Admission, Transfer, Referrals , and Discharge

Patients Admission Process:

An entering to the health care agency for nursing care and medical or surgical treatment to meet patients' healthcare needs. During the admission process, nurses provide a holistic care and establish the basis for how patients will respond to and evaluate the remainder of their stay.

Admission process (Admission requirement) involves:

1. Authorization from a physician that the person requires specialized care and treatment.
2. Collection of information by the admitting department of the health care agency.
3. Completion of the agency's admission data base by nursing personnel.
4. Documentation of medical history and findings from physical examination.
5. Development of an initial nursing care plan.
6. Initial medical orders for treatment.

Nursing Admission Activities:

a. Preparing the client's room.
b. Welcoming the client.
c. Orienting the client.
d. Safeguarding valuables and clothing.
e. Helping the client undress.
f. Compiling the nursing data base.

Psychosocial Responses on Admission:

a. Anxiety and fear.
b. Decisional conflict.
c. Situational low self-esteem.
d. Powerlessness.
e. Social isolation.
f. Risk for ineffective therapeutic regimen management.

Factors effects on admission psychosocial responses:

1. Every patient admitted to a healthcare facility is nervous, even if it is not a first admission. This condition as a result of:
   a. The strange surroundings.
   b. The busy nursing staff.
   c. The sight of other patients may add to the patient's feelings of helplessness.

2. Whether temporary or permanent, admission to a healthcare facility causes many changes in their lifestyle.
   a. Confusion and disorientation often occur when patients are first admitted because they have left friends, family, and everything familiar behind.
   b. They may feel they no longer have control over their lives.
   c. They may be physically powerless and almost completely dependent on strangers for everyday care.

Preparing the patient's room:

1. Before a patient is admitted, make sure the room is ready for his/her arrival.
   a. Check necessary equipment, admission check list, Pen or pencil.
   b. Gown or nightdress (if the patient is to be put to bed).
   c. Portable scale, thermometer, sphygmomanometer, and stethoscope.
2. Make sure there is adequate light and proper ventilation.
3. Open the bed for patients by fan-folding the covers back, and attach the signal cord within easy reach.
4. Ensure patient supplies and equipment are present.
   a. Wash basin, emesis basin, soap, towels, and lotion.
   b. Bedpan and cover.
   c. Urinal for male patients.
   d. Other equipment may be brought to the unit to meet the needs of a particular patient. For example, one patient may need an over bed trapeze, or an intravenous pole.
5. Make a final survey of the room to be sure it is clean, neat and orderly.

Greeting the Patient:

1. In some healthcare facilities, the patient is taken directly to the room, where the actual admission process begins.
2. Most larger facilities, start the admission process in the admitting office.
   a. a preliminary interview of the patient is done to obtain the necessary medical and financial information.
   b. It is important for the family to remain with the patient for this interview.
   c. If an ID bracelet is used, it may be placed on the patient's wrist at this time.
3. The patient's first impression of the facility will depend on how he/she is greeted.
   a. Greet each patient in a friendly, cheerful manner.
   b. Introduce yourself, and take the patient to their room.
   c. Introduce the patient to other patients in the room.

The Admission Procedure:

1. Help the patient become familiar with the new surroundings.
   a. Explain the facility's policy on visitors, the procedure for mail, and the use of the television, telephone, and automatic bed controls.
   b. Demonstrate how to tell the patient when meals are served.
   c. Answer any questions he/she has about daily routine.
2. Ask the patient to put on a hospital gown.
3. Assess the patient's general physical condition, appearance, and behavior as the admission process is continued.
4. Record vital signs.
5. Ask about previous hospitalizations, allergies, or diseases other than the one for which the patient is being admitted.
6. Record all information and observations on the admissions checklist.
7. Make the patient comfortable.
8. Storage Space:
   a. Show the patient where supplies and equipment are located in the bedside stand.
   b. Valuables should be placed in an envelope-properly labeled with the patient's name, room, date, and a complete description of the articles included and record in the patient's chart.

