Hospital Unit Administration

Hospital Unit Administration

NANCY WEATHERHEAD

Conestoga College Open Learning
Kitchener

Contents

CHAPTER 9: TRANSFER AND DISCHARGE PROCEDURES

Introduction

Hospital Unit Administration evolved from a simple course pack for ADMN 2270: Hospital Unit Administration 1, a third-semester course within the health office administration program at Conestoga College. While this OER was intended to complement this specific course, it may be of interest to any office administration or health services program as a theory resource dedicated to the role of hospital unit coordinator (HUC), or any health-related program looking for an overview of hospital departments, risk management processes, filing resources, or communication resources.[1]

This resource has several parts dedicated to broad topics of the HUC role in hospital administration:

- Introduction to the role of the HUC
- The role of common hospital staff
- The organization of hospitals (including general, clinical departments, and patient care areas)
- Risk management, staffing, and communication processes within the hospital environment
- Electronic and hybrid hospital records
- Admitting, transfer, and discharge procedures

Note that because of computerized provider order entry (CPOE), the HUC's role in processing physician's orders is not covered in this resource.

Interactive H5P **Practice Activities** and **Review Activities** are included throughout the OER to supplement and reinforce the learning material. These activities can be attempted as many times as the student wishes without assigning a grade. An **Appendix** includes a list of common abbreviations used in hospitals. The terms defined in the **Glossary** also include pop-ups where they appear in the text.

If you encounter any concerns, your suggestions and ideas for enhancements are appreciated. Please contact me at nweatherhead@conestogac.on.ca.

— Nancy Weatherhead

1. Note: This OER utilizes the term HUC for the clerical role in the hospital; however, this role may also be known as clinical secretary, communication clerk, clerical associate, or unit clerk.

CONESTOGA
OPEN LEARNING

As part of our commitment to delivering high-quality open educational resources (OERs) and open access learning materials (OAs), we invite you to report your OER and OA adoptions. The information you provide helps us to continue supporting high-quality OERs, track impact statistics, and save costs. We will use the data collected in this form to gather information about your use of OERs supported by Open Learning at Conestoga College.

If you've adopted an open textbook supported by Open Learning at Conestoga College, we'd love to hear from you! Please share your adoptions with us by completing our Report an Adoption Form.

Acknowledgments

LAND ACKNOWLEDGMENT

At Conestoga College, we would like to acknowledge that in Kitchener, Waterloo, Cambridge, and Brantford, we are located on the Haldimand Tract, the land promised to the Haudenosaunee people of Six Nations, which includes six miles on either side of the Grand River. This is the traditional territory of the Anishinaabe, Haudenosaunee, and Neutral peoples. Recognizing the land is an expression of gratitude and appreciation to those whose environment we reside in and a way of honouring the Indigenous people living and working on the ground for thousands of years.

LEADERSHIP TEAM

- Michelle Grimes – Executive Dean, School of Business
- Lil Premsukh Singh – Dean, School of Business
- Mona Nouroozifar – Dean, School of Business
- Amanda Di Battista – Chair, School of Business

OPEN LEARNING TEAM

- Kimberlee Carter, MA, BEd, OER Consultant
- Daleara (Dela) Hirjikaka, MA, Instructional Designer — OER
- Simone Larin, MSCom, Administrative & Quality Assurance Officer
- Cecile Monique Michniewicz, MEd, Instructional Designer — OER
- Olu Oke, MA, BEd, OER Project Coordinator
- Rachel Stuckey, MA, Instructional Designer — OER

Student OER Assistants

- Silvana Morales Cortes
- Sarthak Gupta
- Esther Oko

Author Acknowledgments

Many thanks to **Rachel Stuckey** for her many hours of editing, copyright proofing, AODA compliance checking, photo sourcing, suggestions and support. Thank you for taking my Pressbook and making it into OER reality!

Many thanks to the many wonderful **Conestoga partial load** and **part-time instructors** who have provided insight and feedback on hospital-related content over the years.

I am always grateful for the ongoing support from the Conestoga full-time Health Office Administration team, especially **Ellen Dilgert, Leah Klassen**, and **Claire Palvetzian** who have paved the way in OER development for our team and encouraged me to do likewise.

Finally, many thanks to **Kimberlee Carter** for championing OERs from the onset both in our program and at Conestoga College.

— Nancy Weatherhead

Attributions

Media attributions appear at the bottom of each page, as required.

Book cover image: "St. Mary's General Hospital, Kitchener, Ontario" by Rachel Stuckey, © Conestoga College, licensed CC BY-NC-SA.

ARTIFICIAL INTELLIGENCE DISCLOSURE

Most of the alternative text included in the metadata of the images in this publication was created by revising the output from the Arizona State University Image Accessibility Creator tool. The alternative text is, therefore, shared under a Creative Commons – CC0 1.0 Universal license.

Our commitment to quality at Conestoga College ensures that Open Learning holds faculty and staff to high standards. Therefore, any use of AI is vetted for transparency and disclosed, and authors are accountable for their content's accuracy, integrity, and originality. We are committed to transparency and believe that the use of AI contributes to the quality and accessibility of this resource.

Accessibility Statement

Conestoga College Open Learning is committed to producing open educational resources that are accessible to as many learners as possible. We encourage our authors to adopt a universal design for learning approach and aim to comply with the accessibility standards of the AODA and WCAG.

If you experience challenges accessing this resource or have suggestions for how we might improve accessibility in our OER, please contact us at openlearning@conestogac.on.ca.

For more information about how we strive to meet accessibility standards, please review the Conestoga College Accessibility Statement for OER Projects.

NOTE REGARDING CITATION PRACTICES

This resource uses APA Style, 7th edition, for citations and references. As a digital-first publication, however, citation rules have been adapted according to the APA recommendations for web accessibility by using descriptive links in APA Style.

MULTIPLE FORMATS AVAILABLE

This OER is available in multiple formats, including PDF. To download, select the desired format from the "Download this book" dropdown menu beneath the cover image on the title page.

About the Author

Nancy Weatherhead is a professor in the School of Business at Conestoga College, where she has been teaching courses in the health office and medical office administration programs since 2010. She holds an MA in adult education, a Bachelor of Health Administration, and a diploma in human resources management. Before joining the college, Nancy worked for several years at St. Mary's General Hospital, the LHIN (now HCCSS), and in private dental practices.

CHAPTER 1: INTRODUCTION TO THE ROLE OF THE HOSPITAL UNIT COORDINATOR

Overview of the HUC Role

In our first section, we will be reviewing the role of the **hospital unit coordinator (HUC)** in hospitals, as well as the role of other professionals that they will be interacting with in the hospital environment. Hospital unit coordinator or HUC is the term we will use for the health office administrative role within hospitals. You will see other terms used for the same role, including *health unit coordinator*, *communication clerk*, *clerical associate*, *unit clerk*, or *clinical secretary*.

> *"A new helper introduced to the nursing unit to take care of the many details of a secretarial nature that formerly made demands on the limited time of the nurse."*
>
> *— Abraham Oseroff, 1940*[1]

THE EVOLUTION OF THE HUC ROLE

Prior to World War II, there were few support personnel employed in hospitals. As the nurse's clinical role expanded, it became more difficult for them to manage the desk duties on the clinical unit. At that time, a support role called "*floor clerk*" was introduced to many hospital units to relieve some of the pressure on the nursing staff. Following the war, as healthcare facilities expanded and nursing shortages were experienced, more responsibilities were placed upon the "ward clerk." Many of these duties were assumed from head nurses, including ordering supplies, preparing reports, doing staffing, and transcribing simple physician orders (National Association of Health Unit Coordinators, n.d.).

1. As cited in National Association of Health Unit Coordinators, n.d., para. 3.

After World War II, an administrative role was added to hospitals to manage many of the clerical and administrative tasks previously done by nurses. This freed nurses to focus more time on patient care.

By the 1960s, formal education for the ward clerk role started to appear in vocational schools and community colleges. By the 1980s, formal diplomas and certificates were offered at many post-secondary institutions, and professional associations were developed. In the United States, a national professional organization named the National Association of Health Unit Coordinators (NAHUC) developed a professional Code of Ethics and Standards for Practice, National Certification Exam, professional certification and code of ethics specifically for the HUC, along with a national HUC day of recognition (National Association of Health Unit Coordinators, n.d.).

The financial pressure that hospitals experienced throughout the 1980s and 1990s increased their interest in utilizing their higher-paid nursing staff to their full advantage. This resulted in the reduction of nursing desk tasks and more administrative clinical tasks being assigned to the *unit coordinator*, such as transcription of medications, and as new electronic health records (EHRs) were developed, *computerized order entry*. With this increase in responsibility, the unit coordinator role also had increased expectations for formal education. Hospitals are now

moving towards an increased level of computerization, which will change some of the HUC's clinical role; however, the need for skilled HUCs still remains to effectively communicate and manage critical unit functions.

Take Note! HUC Week

August 23 to 29 is the annual "Health Unit Coordinator Week" in the United States.

Learn more on the NAHUC website.

HUC DUTIES

HUCs typically work in forward-facing roles in a variety of hospital settings and may complete a wide variety of tasks, such as

- managing the pre-registration, registration, transfer, and discharge processes for patients,
- using scheduling software to schedule inpatient and outpatient tests and surgical procedures,
- transcribing physician's orders for medication, laboratory, diagnostic imaging, and treatments into computer systems and medication records,
- managing the staffing, scheduling and payroll functions for their unit,
- arranging for urgent and non-urgent patient transportation services,
- completing various administrative tasks such as sending emails, ordering supplies, scheduling meetings, taking minutes, and keeping statistics,
- completing various communication tasks such as answering telephones and call bells, utilizing paging systems, greeting patients, and updating bed boards and patient tracking systems,
- completing various health information management tasks such as scanning, filing, purging charts, and performing post-discharge processing of patient records, and
- applying security measures to ensure confidentiality and safety of patient information.

WORKING CONDITIONS

The HUC usually works day and evening shifts seven days a week in hospitals and other health care facilities, such as long-term care. However, in some hospital critical care units, such as the emergency department (ED) or intensive care unit (ICU), they may be required to work rotating shifts that also include nights. The HUC's schedule reflects the general staff utilization patterns in the hospital where they are employed and may change depending upon their status as full-time or part-time employees or changing hospital requirements. In general, the HUC may expect to work 4-, 8-, 10- or 12-hour shifts, or some mixture of these.

The HUC may experience a variety of workplace stressors. They work in very busy environments and continually interact with other people both in person and on the telephone. Accordingly, they must have the ability to work effectively despite frequent interruptions. They may experience a large variety of background noise, odours, and infectious materials in their typical day. The HUC may also face ongoing exposure to the emotional stress that illness or injury causes patients and their families and must effectively communicate with and support patients and families experiencing medical crises or loss (ALIS, 2021).

The HUC can expect that they will be moderately active in this role. While the majority of their work takes place at a desk (often called a communication centre/nursing station), they may also be standing and walking for a large portion of their shift as they retrieve patients from wait areas, escort patients and/or families to rooms, retrieve supplies, medications, and dietary trays, and deliver specimens to the laboratory.

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES

While each organization will have unique requirements, the basic qualifications for an HUC include the completion of a formal post-secondary medical administrative program that includes

- medical terminology and abbreviations,
- health information management, including filing, scanning, privacy laws, filing, and documentation methods,
- knowledge of common lab and diagnostic tests, including patient preparation,
- basic pharmacology, including the ability to read and transcribe physician medication orders,
- communication, including interpersonal, written, therapeutic, and conflict management, and
- computer skills, including database management, EHR, file management, and MS Office.

In addition, HUCs are usually expected to demonstrate:

- keyboarding skills (minimum of 50-60 wpm with 97% accuracy, which is often tested),
- completion of immunizations required under the Public Hospitals Act,
- completion of a recognized CPR course and a clear vulnerable sector (VSS) police check,
- strong customer service, organization, attention to detail, and prioritization skills, and
- strong attendance records.

References

ALIS. (2021, March 5). *Occupations in Alberta: Unit clerk*. Government of Alberta.

Gillingham, E. A., & Wadsworth Seibel, M.M. (2014). LaFleur Brooks' health unit coordinating. (7th ed.). Elsevier.

National Association of Health Unit Coordinators. (n.d.). *NAHUC history*.

Attributions

"A nurse filling out a patient report in the children's ward at St. Joseph's Hospital, Victoria, B.C." by unknown.

Canada Department of Manpower and Immigration. Library and Archives Canada, e010982306 on flickr; licensed Creative Commons – Attribution 2.0 Generic.

Physician/Specialist Terms

The HUC will interact with a wide variety of physicians in the hospital environment during the course of their daily duties. They will also be expected to enter correct physician data into the patient record and contact the appropriate physician for referrals, consults, and patient care-related issues. Therefore, it is important that they have a good understanding of the most common types of physicians in the hospital, and their scope of practice.

GENERAL TERMS RELATED TO HOSPITAL PHYSICIANS

Working in a hospital, the HUC will hear several terms related to physicians based upon where they are in their training, clinical role in care of the patient, or even the time of day. Below are some common general terms that may be used to describe physicians of any specialty within the hospital environment.

Attending Physicians/Most Responsible Physicians (MRPs): These physicians have completed their residency and are certified in their chosen specialty. They make the primary decisions when it comes to patient care and supervise the work of medical students, residents, and interns. The MRP is typically a surgeon, medical specialist, or hospitalist. Only one doctor may be MRP for a patient at one time, although the MRP may change throughout a hospital admission.

Consultant: These doctors provide opinions or recommendations on patient conditions outside the MRP's area of expertise at their request. Some common consults may include cardiology or anaesthesia consultations prior to proposed surgical procedures.

Doctors On-Call/On-Call Physicians: In addition to their own practice, these doctors work on weekends, evenings, and other shifts to answer questions or cover emergencies. On-call duties are typically divided evenly amongst a specialty type; for example, general surgeons, so that one of them is always available after hours.

Interns: These doctors have completed medical school and are in their first year of residency.

Residents: These doctors have graduated medical school and are continuing their training for two to seven years in a specific medical area, like family medicine or surgery. Residents provide direct care, under the supervision of a fully credentialed attending physician who approves their decisions.

SPECIALISTS AND SUBSPECIALISTS

There are a number of different specialties that a physician can complete, and they may change specialties during their career. Some of the more common specialties are described below, along with reasons why a patient might be referred to them.

Anaesthesiologists: These doctors work mostly with patients undergoing surgery. They use their knowledge of

pharmacy and physiology to ensure that patients remain unconscious or with no sensation during their surgical procedures. Anaesthesiologists may also be consulted to help with pain management in patients with pain problems outside the operating room, such as administering epidurals during labour and post-operative pain management.

Cardiologists: These medical doctors specialize in diagnosing and treating heart disease. They do not perform surgery but treat common cardiac issues such as arrhythmias, congestive heart failure, and other cardiac pathologies.

Cardiovascular Surgeons: These doctors perform surgical treatments for the heart and other thoracic organs. They do not provide ongoing care as cardiologists do, but they complete the required patient assessments, surgical procedures, and immediate aftercare.

Emergentologists/Emergency Medicine: These doctors work in emergency departments to provide care to acutely ill or injured patients. Their patients can present with a variety of different pathologies and injuries.

Endocrinologists: These doctors specialize in the treatment of endocrine system disorders that affect hormone levels and may treat patients who have either high or low levels of certain hormones, such as diabetes and growth problems.

Gastroenterologists: These doctors specialize in the diagnosis and medical treatment of conditions affecting the digestive system. They may treat patients with an array of digestive pathologies that could include gastroesophageal reflux disease (GERD), Crohn's disease, and ulcerative colitis.

General Surgeons: These doctors perform surgical procedures on many organs and bodily systems, including the gastrointestinal system, the endocrine system, the breasts, and the skin (Berry, 2019).

Geriatric Medicine Physicians/Geriatricians: These internal medicine or family medicine doctors treat older patients, often over 75 years of age, for any medical needs and assessments they may require.

Hematologists: These doctors specialize in diagnosing and treating blood disorders. They are very knowledgeable about different blood conditions and laboratory procedures. A patient could be referred to this physician if they have a blood disorder related to clotting, anemia, hemophilia, or other blood-related factors.

Hospitalists: These doctors specialize in primary care for hospitalized patients. These doctors cover the gap in primary care that occurs during hospitalization by assuming the primary care role during the hospitalization period. Hospitalists may be family physicians or Internists.

Infectious Disease Doctors: These doctors specialize in diseases and conditions that are contagious or difficult to diagnose, such as **nosocomial infections**, TB, influenza, or cellulitis. This specialist can assist with the diagnosis, treatment, and ways of decreasing the spread of an illness.

Intensivists: These doctors, often internists with advanced training, work in intensive care units treating critically ill patients. May also be called *critical care physicians* (Santiago, 2023).

Internal Medicine Physicians/Internists: These doctors specialize in medically treating disorders with the internal organs and systems of the body for adults. May be general internists or specialize in a subspecialty (WebMD Editorial Contributors, 2023).

Neonatologists: These doctors are pediatricians with specialty training in the care of premature and critically ill newborns (Nemours KidsHealth, 2022).

Nephrologists: These doctors specialize in diagnosing and medically treating kidney diseases. They treat patients with kidney failure and other pathologies that relate to the kidneys.

Neurologists: These doctors specialize in the prevention, diagnosis, and medical treatment of disorders and conditions related to the brain, spinal cord, nerves, and muscles. They may treat pathologies such as multiple sclerosis, epilepsy, tremors, cerebral palsy, Alzheimer's disease, and Parkinson's disease.

Obstetrician/Gynecologists (OB/GYNs): Obstetricians provide care to the mother and fetus through pregnancy and labour, and to the mother during the postpartum period. Gynecologists focus on the diagnosis, treatment, management, and prevention of diseases and disorders of the female reproductive system. A patient may see a gynecologist if they have conditions such as pelvic inflammatory disease, endometriosis, or other pathologies that affect the female reproductive system. OB/GYNs provide both obstetric and gynecology services to patients.

Oncologists: These doctors specialize in diagnosing and treating patients who have cancer and malignancies in any area of the body.

Ophthalmologists: These doctors specialize in screening, diagnosing, and managing the care of patients with optical, medical, and surgical diseases or disorders of the eye, such as cataracts or detached retinas.

Orthopedic Surgeons: These doctors specialize in the prevention, diagnosis, treatment, and surgery of disorders and diseases related to the musculoskeletal system. They may treat patients who have injuries to their musculoskeletal system from trauma or from complications of aging or repetitive use.

Otolaryngologists (ENTs): These doctors specialize in the treatment of conditions in the ears, nose, and throat. They may see patients with hearing difficulties, difficulty swallowing, issues with balance, or tinnitus.

Palliative Medicine Specialists: These doctors help patients who have serious illnesses or are at the end of life by focusing on managing pain and improving quality of life.

Pathologists: These doctors specialize in the study aspects of disease. They often work in the lab, studying tissue, blood, and body fluid samples from patients and working to assist in the diagnosis and prognosis of disease and illness.

Pediatricians: These doctors provide ongoing care to children, for any medical needs they may have. These doctors can provide both long-term and acute care, and children can be referred to them from family physicians if they require more specialized care.

Plastic Surgeons: These doctors specialize in medically necessary reconstructive and cosmetic procedures and/or surgeries which modify a person's appearance (Santiago, 2023).

Psychiatrists: These medical doctors specialize in providing treatment for diseases of the mind. They complete comprehensive assessments and diagnose and plan care for patients who are experiencing various forms of mental illness and emotional and behavioural disorders.

Pulmonologists/Respirologists: These medical doctors specialize in the diagnosis and treatment of diseases related to the respiratory system. Patients may see this specialist if they have asthma, chronic obstructive pulmonary disease (COPD), emphysema, or other respiratory signs or symptoms.

Radiologists: These doctors specialize in using medical imaging techniques such as X-rays, CT scans or MRIs in the study, diagnosis, and treatment of disease. Their role is often as a consultant to other physicians for patients who require diagnostic imaging.

Rheumatologists: These doctors specialize in medically treating systemic diseases that affect the joints and muscles, including autoimmune disorders that affect multiple body systems, as well as rheumatoid arthritis, lupus, and psoriasis.

Urologists: These doctors specialize in the diagnosis and treatment of urinary and male genitourinary system conditions, disorders, and diseases such as prostate disease and renal and bladder dysfunctions. In addition to diagnosis and medical treatment, they may also perform surgical repair. Common patient conditions that they treat include kidney stones, kidney failure, benign prostatic hyperplasia, and bladder dysfunction. It is important to note that this specialist provides care and assessment for both male and female urinary systems.

Vascular Surgeons: These doctors specialize in treating diseases of the blood and lymphatic vessels. They repair and replace diseased or damaged vessels, remove plaque from vessels, insert venous catheters, and perform traditional surgery.

References

Berry, J. (2019, December 16). *Types of doctors and what they do*. Medical News Today.

Nemurs Kid's Health. (2022). *Doctors and hospitals.*

Santiago, A.(2023, November 4). *Common types of doctors and what they do.* verywell health.

WebMD Editorial Contributors. (2023, July 15). *What is an internist?* WebMD.

Attributions

Nursing/Allied Health Care Worker Terms

In the hospital environment, there are wide variety of professionals who work collaboratively to provide the best possible care for patients. In addition to physicians, the HUC acts as a liaison between these professionals in the course of their daily duties. Below you will find a list of the most common nursing and allied health professionals that the HUC will typically interact with in their duties within the hospital setting, along with their scope of practice.

NURSES

Nurses provide much of the day-to-day care in hospitals, closely monitoring a patient's condition and performing vital jobs like giving medicine and educating patients about self-care. Many kinds of nurses provide varying levels of care; the type of nursing staff utilized in each department is directly correlated to the type of patient care required to provide safe care.

Registered Practical Nurses (RPNs): These regulated nurses typically work in less acute hospital areas and provide basic patient care such as collecting patient assessment information, administering medications, and performing nursing procedures according to their scope of practice. RPNs generally complete a two- to three-year diploma and must write a licensing exam. RPNs often work with RNs in team nursing models, or may take primary care of patients in less acute areas. In many areas, RPNs are assuming increased responsibilities and may assume charge positions in some non-acute care facilities, such as long-term care.

Registered Nurses (RNs): These regulated nurses provide similar patient care as RPNs but with an increased scope of practice. RNs must complete a four-year degree and pass a licensing exam in order to practice. RNs may lead a team in team nursing models, or take primary care of patients in acute and critical care areas.

Nurse Practitioners (NPs): These regulated nurses are RNs who complete two years of additional graduate work and licensing. They work in a variety of settings and complete physical examinations, diagnose and treat common acute illnesses, and manage chronic illnesses. NPs can work independently, order laboratory and diagnostic tests, and prescribe medications.

SUPERVISOR ROLES

In addition to the above nurses who perform hands-on clinical care, the HUC will also closely interact with their unit's *clinical resource nurse* and their *nurse manager*, who provide unit leadership.

Clinical Resource Nurse/Charge Nurse: The nurse, usually an RN, who is in charge of coordinating and managing the clinical care on the unit during their shift. This nurse may work full-time or part-time and can be assigned to this role on a continuous or rotating basis among staff members. The HUC collaborates closely with the clinical resource nurse and reports to them regarding daily concerns during the shift, such as staffing and bed management.

Nurse Manager/Unit Manager: The nurse, usually an RN with additional education and leadership skills, who supervises a nursing unit, by managing staff, budgets, patient care, and implementing hospital policy. Due to budget restrictions, nurse managers in many hospitals manage a set of interrelated departments, such as Surgical Services or Cardiology Services.

OTHER PROFESSIONALS/ALLIED HEALTH CARE WORKERS

Cardiology Technologists: These health professionals perform diagnostic tests such as electrocardiograms (ECGs), stress testing, Holter monitor testing, ambulatory blood pressure testing, and pacemaker monitoring and programming.

Child Life Specialists: These specialists work to assist children and their families reduce stress and during hospitalization through play, preparation, self-expression, and education (Nemours KidsHealth, n.d.).

Dietitians (RDs): These health professionals assess, plan, implement, and evaluate interventions related to the nutritional needs of patients. They work with patients with regular dietary needs, as well as those on therapeutic diets. They also provide dietary education to patients, families, and other healthcare providers. In addition, dietitians work with other members of the healthcare team when a client has dietary needs related to physical disorders such as dysphagia.

Environmental Service Personnel (ESPs): These health care workers ensure a safe, hygienic environment for patients and staff. They maintain the cleanliness of patient rooms, including disinfecting patient beds and high-touch areas, and perform unit cleaning tasks, including floor cleaning and disposal of used equipment and soiled linens.

Home Care Coordinators: These health professionals assess care needs and eligibility for services and equipment for patients upon discharge, as well as coordinate admission to long-term care facilities. Home care coordinators are often RNs; however, other regulated health care professionals may also assume this role.

Laboratory Technologists/Technicians, and Phlebotomists: Technologists perform complex analyses of tissue, blood, and other body fluids. Technicians and phlebotomists spend the majority of their time processing samples and, in some unique cases, collecting them.

Medical Radiation Technologists (MRTs): These health professionals use imaging, such as X-rays and computerized tomography (CT), to assist in the diagnosis and treatment of diseases.

Nuclear Medicine Technologists: These health professionals use equipment to acquire scans of areas such as the thyroid, heart, bones, and kidneys using some form of radioactive contrast material.

Occupational Therapists (OTs): These health professionals work with patients with illnesses, injuries, delayed development, or disabilities to develop or improve skills needed for daily living and working, such as bathing, grooming, eating or dressing. They also can assess the home for safety and evaluate the patient's need for assistive devices for when they are discharged from the hospital or rehabilitation facility.

Patient Transport Worker/Porter: These staff members transfer patients and their equipment between hospital areas for tests, appointments and procedures. They may transport patients in wheelchairs or on their beds or stretchers depending on the patients' requirements.

Personal Support Workers (PSWs): These certificate program graduates assist patients with daily tasks such

as bathing, dressing, feeding, and toileting. PSWs and/or health care aides typically work with nurses in a team nursing model in less acute hospital departments.

Pharmacists: These health care professionals ensure medication safety and are a vital resource for other medical professionals who have questions or concerns about the medications being administered to patients. Pharmacists not only ensure that patients get the correct medication and dosing, but also that they have the guidance they need to use the medication safely and effectively.

