Section:	Division of Nursing	**********	Index:	7420.005a
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HACKETTSTOWN REGIONAL MEDICAL CENTER

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OR
(Scope)

TITLE: **ADMISION OF PATIENT TO OR BY RN**

PURPOSE: To ensure continuity of nursing care for surgical patients. To outline procedure for admitting a patient to the OR by an RN.

EQUIPMENT LIST:
1. Patient's chart
2. OR schedule

CONTENT:	**PROCEDURE STEPS:**	**KEY POINTS:**
Interview Patient	1. Greet patient and support person. Identify self.	Develop rapport between patient, family and OR nurse.
	2. Ask his/her name and check name and number against: a. arm band b. addressograph plate c. chart	Determine proper identification of patient.
	3. Verify allergies,	
	4. Verify NPO status.	
	5. Check if patient is wearing contact lenses, hearing aid, jewelry or any body piercing.	Remove if necessary.
	6. Ask patient if he/she has any loose teeth, capped teeth or dentures.	Warn anesthesiologist concerning loose capped teeth. Dentures must be removed.
	7. Ask patient if he/she has removed undergarments (if applicable).	
	8. Verify procedure with patient, OR schedule, and pre-op orders.	In the event that an appendage is involved, or a body area that could be right or left –consent, H&P, and patient must all be in agreement.
	9. Verify procedural/surgical verification form is on patient's chart and pertinent information is completed.	

Obtain Data Base from Chart	1. Read operative consent for completeness and validity.	Make sure that any lab work, medications, x-rays, medical clearance, etc., ordered is present in chart.
	2. Check any other consents for completeness and validity (administration of blood, support person for C-section, etc.).	Important for positioning of patients.
	3. Check for history and physical.	Loss of hearing or sight may affect communication with patient.
	4. Read pre-op orders.	Allay fears or apprehensions of patient and family.
Assess Patient Need	1. Determine mobility of body parts.	Careful handling of lines and catheters. Absence of these may require planning for insertion. Check IV's for patency and fluid levels.
	2. Note sensory impairments.	Patients may require careful planning for placement of cautery, positioning, temperature control, etc.
	3. Determine knowledge level, perception of surgery, ability to understand.	Ensures continuity of care.
	4. Note presence of IVs, catheters.	Alerts physicians to potential problems.
	5. Assess general physical status of patient.	Sending unit will be notified to correct deficiencies before the surgery begins.
Documentation/ Communication	1. Communicate physiological data relevant to planning patient's care to all team members.	**OR patient identification.**
	2. Report deviations of diagnostic studies to anesthesiologist and surgeon.	
	3. Report deficiencies of chart to OR Manager or Unit coordinator.	
	4. Document on operative record that patient has been checked into the OR.	

Reference: AORN Standards, Recommended Practices, and Guidelines (2004) Edition