

SUBJECT:	Outpatient Special Procedures (OSP) Admission of a Patient		NO:	873-2019		
<input checked="" type="checkbox"/> Policy <input checked="" type="checkbox"/> Procedure <input type="checkbox"/> Protocol/Pre-Printed Order <input type="checkbox"/> Other:						
<input checked="" type="checkbox"/> New <input type="checkbox"/> Supersedes				Effective Date	01/14/2014	
Author	Donna Tuning, MSN, CEN		Date of Electronic Distribution	01/15/2014		
Dept. Manager	Melissa Farris, RN, BSN, CNOR		Medical Director/ CAH Oversight			
Administrative	Tina Glockner, RN		Policy Committee			
Committee			Other			
Audit Review:	Initials:	DG				
	Date:	3/07/14				

Purpose: Outline and describe the admission process for patient receiving an Outpatient Special Procedure (OSP).

Policy:

1. All patients admitted for OSP services must have physician/Licensed Independent Practitioner (LIP) orders signed by a medical provider.
2. When possible, the patient will be escorted to the floor by a Registration Service Representative or the OSP Nurse Coordinator.
3. The nurse must assess the patient within the first half hour after their arrival in the department for the chief complaint/current problem
4. Clinical narrative notes will be documented on each current problem that deviates from the patient's normal state or baseline
5. The clinical narrative notes should paint a picture of the patient's condition and should address the current problem
6. Reassessments are driven by the current problem and any changes in patient condition
7. Vital signs are obtained on admission and based on the procedure/therapy or any changes in patient condition.
8. The Nursing Admission Assessment (history) should be completed every 30 days or with any changes in history.
9. A focused physical assessment will occur with each visit and will be dependent on the patient's clinical procedure
10. Do not provide water or nourishment to an outpatient until there has been a brief clinical assessment of the patient condition.
11. Any unresolved problems at time of discharge require patient education. For example: wound care, use of pain meds, potential for falls, and/or need for referrals.
12. All outpatients will receive discharge instructions at their first visit and at completion of their treatment regimen.

PROCEDURE:

1. Ensure that orders are current, comparing with most recent physician order
2. Check that you are using current month's account
3. Assist patient with changing into gown prn
4. Assists patient with getting into bed or recliner prn
5. Obtain current vital signs The patient is
6. Oriented to use of bed, recliner, call lights, phone, bathroom, and visitation and smoking policies.
7. Orient to routine of OSP care, explain specific procedures to patient as you perform them
8. RN performs admission assessment to include;
 - a. notify the medical provider for any issues

- b. Evaluate physical, psychosocial, environmental, self-care, educational, spiritual, pain (including pain score/goal), cultural and discharge needs.
 - c. Prioritize which **interdisciplinary health care team members** will assist with the patient's needs (i.e. referrals that may be needed).
9. Document findings in the OSP flow sheet as soon as possible. Ideally this occurs concurrent with interview and assessment process.
10. In the event that a patient requires medical intervention from a physician while in the OSP department, the OSP nurse will either overhead page a code blue or a rapid response per hospital policy, or will escort the patient to the emergency department to be evaluated by the ED physician depending on the patient's status.

SUBJECT:	Swing Bed Admission Agreement	NO:	607-0002
<input checked="" type="checkbox"/> Policy <input checked="" type="checkbox"/> Procedure <input type="checkbox"/> Protocol/Pre-Printed Order <input type="checkbox"/> Other:			
<input type="checkbox"/> New <input checked="" type="checkbox"/> Supersedes # 607-0002 11/11/08; 7/14/109		Effective Date	11/09/2010
Author	Karen Livezey	Date of Electronic Distribution	11/09/2010
Dept. Manager	Judy Folk	Medical Director/ CAH Oversight	
Administrative	Leann Anderson	Policy Committee	
Committee		Other	
Audit Review:	Initials:	sc	S.CARR
	Date:	12/11	04/01/12

POLICY

It is the policy of Prosser Public Hospital District to provide information to the patient regarding his or her rights and all the rules and regulations governing patient conduct and responsibilities during their stay in the facility. This is provided both verbally and in writing, in a language that the patient understands.

Each patient (or the patient’s representative) admitted to this facility must sign an admission agreement which includes: consent for treatment and acknowledgement of explanation and receipt of written copies of facility practices; Resident Rights Policy 483.10; Admissions, Transfer & Discharge Rights Policy 483.12; and Residents Behavior and Facility Practices Policy 483.13 at the time of admission or within forty-eight (48) hours prior to admission. Proper orientation will be given to each patient and/or representative to the facility, staff, and facility services.

