Patient Admission Process

Central Nursing Orientation
2012

Prepared by
Day 2 Facilitators
Objectives

Review process for completing:
1) Initial patient assessment/nursing history
2) Allergy record
3) Medication Reconciliation
4) Braden Scale
5) Antibiotic Resistant Organism (ARO) screening
6) Resuscitation/End-of-Life Care Plan
7) Fall Risk Assessment
8) Discharge Policy
Admission Checklist: Complete within 24 hours of admission

- Change patient identification band
- Apply allergy band (if necessary)
- Initial patient assessment/nursing history
- Valuables/belongings
- Allergy History and Allergy Record
- Medication History/Medication Reconciliation
- Braden scale
- ARO screening
- Resuscitation/End-of-Life Care Plan
- Fall Risk Assessment (signage + yellow armband)
- Discharge Planning
Getting Prepared….

• Review patient data at hand (e.g., patient care report, patient ‘s old health record)

• Clarify information

• Familiarize yourself with unclear diagnoses, surgeries, etc.

• Prepare patient environment as able
Once the patient arrives…

- Ensure a comfortable and private environment for interview

- Settle the patient

- Does the patient want family members present for support?
Nursing History Forms

• Two main adult nursing history forms
  • VH & UH

• Specialty programs have augmented versions of standard nursing history forms
  • E.g. Psychiatry, Obstetrics, Paeds
# Nursing History Forms

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**NURSING ADMISSION ASSESSMENT**

<table>
<thead>
<tr>
<th>Key</th>
<th>VNL - Within normal limits</th>
<th>N/A - Not applicable</th>
<th>NAP - Not a priority at this time</th>
<th>UTA - Unable to answer</th>
<th>* - Significant Findings</th>
</tr>
</thead>
</table>

**Admission Date**: ___________________________  **Time**: ____________  □ Planned  □ Unplanned

**Age**: ____________  **Mental Status**: ____________  **Languages Spoken**: ____________

**Ht**: ____________  **Wt**: ____________  **Vital Signs**: T ____________  P ____________  R ____________  BP(L) ____________ (S) ____________

**Allergies (drug, food, tape, dyes, latex, other)**: □ NKA

**Adverse Reaction**: ____________

**Allergy band on**: ____________

**Emergency Contact Name**: ____________  **Relationship**: ____________

**Phone No**: Permanent: ____________  Temporary: ____________

---

**NURSING CARE PLAN**  Dr. ____________  Notified: □ Yes  □ No

<table>
<thead>
<tr>
<th>DATE INITIATED (MM/DD/YY)</th>
<th>NURSING DIAGNOSIS/ COLLABORATIVE PROBLEM/OTHER</th>
<th>RING</th>
<th>EXPECTED PATIENT OUTCOMES AND DATE</th>
<th>PATIENT SPECIFIC NURSING INTERVENTIONS</th>
<th>INITIALS</th>
<th>DATE PERFORMED AND INITIAL</th>
<th>DATE REVIEWED AND INITIAL</th>
</tr>
</thead>
</table>

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**LONDON, ONTARIO**

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*Standard of Nursing Care*
Nursing History Forms

• To be completed within 24 hours of admission
  • One nurse can start it (e.g. middle of the night admissions) and nurse on next shift can complete
  • Must be completed before transferring patient from one unit to another
• Admission notes
  • record time, method of arrival, accompanied by whom if relevant, reason for admission and record all significant psychological findings. In the clinical progress notes
  • all other significant findings identified during the admission assessment are recorded as per unit
  • Includes reason why Nursing History not completed (if applicable)
Elements of a good nursing history

- Patient Information
- Allergy Assessment
- Chief Complaint/Reason For Admission
- Past Health History
- Current Home Medication List
- Personal & Social History
- Review of Systems
Identify Problems/ Potential Problems

- Take the time now to identify problems/ potential problems
  - May or may not be related to the chief complaint

- Document deviations from normal in the progress notes (UH) or on the Assessment and Intervention (A & I) flowsheet (VH)
Valuables/Belongings
Valuables/Belongings

- LHSC discourages patients from bringing valuables or excess belongings to the hospital
- Send home any valuables, unnecessary personal items, and home medications, which are not required while in hospital, with family/friend
- If unable to send home:
  - Valuables must be deposited in the Business Office
  - Home Medications are stored in designated locked area of the unit
- Refer to corporate policy for "Safekeeping of Patient's Valuables And Belongings"
Allergy Assessment
Ask about...

✓ all allergies, side effects and intolerances
✓ as well as reaction symptoms

• Drug
• Environmental
• Food
Definitions

- **Allergy**: An adverse reaction mediated by an immune response to a normally harmless substance
  - Anaphylaxis, hives, lip swelling

- **Side Effect**: an expected and known effect of a substance that is not the intended therapeutic outcome
  - Opioid induced constipation

- **Intolerance**: An increased sensitivity to a substance. Avoid or limit exposure. Can be managed if taken with food
  - Gastrointestinal upset after NSAIDS
What if the reaction type is unclear?

