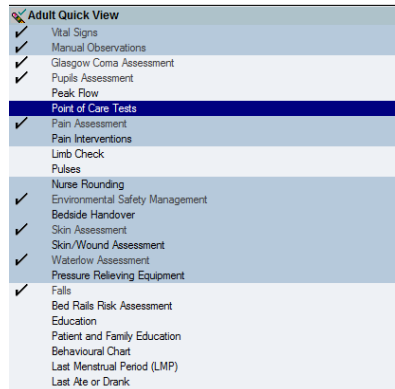


DIRECT ASSESSMENTS – POINT OF CARE, NURSE ROUNDING, SKIN AND WATERLOW ASSESSMENTS

1. Assessments can be directly accessed and completed by using the Assessment/Fluid Balance menu. This guide will take you through the Point Of Care, Nurse Rounding, Skin and Waterlow assessments. But note the other assessment choices below:



2. To complete these, select the CareCompass:

3. From your list of patients, select their blue name to open their patient record:

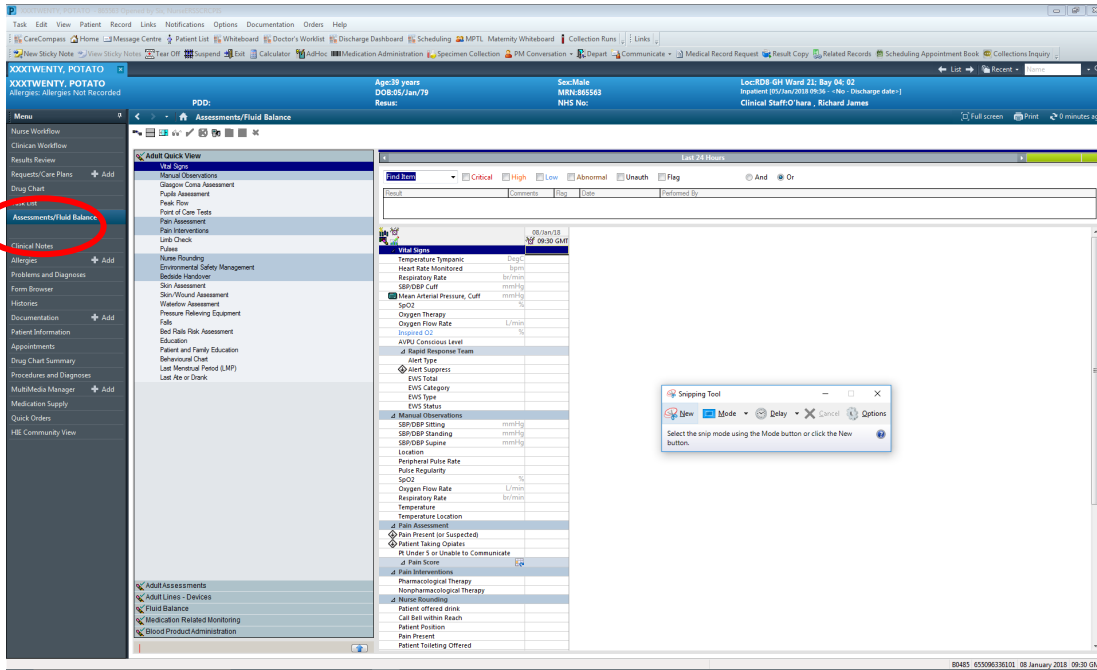
| Location | Patient | Age | Sex | Allergies | LOS | Care Team | NEWS | Activities |
|-------------|-----------------------|-------|--------|-----------------------|-------|-------------------------------|------|----------------|
| Bay 02 - 01 | ZZZTEST, PRISCILLA | 34yrs | Female | No Known Allergies | 4w 4d | Madhotra, Ravi | -- | 34 |
| Bay 02 - 03 | XXXTESTPATIENT, MINUS | 52yrs | Female | No Allergies Recorded | 18d | Hacker, Andrew Gavin | -- | 37 |
| Bay 02 - 04 | XXXTESTPATIENT, ZERO | 47yrs | Female | No Allergies Recorded | 18d | Flynn, Julian Robert | -- | 34 |
| Bay 02 - 05 | XXXTESTPATIENT, ONE | 28yrs | Female | No Allergies Recorded | 18d | Flynn, Julian Robert | -- | 33 |
