Community Nursing

BULLETIN No. 35 (Clinical)

February 2022

FOR DISTRIBUTION TO ALL DVA COMMUNITY NURSING STAFF

DVA is committed to supporting providers to deliver veteran centric care. The use of comprehensive and validated assessment tools is one way to promote care that is person centred, facilitates the delivery of evidence based care, ensures nothing is forgotten, and supports an environment of quality and safety.

This clinical bulletin is being issued to provide an update to Department of Veterans' Affairs (DVA) Community Nursing (CN) providers in relation to the nursing assessment process.

Nursing Assessments

This bulletin outlines DVA's requirements for formal nursing assessments in line with the *DVA Notes for Community Nursing Providers, December 2021* and includes;

- Types of assessments expected in delivering care to DVA clients
- Comprehensive assessments
- Validated assessment tools
- Assessment review frequency.

Nursing assessments form part of the nursing process and are completed by nurses in a formal or informal manner at every home visit. Comprehensive assessments influence the creation and ongoing review of the nursing care plan by identifying health related issues requiring nursing intervention. Comprehensive assessments should be holistic and person centred. The use of validated assessment tools in areas of clinical concern further assists the registered nurse (RN) to complete the comprehensive assessment. Validated assessment tools can be used at any other time during care delivery when clinically indicated to facilitate care plan adjustment. All nursing assessments should be conducted and reviewed as per the *DVA Notes for Community Nursing Providers, December 2021*, section 6, Assessment. This can be read in conjunction with Section 8, Review of Care.

The *Nursing and Midwifery Board of Australia registered nurse standards for practice* states that an RN will "accurately conduct comprehensive and systematic assessments. They analyse information and data and communicate outcomes as the basis for practice. The RN conducts assessments that are holistic as well as culturally appropriate; uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice; works in partnership to determine factors that affect, or potentially affect, the health and wellbeing of people and populations to determine priorities for action and/ or for referral, and assesses the resources available to inform planning."

What is a comprehensive assessment undertaken by an RN?

This assessment is the first step in the nursing process that guides the development of a nursing care plan to meet the client's individual needs and to deliver the most appropriate care. For DVA clients this comprehensive assessment MUST be undertaken by an RN. The collection of both subjective and objective data is an integral part of this process and of the assessment.

Completing a comprehensive assessment supports clinicians to better identify conditions and risks and be able to respond to the person's needs and goals. It can provide an understanding of the client's goals (short and long term) and the issues that may impact them. It enables the clinician to be person-centred and provides a baseline assessment enabling future monitoring of the client's health.

What can be included in the comprehensive assessment?

A comprehensive assessment may include, but is not limited to:

- medical and surgical history
- present health status
- medication list including allergies
- vital signs
- head to toe assessment
- physical functioning
- cognitive/psychological assessment
- alcohol and other drugs history
- mobility and falls risk
- nutrition and hydration
- weight gain or loss
- continence and bowel habits
- skin integrity, wounds, and pressure injury risk
- sleep patterns
- social interactions/living arrangements
- spiritual health
- lifestyle
- family contact/support
- finances
- advanced health directives/enduring power of attorney
- other home care provider arrangements.

How often do I need to undertake a comprehensive assessment?

For DVA clients, a comprehensive assessment needs to be conducted:

- Initially upon receiving a referral from an authorised referral source (GP/Specialist/Hospital Discharge Planner/Nurse Practitioner specialising in CN);
- If the client has been transferred to your service from another CN provider;
- On the 12-month anniversary from the commencement of care; and
- At times of significant acute care changes (e.g. hospitalisation, palliative care, significant medical event).

What type of assessment tools can be used when undertaking an assessment?

Validated tools should be used that have:

- been psychometrically tested for reliability - the ability of the tool to produce consistent results;
- validity - the ability of the tool to produce true results; and

- sensitivity -the probability of correctly identifying a patient with the condition.

A non-validated tool is one that has not undergone testing and may be a "home-grown" tool that has been developed by an organisation to meet a particular need. Validated tools may be used in conjunction with your comprehensive or focused assessments. Examples of validated tools include, but are not limited to:

- Standardised Mini-Mental State Examination (SMMSE)
- Mini-Mental State Examination (MMSE)
- Rowland Universal Dementia Assessment Scale (RUDAS)
- Falls Risk Assessment Tool (FRAT)
- Geriatric Depression Scale
- Barthel Index of ADL
- Mini Nutritional Assessment (MNA)
- Abbey Pain Scale
- Braden PI Risk, and
- Carer Strain Index (CSI).

Can an assessment be conducted outside of the comprehensive assessment process?

Yes, an assessment can be done at any time in response to a specific client health problem that you have identified as requiring further assessment. An example of this may be a fall or increased risk of falls which triggers a FRAT, or acute changes in cognition that trigger assessments such as a delirium screen / MMSE / infection screen. Such assessments should be undertaken as required, at any time during the client's episode of care.

Is the clinical RN/EN review different from the comprehensive assessment?

Yes, the objective of the clinical review is to assess and monitor the ongoing care needs and outcomes of care provision that were primarily based on the initial comprehensive assessment. This review may trigger a review of the original assessment and subsequent updating of the nursing care plan. This process should include a review of the client's capacity and level of independence. It is expected that, where possible, these reviews occur in the same visit as care provision.

Timeframes for clinical reviews for DVA clients

- A seven day review by an RN (or EN with an approved qualification in medication administration) is required when the client is classified in the Personal Care Schedule and requires assistance with self-administered medication of Schedule 8 drugs administered from a Dose Administration Aid (DAA).
- A seven day review by an RN is required for all clients with an Exceptional Case approval, to review their clinical and personal care needs.
- A 28 day review occurs at the end of each 28-day claim period. If classified under the Clinical Care schedule (Core or Add-on) this review must be undertaken by an RN. If classified under the Personal Care schedule the review can be undertaken by and RN or EN.
- A three month review must be undertaken by an RN to identify any changed care needs, and nursing care plans are updated at this time to reflect changes.
- Ad hoc reviews are undertaken when there is a change in care and should include a review and update of relevant clinical documentation including the assessment and nursing care plan.

References:

DVA Notes for Community Nursing Providers, December 2021

Nursing and Midwifery Board Australia Registered Nurses Standards, Standard 4