ERR ON THE SIDE OF CAUTION AND CLASSIFY IT AS AN ALLERGY
Documenting Allergies

- Allergies are ONLY documented on the Allergy Record
  - single multidisciplinary document for recording allergies

“One source of truth”
Electronic Record (Powerchart)

Allergy tab in PowerChart

- Read only for most nurses
- Ambulatory Programs: Emergency Department (ED), PreAdmission Clinics & the Renal Program, enter allergy information directly into PowerChart
- Reflects electronic information entered by Pharmacy/ED / PAC
- Any new allergies need to be communicated to a pharmacist to be added
- With any changes to allergy information – complete new allergy record and send to pharmacy
# Allergy Profile

**Active Allergy Profile (As of 2011/09/28)**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Reaction Symptoms</th>
<th>Comments</th>
<th>Last Updated By</th>
</tr>
</thead>
<tbody>
<tr>
<td>morphine</td>
<td>Nausea, Vomiting</td>
<td></td>
<td>Kiefer, Carol Mary-Jo (RN) on 2011/09/27</td>
</tr>
<tr>
<td>Plastic tape</td>
<td>Rash</td>
<td></td>
<td>Kiefer, Carol Mary-Jo (RN) on 2011/09/27</td>
</tr>
<tr>
<td>No Known Food Allergies</td>
<td></td>
<td></td>
<td>Kiefer, Carol Mary-Jo (RN) on 2011/09/27</td>
</tr>
</tbody>
</table>

*(end of report)*

Printed By: Deaville, Elizabeth Jane
Printed: 2011/09/28 11:35:27

Page: 1 OF 1
Allergy Record

Document here if no changes from electronic

Use this section for adding/updating allergy information or if new patient to LHSC

Always send Yellow copy to pharmacy

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ALLERGY RECORD

Allergies to be assessed include:
1. Drug
2. Food
3. Environmental agents (including latex, tape, contrast media)

See guidelines on reverse.

No Change in Allergy Information

☐ Allergy information confirmed as per current PowerChart Allergy Profile with NO CHANGES.
(as viewed in PowerChart and the attached Allergy Profile)

Printed Name/Signature: ___________________________ Date: __________ Time: __________

PROCESSED BY: ___________________________ DATE (YYYY/MM/DD): ___________________________
RN / RPN INITIALS: ___________________________ TIME: __________

OR

Allergy Information Not Previously Recorded or Requires Updating

☐ No Known Drug Allergies
☐ No Known Food Allergies
☐ No Known Environmental Allergies (including latex, tape and contrast media)
☐ Unable to Collect Drug Allergies
☐ Unable to Collect Food Allergies
☐ Unable to Collect Environmental Allergies

ADD (✓) CANCEL (✓) MODIFY (✓)

SUBSTANCE

REACTION TYPE
A = Allergy
G = Side Effect
I = Intolerance

REACTION / SYMPTOMS OR REASON FOR CHANGE

☐ Allergy information continued on next page.

Printed Name / Signature: ___________________________ Date (YYYY/MM/DD): ___________________________

PROCESSED BY: ___________________________ DATE (YYYY/MM/DD): ___________________________
RN / RPN INITIALS: ___________________________ TIME: __________
Allergy alert bracelet

• Allergy bracelets are to be placed on the patient's wrist

• Do not write allergies on armband

• Meant to “alert” HealthCare Provider of need to review allergies
MEDICATION RECONCILIATION

a good med history = no med mystery

Preventing Adverse Drug Events... one patient at a time
Medication Reconciliation – What is it?

- A formal process where an accurate and comprehensive medication list is communicated consistently across transition of care:
  - Admission
  - Transfer
  - Discharge

- ALL healthcare providers work together with patients, family members, or care providers in this process
MEDICATION RECONCILIATION

a good med history = no med mystery

Admission Process
**OVERVIEW**

**Step 1:** Create a BPMH

**Step 2:** Reconcile and create orders

**Step 3:** Compare & Report

---

### List Home Medications

- [ ] Family Doctor
- [ ] Specialist
- [ ] Community Pharmacy
- [ ] Other
- [ ] Medication Administration Record
- [ ] Discharge medications
- [ ] Form prior to the hospital
- [ ] Continues Drug Benefit Drug Profile Viewer
- [ ] Medications unavailable
- [ ] Patient family

### Reconciled admission medication orders

- [ ] Continue
- [ ] Modify
- [ ] Hold
- [ ] Discontinue

### Compare

- [ ] Initial medication history
- [ ] Date
- [ ] Time
- [ ] Order processed by
- [ ] Signature/designation
- [ ] Additional history information
- [ ] Date
- [ ] Time
- [ ] Signed by
- [ ] Signature/designation
- [ ] Preprinted name, college or medical director
- [ ] Signature/designation

---

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2012/12/21
### BEST POSSIBLE MEDICATION HISTORY (BPMH)

<table>
<thead>
<tr>
<th>HOME MEDICATION</th>
<th>DOSE / ROUTE / FREQUENCY</th>
<th>INH</th>
<th>INIT</th>
<th>RECONCILE</th>
</tr>
</thead>
<tbody>
<tr>
<td>atenolol</td>
<td>12.5 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>atorvastatin</td>
<td>10 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pantoprazole</td>
<td>40 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>methotrexate</td>
<td>12.5 mg po weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>acetaminophen</td>
<td>650 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>aspirin</td>
<td>81 mg EC po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>calcium carbonate</td>
<td>1.25 mg po BID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>glucosamine</td>
<td>500 mg po TID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>warfarin</td>
<td>1.5 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient weight:** 160 lb and height: 5'10"

---

**RECONCILED ADMISSION MEDICATION ORDERS**

Specify changes to HOME medications ONLY in section below.

