GIG CYMRU NHS WALES | Bwrdd Iechyd Hywel Dda Health Board

PART B - EMERGENCY NURSING ASSESSMENT AND CARE DOCUMENT

PART B

Date	Time of Admission	Route of admission / referral	Unit	Hospital	Named nurse accepting patient

THIS DOCUMENT IS ONLY TO BE USED IN THE EMERGENCY AND URGENT CARE CENTRES AND THE MEDICAL AND SURGICAL ASSESSMENT UNITS

This document is to be used in conjunction with Part A – First Contact document
Before writing in this document all members of staff MUST complete the signature list on page 2
Further guidance for completing this document can be found on the back page

PATIENT ID

Patient ID Label

Preferred Name:	ID Band in situ
	YES / NO
Preferred Language	**Communication difficulties**

RELATIVES AND FRIENDS

RELATIVES / FRIENDS – please delete what does not apply

Is the patient accompanied? YES / NO	Are relatives/friends following on? YES / NO
Name of person with the patient:	**If the patient is under 16, who has parental responsibility?**
	Name: / **Relationship:**
Relationship:	

Are relatives/friends aware the patient is here? YES / NO	Patient does NOT wish anyone to be informed Patient is UNABLE TO SAY whether they wish anyone informed	Is there a need to contact someone? YES / NO

Name & phone number of person to be contacted:	Contacted by: (Name & Time)

Is the patient happy for information to be shared with their relatives and / or friends?	YES NO	Details:
Is the patient happy for information to be shared with other clinical staff?	YES NO	Details:

DESCRIPTION

ONLY to be recorded if the patient could be in danger if they were to leave the hospital unsupervised **OR** patient is unidentified

Approx Height		**Clothing**	**Other distinguishing features**
Build	SLIGHT / MEDIUM / HEAVY		
Hair			

POLICE

Have the police service been involved at any point during the pre-hospital or emergency care phase of this patient's stay?
YES / NO If YES, complete the information below:-

Name & number of officer:	
Station:	Contact details:

Please write in BLACK ink

Specimen signature list of ALL staff writing in this care record - If not based on Unit please **ALSO** complete section below

SPECIMEN SIGNATURES

Name of staff member	Designation	Signature	Initials

OTHER STAFF ASSESSING PATIENT – Record the names of AHPs or other staff (not medical) external to Unit

EXTERNAL STAFF

Name	**Designation**	**Department**	**Contact no.**

BACKGROUND

PRESENTING COMPLAINT	A brief description of the background to the current problem that has brought the patient into hospital. Include details of any relevant pre-hospital information

BACKGROUND

CAPACITY TO CONSENT TO EMERGENCY NURSING CARE

MENTAL CAPACITY (for Adults aged 16 yrs and over)

If you have reason to doubt the patient's mental capacity to consent to their emergency **nursing** care or treatment, consider the following and record your decision making in the patients notes:

Consideration	Action
a) Does the patient's clinical condition mean that you **can't delay** emergency nursing care or treatment in order to undertake an assessment of capacity?	**Can't delay treatment:** Essential care should be carried out under a duty of care. For other non-urgent treatment, assess capacity as soon as it becomes possible.
	Can delay treatment: Assess capacity.
b) When **assessing capacity** you need to consider whether the patient can: • Understand the information relevant to the decision? • Retain the information long enough to make the decision? • Use and weigh the information in making the decision? • Communicate their decision in any way?	The significance of the decision to be made will affect how formal the assessment of capacity needs to be. For more significant decisions, follow the guidance in the Mental Capacity section in PART A. **Ensure that you document your decision making.**
c) If the patient does lack capacity to consent to their emergency nursing care or treatment, is this lack of capacity likely to be **temporary**?	**Lack of capacity is temporary:** Can the care or treatment wait until the patient regains capacity and can consent for themselves? If not, treat in best interests following the guidance in the Mental Capacity section in PART A.
	Lack of capacity is permanent: Treat in best interests following the guidance in the Mental Capacity section in PART A.

CHILDREN UNDER 16

Some children under 16 years of age have sufficient maturity and intelligence to be capable of understanding fully the care or treatment proposed and making a decision based on the information provided. These children are considered to be 'Gillick competent' and can consent for themselves. N.B. If a Gillick competent child refuses to give consent, a parent can overrule this refusal and give consent on their behalf.

