

Admission, Transfer, and Discharge of a Patient

Course

Health Science

Unit XI

Occupationally
Specific
Knowledge and
Skills

Essential Question

How do health
care skills help
to promote
health and
prevent
disease?

TEKS

130.204 (c) 1B,
1D, 5A, 5B, 8E,
8I

Prior Student Learning

Basic
communication
skills.

Estimated time

1.5-3 hours

Rationale

There are many things to consider when admitting or discharging a patient in a health care facility.

Objectives

Upon completion of this lesson, the student will be able to:

- Recognize and demonstrate established procedures for admitting transferring and discharging a patient at a healthcare facility
- Assess the importance of observing the patient's general physical condition, appearance, and behavior
- Communicate what information must be documented concerning the admission, transfer, or discharge of a patient

Engage

Introduce the lesson by reading the information regarding patient, James Willmark, found at the end of the lesson. Explain that students will be learning the established procedures and rationale for them demonstrated in that scenario.

Key Points

- I. Helping Patients Adjust to the Healthcare Facility
 - A. Every patient admitted to a healthcare facility is nervous, even if it is not a first admission.
 1. The strange surroundings
 2. the busy nursing staff
 3. the sight of other patients may add to the patient's feelings of helplessness.
 4. If this is a first admission, the patient will not know what to expect.
 - B. Admission to a healthcare facility
 1. temporary - patients are hospitalized for surgery or treatment of an acute illness
 2. permanent - patients are no longer able to take care of themselves.
 3. 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.

II. Preparing the Patient's Room

- A. Before a patient is admitted, make sure the room is ready for his/her arrival
 - 1. Check necessary equipment
 - a. admission checklist
 - b. pen or pencil
 - c. gown or pajamas (if the patient is to be put to bed)
 - d. portable scale
 - e. thermometer
 - f. sphygmomanometer
 - g. stethoscope
 - h. envelope for the patient's valuables
 - 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. Washbasin
 - b. emesis basin
 - c. soap
 - d. towels
 - e. lotion
 - f. bedpan and cover
 - g. urinal for male patients.
 - h. other equipment may be brought to the unit to meet the needs of a particular patient. For example, one patient may need an overbed trapeze, or an intravenous pole.
 - 5. Make a final survey of the room to be sure it is clean, neat and orderly.

III. Greeting the Patient

- A. Admission procedures depend on the policy of the healthcare facility
- B. In some healthcare facilities, the patient is taken directly to the room, where the actual admission process begins.
- C. Most larger facilities, however, start the admission process in the admitting office.
 - 1. a preliminary interview of the patient is done to obtain the necessary medical and financial information.
 - 2. It is important for the family to remain with the patient for this interview.
 - 3. If an ID bracelet is used, it may be placed on the patient's wrist at this time.
- D. The patient's first impression of the facility will depend on how he/she is greeted.
 - 1. Greet each patient in a friendly, cheerful manner.
 - 2. Introduce yourself, and take the patient to their room.
 - 3. If the patient has a friend or relative with him/her, invite them to

accompany you to the room.

4. Introduce the patient to other patients in the room.

IV. The Admission Procedure

A. Help the patient become familiar with the new surroundings.

1. Explain the facility's policy on visitors, the procedure for mail, and the use of the television and telephone.
2. Demonstrate how to use
 - a. intercom and signal cord system
 - b. remote-control television
 - c. automatic bed controls
3. Tell the patient when meals are served
4. answer any questions he/she has about daily routine.

B. Storage Space

1. Show the patient where supplies and equipment are located in the bedside stand.
2. Have the patient put personal articles and other small belongings in the drawer of the bedside stand where they can be reached easily.
3. Depending on the procedure used in the healthcare facility, the patient may be allowed to keep his/her clothes and suitcase in the room, or the family may be asked to take them home and return them when the patient is discharged.
4. In a healthcare facility, the patient's clothing and other belongings will be marked with the patient's name and room number.
 - a. Make a list of the clothing, have the patient or a member of the family sign the list, and give it to the nursing supervisor to include in the patient's chart.
 - b. If the patient has brought valuables, suggest that a relative take them home.

(1) valuables should be placed in an envelope—properly labeled with the patient's name, room, date, and a complete description of the articles included.

(2) The list of valuables should also be given to the nursing supervisor to record in the patient's chart.

(3) The envelope will be kept in a safe until the patient is ready to go home.

C. Screen or curtain off the bed or close the door to a private room.

1. Ask the patient to put on a hospital gown, or a gown or pajamas brought from home.
2. Assist the patient as needed.
3. If the patient wants a family member to be present, invite the person in.

