Standard Operating Procedures (SOP) for Step-down Facility in Hub-hospitals of Nepal

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With the federalism in the country and the need of an entity to manage health sector disaster response, the Ministry of Health and Population (MoHP) has established Health Emergency and Disaster Management Unit (HEDMU) and Health Emergency Operation Centre (HEOC) as a focal point to coordinate with federal, provincial and local level for health sector response to emergency and disaster. As the focal point, HEDMU/HEOC has fulfilled the role of coordinating with National Emergency Operation Centre (NEOC) and NRDRRMA at Federal level under Ministry of Home Affairs and supervising capacity building initiatives for health sector disaster preparedness and response at national and Subnational.

During Nepal Earthquake 2015, due to the overflow of patients, less time for routine care as well as limited opportunity to offer rehabilitation services. Thus, because of the very high number of injured and the limited capacity of health facilities to provide immediate care for all led many patients lost to follow up once discharged.

Current global recommendations for technical standards in emergency highlight the essential role of early rehabilitation interventions as a part of the immediate response. They also acknowledge that as rehabilitation needs often persist beyond the immediate medical response, it is essential to sustain care (including provision of assistive devices) and Psycho social support for patients with long-term or permanent disability after immediate medical care is provided. Therefore, the setup of Step-Down Facility (SDF) can be effective to support hub-hospitals to initiate and provide transition care between hub-hospitals and home/community for people suffering from injury, functional limitation and disability after a disaster.

The **"Standard Operating Procedures (SOP) for Step-down Facility (SDF) in Hub-hospitals of Nepal"** provides the terms of reference which can be used by the hub-hospitals to ensure the standardization of services as well as ease the transition to the inclusive emergency health management operation at an appropriate time.

In this regard, I would express my gratitude to the all Divisions, section/unit chief of MoHP and Department of Health Services (DoHS) along with the world Health organization for their thematic contributions, continuous coordination and technical support during the whole process of developing, finalizing and publishing this SOP. I would like to express sincere thanks to Medial Professionals, Handicap International (HI), and Health System Strengthening Project team of HI for all the logistic and technical support to design, develop and publish this SOP. I hope that this SOP can be used as a starting point for the organizational policies and procedures for both planning and managing SDF.

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ABOUT THE SOP

This Standard Operating Procedure (SOP) for Step-down Facility (SDF) is designed to support hub-hospitals to initiate and provide transition care between hub-hospital and home/community for people suffering from injury, functional limitation and disability after a disaster. This document is the result of the collaborative work of Health Emergency and Disaster Management Unit (HEDMU), Ministry of Health and Population (MoHP), World Health Organization (WHO) and Handicap International. This document has been developed taking into account the lessons learned and resources developed in preparedness activities and response interventions following the Nepal earthquake 2015 and the information contained herein is subject to change as per local setting.

Use: This SOP presents the fundamental aspects of management and operations of the SDF. The content herein can be used as a starting point for the organizational policies and procedures. The SOP is anticipated to be used by the hub-hospitals for both planning and managing SDF. Modifications of this SOP are encouraged to make it suitable to local context and need.
This guideline is also the reference for foreign emergency medical teams that might convert their field hospitals into step-down facilities as demand for acute surgical and medical needs decreases over time. This should be done in consultation with HEDMU, MoHP according to the needs in order to ensure the efficient use of resources.

Roll out: Successful implementation of the guideline is expected considering that HEDMU, MoHP will take main stake of the transitional services to be rendered at the time of mass casualty management. The hub-hospitals, local governing authorities, Foreign Medical Teams and civil society organizations should jointly establish SDF to render transitional health service from hospital till patient goes home or are referred to higher centre. The functional coordination mechanism among HEOC, Provincial Health Directorate, PHEOC, Ministry of social development and hospital development and operation committee need to be established where the responsibilities rest with hub-hospitals. Timely and successful implementation should be ensured through hospital staffs, their enhanced competency and timely logistic arrangement.

ABBREVIATION

ADL	Activities of Daily Living
CBO	Community Based Organization
CSO	Civil Society Organization
DEOC	District Emergency Operation Centre
OPD	Organizations of Persons with Disabilities
ECHO	European Civil Protection and Humanitarian Aid Operations
GoN	Government of Nepal
HA	Health Assistant
HEDMU	Health Emergency and Disaster Management Unit
HI	Handicap International
HMIS	Health Management Information System
HPH	Health Promoting Hospitals
IADL	Instrumental Activities of Daily Living
IMC	International Medical Corps
INGO	International Non-Governmental Organization
IOM	International Organization of Migration
MoHA	Ministry of Home Affairs
MoHP	Ministry of Health and Population
MSF	Medecins Sans Frontiere
NGO	Non-Governmental Organization
P&O	Prosthetics & Orthotics
SDF	Step-down Facility
SDRF	Step-down Rehabilitation Facility
SIRC	Spinal Injury Rehabilitation Centre
SOD	Sudden Onset of Disaster
SOP	Standard Operating Procedure
UN	United Nations
VFPN	Vulnerability Focal Point Network
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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1. Background

1.1. Introduction

Nepal is prone to various types of natural disasters. According to Seismic and Disaster Vulnerability study, Nepal ranks 11th in earthquake and 30th in the flood hazard. High susceptibility to seismic and hydro metrological hazards and pre-existing socioeconomic vulnerability tags Nepal as the high risk country for natural disasters.

In Nepal earthquake 2015, total 8,969 people were killed and 22,302 were injured (Source: http://www.drrportal.gov.np/). Additionally, more than 400 health facilities were destroyed and over 700 partially damaged. Timely activation of health cluster and responsiveness of MoHP, Ministry of Home Affair (MoHA), UN agencies, humanitarian organizations and private sector had helped to identify referral need of injured cases to the tertiary care setting in the Kathmandu Valley. However, Kathmandu Valley was the only nearest and feasible option as most of affected districts were near to it. Because of that there was the overflow of injured survivors to the tertiary hospitals in Kathmandu Valley. On the first few weeks of Nepal earthquake, priority of the hospital was to save the life of injured people and discharge them so that more cases could be admitted with the genuine intention to save more lives. Due to this situation, limited time was available to hospital to keep the cases in wards that means less time for routine care as well and limited opportunity to offer the rehabilitation services. As it is well known that limited medical follow up and rehabilitation leads to the disabling condition which again adds economic burden to families, society and the country. Prevention of the disabling effect of injury after the disaster is the priority of the health system for both preparedness and response.

Though not defined properly during the preparedness phase, the concept of SDF came spontaneously after Nepal Earthquake 2015 as NGOs, CBOs and Civil Society groups based in Kathmandu Valley offered different types of services. Nutritional rehabilitation centers and elderly care homes attempted to convert their facility to admit people who were discharged from the hospital but still requiring routine medical follow up, nursing and rehabilitation services. Slowly such facilities started offering the rehabilitation services by collaborating with humanitarian agencies. The transfer of injured survivors to such homes was managed by International Organization for Migration (IOM), International Medical Corps (IMC) and Spinal Injury Rehabilitation Centre (SIRC) in collaboration with Medicins Sans Frontiere (MSF) Belgium.

The need of SDF was realized by the service providers working in the field of health and rehabilitation including Handicap International for addressing the problems encountered during the emergency. SDF offer different types of care depending on the capacity of each structure.

This included mostly basic medical and nursing care, provision of transportation for follow-up if needed, accommodation, food and medicines free of cost. Besides the direct provision of rehabilitation interventions in the facilities, all SDF should ensure safe discharge to their patients by developing individual discharge plans that included home care interventions, community-based care plans and appropriate and timely referral to other relevant services.

In the 2015 Nepal earthquake, four step-down facilities were formed by field hospitals and local facilities and often supported by international partners, to provide longer-term supportive care and rehabilitation. These step-down facilities remained operational for several months (several local-facilities continued to be used as step-down facilities for over a year) and were staffed predominantly by Nepalese physiotherapists and nurses, who were able to assist with linking those with ongoing health and social support needs to appropriate local services when needed. In short, step-down facilities should be capable of providing medical and nursing support as well as rehabilitation, with an emphasis on preparing patients with long-term impairments, their care providers, and local rehabilitation personnel to adequately manage ongoing needs beyond the departure of the EMT (WHO, 2016).