SUPPORTIVE DATA:

- Swing Bed Admission Agreement Packet (Located in Forms)
- Admission Agreement Signature Pages (Located in Forms)
- Re-Admission Agreement (Located in Forms)
- Medicare Certification Form (Located in Forms) PMH form SNF-46 Rev 12/96
- Swing Bed: Medical Record Content & Forms Policy #607-0009

RESPONSIBLE PARTIES:

1. Admissions Coordinator
2. Patient Financial Representative

PROCEDURE:

The Admissions Coordinator is responsible for the following:

1. The Admissions Coordinator or designee will meet with the patient and/or representative prior to or upon admission to review the Admission Agreement and complete 1 through 2 of the signature pages.
2. The patient and/or representative must sign the Admission Agreement signature pages within 48 hours prior to or upon admission.
 - a. If it has been less than 6 months since the Resident was admitted to swing bed status, they only need to sign the Re-Admission Agreement
3. The original signature pages of the Admission Agreement will be filed in the patient’s clinical chart.
4. A copy of the signature pages and the Admission Agreement Packet will be given to the patient and/or representative.

The Patient Financial Representative is responsible for the following:

1. The Financial Representative will meet with the Resident and/or Legal Representative and review the financial chapter of the Admission Agreement and complete page 4 of the signature pages.
2. The original signature pages of the Admission Agreement (page 3) will be filed in the Resident's clinical chart.
3. A copy of the insurance cards will be obtained for admission registration, census data and information for billing purposes.
4. If the Resident admits under Medicaid as their primary coverage; a 15-31 form will be faxed to local CSO

The Admissions Coordinator will also confirm that the following documentation is provided to the facility upon admission.

1. Orders signed by admitting physician
2. Copy of History and Physical
3. PASRR Screen
4. Copy of advanced directives and Power of Attorney documents (If Resident has one)
5. Copy of insurance cards
6. Insurance verification form (when applicable)
 - a. Medicare: Medicare Certification Form– Physician must sign
 - b. Medicaid: Authorization from DSHS (15-31 form)
 - c. Self-Pay: Medicare determination form (if applicable) (decertification letter)
 - d. Private Insurance: Name and phone number of agent or case manager.

SUBJECT:	Swing Bed Admission Criteria			NO:	607-0006		
<input checked="" type="checkbox"/> Policy <input type="checkbox"/> Procedure <input type="checkbox"/> Protocol/Pre-Printed Order <input type="checkbox"/> Other:							
<input type="checkbox"/> New <input type="checkbox"/> Supersedes #607-0006; 09/05/2005				Effective Date	11/09/2010		
Author	Karen Livezey		Date of Electronic Distribution	11/09/2010			
Dept. Manager	Mary Ella Clark, RN		Medical Director/ CAH Oversight				
Administrative			Policy Committee				
Committee			Other				
Audit Review:	Initials:	sc	S. CARR	mec			
	Date:	01/2012	04/25/12	03/19/14			

PURPOSE: To define parameters to place a person into a swing bed designation. Swing bed designation is used for short-term skilled nursing care or skilled rehabilitation services. The expected length of stay shall be less than 100 days. Swing bed designation shall not be used for non-skilled or custodial care services.

ELIGIBILITY CRITERIA:

Financial requirements: Needs to meet one of the following:

Medicare

- Enrolled in Medicare Part A
- Has benefit days available to use
- Three day qualifying acute inpatient admission
- Within 30 days of discharge from an acute care facility
- Qualifying medical condition
- Requires daily skilled nursing services or skilled rehabilitation which can only be provided in a skilled nursing facility or swing bed.

Medicaid (co-pay)

- Enrolled in Washington State Medicaid program
- Qualifying medical condition
- Requires daily skilled nursing services or skilled rehabilitation which can only be provided in a skilled nursing facility or swing bed.
- If admitted from home, pre-authorization needs to be obtained from DSHS Home and Community Services Caseworker

Private pay with or without secondary insurance

- Qualifying medical condition
- Requires daily skilled nursing services or skilled rehabilitation which can only be provided in a skilled nursing facility or swing bed.

Private (commercial) Insurance

- Pre authorization
- Qualifying medical condition
- Requires daily skilled nursing services or skilled rehabilitation which can only be provided in a skilled nursing facility or swing bed.