D. Assess the patient's general physical condition, appearance, and

behavior as the admission process is continued.

1. Observe the patient for unusual conditions
 - a. cuts or bruises
 - b. loss of function
 - c. signs of weakness
 - d. any prosthesis
 - e. other physical complaints the patient may have.
- E. Record vital signs
- F. Ask about previous hospitalizations, allergies, or diseases other than the one for which the patient is being admitted.
- G. Record all information and observations on the admissions checklist.
- H. Records taken during admission should be thorough with as much pertinent information about the patient as possible.
- I. In acute care hospitals, the patient must provide a urine specimen.
 1. Assist the patient to the bathroom, or offer the bedpan or urinal as needed.
 2. Pour the urine specimen from the bedpan or urinal to the specimen bottle, and replace the cap.
 3. Label the specimen with the patient's name, doctor's name, and room number, and send it to the laboratory along with the requisition for the admission urine test.
 4. Always wash your hands after handling urine specimens.
- J. Make the patient comfortable.
 1. If the patient is ambulatory, he/she may wish to sit up and visit with family members.
 2. In an acute care hospital, the patient is put to bed.
 - a. Raise the side rails if the nursing supervisor orders it—side rails may be needed if the patient cannot or should not get out of bed unassisted, or if the patient's bed is not in the lowest position.
 - b. Give the patient water if it is allowed.
 - c. Make sure the patient can reach the signal cord and anything else he/she might need while you are not in the room.
 - d. Remove the screen or curtains surrounding the patient, or open the door so others will know you are finished.
 - e. Tell family members they may return to the patient's room.
 3. If the patient is unconscious or unable to answer the admission questions
 - a. have a family member help you with the information needed on the admission checklist.
 - b. Get as much information as you can about the patient.
- K. Always be courteous and helpful to the patient and the patient's family.
 1. Don't rush the patient through the admission process.

2. Allow the patient time to get acquainted with you and the healthcare setting.
 3. Create an atmosphere of warmth and understanding for the patient and the patient's family.
- V. 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
 1. wheelchair
 2. ambulatory
 3. stretcher
 - D. observations or unusual conditions noted
 - E. chief complaint of the patient
 - F. Be brief but complete, and write *legibly*
- VI. Transferring the Patient
- A. A 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. a different type of room (such as a private room)
 - b. a transfer for personal reasons, such as to find a more compatible roommate
 2. medical staff may request it.
 - 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.
 - (1) the patient may be moved into intensive care when his/her condition becomes more critical
 - (2) transferred onto a regular medical floor when his/her condition improves.
 - 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. The patient may also be transferred if the room location or equipment in the room is needed for a more critically ill patient.
 - B. If the patient did not ask to be transferred, he/she may be upset, especially if the patient does not understand the reason for the transfer.
 - C. Responsibilities
 1. make sure all the patient's belongings are transferred with him/her
 - a. Collect the belongings and any equipment that will be moved
 - b. Check with the nursing supervisor before moving any equipment to another floor

- c. Check drawers, closets, tables, windowsills, the bathroom, and the bed covers for articles that might be forgotten
 2. The nurse will collect the patient's chart and medicines.
 3. The ward clerk will make the necessary changes in the patient's records, billing charges, and other forms.
 4. You or the nurse will post the transfer on the patient's chart.
 - a. include the time
 - b. room numbers transferred from and to
 - c. the reason for the transfer
 - d. The patient's attitude toward the move should also be charted.
- D. Moving the Patient
 1. Before moving the patient, make sure the new room or floor is ready to receive the patient.
 2. If the patient is moved in the bed, personal belongings can be placed on the bed.
 3. The patient should be in a comfortable position with the side rails raised.
 4. If the patient is moved by stretcher or wheelchair, move the patient first. Then move the patient's belongings on a cart.
- E. To prevent falls, never leave the patient alone in the hallway when you are transferring him/her to another floor.
- F. When the patient arrives at the new room
 1. introduce the patient to the personnel who will be caring for them and their new roommates
 2. Orient the patient to the new room
 3. Assist the patient into the bed or a comfortable chair, attach the signal cord within easy reach, and make sure the patient is comfortable before leaving.
- G. After transferring the patient in the new unit
 1. return any wheelchair or stretcher used to transport the patient to the proper place
 2. clean the patient's room
 3. Report to the nursing supervisor when the room is ready for another patient.
- VII. Planning for the Patient's Discharge
 - A. There are many things to consider when planning for the patient's discharge.
 1. If the illness has not been long, complicated, or severe, no special preparation is made other than general health instructions and information concerning the actual discharge (such as the time and date the patient will be discharged).
 2. For other patients, the discharge process is more complicated.
 3. The patient's attitude towards discharge and continued progress toward recovery must be considered.
 - B. If being discharged to home, the patient may need reassurance

that recovery will continue at home.