Functionality of Hospital

After the sudden onset of disaster (SOD) like earthquake, hospital might get lots of injured patients/cases to be treated, but the challenge is that, immediately after the disaster there might be more influx of the injured survivors in hospital as shown in below figure:

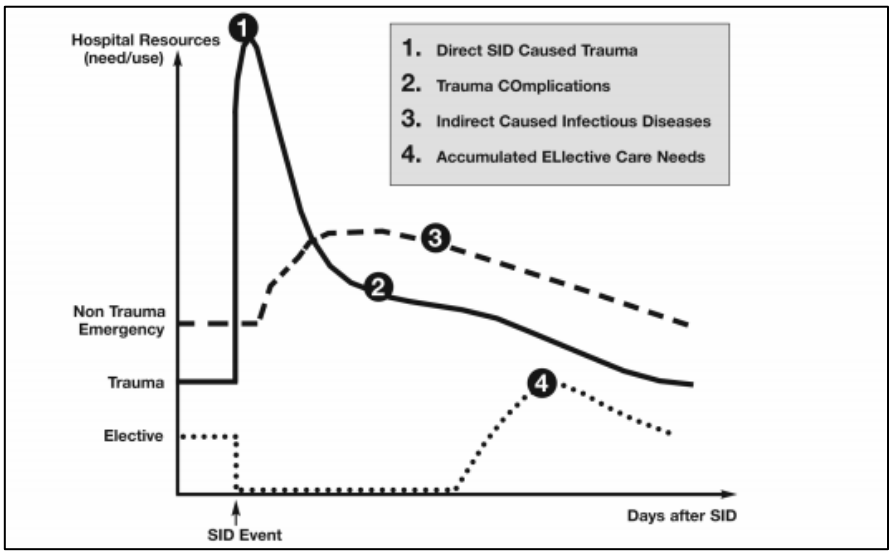


Figure 1: Conceptual model for the variation of over time needs/use of hospital resources for non-trauma emergencies, trauma complications and elective surgery before and following a SOD

This may compromise the continuation of other essential services of the hospital besides trauma management. To manage the injured survivor because of disaster and then gradual resumption to normal/routine functioning of the hospital is one of the important aspects of hospital resiliency (bouncing back) after the disaster as shown in Figure 2. To ensure better resiliency of the hospital and to prevent the disabling effect of the injury, an intermediate step-down facility is important. This should be part of the hospital emergency preparedness and response framework.

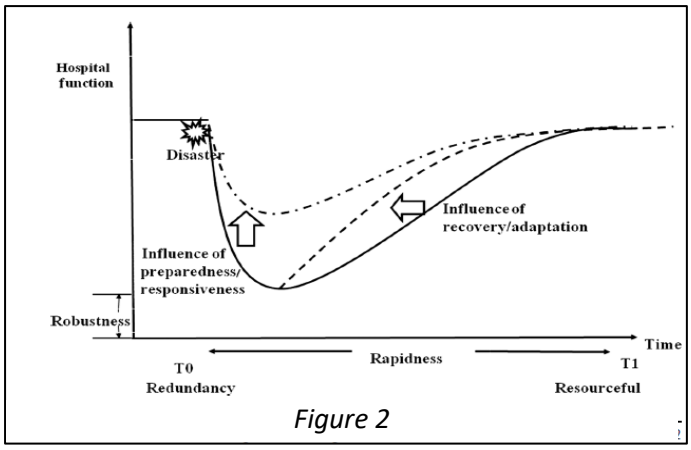


Figure 2

1.2. Definition of SDF

A step-down facility is an inpatient unit with a mandate to provide interim care for medically Stable patients while they are prepared for discharge into the community. In the context of emergency response, the concept of a "step-down facility" would be an inpatient unit with the capacity to provide interim care for medically stable patients while preparing them for discharge into the home/community (WHO, 2016).

SDF is a facility established as a part of an existing hub-hospital that provides multi-disciplinary inpatient health care services to injured patients. These services include Medical, Physiotherapy/ multi or trans-disciplinary rehabilitation, nursing care, psychosocial support and referrals to other health facilities and services that would support recovery and patient's well-being. It is considered as a transitional step between the hospital and home.

SDF allows the health service transition between hospital and home/community for people with injury, functional limitation, disability and psychosocial distress due to the health disaster with the objective of reducing the overburden of the hospitals and guarantee a proper follow-up to patients discharged.

1.3. Step-down Facility (SDF) vs. Step-down Rehabilitation Facility (SDRF)

Step-down Rehabilitation Facility (SDRF) is more intensive and rehabilitation focused whereas SDF is basic facility that provides nursing and rehabilitation follow-up including public health

interventions and psychosocial support. So, SDF is not similar with SDRF. Generally, SDRF comes after SDF, and can be one of the components of SDF.

1.4. Rationale

Because of the very high number of injured persons and the limited capacity of health facilities to provide immediate medical care for all, many patients were liable to lost to follow up once discharged. On the other hand, the setup of SDF by different actors can be effective in ensuring the essential follow-up care needed. Because of this, many injured can have access to medical, nursing, physiotherapy, trans-disciplinary rehabilitation, assistive/mobility devices, psychological and referral services.

However, these initiatives were implemented in the absence of common standards and they had to be adapted to what was available locally or to the mandate and means deployed by each organization. Current global recommendations for technical standards in emergencies highlight the importance of early rehabilitation interventions as part of the immediate response. They also acknowledge that as rehabilitation needs often persist beyond the immediate medical response, it is essential to sustain care (including provision of assistive devices) and social support for patients with long-term or permanent disability after immediate medical care is provided.

Based on the lessons learned from the experience of Nepal Earthquake 2015 and current global recommendations, stakeholders agreed on the need of strengthening the capacity of the health system to establish transitory care service after acute care in emergency as part of the hub-hospital preparedness developed by the MoHP. The terms of reference can be used by MoHP and hub-hospitals to ensure standardization of services and systematic transition of care as part of emergency health management operations over a period of time.

2. Objectives of Step-down Facility

2.1. General Objective

- To contribute to improved health and functional outcomes among people injured during disaster.

2.2. Specific Objectives

- To create operational awareness to MoHP stakeholders, hub-hospitals, and development partners and foreign medical teams on establishing and operating the SDF in large scale disasters.

- To provide transitional health and rehabilitation services in between hospitals and home/community to people with injury, functional limitation and disability.
- To ensure timely referral to specialized services when needed, in particular for fitting prosthesis and orthotics, to rehabilitation centre and reconstructive surgery, to specialized hospital.
- To ensure that the services are delivered according to quality criteria in health care such as effectiveness, efficiency, patient-centred, equity and accessibility.

3. Operational Guideline for the Establishment of Step-down Facility

3.1. Management

3.1.1. Need Assessment

The decision to set up SDF should be based on the surge capacity and bed occupancy of the hospital. As stated, rationale to establish the SDF is to ensure the medical & rehabilitation care while allowing hospital to decongest the occupied beds to offer medical services for those requiring it. SDF is part of the preparedness and response plan, and it should be activated when the bed occupancy exceeds 80% during the disaster. The remaining 20% of the bed should be kept vacant at all times for sudden influx of mass casualties.

The preparatory arrangement of step-down facility should be based on the information assessed during the rapid assessment carried out by MoHP authority and/or concern hospital immediately following the disaster.

3.1.2. Identification of Additional Resources and Partners

After the needs assessment, the hub-hospital will communicate with HEOC/HEDMU to coordinate with other hub-hospitals or other sites and identify additional resources that need to be deployed for the establishment and operation of SDF. Additional needs can be shared with the partners during the health cluster meetings for their support and collaboration to provide necessary materials, staffing and financial resources. Potential partners are WHO, bilateral/multilateral donors, I/NGOS, Community Based Organizations (CBOs)/Civil Society Organizations (CSOs), self-help groups including Disabled People Organizations (DPOs).

3.1.3. Leadership and Administration

- The medical, nursing and rehabilitation liability is always with hub-hospital. So the location of SDF establishment depends upon hospital management board and District Disaster

Management Committee's decision, space availability and contribution of potential stakeholders-CSO/NGOs/DPOs and external development partners. Generally it should be established not within but in nearby places as close as possible to the Hub-hospital;

- Possible places are nearby satellite hospitals, community hall and spaces provided by CSOs/NGOs/OPDs;
- The SDF will follow hub-hospital applicable institutional rules and regulations;
- The overall leadership and management of SDF will be done by hub-hospital coordinator referred as "Incident Commander";
- The SDF is designed to be managed by a disaster focal person of hospital;
- The hospital will be responsible for admission and stay of all patients through a disaster focal person in conjunction of incident commander;
- The disaster focal person will report to the incident commander;
- The disaster focal person will liaise with an appropriate SDF coordinator (who could be the nursing officer, Health Assistant (HA)/Paramedic or a person with clinical background as designated by incident commander); and,
- The SDF coordinator will provide technical guidance and ensure the use of best practices in medical and rehabilitation care.

3.1.4. Information on Services and Communication

An effective communication and information about SDF and its location should be done with local governing authority, provincial and federal health authorities, DRR actors and affected communities.

The referral services from hospital and SDF should be integrated into the national and provincial emergency plan with a mapping of SDF potential location. Coordination with vulnerability focal point network (VFPN) and Organizations of Persons with Disabilities (OPDs) will ease in the referral of cases identified in the community.

3.1.5 Health Management Information System (HMIS)

There must be well established HMIS for recording and reporting including SDF's service utilization disaggregated data. The minimum information to be collected is tabulated below.

S.N	Name	Age	Gender	Disability	Address	Contact Number	Diagnosis	Functional Status	Date of Admission	Date of Discharge

These data will be collected and regularly shared with incident commander through disaster focal points to update and review on needs, services provided, in order to help coordination efforts (data-driven advocacy) and improve services during the response and after.

3.1.6. Finances

It is advised to allocate the budget for prepositioning of the equipment & supplies for at least 3 months in the preparedness phase by federal, provincial and local government possibly in partnership with development partners under the leadership of HEOC/HEDMU. Humanitarian agencies with the expertise on such facility should support the government to build the capacity of SDF while operating during the emergency.

3.2. Transition Period

Period of SDF implementation is not fixed. This period depends on the needs and number of patients requiring medium & long term follow-up without possibility of safe discharge due to unavailability of adequate health and rehabilitation services in their communities. However, based on data from the 2015 earthquake response, it is estimated that the patients with fractures (multiple fractures, external fixators) require an average stay of 3 to 12 weeks, until removal of fixators and discharge. Patients with complex needs such as spinal cord injury require longer stay, until they can be admitted in specialized rehabilitation services for long term care.

