Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Medical Surgical Division, ChCh Hospital
Ashburton and Rural Health Services

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

RISK SCREENING / ASSESSMENT

Risk Screening

This section to be commenced for all patients at point of entry (use Patient Assessment Questionnaire as appropriate) and completed within 6 hours of presentation (use an * to denote change/reassessment and sign with * in sign off section)

Identification Confidentiality

☐ Patient/whānau are aware that valuables are held at their own risk
☐ Patient label or NOK details **not** correct → ☐ Update PMS and Update Admission Form
☐ Patient's name requested to be removed from identification boards **OR**
☐ Personal information **not to** be shared with person/group *(specify below)*
→ ☐ Ward Clerk and Telephone Office notified as required → ☐ Alerts complete

Adverse Reaction

☐ Medicine *(specify)* → ☐ Alerts completed
☐ Food *(specify)* → ☐ Update diet
For 3 or more food allergies →☐ Dietitian referral
☐ Other *(specify)* Or No Risk ☐

IP&C

☐ PMS Alert checked for MRSA, ESBL, VRE, MDRO ☐ MRSA screening swabs taken
☐ Recent diarrhoea / vomiting (potentially infectious) ☐ Other *(specify)*
☐ Transmission based isolation precautions required → ☐ Contact ☐ Droplet ☐ Airborne ☐ Protective
Or No Risk ☐

Mental Health/Safety Communication

☐ Interpreter required *(specify language)* ☐ Interpreter arranged (ext 80843) or Duty Manager paged A/H
Hearing/Vision impaired (circle) → Hearing aids Glasses Dentures Plate (circle) **with patient** Or → ☐ Advised to bring in
☐ Recent change in ability to make self understood/express self → ☐ SLT referral
☐ Known Communication Barrier (specify) → Document management strategies in Care Plan
☐ Cognitive deficits/previous delirium ☐ Known behavior that causes safety concerns to staff/patients/visitors *(specify below)*
Or No Risk ☐

Pressure injury

Braden Score _____ At risk (15-18) Mod risk (13,14) High risk (10-12) Very High risk (9 and below)
☐ Current PI on admission (location) **Stage** (circle) 1 2 3 4 Unstageable Deep Tissue
Current PI → Automatically ☐ Very high risk (9 or below) → ☐ Incident Form completed (identify if community or hospital acquired)
☐ Clinical judgment increases Risk category *(specify)* **OR** ☐ Risk category not altered
Current Score + Clinical judgement = ☐ At risk ☐ Mod risk ☐ High risk ☐ Very High risk
→ Once admitted to ward flipchart strategies documented in Care plan ☐
Or no risk / comorbidities don't increase risk ☐

Smoking Cessation

☐ Current smoker →
☐ Ex Smoker
☐ Exposed to second hand smoke
☐ Never Smoked /No Risk

ALL patients identified as a smoker (smoked at least 1 cigarette in the last month)
☐ Brief advice given ☐ Patient advised of CDHB Smokefree policy ☐ Quit pack given or ☐ declined
☐ External referral sent or ☐ declined
Patient discharged → ☐ Quit card/NRT/Cessation meds prescribed or ☐ declined
Patient admitted to ward → ☐ NRT prescribed for withdrawal/cessation or ☐ declined

Fall Prevention

☐ A. Previous Slip/Trip/Fall/Collapse
☐ B. Unable/Difficulty to Get up and Go
☐ C. Risk Taking Behaviour
☐ D. Complex medications/side effects
☐ E. Confusion/Disorientation/Sensory
☐ F. Altered Elimination
☐ Clinical judgement denotes High Risk
☐ **Or** No Risk

☐ **High Risk - 2 + Fall category/s** selected **or** Clinical judgement denotes high risk → *(Specify rationale)*
→ Flipchart management strategies and/or clinical judgment strategies in Care plan ☐
☐ Patient/family informed of risk & given fall prevention pamphlets ☐ Fall risk sign/bracelet
☐ Referral to community programme (see intranet) ☐ GP Notification in Discharge plan
☐ **If discharge in ED -** Occupational therapist and Physio therapist paged for review
☐ **1 Fall Category** ticked → add flipchart strategies to Care Plan ☐

Alcohol

☐ Alcohol related admission or high alcohol intake → complete CAGE/CRAFFT (<18) screen Score _____ (if score 1 or above) →
☐ Brief advice given → ☐ Refer to Medical Team and Social Worker
☐ Recreational Drug User *(specify)* ☐ Refer to Medical Team and Social Worker Or No Risk ☐