- Decrease atenolol to 12.5 mg once daily due to low BP.

---

**Document rationale for any changes**

Prescriber signs and dates here

Reconcile home meds here
White copy is placed in the Patient Care Order section of chart after copied to Pharmacy.

Blue copy is placed at the front of the Patient Care Order sections.

Processer signs and dates here that the orders are processed.

Nurse signs and dates here when Page 1 is copied to pharmacy.

Unit Clerk/Nurse signs and dates here when Page 1 is copied to pharmacy.
**BEST POSSIBLE MEDICATION HISTORY (BPMH)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Start Date</th>
<th>Stop Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/12/21</td>
<td>Atorvastatin 10mg po daily</td>
<td>10mg po daily</td>
<td>q.d.</td>
<td>2012/12/21</td>
<td>2012/12/21</td>
<td>2012/12/21</td>
</tr>
<tr>
<td>2012/12/21</td>
<td>Metformin 500mg po tid</td>
<td>500mg po tid</td>
<td>t.i.d.</td>
<td>2012/12/21</td>
<td>2012/12/21</td>
<td>2012/12/21</td>
</tr>
</tbody>
</table>

**RECONCILED ADMISSION MEDICATION ORDERS**

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Start Date</th>
<th>Stop Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/12/21</td>
<td>Atorvastatin 10mg po daily</td>
<td>10mg po daily</td>
<td>q.d.</td>
<td>2012/12/21</td>
<td>2012/12/21</td>
<td>2012/12/21</td>
</tr>
<tr>
<td>2012/12/21</td>
<td>Metformin 500mg po tid</td>
<td>500mg po tid</td>
<td>t.i.d.</td>
<td>2012/12/21</td>
<td>2012/12/21</td>
<td>2012/12/21</td>
</tr>
</tbody>
</table>

**DOCUMENT FOLLOW-UP ACTIONS FOR NEWLY REPORTED HOME MEDICATIONS (Post Admission)**

- Atorvastatin 10mg po daily
- Metformin 500mg po tid

**ADDITIONAL HISTORY INFORMATION**

- Family History: No significant
- Allergies: None noted
- Medication Administration Record: No significant
- Discharge Instructions: None noted
- Medication Education: None noted
### BEST POSSIBLE MEDICATION HISTORY (BPMH)

**Source of Home Medication History**
- Family Doctor
- Specialist
- Community Pharmacy
- Other:
  - Medicare Administration Record
  - Discharge note:
  - Visit from prior institution
  - Ontario Drug Benefit Drug Profile Viewer
  - Medication vials/containers
  - Patient recall
  - Family

### POST ADMISSION MEDICATION FOLLOW-UP

- **Patient weight:** 180 kg, **height:** 158 cm
- **ACTUAL** or **ESTIMATE** (circle one)

### DOCUMENT FOLLOW-UP ACTIONS FOR NEWLY REPORTED HOME MEDICATIONS (Post Admission)

(e.g. discovered phenytoin 3rd day, Dr. notified, order received)

**Action Taken**

<table>
<thead>
<tr>
<th>HOME MEDICATION / DOSE / ROUTE / FREQUENCY</th>
<th>INITIAL</th>
<th>DETAIL ACTIONS TAKEN</th>
<th>INITIAL AND DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amiodarone 1 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atorvastatin 10 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium carbonate 1250 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium pantothenate 300 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atenolol 25 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ramipril 1 mg po daily</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sign and date:**
- Nurse signs and dates after reviewing BPMH within 24 hrs of admission
- Initial and date when prescriber is notified
- Document action taken with new information received

**Additions and changes documented on the BPMH**
All must be reported to prescriber for consideration.

**Sign and date when additional information received and documented**

---

**STEP 3:** Compare & Report

--

**Nurse signs and dates after reviewing BPMH within 24 hrs of admission**
MEDICATION RECONCILIATION

a good med history = no med mystery

Elective Surgery Admission
List Home Medications (RN or MD)

Write instructions for home meds prior to day of surgery

Original History obtained by:

APN/MD/Anesthesia to sign here

When pt returns, Surg Prep RN reviews/validates BPMH

Identify number of pages needed
Home Medication List captured in Preadmission Clinic

Reconcile home meds here post-op

Document rationale for any changes

Prescriber signs and dates here
Additions and changes documented on the BPMH
All must be reported to prescriber for consideration