Physician Assistants (PAs): These professionals are licensed to practise medicine under the supervision of a physician in a clinic or hospital. PAs can diagnose and treat patients and prescribe medicine, and some may be surgical assistants (Albany Medical College, 2022).

Physiotherapists (PTs): These healthcare professionals who assess, plan, implement, and evaluate interventions, including those related to the patient's strength, mobility, balance, gait, coordination, and joint range of motion. Treatments may include exercises, massage, joint manipulation, and occupational retraining (Carter & Rutherford, 2020).

Respiratory Therapists (RTs): These health professionals treat patients with respiratory-related conditions. Their specialized respiratory care includes managing oxygen therapy, drawing arterial blood gases, managing patients on specialized oxygenation devices such as mechanical ventilators, CPAP, and Bi-PAP machines, and administering respiratory medications such as inhalers and nebulizers. They also serve as an integral part of code teams during cardiac and respiratory arrests.

Social Workers: These professionals focus on providing psychological and emotional support to patients and families in need and connecting them with community resources. They ensure continuity of care and make sure the patient has the resources they require when they leave the hospital.

Speech-Language Pathologists (SLPs): These health professionals assess, diagnose and treat patients with speech and communication problems related to a variety of physical disorders, disabilities, or developmental delays.

Volunteers: These people of all ages donate their time to help enhance patient care within the hospital through activities such as working in gift shops, visiting patients, escorting patients, and providing support to staff.

PRACTICE ACTIVITY: HEALTH CARE WORKERS

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=331#h5p-49

References

Nemours KidsHealth. (2022). *Doctors and hospital: Doctor & hospital visits*.

Albany Medical College. (2022). Medical staff titles & terminology.

Carter, K., & Rutherford, M. (2020). Building a medical terminology foundation. eCampusOntario.

Attributions

Chapter 1 Review Activities

Test your knowledge of this chapter's content by completing the following exercises below. You may complete these as many times as you like.

REVIEW ACTIVITY: PHYSICIAN TERMS

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=343#h5p-3

REVIEW ACTIVITY: SPECIALIST TERMS

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=343#h5p-4

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=343#h5p-69

REVIEW ACTIVITY: NURSING TERMS

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=343#h5p-5

REVIEW ACTIVITY: ALLIED HEALTH CARE WORKER TERMS

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=343#h5p-70

KEY TERM SEARCH AND FIND

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=343#h5p-6

CHAPTER 2: THE ORGANIZATION OF HOSPITALS

Types of Hospitals in Ontario

Ontario has three broad types of hospitals: *public*, *private*, and *specialty psychiatric*. Each of these types are briefly explained below.

PUBLIC HOSPITALS

The vast majority of hospitals in Ontario are *public hospitals*. Public hospitals are independent non-profit corporations, largely funded by the government, where patients receive basic, medically necessary hospital care covered by provincial health insurance (Canadian Medical Association, 2024). Public hospitals may have extra services available, such as private rooms, which are not covered by provincial plans.

Ontario public hospitals operate within the framework provided by the Public Hospitals Act and its regulations. Within this act, hospitals are classified in the following manner:

- **General (Acute Care) Hospitals**
    - Open 24/7 to provide the community with a variety of inpatient and outpatient services, including surgical, obstetric and emergency services. Most hospitals in Ontario fall under this classification.
- **Convalescent Hospitals**
    - Provide recuperative care to patients who are expected to make a recovery and return to either their homes or other community placements.
- **Chronic Care Hospitals**
    - Provide continuing care for patients with chronic illnesses or marked disability who require non-acute hospitalization.
- **Active Treatment Psychiatric Hospitals**
    - Provide diagnosis and clinical treatment for those with a mental illness or those who require mental rehabilitation.
- **Active Treatment Alcoholism and Drug Addiction Centres**
    - Provide inpatient and outpatient rehabilitative care for those suffering from drug or alcohol addiction.
- **Regional Rehabilitation Hospitals**
    - Provide specialized rehabilitative care to help those recovering from a variety of serious medical concerns, including brain injuries, strokes, spinal cord injuries, and amputations (Ministry of Health, 2024; Thompson, 2018).

Ontario has 140 public hospital corporations with services located across 217 sites (Ontario Hospital Association, 2024). Several corporations, such as Grand River Hospital in Waterloo Region, operate at more than one site. Ontario's public hospital sector is extremely diverse in size and function, with some hospitals being designated academic/teaching hospitals, pediatrics hospitals, or rural hospitals.

Michael Garron Hospital (previously known as Toronto East General) is one of Toronto's major public hospitals.

PRIVATE HOSPITALS

In 1971, Ontario's Private Hospitals Act was amended to ban any new private hospitals, but those already in operation were grandfathered in. There are only three private, for-profit hospitals left in Ontario; the most well-known is the Shouldice Hospital, which specializes in hernia repairs (Gollom, 2022). The status of private hospitals may change as governments struggle with rising health care costs and surgical patient backlogs.

Private hospitals are facilities that are independently owned and operated on a for-profit basis. Yet, private hospitals do not necessarily need to charge patients directly for services. The provincial health insurance plan may pay private hospitals a fee to provide medically necessary services to insured residents, which may or may not cover the full costs of the services performed. Patients may be responsible for a co-payment for some services and may be offered other extended health care services not covered by health care plans, which they would have to pay for out of pocket.

SPECIALTY PSYCHIATRIC HOSPITALS

Approximately one-half of all long-term psychiatric beds are found in 35 different general hospitals in Ontario. In these cases, these hospitals have an inpatient unit or floor assigned for mental health treatment as one of the many programs they run. The other half of mental health beds are found in this final category of hospital, which includes four hospitals in Ontario whose primary purpose is to provide mental health care (Ministry of Health and Long-Term Care, 2016). One of the most high-profile of these hospitals is the Centre for Addiction and Mental Health (CAMH) in Toronto, which is commonly referred to by its acronym, *"cam-h"*

Specialty psychiatric hospitals provide inpatient and outpatient mental health services for a variety of patients, including those who have, or are suspected of having, a mental illness and are charged with a criminal offence (Ministry of Health and Long-Term Care, 2016). These are **tertiary care** hospitals and patients require a referral to be admitted. Wait times for care in specialty psychiatric hospitals have increased significantly over time, with large waits now experienced for many types of care.

References

Canadian Medical Association. (2024). *Understanding public and private health care*.

Gollom, M. (2022, September 3). *It's a world-renowned, for-profit Ontario hospital. Could Shouldice be a model for private health care?* CBC News.

Ministry of Health. (2024, January 23). *Classification of hospitals*. Government of Ontario.

Ministry of Health and Long-Term Care. (2016). Chapter 3: Section 3.12 specialty psychiatric hospital services. *2016 Annual Report of the Office of the Auditor General of Ontario*.

Ontario Hospital Association. (2024). *Ontario's hospitals*.

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional* (4th ed.). Pearson Canada.

Attributions

Hospital Leadership

It is important for the HUC to have a basic understanding of the organizational structures of the hospital that they are employed within, and understand the basic roles of the senior leadership team. This section will review the basic hospital structure for Ontario public hospitals starting from the top positions on down.

BOARD OF DIRECTORS

Public hospitals are independent corporations run by their own *board of directors*. The boards are responsible for day-to-day operational decisions on how to utilize the public funding they receive. Hospital boards are accountable to Ontario Health and the Ontario government for the quality and efficiency of the care they provide (Ministry of Health, 2023).

Many hospitals have formed partnerships with other hospitals, resulting in centralized management, which reduces overall costs. Hospital boards are either appointed or elected by their own memberships, with membership balanced between a variety of stakeholders, including local business leaders, government leaders, healthcare professionals, donors, and lawyers (Diligent team, 2018).

Take Note! Hospitals with Centralized Management

There are several examples of centralized hospital systems in Ontario:

- London Sciences Health System
- Hamilton Health Sciences
- Unity Health Toronto
- University Health Network (Toronto)

CHIEF EXECUTIVE OFFICER

Hospital CEOs are appointed by the hospital's board of directors or trustees. They are ultimately responsible

for managing the hospital and operating within the established budget (USCPrice, 2023). CEOs of a centralized hospital system may oversee the management of several hospitals within the system and are ultimately responsible to the board of directors.

Other Members of the Executive Team

The remaining organizational structure within hospitals may differ; however, in most cases, you will also find the following executive management roles:

Chief of Staff (COS): a physician who oversees hospital care, acts as the liaison between physicians and hospital executives, and ensures that medical care is necessary and proper.

Chief Nursing Officer (CNO): an RN in a similar position to the COS for nursing staff, with a focus on nursing operations and protocols and the quality and delivery of patient care.

Chief Information Officer (CIO): the individual responsible for all health care technology infrastructure, patient information, and health care data security issues.

Chief Operating Officer (COO): the individual responsible for running hospital operations and executing the decisions of the CEO.

Chief Compliance Officer (CCO): the individual responsible for overseeing the organization's regulatory compliance initiatives and internal policies and procedures (USCPrice, 2023).

MANAGEMENT AND STAFF

There may be many different layers of administration, management, and staff further down in the organizational chart depending upon the size of the hospital and the services provided. However, most hospitals will have at least one layer of manager above the health care service provider level.

Department Managers: the administrators who manage day-to-day operations of non-clinical hospital departments; for example, HR manager, IT services manager, or HIM manager.

Patient Care Managers: the individuals who manage groups of professionals who provide patient care; for example, *OR manager* or *inpatient surgery manager*. The majority of patient care managers are RNs or regulated health care professionals for the specific type of care provided in a department; for example, a medical radiation technologist may manage the diagnostic imaging department.

Health Care Service Providers

The vast majority of hospital workers are health care service providers, such as nurses, clerical, environmental workers, allied health care workers, laundry workers, and the many other people required in order for a hospital to function. They provide patient care, maintain records, and ensure that the hospital is able to deliver care to patients in an effective manner. Some types of providers may have designated leaders within their groups, such as team or clinical leads.

References

Diligent team. (2018, September 18). *What is the composition of a hospital board of directors?* Diligent.

Ministry of Health. (2023, July 18). *Ontario's public hospitals.* Government of Ontario.

USCPrice. (2023, November 17). *Leadership in health care: How to advance into the hospital C-suite.*

General Hospital Departments

Hospital departments may be classified in several ways, including **general departments**, **inpatient units**, and **outpatient units/clinics**. The numbers, functions, and names of hospital departments vary. In general, the HUC can expect that larger general hospitals will have more departments and services than smaller general hospitals as well as more complicated organizational structures.

Large hospitals have many different general departments, in-patient units, and out-patient clinics, as this way-finding sign in a U.K. hospital illustrates.

PRACTICE ACTIVITY: HOSPITAL DEPARTMENTS

Review the Programs & Services page of the London Health Sciences Centre website. This website provides a good overview of the different outpatient clinics and inpatient units you will find at a large teaching hospital.

As you review these departments, think about how many of these you have seen at hospitals in your community.

GENERAL HOSPITAL DEPARTMENTS

It is essential for the HUC to have a solid understanding of the role of general hospital departments, as they must interact with many of them daily in order to effectively complete their job duties. Below is a list of the most common general hospital departments that they may interact with. Note that while these areas do not provide hands-on patient care, they are imperative to the smooth running of the hospital.

In addition to working in patient care units, the HUC may also find employment in many of these general hospital departments, including roles such as admitting clerk, HIM/medical records clerk, pharmacy clerk, OR Bookings clerk, billing clerk, and general clerical support.

Admitting/Patient Flow Department*:* Responsible for the intake process for all inpatient and outpatient patient encounters and the assignment of all hospital beds according to medical needs and insurance coverage. All patient records flow from the initial patient registration and intake process from this department.

Bookings Departments (Central Bookings/Bookings HUB/OR Bookings): Responsible for booking prescheduled patient tests and surgical procedures. This may include intake of referrals, pre-registration of patient encounters in the system, booking of tests in the clinical schedule, and communicating appointment time to booking physicians and/or patients.

Business Office/Patient Accounts: Responsible for managing and overseeing all aspects of patient billing for insured and non-insured services, including provincial health insurance plans, private health insurance plans, and self-payments. The business office also oversees billing for preferred accommodation such as private or semi-private rooms.

Central Supply Reserve (CSR)/ Sterile Processing Department (SPD): Responsible for sterilizing, storing and distributing reusable medical supplies and equipment (MOAB Healthcare. 2024), such as feeding pumps or metal bedpans. CSR/SPD also supports surgical processes by selecting and arranging the required instruments for specific procedures, ensuring all components are sterilized and ready for use.

Dietary/Nutritional Services: Responsible for providing all patient snacks, meals, and special diets such as tube feeds, as well as cafeteria food for visitors. Some hospitals may prepare all meals in hospital, while others may contract some meal preparation out.

Environmental Services/Housekeeping: Responsible for the cleaning and sanitizing of the hospital facility, including **terminal cleaning** of isolation rooms (Thompson, 2018). In some hospitals, environmental services are responsible for shared areas, whereas each unit's environmental service personnel are responsible for the cleanliness of their respective unit.

Health Information Management (HIM): Responsible for maintaining, organizing, storing and archiving all patient records. Also responsible for medical record coding, generation of reports through the medical transcription process, and release of information to patients, providers and insurance companies.

Human Resources (HR): Responsible for recruitment and staffing, onboarding and orientation, employee relations, training and development opportunities, compensation, performance management, workforce planning, and negotiating collective agreements with trade unions representing hospital bargaining units.

IT/Information Services: Responsible for managing and supporting the hospital's technology infrastructure including communication systems, computer services, and EMR/other software applications.

Linen/Laundry: Responsible for supplying clean, sanitized linens, including gowns, bedding and towels, to all patient care areas in the hospital. Due to cost-saving measures, these services may be subcontracted to off-site services such as London Hospital Linen Services (LHLS) in London, Ontario.

Maintenance: Responsible for routine day-to-day facility maintenance, performing inspections of plumbing, HVAC, and refrigeration systems, ensuring that all buildings meet code, safety and security standards, and implementing energy management initiatives (Accruent, 2024).

Occupational Health/Employee Health: Responsible for employees' work-related health and wellness needs, including preventing workplace injuries, injury treatment and rehabilitation, return to work plans, immunizations, and worker's compensation referrals.

Pharmacy: Responsible for all aspects of medication management for hospital inpatients, including storing, compounding, and dispensing drugs; consulting with physicians to make drug-based decisions; providing drug education to patients and staff; and managing the patient medication profile/record. Some hospitals may also have an outpatient pharmacy, where patients may fill prescriptions upon discharge.

Privacy Office: Responsible for ensuring the hospital complies with legislation relating to the privacy and security of personal health information; provides advice, guidance, and education staff on the practical application of the law, including privacy procedures (Trillium Health Partners, 2024). This office may also investigate privacy breaches.

Public Relations: Responsible for managing the hospital's media relations, internal and external communications, community engagement and marketing events, and social media presence.

Purchasing: Responsible for procuring the goods and services the hospital requires to operate efficiently, including the sourcing, acquisition, distribution, control and disposal of goods (Grand River Hospital, 2024).

Risk Management/Infection Control: Responsible for identifying, evaluating and mitigating risks that could negatively impact patients and staff, including the spread of disease or infections within the hospital. There may be two separate departments in larger hospitals.

Staffing/Scheduling Office: Responsible for the delivery of centralized scheduling and staffing services for the hospital, posting staff schedules, replacing shifts, and preparing accurate time cards for payroll. These services may also be decentralized and completed by the HUC at the unit level.

Stores/Materials Management: Responsible for stocking patient care units with one-time-use equipment and supplies, such as urinary catheters, IV supplies, and paper goods.

Switchboard: Responsible for directing incoming communications to the hospitals. Also called "locating," this department is also responsible for hospital-wide paging and the first point of contact during hospital emergencies.

Volunteer Services: Responsible for recruiting and onboarding volunteers, training, scheduling and monitoring volunteers, and volunteer recognition and retention activities. In some hospitals, volunteer services may also be responsible for arranging student placements, while in others, this function is handled by HR or clinical educators.

References

Accruent. (2024). *What is healthcare facilities management (HFM)?*

Grand River Hospital. (n.d.). *Purchasing & vendor inquiries*.

MOAB Healthcare. (2024). *SPD: The heart of the hospital*.

Thompson, V.D. (2018). *Administrative and clinical procedures for the Canadian health professional* (4th ed.). Pearson Canada.

Trillium Health Partners. (2024). *Protecting your privacy and personal information*.

Attributions

"Homerton hospital signs, Hackney" by Momentum Sign Consultants on flickr, licensed Creative Commons – Attribution-NonCommercial-NoDerivs 2.0 Generic.

Inpatient Hospital Departments

Inpatient care departments are typically refered to as *units* or *floors*; for example, the *orthopedic unit* or *ortho floor*. Larger hospitals typically have a mix of inpatient units, including *critical care units*, *step-down units*, *medical units*, and *surgical units*. All of these units will require clerical support from an HUC; however, the duties and hours associated with each unit may vary.

Below is a list and explanation of possible units the HUC may encounter, but it is not exhaustive. The list also includes examples of common pathologies and conditions that would cause a patient to be admitted to these units; however, sometimes, due to bed shortages, there may be patients with other reasons for admission present on any given unit.

CRITICAL CARE UNITS

Coronary Care Unit (CCU): Provides specialized, intensive treatment for patients with complex or unstable medical cardiac issues, such as unstable angina or myocardial infarctions. In smaller hospitals, the CCU may be combined with the ICU.

Cardiovascular Intensive Care Unit (CVICU): Provides specialized, intensive treatment for patients who have had complex cardiac surgery, such as CABG.

Intensive Care Unit (ICU): Provides specialized, intensive treatment for patients who require close monitoring and advanced life support due to severe injuries or critical illness, such as those with severe infections or trauma injuries.

Neonatal Intensive Care Unit (NICU): Provides specialized, intensive treatment for critically ill newborns who require monitoring and advanced life support, often premature babies or those with birth complications.

Pediatric Intensive Care Unit (PICU): Provides specialized, intensive treatment for children and adolescents who are critically ill. Smaller facilities may have a PICU only, where infants are also treated.

STEP-DOWN UNITS

Step-Down Units (surgical/cardiac): These units provide intermediate care between that of an ICU and a normally staffed inpatient unit (Whitlock, 2023).

MEDICAL AND SURGICAL UNITS

Burn Unit: This unit provides care to patients who have suffered advanced and complicated burn injuries. These

patients have complex and intensive care requirements because a number of complications, including infections, are common when a patient has severe burns.

Cardiology: Provides care for patients with medical cardiac-related issues. The cardiology unit typically does not care for a patient in the acute phase of a myocardial infarction but would handle the aftercare once the patient is somewhat stabilized. The unit would also have patients with congestive heart failure, unstable blood pressure, and other cardiac pathologies.

General Medicine: Provides treatment for a vast array of illnesses, such as pneumonia, bronchitis, or mobility issues, or they are waiting for placement in another facility, such as long-term care. Often a patient's condition does not warrant being on a more specialized unit, but rather the patient may have a number of comorbidities (more than one condition or disease at the same time).

General Surgery: Provides pre- and post-operative treatment for patients who have had a variety of routine procedures that do not require specialized or complex care, such as appendectomies, mastectomies, or hernia repairs.

A surgical patient is transferred post-operatively from the post-anesthesia care unit (PACU) to the surgical inpatient unit, just one of the many different types of inpatient units in modern hospitals.

Gerontology: Provides inpatient services for frail older adults with multiple or complex medical problems, with the goal of helping them become independent again (Alberta Health Services, n.d.). Concerns addressed may include recent changes in mental, physical and functional abilities and/or safety concerns. Geriatric patients are

generally over the age of 75, though that may vary depending on the policy and specific cutoff age for geriatric status in the local area.

Gynecology: Provides medical and surgical treatment for patients with ailments of the female reproductive system, such as fibroid tumours, exacerbations of endometriosis, uterine bleeding, or other disorders. However, patients would not go to this unit for pregnancy-related issues.

Mat/Child/Labour and Delivery: Provides care to women in labour or at risk for immediate labour. Patients would not come to this unit if they were early on in their pregnancy or for fertility issues. Once the patient has delivered the baby, the mother and infant stay on the unit until stable, but they are often discharged within a day or two at the most.

Mental Health: Provides care for individuals with a mental health diagnosis, including schizophrenia or major depressive disorders. There may be different types of mental health or psychiatric/psych units in hospitals, including locked units, full-time units, or units which allow patients to leave during the day and return in the evening.

Nephrology: Provides care for patients with a pathology that affects the kidneys. They may require dialysis, which is often done in a dialysis unit, but they may have other pathologies such as kidney stones, blockages, or other issues with kidney function.

Neurology: Provides non-surgical treatment of disorders related to the nervous system, including stroke, head trauma, epilepsy, and neuromuscular disorders.

Neurosurgery: Provides care for patients who have had surgery procedures related to the nervous system, including aneurysm surgery and spinal fusions.

Oncology/Systemic Therapy: Provides therapies intended to improve or cure cancer, including radiation or chemotherapy (Whitlock, 2023).

Orthopedics: Provides care to patients with injury or chronic anomaly to their bones or joints which requires surgical treatment and intervention, such as joint replacement or internal fixation of fractures.

Palliative: Provides care which focuses on providing comfort and optimizing the quality of life for terminal and life-limiting illnesses, which may or may not be cancer-related.

Pediatrics: Provides medical and surgical care to patients under the age of 18. Pediatric units may be general or specialized for certain conditions, such as trauma or pulmonary conditions.

Plastic and Reconstructive Surgery: Provides plastic surgery services, including reconstructive surgery to reconstruct damaged tissues and cosmetic care to enhance physical appearance. Some plastic and reconstructive units will also provide hand surgery, while this may be a function of orthopedic units in other hospitals.

Rehab: Provides care for patients after an injury or surgery to increase their strength and improve their functioning so that they can go home.

Respiratory/Pulmonary: Provides medical treatment to patients with some form of acute or chronic pulmonary condition; for example, injuries to the lungs such as atelectasis or pleural effusion. They might also have chronic conditions such as uncontrolled asthma, bronchitis, COPD, or inflammation or infection in the respiratory system. In smaller hospitals, these patients may be admitted to a general medicine unit.

Telemetry: Provides continuous cardiac monitoring 24/7 for patients with heart disease, irregular heart rhythms, and heart failure (National Telemetry Association, 2024). Telemetry units may be stand-alone units or may be part of a cardiology unit.

Thoracic/Chest: Provides treatment for patients with surgery of the chest or respiratory system, such as thoracotomy or bullectomy.

Urology: Provides surgical treatment for patients with a pathology or anomaly that relates to the urinary system and/or male genitourinary systems, such as prostate disease and renal and bladder dysfunctions.

References

Alberta Health Services. (n.d.). *Programs & services: Acute geriatric unit.*

National Telemetry Association. (2024). *The importance of a telemetry medical unit in hospitals.*

Whitlock, J. (2023, August 31). *Understanding hospital acronyms for floors and units.* verywell health.

Attributions

Outpatient Hospital Departments

Hospitals often have a variety of specialized outpatient clinics which complement the type of inpatient services they offer. Patients who do not need to spend a night in a hospital are considered *outpatients*; their hospital stay is less than 24 hours. For example, if a hospital is designated as the cardiology centre for the region, it will likely have a variety of outpatient cardiac clinics, as well as inpatient cardiac units such as CCU, cardiology, or CVICU. In addition, most general hospitals will offer a variety of routine diagnostic and therapeutic services that serve the needs of both outpatients and inpatients, such as laboratory or diagnostic imaging services.

Similar to inpatient units, outpatient departments typically require clerical support. Given their outpatient nature, these departments are typically staffed during the day from Mondays to Fridays. However, some diagnostic services which provide 24/7 support for inpatient units and the emergency department may have expanded clerical coverage.

Below is a list of some outpatient departments commonly found in mid-size hospitals. Larger hospitals, or hospitals providing specialized services, will have many more focused outpatient clinics and services that are noted here.

OUTPATIENT HOSPITAL DEPARTMENTS/CLINICS

Airway Clinic/Pulmonary Function Lab: Provides respiratory education, rehabilitation, and diagnostic testing such as pulmonary function tests (St. Mary's General Hospital, 2024a).

Cardiac Rehab: Provides exercise programs, education and counselling regarding healthy lifestyles for patients with a cardiovascular condition (St. Mary's General Hospital, 2024b).

Cardiac Catheterization/Cath Lab: Performs cardiac catheterization procedures to diagnose or treat heart conditions, including coronary artery disease, arrhythmias, heart failure, or valve disease.

Cardiac Testing: Provides a variety of cardiac outpatient testing such as echocardiograms, ECGs, Holter monitors, and stress tests.

Colposcopy Clinic: Provides diagnosis and treatment for women who have an abnormal pap test, precancerous disorders or vulva, cervix and vagina, or genital warts (University Health Network, 2024a).

Cystoscopy Clinic: Performs diagnostic procedures to evaluate the lower urinary tract, including the bladder and, in men, the prostate, to identify tumours, stones or other abnormalities (University Health Network, 2024b).

Diabetic Clinics: Provides patient teaching from both RNs and *dietitians* about managing type 1, type 2, gestational, and pre-diabetes.

Diagnostic/Medical Imaging: Provides a wide range of imaging services such as x-rays, ultrasound, CT, and MRI imaging to diagnose and monitor medical conditions.

A medical radiation technologist (MRT) prepares a patient for an MRI scan; diagnostic or medical imaging is one of the many outpatient departments in hospitals.

Dialysis Unit: Provides outpatient blood filtration procedures for patients with kidney failure. Often the same patients come in weekly or a few times a week for dialysis (Sturdy & Erikson, 2022).

Endoscopy Unit: Provides a wide range of clinical investigations and procedures to patients with bowel, stomach, liver, pancreas, and lung-related disorders, such as colonoscopy or bronchoscopy (Hamilton Health Sciences, 2023).

Fracture Clinic: Provides casting, splinting, some dressing changes and removal of sutures, injections, and aspirations for patients with bone, joint, and soft tissue injuries (Grand River Hospital, 2024).

Geriatric Medicine Clinic: Provides comprehensive assessment and community support referrals for patients who have complex conditions associated with aging, including memory loss, mobility problems and falls (University Health Network, 2024c).

Infusion Clinic: Provides outpatient intravenous therapy for patients requiring IV medications such as biologics, antibiotics, or blood products.

