GUIDELINE

TITLE: **ADMISSION DATA BASE GUIDELINE**

PURPOSE: To collect data which will enable hospital personnel to assess the needs of each patient and their families in order to provide the necessary care during hospitalization and upon discharge.

NATURE OF FORM: Permanent

DEFINITIONS:

SUPPORTIVE DATA:

1. If patient is admitted from ED, the ED triage form is to be reviewed and referenced for information if needed. Review and complete the needed information on the data base.
2. Complete all parts for **direct admissions**. Start with page 1 of Admission database form.
3. For patients admitted from **PAT/SDS**, review information on page 1 and complete if any information is missing. Sign page one as the reviewing/admitted nurse. Review entire document for completeness, complete any blank areas. Complete the referral section. This will not be done prior to the patient being on the unit.
4. Data Base to be initiated within 8 hours of admission and completed within 24 hours.

RESPONSIBILITY:

Page 1	Registered Nurse or Licensed Practical Nurse
Page 2-6	Registered Nurse. S/he may delegate non –assessment questions and sections to the LPN.

Targeted Patient Population: All medical, surgical, PCU, ICU inpatients. Post op GYN patients admitted to the 4th floor and SDS patients.

CONTENT: **PROCEDURE**:

Emergency Dept. Triage & Nurses Note Form

1. Place all notes from ED in the Nurses notes section of the chart.
2. Review page 1and obtain any needed information.
3. Continue admission with "Admission Data Base".

Hospital Data Base

1. Admitting nurse records date and time of admission.
2. Record unit patient admitted to.
3. Record temperature and check box to indicate which method was used to obtain patients temperature.
4. Record (P) pulse.
5. Record ® respirations.
6. Record blood pressure and check box to indicate which arm it was obtained from.
7. Record pulse oximetry.
8. If o2 is used record amount and device.
9. Indicate where patient was admitted from.
10. Record height and weight.
11. Check off all items that were reviewed with the patient for unit orientation. Check off that the patient and/or family verbalized understanding of this initial education. Or check off the patient/family requires additional reinforcement. If the patient requires additional reinforcement enter the specific lesson in which reinforcement is required on the teaching record.

12. Also indicate that ID bracelet was applied and check box that corresponds with where the bracelet was applied.
13. Indicate who is providing the information for the admission database. If a translator is used, record name.
14. Record chief complaint or admitting diagnosis.
15. Record name, relationship and phone number of emergency contacts. Also record name and phone number of person patient wants medical information released to.
16. Answer yes or not to the barriers to communication and learning, or check off "denies". Add comments if necessary to explain any barrier.
17. Check off yes/no if interpreter needed. If the patient requires a interpreter, but refuses, check the appropriate box to indicate that. State the language in which the interpreter services are required, or check off American Sign Language. Write in the name and/or service providing the interpreter.
18. Learning needs: Assess the learning needs of the patient by checking appropriate boxes for learning style and ability to read and comprehend English. Check yes or no if the patient has desire and motivation to learn. Add comments if necessary. If unable to assess patient, make a note that the learning needs of the family was assessed and the information obtained is related to family needs.
19. Enter any allergies and type of reaction or check box "**Patient denies allergies**".
20. Enter medication patient takes at home include over the counter, herbs, vitamins etc. on the medication reconciliation form.
21. Enter past medical and surgical history or check box none/denies. If patient was previously admitted within last 2 years you may refer to "clinical circumstances" for past history. Use this section for updated information. Update the "clinicals" with any new information.
22. Document by checking yes/no box for alcohol use and write in amount per day.
23. Document by checking yes/no box for substance use and write in explanation if answer is yes.
24. Document by checking yes/no box for caffeine intake use and write in amount per day.
25. Document by checking yes/no box for tobacco use. Circle whether information applies to patient or family member. Family member information is taken when the patient is a non smoker. Check off type of tobacco. Document how many years and amount per day. If they have discontinued use of tobacco document when they stopped.
26. Check yes/ no for recent exposure to communicable disease within the past month. If yes, explain. Check for any travel outside US within last 6 months.
27. Check if history of MRSA/VRE. If yes, explain.
28. Check off yes or no to blood transfusion reaction, reaction to anesthesia, cortisone use or family history of reaction to anesthesia. If any are yes, then explain.
29. Sign name, date and time when information obtained if completing. If already complete, sign name, date and time when information was reviewed.
30. For all pediatric patients complete this section in addition to above. If not pediatric patient then leave blank.
31. SDS/PAT: completed by PAT nurse if patient was admitted via SDS, otherwise leave blank.

Initial Physical Assessment

32. Review/assess patient for all parameters listed under each assessment category. If all statements in category are true then check off the within normal limits (WNL) box. If any part of the category has a deviation then list all the exceptions noted to that particular assessment.
33. Pediatric information: to be assessed on all pediatric patients. If the patient does not meet pediatric criteria, then those assessments will not be done. Checking off WNL box or exception for the adult patient would mean only the adult portion of the assessment was completed, though the pediatric criteria is listed as well.
34. Answer any questions within the assessment category that are pertinent to the particular patient. (pediatric patient, adult patient, male or female)
35. Sign, date and time assessment.

