PROTOCOL FOR: **<u>Admission: Care of the Patient Admitted to Psychiatry</u>**

POLICY:

1. Patients admitted from the Emergency Department or CL services will have completed admission orders before they arrive to the unit.
2. The nurse must immediately call the psychiatric officer of the day (POD) for admission orders on direct admissions. If the POD is unreachable the nurse should then contact the attending physician.
3. The patient database must be completed within 24 hours of admission.
4. An initial nursing treatment plan will be completed within 8 hours of admission.
5. Patient belongings and clothing will be searched for prohibited items upon admission to the unit in the presence of the patient. The gender of the patient and the staff member assigned to search will be the same.
6. Voluntarily admitted patients will sign the *Formal Voluntary Status* form upon admission. Involuntarily admitted patients will have their rights explained to them under the Physician Emergency Certificate (PEC).

DESIRED PATIENT OUTCOMES:

1. The patient will be oriented to the unit and to the hospital admission.
2. The patient will be knowledgeable about procedure for request to leave unit.

CLINICAL ASSESSMENT AND CARE:

1. Upon arrival to the unit, a designated staff member will greet and introduce themselves to the patient and assign them an appropriate status.
2. Document vital signs, height, weight, and urinalysis on the unit flow sheet. Obtain breathalyzer and urine testing, as indicated/ordered.
3. Apply patient identification band, and falls risk and allergy bands, as appropriate.
4. Assess patient’s status to determine patient’s ability to participate in admission process and involve the family/significant other in the process, as needed.
5. Review Hospital Admission packet, Family Guidelines, and Smoke Free Environment information with patient and family/significant others. The Admission Nurse will witness and sign forms where indicated.
6. Inform patient a routine physical exam will be completed by M.D. within 24 hours.
7. Escort patient to assigned room and provide hospital pajamas and slippers.

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   a. Remain with patient while he/she is changing.

   b. Thoroughly search clothing, shoes, and all items on the patient.

   c. Contents of the suitcase, purse, and any other containers will be completely emptied and searched.

8. Remove the following items from the patient and place in the unit safety cabinet:

   a. All sharp items, including: scissors, tweezers, razors, glass items, mirrors, vases, craft needles, car keys.

   b. All medication, prescribed and over-the-counter.

   c. All toxins such as hair spray, mouthwash, make-up and aerosols.

   d. Recreation items such as portable CD/radio, cassettes, electronic games, cameras, portable telephones and beepers.

   e. Metal or glass soda cans.

   f. Smoking materials.

9. Secure patient's valuables such as money, credit cards, etc., in the hospital safe.

10. Provide visitor information to family/significant others accompanying patient. Inform patient and family/significant others of weekly Multifamily Group.

11. Document nursing history and system assessment on Interdisciplinary Database; document inventory of personal items placed in the unit safety cabinet on the Interdisciplinary Database.

12. Inform patient of unit practices for use of restraints and/or alternatives to restraints.

13. Orient patient to unit or re-assign and introduce patient guide as appropriate.

14. Notify physician of acute symptomatology requiring immediate intervention.

15. Notify physician if patient is admitted on a PEC.

PATIENT TEACHING:

1. Educate the patient to his/her role in treatment.

2. Review function of treatment team and primary nursing.

3. Educate regarding patient rights and responsibilities.

DOCUMENTATION:

1. Complete the following:

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a. Interdisciplinary Database

b. Patient Orientation Checklist

c. Initial Treatment Plan

d. Inpatient Unit Flowsheet

e. Inpatient Psychiatric Admission Packet Checklist, including:

1) Permit to Treat

2) Personal Property Release

3) Advanced Directive Form

4) Information Packet

5) Message from Medicare

6) Medical Record Release of Information

f. Voluntary Application for Admission

g. Patient and Family Teaching Plan

2. Initiate 15 Minute Checklist.

3. Document team members on patient orientation checklist.

4. Complete family reference card.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 1/90

REVISION DATES: 1/91, 2/92, 5/92, 11/94, 2/99, 10/00, 10/03, 6/06, 8/08, 6/09