MANUAL FOR THE MANAGEMENT OF PRIMARY MEDICAL CARE UNITS

2025

Directorate of Planning – Management, Development & Planning Unit
Ministry of Health, Sri Lanka

MANUAL FOR THE MANAGEMENT OF PRIMARY MEDICAL CARE UNITS

2025
MINISTRY OF HEALTH

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Foreword

I am pleased to introduce the **Manual for the Management of Primary Medical Care Units (PMCUs)**, a key resource aimed at enhancing the delivery of primary health care services at the grassroots level.

Primary care serves as the foundation of any health system, is the first point of contact for individuals seeking health care. It provides essential curative services and plays a critical role in addressing the health needs of communities. The World Health Organization (WHO) recognizes primary care as a cornerstone of a comprehensive and inclusive primary health care strategy to achieve Universal Health Coverage (UHC).

The Government of Sri Lanka (GOSL) has prioritized the strengthening of the primary health care system with a shared care cluster approach. This initiative emphasizes upgrading PMCUs into model units that meet minimum standards for delivering the Sri Lanka Essential Service Package. The reorganization aims to ensure equitable access, quality care, and an improved health experience for all in order to reduce out-of-pocket expenditure.

This manual provides detailed guidance on key aspects of managing PMCUs, including service provision, quality and safety standards, infection prevention, asset and financial management, community participation, and much more. It serves as a practical tool for Medical Officers and all health care professionals working in PMCUs to navigate the reorganization and ensure effective implementation of primary health care services.

I encourage all stakeholders to use this manual as a comprehensive guide to enhance the functioning of PMCUs, strengthen primary care delivery, and support the health and well-being of our communities. Your dedication to this shared vision is essential to achieving a resilient and inclusive health care system for Sri Lanka.

Dr. S. Sridharan
Deputy Director General (Planning)
January 22, 2025

List of Abbreviations

AFB	Acid-Fast Bacillus
ALT	Alanine Transaminase
AST	Aspartate Tminotransferas
BH	Base Hospital
BHT	Bed Head Ticket
BI	Biological Indicators
BMI	Body Mass Index
BP	Blood Pressure
CBO	Community-Based Organizations
CFL	Compact Fluorescent Lamp
CI	Chemical Indicators
CRP	C-Reactive Protein
CSF	Cerebrospinal Fluid
CSO	Civil Society Organization
CVD	Cardio Vascular Diseases
DDG	Deputy Director General
DH	Divisional Hospital
DHQS	Directorate of Health care Quality and Safety
DO	Development Officer
DS	Dental Surgeon
E&OH	Environmental Health, Occupational Health
ECG	Electrocardiogram
EDO	Economic Development Officer
EDTA	Ethylenediaminetetraacetic acid
ESR	Erythrocyte Sedimentation Rate
ETU	Emergency Treatment Unit
FBC	Full Blood Count
FBS	Fasting Blood Sugar
FEFO	First Expired, First Out
FR	Financial Regulations
GIC	Glass Ionomer Cement
GN	Grama Niladhari
GOSL	Government of Sri Lanka
GP	Gutta Purcha
GPD	General Purpose Detargent
GRM	Grievance Redress Mechanisms
H2O2	Hydrogen Peroxide
HAI	Health care-Associated Infections
HbA1C	Glycated Haemoglobin
HBsAb	Hepatitis B Surface Antibody
HCF	Health-Care Facility
HCG	Human Chorionic Gonadotropin
HCW	Health care Workers
HCWM	Health care Waste Management
HDC	Hospital Development Committee
HIMS	Hospital Information Management System
HIU	Health Information Unit
HIV	Human Immunodeficiency Virus
HLC	Healthy Lifestyle Clinic
HLD	High Level Disinfectant
HMC	Hospital Management Committee
HQS	Health care Quality and Safety
HSEP	Health System Enhancement Project
IADL	Instrumental Activities of Daily Living
ICU	Intensive Care Unit
IOH	Institute of Oral Health
IOM	Institute of Medicine
IPC	Infection Prevention and Control
ISH	International Society of Hypertension
IV	Intravenous
LA	Local Authority
MDRO	Multidrug-Resistant Organisms
MLT	Medical Laboratory Technologists

MO	Medical Officer
MOH	Ministry of Health
MOIC	Medical Officer in Charge
MS	Medical Superintendent
NCD	Non Communicable Diseases
NG	Nasogastric
NGO	Non-Governmental Organization
NIHS	National Institute of Health Sciences
NMRA	National Medicines Regulatory Authority
NO	Nursing Officer
OGTT	Oral Glucose Tolerance Tests
OHU	Oral Health Unit
OIC	Officer in Charge
OPD	Outpatient Department
OPMD	Oral Potentially Malignant Disorders
PAP	Papanicolaou Test
PBU	Premature Babies Unit
PCHC	Patient-centered Health care
PCU	Preliminary Care Unit
PDHS	Provincial Directorate of Health Services
PHC	Primary Health Care
PHI	Public Health Inspector
PHM	Public Health Midwife
PHN	Personal Health Number
PHNO	Public Health Nursing Officer
PIV	Paying in Voucher
PMCI	Primary Medical Care Institutions
PMCU	Primary Medical Care Unit
PMR	Personal Medical Record
POCT	Point-of-Care Testing
POI ID	Point of Issue ID
PPE	Personal Protective Equipment
PSSP	Primary Health care System Strengthening Project
QMU	Quality Management Unit
RBS	Random Blood Sugar
RDHS	Regional Director of Health Services
RDT	Rapid Diagnostic Test
RMO	Registered Medical Officer
RMSD	Regional Medical Supplies Division
SDG	Sustainable Development Goals
SEAR	South-East Asia Region
SLESP	Sri Lanka Essential Health Services Package
SMLT	Senior Medical Laboratory Technologist
SOP	Standard Operating Procedure
STD	Sexually Transmitted Diseases
SWML	Scheduled Waste Management License
TB	Tuberculosis
TC	Tungsten Carbide
TCL	Topical Chlorite of Lime
TH	Teaching Hospital
UFR	Urine Full Report
VDRL	Venereal Disease Research Laboratory Test
WHO	World Health Organisation
WIT	Work Improvement Team

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CHAPTER 1

INTRODUCTION

Primary care serves as the first point of contact for health care at the grassroots level, offering the initial level of curative care for patients. The WHO identifies essential primary care as a fundamental component of an inclusive primary health care strategy.

Primary care encompasses a broad spectrum of health care services, addressing the needs of individuals across all ages, socioeconomic statuses, and geographic locations. It supports both those seeking to maintain optimal health and individuals with acute or chronic physical, mental, and social health conditions. As a result, primary care practitioners must possess a wide-ranging knowledge base to address diverse health concerns effectively.

A defining feature of primary care is its continuity, as patients often prefer to consult the same practitioner for routine checkups, preventive care, health education, and initial consultations for new health issues. Primary care also incorporates essential services, such as maternal and child health, family planning, and immunization programs.

In Sri Lanka, primary care is delivered through 523 institutions across the country, referred to as Primary Medical Care Units (PMCUs).

This manual aims to guide health care staff in managing PMCUs efficiently and effectively, ensuring the delivery of high-quality care to the community.

CHAPTER 2

STRENGTHENING THE PRIMARY CARE SYSTEM

Several factors contribute to patients bypassing smaller health care facilities in favor of secondary and tertiary-level institutions. These include deficiencies within the primary health care system, resource shortages and unequal distribution, the absence of a gate keeping mechanism, and community perceptions regarding the quality of services at different levels. Consequently, primary health care institutions are underutilized, while higher-level facilities face overcrowding.

Sri Lanka is currently in the fifth stage of demographic transition, marked by a growing burden of non-communicable diseases (NCDs). The existing primary health care infrastructure has not been adequately equipped to address these evolving health demands.

To tackle these challenges and progress toward achieving Universal Health Coverage and health-related Sustainable Development Goals (SDGs), the Government of Sri Lanka (GOSL) has initiated efforts to strengthen the primary health care system through a shared care cluster approach.

Re-organization of the PHC system

The catchment area for each Primary Medical Care Unit (PMCU) was identified, followed by the designation of a secondary or tertiary institution as its referral facility. The apex secondary or tertiary care institution and the PMCUs it serves form a cluster. Each cluster includes a PMCU, laboratory services, and Healthy Lifestyle Centers (HLCs).

Population empanelment was conducted by assigning each individual to a PMCU based on travel time and distance, as outlined in General Circular No: 01-01/2022 dated 03-02-2022 on Population Empanelment for Delivery of Primary Health Care to Achieve Universal Health Coverage.

Each PMCU is tasked with providing primary health care (PHC) services to the empaneled population, including outpatient care, emergency care, and services offered by HLCs, such as non-communicable disease (NCD) screening, cardiovascular disease (CVD) risk assessment, and follow-up care. In 2019, the Sri Lanka Essential Health Services Package (SLESP) was introduced, detailing the comprehensive services to be provided at each level. For further information about PMCU services, please visit http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/2019/SLESP- 2019.pdf.

The reorganization initiative focuses on upgrading PMCUs into model units that meet minimum standards for delivering the SLESP. Key measures include ensuring adequate human resources, developing policies and protocols, establishing personal health records and an information management system, creating a laboratory network, ensuring the availability of essential drugs, and enhancing citizen engagement. The following chapters will detail the implementation of PHC service reorganization.

CHAPTER 3

SERVICES PROVIDED BY PRIMARY MEDICAL CARE UNITS

PMCUs play a vital role in delivering essential health care services to local communities, focusing on promoting well-being and maintaining good health. They emphasize early diagnosis, timely treatment, appropriate referrals, and the promotion of preventive care, proactively addressing health concerns to ensure overall wellness.

3.1 Opening Hours

All PMCUs (both the services and the office) should be kept open during the following hours.

- 8.00 am to 4.00 pm on weekdays
- 8.00 am to 12.00 noon on Saturdays

PMCUs will remain closed on Sundays and public holidays, unless otherwise directed by the relevant RDHS.

3.2 Human Resources

The workforce of a PMCU may include Medical Officers, Assistant Medical Officers/Registered Medical Officers, Dental Surgeons, Dispensers/Pharmacists, Public Health Nursing Officers (PHNO)/Nursing Officers, Development Officers, and Saukya Karya Sahayakas (SKS). A Medical Officer will be appointed as the Medical Officer in Charge (MOIC) of the PMCU.

3.3 Services Provided at PMCUs

PMCUs are expected to provide the following PHC services on an outpatient basis.

- Outpatient care
- Emergency care
- Continuum of care (pre-organized referral system in place)
- Rehabilitative care
- Palliative care
- Diagnostic services
- Medical supplies
- Prevention and management of communicable diseases
- Prevention and management of Non-Communicable Diseases (NCDs)

- Health promotion and community empowerment
- Supportive care for maternal and child health
- Conducting mobile care services
- Disaster preparedness and response
- Basic elderly health care services

The MOIC is responsible for developing plans to implement services, identifying the service requirements of the area, and projecting them to optimize PHC services under the directives of the RDHS. The availability of space, resources, and standard processes and procedures should be considered when delivering services.

3.3.a. Outpatient Care

- Management of common conditions
- Providing facilities to the MOH team to conduct a polyclinic including antenatal, postnatal, family planning, child health / well baby clinic, well woman clinic, etc.
- Minor surgical procedures
- Oral health care
- Patient referral to the apex or higher facilities
- Healthy Lifestyle Clinics (HLC)
- Medical clinics
- Mental health clinics

The service requirements of the empaneled population should be assessed before establishing these services.

3.3.b. Emergency Care

- Identification and stabilization of emergency cases
- Resuscitation with basic life support measures
- Referral: communication and transportation
- Management of minor emergencies

A suitable space with easy access should be identified to provide emergency services with adequate ventilation and light. MO, PHNO/ NO and a supportive staff member should be readily available during working hours in the station to offer the services. The following procedures should be established to offer effective emergency services.

i.) Mechanism to receive patients without any delay

ii.) Triaging mechanism

iii.) Patient registration procedure

iv.) Emergency management protocols for common emergencies

v.) Essential medical/ surgical/ general equipment/ items in the functional state

vi.) Adequate and continuous supply of medical, surgical and general consumables

vii.) Communication methods for calling emergency teams

viii.) Pre-arranged referral system with shared care apex center

ix.) Ambulance service

x.) Emergency care training to all staff – refer to Chapter 4 on Emergency Care

3.3.c. Continuum of Care

PMCUs should provide a continuum of care services to patients on an outpatient basis. When a patient is discharged from a secondary or tertiary care hospital and referred to a PMCU for the continuation of medications, the treating consultant should provide the plan in writing. In such cases, the necessary medical supplies for the patient should be requested by the PMCU from the head of the relevant secondary or tertiary care facility, who will authorize the chief pharmacist to issue the drugs to the PMCU. Additionally, other necessary drugs can be requested from the RMSD if needed.

As the patient receives continuous care from the PMCU, their annual medical supply requirements should be estimated and included in the yearly PMCU estimate to the RMSD. Medical Officers should maintain consistent communication with and seek guidance from clinical and administrative leadership when facing challenges.

3.3.d. Rehabilitative Care

- Assessment of rehabilitation requirements in selected delivery sites
- Referral to rehabilitation departments / hospitals

PMCUs are expected to cover step-down care referred from higher facilities. These services are expected to be provided on a roster basis. MOIC can arrange such services by liaising with the apex hospital.

3.3.e. Palliative Care

- Counseling for patients and their families
- Support self-help groups

- Control of acute and chronic pain
- Delivery of home-based palliative care only at selected delivery sites

The provision of palliative care is a prime responsibility of the Public Health Nursing Officer (PHNO). This service is delivered at the home of the patient if their condition requires it, under the directives of the MOIC.

3.3.f. Diagnostic Services

- Chemical Pathology - blood sugar, total cholesterol, urine albumin (point of care testing)
- Collection of samples for UFR, lipid profile, HbA1C, serum creatinine, FBS, FBC, ESR, ALT and Investigations as per Sri Lanka Essential Health Services Package, Ministry of Health 2019.
- ECG facilities -This service should be assigned to a Nursing Officer. Any Medical Officer/ Nursing Officer should be able to take ECGs if required.

PMCUs are provided with mobile laboratory facilities. MOIC should coordinate with the cluster laboratory to provide uninterrupted services to the patients.

3.4 Medical Supplies

The MOIC should ensure the availability of all essential drugs as per the SLESP and proper storage facilities. All relevant officers should contribute to maintaining the supply chain management of drugs. Additionally, the Pharmacist/Dispenser should request special requirements from the RMSD/apex center to ensure the continuum of care for patients referred for step-down care.

3.4.a. Prevention and Management of Communicable Diseases

In addition to providing services as per the SLESP, the MOIC should ensure that all notifiable diseases are promptly reported to the relevant MOH and other authorities upon suspicion, to aid in the identification of early warning signals and outbreak management. The MOIC must also ensure the proper functioning of infection control activities within the PMCU. The PHNO can be designated as the infection control nurse and should receive training for this role.

3.4.b. Prevention and Management of Non-communicable Diseases

The establishment of HLCs in PMCUs is a mandatory requirement to provide the services in SLESP.

Reference:

- General Circular on ‘Facilities offered at different categories of Medical Care Institutions’ with the No: 01-18/2020, dated 03.03.2020 issued by the Ministry of Health care and Indigenous Medical Services
- Surveillance case definition for notifiable diseases in Sri Lanka, Epidemiology Unit, Ministry of Health

CHAPTER 4

GENERAL AND OFFICE MANAGEMENT

In addition to clinical duties, the MOIC serves as the overall administrator of the PMCU and directly reports to the RDHS. The MOIC should arrange for cover or relief duties from the RDHS whenever they are on leave or duty. Under no circumstances should the PMCUs be closed to the public, except on public holidays or Sundays. The MOIC should be familiar with office procedures and is expected to coordinate with the RDHS and MOH office when necessary. A Saukya Karya Sahayaka may be assigned to support office work. In special circumstances, the MOIC has the flexibility to assign any capable and responsible staff member to assist with office activities.

4.1 Norms on Physical Spaces

There should be a definitive physical space to carry out office functions in a PMCU. At least 300 square feet of space is required to function the MOIC's office and consultation room (150 sq ft) and for the general office (150 sq. ft. in accordance with the stipulated norms **(**General Circular: 01- 29 / 2018).

4.2 Duty Lists

The MOIC should be familiar with the job descriptions and duty lists already assigned to the service categories and should create duty lists based on the services delivered by the PMCU, without violating the existing duty lists. However, the MOIC has the authority to allocate essential duties to the staff following constructive dialogue, and the relevant staff members are accountable for carrying out the duties assigned by the MOIC.

4.4 Attending Meetings

The MOIC is expected to attend all meetings to which they are invited by the RDHS. If the MOIC is unable to attend, they should promptly inform the RDHS of their unavailability and arrange for a representative to attend, if available. Prior preparation with relevant information is required of the MOIC. The MOIC is also responsible for disseminating relevant information to staff members. Additionally, the MOIC should participate in the monthly conference held at the MOH office.

The MOIC should hold regular meetings at the institutional level to address important matters. They are also responsible for establishing essential committees within the PMCU as needed. Committees such as the Hospital Management Committee (HMC), Hospital Development Committee (HDC), Health care Quality and Safety Management Committee, and the 'Suwa Sewa Mithuro' Committee play a vital role in enhancing service development at the PMCU.

4.5 Service Delivery Processes

The MOIC should ensure that service processes and procedures are formulated and implemented in accordance with standard protocols or guidelines. The MOIC may develop new processes as needed, in consultation with the RDHS.

4.6 Management of the Built Environment

All buildings belonging to the PMCU should be locked when the station is closed. The main keys should be kept at the nearest police station or with an authorized officer. The MOIC and all staff members are responsible for ensuring proper closure of the property before leaving the station.

4.7 Institutional Premises

The MOIC should ensure a clean and pleasant environment with appropriate beautification. The premises must be free of garbage and clinical waste (see Chapter 12). The land should be clearly demarcated from adjacent properties by a parapet wall or barbed wire fence.

The MOIC is responsible for keeping copies of the land deeds and survey plans in their office. If the land has not been properly acquired, the MOIC should initiate necessary action with the guidance of the RDHS to acquire the land.

Any income generated from the land should be deposited as per the instructions provided (see Chapter 5).

4.9 Donations

Donations from the community or organizations may be accepted for the development of the PMCUs. However, such donations must align with the organizational requirements identified by the MOIC, and prior permission must be obtained from the RDHS before accepting any donations. The MOIC should ensure that there are no conflicting interests associated with the donations.

Cash donations must not be accepted under any circumstances. All material donations should be recorded in a donation register and relevant inventories, with a copy sent to the appropriate authority. The MOIC should send an acknowledgment letter to the donor once the donation has been received by the institution.

4.10 Community Engagement, Grievance Redress Mechanism, and Conflict Resolution

Each PMCU should prominently display posters along with a mechanism for receiving suggestions, complaints, and other feedback. The MOIC and selected staff members should receive relevant training when offered by the Ministry of Health (MoH). Further information on community engagement and the Grievance Redress Mechanism can be found in the

Guidelines for Community Engagement and Grievance Redress Mechanism published by the Ministry of Health.

The MOIC should be capable of handling conflicts confidently and working towards their resolution. If necessary, the MOIC may seek assistance from the RDHS to manage such situations.

4.11 Security of the PMCU

If security services are not provided by the department, the MOIC may need to arrange for security services with the assistance of the nearest police station.

4.12 Maintenance of Discipline

The MOIC must ensure that all health care workers adhere to proper conduct. Staff members who have been assigned uniforms are required to wear them appropriately during working hours. Any breach of conduct should be reported to the RDHS for appropriate disciplinary action.

