ALL ASSESSMENTS MUST BE COMPLETED WITHIN 4 HOURS OF ADMISSION AND AS SPECIFIED BELOW. DOCUMENT ALL ACTION IN CONTEMPORANEOUS NOTES.

Infection, Prevention and Control
Complete on admission
Implement appropriate action and document in casenotes

Cannula Record/site assessment
Complete record at each insertion/removal of cannula.
Evaluate cannula site at least daily and as directed on Page 3 and document in care plan.

Waterlow Pressure Ulcer Risk Assessment
Reassess when there is a change in condition or situation (transfer of ward) and/or weekly.

‘Malnutrition Universal Screening Tool’ (‘MUST’)
Reassess or as determined by Dietitian and complete on discharge and/or weekly.

Falls Assessment
Reassess when there is a change in condition or situation (transfer of ward).

Patient Moving and Handling
Reassess weekly and when there is a change in condition or situation (transfer of ward).

Continence Assessment
Complete ‘Continence Assessment’ within 72 hours of admission if trigger question on initial assessment identifies incontinence as a problem or if incontinence is identified as a new problem during in-patient stay

Alcohol Screening
Complete on admission

Safety sides
Reassess when there is a change in condition or situation (transfer of ward).

Does this patient smoke?  □ Yes  □ No
If ‘Yes’:
• Notify patient of Trusts ‘Smoke Free’ Policy
□ ‘Smoke Free Assessment’ completed

On Admission - Date: __________________________
Height: ............. cm estimated/measured*
Weight: ............. kg
BMI: ............. kg/m²

Use this information for all initial assessments
Designation & Name: __________________________ Signature: __________________________
This form must be completed in conjunction with other discharge/transfer documentation.

Screened for MRSA Date: ___________________________ Result: ☐ Positive ☐ Negative
If result ‘Positive’, please complete the ‘Infection Control Source Isolation Care Sheet’.

Consultant: ____________________________________________ Transferring facility: ☐ Hospital ☐ Ward
GP: ________________________________________________ ☐ Care home ☐ Other: _____________________________
Current patient/client location: _____________________________ Contact no: ________________________________

Is the Infection Prevention and Control team aware of transfer? ☐ Yes ☐ No

Receiving facility: ☐ Hospital ☐ Ward ☐ Care home ☐ Community
Who is aware of the transfer:
Discussed with: __________________________________________________ Date /Time: _____________________________
Completed by: __________________________________________________ Date completed: ___________________________
Nurse’s signature: ____________________________ Print name: ____________________________ Designation: ____________________________

Is this patient/client an infection risk?
Please tick most appropriate box and give confirmed or suspected organism
☐ Confirmed risk Organism: ____________________________
☐ Suspected risk Organism: ____________________________

No known risk. Patient/client exposed to others with infection e.g. D&V ☐ Yes ☐ No
Is the patient/client aware of their diagnosis/risk of infection? ☐ Yes ☐ No

If patient/client has diarrhoeal illness, please indicate bowel history for last week: (based on Bristol stool form scale)

1. Separate hard lumps, like nuts (hard to pass) 2. Sausage-shaped but lumpy
3. Like a sausage but with cracks on its surface 4. Like a sausage or snake, smooth and soft
5. Soft blobs with clear-cut edges (passed easily) 6. Fluffy pieces with ragged edges, a mushy stool
7. Watery, not solid pieces ENTIRELY LIQUID

<table>
<thead>
<tr>
<th>Day</th>
<th>Number of episodes</th>
<th>Is the diarrhoea thought to be of an infectious nature? Yes/No</th>
<th>Does the patient/client require isolation? Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
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<tr>
<td>Tuesday</td>
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<td>Wednesday</td>
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<td>Thursday</td>
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<td>Friday</td>
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<td>Saturday</td>
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<tr>
<td>Sunday</td>
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</tbody>
</table>

Should the patient/client require isolation, please phone the receiving unit in advance

Relevant specimen results (including admission screens - MRSA, C. difficile, other multi-resistant organisms) and treatment information, including antimicrobial:

