FirstNet
Nursing Initial Assessment

Digital Health
CONNECTING BEST CARE

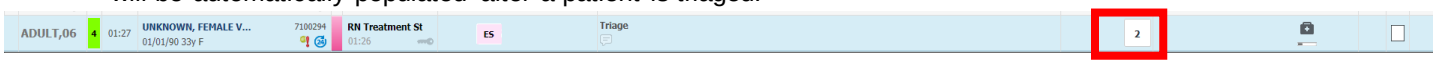
Digital Health
Quick Reference Guide

This Quick Reference Guide will explain how to:

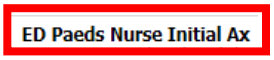
Complete a nursing initial assessment for the ED patient at the start of their ED journey.

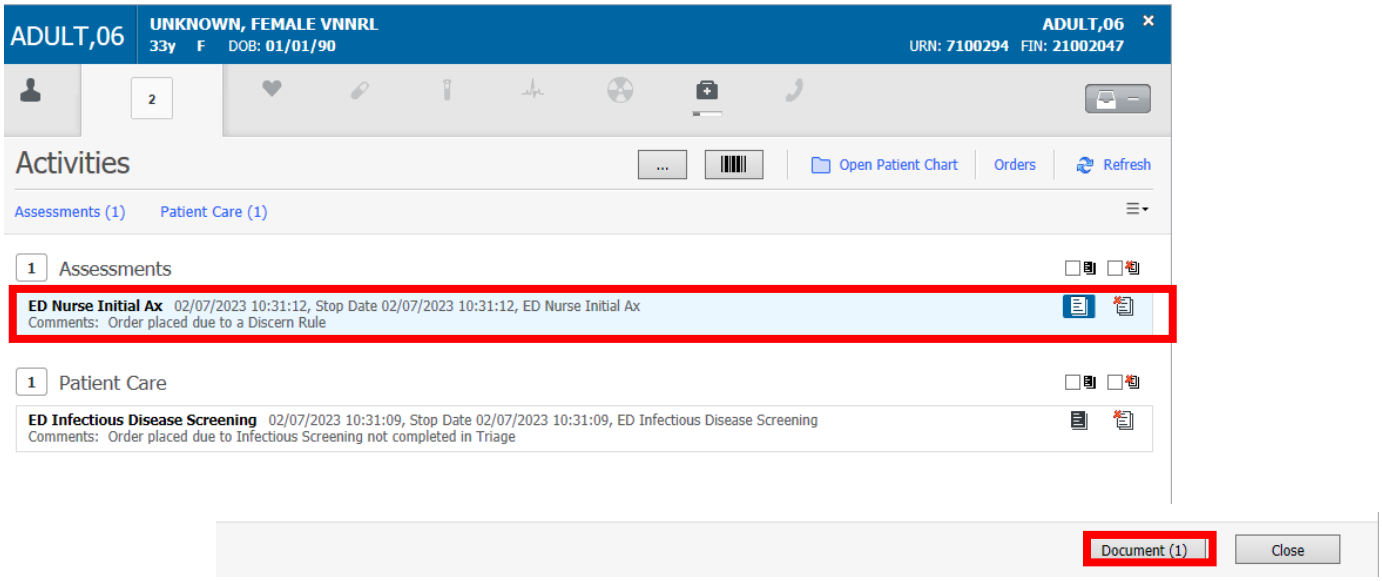
This QRG is applicable to the bedside/cubicle nurse. Including both **paediatric** and **adult** patients.

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.



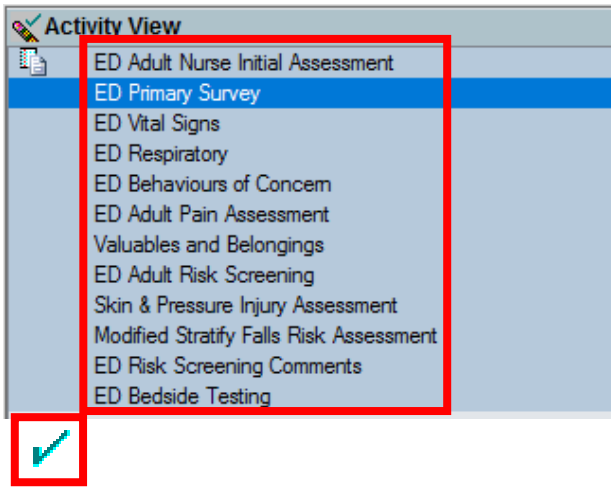
2. Click on the **ED Nurse Initial Ax**. This will highlight the task light blue.
   Note: for the paediatric patient (<18yo) this will display as the '**ED Paeds Nurse Initial Ax'** and will include different risk screening questions.
3. Select **'Document'**





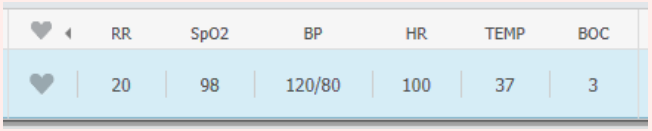
4. This will open a documentation set in iView. Click through the sections to document the nursing initial assessment:
   - Primary Survey
   - Vital Signs
   - Respiratory
   - BOC
   - Pain assessment
   - Valuables
   - Risk Screening
   - Skin/Pressure
   - Falls
   - Comments
   - BGL/Ketones

