COMMUNITY HEALTH CENTRE, SAINKUL	
HOSPITAL CLINICAL MANUAL	
IN PATIENT MANAGEMENT	STANDARD OPERATING PROCEDURE HCM.02

STANDARD OPERATING PROCEDURES

FOR

INPATIENT MANAGEMENT

COMMUNITY HEALTH CENTRE, SAINKUL
758043
ODISHA

Superintendent
CHC Sainkul,Keonjhar

COMMUNITY HEALTH CENTRE, SAINKUL	
HOSPITAL CLINICAL MANUAL	
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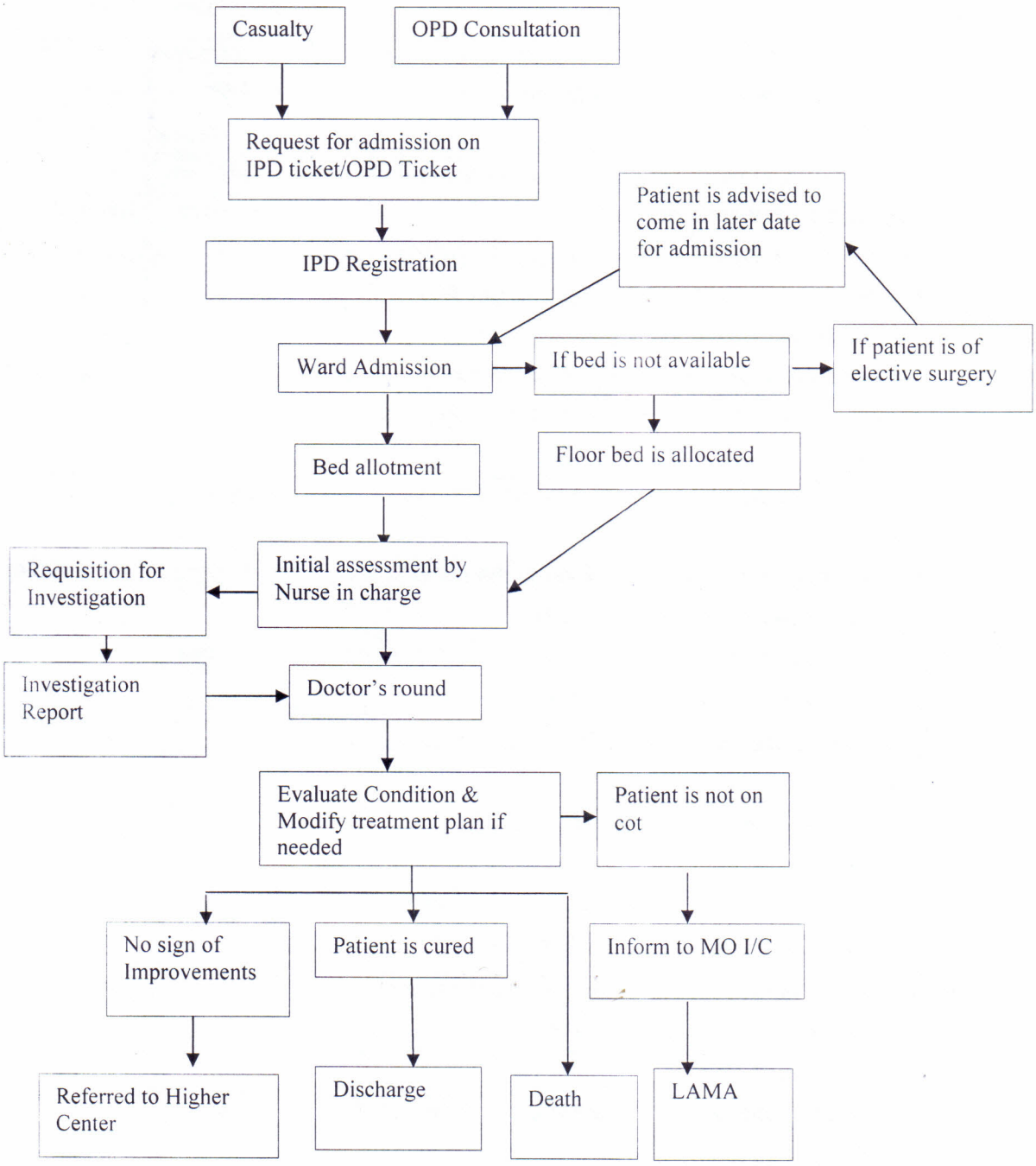
1.0 **Purpose:** To document, establish and maintain the process of inpatient care in the wards.

