Identification Label:

Emergency Unit Adult Nursing Assessment

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Completed in conjunction with the casualty card.
Complete the adult in-patient assessment when patient has been in the department over 24hrs
Complete signature list on back page

Preferred Name:

Preferred Language:

ID band in situ ☐

Religious/spiritual/cultural preference:

Date & Time of assessment	Date & Time of decision to admit	Communication concerns (e.g. learning difficulties, sensory loss)	Sharing Information agreed (see record of care)				Weight (Kg)
			Yes		No		

Emergency Contact:		Relationship to patient:	
Address: Contact N°:		Contacted by who & when:	
Accompanied by:		Relationship to patient:	

Have the Police services been involved in relation to this EU attendance? **Yes / No**		Description: Height/Build/ Hair	Clothing	Distinguishing Features
Officer name /contact details/incident number				

Triage / Presenting Complaint	Medical & Surgical History
Sepsis Screen: **Yes / No**	Mental Health History (complete relevant risk assessments) Is the patient receiving support from a MH specialist team? Yes ☐ No ☐ N/A ☐ If any concern are identified, complete Risk Assessment

Infection Control	Complete **INFECTION PREVENTION & CONTROL PATIENT ADMISSION CLINICAL RISK ASSESSMENT and SCREENING TOOL**	Tick once complete	

Does the patient have a valid DNACPR form in place? Yes ☐ No ☐ N/A ☐ *Valid copy in the medical notes* ☐

Allergies:	**Type of reaction**	Epi pen used? Yes ☐ No ☐	Concerns with cognitive function? Yes ☐ No ☐

Signature	Reviewer Signature	Date	Time

Please write in BLACK ink

Primary Nursing Assessment *(Please Circle or tick as appropriate)*

	Emergency Assessment		Nursing Interventions	Care Plan & Actions
Airway	No airway problems Airway at risk ET tube in situ Adjunct in situ	Noisy / Drooling Inhalation injury Unable to maintain own airway	Manual manipulation of airway Airway adjunct inserted Suction of secretions	
Breathing	Normal, Quiet Breathing Respiratory rate ↑ Respiratory rate ↓ Increased work of Breathing	Cyanosis O_2 saturation on air <94% CO2 retainer Apnoea	O_2 administered at: ☐ SaO_2 maintained at 94-98% / 88-92% Blood gases Nebuliser administered NIV	
Circulation	Heart rate (normal, within range) BP normal, within range for patient CRT 1-2 sec **Critical Bleed: Consider major haemorrhage protocol** ☐	CRT > 2 sec Heart rate ↑ Heart rate ↓ BP ↑ BP ↓	Cardiac monitor ECG performed Sepsis Screen & bundle IV cannula inserted IV fluids commenced Bloods taken Tranexamic acid	
Disability	**A V P U** Altered mental state Limb weakness Facial asymmetry	HYPERglycaemic HYPOglygaemic	Positioned on side Blood sugar recorded Hypo stop / Glucose tablets Ketones recorded	
Exposure	No suspected fractures Triply Immobilised Open fracture Critical skin Gross deformity	Splint in-situ Pulses: present/ absent Sensation: normal / abnormal	Removed from spinal board Wound covered Preparation for urgent manipulation Injury photographed –(with consent)	
	No wound seen Self-inflicted wound Dirty wound	Foreign body in wound Burn	Pressure dressing applied Burn first aid (cooling) started Burn mapping chart started Wound photographed –(with consent) Temporary dressing applied	
Comfort	No pain Too warm Feels Cold Wet / Soiled Blood-stained	Heightened anxiety Psychological distress Pain Score ☐	Analgesic given Antiemetic given Warming (blanket / fluids) Temperature recorded Skin bundle & Intentional Rounding	
News chart ☐				