Implantable Devices

36. Check off either yes or no for each device listed. If the answer is yes then write in the location of the device. If the patient has a device that is not listed, add the information under "other". Identify the type of device and location.

Braden Scale/Pressure Ulcer Assessment

37. Assess the patient for pressure ulcer risk. Under each category assess and circle the point value associated with the assessment findings. Total all 6 categories. Write in the total number where indicated.
38. If a pediatric patient, check off the NA box.
39. If the total points are equal or less than 14 then the prevention protocol needs to be implemented. Check off the box indicated. If the score is greater than 14 then check off the "no" box that indicates the protocol did not need to be implemented.
40. Assess the skin. Check off whether the patient's skin is intact, has a lesion, pressure ulcer or any other type of skin deviation.
41. If the skin is not intact, describe deviation, mark the site on the figure. If a pressure ulcer, mark the figure and add the letters "PU" to further clarify that it is a pressure ulcer. All pressure ulcers must be measured and staged on admission unless dressing is covering it and it is not to be removed. In that case, stage and measure pressure ulcer with next dressing change.

Fall Assessment

42. Assess the patient for potential fall risk using the fall assessment tool. Circle all categories that are applicable to the patient at the time of assessment.
43. Total the points and enter the value.
44. If the patient total score is 25 or greater, Check off the fall prevention program was implemented. If the patient score is considered low risk then check off "no" the prevention program was not implemented. Chart all intervention implemented in nurses notes.
45. Sign, date and time assessment

Pain Assessment (ACUTE)

46. Ask the patient if they are currently having pain. If no, check no box and proceed to next pain section. If yes, check the yes box and continue the pain assessment. Check off all appropriate boxes that describe the patient's pain assessment. (location, intensity, scale, type, duration and pain relief)

Pain Assessment (CHRONIC)

47. Ask the patient if they are having pain that is not related to this admission. This is usually described as some type of chronic pain. If no, then the section is completed. If yes, check appropriate box. Continue to complete the rest of the assessment.

Functional Health Lifestyle information

48. Enter the number of hours a night the patient averages for sleep.
49. Continue to ask the rest of the questions in the section. Only if the patient answers yes, does there need to be an explanation.
50. Peds only: Only complete if the patient meets the criteria of pediatrics. Complete all information related to sleep pattern. Check off yes or no for bed wetting and sleep walking
51. Check the box after patient has been instructed on plan of care. This is for all patients. Complete this after you have assessed the patient and informed them about their plan of care.
52. Check appropriate box for understanding of the plan of care.

Nutritional Screening

53. The Nutritional screening is completed by the Nursing Staff on all patients. If yes to any of the questions, a Nutrition Consult is required.
54. RN to sign, date and time for information completed to this point on page 4.

Home Environment

55. Check off all appropriate boxes related to home environment.

Abuse

56. All patients will be screened for abuse by asking if the patient if they have been abused, if they any concerns about their safety in returning home and if the anyone has withheld or prevented them from obtaining food , shelter, medical care or if any one has taken their money without their permission. Only if yes, explain and refer to the Abuse Policy.

ADL's

57. ADL's: Either check off independent or check off all that the patient needs assistance with. If the patient needs assistance then check off whether or not this is new onset or chronic.
58. Sign, date and time completion of this section.

Patient Belongings and Medical Equipment Usage

59. Review the list of personal/medical equipment listed. Check yes or no to each individual item. This assesses whether or not the patient uses/needs the equipment.
60. In the third column, check off yes or no for each item assessing whether or not the patient actually has the device/devices with them for this hospital stay.
61. List any comments in fourth column. Such as if any equipment is noticeably damaged or not functioning properly.
62. Personal valuables; Describe in generic terms all the items the patient has with them.
63. In the next column check yes or no if the patient is leaving the valuables at the bedside.
64. Only if the patient is not leaving the valuables at the bedside, check off where the items went. (Either Home (H) or the safe (S))
65. If items went to the safe, check off the box that states "valuables deposited in the hospital safe" and write the receipt number of the envelope it was put in.
66. If the patient/family has brought medication in from home. Send medication home. If unable, send to pharmacy. Chart disposition of medication.
67. Have patient or their representative sign the valuable sheet after it is completed. Their signature is confirmation of what they have left at the bedside, what they have sent home or what they have sent to the safe.
68. Employee completing this section also signs and dates.

Referral and Discharge Planning

69. Look at each referral category. Under each category check off all that apply to the patient's current status.
70. If any box is checked off, check the “yes” box - referral needed.
71. If no box is checked off within a category, check off "no need identified" box
72. If a referral is needed, generate this nursing assessment/screening via the computer to the individual department. This is not a physician order.
73. After the department receives the request, they will sign and date their appropriate section.
74. The RN will sign this section at the bottom. This signature means you have addressed each category and identified whether the patient needs an interdisciplinary screening. This is not assessing that the interdisciplinary team will continue to see the patient for hospital stay.