2.0 **Scope:** This includes:

- Admission of the patient
- Assessment of patient by doctors/ nurses
- Medication by doctors
- Administration of drugs
- Monitoring of patient's condition
- General hygiene and upkeep of ward
- Consent for procedures
- Complaint handling
- Discharge of patients
- Death of patients

3.0 **Reference:** Quality Management System Manual, MNL: QSM: 01, Section 7.1

4.0 Process Flow



5.0 Standard Procedures

S.No.	Activity	Responsibility	Related Document
5.1	Based on the assessment of the patient's condition, the doctor advices admission.	**Doctor**	**OPD / IPD Ticket**
5.2	Patient is also admitted through emergency department.	Doctor	IPD ticket
5.3	**Registration & Payment:** Registration of patient is done at the IPD registration counter. The fees for admission are collected by the IPD registration clerk. The demographic details of patient are recorded and unique ID no. is generated. This ID no. is noted on the bed head ticket and is provided to the patient.	**Registration clerk**	**Case Sheet**
5.4	Patient is escorted to the ward by attendant / verbally directed to the patient	Attendant	
5.5	Patient provides the bed head ticket to the nurse in the ward and a bed is provided to the patient	**Ward nurse**	**Case Sheet**
5.6	Nurse prepares the bed for the patient and enters the patient details in the admission register	Ward nurse	Admission register
5.7	The nursing assessment is performed and documented in the patient record.	Nurse	Nurses daily record
5.8	The doctor assess the patient and prepares the care plan and advices medication	Doctor	Doctor's orders
5.9	Nurse starts the treatment as documented by the doctor and administers the drugs prescribed.	Nurse	Nurses' daily record
5.10	Clinical progress of the patient is monitored by the nursing staff with the help of TPR chart, intake/output chart, BP check etc.	Nurse	**Case Sheet**
5.11	Diet sheet is prepared and details are recorded in the diet register.	Nurses	Diet sheet Diet Register
5.12	Nurse indents the medicines and consumables required for patient's treatment to the stores' incharge. The medicines that are not available in the hospital stores are procured from outside by the patient party.	Nurses	IPD Indent Register

5.13	For laboratory investigations required for the treatment, the blood sample is collected by the nurse, labeled and sent to the lab.	Nurse	
5.14	For radiological investigations required for the treatment, the patient is sent to the radiology department in wheelchair/ trolley with a attendant	Attendant	
5.15	Nursing staff reassess patients at least once in every shift.	Nurses	
5.16	During change of shift of nurses, nurse on duty writes a treatment note and hands it over to the nurse taking charge	Nurse	Handover register
5.17	**Nursing Care Management:** • Inserting Cannula and Cannula care • Sponging • Giving Oral Drugs • Injections • Catheterization • Dressing/ wound care • Enema	Nurse	Work instructions
5.18	**Equipment Handling:** • Oxygen Cylinder • Nebuliser • Suction Machine	Nurse	Work instructions
5.19	**Consent**		
5.19.1	A written Informed Consent is obtained for all invasive procedures and surgeries.	Nurse	Consent form
5.19.2	Informed Consent is taken in following cases: All procedures performed in the Operating theatre All invasive Curative or Diagnostic procedures such as FNAC, CVP, Lumbar Puncture etc Blood Transfusion Anaesthesia	Nurse	Consent form
5.20	**Infection control in wards:**		
	• Hand washing techniques are followed in the wards as per Universal Standards. • Needles are destroyed in the needle cutter.	Nurse, housekeeping staff	