Any incidents, such as losses, theft, riots, unrest, strikes, or assaults, should be reported immediately to the relevant authorities, including the RDHS and the police. All incidents should be investigated by the MOIC or a team nominated by the MOIC to determine the circumstances leading to the incident and to record evidence before it is lost or fades away. The investigation reports, along with recommendations, should be forwarded to the RDHS.

4.13 Supervision

MOIC is expected to visit sub-units and service delivery areas to supervise how the services are delivered and to identify the gaps which may affect the service delivery.

4.14 Monitoring

The MOIC should maintain a well-organized database to monitor the functions of each sub-unit. Data from daily OPD/clinic attendance registers, transfer registers, public complaints, and other relevant sources can serve as a valuable database to enhance the services provided at PMCUs.

4.15 Surveys and Clinical Audits

MOICs are expected to conduct small-scale surveys, such as patient satisfaction surveys, hand hygiene surveys, and others. The Directorate of Health Care Quality and Safety has published standard tools for conducting such surveys (see Chapter 10). Clinical audits and research are also encouraged to enhance PHC services.

4.16 Performance Reviews and Progress Report

MOICs are expected to conduct periodic performance reviews at the institutional level, in addition to the mandatory reviews prescribed. Reporting the annual progress of the PMCU will help monitor its trajectory and facilitate the identification of areas for improvement. This process also supports the administrative hierarchy in further strengthening the facility.

4.17 System Developments

Surveys, research, monitoring, and evaluation of PMCUs provide valuable insights that contribute to the further development of PMCUs and other health services. MOICs and the staff of PMCUs are responsible for guiding the facilities towards achieving the desired objectives of primary health care.

4.18 Instructions to MOICs

MOICs are expected to have copies of the Establishment Code volumes I and II and refer to them as needed, in addition to this manual. They should also maintain copies of circulars, guidelines, and other publications relevant to general administration, which may be available online or as hard copies. The MOIC's administrative decisions should always be guided by these documents, unless otherwise specified by higher administrative authorities.

4.19 Information and File Management

MOIC should be familiar with the formats of office registers, those developed for special functions, and all types of leave forms. Additionally, the MOIC may introduce new registers or files based on the specific requirements of the institution.

Certain files and registers are mandatory to be maintained in the office and are often subject to auditing. Therefore, MOICs are advised to ensure that these mandatory files are readily accessible at all times. Below are some of the registers, files, and formats that must be kept at the station.

4.19.a Attendance and leave related registers

i.) Attendance register G-18

ii.) Leave register G-190

iii.) Hospital attendance roll H-105

iv.) Diary of MOO -H-99 / PHNO diary

v.) Relief duty diary

vi.) Visitors’ book

vii.) Duty leave book

viii.) Short leave book

ix.) Going out for work book

x.) Diary of MO's H-99 / PHNO diary

xi.) Details on staff training book

xii.) MOIC duty/ other staff handing over book

At the end of each month, attendance should be checked and returns should be sent to the RDHS office.

4.19.b Registers of counterfoil books (Government Agent H-20)

i.) Issue order book -G-141

ii.) Receipt order book- G-219

iii.) Private medical book- H-307

iv.) W.P. cash receipt -G-1

v.) Request note -H-500

vi.) Medical certificate – SKS

vii.) Medical certificate major staff- 170

viii.) Medical certificate - private

ix.) Railway warrant book – RAB-70

x.) Laundry account -H -87

xi.) Register of holiday warrant -G-164

xii.) Receipt issue book-287

4.19.c Other registers

i.) Register of remittance received and disbursement-696

ii.) Dispatch register

iii.) Miscellaneous cash register

iv.) Consumable register

v.) Donation register

vi.) Inventory registers -H-311

vii.) General inventory -H-287

viii.) Surgical inventory book

ix.) Consumable register

x.) Drug inventory H-287

xi.) Building inventory

xii.) Remittance register

xiii.) Petty cash register

xiv.) OPD register

xv.) Clinic registers

xvi.) Notification register

xvii.) Complaints/ suggestions book / box

xviii.) Hospital development committee/ "Suwa Sewa Mithuro" committee meeting minutes and attendance

4.19.d Registers and files related to service delivery

i.) OPD register

ii.) Clinic register

iii.) ETU, A & E, PCU admission register

iv.) Discharge/transfer book

v.) On admission death register

vi.) Referral register

vii.) Laboratory investigation register

viii.) Appointment register – for dental care

ix.) Call register – for service matters

x.) Complain box and register

xi.) Health care quality related registers and files

xii.) Maintenance/repair requests file/register

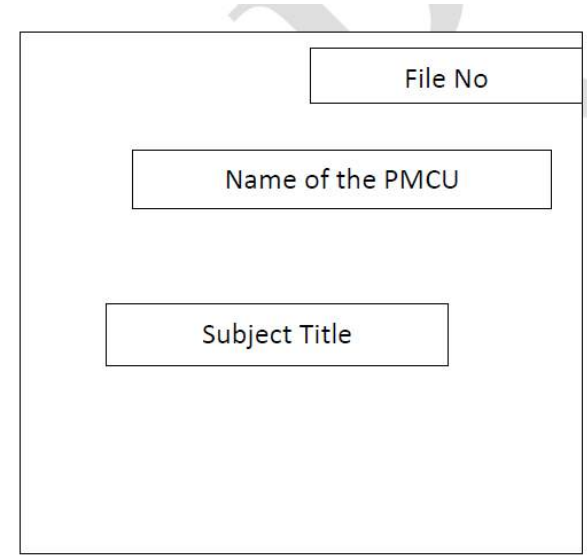
xiii.) Supplies and logistic register

xiv.) Any register/file which may be required according to the services provided by a given PMCU

4.19.e File management

Letter writing, e-mail management, telephone conversations, minutes writing, speeches and all other forms of formal channels of communication methods should be practiced effectively in office management.

The following format is suggested for labeling office files:



Front Cover – Outer

Date	Ref To	Date	Ref To

Front Cover- Inner

Fig 4.1: Front side of an office file

Inside the file, communications should be arranged chronologically on the right-hand side. Each page of communication, referred to as a folio, should be numbered sequentially from the bottom upwards. Minute sheets should be affixed to the left-hand side of the file. The following format may be used for the minute sheets:

Ref to.	**Minutes**
Director	M 1 F 1 – 7 is referred to you for approval ……. …….. (Date) (Signature)
DD	M 2 F 1 - 7 is approved ……. …….. (Date) (Signature)

Fig 4.2: Format of a minute sheet (Reference)

Documents should be organized according to the following categories of functions.

- Establishment matters related to documents/communications
- Financial matters related documents /communications
- Development and planning related documents/communications

In addition, circulars, guidelines, protocols, and other management-related documents should be kept compiled under each category.

4.19.f The following files are mandatory and must be maintained in accordance with departmental guidelines:

i.) Correspondence with RDHS/ MOH

ii.) Communication files for staff categories – MOs, NOs, Paramedical, SKS etc

iii.) Unit communication files – requests from main units in the PMCU

iv.) Maintenance files

v.) Ambulance movement file (keep all correspondences relevant to patient transfers)

vi.) Correspondence with other organizations

vii.) Inquiry file

viii.) Miscellaneous file

ix.) Common file

x.) Circular file

xi.) Referral to the MOIC file

4.19.g Files to be maintained for financial purposes

i.) Correspondence with MOIC/ RDHS/ Accountant

ii.) The budget request, expenditure, and local purchase file

iii.) Miscellaneous file

iv.) Common file

v.) Circular file

4.19.h Development or planning-related files to be maintained

i.) Annual action plan

ii.) Development plan (Ex: 5-year development plan)

iii.) Survey plans and building layout plans, architectural plans

iv.) Project files (Ex: PSSP, HSEP, etc)

v.) Project proposal file

vi.) Training file

vii.) Health care quality and safety files

viii.) Survey file

ix.) Complaint file

x.) Research file

xi.) Publication file – Annual Health Bulletin, paper articles, journal articles, symposia, abstracts, poster presentations, etc

The MOIC has the authority to maintain or discontinue any file based on the work plans related to primary subjects. It is important to note that the list provided above is not exhaustive and may be adjusted to align with the specific functions and operational needs of the PMCU.

4.20 Correspondence Management

MOICs should maintain proper channels of communication in all of their correspondences.

The following method may be adopted according to the requirement of communication:

Step 1: Identify the action addressee who can provide the answer to the query.

Step 2: Identify other stakeholders who can support the action addressee in solving the problem and copy the letter to them.

Step 3: Identify the level at which the problem could be addressed (district level, provincial level, or national level).

Step 4: Formulate the topic or heading properly (short and comprehensive).

Step 5: Identify previous references on the same topic or issue under discussion (if any) and indicate them underneath the topic.

Step 6: Write a concise paragraph on the background of the topic (one or two sentences). Some letters may only need one paragraph, so be concise and considerate about the topic of the letter and its length accordingly.

Step 7: In the second paragraph, write about the gravity and implications of the issue.

Step 8: In the third paragraph, write the request.

Step 9: Finish the letter by placing the signature, designation, and contact number and adding the copy list at the bottom of the letter.

Additional tips for generating correct communication.

i.) Identify the administrative hierarchy and channel of communication - Ensure proper understanding of the hierarchy. This is especially important when addressing letters to higher levels through middle-level managers and preparing the list of individuals to copy the letter.

ii.) Use of Attention (Atten:) - Include "Attention (Atten:)" when a letter is addressed to the head of a department, but the action needs to be carried out by a deputy or another senior officer.

iii.) Enclosure - Attach all relevant documents whenever necessary. Include a list of enclosures below the signature section of the letter.

iv.) Keep the letter concise and informative -Ensure the letter is short yet contains all essential information.

v.) Single-purpose letters - Draft one letter for a single request. However, multiple requests may be included in a single letter if they fall under a generic heading (e.g., furniture requests, equipment requests).

Try to save paper by using half pages, using emails etc whenever possible.

4.21 General Advice to MOICs:

Most of these registers, files, and formats contain mandatory information that must be maintained. All documents should be securely stored under lock and key and be readily accessible when required. Past documents should be preserved in a secure location, such as a general record room, until they are appropriately discarded.

4.22 Routine Office Work

- Preparing and sending vouchers to RDHS office. Ex: water, electricity, telephone bills
- Sending quarterly OPD & clinic return

Model Letters

Model Letter 1: Material or financial requests from higher authorities

(Letter Heading)

eference No: (file no)

Date:

Regional Director of Health Services, Kalutara

Request for laboratory services

The DH Aluthgama provides both outpatient (OPD) and inpatient services, with a daily OPD turnover of approximately 200–250 patients and 20–30 inpatient admissions. On clinic days, these numbers increase to about 500 patients. Many of these patients require blood tests, and the daily average number of blood tests is around 300.

Currently, the PMCU Dediyawala lacks the facilities to conduct blood tests, which has created a significant challenge in providing comprehensive care to our patients. Additionally, I do not have the financial authority to purchase these tests locally.

In light of the above, I kindly request your assistance in arranging for a mobile laboratory or an alternative method for conducting blood tests at the PMCU Dediyawala at the earliest possible opportunity. This will greatly enhance our ability to provide timely and effective care for the patients.

Thank you for considering this request. I look forward to your prompt response and am available for any further information or clarification.

Dr K S Samaraweera

MOIC

PMCU Dediyawala

Copy: Provincial Director of Health Services, Western Province

References,

- Revised Guidelines for Community Engagement and Grievance Redress Mechanism for the Primary Health care, Ministry of Health , 2023

CHAPTER 5

FINANCIAL & ASSET MANAGEMENT

Financial management is a crucial function in any government institution, ensuring that financial resources are utilized efficiently and effectively to achieve organizational goals. This process encompasses planning, organizing, controlling, and monitoring financial resources to ensure optimal use and accountability.

The financial management of PMCUs plays an essential role in the broader financial system of the RDHS. The MOIC of the PMCU is responsible for overseeing financial management within the PMCU, ensuring that all financial activities comply with established protocols and guidelines. This includes managing budgets, maintaining financial registers, and adhering to the financial policies as directed by the RDHS.

Effective financial management practices help the PMCU achieve cost containment and optimize resource use. Proper budgeting and financial tracking minimize unnecessary expenses, improve asset management, and reduce the risk of errors and financial discrepancies. Additionally, maintaining clear financial documentation, such as bookkeeping records and financial registers, is essential for ensuring transparency and accountability.

5.1 Financial Management Practices in PMCUs

The primary financial functions carried out in the PMCU include the management of revenues, petty cash, expenditures, and inventories. It is crucial to maintain accurate financial records and registers in accordance with standard protocols, as these documents are subject to periodic audits. The MOIC should regularly consult with the RDHS to ensure that all financial activities are managed effectively and in compliance with established guidelines and regulations.

5.2 Revenue (Payment Collection)

The main revenue source for a PMCU is the payments received for the issuance of medical certificates. The Medical Officer (MO) issuing the medical certificate must ensure that the stipulated amount is charged from the patient, and a receipt (General 172) is issued to confirm the transaction. This transaction should be recorded in the revenue register, noting the invoice number and the medical certificate number.

The MOIC is responsible for periodically debiting the collected revenue at the PMCU to the bank account of the RDHS office, through the Shroff, by completing a Paying-in Voucher (PIV). Revenue collected at the PMCU cannot be used for any other purpose without prior approval from the RDHS.

For payment collection, the following procedures should be followed: when cash is received, an official receipt on form General 172 should be issued using double-sided carbon. The

officer-in-charge remains responsible for ensuring this process is followed correctly.

The head of the institution should regularly verify these entries against the actual money orders to ensure the cash has been remitted and that entries in the register are genuine. An official receipt from General 172 should be obtained from the PDHS or RDHS office in respect of any remittance made and should be filed for record-keeping. The head of the institution should also check these receipts against the actual money orders to ensure that receipts correspond to all remittances.

MOICs should also be aware of other potential revenue sources, such as income from home gardening, selling of solid waste, and rentals. These revenue streams should be appropriately recorded, and the amounts should be deposited into the RDHS account through a Paying-in Voucher (PIV).

5.3 Petty Cash Imprest

PMCUs are allocated a petty cash imprest to cover day-to-day miscellaneous expenses. The amount of petty cash imprest and the maximum amount that can be spent at any given time will be communicated by the relevant RDHS office. At the beginning of the year, a petty cash cheque will be issued from the RDHS office, which should be cashed by the MOIC.

The MOIC may locally purchase items such as office consumables, stationery, fuel for lawnmowers, etc., which are not provided by the RDHS office and should obtain receipts from the vendors. When half of the imprest has been spent, a voucher must be prepared, including all bills, and forwarded to the RDHS office for reimbursement.

5.4 Expenditure

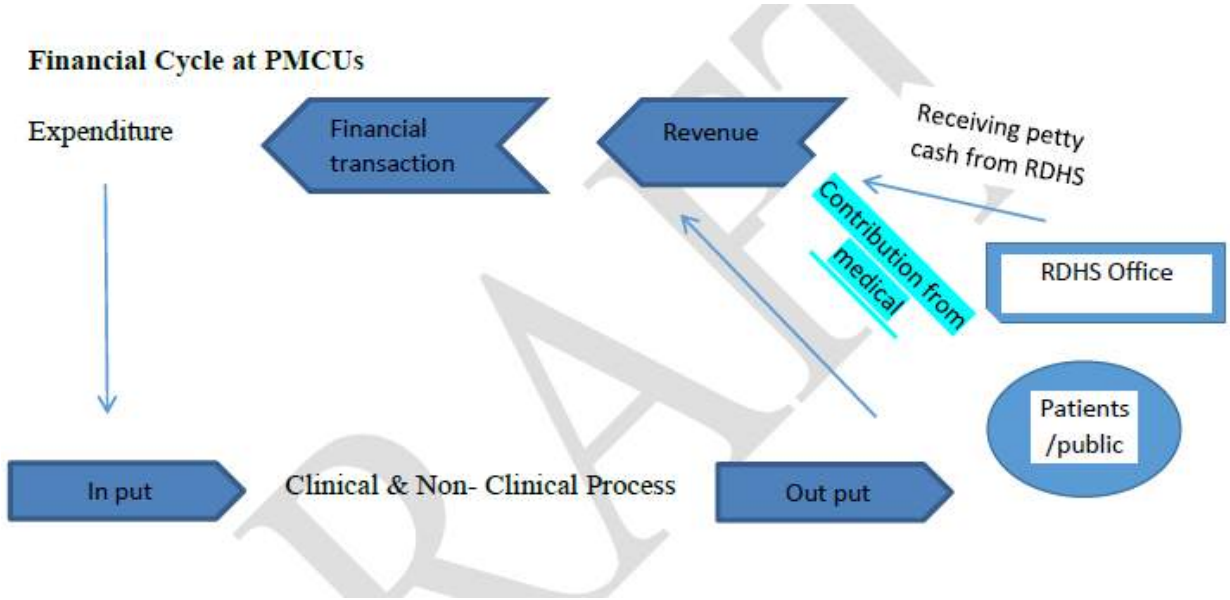
Expenditures at the PMCUs are controlled by the MOIC. All payment vouchers, except those settled by petty cash, should be forwarded to the RDHS office for processing. The subject clerk in charge should maintain records of each voucher forwarded to the RDHS office. Therefore, it is necessary to keep a register for all expenditure to ensure proper documentation and tracking.

5.5 Bookkeeping and Reporting

Bookkeeping includes the basic recordings of each and every transaction undertaken by the relevant PMCUs. E.g.: - cash register, register for detailed extra duty vouchers (for internal decision makings), fuel register, register for vehicle maintenance, and inventory register etc. related to maintaining registers for all the income and expenditures (capital and recurrent) which are forwarded to the RDHS office for the financial procedures.

The registers such as report of institute accounts, forwarded payment voucher registers, asset management registers, stock verification registers and budgeting and bookkeeping are maintained under the supervision of the MOIC.

Payment vouchers prepared at the PMCU are forwarded to the accounts branch of the RDHS office for the payment process. The monthly expenditure report should be prepared by the in-charge subject clerk of the relevant institute. The expenditure registers should be maintained by considering the vouchers that are received for particular payments.



5.6 Inventory Management

PMCUs should maintain an asset register, which must be updated monthly. All assets should be clearly labeled. The physical inventory should be reconciled with the asset register annually, and any discrepancies should be investigated and analyzed. The disposal of assets requires the MOIC's approval, and proper documentation should be maintained until the assets are handed over to the RDHS office by the relevant institution. The RDHS office is responsible for maintaining manual inventory books and confirming receipt of equipment to the relevant institution by issuing a receipt order, referencing the corresponding inventory book page.

5.7 Petty Cash Imprest Ledger

Heads of the institution should maintain separate registers for each type of imprest granted, using a specific form. The receipt of the imprest should be debited, and payments should be credited in the petty cash ledger. The register should be balanced daily, with the balance in the register verified and tallied with the cash in hand before being deposited in the safe. To ensure sufficient petty cash funds, it is recommended to replenish the petty cash at least once per month, with the reload completed no later than the 25th of each month. However, the Head of the Institution should take necessary action to renew the imprest when 40% of the imprest has been used.

5.8 Daily Cash Balance Statement Register

A record of the balance of money in hand should be prepared at the end of each day in a register. This record should include the balance of petty cash, miscellaneous cash collections, postal imprest, and any other relevant funds. The register should be maintained accurately to ensure transparency and accountability in financial management.

5.9 Custody of Safe Keys

Cash and other valuables should be securely stored in the safe, with the officer in charge responsible for their safekeeping. The keys to the safe must be in the personal custody of the MOIC. In the event of the MOIC's absence, arrangements for the custody of the safe key should be made by the Head of the Institution in consultation with the PDHS and RDHS. A duplicate key of the safe should be treated with anticorrosive and deposited at the treasury for safekeeping. In the event the original key is lost, it is crucial to report the loss immediately to the RDHS/PDHS office without delay.