DEFINITIONS:

Qualifying condition

Requires and receives daily Skilled Nursing Services &/or Skilled Rehabilitation Therapies

- Daily in terms of skilled nursing requires skilled nursing care 7 days/week
- Daily in terms of skilled rehab therapies may be translated to 5 days/week if the services are not available 7 days per week and skilled rehab is the only reason for admission.

Skilled nursing and/or skilled rehabilitation services are services that:

- Are ordered by a physician
- Require the skills of a qualified technical or health professional
- Must be provided directly by or under the general supervision of skilled personnel to ensure patient safety and achieve desired results
- May require skilled personnel to perform or supervise because of special medical conditions

Practical Matter

As a “practical matter” the services can only be provided on an inpatient basis in a Swing Bed or Skilled Nursing Facility. The following may be used as requirements for designation for practical matter:

- Individual’s condition
- Availability of other types of services
- Feasibility of using other types of services
- Excessive physical hardship
- Less economical
- Less efficient or effective
- Limited support system

SUBJECT:		ADMISSION TO INPATIENT OB PROCEDURE				NO: 701-0009	
POLICY:		PROCEDURE:	X	GUIDELINE:		PROTOCOL:	
Supersedes:		new				Effective Date:	09-01-02
Development Team/Authors(s):		Susan McCoy RNC					
Committee Approval/Review:							
Administrative Approval:							
Audit Review:	Initials:	TM	LA	SD	LK	PM	JF
	Date:	4/9/03	5/5/05	4/10/06	9/5/07	11/11/09	08/6/2010

POLICY

PURPOSE: **A Perinatal Registered Nurse will perform assessment and direct the antepartum, intrapartum and postpartum care management of women experiencing pregnancy and childbirth.**

SUPPORTIVE DATA

- EFM Protocol
- Documentation Guidelines
- Standard Precautions
- Urine Testing for protein
- Infant Security

SUPPLIES

- CPSI charting access for Outpatient OB, Initial Interview, Admission Assessment, Labor Flowsheet
- Specimen cup, clean wipes
- EFM t
- Floor scale, Thermometer, B/P cuff, Stethoscope
- Patient gown and monitor belts

STEPS

1. Escort woman to triage or labor room. Weigh on floor scale. Instruct her to obtain clean catch urine, remove personal clothing, and don hospital gown. Provide bag for personal items if needed.
2. Orient to room, nurse call, bathroom, routines, and plans for care.
3. Do not leave alone in presence of frequent and strong contractions, pelvic pressure, or extreme anxiety.
4. Review procedures for woman concerning her progress through labor management.
5. Review prenatal history.
 - ❖ Obtain Blood type and Rh factor, VDRL status, Hepatitis screen, Rubella titer, GBS status. Determine Gravity, Parity, and EDC. Confirm Allergies and coexisting medical conditions.
6. Place EFM to begin baseline and /or ongoing assessment of fetal heart rate and uterine activity. Routine 30-minute strip on admission.

7. Perform Vaginal exam if indicated
 - a. Do not perform vaginal exam in presence of heavy vaginal bleeding or preterm labor
 - b. Update physician on status and obtain orders.
 - c. Determine cervical status, status of membranes
8. Complete Outpatient OB Patient on CPSI and determine disposition. Admit to labor, or discharge to home per Dr's order.
9. Determine educational needs for woman during labor management, delivery and postpartum care and newborn care and breastfeeding.
10. Initiate routine labor/delivery management orders and protocols, or other orders as indicated by Healthcare provider.
11. Determine expected outcomes and initiate plan of care

DOCUMENTATION

12. Document exceptions, reportable concerns, and patient responses in the medical record. Include all communications with the health care provider.

PROSSER MEMORIAL HOSPITAL

723 Memorial Street, Prosser, WA 99350

SUBJECT:		ADMISSION TO OUTPATIENT OB PROCEDURE				NO: 701.0010			
POLICY:		PROCEDURE:	X	GUIDELINE:		PROTOCOL:		OTHER (SPECIFY):	
Supersedes:							Effective Date:	04-02-02	
Development Team/Authors(s):			Susan McCoy RNC						
Committee Approval/Review:									
Administrative Approval:									
Audit Review:		Initials:	TM	LA	SD	LK	PM	JF	
		Date:	4/8/03	5/05	4/10/06	5/10/07	11/11/09	8/6/10	

POLICY

PURPOSE: To outline the nursing management and responsibilities of scheduling and processing outpatient obstetrical procedures.

