Guide to admission - nursing

Care Delivery

Quick reference guide

This resource will provide an overview of the documentation that should occur when a patient is *admitted* to an inpatient area.

Please refer to *Clinical Handover Quick Tips* to see the areas of the chart that should be viewed and the checks that should occur during Clinical Handover.

Nursing Assessment

Once the patient has been admitted to a bed in HBCIS they will appear on the ward level *CareCompass* patient list. The paediatric admission rule will fire when a patient is admitted to an inpatient unit at LCCH with the exception of PICU. The admission rule places an order for the following activities:

- **Admission History Paediatric** 18-Oct-2017 09:35:00, Stop date 18-Oct-2017 09:35:00
- **Basic Admission Information Paediatric** 18-Oct-2017 09:35:00, Stop date 18-Oct-2017 09:35:00
- **Falls Risk Assessment Paediatric** 18-Oct-2017 09:35:00, Stop date 18-Oct-2017 09:35:00
- **Glamorgan** Glamorgan Assessment 18-Oct-2017 09:35:00, Stop date 18-Oct-2017 09:35:00
- **Hypoglycaemia Risk Assessment** Hypoglycaemia 18-Oct-2017 09:35:00, Stop date 18-Oct-2017 09:35:00
- **Nutrition MST** 18-Oct-2017 09:35:00, Stop date 18-Oct-2017 09:35:00
- **Skin Inspection** 18-Oct-2017 09:35:00, Stop date 18-Oct-2017 09:35:00
- **Substance Use Paediatric** 18-Oct-2017 09:35:00, Stop date 18-Oct-2017 09:35:00

Admission History: is a *PowerForm* to record patient history information – similar to the Daily Patient Care Record and Initial Clinical Assessment and Risk Screening tool.

Substance Use Paediatric, Falls Risk Assessment Paediatric, Glamorgan, Hypoglycaemia Risk Assessment, Nutrition MST and Skin Inspection are all Risk Assessments.

Substance Use will not fire for patients less than 11yrs of age. Complete the above activities as part of the admission documentation.

You can multi-select the admission tasks and click Document – this will open the correct PowerForms and take you to the correct places in the patient chart to document your initial assessment.

Note: A system generated order for a daily Glamorgan task will automatically be placed if the score is >10.

Note: A system generated Consult to Dietetics order will be placed if the Nutrition MST score is >2. You should also review, customise and initiate the *Nutritional Deficit IPOC* for this patient group.

Note: A system generated twice daily skin inspection order will be placed for all patients with a Glamorgan >10.

Vital signs

Use the Managing Deterioration module to record vital signs. This will allow you to view the trend and recognise any deterioration.

Patient Flow Manager

Patient Flow Manager (PFM) will still be used alongside ieMR. Continue to complete the patient's *diet* requirements and *allergy status* in PFM. *Allied Health consult orders* and *consult orders to the Safety CNC* will be placed in the ieMR.

Note: Always remember to add *allergies* including *food allergies* to *PFM* as well as ieMR.

Care Planning

Review the *orders profile* for current orders. Using the information obtained from *handover* and your *nursing assessment*, place the required *patient care orders.*

The LCCH Nursing Leadership group have agreed that a Personal PowerPlan will be used to order standard nursing activities. This plan is to be shared from the ward NUM to all nursing staff. See your Nurse Educator if you need assistance with this.

Before adding the plan to the patient's order profile, you should review the order frequencies and order information and modify as necessary prior to signing. This will ensure the care tasks will fall on *CareCompass* at appropriate times.

LCCH Nursing Basic Admission Tasks (Planned Pending)

This powerplan is to facilitate ordering Patient care tasks and medications for future encounters.
Use the "add to phase" icon to create orders you wish to commence in a future encounter.
Once the orders have been planned and signed, they will be available for use in a future encounter. Do not specify dates on thes
DO NOT INITIATE this phase while planning.

These orders have been placed and signed by a prescriber in advance. Check for clinical appropriateness, then INITIATE phase.