5.10 General Instructions to MOIC:

MOICs are expected to be well-versed in the provisions outlined in the Financial Regulations (FR), Establishment Code (E-Code), provincial-level financial and establishment regulations, Finance Ministry and Treasury Circulars, General Circulars, and other relevant documents pertaining to financial management. It is advisable to seek guidance from the RDHS or Accountants when dealing with financial matters where instructions are unclear. In cases involving special financial allocations, utmost care should be exercised to ensure strict adherence to the provided instructions, preventing any violations.

CHAPTER 6

HEALTHY LIFESTYLE CENTERS

The Directorate of Non-Communicable Diseases (NCDs) of the Ministry of Health initiated Healthy Lifestyle Centers (HLCs) in 2011 to establish a structured NCD screening service through PMCUs.

The primary objective of HLCs is to reduce the risk of NCDs among individuals aged 35 years and above by identifying risk factors early and improving access to specialized care. Clients screened at HLCs are assessed using the World Health Organization/International Society of Hypertension (WHO-ISH) risk prediction chart and other relevant guidelines.

HLC sessions are expected to be conducted at least once a week, with an anticipated daily attendance of approximately 20 clients per session.

6.1 Services Provided at Healthy Lifestyle Centers (HLC)

i.) Registration of all eligible clients

ii.) Explanation of all procedures to clients

iii.) Anthropometric measurements (height, weight, Body Mass Index calculation, waist circumference, waist: height ratio)

iv.) Visual acuity check

v.) Clinical breast examination

vi.) Oral examination (for oral potentially malignant diseases)

vii.) Biochemical tests (capillary blood sugar and total cholesterol)

viii.) Assessment of ten-year cardiovascular risk using WHO Risk Prediction Chart (Country Office for SEAR B) 2019

ix.) Health promotion initiatives including lifestyle modification advice and counseling carried out:

- Physical activity promotion sessions, healthy cooking
- Counseling for cessation of tobacco and alcohol, physical activity promotion, and a healthy diet

x.) Referral and follow-up

6.2 Eligible Clients Who Could be Screened at HLCs

i.) Eligible Category A

The primary target group includes individuals aged 35 years and above who are apparently healthy. This group consists of those who have not been diagnosed with, nor are on routine follow-up for, cardiovascular diseases (coronary heart disease, cerebrovascular disease, hypertension), diabetes mellitus, cancer, chronic kidney disease, chronic liver disease, and dyslipidemia; and have no documentary evidence of routine follow-up.

ii.) Eligible category B

If the participant is in the age group of 20-34 years but has any of the following risk factors, he/she should be screened.

i.) Smoking tobacco during the past year

ii.) Overweight and obesity (BMI $\geq$ 25kg/m^2)

iii.) Abdominal obesity (waist circumference – male > 90 cm, female >80cm)

iv.) Raised BP ($\geq$ 140/ 90mmHg)

v.) Symptoms suggestive of diabetes mellitus

vi.) History of premature cardiovascular disease in first-degree relatives (male relative < 55 years, female relative < 65 years)

vii.) History of diabetes mellitus in first-degree relatives

viii.) History of familial dyslipidemias in first-degree relatives

6.3 Registration of Clients

Each client is checked for eligibility to participate in the NCD screening program prior to registration.

The medical history of each client is checked for the following:

a.) For individuals with a documented medical history who are under treatment and routine follow-up, evidence such as a clinic book or diagnosis card is required. These clients should not be registered at the HLC and should be encouraged to continue their routine follow-up.

b.) Participants with a medical history who are not under regular follow-up and lack documentary evidence should be registered at the HLC and screened accordingly.

c.) Participants with a medical history who are not under regular follow-up but have documentary evidence should be redirected to the medical clinic to recommence their medical management.

Each client is issued a Personal Medical Record (PMR) upon registration. A blue PMR (H1309) is provided for males, and a pink PMR (H1310) is issued for females.

6.4 Referral and Follow-up

Participants without risk factors or with a cardiovascular disease (CVD) risk of less than 10% should be reviewed at least once every three years at the Healthy Lifestyle Center (HLC). Those with modifiable risk factors or a CVD risk between 10% and 20% require more frequent reviews, as outlined in the *National Guideline for Cardiovascular Risk Management* (3rd Edition), published by the Non-Communicable Diseases Directorate of the Ministry of Health.

The Medical Officer will make the final decision regarding follow-up and referrals, considering the participant's clinical, social, and cultural circumstances. Clients referred to medical clinics are not eligible for follow-up at HLCs.

6.5 NCD Screening Process at HLC

i.) Registration and screening procedures

a) Eligible Registration

- Individuals aged 35 years and above are eligible for screening.
- Each participant is issued a Personal Medical Record (PMR).

b) Target Population - comprises apparently healthy individuals aged 35 years and above, estimated to be 40% of the mid-year population.

c) History Taking - comprehensive history including past medical history, family history, lifestyle & behaviors - sedentary or not, smoking/smokeless tobacco use, alcohol, betel chewing, dietary habits etc.

d) Examination - includes weight, height, and Body Mass Index (BMI); visual acuity; waist circumference and waist-to-height ratio; blood pressure (BP); clinical examination of the heart, lungs, breasts, and oral cavity

e) Investigations - FBS/ RBS, total cholesterol (with glucometer/cholesterol meter)

f) CVD risk assessment (WHO risk prediction chart 2019)

g) Health promotion to reduce risk - participants are guided on lifestyle modifications, including:

- Exercise prescription
- Nutrition counseling
- Brief intervention for tobacco cessation
- Counseling for alcohol cessation

h) Referrals

i) Follow-up

ii.) Online Database Maintenance (HIMS Database and Returns)

a) HLC participant registers: H1236A, H1236B

b) Follow-up register: H1237

c) Daily Summary: Activities conducted for screening are documented using H1238.

d) Monthly Reports: NCD screening activities are summarized in H1239 and sent to the district level.

CHAPTER 7

ORAL HEALTH CARE SERVICES

7.1 Introduction

Oral health is an integral component of health care services in Sri Lanka. Dental Surgeons (DSs) within the hospital network across the country play a vital role in providing oral health care services to the population. Oral Health Units (OHUs) function as part of the Outpatient Department (OPD) in Primary Medical Care Units (PMCUs).

The objective of the oral health care service is to deliver comprehensive oral health care, encompassing both preventive and curative services, to the public.

The OHU is staffed by a Dental Surgeon (DS) and a Nursing Officer (NO) / Saukya Karya Sahayaka (SKS). Retaining trained Nursing Officers or other supportive staff in the OHU for at least two (02) years is encouraged to enhance the productivity and efficiency of the service. (Refer to General Circular No. 1757, dated 23/09/1981.)

A Dental Surgeon is required to serve a minimum of two (02) years at a station to be eligible for transfer. In the event of a transfer order, the Dental Surgeon should be released only if a proper replacement or covering arrangement has been ensured.

An OHU in a PMCU should have the following basic equipment:

a) Dental chair/unit per DS

b) Mini autoclave or sterilizer

c) Dental instruments (Annexure 2)

d) Dental materials and drugs (Annexure 2)

e) Furniture and hardware

To procure new equipment for the OHU, it is necessary to place orders through MOIC to the RDHS

Leave taken by the DS must be approved in advance by the head of the institution. If the DS requires leave exceeding two days, they should inform the RDHS, arrange relief from the closest station, and notify the head of the institution.

7.2 Range of Services and Procedures

Greater attention should be directed toward preventive aspects of oral health care, including oral health promotion, disease prevention, screening, cleaning, fluoride application, and sealant application to prevent cavities. Primary oral health care providers should educate patients on proper oral hygiene practices, such as brushing and flossing, and provide counseling on lifestyle behaviors, including tobacco cessation and adopting healthy dietary habits. Opportunistic screening for Oral Potentially Malignant Disorders (OPMDs) and oral

cancer should be conducted for all patients visiting the dental clinic. Priority for screening must be given to individuals referred by PHC staff or self-referred individuals.

Curative services provided include managing dental pain, treating dental trauma, performing extractions, simple restorations, scaling, and minor oral surgeries, such as incision and drainage and apicectomies. Selected root canal treatments are also offered. Appointments for procedures like permanent restorations should be scheduled for afternoon sessions. When time permits, the dental officer should engage in health education activities in the outpatient department. Dental staff must also be prepared to attend to emergencies without delay.

Oral health care for pregnant mothers focuses on improving the oral health of both mothers and young children by providing comprehensive care during prenatal and antenatal periods. A specific time for these services should be allocated in all PMCUs and OHUs, with at least one session per week dedicated to pregnant mothers. Saturday mornings are reserved for children, although adults may be treated during this time if the schedule permits.

Patients whose needs exceed the scope of general dental care should be referred to the nearest specialist dental clinic, where advanced restorative treatments, orthodontic procedures, and complex oral surgeries are conducted by dental consultants. Cases referred back to the general clinic should be followed up thoroughly, ensuring the patient's oral health improves in accordance with the treatment plan.

Stringent attention must be given to the proper sterilization of dental instruments. The Dental Surgeon should supervise sterilization procedures and ensure that the clinic is maintained in a clean and orderly condition. Sufficient time must be dedicated to delivering high-quality care to patients. Additionally, patients should be educated about their oral health and provided with information on further treatment requirements

7.3 Record Keeping

The patient's history, a charting of the mouth, and the treatment provided should be recorded on the treatment card by the Dental Surgeon (DS) and filed or preserved for future reference. The patient's registration number, name, and details of the treatment provided must be systematically entered into the patient register. Daily entries should be documented in Form H 1201 in triplicate. These records must be forwarded to the Research and Surveillance Unit at IOH Maharagama and the Regional Dental Surgeon before the 5th of the following month, with the third copy retained in the clinic for reference.

7.4 Recommended List of Instruments and Equipment (For a New Oral Health care Clinic)

- Dental chair, dental handpiece (high-speed and micromotor – straight and contrangled) suction apparatus
- Sterilizer electric / non-electric
- Aseptic table

- Instrument cabinet
- Instrument tray with lid (aluminium/stainless steel)
- Micro-motor hand piece (straight & contra-angle)
- Cheatle forceps
- Tooth extracting forceps
- Root elevators (W. James, Coupland, Winters – Right & Left)
- Extracting tweezers (locking & un-locking)
- Amalgam carver & amalgam carver (Wards)
- Scaler unit
- Mortar & pestle
- Light cure unit
- Mercury holder
- Mixing slab - glass
- Matrix bands & matrix strips
- Burs stand
- Silver alloy
- Zinc phosphate cement powder & liquid
- Finishing strips
- Waxed Nylon floss Eugenol 30ml
- Zinc Oxide powder
- Composite filling material (full pack)
- Cellulose strips
- Stain remover
- Prophylaxis paste jars
- Tooth polishing brushes
- Bristle brushes
- Mercury 30G
- Mouth wash bottles
- GIC – anterior & posterior
- Sodium Hyphochlorite 3% - 6% solution

- Gutta Percha (GP) – 15-40, 45-80, auxillary, auxillary medium, F-medium
- GP solvent
- Paper points
- Root canal sealers (Calcium Hydroxide base)
- Root canal files
- Surgical spirit
- Surgical blades (as required)
- Suture materials (as required)
- Syringes (as required)
- Necessary diamond & TC burs
- Saline
- Scalpel handle
- Dental model & brush
- Bonding agents
- Acid etchant
- EDTA gel
- Vaseline
- Cavity liner
- Matrix band holders
- Calcium Hydroxide

CHAPTER 8

LABORATORY SERVICES

8.1 The Present State of Laboratories in Primary Medical Care Units

According to the 2019 laboratory guidelines, health care institutions are categorized into four levels, from Level 1 to Level 4. Tertiary care institutions are classified as Level 4, while secondary care institutions (Base Hospital Type A and B) fall under Level 3. Primary Medical Care Institutions (PMCIs), which include divisional hospitals and PMCUs, are categorized as Level 2 and Level 1, respectively.

PMCUs provide the most basic level of laboratory testing services, as they do not have Medical Laboratory Technologists (MLTs). These institutions offer limited Point-of-Care Testing (POCT) facilities to the empaneled population. Point-of-Care Testing (POCT) refers to laboratory testing typically performed by non-laboratory staff, such as medical and nursing personnel.

Point-of-Care Tests can be conducted in two ways:

i.) POCT device using strips: (E.g., capillary blood sugar by Glucometer, total cholesterol, urine analysis test strips for protein, glucose, and ketone bodies).

ii.) POCT diagnostic devices with disposable single use cartridge/cassette/ reagent disk which contain multiple tests: (E.g., blood sugar, cholesterol, serum electrolytes, UFR, HbA1C etc.)

Laboratory tests that cannot be performed at the PMCU should be carried out at Level 2 divisional hospitals or Level 3 base hospitals, to which samples must be transported safely and securely. Base hospitals (Type A and B) have laboratory consultants, medical laboratory technologists (MLTs), and other laboratory staff to perform these tests. In some cases, samples may be sent to District General Hospitals or Teaching Hospitals offering Level 4 laboratory services. Prior arrangements must be made with the concerned hospital staff, including the Medical Superintendent, Director, Laboratory Consultant, or Senior Medical Laboratory Technologist (SMLT), before transporting specimens from PMCUs.

A schedule should be developed for each non-urgent sample, adhering to the pre-agreed quota. Support, guidance, and supervision from relevant regional or provincial administrative authorities, such as the RDHS or PDHS, are essential to ensure the process runs smoothly and to prevent errors or conflicts.

The transportation of samples should be organized by the respective PMCUs under the guidance of the RDHS or cluster manager.

8.2 Objective

a) To provide timely and quality laboratory reports to the Medical Officers who are responsible for managing patients effectively at the PMCUs

b) To facilitate efficient utilization of laboratory cluster services

8.3 Mode of Performing Laboratory Investigations at PMCUs

The mode of conducting laboratory investigations should be determined by the district health authorities in collaboration with the respective Provincial Director of Health Services (PDHS).

a) Use of Point of Care Testing (POCT)

b) Use of level 2 laboratories at Divisional Hospitals in the district.

c) Laboratory service network/distance laboratory service can be used (collecting specimens from the PMCUs (feed-in institutions) and delivering specimens and performing tests at a referral laboratory).

d) Provision of mobile laboratory service on a designated day.

8.4 Transportation Models

The Ministry of Health has identified three transportation models, and selecting the appropriate model is the responsibility of the Provincial Director of Health Services or Regional Director of Health Services.

a) Pick up by referral hospital

b) Delivery by feed-in institutions

c) Hybrid (combination of both above)

Selecting the most appropriate transportation model for each network cluster is critical. If specimens cannot be transported to the laboratory and the results returned to the feed-in institutions promptly, the entire network risks failure. Therefore, it is vital to choose a transportation model that is effective under the specific conditions of each cluster. Factors such as geographical terrain and road conditions must be thoroughly assessed, and the feasibility of the chosen model verified before making a decision.

8.5. Categorization of Laboratory Investigations

8.5.1. Basic Investigation Package

The following investigations are identified as being available at the PMCU. These tests can be performed using Point-of-Care Testing (POCT) devices, such as strips or disposable single-use cartridges, cassettes, or reagent disks. Alternatively, samples may be transported to a higher-level laboratory for testing.

Category	Investigation	From strip/ POCT Machine	From Distance Lab service
Haematology	ESR	NO	YES
	FBC	NO	YES
	MP	NO	YES
	Blood picture	NO	YES
Chemical Pathology	Blood glucose	YES	YES
	*S. Creatinine	NO#	YES
	*ALT/ AST	NO#	YES
	Total cholesterol	YES	YES
	*Lipid profile	NO	YES
	*CRP	NO#	YES
	*Urine microalbumin to Creatinine ratio	NO	YES
	*HbA1C	NO	YES
	UFR	NO	YES
	Urine for bilirubin	YES	YES
	Urine for glucose	YES	YES
	Urine for ketone bodies	YES	YES
	Urine for proteins	YES	YES
	Urine for reducing substances	YES	YES
	Urine for urobilinogen	YES	YES
	Urine for HCG	YES	YES

	Stool full report	NO	YES
Microbiology	AFB	NO	YES
	Urine/stool direct microscopy	NO	YES
	Specimens for culture	NO	YES
Histopathology	PAP- smear	NO	YES

Table: 8.1 Basic Investigation Package for OPD/ Clinic Patients

** It is recommended to get these tests done from a more cost-effective distant laboratory service; (either L2 or L3)*

 # However, POCT diagnostic devices with disposable single use cartridge/cassette/ reagent disk which contain different test panels are available in remote PMCUs, these can be used to detect acute conditions of the OPD patients which warrants urgent diagnosis and should not be used for clinic/follow up patients and screening purposes as these are not cost effective.

8.5.2 Investigations to be Performed for Disease Screening

Category	Investigation	From Strip/ POCT machine	From Distance Lab service
Healthy Lifestyle Clinics (HLC)	Fasting blood glucose	YES	YES
	Urine albumin	YES	YES
	Total cholesterol	YES	YES
	S. creatinine	NO	YES
Well Woman Clinic	Blood sugar	YES	YES
	PAP smear	NO	YES
Antenatal / Maternal / Child Health	Full blood count	NO	YES
	HIV/ VDRL* samples are to be sent to district STD clinics	NO	YES
	Urine full report**	NO	YES
	Blood glucose	YES	YES
	Oral Glucose Tolerance Test (OGTT)	NO	YES

Category	Investigation	From Strip/ POCT machine	From Distance Lab service
	Blood grouping & Rh* sent the nearest blood bank	NO	YES
Thalassemia screening	FBC (Details to be discussed with the nearest Thalassemia center and the consultant haematologist)	NO	YES

** To be sent to STD clinic and Blood Bank*

*** However, urine sugar/ albumin can be detected at anti natal /well women clinics by using strip method.*

8.5.3 Investigations Relevant to Communicable Diseases

Category	Investigation	From Strip/ POCT machine	From Distance Lab service
Dengue	FBC/ Platelet count/ packed cell volume	NO	YES
Tuberculosis	Sputum for AFB	NO	YES
Malaria	Blood film for MP *Rapid diagnostic test for Malaria (RDT-Ag)	YES	YES

**If the RDT-Ag kits are available at the PMCU. Unless blood sample has to be sent L2 or L3 laboratory*

Specimen transportation to the nearest laboratory, whether at a divisional hospital or apex hospital, should be arranged based on the probable diagnosis of the patient. For example, in suspected cases of leptospirosis, it is recommended to transfer the patient to an apex hospital where a comprehensive range of laboratory tests can be performed. In cases of suspected tuberculosis, a sputum sample for Acid-Fast Bacilli (AFB) testing can be transported as it does not require immediate action. Similarly, samples for Urine Full Report (UFR), Erythrocyte Sedimentation Rate (ESR), and Full Blood Count (FBC) can be sent to a Level 2 laboratory where a medical laboratory technologist is available.

Tests like lipid profiles and HbA1c are relatively expensive and should not be performed as routine investigations. Primary medical care doctors are advised to refrain from ordering tests such as C-Reactive Protein (CRP) without clear clinical indications, as they are

accountable for the costs incurred for such investigations. Rational use of laboratory investigations in government hospitals must be ensured in accordance with Health Ministry circular D/LS/NLP/let/2010.

8.6 Sample Collecting Centers (Laboratory Service Network) for Hospitals without Laboratory Facilities (Feed-in Institutions)

The laboratory service network will designate one laboratory at a referral hospital and several feed-in institutions within its catchment area as a single "network cluster." This arrangement enhances patient accessibility and affordability to laboratory services, allowing them to receive the necessary care at their nearest institution.

