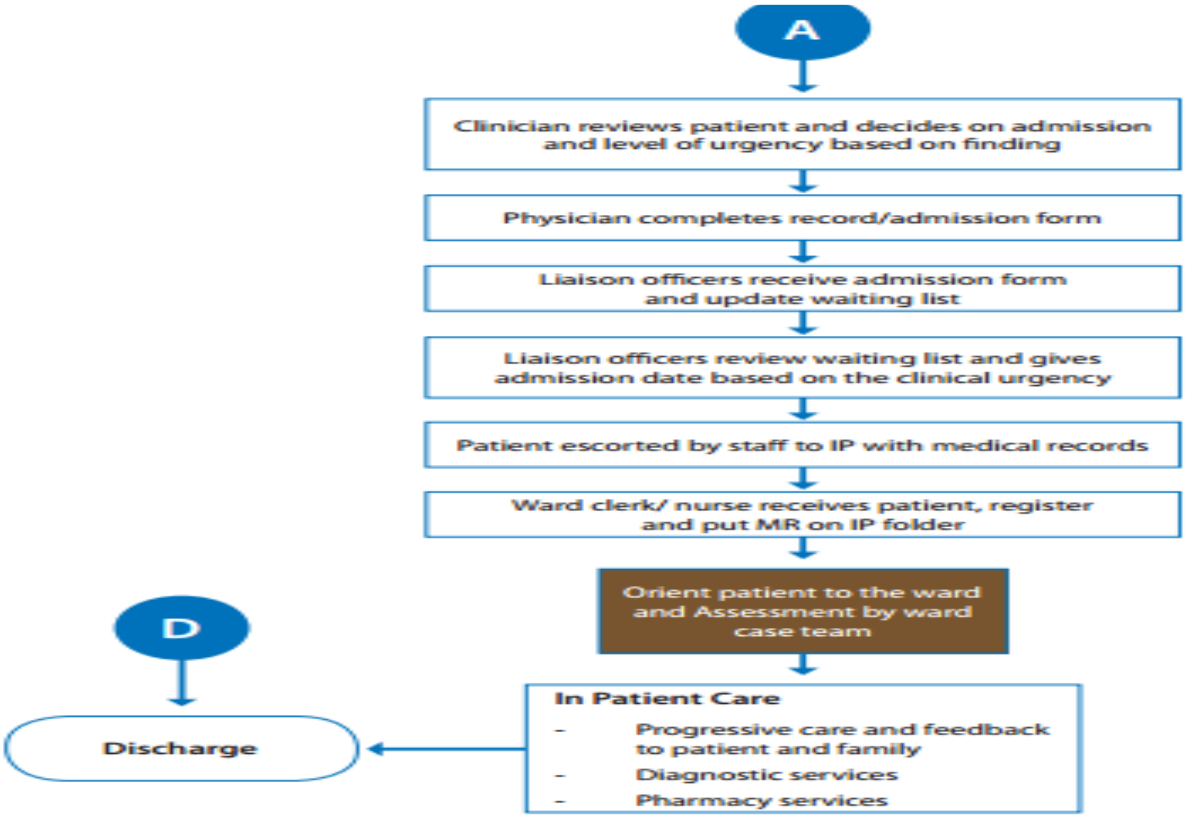
# DEDER GENERAL HOSPITAL

## ADMISSION AND DISCHARGE PROTOCOLS




***PREPARED BY: HSQU***

***JULY 2016 E.C***

***DEDER, EASTERN ETHIOPIA***

# PROTOCOL APPROVAL SHEET

***NAME OF PROTOCOL: ADMISSION AND DISCHARGE PROTOCOLS***

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*THIS PROTOCOL IS EFFECTIVE FROM JULY 2016 E.C TO JUNE 2018 E.C*

# Table of Content

# Introduction

This admission and discharge protocol is developed to ensure proper implementations of patient flows in Deder Hospital.

