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Assessment and Care Planning Integrated Resident Record and Policy Documentation Set

Nursing Homes Ireland is the representative organization for the private and voluntary Nursing Home Sector.

This sector, and the care our members provide, is a key part of the Irish health service.

Providing Leadership, Supporting Members, Promoting Excellence

nursinghomes*ireland*
Unit G6, Centrepoint Business Park, Oak Road, Dublin 12
Telephone: 01 429 2570 • fax: 01 429 1845 • e mail: info@ nhi.ie • www.nhi.ie

Foreword

I am delighted to present this document "Nursing Homes Ireland's Assessment and Care Planning Integrated Resident Record". The document was developed for use by staff in Nursing Homes Ireland member nursing homes.

This document represents a culmination of over a year's project to enhance and standardise the assessment, care planning and overall standard and quality of documentation and record keeping in member nursing homes nationally and the introduction and implementation of a National framework to improve care planning throughout the Nursing Homes Sector.

The development and management of comprehensive, accurate and user-friendly individualised resident records is an essential component in the continuous drive towards high quality care/service provision in residential care. Integrated records for each resident will allow all information pertaining to the individual residents to be stored in one central file. This facilitates the delivery of high quality care/service, as it allows healthcare professionals easy access to all of the information that they require to deliver their day-to-day care.

I would like to thank the steering group for the project who provided a wealth of information Guidance and support for the project and many of whom were also fully involved in the audit process.

I would like to acknowledge and thank the National Council for Nursing and Midwifery (NCNM) for the provision of part funding for the post of Practice Development Facilitator, this funding was provided through the NMPDU HSE South. Can I also thank the Director of the Nursing and Midwifery Planning and Development unit (NMPDU) HSE South, Ms Catherine Killilea and her team for their continued support and advice.

I also wish to thank Mr. Tadhg Daly Chief Executive NHI and the board members of INHO and NHI for their vision in committing finance to this initiative and for their support and advice throughout.

And finally to thank Mr. John Sweeney and the Health Care Informed team for the professional undertaking of the Audit.

Caroline Connelly

Practice Development Facilitator NHI

NURSING HOMES IRELAND LTD.

Unit G6, Centrepoint Business Park, Oak Road. Dublin 12

Telephone: 01 429 2570 • Fax: 01 429 1845 • e-mail: info@nhi.ie • www.nhi.ie

Background

In 2006 the Irish Nursing Home Organisation (INHO) identified the need for a template Resident Record for use by its members. The INHO saw that the development and management of a comprehensive, accurate and user-friendly individualised assessment and care planning standardised documentation set as an essential component of a movement towards high quality care/service provision in residential care. An additional catalyst in this regard was the imminent arrival of the Health Information and Quality Authority's Draft National Quality Standards for Residential Care Settings for Older People.

With input from a number of stakeholders, the INHO developed a comprehensive, evidence based, integrated draft Resident Record for use in residential care settings. This record was then piloted in six residential care units throughout the country. In order to finalise the record the INHO appointed Health Care Informed (HCI) to evaluate its use and appropriateness.

The record was also sent out to a number of key stakeholders for consultation and review.

The Resident Record Audit was undertaken by HCI via three distinct phases. These included:

- Data Audit (evaluating utilisation, comprehensiveness and appropriateness)
- Users Interviews (evaluating benefits and perceived difficulties)
- Resident Record Compliance Review (evaluating the compliance of the record against the Draft National Quality Standards for Residential Care Settings for Older People.)

"Each resident is safeguarded by the residential care setting's record-keeping
Policies and procedures". (Std. 32 Draft Aug 2007)

The HCI Team members reviewed a sample of 5-7 resident records per nursing home. The pilot organisations included:

- Cuil Didin Residential Care Tralee, Co. Kerry
- Castleturvin, Nursing Home, Athenry, Co. Galway
- Belmont House Nursing Home, Stillorgan Co. Dublin
- Tara Care Centre, Bray, Co. Wicklow
- Ashlawn House Nursing Home, Nenagh, Co. Tipperary
- Skibbereen Residential Care Centre. Skibbereen, Co. Cork

Nursing Homes Ireland and Health Care Informed (HCI) would like to express its thanks to the proprietors, managers, and staff, of the pilot organisations for their assistance in carrying out this audit.

Audit Findings

The resultant findings from the audit identified that the draft Resident Record was, overall, seen as a very beneficial tool for gathering and controlling residents care information. All of the pilot users were satisfied with the draft Resident Record. All users interviewed said that they would recommend it to others. Several areas of the draft Resident Record were not completed, however this was deemed to relate to time constraints rather than a perceived inappropriateness. Basic good documentation processes were found to be lacking in several areas. The use of regular record audits to combat this was also found to be lacking. Overall the audit highlighted a distinct need for a change in culture within nursing homes with regards to the necessity of appropriate record keeping and identified a need for education and training with regards to the utilisation of specific sections.

Although the draft Resident Record had been developed and piloted prior to the arrival of the draft National Quality Standards for Residential Care Settings for Older People it was identified that record was found to cover a significant amount of the requirements identified in the draft HIQA standards.

Updated Record

The resident record has now been updated as a result of the areas and issues identified in the audit and feedback from stakeholders, and also to comply with the HIQA draft national standards for residential care settings for older people (standard 32.Aug 07) An audit tool is available at the back of the resident record to ensure ongoing audit

On going education and the need for specific training was identified and Nursing Homes Ireland and Health Care Iinformed are to hold a number of workshops around the country on the integrated resident record and further provision of training will be ongoing.

Members of the Steering group.

