Topic 2.13. In the Hospital/ Тема 2.13. В больнице

Hospitals are key institutions in the healthcare system, providing diagnosis, treatment, rehabilitation, and emergency care. For medical and allied professionals, as well as for those who interact with healthcare services in their work (e.g., translators, administrators, social workers), knowing the typical hospital structure, common procedures, and the language used in this setting is essential for effective communication. This lecture focuses on the main hospital departments, patient pathways, typical interactions, and professional vocabulary relevant to working or communicating in a hospital environment.

Main Hospital Departments and Their Functions

Each department in a hospital has a specific role and uses particular terminology. Understanding these roles helps professionals navigate the hospital system and communicate clearly with staff and patients.

- **Emergency Department (A&E / ER)** — the first point of contact for acute and life-threatening conditions. It handles trauma, heart attacks, strokes, severe infections, and other emergencies. Triage is performed here to prioritise patients by severity.
- **Outpatient Department (OPD) / Polyclinic** — for patients who do not require admission. Consultations, follow-ups, and minor procedures are carried out here. Appointments are usually scheduled in advance.
- **Inpatient Wards** — general or specialised units where patients stay overnight or for longer periods. Wards are often organised by specialty: medical, surgical, paediatric, geriatric, maternity, etc.
- **Intensive Care Unit (ICU) / Critical Care Unit** — for the most seriously ill patients requiring continuous monitoring and life support. Subunits may include CCU (Coronary Care Unit) and NICU (Neonatal Intensive Care Unit).
- **Operating Theatre (OT) / Operating Room (OR)** — where surgical procedures are performed under sterile conditions. The team includes surgeons, anaesthetists, scrub nurses, and circulating nurses.
- **Diagnostic Departments** — Radiology (X-ray, CT, MRI, ultrasound), Pathology (tissue and fluid analysis), and Laboratory (blood tests, microbiology).
- **Rehabilitation Department** — provides physiotherapy, occupational therapy, speech therapy, and other services to help patients regain function after illness or injury.
- **Pharmacy** — prepares and dispenses medications, advises on drug interactions, and supports safe prescribing practices.
- **Admission and Discharge Office** — manages patient registration, documentation, insurance, and discharge planning.

Typical Patient Pathways

Understanding how patients move through the hospital helps professionals anticipate steps and coordinate care.

Emergency admission: A patient arrives at the Emergency Department with an acute condition. Triage determines urgency. A doctor performs an initial assessment, orders tests (blood work, imaging), and may admit the patient to a ward or ICU, transfer them to the OR, or discharge them with instructions.

Planned (elective) admission: The patient is referred by a GP or specialist for a procedure or further evaluation. They come to the Admission Office, complete paperwork, undergo preliminary tests if needed, and are assigned to a ward. Pre-operative checks are done before surgery if applicable.

Outpatient visit: The patient attends a scheduled appointment in the OPD. The doctor reviews symptoms, performs an examination, orders tests, and provides a diagnosis and treatment plan. Follow-up appointments or referrals may be arranged.

Discharge: Before leaving the hospital, the patient receives a discharge summary with diagnoses, treatments received, medication list, dosing instructions, activity restrictions, and follow-up plans. The discharge nurse or doctor explains these points and answers questions.

Common Interactions and Professional Language

In a hospital setting, communication is often time-sensitive and must be precise. Below are typical situations and useful language patterns.

At admission:

- "Please state your full name and date of birth."
- "Do you have any known allergies?"
- "Have you had any previous surgeries or serious illnesses?"
- "Are you currently taking any medications?"

During examination:

- "I'm going to check your blood pressure and temperature."
- "Take a deep breath and hold it for a moment."
- "Tell me where it hurts and how long you've had this pain."
- "On a scale from 0 to 10, where 0 is no pain and 10 is the worst pain, how would you rate your pain now?"

Giving instructions:

- "You need to fast for 8 hours before the procedure."
- "Take this tablet twice a day after meals."
- "Avoid heavy lifting for two weeks."
- "Make an appointment with your GP in one week for a follow-up."

