Confidential

NHS Lothian

District Nursing Risk Assessment and Person Centred Care Bundle

Short Term

Patient Details	
Risk Assessment/Care Rounding Book Number:	
Forename:	Surname:
CHI Number:	
DOB: __ __ / __ __ / __ __	Male/Female:
File Number:	
Start Date: __ __ / __ __ / __ __	

4AT

Assessment test for delirium & cognitive impairment

Addressograph

Name

DOB

CHI

NHS Lothian

Please note the 4AT is a screening assessment only, diagnosis should always be based on clinical global impression

[1] ALERTNESS

This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

	(Circle)
Normal (fully alert, but not agitated, throughout assessment)	0
Mild sleepiness for <10 seconds after waking, then normal	0
Clearly abnormal	4

[2] AMT4

Age, date of birth, place (name of hospital or building), current year

No Mistakes	0
1 Mistake	1
2 or more mistakes/ untestable	2

[3] ATTENTION

Ask the patient; "please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Achieves 7 months or more correctly	0
Starts but scores <7 months/ refuses to start	1
Untestable (cannot start because unwell, drowsy, inattentive?	2

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24 hours.

No	0
Yes	4

Score of 4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

Medical staff should be informed of scores >0 ; NB scores >3 indicate possible medical emergency

Date	Time	Score	Action Plan	Signature

GUIDANCE NOTES: The 4AT is an assessment test for the rapid initial assessment of delirium and cognitive impairment. A score of 4 or more suggests delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated solely on observation of the patient at the time of assessment. Item 4 requires information from one or more source(s), e.g. your own knowledge of the patient, other staff who know the patient (e.g. ward nurses), GP letter, case notes, or carers.

If individual risk is identified then please complete an appropriate Care Plan

District Nursing Person Centred Care Plan **Care Plan Number** _____	Addressograph Name DOB CHI

4AT and Delirium

Patient's present function/ability on admission	Risk considered but not relevant at this time ☐ Rationale:
Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Initials: _____	Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Initials: _____

Consider:

- What information does the patient and their family require?
- Is there an existing Learning Disability or diagnosis of cognitive impairment?
- Adults at risk or with incapacity/legal status/power of attorney
- Signs of infection?
- Alternative test/assessment where 4AT not appropriate or patient un-testable & still demonstrates a risk
- Escalate concerns to GP
- Any current support services
- Anticipate the increasing needs of the deteriorating patient

Date/Time	Actual/Potential problems, clinical concerns, conditions or needs	Initial

Date/Time	Patients Desired Outcome	Initial
	What we agree we are working towards? What changes we will see? What needs to happen to achieve this?	

District Nursing Person Centred Care Plan	Addressograph Name DOB CHI

Date/Time	Nursing/Patient action (Agreed action)	Initial

Consider re-assessment of risks and frequency of care rounding when condition changes

Review of planned nursing care 6 monthly or when condition changes	Review Date: __ __ / __ __ / __ __

What was achieved?

Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __
Initials: Initials

Review of planned nursing care 6 monthly or when condition changes	Review Date: __ __ / __ __ / __ __

What was achieved?

Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __
Initials: Initials

Malnutrition Universal Screening Tool Refer to full guidance prior to undertaking MUST Screening	Addressograph Name DOB CHI

Full MUST guidance is recommended when carrying out the Malnutrition Screening Tool to ensure accurate results and full guidance following outcome of result. Within the Care Plan, please document plan of care and frequency for MUST to be completed.

