Admission: Adult History In-patient

Site Applicability

All VCH, PHC, & PHSA sites that use Cerner.

NOTE: Implementation only at Lions Gate Hospital & Squamish General Hospital to support CST Go Live.

Practice Level

Basic skill for the following professions within their scope of practice:

RN, RPN, LPN, ESN and student nurses.

Scope

Assessment of patient on admission to inpatient care unit; Includes admitted ED patients.

Need to Know

- A nursing initial assessment is to be completed within the shift of the nurse admitting the patient.
- The nursing initial assessment includes the completion of a baseline status prior to admission, communication data (language, vision, hearing, etc.) and required screening tools as well as a physical assessment (including height and weight).
- Some information may already be completed from previous encounters or from documentation previously on this visit. Verify this information and complete other initial assessment components.
- If the patient is being transferred from another unit or area, review the Handoff Tool or other transfer form, verify and complete any assessment requirements that are not already done.
- Provide patient and family with orientation to the clinical area including:
  - How to get help from staff (call bell)
  - General unit layout
  - Any special unit 'rules" or expectations
  - Bathrooms
  - Bed functions
  - Phone/TV etc.
- Initiate referrals to allied health as applicable (e.g. dietitian)
- Document patients stated goals and any preferences in the health record as applicable
- Contact Physician/NP with any concerns related to the admission assessment
- Activate or update any Process Alerts that arise from assessments on screening tools (e.g. Fall Risk, Violence Risk)

Documentation

Fields in the admission assessment are completed as applicable

Information *Information remains in the record across encounters	Action (s) Required
Screen patients for risk using the appropriate trigger questions and screens	• Violence Risk • Advance Care Planning/Substitute Decision Maker • Prescription Drug and Substance Use • Tobacco Use - Nicotine Dependence Assessment • Dysphagia Risk • Columbia Suicide Severity Rating Scale-if applicable • Skin/Wound Care (Braden Scale) • Alcohol or Drug Withdrawal (CAGE-AID) • Falls Risk • Delirium Risk
Subjective	Patients own report of their physical condition, functional and emotional status (e.g. pre-hospital function)
Problem History*	Review list of patient problems (past medical history) from past encounters and stated history.
Medication History*	Complete list of patient medications from past encounters stated history. Add/Validate/Review patient's Best Possible Medication (BPMH) if not already completed for this encounter
Family History	Review relevant historical information where available. Validate and record past family history by selecting 'Mark as Reviewed'
Allergies	Allergy information which includes allergies, contraindications, intolerance and side-effects are captured in the CST Cerner Allergy Control or on approved paper forms. Refer to the Allergy Policy.
Immunizations	Record immunization status with focus on tetanus, influenza and pneumococcal vaccines. If patient is missing immunizations, document reasons for missing immunizations, if known.
Procedure History	Complete list of patient procedures from past

Information *Information remains in the record across encounters	Action (s) Required
	encounters and previously in this encounter Add historical procedures as necessary.
Anesthesia/ Sedation	Record prior anesthesia experience including any prior reactions. Review, complete and 'mark as reviewed'. Every patient scheduled for OR or likely to require surgical interventions must have the Anesthesia/Sedation section completed.
Transfusion	Contains blood related product transfusion reaction and consents.
Nutrition	Captures patient information related to diet, feeding ability, specialized equipment, weight and dental hygiene. All patients with difficulties chewing, swallowing, or with loose teeth or no teeth to be screened for dysphagia and/or malnutrition.
Functional	Review patient's baseline health status prior to acute event on admission. All patients with a fall within the last year or have any mobility/ADL challenge require a Falls Assessment (MORSE). Refer to Falls Guidelines for your specific health authority on SHOP
Living and Resources	Patient's baseline living conditions and support system prior to the event that brought them to receive care
Social History*	Obtain patient's social history including tobacco, alcohol or substance use. Review and validate information with patient if clinically relevant to this admission and/or clinical role.
Psychosocial/ Spiritual	Collect baseline information
Education Needs	Identify any education needs based on admission assessment
Discharge Needs	Obtain information about patient's needs upon discharge.

Related Documents

- CST Documentation Policy
- Allergy Policy
- Falls Guidelines (SHOP)

References

Accreditation Canada (2011). https://accreditation.ca/

Elsevier Clinical Skills, (2017) Admission. St. Louis, MO. Elsevier. Retrieved January 24 2018 from www.elsevierskills.com.

Definitions

Clinically relevant: Having a sensible or logical connection and benefit to the patient's health status based on assessment, medical treatment, observation, diagnosis and/or identified by the patient themselves.

Encounter: Describes a particular instance when a patient is registered within the healthcare system (e.g., hospital, clinic, daycare, homecare, or any other department where they receive service). It is a single patient interaction such as patient registered as inpatient or patient registered as outpatient.

Problem/Problem List: A list of all previous problems and chronic diagnosis, etc. (i.e., all conditions that are inherent to the patient, but not the specific diagnosis for the current visit). For example: a patient has diabetes, but is here for an appendectomy. Their diagnosis is appendicitis and diabetes goes onto their problem list. A problem can be an active problem or a history of something resolved.

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			To Support Cerner Go Live
Owners: *(optional)*	PHC	PHSA	VCH
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