Assessment of Nursing / Healthcare Needs

Title and Name Known as		**Unit number:** **Swift number:**	
Address: **Post code:** **Telephone No:**		**Date of Birth:**	
		Gender:	**Religion:**
		Ethnicity:	
		Preferred Language:	
First contact name and address:		**Home telephone No:** **Work telephone No:** **Mobile telephone No:**	
Relationship:			
Second contact name and address:		**Home telephone No:** **Work telephone No:** **Mobile telephone No:**	
Relationship:			
Name of GP: **Surgery:**		**Telephone No:** **Fax:**	
Name of person present at assessment:		**Current Location:**	Home
Cathy sands		**Date of admission to hospital:**	
		Date of admission to Care home:	
Name and title of referral source:		**Name and title of case manager / key worker:**	
Telephone No:	01206 286724	**Telephone No:**	
Date:		**Date:**	

MDT members involved:	**Name**	**Contact details**	**Last Seen**
Social Worker: Occupational Therapist: Physiotherapist: Speech and Language Therapist: Community Psychiatric Nurse: Other:			

Sharing Information: In order to provide effective and quality care, your assessment could be shared with other agencies or professionals. If you agree to this please sign and date. Please give details of any exceptions.		
Service User Signature:	**Date:**	
Please indicate if consent has already been sought. ***Yes*** ***/ No***	**Date:**	

Details of nurse assessor completing this assessment:

Nurse assessors name:	**Nurse assessors signature:**	**Date:**
Cathy Sands		

Designation	Staff Nurse	Contact Nº	01206 286681	Time:	
Name of Patient:		Name of Assessor:	Louise Cook		

Clinical Background *Diagnosis* *Medical History* *Medical Plan*								
Pain *Pain Management* *Frequency of intervention*								
Breathing								
Altered State Of Consciousness								
Personal Care Needs *Details:*	**Washing & Dressing**	Self caring		One carer		Two carers		
	Mobility	Independent		Stick		Frame		
		Immobile		One carer		Two carers		
	Transfers	Independent		One carer		Two carers		
	Continence	Fully Continent		Incontinent of urine		Incontinent of faeces		
		Catheterised		ISC		Stoma		
Continence Management:	**Referral to Continence advisor:**		**Yes**		**No**			
Night-time needs *Sleep pattern* *Level of supervision*								
Skin - Tissue Viability *Skin Integrity/Wounds* *Dressing type / frequency* *Pressure ulcer prevention* *State risk assessment tool*								
	Risk Assessment Score ☐ **Low / Medium / High / Very high**							
Nutrition- Food & Drink **Detail swallow difficulty* *Appetite* *Weight loss / gain*	Eats unaided		Requires supervision assistance		Requires feeding			
	Skilled feeding		Swallow difficulty [please detail]		Parenteral feeding			
	Weight _____ **BMI** _____							

Patient's Perspective *Patient's preferred outcome* *View of family / friends*	
Leisure Activity's *Hobbies / interests*	
Senses *Ability to communicate* *Sight* *Hearing*	
Mental Health *Behaviour* *Cognitive ability* *Psychological & Emotional needs*	
	Assessment by Mental health professional required: Yes ☐ **No** ☐
Safety *Personal safety* *Safety of others* *History of falls* *-circumstances of falls.*	

Equipment:		**Provided by:**		
	Type [if applicable]	**Care Home**	**Patient**	**Other [please state]**
Mattress				
Hospital bed				
Cot-sides				
Cushion				
Syringe Driver				
Nebuliser				
Suction Machine				
Walking Aid / Wheelchair				
Hoist				
Consumables i.e. tracheostomy equipment, suction catheters				

Medication List							
Name of Drug	**Dose**	**Route**	**Frequency**	**Name of Drug**	**Dose**	**Route**	**Frequency**

Ability to Self-Medicate: **Yes** **No**

ADDENDUM TO NURSING / HEALTHCARE NEEDS

Frequency of interventions required by a carer / spouse / friend / neighbour

Less than once a week	Once a week	2-5 times a week	Daily, or at predictable times	Unpredictably over 24 hours	Intense & Continuous
☐	☐	☐	☐	☐	☐

How often does the individual require Registered Nurse intervention in either the direct provision of care or the planning, supervision or delegation of that care?

Less than once a week	Once a week	2-5 times a week	Daily, or at predictable times	Unpredictably over 24 hours	Intense & continuous
☐	☐	☐	☐	☐	☐

Assessment of Nursing/Healthcare Needs

Name of Patient:		Name of assessor:	

Recommendation

When making a recommendation the first consideration should always be the extent to which the individual meets or does not meet the current Essex NHS health continuing Care criteria. This is regardless of the eventual setting in which that person is likely to be cared for.

A] The individual's needs meet the eligibility criteria for NHS Continuing Health Care

1. NHS Health Continuing Health Care in a care Home with 24hr registered nurse input [nursing home] ☐
2. NHS Health Continuing Care at home to complement existing care. ☐
3. Palliative care in a care home with 24hr registered nurse input [nursing home] Please include letter from a doctor stating diagnosis and prognosis. ☐
4. Palliative care at home with health funding to complement existing care. Please include letter from a doctor stating diagnosis and prognosis. ☐

B] The individual does not meet the eligibility criteria for NHS Continuing Health Care but requires a placement in a care home with 24hr Registered Nurse input.

1. Care Home Placement that has 24hour Registered Nurse input [Nursing Home] ☐

C] The individual's nursing needs can be met by the existing community nursing service.

1. Care Home Placement with Community nursing support [Residential Home] ☐
2. Care in the individual's own home with community nursing support if required. ☐

NHS signatory	Social care signatory

Signature……	**Signature**……
Date……	**Date**……..
Print……	**Print**……..
Job Title…..……..…….	**Job Title**…..……..……

Decision-Support Tool for NHS Continuing Healthcare
Section 2: Care domains

Please refer to the user notes.