Health and Social Care

Person-centred Nursing Assessment and Plan of Care - Adult Inpatient Care Setting

I would like to be called: ______________________

First language: ______________________

Interpreter required: ☐ Yes ☐ No

Uses sign language:
☐ British ☐ Irish sign ☐ Makaton ☐ None

Hospital Passport: ☐ Yes ☐ No Age: ☐

Contact number: ______________________

Use addressograph (otherwise write in capitals)

Surname: ______________________

First names: ______________________

Address: ______________________

____

H and C Number: ____________ DOB: ________

Check identity

Resuscitation Status

Do **N**ot **A**ttempt **C**ardiopulmonary **R**esuscitation (**DNACPR** order in place)
☐ Yes ☐ No ☐ Not known

Is the assessed Person able to participate in the assessment:
☐ Fully ☐ Partially ☐ No If Partially/No, details of information source:

____

____

Next Of Kin

Name: ______________________

Relationship: ______________________

Address (if different): ______________________

Contact No: ______________________

To be first contact: ☐ Yes ☐ No

First Contact (if different from Next Of Kin)

Name: ______________________

Relationship: ______________________

Contact No: ______________________

Second contact (if required): ______________________

Name: ______________________

Relationship: ______________________

Contact Number: ______________________

Name and practice of GP:

Admission

Hospital: ____________ Ward: ____________ Date: ________ Time (24 Hour): ________

☐ Emergency ☐ Elective ☐ Transfer Details: ______________________

Accompanied by: ____________ Relationship to Person: ____________ ☐ Not accompanied

Allergies / Sensitivities on admission

Date of reaction	Medicine/Food/Allergen	Type of reaction (e.g. rash)	Signature/Designation/Date

☐ No known allergies Signature / Designation: ____________ Time: ________ Date: ________

Alerts

Risk of choking: ☐ Yes ☐ No Details: ______________________

Tracheostomy: ☐ Yes ☐ No Laryngectomy: ☐ Yes ☐ No Neck Breather: ☐ Yes ☐ No Other: ________

Dialysis Fistula: ☐ Yes ☐ No If Yes: ☐ Right arm ☐ Left arm

Pacemaker: ☐ Yes ☐ No Implantable Cardioverter Defibrillator (ICD): ☐ Yes ☐ No

Is the Person taking time critical medication: ☐ Yes, Complete pg.13 ☐ No

Person Centred Holistic Nursing Assessment

Infection Prevention and Control (IPC) Risk Assessment

IPC Completed in Emergency Department: ☐ Yes use to inform below ☐ No complete below

Infective Diarrhoea - The Person:			
Is currently having diarrhoea that may be infective	☐ Yes	☐ No	☐ Unknown
Has been in a ward or nursing/residential home where others have a history of diarrhoea and/or vomiting in the last 5 days	☐ Yes	☐ No	☐ Unknown
Has family members who have had diarrhoea and/or vomiting in last 5 days	☐ Yes	☐ No	☐ Unknown
Has suspected/confirmed viral gastroenteritis/norovirus *circle as appropriate	☐ Yes	☐ No	☐ Unknown
Has a history of Clostridium Difficile	☐ Yes	☐ No	☐ Unknown

Respiratory assessment - The Person:			
Has respiratory symptoms indicative of tuberculosis	☐ Yes	☐ No	☐ Unknown
Has confirmed tuberculosis (pulmonary)	☐ Yes	☐ No	☐ Unknown
Has symptoms of Influenza	☐ Yes	☐ No	☐ Unknown

Multidrug Resistant Organisms (MDROs) - The Person has a history of:

CPE/CPO (Carbapenemase Producing Enterobacteriaceae/Organism)	MRSA (Meticillin Resistant Staphylococcus Aureus)	VRE/GRE (Vancomycin/Glycopeptide Resistant Enterococci)
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
	ESBL (Extended-Spectrum Beta-Lactamase producers)	
	☐ Yes ☐ No ☐ Unknown	

Has been in close contact/living in the same house with a Person with CPE/CPO:	☐ Yes	☐ No	☐ Unknown
Has been admitted to a hospital outside NI (or has been transferred) in last 12 months:	☐ Yes	☐ No	☐ Unknown
Has the Person ever been admitted to an Intensive Care Unit:	☐ Yes	☐ No	☐ Unknown
Is the Person immunocompromised:	☐ Yes	☐ No	☐ Unknown

Person placement

☐ Single Room ☐ Cohort Bay ☐ Standard Bay	Reason:

Person Centred Holistic Nursing Assessment

Reason for admission

Medical history

The Person's story

What matters to you to enable your discharge

Date of Last Menstrual Period (LMP):_____________ ☐ N/A	Pregnancy test: ☐ Yes ☐ No ☐ N/A Result: ____________________

Communication

Person – All About Me	Assessment
Have you any difficulties with: ☐ Speech ☐ Hearing ☐ Vision ☐ None **Hearing aid(s):** ☐ Right ☐ Left ☐ None ☐ Present on arrival Have you an eye condition: ☐ Yes ☐ No **Registered Blind:** ☐ Yes ☐ No **Wears:** ☐ Contact lens ☐ Glasses ☐ None If wears glasses, worn for: ☐ Reading ☐ Distance ☐ Everything ☐ Present on arrival	☐ Alert ☐ Drowsy ☐ Unresponsive ☐ Unconscious Diagnosed cognitive impairment ☐ Yes ☐ No