Sign and date when additional information received and documented

Initial and date when prescriber is notified
Document action taken with new information received
Nurse signs and dates after reviewing BPMH within 24 hrs of admission
MEDICATION RECONCILIATION

a good med history = no med mystery

Transfer / Post-Op Process
**Transfer or Post-Operative Medication Orders**

<table>
<thead>
<tr>
<th>Location: U-6/A6-303/A</th>
<th>Patient: PharmNet, Helen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hi: 193.0cm As of: 2012/03/15</td>
<td>VISIT#: 420740000</td>
</tr>
<tr>
<td>Wt: 90.0kg As of: 2012/03/15</td>
<td>PIN: 11842236</td>
</tr>
<tr>
<td>Allergies: TEST, sensitivity</td>
<td></td>
</tr>
</tbody>
</table>

**All Medications must be Reconciled against Best Possible Medication History (BPMH)**

**Regular medication(s)**
- amlopidine 5 mg PO daily
- dabigatran 500 units / 0.2 ml SC DAILY
- tental 25 mg q4hr topical q2h
- HYDROMorphone CR 24 mg PO q12h
- perindopril 4 mg PO daily

**PRN medication(s)**
- acetaminophen 325-650 mg PO q6h PRN
- dexamethasone 0.1% OPH SOLUTION 1 drop ophthalmic q6h
- doxazosin 100 mg PO BID PRN
- ondansetron 4 mg PO q4h PRN
- oxyCODONE 10 mg PO BID PRN
- oxycodone 7.5 mg PO at bedtime PRN

**On hold medication(s)**
- codeine CR 50 mg PO q12h
- acetaminophen 325-650 mg rectal q4h
- nitroglycerin (0.4 mg/spray) SOLUTION 1 spray SL as directed
- sennosides 8.6-17.2 mg PO BID

**Provide rationale if any medications are modified/held/discontinued**
- Re- assessed pain
- Not required
- Patient can take med by mouth

---

**Reconciliation / Signature by Prescriber**

**Patient demographics**

**Reconcile hospital meds here**

---

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New medication orders

Reconciliation verification by Prescriber
Copy to pharmacy

Indicate each order has been processed

Nurse signs and dates once all orders have been processed

After form is completed by prescriber...

Original form is placed in the Patient Care Order section of chart after a copy is made for Pharmacy.
**Allergy Information**

Age: 80 Years  
DOB: 1931/04/03  
Sex: Male  
Location: U-4 A4-204-A  
Visit #: 420583541  
PIN:  
Admission Date: 2012/02/17 03:18  
Discharge Date: Not Discharged - Yellow  
Visit Type: Inpatient

**Flowsheet**

**February 25, 2012 10:52 - March 02, 2012 10:52 (Clinical Range)**

<table>
<thead>
<tr>
<th>Navigator</th>
<th>Results</th>
<th>2012/03/01 05:00</th>
<th>2012/02/28 15:35</th>
<th>2012/02/27 13:00</th>
<th>2012/02/27 12:48</th>
<th>2012/02/27 12:57</th>
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</thead>
<tbody>
<tr>
<td><strong>Chemistry</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sodium</td>
<td></td>
<td>L 128</td>
<td></td>
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<tr>
<td>Potassium</td>
<td></td>
<td>4.7</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chloride</td>
<td></td>
<td>L 90</td>
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</tr>
<tr>
<td>Bicarbonate (TCO2)</td>
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<tr>
<td><strong>Hematology</strong></td>
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<tr>
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<td>H 10.6</td>
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<tr>
<td>ERC</td>
<td></td>
<td>L 3.65</td>
<td></td>
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<td></td>
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<tr>
<td>Hemoglobin</td>
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<td>L 130</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>HCT</td>
<td></td>
<td>L 0.38</td>
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<tr>
<td>MCV</td>
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<tr>
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<td>346</td>
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<td><strong>Urine and Fecal Chemistry</strong></td>
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<td></td>
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</tr>
<tr>
<td>Leukocytes,U</td>
<td></td>
<td>#15</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sediment,U</td>
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<td>100</td>
<td></td>
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</tr>
</tbody>
</table>
MEDICATION RECONCILIATION

a good med history = no med mystery

Discharge Process
<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
<th>Dose:</th>
<th>Route:</th>
<th>Initial</th>
<th>Order Step:</th>
<th>Admin Time:</th>
<th>Status:</th>
<th>Provider:</th>
<th>Date:</th>
<th>Sign:</th>
</tr>
</thead>
<tbody>
<tr>
<td>norfloxacin</td>
<td>2012/03/15</td>
<td>400 mg</td>
<td>PO</td>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>2012/04/04</td>
<td></td>
</tr>
<tr>
<td>lansoprazole</td>
<td>2012/03/15</td>
<td>30 mg</td>
<td>PO</td>
<td></td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td>2012/04/04</td>
<td></td>
</tr>
<tr>
<td>omeprazole</td>
<td>2012/03/15</td>
<td>40 mg</td>
<td>IV</td>
<td></td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td>2012/04/04</td>
<td></td>
</tr>
<tr>
<td>famotidine</td>
<td>2012/03/15</td>
<td>20 mg</td>
<td>SQ</td>
<td></td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td>2012/04/04</td>
<td></td>
</tr>
</tbody>
</table>

**Prescriber Signature:**

Ahrens, Physician C0207

CPS0123456

CPS0 #

Printed: 2012/04/04 14:27

DO NOT TINN FROM CHART

Distribution: Original to go with patient on discharge. Place copy in Patient Care Order Section of Chart.
Narcotics and Controlled Drugs

Prescribe in accordance with CDSA

Prescriber must print their name. CPSO # & date on each page, then sign page
Home meds discontinued while in hospital will be written in this area. This provides an opportunity to reconcile and determine if they need to be restarted, modified or stopped. This is COMMUNICATION to clearly indicate to the patient and community pharmacist/next HCP what is to be done with medication taken prior to admission.

