Acute and Emergency Medicine

UHW

Part A

Patient Risk Assessment and Care Documentation

Addressograph:

Please check all details are correct on addressograph before applying

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Version 2

PRACD21

(All grades of staff can document in this booklet)

Print Name	Initials	Signature	Designation	Ward/Area	Date

☐ Patient has correct identity bracelet with information verified by patient (please tick to verify)

☐ I.D. confirmed (please tick to verify)

NEWS CHART

	Physiological Parameters	3	2	1	0	1	2	3
A	Respiratory Rate (bpm)	≤ 8		9-11	12-20		21-24	25
B	O2 Saturations (%)	≤ 91	92-93	94-95	96			
	Any supplemental Oxygen		YES		NONE			
C	Systolic BP (mmHg)	≤ 90	91-100	101-110	111-219			220
	Pulse (BPM)	≤ 40		41-50	51-90	91-110	111-130	131
D	CAVPU score	C			ALERT			VPU
E	Temperature (˚C)	≤ 35.0		35.1-36.0	36.1-38.0	38.1-39.0	39.1	

Concern about a patient should lead to escalation, regardless of the score

Observations on arrival of all patients
Observations 30mins later on all 'majors' patients

NEWS	MINIMUM MONITORING	ALERT	REVIEW
Score 0-2	4 Hourly	If concerned inform Nurse in Charge (NIC)	
Score 3-5	2 Hourly **Increase frequency dependant on patient response**	Inform Nurse in Charge, inform designated nurse/doctor	Review in 1 hour. SBAR
Score 6-8	1 Hourly **WARNING - If patient is scoring in 1 red box or more please consider hourly observations until patient stabilises**	**Emergency Unit** - Inform NIC and the senior doctor in the unit **AU / MEAU** - Inform NIC and the senior doctor in the unit. Contact MRRT	Review 30 minutes SBAR
Score 9	15 - 30 mins	**Emergency Unit** - Inform NIC and the senior doctor in the unit **AU / MEAU** - Inform NIC. Inform senior doctor, if they are unable to review the patients within 10 minutes call Resuscitation Team via 2222	Immediate SBAR

The Nurse in Charge of each shift must ensure that the designated nurse/doctor names and bleep numbers are updated and clearly displayed on a Patient Status at a Glance Board (PSAG).
Frequency of Observations are increased in relation to the patient's condition. If there is any concern, please escalate regardless of the NEWS score.

RED FLAG SEPSIS SCREENING

Use Sepsis Screening & action tool if NEWS is 3 or above and suspicion of infection plus any ONE of the following Red Flags

- ☐ Responds only to voice
- ☐ Systolic BP≤ 90mmHg (or drop from > 40 from normal)
- ☐ Heart rate > 130 per minute
- ☐ Respiratory rate ≥ 25 per minute
- ☐ Needs oxygen to keep Sa02 ≥ 92%
- ☐ Non-blanching rash, mottled, ashen, cyanotic
- ☐ Not passed urine in last 18 hours
- ☐ Urine output less than 0.5 mls/kg/hr
- ☐ Lactate ≥ 2 mmols/l
- ☐ Recent chemotherapy

RED FLAG SEPSIS - Start Sepsis 6 pathway NOW

1. Communication >4hrs

USE BLACK INK TO COMPLETE ALL SECTIONS

The following questions are in relation to your personal preferences and personal details

What language would you prefer to communicate in?
How would you prefer to be addressed?
Is there any special assistance that you feel would help you? e.g. large print, Braille, an interpreter e.g. BLS?
Do you want anyone with you to help answer these questions/ discuss your request for support? Are you happy to continue? Yes / No

First Language: Welsh ☐ English ☐ Other please state: ☐

If first language Welsh would you prefer consultation to be through the medium of Welsh / English?

Patient/Family Worries or concerns:

2. General Demographics <4hrs

Title: Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other:		Primary Address
Fornames:		
Surnames:		
Home Telephone:		
Mobile:		
Email Address:		Temporary Address:
D.O.B.:		
NHS Number:	Social Care Number:	
PARIS Number:	National Insurance Number:	

Affix Addressograph

Reason for admission:

Operation / procedure date:

Significant health conditions (past medical history):

Medication on admission:

Are there time critical medication	Parkinson	☐	Diabetic	☐
	Epilepsy	☐	Anti-coag	☐
	Anti-retroviral	☐	Long term Pain relief	☐
Multiple dose system? (e.g. blister pack)	Yes	☐	No	☐

Allergies:

Any known allergies?	Yes	☐	No ☐	Not known ☐
Allergy to what?	Type of reaction?			
Action required:				

3. GP and Next of Kin Details >4hrs

Marital Status:	Civil partnership ☐	Married ☐	Divorced ☐
Widowed ☐	Separated ☐	Other ☐	Single ☐
Occupation: (include previous occupation)			
Religion:		Ethnic Group:	

GP:

GP Surgery Name:	GP Surgery Telephone Number:
Address:	Fax:
	Surgery email:

Next of Kin/Carer/Contacts:

Details:	Next of Kin/Significant Other/Legal Representative *(POA, Deputy etc.):*		1st Contact:		Additional contact: *(if applicable)*	
Name:						
Relationship/Legal Status:						
Home number:						
Mobile number:						
Email:						
Is this contact a carer for the patient/citizen?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
Happy to contact 24/7?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
If No to above when can they be contacted?						
Who should we contact in an emergency?						
Name:	Telephone number:		Mobile number:			

4. Living Arrangements

Living Arrangements, Dependants and Caring Responsibilities

Patient/citizen lives with:	Alone ☐	Spouse ☐	Relative ☐	Other ☐
please specify:				
Does the patient/citizen have any dependents?	Yes ☐	No ☐	*Details:*	
Is the patient/citizen a parent/carer with responsibility for the care of children / others?	Yes ☐	No ☐	*Details:*	
Does the patient's/citizen's condition directly affect the care of others?	Yes ☐	No ☐	*Details:*	
What arrangements have been made to care for dependants? *(including pets)*				
Does the patient/citizen have any family, friends or, neighbours that may help to care for them? *(The care they give in unpaid).*	Yes* ☐	No ☐	**If 'Yes', as a carer they are entitled to a separate carer's assessment*	

Please complete if appropriate for the patients needs...

Type of Accommodation and accommodation facilities:

House	☐	Bungalow	☐	Flat	☐	Floor No.G/1/2/3	☐	Other Please state:	☐
Stairs	☐	Stair lift/lift	☐	Stair rails	☐	Hand rails	☐	External Steps	☐
Shower	☐	Bath	☐	Bathroom: upstairs			☐	downstairs	☐
Toilet: upstairs	☐	downstairs	☐	outside	☐	Bed: upstairs	☐	downstairs	☐
Equipment	☐	Hoist	☐	Type used:				Commode:	☐
POC	☐	*frequency:*						Home Support	☐
Agency:				Tel. No:					

Additional Accommodation Details: (complete if required for discharge planning)

Private Rented	☐	Owner occupier	☐	Rented from Housing association			☐
Sheltered Accom.	☐	Rented from Council	☐	Residential Home	☐	Nursing Home	☐
Group Home	☐	Supported Accommodation	☐	Tied House	☐	Extra Care	☐
Other	☐	*please specify*					
Landlord details:							

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Acute & Emergency Medicine

University Hospital of Wales

Visual Infusion Phlebitis Tool

Patient Addressograph

Insertion Date			Area Inserted				Removed:
Cannula Size			VIPS on Insertion				Yes / No
Day	1		2		3		Reason:
Date							
	0700-1930	1930-0700	0700-1930	1930-0700	0700-1930	1930-0700	By Whom:
VIPS							
Sign							Date and Time:

Insertion Date			Area Inserted				Removed:
Cannula Size			VIPS on Insertion				Yes / No
Day	1		2		3		Reason:
Date							
	0700-1930	1930-0700	0700-1930	1930-0700	0700-1930	1930-0700	By Whom:
VIPS							
Sign							Date and Time:

Insertion Date			Area Inserted				Removed:
Cannula Size			VIPS on Insertion				Yes / No
Day	1		2		3		Reason:
Date							
	0700-1930	1930-0700	0700-1930	1930-0700	0700-1930	1930-0700	By Whom:
VIPS							
Sign							Date and Time:

3M™ Tegaderm™ I.V. Dressings

V. I.P. Score (Visual Infusion Phlebitis Score)

Observation	Score	Action
I.V. site appears healthy	0	No signs of phlebitis ☐ OBSERVE CANNULA
One of the following is evident: • Slight pain near I.V. site • Slight redness near I.V. site	1	Possible first signs of phlebitis ☐ OBSERVE CANNULA
Two of the following are evident: • Pain near I.V. site • Erythema • Swelling	2	Early stage of phlebitis ☐ RESITE CANNULA
ALL of the following are evident: • Pain along path of cannula • Erythema • Induration	3	Medium stage of phlebitis ☐ RESITE CANNULA ☐ CONSIDER TREATMENT
All of the following are evident & extensive: • Pain along path of cannula • Erythema • Induration • Palpable venous cord	4	Advanced stage of phlebitis or start of thrombophlebitis ☐ RESITE CANNULA ☐ CONSIDER TREATMENT
All of the following are evident & extensive: • Pain along path of cannula • Erythema • Induration • Palpable venous cord • Pyrexia	5	Advanced stage of thrombophlebitis ☐ INITIATE TREATMENT ☐ RESITE CANNULA

Developed by Andrew Jackson, Consultant Nurse Intravenous Therapy and Care, Rotherham General Hospitals, NHS Trust United Kingdom.

3M

Addressograph

NEWS CHART

Ward / Dept

Score	1	2	3

Consider SEPSIS on ALL NEWS scores ≥ 3

NEWS ≥ 3

Acute illness or unstable chronic disease

NEWS ≥ 6 = sick

Likely to deteriorate rapidly

NEWS ≥ 9 = NOW

Immediately life threatening critical illness

Concern about patient or difficulty obtaining any single parameter should lead to escalation regardless of score

Date												
Time of Observation												
Frequency of Observations												
Respiratory Rate A+B Accept ≤ ..... / ≥..... Signed: Date:	25											
	21-24											
	12-20											
	9-11											
	8											
O2 Saturations (%) A+B Accept ≥..... / ≤..... Signed: Date:	96											
	94-95											
	92-93											
	91											
Inspired Oxygen												
Blood Pressure C Note record both systolic and diastolic pressures but use systolic only to score **Note:** In atrial fibrillation measure the BP manually Accept systolic BP of ..... mmHg For this patient Signed: Date:	220											
	210-219											
	200-209											
	190-199											
	180-189											
	170-179											
	160-169											
	150-159											
	140-149											
	130-139											
	120-129											
	111-119											
	101-110											
	91-100											
	80-90											
	70-79											
	60-69											
	50-59											
	40-49											
Heart Rate C Accept Heart rate of < ..... / > bpm for as normal for this patient **Note:** In atrial fibrillation measure the Heart Rate manually Signed: Date:	131											
	121-130											
	111-120											
	101-110											
	91-100											
	81-90											
	71-80											
	61-70											
	51-60											
	41-50											
	40											
Neuro D	C A V P U											
	New Onset or worsening confusion											
	Alert											
	Voice											
	Pain											
	Unresponsive											
Temperature °C E	≥ 39.1											
	38.1-39											
	36.1-38											
	35.1-36											
	≤ 35											
NEWS total score												
OBS Performed by Initials												
Qualified Nurse Initials												
Escalation required (Y/N)												

Addressograph

Neurological Observation Chart

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Cardiff and Vale University Health Board

Ward
Department

Date
Time
Frequency
Completed by

COMA SCALE	EYES OPEN	4	SPONTANEOUSLY
		3	TO SPEECH
		2	TO PAIN
		1	NONE
		C	CLOSED DUE TO SWELLING
	BEST VERBAL RESPONSE	5	ORIENTATED
		4	CONFUSED
		3	INAPPROPRIATE WORDS
		2	INCOMPREHENSIBLE SOUNDS
		1	NONE
	BEST MOTOR RESPONSE	6	OBEY COMMANDS
		5	LOCALISE TO PAIN
		4	WITHDRAWS TO PAIN
		3	FLEXION TO PAIN
		2	EXTENSION TO PAIN
		1	NONE
			COMA SCALE SCORE
LIMB MOVEMENTS	ARMS		NORMAL POWER
			MILD WEAKNESS
			SEVERE WEAKNESS
			FLEXION
			EXTENSION
			NONE
	LEGS		NORMAL POWER
			MILD WEAKNESS
			SEVERE WEAKNESS
			FLEXION
			EXTENSION
			NONE
PUPILS	R	C = CLOSED	SIZE
			REACTION
	L	C = CLOSED	SIZE
			REACTION

10mm
9mm
8mm
7mm
6mm
5mm
4mm
3mm
2mm
1mm

Pupil Scale (mm)

✓ **Reacts**
✓✓ **Sluggish**
– **None**

If limb power differs indicate
R = Right
L = Left

Observations for Head Injury (Neuro and Vital)

30mins for 2 hrs, Hourly for 4 hrs, 2 hrly thereafter with review.
If any decrease in GCS revert to recording neurological observations every 30mins and escalate immediately.

Blood Glucose (mmol/litre)	Date:												Date:											
≥20.0																								
10.9 - 19.9																								
4.0 - 11.0																								
≤3.9																								
Time	Before Breakfast	Other:	Other:	Before Lunch	Other:	Other:	Before Dinner	Other:	Other:	Before Bedtime	Other:	Other:	Before Breakfast	Other:	Other:	Before Lunch	Other:	Other:	Before Dinner	Other:	Other:	Before Bedtime	Other:	Other:
Ketones																								
Taken by:																								
Qualified Signature																								

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

All Wales Pain Assessment

TO BE COMPLETED IN BLACK INK

GIG CYMRU NHS WALES

- Pain scores should be recorded on the electronic system but if unavailable, paper format can be used
- ALL patients must have a pain assessment on admission (on movement) and further evaluation as indicated overleaf
- Indicate the pain assessment tool being used and ensure it is appropriate for this patient's level of communication (guidance overleaf)
- Once the patient has been assessed, using the guidance overleaf, transcribe the pain score in to the Equivalent Categorical Pain Scale below (NONE, MILD, MODERATE, SEVERE)
- If an action is documented, the pain score must be re-evaluated at an appropriate interval (guidance on frequency overleaf)

Date & Time	Pain assessment tool used:	Pain Score	Equivalent Categorical Pain Scale (see overleaf)				Action/comments	Signature
			NONE	MILD	MODERATE	SEVERE		
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							
	Categorical (N-M-M-S)		☐	☐	☐	☐	Details:	
	0-10							
	PainAD							
	Abbey							

Version: 2.4 (pilot release)
Approval Date: 29/04/2019
Approved by: Directors of Nursing

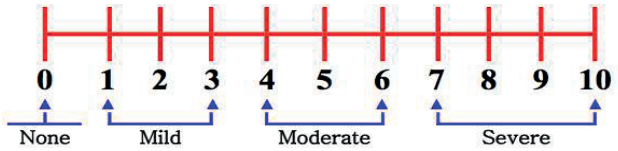
All Wales Pain Assessment Pain Tool Guidance