<table>
<thead>
<tr>
<th>Specimen</th>
<th>Date</th>
<th>Result</th>
<th>Treatment</th>
</tr>
</thead>
</table>

Other information:
### Build/weight for height:
- Average (BMI 20.1 - 24.9) 0
- Above average (BMI 25 - 29.9) 1
- Obese (BMI ≥30) 2
- Below average (BMI ≤20) 3

### Continence:
- Complete/catheterised 0
- Urinary incontinence 1
- Faecal incontinence 2
- Urinary and faecal incontinent 3

### Skin tissue:
(score for each type)
- Healthy 0
- Tissue paper, Dry, Oedematous 1
- Clammy/pyrexia 1
- Non-blanching erythema - Category 1 PU 2
- Category 2,3,4,UN 3

### Mobility:
- Fully mobile 0
- Restless/fidgety 1
- Apathetic 2
- Restricted 3
- Bedbound/ traction 4
- Chairbound (eg wheelchair) 5

### Sex:
- Male 1
- Female 2

### Age:
- 14 - 49 1
- 50 - 64 2
- 65 - 74 3
- 75 - 80 4
- 81+ 5

### Appetite:
- Average 0
- Poor 1
- NG tube fluids only 2
- Nil by mouth/anorexic 3

### Tissue malnutrition:
(score for each type)
- Terminal cachexia 8
- Multiple organ failure 8
- Single organ failure (resp., renal, cardiac) 5
- Peripheral Vascular disease 5
- Anaemia (Hb<8) 2
- Smoking 1

### Neurological deficit:
- Diabetes, MS, CVA 4 - 6
- Motor/sensory 4 - 6
- Paraplegia 4 - 6

### Major surgery trauma:
- Orthopaedic, spinal 5
- On table more than 2 hours 5
- On table more than 6 hours 8

### Medication:
- Long-term, high-dose steroids, cytotoxics, high-dose anti-inflammatory 4

### SCORE:
10+ At Risk, 15+ High Risk, 20+ Very High Risk
If total Waterlow Score of 10+ is identified, complete care sheet

### Waterlow Score:

### Action required:

### Signature:
Problem: Patient is ‘at risk’ of pressure ulcer development and has a Waterlow score of 10+

Aim: Maintain skin integrity in order to prevent pressure ulcer development

This patient was put on this care sheet on (date): ....................................................
Nurse’s signature: ..........................................................................................................................

Update the daily plan of care as specified below:
1. All ‘at risk’ areas should be checked by a Registered Nurse on admission and / or transfer.
2. All ‘at risk’ areas should be checked by a Registered Nurse at least 3 times per day.
3. Changes in skin condition should be documented in patient notes.
4. All patients ‘at risk’ of pressure ulceration should be encouraged to actively mobilise, change their position or be re-positioned as per plan of care (patient non-concordance should be recorded).
5. All position changes should be documented on the re-positioning schedule (patient non-concordance should be recorded).
6. Minimise pressure on bony prominences and avoid positioning on ‘at risk’ areas.
7. Sitting time should be restricted, and should not exceed 2 hours.
8. Assess need for pressure-relieving aids in accordance with Trust policies PAT/T3, PAT/T4 and PAT/T5.
9. Pressure-relieving equipment must be in-situ within 2 hours of identified risk (if >2 hours, document reason why)
10. Equipment selection:
    Date/time requested: Reference No: Date/time supplied:
    
    | Mattress     | Date       | Date       |
    |--------------|------------|------------|
    | Static mattress |          |            |
    | Alpha X cell  |           |            |
    | Nimbus/transair |         |            |
    
    | Chair        |            |            |
    | Karomed chair |          |            |
    
    | Stool        |            |            |
    | Karomed stool |          |            |

11. Refer to Tissue Viability Specialist Nurse as per referral guidelines.
12. Patient / Carer comprehension:
    Ensure that the patient/ carers are fully aware of the patient’s risk status and requirement for a pressure ulcer prevention plan.
    Patient: ☐ Yes ☐ No
    Patient: ☐ Good ☐ Needs reinforcement ☐ Unable to comprehend
    Carer: ☐ Good ☐ Needs reinforcement

13. Give patient information. Date information given: ..........................................................................................................................
14. If tissue damage occurs, commence Pressure Ulcer IPOC.
    Level of tissue damage
    ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ UN
    Date IPOC commenced: ..........................................................................................................................

