Guidance for the

Person- centred Nursing Assessment and Plan of Care

Adult Inpatient Care Setting

- ✓ This document is **to be used in Adult Inpatient Settings**
- ✓ This document is for **single use only** i.e. to be used for one admission and **should not be transferred** to another HSC Trust if a person transfers for care delivery
- ✓ This document is to be used to care for people **aged 18 years and over**. If a person younger than this is admitted to the clinical area, expert guidance should be sought in relation to completing nursing documents e.g. the risk assessments that are suitable for the person. Additional advice is in the NIPEC webinar in relation to this area of guidance
- ✓ Only a nurse registered with the Nursing and Midwifery Council should complete this document. A nursing student may complete this document but where the student has recorded, the registered nurse (RN) who has supported the student throughout the person's admission, for example, MUST countersign. A nursing assistant (NA) may record in the document appropriately (as permitted in relation to the Record Keeping Framework for Nursing Assistants and his/ her competence and confidence level)
- ✓ The 'Signature register' is located on the last page of the booklet and should be completed by **ALL** RNs/ NAs who are documenting in the booklet

- ✓ All information in the document is taken at the point of admission, unless otherwise stated
- ✓ At the point of admission, the assessment and risk assessments within this document should be completed **within 6 hours of admission** (except MUST and Audit – C which should be completed no more than 24 hours from point of admission)
- ✓ The 'Summary of identified needs' (P.14)/ 'Record incomplete sections from initial assessment'(P.15)/ 'Referrals' (P.44) sections should be completed throughout the admission/ care delivery processes e.g. an entry in the 'Referrals' section (P.44) should be completed when the RN identifies that a dietetic referral is required following completion of the MUST risk assessment
- ✓ Clinical and professional judgement should be used alongside critical thinking in order to accurately, safely and effectively assess and deliver care. Explanation should be given as to how and why decisions were made/ care was planned and who or what was consulted e.g. related guidance/ policies

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- ✓ This document is formatted using the **PACE** framework. The document should be completed by the RN recording information, ticking relevant/ correct boxes and scoring in certain sections e.g. The Braden Scale, the AMT4. If **PACE** is not implemented in the care setting, recording of care should be completed as guided at awareness sessions/ in presentation on NIPEC microsite
- ✓ Within the sections of the booklet, information is being recorded from the person's perspective and from the RN's assessment e.g. '**P**erson- All About Me' (Person admitted into hospital) and '**A**ssessment' (RN's Assessment). Information should be documented in **both** sections
- ✓ Colour-filled banners are used to format the document i.e.

  'Life critical information' sections are in **RED** filled banners.
  Risk assessment sections are in **GREEN** filled banners.
  Identification of needs sections, whether acute or existing, are in **BLUE** filled banners and are situated beside related risk assessments e.g. The Braden Scale and 'Skin Check' section are placed together in the document.

- ✓ A **'traffic light' colour format** is throughout the document. This system can help to indicate the level of risk that is present/ level of nursing intervention that may be required when considering a plan of care i.e.

  Red *indicating a high level of risk/ a high level of nursing intervention may be required.*
  Amber *indicating a moderate level of risk/ a moderate level of nursing intervention may be required.*
  Green *indicating a low level of risk/ a low level of nursing intervention may be required.*

- ✓ Consideration should be given to other sources of information the RN should utilise when assessing and planning care for the Person e.g. general practitioner/ community nurse/ digital information systems
- ✓ The safe and timely discharge of the person into e.g. community care/ residential or nursing home care should be considered **as soon as possible**. This is in order to ensure the Person is in the ideal location for care to be delivered

