** UNIT BASED NURSING SCORECARD**

**MEDICINE/SURGICAL FLOOR - ? QUARTER 2016**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MEASURE** | **MEASURE DEFINITION** | **ACTUAL** | **TARGET** | **INDEX** | **INDEX INDICATOR** | **ACTUAL YTD** | **TARGET YTD** | **INDEX YTD** | **INDEX INDICATOR YTD** | **COMMENTS**  |
| **Nursing Assessment** | **Nursing assessment complete within time frame indicated in P&P** | **100%** | **100%** | **100%** | **GOOD** | **98%** | **100%** | **98%** | **GOOD** |  |
| **Fall Risk**  | **Potential for falls assessed upon admission. High risk identification applied. Care plan for high risk for falls documented. Interventions initiated and documented. Patient re-assessed according to Fall Risk Plan. Fall risk included in handoff.** | **75%** | **100%** | **75%** | **CAUTION** | **82%** | **100%** | **78.5%** | **CAUTION** |  |
| **Skin Integrity** | **Nursing assessment includes a complete skin assessment upon admission. Findings of any skin impairment are documented and communicated to physician. Wounds are measured per hospital p&p. Wounds or wound dressings are reassessed every shift according to hospital p&p. Wound status included in handoff. Care plan for actual or potential skin impairment is implemented.** | **89%** | **100%** | **89%** | **POOR** | **85%** | **100%** | **87%** | **POOR** |  |
| **Informed Consent** | **Informed Consent for surgical or invasive procedure is present in record with date/time and signature of physician, patient and witness. Completed document is present prior to patient receiving anesthesia.** |  |  |  |  |  |  |  |  |  |
| **Critical Values** | **Critical results from lab, radiology or other diagnostic testing are documented and reported to attending physician within designated time frame according to hospital P&P. Evidence of physician follow up is documented.** |  |  |  |  |  |  |  |  |  |
| **Verbal Orders** | **Verbal orders (excluding telephone orders) are used only for emergencies. Nurse reads back ALL verbal orders. There are no “blanket orders” such as “continue home meds”.** |  |  |  |  |  |  |  |  |  |
| **Cultural or Lanquage barriers identified** | **Initial assessment for cultural or lanquage barriers are identified. Care plan includes interventions for reducing risk associated with barrier(s).** |  |  |  |  |  |  |  |  |  |

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