Is your patient able to verbalise their pain? If **Yes**, use the Categorical Scale (NONE, MILD, MODERATE, SEVERE) **OR** Numerical Pain scale (0-10) as **typically used in your clinical area**. **Use one tool only**. If UNABLE to verbalise pain**,** use PainAD **OR** Adapted Abbey. If necessary, convert the score into the Categorical Scale (NONE, MILD, MODERATE, SEVERE) and record overleaf. All pain scored MUST be assessed on **movement / patient activity.**

CATEGORICAL SCALE

0	1	2	3
NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN

NUMERICAL SCALE



Numerical Rating Scale	Equivalent Categorical Scale
0	NO PAIN
1-3	MILD PAIN
4-6	MODERATE PAIN
7-10	SEVERE PAIN

PAINAD SCALE

PAINAD	0	1	2
Breathing (Independent of vocalization)	Normal	Occasional laboured breathing. Short period of hyperventilation	Noisy laboured breathing. Long period of hyperventilation. Cheyne-stokes respirations
Negative Vocalisation	None	Occasional moan or groan / low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying
Facial Expression	Smiling or inexpressive	Sad Frightened Frown	Facial grimacing
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or punching away. Striking out
Consolable	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure

PainAD Scale Total Score:	Equivalent Categorical Scale
0	NO PAIN
1-3	MILD PAIN
4-6	MODERATE PAIN
7-10	SEVERE PAIN

Score guidance for each category: (0, 1 or 2) when screening for pain related behaviours during activity (MAX=10)

ADAPTED ABBEY SCALE

Vocalisation (score 0-3)	Whimpering, groaning, crying
Facial Expression (score 0-3)	Grimacing, frowning, looking tense, looking frightened
Change in Body Language (score 0-3)	Fidgeting, rocking, guarding part of body, withdrawn
Behavioural Change (score 0-3)	Alterations in usual patterns, increased confusion, refusing to eat
Physiological Change (score 0-3)	Temperature, rapid pulse, blood pressure outside normal limits
Physical Changes (score 0-3)	Skin tears, pressure areas, arthritis, contractures

Adapted Abbey Pain Scale Total score:	Equivalent Categorical Scale
0-2	NO PAIN
3-7	MILD PAIN
8-13	MODERATE PAIN
14+	SEVERE PAIN

Acknowledgment:
Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B. Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002

Score guidance for each category: Absent = 0, Mild = 1, Moderate =2, Severe=3 (MAX=18)

Discuss with family / carers how the person usually reacts to pain (past and present). Ask about their usual behaviour patterns. Check any getting to know you forms such as "This is Me", "Reach Out to Me", DIS-DAT for individual pain behaviours. Record any particular pain behaviours in the sections above.

FREQUENCY OF PAIN ASSESSMENT AND ANALGESIA ADMINISTRATION

NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN
Reassess 12-hourly as per NEWS observations	Give step 1 analgesia Reassess 4-hourly	Give step 2 analgesia Reassess after 30-60 minutes Ongoing assessment minimum 4-hourly	**Give step 3 analgesia** **Reassess after 30 and 60 minutes** **Ongoing assessment minimum 4-hourly**

<4hrs Essential

Fluid Balance Chart (EU, AU, MEAU)

Body Weight: _____ 24hrs from _____ on _____ to _____ on _____	Surname: _____ Mr /Mrs / Miss First Name: _____
<u>Previous 24 Hour Balance</u> Input _____ mls Output _____ mls 24 hour balance _____ mls	<u>Daily Urinalysis</u> Jug filled to _____ mls at _____ Fluid restriction of _____ in 24 hours

TIME	INTAKE					OUTPUT				
	INTRAVENOUS FLUIDS			ORAL		URINE		GASTRIC		Other
	Type	Vol. set up	given vol.	Vol.	Type	Vol.	Total	Vol.	Nature	Vol.
c/f										
12hour Total										
12hour Total										
12hour Total										

CUMMULATIVE BALANCE

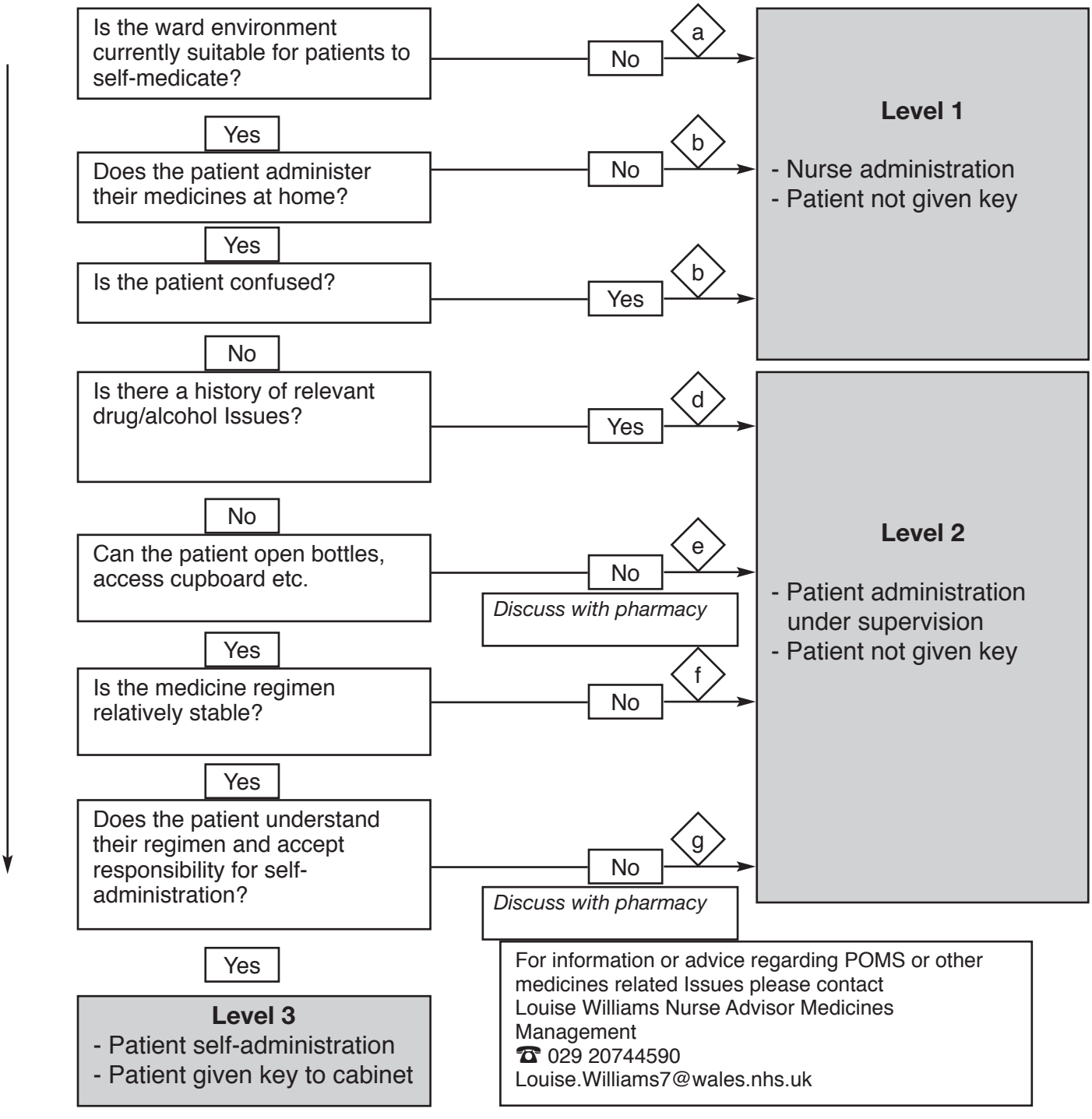
PATIENT ORIENTATED MEDICATION SYSTEM (POMS) ASSESSMENT

1. Each patient should be assessed on admission to the ward as soon as their condition allows
2. Re-assessment must be scheduled as determined by patient's condition and treatment
3. Patients can move up and down level as required

Assessment date						
Level						
Reason						
Nurse signature						

Patient agreement for self medication (level 3) – I have received and understand the information given to me on self administration of medicines and I agree to self administer. I am aware that I may change my mind at any time but must inform my named nurse. I understand that in future the nursing staff may also advise against self-administration if my condition changes.

