

Canterbury

District Health Board

Te Pōari Hauora o Waitaha

SCREENING TOOLS AND MANAGEMENT FLIP CHART

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Please refer to the Nursing Documentation website for references

Contents

CAGE and CRAFFT with ALAC guidelines

CAGE Screen (18 years and over)

Positive if 1 or more of following are selected

Cut down – has felt should reduce intake

Annoyed – by criticism of intake

Guilty – about quantity of intake

Eye Opener – drinks in the morning

CRAFFT (18 years and under)

Positive if 1 or more of following are selected

C Ridden in a **C**ar that was being driven by someone (including self) who was consuming alcohol or drugs to get “high”

R Use of alcohol/drugs to **R**elax, fit in or to feel better

A Use of alcohol/drugs when **A**lone

F **F**orget actions whilst under the influence

F **F**amily/ friends have advised to reduce use

T got into **T**rouble when under the influence

Approx Standard Drink Measures (10 g alcohol) ALAC source

- Beer 330 ml
- Wine 100 ml
- Spirits 30 ml

High Risk/Harmful Amounts

Male 6 standard drinks /per occasion or 21 standard drinks/week

Female 4 standard drinks /per occasion or 14 standard drinks/week

CAGE and CRAFFT with ALAC guidelines

Cognitive Assessment – CAM and MSQ

CAM Score (Delirium)

A positive CAM score requires the patient's diagnosis to feature 1 and 2 and either 3 or 4 of the following:

- 1 Acute onset and Fluctuating course **and**
2. Inattention
- and either**
3. Disorganised thinking **or**
4. Altered level of consciousness

***A Positive CAM score requires the patient to feature 1 and 2 and either 3 or 4**

Refer to Delirium Services website for additional information on subtypes/management/direction

MSQ Directions for Questioning

MSQ	What to ask	How to assess
1. Age	What is your age? Or How old are you	Allow one year error
2. Time to nearest hour	What time is it? Or What is the time?	Allow looking at clock/watch & error up to one hr
3. Address (for recall at end)	<i>"Please repeat this address after me, 201 Queen Street".</i> Patient to repeat address to ensure registration	Then say <i>"I want you to try and remember this address, as I will ask you to repeat it at the end"</i> ASK TO REPEAT AT END
4. Year	What year is it now?	Allow previous year
5. Name of hospital	What is the name of this hospital?	
6. Recognition of two people	<i>"Who is this person?"</i> Indicate e.g. nurse, other patient, doctor, family member.	The people must be present and visible to the patient
7. Date of birth	What is your date of birth? Or When is your birthday?	Date and month only
8. Years of Second World War	When was World War II?	Allow anything from 1939 to 1945
9. Name of Prime Minister	Who is the current Prime minister of New Zealand?	Surname required
10. Count backwards from 20 to 1	<i>"Please count backwards from 20 to 1."</i>	No prompting or errors permitted
3. Address recall	<i>"Can you remember the address I gave you at the beginning of the assessment?"</i>	Score for criteria 3

A score equal to or below 7 indicates impaired cognition (this can be compared to future scores). Count 1 for each question answered correctly.

Administration and Scoring:

- Ask each question using standard/suggested format
- Allow a maximum of 30 seconds for each response
- No prompting from the examiner or other people is permitted.
- Score 1 for each question answered correctly (i.e. no half scores)

Cognitive Assessment – CAM and MSQ

Smoking Cessation

Smoking status definitions:

Current smoker: has smoked within the last month

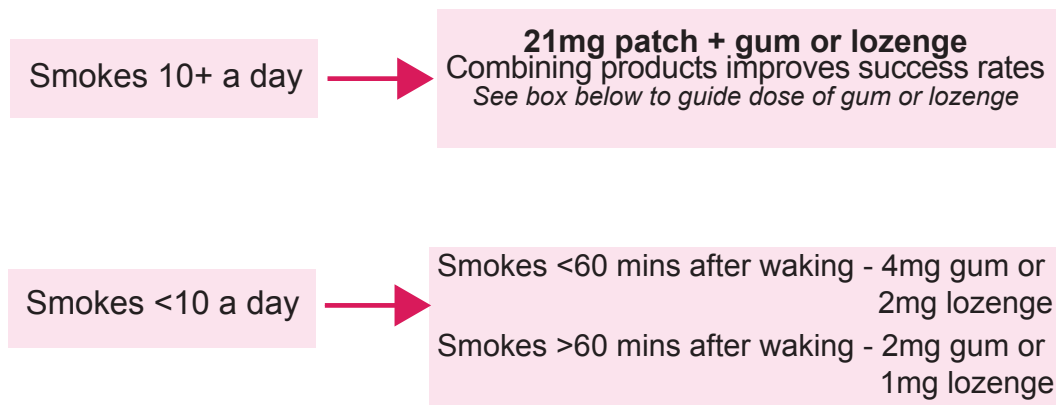
Never smoked: has had less than 100 cigarettes in a lifetime

Ex-smoker: has smoked more than 100 cigarettes but not smoked in the last month

All Nurses that have completed their Elearning: www.learnonline.health.nz can chart NRT under the CDHB "Limited Nurse Admin of NRT" guideline

Assessing nicotine dependence and determining correct product and dosage

Ask: How many cigarettes smoked per day, and how soon he/she smokes after waking?



For pregnancy, <2 weeks post MI or stroke, Quitting without medication is preferable. NRT can be used if smoking is the alternative.

If possible, review after 24 hours

- If person is still craving, increase dose and/or combine products.
- If person feels nauseous/dizzy, reduce dose.

These are guidelines only – we need to ensure people get enough NRT to suppress cravings or agitation.

Smoking Cessation

Kessler Screening Tool

- Offer Kessler screening tool to all adults (this table is included in the Patient Questionnaire)
- If the patient hasn't had the opportunity to complete this assessment offer to any patients who appear depressed or anxious
- If any patients score any 4 or 5's please discuss with patient and action any strategies. If the patients total score is 30 or above refer to medical team or GP if discharge imminent.