| Bay 02 - 06 | XXXTESTPATIENT, TWO | 32yrs | Female | Allergies | 18d | Pearce, Oliver James Nicholas | -- | 60 |
| Bay 03 - 01 | ZZZFATEST, CONSLICE | 38yrs | Male | No Allergies Recorded | 4w 2d | Ramanathan, Venkiteswaran | -- | 34 |
| Bay 03 - 04 | XXXFINGER, FISH | 38yrs | Male | No Allergies Recorded | 21d | O'hara, Richard James | -- | 36 |
| Bay 03 - 05 | XXXGIN, PINK | 37yrs | Female | No Known Allergies | 28d | O'hara, Richard James | 8 | PRN/Continuous |
| Bay 03 - 06 | XXXTHIRTEEN, POTATO | 18yrs | Female | No Allergies Recorded | 4w 3d | Flynn, Julian Robert | -- | 5 |
| Bay 04 - 01 | XXXTHIRTEEN, POTATO | 73yrs | Female | No Allergies Recorded | 4w 4d | Flynn, Julian Robert | -- | 41 |
| Bay 04 - 02 | XXXTWENTY, POTATO | 29yrs | Male | No Allergies Recorded | 6m | O'hara, Richard James | -- | 4 |
| Bay 04 - 05 | XXXFIFTEEN, POTATO | 19yrs | Female | No Allergies Recorded | 24d | Flynn, Julian Robert | -- | 34 |
| Bay 04 - 06 | ZZZSTANDEN, DEMO4 | 40yrs | Male | No Known Allergies | 5w 1d | Chin, Kian H | -- | 29 |
| Side Room | XXXELEVEN, POTATO | 27yrs | Male | No Allergies Recorded | 5w | Flynn, Julian Robert | -- | 33 |
| Side Room | XXXONE, POTATO | 67yrs | Female | Allergies | 4w 1d | Flynn, Julian Robert | -- | 29 |