   To submit documentation select the green tick

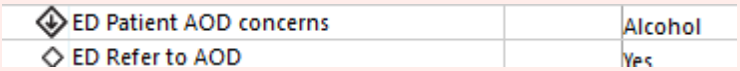


Handy Hint

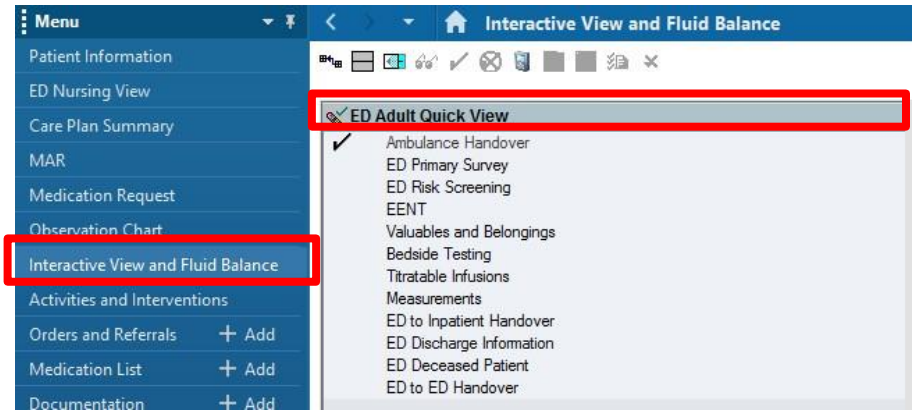
- Vitals signs will display in the patient observation chart and also on the front page of LaunchPoint.



- High falls risk identified in the initial assessment will populate an alert on LaunchPoint.
- Selecting 'yes' on 'ED refer to ACE or AOD' in the risk screening will automatically create a consult order for the relevant team.

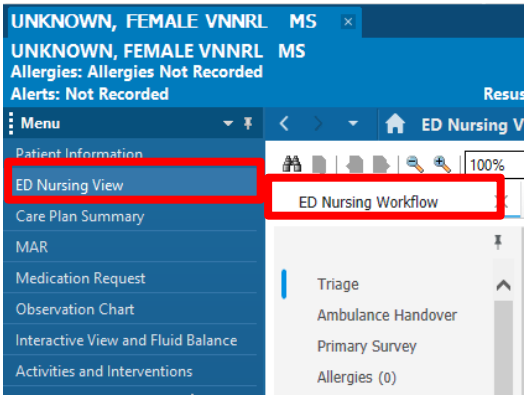


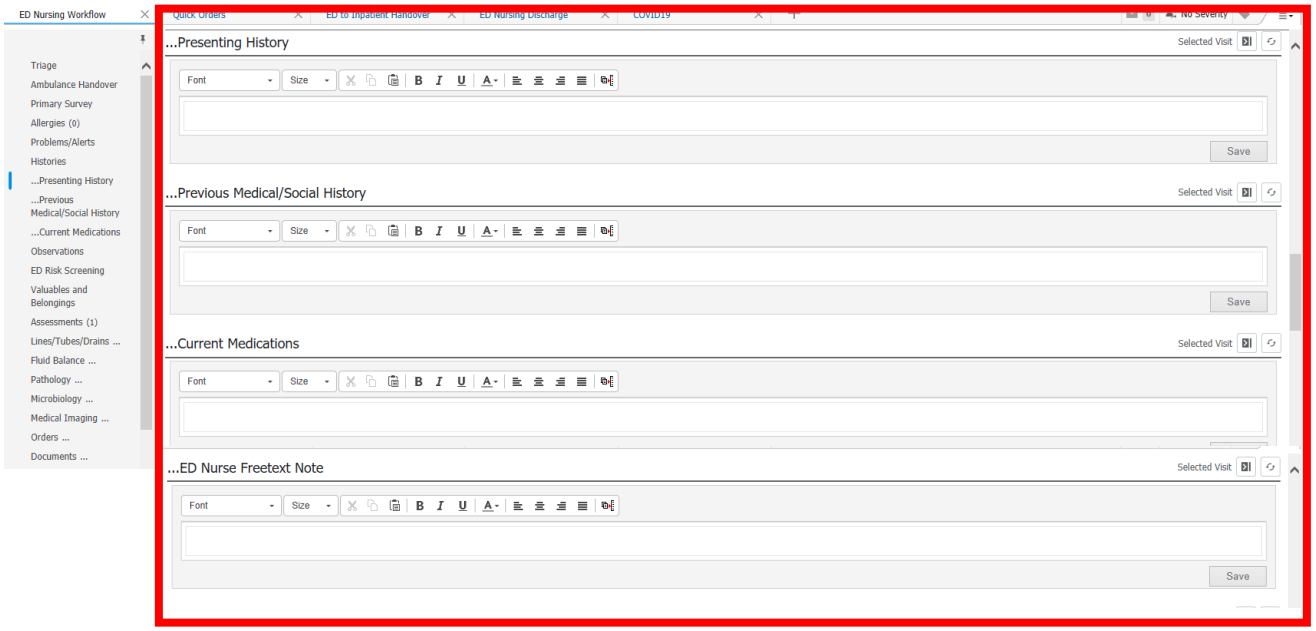
5. If you need to step away from documenting part way through, select the green tick to submit what you have done so far. You can then find all of these sections in **Interactive View and Fluid Balance tab – ED Quick View** to complete later.



