaned regularly.

7. Identify a storage area for waste prior to treatment or being taken to final disposal.

Methods of disposal

(1). Sharps:

- Autoclave, shred and land-fill or microwave, shred and land-fill or treat by plasma pyrolysis of puncture-proof containers storing discarded sharps.
- Deep burial in a secure area. Burial should be 2 to 3 meters deep and at least 1.5 meters above the groundwater table.

(2). Waste requiring incineration

- Anatomical parts and animal carcasses;.
- Cytotoxic drugs (residues or outdated);.
- Toxic laboratory chemicals other than mercury.

(3). Waste that may be incinerated

- Patient-contaminated non-plastics and non-chlorinated plastics.

(4). Waste that should not be incinerated

- Chlorinated plastics.
- Volatile toxic wastes such as mercury.
- Plastics, non-plastics contaminated with blood, body fluids, secretions and excretions and infectious laboratory wastes. (Such wastes should be treated by steam sterilization in auto clavable bags or microwave treatment. Shredding may follow both these methods. If neither method is available, chemical treatment with 1% hypochlorite or a similar disinfectant is recommended. However, excessive use of chemical disinfectants should be avoided as it may be a health and environmental hazard).
- Burning should be burned at night

(5). Laundry

(i). Linen

- Place used linen in appropriate bags at the point of generation.
- Contain linen soiled with body substances or other fluids within suitable impermeable bags and close the bags securely for transportation to avoid any spills or drips of blood, body fluids, secretions or excretions.
- Do not rinse or sort linen in patient care areas (sort in appropriate areas).
- Handle all linen with minimum agitation to avoid aerosolisation of pathogenic micro-organisms.
- Separate clean linen from soiled linen and transport/store separately.
- Wash used linen (sheets, cotton blankets) in hot water (70°C to 80°C) and detergent, rinse an dry preferably in a dryer or in the sun. Heavy duty washers/dryers are recommended for the hospital laundry.
- Autoclave linen before being supplied to the operating rooms/theatres.
- Wash woolen blankets in warm water and dry in the sun, in dryers at cool temperatures or dry-clean.

(ii). Bedding

- Mattresses and pillows with plastic covers should be wiped over with a neutral detergent.
- Mattresses without plastic covers should be steam cleaned if they have been contaminated with body fluids. If this is not possible, contaminations should be removed by manual washing ensuring adequate personnel and environmental protection.

- Wash pillows either by using the standard laundering procedure described above, or dry clean if contaminated with body fluids.

6. Cleaning and Sterilization

(i). Equipment

- Staff trained, certified and experienced in decontamination, cleaning, disinfection and sterilization of medical equipment should be available.
- Classification of used medical equipment according to level of processing needed should always be undertaken. Special consideration according to manufacturers' instructions should be kept while handling all equipment.
- Processing (decontamination, cleaning, disinfection, sterilization and storage) should be done according to the appropriate FHOK Quality of Care Guidelines and the national Ministry of Health Infection Prevention guidelines.

(ii). Hospital Environment

- Dry sweeping should be avoided.
- General common hospital areas should be cleaned at least twice a day with hot water and neutral detergent.
- Horizontal surfaces and toilets should be cleaned at least twice a day with appropriate detergent and as need may arise.
- Surfaces visibly contaminated with blood and or body fluids should be cleaned immediately with hot water, detergent and disinfectant.
- Isolation rooms and other areas that have patients with known transmissible infectious diseases should be cleaned with a detergent disinfectant solution at least twice daily.

8. Care of Health Care Workers

- Employees' health should be reviewed at recruitment, including immunization history and previous exposures to communicable diseases (e.g. tuberculosis) and immune status. Some previous infections such as varicella-zoster virus may be assessed by serological tests.
- Immunization recommended for staff includes: hepatitis A and B, influenza, measles, mumps, rubella, tetanus, and diphtheria. Immunization against varicella, rabies may be considered in specific cases. The Mantoux skin test will document a previous tuberculosis (TB) exposure.
- Specific post-exposure policies must be developed, and compliance ensured for a number of infectious diseases for example: human immunodeficiency virus (HIV), viral hepatitis, Severe Acute Respiratory Syndrome (SARS), varicella, rubella and tuberculosis.

- Health care workers with infections should report their illnesses/incident to the incharge for further evaluation and management.

1.8.6. Exposure to Infections and Injuries

(1). Human Immunodeficiency Virus (HIV)

- The route of transmission for HIV is person to person via sexual contact, sharing of needles contaminated with HIV, infusions that are contaminated with HIV, transplantation of organs or tissues that are infected with HIV.
- The risk of a health care worker acquiring HIV after a needlestick or other "sharps" injury is less than 0.5%. Risk reduction must be undertaken for all bloodborne pathogens, including: adherence to standard precautions using personal protective equipment and appropriate use of safety devices and a needle disposal system to limit sharps exposure. Training for Healthcare workers in safe sharps practice should be ongoing as part of on the job Training (OJT).
- Information on preventive measures must be provided to all staff with potential exposure to blood and blood products. Policies which are in keeping with the local and national guidelines must include screening of patients, disposal of sharps and wastes, protective clothing, managing inoculation accidents, sterilization and disinfection.
- Hospital policy must include measures to obtain serological testing of source patients promptly where necessary, usually with the patient's informed consent. Post exposure prophylaxis should be started as per local or national guidelines.

(2). Exposure to Hepatitis B Virus

- The route of transmission for hepatitis B virus is through body substances such as blood and blood products, saliva, cerebrospinal fluid, peritoneal, pleural, pericardial and synovial fluid, amniotic fluid, semen and vaginal secretions and any other body fluid containing blood.
- Following standard precautions is important, but immunization is the best way of preventing transmission to health care staff. All HCWs at risk must be vaccinated.
- Staff infected with blood-borne pathogens may transmit these infections to patients and require careful evaluation with respect to their duties. This status should not be used as cause for discrimination.

(3). Exposure to Hepatitis C Virus

- The route of infection is mainly parenteral. Sexual transmission does occur but is far less frequent.

- No post exposure therapy is available for hepatitis C, but seroconversion (if any) must be documented.
- As for hepatitis B viral infection, the source person must be tested for HCV infection.
- For any occupational exposure to bloodborne pathogens, counselling and appropriate clinical and serological follow-up must be provided.

(4). Sharp Injuries

- Needlestick injuries are the most common of sharps injuries, although other contaminated sharp instruments may also cause injuries.
- All health care workers with potential exposure should be vaccinated. For other personnel, the risk of Hepatitis B, Hepatitis C and HIV infection should be assessed and appropriate immunization or chemoprophylactic steps taken.
- Immediate treatment of such injuries should encourage washing thoroughly with running water and an antiseptic solution. Consult the facility in-charge for further advice.
- An incident reporting flow chart is annexed to the SOPs document and displayed in all clinic procedures rooms and active support by Centre Managers should encourage prompt and accurate reporting.

(5). Tuberculosis

- Health care workers have varying risks for exposure to tuberculosis (TB).
- Health care workers at the greatest risk of exposure are those working in TB-risk areas such as medical wards, chest clinics, bronchoscopy units, radiology units, TB laboratories, HIV wards and autopsy rooms.
- If a staff member has been exposed to TB they should report to the department head and or facility in-charge.

(6). Meningococcal Meningitis

- Transmission of meningococci to health care staff is most likely within 24 hours of admission of the patient, prior to the patient receiving appropriate antibiotic/chemoprophylaxis.
- Health care workers in close respiratory contact with such cases may receive chemoprophylaxis with ciprofloxacin or an effective alternative agent. Close respiratory contact with the patient includes mouth-to-mouth contact, sharing of drink containers or cigarettes.

1.8.7. Care of the deceased

- Health care workers must follow all infection control precautions when caring for the deceased patient including removal of drains, catheters and tubes.

- Wear appropriate personal protective equipment.
- Wound drainage and needle puncture holes should be disinfected and sealed.
- Secretions in oral and nasal orifices can be cleared with gentle suction.
- Oral, nasal and rectal orifices should be plugged to prevent body fluids leakage.
- Ensure that the body is sealed in an impermeable body bag prior to transfer to the mortuary.
- Ensure that there is no leaking of body fluids and the outside of the bag is clean.
- Recognize and consider cultural sensitivities.
- If the family of the patient wishes to view the body, allow them to do so as long as they wear personal protective equipment. This should happen before the body is transferred to the mortuary.
- Transfer of the body to the mortuary.
- Used linen and equipment should be processed according to the guidelines expounded on in section 5 above.
- Contaminated surfaces should be cleaned according to the guidelines expounded on in section 5 above.
- Map out a good route to pass the body and avoid exposing it to public/clients

Tissue Disposal

Tissues such as placenta, uterus, and Cancerous tissues need to be disposed as per Ministry of Health National Disposal Guidelines.

