Revolutionary Government of Zanzibar

Ministry of Health

STANDARD OPERATION PROCEDURES FOR PROVISION OF QUALITY HEALTH CARE SERVICE

Milele Zanzibar Foundation

Kuongeza Maendeleo, Accelerating Progress

Version 1: 2023

Author: Milele Zanzibar Foundation

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List of Acronyms

ADR	–	Adverse Drug Reactions
ANC	–	Ante-Natal Care
APGAR	–	Appearance, Pulse, Grimace, Activity and Respiration
BS	–	Bed Sheet
DPHNO	–	District Public Health Nursing Officer
DS	–	Draw Sheet
FAR	–	Fixed Asset Register
FIFO	–	First In First Out
FP	–	Family Planning
ICU	–	Intensive Care Unit
IPC	–	Infection Prevention and Control
IPD	–	In Patient's Department
MoH	–	Ministry of Health
OPD	–	Out Patient's Department
OT	–	Operating Theatre
PC	–	Pillow Case
PG	–	Patient Gown
PNC	–	Post-Natal Care
PPE	–	Personal Protective Equipment
SOPs	–	Standard Operating Procedures
TAZIHA	–	Treasure, Accord, Zest, Immaculate, Hope, Abundant

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Sincerely;

_____

Dr. Slim Salim

Director for Preventive Services and Health Education

Ministry of Health

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INTRODUCTION

Standard Control

Title: Standard Operating Procedure for Quality Improvement of Health Care Services Using Safe Care Standards			
Author:		**Author Job Title:** Health Program Coordinator	
Directory: Health Coordinator	**Department:** Health Sector	**Team/Specialist:** Quality Improvement Team	
SERVICE ELEMENT 1: GOVERNANCE AND MANAGEMENT			
SOP Version:	**Date Issued:**	**Status:** Working SOP	**Comments /Changes/ Approval:**
Version 1.0	July 2023	**SOP Code No. 1:** Keeps tracking of fixed assets. **SOP Code No. 2:** Health facility organogram.	
SERVICE ELEMENT 2: HUMAN RESOURCE MANAGEMENT			
Version 1.0	July 2023	**SOP Code No. 3:** Staff requirement table. **SOP Code No. 4:** Personal files and credentials.	
SERVICE ELEMENT 3: PATIENT AND FAMILY RIGHTS & ACCESS TO ACCESS TO CARE			
Version 1.0	July 2023	**SOP Code No. 5:** Receiving and dealing with patient complaints. **SOP Code No. 6:** Patient & Family rights. **SOP Code No. 7:** Health care providers job description at the health facility. **SOP Code No. 8:** Client satisfaction tracking tool. **SOP Code No. 9:** Access to care.	
SERVICE ELEMENT 4: MANAGEMENT INFORMATION SYSTEM			
Version 1.0	July 2023	**SOP Code No. 10**: Patient files. **SOP Code No. 11:** Patient record.	
SERVICE ELEMENT 5: RISK MANAGEMENT			
Version 1.0	July 2023	**SOP Code No. 12:** Reagent storage. **SOP Code No. 13:** PPE. **SOP Code No. 14:** Hand hygiene. **SOP Code No. 15:** Waste management and disposal. **SOP Code No. 16:** Laundry use.	

		SOP Code No. 17: Waste transportaion to the incenarator.	
SERVICE ELEMENT 6: PRIMARY HEALTHCARE (OUT PATIENT) SERVICES			
Version 1.0	July 2023	**SOP Code No. 18:** Triaging of patients **SOP Code No. 19:** Operation of autoclave. **SOP Code No. 20:** APGAR Score.	
SERVICE ELEMENT 7: IN-PATIENT CARE			
Version 1.0	July 2023	**SOP Code No. 21:** Patient health records.	
SERVICE ELEMENT 8: SURGERY & ANESTHESIA			
Version 1.0	July 2023	**No Code SOP**: No services.	
SERVICE ELEMENT 9: MEDICAL LABORATORY			
Version 1.0	July 2023	**SOP Code No. 22**: Laboratory services.	
SERVICE ELEMENT 10: DIAGNOSTIC IMAGING SERVICES			
Version 1.0	July 2023	**No Code SOP**: No services.	
SERVICE ELEMENT 11: MEDICATION MANAGEMENT			
Version 1.0	July 2023	**SOP Code No. 23**: Admission of medication. **SOP Code No. 24**: Hazardous/ flammable materials. **SOP Code No. 25:** Drug reaction. **SOP Code No. 26:** Negative incidence monitoring & reporting tool.	
SERVICE ELEMENT 12: FACILITY MANAGEMENT SERVICES			
Version 1.0	July 2023	**SOP Code No. 27:** Inspection procedure for health facility buildings.	
SERVICE ELEMENT 13: SUPPORT SERVICES			
Version 1.0	July 2023	**SOP Code No. 28**: General cleanliness. **SOP Code No. 29:** For Precaution Signals	

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Lead Director:

- Health Coordinator.

Document Class:

- Standard Operating Procedure.

Target Audience:

- All staff involved and working at health facilities.

Consulted with the following stakeholders:

- Health Coordinator Zanzibar Millele Foundation;
- Quality Improvement Officer PharmAccess Tanzania;
- Quality Improvement Officer MoH Zanzibar;
- Zanzibar Quality Improvement Assessors;

• Administrator Milele Zanzibar Foundation; and • Staff members Milele Zanzibar Foundation.
Contact responsible for implementation and monitoring compliance: • District Health Management Team. • Health facility In charge.
Educational/ Training will be provided by: • The Health Program Coordinator Milele Zanzibar Foundation; • Assessors of Quality Improvement of health care services.
Local Archive Reference: • Zanzibar Quality Improvement Guidelines; • Zanzibar Infection Prevention Control Guidelines.
Approval and Review Process: • MoH Quality Improvement Committee.
File Name: • Standards for Quality Improvement of Health Care Services Version 1 July 2023.

Background

1.1. It is the responsibility of staff to provide quality care according to the roles and responsibilities issued by the Ministry of Health and professional bodies. Quality of health care services is contained in the Zanzibar Quality Improvement Guideline for Healthcare Services October 2020.

1.2. When providing health care professional standards must also be adhered.

Purpose

1.3. The Standard Operating Procedure (SOP) has been written to:

- Inform healthcare professionals about safe and appropriate procedures for providing total quality healthcare services to patients.

Scope

1.4. This Standard Operating Procedure (SOP) relates to the following staff groups working at health facilities:

- Registered nurse and midwife;
- Laboratory technicians;
- Pharmaceutical technicians;
- Clinical Officers;
- Student nurses and midwives; and
- Hospital orderlies.

Location

1.5. This Standard Operating Procedure can be implemented in all clinical areas where competent staff are available to undertake this role.

1.6. Staff undertaking this procedure must be able to demonstrate continued competence as per the organisation's policy on assessing and maintaining competence.

Equipment

1.7. Equipment to support the provision of quality health care services are together with the following:
- Zanzibar Quality Improvement Guideline;
- Zanzibar Integrated IPC guidelines;
- Zanzibar Health Quality Strategic Plan;
- Other guidelines such as ANC. PNC, F/P, Immunization, etc.

Procedure for Providing Quality Care

Healthcare services should be provided by registered healthcare providers with recognised licences to practice. The safe care standard was developed to improve the quality and levels of healthcare services. Quality is the degree of excellence whereby healthcare providers must provide according to stipulated standards. These standards are developed and stipulated from 13 services element based on the health care provided at the primary level (dispensary and health care center).

Quality of health care services includes different service elements that are assessed depending on the type and level of the facility (dispensary, health facility, district, regional, national and super-specialist). The following service element and Standards are as follows: -

SERVICE ELEMENT 1: GOVERNANCE AND MANAGEMENT

Standard intent:

The governance structure as well as responsibilities and accountability of the governing body are documented and known to the health facility managers/leaders and employees.

SOP Code No. 1: Keeps Track of Fixed Assets

Standard Intent:

Fixed assets can be defined as assets which are generally used longer than one year, such as a generator, a delivery bed or a microscope. Assets which last less than one year are generally referred to as current assets. These are seen as part of an inventory.

A fixed asset register (FAR) is a way of recording and tracking all the fixed assets that an organization owns. This helps to identify loss of assets through theft or carelessness, provides a place where depreciation can be calculated and details of the insurance can be recorded and can serve as a maintenance planning list.

In health facilities the FAR mainly consists of office furniture and (medical) equipment (as noted above) which are held for the purpose of rendering services.

A fixed asset register must be kept in order to be in compliance with in-country legislation and where applicable, requirements of governing bodies.

As a rule of thumb, the format/details to be provided in a FAR generally depend upon the following factors:

- Basic asset list containing things like, general name, supplier, manufacturer, model/type, procurement date, procurement cost, and location;
- Define if the fixed assets are in a maintenance program, specify cost;
- Extent of owned, and assets taken on lease / hire purchase & insurance details where applicable;
- Identification number/tagging of fixed assets; and
- Status of the asset (working, in repair, replaced, disposed, planned replacement, etc.

Criteria 1.2.7.1: There is a Fixed Asset Register (FAR) which contains the relevant information for all fixed assets in the health facility.

SOP Code No. 2: Health Facility Organogram

Standard Intent:

An organizational document (organogram/chart) should be in place and clearly list/describe the key functions of all staff members, bodies and their responsibilities and

accountabilities. Staff should be aware of the in-house division of tasks. This is NA for health facilities owned and run by a single person

It is important that these structures, responsibilities, and accountabilities are described in a document(s) to be familiar and known to all staff in an organization.

This can be done in an organizational chart or other document that shows lines of authority and accountability. The individual indicated in the chart should be identified by the title/position or name.

SERVICE ELEMENT 2: HUMAN RESOURCE MANAGEMENT

Standard Intent:

There is a plan for the recruitment of health facility staff. There is a (performance) review process for all staff in the health facility. Each staff member's responsibilities are defined in a current job description.

Appropriate and adequate numbers of staff are critical in order to provide quality care. The health facility's leaders define the number and desired education, skills, knowledge and any other requirements to meet the needs of patients. To project staffing needs, health facility leaders use factors such as the following:

- The type of services provided by the health facility;
- The volume of outpatients and inpatients/bed occupancy; and
- Catchment area population and their health needs. Staffing levels (numbers) for professional staff are based on laws and regulations and/or accepted national norms/standards, such as the number of qualified individuals in certain critical care units. Actual staffing levels are used to evaluate the plan in terms of the number and mix of staff.

Criteria 2.1.1.1: There is a staffing plan based on accepted National or international norms.

SOP Code No. 3: Staff Requirement (Table)

Designation	Standards	Available	Needed	Gaps

List of Staffs

Sn	Name	Designation	Phone Number	Email
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				

SOP Code No. 4: Personal Files and Credentials

Standard Intent:

The job description provides details of accountability, responsibility, formal lines of communication, principal duties and entitlements. An individual staff member has his/her responsibilities defined in a job description that is kept up to date. It is a guide for an individual in a specific position within an organization. Job descriptions are the basis for staff assignments, orientation to their work, and evaluation of how well they fulfil job responsibilities. This standard applies to all types of "staff" (for example, full-time, part-time, employed, voluntary, or temporary).

Criteria 2.2.1.1: Each staff member has a written job description which defines their responsibilities.

Criteria 2.2.1.2: Each staff member signs their job description/performance agreement to show that that they accept it.

SERVICE ELEMENT 3: PATIENT AND FAMILY RIGHTS & ACCESS TO ACCESS TO CARE

Standard Intent:

Patients have a right to express complaints (verbally or written) about their care, and to have those complaints reviewed and, where possible, resolved. Also, decisions regarding care sometimes present questions, conflicts or other dilemmas for the health facility and the patient, family or other decision-makers.

These dilemmas may arise around issues of access, treatment and care or discharge. The health facility has established processes and procedures for seeking resolutions to such dilemmas and complaints and informs patients about the process.

The process also identifies who needs to be involved in the process and how the patient and family participate. Patients and families are involved in the process.

