POLICY ON ADMISSION AND DISCHARGE
AT MEDICAL/ SURGICAL WARD

POLICY NO: NSO - 010

DIVISION: NURSING SERVICE DIVISION

SECTION: MEDICAL SURGICAL WARD

POLICY REVIEWED: July 12, 2016

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OBJECTIVES: This policy defines the standard flow of admission and discharge in the medical and surgical unit regardless of cases to their designated room.

VISION: A nursing section dedicated in attaining excellent healthcare and recognized in giving quality medical and surgical care.

MISSION:

1. To improve and sustain the health of our fellow Paraqueños, by ensuring them with rational use and access to a safe, effective, good quality and affordable healthcare.
2. To promote and provide health services that is appropriate, equitable and sustainable by utilizing suitably qualified and motivated staff that is committed to excellence and professionalism.

Specific Objectives:

1. Instill the right attitude by proper education regarding laudable behaviour that will provide a positive atmosphere among staff and customers.

2. Strict adherence to the standard of care in accordance to the set policy of the local/international nursing administrators.

3. Proper coordination with all the concerned personnel from top to bottom regarding the use of hospital resources.

4. Apply the standard performance appraisal that will determine strength and weaknesses of the staff and develop their competencies in the process.

COVERAGE: All hospital employees, medical and non-medical, and students who have contact with patients in the Medical-Surgical floor.

I. Duties and Responsibilities:

It shall be the responsibility of the Medical and Nursing staff to abide with the procedure incorporated to this policy.

Head Nurse

1. Supervise, assess and evaluate the activities of the medical and surgical team.
2. Conduct orientation of the newly hired employees.
3. Schedule shifts for the nurses and assign duties to them.
4. Orient staff of this policy and to monitor the general activities in the unit.
5. Develop anticipated solutions to problems regarding health needs that may arise.
6. Assist in discharge planning, referral to other agencies and return to Out-Patient department.
7. Counsel guide personnel with their strengths and weaknesses and recommends disciplinary actions when needed.
8. Analyze unit problems with the staff and elevate to superiors those that cannot be solved in the unit level.
9. When the need arises, he may carry out professional nursing duties as a staff nurse on the floor.

Assistant Head Nurse

Supervises over the work of the nursing staff, support them and assume the responsibilities of the Head Nurse in the absence of the latter.

Medical Staff Nurse

1. Provide medications and injections as prescribed by the doctor.
2. Administer Intravenous Fluids and oxygen, if required.
3. Do the initial vital signs or as need arises like BP, Temperature, and Pulse etc. record and update the doctor including medical information.

4. Provide frequent patient evaluations including performing essential procedures.
5. Refer any changes in patient's status or untoward reaction to the doctor.
6. Monitor, analyse and record urine and stool output.
7. Assist doctors during rounds and treatment and caries out instructions properly.
8. Prepare the patient for various procedures like Ultra Sound, ECG, CT SCAN, MRI, Endoscopy, etc.
9. Provide general nursing care to all patients.
10. Give psychological support to the patient and family members. Educate patient and family about the disease and other laboratory procedures needed.
11. Record all care information in concisely, accurately and completely in a timely manner on patients nurses notes.
12. Participate in service nurse education programmes conducted by the hospital.
13. Inform patient and relatives in proper feeding as ordered by the doctor.
14. Responsible in maintenance of supplies, instruments, equipments and area cleanliness.

Surgical Staff Nurse:

1. Prepare the patient and equipments for various procedures and assist the Surgeon.
2. Provide Oxygen therapy and secretion suctions if needed.
3. Monitor any untoward reactions of patient and report to the surgeon.
4. Provide basic bedside care for Pre and Post surgical patients.
5. Use universal aseptic techniques during wound care and dressings.
6. Provide psychological support to the patient and relatives and educate how to manage their wound/injury.
7. Make proper endorsement of patient to staff in the Operating Room.
8. Perform the responsibilities of the medical ward nurse as stated in their duties and responsibilities.