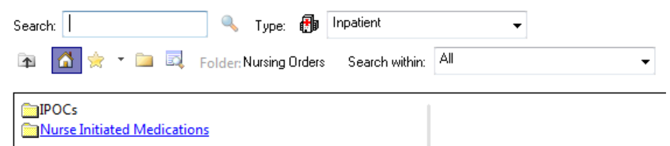
Selected	Order	Details
☑	Weight	T;N, ONCE a week on (c) Wed
☑	Glamorgan	T;N, daily
☑	Nutrition MST	T;N, ONCE a week on (c) Wed
☑	Falls Risk Assessment Paediatric	T;N, daily
☑	Safety Checks	T;N, BD
☑	Vital Signs Paediatric	T;N, SIX times a day
☑	Pain Assessment Paediatric	T;N, TDS
☐	Fluid Balance	
☐	Urine Dipstick POC	
☐	Respiratory Observations Paediatric	
☐	Neurological Observations Paediatric	
☐	Lower Limb Neurovascular Observations Paediatric	
☐	Upper Limb Neurovascular Observations Paediatric	
☐	Line care	
☑	Enteral Feed Bolus Paediatric	Nursing task only. Reminder for oral bottl
☑	Skin Inspection	T;N, Assess Glamorgan - modify skin insp

You will need to review the orders for your patient and remove any duplicate orders. For example patients may have a system generated daily Glamorgan order (based on a Glamorgan >10) and one initiated by a nurse.

Note: The *orders profile* MUST be reviewed each shift.

Interdisciplinary Plans of Care

There are 7 *plans of care* suggested on admission to LCCH. There are also a number of other plans of care that can be ordered for a patient and you will find these can be found in the *IPOCs* folder.



These plans may have an adult focus so ensure that you modify and customise as necessary.

- Alteration in Tissue Perfusion Plan of Care
- Alteration of Body Temperature Plan of Care
- Altered Body Image Plan of Care
- Altered Mental Status Plan of Care
- Anxiety Plan of Care
- Autonomic Dysreflexia Plan of Care
- Behavioural Symptoms and/or Wandering/Absconding Plan...
- Bladder Elimination Plan of Care
- Bleeding Precautions Plan of Care
- Bowel Dysfunction Plan of Care
- Decreased Peripheral Perfusion Plan of Care
- Difficulty Swallowing Plan of Care
- Disturbed Sleep Pattern Plan of Care
- Falls Risk Plan of Care
- Fluid Deficit Plan of Care
- Impaired Communication Plan of Care
- Impaired Physical Mobility Plan of Care
- Impaired Respiratory Status Plan of Care
- Nutritional Deficit Plan of Care
- Paediatric Breast Feeding Plan of Care
- Paediatric Complex Care Plan of Care
- Paediatric Family Centred Care Plan of Care
- Paediatric Hygiene Plan of Care
- Paediatric Routines/Behaviours Plan of Care
- Pain Management Plan of Care
- Palliative Care Plan of Care
- Risk for Aspiration Plan of Care
- Risk for Infection Plan of Care
- Risk for Unstable Glucose Plan of Care
- Risk of Skin Integrity Plan of Care
- Self Care Deficit Plan of Care
- Suicide Risk Plan of Care

Document acitivity against the *plans of care* throughout the shift as you would currently sign and update the Daily *Patient Care Record*.

Create any dynamic groups to perform documentation for lines, tubes and drains. Document the EDD in iView

The following QRGs will provide step by step guidance to aid in completing the above activities

CareCompass overview – QRG

Documenting a glamorgan assessment – QRG

Documenting plans of care – QRG

Fluid balance chart – paediatrics – QRG

Interactive view – documenting patient tubes, lines, devices – QRG

Interactive view setting and viewing an estimated discharge date – QRG

Managing deterioration – nursing – QRG

Specialty observations – neurological observations paediatric – QRG

Initiating a planned PowerPlan – nursing – QRG

MAR overview – QRG

Reschedule medication times via the MAR – QRG