Criteria 3.1.6.1: There is a process and procedures to allow complaints to be heard

SOP Code No. 5: Receiving & Dealing with Client Complaints

Patients/clients' complaints and suggestions are grievances or criticism, raised by clients regards how services are delivered at the facility:

- All staff need to understand that complaints and suggestions given by patients/clients are to be received and taken positively for the improvement of services;
- Patients' complaints are to be taken and dealt with confidentially; and
- Investigation will be done in order to prove the complaints raised against the employee once proved.

Guide on Dealing with Patient Complaints

Introduction

Patient complaints and various suggestions submitted on services in most cases are healthy to the improvement of services. It should be remembered that one of the principles for quality improvements is having client-centred service minds. Although the client's desire and complaints need to be examined with care, genuine complaints and constructive suggestions or critics must be taken positively.

Receiving Patient's Complaints

The ways through which a facility receives complaints from patients and clients should be clear and known to service users. This could be through the suggestion box or through a mobile telephone number posted in an area where everybody can see it. It can also be through a facility leader e.g. the hospital secretary, Medical Officer in charge or matron.

These ways through which complaints can be submitted should be open and clients should be encouraged to use them whenever they feel to have something to speak in relation to our services.

The clients should be assured of the confidentiality of their opinions and critics as well as fairness in the process of dealing with complaints.

Dealing with Complaints

- There should be a well-known and transparent process of dealing with patient's complaints;
- A person involved in opening the suggestion box for instance or a group of people involved in discussing and dealing with collected or submitted complaints have to be known;
- There should be a specific file for keeping documentation on actions taken against complaints submitted by patients;
- The actions taken against a certain suggestion or complaint has to be documented;
- Whenever possible feedback should be sent to clients submitting the complaints in case they showed interest in receiving feedback;
- As it may not be easy to trust each complaint submitted when it happens that complaints are directed to specific staff, it is wise for the disciplinary committee or the facility administration to conduct a thorough investigation against the staff in question in order to come up with the truth over the allegation;
- When investigations or follow up are done and the problem identified, corrective measures have to be taken to prevent such a problem from happening I future and also build trust from clients and public;
- There should be a patient complaint file, and all the patient's complaints received and how they were managed have to be documented and records kept into the patient's complaint file.

SOP Code No. 6: Patients and Family Rights

Standard Intent:

Health facility staffs need to know and understand patient and family rights and their health facility's responsibilities as specified in laws, policy, client services charters and regulations. The leaders then provide direction to ensure that the staffs throughout the health facility assume responsibility for protecting these rights.

Criteria 3.1.1.1: The patient and family rights are clearly displayed in the health facility and in line with national and international laws and regulations.

Patient's Rights

1. Right to receive service;
2. Right to privacy;
3. Right to know her/his clinician/nurse;

4. Right to know his/her Diagnosis;
5. Right to listen/hear his/her feelings/expression;
6. Right to receive treatment;
7. Right for information e.g. preventive health education;
8. Right to accept and refuse treatment.

Patients Responsibilities

1. Obey and follow the rules and instructions;
2. Respect the providers and fellow patients;
3. Give information about his/her illness as will be inquired by clinicians.

SOP Code No. 7: Healthcare Providers Job Description at the Health Facility

Services Provided at the Injection Room

1. Receive patients;
2. Injection of patients;
3. Quick assessment;
4. Vital signs monitoring;
5. Health Education.

Services in the Dressing Room

1. Receiving of clients;
2. Quick assessment;
3. Wound irrigation;
4. Incision and drainage;
5. Suture removal;
6. Dressing;
7. Health education for patients.

Functions of Laboratory

1. Health education for clients;
2. Instructions on how to collect specimens;
3. Collection of specimens;
4. Labelling of specimens;
5. Examination of specimens collected under a microscope;
6. Sending lab results to clinicians.

Functions of Pharmacy

1. Health education to clients;
2. Ordering and issuing of drugs;
3. Reception and storage of rugs;
4. Dispensing on drugs;
5. Instruction on drug intake;
6. Provide inputs to the management a drugs related issues.

Functions of OPD Unit

1. Reception of patients(outpatients);

2. Quick assessment of patients;
3. History taking plus an examination of patients (physical and systemic);
4. Ordering of investigations;
5. Prescription of drugs;
6. Health Education.

Functions of Maternity Ward

1. Admission of pregnant mothers;
2. Registration;
3. Examination (physical exam);
4. Monitoring the progress of labour;
5. Postnatal check-up;
6. Assessment of newborn baby;
7. Resuscitations;
8. Family planning information;
9. Weighing of newborn;
10. Dispensing;
11. Health Education;
12. Discharge.

Functions of RCH Unit

1. Registration of under-five and anti-natal mothers;
2. Growth monitoring of under-five (weighing of children and documentation);
3. Pregnancy monitoring;
4. Immunization;
5. Screening and counselling in HIV and STD(voluntary);
6. Family planning(natural).

SOP Code No. 8: Client Satisfaction Tracking Tool (English)

Name of facility ……

Dear Client/Patient, this tool has been developed to allow us to get your view on how you are satisfied with the services you have been given at this facility. You are requested to give information requested asked without fear. The information you provide will be purposely used to improve services at this facility so feel free to respond to the questions asked below

1. Was there staff to pay attention to you within **10 to 15 min** of your arrival
   Yes--……, No……
2. Were the services you received from the clinician satisfactory, Yes---------, No…… If not, what are the reasons
   ……
   ……

……

3. How do you rate the services at the laboratory?
   a) Very satisfactory b) Satisfactory c) Unsatisfactory d) Very satisfactory
4. If Unsatisfactory or very unsatisfactory, what are the reasons……
   ……..……
   ……
5. Does the facility environment satisfy, Yes……, No……..……
6. If no in question no 5 why……..……
7. What would be your last comment regarding improving the quality of services at our facility

   ……
   ……
   ……
   ……..……

SOP Code No. 9: Access to Care

Standard Intent:

Health facilities (primary, secondary and tertiary) frequently serve communities with a diverse population. The patient population may be aged, have disabilities, speak multiple languages or dialects, be culturally diverse, or present other barriers that make the process of entering the health facility and receiving care very confusing or difficult.

The health facility can best serve the needs of the community by providing consistent opening and closing hours, facilitating transportation services, and becoming familiar with potential barriers to accessing care. Thus, the health facility can develop and implement processes to eliminate or reduce these barriers to ensure all patient/clients have access to the health facility and to treatment and care.

Criteria 3.2.1.1: The opening and closing hours of the health facility are displayed and compliant with country regulations.

SERVICE ELEMENT 4: MANAGEMENT INFORMATION SYSTEM

SOP Code No. 10: Patient Files

Standard Intent:

Patient files (including patient-held cards) need to have a unique number in order to retrieve the correct patient file and to track all activities throughout the health facility (e.g. lab tests, medication, diagnostic images, etc.).

When an insurance company requires that the records of all family members are kept together, the information of the individual members needs to be separated, e.g. by adding a letter to the family number.

There must be a system to ensure that each newly handed out number is indeed unique, e.g. a registration book or a database/excel sheet. Check files in the relevant departments (outpatients, inpatients, observation, operating theatre, pharmacy, dispensaries etc.) to see if the unique patient number is consistently used so that every patient-related data entry can always reliably be linked to the patient file.

Criteria 4.2.1.1: Each patient has a health record which has a unique identifier number

SOP Code No. 11: Patient Records

The medical records unit is one of the very sensitive parts of the facility. Patient information has generally to be held under legal and ethical obligations of confidentiality. Information provided in confidence should not be used or disclosed in a form that might identify a patient without his or her consent.

Staff must understand that patients entrust and allow providers to gather sensitive information relating to their health and personal matters as part of seeking treatment. They do so in confidence and they have the legitimate expectation that staff will respect this trust.

Even if a patient is unconscious, this does not diminish the duty of confidence. It is essential if the legal requirements are to be met and the trust of patients to provide a confidential service. To avoid this the following should be observed:

- Patient's records must be kept in a well-secured place to prevent misuse or loss;
- Staff involved in medical records management must be qualified for the job authorised and aware of the legal implications that may arise in case of breach of patients' confidentiality as a result of poor management or misuse of patients' records;
- The medical records room should be locked all the time when out of use and the key kept by the person who is a custodian of the records;

- Ideally no patient should be allowed to carry his or her own file, files have to be carried by a facility staff between departments;
- There should be warning signs, restricting entry to the medical records room for unauthorized persons if applicable;
- On submission of a request for medical information in writing, medical records may be provided to patients. However, the provider may withhold the records if he/she thinks that providing the medical records to the patient may result in effects like the patient harming him/herself or another person;
- In this case the provider can hand the medical records information to third party person or to another provider who can then release the medical records information;
- The patient's records should not be given to anyone unless authorized by the medical/clinical officer in charge through the management or appropriate channel;
- Any event of loss or misuse of patients' medical records has to be documented, and reported to the management, and also documentation of action taken should be kept.

SERVICE ELEMENT 5: RISK MANAGEMENT

Standard Intent:

All test kits and reagents come with storage specifications from the manufacturer. It is essential to ensure these consumables are stored according to recommended specifications to preserve the potency and ultimately the integrity of the result.

Validation of test results is important to ensure favourable patient outcomes. Quality control ensures test results are accurate, reliable and reported in a timely manner. Most test kits come with their specific control kit inside. Internal quality controls should be implemented and a validation/quality control officer should be in charge of minimizing test errors.

Criteria 6.4.4.3: Test kits are correctly stored, are verified, and test results validated using appropriate internal controls, and validation results are recorded.

SOP Code No. 12: Reagent Storage

Reagents Storage at the Laboratory

- All reagents have to be stored according to the producers' instructions;
- Manufacture and expiry dates must be regularly well-checked to avoid using expiry reagents and test kits;
- The FIFO system must be abided by, the near to expire reagents should be used first before the reagents which still have a long time of use before expiry;
- A register should be available to record all the reagents received and expiry dates;
- The register should also be used to monitor the stock of the reagents as they get used;
- Reordering of reagents/test kits should be done at a certain stock level and not to wait until the stock is at its lowest or completely out of stock which might interrupt services;
- It is wise for the Laboratory in charge to give updates on the reagent stock levels to the clinical team during routine clinical meetings;
- Expired reagents should be well documented in specific registers and reported to the clinical officer in charge/medical officer in charge;
- The refrigerator temperature has to be monitored on a daily basis and the temperature recorded on the temperature log.

Infection Prevention and Control

Standard Intent:

Policies and procedures on infection prevention control (IPC) are in place and guide the staff in the implementation. An infection prevention and control program (IPC) is the umbrella name for all the activities that relate to the prevention and control of infections in a healthcare facility.

Within an IPC program several components are required to be addressed to ensure hospital-acquired infection to patients, healthcare workers or visitors are prevented. These components are:

1. Standard precautions (e.g., Hand hygiene, use of PPE, processing instruments and linen, traffic flow, prevention of specific isolated disease- droplets, airborne and contagious disease);
2. Healthcare waste management;
3. Behaviour change and communication with healthcare workers on IPC
4. Injection safety for the prevention of needle/sharp injuries; and
5. IPC logistics and supplies.

This risk management policy has been developed to guide the facility and personnel in understanding, observing and taking appropriate actions on identified key risk areas to prevent or minimize hazardous events and their effects.

The key risk area has to be identified and a strategic plan has to be developed on how to deal with the identified risks.

There will be a risk manager who wills be overall in charge in leading all risk management-related activities.

Heads of units will be responsible for leading efforts in risk mitigation in their respective departments. They will have to work closely with the risk manager to ensure the safety of the overall institution. The overall risk management efforts will have a goal of:

1. Identification of areas of actual or potential risk;
2. Prevent as much as possible, injuries to patients, visitors and employees;
3. Keep all staff aware of existing risks, maintain their knowledge on risk management through regular trainings.

Several areas are identified as of high risk to staff, patients and visitors, thus processes related to execution of these activities have to be well planned and conducted in line with existing institutional and National guidelines. These key areas includes:

1. Hospital wastes management process;
2. Medications management process;
3. Patient management processes;
4. Fire safety;
5. Security;
6. Facility surroundings.

The risk manager will be responsible to assist the departmental heads in determining the risk areas associated with processes mentioned above and re-identification of other additional risk existing in each specific department and develop workable strategies to overcome the risk.