Reassessment
15. Ensure initial and ongoing Waterlow pressure ulcer risk assessment is undertaken when there is a change in patient’s condition, on transfer or weekly (whichever is more frequent).
16. Review equipment in-situ and down-grade or up-grade as patient’s clinical condition dictates.

Problem resolved date: ..........................................................................................................................
Nurse’s signature: ..........................................................................................................................
**Step 1**
BMI Score

<table>
<thead>
<tr>
<th>BMI kg/m²</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>&gt;20 (&gt;30 obese)</td>
<td>0</td>
</tr>
<tr>
<td>18.5 - 20</td>
<td>1</td>
</tr>
<tr>
<td>&lt;18.5</td>
<td>2</td>
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</tbody>
</table>

**Step 2**
Weight Loss Score

<table>
<thead>
<tr>
<th>Unplanned weight loss in past 3 - 6 months</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>%&lt;5</td>
<td>0</td>
</tr>
<tr>
<td>5 - 10</td>
<td>1</td>
</tr>
<tr>
<td>&gt;10</td>
<td>2</td>
</tr>
</tbody>
</table>

If patient is acutely ill and there has been, or is likely to be, no nutritional intake for >5 days, Score 2

**Step 3**
Acute Disease Effect Score

**Step 4**
Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition:

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Low Risk</td>
</tr>
<tr>
<td>1</td>
<td>Medium Risk</td>
</tr>
<tr>
<td>2 or more</td>
<td>High Risk</td>
</tr>
</tbody>
</table>

**Step 5**
Management Guidelines

0 Low Risk
- Repeat screening weekly and record score.
- Ensure nutritional needs are met through the standard menu.

1 Medium Risk
- Order and encourage high/energy/fortified diet.
- Offer snacks between meals.
- Document dietary intake for 3 days.
- If no improvement in oral intake, commence Oral Nutrition Supplements (ONS).
- Repeat screening weekly.
- If weight stable/gained, continue.
- If weight continues to fall, refer to the dietitian.

2 - 3 High Risk
- Order and encourage enriched/high-energy/fortified diet and
- Offer snacks between meals and/or ONS. Use ONS if parts of meals are not taken.
- Document dietary intake for 3 days.
- Repeat screening weekly.
- If weight stable/gained, continue.
- If weight continues to fall, refer to the dietitian.

4 - 6 High Risk
- Commence as above
- Contact dietitian immediately for full nutritional assessment

**Acute Disease Effect**
Acute disease effect is applicable to patients who are acutely ill. For example: Critically ill, swallowing problems (after stroke), head injury, GI surgery etc.

**Obesity**
- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.
- If patient is clinically stable, has a BMI >30, or >28 with co-morbidities and wishes to lose weight, please use the Weight Management Information on Sheet Dysphagia your ward.
- If patient requests to see the dietitian, please use the dietetic referral form.

**Note:** For individuals with weight loss, contact dietitian for advice if no improvement in weight after appropriate strategies have been put in place.
- For patients who refuse to take food and drink, ensure that the strategies for dealing with food refusal have been considered and documented.
- If further guidance is then required and the patient continues to lose weight, contact the dietitian.
- Oral nutritional supplements and other nutritional supplements (e.g. vitamins) that are documented currently on the drug chart and are to be continued after discharge should be documented on the discharge chart and 7 days supply of the product provided.

