

**PRE ADMISSION ASSESSMENT FORM**

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| Name | | | Date of Birth | | |
| How would you like us (NH) to address you? (eg first name, title, known as) | | | | | |
| Address | | Place where assessed | | | |
| Lasting Power of Attorney/Enduring Power of Attorney Yes 🞏 No 🞏  Welfare 🞏 Finance 🞏 Both 🞏  Copy of document available Yes 🞏 No 🞏 | | | | | |
| Name of LPA/EPA | | | | | |
| Advanced Directive Refusing Treatment (ADRT)/Advanced Directive (AD) Yes 🞏 No 🞏  Copy of document available Yes 🞏 No 🞏 | | | | | |
| Next of Kin  Relationship  Address:  Email: | | Next of Kin  Relationship  Address:  Email | | | |
| Relative present Yes 🞏 No 🞏 Name(s) | | | | | |
| Relationship | Assessment Date | | |  |  |

Overview Assessment

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| Resident Perspective | | | | | | | | | | | |
| 1. Resident’s perspective of current situation and needs | | | | | | | | | Guidance | | |
|  | | | | | | | | | Significance of problem/  Length of time experienced  Expectations/objectives/goals | | |
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| 1. Carer’s or significant person’s perspective of current situation and service user’s needs | | | | | | | | | Guidance | | |
|  | | | | | | | | | How is situation affecting carer/family?  Expectations and goals | | |
| Is the resident aware they are coming to Nightingale House | | | | | | | | |  | | |
| If YES how does the resident feel about this | | If NO – why not | | | | | | | Circle Yes/No and give explanation | | |
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| 1. Personal information | | | | | | | | | Guidance | | |
| Are you a people person? | | | | | | | | | Is the person sociable? Does the person like to be around people or prefers the company of themselves or a select few? | | |
| What are your main interests? | | | | | | | | | Past employment, life changes, education | | |
| What is your preferred time to wake up in the morning? | | | | | | | | | | | |
| What do you enjoy doing during the day? | | | | | | | | | | | |
| Is there anything that upsets you that we should know about? | | | | | | | | | | | |
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| 1. Cultural, Religious and Dietary Needs Guidance | | | | | | | | | | | |
|  | | | | | | | | | Description of race and culture  1st/2nd language  Interpretation?  Ethnic origin  Religion/observances/customs  Any specific instructions regarding contact with the person | | |
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| Relationships (involvement in family, work and wider community life/carers | | | | | | | | | | | |
| 1. Current support networks | | | | | | | Guidance | | | | |
|  | | | | | | | Friends or family that visit?  What support do they provide? Are they willing to continue this support?  What support does the service user have in emergencies? Are they happy with this current level of support | | | | |
| 1. Medical history (Medication/food/dressings/other) | | | | | | | | | | | |
| Allergies: Medications/food dressings | | | | | | | History of medical/psychiatric conditions and diagnosis, consultant appointments, hospital, therapists etc | | | | |
| 7. Medication | | | | | | | Guidance | | | | |
| Do you take any prescribed medication ? | | | | | | |  | | | | |
| Has no medication 🞏 Self medicates 🞏 Requires Assistance 🞏  Unwilling to comply 🞏 Reliant on other 🞏 | | | | | | | People over 75 should have a medication review at least annually and those taking 4 or more medicines should have a 6 month review | | | | |
| Medication list | | | | | | | | | | | |
| Any issues taking medications (swallowing difficulties) Yes 🞏 No 🞏  When was last medication review? | | | | | | | Medication review needed / Refer to GP | | | | |
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| Physical wellbeing and senses (needs relating to autonomy and freedom to make choices | | | | | | | | | | | |
| 1. Physical wellbeing | | | | | | | Guidance | | | | |
