

NAME: _____ NHI: _____

GENDER: _____ DOB: _____ AGE: _____ WARD: _____

RISK SCREENING / ASSESSMENT

Risk Screening

This section to be commenced for all patients at point of entry (use Patient Assessment Questionnaire as appropriate) and completed within 6 hours of presentation (use an * to denote change/reassessment and sign with * in sign off section)

Identification Confidentiality	<input type="checkbox"/> Patient/whānau are aware that valuables are held at their own risk <input type="checkbox"/> Patient label or NOK details not correct → <input type="checkbox"/> Update PMS and Update Admission Form <input type="checkbox"/> Patient's name requested to be removed from identification boards OR → <input type="checkbox"/> Ward Clerk and Telephone Office notified as required → <input type="checkbox"/> Alerts complete <input type="checkbox"/> Personal information not to be shared with person/group (specify below)			
Adverse Reaction	<input type="checkbox"/> Medicine (specify) → <input type="checkbox"/> Alerts completed <input type="checkbox"/> Food (specify) → <input type="checkbox"/> Update diet <input type="checkbox"/> Other (specify) For 3 or more food allergies → <input type="checkbox"/> Dietitian referral Or No Risk <input type="checkbox"/>			
IP&C	<input type="checkbox"/> PMS Alert checked for MRSA, ESBL, VRE, MDRO <input type="checkbox"/> Recent diarrhoea / vomiting (potentially infectious) <input type="checkbox"/> Transmission based isolation precautions required → <input type="checkbox"/> MRSA screening swabs taken <input type="checkbox"/> Other (specify) <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne <input type="checkbox"/> Protective Or No Risk <input type="checkbox"/>			
Mental Health/Safety Communication	<input type="checkbox"/> Interpreter required (specify language) → <input type="checkbox"/> Interpreter arranged (ext 80843) or Duty Manager paged A/H Hearing/Vision impaired (circle) → Hearing aids Glasses Dentures Plate (circle) with patient Or → <input type="checkbox"/> Advised to bring in <input type="checkbox"/> Recent change in ability to make self understood/express self → <input type="checkbox"/> SLT referral <input type="checkbox"/> Known Communication Barrier (specify) → Document management strategies in Care Plan <input type="checkbox"/> Cognitive deficits/previous delirium <input type="checkbox"/> Known behavior that causes safety concerns to staff/patients/visitors (specify below) Or No Risk <input type="checkbox"/>			
Pressure injury	Braden Score _____ At risk (15-18) Mod risk (13,14) High risk (10-12) Very High risk (9 and below) <input type="checkbox"/> Current PI on admission (location) Stage (circle) 1 2 3 4 Unstageable Deep Tissue Current PI → Automatically <input type="checkbox"/> Very high risk (9 or below) → <input type="checkbox"/> Incident Form completed (identify if community or hospital acquired) <input type="checkbox"/> Clinical judgment increases Risk category (specify) OR <input type="checkbox"/> Risk category not altered Current Score + Clinical judgement = <input type="checkbox"/> At risk <input type="checkbox"/> Mod risk <input type="checkbox"/> High risk <input type="checkbox"/> Very High risk → Once admitted to ward flipchart strategies documented in Care plan <input type="checkbox"/> Or no risk / comorbidities don't increase risk <input type="checkbox"/>			