Laboratory Services: Provides a wide range of tests on specimens, including blood, body fluids, and tissues,

to diagnose, monitor and treat disease. Laboratory services in larger hospitals are typically divided into several departments, including biochemistry, hematology, microbiology, blood bank, pathology, and immunology.

Mammography Unit: Provides services to examine and diagnose breast tissue health and screen high-risk and average-risk individuals for breast cancer.

Newborn Clinic/Bilirubin Clinic: Provides infant assessment, bilirubin level monitoring, and breastfeeding assistance for the immediate post-delivery period (North York General, 2024).

Nuclear Medicine: Provides a range of scans using special radioisotopes for diagnosis and treatment of disease (St. Mary's General Hospital, 2024c).

Physiotherapy Clinic: Provides physical rehabilitation to help patients regain, maintain and improve their physical function after surgery or injury, or to help manage chronic conditions.

Rheumatology Clinic: Provides treatments to reduce pain, disability, and joint damage to patients with diseases such as arthritis, gout, scleroderma, and lupus (St. Joseph's Health Care London, 2023).

Special Testing: Provides a variety of neurology tests such as EMGs and EEGs.

References

Grand River Hospital. (2024). *Fracture clinic*.

Hamilton Health Sciences. (2023). *Endoscopy procedures and & GI investigations*.

North York General. (2024). *Newborn follow-up clinic*.

St. Joseph's Health Care London. (2023). *Rheumatology centre*.

St. Mary's General Hospital. (2024a). *Airways clinic: Outpatient respiratory care*.

St. Mary's General Hospital. (2024b). *Cardiac rehabilitation.*

St. Mary's General Hospital. (2024c). *Nuclear Medicine*.

Sturdy, L. & Erikson, S. (2022). *The Language of Medical Terminology*. NorQuest College, Open Education Alberta.

University Health Network. (2024a, January 23). *Colposcopy clinic*.

University Health Network. (2024b). *Cystoscopy clinic*.

University Health Network. (2024c). *Geriatric Medicine Clinic*.

Attributions

"Man During Magnetic Resonance Imaging" by Charlss GonzHu; used under the Pexels license.

Emergency and Surgical Services

EMERGENCY SERVICES

In addition to inpatient and outpatient departments, most general hospitals will have an emergency department (ED); note that emergency room (ER) is often used interchangeably with emergency department (ED). EDs are designed to handle a wide range of emergencies, from minor injuries to life-threatening situations, and operate 24/7 to address urgent and emergent health care needs.

Some EDs may treat certain populations only, such as children. Due to the large variety in patient acuity, some EDs are subdivided into varying zones such as acute care, sub-acute care, and minor-treatment/ambulatory care. Patients in the ED department are prioritized by RNs who assess and prioritize their condition. Many hospitals in Canada use the Canadian Triage and Acuity Scale (CTAS) as a triage system to prioritize patient care to ensure that the most critical patients are taken care of first. As the table below outlines, there are five levels of triage, with Level 1 being the most severe (CTAS National Working Group, 2012).

Table: Emergency Triage Levels[1]

Triage Level	Description
LEVEL 1: Resuscitation	Conditions that are threats to life and limb requiring immediate aggressive treatment.
LEVEL 2: Emergent	Conditions that are potential threats to life and limb requiring immediate aggressive treatment.
LEVEL 3: Urgent	Conditions that could potentially progress to a serious medical problem.
LEVEL 4: Less Urgent	Conditions that relate to a potential for deterioration that would benefit from treatment.
LEVEL 5: Non-Urgent	Conditions that may be acute but non-urgent; interventions can be safely delayed.
(LEVEL 0): Expectant	Vital signs absent, mortal wounds, or condition unsalvageable.

SURGICAL SERVICES

The earlier sections on inpatient units covered several pre and post-operative surgical departments, for example, the orthopedic unit, general surgery unit, urology unit, or cardiovascular intensive care unit (CVICU). However, there are also several departments which support the surgical services process itself. Below is a list of the most common units supporting surgical processes, along with basic timelines for their use.

Pre-surgical Clinic (PSC): This outpatient department is where patients are booked two to three weeks prior to surgery, to be educated and prepared for the procedure they will be having. The nurses on this unit perform a

1. Based on CTAS National Working Group. (2012). *The Canadian triage and acuity scale: Education manual. Version 2.5*. Canadian Association of Emergency Physicians.

variety of tests, including bloodwork and ECGs, and take vital signs and patients' medical histories to ensure they are in the condition required for surgery to be performed. The surgeon booking the procedure may also require a variety of consultations to be performed at this visit, including an anaesthetic consultation.

Day Surgery Unit (DS): This is the unit where patients having simple procedures that do not require overnight stays are admitted to on the day of surgery. They typically arrive two to three hours before their scheduled surgery and are discharged one to two hours following their procedure once they are stable.

AM Admission Unit/Pre-operative Unit: This is the unit where patients having more complicated surgeries requiring overnight stays are admitted on the day of surgery. They typically arrive two to three hours before their scheduled surgery and are transferred to the appropriate surgical inpatient unit from the PACU when stable.

Operating Rooms (ORs): This is where inpatients and outpatients are administered anaesthetic, and the actual surgical procedures are performed. Effective utilization of OR time is essential within the hospital environment, with surgeries scheduled back-to-back within **OR blocks**. Many routine surgeries, such as hernia repair or appendectomy, are scheduled for less than one hour, while more complicated surgeries, such as CABG, may be scheduled for four or more hours. Surgeons typically have OR blocks on the same day and time each week, and the staff ensure the time is fully utilized; some surgeons may have blocks at more than one hospital (Allen, 2018).

Post-Anaesthetic Care Unit (PACU)/Recovery Room (RR): This area is where inpatients and outpatients who have received anaesthesia during surgery are taken immediately after their procedure to be monitored until the anaesthesia wears off, typically for one to two hours. Once stable, they will either return to the day surgery unit if they are to be discharged that day or be transferred to the appropriate inpatient surgical unit.

PRACTICE ACTIVITY: HOSPITAL DEPARTMENTS

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=368#h5p-48

References

CTAS National Working Group. (2012). *The Canadian triage and acuity scale: Education manual. Version 2.5*. Canadian Association of Emergency Physicians.

Allen, J. (2018, October 5). *Optimizing surgical block time*. What I've Learned as a Hospital Medical Director.

The Organization of Patient Care Units

Next, we will review the organization of a patient care unit. Although the layout may vary depending upon the type of unit and the age of the hospital, most units will have the following rooms/areas.

COMMUNICATION CENTRE/NURSING STATION

This area is the communication epicentre of the hospital unit. Newer hospital units are designed with this area centrally located in the unit, with patient care rooms and supply rooms flanking it on all sides. This provides an easily recognizable reception area for visitors and reduces the amount of walking for hospital staff completing their duties.

Privacy and noise can be a concern given the openness of new communication centre designs; therefore, the HUC and other staff at the communication centre must ensure to modulate the volume of their conversations, avoid discussions which involve patient health information, and ensure to position any materials with patient health information out of the view of visitors and other patients.

In newer hospitals, communication centres or nurses' stations like this one are centrally located in the unit to facilitate the work of the staff.

The HUC is typically stationed at the communication centre but may share the area with the clinical resource/"charge nurse", and other staff. It is common for the communication centre to host the following resources:

- physical patient charts and chart racks, if using a hybrid patient record system which includes paper records,
- chart forms (if using hybrid patient records), labels, stationery supplies, prescription pads, and community referral forms,
- several desktop computers and a computerized bed board,
- communication board,
- multi-line phone system and portable phones for nursing and environmental service staff,
- overhead paging system and call-bell system,
- printer, fax machine, photocopier/scanner,
- shredder box, and
- some clinical supplies (extra stethoscopes, tongue depressors, etc.).

It is also common for mobile computers such as "computers on wheels" (COWs) to be centrally located at or near the communication station for HUCs and nurses to take into patient rooms as required for admission interviews or charting purposes.

MEDICATION/MED ROOM

This is a designated area in a hospital department where all stock and patient-specific medications are securely stored, prepared, and dispensed. Medications are sorted by type, dosage, and frequency for easy retrieval by nurses with some being kept in locked or temperature controlled environments (such as medication fridges), to ensure their effectiveness and prevent unauthorized access. The medication room is typically close to the communication centre so that it is visible and central to all patient rooms. The HUC may be required to put away medications sent up to their unit from the pharmacy, stock narcotic count records, or respond to queries from the pharmacy about how many doses of medication are remaining in the medication room.

CLEAN UTILITY ROOM

This room is for storing frequently used supplies for that unit; for example, a general surgery unit may store dressing trays, bandages, intravenous supplies, and suture removal kits, while a urology unit may store many types of catheters. These supplies are usually displayed on large mobile carts with areas labelled for each type of supply. The HUC should be aware of the layout of common supplies, as they may be asked to retrieve supplies or order supplies when they are low. In some hospitals, these carts are restocked on the unit daily by materials management associates while in other hospitals, carts may be changed out at set intervals with fully stocked carts.

DIRTY UTILITY ROOM

This area is where used supplies and equipment are stored. Used linen may also be stored in this room or in separate dirty linen containers throughout the unit, typically in the hallways outside of patient rooms.

- Dirty *disposable* supplies, such as suction or urinary catheters, plastic dressing tray, and IV tubing will be disposed of according to agency guidelines.
- Dirty *reusable* supplies, such as metal dressing trays, bedpans, or IV pumps, will be returned to the CSR/SPD department for cleaning/sterilization before they are redistributed to patient care departments again.
- Dirty *linen* may be sent to the laundry/linen department for cleaning or bagged and sent to outsourced linen companies.

CONFERENCE ROOM

Many units will have a conference room for interdisciplinary team conferences and family and staff meetings. Due to space constrictions, this is often also the unit's break room and may contain lockers for staff to store their personal items. The conference room may also be where the nursing staff give their taped or verbal reports at shift change.

TREATMENT ROOM

This is a specialized area designed for performing a variety of minor medical procedures and treatments common

to the specific needs of the unit and type of care provided. This room is especially helpful for performing a private examination when a patient is admitted to a ward room and privacy is a concern. The HUC may need to manage physician bookings for this room and ensure that equipment for any scheduled procedures is ordered from the SPD/CSR department and/or *stores*.

KITCHENETTE

Most units will have a small kitchen area which includes an ice machine, refrigerator, kettle, microwave, and sink, as well as disposable cutlery, plates, and glasses (Thompson, 2018). This area is typically stocked with light refreshments, such as juices, tea and milk, and crackers to provide nutrition for patients outside of the regular meal time hours. The HUC may be asked to retrieve ice for water jugs or ice packs from this area, as well as patient snacks or drinks. They may also need to put away nutritional supplies sent from the dietary department.

WAIT ROOM

Some units will have a dedicated family wait area or patient lounge families and patients may visit. However, with space at a premium, many hospitals have removed this area and created shared wait areas, such as a surgical wait room, for patients' families to wait in during procedures. The HUC may be required to retrieve patients' families from the wait area or page them back to the unit once a patient returns from a procedure.

DICTATION ROOM/CHARTING AREA

This area typically adjoins the communication centre and provides physicians with a confidential area to dictate notes through voice recognition and nursing and allied staff a place to complete their required patient charting (Thompson, 2018). This area typically includes several workstations with computers and chairs, and may also be used for interdisciplinary team meetings, such as discharge planning. If the HUC is employed in a hospital using physical charts, they should check this area frequently for charts which have been left after the documentation process, ensure that there are no outstanding orders left in them, and return them to their appropriate place on the unit.

STORAGE ROOM

Some units may have a separate storage room to house bulky items commonly used on the unit; however, some other units will store these items in the clean and dirty utility rooms or even the hallways. Common items that may be kept in storage rooms include mobility devices such as crutches, walkers, and wheelchairs, extra stretchers and bed attachments such as air mattresses, sheepskins, bed hoops, and positioning devices.

HOUSEKEEPING AREA

This area is where the housekeeping/environmental staff keep their cleaning supplies, including cleaning agents, mops, rags, sanitizer, paper towels and rolls of toilet tissue. These areas may also host a computer workstation for the environmental staff to monitor the unit's pending discharges and update the status of rooms from dirty to clean post-discharge.

TRANSPORT EQUIPMENT

In addition to the above areas, there are also a few specific types of transport equipment found on a patient care unit.

Pneumatic Tube System

This is a system used for swiftly moving materials such as specimens, paperwork, and pharmaceutical supplies between hospital departments through a system of tunnels built into the hospital architecture. A pneumatic tube system consists of a number of stations, typically one per unit or floor, and a variety of cylindrical carriers which may be loaded with materials and sent through the system. The HUC is responsible for both sending materials to other departments through the station's launchpad and receiving and appropriately responding to incoming materials to their unit.

Lift System

Lift systems are centrally located mini elevator systems that are used for sending small objects through the hospital, such as clean equipment, patient trays, and non-narcotic medications from the pharmacy. (These systems may also be called *dumb waiters*, which comes from their original use in hotels and large residences to transport trays between the kitchen and the upper floors.) The lift requires a key to open it and works using two buttons: one to summon the lift to the unit you are on, and one to send it to another location (Thompson, 2018). The HUC may make several trips to the lift daily to retrieve supplies. It is important to never put any patient records on the lift, as these may be lost, or inappropriately accessed.

SHREDDERS

All units should have a shredder box to dispose of confidential paper. These are typically locked boxes where confidential papers are stored until they are transported for destruction by a company which specializes in destroying patient records, usually on a weekly basis. The HUC should ensure that every piece of paper which contains patient information on it is disposed of in the shredder box. Each unit typically has the key to the box and the HUC may need to open the box occasionally to review contents if a document has gone missing.

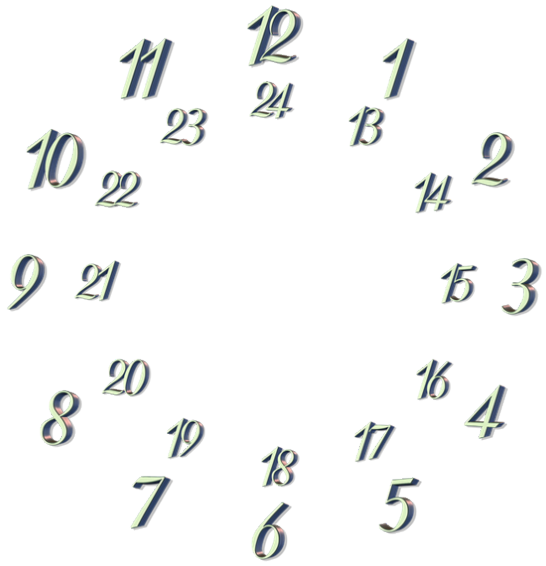
THE 24-HOUR CLOCK

Hospital staff are expected to follow the 24-hour clock. In the 24-hour clock, the day runs from midnight to midnight and is divided into 24-hour increments. Many cultures or languages (such as French) tell time using the 24-hour clock, as do railway and flight schedules. In the 24-hour clock, the morning hours remain the same as in the a.m./p.m. system up until 12:59. After that, you must add 12 to 1 p.m., 2 p.m., etc. So, 1 p.m. is 13:00.

The specific method of recording time on the 24-hour clock in hospitals is commonly used in the military, government, emergency services, and other areas which require precise timekeeping and where time errors may occur. This system is often referred to as "military time," whereas the a.m./p.m. is often referred to as "standard time."

This is how military time notation works:

- The 24-hour clock is expressed in 4 numbers, without a colon dividing them.
- The day starts at midnight and is written as 0000.
- The last minute of the day is written as 2359 (2400 minus 1 minute).
- Sometimes you may see 0000 written as 2400. Both are acceptable.



Hospitals use the 24-hour clock to avoid confusion. The hours after noon are numbered from 13 to 24.

Example: Hospital Military Time

Here are examples of how time is expressed in the hospital:

- 2:30 a.m. = 0230
- 2:30 p.m. = 1430
- 5:35 p.m. = 1735
- 5:35 a.m. = 0535

PRACTICE ACTIVITY: PATIENT CARE UNIT

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=370#h5p-47

References

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional* (4th ed.). Pearson Canada.

Attributions

“Kit Carson County Memorial Hospital – Central Nurses Station” by The Neenan Company on flickr; Creative Commons – Attribution-NonCommercial 2.0 Generic.

“24-hour clock” by EJM_Missouri on flickr; identified as CC0 by the creator; used under the Pixabay license.

Chapter 2 Review Activities

Test your knowledge of this chapter's content by completing the following exercises below. You may complete these as many times as you like.

REVIEW EXERCISE: HOSPITAL STRUCTURE

Rashida works in a hospital which organizes services by these general areas:

- **Clinical Services**: areas which diagnose and treat specific medical conditions (e.g., neurology services, surgical services, neurology services).
- **Support Services**: services providing essential operational support (e.g., environmental services, maintenance).
- **Diagnostic Services**: departments which perform diagnostic tests (e.g., diagnostic imaging).
- **Therapeutic Services**: departments which assist patients to recover and improve function (e.g., occupational therapy).
- **Administrative Services**: departments which manage administrative tasks (e.g., business office).

Complete the matching exercise below to correctly match individual departments to their correct place in the organizational structure:

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=372#h5p-71

REVIEW ACTIVITY: GENERAL DEPARTMENTS

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=372#h5p-10

REVIEW ACTIVITY: INPATIENT UNITS

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=372#h5p-11

REVIEW ACTIVITY: OUTPATIENT CLINICS

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=372#h5p-12

REVIEW ACTIVITY: 24-HOUR CLOCK

In this chapter, we discussed how to change standard time to “military time” (24-hour clock). Remember that military time always includes four numbers and does not include an a.m., p.m. or colon in between the numbers (for example, 0745 not 07:45 am).

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=372#h5p-13

CHAPTER 3: THE HUC'S ROLE IN STAFFING AND SCHEDULING

Types of Scheduling Activities in Hospitals

There are many different types of scheduling associated with hospitals, including operating room, outpatient, general staff and nursing, and emergency room.

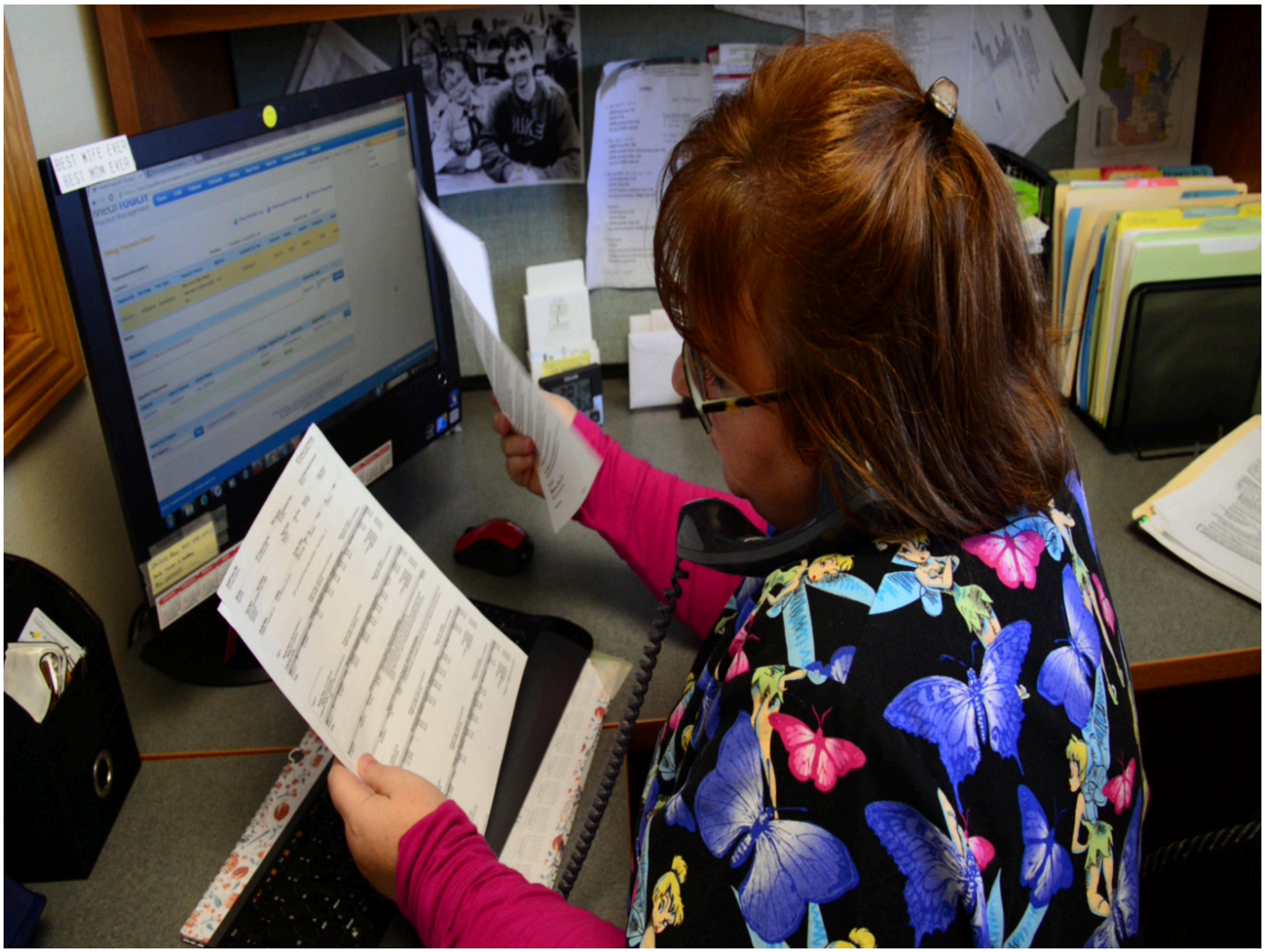
OPERATING ROOM SCHEDULING

Scheduling of surgical procedures in the operating theatre. Typically, surgeons are assigned operative blocks (for example, every Thursday) and their offices schedule procedures within this block. These bookings are communicated to the hospital's *OR bookings department* using the **surgical booking form**, and the hospital *OR booking clerk* pre-registers the patient into the hospital for the day of surgery and enters surgical details into the hospital's OR system.

OUTPATIENT SCHEDULING

Scheduling of patients for outpatient procedures such as ultrasounds, CT scans or MRIs. Outpatient scheduling may occur through different ways, including:

- Booking of procedures by physician's office through e-referral or portals such as Ocean.
- Patient self booking-patient is given a requisition from a physician and calls the hospital booking department to schedule their appointment. The *scheduling clerk* preregisters them in the clinical software system for the appointment and provides any preparation instructions. The registration is completed upon the patient's arrival to the department; the patient must bring a requisition with them.



Scheduling patient appointments, surgical procedures, and staffing shifts are some of the staffing activities in hospitals.

GENERAL STAFFING/NURSING SCHEDULING

Scheduling of staff required to effectively run general and clinical hospital departments typically involved the assignment of personnel in various departments and time slots such as shifts. Scheduling is influenced by a variety of factors, including the mix of skills required, collective agreement provisions, historical and anticipated patient levels, patient acuity, and time of day.

EMERGENCY DEPARTMENT SCHEDULING

This is very similar to general staff scheduling but specific to the ED with the added scheduling of ER physicians.

In the next several sections, we will be focusing on the basics of *general staff scheduling* in hospitals. We will be focused on key terms, the impact of collective agreements in staffing, and the creation and alteration of master schedules.

Attributions

“Medical Office Specialist.Still001” by Wisconsin Technical Colleges on flickr; Creative Commons – Attribution-NonCommercial-NoDerivs 2.0 Generic.

Introduction to Staff Scheduling

Hospital staffing can be a very complicated but vital task. Understaffing can lead to chaotic days, burnout, treatment delays, increase in medical errors, and high staff turnover (FloatCare, 2023). Yet, overstaffing can lead to inflated budgets, cutbacks, and lack of staff available for other shifts.

Every hospital takes their own approach to administering the staff scheduling process. These approaches may include *centralized*, *decentralized*, or *hybrid staffing*.

CENTRALIZED STAFFING

All staffing and scheduling for the hospital is administered through one central scheduling department. Within the department, scheduling staff/clerks may be assigned to staff-specific units, and they work closely with these unit managers to develop staffing plans for the unit.

Take Note! — Hospital Staffing Role

Graduates of health office administration programs are qualified to work in hospital staffing departs.

Learn more about this role at Grand River Hospital by reading this employee story: Katie Hendricks: Ensuring a full complement of staff to advance exceptional care.

Learn more about the skills and duties of schedulers on the Indeed Career Guide website: What Does a Scheduler Do? (With Job Description and Salary).

This general job description for the role of scheduler is approved by all the health care worker unions in Ontario: Provincial Job Description: Staff Scheduler [PDF].

DECENTRALIZED STAFFING

Each unit administers its own staffing and scheduling processes under the direction of its unit manager. In this case, the clerical staff manage the staffing process for all nursing staff, clerical staff, and support staff, such as PSWs, unit assistants, or environmental support personnel on their unit.

HYBRID STAFFING

Some aspects of staffing are managed by a centralized office, while others are managed at the unit level. For example, a centralized office creates unit schedules, but the individual unit handles all staff additions and cancellations for the unit staff.

Regardless of the method of staffing and scheduling used in a hospital, it is important for clerical staff to understand the basics of this process, as they will be involved in it at some level in their day-to-day role.

VIDEO: STAFF SCHEDULING TECHNOLOGY

Due to increasing complexity and the amount of time staffing may take, some hospitals are trialling or moving to automated scheduling apps, such as Centricity, AMN, ConnectTeam, Smart Call, Symplr, etc.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=378#oembed-1

Source: Saskatchewan Health Authority — Saskatoon area. (2014, June 19). Staff scheduling made easy! [Video]. YouTube. https://www.youtube.com/watch?v=eDQ4u0AqTCM

References

FloatCare. (2023, January 17). *How to manage staff scheduling in healthcare*.

The Collective Agreement

Fifty-four percent (54%) of health care workers in Canada are ***unionized*** (Statistics Canada, 2023), with many of these health care workers employed in hospitals and government agencies.

In unionized workplaces, a ***trade union*** represents the interests of a set of workers (called a **bargaining unit**) within that workplace (Legalline, 2023). In the hospital sector, it is common to have a mixture of unionized and non-unionized workers, as well as several unions representing different types of workers within each hospital.

