



FAST FACTS
ED RECORD

EMERGENCY DEPARTMENT PERSON-CENTRED NURSING ASSESSMENT AND PLAN OF CARE

Adult

WHO IS IT 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 4 hours since time of arrival

DESIGNED TO AVOID DUPLICATION
Use in conjunction with the ED flimsy

record the **nursing contribution** on the **Emergency Department flimsy**

SIGNATURE REGISTER

This section will serve as a record of your full signature and thus satisfy professional and legal requirements

MOVING AND HANDLING RISK ASSESSMENT

Assessing moving and handling risk is a statutory requirement
Once completed , if a need is identified a plan must be put in place

INFECTION PREVENTION CONTROL (IPC) RISK ASSESSMENT

There is a separate IPC assessment to be completed.
If unable to complete state reason

Person placement – indicate if the person requires isolation and if unable to facilitate this state reason

CRITICAL MEDICATION

If a person is on the following time critical medication at home please inform a medical staff and record

Medication	
Anti-infectives (injectable)	Oxygen
Anticoagulants	Opioids
Antiplatelets and thrombolytics (for acute indications)	Immunoglobulin
Anticholinesterases	Immunosuppressants
Anticonvulsants	Insulin
Antiretrovirals	Parkinson’s disease medicines
Bronchodilator (injectable or nebulised route)	Proton-pump inhibitors (injectable route)
Chemotherapy (injectable route)	Resuscitation medicines including plasma expanders and reversal agents eg phytomenadione, naloxone, flumazenil, prothrombin complex
Clozapine	Desmopressin(treatment of cranial diabetes insipidus)
Corticosteroids	

FRONT PAGE

PERSON CENTRED ASSESSMENT

Person Centred Assessment	
Communication	
AVPU ←	
<input type="checkbox"/> Able to communicate using all senses <input type="checkbox"/> Impairment of one or more senses <input type="checkbox"/> Complete impairment due to either loss of one or more senses <input type="checkbox"/> No language barrier <input type="checkbox"/> Difficulty due to barrier <input type="checkbox"/> Language barrier <input type="checkbox"/> Co-operative / relaxed <input type="checkbox"/> Anxious / fearful / distressed <input type="checkbox"/> Extensive behavioural problems <input type="checkbox"/> Pain > 5 <input type="checkbox"/> Pain 5 <input type="checkbox"/> Pain < 5	AVPU – circle as appropriate Tick one box only - green / blue/ red <i>This is the same for each section</i>
Airway, Breathing, Circulation	
<input type="checkbox"/> Cardiac / respiratory arrest or at risk of arrest <input type="checkbox"/> No ABC problems <input type="checkbox"/> Risk of impairment of ABC (potential for shock due to condition) <input type="checkbox"/> Complete impairment of ABC or shock <input type="checkbox"/> Minor wounds	
Mobility	
<input type="checkbox"/> Fully mobile <input type="checkbox"/> Partial mobility loss <input type="checkbox"/> Total immobility <input type="checkbox"/> Minor limb problem <input type="checkbox"/> Requires trolley/wheelchair Falls Risk Have you ever fallen in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below Have you had 2 or more falls in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you presented with a fall? <input type="checkbox"/> Yes <input type="checkbox"/> No Problems with walking/balance? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the person taken any alcohol/drugs?	Complete pressure damage risk assessment and skin check on reverse
Eating/Drinking, Elimination, Personal care	
<input type="checkbox"/> Normal bowel / bladder control/no vomiting <input type="checkbox"/> Partial loss of bowel / bladder function and/ or vomiting <input type="checkbox"/> Total loss of bowel / bladder function and/ or incontinence <input type="checkbox"/> Able to maintain independent self-care <input type="checkbox"/> Partial loss of independent self-care <input type="checkbox"/> Not self-caring Nil by mouth <input type="checkbox"/> Yes <input type="checkbox"/> No Enteral feeding <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin dependent diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary catheter <input type="checkbox"/> Yes <input type="checkbox"/> No Ability to feed: Independent/Help required/Full assistance. Dietary requirements: Food allergies/intolerances Personal care: Independent/Help required/Full assistance.	Use the blank space to expand upon the assessment record what matters to the person and identify needs
Environmental Safety Health and Social Needs	
<input type="checkbox"/> Ability to fully understand risks <input type="checkbox"/> Appears unable to fully understand risks <input type="checkbox"/> Demonstrates danger to self or others <input type="checkbox"/> Does not require social support <input type="checkbox"/> Requires some social support <input type="checkbox"/> Requires extensive social support Risk of absconding? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a carer? <input type="checkbox"/> Yes <input type="checkbox"/> No	This section is enables the nurse to record identify needs , a plan of care/treatment/support that addresses these needs must be record in the section
Date: _____ Time: _____ Signature: _____	

