ADMITTING A PATIENT & DISCHARGE FROM HOSPITAL

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- Approximately Total Number of Admissions: 84,000
- 70% ward in-patients admissions
- 30% Day Cases
- 39% A&E, Out-Patients
- 48% Males/ 52% Females 35% 60 years or >
- Mean length of stay is 4.5 days
- 154 admissions/day
- 1508 deaths
- 52,000 in-patient discharges
Facts

• **Increase** in costs means decrease in hospital stay, therefore more **instabilities**, more care.

• Admissions to the hospital can be **traumatic**.

• A person in a hospital loses identity, independence and control of daily activities
• Going home after discharge can also be traumatic.
• Establishment and maintenance of continuity in the delivery of care are the responsibility of the nurse.
ADMITTING THE PATIENT

- Nurse acts not only as a practitioner but also as a person concerned about welfare of client and family.
- Obtain information for computer
- Identification Band/Allergy Band
- Preparation of room/Equipment
• Greetings to client/relatives. Casual discussion. Call client by name. Client feels less frightened.
• Introduce yourself
• Explain use of bathroom, equipment, personal items, routines, meal times, visiting hours etc
• Adjust nurse call system. Reduces accidents
• Weight on scale, T, P, R, BP.
• Provide privacy. Shows respect and interest.
• Help client to undress and wear hospital gown: relatives may help.
• Transfer to bed/Comfortable position in bed. Side-rails.
• Take care of client’s clothing and valuables. Upsetting if lost/ legal problems. Inventory of belongings.
• Encourage family to take home valuable items. If that is not possible, arrange to have valuables placed in the hospital safe.
• Explain to client what will happen and what to expect. This will decrease some anxiety. Answer all questions.
• Recording on client’s record, prepares nursing history. (Nursing admission assessment). Client may divulge information after the family has left.
• Care Plans/clinical pathways to be followed and co-coordinated from admission to discharge.
DISCHARGE PLANNING

• Discharge planning must be co-ordinated, inter-disciplinary, initiated as early as possible, and carefully planned.

• Clients and their families are expected to adhere to complicated, highly technical treatment plans.

• The key to successful discharge planning is an exchange of information among the client, present caregivers and those responsible for care after release.
• The ultimate goal in assisting the client and family is the achievement of an optimal level of wellness, which will guarantee continuity of care in the least stressful manner.

• Check that the patient actually knows about the discharge from hospital.

• Time of discharge
• Check client has discharge order in patient’s notes. (Physician's responsibility)
• Check client or support person has discharge letter/ instructions.
• Check all necessary equipment and supplies ready for the client
• Settle finances (foreigners), valuables etc.
• Assist client to dress and pack.
• Arrange for transportation. Notify relatives or carers. Parking.
• Wheelchair/ Stretcher/Ambulance
• Make necessary recordings on client’s records (Nursing reports/Discharge planning).
• **METHOD** Discharge Planning:
• **Medication**-Drug name, dose, purpose, effects, adverse reactions

• **Environment**-homemaking skills, physical hazards, emotional support, economic support, transportation

• **Treatment**-Purpose of treatment to be continued at home, correct performance of treatment
• **Health Teaching**-Describe how condition affects body function, describe the means necessary to maintain present level of health.

• **Outpatient Referral**-When and where, whom to call for medical help, take home written discharge instructions.

• **Diet**-Purpose, plan several menus.
SPECIAL CONSIDERATIONS

• Discharge at Request-proper form. Client may refuse to sign, therefore document explanation to client and notify physician.
• Transfer to Psychiatric Institution-proper Mental Health Act forms. If discharged at request immediate relative to take full responsibility.
• Discharge to no fixed address- Client is homeless. Involve Social Workers or 179.

• Discharge of ‘Police Case’. Notify PC informed on day of admission at Casualty.

• Client/Carer refusing discharge- ‘problematic discharges’ leading to ‘social cases’.
Documentation Guidelines related to Nursing Observation Flow Sheet

General guidelines

✓ Insert initials in spaces provided when taking vital observations; taking HGT & administering IVs. - *For example*: R.S.; C.G.
✓ Use blue or black ink only when completing up flowsheet.
✓ Round the time to the hour. - *For example*: the blood pressure was taken at 15.55, then 16.00 is to be documented.
✓ Insert daily weight when required in space provided rather than on a separate sheet.
• Use the 24 hour format throughout

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</table>
Vital observation documentation

✓ Use continuous line in BP documentation rather than dotted.

✓ Join “temperature” and “pulse” points to visualise a trend rather than single points.

✓ Do not write words such as “axillary”, “orally”, “paracetamol given” etc. on vital observations section.

✓ Do not insert numerical systolic and diastolic values; only a graphical presentation is expected.

✓ Temperature is to be measured only in degree Celsius.
Blood Pressure Recording

• For accuracy wait 1-5 mins before re-inflating the cuff. Clean stethoscope.
• Take BP when patient appears rested.
• Remove constricting clothing
• Position arm so that anticubital fold is at level with heart
• Cuff size accurate and over brachial artery, 2cm above fold
• Palpate radial pulse, inflate cuff until pulse disappears. This is the Systolic BP.
• Place stethoscope over over brachial artery.
• Inflate cuff 30mmHg over estimated systolic.
• Release pressure slowly
• Read at eye level
Temperature Measurement Sites

- **Tympanic** – External ear canal with gentle pressure for two seconds \((37^\circ\text{C} \pm 1^\circ\text{C})\).
- **Oral** – Under tongue in posterior lateral sublingual pocket for two minutes \((37^\circ\text{C} \pm 1^\circ\text{C})\).
- **Rectal** – Insert tip into anus toward umbilicus to a depth of 1.5cm for two minutes \((37.6^\circ\text{C} \pm 1^\circ\text{C})\).
- **Axillary** – Centre of axilla and firmly hold arm against side for five minutes \((36.4^\circ\text{C} \pm 1^\circ\text{C})\).
Body Temperature

• Body Temperature is at its lowest level between 1am and 4am (Torrence 1999) and highest peak between 5pm and 8pm (Toms 1993)
• Take temperatures readings at the same time each day and between 5 to 8pm.
• Routine measurement of TPR to all patients is unnecessary.
• Hot drinks may raise the temperature by 1 degree whilst ice cold drinks may reduce the temperature by 3 degrees. These may persist for 15 mins. (Closs 1987).
BGM

- Non-sterile gloves.
- Patient to wash hands with soap and water. NO ALCOHOL.
- Prick side of 4th finger tip with lancet or device.
- Code of meter must correlate with strips.
- Sharps.
- Document results and report findings immediately.
Intake-output documentation

✓ The rate of the regime is expected to be written alongside the regime:
   • Example:
     The patient is to be administered 1 litre of 5% dextrose at 8 hourly rate. Hence, regime is written 1 litre 5% dextrose 8 hourly (125 ml/hr).

✓ The best time to close the intake-output balance should be agreed and be consistent:
   • Example:
     00:00hrs, 06:00hrs or 08:00hrs.