In Ontario hospitals, RNs are typically represented by the Ontario Nurses' Association (ONA). However, other staff such as RPN, clerical, allied health and environmental workers *may* be covered by a variety of unions, including:

- Ontario Public Service Employees Union (OPSEU)
- Unifor[1]
- Service Employees International Union (SEIU)

WHAT IS A COLLECTIVE AGREEMENT?

In unionized workplaces, a trade union and management negotiate the terms and conditions of employment for the group of workers through a process called ***collective bargaining***. In this process, the union and management usually focus on such issues as wages, benefits, and working conditions.

The collective bargaining process usually results in a tentative ***collective agreement*** acceptable to both the union and employer. This agreement must then be *ratified,* or voted on, by secret ballot by union members. If at least 50% of the union members who vote agree, the collective agreement is finalized and becomes legally binding (Legalline, 2023).

Collective agreements are usually negotiated for a term of two or three years. Before the agreement expires, the union and the employer will start negotiating for a renewal agreement. If a new collective agreement is not reached before the current one expires, it will stay in force until a new collective agreement is negotiated (Legalline, 2023).

Collective agreements often deal with the following:

- wage rates,
- vacation entitlement,
- bereavement leave,

1. A large private sector union formed by the merger of the Canadian Auto Workers (CAW) and the Commuications, Energy, and Paperworkers (CEP) unions.

- health benefits,
- hours of work, paid breaks, on-call, and call-back provisions,
- layoff rules,
- the right to challenge employer disciplinary actions,
- holidays,
- jury duty leave,
- promotion selection rules, and
- occupational safety provisions (Legalline, 2023).

VIDEO: THE COLLECTIVE AGREEMENT

This short video by OPSEU explains how collective agreements work.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=381#oembed-1

Source: OPSEU Education. (2015, June 16). The collective agreement. [Video]. YouTube. https://www.youtube.com/watch?v=zf169H8Oszg

Note: This video mentions *seniority* and discusses the role of the union steward in grievances. We will discuss more about these concepts in later sections.

Take Note! — What happens if members vote no?

If members do not ratify (or vote yes, to approve) a proposed agreement, the parties can either return to

bargaining, engage in mediation, or voluntary interest arbitration. Many unionized health care workers are deemed essential workers and, as such, may have limited options to strike.

References

Government of Ontario. (2023, September 25). *Collective bargaining.*

Legalline. (2023). *What is a collective agreement?*

Statistics Canada. (2023, January 06). *Table 14-10-0132-01 Union status by industry.* https://doi.org/10.25318/1410013201-eng

Staffing and Scheduling Provisions in a Collective Agreement

Collective agreements in health care often include many different provisions specific to the staffing and scheduling process. Below are some typical provisions, along with some usual guidelines for each. Note that each collective agreement will differ in provisions, and these are just examples of what you may see.

ADVANCE NOTICE OF SCHEDULING

- How far in advance schedules need to be posted for staff.
- Typical provisions may range from 3 to 6 weeks prior to the start of the schedule and may include specific provisions for holiday-related schedules.

LENGTH OF SCHEDULES

- Typical provisions may range from a 4- to 8-week schedule length.

AVAILABILITY FOR PART-TIME STAFF

- Shifts per week: How many shifts per week a part-time staff member must be available for (note: this does not mean that they are scheduled for these). This part-time "commitment" is typically two shifts a week or 22.5 hours per week.
- Weekend requirements: How many weekends a part-time staff member must be available for (typically every other weekend or every third weekend).
- Statutory holiday requirements: How many statutory holidays a part-time staff member must be available for. (Note: Some collective agreements may state explicitly that a member must be available to work either Christmas or New Years and state a minimum number of consecutive days off during this period).
- Note: shifts may be termed "tours"

SCHEDULING FOR FULL-TIME STAFF

- Number of hours in a full-time schedule (typically 37.5 hours per week).
- Requirements for shift work-typically, full time staff working traditional 8-hour shifts (days, evenings, nights) are only scheduled for two of the types of shifts.

- Weekend requirements: how many weekends a part-time staff member must be available for (typically every other weekend or every third weekend).
- Statutory holiday requirements: How many statutory holidays a full-time staff member must be available for. (Note: Some collective agreements may state explicitly that a member must be available to work either Christmas or New Year's and state a minimum number of consecutive days off during this period.)

In addition to scheduling rules, most collective agreements also outline the number and length of breaks staff members are entitled to during their shift.

PROVISIONS FOR OVERTIME (OT)

- When overtime starts in a pay period or week (typically more than 75 hours in a 2-week pay period).
- When overtime occurs in a day (typically when regularly scheduled full shift is exceeded, such as asked to work a double shift or asked to work 12 hours when scheduled for an 8-hour shift). A short grace period may be applied before OT starts, such as a 15-minute reporting time window.
- Who is offered premium hours first. Typically, OT is offered by *seniority* in the following order:
    - Full-time employees
    - Part-time employees

- Casual part-time employees

ORDER OF CANCELLATION OF SHIFTS

- Which employees are cancelled first.
- Typically, staff is cancelled in this order:
  - Casual part-time employees
  - Part-time employees
  - Full-time employees
  - Note that in some contracts, part-time and full-time workers may have the opportunity to volunteer for cancellation prior to cancellation of staff.
- The least senior staff member scheduled for that shift in that job category would be cancelled first.
  - For example, the least senior casual employee would be cancelled first. If there are no casual employees working, then the least senior part-time would be cancelled.

TIME PARAMETERS FOR SHIFT CANCELLATION

- There are large differences in parameters for cancellation across collective agreements.
- ONA's collective agreements provide the most protection for RNs, providing them with the following:
  - Part-time RNs: 24-hour notice requirement for cancellation
  - Full-time RNs: 48-hour notice requirement for cancellation
- It is not uncommon for cancellation notice to be 4 to 12 hours for other job categories. If an employee is not cancelled within that period, they are provided with 4 hours of work at their regular pay and then sent home.

BUMPING RIGHTS

- Provisions for an employee who is cancelled for a scheduled shift to displace ("Bump") a less senior employee for that same shift.
- An employee may only bump another employee with the same qualifications and job status.
  - For example, if a part-time RPN is cancelled for a day shift on Saturday, they may bump the least senior part-time RPN working in another unit in the hospital for a day shift on Saturday.

TIME BETWEEN SHIFTS

- Minimum time requirements between the end of a shift and the start of the next scheduled shift.
- Typically, the requirement is 12 hours between shifts, however, longer requirements may be mandated when switching from night shifts to days.

PROCESS FOR CALLING IN SICK AND RETURNING TO WORK

- Time parameters associated with sick calls.
- Some contracts may outline recommended time periods to call in sick by, for example, a minimum of 4 hours prior to the start of a shift, but also acknowledge that this may not be possible.
- Most contracts also specify a minimum reporting period for return to work, for example:
    - By 1:00 p.m. the day prior to a day shift.
    - By 9:00 a.m. the day of an evening shift.
    - By 11:00 a.m. the day of a night shift.

PROCESS FOR THE ASSIGNMENT OF ADDITIONAL SHIFTS

- Guidelines for how additional shifts will be assigned after the schedule has been posted. These are typically due to staff illness, unfilled needs, or an increase in patient acuity.
- Shifts are typically offered by *seniority* in this order:
    - Regular part-time: Most senior part-time staff member available to work at straight time (no overtime or short shifting), then
    - Casual part-time: Most senior casual part-time staff member available to work at straight time (no overtime or short shifting)
    - Full-time: Finally, most senior full-time. Note: full-time are asked last, as they are already assigned full-time hours. **Any additional hours will result in overtime.**
- Collective agreement provisions vary between bargaining units, however, there are often provisions such as:
    - Requirement for part-time staff members who were not assigned the minimum commitment to be offered shift first.
    - Requirement for staff members to indicate availability prior to shifts.
    - Time periods to allow a staff member to respond before offering to the next staff member. These are often outlined according to the window before the shift starts, for example:

> "Shifts commencing within one (1) to eight (8) hours: The first employee eligible to be called for the shift will be given five (5) minutes to respond before the Hospital proceeds down the availability list."
>
> (Ontario Nurses Association and Grand River Hospital Corporation, 2023., pp. 12., para. 1).

SHIFT PREMIUMS

- Additional stipends to regular wages based upon when shifts are scheduled, which typically include:
    - *Evening premiums*: Paid for all hours between 1500-2300
    - *Night premiums*: Paid for all hours between 2300-0700
    - *Weekend premiums*: Paid for all hours worked between 2300 hours Friday and 2300 hours Sunday

- *On-call premiums:* Paid for all hours that a staff member is assigned on-call duties (typically overnight, weekends, or holidays)
- *Charge premiums:* Paid for all hours that a nurse is assigned the clinical resource nurse/charge nurse duties in a shift

BEREAVEMENT LEAVE

- Provisions for paid time off resulting from the death of a family member.
- Typical provisions may allow for an employee's paid absence from their next 3 to 5 booked shifts.

References

Ontario Nurses Association and Grand River Hospital Corporation. (2023). *Local appendices to the collective agreement: April 1, 2021 to March 31, 2023*.

Attributions

"Photo Of Woman Resting On The Couch" by Cedric Fauntleroy; used under the Pexels license.

Common Staffing Models

Hospital scheduling is dynamic and changes to meet the organization's needs and staff preferences. It is not uncommon for staffing models to change on units, for units to use a hybrid scheduling model, or for different categories of staff within one unit to use different staffing models. These models may be introduced by management with little staff input or may be proposed and voted on by staff. Below, you will see a brief explanation of the most common staffing models used in hospitals (Ontario Nurses Association and Grand River Hospital Corporation, 2023).

8-HOUR (NORMAL SHIFT) MODEL (7.5 PAID HOURS)

- Staff works 7.5-hour days, evenings and/or night shifts.
- Traditional rotation of 7 days on, 3 days off, 2 days on, 2 days off.

12-HOUR (EXTENDED SHIFT) MODELS (11.25 PAID HOURS)

- **Traditional 11.25 Hour Scheduling Model:**
    - Staff works 12-hour day and night shifts with a rotation of 3 on, 2 off, 2 on, 3 off.
    - This results in a 1 week break every 6 weeks.
- **4 On 5 Off:**
    - Staff works 12-hour day and night shifts with a rotation of 4 shifts on and 5 shifts off.

10-HOUR SCHEDULE MODEL (9.375 PAID HOURS)

- Staff works a combination of 10-hour shifts, with no more than 4 shifts in a row.

HYBRID SCHEDULE MODEL

- The hybrid schedule results in an employee working a combination of 8-hour or normal shifts, 10-hour shifts, and 12-hour or extended shifts, within the scheduling period.

LESS THAN 7.5 HOURS

- In some areas, it may be necessary to schedule staff for less than an 8-hour shift, for example, 6-hour or 4-hour shifts for meal coverage or break coverage. Short shifts are typically only assigned to part-time and/or casual part-time employees and do not include an unpaid break period.

ON-CALL/STANDBY

- In addition to regular shifts, full-time, part-time, and casual part-time employees may be scheduled to be "on-call" during off periods, such as evenings or weekends, in areas such as the operating room.
- The staff who is on-call must be available to attend work within a certain period while on-call.
- The on-call employee is typically paid a stipend for every hour that they are on call, plus a guaranteed minimum of time paid at 1.5 times their hourly wage if called in.

EXAMPLE: HUC STAFFING

Day Surgery

- Unit is open from 0600-2100 Monday to Friday, with the majority of clerical activity occurring between 0600-1800.
- The HUC staffing may be:
    - One 12-hour shift shift Monday through Friday (0600-1800) + one 8-hour shift daily (0900-1700)

ICU

- Unit is open 24/7, with clerical activity heavy during the day but continuing through the evening and night.
- The HUC staffing may be:
    - Two 12-hour shifts daily (0700-1900) + (1900-0700)

Surgical Unit

- Unit is open 24/7, with very heavy clerical activity in days and moderate activity into each evening.
- The HUC staffing may be:
    - One 12-hour shift daily (0600-1800), two 8-hour shifts daily (1000-1800) + (1800-0200)

References

Ontario Nurses Association and Grand River Hospital Corporation. (2023). *Local appendices to the collective agreement: April 1, 2021 to March 31, 2023*.

Master Schedules

You may have noticed guidelines in earlier sections related to the posting of *schedules*. But what exactly is a hospital schedule, how is it organized, and what information does it contain?

As you learned earlier, hospital schedules are typically 4 to 8 weeks long and typically must be released 3 to 6 weeks prior to the first day of the schedule. It is common for each type of job category to have its own schedule, so schedulers or unit clerical staff may be referring to several different schedules in their daily staffing needs.

ORGANIZATION OF SCHEDULES

Master schedules show the assigned shifts for all staff for that employee group for a certain period, such as 6 weeks.

Employees are organized by job status, typically as follows:

- Full-time (F/T)
- Part-time (P/T)
- Casual or temporary (if allowed by contract)

Within each of these sections, employees are organized by *seniority,* with the most senior staff listed *first.*

Take Note! What Is Seniority?

Union Seniority refers to a bargaining unit member's length of employment during the course of their contract. The length of continuous employment for an employee is referred to as union seniority in the bargaining unit.

Seniority is usually calculated by one of these two methods:

- Start date of employment (regardless of hours worked)
- Continuous hours worked in the bargaining unit (common with ONA) (Blackwell Firm, 2023)

Seniority lists are usually updated twice yearly and provided to each patient care unit. It is important to update master schedules to reflect any changes in seniority.

Shifts are typically indicated by a symbol, such as “D” for the day shift and “N” for the night shift. It is common to have some sort of legend at the bottom of the schedule which outlines any symbols. It is easy to pick out patterns in full-time employees’ schedules. They typically follow a consistent pattern which repeats every two weeks per pay period, with their hours worked usually totalling 75 hours. These may be referred to as *lines;* for example, the most senior staff member’s full-time line may consist of days and evening shifts, whereas the most junior staff member’s line is days and night shifts.

Typically, full-time employees apply to positions with an established line and keep that line every schedule. However, part-time employees’ schedules tend to have less of a pattern, as their purpose is to fill in the gaps in the schedule when full-time employees are not scheduled and provide flexibility in staffing.

EXAMPLE: UNIT SCHEDULE

Full-Time Staff Schedule

Name	Phone	Week 1							Week 2						
		S	S	M	T	W	T	F	S	S	M	T	W	T	F
		9	10	11	12	13	14	15	16	17	18	19	25	21	22
Kumar, Raj	(226) 555-5678	D	D	D	D	D	D	D	–	–	D	D	D	–	–
Yamamoto, Kayla	(548) 555-9012	–	–	D	D	D	–	–	D	D	D	D	D	D	D
O’Connor, Mia	(647) 555-1234	E	E	E	E	E	E	E	–	–	E	E	E	–	–
Nguyen, Lisa	(905) 555-5678	–	–	D	D	D	D	D	D	D	–	–	D	D	D
Hernandez, Sofie	(226) 555-3456	–	–	–	–	E	E	E	E	E	–	–	N	N	N
Ivanov, Alexei	(519) 555-9012	N	N	N	N	N	N	N	–	–	–	–	D	D	D
Garcia, Maria	(519) 555-1234	N	N	N	N	N	N	N	–	–	N	N	N	–	–

Part-Time Staff Schedule

Name	Phone	Week 1							Week 2						
		S	S	M	T	W	T	F	S	S	M	T	W	T	F
		9	10	11	12	13	14	15	16	17	18	19	25	21	22
Dubois, Jennifer	(705) 555-7890	D	D	–	N	–	D	–	N	–	N	N	–	–	D
Al-Farsi, Layla	(647) 555-2345	–	–	D	D	–	D	–	E	E	E	–	–	E	E
Petrov, Elena	(905) 555-6789	D	D	–	–	–	–	–	–	–	E	E	E	–	–
Shantz, Taylor	(519) 555-0123	E	E	–	–	–	–	–	–	–	D	D	–	E	E
Rossi, Luca	(226) 555-4567	N	–	D	D	–	–	D	D	D		E	–	–	–

Deciphering a Schedule:

This schedule shows a 2-week pay period, starting on Saturday and ending on Friday (note the days of the week on top). The abbreviations of D, E, and N, are for *day*, *evening*, and *night shifts*.

The full-time staff are listed first on the schedule by seniority, with the most senior first. They have a consistent 8-hour schedule, with 10 shifts in every 2-week pay period (a total of 7.5 hrs per day x 10 days =75 hours per pay).

The part-time staff are listed next on the schedule by seniority, with the most senior first. Notice that the part-time staff do not have a consistent line like the full-time staff, instead they are scheduled around the gaps left in the schedule.

References

The Blackwell Firm. (2023, July 14). *How does union seniority work with different departments?*

Staffing Guidelines for the Master Schedule

It is impossible to know how many staff will be required for every shift several months in advance as there is no way to know the number and acuity of patients that far ahead. Instead, master schedules are created based on projected staffing needs, with the understanding that adjustments may need to be made each day based on actual needs.

Master schedules must accommodate the full-time hours required for full-time staff, and then any additional shifts are divided amongst part-time and casual staff (if the contract allows for casual employees).

Staff are scheduled based on the following:

- projected ***patient census***, or the number of patients expected to be admitted to that unit, and
- established ***patient care ratios*** for that unit, which are the number of patients the nursing staff is expected to provide care to.

British Columbia is the only province in Canada with mandated staffing ratios (Gamage, 2024). All other provinces and territories are free to set their own ratios based on a number of factors.

PRACTICE ACTIVITY: STAFFING

Perform an internet search for "safe patient staffing levels images" for a variety of informative infographics outlining suggested ratios for nurse-to-patient staffing based on department.

FACTORS INFLUENCING PATENT CARE RATIOS

Patient care ratios will be influenced by the type of patient care unit, the shift/time of day, and the model of care. See the examples outlined below.

Type of Patient Care Unit

An ICU may have a ratio of 1 nurse: 1 patient; whereas a rehab unit may have a ratio of 1 nurse: 6 patients.

Shift/Time of Day

Ratios may change between days, evenings, and night shifts, with day shifts typically having the highest number

of staff scheduled to accommodate the greater workload associated with meals, bathing, scheduled tests, operations, and treatments, and increased interactions with allied health care workers, physicians, and family members. Night shift typically has less staff scheduled, due to lower workloads associated with these hours.

Models of Care

Whether a nurse looks after all the patient's needs by themselves (i.e., **primary nursing**) or whether a group of health care workers such as RNs, RPNS, and PSWs work together to deliver patient care (i.e., **team nursing**).

EXAMPLE: STAFFING RATIOS

Primary Nursing

- Days — 1 RN: 5 Patients
- Evenings — 1 RN: 7 Patients
- Nights — 1 RN: 10 Patients

Team Nursing

- Days — 1 RN, 2 PSW: 10 Patients
- Evenings — 1 RN, 2 PSW: 14 Patients
- Nights — 1 RN, 2 PSW: 18 Patients

References

Gamage, M. (2024, March 6). BC introduces Canada's first mandatory nurse-to-patient ratios. *The Tyee.*

Adjusting the Master Schedule Based on Unit Requirements

CALCULATING STAFFING NEEDS

When staffing is completed at the unit level, the HUC, along with the *clinical resource nurse/charge nurse* or *unit manager*, keeps a close watch on staffing needs. This involves taking into consideration the following:

- actual number of *patients on the unit* (**unit census**) now,
- anticipated number of *discharges* for the next few days,
- anticipated number of *elective admissions* scheduled for the next few days (if surgical unit),
- number of *ER patients* waiting to be admitted, and
- number of pending *patient transfers*, either into or out of the patient care unit.

Once this **projected unit census** is calculated, the HUC and charge nurse will calculate the number of staff required for each shift of the day, using the unit's staffing ratios. They will check this against the actual staff booked, and any sick calls for that day, and add staff or cancel staff as required. Staffing on units with RNs must be looked at a minimum of 24-48 hours prior to shifts to accommodate the collective agreement cancellation provisions.

Example: Calculating Staff

It is Thursday at 1200 and Maria, the HUC, and Joseph, the clinical resource nurse, are looking ahead at staffing. The current unit census is 30, and they are expecting 2 discharges later today, as well as 4 admissions and 1 discharge tomorrow morning.

What is the projected census for evenings on Friday?
Answer

$$30 - 2 = 28$$
$$28 + 3 = 31$$

The unit staffs using the primary nursing model. The staffing ratios for their unit are as follows:

- Days (0700-1500): 1 RN: 5 patients
- Evenings (1500-2300): 1 RN: 8 patients
- Nights (2300-0700): 1 RN: 10 patients

How many RNs should they have scheduled for evenings tomorrow?
Answer

$$31 \div 8 = 3.875$$

As you cannot have 0.875 of a person, you would round up to 4 **RNs.**

Next, Maria and Joseph would check the schedule to see how many staff were actually booked.
Answer

If fewer than 4 RNs are scheduled, then Maria would call in an RN according to the collective agreement provisions (typically the most senior part-time RN).

If more than 4 RNs are scheduled, then Maria would cancel RN(s) according to the collective agreement provisions (typically the most junior casual part-time RN, if no casual, the most junior part-time RN).

Remember that the collective agreement outlines time restrictions for cancellations for staff. As casual and part-time RNs require 24 hours notice, Maria may still cancel the most junior until 1500 today.

If 4 RNs are scheduled, then no further action is required.

Seniority and Equitability

In the example above, we are assuming that the collective agreement stipulates that cancellations and call-ins are based on seniority, which is often the case. However, some collective agreements will stipulate that call-ins be based upon both *seniority and equitability,* to reward seniority but also limit large variations in hours between junior and senior staff members. In these cases, the staffing office and/or unit clerical staff must calculate each part-time staff's hours worked and follow parameters for assigning additional shifts based on availability, seniority and whether the staff has met hours requirements.

This excerpt from an expired collective agreement at Grand River Hospital outlines how to handle the issue of staffing seniority and equity:

> The available shifts will be scheduled by seniority and availability starting with the most senior employee on the nursing unit or service department, up to 45 hours in a pay period. Once all regular part time employees in the nursing unit or

> service department have 45 hours, shifts will be scheduled one at a time by seniority and availability, so as to equalize hours, in the nursing unit or service department.
>
> For clarity, shifts that become available after the schedule is posted will be offered by seniority and availability starting with the most senior part time employee on the nursing unit or service department, up to 45 hours in a pay period. Once all regular part time employees in the nursing unit or service department have 45 hours, shifts will be offered one at a time by seniority and availability, so as to equalize hours, in the nursing unit or service department.
>
> (Grand River Hospital and Unifor-Local 1106, 2018, pp. 37, para. 5)

GRIEVANCES

It is very important the HUC and/or schedulers are aware of and follow all collective agreement provisions for cancellations or calling in extra staff to avoid a ***grievance***. A grievance is a formal complaint alleging that the employer has violated the collective agreement. Grievances related to daily staffing are often individual grievances-for example, one person grieves that a management action (in this case completed by the HUC who reports to management) has violated their rights, such as denial of a shift or overtime (OPSEU, 2015).

Video: Grievance Procedure

Learn more about the grievance process in the short video below:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=391#oembed-1

Source: OPSEU Education. (2015, June 16). *The grievance procedure* [Video]. YouTube. https://www.youtube.com/watch?v=vgYUToBBEns&t=1s

References

Grand River Hospital and Unifor-Local 1106. (2018). *Full-Time and Part-Time Clerical Bargaining Units: October 11, 2028, to March 31, 2021 [PDF]*.

OPSEU. (2015, August). *Legal tools: Grievances and more [PDF].*

Chapter 3 Review Activities

Test your knowledge of this chapter's content by completing the following exercises. You may complete these as many times as you like.

PRACTICE ACTIVITY: KNOWLEDGE CHECK

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=395#h5p-67

PRACTICE ACTIVITY: STAFFING

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=395#h5p-50

STAFFING KEY TERM SEARCH & FIND

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=395#h5p-32

CHAPTER 4: RISK MANAGEMENT AND THE HUC

Hospital Codes

Hospitals by nature are subject to a variety of clinical and environmental dangers daily which require a method to alert staff to an emergency. Codes allow trained hospital personnel to respond quickly and suitably to various events while preventing concern or panic by visitors and patients (Dix, 2023). These codes are usually communicated by the switchboard department overhead to all departments via the hospital intercom/paging system. Because it is vital for all hospital staff to be familiar with the emergency code system in the hospital they work in, yearly training on hospital codes and the appropriate response is mandatory for all staff.

The codes outlined in the **Hospital Emergency Codes** table are recommended by the Ontario Hospital Association (n.d.); however, they are fairly standard across North America, with variations of these also used in law enforcement agencies, long-term care, and educational facilities (Dix, 2023). This list is periodically updated with new codes to reflect current risks within the hospital and surrounding environment.

Table: Hospital Emergency Codes

Code	Description
Code Green	Evacuation
Code Yellow/Amber	Missing Person/Missing Child
Code Orange	Disaster/CBRN Disaster
Code Red	Fire
Code White	Violent Person
Code Purple	Hostage Situation
Code Brown	Hazardous/Chemical Spill
Code Silver	Person with a Weapon
Code Black	Bomb Threat / Suspicious Object
Code Grey	Infrastructure Failure
Code Aqua	Water Emergency/Flooding
Code Blue	Cardiac Arrest/Medical Emergency – Adult
Code Pink	Cardiac Arrest/Medical Emergency – Infant/Child

THE HUC ROLE IN CALLING CODES

It is often the HUC's responsibility to give the emergency signal. Therefore, it is important that the HUC

- be familiar with emergency protocols and their role in each code situation,
- ensure that they have all the required information to be able to clearly communicate the emergency (depending upon the code, this may include the patient room number or description of patient), and

- immediately contacts the appropriate area—in most cases, this will be switchboard/locating.

It is also important for the HUC to be familiar with the hospital's **emergency fan out notification system**. In many jurisdictions, there are requirements for hospitals to develop, implement, and document 24/7 notification protocols for communications with their staff according to public health emergency preparedness protocols. Fan out systems are in place to quickly call all permanent, part-time, full-time and casual staff to the hospital in case of emergency or incident. These systems typically require the direct contact of all staff members, utilize a prescribed script, and require ongoing testing and documentation (Simcoe Muskoka District Health Unit, 2013).

Take Note! Code Phone

It is common to have a dedicated internal emergency number (such as 999 or 555). or a **code phone** on the unit for such cases.