1.9. Standard Operating Procedures for Clinical Record Keeping

1. Manual records

(a). Inpatients

(i). Patient admitted on basis of;

- Referral letter from admitting doctor or
- Advice from doctor or nurse attending to the client.

(ii). File opened and admission number assigned. File should comprise of;

- Admission form – filled by nurses.
- Patient transfer form.
- Doctors' continuation forms.
- Treatment sheet.
- Observation sheet.
- Partograph
- Cadex

- Fluid chart.
- Consent forms (Pre and postoperative).
- Tally/charge sheet.
- Financial agreement form.

(iii). File kept at reception in maternity during the duration of patients stay. At this point file only accessible to nurses and doctor attending to the client.

(iv). During discharge file goes to accounts for billing.

(v). Once bill cleared, file should be kept at records section and maintained by medical records officer or designated person at clinic.

(vi). If patient comes back for review or for another consultation, same file is retrieved using the generated admission number. If unavailable, patient name will be used to trace the file.

(b). Out-patient

- Daily Activity Register
- MCH booklet
- MoH Registers

(c). Other records;

Other records kept at clinic's records office are;

- Patient File.
- Admission book.
- Delivery book.
- Birth notification.
- Death notification.
- Maternal death notification form
- Theatre procedure book.
- Verbal autopsy tool.
- Maternal death review.
- Perinatal death review.
- Checklist for facility based MDR committee.

These are used on need basis and are stored for a minimum 8 years at facility.
After 8 years Centre Manager should contact Head Office (Procurement officer) for disposal arrangements. Patient's records should be kept under lock and key.

2. Electronic records

Standard Operating Procedures for Use of Electronic Clinic Information System (eCMIS)

All FCMCs are required to use the Electronic Clinic Information System for service provision. The following guidelines will apply on the use of the eCMIS;

1. All consultation rooms, reception, pharmacy, laboratory, accounts and other relevant clinic rooms should have a working computer for use by persons working in those rooms.
2. All clinicians, Lab. Techs, Pharm Techs, receptionists, procurement staffs, and accounts staff working in FCMCs must use eCMIS. This includes the locum staff and consultants working in FHOK-FCMCs. This is one of the requirements to work in FHOK-FCMCs.
3. All clients making payments at the clinic payment points must be given an eCMIS generated receipt
4. 1/[All Heads of Department's (HODs) reports submitted to HQ must be in eCMIS format
5. All service providers must serve clients using their own account name and this includes the locum staffs and consultants.
6. Any locum staff and consultants who wish to work in FHOK-FCMC's should be orientated on the eCMIS at least for one day prior to engagement in the facility.
7. The Medical Centre Manager or designated staff is the authorized administrator of clinic eCMIS account.
8. All facilities must have an external backup and administrator or designate should update it on daily basis.
9. The clinic server should be placed in a secure room with limited access to unauthorized personnel.
10. In the event of a black out, use manual records and upload data into the system when power is back.

1.10. Ambulance Use Standard Operating Procedures

Below are guidelines and standard operating procedures for FHOK's ambulance operations.

1. The ambulance should be staffed by at least 2 staff members, a driver and either a paramedic, nurse or clinician.
2. The driver is responsible for the safety of all passengers on board. He/she is also responsible for the road-worthiness of the ambulance.
3. The ambulance driver is responsible for ensuring that the ambulance siren, 2-way radio and air conditioning are functional.
4. The ambulance driver is responsible for vehicle work-ticket documentation and fueling.

5. Any issues involving the ambulance operability should be channeled to the Centre Manager promptly.
6. The ambulance should be cleaned at least once daily and after transfer of a patient according to the Infection Prevention and Control Guidelines.
7. The Centre Manager should assign at least 1 clinical staff member to be responsible for inventory checking of the ambulance equipment, consumables, drugs and fluids and filling in the checklist form at least once weekly.
8. Any consumables, drugs or fluids that are due for expiry before the next inventory check should be replaced immediately.
9. Any equipment breakdown or malfunction should be reported to the Centre Manager for repair or replacement.
10. Any organization that may wish to hire FHOK ambulance services can be accorded the services subject to a signed MOU.

1.11. Consultants' Engagement Guidelines

The guidelines below should be followed while engaging consultants and specialists who collaborate with FHOK facilities to offer quality services to clients. The decision to engage the consultant should be made by the Hospital Management Team (HMT) in collaboration with other consultants with admission rights, the Director of Clinical Services and the Executive Director.

Requirements

1. Application letter by the consultant
2. The consultant's resume with referees
3. Copies of the consultant's professional certificates, registration and retention certificates and practicing license.
4. Certificate of indemnity cover

The Memorandum of Understanding between FHOK and the consultant should cover the following broad areas;

1. Consultant's clinic days
2. Consultant's in-patient call duties
3. Code of conduct adherence
4. Documentation and use of eCMIS
5. Obligations by the consultant to support FHOK facilities like pharmacy and laboratory.
6. Invoicing by the consultant and remittance of dues by FHOK to the consultant.
7. Addressing of grievances.
8. Termination of the contract

1.12. Locum Engagement Guidelines

The guidelines below should apply while engaging locums in all the departments. The decision to engage the locum should be made by the Medical Centre Manager in collaboration with the head of the relevant department and the Accounts department. All locums must be well oriented by the department heads before being allocated duties.

Requirements

1. Application letter
2. Resume with three referees
3. Copies of professional certificates and current licenses
4. Competency to use eCMIS

The locum staff must sign the following documents before engagement;

1. Locum Engagement Agreement Form
2. Code of Conduct and Standards

The locum staff must also read and understand the following documents and before engagement;

1. FHOK Facility Standard Operating Procedures.
2. FHOK Quality of Care Guidelines.
3. FHOK Service Charter.

1.13. Complaints and Grievances Handling Guidelines

Grievances and complaints by clients/patients, staff, consultants and other partners should be handled using the guidelines below. The grievances or complaints may be verbal or written.

1. Clients/patients grievances or complaints should be handled by the relevant staff they are directed to. If unable to resolve, the supervisor and or head of department should be involved to assist.
2. All grievances and complaints not settled at the department level should be forwarded to the facility in-charge who, alone or with assistance, should try to resolve the matter.
3. All suggestion box correspondence should be read and resolved by the Hospital Management Team (HMT).
4. The facility In-charge with the assistance of the department head and the relevant staff should handle all complaints relating to patient mismanagement or negligence during care. The same applies for any complaints or grievances with potential medico-legal implications.
5. Billing grievances, complaints and misunderstandings should be directed to the department head and the accounts department head. If no solution is found the In-

charge should be involved.

6. Any patient/client wishing to see or speak to the In-charge should be allowed to do so immediately or as soon as the In-charge is available.
7. A member of the Hospital Management Team should always be available on weekends and holiday to handle any grievances and or complaints. A designated staff member should be as signed the same task by the In-charge during night shifts.
8. The facility In-charge should seek the involvement of The Director of Clinical Services for any grievances or complaints that cannot be resolved at the facility level. The Human Resources Manager should also be involved in matters touching on staff grievances and complaints.

1.14. Facility Care Environment and Safety Management Guidelines

The facility care environment is made up of three components: building(s), equipment, and people. To effectively manage the care environment and ensure facility safety, the following should be done:

1. Reduce and control environmental hazards and risks.
2. Prevent accidents and injuries.
3. Maintain safe conditions for patients, staff, and visitors.
4. Maintain a care environment that is sensitive to patient needs for comfort and social interaction.
5. Maintain a care environment that minimizes unnecessary environmental stresses for patients, staff and visitors.

1.15. General Safety Management

1. Hazard Recognition

Hazard identification is the process used to identify all possible situations in the hospital where people (patient, staff, visitors etc) may be exposed to injury, infections or disease. The risk management authorities/HMT undertake periodic evaluation of safety precautions to be followed by each department.

For hazard recognition the following steps will be undertaken:

1. Both clinical and non-clinical audits will be undertaken on annual basis to identify the measures taken to prevent/reduce the impact of the potential hazards.
2. All the staff of the health facility will be encouraged to routinely assess all activities to identify potential hazards.
3. Departmental heads and centre managers will identify hazards within their specific area of control. The same should be notified to the appropriate health facility authorities for immediate corrective actions.

