Nursing Admission Assessment Example

NURSING ADMISSION DATABASE

Name: _____

Patient Identification

ADMISSION NOTES

Date of Admission: ____/____/____ Time of Admission: ____ ____ am / pm
Transported By: _____ Accompanied By: _____
Age: ____ Sex: ❑Male ❑Female
Vital Signs: B/P ____/____, T _____, P _____ (❑Regular / ❑Irregular), R _____
Diagnosis: _____
Reason for Admission: ❑Rehab ❑Wound Care ❑IV ❑Tube Feeding ❑Respiratory ❑Dialysis
TB Status: ❑CXR Date: ____/____/____ (❑Neg / ❑Pos) or ❑Physician Statement of No TB

MEDICATION

ALLERGIES: ❑NKDA / ❑NKFA

Medication/Food	Medication/Food

Medications:
❑See Admission/Transfer Orders
_____
_____
_____
_____

REVIEW OF SYSTEMS

CARDIOVASCULAR

Chest: ❑Symmetrical ❑Asymmetrical
Heart: ❑Regular ❑Irregular ❑Tachy ❑Brady
❑Murmur ❑Rub ❑Gallop ❑Pacemaker
Pulses:
Radial: ❑Present, ❑L ❑R / ❑Absent, ❑L ❑R
Pedal: ❑Present, ❑L ❑R / ❑Absent, ❑L ❑R
Edema: ❑None or _____

RESPIRATORY

❑Dyspnea ❑Tachypnea ❑S.O.B.
Cough: ❑None ❑Dry ❑Productive
Sputum: ❑Scant ❑Moderate ❑Copious
❑Oxygen ❑Vent ❑Trach

❑ Right	CLEAR	❑Left
❑ Right	DIMINISHED	❑Left
❑Right	COURSE	❑Left
❑Right	WHEEZES	❑Left

GASTROINTESTINAL

❑Soft ❑Round ❑Flat ❑Non-Tender ❑Tender
❑Distended ❑Acsites
Bowel Sounds: ❑Active x 4 Quadrants
❑Hypoactive ❑Hyperactive ❑Absent
Site: ❑RUQ ❑RLQ ❑LUQ ❑LLQ
❑Nausea/Vomiting

NEUROLOGIC

❑ Unable to Assess/Unresponsive

Pupil Reaction: ❑PERRL Other: _____
Grips: ❑R/L Equal ❑L>R ❑R>L
Push/Pull: ❑R/L Equal ❑L>R ❑R>L
❑Dizziness ❑Syncope ❑Seizures

COGNITIVE/COMMUNICATION

❑Alert & Oriented x4 ❑Comatose
❑Intermittent Confusion ❑Disoriented
Speech: ❑Clear ❑Garbled/Mumbles ❑Aphasia
❑Communication Board
❑Gestures/Sounds
Language: ❑English ❑Spanish
❑Other: _____
Comprehension: ❑Slow ❑Quick ❑Unable

SENSORY

❑Numbness ❑Tingling Site: _____
❑Weakness Site: _____

Vision		Hearing	
Adequate	❑L ❑R	Adequate	❑L ❑R
w/Glasses	❑L ❑R	w/Aids	❑L ❑R
Poor	❑L ❑R	Poor	❑L ❑R
Blind	❑L ❑R	Deaf	❑L ❑R

FUNCTIONING/PHYSICAL

	Indep.	Assist	Dep.
Ambulation			
Transfer			
Dressing			
Toileting			
Bathing			
Eating			

❑Paralysis/Paresis Site: _____
❑Contractures Site: _____
❑Prosthesis Specify: _____

Weight Bearing Status: ❑As Tolerated (WBAT)
❑TTWB or ❑NWB Site: _____
Other: _____

Nursing admission assessment example is a critical component of the nursing process that lays the foundation for patient care. This assessment serves as a comprehensive evaluation of a patient's health status, which is essential for developing an effective and individualized care plan. It involves gathering information about the patient's medical history, physical health, psychological state, and social circumstances. This article will delve into the components of a nursing admission assessment, the tools used, and an example to illustrate how these assessments are conducted.

Understanding Nursing Admission Assessment

Nursing admission assessments are the initial evaluations conducted when a patient enters a healthcare facility. They provide a holistic view of the patient's condition and are essential for:

- Identifying health problems
- Establishing a baseline for future assessments
- Developing a personalized care plan
- Ensuring continuity of care
- Facilitating communication among healthcare team members

The assessment typically encompasses various domains, including physical, psychological, social, and spiritual health.

Key Components of Nursing Admission Assessment

The nursing admission assessment can be divided into several key components:

1. Patient Identification and Demographics

This section includes collecting basic information such as:

- Full name
- Age
- Gender
- Date of birth
- Address
- Phone number
- Insurance information
- Emergency contact details

2. Medical History

A thorough medical history is crucial for understanding the patient's health background. Key elements include:

- Previous illnesses and surgeries
- Current medications (prescription and over-the-counter)
- Allergies (medications, food, environmental)
- Family medical history
- Immunization status

3. Presenting Complaint

Documenting the reason for the patient's visit is essential. This includes:

- Description of symptoms
- Duration of symptoms
- Severity and frequency of symptoms
- Any previous treatments attempted

4. Physical Examination

A systematic physical examination should be performed, which typically includes:

- Vital signs (temperature, pulse, respiration, blood pressure)
- General appearance
- Assessment of all body systems (e.g., cardiovascular, respiratory, gastrointestinal)
- Neurological examination
- Skin assessment

5. Psychological Assessment

Evaluating the patient's mental and emotional health is vital. This assessment may cover:

- Mood and affect
- Cognitive function
- Coping mechanisms
- History of mental health issues
- Any current stressors

6. Social and Environmental Factors

Understanding the patient's social circumstances can significantly impact their health and recovery. This section may include:

- Living situation
- Support systems (family, friends)
- Employment status
- Financial circumstances
- Cultural and spiritual beliefs

Tools and Techniques for Nursing Admission Assessment

Nurses utilize various tools and techniques to conduct effective admission assessments. These include:

1. Assessment Forms

Standardized assessment forms help ensure that all necessary information is collected. These forms often include checklists and space for free-text responses.