**Re-assess subjects at risk as they move through care settings**
‘MUST’ - RECORDING SHEET

Height: .......... cm measured/recall/estimate
Or   Ulna: .......... cm and conversion to height: .......... cm   Or   MUAC: .......... cm

Weight (kg) prior to admission: .......... Take weight from last 3 - 6 months last 3-6 months estimated  /  actual’

Objective Criteria, (Steps 1- 4) should be used on all patients, if this is not possible, use subjective criteria below:

<table>
<thead>
<tr>
<th>Date:</th>
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</tbody>
</table>

Weight (kg)

Step 1

BMI =

BMI Score =

Step 2

Weight loss (compared to original wt) Kg =

Weight loss % =

Weight loss score =

Step 3

Acute Disease Score =

Step 4

‘MUST’ Risk Score (Total) =

Subjective Criteria - Estimate a ‘MUST’ Risk Score based on your evaluation of information below only if objective criteria cannot be used:

(i) BMI
   - Clinical impression - thin, acceptable wt, over wt, obvious wasting (very thin) and obesity (very over weight) can be noted

(ii) Weight Loss
   - Clothes and/or jewellery have become loose fitting
   - History of decreased food intake, reduced appetite or dysphagia (swallowing problems) over 3 - 6 months and underlying disease or psychosocial/physical disabilities likely to cause weight loss

(iii) Acute Disease
   - No nutritional intake or likelihood of no intake for more than 5 days

Overall impression Score =

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Action Plan</th>
<th>Signature/Print name</th>
</tr>
</thead>
<tbody>
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</table>
FALLS ASSESSMENT

Has the patient:
• Been admitted with a fall?
• Had a recent fall?
• Got a history of falling?
• Had a near miss in the last year?

Complete:
• Critical Incident Form
• Yellow falls sticker
• Falls register form
• Productive ward safety cross
• Status at a glance board

If the patient has banged their head / unwitnessed fall:
• Assessment by Medical Practitioner
• Neuro Observations and EWS
• Check BM
• Refer to Trust guidance for further actions

OUTCOME 1
• Refer to doctor for Falls Assessment
• Refer to Ward Physiotherapist
• Nurse as close as possible to Nurse’s Station (escalate to CSU bleep holder or Clinic Site Manager if bed not available)
• Ensure Call Bell in reach
• Ensure hearing aid / glasses used / in reach
• Footwear - secure fit, non-slip sole, no trailing laces (ask a relative to provide suitable replacement)
• Falls leaflet / booklet given to relatives or carers

Complete:
• Safety sides / bed suitability Assessment (below)
• Continence Assessment (regular toileting)
• Status At A Glance Board
• Send MSU for analysis

Does the patient require specialising? (see outcome 3)

OUTCOME 2
Reassess at:
Change of condition / On transfer / Weekly

OUTCOME 3
Patient
• Can’t follow instruction
• Can only stand not walk
• Is agitated / restless
• Has unpredictable behaviour

CHECK

Outcome: __________________ Signature: ________________ Date: __________ Date discussed with patient / relative: __________
Outcome: __________________ Signature: ________________ Date: __________ Date discussed with patient / relative: __________
Outcome: __________________ Signature: ________________ Date: __________ Date discussed with patient / relative: __________
Outcome: __________________ Signature: ________________ Date: __________ Date discussed with patient / relative: __________
**SAFETY SIDES**

- **Outcome 1**: Use of safety sides indicated. Use guidelines (see policy file)
- **Outcome 2**: Use of safety sides indicated. Consider using safety bumper
- **Outcome 3**: Use of safety sides not indicated

Consider the use of low bed mattress on floor / crash mats

---

Outcome: ____________________  Signature: ____________________  Date: ______________  Date discussed with patient / relative: ______________

Outcome: ____________________  Signature: ____________________  Date: ______________  Date discussed with patient / relative: ______________

Outcome: ____________________  Signature: ____________________  Date: ______________  Date discussed with patient / relative: ______________

Outcome: ____________________  Signature: ____________________  Date: ______________  Date discussed with patient / relative: ______________

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>FALLS / SAFETY SIDES Progress, Action Plan and Exception Reporting</th>
<th>Signature / Print name Designation</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
## PATIENT HANDLING