In the past 4 weeks about how often did you feel...(please circle the number under the heading that applies)

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Tired out for no good reason?	1	2	3	4	5
Nervous?	1	2	3	4	5
So nervous that nothing could calm you down?	1	2	3	4	5
Hopeless?	1	2	3	4	5
Restless or fidgety?	1	2	3	4	5
So restless you could not sit still?	1	2	3	4	5
Depressed?	1	2	3	4	5
That everything was an effort?	1	2	3	4	5
So sad that nothing would cheer you up?	1	2	3	4	5
Worthless?	1	2	3	4	5

Total your circled numbers

Total score (Kessler):

Add to Clinical notes/Care plan with detail on outcome and any plan for management

Kessler Screening Tool

Malnutrition Screening Tool (MST)

Patient has lost weight in the last 3 months without trying:

If *no* - **score 0**

If *unsure* - **score 2**

If *yes* - how much weight have they lost (in kg)?

0.5 - 5 kg **score 1**

5 - 10 kg **score 2**

>10 kg - 15 kg **score 3**

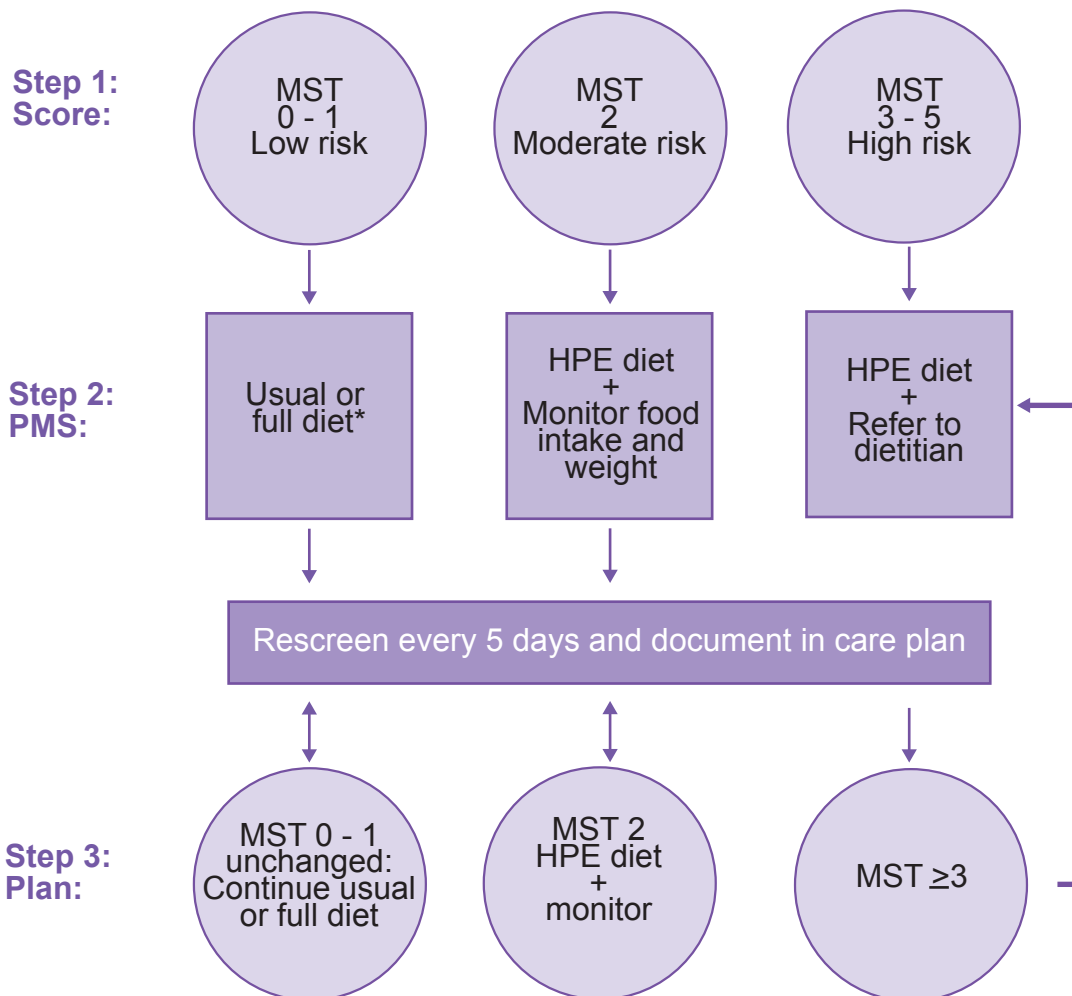
>15kg **score 4**

Patient has been eating poorly because of poor appetite? If *no* - **score 0** If *yes* - **score 1**