Signed ..... Print ..... Date .....



For information or advice regarding POMS or other medicines related Issues please contact
Louise Williams Nurse Advisor Medicines Management
☎ 029 20744590
Louise.Williams7@wales.nhs.uk

Patient's Property Liability Disclaimer

To be completed within 6 hours of arrival at hospital, as part of the patient admission process.

I _____ acknowledge that the opportunity has been given to me to hand over my personal property, medications and valuables to be placed in safekeeping in accordance with the Cardiff & Vale University Health Board's policy on Patient's Property.

I _____ have declined the offer to hand over my personal property, medications and valuables to be placed in safekeeping in accordance with the Cardiff & Vale University Health Board's policy on Patient's Property.

Name of Patient _____ Signature _____

Dated _____

Name of Witness *(must be staff member)* **_____**

Designation _____

Signature Date _____

<u>Valuables have been handed over for safekeeping</u>

Name *(must be staff member)* **_____**

Designation _____

Signature Dated _____

Patient's Property Book reference _____

<u>Please file completed disclaimer in the patient's records</u>

Property List (EU, AU, MEAU)

<4hrs

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Date:	Time:
Signature (Nurse)	
Signature (Witness)	
Signature (Patient)	

Item	Quantity	Personal Items	Quantity/Description
Clothing (List Items)		Denture Top	
		Denture Bottom	
		Hearing Aids	
		Glasses	
		Contact Lenses	
		Wig	
		Walking Aids	
		Wheelchair	
		Keys	
Jewellery		Wallet	
Mobile/Digital Equipment (describe/list)		Bank Card (Bank Name)	Last 4 Digits

Property Location (Including medication)			
With Patient	☐	Disclaimer Signed	☐
Cashier Office	☐	Reference Number ……. Staff Name …… Staff Signature……	

Transferred to Area/Ward	**Area/Ward Name**	**Staff Transferring**	**Staff Accepting**	**Date**

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

PURPOSE T PRESSURE ULCER RISK ASSESSMENT

NHS Wales v2.1 (24/07/2020)

GIG CYMRU NHS WALES

Step 1 – screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk ☐
- Spends all or the majority of time in bed or chair ☐
- Remains in the same position for long periods ☐
- Walks independently with or without walking aids ☐

If **ONLY** blue box is ticked

Skin status – *tick all applicable*

- Current PU category 1 or above? ☐
- Reported history of previous PU? ☐
- Vulnerable skin ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐
- Normal skin ☐

If **ONLY** blue box is ticked

Clinical Judgement – *tick as applicable*

- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids ☐
- No problem ☐

If **ONLY** blue box is ticked

No pressure ulcer **not currently at risk**
Tick if applicable ☐

Not currently at risk pathway

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem ☐
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural ☐

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional ☐
- Frequent (2 – 4 times a day) ☐
- Constant ☐

Perfusion – *tick all applicable*

- No problem ☐
- Conditions affecting central circulation e.g. shock, heart failure, hypotension ☐
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease ☐

Nutrition – *tick all applicable*

- No problem ☐
- Unplanned weight loss ☐
- Poor nutritional intake ☐
- Low BMI (less than 18.5) ☐
- High BMI (30 or more) ☐

Medical device – *tick as applicable*

- No problem ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐

Diabetes – *tick as applicable*

- Not diabetic ☐
- Diabetic ☐

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2014)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Suspected Deep Tissue Injury (Depth Unknown)
Purple localized area of discloloured intact skin or blood-filled blister

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*

For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin	Skin site	Pain	Vulnerable skin	PU category	Normal skin	Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐	☐	☐	R Hip	☐	☐	☐	☐	R Elbow	☐	☐	☐	☐
L Buttock	☐	☐	☐	☐	L Heel	☐	☐	☐	☐	Other as applicable *(may be medical device site)*				
R Buttock	☐	☐	☐	☐	R Heel	☐	☐	☐	☐		☐	☐	☐	☐
L Ischial	☐	☐	☐	☐	L Ankle	☐	☐	☐	☐		☐	☐	☐	☐
R Ischial	☐	☐	☐	☐	R Ankle	☐	☐	☐	☐		☐	☐	☐	☐
L Hip	☐	☐	☐	☐	L Elbow	☐	☐	☐	☐		☐	☐	☐	☐

Previous PU history – *tick as applicable*

- No known PU history ☐
- PU history – *complete below* ☐
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

PU Category 1 or above or scarring from previous pressure ulcers
Tick if applicable ☐
PU Prevention/Management Care Plan

No pressure ulcer but **at risk**
Tick if applicable ☐
PU Prevention/Management Care Plan

No pressure ulcer **not currently** at risk
Tick if applicable ☐
Reassess risk as per Pressure Ulcer Policy

Nurse Printed Name	Nurse Signature	Date	Time
		DD / MM / YYYY	HH:MM

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

PATIENT HANDLING ASSESSMENT & SAFER HANDLING PLAN

GIG CYMRU NHS WALES

TO BE COMPLETED IN BLACK INK

Overall Mobility Classification				
				
A	B	C	D	E

Fully Independent				Risk of Falls			
Yes		No		Yes		No	

Hospital:	Ward:
Height: cms or ft, ins	Weight: Kg Weighed / Estimated / Patient Reported

Sensory Factors						
Hearing deficit		Hearing aid	Yes		No	
Sight deficit		Spectacles	Yes		No	

Manual Handling Risk Factors / Constraints (tick if present)			
Lack of comprehension / understanding		Disability	
Has confusion / agitation		Weakness	
Lack of co-operation / compliance		Pain	
Skin lesions / wounds		Infusion / catheter / drain etc.	
Day / Night variation		Cultural considerations	
Other e.g. traction, limb oedema (state)			
(Consult patients notes for detail)			

Moving in bed (i.e. rolling, turning & up/down bed)						Staff 1 2 3 other
Rolling/Turning		**Up/down bed**		**Equipment** (if reqd.)		Additional information: e.g. method/manoeuvre, other equipment etc
Independent		Independent		Slide sheets		
Supervision / verbal prompt		Supervision / verbal prompt		Grab handle		
Assisted		Assisted		Other		

Supine ⟷ sitting on edge of bed				**Bed Rest**		Staff 1 2 3 other
Supine to sitting on edge of bed		**Sitting on edge of bed to supine**		**Equipment** (if reqd.)		Additional information: e.g. method/manoeuvre, other equipment etc.
Independent		Independent		Slide sheets		
Supervision / verbal prompt		Supervision / verbal prompt		Grab handle		
Assisted		Assisted		Leg lifter		

Showering		**Equipment**			Staff 1 2 3 other
Independent		Hi-low hygiene chair			Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Fixed Height Shower chair			
Assisted		Shower trolley			

Bathing		**Equipment**			Staff 1 2 3 other
Independent		Bath / Hi-low bath			Additional information: e.g. method/manoeuvre, other equipment etc
Supervision / verbal prompt		Bath trolley / hoist			
Assisted		Hoist & sling		Bathing sling size **S M L LL XL**	

ADDRESSOGRAPH

PATIENT HANDLING ASSESSMENT & SAFER HANDLING PLAN

GIG CYMRU NHS WALES

TO BE COMPLETED IN BLACK INK

Washing		**Equipment**			**Staff 1 2 3 other**
Independent		Bed/assisted wash			Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Chair			
Assisted					