CAPACITY TO CONSENT

Child Protection / POVA / Domestic Violence

Is there anything in this person's presentation that gives you cause for concern?				
Summary of action taken – please write details in record of care (p8-11)				
	Child protection register checked:	**YES / NO**	**On Register / Not on Register**	
Is the child a **'looked after'** child?	**YES / NO**	**Name of foster parents:**		
Does the patient already have a social worker?	**YES / NO**	Name:	Contacted by:	
COMPLETED BY:	Signed:	Countersigned (if needed):	Time:	

SAFEGUARDING

Patient's Hospital Number:-……

Please write in BLACK ink

PH	Pre-Hospital Interventions	Airway adjunct	O_2 in situ	IV cannula	IV fluids	Triply Imm.

PRIMARY NURSING ASSESSMENT AND CARE PLAN

OBSERVATIONS

INITIAL OBSERVATIONS				TIME:-		
Temp	**Pulse**	**Resp**	**BP**	**O_2 Sats**	**PEFR**	**Blood Sugar**

Frequency of repeat: **15min : 30min : 1hr : 2hr : 4hr** (Please circle what applies)

PRIMARY NURSING ASSESSMENT

	Assessment – Please CIRCLE what applies and ADD additional information		**Urgent nursing interventions**
AIRWAY	No airway problems	Unable to maintain own airway ET tube in situ Adjunct in situ Noisy / drooling Inhalation injury Airway at risk	Manual manipulation of airway Airway adjunct inserted Suction of secretions
BREATHING	Normal, quiet breathing	Resp Rate ↑ Resp Rate ↓ Increased work of breathing Cyanosis O_2 sats on AIR < 94% O_2 sats below agreed level for patient	O_2 administered at SaO_2 maintained at 94-98% / 88-92% Urgent blood gases requested Nebuliser administered Non-invasive ventilation commenced
CIRCULATION	Heart rate normal (for patient) BP normal (for patient)	Heart rate ↑ Heart rate ↓ Rhythm irregular BP ↑ BP ↓ CRT > 2secs Exsanguinating haemorrhage	Attached to cardiac monitor ECG performed Sepsis screen completed IV cannula inserted IV fluids commenced Blood tests taken
DISABILITY	Alert & Orientated	Only responding to VOICE / PAIN Unresponsive Altered mental state Limb weakness Facial asymetry HYPOglycaemic / HYPERglycaemic	Positioned on side BM recorded Hypostop / Glucose tablets given Ketones recorded
FRACTURES	LOCATION OF FRACTURE: Triply immobilised No fractures	Open fracture Critical skin Gross deformity Splint-in-situ Pulses: Present / Absent Sensation: Normal / Abnormal	Removed from spinal board Injury photographed Wound covered Preparation for urgent manipulation
WOUNDS	LOCATION OF WOUND: No wound seen	Haemorrhage: Major / Minor / None Burn : Cooling in place Self-inflicted wound Dirty wound Foreign body in situ	Pressure dressing applied Burn first aid (cooling) started Burn mapping chart started Wound photographed Temporary dressing applied
COMFORT (FoC 7)	PAIN SCORE No pain Prepared for examination Psychological distress	Nausea / Vomiting Too warm / Feels cold Wet / Soiled / Bloodstained Heightened anxiety	Analgesic given Antiemetic given In gown / undressed Washed & dry clothes / bedding Careful explanations given Family / friend with patient

PRIMARY ASSESSMENT

Pre-Hospital Drugs given	Morphine	Salbutamol	Other	ALS drugs	PH

PRIMARY NURSING ASSESSMENT AND CARE PLAN — OBSERVATIONS

COMPLETED BY:-	Signed:	Countersigned (if needed):	Time:

Glasgow Coma Scale				Visual Acuity		Weight
Eyes (4)	Motor (6)	Verbal (5)	Total (15)	Left	Right	Estimated / Weighed Kg

Repeat: **30mins : 1hr : 2hr** (Please circle what applies)

EMERGENCY CARE PLAN

PRIMARY ASSESSMENT

ADD any additional interventions undertaken and / or care needed, & initial when complete

	AIRWAY
	BREATHING
	CIRCULATION
	DISABILITY
	FRACTURES
	WOUNDS
	COMFORT (FoC 7)

