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Admission, Transfer and Discharge

Nursing Foundation

Patient admission procedures, assessment on admission, transfer protocols, discharge planning, discharge procedures and nursing responsibilities.

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08. ADMISSION, TRANSFER AND DISCHARGE

1. Patient Admission

Admission is the process of accepting a patient into a healthcare institution for observation, investigation, treatment or nursing care.

Types of Admission

- Planned or elective admission.
- Emergency admission.
- Direct admission.
- Admission through referral.
- Day-care admission.

2. Purposes of Admission

- Provide medical treatment.
- Conduct diagnostic investigations.
- Provide nursing care.
- Monitor health status.
- Perform surgical procedures.
- Support rehabilitation.

3. Articles Required

- Admission forms and patient records.
- Identification band.
- Vital signs equipment.
- Weighing scale.
- Prepared hospital bed.
- Personal hygiene supplies.
- Patient belongings documentation form.

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4. Admission Procedure

1. Prepare the patient's bed and necessary equipment.
2. Receive and introduce yourself to the patient.
3. Verify identity using at least two approved identifiers.
4. Assess immediate clinical stability.
5. Complete admission documentation.
6. Obtain relevant medical and nursing history.
7. Measure baseline vital signs.
8. Assess allergies, medications and safety risks.
9. Orient the patient to the ward and call bell.
10. Inform the responsible healthcare team.
11. Implement prescribed investigations and treatment.
12. Document all findings.

5. Admission Assessment

Includes:

- Presenting complaints.
- Medical and surgical history.
- Allergies.
- Current medications.
- Vital signs.
- Pain assessment.
- Nutritional status.
- Elimination pattern.
- Mobility and fall risk.
- Pressure injury risk.
- Psychological and social needs.

6. Patient Transfer

Transfer is the movement of a patient from one unit, department or healthcare facility to another.

Types

- Intrahospital transfer.
- Interhospital transfer.
- Transfer to a higher level of care.

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- Transfer to a rehabilitation or long-term care facility.

Transfer Procedure

- Verify the transfer order and destination.
- Assess patient stability.
- Explain the transfer.
- Notify the receiving team.
- Arrange appropriate transport and monitoring.
- Secure IV lines, oxygen, drains and other devices.
- Transfer relevant records and belongings.
- Provide structured clinical handover.
- Document transfer time and patient condition.

7. Discharge

Discharge is the planned release of a patient from hospital care after clinical assessment and completion of the required discharge arrangements.

Types

- Routine discharge.
- Discharge against medical advice.
- Transfer or referral discharge.
- Discharge to rehabilitation or home care.

8. Discharge Planning

Discharge planning begins during admission.

Important components:

- Medication reconciliation.
- Patient and caregiver education.
- Dietary instructions.
- Activity recommendations.
- Wound care.
- Follow-up appointments.
- Warning signs requiring urgent care.
- Accessibility of medicines and transport.
- Home support requirements.

9. Discharge Procedure

1. Verify the discharge decision.
2. Assess readiness for discharge.
3. Review medications and instructions.
4. Use teach-back to confirm understanding.
5. Complete relevant documentation.
6. Return patient belongings.
7. Arrange transport when required.
8. Document discharge time, destination and condition.

10. Nursing Responsibilities

- Ensure continuity of care.
- Protect patient dignity and confidentiality.
- Verify medication and treatment instructions.
- Maintain accurate records.
- Identify barriers to safe discharge.
- Communicate relevant information to caregivers with appropriate consent.

Important Examination Questions

1. Describe the admission procedure.
2. Explain nursing assessment on admission.
3. Describe patient transfer and nursing responsibilities.
4. Explain discharge planning and discharge procedures.

Conclusion

Safe admission, transfer and discharge procedures ensure continuity, communication, patient safety and effective utilization of healthcare services.

Quick Revision

- Admission accepts a patient for observation, investigation, treatment or nursing care.
- Verify identity with at least two approved identifiers and assess immediate clinical stability.
- Admission assessment includes history, allergies, medicines, baseline observations, pain and safety risks.
- Transfer requires stability assessment, receiving-team communication, safe transport and structured handover.
- Discharge planning begins during admission and includes medication reconciliation, education, follow-up and home support.
- Use teach-back and document discharge time, destination and condition.

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Practice questions

Choose one best answer. The answer key and explanations follow the questions.

1. When should discharge planning begin?

A. After final billing

B. Only after recovery

C. During admission

D. When transport arrives

2. Which method confirms that a patient understands discharge instructions?

A. Providing a leaflet without review

B. Using medical jargon

C. Asking only whether instructions were received

D. Teach-back

3. Which action supports continuity during patient transfer?

A. Provide structured clinical handover

B. Send the patient before notifying the receiving team

C. Leave relevant records on the original ward

D. Disconnect devices without a care plan

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Answer key and explanations

1. C - During admission

Discharge planning begins at admission.

2. D - Teach-back

Teach-back checks the patient's understanding.

3. A - Provide structured clinical handover

Structured handover conveys clinical information to the receiving team.

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