



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	>

Addressograph

NHS

Name DOB

Assessment test for delirium & cognitive impairment

CHI

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

0 No Mistakes

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

4 Yes

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

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

Name

Addressograph

Lothian

DOB

Care Plan Number	CHI		
4AT and Delirium			
Patient's present function/ability on	Risk considered but not relevant at this time		
<u>admission</u>	Rationale:		
Date: / / Time: : :	Date: / / Time: : :		
Initials:	Initials:		
Consider:			
What information does the patient and their	· ·		
Is there an existing Learning Disability or diAdults at risk or with incapacity/legal status.			
Adults at risk or with incapacity/legal statusSigns of infection?	power of attorney		
 Alternative test/assessment where 4AT not 	appropriate or patient un-testable & still		
demonstrates a risk			
Escalate concerns to GP			
Any current support servicesAnticipate the increasing needs of the determinant	riorating nationt		
	inical concerns, conditions or needs Initial		
	,		
Date/Time Patients D	Desired Outcome Initial		
What we agree we are working			
What changes we will see?			
What changes we will see:			
What was do to begin on to calci	and this O		
What needs to happen to achie	eve mis?		
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Name

Addressograph

NHS

DOB

Date/Time	Nursing/Patient action (Agreed action)	Initial
Consider re-	assessment of risks and frequency of care rounding when	condition changes
Review of plant	anned nursing care 6 monthly or when condition changes	Review Date:
What was ac		//
Wilat was at	illevea :	
Date: / _ Initials:	/ Time: : Discontinued Date: // Initials	Time: : :
Review of plant	anned nursing care 6 monthly or when condition changes	Review Date:
What was ac	hieved?	//
Date: / _ Initials:	/ Time:: Discontinued Date:/// Initials	Time: : :

	versal Screening T nce prior to underta		Name DOB	Addressogra	aph	NHS
Corocining			CHI			
accurate results ar	ce is recommended nd full guidance follo care and frequency	owing outcon	ng out the Mane of result. V	Vithin the Ca		
Previous referral to	Dietitian Yes	No 🗌	Current care Community		Yes 🗌 🛚 1	No 🗌
Usual weight kg:			Height:			
Patient height in	metres:		Measured	Estima	ted \square	
Date:			Measurea			
Weight in Kilogram	ne (ka)					
BMI = Weight (kg)	ν Ο,					
Step One	7 i loight ivi					
>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% = 1						
Step Three						
If patient is acutely	ill and there has					
been or is likely to						
intake for >5 days	= Score 2					
Step Four						
MUST score	0					
add steps 1 + 2 + 3 Step Five	3					
Action Taken						
Low = 0						
Medium = 1 ref to	guidance					
High = 2 or more						
	Sign and Initial					
Low Risk 0	Medium Risk 1	Score 2		Score 2 o		
Routine clinical	Observe	No weight lo	oss	With weig		
care •Repeat screening	 Document dietary intake for 3 days 	High Risk	ulated as 2 from	High Risk	dietary intake f	or 3 days
6 monthly or as	•Encourage intake	Step 1 (low BI			intake of high	
clinically indicated	of high calorie		tary intake for 3	options as p	er "High/Mediu	
	options as per "High/Medium Risk	days	otalia of bigh	Dietary Gui		
	Dietary Guidelines"	 Encourage in calorie options 		oRepeat sc	reening monthly licated	or as
	 If improved or 	"High/Medium		•Refer to d		
	adequate intake and little clinical concern,	Guidelines"				
	repeat screening 6	as clinically in	ening monthly or dicated		imental or no be om nutritional s	
	monthly or as	ao omnoany m	aioatoa	palliative pa		apport c.g.
	clinically indicated				"Nourishing Ide	eas" leaflet
	 If no improvement and clinical concern, 					
	repeat screening 3					
	monthly or as					
If indiv	clinically indicated vidual risk is identifie	ed then pleas	se complete a	an annronria	te Care Plan	

Name

Addressograph

NHS

Care Plan Number _____

DOB CHI

Assessment of Nutrition and Hydration					
Patient's present function/ability on admission	Risk considered but not relevant at this time Rationale:				
Date: / Time: : :	Date: / / Time: : :				
Initials:	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
	What we agree we are working towards?	
	What changes we will see?	
	What pands to happen to achieve this?	
	What needs to happen to achieve this?	

