|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 completed  Date: | | | | | |
| 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/No  If 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/No  Who 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 score  Previous 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/NO  Are there any Best Interest decisions? Yes/No  Is there a DoLs in place – if so why? Yes/No  Who has POA – finance and health and well being  Previous 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/No  Previous ability:  Current ability: | | | | | | | | | | | | | |
| Social | | | | | | | | | | | | | |
| Does the patient have an existing package of care? Yes/No  If yes, who is the care agency?  Are there any other services involved? Yes/No  If 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 | | | | |  | | | | | | | | |