

# POTOTAN RURAL HEALTH UNIT AND BIRTHING CENTER AND PRIMARY CARE FACILITY

## I PATIENTS' RIGHTS AND ORGANIZATION ETHICS

### SAT 1

Pototan Rural Health Unit and Birthing and Primary Health Care Facility understands that communication and information are important areas of rights and respect for patients. It is the policy of our health facility to provide patients with unrestricted access to all forms of communication. Sometimes, however, it may be necessary to restrict visitors, mail, telephone calls, or other forms of communication as a component of a patient's care (for example, to prevent injury or deterioration in the patient, damage to the environment or infringement on the rights of others).

The Pototan Rural Health Unit and Birthing and Primary Health Care Facility shall adapt and ensure the implementation of the rights of the patient;

1. **Right to medical care of good quality** – the person is entitled to receive quality medical care without discrimination, regardless of race, creed, color, religion and political affiliations.
2. **The right to continuity of care** – the physician is obligated to cooperate with treatment regimen, initiated by other practitioners or other health facilities granting that said regimen is medically indicated, following established treatment protocols.
3. **Right to Information** – the patient has the right to receive information about himself / herself, data written in his / her medical records, and the status/progress of his / her medical condition. Further he / she has the right to choose who else shall have access to the data / documents.
4. **Right to freedom of choice** – the person has the right to choose freely his/her doctor / health care provider, the health facility he/she shall avail services from, and the seek another health worker's opinion.
5. **Right to self-determination** – the patient has the right to make free decision pertinent to himself/herself and his/her treatment information necessary to make his/her decision which should include rationale for any procedure, the consequences of undergoing or not undergoing said procedure, and the implications of whatever decisions he/she will come up with. All invasive procedures should therefore require a signed consent from the client or any legal representative of the client.
6. **Right to confidentiality** – all information about the patient, his/her condition, diagnosis, and treatment must be kept confidential. Patient confidentiality shall be ensured by:
  - a. Providing a family record for all families in Pototan which shall be kept in an assigned cabinet.
  - b. Limiting the access to the records area to RHU personnel only



- c. Requiring a letter of request from agencies such as Barangay Courts, Philippine National Police and the Court of copies/ or duplicates of any documents pertaining to the client
  - d. Preventing health personnel to openly discuss client's conditions or illness
  - e. Avoid posting of client's names with conditions requiring follow – ups in conspicuous places
7. **Right to be treated with dignity** – the patient's dignity shall be respected at all times during the course of the medical care taking into consideration his/her cultural beliefs and religious inclinations. Privacy of the person shall be ensured by providing a decent and private parts and divulging of confidential information.
- a. **Right to health education** – every patient has the right to information that will assist him / her in making informed choices with regards his/her health & condition.
  - b. **Rights of the unconscious patient** – for unconscious client, informed consent shall be obtained from the nearest of kin or any legally entitled representative. In situations where their urgency for medical interventions in the absence of a legal representatives, consent from the unconscious client is presumed.
  - c. **Rights of the legally incompetent patient** – for minors and other legally incompetent clients, consent shall be obtained from legally entitled representatives with full participation of the client.
  - d. **Right to religious assistance** – the patient has the right to receive or decline spiritual & moral comfort.
8. **Right to leave against medical service**
9. **Right to express grievance**

To ensure the opportunities for health care, all clients of the health services are expected to perform their **OBLIGATION/RESPONSIBILITIES**

1. Patients have the responsibility to seek immediate medical condition in all tiers of the Pototan Rural Health Unit and Birthing and Primary Health Care Facility
2. Patients have the responsibility to provide as much information as possible to health care providers about present health, past medical history, any other information such as allergies, family medical history and other details relevant to his care.
3. Patients have the responsibility to follow prescribed and agreed treatment regimen.

4. Patients have the responsibility to inform health care providers of any difficulties or issues regarding the suggested medical regimen or any untoward reactions to prescribed treatments
5. Clients have the responsibility to contribute to community well-being and encourage other people to seek consultation or medical advice.
6. Clients have the responsibility to show consideration to other clients of the health facility or health worker.

The facility management shall endeavor to disseminate this patient rights and responsibilities through the following:

1. Posting of the rights and responsibilities in conspicuous areas within the Main Health Center.
2. Reproduction of said rights and responsibilities in leaflets / flyers for distribution to clients.
3. Dissemination during opportunities of client health education activities
4. All auxiliary health workers (Community Health Team) are to be oriented on client rights and responsibilities.

The employees of Pototan Rural Health Unit and Birthing and Primary Health Care Facility area expected to adhere to the norms and conducts expected of public officials and employees, as follows:

**a. Commitment to public interest**

The employee is expected to uphold the public interest over and above her / his personal interest. All government resources and powers in the office must be used efficiently, effectively, honestly and economically, to avoid waste of public funds and revenues.

**b. Professionalism**

Employee is expected to perform his/her duties with the highest degree of excellence, intelligence and skill, serving with outmost devotion and dedication to duty.

**c. Justness and Sincerity**

Remain true to the people at all times. Be honest, just and sincere, not discriminating against any person regardless of race, creed, color, political learning and religious inclinations. Services and undue favors are not to be given to relatives or close friends on account of the health services.



**d. Political Neutrality**

Provide service to anyone, regardless of party affiliation or preferences, without discrimination

**e. Responsiveness to the public**

Extend prompt, courteous and adequate service to the public. Ensure openness through consultations, meetings and public hearings. Encourage suggestions; simplify systems and policies, avoiding red tape in the process of service delivery. Furthermore, there should be an understanding and appreciation of the prevailing conditions within the locality pertaining to socio-economics, health profile and the prevailing developmental directions of the leadership.

**f. Nationalism and Patriotism**

Be loyal to the republic and to the Filipino people, promoting the use of locally produces goods, resources and technologies.

**g. Commitment to Democracy**

Uphold the constitution at all times, putting loyalty to country above loyalty to persons or party while committing to a democratic way of life and values, and observing the principle of public accountability.

**h. Simple Living**

Lead a modest life and not indulging in extravagant display of wealth in any form.

As health workers, all RHU staff is also expected to imbibe the values stated in the Code of Conduct of Public Health Workers, mandated in 1992, summarized as follows:

**1. The public health worker shall be humane**

- a) He shall accord his every client with respect befitting a human being who is unique and made in the image of his Divine Creator
- b) He shall serve everybody to the best of his transactions with eagerness and compassion, sensitive and responsive to his client's expressed and implied needs, including those beyond health matters.
- c) He shall conduct his services and other transactions with eagerness and compassion.
- d) He shall endeavor to provide his clients with the fullest and truthful information possible to help them decide on or choose methods of health care or other matters for which his services are sought.
- e) He shall at all times uphold the sanctity of his profession.



**2. The public health worker shall uphold his personal integrity and that of his profession**

- a) He shall continually seek to improve on his professional skill, knowledge and expertise. He shall also share his knowledge and expertise with other members of his profession without regard for compensation and encourage the professional development of his peers.
- b) He shall practice his profession always to be the best of his ability and endeavor produce quality outputs.
- c) He shall not claim expertise over matters beyond his position or capability. He shall not use his position to obtain personal favors.
- d) He shall endeavor to be a role model for a respectable healthy lifestyle.
- e) He shall take pride in being a public health servant and not allow anyone to degrade him or his position.

**3. The public health worker shall be just**

- a) He shall treat all persons equally without bias to race, social class, sex, age, physical or mental capabilities, political and religious affiliations.
- b) He shall make professional, administrative and technical judgments in favor of the common good.

**4. The public health worker shall be generous in spirit and in deed.**

- a) He shall actively seek to be of service to his superiors, clients and peers.
- b) He shall be prepared to respond to the call of duty emergencies and situations demanding additional manpower or hours of work.
- c) He shall volunteer to provide his services where and when they are most needed.
- d) He shall welcome all opportunities to coordinate and work with other offices, agencies and organization for the furtherance of public health services.

**5. The public health worker shall exercise courage to protect the interest of public health.**

- a) He shall assert his rights as a public health worker when necessary
- b) He shall readily take the risks necessary to perform his duties and functions in public health service.

- c) He shall practice & protect known and accepted ideals in public health delivery systems, and enforce rules and regulations and standards by the duly constituted authority without fear and favor.

The following practices among health workers are **ABSOLUTELY PROHIBITED** in the premises of all health facilities:

- ✿ Selling of donated medicines and drug samples
- ✿ Providing and collection of fees for services not officially authorized by the local government
- ✿ Making use of official time to conduct personal work and other non-work-related duties and obligations
- ✿ Selling of commercial products while providing services
- ✿ Smoking, drinking alcoholic drinks
- ✿ Promotion of milk products unless medically indicated for certain conditions such as lactose intolerance, G6-PD deficiency, etc.

For non-compliance to the above code of ethics, issues will be discussed with specific person and during the monthly staff meetings.

The above organizational policies pertinent to the RHU personnel shall be disseminated through:

1. Staff Meetings
2. Provision of copies of said documents to each personnel, and
3. Posting of policies.

The office of the Municipal Mayor through the Human Resource Management Officer shall be provided with a copy of said policies as a reference for any administrative actions on non-compliant personnel.

#### **GOALS FOR SERVICE DELIVERY:**

1. **Access Goal** – the facility is accessible to the community that it aims to serve.
2. **Entry Goal** – the entrance of the client is facilitated to avail of appropriate services in a timely manner and in a suitable environment.
3. **Assessment Goal** – clients are comprehensively assessed and re-assessed as a basis for planning and delivery of their appropriate care.

4. **Care Delivery Goal** – the client, in partnership with the health care team, receive a well – planned, properly coordinated, competent and safe care.
5. **Continuity of Care Goal** – clients receive continuous care coordinated between the facility with the higher level of care facilities and/ or community health care providers.
6. **Client & Family Education Goals** – clients and community members are enabled to better participate in their care, make informed decisions towards changed behavior
7. **Medication Use and Management Goal** – the clients benefit from safe & efficient system for managing and administering drugs and vaccines



## **SAT 2**

### **PATIENTS RIGHTS AND RESPONSIBILITIES**

#### **Purpose:**

To ensure high quality compassionate care provided in respectful manner that fosters patient dignity. Recognize and respect patient rights which directly affect their care to promote patient autonomy, dignity and respect for personal values, beliefs and care preference. To ensure the patient, their families, or their designee, are aware of their rights and responsibilities.

#### **Policy Statement**

It is the policy of Pototan Rural Health Unit and Birthing and Primary Health Care Facility Municipal Health Office to support and inform each patient of his/her rights and responsibilities. These rights are extended to each patient regardless of the patient's age, sex, race, creed, national origin, ethnic group, religion, economic, or cultural background or source of payment. Patients are informed of their rights, as appropriate. These rights can be exercised on the patient's behalf by a parent or legal guardian if the patient is a minor, or if the patient lacks decision- making capacity or has been deemed legally incompetent.

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## PATIENT'S RIGHTS

We encourage you to speak openly with your health care provider, take part in your treatment choices, and protect your own safety by being well informed and involved in your care. As a patient at \_\_\_\_\_ (name of Hospital), you have the following rights:

1. You have the right to receive considerate, respectful and compassionate health care in a safe setting regardless of your age, sex, gender, religion, ethnicity, political affiliation, disability or capacity to pay free from all forms of abuse, neglect, or ill treatment.
2. You have the right to be assigned to a competent doctor/resident physician and be told of the names of all health care team members who are qualified to provide diagnosis, treatment and medical advice. Likewise, you have the right to know your hospital and physician fees, and receive information about the possibility of financial assistance.
3. You have the right to notify a family member or person of your choice and your chosen doctor of your admission to the hospital.
4. You have the right to have someone remain with you during your hospital stay unless it compromises your or others' rights, safety or health.
5. You have the right to exercise your spiritual and cultural beliefs within the capacity and rules of the hospital/medical center.
6. You have the right to be informed and give consent before any non-emergency procedure or research/experiment or to refuse such.
7. You have the right to privacy and confidentiality of your medical records according to laws, as well as in care discussions, examinations, and treatments and the right to see or get a copy of your medical records except those records restricted by law.
8. You may request for an escort during physical examinations.
9. You have the right to be represented by someone (assignee) to decide on your behalf when the circumstances warrant.
10. You have the right to ask about and be informed of the complaint process and express grievances without fear of recrimination or reprisal. You are encouraged to speak directly to the health care provider involved in your care.

*If there are issues not resolved to your satisfaction, or if you would like the help of someone not immediately involved, talk to the Patient Relations Staff or to the Chief of Hospital or Hospital Director.*

*If you find the above avenues unsatisfactory, you may choose to file a formal grievance with following agencies:*

*DOH-Regional Office \_\_\_\_\_*

*Department of Health- Central Office  
Health Facilities & Services Regulatory Bureau  
(02) 651-7800 local \_\_\_\_\_*



## Statement of Patients' Rights and Responsibilities

- ✓ Medical care and services without discrimination;
- ✓ Care that is considerate and respectful of his or her personal values and beliefs and the right to express those values and beliefs which do not harm others or interfere with medical therapy;
- ✓ Know the name and professional status of the physician, who has primary responsibility for his or her care, as well as other physicians and non-physicians involved in providing care;
- ✓ Be informed about his or her responsibilities related to his or her care, treatment, and services;
- ✓ Receive information in a manner tailored to the patient's age, language, and ability to understand. This information is to be relevant, current, and easily understood concerning diagnosis, treatment, and prognosis;
- ✓ Be provided interpreting and translation services, as necessary;
- ✓ Receive communication with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs;
- ✓ Participate in making decisions about his or her care, treatment, and services, including the right to have his or her own physician promptly notified of his or her admission to the RHU;
- ✓ Patients who have decisional capacity have the right to refuse care, treatment, and services including leaving against medical advice and be respected of this decision, give or withhold informed consent;
- ✓ Give or withhold informed consent to produce or use recordings, films, or other images of the patient for purposes other than his or her care;
- ✓ Be informed of the risks, benefits, alternatives, and procedures to be followed if experimental treatment or research is being proposed; the patient has the right to refuse to participate in such treatment or research without limiting his or her access to care and services;
- ✓ To be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.
- ✓ To be in an environment that preserves dignity and contributes to a positive self-image;
- ✓ File a complaint and to expect prompt referral to appropriate RHU administrative personnel for resolution. The patient also has the right to file a complaint with state and federal advocacy and licensing groups, as well as accreditation agencies.
- ✓ Access protective and advocacy services;
- ✓ To be free from restraints and seclusion of any kind that is used as a means of coercion, discipline, convenience, or retaliation by staff;
- ✓ Confidentiality regarding his or her care and clinical records and the right to access information contained in his or her records within a reasonable time frame;
- ✓ Be informed of unexpected as well as expected outcomes resulting from care provided;
- ✓ Have his/her pain managed safely and effectively through ongoing assessment and timely responsive interventions and minimize the risks associated with pain treatment. Patients can expect to receive information about pain relief measures, as appropriate, and to be involved in decisions related to their pain management;
- ✓ Receive quality care and clinical decisions regarding care based on health care needs, not financial incentives;
- ✓ Obtain knowledge of any professional and/or business relationships that may exist between individuals, other organizations or health care services, or educational institutions involved in his/her care;

- ✓ Receive referrals based on patient choice, after receiving information, including disclosure of any relationships that may exist.
- ✓ The patient's presence in the RHU and condition may be released to those requesting the information, unless the patient has stipulated otherwise or unless the patient is admitted for treatment of psychiatric illnesses. In cases that are reportable to public authorities, the patient's identity, the nature of the illness or injury and the patient's condition may be released without the patient's consent.
- ✓ The right to request and receive a detailed explanation of the RHU bill and to receive information and counseling on the availability of known financial resources for health care.
- ✓ Patient has the right to receive, hold, and dispose of personal property; however, access to personal property may be restricted for medical and/or security reasons.

## A. INFORMED CONSENT FOR PROCEDURES OR REFUSAL TO CONSENT TO CARE

### Purpose

To ensure that patients receiving care or treatment in Pototan Rural Health Unit and Birthing and Primary Health Care Facility Municipal Health Office are properly informed of the relevant risks, benefits and alternatives before receiving care so that they make informed decisions concerning their health care, and to ensure that the patients consent or refusal of treatment is appropriately documented in the medical record.

### Policy

Except in emergencies, practitioners who provide care or treatment in Pototan Rural Health Unit and Birthing and Primary Health Care Facility Municipal Health Office shall, before providing treatment, obtain document informed consent or refusal of treatment from the patient or the patient's guardian or surrogate decision-maker.

### Procedure

1. **Responsibility for Obtaining Consent.** The physician is ultimately responsible for discussing the proposed care with the patient, obtaining valid informed consent from the patient or their authorized surrogate decision maker. Nurse or midwife may serve as a witness and may assist the physician. However, the physician may utilize their staff to help obtain or document patients consent or refusal.
2. **Process of Obtaining Informed Consent.** Except in emergencies, primary health care workers should comply with the following process when obtaining and documenting informed consent or refusal of treatment.
  - a. Upon informing the patient or his qualified surrogate decision-maker, informed consent shall be obtained after thorough explanation of the treatment/procedure risks, advantages and possible complications.
  - b. The primary care facility shall obtain informed consent prior to procedure limited to the following, circumcision, incision and drainage, excision of small cyst, debridement (partial



superficial wound only), wound suture (partial wound only) and sterilization, and immunization for adults.

- c. In obtaining informed consent, the physician or their designated staff should generally discuss with the patient or guardians the need and nature of procedure, reasonably probable benefits and significant risk, side effects and potential consequences of proposed treatment/procedure. Treatment alternatives shall also be discussed with their associated risks and benefits.
  - d. The patient's or surrogate decision-makers informed consent shall be documented in patients' medical record.
  - e. Any consent forms or written material used to explain the procedures and associated risk or benefits should be reviewed periodically by the healthcare provider to ensure information contained in the forms is current and accurate.
  - f. After performing all necessary steps prior to procedure, let the patient, legal guardian or surrogate decision-maker to sign the Consent for Procedure/Treatment Form and document in the medical record accordingly.
- 3. Oral Consent.** In rare circumstances, it may be necessary to obtain consent from patient's guardian through telephone. In such cases, healthcare worker should immediately document the conversation in medical record and forward a written consent to complete and return to the primary care facility for inclusion in the medical record.
  - 4. Emergencies.** In an emergency situation, practitioners may initiate appropriate care without obtaining prior informed consent if he/she determines that there is substantial likelihood that the patient's life or health may be seriously endangered without immediate treatment. The practitioner must document in the medical record the facts that makes the situation emergency.
  - 5. Scope and Duration of Consent.** Informed consent is generally limited to the specific treatment or course of treatment identified in the communication with the patient and any incidental, included procedures. The practitioner shall obtain and document patients consent if; 1. New or different procedure is contemplated, 2. Circumstances has changed, 3. Significant lapse of more than 7 days has occurred since the original consent is obtained or, 3. The patient or surrogate decision-maker expresses doubts and objections suggesting that they may withdraw consent.
  - 6. Withdrawal of Consent.** A competent patient or their surrogate decision-maker generally may withdraw their consent anytime. The practitioner should address the patient's or surrogate decision-maker's concern before discontinuing or continuing the procedure or treatment.
  - 7. Person who May Consent to or Refuse to Care.** An adult person who are competent and someone who shows capacity to decide for their selves may signed or refuse to care. Minors requires guardian while people with physical and mental incapability's need to have a surrogate decision-maker. Emancipated minor may consent for their own health care.
  - 8. Refusal of Treatment/Procedures.** A competent adult, legal guardian or surrogate decision-maker approved by the law may refuse the prescribed procedure and treatment. The practitioner should document that she/he explained the risk and benefits of the proposed treatment. The practitioner should confirm the decision by signing the Refuse to Procedure/Treatment Form.

Republic of the Philippines  
Province of Iloilo  
Municipality of Pototan

POTOTAN RURAL HEALTH UNIT BIRTHING CLINIC AND PRIMARY HEALTH CARE FACILITY

CONSENT FORM

I, \_\_\_\_\_ (patient name/parent/guardian name), hereby give my consent to perform this procedure: \_\_\_\_\_.

I understand that the procedure is to be performed at **POTOTAN RURAL HEALTH UNIT BIRTHING CLINIC AND PRIMARY HEALTH CARE FACILITY** on \_\_\_\_\_ (Date).

I understand that the procedure will be using local anesthesia.

I understand that the risks of the procedure include, but are not limited to:

- Bleeding
- Infection
- Pain
- Scarring
- Complications related to anesthesia

That I fully understood everything after proper appraisal and removed the physician and health care workers of this facility from any liabilities.

Patient signature \_\_\_\_\_ [Date] \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_  
[Date] \_\_\_\_\_

\_\_\_\_\_ Witness signature \_\_\_\_\_



I am fully aware and understood that the procedure to be done cost \_\_\_\_\_ base on the Municipal Tax Revenue and thereby adhere to pay to the municipal treasury.

Patient/Guardian Signature

## II. PATIENT CARE

### SAT 3 CLINICAL SERVICES

#### POTOTAN RURAL HEALTH UNIT AND BIRTHING AND PRIMARY HEALTH CARE FACILITY

##### ☆ LIST OF SERVICES

The following are the services that are offered by the Municipal Health Services

##### 1. Child Welfare Services

- Expanded Program of Immunization
- Growth Monitoring
- Micronutrient Supplementation
- Infant & Young Child Feeding
- Integrated Management of Childhood Illnesses
- Newborn Screening Test, Referral of newborn for confirmatory test
- Management of TB in children

##### 2. Maternal Care Services

- Micronutrient Supplementation for pregnant & post – partum women
- Tetanus Immunization
- Community Managed Maternal & Newborn Care
- Birth Planning
- Reproductive Health
- Care during Pregnancy, Labor, Delivery, and Post – partum
- Early referral to OB-Gyn Specialist for complicated pregnancies and deliveries

##### 3. Family Planning Services/Reproductive Health

- Natural Family Planning – Responsible Parenthood Movement (NFP-RPM)
- Pre-marital Counselling
- Family Planning counselling
- Provision of Artificial FP Methods (Implanon)

- Referral to higher facility on Permanent FP Method
4. Environmental Sanitation
- Inspection and licensing of facilities covered by sanitation code
  - Water quality determination
  - Accreditation of Food Handlers
  - Waste Management
  - Vector Control
  - Advocacy activities
5. Control of Non- Communicable Diseases
- Detection and Management of Lifestyle Related Diseases and other Non-communicable Diseases
  - Promotion of Healthy Lifestyle /Exercise
  - Counselling on Nutrition
  - Cessation for Smoking
6. Control of Infectious Diseases
- National Tuberculosis Program
  - Control of Soil – Transmitted Helminthiasis
  - Dengue – Control Program
  - Management of Sexually Transmitted Diseases
  - Leprosy Control Program/” Kilatis-Kutis”
7. General Wound Care including minor surgeries;
- Wound suturing and suture removal
  - Incision and Drainage
  - Debridement
  - Excision of small cyst
  - Circumcision
8. Laboratory Services
- Complete Blood Count
  - Platelet Count

- Blood Typing
- Pregnancy Testing
- Urinalysis
- Fecal Analysis
- Blood Glucose Determination
- Dengue IgM / IgG Determination
- Dengue NS1
- Direct Sputum Smear Microscopy for Acid Fast Bacilli
- Larval Survey for Dengue vector determination
- RPR
- Hepatitis B screening
- Blood Typing
- Covid-19 Rapid Antigen Testing
- Covid-19 specimen collection for RT-PCR

9. Dental Services

10. Adolescent Services

11. National Voluntary Blood Donation Program

12. Health Emergency Services

- Outbreak Investigation, Management & Control
- Management of Mass Casualty Incidents

13. Ancillary Services (Outsourced)

- Blood Chemistry Examination
- Chest x-ray
- ECG
- Pharmacy
- Ambulance



#### 14. Referral Services:

- Community-based Rehabilitation Services (Physical therapy, Occupational therapy, speech therapy)
- Developmental and mental health evaluation
- Substance abuse services

#### 15. Assistance in Registration of Births & Deaths

#### 16. Medico – legal Services

#### 17. Administrative Services

- Issuance of Medical Certificates
- Issuance of Sanitary Permits

#### ☆ **CLINIC HOURS**

The RHU services shall be from 8:00 am thru 5:00 pm, no noon break Mondays thru Fridays. On weekends and holidays, only emergency calls will be attended to.

Office hours shall be extended as need arises such as in mass casualty incidents, outbreak situations and the like

General Consultations shall be conducted every day. However, specific services shall be provided on specific days to minimize wastage of logistics (vaccines) and to avoid undue exposure of well – babies and well – mothers to infectious diseases.

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The following shall be the schedule of consultations

**SCHEDULE OF ACTIVITIES**

**MONDAY – FRIDAY**

**8:00 AM to 5:00 PM**

<b>DAYS</b>	<b>TIME</b>	<b>ACTIVITIES</b>
<b>MONDAY</b>	<b>AM</b> (8:00 am – 12:00 noon)	GENERAL CONSULTATION AND TREATMENT
	<b>PM</b> (1:00 pm – 5:00 pm)	GENERAL CONSULTATION AND TREATMENT/STAFF MEETING
<b>TUESDAY</b>	<b>AM</b> (8:00 am – 12:00 noon)	GENERAL CONSULTATION AND TREATMENT
	<b>PM</b> (1:00 pm – 5:00 pm)	PREMARITAL COUNSELING
<b>WEDNESDAY</b>	<b>AM</b> (8:00 am – 12:00 noon)	IMMUNIZATION DAY
	<b>PM</b> (1:00 pm – 5:00 pm)	FIELD VISIT
<b>THURSDAY</b>	<b>AM</b> (8:00 am – 12:00 noon)	FAMILY PLANNING DAY IMPLANON INSERTION PRENATAL/BUNTIS DAY
	<b>PM</b> (1:00 pm – 5:00 pm)	FIELD VISIT
<b>FRIDAY</b>	<b>AM</b> (8:00 am – 12:00 noon)	GENERAL CONSULTATION AND TREATMENT
	<b>PM</b> (1:00 pm – 5:00 pm)	STAFF MEETING

## **SAT 4**

### **Population Base Primary Health Care Service**

#### **4A. HEALTH PROMOTION**

Programs for illness prevention and health promotion emphasize maintaining people's health. Programs for promoting health are designed to encourage and enable people to make healthy decisions, alter their lifestyles to lower their chance of contracting chronic illnesses and other morbidities. The World Health Organization defines health promotion as: "allows individuals to have more control over their own health. It includes a wide range of environmental and social initiatives that aim to improve and safeguard each person's health and quality of life by addressing and preventing the underlying causes of illness rather than only concentrating on treatment and cure.

#### **HEALTH PROMOTION AND EDUCATION**

- **BIRTH PLANNING AND PREPAREDNESS**

1. Every pregnant should be provided with Family Health Diary (FHD) by health facility with first contact. The FHD must be properly filled out.
2. The FHD must be brought always whenever pregnant visits a health facility.
3. Every pregnancy is considered risk.
4. Birth Planning and Preparedness must be established during the first visit wherein important details regarding preparation on expected delivery are discussed.
5. All pregnant is advised to have at least 4 ante-natal check – up from a midwife or nurse or doctor in any BHS, RHU, birthing centers, clinics, RHU on the following schedules:
  - As soon as menstruation is missed for one month, or at least 1 during the first three months of pregnancy
  - At least 1 during the 4<sup>th</sup> to 6<sup>th</sup> months of pregnancy
  - At least 1 during the 8<sup>th</sup> month of pregnancy
  - At least 1 during the 9<sup>th</sup> month of pregnancy

Note: It is most advisable to visit the health facility every month starting from the month of missed period up to the 9<sup>th</sup> month for uncomplicated pregnancy. For complicated pregnancy, clinic visit is as often as required by the health worker.

6. Complete Blood Count (CBC) and routine urinalysis as early as first trimester is a must to all pregnant.
7. Oral health check – up with the municipal dentist at least twice during the whole duration of pregnancy.
8. Breast examination is done on the first and third trimester.
9. All pregnant with plan of delivering at the Maternal and Child Health Clinic or in any RHU are instructed by the concerned midwife/nurse to have check – up in the facility of choice during the 3<sup>rd</sup> trimester.

#### DEVELOP A BIRTH AND EMERGENCY PLAN

1. The mother together with her partner with the assistance of the health worker or Community Health Team (CHT) member shall accomplish Birth and Emergency Plan in the Family Health Diary (FHD).
2. All pregnant must deliver in a RHU/health center/birthing clinic and attended by a skilled birth attendant (doctor, nurse, midwife)
3. CHT members must know expected date of confinement of pregnant in her area and advise pregnant to call her once labor sign is appreciated
4. CHT members shall accompany pregnant in labor to MCHC or in any RHU for facility delivery.
5. Facility delivery is recommended because: 1.) it has staff, equipment, supplies, and drugs available to provide best care if needed, and a referral system; and 2.) complications are unpredictable and can develop anytime during labor, and delivery.
6. Advise pregnant to enroll in Philhealth if not a NHTS indigent or sponsored member.

During “Buntis Day” there is a 30 minutes allotted schedule on educating the mothers on:

#### ✓ MATERNAL and NEWBORN CARE (Unang Yakap)

Pototan RHU adheres to the standards of rooming –in and breastfeeding. All well infants without complication shall be given to their mothers to hold and caress immediately after birth. The delivery attendant at the RHU-MCHC shall assist the mother to initiate breastfeeding in the delivery room by latching –on. Mothers are advised that:

- It takes few days for the milk to come out. The breast may feel empty but it does not mean that there is no milk.
- It is necessary to wash the breast every feed

- Let the baby suck as often as he wants and as long as he wants
- The baby does not need milk supplements, glucose, water or anything else.
- Colostrum is exactly what a baby needs for the first few days. Do not throw it away.
- Frequent sucking of the breast helps the milk to come out and it is the best way to build up your milk supply.

✓ INFANT and YOUNG CHILD FEEDING and LACTATION MANAGEMENT

Health education on infant and young child feeding is incorporated to other programs. It is also included during the 30 minutes lecture of pregnant mothers during “Araw ng Buntis”.

✓ HYGIENE

Mother and Baby’s hygiene is of paramount importance to avoid infection and acquiring other diseases within and outside the facility as well as the health staff. It is for the reason that hand washing is practiced before and after procedure. They are constantly reminded during consultation check-ups and upon admissions.

✓ HEALTH FINANCING MEMBERSHIP

Pototan Rural Health Unit is PhilHealth accredited as Birthing facility and Primary Care Benefit package provider.

All pregnant women with active Philhealth membership giving birth at MCHC:

- No balance billing
- Provided with complete Maternal Care Package
- Given complete postpartum medications and supplements
- Essential Newborn Care: all newborns are provided with complete essential newborn care
- FREE newborn screening test
- FREE Newborn Hearing Test done at Pototan District RHU

All pregnant women without Philhealth membership giving birth at MCHC (as per Municipal Ordinance):

- Cost of payment for the supplies used at the facility – P 2, 500
- Given complete postpartum medications and supplements

- For the newborn: complete essential newborn care – P 900.00
- Cost of payment of NBS filter card used for **Traditional** newborn screening test – P 600.00
- Cost of payment of NBS filter card used for **Expanded** newborn screening test – P 1,600.00

The strategies used by the Pototan Rural Health Unit in order to reach its objective in making the community aware of health risks present on them and ways on preventing are the following:

1. Health communication which includes verbal and written strategies to influence and empower individuals, populations, and communities to make healthier choices. Through the use of communication channels:

- a. small group
- b. Community level campaigns.

Through:

- Brochures
- Internet
- Social media tool Facebook Account
- Streamers

2. Health Education-One method for putting health promotion and illness prevention plans into action is health education. Health-related learning opportunities are provided by health education. The target audience is taken into account when developing health education initiatives. Health education provides tools to build capacity and support behavior change in an appropriate setting, as well as knowledge to target people on specific health subjects, including the health benefits and hazards they face.

- A. Lecture
- B. Workshop
- C. Classes

### 3. Policy Use

Request for Ordinances and Resolution for commitment of the Barangay Officials and community in the process of implementation

### 4. Systems Change

Developing PPA for implementing new interventions and processes

- Adaption of a proven health promotion model
  - Activation of Barangay Health Board
  - Activation of Barangay Nutrition Committee
- Implementing new technologies

The role of a health promotion officer is to help individuals and communities improve their health by raising awareness of healthy lifestyles, disease and disability, and other health-related issues. They do this by planning and coordinating health promotion programs, developing and delivering educational materials, and working with other organizations to promote health.

Some of the specific responsibilities of a health promotion officer include:

- Identifying health needs and priorities: The first step in any health promotion program is to identify the health needs and priorities of the target population. This involves collecting data on health status, risk factors, and access to health care.
- Planning and implementing health promotion programs: Once the health needs and priorities have been identified, the health promotion officer can begin planning and implementing programs to address them. This may involve developing educational materials, organizing events, or working with other organizations to provide services.
- Evaluating health promotion programs: It is important to evaluate the effectiveness of health promotion programs in order to ensure that they are meeting their goals. This involves collecting data on program participation, knowledge, and behavior change.
- Collaborating with other organizations: Health promotion officers will collaborate with other organizations, such as schools, RHUs, and community groups, to promote health. This can involve sharing information, resources, and expertise.

The materials that a health promotion officer might use include:

- Educational materials: This could include pamphlets, brochures, posters, websites, or even social media campaigns. The materials will be tailored to the target audience and easy to understand and use.
- Visual aids: These could include pictures, graphs, or charts that can help to explain health concepts or promote healthy behaviors.
- Hands-on activities: These could include workshops, demonstrations, or games that can help people to learn about health and make healthy choices.

The most effective health promotion materials are those that are:

- Targeted to the specific needs of the audience: Relevant to the audience's interests and concerns.
- Easy to understand: The materials will be written in clear and concise language.
- Useful: The materials will provide the audience with information that they can use to improve their health.
- Engaging: The materials will be interesting and engaging to the audience.

Health promotion officers play an important role in improving the health of individuals and communities. By using a variety of materials and strategies, they can help people to make healthy choices and live healthier lives.

The Municipal Health Officers appoints a focal person nurse or midwife for Health Promotion alone and be the one to attend trainings and orientations being conducted by PHO or DOH.

## **WORKPLACE PROCEDURES**

**Purpose:**

The main purpose of these policies is to comply with the commitment to promote equitable, safe and dignified workplace and environment both for clients and staffs of the facility. In general, the following steps are recommended;

- ✓ The facility should be open for all and adheres with the existing national policies on Primary Health Care. Before beginning the services, check that equipment is clean and functioning and that supplies and drugs are in place.
- ✓ Keep the facility clean by regular cleaning.
- ✓ At the end of the service:
  - a. Discard litter and sharps safely
  - b. Prepare for disinfection; clean and disinfect equipment and supplies
  - c. Replace linen, prepare for washing
  - d. Replenish supplies and drugs
  - e. Ensure routine cleaning of all areas
- ✓ Hand over essential information to the colleague who follows on duty.

**9. REGISTRATION**

- A. The staff greets clients upon entry and tries to establish rapport to the patient.
- B. The staff prepares the individual treatment record of new patients or retrieves record of old clients from the medical records room through the appointed medical records officer.
- C. The staff elicits and records the client's chief complaint and clinical history through iClinicsys System
- D. The staff performs physical examination on the clients and encode it accordingly in the EMR.
- E. For sick individual with respiratory symptoms, patient will be directed to proceed to the TB out-patient area. All promotive and preventive services shall be at information area.

**10. WAITING TIME**

- A. The staff gives priority numbers to patient's senior citizens, PWD and pregnant
- B. "First come first serve policy" is implemented except for emergency or urgent cases and priorities.
- C. Wait for the queue by calling the number provided in registration area.

**11. TRIAGING**

- A. The trained staff (nurses and midwives) manages program-based cases like IMCI
- B. The staff all non-programs-based cases to the physician. Nurses and midwives provide palliative care to patients in the absence of the physician.
- C. The staff provides first-aid treatment to emergency cases and refers when necessary to the next level of care.



## 12. CLINICAL EVALUATION

- A. The Physician validates clinical history and physical examination
- B. The Physician arrives at evidence-based diagnosis and provides rational drug treatment based on DOH programs and other acceptable treatment algorithms.
- C. The Physician informs the client on the nature of the illness, appropriate treatment, and prevention, and control measures

## II. LABORATORY EXAM

- a. After patient's examination, and laboratory test will be needed, the practitioner shall order the needed exam in the patient individual treatment record.
- b. Laboratory request form shall be fill-out accordingly and properly signed by the requesting practitioner.
- c. The patient shall pay the corresponding price in the treasury office. With the official receipt, proceed to the laboratory for necessary testing requested by the physician.
- d. Wait for the order of Medical Technologist when to get the result/s.
- e. Go back to the requesting practitioner for further assessment and correlation.

***Revision of this policy will be considered whenever there is urgent reasons for new development and new guidelines***

## 4B. EPIDEMIOLOGIC SURVEILLANCE

### a. Purpose

Early identification of an outbreak is important to limit transmission among patients by health care workers or through contaminated materials. A potential problem may be initially identified by nurse, physician, or any other healthcare workers, through surveillance program. Appropriate investigation is required to identify the source of the outbreak, and to implement control measure. The control measures will vary depending on the agent and mode of transmission, but may include isolation procedures or improvements in patient care and environmental cleaning.

### b. Policy Description

- A. The Pototan Rural Health Unit and Birthing and Primary Health Care Facility Municipal Health Office as a primary care provider shall adhere with the policies and procedure set by Philippine Integrated Disease Surveillance and Response.
- B. The facility shall set up and maintain municipal surveillance system equipped with necessary resources.
- C. The Municipal Epidemiology Surveillance Officer of the facility is responsible in systematic planning, implementation and reporting of an outbreak investigation. Care definition shall be developing.
- D. Collect, organize, analyze, interpret surveillance data weekly.

- E. There shall be a proof of weekly submission of Notifiable Disease using the Weekly Notifiable Diseases in the facility to the provincial level.
- F. Report all available essential information (clinical description, laboratory results, number of human cases and deaths).
- G. Establish, operate and maintain the epidemic preparedness according to the principles of PIDSR.
- H. The trained designated DSO and the Head of the Infectious Committee has responsibility in notifying the appropriate individual the facility in the institution. This includes the development of an outbreak team and clear delineation of authority.
- I. Facilitate submission of weekly notifiable reports to the provincial health office.

**c. Procedure**

- A. The out-patient department are being oriented and alert to report to the public health nurse and/or members of the health facility for any patients/clients suspected or confirmed cases immediately upon client's entry.
- B. Reporting of reportable disease/s shall be incorporated in the individual treatment record or medical chart of each patient.
- C. During recording, any notifiable disease seen shall be consolidated daily and to be immediately forwarded to the Disease Surveillance Coordinator for consolidation, analysis and reporting.
- D. Infectious disease or any outbreaks or clusters of disease in a community under Category 1 in CIF, shall be reported within 24 hours to the nearest direct reporting unit.
- E. Report all case of notifiable disease/syndromes under Category II in CIF every Friday of the week.

**DISEASE SURVEILLANCE PROGRAM**

**RESOLUTION ON THE WHOLE OF LGU APPROACH TO COMBAT EMERGING AND RE EMERGING DISEASES HIV/AIDS, TB, DENGUE, INFLUENZA, SARS, WEST NILE VIRUS, MARGBURG VIRUS, COVID19 and BIOTERRORISM**

**POLICY TITLE:**

Policies and Procedure on Reporting of Infections to Personnel and Public Health Agencies

**I.PURPOSE / INTRODUCTION:**

Early identification of an outbreak is important to limit transmission among patients by health care workers or through contaminated materials. A potential problem may be initially identified by nurse, physician, rural health midwives or any other healthcare workers, through surveillance program. Appropriate investigation is required to identify the source of the outbreak, and to implement control measure. The control measures will vary depending on the agent and mode of transmission, but may include isolation procedures or improvements in patient care and environmental cleaning.



## II. POLICY DESCRIPTION:

- J. The Pototan Rural Health Unit and Birthing and Primary Care Facility shall establish and formulate policies and guidelines on surveillance program.
- K. The facility shall designate Disease Surveillance Officer (PHN of RHM) as overseer in the systematic planning, implementation and reporting of an outbreak investigation. Care definition shall be developed.
- L. There shall proof of weekly submission of Notifiable Disease using the PIDSR in the rural health unit to provincial level.

## III. DEFINITION:

**Outbreak-** is defined as an unusual or unexpected increase of cases of a knowledge disease or the emergence of cases of new infection in a particular place or area.

**Case Definition** - includes a unit of time, place and specific biological and/or clinical criteria.

**RHU** - Rural Health Unit

**PESU-** Provincial Epidemiological Surveillance Unit

**RESU** - Regional Epidemiological Surveillance Unit

**CIF** - Case Investigation Form

**DSC** - Disease Surveillance Coordinator

**DRU** - Disease Reporting Unit

**NDRR** - Notifiable Disease Report Registry

## IV. RIGHTS AND RESPONSIBILITY:

The trained designated MESU and the ICN has responsibility in notifying the appropriate individual such as the LCE, the LHB, PHO and the DOH RO6. This includes the development of an outbreak team and clear delineation of authority.

## V. PROCEDURE

- F. The out-patient department are being oriented and alert to report to the public health nurse and/or members of the health facility for any patients/clients suspected or confirmed cases immediately upon client's entry.
- G. Infectious disease or any outbreaks or clusters of disease in a community under Category 1 in CIF, shall be reported within 24 hours to the nearest direct reporting unit.
- H. Report all case of notifiable disease/syndromes under Category II in CIF every Friday of the week to the nearest DSU.

## VI. MONITORING:

- A. 24/7 Monitoring of reportable disease and Encode
- B. Endorsement outbreak tracing or clustering

C. Reports Increase or Decrease in incidence of mortality/morbidity cases

D. Evaluation

E. Weekly NDRR

## **VII: INTERNAL MESU COMMITTEE**

Jean Domingo- PIDSR Focal person

Aura Marie Ceballos-Cold Chain Vaccine Handler

Ronel Pendon Encoder and Uploader of Report

## **VII. DESSIMINATION:**

A. Memorandum

B. Orientation

C. Continuing education, training & seminar.

## **VIII. REFERENCE:**

Philippine Integrated Disease Surveillance and Response under R.A 3573(Law of Reporting Communicable Disease to local and national public health authorities)

### **I. PREVENTION/PREPAREDNESS**

#### **A. GENERAL**

#### **HUMAN**

1. Adequate Knowledge on Basic Disease Transmission through BHERTS once a week education class
2. Provision of Water system for adequate supply of water (Local Government Code Implementation) with MPDC as lead agency and engineering as implementer  
Task Force for Water System to Ensure Adequate Water Supply  
Chairman: MPDO  
Vice Chairman: ME  
Members:
3. Practice of hand washing at home
4. Implementation of Smoking Ordinance (amendment as to prohibition among drivers of PUJ while driving.

#### **BARANGAY**

1. BHERT to have a once a week lecture on Infection Prevention (Every Friday or Saturday)
2. Barangay F1 K lecture 2x a week for every purok on malnutrition prevention (Lead by Barangay Nutrition Council)
3. Food Sufficiency Program for House Holds with 0-5 years old children, pregnant women and postpartum partner with 4Ps (partnership with NGO-Holistic Living Center for Community Development Inc.)
4. Functional and Clean Drainage System  
Task Force Clean Up Drainage



Chairman: MDRRMC

Vice Chairman: ME

5. Clean up of vacant lots by lot owners

Chairman: MTO

Vice Chairman:

Members: Job Orders

6. Issuance of Certificate of Clean and Free of Empty Bottles and Plastics Vacant Lots by the barangay prior to payment of RPT

## **SCHOOLS**

- 1 Collaboration with Schools in the Municipality to have lectures on Common and Infectious Diseases be incorporated focusing on transmission and prevention.
- 2 Create Awareness on available Municipal Ordinances and resolution to the students
- 3 Provision of Wash Area at a strategic place for all students prior to entrance to school
- 4 Provision of Foot Bath

## **BOUNDARIES**

1. Presence of checkpoints lead by the barangay in case of outbreaks as defined by WHO but for epidemics and pandemics national policy will over rule

## **PUBLIC PLACES**

### **Market and Business Establishment**

1. Increase frequency of market days to 3x in a week market
2. Screening of Ambulant Vendors as to:
  - 1.Mandatory wearing of health cards
  - 2.1 Meter distancing of each vendor
3. Marking of passageway to maintain social distancing to include all business establishment
4. Provision of Foot Bath
- 5.Mandatory Face Mask
6. Provision of Wash Area at Market Entrance

## **SECURITY and ORDER**

- 1.Continue check point to monitor

## **GOVERNMENT AND RELIGIOUS GATHERING PLACES SUCH AS COLISEUM, SPORTS COMPLEX, PUBLIC PLAZA CHURCHES, TERMINALS**

1. Must observe social distancing at all times
2. Must wear mask all the time
3. Provision of Disinfectant at the Entrance
4. Must have schedule of disinfection prior and after use

## **PUBLIC COMFORT ROOMS**

1. Maintenance and Improvement of Comfort Rooms
2. Provision of Disinfectants

## **TRANSPORTATION**

1. Overcrowding PUV
  1. Provision partition side and middle (plastic)
  2. Maintain Social Distancing
2. Mandatory use of mask inside the PUJ

## **SPECIFIC TASK AND WARNING SYSTEM**

### **A. LCE**

**Pre planning and Preparation on Local Task Force**

### **B.**

#### **MDRMMC**

1. Preparation of Incident Action Plan

### **C. PUBLIC HEALTH**

#### **ALPHA CODE BLUE**

LGU has no known local case of COVID

1. Preparation of Incident Action Plan
2. Organize Incident Management Team
3. Contact Tracing Team and Notification System
4. Test Surveillance
5. Rapid Needs Assessment
6. Prepositioning of Health Care Equipment and Supplies
7. Trainings and Orientation of HCW and members of BHERT
8. Identification of Vulnerable and high-risk areas and population groups
9. Timely and Accurate Information

#### **C. DSWD**

1. Updated Listing of 4Ps, Listahanan, Vulnerable Groups, Informal Sectors of Labor Group
2. Preparation of Social Safety nets

#### **D. PNP**

1. Monitoring of ingress and egress of people into and out of community especially from areas where there is confirmed local transmission for possible vectors and carriers.

#### **E. Engineering**

1. Construction of Community Quarantine Facility
2. Secure Communication and Information Lines

## II. MITIGATION BRAVO CODE ORANGE

Alert Sublevel 1

### A. MDRRMC

1. Activation of Emergency Command Center
2. Implementation of Incident Action Plan
3. Spearhead in the regular meetings, update, coordination and decision making

### B Health

1. Set up platforms for information dissemination and health education (Social Media Apps, Chat Box, TeleHealth, TelePsychosocial Support)
2. HOTLINES
3. Activation of BHERTS for Contact Tracing

### C. DSWD

1. House Hold Profiling of the Vulnerable Population Groups
  - a. Elderly
  - b. Lifelong Conditions
  - c. Immunocompromised
  - d. Pregnant
  - e. Social /economics safety nets (e.g. TUPAD, program of DOLE, AICS are in place ready to assist disadvantage populations)

### E. PNP

1. Implement Social Re Engineering Measure to include  
Physical Distancing  
Prohibition of Mass Gathering

### F. Barangay Government

1. Household place under home quarantine shall be provided with basic physiological needs (food and non-food items)

### Engineering

1. Transfer and Transport of Logistics

### G. Faith Base Organization, NGO and volunteers

1. Provide Psychosocial Support
2. Identify ways to promote Bayanihan spirit to promote social solidarity

## III. RESPONSE

### BRAVO CODE RED

Alert Sublevel 2

### LCE

1. Issue Directives for Implementation of ECQ
2. Establish community protocols for community quarantine measures
  - Curfew hours

- Quarantine Pass
- Provision of transportation for frontliners in essential services
- Provision of support systems for families of frontliners

#### MDRRMC

1. Prepare and submit situational report to LCE and other National Government Agency
2. Conduct daily command conferences in order to monitor progress of incident
3. Update and amend IAP as needed

#### HEALTH

1. Operationalize Community Isolations
2. Activate referral system for admission and testing of suspected and probable cases
3. Close coordination with funeral parlors and religious group for culture sensitive management of the dead

#### FAITH BASE ORGANIZATION, NGO AND VOLUNTEERS

1. Provision of Psychosocial Support
2. Community Solidarity Activities

#### BARANGAY GOVERNMENT

1. Activation of BHERTS
2. Reporting of Susceptible and suspected COVID to MESU

### IV RECOVERY BLUE PRINT

#### FOOD SUFFICIENCY

##### DA

- Backyard Gardens
- Individual Farming and Livestock Growing
- Barangay Cooperatives

##### DSWD livelihood

##### LEPO

##### TRADING

##### SMALL SCALE BUSINESSES

- Physical Store
- Online Store

##### PESO

- Employment

##### TOURISM

- Tourist areas

##### DA

##### LIVESTOCK INDUSTRY

- NGO/cooperatives

##### MANUFACTURING



SMALL SCALE MANUFACTURING INDUSTRY SUPPORT  
SPORTS and LEISURE  
UNIFIED TASK FORCE FOR POLICY IMPLEMENTATION

Chairman- PNP  
MDRRMC-  
HEALTH  
MARKET -  
Engineering

Implementation of Minimum Health Risk Protocol (Dengue, COVID etc.)  
First Offense- Reprimand (Education Community Service)  
Second Offense-Imprisonment  
Implementation of Smoking Ordinance  
Anti-Littering Ordinance  
Comprehensive Solid Waste Ordinance  
Drainage Inspection – Task Force issue notice to PB  
Other Offices for JO additional jo

**Operational Guidelines on QUARANTINE FACILITY**  
**Quarantine Facility Manager**

**Support Members: Aura Ceballos**  
**Cristina Tabladillo**

**Jessahlyn Parreno Subade**

**COMMITTEE ON CLEAN UP**

Chairman: Rudy Parcon

Vice Chairman: Ramona Porras – 09158954399/09494963201–Incident Commander on Health  
Logistics

Members: all plaza utility

Responsibility:

1. Initial clean-up of quarantine facility
2. After use clean-up of quarantine facility
3. Move out of school fixtures
4. Placement of amenities

**COMITTEES ON DISINFECTION and WASTE DISPOSAL**

Chairman: Richard Pendon – 09193718459 / 09279117655

Incident Commander for Risk Reduction

Vice Chairman: - Heide Dolorota

Members: MDRRMC Unit

Mountain Tigers

Responsibilities:

1. Pre disinfection of quarantine facility
2. Post disinfection of facility  
Provision of garbage bag/container w/ receptacle  
Contamination prior collection



- Every other day / scheduled of disinfection of surrounding facility

### **COMMITTEE ON DISCIPLINE, ORDER AND SAFETY**

Chairman- COP

Vice Chairman-

Members: All PNP Units authorize only

PhiArmy Reservist authorize only

Responsibilities:

1. Secure the area from unauthorized people
2. Secure that PUMS are confine only to the allowed area
3. Secure security of PUMS from threat of the community

### **COMMITTEES ON TRANSPORTATION**

CHAIRMAN- CARELL GONZALES -

Vice Chairman- Cecile Pavorito - 09515962555

Members- MDRRMC Unit

Nilo Saranillo

### **COMMITTEE ON WATER SUPPLY**

Chairman- BFP Chief

Members

1. Flushing facility before and after
2. Water supply for QF

### **COMMITTEE ON FOOD**

Chairman: Rhea Bolivar - 09995507923

Members: POMECCO

### **COMMITTEE ON TRANSPORTATION Bldg. Maintenance & Repair**

Chairman: Engr. Adolacion

Members: Engineering Dept.

1. Transportation and bldg. maintenance / repair

### **COMMITTEE ON ELECTRICAL**

Chairman: Noli Parrenas – 09213580136

Vice Chairman

1. Responsibilities

1. Steady power supply
2. Trouble shoot electrical problems with authorization according to IPC protocol
3. Standby generator

### **COMMITTEE ON DOCUMENTATION and REPORTING**

Chairman: Lyndie Aventura RSI

Vice Chairman: Warlito Victorio Escaner-DILG

### **PERSON UNDER MONITORING HOUSE RULES**



1. Must maintain 1-meter distance with fellow PUM inside and outside the QF
2. Must wash hands every hour for 20 minutes
3. Must observe cough etiquette
4. Must be responsible in disinfection of fixtures in their place of confinement
5. Must have no contact policy with authorize Quarantine Facility personnel
6. Must get their food at area assigned
7. Must dispose their utensil at area assigned for disinfection and proper disposal
8. Must respect each other's privacy
9. Must follow quarantine rules at all time
10. Must wash their own clothes at a designated area
11. Must take care of Schools Facilities
12. Must use facemask at all times

#### **4C HEALTH PROTECTION: VECTOR CONTROL Population Base Services**

##### **Purpose:**

Vector control involves using preventive methods to eradicate or control vector populations, in order to limit the transmission and spread of diseases. Preventative measures include;

- ✓ **Habitat control:** Removing or reducing the number of places where the vector can breed helps to limit populations from growing excessively. For example, by removing stagnant water, removing old tires and empty cans which serve as mosquito breeding habitats and through good management of used water.
- ✓ **Reducing contact with vectors:** Reducing the risk of exposure to insects or animals that are vectors of diseases can limit the risk of infection. For example, using bed nets, adding window screens to homes, or wearing protective clothing can help reduce the likelihood of coming into contact with vectors. An important component of exposure reduction is also the promotion of health education and raising awareness of risks. Bed nets treated with insecticide can reduce the risk of insect bites and infection.
- ✓ **Chemical control:** Insecticides, larvicides, rodenticides and repellents are used to control pests and can be used to control vectors. For example, larvicides can be used in mosquito breeding zones; insecticides can be applied to house walls (indoor residual spraying); bed nets treated with insecticide and use of personal skin repellents can reduce the risk of insect bites and thus infection. The use of pesticides for vector control is supported by the World Health Organization (WHO) and has proven to be highly effective.

a. Dengue is a mosquito-borne disease that can be prevented by controlling the mosquito vector. There are two main vector control measures:

- Source reduction: This involves eliminating or reducing the number of places where mosquitoes can breed. This includes emptying and scrubbing containers that hold water, repairing holes in screens, and disposing of tires and other debris that can collect water.
- Insecticide application: This involves using insecticides to kill mosquitoes or prevent them from breeding. This can be done by spraying insecticides on the ground, in water, or on surfaces where mosquitoes rest.

Fogging- Fogging is a technique used to kill mosquitoes by spraying a fine mist of insecticide into the air. The insecticide used in fogging is typically a synthetic pyrethroid, which is a type of pesticide that is highly effective at killing mosquitoes.

Fogging is a relatively effective way to kill mosquitoes, but it is not a permanent solution. The insecticide used in fogging will only kill adult mosquitoes, so it is important to also take steps to control mosquito breeding sites.

Here are some of the benefits of using fogging to kill mosquitoes:

- It is a relatively quick and easy way to kill a large number of mosquitoes.
- It can be used in areas where it is difficult to reach with other methods, such as dense vegetation or swamps.
- It can be used to control mosquito populations in a wide area.

However, there are also some drawbacks to using fogging to kill mosquitoes:

- The insecticide used in fogging can be harmful to humans and other animals.
- It can be difficult to target the insecticide specifically to mosquitoes, so it may also kill other insects.
- The insecticide used in fogging can be washed away by rain, so it may need to be applied repeatedly.

Overall, fogging can be an effective way to kill mosquitoes, but it is important to weigh the benefits and drawbacks before using it. If you are considering using fogging, it is important to talk to your local health department to get more information about the risks and benefits.

Here are some additional tips for using fogging to kill mosquitoes:

- Fogging should only be used as a last resort, after other methods of mosquito control have been tried.
- Fogging should only be done in areas where there is a risk of mosquito-borne diseases.
- Fogging should be done by a qualified professional.
- People and pets should be kept away from the area being fogged.
- The area should be ventilated after fogging.

In addition to these two main measures, there are a number of other things that can be done to prevent dengue, such as:

- Wearing long sleeves and pants: This will help to protect your skin from mosquito bites.
- Using insect repellent: Insect repellents that contain DEET, IR3535, or picaridin are effective at preventing mosquito bites.

- Sleeping under a mosquito net: This will protect you from mosquito bites while you sleep.
- Keeping your home cool: Mosquitoes are more active in warm weather, so keeping your home cool will help to reduce the number of mosquitoes that enter your home.

Here are some additional tips for mosquito vector control:

- Education of the community about dengue and how to prevent it.
- Work with Engineering to improve sanitation and drainage.

## COMMITTEE ON WASTE MANAGEMENT IN PREVENTING DENGUE OUTBREAK

### 1. Infrastructure (MENRO)

Private Partnership for Garbage Truck priority areas

Mandatory MRF- Noncompliance Penalties

Activation on Committee of Environment-Done by MENRO

Legislative -Policy Support Adopted at Barangay Level

Clogged Drainage – Identification of areas: San Jose Area (DBP), Ledesma (Rizal)

Legislative-Drainage outflow identification-Brgy. level (Policy Support)

Clean Up Drive to Include De clogging

### 2. Behavior Change (Legislative Measures)

Check List-Per HH

Negative Motivation and Positive Motivation

Go Green -MENRO-and SK

Advocacy on impact of water storage resulting to increase in dengue case

Education on consistent Cleaning Practice among HH-Day Care, DE PED incorporation to Brigada

Eskwela

DSWD

Inclusion of Dengue Advocacy to Monthly FDS

Inclusion of Clean up to Cash for Work (last day 4S) (KALAHICIDSS)

### 3. Climate Change Measures

Legislative Policy on softening the impact

### 4. Treatment

Strengthen Bloodletting Activities

Sustainable Hydration

## ACTION PRIORITY MATRIX

IMPACT

High Impact: Low Effort Yes <b>Re Orientation at Brgy. Level Solid Waste Management: Officials BHERTS Clustering: 25 Brgys-1 day 25 brgys-1 day Mandatory MRF Behaviour Change Strategy through Legislation</b>	High Impact: High Effort Maybe
Low Impact: Low Effort Maybe	High Effort: Low Impact No

EFFORT

### DENGUE ALERT LEVEL

Cluster- > 3 or more cases in 4 consecutive weeks in the same barangay

Blue- < 5 cases in barangay in different area

Barangay Level- Advocacy:

**Seek and Destroy House to House Strategy**

Early Consultation

Application of Larvicidal and Chemical in selected areas

Epidemiology Surveillance RHU- Raisa Teodosio

Jean Domingo

Jessahlyn Subade

Orange – clustering of cases in 1 barangay alone

Advocacy:

Seek and Destroy Strategy

Early Consultation

Application of Larvicidal and Chemical in selected areas

Epidemiology Surveillance RHU- Raisa Teodosio

Jean Domingo

Jessahlyn Subade

PLUS

Fogging on Affected Cluster Cases (Purok/Sitio)



## Red-> 2 or more cluster in barangays

Advocacy:

Seek and Destroy Strategy  
Early Consultation  
Application of Larvicidal and Chemical in selected areas  
Epidemiology Surveillance RHU- Raisa Teodosio  
Jean Domingo  
Jessahlyn Subade

PLUS

Fogging Affected Cluster Cases (Purok/Sitio)  
Establish ICS  
Activate Alert Level  
Set Up Hydration  
Epidemic level reached base dengue epidemic alert threshold-DOH  
MDRRMC Council Meeting- Declaration of State of Calamity- 2 or more barangays doubled from previous year, > 2 mortalities  
Presence of Uncollected and Non segregated garbage's-  
Absence of MRF  
Re Orientation at Brgy Level Solid Waste Management: Officials and community  
Reduce ReUse ReCycle  
Resource Speaker from Environmental and DILG  
Advocacy and Instruction Materials

## b. LEPTOSPIROSIS VECTOR CONTROL

Leptospirosis is a bacterial infection that can be spread to humans through contact with the urine of infected animals. The main vectors of leptospirosis are rodents, but other animals, such as cattle, pigs, and dogs, can also be infected.

