Connecticut Valley Hospital Nursing Policy and Procedure	**SECTION B: THE NURSING PROCESS** **CHAPTER 6: ADMISSION, NURSING ASSESSMENT, NURSING REASSESSMENT** **POLICY AND PROCEDURE 6.2: NURSING ADMISSION ASSESSMENT**
Authorization: Nursing Executive Committee	Date Effective: May 1, 2018 Scope: Connecticut Valley Hospital

Standard of Practice:
The RN will assess each patient on admission and develop an individual Nursing Plan of Care.

Standard of Care:
The patient will be assessed by a RN within 24 hours of admission in an atmosphere that promotes trust and confidentiality. Significant others, as well as other agency reports, may be utilized in the data gathering process.

Policy:
A multi-dimensional nursing assessment will be initiated on all patients admitted to the hospital at the time of admission and completed within 24 hours of admission. The Nursing Assessment shall explore all venues within the context of the psychiatric and substance abuse experience, high risk areas, bio-physical conditions, etc. resulting in an evaluation of how these conditions impact the patient's functioning. The RN/designee will contact medical staff and/or other appropriate clinicians for further assessment based on the results of his/her finding as required.

Procedure:
Initiate the Nursing Assessment upon the patient's admission and obtain all data denoted by asterisk (*) within 8 hours of admission including medications and assessment of pain.
Sign and date all entries.

All non-asterisked items if not completed at the time of admission, are to be completed within 24 hours of admission. RN's on all shifts are expected to contribute to the assessment at any time during the twenty-four (24) hour period following admission. Initial and date all subsequent entries adjacent to the items entered and enter full signature and initials.

If the patient's condition on admission and within 24 hours make it impossible to complete the Nursing Assessment, the Head/Charge Nurse is responsible for ensuring that the Assessment is completed to the degree possible. The patient's inability to participate in a full assessment is noted in the Nursing Plan of Care with correlating interventions. Blank spaces are not permitted and a notation is expected for every entry not obtained.

Summarize the data gathered in the Nursing Assessment by contributing information to the patient's goals, strengths, assets, and barriers in the Initial Plan of Care/Master Treatment Plan.

At a minimum, it is likely that most patients will have a psychiatric/substance abuse and medical goal with corresponding nursing care interventions. The Initial Plan of Care is developed in conjunction with the patient by the Psychiatrist/Physician and Registered Nurse within the first 24 hours of admission and is recorded in the Recovery Management System (RMS). The Initial Plan of Care addresses immediate treatment objectives defined by the MD, RN and person in recovery's goals related to physical and mental health.

Prior to the development of the Master Treatment Plan (MTP), the patient's assigned Primary Nurse/designee will review and revise the Nursing Plan of Care as appropriate, the patient's goals, strengths, assets and barriers. Once finalized, the Primary Nurse/designee will print the Nursing Plan of Care and place it in the Change of Shift report book.