Name

DOB



Addressograph

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Date/Time	Nursing/Patient action (Agreed action)	Initial
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_	anned nursing care 6 monthly or when condition changes	Review date: //
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Date: / Initials:	/ Time:: : Discontinued Date:/ / Initials:	_ Time: : :
		Review date:
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Date:/ _ Initials:	/ Time: : Discontinued Date: // Initials:	_ Time: : :

Adapted Waterlow Name			Address	ograph		NHS
Pressure Area Risk Assessment Chart DOB					Lothian	
To be completed of	on first home visit	CHI				
-		Date				
improvement or deterior		······	Time			
	ration		Initial			
Sex	Male		1			
	Female	Female				
Age	14 - 49		1			
J	50 - 64		2			
	65 - 74		3			
	75 - 80		4			
	81+		5			
Build/ Weight for	Average (BMI 20 – 24.9)		0			
Height	Above average (BMI 25 – 29.9)		1			
(BMI = weight in Kg	Obese (BMI > 30)		2			
height in m 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	Healthy		0			
(Visual Risk Area) *	Tissue paper (thin/fragile)		1			
(1100001100010000)	Dry (appears flaky)		1			
	Oedematous (puffy)		1			
	Clammy (moist to touch /pyrexial)		1			
	Discoloured (bruising/mottled)		2			
	Broken (established ulcer)		3			
	Fully mobile		0			
Mobility	Restless / fidgety		1			
	Apathetic (sedated/ depressed/ reluc	tant to move)	2			
	Restricted (restricted by severe pain		3			
	Bedbound (unconscious/unable to ch					
	position/traction)		4			
	Chair bound (unable to leave chair w	/ithout				
	assistance)		5			
Nutritional *	Unplanned weight loss in past 3 – 6 r	nonthe		<u> </u>		II.
Element	< 5 % score	HOHUIS	0			
Lienient	5 – 10 %		1			
	> 10%		2			
	BMI > 20		0			
	BMI 18.5 – 20		1 1			
	BMI < 18.5		2			
	Patient/ client acutely ill or no nutrition	nal intake to				
	> 5 days	iai iiitako to	2			
Special Risks *	Smoking		1			
(Tissue Malnutrition)	Anaemia = Hb < 8		2			
(Tioodo Mainathtion)	Single organ failure ie cardiac, renal,	respiratory	5			
	Peripheral Vascular Disease	Toophatory	5			
	Multiple organ failure/ terminal cache	xia	8			
Special Risks*	Diabetes/ MS/ CVA/ Motor/ Sensory					
(Neurological Deficit)	Diabetee, me, evry meter, correctly	odiapiogia	4-6			
	Orthopoedia / balaw waist (up to 49 h	oure post on	5			
Special Risks (Surgery/Trauma)*	Orthopaedic / below waist (up to 48 h On table > 2 hours (up to 48 hours p		5			
(Surgery/Trauma)	On table > 6 hours	οσι ορη	8			
Special risk	Cytotoxic anti inflammatory long term	/ high doco				
(Medication)	steroids	, mgn dose	4			
10+= 'At Risk': 15+ = 'High Risk': 20+ = 'Very High Risk' Total Score						
*More than one score can be used in some categories						
Adapted from tissueviabilityonline.com. Version 1 (March 2009) NHS Quality Imp				romant Castle and		
If in	dividual risk is identified then pleas	e complete ar	appropi	riate Care P	lan	

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	Addressograph Name	NHS
Equipment List	DOB	
	СНІ	

Date	Time	Waterlow Score	Equipment	Comments	Initials
//	:				
//	:				
//	:				
//	:				
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Adapted from tissueviabilityonline.com. Version 1 (March 2009) NHS Quality Improvement Scotland

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Name DOB Addressograph

NHS

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Care Plan Number _____

CHI

Assessment of skin integrit	y and pressure ulcer prevention

Patient's present function/ability on admission	Risk considered but not relevant at this time Rationale:			
Date:/ Time:::	Date:/ Time: : :			
Initials:	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
	What we agree we are working towards?	
	What changes we will see?	
	What needs to happen to achieve this?	