New medication prescriptions

Patient instruction or additional information

Prescriber signature

MD/Nurse signs med review completed with pt/family
Braden Scale
Braden Scale

• A clinically validated tool that allows nurses and other HCPs to reliably score a patient/client's level of risk for developing pressure ulcers
  • Also determines if patient is on correct therapeutic mattress

• Recommended by RNAO

• Completed on admission, every Thursday and with any changes in patient condition
**GUIDELINES FOR COMPLETION:**
- Assessment to be completed - within 24 hours of admission
- q Thursday
- Document date, total score and initials

<table>
<thead>
<tr>
<th>SCORE 1 POINT</th>
<th>SCORE 2 POINTS</th>
<th>SCORE 3 POINTS</th>
<th>SCORE 4 POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SENSORY PERCEPTION</strong></td>
<td><strong>COMPLETELY LIMITED:</strong> Unresponsive (does not moan, flinch or grasp) to</td>
<td><strong>VERY LIMITED:</strong> Responds only to painful stimuli. Cannot communi-</td>
<td><strong>SLIGHTLY LIMITED:</strong> Responds to verbal commands, but cannot</td>
</tr>
<tr>
<td><strong>MOISTURE</strong> (degree to which skin is kept moist)</td>
<td><strong>CONSTANTLY MOIST:</strong> Skin is kept moist almost constantly by perspiration, urine, etc.</td>
<td><strong>OFTEN MOIST:</strong> Skin is often, but not always moist. Linen must be changed at least once</td>
<td><strong>OCCASIONALLY MOIST:</strong> Skin is occasionally moist requiring an extra linen change approximately</td>
</tr>
<tr>
<td><strong>ACTIVITY</strong></td>
<td><strong>BEDFAST:</strong> Confined to bed</td>
<td><strong>CHAIRFAST:</strong> Ability to walk severely</td>
<td><strong>WALKS OCCASIONALLY:</strong> Walks occasionally</td>
</tr>
<tr>
<td><strong>NUTRITION</strong> (usual food)</td>
<td><strong>VERY POOR:</strong> Never eats a complete meal. Rarely eats more than 1/3 of any food</td>
<td><strong>PROBABLY INADEQUATE:</strong> Rarely eats a complete meal and generally eats</td>
<td><strong>ADEQUATE:</strong> Eats over half of most meals. Eats a total of 4 servings of protein</td>
</tr>
<tr>
<td><strong>FRICION AND SHEAR</strong></td>
<td><strong>PROBLEM:</strong> Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. S occasionally or almost constantly</td>
<td><strong>POTENTIAL PROBLEM:</strong> Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains good position in chair or bed</td>
<td><strong>NO APPARENT PROBLEM:</strong> Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times</td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

- **Very High Risk:** Total Score ≤ 9
- **High Risk:** Total Score 10 - 12
- **Moderate Risk:** Total Score 13 - 14
- **At Risk:** Total Score 15 - 18

**Initials**
## INTERVENTIONS FOR PRESSURE SORE RISK MANAGEMENT

<table>
<thead>
<tr>
<th>AT RISK (15-18)*</th>
<th>MANAGE MOISTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Frequent turning</td>
<td>• Use commercial moisture barrier</td>
</tr>
<tr>
<td>• Maximal repositioning</td>
<td>• Use absorbent pads or diapers that wick and hold moisture</td>
</tr>
<tr>
<td>• Protect heels</td>
<td>• Address cause if possible</td>
</tr>
<tr>
<td>• Manage moisture, nutrition and friction and shear</td>
<td>• Offer bedpan, urinal and glass of water in conjunction with turning schedules</td>
</tr>
<tr>
<td>• Pressure-reduction support surface if bed- or chair-bound</td>
<td></td>
</tr>
<tr>
<td>♦ If other major risk factors are present (advanced age, fever, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability) advance to next level of risk.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MODERATE RISK (13-14)*</th>
<th>MANAGE NUTRITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Turning schedule</td>
<td>• Increase protein intake</td>
</tr>
<tr>
<td>• Use foam wedges for 30° lateral positioning</td>
<td>• Increase calorie intake to spare proteins</td>
</tr>
<tr>
<td>• Pressure-reduction support surface</td>
<td>• Supplement with multi-vitamin (Should have Vitamin A, C &amp; E)</td>
</tr>
<tr>
<td>• Maximal repositioning</td>
<td>• Act quickly to alleviate deficits</td>
</tr>
<tr>
<td>• Protect heels</td>
<td>• Consult dietitian</td>
</tr>
<tr>
<td>• Manage moisture, nutrition and friction and shear</td>
<td></td>
</tr>
<tr>
<td>♦ If other major risk factors present, advance to next level of risk.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIGH RISK (10-12)</th>
<th>MANAGE FRICTION &amp; SHEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increase frequency of turning</td>
<td>• Elevate HOB no more than 30°</td>
</tr>
<tr>
<td>• Suppleimen with small shifts</td>
<td>• Use trapeze when indicated</td>
</tr>
<tr>
<td>• Pressure reduction support surface</td>
<td>• Use lift sheet to move patient</td>
</tr>
<tr>
<td>• Use foam wedges for 30° lateral positioning</td>
<td>• Protect elbows and heels if being exposed to friction</td>
</tr>
<tr>
<td>• Maximal repositioning</td>
<td></td>
</tr>
<tr>
<td>• Protect heels</td>
<td></td>
</tr>
<tr>
<td>• Manage moisture, nutrition and friction and shear</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VERY HIGH RISK (9 or below)</th>
<th>OTHER GENERAL CARE ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All of the above</td>
<td>• No increase or reddened bony prominences</td>
</tr>
<tr>
<td>+</td>
<td>• No do-rut type devices</td>
</tr>
<tr>
<td>• Use pressure-relieving surface if patient has intractable pain</td>
<td>• Maintain good hydration</td>
</tr>
<tr>
<td>OR</td>
<td>• Avoid drying the skin</td>
</tr>
<tr>
<td>• Severe pain exacerbated by turning</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>• Additional risk factors</td>
<td></td>
</tr>
<tr>
<td>♦ Low air loss beds do not substitute for turning schedules</td>
<td></td>
</tr>
</tbody>
</table>