### OTHER PATIENT INFORMATION
- **Impaired hearing:**
  - [ ] Yes  [ ] No
- **Impaired sight:**
  - [ ] Yes  [ ] No
- **Other state:**

### Tick factors identified or comment as appropriate

<table>
<thead>
<tr>
<th>Assessment 1</th>
<th>Assessment 2</th>
<th>Assessment 3</th>
<th>Assessment 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>Ward</td>
<td>Ward</td>
<td>Ward</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
<td>Date</td>
<td>Date</td>
</tr>
</tbody>
</table>

- Unpredictable behaviour
- Variable/no co-operation
- Variable/no comprehension
- Pain (state where)
- Pressure ulcer/wounds/at risk
- Type of bed e.g. electric, manual, profiling (state)
- Type of mattress (state)
- Infusions/attachment to equipment
- Traction/splints etc.
- Oedema (state where)
- Patient for rehabilitation
- Muscular spasm/rigidity
- Paralysis/weakness
- Continence problems
- History of falls (see page 8)
- Additional factors e.g. barrier nursing
- Other

### Insert code

<table>
<thead>
<tr>
<th>Code* Code* Code* Code*</th>
</tr>
</thead>
</table>

- Turning (from one side to other)
- Sitting up in bed
- Moving up bed
- Sitting up over edge of bed
- Getting into bed
- Transferring from bed/chair/bed
- Sitting to standing
- Toileting
- Walking
- Climbing stairs
- Bathing

### Code

- **I** = Independent - patient requires no assistance whatsoever
- **S** = Supervision - patient requires verbal encouragement/physical presence of handler but no assistance
- **A** = Assistance - patient requires physical assistance of handler but able to help
- **U** = Unable - patient requires assistance of handlers or hoist because unable to help

*If codes A or U have been used there is a manual handling risk and a Patient Movement Plan MUST be completed.*  
[ ] Generic Assessment Relevant - see Manual Handling Assessment Folder

### Assessor details

<table>
<thead>
<tr>
<th>Assessment 1</th>
<th>Assessment 2</th>
<th>Assessment 3</th>
<th>Assessment 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor name (PRINT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessor designation</td>
<td></td>
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<tr>
<td>Assessor signature</td>
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<td></td>
</tr>
</tbody>
</table>
# PATIENT MOVEMENT PLAN

Tick method in date column and insert number of persons required

<table>
<thead>
<tr>
<th>Bed Mobility</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Turning</strong></td>
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<tr>
<td><strong>Sitting up</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sit up assisted from behind</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sit up assisted with towel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Moving up bed</strong></td>
<td></td>
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<tr>
<td>Sitting slide: <strong>state:</strong> towel: sheet slide</td>
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<tr>
<td>Supine sheet slide</td>
<td></td>
<td></td>
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<tr>
<td>Hoist - <strong>state</strong>: make and sling size</td>
<td></td>
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<tr>
<td><strong>Sit up over edge of bed</strong></td>
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<tr>
<td>Swivel method</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Roll onto side method</td>
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<tr>
<td><strong>Getting into bed</strong></td>
<td></td>
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<tr>
<td>Swivel method</td>
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</tr>
<tr>
<td>Roll onto side method</td>
<td></td>
<td></td>
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<tr>
<td><strong>Sit to Stand only</strong></td>
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<tr>
<td>Assisted stand patient supported at side</td>
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<tr>
<td>Standing hoist</td>
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<tr>
<td>Other aid - <strong>state</strong></td>
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<tr>
<td><strong>Transfers</strong></td>
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<td></td>
</tr>
<tr>
<td>Trolley to bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lateral transfer with slideboard</td>
<td></td>
<td></td>
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<tr>
<td><strong>Bed to chair - chair to bed</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Assisted stepping patient supported at side</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Assisted stepping with walking frame</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shuffle transfer with slideboard</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Shuffle transfer without slideboard</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Reach across 1/2 standing transfer</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Standing hoist - <strong>state</strong> make</td>
<td></td>
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<tr>
<td>Hoist - <strong>state</strong> make and sling size</td>
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<tr>
<td>Chair to chair</td>
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<tr>
<td>Assisted stepping patient supported at side</td>
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<td>Assisted stepping with walking frame</td>
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<tr>
<td>Shuffle transfer with slideboard</td>
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<tr>
<td>Shuffle transfer without slideboard</td>
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<tr>
<td>Reach across 1/2 standing transfer</td>
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</tr>
<tr>
<td>Standing hoist - <strong>state</strong> make</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoist - <strong>state</strong> make and sling size</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Toileting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On/off toilet or commode</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisted stepping patient supported at side</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisted stepping with walking frame</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commode placed behind standing patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shuffle transfer with slideboard</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shuffle transfer without slideboard</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach across 1/2 standing transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing hoist - <strong>state</strong> make</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoist - <strong>state</strong> make and sling size</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridging (raising of pelvis) onto bedpan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roll onto bedpan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoist onto bedpan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mobilising</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moving around</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisted walking patient supported at side</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisted walking patient using frame</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisted walking patient using stick(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile in wheelchair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climbing stairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insert details</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bathing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoist/ambulift into bath</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed bath</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shower</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assessor Initials
CONTINENCE ASSESSMENT

