Comprehensive Care - Admission Assessments, Adult Risk Assessments & Creating a Comprehensive Care IPOC

Digital Health
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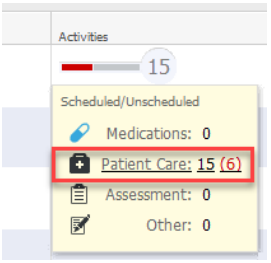
Quick Reference Guide

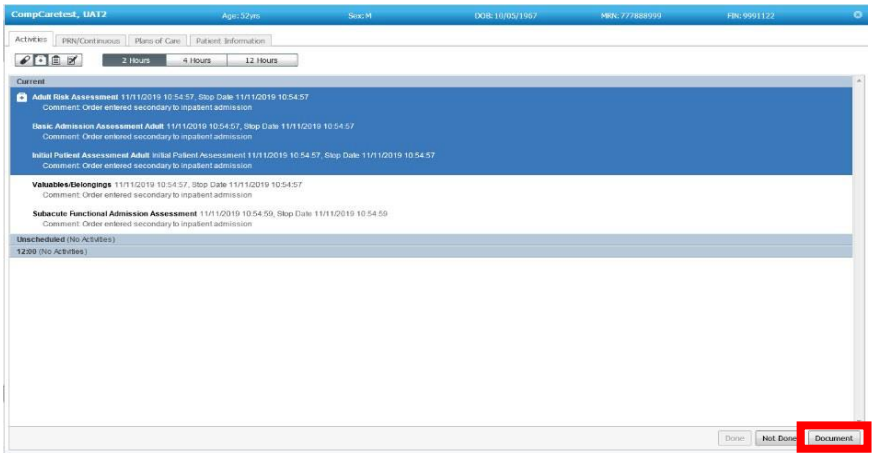
This Quick Reference Guide will explain how to:

- Document Admission Assessments, Adult Risk Assessments
- Create/manage a Comprehensive Care IPOC (Nursing Care Plan)

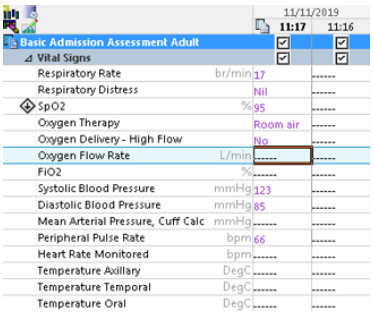
Patient admission to ward



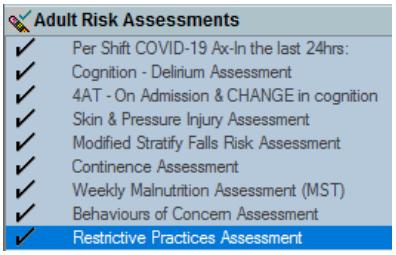
1. In **Care Compass** hover over the Activities column to the right of the screen to identify admission assessments due under Patient Care.
2. Click **Patient Care.**
3. All **admission documentation** is displayed here. This includes:
   - Adult Risk Assessment
   - Basic Admission Assessment Adult (Vital Signs and Weights)
   - Initial Patient Assessment



4. Click on each document to be completed.
5. Once all are highlighted select **Document** in the bottom right-hand corner.



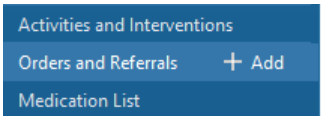
6. Complete Basic Admission Assessment.
7. Complete physical assessment and enter assessment information into iView. E.g. Vital signs, weight etc.



8. Complete Adult Risk Assessments at the bedside, with the patient. Document patient's risk assessments from *Interactive View and Fluid Balance (iView)* page.
9. Be sure to complete every risk assessment, including both the Cognition – Delirium Assessment and 4AT assessment.

Initiate Comprehensive Care IPOC

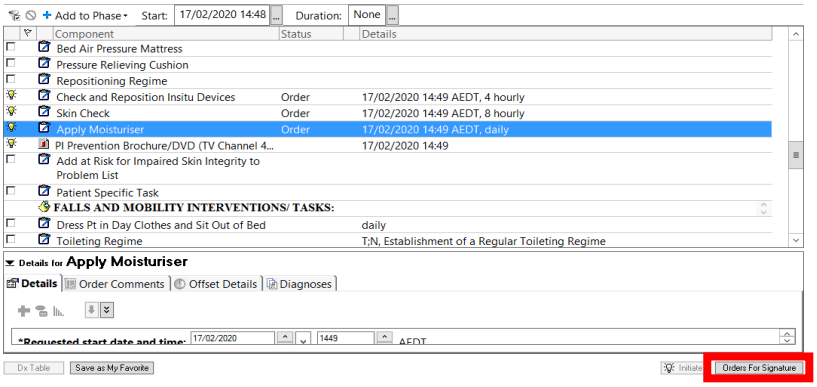
1. From the Table of Contents, select **Orders and Referrals**.



