Ward – Admission Checklist

Patients Name……. Unit Number……....

Date and Time of Admission……..

	Tick	Sign
Add patients name to all boards & allocate named nurse when informed of admission		
Contact NOK/Nearest relative and provide them with ward contact details and visiting arrangements		
Commence level 2:15 observations as a minimum		
Orientate patient to ward environment and provide ward information leaflet		
Inform ward doctors or on call doctor that the patient has arrived for clerking		
Dr's to take admission bloods and complete ECG. If not suitable at time of admission, request blood form to be completed and forward in ward diary for following day		
Inform patient of no smoking policy – offer nicotine gum/inhaler. Contact Smokers.Clinic@wales.nhs.uk if they would like a referral		
Check property (remove restricted items) and fill in property admission book		
Discuss food allergies and dietary requirements – update catering department if required		
Physical observations to be completed within 2 hours (NEWS, BM's)		
MUST to be completed within 24hrs		
Complete Med 10, forward 4 weeks in diary and send to the relevant benefit office		
Check transfer documents (if applicable)		
Create a basic S17 leave document (if applicable)		
Complete H014 if detained, scrutinise section papers and accept		
Scan all MHA section papers to the MHA dept. Ensure original papers are posted to MHA dept.		
Read patients their rights under the MHA 1983, complete proforma and scan to MHA dept.		
Complete initial CTP & forward review date in diary		
Admitting nurse to start completing WARRN on Care Partner		
Assess risk of falls & open falls risk assessment if appropriate		
Offer advocacy and provide leaflet – complete and send referral form		
Complete G.P letter and send to relevant practice		
Discuss caring responsibilities or safeguarding issues (Pets, children, dependants, house locked)		
Add patient to Carefusion and ensure patient is admitted onto WPAS		
Check/order medication if necessary		
Complete core 10 with patient		
Provide DVLA info sheet to patient		
Complete admission entry on care partner using 'new admission template'		
Complete Purpose T Pressure ulcer risk assessment tool		