## *General Objectives*

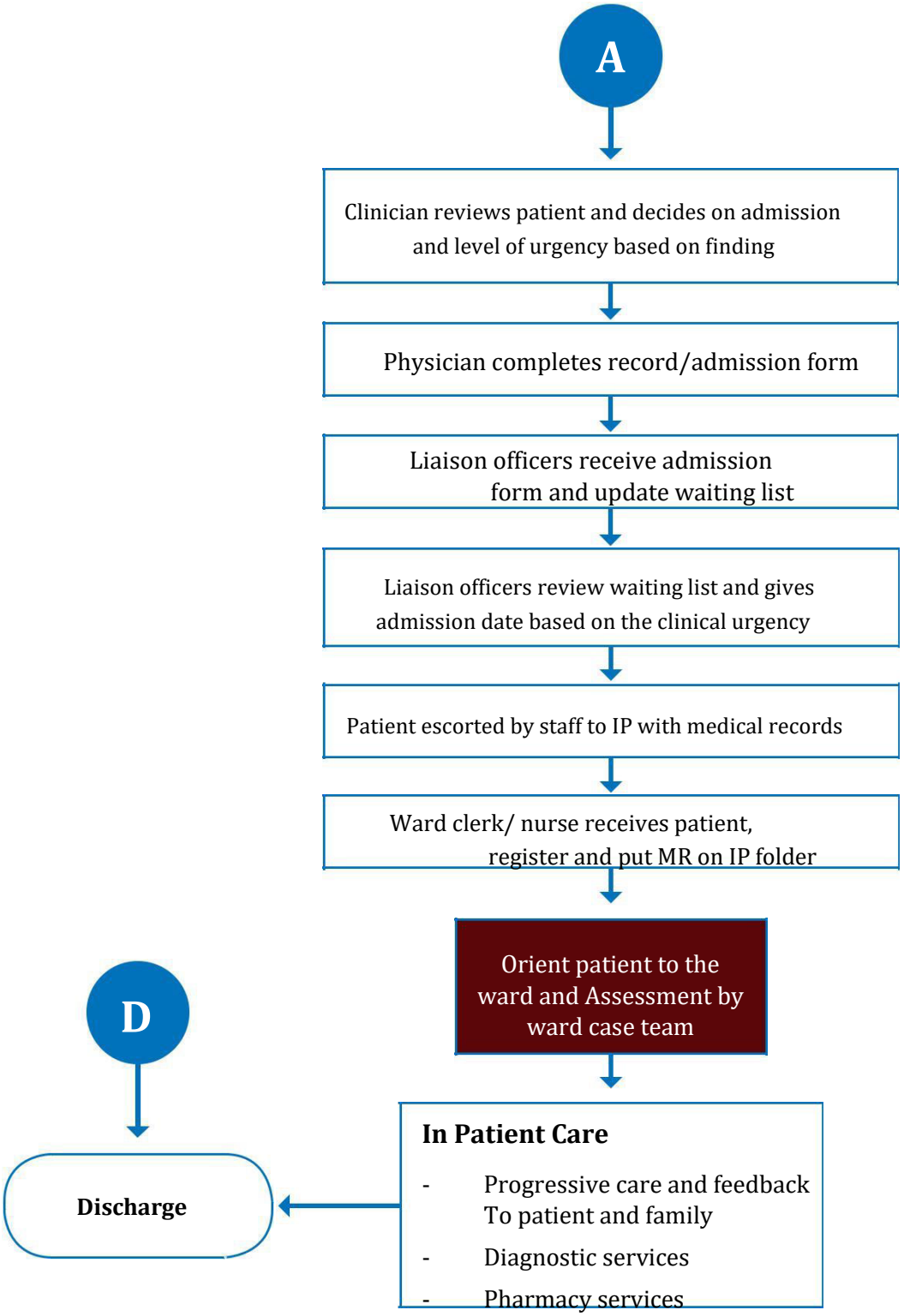
The purpose of this protocol document is to provide health professionals with best practices, processes, and guidelines to deliver both effective and efficient admission and discharge processes

## *Specific Objectives*

1. To show standardized processes for admission and discharges that should be adhered to by all staff.
2. To provide technical guidance that can be used for training and development of relevant staff particularly the liaison officers.
3. To provide guidance for Coordinators and Team leaders on monitoring and evaluation of the admission and discharge process.
4. To ensure elective admissions are prioritized and effected on the strict basis of clinical need.
5. To support the improvement of bed management

## Application

These Procedures are to be followed by all clinical staff at Hospital



## *Roles and Responsibilities*

### Hospital SMT

a) Ensure that there is hospital- wide communication and awareness of the A&D protocols;
b) Ensure training is given to relevant staff.
c) Avail necessary inputs for implementation.
d) Carryout periodic monitoring and evaluation of the proper application of the A&D Protocols.
e) Ensure that Admission and discharges are carried out seven days a week.
f) Receive and review regular reports on bed occupancy and bed management improvement processes

### Medical Director/Chief Clinical Officer

a) Champion the implementation of the A&D Protocols.
b) Discuss A&D protocols with doctors in the "morning sessions".
c) Ensure that all Case Team Leaders and those admitting and discharging patients are thoroughly familiar with the protocols.
d) Review and discuss monitoring and evaluation reports with the Hospital liaison service and make recommendations for improvement.

### Liaison officers

a) Update the elective admissions waiting list.
b) Assign an admission date to patients based on the urgency of the clinical need as date indicated by the physician in the patient notes.
c) Secure a bed for the patient.
d) Maintain good communications with inpatient case teams and the wards.
e) Ensure that the patient receives proper directions to the ward.
f) In collaboration with ward staff, play a leading role in co-ordination of discharges.
g) Ensure regular bed census is carried out, reported and used to update and manage the bed resources

## Admitting Physicians

A. Adhere to hospital guidelines when deciding on admitting a patient.
B. Indicate the level of urgency for admission based on the urgency of clinical need.
    - ☞ Emergency – immediate admissions
    - ☞ Non emergency but priority: within two weeks
    - ☞ Non emergency: two weeks or more
C. Ensure that these protocols and existing national guidelines relating to children, birthing mothers and major diseases are followed during admission.
D. Ensure that an estimated length of stay, where possible, is placed in the patients notes.

