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| Trusted Assessment – pathways 2 & 3 |
| It is imperative that the information contained in this document is a true and honest reflection of the patient at the time of assessment and, if necessary, if updated prior to discharge – if the document is not produced electronically, please complete entries in BLOCK CAPITALS |
| **Assessment details** |
| Date form completed | Location where form completed |
| Assessment completed by | Designation |
| Information gained from: Patient/relatives/carers/ notes | Ward contact number |
| **Patient information and Admission/GP details** |
| Surname |  | Admitted from: home/Care Home/ other hospital |
| Forename |  | Method of admission Emergency/ elective |
| Likes to be known as |  | First language |  |
| Male/female/trans sexual | Previous occupation: if known |
| Single/married/widowed/Partner/Civil Partner | Date of discharge |
| Date of birth | Ward contact number |
| NHS hospital number | GP Name |
| Address | GP address |
| Telephone number | GP contact number |
| Is the patient a carer? Yes/no | How is the cared for person being looked after? |
| Does the patient live alone? Yes/No | If Yes: who do they live with? |
| What type of accommodation do they live in? |
| Does the patient need to be able to do stairs/steps? Yes/No – if yes, put detail in ‘mobility’ |
| **Contacts** |
| Next of Kin 1 Name |  | Next of Kin 2 Name |  |
| Relation to person |  | Relation to person |  |
| Do they care for the person? | Yes/No | Do they care for the person? | Yes/No |
| Address | Address |
| Telephone number |  | Telephone number |  |
| Informed of discharge | Yes/No | Informed of discharge | Yes/No |
| **Inpatient and medical information** |
| Date of admission: | Reason for admission: |
| Patient has been nursed on: (ward name(s) | Hospital treatment (surgical procedures, x-rays, blood results, to include all tests and results carried out whilst an inpatient) |
| Past medical history | Diagnosis on discharge:  |
| TEP form completedDate: |
| Allergies | TEP form completed by: |
| Infection status | Is the patient considered to have capacity?Yes/No |
| If no has a Best Interest meeting been held? Yes/NoIf yes, please provide details within ‘cognition’ section of form |
| Patient’s height, weight and BMI on admission | If not recorded state reason | Patient’s height, weight and BMI on referral/discharge: |
| Is the patient a wheel chair user?Yes/No | If yes, what is width of wheelchair? | Has the patient got bariatric needs? Yes/No If yes, please include details in ADL section  |
| Are there any Continuing health needs? Yes/No If yes – please put details in ADL sections |
| **Multi disciplinary involvement** |
| **Profession** | **Name or N/A if not applicable** | **Contact details** | **Treatment/interventions** |
| Occupational Therapist |  |  |  |
| Physiotherapist |  |  |  |
| Dietician *Include MUST score. If required referral to dietician must be made before discharge* |  |  |  |
| Speech and Language therapist |  |  |  |
| Stroke Nurse |  |  |  |
| Tissue Viability Nurse *Include wound care plan and body map* |  |  |  |
| Mental Health Liaison nurse/CPN |  |  |  |
| Social Worker |  |  | See separate assessment |
| Other |  |  |  |
| **Activity of Daily Living (ADLs) This information MUST accurately reflect the patient’s current abilities on assessment, to also include the patient’s rehabilitation goals.** |
| Breathing |
| *Any medical conditions, symptoms/inhalers/medication/oxygen, smoking/vaping/patches*Previous ability:Current ability: |
| Eating |
| *Nutritional assessment score(MUST), ability to feed self, special diets/supplements – diabetic/gluten free/PEG/ food consistency, position for eating. Have SALT been involved?**False teeth.* Has a kitchen assessment been completed? Yes/No Does the patient need one? Yes/NoWho provides meals?Previous ability:Current ability: |
| Drinking |
| *Swallowing difficulties, thickened fluids, position for drinking.* Previous ability:Current ability: |
| Mobility |
| *Distance able to walk, detail any aids used, what assistance is required?**Can they do the stairs? Do they need to do stairs?* *Are they a wheelchair user – width of wheelchair*Previous ability:Current ability: |
| Transfers – describe how the patient transfers to/from: |