Smoking Cessation	<input type="checkbox"/> Current smoker → ALL patients identified as a smoker (smoked at least 1 cigarette in the last month) <input type="checkbox"/> Ex Smoker <input type="checkbox"/> Brief advice given <input type="checkbox"/> Patient advised of CDHB Smokefree policy <input type="checkbox"/> Quit pack given or <input type="checkbox"/> declined <input type="checkbox"/> Exposed to second hand smoke <input type="checkbox"/> External referral sent or <input type="checkbox"/> declined <input type="checkbox"/> Never Smoked /No Risk Patient discharged → <input type="checkbox"/> Quit card/NRT/Cessation meds prescribed or <input type="checkbox"/> declined Patient admitted to ward → <input type="checkbox"/> NRT prescribed for withdrawal/cessation or <input type="checkbox"/> declined			
Fall Prevention	<input type="checkbox"/> A. Previous Slip/Trip/Fall/Collapse <input type="checkbox"/> B. Unable/Difficulty to Get up and Go <input type="checkbox"/> C. Risk Taking Behaviour <input type="checkbox"/> D. Complex medications/side effects <input type="checkbox"/> E. Confusion/Disorientation/Sensory <input type="checkbox"/> F. Altered Elimination <input type="checkbox"/> Clinical judgement denotes High Risk <input type="checkbox"/> Or No Risk <input type="checkbox"/> High Risk - 2 + Fall category/s selected or Clinical judgement denotes high risk → (Specify rationale) → Flipchart management strategies and/or clinical judgment strategies in Care plan <input type="checkbox"/> <input type="checkbox"/> Patient/family informed of risk & given fall prevention pamphlets <input type="checkbox"/> Fall risk sign/bracelet <input type="checkbox"/> Referral to community programme (see intranet) <input type="checkbox"/> GP Notification in Discharge plan <input type="checkbox"/> If discharge in ED - Occupational therapist and Physio therapist paged for review <input type="checkbox"/> 1 Fall Category ticked → add flipchart strategies to Care Plan <input type="checkbox"/>			
Alcohol	<input type="checkbox"/> Alcohol related admission or high alcohol intake → complete CAGE/CRAFFT (<18) screen Score _____ (if score 1 or above) → <input type="checkbox"/> Brief advice given → <input type="checkbox"/> Refer to Medical Team and Social Worker <input type="checkbox"/> Recreational Drug User (specify) <input type="checkbox"/> Refer to Medical Team and Social Worker Or No Risk <input type="checkbox"/>			
FVSQ	<input type="checkbox"/> FV + or <input type="checkbox"/> FV (Signs/symptoms?) → <input type="checkbox"/> Preliminary Risk Assessment Form completed → <input type="checkbox"/> Refer to social worker for FV or care/protection Or <input type="checkbox"/> Not asked screening questions → <input type="checkbox"/> No staff education (refer to social worker if signs are present) FV -ve No Risk <input type="checkbox"/>			
Sign off	Full Name	Designation	Signature	Date