- 3.5 Alternatively you can also Right Click the patients name and select Assessment/Fluid Balance:

| | | | | | | | | |
|-------------|--------------------|-------|--------|-----------------------|-------|-----------------------|----|----|
| Bay 04 - 02 | XXXTWENTY, POTATO | 29yrs | Male | No Allergies Recorded | 3d | O'hara, Richard James | -- | 8 |
| Bay 04 - 05 | XXXFIFTEEN, POTATO | 19yrs | Female | No Allergies Recorded | 27d | Flynn, Julian Robert | -- | 34 |
| Bay 04 - 06 | ZZZSTANDEN, DEMO4 | 40yrs | Male | No Known Allergies | 5w 1d | Chin, Kian H | -- | 29 |

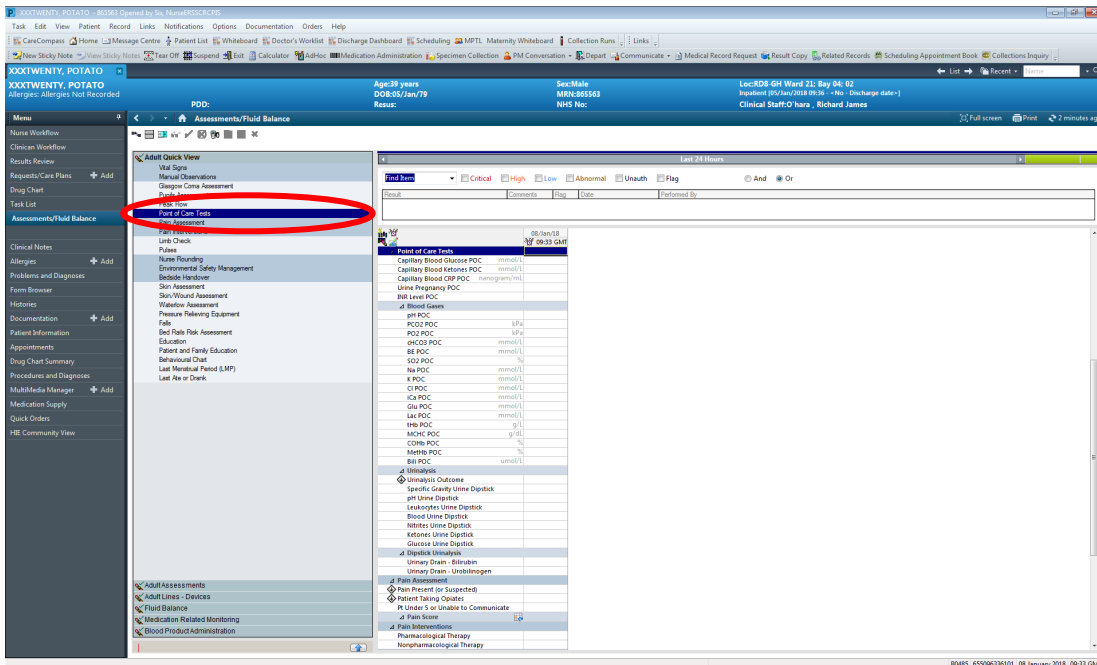
This will bring up a new menu and you will see the list of assessments mentioned in Step 1:

4.



POINT OF CARE TESTS

5. Select Point Of Care Tests, 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:




6. Complete your necessary fields, you should double click in the blue boxes, next to the headings to ensure that they have tick boxes:

The below is an example of completed information:

The screenshot shows the eCARE software interface for patient 'XXXI TWENTY, POTATO'. The patient is 39 years old, male, and has been admitted on 05/Jan/2018. The interface displays various assessment categories on the left, including 'Assessments/Fluid Balance'. The main area shows a table of test results with columns for 'Find Item', 'Comments', 'Flag', 'Date', and 'Performed By'. A red bracket highlights a section of the table containing various blood and urine test results, such as 'Capillary Blood Ketones POC', 'pH POC', 'PCO2 POC', 'PO2 POC', 'cHCO3 POC', 'BE POC', 'S2O POC', 'Na POC', 'K POC', 'Cl POC', 'Ca POC', 'Glu POC', 'Lac POC', 'TbHb POC', 'MCHC POC', 'CtHb POC', 'Methb POC', 'Bili POC', 'Urinalysis Outcome', 'Specific Gravity Urine Dipstick', 'pH Urine Dipstick', 'Leukocytes Urine Dipstick', 'Blood Urine Dipstick', 'Nitrites Urine Dipstick', 'Ketones Urine Dipstick', 'Glucose Urine Dipstick', 'Dipstick Urinalysis', 'Urinary Drain - Bilirubin', and 'Urinary Drain - Urobilinogen'. A red arrow points to the 'Flag' column, which contains a blue ribbon with a tick mark next to the 'Normal' result for 'Urinary Drain - Urobilinogen'.

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 put in for you.

7. 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.

Task Edit View Patient Record Links Notifications Options Documentation Orders Help

Age: 39 years DOB: 05/Jan/79 Resus: Sec: Male MRN: 865563 NHS No: Loc: RDB GH Ward 21: Bay 04: 02 Inpatient (05/Jan/2018 09:36 - No Discharge date-) Clinical Staff: O hera, Richard James

