NSW GOVERNMENT Health

ADULT EMERGENCY DEPARTMENT OBSERVATION CHART

☐ Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PATHOLOGY TEST ATTENDED

☐ EUC
☐ GLUCOSE
☐ FBC
☐ INR
☐ APTT
☐ Blood Cultures
☐ Group & Hold
☐ β HCG
☐ ABG / VBG
☐ Serum Lactate
☐ LFT
☐ Blood Alcohol N°:
☐ Initial trop / CK | Time: | Time:

VASCULAR ACCESS/ART LINES

	Type	Size	Location
1.			
2.			
3.			
4.			

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ALLERGY / ALERTS:

WEIGHT:
Fluid restriction: N/A ☐ Yes ☐
Volume:

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SMR040010

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

Additional RED ZONE Criteria

Cardiac or respiratory arrest
Airway obstruction or stridor
Patient unresponsive

- Deterioration not reversed within 1 hour of Clinical Review
- Increasing oxygen requirements to maintain oxygen saturations > 90%
- Arterial Blood Gas: PaO_2 < 60, or $PaCO_2$ > 60 or pH < 7.2 or BE < -5
- Venous Blood Gas: $PvCO_2$ > 65 or pH < 7.2
- Fluctuating or 2 point drop in GCS
- Seizures
- Low urine output persistent for 8 hours (< 200mLs over 8 hours or < 0.5mL/kg/hr via an IDC)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with a decreased Level of Consciousness
- Lactate ≥ 4mmol/L
- **Serious concern by any patient or family member**
- **Serious concern by you or any staff member**

- Senior Medical Officer or Nurse review within 10 minutes.
- Observations recorded at least 15 minutely.
- Must have continuous monitoring.

Additional YELLOW ZONE Criteria

- Increasing oxygen requirement
- Poor peripheral circulation
- Excess or increasing blood loss
- Decrease in Level of Consciousness or new onset of confusion
- Low urine output persistent for 4 hours (< 100mLs over 4 hours or < 0.5mL/kg/hr via an IDC)
- New, increasing or uncontrolled pain (including chest pain)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with no decreased Level of Consciousness
- **Concern by patient or family member**
- **Concern by you or any staff member**

- Senior Medical Officer or Nurse review within 30 minutes.
- Observations recorded at least 30 minutely for the first hour and then hourly thereafter.
- Consider the need for continuous monitoring.
- Prioritise care if deteriorating.

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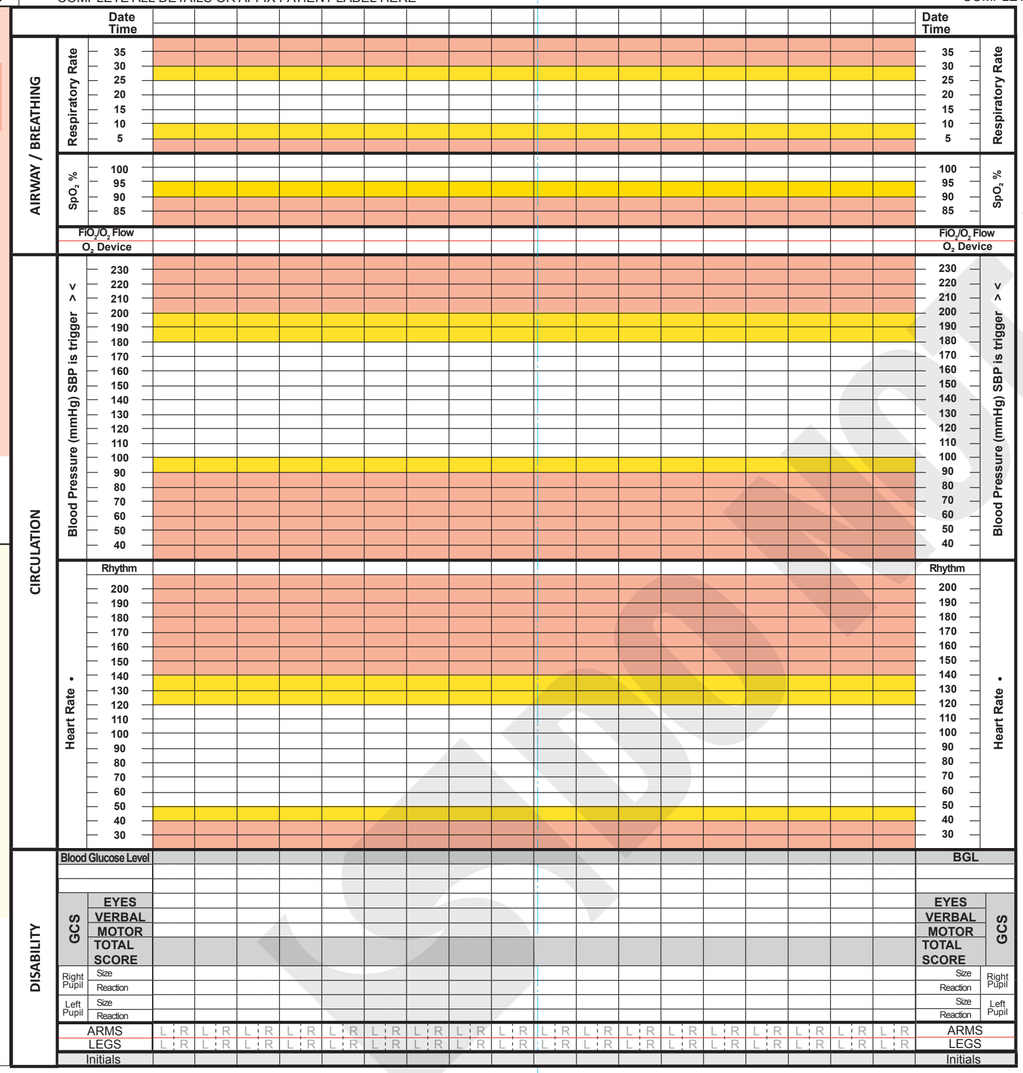


