Service Priorities and Programmes

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Nursing Assessment Record on Admission

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Introduction

The previous nursing assessment on admission was a fragmented information collection system. Nurses have difficulty to get a clear or full picture of patient's information from various assessment forms or charts.

Objectives

Implementation of the updated Nursing Assesssment Record on Admission to improve the documenttation of clinical data and baseline information at the first contact with patient.

Methodology

Through a series of training, on-site briefing and consultation, the updated Nursing Assessment Record on Admission was implemented in August 2012 in all clinical areas. The assessment form incorporates a number of risk screening tools on fall, pressure sore, malnutrition and suicidal ideas; current medication and initial discharge planning etc. The form prompts nurses to initiate guideline / protocol driven nursing intervention and referrals to allied health or specialist services for identified "at risk" patients.

Result

The updated assessment record has good applicability in all clinical areas. The success of the assessment record is evidenced by the results of staff compliance audit and overall nurses' satisfaction of the assessment form. The result of the staff compliance audit conducted in Sep 2012 and Jan 2013 (compliance rate: 63.33% and 93.33% respectively) were encouraging. Nurses expressed positive feedback from the 2 staff feedback surveys conducted in Aug and Nov 2012 in order to improve the Nursing Assessment Record on Admission continuously.