Health and Social Care

Person-centred Nursing Assessment and Plan of Care - Adult Inpatient Care Setting

Continuation Booklet

PACE

- **The continuation booklet should only be used following an initial assessment, at the point of admission**
- **The continuation booklet should only be used when the 'Record of person-centred assessment, care and evaluation' pages have been used in the Person's admission booklet.**

Use addressograph (otherwise write in capitals)

Surname: _____

First names: _____

Address: _____

_____

H and C Number: _____ DOB: _____

Check identity

Hospital: _____ Ward: _____ Date of first entry in booklet: _____

Signature register

Date	**Full name** (BLOCK CAPITALS)	**Designation** (e.g Registered Nurse, Nursing Assistant)	**Initials**	**Full signature**	**Status** Permanent = P Temporary = T Bank = B Agency = A

Person	**A**ssessment	Plan of **C**are	**E**valuation
What matters to the Person? Communicating with the Person and family to identify their needs	Using nursing assessment skills to identify the needs of the Person. Collecting ongoing information/clinical observation. Building a picture.	Plan Care/Treatment/Support based on the identified needs from P and A. Specify desired outcome (aim). Obtain consent for the plan.	Look at the effectiveness of the plan. How does the Person feel? Progress towards outcomes/ meeting needs

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Date and Time		**Signature and Designation**

Moving and Handling **Complete if the Person's condition changes and/or Person transfers and/or new equipment/aids put in place**			
Is the Person's weight within safe working load (SWL) of equipment e.g. bed, chair, hoist, wheelchair Detail new equipment:	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment
Is equipment wide enough for the Person's safety and comfort e.g. bed, chair, hoist, wheelchair	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment
The Person requires a mobility aid e.g. walking frame, wheelchair Detail new mobility aid:	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment
Is the mobility aid available	☐ Yes ☐ No ☐ N/A If Yes, Person's own: ☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A If Yes, Person's own: ☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A If Yes, Person's own: ☐ Yes ☐ No
Handling constraints since admission e.g. pain, external attachments, fractures, behaviour, environment, posture Detail new handling constraint:	☐ Yes ☐ No If Yes, expand in **A**ssessment	☐ Yes ☐ No If Yes, expand in **A**ssessment	☐ Yes ☐ No If Yes, expand in **A**ssessment
Date:			
Time:			
Signature:			

Complete if falls incident and/or fear of falling and/or new problem with balance or walking since admission			
Date of fall incident:			
New fear of falling since admission	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
New problem with walking/balance since admission	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Lying and standing Blood Pressure (BP)	Lying BP: _____ Standing BP: _____ ☐ Not able to stand	Lying BP: _____ Standing BP: _____ ☐ Not able to stand	Lying BP: _____ Standing BP: _____ ☐ Not able to stand
Date:			
Time:			
Signature:			

Bedrails Assessment

Mental State	Mobility			
		Person is very immobile (bedfast/hoist dependent)	Person unable to mobilise independently	Person can mobilise without help from staff
	Person is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
	Person is drowsy	Recommend Bedrails	Use bedrails with care	Bedrails NOT recommended
	Person is orientated and alert	Recommend Bedrails	Recommend Bedrails	Bedrails NOT recommended
	Person is unconscious	Recommend Bedrails	N/A	N/A

Formatted from the National Patient Safety Agency's Safer practice notice 'Using bedrails safely and effectively' (NPSA/2007/17)

Bedrails Assessment Outcome - Complete if Person's condition changes and/or consider completion if Person transfers

Record reason for assessment e.g. details of change in Person's condition and decision making details

	Date:	**Date:**	**Date:**
	Time:	**Time:**	**Time:**
	Signature:	**Signature:**	**Signature:**
☐ Bedrails **NOT** recommended			
☐ Use bedrails with care			
☐ Recommend bedrails			

Malnutrition Universal Screening Tool (MUST)

To identify those adults who are at risk of malnourishment or who are malnourished

		Date:	**Date:**	**Date:**
		Time:	**Time:**	**Time:**
		Signature:	**Signature:**	**Signature:**
		Height:	**Height:**	**Height:**
		Weight:	**Weight:**	**Weight:**
		BMI:	**BMI:**	**BMI:**
Step 1: BMI score - BMI kg/m2		**Score:**	**Score:**	**Score:**
Over 20 (over 30 obese)	0			
18.5 to 20	1			
Less than 18.5	2			
If unable to calculate BMI: Estimating BMI category can be done from Mid Upper Arm Circumference (MUAC) MUAC less than 23.5 BMI likely <20 MUAC greater than 32.0cm BMI likely > 30				
Step 2: weight loss score unplanned weight loss in last 3 – 6 months				
Less than 5%	0			
Between 5 – 10%	1			
More than 10%	2			
Step 3: acute disease effect score				
If the Person is acutely ill and there has been, or is likely to be no nutritional intake for more than 5 days	2			
Total MUST score				
Low Risk = 0	Medium Risk = 1		High Risk ≥ 2	

Malnutrition **U**niversal **S**creening **T**ool **(MUST)** flowchart

Low risk - MUST score = 0

- **Record MUST details**
- **Recommend a well balanced diet**

Rescreen
Weekly

Medium risk - MUST score = 1

- **Record MUST details**
- **Recommend high protein/energy diet**
- **Monitor intake for 3 days** (record on food chart)

