

Chapter 19

Admission, Preoperative, and Postoperative Procedures

3 types of admissions **entry, patient, service**



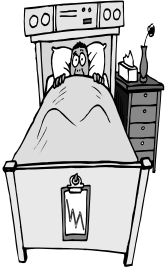
- **Entry Types:**
 - A. Scheduled – planned in advance, enter through admitting, 2 Types.
 1. Urgent - Dr. calls hosp from office.
 2. Scheduled/elective – Pt and doc elect when to schedule a nonemergency surgery or procedure
- **Emergency** unplanned, injury or sudden illness. Enter through emergency department.
- Emergency Department Record (pg 366) is sent to nursing unit and HUC reviews to see if all requested tests have been completed, process any tests remaining if patient is admitted.
- **Direct Admissions** Bypass the admitting/emergency room go directly to nursing unit.
- An example of a direct admission would be a woman going directly to labor/delivery, or a pt being transported by ambulance/ helicopter from another facility.

Admission by Patient Type, Inpatient, Observation, Outpatient



- **Inpatient** Admitted and assigned a bed
- **Observation Patient (short-stay, ambulatory)** assigned bed to receive care for <24 hrs.
- Some hospitals have **MSSU**(medical short stay unit or **Ambulatory Care Units** to provide care.
- After 24 hrs if pt requires more care, HUC obtains Dr. order for hospital admission.
- **Outpatient** Receives care in hosp, but not overnight. Assembly of chart not required.
- **Service Type** Type of unit, Med/surg, OB, Peds, Neuro, Surgical, Urology, Telemetry, etc.
- Admission Agreement - Physician authorizes admission, writes diagnosis/reason for admit.

Admission Arrangement



- Hospitals open 24hrs/day
- Computerized census lists occupied/unoccupied beds.
- Admitting diagnosis determines unit.
- Nursing staff may decide bed assignment
- Roommate issues, staffing regs.
- After receiving name, diagnosis, sex, nurse/HUC assigns room/bed number.
- Patient escorted to unit by volunteer, admitting personnel or HUC.
- If patient is already registered, the admitting papers are delivered by escort.

HUC Registration Tasks

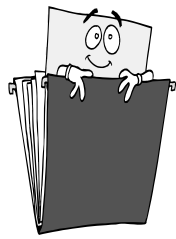


- Copy insurance cards, verify coverage, obtain signatures.
- Interview pt/family obtain personal info.
- Prepare forms (admission agreement, facesheet, signatures, test results, doctor's orders/consents.
- Prepare patient's ID bracelet
- Prepare patient's imprinter card/ID labels
- Secure patient's valuables
- Supply/explain required information, including privacy laws, and Patients Bill of Rights.
- Ask about advanced directives

The Interview



- **Information Sheet** Preadmission info by mail/phone, or at admission.
- Protect provacy/confidentiality
- Be proficient/professional
don't ask repetitive questions
ask any previous hospitalizations
obtain insurance card
treat each patient as an individual
- Listen carefully
- Project a friendly, courteous, caring attitude



Forms

- Admission Agreement or Conditions of Admission – between pt/hosp lists services hosp provides, financial responsibility
- Patient signs this form or representative
- Copy given to pt, original filed in chart.
- Facesheet/summary sheet/information sheet– first page of medical record, includes address, phone, next of kin, insurance,
- File tests performed prior to admission
- File physicians orders and consents.
- Write health records number on all forms. All charges refer to this #
- Pt may be assigned a new health records number c each admission, then give old records the updated number.



Identification and Valuables

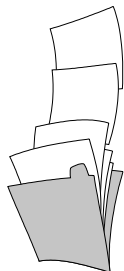
- Bracelet/band – registration prepares, includes name, sex, age, DOB, Dr, health records number, account number, type of insurance, date of admission, room number.
- Imprinter Card – plastic charge card with pt name, dr, health records number, room, bed, not used as often as previously.
- Imprinter Labels – self adhesive labels instead of card. Peeled off and placed on all forms, supplies, etc.
- Valuables – Pts. Are requested to place expensive jewelry, money in numbered envelope in safe. Pt given a duplicate numbered claim check. Or send home.
- Clothing and Valuables form – will list all other items, and reference the safe.



Advance Directives

- The right to self-determination about future medical treatment, and end of life care. Adult witness or notary must sign who is not related to the patient or an heir or not Power of Attorney.
- **Several options available:**
- The Living Will – Patient states what is to be done in the event of a terminal illness.
- Power of Attorney for Health Care - allows patient to appoint persons (proxy/agent) to make health care decisions

Admission Orders



- Written directions by Doctor for care and tx
- May be written on unit by hospitalist, nurse practitioner, attending, or resident or by phone immediately upon pts arrival.
- Preprinted order sets or reg orders may be left before pt arrives.
- Pts name must be written on order sheet, stamp or use labels when available.
- Common components of admission orders:
 - 1. Admitting diagnosis, diet, activity level.
 - 2. Diagnostic Orders
 - 3. Medications
 - 4. Treatment (tx) Orders
 - 5. Request for old records
 - 6. Code status, full code, modified support, DNR

The Surgery Patient – General Information



- Diagnostic tests performed ASAP.
- Trend is to admit patient the day of surgery.
- All preoperative tests completed before admission.
- Pt. starts in admission day surgery area/same day surgery/Am admission (AMAD)
- Admitted to surgical unit after surgery/recovery
- Before admission the patient:
 - 1. Visits the doctor
 - 2. Registers for the hospital
 - 3. Completes blood tests, chest x-ray, EKG.
 - 4. Visits with anesthesiologist.
- On day of surgery pt reports to admission area:
 - 1. Admission will send pt to day surgery area with ID band, doctor's orders, all tests reports, imprinter card (addressograph plate) or labels, admission/consent forms.

The Preoperative Orders



- Surgeon will write orders before surgery.
- Name of surgery written on orders.
- Any discrepancy of procedure named on operative permit and dr's order must be checked
- Consents must be in ink, no abbreviations, legible
- Surgeon will designate the anesthesiologist.
- Anesthesiologist writes orders day before surgery
- Anesthesiologist writes time to d/c food/fluids and pre-op meds to relieve anxiety and aid in the induction of anesthesia.
- Preoperative Surgeon's Orders Components:
 - 1. Name of surgery for operative permit
 - 2. Enemas, scrubs, shaves, showers
 - 3. Name of anesthesiologist
 - 4. Miscellaneous (diagnostics, blood, IV's, meds, TEDS, treatments, additional meds.)

Preoperative Routine



- Pre-op check list
- Following records must be on chart: H&P, consent, blood consent, admission service agreement, MAR, test results,
- Patients spend 1-2 hrs in Recovery Room
- Post op orders initiated in PACU
- PACU writes on dr's orders what they did.
- HUC informs nurse of pts arrival in PACU
- " informs ward nurse of expected arrival.
- " removes imprinter card from chart and file
- " File operating records behind divider
- " write date of surgery/procedure in Kardex
- Write date of surgery on appropriate forms
- Transcribe physicians' postoperative orders and notify nurse of stat orders.

Postoperative Orders and Routine



- All surgery records, Operating Room Nurse's Notes and Anesthesia Chart becomes part of medical record.
- **Postoperative Order Components**
- Diet
- Intake and Output
- Intravenous Fluids
- Vital Signs
- Catheters, Tubes, Drains
- Activity
- Positioning
- Observation of the Operative Site
- Medications
- **Postoperative orders cancel all previous orders**

Summary

- For most patients, admission to the hospital is a stressful or even frightening experience.
- The Health Unit Coordinator can do much in the field of public relations for the hospital at this time.
