

 <p><b>Connecticut Valley Hospital Nursing Policy and Procedure</b></p>	<p><b>SECTION B: THE NURSING PROCESS</b></p> <p><b>CHAPTER 6: ADMISSION, NURSING ASSESSMENT, NURSING RE-ASSESSMENT</b></p> <p><b>Policy and Procedure: 6.1 Admission of Patient</b></p>
<p>Authorization: Nursing Executive Committee</p>	<p>Date Effective: May 1, 2018 Scope: Registered Nurses</p>

**Standard of Practice:**

A Registered Nurse will facilitate the patient's adjustment to the hospital environment through orientation, a nursing assessment, and individualized care processes based on the patient's needs.

**Standards of Care:**

The patient can expect to have his/her needs assessed by a Registered Nurse and to participate in the development of his/her individualized Plan of Care.

The patient and family can expect to receive information regarding hospitalization, continuing care needs and discharge planning.

**Policy:**

The Admission Nursing Process will include a Nursing Assessment, completion of Nursing's Initial Plan of Care and an Admission Note.

**Procedure:**

Triage and admission screening will be carried out within written guidelines specific to each division.

A Registered Nurse and/or other member of the nursing staff will greet the patient and initiate admission procedures.

The Admissions Department will notify physician(s) and Nurse Supervisor of admission.

Orient the patient to the assigned RN, Primary Nursing MHA/FTS, Freedom of Movement Policy and Privilege Levels, Tobacco Free Policy, Policies on Personal Property and Valuables, including contraband (sharps, weapons, unauthorized substances) Policies regarding the appropriate use of Seclusion and Restraint and reporting of incidents, concerns and complaints, including allegations of abuse, neglect and exploitations.

The Admission RN will provide the patient with general information concerning their right to make health care decisions, and will advise them that the pamphlet entitled Your Rights to Make Healthcare Decisions, A Summary of CT Law, prepared by Office of Attorney General 2006 **is in their chart and available for review as requested.**

The patient and/or conservator will be given the Advance Medical Directive and Anatomical Donation Form (CVH-407, CVH 407a rev. 4/13, & 407b, rev 4/13). This form will be completed by the RN and patient and/or patient and conservator and filed in the legal section of the patient's medical record. If the patient indicates that they have either an Advanced Medical Directive or wish to make an Anatomical Donation, place respective sticker ("Advanced Directive" and/or "Organ Donor") on the binder of the chart.

If the patient indicates they have a Living Will or other Advanced Directive, **The RN will inform the Unit Social Worker who will** indicate in the CVH Staff section of the Advance Medical Directive and Anatomical Donation form what action was taken to procure the document, i.e. phone call made to family, name of attorney and phone number where document resides, or any other information known as to the whereabouts of the document.

**At the time of Admission, the RN will ask the patient if they have an Advance Directive or Anatomical Donation in place. If not, they will advise them that they can speak with the Social Worker about these procedures when ready to do so.**

A copy of the Advance Medical Directive and Anatomical Donation form will be given to the patient. If the patient refuses their copy, note on the form that patient refused his/her copy.

The Admissions RN enters the admission data into Web Infrastructure for Treatment Services (WITS)

The unit staff will orient patient to the Clinical Unit. Provide tour of unit, including the location of the bathroom, dining room, nursing station, treatment room, assigned bedroom, and who to contact if issues or concerns arise. The patient will also be oriented to the unit program schedule and level system. Information on mealtime hours, fire alarm response procedures and hand hygiene will be provided.

Unit staff will introduce patient/family to roommate, other patients and staff on unit.

**The Admissions RN will begin the Nursing Assessment** write a brief Admission Note. The admission RN will also complete the admission checklist (CVH-639) and set up the chart.

The Unit RN will complete chart set up and include data on information boards. Only patient's initials may be used. (See HIPAA De-identifying Policy). **Place Allergy sticker on chart if appropriate.** Name in admission/census book.

An RN will assist the Ambulatory Care Clinician with physical exam as required