Ms Sue Cameron Director of Operations, Firstcare Ireland Dunlaoire Dublin

Ms Rebecca Carolan Director of Nursing Hillview Nursing Home Tara Co. Meath

Ms Eilis Carroll Operations Manager Silverstream Health Care Rathoath Co. Meath

Ms Anne Costello Director of Nursing, Tara Nursing Home, Bray Co. Wicklow

Ms Caroline Connelly Practice Development Facilitator, Nursing Homes Ireland

Ms Alene Curtin Director of Nursing Ashlawn House Nursing Home Nenagh Co. Tipperary

Ms Marie Fitzpatrick Director of Nursing St Eunan's Private Nursing Home
Letterkenny, Co. Donegal

Ms Caroline Gibbons Director of Nursing St Attracta's Nursing Home Charlestown Co. Mayo

Ms Julia Horgan Director of Nursing St Luke's Nursing Home, Mahon, Cork

Ms Carmel Killeen Director of Nursing Castleturvin House Nursing Home Athenry Co. Galway

Ms Anne-Marie Moore Director of Nursing Beechlodge Nursing Home, Bruree Co. Limerick

Ms Catriona O'Connor Director of Nursing, Cuil Didin Residential Care, Tralee Co. Kerry.

Ms Catriona Quealy Director of Nursing Villa Marie Nursing Home Roscrea Co. Tipperary

Ms Margaret Wafer Director of Nursing, Belmont House Nursing Home Stillorgan Dublin

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GUIDELINES FOR USING THE NHI ASSESSMENT AND CARE PLANING INTEGRATED RESIDENT RECORD

INTRODUCTION

An Bord Altranais states that each nurse should establish and maintain accurate, clear and current client records within a legal, ethical and professional framework. Nurses are professionally and legally accountable for the standard of the professional practice. An Bord Altranais Recording Clinical Practice Guidance to nurses and Midwives (November 2002).

The aim of the user guide is to provide assistance to staff using the resident record. The record should where possible, be planned, agreed and evaluated with the resident and/or their Representative.

GENERAL POINTS FOR NURSING DOCUMENTATION

- Use Black pen only.
- Complete the signature list before completing the care planning documents. (Sample signature and initials).
- Fill in all sections of the assessment and care planning documentation. Document if a section is not applicable.
- Name, Date of Birth, Next of Kin and contact details. Presenting history, a set of observations, any know allergies, pressure sore risk assessment, falls risk assessment and any other risk assessments identified must be completed on admission.
- The comprehensive Nursing assessments must be commenced on admission and completed within seven days and a plan of care commenced within 48 hours or sooner if indicated by the general risk assessment
- Write in block capitals for Residents name, next of kin and contact telephone numbers.
- Write legibly.
- Use the 24hr clock, date and sign each entry.
- Make all entries as soon as possible after the event.
- Be accurate, concise and factual.
- Abbreviations only from the approved list and must not be used on transfer or discharge letters.
- Alterations and errors must be dated and signed with a single line through the error.
- When a student nurse documents ensure that it is countersigned by a Registered Nurse

List of Pages

Section 1: Resident Register & Contract of Care

Cover Sheet/Resident Register: Complete name, date of birth, medical card number, room number. Date of admission, date of discharge, date of transfer out of the residential care facility and forwarding address. If a resident is admitted to hospital date of admission, reason for admission and name of the hospital. If the resident dies, date of death and certified cause of death needs to be documented.

Contract of care

Each Resident is provided with a written contact /statement specifying the terms and conditions with the registered provider of the residential care setting

Section 2: Admission Details and Risk Assessments

Biographical Information: Residents Admission form

- Complete on first admission.
- May need revision if details change.
- Ensure all details are correct, especially if transferring information from old notes i.e. date of birth, next of kin and contact details. Details of who to contact first in an emergency or at night are very important .
- Occupation do not write retired, explain i.e. retired farmer/housewife.
- **Allergies must be completed if known, and none known documented if applicable** .

Signature Page:
To be completed by all staff documenting in the standardised documentation set
Must be completed the first time you document in the residents notes using the name by which you registered with An Bord Altranais.

Fall Risk Assessment:
to be completed on admission Stratify or Cannard Circle the scores of all applicable risk factors and add to find total falls risk score. Follow policy guidelines if a risk is indicated. Reassess at least three least monthly or sooner if condition improves or deteriorates in any way.

Waterlow or Braden (risk assessments for pressure sore formation): to be completed on admission. Circle scores from each section. Several scores can be used in any section if necessary. Add to get total and assign appropriate risk measurement. Follow local policy if scores indicate any risk to the person.
Reassess as least three monthly or sooner if condition improves or deteriorates in any way.

A choice of risk assessment tools is available for pressure sore managing i.e. Waterlow or Braden and for Falls Assessment Stratify or Cannard, only one of those tools needs to be completed this gives nursing home staff the opportunity to choose the tool they are familiar with.

Admission Checklist:
Completed ticked and signed as items are explained and shown to residents, items completed as required.