Most of SDF in Kathmandu Valley that mainly received fracture cases were active for less than 6 months and could rely on a network of existing rehabilitation services for follow up of more complex cases after discharge. However, SDF in Sindhupalchowk was active for a longer period since it was situated in a remote area with limited access to regular rehabilitation services.

Thus, the duration of SDF depends on the availability of other rehabilitation services as well in the surrounding areas and possibility of referrals. When SDF are set up in areas with very low coverage of rehabilitation services, they need to be prepared to be active for longer periods.

Alternative support and linkages with telemedicine/Tele rehabilitation facilities, home care interventions, training of care givers and primary health care workers during the preparedness phase should be considered.

3.3. Facility Requirement

3.3.1. Space and Accessibility

- The area should be calculated taking into account that space per bed should be 1.5 meter square;
- The minimum space required for the delivery of rehabilitation service should be 12 square meter;
- Site gradient should not exceed 6% unless extensive drainage and erosion control measures are taken;
- Lowest point of site should not be less than 3 meter above the estimated level of ground water table in the rainy season;
- Minimum distance of 25 meter from nearby stream to minimize potential flooding is required;
- Land should be level enough so that it will be disabled friendly and disabled friendly structures can be easily constructed;
- Pathways to places accessed by patients (such as latrines) should be flat or ramped where necessary and the ground should be compacted or levelled to facilitate safe and independent access for people with restricted mobility, such as those using a wheelchair or crutches, older people and pregnant women;
- At least one latrine should be gender neutral to allow a care provider of the opposite sex enter with the patient;
- All doors should be 90 cm wide. If possible, sliding doors should be used. Otherwise, they should open outwards;
- All emergency exits should remain unobstructed; and,
- Step-down facilities should ease patients return to their home environment. They should be adapted to maximize patients' independence and safety.

3.3.2. Doorway

- Operational devices on doors, such as levers or pull handles should be easy to grip with one hand.

3.3.3. Structure

- As SDF being transitory facilities, tents can be used with all the utilities for resisting to the climate; and,
- All construction materials should be appropriate for potential hazards like earthquake.

3.3.4. WASH Utilities

- Safe source of water such as tap, natural spring, wells, etc. should be available;
- At least two latrines and bathroom should be available and should be disabled friendly;
- Showers or washrooms should have a seat 45-50 cm high, positioned for easy access to the showerhead or water source;
- The minimum surface of a latrine should include a turning circle of 150 cm to allow full manoeuvring of a wheelchair (ISO measurements are 80 × 130 cm);
- Grab bars should be mounted at a height of 85-95 cm from the floor for latrines;
- Latrines, commodes or other seat adaptations should be 45-50 cm high and 45-50 cm from the wall on which the grab bar is positioned; and,
- Washbasins should be 65-70 cm from the ground and extend 35-45 cm from the wall.

3.3.5. Sanitation

- There should be separate dustbins to collect organic and inorganic solid waste; and,
- Solid waste disposal pits need to be constructed at least 30 meter away from kitchen area.

3.3.6. Electricity

- Electricity for light and operating equipment is essential;
- 3 phase electricity connection is preferred; and,
- Backup option such a connection to hospital generator should be ensured.

3.3.7. Cooking Facility

- Proper ventilated separate kitchen and dining area is recommended;
- Kitchen should be minimum 30 meter apart from WASH area; and,
- Dining table height should be disabled friendly.

3.3.8. Vehicle

- Existing vehicle from the hub-hospital and other health facilities should be available for transporting injured patients to/from hub-hospital and their home for the discharge if the patients cannot use the public transport (wheelchair or others assistive devices users for example);
- Operational budget for using the vehicle (eg: fuel provision) must be managed by hub-hospital itself; and,

- If transportation is not available, the hub-hospital should coordinate with other available services/partners (for example charities or international organizations).

3.3.9. Fuel

- There should be provision of storing fuel for minimum 1 week period for unforeseen fuel shortage and scarcity prior to disaster. The fuel should be stored properly with all possible precautions.

3.3.10. Safety

- Fire alarm and smoke detector must be installed;
- Fire extinguisher should be placed and regular inspections should be done to ensure they are functional and up to date; and,
- Guard system must be in place to guarantee security of the equipment and the patients.

3.4. Infrastructure and Equipment Needed

3.4.1. Number of Beds

There is no evidence of the number of disasters' victims needing SDF services after having received emergency care during a disaster. In Nepal earthquake 2015, it has been estimated that 10% of the earthquake injured needed rehabilitation services and long-term follow up. Based on those data, we may suggest that number of SDF's beds may reach 10% of the total beds in the associated hub-hospital.

3.4.2. List of Infrastructure and Equipment

Following infrastructure and equipment need to be considered while designing and running SDF.

Equipment	Quantity
Beds	
Patient beds	**20 beds (or 10% of hub hospital bed capacity)**
Caretaker beds	**20 beds (or same or proportion of patient beds**
Buildings/Tents	
General tents (sleeping quarters) for staff and patients	6 tents

Transition tent for patients and caretaker	4 beds
Tent for administration and staff quarters	3 beds
Security tent	1 tent
Physiotherapy tent	1 tent
Psychosocial tent	1 tent
Kitchen and adjoining dining room	1 kitchen/dining hut
Laundry area	1 outdoor area
WASH Facilities	
Patient latrines (2F/2M)	4 latrines
Patient bathrooms (2F/2M)	4 bathrooms
Staff latrines (1F/1M)	2 latrines
Staff bathrooms (1F/1M)	2 bathrooms
Water tanks-large (3000 Litres)	2
Hand washing stations-small tanks (200 Litres)	8

Based on this comprehensive list of space, equipment and supplies, the hub hospital will assess the needs of additional equipment based on the following criteria:

- Bed capacity of the hospital and number of people in need of follow-up care
- Access to kitchen and other services
- Safety of the building

(Note: The infrastructure requirement listed in this section is based on an independent/separate facility with 20 patients and 10-20 caretakers. This list should function as a starting point for outfitting and SDF should be modified as necessary depending on the number of beds in the associated hub-hospitals).

4. Staff Structure for Step-down Facility

4.1. Roster Update

A roster of available health and rehabilitation staff with the valuable competencies **(TOR for staff is attached in annex 10.1)** should be available as a preparedness activity prior to disaster and should be updated timely.

4.2. Skills Required

All staff should be able to independently provide Medical, Physiotherapy/ multi or trans-disciplinary rehabilitation, nursing care, psychosocial support and referrals for patients (including pediatric and geriatric) under supervision of hub-hospital coordinator (incident commander) with:

- Fracture, including those with external fixation or traction;
- Amputation;
- Peripheral nerve injury;
- Burns, grafts or flaps if not yet referred to specialized centres;
- Patients with traumatic brain injury and spinal cord injury while they await specialist rehabilitation; and,
- COVID-19 Patients with moderate to severe breathlessness and other complications.

Essential Clinical Skills Required for Rehabilitation Staff

- Basic splinting;
- Assistive device prescription, fitting and training;
- Positioning and patient mobilization, including early mobilization;
- Education and re-training of patients and care providers in daily activities;
- Provision of psycho-social support, for example: psychological first aid;
- Respiratory care:
  - Sputum clearance techniques-Percussion (Clapping), Vibration and huffing or coughing
  - Proper Positioning-High side lying, Prone Positioning, Forward Lean Sitting, Forward Lean Standing
  - Breathing Techniques- Deep Breathing, Controlled Breathing and Paced Breathing Exercises
  - Proper Techniques about using Incentive Spirometer and Balloon Filling; and,
- Other Post COVID-19 Conditions:
  - Multi or Tran's disciplinary rehabilitation @ secondary and primary level.

Essential Clinical Skills Required for Nurses

- Safe transfers;

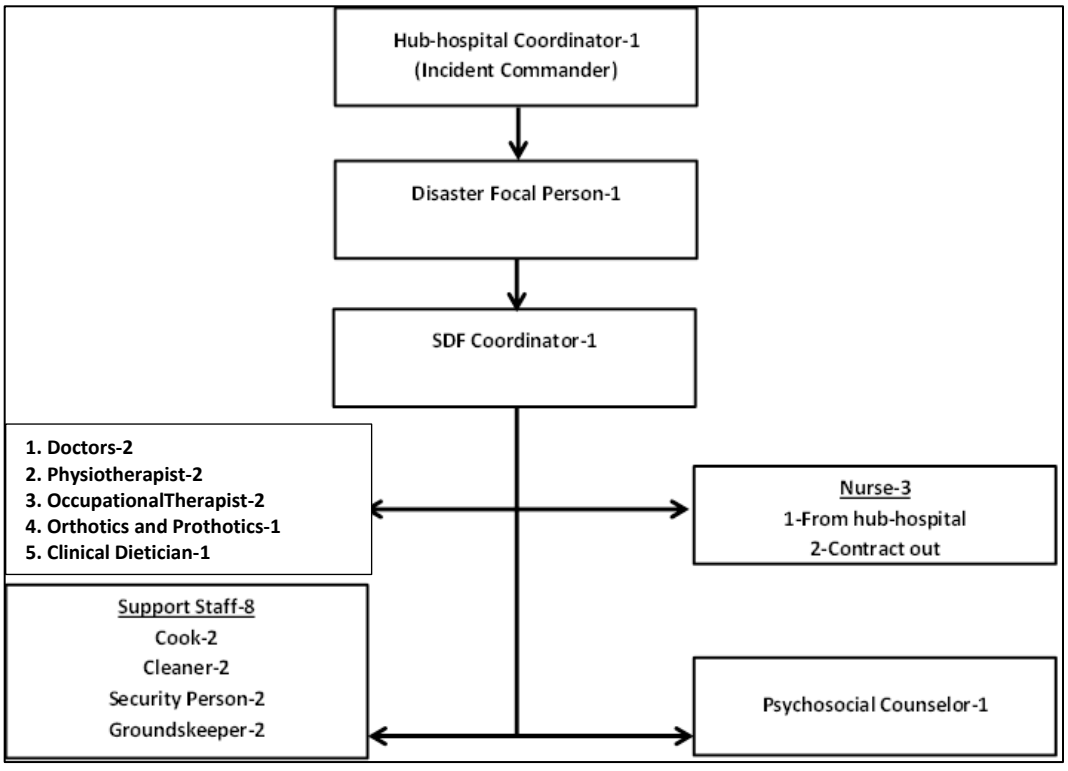
- Basic knowledge of prevention of complications in bedridden patients (positioning for prevention of bed sore, bowel and bladder management);and,
- Wound care.