Cognitive Assessment: Abbreviated Mental Test (AMT4)

	Yes	No
Age	0	1
Date of birth	0	1
Place	0	1
Current year	0	1
0 = normal cognition, 1 or more = possible abnormal cognition — **Score**		

Airway/Breathing/Circulation

Person – All About Me	Assessment
Have you any difficulties with: ☐ Airway ☐ Breathing ☐ Circulation ☐ No difficulties **Home:** ☐ Inhalers ☐ Nebuliser ☐ Oxygen ☐ CPAP[1] ☐ NIV[2]	

Health and Wellbeing

Smoking

Do you smoke: ☐ Yes ☐ No

If yes, number per day: ________________

How long have you been smoking: ________________

Do you take recreational drugs: ☐ Yes ☐ No

Do you wish to be referred to the smoking cessation service:

☐ Yes ☐ No ☐ N/A

Do you wish to have Nicotine Replacement Therapy:

☐ Yes ☐ No ☐ N/A

[1] **C**ontinuous **P**ositive **A**irway **P**ressure [2] **N**on **I**nvasive **V**entilation

Moving and Handling Assessment

Is the Person's weight within safe working load (SWL) of equipment e.g. bed, chair, hoist, wheelchair	☐ Yes	☐ No	☐ Unknown
Is the equipment wide enough for the Person's safety and comfort e.g. bed, chair, hoist, wheelchair	☐ Yes	☐ No	☐ Unknown
Does the Person use a mobility aid e.g. walking frame, wheelchair	☐ Yes	☐ No	☐ Unknown
The mobility aid is available: ☐ Yes ☐ No ☐ N/A If Yes, Person's own:	☐ Yes	☐ No	
Is the person experiencing handling constraints e.g. pain, external attachments, fractures, behaviour, environment, posture	☐ Yes	☐ No	☐ Unknown

Falls Assessment

Presented with falls: ☐ Yes ☐ No		Have you a fear of falling: ☐ Yes ☐ No
Have you a history of falls in the last 12 months: ☐ Yes ☐ No		Do you have problems with walking/balance: ☐ Yes ☐ No
If Yes to any of the above and/or aged 65 and over, and/or has a condition that increases risk of falling , complete remainder of falls assessment:		
Have you postural hypotension : ☐ Yes ☐ No		
Lying BP:	Standing BP:	☐ Unable to check, Reason:
Pulse check - arrhythmias present: ☐ Yes ☐ No		☐ Unable to check, Reason:
Approximately when was your last eye test:		☐ Unable to check, Reason:
FallSafe Bundle implemented: ☐ Yes ☐ No		

Mobility

Person – All About Me	**A**ssessment
Mobilises: ☐ Independently ☐ Help required ☐ Full assistance Chair bound: ☐ Yes ☐ No Bed bound: ☐ Yes ☐ No Equipment used at home: ☐ Yes ☐ No If Yes, Details:	

Bedrails Assessment

Mobility

Mental State	Person is very immobile (bedfast/hoist dependent)	Person unable to mobilise independently	Person can mobilise without help from staff
Person is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
Person is drowsy	Recommend Bedrails	Use bedrails with care	Bedrails NOT recommended
Person is orientated and alert	Recommend Bedrails	Recommend Bedrails	Bedrails NOT recommended
Person is unconscious	Recommend Bedrails	N/A	N/A

Formatted from the National Patient Safety Agency's Safer practice notice 'Using bedrails safely and effectively' (NPSA/2007/17)

Bedrails Assessment Outcome

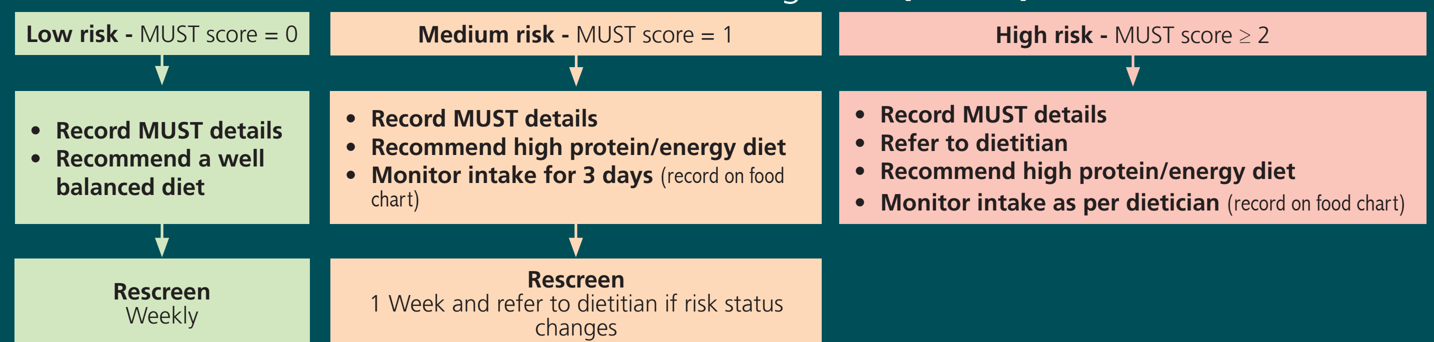
Use risk assessment in conjunction with clinical judgement and discussion with the Person / family	Decision making details
☐ Bedrails NOT recommended	
☐ Use bedrails with care	
☐ Recommend bedrails	

