Chapter 11

Admission, Transfer, and Discharge
Common Patient Reactions to Hospitalization

- Admission
  - Entry of a patient into the health care facility
- Health Care Facility
  - Any agency that provides health care
  - The patient is usually very concerned about health problems or potential health problems and the potential outcome of treatment.
  - The first contact with nurses and health care workers is important; anxiety and fears can be lessened and a positive attitude regarding the care to be received can be initiated.
Common Patient Reactions to Hospitalization

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

• HIPAA

• The nurse can anticipate some common reactions:
  - Fear of the unknown
  - Loss of identity
  - Disorientation
  - Separation anxiety
  - Loneliness
Common Patient Reactions to Hospitalization

• The nurse may help reduce the severity of common reactions:
  ▪ Have a warm, caring attitude and be courteous
  ▪ Show empathy
  ▪ Treat patients with respect
  ▪ Maintain their dignity
  ▪ Involve them in the plan of care
  ▪ Whenever possible, adjust hospital routine to meet their desires
Cultural Considerations for the Hospitalized Patient

• Secure an interpreter when needed.
• Respect the patient as an individual.
• Avoid treating these patients differently than other patients; “special” treatment may be interpreted as patronizing.
• Do not assume they are angry, aggressive, or hostile if they speak loudly or more emotionally than most patients.
• Use titles such as “Mr.” or “Mrs.”
Cultural Considerations for the Hospitalized Patient

- Never attempt to use ethnic dialects with patients.
- Avoid trying to impress patients by saying you have friends of the same racial background.
- Be attentive to the patient’s nonverbal communication.
- If you do not understand what a patient is saying, ask for clarification.
Admitting a Patient

- Admitting Department
  - Information usually includes
    - Name, address, telephone number
    - Age, birth date
    - Social security number
    - Next of kin
    - Insurance company, policy number
    - Place of employment
    - Physician’s name
    - Reason for admission
Admitting a Patient

- Admitting Department
  - ID band is prepared and put on patient’s wrist.
  - Information includes
    - Patient’s name
    - Age
    - Admitting number
    - Physician’s name
    - Room number
Admitting a Patient

- Telephone Admission
  - The day before a planned admission, a clerk from the admitting office calls the patient at home and gathers all the information needed to begin the records.
  - Instructions are given regarding time to arrive at the hospital, items to bring to the hospital, and things that should not be brought to the hospital (jewelry and large sums of money).
Admitting a Patient

• Emergency Department
  ▪ People brought to the emergency department may be admitted directly to a patient care room or a special care unit, intensive care unit, coronary care unit, or burn unit.
  ▪ A family member goes to the admitting office to provide the necessary information.
Admitting a Patient

• When the unit staff are notified that a new patient is being escorted to a room, the room should be made ready. The room should be
  ▪ Clean and neat
  ▪ Of appropriate temperature
  ▪ Have personal care items in place
• Any special equipment should be placed and ready when the patient arrives.
Admitting a Patient

• Greeting the patient by name and making the patient feel welcome is one of the most important aspects of the admission procedure.

• Regardless of the time or activity occurring on the unit, the nurse should be courteous to, interested in, and receptive of the new patient.

• The new patient should be given an orientation to the unit and the room.
Admitting a Patient

- The hospital routine should be explained:
  - When meals are served
  - When family and friends may visit
  - When laboratory or diagnostic imaging evaluations are scheduled
  - When the physician usually makes rounds
  - Policy on use of side rails
  - Many hospitals have booklets for the patient that explain these routine activities.
Admitting a Patient

- Admitting Procedure on the Patient Care Unit
  - Check the ID band and verify the information with the patient.
  - Assess immediate needs such as pain, shortness of breath, or severe anxiety.
  - Introduce roommate, if one is present.
Admitting a Patient

