Emergency Department Person-Centred Nursing Assessment and Plan of Care

Version 1.0 July 2017

Keep original with ED records

Use addressograph-otherwise write in capitals

Surname: _____

First names: _____

ED No: _____ DOB: _____

Health and Care No: _____

Check identity

This record must be commenced for:

- Any person with a functional deficit within 4 hours of their arrival in the department.
- Any person that is awaiting transfer or there has been a decision to admit and have been in the department for four hours since time of arrival.

All other patients - The nursing contribution must be recorded on the Emergency Department record / flimsy.

Signature Register

Date and Time (24 hours)	Full Name (BLOCK CAPITALS)	Designation	Full Signature	Status: *Bank = B, Agency = A Permanent = P Temporary = T*

Moving And Handling Risk Assessment

1. Is the person's weight within safe working load (SWL) of equipment? ☐ Yes ☐ No If **no**, Specify: _____

2. Is the equipment wide enough for the person's safety? ☐ Yes ☐ No If **no**, Specify: _____

3. Is the person independent for all moving and handling activities? ☐ Yes ☐ No If **no, complete questions 4, 5 and 6**

4. Does the person use a mobility aid? ☐ Yes ☐ No If **yes**, Specify: _____

5. Is the mobility aid available in the department? ☐ Yes ☐ No

If yes, Specify if person's own aid? ☐ Yes ☐ No

6. Are there any handling constraints? E.g. pain, external attachments, fractures, behaviour or environment ☐ Yes ☐ No If **yes**, Specify: _____

Infection Prevention Control (IP&C) Risk Assessment

Full IP&C Completed ☐ Yes ☐ No, State Reason: _____ **Remember Standard Precautions**

Person Placement - Requires isolation: ☐ Yes ☐ No

If yes and not able to isolate, state reason: _____

Identity Bands applied: ☐ Yes ☐ No, State Reason: _____

Is the person on time critical medication (Prior to ED attendance)? ☐ Yes ☐ No

If yes, name of medical staff informed: _____

Date: _____ Time: _____ Signature: _____

Person Centred Assessment

Communication

A V P U

- ☐ Able to communicate using all senses
- ☐ Impairment of one or more senses
- ☐ Complete impairment due to either loss of one or more senses

- ☐ No language barrier
- ☐ Difficulty due to barrier
- ☐ Language barrier

- ☐ Co-operative / relaxed
- ☐ Anxious / tearful / distressed
- ☐ Extensive behavioural problems

☐ Pain less than 5 ☐ Pain 5 ☐ Pain greater than 5

Airway, Breathing, Circulation

- ☐ Cardiac / respiratory arrest or at risk of arrest

- ☐ No ABC problems
- ☐ Risk of impairment of ABC (potential for shock due to condition)
- ☐ Complete impairment of ABC or shock

- ☐ Minor wounds

Mobility

- ☐ Fully mobile
- ☐ Partial mobility loss
- ☐ Total immobility

- ☐ Minor limb problem
- ☐ Requires trolley/wheelchair

Falls Risk

Have you ever fallen in the last 12 months? ☐ Yes ☐ No
If yes, complete below
Have you had 2 or more falls in the last 12 months?
☐ Yes ☐ No
Have you presented with a fall? ☐ Yes ☐ No
Problems with walking/balance? ☐ Yes ☐ No

Pressure damage risk assessment and skin check **must** be completed - on reverse

Has the person taken any alcohol/drugs?

Eating/Drinking, Elimination, Personal care

- ☐ Normal bowel / bladder control/no vomiting
- ☐ Partial loss of bowel / bladder function and / or vomiting
- ☐ Total loss of bowel / bladder function and / or hyperemesis

- ☐ Able to maintain independent self-care
- ☐ Partial loss of independent self-care
- ☐ Not self-caring

Nil by mouth ☐ Yes ☐ No
Enteral feeding ☐ Yes ☐ No
Insulin dependent diabetic ☐ Yes ☐ No
Urinary catheter ☐ Yes ☐ No

Ability to feed: Independent/Help required/Full assistance.
Dietary requirements: food allergies/intolerances

Personal care: Independent/Help required/Full assistance.