Maintaining a safe environment

Person – All About Me	**A**ssessment
	Ability to use call bell assessed: ☐ Yes ☐ No, Reason: ________________________________ Person's footwear assessed: ☐ Yes Details:________________________________

Malnutrition Universal Screening Tool (MUST)
To identify those adults who are at risk of malnourishment or who are malnourished

	BMI	Date/Time	Height: ________ ☐ Actual ☐ Recalled ☐ Unable to measure/recall Reason: ____________	Weight: ______ ☐ Actual ☐ Recalled ☐ Unable to weigh/recall Reason: ____________
Step 1: BMI score - BMI kg/m2		**Score**		
Over 20 (over 30 obese)	0			
18.5 to 20	1			
Less than 18.5	2			
If unable to calculate BMI: Estimating BMI category can be done from Mid Upper Arm Circumference (MUAC) MUAC less than 23.5 BMI likely <20 MUAC greater than 32.0cm BMI likely >30				
Step 2: weight loss score unplanned weight loss in last 3 – 6 months				
Less than 5%	0			
Between 5 – 10%	1			
More than 10%	2			
Step 3: acute disease effect score				
If the Person is acutely ill and there has been, or is likely to be no nutritional intake for more than 5 days	2			
Total MUST score				
Low Risk = 0	Medium Risk = 1	High Risk ≥ 2		



Eating and drinking

Person – All About Me

Able to eat and drink:

☐ Independently ☐ Help required ☐ Full assistance

Difficulty swallowing: ☐ Yes ☐ No

Appetite: ☐ Good ☐ Fair ☐ Poor

Appetite change: ☐ Yes ☐ No

Dietary Requirements/Modifications including preferences:

Food intolerances:

Do you wear dentures: ☐ Yes ☐ No

Top present: ☐ Yes ☐ No

Bottom present: ☐ Yes ☐ No

Secure fitting: ☐ Yes ☐ No

Diabetes: ☐ Type1 ☐ Type 2 ☐ None

Controlled by: ☐ Diet ☐ Tablet ☐ Hormone ☐ Insulin

Other: ____

Assessment

Nil by mouth ☐ Yes ☐ No

Last ate: ____________________________________

Last drank: __________________________________

Enteral feeding: ☐ Yes ☐ No

Type of feed:

Regime:

Route/ Device type:

Size:

Frequency of change:

Date next change due:

Are you taking oral steroids: ☐ Yes ☐ No

Do you wish to be involved in your insulin administration: ☐ Yes ☐ No ☐ NA

If Yes, Person able and agrees to administer insulin under supervision: ☐ Yes

Elimination

Person – All About Me	Assessment
Able to use toilet: ☐ Independently ☐ Help required ☐ Full assistance Have you any difficulties with your bladder: ☐ Yes ☐ No If Yes, do you use continence products: ☐ Yes ☐ No ☐ Prescribed ☐ Purchased Has your incontinence escalated/been triggered by your current condition: ☐ Yes ☐ No	**Urinalysis:** ☐ Yes, Result: ______ ☐ No, Reason: ______ Further continence assessment on discharge required: ☐ Yes ☐ No The Person has/carries out: ☐ Urethral catheter ☐ Suprapubic catheter ☐ No catheter ☐ Urostomy ☐ Nephrostomy ☐ Intermittent catheterisation Type (if applicable): Size (if applicable): Insertion date (if applicable): Date due to be changed (if applicable): Frequency of change/intermittent catheterisation (if applicable): If Person has catheter, who undertakes change: ______
Have you any difficulties with your bowel: ☐ Yes ☐ No Details of normal bowel habit:	Stoma type: ______ ☐ N/A Last bowel movement: ______ Constipation: ☐ Yes ☐ No Drains in situ: ☐ Yes ☐ No

Personal Care

Person – All About Me	Assessment
Able to wash and dress: ☐ Independently ☐ Help required ☐ Full assistance **Able to complete oral hygiene:** ☐ Independently ☐ Help required ☐ Full assistance	Condition of mouth:

