SOP	Admission of a Patient to a Nursing Department				
All staff and Directors		Effective Date	Jan 2024	Compiled by	Anneline van Dyk
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ADMISSION OF A PATIENT TO A NURSING DEPARTMENT

1. SCOPE

The scope of this procedure covers the process to be followed and requirements to be met by the nursing department for the admission of a patient to a nursing department after the completion of admission by the patient administration department. The patient will be admitted on request of a referring/treating doctor to the appropriate nursing department depending the patient's diagnosis and age group. This standard operating procedure applies to all Crestcare Hospitals.

2. PURPOSE

- Correctly identify the patient on admission
- Obtain a complete medical/surgical history from the patient
- Assess specific physical and/or psychological needs, existing treatment and health risks
- Assess patient's baseline data e.g. vital signs, general condition, urine analysis
- Prepare a nursing care plan for the specific patient's needs and problems
- Ensure patient comfort and establish effective communication between nurse and patient
- Educate the patient on the treatment plan, expected outcome and continue updates
- Inform the treating doctor regarding the admission of a patient (if indicated) and data collected on the patient

3. DEFINITIONS

- Admission: A medical record of an actual admission of a patient that takes place in the Hospital
- Paediatric A patient discharged from a health care facility after birth till the age of 12 years
- Premature labour patient: Patient with a viable pregnancy but not to term (less than 36 weeks gestation'

4. METHODOLOGY AND PROCEDURES

- The patient needs to be admitted through the reception/patient administration department of the hospital before being admitted to the nursing department. The patient. next of kin or a family member needs to present to reception for admission to the hospital
- Paediatric patients need to be accompanied by parent(s) or a legal guardian
- If a patient is not admitted for a specific doctor, the patient will have to be admitted via casualty
- If a patient in labour is to be admitted without a dedicated doctor, the reception staff will have to find a receiving doctor for the patient prior to admission
- The patient then arrives to the ward from reception. The Personal assistant (nurse after hours) welcomes patient to the ward and escorts patient to the room/bed
- Personal assistant/nurse to confirm patient's identification, apply patient's sticker in the admission book and enter required data
- Check with the patient if relatives have been notified/aware of the admission
- The nurse introduce herself to the patient
- Screen the patient for privacy

- Ensure a safe environment for patient; bed breaks on, cot sides up if applicable, nurse call system close by
- Orientate the patient/parents about the layout of the room/department and introduce the patient/family to the other patients
- Explain admission procedure to the patient and reassure patient at all times
- Identify the patient according to file/stickers and verbally by name and number. Apply ID bands/allergy/risk factors on wrist of patient and explain importance of ID band at all times
- Request patient to change into own attire/theatre attire if applicable
- Ensure patient is comfortable
- Obtain the complete medical history with risk factors from the patient
- Base line data is done and recorded: Vital signs, height and weight, hand a urine beaker for testing of urine and test when specimen is delivered
- Assess patient's risks (skin integrity as per Waterlow or Norton Scale) and record findings if required
- Cell phone etiquette must be explained and signed on admission
- Patient will be informed to send valuables home. Valuables consent must be signed if to be taken into safe keeping by the department e.g. if the patient is going to theatre, kit and lock valuables. (See the procedure on admission of a patient by the administration department) "It is recommended that the patients are advised not to bring any jewellery, valuable articles, large amounts of money or firearms as the hospital doesn't take responsibility for the safekeeping of these articles, as endorsed in the bed letter; refer to disclaimer in respect of property"
- Ensure patient's name entered on board at bedside
- Document all findings and compile file with nursing documents
- Orientate patient to nurse call system, visiting times and routine/layout of ward
- Request/check if patient needs ear phones for television
- If patient is not nil per mouth, ensure carafe of water is given to patient
- Check with registered nurse which diet is to be ordered from the kitchen
- Ensure that admission notes is taken to the registered nurse to check and sign if admission was done by an enrolled or auxiliary nurse
- Inform doctor of admission of patient unless otherwise stated; report abnormalities
- Treatment/preparation must be commenced as prescribed/as soon as possible
- Check if any investigations need to be done, arrange/execute and follow up on delivery of results

5. CAUTIONS AND EMERGENCY STANDARD CARE

- If a patient is admitted from another hospital, a MRSA screening has to be done on admission, discuss with the admitting doctor.
- Inform the infection control nurse about the admission.

6. RESPONSIBILITY AND AUTHORITY

- The Unit Manager
- The Personal Assistant of the department
- The nurse admitting the patient in the nursing department
- The Registered Nurse in charge/Team Leader

7. DOCUMENTATION

- Hospital file per individual patient
- Admission document as generated by system
- Daily nursing care plan
- Medication and prescription chart

- Doctors clinical notes
- Vital signs/EWS chart
- Fluid balance chart
- Risk assessment document
- Admission and discharge record

8. REFERENCES

None

9. APPENDICES

None