- Admitting Procedure on the Patient Care Unit (continued)
  - Jewelry, money, and medications should be given to the family to take home.
  - If no family is present
    - Valuables must be put in the hospital safe. Follow the hospital policy.
    - Some facilities require all medications brought in by the patient be sent to the pharmacy to be identified; they are then returned to the patient upon dismissal.
Admitting a Patient

- The patient is usually asked to put on pajamas or hospital gown; the nurse may need to help the patient change clothes.
- Clothing should be inventoried along with other personal items the patient uses.
- Jewelry and money kept in the room must be recorded.
Admitting a Patient

• Once the patient is established in the room, the nurse should
  ▪ Take the health history
  ▪ Perform the initial assessment
    • Admission assessment must be prepared by a registered nurse.
    • Aspects of the data collection may then be delegated by the RN to the LPN/LVN.
  ▪ The physician is notified when the patient has been admitted.
Transferring a Patient

- The changing condition of a patient, whether improved or more critical, may require transfer either to another unit in the hospital or to another health care institution, such as a nursing home or rehabilitation hospital.
Transferring a Patient

• The patient transfer requires thorough preparation and careful documentation.
  
  **Preparation**
  
  • Explain transfer to patient and family; discuss the patient’s condition and plan of care with the staff of the receiving unit or facility; arrangements for transportation.

  **Documentation of the patient’s condition before and during transfer and adequate communication among nursing staff ensures continuity of care.**
Discharge Planning

• Systematic process of planning for patient care after discharge from the hospital.
• Although discharge from a health care facility is usually considered routine, effective discharge requires careful planning and continuing assessment of the patient’s needs during hospitalization.
Discharge Planning

- Ideally, discharge planning begins shortly after admission.
  - Teach the patient and family about the patient’s illness and its effect on his or her lifestyle.
  - Provide instructions for home care.
  - Communicate dietary or activity instructions.
  - Explain the purpose, adverse effects, and scheduling of medication treatment.
  - Planning can include arranging transportation.
  - Follow-up care may be necessary.
  - Coordinate outpatient or home care services.
Discharge Planning

- Risk factors should be identified.
  - Older adults
  - Multisystem disease processes
  - Major surgical procedure
  - Chronic or terminal disease
Discharge Planning

- Discharge planning involves multidisciplinary action with participation by all members of the health care team, the patient, and the patient’s family.
- Many larger hospitals have discharge planners or coordinators; they orchestrate the discharge planning.
Discharge Planning

• Transitional Care
  • Another approach to discharge planning using transition specialists
    • Transitional specialists begin discharge planning and usually makes a home visit before the patient is discharged.
    • Following discharge to the home, this specialist is available to patient and family.
    • It has proved to be cost-effective and has improved the quality of care.
Discharge Planning

• Communication among the patient, family, and health agencies is essential for effective discharge planning.

• Discharge Summary
  ▪ Includes patient’s learning needs, how well they were met, the patient teaching completed, short- and long-term goals of care, referrals made, and coordinate care plan to be implemented after discharge
A patient may require the services of various disciplines within a hospital. The nurse is often the first to recognize the patient’s needs. Referrals should be made as soon as possible after the patient’s need is identified. In many agencies, a physician’s order is needed for a referral.
Referrals for Health Care Services

• Various Health Disciplines
  ▪ Dietitian
  ▪ Social worker
  ▪ Physical therapist
  ▪ Occupational therapist
  ▪ Speech therapist
  ▪ Clinical nurse specialist
  ▪ Home health care nurse
Discharging a Patient

• Many hospitals have a form with written instructions and teaching documentation for the patient to sign and acknowledge understanding of the instructions.
• These instructions serve as a guide for the patient to use at home.
Discharging a Patient

- Discharge: Against Medical Advice (AMA)
  - This is when a patient leaves a health care facility without a physician's order for discharge.
  - Notify the physician immediately.
  - If the physician fails to convince the patient to remain in the facility, the physician will ask the patient to sign an AMA form, releasing the facility from legal responsibility for any medical problems the patient may experience after discharge.
  - Do not detain the patient; this violates his or her legal rights.