Assessments/Fluid Balance

Adult Quick View

| Find Item | Critical | High | Low | Abnormal | Unauth | Flag | And | Or |
|-------------------------------------|----------|------|-----|----------|--------|------|-----|----|
| Capillary Blood Ketones POC | | | | | | | | |
| Capillary Blood CRP POC | | | | | | | | |
| Urine Pregnancy POC | | | | | | | | |
| INR Level POC | | | | | | | | |
| pH POC | | | | | | | | |
| PCO2 POC | | | | | | | | |
| PO2 POC | | | | | | | | |
| oxygen Sat POC | | | | | | | | |
| BE POC | | | | | | | | |
| SO2 POC | | | | | | | | |
| Na POC | | | | | | | | |
| K POC | | | | | | | | |
| Cl POC | | | | | | | | |
| Ca POC | | | | | | | | |
| Glu POC | | | | | | | | |
| Lac POC | | | | | | | | |
| Urb POC | | | | | | | | |
| MCHC POC | | | | | | | | |
| COHb POC | | | | | | | | |
| Methb POC | | | | | | | | |
| Bil POC | | | | | | | | |
| Urinalysis Outcome | | | | | | | | |
| Specific Gravity Urine Dipstick | | | | | | | | |
| pH Urine Dipstick | | | | | | | | |
| Leukocytes Urine Dipstick | | | | | | | | |
| Blood Urine Dipstick | | | | | | | | |
| Nitrites Urine Dipstick | | | | | | | | |
| Ketones Urine Dipstick | | | | | | | | |
| Glucose Urine Dipstick | | | | | | | | |
| Dipstick Urinalysis | | | | | | | | |
| Urinary Drain - Bilirubin | | | | | | | | |
| Urinary Drain - Urobilinogen | | | | | | | | |
| Pain Assessment | | | | | | | | |
| Pain Present (or Suspected) | | | | | | | | |
| Patient Taking Opiates | | | | | | | | |
| PT Under 5 or Unable to Communicate | | | | | | | | |
| Pain Score | | | | | | | | |
| Pain Interventions | | | | | | | | |
| Pharmacological Therapy | | | | | | | | |
| Nonpharmacological Therapy | | | | | | | | |
| Nurse Rounding | | | | | | | | |
| Patient offered drink | | | | | | | | |

7.5 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:

Task Edit View Patient Record Links Notifications Options Documentation Orders Help

Age: 39 years DOB: 05/Jan/79 Resus: Sec: Male MRN: 865563 NHS No: Loc: RDB GH Ward 21: Bay 04: 02 Inpatient (05/Jan/2018 09:36 - No Discharge date-) Clinical Staff: O hera, Richard James

Assessments/Fluid Balance

Adult Quick View

You have unsigned results in the Adult Quick View interactive view. Do you wish to continue?

Yes No

8. 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:

Task Edit View Patient Record Links Notifications Options Documentation Orders Help

Age: 39 years DOB: 05/Jan/79 Sex: Male MRN: 65563 NHS No: Loc: RD8-GH Ward 21; Bay 04; 02

Menu

- Adult Quick View
 - vital Signs
 - Manual Observations
 - Glasgow Coma Assessment
 - Fluid Assessment
 - Peak Flow
 - Point of Care Tests
 - Pain Assessment
 - Pain Interventions
 - Limb Check
 - Tubes
 - Nurse Rounding
 - Environmental Safety Management
 - Bedside Handover
 - Skin Assessment
 - Skin Wound Assessment
 - Waterlow Assessment
 - Pressure Relieving Equipment
 - Falls
 - Bed Rails Risk Assessment
 - Education
 - Patient and Family Education
 - Behavioural Chart
 - Last Menstrual Period (LMP)
 - Last Ate or Drank
- ADULT Assessments
 - ADULT Lines - Devices
 - Fluid Balance
 - Medication Related Monitoring
 - Blood Product Administration

