KLICKITAT VALLEY HEALTH Caring for our Community	Procedure Number: PR008-364
	Effective Date: 12/12/2011
	Title: Admission of the adult patient

SCOPE (*choose from: District wide, Ambulance, Family Practice Clinic, Golden View Terrace, Home Health Hospice, Hospital****):***   ***Hospital***
LEVEL (*any departments within service areas that the procedure applies to*)***:***   ***Nursing and Emergency room***
POSITION(S) RESPONSIBLE: ***Nursing***
PURPOSE: ***To document in patient electronic medical record***

PROCEDURE:

1. Greet patient by name and introduce yourself and other staff present.

2. Confirm the patient's identify using two patient identifiers. Verify the name and its spelling with the patient. Notify registration of any corrections.

3. Quickly review the practitioner's orders. Note Admit Decision Date and Time in Electronic Form (E-Form). Note the reason for admission in the patient's own words use quotation marks. Note any restrictions on activity/diet orders. Note any orders for other ancillary departments, and order any diagnostic tests that have not been previously entered via CPOE.

4. Escort the patient to their room. If they are not in great distress, introduce them to their roommate, if they have one. Wash your hands and help the patient change into a gown or pajamas; if he's sharing a room, provide privacy. Itemize all valuables, clothing, and prostheses on the Clothing Sheet E-Form. Encourage the patient to store valuables or money in the locked drawer at the nurses' station or, preferably, to send them home along with medications they may have bought.

5. Obtain a complete list of the patient's current medications and dosages if not previously obtained. Verify this list with the medication reconciliation form in the patient's flow chart under current medications. Make any necessary changes. Print medication reconciliation report for physician to continue, discontinue, or modify medications. Place the medication reconciliation signed by the physician, in the patient's chart under the medication tab.

6. Take and record the patient's vital signs, and collect ordered specimens. Measure their height and weight if possible. If the patient can't' stand use the Hoyer lift or Sit to stand with scale.

7. Show the patient how to use the equipment in the room. Be sure to include the call system, bed controls, television controls, telephone, lights and location of bathroom.

8. Explain the routine. Mention when to expect meals, vital signs checks, and medications. Review visiting hours and restrictions.

9. Take a complete patient history using the appropriate flow chart and E-forms (see appendix A for complete list of available flowcharts) to complete the physical assessment. Be sure to answer all questions in the flow chart

10. Record any allergies in the demographics portion of the electronic medical record.

11. Open any additional flow charts and E-forms as needed to complete a thorough assessment (see appendix A for a complete list of available flowcharts).

12. After assessing the patient, inform them of tests that have been ordered and when they're scheduled. Describe what they should expect.

13. Complete the Advanced Directives E-Form located in the patient's electronic medical record.

14. Complete the Pneumonia/Influenza E-Form located in the patient's electronic medical record.

15. Record Immunizations: Flu/Pneumonia, TDap in the demographics portion of the electronic medical record.

16. Be sure all boxes are answered in the demographics portion of the electronic medical record.

17. Place at least four problems in the problem list. (There is no problem list required for patients placed in observation).

18. Before leaving the patient's room, make sure that they are comfortable and safe. Return the bed to the low position; turn on bed alarm (if applicable). Place the call button and other equipment (such as water cup, emesis bag and facial tissues) within easy reach.

Appendix A

Flow Charts

Blood transfusion	Newborn: Daily assessment
CIWA Assessment	Newborn: Discharge summary instructions
DKA Flowsheet	Newborn: Initial newborn assessment
Discharge summary and instructions	Nursing assistant flowchart
Heparin (cardiac dose)	OB: discharge summary and instructions
Heparin (full dose)	OB: Labor and delivery flowchart
Neuro checks	OB: Labor and delivery initial interview
Restraints flowchart	OB: post partum record
Wound care flowchart	OBS: observation
Pain flow chart	OT: Discharge summary
CM: Discharge planner	OT: discharge summary (ext. swing)
CM: initial Interview	OT: Discharge summary (swing)
CR: phase II flowchart	OT: Initial evaluation
Ext swing: admission/monthly physical assessment	OT: Initial evaluation (ext. swing)
Ext swing: Braden/Nutritional/ assessment	OT: Initial evaluation (swing)
Ext swing: CNA daily flowchart	OT: visit note
Ext swing: Daily activities	Outpatient procedure flowchart
Ext swing: initial interview	PCA assessment
Ext swing: restorative program	PEDS: flowchart
Ext swing: weekly care cong.	PEDS: Initial interview
IP: Daily physical assessment	PEDS: Observation
IP: Initial Interview/ Physical assessment	PT: daily note
RC: hospice and respite care	PT: Daily note (swing)
RT: charging flow chart	PT: daily note (ext. swing)
Swing bed: Braden/nutrition flowchart	PT: Discharge note
Swing bed: Initial interview	PT Discharge note (swing)
Swing bed: CNA Daily flowchart	PT discharge note (ext swing.)
Swing bed: Daily activities	PT: Initial assessment
Swing bed: Daily assessment	PT: Initial assessment (swing)
Swing bed: weekly care conference	PT: Initial assessment (ext. swing)
Swing bed: IV flow chart	Transfer flowchart
Swing: Restorative flow chart	

ELECTRONIC FORMS

Advance directive acknowledgement	Authorization for transfer
Clothing sheet	Extended swing bed admission
RT: Oximetry report	Pneumococcal/influenza Immunization
Transfer check off	DM: Diabetes Self Management Education Session 1
DM: Diabetes Self Management Education Session 2	DM: Diabetes Self Management Education Session 3
DM: Diabetes Self Management Education Session 4	DM: Diabetes Self Management Education Session 5
RT: Patient Education Encounter	Instructions for viewing CD