To maximize the benefits of this laboratory service, feed-in institutions must take the following factors into consideration:

8.6.1 Collection Premises

The collection premises must adhere to the following requirements:

a) It should be located in an easily accessible area for all, including staff, patients, and individuals with disabilities.

b) The premises must have an easily cleanable surface designated for clerical work, specimen collection, and specimen handling.

c) A suitable and secure storage facility for supplies must be provided, with access restricted to authorized staff.

d) The floor covering must have a non-porous surface to maintain hygiene.

e) Patients' toilets should be kept clean and dry at all times. The toilet door must be lockable from the inside and unlockable from the outside in case of an emergency, and the door design should accommodate wheelchair access for disabled individuals.

f) Specimen collection times should be clearly displayed, along with public-facing information regarding patient preparation.

g) Instructions for patients should be provided in three languages or other formats relevant to the population served.

h) The collection area must be separated from the waiting area to ensure patient privacy.

8.6.2. Equipment, Supplies, and Consumables Required

a) Refrigerator with freezer: to keep specimens at 2- 8 C when immediate transport is not available. A freezer is needed to prepare ice packs for the cool box.

b) Syringes with needles, 70 % alcohol, and cotton wool.

c) Racks for blood collecting tubes, blood collecting tubes, labels for tubes, sharp bin, gloves, and bags for clinical waste.

d) Cool box, ice packs for sample transportation

e) Laboratory request forms

f) Specimen register forms (in 3-ply sheet)

g) Comfortable chair with arm to rest the hand of the patient

8.6.3. Assigning Roles and Responsibilities

At the delivery point when blood is drawn the following staff member/members will be needed

- Staff to draw blood - Nursing Officer for drawing blood from the client and transferring it into specimen tubes
- Staff to assist in preparing blood samples - by preparing blood collecting tubes and pasting labels
- Staff to transport - One staff member is responsible for delivery of the sample and receiving reports using a suitable transportation method (if pick-up is not arranged by the referral hospital)

8.6.4 Specimen collection procedure

a) The patient must be informed of the procedure about to take place

b) Laboratory request form should be clearly filled with relevant details

c) Confirm the client and preparation for the test

d) Identify the correct tube and clearly label the test on the tubes

e) Draw the blood and place it in the relevant blood collecting tube/s

f) Write down the client's telephone number on the request form and sample registration form.

g) Register the sample in the specimen register form and mention the mode of deliveryof the report (transporter/ courier service /by post)

h) Trained staff must collect samples (They must know what samples should be mixed to prevent clotting and what samples should be allowed to clot.)

8.6.5 Preparing Specimens for Transport and Receiving Reports

a) Specimens and laboratory request forms should be arranged according to the specimen number in the blood collecting tube and the request form.

b) Pack and keep all the blood samples at +4 ^{0}C until dispatched

c) Transport the specimens at + 4 ^{0}C

d) Two copies of the specimen register form (including the original form) should be handed over to the transporter

e) Receiving reports

The report will be received by the feed-in institution via the transportation system.

- The date of receipt has to be recorded in the specimen register form copy
- The reports should be delivered to the relevant section (OPD/ Clinic) by a responsible person
- If not delivered, reports should be kept at the main reception in an organized manner
- When a laboratory investigation report is issued to a client, the date of issue should be recorded in the relevant specimen register form
- If by post: a self-addressed envelope (with a stamp) has to be attached to the request form and the report will be sent by post to the client.

8.7 Referral Laboratory (level 2 and above)

8.7.1 Main Tasks at the Referral Laboratory

Main tasks involved at the referral laboratory include:

i.) Supply management of laboratory reagents/consumables/printed formats

ii.) Issuing of different types of blood collecting tubes for feed in institutions

iii.) Defining the criteria for accepting specimens from feed-in institutions

iv.) Receiving, registering, and recording client data

v.) Testing of laboratory specimens (analytical stage)

vi.) Dispatching results (post analytical stage)

a) Reports should be issued only to authorized persons.

b) Timely release of provisional and final reports should be ensured.

c) Any test results which exceed the normal reference limit must be clearly documented, understood, and conveyed verbally, electronically, or in printed form.

d) Referral laboratories must be provided with a communication facility for this purpose. (Two-way communication will ensure the timeliness of reports and facilitate early diagnosis)

8.7.2 Recording Incoming Specimens and Sending of Results

An effective tracking system for specimens and client information is essential to ensure that laboratory reports are accurately returned to the correct individual at the appropriate institution.

i.) A standard laboratory request form including the name of the institution and the frank of the requesting Medical Officer should be used in sending specimens to the referral laboratory.

ii.) A unique laboratory number should be used for each specimen received at the referral laboratory

iii.) The method of sending reports has to be decided and be entered in the original copy of the specimen register form

iv.) A duplicate copy of the specimen registration form can be sent back with the reports to feed-in institutions

8.8. Mobile Laboratory Service on a Designated Day

Each PDHS division should have at least one mobile laboratory, with plans to expand this service by allocating one mobile laboratory to each district in the future. Mobile laboratories are recommended in the following situations:

a) Where there is a severe dearth of human resources with a limited number of MLTTs.

b) Where there is a shortage of reagents.

c) During sudden unexpected failures in established laboratories such as equipment failure or reagent shortage.

d) Where there are poor transport facilities to forward samples to apex hospitals.

e) During epidemics and disaster situations.

f) During special screening campaigns.

8.9 Use of Point of Care Testing (POCT)

In all places where POCT (strip or another method) is established with or without an MLT, a periodic quality assurance process (according to ISO 22870: 2016) has to be established. POCT Strips should be made available at PMCUs.

8.9.1 POCT implementation

a) A clear need for Point-of-Care Testing (POCT) as a service requirement must be established.

b) Each POCT device has its own limitations, which the operator must understand. It is advisable for the operator to consult an L2 or L3 laboratory for expert opinions when necessary.

c) The risks associated with using and interpreting POCT results must be effectively managed through proper training and support from a laboratory with a medical laboratory technologist (MLT) or laboratory consultant.

d) Training must be specified and supervised by a qualified individual, provided by the supplier or a trained MLT, under the discretion of the RDHS or cluster manager overseeing the POCT device.

e) Re-training or refresher courses should be offered as needed to ensure POCT operators maintain their competency. Records of all training and re-training activities must be kept at the PMCU level

f) Only competent staff shall be authorized to use the POCT devices.

g) A Standard Operating Procedure (SOP) must be documented and should include the following:

- Sample collection and safe handling of specimens
- Preparation, storing, and safe disposal of strips, and cartridges.
- Instructions on safe operating practices
- Interpretation of error messages and results
- Recording of data and relevant quality control and calibration procedures.
- Recording and reporting of results

h) POCT equipment must have a preventive maintenance schedule and/or a service contract. A logbook should be maintained to document operational details, faults, repairs, and corrective actions. Additionally, patient information—such as the patient's name, BHT/clinic number, ward/clinic, POCT tests conducted, test results, relevant quality control results, and the identity of the POCT operator—must be properly recorded.

i) Designated POCT operators shall be responsible for:

- Day-to-day care of the device including control of environmental conditions that may affect POCT performance.
- Inventory monitoring of reagents, consumables, and other accessories

j) If the device fails to meet specified analytical, safety, or maintenance requirements the device should be withdrawn from service immediately until full remedial action has been undertaken.

k) The diagnostic accuracy and provider availability during the stipulated working hours of the PMCU reflect the system's capacity, while the quality assurance of laboratory procedures and the timely availability of reports to patients reflect the system's overall quality.

8.9.2 Quality Assurance and Timeliness of Reports

The MCU staff must have comprehensive knowledge of the three phases of laboratory testing to ensure high-quality reports for clients. These phases include:

a.) **Preanalytical Phase:** This involves selecting the appropriate test, obtaining the specimen, labeling it with the patient's name, ensuring timely transport to the laboratory, registering its receipt, and processing it before testing.

b.) **Analytical Phase:** This phase encompasses performing the test and interpreting the results accurately.

c.) **Postanalytical Phase:** This includes preparing a detailed report of the results and their interpretation, authorizing the report, and transmitting it to the Medical Officers so that appropriate actions can be taken.

8.9.3 Supervision of Total Quality Management/ Assurance Program

The laboratory consultant at the apex hospital will establish a total quality management/assurance program for the cluster, working in collaboration with the senior MLT and in consultation with the RDHS, PDHS, and the head of the respective institution.

8.9.4 Quality Control

a) Internal Quality Control: The number of samples and tests should be determined based on factors such as the stability of the POCT device, the type of test, the frequency of testing, and the frequency of lot changes.

b) External Quality Control: Assistance can be sought from the Medical Research Institute under the guidance of the relevant laboratory consultant at the apex hospital.

c) Calibrations: Calibration activities must be documented according to the frequency specified by the device manufacturer.

d) Appropriate Method: Periodic comparisons should be conducted with the referral laboratory to ensure accuracy and reliability.

e) Frequency of Quality Control: The frequency can be determined based on the test type, number of tests, type of POCT, and the technology used.

f) Range of Quality Control Materials**:** Quality control materials should cover medical decision levels, including normal, high, and low ranges.

8.10 General Considerations

a) The Medical Officers of PMCUs may seek opinions from the nearest laboratory consultant and the trained MLT at the nearest Level 2 hospital (Divisional Hospital) through proper communication channels to ensure the maintenance of quality standards.

b) The RDHS is responsible for organizing the necessary training for the MOICs of each PMCU at apex hospitals, where laboratory consultants and MLTs are available. Continuous supervision and monitoring of laboratory performance at the PMCU level are critical to maintaining standards.

c) Laboratory test statistics must be collected regularly and presented during provincial and district laboratory performance reviews, which should include participation by the Deputy Director General of Laboratory Services or the Director of Laboratory Services of the Ministry of Health at least once a year.

d) Efforts must be made to ensure an uninterrupted supply of reagent strips to the PMCUs. To achieve this, the MOICs, RDHS, and PDHS must estimate the required quantities for each PMCU with support from the responsible SMLT in the district and coordinate with the RMSD and MSD of the Ministry of Health.

e) Cost considerations must be factored in when selecting the appropriate test methods, guided by the relevant laboratory consultant at the apex hospital.

It is recommended to consult Chapter 12 ("Laboratory Services") of the *Manual on Management of Divisional Hospitals* for a comprehensive understanding of the laboratory services provided by primary medical care institutions.

References

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CHAPTER 9

MANAGEMENT OF MEDICAL SUPPLIES AND STORE MANAGEMENT

9.1 Introduction

Pharmaceuticals are essential to both preventive and curative health care, representing a critical and costly component of health service delivery. A significant portion of the health budget is allocated to pharmaceuticals. To maximize the benefits of this investment, drug requirements must be based on realistic and accurate estimates. Ensuring rational prescribing practices is essential for optimizing the use of available resources and funds.

The allocation and utilization of drugs and consumables should align with evolving disease patterns, including the increasing prevalence of non-communicable diseases (NCDs), elderly care, rehabilitation needs, and new and emerging diseases. Such alignment helps reduce out-of-pocket expenditures for patients and their caregivers, thereby improving the overall efficiency and equity of health care delivery.

9.2 Objectives

a) To promote rational prescribing

b) To make the prescriber cost conscious

c) To ensure rational supplies of safe and effective drugs in adequate quantities to the respective institution throughout the year, within a realistic estimate

d) To practice standard inventorying protocols such as receiving, storing, issuing and dispensing

e) To ensure proper annual stock management

f) To establish periodical, multi-disciplinary activities to prevent pilferage, condemning of drugs, and to optimize stock controlling

9.3 Care in Prescribing

a) As per Chapter 56, Section 01 of the NMRA Act, No. 05 of 2015, all drugs must be prescribed using their generic names.

b) Prescriptions should include the tentative diagnosis or indication for the drug's use, the correct dosage, the frequency of administration, and the duration of treatment. They must be legibly written and include the name and signature of the prescribing officer.

c) For OPD patients, drugs should be prescribed for a duration that complies with the *Manual of Management of Drugs* and the directives issued by the Regional Drugs and Therapeutics Committee.

d) The prescribing officer should ensure that:

- polypharmacy is avoided
- the best possible cost-effective treatment regime is selected considering the benefit to the patient

e) The dispensing officers should:

- dispense the exact drugs in exact amounts as prescribed
- provide dosage instructions to the patients
- ensure the relevant records are maintained

f) The prescribing officer and the dispensing officer are jointly responsible to ensure that,

- the patients are educated on the use of drugs and their possible side effects
- the patients are advised to take the full course of drugs prescribed
- the patient clearly understands how the drugs prescribed are to be taken

g) All authorized prescribing officers should exercise the utmost care in prescribing expensive drugs. The Medical Officer in Charge should proactively inform all authorized prescribing officers about the costs of antibiotics and other expensive, frequently used drugs. Furthermore, the MOIC should encourage them to be mindful of costs and promote cost-conscious prescribing practices.

h) Whenever possible, prescribing officers should refrain from issuing prescriptions for borderline products and supplements, etc. even upon request, to be purchased outside.

i) In clinics, it is recommended to review and re-prescribe the full regimen at each visit. The standard duration of the prescription is for one month. But the duration could be altered in accordance with the circulars and instructions issued by the Ministry of Health.

j) Periodical audits should be conducted to evaluate the efficient use of drugs by the prescribing officers and dispensing officers within the institution.

k) All antibiotics and drugs prescribed from the OPD should be authorized by the MOIC, and further opinion must be taken by the referral hospital.

9.4 Major Activities

PMCUs are categorized as Level 1 in the medical supplies management system. The Pharmacist or Dispenser is responsible for managing medical supplies at the PMCU under the directives and supervision of the MOIC. In the absence of a Pharmacist or Dispenser, this responsibility falls to the MOIC or RMO. The following major activities must be undertaken:

a) Proper estimation of annual requirement of medical supplies (Refer to the latest guideline)
b) Receipt and maintenance of records related to medical supplies
c) Storage of medical supplies
d) Issuance of medical supplies to the dispensing section
e) Adherence to the latest and standard stock control practices (electronic drug storage systems)
f) Management of complaints of suspected substandard drugs (quality failed) including sample collection and dispatch to the NMRA through the RMSD
g) Withhold/ withdraw quality failed items as per the instructions sent by the DDG or Director / MSD.
h) Annual verification of medical supplies.
i) Condemning of unserviceable medical supplies.

9.5 Estimation of Annual Requirements of Drugs

a) Estimating the drug requirements for the following year is a crucial activity and is the responsibility of the MOIC, all prescribing officers, and the pharmacist within the institution. The Drug and Therapeutic Committee, chaired by the MOIC, must carry out the forecasting and estimation within the timeframes provided by the MSD.
b) Annual estimates should be based on the morbidity, past usage patterns, and standard treatment regimes, ideally. If morbidity data is not available, adjusted consumption data can be used as the base of the estimation.
c) The MOIC should ensure the estimate is done with the use of an available advanced method (i.e., web-based, online, or any other electronic drug-requesting process).
d) The head of the institution or the Pharmacist/Dispenser should prepare the adjusted average monthly consumption of all items, as outlined in the *Manual on Management of Drugs*, circulars, and guidelines from the Ministry of Health.

e) Annual financial allocation must be considered in the estimation process. It is vital to perform the estimation using a justifiable and effective cost analysis to ensure optimal utilization of allocated funds. The MOIC must ensure that both overestimations and underestimations are avoided.

f) E-estimates must be submitted for the approval of PDHS/ RDHS.

9.6 Receipt Order, Issues Order & Stock Control

a) At the end of each quarter, the MOIC or Pharmacist must prepare a quarterly return of items required for the next quarter, specifying the SR number, remaining quantity, and required quantity. Items will be issued based on justifiable requirements and availability from the RMSD.

b) Upon receiving requested items, the officer in charge of the drug stores must verify the quantity of each drug, their expiry dates, and batch numbers. Invoices must be entered into the ledgers or e-database on the same day. Any discrepancies or breakages must be reported immediately to the MOIC, District Pharmacist, and the RMSD officer in charge. These discrepancies should also be noted on the invoices and in the delivery register.

c) Preferably, an electronic database should be maintained for all dated products, including the item name, expiry date, batch number, and quantity, and updated with each transaction.

d) Form H141 must be used for issuing items to another institution, while Form H219 should be used to confirm receipts from other institutions.

e) The FEFO (First Expiry, First Out) method must be followed when issuing items.

f) Items should only be issued with the authorization of the MOIC.

g) It is recommended to issue only a week's supply of drugs to units. Whenever possible, empty vials and containers should be collected during the drug issuance process. This practice will enhance control over medication inventory and usage. The maximum quantity that can be retained in a unit should not exceed two weeks' consumption.

h) Empty containers must be recorded in a register. Their disposal, auctioning, or return to RMSD should be carried out periodically with approval from the Regional Director of Health Services (RDHS).

9.7 Surgical Inventory Management

a) Surgical non-consumable items and bio-medical equipment used in health care facilities are considered permanent assets of the institution.

b) They require special documentation and procedures to be followed in order to ensure proper management and maximum utilization.

c) It is mandatory to keep ward/ unit copies, office copies, and updated distribution register for the above items. Standard formats used in maintaining surgical inventory are

- Main inventory register - H311-to record transactions
- Sectional and office copies - H501- to be used as a proof of list of items
- Distribution register – no standard printed format
- Issue notes - H500- to request and issue items.
- Receiving notes - H503 – to return or exchange the items.

9.8 Storage of Drugs

a) Drugs must be stored in a dry, cool environment, away from light, in accordance with accepted standards. Ideally, drug stores should be air-conditioned. The head of the institution is responsible for identifying a suitable space, designating it for pharmaceutical storage, and ensuring it is properly furnished and equipped.

b) The ideal place should:

- have easy access to a vehicle,
- be well-ventilated
- be free from the threats of natural hazards.
- be free from pest attacks.
- be able to keep locked safely and with a minimum threat of breakthroughs.
- have a suitable rack system.

c) Drugs must be organized according to the latest standards to ensure safety and quality, preferably grouped by their pharmacological categories. Within each group, arrangements should follow VEN (Vital, Essential, Non-essential) and ABC (Always, Better, Control) analysis. Vital items should be closely monitored and prioritized to ensure their availability and proper management.

d) Drugs should be stored in a manner that would facilitates the following:

- Issuing drugs based on the closest expiry date first.
- Issuing drugs according to their manufacturing dates if expiry dates are not indicated.
- Easy monitoring of batch numbers and other relevant details.

e) A list of drugs with their expiry dates should be displayed for easy reference and monitoring.

f) Dangerous and narcotic drugs must be stored in a locked cupboard, inaccessible to unauthorized persons. The key should be kept exclusively with the MOIC or chief pharmacist.

g) Expensive drugs, particularly those in Group A of the ABC analysis, must always be kept under lock and key and closely monitored.

h) In addition to drug registers, Bin Cards should be used to indicate stock reorder levels, reorder quantities, and other relevant details.

i) Expired drugs, substandard drugs, drugs without labels, and drugs that have been withdrawn must be stored separately from others. These items should be condemned as soon as possible, with at least one condemning session conducted annually.

j) The head of the institution and the pharmacist must actively work to minimize drug expirations. Arrangements should be made to exchange or transfer short-expiring drugs to institutions in need. A quarterly list of short-expiring and non-moving drugs should be prepared and submitted to the RDHS and Divisional Pharmacist.

k) Periodic test checks should be conducted as outlined in the *Manual on Management of Drugs*.

