PMH MEDICAL CENTER

Policy: Admission to Operating Room

Policy Number: 702-0002

Effective: 05/07/02 **Audit Review: 03/06/15**

POLICY: All patients arriving in the operating room suite will undergo the admission procedure that shall be performed 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.
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.