The Braden Scale©

Sensory perception - Ability to respond meaningfully to pressure-related discomfort				
COMPLETELY LIMITED Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body surface	**VERY LIMITED** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body	**SLIGHTLY LIMITED** Responds to verbal commands but cannot always communicate discomfort or need to be turned **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**NO IMPAIRMENT** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	
1	**2**	**3**	**4**	
Moisture - Degree to which skin is exposed to moisture				
CONSTANTLY MOIST Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	**OFTEN MOIST** Skin is often but not always moist. Linen must be changed at least once a shift	**OCCASIONALLY MOIST** Skin is occasionally moist, requiring an extra linen change approximately once a day	**RARELY MOIST** Skin is usually dry; linen only requires changing at routine intervals	
1	**2**	**3**	**4**	
Activity - Degree of physical activity				
BEDFAST Confined to bed	**CHAIRFAST** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair	**WALKS OCCASIONALLY** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. **SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently	**WALKS FREQUENTLY** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours	
1	**2**	**3**	**4**	
Mobility - Ability to change and control body position				
COMPLETELY IMMOBILE Does not make even slight changes in body or extremity position without assistance	**VERY LIMITED** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently	**NO LIMITATIONS** Makes major and frequent changes in position without assistance	
1	**2**	**3**	**4**	
Nutrition - Usual food intake pattern				
VERY POOR Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is Nil Per Orally and/or maintained on clear fluids or Intra Venous for more than 5 days	**PROBABLY INADEQUATE** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**ADEQUATE** Eats over ½ of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal but will usually take a supplement if offered **OR** Is on a tube feeding or Total Parenteral Nutrition regime which probably meets most of nutritional needs.	**EXCELLENT** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat or dairy products. Occasionally eats between meals. Does not require supplementation	
1	**2**	**3**	**4**	
Friction and Shear				
PROBLEM Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**POTENTIAL PROBLEM** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**NO APPRARENT PROBLEM** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times		
1	**2**	**3**		
			Total Score	
Reproduced with permission			**9 or below: Severe Risk** **10-12: High Risk** **13-14: Moderate Risk** **15-18: Mild Risk**	**Date and Time Assessed:**

Skin Check

☐ Actual ☐ Verbal Details: ____________________

____

All skin observed and intact unless indicated on map: ☐ Yes

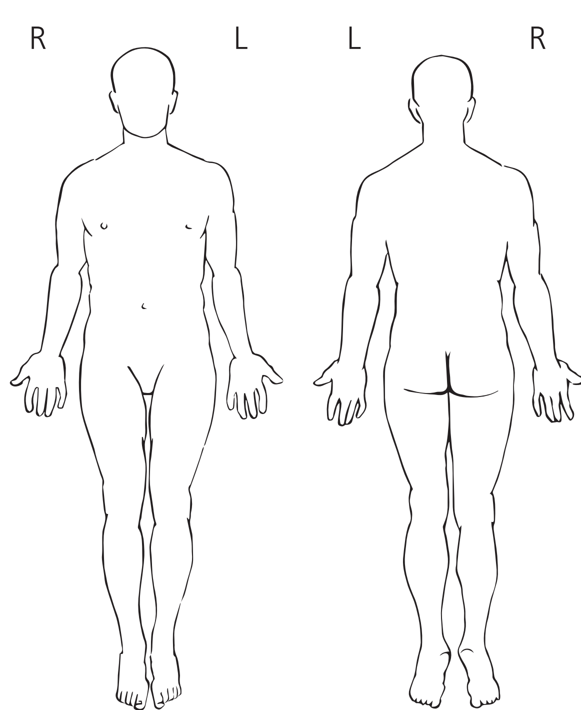
☐ Unable to check, Reason: ____________________

Document on the map and table below:

Tissue damage - check over bony prominence/around devices and use codes in descriptor box

Tissue damage - marks, bruising, rashes, skin conditions, or any other wounds write description

People with diabetes - check both feet: is there a skin break below the ankle: ☐ Yes ☐ No



Type of tissue damage and reason/duration (if known) should be documented on map:

Wound assessment chart commenced: ☐ Yes ☐ Not Required

Descriptor and Codes

S/G1	**Stage/Grade 1** - Non blanching erythema. Non blanchable redness of intact skin of a localised area usually over a bony prominence.	**S/G4**	Stage/Grade 4 - Full thickness skin loss with exposed bone, tendon or muscle slough or eschar may be present on some parts of the wound bed. The depth varies by anatomical location.
S/G2	**Stage/Grade 2** - Partial thickness skin loss of dermis presenting as a shallow open ulcer with a pink wound bed, without slough. May also present as an intact or ruptured serum filled blister.	**US/UG**	**Unstagable/Ungradable** Depth unknown. Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.
S/G3	**Stage/Grade 3** - Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. The depth varies by anatomical location.	**SDTI**	**Suspected Deep Tissue Injury** Purple or maroon localised area of discoloured intact or blood-filled blister.

Descriptors and Codes

MU	Mucosal Ulcer	**ML**	Moisture Lesion	**IAD**	Incontinence Associated Dermatitis

- Braden score is **18 or less** and in conjunction with clinical judgement
- The Person has existing pressure damage

Document identified need(s) on page 14

Sleep

Person – All About Me	Assessment
What is your usual sleep pattern: What helps you sleep:	

Circle as appropriate — **Audit - C**

Question					
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
Score	0	1	2	3	4
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+
Score	0	1	2	3	4
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Score	0	1	2	3	4
Total Score					

under 4 No further action required	**5-7** Harmful drinkers: Advice, leaflet available	**8+** Dependent drinkers: Advice, leaflet available and consider onward referral to alcohol/substance misuse liaison nurse