Signature	Reviewer Signature	Date	Time

Secondary Nursing Assessment *(Please Circle/tick as appropriate)*

Mental Capacity	Do you have reason to doubt the patient's capacity to make decisions about their care and treatment? **Yes** ☐ **No** ☐	If Yes, detail:		
Is this due to:	☐ A pre-existing diagnosis (e.g. learning disability, dementia, stroke, other cognitive impairment) ☐ A new presentation (e.g. delirium, confusion, new head injury, new stroke)			
Does the patient have any of the following?	"This is Me" document / Butterfly Sceme	Yes	No	Not Known
	Advance Decision to Refuse Treatment	Yes	No	Not Known
	Health & Welfare Lasting Power of Attorney or Court Appointed Deputy	Yes	No	Not Known
Does the patient have a learning disability? If Yes, consider LD passport and Care Bundle		Yes	No	Not Known
If Yes, Referral to LD team <4hrs of arrival in EU (see LD bundle)		Yes	No	
Enhanced Support Level	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐			

Referral to an Independent Mental Capacity Advocate (IMCA) may be required if the patient has no family. Friends or Deputy to consult regarding best interests decisions.

	Emergency Assessment	Interventions & Care Plan
Communication	No Problems identified Uses Glasses / Lenses Communicates via 3rd party Uses Speech aid Impaired Vision Impaired Speech Uses Hearing Aid	
Nutrition Hydration	Able to eat & drink Food Intolerance Supplementary Fluids Gluten Free Textured / modified: diet / fluids High calorie / Protein diet Vegetarian / Vegan Nil by Mouth Diabetic Food Allergy	Diet Ordered Swallowing assessment **Nutrition Risk Screening Completed <24hrs** ☐ Referred to dietitian ☐ Last ate & drank Fluid chart commenced ☐ Food chart commenced ☐ Patient given: Sandwich / Meal / Hot Drink / Water

Moving & Handling

Weight	Clinical Condition	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 (e.g. O_2, IVI)
	Suspected 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

Equipment

Hoist
Zimmer Frame
Sling Size:
Wheelchair
Walking Stick (s)
Glide sheet
Steady Stand
Pat slide

Activity	No of staff
Walking	
Standing	
Chair to trolley	
Moving on bed / trolley	

Moving & handling Risk Assessment & Plan completed ☐

Bariatric equipment ordered

Skin

Moisture damage: Yes / No Datix completed : Pressure Damage Passport

Dynamic mattress / Chair ordered Skin Bundle & Intentional Rounding Wound chart / Body Map

Complete step 1 Purpose T screening (see references) below for all patients. If Step 2 required complete full risk assessment tool0

Step **1** – Screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk ☐
- Spends all or the majority of time in bed or chair ☐
- Remains in the same position for long periods ☐
- Walks independently with or without walking aids ☐

If **ONLY** blue box is ticked

If **ANY** yellow boxes are ticked, **go to Step 2**

Skin status – *tick all applicable*

- Current PU category 1 or above? ☐
- Reported history of previous PU? ☐
- Vulnerable skin ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐
- Normal skin ☐

If **ONLY** blue box is ticked

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

Clinical Judgement – *tick as applicable*

- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids ☐
- No problem ☐

If **ONLY** blue box is ticked

If **ANY** yellow boxes are ticked, **go to Step 2**

No pressure ulcer **not currently at risk**

Tick if applicable ☐

Not currently at risk pathway

Please write in BLACK ink

Personal Care	Independent	Assistance	Dependant
Washing & Dressing			
Mouth Care			
Foot Care			

Mouth Care Risk Assessment < 24hrs ☐

Continence

Fully Independent

Needs Assistance

Fully Dependent

Uses continence products

Diarrhoea / Constipation

Incontinent: Urine / Faeces

Urinary: Urgency / Frequency / Retention

Stoma: Urostomy / Illeostomy Colostomy

Catheter: Intermittent /Indwelling

Time last voided urine: Bowels last opened:

Continence Risk Assessment completed ☐

Bladder Scan / Trial without Catheter / Catheter inserted

Catheter Bundle

Consider urinalysis / MSU

Clinical Frailty Screen

Circle current frailty & tick ✓ baseline score

*1. Canadian Study on Health & Aging, Revised 2008.
2.K. Rockwood *et al.* A Global Clinical Measure of Fitness and Frailty in Elderly People. CMAJ 2005;173:489-495

1. Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally** e.g. seasonally.

3. Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4. Vulnerable – While **not dependent** on others for daily help often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5. Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty impairs shopping and walking outside alone, meal preparation and housework

6. Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing standby) with dressing.

7. Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within – 6 months).

8. Very Severely Frail – Completely dependent, approaching end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill – Approaching the end of life. This category applies to people with **a life expectancy <6mnths**, who are **not otherwise evidently frail.**

Actions taken:

Falls	Tick if applicable
Patient taking 4> medications?	
Patient has pain affecting mobility?	
Has the patient fallen in the last 12 months or fears falling?	
History of stroke or Parkinson's (or other progressive neurological disorder)?	
Existing problems with balance, gait or coordination?	
Prescribed medications that increase falls risk e.g. psychotropic, antihypertensive, diuretics, alpha blockers or opiate based analgesia?	
History of light-headedness or giddiness on getting up from low furniture?	

If Yes to any of the above complete All Wales Multifactorial Falls Risk Assessment ☐

Actions taken

- Intentional Rounding ☐
- Lying / standing BP ☐
- Hi-Lo Bed ☐
- Bed rails assessment ☐
- Medication review ☐
- Care Plan ☐
- Other:

Safeguarding	Yes	No
Is there a concern there may be an "adult or child at risk"?		
Do you have any concerns for your safety?		
Are there concerns about sexual abuse?		
Are there concerns about violence against women?		
Are there concerns about domestic abuse?		

If Yes, follow local safeguarding procedures as per legal and statutory duty to report & record actions taken in the record of care.

Actions taken

Referred to safeguarding ☐

Date & Time referred:

All Wales DASH Risk identification checklist ☐

MARAC referral completed ☐ Date & Time referred:

Other:

Signature	Reviewer Signature	Date	Time

Property List Completed	Yes	No	N/A	Reference Number:	
Property sent to General Office	Yes	No	Please specify:	Date &Time sent	Sign
Property taken home by Next of kin/Significant other/carer	Yes	No	Please specify:		

Eiddo Claf – Ffurflen Ymwadiad

Mae _____ wedi egluro i mi'r weithdrefn i gadw arian ac eiddo yn ddiogel. Rydw i wedi cael cynnig trosglwyddo fy eiddo a nwyddau gwerthfawr personol yn unol â'r weithdrefn honno, fodd bynnag, rydw i wedi penderfynu cadw fy nwyddau gwerthfawr gyda mi yn ystod fy arhosiad yn yr ysbyty ac wrth wneud hynny, rydw i'n derbyn cyfrifoldeb llawn dros eu cadw'n ddiogel.

Rydw i,_____ yn cydnabod yma na all Bwrdd Iechyd Hywel Dda dderbyn unrhyw gyfrifoldeb pellach am unrhyw golled neu ddifrod i'm nwyddau gwerthfawr ar y safle hwn, mae'r holl eiddo personol a gedwir gennyf i ar y ward neu ar fy mherson tra byddaf yn yr ysbyty yn gyfrifoldeb i minnau, ac felly rydw i'n indemnio'r ysbyty rhag unrhyw gyfrifoldeb sy'n codi o'u colli neu eu difrodi.

Eitemau a gedwir gan y claf (modrwyau priodas, cadwyni, eitemau electronig, dillad, ati)

Llofnod y Claf Perthynas/Ffrind ar rhan y claf:

Llofnod Tyst (staff) Dynodiad: Dyddiad:

Patient's Property - Disclaimer Form

_____ has explained to me the procedure for the safe keeping of money and property. I have been offered the opportunity to hand over my personal property and valuables in accordance with that procedure, however, I have decided to keep my valuables in my possession during my stay in hospital and in doing so accept full responsibility for their safe keeping.

I,_____ hereby acknowledge that Hywel Dda Health Board cannot now accept any responsibility for any loss or damage to my valuables on these premises, all personal property retained by me on the ward or on my person while in hospital, is my responsibility, and therefore, I indemnify the hospital from any liability arising from the loss or damage thereof.