Total Malnutrition Risk Score: _____

ACTION PLAN

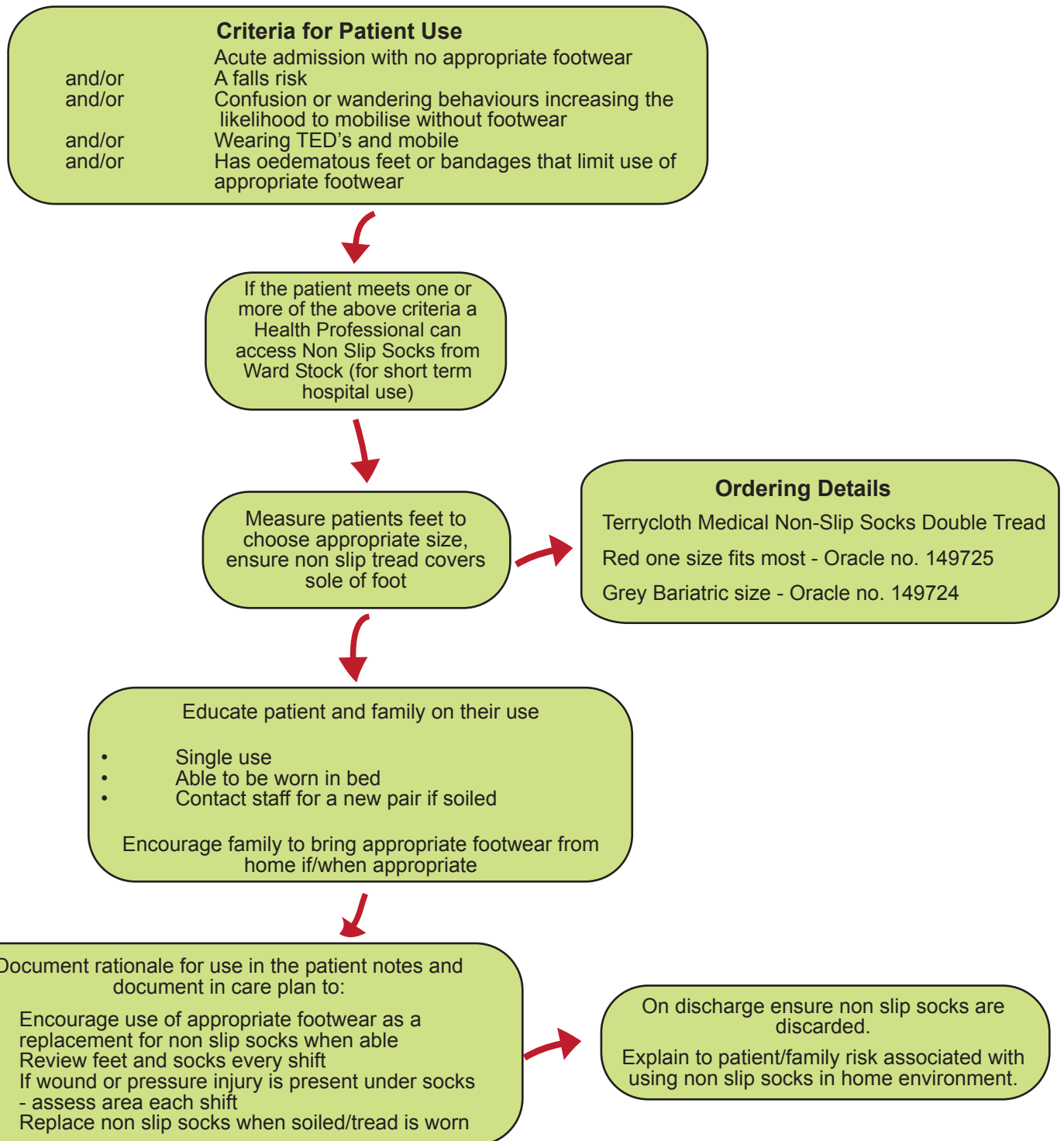
to be documented in care plan



*Includes special or modified texture diets

Malnutrition Screening Tool and strategies for care planning

Guidelines for Non Slip Socks Use and Management



Falls - identifying risk

Modified Hendrich II Falls Risk Assessment Scale

This screen is used for all patients on admission and regularly during their hospital stay. Staff can also use their clinical judgment to identify a patient at high risk of falling – see over for details on using clinical judgement. Each indicator below carries its own risk. Once you identify your patients particular risks devise strategies with them or and their family, to minimise these. Refer to the Management flipchart for a list of some appropriate strategies you can record in their care plan to communicate appropriate management. Involve and educate the patient and their whanau frequently and when situations change.

Previous Slip/trip/fall/collapse

- Patient has had a slip/trip/fall when walking within the last 6 months
- Patient/family reported falls within the last 6 months
- Fall/collapse has brought them into hospital
- Feeling of dizziness when moving/getting up

Unable to Get Up and Go

- Patient was admitted due to a fall
- Physically weak due to clinical status
- Reduced ability to mobilise due to condition/changes in ADL's
- Unsuccessful in getting up or out of bed/chair without assistance
- Use aids in their own home not accessible here that will make it difficult for them to get up and go

Risk Taking Behaviour

- Strongly independent/not readily accepting of advice
- Wanting to maintain independence (unlikely to ask for assistance)
- Unaware of their current limitations/restrictions or lack of insight
- Perceptual difficulties
- Reduced/changes in cognitive function

Medications

- Recent changes to medications that impact the person's perceptual abilities or mobility
- Potential side effects – drowsiness, dizziness, increased toileting requirements or urgency
- Additional fluid intake or bowel preparations
- Withdrawal from alcohol or drugs (including nicotine)

Confusion/disorientation

- Unable to reliably use a call bell
- Disordered thought processes
- Changes to memory
- Unable to follow instructions

Altered Elimination

- Increased frequency/urgency for bladder or bowel
- Night toileting requirements or nocturia
- Bowel preparations or laxatives

Falls - identifying risk

Falls - Clinical Judgement/Screening periods/Documentation/Post fall direction

Use your clinical judgement when screening and assessing patient's for their risk of falling. For example.

- Where you believe your patient is at a high risk of falling and this risk isn't related to any of the *Modified Hendrich II Screening* categories but your judgement identifies they are a high falls risk OR
- Your patient meets 1 of the categories under the Modified Hendrich Screen but you feel they are a high falls risk (consider reason for admission etc)

Use on admission, change in condition or environment and at every re screen (daily) by:

1. Specifying the risk/s posed to the patient (on risk screening form and in ongoing care plan entries)
2. Devising and documenting the strategy/ies you feel will manage the risk/s (care planning)

Note: If they are withdrawing or anxious related to smoking cessation and or alcohol withdrawal, screen for possible confusion /or risk taking behaviours. Consider patient's increased fluid intake (e.g. Intravenous therapy) which may increase toileting needs or dehydration that may increase risk for postural hypotension/ dizziness on getting out of bed.

