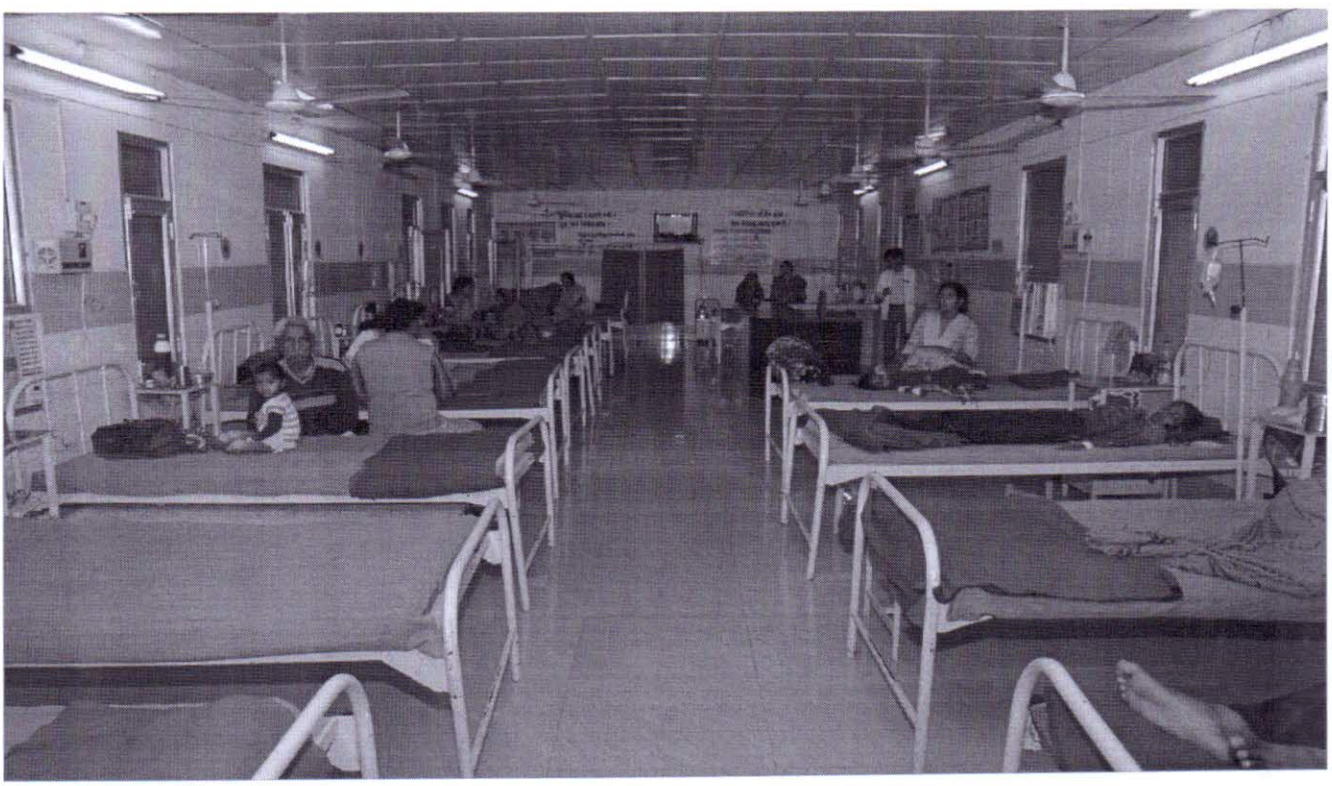
Standard Operating Procedures for District Hospitals- Uttar Pradesh

SOP for IPD



SOP : In-patient Management

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 honoured.
   - To enhance patient satisfaction on continual basis.
2. **Scope:**
   It covers all indoor patients admitted and receiving treatment at Hospital.
3. **Responsibility:**
   Doctor, Head Nurse, Staff Nurse and Housekeeping Supervisor
4. **Procedure:**