Please write in BLACK ink

SECONDARY NURSING ASSESSMENT – complete only for ADULTS 16yrs and above

SECONDARY NURSING ASSESSMENT

ASSESSMENT

COMMUNICTION

Communication (FOC1) – please CIRCLE what applies and **ADD additional information**

No identified problems	Communication via 3rd party	Acute confusional state
Use glasses / contact lenses	Impaired vision	Long standing memory problems
Uses a hearing aid	Impaired hearing	Diagnosis of dementia
Uses a speech aid	Impaired speech	Diagnosis of a learning disability

ENSURING SAFETY

Ensuring Safety (FOC 3) – Please TICK yes or no

FALLS RISK ASSESSMENT (F.R.A)	YES	NO
Has patient fallen in the last 12 months and therefore at high risk of falls?		
Is the patient taking > 4 regular medications		
Is there a history of stroke or Parkinson's disease (or other progressive neurological disorder)?		
Is there any history of light headedness or giddiness on getting up from low furniture?		
Are there any problems with balance, gait or coordination?		
Is the patient prescribed any psychotropics, antihypertensives, diuretics, alphablockers or opiate based analgesia? If YES highlight to doctor reviewing patient for GP medication review		
Does the patient have a carer?	YES	NO

PROMOTING INDEPENDENCE

Promoting Independence (FOC 4) - please CIRCLE what applies and **ADD additional information**

MOVING AND HANDLING RISK ASSESSMENT – please CIRCLE what applies

Weight	Medical History	Mobility	Mental State	Environmental
< 18 stone (<114Kg)	Injury to 1 limb	Independent	Co-operative	No attachments
18 – 25 stone (114-159Kg)	Hemiplegic / Paraplegic	Minimal assistance	Normally altered	Attachments eg. O_2, IVI,
	?Spinal injury	Moderate assistance	Confused / agitated	Triply immobilised
>25 stone (>159Kg) Contact site manager	Seriously ill	Fully dependent	Unconscious	Confined to chair
	Multiple injuries	Med / High risk of falls		Confined to trolley

HYGIENE

Personal Hygiene including Oral Care (FOC 8 & 10) - please CIRCLE what applies and **ADD additional information**

Hygiene & Dressing	Fully independent	Needs assistance	Dependent
Oral Hygiene	Fully independent	Needs assistance	Dependent

EATING & DRINKING

Eating & Drinking (FOC 9) – please CIRCLE what applies **ADD additional information**

Able to eat & drink	**Nil by Mouth**	Potential / actual swallowing problems	Needs assistance to eat & drink			
Special diet needed?	**Food Allergies**	**Diabetic**	Gluten free	Vegetarian	Low protein	Puree

Nutrition screen YES / NO

TOILET NEEDS

Toilet Needs (FOC 11) – please CIRCLE what applies **ADD additional information**

Using the toilet	Fully independent	Needs assistance	Dependent	
In urinary retention	Constipated	Diarrhoea	Uses incontinence pads	Incontinent: urinary/ faecal
Stoma : Ileostomy / Colostomy / Urostomy		Urinary catheter : Indwelling / Intermittent self-catheterisation		

PREVENTING PRESSURE SORES

Preventing Pressure Sores (FOC 12) – please CIRCLE what applies and **ADD additional information**

Are there any signs of pressure damage?	**Yes**	If **YES** – Location of pressure damage:-
	No	

P.S.P.S.	No	No, but	Yes, but	Yes		No	Yes & No	Yes
Sitting up? (long time)	0	1	2	3	Lifts up?	2	1	0
Unconscious?	0	1	2	3	Gets up and walks?	2	1	0
Poor general condition?	0	1	2	3	**If there is current pressure damage minimum score must be at least 10**		**TOTAL SCORE**	
Incontinent?	0	1	2	3				

EXTENDED EMERGENCY CARE PLAN

PLANNED INTERVENTIONS – ADD any additional actions & INITIAL when action taken

SECONARY NURSING ASSESSMENT

COMMUNICTION

Communication – please CIRCLE what applies and **ADD additional information**

Patient positioned so they can be observed	Call bell placed within reach
Patient encouraged to wear hearing aid / glasses	Butterfly scheme discussed