	• Wet mopping is done with phenyl / Ecoshield twice a day. • Spills of blood / body fluid are cleaned with 1 % hypochlorite solution. • Barrier nursing is followed for infectious patients		
5.21	Bio-medical waste management:	Doctors, Nurse	
	• Colour coded plastic bags are used to segregate waste. • Burnt needles, tubes etc. are kept in hypochlorite solution before disposal • Infected waste is kept in the yellow bag • Sharp wastes are kept in the blue bag • PPE is used while handling bio-medical waste.		
5.22	**Referral of the Patient:** In case patient's condition worsens, doctor refers the patient to higher medical institutions for better treatment.	**Doctor**	**Referral card**
5.23	**Discharge**		
5.24	If the doctor feels that the patient has recovered and is fit for discharge, he informs the nursing staff.	**Doctor**	**Discharge summary**
5.25	The nursing staff informs the patient party about the discharge and asks them to pay the bills.	**Nurse**	
5.26	On the day of discharge, concerned doctor reassesses the patient and writes discharge on the Case Sheet.	**Doctor**	**Case sheet**
5.27	Discharge slip is prepared by the nurse and the doctor signs it and is given to the patient.	**Doctor**	**Discharge summary**
5.28	**Updating IPD Register:** Nurse enters the discharge details in the admission and discharge register.	**Nurse**	**Admission and discharge register**
5.29	**LAMA:** If a patient wants to leave the hospital but as per the treating doctor she/ he is not fit for discharge then a declaration is signed by the patient / next to kin on the BHT. In case patient / next of kin are illiterate then the thumb impression of the patient is taken. LAMA/	**Doctor / Nurse**	**BHT, Admission and Discharge Register, Discharge**

	Discharge summary is prepared and the same is handed over to the patient.		**Summary**
5.30	**Absconding Patient:** Nurse meets all the patients when the shift is changed. She checks if the patients are available on their bed.	**Nurse**	
5.30.1	If the patient is not found on Bed/ toilet/ or taken for investigation the nurse raises an alarm and informs the Security Supervisor.	**Nurse**	
5.30.2	The security supervisor calls for the patient's relatives in the waiting area.	**Security supervisor**	
5.30.3	If no one is available then search for the patient and relatives start in the hospital. If not traceable in the hospital premises the nurse then call at their home address and inform them about the missing patient.	**Nurse**	
5.30.4	The nurse will wait for 2 hours before confirm that the patient is not traceable. She then informs the BPM.	**Nurse**	
5.30.5	BPM then informs police about the same.	**BPM**	
5.30.6	Nurse the notes down the details of the event in the Case Sheet and also notes it down in the Admission Discharge Register.	**Nurse**	**Case Sheet Admission Discharge Register**
5.31	**Complaint Handling**		
5.31.1	Any complaints/ suggestions made by the patient/relatives pertaining to violation of patients' rights, provision of medical care, etc. are brought into the notice of Sister Incharge either by the patient/relatives directly or by a hospital staff through the IPD patient feedback form.	**Sister Incharge**	
5.31.2	Based on the findings of the investigations, appropriate actions will be initiated to resolve the issue and address the patient/relative's grievance.	**MO I/C**	**IPD Feedback form**
5.32	**Management of Death:** In case of death of any IPD patient the procedure followed for the same is given in the SOP of Management of Death	**Doctor/ Nurse**	**HCM. 12**

6. **Formats: (Enclose in appendix)**

S. No.	Format No.	Format Name	Type
1.	FF/IPD/01	Case Sheet – it includes the below mentioned fields	Form
2.	FF/IPD/01	Admission record	Form
3.	FF/IPD/01	History	Form
4	FF/IPD/01	Physical Examination	Form
5.	FF/IPD/01	Patient progress notes	Form
6.	FF/IPD/01	Nurses Daily record	Form
7.	FF/IPD/01	TPR Chart	Form
8.	FF/IPD/01	Patient general consent form	Form
9.	FF/IPD/01	Discharge summary	Form
10.	FF/IPD/01	Diet Sheet	Form

7. **Records:**

S. No.	Record Number	Record Name	Type	Retention Period
1.	RG/IPD/01	Admission register	Register	**3 years**
2.	RG /IPD/02	Discharge register	Register	**3 years**
3.	RG /IPD/03	Death Record register	Register	**3 years**
4.	RG /IPD/04	Police Case (Injury register)	Register	**3 years**
5.	RG /IPD/05	IPD Indent Register	Register	**3 years**
6.	RG /IPD/06	Diet Register	Register	**3 years**
7.	RG /IPD/07	Linen Register	Register	**3 years**

APPENDIX

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Case Sheet:

ADMISSION RECORD

Name of Patient Age Sex Unit Ward Father's/Husband Name Address H. No. Tq. Dist. Emergency Address Head of Service Date of Admission		Religion: Registration No.: Occupation: Income Village Town Post Telephone No. Time Prepared by

Date of Discharge by | No. of Hospital Days | Deficiency Checked

Provisional Admission Diagnosis:		International Code
Final Diagnosis:		
Secondary Diagnosis:		
Complications:		
Operative Procedures:		
Consultations		
Discharge		

Discharge Status Cured Relived Improved Unchanged Lama +
Expired

+ Cause of Death Expired 48 hrs/
48 hrs

Autopsy

YES/NO

(Signature of Medical Officer) (Signature of Head of Unit)

Paying Room / Ward

Allotted on Signature of M.O.

