Leamington Mennonite Home
Retirement Residence

POLICY & PROCEDURE

CATEGORY:	**SUBJECT:**	**SECTION:**
Resident Care	**Admission of a Resident – RR**	**A**
		POLICY:
		4
DATE:	**Administrator:**	
April 2013		
REVISION DATE:	**Director of Care:**	
August 2016		

ADMISSION OF A RESIDENT - RETIREMENT RESIDENCE

POLICY:

When a resident is admitted to the Retirement Home, a Resident chart is prepared (physical and electronic) and the resident begins his/her orientation to the Retirement 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 Retirement Home.

PROCEDURE:

- The Resident and the Resident Representative is provided with an information package from the Registered Staff member admitting the resident on the day of admission – or when possible prior to. The package contains information about Retirement Residence, its policies, values, and mission statement.
- The resident chart is prepared in advance 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 (for assessments not available on the electronic documentation record)
    - Nurse's Notes (for when unable to record electronically)
    - Lab Results Flow Sheet
    - Physician's Progress Notes (for when unable to record electronically)
- The admission forms are assembled and pertinent information such as birth date and health card number are filled out where possible prior to the admission. The medical and personal care form package is obtained from the front office, reviewed, and signed. These forms are then filed in the designated areas of the resident's chart.
- The sheets for the PSW Binder include:
    - Daily Flow Sheet
    - Record/ Beverage/Snack Nourishment Flow Sheet
    - Bladder / Bowel Audit

- 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 Retirement Home and introduced to staff, volunteers, and their roommate (if in semi-private room).
- The admission package is explained, and the necessary paperwork completed. An appointment is made with the Chief Financial Officer. Forms for the Nursing Dept. are inserted in the resident's chart. Evacuation information is completed and inserted into the Evacuation binder.
- The admission forms are reviewed and completed. The Registered Staff member must sign and date what he/she has completed. The Retirement Residence Admission Information and Care Plan is completed within 2 days of admission and filed in the PSW flow sheet binder to be used for proper care information.
- The initial assessment shall consider the following matters with respect to the resident:
    - Continence
    - presence of infectious disease
    - risk of falling
    - allergies, dietary needs – including known food restrictions
    - cognitive ability
    - risk of harm to self and to others
    - risk of wandering
    - needs related to drugs and other substances.
- A full assessment of the resident's care needs and preferences is conducted no later than 14 days of admission and shall consider the following:
    - physical and mental health
    - functional capacity
    - cognitive ability
    - behavioural issues
    - need for care services
    - need for assistance with activities of daily living
    - the information from their initial assessment
    - any other pertinent information to the plan of care) if dementia care/ skin/wound care or PSADs.
    - If a RR staff member conducts a full assessment of the resident within 30 days of admission, then this may be used as the initial assessment.
- Any additional mapping found necessary during the admission process is implemented, i.e., pain mapping, skin assessment, fall risk mapping, nutritional mapping, bladder/bowel audit.
- Upon admission, the Physician orders will be obtained for medications, diet, and medical directives.
- All admission assessments are completed in the electronic documentation record.
- The admission is documented in the electronic record of the resident.
- Admission vital signs and weight/height are taken and charted on the 24-hour care plan and in the electronic documentation record. The resident is added to the PSW weight worksheet in the weight binder.
- The resident's admission physical is scheduled on the doctor's visit list. Once completed, the physical form is printed and placed in the front of the chart on the other side of the Personal Care Decision Form.
- A Resident Care Conference Meeting is arranged upon admission and again every 6 months. The Care Conference is reviewed by the Registered Staff with the resident. The resident has the option to invite a family member to attend this meeting if they choose.