Nursing Attendant:

1. Participate in endorsement rounds.
2. Taking and recoding vital signs and keep record of patient’s intake and output.
3. Properly dispose used linens of discharged patients and prepare the room for newly admitted patients.
4. Assist in changing in to patient’s hospital gown.
5. Help patients get in and out of bed
6. Receive and endorse area supplies, instruments and equipments and report any loss or breakage for proper action.
7. Monitor and charge oxygen consumption used by the patient.
8. Carry out clerical jobs in absence of the unit clerk.
9. Assist the nurse in performing simple nursing procedures (TSB, enema, bed bath,cleaning of wounds)

10. Collect specimens including sputum, stool, and urine and send it for medical analysis to laboratory.
11. Maintain the area's cleanliness.

UTILITY WORKER

1. Provide patients with help walking and moving in and out of bed.
2. Transport patient to treatment units using wheelchair or stretcher.
3. Accompany patients in ambulance conduction or transfer to hospital of choice.
4. Assist in turning or to reposition bedridden patients alone or with assistance to prevent bedsores.
5. Restrain patients if necessary.
6. Deliver specimens like urine/stool etc. for examination to the laboratory.
7. Assist in shaving male patients with supervision.
8. Properly dispose used linens of discharged patients and prepare the room for newly admitted patients.
9. Check and maintain the availability of oxygen tank needed in the unit.
10. Ensure safety of the environment through regular rounds and cleaning of all equipment and report any loss or breakage for proper action.

CLINICAL CLERK

1. Perform clerical duties such as processing documents and maintenance of record.
2. Keep patients chart in order
3. Record all admitted and discharged patients
4. Record and submit all discharged patients documents with final diagnosis to the record section; if with NO final diagnosis is noted, submit the record to the medical officer for completion.
5. Submit and coordinate patient's record to accounting office for proper billing.
6. Update the area bulletin board.
7. Prepare and submit requisition for job order for proper action
8. Keeps the staff's DTR, leave of absence, record of meetings and lectures.
9. Answer and make telephone calls.
10. Bring written communications and referrals to appropriate department.
11. Help in cleanliness and orderliness of the unit.
12. Record minutes of the meetings.

POLICY: This policy shall enforce compliance by all with the guidelines incorporated into it to institute order and quality delivered services.

II. Procedure on Admission:

Routine Admission Procedures

A**. From Emergency Room**

1. Each admitted case must have a confirmed designated room and bed assignment.
2. Do bedside endorsement, ER/WARD nurse.
3. Check for completeness of patient chart and patient classification entered by Social Worker.
4. Carry out doctor's order promptly.
5. Notify dietary for patient nutritional requirements.
6. Follow-up referral to the attending physician thru Medical Officer.
7. Elective cases procedure scheduling:

Chart from the emergency room endorse to ward with the following:

- Consent signed by the patient's relative as witness.
- OR proposal approved by the Medical Director, Chief of Clinics in his absence.
- Check date of surgery, CP clearance for patient 35 years old and above and pediatric clearance for patient 18 years and below.
- Consent for Blood Transfusion signed by the patient/patient's relatives.

For elective surgical cases notification of anaesthesiologist and surgical consultant and accomplishment of pre-anesthesia form must be done by the admitting medical officer.

B. **To the Operating Room (the night prior to surgery up to the day of operation)**

a. For elective surgery:

1. Begin the preparation based on the checklist form prior to surgery.
2. Check the Surgeon and Anesthesiologist's order a night prior to surgery and give the necessary medications and final preparations (if any).
3. Coordinate with the operating room to validate the schedule of operation and if visit prior to surgery has been made.
4. Follow up the anesthesiologist order to the resident on duty if the pre-anesthetic order has not been made.
5. Check the vital signs prior to admission to the operating room and report to the medical officer on duty for any abnormality.
6. Check again the doctors order if there is any medications to be given before endorsing the patient to the operating room nurse.
7. Validate the preparation made with the checklist form.
8. Do bedside endorsement, WARD/OR nurse.

b. For STAT operation:

1. Begin the preparation based on the checklist form prior to surgery.
2. Inform the anaesthesiologist thru medical officer for her availability.
3. Check the vital signs prior to admission to the operating room and report to the medical officer on duty for any abnormality.
4. Inform the operating room nurse through phone call prior to transporting the patient to the operating room.
5. Accompany the utility worker in transporting the patient to the operating room. Bed rails must be up at all times. The patient shall be covered with a blanket for warmth and privacy.

