CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: NURSING DEPARTMENT DOCUMENT NO: SOP/CRH/COP/Nursing/05 REVISION NO: 00 REVISION DATE: 00 VERSION NO. 01 ISSUE/EFFECTIVE DATE: 10th Mar. 2017 PAGE NO: Page 1 to 32 DOCUMENT CONTROL STATUS: MASTER COPY

Standard Operating Procedure

NURSING DEPARTMENT

CONTROLLED

MASTER

Prepared By	Reviewed By	Approved By	DP

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: NURSING SOP DOCUMENT NO: SOP/CRH/COP/Nursing/05 REVISION NO: 00 REVISION DATE: 00 VERSION NO. 01 ISSUE/EFFECTIVE DATE: 10th Mar. 2017 PAGE NO: 1 to 32 DOCUMENT CONTROL STATUS: MASTER COPY

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: **NURSING SOP**
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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Admission of a Patient to CRH
	DOCUMENT NO: DP : 01 (SOP/CRH/COP/Nursing/05)
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1. Abbreviations and Definition

1.1 **Abbreviation:**

IP: In Patient
OP: Out Patient
HIS: Hospital Information System

1.2 **Definition:**

It is the entry and acceptance of a patient to stay in the hospital for observation, investigation, treatment and care.

2. Expected Outcome:

To ensure patients are admitted in the facility appropriately as per the need with safety.

3. Objectives:

3.1 To receive the patient in the respective area according to his condition.
3.2 To make the patient feel welcome, comfortable and at ease.
3.3 To provide comfort and safety to the patient.
3.4 To do the assessment of the patient following nursing process
3.5 To provide immediate care and treatment to the patient: need based

4. Scope:

To admit a patient into a hospital ward for therapeutic or diagnostic purpose such as nursing care and medical or surgical treatment.

5. Process:

Sl no:	PROCESS	RESPONSIBILITY
5.1	Advice for admission	Doctor

5.2	Enquires if the patient is covered under any Insurance scheme	Nurse
5.3	Fills up the admission form	Doctor
5.4	Patient party is directed to the admission department for admission	Doctor / Nurse
5.5	File taken to the admission department for admission	Patient Party
5.6	Admission formalities done	Billing Personnel
5.7	Receives the patient with the file	Nurse
5.8	Checks the file and necessary documents i.e IP & OP records, patient identification tags, consent for treatment, visitor pass & doctor's orders.	Nurse Nurse
5.9	- Receives the patient in the bed - Introduces self and other staff and - Orients the patient and patient party to the ward	Nurse
5.10	Documents admission details in the HIS & manual documentation done	Nurse

6. Responsibilities: Doctors, Nurses, Billing personnel

7. Records:

- Admission form
- Doctors Order
- Nurses Record
- Admission Log book
- HIS

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Discharge of Patient
	DOCUMENT NO: DP : 02 (SOP/CRH/COP/Nursing/05)
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1. Abbreviations and Definition

1.1 Abbreviation:

OPD: Out Patient Department
HOD: Head of the Department
HIS: Hospital Information System

1.2 Definition:

Discharge occurs when a patient leaves the hospital after a period of treatment to his or her home; it is normally done at the discretion of the medical team when patient is fit or his condition is stable or upon patient's own request.

2. Expected Outcome:

To facilitate smooth transition of the patient from hospital to home for continuity of care and treatment and follow up.

3. Objectives:

3.1 To give prior information of the intended discharge to patient and his relatives.
3.2 To reduce the length of hospital stay
3.3 To improve coordination of services between hospital and home.

