Exemplar of Documentation used in Northampton

Adult Inpatient Admission/Discharge Form and

Trust Core Patient Activities of Daily Living (ADL)

Initial Assessment

Ward _____

ADDRESSOGRAPH

LABEL

Type of admission

Accident and Emergency ☐ Clinic ☐

General Practitioner (GP) ☐ Other ☐

Date of admission:_____ Time: _____

Estimated date of discharge: _____

Consultant: _____

Named nurse : _____

Reason for admission:

_____

_____

Diagnosis/operation:

_____

_____

_____

Previous medical history:

_____

_____

_____

_____

_____

_____

Single assessment document Yes ☐ No ☐

Preferred Name: _____

Age: _____ Status _____

Religion: _____ Ethnic origin _____

Does the patient agree to their name/information being written on white boards in wards? Yes ☐ No ☐

Is the above address your permanent residence? Yes ☐ No ☐

Have you been resident in the UK for 12 months?. If NO, complete NGV1398 Notification of overseas visitors. Yes ☐ No ☐

Next of kin

Name _____

Relationship: _____

Address: _____

_____ Postcode _____

Telephone numbers Home _____

Work: _____ Mobile: _____

Does the patient agree to next of kin being notified of admission and condition? Yes ☐ No ☐

Notified Yes ☐ No ☐ If NO, reason:

Significant others

Name: _____

Relationship: _____

Address: _____

_____ Postcode _____

Telephone numbers Home: _____

Work: _____ Mobile: _____

Notified Yes ☐ No ☐ If NO, reason:

Name and Contact number for night time:

_____

VALUABLES Yes ☐ No ☐ Hospital policy explained ☐

House keys ☐ Glasses ☐ Hearing aid ☐

Dentures ☐ Contact lens ☐

Property details:

General office ☐ Home ☐ Retained by patient ☐

NB. Refer to disclaimer on page 2.

Medication Brought in Yes ☐ No ☐

If YES, Retained on ward ☐ Sent home ☐

Patient Orientation Checklist – Nursing Staff to Complete

All items in this checklist must be discussed with the patient on admission and on internal transfer.

	Please tick when discussed
Patient Orientation Checklist discussed with patient	
Introductions made – Introduce yourself by full name to the patient	
Name of ward - Advise the patient of the name of the ward that they have been admitted to and what sort of ward it is	
Name of ward –Either show the patient around the ward or advise where the toilet/bathroom facilities/ day rooms/visitors lounge etc. are located on the ward	
Call bell devices – Explain to the patient how the call bell device works and when to use it	
Drinks/snacks – Advise the patient how to get snacks/drinks in between meals should they want them	
Personal belongings – Advise the patient where to store personal belongings and for security reasons, not to store anything of value here. Anything of value is to be stored as per Trust policy (member of staff to advise)	
Visitor information – Advise the patient of visiting times, car parking for visitors and temporary permit provisions if appropriate.	
Patient information leaflet given	
Patient's comments (if any):	
Patient Safety information leaflet – NGV1467 given	

Sign and PRINT your name below to confirm that you have discussed this checklist with the patient.

Signature _____ **PRINT name** _____

Designation _____ **Ward** _____ **Date** _____

DISCLAIMER

I hereby indemnify the _____ NHS Trust against any loss or damage to property/monies that I do not wish to be held in safe custody on my behalf by the hospital.

