Chapter 23

Admitting, Transferring, and Discharging Patients

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Chapter 23

Lesson 23.1

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Learning Objectives

Theory

1) Differentiate between routine and emergency admissions.

2) Describe the role of the admitting department.

3) Identify the elements included in a patient's orientation to the nursing unit.

Clinical Practice

1) Orient a patient to the patient unit and the hospital.

2) Assist with the performance of an admission assessment.

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Routine Admissions

- Scheduled in advance
- Physician and patient have agreed to the admission
- The patient has had a short time in which to make the arrangements

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Emergency Admissions

- One for which there was no planning
- Occur when sudden illness, injury, or abrupt worsening of an existing condition requires immediate treatment
- Stressful for the patient, close family, and friends

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Admission Process

- Admission criteria must be met for patients to be admitted to the hospital
- For routine admissions, these must be met in advance
- Criteria include the authorization for admission, which is usually handled by the physician’s office
- Criteria also may include laboratory tests or x-rays

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Preadmission Procedures and Requirements

- Authorization for admission
  - Most third-party payers require prior authorization for hospital admission
  - All payment programs and plans have criteria that define the services covered
  - Most plans do not cover procedures that are regarded as purely cosmetic

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Preadmission Procedures and Requirements (cont'd)

- Admitting department function
  - Responsible for making sure that all admission criteria are met
  - Collect the personal and insurance information and verify the authorization for admission
  - May be responsible for making payment arrangements on insurance deductibles and copays

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Preadmission Procedures and Requirements (cont'd)

- Laboratory work and x-ray examinations
  - Usually performed before admission
  - Includes laboratory tests, MRIs, bone scans, CT scans, and ECGs
  - May include donation of own blood for patients having surgery
  - Depends on the reason for admission

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Day of Admission: Orientation to Nursing Unit

- Smile, make eye contact, address patient by last name
- Show the location of the call bell and demonstrate its use
- Show the location of the bathroom and use of the emergency call bell next to the toilet
- Show patient how to operate the television and telephone
- Allow time to answer any questions about the admission or scheduled procedures
- Explain visiting hours
- Fill the water pitcher if patient is not NPO
- Give a printed handout of information if possible

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Day of Admission: Care of Patient Belongings

- Assist your patients to put belongings in the closet
- Encourage them to send home anything they don't need
- Valuables such as credit cards, money, or jewelry should be sent home
- Make a list of the medications, then send them home
- Notify the physician of any medications the patient is taking at home but that are not on admissions orders
- List all over-the-counter and herbal preparations that the patient is taking

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Day of Admission: Admission Assessment

- In acute care facilities, the assessment must be performed by an RN
- Assessment performed according to guidelines listed in the nursing policy and procedure manual
- Checklist may be allowed, but some form of narrative documentation is still required

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Day of Admission: Admission Assessment (cont'd)

- Level of consciousness
- Vital signs
- Respiratory effort/difficulty
- Ability to communicate
- Vision and hearing abilities or difficulties
- Condition of skin
- Prosthetic devices
- Other health concerns

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Charts: Preparing the Chart

- Most facilities have charts prepared in advance by unit clerks or clerical support
- Admission orders usually need to be transcribed, and laboratory requests, consent forms, and dietary requests need to be sent
- The nurse verifying the admission orders must check and verify the accuracy of each form before signing off the orders

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Charts: Admission Orders

- A line should be drawn across the order page just below the orders and signed with the licensed person’s name, time, and date
- Follow your facility's protocol for noting allergies
- Plan of care should be developed immediately following admission assessment

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Charts: Plan of Care

- Preparation of the written plan of care is part of the assessment
- Done by the nurse with input from all the members of the health care team
- The basis of the plan of care is the nursing process and nursing diagnosis

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Question 1

Tracy is admitting a new patient on her floor for a routine admission. A routine admission is best described as an admission:

1) with no prior planning.
2) for an injury.
3) that was scheduled in advance.
4) for a sudden illness.

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Question 2

Jessica is taking care of an outpatient surgical patient who is 70 years old and retired. She states, “I hope that my doctor’s office has gotten authorization for my surgery.” Because Jessica’s patient is 70 and retired, which health care plan does she most likely have?

