Admission & Discharge Process
N101

- Admission Process
  - **Admission**
    - Covers the entire period from the time the client enters the door until the time settled in
  - **Discharge**
    - Official procedure helping clients to learn to leave the health care facility
  - **Transfer**
    - From one room, unit, or facility to another
- Admission: Overview
  - **Challenge to nursing:**
    - Meet the needs of clients & families
    - Comprehensive & holistic
    - Admission increases stress
  - **Nurses are the primary resource:**
    - Spend more time with the patient
    - Assure continuity of care
    - Coordinate care with other interdisciplinary teams
  - **Discharge process**
- **Patient Bill of Rights**
- **What are your rights?**
  - **You have the right to be informed about the care you will receive.**
  - **You have the right to get important information about your care in your preferred language.**
  - **You have the right to get information in a manner that meets your needs, if you have vision, speech, hearing or mental impairments.**
  - **You have the right to make decisions about your care.**
  - **You have the right to refuse care.**
  - **You have the right to know the names of the caregivers who treat you.**
  - **You have the right to safe care.**
  - **You have a right to have your pain addressed.**
  - **You have the right to learn about your care in your preferred language**
- Advance Directives/Living Will
  - **Advance Directives:**
    - Written instructions to convey wishes regarding medical treatment
  - **Living Will:**
    - Specifies end of life decisions when no longer able to make
    - Legalities vary from state to state
  - **Healthcare POA:**
    - An agent to make medical decisions if you are unable to do so
- Preliminary Admission Procedure
  - Prior to reaching the unit:
    - By order from MD
  - Admission into Acute Care:
    - Registration:
      - Basic demographic information
      - Assures correct legal identification
      - Info entered onto computer ‘face sheet’
      - Informed consent

- Informed Consent
    - Diagnosis of patient, if known
    - Nature & purpose of proposed treatment
    - Risks & benefits
    - Alternatives (regardless of cost)
    - Risk & benefits of alternative treatment
    - Risks & benefits of not receiving a procedure
    - Complete description of treatment procedure
    - Description who will participate in procedure
    - Description of potential harm, pain, discomfort
    - Options for other treatment
    - Right to refuse treatment
- Patient Identification
    - Always read ID and ask client to verbally give name & DOB to compare & confirm accuracy
    - Patient Identification:
        - Assigned permanent ID #
        - Name, DOB, ID #
        - Used for all procedures and interactions
        - Must verify before placing name band on client
- Admission to Unit
    - **Room Preparation**
        - **Gather supplies**
        - **Bed in lowest position unless transfer from stretcher**
        - **Be sure to zero bed scale before patient arrival**
    - **Nursing Admission**
        - **Greet patient, identify self**
        - **Establish identification**
        - **Provide privacy**
        - **Weight/height**
        - **Orient to call bell**
        - **Head/Toe, admission assessment**
        - **Place care items within reach**
- During Admission Process…
    - Make patient feel comfortable and accepted; treat each person with dignity
    - Allay fears
    - Establish good rapport
    - Routines
- Discharge Process
    - Discharge process begins on admission
    - Planning more than completion (ongoing)
    - ALL WHO CARE FOR PATIENT SHOULD PARTICIPATE!
    - Case managers fill this role
        - Need our expertise & knowledge of patient
        - Liaisons between hospital & community
        - Ensure smooth transition
    - Home health vs. nursing home
    - Emotional stability to go home
    - Financial concerns

    - Special Needs
- Indications for Discharge & Transfer
    - Level of care has changed
    - Another setting is required
    - Facility does not offer care required
    - Patient is ready for discharge
    - Nurse's Role
- Discharge Process
    - Case Management Referrals
        - Behavioral Health
        - Durable Medical Equipment (DME)
            - Walker, commode, etc.
        - Acute Rehabilitation Facility (ARC)
        - Sub-Acute Care (SNF)
        - Long-term Care (LTC)
        - Home Health Care Services (HHC)
        - Hospice/Palliative Care
- Referrals
    - Health Care Referral
        - Request for service outside scope of referring professional
        - Social worker, hospice, palliative care, home health aide, housekeeper, etc.
    - Level of discharge depends on needs:
        - Basic plan (basic self-care i.e. smoking cessation hotline)
        - Simple referral (community resource i.e. AAA)
        - Complex referral (requires case management)
- Referrals: HHC
    - Referral for home health care
    - Use of professional, para-professional, & equipment to patients in their homes
    - Health maintenance & prevention of illness
    - Patient & family education
    - Rehabilitation
- Reimbursement through private or government insurance & JCAHO accreditation to assure quality standards
- Day of Discharge/Transfer
    - Communicate anticipated time of discharge or time of arrival to new facility
    - Complete documentation (including teaching)
    - Give verbal report to nurse at receiving facility
    - Confirm mode of transportation (private vehicle, ambulance…)
    - Make sure the patient is dressed and items packed up
    - Account for all items (medications, equipment, items sent to security etc.)
- Discharge Education
    - Patient & Family Education
    - Language
    - Includes procedures, diets, medications, referrals, extended care facilities, follow-up
    - Test knowledge
        - Return demonstration
        - Teach-back
    - Provide paperwork, manuals, charts

- Standards for Discharge Education
    - Identify safety concerns at home
    - Review signs & symptoms
    - Provide phone numbers
    - Provide community resources
    - Instructions for treatment
    - Dietary restrictions & guidelines
    - Amount & frequency of therapies
    - Medication instructions
- Discharge Documentation
    - Need MD order on chart/EMR
    - Reconcile all medications
    - With Cerner, we use patient education from EMR- select topics to educate on, print copies for discharge folder
    - Make a copy of the signed discharge paperwork for the paper chart and patient receives a copy
    - Document discontinued equipment (i.e. PIV )
    - If transferred- document where the patient is going, with what equipment, to whom report was provided, means of transport, and time left.
    - If transferred to another facility: complete interagency form prior to transfer
- Other Discharges
    - Death
        - Death certificate
        - Expiration release form
        - Notify MD if not present
        - Notify Nurse Supervisor
    - Against Medical Advice (AMA)
        - Documentation in notes
        - MD & Supervisor aware
        - MD still writes an order!!!
        - Patient Right
- After discharge…
    - Transport notified: can assist to car when ride downstairs or taxi available
    - Break down the room – linens, trash, IV pumps/bags
    - Housekeeping notified
    - Supervisor notified
    - Paper Chart broken down and sent to medical records
    - A discharge cancels ongoing orders: meal trays from dietary, daily services etc…