2. Electronic Health Records (EHR)

EHR systems streamline the assessment process by providing templates and prompts for nurses. They allow for easy documentation and sharing of patient information among healthcare providers.

3. Interview Techniques

Effective communication skills are essential during the assessment. Nurses should use open-ended questions to encourage patients to share information fully. Active listening and empathy are also crucial components of the interviewing process.

4. Observation

Nonverbal cues can provide valuable insights into a patient’s condition. Nurses should observe body language, facial expressions, and overall demeanor during the assessment.

Nursing Admission Assessment Example

To illustrate a nursing admission assessment, let’s consider the case of a hypothetical patient, Jane Doe, a 62-year-old female who presents to the emergency department with shortness of breath and chest discomfort.

Patient Identification and Demographics

- Name: Jane Doe
- Age: 62
- Gender: Female
- Date of Birth: 01/15/1961
- Address: 123 Main St, Springfield, IL 62704
- Phone Number: (555) 123-4567
- Emergency Contact: John Doe (husband) - (555) 987-6543
- Insurance: Medicare

Medical History

- Previous Illnesses: Hypertension, Type 2 Diabetes Mellitus
- Surgical History: Appendectomy in 2005
- Current Medications: Lisinopril, Metformin, Atorvastatin
- Allergies: No known drug allergies
- Family History: Father had a heart attack at age 70; mother has Type 2 diabetes.

Presenting Complaint

- Description of Symptoms: Jane reports that she has been experiencing shortness of breath for the past two days, which worsened this morning. She also reports a tight sensation in her chest.
- Duration of Symptoms: 2 days
- Severity: 7/10 on the pain scale
- Previous Treatments: Over-the-counter antacids with minimal relief.

Physical Examination

- Vital Signs:
- Temperature: 98.6°F
- Pulse: 110 bpm
- Respiratory Rate: 24 breaths/min
- Blood Pressure: 145/90 mmHg
- General Appearance: Anxious, slightly diaphoretic, appears in moderate distress.
- Cardiovascular Assessment: Slightly elevated heart rate; regular rhythm with no murmurs.
- Respiratory Assessment: Increased work of breathing, bilateral wheezes on auscultation.
- Neurological Examination: Alert and oriented to person, place, and time.

Psychological Assessment

- Mood and Affect: Anxious demeanor; reports feeling overwhelmed.
- Cognitive Function: No apparent deficits, able to answer questions appropriately.
- Coping Mechanisms: Has been trying to manage stress through meditation but feels it is insufficient.

Social and Environmental Factors

- Living Situation: Lives alone; family nearby but not frequently involved in daily care.
- Support Systems: Limited; primarily relies on her husband for emotional support.
- Employment Status: Retired teacher.
- Financial Circumstances: Adequate; lives on a pension.
- Cultural and Spiritual Beliefs: Identifies as Christian and attends church services occasionally.

Conclusion

The nursing admission assessment is an essential step in providing high-quality patient care. By systematically gathering information across various domains, nurses can develop tailored care plans that address the unique needs of each patient. The example of Jane Doe illustrates how a thorough assessment can identify potential health issues and guide subsequent interventions. As healthcare continues to evolve, mastering the art and science of nursing admission assessments will remain crucial for nursing professionals.

Frequently Asked Questions

What is a nursing admission assessment?

A nursing admission assessment is a comprehensive evaluation of a patient's health status conducted by a nurse upon their admission to a healthcare facility, which includes gathering medical history, performing physical examinations, and identifying patient needs.

Why is the nursing admission assessment important?

It is crucial because it establishes a baseline for the patient's health, helps in developing an individualized care plan, and ensures that any immediate health concerns are addressed promptly.

What are the key components of a nursing admission assessment?

Key components include patient demographics, medical history, medication review, allergies, vital signs, physical examination findings, and psychosocial assessment.

How does a nurse prepare for a nursing admission assessment?

A nurse prepares by reviewing the patient's medical records, ensuring necessary equipment is available, and creating a comfortable environment to facilitate open communication.

What tools are commonly used during a nursing admission assessment?

Common tools include assessment forms, electronic health record systems, vital sign monitors, and diagnostic equipment like stethoscopes and otoscopes.

How long does a nursing admission assessment typically take?

The duration can vary but typically lasts between 30 minutes to an hour, depending on the complexity of the patient's condition.

What role does the patient play during the admission assessment?

The patient plays a crucial role by providing accurate information about their health history, current symptoms, and any concerns they may have, which helps in creating an effective care plan.

Can admission assessments vary by patient population?

Yes, admission assessments can vary based on patient demographics such as age, medical condition, and specific healthcare needs, requiring tailored approaches.

What challenges might a nurse face during a nursing admission assessment?

Challenges can include communication barriers, incomplete medical histories, language differences, and distressed or non-cooperative patients.

How can technology aid in the nursing admission assessment process?

Technology can aid by streamlining data collection through electronic health records, utilizing telehealth for remote assessments, and employing decision support tools for improved accuracy.

Nursing Admission Assessment Example

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