FAST FACTS
ED RECORD

EMERGENCY DEPARTMENT PERSON-CENTRED NURSING ASSESSMENT AND PLAN OF CARE

Adult

FRONT PAGE

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

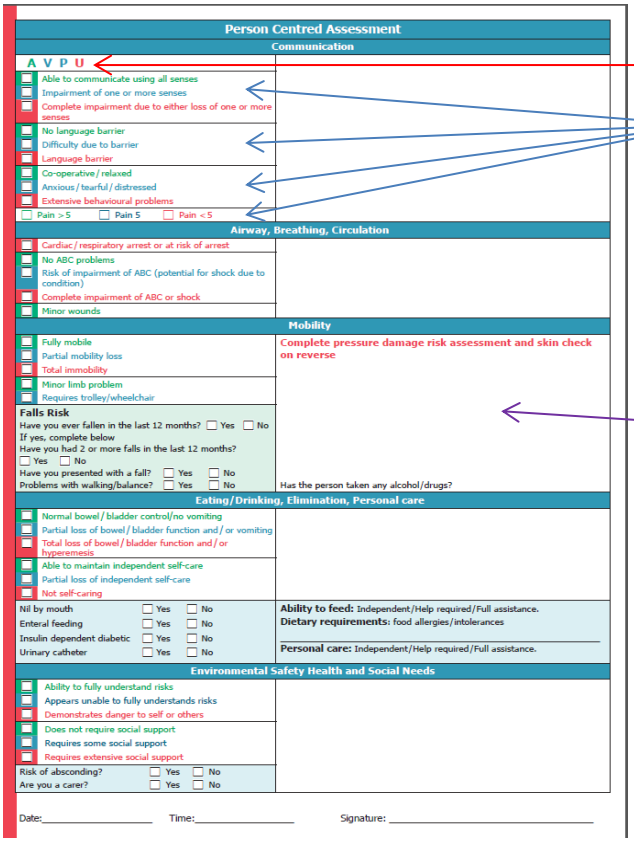
Person placement – indicate if the person requires isolation and if unable to facilitate this state reason

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)
Corticosteriods	

PERSON CENTRED ASSESSMENT



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

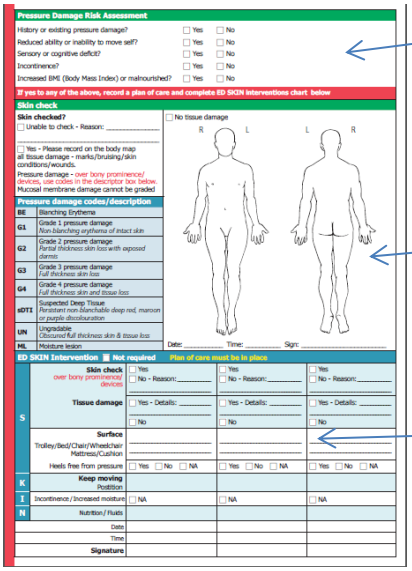
This section is enables the nurse to record identify needs , a plan of care/treatment/support that addresses these needs must be record in the section

RECORD OF NURSING CARE AND OUTCOMES

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



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&qrg

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