| In general would you say you are in good health Yes 🞏 No 🞏 | | | | | | | Are you unable to partake of activities due to a chronic/physical/mental condition? | | | | |
| Additional information including any evidence received, sources available, older person’s comments | | | | | | | | | | | |
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| 1. Sight, hearing and communication – assessment | | | | | | | | | | | |
| First language English 🞏 | Other 🞏 (state) | | | | | | Translation/interpreter required 🞏 | | | | |
| **Sight**  No problems 🞏 Limited 🞏 (Registered blind, macular degeneration, diabetes (risk of glaucoma) Cataracts 🞏  Aids: Please state | | | | | | | Eye Test 🞏 New Glasses 🞏  Assistance with reading 🞏 | | | | |
| **Hearing**  No problems 🞏 Limited 🞏 Deaf 🞏  Aids: Please state the hospital that provided the aids | | | | | | | Hearing Test 🞏 Hearing Aid 🞏 | | | | |
| **Understanding of spoken word**  Fully understands 🞏 Appears to have difficulty 🞏  Appears to be unable to understand 🞏 Not known🞏 | | | | | | | Speech therapy referral 🞏  Assistance with communication 🞏 | | | | |
| **Ability to make needs known**  Fully able 🞏 Intermittent – sometimes able 🞏  Can make needs known by gesture/aids 🞏 Unable to communicate 🞏  Communications aids (eg picture cards) state: | | | | | | | Risk of social isolation 🞏  Verbal communication 🞏  Written communication 🞏  Visual prompts 🞏 | | | | |
| **Sight, hearing and communication – notes**  eg would like to use the mobile audio library service Yes 🞏 No 🞏 | | | | | | | | | | | |
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| 1. Respiratory / Breathing | | | | | | | | | | | |
| How is your breathing normally? | | | | | | | | Guidance | | | |
| Normal 🞏 Difficulty on exertion 🞏 Difficulty at rest 🞏  Breathlessness needing medication 🞏  Severe breathing problems needing oxygen 🞏  Continuous or intermittent oxygen 🞏  Prescribed oxygen rate  Never smoked 🞏 Has quit smoking 🞏 Currently smokes 🞏  How many per day………………………. Wants to quit 🞏  Smoking policy explained 🞏 | | | | | | | | Length of time suffering with breathlessness, any cough, any sputum,  Smoker/non-smoker  Affected by exertion?  If being treated, is treatment effective | | | |
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| 1. Pain Guidance | | | | | | | | | | | |
| Pain  Do you suffer from pain Yes 🞏 No 🞏  Acute 🞏 Chronic 🞏  Details (include pain management) | | | | | | | | Site, time, duration, type, spurred on by touch or activities limited. What helps relieve pain? Any analgesia?  Any controlled pain medications | | | |
| Explain the pain: What makes the pain worse or relieves the pain? What is the current plan? | | | | | | | | | | | |
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| 1. Skin condition Guidance | | | | | | | | | | | |
| How would you describe the condition of your skin?  Good 🞏 Poor 🞏 | | | | | | | | State skin condition, dry, thin, bruises etc, dressings | | | |
| Additional information including any evidence received, resources available | | | | | | | | | | | |
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| 1. Pressure sores Guidance | | | | | | | | | | | |
| Do you have any sore skin?  None  Redness  Skin broken  Deep  Multiple deep sores or necrotic  Waterlow Risk Score ………………. | | | Grade 1  Grade 2  Grade 3  Grade 4 | | | 🞏  🞏  🞏  🞏  🞏 | | Present treatment of pressure sores or aids in use or required | | | |
| Additional information, including any evidence received, resources available | | | | | | | | | | | |
| 1. Foot care Guidance | | | | | | | | | | | |
| Any problems with the person’s feet? Yes 🞏 No 🞏  If YES what is the problem?  Would you like to be referred to a podiatrist? Yes 🞏 No 🞏 | | | | | | | | If NO move to Q.15  Patients with peripheral neuropathy should have their feet checked  If they haven’t been seen in a while may need to follow up their appointment. Refer to foot health | | | |
| Additional information, including any evidence received, resources available | | | | | | | | | | | |