URINALYSIS

Date:			
Time:			
Specific Gravity		Nitrite	
pH		Bilirubin	
Blood		Urobilinogen	
Leukocytes		Protein	
Ketones		Glucose	
Urine HCG			
MSU/CSU	YES ☐	NO ☐	

Pupil Scale (mm)

1 2 3 4 5 6 7 8

GLASGOW COMA SCALE

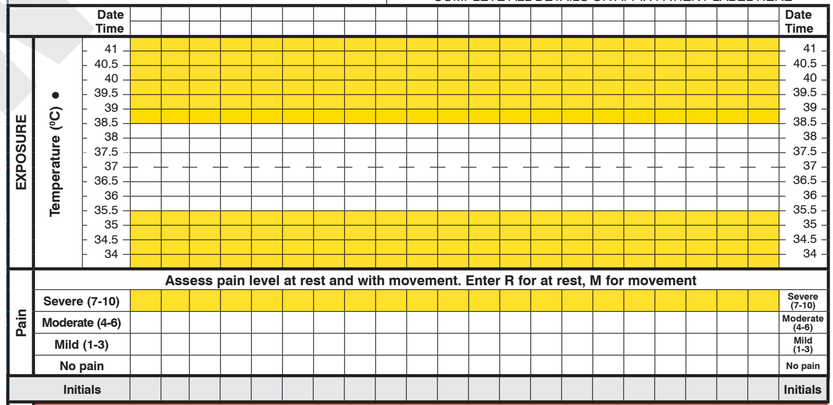
EYES OPEN	
Spontaneous	4
Voice	3
Pain	2
None	1
BEST VERBAL	
Orientated	5
Confused	4
Inappropriate	3
Incomprehensible	2
None	1
BEST MOTOR	
Obeys Commands	6
Localises to Pain	5
Withdraws	4
Flexion	3
Extension	2
None	1

GCS/PUPIL RESPONSE KEY

+	Reactive
SL	Sluggish
-	Non Reactive
C	Closed Eyes
T	ETT

LIMB RESPONSE KEY

0	None
1	Extension
2	Flexion
3	Severe Weakness
4	Mild Weakness
5	NORMAL



FLUID BALANCE CHART

FLUIDS

INTAKE					OUTPUT				
TIME	INTRAVENOUS FLUIDS 1	INTRAVENOUS FLUIDS 2	ORAL & NG	PROG. TOTAL	TIME	URINE	VOMIT	Other	PROG. TOTAL
Totals				mLs	Totals				mLs

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SUBSTANCE USE SCREEN

1. Does the patient smoke cigarettes daily? NO ☐ YES ☐ *If 'YES' consider Nicotine Replacement Therapy*
2. Does the patient drink alcohol daily? NO ☐ YES ☐ *If 'YES' how many standard drinks* _____
3. Has the patient ever experienced alcohol or other drug withdrawal? NO ☐ YES ☐ *Has a Withdrawal Chart been started?* NO ☐ YES ☐

ED Nurse Name: **Signature:**

FALLS RISK SCREEN

Screen to be completed on admission and again following a fall or significant change in condition