4.3. Staff Selection

Staff will be recruited in accordance to roster as per availability, hired and paid by the hub-hospital with support of public, private, I/NGOS and CBOs/CSOs fund as available. Once the plan to set up the SDF in hub-hospital is fixed, it is important to orient the hospital staff about SDF, its intended services and referral mechanism.

4.4. Organogram

The SDF team should be multi-disciplinary with at least nurses, physiotherapists and psychosocial counselors. Prosthetics/Orthotics (P&O) and occupational therapist should visit the SDF as per need. The SDF can be managed in accordance to below organogram.



(Note: The number of staff can be modified based on availability of fund and human resource in each hub-hospital. If multi-disciplinary team is NOT available, a PT with Tran's disciplinary training, who can give secondary level rehabilitation involving all disciplines of rehabilitation, should be hired).

4.5. Work Shift Model

The staff work shift can be planned as follow:

S.N.	Staff	Work Shift Model
1.	Physiotherapist, Occupational Therapist and psychosocial counsellor(Other Rehabilitation Team Members)	▪ 40 hours a week (9am-5pm) ▪ 7 days a week
2.	Nurse	▪ 40 hours a week ▪ 7 days a week ▪ One staff member per shift - Morning (7am-2pm) - Evening (2pm-9 pm) - Night (9pm-7am)
3.	Support Staff (Cook, Cleaner, Security personnel and Groundskeeper)	▪ 40 hours a Week ▪ 7 days a week ▪ One staff member per shift - Cook and Cleaner ➢ Morning (7 am-3pm) ➢ Evening (11 am-7pm) - Groundskeeper ➢ Morning (7 am-2pm) ➢ Evening (12pm-7pm) - Security personnel ➢ Morning (7 am-2pm) ➢ Evening (12pm-7pm)

4.6. Staff Orientation

To handle work promptly, experienced staffs will be deployed to manage patients with trauma. An essential orientation should be provided according to the need for different areas as appropriate to their job functions. Trauma management protocols and guidelines endorsed by MoHP should also be used as a reference for the delivery of training by external international partners' Staff should also be oriented on recording and reporting mechanism.

5. Admission and Discharge Procedure

5.1. Eligibility Criteria

5.1.1. Inclusion Criteria

All admission to the SDF will be validated by the department in-charge (medical officer/surgeon, Physiotherapist, Occupational Therapist, other Rehabilitation team member and nurse) following assessment according to the following criteria:

- Patient medically stable and conscious (GCS 15/15);
- Patient from the remote location who will not have access to rehabilitation services at their place once discharged from the hospital;
- Expected prosthetic and wheelchair users;
- Patient needing the graded functional mobility;
- Injured people who need supervised care;
- Patient with internal or external fixators;
- Patient undergone ligament repair, osteotomy and joint replacement surgery;
- Patient with disability injured by disasters;
- Patient with risk of having the pressure ulcers;
- Patient who will benefit from short duration of rehabilitation care;
- Patients who have a carer, who is willing to take care of the patient when required (eg: pregnant, children, elderly, people with disability);and,
- Patients with moderate to severe post Covid 19 Conditions.

5.1.2. Exclusion Criteria

- GCS less than 15/15;
- Patients with unstable vital;
- Patient with acute infectious diseases;
- Patient with acute myocardial infraction and on-going unstable angina;
- Patient with severe anaemia and electrolyte imbalance;
- Patients who require acute intensive health services, no medically stabilized or unconscious; and,
- Patients with severe or uncontrolled co-morbidities

(Note: Patient who comes directly to the SDF will first go to hub-hospital for assessment)

5.2. Admission Protocol

The nurse on duty will brief the patient and caregiver about the rules and regulations and overall activities of the facility and will fill the admission form **(attached in annex in 10.5)**. The facility health care team will conduct a full assessment of medical, functional and psychosocial needs. Then, the patient will be placed on a treatment plan following SDF treatment protocols.

5.3. Discharge Protocol

Discharge should be the coordinated decision of consultant or medical officer, Physiotherapist, Occupational Therapist, other Rehabilitation team member and nurse of hub-hospital **(discharge form is attached in annex 10.6)**. There are 3 types of discharge:

5.3.1. Discharge on Request

Discharge may be requested by patient party even though interventions are still needed. But SDF team should make clear that SDF is not responsible for any further complication or unexpected medical events. The discharge form should be signed by both patient and caregivers explaining that the facility and the staff of the unit were not responsible for any complications or incidents that occur following discharge or in the future.

5.3.2. General Discharge

Patient discharge can be decided by SDF team after assessment of the patients who is presenting the following criteria:

- The short and medium terms functional goals are achieved;
- Assistive device users completed the user training;
- Patient has minimal risk of developing the complications;
- Patient has good balance and stump for the prosthetic fitting;
- Caregiver is able to assist the patient;and,
- Patients still needs follow up rehabilitation which is then available near to his/her place.

5.3.3. Discharge for Referral

The patient might be discharged for the purpose of referral (step-up) to specialized rehabilitation services like rehabilitation center to receive tailored assistive devices (prosthesis, orthotics or modified wheelchairs) or other services.

5.4. Patient Transport

Any patients requiring transportation to go to the SDF or to leave the SDF must be stable enough before departure. As a general principle, patient should be transported only if they are going to a facility for follow up or to their home after proper discharge order. Vital signs need to be assessed and recorded pre and post transfer of the patients. Any underlying disease factors, age factors, comorbidity or medical history of patients need to be assessed and should be informed to SDF coordinator for evaluation.

Means and procedures to support ultra-poor patients should be identified according to government regulation. In any case, eligibility criteria should be clearly established to provide free of cost transportation (either through vehicle available in the hub-hospital or through other means).

5.5. Patient Record

Patient record form **(attached in annex 10.11)** should be well maintained in confidential manner for each patient admitted to SDF.

6. Referral Process

6.1. Mapping of Referral Centre

Mapping should be done for all the potential referral centers and its services available by the hub-hospital as part of hospital preparedness to disaster in coordination with relevant stakeholders. A list of services with a description of admission criteria/procedures, number of beds, types of health and rehabilitation interventions available, costs and contact number of focal person should be available already. The list should be updated timely. Support from the DPOs and I/NGOs working in disability and rehabilitation can be sought in the mapping of referral center/step-up facility.

6.2. Preparing Referral and Transfer

- The SDF will assess the need of patients needing transfer to ensure that they are fulfilling the inclusion criteria of referral center;
- The SDF should inform the patient or responsible party the reasons for, risks and likely benefit of referral, and make an informed decision weighing risks vs. benefits;
- After agreement from the patient (in term of cost and time), selection of the referral center that can provide specialized care needed by the patient is identified;
- SDF must contact the focal person in the referral facility to agree on the referral; and,
- The SDF should submit referral form **(attached in annex 10.7)** to referral facility. SDF should notify referral centers of the cancellation of the referral in the event that the referral is no longer required. Response to SDF from referral center should be given within 2 working days of receipt of application. Responses to referrals should be specific to one of the following response categories:

  1. **Referral is accepted**
     - Provide date of admission

2. **Referral is accepted and waitlisted**
    - Provide estimated date of admission due to:
        - Current bed availability;
        - Current resource availability to accommodate complex patient need; and,
        - Infection control issues.
3. **Referral is pending**
    - Referral will be sent back and decisions is pending because
        - Referral form is incomplete; and,
        - Information is insufficient/inconsistent to make decision.
4. **Referral is denied because:**
    - Referral is cancelled;
    - Patient does not meet program criteria/requirement;
    - Patient need a secured unit; and
    - Referral centre cannot accommodate medical need, behavioural issues and psychiatric issues.

- If referral accepted, focal person of referral center must agree to accept the patient according to their inclusion criteria and specific appointment jointly scheduled by the SDF and referral center;
- Written consent for transfer should be obtained from the patient or person legally responsible; and,
- The SDF coordinator will ensure that all necessary and appropriate medical summaries with other pertinent records, including diagnostic result (laboratory, radiological studies etc.) accompany the patient.