S. no	Activity	Responsibility	Ref document/Record
4.1	**Admission**		
4.1.1	**Admission Advise** Patient visits the OPD/emergency for doctor's consultation. Depending upon the doctors assessment, he advises admission (in writing on the OPD Slip) to one of the different inpatients areas of the hospital like Inpatients Ward, and Labor Room etc.	Treating Doctor	OPD Slip, Patient Registration no, Doctors Instruction for admission
4.1.2	**Inpatient Registration-** Inpatient registration and allocation of beds is done as per the procedure for Patient registration, admission and Discharge Management	Registration Clerk	SOP for Patient Registration, Admission &Discharge Management, Case sheet.
4.2	**Shifting of Patient to concerned Ward**	Attendant	

	Stable patient is shifted to the concerned inpatient facilities accompanied by an 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 observation ward only. Patient is shifted to the ward when the patient is stabilized. In case the patient has to be transferred to Emergency observation ward /OT Wards he/she is accompanied by a doctor /Nurse Preferably.		
	Patient warding in - The ward nurse receives the patient. Patient/Attendant hand over admission slip or case sheet to the Sister in- charge. 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 Sister in charge	Registration Slip IPD register
4.4	**Bed Allotment** Bed is allocated based on clinical and personal needs of the patient and availability of beds. Bed no of allocated bed is recorded in Case sheet and admission register.	Sister Incharge	

	Patient is shifted to the bed, made comfortable and is oriented about the layout of ward with instructions on how to call her in case of emergency. A bed side locker is allotted to the patient. In case of non availability of bed the ward nurse makes alternate arrangement for additional cots		
4.5	**Patient Property** – Valuables like jewelry, mobile and cash is handover to the patient relatives. Patient is instructed to not keep any valuables with them.		
4.6	**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.	Sister In charge	Consent Format
4.7	**Initial Assessment-** Once patient is settled in the ward, nurse conducts a nursing need assessment (**Annexure-1**). 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 Case sheet.	Doctor on Duty/ Ward Nurse	Case sheet Nursing assessment form
4.8	**Priority to treatment –** If an admission is done from the OPD on or from causality on urgent basis life saving treatment/ procedures supersedes any documentation work.	Doctor on Duty/ Ward Nurse	

4.9	**Orphan/Lawaris Patients** – Orphan patients having not 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. Names of all such patients are reported to local police.	Doctor on Duty/ Ward Nurse	
4.10	**Rights and Dignity of patient:** • Simple and clear language is used while communicating to patient. • Before anyexamination permission is taken from patient and procedure is explained to her. • During the examination privacy of patient is maintained. Screens and curtains are provided in examination area and it is ensured that woman is protected from view of other people. • consent is taken before discussing with her family or parents. • Confidential information about patient is never discussed with other staff members or outside the facility. **People living with HIV AIDS** Confidentiality of such patient is be maintained in all cases. Patient is not isolates/segregated. Beds / Case sheet 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/ Ward Nurse	

	Preparation of patient for Surgical Procedure- • Procedure to be performed and its purpose is explained to the patient. If the patient is unconscious, it is explained to her family. • Informed consent for the procedure is obtained from the patient. • Bladder if cauterized if necessary and urine output is monitored.		
4.11	**Patient Care**		
4.11.1	Nurse starts the treatment as per the instructions on bed head ticket.	Ward Nurse	
4.11.2	**Monitoring Temperature-** The timing for measuring the body temperature is checked from the Doctor's order or 6 hourly as per nursing chart. Temperature is recorded in nursing chart. Duty doctor is informed in the case of abnormal values. Thermometer is disinfected in isopropyl alcohol, covered with a barrier wrap.	Doctor on Duty/ Ward Nurse	TPR Chart, intake & output Chart, Nurse assessment sheet, Treatment Register
4.11.3	**Monitoring Pulse rate-** Radial pulse is felt and counted for 60 seconds with elbow and forearm resting comfortably on the bed/table and the palm of the hand turned upward. If Radial Pulse is not palpable, other arteries are palpated. In case of difficulty doctor on duty is informed. Pulse for the concerned patient is recorded in nursing chart. Doctor on duty is		Nursing Chart