4 Scope:

To provide good continuity of care to ensure good patient outcomes, hence effective handover to primary care giver

5 Process:

Sl no:	Process	Responsibility
5.1	Advice for discharge & documentation of the same in the patients file	Doctor
5.2	Informs the patient and the patient party regarding discharge	Doctor & Nurse
5.3	Prepares the discharge summary	Doctor

5.4	File sent to OPD through housekeeping staff for obtaining signature of the HOD	Doctor/Nurse
5.5	Fills up the pending slip and the pink slip for the required details	Nurse
5.6	Pending slip along with the left over drugs and follow up drugs sent through patient party/ward attendant to the pharmacy	Nurse
5.7	Arranges the documents in the file according to the checklist provided	Nurse
5.8	File sent to the billing section through housekeeping staff after obtaining pharmacy clearance	Nurse
5.9	The patient is marked for discharge in HIS	Nurse
5.10	Discharge formalities carried out	Billing personnel
5.11	Receives the clearance form with the bill and documents in the billing register	Nurse
5.12	Gives the discharge advice on medication, diet and follow up to the patient / patient party	Nurse
5.13	Patient is transferred to the wheel chair and escorted to the lobby 3rd floor	Housekeeping staff
5.14	Discharges the patient from HIS to ensure vacancy of the bed	Nurse

6 Responsibilities: Doctors, Nurses, MRD/Billing personnel

7 Record:

- Pending Slip
- Discharge Book
- Discharge Summary
- Nurses Record
- HIS

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Transfer of a patient
	DOCUMENT NO: DP : 03 (SOP/CRH/COP/Nursing/as
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1. Abbreviations and Definition

1.1 Abbreviations

ICU: Intensive Care Unit
IP: In Patient
OP: Out Patient
HIS: Hospital Information System

1.2 Definition:

It is the physical relocation of patients in the ward/unit of the hospital with change in the patient's condition with safety and effective communication.

2. Expected Outcome

To ensure that patient is placed put up in the area of the hospital catering to the condition of the patient

3. Objectives:

3.1 To ensure timely preparation for continuity of patient care and treatment
3.2 To shift the patient to an appropriate unit that caters to the need of the patient

4. Scope :

To ensure the safe, appropriate and timely transfer of patients between departments

5. Process

Sl no:	Transfer In Process	Responsibility
5.1	Advice for transfer of patient	Doctor
5.2	Receives the information from the concerned area	Nurse
5.3	Prepares the unit according to the need of the patient	Nurse
5.4	Receives the patient with the IP & OP records in respective bed/unit prepared	Nurse
5.5	Carries out bedside handoff	Receiving & transferring Nurse

5.6	Documents patient details in the HIS & manual documentation carried out	Nurse

Sl no:	Transfer Out Process	Responsibility
5.7	Advice for transfer of the patient	Doctor
5.8	Informs the concerned area regarding transfer of the patient	Nurse
5.9	Informs the patient and the patient party regarding the need for transfer of the patient	Doctor/Nurse
5.10	Prepares the patient and the documents (IP & OP records)	Nurse
5.11	In case the patient is transferred to ICU/Pvt wards the admission slip is sent to the billing section for required billing formalities through patient party/ward attendant	Nurse
5.12	Gives reminder information to the concerned area for transfer of the patient	Nurse
5.13	- Patient is transferred to the wheel chair or trolley (need based) - Attaches the monitoring equipments (need based) - Lines are secured if any - Patient belongings are handed over to the patient party	Nurse
5.14	Patient is safely transferred to the respective area accompanied by housekeeping staff & patient party	Nurse
5.15	Documents the transfer details in HIS and manual documentation is done	Nurse

6. **Responsibilities: Doctors, Nurses, Housekeeping staff**

7. **Records:**

- Doctors Order Sheet
- Nurses Record
- Transfer Record Sheet
- Transfer Book

			DP: 03
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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Safe Transfer of Patients
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1. Abbreviations and Definition

1.1 Abbreviation

1.2 Definition: It's a mechanism to facilitate safe transfer of the patient from one unit to the other.

2. Expected Outcome:

To ensure that safety is not compromised

3. **Objectives:**

3.1 To select appropriate method of transfer

3.2 To use an assistant when in doubt

3.3 To ensure that transfer equipments are always stabilized (use wheel locks)

4. Scope

To transfer the patient safely to an appropriate area in the facility.

