DEDER GENERAL HOSPITAL

INPATIENT SERVICE PROTOCOL

PREPARED BY*: *HSQU

JULY 2016 E.C

DEDER, EASTERN ETHIOPIA

PROTOCOL APPROVEAL SHEET

NAME OF PROTOCOL: INPATIENT SERVICE PROTOCOL

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THIS PROTOCOL IS EFFECTIVE FROM JULY 2016 E.C TO JUNE 2018 E.C

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Abbreviations

- CLD - Chronic Liver Disease
- COT - Central Operation Theatre
- DM - Diabetes Mellitus
- HCW - Healthcare Worker
- HMIS - Health Management Information System
- HTN - Hypertension
- ICU - Intensive Care Unit
- IPC - Infection Prevention and Control
- IPD - Inpatient Department
- MDT - Multidisciplinary Team
- OPD - Outpatient Department
- PSA - Pressure Swing Adsorption
- QI - Quality Improvement
- SOP - Standard Operating Procedure
- SPO2 - Oxygen Saturation
- TAT - Turnaround Time

PURPOSE:

- ☞ To provide standardized, high-quality care for all inpatients, ensuring patient safety, comfort, and satisfaction throughout their hospital stay.
- ☞ To provide guidance on establishing effective, efficient and integrated inpatient care services from admission through discharge.

SCOPE:

- ☞ This protocol applies to all hospital staff involved in the care of inpatients, across all specialties, including physicians, nurses, pharmacists, and support staff.

1. INTRODUCTION

Inpatient Hospital Services are medical care and treatment of inpatients provided under the direction of a physician in an organized, furnished and licensed hospital, established and maintained primarily for the care and treatment of patients with various health conditions, including mental health problems.

Our inpatient services include units like Pediatrics, Internal Medicine, Surgery, Obstetrics-Gynecology, Rehabilitation, Critical Care, Adult and Neonatal Intensive Care, Labor and Delivery, Operating Rooms, and Post Anesthesia Care.

Inpatient services encompass use of facilities, diagnostic and therapeutic services, medications, supplies, room and board, nursing care, and all necessary provisions for adequate patient care. The inpatient department is a major area for provision of hospital services.

Patients referred from other departments, clinics or healthcare facilities are admitted based on the hospital's admission criteria to receive comprehensive inpatient care services.

