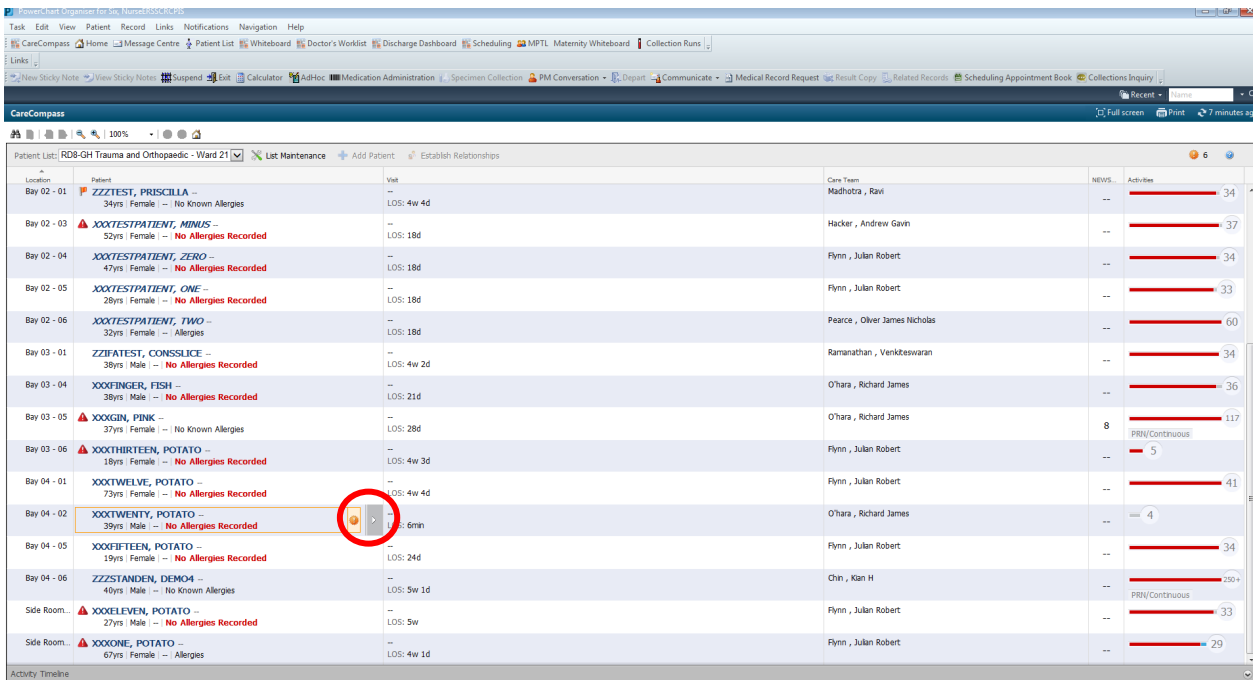


## AUTOMATED ASSESSMENTS AND TASKS ON ADMISSION – ABAA, ADL, ES, SA

1. With a new admission of a patient, there will be 4 automated assessments to be completed. These are:
1. Adult Basic Admission Assessment
  2. Activities of Daily Living Assessment
  3. Environmental Safety
  4. Safety Assessment

2. To complete these, select the CareCompass:

3. From your list of patients, select the arrow to the right of the persons name:



4. This will load up a new menu and you will see the list of assessments mentioned in Step 1:

The screenshot shows the CareCompass interface. On the left is a patient list for 'RDB-GH Trauma and Orthopaedic - Ward 21'. The patient 'XXXTWENTY, POTATO' is highlighted. On the right, the task view for this patient is shown. A red circle highlights the 'Activities of Daily Living Assessment' task under the 'Current' section. The task details include: 'Activities of Daily Living Assessment Requested Start Date/Time 05/Jan/18 10:00:00 GMT, Comment: Ordered automatically on admission.' Below the task list is an 'Activity Timeline' chart showing overdue tasks and a 'Document' button at the bottom right.

5. Click the assessment you wish to complete and click Document: (for this example we will be using the Activities of Daily Living Assessment)

This is a close-up of the task view for 'XXXTWENTY, POTATO'. The 'Activities of Daily Living Assessment' task is selected and highlighted in blue. At the bottom right of the task view, there are three buttons: 'Done', 'Not Done', and 'Document'. The 'Document' button is circled in red, indicating the next step in the process.

