1. Preadmission:
   - Primary Dx, Reason for hospitalization, Previous hospitalization’s H&P/Discharge Summary/Baseline
   - **High Risk Categories:** Heart Failure, (End Stage Categories without ADV Dir/Full Code>>> is appropriate level of care Hospice?) Pneumonia, MI, Sepsis or SID
   - **Think Sepsis Risk:** Medication Categories Can Be Telling: *The Discharge Dx may not reflect prior Hx or past TX for Sepsis, Sepsis always has an origin. If being admitted with resolving PNA: Have they been treated for Sepsis; Other possible indicators: labs/pending, (What, when available, how to obtain), Recent Leukocytosis or WBC>12,000 Current or recent devices? Catheter present or recently dc’ed? Voiding patters established post catheter? Hx UTI? Hx ICU?
   - Goals of care/Discharge Plan (LOS in hospital is Important, ICU?)
   - Who is primary contact for report? Partners: Who do we need to include in Care Delivery? Case Manager, Primary Hospital Nurse contact? Wound MD, RD, Therapy, RT?
   - Suggest RT screen non vent/trach with Respiratory Dx

2. Assessment Priorities based on Dx/Comorbidities, Prognosis
   Nursing: What will we document to and assess for?
   - Dx: Reason for admission, Chief Complaint, Risk Factors, Goals of Care/Discharge Plan
   - Check Bundles and look for cross over to Admitting Dx (Keep list for PPS)
   - Risk/Target Areas: what could trigger UPHD

3. **Whiteboard Rounds Targets: Consistent Eyes on New admit>initial CP**

4. **Identify Red Flag Admissions:** Provide the right information/report to admitting staff
   (Who is responsible for oversight? Are we ready for the admission(s)
   a. `Return admissions/reason for transfer
   b. New admissions: CHF, Pneumonia, Infections, Multiple co morbidities\
   c. Acute Changes/safety

**Surveyor, Safety, Standard of Care Probes: What are the Immediate Needs Orders for the essential needs of the resident?**

5. Infection Oversight (How do we assess?) McGeer s updates: How do we assess?
   Shift to shift documentation during ABT curse and 3 days post completion
   - Admitted with IV ABT needs to be risk managed
     o Med availability
     o ABT intent/reason for/resolution or side effects
     o UTI criteria
     o Catheter management>observations
     o Hydration
• Skin Integrity: Why? Factors?
  o Prevention
  o Right Surface and interventions admit
  o Eyes on the resident, staff knowledge
  o Referrals>ASAP
  o Is there a risk for decline?>whiteboard potential for declines

• Stability of Condition
  o What is the baseline? What is the expectation?
  o Use of the dashboard>Trends within VS Report
  o Mobilize on unit observations of those on top ten RADAR:
  o Take a Nurse/CNA with Symptoms cheat sheet or Pathway if needed
  o Build assessment skills with SBAR bedside coaching: What is the situation/any noted changes> Background of the resident> (Normal baseline) Assessment findings>changes? Recommendations (what have we done this far? Effective?

• Role of SS> Adv Directives: Five Wishes
• Advance Directives: Available and in place
• Targeted residents for Physician/Extender visits: Who needs visit ASAP?
• RADAR and Projected Care Plan Schedules for Vitas, or Goals of care Referrals to Hospice (Meet with local Hospice)

Admission Process:
1. Discuss Process/Needs with Nurses
2. How does 3-11 manage and prioritize? Allow enough support for a good head to toe
3. How/who determines initial needs? 48 Hour Baseline needs to address risks
4. Nurse readiness> Smart Staffing?
   Plan for the flow of admissions
   Verification of needs: Eyes on the resident: Every day practice
5. Goals of Care Confirmation>48 hour mark
6. Observe: Prognosis> has it changed? Is it reported?
7. For Acute needs still being Txed: Is it effective?
8. IV ABT: Needs to be observed/assessed as active infection risk

Probes: What made the person stable enough for admission?> Are they? If not>>> who knows?
ASSESS FOR RISK OF SEPSIS. Are there admission protocols to implement proactively?
Vs FREQUENCY, VS Parameters for Physician notification? Changes in LOC, Output