COMMON HOSPITAL CODES EXPLAINED

CODE GREEN – Evacuation

Refers to a disaster and other situations requiring a partial or complete evacuation of the health care facility. A CODE GREEN may occur because of either an internal or external event and may occur in conjunction with another code, for example a CODE RED – Fire or CODE BLACK – Bomb may necessitate evacuation. The two stages of CODE GREENs are usually differentiated by the intensity of the bell or siren that accompanies the pages overhead. Alternatively, they may be paged as Level 1 or 2.

CODE YELLOW – Missing Patient/Resident

Refers to a missing patient or resident, who is described in detail in the paged announcement. When this is paged, hospital staff are expected to search their specific area for the missing individual. When the patient is found, the care area notifies the switchboard, and the patient is returned to the appropriate care area. In some hospitals, patients who are known to wander may be outfitted in a special gown or robe, such as a striped one, so that hospital staff can easily identify them.

CODE ORANGE – Disaster or Chemical, Biological, Radiological or Nuclear (CBRN)

Refers to an event in which the hospital's human or physical resources are overwhelmed (CODE ORANGE – Disaster) or an event involving a chemical, biological, radioactive, or nuclear agent (CODE ORANGE – CBRN) (North Shore Health Network, n.d.). External disasters include natural disasters such as tornadoes, explosions, plane or train crashes, and toxic spills. There are various responses to CODE ORANGES which typically focus on calling in more staff, decanting existing patients, and finding alternate treatment areas for overflow.

CODE AMBER – Missing Infant/Child

Refers to a missing infant/child. Like CODE YELLOW, there is a description provided on the overhead page, and staff are expected to search their specific care area. The hospital may be locked down in the event of a CODE AMBER to prevent the individual who has taken the child from leaving the premises, and the police may be notified (North Shore Health Network, n.d.).

CODE RED – Fire

Refers to a fire within the hospital. When a CODE RED is called and fire alarms are pulled, most doors will close automatically and elevators lock. All patients should be returned to their rooms and staff should congregate in one area, typically the communication centre, to await further instructions. If an area is required to evacuate, all staff participate in patient evacuation measures. Regardless of whether it is a drill, or when their shift ends, staff may not leave the unit until the ALL CLEAR is called.

CODE WHITE – Violent Person

Refers to a behavioural emergency, whether it be a patient, visitor, or staff member, where there is an immediate risk of harm to self or others. When a CODE WHITE is called, the overhead page states the location of the occurrence, and a trained response team attends to de-escalate the situation. CODE WHITES may be seen on many units, but may be more common in ERs, mental health units, and dementia units where these behaviours are symptomatic of their illness and require responses that balance a therapeutic response and the need for control and protection (North Shore Health Network, n.d.).

CODE PURPLE – Hostage Situation

Refers to a situation where any person is forcibly held against their will, with the threat of a weapon or threat of violence. When a CODE PURPLE is called, the police will be notified. Staff should not attempt any action or put themselves at risk but answer when spoken to and note any demands the hostage-taker may have. Staff away from the area should not contact persons outside of the hospital. This may result in many unwanted phone calls and visitors to the site (North Shore Health Network, n.d.).

CODE BROWN – Chemical Spill

Refers to a chemical spill or toxic fumes within the building or on the grounds. A CODE BROWN may require evacuation of an area if the spill is hazardous (chemical, flammable or explosive)(North Shore Health Network, n.d.). A spill that poses no threat may be cleaned up by environmental services.

CODE SILVER – Person with a Weapon/Active Shooter

Refers to a person with a weapon. Staff are advised to close all doors, turn off lights and hide out of the assailant's view. They should silence cell phones, take cover, remain low to the ground, and not come out until the ALL CLEAR is called or orders to evacuate are given by the police response unit (North Shore Health Network, n.d.).

CODE BLACK – Bomb Threat

Refers to a bomb threat. Like CODE RED, internal doors will close, and elevators will turn off. Staff are expected to search their immediate area for anything suspicious and once their entire unit has been searched, call in their unit's clearance. Once all units have responded that their units are clear, an ALL CLEAR will may be paged. If staff do find a suspicious item, they must call switchboard immediately.

CODE GREY – Infrastructure Loss or External Air Exclusion

Refers to a significant infrastructure loss that it interrupts day-to-day operations and negatively affects patient care, for example loss of power, water, power, or IT systems. Staff should wait for further instructions which may include reverting to down time procedures. May also refer to dangerous outside air conditions which may affect people within the building, for example, a large smoky fire. All exit doors will be sealed/locked down except for the main entrance and the ventilation systems will be turned off to minimize air infiltration (North Shore Health Network, n.d.).

CODE AQUA – Water Emergency/Flooding

Refers to a significant water event, either internal or external, which interrupt day-to-day operations and negatively affect patient care, for example, internal flood due to pipes bursting. Water emergencies typically affect functions situated in the lower levels of the hospital, including mechanical, sterilization, and materials management functions. Staff should wait for further instructions which may include cancellation of elective surgeries and procedures.

CODE BLUE or PINK – Medical Emergency/Cardiac Arrest

A CODE BLUE refers to a medical emergency/cardiac arrest of an adult; whereas, a CODE PINK refers to a medical emergency/cardiac arrest of a child/infant. In both cases, a rapid response/code team will transport a crash cart to the scene and take charge although medical staff may be expected to start treatment and assist as necessary. Clerical staff in an area that has a CODE BLUE/PINK emergency should remain close by to liaise with the switchboard for additional paging requirements, order any supplies, and communicate with the **bed allocator** regarding urgent transfers to areas such as ICU, CCU or NICU.

MOCK CODES

It is common for hospitals' risk management departments to organize *mock code drills* monthly or quarterly to rehearse responses to common code scenarios. Mock codes provide staff members the opportunity to practice their response and help increase staff's self-confidence, teamwork, and response time (Chu & Robilotto, 2018).

References

Chu, R. & Robilotto, T. (2018, March). Mock code training to enhance CPR skills. *Nursing Made Incredibly Easy! 16*(2), 11-15.

Dix, M. (2023, April 14). Code Blue, Code red, Code black: Definition of hospital color codes. *Health Line.*

North Shore Health Network. (n.d.). *Emergency codes.*

Ontario Hospital Association. (n.d.). *Tools and resources: Emergency preparedness colour codes badges 2 x 3.*

Simcoe Muskoka District Health Unit. (2013). *Policy and procedure manual: Emergency fan out notification system.*

Secure Units

Some units in the hospital may be designated as *secure units* to protect vulnerable patients, for instance:

- psychiatric units
- mat-child units
- critical care units (ICU/NICU/CCU)

Levels of security for these units may differ; however, most will include locked exterior doors which staff may access with ID swipe cards and video cameras outside the unit with an intercom or call bell system. It is often the HUC's role to screen any visitors to the unit prior to opening the unit doors and ascertain from nursing staff whether this is an appropriate time for a visit. The HUC should identify the individual and their purpose for entry prior to admitting them to the unit.

MAT-CHILD UNITS

There may be numerous other security measures in mat-child units, including:

- implementing an infant security tag or abduction alarm system (such as an electronic armband) which triggers an alarm, locks doors, and freezes elevators if an infant comes within a specified distance of an exit or elevator,
- footprinting the infant and taking a colour photograph within 2 hours of birth (Miller, 2007; Vincent, 2009), and
- implementing protocols for protecting new mothers from estranged partners (Thompson, 2018).

The HUC plays a large role in the safety of newborn infants and their mothers as they are typically the first person who interacts with visitors. The HUC should clearly communicate the unit security policies to patients and visitors upon admission and ensure that they only allow visitors into the unit who have the appropriate identification and challenge any staff members who are not wearing the appropriate hospital identification.

In addition to the usual measures of secure units like card swipe access, mat-child units use additional measures to protect infants from abduction.

PSYCHIATRIC AND DEMENTIA UNITS

Some psychiatric and dementia units may have additional security measures for their patients, including controlled exits to limit patients from wandering, or leaving the facility when deemed incapacitated to make treatment decisions. In psychiatric areas where patient safety is an issue, the HUC may also need to screen any gifts brought in by visitors. The HUC in locked units may interact with aggressive, upset, or confused patients wishing to leave the unit and must interact and redirect in an empathetic, professional manner.

References

Miller, R. (2007, October). Preventing infant abduction in the hospital. *Nursing, 37*(10), 20–22.

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional* (4th ed.). Pearson Canada.

Vincent, J. (2009, June). Infant hospital abduction: Security measures to aid in prevention. *The American Journal of Maternal Child Nursing, 34*(3), 179–183.

Attributions

“Baby, Newborn, Child image” by Engin_Akyurt; used under the Pixabay license.

Chapter 4 Review Activities

Test your knowledge of this chapter's content by completing the following exercises below. You may complete these as many times as you like.

REVIEW ACTIVITY: THE HUC ROLE IN HOSPITAL CODES

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=604#h5p-51

REVIEW ACTIVITY: MATCHING HOSPITAL CODES

Activity 1

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=604#h5p-27

Activity 2

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=604#h5p-26

CHAPTER 5: HOSPITAL COMMUNICATION PROCESSES

Hospital Telephone Protocols

Operating and monitoring communication systems and devices are among the main tasks of the HUC. There are many different types of communication tools used in the hospital environment; you will briefly learn about each in the following sections.

A *multiline telephone system* is the most commonly used communication tool at the communication centre. Communicating effectively by phone involves different techniques than in-person conversations and is key to ensuring smooth communication and efficient workflow.

TAKE NOTE! TELEPHONE ETIQUETTE BASICS

- Answer the phone promptly and politely, stating your department, name, and position clearly. For example: *"3 South, Rashida, hospital unit coordinator. How can I help you?"*
- Speak clearly and professionally, avoiding distractions like drinking, eating or chewing gum while on call.
- Listen actively throughout, jot down important details such as the caller's name, and avoid interrupting.
- If you don't know the answer to the caller's inquiry, let them know you'll find out or direct them to someone who can help.
- End the call courteously; for example, thanking the caller or wishing them a nice day.
- Complete any follow up discussed during the call immediately if possible, or make a note to complete when time allows to ensure that you do not forget.

ADHERING TO PRIVACY AND CONFIDENTIALITY STANDARDS

The HUC must legally and ethically protect all personal health information (PHI) from unauthorized disclosure. Under current privacy legislation, hospitals may provide general information regarding a patient's admission status and location in hospital, unless directed not to by the patient on admission. Any further information may not be shared without the consent of the patient (Grand River Hospital, 2024).

Many hospitals have moved to a privacy code or PIN number system to protect patient confidentiality while still providing an effective flow of communication to patients' families. Upon admission to the hospital, patients are provided with a privacy pamphlet which includes their own specific privacy code or PIN number which they may choose to share with the family and/or friends they wish to have information. Only those individuals with the specific code or number will be provided with any information on that specific patient (Grand River Hospital, 2024). Alternatively, hospitals may allow for a designated system: upon admission, the patient gives the names of a certain number of individuals (for example, up to three) who may be given medical information.

The HUC must always ensure to follow their hospital's privacy policy in both telephone and in person communications by asking for the code or checking to see if the caller is designated to receive information. Regardless of relationship or level of concern, the HUC may not legally provide a caller with any PHI if they do not not qualify under the hospital's privacy policy.

Practice Activity: Privacy Codes/Pin Numbers

You are the HUC on 6 North at Conestoga General Hospital. Mrs. Brown's cousin has called to check on her condition after major surgery. She does not have a privacy code to receive any information and becomes very upset with you when you do not provide information on her status.

Outline an appropriate greeting for answering an incoming call for the above scenario. Remember to include a greeting such as "Hello," your department or organization, your name, and a query as to how you may assist the caller.

If you require inspiration, it should sound something like this:

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1279#h5p-14

Audio Recording Transcript

Good morning, 6 North, Conestoga General Hospital, Nancy speaking. How may I help you?

Record Your Message

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1279#h5p-15

- Listen to your recorded greeting—how professional do you think you sounded?
- Imagine you are Mrs. Brown's cousin—what would your initial impression be?
- How would you respond to Mrs. Brown's cousin's question as to why a PIN number was necessary?
- What suggestions might you offer to Mrs. Brown's cousin to problem-solve this situation?

USING THE TELEPHONE

The Hold Feature

Most hospital department phones have multiple incoming lines and a hold feature that allows callers to wait while other calls are answered. The HUC may use the hold feature:

- To handle additional incoming calls.
- To find information or connect the caller with another staff member.
- To maintain patient confidentiality when discussing sensitive information in the presence of other visitors or patients (Gillingham & Wadsworth Seibel, 2014).

It is best to politely ask the caller's permission to put on hold and offer an estimate of the length of hold if possible, for example, "May I put you on hold for a few minutes while I find out that information?". If the callers refuses to be put on hold, the HUC may offer a time to call back, or take the caller's number for a return call. If the hold extends longer than expected, the HUC should check back with the caller to update them on the status.

A multiline telephone system is the main method of communication in hospitals; the HUC must develop good telephone skills.

The Transfer Feature

The HUC will need to route an incoming call to another department or staff member when the caller has reached the incorrect department or requires the assistance of a specific staff member. When transferring a call, the HUC should:

- Ask permission to transfer the caller; for example: *"Is it alright if I transfer you to our patient accounts department for further assistance?"*
- Give the caller the name of the person or department they will be transferred to and the extension in case the call fails to transfer.
- Briefly stay on the line to ensure the transfer is successful and the new party is available to take the call.
- Once the transfer is complete, introduce the caller to the new person or department. For example, "This is Mr. Emery; he would like some information regarding the cost of a private room for his wife."

MESSAGE TAKING

The HUC will need to take many messages during the day, so they should always have note paper and a writing tool close to their phone. When taking messages by phone or in person, it's crucial that the HUC records the following:

- The correct spelling of the caller's first and last name.
- Who the message is for.
- The date and time of the call, and the reason for the call.
- A contact number if callback is expected.

The HUC should repeat the message back to the caller to ensure accuracy. After the call, the HUC must promptly pass the message to the intended recipient.

Example: Importance of Message Taking

Rashida, HUC, has taken a message from the operating room (OR) that they are moving up Mrs. Kaur's surgery from 1400 to 1230. Although Rashida intended to give the message to Phillip, the clinical resource nurse, she forgot after being interrupted by other calls.

When the porter arrives to pick up Mrs. Kaur for surgery, they find that she is not ready. The nurses must quickly act to finish her documentation and administer pre-operative medications, while the OR comes to a standstill. The surgeon angrily calls the unit to ascertain the hold-up, the OR schedule falls behind, necessitating cancellation of a patient's surgery at the end of the day.

PLACING CALLS

The HUC will be asked to place several calls throughout their shift to other departments, physicians, and individuals or agencies outside of the hospital. When asked to place a call, the HUC should:

- Note the name of the person/department to be called; for example, Dr. Aaron Smith's office.
- Reason for the call; for example, requesting a pain medication change for patient Ali Khan.
- The name of the person who is requesting the call; for example, Mr. Khan's team leader RN, Mary.
- The designate for who will take the call back if the person who is requesting the call is not available.

It is important for the HUC to write down all of these above details in case the line is busy and the call needs to be placed again later.

Take Note! Emergency Calls

Remember from the section on Hospital Codes that the HUC may contact the switchboard in an emergency through either a dedicated emergency line or the **code phone**.

LEAVING MESSAGES/VOICEMAILS

The HUC may need to leave non-urgent messages on voicemail. To leave effective messages, the HUC should:

- Start by clearly stating their name, department, and position.
- Clearly explain the reason for the message.
- Include any specific information and actions required, such as a request for a callback.
- Provide contact information including phone number, and contact to ask for if asking for a callback.
- Repeat important details to ensure accuracy, including phone number, name, and any lab values/result.
- Be courteous throughout and end the message politely.

Practice Activity: Leaving Messages

You are the HUC on 6 North at Conestoga General Hospital—your unit direct telephone number is 519-743-1110. The charge nurse, Patricia, has asked you to call Dr. Sharma's office to report Maria DaSilva's INR result of 2.4 and ask for Coumadin orders. When you call the office, a message indicates that the medical office assistant (MOA) is on the other line, and you should leave a message, which will be checked within the hour.

First, consider what information you should include in this message, then record it below:

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1279#h5p-23

Next, review your message—did you include all relevant parts of the message?

Did it sound like this?

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1279#h5p-24

Audio Recording Transcript

Good morning, it's Nancy calling from 6 North at Conestoga General Hospital. I am calling this morning with an INR result on Maria Dasilva. Her INR is 2.4. Can you please ask Dr. Sharma to give Patricia a call here at 519-742-1110 with Coumadin orders? Thanks, have a great day!

Finally, re-record your message until you think you have created a professional voicemail.

References

Gillingham, E. A, & Wadsworth Seibel, M.M. (2014). *LaFleur Brooks' health unit coordinating (7th ed.)*. Elsevier.

Grand River Hospital. (2024). *Privacy and confidentiality.*

Attributions

Other Communication Devices

In addition to the telephone, the HUC will interact daily with a variety of other communication devices on the patient care unit, with the most common outlined below. In addition to these, the unit that they work in may use a variety of other communication devices and tools, such as on-demand interpretation services and augmentative and alternative communication devices, such as picture boards, iPads, amplifiers, and apps.

OVERHEAD PAGING SYSTEMS

In addition to hospital-wide overhead paging systems used by switchboards, each hospital department also has its own intercom or overhead paging system to make localized announcements. Unit intercom systems are located at the communication centre and may be stand-alone units, or part of a patient call bell system.

The HUC typically uses the unit intercom to locate staff or call staff to the desk to answer a telephone call. Unit intercom systems may have several different zones, for example, the break room, conference room or med room.

When paging, the HUC should consider the following:

- time of day (it would not be appropriate to page a non-urgent page communication overhead during hours that patients typically sleep),
- the zone required (should they page into a specific zone or all zones?),
- the intended staff member, and what they wish them to do, and
- confidentiality-never broadcast patient's names.

HUCs must also ensure to speak clearly and repeat important information in the page. For example: *"Giovanni, pick up on line 2, Giovanni, line 2."*

Practice Activity: Overhead Paging

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1284#h5p-68

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1284#h5p-16

CALL BELL SYSTEM

The unit's call bell system, another type of intercom, allows remote communication with patients. Each bed has its own unit and a button or cord that the patient can press or pull to alert the staff that they require assistance. When the bell is activated, it triggers a light and an audible alarm outside the patient's room and at the communication station, indicating that the patient needs help. This signal will remain active until manually deactivated by staff in the room or at the desk.

The HUC may be required to respond to call bells, especially during times when the unit is short-staffed or during shift change. If the HUC does respond, they should:

- Identify themselves. For example, *"Hello, this is Rashida at the desk, how may I help you?"*
- Ask for specifics of what they need.
- Reassure them that you will relay this information to the appropriate person. For example, *"I will let your nurse Joseph know that you are asking for pain medication. He will be in as soon as he can."*

After answering the call bell, it is imperative that the HUC passes on the message immediately to the appropriate staff member as missed messages may cause the patient to suffer needlessly for an extended time. If the request is something that the HUC can handle on their own, such as getting more ice, or another blanket, they may do so or ask any member of the staff to assist.

Practice Activity: Call Bells

As the HUC at the desk, you may need to answer call bells when no clinical staff is around. Formulate an appropriate answer to each of the following calls. Remember to answer each "bell" professionally:

Patient #1: I really need something for pain.

Patient #2: (angrily) I have been waiting for half an hour for someone to take me to the bathroom. If someone doesn't come now, I am going to wet my bed!

Patient #3: Do you know when my doctor is coming in to see me?

PAGERS

Many hospitals provide "restaurant-style" pagers to family members waiting for a loved one in surgery or undergoing procedures. This allows families to be relocated outside of the immediate surgical department, freeing up space for other patients and families to receive pre and postoperative care and allowing waiting family members to move freely around the hospital. The HUC would be responsible for recording the pager number and activating it when the patient has completed their procedure and the family is allowed back to the surgical area to wait while they recuperate or for pick up.

PATIENT TRACKING SYSTEMS

Patient tracking systems help improve communications and the availability of up-to-date patient information for both staff and families. One of the most common uses for patient tracking systems is for surgical patients.

Surgical patient tracking boards for waiting rooms are designed to provide families with patients' real-time progress through the surgical procedure through a progress bar that indicates their movement through each area of the surgical procedure. Each patient is represented by a unique identifier (like the PIN number discussed in the previous section) for privacy reasons (Surgical Information Systems, 2023).

BED BOARDS

Hospital bed boards present the current picture of beds for each unit of the hospital. The HUC for each patient care unit is responsible for managing patient flow in their designated unit and for ensuring that the patient flow/admitting department is kept up to date on their unit's bed status (Thompson, 2018).

The HUC must accurately update their unit bed board with confirmed and pending discharges, completed transfers, and patients in isolation. This information is necessary to provide the **bed allocator** the most accurate and up-to-date information on bed availability on which to base their admitting decisions.

COMMUNICATION BOARDS

Many units have communication boards which record general census information. Communication boards are typically large whiteboards with a printed grid or table, with rows and columns to record the following:

- room number
- patient name
- attending physician/MRP
- the nurse attending to the patient for that shift
- additional information such as discharge date

The HUC is responsible for maintaining the communication board and typically makes several changes to it daily as patients are admitted and discharged.

Changes to privacy legislation have necessitated changes to the use of communication boards, with many hospitals now positioning them away from the public, omitting patient names, or using initials or other non-identifying information.

The whiteboard on the wall of this communication centre is tracking general census information; the HUC is usually responsible for maintaining the communication board.

FAX MACHINES

A fax machine is a telecommunication device that transmits copies of written material wirelessly or over a telephone wire from one site to another. Faxes are transmitted by placing the document(s) to be sent in the direction indicated on the fax feeder tray, entering the recipient's fax number, and pushing the send button. The scanner then turns the document into a digital signal that is transferred to the receiving machine where it is decoded to reproduce the original document before printing it (Gillingham & Seibel, 2014).

Fax machines have been replaced by digital technology in most cases but are still commonly used in health care settings for transferring information.

Despite the use of more advanced medical office equipment, the fax is still used in many health care facilities, including hospitals. In the hospital, the HUC may use a fax machine for the following tasks.

- **Order entry process:** In hospitals where physicians still use paper-based orders, the HUC must fax all order sheets containing medication orders to the pharmacy department to be reviewed, entered in the electronic MAR, and filled.
- **Release of information requests:** These forms are signed by the patient and faxed to the information management department at other health care facilities, which in turn will collate, prepare and fax the requested records to the requesting patient unit or the HIM department.
- **Booking requests:** Requisitions sent from physicians' offices requesting an appointment for clinical evaluation for their patient (for example, an MRI or CT). OR booking requests may also be sent via fax to the OR Bookings Department.

Best Practices for Using Fax Machines

Using a fax is straightforward; however, there are a few best practices the HUC should keep in mind.

- When sending a fax outside of the hospital, always use a cover sheet, and specify the number of pages the fax includes.

- When receiving a fax, ensure that you have the number of pages noted on the cover page.
- If uncertain whether a fax has been sent, review the fax transmission report which itemizes the date, time, and destination of both outgoing and incoming transmissions.
- When scanning faxed documents into the patient's EHR, always validate that you have the correct patient by double-checking both the full name and date of birth or by medical record number (MRN).

References

Gillingham, E. A. & Wadsworth Seibel, M. M. (2014). *LaFleur Brooks' health unit coordinating. (7th ed.)*. Elsevier.

Surgical Information Systems. (2023, March 2). *8 ways an ASC patient tracking system improves facility management*.

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional (4th ed.)*. Pearson Canada.

Attributions

"A Doctor and Nurses having Conversation" by RDNE Stock project; used under the Pexels license.

"Setting up a new fax machine" by Elliott Plack on flicker, Creative Commons – Attribution-Sharealike 2.0 Generic.

CHAPTER 6: THE BASICS OF THE INPATIENT CARE RECORD

Hybrid Patient Care Records

All patients' charts flow from the patient registration/admission process. The type of patient record that is produced depends on the clinical information system the hospital uses, the level of electronic health records adopted, and even the department or type of admission. Patient records may be fully electronic or hybrid, using both electronic portions and paper-based portions.

HYBRID RECORDS—CARE OF THE PHYSICAL CHART

With hybrid charts, the electronic chart (e-Chart) portion is stored electronically in the clinical information system while the physical chart (p-Chart) is stored at the communication centre in a designated chart area. With hybrid charts, it is the HUC's role to:

- create the initial p-Chart (includes labelling the exterior and adding and physically labelling the required paper chart forms for the type of admission with pre-printed patient labels),
- file patient records/reports in the p-Chart,
- maintain the p-Chart by adding additional chart forms when required or **thinning** the p-Chart when it becomes too cumbersome, and
- dissemble the p-Chart to send to the health information management (HIM) department for processing when the patient is discharged home or to another facility, or expires.

Physical charts are often housed in three-ring binders and arranged on a chart rack in the unit by *room number* instead of alphabetically to facilitate ease of removal and replacement in the corresponding chart slot. Most p-Charts have a plastic exterior sleeve for identification, which typically includes an initial, last name, bed number, and doctor's name. No diagnoses should even be indicated on the outside of a physical chart.

An inpatient p-Chart has several sections within, which are arranged in **universal order**, which allows for quicker filing and access to records. Health information in each of these sections is arranged in "reverse chronological" order, which means that the most current information is at the top of each section.

Regardless of whether the hospital is using a hybrid system with a p-Chart or a stand-alone e-Chart, the HUC may expect to see the same type of patient care forms or sections. Some common types of chart forms in a standard inpatient *medical* chart and inpatient *surgical* chart are outlined below.

TAKE NOTE! — UNIVERSAL ORDER

Universal order allows for quicker access to information for medical professionals and easier and more accurate filing for clerical staff. Universal order also reduces the need for colour-coded documents and ensures that discharge charts are all received in the same order in HIM. Hospitals can choose the layout of their ordering; however, most use 10 to 12 tabs arranged in this order:

1. Admission record/ER record
2. Drs. orders
3. Advanced directives
4. History
5. Progress records
6. Consults
7. Laboratory
8. U/S
9. EKG
10. XRAY
11. Medication records
12. Consent/OR
13. Miscellaneous

Source: Relias Media. (2000, May). *Universal chart order aids HIM professionals.*

Inpatient Medical Chart Forms

- **Face sheet/Admission record**
    - This initial record produced from the registration process summarizes the relevant demographic, clinical, and financial information for the patient encounter. The record is the "face" of the chart, arranged at the start of the physical record. Upon discharge, the physician must document key facts of the stay on this record.
- **Advance directives**
    - This legal document communicates a person's wishes about health care decisions in the event they become incapable of making health care decisions (either permanently or temporarily). There are two basic kinds of advance directives: living wills and health care powers of attorney.
        - Living wills express a person's instructions or preferences about future medical

treatments, particularly end-of-life care, in the event the person loses the capacity to make health care decisions.

