SOP 2: IPD

CHC Kanas, Puri

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SOP 2: IPD

1. **Purpose:**

- To establish, implement & maintain a system for patient admission in order to provide IPD services offered by the hospital.
- To provide guideline instructions for General Nursing care with the aim that needs and expectations of patients are honored.
- To enhance patient satisfaction on continual basis.

2. **Scope:**
It covers all indoor patients admitted and receiving treatment at Hospital.

3. **Responsibility:**
Medical Officer I/C, Medical Officer, Staff Nurse and Housekeeping Staff.

4. **Procedure:**

S No	Activity	Responsibility	Ref Document/ Record
1	**Admission** **Admission Advise** Patient visits the OPD/emergency for doctor's consultation. Depending upon the doctor's assessment, he/she advises admission (in writing on the OPD Card and IPD file) to inpatients areas of the CHC Admission formalities are done after assignment of UHID to the patient.	MO and SN on duty	OPD Card , IPD file Patient Registration no.
2	**Shifting of Patient to the Ward** Patient is shifted to the ward accompanied by the patient attendant. Stretcher/wheel chair/Trolley are used for shifting of patient as required. Critical patients who reach emergency are first assessed and primary treatment is given at emergency room. Patient is shifted to the ward when the patient is stabilized.	SN/ Attendant	
3	**Patient warding in and Bed Allotment** The ward nurse receives the patient. Patient/Attendant hand over admission slip or Bed Head Ticket (BHT) to the staff nurse on duty Ward Nurse confirms the identity of the patient. Ward Nurse reviews the admission notes/instructions and acts on any urgent instructions by admitting doctor. Ward Nurse records the patient details in the patient admission/discharge register	On duty Staff Nurse	IPD register
4	**Patient Property –** Valuables like jewelry, mobile and cash is handover to the patient relatives. Patient is instructed to not keep any valuables with them.		

5	**Consent** Consent is signed by all the patients admitted in the ward. In case patient/ Next to Kin is illiterate then the thumb impression of the patient is taken which is witnessed by a neutral person.	Staff Nurse	Consent Format
6	**Initial Assessment-** Once patient is settled in the ward, nurse conducts a nursing need assessment. She calls the duty doctor who conducts the initial assessment if it is not done at emergency/OPD of the patient records the findings/ directions in the indoor file.	Doctor on Duty, staff Nurse	Indoor file
7	**Priority to treatment –** If an admission is done from the OPD or from emergency on urgent basis lifesaving treatment/ procedures supersedes any documentation work.	Doctor on Duty Ward Nurse	
8	**Orphan/Lawaris Patients –** Orphan patients having no accompanier/ relative are specially monitored. Efforts are made to appoint some from local NGOs/ volunteers who can take care of non-clinical needs of these patients.	Ward Nurse	
9	**People living with HIV AIDS** Confidentiality of such patient is to be maintained in all cases. Patient is not isolates/segregated. Beds / BHT of such patients are not labeled marked which denotes their HIV positive status. Status of such patients is not discussed with anybody who is not involved in direct care of patient.	Doctor on Duty Staff Nurse	
10	**Patient Care** Nurse starts the treatment as per the instructions on Bed Head Ticket indoor file. Monitors of vitals for general patient are done at least two times in 24 hours. Monitors of vitals for labor patients is done as per parto graph **Handling of Medical Devices and instrument** All medical devices and instruments are cleaned after each patient use in accordance with procedures for Hospital Infection Control	Staff Nurse	
11	**Administration of Medication** Before administering any drug name of the drug, time of administering the medication, dosage, route of administration and in case of oral drugs, whether to give before or after food is thoroughly checked from the medication chart of the concerned patient. In case of any discrepancy in name doctor on duty /SN/ Pharmacist is consulted and generic name is matched. It is made sure that medication is not discontinued in the	Doctor on Duty Staff Nurse	Medication Chart

	Medication Chart. Drug is checked for proper storage procedure and any sign of damage which may harm the efficacy. Parenteral drugs are checked for any turbidity in the container. Date of expiry and batch no. of the drug is checked and in case of any discrepancy MO I/C and Pharmacists are informed. In case Doctor is administering the drug, he checks for any allergies, contraindication as well as benefits against the adverse effects of the drugs on evidence		
12	**Medical Documentation –** Patient's complete medical records are available at all the times during their stay in CHC. Documentation within the medical record follows the logical sequence of date, time. Drug prescription chart, diagnostic results, nursing care plan are kept as separate sections for prompt easy access**.** Data recorded or communicated on admission, handover and discharge is recorded using standard format**.** Every entry in the medical record is dated, timed (preferably in 24-Hour format), legible and signed by the person making the entry. Deletion and alterations are countersigned. Entries to medical records are made as soon as possible after seeing or intervention (e.g. Change in clinical state, ward round, diagnostic) and before the relevant staff members goes off duty. Every entry made in medical record identifies the person who is responsible for decision making. An entry is made in the medical records whenever a patient is seen by a doctor. Consent form and resuscitation status statements must be clearly recorded in medical records.	Doctor on Duty, Staff Nurse	Indoor file
13	**Nursing Care procedures** Nursing procedures are performed as per protocols/ guideline of state • Oral Medication • Intramuscular Injection • Subcutaneous Injection • Assisting Intravenous Transfusion • Steam Inhalation • Oxygen through Nasal Cannula • Surgical Dressing • Cardio-Pulmonary Resuscitation **Inventory** Nurse maintains record of the patient progress, treatment offered, stocks of inventory & medicines in the ward. Ward nurse also change the linen at defined frequency preferably in morning hours.	Nurses	