Previous referral to Dietitian Yes ☐ No ☐ Please state:	Current care of Dietitian Yes ☐ No ☐ Community / Other
Usual weight kg:	Height:
Patient height in metres:	Measured ☐ Estimated ☐

Date:					
Weight in Kilograms (kg)					
BMI = Weight (kg) / Height M^2					
Step One >20 = 0 18.5 -20 = 1 <18.5 = 2					
Step Two Unplanned weight loss in past 3-6 months 5% = 0 5-10% = 1 >10% = 2					
Step Three If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days = Score 2					
Step Four MUST score add steps 1 + 2 + 3					
Step Five Action Taken Low = 0 Medium = 1 ref to guidance High = 2 or more					
Sign and Initial					

Low Risk 0 **Routine clinical care**	**Medium Risk 1** **Observe**	**Score 2** **No weight loss** **High Risk**	**Score 2 or above** **With weight loss** **High Risk**
•Repeat screening 6 monthly or as clinically indicated	•Document dietary intake for 3 days •Encourage intake of high calorie options as per "High/Medium Risk Dietary Guidelines" •If improved or adequate intake and little clinical concern, repeat screening 6 monthly or as clinically indicated •If no improvement and clinical concern, repeat screening 3 monthly or as clinically indicated	•If score calculated as 2 from Step 1 (low BMI only) then Document dietary intake for 3 days •Encourage intake of high calorie options as per "High/Medium Risk Dietary Guidelines" •Repeat screening monthly or as clinically indicated	•Document dietary intake for 3 days •Encourage intake of high calorie options as per "High/Medium Risk Dietary Guidelines" •Repeat screening monthly or as clinically indicated •**Refer to dietician.** Unless detrimental or no benefit is expected from nutritional support e.g. palliative patients. Please give "Nourishing Ideas" leaflet

If individual risk is identified then please complete an appropriate Care Plan

District Nursing **Person Centred Care Plan** **Care Plan Number** _____	Addressograph Name DOB CHI

Assessment of Nutrition and Hydration

Patient's present function/ability on admission Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Initials: _____	Risk considered but not relevant at this time ☐ Rationale: Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Initials: _____

Consider:

- What information does the patient, family and carer require? Patient's preferences/likes/dislikes
- Levels of assistance required with eating and drinking
- Rationale for the frequency of weight measurement and commencement of 3 day food charts as required
- Steps required to enhance nutritional intake: introduction of nourishing drinks/snacks /relief of nausea, pain or constipation
- Wound healing concerns
- Optimal diabetic management
- Artificial feeding requirement/PEG/RIG/Jejostomy tube
- Escalate to GP/Dietician
- Any current support services
- Anticipate the increasing needs of the deteriorating patient

Date/Time	Actual/Potential problems, clinical concerns, conditions or needs	Initial

Date/Time	Patients Desired Outcome	Initial
	<u>What we agree we are working towards?</u> <u>What changes we will see?</u> <u>What needs to happen to achieve this?</u>	

District Nursing Person Centred Care Plan	Addressograph Name DOB CHI

Date/Time	Nursing/Patient action (Agreed action)	Initial

Consider re-assessment of risks and frequency of care rounding when condition changes

Review of planned nursing care 6 monthly or when condition changes	Review date: __ __ / __ __/ __ __

What was achieved?

Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __
Initials: Initials:

Review of planned nursing care 6 monthly or when condition changes	Review date: __ __ / __ __/ __ __

What was achieved?

Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __
Initials: Initials:

Adapted Waterlow

Pressure Area Risk Assessment Chart

To be completed on first home visit

Addressograph

Name

DOB

CHI

NHS Lothian

Reassess if there is a change in individual's clinical condition either improvement or deterioration								
		Date	_ _					
		Time						
		Initial						
Sex	Male	1						
	Female	2						
Age	14 - 49	1						
	50 - 64	2						
	65 - 74	3						
	75 - 80	4						
	81+	5						
Build/ Weight for Height (BMI = weight in Kg height in m^2)	Average *(BMI 20 – 24.9)*	0						
	Above average *(BMI 25 – 29.9)*	1						
	Obese *(BMI > 30)*	2						
	Below average *(BMI < 20)*	3						
Continence	Complete / Catheterised	0						
	Incontinent of urine	1						
	Incontinent of faeces	2						
	Doubly incontinent *(urine & faeces)*	3						
Skin Type (Visual Risk Area) *	Healthy	0						
	Tissue paper *(thin/fragile)*	1						
	Dry *(appears flaky)*	1						
	Oedematous *(puffy)*	1						
	Clammy *(moist to touch /pyrexial)*	1						
	Discoloured *(bruising/mottled)*	2						
	Broken *(established ulcer)*	3						
Mobility	Fully mobile	0						
	Restless / fidgety	1						
	Apathetic *(sedated/ depressed/ reluctant to move)*	2						
	Restricted *(restricted by severe pain or disease)*	3						
	Bedbound *(unconscious/unable to change position/traction)*	4						
	Chair bound *(unable to leave chair without assistance)*	5						
Nutritional * Element	Unplanned weight loss in past 3 – 6 months							
	< 5 % score	0						
	5 – 10 %	1						
	> 10%	2						
	BMI > 20	0						
	BMI 18.5 – 20	1						
	BMI < 18.5	2						
	Patient/ client acutely ill or no nutritional intake to > 5 days	2						
Special Risks * (Tissue Malnutrition)	Smoking	1						
	Anaemia = Hb < 8	2						
	Single organ failure ie cardiac, renal, respiratory	5						
	Peripheral Vascular Disease	5						
	Multiple organ failure/ terminal cachexia	8						
Special Risks* (Neurological Deficit)	Diabetes/ MS/ CVA/ Motor/ Sensory paraplegia	4-6						
Special Risks (Surgery/Trauma)*	Orthopaedic / below waist (up to 48 hours post op)	5						
	On table > 2 hours (up to 48 hours post op)	5						
	On table > 6 hours	8						
Special risk (Medication)	Cytotoxic anti inflammatory long term / high dose steroids	4						
10+= 'At Risk': 15+ = 'High Risk': 20+ = 'Very High Risk' ***More than one score can be used in some categories**		Total Score						

Adapted from tissueviabilityonline.com. Version 1 (March 2009) NHS Quality Improvement Scotland

If individual risk is identified then please complete an appropriate Care Plan

Equipment List	Addressograph Name DOB CHI	NHS Lothian

Date	Time	Waterlow Score	Equipment	Comments	Initials
__ __/ __ __/ __ __	__ __:__ __				
__ __/ __ __/ __ __	__ __:__ __				
__ __/ __ __/ __ __	__ __:__ __				
__ __/ __ __/ __ __	__ __:__ __				
__ __/ __ __/ __ __	__ __:__ __				
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__ __/ __ __/ __ __	__ __:__ __				
__ __/ __ __/ __ __	__ __:__ __				

Adapted from tissueviabilityonline.com. Version 1 (March 2009) NHS Quality Improvement Scotland

District Nursing **Person Centred Care Plan** **Care Plan Number** _____	Addressograph Name DOB CHI

Assessment of skin integrity and pressure ulcer prevention	
Patient's present function/ability on admission Date: __ __/ __ __/ __ __ Time: __ __ : __ __ Initials: _____	Risk considered but not relevant at this time ☐ Rationale: Date: __ __/ __ __/ __ __ Time: __ __ : __ __ Initials: _____

Consider:

- What information does the patient, family and carer require?
- Can the patient feel / communicate pain or discomfort?
- Changes in position and interventions are required to achieve this
- Does patient have appropriate pressure relieving equipment appropriate and suitable to their risk score?
- Is the patient concordant with advice and equipment?
- Continence status and increased skin moisture from wounds and/or sweating
- Datix Grade 2 pressure ulcers and above
- Escalate concerns to GP/ Link nurse/TVN
- Any current support services
- Anticipate the increasing needs of the deteriorating patient.

Date/Time	Actual/Potential problems, clinical concerns, conditions or needs	Initial

Date/Time	Patients Desired Outcome	Initial
	<u>What we agree we are working towards?</u> <u>What changes we will see?</u> <u>What needs to happen to achieve this?</u>	

District Nursing **Person Centred Care Plan** Assessment of skin integrity and pressure ulcer prevention	Addressograph Name DOB CHI

Date/Time	Nursing/Patient action (Agreed action)	Initial

Consider re-assessment of risks and frequency of care rounding when condition changes	
Review of planned nursing care 6 monthly or when condition changes	Review date: __ __ / __ __ / __ __
What was achieved?	
Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Initials:	Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __ Initials:
Review of planned nursing care 6 monthly or when condition changes	Review date: __ __ / __ __/ __ __
What was achieved?	
Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Initials:	Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __ Initials:

Mobility Assessment	Addressograph Name DOB CHI

Key factors to consider:

- The patient's physical abilities, cognition (4AT), communication, weight/shape/size, environment - including set up of furniture and equipment
- If it is identified that the patient requires control and restraint techniques to be used as part of personal care tasks, this must be assessed and fully documented in their restraint care plan
- This assessment should be undertaken on admission and reviewed regularly, updating when the patient's handling needs change

A risk assessment should be carried out prior to every handling intervention. Any changes should be documented in a new column and write N/A in those columns where the manoeuvre is not applicable

Mobility Dependency Codes (specify for each task and document if restraint is required)

Assistance of 1/2/3 or more staff	**AST 1/2/3**	Independent	**IND**	Supervision	**SUP**	Restraint required	**RR**
Non weight bearing	**NWB**	Partial weight bearing		**PWB**	Full weight bearing		**FWB**

Equipment Codes/Handling Aids (for all hoists / stand aids please specify type and sling size)

Glidesheet	GS	Shower chair	SC	Patslide	PAT	Zimmer/ Rollator	ZWA
Stand aid	STA	Bathing hoist	BH	Bed pan	BP	Stick(s)	St
Patient turner	Pt T	Commode	Com	Wheelchair	Wh	Crutches	Cr

Full Body lifting hoist: _____ Sling *(circle)*: S M L XL

Date:	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
Rolling in bed					
Moving up the bed					
Getting out of bed					
Getting into bed					
Sit to stand to sit					
Walking					
Toileting					
Bathing showering					
Lateral transfers					
Up from floor					
Initial					
Time	__ __ : __ __	__ __ : __ __	__ __ : __ __	__ __ : __ __	__ __ : __ __

Key handling information - e.g.

- Hoist/sling – type / size / configuration; if appropriate, complete a sling compatibility assessment
- Glidesheet – type / style used
- Furniture/equipment - specific setup
- Specific instructions to patients

	Initial / Date

Review Date:	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __	

If individual risk is identified then please complete an appropriate Care Plan

District Nursing **Person Centred Care Plan** **Care Plan Number** _____	Addressograph Name DOB CHI

Mobility	
Patient's present function/ability on admission Date: __ __/ __ __/ __ __Time: __ __ : __ __ Initials: _____	Risk considered but not relevant at this time ☐ Rationale: Date: __ __/ __ __/ __ __Time: __ __ : __ __ Initials: _____

Consider:

- What information does the patient and their family require?
- Decisions made with patient regarding goal setting for mobility
- Whether the patient is at risk of falls or has fallen as a result of poor mobility/difficulty getting out of bed/transferring
- Furniture/equipment configuration
- Referrals to OT/ Physio/Social Work
- Issues affecting mobility / balance
- Is patient concordant with mobility aids?
- Sizing of hoist slings / bariatric equipment required
- Escalate concerns to GP / Physio
- Any current support services
- Anticipate the increasing needs of the deteriorating patient

Date/Time	Actual/Potential problems, clinical concerns, conditions or needs	Initial

Date/Time	Patients Desired Outcome	Initial
	What we agree we are working towards? What changes we will see? What needs to happen to achieve this?	

District Nursing **Person Centred Care Plan** Mobility	Addressograph Name DOB CHI

Date/Time	Nursing/Patient action (Agreed action)	Initial

Consider re-assessment of risks and frequency of care rounding when condition changes

Review of planned nursing care 6 monthly or when condition changes	Review date: __ __ / __ __ / __ __

What was achieved?

Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __
Initials: Initials:

Review of planned nursing care 6 monthly or when condition changes	Review date: __ __ / __ __ / __ __

What was achieved?

Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __
Initials: Initials:

District Nursing **Person Centred Care Plan** **Care Plan Number** _____	Addressograph Name DOB CHI

Falls Risk

Patient's present function/ability on admission Date: __ __/ __ __/ __ __Time: __ __ : __ __ Initials: _____	Risk considered but not relevant at this time ☐ Rationale: Date: __ __/ __ __/ __ __Time: __ __ : __ __ Initials: _____

Consider:

- What information does the patient and their family require?
- Identify factors impacting on the risk of falls or need for bedrails, such as dementia, visual impairment or confusion levels (check 4AT accordingly)
- Is mobility associated with toileting needs?
- Review of medication.
- Lying / standing BP advised?
- Environment risk
- Presence of Long Term Condition
- Escalate concerns to GP / Follow falls pathway
- Any current support services
- Anticipate the increasing needs of the deteriorating patient

Date/Time	Actual/Potential problems, clinical concerns, conditions or needs	Initial

Date/Time	Patients Desired Outcome	Initial
	What we agree we are working towards? What changes we will see? What needs to happen to achieve this?	

District Nursing **Person Centred Care Plan** Falls Risk	*Addressograph* Name DOB CHI

Date/Time	Nursing/Patient action (Agreed action)	Initial

Consider re-assessment of risks and frequency of care rounding when condition changes	
Review of planned nursing care 6 monthly or when condition changes	Review date: __ __ / __ __/ __ __
What was achieved?	
Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Initials:	Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __ Initials:
Review of planned nursing care 6 monthly or when condition changes	Review date: __ __ / __ __/ __ __
What was achieved?	
Date: __ __ / __ __/ __ __ Time: __ __ : __ __ Initials:	Discontinued Date: __ __ / __ __/ __ __ Time:__ __ : __ __ Initials:

District Nursing Care Rounding **Risk Categories circle all that apply:** Bladder Function Bowel function Capacity Cognition Diabetes Falls Hydration Nutrition Pain Wounds / Pressure Ulcer Other:		*Addressograph* Name DOB CHI						
Date of visit								
Time of visit (24hours)								
Any concern regarding person's cognition?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
4AT last screened?	*Date(s)*							
Nutrition								
Re-assessment of nutritional risk made?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
If risk identified, has the person been given advice on maintaining good nutrition?	*Date and information given:*							
MUST last completed?	*Date(s)*							
Skin Integrity								
Has the person been identified as at risk of pressure area damage, either through MUST, Waterlow or clinical judgement?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Does the person report any problems with skin integrity?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Have you assessed the person for new, existing or deteriorating pressure area damage?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
If risk identified, has the person been given advice / equipment for pressure area prevention?	*Date and information given:*							
Waterlow last completed?	*Date(s)*							
Falls / Mobility								
1. "Have you fallen more than once in the last 12 months?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
2. "Do you have any unsteadiness on your feet or difficulty with walking or balance?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
3. As reviewer have you identified any unsteadiness or difficulties with mobility?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Is person using safety equipment reliably?	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*
If risk identified, has the person been given advice on Falls at home?	*Date and information given:*							
Mobility assessment last completed?	*Date(s)*							
Bladder/ Bowel Function								
"Are you having any new problems with your bladder?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
"Are you having any new problems with your bowels?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Are continence problems being managed?	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*
Has catheter been managed as per CAUTI guidelines and recorded in Catheter Passport?	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*
Advice given on healthy bladder/bowel function?	*Date and information given:*							
Other Needs								
"Are you in pain?" (1-10 on NEWS Chart)	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Are there any indication of clinical deterioration?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
"Is there something else I can do?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Next review due?								
Initials								

