Learning Outcomes

• Describe the components of the admission procedure
• Discuss the importance of a comprehensive baseline assessment when a new patient is admitted
• Identify some of the common problems with the admission procedure by referring to the admission checklist
• Identify the correct procedure to assess for postural hypotension in a newly admitted patient
• List National Standards that are relevant to the admission care of patients within your unit
What Do We Need to Look For?

- Patient safety and records
- Observations on arrival
- Risk Screening and Care Planning
- Communication and Escalation
Patient Safety and Records

- Patient details checked and correct
- Family notified of arrival
- Oriented to ward, including buzzer
- Patient identification band applied
- Patient information provided and discussed – client consent
- Check if there are any appointments due
- Patient details entered into TREND and PFM
- Laundry details discussed and clarified
- Encourage patients to have meals in the dining room as part of their therapy
Observations on Arrival

- Weight
- Complete set of observations using QADDS tool
- Lying and standing BP – three consecutive readings, noting if patient has any symptoms as well
- ECG for rehab patients
- Post-void bladder scan – all patients – WHY?
- BGL
- Urinalysis
- Check current medication history, patient’s own medications supplied and allergies
- Check if the patient has an Acute Resuscitation Plan
Transition Care Program Only

- Confirm Warfarin enrolment from discharging unit for INR and dosing
- Check that you have five days supply of medications
- EPIC Pharmacy registration completed and given to AO for emailing
- Confirm medications have been received from pharmacy
- Check that a discharge summary has been included in patient’s documentation
- Commence Modified Barthel Index
Risk Screening and Care Planning

✓ Falls Assessment and Management Plan within the eight hours of admission
✓ Implement Falls Management plan and document in medical record
✓ Adult Pressure Injury Assessment completed within eight hours of admission
✓ Three day food chart if clinically indicated by Malnutrition Screening Tool score of two or more – referral to dietitian
✓ Continence assessment within 48 hours of admission
✓ Complete FIM/AROC within 48 hours of admission
✓ Complete any multidisciplinary referrals as indicated, including the podiatrist
✓ Goal-oriented care planning commenced
✓ Referral to wound or stoma CNC if required
Communication

• Inform multidisciplinary team members of the arrival of any rehabilitation patients
• Inform team leader of all admissions
• Effective communication keeps patients safe and promotes prompt and efficient care delivery
• Ensure you have received all the information you need to continue providing care for the patient
Principles

- Evaluate care
- Demonstrate clinical decision making
- Report by exception if using a Care Plan or Clinical Pathway
- Accurate
- Up to date
- Appropriate

Quality/Quantity:
- Constructive
- Relevant
- Objective
- Verbatim
- Outcome/goal focused
Clinical handover

• Update handover sheet
• Objective language – facts, not opinions
• Concise and relevant
• Sensitive issues
• Identify patient using three identifiers
• Only use acceptable abbreviations, preferably avoid
What to Document

ADLs – Provide detail on **level of assistance** required
– use MBI or FIM as a guide
– is the person demonstrating safe technique?
- Is the person requiring aids/equipment?
Are they co-operative?
Consider who else might need that information
Mobility – are they using a mobility aid/safe technique/
cues/assistance/ pain?
Continence – urge/stress/frequency/aids/referral/PVR
Nutrition and hydration – intake/difficulty with feeding/
dietary restrictions/ likes and dislikes/ weight loss or
gain
Alerts

- Allergies
- Acute Resuscitation Plan
- Advanced Health Directive
- Mental Health Act
- Infections
- Falls and other risks

Where do you record it? Who records it?
Good Documentation

- Can the person communicate or do they have special needs?
- Can they hear/see/understand?
- Skin integrity – is there anything that needs further action? **Top to toe**
- Falls risk strategies
- Cognitive condition – any concerns? Is the person co-operative?
- Any deviations from normal limits in the observations?
- Wounds – commence care plan and complete assessment
- Are there any appointments or tests required?
Scope of Practice

• Who should complete the first assessment?
• Teamwork
• Why do we need such detailed information regarding nursing care?
National Standards

- Clinical Governance Standard
- Partnering with Consumers Standard
- Preventing and Controlling Healthcare-Associated Infection Standard
- Medication Safety Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Blood Management Standard
- Recognising and Responding to Acute Deterioration Standard
Communicating For Safety

Intention of this standard

To ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Criteria

Clinical governance and quality improvement to support effective communication
Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.