FVSQ

☐ FV + or ☐ FV (Signs/symptoms?) → ☐ Preliminary Risk Assessment Form completed →
☐ Refer to social worker for FV or care/protection
Or ☐ Not asked screening questions → ☐ No staff education (refer to social worker if signs are present) FV –ve No Risk ☐

Sign off

Full Name	Designation	Signature	Date	Time

RISK SCREENING

C240076

MEDISTOCK 153392

PLEASE COMPLETE REVERSE SIDE

Assessment

This section is to be completed within 24 hours of presentation, complete in conjunction with the Referral form and Care Plan

Pain Comfort Wound

☐ Pain score above 3 → ☐ Referred to Medical Team for urgent review
Description/Location of Pain:

☐ Regular analgesia charted Last given at: by: ☐ GP ☐ ED ☐ Ward/Other
☐ Wound on admission *(specify)* →

☐ Wound treatment sheet completed management in Care Plan
☐ Internal referral form completed (as required)
☐ Wound CNC ☐ Vascular Nurse ☐ Infectious Disease Nurse ☐ Diabetes Podiatrist Or No Risk ☐

Cognitive continued

☐ Altered cognition due to a chronic condition *(specify)*
☐ Hx of delirium or ☐ Hx of dementia or ☐ Cognitive changes within last few days → ☐ CAM and MSQ performed
☐ CAM positive and/or MSQ = or below 7 → ☐ Medical Team assessment
☐ Patient's delirium/dementia management plan is identified in Care plan
☐ Patient's behavioural management is documented in Care plan Or No Risk ☐

Mental Health continued

☐ Patient having suicidal thoughts → ☐ Medical referral for psych consult
☐ Kessler screening tool positive or/and patient has history of or appears ☐ Depressed or ☐ Anxious →
☐ Medical referral for management by team or GP Or No Risk ☐

Safety

☐ Current patient self harm / violence /security risk / clinical management issue *(specify)*
☐ Visitor/family/whānau risk to patient or staff *(specify)*
☐ Place alert on PMS ☐ Potential weapons removed ☐ Security notified ☐ Medical team review ☐ Duty Nurse Manager notified
☐ Documented above risks in Care Plan and identify if patient has:
☐ Security Guard ☐ Police Escort ☐ Prison Guard ☐ Psych Nurse ☐ Other *(specify)* Or No Risk ☐

Resp.

☐ Acute respiratory deterioration or is at risk of deterioration with increasing EWS
☐ Increased work of breathing → ☐ Urgent Medical review and Physio paged
Internal Referrals sent ☐ Physio review ☐ Trache/stomal nurse Or No Risk ☐

Support Cultural Lifestyle

☐ Specific disability requirements documented in Care Plan or ☐ Use disability health passport Or No Risk ☐
☐ Specific cultural, wairua or spiritual lifestyle practices documented in Care plan
Internal Referral completed for ☐ Māori Chaplain ☐ Healthcare Chaplain ☐ Māori Health worker visit as indicated ☐ Kaumatua

Nutrition Malnutrition

Malnutrition Screening Tool (MST) score: _____ Malnutrition risk score 3 or > → ☐ Dietitian referral completed
Malnutrition risk score < 3 → ☐ Document actions in care plan (refer to MST)
☐ Patient on enteral feed/nutrition supplement drinks →☐ Dietitian referral completed
☐ Special/ texture / modified diet / fluids →☐ SLT/Dietitian referral completed if indicated / documented in Care Plan

Dysphagia

☐ Patient admitted with suspected/confirmed stroke → ☐ NBM → ☐ SLT referral completed /Certified Nurse Dysphagia screen
☐ Recent change in swallowing *(specify)* :
→ ☐ SLT referral complete Or No Risk ☐

ADL

☐ Assistance with activities of daily living identified in care plan → ☐ Equipment required documented in care plan
☐ Change in functional activities (motor/cognitive/psychosocial impairment) → ☐ Occupational Therapy referral completed
☐ Change in mobility/functional activities → ☐ Physiotherapy referral completed for mobility/functional review
☐ Falls Risk identified (A and/or B category) → ☐ Physiotherapy and Occupational therapist referral completed
☐ Patient requires assistance with eating → ☐ Documented in care plan Or Independent /No Falls Risk ☐

Meds

☐ Patient medications brought into hospital → ☐ Medication reconciliation completed → ☐ Medicines sent home with family/carer
☐ Patient has brought controlled/recorded medications into hospital → ☐ Stored appropriately and entered in register
☐ Pharmacist referral completed for changes to ☐ Yellow Card ☐ Problems with medications ☐ Medicine counselling
Or No medications ☐

Patient /Area Specific

Sign off

Full Name	Designation	Signature	Date	Time