

TECHNIQUES IN CLINICAL NURSING



BARBARA KOZIER

GLENORA ERB

Third Edition

TECHNIQUES IN CLINICAL NURSING

THIRD EDITION

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ASSISTING THE CLIENT TO ENTER AND LEAVE THE HEALTH CARE SYSTEM



ADMISSION



Entering a health care facility is a stressful experience for clients. They may or may not be in discomfort, but most—if not all—feel anxious. Relatives and friends are also worried. Thus, the first contact of the client and the support persons with personnel in the facility is extremely important. Admitting and health care personnel need to convey kindness, concern, and competence in what they do.

Each health care agency has established policies and procedures for the admission of clients, the transfer of clients within the agency and to outside agencies, and the discharge of clients. This chapter focuses on the admission procedures common to many agencies. Chapter 2 presents transfer and discharge procedures.

CHAPTER OUTLINE

Preliminary Admission Practices

Technique 1–1

Admitting a Client to a Health Care Agency

Technique 1–2

Performing a Nursing Assessment

OBJECTIVES

Upon completion of this chapter, the student will

- Identify preliminary admission procedures
- Describe the essential activities in preparing a client's room prior to admission
- List information needed to orient a client to the agency
- Describe policies related to handling of clothes, valuables, and medications
- Explain rationales for routine admission tests
- Discuss the importance of determining the client's allergies
- Perform a nursing assessment
- Identify essential admission data to be recorded on the nursing assessment record

ASSESSMENT GUIDE

Observe general appearance and responses

- Sex, race
- Posture and gait
- General condition (eg, alert, oriented, lethargic, cachectic)
- Respiratory status (eg, wheezing, coughing, shortness of breath)
- Skin condition: include observations of color, temperature, turgor, lesions, abrasions, decubitus ulcers, scars
- Mobility
- Affect/mood/self-perception
 - Revealed through verbal responses to explanation and greetings
 - Revealed through nonverbal behaviors
- Behaviors indicative of stress (eg, increased muscle tension, clammy hands and skin, false cheerfulness)

Measure

- Height and weight
- Vital signs
 - Temperature, pulse, respirations
 - Blood pressure

Determine

- Current health status and past health history
 - Reason for admission
 - Past illnesses and previous agency admissions
 - Current medications
 - Allergies
 - Immunization status (for children and elderly)
 - Substance use/abuse
- Activities of daily living
 - Eating pattern
 - Sleep/rest pattern
 - Elimination pattern
 - Activity/exercise pattern
 - Use of prostheses
- Social and family data
 - Languages spoken
 - Occupation or school
 - Family/home situation
 - Religious practices
 - Financial status

CHAPTER 1

ADMISSION

PRELIMINARY ADMISSION PRACTICES

The admission of clients to a health care agency involves (a) preliminary routine admission procedures that are usually handled by the admitting office, (b) preparation of the client's room, and (c) admission

procedures conducted by the nurse when the client arrives at the room.

Clients who are not critically ill generally report first to the admitting office. In some agencies, nurses carry out the initial admission functions; in other agencies, personnel from the business office do. Clients who are critically ill or injured are admitted directly

to the emergency unit or, in some agencies, the intensive care unit (ICU).

Preliminary admission procedures generally include

1. Obtaining essential personal and identifying data for the admission record. Such data include the client's full name, age, birth date, address, next of kin and/or support person, physician, religion, and dates of past admissions.

Rationale Appropriate identification of the client is necessary to ensure that the correct prescribed tests and treatments are provided to the right client.

2. Acquiring a signed general consent for care.

Rationale A signed general consent for care legally permits the health care agency to provide routine care.

3. Putting an identification bracelet (Identaband) on the client. These are usually made of clear, waterproof plastic and cannot be removed except by cutting. Information on the bracelet may include the client's name and admission number, the attending physician, and the client's room number. Bands listing the client's allergies can also be applied at this time.

Rationale The identification bracelet is used to identify the client when prescribed therapies are administered. Both the Identaband and the allergy band help prevent errors in client care.

4. Notifying the nursing unit that a new client is being admitted and specifying the room and bed he or she will occupy, what the client's diagnosis is, who the attending physician is, and other information relevant to the admission (such as "requires continuous oxygen").

Rationale Notification alerts the nursing staff to possible immediate intervention required and enables them to make necessary arrangements.

5. Transporting the client to the room. The client is always accompanied to the nursing unit by a person designated or assigned by the agency. Many agencies have volunteer staff or porters for this purpose. Depending upon the client's condition, a wheelchair or stretcher may be necessary. Most clients, however, can walk to the unit. The unit clerk or nurse there then assists the client to the room.

Rationale Escorted transport appropriate to the client's physical status ensures the client's safe arrival to his or her room on the nursing unit.

TECHNIQUE 1-1 Admitting a Client to a Health Care Agency

Before admitting a client it is important to know the following:

1. The agency's policies and practices for admitting clients, in particular in regard to the client's medications, personal property, and security for valuables
2. The bed and/or room to which the client will be admitted
3. The client's general condition and/or medical diagnosis
4. Whether upon admission the client needs any special equipment such as an oxygen device
5. Whether the physician has written special orders to be implemented immediately upon the client's arrival

EQUIPMENT

- A stethoscope and a sphygmomanometer with a cuff to take blood pressure. See Chapter 6.
- A watch with a second hand to assess the client's pulse and respirations.
- A thermometer, if not provided at the bedside, to assess the client's temperature.
- A portable scale to assess the weight, in agencies that require this. In many agencies the client's weight and height are recorded as the client states them.
- A bedpan or urinal in which to acquire a specimen of urine if ordered.
- A urine specimen container and laboratory urinalysis requisition, both clearly labeled if a urine specimen is ordered.