	informed in the case of abnormal values.		
4.11.4	Respiratory rate is measured and Pattern, effort level and rate of breathing is observed. For infants and children less than 6-7 years of age abdominal movements are counted since they are abdominal breathers. Signs of respiratory distress such as nasal flaring, wheezing, use of accessory muscles of respiration, chest shape and movement are also looked. If there is any difficulty in breathing doctor on duty is informed. Respiratory rate is recorded in nurses chart. Doctor on duty is informed if the respiratory rate recorded is abnormal.	Doctor on duty/ Ward nurse	Nurses chart
4.11.5	**Monitoring Blood Pressure-** The timing for measuring the Blood Pressure is checked from the Doctor's order or 6 hourly as per nursing chart. The auscultatory method of BP measurement with a properly calibrated and validated instrument is used. An appropriate sized cuff (cuff bladder encircling at least 80 percent of the arm) is used to ensure the accuracy. Arm of the patient is positioned at the level of heart and well supported. Doctor on duty is informed if recorded if recorded BP is above / below expected or as mentioned in doctors" order. BP for concerned patient is recorded in	Doctor on Duty Ward Nurse	Nursing Chart

	the nursing chart.		
	Blood Transfusion: - Blood transfusion may required in condition like blood loss at operative procedure and severe anemia. • Transfusion should be prescribed only when the benefits to the patient are likely to outweigh the risks. • 24X7 blood transfusion facility is available in hospital. • In emergency life saving conditions blood is issued. • Cross matching of donor and recipient blood is mandatory before transfusion. For High Risk & elective surgeries patient, attendants are told to arrange blood in advance if enquired		
4.11.6	**Environment cleaning and processing of the equipment:** Ward incharge make sure that the cleaning and Mopping should be done in a unidirectional manner and instruct strictly that broom sticks and unhygienic mop sticks are not used in the Ward. **Handling of medical devices and instruments** All medical devices and instruments are cleaned after each patient use in accordance with procedures for hospital infection control. All the measuring equipments used in patient care are regularly calibrated in accordance with manufacturer's instructions and procedures for infrastructure and	Doctor on duty/Ward nurse	Procedure for hospital infection control, procedure for infrastructure and equipment maintenance

	equipment maintenance All medical devices and equipments are appropriately stored with access to authorized individuals only		
4.12	**Administration of Medication**		
	Essential checks- 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 /Pharmacist is consulted and generic name is matched. It is made sure that medication is not discontinued in the 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 head nurse 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.	Doctor on duty/ward nurse	Medication chart
4.12.2	**Preparation-** For oral drugs after washing the hands pills	Doctors on duty/ward nurse	Medication chart

	are dropped in a small cup and handed to patient. this is done immediately prior to giving drugs and not in advance If the medication is liquid, the bottle is shaken and correct dose is poured in a measuring cup. In case of pills only break which are not enteric coated. For parental drugs instructions of manufacturer are followed.		
4.12.3	**Administration-** Name of the patient is confirmed by asking the patient/attendant or wristband if available. Oral drugs are administered using sufficient amount of water/liquid or as per special instructions from the doctors" order. For oral drugs are given to fully conscious patients in a sitting/propped up position.	Doctor on Duty/ Ward Nurse	Medication Chart
4.12.4	**Monitoring/ Recording-** After ensuring the drug has been administered the nurse records the time and dose that has been given in medication chart. If complete dose is not given because of any reason (like vomiting of oral drugs) it is recorded in nursing chart and informed to doctor on duty. Patient is watched for adverse effects and if any Doctor on Duty is informed. Disposal of remaining drugs is done as per Bio Medical Waste Rules 2018	Doctor on Duty/ Ward Nurse	Medication Chart

4.13	**Medical Documentation –** Patient"s complete medical records are available at all the times during their stay in Hospital. Every page in the medical record has patient name, identification number and name of the ward. 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 (eg. 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.	Doctoron Duty/ Ward Nurse	Case sheet