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| 1. Alcohol | | | | | | | | | | | |
| Do you usually have an alcoholic drink to help you  Relax 🞏 Sleep 🞏 Eat 🞏 Does not drink alcohol 🞏 | | | | | | | | Does this adversely affect them (physically or mentally) or people close to them? | | | |
| What type of drink do you usually have?  How often? | | | | | | | | | | | |
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| 1. Physical Activity | | | | | | | | | | | |
| Do you do any form of physical activity on a daily basis? Yes 🞏 No 🞏 | | | | | | | | | | | |
| Additional information including any evidence received, resources available | | | | | | | | | | | |
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| 1. Nutrition / Diet | | | | | | | | | | | |
| How is your appetite? how much fluid do you take per day? | | | | | | | | Guidance | | | |
| Fluid intake adequate 🞏 Fluid intake sufficient 🞏 Takes balanced diet 🞏  Diet inadequate / reasons why  Special diet 🞏  Any weight loss/gain in the last 6 months 🞏  Weight (if possible) …………………. Height (if possible) …………………..  Heavy /bariatric 🞏 | | | | | | | | Eating pattern, appetite, therapeutic, cultural or other diet, and healthy eating advice given. Fluid intake, type, amount, frequency, etc | | | |
| Additional information including any evidence received, resources available | | | | | | | | | | | |
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| 1. Eating & Drinking | | | | | | | | | | | |
| Do you have any difficulties eating or drinking? | | | | | | | | Guidance | | | |
| Unaided 🞏 Requires minimum assistance 🞏 Needs to be supported by staff 🞏  Tube fed – PEG/NGT 🞏  Do you have difficulty swallowing food or drinks 🞏  (coughing, choking, foods stuck in your throat) | | | | | | | | State assistance required  State if any thickening agents are used  If tube fed, state the regime | | | |
| What foods and drinks do you particularly enjoy?  What foods and drinks do you avoid?  Any eating/drinking aids used? | | | | | | | | State preferences | | | |
| Additional information including any evidence received, resources available | | | | | | | | | | | |
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| 1. Sleep | | | | | | | | | | | |
| How well do you sleep? | | | | | | | | Guidance | | | |
| 1. Normal / no problems 🞏   Answer (1) go to next section  Answer (2)-(4) ask the following   1. Minor occasional difficulty 🞏 2. Regular disturbance requiring sedation 🞏 3. Disturbed nights even with sedation 🞏 | | | | | | | | Sleep pattern, day nap, bed, chair, pillow, mattress, back rest, bed cradle, restlessness | | | |
| What do you use to help you to sleep? | | | | | | | | Alcohol/herbal remedies/medicines etc | | | |
| Additional information including any evidence received, resources available | | | | | | | | | | | |
| 1. Oral Hygiene | | | | | | | | | | | |
| Do you have mouth, dental or denture problems? | | | | | | | | Guidance | | | |
| Adequate 🞏 With Supervision 🞏 Severely neglected 🞏 Gums infected 🞏  Dentures: Full set 🞏 Top dentures only 🞏 Bottom dentures only 🞏 | | | | | | | | *Dentures top/bottom, last visit to the dentist. Able/unable to chew food, any advice given* | | | |
| Additional information including any evidence received, resources available | | | | | | | | | | | |
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| 1. Bathing / Washing | | | | | | | | | | | |
| Are you able to bath or wash independently? | | | | | | | | Guidance | | | |
| Can bath/shower/strip wash unaided 🞏 Bath/shower with supervision 🞏  Bath/shower with assistance 🞏 Wash self independently 🞏  Can only wash face and hands 🞏 Ability to shave 🞏 Ability to wash hair 🞏  Ability to cut toe nails/finger nails 🞏 Total care required 🞏 | | | | | | | | *Quantify if statement washing in bath/shower*  *Bath/shower aids, rails, help required*  *1 or 2 persons, lifting/hoist required* | | | |
| Additional information, including any evidence received, resources available | | | | | | | | | | | |