Name

Addressograph

Assessment of skin integrity and pressure ulcer prevention

DOB

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D. (/Ti	Name of Definition (Association)	1.20.1
Date/Time	Nursing/Patient action (Agreed action)	Initial
Consider re-	assessment of risks and frequency of care rounding when	
Review of pl	anned nursing care 6 monthly or when condition changes	Review date://
What was ac	chieved?	
Date: /	/ Time: : Discontinued Date: / /	Time: : :
Initials:		
Review of pl	anned nursing care 6 monthly or when condition changes	Review date:
What was ac	hieved?	
Wilat was at	micved:	
Doto: /		
Initials:	/ Time: : Discontinued Date:/ Initials:	Time: : :

Mobility Assessment				D	ame OB HI	A	ddresso	ogra	oh),	JHS othian
 If it is ide personal This ass patient's A risk assess 	ent's ph g set up entified f l care ta essmer handlir sment s	nysical abilities of furniture a that the patienasks, this musent should be ung needs charshould be carr	s, cognition (4 nd equipment nt requires count to be assessed indertaken on nge ied out prior to divite N/A in the second out prior to divite N/A in the second in the sec	ntrol a d and d admis	nd res fully do ssion a y hanc	train ocur and dling	nt techn mented reviewe g interve	iques in the d reg	s to be u eir restra gularly, u . Any cl	sed as lint care lpdating hanges	part of plan when should	f the d be
			pecify for eacl	h task	and d	ocu	ment if ı	restra	aint is re			ı
Assistance o or more staff		AST 1/2/3	Independent	: IN	D	Su	pervisio	n	SUP	Restra require		RR
Non weight b		NWB	Partial weigh	nt bea	ring	PW	/B		Full wei			FWB
Equipment	Codes		ds (for all hoi			aid	s please	e spe				size)
Glidesheet	GS	Shower chair		Pats			PAT		mer/ Ro	llator	ZW	A
Stand aid	STA	Bathing hoist	t BH	Bed	pan		BP	Stic	k(s)		St	
Patient turner	Pt T	Commode	Com		elchair		Wh	Cru	tches	T .	Cr	
Full Body lifti	ng hois	st:		Sling	(circle):		S		M	<u>L</u>		XL
Date:		//_	/			/	_/		_//_	-	_/_	_/
Rolling in bed	d											
Moving up th	e bed											
Getting out o	f bed											
Getting into b	oed											
Sit to stand to	o sit											
Walking												
Toileting												
Bathing showering												
Lateral trans	fers											
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		///	/	/	/	/	_/		.//_			

LOT1213

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Pers	District Nursing on Centred Care Plan	Addressograph Name	NHS
		DOB	Lothian
Care	e Plan Number	СНІ	
	N	lobility	
Patient's pres	ent function/ability on admission	Risk considered but not relevant at th Rationale:	is time 🗌
Date: / _	/ Time: : :	Date://Time:: _	
Initials:		Initials:	
Consider:			
	rmation does the patient and their	•	
	s made with patient regarding goal	,	, gotting out
Whether to the of bed/training to the or the original to		fallen as a result of poor mobility/difficulty	, getting out
	equipment configuration		
	to OT/ Physio/Social Work		
	fecting mobility / balance		
	concordant with mobility aids?		
Sizing of	hoist slings / bariatric equipment r	equired	
	concerns to GP / Physio		
	ent support services		
	the increasing needs of the dete	.	
Date/Time	Actual/Potential problems, cli	nical concerns, conditions or needs	Initial
Date/Time		Desired Outcome	Initial
	What we agree we are working	g towards?	
	What shanges we will see?		
	What changes we will see?		
	What needs to happen to achie	eve this?	
]
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Name