        - Health care power of attorney appoints a person (called a POA) to make decisions for them in the event of incapacity (temporary or permanent) to make health care decisions.

    - If a patient presents to the hospital with an advance directive, the HUC should make a copy of this document and return the original to the patient. If a patient does not have an advance directive upon admission, it may be hospital policy for the patient (and/or their family) to complete a form outlining their preferences for end-of-life care (Sabatino, 2021).

- **ER record**
    - This form, resulting from a patient's visit to the emergency department, documents the care received during their emergency stay. If a patient is discharged from the ER, this record is the single record of their encounter. If a patient is admitted to an inpatient unit, this document will become part of their inpatient chart. When receiving an admission from the ER, the HUC should review the ER record for any outstanding physician orders which need to be processed.
- **Drs. order sheet**
    - This form is where physicians record all orders related to the patient. Two types of paper-based "doctor's orders" sheets are common:
        - Blank record where the physician handwrites in all their orders for the patient (typically used when orders are very specific to a patient).
        - "Pre-printed" order sheet where a physician must fill in blanks or tick off boxes besides interventions they wish to order. These are typically used for standard procedures such as knee replacement (Thompson, 2018).
- **History and physical**
    - This dictated formal transcription report results from the physician's interview with the patient, the physical exam, and the summary of the testing either obtained or pending. In a hospital, the H&P result should be dictated within 24 hours of admission. If a patient is a surgical patient, the H&P must be on the physical chart or EMR prior to the procedure. The H&P should include
        - Chief complaint history of present illness
        - Past medical & surgical history, personal/social history
        - Family history
        - Drugs on admission
        - History of allergies (if any)
        - Systems review
        - Physical examination
        - Diagnostic impression. (South Shore District Health Authority, 2007).
- **Progress record**
    - This record is the main form of communication between physicians and other staff. The physician typically documents on this record after each interaction with the patient, outlining their progress, prognosis and plan of treatment. Progress notes should be written as events

occur to give a chronological report of the patient's progress and should be sufficient to describe the changes in the patient's condition and the outcome of treatment. A minimum standard for written progress notes by the MRP is daily for acutely ill patients and at least once every 3 days following an acute illness. Each progress note must be dated and signed by the physician (South Shore District Health Authority, 2007).

- **Consultation record**
    - This record documents a second physician's written opinion based on an examination of the patient and a review of the patient's health record. This is a form on which a specialist who is asked to provide a consult for a patient would document their assessment, findings, and medical opinion (South Shore District Health Authority, 2007).
- **Diagnostic imaging report**
    - This refers broadly to reports from tests completed in the hospital's diagnostic imaging department. These reports may be further broken down into x-ray reports, ultrasound reports, nuclear medicine reports, mammography reports, MRI and CT reports, etc.
- **Lab report**
    - This refers broadly to all tests completed in the hospital's laboratory. These may be further broken down into biochemistry reports, microbiology reports, hematology reports, pathology reports, etc.
- **ECG report**
    - These are the reports resulting from electrocardiograms. An ECG report may include a visual tracing as well as a dictated report once the tracing is read by a cardiologist (Thompson, 2018).
- **MARs**
    - These are the forms that nurses document all medications given to a patient. MARs (medication administration records) may be electronic or paper-based. Paper-based MARs vary in length of use, usually from 1 to 7 days. In some areas, it may be part of the HUC's role to transcribe all medications ordered by the physician to the MARs (Thompson, 2018). When MARs documentation is restricted to initials only, a separate signature sheet may be required to record full names and designations.

In addition to medical reports, patient charts will include paper questionnaires and consent forms completed and signed by patients.

Inpatient Surgical Chart Forms

In addition to the above records, the surgical chart will also include the following records:

- **Consent form**
    - This is the written form a patient signs before a surgical procedure. In many areas, the HUC prepares this form, outlining the physician's name and the full surgical procedure. This may also be called a "verification of procedure" form.
- **Pre-anaesthetic questionnaire**
    - This questionnaire is completed by the patient/patient's family prior to the surgical procedure. In the case of elective surgery, this form is provided to the patient by the surgeon's office, and the patient brings the completed form to their pre-surgical clinic visit or with them on the day of surgery. Emergent surgical patients will be given this form to complete in the nursing unit.
- **Anaesthetic record**
    - This record is the main document of the intraoperative course of anaesthesia administration. This record is completed by the anaesthetist throughout the operative procedure, who documents the anaesthetic given and the physiologic responses of the patient (Schwartz, 2016).

- **OR checklist**
    - This form assists nursing staff in preparing the surgical patient for their procedure. It provides a set of general and surgical-specific items which the nurse must "check off" prior to sending the patient to the Operating Room; for example, removal of glasses and hearing aids, signing the consent form, or having an electrocardiogram completed.
- **Operative report**
    - This dictated transcription report provides a detailed account of the patient's procedural or operative encounters. The operating surgeon must dictate an operative report for all major and minor procedures performed in the hospital within 24 hours following the procedure. (South Shore District Health Authority, 2007).

Discharge Summary

Regardless of the reason for admission, all inpatients require a dictated **discharge summary**. This summary is a concise record of the patient's clinical progress in the hospital and includes the following (South Short District Health Authority, 2007):

- Admitting diagnosis
- Final diagnosis (primary & secondary)
- Operations performed
- History of present illness
- Relevant past history,
- Family & social history
- Allergies
- Relevant functional inquiry
- Physical findings on admission
- Appropriate investigations
- Course in hospital
- Medications on discharge
- Arrangements for follow-up

MEDICAL TRANSCRIPTION AND THE PATIENT CHART

Some of the above chart forms are created automatically from the clinical software system upon the completion of a process; for example, the *face sheet* is generated from the admission process, a *lab report* is generated from the automated analysis of the specimen obtained. Other records may be physically completed by the health care provider, such as a physician hand writing or keying in orders or a progress note, or a nurse or allied health care worker documenting on nursing notes or interdisciplinary notes. Finally, some reports are created through the medical transcription process, where the health care provider (typically the physician or consultant) dictates a report, which is then transcribed by the transcription department.

While full dictation of medical records was once the norm in hospitals, changes in voice recognition software

technology have shifted the responsibilities of the hospital medical transcriptionist. While the position used to entail keying full reports from dictated voice files, the focus is now editing and catching errors which may occur when technology translates complex medical terms (Fast Chart, 2018).

Common transcribed reports in a hospital include:

- History and physical,
- Operative report,
- Discharge summary,
- Consult report and,
- any diagnostic testing report which is reviewed by a physician such as x-ray/MRI/US/CT/EKG/ mammography reports.

OLD CHARTS

If a patient is readmitted to a hospital, the doctor may request to see their previous patient care records. Old physical records may be scanned into the patient's EHR and visible electronically under their "history" section, or they may be stored as physical charts (Thompson, 2018). Physical charts must be requested from the HIM department, which may also be referred to as *health records* or *medical records*. The HUC can request these through an electronic request, or through a telephone call to the HIM department. Once received, these previous records are often stored beside the current p-Chart.

TAKE NOTE! — HOW TO THIN A CHART

Thinning a medical record is the process of removing documents older than a certain date and moving them into a separate secondary record known as the overflow record. The overflow record must be appropriately secured and easily accessible to clinical staff for review (for example, in a separate envelope or folder in the patient care unit)

The goal of the chart thinning guideline is to retain documentation in the patient's chart that reflects the current plan of care and services provided, as well as maintain a record of manageable size for use by the care providers.

Source: American Health Information Management Association. (2019). *AHIMA's long-term care health information practice and documentation guidelines.*

References

American Health Information Management Association. (2019). *AHIMA's long-term care health information practice and documentation guidelines.*

Fast Chart. (2018). *How medical transcription services have changed over the years.*

Relias Media. (2000, May). *Universal chart order aids HIM professionals.*

Sabatino, C. (2021, May). *Advance directives.* Merk Manual.

Schwartz, A. J. (2016, June). Anesthetic records: Lesson about ethics and education. *Anesthesiology, 124* (6).

South Shore District Health Authority. (2007). *Documentation: Standards for medical*. Nova Scotia Health Policy Office.

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional (4th ed.).* Pearson Canada.

Attributions

"Patient writing her Signature on a Document" by SHVETS production; used under the Pexels license.

Electronic Patient Care Records

Even in the computerized environment, HUC must still be familiar with the e-Chart and where to locate relevant patient information.

The HUC or registration clerk creates the electronic patient care record or e-Chart for all patient encounters through the admission process. Once the admission **conversation** is complete and the admission filed or saved in the clinical information system, the e-Chart is visible and ready to access. However, at this point, the e-Chart is just a shell with basic admission information awaiting further direction. An appropriate **care plan** or **critical path** must be electronically added to the e-Chart to guide basic patient care. Once attached, the care plan or critical path will populate a variety of screens with interventions and assessments appropriate for the patient's diagnosis for the nursing and allied staff to follow.

The physician then will add admission orders for investigations, treatments/consults, and medications to further direct patient care. In a fully computerized environment, the physician's orders are entered through the **computerized physician order entry (CPOE)** process, while in hybrid environments, the physician will either write them by hand on Drs. order sheets or use pre-printed or standing orders. With CPOE, the HUC does not need to manually enter diagnostic tests, medications, or directions for care into the patient chart as they will automatically flow from the computerized order (Gillingham & Wadsworth Seibel, 2014).

Even in the fully electronic environment, the HUC must still be aware of the purpose of each section of the e-Chart and where to locate relevant patient information within the chart, as they will still need to access information regarding patient activity, diets, consults, test results, and medications in their day-to-day duties.

EXAMPLE: CRITICAL PATH

A *total hip replacement critical path* may include the following interventions:

- ambulation
- surgical incision assessment
- vital sign assessment
- oxygen saturation monitoring
- intravenous monitoring
- pain and respiratory assessments
- and much more!

The MRP (orthopedic surgeon) would then add patient-specific orders (often daily) that address areas such as:

- diet
- pain medications
- antibiotics
- home medications
- physiotherapy
- home care referrals
- specific equipment
- weight-bearing status
- blood work
- and much more!

References

Gillingham, E. A. & Wadsworth Seibel, M. M. (2014). *LaFleur Brooks' health unit coordinating (7th ed.)*. Elsevier.

Vera, M. (2024, August 9). *Nursing care plans (NCP) ultimate guide and list.* Nurseslabs.

Attributions

"Woman in blue scrubs in mask at computer display," © Conestoga College, licensed Creative Commons – Attribution-NonCommercial-ShareAlike 4.0 International.

Integrating Outside Records into the Active Patient Chart

It is not uncommon for the HUC to receive documentation from outside the hospital that must be added to the patient care record. This documentation may present through various methods:

- **Patient-supplied records,** including:
    - advanced directives,
    - medication lists, and
    - test results or copies of consults.
- **Requests for records from health care providers through formal Release of Information requests,** including:
    - copies of tests from outside diagnostic providers such as sleep study results or ECHO results, or
    - copies of prior surgical or consult records from previous admissions to other hospitals.
- **OR Booking forms** originating from specialist offices for inpatient and outpatient procedures.
- **Requisitions** for outpatient diagnostic procedures, such as MRIs, ultrasounds, or nuclear medicine tests.

HYBRID PATIENT RECORDS

Adding outside records to the p-Chart is a simple process. If it is original documentation from the patient (such as a power of attorney or advance directive), the HUC will make a copy of the original for the chart and return the original to the patient. The copy is filed in the p-Chart under the most appropriate chart section, or in the miscellaneous section. If the documentation is already a paper copy, for example, received in a release of information request from another facility, the HUC would add it to the p-Chart under the appropriate section, history, or miscellaneous section.

If the record is received in digital form, for example, through email or a portal, the HUC may print the copy and file on p-Chart or upload it to the e-Chart, as per hospital policy.

E-CHARTS

With e-Charts, any outside documentation must be added to the chart electronically, as there is no p-Chart. Depending upon how it is received (e.g., electronic fax, portal, or a physical record), there may be different methods to do this, including:

- downloading the document, printing it, scanning it into the patient record
- dragging and dropping the document into the patient record, or

- downloading the document and uploading to the patient record (S. Bellefeuille, personal communication, February 21, 2024).

Best Practices When Scanning Documents to e-Chart

Each organization will have their own system for adding documents to the e-Chart; however, all processes should include:

- following correct naming conventions: barcoding, MRN#, or ANSI Standards Z1.4 (First Name, Last Name, DOB, HC #)
- confirming the correct electronic record
- confirming document quality and cross-referencing with original document(s) to confirm that
    - image quality is acceptable
    - all pages were scanned successfully
    - the images are in the correct order and rotation
- confirming document security, including saving documents as read-only and policies for the retention and destruction of the original physical or electronic record (Goodrum et al., 2020).

Adding Document to Correct e-Chart Section

Ideally, scanned documents are sorted into appropriate e-Chart categories; for example, a result for a scanned ECG is in the same folder as structured ECG tests. This allows for easier access to clinically relevant documents. However, some e-Charts do not allow for this, and all outside documentation will be scanned into an "outside records" section. It is important for the HUC to ensure that all scanned items are uploaded to the correct area so that clinicians do not miss important, time-sensitive information (Goodrum et al., 2020).

References

Goodrum, H., Roberts, K. & Bernstam, E. V. (2020). Automatic classification of scanned electronic health record documents. *International journal of medical informatics*, *144*, 104302.

Charting Guidelines for the HUC

PURPOSE OF CHARTING

Clear, accurate and accessible documentation is essential to safe, quality care in hospitals. Charting in the hospital refers to documentation that includes medical and clinical data. Many health care professionals, including physicians and allied health care professionals such as physiotherapists, social workers, dietitians, or nurses, may be involved in creating and managing medical records (Ighani, 2024). Effective charting serves many purposes:

- It provides a permanent record of the patient's information.
- It tracks the progress of the patient's condition throughout the hospitalization from admission to discharge. It serves as an information sheet of the medications and procedures rendered to the patient.
- It provides legal evidence for cross-examination in the event of a complaint or lawsuit.
- It serves as evidence of continuity of care.
- It serves as research material for retrospective studies (Hope, 2023).

HUCs must be familiar with best practices for charting so that they can document in the patient record when needed.

TYPES OF CHARTING USED IN THE HOSPITAL

The type of charting used depends upon the type of caregiver, the information being charted, the type of clinical information system used, and the hospital's specific guidelines. Some of the most common charting methods include:

- **Charting by exception (CBE)**: Instead of comprehensive note-taking, CBE focuses on documenting only significant deviations from the norm. It assumes that everything is normal unless noted otherwise. This approach streamlines charting by using checklists and flow sheets to document patient information, allowing nurses to to simply check some boxes; however, the down side is that information may be missed (Correll, 2023).
- **SOAP notes**: SOAP charting is an acronym for *subjective*, *objective*, *assessment*, and *plan*. It is a method of organizing medical notes into a structured format that provides a clear and concise picture of a patient's health status and treatment plan. Each component is broken down as follows:
    - **Subjective (S):** This section captures the patient's subjective experiences and feelings.
    - **Objective (O):** This section includes observable and measurable data, for example, vital signs.
    - **Assessment (A):** This section includes assessment data summarizing the salient points based on the information collected in the subjective and objective sections.
    - **Plan (P):** Outlines the plan of care including interventions, medications, and follow-up steps (TrackStat, 2020).
- **Narrative notes**: These are like a running log of everything that happened with the patient during a particular shift. Events are recording in a chronological order, and should be concise and objective in description (Correll, 2023). This method is the one the HUC would typically use when documenting an occurrence.

GUIDELINES FOR HUC CHARTING

The HUC does not provide direct patient care in a hospital; however, they may occasionally be required to document in the patient record, including:

- notations indicating what steps they have taken with a physician order if not CPOE,
- stat verbal reports from care areas/providers inside or outside of the hospital (should be introduced by what report type and provider, then written word-for-word using parentheses to denote the information provided), and
- documenting a situation that occurred where they were the witness, such as witnessing a patient fall or a patient leaving the hospital against medical advice (narrative charting).

In all cases of documenting on paper-based records, the HUC should follow all of these best practices:

- ensure that it is the correct patient record,
- use a black pen,
- write clearly,
- include the date and time of entry, and
- sign any entry with their First Name, Last Name, and designation.

Error Correction

Occasionally, a health care provider will need to correct an error in their documentation caused by:

- documenting on the incorrect patient record
- documenting incorrect information

It is important for the HUC to remember that only the person who made the error may correct it. Error correction methods will differ depending on the type of documentation. Error correction in the e-Chart is usually quite simple and just requires editing existing documentation. However, correcting documentation in the p-Chart requires the following:

- stroking through the incorrect information in black pen once (it is essential to leave the information viewable, the HUC should *never* use whiteout/correction tape or scratch through documentation),
- writing "error" immediately adjacent to the incorrect documentation,
- adding the correct documentation beside the incorrect documentation, and
- signing and dating the correction.

PRACTICE ACTIVITY: CHARTING

It is 1:30 p.m. on March 1, 2025 and you are an HUC working in an inpatient chest unit. You have just received the following telephone verbal report:

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=409#h5p-33

Audio Recording Transcript

Hi. It's Rachel from X-ray calling with a verbal report for Olive Brown's stat portable chest X-ray. PA and lateral views of the chest reveal no evidence of active pleural or pulmonary abnormality. Both lungs are clear and expanded with no infiltrates and heart size is normal.

- Where would you document this?
- What charting method would you use?
- What type of writing utensil would you use?

Write out on a piece of paper exactly how you would word this.

Hint

You must consider date, time, who you took a report from and what type of report, the exact wording of the report "in parentheses," and your own credentials behind charting.

OOPS! You have just realized that you wrote in Rebecca as the tech who gave you the report, not Rachel. Correct your charting as discussed above.

References

Correll, R. (2023, December 21). *Nurse charting 101: Your guide to patient documentation*. Berxi.

Hope, I. (2023, June 29). *Charting for nurses*. RN Speak.

Ighani, L. (2024, January 15). *Ultimate guide to nurse charting, documentation, and notes*. Nursa.

TrackStat. (2020). *An Introduction to SOAP charting: Streamlining medical documentation and improving healthcare records*.

Attributions

Confidentiality of Hospital Records

PRIVACY REQUIREMENTS FOR PERSONAL HEALTH INFORMATION

Personal health information (PHI) is strictly controlled through provincial and/or territorial legislation. In Ontario, this is the Personal Health Information Protection Act (PHIPA). PHIPA establishes a set of rules regarding the collection, use and disclosure of PHI, along with patients' rights in many areas, including consent, access, complaints and notification of breaches (Information and Privacy Commissioner of Ontario, 2015).

In the hospital, the responsibility for ensuring compliance with PHIPA requirements and setting standards for the collection, use, disclosure, storage, retention and destruction of records is typically delegated to the Privacy Office and HIM department. Hospitals often implement numerous policies and safeguards to ensure that they are compliant with privacy requirements, such as:

- mandatory staff training regarding privacy and confidentiality,
- mandatory confidentiality agreements for all employees, volunteers and students,
- secure logins to all clinical information systems,
- structural barriers or secured storage areas for patient records,
- secured shredder boxes for disposal of patient-related documentation,
- routine electronic chart audits, and
- reminders regarding privacy and confidentiality in the form of screen wraps, login reminders, and posters.

ACCESS TO PERSONAL HEALTH INFORMATION

Only these individuals within the patient's *circle of care* should be accessing a patient's PHI. The circle of care for a patient admitted to the hospital includes anyone involved directly in their care within the hospital and other outside organizations providing care to the patient. Anyone outside of the circle of care should not access a patient's e-Chart or p-Chart to view PHI, regardless of relationship or good intent. To discourage unlawful access of PHI, audits are performed routinely by hospital IT departments and by the clinical information system itself to ensure that there is no unauthorized use. Individuals found to have inappropriately accessed PHI may face suspension, termination, fines, or legal repercussions (Information and Privacy Commissioner of Ontario, 2015).

THE PATIENT'S RIGHT TO PRIVACY—LOCKBOXING

Patients have the ability to withdraw or withhold consent for the use or disclosure of their PHI for health care purposes, which is referred to as ***lockboxing***. This may take on various forms, including:

- not collecting, using or disclosing a specific item of information contained in the patient's medical record (i.e. a particular diagnosis),
- not collecting, using or disclosing the contents of the patient's entire medical record or specific hospital encounter,
- not disclosing the patient's personal health information to a particular group of health care providers (i.e. physicians, nurses or social workers), and
- not enabling a particular health care provider to use the patient's PHI (Royal Victoria Hospital, 2021).

Patients wishing to lockbox their PHI must submit a formal request to the hospital's privacy office. Once received, the hospital has seven days to enable a lockbox in a way that most closely resembles the patient's request. This may include electronically locking PHI in the EMR and/or applying a lockbox to paper records by securing records in the HIM department (Royal Victoria Hospital, 2021). When viewing a patient's record where lockboxing has occurred, health care providers receive a notification that some information has been withheld.

When some PHI is separated out from a patient's record to ensure an additional level of privacy, it is like putting the information into a lockbox–the information is still there, but only accessible by a person who has the key to the box.

Lockboxing is not without risks, including:

- healthcare providers may not have access to the information they need in order to treat and care for patients in a timely manner,
- duplicate tests, procedures and/or health history questions may be required if information is locked and unavailable to healthcare providers,
- more difficulty in sharing information in an emergency, and
- increased risk for errors in assessments, treatments or medications if health care providers do not have enough information or the correct information about patients (Royal Victoria Hospital, 2021).

Lockboxes may be overridden in the following circumstances:

- with the patient's express consent, or the consent of their power of attorney (POA) if they are incapable, or
- in the event the information is required to reduce the risk of serious harm to the patient or others (Royal Victoria Hospital, 2021).

Example: Lockboxing

Franko is a patient at City Hospital— he has asked for all of his PHI to be lockboxed from his ex-spouse, Martin, who works at City Hospital as a Respiratory Therapist.

Phillipa is an RN employed at City Hospital — she has asked for her outpatient therapeutic abortion encounter record to be lockboxed from all City Hospital nursing and allied staff.

Jai is a surgeon at City Hospital — he has asked for his diagnosis of depression to be lockboxed from his health care record.

References

Information and Privacy Commissioner of Ontario. (2015, September). *Frequently asked questions Personal Health Information Protection Act.* Office of the Information and Privacy Commissioner of Ontario.

Royal Victoria Hospital. (2021, September). *Lockbox fact sheet.*

Attributions

"GTA IV safety deposit box" by Rowena Blair on flicker, Creative Commons – Attribution-Noncommerical-Noderivs 2.0 Generic.

Post Discharge HIM Routines

Post-discharge processing is the steps that occur with a patient's record upon discharge. In fully electronic environments, the record is already stored in the clinical information system, and post-discharge processing consists of ensuring that the record is accurate and complete before being archived. With a hybrid record, this also involves a series of procedures aimed at storage, or retention, of an accurate and complete physical record (Davis, 2019).

The post-discharge processing routine is managed and performed by the HIM department, with a wide variety of individuals involved, depending upon organizational size. While some of these functions, such as coding, are performed by certified health information management professionals (CHIMs), other tasks in this process may be completed by HIM clerks (often graduates of medical office administration diploma programs).

IDENTIFICATION OF RECORDS

Post-discharge processing starts with identifying patients who have actually been discharged. The HIM clerk can determine this by checking the discharge register, a list generated from the **master patient index (MPI)** that includes all patients discharged by date.

In a hybrid patient record environment, the physical chart (p-Chart) moves from the point of care, or patient care unit, to the HIM department after discharge. The HUC on the patient care unit typically dissembles the p-Chart on the day of discharge, and the record remains on the patient unit until the following morning to provide time for physicians and other clinicians time to complete their documentation (Davis, 2019). It is common for the HUC to leave dissembled discharge p-Charts in a designated pile/bin for pickup and for an authorized person, such as a HIM clerk or volunteer, to retrieve and deliver the charts to the HIM department at designated periods. In a hybrid or fully electronic environment, the electronic record (e-Chart) may be accessed by HIM staff without any physical transfers.

When a patient is discharged, the p-Chart moves from the unit to the HIM department for assembly and further processing.

In hybrid environments, post-discharge processing cannot begin until the p-Chart actually arrives in the HIM. The HIM clerk must first check that there is a physical discharge chart for each entry on the discharge register and follow up with the patient care unit if there are any discrepancies. It is not uncommon for a patient to be discharged, yet no p-Chart sent to HIM. The most common reason for this is that the HUC forgets to disassemble or it was left in the charting area after a health care provider documented on it. However, in odd cases, it has been sent to another facility upon transfer, taken home by a patient, or even mistakenly put in the shredder! Early identification is essential to finding missing records, so HIM staff should contact care areas immediately to ascertain the patient's status and whereabouts of the chart.

ASSEMBLE AND BIND

Assembly is the process of reorganizing a paper record after discharge and preparing it for further processing—this is done manually for paper records by HIM staff members called assemblers (Davis, 2019). The amount of preparation required can vary, depending upon differences between the organization of the chart on the patient care unit and the HIM unit's post discharge process and the care the HUC on the unit takes with the chart. Once the paper record is correctly organized, the pages are *bound* within a permanent manilla folder.

Though not as detailed, assembly may still occur within the e-Chart when there are paper records which have not yet been attached, such as advanced directives or consent forms, or printed reports which contain additional hand-written documentation. The assembler must then scan these to the e-Chart so that they are retained as part of the hospital record.

QUANTITATIVE ANALYSIS (ANALYZING FOR DEFICIENCIES)

Next, the records undergo *quantitative analysis,* which is the formal process of reviewing a health record to ensure completeness and accuracy. HIM staff review the chart, often with the assistance of a checklist, to ensure that all required data is present, correctly completed, correctly labelled/identified, and includes the required signatures.