2. Electricity safety

The following measures should be undertaken to ensure Electrical Safety:

1. Routine inspection of the power outlets throughout the health facility should be done by an electrician.
2. Trip Switches should be located in different parts of the health facility to prevent short circuits.
3. Periodic inspection of wires to ensures that they are in appropriate conditions.
4. Before any electrical equipment is installed in the facility, a safety inspection should be done by a qualified person.
5. Electrical equipment not in use should be switched off.
6. Areas around electrical switchboards must be kept clear for a distance of at least 1 meter.
7. ABC type fire extinguisher should be located adjacent to electrical switchboards.
8. All electrical equipment should have power surge protectors at point of purchase

3. Power Loss

In the event of power loss without generator-back up, electrical equipment should be switched off unless necessary, until power is restored.

4. Fire

The two-fold objectives of the Fire Safety Plan are:

I). Fire Prevention:

To prevent the incidence of fire by implementing appropriate measures to control fire hazards in the building and by the maintenance of the building facilities provided for the safety of the occupants.

1. The facility should be declared 'No Smoking' zone.
2. Smoke Detection Devices may be placed in different parts of the health facility.
3. Fire extinguishers, in appropriate sizes and types (ABC), should be provided throughout the health facility in every floor of the health facility. Extinguishers should be inspected as required by a qualified contractor. The theft of or tampering with an extinguisher should be reported immediately to the facility In-charge.

ii). Emergency Evacuation

The R.A.C.E. procedure should be observed to minimize the effects of Fire Accidents in the facility and to establish a systematic method of safe and orderly evacuation of the facility occupants.

a. Rescue

Remove patients or others in immediate danger and close the door behind. If the person is busy in rescue effort; he should shout "FIRE' so that other employees can pull the alarm.

b. Alarm:

Break open Alarm system, should be placed in different parts of the facility which can be activated at the time of fire by breaking the glass panel.

Smoke detectors should also be located in different parts of the facility which in the event of detecting smoke will activate the alarm system.

c. Contain:

Contain the fire by closing doors and windows so that it does not spread to other parts of the health facility.

d. Extinguish/evacuate

1. Extinguish fire if possible.
2. Use correct extinguisher for the type of fire.
3. Evacuate all persons to a safe area, if necessary and perform head count.
4. Provide safety blankets especially for evacuation of clients.
5. Follow directions of Safety Officer, Fire Department or Nursing Supervisor.

Fire plan should be placed in every floor which indicates the exact location of the fire exits and fire extinguishers hence in case of any fire accidents; the nearest fire exit in the floors can be easily traced.

e. Procedure for use of fire extinguisher

The procedure for use of any fire extinguisher is:

1. Pull Pin (from handles)
2. Aim at base of fire
3. Squeeze handles
4. Sweep nozzle or hose from side to side:
    - Fire Training and Fire drills should be held at periodic intervals .All employees should be provided adequate fire training, and informed about the fire evacuation procedures including fire exits located in their work places.
    - No obstructions should be placed in front of or upon any exit door.
    - No aisle, exit access, or stairway should be obstructed with furniture or other obstructions so as to reduce the required width of the exit unless it is required

for some maintenance purpose or during night hours when the main entrance is closed.

- The area immediately outside of building exits should be maintained free of material at all times. Vehicles should not be permitted on sidewalks immediately adjacent to an exit.
- Every facility should have a designated fire assembly point and all staff should be sensitized appropriately
- Conduct quarterly training for staff in emergency response and general safety management
- Confirm the type of fire extinguisher and the its operation procedure.

2. Infectious/Biohazard Material Safety Management

The infection Prevention and Control Protocols should be used to handle Infectious or biohazard material and related incidences.

(i). Disaster and Security Threat Management

Internal and external disasters should be handled according to the available national and local manuals and protocols/guidelines. In case of a security threat, the following procedures should be followed;

1. Facility Security Personnel should be immediately informed by any member of staff.
2. Police and other security agencies should be contacted through hotlines that should be well displayed throughout the facility by the In-charge or any available member of staff if the In-charge is unable or unavailable to do so.
3. Instructions from security personnel should be strictly complied with.
4. Evacuation of the facility should be commenced if deemed necessary with the evacuation of patients taking priority. Evacuation procedures and protocols should be familiar to all staff.
5. Re-entry into the facility should only be allowed after the all-clear from security personnel.
6. All staff should be vigilant and report any suspicious activity or packages to the In-charge for further action.

(ii). Facility Safety Committee and Safety Officer.

A facility safety committee should be in place headed by the facility In-charge to handle all matters related to the care environment and safety in the facility. The committee shall appoint a safety officer to carry out mandated tasks expounded on below. The Safety Committee and safety officer are responsible for;

1. Providing guidance and direction in all phases of the Safety Management of the facility.
2. Pro-active safety risk assessments of the clinical and clinical support areas of the facility.

3. Facilitation of the Environmental Monitoring Rounds.
4. Advising management of unsafe conditions or of non-compliance with regulations and standards.
5. Conducting on-going safety education classes.
6. Proposing/revising safety policies.
7. The required licenses and other regulatory requirements are duly satisfied.

The Facility Safety Officer with help from other personnel as it may be deemed necessary should conduct periodic facility inspections focusing on the following areas;

1. Environmental (lighting, dusts, gases, sprays, noises).
2. Hazardous materials (flammable and caustic).
3. Equipment (biomedical equipments etc.).
4. Power equipment (boilers, motors, etc.).
5. Electrical equipment (switches, breakers, fuses, outlets, connections).
6. Hand tools.
7. Personal protective equipment (safety glasses, ventilators, radiation safety aprons etc).
8. Personal service/first aid supplies (Medical Check Up).
9. Fire protection equipment (alarms and extinguishers).
10. Walkways/roadways (sidewalks, roadways).
11. Transportation equipment (Ambulances, lifts).
12. Containers (hazardous waste bags).
13. Structural openings (windows, doors, stairways).
14. Buildings/structures (floors, roofs, planter walls, fences).
15. Miscellaneous (any items not covered above).

A detailed inspection report should be discussed by the safety committee and appropriate action taken.

1.16. Equipment Care, Maintenance and Repair Guidelines

The guidelines below relate to the maintenance and repair of all the equipment in the facility;

1. The department heads should have an updated inventory of all the equipment in their departments which should be displayed. Accordingly, the facility In-charge should have a master checklist of all the facility equipment.
2. All staff with the supervision of the department heads is responsible for the care, proper use and maintenance of the equipment they use. The department heads take overall responsibility for all the equipment in their department.
3. Department heads should ensure that routine maintenance and or recalibration of equipment under their responsibility is carried out in time.
4. Any damage to or malfunctioning of equipment should be reported to the department

head who then should liaise with the in-charge and the finance/procurement department to organize for repairs or replacement. A similar procedure should be followed for replacement of outdated or obsolete equipment.

5. The facility In-charge in liaison with the accounts/procurement department and the Director of Clinical Services will be responsible for disposal of irreparable or obsolete equipment.
6. Staff handling essential equipment e.g. Theatre machines must make sure there is back-up equipment in-case of break-down or malfunction. This must be done in conjunction with the department heads and the facility In-charge.
7. If there is need for procurement of new equipment, the department head should inform the In-charge who will liaise with the accounts/procurement department and the Director of Clinical Services to facilitate the same.
8. For centralized procurement, technical staff using the equipment should provide input/advice/approval to ensure quality equipment is procured.
9. Procurement at clinic level should be spearheaded by the procurement committee.
10. Theft or loss of equipment should immediately be reported to the department head for further action.
11. Staff shall be held responsible if equipment under their care is lost or damaged through mishandling or negligence.
12. Equipment should not leave the facility without the documented authorization of the department head and or the In-charge.

1.17. Standard Operating Procedures for telephone use

FCMCs have intercom, mobile and external telephone services in all departments. Staffs working in FCMCs are required to observe courtesy of telephone use.

1. Pick the phone when it rings in your presence and identify yourself. Phone should not ring more than 3 times.
2. If you are not the intended person, take the message and pass it to the right person at the right time or transfer the phone to the person in case the person is in a different extension.
3. Wait till the caller has replaced the phone on the other side then replace it.
4. Use courteous language all the time when talking to clients over the phone.
5. All staff are required to know how to transfer or recall phones.
6. Clinic receptionists to ensure phone transfer instructions are on every telephone head.
7. Misuse/abuse of phone use may lead to disciplinary action.