1. The patient may be concerned about being able to manage for himself/herself.
 2. These worries may keep the patient from looking forward to leaving the healthcare facility.
 3. The patient may wonder what kinds of treatment, if any, will be needed at home and how it will be done.
 4. Provisions for special nursing care, such as provided by visiting nurses, may be needed for the patient who is unable to manage his/her own hygiene and personal care.
 5. An important consideration may be whether help will be required for meals, grocery shopping, etc., for a patient living alone and how long such help will be needed.
- C. Planning for the patient's discharge involves the entire healthcare team.
1. 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.
 2. The doctor plans the discharge with the patient and leaves a written order on the patient's chart.
 3. The nurse
 - a. The nurse makes sure the discharge order has been written by the doctor.
 - b. The nurse will then make the necessary arrangements with other departments to prepare for the patient's discharge.
 - c. The nurse will also make sure the patient has been given instructions by the doctor for home care and understands the instructions.
 - (1) taking medications
 - (2) exercise programs
 - (3) physical therapy
 - (4) changing dressings
 - (5) giving injections
 - (6) 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 to the doctor
 4. The family must be notified of the patient's discharge time so they can make arrangements for transportation.
- D. Patient care does not end when the patient is discharged.
1. The patient may receive visits from a home health agency to supervise the care and treatment.
 2. The patient's home care should make use of existing community resources so the patient and the family will not have to undertake the financial and emotional burden of

extensive home nursing care alone.

E. 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.

F. When the patient's condition indicates the need for long-term nursing care, he/she may be discharged directly to a residential facility.

VIII. The Procedure for Discharge

A. Always check with the nursing supervisor to be sure the patient has officially been discharged by the doctor.

1. Sometimes the doctor will discharge the patient on the day the order is written.

2. Other times the patient will know several days before.

B. On the day the patient is to be discharged

1. check when the patient will be leaving

2. Set up a schedule for the patient's care so that the patient does not become too tired.

3. Allow for a rest period between the bath and packing

4. Make sure the patient is ready when family members arrive

5. As you help the patient with her/his care, make sure the instructions are understood about home care and follow-up visits.

6. Have the nurse answer any questions the patient has.

C. Ask a family member to check with the business office - this person will be given a release paper stating financial matters for the patient have been taken care of and the patient is ready for discharge.

D. Help the patient into a wheelchair, and wheel him/her to the entrance of the healthcare facility nearest the car.

1. Ask the family to drive up to the entrance.

2. To avoid injuries, do not leave the patient unattended until the family members have arrived with their car, and help the patient into the car.

3. Make sure all the patient's belongings are put in the car.

4. Say goodbye and wish the patient well.

5. Return the wheelchair to its proper place.

6. Your final responsibility is the terminal cleaning of the patient's unit.

IX. Chart the Patient's Discharge

A. The following information should be charted

1. the date and time the patient was discharged

2. the way the patient left the healthcare facility

3. any special instructions, diet, or medications the patient is to continue after discharge.

4. A notation should also be made on the chart that the patient's personal belongings were sent with the patient.

Activity

- I. Complete Admission Checklist
- II. Role Play Admission, Transfer and Discharge Situations

Assessment

Admission, Transfer, Discharge Test

Materials

Admission, Transfer, Discharge Test – KEY
Admission Checklist

Accommodations for Learning Differences

For reinforcement, the student will complete Admission, Transfer and Discharge.

For enrichment, the student will shadow a patient as they go through the process of being admitted, transferred or discharged.

National and State Education Standards

HLC 10.01 Technical Skills

Healthcare workers will apply technical skills required for all career specialties. They will demonstrate skills and knowledge as appropriate.

TEKS

130.204 (c)(1)(B) communicate using medical terminology;

130.204 (c)(1)(D) interpret complex technical material related to the health science industry.

130.204 (c)(5)(A) describe document formats;

130.204 (c)(5)(B) compile and record data according to regulatory agency policy.

130.204 (c)(8)(E) perform admission, discharge, and transfer functions in a simulated setting;

130.204 (c)(8)(I) perform skills specific to a health science professional such as medical assistant, dental assistant, emergency medical technician-basic, phlebotomy technician, and pharmacy technician.