Signature of patient _____

Name (block capitals) _____

Date _____

On Admission

Allergies (include medicines, latex, food, other)	State reaction experienced:

1. Do you have a reaction to latex/rubber products — Yes ☐ Go to question 2

No ☐ (no allergy) Go to question 3

2. What kind of reaction do you have:

Localised eczema on skin in contact with rubber only — Yes ☐ (Type 4)

No ☐ (no allergy)

and/or

	(Type 1)	(Type 4)
Hives	Yes ☐	No ☐
Wheezing	Yes ☐	No ☐
Difficulty breathing	Yes ☐	No ☐
Swelling of lips/tongue/throat	Yes ☐	No ☐
Collapse	Yes ☐	No ☐
Other (please describe):	Yes ☐	No ☐

3. Do you have a rash, itching, swelling or hives after contact with rubber products such as household gloves or balloons, — Yes ☐ No ☐

If YES, go back to question 2

Allergy identified, inform medical staff, anaesthetist as appropriate

No allergy ☐ Type 4 allergy ☐ Type 1 allergy ☐

Making every Contact Count – NGH Nursing Admission Questions

Smoking

1. Does the patient smoke? Yes ☐ No ☐

No – No further action
Yes – Offer a 'Time for a QUIT Chat' brief advice intervention and recommend a referral to the NHS Stop Smoking Service.

- Complete a Time for a QUIT Chat Referral form NGV1547 or via the referral form on the ICE System
- Combustibles - Sent home ☐ Locked away ☐

Date of referral _____ Signature _____

Alcohol Harm Reduction	**Scoring system**					**Score**
	0	**1**	**2**	**3**	**4**	
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	
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+	
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	

TOTAL	

Alcohol Harm Reduction continued

A score of **0-7** indicates *lower risk drinking*

A score of **8-15** indicates *increasing risk drinking* – Give the patient a copy of Patient Information Healthy Lifestyles Leaflet NGV1577.

A score of **16-20+** refer to the NGH Alcohol Liaison Nurse

Date of Referral _____ Signature _____

Social History

Do you live alone ☐ With others ☐ Who _____

Do you have dependents Yes ☐ No ☐

If yes, who is caring for them

_____

Type of accommodation and how long at this address:

House ☐ Flat ☐ Floor e.g. 1,2,3,4,5,6 _____ Lift: Yes ☐ No ☐ Bungalow ☐

Mobile home ☐ Other _____ Warden controlled accommodation ☐

Contact number: _____

Nursing home ☐ Residential home ☐ Name and address

_____

Access to home

What is the access to the property – specify how many steps, slope, etc_____

How many toilets are there in the property and where are they located?

_____

Type of heating: Central heating ☐ Electric ☐ Gas ☐ Wood/coal ☐

Where is the bathroom located (indicate floor) _____

Where do you sleep? Upstairs ☐ Downstairs ☐

What equipment do you have at home? Grab rails ☐ Where are these situated_____

Zimmer frame ☐ Rota stand ☐ Stair lift ☐ Hoist ☐

Pressure relieving mattress ☐ Pressure relieving cushion ☐

Other (please specify)

_____

Do you have dependent others or pets that will require support whilst you are in hospital?

Yes ☐ No ☐ Specify

_____

PRINT name _____ Signature _____

Designation _____ Date _____

Pre admission services

Social worker name and contact number _____

Care package	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
How many times							

Care package includes: _____

	Yes	**No**
Community/specialist nurse		
Physiotherapist		
Occupational therapist		
Health Visitor		
Psychiatric nurse		
Warden		
Life line/Vitalink/Other		
Pet system		
Keysafe		

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Age concern							
Voluntary							
Meals on wheels (hot/frozen)							
Day Hospital							
Day Centre							

Interagency Community Team _____

Other (please specify) _____

Informal care arrangements

Are there any friends/neighbours/family providing help? Yes ☐ No ☐

Please specify _____

Are they happy to continue this – Patient Yes ☐ No ☐ Carer Yes ☐ No ☐

Personal tasks Who does the following?

	Self	Others - identify		Self	Others - identify
Cooking			Cleaning		
Laundry			Ironing		
Hygiene needs			Medication		
Shopping			Finances		

Is a continuing health care assessment required? Yes ☐ No ☐

If yes, contact social work department.

Trust Core Patient Activities of Daily Living – Initial Assessment

NHS Trust applies The Roper, Logan and Tierney model of nursing which is a model of care based upon activities of daily living (ADL's). These activities are mainly used on admission as a basis to assess and compare how life has changed due to illness or injury resulting in admission to hospital and to plan appropriate nursing care following assessment.

