CDX ADMISSIONS

PROCEDURES

1. Check the calendar/internal communications for any incoming admissions to prepare for them ahead of time.
    a. Note: Find the client's prescreen in the "Pre-Admission" section in Kipu. Print it. Read it to learn more about the client.
2. Print the "Nursing Admission Tool" and "pre-prep" it with the following information:
    a. Date
    a. Client's name
    a. Client's date of birth
    a. Client's "Reason for Admission" (i.e. substance of choice)
        . Note: Use prescreen.
    a. Client's "Pre-Admission Medication List"
        . Note: Use prescreen.
2. Collect nursing-specific items related to admissions, including the following:
    a. Breathalyzer
    a. Glucometer kit (if applicable)
    a. Pregnancy test (if female)
    a. Scale
    a. UDS cup
    a. Wristband
2. Upon client arrival, BHT will escort the client into the detox unit.
3. Complete the client's body search and UDS by doing the following:
    a. Put on personal protective equipment (e.g. gloves etc.).
    a. Go into the bathroom of the client's assigned room with a BHT and search every item of clothing (female clients are to remove bra from under shirt and give to BHT to search, we do not search underwear), hair, and accessories thoroughly for contraband.
        . Note: It is strongly preferred for a female employee to perform the body search for a female client. If the client is female, then find a female BHT, female nurse, or other female member of staff who can assist you.
    a. Complete a visual skin assessment. Update the back of the "Nursing Admission Tool."
        . Note: This information will also be used to complete the "Nursing Admission" in Kipu.
    a. Provide the client with a UDS cup. Wait for the client to complete the UDS.
    a. Receive the UDS with the client's urine. Read the results.
    a. Update the "Nursing Admission Tool" with the results of the UDS cup.
        . Note: This information will also be used to complete the "Nursing Admission" in Kipu.
2. Apply a wristband to the client's wrist, ensuring that it is labeled with the following information:
    a. Client's name
    a. Client's date of birth
    a. Client's allergies (if applicable)
2. Check the client's vital signs and weight. Ask for their height. Update the "Nursing Admission Tool" with this information.

3. Check the client's blood sugar (if the client is diabetic). Record the blood sugar reading in the client's profile in the "MAR" section in Kipu.
4. Perform a pregnancy test for the client (if applicable).
    a. Note: Use the urine from the UDS for this step.
    a. Note: This information will also be used to complete the "Pregnancy Test Results" in Kipu.
2. Dispose of the UDS cup as well as the urine contained therein.
3. Check the client's BAC level using the breathalyzer (BHT may perform this step and share results). Update the "Nursing Admission Tool" with this information.
    a. Note: This information will also be used to complete the "Nursing Admission" in Kipu.
2. Finish "Nursing Admission Tool." Send a picture of it to the on-call provider.
3. Finish the remainder of the admission using Kipu. Remember that there are TWO (2) sections in Kipu that you are responsible for: Nursing Intake and Treatment Plans. Be familiar with the sections and what is required so that you can successfully answer any questions. Do the following in order for the best results:
    a. Nursing Intake
        . Note: Complete ALL forms, even if the client did not bring any medications into the facility, EXCEPT for "Pregnancy Test Results" for male clients, which can be deleted.
    a. Nursing
    a. Treatment Plans
        . Note: Only start the "Initial Treatment Plan (Updated)" form by completing the Nursing section. Make sure client signs initial TX plan.
2. Following the admission, nurse or BHT give the client a tour of the facility (unless client is too sedated to do so)
    a. Note: If you are very busy or working by yourself, it is okay to ask a BHT to give the client a tour of the facility.

FAQ

1. What do I do if the client is ready to complete their nursing admission during shift change or when I am in the middle of another admission?
    a. Complete Step 5 (Body Search and UDS). Tell the client that they will be retrieved later to complete the remainder of the nursing admission process and that they can freely roam the facility in the meantime. The only exception to this would be if the client is presenting with an emergent biomedical / psychiatric issue, in which case they should be attended to immediately.
2. What do I do if I am seriously concerned about the client's mental, physical, and / or emotional state?
    a. Notify the on-call provider (or Medical operations Manager if provider cannot be reached). Or make a decision if one of the following conditions is met:
        . The on-call provider cannot be reached within 5-10 minutes
        . The client is experiencing a life-threatening condition
2. What do I do if the admission is canceled?
    a. Return any nursing-specific items related to admissions that were collected. Shred any documents with private health information related to admissions that were printed. Throw everything else away.
2. What do I do if I think I made a mistake?

a. Inform another nurse, a supervisor, and / or Administration. Ask for assistance. Mistakes can usually be fixed.

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