PMH MEDICAL CENTER

Policy: Outpatient Special Procedures (OSP)

Admission of a Patient

Policy Number: 873-2019

Effective: 01/14/14 Audit Review: 03/06/15

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.