One category ticked ✓

- Document appropriate strategies for that category in the Care Plan

Two or more categories ticked ✓✓

- Inform patient and family / consider sending community referral and record notification/actions
- Use fall sign, bracelet and ensure fall risk is noted on whiteboard - document actions
- Tick management box in management column

Change in health status / environment

Screen patient for fall risk or if patient is currently a fall risk adjust/add fall risk strategies in care plan as appropriate

Fall in hospital?

- Follow the post fall pathway
- Identify causes, keep self and patient safe
- Inform medical team and family
- Anticoagulants/platelet issues with head injury?
- Consider neuro and orthostatic BP obs, discuss observation plan with medical team. Medical team consider CT scan for unwitnessed fall
- Rescreen and add/alter strategies - where one or more categories identified document strategies /additions in care plan
- Complete the necessary forms - **Post Fall pathway** (ref 3612) / **Fall Event Notification Sticker AND Incident notification** - electronically or by form (ref 1077)

Falls - Appropriate Strategies for Care Plan

STRATEGIES to manage risk need to be documented in the Care plan - these are required to be reviewed every shift and redone/updated at least every 24hrs on start of a new care plan document

KEY for which area to document in Care Plan	
 Risk screening section	 ADL's section
 Elimination section	 Symptom Obs
 Referrals	 Discharge planning
Categories	Corresponding strategies for care plan consideration
A Previous fall/slip/stumble/collapse	Continue to orientate patient to ward and surroundings.
	Discuss reasons for previous fall, discuss with family/whānau and document appropriate strategies.
	Ensure hearing, visual, and mobility aids are within reach and used.
	Document agreement with patient on the use of call bell before mobilising and strategies to avoid collapse/syncope when moving from lying to standing.
	Referral to Physio and Occupational Therapist.
B Unable/difficulty to get up and go	Consider referring to community based fall prevention programme. Add to Discharge section of Care Plan as a reminder to do when discharged.
	Ensure walking/mobility aids are kept within reach, on the correct side of bed, and keep path clear to toilet.
	Document agreement in care plan that patient will call for assistance before mobilising. Referral to physio or occupational therapist.
	Document use of safe well fitting/non slip footwear. Check grip on non slip footwear. Check footwear is within reach and on correct side of bed.
C Risk taking behaviour	Document agreement with the family to use sensor system if unlikely to use call bell.
	Place patient near nursing station. Document mobility frequency and agreement on supervision plan times/day.
	Document to keep bed area clutter free. Bed kept at appropriate height e.g low for roll risk, just above knee for ease to get out. Document height requirements in Care Plan.
	Discuss family support and document agreement on assistance family will give in Care Plan. Where no family support can be provided - Discuss Hospital Aid use for support where high frequent risk or no family support.
D Complex medications /side effects	Request pharmacy/team review where hypnotics are used. Ensure strategy documented for assistance at night.
	Approach medical team regarding calcium & Vitamin D supplementation if over 65yrs.
	Document strategies to reduce symptoms/hypotension/risk of falling e.g. document agreement for patient to sit up slowly and wait before standing.
	Ask for a pharmacy/team review of any medications that have been identified as increasing fall risk (see list on SLP).
E Confusion/disorientation/sensory deficits	Document in care plan if requires low stimulus environment and sit in chair during day.
	Baseline assessment with CAM & MSQ - document when repeat required.
	Interview family/ whānau and document delirium strategies – hydration, (re)-orientation, regular mobilisation, NRT, alcohol withdrawal mgmt, pain management, family involvement, etc and document what the patient's plan is.
F Altered elimination	Occupational Therapist referral if further cognitive assessment required. Pharmacy review.
	Document that hearing and visual aids will be checked for availability and condition of use
	Discuss toileting plan - document agreement to take to toilet or use commode or situate nearer to toilet.
	Document patient agreement to call for assistance before urgency is an issue.
	Document hydration plan.
Document agreement to manage nocturia and ensure lighting is used/in reach/ or supplied.	
Document agreed plan to manage bowel changes and bowel prep.	

Pressure Injury Prevention Screening, Identification and Care planning requirements

Steps – on admission and every 24 hr period

1. Perform Braden Score using the Braden Scale.
2. Includes identifying the higher risk subscales (any in 1-3 range) and documenting prevention strategies on the care plan.
3. Document your Braden Score on the risk screening section and subsequently on the care plan every 24hrs
4. Identify any additional factors that will increase the patients risk e.g. advanced age, fever, poor nutrition/protein intake, diastolic BP under 60, haemodynamically unstable, co morbidities such as diabetes with neuropathy, PVD, lengthy surgical procedures, use of medical related devices, POP,s NGT's, nasal prongs, CPAP masks – use clinical judgement – Document judgement in the clinical notes or care plan.
5. Use the table attached to assist with documenting appropriate prevention strategies as above.

Patient already has a P.I. on admission?

- Document that the patient had the PI on admission in their clinical notes so this can be coded correctly
- An *ACC45* form* needs completing when the patient has come from an Aged Residential Care Facility or the PI developed in hospital – this form needs to be signed by the patient
- Score the patient using the Braden Scale daily and place in 'very high risk' category
- Document strategies for every category of risk in Care plan as appropriate
- Daily skin assessment for further deterioration or new areas
- Re assess PI at dressing changes (never downgrade PI stage)
- Complete *Incident Form* (ref 1077)
- Complete *Wound Care Chart*

Ongoing ACC treatment requirements

If 2-3 days prior to discharge the wound will require further treatment after discharge, an *ACC2152* form* must be completed. The free text sections must be completed providing as much information as possible.

Who can complete the ACC forms

Both the *ACC45* and the *ACC2152* can be completed by nursing staff if the patient does not require time off work – if time off work is required the *ACC45* must be signed by a Doctor.