There are a number of vector control measures that can be used to prevent the spread of leptospirosis:

- Source reduction: This involves eliminating or reducing the number of places where rodents can live and breed. This includes cleaning up garbage and debris, repairing holes in buildings, and sealing up cracks in foundations.
- Rodent control: This involves using traps, baits, and other methods to kill rodents.
- Insecticide application: This involves using insecticides to kill mosquitoes or prevent them from breeding. This can be done by spraying insecticides on the ground, in water, or on surfaces where mosquitoes rest.
- Education: This involves educating people about leptospirosis and how to prevent it. This includes teaching people about the importance of handwashing, avoiding contact with contaminated water, and wearing protective clothing when working with animals.

Here are some specific examples of vector control measures that can be used to prevent leptospirosis:

- Source reduction: In rural areas, this might involve clearing brush and debris from around homes and buildings to make it less likely that rodents will live there. In urban areas, this might involve cleaning up garbage and debris from streets and alleyways.
- Rodent control: This might involve using traps, baits, or fumigants to kill rodents. It is important to use methods that are effective and safe for humans and the environment.
- Insecticide application: This might involve spraying insecticides on the ground, in water, or on surfaces where mosquitoes rest. It is important to use insecticides that are effective against leptospirosis-carrying mosquitoes and that are safe for humans and the environment.
- Education: This might involve teaching people about the signs and symptoms of leptospirosis, how to prevent it, and what to do if they think they have been infected. It is important to make sure that people have access to accurate information about leptospirosis.

The Rural Sanitary Inspectors with the midwives are tasked to educate the community and discuss rodents control with the Barangay officials through the Barangay Health Board on steps to undertake. Farm areas that are swampy and near the open dump site are targeted each year since they are recurrently with cases.

#### **4C. Health Protection: Environmental Health Work Place Risks**

A number of environmental hazards that can be present in the workplace of a primary care facility. These hazards can include:

- Biohazards: Biohazards are materials that contain infectious agents, such as blood, body fluids, and tissues. These materials can pose a risk of infection to healthcare workers and other people who come into contact with them.
- Chemical hazards: Chemical hazards are materials that can be harmful to human health if they are inhaled, ingested, or absorbed through the skin. These materials can include cleaning products, medications, and other chemicals used in healthcare settings.
- Physical hazards: Physical hazards are materials or conditions that can cause injury, such as sharp objects, slippery surfaces, and electrical hazards.
- Radiation hazards: Radiation hazards are materials or conditions that can expose people to radiation. These materials can include radioactive isotopes used in medical procedures and x-ray machines.
- Ergonomic hazards: Ergonomic hazards are conditions that can cause pain or injury to the musculoskeletal system. These conditions can include poorly designed workstations, repetitive tasks, and heavy lifting.

It is important to take steps to prevent exposure to these hazards in the workplace of a primary care facility. This can be done by implementing safety procedures, using personal protective equipment, and providing training to employees on how to identify and avoid hazards.

Here are some specific examples of environmental hazards that can be present in a primary care facility:

- Biohazards: Blood, body fluids, and tissues from patients who are infected with diseases such as HIV, hepatitis B, and hepatitis C.



- Chemical hazards: Cleaning products, medications, and other chemicals used in healthcare settings.
- Physical hazards: Sharp objects, slippery surfaces, and electrical hazards.
- Radiation hazards: Radioactive isotopes used in medical procedures and x-ray machines.
- Ergonomic hazards: Poorly designed workstations, repetitive tasks, and heavy lifting.

It is important to take steps to prevent exposure to these hazards in the workplace of a primary care facility. This can be done by implementing safety procedures, using personal protective equipment, and providing training to employees on how to identify and avoid hazards.

Here are the facility's ways for preventing exposure to environmental hazards in a primary care facility:

- Use personal protective equipment (PPE): This includes gloves, gowns, masks, and eye protection.
  - Following safety procedures: This includes washing your hands frequently, disposing of hazardous materials properly, and using equipment safely.
  - Being aware of your surroundings: This includes paying attention to slippery surfaces, electrical hazards, and other potential hazards.
  - Report hazards to your supervisor: If you see a hazard, report it to your supervisor so that it can be corrected.
1. Pototan Rural Health Unit and Birthing and Primary Health Care Facility Municipal Health Office accepts full responsibility for protecting workers and the environment.
  2. Give health, safety and environmental considerations and integrate them into all aspects of work.
  3. Work actively to continuously improve health, safety and environmental performance.
  4. Only start work after confirming that essential health, safety and environmental protection systems are in place, and willingly suspend activities if safety, health or the protection of the environment would be compromised.
  5. Encourage supervisors and workers to be individually responsible for identifying and eliminating hazards, preventing injury to themselves and others, and preventing adverse environmental impacts.
  6. Provide personnel with sufficient training, resources and systems.
  7. Provide and maintain properly the laboratory and equipment's to avoid health care worker infection.
  8. Minimize waste generation proper ventilation and air emissions and other discharges from our activities to the environment.
  9. Actively monitor, audit and review to improve systems, processes, health, safety and environmental performance.

10. As a minimum, ensure regulatory compliance at all times.
11. Hold everyone accountable for ensuring and promoting a safe and healthful workplace and the protection of the environment within their areas of responsibility by ensuring that workers are knowledgeable and have access to:
  - health, safety and environment rules and safe work standards
  - operating and critical task procedures
  - emergency response procedures
  - environmental protection requirements
12. Shall comply with all existing national policies and regulations.

#### **4C. Health Protection Community Risk**

**A comprehensive list of policies and committees is encoded in Disaster Risk Reduction Plan for Health or HEPRRP of the Health Facility**

#### **ENVIRONMENTAL HAZARDS**

If environmental hazards like flooding, typhoon, earthquake, water contamination, and air pollutants occur in your municipality: Community Education Tips on What to Do

- **Flooding:**
  - If you live in a flood-prone area, make sure you have a plan in place in case of flooding. This plan should include knowing where to go if you need to evacuate, and having a way to contact your family and friends.
  - If flooding occurs, stay away from floodwaters. Floodwaters can be contaminated with sewage and other dangerous materials.
  - If you must drive through floodwaters, do so slowly and carefully. Avoid driving through areas where the water is deep or where there is debris.
- **Typhoon:**
  - If a typhoon is approaching, listen to local news and weather reports for updates on the storm's path and severity.
  - If you live in an area that is likely to be affected by the typhoon, take steps to secure your home and belongings. This may include boarding up windows, moving furniture to higher ground, and filling sandbags.
  - If you are told to evacuate, do so immediately.
- **Earthquake:**
  - If you feel an earthquake, drop, cover, and hold on. This means getting under a sturdy piece of furniture and covering your head and neck with your arms.
  - Stay away from windows and doors, and avoid using elevators.
  - If you are outside, move to a clear area away from buildings and trees.
- **Water contamination:**
  - If you are told that your water supply is contaminated, do not drink the water. Boil water for at least one minute before drinking it, or use bottled water.



- Avoid contact with contaminated water, and wash your hands frequently with soap and water.
- Air pollutants:
  - If you are told that the air quality is unhealthy, stay indoors and avoid strenuous activity.
  - If you must go outside, wear a mask to protect your lungs.
  - Monitor the air quality for updates, and follow the instructions of local officials

#### **4C. Health Protection: Occupational Health Hazard**

##### **The Pototan Rural Health Unit Birthing and Primary Care Facility shall adopt the Occupational Safety and Health Standards of 2017**

The Occupational Safety and Health Standards (OSHS) 2017 in the Philippines provides a number of provisions that are applicable for an urban community surrounded by farmland like Pototan. These provisions include:

- Hazard identification and assessment: The LGU/ Employers are required to identify and assess the hazards present in the workplace, including those that may be associated with the presence of farmland. This includes hazards such as exposure to pesticides, fertilizers, and other agricultural chemicals.
- Risk control: The LGU/Employers are required to implement measures to control the risks associated with the hazards identified in the workplace. This may include measures such as providing personal protective equipment, training employees on how to handle hazardous materials, and implementing safe work practices.
- Emergency preparedness: Employers are required to have an emergency preparedness plan in place in case of an accident or other emergency. This plan should include procedures for evacuating employees, providing first aid, and contacting emergency services such as BLS, Safety First Aid, Bomb Threat and Fire Drill.
- Information and training: LGU/ Employers are required to provide employees with information and training on occupational safety and health. This information and training should be tailored to the specific hazards present in the workplace.

In addition to these provisions, the OSHS 2017 also includes a number of other provisions that are applicable to all workplaces, regardless of whether they are located in an urban community or surrounded by farmland. These provisions include provisions on:

- Health surveillance: LGU/Employers are required to monitor the health of employees who may be exposed to hazardous substances.
- Recordkeeping: LGU/ Employers are required to keep records of occupational accidents and injuries.
- Inspection: The Department of Labor and Employment (DOLE) is authorized to inspect workplaces to ensure compliance with the OSHS 2017.

By following the provisions of the OSHS 2017, LGU employers can help to protect the safety and health of their employees who work in urban communities surrounded by farmland.



- Education of the community on awareness of the hazards associated with agriculture: Pesticides, fertilizers, and other agricultural chemicals can be hazardous to human health. Employers should be aware of the hazards associated with these substances and take steps to control the risks.
- Provision of training to employees: Employees should be trained on how to handle hazardous substances safely and how to respond to accidents.
- Emergency plan in place: In case of an accident, employees should know what to do to stay safe. Employers should have an emergency plan in place that outlines the procedures for evacuating employees and providing first aid.
- Monitor the health of employees: Employees who are exposed to hazardous substances should be monitored for health problems. Employers should keep records of the health of these employees and report any problems to the DOLE.

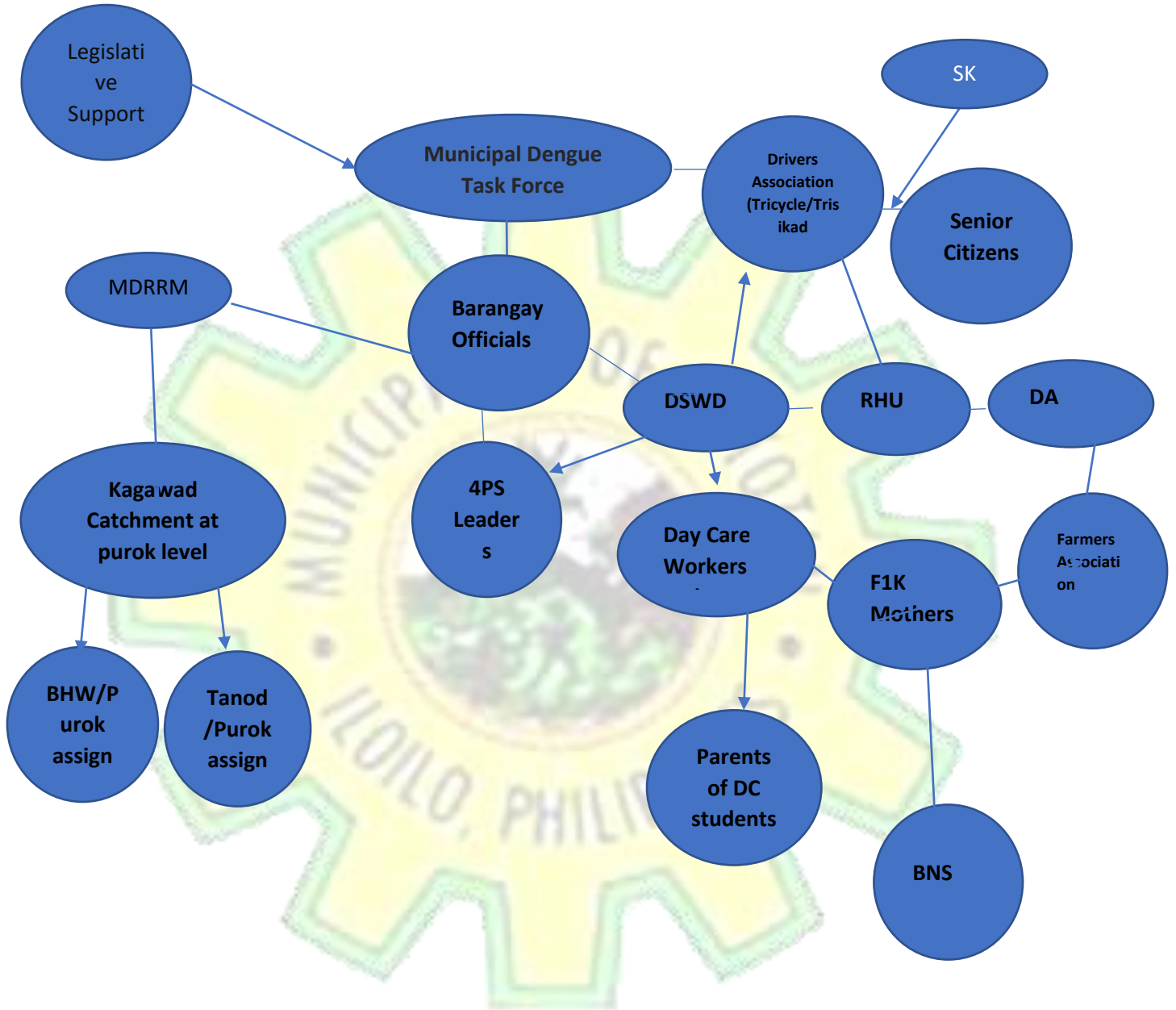
1. Specific to the organization and appropriate to its size and the nature of its activities;
2. Concise, clearly written, dated and made effective by the signature or endorsement of the employer or the most senior accountable person in the organization;
3. Communicated and readily accessible to all persons at their place of work;
4. Reviewed for continuing suitability;
5. Made available to relevant external interested parties

The OSH policy should include, as a minimum, the following key principles and objectives to which the organization is committed:

1. Protecting the safety and health of all members of the organization by preventing work-related injuries, ill health, diseases and incidents;
2. Complying with relevant OSH national laws and regulations, voluntary programs, collective agreements on OSH and other requirements to which the organization subscribes;
3. Ensuring that workers and their representatives are consulted and encouraged to participate actively in all elements of the OSH management system;
4. Continually improving the performance of the OSH management system.
5. The OSH management system should be compatible with or integrated in other management systems in the organization.

**PROCESS FLOW OF REFERRAL FROM BARANGAY LEVEL INNOVATION**

**Municipal Disease Surveillance Organizational Structure**



Key program strategies. This is through a combination of health education, environmental sanitation and community mobilization.

### **DOH Regional Office 6 and Provincial Health Office**

Support systems (1) Training – Training of coordinators and field implementors, including orientation meetings of key leaders of community, is one of the key elements of this new programme.

(2) Health education – Long-term control and prevention is based on properly informed community that understands and practices dengue prevention and control measures at their own capability level. This will facilitate participation of the community and governmental organizations (GOs), NGOs and POs.

(3) Laboratory facilities/diagnostic support – For proper clinical diagnosis of dengue, laboratories are to be supported to be able to do platelet and hematocrit determination.

(4) Rapid response emergency mosquito control – This support strategy is in place to immediately contain an incipient outbreak before it spreads to other areas. This approach includes chemical control of the vectors combined with other integrated vector control approaches.

(5) Epidemic contingency planning – This includes estimating resources needed during outbreak management so that a ready plan of action can be immediately implemented.

(6) Research and project development – Basic and operational research is encouraged for improvement of program implementation. Program policies

(1) The National Dengue Prevention and Control Program shall be a community-based and community managed program

(2) The Department of Health shall support an integrated vector control approach and decentralization of decision-making.

(3) Chemical management in the control of dengue shall be confined to areas with confirmed dengue outbreaks

## 4C Health Protection: FOOD SAFETY MEASURES

### 1A. Issuance of Sanitary Permit to Operate

#### 3. SANITATION INSPECTION AND ISSUANCE OF SANITARY PERMIT

##### Types of Inspections

- **Routine Inspection:** This is a scheduled inspection, unannounced to the restaurant. The Rural Sanitation Inspector conducts a complete inspection covering all items in the regulations for compliance.
- **Follow-up Inspection:** This is an inspection for the specific purpose of re-inspecting critical violations that were not in compliance at the time of the routine inspection.
- **Critical Control Point Inspection:** This type of inspection, which is conducted in food service operations, involves analyzing recipes and tracking potentially hazardous foods from the loading dock to the table, to assure all food is safe and wholesome.
- **Process Review Inspection:** This type of inspection, which is conducted in retail food establishments, involves analyzing recipes and tracking potentially hazardous foods from the loading dock to the table, to assure all food is safe and wholesome.
- **Complaint Inspection:** This is an inspection conducted as a result of a complaint received by the Municipal Health Office. The specifics of the complaint will be evaluated and discussed with the person in charge.
- **Foodborne Illness Investigation:** Foodborne illness complaints are received and a food inspector conducts an inspection at the facility reported to be involved in the foodborne illness. The inspection focuses on food source, storage practices, food processing techniques, food handling and employee practices.
- **Training:** The inspector visits the restaurant to present a formal training event for the restaurant's staff.

## **STEPS IN ISSUANCE OF SANITARY PERMIT**

### **Application Process**

1. Secure a checklist of requirements for securing sanitary permit/health cards at the Business Permits and Licensing Office (BPLO). The Licensing officer issues checklist of requirements.
2. Pay the corresponding laboratory fee at the Municipal Treasury Office
3. After payment, applicant will present official receipt to Medical technologist for the processing of laboratory examination. (HAV, HBsAg, fecalalysis)
4. Processing time is 45 minutes to 1 hour.
5. Results are released directly to client if results are normal, but if there are abnormalities (if HAV/HBsAg is reactive), will proceed to the MHO for plan of treatment and health education.
6. If negative results, RSI will issue a temporary Sanitary permit pending inspection of establishment

### **A. Approval of Sanitary Permit**

#### **Receiving of Application and Other Requirements:**

1. Sanitation Inspector shall verify the transaction number from the application for business permit issued by the Business Permit and Licensing Office.
2. Sanitation Inspector shall verify the transaction number indicated in the assessment form issued by the Municipal Planning Office.
3. Sanitation Inspector shall verify the line of business of applicant;
4. Shall check requirement as for business type for compliance, as applicable;
  - Food Establishments: Yellow Health Certificates, Food Handler's Orientation Certificate and Working Permits
  - For water refilling station, shall comply with the additional requirements: Certificate of Potability for Drinking Water, Sanitary Engineer's report, Certificate of Water Operator's Course, monthly bacteriological tests, bi-annual physical and chemical tests.
  - Non-Food establishments: Green Health Certificates and working permits



## B. Scheduling of Inspection

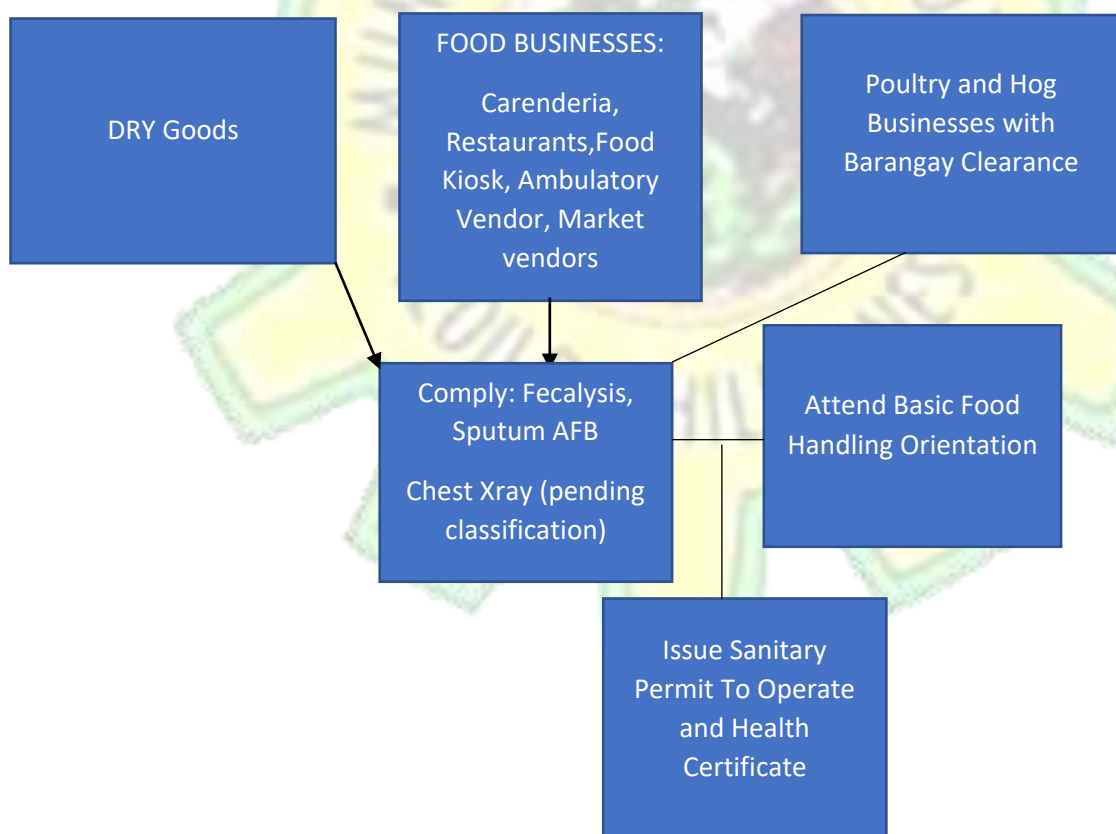
1. For new food establishments, the Sanitation Inspector shall do ocular inspection of the business establishment.
2. Two (2) working days are allotted for the inspection activity, reckoned from the date of endorsement.

## C. Inspection Process

1. Sanitation Inspector shall inspect the establishment, if necessary, especially for new establishments on the business type and compliance to sanitation requirements as filed.
  - Use the checklist corresponding to the type of the establishment.
  - For medical and dental laboratories, shall present health care waste management plan.

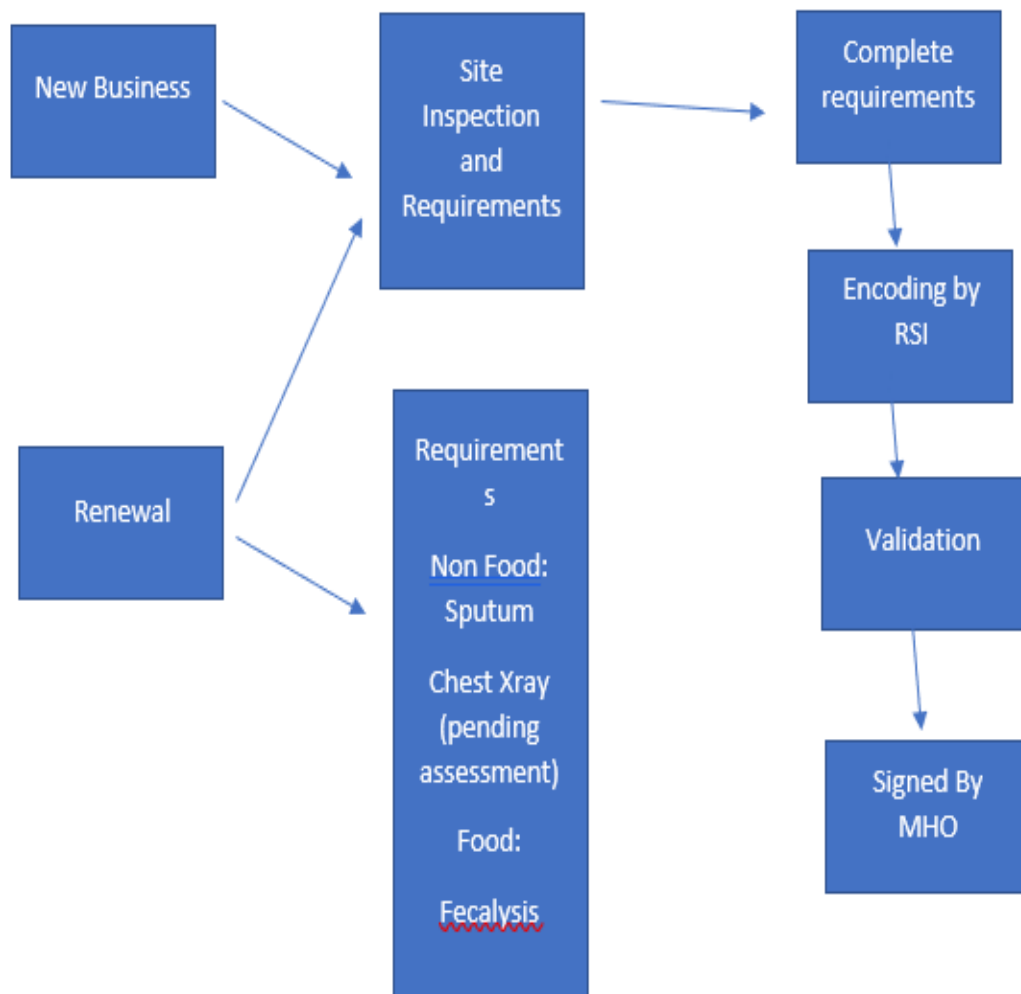
## D. Approval of Sanitary Permit

Once all requirements have been complied with, the Sanitation Inspector shall approve and issue final sanitary permit.



## Sanitation Inspection and Issuance of Sanitary Permit

Sanitary Permit means **the official document issued by the Department of Public Health and Social Services authorizing the establishment to operate its business.**



## 4C 1B Food Safety Process Flow

**Food Safety** is the assurance/guarantee that food will not cause harm to the consumers when it is prepared and/or eaten according to its intended use.

**Food and Water-borne Diseases** is group of illness caused by any infectious (bacteria, viruses and parasites) and non-infectious agents (chemical, animal and plant toxins).

### Common Causes of Food and Water Borne Diseases

- unsafe sources of drinking water
- improper disposal of human waste
- unhygienic practices like spitting anywhere, blowing or picking the nose
- unsafe food handling and preparation practices i.e., street vended foods

### Five Keys to Safer Food (Source: WHO)

1. Keep Clean.
2. Separate raw and cooked foods.
3. Cook foods thoroughly.
4. Keep food at safe temperatures.
5. Use safe water and raw materials.

### In case of Suspected Foodborne Illnesses

1. Preserve the evidence. If a portion of the suspected food is available, wrap it securely “danger” and freeze it.
2. Seek treatment as necessary. If symptoms persist or are severe (i.e., bloody diarrhea, excessive nausea and vomiting or high temperature), immediately consult a doctor.
3. Report the incidence to the local health department.

## 4D

### Emergency Preparedness and Response

#### Purpose:

To provide uninterrupted health services during disaster like typhoon, avert preventable morbidities and mortalities and ensure that no outbreak will occur secondary to disasters.

#### Procedure:

1. The primary care facility shall conduct annual orientation of staff regarding disaster risk reduction management and organize committee.
2. Designate staff to lead four sets of essential services of the health cluster;
  - Medical and Public health--- Municipal Health Officer
  - Nutrition in Emergencies--- Nutrition Coordinator
  - Water, Sanitation and Hygiene--- Sanitary Inspector
  - Mental Health and Psychosocial Support—Mental Health Coordinator
  - Basic Life Support-
  - Safe First AID
  - Earthquake Drill
  - Bomb Threat Simulation Drill
  - Fire Drill
3. Conduct and regularly update the hazard and risk assessment.
4. The scheduling and staffing shall be 24/7 during acute disasters such as typhoon. All staffs are required to duty.
5. There shall be allocated and dedicated supplies and logistics for disaster program.
6. Prior to typhoon, utility workers must ensure safety of the building, check all windows and keep the area safe for onset of expected disasters.
7. During disaster, no staff shall be allowed to respond to critical areas unless in extreme emergencies with approval of the Municipal Health Officer.
8. After the onset of disaster, the primary care facility shall immediately open to provide acute care services for medical and psychosocial services.
9. After disaster, all staffs shall separately assess their respective areas for any damages. It shall be reported within 24 hours.
10. Review plan annually and update as necessary.

## EMERGENCY RESPONSIVENESS

Primary Care Facility must be adequately prepared to handle clinical emergency situations, as follows:

- There is a written plan for the management of on-site medical emergencies, emergencies requiring ambulance services and RHU admission.
- All health and non-health staff are trained in basic cardiopulmonary resuscitation (CPR) and emergency medical action. Staff trained in CPR must be present during all hours of clinic operation.
- Written protocols to address vasovagal reactions, anaphylaxis, syncope, cardiac arrest, shock, hemorrhage, and respiratory difficulties
  - Emergency resuscitative drugs, supplies, and equipment appropriate to the services provided at that site and appropriately trained staff when clients are present.
- Documentation is maintained in personnel files that staff has been trained regarding these written plans or protocols.

## EMERGENCY PREPAREDNESS

- There must be a written safety plan that includes maintenance of fire-safety equipment, an emergency evacuation plan, and a disaster response plan.

### A. Physical Attributes of POTOTAN OPERATION CENTER

Rizal Operation Center will be located at the 1<sup>st</sup> floor of the POTOTAN RHU with approximately 10 sq. meters in area. This will serve as the center for health concerns during emergencies or disasters.

The POTOTAN Operation Center (POTOTAN OPCEN) will be guided with the following protocols below:

Safe from hazards <sup>[L]</sup><sub>[SEP]</sub>

Adequate electrical, water and sewage systems <sup>[L]</sup><sub>[SEP]</sub>

Sufficient space for all functions – a mix of open and closed work spaces

Secured storage area <sup>[L]</sup><sub>[SEP]</sub>

Open work space for management, operations, logistics and planning <sup>[L]</sup><sub>[SEP]</sub> functions <sup>[L]</sup><sub>[SEP]</sub>

Closed work space available for teleconferences, break-out groups, <sup>[L]</sup><sub>[SEP]</sub> policy group



meetings. (This is located right across the OPCEN (Rizal [L] [SEP] RHU conference room). [L] [SEP]

Data telephone and electrical connections [L] [SEP]

Adequate wall space for big whiteboards or equivalent [L] [SEP]

Adequate lightning, ventilation, heating and cooling capacity [L] [SEP]

Equipped with:

Floors plans, mapping or work stations, and wiring [L] [SEP]

Well-posted fire evacuation plans and assembly areas [L] [SEP]

With available EOC protocol plans (flowcharts) (hard and soft copies) [L] [SEP]

Staff roles and standard operating procedures [L] [SEP]

Toilet/personal hygiene area is located at the nearby building. [L] [SEP]

B. POTOTAN OPERATION CENTER ORGANIZATIONAL STRUCTURE OPCEN will be manned by the following staffs:

One supervisor [L] [SEP]

Emergency Office on Duty (EOD) – Two persons for every 24 hours [L] [SEP]

One Administrative Aide [L] [SEP]

PRE -POSITIONING OF HEALTH & NUTRITION LOGISTICS

TO identified Evacuation Center - ----- 500, 000.00 – Health Nutrition

PUBLIC HEALTH EMERGENCY MANAGER: RODINA P. MONDRAGON, MD. – Cel.#  
09178531616

DRIVER:

CLEO PIMENTEL – 09086780871

RHYS – 09078027670

CARELL GONZALES – 09297030001

TEAM A: DAY 1

EMERGENCY OFFICER ON DUTY1 – LOURDES P. PORCALLA

– Cel.# 09209013493

-Identification of problem, analysis and  
immediate solution

-reports

**EMERGENCY OFFICER ON DUTY2 – ARACELI CAMIQUE**

- Identification of problem, analysis and immediate  
solution.

-reports

**MEMBERS: LOURDES PAPILOTA– Cel. # 09205830116**

**RAMONA A. PORRAS - mass immunization**

- Treatment of different diseases

**NELIA PORAL**

**ANNA ROSE ILISAN** - transport of supply

- vector control
- Waste disposal

**EVELYN PENUELA** - Health Education at evacuation center

- oversees safe water
- Food hygiene

- Waste disposal

**TEAM B: DAY 2**

**EMERGENCY OFFICER ON DUTY 1– JOANNE ROSE ROSAL – Cel.# 09176340428**

- Identification of problem, analysis and immediate solution.
- reports

**EMERGENCY OFFICER ON DUTY 2– CRISTINA GANDO – Cel.# 09176339843**

- Identification of problem, analysis and immediate solution.
- reports

**MEMBERS: AURA MARIE CEBALLOS**

**MARIA CARMELI PULMONES** - mass immunization

- Treatment of different diseases

**PRINCESS MAY PADUGA** – transport of supply

- Vector control
- Waste disposal

**CECIL PAVORITO** - Health Education at evacuation center

- oversees safe water
- Food hygiene

- Waste disposal

**TEAM C: DAY 3**

**EMERGENCY OFFICER ON DUTY – VIRGINIA G. PASTOLERO - Cel. # 09086779623**

- Identification of problem, analysis and immediate solution.

- forward report to SPEED
- reports

**EMERGENCY OFFICER ON DUTY – MA. FE SA4PILO – Cel. # 09072223277**

- Identification of problem, analysis and immediate solution.
- reports

**MEMBERS: CHRISTINE S. GONZALES – Cel. # 09095172487**

- RITA JOY POLINES** - mass immunization  
- treatment of different diseases

**HYACINTH S. RELLO**- Health Education at evacuation center

- oversees safe water
- Food hygiene
- Waste disposal
- update REDCROSS Project 143

**JEAN DOMINGO** - transport of supply

- Vector control
- Waste disposa

**OPERATION CENTER - MAIN HEALTH CENTER-**

**LOGISTIC OFFICER:** Dr. Rogielyn D. Talamera, Renely Paredes

- Heide Dolorota & Lyndie Cordero - report consolidation/encoding  
Inventory of supply and release

**C. RESPONSIBILITIES OF PERSONNEL OF OPCEN**

**Operations Center Supervisor**

Oversee the operations of the OpCen.

Review, analyze and correct reports. [SEP]

Accomplishment report of EODs. [SEP]

Review the following:

Endorsement logbook [SEP]





Radio check monitoring checklist [L] [SEP]

Incoming and outgoing communications logbook [L] [SEP]

Incoming and outgoing text messages logbook [L] [SEP]

Attend the endorsement of EODs. [L] [SEP]

Prepare the duty schedule of the OpCen staff. [L] [SEP]

Report directly to the Division Chief for any problems encountered at OpCen. [L] [SEP]

### Emergency Officer on Duty (EOD)

Duties and Responsibilities	EOD 1	EOD 2
Assumption of Duty	<p>Receive endorsements from the outgoing EODs and lead in the endorsement to incoming EODs [L] [SEP]</p> <p>Orient him/herself in what transpired in the past few days. [L] [SEP]</p> <p>Review the following: [L] [SEP] Endorsement logbook Previous HEARS Plus [L] [SEP]</p> <p>Know the DOH Officer on Duty during weekends and holidays. [L] [SEP]</p> <p>Be aware of the stock level of logistical supply of the [L] [SEP] office.</p> <p>Answer/log incoming and [L] [SEP] outgoing telephone, cell phone, calls, radio and text messages. [L] [SEP]</p> <p>Answer all calls coming from superiors and important persons. [L] [SEP]</p> <p>Answer inquiries from the public and refer accordingly when necessary. [L] [SEP]</p> <p>Decide on all issues in coordination with EOD2 or with superiors if necessary. [L] [SEP]</p> <p>Refer matters that need the attention or action of the Division Chief or designate. [L] [SEP]</p> <p>Review the completeness of the</p>	<p>Together with EOD1 receive endorsements from the outgoing EODs. [L] [SEP]</p> <p>Review the endorsement logbook and previous HEARS on what have transpired during the past few days. [L] [SEP]</p> <p>Know the DOH Officer on Duty during weekends and holidays. [L] [SEP]</p> <p>Answer/log incoming and outgoing telephone, cell phone calls and radio messages. [L] [SEP]</p> <p>Answer inquiries from the [L] [SEP] public and refer to superior accordingly, when necessary.</p> <p>Relay information/matters [L] [SEP] that need immediate action [L] [SEP] to the EOD1 [L] [SEP]</p> <p>Perform functions in close [L] [SEP] coordination with the EOD1 [L] [SEP]</p>



	<p>reports prepared by the EOD2 [L] [SEP]</p> <p>Report and document any problems encountered during the tour of duty to the Division Chief or designate. Personally have the HEARS signed by the Directors or designate and answer any inquiries on the HEARS. [L] [SEP]</p>	
Monitoring	<p>Monitoring the following:</p> <p>Reports coming from [L] [SEP] UHF/VHF radio [L] [SEP]</p> <p>Telephone calls requiring [L] [SEP] DOH intervention [L] [SEP]</p> <p>Emergencies and disasters [L] [SEP] by personally calling regions, RHUs and other agencies affected. [L] [SEP]</p> <p>Internet reports related to health form local as well as international sources. [L] [SEP]</p> <p>OCD website, GMA, ABS- CBN and other TV and radio network websites [L] [SEP]</p>	<p>Monitor the following:</p> <p>Radio [L] [SEP]</p> <p>Television [L] [SEP]</p> <p>News/print media [L] [SEP]</p> <p>Status of communication by [L] [SEP] conducting daily radio check; refer any radio communication problems encountered during the tour of duty to the Communication Officer/designate [L] [SEP]</p>
Reporting/Documentation	<p>Report to Division Chief at 6:00am and 6:00pm and to the Director at 8:00am and 8:00pm, with or without monitored events. [L] [SEP]</p> <p>In coordination with the EOD2, prepare the following reports: Flash Reports, HEARS, Typhoon Alerts. [L] [SEP]</p> <p>Review, analyze and evaluate, for 24 hours, rapid assessment reports, follow- up reports, delayed reports and other reportable events. [L] [SEP]</p> <p>Determine necessary data [L] [SEP] to be incorporated into all reports, if</p>	<p>Report to EOD1 on the incidents he/she had monitored. [L] [SEP]</p> <p>Prepare the following reports for review by EOD1 for its completeness and veracity: [L] [SEP] Daily HEARS Plus [L] [SEP] Flash Report [L] [SEP] Memorandum, etc. [L] [SEP]</p> <p>File and update documents and data. [L] [SEP]</p> <p>Make detailed documentation of all reportable events. [L] [SEP]</p> <p>Put detailed important</p>



	<p>needed, verify reports. Ensure proper documentation of all reportable events, including the updating of the monthly monitoring board.</p>	<p>information on the white board on all ongoing operations</p>
<p>Coordinating and Dispatching</p>	<p>Be responsible for coordinating with the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> DOH Central offices</li> <li><input type="checkbox"/> DOH implementing regions and Field Medical Commander in case of Mass Casualty Incident</li> <li><input type="checkbox"/> Other member of the NDCC family</li> <li><input type="checkbox"/> Private RHUs regarding status of patients including needs/concerns.</li> <li><input type="checkbox"/> Other GOs, NGOs, private organizations, etc.</li> </ul> <p>For Iloilo City, lead in the dispatching of teams for MCI to the site in coordination with the Medical Controller or Division Chief; for regions, lead in the dispatching of rapid assessment teams.</p>	<p>Assist the EOD1 in contracting agencies and facilities. Update database of important facilities and organizations. Get continuous updates until final reports is submitted.</p>
<p>Admin on Duty</p>	<p>Be responsible for other administrative concerns after office hours, during weekends and holidays, such as:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Signing of trip tickets for urgent/official trips</li> <li><input type="checkbox"/> Approval of the Requisition &amp; Issue Request of drugs/medicines &amp; other medical supplies</li> <li><input type="checkbox"/> Preparing Department Personnel Orders (DPOs) of team dispatched</li> </ul> <p>Perform other duties stated</p>	<p>Be responsible for faxing, documenting reports, memorandums, etc. To concerned agencies.</p> <p>Check/record cell phone account balance and incoming text messages</p> <p>Follow up status of the following:</p> <ul style="list-style-type: none"> <li>Department Order</li> <li>Memorandum</li> </ul>



	in the endorsement checklist.	Update report, etc. [L] [SEP] Encode PLDT bills. [L] [SEP] Cut newspaper clippings [L] [SEP] Prepare Request & Issuance [SEP] Slip (RIS) [L] [SEP] Prepare daily [SEP] accomplishment report. [L] [SEP]
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**Administrative Aide/Driver**

- Evaluate pre-need of vehicles for maintaining good condition.
- Transport officials and staff on official travel and during emergencies and disasters.
- Prepare report of gasoline expenses (RIS, trip tickets and summary report)
- Maintain and ensure the serviceability of the vehicles.
- Perform other related functions as may be assigned.

**Other Responsibilities:**

- Assist the EOD in monitoring
- Answer telephone and radio transceivers.
- Report to the EOD on the incidents he had monitored. [L] [SEP]



**SAT 5**  
**INDIVIDUAL BASE PRIMARY CARE SERVICE**  
**5A. MATERNAL AND NEWBORN CARE**

Our outmost priorities are quality and safe pregnancy of women, their partners and future newborn babies, by offering them to live to the best possible experience of pregnancy and birth, in a safe environment. Also, to ensure safe pregnancy and delivery up to post-natal period to mothers.

**Contributory Objectives:**

1. Care for and monitor the progress of the mother in the post-natal period and to give necessary advice for her child care to ensure the optimum health.
2. Encourage mother to have a complete preparation for child birth including financial, hygiene and nutrition.
3. Provide sound family planning information and advice.
4. Carry out the treatment prescribed by obstetrician/ pediatrician.

**Quality Assurance Policies:**

A quality assurance program shall exist in the conduct of performances reviews for direct maternal and new born care. It shall include but is not limited to:

1. An annual review of protocols, policies and procedures relating to maternal and newborn care.
2. Review risk criteria for determining eligibility for admission and continuation in the lying-in program care.
3. Review the necessity of diagnostics and screening procedures including laboratory test and ultrasound on the quality of care and cost to the patient.
4. Review appropriateness of medications prescribed, dispensed and administered.
5. Evaluation of performance of providers (peer review)

6. An annual review of management of care and make recommendations for improving the plan of care.
7. An annual review of all referred mothers and newborns to RHUs.

**A. ESSENTIAL NEWBORN CARE**

- Ensure the room is warm (not less than 25 degrees centigrade and no drought) before performing essential newborn care.



- Always observe aseptic procedures (wear sterile gloves) when performing essential newborn care.

## **1. Ensure Quality Provision of Time-Bound Interventions**

### **a. Within the first 30 seconds**

**Objective:** To stimulate breathing, provide warmth to the newborn to prevent hypothermia.

- Put on double gloves
- Call out time of birth and sex of the baby
- Deliver the baby onto the dry cloth draped over the mother's abdomen.
- Use a clean, dry cloth to wipe the eyes, face, nose, head, body, arms and legs. Wipe off blood and meconium only. Do not remove vernix caseosa.
- Suctioning is not mandatory. It is done if the mouth/nose is blocked with secretions or other materials.
- Cover the head with a clean, dry, bonnet.
- Remove the wet cloth.
- Do a rapid assessment of newborn's breathing while drying (Institute necessary measures in cases of distress)
- Do not bathe the newborn until at least 6 hours of life.
- Do not put the newborn on a cold or wet surface.
- APGAR scoring

### **b.**

#### **After thorough drying.**

**Objective:** Facilitate bonding between the mother and her newborn through skin-to-skin contact to reduce likelihood of infection and hypoglycemia. (Unang Yakap)

- Place the newborn prone on the mother's abdomen or chest, skin-to-skin.
- Cover the newborn's back with a warm, dry blanket.
- Do not separate the newborn from the mother unless the newborn exhibit severe chest in-drawing, gasping, apnea and the mother does not need urgent medical/surgical intervention.

### **c. While on skin-to-skin contact (up to 3 minutes post-delivery)**

**Objective:** Reduce the incidence of anemia in term and preterm newborn and intra-ventricular hemorrhage and transfusions in pre-term by

delaying or non-immediate cord clamping.

- Clamp and cut the cord after cord pulsations have stopped (typically at 1 to 3 minutes. Do not milk and cord towards the newborn.
- Clamp cord 2cm and 5cm from newborn's abdomen.
- Cut between clamps with sterile surgical blade, G20.
- Observe for oozing of blood.

**d. Within 90 minutes of age.**

**Objective 1:** To facilitate the newborn's early initiation to breastfeeding and transfer colostrum through support and sustained contact.

- Leave the newborn on the mother's chest in skin-to-skin contact for 90 minutes. Health workers should not touch the newborn unless there is a medical indication.
- Initiate breastfeeding within first hour of life. Make verbal suggestions to the mother to encourage her new born to move toward the breast e.g. nudging.
- Counsel on positioning and attachment. When the new born is ready, advise the mother to position and attach her newborn.
- Colostrum feeding must be offered. Advise the mother not to throw away the colostrum.
- If the attachment or suckling is not good, try again and reassess.
- A small amount of breast milk may be expressed before starting breastfeeding to soften the nipple area so that it is easier for the newborn to attach.
- Mothers should be informed about the importance and techniques of breast feeding.
- Demand feeding is encouraged.
- Exclusive breastfeeding procedures should be explained to the mother and family members.

**Objective2.** To prevent ophthalmia neonatorum through proper eye care

- Administer erythromycin or tetracycline ointment to both eyes after the newborn has located the breast.
- Do not wash away the eye antimicrobial.

**2. Non-immediate Interventions**

**a. Give Vitamin K prophylaxis**

- Inject a single dose of Vitamin K 1mg or 0.1ml intramuscularly for term infants; 0.5mg or .05ml for pre-term babies

**b. Immunized with first dose of Hepatitis B and BCG vaccine**

- Inject 0.5ml Hepatitis B vaccine intramuscularly.

*Note: babies born to HBsAg positive mothers must be given Immunoglobulin ideally after 24 hours of life.*

*It is given intramuscularly.*

- Inject 0.05ml BCG vaccine intradermally

**c. Newborn Screening Test (NBS)**

- NBS is performed by the Medical Technologist or the trained nurse/midwife on the 24<sup>th</sup> to 48<sup>th</sup> hour of life.

**3. Physical Examination of the newborn (to be done by the attending physician)**

- This can be done immediately after essential newborn care.
- Assess breathing (newborn must be calm)
  - a. Listen for grunting
  - b. Count breaths: Normal is 30-60 per minute.
  - c. Look at the chest for in-drawing.
- Assess heart beat: Normal is 120-160 bpm: Is there murmur?
- Look at the movements: are they normal and symmetrical?
- Look at the presenting part – is there swelling and bruises?
- Look at the abdomen for pallor.
- Look at the malformations or defects.
- Feel the tone: is it normal?
- Measure temperature via anus. Normal body temperature is 35-36.9 degrees centigrade.
- If with hypothermia, rewarm newborn skin-skin contact with mother.
- Or wrap newborn in a clean, dry, warm cloth and place in the bassinet.



- Cover with a blanket and warm baby with a droplight.
- If normal, wrap baby in a clean, dry, warm cloth.
- Weigh newborn and perform anthropometric measurements.
- Recording to be done accurately about the event of the birth (birthdate, time, sex, examination findings) in the delivery record sheet.
- The mother and baby should transfer to ward usually after 1 hour of observation in the delivery room and when the condition permits.
- Sick or at-risk neonates need special care in special settings

#### **4. Health Education**

##### **a. Cord Care**

- Another to look into is the care of the umbilical cord. Upon cutting aseptically the cord should be tied or clamped and inspected for bleeding.
- Wash hands before touching the baby
- Fold diaper below stump. Keep cord stump loosely covered with clean clothes.
- If stump is soiled, wash it with clean water and soap. Dry it thoroughly with sterile gauze.
- Explain to the mother that she should seek care if the umbilicus is red or draining pus.
- Mother is advised that the stump should fall after 5-10 days.

##### **b. Skin care**

- Skin care and baby bath should be done to remove blood, mucus and meconium. This should be done gently while using warm water to prevent hypothermia.

##### **c. Care for Eyes**

- Eyes should be cleaned at birth and once a day using sterile cotton swab soaked in sterile water.
- Each eye should be cleaned using a separate swab
- The eyes should be observed for redness, discharges or the excessive tearing for early detection of problems

##### **d. Clothing of baby**

- The baby should be dressed with loose, soft and cotton clothes

- Large buttons synthetic and plastic or nylon should be avoided.
- A triangular shaped soft, absorbent cloth should be used as napkin.
- The clothes should not be tight especially around the neck and abdomen

#### **e. Weight recording**

- Assess daily weight gain in healthy term babies.
- Most infants double their weight by 4-5 months but in first week of life there is physiological loss of body weight because of removal of vernix, mucus, blood, passage of meconium and reduction of extra cellular blood volume and adoption to new environment.
- With adequate breastfeeding majority of babies regain weight within 7-10 days of birth

#### **f. Immunization**

- Within first week of life mother is informed of national immunization schedule and explanation is given about importance and completeness of immunization and all possible reaction following vaccination.
- In institutional deliveries all neonates are immunized with BCG and polio; while for home deliveries mothers and newborns are immediately brought to the RHU-MCHC for post-partum and newborn care.

All infants are followed up at least every month and subsequently 3 months interval till age 1. Follow up of assessment of growth and development, early detection and management of health problems. Care for the newborn is discussed with the mother and the whole family.

## 5B. FAMILY PLANNING

The national Family Policy (Administrative Order No. 50-A S.2001), prescribes the key policies for Family Planning methods including natural family planning. Policy statements that guide family planning program promotion and implementation are the following:

1. Family planning as a health intervention to promote the over-all health of all Filipinos particularly our women and children by:
  - a.) Preventing high risk pregnancies
  - b.) Preventing unplanned pregnancies
  - c.) Reducing maternal deaths
  - d.) Responding to unmet needs of women
2. Family planning and services is provided based on voluntary and informed choice to all women and men of reproductive age regardless of age, number of children, marital status, religious beliefs, and cultural values.
3. Only medically safe and legally acceptable family planning methods shall be available in all public, NGOs and private health facilities.
4. Quality care is promoted and ensured in providing family planning services. Privacy and confidentiality are strictly observed in the provision of services at all times.
5. Efforts are undertaken to orient clients on fertility awareness as the basic information to fully understand and appreciate FP.
6. Multi-agency participation is essential. Involvement of the private sector, academe, church, media, community, and other stake holders is encouraged at all levels of operation.
7. FP service, in the context of the RH approach, is integrated with the delivery of other basic health services.
8. Sustainability of FP services and commodities is promoted through the localization and adoption of the Contraceptive Self- Reliance strategy.

### **FP Program methods**

- Permanent Methods
  - Female sterilization / Bilateral Tubal Ligation
  - Male sterilization / Vasectomy
- Temporary Methods
  - Supply Methods
  - Pills
  - Intrauterine Device

- Injectable
- Male Condom
- Fertility Awareness Based Method
  - Billings Ovulation Cervical Mucus Method
  - Basal Body Temperature
  - Symptothermal Method
  - Standard Days method
  - Lactational Amenorrhea Method

## FAMILY PLANNING SCHEDULE

### SCHEDULE

Barangay- Agreed FP Day  
Main Health Center-Every Thursday

### SERVICES AND LOGISTICS

#### Family Planning Methods

**Implanon Insertion-Every Thursday**

**In Charge: MHO**

**Certified and Trained RHM**

#### Modern Natural Family Planning (NFP) Methods

Modern NFP methods are used to plan or prevent pregnancies by identifying the woman's fertile period. These methods do not require the use of drugs, surgical procedures or devices to promote or prevent conception. NFP is recommended for couples that can postpone intercourse when the woman is fertile. Consult your midwife, nurse or doctor to know the suitable method for you.

#### *Breastfeeding method (Lactational Amenorrhea Method or LAM)*

After you give birth, there is a period where the chances of getting pregnant are low. It is effective only if your period has not yet returned and your baby only receives breast milk for the first six months, without water, milk formula, juice, other liquids, and food.

#### *Thermometer Method*



*Handwritten signature*

In this method, your body temperature is used to tell you (the woman) if you are ovulating. You can get pregnant during unprotected sex at that time. Its effectiveness depends on correctly taking your body temperature.

### Modern Natural Family Planning (NFP) Methods



#### *Cervical mucus method*

This method requires you (the woman) to observe the consistency of your cervical mucus to know when you are fertile. You can get pregnant during unprotected sex at that time.

#### **Sympto-thermal Method**

This method is a combination of the thermometer and cervical mucus methods, and relates to other symptoms felt during the menstrual cycle.

#### *Standard Days Method*

This works best if your menstrual cycle is between 26 and 32 days long. It specifies days within your cycle when you should avoid unprotected sex. The beads help you remember the safe period for intercourse.

## Standard Days Method (SDM)



### Other Modern Family Planning Methods

Other modern family planning methods prevent pregnancy by using drugs, devices or surgical procedures. You can use these methods even if you have sex during your fertile period. Consult your midwife, nurse or doctor to know the suitable method for you.



#### *Contraceptive Pills*

They contain hormones that prevent pregnancy when taken daily. If you are breastfeeding, there are pills that may be suitable for you.

#### *Condom*

This rubber barrier prevents semen from entering your (the woman's) body. It also prevents transmission of sexually transmitted infections.

#### *Injectable hormones*

This method also contains hormones that prevent pregnancy when you (the woman) are injected every three months. It is safe to use even when breastfeeding.

#### *Intra-Uterine Device (IUD)*

This method uses a small and flexible device placed inside your womb to prevent pregnancy.

IUDs can be used continuously for up to 8 to 10 years with only periodic check-



upsrequire

## 5C. NUTRITION SERVICES

The following guidelines provide guidance in the delivery of essential nutrition services to minimize the health outcomes of malnutrition. These services are made available to protect people of all ages, especially the most vulnerable groups: infants and children less than 5 years old, pregnant, postpartum and/or lactating women.

### Prevention of Micronutrient Deficiencies

1. Routine micronutrient supplementation to target infants, children, pregnant and lactating women, adolescent girls and women of reproductive age
2. The following micronutrient commodities are provided: Vit A capsules, micronutrient powder sachets among infants, and children 6 mos to 5 years old, iodized oil capsules for pregnant, postpartum and lactating women. Likewise, iron with folic acid for pregnant, postpartum and lactating women

### Infant and Young Child Feeding

1. All health care providers (HCPs) inform pregnant women of the benefits of breastfeeding as well as the risks and harm of formula feeding, during prenatal visits
2. Pregnant women and health care provider discuss the birth plan, including early initiation of exclusive breastfeeding following the essential intra-partum and newborn care protocol and rooming-in after delivery

3. HCPs encourage mothers to exclusively breastfeed from birth up to 6 months of age and continue breastfeeding their infants and young children
4. At 6 months of age, mothers are advised to introduce and provide age-appropriate complementary foods with continued breastfeeding

#### **Management of Acute Malnutrition**

1. Parents and caregivers are advised to continue responsive feeding during the administration of ready-to-use supplementary foods (RUSF) or ready-to-use therapeutic foods (RUTF) with continued breastfeeding and complementary feeding as appropriate. Infants and young children with moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) have greater need for responsive feeding and stimulation
2. Continuity of provision of treatment of MAM and SAM using RUSF and RUTF among infants and children 6 months to 5 years old and nutritionally-at-risk pregnant, postpartum or lactating women, including adolescent girls is ensured.
3. Follow up MAM and SAM cases for re-supply when needed or referral of non-responsive SAM cases or those whose conditions have deteriorated to the referral RHU is ensured.

#### **Growth and Development Monitoring**

1. Monitoring of growth and development of infants and children under 5 years old is done during facility visits, community outreach and during the conduct of OPT
2. HCPs give feedbacks to parents or caregivers on maintaining or improving the nutritional status, growth and development of their children
3. HCPs encourage parents to promote early childhood development through responsive parenting and caregiving

#### **Promotion of Healthy Diet for the Prevention or Management of NCDs including Overweight and Obesity**

1. Promote healthy diet following the Nutritional Guidelines for Filipinos (Pinggang Pinoy, 10 Kumainments) for children, adolescents, pregnant and lactating women, adult, and the elderly
2. Assess body mass index (BMI) using standard growth charts and nationally adapted guidelines



3. Provide nutrition counseling and information and education messages

FOCAL PERSON- Assigned Nutritionist-Lyndie Aventura RN

Rhea Canaway-BNS President

### Human Resource Capacity Development

Mentoring

Correction of Reports

Unit meeting (10 BNS) every unit once a month for 5 days

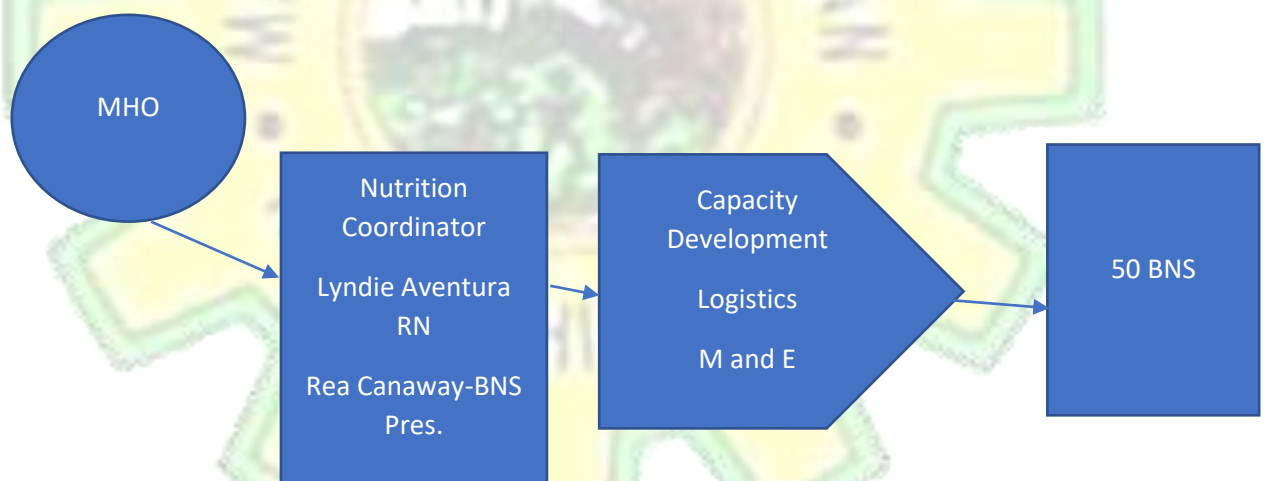
### Logistics

Giving out of goods (nutribun or rice for target pregnant and malnourished children aging 6-59 months)

### Monitoring and Evaluation

Once a month feedbacking for the 50 BNS

### Process Flow



### 5D Dental Consultation

This is a medical service where clients seek dental consultation like tooth extraction and examination.

