



Standard Operating Procedures for District Hospitals- Uttar Pradesh

SOP for IPD





National Quality Assurance System
Standard Operating Procedure for In-Patient Management

NQAS Policy-IPD

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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	

Prepared by : Department In-charge

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	<p>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.</p> <p>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.</p> <p>In case the patient has to be transferred to Emergency observation ward /OT Wards he/she is accompanied by a doctor /Nurse Preferably.</p>		
	<p>Patient warding in -</p> <p>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.</p> <p>Ward nurse reviews the admission notes/ instructions and acts on any urgent instructions by admitting doctor.</p> <p>Ward Nurse records the patient details in the patient admission/discharge register.</p>	<p>On duty Sister in charge</p>	<p>Registration Slip IPD register</p>
<p>4.4</p>	<p>Bed Allotment</p> <p>Bed is allocated based on clinical and personal needs of the patient and availability of beds.</p> <p>Bed no of allocated bed is recorded in Case sheet and admission register.</p>	<p>Sister Incharge</p>	

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

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