ADMISSION DOCUMENTATION

When admitting a patient, there are multiple documents need to be completed. The following is a list of ***required documents*** for admission:

- 8 E-forms labeled 1/8 thru 8/8 under category "**MPH-ADMIT PKG**".

Category	Title
MPH-ADMIT PKG	1/8 INITIAL ASSESSMENT/SCREENING
MPH-ADMIT PKG	2/8 PRESENT ON ADMISSION FORM
MPH-ADMIT PKG	3/8 MRSA ADMISSION/DISCHARGE SCREENING
MPH-ADMIT PKG	4/8 VENOUS THROMBOEMBOLISM (VTE) ASSESSMENT
MPH-ADMIT PKG	5/8 ADULT VACCINE SCREENING ORDER FORM
MPH-ADMIT PKG	6/8 BELONGING TRACKING RECORD
MPH-ADMIT PKG	7/8 INTERDISCIPLINARY PATIENT FAMILY EDUCATION REC
MPH-ADMIT PKG	8/8 INTERDISCIPLINARY PLAN OF CARE

- MS/Tele: Assessment Flowchart (Med-Surg and Telemetry)
- MS/Tele: Vital Signs, I&O, and ADL (Med-Surg and Telemetry)
- ICU: Assessment Flowchart (ICU)
- ICU: Vital Signs and I&O Flowchart (ICU)
- OB/GYN: Postpartum Assessment Flowchart (Postpartum)
- OB/GYN: Postpartum VS, I&O, Activities FC (Postpartum)
- Newborn: Assessment Flowchart (Postpartum)
- Newborn: Vital Signs and I&O Flowchart (Postpartum)

Reminder
Meaningful use is **EXTREMELY IMPORTANT** when doing electronic documentation. If the field is required by meaningful use, it is equally important as required by the Joint Commission. Remember to complete the field properly.

E-Form: “*1/8 INITIAL ASSESSMENT/SCREENING*”

1. *Admission Decision Date and Time* are **required fields** for meaningful use and should be automatically populated.
   For direct admit patients, please document the admission decision date & time according to the admission order written time OR the time the patient arrived in the hospital. Information may be obtained from admitting department.

2. Complete the patient’s vital signs, height & weight, and allergy information fields. **No exception**.

VITAL SIGNS

Vital Signs

Temperature	Pulse	Respiration	Blood Pressure	O2 Saturation
97.6 ORAL	72 RADIAL	20	118/70 R ARM LYING	98

Signs: New

HEIGHT & WEIGHT

Height & Weight: 123 lbs oz 55.79 kg 55791.9 g in 0.01 m2 Bed Scale

Height & Weight: New

ALLERGY / REACTION

ASPIRIN		No Known Drug Allergies	
WHEAT			

3. If any referral is indicated on initial screening place a call to appropriate department accordingly.
4. **Medication Reconciliation** can be accessed by clicking the link on the *Initial Assessment/Screening* E-form. The Medication Reconciliation Application will open automatically. Please see the section below for further instruction to complete the Medication Reconciliation.

MEDICATION RECONCILIATION

Click Here for Medication Reconciliation

5. Initial assessment needs to be signed or cosigned by a RN.
6. Nurses must type in their first initial, last name, and credential (i.e. J. Doe, RN) at the bottom and/or the end of the forms along with date and time. Date and time format should be MMDDYY and HHMM. No dash, no slash. Example: 101012 for October 10th 2012.