NHS

Addressograph

DOB

Mobility

D / /T:		1 10 1
Date/Time	Nursing/Patient action (Agreed action)	Initial
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	assessment of risks and frequency of care rounding when	Review date:
Review of plant	anned nursing care 6 monthly or when condition changes	/ /
What was ac	chieved?	
Date: / _ Initials:	/ Time:: Discontinued Date:// Initials:	Time: : :
Review of pla	anned nursing care 6 monthly or when condition changes	Review date: / /
What was ac	chieved?	
Date: /	/ Time: : Discontinued Date:/ /	Time: :
Initials:	Initials:	-

		A al alva a a a ava in la	
District Nur Person Centred	_	Addressograph Name	NHS
. 0.00 0000	ou. or run	DOB	Lothian
Care Plan Numb	per	СНІ	
	F	alls Risk	
Patient's present function admission		Risk considered but not relevant at th Rationale:	is time 🗌
Date://Ti	me: : :	Date://Time: : _	
Initials:		Initials:	
Consider:What information doe			
	cting on the risk of the sion levels (check 4 d with toileting need not be advised? From Condition of GP / Follow falls provides	falls or need for bedrails, such as demential AT accordingly) ds? pathway	ı, visual
		inical concerns, conditions or needs	Initial
Date/Time Patients De	sired Outcome		Initial
	ree we are workii	ng towards?	miliai
	jes we will see?		
viriat chang	ges we will see :		
What needs	s to happen to ach	nieve this?	

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Name

NHS Lothian

Addressograph

DOB

Falls Risk

			·
Date/Time	Nursing/P	atient action (Agreed action)	Initial
Consider re-	assessment of risks and	d frequency of care rounding whe	n condition changes
		nonthly or when condition changes	Poviow data:
What was ac	 hieved?		
Date: / _	/ Time: : _		:::
Initials:		Initials:	Review date:
Review of pl	anned nursing care 6 m	onthly or when condition changes	//
What was ac	hieved?		
Date: / _ Initials:	/ Time: :	Discontinued Date: // _ Initials:	:::