6.3. Conducting and Managing the Transfer

- The SDF will forward all medical details of the referral to referral facility;
- Necessary arrangement should be made by SDF for safe transfer of the patients and is also required to facilitate for the admission at the referral centre;
- The patient's vital signs should be monitored. Appropriate medications, as ordered by the physician or as dictated by medical management protocols should be used;
- Adequate records including vital signs and treatment given should be maintained during the transfer and at the handover;
- Communication should be maintained with a referral facility during transfer; and,

- Referral facility should acknowledge the referral to the SDF when the patient is admitted.

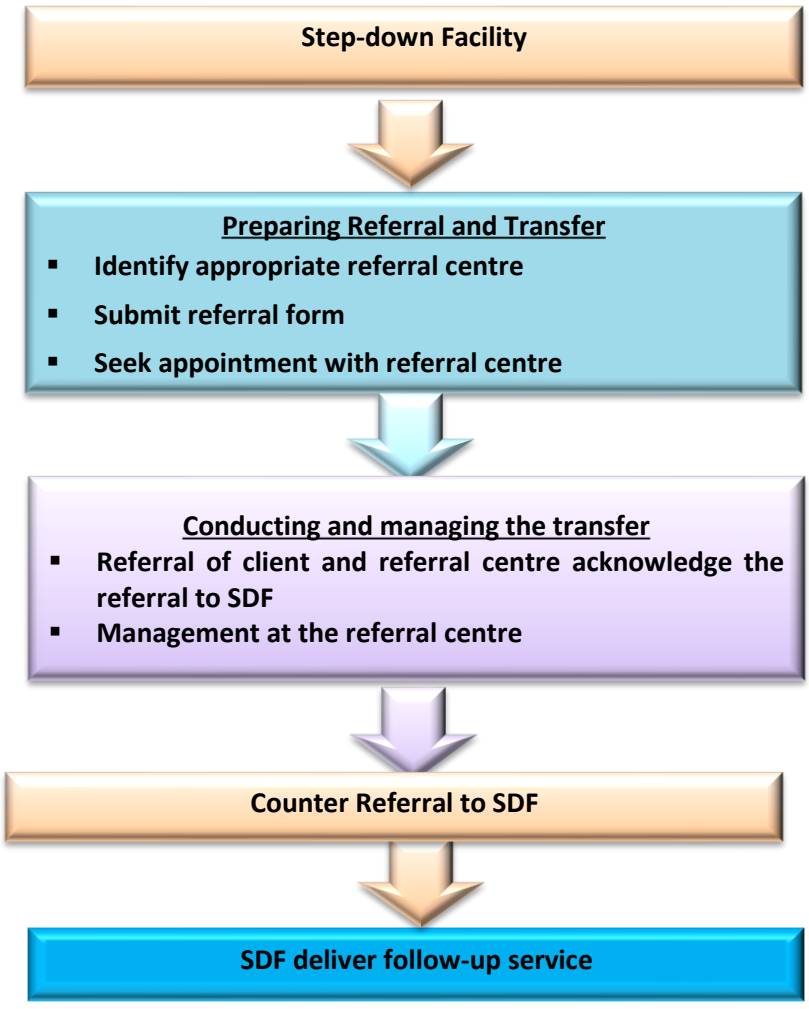
6.4. Counter Referral

- After provision of services by the referral facility, counter referral (or return referral) process to SDF must be done;
- The counter referral form **(attached in annex 10.8)** must be completed with as much information as necessary for the adequate continuance of patient care; and,
- In case of death of the patient, the counter referral form should be sent to the SDF and should reflect the cause of death.

6.5. Record Keeping and Data Management

Accurate list of all referred patients should be well maintained in confidential manner in referral register **(attached in annex 10.9 and 10.10)** by both SDF and referral center. Its main goal is to improve and streamline communication among health facilities and health providers involved in a patient's care.

6.6. Referral Pathway



7. Services

7.1. Rehabilitation Services

A. Rehabilitation team and their responsibilities. (Annex-10: TOR for SDF Staff)

1. Doctor

Diagnosis and management of medical problems, design client centric comprehensive treatment plans in rehabilitation set up in coordination with multidisciplinary team and co-ordination and supervision of overall rehabilitation program. Physical Medicine and Rehabilitation physician (Physiatrist or Rehabilitation physician) would be ideal however in shortage of PM&R physicians any clinician who has accredited training in PM&R or Rehabilitation Medicine will be acceptable. Nurse: Assessment, education, overall nursing care, positioning, skin, bowel and bladder care. S/he can be supported by virtual expert pool of rehab experts (including rehab physicians/doctors) at the provincial and federal level or though telemedicine/Tele rehabilitation facilities.

2. Physiotherapist

Assessment, education, application of exercises, transfers, balance, coordination and mobility training, apply physical modalities.

3. **Physiotherapist (with trans-disciplinary training)**

Comprehensive rehab assessment covering all rehabilitation elements/disciplines, record, plan (short, mid-term and long-term) deliver interventions as per identified needs, weekly record of change in functioning, final record of outcome (change in functioning status), plan and train in home care interventions, step-up or step-down referral, review & follow-up (physical or virtual)

3. Dietician: Assessments, counselling and proper dietary plan of Individual Patients.

4. Occupational therapist

Assessment, education, ADL`s and IADL1s training, home and environment modifications, occupation assessment.

Speech and language therapist: Assessment, education, optimizing communication swallowing.

5. Psychosocial counsellor/Worker

Assessment, psychosocial counselling/support, Medico-social support, legal support as per need and social protection service for person with disability as required.

6. Prosthesis and Orthotic

Assessment and prescription, fitting and user training, follow-up, maintenance and repairs of orthotic, splints, assistive devices to prevent deformity, improve function and mobility.

7. Patient/family or care giver

Needs agreed client cantered rehabilitation services from the core and non-core team. Other non-core but important

8. Clinical team

Neurologist, Neurosurgeon, Paediatric neurologist, orthopaedic surgeons and other physicians, surgeons or other health professionals not limited to this.

B. Assessment and Goal Setting

- The Rehabilitation Team conducts the initial assessment and based on needs, sets the patient oriented goals;
- The Rehabilitation Team advises on the patient's condition, prognosis and procedure of treatment, precautions and contraindications;
- The Rehabilitation Team advises on the patient's weight bearing status, precautions and contraindications for physiotherapy treatment; and,
- The Rehabilitation Team will complete the patient intake form and the physiotherapy assessment after the patient is admitted at their mid-term point and prior to discharge.

C. Session Plan and Delivery

- The Rehabilitation Team will determine the patient's treatment category, discuss the treatment plan and deliver the session;
- The Rehabilitation Team will consult with other members of the health team on a weekly basis during rounds to discuss the progress of the patients and discharge plans; and ,
- The Rehabilitation Team who requires ADL and IADL training will spend 1-3 days in the transition home prior to discharge.

D. Discharge

- The Rehabilitation Team will complete the physiotherapy section of the discharge summary form in collaboration with all members of the rehabilitation team one day prior to discharge. The discharge care plan that is sent home with the patient includes a copy of the physiotherapy assessment form, a copy of the home exercise program, health hand-outs and information regarding community follow-up (if required).

E. Follow-up and Home Visit

- The Rehabilitation Team from hospital wills follow-up the discharge patients in their local health facility/home as appropriate.

7.1.2. Provision of Assistive & Mobility Devices

Many of the patients will require temporary or lifelong assistive devices for recovering functionality. For tailored/Customized assistive devices such as prosthesis, orthotics or modified wheelchair, referral to specialized services is compulsory.

For others mobility devices, the service pathway of all mobility aids and braces available in the facility should comply with the standard of the WHO. For the wheelchair services, as the process of selecting a device, fitting to individuals and training to use is similar for all mobility aids.

Referral and appointment	The client is referred and admitted to SDF.
Assessment	Proper assessment of the client (both physical and environment) is done by Rehabilitation Team.
Prescription	The type of assistive device is selected and general modification need is identified.
Funding & Ordering	If there are different models available for the same device, then client is given an option to choose the one that s/he likes more.
Fitment Session	The device is tested and checked to identify needs of individual adaptations.
User Training	Proper use of device in different surfaces and different environment including minor repair and maintenance is taught.
Follow up	Minor repair and maintenance need is assessed and then it is fixed if required.

(Note: Measurement and fitting for complex devices like prosthetic & orthotics will need prosthetist and orthotist. Likewise for wheelchair service provision, it is preferable to have service personnel trained on basic level wheelchair service training package.

For additional information on prescription and assessment of priority assistive devices, please refer to MoHP/EDCD/LCDMS document on "Priority Assistive Products List of Nepal, 2018).

