ADMITTING A PATIENT & DISCHARGE FROM HOSPITAL NURSE OBSERVATIONS

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Statistics

- 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.

Adjustment

Every patient admitted to a healthcare facility is nervous, even if it is not a first admission.

• The strange surroundings

• The busy nursing staff

• The sight of other patients may add to the patient's feelings of helplessness

•If this is a first admission, the patient will not know what to expect

- 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

Changes in lifestyle

- Confusion and disorientation often occur when patients are first admitted because they have left friends, family, and everything familiar behind.
- They may feel they no longer have control over their lives.
- They may be physically powerless and almost completely dependent on strangers for everyday care.

Moving and Handling

- Stretchers and wheelchairs
- Pat slides/ slide sheets
- Hoists
- Air mattresses

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:

- **M**edication-Drug name, dose, purpose, effects, adverse reactions
- **E**nvironment-homemaking skills, physical hazards, emotional support, economic support, transportation
- **T**reatment-Purpose of treatment to be continued at home, correct performance of treatment

- **H**ealth Teaching-Describe how condition affects body function, describe the means necessary to maintain present level of health.
- **O**utpatient Referral-When and where, whom to call for medical help, take home written discharge instructions.
- **D**iet-Purpose, plan several menus.

SPECIAL CONSIDERATIONS

- Discharge at Request-proper form. Client may refuse to sign, therefore document explanation to client and notify physician.
- Discharge at Request unaccepted in Quarantine Law
- 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' or intermediate care 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

00:00hrs	08:00hrs	16:00hrs
01:00hrs	09:00hrs	17:00hrs
02:00hrs	10:00hrs	18:00hrs
03:00hrs	11:00hrs	19:00hrs
04:00hrs	12:00hrs	20:00hrs
05:00hrs	13:00hrs	21:00hrs
06:00hrs	14:00hrs	22:00hrs
07:00hrs	15:00hrs	23:00hrs

Vital observation documentation

- ✓ **Use continous 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°C +/- 1°C).**
- **Oral – Under tongue in posterior lateral sublingual pocket for two minutes (37°C +/- 1°C).**
- **Rectal – Insert tip into anus toward umbilicus to a depth of 1.5cm for two minutes (37.6°C +/- 1°C).**
- **Axillary – Centre of axilla and firmly hold arm against side for five minutes (36.4°C +/- 1°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

HGT Documentation

✓**Do not write mmols with every numerical HGT value inserted - the subtitle explains it all (HGT (mmols)).**

✓Write in the space provided in accordance with . sub heading.

Date	Time	HGT (mmols)	Initials
05/06/04	18:00	6.2	R.S.

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.

Output

- ✓ **When there is a patient with a nappy, the output still needs to be monitored.**

  This is done by:
  - **weigh the nappy prior to be used.**
  - **write its weight (when still new) on the nappy itself.**
  - **weigh again when removed from the patient.**
  - **from the second weight, subtract the previous one.**
  - **the result is recorded as the OUTPUT amount.**