			A	ddressa	ograph			
Risk Categories circle all that apply: Bladder		Name					1	NHS
Function Bowel function Capacity Cognition Diabetes Falls Hydration Nutrition Pain Wound	c /	DOB						Lothian
Pressure Ulcer	3 <i>1</i>	CHI						
Other:		Cili						
Date of visit								
Time of visit (24hours)								
Any concern regarding person's cognition?	ΥN	ΥN	YN	ΥN	ΥN	ΥN	ΥN	ΥN
4AT last screened?	Date(s							
Nutrition	(/						
Re-assessment of nutritional risk made?	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
If risk identified, has the person been given advice on maintaining good nutrition?	Date a	nd infor	mation	given:				
MUST last completed?	Date(s)						
Skin Integrity		/						
Has the person been identified as at risk of								
pressure area damage, either through MUST,	YN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
Waterlow or clinical judgement?								
Does the person report any problems with skin	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
integrity?	1 11	7 7 7	7 7 7	1 11	1 11	1 11	1 11	1 11
Have you assessed the person for new,								
existing or deteriorating pressure area	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
damage?								
If risk identified, has the person been given	Date a	nd infor	mation	given:				
advice / equipment for pressure area								
prevention?								
Waterlow last completed?	Date(s)						
Falls / Mobility								
1. "Have you fallen more than once in the last 12 months?"	ΥN	ΥN	ΥN	ΥN	ΥN	YN	ΥN	ΥN
2. "Do you have any unsteadiness on your feet	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
or difficulty with walking or balance?"	YN	ΥN	YN	YN	YN	YN	ΥN	YN
or difficulty with walking or balance?" 3. As reviewer have you identified any	YN YN	Y N Y N	YN YN	Y N Y N	Y N Y N	Y N Y N	YN YN	YN YN
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility?	YN	YN	YN	YN	YN	YN	YN	YN
or difficulty with walking or balance?" 3. As reviewer have you identified any	YN YN	Y N Y N	Y N Y N	Y N Y N	Y N Y N	Y N Y N	YN YN	YN YN
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility? Is person using safety equipment reliably?	Y N Y N NA	Y N Y N NA	Y N Y N NA	Y N Y N NA	YN	YN	YN	YN
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility?	Y N Y N NA	Y N Y N	Y N Y N NA	Y N Y N NA	Y N Y N	Y N Y N	YN YN	YN YN
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility? Is person using safety equipment reliably? If risk identified, has the person been given advice on Falls at home?	Y N Y N NA	Y N Y N NA nd infor	Y N Y N NA	Y N Y N NA	Y N Y N	Y N Y N	YN YN	YN YN
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility? Is person using safety equipment reliably? If risk identified, has the person been given	Y N Y N NA Date a	Y N Y N NA nd infor	Y N Y N NA	Y N Y N NA	Y N Y N	Y N Y N	YN YN	YN YN
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility? Is person using safety equipment reliably? If risk identified, has the person been given advice on Falls at home? Mobility assessment last completed?	Y N Y N NA Date a	Y N Y N NA nd infor	Y N Y N NA	Y N Y N NA	Y N Y N	Y N Y N	YN YN	YN YN
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility? Is person using safety equipment reliably? If risk identified, has the person been given advice on Falls at home? Mobility assessment last completed? Bladder/ Bowel Function "Are you having any new problems with your	Y N Y N NA Date a Date(s	Y N Y N NA nd infor	Y N Y N NA mation	Y N Y N NA given:	YN YN NA	Y N Y N NA	YN YN NA	YN YN NA YN
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility? Is person using safety equipment reliably? If risk identified, has the person been given advice on Falls at home? Mobility assessment last completed? Bladder/ Bowel Function "Are you having any new problems with your bladder?"	Y N Y N NA Date a	Y N Y N NA nd infor	Y N Y N NA mation	Y N Y N NA given:	Y N Y N NA	Y N Y N NA	Y N Y N NA	Y N Y N NA
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility? Is person using safety equipment reliably? If risk identified, has the person been given advice on Falls at home? Mobility assessment last completed? Bladder/ Bowel Function "Are you having any new problems with your bladder?" "Are you having any new problems with your bowels?"	Y N Y N NA Date a Date(s	Y N Y N NA nd infor	Y N Y N NA mation	Y N Y N NA given:	YN YN NA	Y N Y N NA	YN YN NA	YN YN NA YN
or difficulty with walking or balance?" 3. As reviewer have you identified any unsteadiness or difficulties with mobility? Is person using safety equipment reliably? If risk identified, has the person been given advice on Falls at home? Mobility assessment last completed? Bladder/ Bowel Function "Are you having any new problems with your bladder?" "Are you having any new problems with your	Y N Y N NA Date a Date(s	Y N Y N NA nd infor	Y N Y N NA mation Y N Y N	Y N Y N NA given: Y N Y N	YN YN NA YN	YN YN NA YN	YN YN NA YN YN	YN YN NA YN
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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:	s/	Name DOB CHI	Addre	essograp	oh, or			NHS
Date of visit								
Time of visit (24hours)								
Any concern regarding person's cognition?	YN	YN	YN	YN	YN	YN	ΥN	ΥN
4AT last screened?	Date(s)						
Nutrition	\	VAL	\/ N/	VAN	VAN	\	\)
Re-assessment of nutritional risk made?	YN	YN	YN	YN	ΥN	ΥN	ΥN	YN
If risk identified, has the person been given advice on maintaining good nutrition?	Date a	nd infor	mauon	giveri.				
MUST last completed?	Date(s)						
Skin Integrity	Date(3	<i>)</i>						
Has the person been identified as at risk of								
pressure area damage, either through MUST,	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
Waterlow or clinical judgement?								
Does the person report any problems with skin	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
integrity?	1 11	7 / 1	7 / 1	1 IV	1 IV	1 IV	7 10	1 IV
Have you assessed the person for new,								
existing or deteriorating pressure area	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
damage?								
If risk identified, has the person been given advice / equipment for pressure area	Date a	nd infor	mation	given:				
prevention?								
Waterlow last completed?	Date(s)						
Falls / Mobility 1. "Have you fallen more than once in the last 12 months?"	YN	YN	ΥN	ΥN	ΥN	ΥN	ΥN	YN
2. "Do you have any unsteadiness on your feet or difficulty with walking or balance?"	YN	YN	ΥN	YN	YN	YN	ΥN	YN
3. As reviewer have you identified any	ΥN	YN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
unsteadiness or difficulties with mobility?								
Is person using safety equipment reliably?	YN	YN	YN	YN	YN	YN	ΥN	YN
If vials identified has the passes become vives	NA	NA	NA	NA	NA	NA	NA	NA
If risk identified, has the person been given advice on Falls at home?	Date a	nd infor	mation	given:				
Mobility assessment last completed?	Date(s)						
Bladder/ Bowel Function	Date(s	/						
"Are you having any new problems with your bladder?"	YN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
"Are you having any new problems with your bowels?"	YN	YN	ΥN	YN	YN	YN	YN	YN
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	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
guidelines and recorded in Catheter Passport?	NA	NA	NA	NA	NA	NA	NA	NA
Advice given on healthy bladder/bowel function?	Date a	nd infor	mation	given:				
Other Needs	\/ A1	\	\/ A/	\/ A/	\/ A1	\/ A1	V A1)
"Are you in pain?" (1-10 on NEWS Chart)	YN	YN	YN	YN	YN	YN	YN	YN
Are there any indication of clinical deterioration?	Y N Y N	Y N Y N	Y N Y N	Y N Y N	Y N Y N	Y N Y N	Y N Y N	Y N Y N
"Is there something else I can do?" Next review due?	1 IV	1 IV	r IV	1 IV				
Initials	1							
minuo	<u> </u>							