	Handover At the end of each shift nurse on duty handover, the details of treatment provided and patient progress, in writing to the nurse on duty for the next shift. **Indenting** All the drugs and consumables required are indented by the staff nurse on a regular basis. For specific drugs and consumables sisters raise the indent according to the requirement. If the condition of patient worsens in ward, the treating doctor is immediately informed and treatment is given as per the doctor's advice or patient is shifted the higher center as per the doctor's advise		
14	**Diagnostics** If any laboratory test is required to be done then the laboratory technician is informed. Lab technician comes to ward and collect the sample In case, X-Ray, ECG or USG needs to be done, nurse informs the doctor in charge and patient is referred to the higher facility for the investigation.	Staff nurse/Lab technician	
15	**Discharge of patient:** Assessment of the patient is made on daily basis. When the patient's condition is up to the level of discharge, the physician writes discharge note in the patients IPD file and prepares a discharge slip Nurse ensures that all items issued to the patient are returned back	MO	Discharge summary
16	**Making Payment (if any)** The ANC, maternal and IPD services are given free of cost under JSSK scheme. OPD and drugs are also free of cost at CHC under. All lab investigations are also provided free of cost under Nidana.	Staff Nurse/MO I/C	
17	**Provisions under Janani-Shishu Surakhya Karyakram** All indoor services including stay (up to 3days for normal delivery and 7 days for caesarean section, drugs & Consumables, diagnostics are free of cost for pregnant women. Any kind of user charges are exempted in all such cases. Similarly all sick new born till 30 days of birth is given all IPD services free cost.	MO I/C	JSSK Guidelines
18	**Handing over Discharge Slip to Patient/Attendant** Patient is discharged from the CHC with discharge summary. Briefing is done to the patient/attendant about the follow up, prescribed medicines, precaution to be taken and diet.	MO/ SN	Discharge Summary

19	**Updating IPD Register** After discharge of patient, the relevant register/record such as IPD register/Diet Register, indoor file is updated.	Concerned nurse	IPD register/ indoor file
20	**Removing of used linens** After discharge of patient, the used linen such as bed sheets, pillow cover etc. is taken away for cleaning.	Housekeeping Staff	
21	**Referral of patient** During course of treatment if the patient is required to be shifted to other center then the staff nurse/ MO prepares a referral note.	MO/ Staff Nurse	Referral Slip
22	**Absconding** If any patient leaves the hospital during the course of treatment without informing the concerned staff.	Staff Nurse	IPD Register /indoor file
23	**LAMA** If a patient wants to leave the hospital but as per the treating doctor she/he is not fit for discharge, a declaration is signed by the patient/ Next to Kin in the language she/he understands on indoor file. In case patient/ Next to Kin is illiterate then the thumb impression of the patient/attendant is taken on the declaration which is witnessed by one neutral person.	MO/ Staff Nurse	Lama declaration format IPD Register / BHT
24	**Management of Death** If any IPD patient dies then the procedure of Management of Death is followed	MO/ Staff Nurse	Death Register
25	**Visiting hours-** Visiting hours for Wards/ Rooms are between 07:00AM-09:00AM 12:00AM to 02:00PM & 06:00 PM to 08:00 PM (Monday to Sunday). Any visitors having no patient in the hospital including Media Person and police are not allowed in the wards without prior permission from Mo In- charge.	MO in charge	Visitor Policy
26	**Patient Satisfaction Survey** Patient satisfaction survey is conducted on a periodic basis (30 patients per month). Analysis of data collected is done on quarterly basis.	Mo in charge	IPD feedback form

5. Records

S No	Name of Record	Record No	Minimum Retention period
1	Admission Register	KN /IPD/RC/1	1 years
2	Delivery Register	KN /IPD/RC/2	1 years
3	Referral Register	KN /IPD/RC/3	1 years
4	IUCD/PPIUCD Register	KN /IPD/RC/4	1 years
5	Hand Over Register	KN /IPD/RC/5	1 year
6	Hand Over Register (equipment)	KN /IPD/RC/6	1 year
7	Autoclave Register	KN /IPD/RC/7	1 year
8	Linen Stock register	KN /IPD/RC/8	1year
9	Stock and issue register of medicines	KN /IPD/RC/9	1year
10	Diet register	KN /IPD/RC/10	1year

**** End of SoP****