Assessments/Fluid Balance

Peak Flow

08/Jan/20

| Find Item | Critical | High | Low | Abnormal | Unauth | Flag | And | Or |
|-------------------------------------|----------|------|------|--------------|--------|------|-----|----|
| Result | Comments | Flag | Date | Performed by | | | | |
| Peak Flow | | | | | | | | |
| Peak Flow | | | | | | | | |
| Point of Care Tests | | | | | | | | |
| Capillary Blood Glucose POC | | | | | | | | |
| Capillary Blood Ketones POC | | | | | | | | |
| Capillary Blood CRP POC | | | | | | | | |
| Urine Pregnancy POC | | | | | | | | |
| INR Level POC | | | | | | | | |
| Blood Gases | | | | | | | | |
| pH POC | | | | | | | | |
| PCO2 POC | | | | | | | | |
| PO2 POC | | | | | | | | |
| CHCO3 POC | | | | | | | | |
| BE POC | | | | | | | | |
| SO2 POC | | | | | | | | |
| Ha POC | | | | | | | | |
| Hb POC | | | | | | | | |
| Cl POC | | | | | | | | |
| Ca POC | | | | | | | | |
| Glu POC | | | | | | | | |
| Lak POC | | | | | | | | |
| Urb POC | | | | | | | | |
| MCHC POC | | | | | | | | |
| CDHb POC | | | | | | | | |
| Mentio POC | | | | | | | | |
| Bil POC | | | | | | | | |
| Urtinalysis | | | | | | | | |
| Urinalysis Outcome | | | | | | | | |
| Specific Gravity Urine Dipstick | | | | | | | | |
| pH Urine Dipstick | | | | | | | | |
| Leukocytes Urine Dipstick | | | | | | | | |
| Blood Urine Dipstick | | | | | | | | |
| Nitrite Urine Dipstick | | | | | | | | |
| Ketones Urine Dipstick | | | | | | | | |
| Glucose Urine Dipstick | | | | | | | | |
| Dipstick Urinalysis | | | | | | | | |
| Urinary Drain - Bilirubin | | | | | | | | |
| Urinary Drain - Urobilinogen | | | | | | | | |
| Pain Assessment | | | | | | | | |
| Pain Present (or Suspected) | | | | | | | | |
| Patient Talking/Opines | | | | | | | | |
| Pt Under 5 or Unable to Communicate | | | | | | | | |
| Pain Score | | | | | | | | |
| Pain Interventions | | | | | | | | |

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,

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

Task Edit View Patient Record Links Notifications Navigation Help

Age: 39 years DOB: 05/Jan/79 Sex: Male MRN: 65563 NHS No: Loc: RD8-GH Ward 21; Bay 04; 02

Menu

- Nurse Workflow
 - Handover
 - Nursing Handover
 - Presenting Complaint
 - Problem List
 - Past Medical History
 - Handover Documentation (0)
 - Allergies (0)
 - Home Medications (0)
 - Medications ...
 - Vital Signs ...
 - Fluid Balance ...
 - Assessments ...
 - Labo ...
 - Imaging ...
 - Outstanding Orders ...
 - Order Profile ...
 - Create Note
 - Nurse Handover (Nursing Handover Note)
 - Select Other Note

Nurse Rounding

Nursing Handover

Presenting Complaint

Problem List

Past Medical History

NURSE ROUNDING

Repeat Steps 1-5 and choose Nurse Rounding:

10.

| Find Item | Critical | High | Low | Abnormal | Unauth | Flag | Performed By |
|--|----------|------|-----|----------|--------|------|--------------|
| 08/Jan/18 | | | | | | | |
| 10:24 GMT 10:06 GMT 09:37 GMT | | | | | | | |
| Nurse Rounding | | | | | | | |
| Patient offered drink | | | | | | | |
| Call Bell within Reach | | | | | | | |
| Patient Position | | | | | | | |
| Pain Present | | | | | | | |
| Patient Toileting Offered | | | | | | | |
| Assistive Device(s) with Patient | | | | | | | |
| Environmental Safety Management | | | | | | | |
| Environmental Safety Implemented | | | | | | | |
| Action | | | | | | | |
| Primary Criterion | | | | | | | |
| Name Band Location | | | | | | | |
| Patient Specific Safety Measures | | | | | | | |
| Bed Rail Location | | | | | | | |
| Type of Alarm | | | | | | | |
| Patient Identified | | | | | | | |
| Manage Sensory Impairment | | | | | | | |
| Demos Ability-Uses Call Light w/ Success | | | | | | | |
| Room Checked | | | | | | | |
| Contraband | | | | | | | |
| Special Call Device | | | | | | | |
| Bedside Handover | | | | | | | |
| Transfer | | | | | | | |
| Accompanied By Staff | | | | | | | |
| Report Given at Bedside | | | | | | | |
| Reason Bedside Report Not Given | | | | | | | |
| Nurse Receiving Report | | | | | | | |
| Nurse Giving Report | | | | | | | |
| Patient ID Band on and Verified | | | | | | | |
| Parent/Guardian ID Band Verified | | | | | | | |
| MDT Plan Reviewed | | | | | | | |
| Lines Identified | | | | | | | |
| Assistive Device(s) with Patient | | | | | | | |
| Handover Comments | | | | | | | |
| Shift Summary | | | | | | | |