## Ward Nurses

a) Welcome and familiarize the patient with the ward surroundings.
b) Review notes and ensure all requirements are met/planned to be met.
c) Assess the patient and prepare the nursing Care Plan, involving the patient, and relevant others, and place in the patient medical record within 24 hours of admission.
d) Follow the guidance set out for admissions and discharges.
e) Maintain good communication with the Liaison office particularly in relation to emergency admissions, pending and actual discharges, and bed status reports

## Discharging Physicians

a) Adhere to the hospitals' discharge protocols or these set out in this document.
b) Wherever possible do ward rounds early in the day and discharge early in the day.
c) Has responsibility for correctly completing all the relevant documentation.
d) Discharging at weekends shall be made

## ADMISSIONS POLICY AND PROCEDURES

### *Objectives*

The key objectives underpinning an effective and coherent admissions and discharge policy for emergency and elective patients are:

- The provision of an integrated personal health and social services as per the hospital guideline/ practice/ implemented through social worker.
- The utilization of resources to maximize clinical and organizational effectiveness and outcomes.
- The establishment of fully integrated networks (within or between the facilities) of emergency care, which are accessible to each person.
- The provision of levels of local access to emergency care while simultaneously ensuring high quality clinical care.
- The acquisition of clinical admissions data to assist service planning and monitoring.

## Eligibility for Free Services

- The eligibility for free health care is based on Regional Health Care Financing Reform Proclamations. These Proclamations must be adhered to.
- Eligibility is not an automatic right. Each adult has to demonstrate eligibility in his or her own right. This is normally demonstrated by the possession of a Fee Waiver letter.
- In addition, according to Oromia law, there is a minimum list of exempt services that all are entitled to receive, free of cost.
- Only persons who meet the eligibility criteria, as defined by the Government can receive publicly funded (i.e. free or subsidized) health and disability services.

## Principles

- Emergency Department (ED) admissions
- The principles of emergency department admissions are discussed in the coming sections.
- Elective admissions
- The principles of elective admissions are discussed in the coming sections.

## Process

*Introduction*

- All admissions should be arranged through the Liaison Service following the process described below.

    - ☞ Upon arrival on the ward, the nurse should receive the patient to initiate admission process and give orientation and instruction about facilities (such as toilet and showers) to the patient and care-givers etc.
- The patient should be assessed by a medical doctor upon arrival on the ward and a History and Physical Examination Assessment should be completed. This should include the immediate management plan for the patient.
- Additionally, a Nursing Assessment should be completed within 24 hours of admission and a Nursing Care Plan developed.

- All emergency patients who require admission to Hospital (as assessed by an appropriate health professional) will be admitted under the care of an appropriate senior physician /Midwife/an appropriate health professional The decision as to whether to admit the patient is to be made on clinical grounds.
- Patients who require hospital admission but where the hospital does not have adequate services to meet their needs are to be transferred to a more appropriate hospital (as per the requirements of the Inter-Facilities Transfer of Patients Procedure)

## Admission to Hospital Pediatric Unit

- All children admitted to a hospital are to be admitted to a Pediatric Unit, and are to remain there for the duration of their hospital stay, unless there are specific exceptional circumstances, which warrant a shift to another ward.

- Children requiring intensive monitoring are to be admitted to the Intensive Care Unit (ICU) at the hospital.

- A sick mother with a 'boarder infant' may be admitted to a Pediatric Unit, provided that:

    i. The mother's illness is of short duration;
    ii. The mother is not an isolation patient, and;
    iii. In the absence of the mother, nursing staff should ensure that all of the baby's needs including nutrition are fully met

    - Sick adults are not to be admitted to the Pediatric Unit, unless there are specific exceptional circumstances, which warrant such an admission.
    - Conditions of existing patients are to be taken into account when well children are accompanying a sick mother into the Pediatric Unit.
    - The nurse in charge of Pediatric Unit, in consultation with the ward doctor, is responsible for making the decision regarding the admitting of a sick mother and a well child into the Pediatric Unit.

## Precautions and Consideration

☞ All emergency patients who require admission to hospital (as assessed by a doctor) will be admitted under the care of an appropriate health professional.

☞ Elective admissions are undertaken on the basis of a referral from health facilities to a hospital.

☞ All children admitted to Hospital are to be admitted to Pediatric Ward.

☞ Hospitals operate a policy where no patient is refused admission, but the admission may be delayed and managed according to the individual health facilities waiting list guidelines and requirements. \

### Medical Determination for Admission

❖ To support the medical necessity of an inpatient admission, the doctor/Admitting health professional must adequately document (in the patient's medical record) that a provider with applicable expertise expressly determined that the patient required services involving a greater intensity of care that could be provided safely and effectively in an outpatient setting.

- Such a determination may take into account: the amount of time the patient is expected to require inpatient services, but must not be based solely on this factor. The decision to admit is a medical determination that is based on factors, including but not limited to the:
    1. patient's medical history;
    2. patient's current medical needs;
    3. severity of the signs and symptoms exhibited by the patient;
    4. medical predictability of an adverse clinical event occurring with the patient;
    5. results of outpatient diagnostic studies;
    6. types of facilities available to inpatients and outpatients, and;
    7. Ethiopian Inpatient Hospital Admission Guidelines

## 6. Contra Indications for Admission

- The patient's condition has been improving substantially and is approaching either normal clinical parameters or the patient's baseline.
- The admission is for monitoring, observation or other interventions that have to date been successfully delivered outside of a hospital setting.
- The admission is primarily to observe for the possible progression of labor when examination and monitoring does not indicate definite progression of active labor leading to delivery.
- The admission is primarily for education, teaching, minor medication changes and/or monitoring, or adjustment of therapies associated with a medically stable condition(s)
- The admission is primarily due to the:
    1. Amount of time a patient has spent as an outpatient in a hospital or other outpatient setting;
    2. need for diagnostic testing or obtaining consultations;
    3. services;
    4. age of the patient, and;
    5. convenience of the physician, hospital, patient, family, or other medical provider.