Items retained by patient (wedding rings, necklaces, electronic devices, clothing etc):

Patient Signature : Relative/Friend on behalf of Patient

Witness Signature Designation Date:

Please write in BLACK ink

Health & Wellbeing	Yes	No
Do you currently smoke or vape? (If yes, consider nicotine replacement whilst in hospital)		
Would you like support to stop smoking? (If yes consider referral to smoking cessation service)		
Do you drink alcohol?		
If Yes, how many units per week?		
Do you wish to receive information / advice for reducing or stopping?		
If Yes, please detail:		
Do you have difficulties with substance misuse? (e.g. prescription, non-prescription or other illicit substances)		
If Yes, please detail actions taken:		

Home Circumstances & Current Support	Yes	No
Patient has a main carer?		
Patient/carer struggling to cope at home **OR** may not cope on discharge. If Yes, consider who can help?		
Existing care package that is perceived by client, carer or nurse to be inadequate to meet needs? (If Yes provide details in record of care)		
Patient is main carer for a relative who will not be able to cope at home alone?		
Do they provide regular and substantial care? (If Yes, consider if they wish to have a carer's needs assessment? If Yes, and they are a young carer consider referral to young carers support.)		
Carer name and contact details:		

Signature	Reviewer Signature	Date	Time

Date & Time	Record of Care	Signature

Date & Time	Record of Care	Signature

Please write in BLACK ink

Date & Time	Record of Care	Signature

Date & Time	Record of Care	Signature

Please write in BLACK ink

Date & Time	Record of Care	Signature

Date & Time	Record of Care	Signature

Please write in BLACK ink

Date & Time	Record of Care	Signature

SBAR TRANSFER RECORD FROM EMERGENCY UNIT

Date of Transfer	/ /	Time Handover Given	:		Area Transferred TO	
Admitting consultant		Handover by phone:	Yes	No	Admitting specialty	Yes

Situation (tick when handover communicated)

Presenting Complaint (See pg. 1)	☐	DNACPR status	☐
Diagnosis (if known)	☐	Allergies	☐

Background (tick when hand over communicated)

Relevant PMH	☐	Plan of care	☐	Infection Control Status	☐
Presenting Issues	☐	Relatives / Friends	☐	Risk Assessments	☐

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

NEWS Chart & NEWS Score handed over ☐

Additional documents used and given to receiving ward (please tick what applies)

NEWS chart	Neck of Femur Pathway	ECG (s)	
IV fluid chart	Stroke Pathway	Consent Form	
Pump Chart	Sepsis Bundle		
Fluid Chart	DKA Pathway		
IV cannula bundle	Medication chart		
Urinary catheter bundle	Medical Notes		

Recommendations (including nursing plan of care)

Transferring Nurse Handed over: Signature		Handover received & understood by: Signature	

Time of transfer to ward	:

Discharge From Emergency Care Only

SIMPLE DISCHARGE (please tick)	**Yes**	**No**	**Comments & Actions**
Is the patient independent and able to care for all own needs?			If No, also use complex discharge
Is this discharge out of hours? If Yes, please outline actions to ensure that this is still a safe discharge			
Intravenous cannula removed?			
Transport arranged?			
Next of kin/ significant other aware and agree to discharge plan?			If no, document reasons why:
Does the patient/carer understand the instructions for medication administration?			
Does the patient/carer have the required medication?			
Is the patient being discharged to their own home? (Consider access to food supplies, heating, warm clothing)			
Existing package of care restarted and carer informed?			Time of next call:
Does the patient/parent have their house keys for access?			Consider if the patient has key code access
Will anyone be accompanying the patient / at the patient's home to meet them?			
Is a follow up appointment arranged if required?			
Does the patient/parent require an initial supply of dressings?			
Are there additional referrals to make?			
COMPLEX DISCHARGE			
Are there any identified difficulties that are going to compromise the patients' previous ability to cope?			
Is there an existing package of care? If Yes, is the existing care package perceived by the patient/carer/nurse 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, refer to the multi-agency discharge team.			Referred by: Time referred:
If there is a carer, are they confident and able to take patient home and cope with existing support systems?			
Residential/ nursing home been informed?			
Transfer of care document completed?			

