

Admission, Transfer, and Discharge Procedures

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Admission:

Admission to the nursing unit prepares the patient for his stay in the health care facility. Whether the admission is scheduled or follows emergency treatment.

Effective admission procedures should accomplish the following goals:

1. Verify the patient's identity and assess his clinical status,
2. Make him as comfortable as possible,
3. Introduce him to his roommates and the staff,
4. Orient him to the environment and routine,
5. Provide supplies and special equipment needed for daily care.

Admission routines that are efficient and show appropriate concern for the patient can ease his anxiety and promote cooperation and receptivity to treatment.

Conversely, admission routines that the patient perceives as careless or excessively impersonal can lead to:

1. Heighten anxiety,
2. Reduce cooperation,
3. Impair his response to treatment,
4. Perhaps aggravate symptoms.

Equipment:

Gown , personal property form , valuables envelope , admission form , nursing assessment form, , thermometer , emesis basin , bedpan or urinal , bath basin , water pitcher, cup, and tray , urine specimen container, if needed.

An admission pack usually contains soap, comb, toothbrush, toothpaste, mouthwash, water pitcher, cup, tray, lotion, facial tissues, and thermometer. An admission pack helps prevent cross-contamination and increases nursing efficiency.

Preparation of equipment:

1. Obtain a gown and an admission pack.
2. Position the bed as the patient's condition requires. If the patient is ambulatory, place the bed in the low position; if he's arriving on a stretcher, place the bed in the high position.
3. Fold down the top linens.
4. Prepare any emergency or special equipment, such as oxygen or suction, as needed.

Implementation:

1. Adjust the room lights, temperature, and ventilation.
2. Make sure all equipment is in working order prior to the patient's admission.
3. Admitting the adult patient.
4. Speak slowly and clearly, greet the patient by his proper name, and introduce yourself and any staff present.
5. Compare the name and number on the patient's identification bracelet with that listed on the admission form. Verify the name and its spelling with the patient. Notify the admission office of any corrections.
6. Quickly review the admission form and the physician's orders. Note the reason for admission, any restrictions on activity or diet, and any orders for diagnostic tests requiring specimen collection.
7. Escort the patient to his room and, if he isn't in great distress, introduce him to his roommate. Then wash your hands, and help him change into a gown or pajamas; if the patient is sharing a room, provide privacy.
8. Take and record the patient's vital signs, and collect specimens if ordered. Measure his height and weight if possible. If he can't stand, use a chair or bed scale and ask him his height. ***Knowing the patient's height and weight is important for planning treatment and diet and for calculating medication and anesthetic dosages.***
9. Show the patient how to use the equipment in his room. Be sure to include the call system, bed controls, TV controls, telephone, and lights.
10. Explain the routine at your health care facility. Mention when to expect meals, vital sign checks, and medications. Review visiting hours and any restrictions.

11. Take a complete patient history. Include all previous hospitalizations, illnesses, and surgeries; current drug therapy; and food or drug allergies. Ask the patient to tell you why he came to the facility. Record the answers (in the patient's own words) as the chief complaint. Follow up with a physical assessment, emphasizing complaints. Record any wounds, marks, bruises, or discoloration on the nursing assessment form.
12. After assessing the patient, inform him of any tests that have been ordered and when they're scheduled. Describe what he should expect.
13. Before leaving the patient's room, make sure he's comfortable and safe. Adjust his bed, and place the call button and other equipment (such as water pitcher and cup, emesis basin, and facial tissues) within easy reach. Raise the side rails.

USING PATIENT CARE REMINDERS

When placed at the head of the patient's bed, care reminders call attention to the patient's special needs and help ensure consistent care by communicating these needs to the hospital staff, the patient's family, and other visitors.

You can use a specially designed card or a plain piece of paper to post important information about the patient, such as:

1. Allergies
2. Dietary restrictions
3. Fluid restrictions
4. Specimen collection
5. Patient deaf or hearing-impaired in right ear
6. Foreign-language speaker.

You can also use care reminders to post special instructions, such as:

7. Complete bed rest
8. No blood pressure on right arm
9. Turn every 1 hour
10. Nothing by mouth.

Admitting the pediatric patient:

1. Your initial goal will be to establish a friendly, trusting relationship with the child and his parents *to help relieve fears and anxiety*.
2. Speak directly to the child, and allow him to answer questions before obtaining more information from his parents.

