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Prescription for Admission

A Doctor's Guide for Navigating the Hospital, Advocating for Yourself, and Having a Better Hospitalization

quick guide

This quick guide to ***Prescription for Admission*** includes high-value items with short explanations and lists.

Please refer to the corresponding page in the book for more insights.

PRE-DAY 1

Before a Hospitalization

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One of the most important things you can do is to be a source of complete and consistent information about yourself. If you are not able to recall these items off the top of your head, you should know where to find the information.

1. Current medications
2. Medical and surgical history
3. Allergies to medications and foods
4. Name and contact information of any specialists or specialized care teams you are seeing
5. Advance directive/living will
6. Mobile medical order (MOLST/POLST forms)

What to Bring to the Hospital

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1. Identification and insurance cards
2. Specialized medications, such as rare or expensive medicines that may not be on the hospital formulary
3. Personal assistive devices like glasses, hearing aids, dentures, etc.
4. Mobile medical order (MOLST/POLST forms)

5. Advance directive/living will

6. Contact information for your health care proxy and care partner

IN THE EMERGENCY DEPARTMENT

Urgent Care vs. Emergency Department

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	URGENT CARE	EMERGENCY DEPARTMENT
Open 24 Hours	Yes/No	Yes
Staffed by Emergency Medicine Provider	Yes/No	Yes
Supported by a Larger Hospital	Yes/No	Yes
Required to Follow EMTALA*	Yes/No	Yes

**EMTALA—Emergency Medical Treatment and Labor Act—this law states that emergency departments must assess and stabilize any patient who presents to the emergency department regardless of insurance status or ability to pay.*

Your First Conversation in the ED

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Focus on answering the questions below with as many relevant details as possible.

- Why did you come to the hospital today?
- When was the last time you felt well?
- Do you feel as if you are getting better or worse?
- What have you tried to alleviate your symptoms?
- What makes you feel worse?
- Be able to give a complete medical and surgical history.
- Be able to give a complete list of your current medications.

Medication Reconciliation

An accurate and complete list of your current medications is necessary so that your care team can appropriately prescribe you new medications, continue important medications you regularly take, and avoid medications that could harm you. The medication reconciliation process will at minimum occur at the time of admission and discharge. Please include over-the-counter medicines and any herbal supplements in your medication list, as these can interact with prescribed medicines. This is also a good time to tell your physician about any illicit substance use so they can plan to help you manage any withdrawal symptoms that may arise during your hospitalization.

Should I Stay or Should I Go?

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If the emergency medicine team is suggesting that you be admitted to the hospital, but you would like to leave, I recommend you ask yourself these questions and be able to answer *yes* to each one before you leave:

- → Is it safe to leave the hospital in the physical state that you are currently in?
- → Is your pain/nausea/vomiting or any other concerning symptom controlled, or will you need to come back because of worsening or uncontrolled symptoms?
- → Will you be able to get and take necessary medications at home?
- → Will you have a medical (e.g., wound care, medicines) and emotional (e.g., friends, family) support system to continue your care after leaving the hospital?
- → If you leave, will you have access to the physicians you need to see, like your primary care physician or any specialists?
- → Will you be able to safely and consistently access food and water?
- → Are you physically safe in your home?
  - Are there stairs you need to go up or down?
  - Will you be able to sleep where you usually sleep?
  - Can you move easily around your home in your current condition?

Transfers

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It may be necessary for you to be transferred to another hospital if a higher level of care or a highly specialized treatment is required. Transfers can happen any time during a hospitalization. For a transfer to occur, the accepting hospital has to agree that it is medically necessary for you to be transferred, in addition to having space to accept new patients.

Code Status and Advance Directives

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Code status is a medical order stating what interventions you have consented to have done in the case of a cardiac or respiratory arrest. An *advance directive* (sometimes called a *living will*) is a comprehensive document detailing your wishes beyond code status, including the name of the person whom you have identified to serve as your healthcare proxy. For easy referencing, some common code statuses include the following:

- Full Code: YES—CPR, medications, shocks, intubation
- Do Not Resuscitate: NO—CPR, medications, shocks, intubation
- Do Not Intubate: YES—CPR, medications, shocks but NO intubation

DAY ONE

Big Goals and Little Goals

Write down 1–3 little goals (day-to-day objectives) and 1–2 big goals (overall objectives for the hospitalization), and discuss them with your care team every day.

Diet

Food in the hospital can be tailored to support patients' specific nutritional and textural needs. The following are common diet plans in the hospital:

- → Diabetic diet
- → Renal diet
- → Cardiac diet
- → NPO—nothing to eat/drink by mouth
- → Changes in food texture, e.g., puréed or soft diets

Artificial Nutrition Options:

- → Enteral feeding, or tube feeding, where a tube delivers liquid food to the GI tract
- → Total parenteral nutrition (TPN), where a nutritionally dense fluid is given intravenously (through a vein)

DAY TWO

Clinical Testing

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- Blood tests
- Body fluid testing, e.g., urine analysis, CSF studies
- Microbiology—testing to identify infectious pathogens, i.e., bacteria, viruses, and fungus
- Radiology
- Functional testing
- Biopsy
- Endoscopic procedures

Social Supports in the Hospital

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Each patient should have an assigned *social worker* or *case manager* during their hospitalization. The social worker and case manager are vital in helping to addressing social issues that are necessary to create a safe discharge plan, including placement in a post–acute care facility if necessary.

