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Owner:	*Tracy Hasty: Manager, Unit*
Policy Area:	*Pre-Surgery Unit*
References:	

Admission of Surgical Patients, 67.03.00

Document Type: Policy, Procedure

PURPOSE:

The nursing role is focused on physical, psychological, sociocultural, and spiritual preparation for the experience, with education and interventions to optimize a positive outcome. Interviewing and assessment techniques are used to identify potential or actual problems that may result while validating existing information and providing nursing care to complete preparation including preparing the patient/family/significant other for his or her experience throughout the perianesthesia continuum.

Admission of Surgical Patients: Adults

PROCEDURE:

The admission process will include a pre-procedure evaluation with documentation which includes:

1. **Admission date/time** with reason for admission and type of procedure to be performed.
2. **Patient/procedure verification:**
    - Identify the correct patient by confirming the name and birth date as stated by the patient and compared to the patient's identification band.
    - Check the medical record documentation and compare information with the consent form and as applicable to the following: H & P/Physician's Orders/Procedure schedule
    - Verbally identify with the patient the correct procedure, site and laterality. If the patient is a minor or not capable of confirming the information, a parent or legal guardian is permitted to confirm this information.
    - Ensure that patient has the correct patient identification band; allergy and blood bank band as applicable.
3. **Pre-Operative Checklist**:
    - Patient Identification
    - Fasting Status
    - Conditions of Admission/Operative Consent

- History & Physical
- Laboratory tests, EKG, CXR as applicable
- Removal of clothing, jewelry, hairpins, glasses, dentures
  Documentation of person who received these items/location of items.
  Complete the Personal Belongings Inventory Form (for inpatients)
- Location of loose teeth i.e., upper/lower
- Presence of hearing aid
- Presence of patient identification band; allergy band and blood bank if applicable
- Pre-operative medication
- Pre-operative teaching
- Void prior to surgery

4. **Medication/Food Allergies**
5. **Medication History:** Includes prescription, over the counter and herbal medications.
6. **Safe Transport Home**: For outpatient surgery/procedures, confirm the availability of safe transport home with accompanying responsible adult.
7. **Discharge Planning**: For inpatient surgical procedures, assess for discharge planning needs at home. Initiate Social Services consult as needed.
8. **Admit History:** The Admission Navigator will be completed in Epic.
9. **Physical Assessment**
   The initial assessment of the patient must be completed before the patient is transported to the Operating Room or to the department where the procedure is being performed. Documentation of this assessment will be completed within 2 hours of admission. The physical assessment will include but is not limited to:

Vital Signs:	Blood pressure, pulse, respiratory rate, temperature, oxygen saturation, Pain rating Height/Weight
Neurological:	Assess for orientation/level of consciousness; motor movement, sensation. Check reaction of pupils, movement and strength of all extremities Glasgow coma scale as indicated (for neurological surgery patients)
Cardiovascular:	Auscultation of heart sounds rate and regularity. Palpation of radial, posterior tibial and dorsalis pedis pulses as applicable Assess for presence of edema, chest pain, dizziness Capillary refill
Respiratory:	Color of skin, lips, nail bed. Lung sounds, respiratory rate, depth, rhythm and effort.
Gastrointestinal:	Assessment of abdomen, bowel sounds Presence of nausea/vomiting
Renal Urinary:	Deferred unless able to assess during admission process. Color and clarity of urine. Presence of odor.
Musculoskeletal:	Assess ambulation and movement of all extremities Assess color, motion, sensitivity of extremities
Skin:	Assess for general integrity of skin, color, temperature, bruises, rash. Assess condition of incisions, if applicable.

EENT:	Assess for redness, drainage or pain in eyes, ears, nose or throat.
Psychosocial:	Observed behavior. Patient interaction with family/staff.
Pain Status:	Assess for presence, rating, description and location of pain.

10. **Special Assessments/Interventions:**
    The following assessments/interventions will be completed and documented in the patient's medical record:
    a. Complete pre-operative physician orders for medications and treatments.
    b. Perform Fall/Skin Risk assessment.
    c. Initiate care plan.
    d. Provide patient education for the procedure/surgery.
    e. Apply the anti-embolism devices as ordered by the physician.
    f. Intravenous Therapy: Start intravenous line with an 18-gauge angiocath for surgical patients. Smaller gauge angiocaths may be used for patients who have limited intravenous access or for non-surgical procedures. Document size, type, rate of infusion and location of intravenous placement.

Admission of Surgical Patients: Pediatrics

1. **Admission date/time** with reason for admission and type of procedure to be performed.
2. **Patient/procedure verification:**
    - Identify the correct patient by confirming the name and birth date as stated by the patient and compared to the patient's identification band.
    - Check the medical record documentation and compare information with the consent form and as applicable to the following: H & P/Physician's Orders/Procedure schedule
    - Verbally identify with the patient the correct procedure, site and side. If the patient is a minor or not capable of confirming the information, a parent or legal guardian is permitted to confirm this information.
    - Ensure that patient has the correct patient identification band; allergy and blood bank band as applicable.
    - The pediatric nursing admission history will be completed in Epic.
3. **Pre-Operative Checklist**:
    - Patient Identification
    - Fasting Status
    - Conditions of Admission/Operative Consent
    - History & Physical
    - Laboratory tests, EKG, CXR as applicable
    - Removal of clothing, jewelry, hairpins, glasses, dentures
      Documentation of person who received these items/location of items.
      Complete the Personal Belongings Inventory Form (for inpatients)
    - Location of loose teeth i.e., upper/lower

- Presence of mobility and/or assist devices
- Presence of patient identification band; allergy band and blood bank if applicable
- Pre-operative medication
- Pre-operative teaching
- Void prior to surgery

4. **Medication History:** Includes prescription, over the counter and herbal medications.
5. **Safe Transport Home**: For outpatient surgery/procedures, confirm the availability of safe transport home with accompanying responsible adult.
6. **Discharge Planning and Education**: For inpatient surgical procedures, assess for discharge planning needs at home. Initiate Social Services consult as needed.
7. **Physical Assessment**
   The initial assessment of the patient must be completed before the patient is transported to the Operating Room or the department where the procedure is to be performed. Documentation of this assessment will be completed within 2 hours of admission. The physical assessment will include the systems as outlined in the Pediatric Assessment Policy 27.03.00.
8. **Pre-operative physician orders** for medications and treatments will be completed.
   See Pediatric Policy # 27.03.00 for specific guidelines with Pediatric patients
9. **Initiate care plan**.
10. **Intravenous therapy:**
    - SDS: Pediatric patients under 12 years of age: intravenous access by anesthesiologist.
    - Diagnostic Imaging: intravenous access by registered nurse as directed by physician based on type of procedure.

Attachments:

No Attachments

Approval Signatures

Approver	Date
Kirk Harper: VP, Nursing & CNO	10/2017
Crystal Wise: Administrative Assistant	10/2017
Tracy Hasty: Manager, Unit	10/2017

Applicability

Kadlec Regional Medical Center