Psychological / Emotional

Person – All About Me	Assessment
How do you view your mental health and emotional wellbeing: ☐ Good ☐ It varies ☐ Quite bad ☐ Very Bad Do you have, or have you had, any diagnosed mental health conditions: ☐ Yes ☐ No Have any recent events affected your mental health or emotional wellbeing: ☐ Yes ☐ No Have you been more forgetful in the past 12 months to the extent it is having an impact on your daily life: ☐ Yes ☐ No ☐ Unknown **Carer or relative:** Have you noticed a recent change (past 4 weeks) in their level of confusion/cognitive impairment: ☐ Yes ☐ No ☐ Unaccompanied	

Body Image

Religious / Spiritual / Cultural

Have you particular religious/spiritual/cultural needs that need to be taken into account while you are in hospital: Would you like a visit from the Chaplaincy Service: ☐ Yes ☐ No If 'yes' please specify your religion/ denomination/belief group:	

Palliative Care (if applicable) ☐ N/A

Are you receiving palliative care services: ☐ Yes ☐ No Do you need palliative care support: ☐ Yes ☐ No	

Social

Person – All About Me	Assessment
Do you live alone: ☐ Yes ☐ No If No, who do you live with: ______________________ ______________________ ______________________ **Daily personal and household activities:** ☐ Independent ☐ Help required ☐ Full assistance Are you a main carer: ☐ Yes ☐ No If Yes complete questions below Have you had a carer's assessment: ☐ Yes ☐ No ☐ Unknown ☐ Yes, who do you care for: ☐ Child (0 – 18yrs) ☐ Dependant Adult Details: ______________________ ______________________ Are you happy with the care arrangements in place while you are in hospital: ☐ Yes ☐ No	

Social and Home Support

Name / profession / contact details	Details of support

Work and recreation

Any impact on work/day activity due to admission ☐ Yes ☐ No	

Pain

Person – All About Me

Pain management strategies: ☐ Yes ☐ No

Assessment

Pain: ☐ Acute ☐ Chronic ☐ None

Pain Score

0 1 2 3 4 5 6 7 8 9 10

(Circle 0 = No pain - 10 = Worst pain)

Consider using Abbey Pain Scale for Adult patients unable to verbalise

Analgesic(s) - date and time of last dose(s) taken:

Analgesic: ________________ Analgesic: ________________

Date: ________________ Date: ________________

Time: ________________ Time: ________________

Person's medications

Has medication been brought to hospital: ☐ Yes, *complete below* ☐ No ☐ N/A

Medicines retained for medication reconciliation: ☐ Yes ☐ No

☐ Yes ☐ N/A Consent obtained for retention and use in accordance with Trust's 'Patients own drugs scheme'

☐ Yes ☐ N/A Securely stored in dedicated place

☐ Yes ☐ N/A Drugs stored in ward fridge as appropriate

☐ Yes ☐ N/A Controlled Drugs (CD) stored in CD cupboard and entered in the appropriate register

The Person: (tick if applicable):

☐ Takes over the counter medication ☐ Takes alternative medicine products

☐ Involved in clinical trial ☐ Patch in place

Details: ____

Time Critical Medications

Is the Person on any of the medicines listed below: ☐ No ☐ Unable to establish ☐ Yes, complete below

Medication	Yes	Date and time - last dose	Missed dose
STAT doses of any medicine (prescribed for immediate administration)	☐		☐
Anticholinesterases	☐		☐
Anticoagulants	☐		☐
Anticonvulsants	☐		☐
Antidotes	☐		☐
Anti-infectives (injectable route/ oral first dose)	☐		☐
Antiplatelets and thrombolytics (for acute indications)	☐		☐
Antiretrovirals	☐		☐
Bronchodilator (injectable or nebulised route)	☐		☐
Chemotherapy (injectable route)	☐		☐
Clozapine	☐		☐
Corticosteroids	☐		☐
Desmopressin (treatment of cranial diabetes insipidus)	☐		☐
End of life medication	☐		☐
Immunoglobulin	☐		☐
Immunosuppressants	☐		☐
Insulin	☐		☐
Medicines for active bleeding	☐		☐
Opioids (all routes)	☐		☐
Oxygen	☐		☐
Parenteral electrolyte replacement	☐		☐
Parkinson's Disease medicines	☐		☐

Missed doses - Name of doctor informed: ________________________________

Time: ____________ Date: ____________ Signature: ________________________

All risk assessments must be completed within 6 hours of admission (except MUST and AUDIT - C = 24 hours).

If Person is transferred, 'Hospital/ ward transfer' (page 43) must be completed.

When Person transfers to another location of care, professional judgement should be used when considering if completion of review risk assessments (pages 45- 49) is required. If Person's condition changes, review risk assessments must be completed appropriately.