	Area of Guidance	Guidance
FRONT PAGE/ PAGE 1	Hospital Passport	HSC passport is used for people with a learning disability in contact with a general hospital
	Resuscitation Status	**Refers to current admission status. Update if information changes during admission. Ensure appropriate medical documentation accompanies this alert**
	Next of Kin/ First Contact	Update if information changes during admission
	Person's participation	Document why he/she cannot fully participate e.g. sepsis causing delirium
	Allergies & sensitives on admission	'Other allergens' may include e.g. latex, animal hair. **If new allergies or sensitivities develop during admission, ensure they are documented on the 'Medicine Prescription and Administration Record' and on Page 43**
	Alerts	Risk of choking details should include Speech and Language recommendations in the community, if applicable/ if known
PAGE 2	Infection Prevention and Control (IPC) Risk Assessment	When completing risk assessment, consider how the results may affect others who the person is in contact with e.g. if person has community staff support at home and he/she has been admitted with symptoms indicative of tuberculosis. When completing risk assessment/ associated care, the organisation's local policy/ guidance should be followed and the IPC Specialist team should be contacted if there are any queries or concerns
	Cohort Bay	E.g. people within an area of the setting are admitted with vomiting and diarrhoea AND the same medical diagnosis
	Pregnancy test	Consider if carried out in emergency department. Considering presenting symptoms and admitting information, could person be pregnant/ does one need to be performed to negate possibility?
PAGE 3	Communication	**Person-All About Me:** If person is registered blind, assess if blind in one eye or both. If person wears contact lenses, check if they are in eye(s) **Assessment:** If person is not fully alert, consider all possible causes for this e.g. hypoglycaemia, head injury etc.
	Cognitive assessment	If abnormal cognition is indicated, consider if person e.g. has a diagnosed condition, has an undiagnosed condition, has a reversible condition. Give consideration as to whether the person is able to answer questions accurately if cognitive impairment is indicated
	Airway/ Breathing/ Circulation	**Person-All About Me:** Document how much oxygen/ which nebs the person advises are required at home (if any). Document all information in relation to airway, breathing, circulatory maintenance e.g. settings of respiratory machine **Assessment:** Assess e.g. how much oxygen is required to maintain oxygen level
	Health and Wellbeing	Documenting if person has ever stopped smoking and what symptoms presented when he/she did stop
PAGE 4	Moving and Handling	Under certain circumstances, weighing may not be possible and clinical judgement may need to be used. Actual weight should be established as soon as is reasonably practicable. Reasons for certain responses must be given e.g. unable to weigh due to the clinical condition of the person. Consideration should also be given as to whether e.g. the person needs to be moved onto a bariatric bed, using a bariatric hoist for safety, if his/ her weight is unknown. If using a hoist and the person's weight is unknown, staff must hoist over a safe surface. Ensure supporting trust documentation is completed e.g. Moving and Handling Care Pathway and policies/ guidance are followed e.g. care of the bariatric person
	Falls Assessment	FallSafe is a regional approach to falls prevention. Not all clinical areas will have FallSafe implemented but many of the elements evidentially proven to help reduce falls are throughout this document e.g. completion of urinalysis. Preventative measures are often being taken e.g. decluttering. Consult with falls prevention staff and refer to FallSafe guidance for further information (Royal College of Physicians). An arrhythmia is an abnormal heart rhythm meaning the heart beating too quickly, too slowly or irregularly (British Heart Foundation). A manual pulse should detect this. Consultation with a medical colleague is advised if this is detected.
PAGE 5	Bedrails Assessment	Any use of bedrails should consider the following in the decision making processes regarding their use: *their intended purpose* *if there is a less restrictive measure that can be used* *capacity to consent* *if there are any consent considerations relevant to the person's age (children and young people)* *compliance with deprivation of liberty safeguards.* Please note there may be circumstances when specific specialist and/ or legal advice may be required.
	Maintaining a safe environment	**Person-All About Me:** e.g. RN may wish to document conversations such as, "I do not want to wear recommended slippers, I do not feel safe without my inhalers beside me" **Assessment:** Examples include person may require a low rising bed, light left on at night, person not placed in a side room because risk of falls, person placed in a side room because of a diagnosis of an infective disease
PAGE 6	Eating and Drinking	**Person-All About Me:** person may inform admitting RN he/ she is taking supplements at home. Consider how this may be affecting his/her e.g. blood glucose level. Document if person discusses vomiting or nausea **Assessment:** Consider fluid restrictions in place. Observe feeding tube and obtain relevant information as part of assessment e.g. if balloon holds tube in place, position of feeding tube (cm). If relevant, obtain information where person undergoes replacement procedure e.g. jejunostomy feeding tube
PAGE 7	Elimination	**Assessment:** if urinalysis has not been obtained, document reason e.g. dysuria. Urinalysis can indicate many conditions/ diagnoses e.g. diabetes, infection, dehydration. If person has a catheter at time of admission, observe tube and obtain relevant information as part of your assessment e.g. what size of catheter is in place. If person has stoma in place, document e.g. when surgery was performed and why, what appliances the person uses, history of leakage/ blood/separation
PAGE 9	Skin Check	**Person-All About Me/ Assessment:** Only a person who is fully mobile and has no sensory or cognitive impairment should have a verbal pressure ulcer check (preferable to complete an actual skin check). Detail such a "states all skin is intact" should be documented if a verbal check has been carried out. The RN should select appropriate descriptor(s) and codes(s) of pressure damage (from purple section on Page 9), depending on what pressure damage is observed and assessed at the point of admission. Use the code(s) when body mapping i.e. use a line to point to location of skin damage and document the code and reason/ duration e.g. draw a line from nose on the body map and document "S/ G2, nasal specs, states broken skin for one week". This means the Person has had Grade 2 pressure damage on their nose for one week that was caused by their nasal specs (from person's perspective). If person is refusing skin checks, further support may be required