5. Process:

Sl no:	Process	Responsibility
	1. Advice for transfer	Doctor
5.1	2. Checks the doctor's advice for transfer of patients 3. Informs the patient and the patient party 4. Inform to the ward sister where the patient needs to be transferred	Nurse
5.2	Patient is assessed for function capabilities before transfer by some examinations: • Strength • Range of motion • Pain • Cognitive abilities • Movement dysfunctions	Doctor / Nurse
5.3	5. Checks the file for complete recording of vital signs, nursing care and treatment given.	Nurse

5.4	6. Collects patients X-ray, due reports, medicine and other belongings.	Nurse
5.5	7. Makes arrangements to settle the due bills if going to another hospital as per the discharge process	Nurse
5.6	Prepares the patient/ self and environment for transfer • Consideration of direction of transfer from left to right or right to left. • Moving patient to their stronger side is the easiest. • Personnel performing transfer should avoid wearing jewellery that can entangle or scratch patients during patient care. • All equipment should be ready before transfer begin. • Clear and define instruction should be verbalized clearly to patient and assistance. • Patients feel comfortable knowing what is about to take place • Assess the method for transport, inform the receiving nurse.	Doctor / Nurse
5.7	8. Completes all documentation	Nurse
5.8	9. Maintains patients physical wellbeing during transport to new nursing unit/facility	Doctor/Nurse
5.9	10. Assist in transferring sick patient to wheel chair/ stretcher and accompany patient to new area	Nurse
5.10	11. Assist patient's arrival to the new unit. 12. Transport patient to the new unit and assist in transfer to the bed.	
5.11	13. Hand over to the receiving nurse. Patient handoff carried out, Signs out	Transferring Nurse
5.12	14. Receives the patient, Signs in	Receiving Nurse
5.13	15. Inform to the concern person/ department regarding transfer of the patient.	Nurse

6. **Responsibilities: Doctors, Nurses and Housekeeping Staff**

7. **Records:**
   - Nurses Record

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Specimen Collection
	DOCUMENT NO: DP : 05 (SOP/CRH/COP/NURSING/05)
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1. Abbreviations and Definition

1.1 Abbreviation

1.2 Definition:

It is the process of collection of sample of blood or body fluid or tissue etc for the purpose of diagnosis and treatment of a disease.

2. Expected Outcome:

To ensure appropriate collection of samples with precise sample identification

3. Objectives:

3.1 To ensure all selected supplies are suitable for collection
3.2 To ensure timely transfer of specimen to the lab
3.3 To give information to the client on the procedure

4. Scope:

Proper specimen procurement and handling is an integral part of obtaining a valid and timely laboratory test result patient preparation, collection of specimen in proper tubes and containers, correctly labelled according to the request and promptly transportation to the laboratory are important aspects of specimen collection

5. Process:

Sl no:	Activity/Process	Responsibility
5.1	Advice for specimen collection	Doctor
5.2	Explanation of the need for specimen collection to the patient/patient party	Doctor/ Nurse
5.3	Fills up the requisition form as per the nature of specimen & investigation required	Doctor

5.4	Requisition form is sent through the patient party to the billing section for billing	Nurse
5.5	Receives the requisition form and ensures billing is done	Nurse
5.6	Preparation of the articles and the patient for the prescribed specimen collection	Nurse
5.7	Specimen is collected following appropriate specimen collection technique	Nurse
5.8	Documents the procedure of specimen collection in the nurses record	Nurse
5.9	Documents the identification details of the patient, nature of specimen and date and time of dispatch with signature in local delivery book.	Nurse
5.10	Sends the specimen through the housekeeping staff in an appropriate container as early as possible or within 30 mins of specimen collection	Nurse
5.11	Receives the specimen with requisition & documents date and time of receipt with signature	Lab technician/ Lab Personnel
5.12	Brings back the local delivery book to the ward and gets it checked by the nursing staff	Housekeeping Staff
5.13	Checks the local delivery book for completion of necessary documentation	Nurse