☞ Example of clinical conditions

Clinical conditions accepted for admission into the ICU at a hospital include:

1. Acute Chest Pain
2. Acute Myocardial Infarction
3. Arrhythmias
4. Insertion of Temporary Pacemaker
2. Pulmonary Embolism (requiring high level support)
3. Inotropic Treatment
4. Intensive Airway Management
5. Ventilator Care
6. Trauma
7. Overdose
8. Ketoacidosis
9. Eclampsia
10. Unconscious/semi-conscious

## Documentation

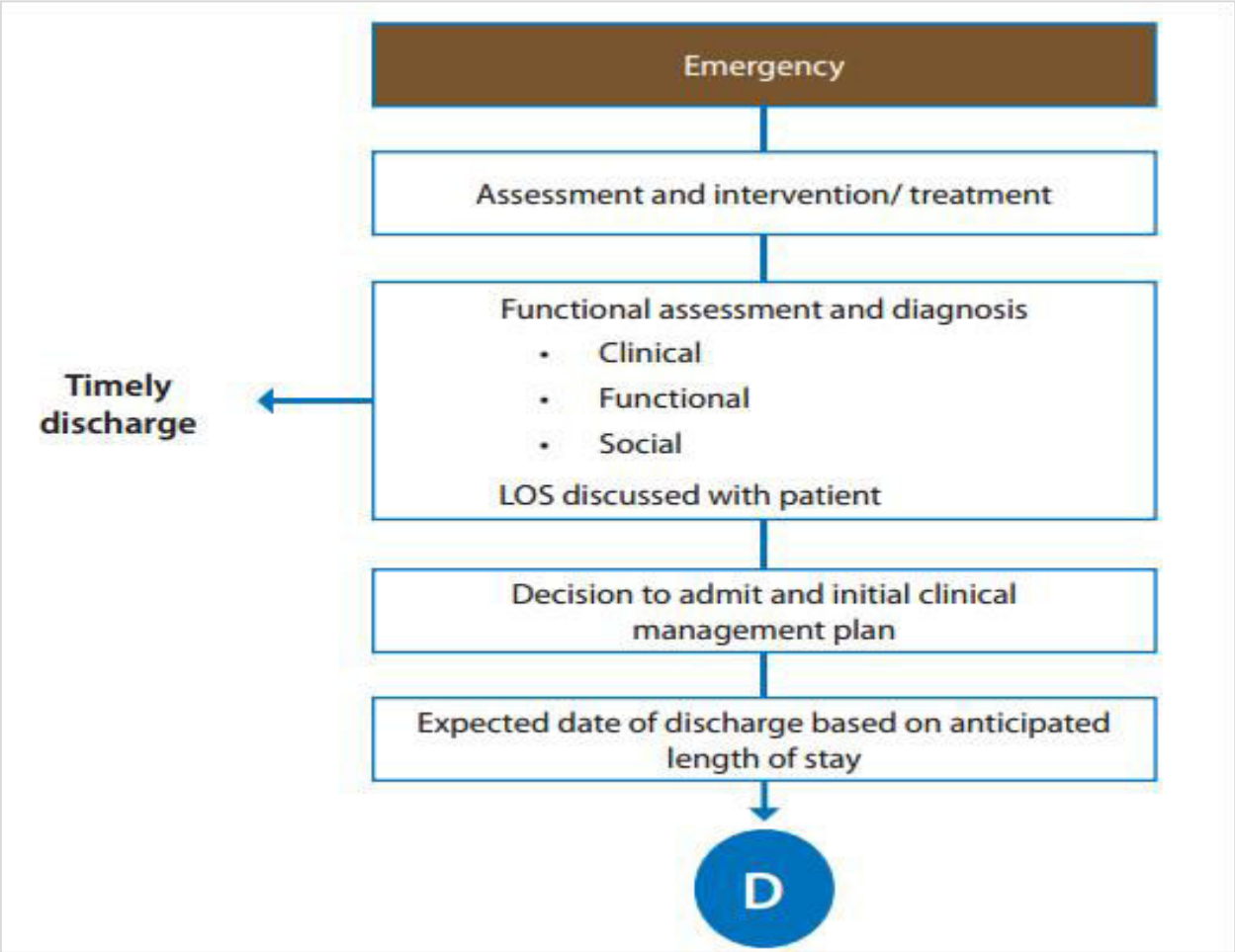
- The Liaison Officer (during working hours) or after-hours will process the admission and send all paper-work and patient medical records to the Ward on completion. The exception to this is where during working hours where the Ward Clerk has chosen to do the emergency admissions and arranged admissions.
- When a patient arrives directly at a ward, as a transfer from another Hospital or on referral from a GP, the ward is to inform the Liaison Officer that the patient has arrived, and then send down a completed Manual Data Sheet for admissions so it can then be processed.
- There should also be a process for documentation of admissions in the ER and the ICU.

