CHAPTER IV

INTENSIVE CARE AREA LIKE OPERATION THEATRE, LABOUR ROOM, RECOVERY ROOMS, POSTOPERATIVE ROOM, INTENSIVE CARE UNIT, CORONARY CARE UNIT ETC.

4.1 Since these departments handle serious cases or those who require intensive monitoring, they assume importance in the hospital and hence should be accorded top priority by the hospital administration. The senior doctors should be available on call round the clock for these areas.

4.2 All theatres, labour rooms and recovery rooms etc. should be under the control of a responsible person, who will be known as 'Officer Incharge'. Trained and experienced senior nurses for routine supervision should assist him.

4.3 An organizational chart showing the relative position of the staff working in the department should be prepared and exhibited. Normally, technicians working in the theatres, labour rooms, recovery rooms, etc. should be under the control of the senior nursing staff unless indicated otherwise.

4.4 Duties of all categories of staff working in the operation theatre, labour rooms, and recovery rooms should be specified and exhibited. Technicians besides attending to proper sterilization and arrangement of theatre equipment should be familiar with their routine maintenance and repairs as well.

4.5 Adequate staff as per norms should be posted in these areas. Duty roster of the subordinate staff should be prepared by the nurse incharge of each theatre, labour room or recovery room. The unscheduled absenteeism of the staff in these areas should be seriously discouraged and suitable administrative measures should be taken in this regard as it affects the patient care in such sensitive areas.

4.6 All the staff working in the theatres, labour rooms and recovery rooms should be given periodical exposure to aseptic procedures.

4.7 Weekly reports should be obtained from the microbiologist about the sterility of the operation theatres, labour rooms and recovery rooms and appropriate action taken and be properly recorded.

4.8 Arrangement should be made for informing the relations of patients about the progress of operations.

4.9 In case of death of a patient on the operating table, labour room or recovery room, the Chief of the hospital should be informed by the officer incharge theatres for holding an immediate enquiry and for taking into his custody all relevant records of the case. This should be done in case of all deaths in the hospital whether suspicious or otherwise by the Unit concerned.

4.10 In the case of postponement of scheduled operations for reasons other than medical, the officer incharge theatres should send a weekly written report to the Chief of the Hospital together with reasons.

4.11 The officer in charge of theatres should clearly issue written administrative and technical instructions for dealing with emergency operations as well as daily scheduled operations. He would also specify the ward and theatre's responsibility for preparing patients.

4.12 Operating surgeons and concerned physicians should see that the medical record case sheets of the patients are complete in all respects while they are in the theatre, labour rooms or recovery room.

4.13 The officer in charge of the theatres, in consultation with the surgeon/physicians concerned should see to the prompt clearnace of patients from the recovery room.

4.14 Visiting hours to the recovery room to be laid down by the officer incharge.

4.15 Consent for operations and for anaesthesia to be administered should be obtained from the patient or from the nearest relation in case of unconscious patients by the nursing staff in the prescribed form and attached to the case sheet. If no consent is forthcoming the surgeon concerned should decide the matter on merits of the case. In the case of minor, written statement of either parents or the guardians of the patient is essential.

4.16 Steps should be taken to minimize the risk of foreign body being inadvertently left in a patient following surgical procedure. Recommended steps for this purpose are as follows.

(i) Swab and pack count should never be missed.

(ii) All swabs and packs included in the count should be white.

(iii) Swabs used for minor procedures to be carried out in conjunction with a major operation should be coloured if available so that they are easily distinguishable.

(iv) The sizes of packs and swabs should be of irreducible minimum.

(v) Swabs and packs should never be cut or divided.

(vi) All packs should have a tape and normally have clip attached to it.

4.17 If gauze cut from a roll is inserted in the patient's body and is completely hidden from view, a label or a tag should be attached to the patient's forehead. If forehead is the field of operation some other suitable area of skin should be used.

4.18 When a patient is returned to the ward with a swab or pack or tube deliberately left in the vagina or other cavity or in a wound after an operation, this fact should be reported to the ward sister and written instruction on the patient's case sheet should be given of the date and time on which it is to be removed.

4.19 All swabs and packs to be used during operation should be in bundles of five and counted again before the start of the operation. There should be a double check of the number of swabs in bundle, packs and instruments issued to the scrub nurse. The list should be displayed in the operating theatre on a slate or black board before the commencement of operations.

4.20 The discarded swabs and packs should not be removed from the theatres till such time as all the swabs and instruments are accounted for by scrubbed nurse, the circulating nurse and the surgeon at the end of the operation, preferably before the closure of the wounds.

4.21 The scrubbed nurse should control the number of swabs on the table.

4.22 At the commencement and the closure of the operations wound, the scrubbed nurse must count the swabs used and satisfy herself that these are correct and inform the surgeons accordingly. The surgeon should

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satisfy himself/herself that all swabs have been accounted for before the completion of the operation. This is his personal responsibility and should in no circumstances be delegated.