Generally, the risk mitigation activities will involve, ensuring:

1. Infection Prevention and Control measures;
2. Firefighting plans;
3. Building safety and emergency plans;
4. Natural disaster management plans;
5. Investigating patients' complaints and medical malpractice claims;
6. Patients' safety;
7. Sound medication management practices.

SOP Code No. 13: For Personal Protective Equipment

Figure 1: Sequence for Putting on Personal Protective Equipment (PPE)

Figure 2: Sequence for Taking off Personal Protective Equipment (PPE)

Guide for the Use of Personal Protective Equipment

Type of PPE when Used

Gloves (preferably household utility gloves), boots, plastic apron, masks and protective eyewear:

- Handling disinfectant cleaning solutions;
- Cleaning patient care areas;

- Cleaning heavily contaminated areas;
- Handling soiled linen;
- Handling soiled items and instruments;
- Handling or disposing of waste;
- When spills or splashes are expected.

Figure 3: Types of Personal Protective Equipment (PPE)

SOP Code No. 14: For Hand Hygiene

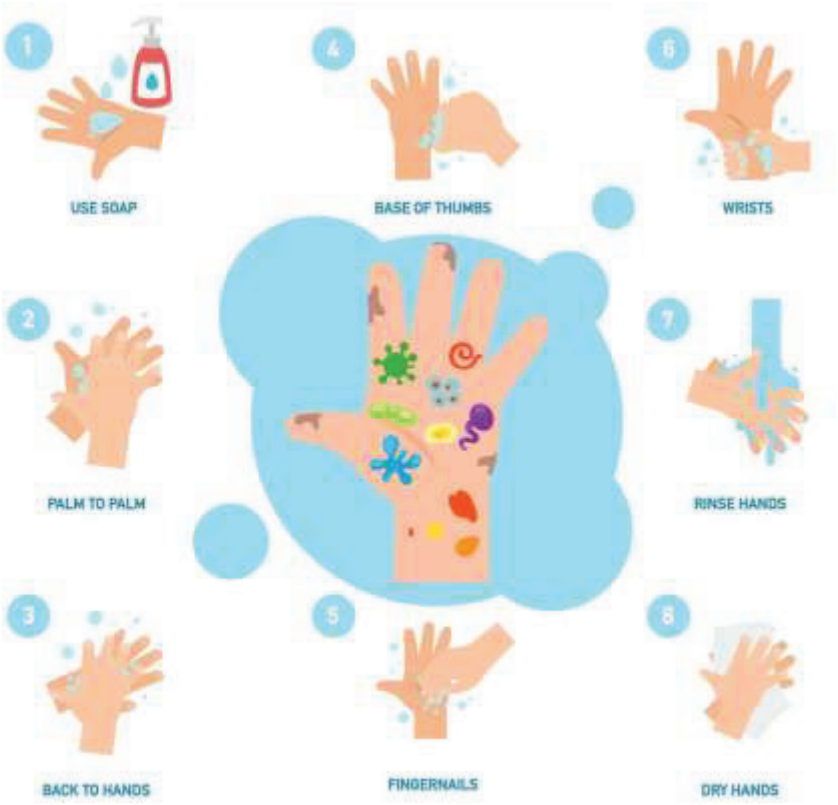


Figure 4: Hand Washing

Guide for Hand Hygiene

Hand hygiene includes care of hands, nails, skin, and the use of lotions and surgical scrubs. Failure to perform appropriate hand hygiene is considered to be a leading cause of nosocomial (hospital-acquired) infections and the spread of multiresistant micro-organisms and has been recognized as a significant contributor to outbreaks of disease (Boyce and Pittet, 2002).

Hand hygiene can be accomplished by:

- Hand washing with or without an antiseptic agent;
- Surgical hand scrub;
- Antiseptic hand rub using a waterless, alcohol-based antiseptic agent.

Types of Hand Hygiene

Routine Hand washing

Hand washing is a process of mechanically removing soil, debris and organisms from the skin using plain soap and water. Four elements are essential for effective hand washing.

- Soap;
- Running water;
- Friction;
- Drying.

When Hand Washing Should Be Done

- Before and after eating, after using the toilet and when soiled;
- Immediately on arrival at work and before leaving work;
- Before and after each patient contact;
- Before and after gloves are removed;
- Before putting on gloves for performing clinical and invasive procedures
- (e.g., insertion of an Intra Uterine Device);
- Before preparing, handling, serving or eating food, and before feeding a patient;
- Before medication preparation;
- Whenever there is a chance of contamination.

Hand washing should also be done after the following:

- Touching blood, body fluids, secretions, excretions, and exudates from wounds;
- Contact with items known or considered likely to be contaminated with blood, body fluids, secretions, or excretions (e.g., bedpans, urinals, wound dressings) whether or not gloves are worn;

- Attending to children's toilet needs;
- After a person's body functions such as using the toilet, wiping or blowing one's nose;
- Hand washing should be done between all procedures done on the same patient where soiling of hands is likely, to avoid cross-contamination of body sites;
- Patients and family members should be educated in proper hand washing.

How to Wash Hands

- Turn on the tap;
- Wet hands thoroughly under running water to at least 4 inches above the wrist;
- Soap hands adequately;
- Hand washing should be done by vigorously rubbing together all surfaces of lathered hands;
- Rub hands vigorously back and front, in between fingers up to and including the wrist, followed by thorough rinsing under running water. This should be for 10-15 seconds;
- Dry hands from the tip of fingers to wrist with a paper towel. If paper towels are not available, shake off excess water and allow hands to air-dry;
- Use the same paper towel to turn off the tap if the tap is not elbow controlled;
- National Infection Prevention and Control Guidelines for Healthcare Services in Tanzania.

Important Notes

- Immediate re-contamination of the hands by touching sink fixtures may be avoided by using a paper towel to turn off taps;
- When running tap water is not available, use a bucket with a tap that can be turned on to wet hands, off to lather hands and turned on again for rinsing;
- Design of the taps/sinks and the right purchase of the taps, e.g., elbow, is desirable;
- If a bucket with a tap is not available, a bucket/basin and pitcher can be used to create a running stream of water. A helper can pour water from the pitcher/jug over the hands being washed;
- Hand washing should not be repeated in the same container of water.
- Hands should be dried with paper towels/sterile towels per procedure.

Hand washing with Antiseptic and Running Water or with Alcohol Hand Rub

Removes transient microorganisms, dirt and kills or inhibits the growth of resident Microorganisms it also may reduce the risk of infections in high-risk situations such as:

- When there is heavy microbial contamination before performing invasive;

- procedures, (e.g., the placement and care of intravascular devices, indwelling urinary catheters);
- Before contact with patients who have immune defects, damage to the integumentary system (e.g., burns, wounds) and percutaneous implanted devices;
- Before and after direct contact with patients who have antimicrobial-resistant organisms.

Alcohol Hand Rub is only one kind of antiseptic hand rub it

- Kills or inhibits the growth of most transient and resident micro-organisms, but does not remove micro-organisms or dirt;
- Can be used when hand washing with soap and running water is not possible, as long as hands are not visibly soiled with dirt, blood, or other organic material.

The use of an antiseptic hand rub is more effective in killing transient and resident flora than hand washing with antimicrobial agents or plain soap and water; it is quick and convenient to perform and gives a greater initial reduction in hand flora (Girou et al., 2002).

Antiseptic hand rubs also contain a small amount of an emollient such as glycerin, propylene glycol or sorbitol that protects and softens skin. The steps for performing antiseptic hand rub include the following: National Infection Prevention and Control Guidelines for Healthcare Services in Tanzania.

Step 1: Apply enough antiseptic hand rub to cover the entire surface of the hands and fingers (about a teaspoonful).

Step 2: Rub the solution vigorously into hands, especially between fingers and under nails, until dry. To be effective, an adequate amount of hand rub solution should be used. For example, by increasing the amount of hand rub from 1 ml to 5 ml per application (about 1 teaspoonful), the effectiveness is increased significantly (Larson, 1988). Since antiseptic hand rubs do not remove soil or organic matter, if hands are visibly soiled or contaminated with blood or body fluids, hand washing with soap and water should be done first.

Antiseptic agents: Liquid soap with or without an antimicrobial agent.

Antiseptic agents recommended are Povidone-iodine 7.5% surgical scrub or Chlorhexidine 5% surgical scrub (undiluted).

Surgical Hand Scrub

Definition: Scrubbing of hands with soap, water, antiseptic and friction. **Note**: The use of a brush is not recommended.

When is it done? Before beginning surgical procedures. Purpose of surgical hand scrub

- To prevent wound contamination by microorganisms from hands and arms of surgeons and assistants;
- To prevent the growth of microorganisms (scrubbing with antiseptic before beginning surgical procedures).

Alcohol-Based Solution for Hand Rub

A non-irritating antiseptic hand rub can be made by adding glycerin, propylene glycol or sorbitol to alcohol (2ml in 100ml of 60-90% ethyl or isopropyl alcohol solution) Use 5ml (about one teaspoonful) for each application and continue rubbing the solution over the hands until they are dry (15-30 seconds). Glycerin is often sold in cosmetic departments because it is used as a hand softener.

Steps of the surgical hand scrub procedure

Step 1: Remove hand/arm-worn jewellery, e.g., rings, watches, bracelets.

Step 2: Wet hands and arms up to the elbow under clean running water, always holding hands with fingers up on a vertical position.

Step 3: Clean nails with a nail cleaner.

Step 4: Apply soap generously.

Step 5: Using a circular motion to avoid abrasions, begin at the fingertips of one hand and lather and wash between the fingers, continuing from fingertips to elbow; continue washing for 3-5 minutes.

Step 6: Wash surfaces between fingers, sides of hands, tips of fingers, palms and dorsum of hands up to the elbow of one arm.

Step 7: Repeat the procedure for the second hand and arm.

Step 8: Rinse each arm separately, fingertips first, holding hands above the level of the elbow.

Step 9: Dry hands in a fingers-up, vertical position with a sterile towel; wipe from

the fingertips to the elbow.

Step 10: Apply 5ml (about one teaspoonful) of a waterless, alcohol-based hand rub to hands fingers and forearms and rub until dry; repeat application and rubbing 2 more times for a total of at least 2 minutes, using a total of about 15 ml (3 teaspoons full) of hand rub.

SOP Code No. 15: Waste Management and Disposal

Criteria 5.3.2.4: The waste disposal and removal according to the waste management plan is monitored.

Waste: Collect waste from all areas at least two times a day (or more frequently as needed). Avoid overflowing.

Waste containers: Disinfectant and clean contaminated waste containers after emptying each time and non-contaminated waste containers when soiled. Use a disinfectant cleaning solution and scrub to remove soil and organic material.

Soiled linen: Collect soiled linen at least two times daily (or more often as needed) in closed leak-proof containers.

SOP Code No. 16: Laundry Use

Figure 5: Hamper

Guide for Laundry Use

Aim

The aim of the Laundry Department is to provide all the hospital departments served, with an adequate supply of clean linen conforming to the highest standards of cleanliness and hygiene immediately and constantly available for routine and emergency use from a central place thus reducing the overall cost and contributing towards the efficient and effective supply of linen to all Hospital Departments.

Objectives

The objectives of the Laundry Department are as follows:

1. To provide linen free of dirt, soil and stains to all User Departments.
2. To monitor and enforce controls necessary to prevent spoilage (wear & tear due to washing) of linen and reduce the frequency of linen turnover by increasing their life period.
3. To maintain a record of the effectiveness of cleaning, disinfecting and turnover.
4. To stay updated regarding developments in the field in the interest of efficiency, economy, accuracy and provision of better patient care.
5. To undertake studies for improvement of clean practices and processing methods to provide supplies economically.
6. To develop a cost-effective program by cost analysis of personnel, supplies and equipment.

Working Principles

1. **Responsibility**
   The first basic principle is that the responsibility of the supervision of routine cleaning, collection and distribution tasks should be clearly defined, clearly understood and undivided.