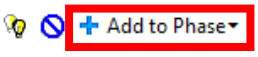
2. Use the ⊞ symbol to expand suggested plans. Select Comprehensive Care IPOC.

3. Select Initiate Now

4. Select appropriate goals and nursing interventions for your patient. **These should reflect all clinical care your patient requires and reflect strategies to address identified risks.** This is your nursing care plan.



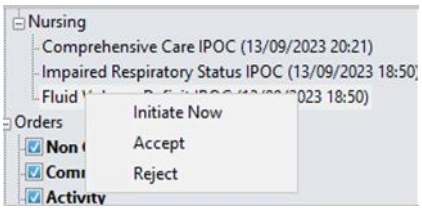
5. Any additionally required nursing care orders not included in the Comprehensive Care template, must be added using the "**Add to Phase**" function. Eg. Wound care order.



6. **Sign**, then **Refresh** page.

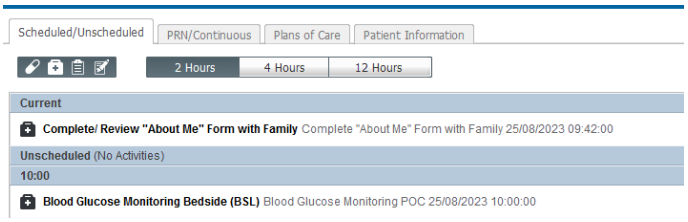
7. In the **Orders and Referrals** page, review any additional "**Suggested Plans**" each shift, and initiate those that are required for your patient. Ensure that you do not duplicate orders and tasks that already exist in the Comprehensive Care IPOC.

8. If a suggested IPOC is not required for your patient, you may Reject that suggestion by **right-click**, then select **Reject**.



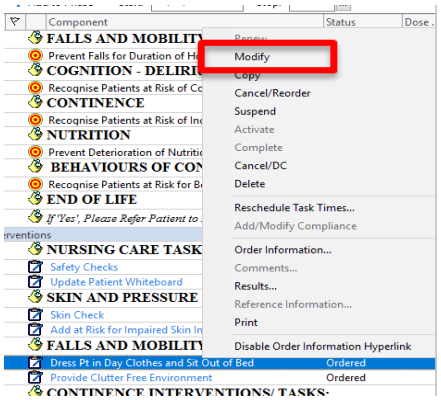
During your shift, document your interventions

1. Use the **Care Compass** "**Activities**" tab to document the required tasks for your patient. Alternatively, you may use the **Multi-Patient task list** page.



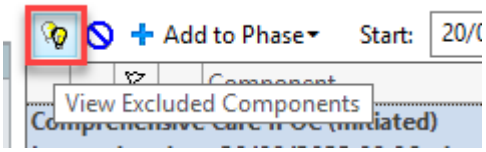
Every Shift - Review and Update the Comprehensive Care IPOC

1. **Right-click** on an intervention to **Modify** or **Cancel/DC** (Discontinue) any interventions and orders no longer required.



2. Add new nursing interventions and patient goals using **+Add to Phase** function.

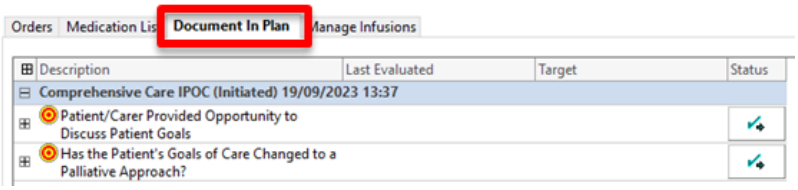
3. Review excluded components of the Comprehensive care template by selecting the **light bulb icon** located near the *Add to Phase* button.



4. **Sign** the changes into the IPOC.

Document In Plan (Orders and Referrals page)

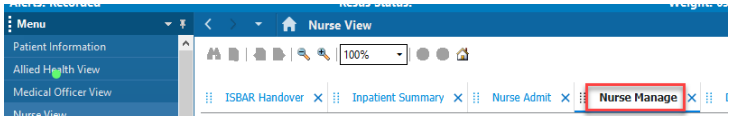
1. At the end of every shift, document the patients progress towards achieving selected goals and interventions using **Document In Plan**.



2. Tick ✔ if your patient's outcomes have been met in your shift.

Nursing Shift Note

1. In **Nurse View** page (**Nurse Manage** tab), document at the end of each shift using either the **Nursing Shift Progress Note**, or the **Nursing Shift Note (Med/Surg)** - depending on the area in which you work.



2. Save the document into the patient chart, selecting **Progress Note** as the note type.