Assistive devices might also be available in stocks in health facilities if preparedness plans have been implemented. Referral to other rehabilitation services or providers for assistive devices should be taken into account. Following is a list of assistive devices required for SDF with 20 patients for bed-side therapy. The list can be updated based on the number of patients as per requirement:

S.N.	Items	Quantity
1.	Stump boards	3
2.	Patient transfer boards from chair to bed and bed/trolley to bed	1
3.	Leg raisers for wheelchairs	1
4.	Portable commodes (chairs for shower/toilet)	1
5.	Discharge wheelchair	4
6.	Pressure relieving cushions for wheelchairs	Align quantity with number of wheelchairs
7.	Slide sheets (to remain in the SDF)	10
8.	Inpatient wheelchairs	2
9.	Pairs of crutches	20 adult 10 paediatric
10.	Walking frames	4
11.	Pre-fabricated ankle and foot orthotics	5 right and 5 left for shoe sizes 38-45 5 right and 5 left for shoe sizes 35-40
12.	Rigid adjustable cervical collars	5
13.	Incentive Spirometer	10
14.	Balloons for Filling for Respiratory Conditions	100
15.	Portable Pulse Oximeter	20

7.2. Medical and Nursing Services

7.2.1. At the time of Admission

Activities include:

- Receive patient;
- Fill in admission form;
- Check and record vital signs;
- Prepare admission note;
- Check previous medical document and attach a copy of discharge summary from previous treating hospital;
- Document caretaker information;
- Provide hygiene kit;
- Maintain admission/ discharge register; and,
- Maintain referral register;

7.2.2. During Treatment

Activities include:

- Determine intensity of nursing and medical care required per individual patient on a daily basis during handover in the morning;
- Dressing and medication whenever required;
- Conduct hygiene assessment twice weekly;
- Conduct hygiene promotion sessions weekly;
- Conduct recreational activities weekly;
- Coordinate with team regarding the patients progress and challenges;
- Maintain progress note of patients on shift basis;
- Maintain daily census; and,
- Follow infection control practices.

7.2.3. At the time of Discharge

Activities include:

- Prepare discharge summary in coordination with consultant or medical officer, Physiotherapist, Occupational Therapist, other Rehabilitation team member;
- Distribute kitchen kit and hygiene kit;
- Hand over documents to patients; and,
- Maintain discharge records.

7.3. Psychosocial Support

7.3.1. Psychological Support

Patients will be assessed for psychological need in SDF. As necessary, the psychosocial counselor will develop and implement a treatment plan including individual and group sessions. The psychosocial counselor will make necessary referrals for additional mental health care upon discharge to others specialized services.

7.3.2. Social Support and Protection

Mostly vulnerable people are affected by disaster. The vulnerable people include children, elderly people, pregnant women, postpartum mother, chronically ill and people with disability or difficult life circumstances. SDF should ensure the protection of such group and should have special provision for them to ensure inclusive humanitarian planning and response which include activities such as:

- Financial support for the referral to any specialized rehabilitation services needed, including the cost of the service (if not free), transportation and accommodation cost for the patient and caregiver;
- Support for the transportation to their community after discharge; and,
- Support for receiving all the social support needs such as inclusive education, inclusive livelihood and support to get access to government social scheme.

7.4. Health Promotion Intervention

Health promotion interventions at the facility will focus on four areas adapting WHO's HPH movement: promoting the health of patients and caretakers, promoting the health of staffs, adapting a health promoting setting at the SDF and promoting the health of the community in the catchment area of the facility.

Regular monthly health promotion sessions will be conducted by the public health focal point to all the staff in the facility. Basic topics include:

- Nutrition;
- Personal hygiene and sanitation;
- Menstrual hygiene; and,
- Safe defecation.

Additional sessions can be added to address social needs in the community such as gender-based violence or post-disaster needs such as safe building construction. Staff will conduct health promotion sessions to the patients and caretakers on a weekly basis.

8. Tools for the Management of SDF

8.1. Admission Form

- Admission form is to be filled up by SDF;
- SDF will prepare two copies of admission form for each client; and,
- 1st copy is sent with the client whereas 2nd copy is maintained in client note at SDF.

8.2. Discharge Form

- Discharge form is to be filled up by SDF;
- SDF will prepare two copies of discharge form for each client; and,
- 1st copy is sent with the client whereas 2nd copy is maintained in client note at SDF.

8.3. Referral Form

- Referral form is to be filled up by SDF;
- SDF will prepare four copies of referral form for each client; and,
- 1st copy is sent with the client, 2nd kept as a copy in the client notes in SDF whereas 3rd and 4th copies is sent to the referral centre where 3rd is kept in referral centre and last sent to the SDF attached with counter referral form.

8.4. Counter Referral Form

- SDF should attach counter referral form along with referral form while referring the patients; and,
- Referral centre should prepare 3 copies of counter referral form: 1st sent with client, 2nd sent to SDF and 3rd kept as a copy of client note in referral centre.

8.5. Register for Referral Out

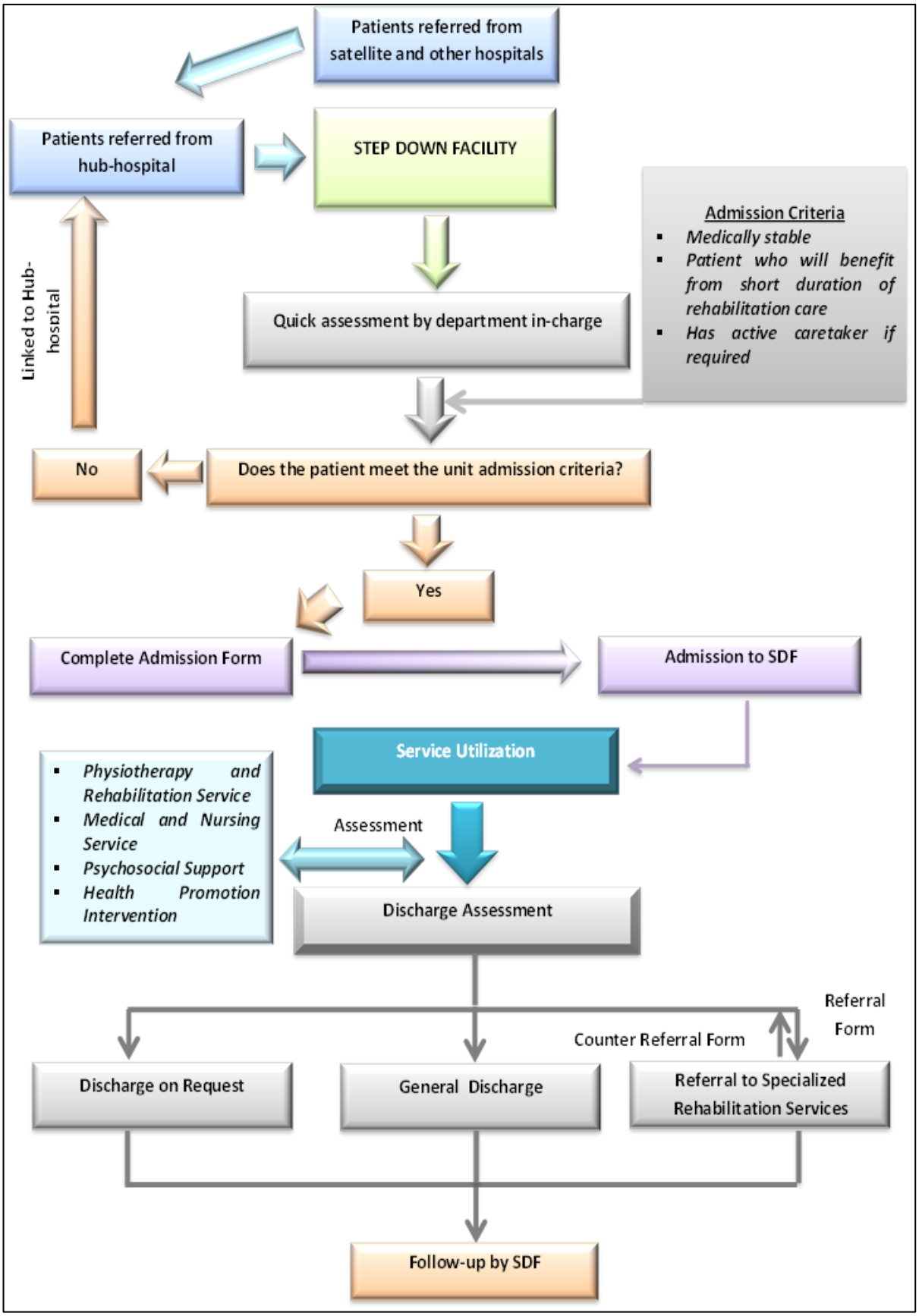
- Referrals made out from SDF should be recorded in referral out register.

8.6. Register for Referral In

- Referrals received into a referral centre should be recorded in referral in register.

8.7. Patient Record Form

- Record of each patient should be maintained in patient record form by SDF.



9. Care Pathway of SDF: Eligibility, Admission & Discharge/Referral

10. Annexes

10.1. TOR for SDF Staff

10.1.1. Incident Command Coordinator role and responsibilities (as per SOP of HEOC/PHEOC)

Following are the Key role and responsibilities of incident command coordinator:

- Overall planning, directing and supervising all administrative and technical aspects of the SDF in accordance with the hub-hospital authority's standards and regulations;
- Personnel management;
- Participating in quality improvement activities in conjunction with hospital programs to facilitate the delivery of quality services in the most cost effective manner possible;
- Maintaining all operational policies and procedures within the facility to ensure the provision of safe and efficient services;
- Actively participating in all hospital committees meeting which impact the facility with specific responsibility for referral and rehabilitation care; and,
- Actively participating in organizational committees and group meetings regarding improvement of the quality of services in the facility and community.