2. **Unidirectional Workflow**
   There are three categories of dirty linen to be dealt with within the Laundry.

   i. Soiled items that are drenched/soaked with faecal matter, Urine and Blood stains;
   ii. Stained items due to stains from some injections that can be removed only through bleaching and caustic soda;
   iii. Dirty linen with normal dirt and dust.

> **Note:** It is safe to consider all used items as contaminated.

The term clean supply covers all articles, which have been washed, pressed and ready for the User Departments for further processes of sterilization and usage. It is important that a unidirectional flow of activities is followed and all steps should be taken to avoid mixing up of contaminated and clean articles at any stage of processing or transportation.

3. **Contaminated Linen to be Transported Separately from Clean Supplies**
   In accordance with the second principle stated above, never should clean supplies and contaminated articles be carried on the same trolleys at the same time as there is a real risk that the two may get mixed up. Separate rounds one for delivery and another for collection should be insisted upon.

Functions of the Laundry Department

The functional flow of activities in the Laundry shall be specified as follows:

1. **Receipt of Articles**
   To receive used and dirty linen from various user departments like operation theatres, ICUs, emergency, IPD, OPD and radiology etc.

2. **Cleaning & Disinfection**
   All reusable linens are thoroughly cleaned with bleaching powder/ caustic soda and disinfected using disinfectants depending on the type of soil and its compatibility with the linen.

3. **Inspection and Assembly**
   Each item to be washed is inspected for wear & tear, defects, and stains and then appropriately put in the washing machine. After washing, the linen is drained of excess water using a water extractor and dried in a drier before assembling the press in the pressing machine. The operation of the machines shall be entrusted to a responsible and fully trained person. It should be kept in a state of good maintenance and repair.

4. **Clean Storage**
   Clean and contaminated supplies are stored separately. Clean storage environment is designed primarily to prevent contamination of Clean Linen.

5. **Distribution**
   Refers to the distribution of clean goods to the patient care areas. User departments like OT, IPD, OPD, Support, Casualty.

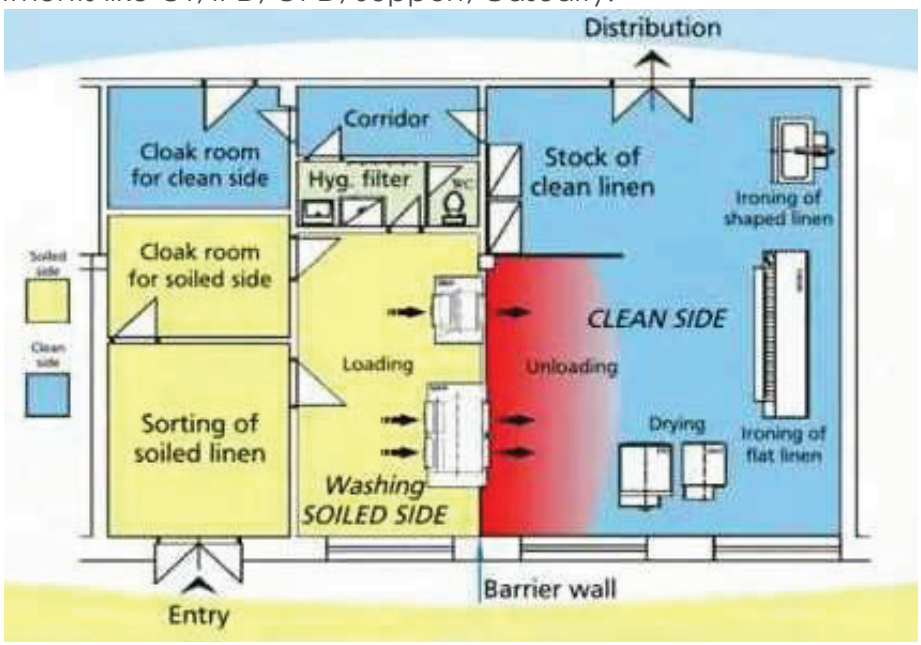


Figure 6: Scheme of Hygienic Barrier Laundry

Layout of Laundry

The layout of the Laundry should be done in such a way that there is a unidirectional flow of materials so that mixing up of the dirty linen and the clean line is avoided:

1. Reception and Sorting Area;
2. Scrub Area for Soiled and Stained Line;
3. Machine Area (for Washing, Water Extracting and Dryers);
4. Sorting Table for torn Clothes;
5. Press Machine;
6. Clean Storage and Tailoring Room;
7. In Laundry, the importance is given mainly to the storage area.

Storage Area

Surfaces:

The walls, ceilings, floors and work surfaces should:

- Not have difficulty to clean corners and crevices;
- Be made of non-porous, smooth, easily cleaned and maintained materials.

Temperature and Humidity:

- Temperature ranges from approximately 22-27 degree;
- A relative humidity range of 35-75%.

Access to Personnel:

Access should be limited to personnel who:

i. Are authorized to be in the area;
ii. Are free of communicable diseases and observe good personnel hygiene;
iii. Are wearing freshly laundered attire provided by the hospital.

Storage System:

- The storage system should be designed as to: Enable items to be stored at least 8 inches from the floor, 2 inches from the outside walls and at least 18 inches from ceiling fixtures;
- Have enough space between storage units.

Receipt of Dirty Linen

- The Linen inventory shall be maintained in the wards itself by the respective;
- Sister Incharges with a copy of it in the Materials Management and Laundry;
- Every morning, the laundry attendant will go to different wards, OT, OPD and collect the dirty linen. It is preferred that the trolley has different chambers for soiled and normal dirty linen. Whenever the attendant collects the linen, it has to be clearly mentioned about the different linen and quantity along with the

signature of the Sister I/C. A separate register has to be maintained in different wards for the same;

- Each linen should have an identity of its own. The proposed identity for the Linen is as follows:
  - Name of health facility.
  - Name or No. of the Ward/ Room: Ortho II or 6.
  - Name of the Material: BS (Bedsheet), PG (Patient Gown), DS (Draw Sheet), PC (Pillow Case), etc,.
  - The number of the Linen.

This system can enhance inventory management and avoid loss of inventory.

Sorting of Linen:

The linen after being collected from the different wards has to be sorted out in the Laundry. The Soiled, stained and normal dirty linen has to be sorted out.

Removal of Soils/ Stains:

It is recommended that 4 gms of bleaching powder for every litre of hot water (20 – 43 C) and dipping the clothes for at least 20 minutes is recommended for the removal of Soils and stains. If necessary, rubbing the stained area should also be done to remove strong stains & soils. The persons handling the soiled/stained linen should use a thick rubber glove that can tolerate Bleach and Luke Warm water.

Washing:

Hot water (20 – 43 C) is recommended for use in washing machines. This can act as a disinfecting agent too. The time of linen in the washing machine depends on different types of linen. Usually, it is recommended for 30 minutes the mode of strong wash.

Water Extractors & Dryers:

The washed linen is put in the water extractors for 3 – 5 minutes (or manually drained of excess water) and then sent to dryers for drying.

Sorting of torn linen for tailoring:

After drying, the linen is checked for wear and tears. The torn clothes should be sent for mending/ tailoring. If the linen is out of the scope of mending, then the condemnation committee should condemn it.

The Condemnation Committee should consist of the following members:

1. Laundry Supervisor;
2. Store Officer;
3. Responsible person from the User Department.

A separate register has to be maintained for the condemnation materials and a record has to be kept for the replaced materials, which can help the facility administration in knowing the linen turnover.

Distribution:

The finished goods are to be stored in a clean storage area before distribution. The clean linen should be checked for quantity before delivery. Then the linen should be distributed to different Departments in a separate trolley which is not used for collection. The receipt vouchers that were used during collection should be checked and signed again by the sister In charge while getting back the clean linen from the Laundry.

Record Keeping:

The following records shall be maintained for all instruments processed:

a) Dispatch record;
b) Receipt record;
c) Storage record.

The following documents should be maintained:

1) Instruction manual for all the equipment;
2) Records of all preventive maintenance, calibration and repairs of equipment;
3) Load Records including contents of each load, initials of the operator, equipment number or other identification and the date and time of the cycle.

Guide for Use Incinerator at Dispensary, Health Centre & Primary Level Hospital

Introduction

Waste produced while providing health services at Dispensaries, Health Centre and Primary level hospitals include:

1. Uncontaminated waste such as papers and materials used for wrapping sterile items packed individually;
2. Contaminated waste such as cotton wool, gauze, disposable specimen containers, catheters, gloves, etc contaminated with or containing body fluids and excreta;
3. Contaminated waste with sharp ends such as used syringes with needles, sutures, lancets, broken glass, used medicine vials, etc;
4. Body parts such as placenta, body parts removed during surgery, expired units of blood;
5. Damaged medicines during transport from the suppliers to facilities (spilled / leaking), and expired medicines and supplies;
6. Waste. Collect and remove all waste from the operating room in a closed leak-proof container.

Brick incinerators built in Dispensaries, Health centres and Primary Level Hospitals may be used for destroying waste types 1, 2 & 3. Body parts must be disposed of in a placenta pit daily. Damaged and expired medicines must be separated from medicines in use and be disposed of according to regulations provided by Zanzibar Drug and Food Authorities. Do not use locally made brick incinerators for destroying expired medicines.

Management of Waste Collection and Incineration at Primary Level Health Facility:

The Primary Level Health facility shall have a Waste Management Committee. The facility in charge shall appoint a person to supervise all activities related to waste collection, treatment and disposal including incineration. Each facility section/unit/department shall have a dedicated person to transport waste to the incinerator. There shall be a dedicated person responsible for operating, cleaning and maintenance of the incinerator.

Waste Segregation:

Sections and departments of Dispensaries, Health centres and Primary Level Hospitals must be provided with the following containers for waste collection and temporary storage prior to disposal:

1. A green / black bucket with a lid and lined with green/black poly bag - for disposal of uncontaminated waste;
2. A yellow bucket with a lid and lined with yellow poly bag - for disposal of contaminated waste;
3. A red bucket with a lid and lined with red poly bag - for disposal of body parts and blood specimens;
4. A sharps container.

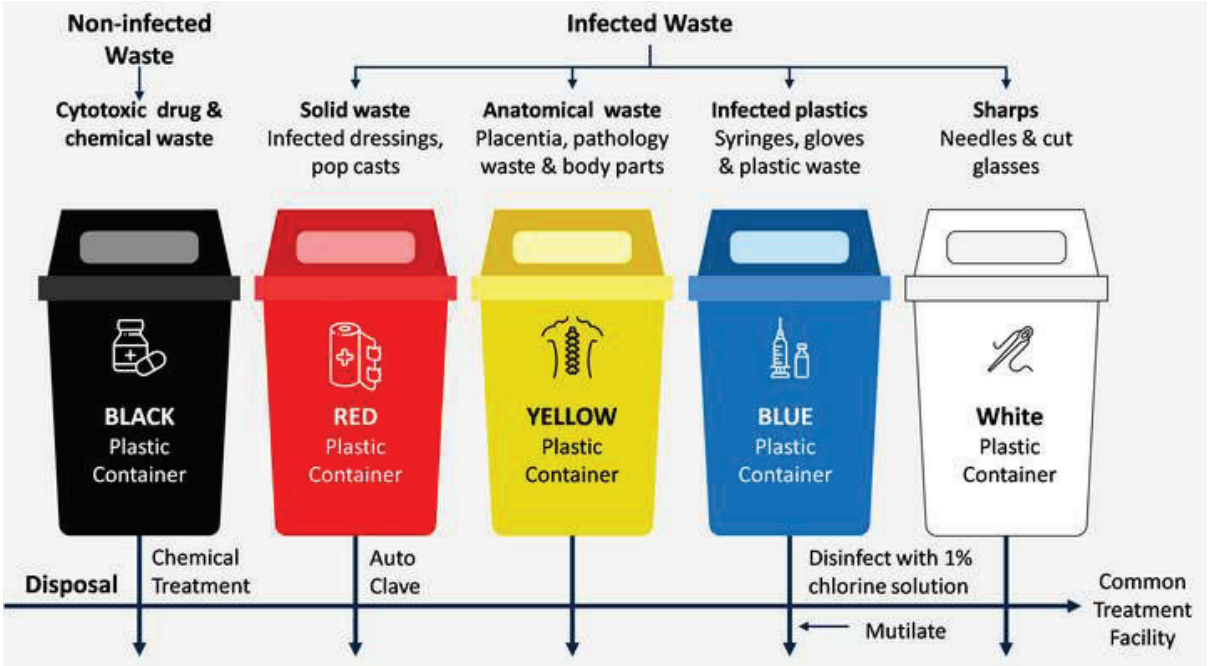
All staff in each section must be trained on waste segregation and use of different colour coded containers for collection of infectious waste.