| *Bed, Chair, Toilet, Equipment/assistance used to support transfers*Previous ability:Current ability:  |
| Falls |
| *Any history of falls, date of last fall, details of falls, Risk assessment if completed*Previous ability:Current ability: |
| Personal hygiene and dressing |
| *Any assistance required for washing and dressing – number of staff and frequency, details of any prescribed creams to wash/ moisturise with**Any equipment required*Previous ability:Current ability: |
| Sleeping |
| *Usual pattern, night sedation, bed rails, night needs – turning, toileting*Previous ability:Current ability: |
| Communication |
| *Sight, Hearing, Speech, first language, Glasses? Hearing aids?*Previous ability:Current ability: |
| Bowels |
| Is the patient able to toilet self?Any constipation/continence issues, colostomy, aids Pads – frequency of change (**ensure patient is discharged with 3 day’s supply**)Previous ability:Current ability: |
| Bladder |
| *Is patient able to toilet self? Any continence issues, aids used**If catheterised: reason for catheter, date of last catheter change, size and type, if newly catheterised (not currently on ‘Passport’ system) include* ***next catheter in discharge pack****Has there been a continence assessment?**Pads – frequency of change/type (****discharge with 3 day’s supply****)*Previous ability:Current ability: |
| Skin integrity |
| *Any areas of risk/open wounds –include a body map* *Any wounds that are Grade 3 or 4 – have they been referred to safeguarding?**Any areas that require dressings – type and frequency of dressings, time taken to complete the dressings* ***(provide 3 changes of dressings on discharge)****Any pressure relieving equipment required**Any creams prescribed?*Braden score/Prurat scorePrevious ability:Current ability: |
| Infection status |
| *Current infection status**Infection status during this inpatient episode – list swabs and results*Is a side room required? Yes/No |
| Cognition |
| *Orientation – time and place, any short/long term memory issues, challenging behaviours, wandering, aggression – verbal/physical, dis inhibition*. Has there been a Mental Capacity assessment? Yes/NOAre there any Best Interest decisions? Yes/NoIs there a DoLs in place – if so why? Yes/NoWho has POA – finance and health and well beingPrevious ability:Current ability: |
| Mental Health |
| *Any mental health history/diagnosis/concerns*Previous ability:Current ability: |
| Pain |
| *Sites of any pain, medication (ensure discharged with adequate analgesia)* |
| Medication |
| **Discharge with 14 day’s supply of medication***Any ‘old’ (now unused medication) either place into a separate bag (clearly labelled) or ask patient if you can dispose of the ‘old’ medication*.Does the patient self medicate? Yes/No Is a dosette box required? Yes/NoPrevious ability:Current ability: |
| Social  |
| Does the patient have an existing package of care? Yes/NoIf yes, who is the care agency?Are there any other services involved? Yes/NoIf yes, please list.Previous:Current: |
| Safeguarding |
| *Are there any Safeguarding concerns for this admission or any outstanding safeguarding issues? Please include any other risks or alerts.**If yes, please include contact details of the key person who holds this information*  |
| Advice |
| *List any outstanding test results or outpatient appointments**Has transport been arranged for any outpatient appointments and by who* |
| Any other useful information |
| *Relevant family dynamics or any other useful information* |
| **Medication/changes to medication while in hospital (consider if any EOL medication is required)**  |
| Prior to discharge, when was medication last administered? | Time:  | Date: |
| **Social Care information – if required** |
| Date of last social care assessment |  |
| The following details will be found in the social care assessment (if completed): |
| * Spiritual needs
* Social activity needs
* Details of any previous support
* Power of attorney – Finance/Health and wellbeing
* Mental Capacity/Safeguarding concerns/any family dynamics
* Advanced decisions
 |
| **Trusted assessment completed by:** |
| I confirm that the above information is a true and honest representation of the patient’s current health needs and abilities. |
| Print name |  |
| Signature |  |
| Role |  |
| Date |  |
| Telephone number/bleep |  |