6. **Responsibilities: Doctors, Nurses, Lab personnel, Housekeeping Staff**

7. **Records:**
   - Doctors Order Sheet
   - Nurses Record
   - Investigation Requisition Form
   - Local Delivery Book

			DP: 05
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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Specimen Collection in OT
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1. Abbreviations and Definition

1.1Abbreviation

- OT: Operation Theatre
- CSF: Cerebro Spinal Fluid

1.2Definition:

It is the process of collection of sample of blood or body fluid or tissue etc for the purpose of diagnosis and treatment of a disease.

2. Expected Outcome:

To ensure appropriate collection of samples with precise sample identification and to obtain a valid and timely laboratory test result.

3. Objectives:

3.1 To ensuring appropriate collection of samples with precise sample identification
3.2 To ensure all selected supplies are suitable for collection
3.3 To ensure timely transfer of specimen to the lab
3.4 To give information to the patient/ patient party on the procedure

4. Scope:

Patient preparation, collection of specimen in proper tubes and containers, correctly labelled according to the request and promptly transportation to the laboratory are important aspects of specimen collection

5. Process:

Sl no:	Process	Responsibility
5.1	Derives the specimen in the form of tissues, organs, bones, disc, pus, CSF	Doctor
5.2	Receives the specimen and keeps aside	Scrub Nurse

5.3	Transfers the specimen in a sterile container / formalin solution or NS as preferred	Scrub Nurse /Circulating Nurse
5,4	Labels the specimen with the patients details and nature of the specimen	Circulating Nurse
5.5	Fills up the requisition form as per the requirement ie Histopathology/Culture	Doctor
5.6	Documents the procedure of specimen collection in the nurses record	Circulating Nurse
5.7	Documents the identification details of the patient, nature of specimen and date and time of dispatch with signature in local delivery book.	Circulating Nurse
5.8	Explanation of the need for specimen collection and examination to the patient party	Doctor
5.9	Sends the requisition form to the billing section for billing through the patient party	Circulating Nurse
5.10	Receives the requisition form and adds the service added in the register	Circulating Nurse
5.11	Documents the identification details of the patient, nature of specimen and date and time of dispatch with signature in local delivery book.	Circulating Nurse
5.12	Sends the specimen through the OT attender in an appropriate container as early as possible or within 30 mins of specimen collection	Circulating Nurse
5.13	Receives the specimen with requisition & documents date and time of receipt with signature	Lab technician/ Lab Personnel
5.14	Brings back the local delivery book to the ward and gets it checked by the nursing staff	OT Attender
5.15	Checks the local delivery book for completion of necessary documentation	Nurse

6. Responsibilities: Surgeons, OT Nurses, Lab personnel, Housekeeping Staff

7. Records:

- Doctors Order Sheet
- Nurses Record
- Investigation Requisition Form
- Local Delivery Book

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Patient Handoff
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1. **Abbreviations and Definition**
   1.1 Abbreviation

   1.2 Definition:
   It is the process of transfer of information between the change of shift, communication between care providers about patient care, records, and information to assist in communication between care providers about patient care

2. **Expected Outcome**
   To support the transition of critical information and continuity of care and treatment

3. **Objectives:**
   3.1 To ensure transfer of essential information and the responsibility for care of the patient from one health care provider to another
   3.2 To seek opportunity to clear the doubts and take corrective actions

4. **Scope:**
   To effectively transfer the information and responsibility of care for enhancing continuity of care and treatment.