Toileting		**Equipment**			**Staff 1 2 3 other**
Independent		Toilet			Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Commode			
Assisted		Bedpan			

Walking		**Equipment**			**Staff 1 2 3 other**
Independent		Walking stick			Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Walking Frame			
Assisted		Walking Hoist			

All Transfers (i.e to/from bed, chair, commode, toilet etc.)					**Staff 1 2 3 other**
Independent		**Equipment**			Additional information: e.g. method/manoeuvre, other equipment etc.
Supervision / verbal prompt		Standing turntable		Standing Aid	
Assisted		Bed assist, stand		Transfer Board	
Active/Standing Hoist		Model:		Sling size **S M L XL**	
Passive Hoist		Model:		Sling size **S M L LL XL**	

Other Specific Risks e.g. environmental, equipment or task-related etc.		
Details	**Risk Reduction Measures**	
Assessor Name	**Date**	**Mobility Classification Tool (LOCOmotor ©)**

ADDITIONAL RESOURCES REQUIRED

Resource Required	**Reason/ Justification**	**Specification**	**Date Requested**	**Date Provided**
Manager Name		**Signature**	**Date**	

Version: 1.0 (pilot release)
Approval Date: 25/01/2019

Approved by: Directors of Nursing

ADDRESSOGRAPH

PATIENT HANDLING ASSESSMENT & SAFER HANDLING PLAN

TO BE COMPLETED IN BLACK INK

SAFER HANDLING PLAN REVIEW

Reason for Review	Routine		More assistance reqd		Less assistance reqd.		Following Incident	

Activity	**Change(s) to Documented plan**	**Overall Mobility Classification**  A B C D E
Moving in Bed		
Getting in/out of bed		
Showering / bathing / washing		
Toileting		
Transfers		
Walking		

Other relevant information:

Assessor Name		**Signature**		**Date**	

SAFER HANDLING PLAN REVIEW

Reason for Review	Routine		More assistance reqd.		Less assistance reqd.		Following Incident	

Activity	**Change(s) to Documented Plan**	**Overall Mobility Classification**  A B C D E
Moving in Bed		
Getting in/out of bed		
Showering / bathing / washing		
Toileting		
Transfers		
Walking		

Other relevant information:

Assessor Name		**Signature**		**Date**	

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

ADDRESSOGRAPH

PATIENT HANDLING ASSESSMENT & SAFER HANDLING PLAN

GIG CYMRU NHS WALES

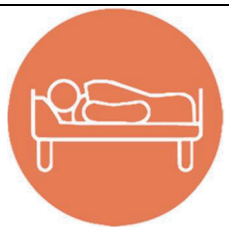
TO BE COMPLETED IN BLACK INK

Guidance Notes: Patient Handling Risk Assessment & Safer Handling Plan

Whom should complete this assessment: A Registered Healthcare Professional (RHP). If a suitably experienced person who is not an RHP completes the assessment form, then it must be checked and countersigned by an RHP.

Fix Patient Addressograph: Ensure correct addressograph is attached, if not available write patient's details in the box.

Functional Mobility Level: Consider the level of the patient's functional mobility i.e. what the patient is physically able to do in assisting with each task. Record this level using the Mobility classification tool (LOCOmotor ©) as detailed below **A,B,C,D or E** where indicated on the form.

Mobility Classification Tool (LOCOmotor ©)	
	A Ambulatory, but may use a walking stick for support Independent, can clean and dress oneself. Usually no risk of dynamic or static overload to carer. Simulation of functional mobility is very important
	B Can support oneself to some degree and uses walking frame or similar. Dependant on carer in some situations. Usually no risk of dynamic overload to carer. A risk of static overload to carer can occur if not using proper equipment. Stimulation of functional mobility is very important
	C Is able to partially weight bear on at least one leg. Often sits in a wheelchair and has some trunk stability. Dependant on carer in many situations. A risk of dynamic and static overload to carer when not using proper aids. Stimulation of functional mobility is very important
	D Cannot stand and is not able to weight bear. Is able to sit if well supported. Dependant on carer in most situations. A high risk of dynamic and static overload to carer when not using proper equipment. Stimulation of functional participation is very important
	E Might be almost completely bedridden, can sit out only in a special chair. Always dependent on carer. A high risk of dynamic and static overload to carer when not using proper equipment. Stimulation of functional participation is not a primary goal

Body Maps

Guidance for completion.

Use to document and illustrate vital signs of physical injury or harm.

This table is to be completed and recorded even if no injury/damage is present (see example)

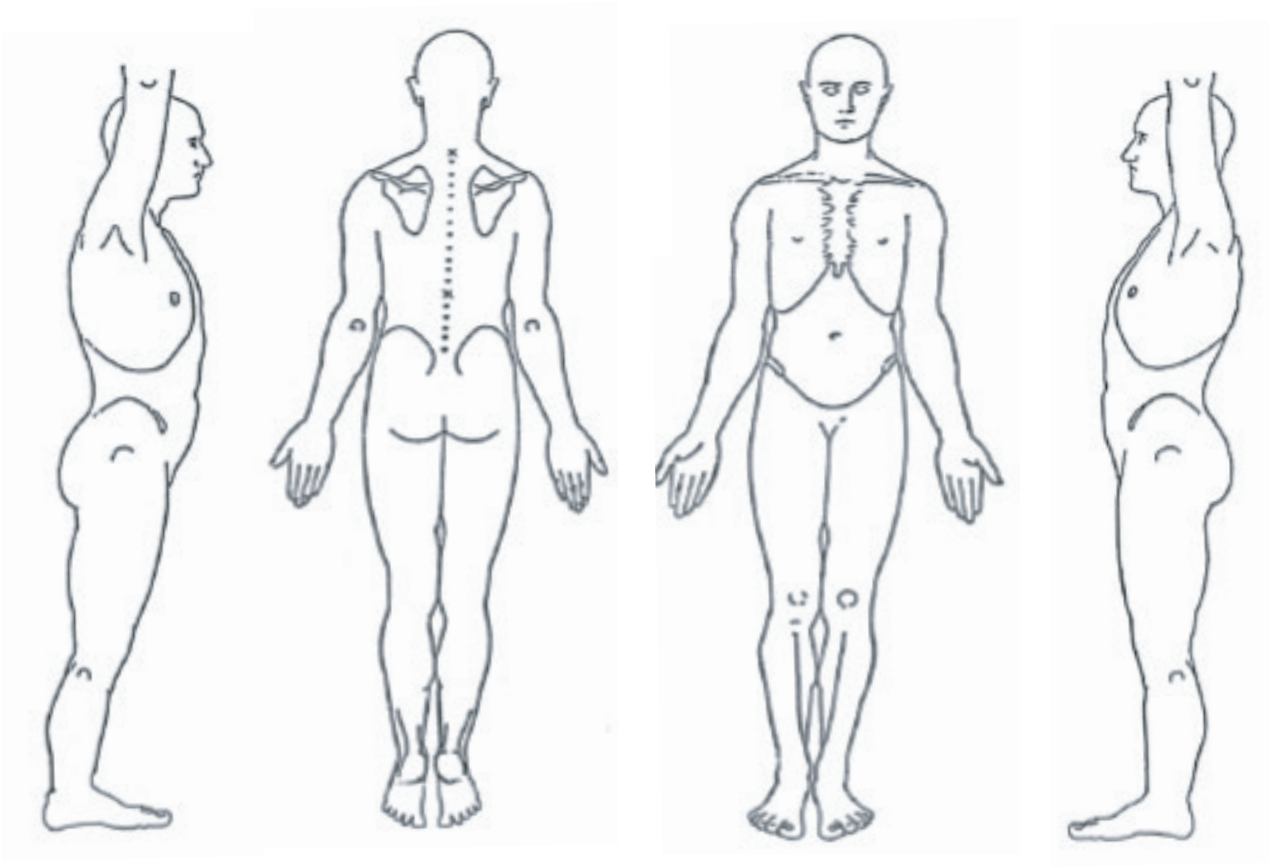
Drawn on the body map in black ink, using the key to indicate the different types of injury (shading or alphabetical code).