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| 1. Dressing / Undressing | | | | | | | | | | | |
| Are you able to dress/undress independently? | | | | | | | | Guidance | | | |
| Able to make a choice 🞏 Independently without aids 🞏  Independently with aids 🞏 Requires supervision 🞏 Requires assistance 🞏  Unable to dress/undress self 🞏 | | | | | | | | *State if dressing aids are required, whether 1 or 2 persons to assist, other interventions* | | | |
| Additional information, including any evidence received, resources available | | | | | | | | | | | |
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| 1. Toileting | | | | | | | | | | | |
| Are you able to use the toilet/commode/ independently? | | | | | | | | Guidance | | | |
| Unaided 🞏 Self with difficulty 🞏 Self with prompting 🞏  Requires help to toilet 🞏 Unable to use toilet 🞏 | | | | | | | | *State whether bedpan, commode with wheels, commode or hoist required. Where is toilet/commode?*  *Whether 1 or 2 persons required* | | | |
| Additional information, including any evidence received, resources available | | | | | | | | | | | |
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| 1. Continence Assessment | | | | | | | | | | | |
| Elimination – **Urine**  Continent 🞏 Occasional incontinent 🞏 Incontinent 🞏  Continence aids…………………………………………………………..  Urinary catheter 🞏 Suprapubic catheter 🞏  Elimination – **Bowels**  Continent 🞏 Occasional incontinent 🞏 Incontinent 🞏 Colostomy 🞏  Continence aids used……………………………………………………………………  Usual bowel habits (frequency)…………………………………  Laxatives 🞏 Enema 🞏 Suppositories 🞏 | | | | | | | | Guidance  Urinary continence promotion programme  Catheter maintenance/  management  Bowel continence promotion programme  Bowel management | | | |
| Additional information, including any evidence received, resources available | | | | | | | | | | | |
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| 1. Mobility | | | | | | | | | | | |
| How mobile are you? | | | | | | | | | | Guidance | |
| Able to walk independently 🞏 Walks with assistance 🞏  Please specify assistance needed (1 person/sticks/frame/aids)  Able to manage stairs/steps 🞏  Please specify independently/with assistance of 1 person  Able to stand from sitting 🞏  Please specify independently/with assistance of 1 person  **Uses wheelchair**  Independently 🞏 Indoors 🞏 Outdoors 🞏  Unable to stand 🞏 Unable to walk 🞏 | | | | | | | | | | Please mention any Community Therapy input-NHS/Private and their contact details | |
| Additional information, including any evidence received, resources available | | | | | | | | | | | |
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| 1. Transfers Guidance | | | | | | | | | | | |
| Are you able to get out of a chair / bed independently? | | | | | | | | | | | |
| Able to transfer unaided 🞏 Able to transfer independently with aids 🞏  (bed rail / toilet rails / monkey pole)  Able to transfer with supervision only 🞏 Able to transfer with help of 1 or 2person 🞏  Bedbound/Chair bound 🞏 Hoist needed 🞎  Specify type of hoist that is used (eg stand aid hoist Full body hoist)………………………………..  Height……………. Sling colour / Size …………………………./…………………………… | | | | | | | | | |  | |
| Additional information, including any evidence received, resources available | | | | | | | | | | | |
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| 1. History of falls Guidance | | | | | | | | | | | |
| Number of falls in the last 6 months  Date of last fall  Equipment used to minimise falls Bed rails 🞏 Falls sensor mat 🞏  Other 🞏…………………………………………………………………………………………………………… | | | | | | | | | | Any risks of falls identified – eg  Postural hypotension, vertigo, acute confusion | |
| Additional information, including any evidence received, resources available | | | | | | | | | | | |
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| 1. Mental State and Cognition – Assessment | | | | | | | | | | Guidance | |