Services Offered:

Oral Examination (all age group)-**Thursday**

Fluoride Varnish Application (1-5 y.o.)-**Wednesday**

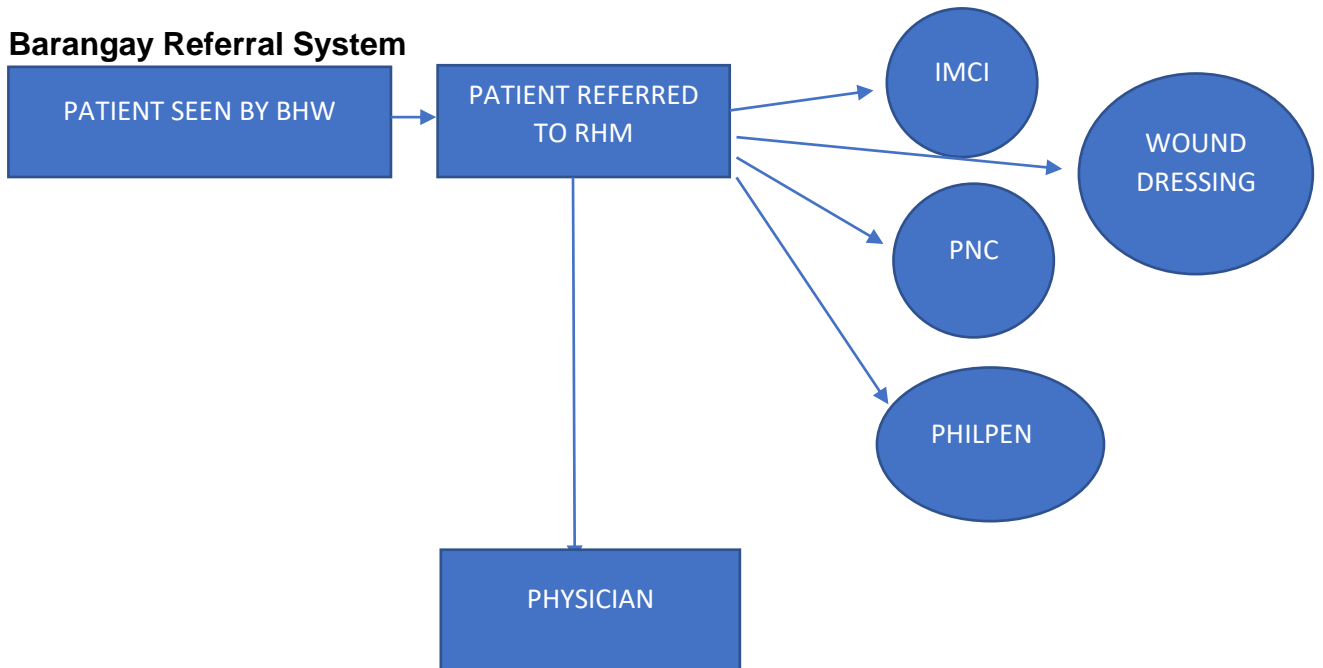
Dental Sealant Application (6-12 y.o.)-**Scheduled**

Temporary Filling-Schedule-**Scheduled**

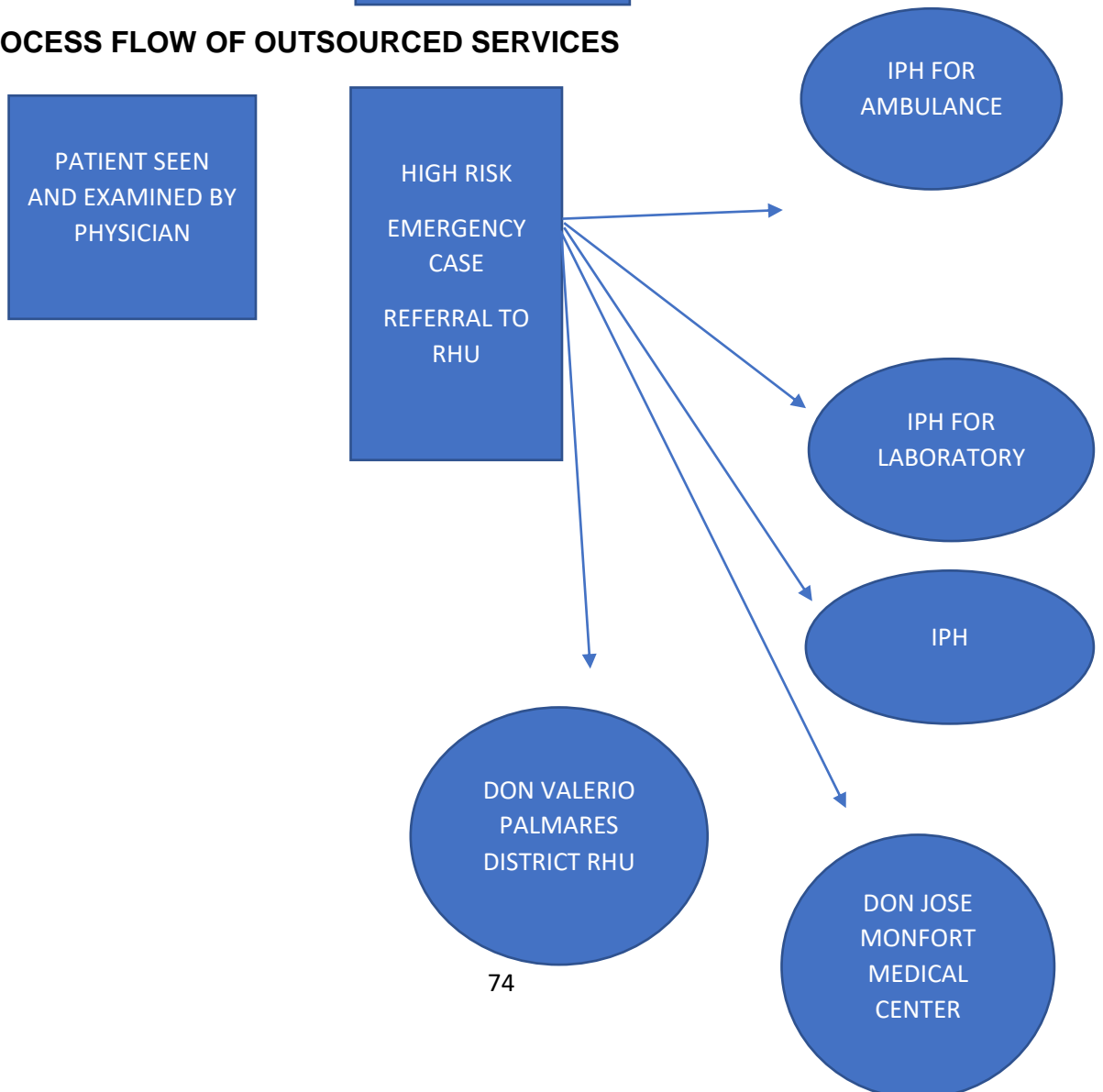
Permanent Filling-Schedule-Scheduled  
Tooth Extraction (pedia and adult) - **Tuesday and Friday**

### 5E REFERRAL SERVICES

#### Barangay Referral System



#### PROCESS FLOW OF OUTSOURCED SERVICES



## 5E1

### **Policy Title: Referral Protocol for Patients with Speech Impairment due to Developmental Delay or Stroke( Physical Therapy) in Rural Health Units and Primary Care Facilities**

1. Purpose: This policy aims to establish a clear and consistent referral protocol for patients with speech impairment in rural health units and primary care facilities. It specifically targets two groups: children with speech impairment due to developmental delay and adults with speech impairment resulting from stroke. The policy aims to ensure timely and appropriate care by directing patients to specialized healthcare providers.
2. Scope: This policy applies to all rural health units and primary care facilities within the jurisdiction of the specified municipality or region.
3. Definitions: a. Speech Impairment: Any disorder that affects an individual's ability to produce sounds, fluently articulate words, or communicate effectively. b. Developmental Delay: A condition where a child's milestones, including speech and language development, are not reached within the expected age range. c. Stroke: A medical condition resulting from a sudden interruption of blood flow to the brain, causing damage to brain cells and potentially leading to speech impairment.
4. Referral Guidelines: a. Children with Speech Impairment due to Developmental Delay:
  - Upon diagnosing a child with speech impairment attributed to developmental delay, the primary healthcare provider at the rural health unit or primary care facility shall refer the patient to a Pediatrician specializing in developmental milestones
- Speech delay:
  - Speech delay is a condition in which a child's speech development is delayed compared to other children of the same age.
  - Speech delay can be caused by a variety of factors, including hearing loss, developmental delay, and neurological disorders.
  - If a child is experiencing speech delay, it is important to get them evaluated by a speech-language pathologist (SLP) as soon as possible.
  - The SLP will be able to assess the child's speech and language skills and develop a treatment plan.
- Stroke:
  - A stroke is a sudden interruption of blood flow to the brain that can cause a variety of impairments, including speech problems.
  - Speech problems after a stroke can include aphasia, dysarthria, and dysphagia.
  - Aphasia is a language disorder that can cause difficulty with understanding or expressing speech.
  - Dysarthria is a motor speech disorder that can cause difficulty with the physical production of speech.
  - Dysphagia is a swallowing disorder that can make it difficult to eat or drink safely.
  - If a stroke patient is experiencing speech problems, it is important to get them evaluated by an SLP as soon as possible.
  - The SLP will be able to assess the patient's speech and swallowing skills and develop a treatment plan.

When to refer a patient for rehabilitation:

- Speech delay:
  - If a child is not talking by the age of 18 months, or if they are not using two-word phrases by the age of 24 months, they should be evaluated by an SLP.
  - If a child is making progress in speech therapy, but they are still not meeting their developmental milestones, they may need to be referred for a more intensive treatment program.
- Stroke:
  - If a stroke patient is experiencing speech problems, they should be referred to an SLP as soon as possible.
  - The SLP will be able to assess the patient's speech and swallowing skills and develop a treatment plan.

Benefits of rehabilitation:

- Speech delay:
  - Early intervention can help children with speech delay catch up to their peers.
  - Rehabilitation can help children develop the skills they need to communicate effectively.
- Stroke:
  - Rehabilitation can help stroke patients improve their speech and swallowing skills.
  - Rehabilitation can also help stroke patients regain their independence and quality of life.

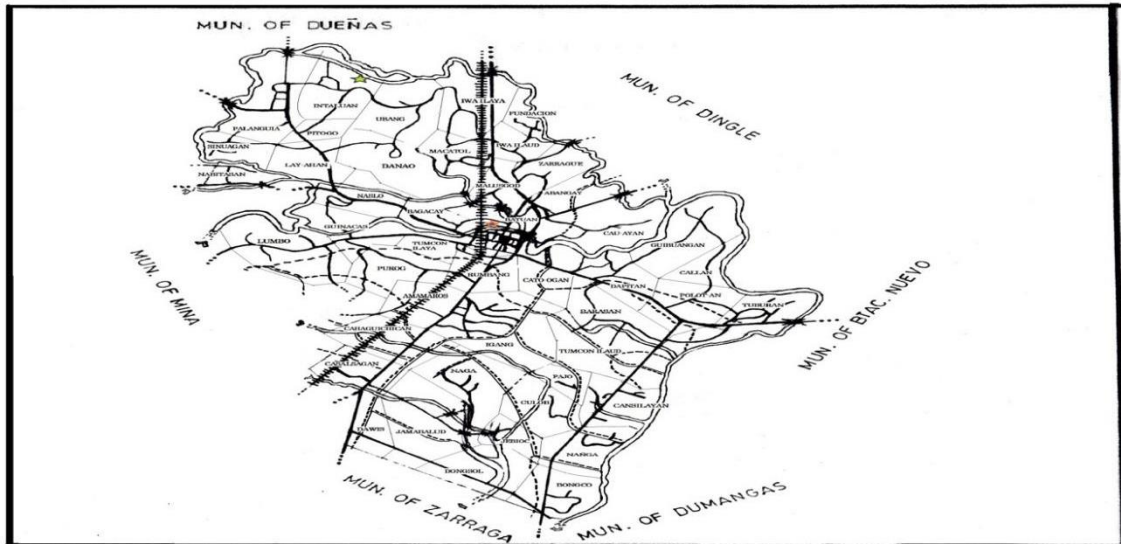
Conclusion:

Rehabilitation can be a very beneficial treatment for speech delay and stroke patients. If you are concerned about your child's speech development, or if you are a stroke patient who is experiencing speech problems, please talk to your doctor about getting a referral to an SLP.

## 6E DEVELOPMENTAL AND MENTAL HEALTH EVALUATION

### Mental Health

Psychoeducation: Use Of Clients Handbook Schedule For Moderators For Health Facility Base Rehabilitation



The Municipality of Pototan is located 2 kilometer away from the Regional Mental RHU however despite the proximity there are still many patients around with less or no compliance to medication because of inability to continually purchase the medication prescribed because of lack of community engagement and that mental health program had not been a priority program in the primary health care.

OBJE CTVE	MAJOR ACTIVIT Y	RESU LT AND SUCC ESS INDIC ATOR	PERSO N OR GROU P RESPO NSIBLE	TIM E FRA ME	RISK	RISK TREATMENT	BUD GET
To Implement Mental Health program In the Municipality of	Master listing of person with mental illness in 50 barangays and status of complian	At least 60% patient master listed	BHW and BNS	June 2018			2,,000

Pototan	ce to medication						
	Creation and Orientation of Responsibilities of Core Leaders in Mental Health Barangay Program (Barangay Captain, 2 BHW, 1 Brgy. Leader (NGO), RHM, HRH, MHO)	Core Group Created through Executive Order				Snacks and Incentivize (Last Friday of the Month )	10,000
	Orientation of Core Groups to basic signs and symptoms of mental illness. Case Detection Rate and Tracking Tool				Non Commitment	Incentivize(250/p participation)	10,000
	Development of System for						

	storage and logistics handling up to barangay level						
	Development a system of drug inventory and request	Trained Core Groups on MHP	DOH, MHO		Conflict of Schedules of Trainers'		
	Conduct of Outreach Check up with Regional Mental Hospital	60% of the target clients seen	MHO				15,000
	Adopt a 1 Treatment Partner to 1 Client Mental Health Clinic	100% of clients with identified partner Mental Health Clinic at Main Health Center	RMH, BHW RHM, Logistics Officer (MHC)			incentives	10,000
	Quarterly Evaluation of Barangay Mental Health Program	Barangays with clients evaluated	MHO, PB, BHW				5,000
	End of the Year meeting with	Meeting Conducted	RO 6, LCE, MHO				10,000

	Regional Mental RHU	with exit output s					
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### Developmental Delay

There are several child developmental evaluation instruments used by professionals to assess various aspects of a child's development. These instruments are designed to measure a child's cognitive, motor, language, social-emotional, and adaptive skills. Here are some commonly used child developmental evaluation instruments:

**Ages and Stages Questionnaires (ASQ):** ASQ is a series of age-specific questionnaires used to screen and assess children's development from birth to 5 years. It covers communication, gross and fine motor skills, problem-solving, and personal-social abilities.





## 5F SUBSTANCE ABUSE

### COMMUNITY BASE DRUG REHAB

#### I. Rationale:

The war on drugs had been continuously implemented despite the fight on COVID that hinders movement of the people however our municipality stayed focus on community base drug thus despite the drug clearance of 49 barangays we still continue to roll our CBDRP since we all understand that behavioral changes is a long process.

After 5 years of handling CBDRP we came to analyze that values are the most important anchor for changes thus a need for a face to face interaction however with minimum health standard in place.

Status of Outpatient Services	No. of People	
Total Population	77,500	(2% - 1,550)
Surrenderers	642	<b>83%</b>
Screened surrenderers	412	<b>64%</b>
Assessed	113	<b>27%</b>
Enrolled	49	<b>43%</b>
Attendees	19	<b>39% / 4.6%</b>
Community services	56	<b>35.71%</b>

#### 2. Objective:

1. To prevent relapse of PWUDS in the Municipality of Pototan
2. To strengthen value and mental health among our PWUDS
3. To educate family of PWUDS for the daily support need.
4. To conduct community orientation on COVID free areas

#### 3. Activity on Relapse Prevention and Psychoeducation

##### Individual Session

Session on CBDRP 2x a week

2 pm to 3 pm

15 PWUDS/Sessions

Pototan Rural Health Unit

**Family Session** Family Support Session

1 hour /month

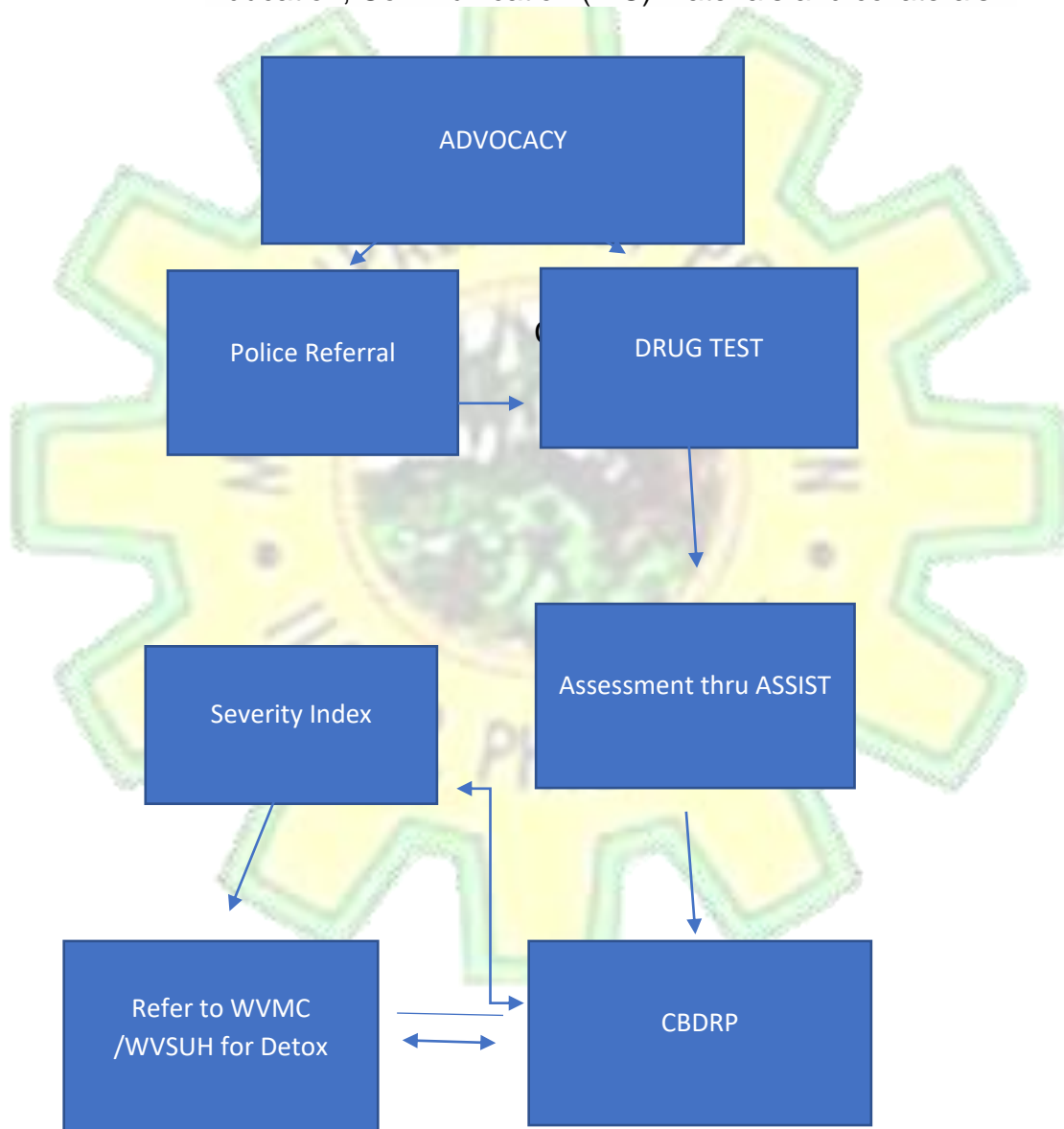
15 Family Representative per session

## Community Awareness Program

1 hour/Month/Evacuation Center

### CIVIC AWARENESS AND RESPONSE

The concept is to **promote public awareness on the evils of dangerous drugs & social response** by advocating the non-use of dangerous drugs. Production and Distribution of Information, Education, Communication (IEC) materials and collaterals.



Baran gay	Na me of Clie nt	Vita l Sig ns	Dru g Test Res ult	ASSISST RESULTS				Initial Screen ing	Admiss ion and Orienta tion	Evaluati on
				AL C	SMOKI NG	ME TH	TH C			
			Neg	M	M	L	M	done	done	Commu nity
			Neg	L	M	L	M	done	done	Commu nity
			Neg	M	M	L	M	done	done	Commu nity
			Neg	H	M	L	M	done	done	Commu nity
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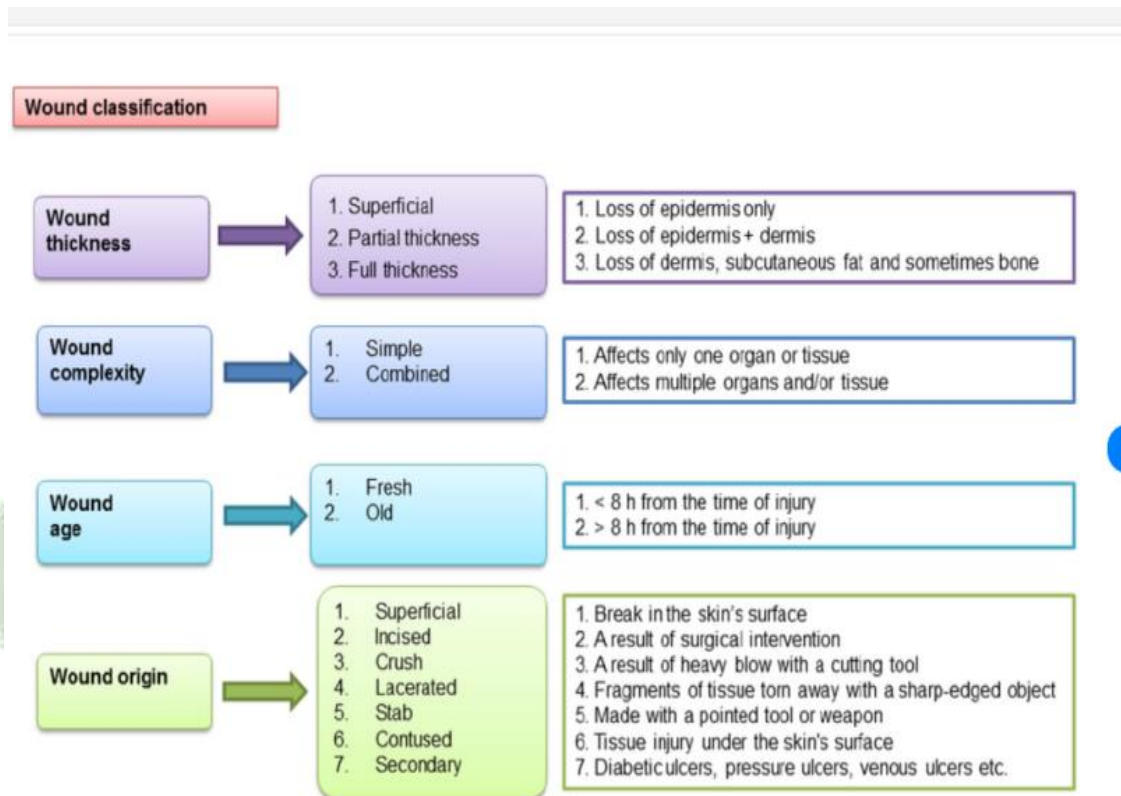


## SAT 6

### MINOR SURGERIES

Minor surgeries will be performed pending clearance of the patient as to its medical record, bleeding parameters and intake of oral medication.

#### 6A. Suturing of Superficial Lacerations-this procedure will be limited only to partial thickness



#### A. PROCEDURE ON SUTURING SUPERFICIAL LACERATIONS

Wound Management & Suturing Accurate assessment of the patient and the wound is imperative. The wound should not be treated in isolation but a holistic approach adopted in caring for the patient.

**A clear history of the present illness, past medical history and how the wound occurred is obtained**

- Establish the possibility of foreign material in the wound (Always x-ray if caused by glass)
- Depth of wound
- Is healing through primary closure appropriate?
- Tetanus status is also asked
- Allergies to drugs/dressing

- General health i.e. diabetic, anti-coagulation
- Patients' age/physical condition/occupation/medical history
- When the wound was inflicted. **Suturing a wound > than 6 hours old may increase the risk of infection and is contraindicated**

The type of wound will dictate the technique of suturing for example, closure of small fresh wounds is best achieved using interrupted sutures. **All Dog bites are “high risk” wounds and should not be sutured unless the failure to do so may have cosmetic implications.** More serious injuries with tendon and nerve damage are often overlooked as the patient will not complain so readily of pain.

#### **Evaluate Wound for suturing:**

- Determine where wound is – location can affect cosmetic appearance or mobility.
- Arrest and control bleeding
- A facial wound is best sutured by very experienced practitioners, or medical staff due to increased risk of scarring
- Determine condition of surrounding skin (is wound jaggy/smooth).

#### **Principles of Wound Management**

There are four main principles of wound management

- Deal with priorities first ABC.
- Check area distal to wound for neurovascular + motor damage, skin colour temperature, and distal pulses.
- Decrease likelihood of infection
- Promote optimal healing which may require suturing

#### **Wound Cleansing**

Wound cleansing is the most important aspect of wound management. All wounds will heal eventually if infection is avoided and this is best achieved by thorough cleansing of the wound. Wounds which are not grossly contaminated should be thoroughly cleansed with warm sterile solution of 0.9% sodium chloride. Cleaning of a wound may be more of a physical than a clinical process and the need to irrigate, clean or even scrub the wound should be considered. Wounds that are obviously contaminated should be thoroughly irrigated, then cleaned with a broad-

spectrum antiseptic solution. The main aim of irrigation is to flush out small particles of dirt. Scrubbing with a sterile nail brush or toothbrush may also be necessary to remove dirt which, if left in place, could cause infection or tattooing.

### **Suturing Procedure**

1. Selecting the suture material Suture material should be flexible enough for use in any operation, the only variable being determined by tensile strength. There are two types of sutures:

- a) Absorbable (temporary support)
- b) Non-absorbable (permanent support).

A.) Absorbable (catgut)- This type of suture is capable of being absorbed by living mammalian tissue. It is manufactured from the submucosal layer of sheep intestine or the serosal layer of beef intestine, and is available in plain or chromic. Plain: loses half its strength in 10-14 days and all its effective strength in 21 days. Complete absorption occurs within 30-50 days.

Chromic: loses half its strength in 11-14 days and all its effective strength in 28 days. Complete absorption occurs within 45-90 days.

B) Non – absorbable- These sutures can be made from silk, polyester, polypropylene or stainless steel.

C) Selecting the Size of Suture Material- If the suture used for wound closure is too thick wound healing can be delayed.

- Surgical needles for suturing

- 1. Needle Types

- Round bodied: designed to separate tissue fibers rather than cut ~ used for soft tissue cardiovascular / intestinal surgery.
    - Conventional cutting: a cross section, cutting edges restricted to front section of needle has three cutting edges.
    - Reverse cutting: is particularly resistant to bending and reduces the tendency for the suture to be pulled through the tissue

- Trocar point: has strong cutting head and ensures powerful penetration when in dense tissue.
- Taper cut: contains initial penetration of cutting needle with characteristics or round-bodied.

## 2. Needle Shape

For most applications, curved suture needles are used. The curve of the needle is governed by the accessibility of the tissue to be sutured. The more confined the operative site, the greater the curvature required.

## 3. Needle Strength

Diameter of the wire from which the needle is manufactured is a major factor in determining its strength. A factor also to be considered is where the force is applied greater than that for which it is designed. The needle should bend, not break. When bending occurs, it is an indication that the critical point has been passed, so the needle should be discarded rather than attempt to straighten it.

## 4. Use of Needle Holders

The needle holder should be carefully selected to match the size of needle used. Needles should be held on flatted area, not at the needle point or attachment area. (Benbow, 1995)

### **Procedural Guidelines**

The aim of suturing is to appose the edges of a wound together without tension. Assess the wound and determine the most appropriate course of action.

**6B Circumcisions- this procedure can be done on a scheduled basis by our trained RHM** There are different methods of circumcision. Either local or general anesthesia should always be used.

The plastibell procedure involves numbing the area with local anesthetic creams or injection. A bell-shaped instrument is inserted under the foreskin to separate it from the penis. The foreskin is then removed using scissors or a scalpel.

Alternatively, circumcision can be performed as a formal surgical procedure, using dissolving sutures or tissue glue.

**Incision and Drainage-this will be limited to wound of partial thickness. I and D will be done only by the Physician or Medical Officer**  
**6C. INCISION AND DRAINAGE**

Before a skin abscess drainage procedure, a course of antibiotic therapy may be started to help treat the infection and prevent associated infection from occurring elsewhere in the body.

The procedure is typically done on an outpatient basis. If a severe bacterial infection is noted, a referral to Pototan District RHU is done for additional treatment and observation.

Prior to making an incision, the doctor will clean and sterilize the affected area.

Usually, a local anesthesia is sufficient to keep the patient comfortable. It's administered with a needle into the skin near the roof of the abscess where the doctor will make the incision for drainage. Examples of local anesthetics include lidocaine and bupivacaine.

The abscess drainage procedure itself is simple:

1. The doctor makes an incision through the numbed skin over the abscess.
2. Pus is drained out of the abscess pocket.
3. After the pus has drained out, the doctor cleans out the pocket with a sterile saline solution.
4. The abscess is left open but covered with a wound dressing to absorb any more pus that is produced initially after the procedure.
5. A deeper or larger abscess may require a gauze "wick" to be placed inside to help keep the abscess open. This allows the tissue to heal properly from inside out and helps absorb pus or blood during the healing process.
6. The doctor may send a sample of the pus to a lab for a culture to determine the cause of the bacterial infection.
7. In cases, where severe infection is noted, the patient is referred to higher facility for treatment.



**6D Debridement -this will be limited to wound of partial thickness. I and D will be done only by the Physician or Medical Officer**

**PROCEDURE:**

1. Dressings are removed
2. Put on sterile gloves or clean gloves, as appropriate
3. Perform sterile preparation and draping of the wound area, as appropriate
4. Sharply cut away the non-viable tissue until bleeding tissue is encountered
5. The AHP may not excise arteries, veins, nerves or tendons without specific discussion and approval from the Vascular Surgery team and/or responsible attending STANDARDIZED PROCEDURE WOUND DEBRIDEMENT (Adult, Neonatal, Peds)
6. Control bleeding initially with direct pressure; if bleeding persists, use silver nitrate cautery sticks or place a suture as needed
7. If the patient experiences pain, avoid further debridement in area that produces pain
8. Collect culture specimen if indicated
9. Pack the wound as needed, then dress.
10. In cases where the wound area is large, a referral to higher facility is done.

**6E**

**Excision of Small Cyst--this will be limited to cyst with the depth up to dermis. Excision will be done only by the Physician or Medical Officer on a scheduled basis**

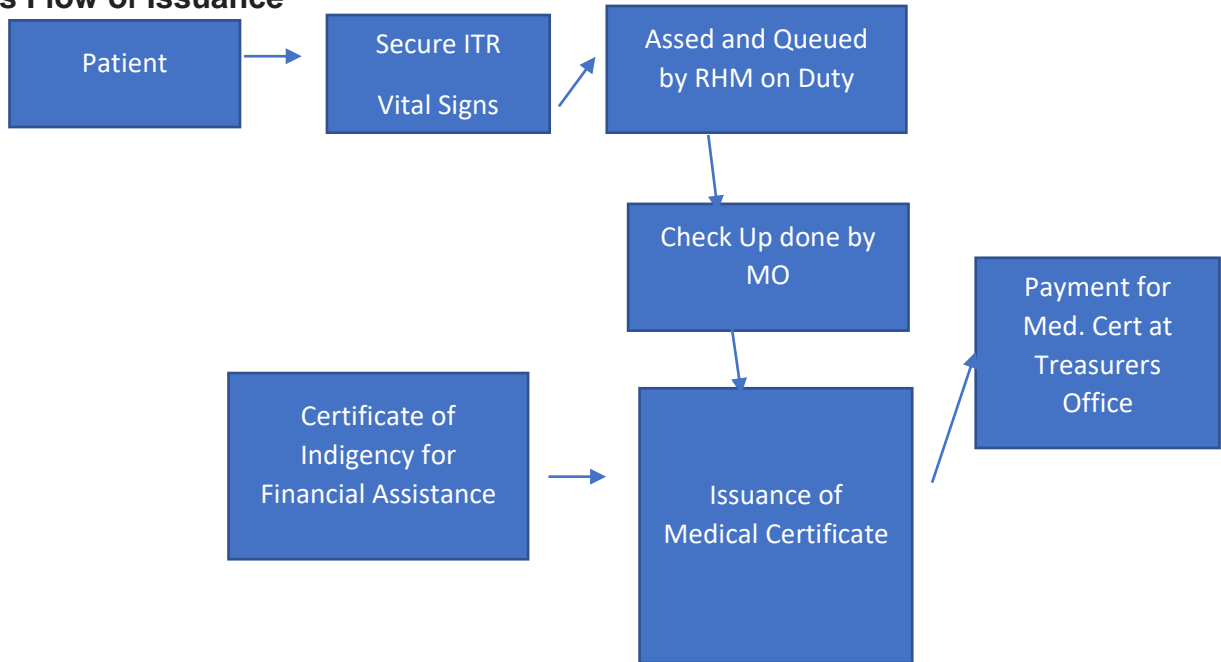
Removal of cysts with only requiring local anesthesia is done at the facility. Large cyst removal performed under general anesthesia or sedation is not done because it must be under the supervision of an Anesthesiologist. The surgeon/physician makes an incision on the skin above or near the cyst to either drain or remove it. The skin may be sutured closed and covered with steri-strips and a gauze dressing or surgical glue. If more than one cyst is noted, they can often all be removed during the same visit

## SAT 7

### ADMINISTRATIVE SERVICES 7A ISSUANCE OF MEDICAL CERTIFICATE

A document signed by a doctor that proves that someone is in good health or healthy enough do a particular type of work.

#### Process Flow of Issuance

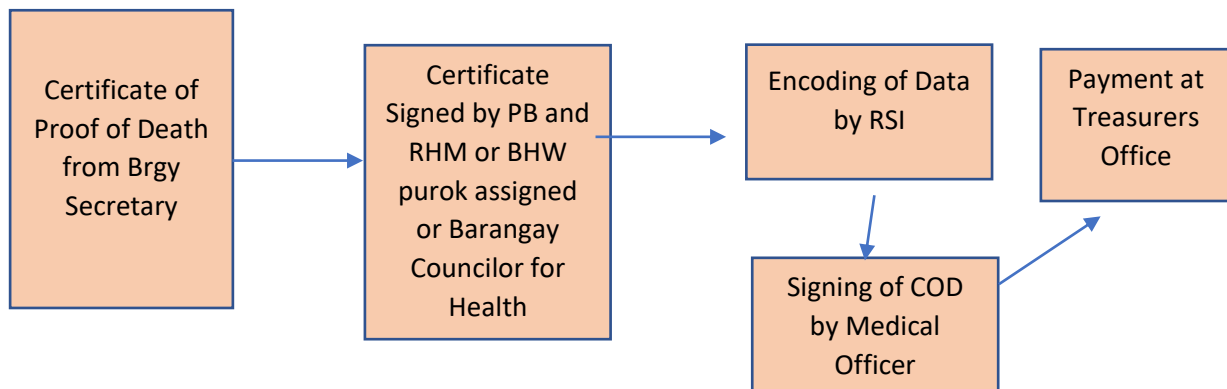


**7B DEATH CERTIFICATE-** A **Death Certificate** is an official document setting forth particulars relating to a dead person, including the name of the individual, the date of birth and the date of death.

When requesting for death certificate, the interested party shall provide the following information to facilitate verification and issuance of certification.

**Death Certificate:**

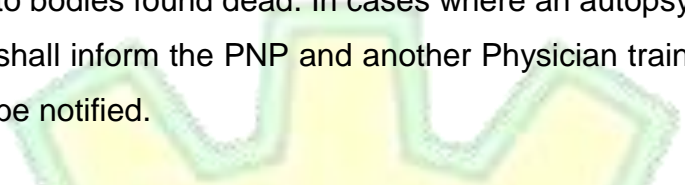
1. Complete name of the deceased person
2. Date of death
3. Place of death
4. Place of marriage
5. Complete name and address of the requesting party
6. Number of copies needed
7. Purpose of the certification



**Guidelines:**

- Death that occurred in the RHU: the physician who last attended the deceased where the person died is responsible to prepare the Cause of Death and certify as to the cause of death. The Municipal Health Officer in the locality where death occurred will only review and attest his/her signature on the “Reviewed by” part of the certificate.
- For “Dead on Arrival” at the RHU: the Municipal Health Officer certifies the Certificate of Death
- Death that occurred in the ambulance: in the absence of attending physician during transport, the Municipal Health Officer certifies Certificate of Death

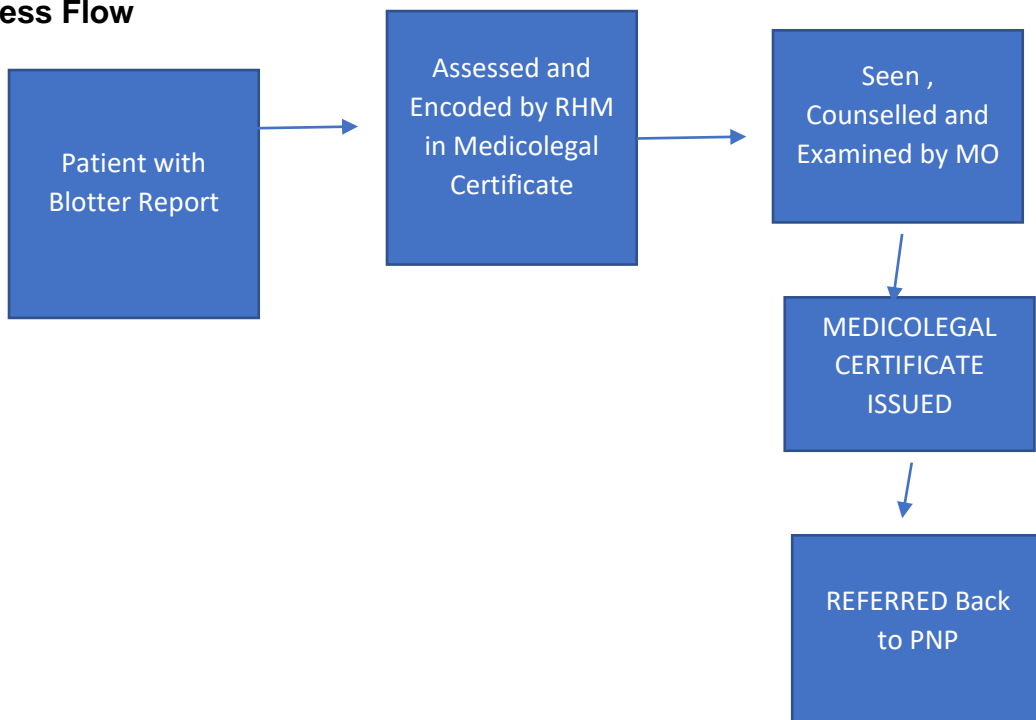
- Death that occurred outside the RHU/in the community: the Municipal Health Officer certifies the Certificate of Death, in the absence or unavailability of the MHO, the Municipal Mayor or the Sangguniang Bayan for Health may issue a certificate of death for burial purposes only
- Death under Medico-legal examination: needs request from the PNP to do postmortem examination to deaths with suspected violence, and to bodies found dead. In cases where an autopsy is needed, the MHO shall inform the PNP and another Physician trained to do autopsy will be notified.



### 7C MEDICOLEGAL CERTIFICATE

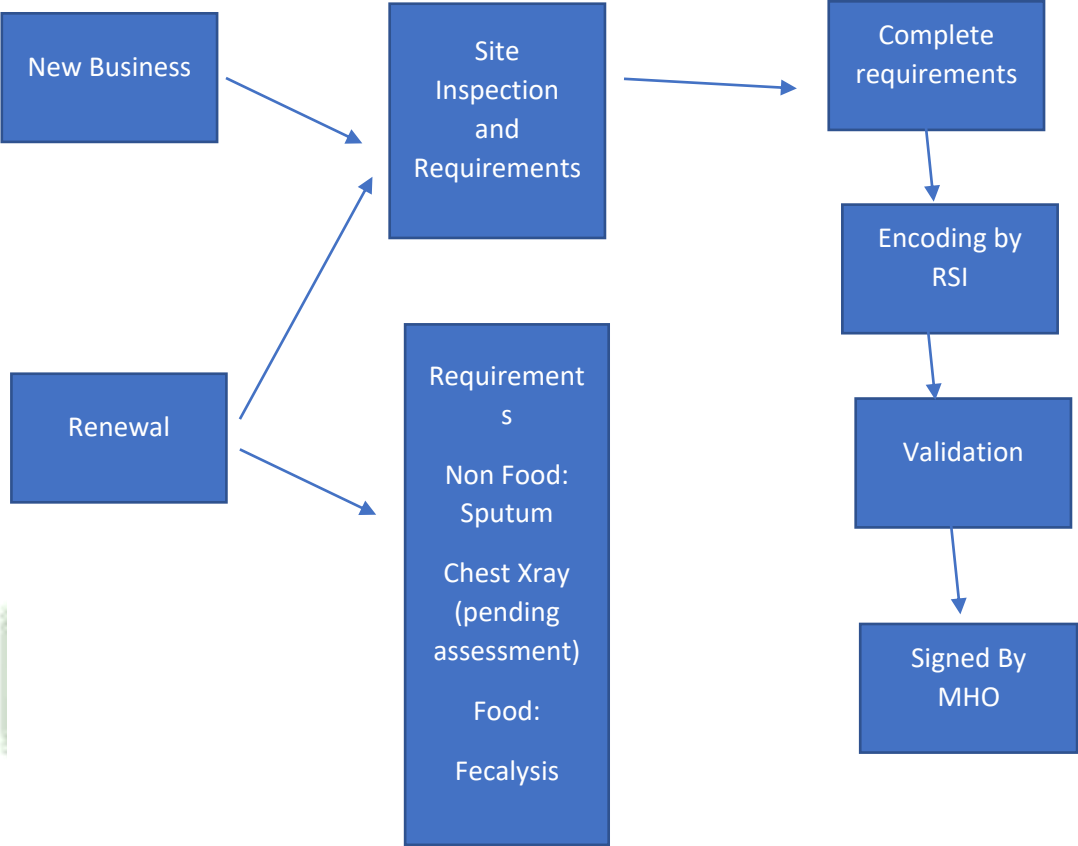
A medical certificate for medico-legal cases **provides the medical findings by the doctor of the injuries you sustained as a result, say, of an accident or a crime**. It is issued following the medical assessment conducted on your person, if possible immediately following the incident, by a medical professional

#### Process Flow



### 7D Sanitation Inspection and Issuance of Sanitary Permit

Sanitary Permit means **the official document issued by the Department of Public Health and Social Services authorizing the establishment to operate its business.**



## **SAT 8**

### **SUPERVISORY SERVICES**

**SUPERVISION** aims to achieve the goals of improved performance and quality of services. It can be done at various levels, between supervisors and the members of the health team, such as the nurse ensuring that the work done by the midwife is effective and efficient, the physician overseeing the work of the rest of the team, the midwife making sure that the barangay health workers and other community volunteers perform their tasks satisfactorily.

#### **Steps to Supportive Supervision:**

1. Set expectations for performance – set clear job expectations or standards against which individual/team/organization performance and results can be measured. The supervisor helps define and implement these standards
2. Monitor and assess performance – once standards or guidelines have been set, the task of gauging the extent to which they are met becomes an ongoing activity that occurs at all levels of the organization. Skills are assessed, compliance to standards are monitored, and problems impeding quality are identified and enabling solutions are developed.
3. Identify problems and opportunities – where there are gaps between expectations and results, the supervisor facilitates a team process for examining potential causes and possible solutions. By facilitating open communication and teamwork, the supervisor can help spot opportunities to improve the overall quality of care and services
4. Take action – the supervisor helps mobilize resources necessary (human, financial, material, political and institutional) and motivates/coaches and empowers and supports providers to implement interventions and activities to address performance gaps or to take advantage of opportunities for improvement. The process continues as new activities begin, with the establishment of expectations for results.

**Patient Navigation in its Primary Care Provider Network**

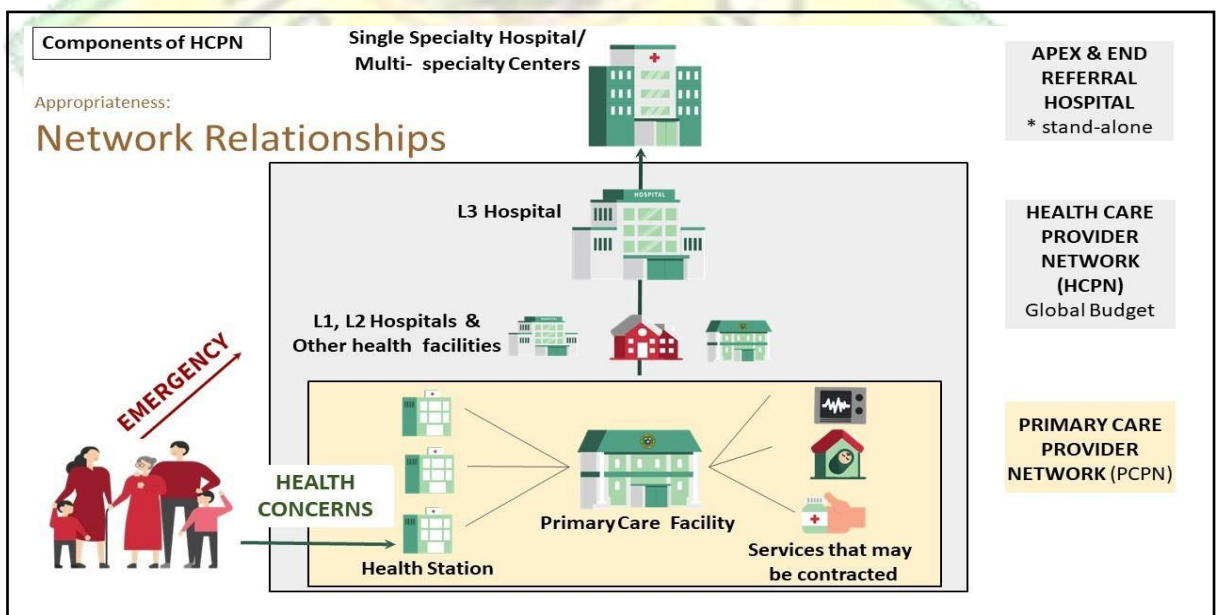
**Principle and its Concepts**

According to the DOH AO 2020 – 0019, which provides the guidelines on HCPN service delivery design consistent with the provisions of UHC Law, the referral system shall operate within the framework of HCPN and its sub-provincial health system with the Primary Care Provider Network (PCPN) as its foundation.

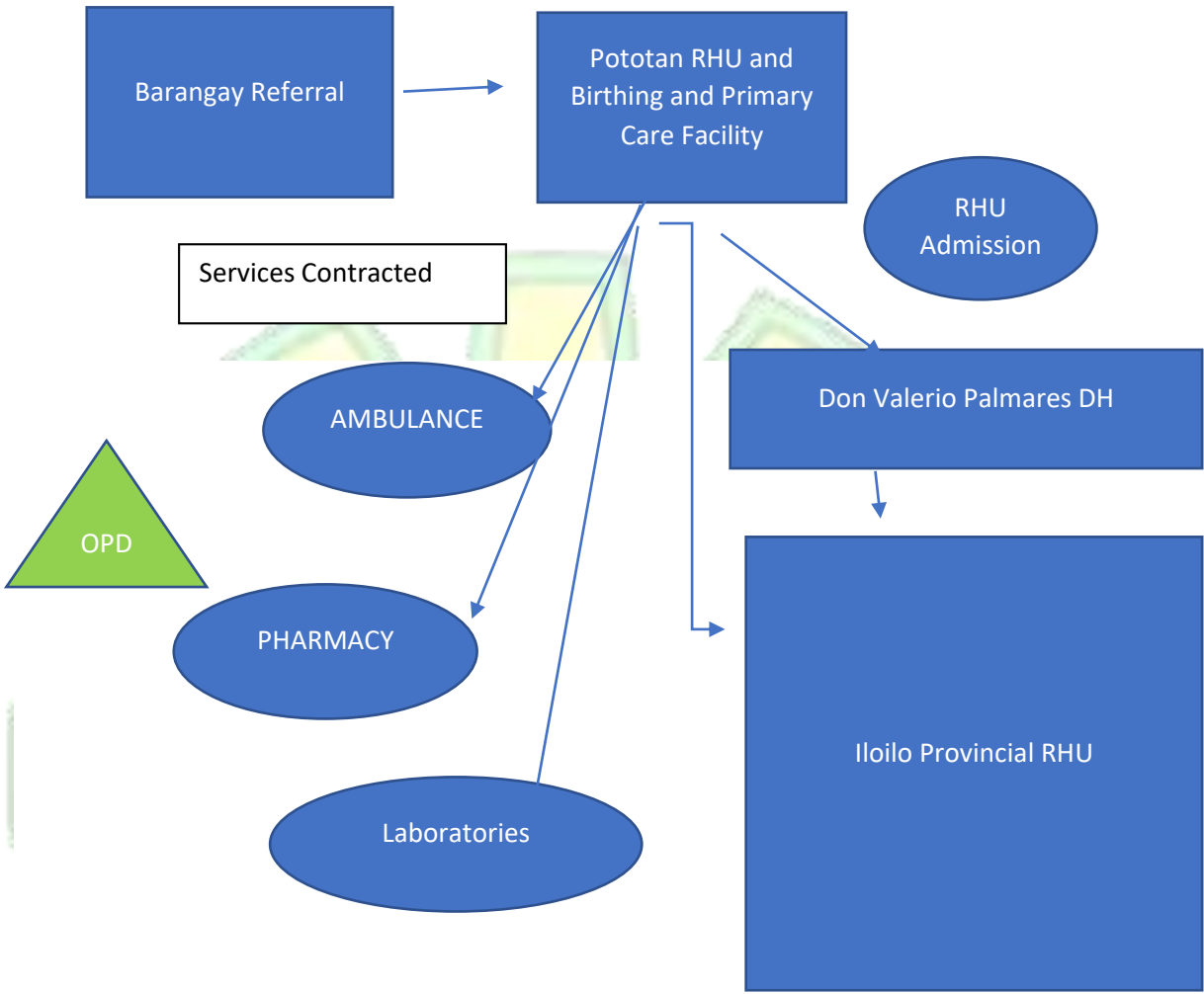
HCPN is a group of primary to tertiary care providers whether public, private, or mixed offering people-centered comprehensive care in integrated and coordinated manner with the primary care provider acting as the navigator and coordinator of health care within the network.

There are three (3) types of health care provider network:

1. **Public HCPN** - is created by grouping the public primary care providers and facilities into Primary Care Provider Networks (PCPNs) that are linked to secondary and/or tertiary care providers within geographic or political boundaries.
2. **Private HCPN** - is driven by market-based forces and may not be limited to defined geo-political boundaries. It is created by grouping the private primary care providers and facilities into Primary Care Provider Networks (PCPNs) that are linked to secondary and/or tertiary care providers within geographic or political boundaries.
3. **Mixed HCPN** - both public and private entities have co-ownership of all health facilities and services within the network. Co-ownership refers to ownership of



**Taking from the DOH Memorandum. Pototan RHU will follow this Process Flow**





MHO- The MHO is the overall responsible officer of the Rural health Unit. He/ she is the **overall manager, supervisor, trainer, epidemiologist and medical and legal officer of the unit**. She/ he is ultimate responsible for all office and program activities

- Take charge of the office on health services, supervise the personnel and staff of said office, formulate program implementation guidelines and rules and regulations for the operation of the said office for the approval of the mayor, in order to assist him in the efficient, effective and economical implementation of a health services program geared to implementation of health related projects and activities;
- Formulate measures for the consideration of the sanggunian and provide technical assistance and support to the mayor, in carrying out activities to ensure the delivery of basic services and provision of adequate facilities relative to health services provided under Section 17 of this Code;
- Develop plans and strategies and upon approval thereof by the mayor, implement the same, particularly those which have to do with health programs and projects which the mayor is empowered to implement and which the sanggunian is empowered to provide for
- In addition to the foregoing duties and functions, the health officer shall :
  1. Formulate and implement policies, plans, programs and projects to promote the health of the people in the local government unit concerned;
  2. Advise the mayor and the sanggunian on matters pertaining to health;
  3. Execute and enforce all laws, ordinances and regulations relating to public health;
  4. Recommend to the sanggunian, through the local health board, the passage of such ordinances as he may deem necessary for the preservation of public health;
  5. Recommend the prosecution of any violation of sanitary laws, ordinances or regulations;
  6. Direct the sanitary inspection of all business establishments selling food items or providing accommodations such as hotels, motels, lodging houses, pension houses, and the like, in accordance with the Sanitation Code;
  7. Conduct health information campaigns and render health intelligence services; (viii)Coordinate with other government agencies and non-governmental organizations involved in the promotion and delivery of health services; and
- Be in the frontline of health services delivery, particularly during and in the aftermath of man-made and natural disasters and calamities; and Exercise such other powers and perform such other duties and functions as may be prescribed by law or ordinance.

Medical Officer- **Contributing clinical expertise to patient care and providing guidance to junior physicians**. Performing administrative duties and risk

management. Ensuring the highest standards in patient care are maintained. Verifying complex diagnoses and facilitating treatment plans.

They may also help assess and diagnose needs and plans of action for individual and families.

**PUBLIC HEALTH NURSE-** They include strategies aimed at entire population groups, families, or individuals. In any setting, the role of public health nurses focuses on the **prevention of illness, injury or disability, the promotion of health, and maintenance of the health of populations.**

**MEDICAL TECHNOLOGIST-** A Medical Technologist, or Laboratory Technologist, **analyzes various biological samples to treat or diagnose different diseases.** Their main duties include getting biological samples ready to test, conducting blood tests and creating reports of their findings.

## **8B SUPERVISION OF BARANGAY HEALTH STATIONS**

- All Barangay Health Stations shall be under the banner of the Municipal Rural Health Unit, and all Rural Health Midwives and HRH shall be under the immediate supervision of the Public Health Nurse
- The Municipal Health Officer shall be the over-all Supervisor of the RHU
- Patients from the community are first seen at their respective Barangay Health Stations. In cases where, the patient needs further management, the Health Worker -in-charge refers them to the Municipal Health Officer who shall then give the treatment plan and further refer to higher facility, if necessary.
- All medicines, drugs and other supplies for the BHS will be primarily allocated from the LGU budget for health and also augmentation from DOH, barangay and other agencies. The Health Worker-in-charge shall collect his/her medicine/drug allocation from the Main RHU on a quarterly basis or as logistics arrive.

## **8C SUPERVISION OF HEALTH WORKERS**

- All barangays shall have at least 7 Barangay Health Workers in each Barangay Health Stations, except for those small barangays (Low Population, Low House hold number)
- Each Barangay has a BHW Coordinator, who will be contacted whenever there are announcements or information regarding their organization.
- The municipality has a BHW Federation, with sets of officers who shall be the leaders of all BHWs in the municipality.

- Annually, all BHWs attend a BHW Congress through the leadership of the Provincial Health Office and PDOHO. Through this congress they are refreshed of all their roles and responsibilities. They are also capacitated in the different health programs.
- In addition to their honorarium from the barangay, they are also given incentives by the Provincial Government annually.



## **SAT 9**

### **Appropriate History and PE on Patients Record RECEIVING / ADMITTING CLIENTS**

1. An admission desk shall be placed in a conspicuous area at the entrance of the Main Health Center
2. The desk shall be manned by available health personnel or BHWs duly oriented on the procedure of admission
3. The following documents are required to be presented on admission:
  - a) 0–5-year-old clients – ECCD card OR Mother & Child Book OR Family Health Diary
  - b) Pregnant Women – Mother & Child Book OR Family Health Diary OR home-based Maternal Record
  - c) Referred clients – referral slip from referring facility
  - d) Referred – back clients – back – referral slip
4. New clients are to inform the desk of their status; a new individual client record shall then be accomplished.
5. Old clients or those with previous history of consultations in the facility shall inform the admitting personnel the name of the family head.
6. Retrieval of family envelopes and the individual client record as to date of consultation, complaints, and vital signs.

## **9C**

### **ESSENTIAL ELEMENTS TO BE DOCUMENTED DURING THE INITIAL ASSESSMENT:**

The individual Client Record shall serve as the recording document for all client visits to the facility.

All entries shall follow the S-O-A-P format described as follows:

**S** = subjective findings to include:

- a.1 Chief Complaint – the main compelling reason for coming to the health facility; can be written verbatim or in the vernacular
- a.2 History of present illness – an account of the current complaint from the start of the illness up to the present

a.3 Past Medical History pertinent to current illness

a.4 Family Medical History especially for lifestyle or genetically determined

diseases

a.5 Obstetric History

a.6. Pediatric History – Immunization, nutrition, and developmental history

**O** = Objective Findings

b.1 Vital signs

b.2 General survey

b.3 Physical examination findings

**A** = Assessment / Diagnosis; refers to the condition / ailment of the client from the point of view of the health care provider

**P** = Plan / Management/Treatment. This is a summary of the next steps for the client which can include:

- Recommended diet
- Requested laboratory tests
- Prescribed medications
- Supportive measures
- Health education messages
- Follow – up schedule

In eliciting data for the **S** or **SUBJECTIVE** component of the client's records, the following are recommended to ensure a thorough CLIENT HISTORY for specific client groups:

1. General Data – should include the complaints, date/time of onset, medications taken, home interventions done, any maintenance medicines relevant to the current condition, any laboratory / diagnostic procedures undertaken relevant to complaint; this is equivalent to subjective complaint or S.
2. For clients below 1 year old, immunization history is essential

3. For pregnant women, the following are essential:

- Obstetric History: Parity, Gravida, Term, Preterm, Abortions, Living
- Last Menstrual Period (LMP)
- Immunization History (tetanus toxoid)
- Condition of current pregnancy

4. For Family Planning Clients (utilize the FP Service Record)

- Obstetric history
- History of contraceptive use
- Medical history
- History of risk factors: smoking, allergies, drug intake, STD, multiple partners, bleeding tendencies, anemia, diabetes
- History of medical conditions such as H-mole, ectopic pregnancies, breast masses

5. For STI clients

- Sexual history
- Contact tracing

6. For Violence Against Women & Children & other medico – legal cases:

- Natures of Incidence (NOI)
- Time of Incidence (TOI)
- Date of Incidence (DOI)
- Place of Incidence (POI)
- History of prior attacks or incidences of VAWC

7. For confirmed TB cases

- History of prior treatment with anti-TB medications, the duration of treatment
- Household members or contacts categorized as those below and above 10years old
- BCG immunization/scar

8. For Lifestyle – Related Diseases

- Essential are history of smoking, intake of alcoholic beverages, drug intake, diet, exposure to irritants

- Family history of lifestyle related diseases such as hypertension, heart diseases, diabetes

## TRIAGING

1. All clients entering the facility shall be entertained on a FIRST COME FIRST SERVED basis except in situations requiring urgent medical care.

