Mary Potter Hospice Nursing Acuity Tool – In Patient Unit

Core Care Issues	1	2	3	4	SCORE
Cognition	Alert/ Rational / Responsive / Orientated	Unconcious Slightly confused / mild dementia	Changing mental status. Increased assessment required Confused / agitated / restless / delirious	Severe confusion / agitated / restless / delirious / acute psychosis	
Symptom Management	Asymptomatic	Symptomatic / non complex Intermittent interventions Asymptomatic with Syringe Driver	Complex symptoms Complex medication regime Initial Syringe Driver set-up. SD review & changes Liaison with other specialist service.	Highly complex symptoms Increased interventions / Blood transfusion / SC fluids / IV fluids	
Hydration / Nutrition	Independent No oral intake	Independent once set up	Meal supervision NG/PEG / JEJ feeds – set up	Full assistance NG/PEG / JEJ – full assistance Dysphagia	
Elimination	Continent / independent	Requires regular toileting Urodome / IDC Stoma with assistance Simple bowel management	1 staff transfer Incontinent of urine or bowels Stoma full support / education Complex bowel management IDC insertion	2 staff + transfer Doubly incontinent Complex stoma needs Fistula management – Highly complex bowel management Complex IDC insertion/management	
Personal Cares / Mouth Cares	Independent	HCA supervision / set up	1 staff assist with personal cares	2 staff + assist	
Skin Integrity	Healthy / Intact Waterlow – low risk	Fragile skin Waterlow assessment – at risk	Non complex interventions/ wound care Positioning assistance with 1 staff Waterlow assessment – high risk.	Complex interventions/wound care Regular pressure area care/turns with 2+ staff assist Waterlow assessment – very high risk	
Mobility / Falls Risk / Restraint	Independently mobile Low falls risk No restraint	Supervised mobility No assistance needed with transfers Medium falls risk Restraint as enabler	Supervised mobility / 1staff transfer High falls risk Restraint / patient monitoring	Total cares Hoist transfer 2 + staff transfer High falls risk / restraint	
Psychosocial	Support network meets identified needs	Low level of nursing support required by patient, family and carers regarding illness, treatment and / or future care.	Increased level of nursing input for patient / family emotional support Goal setting Communication issues	Grief / anxiety / loss / death requiring high levels of nursing support to family / patient. Complex family dynamics.	
Spiritual / Cultural	No current issues	Low level of nursing support required for spiritual/cultural needs	Increased level of nursing input for patient / family support. Increased anxiety Seeking purpose and meaning.	Anguish / distress / unresolved issues. Continuous family / patient support Existential support Disconnected from faith /	

				spiritual community / culture	
Planning for Future Care	No current issues Deceased patient awaiting uplifting	Nursing assessment of current home based supports. Basic patient / family / carer education. Ongoing LCP support	Routine discharge. Patient / family education eg s/c meds / LCP/ food / skin Nurse liaison with ARC / PCCs / MDT 24 hour nursing care record ACP/EOLC discussions Family meeting (nursing attendance)	Admission – planned/acute Complex discharge planning / liaison / support.	
Score each care issue in score column to give total Acuity score from 1 to 40 **TOTAL SCORE=**					
0-10 = Acuity 1, **11-20= Acuity 2,** **21-30= Acuity 3,** **31-40= Acuity 4** **ACUITY=**					

IPU NURSING ACUITY TOOL GUIDELINES

AIM:

This tool provides a numerical guideline calculated according to risk factors to:

- Assess individual patient acuity levels.
- Ensure adequate nurse staffing of the IPU, according to the current total patient acuity level.
- Ensure continued ability to provide a high standard of nursing care.
- Ensure staff, patient and family safety.

PROCESS:

- To be done x1 per duty by the nursing staff:

  - AM by 11am
  - PM by 6pm
  - Nocte by 6am

- Assess the patient for each of the 10 categories related to the core care plan issues on the tool and write the score 1-4 on the tool accordingly.
  NB: - "symptom management" incorporates pain/respiratory/nausea & vomiting
  - Restraint is to be considered alongside Mobility and Falls Risk.
- Scores reflect the nursing needs and issues of each patient for that particular duty.
- It is the nurses' responsibility to advise the Clinical Co-ordinator or Duty Lead of any anticipated change in the patient acuity for the next duty.
- Add up the total score, 1-40, and record in column.
- Allocate acuity level 1 – 4, according to total score, record in column.
- Advise Clinical Co-ordinator or Duty Lead of acuity score, which is then recorded in the daily allocation book, and on the whiteboard against the patient name.

MAXIMUM NURSE LOADING:

- Patients are allocated to nurses according to the maximum nurse loading outlined below.
- Oversight is by Clinical Co-ordinator Monday – Friday.
- After-hours assessed by Duty Lead for each duty.
- Daily acuity totals are recorded by Clinical Co-ordinator in IPU acuity levels database for monthly report to management.
- If total acuity level is high, indicating the need for extra staff, Clinical Co-ordinator / Duty Lead are to consider if the need is for an extra RN or an extra HCA:
  - HCA if high acuity due to increased 2 person transfers and/or personal cares
  - RN if high acuity due to increased clinical care or complexities requiring nursing skills
- Clinical Co-ordinator on AM duty, in liaison with IPU Nurse Manager Monday- Friday, to consider extra weighting requirements that are apparent for preceptoring of students or new staff.

Maximum loading per nurse

AM duty	10
PM duty	15 / Duty Lead 12
Nocte	20