All inpatients require these assessment tools to be completed on admission to the hospital as indicated following Activities of Daily Living Assessment.

A Trust Fall Assessment Tool – within 12 hours

B Trust Patient Handling Assessment Tool – within 12 hours

C Trust Pressure Prevention Assessment Tool – within 8 hours

D Trust Nutritional Screening Assessment Tool – within 24 hours

E Trust Pain Assessment Tool – on admission

Signature _____ Time _____ Date _____

PRINT NAME/Stamp _____

To be completed in full by admitting nurse.

Activities of Daily Living Assessments

1a Maintaining a safe environment (prompts)

a	Orientation to place	Yes ☐ No ☐	d	History of confusion	Yes ☐ No ☐
b	Orientation to time	Yes ☐ No ☐	e	Have you fallen recently	Yes ☐ No ☐
c	Orientation to ward and bed area given	Yes ☐ No ☐	f	Appears rational	Yes ☐ No ☐

Additional information:

If YES to d, e, or f, complete Trust Falls Care Plan page 11

1b Is the VTE Risk Assessment complete Yes ☐ No ☐

If Yes – commence appropriate prescribed treatment

- refer to AES core care plan NGV1459

If No - escalate to medical staff

1c Dementia and carers of patients with dementia

Has the patient a diagnosis of dementia?

Yes ☐ • Utilise Butterfly magnet • Complete Butterfly patient profile • Give the patient/carer 'Information for Carers of patients with dementia' leaflet NGV1581 • Does the carer want to be involved in the patient's care whilst in hospital? Refer to Carer's policy • Does the carer require further support? If yes, contact Carer Assessment and Support Worker (CASW)	No ☐ • Does the patient have signs of delirium or cognitive impairment? If yes, Utilise 'Outline Butterfly' magnet

2. Communication (prompts)

Blind	Yes ☐ No ☐	Partially sighted	Yes ☐ No ☐
Glasses	Yes ☐ No ☐	Contact lens	Yes ☐ No ☐
Glasses/lens with patient	Yes ☐ No ☐		

Additional information :

N.B. Are there any learning disability concerns Yes ☐ No ☐

If YES, commence Learning Disabilities Passport NGV1516

If YES, contact the Learning Disability Nurse, ext (Monday-Friday) 09.00-17.00 or on call duty nurse

Community hospitals ring _____

N.B. Are there any safeguarding/mental capacity concerns Yes ☐ No ☐

Is a Mental Capacity Assessment required? Yes ☐ No ☐

If YES, contact Safeguarding Lead, bleep (Monday-Friday) 09.00-17.00 or on call duty nurse for further advice and support.

Community hospitals ring _____

b) Hearing:

Deaf	Yes ☐ No ☐	Partially deaf	Yes ☐ No ☐
Lip reader	Yes ☐ No ☐	Sign language	Yes ☐ No ☐
Hearing aid with patient	Yes ☐ No ☐	Does hearing aid work?	Yes ☐ No ☐

If NO, record action taken :
(Consider use of Piticom Booklet) _____

Additional information:

c) Speech and Language (prompts):

Understands English	Yes ☐ No ☐	Speaks English	Yes ☐ No ☐
Translator required	Yes ☐ No ☐		

First language spoken if not English
_____
(Consider use of Piticom booklet)

Additional information :
e.g. patient aphasic or suffers from dysphasia

3. Mobility (prompts) **Complete Trust Pressure Prevention Assessment Tool, page 17**
Complete Patient Handling Assessment, page 14

Independently mobilises Yes ☐ No ☐ Assistance/supervision required Yes ☐ No ☐

Identify aids used
_____

Additional information:

4. Eating and Drinking (prompts) Complete Trust Nutritional Screening Assessment Tool, pg 25

Able to swallow Yes ☐ No ☐ Difficulty swallowing Yes ☐ No ☐

Wears dentures Yes ☐ No ☐ Dentures with patient Yes ☐ No ☐

Top set Yes ☐ No ☐ Bottom set Yes ☐ No ☐

Special diet required Yes ☐ No ☐

If YES, identify _____

Information required regarding - healthy eating Yes ☐ No ☐

- weight management Yes ☐ No ☐

If YES, refer to nutritional team

Referral date_____ Signature _____

Additional information

5. Personal hygiene and dressing (prompts) Complete Trust Oral Care Assessment Tool NGV1465

Independent Yes ☐ No ☐ Requires assistance Yes ☐ No ☐

Additional information:

6. Elimination (prompts)
a) Urine

Do you have to go to the bathroom during the night Yes ☐ No ☐

Do you suffer from frequency of passing urine Yes ☐ No ☐

Do you have any concerns regarding passing urine Yes No

Do you have a long term catheter Yes ☐ No ☐

Additional information :

All patients must have a full urinalysis taken and documented below/or attach urometer print out. Any abnormalities detected must be reported to medical staff immediately.

Date	Specific gravity	Urine PH	Leucocytes	Nitrate	Protein
Glucose	Ketones	Urobilinogen	Bilirubin	Blood erythrocytes	

b) Bowels (prompts)

Normal habit

_____

Stoma present Yes ☐ No ☐

Have you noticed any change in your bowel habits, i.e.

Blood in stools Yes ☐ No ☐

Diarrhoea Yes ☐ No ☐

Constipation Yes ☐ No ☐

Other

_____

Additional information :

If YES to any of the above, commence

Diarrhoea Trust Care Plan NGV1106

7. Breathing

Asthma Yes ☐ No ☐ Chronic obstructive airway disease Yes ☐ No ☐

Breathlessness Yes ☐ No ☐ Smoker Yes ☐ No ☐

Other long term breathing problems:

_____

Identify inhalers (if used)

_____

Additional information:

8. Sleeping (prompts)

Usual sleeping habits

_____

Takes night sedation Yes ☐ No ☐ If YES, identify medication

_____

☐ ☐

Sleep interrupted Yes No If YES, by what, e.g. bathroom

_____

If YES, what helps

_____

Additional information:

9. Expressing sexuality (prompts). Be aware of privacy and dignity requirements, cultural and religious beliefs.

Altered body image, e.g. prosthesis, hair loss, stoma Yes ☐ No ☐

Requires further discussion Yes ☐ No ☐ If YES, who

_____

Additional information:

Date of referral _____ Signature _____

10. Death and dying

Visit required from religious/spiritual personnel Yes ☐ No ☐

If YES, what arrangements have been made

_____

Additional information:

If appropriate:

- Has DNACPR status been considered Yes ☐ No ☐
- Has the patient been identified as requiring end of life care Yes ☐ No ☐

  If YES, have relatives/carers been informed/consulted Yes ☐ No ☐
- Has a chosen place of death or care been identified Yes ☐ No ☐

  If YES, where

_____

Does the patient hold any beliefs that required burial within 24 hours of death Yes ☐ No ☐

Additional information:

11. Pain – Complete Pain Assessment, page 27 or if appropriate, then Trust Pain Assessment Tool and Core Care Plan for Patients with Learning Disabilities (Adult) and Patients who have Dementia or Cognitive Impairment NGV1545.

Do you take regular analgesia Yes ☐ No ☐

Are they effective Yes ☐ No ☐

☐ ☐

Are you in pain Yes No

Is analgesia prescribed Yes ☐ No ☐

Additional information: (note alternative methods of pain relief

12. Working and playing

How do you spend your days Work _____ Hobbies/leisure _____

Do you undertake any physical activity? Yes ☐ No ☐

If YES, what are they _____

Is there anything about your stay in hospital that is of concern? Yes ☐ No ☐

If YES, what _____

Action taken _____

Name of nurse assessing:_____ PRINT name _____ Date _____