HOSPITAL ADMISSION ORDERS & CARE

For Elder’s admission to Acute Hospital Care (Part I)

  - admitting & referring physician
  - special needs (tele?, etc)
  - if patient not capable of medical decisions alert POC or Guardian

- Diagnosis list:  primary diagnoses
- Assess functional status

- Discharge planning (begins upon admission)
  - goals for hospitalization
  - patient, family & social work

- Condition & Code status:
  - code status, and document discussion, (if pertinent)
  - diet orders for nursing and
  - if pertinent consult PT
  - fat or delirium risk:  Bed/chair alarms?  Sitter?
  - up in chair, ambulation orders for nursing
  - out of bed for meals?  (if necessary consult PT)

- Nursing Orders:
  - Dietary consult?  (Avoid NPO)
  - dietary instructions for swallowing disorders.
  - Delirium & Depression (screen for)
  - DVT prophylaxis
  - Respiratory therapy

- Labs:
  - Diabetics

- Prescribing:  When possible use meds that treat more than one condition.
  - New meds:  start with short T1/2 agents and convert (when possible) to q. day or bid dosing by discharge, give indications, crushed? liquids?

- Special (other)

- Attachments:
  - reduce tubes & wires
  - Allergies...
  - give adverse reaction if known

- Admit name, admitting & referring physician,
  - outpatient medications reviewed (prescribed and OTC)
  - special needs (tele?, etc)
  - vision assessment and maximization

- Advance directives

- Hearing assessment and maximization

- DAILY
  - Diet screen

  - Vitals:  ?  trajectory of change? what level do they need to reach for discharge?
  - eating?  % meals, - up to meals?  need feed assistance?
  - speech therapy eval?

  - H2 hydration; - I&O status?

  - F all risk precautions

  - Skin (Pressure injury) (total skin check at least M-W-F)
  - Bowel & Bladder - Eliminating?  - Continent?
  - Mobility?:  - has this patient been out of bed?
  - Attachments:  - reduce the tubes & wires

  - Contacts:  - Contact POA in cognitively impaired

- Discharge Planning:
  - Discharge Planning;  - Diet Planning with admission:  location?
  - arrangements?  quality and ready?

- Discharge summary:
  - should contain the following
  - list discharge diagnoses (list top 4 medical dx. first)
  - procedures performed during admission
  - summary of hospital course by problems
  - discharge instructions
  - discharge medication list (what’s stopped, started, and indications, ending dates)
  - rehabilitation orders & follow-up appointments
  - tests results still outstanding & alerts on problems needing f/u
  - information related to goals, surrogate’s names & numbers
  - current advanced directives (code status, etc)
  - include copies to PCP, hosp. consultants & next venue care (e.g. SNF)
  - Adapated portions are used with permission from; Lyons WL, Landefeld C.S.  Hospital Care, Geriatric Review Syllabus 6th edition pp 91-98, permission granted 8-2009.
  - For more information see:  Web site:  geriatrics.unmc.edu & visit GERI Pearls, evv 8-2009.