From Operating Room

a. Post-operative patient

1. OR/RR notify ward of the admission.
2. Check for completeness of patient record anaesthesiologist disposition.
3. Ward N.A. prepares bed and the necessary equipments needed for the incoming post-op patient.
4. Routine check of completeness of chart and bedside endorsement done.
5. Check dressing, patency of IV line, Foley catheter, and NGT and/or Thoracic tubes.
6. Monitor and report any signs of complication.

III. Discharge Routine

a. Upon order of may go home (MGH) by Attending Physician/Resident Doctor
b. Patient record shall be completed prior to submission for billing.
1.Routine May Go Home order on patient's chart
- Final Diagnosis (ICD 10) and procedure done fully accomplished.
-Change in dressing done by staff nurse , health home instruction sheet issued to patient and/or family.

1. If discharge against doctor's order, secure waiver for HAMA and attach to chart, noted by MD with the signature of both nurse and doctor.
2. Billing section issues payment order to relative of patient; Re-billing of MGH patient chart must be done if patient overstays.
3. Clearance issued by cashier upon payment of hospital bill and/ or professional fees.
4. Ward U.W. inspects bedside table and patient's bed for any uncollected wastes or personal belongings. If cleared the charge nurse, home instruction is given in triplicate. The latter issues clearance slip with Official receipt stamped to the security staff, linen staff and admitting staff along with the clearance.
5. Patient's tag inspected by security staff along with the clearance slip.

IV. Documentation

a. Chart should be arranged according to the required chart arrangement.

b. Write legibly and avoid erasures; the use of correction fluid is discouraged.

c. Indicate the number (#) of IVF on the Doctor's order in pencil, to check the accuracy of IVF infused. The one asking for to follow is responsible to #IVF at Doctors order sheet.

d. Medication sheet must be signed by NOD for any medication administered, place "o" mark if not given and indicate the reason at the nurses notes.

Indicate if increase or decreased in dosage and frequency, discontinued, shifted, completed, consumed or refused. Write the date when transcribed in the medication sheet.

e. Record IVF infused, separate sheet for main line/side drip or B.T, I & O, vital signs on TPR sheet; write monitoring in a separate sheet.

f. Laboratory results should be arranged according to date; recent one is on top, same as with the other results. For hgb, hct, platelet monitoring use separate sheet. All results shall be signed by Medical Officer/Medical Specialist date and time relayed.

g. Any procedure to be done must be properly explained and secure consent from the patient of legal age, for minors, parents or guardian, witness on the consent form must be signed by the relatives. Indicate date and time when the consent was secured.

h. Request for laboratory, x-ray and etc. must have a complete data indicate the middle name and date of birth of the patient.

i. Upon discharge check for patient admission record for final diagnosis and disposition; must be filled-up by the Attending Doctor or Medical Officer when discharge order was made.

j. Discharge summary/instruction sheet must be in duplicate with signature of the patient, nurse and the discharging doctor, one will be given to the patient and one will be attached to the patient chart.

k. Refusal to procedure and management (HAMA) must be reported immediately to the Attending Physician thru the MOD. A written waiver must be secured.

l. Admission, and discharges must be recorded on the logbook indicate the age, date, time, case of the patient for Phil health requirement and purposes.

m. Prepare for 24 hours floor census and submit to the supervisor on duty 12:00 midnight

n. Follow coded ink charting, Am-blue, PM-black and Night- red

o. Carry out doctors order promptly; check each line according to the acronym CARED; write a blocking line indicating it was carried out, countersign, indicate date and time it was carried out; use TRODAT.

p. Outgoing Nurse endorse Doctor's Order done during the shift to incoming Nurse, the latter then sign/TRODAT with the date that he/she received the endorsement.

q. Comply on the policy on documentation and charting

V. Endorsement

1. All staff must be in the area 15 minutes before the endorsement time.

2. Prior to ward rounds, a 15 minutes pre-conference endorsement at the nurse's station
3. All staff must not leave the area without the incoming shift. In case of absences, inform the Nurse Supervisor/Coordinator for the staffing arrangement.
4. Incoming Nurses will not receive the area if unclean. Maintain area cleanliness at all times.
5 Every endorsement outgoing nurse must endorse the patient's cardex and patient chart, incoming nurse must review the cardex prior to ward round, chart auditing must be done routinely.

VI. Procedures on Isolation Room:

1. Standard Precautions shall be used in the care of all patients taking into consideration the use of proper PPE and following universal precautions on communicable diseases.