9.9 Management of Vaccines (if available)

The vaccine requirement for the following month should be prepared at the end of the current month and submitted as a return to the MSD/MOH. The MSD will distribute the required vaccines based on the submitted return. It is the responsibility of the OIC/RMSD to ensure that the cold chain is maintained throughout transportation.

a) The head of the institution and/or the pharmacist must ensure that the arrangements made by the RMSD to maintain the cold chain are satisfactory.

b) Vaccines should be stored in a dedicated refrigerator whenever possible. The frequency of opening the vaccine refrigerator should be strictly limited to maintain consistent temperatures.

c) The refrigerator should be placed in a spacious, well-lit room, positioned at least 30 cm away from the walls to allow proper ventilation.

d) A thermometer must be placed in the refrigerator, and the temperature should be monitored twice daily. A cold chain monitoring chart should be maintained and displayed near the refrigerator.

e) A backup power supply must be available for the vaccine refrigerator. Additionally, a backup refrigerator should be identified and designated for use in case of an emergency breakdown.

f) Vaccines should be stored in the middle section of the refrigerator, not in the door. Water bottles or cool packs can be stored in the door to help maintain temperature during power outages.

9.10 Management of Medical Gases (if available)

It is essential to have at least one oxygen cylinder and a regulator ready for emergency use. Ensuring a continuous medical gas supply is the responsibility of the MOIC and the pharmacist. An adequate number of empty gas cylinders should be procured from the RMSD, with empty cylinders exchanged for filled ones at the RMSD or the nearest hospital.

Maintaining an adequate buffer stock of medical gases is crucial, taking lead time into consideration. If alternative transport is unavailable, the MOIC may utilize the ambulance to procure medical gases and urgently required pharmaceuticals.

9.11 Monitoring of Adverse Drug Reactions

a) All adverse drug reactions must be reported and monitored by the MOIC and the pharmacist.

b) Drug reactions should be notified to the relevant authorities (RDHS/ MSD/ NMRA) using the available electronic formats

c) Any instructions received from the MSD regarding drug quality must be promptly communicated to all staff members.

9.12 Annual Drugs and Surgical Verification

The Board of Survey for annual stock verification is appointed by the RDHS. The MOIC, along with the officers in charge of stores (Pharmacist or Dispenser), must confirm the date for verification with the chairman of the Board of Survey. The board will visit the institution according to the agreed schedule to conduct the annual stock verification.

The MOIC must arrange a suitable location with adequate facilities for the board members and provide the necessary assistance to facilitate the process. Stock-handling officers should be prepared with updated registers, ledgers, invoices, and a duly completed H1196 form.

Stock-handling officers must organize items batch-wise to enable easy access and clearly separate serviceable pharmaceuticals from unserviceable ones, such as expired, surplus, quality-failed, damaged, or broken items. Additionally, stock-handling officers must ensure compliance with the recommendations from the previous year’s annual verification, audit queries, inspection officer’s report, and DTC report.

9.13 Condemning of Unserviceable Drugs

By systematically conducting annual indenting and adhering to rational drug use principles, drug expiration can be entirely avoided. Guidelines for proper drug storage must follow the latest defined standards.

However, if drugs are accumulated for condemnation, the following procedures should be adopted:

a) Drugs designated for condemnation should be recorded in a separate register, which must include the name of the drug, manufacturer, batch number, date of manufacture, expiry date, and quantity to be condemned.

b) These drugs must be stored separately from regular stock to prevent accidental use.

c) Three copies of the Gen.47 form must be duly completed by the MOIC, Pharmacist, or Dispenser and submitted to both the RDHS and PDHS. Following this, a board comprising three members will be appointed. For surgical inventory items, Form H818 must be completed and approved by the head of the institution for each item.

d) The MOIC is responsible for ensuring this activity is followed up and that condemnation is carried out periodically.

e) The most appropriate method for condemnation would involve the following:

- The disposal of pharmaceuticals should adhere to the best available methods as outlined in the relevant guidelines. Incineration is the preferred method for ensuring safe and effective disposal.
- Empty bottles should be auctioned only after their labels have been removed to prevent misuse.

CHAPTER 10

ENSURING QUALITY AND SAFETY OF HEALTH CARE

Quality of health care is defined as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (Lohr & Schroeder, 1990). It is widely acknowledged that all health care institutions must priorities the delivery of high-quality and safe health services to their patients.

Seven elements are identified as essential to ensuring quality in health care:

i) Effectiveness – providing evidence-based health care services to those who need them

ii) Safety – avoiding harm to people for whom the care is intended

iii) People-centeredness – providing care that responds to individual preferences, needs and values

iv) Timeliness – reducing waiting times and sometimes harmful delays

v) Equity – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status

vi) Integration – providing care that makes available the full range of health services throughout the life course

vii) Efficiency – maximizing the benefit of available resources and avoiding waste

(Source: World Health Organization)

The Directorate of Health care Quality and Safety (DHQS) of the Ministry of Health, established in 2012, serves as the national focal point for health care quality assurance across the country. It provides technical direction and guidance to hospitals at various levels through the Quality Management Unit (QMU) network, effectively linking the central level with the line ministry and provincial health organizations. Provincial hospitals are connected to the center via QMU units located at the RDHS offices in each district. These units coordinate with individual hospitals within their respective districts, ensuring the quality and safety of services provided.

One of the first guideline aimed at ensuring quality in health care institutions at all levels was published in 2010 by the Ministry of Health. The Quality Series – 1 publication addresses health care quality in hospitals at the Divisional Hospital level and above. These Quality Series publications are available on the DHQS website for reference.

The DHQS plays a crucial role in developing and implementing guidelines, formats, plans, tools, and checklists aimed at enhancing health care quality and safety. These resources,

which address various aspects of health care delivery, are available on the DHQS website.

In 2013, the DHQS issued a circular titled *"Establishment of Hospital Quality Management Units (QMUs) and District/Health Care Quality and Safety (HQS) Units,"* which outlined the functions and responsibilities of these units, the required files to be maintained, and the necessary resources. This circular was revised in 2023 and can be accessed on the DHQS website.

In 2015, a checklist was introduced for assessing Primary Medical Care Institutions (PMCIs), including Primary Medical Care Units (PMCUs). By 2019, the Directorate of Health care Quality and Safety (DHQS) identified the need for sustainable quality improvement at PMCIs. The Primary Health care System Strengthening Project has since emphasized providing comprehensive and high-quality health care at the PMCI level. This initiative focused on addressing gaps in service quality at the primary level to reduce overcrowding at nearby secondary and tertiary care hospitals. As part of this effort, the revised Quality Supervision Tool for Primary Medical Care Institutions in Sri Lanka was published in 2020 and is accessible on the DHQS website. (PMCIs include Divisional Hospitals, Primary Medical Care Units, and outpatient departments of higher-level hospitals.)

The revised quality supervision tool enables regular monitoring of the quality of care and supports ongoing quality improvement at PMCUs. Recognizing that health care delivery demands a deliberate focus on service quality, heads of PMCUs are encouraged to assess the quality of their institutions periodically and implement corrective and preventive actions as needed. With this approach, Regional Directors of Health Services (RDHS) and Provincial Directors of Health Services (PDHS) can ensure that each PMCU is equipped to provide essential primary health care services for the populations they serve.

The following key areas are being assessed in this tool: general infrastructure facilities and cleanliness; availability of human resources; customer feedback mechanisms; adequate availability of medical equipment; attending to emergency care; clinic facilities; functioning of Healthy Lifestyle Clinics; facilities of the pharmacy, the laboratory, storage facilities; and patient satisfaction survey.

Considering the new dimensions of health care quality and safety, the following aspects of health require focused attention:

- Patient care process
- Quality of care giving
- Health screening
- Health promotion
- Medication safety in patient management
- Infection prevention & control
- Clinical audits
- Waste management

- Employee satisfaction
- Continuous monitoring of quality indicators

Staff members from various levels of hospitals are trained by the DHQS as Master Trainers using the *Manual for Health Care Quality and Safety*, which is available on the DHQS website. This manual provides a comprehensive overview of quality and safety concepts, quality improvement techniques, and the implementation of quality improvement programmes. It serves as a practical guide for implementing quality and safety measures in health care institutions.

The revised National Policy on Health care Quality and Safety (2022), National Strategic Plan on Health care Quality and Safety 2021-2025, and National Action Plan on Medication Safety (2021) also offer valuable guidance in quality and safety improvements in PMCU. Similarly, quality indicators and guidelines prepared by DHQS such as the 20 general indicators (selected indicators), circulars on hand hygiene compliance& formats, and guidelines on incident reporting can be referred to as appropriate for the PMCU context.

10.1 Implementing Quality and Safety of Health Care at Institutional Level

This section focuses on ensuring the quality and safety of health care delivered by a PMCU**.** Ensuring quality & safety of health care will:

i) Improve the quality of services provided.

ii) Safeguard the well-being of both clients and staff.

iii) Facilitate supervision and reviews of the institution's health care quality and safety practices.

10.2 Ensuring Quality and Safety in PMCUs

i) The MOIC should take overall leadership of the quality and safety programme. It is essential to appoint a focal point for health care quality and safety at your institution, which could be an MO, RMO, NO, DA, or MA.

ii) In collaboration with the MO/QMU in the respective RDHS area, identify areas for improvement based on feasibility and available resources. Develop a Quality Improvement Action Plan by referring to the relevant guidelines mentioned above.

iii) Inform and create awareness among PMCU staff regarding the importance of health care quality and safety through capacity-building initiatives.

iv) Ensure that all staff members of PMCU are familiar with the action plan and understand the standards that need to be followed and maintained.

v) Conduct an initial assessment, preferably using the *Quality Supervision Tool for PMCIs in Sri Lanka* published in 2020, and use this as a baseline assessment. Ensure adherence to the latest version of the tool available.

vi) Implement a few quality and safety-related activities at your institution, as outlined below.

a) 5S concept implementation

b) Improvements in services involving patient contacts (reception area, immediate service points, and frontline services, responsiveness, medical/pharmaceutical supplies & storage, and equipment management)

c) Patient care-related activities (reduce waiting time, inward patient care, adverse event reporting, clinical audits, medication safety, infection prevention & control)

d) Overall quality and safety improvement (waste management, improve sanitation, health education activities, leadership and management, productivity and quality improvement programme)

vii) Periodic assessments should be conducted at regular intervals (quarterly) to measure progress from the baseline.

viii) Quarterly assessment reports should be submitted to the QMU at the RDHS office.

ix) Results should be discussed and shared with staff at the institution.

x) Further quality improvements should be implemented based on the evaluation results.

10.3 Initiatives that can be Implemented:

i) Applying Kaizen/ Gemba Kaizen techniques

ii.) Carrying out initiatives such as establishing Work Improvement Teams (WIT). Work Improvement Teams may comprise of small numbers of people with a particular talent or interest. For each area/activity selected, follow the steps below. The starting point will depend on the current status of health care quality and safety activities being implemented in the hospital.

a) Assess the current status.

b) Compare the current status with the standards given in the reference documents mentioned above.

c) Identify any gaps, shortcomings or deficiencies.

d) Find out the reasons for identified gaps.

e) Take corrective action.

f) Display the achievements in your ward/unit.

g) Discuss the findings with your staff.

iii.) Training of staff on health care quality & safety

iv.) Training of staff on respective profession-related subject matters

v.) Continuous supervision and reviews

vi.) Staff and patient satisfaction surveys

vii.) Keep suggestion boxes in appropriate locations

viii.) Introduce a no-blame culture for incident reporting

ix.) Staff appraisal, and facilitation for ensuring quality &safety

x.) Participation at the regional, provincial, and national-level productivity and quality award competitions

10.4 Patient- Centred Health care (PCHC):

Patient-centredness is a key element of quality in health care. It is essential to provide patient-centred services to individuals visiting health care institutions. The patient is the most significant individual in a health care delivery institution. The Institute of Medicine (IOM) defines patient-centred care as "providing care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." Patient-centred care involves caring for patients and their families in ways that are meaningful and valuable to the individual. This approach includes listening to, informing, and involving patients in their care.

However, health care systems frequently adopt a problem-oriented, physician-centred approach to service delivery and documentation. In such systems, patients often play a passive role while physicians make management decisions based on the history, clinical examination findings, and investigations. The management plan is typically determined by the physician's expertise, with minimal or no patient involvement in decision-making.

When a patient visits any PMCU, they expect comprehensive care, coordination of services, timely care delivery, clear and reliable communication, convenience, respect, empathy, the opportunity to express their needs and be heard effectively, continuity and stability of care, and equitable service provision based on their needs.

Unfortunately, instances of patient dissatisfaction are commonly observed in health care institutions. Such displeasure often arises from poor communication, including inadequate explanations of medical conditions and management plans, a lack of empathy, rude behaviour by staff, long waiting times at OPDs and clinics, delays in multiple queues for laboratory investigations and pharmacies, the unavailability of medications, and the financial burden of out-of-pocket expenses.

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Practicing patient-centred health care can make a considerable change in patient perceptions and improve the quality of care that is provided. Currently, some initiatives related to patient-centred care are being implemented in health care institutions. These efforts are encouraged, coordinated, and monitored by the Ministry of Health:

i) Patient satisfaction surveys

ii) OPD and clinic patient waiting time surveys

iii) Establishment of suggestion boxes in hospitals

iv) Grievance redress mechanism

v) Networking of health care institution for minimizing delays

Guidelines, supervision tools, formats, and circulars have been issued by the Directorate of Health care Quality and Safety, Ministry of Health, to improve quality and safety in health care institutions, facilitating patient-centred care. Transforming the health care system into a patient-centred model requires immediate, short-term, and long-term actions. This transition should include frequent and well-structured training sessions to help staff understand the importance of patient-centred care, fostering a change in their attitudes towards clients to ensure the delivery of high-quality and safe services.

Additionally, providing the necessary logistics and human resources is essential to create both external and internal patient-contact environments that prioritize the needs and experiences of patients.

10.5 Implementation of Patient Centered Care in PMCU

i.) Physical environment:

a) The external environment of a health institution should be maintained to provide a pleasant and welcoming atmosphere for both patients and employees.

b) Name boards should be displayed in all three languages for easy identification.

c) A sitemap of the hospital should be prominently displayed to assist patients and visitors.

d) Directional boards should be placed at each junction to guide patients and visitors effectively.

e) The hospital garden should be well-maintained to enhance the overall environment.

f) Garbage bins should be strategically placed at necessary locations to maintain cleanliness.

g) Clean and accessible restrooms should be provided within the facility to ensure convenience for patients.

ii.) OPD, Emergency care, and clinic settings:

a) The OPD, emergency care, and clinic premises should be clearly labeled to facilitate easy navigation.

b) A spacious waiting area with adequate seating should be provided for patients attending the OPD or clinics.

c) The premises must be clean, well-lit, and properly ventilated to ensure a comfortable environment.

d) Sitting areas and walking paths should be established for inpatients and visitors to enhance their experience.

e) Health topics can be displayed on television screens in waiting areas, and staff members (MOIC, PHNO) should deliver health education when necessary.

f) Safe and clean drinking water must be made available to patients and visitors at all times.

g) Every effort should be made to minimize OPD waiting times.

h) Patient satisfaction surveys and OPD/clinic waiting time surveys can be conducted to gather feedback and make improvements.

i) A suggestion box, equipped with sufficient stationery and a pen, should be available for client suggestions. The administration must regularly check the box and take appropriate actions to address and resolve any issues raised.

j) Patients and their accompanying persons should be treated with respect, and their queries should be addressed. They should be actively involved in the decision-making process regarding their care.

k) Patients should be treated with dignity, kindness, empathy, and understanding, recognizing the challenges they face regarding their illness.

l) Attention should be given to both the physical needs and emotional wellness of patients.

m) Patient and family preferences, values, cultural traditions, and socioeconomic conditions must be respected at all times.

iii.) Supportive services including pharmacy and investigation services (if available):

a) An efficient, accurate, and patient-friendly service should be delivered, ensuring minimal delays.

b) Patients' queries should be promptly addressed and attended to by the MOIC.

c) Emergency cases must receive immediate attention without any delay.

d) Patients should always be treated with empathy, respect, and consideration.

e) Adequate seating facilities must be provided in the waiting area to ensure patient comfort.

f) A suggestion box equipped with sufficient stationery should be available for patients to share their comments and feedback.

References:

Directorate of Health care Quality and Safety: https://www.quality.health.gov.lk/index.php?lang=en

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CHAPTER 11

INFECTION PREVENTION AND CONTROL

The following Infection Prevention and Control (IPC) measures are recommended for all staff at PMCUs to adhere to in their daily functions. The primary objective is to prevent the transmission of health care-associated infections to patients while also ensuring the safety of health care personnel. Strict infection prevention protocols must be followed during outpatient consultations, wound care and dressing services, injection administration, and drug dispensing to maintain the highest level of safety and minimize the risk of infections.

11.1 Responsibility

i.) The overall responsibility for implementing and monitoring IPC measures lies with the head of the institution.

ii.) All PMCUs must be equipped with adequate facilities for hand hygiene for both staff and patients, including sinks and a consistent supply of soap and water.

iii.) Appropriate antiseptics should be readily available in dressing rooms and injection rooms.

iv.) The Public Health Nursing Officer (PHNO) or Nursing Officer attached to the PMCU should receive training in infection control with support from the IPC team of a nearby hospital that has an established IPC unit.

v.) Facilities for sterilization, such as a sterilizer, small-scale autoclave, or drying oven, should be made available to sterilize all reusable equipment and dressing materials required in dressing and injection rooms.

vi.) In the absence of on-site sterilization facilities, a mechanism must be established in coordination with a nearby hospital equipped with the necessary resources to ensure all consumables and equipment are sterilized prior to use or reuse.

vii.) Sharp bins should be provided at all relevant locations, along with appropriate methods for the safe disposal of sharps.

viii.) A robust mechanism should be in place to safely manage and dispose of infectious waste.

11.2 Staff Training and Pre-requisites

i.) All staff must be vaccinated against Hepatitis B, and their response to the vaccine should be confirmed by measuring Hepatitis B surface antibody (HBsAb) levels.

ii.) All staff should receive training in proper hand hygiene techniques to ensure consistent and effective practices.

iii.) Relevant staff should be trained on standard precautions and the management of body fluid spills, including the appropriate use of personal protective equipment, cleaning, disinfection, and safe injection practices. This training should be ongoing, supplemented with refresher courses, and not limited to a single session.

11.3 Minimum Level of IPC Practices

i.) Standard precautions should be followed in all instances

ii.) The *Hospital Infection Prevention and Control Manual* by the Sri Lanka College of Microbiologists (2021) should be consulted for further technical details. It is freely accessible through the website of the Sri Lanka College of Microbiologists.

11.4 Standard Precautions

Standard precautions are the foundational infection prevention and control practices applicable to all patient care. These measures aim to minimize the transmission of health care-associated infections (HAIs) in any setting where health care is provided. Designed to protect health care workers (HCWs) and prevent them from transmitting infections among patients, these precautions must be employed universally by all HCWs, regardless of a patient's suspected or confirmed infection status.

Standard precautions apply to blood, all body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes. Body fluids include cerebrospinal fluid (CSF), pleural fluid, peritoneal fluid, and amniotic fluid. Secretions include nasal secretions, sputum, tears, and saliva. Excretions include feces, urine, and vomitus.