HISTORY

NAME	AGE	SEX		RELIGION:	HOSP. NO.
SERVICE		WARD		OCCUPATION	INCOME

PRESENT COMPLAINT:

HISTORY OF ILLNESS:

PAST HISTORY:

FAMILY HISTORY:

PERSONAL HISTORY:

PHYSICAL EXAMINATION

COMMUNITY HEALTH CENTRE, GHATGAON

PROGRESS NOTE

Patient Name:		Bed No.:
Age:	Sex:	IPD No.
Ward:		Date of Admission:

Date	Progress Note	Advice

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NURSES DAILY RECORD

NAME AGE SEX DEPT. WARD	

ALL INJECTIONS TO BE INITIALED BY PRESONS ADMINISTERING AND WITHNESSING

Hour	Medications	Diet	Treatment Remarks

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NURSES DAILY RECORD

NAME AGE SEX

DEPT. WARD

ALL INJECTIONS TO BE INITIALED BY PRESONS ADMINISTERING AND WITHNESSING

Hour	Medications	Diet	Treatment Remarks

Medication Sheet

Community Health Centre, Ghatgaon
Medication Chart

Patient Name:		Bed No.:
Age:	Sex:	IPD No.
Ward:		Date of Admission:

Description		Time						
Medicine Name		Early Morning						
		Morning						
		Noon						
		Evening						
Dose	Route	Night						
		Midnight						
Medicine Name		Early Morning						
		Morning						
		Noon						
		Evening						
Dose	Route	Night						
		Midnight						
Medicine Name		Early Morning						
		Morning						
		Noon						
		Evening						
Dose	Route	Night						
		Midnight						
Medicine Name		Early Morning						
		Morning						
		Noon						
		Evening						
Dose	Route	Night						
		Midnight						
Medicine Name		Early Morning						
		Morning						
		Noon						
		Evening						
Dose	Route	Night						
		Midnight						

Any other instruction like SOS medication ____________________

TPR BP & In Put - Out Put Chart

Community Health Centre,Ghatgaon

Patient Name:

Age: Sex: IPD No.: Bed No.:

Ward: Date of Admission:

	Date -						Date -					
Time	6	10	14	18	22	2						
Temperature												
Pulse												
RR												
BP												
SPO2												
In Take												
Out Put												
	Date -						Date -					
Time												
Temperature												
Pulse												
RR												
BP												
SPO2												
In Take												
Out Put												
	Date -						Date -					
Time	6	10	14	18	22	2	6	10	14	18	22	2
Temperature												
Pulse												
RR												
BP												
SPO2												
In Take												
Out Put												

DIET SHEET

Name: Age: Sex: Ward: Register No.

DIET																												
CLASS																												
1. Milk 2. Sago Diet 3. Milk & Bread Diet 4. Rice Diet 5. Chapatti Diet 6. Full Diet 7. Mix Diet 8. Sippy Diet																												
SPECIAL DIET Initials of Medical Officer																												

Patient General Consent Form

COMMUNTY HEALTH CENTRE, GHATGAON

GENERAL CONSENT FORM

IP Reg. No. ..... Bed No. ..... Date: .....

Name..... Age.....years Sex: M / F

AUTHORIZATION FOR INVESTIGATIONS, PROCEDURE, TREATMENT & RELEASE OF INFORMATION

(The contents of this form have been explained to me in my spoken language)

I.....(name of patient), the undersigned, do hereby agree and give my consent for my admission to **Community Health Centre, Ghatgaon** and I hereby request and authorize the hospital, the physicians and nursing staff, assisted by the employees of the hospital, to provide such care and administer such diagnostic, radiological procedures and treatments as, in the judgment of the treating physician(s) is deemed necessary or advisable in my / the above patient's care or (in the case of obstetrical patients) in the care of my newborn. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration, and/or injection of pharmaceutical products and medications, and withdrawal of blood for laboratory examinations including HIV testing. I acknowledge the fact that the hospital has the authority to dispose off specimens taken for laboratory examination. In addition, I hereby authorize any and all persons caring for me to review and/or release my personal health information to other healthcare providers treating me during this hospitalization.

