POLICY ON ADMISSION AND DISCHARGES AT PEDIATRIC WARD

POLICY NO: NSO-011

DIVISION: NURSING SERVICE DIVISION

SECTION: PEDIATRIC WARD

POLICY REVIEWED DATE: **JULY12, 2016**

Reviewed by:		
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OBJECTIVES: This policy defines the standard flow of admissions and discharge in the pediatric ward

COVERAGE: This policy shall be adopted by all Nursing ward staff assigned to this area

VISION: WILL BE A PREMIER LEADER IN PROVIDING SPECIALTY HEALTH CARE FOR CHILDREN AS WELL- KNOWN BY OUR:

- Quality of care
- Service excellence
- Innovation
- Multidisciplinary approach
- Family focus
- Outstanding personnel

MISSION: Provide quality, compassionate and family - centered care to the pediatric client ranging from 28 days old to 18 years of age.

RESPONSIBILITIES:

I. It shall be the responsibility of the **MEDICAL NURSING STAFF** to abide with procedures incorporated into this policy

II. It shall be the responsibility **Head Nurse** (UNIT MANAGER)

a. Orient staff of this policy and to monitor the general activities in the unit
b. Maintain accurate implementation of total nursing care
c. Establish the trust of newly admitted patient and orient them to their surroundings
d. Develop anticipated solutions to problems regarding health needs that may arise
e. Supervises, assesses and evaluates the performance of the unit personnel, provides assistance when needed
f. Coordinates/participates in staff development program research and orientation courses

g. Assure strict implementation of hospital policies, rules and regulations through interpretation/orientation of nursing personnel

III. It shall be the responsibility **Assistant Head Nurse** to supervises over the work of the nursing staff, support and assume the responsibilities of the head nurse in the absence of the latter.

IV. It shall be the responsibility of the **Staff Nurse** to:

a. Accept and do bedside endorsement of any paediatric case from the Emergency room
b. Prepares and administers and record prescribed medications and report adverse reaction to medications or treatments.
c. Help patient to be comfortable and cooperative with examinations/procedures
d. Assist physicians in treating patients during examination, treatment and procedures
e. Provides education, information and support to the patient's family
f. Records all care information concisely ,accurately and completely in a timely manner in the appropriate format and on the appropriate forms
g. Carry out doctor's order legally with promptness
h. Ensure correct diet feeding
i. Evaluate and record the effectiveness of treatment and patient's comfort.
j. Maintain protective measures based on patient's safety
k. Document patient progress through careful record keeping, notifying doctors in the event of any changes in a patient's situation

V. It shall be the responsibility **Nursing Aide** to:

a. Prepare beds for admission.
b. Prepare and assist doctors in wound dressing.
c. Monitor, record, and report vital signs and any anticipated problems.
d. Collect and properly label specimen and deliver it with the corresponding request.
e. Follow proper procedure for lifting and moving patient
f. Observe patient's physical, mental and emotional conditions.
g. Help dress and groom patients. Check supplies and perform clerical task as needed.
h. Receives and endorse ward, articles, instruments and equipments. Reports to the senior nurse any losses/breakages for proper action
i. Monitor and charge oxygen consumption used by patient

VI**.** It shall be the responsibility of the **Ward Clerk** to:

a. Records all admitted and discharged patients
b. Check chart forms for completeness
c. Receive patients and watcher complaints
d. Coordinate activities of patient to different unit as need arises.

e. Assisting NA and UW in monitoring relevant duties as designated
f. Record and submit all discharged with final diagnosis to the record section.
g. Submit and coordinate with accounting section regarding bills and Physician's professional fee.

VII. It shall be the responsibility of the **Utility Worker** to:

a. Assist patient in lifting, turning, positioning, and dressings of patients
b. Check availability of oxygen for patient's use
c. Transport of patients from Emergency room
d. Accompanies patient for conduction and transfer to other hospitals as needed
e. Performs daily routine housekeeping activities in the unit. Participates with the housekeeping staff during general cleaning and fumigation of the area.
f. Ensure safety of environment through regular check-up of IV stands, stretcher and other equipments
g. Clean equipments after each use and maintains them clean during his tour of duty
h. Used vials shall be disposed in a proper container and forwarded to the pharmacy for final disposal every morning shift
i Ensures safety and security of the unit as well as all the items in the unit

PROCEDURE:

I. Routine Admission Procedures
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 the 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 the medical officer.

II. Discharge Procedures
1. Upon order of may go home (MGH) by attending physician/Resident Doctor
2. Patient record to be completed prior to submission for billing
3. Billing section issues order of payment to patient's relative: Re-billing of MGH patient's chart must be done for overstaying patient.
4. Clearance issued by cashier upon payment of hospital bill and/or professional fees.
5. Ward U.W. inspects bedside table and patient's bed for any uncollected wastes or personal belongings
6. If cleared with the nurse in charge, official receipt stamped and signed.
7. Clearance slip and home instruction is given in duplicate, one copy will be given to the patient and another copy retained in patient's chart.
8. Patient's tag inspected by security staff along with clearance slip.

III. Documentation

a. Chart should be arranged according to the required chart arrangement, with complete patient's data
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. Indicate if discontinued, shifted, completed, consumed or refused meds must be documented at the nurse's notes.
e. Record IVF infused, 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.
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 lab, 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. Refusal to procedure and management (HAMA) must be reported immediately to the Attending Physician thru the MOD. A written waiver must be secured.
k. Admission, and discharges must be recorded on the logbook indicate the age, date, time, case of the patient for Phil health requirement and purposes.
l. Prepare for 24 hours floor census and submit to the supervisor on duty 12:00 midnight
m . Follow color coded ink charting, Am-blue, PM-black and Night-red
n. Carry out doctors order promptly; check each line; write a blocking line indicating it was carried out, countersign, indicate date and time it was carried out; use TRODAT.

IV. Endorsement

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

2. 15minutes pre-conference endorsement at the nurse's station, prior to ward rounds.

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. No watcher No admission unless "pulot" patients; for private patients one watcher is allowed; serious patient – 2 watchers

6. No bed reservation at Ward, it should be channelled to Admitting Section to avoid breaking the "first come first serve basis" rule at ER with regards to admission. Furthermore, ICU reservation will also not be allowed since ER is our priority unless the case at ER warrants ICU admission.

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.