Figure 7: Waste Segregation

SOP Code No. 17: Waste Transport to the Incinerator

Whenever the buckets and sharps containers are ¾ full, the poly bags must be carefully closed by a tightened knot and taken to the incinerator. Once closed, the poly bags with waste should never be re-opened for sorting.

The designated person from each section / unit / department shall transport the waste to the incinerator. Some (bigger) facilities may have a designated trolley or wheel barrow for transport of waste to the incinerator. Such a trolley or wheel barrow must not be used for any other purpose. Some (bigger) facilities may have a designated place for keeping poly bags with waste prior to incineration.



Black Bin	Red Bin	Yellow Bin	Blue Bin	White Bin
Discarded medicines Cytotoxic drugs wastes, Chemical wastes, Office stationary, Disposable paper, Cups, Tissue paper for domestic purpose, Kitchen waste.	Plastic wastes such as: Contaminated wastes, Plastic bags, Containers Tubings I.V. Injections, Catheter, Syringes, Bottles, Pipes, Microbiology waste, Waste contaminate with blood.	Infectious wastes, Bandages, Gauzes, Cotton, Sharps, Human/ Animal parts, Soiled waste, Expired medicines, Placenta, or any other things in contact with body fluids.	All type of glass bottles and articles, out carded and discarded medicines, Broken glassware, Cytotoxic waste, Metallic body implant, Contaminate d glasses including vials.	Discarded Scalpels, Blades, Needles, Syringes with fixed needle, Sharp metals, Needle tip cutter.

Figure 8: Colour Coded Bins for Waste Management

Incineration

The designated person for operating the incinerator shall regularly incinerate waste from all units / section / departments of the facility, preferably once every two days on Tuesdays, Thursdays and Saturdays. Waste should not be allowed to accumulate at the designated place or allowed to stay in the incinerator for many days prior to incineration.

Steps to incinerate include:

1. Put-on heavy-duty gloves, aprons, nose and mouth mask and other available personal protection gear;
2. Open the incinerator door;
3. Pack the poly bags with waste in the incinerator chamber;
4. Sprinkle some kerosene over the waste;
5. Start off the fire with a safety match;
6. Close the incinerator door and allow the waste to burn with reduced air circulation;
7. Inspect the incinerator to ensure all waste is completely burnt;
8. Remove the ashes and dispose into a deep covered pit;
9. Clean the area surrounding the incinerator;
10. Close the door of the fence surrounding the incinerator to prevent unauthorized access;
11. Decontaminate the heavy-duty gloves, wash and keep for re-use.

Note: Any accident such as accidental pricks, spillage due to improperly closed bin liners (poly-bags), etc occurring during the process of waste collection, transport and during incineration must be reported to the waste management supervisor, waste management committee and / or to the person in charge of the facility for corrective action to be taken.

Incineration Refer to: National Guidelines for Infection Prevention and Control, Ministry of Health Zanzibar, April 2007.

SERVICE ELEMENT 6: PRIMARY HEALTH CARE (OPD) SERVICES

Triage

The triage process identifies patients who need immediate attention and how to fast track them.

The existing process of triaging patients must be able to sort those who need immediate care and those with less pressing issues. It is important that those requiring immediate care are fast tracked and attended too quickly.

For patients experiencing unexpected long delays, an explanation needs to be given to prevent agitations and repeated queries. Clinical staff and front desk officers will benefit from adequate knowledge of an efficient process through available guidelines.

SOP Code No. 18: Triaging of Patients

Designated, qualified staff members are responsible for patient's identification and triage of patients as they enter the health facility.

To ensure patients needing urgent care are always promptly attended to, a designated qualified staff member should be available during every shift to screen patients as they come into the facility.

The process of triage starts with recognizing an emergency and quickly providing care according to the immediate needs.

There is a system in place to record triage findings, waiting time and other information to ensure that patients are seen within acceptable time frame and professional standards.

Capturing data is very essential in improving work processes generally, providing evidence of what has been done and informing the decision-making process. Data on triage findings and waiting times can be captured electronically or using templates for each patient. The triage checklist can be attached to the patient's record.

Criteria 6.4.1.3: The triage process identifies patients who need immediate attention and how to fast track them.

Autoclave

Infection risk is minimized with proper cleaning, disinfection, and sterilization processes.

There should be checklists for cleaning and disinfection of medical equipment (stethoscope, blood pressure cuffs etc.) and surfaces (examination benches, computer keyboards) and guidelines should be available for sterilization of surgical supplies.

Cleaning, disinfection, and sterilization can take place in a sterilization area, which has adequate space to handle and store soiled, clean and sterile equipment/packs

For infection prevention, it is important that infectious waste and contaminated materials (e.g. secretions, soiled linen) are safely handled and discarded. Sufficient equipment should be provided to perform tasks efficiently e.g. PPE, bed pans and urinals, sputum mags, vomiting bowls, humper, trolley, sharp containers and color-coded bags and bins/container should be available and easily accessible to all staff.

Criteria 6.3.3.1: There is (access to) sterilization equipment (autoclave or equivalent) which is functional and sufficient for the workload.
Certificates of inspections by authorized boiler inspectors should be kept by the autoclave owner. The label of inspection should be displayed at a conspicuous location on the autoclave. Only labels approved by an engineer are to be posted.

SOP Code No. 19: Operation of Autoclave

The following must be written clearly on the label: -

a. Records of spore & chemical (temperature) tests shall be kept by the autoclave owner or users.
b. A record book of the autoclave use should also be maintained.
c. Training records:

   i. Autoclave serial number;
   ii. Inspection registration number;
   iii. Date of inspection;
   iv. Date of next inspection;
   v. Name of the authorized boiler inspector.

Guide for the Operation of the Autoclave

Objective

The purpose of this document is to provide guidance on the safe operation of autoclaves in the healthcare facility.

1. Scope - Applicable to the autoclave(s) currently being used in the laboratory and medical departments.
2. Responsibilities
   Administrator- The administrator must comprehend and communicate the contents of the autoclave user manual to all autoclave users. The administrator shall ensure all users receive appropriate training on the hazards and safe use of the autoclave. All safety & health training on the use of the autoclave should be documented.
   Owner - There shall be a designated person [owner] to oversee the use and maintenance of the autoclave. This person shall:

a. Periodically inspect the autoclave to observe if there are any stains, cracks, etc that may affect its operational performance.
b. Arrange for the yearly external safety certification and conduct monthly spore & temperature tests. These certifications shall be captured in a record book.
c. Make necessary arrangements for repair works to the autoclave.
d. Report unsafe practices by autoclave users to the administrator.

User - Autoclave users shall report any injuries, defects, breakdowns or quality control issues to their owner.

Definition

Autoclaves are Mechanical devices using pressurized steam to destroy microorganisms for decontamination of laboratory waste and sterilization of laboratory glassware, media, and reagents.

Procedures – Preparation and loading of materials

a. Use only autoclavable type of materials such as polypropylene, borosilicate (Pyrex) glass or stainless steel.
b. Biological wastes should be autoclaved in biohazard waste bags that are autoclavable.
c. Add autoclave tape to monitor the autoclaving process
d. Ensure materials do not contain materials that are incompatible for use in an autoclave such as solvents and water-sensitive chemicals.
e. Ensure the drain screen is clear of debris to allow proper circulation of steam.
f. Before using the autoclave, check inside the autoclave for any items left by the previous user that could pose a hazard (e.g. sharps).
g. Liquid containers should be filled to about half of their contents
h. All container caps must be loosened or containers must have vents for release of pressure.
i. Always put biological waste bags onto secondary container pans or trays to catch spills.
j. Position biohazard bags on their sides, with the bag neck taped loosely.
k. Ensure there is adequate space between items to allow for steam circulation.

Time selection

a. Take into account the size of the articles to be autoclaved. A 2-litre flask containing 1 litre of liquid takes longer to sterilize than four 500 ml flasks each containing 250 ml of liquid.
b. Material with a high insulating capacity (animal bedding, high-sided polyethylene containers) increases the time needed for the load to reach sterilizing temperatures.
c. Bags of biological waste should be autoclaved for a minimum of 30 minutes to ensure decontamination. Materials with high organic load would require longer sterilization time.
d. Please refer to the user's manual for the time selection. The minimum time for autoclaving cycle should at least be 15 minutes at 121°C.

Removing the load

a. The autoclave chamber is a pressure vessel. Never attempt to open the door while the machine is operating.
b. Check that the chamber pressure is zero (refer to the pressure gauge).
c. Wear a lab coat, eye protection, heat-insulating gloves and covered-toe shoes.
d. After the slow exhaust cycle, open the autoclave door.
e. Stand behind the door when opening it.
f. Slowly open the door slightly. Beware of the rush of steam. If you feel any resistance, do not force open the door.
g. Allow liquids to cool down to ambient conditions before handling them.
h. For tower-style autoclaves, be extra cautious as load removal may require either standing on a step ladder or bending down to reach the autoclave.

Monitoring & control

Autoclaves used to decontaminate laboratory waste should be tested periodically to assure effectiveness. The following tests are to be used:

- a chemical indicator that fuses when the temperature reaches 121°C, and
- heat-resistant spores (*Bacillus stearothermophilis*) that are killed by exposure to 121°C for approximately 15 minutes.
- Both types of tests should be placed well down in the centre of the bag or container of waste, at the point slowest to heat.
- Chemical indicators should at least be added in one bag per load and the spore test should be done at least once a month.
- If either one of these tests fails, immediately contact the PI, maintenance staff and re-autoclave the waste.

Safety certification of autoclaves

a. Autoclaves must be subjected to safety (mechanical) inspections by Biomedical engineering (inspectors). The frequency of certification, whether yearly or bi-yearly will depend on the capacity of the autoclave.
b. A current certificate bearing the autoclave number must be displayed with last and the next inspection date.

Other considerations: protection from health and first aid

a. Some older autoclaves have little or no heat shielding around the outside. Attach signs warning "Hot Surfaces, Keep Away" on or next to the autoclave to remind people of the hazard;
b. Do not stack or store combustible materials (cardboard, plastic, volatile or flammable liquids) next to an autoclave;
c. If you receive a minor burn, do the following:
    i. Immerse the burn in cool running water immediately. (Do not wait for ice.);
    ii. Remove clothing from the burn area;
    iii. Keep the injured area in cool water for at least 5 minutes (longer is better);

iv. Report the incident to your supervisor and seek professional medical treatment as needed.

SOP Code No. 20: APGAR Score

Standard Intent:

As many as 10% of all newborn infants need some intervention at birth. Although certain episodes of fetal asphyxia cannot be prevented, prompt and skilled resuscitation may prevent lifelong adverse conditions. Adequate neonatal equipment should be readily available and staff needs to be trained in assessing neonates, recording and interpreting Apgar ratings and providing resuscitation.

The Apgar score must be recorded (and signed) for each newborn baby and staff can explain the score. A general APGAR score when provided correctly provides a quick evaluation of a newborn's condition at birth and of the need for immediate attention.

The scores should be done for every newborn at 1st and 5th minute of life. The scores should be recorded in appropriate forms, cards and registers according to country requirements. Staff should be able to explain how the scores are provided.

Criteria 6.6.5.4: Apgar-rating is recorded (and signed) for each newborn baby and staff can explain the score.

