

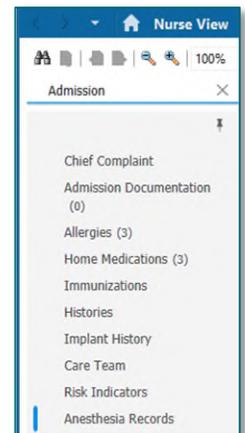
The Admission Workflow MPage consolidates documentation required during the admission process and standardizes the workflow. The following workflow outlines processes within the emergency department and inpatient settings.

Admission Workflow MPage

The Admission Workflow MPage is accessed from Nurse View located in the Menu. The tab title is **Admission**.

➤ Who uses the Admission MPage

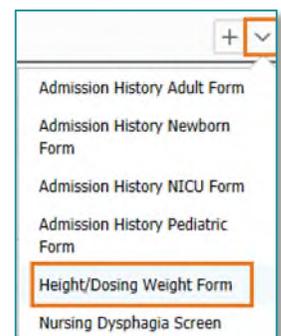
- All nurses responsible for the admission or intake of a patient into the hospital, or procedural area of the hospital, will access the Admission or Preprocedure Checklist forms from the Admission MPage.
- **ED Nursing** staff responsible for patients awaiting inpatient bed placement will access the **Admission MPage** by clicking the + at the end of the MPage tabs.
- Ambulatory RN View will also have the **Admission MPage** for **Mercy Endoscopy nurses**. The MPage may have to be added to view by clicking the + sign at the end of the MPage tabs.



➤ Admission Workflow

NOTE: ED Nursing staff will complete the Admission History Form within Nurse Activities from LaunchPoint. Unless otherwise noted, all other components will be completed in the Admission History MPage.

- Upon patient arrival, nursing will navigate to the **Admission** MPage.
- Review and document on the components listed below first so the information is available to the provider when they complete their order entry.
 - Review the patients **Allergies**.
 - Click **Mark as Reviewed** after reviewing the patient's allergies.
 - Review the patient's **Home Medications**.
 - Document the **Height/Dosing Weight Form** from the **Admission Documentation** component.
- During flu season, review the **Immunization** component prior to documenting the Admission History Form to verify if the patient has received the flu vaccine.



- Review the **Histories** component and update the patient's **Problems** list as needed.
- Document the **Admission History** or **Preprocedure Checklist Form** from the **Admission Documentation** component.

NOTE: The Patient Plan of Care is tasked once per shift and must be documented from CareCompass or LaunchPoint, so the task auto completes upon signature.

- After the necessary forms have been completed, navigate back to the **Admission Documentation** component, and click the appropriate **Systems Assessment** band link for your work area to complete the patient's system review in **Interactive View and I&O**.

NOTE: Documenting the Patient Preferred Pharmacy and Nursing Dysphagia form will continue in CareCompass or LaunchPoint.

- Nursing staff will follow this same workflow for the admission to a Swing Bed encounter.

Admission History Adult Form
Admission History Newborn Form
Admission History NICU Form
Admission History Pediatric Form
Height/Dosing Weight Form
Nursing Dysphagia Screen
Patient Plan of Care
Preprocedure Checklist Form
Outside Labs
PILOT Virtual Scribe Consent Form
Adult Systems Assessment
Adult Crit Care Systems Assess
Pediatric Systems Assessment
PICU Systems Assessment
NICU Systems Assessment
Newborn Systems Assessment
Periop System Assessments

Admission Workflow MPage Components

➤ Chief Complaint

- The **Chief Complaint** populates in this component from the Admission History Form.

NOTE: These components must be completed even if completed during the Emergency Department Intake process.

➤ Allergies

- A number next to the **Allergies** header indicates the number of allergies documented.
- Allergies are reviewed, added, and modified within this component.
- An orange triangle with an exclamation point on an allergy indicates this as a **Non-Multum Allergy** and no interaction checking is available.
- Once the allergy review is completed, click **Mark as Reviewed**. This button must be clicked by nursing staff.

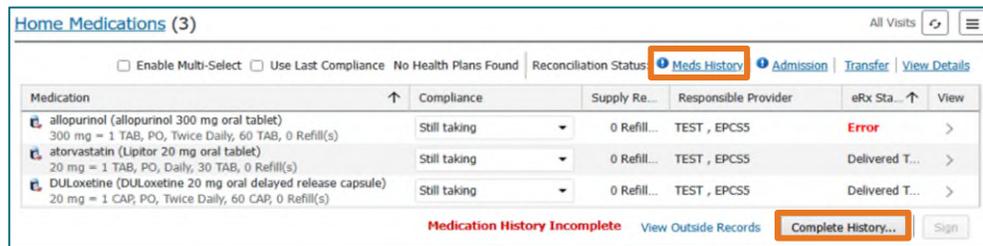
Allergies (2)					
Substance	Severity	Reactions	Category	Type	Last Reviewed
▼ Active					
metoprolol	Moderate	Hives	Drug	Allergy	14 days ago
▲ Peanut	Unknown	Shortness of breath	Food	Allergy	2 months ago
▶ Canceled					

Review Incomplete View Outside Records Mark as Reviewed

- After clicking **Mark as Reviewed**, the nurse's name and the date and time the review was completed displays.

