PART 4: INPATIENT REGISTER

HMIS FORM 054: INPATIENT REGISTER

DESCRIPTION AND INSTRUCTIONS

Objective: Maintain brief record of age, sex, diagnoses, interventions and final status of each inpatient

Copies: One copy which stays at the health unit in the respective ward.

Responsibility: Ward in charge

PROCEDURE:

1. The date the register was started, the name of health unit, name of ward, and the date the register was finished are written on the front cover.

2. This register is used to record inpatient admission and discharge information. The registration will normally be at a central location. Wards can keep a record of their inpatients if they wish; however, the registration of inpatients (and allocation of inpatient numbers) should be done at one central place in order that each patient gets a different IP number.

3. In case of emergencies or at night, an INPATIENT TREATMENT SHEET without an **IPD Num.** (Inpatient number) can be issued. Proper registration should be done as soon as possible. The (night duty) clinician could make a list of all admissions for the medical records staff to follow up on the next morning. But also the ward nurse can easily identify unregistered patients because the sheet lacks an Inpatient Number (**IPD Num.**).

4. At registration the first eight columns are completed, and the file for the inpatient is started. At discharge (or death), the Inpatient's file is returned to the registration office, and the remaining columns are completed. The Inpatient File is then stored according to the **IPD Num**.

5. It is from the INPATIENT REGISTER that all diagnoses of admissions and deaths are tallied. The tallies should normally be done daily. A tick (√) is written in front of a line after the diagnoses have been tallied to keep track of those tallied. This is necessary because patients are not discharged in the same order as they are admitted. More information on tallying is given in TABLE 7: INPATIENT / LABORATORY AND X-RAY SERVICES.

6. The Ministry of Health has provided a list of diagnoses of interest to summarize monthly. The Medical Superintendent and the DHO will determine other additional diagnoses of interest to be summarized monthly. All diagnoses will be summarized and reported at the end of each quarter and also at the end of the year.

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HEADINGS AND COLUMN WIDTHS:

LEFT SIDE

(1)	(2)	(3)		(4)	(5)	(6)	(7)	(8)	(9)	(10)
		RESIDENCE				NEXT				
IPD NUM	NAME	VILLAGE	PARISH	AGE	SEX	OF KIN	REF IN?	REFERRED FROM	DATE IN	DATE OUT
2 cm	3.5 cm	4 cm	3.5 cm	1 cm	1 cm	3.5 cm	1 cm		2 cm	2 cm

RIGHT SIDE

(11)	(12)	(13)	(14)						15	(16)
Tobacco use			FINAL STATUS						Need for Palliative care	
Alcohol use	PROVISIONAL DIAGNOSIS	DIAGNOSIS AT DISCHARGE	D	DD	T	R	S	RAB		REMARKS
Toba. use	7 cm	7 cm								4 cm
Alcohol use										

DESCRIPTION OF COLUMNS:

1. **IPD NUM:**
   This is the unique serial number given to the inpatient during his/ her stay. IPD number begins with 1 at the beginning of the financial year (July) and ends at the end of the financial year (June)

2. **NAME:**
   The patient's name

3. **RESIDENCE:**
   The patient's village and Parish of residence

4. **AGE:**
   Write the patient's age in complete years if over one year. Use months if under one year, writing clearly "MTH" after the age. If the patient is less than one month, then "Days" are written after the age

5. **SEX:**
   The patient's sex. Use "M" for Male or "F" for Female.

6. **NEXT OF KIN:**
   Person responsible in case of follow up or emergency.

7. REF IN
Put a tick if the patient was referred into the unit.

8. REFERRED FROM:
Indicate the name of health facility or ward referring the patient to this ward or health facility.

9. DATE IN:
The date the patient was admitted - day and month are sufficient. It is best to use abbreviations (Jan, Feb, Mar, etc.) and not numbers for the month.

10. DATE OUT:
The date when the patient was discharged. Day and month are sufficient. It is best to use abbreviations (Jan, Feb, Mar, etc.) and not numbers for the month.

11. TOBACCO USE
Put a tick if patient uses tobacco in any form e.g. smoking, sniffing, chewing, shisha, emindi (smoking pipe),
Put a tick if patient consumes any type of alcohol e.g. local brew, beers, wines and spirits.

12. PROVISIONAL DIAGNOSIS:
From the patient's Outpatient Card or other documentation, write the diagnosis upon admission.

13. DIAGNOSIS AT DISCHARGE:
From the INPATIENT TREATMENT SHEET write the FINAL diagnoses. If abbreviations are used, ensure that they are standard and used consistently.

14. FINAL STATUS:
Tick as appropriate: **"D"** for discharge (this includes the MF 74 categories of recovered, improved and unchanged), **"T"** for transferred to another ward, **"R"** for referred out to another health unit, "RAB" if patient referred abroad **"DD"** if the patient died, and **"S"** for self-discharges/ runaways.

15. NEED FOR PALIATIVE CARE
Write YES if patient needs palliative care and NO if he/she doesn't need palliative care.

16. REMARKS:
This can contain any information of interest to the Medical Superintendent. Diagnoses that result from Injuries indicate the incident that caused the Injuries (Road Traffic Accident, gunshot, Domestic Violence, Suicide, Poisoning, etc).

REPORTED MONTHLY TO THE INCHARGE
The number of patients who were referred from lower levels.

The numbers of admissions and deaths for the diagnoses indicated on the Inpatient List of Diseases

REPORTED YEARLY TO THE INCHARGE
The numbers of admissions and deaths for all diagnoses on the Inpatient List of Diseases