Section 3: Comprehensive Assessments

Residents Comprehensive Assessments:
This section contains the complete set of nursing assessments to be commenced on admission and completed within **seven days of admission or sooner if the risk assessment indicates.** Do not leave any question blank if not applicable to that particular resident write N/A. This assessment is reviewed as indicated by the resident's changing needs or circumstances and no less frequently than at three monthly intervals. The purpose of this section is to gain insight into the resident's physical, psychological and social history.
The sections are:

1. **Communication** – contains section on emotional/mental state and pain.
2. **Recreation / Social interaction**
3. **Maintaining a safe environment**
4. **Mobility**
5. **Controlling body temperature**
6. **Personal cleaning and dressing**
7. **Breathing and circulation**
8. **Nutrition**
9. **Self Image**
10. **Eliminations**
11. **Sleep and rest**
12. **Spirituality and dying**

Assessment findings are communicated to the resident or representative in accordance with their wishes

Dependency Assessment
Barthel assessment; to be undertaken on all residents within 48 hrs of admission, PCCC dependency levels are included as a guide and document the residents dependency level, to be reassessed at least three monthly or if there is a change to the resident's condition.

MMSE or Abbreviated Mental test score
To be completed on all resident within 48 hours of admission and retested
On at least three monthly intervals or sooner if the residents condition changes.
Due to copyright we are unable to put the full MMSE in the standardised documentation set but it is the tool that is recommended.

Reassessment of activities of daily living:
Activities of daily living and plans of care need to be formally reassessed at least every three months or sooner if there is a change in the resident's condition. The reassessment must be reviewed by the person in charge or management delegate who in turn needs to inform the person in charge of their findings.

Section 4: Further Assessments

Nursing Assessment Tools Instructions for Use: To be completed within seven days of admission or sooner if condition indicates.

Continence Assessment
To be completed during the first week of admission if continence is assessed as a problem and reassessed at three monthly intervals or sooner if there is a change to the Residents condition.

Manual Handling Chart:
Following a full assessment of the person mobility assign a colour in relation to each activity. Use colour stickers in each section. Complete the instruction section. Add further comments if necessary. Reassess at least three monthly or sooner if condition improves or deteriorates in any way.

Geriatric Depression Scale
To be completed on a resident if any signs of low mood, withdrawal or depression is evident

Section 5: Nutrition

MUST (Nutrition Screening) Follow the instructions on the sheet and guidelines. Reassess at least three monthly or sooner if condition improves or deteriorates in any way.

Weight Chart
A record of Residents weights to chart at least once a month and more frequently if necessary.

Food Intake Chart
To be completed on residents at nutritional risk.

Section 6: Wound Care

Skin Assessment Record
To be completed on any resident who has a wound

Wound Assessment
To be undertaken on any Resident with any type of wound not just pressure ulcers. Use the guide for location of wound and grading criteria and needs to be accompanied by a wound Care Plan.

Section 7: Problem identification and Care Plans.

The Residents Care Plan/Problem identification

A problem is a nursing/medical issue that requires an active plan of care to achieve a specific Aim or goal through appropriate nursing interventions.

- The residents care plan is commenced within 48 hours of admission or earlier if indicated by risk assessments from the comprehensive assessment.
- The care plan reflects the assessment findings and sets out in detail the action and interventions to be taken by staff.
- State the problems clearly and comprehensively in understandable terms.
- Where you document actual individual problems and goals. It must be individualised and specific, observable and measurable.
- The care plan is discussed and drawn up with the involvement of the resident or his/her representative. If the resident is unable or unwilling to participate this must be documented.
- There are a number of Core Care Plans available for specific problems/needs but these plans must be personalised and added to and taken from as required.
- Problems should be organised /numbered in order or priority. Notes should be completed when there are changes in the person's condition, i.e. an improvement or deterioration on the implementation and progress page. Short term problems may need to be evaluated each shift. Longer term problems must be reviewed at least three monthly if the condition of the person has not changed.
- The care plan is formally evaluated by staff in consultation with the resident and/or his/her representative. It is updated as indicated by the residents changing needs and circumstances. Re-evaluation is ongoing, however formal evaluation must take place at no less than then three monthly intervals, and must be reviewed by the person in charge or management delegate for the purpose of quality assurance and monitoring.

Problem identification and evaluation sheet

Interventions and evaluations are documented on the narrative section of the problem identification and evaluation sheet.

Restraint Assessment

Restraint is to be used only as a last resort only after all other options have been considered and after a complete assessment and discussion with the G.P, multidisciplinary team and family, to be signed by the Resident if possible, the nurse and G.P (following the homes policy on restraint) and discussed with the family, ensure all conversations and interventions are documented completely.

If restraint is used there must be a clear record of regular checks on the resident and of release from restraint for at least ten minutes every two hours to undergo an exercise and movement programme.

Section 8: Daily Flow Chart and Communication.

Daily Care Flow Chart: To be completed on a daily bases

Flow charts highlight specific individual information according to pre-established parameters of nursing care. They are used for recording routine aspects of individual care such as nutrition, pain and skin integrity. Using a flow chart does not exempt you from using the communication sheet to describe your observations, individual teaching, individual responses and unusual circumstances. You can insert nursing data quickly and concisely, preferably at the time you give care or observe a change in the individual's condition. They are less time consuming and tend to be more legible than hand-written narrative notes. The format reinforces standards of nursing care and facilitates precise and less fragmented nursing documentation.

The flow chart is only for recording routine activities, and narrative notes must be completed on the communication page for anything outside these parameters.

Do not leave blank spaces, which may imply that an intervention was not completed or was not attempted, if not applicable mark N/A. If you omit something you must document the reason for the omission, in the narrative notes.

Communication Page: To be used to record any information that would not be included in the flow sheet or on the problem intervention sheet.

Section 9: Therapies and Outpatient and investigations record.

Investigations & Outpatient Appointment Record
The investigations & outpatient record is for documenting any investigations carried out e.g. blood tests, x-rays etc and any outpatient appointments.

