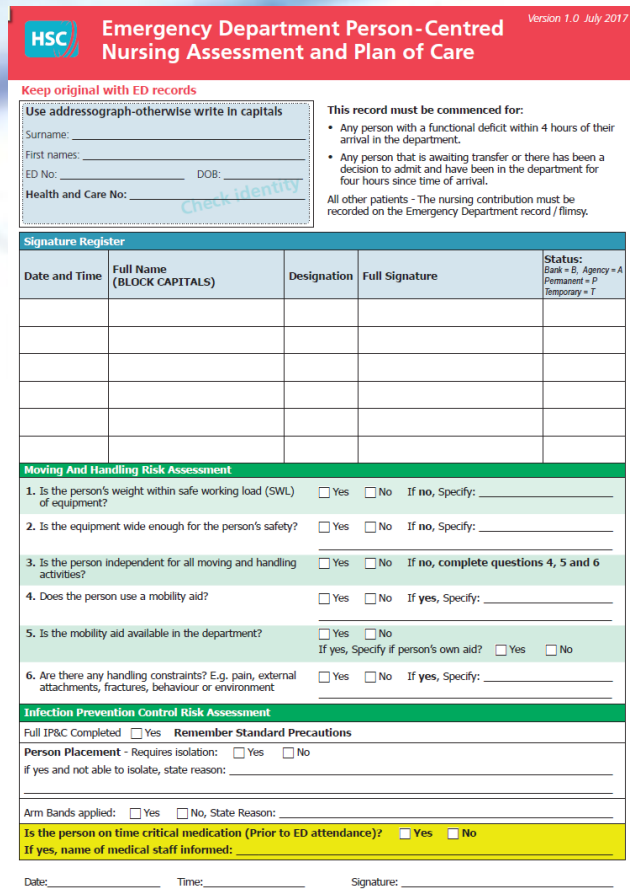
Emergency Department Record



HSC

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	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 Risk Assessment

Full IP&C Completed ☐ Yes **Remember Standard Precautions**

Person Placement - Requires isolation: ☐ Yes ☐ No

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

Arm 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: _____

Designed by ED nurses in NI

- Group ED nurses formed
- Template for record drafted
- Record tested with staff
- ED group & staff - refined & produced a final draft
- Facilitated by NIPEC

2 documents available

- A3 record
- Continuation sheet

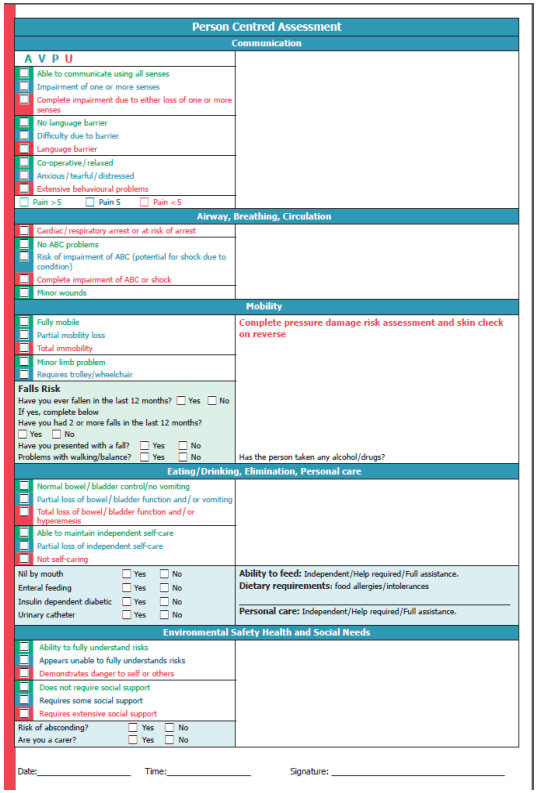
When is the record used

- with any person with a functional deficit within 4 hours of their arrival in the department
- with 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.