Texas College and Career Readiness Standards

English Language Arts

II. B. Understand new vocabulary and concepts and use them accurately in reading writing and speaking.

III. B. Develop effective speaking styles for both group and one on one situations.

IV. A. Apply listening skills as an individual and as a member of a group in a variety of settings.

Admission, Transfer, and Discharge of the Patient

Fill Out an Admission Checklist

Directions: Using the information below, fill in the admission checklist.

The patient is James Willmark, a 70-year-old, who injured his leg yesterday. This is not his first hospitalization. He was admitted to Room 116 at 4:30 p.m. on Friday, January 12, 2006. The unit and equipment were ready to receive the patient. The identification bracelet was checked, and the bed tag was prepared. The patient did not need help to get undressed. He is now in bed with the side rails down. The patient is allergic to chocolate and aspirin. You take the following vital signs: T-98.8, R-20, P-88, Wt. 175 lbs., Ht. 5-11, BP-130/90. The patient gave information about height and weight. An admission urine specimen was not yet collected. The patient wears dentures and a contact lens in his right eye as a result of cataract surgery. He has a watch and \$20.00 he gave to you. He arrived by stretcher, complained of severe pain in his right leg, and told you he took two pain pills before he left home. He brought two more pain pills with him, which have been given to nursing supervisor, Tony Smale. You notice that he has large bruises and several small cuts on his right leg, and the foot and leg are badly swollen. He is not hard of hearing and has no artificial limb or brace. The signal cord is attached to the bed. The patient was given a water pitcher on arrival in his room.

GOOD HEALTH HOSPITAL ADMISSION CHECKLIST

Patient's name _____ Room number _____

Time of admission _____ a.m./p.m. Date of admission _____

Unit ready to receive patient? Yes _____ No _____ Equipment ready? Yes _____ No _____

Admitted by stretcher _____ wheelchair _____ walking _____

Check identification bracelet? Yes _____ No _____ Bed tag in place? Yes _____ No _____

Did the patient need help to get undressed? Yes _____ No _____

Is the patient in bed at this time? Yes _____ No _____ Time _____

Side rails up? Yes _____ No _____

Bruises, marks, rashes, or broken skin noted? Yes _____ No _____

If yes, describe _____

Weight _____ Height _____ Scale used? Yes _____ No _____

Temperature _____ Pulse _____ Respiration _____ Blood Pressure _____

Admission urine specimen collected? Yes _____ No _____ Sent to lab? Yes _____ No _____

Unusual behavior noted? Yes _____ No _____ Unusual appearance noted? Yes _____ No _____

If yes, describe _____

Allergies _____

Reason for admission _____

Complaints _____

Dentures? Yes _____ No _____ Partial? Yes _____ No _____ Full? Yes _____ No _____

Denture cup? Yes _____ No _____

Vision problems? Yes _____ No _____ Does the patient wear glasses? Yes _____ No _____

Valuables: Money? Yes _____ No _____ Describe _____

Jewelry? Yes _____ No _____ Describe _____

Is patient hard of hearing? Yes _____ No _____ Hearing aid? Yes _____ No _____

Artificial limb? Yes _____ No _____ Brace? Yes _____ No _____

Is the signal cord attached to the bed? Yes _____ No _____

Have drugs brought into the hospital by the patient been given to the nursing supervisor?
Yes _____ No _____

Name of the nurse drugs were given to _____

Was the patient told not to eat or drink anything until the doctor's visit? Yes _____ No _____

Admitted by _____

Admission, Transfer, and Discharge of the Patient

Directions: Answer the following questions.

1. How would you help a patient, who is being hospitalized for the first time, feel comfortable and at ease?
2. How would you handle a patient who insisted on wearing a watch during the hospitalization?
3. What might you say to a patient who did not want to be transferred to another unit?

Directions: Write about the procedure followed when transferring a patient from one floor of the healthcare facility to another. Discuss what part other staff members play, what you would do before transferring the patient, and what you would do following the transfer of the patient

Directions: Describe the duties and responsibilities of each of the following individuals when discharging a patient from the healthcare facility.

1. the physician
2. the nursing supervisor
3. the nursing assistant
4. the patient's family

Admission, Transfer, and Discharge of the Patient Role-play Situations

Directions: Choose one of the following situations to role-play in class. Roles are necessary to play the patients' parts and the part of the health care worker.