10.1.2. Disaster Focal Person

The role and responsibilities for disaster focal person includes:

- Overall planning, directing and supervising all administrative and technical aspects of the facility related to treatment, security, transportation for patients, social work, housekeeping, food service, laundry, WASH and waste disposal in accordance with the hub-hospital authority's standards and regulations;
- Establishing and implementing of orientation and training programs for personnel;
- Establishing and maintaining a quality control program and preventive maintenance program to ensure reliability of all equipment in the facility;
- Maintaining all equipment and supplies in optimum operational status with procurement or replacement of equipment as needed;
- Preparing all reports, payroll records, budget and statistics;
- Acting as a primary focal point between the facility and hub-hospital to enhance services; and,
- Actively participating in coordination response meeting, share data on services provided and needs.

10.1.3. SDF Coordinator

The role and responsibilities for SDF coordinator includes:

- Coordinating with incident commander and disaster focal person;
- Providing technical guidance on patient care management;
- Evaluating outcomes;
- Training staff on patient care management and clinical procedures;
- Coordinating with local health authorities and partner organizations; and,
- Working with team to set the criteria for admission.

10.1.4. Doctors

The role and responsibilities for SDF coordinator includes:

- Assess Symptoms, Diagnosis Conditions and Management of Medical Problems;
- Design Client Centric comprehensive treatment plans in rehabilitation set up in coordination with multidisciplinary team;
- Monitoring and supervision of overall Rehabilitation Program;
- Provide follow-up care of patients, interpret their laboratory results and refer them to other Health service Providers as per their needs; and,
- Plan Discharge of Patients in coordination with Rehabilitation Team members.

10.1.5. Physiotherapist

The role and responsibilities for physiotherapist/rehabilitation professional includes:

- Providing quality physiotherapy assessments and treatments as per the facility's protocols;
- Assessing patients and developing individual treatment and care plans to meet their rehabilitation needs;
- Ensuring the assessments and users training for assistive devices;
- Facilitating referrals of patients to the local hospital and coordinating with hospital staff regarding patient's needs;
- Participating in regular interdisciplinary meeting to discuss patients' progress and adapting treatment and care plans accordingly;
- Developing home-based care plans for each patient before discharge and teaching both patient and caregiver to carry out exercises at home;
- Contributing to the development of physiotherapy treatment protocols and assisting in the training of new staff and/or partners;

- Conducting community outreach physiotherapy care as required; and,
- Writing case notes and report and data entry.

10.1.6. Physiotherapist (with trans-disciplinary training)

- Comprehensive rehab assessment covering all rehabilitation elements/disciplines;
- Record, plan (short, mid-term and long-term) deliver interventions @ secondary level as per identified needs;
- Weekly record of change in functioning;
- Final record of outcome (change in functioning status);
- step-up referral (if needed);
- Plan and train in home care interventions (before discharge home);and,
- Review & follow-up (physical or virtual).

10.1.6. Occupational Therapist

The role and responsibilities for physiotherapist/rehabilitation professional includes:

- Providing assessment and Evaluating condition and needs of Patients;
- Developing treatment plans to address the individual patient's needs and help them to meet their individual specific goals;
- Assessing a patient's home and work environment and recommending adaptations to fit the patient's needs and improve independence and quality of life; and,
- Training Patients and their caregivers to use special Equipment in effective Way.

10.1.7. Orthotics and Prosthetics

The role and responsibilities for Orthotics and Prosthetics includes:

- Interview and Evaluate patients to determine their individual specific needs;
- Take measurements or impressions of the part of a patient's body that will be fitted with brace or artificial limb;
- Designs and Fabricate orthopaedic and prosthetic devices based on physician's prescription; and,
- Provide Proper orientation to patients in how to use and care their devices.

10.1.8. Nurse

The role and responsibilities for nurse includes:

- Assessing, planning, implementing and evaluating care for patients from admission to discharge;
- Performing dressing changes and other procedures for patients who have undergone surgery.;
- Administering medications and collaborating with healthcare team regarding patient prognosis and treatment plan;
- Monitoring patients' vital signs and report changes in their health status to the SDF coordinator and counterparts at the hub-hospital;
- Coordinating daily with an interdisciplinary team for optimal patient care and maximum caregiver engagement;
- Participating in nutrition, sanitation and hygiene promotion programs organized in the facility;
- Referring cases for psychosocial support to the counselling team;
- Performing patient escort and community outreach if required; and,
- Preparing patients for discharge and referral.

10.1.9. Psychosocial Counselor

The role and responsibilities for psychosocial counselor includes:

- Providing psychosocial assistance including individual, family and group counselling sessions to patients and caregivers;
- Assessing the psychosocial needs of patients and caregivers at admission and consulting with other team members to develop holistic treatment and care plans;
- Coordinating daily with an interdisciplinary team for optimal patient care and maximum caregiver engagement;
- Assisting in identifying psychosocial services for patients and caregivers post-discharge and facilitate linkages where possible for smooth reintegration into the family and community;
- Working with local livelihoods and vocational training program and referring patients and caregivers where appropriate;
- Organizing group activities on a regular basis at the facility;
- Liaising with local health authorities and national and international partner health agencies relating to mental health/psychosocial issues; and,
- Compiling patient files and entering data into the facility database on a weekly basis.

10.1.10. Clinical Dietician

The role and responsibilities for Clinical Dietician includes:

- Evaluates and assesses nutrition status of patients and screen patients for nutritional risk in accordance with standard protocols;
- Plan individual nutrition plan of patients;
- Educates patients and families on nutritional plans.

10.1.11. Cook

The role and responsibilities for cook includes:

- Preparing buffet meals for the patients and caretakers at the unit in consultation with SDF coordinator;
- Preparing the menu;
- Maintaining inventory and coordinating ordering of food and non-food items;
- Ensuring that food is prepared on time and correctly;
- Maintaining a clean, hygienic and safe environment for all staff related to the food preparations and service; and,
- Ensuring that food is prepared and served in accordance with any local hygiene laws and regulations.

10.1.12. Cleaner

The role and responsibilities for cleaner includes:

- Ensuring that all accommodations, treatment areas and office areas are kept clean;
- Cleaning and disinfecting the toilets, showers and basins daily;
- Monitoring the reserve water-tank level and filling as necessary;
- Ensuring all litter and refuse from both inside and outside is collected and disposed;
- Washing the dishes and putting them away as needed; and,
- Washing bed linens and doing other laundry as required.

10.1.13. Security Personnel

The role and responsibilities for security personnel includes:

- Periodically inspecting buildings and grounds; and examining doors, windows, and gates to determine that they are secure and not tampered with;
- Checking parking lots at least three times a shift;

- Confronting unauthorized persons for questioning, detains them or telephone police for assistance, depending on circumstances;
- Giving fire signal to alert fire department and hospital personnel in event of fire;
- Patrolling hospital grounds to detect unauthorized persons or vehicles;
- Checking vehicle and verifying if vehicles are parked in restricted areas such as fire zones, ambulance entrances or reserved parking spaces;
- Checking exterior lighting and access routes to emergency and fire entrances;
- Escorting personnel to and from parking lots or between buildings as requested; and,
- Answering visitor's questions concerning locations of various offices, rooms and other areas within the hospital.

10.1.14. Groundskeeper

The role and responsibilities for groundskeeper includes:

- Ensuring the facility's overall compounds are kept clean and tidy at all times;
- Monitoring the reserve water-tank level and filling as necessary;
- Unblocking toilets and drainage systems within the facility's compound;
- Collecting and disposing garbage daily;
- Assisting in operational activities like loading, unloading, transferring and carrying of goods and document boxes; and,
- Performing minor repairs.

10.2. List of Consumables and Materials for Bed-side Therapy (20 Beds)

S. N.	Items	Specification	Quantity
1.	Inpatient wheelchair		2
2.	Pairs of crutches	20 adults & 10 pediatric	30 pair
3.	Walking frames		4
4.	Pressure relieving mattress		4
5.	Prefabricated ankle and foot orthotic	(2 right and 2 left for shoe size 38-45 & 2 right and 2 left for 35-40 size)	8
6.	Upper limb slings		2
7.	Stump compression bandages	Suitable for both upper and lower limb amputations	10
8.	Tubular compression		10

	bandages		
9.	Spirometer	1 portable plus single patient Use mouthpieces	1
10.	Balloons		10
11.	Portable Pulse Oximeter		20
10.	Stump boards		100
11.	Patient transfer boards		1
12.	Leg raisers for wheelchairs		1
13.	Portable commodes (chairs for shower/toilet)		1
14.	Discharge wheelchair	Should meet ISO7176 standard & be appropriate for the patient. All wheelchairs should have at least a cushion and preferably a pressure relieving (high-specification foam or gel) cushion, depending on the patient risk for pressure sores	4
15.	Pressure relieving cushions for Wheelchairs	Align quantity with number of wheelchairs	4
16.	Additional pillows for positioning		4
17.	Prefabricated wrist splints and positioning splints (Palmar orthotic)	Sizes for child and adult	10

10.3. List of Items Required for the Establishment of Physiotherapist Unit in SDF

S.N.	Items	Specification	Quantity
1.	Corner chair with detachable tray	Small size	1
2.	Stand in table for children	Small size, height adjustable	1
3.	Foam role(tumble)	15cm*60cm long	1
4.	Activity mattress	120*190*10	1
5.	Activity mattress	120*190*5(Portable)	1
6.	Gym ball	Adult size	1

