

Policy applies to:

All staff and allied health professionals involved in patient care delivery at Mercy Hospital including Manaaki.

Related Standards:

Health & Disability Services (core) Standards NZS 8134.1.1.3:2008
Standard 3.4 Assessment

EQuIP

- ◆ **Criterion 1.1.1** - The assessment system ensures current and ongoing needs of the consumer/patient are identified;
- ◆ **Criterion 1.1.4** - The organisation implements effective systems for the management of medical emergencies, including the identification and care of deteriorating patients;
- ◆ **Criterion 1.5.3** - The incidence and impact of pressure injury is minimised through a pressure injury prevention and management strategy;
- ◆ **Criterion 1.5.4** - The incidence of falls and fall injuries is minimised through a falls management programme.
- ◆ **Criterion 1.5.7** - The organisation ensures that the nutritional needs of consumers are met.

Rationale

Assessment establishes a basis for decision making to provide patients and their whanau/family with the right care at the time it is needed. Assessment informs an individualized plan of care for inpatients and day surgery patients.

Definitions;

- **Holistic:** includes physical, mental, emotional, spiritual and cultural needs, and the lifestyle and informed choices and preferences of the patient
- **Risk Screening:** A simple process to identify patients at increased risk that may require specific assessment and/ or to guide the development of an action plan.
- **Assessment:** A systematic process for gathering, documenting and communicating pertinent information about each patient to identify their current and ongoing needs. Assessment may include obtaining a patient history, physical examination, observing and recording subjective and objective information, measurement of vital signs and the use of tools to guide decision making.
- **Pressure injury:** Localized injury to the skin or underlying tissue, usually over a bony prominence as a result of pressure, shear, friction or a combination of these factors.

- **Fall:** An unexpected event in which the participant comes to rest on the ground, floor or lower level.
- **VTE:** venous thromboembolism refers to pulmonary embolus or deep vein thrombosis
- **Nutritional screening:** Objective classification of a patient's risk of malnutrition using a validated and reliable nutrition screening tool i.e. Adult Failure to Thrive Screening Tool adapted from Malnutrition Universal Screening Tool (MUST).

Objectives

- Risk screening and /or patient assessments are undertaken and documented in a systematic, timely and appropriate manner.
- Interventions are planned, appropriate and meet patient's individual needs.

Implementation

- Education via mandatory training, new staff orientation, staff forums / in-service sessions
- On-line training components for family violence and smoking cessation
- HealthLearn

Evaluation

- ◆ Incident management system records falls and pressure injuries
- ◆ Review of falls data
- ◆ Review of pressure injury prevention data
- ◆ Review of VTE data
- ◆ Clinical Records audits
- ◆ External benchmarking of patient falls and pressure injuries with Australian Council on Healthcare Standards (ACHS) and NZ Private Surgical Hospitals Association (NZPSHA).
- ◆ Audit of risk screening, assessments and action plans
- ◆ Patient feedback
- ◆ Staff feedback

Associated Internal Documents:

- Adverse Reaction to Medication Policy
- Alcohol Withdrawal Protocol – Clinical Services Work Manual
- Cardiac Rehabilitation referral form
- Cardiac Surgery Care Path
- Child Protection Policy
- Clinical Records Management Policy
- Return or Disposal of Body parts and Human Tissue Policy

- Collaborative Nursing Model of Care/Nursing Handover Policy
- Community Coordination Centre referral form
- Consent Policy
- Cultural Policy
- Day Case Form
- Day Surgery Discharge - Clinical Services Work Manual
- Discharge Policy
- Discharge Summary
- Falls Prevention and Management Policy
- Falls Prevention and Management Strategic Framework
- Family Violence Policy
- Incident Policy
- Medication standing orders
- Medicines Management Policy
- Modified Early Warning Score Process - Clinical Services Work Manual
- Nicotine Replacement Therapy Policy
- Nursing Assessment form
- Nursing Scope of Practice
- Nutritional Care Policy
- PACU-Ward Nurse Handover - Clinical Services Work Manual
- Paediatric Pain Assessment & Management - Clinical Services Work Manual
- Patient Admission Forms (Hospital & Day Stay Facility)
- Patient admission information brochure
- Patient care paths and activities sheets
- Patient Restraint Minimisation Policy
- Patient transfer form
- Perioperative Record
- Pre-admission Needs Assessment - Clinical Services Work Manual
- Pre-admission Nursing Assessment - Clinical Services Work Manual
- Pre-admission Telephone Calls - Clinical Services Work Manual
- Pre-operative Checklist
- Pressure injury risk screening tool
- Pressure injury Risk Assessment chart (adapted Waterlow)
- Risk Management Policy
- Safe Handling Policy
- Transfer Policy
- VTE Policy

Assessment Process (excludes out-patients)

The assessment process shall be systematic, comprehensive and multidisciplinary, based on patients' needs and priorities.

Prior to and / or on Admission

The assessment process commences in the Credentialed Specialists' rooms prior to admission to hospital and may include referral to external agencies e.g. pre-operative assessment by Occupational Therapists.

A preadmission clinic is held prior to a patient's admission for surgery, to facilitate an anaesthetic assessment and/or a review by the surgeon. Assessment by a physiotherapist may be undertaken if necessary.

All patients shall have a nursing assessment completed prior to or within the first 2 hours following admission to Mercy Hospital. This will be undertaken:

- a) During a pre-admission phone call from a Registered Nurse or
- b) By a Registered Nurse at their pre-admission clinic visit or
- c) On admission to Mercy Hospital, by either a Registered Nurse or an Enrolled Nurse working under the supervision of a Registered Nurse.