Information obtained by: T. LVNurse, LVN Date: 103112 Time: 1000

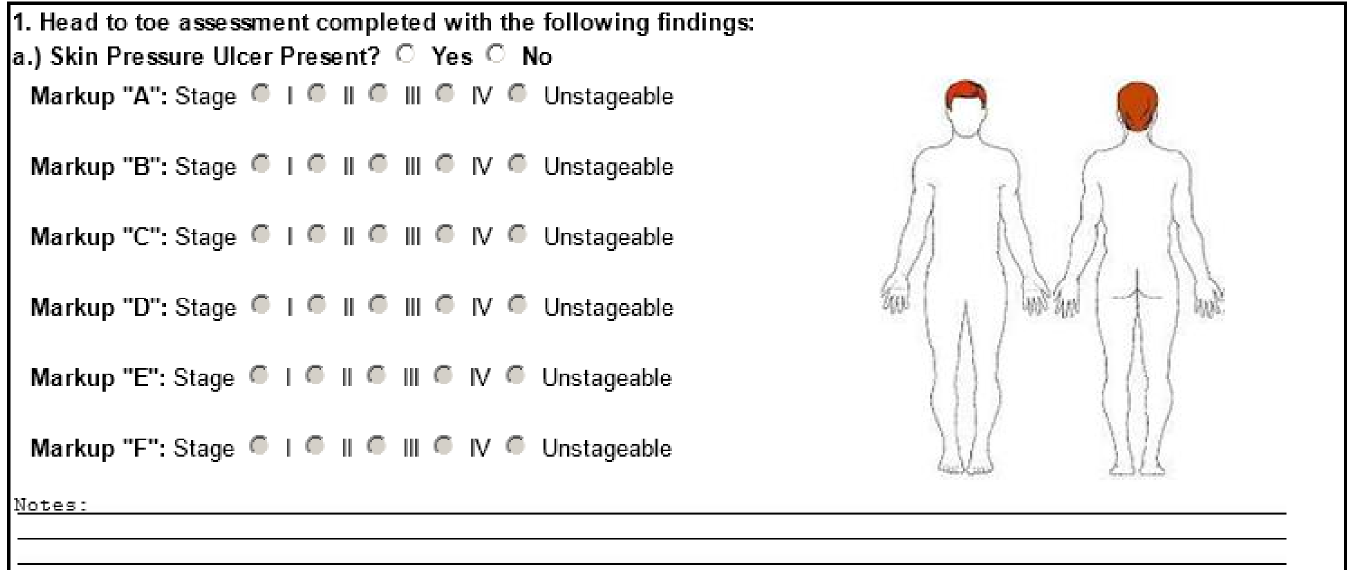
Assessment completed by: T. RNurse, RN Date: 103112 Time: 1100

*** Disclaimer: Above signature identifies the author / responsible party who takes ownership of and attests to the information contained in a record entry or documentation.*

E-Form: “*2/8 PRESENT ON ADMISSION*”

1. Document all the Pressure Ulcer, Central Line, Urinary Catheter, and other drains present on admission.

2. Use the mark-up diagram to document the location of the pressure ulcer. Stage the pressure according to the markup alphabets.



1. Head to toe assessment completed with the following findings:
a.) Skin Pressure Ulcer Present? ○ Yes ○ No

Markup "A": Stage ○ I ○ II ○ III ○ IV ○ Unstageable

Markup "B": Stage ○ I ○ II ○ III ○ IV ○ Unstageable

Markup "C": Stage ○ I ○ II ○ III ○ IV ○ Unstageable

Markup "D": Stage ○ I ○ II ○ III ○ IV ○ Unstageable

Markup "E": Stage ○ I ○ II ○ III ○ IV ○ Unstageable

Markup "F": Stage ○ I ○ II ○ III ○ IV ○ Unstageable

Notes:

3. Print out the E-form for physician signature and place in the patient’s chart unless sign electronically through the signature pad.

4. If Pressure ulcer/wound present on admission then **MUST** initiate the following:
    a. Pressure ulcer/ wound care physician order form (paper)
    b. Skin Care documentation record (E-Form)
    c. Photo documentation (paper) - Take pictures as per policy

E-Form: “3/*8 MRSA ADMISSION/DISCHARGE SCREENING*”

1. Follow the instruction on the E-form. If MRSA screening shows high risk, collect cultures as indicated.

E-Form: "*4/8 VENOUS THROMBOEMBOLISM (VTE) ASSESSMENT & PROPHYLAXIS ORDER*"

1. Follow the instruction on the VTE Assessment E-form.

2. The 2nd page contains physician order, please **print unless electronically signed**.

3. If medication is ordered, print and fax signed order to pharmacy.

PHYSICIAN ORDERS

PHYSICIAN ORDER MUST BE PRINTED UNLESS ELECTRONICALLY SIGNED.
IF MEDICATION IS ORDERED, PRINT & FAX SIGNED ORDER TO PHARMACY.