\*All patient coming in for consultation must undergo triaging for COVID-19.

\*Checks temperature and ask for any signs and symptoms related to COVID-19.

\*Those with signs and symptoms who are unvaccinated are advised to undergo COVID-19 Rapid Antigen Testing.

2. The following are conditions that require immediate medical attention **(EMERGENCY CASES):**

2.a. Newborn with the following danger signs:

- Fast breathing (RR >60 breaths per minute)
- Slow breathing (RR <30 breaths per minute)
- Grunting
- Convulsions
- Floppy or stiff
- Temperature <35° C or not raising after rewarming
- Bleeding from stump or cut
- Cyanosis of lips and mucus membrane
- Apnea, not breathing

2.b. Children with the General danger signs:

- Convulsions
- Unable to eat or breastfeed
- Vomits everything
- Difficult to awaken
- Difficult breathing

2. c. Pregnant and Post – Partum Women with the following emergency signs:

- Unconscious or convulsing
- Vaginal bleeding
- Severe abdominal pain
- Looks very ill
- Severe headache with visual disturbance
- Fever
- Severe vomiting
- Blood pressure of >160/100 mmHg

2.d. Other clients:

- Loss of consciousness
- Hypertension
- Severe dizziness
- Freshly obtained wounds
- Accidents
- Trauma
- Acute sensory or motor deficiencies
- Exposure to chemicals, either accidental or intentional

3. The trained staff nurse and midwives manages program-based cases.

4. The staff refers all non-program based cases to the physician. Nurses and midwives can provide palliative treatment to patients or refer them to the OPD of the FDH in the absence of the physician or MHO.

5. Clients requiring urgent medical attention should be brought immediately to the MHO for further evaluation and management.

6. Clients that cannot be managed in the facility should be given emergency care and be referred to the primary referral RHU, Pototan District RHU, for further evaluation & management

## **GENERAL GUIDELINES IN THE TREATMENT OF CLIENTS**

1. All clients are to be managed, referred or counseled accordingly.



2. Treatment protocols/Management Algorithms are to be followed for program diseases.

3. The facility shall, have a Case Management / Treatment Manual or Guidelines which shall be based on accepted Department of Health protocols, researches and recommendation from specialist of the various fields of medicine.

4. The diseases for inclusion in the Treatment Guideline shall be based on the Annual Morbidity Profile of the municipality.

5. It shall be an institutional activity of the RHU to regularly update or refresh its staff and personnel on the management of program diseases.

6. A review of the response to medications shall be conducted to determine any protocol changes which shall be accommodated in the Annual Procurement Plan.

#### **GUIDELINES IN THE RE-ASSESSMENT OF PATIENTS/PATIENT FOLLOW-UP**

1. Reassessment of clients can be done during the same consultation day, such as in the case of hypertensive and severe pneumonia cases refusing referral or admission to RHU facilities. However, most follow-ups are to be determined by the initial diagnosis.

The recommended follow-up/ reassessment schedule for specific conditions are as follows:

- ✿ Daily BP monitoring for unstable or newly identified hypertensive patients.
- ✿ Twice daily for severe pneumonia pediatric clients refusing RHUization; after 3 days for pneumonia cases
- ✿ After 5 days for UTI and STI clients with or without symptomatic improvement

- ✿ On 3<sup>rd</sup>, 7<sup>th</sup>, 14<sup>th</sup>, 21<sup>st</sup>, & 28<sup>th</sup> day of treatment for laboratory diagnosed Dengue cases
- ✿ After 2 weeks for the first week of Pulmonary TB clients-initiated treatment, otherwise, all other PTB clients are to be required monthly follow – up
- ✿ Every other day for cardiac patients being decongest with anti-diuretics.
- ✿ Monthly for clients diagnosed to have Chronic Obstructive Pulmonary Disease (COPD)
- ✿ ALL PATIENTS ARE TO BE ADVISED TO RETURN IF NO IMPROVEMENT OF CONDITION/S IS OBSERVED.

2. Records of initial check-up should be retrieved

3. The following should be elicited from the patient:

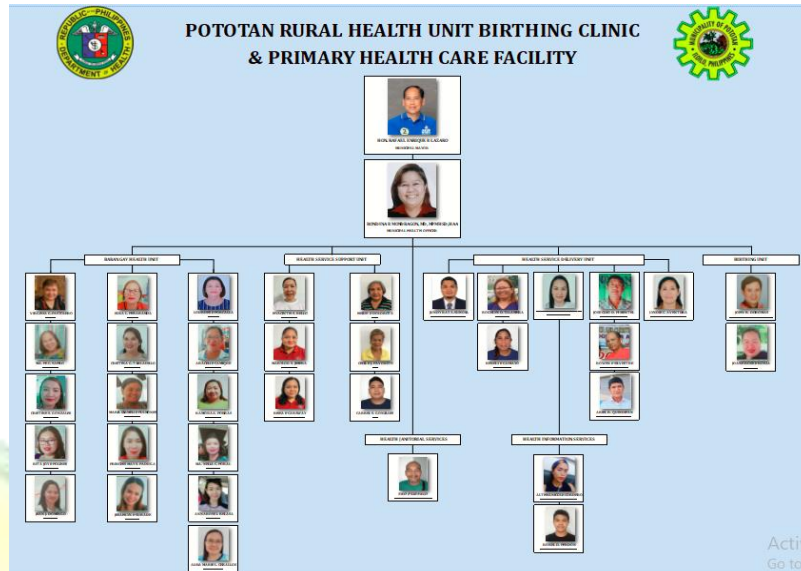
- ✿ Compliance to the medical regimen
- ✿ Observations in the conditions with intake of medications and compliance to other regimen
- ✿ Any untoward reactions to drugs/medicines
- ✿ Records of drug intake for patients enrolled in the TB-DOTS program
- ✿ Clinical assessment of the client in reference to initial findings shall be done and worsening or improvement thereof shall be noted in the client's records

**. To ensure that clients are well-served and program defaulters are limited the following CLIENT TRACKING SYSTEMS are to be institutionalized:**

1. EPI defaulter's master list for midwives and community health team members
2. Pregnancy tracking form for community health teams
3. Case holding for all TB patients enrolled under the TB-DOTS program

### III LEADERSHIP AND MANAGEMENT

#### SAT 11 Organizational Structure



#### SAT 12 Vision and Mission

##### MISSION:

**To Provide the Municipality of Pototan an Equitable, People Centered and Quality Health Services Through Good Governance and Leadership Through Multi Stakeholders Approach Towards Universal Health Care**

##### VISION

**A Globally Competitive and Sustainable Municipality Wide Health System for A Healthier Pototanons by 2025**

# SAT 14 Annual Reports

LOU Health Statement

LOU SCORECARD ON HEALTH

LOU Name - Patison

Province - Balo

Region - NEGROS VI

DOF Year - 2021

Performance Indicator	Performance Level		Reference Table			
	External Benchmark	Internal Benchmark	Performance Result 2021	Performance Result 2020	2021 Avg. 2019	2021 Target 2022
<b>I. ENSURE EQUITABLE HEALTH FINANCING</b>						
<b>A.</b>						
1. Percentage of LOU Budget Allocated for Health (Municipality)	○	↑	18.82	17.86	14.73	NA
2. With Municipal/City Investment Plan for Health (MPC/ICIP) endorsed by the Mayor in the FYD	●	■	100	100	80.14	100
3. Provision of FULL Hazard Pay, subsistence and health allowances to permanent public health workers under the Magna Carta for Public Health Workers	●	■	100	100	55.88	100
<b>II. LOCAL HEALTH SYSTEMS INTEGRATED INTO PROVINCE-WIDE AND CITY-WIDE HEALTH SYSTEMS</b>						
<b>A.</b>						
4. Presence of Integrated Health System (will not be collected for 2021)	●	●	NA	NA	780	780
5. Functional Local Health Board (will not be collected for 2021)	●	●	NA	NA	780	780
6. Organized PHCD (filled vacant positions) (will not be collected for 2021)	●	●	NA	NA	780	780
<b>III. IMPLEMENT COMPREHENSIVE DEVELOPMENT PLAN FOR SERVICE DELIVERY NETWORK</b>						
<b>A.</b>						
7. Adequate Rural Health Unit (RHU) Health Center (HC) to population ratio	●	↓	81.876	76.472	1.31.358	1.25.000
<b>IV. LOCALIZE HIGH IMPACT HEALTH POLICY REFORMS</b>						
<b>A.</b>						
8. Percentage of National Health Policies Translated into Local Policies by the LOUs (will not be collected for 2021)	●	●	NA	NA	780	780
<b>V. IMPROVE PERFORMANCE OF THE LOUs</b>						
<b>A.</b>						
9. Percentage of LOU Health Budget Utilized - Obligation Rate	●	↑	75.81	82.27	82.71	85
10. Percentage of LOU Health Budget Utilized - Disbursement Rate	●	↑	100	82.27	85.11	100
11. Percentage of Facilities with no-stock out of the following commodities	○	↑	100	0	99.84	780
12. With Organized Epidemiology Surveillance Unit (ESU)	●	■	100	100	22.80	100
13. With Institutionalized Disaster Risk Reduction and Management in Health (IDRM-H)	●	■	100	100	45.31	100
14. Percentage of Fully Immunized Child (FIC)	●	↓	72.82	75.25	69.59	85
15. Percentage of adults 20 years old and above who were not assisted using the PhAPEN Protocol	●	■	0	0	2.85	85
16. TB Case Notification Rate (per 100,000 population)	●	↑	416.27	288.89	30%	10% increase
17. TB Treatment Success Rate	●	↑	85.14	83.89	87.20	90
18. Percentage of households using safely managed drinking-water service/connections	●	↑	48.47	27.4	36.16	80
19. Prevalence of Stunting among under-5 children	●	↑	5.55	15.82	23.8	30.8

**Summary of Results**

<https://guhealthscorecard.doh.gov.ph/reports/reportcard>

LOU Health Statement

**Strategic Thrusts**

**External Benchmark**

**Internal Benchmark**

**Legend**

**Performance Description**

**Definition of Terms:**

**Performance Result data value**

**Meaning of the data value of Indicators no. 2, 3, 7, 8 and 9:**

0 NO

100 YES

Source: FHSIS data from ES

Source: Prevalence Stunting among under 5 children data from NHC

Source: TB indicators data from National TB program

<https://guhealthscorecard.doh.gov.ph/reports/reportcard>

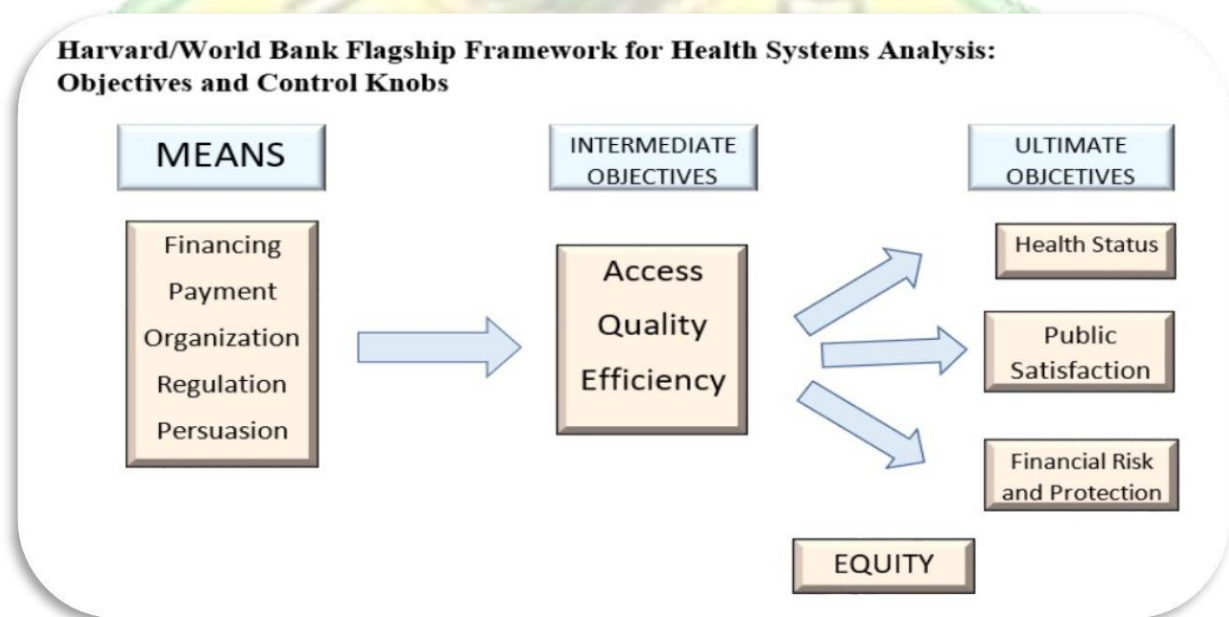
## IV. HUMAN RESOURCE MANAGEMENT A CHANGE PLAN FOR HUMAN RESOURCE FOR HEALTH IN POTOTAN RURAL HEALTH UNIT

The Pototan Rural Health Unit is a devolved agency. It has 22 regular personnel. It is serving 80, 431 population in a community of 50 barangays. It delivers Primary Health Services. It is Implementing 58 population-based program of the Department of Health while still fighting the COVID 19 Pandemic. It gets its directive from both the Regional DOH Office and Provincial Government. The Local Government Unit has the authority over, hiring, recruiting, compensation and benefits of the personnel. It does not possess any blueprint or metrics after hiring for each health human resource. This pandemic was able to expose the weaknesses in health system especially in the personnel infrastructure that lead to a continuous long curve and spikes in its battle against COVID because of inefficiencies. There is now fatigue due to overwhelming demands for health services and a need for multitasking both the regular program and the fight against COVID. The urgency in increasing the number of jobs fit and culture fit personnel for health services is our burning platform.

### System Diagnosis

This diagram shows that Organization with Human Resource as component is one of the five pillars to attain the ultimate objective of the Department of Health which is Better Health Status or Outcome.

### Harvard/World Bank Flagship Framework for Health Systems Analysis: Objectives and Control Knobs



## Strategic Framework for HRH

Specifics for HRH under the management are the cross-cutting problems and the gaps we need to work on to attain our health goals.

### Strategic Framework for HRH

Module Specific Factors	Cross-Cutting Problems	State of HRH	System Goals	Health Goals
Financing Education <b>Management</b> Politics	Traditional Problems: Slow Comprehension Lack of Communication Skill Hesitant to learn Electronic Medical Recording Absenteeism Lack of Motivation Complacent	<b>HRH Level</b> (how many?) HRH Category HRH Distribution (where? who?) Within HRH-category skill- mix Geographical location Sector <b>HRH Performance</b> (what do they do? how do they do it)	Quality Efficiency Equity Sustainability	Health Status Financial Protection Citizen Satisfaction
<i>EXAMPLE: Education Module</i>				
Low # middle/high school graduates	Leads to... Limited health professions applicant pool	Lead to... Insufficient HRH level	Leads to... Compromised quality/equity	Leads to... Unsatisfactory population health status

## Strategic Planning Guideline for Health Human Resource

At the microlevel of the Local Government Unit with the assistance from the Regional DOH 6 control knobs that we can operate for this Change Plan is the density and the talent before their entry to the government and the performance of the existing personnel through Education Modules with Plan Do Study Act.

# Outline of Strategic Planning Guide

## ■ State of HRH

- Densities (levels) of Health Workers
- Distribution
- Performance

## ■ Cross Cutting Problems

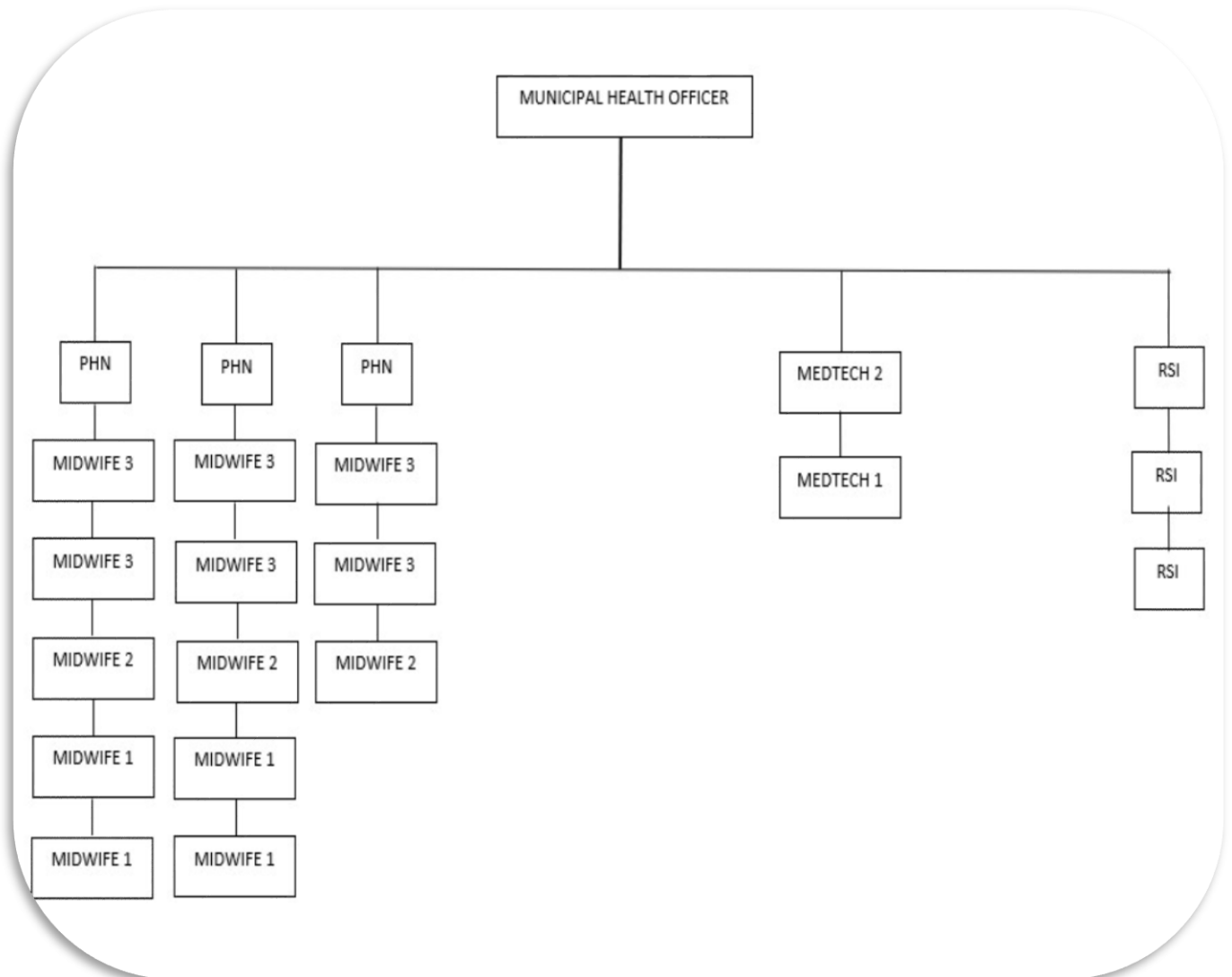
## ■ Modules (Control Knobs)

- Financing
- Education
- Management

## Political Feasibility and Strategies

## MICROLEVEL MANAGEMENT: FACILITY PRACTICE

Present Number of Health Personnel in the Municipality serving 50 Baran





In recent years it has been increasingly recognized that getting HR policy and management "right" has to be at the core of any sustainable solution to health system performance. Buchan J (2004) 1.HRM in the health sector is unique and over the years there had been no template in hiring health human resource in the government service other than suggested WHO of 1 health care worker is to 1,000 population. Hiring of Health workers is often highly politicized.

The RHU has 22 regular personnel and the ratio is 1:3461 population not withstanding of only on doctor.

The aim of this change plan is to provide a template in hiring health personnel as to number, job analysis, interview template and education.

1. There is a need to increase personnel number to deliver more services in the community at least 10% annually until the ideal ratio is reached.

2. Provision of template for hiring to ensure fit in the Human Resource for Health to stop the Culture of Patronage leading to inefficiencies.

3. There must be a linked and coordinated HRM interventions to achieve improvements in organizational performance than single or uncoordinated intervention.

4. There must be institutionalization of these reforms in order to address sustainability.

**GOALS:**

- The health facility has human resource for health plan to ensure adequate, competent and well-motivated staff to achieve its short-term and long-term goals and to meet the needs of its clients.
- Recruitment, selection and appointment of staff comply with statutory requirements and are consistent with the organization's human resource for health policies.
- A comprehensive program of staff learning, management and development meets individual and organizational needs.

**I. STAFFING COMPENSATIONS**

- Personnel compensation shall be based on currently implemented salary standardization law.
- All organic health personnel shall receive hazard, subsistence and laundry allowance as allowed by the Commission on Audit based on the Magna Carta of Health Workers.
- Overtime compensations shall be in the form of monetary compensations or compensatory time off as allowed by the Chief Executive.

- A mechanism of awarding &rewarding shall be developed for high performing health personnel using the various bench marks of the health program such as MNCHN and the LGU Scorecard.

## II. RECRUITMENT, SELECTION AND DEPLOYMENT

### A. Recruitment

- Recruitment of personnel to fill up vacated or new positions shall be based on the implementing rules and regulations of the Commission on Civil Service on personnel recruitment.

### B. Selection

- The selection process shall be based on standards set for each item position in terms of the qualification standards.
- The applicant should meet all the requirements of position including the appropriate civil service eligibility.
- The qualification standards or minimum requirements for position should include education, training experience, civil service eligibility, physical fitness and personality trait required by the job.
- However, there shall be added points for applicants who have worked with the organization as volunteer workers, either as professionals, BHWs or BNSs.

### C. Deployment

- Personnel shall be deployed to the various barangay health centers.
- They are oriented as to their roles and responsibilities before deployment
- Only duly oriented and trained personnel shall be deployed on their own. Casual employees shall be paired up with organic health personnel until such time that they receive due training.
- An office order shall be made for all deployments due copies of which shall be provided the Human Resources Management Officer and the Local Chief Executive.

- At any point of the year, other personnel can be deployed to unserved/underserved areas in situations as follows:
  - Prolonged leave of absence by assigned health personnel
  - Strained relationship between health personnel and community which compromises safety of the personnel and service delivery.
  - Training of health personnel which deprive regular service delivery.
  - Augmentation of personnel from the Office of the Municipal Mayor (Job Orders/Contractual) and the Department of Health under special programs such as the HRH personnel and the like.
  - Detainment of assigned personnel to other posts due to exigency of services

#### D. Supervision

1. The over-all supervisor for the operations of the RHU shall be the MHO.
2. However, the direct supervisors of each personnel are as follows:
  - Public Health Nurse- all midwives
  - Medical Technologist- Dengue microscopist, TB microscopist, RDT trained BHWs
  - Midwife- all members of the Community/Family Health Team
3. Each supervisor shall conduct supervisory activities for all supervisees.
4. Each supervisor should make a supervisory plan which shall be executed as scheduled.
5. The supervisory plan should have the following information:
  - Calendar of supervision (date and program to be supervised)
  - Purpose of supervision
  - Who will be supervised?
  - A supervisory checklist shall be formulated for all programs to facilitate supervision and staff evaluation
6. Each supervisor should follow the supervisory process as follows:
  - Formulation of the supervisory plan

- Discussion of the supervisor and the supervisee on the purpose of the supervision and the program to be supervised.
- Review of program protocols/ flowcharts
- Evaluation of activities using the program checklist
- Documentation of all findings, actions taken and recommendations in the following matrix:

NAME OF SUPERVISEE :	POSITION:			
DATE	AREA/PROGRAM	FINDINGS	ACTIONS TAKEN	RECOMMENDATIONS

- Conduct a TNA for supervisors using the following checklist for training courses with supervisory content:
  - MCI-TOT
  - Training on FP Clinic Supervision for Quality Assurance
  - Refresher course in Family Planning
  - Training on TB-DOTS
  - Guidelines for follow-up after training-IMCI
  - Expanded program on Immunization
  - Midlevel Supervisory Course

7. The core programs to be supervised should include the following:

- MNCHN
- Family Planning
- Prevention & control of infectious diseases
  - Tuberculosis
  - Dengue

- Dengue
  - Rabies
  - Sexually Transmitted Infections
  - Leprosy
  - Soil Transmitted Helminthiasis
- d. Promotion of healthy lifestyle

E. Staff Performance Evaluation

- a. All employees under the Local Government of Pototan shall be evaluated utilizing the IPCR system which is Institutionalized and adapted. This shall be the basis of all incentives, promotions and reprimands.

**MANAGEMENT RESPONSIBILITY**

**Policy on continuing program on staff development and training:**

**Training is needed when:**

- a. A worker is new to a given function and the related skill requirement
- b. The skill requirement of a given function has changed owing to advances in methods, techniques or procedures
- c. The worker's skill has decayed owing to improper use or lack of use.
- d. The worker's basic skill levels need enhancement to perform more advance task and responsibilities.

**Policy for hiring, orientation and promotion of primary health care personnel:**

**Qualified candidates must:**

- a. Fill application forms which include a full job description.
- b. Educational qualifications achieved (including descriptions of classes completed)
- c. Description of related clinical experience must be noted
- d. Must have qualifications to assume responsibility

This application shall be submitted in sufficient time to permit assessment prior to hiring of the individual

**Orientation:** A successful new employee will undergo orientation:

- A. General orientation which discusses the overall policies and procedures to all areas in the facility, this often includes matters of personnel, compensation benefits, employee rights and the employee's general responsibilities
  
- B. Job specific orientation related directly to new employee responsibilities, policies and procedure
  - New employee must report to the facility
  - He/She will be explained of her new duties and responsibilities.
  - He/She will be taught of quality and safe practices in the facility

#### **ANALYSIS OF ROOT CAUSES**

Leadership- Highly Politicize Hiring

Structure- naming only mandatory position but no number of personnel required in the Local Government Code

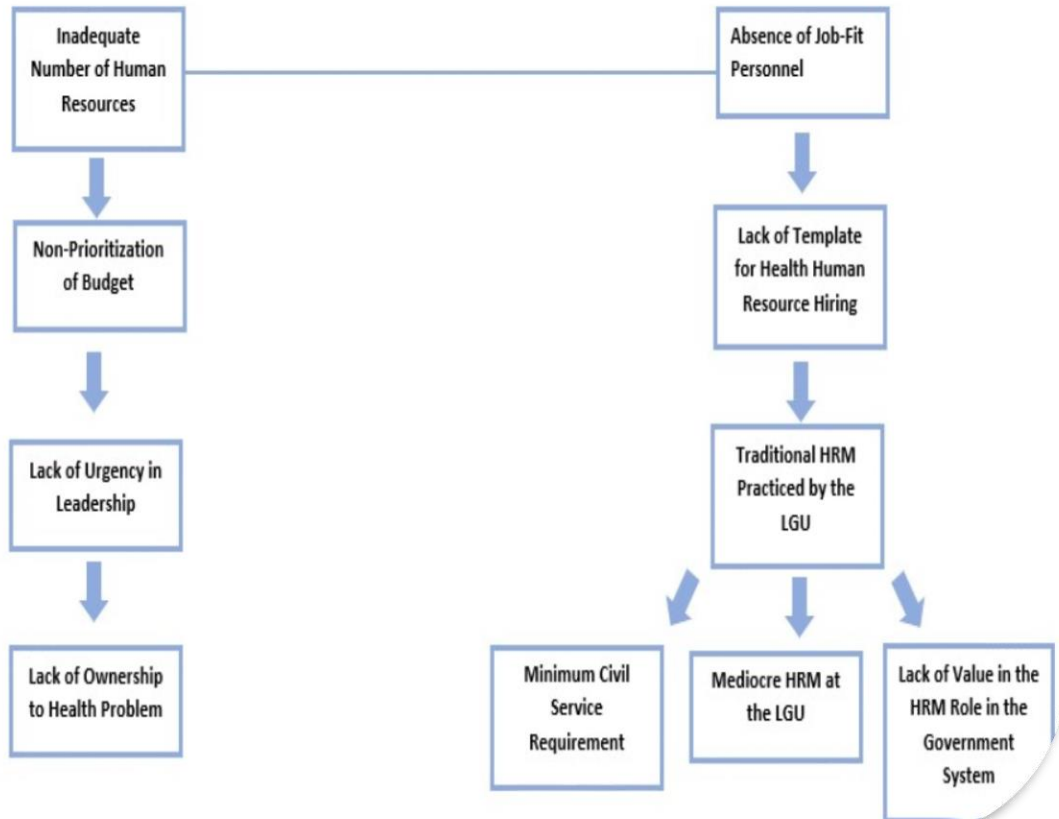
Financial Resources- The Local Chief Executive had been put to position by a vote of popularity thereby lacks the background on financial management of LGU resources.

Talent Management HR Practices- personnel hired are based on the minimum requirement by the Civil Service that had not been amended since 1991

Employee Engagement-benefits and compensation had not been updated in the last 10 years ago.

Culture -The mission and vision of the LGU had not been communicated to the personnel resulting to absence of objective. Working in the government is very much influence by Filipino culture

## Analysis of Root Causes



### MEASURES OF SUCCESS using the DMAIC model

Number of Health Care Worker Hired by the LGU WHO Ideal Number 1 HCW: 1,000 population

Checklist and Scoring for the Human Resource Officer in Hiring New Health Care Worker

Number of Old and New Health Care Worker Committed to Retooling and Education



### CREATING CLIMATE FOR CHANGE

1. Create a sense of urgency with the Lets DOH it messages from the Local Chief Executive and Sanggunian Bayan.

Building of Performance Team Evaluation with inputs from the Non-Government Organization

Observe, interview and figure out issues and reasons for non-hiring and upgrading of salaries

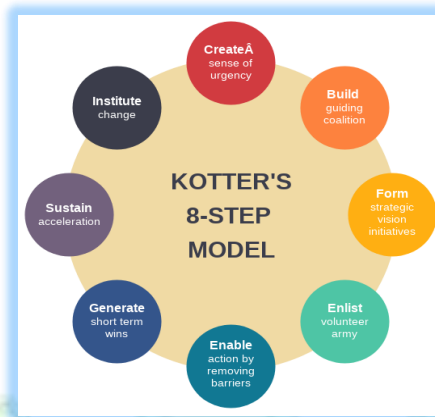
Lead team members to come up with a shared vision, discuss plans and huddles.

### TEAM MEMBERS

<b>Sponsor</b>	<b>Local Chief Executive</b>
<b>Team Leader</b>	<b>Municipal Health Officer</b>
<b>Team Members</b>	<b>NGO-Private Doctor/Sectors DOH-Development Management Officer Legislative Member for Health</b>
<b>Data Analyst</b>	<b>Human Resource Officer</b>
<b>Frontline</b>	<b>Administrative Staff</b>
	<b>Health Human Resource Representatives</b>



Anchored to Kotter's 8 Step Model CHANGE PLAN must be in place.



**ENGAGING AND ENABLING THE WHOLE ORGANIZATION**

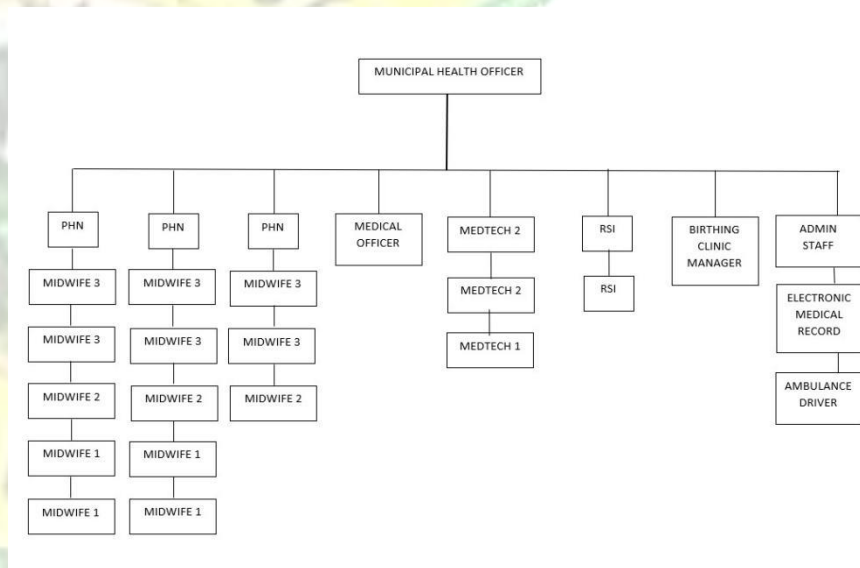
1. Communicate for Buy In
2. Enable Actions
3. Create and Celebrate Short Term Wins

**IMPLEMENTING AND SUSTAINING CHANGES**

**Forecasting of Manpower**

Additional:

- 2 Medical Officer
- 1 Public Health Nurse
- 4 Additional Rural Health Midwife
- 1 Nutritionist
- 1 Pathologist
- 3 Administrative Staff
- 2 Nightshift driver
- 2 Janitor



## Job Description

Title	Job Location	Job Summary	Reporting To	Job Duties and responsibilities	Supervisory Responsibility	Working Conditions/Physical demands/hazards
Medical Officer	Municipality of Pototan	Curative Preventive Planning Administrator Communicator	The Municipal Health Officer	<p>Devotes the morning hours attending to patients in the out- door. Implement all basic health services including family planning. Plan and implement UHC Proper implementation of IMCI as per guidelines. • Organize and conduct Family Planning Implant Organize training of all health personnel –Ensures that national health programmers are being implemented in area properly. • Visits each BHS regularly on fixed days and hours – Provides guidance, supervision and leadership to the health team.</p> <p>Leadership – which the medical officer is able to provide. • The medical officer must be – the planner, – the promoter, – the director, – the supervisor, – the coordinator as well as the evaluator.</p>	Nurses Midwives BHW BNS	<p>Must supervise staff in the field Must know how to communicate with barangay leaders Must travel around the targeted barangays</p>



<b>Public Health Nurse</b>	<b>Municipality of Pototan</b>	<p>Must know how to do planning</p> <p>Must have basic knowledge in IT</p> <p>Consistently Be knowledgeable on all the Public Health Program</p> <p>Must be good at specifics of programmed assigned</p> <p>Must know how to transfer knowledge to subordinates</p>	<b>MHO Barangay Officials</b>	<p>Doing strategies aimed at entire population groups, families, or individuals.</p> <p>Focuses on the prevention of illness, injury or disability, the promotion of health, and maintenance of the health of populations</p>	<b>Barangay Officials RHM BHW BNS Community</b>	
<b>Rural Health Midwife</b>	<b>Municipality of Pototan</b>	<p>Must know how to communicate and advocate,</p> <p>Must have leadership</p> <p>Must be promotive and caring</p>	<b>MHO PHN Barangay Officials</b>	<p>Assists the mother during childbirth and primary maternity care (1). In public health, midwife is playing a positive role, promotes health care system for mother and child, and brings the good change in the maternal</p>	<b>BHW BNS Barangay Local Health Board</b>	

				Ensuring completeness of requirements attached to transactions		
<b>Janitor</b>	<b>Municipality of Pototan</b>	<b>Must possess knowledge and efficiency in cleaning and disinfecting</b>		<p>Cleans and keeps up various surfaces and material within a building or space.</p> <p>Sweeps and mops floors.</p> <p>Vacuums and steam clean carpets.</p> <p>Washes windows and launders drapes.</p> <p>Cleans and disinfects toilets and replenishes supplies such as toilet paper, soap, and paper towels.</p>		
<b>Ambulance Driver</b>	<b>Municipality of Pototan</b>	<p>Have a license in Basic Life Support</p> <p>ACLS license is encouraged</p> <p>Must have knowledge on basic repairs</p> <p>Must clean and disinfect ambulance after every use</p>		<p>Drive <b>ambulances</b> to assist injured or sick individuals.</p> <p>Move patients onto stretchers to bring onto vehicle.</p> <p>Replace supplies in the <b>ambulance</b> weekly.</p> <p>Administer first aid, including CPR and bandaging, once at the destination</p>	<b>MHO MO PHN RHM Medical technologist</b>	



## Job Specifications

Title	Qualification	Work Experience	Skills	Mental Ability	Sensory Demand	Socio Emotional Ability
Medical Officer	A Board Passer Must Have a Master's in Public Health or Public Management (DAP preferably or from Top 5 University in the Province)	Had at least 2 years hospital experience as residence of specialist and a 1-year experience in public health	Undertaking patient consultations and physical examinations organizing workloads performing minor surgical procedures Birth delivery care monitoring and administering medication assessing and planning treatment requirements liaising daily with staff including other doctors, non-medical management staff and healthcare professionals writing reports and maintaining records	Good practical skills Leadership and management skills Communication skills, compassion and a good bedside manner Drive to continue learning throughout career Analytical ability	Works without noise Applies green practice to work Conscious in making workplace clean and smell fresh	Ability to work long hours, often under pressure Displays self-control. Expresses feelings with words. Listens and pays attention. Pride in accomplishments. Has a positive self-image. Asks for help when needed. Shows affection to familiar people.



			promoting health education	Time management		Aware of other people's feelings.
Public Health Nurse	Board Passer Master's in Public Health/Administration/Management	Must have 2 years hospital experience and at least 2 years in community health	excellent communication skills project management. analytical skills. influencing and negotiating skills. ability to work across multi-agency or multi-disciplinary professional networks. good people skills in order to develop and sustain relationships.	Verbal comprehension Inductive reasoning. Word fluency. Associative memory. Perceptual speed.	Works without noise Applies green practice to work Conscious in making workplace clean and smell fresh	Ability to work long hours, often under pressure Displays self-control. Expresses feelings with words. Listens and pays attention. Pride in accomplishments. Has a positive self-image. Asks for help when needed. Shows affection to familiar people. Aware of other people's feelings.
Sanitary Inspector	A bachelor's or master's degree in the major of Occupational Health, a natural science (Biology, Chemistry, Physics), Environmental Science or Public Health. ...	Must have 4 years of work-related experience	excellent communication skills project management. analytical skills. influencing and negotiating skills.	Verbal comprehension Inductive reasoning. Word fluency.	Applies green practice to work Conscious in making	Ability to work long hours, often under pressure Displays self-control.

		Must know basic IT Knowledge (word, excel, powerpoint)		health conditions and newborn baby (2).		
Nutritionist	Municipality of Pototan	Knowledge on Planning and Evaluation. Must know how to transfer skills and advocate Must know basic IT Knowledge (word, excel, powerpoint)		Most nutritionists reported performing food and nutrition actions advocated for PHC, with emphasis on practices for promoting eating habits, diagnosis and care for nutritional deviations	BHW BNS Barangay Nutrition Committee	
Pathologist	Municipality of Pototan			Supervises secondary laboratory as to accuracy and quality of results.	Medical technologist Laboratory Aide Utility	
Administrative Staff	Municipality of Pototan		Municipal Health Officer	Tasks such as scheduling appointments, answering phones, greeting visitors, and maintaining organized file systems for the organization. Encoding Communication Screening of Incoming Supporting Papers	Janitor	

	Must have a Diploma in Sanitary Inspector Course		ability to work across multi-agency or multi-disciplinary professional networks. good people skills in order to develop and sustain relationships.	Associative memory. Perceptual speed.	workplace clean and smell fresh	Expresses feelings with words. Listens and pays attention. Pride in accomplishments. Has a positive self-image. Asks for help when needed. Shows affection to familiar people. Aware of other people's feelings.
Rural Health Midwife	Bachelor of Science in Midwifery Able to earn a masters degree related to course or public health/administration	Must have 2 years training in Hospital delivery Room Must have at least 1-year experience in Public health	an understanding and caring attitude. an ability to get on well with people from a wide range of backgrounds. emotional and mental strength. good observation. an ability to act on own initiative. patience. maturity.	Verbal comprehension Spatial orientation. Inductive reasoning. Number facility. Word fluency. Associative memory. Perceptual speed.	Works without noise Applies green practice to work Conscious in making workplace clean and smell fresh	Ability to work long hours, often under pressure Displays self-control. Expresses feelings with words. Listens and pays attention. Pride in accomplishments. Has a positive self-image. Asks for help when needed.



			willingness to take responsibility.			Shows affection to familiar people. Aware of other people's feelings.
Nutritionist	A Board Passer Able to earn a master's degree related to course or public health/administration	Must have at least 2 years work experience in the government under DOH or NNC	Teamworking skills. Keen interest in the impact of diet on health. Good interpersonal skills. Communication skills, including the ability to explain complex things simply. An understanding of science. Able to motivate others.	Verbal comprehension Spatial orientation. Inductive reasoning. Number facility. Word fluency. Associative memory. Perceptual speed.	Works without noise Applies green practice to work Conscious in making workplace clean and smell fresh	Ability to work long hours, often under pressure Displays self-control. Expresses feelings with words. Listens and pays attention. Pride in accomplishments. Has a positive self-image. Asks for help when needed. Shows affection to familiar people. Aware of other people's feelings.
Pathologist	A Board Passer Certificate in Quality Management	Must have at least 2 years of work-related experience	Teamworking skills. Good interpersonal skills.	Verbal comprehension Spatial orientation.	Works without noise Applies green	Ability to work long hours, often under pressure Displays self-control.

			Communication skills, including the ability to explain complex things simply. An understanding of science. Able to motivate others.	Inductive reasoning. Number facility. Word fluency. Associative memory. Perceptual speed.	practice to work Conscious in making workplace clean and smell fresh	Expresses feelings with words. Listens and pays attention. Pride in accomplishments. Has a positive self-image. Asks for help when needed. Shows affection to familiar people. Aware of other people's feelings.
Administrative Staff	A 4-year graduate Certificate in Information technology or Related Training	Must have at least 2 years' experience in the use of word, excel, ppt. Must have communication and writing skills	Written communication. Verbal communication. Organization. Time management. Attention to detail. Problem-solving. Technology. Independence.	Verbal comprehension Spatial orientation. Inductive reasoning. Number facility. Word fluency. Associative memory. Perceptual speed.	Works without noise Applies green practice to work Conscious in making workplace clean and smell fresh	Ability to work long hours, often under pressure Displays self-control. Expresses feelings with words. Listens and pays attention. Pride in accomplishments. Has a positive self-image. Asks for help when needed.

						Shows affection to familiar people. Aware of other people's feelings.
Janitor	At least college level	Must have at least 2-year work experience in janitorial service	Responsible for cleaning buildings, removing debris, and keeping areas neat and tidy. Vacuums and buffs floors, empties trash receptacles, and replace lining of trash cans. Replace and water plants	Verbal comprehension Spatial orientation. Inductive reasoning. Number facility. Associative memory. Perceptual speed.	Works without noise Applies green practice to work Conscious in making workplace clean and smell fresh	Ability to work long hours, often under pressure Displays self-control. Expresses feelings with words. Listens and pays attention. Pride in accomplishments. Has a positive self-image. Asks for help when needed. Shows affection to familiar people. Aware of other people's feelings.
Ambulance Driver	At least college level, Level 2 drivers license, Certificate Course in BLS, ACLS is a plus	Must have at least 2 years' experience in driving and 1 year in	driving and staffing ambulances and other emergency vehicles. responding to emergency calls.	Verbal comprehension	Works without noise Applies green	Ability to work long hours, often under pressure Displays self-control.

		automotive repair	assessing patients, monitoring and administering medication, pain relief.	Spatial orientation. Inductive reasoning. Number facility. Associative memory. Perceptual speed.	practice to work Conscious in making workplace clean and smell fresh	Expresses feelings with words. Listens and pays attention. Pride in accomplishments. Has a positive self-image. Asks for help when needed. Shows affection to familiar people. Aware of other people's feelings.
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# Assessment Interview

Assessment Interview: Gathering I

- Summarize below key facts showing the applicant's demonstrated capabilities in each Success Factor.
- Record 2 to 3 behavioral evidences for each factor.
- Check the rating that best describes your assessment of the applicant's capabilities.

Leadership

Displays to be a strong communicator (listening, responding, explaining)

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

Proved that it can effectively work in a team environment

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

Can speak up about the things that would like others to be open with.

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

Displays strong collaboration with [previous colleagues, staff, and hospital administration.

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

**Strategic Think** Feel comfortable addressing conflicts as soon as they arise.

Able to	EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
EXC	4	3	2	1	0
	4	3	2	1	0
	4	3	2	1	0
	4	3	2	1	0

Think of new ways to approach a problem from a process perspective.

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

Able to work in a complex practice setting.

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

Able to create unique clinical insights and create competitive advantage for department or organization.

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

Programmable, systematic and rational thinker.

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

**Commitment and Motivation**

Describe a time when you recognized you weren't going to be able to meet multiple deadlines. What did you do about it? What was the outcome?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0



Tell me about a time when you had an idea that was great for own work, your team or your company. How did you get your management/peers excited about it? How did you follow through to ensure your idea came to life?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

When you're able to make extra time in your role, do you ever do anything to make your job more efficient/easy?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

What techniques have you learned or discovered that make your job easier, or make you more productive?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

What motivates you to go to work every day?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

4	3	2	1	0
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Tell me about a time where you went above and beyond your role and expectations. Why did you do this? What exactly did you do?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0



Can you describe a time where you identified a new, or unusual approach to address a problem or task? How did this approach work?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

If you find yourself stuck doing repetitive work, how do you motivate yourself to continue and complete it?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

Have you ever been a part of an unmotivated team? What did you do to stay motivated and make work interesting?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0

4	3	2	1	0
4	3	2	1	0

**Technical Mastery**

How did your education prepare you for this job?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

What **technical** certifications do you have?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0



What do you do to stay up-to-date on your **technical** certifications and knowledge?

EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0
4	3	2	1	0

PART II. RATING SUMMARY					
	EXCEPTIONAL	VERY STRONG	STRONG	MODERATE	WEAK
<b>Leadership</b>	4	3	2	1	0
<b>Strategic Thinking and Results Focus I</b>	4	3	2	1	0
<b>Commitment and Motivation</b>	4	3	2	1	0
<b>Technical Mastery</b>	4	3	2	1	0

**Minimum Requirements For "Pass"**

- Minimum Recruiting Quality Score of 8
- Must be at least Strong in Leadership and Strategic Thinking and Results-focus
- No Weak rating and no more than two Moderate ratings

**Administrative Officer for PCF- Dr. Rodina P. Mondragon**

## V. INFORMATION MANAGEMENT

### SAT 26 GOALS:

- Relevant, accurate & timely data are readily available in the health facility and used as a basis for patient care, health promotion, disease prevention & control, and management of services.
- Integrity, safety, storage, access and security of record are assured and statutory requirements are met.

### 1. CLIENT RECORDS

- a) All clients seeking consultation in the facility shall have an individual client record.
- b) All residents of the municipality shall a family folder wherein all of the individual client records of its members shall be kept.
- c) The family folder shall be marked with the full name of the head of the family and be filed alphabetically using family name as the basis for filing.
- d) Each page of the client record should contain the following data at the top most portion:
  - Client name
  - Birthday
  - Sex
  - Barangay
  - Head of the Family
  - Mother/Spouse
- e) Non-residents of Pototan such as fiesta vendors, personnel of the various government and non-government and visitors shall have only an individual client record which shall be kept in folders marked either as TRANSIENT, PNP, BFP, DEP-ED, and NIA.



- f) All family folders shall be kept in a filing cabinet, Folders shall be color coded as office supply allows and be filed alphabetically using the first letter of the family name as the basis for filing.
- g) Only health personnel shall have access to the files to ensure privacy and security of all records.
- h) For each consultation, the following should be recorded in the individual client record:
  - Date of consultation
  - S=subjective complaints verbalized by patient; service requested or asked e.g. FP, EPI
  - O= clinical findings to include BP, Weight, Temperature, RR, PR
  - A= assessment or clinical diagnosis
  - P= plan or the clinical interventions
  - After all entries for each consultation consulting health personnel should affix his/her signature below the SOAP.
- i) For 0-5 years old, the IMCI assessment and recording form shall be utilized by duly trained or oriented health personnel and be attached to the individual client record.

## **2. RECORDING**

- A. All transaction in the RHU shall be recorded in various logbooks as follows:
  - a. Daily Consultation Logbook
  - b. Drug Dispensing Logbook
  - c. Referral Logbook
  - d. Laboratory Logbook
  - e. Target Clients Lists (TCL)
  - f. NTP Registries for adult TB and TB in Children
  - g. Dengue Registry
  - h. Disease-Specific PIDS recording forms
  - i. STI Logbook
  - j. Rabies Logbook

B. Due to limited number of personnel within the MHC, any of the staff can enter data in the various logbooks after due orientation.

C. The Consultation Logbook should contain the following data:

- Date of Consultation
- Name of Patient
- Age
- Sex
- Family Head (First Name)
- Barangay
- Diagnosis
- Services/ medication given
- Indicate whether 4P's beneficiary or not

D. The Drug Dispensing Logbook shall contain the following data:

- Date of Dispensing
- Name of Patient
- Kind of Quantity of medicines given
- Patient's signature

E. There shall be separate logbooks for the different laboratory procedures available. Common data to all should include name, age, sex and barangay or origin. Standards registries for the National Tuberculosis Program and the Dengue Control Program shall be utilized in the facility

F. All TCLs of each BHS should be regularly updated. However, only the TCL of the barangays served by the Main Health Center are expected to be left in the facility except during the report making period (every end of the month).

### 3. REPORTING

A. All recorded data/ documents in the above logbooks shall be entered into appropriate reporting forms, as follows:

RECORDING FORM/LOGBOOKS	REPORTING FORMS
Daily consultation Logbook	<ul style="list-style-type: none"> <li>▪ Monthly Morbidity Report</li> <li>▪ FHSIS</li> <li>▪ PIDSR</li> <li>▪ NCD Monthly</li> <li>▪ KILATIS KUTIS</li> <li>▪ OPT quarterly report</li> <li>▪ NBS Quarterly</li> <li>▪ Rabies Quarterly</li> <li>▪ Mental health Monthly</li> <li>▪ Child Injury Monthly</li> </ul>
Requisition Logbook	<ul style="list-style-type: none"> <li>▪ Inventory stock card</li> </ul>
Referral Logbook	<ul style="list-style-type: none"> <li>▪ Quarterly referral Reporting Form</li> </ul>
Dengue Laboratory Registry	<ul style="list-style-type: none"> <li>▪ PHILMIS</li> </ul>
NTP Registry Logbooks	<ul style="list-style-type: none"> <li>▪ NTP Quarterly Reports</li> </ul>
Target Client Lists	<ul style="list-style-type: none"> <li>▪ FHSIS</li> </ul>
Dispensed to User Record (DTUR)	<ul style="list-style-type: none"> <li>▪ CDLMIS; FHSIS</li> </ul>
PIDSR disease specific reporting forms	<ul style="list-style-type: none"> <li>▪ Monthly PIDSR report</li> <li>▪ Notifiable Disease Reports</li> </ul>
Notifiable Diseases	<ul style="list-style-type: none"> <li>▪ Quarterly Notifiable Diseases</li> <li>▪ A2</li> </ul>
Death Reporting Form	<ul style="list-style-type: none"> <li>▪ Quarterly Mortality report</li> <li>▪ A3</li> </ul>

B. Official forms shall be utilized in all reports submitted to the PHO &CHD-CAR

namely:

- i. Quarterly FHSIS
- ii. Annual FHSIS
- iii. Quarterly NTP
- iv. NBS Quarterly

- v. Quarterly Kilatis-Kutis
- vi. Quarterly NCD
- vii. Weekly PIDSR

#### **4. STORAGE OF DOCUMENTS**

##### **A. Client-Based Records**

- All individual client records are to be kept in the family folder.
- All family folders are to be stored in the filing cabinet within the RHU with limited access only to health personnel.

##### **B. Reports**

- All reports are to be made in triplicate for the following: (2) RHU, (1) PHO
- RHU file copies are to be filed according to program and be kept in magazine files
- Only (1) RHU file is to be made accessible for reference while the other RHU file be kept.

#### **5. PRIVACY, CONFIDENTIALITY AND THE RELEASE OF PATIENT INFORMATION**

- a) Client-Health Care Provider confidentially should be observed at all times.
- b) The medical record is a confidential document and the patient's right to privacy must be considered at all times.
- c) Client conditions are not to be discussed except for purposes of improving case management protocols, morbidity or mortality case review.
- d) No unauthorized person can take any or part of a medical record out of file, or read, copy or otherwise tamper with them.
- e) Record filed are to be accessible only to RHU personnel.
- f) Copies of clinical findings and case management documents are to be given only to:
  - The client himself/herself if client is of legal age
  - Parent/ legal guardian of any minor
  - Police personnel upon presentation of request for medic-legal findings
  - Court of Law for cases filed in court

- Barangay captain upon presentation of request for medico legal findings cases filed in the Barangay Court.
- If a request is made for the release of information the request should contain the following:
  - Full name of patient, address and date of birth
  - Name of person or institution requesting information.
  - Purpose and need of the information
  - Extent and nature of information to be released including dates
  - A recently dated authorization letter signed by the patient or authorized representative (e.g., parent of a child)

## **I. GENERAL POLICY AND PROCEDURES**

Medical records should be kept by the Health facility as long as required. Before determining a retention policy, the facility should review the record usage after discharge.

A. Culling medical records that have NOT been used for at least 5 years from the active file room. The aim of culling is to remove INACTIVE medical records from file to make more filing space.

B. The Culled records can then be stored in secondary storage or destroyed.

C. Whenever a medical record has been sent. The tracer should have the following:

- a. The patient's name and date of birth
- b. Admission and discharge dates
- c. Name of attending doctor
- d. Diseases treated and operations performed; and
- e. A discharge summary for each admission if more than one.

D. Medical records are considered the property of the health facility and are compiled, and kept primarily for the benefit of the patient. All personal data contained in the medical record is considered a confidential communication and the property of the patient information cannot be released without the consent of the patient except for the following:

- a. By doctors and other health professionals for the continuing care of the patient
- b. For medical research where the patient is not identified; and
- c. For the collection of the health care statistics when the individual patient not identified.

E. Before archiving/destruction of records, it should be reviewed first.

- a. Records may be destroyed 15 years after last attendance in the RHU
- b. For Deceased Patients, may be destroyed 10 years after the date of death
- c. Obstetric Care, 25 years after last delivery, or 15 years since last attendance

F. All medical records, except for medico- legal cases, stored in the secondary for more than 15 years should be sent to the National archive. A letter of request is forwarded to the National Archive for the disposal of the medical records. In cases where in medical records are destroyed due to natural causes, pest infestation, etc.

## **26A -B POLICIES AND PROCEDURES ON RECORD STORAGE, SAFEKEEPING, MAINTENANCE AND RETENTION**

Records are one of the most valuable assets of any type of organization. As we are all aware of, records support decision-making, demonstrate compliance, document the history of the organization, and perhaps most importantly, enable us to do our jobs. Thus, records need to be properly managed in order to maximize their value and minimize their cost.

The Pototan Rural Health Unit and Birthing and Primary Care Facility, as a rural health unit, shall be governed by the existing laws and policies of the government. Thus, in compliance with the Republic Act NO. 9470 otherwise known as the National Archives of the Philippines Act of 2007, shall give priority for the safeguard, protection and preservation of its documents and records, not only as fundamental instruments for efficient and effective governance but also as essential tools for the preservation of the college's history and cultural memory.

Towards this end, the Pototan Rural Health Unit and Birthing and Primary Care Facility acknowledges its obligation to establish and maintain an active continuing program directed to the application of efficient and economical records management methods relating to the creation, utilization, maintenance, retention, preservation, and disposal of public records (Rule 3.1, Art. III, NAP General Circular No. 1.

The RHU shall serve as guidance and resources for all the patients it is responsible for creating, receiving, preparing, processing, storing, and disposing of records. It shall also contain the functions, organizational chart of the records, policies and standard operating procedures of all records management activities. The policies, rules and regulations embodied in the RMM were all based from the pertinent provisions of RA 9470 and its Implementing Rules and Regulations (IRR), and the NAP General Circulars issued under the provisions of said Act.

As provided under Article III of the NAP General Circular No. 1, the RHU shall establish its Records and Archives Office and shall be headed by a qualified

Records Officer. The office is mandated to oversee the records management program of the unit.

Figure 1 shows the organizational set-up of the Records and Archives Office of RHU. The office shall be under the supervision of the Municipal Health Officer.

## **POLICY TITLE: POLICIES ON RETENTION AND DISPOSAL OF MEDICAL RECORDS**

### **Policy on Record Disposition Schedule**

**Purpose:** To establish guidelines for the retention and disposition of records created and maintained by the organization.

**Scope:** This policy applies to all records created and maintained by the organization, regardless of format or medium.

**Policy:** The organization shall maintain records in accordance with legal and regulatory requirements, and for as long as they are needed for business purposes.

**Medical Records:** Medical records shall be retained for a minimum of 5 years from the date of the last patient encounter, in accordance with DOH regulations. After the retention period has expired, medical records shall be forwarded to Municipal Archives up to 10 years and destroyed in a secure manner.

**Medicolegal Records:** Medicolegal records, including records related to malpractice claims, shall be retained for a minimum of 25 years from the date of the last patient encounter. After the retention period has expired, medicolegal records shall be destroyed in a secure manner.

**Non-Medical Records:** Non-medical records, such as logbooks and administrative records, shall be retained for a minimum of 5 years from the date of creation or receipt. After the retention period has expired, non-medical records shall be destroyed in a secure manner.

**Exceptions:** There may be instances where legal, regulatory, or business requirements necessitate the retention of records for a longer period than specified in this policy. In such cases, the organization shall retain the records for the required duration.

**Disposal:** Records that have met the minimum retention period and are no longer needed for business purposes shall be destroyed in a secure manner. Destruction methods shall ensure that the records cannot be reconstructed or accessed by unauthorized persons.

**Responsibilities:** It is the responsibility of all employees and contractors to adhere to this policy and ensure that records are retained and disposed of in accordance with these guidelines. The organization shall designate an individual or department responsible for the implementation and oversight of this policy.

**Training:** All employees and contractors shall receive training on this policy and their responsibilities for record retention and disposal.

**Enforcement:** Non-compliance with this policy may result in disciplinary action, up to and including termination of employment or contract.

### **Policy on Treatment of Valueless Records**

It is important for government agencies to conduct periodic examinations of their files to identify and dispose of valueless records. This helps to maintain an efficient and effective records management system, and ensures that valuable resources are not wasted on storing and maintaining records that are no longer needed.

As per policy, agencies should conduct such examinations at least once a year, separating records that are to be disposed of from those that need to be retained for further use. However, it is important to note that public records under the administration and control of the agency should not be disposed of without the appropriate authority from the National Archives of the Philippines.

This means that any records that are deemed to be of historical, legal, or cultural value must be preserved, even if they are no longer needed for day-to-day operations. Disposing of such records without the proper authorization would be a violation of policy and could have serious consequences.

In summary, the office will be diligent in their efforts to manage their records, identifying and disposing of valueless records on a regular basis, but ensuring that any records of public importance are properly retained and preserved in accordance with the policies and procedures established by the National Archives of the Philippines.