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Refer to Therapy Mattress Selection Guide for surface appropriate bed interventions.
Beds at LHSC

• Hill–Rom is our vendor
• Standard hospital bed
  • Advanta® (newer version) or Advance® (older version)
  • <300 lbs.
• Zone Air®/VersaAir®
  • <300 lbs.
  • Pressure relief
• VersaCare®
  • Same as VersaAir® without a weigh scale
• **Flexicair Eclipse®/Envision®**
  - Rental low air loss therapy unit
  - Fits on standard bed frame
  - <300 lbs

• **TotalCare®**
  - ICU/CCTC bed exclusively
  - Max 300 lbs.

• **TotalCare® Bariatric Plus**
  - Max 500 lbs. LHSC owns 4

• **Excel®**
  - 500–1000 lbs.
  - Rental
ARO Screening
ARO Screening

All new admissions are screened for MRSA

MRSA sites – nasal, perianal, wound (open or draining; max of 2)

Then screened every 14 days while an inpatient
ARO Screening

If contact with positive patient (e.g. roommate), screen weekly x 3

Patients readmitted with a previous positive history will be screened

Prevalence screening will be determined by Infection Control

All precautions must be lifted by an Infection Control Practitioner
Medical Directive: GEN-2010-004  
Screening for Antibiotic Resistant Organisms Criteria - LHSC

### Admission Screening for MRSA and VRE

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>MRSA/VRE Admission Screening Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MRSA screening sites: nasal, perianal*, wound†</td>
</tr>
<tr>
<td></td>
<td>VRE screening sites: perianal*</td>
</tr>
<tr>
<td>All admissions</td>
<td>Overnight stay in any health care facility in the last 12 months</td>
</tr>
</tbody>
</table>

- Maternal/Child: ✓
- Pediatric: ✓
- All other Inpatient Units**: ✓
- Adult Mental Health: MRSA only, nasal swab only

### Additional Screening for MRSA and VRE

<table>
<thead>
<tr>
<th>Indication</th>
<th>MRSA/VRE Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult In-patient***</td>
<td>Q 14 day in-patient stay</td>
</tr>
</tbody>
</table>
| Contact of MRSA or VRE positive patient (e.g., roommate) | Once weekly x 3 weeks  
Discontinue screening if culture positive |
| Readmission of a patient with a MRSA and/or VRE positive history | Screen on admission |
| Increased prevalence or outbreak of MRSA and/or VRE | Screen as indicated by Infection Control |
| Screening for purpose of discontinuing precautions | Screen as indicated by Infection Control |

* Perianal or functioning end of GI tract (i.e., stoma). Immuno-compromised patients: ensure perianal swabs are not invasive
** Exclusions: Pediatric Mental Health
*** Exclusions: all pediatrics, maternal/child, adult/pediatric mental health, wound (open or draining, 2 max)
Collection of Swabs

Nasal swabs:
1. Moisten the sterile swab in the transport medium (clear gel).
2. Insert swab into nostril until all cotton is inside and resistance is felt.
3. Rotate swab so that all surfaces of the mucosa are contacted.
4. Insert the same swab into the other nostril and repeat steps.
5. Insert the swab into transport medium and label the specimen.