## Refusal for Admission

- Hospital has a policy where by the decision to admit a patient is made on clinical grounds,
- But this admission may be delayed and/or managed according to our Hospital Waiting List guidelines and requirements.

## Emergency Admissions

A **typical emergency pathway is shown in figure below.**




## Principles of Emergency Admissions

### *Emergency Department (ED) admissions*

- Only emergency patients should be admitted to the hospital through the Emergency Department. This may require a subtle shift of emphasis from 'semi elective' admission to more rigorous assessments to ensure the appropriateness of hospital admissions and maximize the number of available beds for elective admissions.

### *Emergency Patient Admission Process*

### *Emergency Resuscitation and Rehabilitation Unit in ER;*

Short Stay observation wards or Resuscitation and Rehabilitation Units (RRUs) are advocated in emergency patient care. Such units should be directly adjacent to the

Emergency Department and should be supervised by specialists in Emergency Medicine.

The **length** of stay should not be greater **than 24 hours.**

## *Transfer to ward for proper admission*

**A. If the patient is to be admitted as an emergency, a clinical member of the relevant Case Team should contact the Liaison Service providing, as a minimum, the following information:**

- ✓ Patient name and medical record number;
- ✓ Summary of clinical history and reason for admission;
- ✓ Case team to which patient should be admitted (for example **surgical case team**, **internal medicine case team** etc), and;
- ✓ **Urgency of admission.**

**B. When a request for admission is made, the Liaison Officer should follow the steps below:**

**1. Is a bed immediately available in the relevant inpatient case team/ward?**

**a. If yes admit patient.**

The Liaison Officer should inform the attending clinician of the admission, the patient should be transferred to the ward, and any necessary administrative tasks carried out with the assistance of a runner.

b. **If no** the Liaison Service should consider finding a bed in another facility.

**2. Is there any patient in the relevant case team/ward due to be discharged that day?**

a. **If yes** confirm that patient will be discharged. Identify and address any factors that are delaying discharge. Consider moving patient to Transit Lounge (if available) or another waiting area. In this way the bed can be freed and the new patient can be admitted.

b. **If no** the Liaison Service should consider finding a bed in another facility.

**3. Is a bed available within another case team/ward?**

a. **If yes** discuss with Director of Inpatient Services, and if appropriate, admit patient to that bed and inform the Leader of the Inpatient Case Team that is responsible for the patient where the patient is located.

Ensure that the patient is transferred to 'correct' case team bed/ward as soon as a bed there becomes available.

b. **If no** the Liaison Service should consider finding a bed in another facility.

4. **Is there an elective admission that could be cancelled to make a bed available for the patient**?

a. **If no ,** the Liaison Service should consider finding a bed in another facility.

As far as possible, planned admissions should not be cancelled. However depending on the priority it may be necessary to do so. Factors to be considered are: The clinical urgency of both the planned admission and the emergency patient requiring admission should be performed within 5 minutes; The time on waiting list, distance travelled and other pertinent social circumstances of the elective case, and; The availability of a bed in another facility for the emergency patient requiring admission, and the distance to reach that facility.

**C. What are the important factors influencing patient admission from the Emergency Department (ED) to inpatient services?**

1. Extended access to rapid assessment clinics and outpatient imaging, pharmacy, and basic laboratory services.
2. Rapid assessment and extended access to diagnostics (unnecessary delays in admitting and/or discharging patients from hospital may arise from avoidable delays in patient assessment by specialists, duplication of tests or the absence of high or low dependency beds).
3. Early Senior Medical decision making available at the point of admission.
4. Close multi-disciplinary team work.
5. Nationally agreed standardized triage processes to ensure clinical prioritization of patients on their arrival in the Emergency Department and to ensure timely and appropriate care is delivered.
6. Prioritization should be based on the clinical background and should be decided by the treating physician.
7. There should be regular and influential audit of clinical activity.
8. The critical role of Support Staff should be acknowledged with appropriate support for professional development and influence in decision making at all levels.