6. You will then be taken to your chosen tasks iView screen:

Task Edit View Patient Record Links Notifications Options Documentation Orders Help

Links: CareCompass Home Message Centre Patient List Whiteboard Doctor's Worklist Discharge Dashboard Scheduling MPL Maternity Whiteboard Collection Runs

XXXTWENTY, POTATO Age: 39 years Sex: Male Loc: RDS-GH Ward 21: Bay 04: 02  
 DOB: 05/Jan/79 Resusc: MRN: 865563 Inpatient (05/Jan/2018 09:36 - No Discharge date-)  
 Allergies: Allergies Not Recorded NHS No: Clinical Staff: O'hara, Richard James

Menu: Assessments/Fluid Balance

Activity View:
 

- Activities of Daily Living Assessment
  - Communication
    - First Language
    - Interpreter Required
    - Any Hearing Problems
    - Any Speech Problems
    - Any Visual Problems
    - Any Problems Understanding
    - Capacity to make the required decision?
    - Communication Care Plan Required
  - Breathing
    - Patient Smokes
    - Breathing Problems
    - Age Started Smoking
    - Cigarettes per Day
    - Ex-Smoker: Date of Cessation
    - Refer to Smoking Cessation Nurse
    - Breathless at Rest
    - Breathless on Mild Exertion
    - Breathless Lying Down
    - Breathless After Short Walks
    - Breathless Climbing Stairs
    - Patient has Dry Cough
    - Patient Coughs up Sputum
    - Oxygen Compressor at Home
    - Oxygen Cylinder at Home
    - Inhalers Used at Home
    - Peak Flow Readings at Home
    - Regular Exercise Taken
    - Home Oxygen Therapy Hours per day
    - How this Affects Daily Activities
  - Eating and Drinking
    - Help with Eating
    - Kind of Help Needed
    - ADL - Pre-Admission Diet
    - ADL - Pre-Admission Fluids
    - Alcohol Consumption Per Week
    - Denture Wearer
  - Washing and Dressing
    - Patient Self-Caring
    - Chosen Hygiene Method
    - Frequency of Chosen Hygiene Method
    - Special Hygiene Requirements

6.5 In order to gain a clearer picture, you can expand the columns if needed, look for the Double arrow: that appears between the two columns, hold click and move to the right in order to expand the column:

Task Edit View Patient Record Links Notifications Options Documentation Orders Help

Links: CareCompass Home Message Centre Patient List Whiteboard Doctor's Worklist Discharge Dashboard Scheduling MPL Maternity Whiteboard Collection Runs

XXXTWENTY, POTATO Age: 39 years Sex: Male Loc: RDS-GH Ward 21: Bay 04: 02  
 DOB: 05/Jan/79 Resusc: MRN: 865563 Inpatient (05/Jan/2018 09:36 - No Discharge date-)  
 Allergies: Allergies Not Recorded NHS No: Clinical Staff: O'hara, Richard James

Menu: Assessments/Fluid Balance


Activity View:
 

- Activities of Daily Living Assessment
  - Communication
    - First Language
    - Interpreter Required
    - Any Hearing Problems
    - Any Speech Problems
    - Any Visual Problems
    - Any Problems Understanding
    - Capacity to make the required decision?
    - Communication Care Plan Required
  - Breathing
    - Patient Smokes
    - Breathing Problems
    - Age Started Smoking
    - Cigarettes per Day
    - Ex-Smoker: Date of Cessation
    - Refer to Smoking Cessation Nurse
    - Breathless at Rest
    - Breathless on Mild Exertion
    - Breathless Lying Down
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  - Washing and Dressing
    - Patient Self-Caring
    - Chosen Hygiene Method
    - Frequency of Chosen Hygiene Method
    - Special Hygiene Requirements

