HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (Ward)		
Document:	Departmental Policy and Procedure		
Title:	Admission of Patient in Gynecology Ward		
Applies To:	All Obstetrics and Gynecology Staff		
Preparation Date:	January 08, 2025	**Index No:**	L&D-DPP-041
Approval Date:	January 22, 2025	**Version :**	2
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Review Date:	February 22, 2028	**No. of Pages:**	10

1. PURPOSE:

1.1 Establish a system and set responsibilities for Gynecology patient's admission according to patient's requirement and best utilization of available resources.

2. DEFINITIONS:

2.1 **Emergency Admission** – this category of patient includes those who have serious medical problems and who may be at risk of death or serious injury to their health if not admitted immediately.

2.2 **Urgent Admission** – this category includes patients with serious medical problem who may be at risk of substantial injury to their health if not admitted within 24 hours.

2.3 **Routine Admission** – includes patient with no serious medical problem who are not at risk of substantial injury to their health if not admitted within 24 hours.

3. POLICY:

3.1 Patient are admitted to Gynecological wards through the proper channels like emergency room, obstetric outpatient department, labor ward or transfer from other inpatient wards and intensive care unit), by authorized physician only.

3.2 Physician authorized for admitting patients to Gynecological ward.

3.2.1 Obstetrics and genecology physician on duty in the emergency room and Labor ward

3.2.1 Obstetrics and gynaecology physician at outpatient department, or (physician after approval by consultants or senior physician).

3.3 Timing of admission depends :

3.3.1 Low risk Factors: admission to the ward on the same day or one day before according to the condition of the patient and the need for evaluation and preparation for OR sanctioned by the physician.

3.3.2 High Risk Factor: Admission for more days before surgery may be appropriate; such admission arrangement should always be sanctioned by the physician.

3.3.3 Day cases to be admitted on the same day of procedure provided all needed investigations are ready in her file.

4. PROCEDURE:

4.1 Admission:

4.1.1 In order to ensure that the staff and bed area are ready for the admission:

4.1.1.1 For patients admitted from the Outpatient Department, the admission office should inform the nurse in-charge in the ward for admission.

4.1.1.2 For Patient need admission from emergency room and labor ward, the nurse in-charge should arrange with the nurse in-charge in the wards.

4.1.1.3 For Patients need admission from other inpatient wards (surgery, medicine intensive care unit, etc.), physician should arrange with the nurse in-charge in the ward.

4.1.2 Consent for admission should be obtained from the patient or responsible male member of the family. The consent should be witnesses by the authorized person of the public relation (PRO).

4.1.3 The admission department will be informed of the intended admission and destination point in Order that the medical records can be opened or old file retrieved.

4.1.4 The patient's admission and destination is logged into the computer record.

4.1.5 The patient is escorted to the ward by a member of the nursing staff. Accompanying family or friends should be kept to the minimum i.e. the direct relative of main care only.

4.1.6 The admitting physician would document the following in the admission sheet

- 4.1.6.1 Patient's demographic data.
- 4.1.6.2 Medical Record number.
- 4.1.6.3 Name of her most responsible physician.
- 4.1.6.4 Take and document patient history and physical (general and gynaecological) examination findings and the provisional diagnosis. If pregnant to review the patient antenatal records.
- 4.1.6.5 Preliminary diagnosis.
- 4.1.6.6 Plan of care and any necessary investigations.
- 4.1.6.7 All questions asked on the admission form will be completed in the appropriate manner.
- 4.1.6.8 Inform the physician if patient need intervention or it has any queries.
- 4.1.6.9 Document the estimated length of hospital stay.
- 4.1.6.10 Document Pain assessment and need for analgesia.
- 4.1.6.11 Document Special needs of the patient (e.g if the patient is blind, deaf or otherwise handicapped), and if there is any special nutritional needs.

4.1.7 Admission sheet should contain admitting physician name (Stamp) and signature.

4.1.8 Each patient should have the following:

- 4.1.8.1 Changing into hospital gown.
- 4.1.8.2 Putting I.D band.
- 4.1.8.3 Checking height, weight, vital signs and urine dip stick test for albumin, sugar and acetones. (If abnormal, to be reported promptly to word resident).
- 4.1.8.4 An intravenous access if booked for operation on the morning, if need in some cases such as hyperemesis gravidarum..etc. (see P&P of preoperative and postoperative assessment).
- 4.1.8.5 Blood extraction for complete blood count & blood grouping and sent to the lab. Additional blood tests are done according to physician's orders.
- 4.1.8.6 Required X-rays are done according to doctor's orders, and may be taken on route to the ward. (However the destination of the patient should be clearly recorder on the X-ray request form. (This prevents loss of record and duplications of record and duplications of investigation).
- 4.1.8.7 Obstetric cases need to have CTG on admission for 30-60 minutes and to be reviewed by the SHO in the ward.