Summary of identified needs - from **A**ssessment And Risk Assessments And **P**erson - All About Me		
Nursing need	Admission need	Existing care need
Each of the above identified needs/risks requires a plan of care/treatment/support or maintenance plan		
Record required referrals on page 44		

Person's valuables

Have the Person's valuables been sent home: ☐ Yes ☐ No ☐ N/A

Advised that valuables kept at own risk: ☐ Yes ☐ No ☐ N/A

Has the Valuables/Property Policy been explained: ☐ Yes ☐ No ☐ N/A

Have the Person's valuables been stored and recorded as per Trust policy ☐ Yes ☐ No ☐ N/A

Details: ____

____

____

____

Record incomplete sections from initial assessment (pages 1-14)

Page	Details	Date	Time	Signature
	Completed			
	Completed			
	Completed			
	Completed			
	Completed			
	Completed			
	Completed			

Person	**A**ssessment	Plan of **C**are	**E**valuation
What matters to the Person? Communicating with the Person and family to identify their needs	Using nursing assessment skills to identify the needs of the Person. Collecting ongoing information/clinical observation. Building a picture.	Plan Care/Treatment/Support based on the identified needs from P and A. Specify desired outcome (aim). Obtain consent for the plan.	Look at the effectiveness of the plan. How does the Person feel? Progress towards outcomes/ meeting needs

Record of Person-centred assessment, care and evaluation

Date and Time		**Signature and Designation**

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Date and Time		**Signature and Designation**

Person	**A**ssessment	Plan of **C**are	**E**valuation
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Record of Person-centred assessment, care and evaluation

Date and Time		Signature and Designation

Hospital / ward transfer				
Hospital	Receiving ward	Date	Time	Signature

Alerts/ food allergies since admission (NOT medication allergies/ sensitivities. Record these on the medical prescription record)			
Details	Date	Time	Signature

Referrals

Date and time referral made	Referral to	Reason	Seen by and date

Moving and Handling

Complete if the Person's condition changes and/or Person transfers and/or new equipment / aids put in place

Is the Person's weight within safe working load (SWL) of equipment e.g. bed, chair, hoist, wheelchair	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment
Detail new equipment:			
Is equipment wide enough for the Person's safety and comfort e.g. bed, chair, hoist, wheelchair	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment
The Person requires a mobility aid e.g. walking frame, wheelchair	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment	☐ Yes ☐ No If No, expand in **A**ssessment
Detail new mobility aid:			
Is the mobility aid available	☐ Yes ☐ No ☐ N/A If Yes, Person's own: ☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A If Yes, Person's own: ☐ Yes ☐ No	☐ Yes ☐ No ☐ N/A If Yes, Person's own: ☐ Yes ☐ No
Handling constraints since admission e.g. pain, external attachments, fractures, behaviour, environment, posture	☐ Yes ☐ No If Yes, expand in **A**ssessment	☐ Yes ☐ No If Yes, expand in **A**ssessment	☐ Yes ☐ No If Yes, expand in **A**ssessment
Detail new handling constraint:			
Date:			
Time:			
Signature:			

Complete if falls incident and/or fear of falling and/or new problem with balance or walking since admission

Date of fall incident:			
New fear of falling since admission	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
New problem with walking / balance since admission	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Lying and standing Blood Pressure (BP)	Lying BP: ____________ Standing BP: __________ ☐ Not able to stand	Lying BP: ____________ Standing BP: __________ ☐ Not able to stand	Lying BP: ____________ Standing BP: __________ ☐ Not able to stand
Date:			
Time:			
Signature:			

Bedrails Assessment

Mental State / Mobility	Person is very immobile (bedfast/hoist dependent)	Person unable to mobilise independently	Person can mobilise without help from staff
Person is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
Person is drowsy	Recommend Bedrails	Use bedrails with care	Bedrails NOT recommended
Person is orientated and alert	Recommend Bedrails	Recommend Bedrails	Bedrails NOT recommended
Person is unconscious	Recommend Bedrails	N/A	N/A

Formatted from the National Patient Safety Agency's Safer practice notice 'Using bedrails safely and effectively' (NPSA/2007/17)

Bedrails Assessment Outcome - Complete if Person's condition changes and/or consider completion if Person transfers

Record reason for assessment e.g. details of change in Person's condition and decision making details

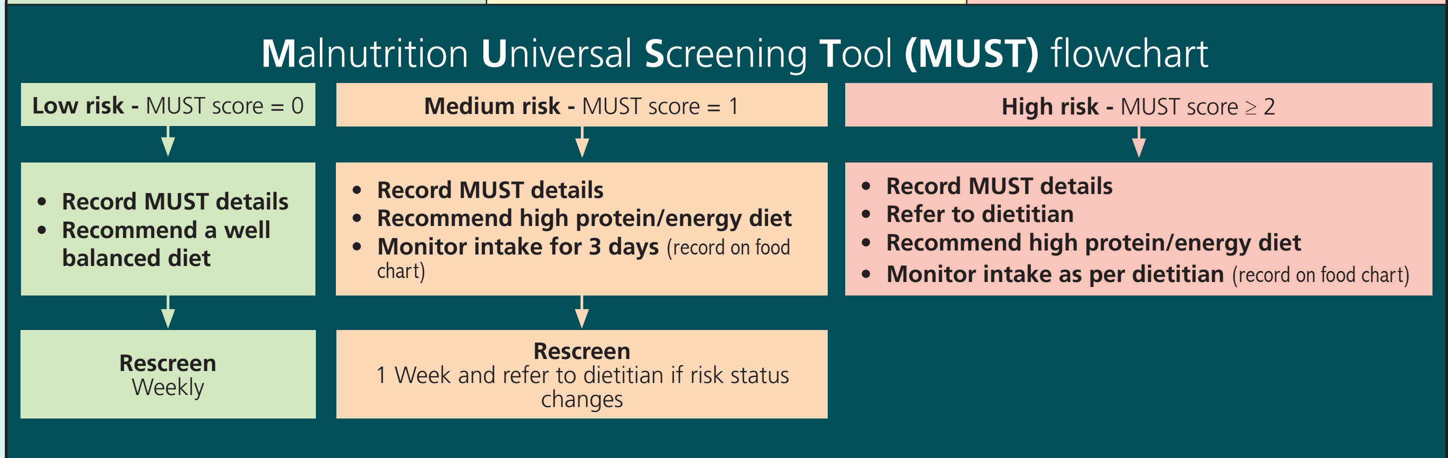
	Date:	**Date:**	**Date:**
	Time:	**Time:**	**Time:**
	Signature:	**Signature:**	**Signature:**
☐ Bedrails **NOT** recommended			
☐ Use bedrails with care			
☐ Recommend bedrails			