When a deficiency is found in a chart, the chart is flagged as incomplete, and the health care provider(s) with outstanding deficiencies are notified electronically. HIM departments typically provide a limited window for providers to address outstanding deficiencies, such as three to seven days. Providers who do not address deficiencies within this period may receive additional notifications with a series of escalating consequences, such as suspension of hospital privileges. Some quantitative analysis can be performed on e-Charts automatically by the clinical information system throughout the patient's active stay done in real-time. This process is termed concurrent analysis. Quantitative analysis for p-Charts typically only occurs after discharge-which is termed retrospective analysis.

CODING AND ABSTRACTING

Coding is the process of analyzing clinical information within a health record, such as diagnosis and procedures and converting this into a universal medical alpha-numeric code for use in a database. Medical coding is performed all over the world, with most countries using the *International Classification of Diseases* (ICD) from the World Health Organization (WHO) (AAPC, 2024). The ICD is modified by each member country to serve its needs; Canada uses the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canada (ICD-10-CA),* which was enhanced by the Canadian Institute for Health Information (2022) to specifically meet Canadian data.

CHIMs now use a computer app to both assist in the coding process and import certain data to other databases for a variety of purposes. CHIMs may perform the coding process remotely for e-Charts. In the case of hybrid records, the CHIM must review both the e-Chart and the p-Chart in the coding process. If the p-Chart has already been scanned into the clinical information system, this coding process may also be done remotely.

The term *abstracting* refers to the process of reviewing patient files, extracting key data and information, and entering it into another database or document for secondary use (Robert Half, 2019). An abstract summarizes a patient's care to avoid reviewing the entire medical record. To create an abstract, the CHIM or HIM clerk checks the health record to confirm key details like MRN, account number, discharge status, and admission diagnosis. In electronic systems, this data is mostly pre-filled and just needs verification. In a hybrid record, the CHIM or HIM clerk ensures all important details are correctly entered after discharge.

RETAIN CHART

It is common to keep track of paper records during post-discharge processing by *batching* the records together by date of discharge. In this method, all records of discharges from June 3, for example, are gathered and kept together as they are moved as a group through assembly, analysis, and coding processes. Once finished these processes, they are divided by completion status. Completed records are taken to the scanning area or permanent file area for storage; incomplete charts are taken to the incomplete chart area. This same process is used to track paper documents that must be scanned (Davis, 2019).

The batch form can be beneficial if a p-Chart must be extracted from the processing cycle for reasons such as:

- readmission,
- release of information,
- legal/insurance purposes, or
- research purposes.

Complete fully electronic records require no further interventions at this point. Completed hybrid physical records which are not scanned must now be manually filed in the HIM department. The most common filing methods are outlined in the next two sections.

References

AAPC. (2024). *What is medical coding?*

Canadian Institute for Health Information. (2022). *A guide for users of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Canada (ICD-10-CA)*.

Davis, N. (2019). *Foundations of health information management (6th ed.).* Elsevier.

Robert Half. (2019, January 19). *What skills do you need to be an electronic medical records abstractor/auditor?*

Attributions

Filing Systems: Alphabetical Filing

Alphabetical filing is one of the most common and uncomplicated filing systems. It is considered a direct access system because you only need the patient's name to file or access the patient record.

Using this system, last names are filed first, followed by the first name and then the second name, if applicable (Thompson, 2018). Records are filed by the first different letter, thus a patient with the last name *Abrams* would be filed before a patient with the last name *Baker*. If two patients have the same first letter of the last name, then the next letter would be considered, for example, a patient with the last name Abrams would be filed before a patient with the last name Adams. If two patients have the same last name, then the first letter of the first name would be considered; for example, Abrams, Amy would be filed before Abrams, Jane.

When it comes to alphabetical filing, there are established rules that help maintain an organized system established by the Association of Records Managers and Administrators (ARMA). The following sections outline how to correctly outline and organize patient files according to ARMA rules (Otsego Northern Catskills BOCES, n.d.).

NAMES OF INDIVIDUALS

Files should be organized and filed in this order:

- **Unit 1**: Last name
- **Unit 2**: First name or initial
- **Unit 3**: Middle name or initial

The principle of *"nothing comes before something"* means that:

- Names that are a single letter come before full names that begin with that same letter.
- Names of a single word come before names of that same word followed by a second name, and so on.

Examples: Records Organized According to Names Rules

Patient's Name	Unit 1	Unit 2	Unit 3
Smith	Smith	–	–
G. Smith	Smith	G.	–
G. John Smith	Smith	G.	John
Steven Smits	Smits	Steven	–
Steven R. Smits	Smits	Steven	R.
T. Smitts	Smitts	T.	–
T.D. Smitts	Smitts	T.	D.
Trevor Smitts	Smitts	Trevor	–
Trevor James	Smitts	Trevor	James

PREFIXES, PARTICLES AND ST.

- Prefixes and particles should not be considered as separate units; for example, Van Damme should be considered one unit and alphabetized as if it is spelled "Vandamme.".
- Common prefixes and particles include d', D', Da, de, De, Del, Dela, Des, Di, Du, Fitz, la, La, le, Le, M', Mac, Mc, O', St., van, Van, Van de, Van der, von, Von, Von der.
- Ignore variations in spacing, punctuation, or capitalization.
- Alphabetize the prefix St. as though it were spelled out – Saint.

Examples: Records Organized According to Prefixes Rules

Patient's Name	Unit 1	Unit 2	Unit 3
Anna Maria DeMelo	DeMelo	Anna	Maria
Annemarie de Melo	DeMelo	Annemarie	–
Janice S. St. Pierre	SaintPierre	Janice	S.
Janice Sharon St. Pierre	SaintPierre	Janice	Sharon
J. Schneider	Schneider	J.	–

HYPHENATED NAMES

Hyphenated names should be considered one unit. Ignore the hyphen and alphabetize according to the first part of the hyphenated name.

Examples: Records Organized According to Hyphenation Rules

Patient's Name	Unit 1	Unit 2	Unit 3
Lu Anne Brown	Brown	Lu	Anne
Lu-Anne Brown	Brown	Lu-Anne	–
Luna Brown-Nicholl	Brown-Nicoll	Luna	–
Luna Brown Nicholl	Nicoll	Luna	Brown

ABBREVIATED NAMES AND NICKNAMES

- Names that are abbreviated (such as Wm. for William) should be alphabetized as if spelled out.
- Initials standing for or representing a first or middle name are not abbreviations.
- Names such as Al, Kate, Bill, Joe should be used as a given name unless it is known that it is a nickname.
- Individuals known only by a nickname, without a surname, should be alphabetized considering each name in the nickname as a unit.

Examples: Records Organized According to Abbreviation and Nickname Rules

Patient's Name	Unit 1	Unit 2	Unit 3
Wm. Harris	Harris	William	–
"Bill" William R. Harris	Harris	William	R.
"JoJo" Joanne Hartford	Hartford	Joanne	–
Joe Hartford	Hartford	Joe	–
Joseph Hartford	Hartford	Joseph	–
Chas. Spencer Hartford	Hartford	Charles	Spencer

TITLE, SENIORITY TERMS, AND OTHER DESIGNATIONS

- Ignore titles such as Dr., Officer, and Reverend if used with the individual's full name, for example, Dr. Anita Hussein.
- Consider a title as the first name if it is used with only one part of an individual's name, for example, Dr. Phil.
- The titles Mr., Mrs., Ms., and Miss are only considered to distinguish individuals with identical names.

Examples: Records Organized According to Title Rules

Patient's Name	Unit 1	Unit 2	Unit 3
Mrs. Mandeep Kaur	Kaur	Mandeep	–
Mrs. Manpreet Kaur	Kaur	Manpreet	Mrs.
Ms. Manpreet Kaur	Kaur	Manpreet	Ms.
Professor Mei Ling	Ling	Mei	–
Princess Leia	Princess	Leia	–
Princess Charlotte Windsor	Windsor	Charlotte	–

- Current practice regarding seniority terms (Sr., Jr., 2d, II, 3d, III), professional certification or academic degrees (CPA, Ph. D., M.D.) is to ignore all except to distinguish between individuals with identical names.

Examples: Records Organized According to Seniority/Certification/Degree Rules

Patient's Name	Unit 1	Unit 2	Unit 3
John Doe	Doe	John	–
Dr. John Doe	Doe	John	Dr.
John Doe Jr.	Doe	John	Jr.
John Doe, PhD	Doe	John	PhD
John Doe 3d.	Doe	John	3rd

PRACTICE ACTIVITY: ALPHABETICAL FILING

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1078#h5p-35

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1078#h5p-36

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1078#h5p-37

References

Otsego Northern Catskills BOCES. (n.d.). *Appendix B: Alphabetizing rules*. Oncboces.org.

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional (4th ed.).* Pearson Canada.

Filing Systems: Numerical Filing

Numeric filing systems are used with records that are filed and retrieved by number. Filing systems that are organized numerically require an index which correlates the patient name and numerical chart reference, which makes them an indirect access filing system (Thompson, 2018). There are three main types of numerical systems, which will be discussed below.

CONSECUTIVE NUMERIC/STRAIGHT NUMERICAL

This system files consecutively numbered records in strict sequential order according to registration number; for example, the records 45677, 45678, 45679, and 45680 would be filed side-by-side. The greatest advantage of straight numerical filing systems is the ease with which staff are trained to work with them. However, there are several disadvantages to this system including:

- higher chance of misfiling as staff must consider all digits of the record number at one time when filing a record,
- the heaviest filing activity is concentrated in the area with the highest new numbers which makes it difficult for several staff to access records at the same time, and
- quality control of filing is difficult as most filing occurs in one area. Since staff members usually file in the area of the most current records, it is not feasible to fix responsibility for a section of the file to one staff (Rajakumar, n.d.).

These files use a consecutive numeric filing system; filing systems can also use terminal digits or middle digits to organize by area.

TERMINAL DIGIT FILING

Terminal digit filing is an adaption of consecutive numerical and was developed to distribute files evenly throughout the system, making it easier to allocate space for expansion, and overcome congestion in large filing systems when the most active records are being filed in consecutive order. In this system, the filing system is based upon the last few digits of the sequence which disperses the files throughout the system, thus allowing easier access. It is particularly valuable when working with records with long number strings (Rajakumar, n.d.; Thompson, 2018).

This system segments the number into three parts or segments, which are used as filing units. For example, record 123456 may be broken into three segments 12-34-56. Within the number, the primary digits are the last two digits, the secondary digits are the middle two, and the tertiary digits are the first two digits as shown below.

MRN	Tertiary Digits (Record)	Secondary Digits (Area)	Primary Digits (Section)
12-34-56	12	**34**	56
13-34-56	13	**34**	56

In the terminal digit filing example, the total filing area would be partitioned into 100 primary sections (00-99). Each section would then be partitioned into 100 areas, and each area would have room for 100 records. Record

12-34-56 would be filed into section 56, area 34, and would be record 12 (Thompson, 2018). Records 11-34-56 and 13-34-56 would be filed immediately before and after this record. The terminal digit method is often described using six numbers, but the length of the number can vary across systems, as will the corresponding sizes of sections, areas, and records.

When filing a number of charts in this system, the staff member would arrange files by primary, secondary and, finally, tertiary digits for ease of filing. For example, the charts 45-50-99, 44-51-99, 45-49-99, 60-49-99, and 44-50-99 would be arranged in the following order to facilitate filing.

- 45-49-99
- 60-49-99
- 44-50-99
- 45-50-99
- 44-51-99

In the above case, the staff member is filing in section 99, and areas 49, 50 and 51. They will have their records ready to file from lowest record number to highest to assist in working through the filing in an organized manner.

Benefits

With terminal digit filing, records are equally distributed throughout the primary 100 sections of the file area—only every 100th new medical record will be filed in the same primary section, which:

- relieves congestion in active record areas where several staff are working at once,
- allows for quality control by allowing the assignment of sections for filing, for example, a staff member may be responsible for sections 00-24,
- even division of work, as the numerical numbers are still assigned in straight numerical order, for example, numbers 346371, 346372, and 346373 are assigned in strict sequence, but the records would be filed in terminal digit sections 71, 72, and 73 respectively, and
- no backshifting of records, as the addition of new records and removal of inactive records should occur at the same pace across each area (Rajakumar, n.d.).

Practice Activity: Terminal Digit Filing

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1091#h5p-38

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1091#h5p-39

MIDDLE DIGIT FILING

In middle digit filing, the staff also files according to pairs of digits like terminal digit filing. However, the primary, secondary, and tertiary digits are in different positions. In this case, the middle set of digits are the primary digits, the digits on the left are the secondary digits, and the digits on the right are the tertiary digits (Rajakumar, n.d.).

In this example, all these charts would be filed in area 34, section 12, and by records 56, 57, and 58, respectively.

MRN	Secondary Digits (Area)	Primary Digits (Section)	Tertiary Digits (Record)
12-34-56	12	34	56
12-34-57	12	34	57
12-34-58	12	34	58

Filing in this method ensures that blocks of 100 charts are filed in straight numerical order, which can be advantageous when sampling blocks of charts for research or switching from straight numerical filing. However, this system does not provide distribution as even as in terminal digit filing, which can lead to gaps and the need for redistribution (Rajakumar, n.d.).

When filing several charts in this system, the staff member would still arrange files by primary, secondary and, finally, tertiary digits for ease of filing. For example, the charts 11-33-34, 01-33-44, 44-32-01, 11-34-00 and 10-33-43 would be arranged in the following order to facilitate filing.

- 44-32-01
- 01-33-44
- 10-33-43

- 11-33-34
- 11-34-00

In the above case, the staff member is filing in sections 32, 33 and 34. They will have their records ready to file from lowest record number to highest to assist in working through the filing in an organized manner.

Practice Activity: Middle Digit Filing

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=1091#h5p-40

References

Rajakumar, M. (n.d.). *Numbering and filing system.*

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional (4th ed.).* Pearson Canada.

Attributions

CHAPTER 7: SCHEDULING AND REGISTRATION PROCESSES

Non-Scheduled Admissions

Because of their emergent nature, admissions to the ER or ED are non-scheduled; with acute cases, the full admission process may not be completed on arrival.

The HUC is integral to the clinical scheduling and registration hospital routines. Every patient **encounter** in the hospital requires a patient be registered in the hospital's clinical software system. The type of registration questions, the length of the registration procedure, and the resulting patient record varies greatly depending upon several factors including:

- whether the patient has already been "pre-registered" in the system,
- if they have been a previous patient in the facility, and
- type of service or treatment they are receiving.

The role of scheduling and registration in the hospital may be performed by many different categories of clerical staff depending upon the department, including HUCs, registration clerks, booking clerks, and ER clerks. You will note that all of these clerical roles are referred to in this section.

Although many admissions to hospital are pre-booked or pre-scheduled, there are some types which are not. In this section, we will discuss the registration processes for the following non-scheduled admissions: **emergency admissions**, **direct admissions**, and walk-in diagnostic testing patients.

EMERGENCY DEPARTMENT ADMISSIONS

Admissions to the emergency room (ER) or emergency department (ED) are not pre-booked due to their emergent nature; therefore, the ED or ER registration clerk must complete a new registration for these patient visits/encounters when they present for treatment. Emergency admissions typically result from an acute illness, set of symptoms (i.e., chest pain), or accident (i.e., a fall). Less acute emergency patients may be assessed and treated fairly quickly in a sub-acute section of the ER department and discharged home from the ER within a few hours. More acute ER patients may require intensive testing, specialist consultation, operative measures, and/or admission to an inpatient unit.

Due to the acuity of some emergency patients, a full admission may not be completed upon their arrival. The ER registration clerk may complete a short registration for the patient to enter them into the system so that treatment may begin and update this information at a later period. ER registration clerks may also register patients under generic aliases when the patient has no identification and is unable to communicate or if an emergency crew calls in an urgent admission en route to the ER department.

If an emergency patient requires admission to an **inpatient unit**, their current ED registration must be changed to an inpatient registration and a bed assigned by the **bed allocator**.

DIRECT ADMISSIONS

Direct admissions are emergent admissions which occur directly from another health care facility or provider. The need for admission has already been ascertained by the MRP, so there is no reason for the patient to attend the emergency department for assessment. Some of the most common examples of direct admissions are transfers from other hospitals and repatriation of patients hospitalized out of province or country. Another less common example would be when a specialist assesses a patient in their office, ascertains they need acute hospitalization, and contacts the hospital to arrange admission directly to the patient care unit as their patient. In all these examples, the sending facility or physician must make arrangements with the bed allocator for admission.

WALK-IN DIAGNOSTIC TESTING APPOINTMENTS

Some diagnostic departments within the hospital may accept patients for diagnostic tests without an appointment on a first-come-first-serve basis. Non-booked tests are typically simple tests which do not require patient preparation such as lab tests and simple X-rays. In these cases, the *diagnostic imaging (DI) registration clerk* must complete a new registration for the patient when they present for treatment.

References

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional (4th ed.).* Pearson Canada.

Attributions

“Emergency Signage” by Pixabay; used under the Pexels license.

Pre-Scheduled/Pre-Registered Admissions

Many areas within hospitals utilize pre-registration routines. *Patient pre-registration* is the process of collecting relevant patient information before the day of the scheduled visit. Like the regular patient intake process followed at the facility, pre-registration practices capture demographics, clinical data, and insurance information.

Pre-registration is typically used when a patient is being scheduled for treatment in the future and patient details must be recorded in the hospital scheduling system to book this treatment and note any important details ahead of time. Pre-registration must be used when scheduling both inpatient and outpatient elective surgery and **outpatient** booked procedures such as:

- MRIs
- CT scans
- Mammography
- Nuclear medicine
- Endoscopies
- Echocardiograms (and many, many more!)

PRE-REGISTRATION FOR DIAGNOSTIC TESTS

Depending upon the hospital system, diagnostic test bookings may be transmitted directly from physicians' and/or specialists' offices through portals such as Ocean or electronic fax. Alternatively, patients may receive a requisition and call the outpatient department or a central booking department themselves to schedule a test.

As part of the pre-registration process, hospital booking clerks or HUCs book the patient into the clinical software system schedule for that procedure, enter basic demographic information into the clinical software system to identify the patient and speed up the registration process on the day of service, and scan the requisition to the encounter. If the requisition is received from a physician's office, the booking clerk would also transmit the appointment information to the office. If the booking occurs through a patient call, the booking clerk would confirm the appointment and prep with the patient, reminding them to bring the requisition on the day of the test.

When pre-registered or pre-scheduled patients arrive at the hospital, a registration clerk checks them in and moves them from a pre-registered to registered status.

PRE-REGISTRATION FOR ELECTIVE SURGERY

Patients scheduled for inpatient and outpatient **elective surgery** are also pre-booked in the hospital's clinical software system; this includes both a booking in the surgeon's **OR block** for that surgical date and a pre-registration for an inpatient or day surgery stay. Surgery bookings are communicated to the OR bookings department from surgeons' offices via the **surgical/OR booking form** either electronically through booking portals or through fax.

This form originates in the specialist's office and includes all of the relevant information required for the surgery, including

- the patient's data: demographic, clinical, wait time
- operative procedure information: type of surgery, surgeon and surgical assistant, type of admission
- requirements: anaesthetic details, length of procedure, special equipment
- required pre-op preparation: pre-surgical clinic requirements, pre-op testing, day of surgery testing

Patients booked for elective surgery often attend a pre-surgical clinic one to two weeks prior to their booked procedure and receive preparation for their surgery in the form of education, laboratory testing, and

anaesthetist and allied health care consults as necessary. OR Booking forms may also include a requirement for a pre-surgical clinic appointment prior to the surgery date. This would require a separate booking and pre-registration for that patient.

PRE-REGISTRATION FOR OBSTETRICAL PATIENTS

Obstetrical admissions are also typically pre-booked in the hospital's clinical information system. Babies' admissions are not pre-registered and occur immediately after birth. Most systems have a registration routine that links the newborn to the mother's chart and a system of matching armbands for both mother and baby (Thompson, 2018). Women typically move through several different areas in an obstetrical admission, including an assessment area, labour and delivery (L&D) area, and a recovery area/maternal room.

PRE-REGISTRATION ROUTINES: DAY OF ADMISSION

When any pre-registered patient presents to the hospital on the day of their procedure, the registration clerk admits them or "checks them in" in the computer, moving them from a pre-registered status to a registered status.

The registration **conversation** is typically shorter for pre-registered and previous patients as most information is already on file and just needs to be confirmed. Registration conversations are typically more detailed for inpatient registrations due to additional questions related

- to supplementary insurance (i.e. private or semi-private coverage as they will be staying overnight),
- increased next of kin and emergency contact information, and
- more detailed information regarding medical history.

Take Note! — Registration Conversation

The registration or admission conversation is a set of questions asked during the registration process. It usually consists of a group of screens that the HUC must move through and answer all required areas. These may change depending upon admission but always include:

- patient's full name
- patient's DOB
- patient's insurance/payment information (OHIP, UHIP, extended health insurance, self-pay)
- health care providers (referring provider and performing provider, if appropriate)
- address
- medical alerts

Depending upon the type of admission, additional information may be asked, such as religion, confidentiality questions, next of kin/emergency contacts, nosocomial screening, and fall risk assessments.

PRACTICE ACTIVITY: PRE-REGISTRATION

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=639#h5p-64

References

Allen, J. (2018, October 5). Optimizing surgical clock time. *What I've Learned as a Hospital Medical Director.*

The Basics of the Admission Process

Hospital clinical software systems typically have many different registration modules, for example, inpatient registration, outpatient registration, ED registration, and day surgery registration. However, the registration process across all these types of registrations is similar.

PERFORMING A PATIENT SEARCH

Upon a patient's initial pre-registration or registration at a hospital, they will be assigned a unique identifier in the hospital's clinical system; depending upon the organization, this may be termed a **MRN**, **HO#**, or *patient/hospital alias*. Once their pre-registration or registration is complete, they will also be recorded in the clinical system's **master patient index (MPI).**

During any subsequent pre-registration or registration process, the registration clerk must carefully search their system's MPI to ensure that they are linking the registration they are completing to the patient's existing health record at that facility if one exists.

First, the registration clerk must perform a search for the patient they wish to register. The most common search method is by Ontario Health Card number – most hospital registration kiosks are equipped with Health Card swipe readers for this purpose. If the patient already exists in the hospital clinical software system, swiping the Health Card will pull up their patient record with their unique identifier (MRN/HO#/patient alias). From there, the registration clerk can choose the existing pre-registration for that date or start a new full registration, which will connect with the patient's existing record.

If the patient does not exist in the system, swiping the Health Card will bring up simple demographic information on file from the Ministry of Health. The registration clerk will then complete the pre-registration or registration process, which will result in the patient being assigned a unique identifier (MRN/HO/patient alias) upon completion. In addition to the MRN, each patient encounter will be assigned a specific code or number in order to differentiate it within the MPI and for billing purposes. This number may be termed an *account number*, ***fin NBR***, or *visit number*.

Take Note! — Not Everyone Has a Health Card

Some patients may not have an Ontario Health Card, such as newcomers to Canada, international or out-of-province students, and members of the Mennonite community. In this case, search methods may include *first name*, *last name*, *D.O.B.*, and even *address*.

It is important to use caution in registering without a Health Card, as many names may be the same or similar.

COMPLETING THE REGISTRATION

The registration conversation or script differs between types of registrations, with the registration clerk being guided by prompts to complete certain fields. In addition to asking for financial and demographic information, the registration clerk may also be required to conduct simple screening or clinical tests during the registration process, such as:

- screening for COVID-19,
- completing a short **falls risk assessment**, and
- screening for **nosocomial infections** such as MRSA and VRE.

At the conclusion of the registration process, the registration clerk will file/complete/save the registration, which will be added to the MPI under the patient's unique identifier. Depending upon what level of electronic records the hospital has implemented, the registration clerk may then be required to print out documents such as:

- face sheet,
- treatment records
- **patient labels** to identify paper records,
- consent forms,
- patient armbands: typically **white**, **red**, **green**, plus a possible **orange** band.

ID bands are required for some outpatient procedures and all inpatient admissions; in addition to ID information, this patient's armbands alert staff to their allergy.

Depending upon the procedure they are having and the type of unit, the clerical staff may also be required to

- apply the patient's armband,
- obtain and witness patient consent on treatment forms,
- instruct the patient on specimens to be collected, and
- take the patient to the room/clinical area and instruct the patient on gowning procedures.

Throughout the registration process, the clerical staff must communicate professionally, empathetically, and discreetly, ensuring that they consider the patient's unique communication needs and any barriers and ensure the accuracy of all information entered into the patient's chart.

TAKE NOTE! — ASSESSING FALLS RISK

A falls risk assessment is usually done for older adults. The most common falls risk assessment is the Morse fall scale. The registration clerk may start the assessment during the admitting process by asking simple questions such as:

- Have you fallen in the past three months?
- Do you feel unsteady when standing or walking?
- Are you worried about falling?

Affirmative answers will be flagged as part of the admission process so that the care team can provide further screening and implement a fall reduction strategy (Medicine Plus, 2021).

TAKE NOTE! — PATIENT LABELS

Patient labels are pre-printed sheets of labels containing key demographic, clinical and billing information for the patient. Depending upon the type of configuration, each sheet may include 24-40 labels. When using paper chart forms, the HUC must ensure that a label is affixed to every blank record and that extra labels are stored in the p-Chart to affix to new paperwork as it is added. Pre-printed labels usually resemble this format:

- Last name, First name, Initial (DOB)
- MRN/OHIP number
- MRP/GP
- Admission date
- Allergies

References

Biddle, M. (2015). Maintaining the master patient index: The impact of patient registration processes on data integrity. *Applied Research Projects*. 32.

Medicine Plus. (2021, September 13). Fall risk assessment. *National Library of Medicine.*

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional* (4th ed.). Pearson Canada.

Attributions

"person wearing orange and white silicone band" by Jon Tyson; used under the Unsplash license.

How to Understand the Master Patient Index

Understanding how a **master patient index (MPI)** works is essential to all clerical roles in the hospital. This is how they ensure that they do not create errors in the MPI database which can affect patient care and how they can view past patient admission information. The most serious clerical MPI errors include:

- a single patient being added multiple times resulting in multiple MRNs (known as an overlap)
- a patient being registered under another patient's MRN, resulting in them sharing the same MRN and intermingling their health records (known as overlay) (Biddle, 2015).

