

Admission Checklist

Initial

Prior to Arrival

Review ROC/Receive Report

-While reviewing ROC, consider having a special mattress brought up- this is done by emailing materials management (will require order in patient's chart after arrival)

Collect Supplies- bed alarm, swabs, urine collection container

Set up room- bed/mattress in place, bedding, pads, tube feed pump, IV pole

Immediately upon arrival

Obtain Consent to Treat or ensure that Admissions has already completed

Place wristband on patient- ensure code status and risk stickers are on bracelet

Obtain vitals, weight, and perform initial assessment

If patient is diabetic- blood sugar and tube feed orders are important beginning steps

Off shift- Call House Officer to assess patient and enter orders

Off shift- fax medication list to pharmacy

Initiate Admission Note in EMR

If you plan on leaving room for a while- ensure patient has appropriate call bell

A quick General Admission DAR note (stating patients wellbeing and transfer status)

Once Orders are Entered in Computer

Off shift- Contact Cardinal Pharmacy to alert them of admission medication orders

Medication Reconciliation

Ensure appropriate dressing changes are ordered

Ensure appropriate consults are ordered (PT, OT, SLP, Nutrition, TR, etc)

Rest of Shift

Continue Admission Note in EMR- needs to be completed within 24 hours of admission

-Do **NOT** fill out a separate risk assessment- the admission note includes 2 nurse skin check and risk assessments (elopement and fall) and initial assessment

-This is where you document that initial assessment- no need to add initial assessment to the assessment and care flowsheet

Perform 2 Nurse Skin check and document in Admission Note in EMR, complete Wound Rounds, and Braden Score (*due within 8hrs of admission- if you cannot get to WR, that needs to be done within 24hrs*)

-Make sure to add the 2nd nurse as a co-signer to the 2 Nurse Skin Check

Obtain Swabs- Rectal and Nasal routine, wounds (if drainage), lines/tubes/drains (if drainage)

-It makes sense to do this during the skin check- you are already in the areas, and this way you can swab wounds or lines during assessment as well

Make sure there is a mattress order (part of admission note) and add to Care Plan

Initiate Nursing Plan of Care in EMR

EKG if ordered

Change all dressings including PICC line (if no drainage- PICC can wait if done within last 24 hours- Use nursing judgement)

Change Foley or SP tube (this should be done prior to urine collection)

Obtain Urine Sample- needs to be on ice or in fridge within 1 hour of collection

Place appropriate signage in room (PICC Line signs at HOB)

Change Peripheral IV if admitted with one (establish one first prior to removing the current one)

Notes/Important info:

Nasogastric Tube- need STAT x-ray ordered right away- cannot use until confirmation of placement (Unit Secretaries, CELs, and Managers can order in the computer once the Provider has placed the order in EMR)

PICC- cannot use without confirmation of placement- is found in admission paperwork documented with either EKG or x-ray post placement

Only STAT labs are collected off shift- routine labs will be collected in AM by lab

What does not get completed needs to be passed on to next shift to complete