Malnutrition Universal Screening Tool (MUST)

To identify those adults who are at risk of malnourishment or who are malnourished

		Date:	**Date:**	**Date:**
		Time:	**Time:**	**Time:**
		Signature:	**Signature:**	**Signature:**
		Height:	**Height:**	**Height:**
		Weight:	**Weight:**	**Weight:**
		BMI:	**BMI:**	**BMI:**
Step 1: BMI score - BMI kg/m2		**Score:**	**Score:**	**Score:**
Over 20 (over 30 obese)	0			
18.5 to 20	1			
Less than 18.5	2			
If unable to calculate BMI: Estimating BMI category can be done from Mid Upper Arm Circumference (MUAC) MUAC less than 23.5 BMI likely <20 MUAC greater than 32.0cm BMI likely > 30				
Step 2: weight loss score unplanned weight loss in last 3 – 6 months				
Less than 5%	0			
Between 5 – 10%	1			
More than 10%	2			
Step 3: acute disease effect score				
If the Person is acutely ill and there has been, or is likely to be no nutritional intake for more than 5 days	2			
Total MUST score				

Low Risk = 0	Medium Risk = 1	High Risk ≥ 2



The Braden Scale©

Sensory perception - Ability to respond meaningfully to pressure-related discomfort

COMPLETELY LIMITED Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body surface	**VERY LIMITED** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body	**SLIGHTLY LIMITED** Responds to verbal commands but cannot always communicate discomfort or need to be turned **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**NO IMPAIRMENT** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort			
1	2	3	4			

Moisture - Degree to which skin is exposed to moisture

CONSTANTLY MOIST Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	**OFTEN MOIST** Skin is often but not always moist. Linen must be changed at least once a shift	**OCCASIONALLY MOIST** Skin is occasionally moist, requiring an extra linen change approximately once a day	**RARELY MOIST** Skin is usually dry; linen only requires changing at routine intervals			
1	2	3	4			

Activity - Degree of physical activity

BEDFAST Confined to bed	**CHAIRFAST** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair	**WALKS OCCASIONALLY** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair **SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently	**WALKS FREQUENTLY** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours			
1	2	3	4			

Mobility - Ability to change and control body position

COMPLETELY IMMOBILE Does not make even slight changes in body or extremity position without assistance	**VERY LIMITED** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently	**NO LIMITATIONS** Makes major and frequent changes in position without assistance			
1	2	3	4			

Nutrition - Usual food intake pattern

VERY POOR Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** Is Nil Per Orally and/or maintained on clear fluids or Intra Venous for more than 5 days	**PROBABLY INADEQUATE** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**ADEQUATE** Eats over ½ of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal but will usually take a supplement if offered **OR** Is on a tube feeding or Total Parenteral Nutrition regime which probably meets most of nutritional needs.	**EXCELLENT** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation			
1	2	3	4			

Friction and Shear

PROBLEM Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**POTENTIAL PROBLEM** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**NO APPRARENT PROBLEM** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times				
1	2	3				

	Total Score			
Reproduced with permission **9 or below: Severe Risk** **10-12: High Risk** **13-14: Moderate Risk** **15-18: Mild Risk**	**Date** **Time** **Signature**			

Skin Check

☐ Actual ☐ Verbal Details: ____________________

____

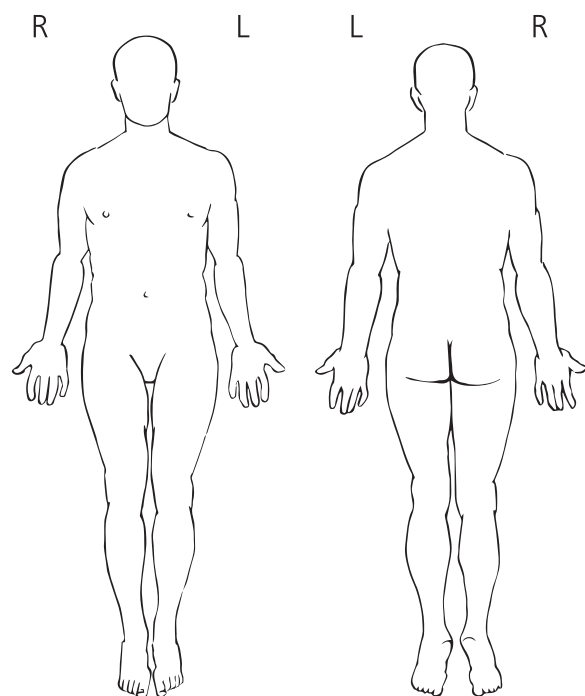
☐ Unable to check, Reason: ____________________