How to obtain the ACC forms

Both the *ACC45* and the *ACC2152* forms are available from Supply department.

When both forms are complete, and signed by the patient, they are to be sent to the Patient Information Office, Christchurch Hospital.

* The *ACC45 form* notifies ACC of the personal injury.

* The *ACC2152* is the Treatment Injury form which must be completed to notify ACC of the Treatment Injury.

If the initial *ACC45 form* has not been received by ACC they will not be able to process the Treatment Injury claim, hence the importance of completing an *ACC45* when a pressure injury is identified.

Pressure Injury Strategies for Care Planning

Key for which area to document in Care plan

- ADL's section
- Elimination section
- Symptom/Obs
- Discharge planning
- Risk screening section
- Nutrition
- Wound

PI screening categories	Corresponding strategies for care plan consideration
Any Risk Braden score 0-18 or can identify strategies from any category of the braden score chart/descriptors or additional factors/judgement increase risk.	Educate patient, family and whanau Move them - encourage mobilisation/position changes Protect heels - heel protector boots Protect elbows/nosrils/ears/bony prominences and protect from medical related device injuries e.g NGT, catheters, POP's Remove creases from sheets and clothing
Moisture	Keep wound exudate controlled - freq of change
	Individualised continence management plan - toileting or absorbent pad use for incontinence/excess skin moisture and freq of change/checks
	Ph balanced cleanser use or Peri Foam (DME) - document freq of washes
	Use skin protectant barrier on intact skin after wash
	Monitor and maintain stable temperature to avoid excessive perspiration
Avoid plastic sheets and multiple layers of linen	
Nutrition	High protein energy diet where MST 2 or above MST 3 or above - Dietitian referral Excessive wound exudant - HPE and increased fluid intake MST rescreen every 5 days - note date of rescreen
Friction shear	Use of manual handling equipment trapeze/monkey bar Transfer sheet Elevate foot of bed 10 - 20 degrees to avoid slipping Keep head of bed below 30 degrees to avoid pressure on sacrum as Medical condition allows
	Check elbows and heels (mirrors may be useful) if any persistent but blanching erythema apply protective silicone dressings to elbows and heels bandage insitu
Additional Moderate Risk Braden score 13-14 or if clinical condition denotes moderate risk	Foam wedges/pillows for lateral positioning - document frequency of positioning changes
Additional High Risk Braden score 10-12 or if clinical condition denotes high risk	All the above Two hourly turns - note times, use turn chart - if skin is marking or redness not recovering - review support surface
Additional Very High Risk Braden score 9 or below or if clinical condition denotes very high risk	All the above Order and use Pressure Relieving and Seating System Redistribution Mattress

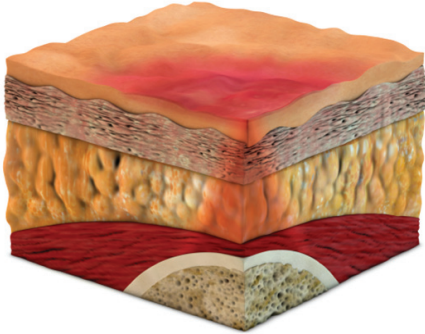
Pressure Injury Screening (Braden Scale) Including Sub Scales

<p>Sensory Perception Ability to respond meaningfully to pressure-related discomfort</p>	<p>1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body.</p>	<p>2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.</p>	<p>3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.</p>	<p>4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.</p>
<p>Moisture Degree to which skin is exposed to moisture</p>	<p>1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.</p>	<p>2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift.</p>	<p>3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.</p>	<p>4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals.</p>
<p>Activity Degree of physical activity</p>	<p>1. Bedfast Confined to bed.</p>	<p>2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</p>	<p>3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.</p>	<p>4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours.</p>
<p>Mobility Ability to change and control body position</p>	<p>1. Completely Immobility Does not make even slight changes in body or extremity position without assistance.</p>	<p>2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently</p>	<p>3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.</p>	<p>4. No Limitation Makes major and frequent changes in position without assistance.</p>
<p>Nutrition Usual/ food intake pattern</p>	<p>1. Very Poor Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV=s for more than 5 days.</p>	<p>2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.</p>	<p>3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.</p>	<p>4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.</p>
<p>Friction & Shear</p>	<p>1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.</p>	<p>2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.</p>	<p>3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.</p>	

NPUAP/EPUAP Pressure Injury Classification System

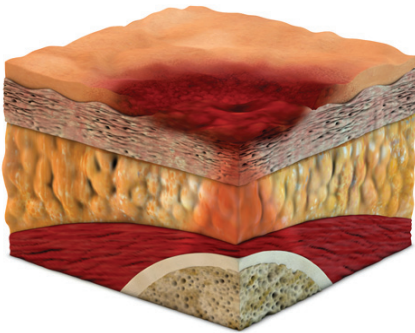
Stage I Pressure Injury: Non-blanchable erythema

- Intact skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching: its colour may differ from the surrounding area.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue.
- May be difficult to detect in individuals with dark skin tones.
- May indicate “at risk” persons (a heralding sign of a risk).



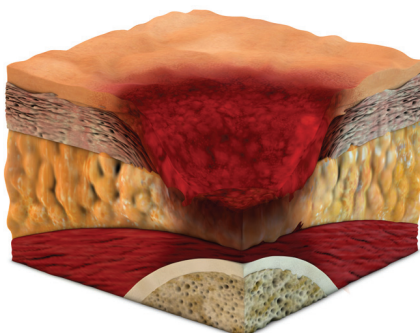
Stage II Pressure Injury: Partial Thickness Skin Loss

- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising (NB indicated suspected deep tissue injury).
- Stage II P.I. should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.