Apgar Scoring			
Apgar Sign	**2**	**1**	**0**
Heart Rate (pulse)	Normal (above 100 beats per minute)	Below 100 beats per minute	Absent (no pulse)
Breathing (rate and effort)	Normal rate and effort, good cry	Slow or irregular breathing, weak cry	Absent (no breathing)
Grimace (responsiveness or "reflex irritability")	Pulls away, sneezes, coughs, or cries with stimulation	Facial movement only (grimace) with stimulation	Absent (no response to stimulation)
Activity (muscle tone)	Active, spontaneous movement	Arms and legs flexed with little movement	No movement, "floppy" tone
Appearance (skin coloration)	Normal color all over (hands and feet are pink)	Normal color (but hands and feet are bluish)	Bluish-grey or pale all over

Figure 9: APGAR Score Components

SOP Code No. 21: Patient Health Records

Standard Intent:

Every patient assessed and/or treated in the health facility as an out-patient, emergency care patient or in-patient has a clinical record, whether it is an inpatient file or an outpatient carry card held by the patient. The record is assigned an identifier unique to the patient, or some other mechanism is used to link the patient with his or her clinical record.

Criteria 4.2.1.1: Each patient has a health record which has a unique number and contains demographic information.

SERVICE ELEMENT 8: SURGERY AND ANAETHESIA

(NO SURGERY SERVICES TAKING PLACE AT PRIMARY HEALTH FACILITIES)

No SOP Code: No Surgical Services

SERVICE ELEMENT 9: MEDICAL LABORATORY SERVICES

Standard Intent:

The laboratory staff needs to have the proper qualifications to perform the duties for which he or she is hired. The qualifications are dependent on the activities that are performed.

Specific regulations apply with regard to qualifications/training needed for performing laboratory services and for supervising lower-qualified laboratory staff. The laboratory is managed by a qualified medical laboratory practitioner. Specimens need to be appropriately processed and kept before the specimens are tested.

SOP Code No. 22: Laboratory Services

An SOP should be in place that describes how specimens have to be processed and stored. Important aspects of these procedures are: -

- Which materials (vacutainers, urine containers, etcetera) to use;
- How to process and safely separate different types of specimens (whole blood, DBS, serum, plasma, urine, stool, sputum, slides, etc.);
- The time required to process materials collection;
- The requirements for storage (e.g. temperature) for different types of specimens; and
- The timelines at when the specimens should be tested. In addition, required materials for separation and storage should be in place in line with the SOP.

SERVICE ELEMENT 10: IMAGING SERVICES

(NO IMAGING SERVICES TAKING PLACE AT PRIMARY HEALTH FACILITIES)

No SOP Code: No Imaging Services

SOP Code No. 23: Administration of Medication

Standard Intent When medicines are administered within a healthcare facility, it is important that the staff monitors this process closely in order to ensure that the medicine is having a positive effect and not causing any allergic or adverse drug reactions.

If the medication dosage needs adjustment, or if multiple medications are causing a drug interaction, these must be documented in a timely manner.

Drugs dispensed are clearly labelled with the name of the medication, dose, name of the patient, date and instruction for use. General Dispensed drugs should be labelled according to national regulations and clear instructions for use should be provided to the patients at the dispensing booth. The next information should at least be available:

- Patient details (name, DOB);
- The proprietary name/approved name or name of each active ingredient;
- Formulation type;
- Route of administration;
- Expiry date;
- Date of issue;
- Amount dispensed;
- Clear instructions for use;
- Storage instructions Relevant warnings of frequent side effects (if applicable).

Documentation of adverse drug reactions and medication errors protects patients and also identifies opportunities to make medication management safer for all patients in the healthcare facility.

Record adverse drug reactions (ADR) is a proactive quality improvement approach to assure the safety of medicines and reduce further risk of adverse reactions of a particular medicine. Country legislation will apply. The healthcare facility must have an internal policy/SOP in place that guide the staff in completing this report

Criteria 11.5.1.2: Adverse drug reactions are recorded and reported in accordance to healthcare facility policy.

SOP Code No. 24: Hazardous/Flammable Materials

Standard Intent:

Hazardous and flammable solutions and chemicals can be recognized by a hazard sign on the packages or bottles. They can be flammable, corrosive, irritant and toxic. The Globally Harmonized System of Classification and Labelling of Chemicals (GHS) is

an internationally agreed-upon system, created by the United Nations with information of communicating hazards i.e. labelling. For facilities that stock these materials, the appropriate labels should be displayed and cautionary signs displayed at their storage areas.

The healthcare facility needs to ensure that:

- Controlled substances are accurately accounted for according to applicable laws and regulations;
- Medications and chemicals used to prepare medications are accurately labelled with contents, expirations dates, and warnings;
- Expirations dates are regularly checked;
- Hazardous and flammable materials are stored in dedicated and clearly labelled storage areas according to specifications;
- Expiry dates need to be checked;
- When there is a digital system in place this check can be performed by the IT system because all the dates of expiry are entered in the system;
- When there is a manual bin card system this should preferably be performed daily or weekly;
- Administration records of this process should be kept accordingly.

Criteria 11.3.2.3: Hazardous and flammable materials are clearly labelled and stored appropriately.

SOP Code No. 25: Drug Reaction

Standard Intent:

When medicines are administered within a healthcare facility, it is important that the staff monitors this process closely in order to ensure that the medicine is having a positive effect and not causing any allergic or adverse drug reactions. If the medication dosage needs adjustment, or if multiple medications are causing a drug-interaction, these must be documented in a timely manner.

Documentation of adverse drug reactions and medication errors protects patients and also identify opportunities to make medication management safer for all patients in the healthcare facility.

Criteria 11.5.1.1: Staff is guided in recording and reporting of medication errors or adverse drug reactions.

SOP Code No. 26: Negative Incidence Monitoring & Reporting Tool

Facility Name ……

Who was involved (Name)		
Department		
What happened		
When (Date)	Time:	
What was the immediate cause		
What was the indirect cause		
Training, instructions, caution were given before the incidents		
How can similar incident be prevented in future		
Recommendation for future action		
By who	Date	Time
Injured worker		
Person in charge		
Supervisor name		
Signature		

SERVICE ELEMENT 12: FACILITY MANAGEMENT

SOP Code No. 27: Inspection Procedure for Health Facility Buildings

Standard Intent:

Buildings, grounds plants and machinery are designed and laid out as appropriate for their use as a health facility. Attention is given to adequate ventilation and temperature control to ensure safe service provision.

The buildings and utility systems (electrical, water, sewage systems, incinerators and other utility systems) are maintained and do not pose hazards to the occupants. The construction of the building in terms of walls, ceilings, floors, doors and windows must be completed.

The general appearance is neat, and painted, without signs of leakage, no visible cracks, no mould spots, etc. It is ideal when the whole health facility is protected against the entry of animals, insects and bugs and for the prevention of the spread of infection.

The highest priority units are the wards, some departments (e.g. ICU) and the unit where food is prepared.

Criteria 12.1.1.1: The building is appropriate as a health facility in terms of size, lay-out, and accessibility.

SOP Code No. 28: General Cleanliness

Standard Intent:

Within the healthcare facility a considerable amount of waste is produced every day. A large portion of that waste is considered to be infectious. Proper disposal of waste reduces the risk of infection throughout the healthcare facility. An implemented system for segregating, collecting, secure storing and transporting waste is essential. Specific points of attention for waste disposal are:

- The development and implementation of clear instructions (SOPs) for the safe segregation, collection, transportation and disposal of (infectious) waste;
- The use of a colour coding system in order to specify specific waste categories;
- The establishment of collection areas for waste before external removal or incineration;
- A system that ensures that waste is collected at the different (clinical) units appropriately. The frequency of collection of waste is dependent on the size, the utilization and the services provided. The frequency should be performed on a daily or weekly basis. The frequency should be clearly defined and documented.

Criteria 13.3.1.1: Cleaning staff is aware of general hygiene, infection control, and safety precautions.

Criteria 13.3.3.1: The healthcare facility has, and has implemented, standard operating procedures for the safe segregation, collection and transportation of all types of waste.

Criteria: 13.3.2.1: Mops and brooms are cleaned and dried before being stored.

Guide for General Cleanliness and Housekeeping

Housekeeping

Housekeeping refers to the general cleaning of a health facility, including the floors, walls, and certain types of equipment, furniture and other surfaces. Cleaning entails the removal of dust, soil and microbial contaminants on environmental surfaces as per schedules, therefore it is necessary to maintain a clean and healthy environment in healthcare settings.

The purposes of general housekeeping are to:

- Reduce the number of microorganisms that may come in contact with patients, visitors, staff and the community;

- Provide a clean and pleasant atmosphere for patients and staff;
- In high-risk areas where heavy contamination is expected, such as toilets and latrines, or for blood or body fluid spills, a disinfectant such as ***0.5% chlorine*** or ***1% phenol*** should be added to the cleaning solution;
- Using a disinfectant in addition to soap and water is also recommended in other high-risk areas such as operating rooms, pre-and postoperative recovery areas and intensive care units (ICUs);
- If the purpose of housekeeping as stated above is to be achieved, it is important that housekeeping staff be trained to perform their assigned tasks and are supervised on a regular basis. As part of their training, it is important that housekeeping staff understand the risk of exposure to contaminated items and surfaces when performing environmental cleaning procedures and follow recommended policies and guidelines, including the use of appropriate personal protective equipment.

Definitions

Cleaning solution: Any combination of soap (or detergent) and water, with or without a chemical disinfectant, used to wash or wipe down environmental surfaces such as floors chairs, benches, walls and ceilings.

Disinfectants: Chemicals that destroy or inactivate microorganisms. Disinfectants are classified as low, intermediate or high level depending on their ability to kill or immobilize some (low- or intermediate-level) or all (high-level) microorganisms (but not all spores).

Phenols, chlorine or chlorine-containing compounds are classes of disinfectants frequently used to clean non-critical surfaces such as floors, walls and furniture.

Disinfectant cleaning solutions are; products that are a combination of a detergent (soap) and a chemical disinfectant.

Environmental controls are standards specifying procedures to be followed for the routine care, cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces.

Sanitizers include chemicals that reduce the number of bacterial contaminants to safe levels on inanimate (non-living) objects based on public health requirements (i.e. a chemical that kills 99.999% of the specific test bacteria in 30 seconds under the conditions of the test).

Soaps and detergents (terms used interchangeably).

These are cleaning products (bar, liquid, leaflet or powder) that lower surface tension, thereby helping remove dirt, debris and transient microorganisms from hands. Plain

soaps require friction (scrubbing) to mechanically remove microorganisms; antiseptic (antimicrobial) soaps kill or inhibit the growth of most microorganisms.

Scrubbing (frictional cleaning) is the best way to physically remove dirt, debris and microorganisms

Cleaning is required prior to any disinfection process because dirt, debris and other materials can decrease the effectiveness of many chemical disinfectants.

Cleaning products should be selected on the basis of their use, efficacy, safety and cost.

Cleaning should always progress from the least soiled areas to the most soiled areas and from high to low areas so that the dirtiest areas and debris that falls on the floor will be cleaned up last.

Dry sweeping, mopping and dusting

This should be avoided to prevent dust, debris and microorganisms from getting into the air and landing on clean surfaces, airborne fungal spores are especially important as they can cause fatal infections in immunosuppressed patients.

Mixing (dilution) instructions should be followed when using disinfectants. (Too much or too little water may reduce the effectiveness of disinfectants).

Cleaning methods and written cleaning schedules should be based on the type of surface, amount and type of soil present and the purpose of the area.

Routine cleaning is necessary to maintain a standard of cleanliness. Schedules and procedures should be consistent and posted.

How to Select Cleaning Product?

Different types of cleaning products are available: liquid soap and detergents, disinfectant combinations (detergent and disinfectant) and sanitizers. Each type has different properties. An ideal cleaning product should accomplish the following:

- Suspension of fats (suspend fats in water);
- specification of fats (make fats water-soluble);
- Surfaction (decrease the surface tension of water and allow greater penetration of the agent into the dirt or soiled. Dispersion (break up of soil into small particles;
- Protein destruction (break up protein;)
- Softening the water (removal of calcium and magnesium).

Cleaning Methods

Cleaning should start with the least soiled area and move to the most soiled area and from high to low surfaces. Common methods of cleaning are briefly described below. Wet mopping is the most common and preferred method to clean floors.

Single-bucket (basin) technique: One bucket of cleaning solution is used. The solution must be changed when dirty. (The killing power of the cleaning product decreases with the increased load of soil an organic material present).

