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| <b>Name of Policy:</b> <u>Patient Admission and Discharge</u><br><b>Policy Number:</b> 3364-110-01-01<br><b>Department:</b> Nursing Service<br><b>Approving Officer:</b> AVP Patient Care Services/CNO<br><b>Responsible Agent:</b> AVP Patient Care Services/CNO<br><b>Scope:</b> The University of Toledo Medical Center (UTMC) | <br><br><b>Effective Date:</b> 3.15.21<br>Initial Effective Date: 6/1979 |
| <input type="checkbox"/> New policy proposal<br><input type="checkbox"/> Major revision of existing policy  |  |
| <input checked="" type="checkbox"/> Minor/technical revision of existing policy<br><input type="checkbox"/> Reaffirmation of existing policy  |  |

### (A) Policy Statement

Patient admission and discharges will be performed in a timely manner. Nursing personnel will encourage open communication with patients and family members. Discharges require a physician order.

### (B) Purpose of Policy

To provide standardization of services and maintain a climate of mutual support and appreciation among patient, family, and staff throughout the admission and discharge.

### (C) Admission Procedure

- \*1. Orient patient to the nursing unit.
2. Initiate, review, and complete nursing admission assessment with the patient/family including mutual discharge goals to guide patient care. This must be completed within 24 hours of admission.
- \*3. Identify location of the patient Welcome Packet for the patient/family, including information about safety, patient's rights and responsibilities, advanced directives, etc. Review and offer clarification, additional information or appropriate resources when needed. Document patient education in the EMR.
4. The Clerical Specialist will:
  - a. Check to ensure that the patient is wearing an identification band.
  - b. Follow procedure for physician notification.
  - c. Verify admission order (In-patient vs. observation) with registration designation. If not the same, notifies admitting office.
  - d. Mark room, bed number, and patient's name on the medical record chart.
  - e. Apply identification labels on paper forms within the medical record.
  - f. Ensure patient information regarding POA, living will, advance directive is updated and accurate.

(Patient's condition may warrant changes in sequence. \*May be completed and documented by Licensed Practical Nurse (LPN) or Nursing Assistant (NA). A Registered Nurse (RN) must complete remaining procedure.)

### (D) Discharge Procedure

1. Inform the patient/family that the physician has initiated discharge.
2. Review discharge and patient teaching plans with patient/family. Refer to Nursing Service Policy