ITEM	FALLS RISK SCREEN		SCORE
1. History of Falls	Did the patient present to hospital with a fall or have they fallen since admission? NO ☐ YES ☐ If not, has the patient fallen within the last two (2) months? NO ☐ YES ☐	Yes to any=6	
2. Mental Status	Is the patient confused? NO ☐ YES ☐ Is the patient disorientated? NO ☐ YES ☐ Is the patient agitated? NO ☐ YES ☐	Yes to any=14	
3. Vision	Does the patient require eye glasses continually? NO ☐ YES ☐ Does the patient report blurred vision? NO ☐ YES ☐ Does the patient have glaucoma, cataracts or macular degeneration? NO ☐ YES ☐	Yes to any=1	
4. Toileting	Are there any alterations in urination? NO ☐ YES ☐	Yes=2	
5. Transfer Score (TS)	Independent - use of aids to be independent is allowed 0 Minor help - one person easily or needs supervision for safety 1 Major help - one strong skilled helper or two normal people; physically can sit 2 Unable - no sitting balance, mechanical lift 3	Add Transfer Score (TS) and Mobility Score (MS) If total between 0-2, then score = 0	Total of TS + MS
6. Mobility Score (MS)	Independent (but may use any aid, e.g. walking stick) 0 Walks with help of one person (verbal or physical) 1 Wheelchair independent including corners, etc 2 Immobile 3	If total between 3-6, then score = 7	

Prevention strategies as per policy must be implemented if score is ≥ 9 SCORE ≥ 9 = HIGH RISK OF FALLS **Total Score**

ED Nurse Name: **Signature:**

WATERLOW PRESSURE ULCER PREVENTION ASSESSMENT

Weight: | Height: | BMI:

Circle the appropriate score in the table below and calculate the total to obtain risk score

Sex and Age	Build/Weight for Height	Mobility	Continence	Skin type visual risk
1 = Male 2 = Female 1 = 14 – 49 2 = 50 – 64 3 = 65 – 74 4 = 75 – 80 5 = 81+	0 = Average (BMI = 20-24.9) 1 = Above average (BMI = 25-29.9) 2 = Obese (BMI >30) 3 = Below average (BMI <20) **BMI=** $\left(\frac{WT(kg)}{Height\ (m)^2}\right)$	0 = Fully 1 = Restless / fidgety 2 = Apathetic 3 = Restricted 4 = Bed bound 5 = Chair bound	0 = Complete/catheterised 1 = Urinary incontinence 2 = Faecal incontinence 3 = Urinary & faecal incontinence	0 = healthy 1 = Clammy, pyrexia 1 = Tissue paper / Dry 1 = Oedematous 2 = Discoloured Grade 1 3 = Broken/spots Grade 2-4

SPECIAL RISKS

Tissue Malnutrition	Neurological deficit	Major Surgery or Trauma	Medication
0 = Not applicable 1 = Smoking 2 = Anaemia (Hb <8g/dL or <80g/L) 5 = Single organ failure 5 = Peripheral vascular disease 8 = Terminal cachexia 8 = Multiple organ failure	4 Diabetes, MS, CVA 5 Motor/sensory 6 Paraplegia *Score depending on severity of condition* **max score of 6**	0 = Not applicable 5 = Orthopaedic / spinal 5 = On table >2 hrs# 8 = On table >4 hrs# # *Scores can be discounted after 48hrs provide patient is recovery normally*	0 = Not applicable 1 = Cytotoxics 1 = Long term steroids 1 = High dose steroids 1 = Anti-inflammatory **max score of 4**

MALNUTRITION SCREENING TOOL (MST) – CIRCLE AND ADD FOR A TOTAL

Has the patient recently lost weight without trying? If yes, how much?
0 = No
1 = Yes: 0.5 – 5 kg
2 = Yes: 5 – 10 kg
3 = 10 – 15 kg
4 = > 15 kg
2 = Unsure

Has the patient been eating poorly because of a decreased appetite?
0 = No
1 = Yes

Total Malnutrition score

If the patient's MST is 2 or more please refer to a dietitian

Total Waterlow Score *(total All score +MST)*

Waterlow Pressure Ulcer Risk: **< 10 = low risk** **10 + = At risk** **15 + High risk** **20 + Very high risk**

Pressure area care: Self ☐ 4/24 ☐ 2/24 ☐ Mattress ☐

Has the patient previously had a pressure injury? **YES** ☐ **NO** ☐
If the patient has a current pressure injury has an IIMS been entered? **YES** ☐ **NO** ☐ **IIMS N°:**

ED Nurse Name: **Signature:**

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OTHER CHARTS IN USE

☐ **ED Medication Chart** ☐ **Neurovascular Observation Chart** ☐ **Vaginal Loss Chart**
☐ **Inpatient Fluid Balance Chart** ☐ **National Inpatient Medication Chart** ☐ **Withdrawal Chart - Specify** .....
☐ **Trauma Chart** ☐ **Stool Chart** ☐ **Other** .....