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

Lets get the record started…

building the picture with the initial assessment



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 >5 / Pain 5 / Pain <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

Complete pressure damage risk assessment and skin check on reverse

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

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

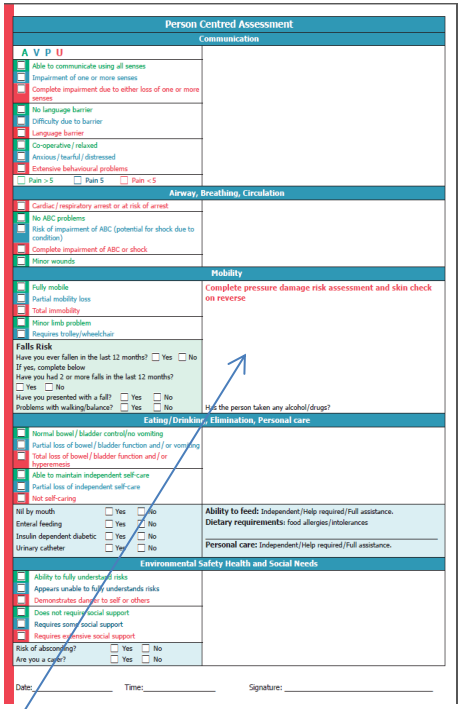
Date:_____ Time:_____ Signature:_____

…identifying needs

Using…

Jones as a framework

Communication
Airway/breathing/Circulation
Mobility
Eating/Drinking, Elimination, Personal care
Environmental Safety, Health and Social Needs



…..**record** identified needs

Then…

record a plan of care/treatment/support with the person for *each* of the identified needs

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

to **record** your evaluation as you do it with the person

in

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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*

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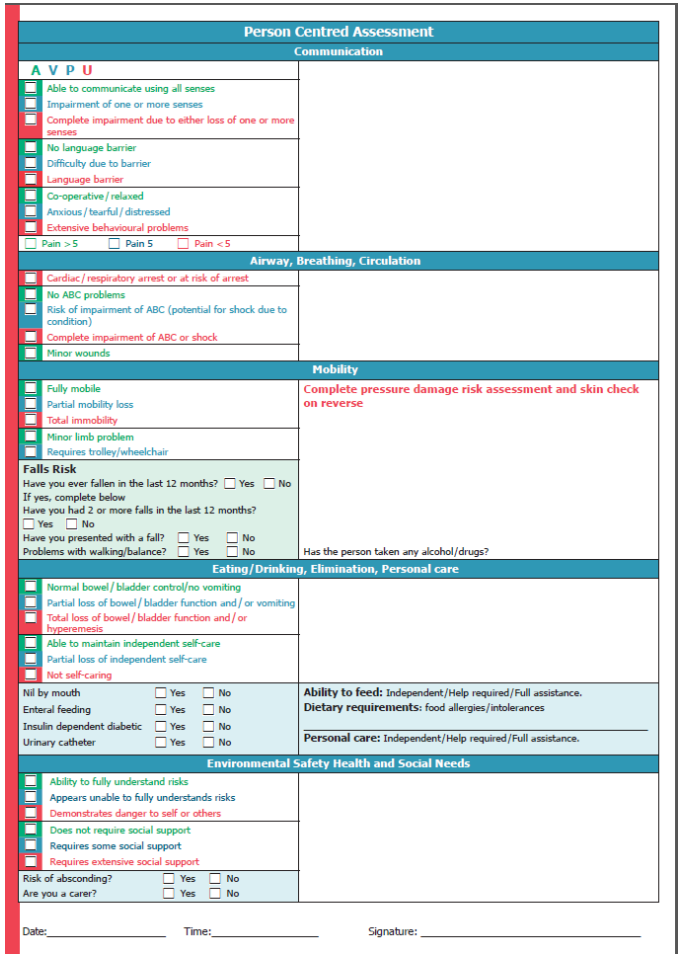
new needs arise through out their stay in the Emergency Department

so

record ongoing assessment in NURSING CARE & OUTCOME SECTION

with the person by their side

An added extra



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

Date:_____ Time:_____ Signature: _____

- the coloured tick boxes can be used by the nurse in charge to calculate the person's dependency
- using the Jones score
- this is just an added function of the record and can be utilised if desired.

Finally…

- Simply **record** what you do
- At the time that you deliver the care
- With the person
- At their side