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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:	s /	Name DOB CHI	Addre	ssograph	ı, or			NHS
Date of visit								
Time of visit (24hours)								
Any concern regarding person's cognition?	YN	YN	ΥN	YN	YN	ΥN	ΥN	ΥN
4AT last screened?	Date(s))						
Nutrition								
Re-assessment of nutritional risk made?	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
If risk identified, has the person been given	Date a	and info	rmation	given:				
advice on maintaining good nutrition?	5	`						
MUST last completed?	Date(s)						
Skin Integrity	ı	I						
Has the person been identified as at risk of	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
pressure area damage, either through MUST, Waterlow or clinical judgement?	1 14	1 14	7 7 4	1 14	7 7 7	1 11	1 14	1 14
Does the person report any problems with skin								
integrity?	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
Have you assessed the person for new,								
existing or deteriorating pressure area	YN	YN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
damage?	, , ,	, , ,	7 7 4	7 7 4	7 7 4	7 7 4	7 7 4	7 7 4
If risk identified, has the person been given	Date a	nd infor	mation	aiven:				
advice / equipment for pressure area	Date a	na mioi	mation	giveri.				
prevention?								
Waterlow last completed?	Date(s)						
Falls / Mobility		/						
1. "Have you fallen more than once in the last 12 months?"	YN	YN	YN	ΥN	YN	YN	YN	ΥN
2. "Do you have any unsteadiness on your feet or difficulty with walking or balance?"	YN	ΥN	ΥN	ΥN	ΥN	ΥN	YN	YN
3. As reviewer have you identified any	YN	ΥN	ΥN	ΥN	YN	ΥN	ΥN	ΥN
unsteadiness or difficulties with mobility?								
Is person using safety equipment reliably?	ΥN	ΥN	YN	ΥN	YN	ΥN	ΥN	ΥN
	NA	NA	NA	NA	NA	NA	NA	NA
If risk identified, has the person been given	Date a	nd infor	mation	gıven:				
advice on Falls at home?	Dete	1						
Mobility assessment last completed? Bladder/ Bowel Function	Date(s)						
"Are you having any new problems with your								
bladder?"	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
"Are you having any new problems with your								
bowels?"	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN	ΥN
Are continence problems being managed?	NA	NA	NA	NA	NA	NA	NA	NA
Has catheter been managed as per CAUTI	YN	YN	YN	YN	YN	YN	YN	YN
guidelines and recorded in Catheter Passport?	NA	NA	NA	NA	NA	NA	NA	NA
		nd infor					. 47 1	
Advice given on healthy bladder/bowel function?	_ 3.5 0			J O				
Other Needs								
"Are you in pain?" (1-10 on NEWS Chart)	YN	YN	YN	YN	YN	YN	Y N	YN
Are there any indication of clinical deterioration?	YN	YN	YN	YN	YN	YN	YN	YN
"Is there something else I can do?"	YN	Y N	Y N	YN	Y N	Y N	YN	ΥN
Next review due?								
Initials								
								- <u>-</u>

