|  |  |
| --- | --- |
| Is Patient EOL?DNACPR decision documented? | Date of Admission:EDD: |
| COVID 19 status:Date of COVID status: | Does patient have mental capacity? |
| **Reason for admission/ treatment whilst in hospital**: |
|

|  |  |
| --- | --- |
| **Previous Level (if known)** | **Level of care needs in last 24 hours** |
| **Walking Aid****Stairs:** | **Walking Aid****Stairs:**  |
| **Transfers** | **Independent** | **Difficulty** | **Assistance****(1 or 2 people)** | **Transfers** | **Independent** | **Difficulty** | **Assistance** **(1 or 2 people)** |
| **BED** |  |  |  | **BED** |  |  |  |
| **CHAIR** |  |  |  | **CHAIR** |  |  |  |
| **TOILET** |  |  |  | **TOILET** |  |  |  |

**Reason for referral (tick and provide description):** Nursing: Reason for referral:Therapy: Reason for referral:Package of care: (Start Date/Time)………………………… **Complete page 2 with details** **Any equipment likely to be required for discharge?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **In Place** | **ELH to order** |  |  | **To be Ordered** | **In Place** |
| Standard Hospital Bed |  |  |  | Molift raiser (with/without belt) |  |  |
| Bed Sides |  |  |  | Rota Stand Solo |  |  |
| Community Mattress |  |  |  | Wheeled walker (zimmer frame) small/med/large |  |  |
| Static Pressure Mattress (medium/high/very high) |  |  |  | Key safe |  |  |
| Airflow mattress (overlay/replacement) |  |  |  | Commode (mobile/static) |  |  |
| Pair Flat Slide Sheets |  |  |  | Other |  |  |
| Mobile Hoist |  |  |  |  |  |  |
| Universal Slings (small/medium/large) |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Continence | Continent |  |
| Medication | Self -managing? |  |
| Skin integrity/issues/risks | Yes/No |  |
| Pain | No Pain |  |
| Swallowing problems | No |  |
| Nutritional concerns | No |  |
| Cognition or Mood issues | No |  |
| Breathing Problems | No |  |

Provide further details as appropriate: |

|  |
| --- |
| **SECTION 2 (To be completed by Hospital Ward/ MDT)****This section is designed to help determine which generic package is required. Please choose package in relation to level of need.** |

|  |  |
| --- | --- |
| **Care Need**  | **Tick** |
| **Requires** 1 carer for personal care tasks, has ability weight bear independently or with assistance of x1 |  |
| Needs assistance with toileting  |  |
| Needs help to empty commode or empty catheter bag/connect night bag |  |
| **Requires** 2 carers, has the ability to weight bear with assistance of x 2 |  |
| Immobile requiring repositioning and transfers using equipment  |  |
| Low to moderate risk of falls |  |
| Fractures (e.g. upper limb/Hip/pelvis/joint replacement) and weight bearing status: NWB/PWB/FWB |  |
| **Challenging behaviour** – any history of verbal or physical aggression? |  |
| Moderate to High risk of falls with a family member who can supervise safely  |  |
| Bed dependent |  |
| **May** **require** night care because of the following;* High risk of falls including all of the below
	+ Unsteady gate or attempts to climb out or bed or get out of chair unaided
	+ No family to supervise safely
	+ Evidenced falls risk with history of falls

**OR*** has pressure ulcer grade 3 and above requiring repositioning during the night
 |  |
| Capacity to take medication – blister pack dispense only |  |
| Capacity to take medication but needs full assistance to do so **OR**Limited capacity to take medication and requires administration  |  |
| Requires full assistance with double incontinence  |  |
| **Needs** one of the following;* oral suctioning
* tracheostomy in situ
* suffer from regular altered states of consciousness requiring medical intervention

require administration of medication via PEG |  |

|  |  |
| --- | --- |
| Tinzaparin  injections: Date/Time Last injection given:  |  |
| Antibiotic therapy (**Newham**  are unable to accept more than twice a day (BD) antibiotics administration**)** |  |
| Has a catheter in situ – Date inserted |  |
| Has a NIV in situ – Date inserted |  |
| Has a PEG in situ – Date inserted |  |
| Requires support with insulin administration  |  |

|  |  |
| --- | --- |
| NOK Name |  |
| NOK Contact no: |  |
| Access Issues/LAS Concerns |  |
| Requires Home & Settle |  |

**Care Plan –Integrated Discharge Hub to complete**

Care Placement: Residential Nursing With dementia

Care at home: New Restart with a change

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | MORNING | LUNCH | TEA | EVENING | NIGHT CARE |
| WORKERS: | SingleDouble | [ ] [ ]  | SingleDouble | [ ] [ ]  | SingleDouble | [ ] [ ]  | SingleDouble | [ ] [ ]  | Single [ ] Double [ ]  |
| TASKS: | Personal CareMeal PreparationMedication | [ ] [ ] [ ]  | Personal CareMeal PreparationMedication | [ ] [ ] [ ]  | Personal CareMeal PreparationMedication | [ ] [ ] [ ]  | Personal CareMeal Preparation Medication | [ ] [ ] [ ]  | Waking Night [ ] Sleeping Night [ ]  |
| DURATION: | 30Mins45Mins1Hr | [ ] [ ] [ ]  | 30Mins45Mins1Hr | [ ] [ ] [ ]  | 30Mins45Mins1Hr | [ ] [ ] [ ]  | 30Mins45Mins1Hr | [ ] [ ] [ ]  |  |
| Informal Care:  |  |  |  |  |  |
|  |  |  |  |
| Pets:  | Yes | [ ]  No [ ]  |  |
| Home & Settle Referred to: | Yes | [ ]  No [ ]  |  |