SUPPORTIVE DATA:

Outpatient procedures to be scheduled include, but not limited to:

- Antepartal testing – NST – CST
- Cervical Ripening
- External versions
- Uterine Activity Monitoring – (UAM), assess for preterm labor
- Assess for rupture of membranes
- Assess for active labor
- Presurgical Admission Testing
- Pre Delivery Assessment
- Postdischarge Assessment (mother)
- Newborn assessment post discharge

APPOINTMENTS

1. Appointments are scheduled according to the patient need and staff utilization.
2. Orders for the procedures may be obtained at the time the appointment is scheduled.
3. Appointments are recorded in the Daily Schedule Book with the following information included:
 - Patient Name, time & type of procedure,
 - Health Care Provider (HCP),
 - Reason for procedure.
 - If orders were orders given
4. All patients register at the Admitting Desk.
5. If a patient does not keep a scheduled appointment, the HCP will be notified and “NS” for no show is placed in the schedule book.
6. The HCP will be responsible to reschedule the procedure.
7. Follow up procedures will be coordinated by the Perinatal RN.

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8. The attending HCP will be notified when the procedure is completed and will be given a verbal report.
 9. Forward all charts to the medical records.
 10. After any prenatal outpatient visits, the chart is coded and it is returned to the Birthplace for the Prenatal Outpatient File.

UTILIZATION

11. Minimum increment of time allotted for each type of procedure is as follows:

NST	30	minutes
CST	60	minutes
External version	60–90	minutes
Assess ROM	30–60	minutes
Assess Uterine Activity	60	minutes
Assess Active Labor	60–90	minutes
Pre- admit assessment	60	minutes
Post discharge assess	60	minutes

DOCUMENTATION

- Document exceptions, reportable concerns, and patient responses in the medical record.
- Include all communications with the health care provider.
- Document all outpatient procedures in the outpatient log with all care time in minutes of service.
- Document all charges on Charge Sheet and submit to Information Systems (Data)

SUBJECT:	ADMISSION ASSESSMENT OF THE LABOR PATIENT	NO:	701-0025
XPolicy X Procedure <input type="checkbox"/> Protocol/Pre-Printed Order <input type="checkbox"/> Other:			
XNew <input type="checkbox"/> Supersedes #			Effective Date 11/11/2008
Author		Date of Electronic Distribution	11/11/2008
Dept. Manager		Medical Director/CAH Oversight	
Administrative		Policy Committee	
Committee		Other	
Audit Review:	Initials:	PM	JF
	Date:	11/11/09	08/09/10

POLICY

- 1) Qualified personnel should collaboratively provide care for patients during the initial assessment of the obstetrical patient.
- 2) Labor patients should be assessed and the provider notified promptly of the patient's arrival to the OB Unit and of nursing assessment.
- 3). Assessment should include, but not be limited to the following:
 1. Maternal physical status
 2. Fetal status
 3. Labor status
 4. Psychosocial needs
 5. Review of prenatal records
 6. Patient interview; including chief complaint.

PROCEDURE

- 1) Receive patient. Instruct patient to remove street clothes and don hospital gown, with no under garments. Obtain clean catch urine sample if possible.

Supplies needed:

1. Fetal monitor, ultrasonic gel, and 2 monitor belts
 2. Prenatal record from upper left file drawer in nurse's station.
 3. Scales, BP cuff, stethoscope, thermometer, and tape measure
 4. Urine specimen cup
 5. Sterile gloves, sterile lubricant, fern tray
 6. Patient gown and underpad
- 2) Assess and document maternal status on CPSI computer charting, '*L&D: Initial Interview & Discharge Plan*' flowchart . If assessment leads to admission, continue documentation with '*L&D: Labor and Delivery*' flowchart.
 1. Patient's chief complaint or description of symptoms
 2. Date and time of arrival
 3. Gravidy and parity
 4. Vital signs, height and weight, fundal height.