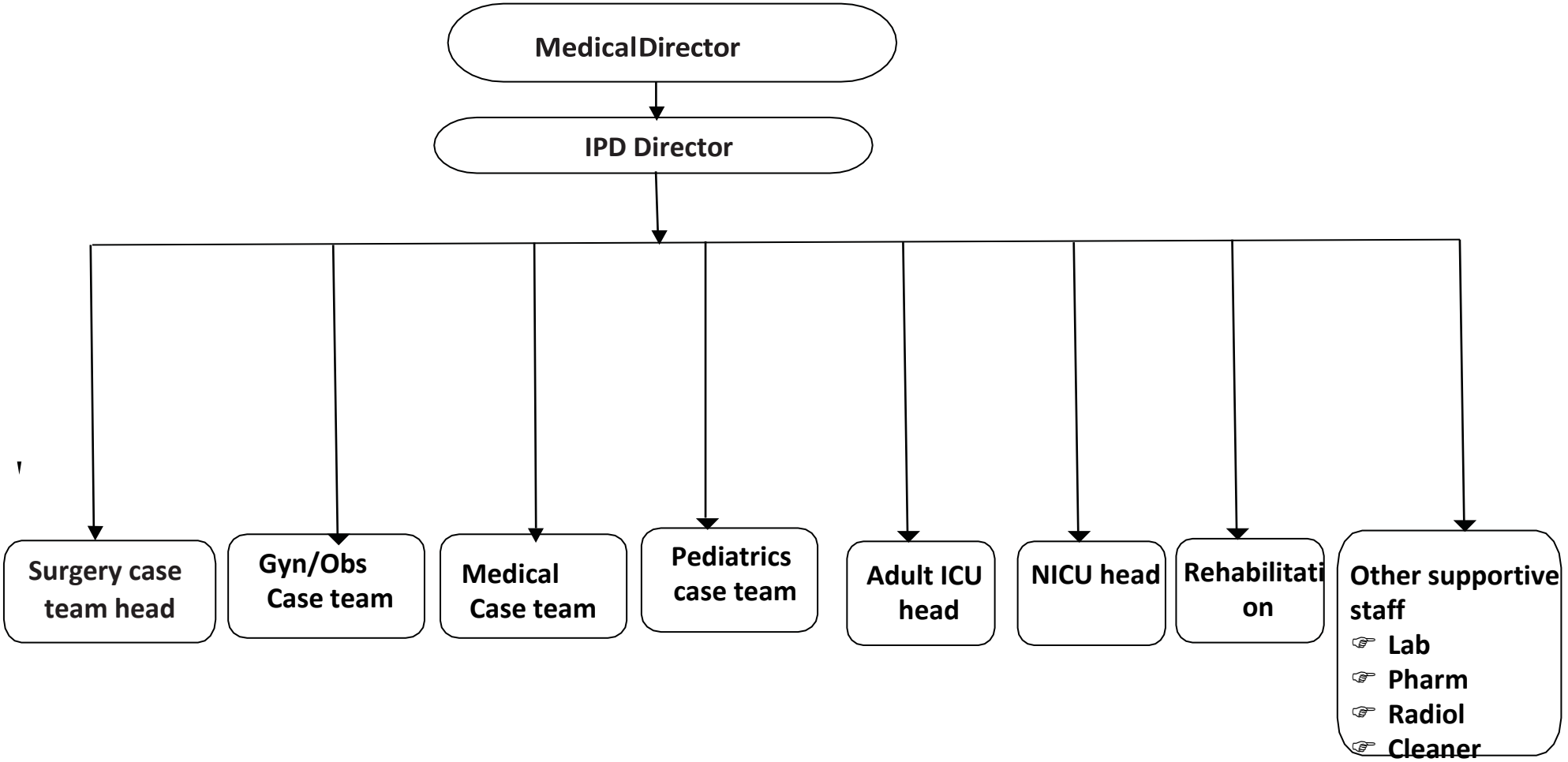
Duration of hospital stay depends on the patient's condition and available resources.

The inpatient department is staffed by multi-disciplinary team including physicians, nurses, clinical pharmacists, laboratory professionals, and other cadres.

1.1. Inpatient Services Management and Organization

- ☞ The Inpatient Services Director should oversee all inpatient activities.
- ☞ Clinical and support staff should be organized into **specialty-based Case Team such as:**
  - ✓ Internal Medicine,
  - ✓ Surgery,
  - ✓ Pediatrics,
  - ✓ Gynecology).
- ☞ Case Teams should comprise specialists, general practitioners, clinical pharmacists, phlebotomists, health officers, nurses, midwives, runners, cleaners, etc. An assigned Case Team Leader reports to the Inpatient Director. Pharmacy, Radiology and Laboratory should also form part of inpatient services and provide support and advice on individual patient care as needed.
- ☞ Efficient inpatient services require coordination with:
  - Nursing,
  - Clinical Support Services (Physiotherapy, Radiology, Social Work),
  - Ancillary Services (Laboratory, Transport, Food Services),
  - Health Information Services (Admissions, Medical Records, IT) and
  - Facility Management (Housekeeping, Maintenance, Security).
- ☞ The Inpatient Director coordinates these services for seamless integrated care.
- ☞ The Nursing Director led nursing services and reports to the Medical Director/Chief Clinical Officer.
  - ✓ Responsibilities include preparing annual plans,
  - ✓ managing and staffing nursing units,
  - ✓ conducting quality improvement initiatives, among others.