AVPU – circle as appropriate

Tick one box only - green / blue/ red
This is the same for each section

The purpose of the colour code is an added extra
The nurse in charge can use it with the triage category to work out Jones dependency score

Use the blank space to expand upon the assessment record what matters to the person and identify needs

This section is enables the nurse to record identify needs , a plan of care/treatment/support that addresses these needs must be record in the section

RECORD OF NURSING CARE AND OUTCOMES

Plan	Intervention	Effect of care	Outcomes

Record on this page

- Plan of Care/Treatment/Support – to meet identified needs
- Evaluation – of the plan
- Ongoing Assessment – to identify new needs

PRESSURE DAMAGE ASSESSMENT AND RECORD OF INTERVENTIONS

Pressure Damage Risk Assessment	
<input type="checkbox"/> History or existing pressure damage? <input type="checkbox"/> Reduced ability or inability to move self? <input type="checkbox"/> Sensory or cognitive deficit? <input type="checkbox"/> Incontinence? <input type="checkbox"/> Increased BMI (Body Mass Index) or malnourished?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to any of the above, record a plan of care and complete ED SKIN Interventions chart below	
Skin check? <input type="checkbox"/> Unable to check - Reason: _____	
<input type="checkbox"/> Yes - Please record on the body map all tissue damage - marks/bruising/skin conditions/wounds. Pressure damage - over bony prominences/devices, the redness/white discoloration below Mucosal membrane damage cannot be graded	
Pressure damage codes / description P1: Grade 1 pressure damage P2: Grade 2 pressure damage P3: Grade 3 pressure damage P4: Grade 4 pressure damage P5: Suspected Deep Tissue MDT: Mucosal membrane damage UN: Ungradable MN: Moisture lesion	
ED SKIN Interventions <input type="checkbox"/> Not needed Skin check over bony prominences/devices: <input type="checkbox"/> Yes - Reason: _____ <input type="checkbox"/> No - Reason: _____ Tissue damage: <input type="checkbox"/> Yes - Details: _____ <input type="checkbox"/> No - Details: _____	
Surface: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Trolley/Bed/Chair/Wheelchair/Mattress/Cushion: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Heels free from pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Keep moving: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Position: <input type="checkbox"/> NA <input type="checkbox"/> NA Incontinence / Diapered resident: <input type="checkbox"/> NA <input type="checkbox"/> NA Nutrition / Fluids: <input type="checkbox"/> NA <input type="checkbox"/> NA Date: _____ Time: _____ Sign: _____	

The Braden scale is not validated for ED, assess the person's risk & existing damage by completing this section. **Don't forget** your clinical judgement.

If yes selected - a plan of care/treatment/support must be recorded in the RECORD OF NURSING CARE & OUTCOMES section

Check skin for tissue damage/marks/bruising/skin conditions/wounds

Record on body map

Check for pressure damage over bony prominence or under devices

Use codes

More information accessed at: <http://www.epuap.org/pu-guidelines/#2014guidelines&qrq>

Once a plan is in place record:

- the interventions that have been completed

This is simply a record of interventions informing your evaluation

It is not a plan of care/treatment/support