Key: ☑ Yes ☒ No

Is the patient: ☐ Continent - no further assessment needed
☐ Urinary incontinent ☐ faecal incontinent ☐ Catheterised - complete catheter care sheet

If ‘Yes’ to any of the above, is the patient able to manage the situation themselves? ☐ Yes ☒ No
(i.e. requiring minimal input/already under the care of the Community Continence Service)

If ‘No’ complete Continence Assessment below.

ACUTE CONTINENCE ASSESSMENT

Symptoms:
Urinary? Yes / No Bowels? Yes / No Did you have to get up at night? Yes / No Number: .....................................................

Date of onset: ..................................................... Related to event?: ..........................................................................................................................

Severity: ☐ Damp underwear ☐ Wet underwear ☐ Wet clothing ☐ Wet floor/furniture

How do you manage at the moment (pads, reduced fluids etc.)? ..........................................................................................................................

Questions to ask:
1. Does it sting or burn when you pass water? Yes/No
2. Is there blood in your water? Yes/No
3. Do you leak when you cough/laugh/bend/lift a heavy object? Yes/No
4. Do you have an urgent need to use the toilet? Yes/No
5. Do you need to visit the toilet frequently? Yes/No
6. Do you ever leak before you reach the toilet? Yes/No
7. Do you only pass small amounts of water at a time? Yes/No
8. Does your bladder still feel full after passing water? Yes/No
9. Do you have to wait or strain to pass water? Yes/No
10. Is your flow of water weak? Yes/No
11. Do you have frequent water infections? Yes/No
12. Do you dribble continuously, or after passing water? Yes/No
13. Have sudden wetness without warning? Yes/No
14. Are you ever unaware that you have been incontinent? Yes/No
15. Do you wet the bed? ☐ Small patch ☐ Large patch Yes/No
16. Do you have problems with mobility resulting in not getting to toilet in time? Yes/No
17. Do you have difficulty managing your clothes when going to toilet? Yes/No
18. Do you present facilities cause/contribute to your urinary problems? Yes/No
19. Do you need to be reminded to go to the toilet to prevent accidents? Yes/No
20. Have you had any operations on your bladder/bowel? ..........................................................................................................................

Obstetric history:
Number of pregnancies: .................. Number of live births: .................. Birth weights: ........................................