1.18. Standard Operating Procedures for Computer & internet use

- All staff working in FHOK health care facilities should adhere to the SOP guiding use of internet use as outlined in internet policy issued to every employee at time of appointment. Refer to the internet use policy.
- FHOK to engage an efficient internet provider
- All the staff to abid by the FHOK internet policy issued at the time of appointment.

1.19. Standard Operating Procedures for Customer Care

Customer care covers all those activities which hold customers or clients to the organization or to the clinics. Every activity that we do that affects the client is a Customer Care activity. The following Standard Operating Procedures should apply while handling our clients

Staff attitudes and behavior

1. Be polite to clients.
2. Avoid being angry to clients.
3. Avoid showing any segregation attitudes to clients.
4. Avoid showing any sexist attitudes.
5. Avoid making blames about colleagues, organization, etc.
6. Avoid superiority or inferiority complex to clients.

Communications: Face to Face

1. Listen well to clients and show interest.
2. Avoid asking inappropriate questions.
3. Do not use wrong voice.
4. Avoid negative body language.
5. Be composed and avoid being emotional.
6. Avoid blames on colleagues.

Communications of the telephone

1. FCMC management to ensure telephone equipment are working well at all times.
2. All staff should be oriented on how to effectively use the telephone (intercom/ mobiles).
3. Answer telephone calls ringing in your presence and give appropriate feedback.
4. Introduce yourself or the organization.
5. Avoid talking rudely on phone.
6. Avoid using wrong tone or voice.
7. Do not keep caller on wait for long, be prompt in replying.
8. Avoid gossip on phone.

Communication in writing

1. Use clearly readable text.
2. Be prompt in replying.
3. Avoid too many lame excuses.
4. Avoid inappropriate tone.

Friendly systems and procedures

1. Have simple and clear procedures i.e invoicing, ordering, others.
2. Have fast decision making processes.
3. Any instructions issued should be clear.
4. Ensure you meet deadlines and fulfill promises to clients.
5. Have clear complaints procedure in place.
6. Uphold teamwork in facility.

Management obligations

1. Conduct continuous capacity building of all staff.
2. Conduct supportive supervision and on the job couching/training.
3. For comprehensive staff issues, refer to the FHOK human resource management policy.

1.20. Service Fee Waiver Guidelines

FHOK-Family Care Medical Centres & Maternities are allowed to waive service fee on certain occasions. The following guidelines will apply;

1. Only the Centre Manager will authorize for any client to be given a waiver after assessing the situation of the client and convinced that client is unable to meet cost of service.
2. All clients given a waiver in line with waiver creteria or at the discretion of the Centre Manager must be recorded (full client details) given, amount waived and reasons for waiving.
3. In the absence of the Centre Manager the Acting Centre Manager will assess and provide the waiver as per waiver creteria / guideline.
4. No client will be turned away because of non-payment for SRH services

1.21. Food Handling Standard Operating Procedures

The guidelines below should be observed by all the food handlers working in the facility including contracted outside caterers. The in-patient in-charge should work closely with the caterer to provide meals to the patients according to their preferences and the clinician/dietician's advice.

1. All food handlers should have the required hygiene certificates.
2. Personal hygiene should always be observed-clean attire including apron, frequent

handwashing, trimmed finger-nails, suitable and effective hair restraints.

3. Contamination of food and utensils should be avoided-observation of proper hygiene, covering exposed food, proper storage of foodstuff and utensils, avoid touching utensil's food contact surfaces.
4. Food should only be served in clean, sanitized and dry utensils.
5. Food contact surfaces, utensils, carts and equipment should be processed according to the appropriate procedures before and between uses and any time contamination occurs.
6. Proper and timely disposal of left-over waste should always be observed.

Any complaints raised by patients should immediately be taken up by the in-patient in-charge and the Medical Centre Manager.

1.22. Standard Operating Procedures for Drug and Services Pricing

The service fee rates and price reviews in the FHOK's health facilities will be informed by the following considerations;

1. Profiling of our clients (economic status of target clients).
2. Prices offered by our competitors (service providers around us).
3. Changes in drug prices in the market.
4. Uniqueness of the facility and catchment population.
5. Service fee visa vis statistics (balancing between reaching statistical targets and cost of services)
6. Need based (when there is need to review).
7. Donations from government and partners (may influence review of prices).

The review will be done annually by the Hospital Management Team during the APB preparation process.

The following considerations will inform the actual costing of specific drugs and services

1. Operational costs.
2. Cost calculator.

1.23. Standard Operating Procedure for Branding and Marketing

Branding of FHOK-FCMCs will be in line with the FHOK's communication strategy. The MCM should ensure that they receive guidelines and approval from the FHOK's Communication Department before any branding or IEC materials are produced. Information and Knowledge Management officer should circulate FHOK colour codes to all MCMs

1.24. Standard Operating Procedure for use of FHOK's facilities, programmes, projects, data, clientale, for operations research/studies/surveys.

Through her health care facilities, youth friendly centres, community based programmes and projects, implemented over the years in different parts of the country, FHOK has accumulated a wealth of data, intervention models and a pool of clientale that provide good opportunities for operations research for evidence-based interventions. FHOK will endeavor to conduct operations research on her own or in partnership with other researchers to generate evidence for informed programming.

Partner organizations, individuals, institutions, seeking to use FHOK facilities, programmes, projects, clientale, data, etc, for operations research, studies, surveys, are required to discuss with FHOK and if agreed enter into formal signed arrangement to conduct the said research. FHOK would like to be fully involved and to participate in the planned research and that final research document(s) bears the logo of FHOK, name(s) of FHOK's researcher(s) participating in the research, co-ownership of the final research document, co-authorship, co-publishing, co-presentation, where applicable.

The research project should also support FHOK's associated costs if any and concept papers, research tools, other relevant documents, final document, shared with FHOK.

1.25. Standard Operating Procedure for Quality of Care (QoC)

Family Care Medical Centres and Maternities aim at providing the highest standards of quality of care across all service delivery operations. Delivering good quality care to all clients, wherever they are, enhances clients' satisfaction and their use of services, increases job satisfaction and motivation among service providers, hence leading to greater sustainability of services. FHOK will institutionalize Quality of Care and management and staff will commit to promote it at all levels. The following guidelines apply;

1. There shall be a Quality of Care Committee at the headquarter (national) level with following Terms of Reference;
    - Be familiar with and have a detailed understanding of the quality of care guidelines from Ministry of Health, FHOK and IPPF.
    - Undertake facility quality of care assessment at once every year using the relevant FHOK's IPPF's Quality of Care tools and develop action plans for quality improvement.
    - Oversee, coordinate, track and report progress on the implementation of the QoC action plans by the clinics and headquarter levels.

- Jointly with clinic Quality of Care committee, conduct regular periodic performance review making actionable recommendations for improvement and share with the management, community and relevant stakeholders through appropriate forums.
- Promote use of Quality of Care and performance review findings for planning and programme development.
- The headquarter Quality of Care Committee should include the Director of Clinical Services, representatives from field facilities, monitoring and evaluation manager, and other key persons critical in delivering of Quality of Care within the organization.
- The composition of the national QoC committee should comprise of head quarter and field representation as well departmental representation.

2. Every clinic should have a quality of care committee with the following Terms of Reference;
   - Ensure that the clinic meets the highest quality of service delivery premised on the rights based approach and underpinned by the IPPF and FHOK's clients' rights charter.
   - Should have a work plan for Quality of Care within the facility.
   - Conducts Quality of Care assessments and develops Quality of Care action plan for the clinic at least 1 per annum.
   - Conduct client exit surveys.
   - Act on the Quality of Care identified gaps.
   - Submits Quality of Care reports and action plans to headquarter's Quality of Care Committee
3. Integrated Package of Essential Services (IPES) will form part of the Quality of Care and every clinic should implement IPES.
4. Quality of Care implementation will be part of the performance appraisal system of the management of the clinic.

1.26 Standard Operating Procedure for Client's Rights.

FHOK's health care facilities must ensure that Rights of the Client are fully observed and adhered to at all times, by all persons who provide various services to our **Client**s. There are 10 **Clients' Rights** which every client seeking SRH services in FHOK is entitled to which include;

01. Information: To learn about the benefits and availability of family planning.

02. Access: To obtain services regardless of sex, creed, colour, marital status, age, religious or political beliefs, ethnicity or disability.

03. Choice: To decide freely whether to practice family planning or child spacing and which method to use. **NO** client should be

	COERCED to use a method against his/her free decision.
04. Safety:	To be able to practice safe, effective, family planning, and protect themselves from diseases and violence
06. Privacy:	To have a private environment during counselling and services.
06. Confidentiality:	To be assured that any personal information will remain confidential.
07. Dignity:	To be treated with courtesy, respect, consideration and attentiveness.
08. Comfort:	To feel comfortable when receiving information and services.
09. Continuity:	To receive sexual and reproductive health information and services for as long as needed.
10. Opinion:	To freely express views on the information and services provided.