Finalise Nursing Initial Assessment with a Note

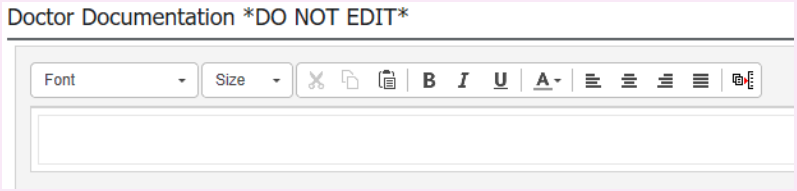
6. In the patient chart navigate to '**ED Nursing View'** and the '**ED Nursing Workflow'** page will open. Review/Add any additional information as you move through each section including allergies/alerts. Free text boxes are provided to document your patients Presenting History, Previous Medical/Social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





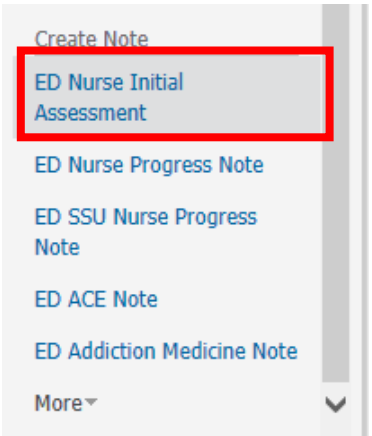
Important

- Do not edit the read only doctor documentation box. This is for viewing the 'draft' plan for the patient.

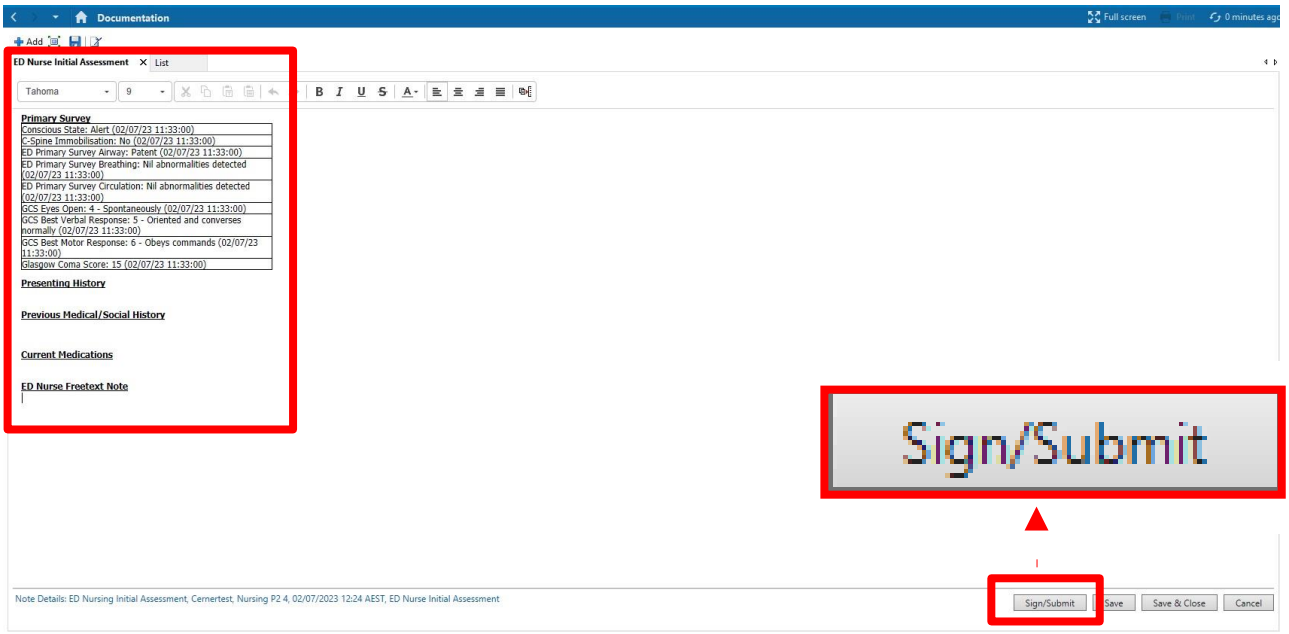


7. It is important to **Sign and Submit** nursing documentation. Scroll to the bottom section of the grey menu on the left side of the page until you reach the **'create note'** section.

8. Select '**ED Nursing Initial Assessment**'



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



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.