Quality of life due to urinary symptoms

<table>
<thead>
<tr>
<th></th>
<th>Delighted</th>
<th>Pleased</th>
<th>Mostly satisfied</th>
<th>Mixed</th>
<th>Mostly dissatisfied</th>
<th>Unhappy</th>
<th>Very unhappy</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Date: .......................... .......................... .......................... .......................... ..........................
Score: .......................... .......................... .......................... .......................... ..........................
### Responses to questions

<table>
<thead>
<tr>
<th>Positive answers</th>
<th>Possible causes</th>
<th>Guidance (see continence algorithm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions 1, or 2</td>
<td>Infection</td>
<td>Urinalysis and/or MSU. Antibiotic treatment Repeated infection requires further investigation.</td>
</tr>
<tr>
<td>Questions 3</td>
<td>Stress incontinence due to poor pelvic floor tone or incomplete sphincter closure</td>
<td>Teach pelvic floor exercises. Consider oestrogens If no improvement refer to Continence clinic for further investigation.</td>
</tr>
<tr>
<td>(stress)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questions 4, 5 or 6</td>
<td>Unstable bladder due to medical condition e.g. MS, CVA, post-prostatecomy. Poor fluid intake/type of fluids, 'bad' habits. Infection.</td>
<td>Bladder retraining. Advice on hygiene and fluids. Refer to Doctor for anticholinergic or antibiotic therapy. If no improvement in 3 months refer to Continence Clinic for review of medication and/or electrical stimulation.</td>
</tr>
<tr>
<td>(Urge)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questions 7, 8, 9, 10, 11, or 12</td>
<td>Incomplete emptying due to enlarged prostate, stricture, faecal impaction, neurogenic bladder or spinal injury.</td>
<td>Aids appliances. Clear the impaction. Bladder stimulation. Intermittent catheterisation. Stricture therapy. Refer to Continence Clinic, with U+E results if residual volume &gt; 200mls.</td>
</tr>
<tr>
<td>(Overflow/dribble)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questions 13, or 14</td>
<td>Passive incontinence due to mental impairment, dementia or confusion. nerve damage.</td>
<td>Habit retraining. Aids and appliances. Adapt the environment. Prompting. Toilet programme.</td>
</tr>
<tr>
<td>(Reflex)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Bed wetting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questions 16, 17, 18 or 19</td>
<td>Functional incontinence due to underlying clinical or environmental problems.</td>
<td>Adapt the environmental/clothing. Prompted toileting. Refer to Occupational Therapist and/or Physiotherapist.</td>
</tr>
<tr>
<td>(Functional)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Problems identified/summary of assessment:

**Initial diagnosis:**

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Print Name: ............................................ Signature: ............................................ Designation: ............................................
Date: ............................................ Time: ............................................
**ALCOHOL SCREENING**

**Date: ........................................................**

<table>
<thead>
<tr>
<th>Questions</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have 8 (men) / 6 (women) or more units of alcohol on one occasion?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td></td>
</tr>
</tbody>
</table>

**Only answer the following questions if the answer above is ‘monthly’ or ‘less than monthly’**

<table>
<thead>
<tr>
<th>Questions</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often in the last year have you not been able to remember what happened when drinking the night before?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>How often in the last year have you failed to do what was expected of you because of drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>Has a relative/friend/doctor/health worker been concerned about you drinking or advised you to cut down?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes during the last year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scoring**

If Q1 scores 0, patient is not misusing alcohol - **no further questions**

If Q1 scores, 3 or 4 patient is a harmful, hazardous or dependent drinker - **no further questions**

If Q1 scores 1 or 2, **ask Q2, 3 and 4**

*A total score of 3+ indicates hazardous or harmful drinking, follow flowchart (opposite) for action.*

Daily units: ................................. Weekly units: .................................

Type of drinker: □ Safe □ Hazardous □ Harmful Dependent: □ Moderately dependent □ Severely dependent

**This table tells you if you are at risk from drinking alcohol**

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Men</th>
<th>Women</th>
<th>Common Effects</th>
</tr>
</thead>
</table>
| Low Risk         | ≤21 units/week or upto 4 units/day - with two alcohol-free days | ≤14 units/week or upto 3 units/day - with two alcohol-free days | • Increased relaxation  
|                  |     |       | • Reduced risk of heart disease  
|                  |     |       | • Sociability  
| Increased Risk   | 22-49 units/week or regular drinking of more than 4 units/day | 15-35 units/week or regular drinking of more than 3 units/day | • Less energy  
|                  |     |       | • Depression/stress  
|                  |     |       | • Insomnia  
|                  |     |       | • Risk of injury  
|                  |     |       | • High blood pressure  
| High Risk        | 50 or more units/week | 36 or more units/week | All of the above and ...  
|                  |     |       | • Memory loss  
|                  |     |       | • Risk of liver disease  
|                  |     |       | • Risk of cancer  
|                  |     |       | • Risk of alcohol dependence  

