

PROTOCOL FOR: Admission to the OB-GYN Unit

- POLICY:**
1. Refer to Structure Standards/Scope of Practice for Admission Criteria.
 2. For admission criteria of non-obstetrical patient: refer to Administrative Protocol.

DESIRED PATIENT

- OUTCOMES:**
1. The patient will verbalize understanding of unit admission policies.
 2. The patient will be acclimated to her physical surroundings.
 3. The patient will be able to demonstrate and/or verbalize understanding of the use of safety measures, i.e., call bed, bed controls, infant security system, etc.

**CLINICAL
ASSESSMENT AND**

- CARE:**
1. Admit/transfer to assigned room.
 2. Assist with physical admission/transfer:
 - a. BED TO BED: Ensure both beds maintained in locked position at same height; instruct/aid patient in correct technique for transfer.
 - b. WHEELCHAIR TO BED: Ensure brakes are locked; assist patient with transfer.
 - c. AMBULATORY: Show patient to assigned bed.
 3. Assess patient's understanding of the reason for her admission/transfer.
 4. Assess patient's ability to understand and carry out admission/transfer instructions (i.e., language barriers, language read, knowledge deficits, sensory deficit and physical limitations).
 5. Assess patient's physical/emotional reaction to admission/transfer to OB-GYN Unit.

PATIENT

- TEACHING:**
1. Orient patient to physical environment.
 - a. Use of bed controls and side rails.
 - b. Use of nurse call system, tv control and telephone.
 - c. Location of closet, bathroom, nursing station, kitchen and patient lounge.
 2. Explain the infant security system.
 3. Review hospital policies that govern visiting hours, smoking and disposition of personal medications.
 4. Instruct the patient in selection of meals and inform her of meal selections (Room Service).

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5. Instruct the patient to return valuables to home. Instruct patient in utilization of the hospital safe for proper disposition of valuables while hospitalized.
6. Educate the patient regarding universal precautions.
7. Address any specific questions/concerns on the part of the patient.
8. Instruct patient in the guidelines for overnight visitors.
9. If the patient is antepartum, explain fetal monitoring and fetal assessment protocols.

- DOCUMENTATION:**
1. Initiate and complete or continue and complete the Nursing Database within 24 hours of admission.
 2. Initiate and/or continue the nursing plan of care applicable to the patient's admission/transfer diagnosis.
 3. Initiate and/or continue the OB-GYN flowsheet at/upon admission.
 4. Initiate or continue appropriate care plan or carepath.
 5. Document patient outcome as per documentation policies - Department of Nursing.
 6. If a patient is a direct admission to unit:
 - a. Following inpatient admission checklist, obtain the following: Permission to Treat, Valuables Release, Advance Directive form.
 - b. Provide patient with hospital admission packet and HIPPA information.
 7. If patient is delivered, provide patient with a Mother's Handouts Packet.
 - a. Explain paperwork necessary to complete following birth.
 8. If patient is antepartum, provide patient with a "While You Wait" antepartum packet.
 9. If patient has delivered and baby has died, provide patient with hospital memento packet.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 1/91

REVISION DATES: 9/93, 3/97, 2/00, 10/03, 1/09