

PROTOCOL FOR: Admission: Nursing Responsibilities for the Patient Being Admitted to a Medical or Surgical Unit

- POLICY:
1. All patients will be assessed by an RN/LPN within 24 hours of admission. If an LPN performs the initial inpatient admission assessment, the assessment must be validated and co-signed by an RN.
 2. The nursing admission process will be completed within 24 hours of admission, or per unit structure standards. A systems assessment (documented on the unit Flowsheet) is completed within 8 hours of admission.

DESIRED PATIENT

- OUTCOMES:
1. The patient will be assessed as completely as possible at the time of admission.
 2. An appropriate individualized plan of care or care path will be initiated.
 3. The patient will be oriented to the unit and hospital experience.

- ASSESSMENT:
1. Conduct a patient interview, history taking, and body systems assessment utilizing the Nursing Data Bases. Both the Core Database and Inpatient Database are required for all hospitalized patients. The Core Database will be completed electronically for patients admitted through the ED or PACU. All direct admissions must have a Core Database completed at the time of admission.
 2. Identify the following: nursing care problems; patient and education needs; discharge issues including assessment of the home environment and/or any community supports in place; and psychosocial issues.
 3. Report any conditions of immediate concern to the physician.

GENERAL

- NURSING CARE:
1. Develop an individualized plan of care addressing those nursing problems identified, and including appropriate desired patient outcomes.
 2. Begin referral to any appropriate support system(s) within the hospital such as case management, social services, financial services, pastoral services dietary, rehabilitation services (PT, OT, ST - require MD/LIP order), clinical nurse specialist, and/or wound and ostomy clinical nurse specialist.

ORIENTATION TO HOSPITAL/UNIT:

1. Provide an orientation to the unit and room environment.
2. Review hospital policies that govern visiting hours, non-smoking, disposition of personal medications and patient valuables.
3. Instruct the patient in the use of the unit call bell, hospital phone system, meal schedules and menu selection, and utilization of the hospital safe for valuables.
4. Educate the patient regarding the hospital's practice of Universal Precautions and Red Bag Waste.

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5. Address any specific questions/concerns on the part of the patient.

DOCUMENTATION: 1. Documentation of a patient admission to the medical-surgical units will be done in accordance with the Clinical Procedure "Documentation: Admission (Inpatients)", located in the Nursing Practice Manual.

APPROVAL: Medical-Surgical Standards Review
Nursing Standards Committee

EFFECTIVE DATE: 3/88

REVISION DATES: 12/90, 12/97, 4/03, 5/06, 6/2009