Record the admission data:

- **a.** Complete the admission checklist.
- **b.** Fill in the date and time of admission.
- **c.** Method of admission - the way the patient came into the room (wheelchair, ambulatory, **or** stretcher).
- **d.** Observations or unusual conditions noted.
- **e.** Chief complaint of the patient.
- **f.** Be brief but complete, and write *legibly.*

Transferring the Patient: Transfer a client from one unit and admitting him or her to another unit without going home in the interim.

Patient may be transferred from one room to another within the healthcare facility for several reasons:

1. Sometimes the transfer is made at the patient's request:
   a. Type of room (such as a private room).
   b. Personal reasons, such as to find a more compatible roommate.
2. Transfer is made at the medical staff request:

a. The physician may request the patient be transferred from one level of nursing care to another because of a change in the patient's condition that might require more or less specialized care.
b. Sometimes the nursing staff will transfer a patient closer to the nursing station where the patient's condition can be supervised more closely.
c. If the room location or equipment in the room is needed for a more critically ill patient.

Steps involved in patient's transfer:

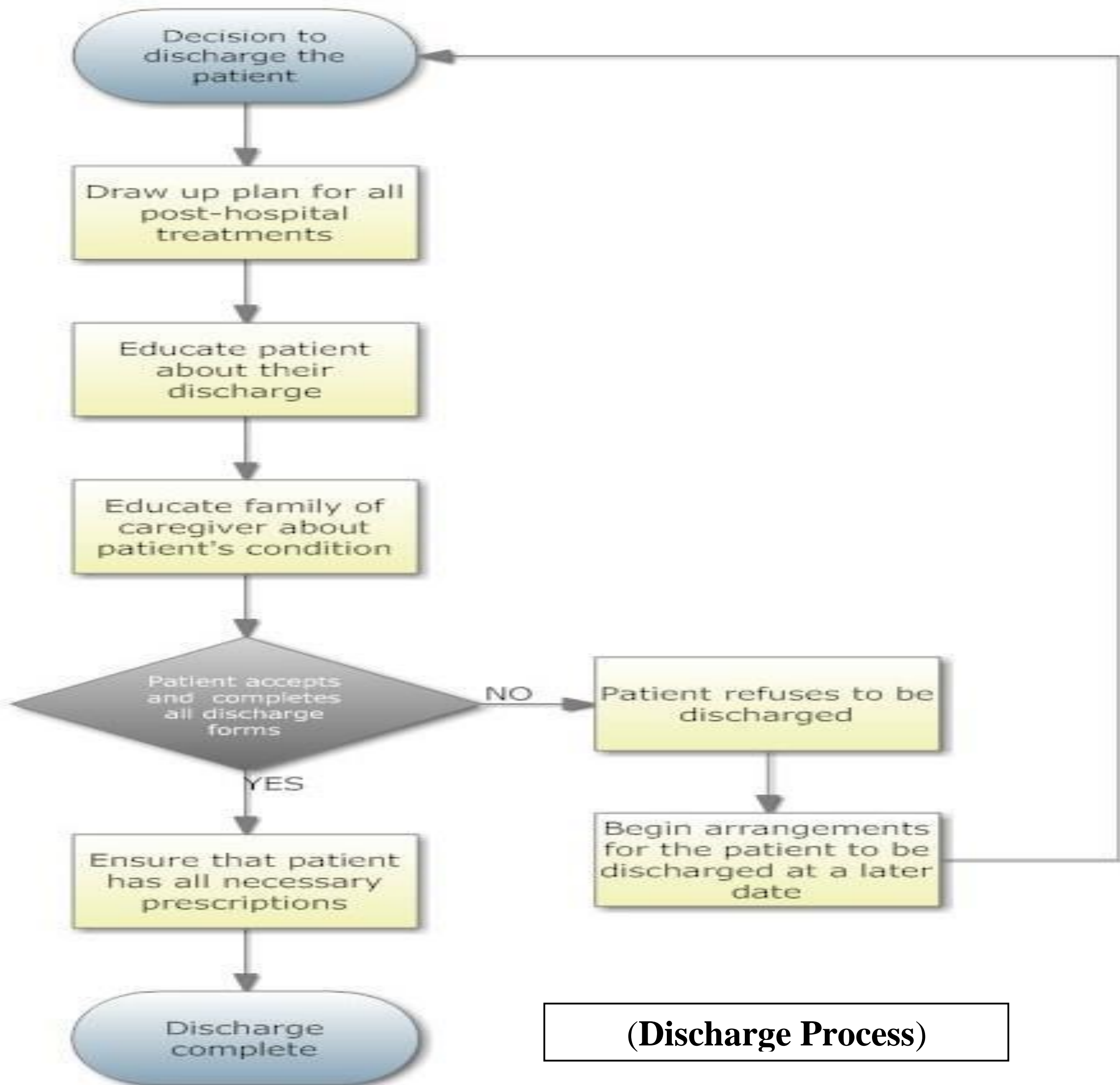
- **a.** Informing client and family about the transfer.
- **b.** Completing a transfer summary.
- **c.** Speaking with a nurse on the transfer unit to coordinate the transfer.
- **d.** Transporting the client and his or her belongings, medications, nursing supplies, and chart to the other unit.
- **e.** The nurse will post the transfer on the patient's chart include: (Time of transfer, room numbers transferred from and to, reason for the transfer, patient's attitude toward the move should also be charted).