Tips from Your Hospitalist

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- Keep a written list of daily questions.

→ Identify one person whom your MD should communicate with for your care.

→ Get the name and business card of every physician on your care team (including specialists).

→ Be open and honest about your concerns/fears.

→ Be realistic about your goals.

→ Keep your support system updated about what you will need when you leave the hospital.

DAYS THREE AND FOUR

Treatment

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Be an active participant in your care so you can avoid a prolonged hospital stay.

→ Participate in your care.

- Get out of bed.
- Take deep breaths; use your incentive spirometer.
- Advocate for help and know how to escalate your requests.
- Do your PT/OT/speech therapy.
- Stick to your prescribed diet.

→ Make follow-up appointments early.

Focus on Your Mental Health

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- Request any psychiatric medications you regularly take.
- Take advantage of the psychiatric services available during a hospitalization.
- Journal.
- Keep in touch with loved ones.
- Do your daily grooming routine.
- Ask your friends/family to visit.
- Maintain regular sleep hours.
- Get out of bed and walk around as much as possible.

Avoiding Delirium

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Delirium is an altered state of consciousness that can occur when someone is ill. Delirium is associated with prolonged hospitalizations and with higher rates of mortality.

- Try to keep a normal sleep-wake cycle.
- Notify your treatment team if you find yourself feeling confused or disoriented.
- Ask family or friends to keep an eye out for you behaving differently.
- Address uncontrolled pain.

- Be up-front about any regular or heavy alcohol use.
- Bring in pictures from family or friends to put around the room.
- Ask the nurse to write the date on a calendar, and make sure you have access to a clock or watch.

Family Meetings

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Family meetings are an excellent tool to give everyone involved in the patient's care an opportunity to ask questions and make hard decisions, if necessary. Although these meetings are useful, they can be challenging. Homing in on these things will help make a family meeting more productive:

- Define the communication goal: why are we meeting?
- Define the key stakeholders and ensure they are present: who should be there?
    - Include anyone who serves as a support for making medical decisions.
- Where will the meeting take place?
    - Meeting at the patient's bedside vs. meeting in a conference room
- Find a time that works for all parties.
    - Try to avoid early morning meetings, as tests and specialist evaluations may not be completed until the afternoon.
    - Leverage technology to make meeting easier. Ask for a conference call or virtual meeting if these options make meeting easier.

DAY FIVE

Post-Acute Care Facilities

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Learn about the different post–acute care facilities that are available to help with ongoing medical and rehabilitation needs that may not make an immediate return home possible.

- → Skilled nursing facilities (SNF)
    - In order to go to a skilled nursing facility, patients must have a *skilled nursing need*—a medical need or intervention that can only be handled by someone with the proper training or equipment (e.g., frequent or complex wound care).
- → Short-term rehabilitation facilities (STR)
    - To be at a STR, you must be able to participate in physical therapy for your recovery—making it a perfect stop for those who aren't quite ready to go home yet because they are still too weak to be in their home safely.
- → Long-term care (LTC)
    - This is a nursing home, where patients receive *custodial care* (help with everyday activities and care) because it is not safe for them to be home alone or their loved ones are not able to care for them at home.
- → Long-term acute care (LTAC)

- LTACs are facilities that are able to care for patients who require ongoing care for complex medical problems (e.g., patients on chronic ventilatory support).

End-of-Life Care After Discharge

During a hospitalization, the goals for a patient can sometimes change from being curative medical interventions to supporting a person by relieving pain and suffering as they pass away. Deciding where to care for a patient at the end of life will be determined by the personal wishes of the patient and capabilities of caregivers. Have an open and honest discussion with the care team to determine where hospice will take place.

- → At home
- → At a facility (hospice center, skilled nursing facility, long-term care facility)
- → In the hospital

Getting Ready to Leave

The day of discharge will require coordination of people, medications, services, etc.

- → Your case manager—this person will be the one making any arrangements you need to be safe outside of the hospital.
- → The logistics—this could include new equipment, new medicine, and follow-up appointments.

- At-home services and equipment—IV medications, dialysis, infusion pumps, etc.
- Paperwork—such as return to work/school notes.

Home May Look Different

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Some adjustments in home and daily routines may need to take place after discharge.

- New equipment—e.g., walker, cane, bedside commode, wound care supplies
- New medications—look at your discharge medication list and compare it with what you were taking prior to being hospitalized.
- New diet—e.g., low fat, low salt, low sugar, limited fluid intake
- Support in the home—part-time or full-time help from family/friends or professionals
- New doctors—continued care with the specialists who saw you in the hospital