Signature:	**Reviewer Signature (If applicable)**	**Date & Time of discharge:**

Glossary of Terms & Abbreviations			
BP	Blood Pressure	IVI	Intravenous infusion
CRT	Capillary Refill Time	NEWS	National Early Warning Score
SaO_2	Saturations of Oxygen	NBM	Nil by Mouth
EU	Emergency Unit	NIV	Non-Invasive Ventilation
HR	Heart Rate	SBAR	Situation, Background, Assessment, Recommendations
PMH	Past Medical History	DNACPR	DNACPR – Do Not Attempt Cardio Pulmonary Resuscitation.
IMCA	Independent Mental Capacity Advocate	MSU	Midstream Specimen of Urine

Falling star symbols appear alongside elements of the assessment / care plan where the patient is a high risk of falls and prompts actions are required accordingly.

Guidance on the use of this document - Complete all entries in black ink		
Page 1	Personal details	Document personal information about the patient, ensuring the correct identification label is place on the booklet. If police have been involved with the attendance to EU document the contact information of the officers. 000000 If the patient is at risk of absconding their description is required including distinguishing features for means of identification.
	Triage & PMH	Use this section to document the required information on triage, including the background to the presentation and past medical history to include surgical and mental health history.
	DNACPR	Document their resuscitation status and ensure copy is within the medical notes
	Infection Alerts	Document infection alerts here and action further screening as per HB procedure.
	Allergies	Document all known allergies and reaction type
	Cognitive Concerns	If there are concerns with cognition document here and follow HB procedures to ensure they have further assessment if required
Page 2	Primary Assessment	Complete the primary assessment of the patient on arrival to the EU. The sepsis screening document and NEWS chart use must be recorded. Areas highlighted in green indicate normal/ baseline observations. Document the care plan alongside the assessment. On completion of the assessment the nurse must sign the signature box.
Page 3-4	Secondary Nursing Assessment	Complete the Secondary Nursing Assessment on arrival to the EU and tick to confirm when further in-depth risk assessments are completed or care bundles and monitoring charts as they form the complete record. On completion of the assessment the nurse must sign the signature box.
	Mental Capacity	If you have reason to doubt the patient's capacity to make decisions about their care or to engage in the assessment process specify the actions taken and if referral to the mental capacity team is indicated.
	Frailty	Complete the frailty assessment by circling the image that reflects current frailty and ticking alongside the baseline frailty level for the patient.
	Falls	Answer Yes or No for the falls questions and if answering Yes to any of the questions a multifactorial risk of falls assessment must be completed. Circle immediate actions taken in the EU.
	Safeguarding	Answer Yes or No if you are concerned that there is a safeguarding issue with the patient or immediate dependents and follow the Health Board procedure for referral and escalation
Page 5	Property disclaimer	Complete the property disclaimer for all patients that come in to the EU and ensure property lists are completed if required. Property taken home by family must be recorded at the top of the page.
Page 6	Home Circumstances	Complete the home circumstances and carer details if applicable to the patient and provide carer contact details.
	Health & Wellbeing	Complete this section on alcohol, smoking and illicit substances and signpost to support services where applicable.
Page 6-10	Record of Care	Include the additional nursing care given including further interventions and evaluations not already covered within the document. Each entry must be dated, timed and signed as per HB policy.
11	SBAR Handover	To be used when patient is handed over from the EU to the ward / other clinical area.
12	Signature list	Prior to making any entries in this booklet, the signature list must be completed fully for traceability and accountability purposes.

References:

1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood *et al*. A Global Clinical Measure of Fitness and Frailty in Elderly People. CMAJ 2005; 173:489-495
Welsh Government (2015) Health & Care Standards.
Welsh Government (2013) Integrated Assessment, Planning and Review Arrangements for Older People.
Social Services & Wellbeing (Wales) Act 2014
Nursing & Midwifery Council (2015) The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives.
Hywel Dda University Health Board - Discharge and Transfer of Care Policy No 370 (2016)
Hywel Dda University Health Board - Record Keeping Policy for Nurses and Midwives. No 289 (2015).
All Wales Care Bundle for Adults with a Learning Disability Requiring Hospital Care Jan 2014
Purpose T Version 2Clinical Trials Research Unit, University of Leeds and Leeds Teaching Hospitals NHS Trust 2017

Please write in BLACK ink

Signature List			
Print Name	**Role**	**Signature**	**Initials**