District Nursing Care Rounding **Risk Categories circle all that apply:** Bladder Function Bowel function Capacity Cognition Diabetes Falls Hydration Nutrition Pain Wounds / Pressure Ulcer Other:		*Addressograph, or* Name DOB CHI NHS Lothian						
Date of visit								
Time of visit (24hours)								
Any concern regarding person's cognition?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
4AT last screened?	*Date(s)*							
Nutrition								
Re-assessment of nutritional risk made?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
If risk identified, has the person been given advice on maintaining good nutrition?	*Date and information given:*							
MUST last completed?	*Date(s)*							
Skin Integrity								
Has the person been identified as at risk of pressure area damage, either through MUST, Waterlow or clinical judgement?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Does the person report any problems with skin integrity?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Have you assessed the person for new, existing or deteriorating pressure area damage?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
If risk identified, has the person been given advice / equipment for pressure area prevention?	*Date and information given:*							
Waterlow last completed?	*Date(s)*							
Falls / Mobility								
1. "Have you fallen more than once in the last 12 months?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
2. "Do you have any unsteadiness on your feet or difficulty with walking or balance?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
3. As reviewer have you identified any unsteadiness or difficulties with mobility?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Is person using safety equipment reliably?	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*
If risk identified, has the person been given advice on Falls at home?	*Date and information given:*							
Mobility assessment last completed?	*Date(s)*							
Bladder/ Bowel Function								
"Are you having any new problems with your bladder?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
"Are you having any new problems with your bowels?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Are continence problems being managed?	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*
Has catheter been managed as per CAUTI guidelines and recorded in Catheter Passport?	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*
Advice given on healthy bladder/bowel function?	*Date and information given:*							
Other Needs								
"Are you in pain?" (1-10 on NEWS Chart)	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Are there any indication of clinical deterioration?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
"Is there something else I can do?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Next review due?								
Initials								

District Nursing Care Rounding **Risk Categories circle all that apply:** Bladder Function Bowel function Capacity Cognition Diabetes Falls Hydration Nutrition Pain Wounds / Pressure Ulcer Other:		*Addressograph, or* Name DOB CHI NHS Lothian						
Date of visit								
Time of visit (24hours)								
Any concern regarding person's cognition?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
4AT last screened?	*Date(s)*							
Nutrition								
Re-assessment of nutritional risk made?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
If risk identified, has the person been given advice on maintaining good nutrition?	*Date and information given:*							
MUST last completed?	*Date(s)*							
Skin Integrity								
Has the person been identified as at risk of pressure area damage, either through MUST, Waterlow or clinical judgement?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Does the person report any problems with skin integrity?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Have you assessed the person for new, existing or deteriorating pressure area damage?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
If risk identified, has the person been given advice / equipment for pressure area prevention?	*Date and information given:*							
Waterlow last completed?	*Date(s)*							
Falls / Mobility								
1. "Have you fallen more than once in the last 12 months?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
2. "Do you have any unsteadiness on your feet or difficulty with walking or balance?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
3. As reviewer have you identified any unsteadiness or difficulties with mobility?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Is person using safety equipment reliably?	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*
If risk identified, has the person been given advice on Falls at home?	*Date and information given:*							
Mobility assessment last completed?	*Date(s)*							
Bladder/ Bowel Function								
"Are you having any new problems with your bladder?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
"Are you having any new problems with your bowels?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Are continence problems being managed?	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*
Has catheter been managed as per CAUTI guidelines and recorded in Catheter Passport?	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*	*Y N NA*
Advice given on healthy bladder/bowel function?	*Date and information given:*							
Other Needs								
"Are you in pain?" (1-10 on NEWS Chart)	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Are there any indication of clinical deterioration?	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
"Is there something else I can do?"	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*	*Y N*
Next review due?								
Initials								

Other Risk Assessment Tools To be used when variance identified	*Addressograph, or* Name DOB CHI NHS Lothian

Assessment Tool	Date Initiated	Comments
Bowel Assessment Form	__/__/__	
Bowel Chart	__/__/__	
Catheter Passport	__/__/__	
CAUTI bundle	__/__/__	
CAUTI checklist record	__/__/__	
Doloplus 2 Pain Assessment Tool	__/__/__	
Excoriation Recording Chart	__/__/__	
Formal Wound Assessment	__/__/__	
Frequency Volume Chart	__/__/__	
Multi-factorial Falls and Bone Health Assessment	__/__/__	
Pressure Ulcer recording chart	__/__/__	
Re-Assessment of Adults with Urinary Dysfunction	__/__/__	
Repositioning and Skin Inspection Chart	__/__/__	
SIGN 106 Initial Pain Assessment and Monitoring Chart	__/__/__	
Scottish Adaptation of the EAUAP Pressure Ulcer Classification Tool	__/__/__	
Scottish Excoriation and Moisture Related Skin Damage Tool	__/__/__	
Three Day Food and Fluid Chart	__/__/__	