ENSURING SAFETY

Ensuring Safety – please CIRCLE what applies and **ADD additional information**

If YES to any of the falls risk assessment questions exclude intrinsic reason for falls / functional decline

ECG performed	Sitting & standing BP recorded	BM recorded	Urinalysis undertaken

If the patient is recognised as being frail with sudden loss of independence in recent weeks, ensure safe discharge assessment and multi-disciplinary referral.	**Referral made:** YES / NO
Does the carer wish to have a Carer's Needs Assessment? YES / NO	**Referral made:** YES / NO

PROMOTING INDEPENDENCE

Promoting Independence – please CIRCLE what applies and **ADD additional information**

SAFER HANDLING PLAN	Size of sling: XS / S / M / L / LL / XL / XXL
Has OWN: Wheel chair / Zimmer frame / Walking stick	Bariatric equipment used / needed

Activity	**Method**		**Aids**			**No of Nurses**						
Walking	Self	Assisted	Zimmer frame	Walking stick	--	0	1	2				
Chair to trolley	Self	Assisted	Hoist	--	--	0	1	2	3	4	5	6
Moving on trolley	Self	Assisted	Hoist	Slide sheet	--	0	1	2	3	4	5	6
Trolley to trolley / bed	Self	Assisted	Hoist	Slide sheet	Pat-slide	0	1	2	3	4	5	6

HYGIENE

Personal Hygiene including oral care – please CIRCLE what applies and **ADD additional information**

Hygiene needs attended to	Hair washed	Oral care given

EATING & DRINKING

Eating & Drinking – please CIRCLE what applies and **ADD additional information**

Swallowing assessment performed	Fluid Balance Chart started	Jug of water given
Diet ordered	Food chart started	

TOILET NEEDS

Toilet Needs – please CIRCLE what applies and **ADD additional information**

Actively offer visits to the toilet	Fluid Balance Chart started	Uses bedpan
Urinary catheter inserted	Urinalysis undertaken	MSU sent

PREVENTING PRESSURE SORES

Preventing Pressure Sores – please CIRCLE what applies **and ADD additional information**

Pressure Sore Prevention Actions			DATIX completed: YES / NO
Score	**Reposition patient**	**Pressure relieving aids**	
6 – 9	2 hrly	Pressure reducing foam mattress	Skin bundle started: YES / NO
10 - 16	1 – 2 hrly	Needs Nimbus bed ASAP	

ASSESSMENT COMPLETED BY:	Signed:	Countersigned (if needed):	Time:

 Please write in BLACK ink

RECORD OF CARE GIVEN

This section includes:

- Care provided & evaluation of care
- Changes to the plan of care
- Details relating to multidisciplinary discussions
- Any communications/discussions with patient, next of kin/significant other/carer MUST be documented in this section including reference to with whom the communication was with

RECORD OF CARE

Time	Details	Sign

TIME	RECORD OF CARE GIVEN	SIGN

RECORD OF CARE

Please write in BLACK ink

RECORD OF CARE

TIME	RECORD OF CARE GIVEN	SIGN

TIME	RECORD OF CARE GIVEN	SIGN

RECORD OF CARE

Please write in BLACK ink

TRANSFER DOCUMENTATION – FIRST transfer

Area Transferred FROM		Area Transferred TO	
Admitting Consultant		Admitting Speciality	

S **SITUATION**

Presenting Complaint (see p3)	
Diagnosis (if known)	

B **BACKGROUND**

History of PC (see p3)	Relevant PMH & DH (see PART A p2)	MRSA check	
Presenting Issues (see p3)	Risk Assessments (see p6-7)	Relatives / Friends (see p1)	

A **ASSESSMENT**

Treatment so far – please TICK the box

Airway management	Oxygen	NIV	Cardiac Monitor	Cannula	IV Fluids	Urinary catheter	Drugs given
Blood taken	Blood back	Cultures	ECG	X-ray	CT/USS	MSU	Swab

Last set of observations: Taken at : **NEWS/PEWS SCORE:**

Temp	Pulse	Resp	BP	O_2 Sats	PEFR	BM	GCS

Current situation

Observations recorded every	15mins	30mins	1hrly	2hrly	4hrly

R **RECOMMENDATIONS** (Plan of Care)

DOCUMENTATION

Additional Documentation - please tick what applies and ADD any additional documentation used