	Consent form and resuscitation status statements must be clearly recorded in medical records.		
4.14	**Nursing Care procedures** Nursing procedures are performed as per protocols/ guideline of state • Oral Medication • Intramuscular Injection • Subcutaneous Injection • Assisting Intravenous Transfusion • Steam Inhalation • Ryles Tube • Oxygen through Nasal Cannula • Surgical Dressing/Sponge bath • Cardio-Pulmonary Resuscitation	Nurses	
4.15	Nurse informs the dietary department / Kitchen for patients diets according to the doctor advice	On duty sister in charge	Diet request
4.16	**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	On duty sister in charge	Nursing register medication chart nursing note sheet stock register

4.17	**Hand over** At the end of each shift nurse on duty hands over, the details of treatment provided and patient progress, in writing to the nurse on duty for the next shift	On duty sister in charge	Nursing register medication chart nursing note sheet stock register, shift transfer records
4.18	**Indenting** All the drugs and consumables required are indented by the sister incharge on regular basis. For specific drugs and consumables sisters raise the indent according to the requirement	Sister Incharge	Indent register
4.19	**Interdepartmental Transfer** If patient is required to be shifted to other ward for any reason, the sister incharge of the other ward is informed and patient is escorted / sent to the ward with all the medical records and drugs. Nurse incharge of both the wards enters the same in their registers.	On duty sister incharge	IPD Register
4.20	If the condition of the patient worsens in the ward , the treating doctor is immediately inform and the treatment is given as per the doctors advice or patients shifted to emergency observation ward (If available) or the higher center as per the doctors advice	On duty sister incharge, Treating doctor	Referral register
4.21	**Diagnostics**		
4.21.1	If any laboratory test is required to be done then the laboratory technician is informed. Lab technicians comes to ward and collect the sample/ nurse collects the sample and	On duty sister incharge	SOP for diagnostic services

	send it to laboratory		
4.21.2	In case X- Ray , ECG or USG needs to be done, nurse informs the concerned technician, and at appointed date & time the patient is transferred to the concerned department for the investigation	On duty sister incharge	SOP for diagnostic services
4.22	**Counselling and Discharge of patient:** Assessment of the patient is made on daily basis. Patient is conselled about the intake of the diet and tablets and follow up instruction given to the patient. When the patient's condition is up to the level of discharge, the physician writes discharge note in the patients Case sheet/IPD file and prepares a discharge slip. In case of MLC patient, Police is informed before the patient is discharged	Treating Doctor	Case sheet, Discharge Note/ Discharge Slip
4.23	Nurse ensures that all items issued to the patient are returned back.	On Duty Sister In charge	
4.24	**Provisions under Janani-Shishu Suraksha Karyakram** All indoor services including stay (up to 3 days for normal delivery and 7 days for caesarean section , drugs & Consumables, blood transfusion, diagnostics and are free of cost for free pregnant women. Any kind of user charges are exempted in all such cases. Similarly all sick new born till 30	Hospital Superintende nt/ Hospital Manager	JSSK Guidelines

	days of birth is given all IPD services free cost.		
4.25	**Handing over Discharge Slip to Patient/Attendant** Patient is discharged from the hospital with discharge slip. Briefing is done to the patient/attendant about the follow up, prescribed medicines, precaution to be taken and diet.	Concerned Nurse / duty doctor	Discharge slip
4.26	**Updating IPD Register** After discharge of patient, the relevant register/record such as IPD register/Diet Register, Case sheet is updated.	Concerned nurse	IPD register/Diet Register, Case sheet
4.27	**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	Linen Management
4.28	**Referral of patient** During course of treatment if the patient is required to be shifted to other centre then the treating doctor prepares a referral note.	Concerned Nurse, doctors	Referral Slip SOP for Referral
4.29	**Absconding** If any patient leaves the hospital during the course of treatment without informing the concerned staff. Police is informed and record of the same is maintained.	Concerned Nurse,	IPD Register / Case sheet
4.30	**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	Duty Doctor Concerned Nurse,	Lama declaration format IPD Register / Case sheet, LAMA

