Name of Policy:	NURSING ADMISSION PROCEDURES
Policy Number:	3364-120-13
Department:	Nursing Service
Approving Officer:	Director of Nursing/CNO
Responsible Agent:	Director/CNO
Scope:	The University of Toledo Medical Center

Effective Date: 3/1/2025
Initial Effective Date: 6/1/14

_____ New policy proposal	_____ Minor/technical revision of existing policy
_____ Major revision of existing policy	__X__ Reaffirmation of existing policy

(A) Policy Statement

A registered nurse is responsible for overseeing the admission of all patients to Senior Behavioral Health. This includes the supervision of staff delegated to orient the patient to the program and Unit, preparation of the environment, and checking of personal belongings brought onto the Unit.

Every patient will receive a Nursing Assessment upon admission. The Nursing Assessment is completed by the admitting RN. All other hospital admission policies and procedures will be followed as delineated in the UTMC nursing policy and procedure manual.

(B) Purpose of Policy

To assure that patients are admitted to the unit in a legal and appropriate manner

(C) Procedure

Admission to the Unit

A. The patient or representative will sign the admission forms, release of information forms, patient rights forms, and phone consent form prior to or at the time of admission.

B. Pre-certification is per UTMC procedure

C. Emergency application (pink slip) for involuntary placement will be in place and dated/timed appropriately.

Assessment

A. Every patient will have a Nursing Assessment completed within 24 hours of admission. The Nursing Assessment is completed by the Registered Nurse. Other hospital admission procedures will be completed as prescribed in the hospital nursing policy and procedure manual.

B. When the patient arrives to Inpatient Behavioral Health he/she is met by the assigned staff. The staff introduces self and then orients the patient to the Unit. The patient should not be left alone or out of view of staff until the nursing assessment is completed.

C. After showing the patient his/her room the staff escorts the patient to the room where the nursing assessment will take place - orienting the patient as they go. The following occurs:

1. The assigned nurse ensures that the designated program admission forms and consents are signed. The inquiry preadmission screening form should be reviewed.

2. The assigned nurse reviews the patient's rights, and key program policies and procedures. The patient and/or designee is given a copy of Patient Rights and Patient Handbook, and the patient's understanding of this information is verified and documented in the patient's chart.

3. The assigned nursing staff member/designee checks the patient's belongings in his/her presence for contraband items and does not allow patient to keep such items.

4. A "Patient's Valuable / Belongings" form is completed.

5. Suicide Risk Assessment is completed.

D. Once the patient nursing history is obtained, the RN initiates the physical assessment component:

1. Explain the physical assessment process to the patient.

2. Escort the patient to his/her room.

3. Have the patient disrobe and put on a hospital gown ensuring as much privacy as possible.

4. Obtain verbal medical/physical history from the patient including any significant areas that require further medical evaluation.

5. Perform the physical assessment and skin assessment while still working actively to engage in a trusting, supportive, therapeutic relationship with the patient.

6. Assist the patient to re-dress; if clothing is soiled or needs washing, keep patient in gown and wash the clothing before returning them to the patient.

E. Once the Nursing Assessment is completed, the RN introduces the patient to the assigned staff member who provides additional orientation and introduction of the patient to the staff, community, and program.

F. The RN notifies the attending physician of any significant findings. Additional orders are obtained as needed.

G. The RN initiates the Problem list and the Interdisciplinary Treatment Plan as well as the individual Treatment Plan based on problems derived from the Nursing Assessment. The first problem identified is the reason for admission. This is completed in conjunction with physician's orders and the physician's plan for care. The Individual Treatment Plan is initiated within 24 hours of admission.

H. If any part of the admission procedure is deferred due to patient's refusal of an assessment, a detailed explanation is written in the progress notes by the RN. Attempts are made to complete the assessment as soon as possible. Progress notes reflect these ongoing attempts.

I. The assigned staff member explains to the patient the necessity for checking belongings; an itemized list is developed and placed with the belongings in a secured area on the Unit, is

sent home with family members, or is locked in the hospital safe. The disposition of belongings and valuables is documented in the patient's medical record.

(D) PATIENT/FAMILY TEACHING

A. Unit schedule
B. Patient handbook
C. Patient rights
D. Visiting times
E. Rationale for valuables and contraband limitations

Approved by: /s/ Kurt Kless MSN, MBA, RN, NE-BC Chief Nursing Officer — Date _/s/ Dionis Kononov, DO Medical Director — Date *Written by: Lindsay Watson LSW MSW* *Review: 3/2021* *Revision Completed By: Stephanie Calmes, Ph.D., LPCC-S, LICDC-CS & Kassa Casey, MSN, RN, 2/2025*	**Review/Revision Date:** 3/2021 3/2023 2/2025 **Next Review Date:** 2/2028
Policies Superseded by This Policy: New	