Double-bucket technique: Two different buckets are used, one containing a cleaning solution and the other containing solution. The double-bucket technique extends the life of the cleaning solution (fewer changes are required), saving both labor and material costs.

Triple-bucket technique: The third bucket is used for wringing out the mop before rinsing, which extends the life of the rising water.

Flooding followed by wet vacuuming is recommended in the surgical suite, if possible. This process eliminates mopping, thus minimizing the spread of microorganisms, and increases the contract time of disinfectants with the surface to be cleaned. But it is necessary to leave the floor wet for several minutes. (Flooding is best done at night or at times when foot traffic is minimal).

Dusting is most commonly used for cleaning walls, ceilings, doors, windows, furniture and other environmental surfaces. Clean cloth or mops are wetted with a cleaning solution contained in a basin or bucket. The double-bucket system minimizes the contamination of the cleaning solution.

Dry dusting should be avoided, and dust cloths and mops should never be shaken to avoid the spread of microorganisms. Dusting should be performed in a systematic way, using a starting point as a reference to ensure that all surfaces have been reached.

> **Note:** When doing high dusting (ceiling tiles and walls), check for stains that may indicate possible leaks. (Leaks should be repaired as soon as possible because moist ceiling tiles provide a reservoir for fungal growth).

Schedule and Procedures for Specific Areas

- Cleaning schedules should be planned, written and closely followed.
- Cleaning schedules should be developed according to the needs of each area.

Walls, windows, ceilings and doors, including door handles: - In general, routine damp dusting is adequate for these areas (disinfection is unnecessary). These surfaces are rarely heavily contaminated with microorganisms, as long the surfaces remain dry and intact.

Chairs, lamps, tables, tabletops, beds, handrails, grab, lights, tops of doors and

counters: Wipe daily and whenever visibly soiled with a damp cloth, containing disinfectant cleaning solution.

Non-critical equipment (e.g. stethoscopes and blood pressure cuffs): Wipe daily and whenever visibly soiled use a damp cloth, detergent and water. If the equipment is visibly soiled with blood or other body fluids, it should be cleaned and disinfected before it is reused.

Floors: Clean floors at least three times daily and as needed with a wet mop, detergent and water. A disinfectant should be used within contamination is present; such as blood and fluid spills.

Sinks: Scrub frequently (daily or more often as needed) with a cloth or brush and a disinfectant cleaning solution. Rinse with water.

Toilets and latrines: scrub frequently at least three times daily and as needed with a separate mop, cloth or brush and a disinfectant cleaning solution (HARPIC).

Patient rooms: Clean at least three times daily and after patient discharge. The same cleaning process applies to the rooms of patients who are under isolation precautions. Any cleaning equipment used in the rooms of patients under isolation precautions should be cleaned and disinfected before being used in another room.

Procedure rooms: Wipe horizontal surfaces, equipment and furniture used for procedures with a disinfectant cleaning solution after each procedure; whenever visibly soiled decontaminate before cleaning.

Examination rooms: Wipe horizontal surfaces with a disinfectant cleaning solution after each procedure and whenever visibly soiled. The linen or paper on the examination table should be changed after each patient. Decontaminate before cleaning blood or other body fluid spills.

Laboratory: Wipe countertops with a disinfectant cleaning solution after each shift: whenever visibly soiled decontaminate before cleaning.

Curtains: Change and clean curtains weekly and when soiled.

Schedule and Procedures for the Operating Room

At the beginning of each day, all flat (horizontal) surfaces (table, chairs, etc) should be wiped with a clean, lint-free moist cloth to remove dust and lint that may have collected overnight.

- Total cleaning is not necessary between each case for surgical procedures.
- Total cleaning or terminal cleaning (mopping floors and scrubbing all surfaces from top to bottom) of the operating room should be done at the end of each day.

Total Cleaning

***Step 1*:** Move covered decontamination buckets to the central supply or processing room. A clean bucket containing fresh 0.5% chlorine solution, or other locally available and approved disinfectant, should be provided at the beginning of each day and after each case.

Step 2: Remove the covered contaminated waste container and replace it with a clean container. Arrange for burning (incineration) or burial as soon as possible.

Step 3: Close and remove sharps containers when three-quarters full.

Step 4: Remove soiled linen in closed leak-proof containers.

Step 5: Soak a cloth in disinfectant cleaning solution and wipe down all surfaces, including counters, tabletops, sinks, lights etc. wash from top to bottom, so that any debris that falls on the floor will be cleaned up last.

Walls and ceilings: Wipe with a damp cloth, detergent and water as needed for visible soil.

Chairs, lamps, sinks, tabletops and counters: Wipe with a damp cloth and disinfectant cleaning solution.

Operating room lamp: Wipe with a damp cloth and disinfectant cleaning solution

Operating room table: Wipe with 0.5% chlorine solution (or other approved disinfectant) to decontaminate. Then clean top, sides, base legs and any accessories (e.g. leg stirrups) with a damp cloth and disinfectant cleaning solution.

Floors: Clean with a wet mop using a disinfectant cleaning solution.

Vents: (heating or air conditioning). Wipe with a damp cloth, soap and water.

Between each patient, do the following:

Spills: Clean spills with 0.5% solution or other locally available and approved disinfectant.

Operating room bed: Wipe all surfaces and mattress pads with a disinfectant cleaning solution.

Instrument tables (trolley and Mayo stand) and other flat surfaces: Wipe all flat surfaces that have come in immediate contact with a patient or body fluids with a disinfectant cleaning solution.

Centre of operating room surrounding the operating room bed: Mop with a disinfectant cleaning solution (if visibly soiled)

Sharps containers. Close and remove containers from the operating room when they are three-quarters full.

Cleaning Outside the Facility Buildings

- The facility surrounds should be cleaned on a daily basis;
- Slashing of glasses in surrounding grounds should also be observed as needed.

The followings are Standards Operating Procedures and guidelines for the proper provision of quality healthcare services – These standards either need to be displayed or documented as a guide and must be known and understood by healthcare providers providing the services.

SOP Code No. 29: For Precaution Signals

Figure 10: Precaution Signs

SWAHILI VERSION SOPS

SOP Code No. 1: Ufuatiliaji wa Mali za Kudumu

- Kituo kitakuwa na nakala ya vifaa iliyoorodhesha vifaa vyote katika kituo vilivyopo na vinavyofanya kazi (INVENTORY).
- Nakala ya orodha ya vifaa katika kila kituo iwe kwa mkuu wa Kituo kwenye file lakini pia kila idara iwe na orodha ya vifaa vilivyopo.
- Uharibufu wowote endapo utatokea basi uripotiwe kwa mkuu wa kituo haraka iwezekanavyo ili hatua zichukuliwe.
- Hatua zilizochukuliwa kurekebisha kifaa kilichoharibika ziandikwe mahali na kumbukumbu kutunzwa na mkuu wa kituo.

SOP Code No. 5: Utumiaji wa Sanduku la Maoni

Ndugu mteja, unakaribishwa kwa kutoa maoni yako kwenye karatasi na kutumbikiza katika sanduku la maoni lililoko hapo chini.

- Maoni yako kuhusu huduma zetu ni muhimu sana katika uboreshaji wa huduma tunazotoa.
- Maoni utakayotoa yatachukuliwa kama siri na si lazima uandike jina lako.
- Hata hivyo kama utahitaji mrejesho kwa maoni yako, waweza kuandika namba yako ya simu kwenye karatasi ya maoni.
- Funguo za sanduku la maoni hutunzwa na wafanya kazi wakituo zaid ya wawili na sanduku hili hufunguliwa mara moja kwa Mwezi.
- Maoni au taarifa zozote zilizotolewa na wateja hufuatiriwa na kutolewa maamuzi kwa haki na uwazi.
- Maelekezo ya peni na karatasi ya kuandikia wapi zinapatikana.
- Majina ya wafanyakazi wanao shuhulikia sanduku.
  1) Jina_____
  2) Jina_____
  3) Jina_____
- Tunaomba tuandikie namba ya simu kwaajili ya kupewa mrejesho

Karibu kwa maoni ili tusaidiane kuboresha huduma za kituo chetu, Asanteni

SOP Code No. 6: Haki za Wateja/Wagonjwa

1. Haki ya kujua huduma zitolewazo katika Kituo cha Afya.
2. Haki ya kupewa huduma / matibabu bora na sahihi ambayo ni endelevu.
3. Haki ya kuhakikishiwa usiri wa taarifa zake anazotoa.
4. Haki ya kujua tatizo lake au ugonjwa wake.
5. Haki ya kusikilizwa maelezo na mapendekezo yake.
6. Haki ya kupewa elimu ya kinga na afya bora.
7. Haki ya kukubali au kukataa matibabu aliyopangiwa.
8. Hali ya kuhakikishiwa usalama awapo maeneo ya Kituo cha Afya.

9. Haki ya kumjua daktari au mhudumu wa afya anayemhudumia.
10. Haki ya kutoa maoni au malalamiko kuhusu huduma itolewayo katika Kituo cha Afya.
11. Wajibu wa kufuata taratibu na kanuni zilizowekwa na zahanati.
12. Wajibu wa kuheshimu wahudumu wote na wagonjwa wenzake.
13. Wajibu wa Kutoa taarifa sahihi juu ya tatizo lake kwa daktari au mhudumu wa afya anayemhudumia.
14. Wajibu wa kusikiliza kwa makini maelezo ya daktari na wahudumu wa afya.
15. Wajibu wa kulipia gharama ili kuchangia matibabu yake kama ilivyopendekezwa na Wizara ya Afya kupitia bima ya Afya.

SOP Code No. 8: Dodoso la taarifa ya mteja kuhusiana na huduma zitolewazo

Ndugu mteja, tunapenda kupata maoni yako kuhisiana na kuridhika kwako na huduma zitolewazo na kituo chetu. Taarifa utakazo toa zitatusaidia kuboresha huduma zetu hapa kituoni ili tuweze kukuhudumia kwa ubora zaidi. Tunakuomba uwe huru kutoa maoni yako kwa kujibu maswali machache yaliyoulizwa hapo chini.

1. Je uliweza kupokelewa na kuanza kuhudumiwa katika dakika **10 mpaka 15** baada ya kufika kituoni? (1) Ndiyo ..... (2) Hapana .....
2. Je umeridhishwa na huduma uliyoipata kwa daktari ? (1) Ndiyo ..... (2) Hapana .....

Kama jibu ni hapana, kwanini hauridhishwi na huduma ya dactari/muuguz/mhudumui.....
.....

3. Je unawezaje kuelezeaje huduma ulizozipate maabara
   A) Zinaridhisha sana
   B) Zinaridhisha kiasi
   C) Haziridhishi
   D) Haziridhishi kabisa
4. Kama haziridhi au haziridhishi kabisa, sababu ni nini? .....
5. Je hali ya mazingira ya kituo kwa ujumla wake yanaridhisha
   a) Ndiyo.....
   b) Hapana
6. Kama Jibu ni hapana, sababu ni nini?
   .....
   .....
7. Je ungependa kitu gani kirekebishe ili kuboresha huduma zetu.....

SOP Code No. 9: Huduma Zinazotolewa katika Kituo cha Afya

Jina la Kituo .....

Huduma Zitolewazo Hapa

1. Kuonana na daktari na matibabu.
2. Ushauri nasaha na upimaji vvu.
3. Huduma za kimaabara.
4. Huduma ya uzazi.
5. Huduma ya kliniki ya baba mama na mtoto.
6. Huduma za uzazi wa mpamgo.
7. Upasuaji mdogo.
8. Kufunga vidonda.
9. Elimu ya afya.

SOP Code No. 15: Uratibu wa Kuagiza, Kupokea, Kutunza na Kutoa Dawa

(a) Kuagiza Dawa

- Dawa ziagizwe kwa wakati muafaka(mara nyingi ni mara moja katika kila miezi 3).
- Ni vizuri kuagiza dawa baada ya kupata mahitaji au matumizi sahiihi ya kila idara ili kuweza kufanya makadirio sahihi ya mahitaji ya dawa kwa kituo katika kipindi cha miezi mitatu ijayo.