4.1.9 During the stay in the hospital:

- 4.1.9.1 She will be attended by a team of physician's comprising of medical specialists, assisted by medical officers and house officers.
- 4.1.9.2 Every care is taken in respect of patient care, treatment, meals, dress and health recovery.
- 4.1.9.3 The daily routine in the ward includes activities such as ward rounds by physician, medication, meals, visiting hours and bedtime. However, this routine may vary as laboratory tests, x-ray, treatment and other procedure will take place when required.
- 4.1.9.4 If required, the physician operates the patient as part of the treatment.
- 4.1.9.5 The patient's medical records and information of their medical condition are confidential. It will only be shared with the patient and the next-of-kin. If the immediate family members wish to know more about the patient's condition, they can approach the appropriate coordinator to arrange for convenient time to meet the concerned physician.

4.1.9.6 The safety and wellbeing of the patient is utmost concern.

4.1.9.7 Patient to remain within the hospital premises until they are discharge by the concerned physician.

4.1.9.8 A discharge summary certificate will be given to the patient before leaving the ward.

4.1.9.9 In case the patient needs a medical certificate, she has to inform thephysician or nurse in advance so that it can be prepared before the patient's leaves.

4.1.10 Follow up care and appointment

4.1.10.1 Before leaving the ward, patient is handed over with detailed discharge summary, which includes physician's advice on their further follow-up treatment, daily routine diet, and medical prescription.

4.1.10.2 The physician's may give the patient an appointment for follow-up at the specialist Outpatient Clinic.

4.1.10.3 If the patient needs to reschedule the outpatient appointment after discharge, they can feel free to contact the concerned physician.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician

6.2 Nurses

7. APPENDICES:

7.1 Admission Forms

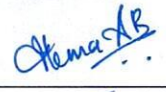
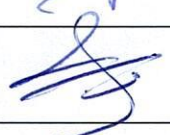
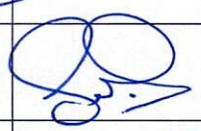
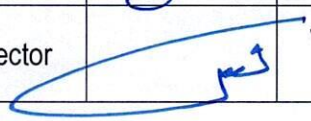
7.2 General Consent

7.3 Blood donation Forms

8. REFERENCES:

8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Hema Robi	Nurse Specialist		January 08, 2025
Prepared by:	Dr. Abdalla Mohamed Albasha	Obstetrician and Gynecologist		January 08, 2025
Reviewed by:	Dr. Mohannad Yaghmour	HOD – OBS &Gynecology		January 12, 2025
Reviewed by:	Mr. Sabah Turayhib Al - Harbi	Director of Nursing		January 12, 2025
Reviewed by:	Dr. Thamer Naguib	Medical Director		January 13, 2025
Reviewed by:	Mr. Abdulelah Ayed Al - Mutairi	QM&PS Director		January 14, 2025
Approved by:	Mr. Fahad Hezam Al - Shammari	Hospital Director		January 15, 2025

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ___/___/14___ H ___/___/20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

MATERNITY PHYSICIAN ADMISSION ASSESSMENT SHEET

Admission Date: ___/___/___ **Time:**..... **Admitting Consultant:**

Admission From: ☐ ER ☐ OPD ☐ Others:.....

Vital signs	Temp:	PR:	HR:	RR:	BP:	Pain Score:	O_2 Sat

Height:.....cm. **Weight:**..... kg. Mobility:.....

ALLERGIES: ☐ No ☐ Yes specify: .....

Language Barrier: ☐ Yes ☐ No

Chief complaint :.....

History of presenting complaint :.....

.....

.....

Past Obstetrical and Gynecological History:.....

.....

Menstral History :.....

Past Medical History :.....

.....

Past Surgical History :.....

Family History: .....

CurrentMedications:.....

Name of Medications	Dose	Route	Frequency

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Name: _____ الاسم:	MRN: رقم الملف الطبي:

DrugHistory:

History Of Blood Transfusion: ☐ Yes ☐ No

Psychosocial History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

Occupation:

Smoking: ☐ No ☐ Yes If yes, how many cigarettes each day?