All cash, jewellery and other valuables shall be removed by me to a place of safety. I shall not hold the hospital authorities responsible for any kind of loss sustained by me or my family.

I certify that I have read and understand this form and that no guarantees have been made to me as to the results of treatments or examinations done in the hospital.

I also agree to abide by all the rules & regulations of the hospital during my stay in the hospital.

Signature of the Patient / Attendant

Name: ..... Relation:.....

Address: .....

Tel:..... .....

Date:...../...../.....Time:.....AM/PM Signature of Admission Personnel

Discharge Summary

ROGI KALYAN SAMITI

C.H.C. GHATGAON, KEONJHAR

DISCHARGE TICKET

Regd. No. _____ Ward _____ Bed No. _____

Department

Patient's Name

Address :

Age / Sex :

Date of Admission :

Date of Discharge :

Disease :

Treatment given :

Cause of Discharge :

Condition at the time of Discharge :

Advice :

Signature of Medical Officer

REGISTERS

1. Admission Register

UID No	Sr. No	Time	Patient's Name	Attendant Name	Age/ Sex	Address	Condition	Depart ment	Discha rge	Referr al	LAMA	Absc ond	Death	BPL (√)	MLC (√)

2. Discharge Register

S.No	Name	Reg no	Date of admission	Bed no	Type of Discharge

3. Death Record Register:

Sr. No.	Monthly Sr. No	IPD Reg. No.	Date/Time of Admission	Name & address	Age/ Sex	Diagnosis	Cause of Death	Date/Time of Death	Ward name	Treating Doctor

4. Police Case (Injury Register):

Name of the Hospital.....
Date.....
Name of the patient.....
Age and sex.....
Father or Guardian.....
Address.....
Brought by.....
Name of the police station where the incident occurred.....
Place date and time of occurrence.....
Date and time of occurrence.....
Date and time of attendance.....
Admitted or not.....
History of injury.....
On Examination:
Nature of Injury, i.e. whether a cut or a bruise, a burn etc.....
Sizes of each injury in inches i.e. length, strength, depth.....
On what part of the body inflicted.....
Slight , Severe or Dangerous.....
By what kind of weapon inflicted.....
Prognosis.....

Date :

Sign of the Medical Officer in full

5. IPD Indent Register

Indent number.....

Section.....No.....

Date.....

Serial No	Name of medicine/ Equipment/Contingency	Item Code	Quantity in stock	Last date of Receipt	Quantity Received last	Quantity Required	Quantity supplied

Indented by.....Received by.....Supplied by.....Verified by.....Authorized by.....

6. Diet Register

Ward Name..... Date:.....

S. No	Bed No.	Name of Patient	Age & Sex	Old / New	Type of Diet	Sign. Of Dietician/ Nurse	Remarks

7.Linen Register

Ward/ Unit

Srl.	Issue Date	Type of Linen	No. of Linen handed over	Receiving Date	No. Received	Sign. of Receiver	Remarks

8. Process Efficiency Criteria:

S.No	Activity	Efficiency criteria
1	Shifting of patient on bed	The patient shall be shifted to the bed within 30 minutes after reaching of patient in the ward.
2	Treatment started	Patient is assessed within 2 hours by treating consultant after admission
3	Time taken to discharge a patient	The overall cycle time to discharge should not exceed 6 hours.
4	Average Length of Stay	• Total patient bed days in a month(excluding new born) ÷ Discharges in the month (including death, LAMA, Absconding) • Average length of stay should be less (5 days)
5	Bed Occupancy Rate	• Total Patient Bed Days ×100 ÷ (Functional Beds in Hospital× calendar days in month) • Bed Occupancy Rate should be in range of 70 -80%

9. Reference Documents

- IPHS Guidelines
- Government/ Office order for Absconding and LAMA Patients.

Superintendent
CHC Sainkul

Superintendent
CHC Sainkul,Keonjhar