Figure 1: Organogram of Inpatient services



1.2. Inpatient Services Layout

- ☞ Inpatient Services Layout
- ☞ Safe, comfortable inpatient rooms facilitate healing.
- ☞ Room sizes should meet minimum standards per the hospital's tier level.
- ☞ Patient wards should be near the emergency & outpatient department, and easily accessible from elevators, ramps or stairs

1.3. Inpatient Case Management

- Patients may be admitted from:
  - Emergency,
  - Operating Rooms,
  - Outpatient and
  - Intensive Care.
- At admission, ambulatory patients are guided through registration while non-ambulatory patients are transported to wards with medical records for seamless care.
- Below are key activities:
  - ✓ Efficient bed management to avoid inappropriate hospitalization and improve bed access
  - ✓ Patient-centered services
  - ✓ Patient involvement in decision-making
  - ✓ Available beds for elective admissions to reduce waiting times

1.4. Admission process

- The Hospital provides 24/7 year-round admission/discharge services including **holidays.**
- The Liaison officers shall facilitate the admission process
- On arrival, a nurse receives and orients the patient and care givers.
- Receiving nurses should assess all patients/clients' conditions on arrival in the ward and make the patient feel welcome, comfortable and at ease.
- For **critically ill patients**, the nurse informs the physician for immediate assessment.
- All patients should be assessed by a doctor within **2 hours of arrival** and a history and physical examination completed.

- The nursing process needs to be completed **within 8 hours** (before the next shift)

Typical Pathway for Inpatient Admission.

