



Assessment

Assessment is made up of 5 trolley bays, and is the first stop for bed-bound or more unwell ambulatory patients. Ambulances arrive and are seen by the ambulance nurse, and patients are most often streamed to assessment.

Assessment is generally staffed by 2 x RNs and 1 x CSW. You will be working closely with the Ambulance nurse/s to safely assess in order of acuity/clinical concern.

▼ Initial Assessment

Each patient that comes into assessment should have a 'basic' nursing assessment completed

This includes:

- Vital signs (need to be repeated on arrival to assessment)
- ECG (if indicated)
- Bloods & cannula (if indicated, not all patients need bloods and/or cannulation)
- Change into hospital gown and skin check
- SBAR Documentation

Escalate all patients that require urgent ED assessment or specific imaging (e.g. limb, hip)

▼ After Assessment

Patients move from assessment to majors or direct to the ward if appropriate/there is a bed available

Ensure that your patient has been handed over to the area they're going to and all belongings move with them

Ensure all patients who are in assessment/corridor for more than 4 hours have rounding documented on iView

▼ **Corridor Care**

The ambulance nurse/s will be looking after the patients in the corridor when required but it is important to have awareness of patients in the corridor that require assessment and ensuring the ambulance nurse is aware of who can and cannot reverse queue