Use the table to provide details for each injury, eg. measurements of wounds, colour of bruise, widespread/localised etc.

Consider the need for a care plan, and evaluate findings and actions.

Key

- ☐ A - Pressure ulcer
- ☐ B - Moisture lesion
- ☐ B - Wounds, cuts, abrasions
- ☐ D - Surgical wound
- ☐ I - Harm
- ☐ F - Bruising
- ☐ G - Other



The body map should be completed within 6 hours of admission or transfer to/from another area. Thereafter, record weekly and as the patients condition improves or deteriorates.

If you identify any areas of concern then a wound assessment form must be completed and the care plan updated accordingly.

Date	Time (24hr clock)	Key	Description of findings	Signature

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT, ACTIONS & INTERVENTIONS FOR ALL ADULT IN-PATIENTS

Complete within 6 hours of admission and on transfer to other clinical area.
Review:

- **Following a fall, following any change in patient's clinical condition; a deterioration or improvement, or every week as a minimum.**
- **Involve patient and family in assessment and action planning, taking into account a patient's ability to understand/retain information**
- **All 'YES' answers must be actioned, but the examples given should be considered as prompts and are not an exhaustive list**
- **Multifactorial Actions and Interventions MUST be reviewed with each reassessment and signed and dated in the right-hand column**

Mandatory actions for all adult patients

	REVIEW 1		REVIEW 2	
Date of Review:	**Time of Review:**	**Date of Review:**	**Time of Review:**	
		Do any of the actions in 'Review 1' need to be repeated due to a change in patient condition or circumstance?		
Please confirm that the following actions have taken place:		**Yes ☐ (Continue to review this section)**	**No ☐ Initials: (Progress to next section)**	
• Advise on safe transfer/mobility and promote consistent messages	**Initials:**	**Initials:**		
• Advise on safe footwear	**Initials:**	**Initials:**		
• Give the 'reducing harm from falls' information leaflet	**Initials:**	**Initials:**		
• Orientate patient to ward	**Initials:**	**Initials:**		

Patient Specific Guidance

• Is the call bell working and in reach (where applicable)	**Yes** Initials:	N/A ☐	**Yes** Initials:	**N/A** ☐
• Advised patient about transfer/mobilising following anaesthetic/procedure (where applicable)	**Yes** Initials :	**N/A** ☐	**Yes** Initials:	**N/A** ☐
• Advise on risks from drips/tubing/aids (where applicable)	**Yes** Initials :	**N/A** ☐	**Yes** Initials:	**N/A** ☐
• The patient is prescribed warfarin/anticoagulants and this information has been shared in safety briefing / handover	**Yes** Initials :	**N/A** ☐	**Yes** Initials:	**N/A** ☐

Version: 1.2 **Approval Date:** Jan 21 **Approved By:** Clinical Nursing Informatics Officers

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

Falls update Falls History: Circle how many falls in the last 12 months (each fall increases risk) 1 2 3 4 5+

REVIEW 1	Date: / Initials:	REVIEW 2	Date: / Initials:
Has the patient had an inpatient fall since the last assessment		**Has the patient had an inpatient fall since the last assessment**	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)
Does the patient have a fear of falling		**Does the patient have a fear of falling**	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)

Medication

- Patients prescribed anticoagulants/ Warfarin are at increased risk of injury following a fall
- Patients prescribed sedatives, hypnotics, antipsychotics or diuretics are at an increased risk of falls
- Medications that lower BP or cause dizziness increase falls risks

REVIEW 1	Date: / Initials:	REVIEW 2	Date: / Initials:
Is the Patient on Medication that could increase the risk of falls, or injury from falls?		**Is the Patient on Medication that could increase the risk of falls, or injury from falls?**	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)
What is being done to reduce the risks associated with medication? Actions to consider may include: medication review, discussion with MDT colleagues		**What is being done to reduce the risks associated with medication?** Actions to consider may include: medication review, discussion with MDT colleagues	

Version: 1.2 **Approval Date:** Jan 21 **Approved By:** Clinical Nursing Informatics Officers

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

Physiological Risks

- Patients who are medically unwell, for example, scoring on NEWS are at an increased risk of falls
- Patients who are at risk of seizures are at an increased risk of falls
- Postural drop in BP increase falls risks

REVIEW 1	Date:	REVIEW 2	Date:
	Initials:		Initials:

Does the patient have physiological risks that could increase the risk of falls		Does the patient have physiological risks that could increase the risk of falls	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)

What is being done to reduce the risks
Actions to consider may include: medication review, discussion with MDT colleagues, lying and standing BP

What is being done to reduce the risks
Actions to consider may include: medication review, discussion with MDT colleagues, lying and standing BP

Cognitive /Mental State

- Being, for example, agitated, restless, impulsive, disoriented or confused increase the risk of falls
- Think Delirium and its causes

REVIEW 1	Date:	REVIEW 2	Date:
	Initials:		Initials:

Does the patient have any issues with Cognitive/ Mental State		Does the patient have any issues with Cognitive/ Mental State	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)

What is being done to reduce the risks
Actions to consider may include: Delirium screen; cognitive Screening tool, 24 hours behaviour chart; utilise life story tool e.g. Read about Me

What is being done to reduce the risks
Actions to consider may include: Delirium screen; cognitive Screening tool, 24 hours behaviour chart; utilise life story tool e.g. Read about Me

Version: 1.2 **Approval Date:** Jan 21 **Approved By:** Clinical Nursing Informatics Officers

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

Mobility

Patients are at an increased risk of falls if:

- they need help to walk, transfer or walk
- try to walk unaided but are unsafe
- use a walking aide
- have gait or balance problems
- have issues with seating, e.g. slipping out of the chair

REVIEW 1	Date:	**REVIEW 2**	Date:
	Initials:		Initials:

Does the patient have risk associated with mobility that could increase the risk of falls		**Does the patient have risk associated with mobility that could increase the risk of falls**	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)

What is being done to reduce the risks
Actions to consider may include: refer to physiotherapy; record and use individual plan for safe patient handling; place aids within reach; one-way glide sheets

What is being done to reduce the risks
Actions to consider may include: refer to physiotherapy; record and use individual plan for safe patient handling; place aids within reach; one-way glide sheets

Foot Health

- Wearing inappropriate footwear increases the patient's risk of falls
- Foot pain or foot health issues for example, overgrown toenails, dressings, pressure damage, oedema increases the patient's risk of falls

REVIEW 1	Date:	**REVIEW 2**	Date:
	Initials:		Initials:

Does the patient have any issues with foot health, foot pain or inappropriate footwear that could increase the risk of falls?		**Does the patient have any issues with foot health, foot pain or inappropriate footwear that could increase the risk of falls?**	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)

What is being done to reduce the risks
Actions to consider may include: advise on appropriate footwear; arrange for social nail cutting; referral to podiatry; use of other assessment for example, body maps

What is being done to reduce the risks
Actions to consider may include: Actions to consider may include: advise on appropriate footwear; arrange for social nail cutting; referral to podiatry; use of other assessment for example, body maps

Version: 1.2 **Approval Date:** Jan 21 **Approved By:** Clinical Nursing Informatics Officers

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FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

Sensory Deficits

- Patients who have visual and/ or hearing impairment are at an increased risk of falls
- Patients without access to their usual glasses or hearing aid are at an increased risk of falls
- Numbness, weakness or spatial perception problems increase the risk of falls

REVIEW 1	Date:	REVIEW 2	Date:
	Initials:		Initials:

Does the patient have sensory deficits that could increase the risk of falls		Does the patient have sensory deficits that could increase the risk of falls	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)

What is being done to reduce the risks
Actions to consider may include: ask relatives to bring in glasses/ hearing aid; replace hearing aid battery; appropriate referral; undertake actions for individual care needs

What is being done to reduce the risks
Actions to consider may include ask relatives to bring in glasses/ hearing aid; replace hearing aid battery; appropriate referral; undertake actions for individual care needs

General /Other

- Factors such as dehydration, continence urgency, dementia, pain, substance misuse or sleep and rest deprivation can increase the risk of falls

REVIEW 1	Date:	REVIEW 2	Date:
	Initials:		Initials:

Does the patient have any general issues that can increase the risk of falls		Does the patient have any issues with Cognitive/ Mental State	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)

What is being done to reduce the risks
Actions to consider may include: refer to local and national pathways and other core risk assessments; consider how the issues contribute to falls

What is being done to reduce the risks
Actions to consider may include: refer to local and national pathways and other core risk assessments; consider how the issues contribute to falls

NHS Number
Hospital No.
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Surname
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Address
Postcode

FALLS AND BONE HEALTH MULTIFACTORIAL ASSESSMENT

Patient /family views

• The patient and/or family may identify factors that can increase the risk of falls

REVIEW 1	Date: / Initials:	REVIEW 2	Date: / Initials:
Does the patient/ family identify any factors that could increase the risk of falls		**Does the patient/ family identify any factors that could increase the risk of falls**	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No(Continue to next section)
What is being done to reduce the risks: Actions to consider may include: refer to physiotherapy; record and use individual plan for safe patient handling; place aids within reach; one-way glide sheets		**What is being done to reduce the risks:** Actions to consider may include: refer to physiotherapy; record and use individual plan for safe patient handling; place aids within reach; one-way glide sheets	

Fractures and Osteoporosis

• History of fractures and osteoporosis increases the risk of falls

REVIEW 1	Date/ Time / Initials:	REVIEW 2	Date/ Time / Initials:
Does the patient have a history of fractures and osteoporosis		**Does the patient have a history of fractures and osteoporosis**	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)
What is being done to reduce the risks: Actions to consider may include: liaise with doctor re: anti osteoporotic medications/screening		**What is being done to reduce the risks:** Actions to consider may include: liaise with doctor re: anti osteoporotic medications/screening	

Targeted Interventions

• In addition to patient centred interventions, targeted interventions may reduce the risk of falls for patients

REVIEW 1	Date/time / Initials:	REVIEW 2	Date/time / Initials:
Based on the assessment, are there any targeted interventions required?		**Based on the assessment, are there any targeted interventions required?**	
Yes (Complete intervention box below)	No (Continue to next section)	Yes (Complete intervention box below)	No (Continue to next section)
What is being done to reduce the risks: Describe measures in use, for example, low bed, bed in observable position, close observations, intentional rounding, safety mat, sensors etc.		**What is being done to reduce the risks** Describe measures in use, for example, low bed, bed in observable position, close observations, intentional rounding, safety mat, sensors etc.	

Version: 1.2 **Approval Date:** Jan 21 **Approved By:** Clinical Nursing Informatics Officers

Patient Identification Label

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

This form is to be completed at the beginning of each shift or whenever there is change

ADULT PATIENT BEDRAIL RISK ASSESSMENT

ENSURE THE BED IS AT THE LOWEST SETTING WHEN PATIENT IS UNATTENDED

Directorate		Ward	

The Falls Risk Assessment (where appropriate) must be completed prior to completion of this bedrail assessment

Staff should use the bedrail risk assessment in addition to their professional jundgement to consider the risks and benefits for individual patients. Tick the box that applies and complete date, time and initial of person completing, this must be countersigned by a trained member of staff if completed by non qualified staff.

RISK FACTOR	USE OF BEDRAILS		Date							
			Time							
			Initial							
Patient is independently mobile	Bedrails not to be used	Check patient has not requested use of bedrails								
Patient is likely to attempt to get out of bed alone	Bedrails not to be used	Use height adjustable bed to suit patients requirements								
Patient has previously attempted to climb over bedrails	Bedrails not to be used	Consider use of low height bed								
Patient has uncontrolled limb movements / restless / significantly confused	Bedrails not to be used	Consider use of low height bed, Consider staffing levels, Consider placement of bed								
Patient has difficulty rolling over in bed	Bedrails not to be used	Consider use of bed levers								
Some of the above risk factors apply but bed rails may be needed for patient and staff safety	Professional decision to be made and documented in the exception section	E.G. patient is extremely agitated and will be continually nursed by staff at the patients bedside								
Patient **is not likely** to attempt to get out of bed alone	Consider use of Bedrails	Optional use of protective bedrail bumpers								
Patient has disruption to their spatial or visual awareness	Consider use of Bedrails	Optional use of protective bedrail bumpers								
Patient has a fear of falling out of bed whilst asleep	Consider use of Bedrails									
Patient is recovering from anaesthetic	Bedrails to be used	Optional use of protective bedrail bumpers								
Patient has requested bedrails or uses bedrails at home	Bedrails to be used									
Patient is unconscious or completely immobile	Bedrails to be used	Optional use of protective bedrail bumpers								

If risk factors conflict e.g. Patient is independently mobile and the patient has requested bedrails, or uses bedrails at home, staff need to use their professional judgement to consider the risks and benefits for individual patients and document it in the exception section. Consideration should be given to other control measures when completing this assessment.

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:
ADDRESSOGRAPH

ADULT NUTRITIONAL RISK SCREENING TOOL (WAASP)

GIG CYMRU NHS WALES

TO BE COMPLETED IN BLACK INK

*Date_____ Height _____ m Weight_____ kg (on admission) *BMI ____kg/m^2
(state if this is **M**easured, **R**eported, **E**stimated, or **U**nable to weigh and record reason in notes)

Category			DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
	Date							
	Time (24hour clock)		HH:MM	HH:MM	HH:MM	HH:MM	HH:MM	HH:MM
	Weight (kg) / indicate reason if no weight							
Weight (consider fluid retention when assessing weight history)	Weight loss of 6 kg or more (1 stone) within last 6 months, extremely thin or cachexic, *BMI < 18.5 kg/m^2	**7**						
	Unintentional weight loss 3kg (7lb) within last 6 months	**2**						
	No weight loss	**0**						
Appetite (current)	Little or no appetite or refuses meals and drinks	**4**						
	Poor – eating less than a quarter (1/4) of meals and drinks	**3**						
	Reduced – eating half of meals	**1**						
	Good – eats 3 meals/day or is fully established on tube feed	**0**						
Ability to eat (current)	NBM for more than 5 days	**7**						
	Unable to tolerate food via gastrointestinal tract due to nausea or vomiting, constipation or diarrhoea, difficulty chewing/swallowing due to dysphagia or mucositis	**4**						
	Requires prompting, encouragement or assistance to eat and drink	**1**						
	No difficulties- able to eat and drink normally and independently	**0**						
Stress Factor (if clinical condition is not listed, choose a similar condition)	Upper GI cancer – pre/post-surgery, extensive bowel resection/high output. Head &neck cancer surgery, kidney& pancreatic transplant BMT, 20% and above missed depth burn	**7**						
	Moderate surgery e.g. cardiothoracic, kidney transplant, vascular Malignant disease, with complication e.g. infection. Recent multiple injuries e.g. spinal injury/trauma, head injury, GBS Uncomplicated bowel surgery, decompensated liver disease Acute kidney injury, renal replacement therapy (HD/PD) Severe infection, sepsis, endocarditis, pneumonia, peritonitis Acute and chronic pancreatitis, HIV, 15-20% mixed depth burn	**4**						
	MND, MS, Parkinson's, dementia, heart failure, COPD, CVA Fractured neck of femur, inflammatory bowel disease Uncomplicated /stable malignant disease, 10-15% mixed depth burn	**2**						
	Uncomplicated condition with no interruption in food intake e.g. MI	**0**						
Pressure Ulcer/ Wound (if ungradable choose highest)	Cat 4 pressure ulcer or open abdomen	**7**						
	Cat 3 pressure ulcer or dehisced/infected/moderate exudate wound	**4**						
	Cat 1-2 pressure ulcer or non-healing/low level exudate wound	**2**						
	Pressure areas intact, healing or healthy wound	**0**						
	Total Score							
	Completed by (Initials)							
	Reviewed by (Initials)							