11. Complete required information and follow Steps 5-9: (Information given is example only)

| Find Item | Critical | High | Low | Abnormal | Unauth | Flag | Performed By |
|--|----------|------|-----|----------|--------|------|--------------|
| 08/Jan/18 | | | | | | | |
| 10:25 GMT 10:06 GMT 09:37 GMT | | | | | | | |
| Nurse Rounding | | | | | | | |
| Patient offered drink | | | | | | | |
| Call Bell within Reach | | | | | | | |
| Patient Position | | | | | | | |
| Pain Present | | | | | | | |
| Patient Toileting Offered | | | | | | | |
| Assistive Device(s) with Patient | | | | | | | |
| Environmental Safety Management | | | | | | | |
| Environmental Safety Implemented | | | | | | | |
| Action | | | | | | | |
| Primary Criterion | | | | | | | |
| Name Band Location | | | | | | | |
| Patient Specific Safety Measures | | | | | | | |
| Bed Rail Location | | | | | | | |
| Type of Alarm | | | | | | | |
| Patient Identified | | | | | | | |
| Manage Sensory Impairment | | | | | | | |
| Demos Ability-Uses Call Light w/ Success | | | | | | | |
| Room Checked | | | | | | | |
| Contraband | | | | | | | |
| Special Call Device | | | | | | | |
| Bedside Handover | | | | | | | |
| Transfer | | | | | | | |
| Accompanied By Staff | | | | | | | |
| Report Given at Bedside | | | | | | | |
| Reason Bedside Report Not Given | | | | | | | |
| Nurse Receiving Report | | | | | | | |
| Nurse Giving Report | | | | | | | |
| Patient ID Band on and Verified | | | | | | | |
| Parent/Guardian ID Band Verified | | | | | | | |
| MDT Plan Reviewed | | | | | | | |
| Lines Identified | | | | | | | |

The screenshot shows the eCARE interface for patient XXXTWEENTY_POTATO. The left-hand menu is expanded to 'Assessments/Fluid Balance'. A red circle highlights the 'Skin Assessment' option, and a red bracket indicates its position relative to other assessment tasks. The main window displays a table of assessment results for 'Last 24 Hours'.

| Find Item | Critical | High | Low | Abnormal | Unauth | Flag | By | Date |
|--|----------|------|-----|----------|--------|------|----|-------------------|
| Urinary Drain - Urubinogen | | | | | | | | 08/Jan/18 |
| 4 Pain Assessment | | | | | | | | 10:27 GMT |
| 4 Pain Present (or Suspected) | | | | | | | | 10:25 GMT |
| 4 Patient Talking Operator | | | | | | | | 10:06 GMT |
| 4 Pain Score | | | | | | | | 09:37 GMT |
| 4 Pain Interventions | | | | | | | | |
| Pharmacological Therapy | | | | | | | | |
| Nonpharmacological Therapy | | | | | | | | |
| 4 Nurse Rounding | | | | | | | | |
| Patient offered drink | | | | | | | | Yes |
| Call Bell within Reach | | | | | | | | Yes |
| Patient Position | | | | | | | | Head of bed... |
| Pain Present | | | | | | | | No actual or... |
| Patient Talking Operator | | | | | | | | Yes |
| Assistive Devices with Patient | | | | | | | | Yes |
| 4 Environmental Safety Management | | | | | | | | |
| Environmental Safety Implemented | | | | | | | | Advocate th... |
| Action | | | | | | | | Initiate |
| Priority Callout | | | | | | | | Fall risk |
| Nurse Band Location | | | | | | | | PI/E |
| Patient Specific Safety Measures | | | | | | | | |
| Bed Rail Location | | | | | | | | Right |
| Type of Alarm | | | | | | | | Bed alarm |
| Patient Identified | | | | | | | | Identification... |
| Manage Sensory Impairment | | | | | | | | |
| Dress Ability/Uses Call Light or Susters | | | | | | | | Yes |
| Room Checked | | | | | | | | Yes |
| Chamberland | | | | | | | | No |
| Special Call Device | | | | | | | | Special dete... |
| 4 Bedside Handover | | | | | | | | |
| Transfer | | | | | | | | |
| Accompanied By Staff | | | | | | | | |
| Report Given or Inside | | | | | | | | |
| Reason Escalate Report Not Given | | | | | | | | |
| Nurse Rounding Report | | | | | | | | |
| Nurse Going Report | | | | | | | | |
| Patient to Band on and Verified | | | | | | | | |
| Parent/Guardian ID Band Verified | | | | | | | | |
| MOT Plan Reviewed | | | | | | | | |
| Lines Identified | | | | | | | | |
| Assistive Devices with Patient | | | | | | | | Yes |
| Handover Comments | | | | | | | | |
| Shift Summary | | | | | | | | |