Therapies Record
This sheet can be used by other disciplines to record care i.e. Physiotherapist Occupational therapist, Dietician, Chiropodist etc, it can also be used to record activities as part of a therapeutic plan of care.

Complaints Record
To be completed on any complaints made by the resident or on their behalf.

Section 10: Medical Notes:

Medical Records
To be completed by the G.P on every contact with the Resident. All medical notes, transfer letters etc can be kept in this section of the notes.

Section 11: Audit Tool

Audit Tool by Health Care Informed (HCI)
The Audit Tool has been developed by Health Care Informed (ww.hci.ie) to allow users of the resident record ensure the ongoing quality of the data being recorded in the provision of resident care. The audit tool is designed to help determine the comprehensiveness, appropriateness and accuracy of the data.

The Audit Tool should be used as a self assessment mechanism to ensure conformance to the local procedures in place for the management of the residents' records. The tool can be used on an ongoing basis to continually evaluate the quality of sample records,or as part of a regular audit programme. A resident record audit should be carried out at least annually. Self assessments may also be support by external independent audits.

All residents records are secure, up to date, in good order and are constructed maintained and used in accordance with the Data Protection Act 1998 and 2003, the freedom of information act(1997/2003) and national guidelines.

References;

An Bord Altranais (2000) The code of professional conduct for each Nurse and Midwife. Dublin: An Bord Altranais
An Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework (April 2000).
An Bord Altranais (2002) Recording Clinical Practice Guidance to nurses and Midwives (November 2002).
Draft National Quality Standards for residential Care Settings for older people
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HSE Midland Area (November 2005)
National Hospitals office Code of practice for health Care Records Management Abbreviations (June 2007)
Nursing and Midwifery planning and Development Unit (South)
Documentation Project June (2003)
St. James Hospital Nursing Documentation Guidelines (2001)
Western Health Board Guidelines for Best practice in Documenting Clinical Care (May 2004)

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Document Code:	
Title of Document:	**Documentation in clinical records**
Written By:	**Nursing committee and C Connelly practice development facilitator (NHI)**
Implementation Date:	**March 2008**
Review date:	**March 2009**
Audit date:	**September 2008**
Authorised by:	**C Connelly**

1.0 Policy Statement:
Each Resident is safeguarded by the residential care setting's record- keeping policies and procedures (HIQA Draft National Quality Standards for Residential Care settings for older people)

2.0Aim/purpose:
To inform Nursing Staff and Nursing Students (under the supervision of a Registered Nurse) of best practice guidelines in relation to nursing documentation.

2.1 Each nurse should establish and maintain accurate, clear and current Resident records within a legal, ethical and professional framework. (Recording Clinical Practice Guidelines, November 2002)

2.2 Nurses are professionally and legally accountable for the standard of their professional practice and this includes record keeping. *(Scope of Nursing and Midwifery Practice Framework, April 2000).*

2.3 Good record keeping protects the interest of the residents by promoting, high standards of care, Continuity of care and communication between members of the multidisciplinary team. (A *Guide to good Clinical Record Keeping, Midland Health Board, 2004).*

3.0 Scope of this Policy
The policy and guideline applies to Nursing Staff and Nursing Students (under the supervision of a Registered Nurse) working in Nursing Homes Ireland members Nursing homes using the assessment and care planning integrated resident record.

4.0 Definition;
Clinical records include: paper records, including books, files, letters, loose papers continuation sheets, diaries, post it notes and computer print outs. Electromagnetic records including discs, servers and databases. Audio-visual records including films, tapes, and videos, CD's. Photographs, maps, plans, X-rays and microfilms, (Midland Health Board, 2004).

4.1 Documentation is defined as written evidence of the interaction between and among healthcare professionals, residents and their families, health Organisations, the administration of tests, procedures, treatments, the results, or the resident's responses to them, and resident education. (England 1994).

5.0 Responsibility;

5.1 It is the responsibility of the person in charge to implement the policy and guidelines for completion of resident documentation**.**

5.2 It is the responsibility of each Nurse to "establish and maintain accurate, clear and current resident records within a legal, ethical and professional framework. *(Recording Clinical Practice Guidance to Nurses and Midwives*, November 2002).

5.3 The quality of a nurse's record keeping should be such that continuity of care for a resident is always supported. (Recording Clinical Practice Guidelines, November 2002).

5.4 It is the responsibility of the Nurse to read this policy and guideline and use it appropriately.

5.5 It is the responsibility of the person in charge to ensure that this policy is reviewed yearly or at a time there is a change.

5.6 It is the responsibility of the person in charge to maintain a list of all nursing signatures (as registered with An Bord Altranais) plus initials. This is in keeping with An Bord Altranais guidelines. *(Recording Clinical Practice Guidance to Nurses and Midwives*, November 2002).

5.7 It is the responsibility of the person in charge or their nominated manager to audit documentation at least once a year using the standardised documentation audit tool

6.0 Procedure;

6.1 All documentation must be legible, indelible and readable on any photocopy. (Black ink only to be used).

6.2 All documentation must be dated; timed (24-hour clock) and signed. Any documentation by a Student Nurse must be countersigned by a Registered Nurse.

6.3 A record of signatures and initials must be kept. Initials must not be used for major events.

6.4 Resident's Name and Date of Birth must be on all nursing documentation and should be transcribed correctly.

6.5 Ensure you have the correct chart/record before you begin writing.

6.6 Any errors will be crossed out with a single line only, signed dated and timed. Tippex/correction fluid must not be used.

6.7 Late entries must be clearly identified, date and time the entry and write 'Late Entry' beside it.

6.8 Documentation is carried out as soon as possible after providing nursing care.

6.9 Entries are in chronological order**.**

6.10 Documentation should demonstrate the sequence of events, the factors observed and the response to care and treatment.

