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**STANDARD OPERATING PROCEDURES FOR PATIENT ADMISSION IN THE ONCOLOGY UNIT**

Approved By:

Chief Medical Officer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

1. **APPROVAL HISTORY**

This is the first time procedure dated august 2024

1. **REVISION HISTORY**

This is revision number 0

1. **PURPOSE**

To establish a standardized procedure for the admission of patients to the oncology unit, ensuring that the process is efficient, patient-centered, and compliant with hospital standards.

1. **SCOPE**

This SOP applies to all healthcare professionals involved in the admission process for patients in the oncology unit, including physicians, nurses, administrative staff, and allied health personnel.

1. **RESPONSIBILITIES**
2. **Physicians:** Determine the need for admission, write admission orders, and establish the initial treatment plan.
3. **Nurses:** Conduct the admission assessment, initiate care, and orient the patient and their family to the unit.
4. **Administrative Staff:** Process admission paperwork, verifies patient information, and enters data into the hospital's information system.
5. **Allied Health Personnel:** Assist with specific needs related to patient care, such as nutrition, physical therapy, or social work support.
6. **REQUIRED MATERIALS/SYSTEMS**
7. Hospital Information System (HIS) , (sanitas)
8. Patient identification documents (e.g., ID card, insurance card)
9. Admission forms and checklists
10. Consent forms (e.g., for treatment, procedures)
11. Medical equipment for initial assessments (e.g., thermometers, blood pressure cuffs, scales)
12. **PROCEDURE**

**7.1 Pre-Admission**

1. **Physician Assessment**
   1. **Decision for Admission:** The attending physician evaluates the patient’s medical condition and decides on the necessity for inpatient care in the oncology unit.
   2. **Admission Orders:** The physician writes detailed admission orders, including diagnosis, treatment plan, and any specific instructions.
   3. **Patient and Family Communication:** Inform the patient and their family about the decision to admit, including what the hospitalization will involve and any immediate steps they should take.
2. **Room Assignment:**
   1. **Coordinate with the Unit:** Communicate with the oncology unit to ensure a suitable room is prepared for the patient.
   2. **Special Considerations:** Consider patient needs such as isolation requirements, mobility limitations, or proximity to specific medical equipment.

**7.2 Patient Arrival and Registration**

1. **Welcome and Identification:**
   1. **Greet the Patient:** The patient and their family should be greeted by a nurse or administrative staff upon arrival.
   2. **Verify Identity:** Confirm the patient’s identity using government-issued ID and insurance documents.
2. **Registration Process:**
   1. **Collect Information:** Gather necessary demographic information, insurance details, and emergency contacts.
   2. **Verify Information:** Ensure that all collected information is accurate and complete before entering it into the HIS/EMR.
   3. **Consent Forms:** Provide the patient with all necessary consent forms, explain them, and obtain required signatures.

**7.3 Admission Assessment**

1. **Nursing Assessment:**
   1. **Vital Signs and Measurements:** Record baseline vital signs, height, and weight.
   2. **Medical History:** Review and document the patient’s medical history, focusing on previous oncology treatments, current medications, allergies, and any comorbid conditions.
   3. **Physical Examination:** Perform a comprehensive physical examination to assess the current health status of the patient.
2. **Psychosocial and Support Needs:**
   1. **Emotional and Social Assessment:** Evaluate the patient’s emotional state, support system, and any specific psychosocial needs.
   2. **Counseling and Support Services:** Offer referrals to social workers, psychologists, or chaplains as appropriate.
3. **Documentation:**
   1. **HIS:** Enter all assessment data into the HISensuring accuracy and completeness.
   2. **Care Plan:** Collaborate with the physician to create an initial care plan based on the assessment findings.

**7.4 Orientation to the Unit**

1. **Unit Orientation:**
   1. **Tour the Unit:** Provide the patient and their family with a brief tour of the unit, including their room, restrooms, common areas, and emergency exits.
   2. **Introduce the Care Team:** Introduce the patient to the primary care team, including nurses, doctors, and other support staff.
   3. **Explain Daily Routines:** Explain the daily routines, such as meal times, medication schedules, and the process for requesting assistance.
2. **Patient Education:**
   1. **Treatment Information:** Provide detailed information about the patient’s treatment plan, including what to expect during their stay and any potential side effects.
   2. **Self-Care and Safety:** Educate the patient on any specific self-care measures they need to follow and how to stay safe during their hospital stay.

**7.5 Initiation of Care**

1. **Implement Care Plan:**
   1. **Treatment Initiation:** Begin administering any prescribed treatments, medications, or therapies as per the physician’s orders.
   2. **Ongoing Monitoring:** Regularly monitor the patient’s condition, documenting observations and any changes in the HIS/EMR.
2. **Patient Communication:**
   1. **Regular Updates:** Provide the patient and their family with regular updates on the patient’s condition and any changes to the treatment plan.
   2. **Address Concerns:** Ensure that any patient or family concerns are addressed promptly and effectively.
3. **DATA SECURITY AND PRIVACY**
4. **Confidentiality:** Ensure that all patient information is handled in accordance with hospital policies and relevant legal requirements
5. **Access Control:** Limit access to patient records to authorized personnel only.
6. **DOCUMENTATION AND RECORD KEEPING**
7. **Maintain Accurate Records:** Ensure that all aspects of the admission process, including assessments, treatments, and patient interactions, are thoroughly documented.
8. **Audit Trail:** Maintain an audit trail in the HIS for all entries and modifications to the patient’s records.
9. **TRAINING AND COMPETENCY**
10. **Regular Training:** Provide regular training to all staff involved in patient admissions to ensure they understand and can competently perform their roles.
11. **Competency Assessment:** Periodically assess staff performance in following the admission procedures and update training as necessary.

**9. QUALITY ASSURANCE**

1. **Ongoing Review:** Regularly review and update this SOP to reflect any changes in hospital policies, regulations, or best practices.
2. **Feedback Mechanism:** Collect and review feedback from patients, families, and staff to identify areas for improvement.