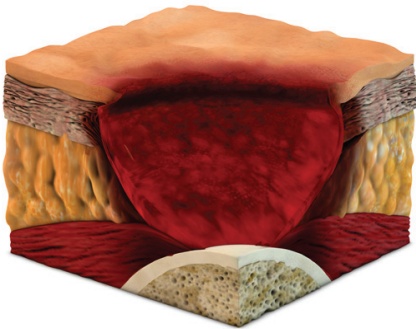
Stage III Pressure Injury: Full Thickness Skin Loss

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.
- The depth of a Stage III P.I. varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III P.I.s can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III P.I.s. Bone or tendon is not visible or directly palpable.



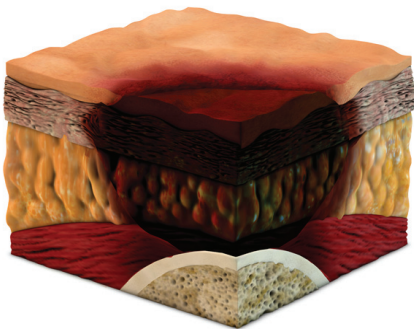
Stage IV Pressure Injury: Full Thickness Skin Loss

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a Stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV P.I.s can extend into muscle and/or supporting structures (e.g. fascia, tendon, or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.



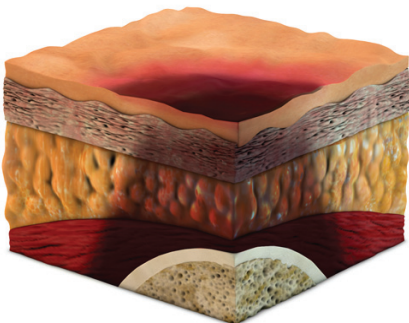
Unstageable Pressure Injury: Depth Unknown

- Full thickness tissue loss in which the base of the P.I. is covered by slough (yellow, tan, grey, green, brown) and/or eschar (tan, brown, or black) in the P.I. bed.
- Until enough slough/eschar is removed to expose the base of the P.I., the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.



Suspected Deep Tissue Injury: Depth Unknown

- Purple or maroon localized area or discolored, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin tone.
- Evolution may include a thin blister over a dark wound bed. The P.I. may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



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Care Plan Sample - SURGICAL

Canterbury

District Health Board

Te Poari Hauora o Waitaha

Medical Surgical Division
Ashburton and Rural Services

Name: Jane Doe

NHI: ABC1234

Gender: F

DOB: 02/04/1945

Age: 69

Ward:

Care Plan - 24 Hour

This plan must be rewritten each 24hr period. Identify management requirements and document strategies including frequency. Document "NC" if there has been no change from the previous shift's strategies.

Patient or Area Specific	MANAGEMENT (Tick appropriate boxes)	Date: 20/08/14	Date:	Date:	
	Discussed with Patient/Whānau/Carer on <u>20/08/14</u>	Night AM PM	Night / AM / PM	Night / AM / PM	
STRATEGIES (document within shift columns)					
Day 1 Post-op	<input checked="" type="checkbox"/> Patient specific goals <input checked="" type="checkbox"/> Education	I want to be comfortable when I get up			
Risk Screening	Daily Braden score <u>14</u> <input checked="" type="checkbox"/> Clinical Judgement added <input checked="" type="checkbox"/> Heels protected <input checked="" type="checkbox"/> Encourage mobilisation <input checked="" type="checkbox"/> Frequent position changes <input checked="" type="checkbox"/> Manage moisture (specify) <input type="checkbox"/> Manage nutrition (specify) <input type="checkbox"/> Manage friction & Shear (specify) Moderate to high risk: <input checked="" type="checkbox"/> Foam wedges <input checked="" type="checkbox"/> Two hourly turning Very high risk <input type="checkbox"/> Pressure relieving mattress <input type="checkbox"/> PI (specify location/mgmt) <input type="checkbox"/> Current PI Stage 1 2 3 4 Deep: tissue unstageable (circle) <input type="checkbox"/> Stage deterioration (Contact Wound Specialist Nurse) Daily Fall Risk (Re)Screen <input checked="" type="checkbox"/> A Previous fall/trip/collapse <input type="checkbox"/> B Unable/difficulty to get up & go (see ADL section) <input type="checkbox"/> C Risk taking behaviours <input checked="" type="checkbox"/> D Complex meds/side effects <input checked="" type="checkbox"/> E Confusion/sensory deficits/disorientation <input type="checkbox"/> F Altered elimination (see elimination section) <input checked="" type="checkbox"/> 2 or more categories ticked OR Clinical Judgement + HIGH RISK <input checked="" type="checkbox"/> Patient/whanau discussion /education given/ sign above bed /bracelet/community referral OR <input type="checkbox"/> No risk <input type="checkbox"/> Follow Advanced Care Plan <input type="checkbox"/> Cognitive function MSQ/CAM score: _____ <input type="checkbox"/> Nicotine Dependence Mgt <input type="checkbox"/> Restraint (type/commencement/discontinued) <input type="checkbox"/> Alcohol/Drug dependence management <input type="checkbox"/> Communication deficits <input type="checkbox"/> Other (specify)	PVD Heel protectors at night. Refer to mobility section for mobility plan. Mrs Smith has agreed to move round bed and change to lateral position 2hrly and to sit out in chair to manage perspiration. Remind to change position at night in obs and toileting intervals. Agreed to call for assistance before mobilising and call early for toileting. PCA - monitor drowsiness and ability to stand unaided Use non slip footwear and check her feet are firmly placed on the ground before standing. Provide opportunities to discuss her fall risk with her and clarify home requirements with the physio and OT assessment.			

CARE PLAN 24 HOUR

C240076B

This plan must be rewritten each 24 hour period. Identify management requirements and document strategies including frequency. Document "NC" if there has been no change from the previous shift's strategies.