6.11 Use the abbreviation list only as well as official grading systems. + + + + is not an official grading system and must not be used. Abbreviations should be kept to a minimum and must not be used in transfer/discharge letters. (SOP: The use of Abbreviations Nursing Documentation).

6.12 Documentation must be clear and unambiguous. Avoid catch all phases that can be open to misinterpretation such as, *some, a lot, ever so often.*

6.13 Documentation should be written; whenever possible in terms the resident can understand.

6.14 Instructions regarding resident care by the multidisciplinary team must be documented and should clearly identify the team member in the record.

6.15 Any advice given including discharge advice by a nurse must be documented.

6.16 All decisions to take no immediate action but review later must be clearly documented as well as the follow up care of the resident.

6.17 Any improvement/deterioration in the resident's condition must be documented as soon as possible after the event.

6.18 Documentation must be audited at least yearly using the approved audit tool.

7.0 References;

An Bord Altranais (2000) The code of professional conduct for each Nurse and Midwife. Dublin: An Bord Altranais
An Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework (April 2000).
An Bord Altranais (2002) Recording Clinical Practice Guidance to nurses and Midwives (November 2002).
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Title of Document:	**Standard operation procedure on Standard abbreviations list**
Written By:	**Nursing committee and C Connelly practice development facilitator (NHI)**
Implementation Date:	**March 2008**
Review date:	**March 2009**
Audit date:	**September 2008**
Authorised by:	**C Connelly**

1.0 Policy Statement: Only abbreviations from the approved standard abbreviation list will be used in the assessment and care planning integrated resident record.

2.0Aim/purpose:

2.1 To inform Nursing Staff and Nursing Students (under the supervision of a Registered nurse), of the appropriate abbreviation list to be used in Nursing documentation.

2.2 To ensure that Nursing staff are aware of the current best practice guidelines in nursing documentation.

2.3 To maintain resident safety through documentation at all times. Each resident is protected by the residential care setting's record keeping policy and procedures (HIQA draft national standards for residential care settings for older people 2007)

2.4 To uphold standards of safe practice, Nurses are professionally and legally accountable for the Standard of Practice to which they contribute and this includes record keeping (scope of Nursing and Midwifery practice framework, April 2000).

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3.0 Scope of the standard operational procedure

The standard operating procedure applies to Nursing Staff and Nursing Students (under the supervision of a Registered Nurse) working in Nursing Homes Ireland member's Nursing homes using the assessment and care planning integrated resident record.

4.0Definition;

An abbreviation is a shortening, summery or synopsis of a word.
(Collins Dictionary and Thesaurus, (1992).

5.0 Responsibility;

5.1 It is the responsibility of the person in charge to implement the standard operating procedure.

5.2 It is the responsibility of each Nurse to read the standard operating procedure and use the abbreviations correctly.

5.3 It is the responsibility of the person in charge to ensure that this standard operating procedure is reviewed yearly or at any time there is a change to best practice.

5.4 It is the responsibility of the person in charge to maintain a list of all nursing signatures (as registered with An Bord Altranais) plus initials (Appendix 1). This is in keeping with An Bord Altanais guidelines. *(Recording Clinical Practice Guidance to Nurses and Midwives*, November 2002).

5.5 A Nurse who uses an abbreviation not included in the approved list is responsible for its interpretation or misinterpretation.

6.0 Procedure;

6.1 Abbreviations must be kept to a minimum in nursing documentation.

6.2 Abbreviations are to be used in the context of care and only refer to diagnosis, treatment and procedures.

6.3 Abbreviations **must not be used** in transfer, discharge, and incident/accident documentation.

6.4 Only official grading systems must be used. **+ + + _ _** Are not official grading systems and **must not be used.**

7.0 References;

An Bord Altranais (2000) The code of professional conduct for each Nurse and Midwife. Dublin: An Bord Altranais
An Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework (April 2000).
An Bord Altranais (2002) Recording Clinical Practice Guidance to nurses and Midwives (November 2002).
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STANDARD ABBREVIATION LISTS

SYMBOLS

#	Fracture
@	At
1/52 or x/52	One week or x number of weeks
1/7 or x/7	One day or number of days
1/12 or x/12	One month or x number of months
A	
AC	Before Food
ADL	Activities of daily living
A & E	Accident and Emergency
A.Fib	Atrial Fibrillation
AIDS	Acquired Immune Deficiency Syndrome
a.m. .	Before noon
ADoN	Assistant Director of Nursing
B	
BD	Twice daily
BO	Bowels opened
BNO	Bowels not opened
BM	Body Mass Index
BP	Blood Pressure
BMs	Blood glucose monitoring
C	

CCF	Congestive Cardiac Failure
C&S	Culture and sensitivity
CXR	Chest Xray
CCU	Coronary care Unit
C-Diff	Clostridium Diffficile
CNM	Clinical nurse manager
COAD	Chronic obstructive airways disease
COPD	Chronic obstructive pulmonary disease
CVA	Cerebral Vascular Accident
CPN	Community psychiatric nurse
CPR	Cardio Pulmonary Resuscitation
CO2	Carbon Dioxide
CSU	Catheter specimen of urine
Cm	Centimetre
D	
DOB	Date of birth
DVT	Deep vein thombosis
Dr.	Doctor
DoN	Director of nursing
E	
ECG	Electrocardiograph
ESR	Erythrocyte sedimentation rate
ET Tube	Endotracheal Tube
FBC	Full blood count
FOB	Faecal occult blood
FBC.	Full Blood Count