R
I
S
K

S
C
R
E
E
N
I
N
G

C
2
4
0
0
7
6

Assessment

This section is to be completed within 24 hours of presentation, complete in conjunction with the Referral form and Care Plan

Pain Comfort Wound	<input type="checkbox"/> Pain score above 3 → <input type="checkbox"/> Referred to Medical Team for urgent review Description/Location of Pain: <input type="checkbox"/> Regular analgesia charted Last given at: by: <input type="checkbox"/> GP <input type="checkbox"/> ED <input type="checkbox"/> Ward/Other <input type="checkbox"/> Wound on admission (<i>specify</i>) → <input type="checkbox"/> Wound treatment sheet completed management in Care Plan <input type="checkbox"/> Internal referral form completed (as required) <input type="checkbox"/> Wound CNC <input type="checkbox"/> Vascular Nurse <input type="checkbox"/> Infectious Disease Nurse <input type="checkbox"/> Diabetes Podiatrist Or No Risk <input type="checkbox"/>				
Cognitive continued	<input type="checkbox"/> Altered cognition due to a chronic condition (<i>specify</i>) <input type="checkbox"/> Hx of delirium or <input type="checkbox"/> Hx of dementia or <input type="checkbox"/> Cognitive changes within last few days → <input type="checkbox"/> CAM and MSQ performed <input type="checkbox"/> CAM positive and/or MSQ = or below 7 → <input type="checkbox"/> Medical Team assessment <input type="checkbox"/> Patient's delirium/dementia management plan is identified in Care plan <input type="checkbox"/> Patient's behavioural management is documented in Care plan Or No Risk <input type="checkbox"/>				
Mental Health continued	<input type="checkbox"/> Patient having suicidal thoughts → <input type="checkbox"/> Medical referral for psych consult <input type="checkbox"/> Kessler screening tool positive or/and patient has history of or appears <input type="checkbox"/> Depressed or <input type="checkbox"/> Anxious → <input type="checkbox"/> Medical referral for management by team or GP Or No Risk <input type="checkbox"/>				
Safety	<input type="checkbox"/> Current patient self harm / violence /security risk / clinical management issue (<i>specify</i>) <input type="checkbox"/> Visitor/family/whānau risk to patient or staff (<i>specify</i>) <input type="checkbox"/> Place alert on PMS <input type="checkbox"/> Potential weapons removed <input type="checkbox"/> Security notified <input type="checkbox"/> Medical team review <input type="checkbox"/> Duty Nurse Manager notified <input type="checkbox"/> Documented above risks in Care Plan and identify if patient has: <input type="checkbox"/> Security Guard <input type="checkbox"/> Police Escort <input type="checkbox"/> Prison Guard <input type="checkbox"/> Psych Nurse <input type="checkbox"/> Other (<i>specify</i>) Or No Risk <input type="checkbox"/>				
Resp.	<input type="checkbox"/> Acute respiratory deterioration or is at risk of deterioration with increasing EWS <input type="checkbox"/> Increased work of breathing → <input type="checkbox"/> Urgent Medical review <u>and</u> Physio paged Internal Referrals sent <input type="checkbox"/> Physio review <input type="checkbox"/> Trache/stomal nurse Or No Risk <input type="checkbox"/>				
Support Cultural Lifestyle	<input type="checkbox"/> Specific disability requirements documented in Care Plan or <input type="checkbox"/> Use disability health passport Or No Risk <input type="checkbox"/> <input type="checkbox"/> Specific cultural, wairua or spiritual lifestyle practices documented in Care plan Internal Referral completed for <input type="checkbox"/> Māori Chaplain <input type="checkbox"/> Healthcare Chaplain <input type="checkbox"/> Māori Health worker visit as indicated <input type="checkbox"/> Kaumatua				
Nutrition Malnutrition	Malnutrition Screening Tool (MST) score: _____ Malnutrition risk score 3 or > → <input type="checkbox"/> Dietitian referral completed Malnutrition risk score < 3 → <input type="checkbox"/> Document actions in care plan (refer to MST) <input type="checkbox"/> Patient on enteral feed/nutrition supplement drinks → <input type="checkbox"/> Dietitian referral completed <input type="checkbox"/> Special/ texture / modified diet / fluids → <input type="checkbox"/> SLT/Dietitian referral completed if indicated / documented in Care Plan				
Dysphagia	<input type="checkbox"/> Patient admitted with suspected/confirmed stroke → <input type="checkbox"/> NBM → <input type="checkbox"/> SLT referral completed /Certified Nurse Dysphagia screen <input type="checkbox"/> Recent change in swallowing (<i>specify</i>): → <input type="checkbox"/> SLT referral complete Or No Risk <input type="checkbox"/>				
ADL	<input type="checkbox"/> Assistance with activities of daily living identified in care plan → <input type="checkbox"/> Equipment required documented in care plan <input type="checkbox"/> Change in functional activities (motor/cognitive/psychosocial impairment) → <input type="checkbox"/> Occupational Therapy referral completed <input type="checkbox"/> Change in mobility/functional activities → <input type="checkbox"/> Physiotherapy referral completed for mobility/functional review <input type="checkbox"/> Falls Risk identified (A and/or B category) → <input type="checkbox"/> Physiotherapy and Occupational therapist referral completed <input type="checkbox"/> Patient requires assistance with eating → <input type="checkbox"/> Documented in care plan Or Independent /No Falls Risk <input type="checkbox"/>				
Meds	<input type="checkbox"/> Patient medications brought into hospital → <input type="checkbox"/> Medication reconciliation completed → <input type="checkbox"/> Medicines sent home with family/carer <input type="checkbox"/> Patient has brought controlled/recorded medications into hospital → <input type="checkbox"/> Stored appropriately and entered in register <input type="checkbox"/> Pharmacist referral completed for changes to <input type="checkbox"/> Yellow Card <input type="checkbox"/> Problems with medications <input type="checkbox"/> Medicine counselling Or No medications <input type="checkbox"/>				
Patient /Area Specific					
Sign off	Full Name	Designation	Signature	Date	Time