ALTERATIONS TO CALLING CRITERIA

Any alterations MUST be signed by a Senior Emergency Department Medical Officer
Document rationale for altering CALLING CRITERIA in the patient's health care record

DATE:	dd/MM/yy					
TIME:	hh:mm					
Next review due Date & Time	dd/MM/yy hh:mm					
Yellow Zone	*xx-xx*					
Red Zone	*≤ or ≥ xx*					
Yellow Zone						
Red Zone						
Yellow Zone						
Red Zone						
Yellow Zone						
Red Zone						
Medical Officer Name (BLOCK letters)	P. SMITH					
Medical Officer Signature	P. SMITH					

EXAMPLE

ADMISSION CHECK

Name Band: ☐ Allergy Band: Yes ☐ N/A ☐

PRESENTING PROBLEM:

PROTOCOL COMMENCED:

Contact person: Relationship: Phone number:

Contact person aware of admission: YES ☐ NO ☐ Cannot be contacted ☐ Religion:

Interpreter required: NO ☐ YES ☐ Specific language: _____

Nurse (BLOCK LETTERS): Date: Time:

VALUABLES CHECKLIST

DESCRIPTION	NONE	SELF	FAMILY	SECURITY
Money (including bank cards)	☐	☐	☐	☐
Glasses	☐	☐	☐	☐
Dentures	☐	☐	☐	☐
Aids (i.e. walking stick/hearing aids)	☐	☐	☐	☐
Watch	☐	☐	☐	☐
Rings / Other Jewellery	☐	☐	☐	☐
Electronic Devices (e.g mobile phone)	☐	☐	☐	☐
Medication	☐	☐	☐	☐
Clothes (include cut off items)	☐	☐	☐	☐
Prohibited Items / Other (e.g keys)	☐	☐	☐	☐

The Hospital takes no responsibility for any lost clothing. It also takes no responsibility for any lost or damage to valuables not lodged for safe keeping. Patients are advised that all valuables (except clothing actually being used) should be sent home or locked in security.

Patient's Signature | Nurse's Signature

Security Ref No: | *(if patient unable to sign)* Witness's Signature:

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SMR040.010

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MEDICAL ADMISSION AT TIME OF ACCEPTANCE OF CARE

PROVISIONAL DIAGNOSIS:

Attending Medical Officer:
Delegate name (If applicable):
Accepted care of patient
Date:
Time:

Clinical plan explained to patient /carer Yes ☐
Clinical plan documented in progress notes Yes ☐
Admission completed by:
ED Medical Officer name:
ED Medical Officer signature:

DEPARTURE CHECKLIST – TO WARD / OTHER FACILITY

NURSING	MEDICAL
Verified that all documentation is complete • Admission/Transfer forms/eMR ☐ • Medications charted Yes ☐ N/A ☐ • Analgesia charted Yes ☐ N/A ☐ • IV fluids charted Yes ☐ N/A ☐ • Fluid balance up to date ☐ • Progress notes up to date ☐ • Risk assessments completed ☐ Diet: Eat & Drink ☐ Nil By Mouth ☐ IVT ☐ NG ☐ Infection status: Precautions / Isolation required Yes ☐ Specify: Contact precautions / Respiratory Patient belongings sent to ward Yes ☐ N/A ☐ Medication sent to ward Yes ☐ N/A ☐ **Ward accepting care:** **Ward Nurse accepting care:** **ED Nurse transferring name:** **ED Nurse transferring sign:**	Medical handover given Yes ☐ No ☐ Outstanding results and actions handed over: **1.** **2.** **3.** **4.** **5.** **Medical Officer accepting care name:** **ED Medical Officer providing handover** **Name:** **Sign:** **Date:** **Time:**

DEPARTURE CHECKLIST – ED TO USUAL PLACE OF RESIDENCE

Cannula / ID band removed Yes ☐	NOK/person responsible aware? Yes ☐ No ☐
Discharge / referral letter Yes ☐	Nursing Home / Hostel aware? Yes ☐ No ☐
Discharge prescription Yes ☐	**Consider**
Fact sheet Yes ☐	Does the patient live alone?
Clothes / belongings Yes ☐	Time of discharge appropriate?

AUTHORISATION FOR DEPARTURE FROM ED

Observations within the last hour Yes ☐	Alterations to calling criteria documented Yes ☐ No ☐
Is the patient 'Between the Flags' Yes ☐ No ☐	Frequency for observations documented Yes ☐ No ☐
If not, clinical reason and plan is documented and signed ☐	

SENIOR ED NURSE	MEDICAL AUTHORISATION
Authorised as safe for departure Yes ☐	**Authorised as safe for departure** Yes ☐
Name (BLOCK LETTERS):	**Name (BLOCK LETTERS):**
Signature:	**Signature:**
Date: **Time:**	**Date:** **Time:**