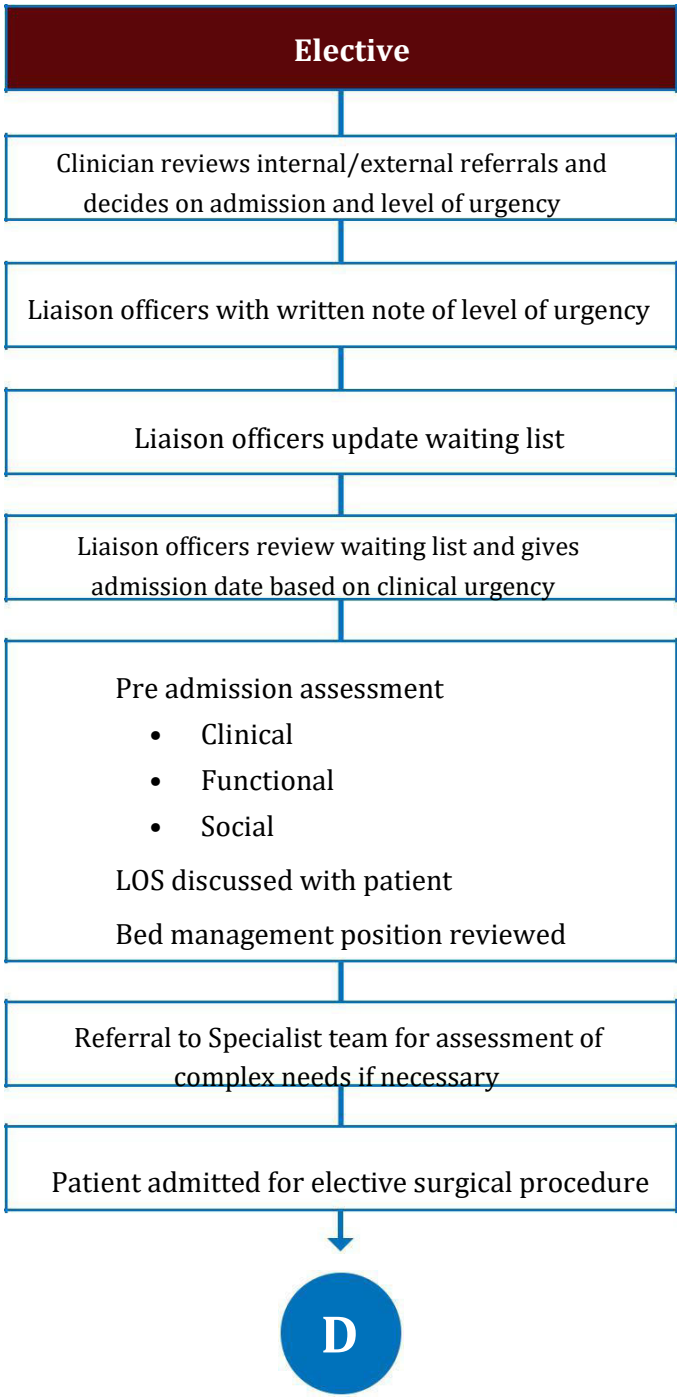
## Emergency obstetrics

- ✓ Birthing mother only to be admitted if in active labor.
- ✓ Birthing Mothers should be transferred immediately to the delivery ward.
- ✓ A rapid assessment for any complications or abnormal risks should be made and plan and actions addressing these put in place.

### *Maternity Admissions*

- ✓ An assessment of the risk of delivery must be carried out before admission during antenatal care.
- ✓ Mothers should be directed, or escorted when necessary, to the delivery ward.
- ✓ High risk and complicated cases must be clearly identified and arrangements put in place to reduce the risk and facilitate safe delivery in complex cases.
- ✓ In caesarian cases and in other low risk non-complex cases an expected length of stay should be given to the mother and placed on the patient notes.
- ✓ On admission, care should be provided according to existing national standards and guidelines.
- ✓ After normal delivery, the mother should be kept under observation for **six hours** by the ward doctor or other appropriate health professional. This must be planned for on admission.
- ✓ Complex and high risk cases must be transferred to the maternity ward and care provided according to existing national standards and guidelines.

# Elective Admissions



## Principles Elective Admissions

- A patient's episode of care should be planned before his/her admission and should take account of the entire pathway up to and after discharge from hospital. Patients and their caregivers should be partners in this planning.
- The bed management service should operate on a permanent basis, i.e. for 24 hours on every day of the year.
- There should be a network information service, which proceeds elective admission after an appointment for admission has been made and the waiting list is checked.