5. **Process:**
   Patient handoff is carried out during change of shift by the outgoing nurse to the upcoming nurse following the handoff format ISBAR

Patient handoff format

SITUATION	
Diagnosis:	Illness Severity:
High Risk/ Present Problem: HIV/HBsAg/HCV/MDR	Allergies:
MLC:	
Restraints Used	

BACKGROUND Chief Complaints: Past Medical/Surgical History: Fall Assessment: Braden Score: Restraints Precautions:
ASSESSMENT Vital Signs: Temp: Pulse: Resp: BP: SPO2: Pain: GCS: Diet: GRBS: IV Line Patency and Dressing: New Sign/Symptoms: Action Taken: Lab / Radiology Reports: Intake: Oral RT: IVF: Volume: Drip Rate IV Drugs: Dose: Rate: Output: Urine: Stool: Drains: Ostomy:
RECOMMENDATIONS Plan/ Goals: Referrals/Consultations: Lab / Radiology Investigations: Procedures Treatment: Any Other:
Hand over Given by:_____ Received by:_____

6. **Responsibilities: Nurses**

7. **Records:**

   - Handoff Book

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Medication Administration Safety practice
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1. Abbreviations and Definitions

1.1Abbreviations:

1.2Definitions:

Administration of medication refers to dispensing medicine to a patient for remedial and or diagnostic purposes.

2. Expected Outcome:

To achieve therapeutic effectiveness with safety

3.Objectives:

3.1To ensure safe administration of medication
3.2To practice preventive aspects of medication error

4. Scope:

Drugs are the primary means of therapy but the drugs have potential for causing problems if not administered properly. In order to prevent errors before, the establishment of protective measures in pivotal.

5. Procedure

Sl.no:	Process	Responsibility
5.1	Writes the medication order in the Doctors order sheet following the essential components of a legal medication order and fills the prescription slip	Doctor

- Read the physicians prescription
- Call the patient to state his /her name

Right Drug

- Identify the drug from the doctor's order. Read the medication order carefully clarify with the doctor if in doubt.
- Be knowledgeable about the drug's actions, indication, and contraindication. Be sure of the trade names of the drug. Check the spelling of the medication carefully.

TRIPLE CHECK

- Avoid distractions and interruption while preparing and administering drugs
- Avoid distractions and interruptions while preparing and administering drugs
- Avoid accepting verbal orders. In an emergency get written orders as early as possible.-
- Be extremely vigilant about known high alert medications
- Be alert to look-a-like, sound-a-like medications
- Do not accept drug name abbreviations

Look at the medication. If there is anything different about the size, shape or color of the medication, call the pharmacist before you give it.

Inform the concerned and the management

Right Dose

- Check the dose read the container label, calculate the dose & check with doctors/Colleagues/seniors if necessary
- TRIPLE CHECK
- Do not accept illegible hand writing. Do not accept leading or trailing zeroes.
- Have two nurses double-check high alert medications

Accurate dosages calculations-

Compare the dose on the prescription label, the medication treatment card. If they do not match, or if there is any doubt that you are giving the right dose inform the concerned doctor.

Right Route

- Make sure the doctors order is clear & clear & only give the medications by the route designed.
- Perform medication administration with proper technique
- Stay with the patient until he has swallowed the medicine(oral medication)
- Know the abbreviations for the different routes.
- If a change in route is needed, request new order from physician
- Do not accept incorrect abbreviations

	Right Time - Check prescription. Order should include frequency of administration - Check the time frequency & give the medication at the prescribed time. - Compare the time on the medication order and the treatment card. If they do not match enquire and confirm. - Drugs should be given within 20 minutes of the prescribed time initial dose - Medication given 30 minutes before or 30 minutes after time ordered in acceptable.	
5.9	**Right Evaluation** - Observe the local or systemic effect of the drug - Always carefully monitor client reactions to medication and ensure that clients are appropriately educated as to the action, side effects, and contraindications of all medications they are receiving. - Clients receiving iv therapy or blood transfusions require constant monitoring for complications. - Observe side effect, toxicity and any other complication	Nurse
5.10	**Right Documentation** - Document that a drug has been given after the client has received the drug. Never ever document before. - Double check your documentation as soon as you have finished giving medications and again at the end of the shift. Always record: - Reason why medicine was omitted/refused - Date, time & your initials or signature , title - Medication, route (Site) and actual time given. Client's response to the medication	Nurse