Patient's Referral Process: A referral is the process of sending someone to another person or agency for special services. Referrals generally are made to private practitioners or community agencies.

Referral summaries usually include some or all of the following:

1. Client's physical, mental, and emotional status at referral.
2. Resolved health problems and continuing care for unresolved problems.
3. Treatment such as wound care and current medications.
4. Restrictions that relate to activity, diet, and bathing.
5. Functional/self-care abilities (vision, hearing, speech, mobility).

Patient's Discharge Process: Discharge is the termination of care from a health care agency. Discharge planning actually begins on admission, when information about the patient is collected and documented.



(Discharge Process)

Steps of patient's discharge:

1. Discharge planning.
   a. Assessing and identifying health care needs.
   b. Setting goals with the patient.
   c. Important teaching topics about self-care at home must be covered before discharge.
   d. Meeting eligibility requirements for home health care.
2. Obtaining a written medical order.
3. Completing discharge instructions.
4. Helping the client leave the agency.

5. Writing a summary of the client's condition at discharge.
6. Requesting that the room be cleaned.

Planning for the Patient's Discharge:

The patient, the family, the medical and nursing staff, and other personnel working in the facility (such as the social worker and dietician) work together to coordinate the patient's discharge.

1. The doctor plans the discharge with the patient and leaves a written order on the patient's chart.
2. The nurse:
   a. Makes sure the discharge order has been written by the doctor.
   b. Make the necessary arrangements with other departments to prepare for the patient's discharge.
   c. Make sure the patient has been given instructions by the doctor for home care and understands the instructions about: (taking medications, exercise programs, Physical therapy, changing dressings, giving injections, and respiratory treatments that will be continued at home).
   d. If possible, the nurse will give the patient a written copy of the instructions, such as a copy of the diet or an appointment card for a return visit.
3. The family must be notified of the patient's discharge time so they can make arrangements for transportation.

The patient who is not yet ready to care for himself/herself at home may be discharged from a hospital to an extended care facility. When the patient's condition indicates the need for long-term nursing care, he/she may be discharged directly to a residential facility.

Chart the Patient's Discharge:

1. Always check with the nursing supervisor to be sure the patient has officially been discharged.
2. The following information should be charted:
   a. Date and time of discharge.
   b. The way the patient left the healthcare facility.
   c. Special instructions, diet, or medications the patient is to continue after discharge.
   d. A notation should also be made on the chart that the patient's personal belongings were sent with the patient.