### **DISPOSAL PROCEDURES FOR HEALTH RECORDS**

1. Document Controller from HIMD conducts an inventory of record holdings and initiates on the disposal of valueless records based on the following:

- General Records Disposition Schedule (GRDS)
- Agency's Records Disposition Schedule
- Specific Rules and Laws

2. Culls out valueless records

3. Prepares request to dispose of records and forwards to the Document Controller



4. Document controller to examine and check request and recommend for approval to MCC
5. MCC approves and signs request
6. DC submits request to NAP
7. NAP receives, evaluates and examines list of records requested for disposal
8. NAP approves the submitted request for authority to dispose with analysis report and recommended manner for disposal and assigns a representative to evaluate and examine records for disposal.
9. Actual disposal depending on the manner prescribed by NAP
- 10.. Issues OR to Official Buyer
- 11.. Signs certificate of Disposal and Provides copy to concerned offices
12. Files copy of the Certificate of Disposal from NAP.

#### STEPS IN PREPARING FOR RDS

Document Controller shall prepare a communication letter to the

Head of Office for the activity.

All officials and heads shall be informed about the planned activity and its purpose thru a Memorandum.

Records Inventory - the process of listing record holdings in an agency usually done by records series indicating its specific location, including dates and volume. (Use NAP Form No. 1)

#### **Disposal Of Damaged Public Records That Have Not Yet Passed Their Prescribed Retention Periods**

Disposal Of Damaged Public Records That Have Not Yet Passed Their Prescribed Retention Periods shall be considered for authorized disposal only upon submission of the following requirements:

1. Official report pertaining to the non-usability and extent of damage done to the records and photo documentation
2. Request for authority to dispose of records ( NAP Form No. 3) in three Copies

#### **OFFENSES**

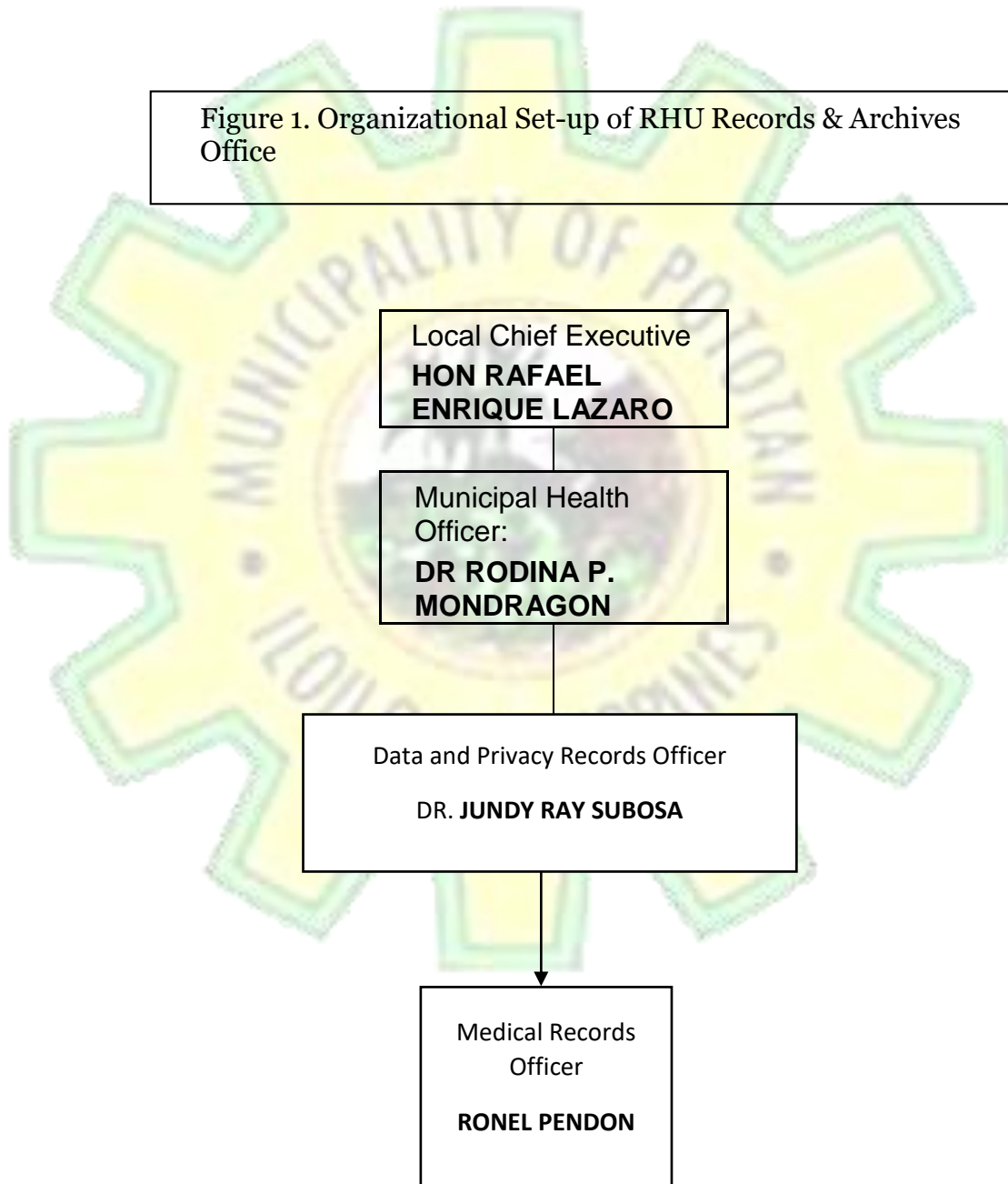
- A person who, willfully or negligently damages a public record or disposes or destroys a public record in violation of the provisions of RA 9470 and its IRR or contravenes or fails to comply with any provisions of the said act and its IRR shall be deemed to

have committed an offense.

## PENALTIES

Any officer committing any of the unlawful acts of omissions mandated under RA 9470 shall be punished by a fine of not less than five hundred thousand pesos (P500.00) but not exceeding one million pesos (P1,000.000.00) or be imprisoned for not less than five (5) years but not more than fifteen years (15) or vice versa or both.

Figure 1. Organizational Set-up of RHU Records & Archives Office



## **SAT 28 MANAGING RHU RECORDS**

### **1. Establishment of RHU's Storage/Mini Archive**

- 1.1 The unit shall maintain and operate records storage/mini archives of ITR records for 5 years preparatory to their transfer to the Records Center or to Archives Repository until 10 years.
- 1.2 All non-current records unit shall transfer records to the Records and Archives Office for repository.

### **2. Records Creation**

- 2.1 Each shall have an integrated program in the creation of necessary records and copies thereof, including reports, forms, and issuances of the absolute minimum in the most effective way consistent with efficiency and economy.
- 2.2 Each unit shall keep and preserve a logbook in which shall be recorded in chronological order all final official acts, decisions, transactions or contract pertaining to their functions. The logbook shall be in the custody of the Data Records Officer concerned and shall be opened to the public for inspection.

### **3. Records Maintenance and Control**

#### **3.1 Operations of Incoming and Outgoing Mails**

- 3.1.1 The unit shall have a centralized receiving and releasing unit of all communications for proper recording and routing procedures under the accountability of the Administrative Records Officer.

#### **3.2 File Classification Guide for Uniform Filing System**

- 3.2.1 The unit shall develop a File Classification Guide or Scheme for a uniform filing system

#### **Retention Code**

- 4.1. Retention Code shall be affected by the unit based on the General Records Disposition Schedule (GRDS).

### **4. Utilization of Filing Equipment and Floor Space**

- 4.1 The unit shall set standards and criteria for the maximum utilization of filing equipment and floor space for maintaining and servicing files.

### **5. Personnel Security and Access to the File**

- 5.1 The Records Officer/Custodian shall have the sole access to the office files and shall be responsible for the security of records at all time.

6.1. Confidential records shall be kept separately from the general files in secured file containers.

6. Servicing with the File

Each unit shall adopt requisition and charge-out procedures in issuing files. A follow-up device shall be developed on charged out records.

Records Disposition

1. Inventory and Appraisal of Records

Each unit shall prepare an inventory and appraisal of its records holding using the prescribed form as an initial step in developing the Records Disposition Schedule

2. General Records Disposition Schedule (GRDS)

2.1. The unit shall observe the enclosed GRDS in determining the disposal of its valueless records.

2.2. The unit shall not dispose of the valueless records earlier than the period indicated for each records series. However, records may be retained for longer periods if there is a need to do so.

3. Records Retention Schedule

3.1. The unit shall establish a Records Disposition Schedule

3.2. Any revision or change in the Schedule shall likewise be submitted for approval to the MHO as the need arises.

4. Turn-Over of Records to Successor

A person having custody of public records, at the expiration of his/her term of office or employment, shall deliver to his/her successor. Transfer and Storage of Non-Current/Inactive Records

Transfer of non-current/inactive records of the unit to the LGU Records Center Division shall be in accordance with the approved retention period and upon recommendation of the Records Management Analyst of LGU

5. Authority to Transfer

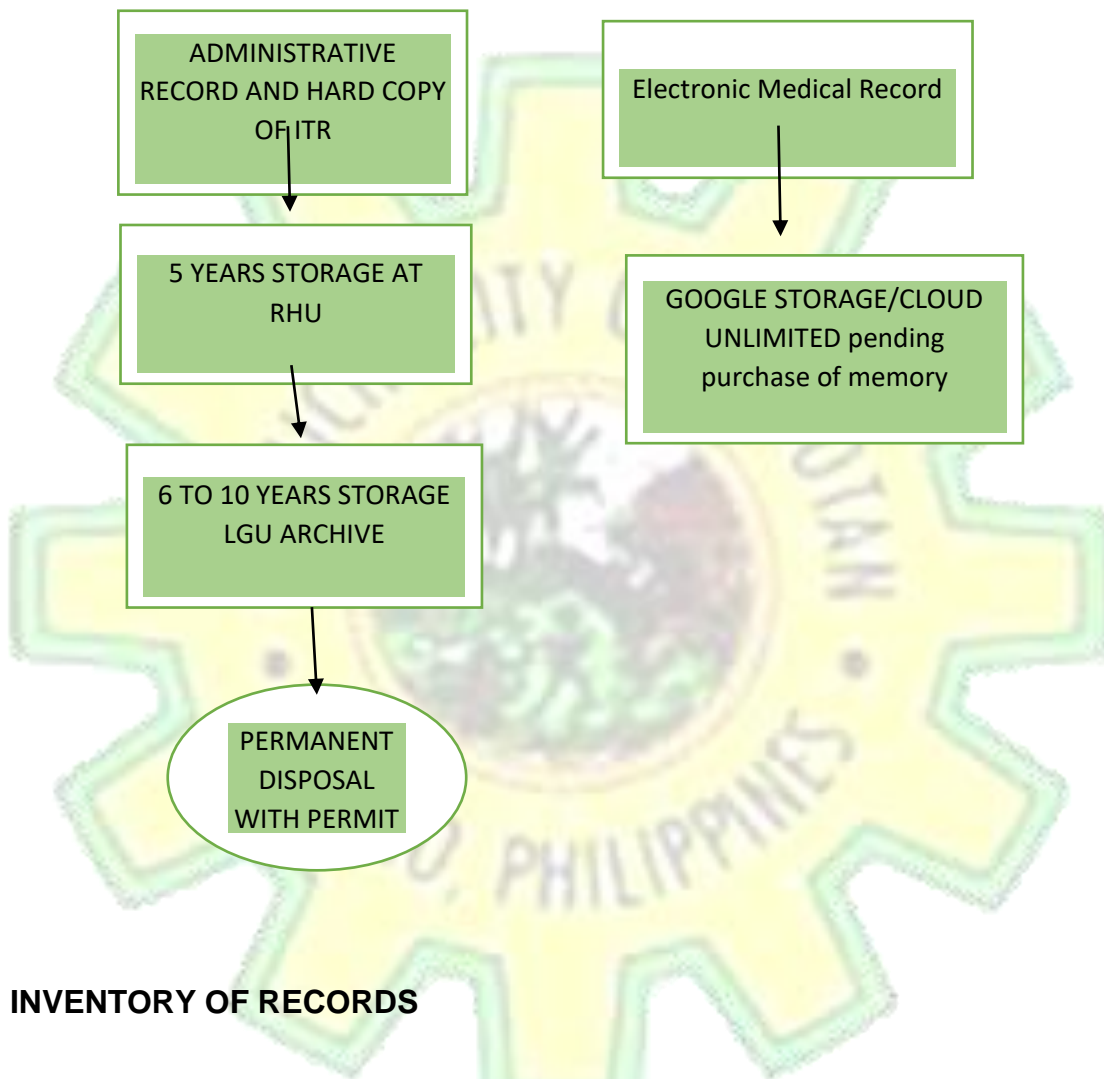
Request for authority to transfer unit records shall be effected upon recommendation of the MHO

Transparency of Transaction and Access to Information

The unit must institute adequate records management controls over the maintenance and use of their records wherever they are located to ensure that all

records, regardless of format or medium, are organized, classified, and described to promote their accessibility

## PROCESS FLOW OF SCHEDULE OF RECORDS RETENTION AND DISPOSITION



## INVENTORY OF RECORDS

Pursuant to Article III, Section 15 of Republic Act 9470, the Records Officer/Custodian of ASCOT shall conduct an inventory of all Pototan Rural Health Unit and Birthing and Primary Health Care Facility records and shall be mandated to keep the following data in the respective registry:

- (a) All Pototan Rural Health Unit and Birthing and Primary Health Care Facility records under its custody
- (b) All records transferred to the POTOTAN RURAL HEALTH UNIT AND BIRTHING AND PRIMARY HEALTH CARE FACILITY

(c) All records disposed of with authority (Section 18 and 19 of RA 9470)

(d) Data of deferred transfer of records (Section 21 of RA 9470)

(e) A public access register that contains information on:

- (1) Restrictions on public access to Pototan Rural Health Unit and Birthing and Primary Health Care Facility records;
- (2) Prohibitions imposed on public access to public archives or protected records under the control of the Executive Director;
- (3) The grounds for the prohibitions and restrictions;
- (4) The conditions agreed on as to public access for protected records transferred to the control of the Executive Director of POTOTAN RURAL HEALTH UNIT AND BIRTHING AND PRIMARY HEALTH CARE FACILITY.

The inventory of records will allow the POTOTAN RURAL HEALTH UNIT AND BIRTHING AND PRIMARY HEALTH CARE FACILITY to create a List of Record Series that will strengthen the present system of records keeping while promoting a meaningful awareness among stakeholders of the importance and relevance of records and archives as significant aspects of Philippines cultural heritage.

The inventory aims to assist researchers and other members of the public interested in specific records holdings of the Pototan Rural Health Unit and Birthing and Primary Health Care Facility. It shall promote the awareness that the Pototan Rural Health Unit and Birthing and Primary Health Care Facility must keep records according to their prescribed disposition period and that the general public can access such records provided no restrictions have been included.

#### Steps/Procedures in the Conduct of Inventory

1. The Records Officer/Custodian of the Pototan Rural Health Unit and Birthing and Primary Health Care Facility shall conduct the physical inventory of records. He/she shall:

Step 1. Identify all records by records series title or records series name including those records that cannot be classified/determined as official records whether located in the official file/repository or other storage areas.

Step 2. Identify the location of each record series including records not properly placed in the designated storage areas such as those located in the stairways, unused restrooms and vehicles, etc.

Step 3. Approximate the volume of each record by cubic meter.

Step 4. Fill up the National Inventory Form (see Appendix A). The following information are needed in filling-up the form:

1) Name of Office

The Pototan Rural Health Unit and Birthing and Primary Health Care Facility will be the office where inventory will be undertaken

2) Department/Division

The department/division of the Pototan Rural Health Unit and Birthing and Primary Health Care Facility

3) Section/Unit

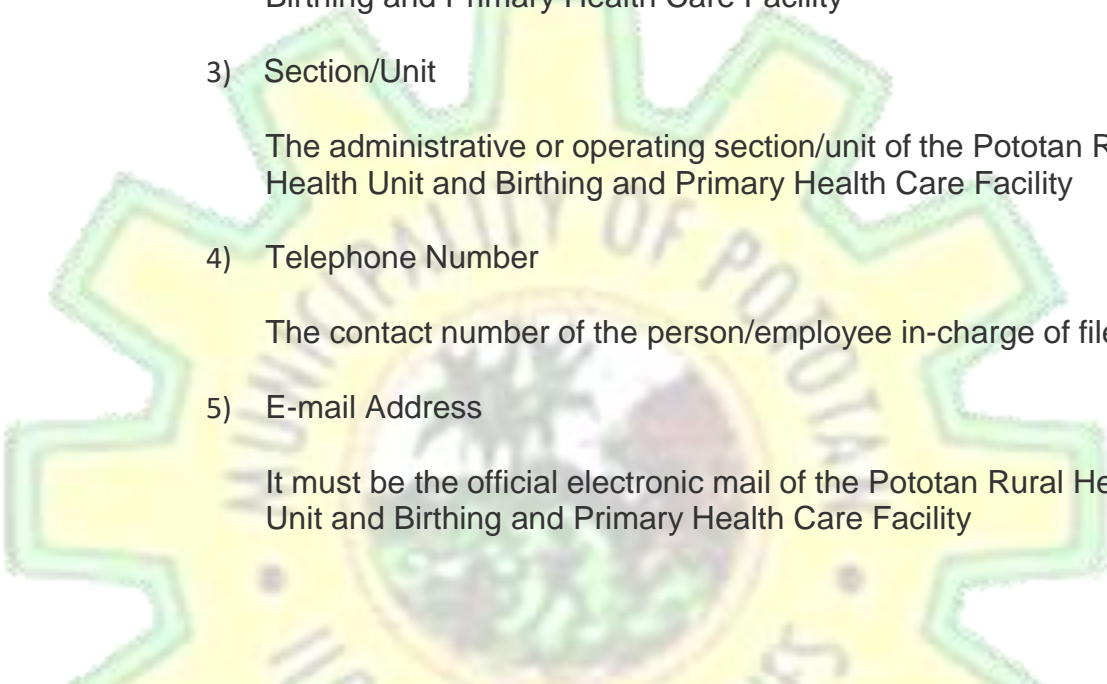
The administrative or operating section/unit of the Pototan Rural Health Unit and Birthing and Primary Health Care Facility

4) Telephone Number

The contact number of the person/employee in-charge of files

5) E-mail Address

It must be the official electronic mail of the Pototan Rural Health Unit and Birthing and Primary Health Care Facility



## SAT 29

### **BORROWING AND RETRIEVAL**

RHU Personnel responsible for a medical record(s) must either: -

A. Report any subsequent movement of the medical record(s) from their area or from their possession immediately to Health Information Services (HIS).

B Update the logbook or in the future a computerized medical record tracking system for subsequent movement of the medical record(s) from their area or from their possession.

C. Access to the computerized medical record tracking system can be arranged through HIS personnel assigned.

### **MISSING MEDICAL RECORD**

A “missing” medical record is defined as any medical record that cannot be located by the date and time that it is required for direct or indirect patient care.

### **DAY ONLY LOAN PRIVILEGES**

A maximum of 5 medical records/document (current and previous volumes are counted separately) may be loaned from HIS between the hours of 8am – 5pm Monday to Friday (excluding Public Holidays). This is limited to staff whose role includes clinical research. Requests for “day only” loan privileges must be made directly to the Municipal Health Officer who reserves the right to accept or reject such applications.

### **ACCESS & RECORD TRACKING**

Only staff employed by Pototan Rural Health Unit and Birthing and Primary Care Facility are permitted to have access to medical records. The purposes of such access and any exceptions to this are in accordance with the Pototan Rural Health Unit and Birthing and Primary Care Facility Information Privacy Policy and Guideline and the Records Guideline.

Medical records that are released for patient attendance will be. At all times, such records are the responsibility of staff working within the area, but are ultimately the responsibility of the Birthing Manager Staff on Duty at OPD in charge of the area. If a record is in the possession of a department, clinic, or ward for longer than the time permitted, HIS staff have the right to retrieve the record.

- 1.1 Medical records that are released for purposes other than patient attendance will be tracked to the individual staff



member. At all times, such records are the responsibility of the individual staff member.

1.2 Original patient records may only leave Pototan Rural Health Unit and Birthing and Primary Care Facility under the following circumstances:

- (i) If they are required for court or are required by search warrant via the police. Only HIS or the PNP are authorized to make arrangements for patient records to be sent to court.
- (ii) If they are required for patient attendance at a satellite clinic or service. In such instances HIS must be given prior notice and the records are to be returned to the unit on the same or following day.

1.3 Prior to release of a medical record for purposes other than patient attendance, the following information will be recorded by HIS: -

- a. Staff member's name
- b. Staff members contact telephone number and/or pager number
- c. The purpose of the request (indirect patient care, clinical audit or another purpose)
- d. Precise location that record will be taken or within HIS if the record is to be viewed internally
- e. The date and time the record is required.

Medical Record Room-Onsite Adjacent to MHO Office  
Medical Record- Isolation Facility Admin Room

## VI SAFE PRACTICE AND ENVIRONMENT

### SAT 32

#### POLICIES ON INVESTIGATING & REPORTING ADVERSE DRUG REACTIONS

##### I. ADVERSE EVENTS FOLLOWING IMMUNIZATION

A. DEFINITION: Adverse Event Following Immunization (AEFI) is any event or condition that follows after immunization and is believed to be caused by immunization.

##### B. CLASSIFICATIONS:

- a. Vaccine Reaction- caused by inherent properties of the vaccines
- b. Program error- caused by error in vaccine preparation, handling or administration
- c. Coincidental- happens after immunization but is not caused by it
- d. Unknown- the caused cannot be determined.

##### C. ADVERSE EVENTS AND THEIR MANAGEMENT

EVENTS	HOW TO MANAGE
<b>COMMON MINOR EVENTS</b>	
1.Pain & redness at injection site	Avoid touching or hitting the swollen area; may give paracetamol
2.Fever	Give paracetamol until fever is gone
3.Rash	None
<b>SERIOUS EVENTS/ ANAPHYLAXIS:</b>  Generalized erythema & urticarial, upper & lower respiratory tract obstruction, limpness, pallor, loss of consciousness, hypotension	<ul style="list-style-type: none"> <li>➤ Place patient in a recumbent position</li> <li>➤ Clear the airway</li> <li>➤ Asses the breathing &amp; the pulse</li> <li>➤ If appropriate give CPR</li> <li>➤ Give epinephrine by deep intramuscular injection at the deltoid area</li> <li>➤ Keep patient warm</li> <li>➤ Give oxygen by facemask, if available</li> <li>➤ Transfer patient to a hospital for further management</li> <li>➤ If there is no improvement in the patient's condition within 5 minutes, repeat the dose of epinephrine up to a maximum of 3 doses.</li> </ul>

D. EVENTS THAT SHOULD BE REPORTED:

1. Anaphylaxis: severe immediate allergic reaction leading to a circulatory failure with or without bronchospasm or laryngospasm/laryngeal edema.
2. Acute Hypersensitivity Reaction: Exaggerated acute allergic reaction, occurring within 2 hours after immunization. It is characterized by wheezing, shortness of breath, laryngospasm/laryngeal edema, one or more skin manifestation
3. Encephalopathy: acute onset of major illness characterized by any of the two of the following: seizures, altered level of consciousness and distinct change in behavior.

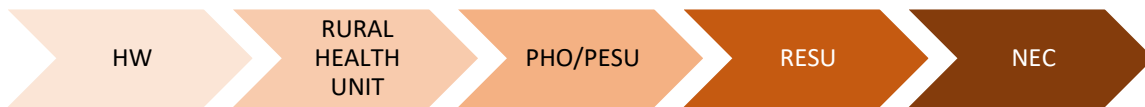
E. RECOMENDED DOSE FOR EPINEPHRINE

AGE IN YEARS	DOSE OF EPINEPHRINE
Less than 1 year old	.05 ml
1 year old	.1 ml
2-year-old	.2 ml
3-4 years old	.3 ml
5 years old	.4 ml

F. WHO SHOULD REPORT THE AEFI:

1. Health Worker
2. Concerned Citizen
3. Parent
4. Teacher

G. FLOW OF REPORT



H. REPORTING FORM: standard reporting form utilized under the EPI Manual shall be used for all reporting units

## II. ADVERSE DRUG REACTION

A. GENERAL PRINCIPLE: The beneficial effects of drugs are coupled with the inescapable risk that they may also cause untoward effects. No drug is completely without side effects and it is important to remember that a side effect in one patient may be a desired pharmacologic effect in another.

B. Adverse drug reaction can be categorized as follows:

1. Exaggeration of the intended pharmacological effect which can be due to
  - a. Abnormally high drug concentration in the receptor site due to altered metabolism and rate of excretion.
  - b. Altered dose-response curve due to increased sensitivity at receptor sites.
  - c. Concomitant drug therapy.
  
2. Toxicity due to concomitant drug's pharmacologic activity, such as:
  - a. Cytotoxic Reactions- reactive metabolites of the drugs affect the various organs, e.g. Hepatotoxicity of isoniazid, effect of sulfonamides on G6PD deficient individuals.

b. Immunologic mechanism- antibody may attack the rug attached to the cell and thereby destroy the cell as in the case of serum sickness in penicillin, or it may also stimulate cell-mediated immune response characterized by contact dermatitis.

3. Toxicity related to genetically determined enzymatic defect- e.g. hemolytic anemia among G6PD deficient clients given primaquine & sulfonamides.

### C. GENERAL GUIDELINES IN MANAGEMENT OF ADVERSE DRUG REACTION:

- a. Take drug history as to name of drug/medicine, strength, preparation, dosage, onset of medication with particular attention to over-the-counter drugs (OTC).
- b. If a single drug was taken discontinue medicine and follow-up for disappearance or relief of signs and symptoms. A presumptive diagnosis of drug –induced illness will be made upon the disappearance of signs and symptoms.
- c. RE-ADMINISTRATION of any drugs that is suspected to cause allergic reactions previously is prohibited as this may cause anaphylactic reactions.
- d. If the patient is receiving many different drugs when an adverse reaction is suspected, the drug most likely to be incriminated is to be identified.
- e. All drugs may be discontinued at once
- f. Drugs may be discontinued one at a time, starting with the drugs under the greatest suspicion and the patient closely monitored for signs of improvement.

- g. Determine previous history of adverse drug effects.
- h. Identify and mark charts of patient with drug allergies and biochemical abnormalities such as GSPD Deficiency.
- i. ALL ADVERSE DRUG REACTIONS ARE TO BE MANAGED BY THE MHO OR REFERRED TO THE APH FOR PROPER EVALUATION AND MANAGEMENT.

**D. CLINICAL MANIFESTATIONS OF ADVERSE REACTIONS TO DRUGS COMMONLY DISPENSED/PRESCRIBED IN THE RHU:**

<b>Category</b>	<b>Symptoms</b>	<b>Drugs</b>
I.	A. Fever	<ul style="list-style-type: none"> <li>• Penicillin</li> <li>• Antihistamine</li> <li>• Cephalosporin</li> <li>• Sulfonamides</li> <li>• Methyldopa</li> </ul>
	B. Drug-Induced lupus erythematosus	<ul style="list-style-type: none"> <li>• Isoniazid</li> </ul>
	C. Serum Sickness	<ul style="list-style-type: none"> <li>• Penicillin</li> <li>• Streptomycin</li> <li>• Sulfonamides</li> </ul>
	D. Anaphylaxis	<ul style="list-style-type: none"> <li>• Penicillin</li> <li>• Cephalosporin</li> <li>• Streptomycin</li> <li>• Lidocaine</li> </ul>
II. ENDOCRINE	A. Disorder of thyroid function	<ul style="list-style-type: none"> <li>• Oral Contraceptives</li> <li>• Sulfonamides</li> </ul>
	B. Gynecomastia	<ul style="list-style-type: none"> <li>• Estrogen</li> <li>• Methyldopa</li> <li>• Isoniazid</li> </ul>
	C. Galactorrhea/amenorrhea	<ul style="list-style-type: none"> <li>• Methyldopa</li> </ul>

	D. Sexual Dysfunction (decreased libido/impotence)	<ul style="list-style-type: none"> <li>• Oral contraceptive</li> <li>• Methyldopa</li> </ul>
III. METABOLIC	A. Hyponatremia	<ul style="list-style-type: none"> <li>• Diuretics</li> </ul>
	B. Hypokalemia	<ul style="list-style-type: none"> <li>• Diuretics</li> <li>• Laxative Abuse</li> <li>• Corticosteroids</li> <li>• Tetracycline</li> <li>• Vitamin B12</li> </ul>
	C. Hypercalcemia	<ul style="list-style-type: none"> <li>• Antacids with absorbable alkali</li> <li>• Thiazides</li> </ul>
	D. Hyperuricemia	<ul style="list-style-type: none"> <li>• Thiazides</li> <li>• Furosemide</li> <li>• Aspirin</li> </ul>
	E. Hyperglycemia	<ul style="list-style-type: none"> <li>• Corticosteroids oral</li> <li>• Contraceptives</li> <li>• Thiazides</li> <li>• Furosemides</li> </ul>
	F. Prophyriaexacerbations	<ul style="list-style-type: none"> <li>• Sulfonylamides</li> <li>• Estrogen</li> <li>• Oral contraceptives</li> <li>• Rifampicin</li> </ul>
	G. Hyperbilirubinemia	<ul style="list-style-type: none"> <li>• Rifampicin</li> </ul>
IV. DERMATOLOGIC	A. Exfoliative Dermatitis	<ul style="list-style-type: none"> <li>• Penicillin</li> <li>• Sulfonamides</li> <li>• Quinidine</li> </ul>
	B. Toxic epidermal necrolysis	<ul style="list-style-type: none"> <li>• Sulfonamide</li> <li>• Penicillin</li> <li>• Allopurinol</li> </ul>
	C. Steven-Johnson Syndrome	<ul style="list-style-type: none"> <li>• Sulfonamides</li> <li>• Tetracyclines</li> <li>• Penicillin</li> </ul>
	D. Erythema Nodosum	<ul style="list-style-type: none"> <li>• Penicillin</li> <li>• Sulfonamides</li> <li>• Oral Contraceptives</li> </ul>
	E. Photodermatitis	<ul style="list-style-type: none"> <li>• Tetracyclines</li> <li>• Sulfonamides</li> <li>• Furosemide</li> <li>• Oral Contraceptives</li> </ul>
	F. Urticaria	<ul style="list-style-type: none"> <li>• Aspirin</li> <li>• Penicillin</li> <li>• Sulfonamides</li> </ul>
	G. Rashes	<ul style="list-style-type: none"> <li>• Ampicillin</li> </ul>

	H.	<ul style="list-style-type: none"> <li>• Allopurinol</li> <li>• Methyldopa</li> </ul>
	I. Hyperpigmentation	<ul style="list-style-type: none"> <li>• Oral Contraceptives</li> <li>• Anti-malarial</li> <li>• Hypervitaminosis A</li> </ul>
	J. Alopecia	<ul style="list-style-type: none"> <li>• Oral Contraceptives (withdrawal)</li> </ul>
	K. Purpura	<ul style="list-style-type: none"> <li>• Corticosteroids</li> <li>• Aspirins</li> </ul>
	L. Lichenoid Reactions	<ul style="list-style-type: none"> <li>• Antimalarials</li> <li>• Methyldopa</li> </ul>
	M. Eczema	<ul style="list-style-type: none"> <li>• Topical Antimicrobials</li> <li>• Topical local anesthetics</li> </ul>
	N. Acne	<ul style="list-style-type: none"> <li>• Androgenic steroids</li> <li>• Corticosteroids</li> <li>• Oral Contraceptive</li> <li>• Isoniazid</li> </ul>
V. HEMATOLOGIC	A. Pancytopenia/aplastic anemia	<ul style="list-style-type: none"> <li>• Chloramphenicol</li> </ul>
	B. Agranulocytosis	<ul style="list-style-type: none"> <li>• Chloramphenicol</li> <li>• Sulfonamides</li> <li>• Cotrimoxazole</li> </ul>
	C. Thrombocytopenia	<ul style="list-style-type: none"> <li>• Quinine</li> <li>• Furosemide</li> <li>• Aspirin</li> <li>• Methyldopa</li> </ul>
	D. Megaloblastic anemia	<ul style="list-style-type: none"> <li>• Cotrimoxazole</li> <li>• Oral Contraceptives</li> </ul>
	E. Hemolytic Anemia	<ul style="list-style-type: none"> <li>• Methyldopa</li> <li>• Mefenamic Acid</li> <li>• Isoniazid</li> <li>• Rifampicin</li> <li>• Sulfonamides</li> <li>• Penicillins</li> <li>• Cephalosporins</li> </ul>
	F. Hemolytic Anemia in G6PD	<ul style="list-style-type: none"> <li>• Primaquine</li> <li>• Chloramphenicol</li> <li>• Sulfonamides</li> <li>• Aspirin</li> </ul>



		<ul style="list-style-type: none"> <li>• Vitamin C</li> <li>• Vitamin K</li> <li>• Cotrimoxazole</li> </ul>
	G. Leukocytosis	<ul style="list-style-type: none"> <li>• Corticosteroids</li> </ul>
	H. Eosinophilia	<ul style="list-style-type: none"> <li>• Erythromycin estolate</li> <li>• Sulfonamides</li> </ul>
VI. CARDIAC	A. Exacerbation of angina	<ul style="list-style-type: none"> <li>• Oxytocin</li> </ul>
	B. Fluid retention on Cong. Heart Failure	<ul style="list-style-type: none"> <li>• Estrogen</li> <li>• Steroids</li> <li>• Propranolol</li> </ul>
	C. Hypotension	<ul style="list-style-type: none"> <li>• Diuretics</li> <li>• Nipeditine</li> </ul>
	D. Hypertension	<ul style="list-style-type: none"> <li>• Oral Contraceptives</li> <li>• Corticosteroids</li> </ul>
	E. thromboembolism	<ul style="list-style-type: none"> <li>• Oral Contraceptives</li> </ul>
VII. RESPIRATORY	A. Nasal Congestion	<ul style="list-style-type: none"> <li>• Oral Contraceptives</li> <li>• Decongestant abuse</li> </ul>
	B. Airway Obstruction	<ul style="list-style-type: none"> <li>• Beta Blockers</li> <li>• NSAIDS</li> <li>• Penicillins</li> <li>• Cephalosporins</li> <li>• Streptomycin</li> </ul>
VIII. GASTRO- INTESTINAL	A. Dental Discoloration	<ul style="list-style-type: none"> <li>• Tetracycline</li> </ul>
	B. Oral Ulceration	<ul style="list-style-type: none"> <li>• Gentian Violet</li> <li>• Aspirin</li> </ul>
	C. Taste Disturbance	<ul style="list-style-type: none"> <li>• Rifampicin</li> <li>• Metronidazole</li> </ul>
	D. Dry Mouth	<ul style="list-style-type: none"> <li>• Methyldopa</li> </ul>
	E. PUD	<ul style="list-style-type: none"> <li>• Aspirin</li> </ul>
	F. Nausea/Vomiting	<ul style="list-style-type: none"> <li>• Estrogens</li> <li>• Ferrous sulfate</li> <li>• Aminophylline</li> </ul>

		<ul style="list-style-type: none"> <li>• Tetracycline</li> </ul>
	G. Diarrhea/Colitis	<ul style="list-style-type: none"> <li>• Broad spectrum antibiotics</li> <li>• Methyldopa</li> <li>• Purgatives</li> </ul>
	H. Constipation/Ileus	<ul style="list-style-type: none"> <li>• Aluminum Hydroxide</li> <li>• Calcium carbonate</li> <li>• Ferrous sulfate</li> </ul>
	I. Pancreatitis	<ul style="list-style-type: none"> <li>• Corticosteroids</li> <li>• Oral Contraceptives</li> <li>• Furosemides</li> </ul>
	J. Diffuse Hepatocellular Damage	<ul style="list-style-type: none"> <li>• Methyldopa</li> <li>• Isoniazid</li> <li>• Rifampicin</li> <li>• Paracetamol</li> <li>• Salicylates</li> <li>• Allopurinol</li> <li>• Sulfonamides</li> <li>• Tetracyclines</li> <li>• Erythromycin estolate</li> <li>• Ketoconazole</li> </ul>
	K. Cholestatic Jaundice	<ul style="list-style-type: none"> <li>• Oral Contraceptives</li> <li>• Erythromycin estolate</li> </ul>
IX. RENAL	A. Tubular necrosis	<ul style="list-style-type: none"> <li>• Aminoglycosides</li> <li>• Tetracyclines</li> </ul>
	B. Interstitial nephritis	<ul style="list-style-type: none"> <li>• Penicillin</li> <li>• Sulfonamides</li> <li>• Furosemide</li> <li>• Allopurinol</li> </ul>
X. NEUROLOGIC	A. Peripheral neuropathy	<ul style="list-style-type: none"> <li>• Isoniazid</li> <li>• Streptomycin</li> <li>• Chloramphenicol</li> <li>• Ethambutol</li> <li>• Metronidazole</li> <li>• Chloroquine</li> </ul>

	B. Exacerbation of myasthenia	<ul style="list-style-type: none"> <li>• Aminoglycosides</li> </ul>
	C. Extrapyramidal Effects	<ul style="list-style-type: none"> <li>• Methyldopa</li> <li>• Metoclopramide</li> <li>• Oral Contraceptives</li> </ul>
	D. Seizures	<ul style="list-style-type: none"> <li>• Isoniazid</li> <li>• Lidocaine</li> <li>• Theophylline</li> <li>• penicillin</li> </ul>
	E. Stroke	<ul style="list-style-type: none"> <li>• Oral Contraceptives</li> </ul>
	F. Pseudotumorcerebri	<ul style="list-style-type: none"> <li>• Corticosteroids</li> <li>• Oral Contraceptives</li> <li>• Tetracyclines</li> <li>• Hypervitaminosis A</li> </ul>
XI. OCULAR	A. Corneal opacities	<ul style="list-style-type: none"> <li>• Chloroquine</li> </ul>
	B. Corneal edema	<ul style="list-style-type: none"> <li>• Oral Contraceptives</li> </ul>
	C. Cataracts	<ul style="list-style-type: none"> <li>• corticosteroids</li> </ul>
	D. Retinopathy	<ul style="list-style-type: none"> <li>• Chloroquine</li> </ul>
	E. Optic neuritis	<ul style="list-style-type: none"> <li>• Chloramphenicol</li> <li>• Streptomycin</li> <li>• Isoniazid</li> <li>• Ethambutol</li> <li>• Quinine</li> </ul>
	F. Altered Colored Vision	<ul style="list-style-type: none"> <li>• Sulfonamides</li> <li>• Streptomycin</li> </ul>
XII. EAR	A. Vestibular Disorders	<ul style="list-style-type: none"> <li>• Aminoglycosides</li> <li>• Quinine</li> </ul>
	B. Deafness	<ul style="list-style-type: none"> <li>• Aminoglycosides</li> <li>• Furosemide</li> <li>• Quinine</li> <li>• Chloroquine</li> <li>• Aspirin</li> </ul>
XIII. MUSCULOSKELETAL	A. Myopathy/myalgia	<ul style="list-style-type: none"> <li>• Corticosteroids</li> <li>• Chloroquine</li> </ul>

		<ul style="list-style-type: none"> <li>• Oral Contraceptives</li> </ul>
	B. Osteoporosis	<ul style="list-style-type: none"> <li>• Corticosteroids</li> </ul>
	C. Osteomalacia	<ul style="list-style-type: none"> <li>• Aluminum hydroxide</li> </ul>
XIV. PSYCHIATRIC DISORDER	A. Paranoid reactions	<ul style="list-style-type: none"> <li>• Corticosteroids</li> </ul>
	B. Depression	<ul style="list-style-type: none"> <li>• Propranolol</li> <li>• Corticosteroids</li> </ul>
	C. Hypomania	<ul style="list-style-type: none"> <li>• Corticosteroids</li> </ul>
	D. Hallucinatory states	<ul style="list-style-type: none"> <li>• Propranolol</li> </ul>
	E. Delirious/confused state	<ul style="list-style-type: none"> <li>• Corticosteroids</li> <li>• Isoniazid</li> <li>• Aminophyllines</li> <li>• Penicillins</li> <li>• Methyldopa</li> </ul>
	F. Drowsy States	<ul style="list-style-type: none"> <li>• Antihistamines</li> <li>• Methyldopa</li> </ul>

## SAF 33 Management Plan Policy and Procedure POLICY ON SAFETY

### Goal:

This facility is committed to a strong safety program that protects its staff, its property and the public from accidents. Employees at every level, including management, are responsible and accountable for the organization's overall safety initiatives. Complete and active participation by everyone, every day, in every job is necessary for the safety among all workers on the job site. Management supports participation in the program by all employees and provides proper equipment, training and procedures. Employees are responsible for following all procedures, working safely, and, wherever possible, improving safety measures. An injury and accident-free workplace is our goal. Through continuous safety and loss control, we can accomplish this

### Management Plan Policy and Procedure on Personnel and Patient Safety

- **Know the evacuation routes** not only from your home but from your work, children's schools and the places you visit frequently, and print out maps, since you can't rely on Google in a disaster.
- **Write down important phone numbers** and store them in your emergency kit. In addition to contacts of family and friends, note emergency contacts and the number for your embassy.
- **Prep a supply of water and nonperishable food** and be sure to check your earthquake kits for expiration dates annually.
- **A standard earthquake kit includes:** a flashlight, a portable radio, batteries, chargers, a can opener, a first-aid kit, blankets, rainwear .
- **Develop a safety mind-set.** For example, fill your car's gas tank when it gets half empty; and take note of evacuation signs, learn quake-related vocabulary.
- **Quake-proof your office.** Secure furniture (cabinets, bookshelves, etc.) and large electronics ( refrigerators, etc.) that could fall over during a quake.

### During a quake

#### If you're inside:

- **Drop:** Lowering your point of gravity will help you stay steady during a tremor.
- **Cover:** Your head and neck are vulnerable to injury as objects may fall off shelves or from the ceiling. If you're outside in an urban area, be careful of broken glass, bricks or cement falling from buildings. Use your bag, a backpack or purse to protect your head and neck.
- **Hold:** Hold on to something to keep yourself in place in case there are violent tremors. Although most earthquakes last only 10 seconds, any one of them could be "the big one" that lasts for minutes and gets increasingly worse.

### After a quake

- If you're trapped under rubble, cover your mouth. Bang rhythmically on a pipe or wall, or send a text for help instead of shouting. You'll conserve energy and oxygen.
- Be creative with communications. If phone lines are down, try other applications or texting services. Kept in touch with family and friends via FB ,Twitter, for example.
- When evacuating buildings, don't use the elevators, even if it seems like the shaking has stopped. Keep in mind the likelihood of aftershocks and use the stairs.
- Turn off your gas immediately (and be careful about flames from lighters until you confirm there hasn't been a gas leak). If you need to evacuate your home, turn off your circuit breaker.

### Earth Quake Drill Done Quarterly





## **Safety and security in Primary Care Facilities**

To keep staff, patients and visitors safe, Primary Care Facilities use a range of security measures, including the use of CCTV cameras. Some Primary Care Facilities also employ security staff.

### **Primary Care Facility visitors and safety**

As a visitor, it is important that you respect visiting hours and rest periods for patients during the day. If you want to bring a gift or something for a loved one, check with the Primary Care Facility to make sure it is okay.

Sometimes, seeing a loved one in pain or suffering can be distressing. Always be courteous to staff, other patients and visitors. Physical or verbal abuse towards staff, patients or other visitors will not be tolerated and you may be asked to leave if you behave like this.

### **Primary Care Facility security arrangements**

Many Primary Care Facilities have security staff and arrangements to protect patients and staff to make sure they are safe with PNP and Brgy. Malusgod.

Health services enforce a code of behavior. They do not tolerate physical or verbal aggression, or abuse towards staff, patients, family members or visitors. Security staff or police will ask aggressive or abusive visitors to leave the Primary Care Facility.

### **Identification checks**

As a Primary Care Facility patient, you will be asked to wear an identification (ID) band with your name and other important details around your wrist or ankle, or both. Your ID band must be worn during your entire stay. This is to make sure that staff can identify you easily and that you receive the right treatment and care. Staff will check your ID band before giving you any medication or treatment.

All staff members have a background and identification check before they are employed by a hospital to make sure they are qualified for their role and are of good character. They must display their ID badge at all times while at the hospital.



## Personal information security

All Primary Care Facility staff, including your administration and medical care team, must take reasonable precautions to protect your personal health information from:

- unauthorized access
- improper use
- disclosure
- unlawful destruction
- accidental loss.

Staff who come into contact with your personal health information must maintain the security of that information.

If you think your personal health information has been improperly used or accessed, raise your complaint with your patient liaison manager or the nurse in charge of the ward.

### **SAFETY OFFICER**

The Pototan RHU shall designate a **Safety Officer** that will be accountable to the supervisor and is responsible for Occupational Health & Safety performance for all employees in all levels. The safety officer must provide leadership in all aspects of health and safety activities at work or otherwise. The safety officer must take an active role in all aspects of safety, within their branch.

### **Roles and responsibilities of a Safety Officer**

1. Ensure that all reasonable steps are taken to prevent accidents.
2. Be familiar with Occupational Health & Safety act, the health facility policy and any other legislation pertaining to health or safety.
3. Ensure all policies and legislation is followed by all levels of employees.
4. Ensure safety meetings are held and minutes are recorded, posted and filed accordingly to Occupational Health & Safety regulations.

5. Ensure all accidents are reported and investigated.
6. Review all MSDS and advise/train employees in the safe use, storage and transportation of controlled or dangerous products including what to do in case of an accidental spill or emergency.
7. Ensure employees are instructed in the procedures and requirements of Occupational Health & Safety.
8. Review all accidents and near misses to determine root and basic causes, with suggestion/implementation of changes to prevent re-occurrence.
9. Shall make plan and coordinate with other agencies on the conduct different trainings and drills in the facility

### **General Safety Rules**

- 1) All accidents, injuries or near misses, regardless of their nature, shall be promptly reported to the safety officer.
- 2) Clothing shall be appropriate to the duties being performed.
- 3). Running is not permitted except in extreme emergencies.
- 4) Smoking is not permitted in any part of the health facility
- 6) Visitors and clients are to be escorted by staff while on the health facility.
- 7) Hand tools are to be used for their intended purpose only.
- 8) All spills of reagents or dangerous substance will be immediately cleaned up and reported.
- 9) Drawers and filing cabinets will be kept closed when not in use.
- 10) Filing cabinet drawers are to be filled from the bottom up or the cabinet is to be securely fastened /anchored.
- 11) Lifts and clutter will be cleaned up before the end of your workday.
- 12) Aisles are to be kept clear at ALL times.

## SAT 34

### BUILDING MAINTENANCE PROGRAM

Building maintenance policy is **a written document, and provides a management framework to the maintenance personnel to determine appropriate maintenance strategy and standard**

In general, maintenance means to hold, keep, sustain or preserve the building or structure to an acceptable standard, in which acceptable standard is defined as one which sustains the utility and value of the facility. While maintenance management should properly be regarded as describing how a system of maintenance effort could be organized to deal with the problems of building maintenance as a whole (B. Hamilton, M. Wan Salleh, 2001)

#### **34 A Safety Program on Maintenance**

Helps provide maintenance service towards the delivery of quality healthcare and public service.

It serves as a direct resource to the RHU in providing a safe, functional, supportive, and effective environment for patients, staff, and personnel, and visitors and clients, who come to our RHU facilities.

Equipment must be maintained to ensure an acceptable level of safety and quality.

#### **Equipment includes:**

##### I. Facility Equipment

- generators
- ambulance
- IT software

##### II. Office Equipment

- refrigerators
- aircondition
- ventilations

##### III. Medical Equipment

- laboratory equipment
- dental equipment
- patient beds
- stretchers
- dental equipment
- operating room equipment
- delivery room equipment
- autoclave

- ecg machine
- suction machine

In order to ensure an acceptable level of health and safety; the RHU identifies the equipment it needs to meet its patient's needs for both-to-day operations and in a likely emergency/ disaster situation, such as mass casualty events resulting from natural disaster, disease outbreaks, internal disasters, etc.

In addition, the RHU must make adequate provisions to ensure the availability and reliability of its equipment needed for its operations and services.

All equipment must be tested for performance and safety before initial use and after major repairs or upgrades. Equipment maintenance activities may be conducted using RHU personnel, contracts, or through a combination of RHU personnel and contracted services.

Corrective & Preventive Maintenance record is being maintained by the respective section heads under the custody of the equipment for an immediate supervision and recommendation & report for repair in case for some breakdown of their equipment.

Minor repairs of the RHU equipment shall be charged from the petty cash fund while funding for major repairs & maintenance shall be process for the approval of the authorities from the Provincial Government of Cagayan. It takes a lot of time to wait before repair of equipment shall be done.

### **Committee on Maintenance**

Traditionally, 5 types of maintenance have been identified:

#### **1. Corrective Maintenance.**

Its purpose is to correct the defects to be found in the different equipment and that are communicated to the maintenance department by users of the same equipment.

#### **2. Preventive Maintenance.**

Its mission is to maintain a level of certain service on equipment, programming the interventions of their vulnerabilities in the most convenient time. The equipment is inspected even if it has not given any symptoms of having a problem.

#### **3. Predictive Maintenance.**

It pursues constantly know and report the status and operational capacity of the installations by knowing the values of certain variables, which represent such state and operational ability. To apply this maintenance, it is necessary to identify physical variables such as the temperature, vibration, power consumption and so on.

#### 4. Zero Hours Maintenance (Overhaul).

The goal is to review the equipment at scheduled intervals before appearing any failure, either when the reliability of the equipment has decreased considerably so it is risky to make forecasts of production capacity.

#### 5. Periodic Maintenance (Time Based Maintenance).

The basic maintenance of equipment made by the users of it. It consists of a series of elementary tasks such as data collections, visual inspection, cleaning, lubrication and retightening screws for which no extensive training is necessary, but perhaps only brief training.

#### 34 B Routine Care & Maintenance

There are no set frequencies for maintenance inspections. However electrical equipment should be inspected according to the manufacturer's guidelines and in line with guarantees or statutory requirements.

The following general guidelines can be used as a rule of thumb:

<b>Weekly</b>	Inspect critical equipment
<b>Three-monthly</b>	Clean/change ventilation filters, inspect floors, steps and external surfaces and
<b>Six-monthly</b>	Inspect firefighting equipment, gullies, drainage channels and gutters
<b>Yearly</b>	Inspect and service gas appliances , door closers and roof tanks, survey fire re ceiling voids
<b>Two-yearly</b>	Inspect lighting and renew lamps
<b>Three-yearly</b>	Internal repairs and repainting
<b>Five-yearly</b>	Test electrical distribution

Since there are tasks that need to be completed on a more and on a less frequent basis, it is recommended for a building to create a daily facility maintenance checklist and a monthly facility maintenance checklist.

#### Facility Maintenance Checklist

##### Roof

Any buildings maintenance schedule should include a rolling programmed of redecoration and improvements to ensure that the building presents a safe, clean, comfortable and pleasant environment at all times. A roof system is arguably the most vulnerable part of a building's exterior. Roof maintenance is critical to preventing roof problems and keeping the roof in a watertight condition. Early identification and repair of roof problems will help provide a long-lasting roof system.

##### External Wall

Allowing the external envelope of a building to deteriorate will not only give a very negative visual impression but also create an environment for materials/components to deteriorate and decay. Exterior walls (including doors and windows) should be carefully inspected at least once a year. Exterior walls and masonry workwear out as

time goes by and should be checked at least monthly, if not more often in detail, and daily for any visible cracks or demolished areas. Building arches, eaves and canopies should be inspected carefully as they tend to ruin more often.

## **Windows & Doors, Gates and Other Openings**

Proper maintenance of your windows and doors start with cleaning. Afterwards, check if there are any cracks or gaps. Studies show that openings and cracks around your windows and doors can account for up to 10% of your heating bills. Caulk and seal any gaps you find. Depending on the materials from which they are built such, doors and windows have various durability and should not be replaced often. But small parts, such as hinges, locks, and handles can break faster and thus prevent proper door functioning.

## **Stairs & Floors**

Mop the entrance and vestibule daily. Sweep the stairs and halls daily. Mop stairs and halls at least twice a week. A stone floor in the public lobby of an office building should state that the floor will be inspected at the beginning of each shift and again each hour. Any spills discovered should be immediately cordoned off to block pedestrian access. The building's janitorial provider or in-house cleaner must prevent items from being left on the floor that might present a slip-and-fall or trip-and-fall hazard.

## **Lighting**

Although lighting has its own voice to tell when it doesn't work, a facility manager mustn't wait for defects to act. Periodical check-ups of the lighting system must be part of the facility management checklist, and the power supply must be inspected on a daily basis.

## **Plumbing**

[Plumbing defects](#) are not so easy to notice until they occur, but if you own a checklist template with equipment replacement guidelines, for instance, when to replace a valve, you can avoid major issues. Irrigation system maintenance is sometimes done as part of plumbing activities, but it can also include additional checkups done by specialists.

## **Fire Equipment**

Checking [fire safety equipment](#) is a law requirement, and if you don't make it a part of the facility maintenance checklist, you can not only bring your facility to risk but also face fines and penalties. Depending on where you are located, fire extinguishers must be serviced at least once a year, while the door and crawl spaces should be inspected more often. If you have a sprinkler system installed, it should also undergo preventative maintenance together with the rest of the equipment.

## **Cooling**

The Airconditioning system requires cleaning and regular maintenance as, although it won't automatically break your business, it is one of the most common complaints by staff, majorly affecting staff morale.

## **Access Control**

Specific elements of the access control system can be integrated with other aspects of the facility, thus causing confusion about when and how each of them needs to be inspected. For instance, fire alarms can activate sprinklers while disabling some access doors. Video cameras can operate in several modes for monitoring, as well as for safety purposes. The Wi-Fi network can be combined. Therefore, it's good to have each of these aspects in a separate box on your daily and monthly facility inspection checklists in order to be able to do them without worrying you've missed an important aspect.

## **Getting Urgent Repairs Done**

A maintenance system should form part of a fault reporting and tracking system whereby faults or potential problem areas are logged and followed up until they are recorded as fixed. Faults or problems should first be subjected to a risk assessment by a competent member of staff and the urgency or seriousness of the repair recorded and communicated to appropriate maintenance staff or contractors. Building managers should then check that any necessary work has been completed satisfactorily.

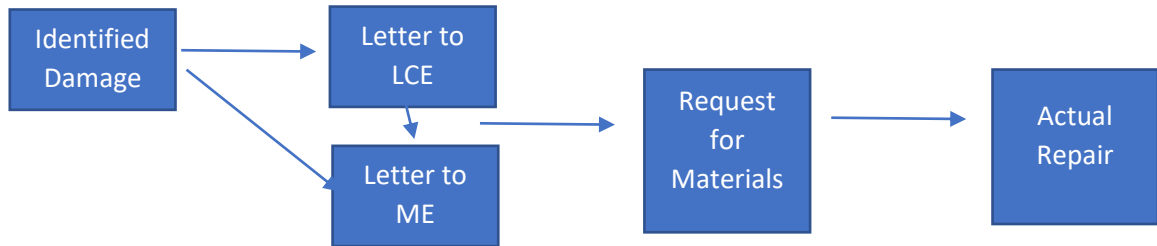
Urgent repairs mean any work needed to repair any of the following:

- a failure or breakdown of the gas, electricity or water supply
- a failure or breakdown of any essential service for hot water, cooking, heating, cooling or laundering
- any fault or damage that makes the premises unsafe or insecure
- serious damage from a natural disaster.

Examples of damage include:

- a burst water
- an appliance or fixture (such as a tap) that is not working or broken and is causing a substantial waste of water
- a blocked or broken toilet
- a serious roof leaks
- a gas leaks
- a dangerous electrical fault
- flooding or serious flood damage
- serious storm or fire damage

### Process Flow of Repair



### Security Arrangement in the Organization to Assure Protection of Patient and Personnel

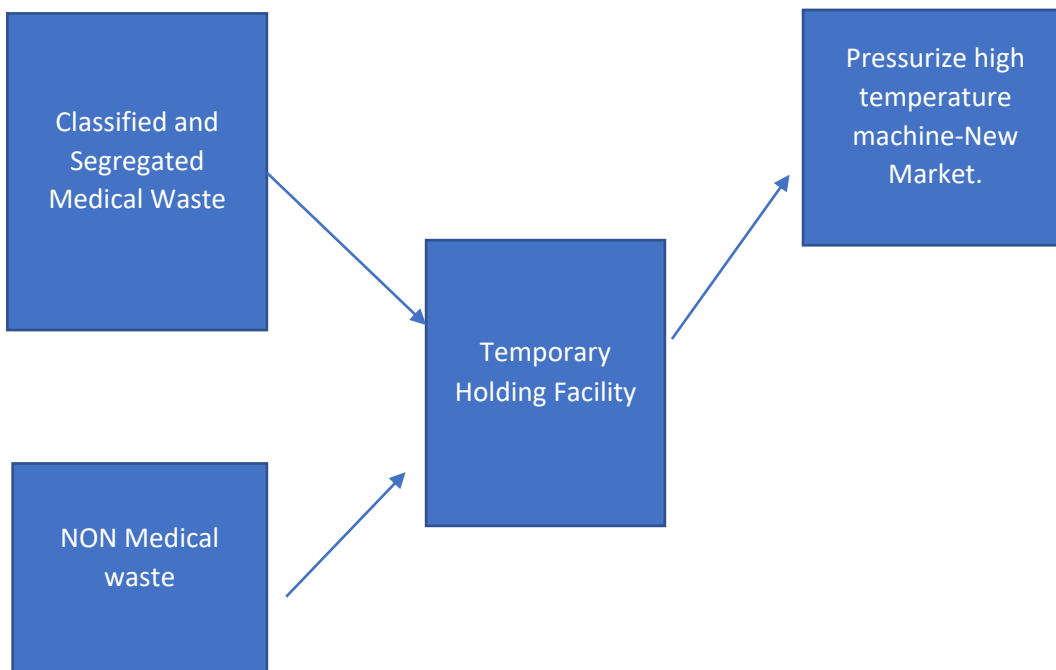
#### In Charge of Facility Security

Monday to Friday

6am-6 pm-NILO SARANILLO (utility)

6:01 pm to 6:00 am the following day to include Saturday and Sunday - ON Duty personnel at birthing are

### Handling, Collection and Disposal



**Collection Time- Daily at 6 am**



**POLICY TITLE:**

**Policies and Procedure For Proper Maintenance And Monitoring Of Physical Facilities**

**I. POLICY DESCRIPTION**

A. Pototan Rural Health Unit Birthing and Primary Care Facility is constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special RHU services appropriate to the needs of the community.

B. The condition of the physical and the overall health facility environment was developed and maintained in such a manner that the safety and well-being of patients are ensured.

**II. Guidelines:**

**PHYSICAL ENVIRONMENT AND BUILDINGS**

A. The Municipal Health Office ensures that the condition of the physical and overall RHU environment is developed and maintained in a manner to ensure the safety and well-being of patients. This includes ensuring that routine and preventive maintenance and testing activities are performed as necessary, in accordance with laws, regulations and guidelines and manufacturer's recommendations, by establishing maintenance schedules and conducting ongoing maintenance inspection to identify areas or equipment in need of repair.