SKIN ASSESSMENT

12. Repeat Steps 1-4 and choose Skin Assessment, remember to double click the blue band to ensure that a tick in a box appears:

The screenshot shows the eCARE interface for patient XXXTWEENTY_POTATO. The left-hand menu is expanded to 'Assessments/Fluid Balance'. A red circle highlights the 'Skin Assessment' option. The main window displays a table of assessment results for 'Last 24 Hours'.

| Find Item | Critical | High | Low | Abnormal | Unauth | Flag | By | Date |
|--|----------|------|-----|----------|--------|------|----|-----------|
| 4 Skin Assessment | | | | | | | | 10:29 GMT |
| Skin Condition | | | | | | | | 10:25 GMT |
| Pressure Areas Checked | | | | | | | | 10:06 GMT |
| Discoloured Detail | | | | | | | | 09:37 GMT |
| Broken Type | | | | | | | | |
| Skin Colour | | | | | | | | |
| Skin Temperature | | | | | | | | |
| Skin Moisture | | | | | | | | |
| Pain/Sensation Changes to Pressure Areas | | | | | | | | |

13. Complete required information and follow Steps 5-9: (Information given is example only)

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,

WATERLOW ASSESSMENT

14. Repeat Steps 1-4 and choose Waterlow Assessment:

The screenshot shows the eCARE interface for patient 'DIXTWENTY, POTATO'. The left-hand menu has 'Assessments/Fluid Balance' circled in red. The main content area shows a list of assessment types, with 'Waterlow Assessment' also circled in red. The right-hand pane shows a table for the 'Waterlow Assessment' with columns for time slots: 10:34 GMT, 10:30 GMT, 10:25 GMT, 10:06 GMT, and 09:37 GMT. The table contains various assessment items like 'Build/Weight for Height', 'Skin Type', 'Broken Type', etc., with some values filled in.

15. Complete required information and follow Steps 5-9: (Information given is example only)

This screenshot shows the 'Waterlow Assessment' form completed with example data. The 'Assessments/Fluid Balance' menu item is now highlighted in blue. The assessment table is populated with the following data:

| Item | 10:36 GMT | 10:35 GMT | 10:30 GMT | 10:25 GMT | 10:06 GMT | 09:37 GMT |
|---------------------------------|------------------|------------------|-----------|-----------|-----------|-----------|
| Build/Weight for Height | Obese BMI | Above avera... | | | | |
| Skin Type | Broken | Dissectatous | | | | |
| Broken Type | Wound | | | | | |
| Gender | Male | Male | | | | |
| Age | 34-49 | 34-49 | | | | |
| Continence | Complete/ca... | Complete/ca... | | | | |
| Mobility | Restless/rid... | Fully mobile | | | | |
| Tissue Malnutrition | N/A | None | | | | |
| Neurological Deficit | None | None | | | | |
| Major Surgery / Trauma | On table for ... | On table for ... | | | | |
| Medication | N/A | N/A | | | | |
| Recent Weight Loss | Yes | Yes | | | | |
| Weight Loss | Yes | Yes | | | | |
| Waterlow Score | 31 | | | | | |
| Pressure Relieving Equipment | | | | | | |
| Pressure Relieving Equipment... | | | | | | |

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,

16. 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