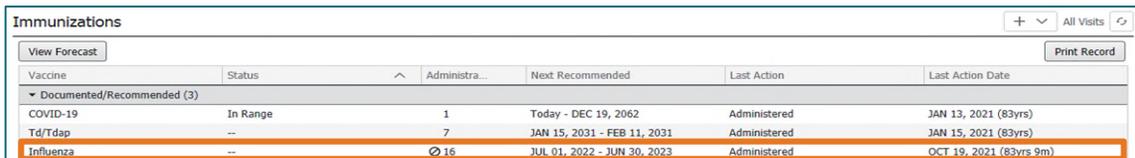
➤ Home Medications

- **Medication History Incomplete** indicates Medication History has not been done.
- Click the **Meds History** link or **Complete History** button to open **Document Medication by Hx**.
- Clicking **Document History** within **Document Medication by Hx** will populate the nurse's name and date and time the medication history was completed.



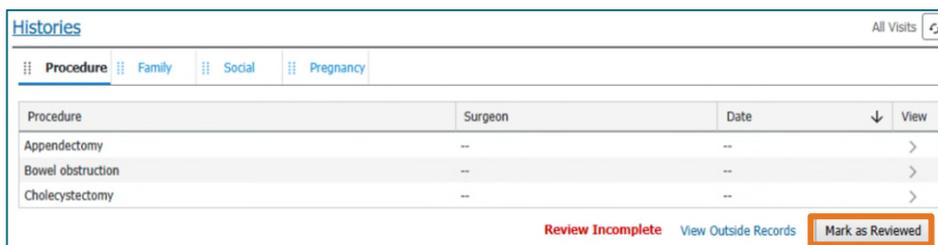
➤ Immunizations

- During flu season, review the **Immunizations** component for Influenza vaccine status.



➤ Histories

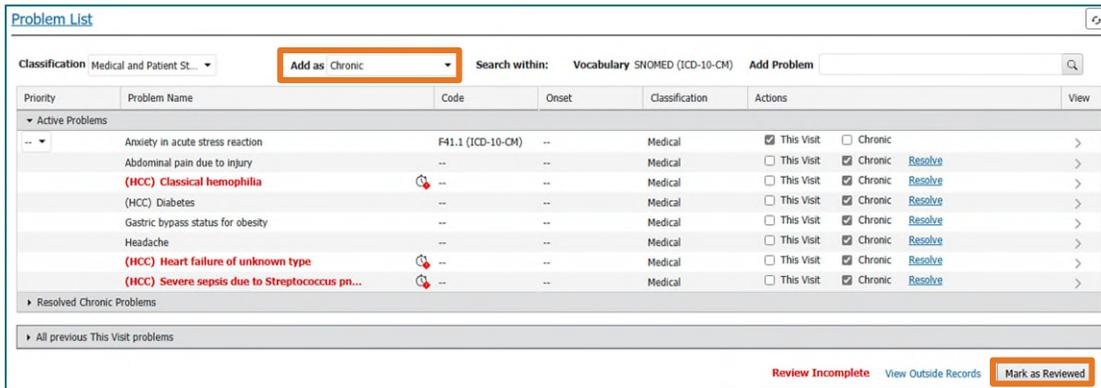
- Information displays based on the tab selected within the component. Selecting different tabs will display different information face up. The **Histories** component on the Workflow MPage can be used to obtain a quick view of the documented histories for patients.
- Clicking the **Histories** header links directly to the **Histories** tool which allows for modifying and/or documenting patient histories.
- After review, the **Mark as Reviewed** button must be clicked by nursing staff.



NOTE: For more information on how to use the Histories tool, please reference this [flyer](#).

➤ **Problem List**

- View and update the patient’s Problem list from this component.
- If adding any problems, be sure to only select **Chronic**.
- Select **Mark as Reviewed** when finished.



➤ **Implant History**

- Historical implants are reviewed from this component.
- Any updates needed, are completed through the **Histories** section in the menu.



➤ **Care Team**

- Providers and non-providers assigned to the patient’s Care Team are listed in this component.

➤ **Risk Indicators**

- The risk for readmission is shown in this component.

➤ **Anesthesia Records**

- Documentation from Anesthesia records is shown in this component.

➤ **Admission Documentation**



- Click the dropdown and select the appropriate form to be documented.
 - **Height/Dosing Weight Form**
 - **Applicable Admission History Form**
 - Certain information documented from the **Adult Admission History Form** will flow to the **Admission Documentation** component.

- Documentation from other admission forms will only flow to this component if the documentation field is the same.
- Clicking the **Documentation Result** opens a **View Details** box to the right. There is no need to do this as all the details available in this component are in view.

Admission Documentation (8)	
Result/Form Name	Result
▼ Results (8)	
Sensory Deficits	Other: Test - Sensory Deficit.
Preferred Communication Mode	Verbal
Chief Complaint	Chest Pain
Patient Admitted From	Home
Advanced Directives	No
Advance Directive Additional Information	No
Diet at home	Regular
Pregnancy Status	N/A

- The applicable **Systems Assessment** iView band can be quickly accessed from the **Admission Documentation** component.

NOTE: Don't forget to go to CareCompass or LaunchPoint to document the Patient Plan of Care, Nursing Dysphagia form, and mark the Patient's Preferred Pharmacy documentation as complete.