1) Managed care plan
2) Medicaid
3) Medicare
4) Self-pay

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Chapter 23

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Learning Objectives

Theory

4) Discuss five types of information that must be included in the discharge form sent with a patient going to another facility.

5) Delineate the necessary information to include on a patient's discharge instructions when the patient is going directly home.

6) Explain the procedure for pronouncing and recording the patient's death.

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Learning Objectives

Clinical Practice

3) Assist with the transfer of a patient to another unit.

4) Use correct communication techniques to ensure safe handoff to another nurse, department, or facility.

5) Interact with the social worker regarding the discharge needs of an assigned patient.

6) Demonstrate appropriate interaction with the family of a patient who has died.

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Transfers

- When a patient is transferred, the physician should be notified immediately
- Transfer to another unit requires documentation of reason for transfer and patient's condition at the time of transfer
- Report given by the nurse caring for the patient on the transferring unit to the nurse on the unit accepting the patient

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Transfers (cont'd)

- Business office notified of the transfer; all patient belongings should be transferred with the patient
- Loss of belongings can occur during transfer
- Label all equipment brought to the hospital by the patient with tape and the patient's name in large letters
- Check drawers for glasses, hearing aids, and dentures

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Discharging a Patient

- Begins at admission
- Discharge planner makes appropriate discharge arrangements for the patient
- When discharge orders are received:
  - Assist as needed in notifying family or significant other
  - Collect patient belongings
  - Prepare patient for the ride home or to a new facility

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Discharge to an Extended Care or Rehabilitation Facility

- Patients may not be well enough to go directly home at the time of discharge
- RN completes a detailed patient information sheet for the receiving facility
- Any records to be transferred with the patient must be ready in an envelope before the transporting vehicle arrives

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Discharge Home

- Verify travel arrangements
- Prepare written discharge instructions; review with the patient and family members

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Home Health Care

- May include skilled nursing, such as wound care, diabetic care and teaching, and IV medication administration
- Physical, occupational, or speech therapy and respiratory care also often part of home care services, as well as personal care performed by a home health aide

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Discharge Against Medical Advice

- Make sure the patient understands the risk of leaving against medical advice (AMA)
- Offer to have the patient talk with the physician or supervising nurse
- Have the patient sign the AMA form
- If the patient refuses to sign the form, it should be documented in the nurse's notes

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Death of a Patient

- Patient must be pronounced dead by a physician
- Document the following in the nurse's notes:
  - Time that life signs ceased, time death was pronounced, and name of person making the official pronouncement
- Autopsies are required in most states for certain conditions or may be requested by the family
- Next of kin is required to sign permission for autopsy

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Death of a Patient (cont'd)

- Providing support for significant others
  - Often the most important gift we can give the bereaved is just being there
  - People need to grieve; it is an important step in healing
  - Offer to call priest, minister, rabbi, or spiritual advisor
  - Allow the family and friends adequate time at the bedside to say their goodbyes

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Death of a Patient (cont'd)

- Autopsies
  - Usually performed when the patient has died of unknown causes, has died at the hands of another, or has not been seen within a specific period of time by a physician
  - May also be performed when it is felt that information valuable to medical research may be obtained

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Organ Donation

- Organ donation may be requested by the patient
- Handled by physician or specially trained nurse
- When handled sensitively, requests can be an opportunity for the family to allow something good to come out of a personal tragedy
- Health care workers must be culturally aware regarding organ donation

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Question 3

Discharge plans are developed by members of the health care team to organize the discharge for the patient. When does the discharge plan begin?

1) On admission
2) Within 12 hours of admission
3) Within 24 hours of admission
4) The day before discharge

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Question 4

Which of the following is *not* a consideration when ordering home health care?

1) Reduced cost
2) Being in a familiar environment
3) Decreased exposure to potentially serious infection
4) Physician's convenience

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Question 5

When a patient wants to leave against medical advice (also known as AMA), it is important to:

1) calm him by saying you understand and that if it were you, you might do the same thing.
2) explain that if he leaves early all of his bills will be paid for the time he was in the hospital only.
3) have him wait until he can speak to his physician.
4) let him leave, try to obtain an AMA form, and document it in the chart.

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