G	
GA	General Anaesthetic
GIT	Gastrointestinal Tract
GP	General Practitioner
g	Gram

H	
Hx	History
Hb	Haemoglobin
HIV	Human Immunodeficiency Virus
I	
INR	International Normalised Ratio
ITU	Intensive Therapy Unit
IM	Intramuscular
IV	Intravenous
K	
Kcals	Kilocalories
KUB	Kidneys, Ureters and bladders
Kg	Kilogram
K+	Potassium
LA	Local Anaesthetic
LFT	Liver function test
Left VF	Left ventricular failure
M	
Mane	In the morning
MDA	Misuse of drugs act

MI	Myocardial Infraction
MRI	Magnetic Resonance Imaging
MRSA	Methicillian Resistant Staphylococcus Aureus
MSU	Midstream Specimen of Urine
Mg	Milligram
mmol	Millimole
MS	Multiple Sclerosis
MMSE	Mini Mental State Examination
N	
N	Nebuliser
NA	Not Applicable
NAD	No abnormality detected
Neg	Negative
NG	Naso Gastic
NOCTE	At Night
Nil PO	Nil by mouth
NKA	No known allergies
O	
02/02 Stats	Oxygen/Oxygen Saturation
OT	Occupational Therapist
Obs	Observations
P	
PCA	Patient controlled analgesia
POP	Plaster of Paris
PEARL	Pupils equal and reacting to light
PEG	Percutaneous Endoscopic Gastrosomy

pm	Afternoon
PR	Per rectum
PE	Pulmonary Embolus/Embolism
PV	Per vagina
PO	Orally
PRN	As required/ as necessary
PU	Passed urine
Pos.	Positive
PHN	Public Health Nurse
PHYSIO	Physiotherapy or Physiotherapist
Q	
QDS	Four times a day

R	
RGN	Registered General Nurse
R/C	Roman catholic
RTI	Respiratory tract infection
RIP	Rest in peace/Deceased
RBC	Red Blood Cells
Rx	Prescribed treatment
Re	Regarding
S	
SB	Seen by
SOB	Shortness of breath
STAT	Immediately/At Once
SC	Subcutaneous

SL	Sublingually
SN	Staff nurse
T	
TDS	Three Times Daily
TPN	Total Parental nutrition
TFT	Thyroid function test
TIA	Trans ischaemic attack
TPR	Temperature, pulse and respiration
TEDS	Thrombo Embolic Deterrent Stockings
TB	Tuberculosis
TCI	To Come In
U	
URTI	Upper respiratory Tract Infection
U&E	Urea and electrolytes
UTI	Urinary tract infection
W	
Wt	Weight
WBC	White Blood count

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Table of contents for the Assessment and Care Planning Integrated Resident Record

Section 7: Problem Identification and Care Planning

- **Problem identification sheet/Care Plan.**
- **Core Activity of daily living care plans**
  1. **Altered Communication pattern**
  2. **Inability to ensure Recreation and social activity**
  3. **Inability to maintain a safe environment**
  4. **Impaired Mobility**
  5. **Inability to Dress/Undress**
  6. **Inability to maintain adequate levels of personal hygiene.**
  7. **Inability to maintain an adequate nutritional state**
  8. **Inability to maintain elimination requirements**
  9. **Inability to ensure adequate rest and sleep**
  10. **Inability to express sexuality in their usual way**
- **Additional core care plans**
  11. **Risk of Falls**
  12. **Urinary Catheter in Situ**
  13. **Resident wound**
  14. **Non Insulin Dependent Diabetic**
- **Implementation of interventions/Evaluation sheets**
- **Risk Assessment for Restraint**
- **Restraint Plan**

Section 8: Daily Flow sheet and Communication

- **Nursing Process Daily Flow Sheet**
- **Communication Sheet**

Section 9: Therapies, outpatients/investigations

- **Investigations & Outpatient Appointment Record**
- **Therapies Record**
- **Complaints Recording Form**

Section 10: Medical Records

- **Medical Notes**
- **Record of Prescribed Medications**

Section 11: Audit Tool

- **Audit Tool for auditing the complete resident record.**

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Nursing Home: _____

Residents Assessment & Nursing Care Plan

Resident Register:

Residents Name: _____

Date of Birth: _____

Medical Card Number: _____

Date of first Admission: _____

Date of Readmission:_____

Date of transfer to Hospital:_____

Name of Hospital and reason for transfer: _____

Date of Discharge:_____

Address of Discharge:_____

Date, Time and Certified Cause of Death:_____

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Core Resident Details

Name: _____

Likes to be known as: _____

Address: _____

_____

Current Address (if different from above)

_____

Telephone: _____

Date of Birth: _____ Age: _____

Gender: Male ☐ Female ☐

Status: Married ☐ Single ☐ Widowed ☐ Separated ☐

Divorced ☐ Other ☐

Religion: _____

Previous / Current Occupation: _____

Spouse's Telephone: _____

Medical Details

G.P. _____

Telephone: _____

Address: _____

Public Health Nurse: _____

Health Centre: _____

Health Centre's Telephone: _____

Medical Card: _____
Expiry date:
Health Insurance: _____
Expiry date:

Ward of Court: Yes ☐ No ☐

Next of Kin Details

Name:
_____

Address:
_____

_____

Telephone: _____

Relationship: _____

Contact at night: Yes ☐ No ☐

Significant Other 1

Name: _____

Address:_____

Telephone: _____

Relationship: _____

Contact at night: Yes ☐ No ☐

Significant Other 2

Name: _____

Address:_____

_____

Telephone: _____ Mobile: _____

Relationship: _____

Contact at night: Yes ☐ No ☐

To be contacted first: _____

Allergies:

_____

Observations

Blood Pressure:	Height:
Respirations	Weight
Pulse:	BMI
Temperature	Bloods taken
Urinalysis:	Swabs

Signature of Assessing Nurse: _____ **Date:** _____ **Time:** _____

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Admission Details	**Information Received with Resident**
Date of Admission: _____Time: _____ Accompanied by: _____ Under care of: _____ Next of Kin aware of admission: Yes ☐ No ☐ Type of admission: Reason for Admission & Recent Health: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Doctor informed of admission: Yes ☐ No ☐ Informed Date: _____ Time: _____ Current Prescription: Yes ☐ No ☐	Transfer Letter: Yes ☐ No ☐ P.H.N. Letter: Yes ☐ No ☐ GP Letter: Yes ☐ No ☐ Consultant Letter: Yes ☐ No ☐ Nurses Transfer Letter: Yes ☐ No ☐ Other: _____ Source of Admission: Acute Hospital ☐(specify) _____ Community☐ (specify) _____ Community Hospital ☐(specify) _____ GP ☐ (specify) _____ Hospice ☐(specify) _____ Nursing Home ☐(specify) _____ Other ☐ (specify) _____ Residents understanding of admission: _____ _____ Does Resident want family informed of his/her care Yes ☐ No ☐ Next of Kin/Carer understanding of admission: _____ _____ _____
Medicines Resident reports to be taking at time of admission: _____ _____ _____ _____ _____ _____	Self Medicating: Yes ☐ No ☐ Flu Vaccine: Yes ☐ Date: _____ No ☐ Pneummococcal Vaccine: Yes ☐Date: _____ No ☐ MSRA Status: Positive: ☐Negative ☐Unknown ☐Date: _____
Spiritual Care prior to admission: Yes ☐ No ☐ By: _____ Date: _____	

Signature of Assessing Nurse: _____ Date: _____ Time: _____

Residents name: _____ DOB: _____

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NURSE SIGNATURE SHEET

Date	Nurse Name in BLOCK CAPITALS	Nurse Signature	Initials

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Title of Document:	**Stratify Falls Risk Assessment Tool**
Date Approved:	
Review date:	

Residents Name: _____

Date of Birth: _____

Assessed by: _____

Signature: _____Date:_____ Time:_____

First Complete the Transfer & Mobility Scores:

Transfer Score =
0 = unable
1 = major help needed (one/two people)
2 = minor help (verbal/physical)
3 – independent

Mobility Score =
0 = immobile
1 = independent with aid of a wheelchair (or two people needed)
2 = walks with help of one person (or with aid/or with aid & one person)
3 – independent

Add the transfer and mobility scores
Transfer + Mobility Score =

Now answer the following questions:

1. Has the individual had a fall within the last six months?
   (Yes = 1, No = 0)

2. Do you think the individual is agitated?
   (Yes = 1, No = 0)

3. Do you think the individual is visually impaired to the extent that everyday function is impaired?
   (Yes = 1, No = 0)

4. Do you think the individual is in need of especially frequent toileting?
   (Yes = 1, No = 0)

5. Does the individual have a transfer + mobility score of 3 or 4?
   (Yes = 1, No = 0)

Risk Factor Assessment Score (Question 1-5) =
Score of 2 or more indicates a high risk of falling.

Adapted from Stratify Assessment Tool – Oliver D., Britton M., Martin F., Hooper A. (1997)

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FALLS RISK ASSESSMENT SCALE FOR THE ELDERLY

(Cannard 1996)

Resident Name:_____ **Date of Birth:**_____ **Room No:**_____

Please circle the scores of all applicable risk factors and add to find total fall risk score.

FALL RISK ASSESSMENT		DATE OF ASSESSMENT						
SEX	**Male** **Female**	**1** **2**						
AGE	**60 – 70** **71 - 80** **81 +**	 **2** **1**						
WALKING ABILITY	**Steady** **Hesitant** **Poor Transfer** **Unsteady**	**0** **1** **3** **3**						
SENSORY DEFICIT	**Sight** **Hearing** **Balance**	**2** **1** **2**						
FALL HISTORY	**None** **At Home** **In Ward** **Both**	**0** **2** **1** **2**						
MEDICATION	**Night sedation** **Hypotensives** **Tranquillisers (e.g. Benzodiazapines Antipsychotic drugs)**	**1** **1** **1**						
MEDICAL HISTORY	**Diabetes** **Organic Brain Disease/Confusion** **Seizures**	**1** 1 1 1						
MOBILITY	**Full** **Uses Aid** **Restricted, requires Assistance** **Bed bound**	**1** **2** **3** **1**						
TOTAL SCORE								

3-8 = LOW RISK **9-12 MEDIUM RISK** **12+ = HIGH RISK**

Signature of Assessing Nurse _____ **Date / Time:** _____

Ref: Cannard G (1996)

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ACTIONS FOR RISK SCORES

SCORE	ACTION	DATE	SIGNATURE
3 – 8	**Tips to avoid falls leaflet to patient and family.** **Fall prevention checklist for staff in care plan.**		
9 – 12	**As above plus** **Sticker over bed to identify fall risk.** **Highlight falls risk to GP re polypharmacy.** **Referral to physiotherapy to assess balance and gait and issue hip protectors if appropriate.**		
13 +	**As above plus** **Discuss hip protectors for resident.** **Check orthostatic BP first thing in the morning.** - **Resident lies down for 5 minutes. BP and Pulse taken.** - **immediately after standing** - **BP & Pulse again** - **2 minutes after standing, repeat BP & Pulse** **Referral to assessment for medical conditions which cause falling.**		

