Lecture 12

Admission and discharge of

Patient from hospital

Admission the patient to the hospital is whether scheduled or follows emergency.

The goals of admission of patient.

1. To assess the clinical status of patient.
2. Make him as comfortable as possible in his new environment.
3. Complete the treatment that he/ she need to become well being.

Information that record by the nurse when the patient admitted the hospital.

1. Information about the patient includes, his name, address, age, date of birth, religion, sex, marital status, occupation or school, telephone number, nearest relative for emergency.
2. Doctor recommending admission.
3. Provisional diagnosis.
4. Check vital signs (temperature, pulse, respiration and pressure).
5. Measure weight and recorded.
6. Obtained the specimen of urine, tested and charted.
7. All valuables and money take home by relatives.
8. History of disease recorded by doctors. And record the doctors order and reason for admission .

Observation made by Nurse:

1. General reaction of patient e.g. anxiety.
2. Cleanliness of clothes, skin, hair, mouth.
3. Abnormalities of skin and other structure.
4. Complaints of patient e.g. pain, breath lessens.
5. Last passing of urine, stool, menstruation.
6. Medication brought with patient.

Discharge from hospital:

1. Discharge planning aims' to teach the patient and his family about his illness and its effect on his life-style.
2. Provide the patient instruction for home care about the diet and the activity of patient.
3. Arrangement made for suitable transport.
4. Give written instruction regarding treatment.
5. Follow up care if necessary, like made dressing if the patient had operation.

After discharge of the patient:

1. Sends linen and blankets to laundry.
2. Sends mattress and pillow to autoclaved.
3. Wash the bed and table bedside.
4. Locker scrubbed out.

Nursing process:

1. **Assessing:** is the act of reviewing a human situation from a data base in order to diagnose, potential client problem**.**

2. **Diagnosis:** is the first diagnosis when the patient entered the hospital, it done by the signs and symptoms that patient compliant of.
3. **Planning:** the nurse put her/ his nursing planning from the information of the patient compliant.
4. **Implementation:** is the complete of action to accomplish nursing care plan, it dependent on the nature of problem, condition of the client as well as action of planned.
5. **Evaluation:** is the effect of action.

Methods of observation of patient by nurse.

1. **Visual observation:** includes physical characteristics facial expressions, behavioral response to interaction with other, and posture of the person being observed **(looking).**
2. **Auditory observation: (listening)** includes a person's cough, breathing sounds and heart sound.
3. **Olfactory observation: (smelling)** includes the odor of drainage from a wound, stool and the odor of breath.
4. **Touctile observation: (touching)** includes the warmth of skin, the nature of pulse and size of various body organs.