Standard precautions include:

i.) Hand hygiene

ii.) Personal protective equipment

iii.) Respiratory hygiene/cough etiquette

iv.) Sharps safety and safe injection practices

v.) Cleaning, disinfection, and sterilization of instruments and equipment

vi.) Environmental cleaning and disinfection

vii.) Linen management

viii.) Waste management

11.5 Hand Hygiene Technique

Nails must be clean and short. Artificial nails, jewelry, and wristwatches should not be worn.

i.) Hand washing with soap and water

a) Wet hands with water and apply the soap necessary to cover all surfaces

b) Vigorously rub all surfaces of lathered hands systematically covering all surfaces (Annexure I)

c) Rinse hands with clean, running water and dry thoroughly with a single-use towel

d) Duration of the entire procedure is 40-60 seconds

e) Leave adequate single-use hand towels beside the sinks

f) Keep a foot-operated bin to discard towels which are then collected and sent to the laundry for washing and reuse

g) Use a towel to turn off the tap/faucet

ii.) Hand hygiene using alcohol-based hand rub

a) Apply 2-3 ml/of alcohol-based hand rub

b) Rub hands until dry, systematically covering all surfaces (Annexure II)

c) Takes only 20–30 seconds to complete

Note:

- Sterile gloves should be used only for aseptic procedures
- Disposable gloves should be used when contact with body fluids suspected
- Gloves should be removed immediately after the task
- Avoid touching door handles, telephones, computers, stationeries or any other objects with gloved hands
- Gloves do not replace the need for hand hygiene
- Hand hygiene is required before putting on gloves and immediately after removing gloves
- Hand hygiene products should not be applied to gloves

11.6 Management of Body Fluid Spills

i.) Spillages should be dealt with immediately

ii.) Make the area safe i.e. do not allow people to walk through the spillage and never leave the spillage unattended. A display sign is helpful

iii.) PPE must be worn

iv.) Gather together all the equipment, disinfectants and waste receptacles/waste bags that are required to correctly and safely manage the spill. A spill kit should be available

v.) All items used to manage a spill must be disposed of correctly as per the local waste policy

vi.) Safe working practices and procedures must be used to prevent exposure incidents during the management of spillages

vii.) If an exposure incident occurs when dealing with a spillage, the local occupational exposure policy should be followed

viii.) Recording and reporting of spillages should be done to avoid future incidents or exposures to blood and other body fluids and ensure that appropriate measures and equipment are in place to manage such spillages

Each ward and site where samples are being taken should have a spill kit. The content of the spill kit must be inspected and the responsibility of maintaining the kit and training of the staff in managing spills should be with the Nursing Officer.

11.7 Contents in a Spill Kit:

Single-use items in the spill kit should be replaced after each use of the spill kit.

i.) Scoop and scraper

ii.) Gloves – heavy-duty rubber gloves

iii.) Plastic apron/ disposable polythene apron

iv.) Medical/surgical mask

v.) Eye protection (face shield/goggles)

vi.) Absorbent material (paper towels/wadding)

vii.) Clinical waste bags (yellow bags) and ties

viii.) Disinfectant (hypochlorite powder or chlorine-releasing granules to prepare 1% and 0.1% hypochlorite freshly prepared solution)

ix.) Detergents

x.) Protocol for spill clean-up procedure (Annexure III)

11.8 Sterilization Procedure

All reusable instruments and equipment must be cleaned, disinfected, or sterilized to prevent the exposure of patients and health care workers to potentially infectious materials. To facilitate this, all PMCUs will be equipped with a mini autoclave.

Based on the intended use of an item, medical and surgical equipment must undergo one of the following processes between uses on different patients:

i.) Cleaning alone

ii.) Cleaning, followed by disinfection

iii.) Cleaning, followed by sterilization

11.8.a Cleaning: A process of physical removal of foreign material (e.g., dust, soil) and organic material (e.g., blood, secretions, excretions, microorganisms). It is accomplished with manual or mechanical action using water and detergents. Medical devices must be cleaned thoroughly before disinfection or sterilization.

11.8.b Disinfection: A process that kills most pathogenic microorganisms. Disinfection does not destroy all bacterial spores. Medical devices must be cleaned thoroughly for effective disinfection. There are 2 levels of disinfection: high and low.

11.8.c Sterilization:

A process used to make a product free from living microorganisms including bacterial spores and is required for reprocessing critical medical devices. There are several methods of sterilization (Steam/ moist heat sterilization, H_2O_2 gas plasma, Ethylene oxide gas):

11.9 Steam Sterilization

Agent	Monitoring	Comment
Steam sterilization (Autoclave) For critical devices which are not damaged by heat or moisture	• Biological indicators (BI) (preferably weekly except with loads with implantable devices which need BI with every load) • Chemical indicators (CI)- External and internal CI with each package • Physical indicators (each cycle)- time, temperature, pressure records Additional monitoring of pre-vacuum sterilizers includes a dynamic air removal test- Bowie-Dick test (daily) This should run within a test pack each day in an empty sterilizer before the 1st processed load.	Contact time/exposure time depends on the item sterilized All loads containing an implantable device shall be monitored with an additional BI and should be quarantined until the results of the biological indicator testing are available

11.9.a Types of Autoclaves:

i.) Gravity displacement steam sterilizer

ii.) Dynamic air removal steam sterilizer

11.9.b Time and Temperature Parameters for Gravity Displacement Steam Sterilization Cycles

Item	Exposure time at 121 °C	Exposure time at 132 °C	Exposure time at 135 °C	Drying time
Wrapped instruments	30minutes	15 minutes		15 -30 minutes
			10 minutes	30 minutes

Textile packs	30minutes	25 minutes		15 minutes
			10 minutes	30 minutes
Wrapped utensils	30minutes	15 minutes		15 -30 minutes
			10 minutes	30 minutes
Unwrapped porous items (e.g. instruments)		3 minutes	3 minutes	0 -1 minute
Unwrapped non porous items and porous items (e.g. mixed load)		10 minutes	10 minutes	0-1 minute

11.9.c Time and Temperature Parameters For Dynamic Air Removal Steam Sterilization Cycle

Item	**Exposure time at 132 °C**	**Exposure time at 135 °C**	**Drying time**
Wrapped instruments	4 minutes		20 -30 minutes
		3 minutes	16 minutes
Textile packs	4 minutes		5-20 minutes
		3 minutes	3 minutes
Wrapped utensils	4 minutes		20 minutes
		3 minutes	16 minutes
Unwrapped porous items (e.g. instruments)	3 minutes	3 minutes	NA
Unwrapped non porous items and	4 minutes	3 minutes	NA

Note: The above tables serve as guidelines for cycle parameters for different items. For specific sterilizers, the manufacturer's instructions for cycle parameters should be followed, as these parameters may vary depending on the instrumen

11.9.d Important Points for Autoclaving

i.) All items should be washed thoroughly with soap and dried for preparation of packets or trays for autoclaving.

ii.) The maximum weight of one packet should not be more than 5 kgs or the limit specified by the manufacturer.

iii.) Wrapping cloth should be double-layered.

iv.) Do not wrap tightly.

v.) Put a name tag on each pack.

vi.) Sign each packet content slip.

vii.) Use a chemical indicator inside the package for sterility. If sterilizing process is successful, the indicator colour will change

viii.) Sterilized packages can be kept for a maximum of 10 days only.

ix.) Maximum size of textile packages is 20 x 28 x 30 cm. Exceeding this size may compromise steam penetration, resulting in packages that remain wet or unsterile after the sterilization process.

x.) Never put packages very close to the sterilizer door and walls.

xi.) Never load the sterilizer tightly.

xii.) Never re-use the packing towels (wrappers) without washing them properly.

xiii.) Proper loading of the autoclave is important to guarantee good penetration of steam and ensure that the supplies sterilized in the autoclave come out dry.

xiv.) Clean the autoclave chamber (when it is cold) at least once a week with water, cleaning agent, and rinse well with water and dry.

xv.) Autoclaves should be handled by well trained staff only.

xvi.) Nurses too should have knowledge and skills to handle the autoclave.

11.9.e Immediate Use of Steam Sterilization (Flash Sterilization)

Immediate-use steam sterilization should be employed only in situations of urgent or unplanned need. A written procedure must be in place, and staff must be adequately trained to perform flash sterilization. Cycle parameters may vary depending on the type and design of the sterilizer. These parameters are established and preset by the sterilizer manufacturer, and their guidelines must be strictly followed. Flash sterilization should not be used for sterilizing implants, complete sets or trays of instruments, or as a solution for inventory shortages or scheduling challenges.

11.10 Quality Control

i.) A chemical indicator strip must be included in every package. The indicator's color change confirms proper sterilization.

ii.) Perform the Bowie-Dick test for autoclaves before starting the sterilization process for packages. A color change indicates that the correct temperature and steam pressure have been achieved, ensuring good steam penetration.

iii.) Regularly check autoclaves using biological indicators (spore tests) to ensure proper function.

iv.) New autoclaves should undergo testing before their initial operation.

v.) Testing should also be conducted following any repairs.

11.11 Low Level Disinfectants and Antiseptics

PMCUs are requested to keep a minimum of two essential disinfectants as given below and use as appropriate.

Chlorine Releasing Compounds		
Agent	Indication/s -uses	Comment
Chlorine releasing compounds - Calcium hypochlorite (TCL- topical chlorite of lime, bleaching powder). Should be not less than 30% w/v of available chlorine.	Blood spills -1% (10,000ppm) Surface cleaning -0.1% (1000 ppm)	Solutions should be made fresh and discarded immediately after use. Avoid inhalation, contact with skin, eyes and clothing. Do not mix or allow contact with other chemicals (soaps, detergents

Sodium hypochlorite liquid form (e.g. 3%, 5%, 10% - stock solutions) 1% (10,000 ppm) 0.1% (1,000 ppm)0.01% (100ppm) e.g. diluted Miltonsolution*Preparation – see below	Disinfection of feeding bottles-0.01% (100ppm)	paints, solvents combustible substances). Can form carcinogenic products in the presence of formaldehyde. Do not use on metal objects (corrosive).
Alcohol		
60-90% (v/v) Ethyl/ Isopropyl alcohol	As an antiseptic -alcohol hand rub75-85% (v/v) ethyl/ isopropyl alcohol As a disinfectant for surface disinfection - 70% (v/v) ethyl/ isopropyl alcohol	Optimum bactericidal concentration is 60%-90% solutions in water. Store at room temperature, in a dark container with a close-fitting lid in a well-ventilated area. Label as inflammable. Can damage the shellac mountings of lensed instruments, rubber and certain plastic tubing, and tonometer tips

- Add powder to water. Do not add water to the powder, because it generates chlorine vapor. Inhalation of released chlorine vapor is toxic at room temperature
- Residual particles can cause irritation, hence filtering of the solution is recommended

11.11.b Using Hypochlorite Powder (TCL/Calcium Hypochlorite/ Bleaching Powder)

Calculate the amount to be mixed with each liter of water by using the following formula:

[% chlorine desired／% chlorine in bleach powder] × 1000 = Grams of bleach powder for each liter of water

Example: To make a 0.5% chlorine solution from bleach powder containing 35% active chlorine

[0.5%／35%] × 1000 = 0.0143 × 1000 = 14.3

Therefore, dissolve 14.3 grams of calcium hypochlorite powder in 1 liter of water to make a 0.5% chlorine solution.

11.11.c Using Liquid Hypochlorite (Sodium Hypochlorite or Household Bleach)

Chlorine in liquid bleach comes in different concentrations. Any concentration can be used to make a dilute chlorine solution by applying the following formula:

(% Chlorine in liquid bleach／% chlorine desired) − 1 = Total parts of water for each part of bleach

Example: To make a 0.5% chlorine solution from 3.5% bleach:

[3.5%／0.5%] − 1 = 7 − 1 = 6 parts water for each part bleach

Therefore, add 1 part 3.5% bleach to 6 parts water to make a 0.5% chlorine solution

11.12 Methods of Cleaning, Disinfection and Sterilization of Equipment and Instruments

The cleaning, disinfection, and sterilization procedures to be followed for commonly used equipment and instruments are illustrated below.

Equipment	**Agents for decontamination/ disinfection**	**Procedure**
Oxygen masks/ mist tents- (Single use or reusable) Do not reuse if used on a patient with known/ suspected infection such as tuberculosis	For reuse Cleaning - General Purpose Detergent (GPD) Sterilization - autoclave Disinfection with High Level Disinfectant (HLD) 70% alcohol	For reuse Clean with GPD, rinse thoroughly with water. Then dry and sterilize by autoclaving If non-autoclavable - Clean with GPD, disinfect with HLD or wipe with 70% alcohol if used on the same patient.

11.12.a Nebulizers

Equipment	Agents for decontamination/ disinfection	Procedure
Nebulizer mask and chamber Single use or reusable Ideally single use	For reuse – Cleaning with GPD, Disinfection with HLD	For reuse - Clean with GPD, rinse thoroughly with water. Disinfect with HLD. Rinse with sterile water.

Equipment	Agents for decontamination/ disinfection	Procedure
Dressing trolley Drug trolley Resuscitation trolley	Cleaning-GPD Disinfection-70% alcohol	Clean thoroughly with GPD daily. Before and after procedures wipe with 70% alcohol. Must be dry before placing sterile packs, drugs or other items on the surface.
Patient trolleys and wheelchairs	Cleaning-GPD Disinfection- 0.1% hypochlorite. If metal, wipe with 70% alcohol after washing with GPD	Clean with GPD between patients and at the end of the day. Disinfection of these non-critical equipment is not routinely required unless the equipment has come into contact with blood or body fluids, or patients with multi drug resistant organisms. Wipe with 0.1% hypochlorite or 70% alcohol (for metal trollies) after washing with soap and water.

11.12.c Personal protective equipment

Equipment	Agents for decontamination/ disinfection	Procedure
Goggles/visors Single use reusable		If reuse-wash with GPD. Then wipe with 70% alcohol
Heavy duty gloves for cleaning staff	Cleaning- GPD Disinfection- 1% hypochlorite	Clean with GPD, immerse in 1% hypochlorite, wash and hang
Foot wear/ boots	Cleaning- GPD Disinfection- 1% hypochlorite	Wash with GPD and dry regularly at least once a week If there is a spill immediately remove and soak in 1% hypochlorite and wash

Equipment	Agents for decontamination/ disinfection	Procedure
Thermometer	Cleaning - GPD Disinfection- 70% alcohol	Clean with GPD and wipe with 70% alcohol in between patients, and if visibly soiled.
Stethoscopes	Disinfection- 70% alcohol	Clean with GPD, dry and wipe with 70% alcohol at the beginning and end of the ward round/clinic session, daily and after examining patients infected with MDROs. Dedicate one stethoscope per patient or clean with 70% alcohol between patients in ICU and PBU.

Mackintosh	Cleaning- GPD Disinfection- 1% hypochlorite	Immerse in 1% hypochlorite for 30 minutes then wash with GPD and hang to dry
Plastic waste bins	Cleaning- GPD Disinfection- 1% hypochlorite	Should be lined with appropriately covered bin liner. At the end of the day, wash with GPD and store inverted for drying. If contaminated with blood or body fluids decontaminate with 1% hypochlorite

References

1. Quality Supervision Tool for Primary Medical Care Institutions in Sri Lanka, December 2020 https://quality.health.gov.lk/images/publication/quality_supervision_tool_for_primary_medical_care_institutions_compressed.pdf

2. Sri Lanka College of Microbiologists, Hospital Infection Prevention and Control Manual available from https://slmicrobiology.lk/hospital-infection-prevention-and-control-manual-2/

CHAPTER 12

HEALTH CARE WASTE MANAGEMENT

12.1 Introduction

Health Care Waste (HCW) encompasses all waste generated within a healthcare facility. Proper management of HCW is a critical component in delivering quality healthcare services. It is also vital for maintaining a healthy environment, safeguarding occupational health and safety, ensuring the well-being of staff responsible for handling waste, and supporting infection prevention and control efforts. Health Care Waste Management (HCWM) should be integrated into the overall management system of a healthcare facility (HCF).

12.2 Responsibility

The MOIC of the PMCU holds administrative responsibility for ensuring the proper management of HCW within the facility. However, all healthcare staff working at the PMCU are equally responsible for actively participating in the safe and proper management of HCW by adhering to the established HCWM guidelines. Patients, visitors, and the surrounding community also share the responsibility of supporting the PMCU's HCWM program.

Every PMCU is responsible for the proper management of the waste that it generates until its final disposal, in accordance with the National Environmental Act No 47 of 1980 and National Environmental (Amendment) Act, No. 53 of 2000.

12.3 Duties and Responsibilities of the MOIC of the PMCU

The MOIC is responsible for overseeing the overall effectiveness of the Health Care Waste Management (HCWM) plan within the PMCU. He/she must take all necessary measures to implement a safe HCWM plan, including assigning specific duties and responsibilities to all staff under their supervision. Additionally, the MOIC is tasked with obtaining the Scheduled Waste Management License (SWML) for the PMCU, which must be renewed annually.

12.4 Types of HCW

HCW can be broadly divided into two groups:

- Non-hazardous (Non-risk) HCW
- Hazardous (Risk) HCW

Around 75% to 90% of HCW generated in the PMCU is considered non-hazardous (non-risk) waste. Around 10% to 25% of the HCW in it is classified as hazardous (risk) waste. Both non-hazardous (non-risk) and hazardous (risk) HCW need to be managed properly. Hazardous HCW must be specifically managed as per the recommendations due to their potentially harmful effects both on the health of humans and the environment.

12.5 Categories of HCW Generated in PMCUs

Non-hazardous (non-risk)	Hazardous (risk)
Food waste	Infectious waste
Garden waste	Sharps waste
Mixed waste	Pharmaceutical waste
Clean plastic/polythene	E - waste
Clean cardboard/paper	Waste items with mercury
Clean glass	

Definitions:

Non-hazardous (non-risk) HCW categories
General bio-degradable HCW

- Food waste - This includes food waste generated in the PMCU
- Garden waste - Leaves and branches collected in the garden need disposal
- General non-recyclable HCW - This includes non-recyclable HCW and includes used lunch sheets, biscuit wrappers, yogurt cups, lunch wrapping paper, paper soiled with food, etc
- General recyclable HCW - These include clean polythene/plastic, cardboard/paper, and glass which can be recycled

Hazardous (risk) HCW categories

- Infectious waste - This includes all waste that may contain pathogens (or their toxins) in sufficient concentration to cause diseases in a potential host. Examples include waste contaminated with blood and other body fluids, excreta, and materials that have been in contact with patients infected with infectious diseases.
- Sharps waste - Sharps are items capable of causing cuts or puncture wounds, such as needle stick injuries. This category includes used hypodermic, intravenous, or other needles; auto-disable syringes; syringes with attached needles; infusion sets; scalpels; pipettes; knives; blades; and broken glass.
- Pharmaceutical waste - This includes expired, unused, spilled, or contaminated pharmaceutical products, drugs, and vaccines. It also encompasses discarded items used in handling pharmaceuticals, such as bottles, vials, and connecting tubing.
- E-waste - Waste electrical and electronic equipment from the hospital, such as computers, printers, refrigerators, and similar items, fall under this category.
- Waste items containing mercury - This includes end-of-life items such as thermometers, sphygmomanometers, fluorescent tubes, CFL bulbs, and amalgam materials containing mercury.

12.6 Health Care Waste Management in the PMCU

The HCW management programme of the PMCU should be planned based on the following principles.

a) Avoid the generation of HCW as much as possible.

b) Minimize the quantity of HCW generated by the HCF.

c) Reuse materials where feasible.

d) Recycle suitable waste items.

e) Ensure proper final treatment and disposal of HCW.

f) Promote occupational health, safety, and the well-being of staff handling HCW.

g) Implement the following steps to manage HCW generated in a PMCU:

- Segregate HCW appropriately.
- Package HCW securely.
- Safely transport HCW to the onsite waste storage facility.
- Store different HCW streams properly in the onsite waste storage facility.

h) Treatment and final disposal of all HCW streams - Non-hazardous (non-risk) and hazardous (risk)

12.7 Segregation of HCW

Segregation of HCW must take place at the source of generation. This process involves the use of bins that follow the standard national color code system for healthcare waste management, as illustrated below.