	by the patient/ Next to Kin in the language she/he understands on Case sheet. 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 2 neutral people. LAMA summary is prepared and the patient/attendant is handed over the same.		Summary
	End of life care: • Respect the dignity of both patient and caregivers; Be sensitive and respectful with the patient's and family's wishes; • Use the most appropriate measures that are consistent with patient choices • Encompass alleviation of pain and other physical symptoms; • Assess and manage psychological, social, and spiritual/religious problems; • Offer continuity (the patient should be able to continue to be cared for, if so desired, by his/her primary care and specialist providers); • Provide access to any therapy which may realistically be expected to improve the patient's quality of life, including alternative or non-traditional treatments. • Provide access to palliative care and hospital care; • Respect the right to refuse treatment; • Respect the physician's professional responsibility to discontinue some treatments when		End of life care Policy

	appropriate, with consideration for both patient and family preferences;		
4.31	**Management of Death** If any IPD patient dies then the procedure of Management of Death is followed	Duty Doctor / Sister In charge	SOP for Management of Death, Death Register MLC register, Death summary
4.32	**Visiting hours-** Visiting hours for outsiders for meeting the patients are displayed as per visitors policy Any visitors having no patient in the hospital including Media Person and police are not allowed in the wards without prior permission from Medical Superintendent/ RMO.	RMO	Visitors Policy
4.33	**Patient Satisfaction Survey** Patient Satisfaction Survey is done on predefined patient satisfaction format. Procedure is same as for OPD	RMO	IPD feedback form Procedure for OPD Management

5. Records:

Sl. No.	Name of Records	Record No.	Minimum Retention Period for Hard Copies
01	IPD Register		3 Years
02	Patient Registration		3 Years
03	MLC Register		Till Case Closes
04	IPD/Discharge Register		3 Years
05	Diet Register		3 Years
06	Laundry register		3 Years

07	Death record register		3 Years
08	Stock Register		3 Years
09	Indent Register		3 Years
10	Death Register		10 years
11	Referral Register		3 Years
12	Police Intimation Register		3 Years

6. Process efficiency criteria

Sr. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Patient Care	Average Length of Stay	**3Days – 5 days**
2	Clinical Care	Proportion of Patients Discharged	**1:1**
3	Clinical Care	Adjusted Death Rate (Death after 48 hours of admissions)	**95-100%**
4	Equity	Proportion of BPL patient admitted	**100%**
5	Patient Satisfaction	Patient Satisfaction Score for IPD	**4.5-4.7**
6	Utilization	Bed Occupancy Rate	**100%**
7	Patient Care	LAMA Rate	**<10%**
8	Patient Care	No. of Adverse drug reaction	**0%**

Annexure-1

Nursing Assessment (To Be Done on Admission in Wards)

IPD no:		**Ward/Unit:**	
Date/Time of arrival:		Walking/Stretcher/Wheelchair:	

Attendant Name& Relation:

Attendant Name:
Relation:
Phone No.:
In case of MLC (Name of constable):

Temp.: ºF	Pulse /min	BP mm Hg	Resp. /min	Ht. cm	Weight Kg

Observation:

	Yes	No	Location
Contusion			
Lacerations			
Rashes			
Scars			
Bruises			
Pain			
Others			

History of Allergies / Adverse Reactions (known or suspected allergies to) :

Related to	Tick (As Applicable)			Details if known
Medication / Drugs	Yes	No	Not Known	
Blood Transfusion	Yes	No	Not Known	
Food	Yes	No	Not Known	

Ability to Perform Activities of Daily Life, Please tick (As Applicable):

Activity	Independently	Assisted	Dependent	Activity	Independently	Assisted	Dependent
Bathing				Bed Activities			
Eating				Sitting			
Dressing				Standing			
Toilet use				Ambulation			
Stair Climbing				Disability			

Remarks:-

7 References

1. Procedure for Admission (SOP)
2. Procedure for Referral (SOP)
3. Procedure for Infection Control (SOP)
4. Procedure for Diagnostic Service (SOP)
5. Standard Treatment Guidelines issued by state & Government of India
6. Procedure for Death Management (SOP)
7. Visitors Policy
8. End of life Care Policy
7. Indian Public Health Standards

Prepared & Reviewed By:

Approved by:

Medical Superintendent