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| --- | --- |
| 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: | |

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| **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.** |

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| **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 |  |

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| 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: | Single  Double | | | |  | | | Single  Double |  | | Single  Double | | |  | Single  Double | |  | | Single  Double |
| TASKS: | Personal Care  Meal Preparation  Medication | | | |  | | | Personal Care  Meal Preparation  Medication |  | | Personal Care  Meal Preparation  Medication | | |  | Personal Care  Meal Preparation  Medication | |  | | Waking Night  Sleeping Night |
| DURATION: | 30Mins  45Mins  1Hr | | | |  | | | 30Mins  45Mins  1Hr |  | | 30Mins  45Mins  1Hr | | |  | 30Mins  45Mins  1Hr | |  | |  |
| Informal Care: | |  |  |  | | | | | |  | | |  | | | | |
|  | | | | | |  |  | | | | |  | | | |
| Pets: | | | | | | Yes | No | | | | |  | | | |
| Home & Settle Referred to: | | | | | | Yes | No | | | | |  | | | |