3. While orienting the parents and child to the unit, describes the layout of the room and bathroom, and tells them the location of the playroom, television room, and snack room, if available.
4. Teach the child how to call the nurse.
5. Explain the facility's rooming-in and visiting policies so the parents can take every opportunity to be with their child.
6. Inquire about the child's usual routine so that favorite foods, bedtime rituals, toileting, and adequate rest can be incorporated into the routine.
7. Encourage the parents to bring some of their child's favorite toys, blankets, or other items to make the child feel more at home amid unfamiliar surroundings.

Special considerations

1. If the patient doesn't speak English and isn't accompanied by a bilingual family member, contact the appropriate resource .
2. Keep in mind that the patient admitted to the emergency department requires special procedures.
3. If the patient brings medications from home, take an inventory and record this information on the nursing assessment form. Instruct the patient not to take any medication unless authorized by the physician.
4. Find out the patient's normal routine, and ask him if he would like to make any adjustments to the facility regimen.

Documentation

After leaving the patient's room, complete the nursing assessment form or your notes, as required. The completed form should include the patient's vital signs, height, weight, allergies, and drug and health history; a list of his belongings and those sent home with family members; the results of your physical assessment; and a record of specimens collected for laboratory tests.

Transfer

Patient transfer either within your facility or to another one requires thorough preparation and careful documentation.

Preparation includes:

1. An explanation of the transfer to the patient and his family,

2. Discussion of the patient's condition and care plan with the staff at the receiving unit or facility,
3. Arrangements for transportation if necessary.

Equipment:

Admission inventory of belongings , patient's chart, medication record, and nursing Kardex , medications , bag or suitcase , wheelchair or stretcher, as necessary.

Implementation:

1. Explain the transfer to the patient and his family. If the patient is anxious about the transfer or his condition precludes patient teaching, be sure to explain the reason for the transfer to his family members, especially if the transfer is the result of a serious change in the patient's condition. Assess his physical condition to determine the means of transfer, such as a wheelchair or a stretcher.
2. Using the admissions inventory of belongings as a checklist, collect the patient's property. Be sure to check the entire room, including the closet, bedside stand, over bed table, and bathroom.
3. Gather the patient's medications from the cart and the refrigerator. If the patient is being transferred to another unit, send the medications to the receiving unit; if he's being transferred to another facility, return them to the pharmacy.
4. Notify the business office and other appropriate departments of the transfer.
5. Have a staff person notify the dietary department, the pharmacy, and the facility telephone operator about the transfer (if within the facility).
6. Contact the nursing staff on the receiving unit about the patient's condition and drug regimen and review the patient's nursing care plan with them to ensure continuity of care.

Transfer within the facility

1. If the patient is being transferred from or to an intensive care unit, your facility may require new care orders from the patient's physician.
2. Send the patient's chart, laboratory request slips, Kardex, special equipment, and other required materials to the receiving unit.

3. Use a wheelchair to transport the ambulatory patient to the newly assigned room.
4. Introduce the patient to the nursing staff at the receiving unit. Then take the patient to his room and, depending on his condition, place him in the bed or seat him in a chair. Introduce him to his new roommate, if appropriate, and tell him about any unfamiliar equipment such as the call bell.

Transfer to an extended-care facility

1. Make sure the patient's physician has written the transfer order on his chart and has completed the special transfer form. ***This form should include the patient's diagnosis, care summary, drug regimen, and special care instructions, such as diet and physical therapy.***
2. Complete the nursing summary, including the patient's assessment, progress, required nursing treatments, and special needs, to ensure continuity of care.
3. Keep one copy of the transfer form and the nursing summary with the patient's chart, and forward the other copies to the receiving facility.

Transfer to an acute-care facility

1. Make sure the physician has written the transfer order on the patient's chart and has completed the transfer form as discussed above. Then complete the nursing summary.
2. Depending on the physician's instructions, send one copy of the transfer form and nursing summary and photocopies of pertinent excerpts from the patient's chart such as laboratory test and X-ray results, patient history and physical progress notes, and records of vital signs to the receiving facility with the patient.

Special considerations

If the patient requires an ambulance to take him to another facility, arrange transportation with the social services department. Ensure that the necessary equipment is assembled to provide care during transport.

Documentation

Record the time and date of transfer, the patient's condition during transfer, the name of the receiving unit or facility, and the means of transportation.

Discharge

Effective discharge requires careful planning and continuing assessment of the patient's needs during his hospitalization. Ideally, discharge planning begins shortly after admission.