Environmental Safety Health and Social Needs

- ☐ Ability to fully understand risks
- ☐ Appears unable to fully understands risks
- ☐ Demonstrates danger to self or others

- ☐ Does not require social support
- ☐ Requires some social support
- ☐ Requires extensive social support

Risk of absconding? ☐ Yes ☐ No
Are you a carer? ☐ Yes ☐ No

Date:_____ Time:_____ Signature: _____

Person	Assessment	Plan of Care	Evaluation
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 outcomes* *Obtain consent for the plan*	Look at the effectiveness of the plan *How does the person feel. Progress towards outcomes/ meeting needs*

Date and Time	Record of Nursing Care and Outcomes	Signature and designation

Pressure Damage Risk Assessment

History or existing pressure damage?	☐ Yes	☐ No
Reduced ability or inability to move self?	☐ Yes	☐ No
Sensory or cognitive deficit?	☐ Yes	☐ No
Incontinence?	☐ Yes	☐ No
Increased BMI (Body Mass Index) or malnourished?	☐ Yes	☐ No

If yes to any of the above, record a plan of care and complete ED SKIN interventions chart below

Skin check

Skin checked?

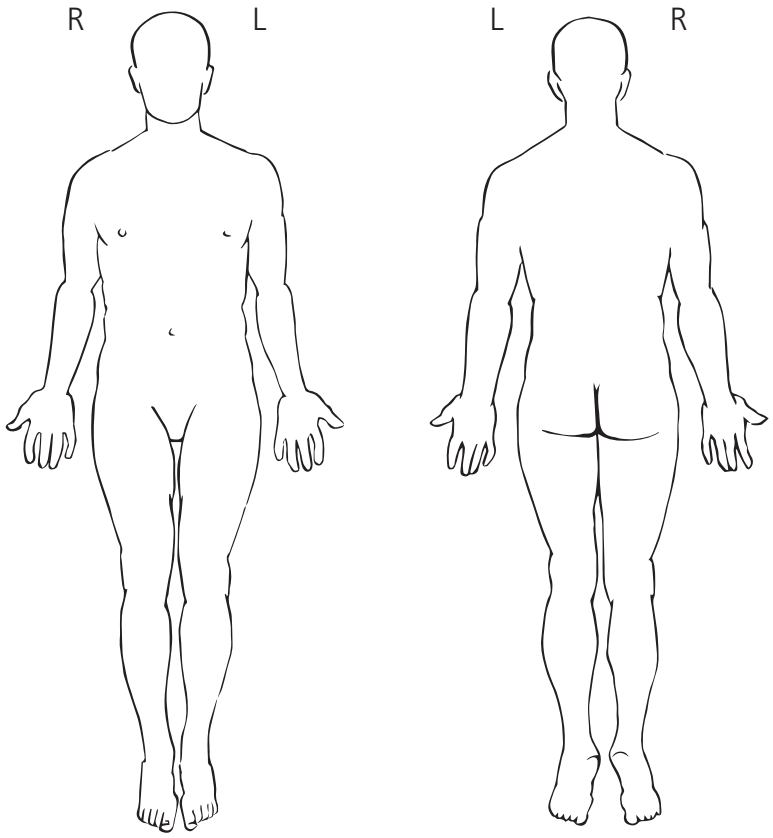
☐ Unable to check - Reason: _____

_____

☐ Yes - Please record on the body map all tissue damage - marks/bruising/skin conditions/wounds.

Pressure damage - over bony prominence/ devices, use codes in the descriptor box below.
Mucosal membrane damage cannot be graded

☐ No tissue damage



Date: _____ Time: _____ Sign: _____

Pressure damage codes/description

BE	Blanching Erythema
G1	Grade 1 pressure damage *Non-blanching erythema of intact skin*
G2	Grade 2 pressure damage *Partial thickness skin loss with exposed dermis*
G3	Grade 3 pressure damage *Full thickness skin loss*
G4	Grade 4 pressure damage *Full thickness skin and tissue loss*
sDTI	Suspected Deep Tissue *Persistent non-blanchable deep red, maroon or purple discolouration*
UN	Ungradable *Obscured full thickness skin & tissue loss*
ML	Moisture lesion

ED SKIN Intervention ☐ Not required

Plan of care must be in place

S	**Skin check** over bony prominence/ devices	☐ Yes ☐ No - Reason:_____	☐ Yes ☐ No - Reason:_____	☐ Yes ☐ No - Reason:_____
	Tissue damage	☐ Yes - Details: _____ ☐ No	☐ Yes - Details: _____ ☐ No	☐ Yes - Details: _____ ☐ No
	Surface Trolley/Bed/Chair/Wheelchair Mattress/Cushion			
	Heels free from pressure	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
K	**Keep moving** Postition			
I	Incontinence / Increased moisture	☐ NA	☐ NA	☐ NA
N	Nutrition / Fluids			
	Date			
	Time			
	Signature			