Swabs from other sites:
1. Moisten the sterile swab in the transport medium (clear gel).
2. Roll the swab at the site for 2-3 seconds.
3. Insert the swab into transport medium and label the specimen.
4. One perianal swab can be used for both MRSA and VRE.
Special Notes about ARO Screening

• Screening process is different for units deemed “in outbreak”

• Ask about prevalence screening on your unit
  • This may be done if in outbreak or to capture “trends”
Resuscitation/End-of-Life Care Plan
Resuscitation/End-of-Life Care

- Resuscitation/End of Life Care plan is completed as part of the admission process*

- Most Responsible Physician (MRP) will be notified if the patient indicates anything other than full resuscitation, or if the nurse makes an assessment that the physician needs to speak with Patient to clarify their wishes

- Resuscitation form will follow the Allergy Record in the patient record

- Process is recommended in some ambulatory (non-inpatient) areas
  - Programs will address individually, e.g. Dialysis
Resuscitation/End-of-Life Care Preparation & Self Awareness

Ask yourself:

• How do I need to prepare myself for this conversation with the patient?
• What would be important to me if I were the patient?
• How comfortable am I to be asked about my own care in the event that I myself should suffer an arrest?
• Have I thought through my own wishes? How do I feel about this issue?
Resuscitation/End-of-Life Care

Asking the question

- It is important to set the stage for the question by using a simple, clear explanation of resuscitation
Resuscitation/End-of-Life Care Examples

• How would you approach the conversation with these patients?

• A 40 year old woman (generally healthy) comes to pre-admit prior to a scheduled cholecystectomy
• An 80 year old woman who has suffered a fractured hip from slipping on ice. She is conscious and alert
• A 45 year old woman transferred to LHSC from a community hospital for a lung resection (cancer). She has no DNAR order on her record
Resuscitation/End-of-Life

A. Resuscitation plan has been discussed with Patient/Substitute Decision Maker (SDM) and their instructions are indicated below.

Name of SDM if applicable: 

Patient’s Resuscitation Wishes: (select one numbered choice by ✓ ticking appropriate box)

☐ Full Resuscitation - Start Emergency Response.

(If #1 deemed inappropriate, health care provider notifies Most Responsible Physician/Professional (MRP) / Delegate.)

☐ Default - Decision Deferred (default is full resuscitation). Review Date: ____________________________ (YYYY/MM/DD)

☐ Restricted Resuscitation.

(Notify MRP/Delegate who completes Section B below indicating Acceptable Interventions for Resuscitation).

☐ No Resuscitation - Allow Natural Death.

(Notify MRP/Delegate who completes Section C below indicating Acceptable End-of-Life Care Choices).

☐ MRP/Delegate Notified ____________________________ Date / Time: 2009/01/16 at 2030

Patient has written Advance Directive, Living Will, Paediatric Advance Treatment Plan (PATP) 

Printed Name of MRP/Delegate 

Dr. Adams

☐ Copy in Health Record

Printed Name/Signature of Healthcare Provider: ____________________________ Date / Time: ____________________________

Tracey Brown/Tracey Brown, RN

2009/01/16 at 2020
Resuscitation/End-of-Life Care

• If the patient has a cardiopulmonary arrest, even if the MRP/delegate has not yet assessed the patient, the wishes of the patient/SDM are honored

• If the patient’s condition deteriorates during the perioperative period, full resuscitation measures will be taken
• The patient/SDM may, at any time, request revisions to the Resuscitation/EOL Care Plan

• Any member of the health care team immediately implements such a request and initiates a new Resuscitation/EOL Care Plan form
Fall Risk Assessment
Fall Risk Assessment

- Completed on **every** patient on admission
  - Thereafter, on transfer, every Thursday, after a fall and with any change in condition
- Morse Scale scoring guide is on back of form
  - **Patient** assessed in 6 categories
    - History of falling
    - Secondary diagnosis
    - Ambulatory aid
    - IV/Saline lok
    - Gait/transferring
    - Mental status
- Score patient and add to obtain total fall risk score
  - Range of 0 – 125
    - Low – score of 0 – 24
    - Moderate –High Risk– score of 25 or greater
### Morse Falls Scale Scoring Guide

*Note: If patient unconscious, indicate fall risk level as “Low”, omit Morse Falls Scale. Educate family. Reassess fall risk weekly and when condition changes.*

#### History of Falling:
- 25 points: Fall during present admission or if there was an immediate or recent history of physiological fall prior to admission (e.g., seizures or impaired gait). Note: If patient falls for first time, score immediately increases by 25.
- 0 points: No fall

#### Secondary Diagnosis:
- 15 points: Greater than one medical diagnosis listed on chart
- 0 points: Only one medical diagnosis on chart

#### Ambulatory Aids:
- 30 points: Amputees by clamping onto furniture for support
- 15 points: Patient uses canes, cane, or walker
- 0 points: Patient ambulates without assistance
- 0 points: Patient ambulates with nurse assistance consistently
- 0 points: Patient with or without walking aid, uses wheelchair, or is on bedrest and doesn’t get out of bed

#### Intravenous Therapy:
- 20 points: IV apparatus or saline lock
- 0 points: No IV or saline lock

#### Gait/Transfer:
- 20 points: Impaired Gait: difficulty rising from chair, may use several attempts or "bounces". Patient keeps head down on ground, loses balance easily, clothes tightly to objects, aids or nurse.
- 10 points: Weak Gait: patient stopped, may shuffle, but keeps head up, does not lose balance, may have weight on chair object/aid for support.
- 0 points: Normal Gait: head erect, strides without hesitation, arms swing freely at sides; OR is immobile, on bedrest and doesn’t get out of bed, uses lift aid, or transfers safety to wheelchair.

