**Hospital Admission Procedure**

DEFINITION

Admission of a patient means allowing and facilitating a patient to stay in the hospital unit or ward for observation, investigation, and treatment of the disease he or she is suffering from.

**Purpose of admission procedure**

1. To provide immediate care.

2. To provide comfort and safety to the patient.

3. To receive the patient in ward for admission according to his condition.

4. To be ready for any emergency.

5. To assist the patient is adjusting

6. to the hospital environment.

7. To obtain information about the client so as to establish therapeutic nurse patient relationship.

8. To involve patient and family in care.

9. To assist proper discharge planning of care.

**Types of Admission**

• Routine Admission: clients are admitted for investigations and planned treatments and for surgeries. eg. diabetes, hypertension.

• Emergency Admission: Patients are admitted for acute, an emergency condition which requires immediate treatment like burns, drowning, road accidents, fall, heart attack.

**Admission, Observation and Charting**

Responsibilities of the admission department

1. Gather patient information (name, age, sex, address, mobile no etc)

2. Prepare medical record

3. Prepare patient identification bracelet

4. Consent form signed

5. Initial orders obtained

6. Inform to floor ward nurse

**Responsibilities of the nurse, Prepare room**

• Prepare a clean and neat admission room with all the necessary items as per the need of the patient.

• Prepare an appropriate type of bed with adequate adjusted height of the bed

Identify self

• Welcome patient and his family with warm approach.

• Make the patient comfortable in bed and provide him with hospital clothes and ensure adequate privacy.

• Alleviate anxiety/fear

**Orient patient**

• Location of nurses’ station

• Room boundaries

• Clothes storage

• Call light

• Bed controls

• Light switches

• Telephone policy

• Tv controls

• Meal times

• Visiting hours

• Diet

• Safety measures-side rails

• Time for doctors’ visit

• What tests are scheduled

**Gather information related to:**

• Medical Orders

• Treatments

• Lab Results

• Tests

• Diet

• Activity

**Charting**

• Record all the basic information in patients record.

• Clearly mention admission date, time patients details, complaints of the clients, any allergies, patients mental status.

• Record in admission register, treatment book, report book, medical legal case (MLC) register, update ward census and nurse’s notes.

• Physical Assessment

• Patients Comfort

• Collect information for database

• Perform initial Admission Assessment

• Obtain physician order for the Lab, Tests, Medical activity

• Identify data

• Chief complaints

• Present history

• Past health history

• Review of body system

**Observation:**

What to look for in newly admitted patients

• Anxiety

• Loneliness

• Increased privacy

• Loss of identity

**Admission Assessment**

Do a good assessment of his physical condition in order to plan his care. If his physical state needs immediate treatment report to physician and prepare your patient for physical examination and carry out the treatment, which the physician prescribes after the physical examination.

**Safety and Comfortable Environment**

The environment in which the patient is placed should be comfortable and safe and it should contribute to his well being and should not retard his recovery.

a. Patient Safety and Comfort Measures:

Safety means protection from possible injury during the process of health care

Medical Safety

• Clear doctors order

• identification of patient with similar names

• proper handling and taking over during change of shift

• check oxygen flow and empty cylinder

• check drip flow speed, drip sets, air bubbles etc

• avoid wrong medication

• discourage telephonic order

Surgical Safety

• Proper patient identification

• performance of correct procedure at correct body site

• improved hand hygiene

• avoid wrong connections of tubings. eg. catheters

• check safety code

• red – allergy

• yellow – fall risk

• purple – do not resuscitate

Laboratory Safety

• Single use of syringe

• avoid needle prick

• avoid spilling of blood

• care in handling acids and inflammable substances

Electrical Safety

• Safety fuses with each equipment

• No loose wires or connection.