B. Assuring the safety and well-being of patients would include developing and implementing appropriate emergency preparedness plans and capabilities. The health facility develops and implements a comprehensive plan to ensure that the safety and well-being of patients are assured during emergency situations. It coordinates with federal state, and local emergency preparedness and health authorities to identify likely risks for their area (e.g., natural disasters, bioterrorism threats, disruption of utilities such as water, sewer, electrical communications, fuel; nuclear accidents, industrial accidents, and other likely mass casualties, etc.) and develop appropriate responses that will assure the safety and well-being of patients. The following issue was being considered when developing the comprehensive emergency plan(s):

- a. The differing needs of each location where other facility operates;
- b. The special needs of patient populations treated at the RHU (e.g., patients with psychiatric diagnosis, patients on special diets, newborns, etc.)
- c. Security of patients and walk- in patients.
- d. Verify that all medical devices and equipment are routinely checked.
- e. Review maintenance logs for significant medical equipment.
- f. There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.

## **VENTILATION**

- A. There must be proper ventilation in at least the following areas:
  - a. Locations where oxygen is transferred from one container to another.
  - b. Isolation rooms and reverse isolation rooms (both must be in compliance with state laws, regulations, and guidelines).
  - c. Pharmaceutical preparation areas (hoods, cabinets, etc.); and
  - d. Laboratory locations.

## **LIGHTING**

- A. There must be adequate lighting in all the patient care areas, and food and medication preparation areas.
- B. Temperature, humidity and airflow in the operating rooms must be maintained within acceptable standards to inhibit bacterial growth and prevent infection, and promote patient comfort. Excessive humidity in the operating room is conducive to bacterial growth and compromises the integrity of wrapped sterile instruments and supplies. Each operating room should have separate temperature control.
- C. The health facility must ensure that an appropriate number of refrigerators and/or heating devices are provided and ensure that food and pharmaceuticals are stored properly and in accordance with nationally accepted guidelines (food) and manufacturer's recommendations (pharmaceuticals).

## **FACILITIES, SUPPLIES, AND EQUIPMENT MUST BE MAINTAINED TO ENSURE AN ACCEPTABLE LEVEL OF SAFETY AND QUALITY.**

- A. Facilities must be maintained to ensure an acceptable level of safety and quality.
- B. Supplies must be maintained to ensure an acceptable level of safety and quality.
  - a. This would include that supplies are stored in such a manner to ensure the safety of the stored supplies (protection against theft or damage, contamination, or deterioration), as well as, that the storage practices do not violate fire codes or otherwise endanger patients (storage of flammables, blocking passageways, storage of contaminated or dangerous materials, safe storage practices for poison, etc).
  - b. Additionally, "supplies must be maintained to ensure an acceptable level of safety" would include that the RHU identifies the supplies it needs to meet its patients' needs for both day-to-day operations and those supplies that are likely to be needed in likely emergency situations such as mass casualty events resulting from natural disasters, mass trauma, disease outbreaks, etc.; and that the RHU makes adequate provisions to ensure the availability of those supplies when needed.
- C. Equipment must be maintained to ensure an acceptable level of safety and quality.

- D. There must be a regular periodical maintenance and testing program for medical devices and equipment. A qualified individual such as a clinical or biomedical engineer, or other qualified maintenance person must monitor, test, calibrate and maintain the equipment periodically in accordance with the manufacturer's recommendation and federal and state laws and regulations. Equipment maintenance may be conducted using RHU staff, contracts, or through a combination of RHU staff and contracted services.
- E. Equipment must be maintained to ensure an acceptable level of safety, it would include that the health facility identifies the equipment it needs to meet its patients' needs for both day-to-day operations and equipment that is likely to be needed in likely emergency/disaster situation such as mass casualty events resulting from natural disasters, mass trauma, disease outbreaks, internal disasters, etc.; and that the RHU makes adequate provisions to ensure the availability of that equipment when needed.

### **LIFE SAFETY FROM FIRE**

- A. Pototan Rural Health Unit and Birthing and Primary Health Care Facility comply with the healthcare Life Safety Code requirements for all inpatient care locations. RHU departments and location such as emergency departments, outpatient care locations, etc. Comply with RHU/healthcare Life Safety Code.
- B. It has procedure for the proper routine storage and prompt disposal of trash.
- C. It has written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with firefighting authorities.
- D. It maintains written evidence of regular inspection and approval by State or local fire control agencies.

### **FACILITIES**

- A. The RHU maintain adequate facilities for its services.
- B. Adequate Facilities means the RHU has facilitates that are;
  - a. Designed and maintained in accordance with Federal, State and local laws, regulations and guidelines; and
  - b. Designed and maintained to reflect the scope and complexity of the services it offers in accordance with accepted standards of practice.
- C. Observe the facility layout and determine in accordance with Federal State and local laws, regulations and guidelines; and
- D. Review the facility's water supply and distribution system to ensure that the water quality is acceptable for its intended use (drinking water, irrigation water, lab water, etc.). Review the facility water quality monitoring and, as appropriate, treatment system.

## **DIAGNOSTIC AND THERAPEUTIC FACILITIES MUST BE LOCATED FOR THE SAFETY OF PATIENTS**

- A. Diagnostic and therapeutic facilities must be in rooms or areas specifically designed for the purpose intended.
- B. Determine that services are provided in areas appropriate for the service provided.
- C. Verify that the facility is in compliance with ventilation requirement for patients with contagious airborne disease, such as tuberculosis, patients receiving treatments with hazardous chemical, surgical areas, and other areas where hazardous materials are stored.
- D. Verify that food products are stored under appropriate conditions (e.g., time, temperature, packaging, location) based on a nationally- accepted sources such as nationally-recognized standard
- E. Verify that pharmaceuticals are stored at temperature recommended by the product manufacturer.
- F. Review temperature and humidity tracking log(s) to ensure that appropriate temperature and humidity levels are maintained.

## **POLICIES AND GUIDELINES ON PHYSICAL CLEANLINESS ORDERLINESS, MAINTENANCE AND SECURE OF THE HEALTH FACILITY**

**GOAL:** Health staff & clients are provided with a safe and functional facility structure & physical environment of care

### **A. HOUSEKEEPING**

This refers to the cleanliness and orderliness of the facility and its grounds. The following are the general principles that are to be in place in the facility to ensure good housekeeping.

#### **A.1. SORTING OR ORGANIZATION**

- This means separating what is essential to daily operations from those that are not.
- This means easier access to supplies, drugs/medicines, and forms that are routinely used for daily client form

#### **A.2. SYSTEMATIZED**

- These involves order and efficiency
- Things needed are easily available when needed while back storing is likewise cumbersome.

### A.3. SWEEPING

- This involves facility and equipment maintenance through regular cleaning.
- The general cleanliness of the facility shall be a responsibility of all personnel.
- The medical technologist and microscopists shall be responsible for maintaining the cleanliness the laboratory as well as in the general upkeep of all equipment within the room.
- The ambulance driver shall have an added function of maintaining cleanliness in the roof and gutters and the facility surroundings.

### A.4. STANDARDIZATION

- This means maintaining the standard of cleanliness and orderliness in the facility & it surrounding as an integral component of office management.

### A.5. SELF DISCIPLINE

- This means being able to break bad habits and maintain or development good ones relevant to office management, specifically, and health care delivery in general.

## B. MAINTENANCE

EQUIPMENT	MAINTENANCE TASKS	INTERVALS OF MAINTENANCE	Person Responsible
<b>GENERAL</b>			
1. Electric Fans	Cleaning	Monthly	All personnel
	Rewinding	As need arises	
2. Gas stove	Cleaning	After each use	All personnel
3. Electricals/lights	Replacement of lights bulbs	As need arises	Noli Parreñas
	Replacement of use	As need arises	LGU Electricians

	Checking of electric lines	As need arises	LGU electricians
4. Audiovisual equipment	Cleaning	After use	All personnel

<b>HEALTH CARE</b>			
1. Nebulizer	Cleaning and disinfection	At the end of the day	Health personnel on duty
2. Weighing Scales	Cleaning And calibration	Daily/ at start of clinic day	Admission personnel
3. Surgical/ OB Instruments	Cleaning and disinfecting sterilizing	After each use	Health Personnel
4. Otoscope/ Ophthalmoscope	Cleaning	Daily	
<b>LABORATORY</b>			
1. Microscope	Cleaning of lenses for dirt, grease and oil	Daily	MedTech
	Replacement of bulbs	As need arises	MedTech/GFMC Point Person
	Cleaning painted or plastic surfaces with silicon cloth or soft cloth with mild detergent	Daily	MedTech
	Periodical Inspection for performance evaluation	As scheduled	GFMC
2. Clinical Centrifuge	Cleaning/ rewinding	Daily as need arises	MedTech
	Replacement of the carbon brush	After 3000 hours of use	MedTech/Technician
3. Hematocrit Centrifuge	Cleaning Rewinding	Daily, as need arises	MedTech
4. Glucometer	Cleaning with damp cloth		Health Personnel
	Replacement of meter's battery	As needed	MedTech
	Calibration	Prior to usage	MedTech

### **C. VENTILLATION & TEMPERATURE**

- The health facility shall endeavor to maintain a good airflow within the facility by minimizing impediments/barriers to air movement.
- Electric fans shall be provided in strategic places.
- The management shall endeavor to install exhaust fan in the laboratory to reduce the stagnation of fumes and chemical odors within the room.
- Windows are to be kept open at all times during clinic hours.

### **D. LIGHTING**

1. The facility shall be provided with electric run lights.
2. The health staff will ensure that all rooms shall have operational lights and electrical sockets.
3. In the absences of electricity from the utilities provider (NPC) efforts are to be exerted to access current supply from the LGU Generator.
4. Impediments to entry of natural light into the facility shall be minimized.
5. At least one (1) emergency light shall be installed to provide lighting in case of emergency particularly in the dispensing area.

### **E. WATER SUPPLY**

1. The RHU shall be connected to the Municipal Deep Well water supply.
2. A running water supply shall be ensured in the service rooms of the facility such as the EPI room, laboratory, ABTC room and examination room to facilitate cleanliness, hand washing and infection control.
3. Until such time that the municipal water supply's potability is established, drinking water for staff and patients shall be bought from a water refilling station.

### **F. SAFETY ENVIRONMENT**

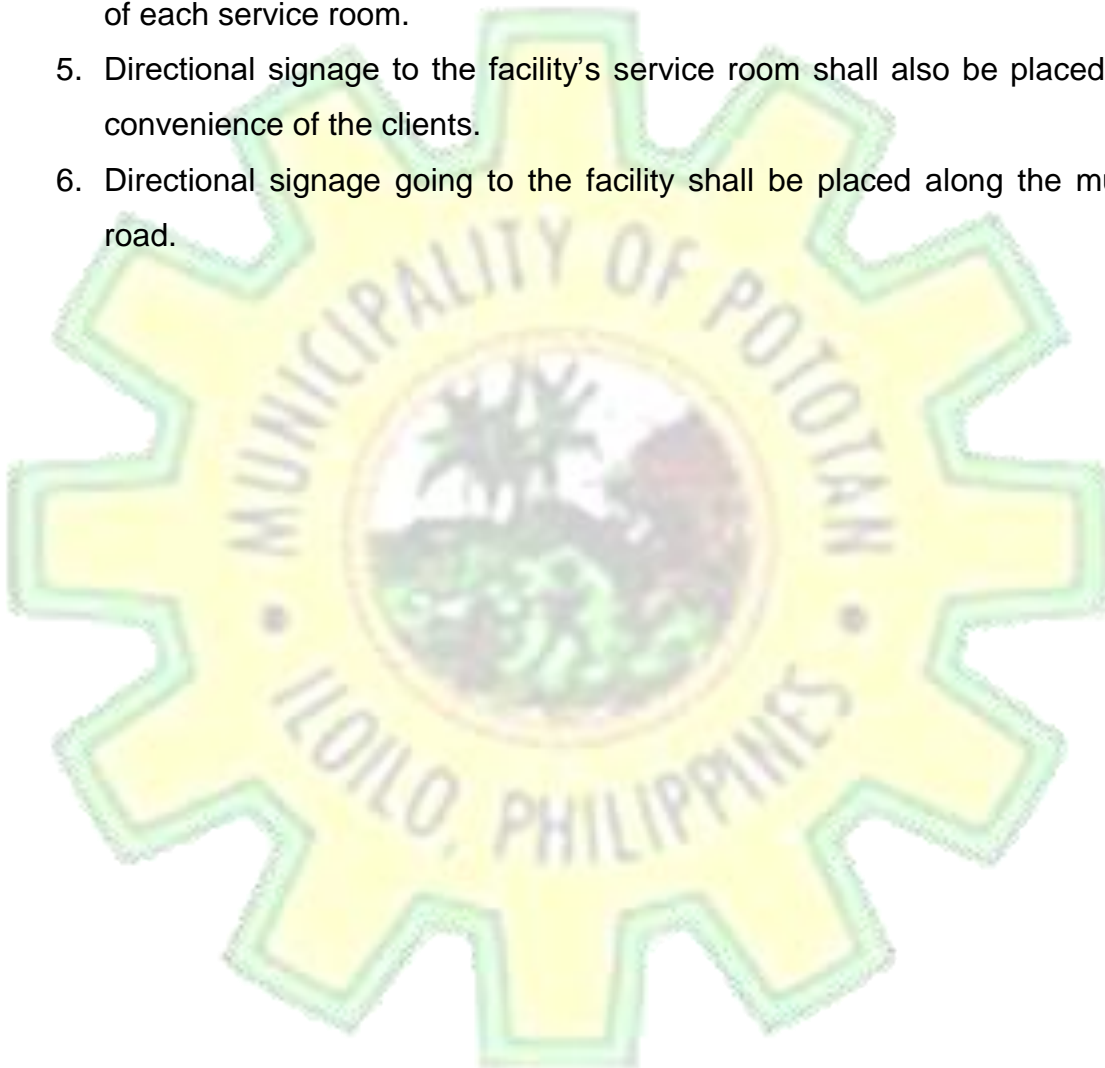
1. All health facility within the municipality shall be considered as SMOKING-FREE areas.
2. All wastes shall be segregated and manage according to the RHU policies.

### **G. SPACE**

1. Adequate space for service delivery shall be ensured.
2. Please refer to attached floor plan.

## H. SIGNAGE

1. The facility shall have a signage that will identify the structure; this signage shall be placed in a conspicuous place.
2. The Phil Health signage shall be placed in a conspicuous area at the MHC
3. A signage identifying the menu of services shall be placed in the frontage of the MHC.
4. All rooms in the facility will have an identifying signage place atop the door jams of each service room.
5. Directional signage to the facility's service room shall also be placed for the convenience of the clients.
6. Directional signage going to the facility shall be placed along the municipal road.





**SAT 35  
POLICIES AND PROCEDURES ON SAFE AND EFFICIENT USE OF  
MEDICAL EQUIPMENT**

**GOAL:** The health staff & clients are assured properly operated and maintained medical laboratory equipment and devices.

**1. SELECTION**

The selection of the medical/laboratory equipment as to type to be obtained shall be based on prevalent and emerging needs of clients. IT is a vision of the facility to eventually have well-equipped laboratory with blood chemistry study capabilities and rapid diagnostic tests for hepatitis, typhoid and other emerging diseases for purposes of screening.

The following are some generalities on the selection of basic equipment/devices:

<b>EQUIPMENT</b>	<b>RECOMMENDED SPECIFICATION</b>
Microscope	<ul style="list-style-type: none"> <li>➤ Can be monocular but preferably binocular</li> <li>➤ It should have a dual source of light, either natural (daylight) and artificial (with a lamp powered by electricity, battery or generator).</li> <li>➤ It must have a lens combination of a x10 eyepiece and a x 100 objective to give a magnification x1000</li> <li>➤ It should also have filter to convert light sources.</li> </ul>
Hemoglobinometer	<ul style="list-style-type: none"> <li>➤ Sahli type of hemoglobinometer</li> </ul>
Hemocentrifuge	<ul style="list-style-type: none"> <li>➤ Micro-hematocrit centrifuge utilizing Adam's Micro Method is the preferred methodology for determining hematocrit</li> </ul>
Clinical Centrifuged	Should have 6-8 chambers
Weighing Scales	<ul style="list-style-type: none"> <li>➤ For infants &amp; children the salter weighing scale is preferred, digital scales, if available can be also be utilized in the Main Health Center.</li> <li>➤ For bigger children &amp; adults- Detecto weighing scales are preferred.</li> </ul>

## 2. PROCUREMENT & ACQUISITION

Medical equipment & devices required by the municipal health services shall be obtained through the following schemes:

- Procurement Utilizing RHU budgetary allocation for the fiscal year granting that said equipment are specified in the Annual Procurement Plan
- Procurement utilizing fund transfers/trust funds such the capitation fund from the Philhealth
- Donation from partner agencies such as USAID, UNICEF, JICA, GFMC
- Requisition to other health agencies, namely, Provincial Health Office and the Center for Health Development-CAR
- Donation from private individuals and foundations

## 3. USE AND OPERATIONS (based on Manual for each equipment)

### 3.1. COMPRESSOR NEBULIZER

- To avoid electrocution, keep the unit away from water.
  - Never operate the unit if it has damaged parts, If it has been dropped or immersed in water
  - The unit should not be used where flammable gas, oxygen or aerosol spray is present
  - Disconnect the unit from the electrical outlet before cleaning.
  - Always connect the product to appropriate voltage outlet for the model
  - Prior to initial operation, the nebulizer should be thoroughly cleaned
  - Follow instructions for operations as stated in the manual
- The compressor has thermal protector which will shut off the unit before the units is overheated. When the thermal protector shuts the unit off, switch the unit off, unplug the unit from the electrical outlet and wait for 30 minutes for the motor to cool down before another treatment.

### 3.2. DIABETES MONITORING SYSTEM/ GLUCOMETER

- Use:
  - a. Professional use in the management of diabetes
  - b. For monitoring glucose in fresh whole blood
  - c. Form monitoring B-ketone in fresh whole blood
- System should be calibrated every time a new box of test strips is utilized to ensure that the results obtained are accurate.
- Refer to the manual for the operation of the system

### 3.3 BIOLOGIC MICROSCOPE

- Use the microscope only for microscopic observation
- The microscope is precision instrument; It should be handled gently; strong shocks and forcible operations will cause severe damage to the instrument.

### 3.4 LOWER SPEED CENTRIFUGAL MACHINE/CLINICAL CENTRIFUGE

- Always keep the machine on a level & strong table and keep working area dry and well-ventilated
- Do not operate the machine if the rotor is not balanced assembled
- Always keep the lid closed during the operation of the machine

## 4. REPAIR AND MAINTENANCE

### 4.1. COMPRESSOR NEBULIZER

- It is recommended that the nebulizer, mouthpiece and mask are thoroughly cleaned with hot water after each used and cleaned with mild detergent after the last treatment of the day.
- Change the filter every 30 days or once it turns gray.

### 4.2. DIABETES MONITORING SYSTEM

- Use damp cloth and mild soap to clean the surface of the meter
- Other acceptable cleaning solution include 10% bleach, 70% alcohol, 10% ammonia
- DO NOT CLEAN STRIP PORT
- Replace meter's battery once the battery low indicator shows up on the meter screen.

### 4.3. BIOLOGICAL MICROSCOPE

- Lenses are to be cleaned regularly to remove dust, fingerprints, grease and oil
- Avoid use of organic solvents in cleaning painted or plastic surfaces
- Printed plastic surfaces should be cleaned using soft moistened cloth

### 1.4 LOWER SPEED CENTRIFUGAL MACHINE

- Do not put anything on the cover
- Replace carbon brush if the motor has been used over 3000 hours

## **5. STORAGE**

### **5.1. COMPRESSOR**

- Do not store under direct sunlight, high temperature, of humidity.
- Keep the unit out of reach of children.
- Always keep the unit unplugged while not in use.

### **5.2. DIABETES MONITORING SYSTEM**

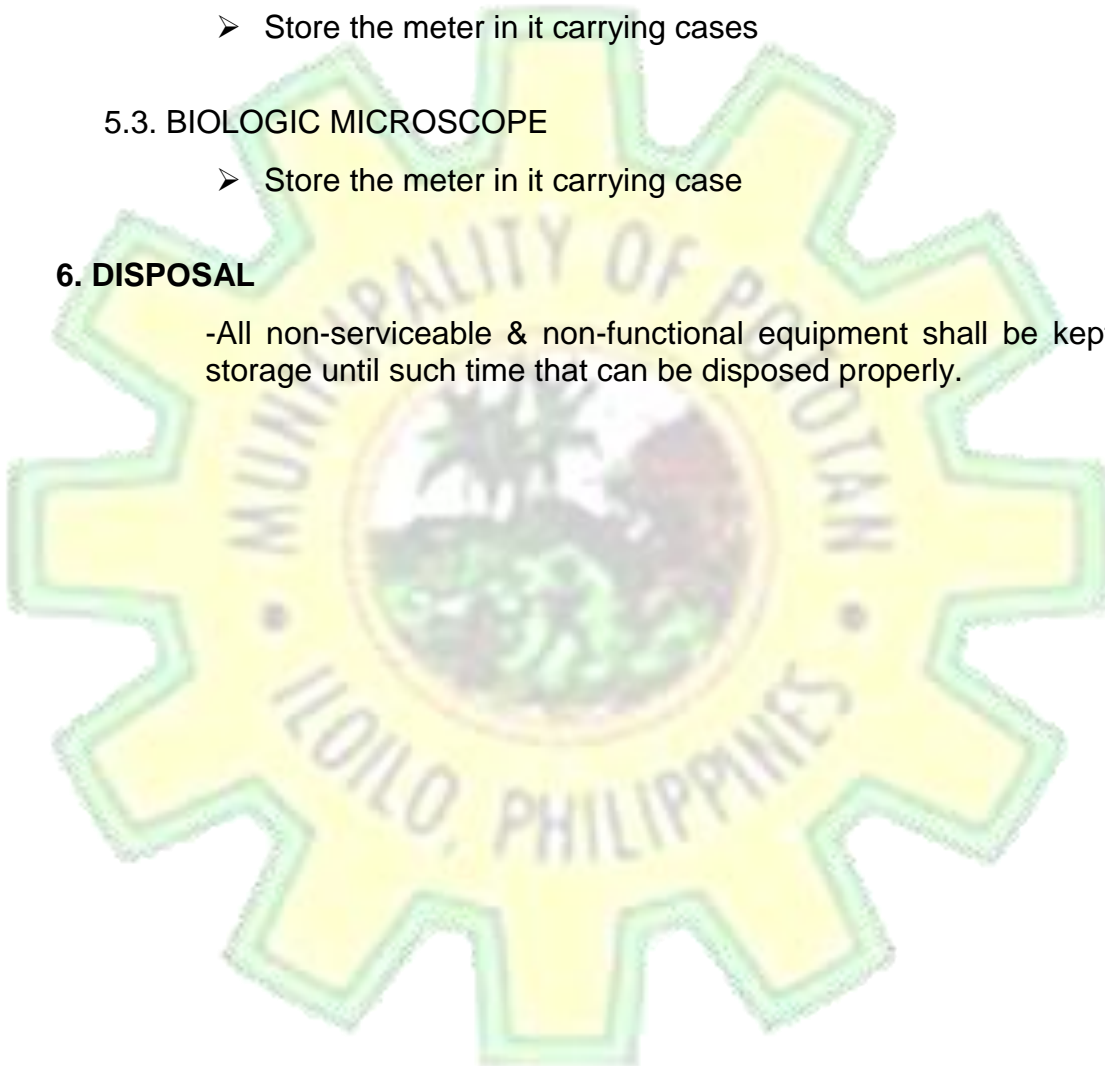
- Store the meter in it carrying cases

### **5.3. BIOLOGIC MICROSCOPE**

- Store the meter in it carrying case

## **6. DISPOSAL**

-All non-serviceable & non-functional equipment shall be kept in the storage until such time that can be disposed properly.



## SAF 35

### POLICIES AND PROCEDURES ON SAFE AND EFFICIENT USE OF MEDICAL EQUIPMENT

**GOAL:** The health staff & clients are assured properly operated and maintained medical laboratory equipment and devices.

#### 1. SELECTION

The selection of the medical/laboratory equipment as to type to be obtained shall be based on prevalent and emerging needs of clients. IT is a vision of the facility to eventually have well-equipped laboratory with blood chemistry study capabilities and rapid diagnostic tests for hepatitis, typhoid and other emerging diseases for purposes of screening.

The following are some generalities on the selection of basic equipment/devices:

EQUIPMENT	RECOMMENDED SPECIFICATION
Microscope	<ul style="list-style-type: none"><li>➤ Can be monocular but preferably binocular</li><li>➤ It should have a dual source of light, either natural (daylight) and artificial (with a lamp powered by electricity, battery or generator).</li><li>➤ It must have a lens combination of a x10 eyepiece and a x 100 objective to give a magnification x1000</li><li>➤ It should also have filter to convert light sources.</li></ul>
Hemoglobinometer	<ul style="list-style-type: none"><li>➤ Sahli type of hemoglobinometer</li></ul>
Hemocentrifuge	<ul style="list-style-type: none"><li>➤ Micro-hematocrit centrifuge utilizing Adam's Micro Method is the preferred methodology for determining hematocrit</li></ul>
Clinical Centrifuged	Should have 6-8 chambers
Weighing Scales	<ul style="list-style-type: none"><li>➤ For infants &amp; children the salter weighing scale is preferred, digital scales, if available can be also be utilized in the Main Health Center.</li><li>➤ For bigger children &amp; adults- Detecto weighing scales are preferred.</li></ul>

## 2. PROCUREMENT & ACQUISITION

Medical equipment & devices required by the municipal health services shall be obtained through the following schemes:

- Procurement Utilizing RHU budgetary allocation for the fiscal year granting that said equipment are specified in the Annual Procurement Plan
- Procurement utilizing fund transfers/trust funds such the capitation fund from the Philhealth
- Donation from partner agencies such as USAID, UNICEF, JICA, GFMC
- Requisition to other health agencies, namely, Provincial Health Office and the Center for Health Development-CAR
- Donation from private individuals and foundations

## 3. USE AND OPERATIONS (based on Manual for each equipment)

### 3.1. COMPRESSOR NEBULIZER

- To avoid electrocution, keep the unit away from water.
- Never operate the unit if it has damaged parts, If it has been dropped or immersed in water
- The unit should not be used where flammable gas, oxygen or aerosol spray is present
- Disconnect the unit from the electrical outlet before cleaning.
- Always connect the product to appropriate voltage outlet for the model
- Prior to initial operation, the nebulizer should be thoroughly cleaned
- Follow instructions for operations as stated in the manual

The compressor has thermal protector which will shut off the unit before the units is overheated. When the thermal protector shuts the unit off, switch the unit off, unplug the unit from the electrical outlet and wait for 30 minutes for the motor to cool down before another treatment.

### 3.2. DIABETES MONITORING SYSTEM/ GLUCOMETER

- Use:
  - d. Professional use in the management of diabetes
  - e. For monitoring glucose in fresh whole blood
  - f. Form monitoring B-ketone in fresh whole blood
- System should be calibrated every time a new box of test strips is utilized to ensure that the results obtained are accurate.

- Refer to the manual for the operation of the system

### 3.3 BIOLOGIC MICROSCOPE

- Use the microscope only for microscopic observation
- The microscope is precision instrument; It should be handled gently; strong shocks and forcible operations will cause severe damage to the instrument.

### 3.4 LOWER SPEED CENTRIFUGAL MACHINE/CLINICAL CENTRIFUGE

- Always keep the machine on a level & strong table and keep working area dry and well-ventilated
- Do not operate the machine if the rotor is not balanced assembled
- Always keep the lid closed during the operation of the machine

## 4. REPAIR AND MAINTENANCE

### 4.4. COMPRESSOR NEBULIZER

- It is recommended that the nebulizer, mouthpiece and mask are thoroughly cleaned with hot water after each used and cleaned with mild detergent after the last treatment of the day.
- Change the filter every 30 days or once it turns gray.

### 4.5. DIABETES MONITORING SYSTEM

- Use damp cloth and mild soap to clean the surface of the meter
- Other acceptable cleaning solution include 10% bleach, 70% alcohol, 10% ammonia
- DO NOT CLEAN STRIP PORT
- Replace meter's battery once the battery low indicator shows up on the meter screen.

### 4.6. BIOLOGICAL MICROSCOPE

- Lenses are to be cleaned regularly to remove dust, fingerprints, grease and oil
- Avoid use of organic solvents in cleaning painted or plastic surfaces
- Printed plastic surfaces should be cleaned using soft moistened cloth

### 1.5 LOWER SPEED CENTRIFUGAL MACHINE

- Do not put anything on the cover
- Replace carbon brush if the motor has been used over 3000 hours

## 5. STORAGE

### 5.1. COMPRESSOR

- Do not store under direct sunlight, high temperature, of humidity.
- Keep the unit out of reach of children.
- Always keep the unit unplugged while not in use.

### 5.2. DIABETES MONITORING SYSTEM

- Store the meter in it carrying cases

### 5.3. BIOLOGIC MICROSCOPE

- Store the meter in it carrying case

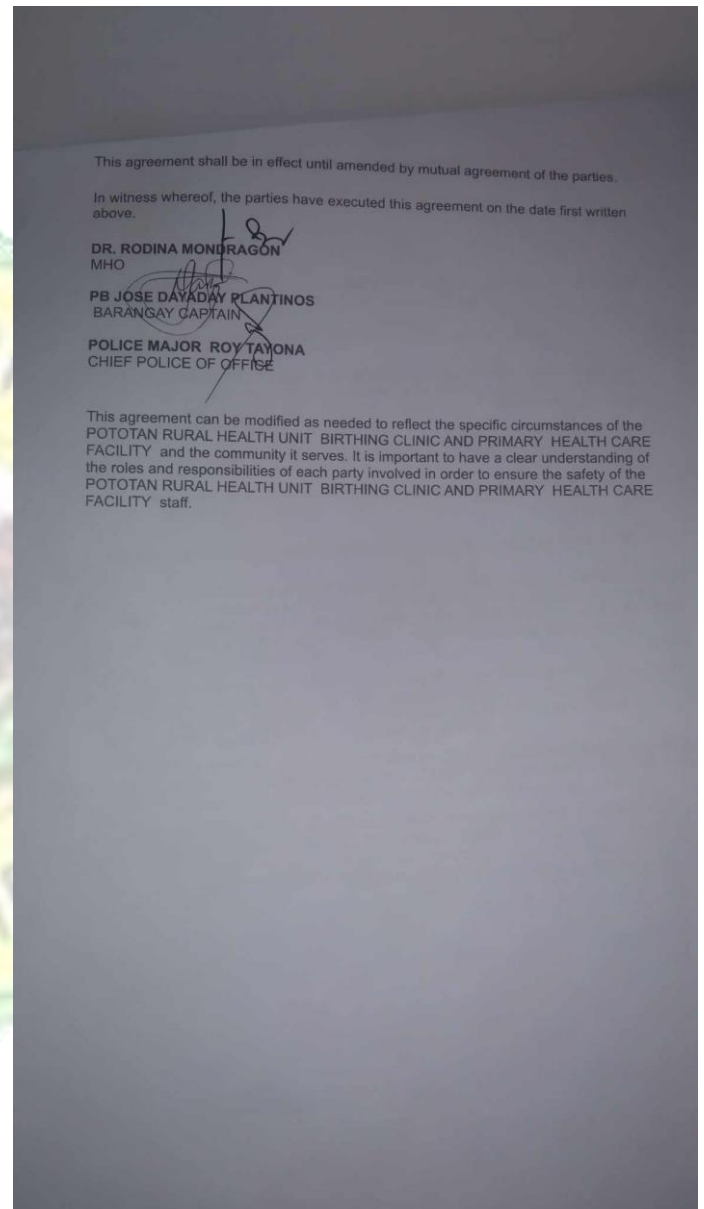
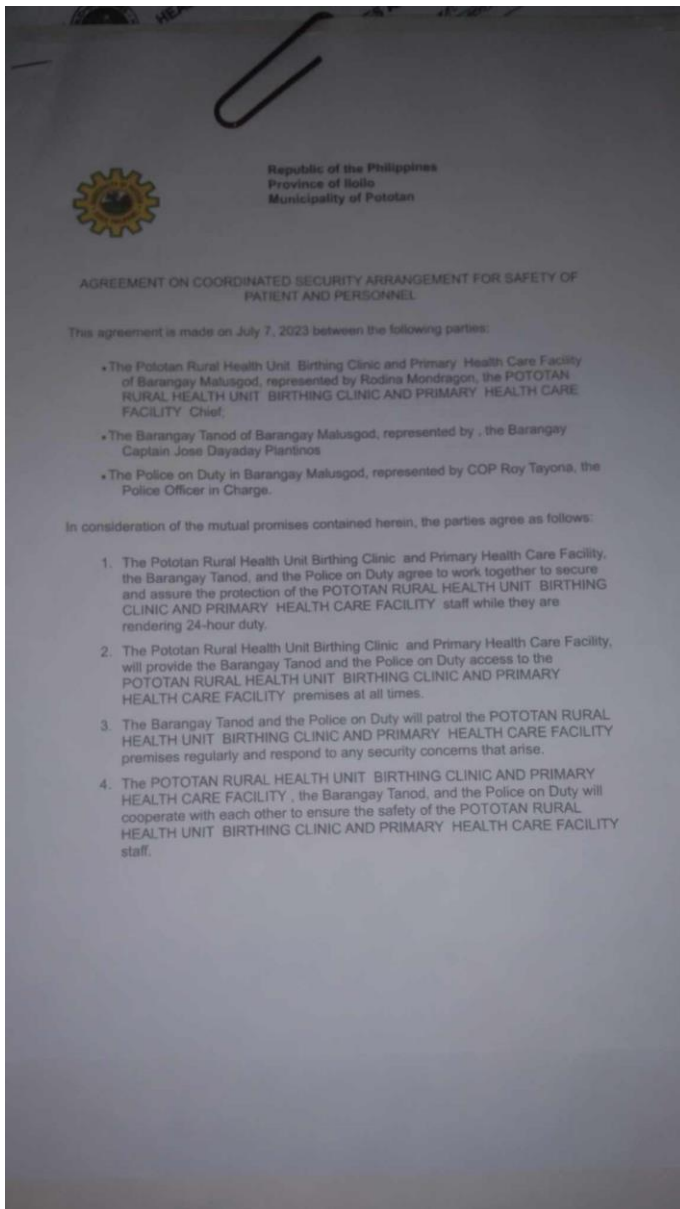
## 6. DISPOSAL

-All non-serviceable & non-functional equipment shall be kept in the storage until such time that can be disposed properly.



## SAT 37

### Coordinated Security Arrangement in the Organization for Protection of Patients and staff



## SAT 38

### Proof of Corrective Maintenance on Generator, Emergency Light and Water System (Logbook)

## SAT 39

### Policies for Non-medical Equipment Maintenance

#### POLICY ON MAINTENANCE OF NON-MEDICAL EQUIPMENT

##### OBJECTIVES

This Policy is intended for the maintenance of non-medical equipment that ensures:

- a. Maximum availability and reliability of equipment
- b. Minimum downtime and Maximum Uptime
- c. Maximum return on investment
- d. Prevention of wastage of consumables and spares
- e. Extended useful life of equipment
- f. Readiness of the equipment for emergency use whenever required

##### MAINTENANCE OF THE EQUIPMENT:

Proper maintenance of non-medical equipment is essential to obtain sustained benefits and to preserve capital investment. Non-Medical equipment must be maintained in working order and periodically calibrated for effectiveness. The Maintenance consists of:

- a. Planned Preventive Maintenance
- b. Breakdown Maintenance

**a. Planned Preventive Maintenance (PPM)** Planned Preventive Maintenance involves maintenance performed to extend the life of the equipment and prevent its failure. Planned Preventive Maintenance is usually scheduled at specific intervals and includes specific maintenance activities such as lubrication, calibration, cleaning (e.g. filters) or replacing parts that are expected to wear (e.g. bearings) or which have a finite life (e.g. tubing). The

procedures and intervals are usually established by the manufacturer. In special cases the user may change the frequency to accommodate local environmental conditions. Planned Preventive maintenance will be a statutory requirement for most of the equipment. It will enhance the efficiency, effectiveness and reliability of equipment and must be carried out at appropriate frequency as suggested by the manufacturer/service provider.

The conditions for preventive maintenance required for non-medical equipment can vary due to factor such as type of equipment, age of the equipment, frequency of use of the equipment, etc.

**b. Breakdown Maintenance** is a task performed to identify, isolate, and rectify a fault so that the out of order equipment, machine, or system can be restored to an operational condition. All non-medical equipment in use should be free from any fault or defect and all repair work should be carried out to accepted standards by competent person(s). Faulty or defective equipment shall not be used regardless of how minor is the problem and must be reported to the administrative order.

#### **PLAN FOR EQUIPMENT REPLACEMENT IN CASE OF BREAKDOWN FOR NON-MEDICAL EQUIPMENT**

1. RHU staff will ensure that equipment is sufficient for required public health needs and that all equipment is kept in good working order.
2. Equipment needs are reviewed annually during program reviews and budget process, equipment requests will be defined by the MHO for medical and office equipment needs.
3. Employees are expected to follow proper utilization procedures, assure maintenance is performed when necessary, and report problems to supervisors in order to assure appropriate assessment of replacement needs.
4. Unless an emergency occurs, equipment will be purchased or replaced during the normal budget process in a manner that is consistent with municipal procedure.

5. Clerk/Administrative Officer continually assess computer equipment needs and gives finance officer copies of needs and priority
6. Consideration is always given to the average life vs. condition at current time. When major repairs are needed, the repair quote is compared to actual replacement costs and a decision is based on this assessment.
7. Staff will keep equipment logs and ensure that all equipment is maintained and serviced as needed.

## SAT 40

### OPERATING MANUALS OF NON-MEDICAL EQUIPMENT (see folder)

### SAF 41 POLICIES AND PROCEDURES ON HEALTH CARE WASTE MANAGEMENT

**GOAL:** Health staff and clients are assure of an effective and efficient management of health

care wastes

1. All facilities under the office of the Municipal Health Services shall follow the principle of waste segregation.
2. There shall be an identification and categorization of health care wastes as follows (applicable to the RHU)
  - a. Non-Infectious Wastes/ General Waste (WET)- BLACK
    - a.1. Kitchen Wastes
  - b. Non-Infectious Wastes/ General Waste (DRY)- BLACK
    - b.1. Bottles, cans and plastics
    - b.2. Paper and cartoons
  - c. Infectious Wastes and Pathologic Waste- YELLOW
  - d. Chemical waste
  - e. Sharps
  - f. Expired Pharmaceutical Waste
  - g. Pathologic Waste
3. Above categorization will be the basis for the collection, storage, treatment disposal of said waste.
4. All RHU wastes shall be collected in specific waste bins strategically located in various service areas of the facility.
5. Non-Infectious waste/General waste
  - These are to be collected in the facility and handed over to the garbage collection system of the municipality.
  - Kitchen waste is to be brought home by staff as pig/cat/dog food.
  - Recyclable materials like glass and plastics shall be sold to junk shops and the generated sale be used as petty cash for the facility.

- Cartons are to be properly stacked for future use as packing material for files, supplies and equipment.
- Waste papers from the RHU and the other LGU offices shall be collected and be recycled as medicine packets/ sachets for dispensed medicines

#### 6. Infectious Waste/Pathologic Waste

- These include wastes from blood and body fluids and materials that has come in contact with potentially contaminated surfaces like wounds and body secretions.
- These also include discarded live attenuated vaccines.
- These are to undergo CHEMICAL DISINFECTION using the most available disinfectant prior to storage and eventual disposal.
- After disinfection wastes can be handed to the municipal garbage collection system.

#### 7. Chemical Waste

- These comprise discarded chemicals from diagnosis procedures.
- The RHU laboratory is the primary source of these wastes.
- The only identified hazardous chemical in the facility is xylene which is utilized for mounting larval sample; these shall be stored in a glass container with tight fitting cap.
- Other chemicals can be disposed of in the laboratory sink.

#### 8. Sharps

- These include needles, syringes; broken glass; and any item that can cause cuts or punctures.
- Storage of these wastes shall be in the standard puncture proof containers provided for by the Department of Health.
- In instances where there shall be shortage of puncture proof container, plastic gallons with relatively thick walls shall be utilized.
- Hub cutters shall be utilized to sever the needle from the syringe, which in turn will still be placed in puncture proof boxes.
- Sharp shall be disposed by placing in a septic vault.

## 9. Expired Pharmaceutical Waste

- These includes pharmaceutical products, drugs, medicines and chemicals that have been spilled, are expired, contaminated or are no longer needed.
- Expired liquid medications can be disposed directly to the sink.
- Medicines in tablet/capsule/gel forms are to be stored temporarily in plastic containers and be disposed only by burying

## 10. General guidelines in waste storage

- All RHU wastes not eligible for collection by the municipal garbage disposal system shall be stored in the warehouse until such time that they shall be buried in septic vault.
- The storage area should be accessible to personnel but should be kept lock to prevent access by unauthorized persons.
- The storage area shall be protected from sun, rain and flood and must not be accessible to rodents or animals.
- The warehouse should be well lighted and well ventilated.

## 11. The RHU shall endeavor to establish a septic vault, which shall have the following features:

- Restricted access to authorized health personnel only
- It should be made of material with low permeability to prevent grounds water contamination
- It will accommodate only hazardous and sharp health care wastes.
- It shall be managed as a landfill, wherein each layer shall be covered with earth and prevent proliferation of rodents.
- It shall build within any LGU properly, preferably within the perimeter of the RHU for easy monitoring.
- The perimeter of the vault should be protected with a perimeter fence if it shall be built away from the RHU premises.
- It shall follow at the recommended engineering specifications.

## 12. Occupational Health Safety

- All RHU personnel are presumed to be exposed to the various wastes in the facility.
- Health personnel are to be oriented on proper waste management and on the hazards associated with improper handling and disposal of these wastes.
- The medical technologist and the microscopists shall be the only persons that are to be handle wastes from diagnostic procedures; they are to be provided with gloves and masks for the handling of the waste.

<b>GREEN BAGS</b>  <b>General non-infectious wet waste like kitchen waste/food</b>	<b>BLACK BAGS</b>  <b>General non-infectious dry waste such as papers, wrappers</b>	<b>YELLOW BAGS</b>  <b>Infectious waste Bandages Gauze, cotton or any other objects in contact with body fluids, human body parts etc.</b>	<b>RED BAGS</b>  <b>Plastic waste such as catheters, syringes without needles, tubings, IV bottles</b>	<b>BLUE BAGS</b>  <b>All types of glass bottles and out-dated and discarded medicines</b>	<b>SHARP CONTAINERS</b>  <b>Needles, sharps, broken glass articles and blades</b>
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# INFECTIOUS WASTE/PATHOLOGICAL WASTE



# SHARP AND DISPOSABLE WASTES



# **INFECTIOUS AND GENERAL WASTE- DAILY COLLECTION AND BURNED THROUGH INCENARATOR AT THE NEW MARKET**

## **SAT 42**

### **IPC MANUAL**

#### **POLICY TITLE: Infection Control Manual (IPC)**

#### **1.INTRODUCTION**

Pototan Rural Health Unit provides a sanitary environment to avoid source and transmission of infectious and communicable diseases including Covid-19. Since the RHU is responsible for the performance of its employees, the importance of providing adequate periodic training and supervision of the personnel in proper infection control practices cannot be overemphasized. Every accredited PCF is required to have an Infection Control Committee tasked to manage a facility-wide infection control program. The responsibility of the PCF in control of infection extends to its patients, personnel and visitors.

#### **2. OBJECTIVE**

- a. To apply several types of measures, to minimize the risk of transmission of Covid-19. In times of community transmission of Covid-19, staff, visitors and patients should observe physical distancing, hand hygiene and respiratory hygiene, and wear mask.
- b. To designate a team to lead for Covid-19 preparedness and response in the facility.
- c. To enhance and increase awareness of healthcare workers on the practice of infection control through continuous education, and training, programs and information dissemination and practical application in the workplace.
- d. To design relevant infection control education and training modules that will enhance knowledge and competence of healthcare workers in the practice of infection control.
- e. To implement infection control policies and procedures recommended and monitor its implementation.
- f. To protect healthcare workers through education and immunization and other prevention programs.
- g. To increase compliance to infection control practice of healthcare workers.

#### **3. INFECTION CONTROL SECTION FOR CONSULTATION AREA**

##### **A. PROCEDURES:**

- a. TRIAGE: Nurse or Midwife
  1. Upon consultation take steps to ensure all persons with symptoms of suspected COVID-19 or other respiratory infections (e.g. fever, cough) adhere to cough etiquette and hand hygiene, social distancing and wearing of mask.
  2. Undertake screening of persons with cough that lasted for two weeks or more for those who are below 60 years old and a current cough for those who are 60 years old

and above as they enter the health center and before they join the queue or have a seat with others.

b. SEPARATION: Nurse or Midwife

1. Undertake screening of persons with cough as they enter the health facility.
2. Physically separate infectious and potentially infectious individuals from others.
3. Separate Presumptive TB and Confirmed TB patient in a designated place which is at the DOTS area.

#### 4. FUNDAMENTALS OF STANDARD PRECAUTIONS

a. Handwashing

Handwashing is the single most important measure to reduce the risks of transmitting microorganism from one patient to another, or from one site to another, on the same patient.

- b. This should be before and between contact with patient and after contact with blood, body fluids, secretions and equipment or articles contaminated by them.

c. GLOVING

Done to provide protective barrier and prevent contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin; to reduce microorganisms present on hands of personnel performing invasive or other patient care procedure that involves touching patient's mucous membrane and non-intact skin; and reduce the spread of microorganism from one patient to another through bare hands

d. MASK, RESPIRATORY PROTECTION, EYE PROTECTION, FACE SHIELDS

Worn alone or in combination to provide barrier protection. Mask should cover both the nose the mouth; goggles or face shield should be worn by the hospital personnel during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions to provide protection of the mucous membranes of the eyes, nose, and the mouth from contact transmission of pathogens.

e. GOWNS

Put on a clean gown and change the gown if it becomes soiled.

#### 5. CARE OF EQUIPMENTS AND ARTICLES

Contaminated reusable medical devices or patient-care equipment are sterilized or disinfected after use to reduce the risk of transmission of microorganisms to other patients. Equipments contaminated with blood, body fluids, secretions or excretions should be cleaned and disinfected after use according to the facilities policy on contaminated disposable patient-care equipment. These should be handled and transported in a manner that reduces the risk of contamination of microorganisms and decrease environmental contamination. The equipment should be disposed according to the facility's policy and regulation.

#### 6. CONTACT PRECAUTIONS

Designed to reduce of transmission of epidemiologically important microorganisms by direct

or

Indirect contact.

Direct contact refers to the physical transfer of microorganisms to a susceptible host from an infected or colonized individual.

Indirect contact refers to the transmission which involves contact of a susceptible host with contaminated intermediate object, usually inanimate in the patient environment.

Contact precaution applies to specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct or indirect contact.

Use contact precautions for patient with gastrointestinal, respiratory, skin or wound infections or colonization with multi drug-resistant bacteria such as:

Enteric infections: Escherichia coli, Shigella, Hepatitis A, Salmonella, Skin infection that are contagious or that may occur on dry skin including:

Diphtheria (cutaneous)

Herpes simplex-virus (neonatal or mucocutaneous)

Major (non-contained) abscess, cellulitis, or decubili

Pediculosis

Scabies

Staphylococcal furunculosis in infants and young children

Zoster (disseminated or in the immunocompromised host)

Viral/Hemorrhagic conjunctivitis

HIH/AIDS

## **7. TRANSMISSION BASED PRECAUTIONS**

Transmission Based Precautions are additional designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond standard precautions are needed to interrupt transmission in the facility. There are three types of transmission base precautions: Airborne, Precautions, Droplet Precautions, and Contact Precautions.

### **a. Airborne Precautions**

Designed to reduce the risk of transmission of infectious agents.

Airborne transmission occurs by dissemination of either airborne droplet nuclei or

dust

particles containing the infected agent. Microorganisms carried in this manner can be widely dispersed by air currents and may be inhaled by or deposited on a susceptible host within the same room or carried over a longer distance from the source patient depending on environmental factors. Therefore, handling and ventilation are required to prevent airborne transmission.

Airborne precautions apply to patients known or suspected to be infected with epidemiologically Important pathogens that can be transmitted by the airborne route.

Airborne precaution is applied for patients known or suspected to have serious illnesses such as:

Measles  
Varicella/Zoster  
Tuberculosis (Pulmonary, cavitating open lesions)  
SARS

## 8. DROPLET PRECAUTIONS

Designed to reduce the risk of droplet transmission of infectious agent.

Droplet infection involves contact of the conjunctivae or the mucous membranes of the nose or mouth of susceptible person with large particle droplet containing microorganisms generated from person who has clinical disease or who is a carrier of the microorganism.

Transmission via large particle droplet requires close contact between source and recipient persons because droplets do not remain suspended in the air and generally travel through the air only distances through the air only to distances of three feet or less.

Droplet precautions apply to any patient known or suspected to be infected with epidemiologically important pathogens that can be transmitted by infectious droplet.

Use droplet precautions for patients known or suspected to have serious illnesses transmitted by large particle droplets such as:

### SARS

- Invasive Haemophilus influenza type B disease, including:
- Meningitis
- Pneumonia, Epiglottitis
- Covid-19

Invasive Neisseria meningitides, including:

- Meningitis
- Meningococemia
- Diphtheria (pharyngeal)
- Pertussis
- Streptococcal pharyngitis
- Influenza

Serious Viral Infections spread by droplet transmission, including:

- Adenovirus
- Influenza
- Mumps
- Rabies

## 9. IMPLEMENT ENVIRONMENTAL INFECTION CONTROL

1. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
2. All surfaces in the consultation area must be clean before the start of work and be decontaminate after work is done with 10% Lysol solution.
3. Clean with 10% hypochlorite solution, Lysol or chlorine whichever is available.

## **10. SURVEILLANCE**

- a. Surveillance is one of the most important elements in an infection Control Program and is defined as a method of monitoring ongoing events and being watchful of activities and occurrences of events that are pertinent to effective control. Complete surveillance is necessary in order to accomplish all elements of an Infection Control Program.
- b. Surveillance of clients for infection shall be done to identify baseline information about the frequency and type of endemic infection in order to permit rapid identification of deviations. All significant clusters of infection above the expected level shall be investigated. Surveillance will be aimed at assessment/observation and early recognition of signs and symptoms of infections, monitoring, analyzing, reporting, and follow-up.
- c. Surveillance activities shall include not only clients but also personnel, the environment. Procedures. And any activity that would be identified as impacting on infections or health risk for the population of the facility.

### **10.1 TYPES OF SURVEILLANCE**

- a. Prospective: Incidences that have occurred in the past. Monthly infections control reports are based upon this type.
- b. Retrospective: Incidences that have occurred in the past. Monthly infections control reports are based upon this type.
- c. Prevalence: Incidence that are occurring now.

### **10.2 METHODS OF SURVEILLANCE**

- a. Surveillance of all clients or occurrences at all times.
- b. Total surveillance is utilized to obtain pertinent baseline data.
- c. Surveillance of a selected population group, ex. Laboratory-based, high-risk population, infections in a particular site such as UTI.
- d. Targeted or selective surveillance is done when specific problems are identified or infections in a particular site are elevated above expected level.
- e. Surveillance done at specific time: ex. Prevalence studies. Environmental studies.

## CONSULTATION PROCEDURES

DESCRIPTION	PERSON RESPONSIBLE	INTERFACE/FORM/DOCUMENT
1. Classify patient as presumptive and confirmed TB patient from Non-TB patient. Determine appropriate service.	Nurse/Midwife	Individual Treatment Record (ITR)
2. Preparation of ITR 2.1 for new patients: make patient fill-up a data form. Then on-duty make an ITR. 2.2 For old patients: Retrieve patient's ITR. 2.3 Issues priority number To patients.	Nurse/Midwife	ITR
3. Vital Signs	Nurse/Midwife	ITR
4. Medical examination/Evaluation of the patient. 4.1 Orders/Issues Laboratory requests and prescribes medicines, treatment, diagnostic and procedures.	Physician	ITR Referral Form Laboratory Request Prescription
5. Facilitates Medical Orders/Requests	Nurse/Midwife	ITR Referral slip
6. Discharges patient and provides health education and home instructions.	Nurse/Midwife	ITR

## SAT 43

### **POLICIES AND PROCEDURE ON CLEANING DISINFECTING DRYING, PACKAGING AND STERILIZING OF EQUIPMENTS, INSTRUMENTS AND SUPPLIES**

#### PRINCIPLES TO REMEMBER WHEN HANDLING CONTAMINATED OR USED PATIENT CARE EQUIPMENTS:

- It is important to avoid any contact between a used piece of equipment and the skin, mucosa or clothing of the health-care worker, including any handles of the equipment.
- The process of cleaning and disinfecting respiratory equipment frequently results in splashes which could be contaminated.

#### WHEN CLEANING AND DISINFECTING RESPIRATORY EQUIPMENT THE HEALTH-CARE WORKER SHOULD WEAR:

1. Rubber gloves
  2. A gown and a rubber apron
  3. Face protection, such as a full-face shield or an eye protection, such as a visor or goggles, plus face mask.
- Re-usable equipment must be cleaned with soap or detergent and water until all visible signs of soiling are removed and must then be appropriately disinfected before the equipment can be used on another patient.
  - Appropriate reprocessing always includes thorough cleaning and may also include disinfection or sterilization depending on the nature and intended use of the device or equipment.
  - Any item designed for single receptacle immediately after use. This is essential to prevent any accidental contamination of either another person or the environment.



## DISINFECTANT USE:

Generally, bleach provides a reasonable level of chemical disinfection, the use of a chemical germicide, such as bleach or a physical method such as autoclaving is usually sufficient. Cleaning should precede any high-level disinfection activity.

## THE STAGES INVOLVED IN REPROCESSING REUSABLE EQUIPMENT AREAS ARE AS FOLLOWS:

1. Wash the piece of equipment with soap or detergent and waterproof
2. Rinse
3. Disinfect
4. Rinse again if using chemicals to disinfect
5. Dry
6. Store

## ESSENTIAL POINTS FOR CLEANING AND DISINFECTING EQUIPMENT

- Clean & disinfect all equipment between uses
- Thorough clean & re-usable equipment prior to disinfection
- Health-care workers must use PPE for cleaning and disinfection of equipment
- Keep clean & disinfected items dry and individual packages

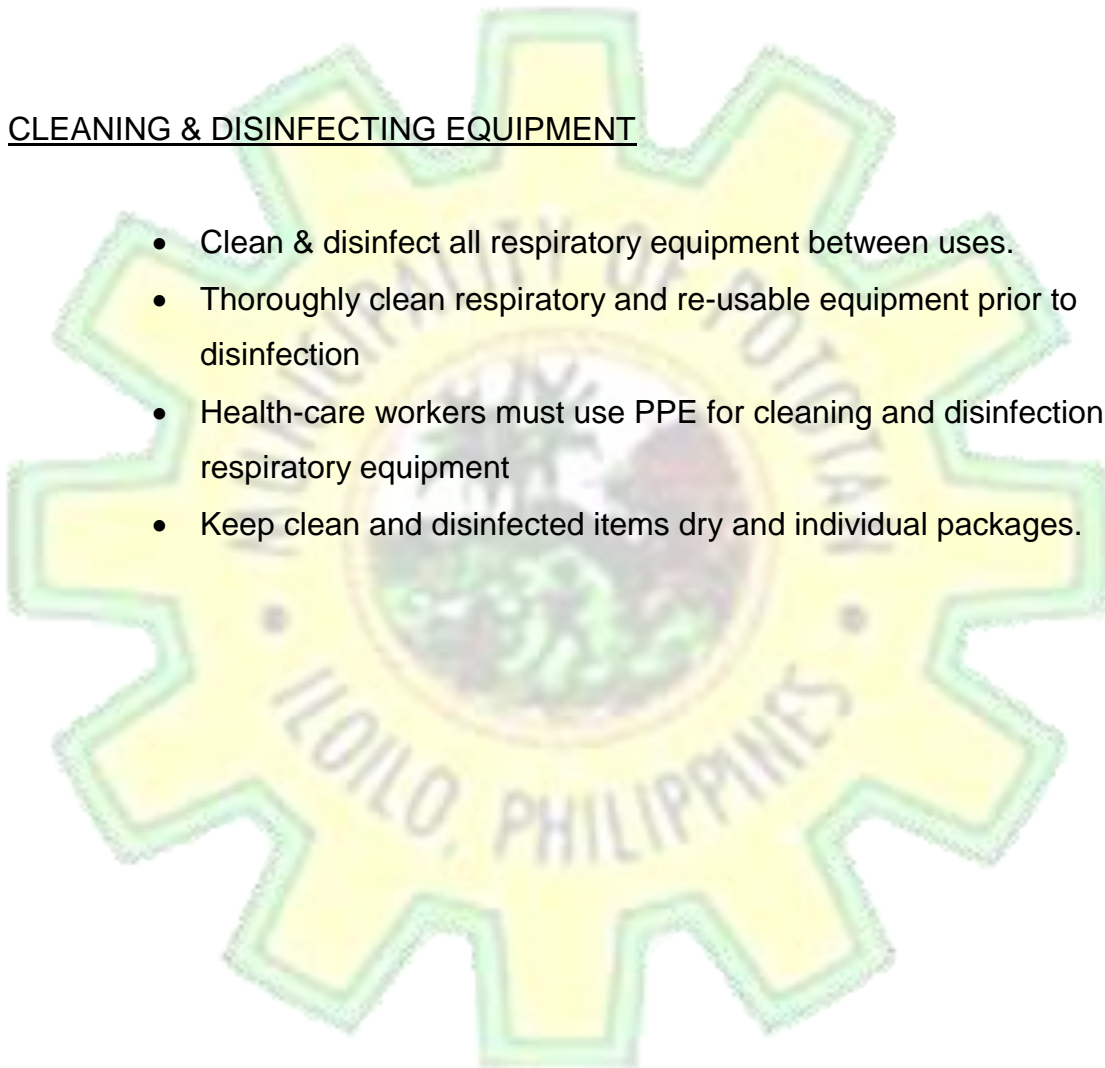
## CLEANING & DISINFECTING PATIENT-CARE ENVIRONMENT

- The environment used by the patient **MUST** be regularly cleaned.
- Cleaning should use proper techniques to avoid aerosolization of dust.

- Only surfaces that enter in contact with the patients' skin/mucosa and surfaces frequently touched by health-care workers require disinfection after cleaning.
- Health-care-workers MUST use PPE for cleaning and disinfection of respiratory equipment and hand hygiene must be performed after PPE removal.

### CLEANING & DISINFECTING EQUIPMENT

- Clean & disinfect all respiratory equipment between uses.
- Thoroughly clean respiratory and re-usable equipment prior to disinfection
- Health-care workers must use PPE for cleaning and disinfection of respiratory equipment
- Keep clean and disinfected items dry and individual packages.