**One standard drink is:**

- Half pint of regular beer, lager or cider
- 1 small glass of wine
- 1 single measure of spirits
- 1 small glass of sherry
- 1 single measure of aperitifs

**The following quantities of alcohol contain more than 1 standard drink**

- Pint of Regular Beer/Lager/Cider
- Alcopop or Can of Lager
- Glass of Wine (175ml)
- Single Measure of Spirits (25ml)
- Bottle of Wine
**ALCOHOL SCREENING**

**FAST Screening completed**

**Alcohol Units daily/weekly identified**

**Type of drinker identified**

<table>
<thead>
<tr>
<th>SAFE</th>
<th>HAZARDOUS</th>
<th>HARMFUL</th>
<th>DEPENDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensible drinking is regular and consistent drinking over 2-3 units per day for women and 3-4 units per day for men. A unit is 8g of alcohol. This is equivalent to half a pint of beer, a small glass of wine or one measure of spirits.</td>
<td>Hazardous drinking is anyone drinking over recommended limits [21 units for men or 14 units for women] but without alcohol related problems. People drinking in excess of eight units in men and six units in women in one session ['binge drinking'] are also at risk of harm even although some may not exceed the 'safe' weekly level.</td>
<td>Harmful drinking is anyone drinking over medically recommended levels, probably at somewhat higher levels than that in hazardous drinking. However, unlike hazardous drinkers, they will show clear evidence of alcohol-related problems but often without this having resulted in their seeking treatment.</td>
<td>Moderate dependent drinker are those people who present with significant drinking problems. Severe dependent drinkers are those people who present with a wide range of alcohol related problems. Some are drinkers with complex problems, such as co-existing physical or physical or mental health needs' polydrug dependence and social problems.</td>
</tr>
</tbody>
</table>

**INTERVENTION**

None required. • Offer brief interventions and support • Encourage reduction of alcohol consumption • Reduce alcohol-related harm • Refer to DANS Service

• Offer brief interventions and support • Encourage reduction of consumption • Reduce alcohol-related harm • Deliver treatment that is designed to control both medical and psychological complications which may occur after a heavy sustained alcohol use • Enable patients to achieve abstinence safely and effectively with the minimum discomfort • Relieve physical withdrawal by appropriate pharmacotherapeutic interventions • Enable to adopt an alcohol free lifestyle • Deliver effective psychosocial interventions as determined by a formulated care plan • Refer to DANS Service

• Provide targeted screening for dependent drinkers • Treat alcohol dependent drinkers in a safe and effective manner

NOTE: This document reflects the contents within the policy document - PAT/T25 Version 1 'Guidelines for the management of alcohol issues in the acute general hospital setting' June 2006
Is the Patient a Carer for either Children or Adults?

Yes
Establish/Ask if the patient's illness/admission or attendance impacts upon their ability to provide care

Yes
Establish whether the patient and their family have organised safe care for the child/adult.

No
Ask if there is anyone within the family able to provide care to the child or adult within the Community?

No
Does this need a referral to Children's or Adult Social Care?

Yes
Need advice?
Contact the Safeguarding Team at DRI on ext: 6468

Yes
Record within the patient's record what arrangements have been made.

Review weekly
and document all arrangements/actions/agreements within the patient's record.

No
No further action necessary
Review weekly

Yes
Make referral in line with relevant safeguarding procedures, available via Trust intranet (open intranet, click Policies/APDs – see section 3). Ensure all actions/arrangements and agreements are documented within the patient's record.