2. Patients with known or suspected communicable diseases will be placed on the appropriate type of Isolation Precautions on admission to the hospital.

3. Proper signs/labels must be posted on the specified rooms and type of Standard Precautions must be included.

4. Hospital personnel should instruct all visitors about what type of precaution to be taken while visiting patients who are admitted.

5. Upon patient discharge, both used and unused items must be disposed properly and hospital equipment must be disinfected.
6. No watcher No admission unless "pulot" patients but with proper coordination with the social service; for private patients one watcher is allowed; serious patient – 2 watchers
7. No bed reservation at Ward, it should be channeled to Admitting section**.**

APPENDIX:

Ward Discharge Flow Chart
Discharged Patients Record Flow Chart
Flowchart of record of Discharged Patient

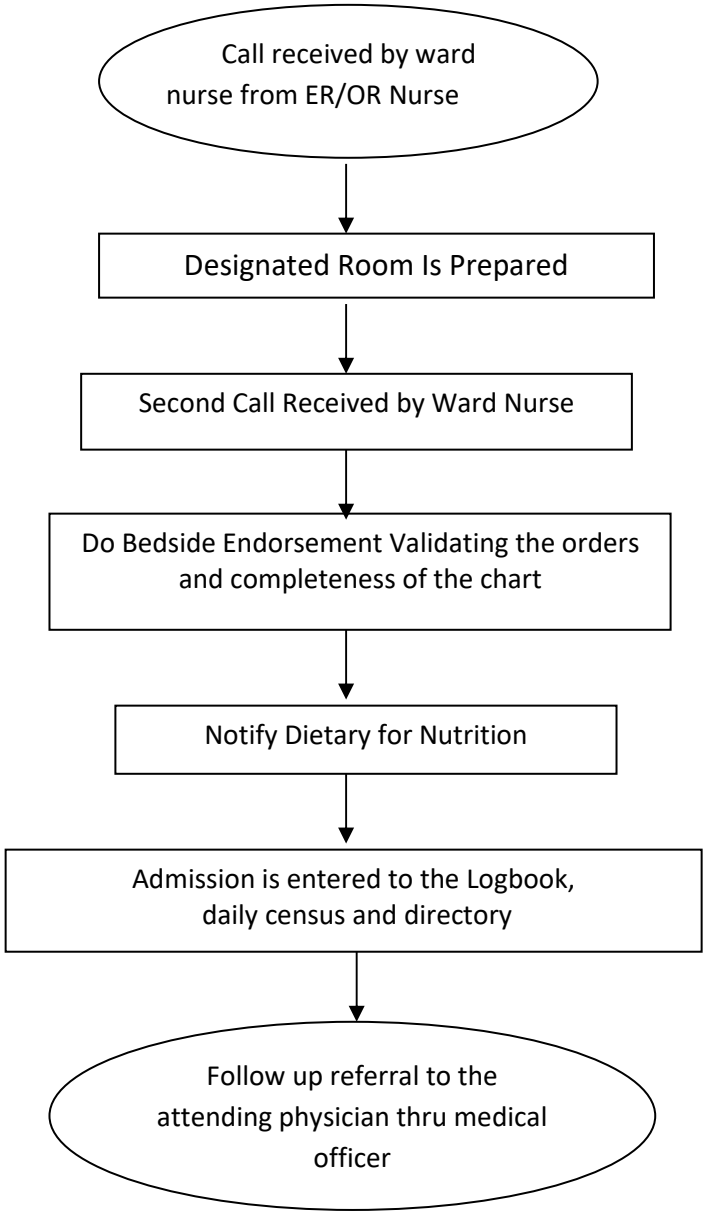
DATE OF IMPLEMENTATION:

This policy has been implemented since 2009, revised 2011 reviewed 2016. This policy will continue to be implemented as rewritten.