PART A – First contact	IV cannula bundle	NOF Pathway	ECG
Observation chart	Urinary catheter bundle	Stroke pathway	Medical notes
IV Fluid Chart	Sepsis bundle	DKA pathway	Hospital notes
Pump Chart	Nutrition screen		Drug chart
Fluid Balance Chart			Consent form

TIME PATIENT LEFT UNIT / DEPARTMENT		Handover by Phone:	YES / NO

TRANSFERRING NURSE SIGNATURE	ACCEPTING NURSE SIGNATURE

TRANSFER DOCUMENTATION – SECOND transfer

Area Transferred FROM		Area Transferred TO	
Admitting Consultant		Admitting Speciality	

SITUATION — **S**

Presenting Complaint (see p3)	
Diagnosis (if known)	

BACKGROUND — **B**

History of PC (see p3)	Relevant PMH & DH (see PART A p2)	MRSA check	
Presenting Issues (see p3)	Risk Assessments (see p6-7)	Relatives / Friends (see p1)	

ASSESSMENT — **A**

Treatment so far – please TICK the box

Airway management	Oxygen	NIV	Cardiac Monitor	Cannula	IV Fluids	Urinary catheter	Drugs given
Blood taken	**Blood back**	**Cultures**	**ECG**	**X-ray**	**CT/USS**	**MSU**	**Swab**

Last set of observations: Taken at : ____ **NEWS/PEWS SCORE:** ____

Temp	**Pulse**	**Resp**	**BP**	**O_2 Sats**	**PEFR**	**BM**	**GCS**

Current situation

Observations recorded every	15mins	30mins	1hrly	2hrly	4hrly

RECOMMENDATIONS (Plan of Care) — **R**

Additional Documentation - please tick what applies and ADD any additional documentation used — **DOCUMENTATION**

PART A – First contact	IV cannula bundle	NOF Pathway	ECG
Observation chart	Urinary catheter bundle	Stroke pathway	Medical notes
IV Fluid Chart	Sepsis bundle	DKA pathway	Hospital notes
Pump Chart	Nutrition screen		Drug chart
Fluid Balance Chart			Consent form

TIME PATIENT LEFT UNIT / DEPARTMENT		Handover by Phone:	YES / NO

TRANSFERRING NURSE SIGNATURE	**ACCEPTING NURSE SIGNATURE**

Please write in BLACK ink

PLANNING A SAFE DISCHARGE FROM EMERGENCY CARE

PROMOTING INDEPENDENCE (FoC 4)

INDEPENDENCE	YES	NO	COMMENTS & ACTIONS
Is the patient fully independent and able to care for all own needs?			
If NO complete below			
Is the patient struggling to cope at home **OR** is the presenting injury / illness going to compromise previous ability to cope?			
Is there an existing care package that is perceived by client / carer / nurse / parent to be inadequate for current needs?			
Is the patient the main carer for a relative who will not be able to cope at home alone?			
If answer 'YES' to any of the above consider referral to community multi-disciplinary team for further assessment as per current County arrangements.			Signed: / Time referred:

EATING & DRINKING (FOC 9)

NUTRITION AND HYDRATION	YES	NO	COMMENTS & ACTIONS
Has there been significant, unintentional, weight loss i.e greater than or equal to 10% in the previous 3 - 6 months, (which may be evidenced by loose clothing, poorly fitting dentures, visual assessment of emaciation) that may signal poor nutrition?			
Is the patient having any difficulties with eating AND / OR drinking? (eg. loss of appetite, unable to finish meals, difficulty preparing meals, signs of dehydration etc)			
If answer **YES** to any of the above, please provide "Good Food First "first line information – sheets 3,4,5 & 6. OR if you have significant concerns regarding a patients nutrition and hydration please refer to the local dietetic service for advice or in the case of **Children please refer to their Health Visitor or School Nurse.** Dietetic Departments: WGH : 01437 774356: GGH: 01267 227067 / 227860 BGH: 01970 635730 PPH: 01554 783061 / 783344			Signed: / Time referred:

PRE-DISCHARGE CHECKLIST

PRE-DISCHARGE CHECKLIST	YES	NO	COMMENTS & ACTIONS
Is this a discharge after 2100hrs?			If yes please outline actions to ensure that this is still a safe discharge
If there is a carer / parent, are they confident and able to take patient home and cope with existing support systems?			Reason if NO
If there is no carer, has the next of kin or significant other been informed of discharge?			Reason if NO:
Has the residential / nursing home been informed, and an appropriate transfer of care document completed?			