Information is obtained from the:

- Patient admission form and health questionnaire
- Preadmission phone call
- Preadmission clinic visit
- Doctor's Admission Letter
- Patient and/or whanau/family as appropriate

The nursing assessment is completed in conjunction with the Patient Health Questionnaire; it enables nurses to work in partnership with patients and their whanau/family to plan their care in hospital and on discharge.

Differences in the assessment process and outcome will be dictated by the purpose and the setting and may include:

- Patient's expectation e.g. goals following their surgery or procedure and/or what matters most to them during their stay
- Relevant medical history
- Allergies / alerts /MDRO status
 - If there are no known allergies, this must be recorded as 'Nil known' or 'NKA' (no known allergies) or 'NKDA' (no known drug allergies) on the nursing assessment form.

- On admission, allergies or NKDA or NKA shall be written on the medication chart under 'allergies'.
- Current medications
- Relevant systems review including pain
- Psychosocial, religious and cultural needs including return of koiwi tangata body parts and tissue
- Any special needs the patient may have. (The patient admission form asks patients to identify any special needs e.g. uses a wheelchair)
- Risk screening/assessment including, falls, pressure injury, VTE risk and contraindications to DVT prophylaxis, nutritional screening (inpatients), smoking status, family violence and alcohol intake (inpatients)
- Discharge planning including home situation, dependents and care arrangements.

Baseline observations T, P, R, BP, SpO₂, weight, height (where required).

The nursing assessment should be updated if new information emerges during the course of the patient's hospitalisation. Where an assessment form is being used, changes including additions should be dated and initialed.

Theatre & PACU Records

- The theatre peri-operative record highlights pre and post-operative skin integrity assessment and records pressure injury prevention interventions that have been implemented.

A verbal briefing of the theatre team is led by the surgeon with all team members encouraged to provide input prior to the start of the operating list. This process facilitates open communication within the surgical team, identifies individual patients and potential risks or concerns. A debrief at the end of the operating list identifies what went well and identifies areas or issues that could be improved.

- Surgical Safety Checklist includes multidisciplinary assessment of the patient and operation to be performed at Sign In, Time Out and Sign Out phases of the procedure.
- Any concerns regarding the patient are handed over to the PACU nurse; this includes VTE prophylaxis.
- PACU nurses undertake a head to toe assessment on patients admitted to PACU and document variations on the anaesthetic record sheet. This forms a base-line for discharge criteria and assists in the handover from PACU to ward staff.
- Prior to leaving PACU, nursing staff will document the MEWS score on the ward observation chart.

Planning

- Any activities planned and undertaken are appropriate to the patient's age, gender, physical capabilities, culture and preference.
- Occupational therapy assessments (where required) are undertaken prior to, or during a patient's admission to Mercy Hospital.
- Individual needs that are identified in the assessment phase are incorporated into the patients care pathway.
- On admission patients are commenced on an appropriate pathway (see Clinical Record Management Policy). Any variations to the standard pathway should be added under "Additional Actions" at this time.
- The Care Path activity form is discussed with the patient (excluding Manaaki) and the activities agreed upon. Any variations should be added at this time.
- The form must be signed by the patient and is kept in the patients notes. Manaaki has an on line system so the patient will not be required to sign an activity form.
- The care path shall be used by all members of the multi-disciplinary team and their input is sought when care paths are updated.

Interventions

- Interventions are planned and based on the nursing and medical assessment and the consultant's admission letter.
- Planned actions/interventions outlined in the patients care plan assist the patient to meet their outcome goals.
- Interventions are initialed by staff to indicate they have been completed.
- Interventions are based on Best Practice and the Lippincott data base is a reference available to all nursing staff.
- A Modified Early Warning System (MEWS) identifies 'at risk' patients and guides management of a deteriorating patient. (see Modified Early Warning System (MEWS) in the Clinical Services Work Manual)
- Pharmacological interventions may be initiated following patient assessment and in accordance with medication standing orders.

Patient Wrist Band Alerts

A **Red 'falls risk' alert wrist band** shall be placed on patients who have been assessed as being at risk of falling or those that have had a fall (excluding near faints) during this hospitalisation.

A **Bright Pink 'lymphoedema alert' wrist band** shall be placed on the affected arm of patients who are at risk of developing lymphedema, such as those who

have had previous surgery for CA breast (removal of lymph nodes), to indicate that no blood pressure recordings or venipuncture are to be taken on this arm.

An **Orange 'renal alert'** in a white wrist band shall be placed on the affected arm of renal patients who have an A-V fistula.

Evaluation

- Variations to the care path and an action plan are written on the pathway or in the clinical notes.
- Outcome goals are recorded on-line in TrendCare on a daily basis. If they are not met, a reason is recorded and plans are altered to reflect either change of nursing care or change of outcome goal. If Surgeon is unaware of the variation, Surgeon should be informed.
- Variances to selected outcome goals are monitored.
- Evaluation is carried out post discharge via follow-up phone call.

Assessment prior to discharge / transfer from ICU, Day Surgery and Manaaki Day Facility

- Prior to discharge home or transfer to the ward, patients are assessed against specific documented criteria especially in the case of nurse-led discharge.

Referrals

Patients that are assessed as requiring input from or ongoing support by allied health or external health professionals e.g. Occupational Therapist; Stomal Therapist; GP, are referred to the appropriate person / agency; this is documented in the patient's clinical notes or on the clinical pathway.

Discharge/Transfer: Refer to Discharge Policy and Transfer Policy for detailed information.