Prosser Memorial Hospital

5. Estimated date of delivery determined by dates and ultrasound
 6. Vaginal bleeding including date, time, duration, & associated events
 7. Pregnancy risk factors
 8. Current medications
 9. Allergies
 10. Time of last meal and fluid intake
 11. Physical assessment
- 3) Assess and document in 'L&D: Labor and Delivery' flowchart fetal status:
1. Fetal movement
 2. Fetal heart rate obtained by auscultation or electronic fetal monitoring upon admission for 20 minutes
- 4) Assess and document in 'L&D: Labor and Delivery' flowchart labor status:
1. Uterine contractions including date and time of onset
 2. Palpate abdomen for tenderness, uterine contractions, and resting tone.
 3. Membrane status including date and time of rupture, color of amniotic fluid.
 4. If no history of prematurity, rupture of membranes, vaginal bleeding, or placenta previa proceed with digital cervical examination to include dilation, effacement, position, and consistency of cervix.
 5. Repeat cervical examination as indicated to assess for change.
- 5) Assess and document in 'L&D: Initial Interview & Discharge Plan' flowchart as well as 'L&D: Labor and Delivery' flowchart psychosocial needs:
1. Labor plan
 2. Significant stress
 3. Relationship problems
 4. Economic problems
 5. Education level and needs
 6. Support systems
 7. Cultural and religious needs
 8. Substance abuse
 9. Nutritional status
 10. Functional status
 11. Abuse
 12. Power of Attorney
- 6) Notify patient's OB provider of initial assessment within 30 minutes of admission. Including any significant abnormal findings and review of patient's prenatal record. Receive physician orders for labor management.
- 7) Provide continuous education and care for the patient and fetus as the labor process progresses. Communicate with the physician as labor progresses. Receive and carry out orders as the labor progresses.
- 8) Prepare for the care of the infant.

SUBJECT:	Admission to Operating Room			NO:	702-0002		
<input checked="" type="checkbox"/> Policy <input checked="" type="checkbox"/> Procedure <input type="checkbox"/> Protocol/Pre-Printed Order <input type="checkbox"/> Other:							
<input type="checkbox"/> New <input checked="" type="checkbox"/> Supersedes #5018				Effective Date	5/07/2002		
Author				Date of Electronic Distribution	09/06/2012		
Dept. Manager				Medical Director/ CAH Oversight			
Administrative				Policy Committee			
Committee				Other			
Audit Review:	Initials: Date:	MDF	MDF	MDF			
		11/14/11	8/30/12	12/31/13			

POLICY: All patients arriving in the operating room suite will undergo the admission procedure that shall be preformed by a Registered Nurse.

Purpose: To ensure accurate identification of the patient, adequacy of the preoperative patient preparation and completeness of the documentation.
 To assess the patient's actual and potential health problems.
 To facilitate implementing and communicating the peri-operative pan of care.

- Procedure:**
- I. Initial Interview
 - A. The identity of all patients admitted for surgery must be verified by verifying patient's full name and date of birth.
 1. The nurse transporting the patient to the OR suite will introduce the patient to the RN circulating nurse on arrival.
 - B. It is a responsibility of the nurse caring for the patient to verify the identity by:
 1. Asking the patient to state his or her full name.
 2. Asking the patient to state his or her date of birth.
 3. Checking identification bracelet.
 4. Comparing name on ID bracelet with patient chart.
 5. Reporting any discrepancies to appropriate person
 - C. The surgeon's name and the procedure to be performed must be verified with the patient.
 - II. Nursing Assessment with assistance from admitting nurse through verbal report.
 - A. A nursing assessment should include:
 1. Information regarding allergies
 2. Presence of jewelry:
 - a. Jewelry will be removed and sent to patient's room or secured for return to patient immediately after procedure.
 3. Presence of dentures, loose or capped teeth, and contact lenses.
 - a. If dentures or lenses are removed, they will be sent to the patient's room or secured for return to the patient immediately after the procedure.
 4. Pre-Op medications given and documented.

Admission to Operating Room

5. Physical Assessment of :
 - a. Skin integrity
 - b. Vision and hearing
 - c. Range of motion of extremities
 - d. Integrity of any vascular access lines, urinary drainage, etc.
 6. Psychosocial assessment of :
 - a. Emotional status
 - b. Mental status
 - c. Language spoken
- III. Chart Assessment
- A. Chart Assessment should include:
 1. Validity of consent
 - a. Appropriate signatures
 - b. Correct procedure including site, when appropriate.
 2. Laboratory reports
 - a. CBC, CMP (if ordered)
 - b. EKG and CXR (chest x-ray), if applicable
 - c. Type and Screen (when necessary)
 - d. UCG if child bearing age.
 3. History and Physical
- IV. Communication and Documentation
- A. All chart discrepancies should be communicated to appropriate member of the surgical team.
 1. Manager/Charge Nurse, Surgeon, Anesthetist
 - B. All actual patient problems should be communicated to all members of the surgical team.
 - C. Documentation should include:
 1. Procedure and site involved as described by the patient.
 2. Allergies
 3. Time of arrival to OR.

