**Leamington Mennonite Home**
**Long Term Care**

## POLICY AND PROCEDURE

| CATEGORY: | SUBJECT: | SECTION: |
|---|---|---|
| Resident Care | Admission of a Resident | A |
| | | POLICY: 2 |
| DATE: September 2004 | Administrator's Signature: _____ | |
| REVISION DATES: January 2006, September 2015 | | |

## ADMISSION OF A RESIDENT

### POLICY:

When a resident is admitted to the Home, a medical chart is prepared, and the resident begins his/her orientation to the Home. The process is formulated to provide nursing staff with a baseline of information on which to expand, as well as provide the resident and family members/resident representatives a comfortable and well-planned entry into the Home.

The admission process is conducted over a two-hour period.

### PROCEDURE:

- The POA/family member/resident representative is contacted and encouraged to obtain an admission package from the front office prior to the admission date. The package contains information about LHM, its policies and beliefs, as well as consent forms which can be read and signed prior to the admission.

- The chart is prepared in advance by the Ward Clerk with all necessary forms. The resident name, admission date and other required information is filled out where necessary. The chart forms include:
    - Patient Transfer Form
    - Doctor's Order Sheet
    - PSW & Registered Staff Signature Sheets
    - Assessment Folder
    - Nurse's Notes
    - Lab Results Flow Sheet
    - Physician's Progress Notes
    - Physician's Annual Physical Form

- The admission forms are assembled and filled out where possible prior to the admission. The admission forms include:
    - Resident Admission Procedure
    - Information for Thomson Guardian Drugs
    - Nutritional Status Form
    - Oral / Teeth Assessment
    - Foot Assessment
    - Electrical Assurance Test

    - Vital Signs Record
    - Evacuation Manual Sheet
    - Head to Toe Assessment (skin integrity)

- The sheets for the PSW Binder include:
    - Weight summary sheet
    - Daily Flow Sheet
    - Behaviour Mapping Sheet
    - Multidisciplinary Care Plan
    - Bladder Audit
    - Bowel Elimination Form

- When the resident arrives for admission, he / she is met by the admitting Registered Staff member. The resident is taken for a tour of the Home and introduced to their roommate (in semi-private room).

- The admission package is explained and completed. Forms that go to the front office are forwarded to the Director of Administrative Services. Forms for the Nursing Dept. are inserted in the following areas of the resident chart:
    - Personal Care Decision Form – front of chart
    - Person Belongings Waiver Form – care plan section
    - Standing Leave Agreement – care plan section
    - Physician Care – Doctor's section
    - Consent to Treatment – Doctor's section
    - Vaccination/Immunization Permission form – Doctor's section
    - Evacuation Information – Evacuation binder

- The admission forms are reviewed and completed. The registered Staff member must sign and date what he/she has completed. The Resident Admission Procedure form is completed as fully as possible and clipped to the front of the chart for other Registered Staff to complete. Upon completion it is filed at the front of the Nurse's Note section. This form is not purged from the resident chart (see attached). Any additional mapping found necessary during the admission process is implemented (i.e. pain mapping, skin assessment, fall risk mapping, nutritional mapping, bladder audit).

- The Foot and Oral/Teeth assessments are completed and filed in the assessment folder.

- The admitting Registered Staff member initiates the Multidisciplinary Care Plan. Other Registered Staff members complete the care plan as required. It is filed in the PSW binder along with the Daily Flow sheet, Behaviour Mapping sheet, Bladder Audit, Bowel Elimination sheet, and Weight Summary sheet.

- The Vital Signs record is placed in the appropriate weight binder.

- The admission is charted on in the Nurse's Notes. Registered Staff will continue charting for 7 consecutive days in the Nurse's Notes.

- The resident's admission physical is scheduled for the next doctor's visit. Once completed, the physical form is placed in the front of the chart on the other side of the Personal Care Decision Form.

- A Multidisciplinary Care Conference Meeting is arranged within 6 weeks of the admission date. A letter is sent to the resident representative informing them of the date and time of the meeting, its purpose and what staff members will be attending the meeting.

- When a resident who resides in our Retirement Residence requires an increase in their care needs, the Erie St. Clair LHIN will be notified by the family. The family will request a long-term care assessment for eligibility for the resident. Once deemed ready for long-term care and the decision is made to transfer to the LTC facility, a completely new admission procedure must take place. The chart from the Retirement Residence will be purged and placed in an active file on the resident's RHA for reference. In the event of the resident's death or discharge, the LTC chart will be purged and placed with the Retirement Residence information and stored in the deceased or discharged files.

- Upon admission, the Physician orders will be obtained for medications, diet, and medical directives.