6. **Responsibilities: Doctors, Nurse**

7. Records:

- Doctors Order Sheet
- Treatment Card
- Nurses Record

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Crash Cart Arrangement
	DOCUMENT NO: DP : 09 (SOP/CRH/COP/nursing/05)
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1. Abbreviations and Definitions

1.1 Abbreviations

1.2Definition:

A Crash Cart or a Crash Trolley is a set of trays/ drawers/ shelves on wheels used in hospitals for transporting and dispensing of emergency medications and equipment at the site of medical / surgical emergency for life support protocols

2. Expected Outcome:

To manage crash effectively and decrease the cost

3. Objectives:

3.1 To ensure availability of complete set of supplies in the crash cart

3.2 To ensure daily check of supplies in the crash cart

4. Scope:

To maintain adequate count of supplies and readily available to dispense in case of life saving protocol

5. Procedure:

- The contents and arrangement of Crash Cart are as follows

Top Shelf:

Medication Racks: ACLS Drugs, RSI Drugs

Table Top: Defibrillator

Drawers

DRAWER NO :	ITEMS
1st Drawer :	Medications - ACLS Drugs - RSI Drugs - Other
2nd Drawer	**IV start** - IV cannula (Peripheral, Central) - Syringes - Three ways Blood Sampling Equipment's - Vials - vacutainers
3rd Drawer	IV Fluids and IV Tubing - Various IV Fluids - IV Set - PMO Line
4th Drawer	Airway Management Supplies - AMBU Bag - Laryngoscope - ET Tube - Airway
5th Drawer	Procedure Supplies: - Gloves, - Adhesives - Xylocaine Jelly - Glucometer with Glucostrips - ABG Strips, ECG Strips - Ryle's tube - Sutures - roller Bandages - Sterile Packs
6th Drawer	Pediatric Supplies

Side Racks: Suction Catheters, Younker Suction, Feeding Tubes

MANAGEMENTS:

Daily check

- ✓ Maintain adequate account of supplies
- ✓ Check for expiry dates
- ✓ Always have complete set of supplies in the crash trolley

Note: In case of too many medications 1st & 2nd drawers can be used for storing them in the sequence of arrangement can be followed. Pediatric supplies may not be kept separately.

6. **Responsibilities: Nurses**

7. **Record:**

- Crash Cart Checking book
- Drug Book

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Management of Blood Spill
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1. Abbreviations and Definitions

1.1.Abbreviations:

- PPE: Personal Protective Equipment

1.2.Definitions:

Prompt removal of spots and Spills of blood and body substance followed by cleaning and disinfection of the area

2. Expected Outcome:

To reduce contamination and cross infection

3. Objectives:

3.1 To clear the spill followed by cleaning and disinfection
3.2 To prevent occupational health hazard

3. Scope:

To practice sound infection control practice and meet occupational health and safety requirements.

5. Procedure:

Sl. no	Process	Responsibility
5.1	- Isolate the area - Call for Spill Kit	Doctor/Nurse/Lab Personnel
5.2	- Wear appropriate PPE	
5.3	- Pick up the broken glass pieces using a pair of tongs/forceps(only in case of spill due to breakage of the samples bottle)	

	- Immediately cover the area with tissue paper	Nurse/ Lab Personnel/ Housekeeping Staff
5.4	- Saturate the area with 1% Sodium Hypochlorite for 15- 30 mins	
5.5	- Clear the spill	
5.6	- Wash the scrapper/pan & tongs/forceps - Perform Hand hygiene	
5.7	Clean with water and floor cleaning agent	Housekeeping Staff