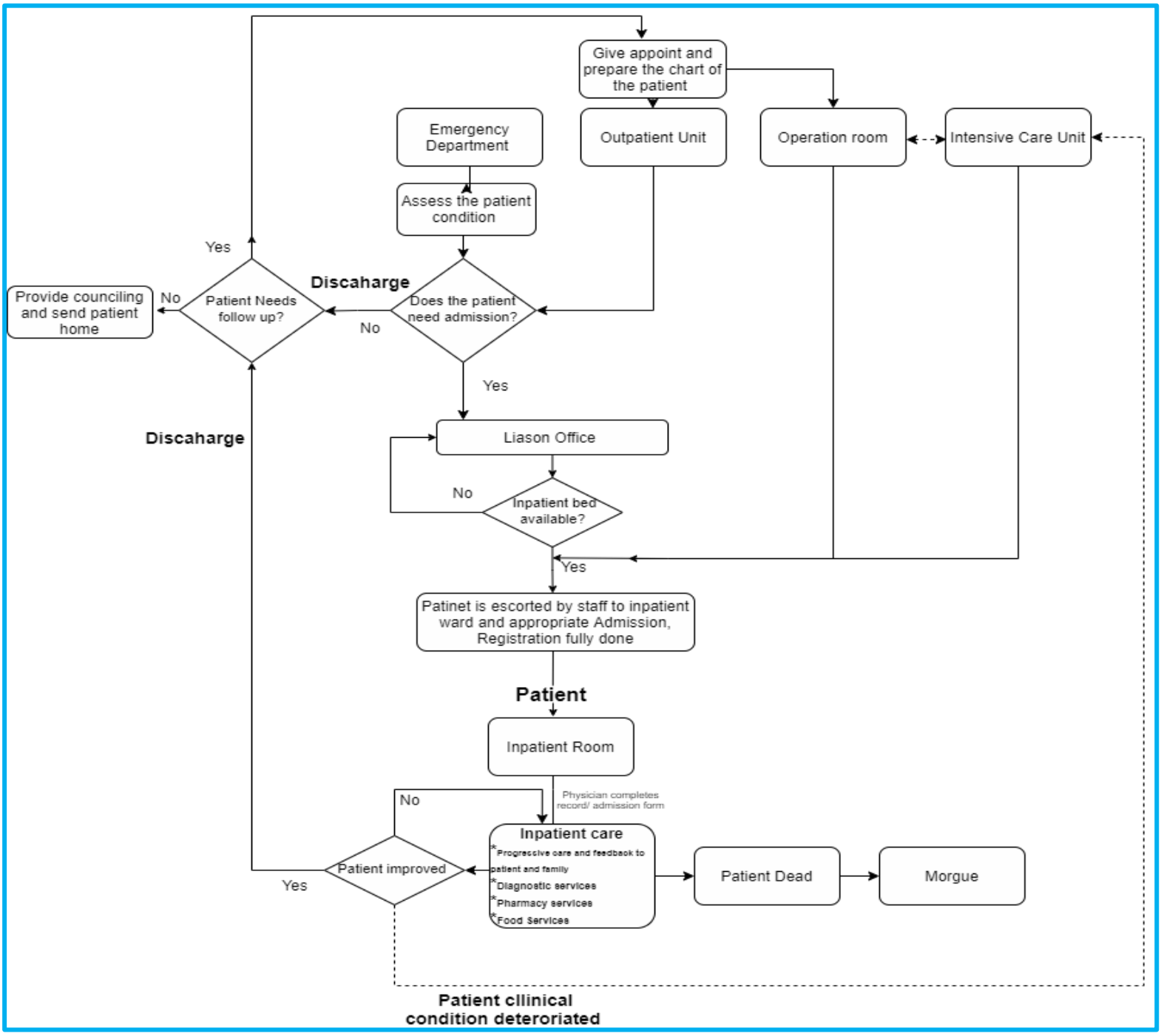


Figure 2:. Typical Pathway for Inpatient Admission.

2. CLINICAL CARE SERVICE ACTIVITY

- After initial assessment, the Care Team shall review patients regularly:
  - Stable patients –
    - Physicians daily,
    - Nurses 4 hourly;
  - Critically ill patients –
    - Physicians twice daily or more,
    - Nurses more frequently.
- Contacts are documented using physician progress notes and nursing/midwifery progress sheets.
- Medications are administered and documented per standardized formats.
- Like other essential medications, supplemental oxygen is **fully prescribed**, **delivered** and adherence monitored by **clinical pharmacists**.
- Complete oxygen orders specify:
  1. Flow rate
  2. Delivery system/mode
  3. Monitoring frequency
  4. When to report
  5. When to change delivery device
  6. When and how to stop administration
- Ordered investigations use relevant request forms.
- Phlebotomists/lab team/nurses collect specimens in wards.
- For x-ray/ultrasound, the physician contacts the department to schedule the patient, who is transported by a runner or clinical staff.
- If mobile x-ray/ultrasound are available, the physician provides the service where patient dignity is respected.
- Findings are documented and explained to the patient.

2.1. Food/Nutrition service

- Menu planning is the cornerstone of food services.
- Menus should meet needs of patient groups like children, elderly, ethnic minorities with adequate choices.
- **Meal timing** should align with **customary patterns**.
- Hospital food service aims to provide safe, adequate and appropriate meals.
- All hospitals Shall develop **meal planning** through a multidisciplinary committee with representatives from:

1. Administration
2. Procurement Unit
3. Ward in-charges/Nursing head (**Matron**)
4. Food Services / Dietitians (where available)
5. Store in charge
6. Cooks
7. IPC Focal
8. Other relevant officials

Roles and responsibilities

A.The kitchen /Store in charge

- Menu planning for inpatients
- Planning food item purchases
- Directing, supervising and monitoring meal preparation and service
- Managing inventory, consumption and cost records

B.Cooks

- Receiving ward food requests
- Planning, cooking, transporting and serving inpatient meals
- Ensuring food areas including storage are clean, pest-free and have minimum contamination risk
- Receiving and communicating patient feedback to the kitchen in-charge
- Prescribing therapeutic diets and modifications based on disease status
- Planning and periodically monitoring food services for best practice

C. Physician

- ☞ Prescribing therapeutic diets based on patient diseases

D. Nurse in charge

- ☞ Completing and submitting diet request forms to cooks

E. Management

- ☞ Planning and periodically monitoring food services for best practices

2.2. Isolation rooms

FUNCTIONS

- ☞ Isolation rooms are for potentially infectious patients like drug-resistant TB.
- ☞ Rooms should have negative pressure ventilation, scrub facilities, and private bathroom. Separate isolation rooms should be available for patients requiring separation to avoid sources of visual or auditory distress, like tetanus cases.
- ☞ **Well-designed isolation rooms are very essential:**
  - To separate patients who are likely to be infectious to other persons
  - To provide an environment that allows reduction of the concentration of airborne Particles through various engineering methods
  - To prevent the escape of airborne particles from such rooms into the corridor and other areas of the facility using directional airflow
  - To protect patients who are immune-compromised from potentially harmful pathogens.

