FirstNet Nursing Initial Assessment



Digital Health Quick Reference Guide

This Quick Reference Guide will explain how to: Complete a nursing initial assessment for the ED patient at the start of their ED journey. This QRG is applicable to the bedside/cubicle nurse. Including both **paediatric** and **adult** patients. 1. Click on numbered square in Nurse Activities column for the selected patient. The ED Nurse initial assessment will be automatically populated after a patient is triaged. RN Treatment St 01:26 ADULT,06 4 01:27 UNKNOWN, FEMALE V... 01/01/90 33y F Triage ٥ ES 2 Click on the ED Nurse Initial Ax. This will highlight the task light blue. 2. Note: for the paediatric patient (<18yo) this will display as the 'ED Paeds Nurse Initial Ax' and will include different risk screening questions. ED Paeds Nurse Initial Ax Select 'Document' 3. UNKNOWN, FEMALE VNNRL ADULT.06 × ADULT.06 DOB: 01/01/90 URN: 7100294 FIN: 21002047 33v F 1 v (٠ 2 D 2 - -Activities Den Patient Chart Orders 🏖 Refresh ≣• Assessments (1) Patient Care (1) 1 Assessments - U - U ED Nurse Initial Ax 02/07/2023 10:31:12, Stop Date 02/07/2023 10:31:12, ED Nurse Initial Ax Comments: Order placed due to a Discern Rule E 1 1 Patient Care - U - U ED Infectious Disease Screening 02/07/2023 10:31:09, Stop Date 02/07/2023 10:31:09, ED Infectious Disease Screening Comments: Order placed due to Infectious Screening not completed in Triage ΞI 包

- 4. This will open a documentation set in iView. Click through the sections to document the nursing initial assessment:
 - Primary Survey
 - Vital Signs
 - Respiratory
 - BOC
 - Pain assessment
 - Valuables
 - Risk Screening
 - Skin/Pressure
 - Falls
 - Comments
 - BGL/Ketones

To submit documentation select the green tick

X Act <u>ivity View</u>				
E.	ED Adult Nurse Initial Assessment			
	ED Primary Survey			
	ED Vital Signs			
	ED Respiratory			
	ED Behaviours of Concern			
	ED Adult Pain Assessment			
	Valuables and Belongings			
	ED Adult Risk Screening			
	Skin & Pressure Injury Assessment			
	Modified Stratify Falls Risk Assessment			
	ED Risk Screening Comments			
	ED Bedside Testing			
/				

Document (1)

Close





 If you need to step away from documenting part way through, select the green tick to submit what you have done so far. You can then find all of these sections in Interactive View and Fluid Balance tab – ED Quick View to complete later.

Menu	* ¥	 The second second
Patient Information		™∎ 🗖 🔐 🖌 🕺 📓 📕 🗐 🖄 ×
ED Nursing View		
Care Plan Summary		C ED Adult Quick View
MAR		Ambulance Handover ED Primary Survey
Medication Request		ED Risk Screening
Observation Chart		Valuables and Belongings
Interactive View and Fl	uid Balance	Bedside Testing Titratable Infusions
Activities and Intervent	tions	Measurements
Orders and Referrals	+ Add	ED to Inpatient Handover ED Discharge Information
Medication List	+ Add	ED Deceased Patient
Documentation	de Add	ED to ED Handover

Finalise Nursing Initial Assessment with a Note

6. In the patient chart navigate to 'ED Nursing View' and the 'ED Nursing Workflow' page will open. Review/Add any additional information as you move through each section including allergies/alerts. Free text boxes are provided to document your patients Presenting History, Previous Medical/Social History, Current Medications as well as an additional free text box to provide any additional information you feel is pertinent.



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Primary Survey		
Allergies (0)		
Problems/Alerts		Save
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Current Medications	Font - Size - X G G B I U A- E E E E E E E	
Observations ED Rick Screening		
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luid Balance	Current Medications	Selected Visit 21 49
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7.	It is important to Sign and Submit nursing documentation. Scroll to the bottom
	section of the grey menu on the left side of the page until you reach the 'create
	note' section.

Doctor Documentation *DO NOT EDIT*

8. Select 'ED Nursing Initial Assessment'

Font



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- 9. This will open the note template. The template includes the following:
 - Primary survey documented in iView
 - o The 4x freetext boxes documented on the workflow page
 - Presenting History
 - Previous Medical/Social History
 - Current Medications
 - ED Nurse Freetext note

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Note Details: ED Nursing Initial Assessment, Cernertest, Nursing P2 4,	2/////2023 12:24 AEST, ED Nurse Initial Assessment	Sign/Submit Save Save & Close Cancel

10. Edit the document as required. Select 'Sign/Submit. Then 'Sign' on the following window.

Important – One Nursing Initial Assessment Note per Patient Encounter

- The Nursing Initial Assessment document set and progress note only needs to be completed when a patient first arrives to a treating space in the emergency department.
- Additional assessments completed at the start of your shift, or when you receive a new transfer from a different ED treatment space still need to have their routine initial assessments done; such as a primary assessment. However, these assessment can be completed via 'Interactive View and Fluid Balance' and do not routinely require an accompanying progress note. Utilise the comments free text box on your assessments to highlight brief patient tracking comments. Eg. "Shift handover completed, initial shift assessment completed, nil issues noted" or "Patient transferred from Resus, initial assessment completed, pt complain of abdominal pain, administered Paracetemol as per MAR".
- 11. This note will now be viewable on the documentation section of the patient chart.

Documents (3)				Modify Print View Document	\Box Enable Continuous Scrolling $ imes$
			in the second	ED Nurse Initial Assessment	
Time of Service	~	Subject	Note Type	ED Nursing Initial Assessment (Auth (Verified))	Author; Contributor(s): Cernertest, Nursing P2 4
 In Progress (0) 				Last Updated: 02 JUL 2023 12:30	Last Updated By: Cernertest, Nursing P2 4
 Completed (3) 					
02 JUL 2023 12:24		ED Nurse Initial Assessment	ED Nursing Initial	Drimory Survey	

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