ADMISSION CHECKLIST

☐ Orientated to ward and introduce to staff. Provide with appropriate nightwear and jug of water and glass if not NBM. Ensure the behind the bed board is completed

☐ Check that N.O.K is aware of admission – Check demographic details with patient

☐ Give patient information leaflets and discharge leaflet- explain discharge policies. Inform patient of HELP phone and Friends and Family Test question asked on discharge- “How likely are you to recommend our ward to friends and family if they needed similar care or treatment?” – patient’s will receive mobile text message or land line message or post card 48 hours post discharge

☐ Apply printed name band- White – all patients plus: red – allergies; orange- infection control; Green- fistula identification/lymphoedema identification

☐ Record baseline clinical observations and calculate EWS. Record BM if appropriate. Request Urine sample for urinalysis or MSU if appropriate. Check target SPO2 set by medical staff (on EPMAR)

☐ Complete Nursing Admission/Assessment Document on EPR* or update document started on SAL/EAU etc

☐ Complete MUST* risk assessment. Complete MUST care plan. Refer to Dietitian if appropriate on EPR

☐ Complete Waterlow* order mattress and cushion if needed

☐ If patient has pressure ulcer on admission complete AIR and arrange photograph and wound chart. Complete body map on Intentional Rounding chart

☐ Complete Falls Assessment* Ensure correct falls traffic light over bed is visible

☐ Complete Bed Safety Rails Assessment*

☐ Ensure medical staff have competed HAT assessment. Apply anti embolic stockings if indicated from HAT assessment and ask medical staff to prescribe LMWH if indicated- document this is done in nursing evaluation.

☐ Complete Moving and Handling Assessment*

☐ Complete Lifestyle assessment * If not already completed for this admission in EAU/SAL/Pre Op

☐ Commence Discharge Checklist* Enter Estimated Date of Discharge (EDD) on EPR* Update Discharge Status column on EPR

☐ Activate appropriate care plans on EPR and complete paper specific if needed. Complete Nursing Evaluation

☐ Complete nursing handover document on EPR*

☐ Commence Intentional Rounding Chart- ensure patient aware of this process.

☐ Ensure the patient has been given an opportunity to view the Patient Safety Briefing film via Hospedia system or a ward computer. The link is - http://vimeo.com/99045142

☐ If patient is over 65 and an emergency admission complete Dementia Assessment if not already completed on EAU- Inform medical staff to complete their section

☐ Commence an Intravenous Device Pathway if appropriate

☐ Complete catheter care flow sheet if appropriate and complete stool chart

* To be completed within 4 hours of admission