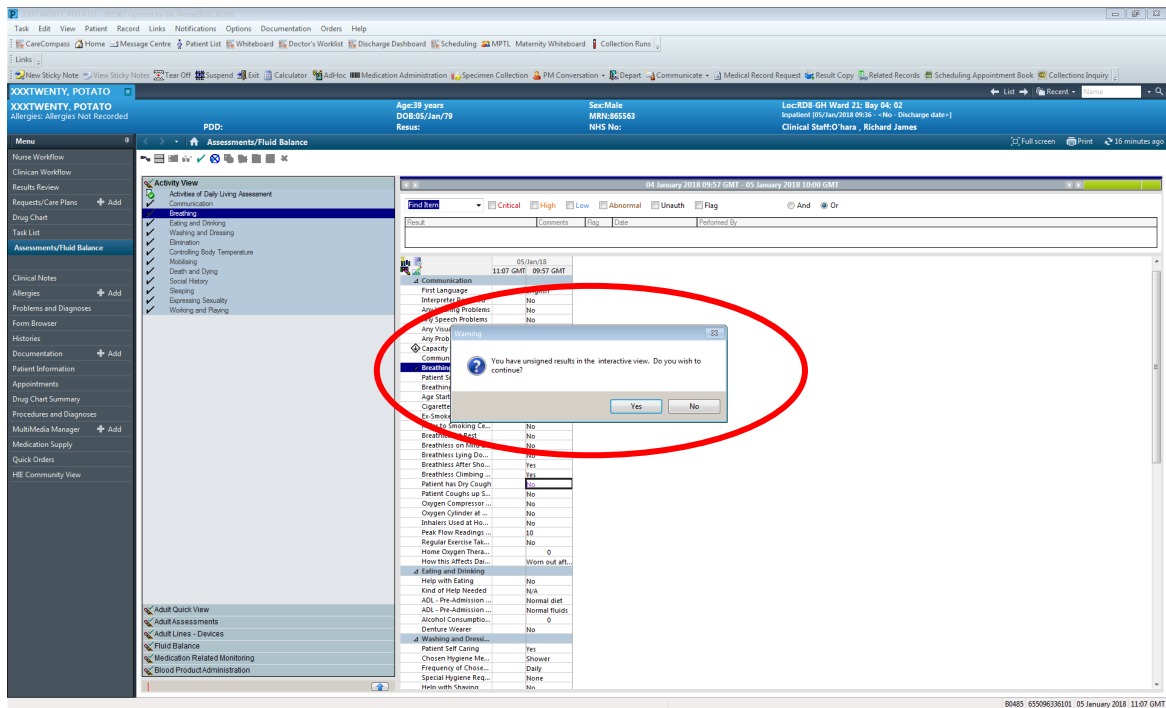
7. Complete your necessary fields, you should notice that the blue 'heading' bands have tick boxes: The below is an example of completed information:

**NOTE: Information entered into the system will be purple before authorised/signed (as shown in example)**

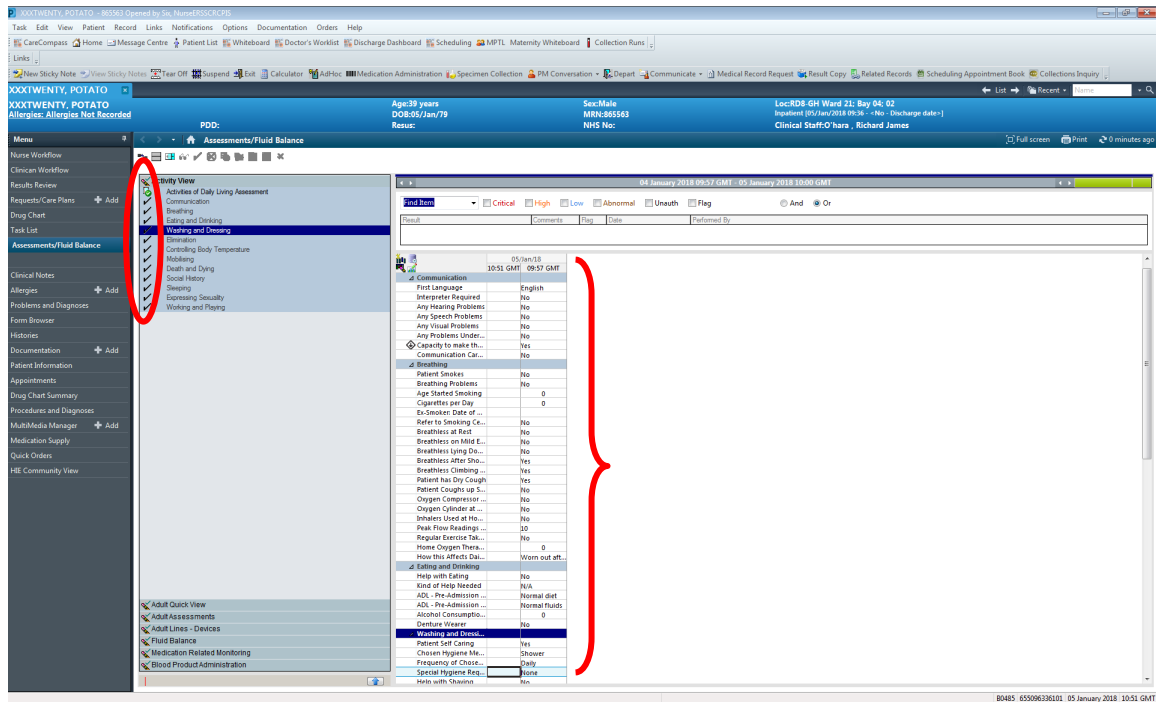
**If no tick is present in blue ribbon, simply double click in the column next to the heading and this will be it in for you.**

8. Once you have completed data in a given section, you will need to 'Sign':  the data for it to be authorised and entered onto the patients file.