2.3. Specific Inpatient facilities and services

❖ **Patient gowns, linen, mattresses –**

- The Hospital ensures adequate supply of clean blankets, sheets, and gowns.
- Mattresses should be plastic-covered without holes.
- Beds should be changed at **least every 48 hours** and more frequently as needed.
- All patients should wear gowns with their clothes stored separately to prevent cross-infection.

2.4. DISCHARGE PROCESS

- The Hospital should have a written discharge protocol defining all steps including summary preparation and medical record handling post-discharge.
- When discharge is planned, the Care Team counsels the patient.
- The treating physician decides discharge and completes a summary - first copy given to the patient and second copy retained in the record.
- For referred patients, the discharging physician also completes the feedback section of the referral form given to the patient to return to the referring facility.
- Pre-discharge counseling by the physician, nurse and pharmacist should cover:
    - Diagnosis, investigations and treatments
    - Medications to continue
    - Follow up arrangements
    - Warning signs to watch out for
- Before sending the patient to the **Liaison Office**, the discharging nurse ensures all registers are completed and administrative issues including **finances settled**.
- The discharge process takes a maximum of **2 hours.**
- The patient is sent to the Liaison Office with **medical records.**
- The Liaison Officer checks document completeness, registers the discharge and sends the patient home with an **appointment card** if follow-up was requested.

2.5. PATIENT DEATH

- The Inpatient service should have a separate room for 'after death care'.
- If post-mortem examination is needed to confirm cause of death, relevant forms are completed and the body transferred to pathology or the morgue.
- After examination, the body is kept in the morgue until collected by relatives or responsible persons.
- Unclaimed bodies become the responsibility of **local authorities.**
- Unexpected deaths are reported to and investigated by the **Hospital's quality improvement unit**.

3. INPATIENT SERVICE HUMAN RESOURCE REQUIREMENTS

- The actual number of personnel shall be determined by workload analysis using recognizable methods;
- Inpatient services should be provided by Case Teams comprised of:
    1. Specialist (s)
    2. General practitioner(s)
    3. Nurses, Psychiatrist, psychologists, radiology (x-Ray technician)
    4. Pharmacy technicians and clinical pharmacists
    5. Laboratory technologists, phlebotomists
    6. Anesthetist
    7. Dietitian
    8. Porters/runners
    9. Cleaners
    10. Cashiers
    11. Security guards

4. INPATIENT SERVICE EQUIPMENT AND SUPPLY REQUIREMENTS

The minimum equipment and supplies for patient wards include:

- Beds, mattresses, pillows, linens, and blankets
- Chairs, tables, and bedside tables
- Emergency trolley with resuscitation equipment and emergency drugs
- Oxygen, pulse oximeter
- Suction machine
- Vital sign and diagnostic Set; sphygmomanometer(s), stethoscope(s), thermometer(s),
- Fundoscopies, Otoscope
- Reflex hammer
- Weight scale and measuring tape
- IV stands, bed screens
- Trolleys, wheelchairs and stretchers
- Personal protective equipment
- Minor Set procedure sets according to the type of ward/case team, dressing sets
- Enema Set, LP set, Catheterization set
- Refrigerators

- Autoclave (at least one, not in central sterilization unit)
- Shelves

5. INPATIENT CARE COMMUNICATION

- Clear communication ensures care continuity, avoids duplication and is essential legally.
- Guidelines should cover
  - ✓ Handovers,
  - ✓ Multidisciplinary rounds and
  - ✓ Communication with patients/relatives.