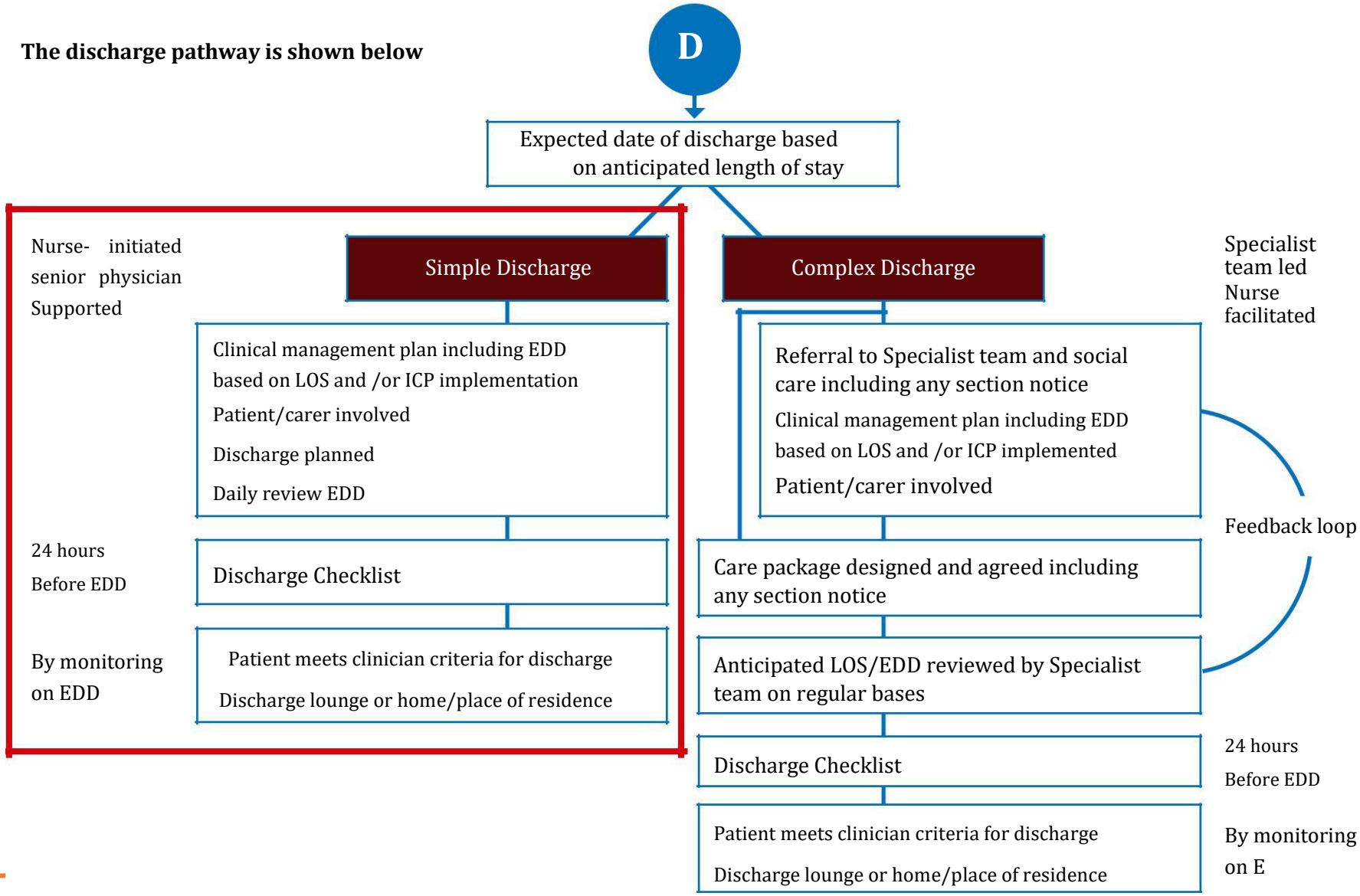
### *Elective Admission Process*

- Elective admissions may be booked by the liaison officer. When a patient requires elective admission the patient is sent to the Liaison Officer with adequate information reflecting: Patient name and medical record number; Summary of clinical history and reason for admission; Case team to which patient should be admitted (for example surgical case team, internal medicine case team etc), and Urgency of admission (set criteria related to: pathology of the disease, socio-economic status of the patient, and distance of the patient's residence).
- The Liaison and Referral Service should book the admission date, the bed and give an appointment card to the patient.
- On the day of admission, the Liaison Officer should submit the medical records of the patient to the admitting clinician on the day of the admission.
- On a daily basis, the Liaison Officer should inform each Inpatient Case Team of any elective admissions for the following day to ensure that the required service is available and allow the Case Team to make all necessary preparations for the admission
- **The following key requirements have been identified to facilitate effective elective admission practices:**
    1. All patients should have a treatment plan within 8 hours of admission.
    2. Centralized waiting list management.
    3. Agreement on the parameters for scheduling operation theatre lists with the OR team.
    4. Pre-admission assessment as a standard requirement for all elective admissions to ensure appropriate planning of the entire patient journey. Diagnostics such as pathology and imaging should be done in advance upon multidisciplinary team decision.

5. The anticipated Length of Stay (LOS) for elective admissions indicated as early as possible by the physician and communicated to the Liaison Service to facilitate scheduling.
6. Increased day surgery can also be supported by pre-admission assessment to ensure appropriate scheduling and to minimize time transfer to inpatient beds.
7. Length of Stay (LOS) after admission should be monitored to minimize hospital-acquired infections, cost for the patients, and appropriately manage bed occupancy.

# DISCHARGE PROTOCOL

**The discharge pathway is shown below**



## Principles of Discharge

**The core principles for effective discharge planning provide that:**

1. A patient's use of a hospital bed and their discharge should be planned before their admission, where possible.
2. The estimated date of discharge should be documented and communicated to the patient and relevant personnel within 8 hours of admission.
3. Discharge should be "streamlined" e.g. prescriptions and letter should be completed in a timely manner; transport booked and test results made available promptly.
4. The MDT to facilitate timely discharge should regularly discuss patients who were seriously ill.

### *Discharge Process*

- A physician who should complete a discharge summary for the patient should make the decision for discharge.
- A copy of the discharge summary containing medical history should be given to the patient and a second copy filed in the Medical Record.
- If a patient was referred from another facility, the discharging physician should also complete the feedback section of the Referral Form.

### The processes required for effective discharge planning provide that:

1. Discharge coordinator/Liaison Officers shall be available to ensure delays are minimized and extensive patient and family involvement in decision-making processes.
2. Referrals to physiotherapy, occupational therapy, and psychosocial support shall be identified as early as possible to access aids and appliances as appropriate.
3. Discharge documentation should be audited to ensure compliance with A and D protocols.
4. Analysis of trends and data should be undertaken by the discharge coordinator/ Liaison Officer and communicated to SMT.
5. Multidisciplinary teamwork is the key to success with discharge planning.