ADULT NUTRITIONAL RISK SCREENING TOOL (WAASP) GUIDANCE

Note: This nutrition risk screening tool does not supersede clinical judgement – please refer to the Dietitian if you have any concerns regarding the patient's nutrition

Guidelines for completion

Complete assessment within 24 hours of admission to hospital

Record weight and height (if unable, ask the patient or relative to estimate)

Select the **highest** score that applies in **each** section

Add the score of each section and record the **tota**l box

Assess risk depending on score and take appropriate action

Reassess weekly

SCORE and ACTION

0-2 LOW RISK

- Repeat screening in one week or sooner if patient condition changes

3-6 MODERATE RISK

Assist with meal choice

Encourage eating and drinking and assist if required

Encourage milky drinks and snacks between meals

Monitor intake on the All Wales Food Record Chart

Complete/initiate local care plans – refer to local policy

Repeat screening in one week or sooner if patient condition changes

7+ HIGH RISK

Refer to the Dietitian & follow actions as per Moderate Risk

Monitor intake on the All Wales Food Record Chart

Complete/initiate local care plans – refer to local policy

Repeat screening in one week or sooner if patient condition changes

Referral to the Dietitian should be made irrespective of WAASP score if the patient:

Requires or is receiving any form of Enteral or Parenteral nutrition support

Reports the use of prescribed nutritional supplements on admission

Newly diagnosed therapeutic diet e.g. gluten free, Type 1 Diabetic

If the patient requires a therapeutic diet e.g. texture modified diet, potassium restriction, food allergy or intolerance– inform catering of the specific dietary need and refer to the Dietitian if the patient requires additional support.

Version: 1.2 (CTMUHB Release)
Approval By: Directors of Nursing 25/01/2019

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address

ADDRESSOGRAPH

Postcode:

CONTINENCE / TOILETING RISK ASSESSMENT TOOL

TO BE COMPLETED IN BLACK INK

GIG CYMRU NHS WALES

Continence/Toileting Risk Initial Assessment to be completed within 4 hours of admission. A review to be undertaken on each transfer to a Clinical Area/Ward.

If continence / toileting needs are identified the patient must be re-assessed at least **weekly** or sooner if their condition changes and their care plan updated accordingly.

If answered YES to **any** questions the patient is at High Risk of becoming incontinent or may already be experiencing incontinence. If risk identified implement an individual **Treatment / Toileting or Management Care Plan.**

Continence status, needs and preferences must be discussed and confirmed at each nursing handover.

At this CURRENT time does your patient:	**Date**	DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY	
	Time	HH:MM		HH:MM		HH:MM		HH:MM		HH:MM		HH:MM		HH:MM	
Need help to get to the toilet		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have any cognitive problems		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have mobility problems		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to rush to the toilet		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to use the toilet frequently		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Leak urine		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick):	Occasionally														
	Regularly														
Leak faeces		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick):	Occasionally														
	Regularly														
Have constipation		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have diarrhoea		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Bristol stool type															
Have difficulty passing urine		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have difficulty passing faeces		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally wear a pad or use other devices		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally use a catheter		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If Yes, (tick):	Indwelling														
	Intermittent Self Catheterisation														
Normally use any equipment to help with toileting		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Signature															
Designation															

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Guide to Nurse or Patient:

Please record every bowel action

STOOL CHART

The Bristol Stool Form Scale

Type 1		Separate hard lumps, like nuts (hard to pass).
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4 semi-formed		Like a sausage or snake, smooth and soft.
Type 5 Loose stool		Soft blobs with clear cut edges (passed easily)
Type 6 Diarrhoea		Fluffy pieces with ragged edges, a mushy stool
Type 7 Diarrhoea		Watery, no solid pieces. Entirely liquid

Reproduced by kind permission of Dr K W Heaton, Reader in Medicine at the University of Bristol.

DATE	TIME	TYPE (1–7)	OFFENSIVE Y / N	AMOUNT		Please✓ if stool sent for MC&S
				small / med / large	Blood	

Date/Time	Care Documentation	Triage Code	Print and Sign

Date/Time	Care Documentation	Triage Code	Print and Sign

For Assessment Unit and MEAU

✓ = Yes ✗ = No NA = Non Applicable v = See Notes

EU: >4hrs and if appropriate for the patient's needs

Date: ___/___/_____

Frequency: 2 hrly / 4 hrly | Initials:

A&EMD Intentional Rounding v2.

	Time	__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__
Q1	**Introductions** Hello my name is												
Q2	**Orientation** **FA** – Fully alert **MC** – mildly confused **SC** – Severely Confused, **AS** – Asleep												
Q3	**Pain** Do you have any pain?												
Q4	**Nutrition and Hydration** Would you like a Drink/Food? Fluid/Food Chart?												
Q5	**Continence** Would you like the toilet?												
Q6	**Mouth Care** Is your mouth sore or painful? Is it Dry?												
Q7	**Position/Comfort** Are you comfortable? Are you warm enough?												
Q8	**Items within Reach** Ensure alarm bell in reach Water = W Glasses = G												
Q9	**Risk of Falls** Trolley at lowest level? Trolley rails up? Appropriate foot wear available?												
Q10	**Is there anything else that I can do for you?**												
	Initials												
Every patient to be assessed for Pressure damage on arrival. Skin inspection should be conducted at least once per shift for low risk patients.													
		__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__	__:__
Surface	**PRM** - Pressure Relieving Mattress, **RC** - Repose Cushion, **RM** - Repose Mattress, **D**=Duo2 **P**=Primo												
Skin Check	**S** - Sacrum, **H**-Heels, **All**- Full Body Check. **D** - declined (Document any damage on the Body Map)												
Skin Check	Document Grade if present **I, II, III, IV** **ML**- Moisture Lesion, **FL**- Flap Lac. **NA** - none seen												
Keep Moving	**R**- Right, **L**- Left, **B**- Back, **S**- Sat in Chair, **TIM** - Triple Immobilised												
Inco	CP- Catheter Patent, NA- non applicable. Catheter Care Bundle Updated?												
Inco	Patient Clean and Dry?												
Inco	Barrier Cream applied?												
HCSW Initial													
RN Initial													

Discharge Checklist

Patients Addressograph

Basic checks:

- ☐ Cannula / Catheter removed
- ☐ TTH's / Own medications returned
- ☐ Key / Key safe number
- ☐ NOK informed
- ☐ Suitable clothes and footwear worn

Transport:

- ☐ Family / Friends / Carer
- ☐ Hospital transport / Booking reference:
- ☐ Taxi
- ☐ Own transport / Public transport

Home support (if applicable:

- ☐ Package of Care restarted
- ☐ RH / NH / Warden informed
- ☐ GP surgery / Practice nurse
- ☐ District nurse
- ☐ Follow up appointments

Other:

- ☐ Transfer document
- ☐ Community NFR letter returned
- ☐ Equipment for home
- ☐ Property / Valuables / Money from cashiers returned

Additional Comments .....

.....

Date: ..... Time: .....

Sign: .....

Print: .....