DISCHARGE CHECKLIST

	YES	NO	COMMENTS & ACTIONS
IV cannula removed?			
Does the patient have warm clothes for discharge/transfer?			
Is the patient being discharged to their own home? If YES, answer questions below			***** If the patient does NOT have their house keys, where are they located?
• Does the patient / parent have their house keys for access?		*	
• Will the heating be on at home?			
• Are there food supplies at home?			
Medication			
Does the patient / parent / carer have the patients take home medication or own drugs to be discharged with?			
Does the patient / parent / carer understand the instructions for medication administration?			
Transport Arrangements			
Has transport been arranged?			If YES, please give details
Will anyone be accompanying the patient?			If YES, please give details
If NO will anyone be at the patient's home to meet them			If YES, please give details
Follow up arrangements			
Is a follow up appointment arranged if required?			
Does the patient / parent require an initial supply of dressings?			If YES please outline actions:
Outstanding Referrals			
Are there any outstanding referrals to make?			If YES please outline:

DISCHARGE CHECKLIST

Signature of Registered Nurse completing discharge assessment			
COMPLETED BY:	Signed:	Countersigned (if needed):	Time:

Actual time of leaving the Unit	Time	Signed:

Please write in BLACK ink

Please record relevant times:-

Arrival in ED		**Transfer to CDU / EAU**		**Transfer to ward**		**Discharged**	

BREACH REASONS	**Breach Reason (if any)**	**Signature**
	Escalation & actions taken	

Glossary of Terms/Abbreviations:	**References:**
PSPS – Pressure Sore Prediction Score	All Wales Minimum Standard Dataset for Documentation (Version 5 - 2012).
FoC – Fundamentals of Care	DoH (2009) Reference guide to consent for examination or treatment 2nd Ed
POVA – Protection of Vulnerable Adults	
AHP – Allied Health Professional	

Guidelines for staff completing this document

THIS DOCUMENT IS ONLY TO BE USED IN THE EMERGENCY AND URGENT CARE CENTRES AND THE MEDICAL AND SURGICAL ASSESSMENT UNITS

There are a number of places to sign the document. If you complete the assessment of that section please sign in the relevant area.
If you undertake an aspect of care that has been planned then please initial next to the action and document in the Record of Care (p8-11)

Page	**Section**	**Completion guidelines**
1	Personal information	Document personal information about the patient and their relatives / friends **Police** – if the police have been involved at all then document the contact details of the PC involved
2	Signatures	All staff writing in this document must sign the signature list. Please also complete the details log if the staff are not part of the unit's normal establishment.
3	Background	**Presenting Complaint** – document the background to the current admission, including relevant pre-hospital information **Consent** – document the patient's CURRENT capacity to consent to emergency nursing care / treatment **Safeguarding** – document any concerns that you may have that require further observation and / or action taken
4-5	Primary Assessment	**Pre-hospital** – document any pre-hospital interventions **Initial observations** – document relevant initial observations including a plan for their repeat **Assessment and care planning** – circle what applies and add additional information The patient may leave the department at this point for transfer to ICU, theatres, paeds or other specialist in-patient areas
6-7	Secondary Assessment ADULT ONLY	**Assessment and care planning** – circle what applies and add additional information Complete embedded risk assessments for Falls, Moving and Handling; Pressure damage
8-11	Record of Care	Use this section to document:- • Care provided & evaluation of care; Changes to the plan of care; Details relating to multidisciplinary discussions • Any communications/discussions with patient, next of kin/significant other/carer including reference to with whom the communication was with Please date, time and sign each entry
12-13	Transfer	Complete the SBAR form prior to transfer of the patient. There are two identical transfer forms to enable two transfers to take place
14-15	Discharge	Complete the discharge planning prior to discharge to enable complex discharges to be identified and appropriate actions to be taken. Complete the discharge check list just prior to discharge to ensure it continues to be a safe discharge
16	Breach Reasons	Emergency Unit only - Document the arrival and departure time, and identify the reasons if the patient breaches the 4hr target

Patient's Hospital Number:- .....