4.23 In instances where the surgeon has been obliged to close the wound without prior swab count due to compelling situation or due to uncompromising count by the nursing staff, that fact should be recorded on the patient's case sheet and the Chief of the hospital informed by the surgeon.

4.24 In case of any discrepancy of swabs, the surgeon should record this fact on the case sheet of the patient and inform the Chief of the Hospital.

4.25 The surgeon should keep the scrubbed nurse informed about the location of swabs in the operational field to facilitate her counting.

4.26 After the first count has been taken, the scrubbed nurse and the surgeon should carefully check the swabs still in use. After the closure of the wound a final count should be made.

4.27 The scrubbed nurse should check all the instruments on the operating table and the haemostats immediately before operation.

4.28 Under the supervision of the surgeon the scrubbed nurse or the technician should check the instruments and haemostats before the closure of the operation wound.

4.29 The scrubbed nurse should count all the needles on the table before the commencement of the operation.

4.30 As a rule the scrubbed nurse should not part with the second needle till the first is a returned to her by the surgeon.

4.31 In the event of more than one needle being in use at the same time, the scrubbed nurse should take extraordinary care to see that all the needles are returned to her. The piece of needle, if broken, should be properly returned to the nurse.

4.32 The scrubbed nurse should make a count of the needles before the closure of the operation wound. In the event of any discrepancy the surgeon should be informed promptly.

4.33 It is the ward sister's responsibility to see that the correct patient is sent to the operating theatre together with his case record, X-ray, consent from, etc

4.34 The ward sister should mark the appropriate side/area of operation by indelible ink.

4.35 The theatre sister should check that the responsibility of ward sister as enunciated at 4.33 and 4.34 has been carried out.

4.36 In the case of emergency operations, utmost care for the identity of the patient, the area of operation, the limb to be operated, to be taken by the surgeon himself before he performs the operation.

4.37 While writing the case sheet the junior doctors should avoid using abbreviations while indicating the area or limb to be operated.

4.38 The officer in-charge theatres should ensure pleasant and calm atmosphere in the theatres under all circumstances. Limited number of medical and paramedical person should be there to avoid infection.

4.39 The officer in-charge of theatres holds the legal liability of any negligent act, in his area. For this purpose he should see that the patient's case record is written with meticulous care indicating the various procedures completed and the checks and counter checks done of number of swabs, instruments, needles, etc. The case record should reveal unambiguously the acts done or left undone and the persons responsible for them.

4.40 X-ray facilities should promptly be made available to operating theatres on request.

4.41 The officer in-charge theatres should draw detailed list of rules and regulations for prevention of fire hazards in the theatre, labour rooms and recovery room and ensure that they are observed. Planned preventive maintenance of all theatre requirements, electrical circuits and wall attachments, storage facilities of X-ray films and of blood and electric-lights, anaesthetic gases, flammable liquids and other combustible materials will go a long way to minimize fire hazards. The operating room technicians if available, otherwise designated persons should be made responsible for this work.

4.42 Fire practice drill should be a regular feature in theatre management.

4.43 Linen control should be properly organized. Theatres, labour rooms and recovery rooms should be well served by a Central Linen Service on a clean exchange basis. Dirty, soiled or blood stained linen should not be allowed to accumulate in the area. The staff, consumables, medicines, etc. should be adequately met in these areas, as they are highly labour intensive areas. The ratio of nurses to patient in these areas should 1:1.

4.44 Infections to the operating theatres are generally carried by patients bringing in dirty and soiled ward clothes, trolleys carrying patients crossing open areas, visitors entering the aseptic zones without changing clothes and foot wears, infected cases not being operated in separate theatres, etc. Officer incharge should issue instructions to avoid infection in the theatres and see that they are implemented.

4.45 Foot-wears used by the staff and visitors inside the operating theatres should be daily washed and cleaned. Different types of identifiable footwears should be issued to the staff and to the visitors.

4.46 The maintenance of equipments, supply line should be an important activity of nursing sister in-charge and doctor in-charge of these areas. No patient should be allowed to suffer on this account. A chart should display non-functioning equipments.

4.47 Services of anaesthetist, pipeline oxygen & suction should be available.

4.48 All waste of the operation theatre and other areas should be disposed off as per guidelines in this regard, see chapter XVI.

4.49 The following documents should be maintained in the operating theatres, labour rooms and recovery rooms as the case may be:

(i) Operation Register.

(ii) Maternity cases Register.

(iii) Operation list file.

(iv) Inventory of dead stock articles and equipment.

(v) Indent books for consumable and non- consumable stores.

(vi) Planned preventive maintenance schedules.

(vii) Linen account.

(viii) History sheet of all expensive equipments.