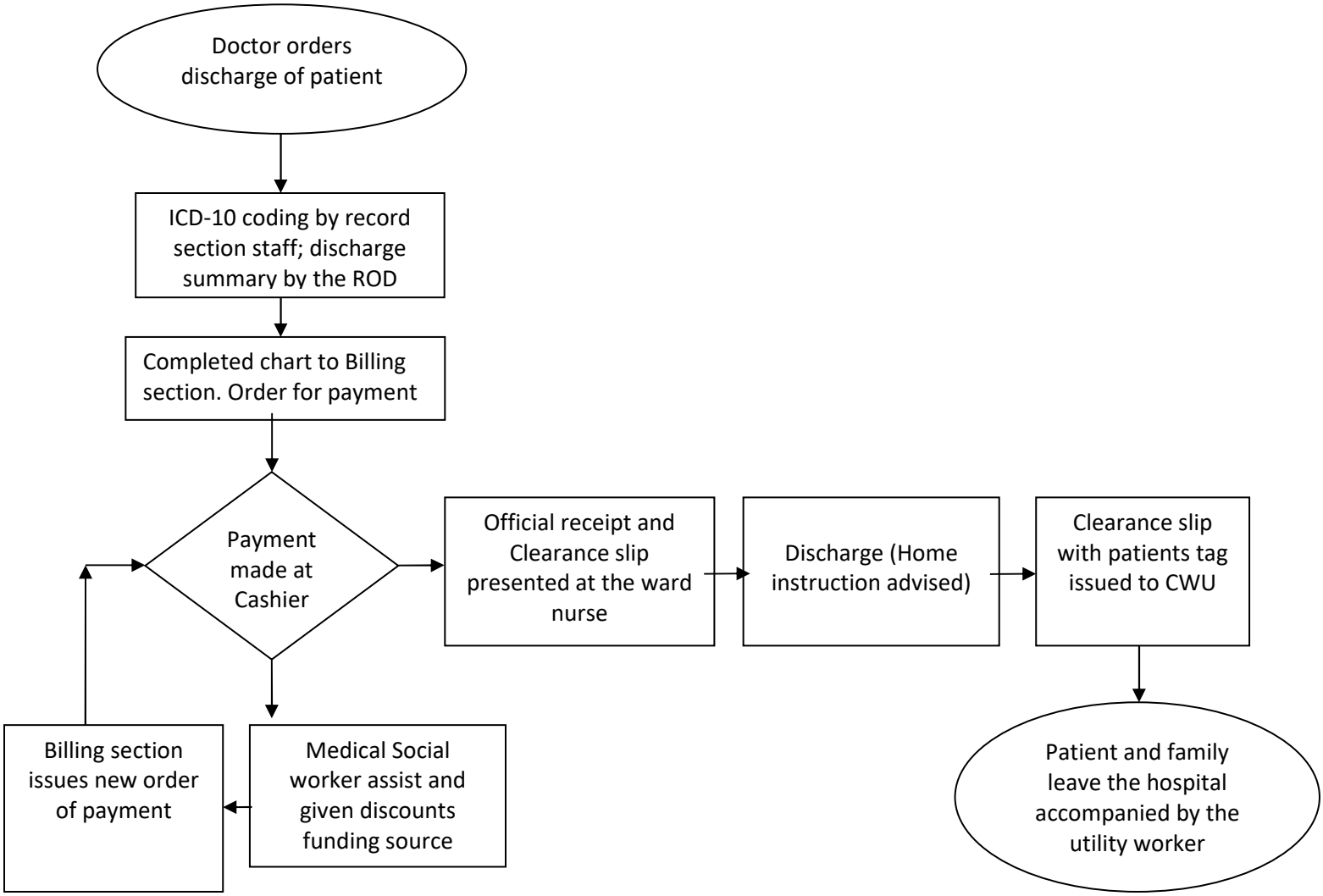
SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