1. Admit Mr. Lahrman, a 55-year-old, who has never been a patient before. He lives alone and has no relatives that live nearby. He is scheduled for surgery tomorrow.
2. Teresa Franco is a Medicare patient who is admitted to a residential facility following a lengthy illness. She is afraid she will never return to her home.
3. Mark Parklyn is a patient who has been admitted for recurrent chest pain. He is blind but is used to caring for his own needs.
4. Miss Trahan is a patient in a four-bed ward. Her condition has become more serious recently. Since there are no empty beds near the nurse's station, Miss Trahan is to be moved to 3 West.
5. Mr. Yueh is a recently diagnosed diabetic who will be discharged this morning. He will be on a diabetic diet and take medication at home. The nursing supervisor is making arrangements for a home health agency to provide care for Mr. Yueh.

Admission, Transfer, and Discharge of the Patient TEST

1. Complete the following statements, using the words listed below, by writing your answer in the blank.

admission
ambulatory
assessment
chief complaint

discharged
function
inventory
legible

prosthesis
unit

- a. If something is _____, it can be easily read.
- b. The patient who is able to walk is said to be _____.
- c. An _____ is a detailed list.
- d. When a patient is ready to leave the healthcare facility, he/she will be _____.
- e. An artificial body part is called a _____.
- f. The portion of the room that contains the patient's furniture is the _____.
- g. The _____ is the reason the patient is being admitted to the healthcare facility.
- h. The procedures followed when a person enters the healthcare facility and becomes a patient are called the _____.
- i. The movement of a body part is called its _____.
- j. _____ is the evaluation of a patient's needs, preferences, and abilities based on medical history and physical examination.
2. Place a check by the equipment needed for admitting a patient to the medical facility.
- | | |
|--|--|
| <input type="checkbox"/> a. thermometer | <input type="checkbox"/> f. pen or pencil |
| <input type="checkbox"/> b. makeup | <input type="checkbox"/> g. watch with second hand |
| <input type="checkbox"/> c. sphygmomanometer | <input type="checkbox"/> h. patient's chart |
| <input type="checkbox"/> d. radio | <input type="checkbox"/> i. admission checklist |
| <input type="checkbox"/> e. stethoscope | <input type="checkbox"/> j. television |
3. Answer the following statements about what you should do when admitting a patient by writing **True or False** before each statement.
- _____ a. Prepare the unit for the patient by making sure that necessary equipment and furniture is in place.
- _____ b. Screen the unit.

- _____ c. Assist the patient in getting into the bed.
- _____ d. Take the temperature, pulse, respiration, and blood pressure only if you think the patient needs it.
- _____ e. Assist the patient to dress only if the patient is a child.

4. List three reasons why a patient might be transferred.

5. When a patient is transferred, what items should be sent with him/her?

6. When transferring the patient—

- a. _____ is responsible for collecting the patient's medications.
- b. _____ is responsible for gathering the patient's belongings.
- c. _____ is responsible for making the necessary changes in the billing records and patient forms.

7. Place a check before each sentence that indicates a correct procedure for discharging the patient.

- _____ a. Make sure the patient wants to go home before he/she is discharged.
- _____ b. Tell the patient what you plan to do.
- _____ c. Assist the patient to dress if necessary.
- _____ d. Accept presents from the patient.
- _____ e. Collect the patient's personal belongings from the closet and bedside stand.
- _____ f. Get the patient's valuables from the safe.
- _____ g. Accept a tip from the patient for providing good nursing care.
- _____ h. Get a wheelchair for the patient.
- _____ i. Assist the patient into the car.

8. Who discharges a patient?

9. Who arranges for the patient's transportation home?

10. List four things that should be charted after a patient is discharged.

**Admission, Transfer, and Discharge
TEST – KEY**

1. a. legible
b. ambulatory
c. inventory
d. discharged
e. prosthesis
f. unit
g. chief complaint
h. admission
i. function
j. assessment
2. a, c, e, f, g, h, i
3. a. True
b. True
c. True
d. False
e. False
4. A patient may be transferred from one room to another within the healthcare facility for several reasons. Sometimes the transfer is made at the patient's request; other times the medical staff may request it. The patient may have requested a different type of room (such as a private room) on admission, and such room may have just become available. The patient may also request a transfer for personal reasons, such as to find a more compatible roommate. 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. For example, the patient may be moved into intensive care when his/her condition becomes more critical, or transferred onto a regular medical floor when his/her condition improves. Sometimes the nursing staff will transfer a patient closer to the nursing station where the patient's condition can be supervised more closely. The patient may also be transferred if the room location or equipment in the room is needed for a more critically ill patient.
5. The patient's medications, medical record, and personal belongings will be transferred to the new unit with the patient.
6. a. nurse
b. nursing assistant
c. ward clerk
7. b, c, e, f, h, i
8. The physician
9. The family or friends of the patient
10. a. date and time of discharge
b. the way the patient left the facility
c. prescribed diet
d. list of medicines the patient will take