## **SAT 44**

### **DISEASE SURVEILLANCE & OUTBREAK MANAGEMENT**

1. For an efficient and effective disease surveillance system, the following are to be institutionalized:
  - a. e-FHSIS for the monthly reporting of notifiable disease
  - b. Philippine integrated Disease Surveillance & Response (PIDSR)
2. Standard case definitions are to be used to identify notifiable diseases and syndromes in the RHU referral RHUs and the community. Cases are to be classified as:
  - a. Suspect Case-Indicative clinical picture without being a confirmed or probable case.
  - b. Probable Case-clear clinical picture, or linked epidemiologically to a confirmed case
  - c. Confirmed Case-Verified by laboratory analysis.
3. A simplified case definition is to be given to the community through Disease Reporting Advocates (DRA) such as the Community Health Teams (CHT) to facilitate early reporting of any suspected disease or conditions.
4. The Municipal Disease Surveillance Coordinator shall be the Municipality Health Officer with the following Functions:
  - a. Notify the next higher level (Provincial Epidemiologic Surveillance Unit) of diseases, events or syndromes classified as "immediate notification" within 24 hours.
  - b. Notify the PESU of a suspected epidemic within 24 hours and perform preliminary investigation.
  - c. Conduct preliminary investigation off all suspected epidemics.
  - d. Assist in epidemic investigation conducted by PESU/RESU/NEC
  - e. Submit PIDSR report forms to the PESU
  - f. Validate disease surveillance reports prepared by the disease surveillance officers.
  - g. Participate in other surveillance related activities and capability enhancement opportunities relevant to disease surveillance and outbreak management.
5. The Municipal Disease Surveillance Officers are the RHU Medical Technologist and the Public Health Nurse with the following functions:
  - a. Collect PIDSR forms from partner agencies and the RHU
  - b. Encode the data into the computer (once3 program is available)
  - c. Manage all records and files of case investigation forms.
  - d. Consolidate data from the different BHS and the FDH for transmittal to the PESU
  - e. Analyze and interpret data.
  - f. Participate in outbreak investigation activities.
7. BHS are expected to submit their monthly notifiable diseases reports for consolidation.
- 8.

## 7. REPORTING AND RECORDING

- a. Standard PIDSR Case Investigation & Reporting Forms shall be utilized
  - i. Sources of information are the following:
    - Patient
    - Guardian
    - Watcher or “bantay”
    - Attending Physician/Nurse or Midwife
  - b. Records from reporting unit
    - i. All investigators should record his/her name in all investigation forms
    - ii. At least 4 copies are to be made for all investigations for distribution to the following tiers of the epidemiologic surveillance system MESU, PESU, RESU and NEC
- c. All RHU personnel involved in the data collection shall be oriented on the various forms so as to ensure quality data collection

## 8. LABORATORY DIAGNOSIS

- a. Local laboratories in the municipality are to be utilized for SCREENING purposes for the following diseases:
  - ✓
  - ✓ Typhoid Fever
  - ✓ Covid-19
- a. These laboratories shall also be responsible for collecting specimens for definitive diagnosis procedures to be done in referral laboratories like the RITM/BGHMC Molecular Laboratory.
- b. Specific Specimen that is to be collected shall be based on the recommended Laboratory Test for Notifiable Disease by the PIDSR
- c. Specimen collected from an outbreak investigation is to be handled according to the recommendations of PIDSR

## **SAT 45 NEEDLE STICK INJURY**

### **A. POLICY AND OBJECTIVE**

In case where the health personnel accidentally pricked by unsterile needle, he/she is required to report it to the immediate supervisor or coordinators. The personnel will be referred to the municipal health officer for further assessment so that proper management will be initiated.

### **B. MANAGEMENT**

- a. Anti-tetanus serum injection for free.
- b. Free medicine as needed.
- c. Proper wound care

### **C. PROCEDURE**

- a. Proper disposal of sharps and needles.
  1. Never remove, recap, bend or break used needles.
  2. Never point the needle toward any body part.
  3. Deposit disposable needles in puncture resistant containers.
  4. Segregation of all waste is practice in the health facility. In each section, sharps and needles have their own containers. There is specific waste beam of sharps before they are dump.
  5. The collecting containers are made up of hard plastic galloons, which cannot be easily punctured by needle. At time, specific collecting box, hard box made up of thick paper boxes.

### **III. Universal Precaution**

1. Handwashing after any direct contact with patients.
2. Preventing two handed recapping needles.
3. Safe collection and disposal of needles and sharps, with required puncture and liquid proof safety boxes in each patient care area.
4. Wearing gloves for contact with body fluids, non-intact skin and mucous membranes.
5. Wearing appropriate personal protective equipment.
6. Covering all cuts and abrasion with a water proof dressing, if available.
7. Promptly and carefully cleaning up spills of blood and other body fluids.
8. Using safe system for health care waste management and disposal.

### **IV. RESPONSIBILITY**

- a. All Staff
- b. Public Health Nurse
- c. Municipal Health Officer/ Municipal Coordinator.

## **SAT 46 POLICY ON REPORTING NOTIFIABLE DISEASES**

### **PURPOSE**

- To protect and promote the right to health of the people and instill health consciousness among them.
- To protect the people from public health threats through the efficient and effective disease surveillance of notifiable diseases including emerging and reemerging infectious diseases, diseases for elimination and eradication, epidemics, and health events including chemical, biological, radioactive, nuclear and environmental agents of public health concern and provide an effective response system.

### **PROCEDURES**

The DOH in close coordination with its local counterparts, is mandated to implement the mandatory reporting of notifiable diseases and health events of public health concern.

1. The Rural Health Unit of Pototan regularly updates and issue a list of nationally notifiable diseases and health events of public health concern with their corresponding case definitions. The priority diseases/syndromes/conditions targeted for surveillance shall be selected based on the following categories:
  - Diseases spread by droplet:
  - Airborne diseases
  - Diseases spread by direct contact:
  - Vehicle-borne diseases
  - Vector-borne diseases
2. Mandatory reporting of notifiable diseases or health events of public health concern is done by submitting the Case Investigation Form (CIF) for diseases/syndromes under Category I diseases/syndromes), or the Case Report Form (CRF) for diseases/syndromes under Category II, from the Municipal Epidemiology and Surveillance Unit (MESU) to the Provincial Epidemiology and Surveillance Unit (PESU)
3. The necessary data for collection in the prescribed official forms under the DOH Manual of Procedures such as the CIF (Annex "B") or the CRF (Annex "C"), are the following:
  - Name of disease reporting unit;
  - Name of interviewer at first point of contact;
  - Name of the person subject of the interview;
  - Age;
  - Sex;
  - Civil status;
  - Date of birth;
  - Permanent residential address (from the smallest identifiable geographical unit such as street, purok or barangay);
  - Current residential address (from the smallest identifiable geographical unit such as street, purok or barangay);
  - Date of onset of illness or symptoms;Contact details such as mobile or landline phone number, or email address

## VII

### IMPROVING PERFORMANCE

#### SAT 47 Continuous Quality Improvement

#### POLICY ON CONTINUING QUALITY IMPROVEMENT

#### ESTABLISHMENT OF THE CONTINUING QUALITY IMPROVEMENT (CQI) PROGRAM AND COMMITTEE IN POTOTAN RURAL HEALTH UNIT

##### I. RATIONALE

Health service delivery has been changing over the past years. The evolving of medicine manifested in the discoveries of new diagnosis and treatment modalities and changes in expectation in the face of limited resources has placed a strain on the capability of health care providers to provide the best care possible. This often results to failure in delivery of effective health services resulting to increased litigation in health care and poor health outcomes. Because of this, the health sector has adopted the quality improvement experience of the manufacturing industry in providing quality services.

Since its inception quality assurance (QA) mechanisms have changed, with the prescriptive mechanisms evolving into more facility-oriented systems. At present, continuing quality improvement (CQI) has become more acceptable and can be described as a process through which the level of quality is defined, pursued, achieved and continuously improved through the establishment of the formal mechanisms/systems and structure within the organization. Continuing Quality Improvement describes the overall effort of the facility organization to achieve the most effective care with available resources and without compromising quality.

Congruent with the requirement of health facility licensure and the intent of the Department Order Nos. 310-Js, 2001 and 2003 on “The creation of the DOH Committee and

Technical Working Group for the Establishment of CQI program for the Health Regulation Cluster and DOH RHUs” and its amendment respectively, to consistently deliver and

continuously improve the quality of health care to our people, there is a need to institutionalize and establish the Continuing Quality Improvement (CQI) Program and Committee in all health facilities. This is also in concurrence with the thrust of PHIC bench book which states that “Achieving total quality is the goal of continuous performance improvement. This means continuously upgrading performance targets from previously accepted minimal standards, a challenge which demands management philosophy advocating continuous improvement in all levels of the organization, and the strategies operationalizing such philosophy.

CQI is a strategic approach to providing the best health care possible. It is a preventive strategy that uses constant innovation to improve work processes by reducing time-consuming, low value activities. Time that was once spent on rework and crisis management is now spent on planning, coordination and control. These includes deferent perspective of quality; 1) Clinical quality (providers) refers to the degree health outcomes and are consistent with current professional knowledge; 2) Service quality (customers). The emphasis on service quality has been most apparent since the growth of managed care. There is perceived restriction to a patient’s freedom of choice; 3) Cultural quality (administration) refers to the recent movement in health care called quality management or continuous quality management (CQM). This is the effort to improve the level of performance across the entire organization to achieve higher levels of customer satisfaction.

Customers are categorized as external and internal. Internal (working within the organization) co-workers, patients, customers, staff and others. External (working outside organization) families of patient, customer, suppliers, government agencies, community agencies.

In order to continuously improve the quality of health care services in all of health facilities, the implementation of the Continuing Quality Improvement Program in all health facilities is essential.



## **II. POLICY STATEMENTS**

- A. To protect and promote the health of the people by ensuring the rights to quality health service appropriate to the levels of care through the regulation of RHUs, RHUs and other health facilities.
- B. Health facilities need to be strengthened to comply with licensing and accreditation requirements.

## **III. GOALS AND OBJECTIVES**

To ensure that all consumers receive the highest quality and most effective health services available through the development and maintenance of qualified, diverse and accessible multidisciplinary network, care and service organization.

### **OBJECTIVES**

1. To ensure establishment and institutionalization of CQI program in managing quality in health care
2. To provide training and other forms of technical assistance relative to quality improvement to all RHU Staff.

## **IV. GENERAL GUIDELINES**

In the CQI Program Implementation, a facility CQI Committee shall be organized. This committee shall serve as the advisory body to the Municipal Health officer. The CQI Committee, in partnership with consumers and providers, will facilitate the development and successful operation of the Quality Improvement Committee. This serves as the policy-making entity with regard to facility quality management.

### **A. FRAMEWORK**

Organization performance is maintained and continuously improved by the committee through the use of an ongoing cycle of monitoring performance and feedback mechanism to improve organizational inputs (outcome). In defining

the framework, it must be a structure that encompasses quality improvement methods and tools to support strategic planning aligned with the vision, mission and objectives of CQI methods.

## B. PRINCIPLES

The principle of CQI guides us through the process of improving our service to our clients.

1. All work is service to others-our clients. They may be consumers, staff members from other departments, family of consumers, or the general public. To meet client's needs, know who the clients are. Ask them, don't wait for complaints, be in determining how best to relate to the client.
2. Quality is achieved by identifying and consistently meeting the needs, requirement and expectation of clients. Getting in habit of consulting with customers will help us to meet their needs. Finding out what they want and asking what we can do to help will result in quality work.
3. All work is part of a process that serves clients, and is organized around the need first. One process we complete is the discharge of patients/consumers. These clients should be consulted early on in discharge planning process in order to meet their needs and expectations.
4. Quality service is the result of teamwork, organized around a process. In order to ensure a smooth flow, we need to integrate our work and perceive the process as cutting across departments. The creation of cross functional teams results in people who do not only talk to one another but begin to understand how the process should "flow". A team who understands the flow of the process can create positive change
5. Part of the daily work is to improve processes by reducing variation. Inconsistencies in your daily work processes in the following: Machines and equipment, materials and supplies, methods and procedures, measurements and calibration and people. Your task is to identify inconsistencies in your work and some forms of variations are simply part of the process and they are unlikely to be modified.

6. Use of data and measurement tools is a good way to improve processes and outcomes. CQI uses a scientific approach to examine a problem. The collection and analysis of meaningful data creates a fact-based understanding of processes. This new knowledge allows teams to design effective and lasting improvement based on facts.
7. Management commitment to quality principles and practices is essential. Management must facilitate a culture empowerment. Collaboration and organization within a person, continually looking at what he or she is doing to see if it can be done better, in a different, more creative way to meet the needs.

### C. COMPONENTS

The core component of the CQI Program shall be the following:

1. Leadership and Management

Leadership and management is a way of promoting a culture of self-responsibility and accountability, openness and desired to change, and commitment to the patient's and staff welfare.

This can be achieved by continuing professional training and development. With the management's commitment to professional development, the staff will feel valued, they will see management as committed to their professional growth and they will be able to participate actively in policy discussion and implementation of the CQI.

2. Quality Improvement

Quality improvement is a means of addressing quality issues that involve looking at what is currently being done with the intention of improving it. The idea is to raise the quality of health care and services no matter how good it may already be. The objective therefore is not just to meet

predefined standards but rather to exceed them and raise them to a level of excellence.

### 3. Risk Management

Risk is defined as the likelihood of the occurrence of an event that can cause damage to the patient, doctor or organization. Risk management is the systematic process of identifying, evaluating, and addressing potential and actual risks. This can be achieved by developing an actual program that can prevent, control and minimize such risks. In the implementation of this program, it is important to promote a “fair blame” and “just” environment.

### 4. System Reporting and Documentation

Records and reports are legal documents which are confidential and should contain complete and accurate set of information to facilitate care for evaluation of care provided.

### 5. Resource Management

Resource management is a way of making sure that resources are available for CQI activities. This may involve generation or re-allocation of resources based on prioritization.

In implementing these core components, the management must consider the internal and external factors needed to be addressed for smooth implementation. External: considers the facility’s needs to be addressed for smooth implementation, examining the community’s needs, health care reforms, accountability, competitiveness, market forces and regulations. Internal: considers the facility’s internal characteristics and functions. It involves leadership, management and human resources, information and improving organization performance.

The Facility CQI is about encouraging every staff to recognize, accept and practice their respective role in providing quality health care and service with the sense of responsibility and accountability. It is about continuously improving

the quality of health care and services through a series of planned activities that consist of evaluation, intervention and monitoring and promoting change. It is about teamwork and management of resources very well to provide high quality health care service. It is about promoting a culture of accountability and openness to change.

It is not promoting a rigid approach to the delivery of health care services. It is not promoting competition among staff and personnel. It is not promoting an environment of reward and punishment.

## **V. IMPLEMENTING MECHANISM**

### **A. Structure**

#### **1. Composition and Functions**

The following is recommended; however it can be modified on the availability of personnel or upon the discretion of the Municipal Health Officer.

Chairperson: Municipal Health Officer

Vice Chairperson: Nurse III

Core Members: RHU Staff

- a) Develop a general framework of their CQI Program;
- b) Recommend internal policy directions to facility management;
- c) Oversee the CQI Annual Planning Activities and QA program in the facility;
- d) Recommend implementing guidelines and strategies within the facility;
- e) Exercise overall supervisions, technical management and coordination of the program among the different section of the RHU;
- f) Oversee the implementation of QA activities such as use of clinical practice guidelines and/or treatment protocols;
- g) Resolve issues related to the implementation of the program;
- h) Provide periodic feedback to the MHO and semi-annual reports to the field implementation and coordination
- i) Implementation to the PHIC bench book on quality assurance

### **B. CQI Committee Deliverables**

1. CQI Program including facility policies and guidelines based on the recommended framework discussed previously
2. Annual Training Program on CQI and Total Quality Management (TQM) for the RHU Staff
3. Inventory Policies and SOPs

#### C. Funding

Funding for this program and activities of the CQI Committee shall be included and provided for by the respective RHU in their annual budget.

### **VI. REPORTING/COMPLIANCE**

The CQI Committee meets on a monthly basis, prepares and distributes and keeps attendance and written minutes of meetings. The Quality Management Committee completes an Annual Evaluation of the program and activities. The annual evaluation serves to analyze and evaluate the overall effectiveness and performance of the quality improvement activities. The evaluation includes a review of the QM program, the work plan, minutes of monthly committee meeting and other reports. As a result of various issues or concerns that occur during the courses of the year in the CQI Committee, there may be defined need to further study. The CQI Committee shall appoint as necessary, workgroups to review, investigate and report back to the CQI Committee meetings and included in the Annual CQI Evaluation.

### **VII. MONITORING**

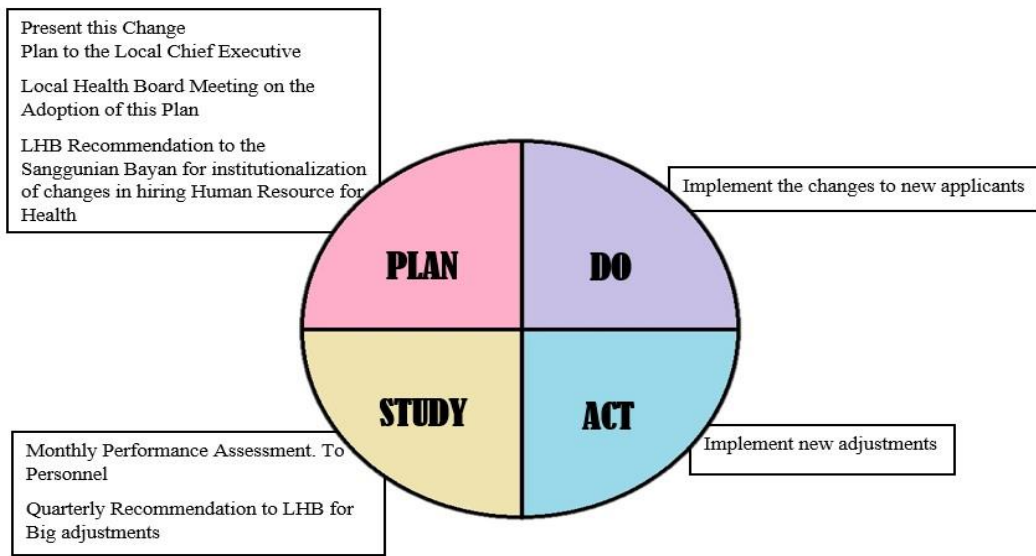
CQI Committee activities should be with other performance monitoring activities, including utilization management, risk management and resolution.

**RETOOLING PATHWAY** In the past improvements had been focused on the technical aspect of the program implementation losing focus on the needs of each personnel resulting to inefficient output over the years. This instrument called training cycle will provide a systematic approach to the development, delivery and continuous improvement of the training program. To help ensure that desired health outcomes

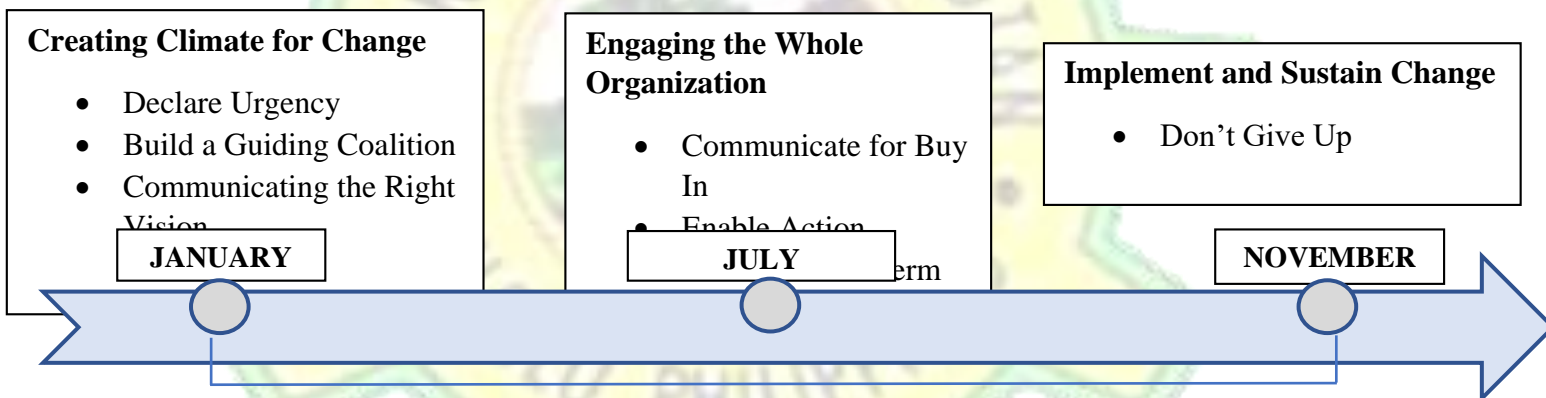


will be realized.

## SUSTAINING CHANGES



## TIMELINE



**PLAN - DO - STUDY - ACT**

## SUMMARY

1. The Rural Health Unit under the Local Government Unit is the service arm of the government.
2. There is a need for a good human resource management in order to deliver effectively government service.
3. Poor Human Resource Management results to cycles of inefficiencies in the government. Hiring the Right People is the Key.
4. Through this Change Plan clarity of roles can be addressed and ownership of the engagement.
5. Human Resource Experience is the key to motivation either in this period of VUCA or in the future new normal.



## **SAF 48 Customer Satisfaction Survey**

### **POLICY TITLE: HANDLING COMPLAINTS POLICIES AND PROCEDURES**

#### **I. Purpose:**

This policy provides a framework for staffs of Pototan Rural Health Unit Birthing and Primary Care Facility who receive and/or address complaints from external clients. Its objectives are to ensure:

- A. Complaints are handled in a structured, timely and professional manner which is fair courteous and respectful of privacy.
- B. All staffs are aware of their responsibilities regarding handling complaints.
- C. Complaints are used to identify problems and to continuously improve the Services of the facility.

Pototan Rural Health Unit Birthing and Primary Care Facility values feedback, including complaints as a means of identifying problems and enabling improvements to systems and processes to improve its service. Effective complaint handling is an essential part of the facility's' approach to providing services that are responsive to needs and meet the expectations of clients.

#### **II. Scope:**

- A. The policy applies to all divisions and authorities within the health facility. It applies to all regular, contractual, and deployed employees who may receive, manage and/or investigate complaints.
- B. The policy applies to complaints made by external clients. Other policies exist for managing concerns raised internally by the staff.
- C. Complaints dealt with under this policy do not include:
  - a. Representations which debate or challenge the substance of the department's policy, programs or regulatory powers.
  - b. complaints solely about the activities of third parties.

#### **III. Policy:**

- A. Clients have a right to know they can complain and how to go about it. The health office will publish its complaints policy and will provide straight forward means for clients to raise concerns or to make a complaint related to the department's service delivery through evaluation tool. The institution is giving evaluation forms design for department for them to address their concerns.
- B. Staff receiving complaints will aim to resolve it at earliest opportunity. It is expected the majority of complaints will be addressed and resolve by frontline

staff providing further information or explanation at the time the original dissatisfaction is raised. If the client is not satisfied with the initial response to the complainant, they will be given the option to progress the issue through the formal complaint handling process outlined in the departments complain handling procedure.

- C. Staff will treat all complaints fairly and impartially as is their obligation under the Code of Conduct.
- D. All complains will be acknowledge and complaints kept informed about.
- E. The progress of their matter particularly if delays occur.
- F. Complainants will not be subjected to any form of prejudice, lose service or be disadvantaged in any ways as a result of having complaint.
- G. Complaints will be treated within an appropriate level of confidentiality. Information about complaints will not be shared on a need - to - know basis, both within the agency and externally.
- H. Reasons will be provided for the decisions made in relation to complaints received.
- I. The departments expect the complainant to:
  - a. Clearly identify the issue of complaint, or ask for help from the departments staff to do this.
  - b. Give the department all the available information in support of the complaint in an organized format at the time of making the complaint and not provide any information that is intentionally misleading or knowingly wrong.
  - c. Cooperate with the departments inquires or investigations.
  - d. Treat the departments staff with courtesy and respect.
- J. If complainants do not meet these expectations, the department may set limits or conditions on the handling of their complaint. Any abuse harassment or threats to safety or welfare of staff will result in discontinuation of the complaint investigation and contact with the complainant will cease. Similarly, if it is found that the complainant has made a frivolous, trivial, knowingly false or vexatious compliant future contact with the complainant may cease.

#### **IV. PROCEDURES**

- . Complaints Handling

#### **V. ROLES AND RESPONSIBILTIES:**

##### **A. Staff:**

Receiving feedback from clients and resolving complaints at the first contact whenever possible

##### **B. Immediate Supervisors**

Ensuring complaints are thoroughly investigated and reported on, suitable recommendations are implemented and the complainant advised of outcomes providing support to staff members dealing with difficult clients.

### C. Municipal Health Officer

- a. Overall responsibility for the operation and management of the complaints handling process, including setting standards and monitoring the consistency and effectiveness of how the process is applied and reviewing the outcomes.
- b. Responsible for the conduct of investigations concerning complaints referred by the administrator, including ensuring all aspects of the complaints are thoroughly examined and reported upon, suitable recommendations are auctioned and response issued to the complainant.

## VI. HOW TO MANAGE CLIENTS' COMPLAINT:

The first step for any organization is to have documented customer complaint procedures. While the procedure itself can be quite simple, the benefits it will provide will be felt throughout the organization. A systematic accounting of each complaint along with response and reaction is essential to improving overall customer relations and customer retention.

**For customers**, a careful and consistent tracking of complaints and procedures shows a level of professionalism and conveys to clients that their complaints are taken seriously.

**For employees**, it provides a roadmap, a set of standard operating procedures and demonstrates management support for those on the frontlines. It also empowers to handle situation more confidently, efficiently and effectively.

**For management**, it identifies potentials weaknesses and more importantly opportunities for improvement.

## VII. COSTUMER COMPLAINTS PROCEDURE:

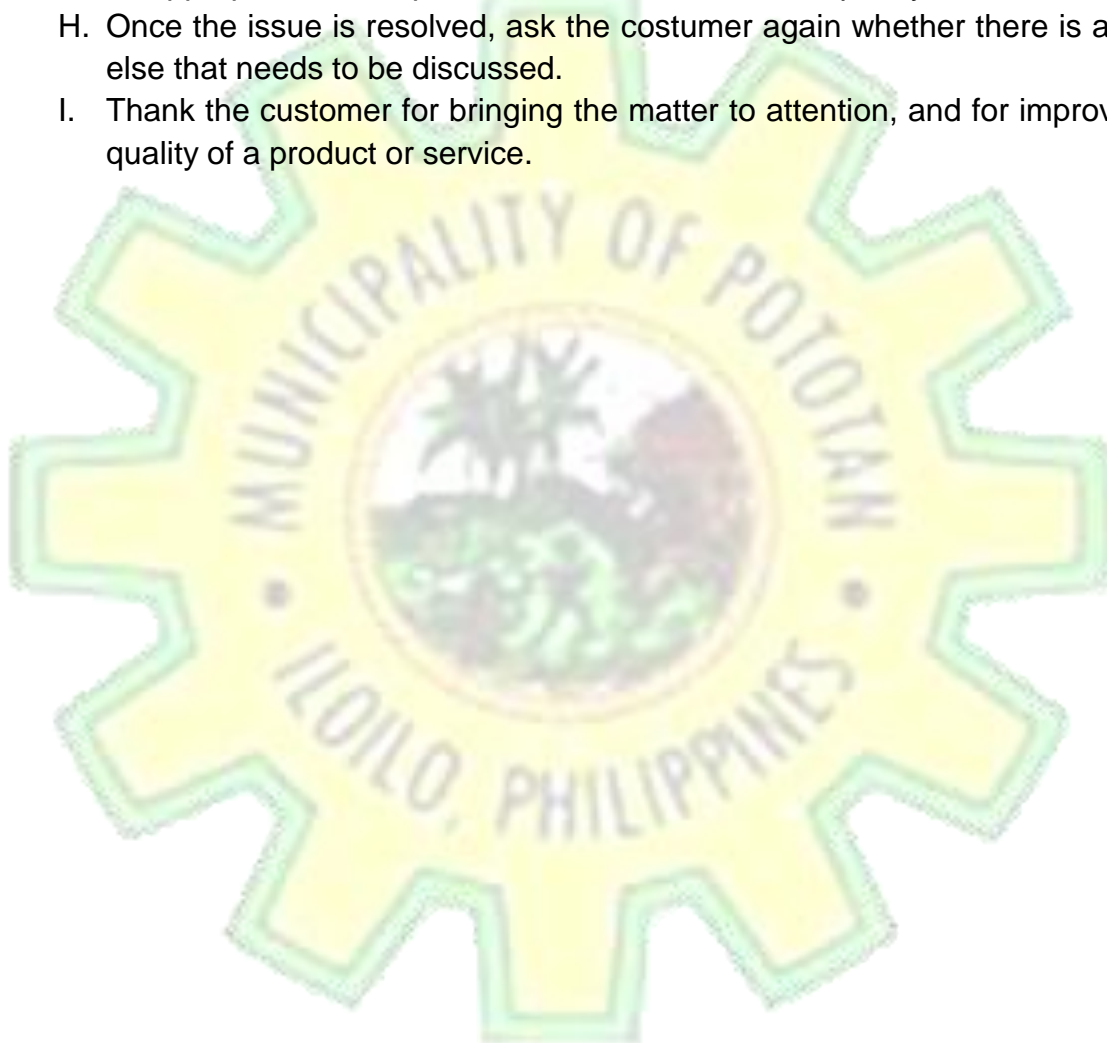
The general guidelines for any procedure dealing with customer complaints are as follows:

A. Make it easy for customers to be heard. Whether over the telephone or in person, make sure that costumers can easily voice their complaints - without having to wait. Finding it difficult to contact the right person will only add to their frustrations and dissatisfaction.

B. Listen carefully to what the customer is expressing and give them (and their complaint) your undivided attention.

- a. Don't interrupt them (if the complaint is being given in person)
- b. Don't presume you understand their complaint before they've had a chance to fully explain their problem.
- c. Don't re-interpret their complaint based on what you think their problem is.
- d. Do not simply scan written communications-read every word of the letter to understand the issues from their perspective.

- D. Once they have expressed themselves, follow up by asking if there is anything else that needs to be addressed.
- E. Agree with the customer that a problem is real and relevant. Don't dismiss or disagree, and never argue.
- F. Apologize. Extend a perfect business apology. A full apology given at the right time can restore dignity, face and reputation, provide an acknowledgement that the recipient was indeed right, and assure the recipient that they are not at fault.
- G. Resolve the issue. Ensure that staff is empowered with the tools required to resolve the matter. Define clear written guidelines for compensation/ restitution as appropriate. It's important that staffs are able to quickly act on a complaint.
- H. Once the issue is resolved, ask the customer again whether there is anything else that needs to be discussed.
- I. Thank the customer for bringing the matter to attention, and for improving the quality of a product or service.



## VIII PHYSICAL PLANT

**SAT 49**  
**ENTRANCE AND EXITS CLEARLY AND PROMINENTLY MARKED (see actual area)**

**SAT 50**  
**DIRECTIONAL SIGNS**

**SAT 51**  
**RAMPS**

## XI PUBLIC ACCESS TO PRICE INFORMATION

**SAT 52**  
**PRICE UPLOADED TO [www.pototanrhu.com](http://www.pototanrhu.com) and FB page**

**SAT 53**  
**PRICELIST OF ALL HEALTH SERVICES ARE ITEMIZED**

**SAT 54**  
**PRICE UPLOADED TO [www.pototanrhu.com](http://www.pototanrhu.com) and FB page**

**SAT 55**  
**PRICE LIST ANNUAL UPDATE**

**SAT 56**  
**SEE LOWER PART OF PATIENT CONSENT**

**SAT 57**  
**SUBMISSION OF PRICES TO DOH AND PHILHEALTH**

## **NATIONAL TB PROGRAM**

### **I.GENERAL INFECTION CONTROL**

#### **1. POLICY AND OBJECTIVE**

This regulation requires the facility to develop, implement and maintain an infections control program for the prevention, control, and investigation of infections (which includes, but is not limited to nosocomial infections) and communicable disease of patients and personnel; (which includes, but it not limited to patient care staff).

The Pototan Rural Health Unit and Birthing and Primary Care Facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections or communicable disease in the Pototan Rural Health Unit and Birthing and Primary Care Facility. There must be a mechanism to evaluate the effectiveness of the problem(s) and take corrective action when necessary. The program must include implementation of nationality recognized system of infection control guidelines to avoid source and transmission of infection and communicable disease

The active infection control program should have policies that address the following:

- a. Definition of nosocomial infections and communicable diseases:
- b. Measures for identifying, investigating, and reporting, investigating, and reporting infection and communicable diseases;
- c. Promptly identify people with TB symptoms and other infectious diseases who have who comes into Rural Health Unit
- d. Physically separate infections and potentially infection individuals from others.
- e. Enforce patients, staffs, and visitors compliance with respiratory hygiene practice.
- f. Reduce the risk of exposure to other patients and staff by minimizing the time diagnosed patients and symptomatic are within the health center.
- g. Prevents staff from acquiring and developing and support those who have contracted in compliance with national guidelines and national employee health regulations.
- h. Ensure that building design and use are appropriate for the buildings intended use and ease of operation.
- i. Ensure sufficient air exchange and control airflow direction.

## 2. APPLICABILITY

Pototan Rural Health Unit and Birthing and Primary Care Facility	Triage	Separation	Cough etiquette	Minimize time	TB screening	National ventilation	Mixed-mode ventilation	Mechanical Ventilation	Respirators
Waiting area	X	X	X	X	X	X	X		
Consultation rooms			X	X	X	X	X		
Collection area/ Smearing area		X				X			
Microscopy laboratory			X	X	X	X	X		
Counseling/ Treatment room		X	X			X	X		

## 3. PROCEDURES:

### a. TRIAGE: Admitting Nurse or midwife responsible

1. Place large notices at the entry way at eye- level, stating that one must immediately inform staff of current cough lasting for two weeks more.
2. Display notices explaining that the facility prioritizes patient with current cough that lasted for two weeks or more over others in waiting queue and makes use of designated separate waiting areas if possible.
3. Undertake screening of persons with cough as they enter the health center and before they have joined the queue or have had a seat with others.

### b. SEPARATION: Admitting nurse or midwife responsible

1. Separate Presumptive TB and diagnosed infectious TB patient in a designated partition of the general waiting area near open windows.
2. Separate diagnosed MDR – TB patients from other patients by giving them a specific time slot for visiting the health facility;.

### c. COUGH ETIQUETTE: Barangay Health Worker responsible

1. Place posters on cough etiquette at the general waiting area and DOTS consultation room, where patients cannot miss to see them (directly in front of them at eye- level and not on back wall).
2. Provide daily health education on cough etiquette(ex. Cover mouth and nose when coughing or sneezing; turn head away from others; do not spit on the floor) as part of one – on – one counseling or as part of pre- clinic lectures.

3. Remind non – adhering persons to comply with the respiratory hygiene policy of rural health unit.
4. If available, provide disposable surgical masks to all confirmed infectious TB patients and Presumptive TB, if not available, make use of personal handkerchief or paper tissues.
5. Instruct them to discard disposable surgical masks and paper tissues in a plastic bag and then in a waste bin.

**d. MINIMIZING TIME SPENT IN THE HEALTH CENTER:** Entire Team Responsible

4. Manage patient flow. Move presumptive TB to the front of the waiting area waiting area to be seen with priority.
5. Document in the patient's chart the date 1) Laboratory tests were completed; 2) the patient received results and Medications; ideally, the turn – around time for sputum examination is 3 days; ideally, the patient is started on treatment within 1 day.
6. Evaluate (delays in) 1) the minimum/ maximum and average time for diagnosis, and 2) between diagnosis and initiation of treatment; (evaluate these monthly).

**e. TB SCREENING OF STAFF:** Entire team responsible

1. Be aware of the occupation risk to acquire TB
2. Be familiar with the TB IC Policy and procedure of the facility and the Magna Carta of public health workers (Rep. Act No. 7305) and other relevant employee.
3. Health regulations including TB screening to ensure that the workplace practice conforms to these national and institutional rules and regulation. Have one copy of the RA No. 7305 available at the center appended to this policy.
4. Be alert to signs and symptoms of TB and seek care promptly in case of signs and symptoms (Presumptive TB screening ex. Sputum examination)
5. Be examined at least annually (periodic TB screening ex. Chest x – ray)

**f. NATURAL VENTILATION:** LGU and RHU responsible

1. Create a designated waiting bay for TB symptomatic/ presumptive TB and TB patients.
2. Ensure that doors and windows on opposing walls are kept open during consultation hours in all consultation rooms.
3. Place furniture in consultation rooms such that staff- patient interactions occur with air flow passing between patient and staff, rather than from patient to staff. Sketch a floor plan for each room and display the (laminated) floor plans at the inside of the doors.



4. Construct and maintain outdoor sputum collection area to improve privacy without hampering ventilation.
5. Maintain moving parts of windows to allow for adequate air exchange.

**g. Mixed – mode Ventilation – LGU and RHU Responsible**

1. Install wall fans, stand fans or industrial fans in the waiting area behind the admitting nurse/midwife.
2. If appropriate, place electric fans in consultation rooms/ counseling room behind the staff to push air from the staff in the direction of the patients.
3. Assign a dedicated person or team to check and to service ventilation equipment on a regular schedule.
4. Administrative controls regarding the operation of the fans should be in place to guarantee a flawless functioning, keep a log to record the date, what was done (ex. Checking, cleaning, replacement of parts, repair) and when the equipment should be service again. Deficiencies must be repaired and replaced as soon as possible.

**National Tuberculosis Program (NTP)** A national mandated public health program responsible for TB control providing TB diagnostic and treatment services thru its basic integrated health services referred to as DOTS (Directly Observed Treatment Short Course) facilities.

**NATIONAL TUBERCULOSIS CONTROL PROGRAM**

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**POLICY TITLE:**

CASE FINDING, CASE HOLDING, PREVENTION OF TUBERCULOSIS, RECORDING AND REPORTING, MANAGEMENT OF DRUGS AND DIAGNOSTIC SUPPLIES, REFERRAL SYSTEM AND INFECTION CONTROL

**DEPARTMENT:**

- Waiting Area
- Consultation Rooms
- TB Counseling and Treatment Room
- Sputum Collection Area
- Smearing Area
- Microscopy Laboratory

**I. ROLES AND FUNCTIONS OF HEALTH WORKERS**

Physician	<ul style="list-style-type: none"> <li>• Organize planning and evaluation of TB control activities in DOTS facilities.</li> <li>• Ensure all staff have been trained in TB DOTS</li> <li>• Supervise staff to ensure proper implementations of NTP policies and guidelines.</li> <li>• Ensure presumptive TB based on clinical and laboratory evidence.</li> <li>• Prescribe appropriate treatment.</li> <li>• Manage adverse reactions.</li> <li>• Provides continuous health education and counseling to all TB patients under treatment.</li> <li>• Refer TB patients to other health facilities as needed.</li> <li>• Encourage community and family support to TB control</li> <li>• Coordinate with local chief executives to ensure funds and personnel are available for program implementation.</li> <li>• Coordinate with other TB stakeholders to ensure that all detected TB cases are reported and services provided are within NTP policies and guidelines.</li> </ul>
Nurse	<ul style="list-style-type: none"> <li>• Manage the process of detecting TB cases in coordination with other staff.</li> <li>• Assist the physician in counseling and initiating treatment of TB patient.</li> <li>• Accomplish the NTP treatment card.</li> <li>• Agree with TB patient the mode of DOT including the treatment partner.</li> <li>• Supervise midwives to ensure proper implementation</li> <li>• Maintain and update the presumptive TB masterlist and TB register.</li> <li>• Facilitate requisition and distribution of anti-TB drugs, laboratory supplies and forms.</li> <li>• Maintain records and logistics and ensure proper storage of drugs.</li> <li>• Provide continuous health education to all patients.</li> <li>• Conduct training of all health workers and community volunteers.</li> <li>• Prepare, analyze and submit reports required by the health department.</li> </ul>
Midwife	<ul style="list-style-type: none"> <li>• Under the supervision of the nurse, do the following: <ul style="list-style-type: none"> <li>- Identify presumptive TB patients and ensure proper collection and transport of sputum specimen.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>- Refer all diagnosed TB patients to physician and nurse for clinical evaluation and initiation of treatment.</li> <li>- Maintain and update NTP treatment card.</li> <li>• Implement DOT with treatment partner. <ul style="list-style-type: none"> <li>- Provide continuous health education to patient.</li> <li>- Supervise intake of anti-TB drugs.</li> <li>- Collect sputum for follow-up examination.</li> <li>- Report and retrieve defaulters within 2 days</li> <li>- Refer patients with adverse reactions to physician for evaluation and management.</li> <li>- Supervise and mentor treatment partners.</li> </ul> </li> </ul>
Medical Technologist	<ul style="list-style-type: none"> <li>• Do DSSM for diagnosis and follow up.</li> <li>• Refer for/Perform Xpert MTB//RIF examination as needed.</li> <li>• Inform the referring health worker or facility of the result of DSSM or Expert MTB/RIF.</li> <li>• Maintain and update the NTP laboratory register.</li> <li>• Prepare quarterly report on laboratory services and submit to the nurse or physician.</li> <li>• Do internal quality control within the laboratory.</li> <li>• Prepare and submit quarterly supplies requirement to the nurse.</li> <li>• Store sputum smears sampling of the provincial TB coordinators for blind rechecking.</li> <li>• Ensure that the microscope are properly maintained and functional.</li> </ul>
Barangay Health Workers/ Community Health Volunteers	<ul style="list-style-type: none"> <li>• Identify and refer presumptive TB to DOTS facility for sputum collection</li> <li>• Collect and ensure transport of sputum specimen.</li> <li>• Assist health staff in doing DOT in TB patient.</li> <li>• Keep and update the NTP ID cards.</li> <li>• Report and retrieve defaulters within two days.</li> <li>• Attend regular consultation with the health personnel, together with the patient and treatment partners.</li> <li>• Refer patient with adverse reaction to health personnel.</li> <li>• Provide health education to patient, family members and the community.</li> </ul>

## II. DEFINITION OF TERMS

1. **Active Case finding-** A health workers purposive effort to find TB cases in the community or among those who do not consult with personnel in a DOTS facility.
2. **Children-** Any person who is less than 15 years old.

3. **DOTS Facility-** A healthcare facility, whether public or private, that's provides TB-DOTS services in accordance with policies and guidelines of the National TB Control Program
4. **Intensified Case Finding-** Active case finding among individuals belonging to special or defined population.
5. **Passive Case Finding-** When symptomatic patients are screened for disease activity upon consultation at health facility.
6. **Presumptive Drug Resistant TB (DR-TB)-** Any person whether adult or child, who belongs to any of the DR-TB groups such as retreatment cases, new TB cases that are contacts of confirmed DR-TB cases, and people living with HIV.
7. **Presumptive TB-** a person whether adult or child with signs and/or symptoms suggestive of TB whether pulmonary or extra-pulmonary, or those with CXR findings suggestive of active TB.
8. **TB Disease-** A presumptive TB who are after clinical and diagnostic evaluation is confirmed.
9. **TB exposure-** A condition in which an individual is in close contact with an active adult TB case, but without any signs and symptoms of TB, with Negative TST reaction, and no radiologic and laboratory findings suggestive of TB.

### **III. IMPLEMENTING POLICY**

#### **A. CASE FINDING**

1. All passive and intensified case finding activities shall be implemented in the facility.
2. Intensified case finding shall be done among close contacts, high risk clinical groups and high risk populations. Priority close contacts investigation shall be among household members. If feasible, screen other contacts of bacteriologically confirmed TB cases, DR-TB patients and index childhood cases.
3. Direct Sputum Smear Microscopy (DSSM), whether by light or fluorescence microscopy shall be the primary diagnostic tool in NTP case finding. All presumptive TB who could expectorate- whether pulmonary or extra-pulmonary shall undergo DSSM prior to treatment initiation.

All presumptive PTB should undergo DSSM unless this is not possible due to the following situations:

- A. Mentally incapacitated as decided by specialist or medical institution.
- B. Debilitated or bedridden.
- C. Children unable to expectorate.
- D. Patients unable to produce sputum despite sputum induction.

4. Two sputum specimens of good quality shall be collected, either as frontloading (i.e. spot-spot one hour apart) or spot-early morning specimens, based on patient's preference. The two specimens shall be collected at most within three days.
5. Available rapid diagnostic test shall be used for TB diagnosis among presumptive DR-TB, PLHIV with signs and symptoms of TB, smear negative adults with CXR findings suggestive of TB, smear negative children and EPTB.
6. If Xpert MTB/RIF is inaccessible, smear-negative patients shall be evaluated by DOTS physician who shall decide using clinical criteria and best clinical judgment. If in doubt, the case may be referred to clinician/specialist.
7. Tuberculin skin test (TST) shall not be used as sole basis for TB diagnosis. It shall be used as a screening tool for children. A 10mm induration is considered a positive TST reaction. Only trained health worker shall do testing and reading.
8. Ensure one microscopy center shall cater to, utmost, 100,000 population.
9. The facility shall participate in External Quality Assessment (EQA) system of the NTP.
10. All presumptive DR-TB shall be referred to the nearest DOTS facility with PMDT services for screening or an Xpert MTB/RIF site for testing.
11. All PLHIV shall be screened for TB co-infection.

## **B. CASE HOLDNG**

1. All diagnosed TB cases shall be provided with adequate appropriate anti-TB treatment regimen promptly.
2. Anti-TB treatment shall be done through patient centered, directly observed treatment (DOT) to foster adherence. DOT should be carried out in settings that are more accessible and acceptable to the patient. Exert all efforts to decentralize DR-TB patients as soon as possible to a treatment facility most accessible to the patient.
3. Anti-TB treatment regimen shall be based on anatomical site, bacteriologic status including drug resistance and history prior to treatment. Except in cases of adverse drug reactions and special circumstances requiring treatment modifications, TB treatment under the NTP shall conform to the standardized regimens. (*see Table No. 10, Recommended Treatment Regimen for adults and Children, MOP 5<sup>th</sup> edition p. 35*)
4. All treatment patients should be screened for MDR-TB before initiating Category II treatment regimen. Initiating Category II treatment regimen without MDR-TB screening can only be done in areas where access to PMDT services is not possible.

5. A patient's anti-TB regimen shall be comprised of at least four-line drugs. Fixed dose combination should be used- except in children unable to take tablet formulations.
6. The national and local government units shall ensure provision for drugs and supplies in the event of unforeseen supply interruptions to ensure the continuity of treatment within their areas of jurisdictions.
7. Quality of FDC must be ensured. FDC must be ordered from the source with a track record of producing FDC's according to WHO prescribed strength and standard of quality.
8. Out-patient shall be preferred mode of care. However, patients with life –threatening conditions shall be recommended for RHUization.
9. A patient diagnosed during confinement in a RHU may start treatment using NTP drug supply upon the approval of the RHU TB team. Once discharged, the patients shall be referred by the RHU TB team to a DOTS facility for registration and continuation of the assigned standard treatment regimen.
10. Treatment response of the PTB patients shall be monitored through follow-up DSSM and clinical signs and symptoms. All adverse drug reaction (ADR's), whether minor or major, shall be reported using the official reporting form of the FDA.
11. Tracking mechanisms for patients lost to follow-up shall be put in place to ensure that patients who fail to follow-up as scheduled are immediately traced.
12. Appropriate infection control measures shall be observed at all times.
13. All registered TB patients Category A and B sites, shall be offered PICT.

Category A and B sites are areas for prioritization based on the number of reported cases, HIV prevalence, Most At Risk Appropriation (MARF) size, results of the Rapid Assessment of HIV vulnerability, presence of multiple risk as categorized by the Philippine National AIDS council.

14. All confirmed drug-resistant TB cases shall be offered PICT.

### **C. SELECTION OF TREATMENT PARTNERS**

1. DOT can be done in any accessible and convenient place for the patient (DOTS facility, treatment partners house, patients place of work or patients' home) as long as treatment partners can effectively ensure the patients intake of prescribed medication or monitor his/her reaction to drugs.

Any of the following can serve as treatment partners;

- a. DOT facility staff, such as the nurse or midwife.
- b. A trained community health member such as the BHW, local government official or a former TB patient with the following criteria.

- ✓ -At least 18 years old and not too old to work
  - ✓ -Not immune-compromised.
  - ✓ -Has basic literacy skills; can read and write.
  - ✓ -Residing within the same barangay, preferably same purok or street,
  - ✓ -Available to supervise treatment every day, including weekend.
  - ✓ -Can observed confidentiality of patient's record.
  - ✓ -Committed to support the patient for the entire duration of treatment.
- c. Trained family members maybe assigned to administer oral medications during weekends and holidays, or as a sole treatment partners in special cases such as;
- ✓ Poor access to a DOTS facility due to geographical barriers including temporarily displaced populations.
  - ✓ Debilitated, or bedridden patients.
  - ✓ DOTS schedule is conflict with patients work/school schedule and unable to access other DOTS facilities.
  - ✓ Cultural beliefs that limit the choice of the treatment partner (e.g. Indigenous people)
  - ✓ Treatment of children
  - ✓ Post disaster scenarios
- d. In such cases where family member is the treatment partner, drug supply is to be distributed on a weekl basis or as agreed by the health worker and family member
- e. Intramuscular injections are to be administered only by trained or authorized health personnel. Patients with no access to such services during weekends/holidays may forego intramuscular injections provided they still recommended number of dose.

#### **D. PREVENTION OF TB**

1. The facility will implement TB IC interventions following in the order of hierarchy; administrative, environmental and respiratory controls.
2. Managerial activities shall ensure that the above intervention are implemented.
3. Use of respirators shall be limited to identify high-risk areas.
4. DOTS facility staff shall ensure that TB patients are informed about TB IC measures for their households, workplace and community.
5. All infants shall be given a single dose of BCG except those who are known to be HIV positive, those whose HIV status is unknown but who are born to HIV-positive mothers and whose symptoms are suggestive of HV.

6. In the absence of PPD, symptomatic screening could be alone to screen household contacts and identify children who will benefit from Isoniazid Preventive Therapy. The unavailability of PPD shall not defer the provision of IPT to 0-4-year-old children who are household contacts of bacteriologically-confirmed index cases.
7. IPT should not be given to child contacts of drug-resistant TB.

#### **E. RECORDING AND REPORTING**

1. Recording and reporting for NTP shall be implemented in the facility. All NTP records should be kept for at least seven years before properly being discarded.
2. Recording and reporting shall include all cases of TTB, classified according to internationally accepted case definitions.
3. Confidentiality of patient records shall be observed at all times.
4. Recording and reporting of NTP shall use the FHSIS network for routine reporting and feedback.
5. The Integrated TB Information System (I-TIS) shall be the official electronic TB information system.
6. All quarterly reports should be sent to the DOH through channels.
7. Records and reports shall allow for the calculation of main indicators for program evaluation.

#### **F. ENSURING PRIVACY AND CONFIDENTIALITY**

1. All data regarding TB patients shall be placed in filing cabinets, preferably with locks to ensure inaccessibility from non-DOTS facility persons.
2. All TB medicine boxes and containers of all patients shall be coded/ numbered carefully in order to ensure confidentiality of identity of TB patients.
3. No data or information shall be given to the public or to anyone without the consent of the patient concerned, except for program monitoring and evaluation, and for legal purposes.
4. Patient information/ data can be given to a second party only with a written authorization of patient concerned.
5. Any personnel of the Rural Health Unit who will be caught and proven to divulge any information regarding patient's identity shall be acted upon accordingly.

#### **G. MANAGEMENT OF ANTI-TB DRUGS AND DIAGNOSTICS SUPPLIES**

1. The over-all management of all TB drugs supplies and diagnostic supplies, and the development and dissemination of corresponding policies and guidelines shall be the responsibility of the NTP with the support of the RO and LGU.



2. The local government shall ensure that NTO policies and guidelines for NTP supplies management are implemented properly at their level. They shall also actively participate in monitoring and evaluation of the policies and guidelines.
3. NTP shall ensure that drugs selected for the use of the program is in accordance to the international guidelines, are indicated in the national standards guidelines, registered within the Philippines FDA and included in the national formulary. Standardized fixed dose combination (FDC) of anti TB drugs shall be used under the NTP whenever appropriate. The NTP with the support of NTRL and FFDA, shall ensure the quality of anti-TB drugs and laboratory supplies used in the program.
4. Quantification and ordering shall be based on utilization rate, projected increase of cases due to strengthen case finding and provision of buffer stocks.  
Buffer stocks equivalent to 50% annual requirement should be maintained.
5. Procurement of TB drugs and diagnostics supplies at the national and local government level shall follow the “Government Procurement Reform Act” or RA 9184 and the DOH policies, guidelines, and standards for the procurement of TB drugs and laboratory supplies.
6. Medicines and supplies shall be stored under appropriate conditions and accounted for through proper recording and reporting. Stock status should be reflected at monthly supply and inventory system.
7. The use of medicines shall be guided by the presence of appropriate indications for treatment based on the NTP standards for diagnosis of TB, and the absence of contraindications to their use.
8. Disposal of expired and damaged drugs and diagnostic supplies shall follow the government rules and regulations.
9. The local government unit shall be responsible for reproduction of all official NTP form to ensure availability and adequacy in the RHU.
10. LGU’s shall set aside funds for the emergency procurement of sufficient quantities of TB drugs and diagnostic supplies in times of impending shortage to ensure continuous availability of NTP commodities at their service delivery points.

#### **H. REFERRAL SYSTEM**

1. Patients shall have the right to know the reason/s for referral and participate in the choice of facilities where she/he will be referred.
2. Health care providers have the responsibility of ensuring prompt and appropriate response to patient’s health needs by immediate referral for services that can be provided by other health facilities/providers.
3. A two-way functional referral must be observed by ensuring that a receiving facility to exert all efforts of ensuring that a referred patient is not lost during the referral process.
4. The facilities must use the standard NTP referral form.

5. Patients who were not referred in accordance to NTP policies and procedures shall be accommodated and evaluated accordingly.

## I. TUBERCULOSIS INFECTION CONTROL

### A. GENERAL POLICY AND OBJECTIVE

1. Promptly identify people with TB symptoms who have who come into \_\_\_\_\_ Rural Health Unit.
2. Physically separate infections and potentially infection individuals from others.
3. Enforce patients, staffs, and visitor's compliance with respiratory hygiene practice.
4. Reduce the risk of TB exposure to other patients and staff by minimizing the time diagnosed TB patients and TB Symptomatic are within the health center.
5. Prevents staff from acquiring and developing TB and support those who have contracted TB in compliance with national guidelines and national employee health regulations.
6. Ensure that building design and use are appropriate for the buildings intended use and ease of operation.
7. Ensure sufficient air exchange and control airflow direction.

### B. APPLICABILITY

Pototan Rural Health Unit	Triage	Separation	Cough etiquette	Minimize time	TB screening	National ventilation	Mixed-mode ventilation	Mechanical Ventilation	Respirators
Waiting area	X	X	X	X	X	X	X		
Consultation rooms			X	X	X	X	X		
Collection area/ Smearing area		X				X			
Microscopy laboratory			X	X	X	X	X		
Counseling/ Treatment room		X	X			X	X		

## C. PROCEDURES:

### Administrative Controls

1. **TRIAGE:** Admitting Nurse or midwife responsible
  - h. Place large notices at the entry way at eye- level, stating that one must immediately inform staff of current cough lasting for two weeks more.
  - i. Display notices explaining that the facility prioritizes patient with current cough that lasted for two weeks or more over others in waiting queue and makes use of designated separate waiting areas if possible.
  - c. Undertake screening of persons with cough as they enter the health center and before they have joined the queue or have had a seat with others. Any patient with 1) current cough that lasted for 2 weeks or more, 2) fever, 3) weight loss, 4) night sweats.
  - d. Direct presumptive TB to the outdoor sputum collection area to provide a sputum sample. Use a sputum cup with a screw cap. Explain how to provide a sputum sample. Instruct them where to bring the sputum sample, a place outside the laboratory. When they return direct them immediately in front of the waiting queue to be seen with priority or to designate waiting area away from the regular patients where they can wait until they can be seen.
    - e. List presumptive TB in the TB Presumptive Masterlist.
  - f. Documents, evaluate and report the number of confirmed sputum smear positive against the total number of TB Symptomatic at the end of every month/ quarter.
2. **SEPARATION:** Admitting nurse or midwife responsible
  3. Separate Presumptive TB and diagnosed infectious TB patient in a designated partition of the general waiting area near open windows.
  4. Separate diagnosed MDR - TB patients from other patients by giving them a specific time slot for visiting the health facility; every tuesday.
3. **COUGH ETIQUETTE:** Barangay Health Worker responsible
  6. Place posters on cough etiquette at the general waiting area and DOTS consultation room, where patients cannot miss to see them (directly in front of them at eye- level and not on back wall).
  7. Provide daily health education on cough etiquette (ex. Cover mouth and nose when coughing or sneezing; turn head away from others; do not spit on the floor) as part of one - on - one counseling or as part of pre- clinic lectures.
  8. Remind non - adhering persons to comply with the respiratory hygiene policy of rural health unit.

9. If available, provide disposable surgical masks to all confirmed infectious TB patients and Presumptive TB, if not available, make use of personal handkerchief or paper tissues.
10. Instruct them to discard disposable surgical masks and paper tissues in a plastic bag and then in a waste bin.

**4. MINIMIZING TIME SPENT IN THE HEALTH CENTER:** Entire Team Responsible

7. Manage patient flow. Move presumptive TB to the front of the waiting area waiting area to be seen with priority.
8. Document in the patient's chart the date 1) Laboratory tests were completed; 2) the patient received results and Medications; ideally, the turn - around time for sputum examination is 3 days; ideally, the patient is started on treatment within 1 day.
9. Evaluate (delays in) 1) the minimum/ maximum and average time for diagnosis, and 2) between diagnosis and initiation of treatment; (evaluate these monthly).

**5. TB SCREENING OF STAFF:** Entire team responsible

- a. Be aware of the occupation risk to acquire TB
- b. Be familiar with the TB IC Policy and procedure of the facility and the Magna Carta of public health workers (Rep. Act No. 7305) and other relevant employee.
- c. Health regulations including TB screening to ensure that the workplace practice conforms to these national and institutional rules and regulation. Have one copy of the RA No. 7305 available at the center appended to this policy.
- d. Be alert to signs and symptoms of TB and seek care promptly in case of signs and symptoms (Presumptive TB screening ex. sputum examination)
- e. Be examined at least annually (periodic TB screening ex. Chest x - ray)

**6. NATURAL VENTILATION:** LGU and RHU responsible

- a. Create a designated waiting bay for TB symptomatic/ presumptive TB and TB patients.
- b. Ensure that doors and windows on opposing walls are kept open during consultation hours in all consultation rooms.
- c. Place furniture in consultation rooms such that staff- patient interactions occur with air flow passing between patient and staff, rather than from patient to staff. Sketch a floor plan for each room and display the (laminated) floor plans at the inside of the doors.
- d. Construct and maintain outdoor sputum collection area to improve privacy without hampering ventilation.
- e. Maintain moving parts of windows to allow for adequate air exchange.

**7. Mixed - mode Ventilation - LGU and RHU Responsible**

5. Install wall fans, stand fans or industrial fans in the waiting area behind the admitting nurse/midwife.
6. If appropriate, place electric fans in consultation rooms/ counseling room behind the staff to push air from the staff in the direction of the patients.
7. Assign a dedicated person or team to check and to service ventilation equipment on a regular schedule.
8. Administrative controls regarding the operation of the fans should be in place to guarantee a flawless functioning, keep a log to record the date, what was done (ex. Checking, cleaning, replacement of parts, repair) and when the equipment should be service again. Deficiencies must be repaired and replaced as soon as possible.