EducationalLevel:

Language Spoken: ☐ Arabic ☐ English ☐ Others

System Review:

Neurological:

Psychiatric:

Cardiovascular:

Respiratory:

Gastrointestinal:

Genitourinary:

Endocrine:

Others:

PHYSICAL EXAMINATION

General Appearance:

Head and Neck Examination:

Breast Examination:

Chest Examination:

Cardiovascular Examination:

Abdomen Examination:

Neurological Examination:

Musculoskeletal Examination:

Pelvic Examination:

1.) External Genitalia: ;

Name:_____ الاسم:	MRN: رقم الملف الطبي:

2.) Vaginal Examination:_____

3.) Speculum Examination:_____

Investigation and Laboratory:_____

Admission Diagnosis:_____

Plan of Care:

1.) Goals:_____

2.) Medication:_____

3.) Investigation:_____

4.) Consultation:_____

5.) Expected Length of Stay: _____ Days

6.) Nutrition and Diet: _____

Education of Patient and Family:_____

Discharged / Planning / Needs:_____

Referral Indicated: ☐ Yes ☐ No

Referral Sent To :

☐ Home Care ☐ Social Services ☐ Physician ☐ Intensives Care (ICU)

☐ Psychiatrist ☐ Physiotherapist ☐ Others _____

PHYSICIAN NAME: _____ **Stamp&Signature:**_____ **Date:**____/___/___

Consultant Notes:_____

CONSULTANT NAME: _____ **Stamp&Signature:**_____ **Date:**____/___/___

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MRN: | | | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ Years سنة ☐ Months شهر ☐ Days يوم العمر:

Date of Birth: ____/____/14____H ____/____/20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

GENERAL CONSENTS إقرارات عامـــة

I (for Named Patient) signed below, authorize and give consent to my attending physician and/or his/her assistant to provide medical, nursing care and other clinical diagnostic or therapeutic procedures with the exception of surgical and invasive procedures, induction of anesthetics, infusion of blood and blood products and other procedures that require special consent.	أفوض أنا (المريض) الموقع أدناه، وأعطي موافقتي للطبيب المعالج ولمن يختار لمساعدته وذلك لتقديم عناية طبية وتمريضية وأي تشخيصات سريرية أو أية طرق علاجية بإستثناء العمليات الجراحية والإجراءات التداخلية حقن الدم أو مشتقاته أو أي عمل آخر يتطلب موافقة خاصة.
I understand that Dr._____ _____ is attending physician and is the person responsible for the assessment of my medical condition & my care plan & he/she will have the responsibility according to my medical condition, to Discharge or Transfer.	لقد تم إعلامي أن الطبيب المعالج د. _____ _____ هو الشخص المسؤول عن تقييم حالتي الطبية وخطة علاجي وتقع عليه/ عليها مسؤولية أمر خروجي من المستشفى أو تحويلي الى أية جهة عناية صحية أخرى وذلك بناء على ما تستدعيه حالتي الصحية.
I understand that the hospital and its employees will respect my rights and privacy at all times and that the confidentiality of my medical information will be guarded carefully and released only to authorized person.	أفهم وأعي أن المستشفى وموظفيه سوف يحترمون خصوصياتي في كل الأوقات وأن سرية المعلومات الطبية الخاصة بي سوف يحافظ عليها بعناية وسوف تستخدم فقط وحصريا لأجل العلاج وأن تعطى فقط لهولاء الأشخاص الذين يقومون على رعايتي. ولن يتم إعطاء المعلومات لأي شخص أو جهة إلا في حالة موافقتي الشخصية أو موافقة الشخص المصرح كبديل عني.
I shall abide by the hospital rules and regulations.	سوف التزم واطيع كل القوانين والنظم الخاصة بالمستشفى.
I understand that the hospital is not responsible for the loss or damage of my money, valuables and other personal property and that in case of emergency or no alternative situations the items should be handed over to the security for safekeeping.	أفهم إن المستشفى لا تتحمل مسؤولية فقدان النقود، المقتنيات الثمينة أو أية ممتلكات خاصة بي الا في الحالة الطارئة أو في حالة عدم وجود بديل للحفاظ على ممتلكاتي حيث ان هذه الممتلكات يجب أن تعطى لمسؤولي الامن في المستشفى للحفاظ عليها.
If it is found that I am not eligible for free treatment, I am obligated to pay for all services rendered as per my healthcare needs, I agree that the authorities and Kingdom's courts will decide any dispute in connection with such costs.	إذا اتضح إني غير مؤهل للعلاج المجاني فإني أتفهم إني مطالب بدفع كل المصاريف المتعلقة بعلاجي وأوافق أن الجهات المختصة والمحاكم بالمملكة العربية السعودية هي التي تقرر مسؤولية الدفع في حالة وجود خلاف حول المصاريف الواجب دفعها.
In case of emergency, where I am not coherent or conscious and unable to make my healthcare decision, I hereby grant the following person (s) the right to take decision of my medical treatment on my behalf:	إذا كان هناك طارئ، أو حالة غيبوبة أو عدم تركيز وكنت غير قادر على إتخاذ قرار بشأن حالتي الصحية فأني أمنح حق إتخاذ القرار بالنيابة عني بشأن حالتي الصحية إلى الاشخاص التالية أسمائهم.
1. Name: _____ Relation to the Patient _____ Date: ____/____/____ Time: _____	الإسم: _____ صلة القرابة: _____ تاريخ: ____/____/____ وقت: _____