1.27 Standard Operating Procedure for Service Charter

FHOK recognizes the importance of a client Service Charter in actualizing the desire to provide quality services to our clients. The charter sets out standards that our clients can expect from us as well as being a tool to generate feedback from our clients on the services we provide. All clinics should display a service charter at reception or other areas where clients can easily see. The service charter should include promises which both Health Care Workers and Clients promise to each other for a safe and quality care. The charter will be reviewed periodically.

Health Care Workers' promise to clients:-

- Be friendly and welcoming to all our clients.
- Handle our clients with dignity, respect and professionalism.
- Provide high quality services in line with nationally and internationally acceptable standards.
- Provide adequate and accurate information to enable our clients make informed choices at all our service points.
- Use a right based approach in the provision of services to our clients.
- Provide services in a professional and non-judgmental way.
- Respect our clinic operating hours and be available when the clients need us.
- Ready to listen and address concerns of our clients.
- Provide our services within reasonable and competitive prices.
- Provide integrated services to ensure our clients receive services under one roof as per our slogan **"your health our concern".**
- Make appropriate referrals where necessary and follow up to ensure our clients receive the best of services.

Clients' promise to Health Care Workers:-

- Treat our staff with courtesy and respect.
- Tell us if you have special needs.
- Refrain from offering us gifts, money or other favors for any preferential treatment.
- Provide adequate, clear and accurate information to service providers, to ensure provision of quality and appropriate services.
- Participate in quarterly review on the quality of our services through filling of the Client's satisfaction forms.
- Observe protocol - first come first served unless there are emergency cases.
- Pay for services rendered as requested.

SECTION TWO:

PHARMACY STANDARD OPERATING PROCEDURES

2.1. Standard Operating Procedure for Dispensing Drugs

Purpose and scope

To ensure that correct drugs in correct doses and dosage forms are issued to the right persons in the pharmacy.

Responsibility

Pharmacy staff

Definitions and abbreviations

DDA –Drugs covered under the narcotics and psychotropic substances (control) act of Chapter 245, Laws of Kenya

Reference documents

1. Prescription.
2. Treatment sheet.
3. Work instruction for dispensing of DDA drugs.
4. Instructions for dispensing of chemotherapy drugs.
5. Instructions for stock modification and adjustment.
6. Work instruction for posting cash prescriptions.
7. Work instruction for changing prescription over the telephone.
8. Work instruction for interdepartmental and other institutions borrowing.
9. Work instruction for posting credit and third party prescriptions.
10. Work instruction for dispensing on treatment sheets.
11. Work instruction for reconstituting dry powder syrup.
12. Work instruction for extemporaneous preparations.
13. Work instruction for filling ward box register.
14. Work instruction for filling prescriptions.

Procedure

1. The client/ nursing staff/clinician should be greeted and received with a smile.
2. Receive prescription in a dignified manner
3. On receipt of a prescription or treatment sheet, the pharmacy staff shall confirm from either the prescription or treatment sheet the patient's detail by verifying the name and age (adult or child) and any other important information needed such as allergies

and previous medication history, as may be applicable.

4. The pharmacy staff shall confirm the validity of the prescription by checking for details such as prescription date, doctor's name and signature.
5. The Pharmacy staff shall check the prescription for clarity and correctness of dose, dosage form, and route of administration, frequency and duration of treatment.
6. If the prescription contains DDA or Chemotherapy drugs, the Pharmacy staff shall refer to the work instruction for dispensing of DDA drugs and work instruction for dispensing chemotherapy drugs.
7. If the prescription is not okay, the Pharmacy staff shall call the doctor to discuss a suitable amendment as per the work instruction for changing prescription over the telephone and record the changes made on the prescription or treatment sheet.
8. If the prescription is okay, the Pharmacy staff shall confirm the required drugs are available, if not available either request transfer from the main store or request transfer from our suppliers or call the doctor for alternative, or borrow from another institution.
9. On receipt of the borrowed drugs, the Pharmacy staff shall adjust the stocks as per work in struction for stock modification and adjustment.
10. For cash paying patients, the Pharmacy staff shall post the prescription online (Electronic Clinic Information Management System (eCMIS) and indicate the cost of the drugs as per the work instruction for posting cash prescriptions.
11. For patients under insurance cover or corporate, the pharmacy staff shall give the prescription to the accountant for clearance and proceed as per the work instruction for posting credit and third party prescriptions.
12. For in-patients, the Pharmacy staff shall post the prescription as per work instruction for dispensing on treatment sheets.
13. For dry powder syrups and extemporaneous preparations, the Pharmacy staff shall prepare them as per the work instruction for reconstituting dry powder syrup and work instruction for extemporaneous preparations.
14. Once posted in the system, the Pharmacy staff shall pack the medicines and label them with clear and legible medicine use instructions.
15. The labelled medicines will then be counterchecked against the prescription by either self or another pharmacy staff and if necessary, corrective action taken.
16. A Pharmacy staff shall issue the medicines to the patient or send them to the relevant ward as per work instruction for filling ward box register. And file the prescription as per the work instruction for filling prescriptions.
17. For FP commodities, invoicing should be done upon confirmation of a successful procedure.

2.2. Standard Operating Procedure for Use of Drug Information

Purpose
To ensure Pharmacy staffs are kept informed and updated on latest drug information.

Responsibility
All Pharmacy staff.

Definitions and abbreviations
1. B.N.F – British National Formulary.
2. B.P – British Pharmacopeia.
3. Martindale – Martindale and complete drug reference Edition.

Reference documents
1. B.N.F.
2. Martindale.
3. B.P.
4. Product Literatures.
5. Other Literature.
6. E-Pharmacy.

Procedure
1. On receipt of a request for information from medical professionals or a customer, whoever receives the request shall, decide on the best service of information depending on the scope of information sought e.g. Martindale, BP, Product Literature, and other Literature.
2. For specialized and complicated information, the receiver shall forward the requests to the Pharmacy in-charge who shall give the information to the enquirer or if the information is to be provided later, inform the inquirer and get necessary details including the phone number, email or address so as to forward the information within a reasonable time.

2.3. Standard Operating Procedure for Stocks Management

Purpose

To ensure drugs in good conditions for sale are available in the pharmacy, both physically and in the Electronic Clinic Management Information System (eCMIS)

Scope
Pharmacy department

Responsibility
All Pharmacy staff

Definitions and abbreviations

eCMIS – Electronic Clinic Management Information System
LPO – Local Purchase Order

Short Expiring Drugs – Drugs expiring within six (6) months

Reference documents

1. ECMIS Reorder level report.
2. Work instruction for interdepartmental and other institutions borrowing.
3. Work instruction for buying drugs using petty cash.
4. Work instruction for stock modification and adjustment.
5. Inter-clinic borrowing file.
6. Work instruction for Managing short expiring drugs.

Procedure

1. On assigned main order days, the Pharmacy staff assigned to do orders, shall generate a list of required medicine and order the items running below reorder level from prequalified suppliers.
2. Emergency orders will be made on demand and posted immediately in the eCMIS.
3. Once drugs are received from suppliers, the Pharmacy staff shall countercheck them for expiry dates, correct quantities and correct costing. The staff shall then ensure that the medicines are shelved in their appropriate shelves. Any short expiry drugs supplied shall be handled as per work instruction for managing short expiry drugs.
4. If the medicines are not available with the supplier, the Pharmacy shall borrow them as per the work instruction for inter-Clinic and other institutions borrowing or arrange to buy the medicine from another Pharmacy as per work instruction for buying drugs using petty cash.
5. The Pharmacy staff shall then avail the medicines procured, borrowed or bought on petty cash in the eCMIS and produce the transaction document.

2.4. Standard Operating Procedure for Management of Short Expiry

Purpose

To give guidelines on how to deal with short expiry and expired products

Responsibility

1. All Pharmacy staff.
2. Procurement and store manager.
3. Accountant.

Definitions

Expiry date: the last day of the indicated expiry month except when the specific expiry date has been specified on the pack.

Short expiry – drugs that are six months or less to the expiry date.

Letter of Undertaking – A letter issued by the supplier to the hospital accepting liability to receive back short expiry medicines for a replacement with a long expiry stock or a credit note.