6. A nominated member of the multidisciplinary case team shall coordinate a patient's discharge plan.
7. Appropriate bodies within the attending case team should be involved in the discharge planning process.
8. Patients and their caregivers should be partners in the discharge planning process.
9. There should be early involvement of Pharmacy to increase compliance with medication.
10. Patients (or parents, caregivers, surrogate, or guardians) should co-sign the patient's discharge letter ensuring that the discharge instructions have been clearly explained to them.
11. An expected date of discharge should be set within 24 hours of admission or in many cases before admission for elective patients and communicated to the patient and all staff in contact with the patient.
12. The expected date of discharge should be proactively managed against the treatment plan by ward staff on a daily basis and changes communicated to the patient.
13. A senior clinical staff member should schedule Ward rounds in a way that it allows a review at least daily of all patients.
14. **Inpatient case teams can make significant improvements by:**
    - identifying anticipated length of stay and expected date of discharge on admission;
    - using a Discharge Predictor as a core tool for effective bed management;
    - providing an updated list of expected discharges on a shift basis;
    - discharging patients in the morning on the day of discharge, and;
    - Discharging patients over the weekend and holidays.

## Key Steps in Timely Discharge

- Expected date of discharge is identified early as part of patient's assessment within 8 hours of admission (or in pre-assessment for elective patients). It is based on the anticipated time needed for tests and interventions to be carried out and for the patient to be clinically stable and fit for discharge.
- The patient and caregiver are involved and informed about the clinical management plan and the expected date for discharge.

- In parallel, all the necessary arrangements are put in place to optimize the (simple) discharge including Discharge Summary, outpatient appointment, hospital sick leave completed, any medicines to be taken away, and patient transport arrangements confirmed.
- Daily review of the patient's condition and response to treatment will determine if the expected date of discharge needs to be revised.
- Review of planned/actual discharge date. Did it go according to plan? Complete audit on a regular basis.

### Medical Determination for Discharge

- Vital signs must be stable and consistent with age and the clinical baseline correct orientation as to time, place and person.
- Adequate pain maintenance and has supply of oral analgesia.
- Understands how to use oral supplied analgesia and has been given written information about these.
- Ability to dress and walk where appropriate.
- Minimal nausea, vomiting or dizziness.
- Has at least taken oral fluids.
- Minimal bleeding or wound drainage.
- Has passed urine (if appropriate).
- Has a responsible adult to take them home.
- Written and verbal instructions given about postoperative care.
- Knows when to come back for follow up (if appropriate).

### Patient Death

❖ Patient Deaths and Care for deceased care shall be managed according to Hospital Death protocol. See the Death protocol for additional information.

## *Monitoring and Evaluation*

1. Conduct periodic audits of the A&D protocols once quarterly using the audit/ framework and checklist.
2. Review findings by the A&D protocols team and make recommendations for improvement to the SMT
3. SMT should get regular reports on bed management and monitor

# Sample Admission Checklist

| | Yes | No | N/A |
|---|---|---|---|
| 1. Has the patient information been collected? | ☐ | ☐ | ☐ |
| 2. Has the clinician seen the patient and decided on admission? | ☐ | ☐ | ☐ |
| 3. If birthing mother, has risk and other antenatal assessment been done? 4. Has the clinician filled out the admission form and notes? | ☐ | ☐ | ☐ |
| 5. Are the following shown? | | | |
| • Clinical priority | ☐ | ☐ | ☐ |
| • Estimated length of stay | ☐ | ☐ | ☐ |
| 6. Has the liaison officers received the admission form? | ☐ | ☐ | ☐ |
| 7. Has the waiting list been updated? | ☐ | ☐ | ☐ |
| 8. Has the clinical, functional and social pre admission assessment been done? | ☐ | ☐ | ☐ |
| 9. Has the liaison officers discussed the admission with the Patient and relatives where relevant? | ☐ | ☐ | ☐ |
| 10. Has the bed been allocated in a timely manner? | ☐ | ☐ | ☐ |
| 11. is the patient eligible for free service. | ☐ | ☐ | ☐ |
| 12. If no, has all financial issues been settled? | ☐ | ☐ | ☐ |

## Sample Discharge Decision Checklist

| | Yes | No | N/A |
|---|---|---|---|
| 1. Has a date of discharge been estimated and documented? 2. | ☐ | ☐ | ☐ |
| Has the patient been involved or informed? | ☐ | ☐ | ☐ |
| 3. Is the patient clinically stable and fit for discharge? | ☐ | ☐ | ☐ |
| 4. Has medications been dispensed and purpose, regime explained to patient? | ☐ | ☐ | ☐ |
| 5. Is the discharge summary and any other relevant information included for the receiving facility? | ☐ | ☐ | ☐ |
| 6. Outpatient appointments made and given to patient? | ☐ | ☐ | ☐ |
| 7. Patient given information about self-care and who to contact if symptoms return? | ☐ | ☐ | ☐ |
| 8. Has the patient been given a hospital sick certificate if required? | ☐ | ☐ | ☐ |
| 9. Has the patient settled all financial issues? | ☐ | ☐ | ☐ |

## Sample Admission Urgency Notification Card

Date ----------

Name of the department issuing admission ----------

Name of the patient ----------

Card number ----------

Name and signature of the physician approving admission

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**Urgency of the admission**

Emergency (immediate admission) ---------- ☐

Non emergency but priority (admission within two weeks) ---------- ☐ Non

emergency (admission in two weeks or more) ---------- ☐

Name and signature of the Liaison officer accepted admission

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