#### Mental Status:
- 15 points: Overestimates abilities, or forgets limits
- 0 points: Judges own ability to ambulate accurately

#### Total Fall Risk Score

### Potential Contributing Factors
- **Unstable Gait & Balance**
  - Consider P1OT2 consult
  - Encourage patient to call for help for ambulation
- **Muscle Strength/Weakness**
  - Evaluate nutrition, hydration
  - Consider diabetes consult
  - Consider O2T1 consult
  - Initiate active/passive ROM exercises of limbs
- **Urinary Frequency**
  - Assess for UTI
  - Review diuretics, renal function
  - Reassess IV fluid rate
  - Promote safe transfers
  - Place commode at bedside
  - Establish toileting routine
- **Orthostatic Hypotension/Dizziness, Vertigo**
  - Assess B/P & Pulse lying & standing
  - Review medications
  - Consult physician & pharmacist PM
- **Pain**
  - Assess with pain scale & treat

### Remember
- Place bedside table & equipment on stronger side
- Have patient exit bed on stronger side
- Assess coordination/balance prior to transfer
- Place items within reach

### Nurse’s Initials

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**Fall Risk Assessment and Intervention Flowsheet**

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London Health Sciences Centre
Fall Risk Assessment

• Standard interventions implemented for **ALL** patients

• High risk interventions implemented for patients with total score of 25 or greater

• Checkmarks are used to indicate which interventions are in place
Fall Risk Assessment – Moderate/High Risk

• Assess for contributing factors

• Use a star to indicate problem areas that you have charted on in progress notes

• Place appropriate signage alerting other HCPs to “high risk for falls” (location as per unit)

• Place yellow “Call Don’t Fall” armband on patient

• Educate patient/SDM on falls prevention and provide with pamphlet on “Preventing Patient Falls”
High Risk for Falls
Patient and Families Role In Safety
Patient Safety Education: Examples

- Orientation to the environment e.g., the patient room, how to adjust the bed
- The importance of an accurate list of home medications and allergies
- How to use the call bell system
- Hand hygiene – ask health care providers to wash their hands before contact
- Non-slip footwear for ambulation
Discharge Policy
Discharge Policy

• LHSC shall optimize patient access to its acute care resources by ensuring that patients who no longer require treatment in hospital are discharged in a timely fashion

• The patient or incapable patient’s substitute decision maker (SDM) shall be informed of LHSC’s discharge policy, prior to or upon admission, as well as the expected length of stay

• The patient’s health care team shall work with the patient and/or SDM to develop an appropriate discharge plan
Discharge Policy

Communication upon Admission to the Floor:

• The nurse/delegate responsible for transfer discusses discharge planning with the patient and family in detail (i.e. potential length of stay, procedures to take place, routine for discharge)

• The nurse/delegate documents the discharge planning discussion in the patient’s health record

• The nurse/delegate refers to Social Work if they anticipate/identify that the patient/SDM may require assistance with discharge planning
Follow up Letters to Patients

- Letter Advising of Discharge Planning Conference
  - Outlines to patient that it is essential that we hold a discharge planning conference immediately to make plans for discharge

- Letter to Patients Who Do Not Comply with Policy
  - Outlines to patient that since they are no longer in need of acute care hospital services, they will be charged the full daily rate for uninsured patients
Alternate Level of Care (ALC)

- A designation used by MOHLTC for a patient who has finished the acute phase of treatment but remains in an acute care bed

- An ALC patient may be unable to be discharged to another setting because of a lack of bed availability or lack of personal resources

- This includes patients waiting for placement in a long-term care home, retirement home, rehabilitation program, peripheral hospital, home care program, chronic care unit or household in the community
Admission Checklist Complete Within 24 hours of Admission

- Change patient identification band
- Apply allergy band (if necessary)
- Initial patient assessment/nursing history
- Valuables/belongings
- Allergy History and Allergy Record
- Medication History/Medication Reconciliation
- Braden scale
- ARO screening
- Resuscitation/End-of-Life Care Plan
- Fall Risk Assessment (signage + yellow armband)
- Discharge Policy
Resources

• Allergy Record
  http://www.lhsc.on.ca/priv/nursing/practice/document.htm (reference material)

• Antibiotic Resistance Organisms Management and Screening
  http://appserver.lhsc.on.ca/policy/search_res.php?polid=INF 015&live=1

• Discharge Policy
  http://appserver.lhsc.on.ca/policy/search_res.php?polid=PC C063&live=1
Resources

• Documentation
  http://www.lhsc.on.ca/priv/nursing/practice/standards.htm

• Fall Risk Assessment
  http://www.lhsc.on.ca/priv/nursing/ebp/bpgdline.htm#link

• Medication Reconciliation
  http://www.lhsc.on.ca/priv/medrecon/

• Patient Belongings/Valuables Policy
  http://appserver.lhsc.on.ca/policy/search_res.php?polid=PC\C027&live=1

• Resuscitation/End of Life Care Plan
  http://appserver.lhsc.on.ca/policy/search_res.php?polid=PC\C055&live=1
Questions?