Document on the map and table below:

Tissue damage - check over bony prominence/around devices and use codes in descriptor box

Tissue damage - marks, bruising, rashes, skin conditions, or any other wounds write description

People with diabetes - check both feet: is there a skin break below the ankle: ☐ Yes ☐ No



Date and time of observation, type of tissue damage and reason/duration (if known) should be documented on map:

Date and Time	Skin observed and intact? If No, complete map	Signature
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Wound assessment chart commenced: ☐ Yes ☐ Not Required

Descriptor and Codes

S/G1	**Stage/Grade 1** - Non blanching erythema. Non blanchable redness of intact skin of a localised area usually over a bony prominence.	**S/G4**	Stage/Grade 4 - Full thickness skin loss with exposed bone, tendon or muscle slough or eschar may be present on some parts of the wound bed. The depth varies by anatomical location.
S/G2	**Stage/Grade 2** - Partial thickness skin loss of dermis presenting as a shallow open ulcer with a pink wound bed , without slough. May also present as an intact or ruptured serum filled blister.	**US/UG**	**Unstagable/Ungradable** Depth unknown. Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.
S/G3	**Stage/Grade 3** - Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. The depth varies by anatomical location.	**SDTI**	**Suspected Deep Tissue Injury** Purple or maroon localised area of discoloured intact or blood-filled blister.

Descriptors and Codes

MU	Mucosal Ulcer	**ML**	Moisture Lesion	**IAD**	Incontinence Associated Dermatitis

- Braden score is **18 or less** and in conjunction with clinical judgement
- The Person has existing pressure damage

→ **Document identified need(s)**

Discharge information / checklist

Electronic discharge complete: ☐ Yes ☐ N/A

Date: ____________ Time: ____________ Signature: ______________________________

The Person is being discharged to:

☐ Their own Home ☐ A relative's/carer's home ☐ Respite Care ☐ Hospice ☐ Other: ____________

Reason for admission: ______________________________

____

____

____

Medication

Prescription sent to pharmacy:	☐ Yes ☐ No	Name: ____________ Date: ____________ Time: ____________
Anticoagulant prescription:	☐ Yes ☐ No	Name: ____________ Date: ____________ Time: ____________
Discharge medication checked and given, including CD/fridge items:	☐ Yes ☐ None required	If Yes, ongoing monitoring confirmed ☐
Person's own medications checked and returned:	☐ Yes ☐ None to return	
Prescribed time critical medications:	☐ Yes ☐ No	If Yes, name of Person advised: ____________
Home oxygen order form completed:	☐ Yes ☐ N/A	If Yes, home oxygen delivered: ☐ Yes
Person/Primary Carer has been advised about medication:	☐ Yes ☐ No ☐ N/A	If Yes, name of Person advised: ____________

Wound management ☐ N/A

Treatment room Nurse/District Nurse letter given:	☐ Yes ☐ No
3-day supply of all dressings provided:	☐ Yes ☐ No
Negative pressure wound therapy: (follow local policy)	☐ Yes, Type: ____________ ☐ No
Pressure ulcer(s):	☐ Yes ☐ No
Grade: ________ / Site: ________	☐ Acquired during admission ☐ Not acquired during admission
Grade: ________ / Site: ________	☐ Acquired during admission ☐ Not acquired during admission

Check prior to discharge

IV access device(s) removed:	☐ Yes ☐ No ☐ N/A, Details/Reason for not removing:
Arm band(s) removed:	☐ Yes ☐ No, Reason:
Property returned:	☐ Yes ☐ N/A
Copy of discharge letter for GP given:	☐ Yes ☐ N/A Given to: ____________
Medical certificate (16 OR OVER) required:	☐ Yes ☐ No ☐ N/A Issued: ☐ Yes ☐ No

Discharge contacts

☐ N/A

Date contacted	Professional contacted and name	Reason for referral	Discharge letter given for professional

Follow up

☐ N/A

Follow up appointment required: ☐ Yes ☐ No If Yes, Date and Time: ______________________

Place: ______________________

Primary Carer informed of follow up arrangements: ☐ Yes ☐ No

Discharge advice leaflets

☐ N/A

Discharge advice / leaflets / teaching provided:

Nurse signature: ______________________ Date: ____________ Time: ____________

Transport

☐ N/A

☐ Ambulance Required	Date and Time requested:	Booking Number:

Special Requirements:

Informed of Infection Status: ☐ Yes Details: ______________________	Informed of DNACPR: ☐ Yes ☐ NA

Transport used on leaving ward: ______________ Accompanied by: ______________

Signature register

Date	Full name (BLOCK CAPITALS)	Designation (e.g Registered Nurse, Nursing Assistant)	Initials	Full signature	Status Permanent = P Temporary = T Bank = B Agency = A