Procedure

1. When issuing drugs to patients, staff must dispense medicine of shorter expiry dates on first-Expiry-first-Out-basis as much as possible and in any case at all times check the expiry dates on the pack before dispensing. Expired medicines must not be dispensed to patients.
2. All items expiring within six (6) months must be returned by the Pharmacy In-charge or designated staff through eCMIS and physical to the supplier.
3. The Pharmacy In-Charge shall contact the suppliers on behalf of the health facility to take back the short expiry stocks. In case the items will not be taken back physically by the supplier, they will be requested to give letter of undertaking in writing that they will take back the items upon expiry or on a specified date.
4. Upon receiving a letter of undertaking by the Pharmacy in-charge, the medicines will be tagged using red circular sticker. The items are then returned to their specific shelves and dispensed as priority (first out) and any unsold balances returned to the store on the agreed date of month.
5. In the event that a short expiry item is required for immediate use or dispensing in a department, and has to be procured from a supplier, a verbal or written confirmation indicating the quantity required shall be issued by the Pharmacy to the suppliers confirming the items will be dispensed immediately.
6. Items expiring in departments: In an event that stocks expire in a department, a list of

expired drugs including the quantity and value shall be prepared and forwarded to the pharmacy incharge, who will then alert the procurement officer and the accountant for further action including seeking approval for expiry disposal.

7. Items with expiry dates of less than 1 year should not be received at the facility. Fast moving items with short expiry of 6 months can be received but should be accompanied by a letter of undertaking from the supplier

2.5. Standard Operating Procedures for Extemporaneous Preparations

Purpose

To provide guidance on predation of specific extemporaneous formulations for individual prescriptions thereby enhancing our effectiveness and specialized service to patients and doctors

Scope

Encompasses all Pharmacy staff and involves all prescriptions from extemporaneous preparations.

Definitions

Extemporaneous Preparations: these are topical or oral preparations made in the pharmacy without necessarily having to be sterilized and are usually prepared by use of pestle, motor, a slab, spatula, bases and the active ingredients. They are mostly creams, ointments, lotions, gel or solutions. The most commonly used preparations are creams and ointments.

Responsibilities

All Pharmacy staff

Procedure

The procedures are varied depending on which preparation is being prepared but generally the following rules shall apply:

i. Clean all equipment and working surface and wipe them dry using clean paper towels soaked in surgical spirit as appropriate or any other suitable disinfectant.
ii. Avail the active ingredients, the vehicle or base in which to suspend the ingredients and all other necessary ingredients.
iii. Proceed to do the preparations following procedures for various preparations in manual for extemporaneous preparations. Label and dispense with necessary patients medicine use instructions.

iv. Clean the working area after completion of exercise.
v. Return all the equipment and materials used to their respective places in an orderly manner.
vi. All safety precautions should be observed and protective gear must be worn as specified in the manual for extemporaneous preparations. This may include using face mask, goggle and gloves as required.

2.6. Standard Operating Instructions for Dispensing DDA Drugs Purpose and scope

To ensure proper dispensing, and prevent misuse of DDA drugs as per Narcotic and psychotropic substances (Control) Act of Chapter 245, laws of Kenya

Responsibility

All Pharmacy staffs
Qualified Ward Nurses

Definitions and abbreviations

DDA drugs – Drugs covered under the Narcotics and Psychotropic substances (Control) Act of Chapter 245, Laws of Kenya.

Pharmacy Staffs – Registered Pharmacist and Enrolled Pharmaceutical Technologists

Reference documents

1. Narcotic and Psychotropic substances (Control) Act of Chapter 245, Laws of Kenya.
2. Prescription
3. Treatment sheet
4. DDA register
5. DDA file

Instructions

1. Receive the prescription or treatment sheet and confirm that it is written clearly and in full; such that all the details about any DDA drug there in are clearly legible and easily understood.
2. Then proceed to post the prescription in eCMIS giving clear usage instructions where necessary.
3. Fill the DDA register with the details on the prescription or treatment sheet and keep a copy of the prescription in the DDA file.

4. Request another pharmacy staff to countercheck the drugs against the prescription and dispense them to the patient (for out-patient) or to a qualified ward nurse (for in-patients).
5. For in-patients dispensing, request the ward nurse to present a filled DDA requisition to Pharmacy form in order to collect the medicines. Consideration will be made to include the DDA black book for in-patient facilities without 24 hours pharmacy services.
6. Attach a copy of the DDA Requisition to Pharmacy Form to a copy of the treatment sheet and file in the DDA file.
7. For DDA ward stock, once issued online from the Pharmacy, countercheck and sign the ward DDA register.
8. Ask the nurse to sign the issue note as well.

2.7. Standard Operating Instructions for Changing Prescriptions over the telephone

Purpose

To facilitate change of prescription instructions by the doctor over the telephone to ensure correct drug treatment and / or substitution.

Scope

i. Drugs out of stock
ii. Inappropriate dosage or formulation.
iii. Possible drug interaction.
iv. Possible drug patient reaction.
v. Illegibility.

Responsibility

All Pharmacy Staff

Definitions and abbreviations

1. Stat Dose – once only dose
2. Formularies – Material of reference used in Pharmacy

Reference documents

1. Prescription
2. Treatment sheet.

Instructions

1. Scrutinize the prescription and on identification of an irregularity, consult colleagues or the shift in-charge for a second opinion.
2. Refer to the formularies for further information.
3. If drug is out of stock, call the supplier to find out about availability of the particular drug with the suppliers.
4. If prescription is illegible, call the ward, in case of inpatient, to find out if the prescription is clear in the doctor's notes or call the prescriber for clarification.
5. If prescribed medicine is not available, check for suitable alternative.
6. Call the prescribing doctor and discuss the prescription concerns.
7. Document the amendments to the prescription or treatment sheet and sign against the amendments or comments.
8. Inform the ward or the patient about the amendment(s).
9. In case the doctor is not available immediately, consult a Senior Pharmacist or alternative consultant and give stat dose of the appropriate alternative while still trying to get in touch with the doctor, if extremely important to initiate therapy.
10. Document interventions taken appropriately and inform the doctor on action taken

2.8. Standard Operating instructions Inter-Departmental, Inter-clinic and other Institutions' Drugs issuing and Borrowing

Purpose

To avail drugs that are out of stock within the Pharmacy and ensure proper record and documentation.

Scope

Borrowed drugs

Responsibility

All Pharmacy staff

Reference document

Stores requisition and issue voucher.

Instructions

1. In case a drug is required for immediate dispensing and it is not in stock in the Pharmacy, the Pharmacy staff will enquire availability of the drug in question from the other Clinic around and if not available from other hospitals.
2. Stocks from other Clinic should be transferred directly and Accepted on eCMIS.

3. Call the driver if you need to send for the drugs from outside hospital.
4. The other FHOK- Clinic will then issue a Transfer Note available in the eCMIS which is dully signed by the one transferring and the one receiving.
5. Receive the drug and confirm that it is in good physical condition and within expiry period.
6. Stocks borrowed from other Hospital should be adjusted in eCMIS as per work instruction for stock modification and adjustment.
7. Upload donated commodities from either Ministry of Health, donors, etc. into the eCMIS
8. Issue outreach commodities and supplies through eCMIS and upload unused stock after outreaches to eCMIS

2.9. Standard Operating Instructions for Pharmacy Stock Modification and Adjustment

Introduction

Stock adjustment will be part and parcel of stock management whose sole objective will be to have a true stock status all times both physically and in eCMIS. Stock variances lead to losses and inefficiencies in service delivery.

Purpose and scope

- To ensure a true stock status all times
- To ensure that all stock are noted as they occur, resolved in time in contrast to having to explain many variances after Monthly Stock taken.

Scope

Positive adjustment
Negative stock adjustment

Responsibility

Senior Pharmacist
Pharmacy manager
Pharmacy staff
Accountant

Definition and abbreviations

Stock adjustment – refers to modification of quantity of stocks in eCMIS to reflect the true stock status physically. This could be negative or positive.

Stock variance – a stock difference between the computer quantity and physical quantity

Negative stock Variances – Physical quantity less than in eCMIS

Positive Stock Variance – Physical quantity more than the computer stock quantity in eCMIS.