	Skin Check continued	from TVN
PAGE 10	Sleep	**Person-All About Me:** being in hospital could affect person's sleep pattern. Document what helps to make the person sleep better e.g. meditation, medication, white noise
	Audit – C	**Assessment:** Tools may be used by RN to support staff in caring for people who may suffer from alcohol withdrawal e.g. GMAWS, CIWA-Ar for Alcohol Withdrawal. Consider using, if appropriate to do so, alongside the Audit - C
PAGE 11	Psychological/ Emotional	**Assessment:** RN should ensure documentation of the person's anxiety, any recent medication usage in relation to anxiety/depression or other mental health diagnoses, any other treatments being utilised by the person to help treat mental health or behavioural diagnoses e.g. cognitive behavioural therapies
	Body Image	**Person-All About Me:** Admitting RN should document if person expresses anxiety/ concern relating to e.g. weight gain/loss, scarring, pigmentation, stoma/ urostomy formation, amputation of body parts, gender related considerations. Also document if person expresses no anxiety/ concern and/ or is confident with his/her body image
PAGE 11	Religious/ Spiritual/ Cultural	Needs may be in relation to e.g. dietary needs, protected times of the day for completion of religious practices
	Palliative Care (if applicable)	**Assessment:** Document if any preferences/ special requirements / considerations are in place e.g. person may express his/ her wish to die at home, donate organs for medical research, he/ she may have 'Advanced Care Planning' in place, organ donation (on register or wish to be on register)
PAGE 12	Social and Home Support	Consider community nursing, carers, specialised nursing support for e.g. cancer care. 'Details of support' may be e.g. administration of insulin by community nursing
PAGE 13	Pain	**Person-All About Me:** Pain management strategies may include analgesia, repositioning, exercise, TENS **Assessment:** Analgesia in last 24 hours must be documented (any route of administration). This will include e.g. via a syringe pump, analgesia in flu remedies. This record should include any drugs administered in the emergency department
	Person's medications	When considering 'Time Critical Medications', doses may have been missed e.g. during transfer to hospital, due to vomiting, due to NBM status. Lists of Time Critical Medications are reviewed ongoing by the PHA. Nurses should always be aware of the current list of Time Critical Medications. 'Date and time – last dose' section refers to last dose taken by Person
PAGE 14	Summary of identified needs	Document ANY need that is identified throughout '**P**erson- All About Me' and from '**A**ssessment' e.g. mouth care because person is undergoing chemotherapy treatment and has ulcers in his/ her mouth, blood monitoring because person is ingesting a high dose of oral steroids
PAGE 15	Person's valuables	If person is keeping valuables in hospital, document what valuables they have e.g. yellow coloured wedding ring
	Incomplete sections	If RN is unable to complete part of the document, there must be a reference to what areas of the document are incomplete and what action is being taken. If RN is unable to obtain information, he/ she should document what is planned in order to acquire relevant knowledge of the person e.g. "phone community nurse in am."
PAGES 43	Hospital/ ward transfer	Document should follow person wherever they transfer to, within the HSC trust
	Alerts/ food allergies since admission	Details of food allergy/ sensitivity should include type of reaction e.g. rash and to what allergen e.g. strawberries
PAGES 45- 49	***Reviews of risk assessments:*** *Moving and Handling/ Falls/ Bedrails/ MUST/ Braden and accompanying skin check need*	Using professional judgement and critical thinking, all risk assessments should be considered for update when person's condition changes, on transfer to another location of care and/ or as local policy/ guidance dictates. In table (Page 49), the person's skin condition can be documented for three skin observations. Please ensure all relevant trust documentation is completed in relation to pressure ulcer prevention/ monitoring of skin integrity e.g. skin bundle
PAGES 50 & 51	**Discharge information/ checklist**	Discharging RN has overall responsibility to ensure that the person's discharge is safe and timely. Certain sections may be completed prior to day of discharge e.g. 'Prescription sent to pharmacy' section. N/A boxes can be ticked where appropriate (in blue filled title banners). Ensure important information is documented when considering the reason for the person's admission e.g. "was admitted with hyperglycaemia. Diagnosed with Type 1 diabetes, commenced on insulin"
	Medication	'Discharge medication checked and given' section must be reconsidered e.g. if delay in discharge. If delayed discharge, RN responsible for person's care should consider the administration of his/her medications while still in the clinical area. First 2 considerations ('Prescription sent to pharmacy' and 'Anticoagulant prescription') require name of professional who has sent scripts to pharmacy and date and time sent
	Check prior to discharge	IV access device may be left in place due to person's need for IV antibiotics in the community e.g. PICC. Armband may be left in place for patient safety reason
	Discharge contacts	Ensure all referrals are made to professionals in the community prior to discharge e.g. to request provision of equipment. Ensure all information is communicated to them to ensure safe discharge. Ensure all equipment is given to person/ carer on discharge or is in place on discharge e.g. pressure relieving equipment. If person e.g. requires administration of medications in the community, ensure correct administration documents are completed and person/ carer advised these should be given to the administrator of the medications
	Follow up appointment required	Follow up appointment date(s) may not be known on discharge. Document if being e.g. posted to person and confirm what address notification is being sent to. Document why primary carer was not advised of arrangements (if applicable)
	Transport	Document who was advised when person left the ward e.g. next of kin, district nurse, nursing home, receiving hospital

***This guidance contains examples of what may be appropriate to document and is not exhaustive**