6. Responsibilities: Doctors, Nurses, Lab Personnel and Housekeeping Staff

7. Records:

- Incident Report

Prepared by:	**Reviewed by:**	**Approved by:**	**DP : 10**

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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Consent Witness by a Nurse
	DOCUMENT NO: DP : 11 (SOP/CRH/COP/nursing/05)
	REVISION NO: 00
	REVISION DATE: 00
	VERSION NO. 01
	ISSUE/EFFECTIVE DATE: 10th Mar. 2017
	PAGE NO: 1 -2
	DOCUMENT CONTROL STATUS: MASTER COPY

1. Abbreviations and Definition

1.1 Abbreviation

1.2 Definition:

Is a process in which the physician / procedure list provides adequate information for the patient or patient's legal representative to make an informed decision on the proposed treatment or procedure.

2. Expected Outcome:

Patients and family members will be informed about the procedures and treatment and thus increase compliance.

3. Objectives:

- To inform patient regarding treatment or procedure by treating physician
- To provide information on risk and benefits information on treatment/procedure
- To verify with the patient and /or by specific documentation of informed consent has been obtained by physician/procedure list prior to the procedure or treatment.

4. Scope:

All patients have a right to make decisions regarding their healthcare and to be provided sufficient information in order to provide sufficient information in order to make informed decisions.

5. Procedure:/procedure

Sl no:	ATIVITY/PROCESS	RESPONSIBILITY
5.1	Verifies that: - Consent has been obtained by the treating physician/or anaesthesiologist before administers anaesthesia and /or performs the procedure.	Nurse

	- A witness was present during the time that the patient received the information constituting an informed consent: and when patient signed the informed consent.	
5.2	Check for validity of the informed consent against the criteria of consent form	Physician/ anesthealogist
5.3	Check the consent form and verify with the patient prior to operation /procedure.	Doctor
5.4	Document the procedure in doctor order/ nurses records.	Doctor / Nurse
5.5	Sign in consent form by the patient and witnessed	Doctor / Nurse/ patient

6. Responsibilities: Treating physician, Nurses (witnessed)

7. Records:

- Consent Form
- Doctors Order Sheet
- Nurses Record

***Check the patient competence for capability of understanding the essential nature of their condition along with the treatment proposed, its intended benefits, risks and possible side effect**

			DP: 11
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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Patient and Family Teaching
	DOCUMENT NO: DP : 12 (SOP/CRH/COP/nursing/0
	REVISION NO: 00
	REVISION DATE: 00
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1. Abbreviations and Definition

1.1 Abbreviation

1.2 Definition:

Patient/family education is an individual systematic, structured process to assess and impart knowledge. It is to develop skills in order to effect changes in behaviour.

2. Expected Outcome:

Patients will receive appropriate information regarding health care and better understand their needs and participate in his/her own health care activities.

3. Objectives:

3.1 To assess patient and family needs for information

3.2 Identifies plans and coordinates the patient/family teaching interventions.

3.3 Evaluates the learners response and documenting/ communicating the outcomes and needs for follow-up –teaching.

4. Scope:

Patient education is an interdisciplinary and collaborative process designed to meet the educational needs of the individual patient/ family throughout the continuum of care.

5. Process

Sl no:	PROCESS	RESPONSIBILITY
5.1	Assessment/ Re-assessment of Patient/ Family Learning needs	Doctor/Nurse
5.2	Patient /Family education planning	Doctor/Nurse
5.3	Implementation of patient/family education plan.	Doctor/Nurse

5.4	Discharge planning	Doctor/Nurse
5.5	Evaluation of outcome	Doctor/Nurse
5.6	Documentation of patient / Family education with the signature of Doctor/nurse /patient/family	Doctor/Nurse

6. Responsibilities: Doctors, Nurses

7. Records:

- Nurses record

- Discharge summary

***Area of teaching is need based**

			DP: 12
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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: Reception of a Patient in Emergency
	DOCUMENT NO: DP : 13(SOP/CRH/COP/nursing/05
	REVISION NO: 00
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1. Abbreviations and Definition

1.1 Abbreviation

- ED: emergency Department

1.2 Definition:

It is the process of receiving the patient in the facility upon arrival to the Emergency Department.