GRN – Goods Receive Note (it is used to enter items to the system)

Reference documents

Request for stock adjustment form

Instructions

Positive adjustment

Positive adjustments are done for the following reasons:

1. Stocks not in eCMIS - in case of positive stock variance and no immediate reason can be identified.
2. Manual issue from store – goods supplied manually from store-this occurs when there is a problem with generation of GRN especially for imports resulting to availability of goods on shelf but not in system.
3. Supply after stores working hours – goods received from supplier after working hours when the store staffs have left and goods are required for immediate dispensing.
4. Dummy stocks awaiting supplier delivery to facilitate charging of discharged patients before the bill is closed and outpatients who need to pay.
5. Reversal of positive adjustments.
6. FOC from supplier – goods received free of charge from suppliers, as in case of new products.
7. Borrowed from other hospitals i.e. Inter-hospital borrowing. Specific hospitals must be indicated.

Negative stock adjustment

Negative stock adjustment are done for the following reasons

1. Positive adjustment – to reverse positive adjustment once a valid reason for the variance has been established or stock issues have been regularized.
2. Missing stock – in case of negative stock variance.
3. Debit Notes – to account for drugs charged as backlog entries (supplementary bills) or as drug / pharmacy charges. These options do not normally move/ update stocks online.
4. Stock-take correction – to adjust errors arising from stock take posting errors.

Stock adjustment process

1. Both the main Pharmacy and the bulk store will be actively involved in stock management. This will involve daily random stock counts to confirm a true stock status at all times.

2. In the event a stock variance is noted, thorough investigation will be done to explain the cause of the stock variance and corrective action taken on the anomaly. This will include any uncharged prescription, receiving any pending issues or issuing any pending credit notes. This is expected to sort out any stock variance.
3. In the event that No. 2 above does not sort the stock variance and no reason can be identified despite thorough investigation, the staff concerned will fill the request for stock adjustment form which will be approved and adjusted by the Senior Pharmacist or pharmacy manager in consultation with the MCM and accounts department.
4. Before any stock adjustment can be made, the Pharmacy Manager should notify the MCM and the accountant

5. The senior Pharmacist may nominate some other staff / shift in-charge who can effect positive modifications only especially after hours to ensure smooth flow of dispensing when an item required for dispensing is not in the system.
6. The accountant will regularly run a report of stock adjustments done in the system and follow up for verification with the Senior Pharmacist or Pharmacy manager if need be.
7. A reason for stock adjustment should at all times be indicated in the adjustment form.
8. The Pharmacy manager must make follow up to regularize the stock movement or find and rectify the anomalies leading to stock variance.

Recognition of stock variance at stock-take

1. Stock variance at stock take will be defined as the stock variance at the time of the quarterly stock take, in addition to net amount for the stock adjustments made over the period

Stock variance = stock variance at monthly stock take + positive adjustment-negative adjust per month

2. Moreover, presence of many items with stock variance (whether positive or negative) at stock take will be evidence of poor stock management practice on the part of the concerned managers.

Monthly Pharmacy eCMIS reports to be generated

1. Stock report

2. Variance report
3. Income and expenditure report
4. Corporate clients daily billing report
5. Drug consumption reports
6. Drug profitability reports
7. Interdepartmental transfer
8. Contraceptives reports

These reports should be sent to the Internal Auditor and copied to, Centre Manager, Senior Pharmaceutical Technologist, Clinic Accountant, Internal Auditor and Director Clinical services

2.10. Standard Instructions for Posting Cash Prescriptions

Purpose

To ensure efficient service to patients and capture of revenues of all cash services given

Scope

Posting cash prescriptions

Responsibility

Pharmacy staffs
Accountants

Instructions

1. Receive the prescription and time it.
2. For new patients, register the patient on eCMIS to generate Patient Hospital Number.
3. Post the prescribed drugs as described in the relevant eCMIS and stamp the prescription then sign as appropriate.
4. Bill the prescription and produce a receipt.
5. Pack the drugs and label correctly.
6. Confirm that the quantity is correct on the voucher against the requirements in the prescription and physical drugs packed.
7. Issue the drugs to the patient with usage instructions and further advice, whenever necessary.

2.11. Standard Operating Instructions for Posting Credit of Third Party Prescriptions

Purpose

To ensure efficient customer service and correct coding and capture of revenues of all credit or third party services given

Scope

Posting credit or third party prescriptions

Responsibility

All pharmacy staff and accountants/Cashier/Receptionist

Reference documents

1. Prescription
2. Label
3. Voucher / invoice
4. Patient medical card
5. Company listing.

Instructions

1. Receive the prescription, time it and hand it over to the accountant for financial clearance.
2. For new patients register the patient on eCMIS with help of the receptionist to generate Patient Hospital Number (PHN).
3. For repeat clients write the PHN on the prescription retrieved from eCMIS or patient medical record.
4. The receptionist/ cashier will confirm the company listing or any other source of the validity of the medical / insurance cover of the patient
5. Cashier will confirm availability of all requirements for medical claim such as duly signed claim forms, referral letters, medical card or smart card.
6. Cashier will indicate on the prescription the name of the insurance or company offering the medical cover.
7. Then post the prescription to the pharmacy staff for posting.
8. Save the details in the system and print out the invoice to be attached on the claim form.
9. Fill any requisite forms for medical claims.
10. Pass the prescription to the cashier for payment for co-pay clients or billing if the patient needs to sign Voucher / invoice.

11. Meanwhile pack the drugs and label correctly.
12. This should be counterchecked.
13. Issue the drugs to the patient with usage instructions and further advice, whenever necessary.
14. Place the prescription in the collection box for later billing and filling by cashier.

2.12. Standard Operating Instructions for Dispensing on Treatment Sheet

Purpose

To ensure effective and efficient service to in-patient and to enhance good inter-departmental working relationships between pharmacy and the wards

Scope

Dispensing of medicine prescriptions on treatment sheets

Responsibilities

All Pharmacy staffs, nurses

Definitions

IP – Inpatient – patient admitted in our Hospital

T/Sheet – Treatment sheet

ICU – Intensive Care Unit

Stat Box – a box used to carry treatment sheets with urgent orders

Regular box – a box used to carry treatment sheets with regular (not urgent) orders

Reference documents

1. Ward's List of patients.
2. Patients enquiry menu
3. Treatment sheet
4. Label

Instructions

1. On receipt of a treatment sheet, identify the medicines required to be dispensed.
2. Select from eCMIS the respective ward and correct patient.
3. If the patient's name is not in the said ward's list of patients, use the patient list in the eCMIS to trace them.
4. In case patient is not admitted in eCMIS, liaise with admissions /discharges department to have the patient admitted in the system.
5. The maternity in-charge should ensure that maternity drugs and laboratory orders are immediately posted in the eCMIS once prescribed by clinician/consultant.
6. Retrieve medicines from the shelves and label appropriately. Sign on the Treatment Sheet.
7. Pass on the Treatment Sheet to a colleague for counterchecking.
8. Pack the drugs in a brown bag and attach the Treatment Sheet.
9. Put the drugs and Treatment Sheet in the box, sign out the box by recording time out and send to the ward as per the work instruction for filling ward box register.

2.13. Standard Operating Instructions for Reconstituting Dry Powder Syrups

Purpose and Scope

To ensure that standards of hygiene and safety measures are observed in reconstituting drugs

Responsibilities

All Pharmacy staffs

Definitions and abbreviations

GMP – Good Manufacturing Practices – Practice of ensuring that a product is produced in clean / hygienic state following recommended procedures

Shelf Life – Time within which a drug remain effective on storage

Reconstitution drugs – those that are packed as dry powder, so as to prevent them due to their short shelf life in their reconstituted state

Reference document

Product information leaflet

Instructions

1. Ensure availability of clean drinking water (distilled or cold water from the water dispenser) for use in reconstitution in keeping with good manufacturing practice.
2. Use only clean containers and in a clean working environment.
3. Shake the bottle to loosen the powder.
4. Measure out the required amount of water for reconstitution.
5. Add a small volume of the water and shake well to a uniform consistency.
6. Top up to the required volume, or to the level marked on the bottle.
7. Shake well and ensure that no granules or powder is visible in the bottle.
8. For products with special instructions, follow the instructions for reconstitution on product information leaflet
9. Label and dispense giving instructions on storage where special conditions e.g., refrigeration, are applicable.
10. All drug reconstitution should be done in the FHOK Pharmacy in line with Pharmacy and Poisons Board Cap 204, Sub-Section 14

2.14. Standard Operating Instructions for Filling Ward Box Register

Purpose

To facilitate the smooth flow in dispensing to ward boxes ensuring that the first boxes to Pharmacy are serviced first or according to urgency of medicine administration, and also to collect data for turnaround time

Responsibility

Pharmacy staff and nurses

Definitions

Ward Boxes – boxes used by the wards to carry treatment sheets and medicines to and from Pharmacy

Regular boxes – boxes containing treatment sheets with regular (not urgent) orders; they are painted white or green

Stat boxes – boxes containing treatment sheets with urgent (stat) orders; they are painted red

References documents

1. Ward box register
2. Treatment sheet

Instructions

1. The Nurse collects and delivers ward box from the ward to Pharmacy.
2. The Nurse records the details in the ward box register on arrival to the Pharmacy, indicating the time, whether the box is stat or regular and the ward from where the box came.
3. Open the box giving priority to the most urgent stat boxes (if any) and sign on the ward box register indicating the time when service was commenced.
4. Open the box and dispense to the treatment sheet as per the work instruction for dispensing on treatment sheets.
5. Close the box and dispatch it to the ward indicating in the ward box register the time of closing.