EXAMPLE: MASTER PATIENT INDEX

The table below represents what you will find in an MPI with headings, including

- name (will always be listed last name first in alphabetical order)
- ACCT/FIN#
- registration status (see below for definitions)
- date of visit
- location of visit
- MRN/HO# or hospital alias

Master Patient Index Sample

Name	Account Num	Status	Date	Location	Med Rec Num
EXAMPLE,KIM	OP000194/25	REG CLI	11/01/25	DI	0000396438
EXAMPLE,KIM	IN000128/19	DIS IN	22/01/19	3W302-1	0000396438
EXAMPLE,KIM	ER000213/23	REG ER	12/04/23	ER	0000541201
EXEMPLAR,SIMRAM	SP000219/25	PRE SDC	17/08/25	DS	0000292165
EXEMPLAR,SIMRAN	OP000193/16	REG CLI	11/04/16	CAR	0000292165
TEST,JOHN	DS000219/24	REG SDC	22/12/24	END	0000459763
TEST,JOHN	SP003287/25	PRE CLI	25/09/25	PSC	0000493431
TEST,JOHN	SP003287/25	PRE IN	18/10/25	SURG	0000493431

Status Abbreviation Definitions

- ADM: currently admitted (will switch to DIS when discharged)
- CLI: clinic visit
- DEP: departed (has been discharged)
- DIS: discharged
- END: endoscopy visit
- ER: ER/ED visit
- IN: inpatient
- PRE: prescheduled (has not yet attended)
- REG: registered (has attended appointment)
- SDC: surgical day care

How to Interpret this MPI

First, note that patients are listed in alphabetical order by last name, with a patient's most recent encounter listed first.

Next, review the MRN on the far-right side of the above table for EXAMPLE, KIM. You will see the MRN is the same for the first two **EXAMPLE, KIM** accounts but not the third. As you have just learned, each person is given their own unique MRN upon their first admission and they will continue to be registered under this number for every subsequent encounter. By checking the MRN number, you have now ascertained that there are two different patients with the name **EXAMPLE, KIM**.

Next, review the Account Numbers for the first **EXAMPLE, KIM** patient. These will be different, as each encounter has its own unique number for billing and administrative reasons. You can tell several things from looking at the Account Number and Status.

- Visit #1: in **EXAMPLE, KIM's** most recent visit, the **OP**000194/**25** indicates an outpatient visit in 2025, while the REG CLI means that she was registered for a clinic visit. Further information may be obtained in the location field, which indicates it was a **DI** (diagnostic imaging visit).
- Visit #2: in **EXAMPLE, KIM's** prior visit, the **IN**000128/**19** indicates an inpatient visit in 2019, while the DIS IN means that she was discharged from an inpatient visit. Further information may be obtained in the location field, which indicates which unit and bed number she was admitted to.

Source: Based on information from Alberta Health Services, 2016, pp. 10.

PRACTICE ACTIVITY: INTERPRET THE MASTER PATIENT INDEX

1. Review the information for the EXEMPLAR, SIMRAN entries.
    - How many patients do these represent?
    - How many visits did the patient(s) have?
    - Where and when were these visits?

2. Review the information for the TEST, JOHN entries.
    - How many patients do these represent?

- How many visits did the patient(s) have?
- Where and when were these visits?

References

Alberta Health Services. (2016, July). *Meditech order entry (OE) user manual [PDF].*

Biddle, M. (2015). Maintaining the master patient index: The impact of patient registration processes on data integrity. *Applied Research Projects*. 32.

CHAPTER 8: SURGICAL PROCEDURES

Preparing the Surgical Patient

In our previous section, we discussed the scheduling and admission process for patients in the hospital setting. Many patients in the hospital are admitted for surgical intervention; therefore, the HUC should also have a solid knowledge of the typical preparation required for surgical procedures.

HUCs prepare consent forms for patients based on the surgeon's orders; the surgeon may also order pre-operative testing.

CONSENT FORMS

In some clinical information systems, the consent form may be automatically created from the **computerized physician order entry (CPOE)** process; however, in other systems, the *OR booking clerk* or *pre-surgical clinic HUC*

prepares consent forms for elective procedures, whereas the HUC in the ER or on the inpatient unit prepares consent forms for emergent procedures. It is important for clerical staff to have a good understanding of the abbreviations for common surgeries and how to spell the extended version correctly on a consent form. Regardless of how the surgeon notes the procedure on a *Drs. order sheet* or an *OR booking sheet*, the HUC should always write the full procedure name on the consent form that the patient signs, for risk management and legal purposes. For example, an order for a *"lap. chole, poss. open chole"* should be written out as *"Laparoscopic cholecystectomy, possible open cholecystectomy".*

It may be part of the HUC role to print and review consent forms with patients prior to tests, especially in outpatient clinics. The HUC should always ensure that the patient has the opportunity to fully review the consent form and has any questions answered by appropriate staff. If a patient is unable to read the consent form due to language barriers, the HUC should contact an interpreter or family member to have them translate the document.

Common Surgical Consent Abbreviations

- AAA: abdominal aortic aneurysm
- Appy: appendectomy
- BIL: bilateral
- BK: below knee
- BP: bypass
- Bx: biopsy
- Chole: cholecystectomy
- Cx: cervix
- D&C: dilation and curettage
- EUA: examination under anaesthesia
- Ext: extraction
- Fem-pop: femoral-popliteal
- FNA: fine needle aspiration
- I&D: incision and drainage
- IOL: intraocular lens
- Lap: laparoscopic
- LP: lumbar puncture
- Lt: left

- ORIF: open reduction internal fixation
- Poss: possible
- Rt: right
- Scope: arthroscopy
- STSG: split-thickness skin graft
- THA: total hip arthroplasty
- TNA: total knee arthroplasty
- TURBT: transurethral resection bladder tumour
- TURP: transurethral resection prostate (RXFiles, 2020).

There are many, many more abbreviations that are used. The HUC will become familiar with the surgical procedures common to the unit that they are employed in, and familiar with the various ways these may be written out.

See the Appendix for a more comprehensive list of common short forms used in the hospital setting.

ROUTINE PRE-OPERATIVE TESTING

Surgeons usually note any pre-operative testing required for elective patients on the OR Booking form. If the patient attends the pre-surgical clinic, this testing is often completed there. If the patient does not attend a pre-op appointment, they may need to have testing done upon admission. The HUC in the pre-surgical clinic or on the unit that the patient is admitted to should carefully review the tests ordered on the OR booking sheet to ensure that they have been requisitioned.

In addition to tests specifically ordered by the surgeon, there may be additional standard investigations *automatically* required for the patient due to factors such as: age, diabetic status, type of surgery, BMI, or use of medications such as blood thinners, diuretics, or methadone. The HUC may need to review standard testing guidelines for to ensure that all required tests are ordered pre-operatively. Every organization will have their own pre-op testing criteria for procedures which may include:

- **Blood Bank Guide**
  - Outlines any required blood product to be on hold for surgical procedures listed. Blood bank requirements may range from a simple G&R (group and reserve) to a requirement to have a predetermined number of units of blood cross-matched and held for that patient's surgical procedure.
- **Pre-Op Testing Guide**
  - Outlines any required lab or ECG testing to be completed prior to surgical procedures based upon patient-specific criteria, such as age, diabetes, or taking certain types of medications such

as blood thinners.

PRACTICE ACTIVITY: CONSENT FORMS

Convert the following abbreviated procedures to full wording for consent forms.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=856#h5p-42

References

RX Files. (2020). *Comprehensive RxFiles abbreviations list [PDF].*

Attributions

“Doctor Writing on a Medical Chart” by RDNE Stock project; used under the Pexels license.

The HUC and the Surgical Chart

THE HYBRID CHART

The HUC may be required to add additional chart forms to the hybrid patient record when a patient is booked for surgery. These records include:

- **Consent form**
- **Pre-anaesthetic questionnaire**
- **Anaesthetic record**
- **OR checklist**
- Applicable pre-printed postoperative orders

In addition, the HUC should ensure that the **history and physical** is on the patient chart prior to surgery, the **MARs** and any preop testing results are in the chart, and that there are additional patient ID stickers in the chart to label any specimens or additional forms.

E-CHART

The HUC will not need to add physical forms to the e-Chart, however, they may be required to scan patient completed forms into the e-Chart, such as a signed consent form and the pre-anaesthetic questionnaire.

THE POST-OPERATIVE CHART

Regardless of the type of chart, all documentation should be ready well in advance. It is typical for the porter to arrive on a patient unit 30 minutes prior to the scheduled surgery time to retrieve the patient. This allows for transportation time to the OR, time to review and confirm the procedure with the surgical team prior to the OR, and time for the anaesthetist to administer medication. Following the procedure, the patient will be transferred to the post-anaesthesia care unit (PACU) and then returned to the post-operative unit for recovery. This process typically takes three to four hours from start to finish.

In a hybrid setting, the HUC must review the physical chart for post-operative orders and process them as required when the patient returns to the post-operative surgical unit. In fully electronic or CPOE environments, the physician will enter the post-op orders in the operating room and the HUC will not need to process these.

References

Schwartz, A. J. (2016, June). Anesthetic records: Lesson about ethics and education. *Anesthesiology, 124*(6).

South Shore District Health Authority. (2007). *Documentation: Standards for medical*. Nova Scotia Health Policy Office.

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional* (4th ed.). Pearson Canada.

CHAPTER 9: TRANSFER AND DISCHARGE PROCEDURES

Transfer Routines

It is common for patients to be transferred from one unit in a hospital to another unit during their hospital stay. This usually occurs for one of two reasons: accommodation or medical/surgical.

- **Accommodation**
    - This includes moves related to isolation, preferred accommodation requests, or consolidation of patients of the same gender. All patient transfers related to accommodation are initiated by the **bed allocator** and do not require a doctor's order.
- **Medical or surgical reasons**
    - A move to receive a type of care that the original unit is not able to provide. For example, a patient may be admitted to a general medicine floor with general abdominal pain NYD (not yet diagnosed). After some investigations, they are found to have a tumour requiring surgery. They would be transferred to the inpatient general surgery unit post-operatively to receive the appropriate surgical nursing care.
    - All patient transfers related to care requirements require a doctor's order. Patient safety with the level of care on their current floor is prioritized with any transfer orders, with the priority being on moving patients requiring more intensive care first.

Porters physically transfer patients from one patient care unit to another, but HUCs help to facilitate patient transfers at both the sending and receiving end of the transfer.

THE HUC'S ROLE IN TRANSFERS

The HUC's role may change somewhat according to the specific processes of their hospital; however, below lists common activities associated with both sending and receiving patient transfers.

The *sending HUC* may do the following:

- Process physician's order by adding pending transfer order onto the electronic bed board and/or notify the bed allocator.
- Prepare the patient physical chart for transfer (if using)–file any loose documents and place any old charts with the physical chart to ensure they remain together during travel.
- Ensure that all patient valuables, equipment from home (walkers, wheelchairs, etc.), medication, and personal belongings are assembled for transfer.

- Contact a porter/transfer attendant for patient transfer once the receiving unit has indicated that the bed is ready and the nursing report has been given.
- Remove all patient information from the communication board and notify the housekeeping department as necessary to clean the empty patient room.
- Notify MRP and family of patient transfer, as necessary.

The *receiving HUC* may do the following:

- Add the incoming transfer to the unit communication board, if using.
- Communicate with the sending unit when the patient's room is clean and ready for transfer (electronically mark on the bed board or call the sending unit to notify).
- Transfer the patient to the unit in the clinical information system when they arrive at the unit. This will indicate to all hospital staff and departments that the patient is now located in the unit.
- If using a physical chart, relabel the exterior and review the *Drs. Order* section, in case there are outstanding orders that need to be completed.
- Update the clinical path or care plan as required.
- Add patient valuables to a locked drawer.
- Deliver any transferred medications to the med room.

Attributions

"Nurse Pushing a Wheelchair on Hospital Hallway" by RDNE Stock project; used under the Pexels license.

Discharge Routines

DISCHARGE PLANNING

A **discharge** is when a patient is released from a health care facility by physician orders and can be applied to patients returning home, moving to a long-term care facility, or another health care facility (Thompson, 2018).

Discharge planning starts at the time of admission or, in the case of patients having elective surgery, prior to admission during the preoperative visit at the pre-surgical clinic. As a crucial component of the patient flow effort, discharge planning takes the following factors into account including the patient's medical diagnosis, the discharge plan (home, long-term care, or another hospital), any equipment needed (hospital bed, walker, raised toilet seat), services needed (home care, home oxygen), prescriptions, follow-up visits, and transportation needs if the patient is unable to drive themselves.

The HUC may be involved in many different aspects of the discharge planning including processing physician referrals for discharge planning and organizing patient services, referrals, equipment, and transportation.

While discharge comes at the end of a patient's hospital experience, discharge planning starts at the time of admission or before.

DISCHARGE ORDERS

A documented doctor's order from the MRP is required for a patient to be discharged. Discharge orders may be written prior to the discharge date, or on the day of discharge. It is not uncommon for the physician to discuss the pending discharge with staff and/or the patient, without actually writing the order. In this case, it is essential to confirm that the patient is being discharged and that the formal discharge order is on the patient's record prior to the patient leaving. It is often the HUC's role to track down the MRP or the doctor on call when there is no order written (Thompson, 2018).

Hospitals typically plan for patients to be discharged in the morning. There are two reasons for this:

- Some provincial plans are charged for another day of hospital stay if the patient is not discharged by noon (Thompson, 2018).

- The first scheduled patients of the day undergoing elective surgery will require admission to post-op operative units by the late morning.

However, given the shortage of hospital beds, patients may be discharged in the afternoon or evening if a physician makes rounds then and signs a discharge order.

LEAVING AGAINST MEDICAL ADVICE (AMA)

Capable patients have the right to leave, refuse treatment, or end treatment by leaving the hospital without a physician's order. While this may occur occasionally in an inpatient department, it is more common in areas such as the Emergency Department, when wait times are long. Any patient leaving the hospital unit without a formal discharge order must be asked to sign a release of responsibility form stating that they understand that they are leaving without permission and that they are assuming all responsibility for the ensuing outcomes. However, it is not uncommon for patients to leave without checking in at the communication centre, or to refuse to sign release forms.

If a patient approaches the communication centre stating that they are leaving without a discharge order, the HUC should seek assistance from the clinical resource nurse or nursing staff. If there are no staff readily available, the HUC should listen empathetically and attempt to redirect them to their room to await a nurse. If the patient insists on leaving prior to a nurse arriving, the HUC should ask them to sign a release of responsibility form and carefully document the conversation as per facility policy. It is essential that the MRP is notified immediately when a patient leaves against medical advice, so their office may follow up as necessary.

THE HUC'S ROLE IN PATIENT DISCHARGES

Once the HUC receives the discharge order, they should

- enter the pending discharge in the bed board, communication board, and patient information screen (if using),
- assemble routine discharge instructions for the patient, including prepared discharge teaching instructions and medication handouts,
- note any follow-up appointments on the discharge record, including the date and phone number of care providers,
- print or copy all relevant medical information including doctor's orders, progress records, medication records, and consultations and put in a sealed envelope if the patient is being discharged to another care facility,
- book urgent or non-urgent patient transportation as required (see next section),
- ensure that all valuables, clothing, and home medications are returned to the patient or family,
- fax the patient's prescriptions to their pharmacy if required,
- dissemble the patient's p-Chart if using, and arrange in the correct order for HIM processing,
- cancel dietary tray,
- discharge the patient in the clinical information system when they physically leave the unit,
- notify family if required, and
- notify housekeeping/environmental services that the room is ready to be cleaned (the computer system

may automatically do this on discharge).

The HUC will often be approached by patients at discharge asking for assistance in removing their armbands. Unless otherwise instructed, the HUC should instruct patients that this should remain on until they physically leave the hospital.

References

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional* (4th ed.). Pearson Canada.

Attributions

“Patient Pick-up & Discharge Only Signage” by Pixabay; used under the Pexels license.

Booking Patient Transportation

HUCs book patient transportation for both non-emergency and urgent transfers. In Ontario, ORNGE provides air ambulance and critical care transfers.

The HUC may spend a substantial amount of their time booking transportation for patients who are booked for tests or consultations at other facilities during their stay or require transportation to return to their home in the community, or long-term care facility at discharge. The HUC will work closely with the clinical resource nurse and other members of the discharge planning team to ensure that the appropriate type of transfer is booked, the timing is appropriate, and the required clinical and demographic details are outlined for the transfer crew.

STEP 1: ACQUIRING TRANSPORTATION APPROVAL

In some jurisdictions, like Ontario, all patients being transported between facilities require authorization prior to transfer in order to limit the spread of infectious diseases (Thompson, 2018). In Ontario, this authorization is by the Provincial Transfer Authorization Centre (PTAC). Each hospital has its own unique login and account on the provincial authorization site to streamline the request process.

The HUC must complete an online transfer request for *every* time a patient requires a transfer to another facility. Transfer requests typically include sending and receiving facility information and clinical screening information for the patient. The HUC will receive a confirmation notification once the transfer is approved, with a unique transfer confirmation number on it (in Ontario, this is called the MT#). Straightforward requests are usually confirmed within minutes; however, complicated requests may take longer to process or may be rejected. The authorization number is typically valid for 24 hours and only covers the single or round-trip transfer.

STEP 2: BOOKING TRANSPORTATION

Once the HUC has obtained transfer authorization, they may then book the patient transfer. The type of transportation service booked depends upon the patient's medical requirements.

Non-Emergency Medical Transport Services

Although there may be several non-emergency medical transport services (NEMTS) in a geographic area, most hospitals contract with one or two service providers to provide the bulk of their routine transfers. Non-emergency transport services may provide a variety of transfer options including wheelchair transfer or stretcher transfer – the discharge planning case worker or the clinical resource nurse will direct the HUC on which type of service to book. Once the HUC has ascertained the trip details, they may book the trip online through a booking portal. They will need to provide:

- transfer authorization number (MT#),
- date and time of transfer, including whether a return trip is required,
- address of transfer, including whether there are stairs,
- clinical information for the patient, including weight and isolation status, and
- escorts or equipment that will be required.

Hospitals typically cover the cost of NEMTS for patients attending testing at another facility; however, they may not cover the cost of patient transportation home. The HUC may be required to provide billing details in these cases, as well as relay any costs to patients and/or their families.

Urgent Patient Transfer Services (Ambulance, Air Ambulance)

Ambulance services should be used only in the case of urgent conditions, such as patients who require immediate transfer, monitoring, medications and/or blood products, specialized equipment, such as a ventilator or external pacemaker, or patients at risk for loss of limb or life (ORNGE, 2024).

The booking procedure for urgent land transfers is similar to non-urgent transfers; however, the booking is usually taken over the telephone with the local EMS services' ambulance operator. The HUC or nurse is expected to answer questions about patient severity, patient information, and clinical information. Most jurisdictions have an exception for very urgent cases, such as loss of life or limb. In Ontario, the sending facility can arrange life or limb transfer by contacting CritiCall, which may arrange air ambulance or specialized ground transfer with ORNGE (Ontario's designated air and critical care ambulance services)(ORNGE, 2024).

Learn more about what's required for booking transfers in Ontario on the "Booking a Patient Transport" checklist from ORNGE [PDF].

Take Note! — Advance Directives and Transportation

It is important that the HUC make a copy of a patient's **advanced directives** or DNR (if one has been completed) for the transfer service providers to provide them with direction in case the patient experiences a life-threatening event during the transfer.

PRACTICE ACTIVITY: TRANSFER, DISCHARGE, AND TRANSPORTATION

Part 1

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=895#h5p-52

Part 2

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=895#h5p-65

References

ORNGE. (2024). *Transporting a patient.*

Thompson, V. D. (2018). *Administrative and clinical procedures for the Canadian health professional* (4th ed.). Pearson Canada.

Attributions

Appendix: Common Medical Abbreviations in the Hospital Setting

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://ecampusontario.pressbooks.pub/hospitalunitadministration/?p=37#h5p-73

Download the Common Medical Abbreviations appendix in PDF format.

Glossary

advance directives
legal documents that communicate a person's wishes about health care decisions in the event they become incapable of making health care decisions (either permanently or temporarily)

anesthetic record
main document of the intraoperative course of anesthesia administration; completed by the anesthetist

bargaining unit
a group within a large trade union that negotiates or "bargains" the terms of employment for a particular category of worker, such as nurses

bed allocator
responsible for the placement, transfer, and discharge of all inpatients, emergency patients, and patient transfers according to priority and preferred accommodation status; often works closely with a RN (or patient flow manager) in their duties.

care plan
pre-developed guide to ensure that patients receive consistent care, minimally acceptable standards are met, and nurse's time is used efficiently; standard care plans provide the same interventions for all patients, without account of the patient's diagnosis

charting by exception (CBE)
documenting only significant deviations from the norm; assumes everything is normal unless noted

code phone
a dedicated phone (often red) or a dedicated phone line used to directly contact the switchboard in case of an emergency

collective agreement
the contract agreed to between the union and the employer

collective bargaining
the process of negotiating the employment contract between union members and the employer

computerized physician order entry (CPOE)
process in which a physician directly enters orders into the patient chart; replaces handwritten orders on an order sheet or prescription

consent form
written form a patient signs before a surgical procedure

consultation record
a second physician's written opinion based on an examination of the patient and a review of the patient's health record

conversation
set of questions asked during the registration process, such as name, DOB, insurance, providers, medical alerts

critical path
a pre-developed guide that outlines the appropriate sequence of clinical interventions, timelines, milestones, and expected outcomes for patients with a specific diagnosis, such as fractured hip or bowel resection

diagnostic imaging report
reports from tests completed in the hospital's diagnostic imaging department, including x-ray reports, ultrasound reports, nuclear medicine reports, mammography reports, MRI and CT reports, etc.

direct admissions
an inpatient hospitalization where a patient is not electively pre-booked for a procedure and does not go through the hospital's ER department for assessment; usually transfers from other facilities or immediate admission from a specialist's office

discharge
a physician's order to release a patient from a health care facility

discharge summary
a concise record of the patient's clinical progress in the hospital; required for all patients regardless of length of stay

drs. order sheet
a form where doctors record all orders related to the patient; including blank and pre-printed forms for standard procedures

EKG/ECG report
reports resulting from electrocardiograms

elective surgery
surgical procedures that are scheduled in advance by the surgeon's office

emergency admissions
admissions that occur through the emergency department

emergency fan out notification system
a system for notifying all staff of an major emergency, which makes direct contact and uses a script

encounter
any visit where a patient receives medical treatment, testing, evaluation and/or management services within any area of the hospital; for example, a patient encounter may be a CT scan, an ER visit, or an inpatient admission for a mastectomy

ER/admission records
resulting from a patient's visit to the emergency department and documents the care received during their emergency stay

face sheet
initial record produced from the registration process

falls risk assessment
assesses how likely it is that a patient—usually an older adult—may fall; the Morse fall scale is the most common

fin NBR
financial number

general departments
hospital departments that support patient care but do not provide patient care; usually administrative, informational, regulatory, or environmental

green armband
indicates patient with diabetes; can be used in combo with red if patient with diabetes has allergies

grievance
a formal allegation reported to the union that the employer has violated the collective agreement

history and physical (H&P)
formal report resulting from the physician's interview with the patient, the physical exam, and the summary of the testing either obtained or pending

HO#
hospital number

hospital unit coordinator (HUC)
a term for the health office administrative role within hospitals; also called health unit coordinator, communication clerk, clerical associate, unit clerk, or clinical secretary

inpatient units
hospital departments that provide clinical care to patients registered for more than 24 hours; the type of care to length of stay may vary greatly, from overnight surgery to extended critical care; however, patients remain under the supervision of a nurse or doctor

lab report
report from any tests completed in the hospital's laboratory

lockboxing
the act of witholding consent for disclosure of PHI for health care purposes; comes from the practice of putting important documents into a small box that can be secured with a lock and key

master patient index (MPI)
a table or database that includes patient information used in registration and billing processes; each individual patient within the database has a unique identifier

medication administration records (MARs)
forms that nurses use to document all medications given to a patient

MRN
medical record number

narrative notes
a running log of everything that happens with patient during a shift; chronological, concise, objective

nosocomial infections
hospital-related infections that were not present on patients when admitted; may also be present on patients who have recently been admitted to hospitals or long-term care facilities

obstetrical admissions
specific to women giving birth; whether vaginally or surgically

operative report
detailed account of the patient's procedural or operative encounters

OR block
block of operating room time the hospital allocates for a surgeon to use for surgical procedures; typically half-days or full-days

OR checklist
a form used to assist nursing staff in preparing the surgical patient for their procedure

orange armband
indicates patient with risk of falling; used in addition to a regular armband

outpatient units/clinics
departments that provide clinical services for less than 24 hours; services range from tests and scans, to treatments and day surgery

patient labels
pre-printed sheets of labels containing key demographic, clinical and billing information for the patient; affixed to documents in the p-Chart

pre-anesthetic questionnaire
questionnaire completed by the patient/patient's family prior to the surgical procedure

primary nursing
when a single nurse handles all the needs of their assigned patients

progress record
main form of communication between physicians and other staff; the physician typically documents on this record after each interaction with the patient, outlining their progress, prognosis and plan of treatment

projected unit census
the unit census plus the anticipated discharges, anticipated elective admissions, waiting ER patients, and pending transfers

red armband
indicates patient with known allergies

SOAP notes
a structured charting system that organizes notes into four sections: **s**ubjective, **o**bjectives, **a**ssessment, and **p**lan

surgical/OR booking form
form to book patient surgical procedures at a hospital, originating in the specialist's office and sent to the hospital's OR bookings department

team nursing
when a group of health care workers, such as RNs, RPNs, and PSWs, work together to care for different needs of their assigned patients

terminal cleaning
thorough cleansing of a patient area, including bed frame, mattress, side table, and curtains, with a disinfect solution

tertiary care
specialist level of care, usually in a hospital setting, often over an extended period of time, such as dialysis, surgery, or psychiatric treatment

thinning
process of removing documents older than a certain date and moving them into a separate secondary record known as the overflow record

trade union
an organization of workers in a particular trade or industry that join together to improve working conditions and terms of employment

unionized
to be a member of a union or a workplace required to follow the rules of a union

unit census
a count of the actual number of patients on a unit

universal order
health information management best practice where hospital personnel rely on the use of chart order guides (or tabs) that are arranged in a consistent fashion

white armband
indicates patient without known allergies or diabetes