MANAGEMENT (Tick appropriate boxes)		Date: 20.08.14	Date:	Date:
Discussed with Patient/Whānau/Carer on <u>20/08/14</u>		Night / AM / PM	Night / AM / PM	Night / AM / PM
STRATEGIES (document within shift columns)				
Airway Resp	<input checked="" type="checkbox"/> Oxygen requirements <input type="checkbox"/> Inhaled medications <input type="checkbox"/> Safe swallowing <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Sleep devices/treatment	Nasal prongs 2L target SpO2 95%		
Symptom observation	<input checked="" type="checkbox"/> Pain relief strategies <input type="checkbox"/> Nausea relief strategies <input checked="" type="checkbox"/> Vital observations (freq) <input checked="" type="checkbox"/> Fluid balance <input checked="" type="checkbox"/> Weight <input type="checkbox"/> Neurological <input type="checkbox"/> BGL <input type="checkbox"/> Circulation checks <input type="checkbox"/> Orthostatic BP	PCA, check she is comfortable on mobilising Obs as per EWS Weigh daily at 0800		
Fluid/Meds/IV management	<input checked="" type="checkbox"/> Medications/fluids due <input checked="" type="checkbox"/> Peripheral cannula change due <input type="checkbox"/> Flushes due <input checked="" type="checkbox"/> IV tubing change due <input type="checkbox"/> CVAD treatment <input type="checkbox"/> Complete management care plan form each shift <input type="checkbox"/> S/C management <input type="checkbox"/> Change due	Refer to QMR0004, IV fluids Cannula change 21/8 Tubing change 21/8		
Nutrition/hydration	<input checked="" type="checkbox"/> NBM special/modified diet <input type="checkbox"/> Fluid restriction <input checked="" type="checkbox"/> Malnutrition rescreen due <input type="checkbox"/> Parenteral/enteral feeds/oral nutrition supplements <input type="checkbox"/> PEG/NGT Management <input type="checkbox"/> Food/Fluid chart	rescreen due 25/8/14		
ADL	<input checked="" type="checkbox"/> Mobility Plan <input checked="" type="checkbox"/> Assistance/Monitoring <input checked="" type="checkbox"/> Equipment <input type="checkbox"/> Enablers <input checked="" type="checkbox"/> TEDs <input type="checkbox"/> Manual handling plan	Assist with Personal Care, Sx2 when mobilising with 2w2c frame, skin check under TED's 0800		
Elimination	<input checked="" type="checkbox"/> Toileting Plan <input type="checkbox"/> Equipment <input type="checkbox"/> IDC/SPC <input type="checkbox"/> Assistance/supervision <input type="checkbox"/> Ostomy <input type="checkbox"/> Bowel chart <input checked="" type="checkbox"/> Bowel management regime	Offer 2hrly and agrees to call before urgent Agrees to notify when passes flatus or BO.		
Wound	<input checked="" type="checkbox"/> Wound management/dressings (specify next due) <input type="checkbox"/> Wound chart <input type="checkbox"/> Drain care <input type="checkbox"/> Pin care	Check incision 2hrly. Remove of staples 21/8.		
Specs	<input type="checkbox"/> Routine blood/drug levels <input type="checkbox"/> MSU <input type="checkbox"/> Urinalysis <input type="checkbox"/> Sputum <input type="checkbox"/> Other (specify)			
Culture disability	<input type="checkbox"/> Cultural/wairua practices (specify) <input type="checkbox"/> Disability requirements (specify)			
Dx planning	<input checked="" type="checkbox"/> MDT care coordination for safe discharge <input type="checkbox"/> Accommodation/transport difficulties on discharge <input type="checkbox"/> Home supports <input checked="" type="checkbox"/> EDD <input type="checkbox"/> External agency notification/referral prior to d/c <input checked="" type="checkbox"/> Other (specify)	Home assessment Occ Therapist and physio. EDD 25.08.14 Request GP appoint For RO staples 21/8.		
Sign off	Name: A nurse Designation: RN Time: 1300hrs Signature: A nurse			

Care Plan Sample - MEDICAL

Canterbury

District Health Board

Te Poari Hauora o Waitaha

Medical Surgical Division
Ashburton and Rural Services

Name: John Doe

NHI: ABC1234

Gender: M

DOB: 02/04/1944

Age: 74

Ward:

Care Plan - 24 Hour

This plan must be rewritten each 24hr period. Identify management requirements and document strategies including frequency. Document "NC" if there has been no change from the previous shift's strategies.

	MANAGEMENT (Tick appropriate boxes) Discussed with Patient/Whānau/Caregiver on <u>20/08/14</u>	Date: <u>20/08/14</u>	Date:	Date:
		Night / AM / PM	Night / AM / PM	Night / AM / PM
STRATEGIES (document within shift columns)				
Patient or Area Specific	<input checked="" type="checkbox"/> Patient goals <input type="checkbox"/> Education	Family want to see his delirium managed - distressing for family.		
Risk Screening	<p>Daily Braden score <u>12</u></p> <input checked="" type="checkbox"/> Clinical Judgement added <input checked="" type="checkbox"/> Heels protected <input checked="" type="checkbox"/> Encourage mobilisation <input checked="" type="checkbox"/> Frequent position changes <input checked="" type="checkbox"/> Manage moisture (specify) <input type="checkbox"/> Manage nutrition (specify) <input checked="" type="checkbox"/> Manage friction & Shear (specify) <p>Moderate to high risk: <input type="checkbox"/> Foam wedges <input checked="" type="checkbox"/> Two hourly turning</p> <p>Very high risk <input checked="" type="checkbox"/> Pressure relieving mattress <input type="checkbox"/> PI (specify location/mgmt) <input type="checkbox"/> Current PI Stage 1 2 3 4 Deep: tissue unstageable (circle) <input type="checkbox"/> Stage deterioration (Contact Wound Specialist Nurse)</p> <p>Daily Fall Risk (Re)Screen <input checked="" type="checkbox"/> A Previous fall/trip/collapse <input type="checkbox"/> B Unable/difficulty to get up & go (see ADL section) <input checked="" type="checkbox"/> C Risk taking behaviours <input checked="" type="checkbox"/> D Complex meds/side effects <input checked="" type="checkbox"/> E Confusion/sensory deficits disorientation <input type="checkbox"/> F Altered elimination (see elimination section)</p> <input checked="" type="checkbox"/> 2 or more categories ticked OR Clinical Judgement + HIGH RISK <input checked="" type="checkbox"/> Patient/whanau discussion /education given/ sign above bed /bracelet/community referral <p>OR <input type="checkbox"/> No risk <input type="checkbox"/> Follow Advanced Care Plan</p> <input checked="" type="checkbox"/> Cognitive function MSQ/CAM score: <u>+ve</u> <input type="checkbox"/> Nicotine Dependence Mgt <input type="checkbox"/> Restraint (type/commencement/discontinued) <input type="checkbox"/> Alcohol/Drug dependence management <input checked="" type="checkbox"/> Communication deficits <input type="checkbox"/> Other (specify)	Type 2 Diabetic Pressure relieving mattress for heels Up in chair as often as tolerates during day. HPE/Diabetes management Bed head to 30 degrees and bed end to 10 degrees to avoid friction. Turn 2hrly at night and during day when out of chair. Mattress and seating system. Physiotherapy organised. Cannot reliably use call bell, family agreed to use sensor system. Observation monitoring for medication side effects. Keep in low stimulus single room nearest to office. Orientate to time place and person each visit, avoid room changes. Family visiting evening to support. Delirium team input Keep hearing aid in during the day		