2.15. Standard Operating Instructions for Filing Prescriptions

Purpose

To ensure proper records are kept of all prescriptions dispensed, and facilitate easy retrieval when a prescription is required.

Scope

All prescription dispensed in the Pharmacy

Responsibility

All Pharmacy staff and cashiers

Reference documents

1. Prescription
2. Prescription file

Instructions

1. Confirm that all prescriptions are billed.
2. Separate the prescriptions from the various Pharmacy (outpatient and Inpatient).
3. File in the prescriptions date-wise as per prescription category:-
   a) Cash prescriptions
   b) Third Party prescriptions.
   c) Staff prescriptions.

2.16. Standard Operating Instructions for Handling Broken Items

Purpose

To ensure that all broken items in the pharmacy are properly accounted for and the report used for stock adjustment and other managerial decision-making. It will also ensure proper disposal of broken items

Responsibility

Pharmacy staff
Senior Pharmacist
Accountant
Internal Auditor

Reference documents

1. Accidental breakage book
2. Cytotoxic drug policy

Instructions

Pharmacy staff

1. Collect the broken pieces from the place of accident and place them in the red box marked “Breakages”.
2. Fill in the accidental breakage book and sign, and let someone else countersign.
3. A report on broken items should be prepared by the senior pharmacist before every monthly stock take, forwarded to the accountant and internal auditor and used for stock variance reconciliations.
4. For cytotoxic drugs the form should be filled immediately and authority for incineration sought by the senior pharmacist on the same day as per cytotoxic drug policy.
5. If an in-patient medicine breaks in the ward (not ward stock), receive the broken item along with a copy of the entry in the accidental breakages book from the ward, replace the item and transfer online the items to the specific ward.
6. Confirm that the transfer transaction has been received online by the ward staff.
7. Senior pharmacist to forward the breakages report to management for information and decision making.

2.17. Standard Operating Instructions for Handling Clients' Complaints – Internal and External

Purpose and Scope

To ensure that a standard format is applied across all pharmacies at Family Health Options Kenya when receiving and handling all customer complaints

Responsibility

All Pharmacy staff
Senior Pharmacist

Reference Documents

1. Drug error form
2. Customer complaint Form
3. Customer Complaints register
4. Customer Complaints file

Instructions

1. Receive the complaint and get all details from the complainant.
2. If it is a matter which the person receiving complaint can sort, then do it on the spot.
3. For other complaints, investigate the issue. If beyond your scope inform the in charge, senior pharmacist as the need may require.
4. If consultation is required do so as soon as possible, apologize to client where necessary.
5. Refer accounting errors to the relevant person in pharmacy or in finance to sort out.
6. Record all drug errors on the Drug error form even after sorting out complaints.
7. Forward all complaints to the Senior Pharmacist / Centre Manager for information and decision making whether a customer complaints form needs to be filled.
8. Where applicable, the customer complaint form should be dully filled and forwarded to Centre Manager for information and close out.
9. Register all complaints that need follow-up in the customer complaints register immediately after receipt and file any related documents in the Customer Complaints File under the custody of Medical Centre Manager.
10. Give feedback to the customers either through verbal communication if the customer is in the premises or by telephone if the customer is out of the premises.
11. File any written complaints and corresponding action taken in the Customer Complaints File kept by the Centre Manager.

2.18. Standard Operating Instructions for Handling Drug Spillage

Purpose

To ensure there is a standard way of handling any drugs spillage in all Pharmacies.

Responsibility

All pharmacy staff

Reference documents

Cytotoxic drugs policy

Instructions

1. Close off spill area to traffic.
2. Wear gloves and protective clothing, including face and eye protection if indicated.
3. Contain the spill with paper towels.
4. Flood the spill with an approved hospital disinfectant concentrically beginning at the outer margin of spill area, working towards the center.
5. Push the towels at the edge of the spill into the spill's center. Add more paper towels as needed.
6. Absorb the disinfectant and the spill with the paper towel(s).
7. Discard the paper towels into the red clinical waste bag. If there is broken glass or other sharps involved use a dustpan or a piece of still cardboard to collect the material and deposit it into a puncture-resistant container for disposal.
8. Discard gloves into the clinical waste bag. Cleanse hands thoroughly with soap and water.
9. Call professional services for final clean up where applicable.
10. Report the incident to senior Pharmacist, Centre Manager and Accountant.
11. If the spill is arising from a chemotherapy / cytotoxic agent deal as per the policy of handling cytotoxic and related waste.

2.19. Standard Operating Instructions for Pharmacovigilance

Pharmacovigilance: It is defined as the science and activities concerned with the detection, assessment, understanding and prevention of adverse reactions to medicines (i.e. adverse drug reactions or ADRs). Pharmacovigilance aims at enhancing the safe and rational use of medicines, thereby improving patient care and public health.

Adverse Drug Reaction (ADR): A reaction as a response to a medicine used in humans or animals, which is noxious and unintended, including lack of efficacy, and which occurs at any dosage and can also result from overdose, misuse or abuse of a medicine.

FHOK will implement the Pharmacovigilance monitoring and reporting in line with the national Ministry of Health guidelines which includes but not limited to;

1. All health care workers, including doctors, dentists, pharmacists, nurses and other health professionals should report all suspected adverse reactions to drugs to in-charge of health facility who should in turn notify the relevant authorities.
2. All suspected adverse reactions to allopathic (modern) medicines, traditional / alternative / herbal medicines, x-ray contrast media, medical devices and cosmetics should be reported.
3. All health care facilities should have relevant adverse drug reaction reporting tools.
4. The Senior Pharmaceutical in-charge should in collaboration with facility in-charge should ensure that health care workers in the facility have knowledge and skills to detect, screen and investigate for ADRs and should follow the national investigative, screening, detection, confirmatory, data collection, and reporting procedures for Pharmacovigilance.

Adverse drug reactions that should be reported to the national Pharmacovigilance authorities include;

- All ADRs to newly marketed drugs or new drugs added to the Essential Drugs List
- All serious reactions and interactions.
- ADRs which are not clearly stated in the package insert.
- Unusual or interesting adverse drug reactions.
- All adverse reactions or poisonings to traditional or herbal remedies.

Product Quality Problems that should be reported include;

- Suspected contamination.
- Moulding.
- Colour change.
- Questionable stability.

- Defective components.
- Poor packaging or labelling.
- Counterfeit medicines.
- Therapeutic failures
- Expired medicines.

Preventing ADRs from occurring in patients.

Health care workers should observe the following basic principles on the rational use of drugs to prevent or minimize ADRs among patients in FHOK's facilities;

1. Use few drugs, whenever possible.
2. Use drug that you know well.
3. Do not change therapy from known drugs to unfamiliar one without good reasons.
4. Use text books and other reference material providing information on drug reactions and interactions.
5. Take extra care when prescribing drugs known to exhibit a large variety of interactions and adverse reactions (anticoagulants, hypoglycemic, and drug affecting the CNS) with careful monitoring of patients with such reactions.
6. Beware of the interaction of drugs with certain food stuffs, alcohol and even with house hold chemicals.
7. Review all the drug used by your patients regularly, taking special notice with those bought without prescription (Over the counter, herbal preparations).
8. Be particularly careful when prescribing to children, the elderly, the pregnant and nursing women, the seriously ill and patients with hepatic and renal diseases. Careful ongoing monitoring is also essential in these patients is essential.
9. If patients show signs or symptoms not clearly explained by the course of their illness, think of adverse drug reaction.
10. If you suspect an adverse reaction, consider stopping the drug, or consult, or reduce the dosage as soon possible and notify the facility in-charge.

SECTION THREE:

LABORATORY STANDARD OPERATING PROCEDURES

Refer to the separate laboratory standard operating procedures manual for detailed laboratory procedures. The manual is available in all FHOK-Family Care Medical Centres and Maternities.

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