Total Points	Incidence of VTE	Risk Level	Recommendations
☐ 0-1	2%	Low	*SCD or Heparin* **OR** *SCD + Heparin*
☐ 2	10%	Low - Moderate	*SCD or Heparin* **OR** *SCD + Heparin*
☐ 3-4	20 - 40%	Moderate	*SCD or Heparin* **OR** *SCD + Heparin*
☐ 5 or greater	40 - 80%	High	*Enoxaparin* **OR** *Enoxaparin + SCD*

☐ **No prophylactic treatment at this time; Reason:**

2008 ACCP Recommended VTE Prohyplaxis for Acutely Ill Medical and Critical Care Patient

☐ **Sequential Compression Device (SCD)**
(Grade 1A - suitable for high risk bleeders, anticoagulant contraindicated)** MUST DOCUMENT IN CHART
AUTOMATIC ORDER ON ALL PATIENTS WHO SCORE 3 POINTS OR ABOVE UNLESS CONTRAINDICATED

☐ **Heparin 5000 units SubQ q8h**
(Grade 1A - suitable for medical patient, critical care patient with moderate VTE risk)

☐ **Enoxaparin SubQ once daily** Dose ◯ 40mg ◯ 30mg (CrCl < 30ml/min)
If spinal/ epidural catheter is present or was removed recently, start 24 hours after catheter is removed
(Grade 1A - suitable for medical patient; critical care patient with high VTE risk;
REQUIRED for hip, knee, colorectal surgical patient regardless of score)

MD Giving TO: ______ RN/LVN Read Back TO ______ Date ____ Time ____
(Signature attests that orders were Read back to the physician/prescriber)
Nurse Noted ______ Date ____ Time ____
24 Hr Chart Check by Nurse ______ Date ____ Time ____

PHYSICIAN SIGNATURE ______ Electronic Signature
Date ____ Time ____

E-Form: “*5/8 ADULT VACCINE SCREENING ORDER FORM*”

1. Unless the patient does **NOT** meet the criteria for the influenza or pneumococcal vaccine, **THE ENTIRE FORM MUST BE PRINTED**.

2. Follow instruction on the E-form to screen patient.

3. Document the administration on the 2nd page of the E-form, and it also serves as the vaccine information for patient.

ADMINISTER BY DAY OF DISCHARGE

☐ Pneumoccocal Polysaccharide Vaccine 0.5ml intramuscularly year round	☐ Influenza Vaccine 0.5ml intramusculary year round
☐ Pt refused to receive vaccine upon D/C	☐ Pt refused to receive vaccine upon D/C
Vaccine Manufacturer:	Vaccine Manufacturer:
Nurse Signature:	Nurse Signature:
Date: Time:	Date: Time:
Lot Number:	Lot Number:
Expiration date:	Expiration date:
Site:	Site:

EDUCATION SHEET - ENTIRE FORM MUST BE PRINTED AND GIVEN TO ALL PATIENTS RECEIVING VACCINATION

Pneumococcal Disease is a serious sickness that causes death. Pneumoccocal disease can lead to serious infection of the lungs (pneumonia), the covering of the brain (meningitis) and the blood (bacteremia). About 1 out of every 20 people who get pneumococcal pneumonia die from it, as do about 2 people out of 10 who get bacteremia and 3 people out of 10 who get meningitis. People with special health problems mentioned below are even more likely to die from the disease.

INDICATION:

1. Adults ages 6 - 64 with with chronic heart, lung, renal, metabolic or HIV disease.
2. Adults with damaged spleen and/or no spleen, Hodgkin's disease, multiple myeloma, lymphoma, leukemia.
3. 65 years and older who are otherwise healthy.
4. Immuno-compromised individuals (except bone marrow transplant less than 12 months)
5. Adults age 19-64 years old with asthma.
6. Individuals who received 1st vaccine were less than 65 years old and 1st dose was more than 5 years ago.

CONTRAINDICATIONS:

1. Allergic reaction to pneumococcal vaccine in the past.
2. History of idiopathic thrombocytopenia purpura.
3. Currently undergoing chemotherapy or radiation therapy.
4. Pregnant women
5. Bone marrow transplant within the last 12 months
6. Children 6 years of age who received a conjugate vaccine within the last 8 weeks

E-Form: “*6/8 BELONGING TRACKING RECORD*”

1. Complete Patient Belonging E-Form and have patient or family member to sign

2. Print to give a copy to patient or family member

The undersigned certifies that he / she agrees with the items named/listed above. It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for loss or any damage. The maximum liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

Patient/Family/SO Signature (Required):

PRINT NAME: Relationship: Date: Time:

ER Nurse / Tech Signature: Date: Time: Room #:

Admitting Floor Nurse Signature: Date: Time: Room #:

E-Form: “*7/8 INTERDISCIPLINARY PATIENT FAMILY EDUCATION RECORD*”

1. The E-form contains the exact same information as the paper form.

2. Follow the instruction and complete the E-form as the paper form.

3. Sign at the bottom of the form.

E-Form: “*8/8 INTERDISCIPLINARY PLAN OF CARE*”

1. The E-form contains the exact same information as the paper form.

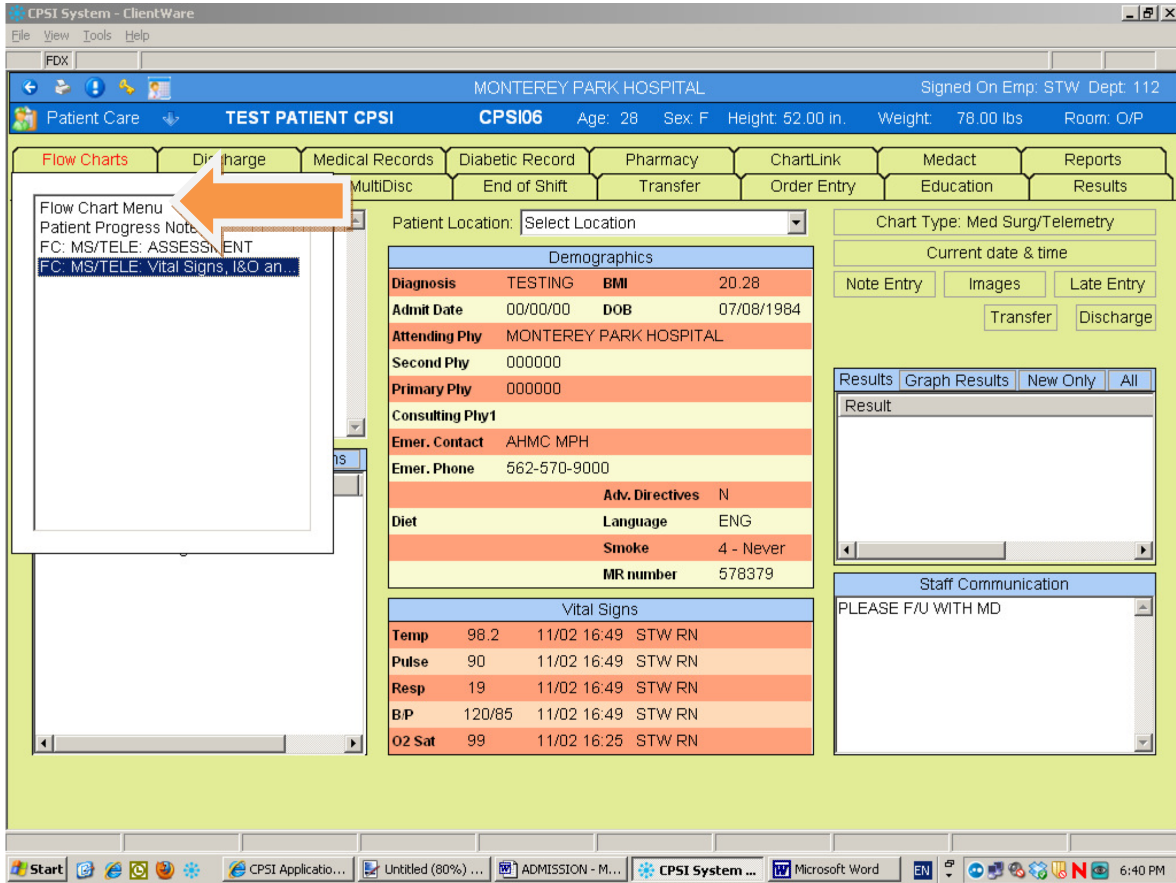
2. This E-form has been broken down into 14 pages, and each page is for one category. Use the left and right green button to navigate this form.

3. Follow the instruction and complete the E-form as the paper form.

4. Sign on Page 14.

Physical Assessment

1. Physical Assessment is documented under the flowchart.
2. Open the flowchart by clicking “Flowchart” Tab and select “Flow Chart Menu”



3. Select “**Initial**” to indicate this as Initial Assessment. Answer all the appropriate questions that apply to the patient to complete the head-to-toe assessment.