

	Procedure Number: PR008-364
	Effective Date: 012/12/2011 <i>Updated 12/14/2021</i>
	Title: Admission of the Adult Patient

<p><b>SCOPE</b> (choose from: District wide, Family Medicine, Hospice, Hospital):  <b>Hospital</b></p>
<p><b>LEVEL</b> (any departments within service areas that the procedure applies to):  <b>Acute Care Department</b>  <b>Surgery Department</b>  <b>Emergency Department</b></p>
<p><b>POSITION(S) RESPONSIBLE:</b>  <b>RN's/LPN's</b>  <b>ED Tech's</b>  <b>NA-C's</b>  <b>Unit Secretaries</b></p>
<p><b>PURPOSE:</b>  To document in the patient electronic medical record</p>

**PROCEDURE:**

1. Greet patient by name and introduce yourself and other staff present.
2. Confirm the patient's identity using two patient identifiers. Verify the name and its spelling with the patient. Notify registration of any corrections.
3. Quickly review the practitioner's orders. Note Admit Decision Date and Time in Admission Assessment under Handoff. Note the reason for admission in the patient's own words, use quotation marks.
4. Escort the patient to their room. If they are not in great distress, introduce them to their roommate, if they have one. Wash your hands and help the patient change into a gown or pajamas; if they are sharing a room, provide privacy. Itemize all valuables, clothing, and prosthesis on the Patient Belongings assessment. Encourage the patient to store valuables or money in the locked drawer in the nurses' medication room or, preferably, to send them home along with medications they may have brought.
5. Obtain a complete list of the patient's current medications and dosages if not previously obtained. Verify this list in the patient's chart under Summary/Home Medications. Make any necessary changes.

 <b>Klickitat Valley</b> —HEALTH—	Procedure Number: PR008-364
	Effective Date: 012/12/2011 <i>Updated 12/14/2021</i>
	Title: Admission of the Adult Patient

6. Take and record the patient’s vital signs, and collect ordered specimens. Measure their height and weight if possible. If the patient can’t stand use the Hoyer lift or Sit-to-Stand with scale.
7. Show the patient how to use the equipment in the room. Be sure to include the call system, bed controls, television controls, telephone, lights and location of bathroom.
8. Explain the routine. Mention when to expect meals, vital signs checks, and medications. Review visiting hours and restrictions.
9. Take a complete patient history using the appropriate assessment and intervention forms to complete the admission assessment. Be sure to answer all applicable questions in the form.
10. Record any allergies in the Allergy/AdvReac section of the electronic medical record located under Summary.
11. Open any additional worklist forms as needed to complete a thorough assessment).
12. After assessing the patient, inform them of tests that have been ordered and when they are scheduled. Describe what they should expect.
13. Complete the Advanced Directive documentation located in the patient’s electronic medical record.
14. Complete the Pneumonia/Influenza documentation located in the patient’s electronic medical record.
15. Record Immunizations: Flu/Pneumonia, TDap documentation in the patient’s electronic medical record.
16. Be sure all boxes are answered in the demographics portion of the electronic medical record.
17. Place at least four problems in the Plan of Care.
18. Before leaving the patient’s room, make sure the communication board in completed, the patient is comfortable and safe. Return the bed to the low position; turn on bed alarm (if applicable). Place the call button and other equipment (such as water cup, emesis bag and facial tissues) within easy reach.



**Klickitat Valley**  
—HEALTH—

Procedure Number: PR008-364

Effective Date: 012/12/2011

*Updated 12/14/2021*

Title: Admission of the Adult  
Patient