• connection Properly plugged and fixed

• If short circuit call electrician

Fire Safety

• Use fire proof material for construction

• Have fire exit in all buildings

• Smoke detection and water sprinklers on the root of all floors

• Fire extinguisher in all areas

• Training in fire management

Equipment and Installation Safety

• Regular checking of equipment

• Proper earthling to avoid shock

• Regular maintenance and repair

• Training nurses and mechanicals of possible hazards.

Blood Safety

• Proper grouping and cross matching

• Test HIV and hepatitis

Environmental Safety

• Adequate light and ventilation

• Stairs with hand rails

• Slip preventing floors

• Fire extinguishers and alarms

• Prevent noise pollution

• Safe wheel chairs and trolleys

• No water logging in bathroom

• Call bell system

• Adequate number of screens

b. Safeguarding Patient’s Personal Belongings

• When documenting valuables make sure to use words like white/yellow metal not gold. Clear stone not diamonds and rubies

• Have a witness

• Have nurse and patient sign valuable list

• Inform the patient that he will get back his valuables on discharge

Sanitation and Infection Control

• Proper segregation transport and disposal of biomedical waste

• Use of sterile procedure

• Formation of hospital infection control committee

• Use of proper disinfection in right dose in right time

• Safely dispose in needle destroyer

• Reorientation of Doctors and nurses of infection control

Patient Comfort During Hospital Stays:

• Provide Privacy (Shut Door, Pull curtain)

• Assist if needed to remove clothing & put hospital gown

• Provide Extra blankets if requested

• Hospitals provide the patient with the right to not only accept their visitors, but also to deny them. It doesn’t help a patient’s recovery if the visitor is someone who will only bring them added stress.

• Visitors are allowed to stay as long as they want, even overnight.

• Provide wireless access along with the usual TV’s and comfortable chairs.

• Counselling services and places to pray and meditate.

• Make waiting time more productive— or at least less boring.

• Help people connect more easily with hospital billing, physicians, scheduling, etc.

• Learn more about your patients and visitors—and about their hospital experiences

**Discharging the Patient**

Discharge is a preparation of a patient and discharge records to leave the hospital.

Purpose

1. To ensure continuity of care to the patient after discharge.

2. To assist the patient in discharge process.

**Guidelines**

The patient are discharged from the hospital in one of the following ways.

1. Discharge to home. The discharge to home or another hospital or another unit within the hospital is initiated by the doctor who advises the patient that he is well enough to leave the hospital or requires treatment in another unit within the hospital or in an another hospital.

2. Discharge to another hospital or another unit within the hospital (referral). When a patient or family is not satisfied with the treatment or care given and wants to leave the hospital against the medical advice, in such cases the patient of the relative is asked to sign a statement that he is going or taking the patient on his own will and responsibility.

3. Discharge against medical advice (AMA). Patient leaves the hospital against the medical officer’s advice when a patient escapes from the hospital without the knowledge of the hospital staff and without signing the said statement he is treated as absconded in the records.

**Nurses Responsibility**

1. Inform the patient and the relatives a day or two before the discharge.

2. Get the discharge slip prepared after checking the vital signs and examining the patient.

3. The nurses should see that the patients personnel hygiene is maintained, he is dressed in home clothes and has taken meals.

4. Hand over the patient’s belongings and any valuables, which have been kept safely, to the patient or the relative under proper receipt.

5. Complete the unit admission and discharge registers, case sheet and other records.

6. Hand over the case sheet and other records to medical records to medical record department under proper receipt.

7. Inform the hospital authorities about the discharge if the patient is medico-legal.

8. Hand over the discharge slip to the patient or relative and explain about

a. The treatment and the diet to be taken at home

b. Follow-up visits and inform to bring the discharge slip on every visits

c. Any special advices pertaining to condition

9. See that the patient receives all the medicines as per discharge slip.

10. Check the hospital things before the patient leaves the ward.

11. Place the patient in the wheel chair or stretcher.

According to the patient’s condition until he leaves the hospital. Immediately after the patient leaves reorganize the patient unit.