8.5 If you do not sign for the data, no changes or data inputs will be saved. If you try to exit out of the patient record, without signing the data, you will have an alert pop up:



9. You should now see that the purple text has turned to black text and a notebook with a tick is shown next to the assessment:



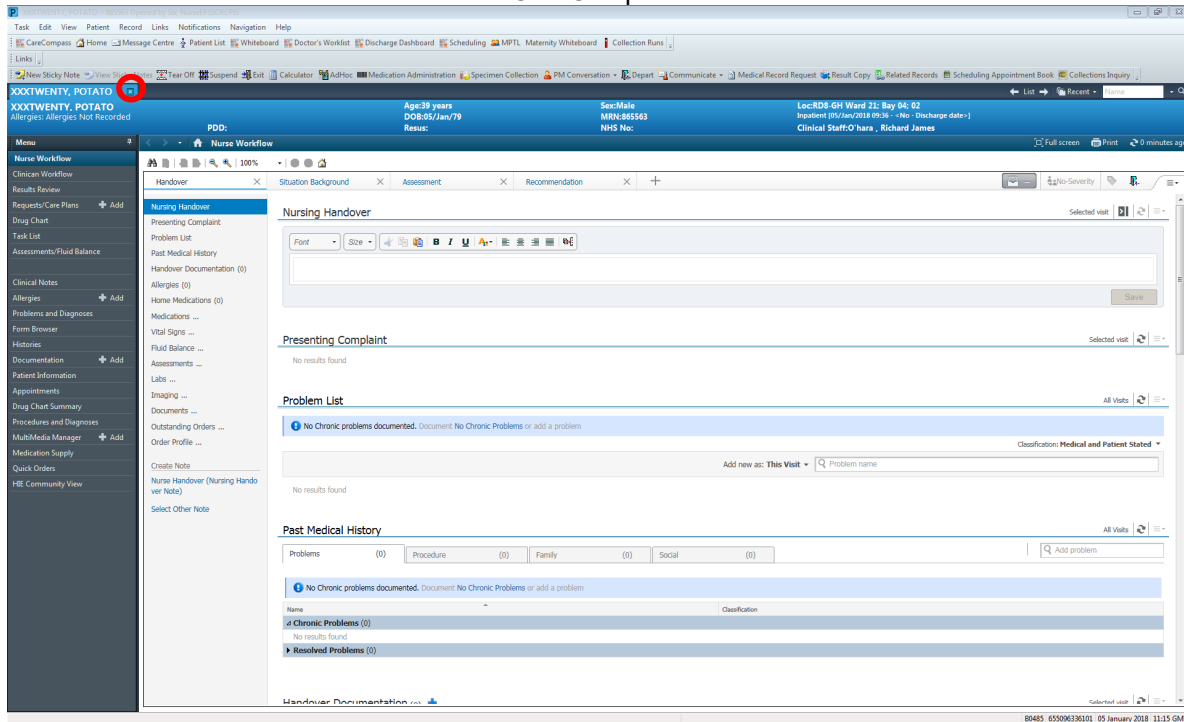
**IMPORTANT:** By signing the information, you are creating a permanent record registered to **YOUR** account and smart card. Ensure all data is accurate and relevant before signing.

You are signing to say that the task/assessment is **COMPLETE** and **YOU** are the one who has completed it. If it is necessary to leave the record at any point, signing the data will complete the task, therefore you will need to make a mental note to return and complete the remainder information.

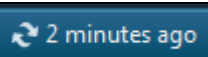
**NOTE:** Depending on your scoring and data entry, you may have a 'Discern Notification' pop up, this will be covered in a separate QRG: QRG Discern Notifications.

10.

Now Exit the patient record by clicking the:  next to the patients name – this will return you to the CareCompass:



11.

Refresh the CareCompass using:  and then click the arrow next to your patients name to display the same page as step 4. You will now see that this task has dissappeared from the list:

The screenshot displays the CareCompass interface. On the left, a patient list shows various patients with their names, ages, genders, and allergy status. The patient 'XXXTWENTY, POTATO' is highlighted. The main panel shows the patient's details, including age (39yrs), gender (Male), and date of birth (05/01/1979). Below this, there are tabs for 'Scheduled/Unscheduled', 'PRN/Continuous', 'Plans of Care', and 'Patient Information'. The 'Current' section lists several assessments: 'Adult Basic Admission Assessment', 'Environmental Safety', and 'Safety Assessment', all with requested start and stop times. The 'Unscheduled (No Activities)' section shows '1200 (No Activities)'. The 'Interdisciplinary' section shows 'VTE on Admission (within 6hrs)'. At the bottom left, an 'Activity Timeline' shows a red bar for 'Overdue' and green bars for activities at 11:00, 12:00, and 13:00.

Now repeat the process for completing the remaining assessments.