Practice Pointer: Admission Documentation

Category: Admission Screening and Assessment Documentation Bundle

Impacts: Nursing staff and their respective student populations

What is the Practice?

Nursing is responsible for completing a collection of screening and assessment documentation, upon the patient's admission to inpatient care (i.e. Admission History, ARO Screener, Risk of Violence Screening Tool, etc.).

- As per Island Health Clinical Documentation Policy, All clinicians and providers are required to document the care and service provided to a patient/client appropriately and clearly in accordance with applicable guidelines and standards of practice.
- As per Adult Health History on Admission procedure documentation and review of a patient's health history will take place, where clinically relevant, within a clinician's scope and knowledge base, and in accordance with documentation timelines.
- The accuracy and integrity of clinical documentation is an individual responsibility, informed by professional, British Columbia, Island Health and national electronic documentation standards, and Accreditation Canada expectations per Clinical Documentation Policy
- Documentation requirements are based on the BC College of Nursing and Midwives (BCCNM) Documentation Standards, clinical judgement, the level of care the patient is scheduled to receive, and are expectations of the role.

What do I need to know:

Upon patient admission, the Single Patient View of Care Compass displays a collection of tasks representative of all documentation required upon admission, referred to as 'the Admission Bundle". These tasks assist nursing in efficiently accessing and completing admission documentation.

Admission screening and assessment information:

- Provides a foundation for further assessment, care and treatment plans
- Communicates to team members what they need to know to plan and provide safe care
- Supports all care team members to be efficient in setting priorities and planning care, especially when working with limited resources

What do I need to Do:

- Use the Single Patient View in Care Compass to review admission screening and documentation tasks for your patient. These include:

- ARO & Infectious Disease Risk Screening Tool
- Risk of Violence Screening Tool
- Admission History PowerForm (includes Prehospital Functional Screener [PHFS])
- Braden Assessment
- Best Possible Medication History (BPMH)
- Valuables and Belongings PowerForm
- Discharge Planning PowerForm

SINGLE PATIENT VIEW

Example of Admission Tasks

CPOE, Natasha BLDIH Age: 38yrs Sex: F

Scheduled/Unscheduled | PRN/Continuous | Plans of Care | Patient Information

2 Hours | 4 Hours | 12 Hours

Current

Valuables/Belongings Valuables and Belongings 07-Mar-2024 10:45 , Stop date 07-Mar-2024 10:45
Comment: Order entered secondary to inpatient admission.

ARO Screener 07-Mar-2024 10:45 , 07-Mar-2024 10:45
Comment: Order entered secondary to inpatient admission.

Admission History Adult 07-Mar-2024 10:45 , Once, Stop date 07-Mar-2024 10:45
Comment: Order entered secondary to inpatient admission.

Discharge (DC) Planning Discharge Planning 07-Mar-2024 10:45 , ONCE, Stop date 07-Mar-2024 10:45 , On Admission
Instruction: On Admission
Comment: Order entered secondary to inpatient admission.

Risk of Violence Screen Risk of Violence Screening Tool 07-Mar-2024 10:45 , Stop date 07-Mar-2024 10:45
Comment: Order entered secondary to inpatient admission.

Done | Not Done | Document

- Select the task and use Document button to access the form
- Sign your documentation
- Communicate outstanding/incomplete documentation (i.e. partially completed forms) to the next shift, to ensure completion of required documentation