Correct identification and procedure matching
Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.

Communication at clinical handover
Processes for structured clinical handover are used to effectively communicate about the health care of patients.

Communication of critical information
Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

Documentation of information
Essential information is documented in the healthcare record to ensure patient safety.
Comprehensive Care Standard

Intention of this standard

To ensure that patients receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient’s expressed goals of care and healthcare needs, considers the effect of the patient’s health issues on their life and wellbeing, and is clinically appropriate.

To ensure that risks of harm for patients during health care are prevented and managed. Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Criteria

Clinical governance and quality improvement to support comprehensive care
Systems are in place to support clinicians to deliver comprehensive care.

Developing the comprehensive care plan
Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.

Delivering comprehensive care
Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and family. Comprehensive care is delivered to patients at the end of life.

Minimising patient harm
Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.
Partnering with Consumers Standard

Intention of this standard

To create an organisation in which there are mutually valuable outcomes by having:

- Consumers as partners in planning, design, delivery, measurement and evaluation of systems and services
- Patients as partners in their own care, to the extent that they choose.

Criteria

Clinical governance and quality improvement systems to support partnering with consumers

Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation.

Partnering with patients in their own care

Systems that are based on partnering with patients in their own care are used to support the delivery of care. Patients are partners in their own care to the extent that they choose.

Health literacy

Health service organisations communicate with patients in a way that supports effective partnerships.

Partnering with consumers in organisational design and governance

Consumers are partners in the design and governance of the organisation.
Any Others?

Medication Safety, which describes the systems and strategies to ensure that clinicians safely prescribe, dispense and administer appropriate medicines to informed patients, and monitor use of the medicines.

Preventing and Controlling Healthcare-Associated Infection, which describes the systems and strategies to prevent infection, to manage infections effectively when they occur, and to limit the development of antimicrobial resistance through prudent use of antimicrobials, as part of effective antimicrobial stewardship.

Clinical Governance, which describes the clinical governance, and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care, and improve health outcomes for patients.

Recognising and Responding to Acute Deterioration, which describes the systems and processes to respond effectively to patients when their physical, mental or cognitive condition deteriorates.
Common problems

- Action => documentation => escalation
- Subjective vs objective
- Print name after signature
- Legibility
- ID stickers on each page, both sides
- Review and change documents as changes occur
- **Time and date very important**
- Don’t forget to use “alert” stickers
New Requirement for All Patients

• Please complete three consecutive readings of lying and standing blood pressure for ALL patients
• Note if the patient is symptomatic or not and the actions you have taken
• This observation is helpful to everyone in the multidisciplinary team and improves patient safety
Orthostatic Hypotension

- Widespread clinical problem
- Commonly seen both with systolic hypertension as a sign of vascular disease and frailty, as a sign of system dysregulation
- Associated with mortality and regarded as a sign of loss of physiological reserve
- Risk factor in falls
- Defined as a change of 20mmHg systolic or 10mmHg diastolic BP from the supine to the upright position within 3 minutes (Freeman et al., 2011.)
- Patient needs to be lying down for 10-15 minutes before measuring BP
- Then check BP again after the patient has been sitting/standing for 3 minutes
- It is important to have a correctly fitted BP cuff to ensure accurate measurement
- If measurement is abnormal, consider using a manual sphygmomanometer to check
Anything else?

- Observations – full, any variations. QADDS score
- Weight - variations
- Complaints of nausea, pain or discomfort – action and evaluation
- Current infections – actions and follow-up
- Any changes in the patient’s physical and cognitive abilities
- Any incidents and their outcomes
- Referrals that need following up
- Any requests or feedback from patient, family member or carer
- Changes to medication regime
- Frequency of prn/ staff initiated meds over the past month – does action need to be taken?

Please refer to CISS Procedure 0017
References


Questions?