Reporting observations:

- "The patient's blood pressure is 140/90 mmHg."
- "Heart rate is 88 beats per minute, regular rhythm."
- "Oxygen saturation is 96% on room air."
- "There's no sign of bleeding or swelling at the incision site."

In emergencies:

- "We need a crash cart immediately."
- "Call the rapid response team."

- “Start CPR and prepare the defibrillator.”
- “This patient needs intubation now.”

Key Medical and Administrative Terms

Term	Meaning / Usage Context
Triage	The process of sorting patients by urgency of need for care.
Admission	The formal process of registering a patient for inpatient care.
Discharge	Releasing a patient from the hospital with instructions and documentation.
Referral	Sending a patient to another specialist or department for further care.
Consultation	A meeting with a specialist to discuss diagnosis and treatment options.
Prescription	A written or electronic order for medication, including dose and frequency.
Medical record	A document containing the patient’s history, test results, diagnoses, and treatments.
Vital signs	Basic measurements: temperature, pulse, respiration rate, blood pressure, oxygen saturation.
Diagnosis	The identification of a disease or condition based on symptoms and tests.
Prognosis	The predicted outcome of a disease or treatment.
Complication	An unexpected problem that arises during or after treatment.
Consent	A patient’s formal agreement to a procedure after being informed of risks and benefits.

Communication with Patients and Families

Effective communication supports patient safety, satisfaction, and adherence to treatment. When speaking with patients and their relatives, clarity, empathy, and respect are vital.

- Use simple language and avoid unnecessary jargon. If a technical term is required, explain it briefly.
- Confirm understanding: “Could you repeat back to me what we decided about your medication?”
- Be mindful of cultural and linguistic differences. If there’s a language barrier, use professional interpreters rather than relying on family members.
- Respect privacy and confidentiality: discussions about diagnosis and treatment should occur in private spaces.
- When delivering difficult news, choose a quiet setting, speak clearly but gently, and allow time for questions and emotional response.

Example phrases:

- “Let me explain what this test is for and what we hope to learn from it.”
- “It’s normal to feel worried; I’ll tell you what to expect step by step.”
- “If you have any concerns later, you can call the ward or your doctor’s office.”

Safety, Protocols, and Professional Etiquette

Hospitals operate under strict safety and infection control protocols. Professionals must follow these rules and be able to explain them to patients.

- **Hand hygiene** is mandatory before and after every patient contact. Alcohol-based hand rubs and soap and water are used according to protocol.
- **Personal protective equipment (PPE)** — gloves, masks, gowns, and eye protection — is worn when there’s risk of exposure to body fluids or infectious agents.
- **Patient identification** is confirmed using at least two identifiers (name and date of birth) before any procedure or medication administration.
- **Medication safety** includes the “five rights”: right patient, right drug, right dose, right route, right time.
- **Incident reporting** is required for any error, near miss, or unexpected event. The goal is to improve safety, not to assign blame.

Professional etiquette includes punctuality, clear handover of information between shifts (handover reports), respectful communication with colleagues, and maintaining patient confidentiality at all times.

Interprofessional Collaboration

Hospital care is delivered by multidisciplinary teams. Effective collaboration relies on clear, structured communication.

- **SBAR** (Situation, Background, Assessment, Recommendation) is a widely used framework for concise and effective handovers and consultations:
    - **Situation**: “This is Nurse A calling from Ward B. I’m concerned about Mr. Smith, bed 4.”
    - **Background**: “He was admitted yesterday with pneumonia. He’s on antibiotics and oxygen.”
    - **Assessment**: “His temperature rose to 39.2°C, respiratory rate is 28, and oxygen saturation dropped to 91%.”
    - **Recommendation**: “I think we need to review him urgently and consider changing antibiotics.”

- Regular team briefings and debriefings help coordinate care, especially in high-risk areas like the ICU and OR.
- Clear documentation in the medical record ensures continuity of care and legal protection.