Table 1: National colour code for segregation of HCW

	Colour	**Type of waste**
	Yellow	Infectious waste
	Yellow with a red stripe	Sharps waste (Sharps bin)
	Green	Bio-degradable waste such as food waste
	Black	Non-biodegradable, non-recyclable, non-hazardous waste eg used lunch sheets
	Blue	Clean cardboard/paper
	Orange	Clean plastic/polythene
	Red	Clean glass
	Grey	E-waste
	White	Pharmaceutical waste

12.8.a Waste Bins

Foot-operated, strong, and durable waste bins with well-fitting lids, aligned with the standard color code, should be used for collecting different streams of HCW. These bins must be placed according to the specific types of HCW generated in each setting. The size of the waste bin (30 liters or 10 liters) should be determined based on the quantity of waste generated at the location, such as a ward, clinic, or OPD.

12.8.b Sharps Bins

The bins should be made of leak-proof and puncture-proof material and must be labeled with the biohazard symbol. The sharps bin should feature a top opening that is just large enough to dispose of used sharps safely and should include a handle for easy carrying.

12.8.c Waste Collecting Bags

The bins must be lined with plastic bags matching the color of the bin. For infectious waste, 75-micron (300-gauge), leak-proof yellow plastic bags should be used. Black, green, red, blue, and orange bags should be 50 microns (200-gauge). All waste bags must be labeled to identify their source, enabling any issues with waste segregation to be traced back to the originating area.

12.8 Waste Packaging

When the bin is ¾ full, the plastic bag needs to be removed from the bin and tied tightly to prevent any spills of HCW.

Waste categories	**Colour of the bin and markings**		**Type of container**	**Collection frequency**
General non-recyclable HCW	Black.		Plastic bag (50 microns) inside a bin	When three-quarters filled
General bio-degradable HCW	Green		Plastic bag (50 microns) inside a bin	When three-quarters filled
General	Orange (Clean plastic)		Plastic bag (50	When three-

Waste categories	Colour of the bin and markings		Type of container	Collection frequency
recyclable waste Non-contaminated plastic / glass / paper, to be recycled	Blue (Clean cardboard/paper)		microns) inside a bin	quarters filled. .
	Red (Clean glass)			
Infectious waste	Yellow		Leak-proof strong plastic bag (75 microns/300 gauge) placed in a bin	When three-quarters filled
Sharps waste	Yellow with a red stripe		Puncture-proof container (safety box)	When three-quarters filled
Pharmaceutical waste	White		Plastic bag or rigid container.	On demand.
E-waste	Grey		Plastic bag or rigid container.	On demand.

Table 12.2: Recommended segregation and collection scheme

12.9 Safe Transportation of HCW to the Onsite Waste Storage Facility

On-site transportation of waste should be conducted during less busy times to minimize disruptions. Collected waste must not be left, even temporarily, in any location other than the designated storage facility. Carts or trolleys used for waste transportation must be exclusively reserved for this purpose and should not be used for any other activities. These transport devices must be cleaned and disinfected daily. To prevent injuries and the transmission of infections, they should meet the following specifications:

a) Easy to load and unload;

b) No sharp edges that could damage waste bags or containers during loading and unloading;

c) Easy to clean

d) Labeled and dedicated to a particular waste type;

e) Easy to push and pull

f) Carts/trolleys should be appropriately sized according to the volumes of waste generated at a facility.

g)

Hazardous and non-hazardous waste should always be transported separately. The transportation of waste to the storage facility should follow these guidelines:

a) Waste transportation carts/trolleys for general waste should be painted black and only be used for non-hazardous (non-risk) waste types. Infectious waste can be transported together with sharps waste.

b) Infectious waste should not be transported together with other hazardous waste to prevent the possible spread of infectious agents. Carts/trolleys should be colored yellow for infectious waste. Infectious waste and sharps should be transported by trained hospital staff.

c) Other hazardous waste, such as pharmaceutical wastes and e-waste should be transported separately in boxes to a storage facility.

12.10 Storage of Different HCW Streams in the Onsite Waste Storage Facility

In all PMCUs, storage facilities must be provided for storing HCW streams in accordance with the National Colour Code for HCWM. The designated storage facility should be located within the hospital premises but away from areas used for food storage or preparation.

The central storage facility must be fully enclosed and secured to prevent unauthorized access. It should be inaccessible to animals, insects, and birds and designed for easy cleaning and disinfection, with adequate ventilation.

General non-recyclable waste should be stored for collection by the local authority (LA). General recyclable waste, such as clean cardboard, paper, plastic, and glass, should be stored in separate compartments within the storage facility.

Infectious and sharps waste must be disposed of as soon as possible. Infectious waste should not be kept in the storage area for more than 48 hours. It must be stored in a manner that maintains container integrity, prevents leakage or release of waste, and protects against water, rain, and wind. Sharps waste can be stored for longer periods.

Pharmaceutical waste and e-waste must be segregated from other waste and stored safely. Mercury-containing items, such as end-of-life thermometers, sphygmomanometers, fluorescent tubes, and CFL bulbs, should be stored in a secure location. CFL bulbs and fluorescent tubes must be kept in a covered storage area to ensure their safety.

12.11 Treatment and Final Disposal of all HCW Streams - Non-Hazardous (Non-Risk) and Hazardous (Risk)

The following treatment and disposal methods are recommended for the different HCW streams.

Waste stream	Method
General degradable HCW	
• Garden waste	Composting on site
• Food waste	Every effort should be made to avoid food wastage in the hospital by the health staff.
General non degradable HCW	Handing over to Local Authority.
General recyclable HCW	Clean plastics, clean glass, and clean cardboard/paper should be handed over to recyclers registered with the Central Environmental Authority of Sri Lanka. The Regional Directors of Health Services should advise about the collection mechanism.
Infectious waste and sharps waste	Incineration or treatment using a MetaMizer (Hybrid Autoclave) is recommended. Final disposal of these wastes should be done as per the district-level clustering plan approved by the Regional Director of Health Services.
Pharmaceutical waste	Handing over to Regional Medical Supplies Division. Obtain advice from the Regional Director of Health Services.
E-waste	Handing over to registered e-waste collectors with the Central Environmental Authority. Obtain advice from the Regional Director of Health Services.
Mercury waste	Safely store mercury-containing waste until a disposal method is notified by the Ministry of Health

Table 12.3: Recommended treatment and disposal methods of HCW.

12.12 Occupational Health and Safety of Staff Handling HCW

Staff handling HCW must wear protective clothing at all times while handling waste. This includes covered shoes and an overall or apron as mandatory attire. Masks and industrial gloves should be worn as required for specific tasks. Routine access to washing facilities with soap and water must be provided to ensure hygiene.

Workers responsible for disposing of sharps and infectious waste must be vaccinated against Hepatitis B. They should also receive training in health and safety to ensure they are aware of

the potential risks associated with healthcare waste. Additionally, they must undergo comprehensive training in the proper procedures for the safe management of such waste.

Staff should be clearly informed about the importance of consistently using personal protective equipment (PPE) to protect themselves and others from potential hazards.

12.13 Implementation of the HCW Management Measures in the PMCU

Implementing adequate procedures to minimize the overall risks associated with HCWM should be a priority for each PMCU. Each PMCU should have a HCWM plan for the hospital. It should include the following

i.) Duties and responsibilities for different categories of hospital staff members who will generate HCW or be involved in their management

ii.) Quantities of hazardous and non-hazardous HCW generated as follows

a) Infectious waste (kg/week)

b) Sharps waste (kg/week)

c) Clean glass, clean cardboard/paper, clean plastic (kg/month)

d) E-waste and Mercury waste (kg/annually) or (Number of items/annually)

iii.) Annual requirements (human resources, equipment, infrastructure, and budget) for the implementation of the HCWM plan

iv.) Monitoring procedures to trace HCW inside the HCF and to ensure that HCWM rules are respected

v.) Training schedule for all categories of HCF staff members on HCWM

12.14 Intra and Inter-Sectoral Coordination in HCWM

MOIC shall work closely with the officials of the district or provincial environmental authority and local authority as and when necessary. Liaising with the RDHS/ PDHS is recommended in managing HCW.

CHAPTER 13

INFORMATION MANAGEMENT

Health information includes all data or information that is generated, captured, transmitted, stored, processed, analyzed, and disseminated—whether on paper or in electronic format—pertaining to health or healthcare services. This term encompasses information related to both preventive and curative health services, health administration, and research.

Healthcare is an information-intensive domain where health information is crucial for decision-making processes. This includes decisions related to screening, diagnosing, treating, and assessing care outcomes, which in turn inform administrative decisions for planning, implementing, and monitoring service delivery.

PMCUs are required to maintain the following registers and submit the specified returns, either in paper-based or electronic format.

13.1 Registers:

13.1.a OPD Register

The particulars of patients attending the OPD must be recorded in the OPD register, which should be maintained according to the headings specified in Annexure I. Subsequent visits, fever and diarrhea cases, sputum collected, and cases notified should be marked with an "x" in the relevant columns. At the end of each day, a line must be drawn, and a summary prepared. A similar register must also be maintained for branch dispensaries and visiting stations.

13.1.b Collection Book

A collection book must be maintained using the headings outlined in Annexure II. Daily totals from the OPD register, as well as from similar registers kept for branch dispensaries and visiting stations, should be recorded in the collection book. These entries must be totaled at the end of each month.

13.2 Clinic Register

If clinics are held, a register has to be maintained to get the number of first and subsequent visits.

13.2.a Family Planning

New acceptors of family planning must be recorded in Form H1200, which is also used for reporting purposes. This form must be completed in duplicate. The return should be submitted monthly, following the instructions provided on the reverse side of the form.

13.2.b Healthy Lifestyle Clinic Register

The PMCU is responsible for providing preventive healthcare to the apparently healthy population within its catchment area through the Healthy Lifestyle Clinic (HLC). A register (H1236A, B) must be maintained to record the registration of participants attending the HLC.

13.3 Returns/ Reports:

13.3.a OPD/clinic Return

This return has to be submitted quarterly to the RDHS. Information to prepare this return has to be obtained from the collection book, and the clinic registers.

13.3.b Notification

Notification card (H544) has to be filled in respect of all cases of notifiable diseases treated at the OPD and submitted to the MOH. It is important that the correct address of the patient is given in the notification card. To facilitate identifying the patient's home, a prominent landmark should be mentioned where necessary.

13.3.c NCD activity return

A monthly return on NCD screening activities is carried out at every PMCU to be forwarded to the RDHS of the district. Format H1239 is used for this purpose.

13.3.d Digital Transformation

Sri Lanka is undertaking a new phase of health sector development through the adoption of eHealth and digital health technologies. The success of this initiative relies on the establishment of uniform digital practices across both curative and preventive healthcare institutions. Consequently, healthcare managers are encouraged to familiarize themselves with these practices, as they are essential for the administrative activities related to implementing and managing health information systems in all healthcare facilities.

To initiate the digital transformation process, the head of the institution is advised to consult the following official publications issued by the Ministry of Health and seek further clarification from the Health Information Unit of the Ministry of Health:

i.) National Digital Health Guidelines and Standards
ii.) Information Security Guideline for Health care Institutions
iii.) National Policy on Health Information

The digital health systems in Sri Lanka's healthcare sector shall utilize the Personal Health Number (PHN) to accurately link healthcare recipients to their health records. The PHN is a unique identifier assigned to an individual upon their first contact with the healthcare system.

The Health Information Unit (HIU) of the Ministry of Health will serve as the issuing authority for assigning identification numbers to the points of issue, referred to as the "Point of Issue ID (POI ID)." Both state and private healthcare institutions are required to obtain their POI ID from the HIU.

CHAPTER 14

COMMUNITY PARTICIPATION

14.1 Introduction

The World Health Organization defines community participation as “a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services, and in taking action to achieve change.” This approach encourages local residents to take an active role in developing health institutions and raising awareness, thereby increasing both the receptivity to and provision of healthcare services.

Through community participation, individuals are involved in the decision-making and implementation of health programs, allowing for the sharing of social and economic resources to enhance healthcare provision. This method is not only cost-effective but also ensures the health needs of the community are met.

Each health care institution serves a specific population, known as the "empaneled population," whose members are expected to primarily access healthcare services from their designated institution. To meet the health needs of this population, hospital staff must work closely with the community.

To foster community involvement and gain support for the institution, it is recommended to establish a dedicated committee. The following steps can be taken to effectively organize such a committee within the healthcare institution:

a) Identification of the local community
b) Identification of empaneled population and Grama Niladhari divisions
c) Identification of main stakeholders in the area including,
    - Government field officers including both health and non-health officers such as Grama Niladari of each Grama Niladari Division , Development Officer, Samurdhi Development Officer, Agrarian Officer, PHM and PHI, etc.
    - Political leaders of the area
    - All the religious places of the area (Buddhist, Catholic, Islam, Hindu etc) get the support of the religious leaders.
    - Government offices such as -Divisional Secretary, Agriculture office, Agrarian service office, Government banks, Police, and schools, etc.
    - Other institutions and organizations such as NGOs, private sector organizations, and community organizations such as business community, trade or industry, NGOs such as Red Cross, St Jones, Sarvodaya, World Vision, Sanasa, Village Development Society, Agriculture Society, Funeral Aid Society, retired government, and private sector officers, etc.

14.2 Composition of the Committee

a) Head of the Institution

b) The Medical Officer of Health (MOH) for the area.

c) Public officers at the village level (GN, DO, EDO, PHI & PHM, etc.), and representatives from each of the Grama Niladhari (GN) Divisions served by the PMCI (empaneled area). These representatives should be strong community leaders with a demonstrable track record. There should be a substantial representation of women and youth.

d) Key religious leaders from the area reflecting the religious composition of the empaneled area.

e) representatives from professionals and the business community.

f) representatives from active CSO/NGOs.

g) Representatives from key disadvantaged groups

14.3 Functions of the Committee

a) Raise awareness and mobilize the community on health issues and help organize the community to effectively, optimally, and rationally use the services provided by the PMCI.

b) Engage in Health Promotional activities in the community.

c) Serve as the main platform for community/community leaders to be a forum for active collaboration between the public and the Institution in improving health care service

d) Actively contribute to the optimal functioning of the PMCU.

e) Help mobilize resources to fulfill the needs of the hospital (through local philanthropists, the business community, NGOs, CSOs, CBOs, etc.)

f) Contribute to the effective functioning of the hospital - early identification of deficiencies and engaging constructively with the Head of the Institution to address the same.

g) Assess the health needs of the community on a continuing basis and be a link/bridge between the PMCU and the MOH to make the system respond to such needs and particularly those marginalized groups.

h) Implement projects to address identified health issues/ needs that could be addressed through community engagement.

i) Members of the committee to act as change agents who will empower the community with correct knowledge and skills.

j) Assist in local emergency situations (outbreaks, disasters, etc.) (Ref. Disaster Preparedness Plan)

k) Help communities to access the GRM services at PMCIs and resolve grievances at the local level.

l) Identify the health needs of the differently abled and elderly in the empaneled area and assist the PMCI to deliver services.

Limitations to the Functions of the Committee

The members shall have no right to:

a) Issue instructions to hospital employees on any matter, and any complaints should be directed to the Head of the Institution.

b) Collect or accept money for or on behalf of the hospital without the prior approval of the proper authority.

c) The members of the committee shall not interfere in the general management or administration of the hospital.

d) No member should issue any press release on matters pertaining to the work of Institution.

e) Public, press, etc. should not be permitted to participate committee meetings without the expressed permission of the proper authority.

f) Shall not misuse the privilege of committee member (priority at the clinic OPD Etc.

Reference

1. Revised Guidelines on Community Engagement and Grievance Redress Mechanism for Primary Health Care- Ministry of Health 2023

CHAPTER 15

RESPONSIBILITIES OF MEDICAL OFFICER/ REGISTERED MEDICAL OFFICER

The Medical Officer or Registered Medical Officer fulfills responsibilities as the team leader in administration, management, supervision, monitoring and evaluation of patient care, staffing, supply chain management, public relations, registry and record maintenance, infrastructure upkeep, finance management, general hygiene, waste management, collaborating with local and international agencies etc

1. Clinical Services: PMCU provides the first-contact care and the initial point of contact for patients seeking medical attention. The MOIC in a PMCU is entrusted with the crucial responsibility of overseeing clinical services to guarantee high-quality patient centred care. This involves supervising medical procedures, diagnosing illnesses, and prescribing treatments based on established protocols. Furthermore, the medical officer collaborates with the health care team to optimize patient outcomes and ensure the delivery of comprehensive medical services, they offer.
2. Preventive Care: The medical officer in a PMCU plays a vital role in spearheading preventive care initiatives. They are tasked with designing and implementing strategies that promote wellness and prevent diseases within the community. This involves conducting health education programs, administering vaccinations, and conducting screenings to ensure early detection and intervention
3. Coordination and Referral: In a PMCU, the MOIC holds the crucial responsibility of coordinating referrals, including both outgoing and back referrals from apex hospitals. MOIC should liaise with specialized units to ensure patients receive necessary advanced care. Moreover, the MOIC should facilitates the flow of information between various health care providers, ensuring a well-coordinated, comprehensive, quality and safe treatment journey for patients.
4. Health Promotion: MOIC bears the responsibility of leading health promotion efforts in the PMCU. This involves designing and implementing initiatives to encourage healthy lifestyles, raise awareness about prevalent health issues, and provide guidance on preventive measures. By conducting educational campaigns and engaging in community outreach initiatives, the MOIC actively promotes the betterment of the local population's health and well-being, all while adhering to the guidelines set forth by the Health Promotion Bureau.
5. Community Engagement: The MOICs role within a PMCU encompasses active engagement with the community. They are tasked with organizing health awareness campaigns, workshops, and outreach programs to educate residents about health issues and promote preventive care. Additionally, the MOIC collaborates with community members to understand their health care needs and concerns, fostering a two-way dialogue for improved health outcomes

6. Data Collection and Reporting: The MOIC should maintain accurate and up-to-date health records of the patients (returns & forms) and various health indicators. MOIC should oversee the systematic gathering of health care information, ensuring accuracy and relevance. The MOIC also guides the preparation and submission of timely reports to relevant authorities, contributing to informed decision-making and improved health care delivery, utilizing available digitalised system.

7. Facility Management: The MOIC in a PMCU bears the responsibility of overseeing facility management, ensuring that the health care environment is conducive to patient care. This includes maintaining the infrastructure, equipment, and cleanliness standards essential for efficient medical operations. Additionally, the MOIC ensures compliance with safety protocols and creates an environment that promotes the well-being of both patients and medical staff.

8. Emergency Response: During emergencies, the MOIC promptly delivers immediate care to stabilize patients before facilitating subsequent medical aid. When necessary collaborates with higher-level health care institutions, ensuring seamless coordination and facilitating patient transfers for advanced care.

9. Training and Capacity Building: The MOICs role in a PMCU extends to training and capacity building, where they are responsible for enhancing the skills of health care staff. This entails designing/planning and conducting training programs, workshops, and skill development sessions to ensure the health care team remains updated. The MOIC also evaluates the effectiveness of these initiatives to continually improve the quality of care provided by the PMCU.

10. Collaborating with Local Authorities: In a PMCU, the medical officer assumes the responsibility of fostering collaboration with local authorities. This involves engaging with municipal bodies, government agencies, and community leaders to align health care services with local needs. The medical officer also works to establish partnerships that facilitate resource allocation, emergency response coordination, and community health initiatives for the mutual benefit of the PMCU and the local population.

11. Medico-legal issues: The MOIC in a PMCU carries the critical responsibility of managing medico-legal concerns within the unit. This includes ensuring proper documentation of medical records and coordinating with legal authorities as needed. Given the complex nature of such matters, it is imperative for the MOIC to consistently consult the RDHS (Regional Director of Health Services) of the respective region

12. Inventory management: in a PMCU holds the responsibility of overseeing inventory management, which involves maintaining accurate records of medical supplies, equipment, and medications within the unit. The MOIC has to ensure seamless transition during handing over and taking over responsibilities, with clear communication and documentation to maintain continuity of patient care and administrative tasks.