Discharge planning aims to:

1. Teach the patient and his family about his illness and its effect on his lifestyle,
2. Provide instructions for home care,
3. Communicate dietary or activity instructions,
4. Explain the purpose, adverse effects, and scheduling of drug treatment.
5. Arranging for transportation,
6. Follow-up care if necessary,
7. Coordination of outpatient or home health care services.

Equipment

Wheelchair, unless the patient leaves by ambulance , patient's chart , patient instruction sheet , discharge summary sheet , plastic bag or patient's suitcase for personal belongings.

Implementation

1. Before the day of discharge, inform the patient's family of the time and date of discharge.
2. Obtain a written discharge order from the physician. If the patient discharges himself against medical advice, obtain the appropriate form.
3. If the patient requires home medical care, confirm arrangements with the appropriate facility department or community agency.
4. On the day of discharge, review the patient's discharge care plan (initiated on admission and modified during his hospitalization) with the patient and his family. List prescribed drugs on the patient instruction sheet along with the dosage, prescribed time schedule, and adverse reactions that he should report to the physician. Ensure that the drug schedule is consistent with the patient's lifestyle to prevent improper administration and to promote patient compliance.
5. Review procedures the patient or his family will perform at home. If necessary, demonstrate these procedures, provide written instructions, and check performance with a return demonstration.

6. List dietary and activity instructions, if applicable, on the patient instruction sheet, and review the reasons for them.
7. Check with the physician about the patient's next office appointment; if the physician hasn't yet done so, inform the patient of the date, time, and location.
8. Retrieve the patient's valuables from the facility's safe and review each item with him. Then obtain the patient's signature to verify receipt of his valuables.
9. Obtain from the pharmacy any drugs the patient brought with him.
10. If appropriate, take and record the patient's vital signs on the discharge summary form. Notify the physician if any signs are abnormal such as an elevated temperature.
11. Help the patient get dressed if necessary.
12. Collect the patient's personal belongings from his room.
13. After checking the room for misplaced belongings, help the patient into the wheelchair, and escort him to the exit; if the patient is leaving by ambulance, help him onto the litter.
14. After the patient has left the area, strip the bed linens and notify the housekeeping staff that the room is ready for terminal cleaning.

Special considerations

1. Whenever possible, involve the patient's family in discharge planning so they can better understand and perform patient care procedures.
2. Before the patient is discharged, perform a physical assessment. If you detect abnormal signs or the patient develops new symptoms, notify the physician and delay discharge until he has seen the patient.

Documentation

1. Record the time and date of discharge,
2. The patient's physical condition,
3. Special dietary or activity instructions,
4. The type and frequency of home care procedures,
5. The patient's drug regimen,
6. The dates of follow-up appointments,
7. The mode of departure and name of the patient's escort,
8. A summary of the patient's hospitalization if necessary.

MANAGING EMERGENCY ADMISSIONS

For the patient admitted through the emergency department (ED), immediate treatment takes priority over routine admission procedures. After ED treatment, the patient arrives on the nursing unit with a temporary identification bracelet, a physician's order sheet, and a record of treatment. Read this record and talk to the nurse who cared for the patient in the ED to ensure continuity of care and to gain insight into the patient's condition and behavior.

Next, record any ongoing treatment, such as an I.V. infusion, in your notes. Take and record the patient's vital signs, and follow the physician's orders for treatment. If the patient is conscious and not in great distress, explain any treatment orders. If family members accompany the patient, ask them to wait in the lounge while you assess the patient and begin treatment. Permit them to visit the patient after he's settled in his room. When the patient's condition allows, precede with routine admission procedures.

DEALING WITH A DISCHARGE AGAINST MEDICAL ADVICE

Occasionally, the patient or his family may demand discharge against medical advice (AMA). If this occurs, notify the physician immediately. If the physician fails to convince the patient to remain in the facility, he'll ask the patient to sign an AMA form releasing the facility from legal responsibility for any medical problems the patient may experience after discharge.

If the physician isn't available, discuss the discharge form with the patient and obtain his signature. If the patient refuses to sign the AMA form, don't detain him. This violates his legal rights. After the patient leaves, document the incident thoroughly in your notes and notify the physician.

References:

Loeb, S., et al.: **Nursing Procedures: Student Version**, 1993, Pennsylvania, Springhouse Corporation, P.P.4-8.