CARE PLAN 24 HOUR

240076B

This plan must be rewritten each 24 hour period. Identify management requirements and document strategies including frequency. Document "NC" if there has been no change from the previous shift's strategies.

	MANAGEMENT (Tick appropriate boxes) Discussed with Patient/Whānau/Carer on <u>20 / 08 / 14</u>	Date: <u>20.08.14</u>	Date:	Date:
		Night (AM) PM	Night / AM / PM	Night / AM / PM
STRATEGIES (document within shift columns)				
Airway Resp	<input type="checkbox"/> Oxygen requirements <input type="checkbox"/> Inhaled medications <input type="checkbox"/> Safe swallowing <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Sleep devices / treatment			
Symptom observation	<input checked="" type="checkbox"/> Pain relief strategies <input type="checkbox"/> Nausea relief strategies <input checked="" type="checkbox"/> Vital observations (freq) <input type="checkbox"/> Fluid balance <input checked="" type="checkbox"/> Weight <input type="checkbox"/> Neurological <input checked="" type="checkbox"/> BGL <input type="checkbox"/> Circulation checks <input type="checkbox"/> Orthostatic BP <input checked="" type="checkbox"/> Falls prevention	Regular Panadol - unable to communicate pain levels with delirium. Bd or as per EWS Weigh 3x weekly-MST 2 4hry BSL. Polypharmacy/antipschotic meds - monitor effects - drowsiness.		
Fluid/Meds/IV management	<input checked="" type="checkbox"/> Medications/fluids due <input type="checkbox"/> Peripheral cannula change due <input type="checkbox"/> Flushes due <input type="checkbox"/> IV tubing change due <input type="checkbox"/> CVAD management care plan <input type="checkbox"/> S/C management <input type="checkbox"/> Change due	Refer to QMR0004		
Nutrition/hydration	<input checked="" type="checkbox"/> NBM (special) modified diet <input type="checkbox"/> Fluid restriction <input checked="" type="checkbox"/> Malnutrition rescreen due <input type="checkbox"/> Parenteral/enteral feeds/oral nutrition supplements <input type="checkbox"/> PEG/NGT Management <input type="checkbox"/> Food/Fluid chart	HPE and Diabetic rescreen due 25/8 Offer Ensure 2hrly		
ADL	<input checked="" type="checkbox"/> Mobility Plan <input checked="" type="checkbox"/> Assistance/Monitoring <input checked="" type="checkbox"/> Equipment <input type="checkbox"/> Enablers <input type="checkbox"/> TEDs <input type="checkbox"/> Manual handling plan	Assist with personal care and eating Ax1 for moving bed to chair 2w2c frame for walking 3x day. Keep in chair as tolerates during day - min. 3x day.		
Elimination	<input checked="" type="checkbox"/> Toileting Plan <input checked="" type="checkbox"/> Equipment <input type="checkbox"/> IDC/SPC <input checked="" type="checkbox"/> Assistance/supervision <input type="checkbox"/> Ostomy <input type="checkbox"/> Bowel chart <input checked="" type="checkbox"/> Bowel management regime	Offer toilet 2hrly, if sensor system alarms, check toileting requirement Commode for use nocte on R side bed, night light use. Aperients daily, report when BNO for 3 days.		
Wound	<input type="checkbox"/> Wound management/dressings (specify next due) <input type="checkbox"/> Wound chart <input type="checkbox"/> Drain care <input type="checkbox"/> Pin care			
Specs	<input type="checkbox"/> Routine blood/drug levels <input checked="" type="checkbox"/> MSU <input type="checkbox"/> Urinalysis <input type="checkbox"/> Sputum <input type="checkbox"/> Other (specify)	Requires MSU		
Culture disability	<input type="checkbox"/> Cultural/wairua practices (specify) <input type="checkbox"/> Disability requirements (specify)			
Dx planning	<input checked="" type="checkbox"/> MDT care coordination for safe discharge <input type="checkbox"/> Accomodation/transport difficulties on discharge <input type="checkbox"/> Home supports <input checked="" type="checkbox"/> EDD <input type="checkbox"/> External agency notification/referral prior to d/c <input type="checkbox"/> Other (specify)	D3 living - social worker and Health of Elderly Service R/v EDD 23/08/14		
Sign off	Name: A nurse Designation: RN Time: 1300hrs Signature: A nurse			