5.1. Handover of Clinical Care

- Handover involves transferring professional responsibility/accountability for some or all aspects of patient care.
- Effective handovers are vital for care continuity and should align with documentation like referrals, transfers and discharge summaries.
- Handover needs systemic and individual attention, education, facilitation and sustained effort to maintain importance amidst busy schedules.
- Standard handover processes improve safety by ensuring critical information transfer and action.
- Relevant, accurate and timely information should be communicated unambiguously using standardized **electronic** or **structured written forms.**
- Handover aims to efficiently convey quality clinical information to support safe care.
- Handovers occur daily in all hospital settings during shift changes, transfers within/between facilities, admission/referral/discharge.
- **METHODS INCLUDE:**
  - Face-to-face,
  - Telephone,
  - Electronic tools.
- **LOCATIONS INCLUDE:**
  - Bedside,
  - Staff areas,
  - Reception desks.

- **Consequences of poor handover include:**
  - Unnecessary delays in diagnosis, treatment, and care;
  - Repeated tests, missed or delayed communication of test results; and
  - Incorrect treatment or medication errors

Benefits of Clinical Care Handover:

- **FOR PATIENTS**
  - ✓ **Improved safety** - lapses can lead to mistakes
  - ✓ **Care continuity**
  - ✓ **Less repetition** - multiple histories are vexing
  - ✓ **Better satisfaction** - team knowledge continuity is accepted
  - ✓ **Increased efficiency** - timely diagnosis/management
- **FOR Healthcare providers**
  - ✓ **Professional protection** - clear documentation prevents wrongful responsibility
  - ✓ **Reduced stress** - information enables confident care
  - ✓ E**ducational** - communication skill development in open environments
  - ✓ **Job satisfaction** - quality care provision is rewarding

5.2. Multidisciplinary ward rounds and chart audit for newly admitted patient

- Multidisciplinary ward rounds allow joint patient assessments and care planning.
- Effective coordination of assessments plans and communication is vital for efficient quality care.
- **Round composition includes:**
  - Doctors of different specialties,
  - Nurses,
  - Clinical pharmacists,
  - Dieticians,
  - Psychiatrists, and
  - Caregivers, etc.

To improve quality of inpatient care and reduce average length of stay hospital should

- Implement multidisciplinary team round **twice per day** (**morning and afternoon**), and

- ❖ Conduct **chart audit** by **senior physician for newly admitted patient**.

☞ The **MDT round decisions** should be documented using the format and attached in the patient's medical record.

5.3. Communicating with patients

- Communicating information in an easily comprehensible manner supports shared care management with the patient and promotes future patient self-care management at the point of discharge.
- Healthcare providers should inform the patient/s and their careers/relatives about pending ward rounds and prepare forward rounds with relevant information on diagnostic tests and clinical findings and with whom they can raise questions after the ward rounds.
- Providing clear explanations about symptoms and disease severity and answering even the simplest of questions can remove patients' fear and anxiety and aid recovery.
- Patient confidentiality should be maintained during discussions.

6. DOCUMENTATION AND RECORD-KEEPING

- Comprehensive clinical documentation is integral to quality care and relies on accessible records (electronic/paper).
- Effective record-keeping enables care continuity and communication between providers.
- Thus, records should be updated by all involved multidisciplinary staff:
  - physicians,
  - nurses,
  - pharmacists,
  - physiotherapists,
  - psychologists etc.
- Patients should access records to understand care provisions.
- Clinical records enable care audits and investigations of incidents, complaints and claims.

Benefits of keeping good records versus disadvantages of poor records

Good clinical records	Poor clinical records

☞ Share relevant information ☞ Coordinate care ☞ Enable continuity ☞ Inform decisions ☞ Assess risks ☞ Investigate incidents ☞ Improve audit capabilities ☞ Legal evidence ☞ Targeted diagnostics/treatment ☞ Time management	☞ Misinformation risks ☞ Care fragmentation ☞ Test/investigation repetition ☞ Incorrect treatment/medication errors ☞ Jeopardies patient care ☞ Lead to serious incidents ☞ Prolonged admissions- Audit capabilities ☞ Compromised care ☞ Litigation risks

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