| Current conditions under the Mental Health Act?  Yes 🞏 No 🞏 (Date of review………………………………………..)  Any previous or current MCA assessments?  Yes 🞏 No 🞏 (Date……………..………………………………………)  Diagnosis of dementia?  Yes 🞏 No 🞏 (State :…………………………………………………….)  Is there a DOLS in place?  Yes 🞏 No 🞏 (Due date of review……….………………………)  Understanding/cognition  Good 🞏 Fair 🞏 Mild confusion 🞏 Confused 🞏  Memory  Normal 🞏 Short term loss 🞏 Long term loss 🞏 | | | | | | | | | | State if under CPN where there are safety concerns and the type of supervision required (30 minutes, 1-2-1) | |
| **Mental state and cognition – Notes**  Include any current mental health issues that potentially requires intervention – provide details of suggested de-escalation techniques | | | | | | | | | | | |
| 1. Orientation | | | | | | | | | | Guidance | |
| Orientation is normal:  All the time 🞏 Occasionally 🞏  Or  Disorientated to Time 🞏 Place 🞏 Person 🞏  Expression/past history of self- harm Yes🞏 No🞏  History of walking around with intention?  Yes 🞏 No 🞏  Distressed behaviour/history of distressed behaviour  Yes 🞏 No🞏  Please specify the behaviour:    Depressed/history of depression  Yes 🞏 No 🞏  Inappropriate behaviour( eg undressing)  Yes 🞏 No 🞏  Details:  Disinhibited behaviour  Yes 🞏 No 🞏  Details | | | | | | | | | | Support for orientation, additional supervision for self-harm, behaviour monitoring and risk reduction | |
| **Orientation – notes**  Include any current mental health issues that potentially requires intervention – provide details of suggested de-escalation techniques | | | | | | | | | | | |
| **Each question scores one point** | | | | | | | | | | | |
| 1. Age | | | | | | | | | | |  |
| 1. Time to nearest hour | | | | | | | | | | |  |
| 1. An address – for example 42 West Street – to be repeated by the resident at the end of the test | | | | | | | | | | |  |
| 1. Year | | | | | | | | | | |  |
| 1. Name of hospital, residential institution or home address, depending on where the resident is situated | | | | | | | | | | |  |
| 1. Recognition of two persons – for example doctor, nurse, home help. etc | | | | | | | | | | |  |
| 1. Date of birth | | | | | | | | | | |  |
| 1. Year First World War started | | | | | | | | | | |  |
| 1. Name of present monarch | | | | | | | | | | |  |
| 1. Count backwards from 20 to 1 | | | | | | | | | | |  |
| **Total score - A score of 6 or less suggests dementia** | | | | | | | | | | |  |
| Other relevant information | | | | | | | | | | | |
| **Please tick the care domains that will require intervention** | | | |  |  | I**ndicate the level of care required**  **High – Medium – Low** | | | | | |
| Personal care | | | |  |  | | | | | |
| Communication | | | |  |  | | | | | |
| Eating and drinking | | | |  |  | | | | | |
| What are the risks in relation to the person’s safety? | | | |  |  | | | | | |
| Eliminating | | | |  |  | | | | | |
| Challenging behaviour | | | |  |  | | | | | |
| Control of body temperature | | | |  |  | | | | | |
| Sensory deprivation (sight / hearing) | | | |  |  | | | | | |
| Mobilising | | | |  |  | | | | | |
| Interest in activities and recreation | | | |  |  | | | | | |
| Evidence of depression | | | |  |  | | | | | |
| Expressing sexuality | | | |  |  | | | | | |
| Skin (including tissue viability) | | | |  |  | | | | | |
| Breathing | | | |  |  | | | | | |
| Sleeping | | | |  |  | | | | | |
| Memory | | | |  |  | | | | | |
| Psychological needs | | | |  |  | | | | | |
| Medication | | | |  |  | | | | | |
| **If assessed in a care home**  Why does the person want to move?  Is there a history of harm to others Yes 🞏 No 🞏  How the distressed behaviour is managed/what are the outcomes/is there a risk to others? | | | | | | | | | | *Check details with staff, look at care plan and medical notes/is there a psychiatric report?*  *How identified/dates* | |

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| Summary of assessment |

**Recommendation:** Nursing 🞏 Residential Care 🞏  **Name of Unit**:

Signed:……………………………………………………………………………… Name of Assessor…………………………………………………………

Date:…………………………………………………………………………………