Rescreen
1 Week and refer to dietitian if risk status changes

High risk - MUST score ≥ 2

- **Record MUST details**
- **Refer to dietitian**
- **Recommend high protein/energy diet**
- **Monitor intake as per dietitian** (record on food chart)

The Braden Scale©

Sensory perception - Ability to respond meaningfully to pressure-related discomfort

1	2	3	4			
COMPLETELY LIMITED Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body surface	**VERY LIMITED** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body	**SLIGHTLY LIMITED** Responds to verbal commands but cannot always communicate discomfort or need to be turned **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**NO IMPAIRMENT** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort			

Moisture - Degree to which skin is exposed to moisture

1	2	3	4			
CONSTANTLY MOIST Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	**OFTEN MOIST** Skin is often but not always moist. Linen must be changed at least once a shift	**OCCASIONALLY MOIST** Skin is occasionally moist, requiring an extra linen change approximately once a day	**RARELY MOIST** Skin is usually dry; linen only requires changing at routine intervals			

Activity - Degree of physical activity

1	2	3	4			
BEDFAST Confined to bed	**CHAIRFAST** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair	**WALKS OCCASIONALLY** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair **SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently	**WALKS FREQUENTLY** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours			

Mobility - Ability to change and control body position

1	2	3	4			
COMPLETELY IMMOBILE Does not make even slight changes in body or extremity position without assistance	**VERY LIMITED** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently	**NO LIMITATIONS** Makes major and frequent changes in position without assistance			

Nutrition - Usual food intake pattern

1	2	3	4			
VERY POOR Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is Nil Per Orally and/or maintained on clear fluids or Intra Venous for more than 5 days	**PROBABLY INADEQUATE** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**ADEQUATE** Eats over ½ of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal but will usually take a supplement if offered **OR** Is on a tube feeding or Total Parenteral Nutrition regime which probably meets most of nutritional needs.	**EXCELLENT** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation			

Friction and Shear

1	2	3				
PROBLEM Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**POTENTIAL PROBLEM** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**NO APPRARENT PROBLEM** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times				

			Total Score		
Reproduced with permission	**9 or below: Severe Risk** **10-12: High Risk** **13-14: Moderate Risk** **15-18: Mild Risk**		**Date**		
			Time		
			Signature		

Skin Check

☐ Actual ☐ Verbal Details: _____

_____

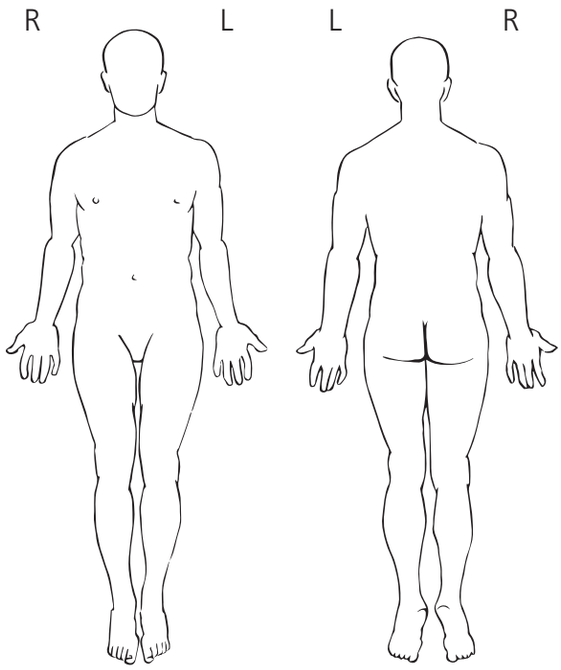
☐ Unable to check, Reason: _____

Document on the map and table below:

Tissue damage - check over bony prominence/around devices and use codes in descriptor box

Tissue damage - marks, bruising, rashes, skin conditions, or any other wounds write description

People with diabetes - check both feet: is there a skin break below the ankle: ☐ Yes ☐ No



Date and time of observation, type of tissue damage and reason/duration (if known) should be documented on map:

Date and Time	Skin observed and intact? If No, complete map	Signature
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Wound assessment chart commenced: ☐ Yes ☐ Not Required

Descriptor and Codes

S/G1	**Stage/Grade 1** - Non blanching erythema. Non blanchable redness of intact skin of a localised area usually over a bony prominence.	**S/G4**	Stage/Grade 4 - Full thickness skin loss with exposed bone, tendon or muscle slough or eschar may be present on some parts of the wound bed. The depth varies by anatomical location.
S/G2	**Stage/Grade 2** - Partial thickness skin loss of dermis presenting as a shallow open ulcer with a pink wound bed , without slough. May also present as an intact or ruptured serum filled blister.	**US/UG**	**Unstagable/Ungradable** Depth unknown. Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.
S/G3	**Stage/Grade 3** - Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. The depth varies by anatomical location.	**SDTI**	**Suspected Deep Tissue Injury** Purple or maroon localised area of discoloured intact or blood-filled blister.

Descriptors and Codes

MU	Mucosal Ulcer	**ML**	Moisture Lesion	**IAD**	Incontinence Associated Dermatitis

- Braden score is **18 or less** and in conjunction with clinical judgement
- The Person has existing pressure damage

Document identified need(s)