13. Drug management: The MOIC should oversee the procurement, storage, and proper dispensing of medications to ensure patient safety and compliance with medical standards. The MOIC must also monitor drug expiration dates, manage inventory levels, and implement protocols for proper medication handling and disposal with the collaboration of the pharmacists and health care staff to maintain a smooth workflow and optimize patient care within the PMCU with the guidance from the Directorate of Quality and Safety.
14. Patient safety and quality: The MOIC holds the responsibility of establishing and managing an adverse events reporting mechanism. The MOIC ensures that health care staff are well-informed about the reporting process and are actively engaged in the collection of relevant data. Additionally, the MOIC collaborates with relevant authorities and stakeholders to analyze reported events, implement corrective measures, and continuously improve patient safety and quality of care within the PMCU by obtaining guidance from the directorate of Health care Quality and Safety.
15. Administrative coordination: The MOIC assumes the responsibility of ensuring administrative coordination and guidance, through the chain of command in the provincial and regional authorities. MOIC should actively participate in meetings convened by the Ministry of Health, RDHS or PDHS and the MOH, ensuring effective communication and collaboration. Through these efforts, the MOIC facilitates streamlined decision-making and the implementation of cohesive health care strategies within the PMCU.

CHAPTER 16

RESPONSIBILITIES OF DENTAL SURGEON

1. Clinical responsibilities: Deliver comprehensive oral healthcare within the PMCU, including dental diagnosis, treatment, and preventive services, while ensuring patient safety and high-quality care. Responsibilities include conducting oral health screenings, performing procedures such as restorations, extractions, and minor oral surgeries, managing pain effectively, addressing dental emergencies, and referring patients requiring specialized care to higher-level hospitals. Comprehensive follow-up services should also be provided to ensure continuity of care.
2. Preventive care: Provide guidance on oral hygiene practices, diet, and lifestyle factors impacting oral health. Educate patients on oral health practices, disease prevention, and the importance of good hygiene habits. Raise awareness about the significance of routine dental check-ups and early intervention to address dental issues proactively.
3. Patient record management: Maintain accurate patient records, documenting treatments provided, outcomes achieved, and follow-up care delivered. This meticulous documentation ensures a thorough overview of patient care. Timely submission of reports with patient statistics to higher authorities is equally essential for effective communication and regulatory compliance.
4. Equipment and supplies management: Ensure diligent maintenance and care of all dental equipment to guarantee optimal functionality and safety. Oversee supplies management, including the procurement, inventory control, and restocking of dental materials and equipment, to support seamless clinical operations.
5. Collaboration: Actively foster collaboration between health and non-health entities. Engage with medical professionals and administrative staff to create a cohesive healthcare environment. Work with community organizations, schools, and local authorities to enhance oral health awareness and outreach initiatives. Building strong connections across sectors ensures a holistic approach to oral health and community well-being.
6. Health promotion: Take a lead role in health promotion initiatives by educating patients on oral hygiene, disease prevention strategies, and the importance of maintaining good oral health. Design and conduct awareness campaigns, workshops, and seminars to improve community understanding of oral health issues. Collaborate

with the Regional Dental Surgeon to empower individuals to make informed decisions about their oral well-being.

7. MOH conference participation: Actively participate in the RDHS/MOH conference on a monthly basis, as mandated by General Circular 3009 of 26.01.89. This engagement facilitates the exchange of knowledge and insights, contributing to improved oral healthcare practices.
8. Leadership and continuity of care: As specified by General Circular 1189 of 23.09.81, assume the role of the officer in charge during the MOIC's absence in a one-person station. This includes overseeing clinic operations, patient care, and administrative tasks, ensuring uninterrupted service delivery.
9. Specialized programs: Oversee specialized programs tailored to provide oral healthcare for pregnant mothers, children, and oral cancer screening activities within the OHU. This involves dedicated scheduling with specific dates allocated for these groups. Adhere strictly to provided guidelines to ensure the effectiveness and success of these programs.
10. Confidentiality and ethics: Uphold the highest standards of confidentiality and ethics by strictly adhering to regulatory guidelines. Safeguard patient information and perform all dental procedures with integrity and professionalism. These principles ensure a safe, respectful, and ethical environment for patients and colleagues alike.

CHAPTER 17

RESPONSIBILITIES OF PUBLIC HEALTH NURSING OFFICER

The role of the Public Health Nurse Officer (PHNO) within a Primary Medical Care Unit (PMCU) involves a wide range of responsibilities. In addition to the fundamental duties of preventing and managing non-communicable diseases and providing holistic nursing care to the community, the PHNO's scope includes specialized areas such as palliative care, geriatric care, and the facilitation of targeted healthcare services. Furthermore, the PHNO plays a vital role in advancing evidence-based practices, thereby enhancing the understanding and delivery of comprehensive healthcare.

17.1 Care Provider in the Healthy Lifestyle Center Activities

a) Assist in the HLC clinics by drawing blood and collecting urine samples for biochemical analysis and taking anthropometric measurements (height and weight).

b) Adequate documentation of the services and maintain the registers

c) Registration of persons under care attending HLC and maintaining records and ensuring follow-up and referrals

d) Conduct health promotional activities on lifestyle changes for healthier living at the HLCs and in outreach programs.

e) Assist with emergencies such as acute exacerbation of bronchial asthma, acute coronary syndrome of patients attending the PMCU

f) Assist in wound management, foot care

g) Assist in the mobile clinic

h) Assist in follow-ups for patients attending the HLC center

i) Conducting breast examinations and doing Pap smears

j) Follow-up for Individuals with Mental Illness.

k) Provide eye care, stroke care, and ostomy care

17.2 Palliative Care

Palliative care focuses on providing relief from symptoms and stresses of chronic illnesses. The goal is to improve the quality of life for both client and the family. Therefore, PHNO needs to,

a) Attend to the client suffering from diseases and provide comprehensive care

b) Administer medicines and injections prescribed by the Medical Officer to the client if needed

c) Consider providing psychological, social, and spiritual support whenever needed

d) Get involve with holistic care

e) Family meeting

f) Management of total pain with pharmacological and non-pharmacological intervention

g) Prevent complications with bedridden patients by providing appropriate care and educating family members in manageing homecare on those who with bed sores, circulation problems, exercises, etc.

h) Insert Nasogastric tube and urinary catheters

i) Provide ostomy care

j) Perform wound dressing when needed and provide first aid

k) Ensure bereavement support and end-of-life support

17.3 Geriatric Care

a) Assessment of the older person (ADL, IADL, frailty)

b) Prioritizing issues with the coordination of a multi-stakeholder approach (especially with the social service officer)

c) Promotion of active healthy aging through advocacy to the older individuals, family members, caregivers, and other age categories according to the life course approach.

d) Basic nursing services provision through home visits

- NG feeding

- IV injection

- Wound dressing

- Urinary catheterization

(When advised by the MO)

- Effective communication with older persons, and caregivers including family members to get the decision she can conduct family meetings regarding care plans
- Assist in elderly clinics, including screening clinics
- Visit elderly homes, day centers, and village committees

- Liaise with a physiotherapist, occupational therapist, speech and language therapist in the rehabilitation of a person at the community level
- Maintain records and returns in relation to geriatric care
- Participation in-service training programmes on elderly care

17.4 Provision of Specific Services

PHNO shall provide specific services when requested by the supervising officers. This may include disaster management, and assisting the Public Health Staff for emergencies.

17.5 Research and Surveys

Shall conduct research studies under the supervision of the supervising officers with a view to evaluating achievements /determining service needs/improving service delivery/identifying patient outcomes and improving community health etc.

17.6 Any other Duties that are Assigned by the MOIC

PHNO shall undertake additional responsibilities or tasks which are required based on the directions of the MOIC. These tasks could encompass a wide range of activities that contribute to the overall functioning and effectiveness of the PMCU, potentially involving administrative, clinical, or coordination roles as needed.

CHAPTER 18

DUTIES OF DEVELOPMENT OFFICER

18.1 Maintenance of Relevant Documents and Records

i.) Maintaining accurate records, files, and documents pertinent to the assigned PMCU.

ii.) Organizing and planning the meetings conducted at the PMCU as instructed by the MOIC.

iii.) Documenting and organizing activities conducted at the PMCU, ensuring comprehensive records are maintained.

iv.) Regularly updating and disseminating circulars, guidelines, and other essential documents stored in the office.

v.) Organizing meetings as requested by the MOIC and managing the minutes of meetings, assisting in drafting meeting minutes held at the PMCU.

vi.) Maintaining organized records of supervision conducted by RDHS or higher officials within the institution.

vii.) Attending meetings, surveys conducted at the PMCU as requested by the MOIC.

18.2 Management of the HIMS system in the institution

i.) Performing efficient data entry and maintain accurate information in the Health Information Management System (HIMS) software, including client registration and all screening procedures of OPD patients.

ii.) Entering information of clients attending various clinics conducted under the PMCU.

iii.) Assisting the MOIC in conducting the 'Healthy Lifestyle Clinic' and maintaining records.

iv.) Keeping and managing participants' registers, monthly reports, follow-up registers, and Personal Medical Records (PMR) under the MOIC/ PHNO's guidance.

v.) Maintaining stock register for Personal Medical Records (PMR).

vi.) Coordinating programs to enhance client registration, screening, and health promotion among the empaneled population.

vii.) Compiling and maintaining a database of disease indicators for the empaneled population, preparing graphical representations for reporting and dissemination.

18.3 Other Supportive Activities

i.) Creating presentations and necessary reports as directed by the MOIC.

ii.) Preparing quarterly returns for Outpatient Department (OPD) and clinics.

iii.) Maintaining medical and dental clinic registers.

iv.) Assisting in general office duties within the institution.

v.) Organizing and managing personnel files of staff members.

vi.) Maintaining attendance and leave registers, as well as other staff-related files and documents.

vii.) Keeping track of the general and surgical inventory.

viii.) Undertaking additional tasks as instructed by the MOIC in unforeseen situations and disasters within the institution.

CHAPTER 19

DUTIES OF DISPENSER / PHARMACIST

19.1 Duties of the Pharmacist

i.) Dispensing the exact amounts of drugs as prescribed when required and providing necessary information to the patients.

ii.) Assigning duties and responsibilities to the staff in the pharmacy. (Dispensers, Saukya Karya Sahayaka)

iii.) Supervising the duties of the staff working under him in the pharmacy. (Dispensers, Saukya Karya Sahayaka)

iv.) Ensuring smooth functioning of the pharmacy.

v.) Keeping and handling the narcotics as per the regulations.

vi.) Handling and maintaining the surgical inventory and general inventory.

vii.) Ensuring continuous supply of medicines to the institution.

viii.) Placing orders to the RMSD and getting down a sufficient quantity of drugs Weekly for the pharmacy and quarterly for the institution

ix.) Maintaining accurate records of medication dispensing and patient interactions in the PMCU's information system.

x.) Counseling and educating the patients on the use of drugs and their possible side effects and advising the patient to take the full course of drugs prescribed.

xi.) Accounting for the medicines in possession as per the instructions.

xii.) Preparing required preparations as requested.

xiii.) Ensuring that pharmaceuticals are not wasted.

xiv.) Checking the expiry dates and informing short expiring items to the RDHS and the prescribers 3 months before the expiry date.

xv.) Advising the patient to take the full course of drugs prescribed.

xvi.) Keeping the pharmacy clean , tidy and safe as per the guidelines.

xvii.) Collecting unserviceable surgical items and forwarded to condemning boards.

xviii.) Assisting and participating in the board of surveys, and in condemning boards.

xix.) Readily assisting in clarifying any doubts regarding prescriptions and conducting of assigned duties.

xx.) Forecasting and estimating the annual institutional requirement of medical supplies

xxi.) Implementing quality assurance measures to ensure the safe and effective use of medications.

xxii.) Managing the PMCU's drug inventory, ensuring proper storage, and handling of pharmaceuticals

19.4 Duties of the Dispensing Officer

i.) Efficiently dispensing the prescribed drugs, ensuring accuracy in both medication and dosage. Additionally, provide patients with essential instructions and pertinent information regarding their medications.

ii.) Facilitating the procurement of an adequate quantity of drugs for the OPD Pharmacy from the Main stores, subject to approval by the MOIC.

iii.) Checking the received quantities and entering them into relevant registers.

iv.) Accounting for the medicines in possession as per the instructions.

v.) Preparing required extemporaneous preparations.

vi.) Ensuring that the pharmaceuticals are not wasted.

vii.) Checking the expiry dates and informing of short expiring items to the MOIC/ pharmacists or the head of the institution 3 months before the expiry date.

viii.) Advising the patient to take the full course of the drugs prescribed.

ix.) Keeping the pharmacy clean and tidy.

CHAPTER 20

DUTIES OF THE SAUKYA KARYA SAHAYAKA (ORDINARY)

The Saukya Karya Sahayaka must adhere to the attendance schedule and uniform dress code as outlined in the government circular. They are responsible for the following:

a) Keeping the land, gates, doors, windows, corridors and floors clean and safe in the institution they work.

b) Keeping the environment of the workplace clean and attractive by landscaping, lawn mowing and growing flowers and decorative plants etc.

c) Washing and cleaning the walls and floors (except bathrooms and toilets).

d) Efforts should be made to keep electrical equipment and water supply in working order, and to use carefully in order to prevent wastage. Bringing and distribution of water required for patients, institution and staff from outside when the water supply is disrupted.

e) Operating and maintaining office equipment when assigned.

f) Assisting in distribution, loading, transportation and storage of stock items such as medicines.

g) Should direct patients and visitors to the designated places and when necessary, direct the patients to the waiting room.

h) Directing patients in an orderly manner to Medical Officers, Registered Medical Officers and Assistant Medical Officers in a queue.

i) Assisting the Medical Officer at OPD in patient examination

j) Issuing relevant tokens/cards and serial numbers for outpatients and patients attending clinics and assisting in patient registration in case of emergencies, assisting in the examination of patients.

k) Assisting in helping patients safely out of ambulances and other vehicles and transporting them to PMCU and out.

l) Assisting patients when they need to go to the bathroom or toilet.

m) Acting as messengers when necessary and directing them correctly to relevant personnel or units.

n) Assisting in the maintenance of records, documents, and files in the office and ensure the utmost confidentiality of all official files.

o) To arrange for the collection and return of office keys kept at the police

station or any other place.

p) Prior approval from the Head of the institute is required for short-term leaves, and proper arrangements for covering duties must be made

q) Carrying out any duty assigned to them by the head of the institution / relevant unit should be performed without flaws.

DUTIES OF THE SAUKYA KARYA SAHAYAKA (JUNIOR)

a) Drains and all toilets should be cleaned with disinfectants. Toilets should be cleaned five times a day, at least three (03) times during the day, and whenever necessary.

b) Adhering to timely attendance and uniform dress code as per the government circular.

c) Washing and disinfecting bedpans, urinals, and spittoons. Washing and disinfecting all materials used by infectious patients as per safety guidelines.

d) Encouraging patients to use toilets and bathrooms properly.

e) Removing, cleaning, and disinfecting when patients defecate or vomit. Discarding parts from surgical excisions as directed by the head of the unit.

f) Keeping the surrounding area clean and safe.

g) Washing, neatly folding and handing over items such as mackintoshes and wet soiled cloths in the emergency room.

h) Carefully cleaning and handing over urine bottles, wash bottles, suction bottles etc. used by the patients following hygienic methods

i) Treating patients visiting the PMCU kindly.

j) Treating property of the PMCU with care, and protecting such with diligence and frugality

k) Assisting the Medical Officer in the outpatient department (OPD) during patient examinations. Assisting other staff in day-to-day duties whenever necessary.

l) Carrying out any duty assigned to them by the head of the institution / relevant unit should be performed without flaws.

m) When it is necessary to leave the institution for a short period during work hours, prior approval must be obtained from the head of the institute, and appropriate arrangements for covering duties must be made.

Annexure

Annexure I – Chapter 11

Hand washing technique poster (WHO)

Annexure II – Chapter 11

Hand rubbing technique poster (WHO)

Annexure III - Chapter 11

Management of spills

- Spills must be addressed immediately to prevent potential hazards.
- Ensure the area is safe by preventing individuals from walking through the spill and never leaving the spill unattended. Displaying a warning sign is recommended.
- Personal Protective Equipment (PPE) must be worn at all times while managing spills.
- Gather all necessary equipment, disinfectants, and waste receptacles or bags to manage the spill safely and effectively. A spill kit should always be readily available.
- Dispose of all items used during the spill management process in accordance with the local waste policy.
- Follow safe working practices and procedures to minimize the risk of exposure incidents while handling spills.
- In the event of an exposure incident during spill management, adhere to the local occupational exposure policy.
- Record and report all spillages to prevent future incidents, reduce exposure risks to blood or other body fluids, and ensure that appropriate measures and equipment are in place for effective spill management.

Contents in a spill kit:

Single-use items in the spills kit should be replaced after each use of the spill kit.

- Scoop and scraper
- Gloves – heavy duty rubber gloves
- Plastic apron/ disposable polythene apron
- Medical/surgical mask
- Eye protection (face shield/goggles)
- Absorbent material (paper towels/wadding)

- Clinical waste bags (yellow bags) and ties
- Disinfectant (hypochlorite powder or chlorine releasing granules to prepare 1% and 0.1% hypochlorite freshly prepared solution)
- Detergents
- Protocol for spill clean-up procedure (laminated)

Management of blood and body fluid spill

- Keep a "caution" board and isolate the area.
- Wear appropriate PPE in the spill kit.
- Cover the area of the spill with absorbent material (disposable paper towels/wadding) and allow to absorb.
- Pour freshly prepared 1% hypochlorite solution (10000 ppm available chlorine) on the absorbent material.
- Allow at least 10 minutes of contact time.
- Remove broken glass pieces using a forceps and discard them into a sharps bin.
- Remove absorbent material and dispose of in a yellow bag.
- Wipe the area with a detergent solution and allow it to dry.
- Remove PPE and place disposable PPE immediately in the yellow bag.
- Tie the mouth of the yellow bag.
- Wash hands wearing heavy-duty gloves with running water. Remove heavy-duty gloves and disinfect them in 1% hypochlorite.
- Wash hands with soap and running water.
- Arrange cleaning and disinfection of reusable supplies (e.g. mops, buckets etc.) immediately after the spill is managed.

Management of other spillages (vomitus, feces, and urine)

Spillages of body fluids containing solid/semi-solid matter e.g. feces and pus, need to be cleaned up and disposed into a yellow bag first as the presence of organic matter can markedly reduce the activity of any disinfectant applied.

- Wear appropriate PPE in the spill kit.
- Cover and contain the spillage with an absorbent material.
- Once absorbed, carefully clean the area removing the absorbent material with all organic matter (vomitus, feces) and absorbed liquid (e.g. urine). Discard all into a yellow bag.
- Mop the area with warm water and a GPD.
- Wipe over the area with 0.1% hypochlorite solution (1000 parts per million available chlorine) and let it dry.
- If the feces, urine, or vomitus was blood-stained, 1% hypochlorite solution (10000 ppm available chlorine) should be used.
- Remove disposable PPE and place it immediately into the yellow bag.
- Tie the mouth of the yellow bag.
- Wash hands wearing heavy-duty gloves with running water. Remove heavy-duty gloves and disinfect them in 1% hypochlorite.
- Wash hands with soap and running water.
- Arrange cleaning and disinfection of reusable supplies (e.g. mops, buckets etc.) immediately after the spill is managed.