Royal United Hospital Bath **NHS**

NHS Trust

Mini Manual

ED Observation Ward

1. **Initial Risk Assessment Part 1 – to be completed and signed by a Registered Nurse within 6 hours of admission.**

Support available:

Please contact your local Champion User

Service Desk:

Tel: 01225 82 5444

Email: ruh-tr.ITServiceDesk@nhs.net

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Bringing it all together

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1   Complete Initial Risk Assessment Part 1

Step 1.   Within PowerChart go to the Patient Access List

Step 2.   Find your patient in the list and click on the corresponding icon.

The task list is displayed

Step 3.   Select the Initial Risk Assessment Part 1 from the task list by clicking on the appropriate check boxes (so that they have a tick ☑)

Step 4.   Click the **Record** [Record] icon

The system opens the Initial Risk Assessment Part 1 Form

The [icon] icons indicate that the information has been "pulled" through from other forms (in this case from the Pre-assessment form.

Any yellow field in an assessment form is **mandatory** eg

Guidance in Blue provides further guidance on actions that may be required

Guidance in Red indicates that the system will add additional tasks/assessment to be completed. If these assessments are to be completed electronically, the system will automatically order them and put them on the PAL. eg in the above Communication Assessment if the **Communication Care Plan.** If the assessments are paper based the system will created a task when this is complete the MPTL can be used to record this fact. ED Observation will only complete the Initial Risk Assessment.

Radio boxes (eg ○ No) are used where users must choices between a number of options-

Check boxes (e.g. ☐ Deaf) are used where the users may select any number of the options

In some cases selecting some options means further

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information needs to be recorded (eg if the patient has hearing problems the type of hearing problems must also be selected). If this is the case the additional fields required will turn yellow

Step 5.   Right click on any field to display context menu. While this is available for all fields it will not be necessary to use the context menu in all cases.

 A good example of the use of this context menu is the Pressure Ulcer and Wound Assessment

Step 6.   Right click on the the first question "Does the patient have a pressure ulcer"

The context menu appears with **Reference Text** bolded

Step 7.   Click on Reference Text

The system display a **Decision Support** screen that provides additional information about Pressure Ulcers and there grading

Step 8.   Click OK [OK] (bottom right) to close decision support screen

Step 9.   Right Click on Pressure Ulcer Site and Grade – Pressure Ulcer site box
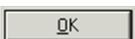
The context menu appears with **Record Details** bolded

Step 10.   Click on Record Details

The **Record Details** dialogue box is displayed

Step 11.   Select pressure ulcer site by clicking appropriate radio box

Step 12.   Enter additional comments (if required) in the lower pane

Step 13.   Click OK [OK] (bottom right) to close Results Details dialogue box

Step 14.   Complete all the mandatory field within the assessment form using the above guidance, and any non mandatory field as required

When all the mandatory fields are complete the status icon on the form menu on the top left of the screen changes from

to ☑.

Many assessments consist of a number of forms - the blue menu on the top left of the screen displays the different forms to be completed. For example, on the **Initial Risk Assessment Part 1** there are six forms

To save the forms (so that you can complete the forms at a later date)

Step 15. Click the save 💾 icon (in the assessment menu)

Once all the mandatory fields in all the forms are complete the form can be "signed",

Step 16. Click Sign Form ✔ icon

Note: The system will record which user "signed" the form, as the form becomes part of the patient record (a legally recognised document.)

Never sign a form electronically unless you are logged on as yourself.

Result: ****The task is now complete and the red heart no longer appears on the PAL next to that patient.***

Business Rules

***** At the present time you can only save the assessments as the infection assessment contains Question: Date of last MRSA Screen, as this cannot be filled in unless patient has had a screening, the form is not completed, so the hearts will not disappear from the patient.**