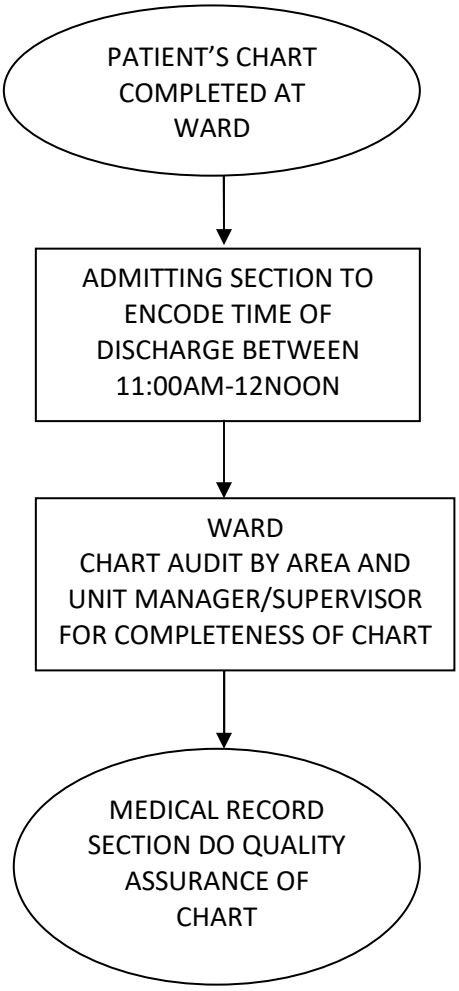
Admission Flowchart



Discharge Flowchart



FLOWCHART OF RECORD OF DISCHARGED PATIENT



Definition of terms:

Excellent- Possessing outstanding quality or superior merit; remarkably good

Laudable- Deserving praise, praiseworthy, commendable

Appraisal- The act of estimating or judging the nature and value of something or someone. An estimate or considered an opinion of the nature, quality, importance, etc.

Standard- A level of quality, achievement, etc., that is considered acceptable or desirable

ECG- is a test that checks for problems with the electrical activity of your heart. An EKG translates the heart's electrical activity into line tracings on paper. The spikes and dips in the line tracings are called waves. a medical device use to determine the activity of the heart.

CT SCAN -The abbreviated term for computed or computerized axial tomography. The test may involve injecting a radioactive contrast into the body. Computers are used to scan for radiation and create cross-sectional images of internal organs.

MRI- The abbreviated term for magnetic resonance imaging. MRI uses a large circular magnet and radio waves to generate signals from atoms in the body. These signals are used to construct images of internal structures.

Endoscopy- Examination of organs accessible to observation through an endoscope passed through the mouth.

Aseptic- Free from infection or septic material.

ELECTIVE- Surgery carried out at a time convenient to client and surgeon. The opposite of emergency surgery.

TRODAT- is a juxtaposition of the syllables TRO and DAT. "TRO" stands for Trolitul plastic previously used for stamp manufacture. "DAT" is the abbreviation for date stamp. It is a self-inking stamps with a built-in stamp pad

Cardex- is a form used by a nurse to record a patient's details in a manner that allows for easy retrieval of the information

Infirmary- health care institution providing patient treatment by specialized staff and equipment.

Pulot- An individual without permanent housing who may live on the streets; stay in a shelter, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.

Spill over- An instance of overflowing or spreading into another area.

Flowchart- A diagram of the sequence of movements or actions of people or things involved in a complex system or activity

Parturation- the action or process of giving birth to offspring

Abbreviations:

DTR- Daily Time Record
CP Clearance- Cardio-Pulmonary Clearance
QA- Quality Assurance
OD- Once a day
PE- Physical Examination
NA- Nursing Attendant
MGH- May Go Home
NGT- Naso-Gastric Tube
HAMA- Home Against Medical Advise
MD- Medical Director
CWU- Civilian Watcher's Unit
IVF- Intravenous Fluid
BT- Blood Transfusion
I & O- Intake and Output
HGB- Hemoglobin
HCT- Hematocrit
MOD- Medical Officer on Duty
CBC- Complete Blood Count
PPE- Personal Protective Equipment
UA- Urinalysis
CARED- Carried; Administered; Requested; Endorsed; Done

CHART ARRANGEMENT

Optional:

Hgt monitoring/ Weighing OD/ Abdominal girth OD

1. ADMISSION AND DISCHARGE RECORD
2. CONCURRENT PATIENT CHART AUDIT FORM
3. CONSENT FOR HOSPITAL CARE AND MANAGEMENT
4. MEDICATION SHEET OR TREATMENT SHEET
5. IVF SHEET
6. VITAL SIGNS/ NEURO VS MONITORING SHEET
7. DOCTOR'S ORDER
8. HISTORY AND PE
9. DOCTOR'S PROGRESS REPORT
10. NURSES NOTES
11. LABORATORY WORK UPS
12. PARTURITION RECORD (OB CASE)
13. OR RECORD (AUTHORIZATION FOR SURGICAL TREATMENT, ANESTHESIA RECORD AND TECHNIQUE OF OPERATION)
14. OTHER PERTINENT RECORDS –OPS CHART, PREVIOUS ADMISSION CHART AND OTHERS