#### **D. RESPONSIBILITY**

- Municipal Health Officer/ Municipal Coordinator.

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***Revision of this policy will be considered whenever there is urgent reasons for new development and new guidelines***

### **DOTS Program**

#### **I. VISION AND MISSION**

**Vision:**

To make Pototan a municipality where tuberculosis is no longer a public health problem

**Mission:**

To ensure TB-DOTS services available, accessible and affordable in the community

#### **II. SERVICES AVAILABLE**

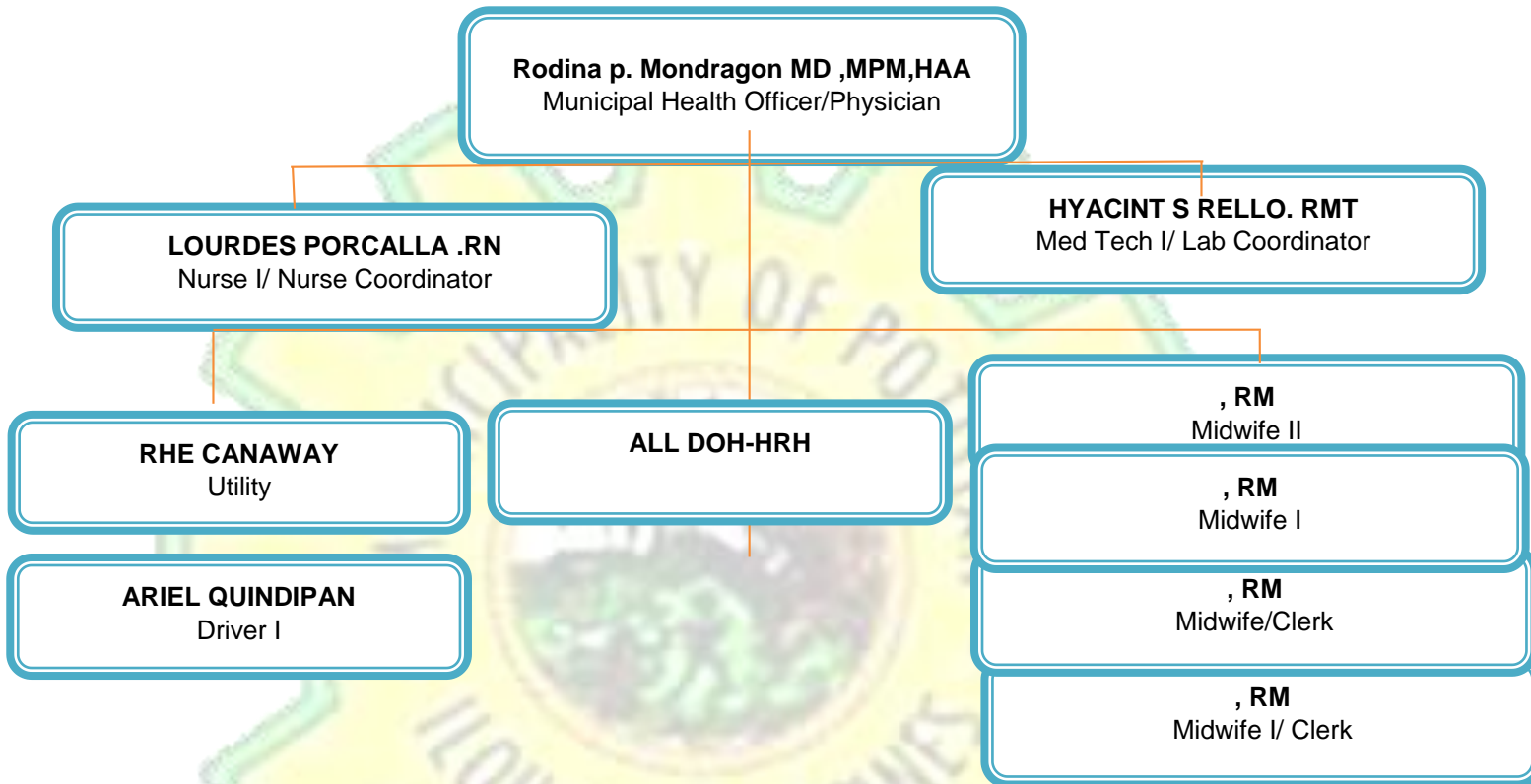
1. Screening and Consultation
2. Tuberculin Skin Testing
3. Sputum Microscopy
4. Medicine Provision
5. Counseling and Health Education
6. Referral

### III. SCHEDULE OF SERVICES

Screening: Mondays to Friday, 8:00am to 4:00pm

Follow-up: Every Monday; 8:00am to 4:00pm

### IV. ORGANIZATIONAL CHART



## V. ROLES AND RESPONSIBILITIES

Physician	<ul style="list-style-type: none"> <li>• Organize planning and evaluation of TB control activities in DOTS facilities.</li> <li>• Ensure all staff have been trained in TB DOTS</li> <li>• Supervise staff to ensure proper implementations of NTP policies and guidelines.</li> <li>• Ensure presumptive TB based on clinical and laboratory evidence.</li> <li>• Prescribe appropriate treatment.</li> <li>• Manage adverse reactions.</li> <li>• Provides continuous health education and counseling to all TB patients under treatment.</li> <li>• Refer TB patients to other health facilities as needed.</li> <li>• Encourage community and family support to TB control</li> <li>• Coordinate with local chief executives to ensure funds and personnel are available for program implementation.</li> <li>• Coordinate with other TB stakeholders to ensure that all detected TB cases are reported and services provided are within NTP policies and guidelines.</li> </ul>
Nurse	<ul style="list-style-type: none"> <li>• Manage the process of detecting TB cases in coordination with other staff.</li> <li>• Assist the physician in counseling and initiating treatment of TB patient.</li> <li>• Accomplish the NTP treatment card.</li> <li>• Agree with TB patient the mode of DOT including the treatment partner.</li> <li>• Supervise midwives to ensure proper implementation</li> <li>• Maintain and update the presumptive TB masterlist and TB register.</li> <li>• Facilitate requisition and distribution of anti-TB drugs, laboratory supplies and forms.</li> <li>• Maintain records and logistics and ensure proper storage of drugs.</li> <li>• Provide continuous health education to all patients.</li> <li>• Conduct training of all health workers and community volunteers.</li> <li>• Prepare, analyze and submit reports required by the health department.</li> </ul>
Midwife	<ul style="list-style-type: none"> <li>• Under the supervision of the nurse, do the following:</li> </ul>

	<ul style="list-style-type: none"> <li>- Identify presumptive TB patients and ensure proper collection and transport of sputum specimen.</li> <li>- Refer all diagnosed TB patients to physician and nurse for clinical evaluation and initiation of treatment.</li> <li>- Maintain and update NTP treatment card.</li> <li>• Implement DOT with treatment partner. <ul style="list-style-type: none"> <li>- Provide continuous health education to patient.</li> <li>- Supervise intake of anti-TB drugs.</li> <li>- Collect sputum for follow-up examination.</li> <li>- Report and retrieve defaulters within 2 days</li> <li>- Refer patients with adverse reactions to physician for evaluation and management.</li> <li>- Supervise and mentor treatment partners.</li> </ul> </li> </ul>
<p>Medical Technologist</p>	<ul style="list-style-type: none"> <li>• Do DSSM for diagnosis and follow up.</li> <li>• Refer for/Perform Xpert MTB//RIF examination as needed.</li> <li>• Inform the referring health worker or facility of the result of DSSM or Expert MTB/RIF.</li> <li>• Maintain and update the NTP laboratory register.</li> <li>• Prepare quarterly report on laboratory services and submit to the nurse or physician.</li> <li>• Do internal quality control within the laboratory.</li> <li>• Prepare and submit quarterly supplies requirement to the nurse.</li> <li>• Store sputum smears sampling of the provincial TB coordinators for blind rechecking.</li> <li>• Ensure that the microscope are properly maintained and functional.</li> </ul>
<p>Barangay Health Workers/ Community Health Volunteers</p>	<ul style="list-style-type: none"> <li>• Identify and refer presumptive TB to DOTS facility for sputum collection</li> <li>• Collect and ensure transport of sputum specimen.</li> <li>• Assist health staff in doing DOT in TB patient.</li> <li>• Keep and update the NTP ID cards.</li> <li>• Report and retrieve defaulters within two days.</li> <li>• Attend regular consultation with the health personnel, together with the patient and treatment partners.</li> <li>• Refer patient with adverse reaction to health personnel.</li> <li>• Provide health education to patient, family members and the community.</li> </ul>



## **VI. DEPARTMENT:**

- Waiting Area
- Consultation Rooms
- TB Counseling and Treatment Room
- Sputum Collection Area
- Smearing Area
- Microscopy Laboratory

## **VII. IMPLEMENTING POLICIES AND PROCEDURES**

### **A. CASE FINDING**

12. All passive, enhanced and intensified case finding activities shall be implemented to aid in higher case detection in the municipality. Systematic screening in the facilities shall be done in all clients visiting the facility regardless of reason of consult.
13. Algorithm in screening shall be based on the manual of procedures to be implemented accordingly.
14. All patients with chest Xray findings suggestive of TB should be identifies a presumptive TB.
15. Xpert-MTB/RIF shall be the primary diagnostic test for PTB and EPTB in adults and children.
16. Smear microscopy shall be alternative diagnostic test if Xpert is not accessible. Unavailability of Xpert-MTB/RIF test shall not be a deterrent to diagnose TB disease bacteriologically.
17. Tuberculin Skin Test or Mantoux Test, shall only be used as an adjuvant when in doubt in making clinical diagnosis in TB in children.
18. Physical assessment and prescription of appropriate regimen for TB patient shall be conducted by the physician.
19. TB Nurse Coordinator shall be responsible in recording on recommended forms and report to authorized next level.
20. The TB Nurse Coordinator will provide health education, and Rural Health Midwife or Nurse Deployment Project shall give weekly health education in the community with emphasis on the following.
  - a. TB is infectious
  - b. TB can be cured but requires regular drug intake.
  - c. Consequences of irregular intake.
  - d. Side effects of anti-TB drugs.
  - e. Importance of follow-up sputum smear examination.
  - f. Importance of family/treatment partner support.
21. Nurse will initiate the intake of first TB drugs at the RHU. Record the date when treatment started and other information required in treatment card and registry.

22. In the absence of TB Nurse, Nurse Assistant Coordinator (NDP) or senior midwife shall perform the job with proper communication such as endorsement from and to the Nurse Coordinator and Physician.
23. Midwife and Nurse of the corresponding barangay shall be automatically assigned as one of treatment supervisors in the whole duration of treatment.
24. Treatment card shall be maintained in the TB-DOTS center while NTP ID card shall be provided to patient/treatment partner to be monitored periodically.
25. TB Laboratory registry shall be maintained by Medical Technologist and shall conduct follow up sputum examinations.

## **J. QUALITY ASSURANCE OF SPUTUM MICROSCOPY AND USE OF LABORATORY**

### **1. Barrier and Safety Precaution**

- a. Perform procedures that create potential aerosol and splashes or those that involve specimens with high concentration or large volume of infectious agent.
- b. Use appropriate protective equipment or clothing; gloves, coats, face shields and safety glasses.

### **2. Safety Precaution**

- a. Ensure clinical specimens are placed in airtight containers to prevent leakage during collection, handling, processing, storage and transport.
- b. Laboratory coats or gowns as well as gloves should not be worn outside laboratory area.
- c. Contaminated or used gloves should be disposed of and never washed or re-used.
- d. Handle sharps with care.
- e. Wash hands and other body parts if contaminated, immediately and thoroughly after handling infectious materials and before leaving laboratory

### **3. Education of Laboratory Workers**

- a. Limit access to the laboratory to authorized personnel only and restrict entry when work with infectious agents.
- b. Practice cleanliness and hygiene in the laboratory.
- c. Personal activities such as eating, drinking and applying cosmetics shall not be done at the laboratory.
- d. Any accidental exposure to infectious materials should be reported to the Municipal Health Officer.

### **4. Microscope Maintenance**

- a. Never attempt to disassemble any part of the microscope for repair.

- b. Treat the microscope with care. Never expose it to sharp knocks, vibrations, moisture, dust and direct sunlight.
- c. Immersion oil should be wiped off by rubbing the surface of the immersion lens with washed soft gauze or lens paper which slightly moistened with ethyl alcohol.
- d. If possible, store microscope in cabinet box with air inlets and outlets for circulation.
- e. Ideally, dry silica gel about 250 grams is placed in shallow plate and positioned at the bottom of the microscope box.

#### **5. Chemical Safety**

- a. Laboratory gowns, gloves and safety glasses are amust when handling strong acids.
- b. Always add acid to water. This avoids splashes of acid that can cause burns to the skin and eyes.
- c. Do not use alcohol near an open flame as they are flammable.

#### **6. Proper Laboratory Arrangement**

- a. Smear preparation and staining: This should be done in a well-lit area, preferably near an open window to ensure adequate ventilation during smear preparation.
- b. Actual Microscopy: This area should have stable table for microscope. Subdued lighting is ideal. If daylight must be used as light source, the microscope must be placed in front of a window.
- c. Record Keeping and storage: This third area will be used for entering data/results into the logbook and for storing slides.

#### **7. Storage of Reagent:** Well-prepared reagents can be kept at least 6 months to one year. Store all reagents in clean and tightly closed bottles with a label showing the name of the reagent and date of preparation. Keep bottles out of direct sunlight.

#### **8. Quality Control of stored staining agents.**

- a. When preparing staining reagents, always perform quality control for each batch of staining reagents prepared.
- b. Keep accurate records in logbook for quality control.
- c. Sometimes, staining reagents may spoil with aging. It is for this reason that stored stains are checked weekly or monthly.
- d. Include positive control smear and record result in logbook.
- e. If result is unsatisfactory, stain another control smear, making sure that the procedure is correct. If this gives a good result, you can use this particular batch. If does not, used new batch of staining reagent.

#### **9. Procedure for sputum collection and smearing**

- a. Al sputum collection shall adhere with the manual of procedures.

- b. All presumptive TB patient shall be instructed by Nurse, midwife or BHW on proper sputum collection.
- c. Specimen shall be collected in specified sputum cups that are properly labeled and sealed in plastic clear container.
- d. The specimen collected shall be immediately smeared, fixed, stained and read within the day of collection. Results shall be informed within 48 hours.
- e. Only trained medical technologist shall be allowed to perform direct sputum smear microscopy.
- f. Label the slides with Laboratory Code Number, Laboratory Registry Number and number of specimen from which smear is taken.
- g. Ensure proper procedure for sputum smearing by selecting the solid yellowish particle, avoid mixing the sputum with the saliva in the container-this may dilute the amount of AFB which can be fished out.
- h. All slides shall be subjected to validation by External Quality Assurance of the Provincial Health Office.

#### **10. AFB Recognition**

- a. The scale recommended by the World Health Organization and International Union Against Tuberculosis and Lung Disease in quantifying AFB's in the stained shall be used.
- b. After use, clean the objectives lens with lens paper moistened with ethyl ether alcohol, then cover with appropriate material, and store in dry and dust-free place.
- c. If xylene is not available, remove the oil on the surface of the slide with a careful sweep using soft tissue paper.
- d. After cleaning the slide, place them in the slide box for confirmation of quality check.

#### **K. CASE HOLDNG**

- 15. All diagnosed TB cases shall be provided with adequate appropriate anti-TB treatment regimen promptly.
- 16. All procedures shall adhere with the Department of Health National Tuberculosis Control Program, Manual of Procedures, 6<sup>th</sup> edition.
- 17. Anti-TB treatment shall be done through patient centered, directly observed treatment (DOT) to foster adherence. DOT should be carried out in settings that are more accessible and acceptable to the patient. Exert all efforts to decentralize DR-TB patients as soon as possible to a treatment facility most accessible to the patient.

18. Anti-TB treatment regimen shall be based on anatomical site, bacteriologic status including drug resistance and history prior to treatment. Except in cases of adverse drug reactions and special circumstances requiring treatment modifications, TB treatment under the NTP shall conform to the standardized regimens
19. Standard Treatment for DS-TB shall be given based on results of Xpert-MTB/RIF. If Xpert is not done, history of treatment will be used as basis for the regimen.
20. Treatment adherence shall be ensured by providing support from family members, monitored weekly by NDP and Midwife of the area and monthly by the TB Nurse Coordinator and physician monthly.
21. All adverse drug reactions shall be investigated and reported accordingly.
22. All patient 15 years old and above shall be offered PICT (if training is done).
23. All TB patients aged 25 years old and above shall be screened for diabetes.
24. Treatment of MDR-TB and RR-TB treatment shall be started as early as possible.
25. Management of drug-resistant case shall be done in strict collaboration of the DOTS and other professionals in accordance with the current clinical practice guidelines and manual of procedures.

#### **L. DETECTING AND MANAGEMENT OF TREATMENT FAILURES AND LOST TO FOLLOW UP**

1. Tracking mechanisms for patients lost to follow-up shall be put in place to ensure that patients who fail to follow-up as scheduled are immediately traced.
2. Medicines can be provided in every two weeks or monthly interval with the patient with direct supervision of his/her treatment partners.
3. The Nurse TB coordinator should have regular communication with patient.
4. Any interruptions in treatment should be discussed with patient and treatment supporter, and interventions to address problems should be instituted.
5. All patients shall be monitored for compliance. In absence of patients schedule to get medicines, the Nurse Coordinator shall call immediately the patient. In case of absence of mobile number, the Nurse Coordinator shall communicate with the treatment partners.
6. Other methods to be implemented is the utilization of Midwives or Nurse Deployment Projects to follow up patient within the day of no medicines to be taken.
7. In case of refusal to continue the medication regiment, it shall be discussed with the Municipal Health Officer.

8. For patients who interrupt treatment for less than one month, continue the treatment and just prolong it to compensate for the missed dose/s.
9. If interruption is more than 1 month but less than two months, perform sputum microscopy and decide on continuation of treatment based on results, seen at DOH NTP-MOP 6<sup>th</sup> edition.
10. If interruption is at least two months, declare lost to follow up. Exert all efforts to trace patient, perform Xpert/MTB-Rif and refer DR-TB treatment center if needed.

## **M. SELECTION OF TREATMENT PARTNERS**

2. DOT can be done in any accessible and convenient place for the patient (DOTS facility, treatment partners house, patients place of work or patients home) as long as treatment partners can effectively ensure the patients intake of prescribed medication or monitor his/her reaction to drugs.

Any of the following can serve as treatment partners;

- a. DOT facility staff, such as the nurse or midwife.
- b. A trained community health member such as the BHW, local government official or a former TB patient with the following criteria.
  - ✓ -At least 18 years old and not too old to work
  - ✓ -Not immune-compromised.
  - ✓ -Has basic literacy skills; can read and write.
  - ✓ -Residing within the same barangay, preferably same purok or street,
  - ✓ -Available to supervise treatment every day, including weekend.
  - ✓ -Can observed confidentiality of patient's record.
  - ✓ -Committed to support the patient for the entire duration of treatment.
- c. Trained family members maybe assigned to administer oral medications during weekends and holidays, or as a sole treatment partners in special cases such as;
  - ✓ Poor access to a DOTS facility due to geographical barriers including temporarily displaced populations.
  - ✓ Debilitated, or bedridden patients.
  - ✓ DOTS schedule is conflict with patients work/school schedule and unable to access other DOTS facilities.
  - ✓ Cultural beliefs that limit the choice of the treatment partner (e.g. Indigenous people)
  - ✓ Treatment of children
  - ✓ Post disaster scenarios

- d. In such cases where family member is the treatment partner, drug supply is to be distributed on a weekly basis or as agreed by the health worker and family member
- e. Intramuscular injections are to be administered only by trained or authorized health personnel. Patients with no access to such services during weekends/holidays may forego intramuscular injections provided they still recommended number of dose.

## **N. PREVENTION OF TB**

8. The facility will implement TB-IC interventions following in the order of hierarchy; administrative, environmental and respiratory controls.
9. Managerial activities shall ensure that the above intervention are implemented.
10. Use of respirators shall be limited to identify high-risk areas.
11. DOTS facility staff shall ensure that TB patients are informed about TB IC measures for their households, workplace and community.
12. All infants shall be given a single dose of BCG except those who are known to be HIV positive, those whose HIV status is unknown but who are born to HIV-positive mothers and whose symptoms are suggestive of HIV.
13. In the absence of PPD, symptomatic screening could be alone to screen household contacts and identify children who will benefit from Isoniazid Preventive Therapy. The unavailability of PPD shall not deter the provision of IPT to 0-4-year-old children who are household contacts of bacteriologically-confirmed index cases.
14. IPT should not be given to child contacts of drug-resistant TB.

## **O. RECORDING AND REPORTING**

8. Recording and reporting for NTP shall be implemented in the facility. All NTP records should be kept for at least seven years before properly being discarded.
9. Recording and reporting shall include all cases of TB, classified according to internationally accepted case definitions.
10. Confidentiality of patient records shall be observed at all times.
11. Recording and reporting of NTP shall use the FHSIS network for routine reporting and feedback.
12. The Integrated TB Information System (I-TIS) shall be the official electronic TB information system.
13. All quarterly reports should be sent to the DOH through channels.
14. Records and reports shall allow for the calculation of main indicators for program evaluation.

## **P. ENSURING PRIVACY AND CONFIDENTIALITY**

6. All data regarding TB patients shall be placed in filing cabinets, preferably with locks to ensure inaccessibility from non-DOTS facility persons.
7. All TB medicine boxes and containers of all patients shall be coded/ numbered carefully in order to ensure confidentiality of identity of TB patients.
8. No data or information shall be given to the public or to anyone without the consent of the patient concerned, except for program monitoring and evaluation, and for legal purposes.
9. Patient information/ data can be given to a second party only with a written authorization of patient concerned.
10. Any personnel of the Rural Health Unit who will be caught and proven to divulge any information regarding patient's identity shall be acted upon accordingly.

## **Q. MANAGEMENT OF ANTI-TB DRUGS AND ASSURING CONTINUOUS SUPPLY OF TB DRUGS**

11. The over-all management of all TB drugs supplies and diagnostic supplies, and the development and dissemination of corresponding policies and guidelines shall be the responsibility of the NTP with the support of the RO and LGU.
12. The local government shall ensure that policies and guidelines for NTP supplies management are implemented properly at their level.
13. NTP shall ensure that drugs selected for the use of the program is in accordance to the international guidelines, are indicated in the national standards guidelines, registered within the Philippines FDA and included in the national formulary. Standardized fixed dose combination (FDC) of anti TB drugs shall be used under the NTP whenever appropriate. The NTP with the support of NTRL and FFDA, shall ensure the quality of anti-TB drugs and laboratory supplies used in the program.
14. Quantification and ordering shall be based on utilization rate, projected increase of cases due to strengthen case finding and provision of buffer stocks.
15. The local government unit shall be responsible for reproduction of all official NTP form to ensure availability and adequacy in the RHU.
16. LGU's shall set aside funds for the emergency procurement of sufficient quantities of TB drugs and diagnostic supplies in times of impending shortage to ensure continuous availability of NTP commodities at their service delivery points.
17. To ensure continuous supply of medicine, the NTP Nurse Coordinator shall compute the medicines needed by the client in the whole duration of treatment prior to start of both intensive and continuation phase.



18. Procurement of medicines, medical supply, equipment and other logistics shall be included in the annual investment plan and procurement plan.

## **R. ASSURANCE OF QUALITY AND SAFETY OF TB DRUGS**

### **1. Medicine and Logistic Good Storage Practice**

- After initially checking the medicines delivered, transfer the goods to their respective areas
- Store the goods in an organized and orderly manner with the label bearing the name of the product in front.
- First-Expire-First-Out will be the basis of disposing drugs.
- Avoid direct contact to the sun or on the walls to avoid moisture accumulation.
- Store expired and recalled goods in the storage room, marking it with “Expired” and “Recalled”, respectively to prevent use.
- Store medicines at stipulated temperature areas, protected from excessive light, dust and humidity. The temperature should be checked daily and recorded in the monitoring sheet if necessary for cold chain drugs.
- Store the other stock in a separated area. Maintain all sales invoice records for return or exchange of products to the supplier.
- Verify the contents of the delivery products for any counterfeit, damage or defect.
- Record the data in an appropriate logbook and computer entry for received medicines and supplies.
- File the invoice receipt or delivery receipt in a folder.
- Store the goods in an organized and orderly manner in their appropriate shelves with the correct label bearing the name of the product in front.
- Have a systematic way of arranging the products in the display cabinet or shelves to avoid confusion or mix ups.
- Specific if medicines are arranged by therapeutic category.
- Avoid direct exposure to sunlight
- Avoid direct contact on the walls to prevent moisture and heat accumulation
- Provide pallets for proper storage of bulk medicines
- Provide proper ventilation in the storage room
- Check if there are inappropriate items inside the refrigerator like food and beverages
- Contingency plan should be provided during emergencies for Cold Chain management.

### **3. FOR PARENTERALS, VACCINES AND OTHER BIOLOGICAL PRODUCTS**

- Store all the biological products and vaccines requiring a temperature of 2-8 degrees Celsius or a negative temperature in the biological refrigerator
- Cold Chain system is implemented to ensure the potency of vaccine from the time of manufacturer to the time it is given to the patient.
- The contingency plan is posted near the refrigerator as a guide, ready reference and reminding for person in charge for the management of medicines
- First - Expiry - First out system is applied
- There should be a calibrated thermometer inside the refrigerator to ensure the regular monitoring in the storage area.
- Ice packs and coolers should be provided for the transfer of products
- A back - up generator should be available in case of electrical failure

### **4. DISPOSAL OF EXPIRED, DAMAGED, RETURNED OR REJECTED PRODUCTS.**

- Personnel in charge will be assigned to a specific shelf for monitoring near expired drugs. Nearly expiry drugs that are 3 months before to expire shall be removed.
- Checking expiry date shall be done every month and shall be recorded and inventoried.
- Nurse Coordinator will ask the attention of the supplier to return nearly expire drugs, damaged, returned and rejected so that the product will be pulled-out and disposed.
- When the supplier cannot accept anymore the product. The pharmacy must then dispose the products in an environmental conscious way. It can be done by coordinating to the garbage collector for proper disposal.

### **5. ADVERSE DRUG REACTION**

- After hearing the complaint, conduct an interview and assessment. The interview should be personal and private.
- While interviewing the client, there should be a documentation of it, and if possible there must be proof of the adverse reaction of the drug such as pictures of it, recording of the talk and so on to forth.
- Ask about his lifestyle and other medicines that he is taking.
- The answer should be true and valid.

- The ADR should be categorized according to its type and classification.
- A form must be filled up and let the interviewee sign it to prove that all written complaints are true and original.
- Keep the ADR form and report it to the company that involved and to the nearest FDA office, so that analyses, tests and studies on that event can be performed.
- Manage and refer the client accordingly.

## **S. REFERRAL SYSTEM**

### **6. General Policy**

- Patients shall have the right to know the reason/s for referral and participate in the choice of facilities where she/he will be referred.
- Health care providers have the responsibility of ensuring prompt and appropriate response to patient's health needs by immediate referral for services that can be provided by other health facilities/providers.
- A two-way functional referral must be observed by ensuring that a receiving facility to exert all efforts of ensuring that a referred patient is not lost during the referral process.
- The facilities must use the standard NTP referral form.
- Patients who were not referred in accordance to NTP policies and procedures shall be accommodated and evaluated accordingly.

### **7. Referral to Xray Providing Facility**

- After negative sputum examination, a presumptive TB patient shall be given appropriate medication for symptoms. If not improved, patient shall be referred to partner outsource facility.
- Patient is may have the option to conduct diagnostic such as Xray related procedures to a facility-of-choice, either public or private.
- Patients or their significant others shall be instructed to bring back the result for further interpretation, evaluation and possible management.

### **8. Referral of patient to TB-Diagnostic Center**

- All TB symptomatic patients shall undergo sputum microscopy, Xray and other diagnostics needed.
- All policies and procedures in acquiring CXR results shall comply with existing policies on Xray referral.
- All smear negative but chest Xray suggestive of pulmonary TB should be referred to accredited TB Diagnostic committee.

- d. Wait for TBDC evaluation of results which shall be sent back to the DOTS facility.
- e. Carry out TBDC recommendation in collaboration with the physician.

#### **9. Referral to and for Other Services**

- a. All TB patients shall have thorough physical examination before enrollment to the TB-DOTS and during scheduled follow ups.
- b. If history taking and physical examinations suggest other or concurrent diseases, the patients shall be referred to appropriate referral RHU to provide further evaluation and management.
- c. The referral shall be two-way referral system to determine action taken by the unit referred upon.
- d. The Specialty Physician referred upon shall provide recommendation to the head of the DOTS facility regarding patient's condition and needed care and condition.
- e. The head of the DOTS facility shall have the prerogative to modify the management at the best of his knowledge in collaboration with specialty physician.
- f. The DOTS facility physician shall recommend follow up examination to the specialty physician regularly to assess the progress of the patient.

#### **T. HEALTH EDUCATION AND PROMOTION**

1. In general, all patient shall receive appropriate health education and information about their disease, its pathology, management and expected outcomes prior, during and after treatment.
2. The office shall conduct health education activities in community, workplace and schools in collaboration with different sectors or groups.
3. Health promotion materials shall be posted in conspicuous areas in the community, with special emphasis on the availability of services provided under the Municipal Health Office.
4. TB signage and posters shall be posted or available in strategic places.
5. Advocate NTP program to local chief executive to encourage funding of the program.
6. Encourage community participation for the program.

#### **U. IDENTIFYING AND WORKING WITH EXTERNAL GROUPS IN PROVIDING DOTS SERVICES**

1. There shall be coordination with different sectors and external groups regarding promotion of NTP services in schools, workplace and tribal groups in the community.

2. A task force is encouraged shall be formulated to aid in achieving desired outcome for the program.
3. Networking with industries/establishments in the community regarding proper referral of TB symptomatic shall be promoted.
4. The DOTS facility shall formulate strategies to build partnerships with other physicians to synchronize diagnosis and treatment of TB cases.
5. All external providers of DOTS shall coordinate with Municipal/Provincial/Regional Health Office regarding provision of DOTS services. All DOTS services shall be compliant to the DOH-NTP manual of procedures. The Municipal Health Office shall coordinate with external providers to monitor compliance.

## **TUBERCULOSIS INFECTION CONTROL**

### **GENERAL POLICY AND OBJECTIVE**

8. Promptly identify people with TB symptoms who have who come into Rural Health Unit.
9. Physically separate infections and potentially infection individuals from others.
10. Enforce patients, staffs, and visitor's compliance with respiratory hygiene practice.
11. Reduce the risk of TB exposure to other patients and staff by minimizing the time diagnosed TB patients and TB Symptomatic are within the health center.
12. Prevents staff from acquiring and developing TB and support those who have contracted TB in compliance with national guidelines and national employee health regulations.
13. Ensure that building design and use are appropriate for the buildings intended use and ease of operation.
14. Ensure sufficient air exchange and control airflow direction.

### **PROCEDURES**

#### **Administrative Controls**

8. **TRIAGE:** Admitting Nurse or midwife responsible
  - j. Place large notices at the entry way at eye- level, stating that one must immediately inform staff of current cough lasting for two weeks more.
  - k. Display notices explaining that the facility prioritizes patient with current cough that lasted for two weeks or more over others in waiting queue and makes use of designated separate waiting areas if possible.

c. Undertake screening of persons with cough as they enter the health center and before they have joined the queue or have had a seat with others. Any patient with 1) current cough that lasted for 2 weeks or more, 2) fever, 3) weight loss, 4) night sweats.

d. Direct presumptive TB to the outdoor sputum collection area to provide a sputum sample. Use a sputum cup with a screw cap. Explain how to provide a sputum sample. Instruct them where to bring the sputum sample, a place outside the laboratory. When they return direct them immediately in front of the waiting queue to be seen with priority or to designate waiting area away from the regular patients where they can wait until they can be seen.

e. List presumptive TB in the TB Presumptive Master list.

f. Document, evaluate and report the number of confirmed sputum smear positive against the total number of TB Symptomatic at the end of every month/quarter.

9. **SEPARATION:** Admitting nurse or midwife responsible

5. Separate Presumptive TB and diagnosed infectious TB patient in a designated partition of the general waiting area near open windows.

6. Separate diagnosed MDR - TB patients from other patients by giving them a specific time slot for visiting the health facility; every tuesday.

10. **COUGH ETIQUETTE:** Barangay Health Worker responsible

11. Place posters on cough etiquette at the general waiting area and DOTS consultation room, where patients cannot miss to see them (directly in front of them at eye- level and not on back wall).

12. Provide daily health education on cough etiquette (ex. Cover mouth and nose when coughing or sneezing; turn head away from others; do not spit on the floor) as part of one - on - one counseling or as part of pre- clinic lectures.

13. Remind non - adhering persons to comply with the respiratory hygiene policy of rural health unit.

14. If available, provide disposable surgical masks to all confirmed infectious TB patients and Presumptive TB, if not available, make use of personal handkerchief or paper tissues.

15. Instruct them to discard disposable surgical masks and paper tissues in a plastic bag and then in a waste bin.

11. **MINIMIZING TIME SPENT IN THE HEALTH CENTER:** Entire Team Responsible

10. Manage patient flow. Move presumptive TB to the front of the waiting area waiting area to be seen with priority.

11. Document in the patient's chart the date 1) Laboratory tests were completed; 2) the patient received results and Medications; ideally, the

turn - around time for sputum examination is 3 days; ideally, the patient is started on treatment within 1 day.

12. Evaluate (delays in) 1) the minimum/ maximum and average time for diagnosis, and 2) between diagnosis and initiation of treatment; (evaluate these monthly).

**12. TB SCREENING OF STAFF:** Entire team responsible

- a. Be aware of the occupation risk to acquire TB
- b. Be familiar with the TB IC Policy and procedure of the facility and the Magna Carta of public health workers (Rep. Act No. 7305) and other relevant employee.
- c. Health regulations including TB screening to ensure that the workplace practice conforms to these national and institutional rules and regulation. Have one copy of the RA No. 7305 available at the center appended to this policy.
- d. Be alert to signs and symptoms of TB and seek care promptly in case of signs and symptoms (Presumptive TB screening ex. sputum examination)
- e. Be examined at least annually (periodic TB screening ex. Chest x - ray)

**13. NATURAL VENTILATION:** LGU and RHU responsible

- b. Create a designated waiting bay for TB symptomatic/ presumptive TB and TB patients.
- b. Ensure that doors and windows on opposing walls are kept open during consultation hours in all consultation rooms.
- c. Place furniture in consultation rooms such that staff- patient interactions occur with air flow passing between patient and staff, rather than from patient to staff. Sketch a floor plan for each room and display the (laminated) floor plans at the inside of the doors.
- d. Construct and maintain outdoor sputum collection area to improve privacy without hampering ventilation.
- e. Maintain moving parts of windows to allow for adequate air exchange.

**14. MIXED - MODE VENTILATION** - LGU and RHU Responsible

9. Install wall fans, stand fans or industrial fans in the waiting area behind the admitting nurse/midwife.
10. If appropriate, place electric fans in consultation rooms/ counseling room behind the staff to push air from the staff in the direction of the patients.
11. Assign a dedicated person or team to check and to service ventilation equipment on a regular schedule.
12. Administrative controls regarding the operation of the fans should be in place to guarantee a flawless functioning, keep a log to record the date, what was done (ex. Checking, cleaning, replacement of parts, repair) and when the equipment should be service again. Deficiencies must be repaired and replaced as soon as possible.

## D. RESPONSIBILITY

### PHARMACEUTICAL AND SUPPLY AND LOGISTICS

#### POLICY AND PROCEDURES TITLE: Product Procedure

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##### I. OBJECTIVE

To provide proper guidelines in procuring of stocks.

##### II. SCOPE

Applied to all products

##### III. RESPONSIBILITY

Person in Charge

##### IV. PROCEDURE

A. The procurement will make an order through phone, SMS, facsimile, sales representative and other media.

B. There should be a copy or list of the products to facilitate checking of them when delivered.

C. Upon delivery of the product, check the product's count, amount, and batch number and make sure that the expiry date is very far, at least two years to make sure that the product is safe, potent, and effective.

D. The procurer will pay the delivery man and ask for official receipt and copy of the sales invoice and filed them.

E. The procurer will price the product through an acceptable price mark- up.

F. The product will then display the ready to be sold.

##### V. QUALITY OF RECORDS:

The purchaser will file the invoice for future use and other case.

##### VI. FORMS:

Logbook, Inventory Sheets



## PHARMACEUTICAL AND SUPPLY AND LOGISTICS

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### POLICY AND PROCEDURES TITLE: Good Storage Practice

#### I. OBJECTIVE:

To have standard operating procedure for Storage of Medicines.

#### II. SCOPE:

All to products that within the drugstore. Should be under specific temperature for other temperature-sensitive drugs and proper categorized.

#### III. RESPONSIBILITY

Person-in-Charge

#### IV. PROCEDURE

##### A. GENERAL GUIDELINES

- After initially checking the medicines delivered, all products should be wrapped by a clear plastic to avoid accumulation of dust particles.
- Transfer the goods to their respective areas
- Store the goods in an organized and orderly manner with the label bearing the name of the product in front.
- First-Expire-First-Out will be the basis of disposing drugs.
- Avoid direct contact to the sun or on the walls to avoid moisture accumulation.
- Store controlled drugs substances and other potent drugs in the designated. Access this area should only be allowed to the pharmacist and owner.
- Store expired and recalled goods in the storage room, marking it with "Expired" and "Recalled", respectively to prevent use.
- Store medicines at stipulated temperature areas, protected from excessive light, dust and humidity. The temperature should be checked by the pharmacist daily and recorded in the monitoring sheet if necessary for cold chain drugs.
- Store the other stock in a separated area. Maintain all sales invoice records for return or exchange of products to the supplier.
- Verify the contents of the delivery products for any counterfeit, damage or defect.
- Record the data in an appropriate logbook and computer entry for received medicines and supplies.
- File the invoice receipt or delivery receipt in a folder.
- Store the goods in an organized and orderly manner in their appropriate shelves with the correct label bearing the name of the product in front.
- Have a systematic way of arranging the products in the display cabinet or shelves to avoid confusion or mix ups.

- Specific if medicines are arranged alphabetically, by therapeutic category or by program.
- Avoid direct exposure to sunlight
- Avoid direct contact on the walls to prevent moisture and heat accumulation
- Provide pallets for proper storage of bulk medicines
- Provide proper ventilation in the storage room
- Store medicines at stipulated temperature areas, protected from excessive light, dust and humidity
- The temperature of the store room and cold chain management should be monitored by the designated person in charge for medicines regularly, recorded in the monitoring sheet and should be updated.
- Check if there are inappropriate items inside the refrigerator like food and beverages
- Contingency plan should be provided during emergencies for Cold Chain management.

#### **B. FOR PARENTERALS, SUPPOSITORIES, VACCINES AND OTHER BIOLOGICAL PRODUCTS**

- a. Store all the biological products and vaccines requiring a temperature of 2-8 degrees Celsius or a negative temperature in the biological refrigerator
- b. Cold Chain system is implemented to ensure the potency of vaccine from the time of manufacturer to the time it is given to the patient.
- c. The contingency plan is posted near the refrigerator as a guide, ready reference and reminding for person in charge for the management of medicines
- d. First - Expiry - First out system is applied
- e. There should be a calibrated thermometer inside the refrigerator to ensure the regular monitoring in the storage area.
- f. Ice packs and coolers should be provided for the transfer of products
- g. A back - up generator should be available in case of electrical failure

#### **C. FOR FLAMMABLE AND CORROSIVE SUBSTANCES;**

- a. Bulk supplies and flammable such as alcohols and acetone should be stored in a separate room to prevent the risk of fire to the storage room or in the facility.
- b. Storeroom should be well ventilated and fire proof, away from open flames and electrical appliances. Always store flammables in the coolest location possible and never in direct sunlight

V. **QUALITY OF RECORDS:**

The person in charge will monitor the expiration and status of the medicines or stocks.

VI. **FORMS:**

Expired Medicines and Recalled Medicine Forms

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**POLICY TITLE:** Infection Control, Prevention and Treatment of Needle Stick Injury  
Pototan Rural Health Unit and Birthing and Primary Care Facility provides a sanitary environment to avoid source and transmission of infections and communicable disease. There was an active program for the prevention, control and investigation of infections and communicable diseases.

**NEEDLE STICK INJURY**

**D. POLICY AND OBJECTIVE**

In case where the health personnel accidentally pricked by unsterile needle, he/she is required to report it to the immediate supervisor of coordinators. The personnel will be referred to the municipal health officer for further assessment so that proper management will be initiated.

**E. MANAGEMENT**

- d. Anti-tetanus serum injection for free.
- e. Free medicine as needed.
- f. Proper wound care

**F. PROCEDURE**

- b. Proper disposal of sharps and needles.
  - 6. Never remove, recap, bend or break used needles.
  - 7. Never point the needle toward any body part.
  - 8. Deposit disposable needles in puncture resistant containers.
  - 9. Segregation of all waste is practice in the health facility. In each section, sharps and needles have their own containers. There is specific waste beam of sharps before they are dump.
  - 10. The collecting containers are made up of hard plastic galloons, which cannot be easily punctured by needle. At time, specific collecting box, hard box made up of thick paper boxes.

**III. Universal Precaution**

- 9. Handwashing after any direct contact with patients.
- 10. Preventing two handed recapping needles.

11. Safe collection and disposal of needles and sharps, with required puncture and liquid proof safety boxes in each patient care area.
12. Wearing gloves for contact with body fluids, non-intact skin and mucous membranes.
13. Wearing appropriate personal protective equipment.
14. Covering all cuts and abrasion with a water proof dressing, if available.
15. Promptly and carefully cleaning up spills of blood and other body fluids.
16. Using safe system for health care waste management and disposal.

#### **IV. RESPONSIBILITY**

- d. All Staff
- e. Public Health Nurse
- f. Municipal Health Officer/ Municipal Coordinator.

#### **Policy on Transfer of Registrants in case of Withdrawal/Suspension or Accreditation of Primary Health Care Facility**

1. Identification of patients: The first step is to identify all the patients registered at the closed facility. This can be done by accessing the facility's patient records or contacting the patients directly.
2. Communication: The patients should be informed about the closure of the facility and the reasons behind it. They should also be informed about their options for transferring to another facility.
3. Transfer of records: The patient records should be transferred to the new facility to ensure continuity of care. This should be done securely and in compliance with any relevant data protection laws.
4. Selection of new facility: The patients should be given the choice of which new facility they would like to transfer to. The new facility should be appropriate for their needs and location should be taken into consideration.
5. Coordination with the new facility: The closed facility should coordinate with the new facility to ensure a smooth transfer of patients. This may include sharing patient records, providing information about the patient's medical history and treatment plan, and arranging for follow-up appointments.
6. Follow-up: The closed facility should follow up with the patients to ensure they have successfully transferred to the new facility and that they are satisfied with their new care.

Overall, this policy ensures that patients are able to receive continuous, high-quality care despite the closure of the primary health care facility.

# IPC MANUAL

## POLICY TITLE: Infection Control

### 1. INTRODUCTION

Pototan Rural Health Unit provides a sanitary environment to avoid source and transmission of infectious and communicable diseases. Since the RHU is responsible for the performance of its employees, the importance of providing adequate periodic training and supervision of the personnel in proper infection control practices cannot be overemphasized. Every accredited PCF is required to have an Infection Control Committee tasked to manage a facility-wide infection control program. The responsibility of the PCF in control of infection extends to its patients, personnel and visitors.

### 2. OBJECTIVE

- a. To enhance and increase awareness of healthcare workers on the practice of infection control through continuous education, and training, programs and information dissemination and practical application in the workplace.
- b. To design relevant infection control education and training modules that will enhance knowledge and competence of healthcare workers in the practice of infection control.
- c. To implement infection control policies and procedures recommended and monitor its implementation.
- d. To protect healthcare workers through education and immunization and other prevention programs.
- e. To increase compliance to infection control practice of healthcare workers.

### 3. INFECTION CONTROL SECTION FOR CONSULTATION AREA

#### B. PROCEDURES:

##### c. TRIAGE: Nurse or Midwife

3. Upon consultation take steps to ensure all persons with symptoms of suspected COVID-19 or other respiratory infections (e.g. fever, cough) adhere to cough etiquette and hand hygiene.
4. Undertake screening of persons with cough that lasted for two weeks or more for those who are below 60 years old and a current cough for those who are 60 years old and above as they enter the health center and before they join the queue or have a seat with others.

##### d. SEPARATION: Nurse or Midwife

4. Undertake screening of persons with cough as they enter the health facility.
5. Physically separate infectious and potentially infectious individuals from others.

6. Separate Presumptive TB and Confirmed TB patient in a designated place which is at the DOTS area.

## **11. FUNDAMENTALS OF STANDARD PRECAUTIONS**

### **f. Handwashing**

Handwashing is the single most important measure to reduce the risks of transmitting microorganism from one patient to another, or from one site to another, on the same patient.

- g. This should be before and between contact with patient and after contact with blood, body fluids, secretions and equipment or articles contaminated by them.

### **h. GLOVING**

Done to provide protective barrier and prevent contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin; to reduce microorganisms present on hands of personnel performing invasive or other patient care procedure that involves touching patient's mucous membrane and non-intact skin; and reduce the spread of microorganism from one patient to another through bare hands

### **i. MASK, RESPIRATORY PROTECTION, EYE PROTECTION, FACE SHIELDS**

Worn alone or in combination to provide barrier protection. Mask should cover both the nose the mouth; goggles or face shield should be worn by the RHU personnel during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions to provide protection of the mucous membranes of the eyes, nose, and the mouth from contact transmission of pathogens.

### **j. GOWNS**

Put on a clean gown and change the gown if it becomes soiled.

## **12. CARE OF EQUIPMENTS AND ARTICLES**

Contaminated reusable medical devices or patient-care equipment are sterilized or disinfected after use to reduce the risk of transmission of microorganisms to other patients. Equipment's contaminated with blood, body fluids, secretions or excretions should be cleaned and disinfected after use according to the facilities policy on contaminated disposable patient-care equipment. These should be handled and transported in a manner that reduces the risk of contamination of microorganisms and decrease environmental contamination. The equipment should be disposed according to the facility's policy and regulation.

## **13. CONTACT PRECAUTIONS**

Designed to reduce of transmission of epidemiologically important microorganisms by direct or

Indirect contact.

Direct contact refers to the physical transfer of microorganisms to a susceptible host from an infected or colonized individual.

Indirect contact refers to the transmission which involves contact of a susceptible host with contaminated intermediate object, usually inanimate in the patient environment.

Contact precaution applies to specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct or indirect contact.

Use contact precautions for patient with gastrointestinal, respiratory, skin or wound infections or colonization with multi drug-resistant bacteria such as:

Enteric infections: Escherichia coli, Shigella, Hepatitis A, Salmonella, Skin infection that are contagious or that may occur on dry skin including:

Diphtheria (cutaneous)

Herpes simplex-virus (neonatal or mucocutaneous)

Major (non-contained) abscess, cellulitis, or decubili

Pediculosis

Scabies

Staphylococcal furunculosis in infants and young children

Zoster (disseminated or in the immunocompromised host)

Viral/Hemorrhagic conjunctivitis

HIH/AIDS

#### **14. TRANSMISSION BASED PRECAUTIONS**

Transmission Based Precautions are additional designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond standard precautions are needed to interrupt transmission in the facility. There are three types of transmission base precautions: Airborne, Precautions, Droplet Precautions, and Contact Precautions.

##### **a. Airborne Precautions**

Designed to reduce the risk of transmission of infectious agents.

Airborne transmission occurs by dissemination of either airborne droplet nuclei or dust

particles containing the infected agent. Microorganisms carried in this manner can be widely dispersed by air currents and may be inhaled by or deposited on a susceptible host within the same room or carried over a longer distance from the source patient depending on environmental factors. Therefore, handling and ventilation are required to prevent airborne transmission.

Airborne precautions apply to patients known or suspected to be infected with epidemiologically Important pathogens that can be transmitted by the airborne route.

Airborne precaution is applied for patients known or suspected to have serious illnesses such as:

Measles  
Varicella/Zoster  
Tuberculosis (Pulmonary, caseating open lesions)  
SARS

## 15. DROPLET PRECAUTIONS

Designed to reduce the risk of droplet transmission of infectious agent. Droplet infection involves contact of the conjunctivae or the mucous membranes of the nose or mouth of susceptible person with large particle droplet containing microorganisms generated from person who has clinical disease or who is a carrier of the microorganism.

Transmission via large particle droplet requires close contact between source and recipient persons because droplets do not remain suspended in the air and generally travel through the air only distances through the air only to distances of three feet or less.

Droplet precautions apply to any patient known or suspected to be infected with epidemiologically important pathogens that can be transmitted by infectious droplet.

Use droplet precautions for patients known or suspected to have serious illnesses transmitted by large particle droplets such as:

SARS

- Invasive Haemophilus influenza type B disease, including:
- Meningitis
- Pneumonia, Epiglottitis

Invasive Neisseria meningitides, including:

- Meningitis
- Meningococemia
- Diphtheria (pharyngeal)
- Pertussis
- Streptococcal pharyngitis
- Influenza

Serious Viral Infections spread by droplet transmission, including:



- Adenovirus
- Influenza
- Mumps
- Rabies

## **16. IMPLEMENT ENVIRONMENTAL INFECTION CONTROL**

4. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
5. All surfaces in the consultation area must be clean before the start of work and be decontaminated after work is done with 10% Lysol solution.
6. Clean with 10% hypochlorite solution, Lysol or chlorine whichever is available.

## **17. SURVEILLANCE**

- a. Surveillance is one of the most important elements in an infection Control Program and is defined as a method of monitoring ongoing events and being watchful of activities and occurrences of events that are pertinent to effective control. Complete surveillance is necessary in order to accomplish all elements of an Infection Control Program.
- b. Surveillance of clients for infection shall be done to identify baseline information about the frequency and type of endemic infection in order to permit rapid identification of deviations. All significant clusters of infection above the expected level shall be investigated. Surveillance will be aimed at assessment/observation and early recognition of signs and symptoms of infections, monitoring, analyzing, reporting, and follow-up.
- c. Surveillance activities shall include not only clients but also personnel, the environment. Procedures. And any activity that would be identified as impacting on infections or health risk for the population of the facility.

### **10.1 TYPES OF SURVEILLANCE**

- d. Prospective: Incidences that have occurred in the past. Monthly infections control reports are based upon this type.
- e. Retrospective: Incidences that have occurred in the past. Monthly infections control reports are based upon this type.
- f. Prevalence: Incidence that are occurring now.

### **10.2 METHODS OF SURVEILLANCE**

- f. Surveillance of all clients or occurrences at all times.
- g. Total surveillance is utilized to obtain pertinent baseline data.
- h. Surveillance of a selected population group, ex. Laboratory-based, high-risk population, infections in a particular site such as UTI.
- i. Targeted or selective surveillance is done when specific problems are identified or infections in a particular site are elevated above expected level.

- j. Surveillance done at specific time: ex. Prevalence studies.  
Environmental studies.

## **SAFETY PROGRAM on EMERGENCY and DISASTER**

### **PREPAREDNESS**

During emergencies or disasters, the Pototan Rural Health Unit must remain safe, accessible at maximum capacity in order to help save lives.

It must at all times ready in providing critical service such as medical and nursing care, laboratory and other health care services as well as respond to increased requirements related to the emergency.

Making our RHU safe involves knowledge of the many factors that contribute during emergency or disaster and the ability of the RHU to withstand adverse natural events.

### **I. FIRE PREVENTION AND RESPONSE**

- All employees and contract staff is included in drills/exercise: must be well oriented and participate during demonstration and on how to operate a fire extinguisher.
- Fire alarm, must be in good working order.
- All exit routes have emergency lighting and signs posting the direction to the exit.
- BFP Hotline must be posted to corridors to every department.

### **II. FOOD SERVICE**

- The LGU must have adequate food on hand for staff and patients for a 3-4 day period.
- Food service is included in facility's emergency exercise.

Security of food products is maintained at all times during emergency & disaster.

### **III. EMERGENCY POWER**

- Emergency power is adequate to provide for all essential service for three days.
- There should also be reliable alternative source of power for emergency lighting and operation of essential equipment in the event of power failures.

Emergency lights should be available for use between the interruption of the power supply and connection to a generator to light important areas inside the RHU such as, hallways, the operating room, emergency room, nurse's station and cashier area.

#### **IV. DRUGS, MEDICINES and MEDICAL SUPPLIES**

- Facility maintain adequate blood bank facilities, with particular attention paid to correct storage and handling of blood and blood products

#### **V. BLOOD BANK/STORAGE SERVICE**

- Every health facility at the first referral level should maintain adequate blood bank facilities, with particular attention paid to correct storage and handling of blood and blood products.

- if a blood bank is not feasible, possible sources of blood products should be identified and a system arranged for quick procurement in emergencies.

#### **VI. WATER SUPPLY**

- Water supply should be safe and potable and there should be a reliable alternate source of water such as manual pump well, or maybe a local fire storage or storage tanks. This is because of the daily water consumption.

#### **VII. MEDICAL OXYGENS**

- The facility sustains medical oxygen to last 3-4 days.

- A utility jeep makes daily routine to check empty oxygen tanks at the RHU to transport to the supplier for refill.

- a back- up vendor has been identified if primary vendor is unavailable.

- The medical gas supply is vital for the survival of some patients in the facility but is also a source of danger if not properly maintained.

- The tanks or medical gas pipes must be inspected regularly by Nursing Attendants to ensure that they are still in good condition.

- Medical oxygen tanks must be in a secured area and there should be safety valves installed to prevent leaks.

### **VIII. TRANSPORTATION and FUEL**

- The RHU ambulance must always be in good running condition at any time to refer patients in cases of referrals.
- A sufficient fuel must be sustained for 3 days of continuous, full- load demand before replenishment is needed.

### **IX. WASTE DISPOSAL**

Facility has procedures for management of increased volume and disposal of contaminated wastes, goods, and fluids.

### **X. DRILLS AND EXERCISES**

- A fire drill will be conducted once a year shall take place on all shifts, on all units and include all facility departments.
- All employees and Contract staff is included in drills/ exercises; must be well oriented and participate during demonstration and on how to operate a fire extinguisher.
- Fire alarm, must be in good working order.

### **XI. SIGNAGES**

- Presence of signage inside the RHU that should indicate the location of escape routes and firefighting equipment. This is to prevent confusion and panic during an emergency which subsequently may cause stampedes or trapping of individual in enclosed spaces.

### **XII. COMMUNICATION**

- Communication is vital to the success of all coordination efforts. A public information center should be established where the public can go to request information concerning family members.
- The center should be coordinated by social worker and staffed by the RHU personnel or volunteer

### **XIII. COMMITTEE ON EMERGENCY AND DISASTER**

The basic prerequisite for personnel on this team is that they must be properly trained in first aid and that they have the necessary means to move immediately to the disaster scene. Other important training includes basic life support, advanced cardiac life support and familiarity with the incident.

**RHU COMMITTEE ON EMERGENCY AND DISASTER  
(TRAINED IN BASIC LIFE SUPPORT)**

**POLICIES ON CONTINUING QUALITY ASSURANCE & QUALITY  
IMPROVEMENT**

**GOAL:** The health facility continuously and systemically improves its performance by always doing the right thing the right way the first time and all the time to satisfy the needs of both its clients and providers.

1. The facility shall endeavor to provide quality health care to its clients.
2. Quality care entails the following from its service providers:
  - Doing the right thing
  - Doing the right way
  - Doing the right, the first time
  - Doing it on time and all the time.
3. Quality is also being able to accomplish the following in terms of the client:
  - Meeting client expectations on time
  - Rendering the right service on time
  - Satisfying client needs on time
  - Treating every client with integrity, respect and courtesy.
4. Ensuring quality will require the participation of the service providers, stakeholder for the health and the recipient of health care themselves who will provide appropriate feedbacks which shall be acted upon by the organization.

5. The goal of quality assurance is **Client Provider Satisfaction**.

6. The following shall be the CORE PRINCIPLES that shall be adapted by the facility to ensure quality health care:

- Client-centered service delivery
- Institutionalized system and processes
- Service delivery assessment
- Teamwork

7. The facility shall utilize the Plan-Do-Check-Act approach in quality improvement.

<b>PDCA COMPONENT</b>	<b>DESCRIPTION</b>	<b>RHU ACTIVITIES</b>
P-PLAN	Identification of targets and goals Identify gaps between performance and target Identify factors contributing or prohibiting accomplishment of goals.	Institutionalize client-feedback system Program Implementation review for previous years' accomplishments Target setting TNA Facility Assessment Plan formulation through the AOP/MIPH
D-DO	Collect data Record baseline or findings Develop solutions Develop services evaluation	Implement/plans solutions identified
C-CHECK	Assessment or evaluation of interventions against pre-set targets/goals	Program monitoring Accomplishment rate vs. target Client feedback Supervisory activities External monitoring by PHO & CHD-CAR program coordinators.
A-ACT	Institutionalize revisions or changes to address on-going gaps in program implantation	Monitoring Re-planning

8. The level of client's satisfaction shall be elicited and monitoring through a CLIENT FEEDBACK SYSTEM with the following features:

## 8.1 SUGGESTION BOX

- a. A client suggestion/ comment/ feedback box strategically located in the waiting area.
- b. Retrieval of all suggestions/comments/ feedback once a month by the MHO & or PHN/Nurse.
- c. Consolidations of all suggestions/ comments /feedback according to service, namely physically plant/facility, personnel and services.
- d. Discussion of all suggestions/ comments/ feedback/ during the monthly staff meeting except for comments specifically addressed to staff/ personnel which shall be discussed personally with the staff concerned.
- e. The client feedback, mechanism shall utilize the prescribed form which shall be made accessible to all clients.

## 8.2 QUESTIONNAIRE

- a. A questionnaire that is lifted from the SS Technical package shall be made available
- b. A staff shall be assigned to conduct the survey.
- c. At least one (1) patient every other day shall be interviewed for a total of 15 clients a month.
- d. Questionnaires shall contain essential questions addressing issues pertinent to:
  - d.1 Facility
  - d.2 RHU staff 7 personnel
  - d.3 Over all facility evaluation
  - d.4 Client suggestion/ comments
- e. The following shall be procedure of collating and analyzing the rating:
  - e.1 For each client interviewed, the number of agree, neither agree or disagree, and disagree responses shall be counted.
  - e.2 All the numerical findings for the different responses are to be collated in one summary report.
  - e.3 The following shall be an interpretation of the collated result for each client:
    - SATISFACTORY RATING- at least 6 agree responses

- UNSATISFACTORY RATING- less than 6 agree responses and any combination of the neither agree nor disagree and disagree responses.

e.4 The summary of ratings shall be entered as follows:

CLIENT	# OF AGREE ANSWERS	RATING
1.		
2.		

e.5 Determining the **OVER-ALL FACILITY RATING**

RATING COMBINATIONS	OVERALL FACILITY RATING
11-15 Clients gave a satisfactory rating	VERY GOOD
5-10 Clients gave a satisfactory rating	GOOD
Less than 5 out of 15 or none gave a satisfactory rating	NEEDS IMPROVEMENT

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