From the Office of Health Informatics

Quick Reference Guide (QRG) Perform the Patient Admission Process

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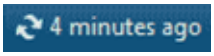
This Quick Reference Guide (QRG) demonstrates how to perform the patient admission.

Common Buttons & Icons

	**Down Arrow** icon
	**Calculator** icon
	**Sign** icon
	**Refresh** icon
	**Notes** icon
	**X Close** button

Complete Admission Documentation

➢ **From the CareCompass screen:**

STEP 1: Click the patient's name. The Nurse View screen displays.

NOTE: If a Missing Active PSO alert is received, the admission orders must be initiated. Contact the provider, if needed. When a patient arrives to the nursing unit, they must show as arrived in Capacity Management.

STEP 2: Click **Admission Documentation** in the table of contents.

NOTE: During admission, document the patient's height and dosing weight, allergies, home medications, history, and immunizations in the order that works best. Rearrange components in the table of contents if needed. To do so, click the desired component to move, and drag it to the desired location.

STEP 3: Click the **Admission Documentation Down Arrow** icon, then click **Height/Dosing Weight Form**.

STEP 4: Click the **Height** field.

STEP 5: Enter the patient's height.

NOTES: Convert standard measures to metric ones. To do so:

- Click the Calculator icon.
- Click the Identify Formula dropdown arrow.
- Click Inches to Centimeters.
- Click the Inches field.

- **Enter the patient's height in inches. Their height in centimeters populates the Centimeters field.**

STEP 6: Click the **X** Close button.

STEP 7: Click the **Dosing Weight** field.

STEP 8: Enter the patient's weight.

NOTES: **Convert standard weights to metric ones. To do so:**

- **Click the Calculator icon.**
- **Click the Identify Formula dropdown arrow.**
- **Click Pounds to Kilograms.**
- **Click the Pounds field.**
- **Enter the patient's weight in pounds. Their weight in kilograms populates the Kilograms field.**
- **Click the X Close button.**

STEP 9: Click the **Height Method** dropdown arrow; then click the appropriate option.

STEP 10: Click the **Dosing Weight Method** dropdown arrow; then click the appropriate option.

STEP 11: Click the **Sign** icon.

STEP 12: Click the **Refresh** icon.

STEP 13: Click **Allergies** in the table of contents.

STEP 14: Verify the patient's allergies, adding allergies as needed.

STEP 15: Click **Complete Reconciliation**.

STEP 16: Click **Home Medications** in the table of contents.

STEP 17: Click **Meds History**. The Document Medication by Hx window displays.

STEP 18: Add and modify medications, as needed.

STEP 19: Click **Document History**.

NOTE: **A Note icon within a medication row indicates the medication contains a comment about the medication. Hover over the icon or click the medication to view the comment.**

STEP 20: Click **Histories** in the table of comments. Verify the patient's problems, adding problems as needed.

STEP 21: Click **Complete Reconciliation**.

STEP 22: Click **Immunizations**.

STEP 23: Review the patient's immunizations.

NOTE: **A status of In Range indicates the patient is in range to receive a vaccine. The Last Action and Last Action Date cells indicates if and when the patient received the vaccine.**

Complete an Admission History Adult Form

➢ **From the Admission tab in the Nurse View screen.**

STEP 1: Click **Admission Documentation** in the table of contents.

STEP 2: Click the **Admission Documentation** down arrow icon, then click **Admission History Adult Form**.

STEP 3: Click **General Info**.

STEP 4: Complete the **General Info** section.

NOTE: **Within Risk Factors for COVID19, a Yes response Known exposure to a COVID+ patient automatically fires a COVID-19 Precaution alert, which prompts to assess the need for modified contact precautions.**

STEP 5: Click **Advanced Directive**.

STEP 6: Complete the **Advanced Directive** section.

STEP 7: Click **CSSRS Screen**.

STEP 8: Complete the **CSSRS Screen** section.

NOTE: **While this section is not required, it must be completed for every patient.**

STEP 9: Click **Nutrition**.

STEP 10: Complete the **Nutrition** section.

NOTES: **Click the Calculator icon to convert pounds to kilograms, if needed.**

- **Based on nutrition documentation, the system may automatically order a dietary consult.**

STEP 11: Click **Sexuality and Reproductive**.

STEP 12: Complete the **Sexuality and Reproductive** section, if applicable.

NOTE: **If the section is not applicable to the patient, the system automatically selects Not Applicable.**

STEP 13: Click **Spiritual/Visitor**.

STEP 14: Document the **Spiritual/Visitor** section, if applicable.

STEP 15: Click **Social History**.

STEP 16: Complete the **Social History** section.

NOTES: **The system requires documenting a patient's tobacco use once annually, along with electronic cigarette or vaping use, alcohol use, substance use, and abuse or neglect, regardless of the facility they are visiting.**

- **When documenting the Alcohol category, the system requires documenting the Alcohol Screening section, which is the next section.**

STEP 17: Click **Procedure History**.

STEP 18: Verify the patient's procedure history, adding new procedures if needed.

STEP 19: Click **Mark All as Reviewed**.

STEP 20: Click **Education Needs**.

STEP 21: Complete the **Education Needs** section, making sure to document the home and lay caregiver name, relationship, and contact information.

NOTE: **The state of Maine requires documentation on home and lay caregiver information.**

STEP 22: Click **Influenza Screening**. The Influenza Vaccine Screening/Order Form displays.

STEP 23: Complete the **Influenza Screening** section, if applicable.

NOTES: **If Unable to screen is selected, an alert will display every 24 hours prompting to complete this documentation.**

- **When signing an Influenza Vaccine Screening Order Form, the system automatically places the vaccine order.**

STEP 24: Click **Pneumococcal**.

STEP 25: Complete the **Pneumococcal** section, if applicable.

NOTE: **The Pneumococcal section functions the same way as the Influenza Screening section.**

STEP 26: Click the **Sign** icon.

STEP 27: Document the following information using the **Admission Documentation** down arrow icon:

- Nursing Dysphagia Screen
- Patient Plan of Care
- Systems Assessment

STEP 28: Document the patient's preferred pharmacy using the **Action** toolbar.