Other Information – All documents are available via the Intranet
Adult Continence Protocols Manual
Advice for a Healthy Bladder
Advice for a Healthy Bowel
High/Medium Risk Dietary Guidelines
MUST (Malnutrition Universal Screening Tool) Guidelines
Nourishing Ideas Leaflet
Preventing Pressure Ulcers Patient Carer Leaflet Final 20 Feb 2014
Up and About Patient Booklet

Referrals

Referred To	Date	Comments
	__/__/__	
	__/__/__	
	__/__/__	

GUIDANCE FOR COMPLETION OF CARE ROUNDING TOOL	
Care Rounding should be completed weekly. Where care is delivered less often, completed on each visit. If deterioration noted, Care Rounding should be completed more frequently based on clinical judgement. If the patient declines to accept care or advice record in continuation booklet and reassess at next visit. Consider referral to GP. Care Rounding should be completed by circling the appropriate response.	
Any Concern regarding person's cognition?	All patients over the age of 65 or as clinically indicated, should have a 4AT score completed as a baseline assessment for delirium. The 4AT should be completed 6 monthly or more frequently if condition deteriorates.
If risk identified, has the person been given advice on maintaining good nutrition?	Advice can be verbal or written, please document the type of advice given and the date.
MUST last completed?	MUST should be completed 6 monthly for all patients or more frequently if condition deteriorates. Follow the guidance available on the tool.
Has the person been identified as at risk for pressure area damage, either through MUST, Waterlow or clinical judgement?	Assess patients risk including any new, existing or deteriorating pressure area damage. If the person requires additional pressure redistribution equipment ensure this is available and document on the equipment list.
Does the person report any problems with skin integrity?	
Have you assessed the person for new, existing or deteriorating pressure area damage?	
If risk identified, has the person been given advice / equipment for pressure area prevention?	Advice can be verbal or written, please document the type of advice given and the date.
Waterlow last completed?	Waterlow should be completed 6 monthly for all patients or more frequently if condition deteriorates.
1. Have you fallen more than once in the last 12 months?	<u>Level 1 Assessment</u> Ask the 3 falls questions. If one or more of the falls questions return a positive answer, then refer the patient for a level two assessment. <u>Level 2 Assessment</u> A Multi-factorial Falls and Bone Health Assessment should be completed or referred onwards, as indicated on the falls pathway for your area. This is available on the District Nursing Intranet Site.
2. Do you have any unsteadiness on your feet or difficulty with walking or balance?	
3. As reviewer have you identified any unsteadiness or difficulties?	
If risk identified, has the person been given advice on Falls at home?	Advice can be verbal or written, please document the type of advice given and the date.
Is person using safety equipment reliably?	Complete as appropriate and record in continuation notes if patient is not using safety equipment reliably. This includes CAS alarm, zimmer, stick.
Mobility assessment last completed?	Mobility Assessment should be completed 6 monthly for all patients or more frequently if condition deteriorates.
Are you having any new problems with your bladder?	If yes refer to the Adult Policies and complete the Urinary Dysfunction Assessment Tool / Bowel Assessment.
Are you having any new problems with your bowels?	
Are continence problems being managed?	If No please refer to Adult Continence Policy
Has catheter been managed as per CAUTI guidelines and recorded in Catheter Passport?	Complete as appropriate
Advice given on healthy bladder and bowel function?	Advice can be verbal or written, please document the type of advice given and the date.
Are you in pain?	If yes please complete "1-10 on NEWS chart, Sign 106 Pain Assessment Tool, Doloplus 2" or Consider referral to GP
Is there any clinical indication of deterioration?	Query Infection: Check Temperature, pulse, respiratory rate and re-assess 4AT
Is there something else I can do?	Consider emotional and psychological well being.