


<b>Name of Policy:</b> <u>Patient Admission and Discharge</u> <b>Policy Number:</b> 3364-110-01-01 <b>Department:</b> Nursing Service <b>Approving Officer:</b> Chief Nursing Officer <b>Responsible Agent:</b> Chief Nursing Officer  <b>Scope:</b> The University of Toledo Medical Center (UTMC)	 <b>Effective Date:</b> 6.1.2025 Initial Effective Date: 6/1979
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> New policy proposal  <input type="checkbox"/> Major revision of existing policy </div> <div> <input type="checkbox"/> Minor/technical revision of existing policy  <input checked="" type="checkbox"/> Reaffirmation of existing policy </div> </div>	

### (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 3364-110-07-04.
3. Discharge orders and instructions will be reviewed and completed with the patient/family by a RN. Provide prescriptions and complete any service specific orders.
4. Collect all personal belongings and home pharmaceuticals. Notify transport of discharge.
5. Enter the discharge into the Bed-tracking system. Specify regular or stat clean.
6. Prepare the room for Environmental Services.

<b>Approved by:</b>		<b>Review/Revision Date:</b>				
<div>/s/</div> <div>Kurt Kless, MSN, MBA, RN, NE-BC</div> <div>Chief Nursing Officer</div> <div>Review: Policy &amp; Standard Committee, 2/2014, 1/15, 3/18, 3/21, 3/20241, 6/2025</div> <div>Revision Completed By: Nancy Gauger, MSN, RN, NPD-BC</div>		1980	1988	3/04	6.1.2025	
		1981	1989	7/07		
		1982	1990	8/31/2010		
			1983	9/93	9.1.2013	
			1984	1/95	2/1/14	
			1985	10/96	1.23.15	
			1986	4/99	3.15.18	
			1987	3/01	3.15.21	
		<b>Next Review Date:</b> 6.1.2028				
<b>Policies Superseded by This Policy:</b>						