**PROCEDURE FOR:** **Documentation: Admission (Inpatients)**

**POLICY:**

1. Each patient is assessed by a RN or LPN upon admission.
2. If the LPN performs the initial inpatient admission assessment, the assessment must be validated and cosigned on the database and flowsheet by an RN.
3. If the LPN initiates the plan of care, the RN must validate and cosign the patient's plan of care where appropriate (e.g., flowsheet and/or SCP).
4. The nursing admission process is completed within twenty-four hours of admission, or as per unit structure standards. A systems assessment (documented on the flow sheet) is completed within 8 hours of admission.
5. Reassessment of patient needs is contingent on the urgency of the patient's condition, and is defined in each unit's structure standards.
6. Documentation of reassessment is reflected on each unit's flowsheet.

**DOCUMENTATION:**

Nursing or Unit-Specific Database
Flowsheet
Patient Care Plan/Standard Care Plan/Care Path/Treatment Plan
Patient and Family Teaching Record
ISBAR form if applicable

**PROCEDURE:**

| ACTION | POINTS OF EMPHASIS |
|---|---|
| 1. Complete the database applicable to the nursing unit. | 1. On admission, the data base should be completed to the best of the admitting nurse's ability given the ability of the patient to communicate, the availability of the family, and the impact of hospitalization.<br><br>On floors utilizing Computerized Physician Order Entry (CPOE), the MD or RN must also complete the patient factors and enter allergy section prior to writing any orders. |
| 2. The RN or LPN will initiate plan of | 2. Admission data serves as a |

**PROCEDURE FOR:** Documentation: Admission (Inpatients)

care (e.g., Standard Care Plan, Care Path, plan of care per flow sheet or Treatment Plan). The plan of care and interventions will be documented in each patient's medical record.

baseline for the patient's plan of care.

3. The RN or LPN will initiate the appropriate patient and family teaching record.

4. The RN or LPN will complete an admission progress note that includes date and time of admission, and mode of admission (e.g. via wheelchair from clinic).

4. The admission may not be written on the back of the ISBAR form.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/90

REVISION DATES: 3/93, 7/93, 1/96, 9/97, 10/97, 11/99, 11/02, 4/03, 10/06, 7/08, 10/09