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Other Risk Assessment Tools

To be used when variance identified

Name

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NHS

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	CHI	
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 av Adult Continence Protocols Manual Advice for a Healthy Bladder Advice for a Healthy Bowel High/Medium Risk Dietary Guidelines MUST (Malnutrition Universal Screening Too Nourishing Ideas Leaflet Preventing Pressure Ulcers Patient Carer Lea Up and About Patient Booklet Referrals	I) Guidelines	
Referred To	Date	Comments
	//	
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GUIDANCE FOR COMPLETION OF	CARE ROUNDING TOOL
	weekly. Where care is delivered less often, completed on each visit. If
	hould be completed more frequently based on clinical judgement. If the
	vice 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	All patients over the age of 65 or as clinically indicated, should have a
cognition?	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	Advice can be verbal or written, please document the type of advice
given advice on maintaining good	given and the date.
nutrition?	
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	Assess patients risk including any new, existing or deteriorating pressure
risk for pressure area damage, either	area damage.
through MUST, Waterlow or clinical	If the person requires additional pressure redistribution equipment
judgement?	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	Advice can be verbal or written, please document the type of advice
given advice / equipment for	given and the date.
pressure area prevention?	
Waterlow last completed?	Waterlow should be completed 6 monthly for all patients or more
A III	frequently if condition deteriorates.
1. Have you fallen more than once in	Level 1 Assessment
the last 12 months?	Ask the 3 falls questions. If one or more of the falls questions return a
2. Do you have any unsteadiness on	positive answer, then refer the patient for a level two assessment. Level 2 Assessment
your feet or difficulty with walking or balance?	A Multi-factorial Falls and Bone Health Assessment should be completed
3. As reviewer have you identified	or referred onwards, as indicated on the falls pathway for your area.
any unsteadiness or difficulties?	This is available on the District Nursing Intranet Site.
If risk identified, has the person been	Advice can be verbal or written, please document the type of advice
given advice on Falls at home?	given and the date.
Is person using safety equipment	Complete as appropriate and record in continuation notes if patient is not
reliably?	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	If yes refer to the Adult Policies and complete the Urinary Dysfunction
with your bladder?	Assessment Tool / Bowel Assessment.
Are you having any new problems	
with your bowels?	
	If No places refer to Adult Continues Delices
Are continence problems being managed?	If No please refer to Adult Continence Policy
	Complete as appropriate
Has catheter been managed as per	Complete as appropriate
CAUTI guidelines and recorded in	
Catheter Passport? Advice given on healthy bladder and	Advice can be verbal or written, please document the type of advice
bowel function?	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	Query Infection: Check Temperature, pulse, respiratory rate and re-
deterioration?	assess 4AT
Is there something else I can do?	Consider emotional and psychological well being.

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