7.	Gym ball	Child size	1
8.	CP chair	Small size	1
9.	CP chair	Medium size	1
10.	Stand in frame	Adult size	1
11.	Stand in frame	Child size	1
12.	Wall mirror	6*5 feet	1
13.	Mushroom board	Child size	1
14.	Smooth exercise board	Top 120 cm * 100 cm, angle adjusted both side	1
15.	Dumb bells	2 kg, covered with plastic incase	1
16.	Dumb bells	3 kg, covered with plastic incase	1
17.	Weight cuffs	250 gm.	2
18.	Weight cuffs	0.5 Kg	2
19.	Weight cuffs	1 KG	2
20.	Molding dough	5 safe molding dough	2
21.	Child friendly room	Back ground Pic and toys	1
22.	Axial shoulder exerciser	With 360 degree scale	1
23.	Continuous passive unit	Lower extremity	1
24.	Quadriceps exercise table	70 CM * 80 CM * 120CM high	1
25.	Climbing stool	10"* 12"* 2" High	1
26.	Climbing stool	16"* 20"* 8 " High	1
27.	Parallel walking bar	Height adjustable from 76 CM to 100 CM	1
28.	Cervical & Lumbar traction kit	Sitting, 5 KG	1
29.	Shoulder pulley set	With Tee Bracket	1
30.	Muscle, TENS IFT & Stimulator	Stimulator, TENS & IFT Combo	1
31.	Moist heat	4 stream packs	1
32.	Wedge	4.30 CM* 60 CM* 70 CM	1
33.	Wall bar (Wooden)	90 CM wide and 250 CM height	1
34.	Balance board	Wooden	1
35.	Cycle exerciser	Semi recumbent seat arrangement	1
36.	Floor carpet	As per the size of therapy room	1
37.	Prone crawling board with wheels	30cm*90cm*7cm	1
38.	Therapeutic Ultrasound	Dual head, 3 and 1 MHZ, with aqua sonic	1

		gel	
39.	Goniometer	360 degree	1
40.	Measuring tape	Metallic, 3 meter	1
41.	Knee hammer	With the metal stand	1
42.	BP set	Manual, Adult size	1
43.	BP set	Manual ,Child size	1
44.	Portable pulse oximeter	Choice Med	1
45.	Stethoscope	Littman	1
46.	Examination couch	High, 72"*24"	1
47.	Examination couch	Low, 36"* 12	1
48.	Wooden foot stool	45 CM deep * 30 CM height	1
49.	Weighing machine	Child and adult size	2
50.	Goniometer	360 degree	1
51.	Towel	Blue color	2
52.	Bed sheet	Large size, Green color	2
53.	Macintosh	6*4 feet	1
54.	Portable curtain divider	Metal stand, 3 folds	1
55.	Curtain	Medium size	3
56.	Pillow	Rexine covered, adult size	2
57.	Pillow	Rexine covered, adult size	1
58.	Wall clock	Battery operated	1
59.	Water filter	Steel	1
60.	Heater	Electric	1
61.	Water Glasses	Metal	4
62.	Body chart	Musculoskeletal system	1
63.	Book	Disabled village children, by David Werner	1
64.	Book	Where there is no doctor by David Werner	1
65.	Construction of ramp	As per Accessibility guideline of GoN	1
66.	Modification of toilet	As per Accessibility guideline of GoN	1
67.	Modification of therapy room	As per Accessibility guideline of G0N	1

10.4. List of Materials for Dining Room, Indoor Kitchen, Administration Office and Storage

Dining room

Table	3
Folding table	5
Chair	20
Water dispenser	1
Indoor Kitchen	
Folding table (small)	4
Folding table (large)	1
Open steel rack (3 story)	1
Utensil rack	1
Wooden rack	1
Rice cooker	1
Oven	1
Mixer	1
Refrigerator	1
Administration Office	
Mobile	4
Laptop	4
Table	4
Printer	1
Chair	4
Rack	1
Bed	3
Storage	
Generator	2
Refrigerator	1

10.5. Admission Form

Personal and Administration Detail
Surname: _____
First name: _____
Date of birth: _____/_____/_____
dd mm YYYY
Gender: Male ☐ Female ☐

Marital Status: _____

Occupation: _____

Residential address:_____

Postal address: _____

Email address: _____

Telephone: Home_____ Mobile_____

History and Service Required

History of patient: _____

_____

_____

Service Required ***(Please tick whichever is applicable)***

☐ Physiotherapy and Rehabilitation service (Detail) _____

☐ Nursing/Medical Service (Detail) _____

☐ Psychosocial support (Detail) _____

☐ Health promotion intervention (Detail) _____

Detail of Caregiver

Name: _____ Relationship to patient:_____

Address: _____

Telephone: Home_____ Mobile_____

Declaration

I hereby declare to give consent to participate in the treatment provided by this facility.

Patient name:_____ Date: _____

Signature: _____

10.6. Discharge Form

Patient Information

Patient name: _____ Identity number: _____

Telephone: Home_____Mobile_____

Name of attending health worker: _____

Caregiver name and contact number: _____

Admission date: _____ Discharge date: _____

Reason for discharge:

Patient deceased ☐

Patient treated ☐

Discharge on request by patient ☐

Others (specify) ☐

Required Document

Following elements need to be put in place prior to discharge. Please verify that the following information is documented in the record, if applicable.

Physician note reflecting readiness for discharge ☐

Discharged plan discussed with patient/caregiver ☐

Therapy note (if applicable) ☐

Discharge plan discussed with patient/caregiver ☐

Description of discharge plan in place ☐

Referral form (if applicable) ☐

Others (specify) ☐

Medical Condition

Please fill in detail specific information about the patient's current medical condition and the reasons why services are no longer reasonable or necessary for the patient are no longer covered by the facility. Use full sentence, plain language and no abbreviation

1. At admission you presented with the following symptoms:

_____

_____

_____

2. You were diagnosed with:

_____

_____

_____

3. You were treated with:

_____

_____

_____

4. Your test were (include results):

_____

_____

_____

5. You were evaluated by:

_____

_____

_____

6. You are now (list current treatment plan and/or state the medical issue is resolved):

_____

_____

_____

7. Your provider feels that your condition has improved and that the care you need now could safely be provided in/at:

_____

_____

_____

8. Your discharge plan and follow up care includes:

_____

_____

_____

Name of person completing the form: _____

Phone number: _____Fax number: _____

Consent

I, the undersigned give consent to the hospital authority, its hospital and subsidiaries to be discharged from the step-down facility.

Patient name:_____ Date: _____

Signature: _____

Only for Discharge on Request
I, the undersigned kindly request for discharge. The facility and the staff of the unit are not responsible for any complications or incidents that occur following discharge or in the future. Patient name:_____ Caregiver name: _____ Signature: _____ Signature: _____ Date: _____ Date: _____

10.7. Referral Form

Referral Form *(to be filled by SDF)*					
Referred by:	Name:			Position:	
Name of facility:	Name & Address:			Date of referral:	
Telephone arrangement made:	Yes	No	Telephone No:	Fax Number:	
Patient name:					
Identity number:		Age:	Sex:	Male	Female
Patient address:					
Clinical history:					
Vital signs:					
Findings:					
Treatment given:					
Reasons for referral:					
Documents accompanying referral:					
Name, sign & date:	Name:		Signature:	Date:	

Note to referral centre: On completion of client management, please fill the attached counter referral form below and send with patient or send by fax or email.			

10.8. Counter Referral Form

Counter Referral Form *(to be filled by referral centre)*					
Referral Centre:	Name & Address:		Telephone No:		Fax Number:
Reply from (Person completing form)	Name:		Date:		
	Position:		Specialty:		
To SDF:	Name and address:				
Patient name:					
Identity number:		Age:	Sex:	Male	Female
Patient address:					
The patient was seen by:	Name and Specialty:		Date:		
Patient History:					
Special investigations and findings:					
Diagnosis:					
Treatment and Operation:					
Medication required:					
Please continue with: (medicines, treatment, follow-up and care)					
Outcome					
Refer back to:	Name:			Date:	
Name, sign & date:	Name:	Signature:		Date:	

10.9. Register for Referral Out

Register of Referral Out								
Date referral made:	Patient name and sex:	Identity number:	Referred to (name of facility/specialty):	Referred for:	Date of counter referral received:	Follow up required (Yes or No):	Follow up completed (Yes or No)	Appropriate referral (Yes or No)

10.10. Register for Referral In

Register of Referral In							
Date referral received:	Patient name and sex:	Identity Number:	Referred from (name of facility /specialty):	Referred for:	Appropriate referral (Yes or No):	Summary of treatment provided:	Date of counter referral sent:

10.11. Patient Record Form

To be filled up for each patient					To be filled up for referred patient only					To be filled up for each patient				
S.N	Patient Name	ID No.	Admission date	Discharge date	Referred to	Referral Date	Back referral Date	Final Outcome	Functional status	Admission and Interventions	Prescribed action	Follow up required (Yes or No)	Follow up completed (Yes or No)	Remarks

11. References

- www.drrportal.gov.np
- International Organization of Migration (IOM)-SDRF Operational Handbook V.1.0
- Handicap International: Standard Operating Procedures for Physiotherapy/Rehabilitation Unit in District Hospitals of Nepal-2017
- Index for Risk Management: INFORM country risk profiles for 191 countries: Nepal [Internet]. JRC. 2018 [cited 2018 Mar 28]. Available from: http://www.inform-index.org/Countries/Country-profiles/iso3/NPL
- WHO Minimum technical standards and recommendations for rehabilitation, Emergency Medical teams,2016
- Priority Assistive Products List of Nepal, MoHP/WHO, 2018

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