(b) Kupokea Dawa

- Hakikisha dawa unazopokea ni zilezile au kwa kiasi kilekile kama ilivyo kwenye delivery note.
- Unapopokea dawa angalia mda wake wa kuhalibika ili kuepuka kupokea dawa zinazokaribia kuisha mda wa kutumika.
- Kama dawa zilizopokelewa zina upungufu record upungufu huo na toa taarifa kwa uongozi wa kituo na supplier.
- Record dawa zilizopokelewa katika rejesta kama utaratibu unavyoelekeza.

(c) Utunzaji Dawa

- Hakikisha stoo ya dawa iko katika hali nzuri, mfano ukavu, mwangi kiasi, na joto la wastani.
- Dawa zitunzwe kufuatana na maelekezo ya mzarishaji, mfano dawa kama za chanjo inaelekezwa zitunzwe kwenye ubaridi (friji).

(d) Utoaji Dawa Stoo

- Wakati ambao stoo ya dawa haitumiki basi ni vizuri ikawa imefungwa mda wote na mwenye kutunza ufungua akajulikana.

- Dawa zitolewe kwa bin card, na dawa zinazotoka kila siku zirekodiwe ikiwa ni pamoja na kurekodi salio la dawa zilizobaki stoo kwa usahihi.
- Hakikisha unatoa dawa zilizotangulia kuingia(FIFO) au dawa muda wake wa kutumika unakaribia kuisha.
- Agalia mda wa mwisho wa dawa kutumika kwa dawa zote unazotoa stoo.

(e) Utoaji wa Dawa kwa Mgonjwa

- Siku zote hakikisha kwamba dawa sahihi na dozi sahihi inatolewa kwa mgonjwa sahihi.
- Baada kupotea karatasi ya dawa(prescription) muite mgojwa kwa majina yake yote mawili kuhakiki kama ni yeye.
- Chota dawa toka kwenye kopo kwa usahihi wa dozi.
- Andika dozi kwa makinikwenye bahasha ya dawa ya mgonjwa (dispensing bag).
- Kisha mpe maelekezo ya matumizi ya dawa mgonjwa.

SOP Code No. 17: Mwongozo wa Matumizi ya Kiteketezaji cha Joto Kali

Utangulizi

Aina za takataka zinazotokana na huduma ya afya (TAZIHA) katika katika kituo cha Afya ni kama ifuatavyo:

1. Takataka zisizosibika (taka zisizokuwa na maambukizi) k.m. karatasi, vifungashio vya mashine na vifaa, maboksi, n.k.
2. Takataka zilizosibika kama pamba na gauze zilizotumika kufunga vidonda, glovu zilizotumika, mirija ya aina mbalimbali inayotumika kuvuta majimaji mwilini (suction
3. tubes), mirija ya njia ya mkojo (catheters), vikasha na chupa zilizotumika kuweka mkojo, makohozi, damu, choo nk kwa ajili ya vipimo vya maabara;
4. Takataka zilizosibika zenye ncha kali k.m aina mbalimbali za sindano zilizotumika (syringes with needles, sutures, lancets), vichupa vya sindano vilivyotumika, n.k,
5. Sehemu za mwili k.m kondo la nyuma, sehemu zilizokatwa wakati wa upasuaji mdogo;
6. Dawa na vifaa vilivyoharibika wakati wa usafirishaji au dawa na vifaa vilivyokwisha muda wake wa kutumika.

Kiteketezaji cha joto kali kilichojengwa katika kituo cha Afya kwa kutumia matofali ya kuchoma kinaweza kutumika kuteketeza takataka aina ya 1, 2 na ya 3. Sehemu za mwili zilizokatwa wakati wa upasuaji mdogo zitupwe kwenye shimo maalum litumikalo kutupa kondo la nyuma. Dawa na vifaa vilivyoharibika au kuisha muda wake wa kutumika zitengwe na kuteketezwe kwa kufuata utaratibu na miongozo ya Mamlaka ya Chakula na Dawa yaani TFDA. Ni marufuku kutumia kiteketezaji cha matofali ya kuchoma kuteketeza dawa au vifaa vilivyoharibika au kuisha muda wake.

Mfumo wa usimamizi wa ukusanyaji, utupaji na uteketezaji wa takataka

Kituo kitakuwa na Kamati ya kushughulikia ukusanyaji, utupaji na uteketezaji wa takataka. Kutakuwepo na mfanya kazi aliyeteuliwa na Mkuu wa kituo kusimamia

shughuli za ukusanyaji, utupaji na uteketezaji wa TAZIHA. Kila Idara itakuwa na mfanyakazi maalum atakayekuwa na wajibu wa kusafirisha takataka hadi kwenye kiteketezaji. Kutakuwepo na mfanyakazi maalum atakaye kuwa na wajibu wa kuteketeza takataka kwa kutumia kiteketezaji cha joto kali.

Utenganishaji wa takataka

Idara zote za Zahanati zimepatiwa vifaa (vikusanyio) vifuatavyo kwa ajili ya ukusanyaji wa taka kabla ya kuteketezwa:

1. Ndoo za rangi ya kijani zenye mifuniko na mifuko ya platiki ya rangi ya kijani au nyeusi - kwa ajili ya taka zisozosibika;
2. Ndoo za rangi ya njano zenye mifuniko na mifuko ya platiki ya rangi ya njano – kwa ajili ya taka zilizosibika;
3. Ndoo za rangi nyekundu zenye mifuniko na mifuko ya plastiki ya rangi nyekundu – kwa ajili ya kondo la nyuma na sehemu za mwili zilizokatwa;
4. Boksi salama zinazohimili kutoboka za takataka zenye ncha kali. Wafanyakazi wa idara zote wamepata mafunzo ya kukinga na kuthibiti maambukizo ikiwa ni pamoja na utenganishaji wa takataka kwa kufuata mfumo wa rangi zilizoonyeshwa hapo juu.

Usafirishaji wa takataka hadi kwenye kiteketezaji cha joto kali

Ndoo za taka zinapofikia kujaa kwa kiasi cha robo tatu (¾), mifuko ya nailoni (bin liners) ifungwe kwa uangalifu na kupelekwa kwenye kiteketezaji. Mifuko ya taka ikishafungwa isifunguliwe tena kwa ajili ya kujaribu kutenganisha taka.

Wafanyakazi walioteuliwa watasafirisha takataka kwenda kwenye kiteketezaji. Ni wajibu wa mkuu wa kila Idara kuhakikisha kuwa takataka zinapelekwa kwenye kiteketezaji mara kwa mara bila kurundikana sehemu za kutolea huduma.

Uteketezaji

Takataka zitateketezwa mara kwa mara, kila baada ya siku mbili siku za Jumanne, Alhamisi na Jumamosi ya kila wiki. Takataka hazitaachwa zikusanyike kwenye kiteketezaji. Mfanyakazi aliyeteuliwa na mkuu wa zahanati atateketeza takataka kutoka idara zote za kituo kwa kutumia kiteketezaji cha joto kali.

Hatua zitakazofuatwa na mfanyakazi anayehusika na uteketezaji ni kama ifuatavyo:

1. Sharti avae glovu ngumu (heavy duty gloves), mabushuti (aprons), na vifaa vingine vinavyotumika kukinga mwili kama barakoa (nose and mouth masks);
2. Atafungua mlango wa kiteketezaji;
3. Atapanga kwa uangalifu mifuko ya nailoni yenye takataka kutoka idara mbalimbali za kituo kwenye sehemu ya kuteketeza (incineration chamber);
4. Atanyunyiza mafuta ya taa kidogo juu ya mifuko ya takataka;
5. Ataanzisha moto wa kuteketeza takataka kwa kutumia kiberiti;

6. Atafunga mlango wa kiteketezaji ili takataka ziendelee kuchomeka na kuteketea katika mazingira ya hewa kidogo ili kupata joto kali ndani ya kiteketezaji.
7. Atahakikisha takataka zote zimechomeka na kuteketea;
8. Ataondoa majivu kutoka kwenye kiteketezaji na kutupa kwenye shimo refu lililofunikwa;
9. Atafanya usafi kwenye eneo linalozunguka kiteketezaji;
10. Atafunga mlango wa ukuta au wavu unaozunguka kiteketezaji ili kuzuia watu wasiohusika wasitumie au kuharibu kiteketezaji cha joto kali.
11. Atasibua glovu ngumu, mabushuti na vifaa vingine vilivyotumika kukinga mwili wakati wa uteketezaji wa takataka kwa kutumia mmumunyo ya klorini wenye mkolezo wa 0.5% kwa dakika kumi (10). Baada ya hapo atasafisha, ataanika na kukausha kwa ajili ya matumizi ya baadae.

Angalizo: Endapo ajali yo yote itatokea wakati wa mchakato wa ukusanyaji, usafirishaji na uteketezaji wa takataka km kuchomwa na kifaa chenye ncha kali, basi matukio haya ni sharti yaripotiwe kwa Mkuu wa Zahanati mara moja.

Kitabu cha rejea: Mwongozo wa Taifa wa kukinga na kuthibiti maambukizo katika utoaji wa Huduma za Afya, IPC April 2007.

Kitabu cha rejea. Refer to: National Guidelines for Infection Prevention and Control, Ministry of Health Zanzibar, April 2007.

SOP Code No. 25: Fomu ya Kuripoti Matukio Mabaya Kazini

Jina La Kituo……

Jina la mtumishi	
Idara	
Tukio lililojiri	
Siku	Wakati:
Sababu zizizokuwa za moja kwa moja zilizopelekea tukio litokee	
Sababu zisizokuwa za moja kwa moja zilizopelekea tukio litokee	
Mafunzo, maelekezo,au tahadhari zilizokuwa zimetolewa kabla ya tukio	
Tukio la nanma hii tunaweza kuepukwaje katika siku zijazo	
Mapendekezo ya hatuo zingine katika siku zijazo	

By who	Date	Time
Mtumishi aliyeumia		
Mkuu wa idara		
Mkuu wa taasis		
Sahihi		

SOP Code No. 26: Utaratibu wa Ukaguzi wa Majengo na Vifaa

Vifaa mbalimbali vitakaguliwa nani uhimu kwa muhudumu kutambua umuhimu wa kutunza vifaaa na majengo.

Ni vyema haya yafuatayo yakazingatiwa:

- Uongozi wa kituo umeamua kuweka muongozo na utaratibu utakotumika kukagua kituo mara kwa mara wa mara ili kuweza kutambua mapema uharibifu wowote unaoweza kujitokeza na kuchukua hatua zinazostahili mapema.
- Majengo yatakaguliwa wa majengo utafanyika.
- Tutatumia kutumia wataalam wa majengo na vifaa kutoka wizara ya Afya kufuatana na aina ya vifaa vinavyofanyiwa ukaguzi ili kuweza kubaini matatizo ambayo siyo rahisi kutambuliwa na mtu abaye siyo mtaalam katika eneo husika (Msaada wa wataalamu hawa utapatikana kutoka kwa mkuu wa afya Wilaya (DMO) ikishirikiana na wajumbe wote wa Afya wilaya (DHMTs).

SOP Code No. 26: Fom ya Ukaguzi wa Majengo na Vifaa

Jina la kituo …… Tarehe

	TAREHE/WAHUSIKA	**MATOKEO YA UKAGUZI/HATUA**
UKAGUZI WA NUSU MWAKA YA KWANZA (JAN-JUNE 2023)	1. 2. 3. 4. 5.	
UKAGUZI WA NUSU MWAKA YA PILI (JUL-DEC 2012	1. 2. 3. 4. 5.	

REFERENCE

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2. Zanzibar Integrated Infection Prevention Control Guidelines October 2020.
3. Zanzibar Quality Improvement Guideline for Healthcare Services October 2020.
4. Standard Operating Procedures for Infection Prevention and Control in Zanzibar October 2020.
5. https://www.hey.nhs.uk/patient-leaflet/hand-hygiene-information/WHO.
6. Girou et al., Efficacy of handrubbing with alcohol based solution versus standard handwashing with antiseptic soap: randomised clinical trial. BMJ 2002; 325:362
7. https://www.names.org/n/taziha/about.

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Foundation