Name:_____ :الاسم	MRN: رقم الملف الطبي:
I acknowledge that my signature on this form signifies that I am in agreement with all the statements. Signature of Patient:_____ Date: ____/____/____ Time: _____	أقر أن توقيعي على هذه الاستمارة يعني إنني موافق على كل بنودها وإنني قرأتها بالكامل قبل توقيعي هذا. توقيع المريض: _____ تاريخ: ____/____/____ وقت: _____
Substitute Decision Maker	**من ينوب عن المريض (أو صانع القرار البديل)**
In case of emergency and the patient is unable to make decision and not granted any person to sign on his behalf. Substitute Decision Maker Name_____ Relation to the Patient _____ Signature: _____ Date: ____/____/____ Time: _____ Reason for Patient not signing to Consent: _____	في الحالة الطارئة وحين يكون المريض غير قادر على إتخاذ القرار ولم يمنح أحد حق التوقيع بالنيابة عنه. إسم من ينوب عن المريض: _____ صلة القرابة: _____ التوقيع: _____ تاريخ: ____/____/____ وقت: _____ سبب عدم توقيع المريض: _____
In case of emergency and no Substitute Decision Maker and patient not granted any person to sign on his behalf We certify that, we have examined the patient and it is our professional opinion that this patient lacks decision capacity to take health care decision and any delay providing medical treatment will endanger his life or lead to serious body harm. **1. Physician Name & ID No.:** _____ Position: _____ Signature: _____ Date: ____/____/____ Time: _____ **2. Physician Name & ID No.:** _____ Position: _____ Signature: _____ Date: ____/____/____ Time: _____	**في الحالة الطارئة وغياب من ينوب عن المريض**، وكون المريض لم يمنح أحد حق التوقيع بالنيابة عنه. نحن نأكد ونوثق أنه عند فحص المريض وحسب رأينا المهني أن هذا المريض غير قادر على إتخاذ القرار بشأن حالته الصحية وأن أي تأخير في تقديم العناية الطبية اللازمة سوف يعرض حياته للخطر أو قد يؤدي الى عواقب وخيمة **إسم الطبيب والرقم الوظيفي:** _____ وظيفته: _____ التوقيع: _____ تاريخ: ____/____/____ وقت: _____ **إسم الطبيب والرقم الوظيفي:** _____ وظيفته: _____ التوقيع: _____ تاريخ: ____/____/____ وقت: _____

WITNESS **شاهد**

Name (الإسم)	Signature (التوقيع)	Date & Time (التاريخ والوقت)
1.)		
2.)		
3.)		

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Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ___/___/14___ H ___/___/20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

BLOOD DONOR FORM نموذج للتبرع بالدم لمرضى العمليات الروتينية

DIAGNOSIS.....	التشخيص.....
AMOUNT REQUESTED:	الكمية المطلوبة :
NUMBER OF UNITS OF WHOLE BLOOD.....	عدد ..... وحدة دم كامل
PHYSICIAN SIGNATURE:_____	توقيع الطبيب _____
Stamp&Signature:_____ Date:___/___/_____	الختم والتوقيع _____التاريخ___/___/_____

BLOOD DONORS	**للاخوة المتبرعين**
You have kindly offered to donate for the above named Patient. Please Observe the notes below:	لقد أبديتم استعدادكم مشكورين للتبرع بالدم للمريض المذكور أعلاه ونرجو منكم مراعاة الاتي:
1. You must be over 18 years old.	١- أن لايقل عمر المتبرع عن ١٨ سنه
2. You must weigh 50 kgs. Or more	٢- أن لايقل وزن المتبرع عن ٥٠كم
3. You **must** bring your Saudi I.D. or Iqama.	٣- يجب أن يكون حاملا البطاقه الشخصيه
4. Please eat and drink before coming to donate.	٤- يرجى تناول الأكل والشرب قبل الحضور للتبرع بالدم

BLOOD BANK OPINION:	رأي بنك الدم:
AMOUNT REQUESTED WAS GIVEN	تم التبرع بالكمية المطلوبة
Blood Bank In Charge:_____	المسؤول في بنك الدم _____
Stamp&Signature:_____ Date:___/___/_____	الختم والتوقيع _____التاريخ___/___/_____

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