2. Expected Outcome:

To improve the emergency care and to prioritize cases in terms of clinical urgency.

3. Objectives:

3.1. To receive the patient assess the condition of the patient
3.2. To evaluate the health needs of the patient, prioritize the need
3.3. To effective manage the patient's condition

4. Scope:

To determine the order and priority of emergency treatment, the order and priority of emergency transport, or the transport destination for the patient.

5. Process:

Sl No:	Process	Responsibility
5.1	Ensures availability of wheelchairs and stretcher trolleys at the Emergency room (ER) main door.	Nurse
5.2	Receives the patient on arrival	Nurse/ Doctor
5.3	Performs Initial Assessment using Nursing Initial Assessment Form	Nurse
5.4	Examines the patient	Doctor
5.5	Advices for the required treatment	Doctor
5.6	Intervenes on the patient's condition	Nurse

5.7	Directs the patient to registration section for registration	Doctor/ Nurse
5.8	Receives the patients file from the patient party after the registration formality is completed.	Nurse / Doctor
5.9	Documents the following details like Date, Name, Hospital Number, chief complaints, department referred to, time in, time out, and outcome.	Nurse

6. Responsibilities: Doctors, Nurse.

7. Records:

- Outpatient register

			DP: 13
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CRH SIKKIM MANIPAL UNIVERSITY CENTRAL REFERRAL HOSPITAL - SMIMS **Documented Procedure**	TITLE: **Triage**
	DOCUMENT NO: DP : 14(SOP/CRH/COP/nursing/0
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	PAGE NO: 1 -2
	DOCUMENT CONTROL STATUS: MASTER COPY

1.Abbreviations and Definition

1.1 Abbreviation

- ED: Emergency Department
- ECG: Electro Cardiography
- MRI: Magnetic Resonance Imaging
- CT: Computed Tomography
- IV: Intravenous
- IM: Intramuscular

1.2 **Definition:**

It is the process of determining the priority of patients' treatments based on the severity of their condition.

2 Expected Outcome

Determining the order and priority of emergency treatment, the order and priority of emergency transport, or the transport destination for the patient.

3 Objectives:

3.1 Rapidly identify patients with urgent, life-threatening conditions
3.2 Assess/determine severity and acuity of the presenting problem
3.3 Direct patients to appropriate treatment areas
3.4 Re-evaluate patients awaiting treatment

4 Scope:

To determine severity of illness or injury for each patient who enters the Emergency Department.

5 Process:

Sl no:	Process	Responsibility
5.1	Assess and determine the severity or acuity of the presenting problem with the following • Chief complaint. • Brief triage history Injury or illness (signs & symptoms) • General appearance. • Vital signs. • Brief physical appraisal at triage.	ER Doctor and Nurse
5.2	Processes the patient into a triage level following the colour coded zone system • **Red Zone** - (immediate) are used to label those who cannot survive without immediate treatment but who have a chance of survival. • **Yellow Zone** - (observation) for those who require observation (and possible later re-triage). Their condition is stable for the moment and, they are not in immediate danger of death. These victims will still need hospital care and would be treated immediately under normal circumstances. • **Green zone** - (wait) are reserved for the "walking wounded" who will need medical care at some point, after more critical injuries have been treated.	ER Doctor
5.3	Determines and directs the patient to appropriate treatment areas.	ER Doctor
5.4	Receives the patient in the appropriate zone	ER Nurse
5.5	Effectively and efficiently assigns appropriate human health resources like: Labs, ECG-X-rays C-T MRI, IV Fluids /hydration , IV /IM Medication, Specialty consult , Simple procedure, Complex procedure	ER Doctor and Nurse

6.Responsibilities: ED Doctor and Nurses

7.Record:

- Doctors Order Sheet
- Nurses Record.

			DP: 14
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