Signature of Assessing Nurse _____ Date / Time: _____

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FALLS CHECK LIST FOR STAFF

1. Avoid Polypharmacy Doctor to review drugs.

2. Glasses – hearing aid.

3. Clothing securely fastened.

4. Appropriate footwear on Resident or nearby.

5. Remove unnecessary equipment – ensure no clutter.

6. Bed height low.

7. Good lighting.

8. Brakes on commode.

9. Mobility aid nearby.

10. Call bell on hand.

11. Locker, table nearby.

12. Suitable chair.

13. Mop up spillages and monitor flexes.

14. Re-orientate confused residents to location.

15. If Resident is leaving the home, please inform relevant Staff - relatives of fall risk.

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Name:_____ Date of Birth: _____Room No / Unit: _____

Waterlow Pressure Ulcer Prevention/Treatment Policy

Ring Scores in Table, Add Total, more than 1 Score/Category Can Be Used

Build/Weight for Height	●	**Skin type Visual Risk Areas**	●	**Sex Age**	●	**Malnutrition Screening Tool (MST) Nutrition Vol. 15, No.6 1999-Australia**		**Date**	**Score**	**Signature**
Average		Healthy	0	Male	1	A – Has Patient Lost Weight Recently Yes - go to **B** No - go to **C** Unsure - go to **C** And score **2**	B – Weight Loss Score 0.5 - 5 kg = 1 5 - 10kg = 2 10 - 15kg = 3 >15kg = 4 unsure = 2			
BMI – 20 – 24.9	0	Tissue Paper	1	Female	2					
Above Average		Dry	1	14-49	1					
BMI – 25 – 29.9	1	Oedematous	1	50-64	2					
Obese		Clammy, Pyrexia	1	65-74	3					
BMI > 30	2	Discoloured		75-80	4					
Below Average		Grade 1	2	81+	5	C – Patient Eating Poorly Or Lack of Appetite 'No' = 0; 'Yes' Score = 1	Nutrition Score If > 2 refer for Nutrition assessment / intervention			
BMI < 20	3	Broken/Spots								
BMI= Wt(kg)/Ht(m)2		Grade 2-4	3							

Continence	●	**Mobility**	●	**Special Risks**						
Complete/ Catherised	0	Fully	0	**Tissue Malnutrition**	●	**Neurological Deficit**	●			
Urine incont.		Restless/Fidgety	1	Terminal Cachexia	8	Diabetes, MS, CVA Motor/Sensory Paraplegia (Max of 6)	4-6 4-6 4-6			
Faecel incon.	1	Apathetic	2	Multiple Organ Failure	8					
Urinary + Faecel Incontinence	2	Restricted	3	Single Organ Failure (Resp, Renal, Cardiac,)		Major Surgery or Trauma				
	3	Bedbound e.g. Traction	4	Peripheral Vascular Disease	5	Orthopaedic / Spinal	5			
		Chairbound e.g. Wheelchair	5	Anaemia (Hb<8)	5	On Table > 2 hr#	5			
		# Scores can be discounted after 48 hours provided patient is recovering normally.		Smoking	2	On Table > 6 hr#	8			
Score					1					
10+ At Risk										
15+ High Risk										
20+ Very High Risk										

Medication – Cytotoxics, Long Term/High Dose Steroids
Anti-Inflammatory Max of 4

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TISSUE DAMAGE MAY START PRIOR TO ADMISSION, IN CASUALTY, A SEATED PATIENT IS AT RISK ASSESSMENT (See Over) IF THE PATIENT FALLS INTO ANY OF THE RISK CATEGORIES, THEN PREVENTATIVE NURSING IS REQUIRED A COMBINATION OF GOOD NURSHING TECHNIQUES AND RPEVENTATIVE AIDS WILL BE NECESSARY
ALL ACTIONS MUST BE DOCUMENTED

PRESSURE REDUCING AIDS	
Special	
Mattress/beds:	10+ Overlays or specialist foam mattresses. 15+ Alternating pressure overlays, mattresses and bed systems. 20+ Bed systems: Fluidised bead, low air loss and Alternating pressure mattresses. Preventative aids cover a wide spectrum of specialist features. Efficacy should be judged, if possible, on the basis of independent evidence.
Cushions:	No person should sit in a wheelchair without some form of cushioning. If nothing else is available – use the person's own pillow.(Consider infection risk) 10+ 100 mm foam cushion 15+ Specialist Gell and/or foam cushion 20+ Specialised cushion, adjustable to individual person.
Bed Clothing:	Avoid plastic draw sheets, inco pads and tightly tucked in sheet/sheet covers, especially when using specialist bed and mattress overlay systems. Use duvet – plus vapour permeable membrane.
General	HAND WASHING, frequent changes of position, lying sitting. Use of pillows.
Pain	Appropriate pain control.
Nutrition	High protein, vitamins and minerals
Patient Handling	Correct lifting techniques – hoists – monkey poles Transfer devices.
Patient Comfort Aids	Real Sheepskin – bed cradle
Operating Table	
Theatre/A&E Trolley	

Skin Care	General hygiene, NO rubbing, cover with an appropriate dressing.
Assessment	Odour, exudates, measure/photograph position.
GRADE 1	Discolouration of intact skin not affected by light finger pressure (non-blanching erythema).
GRADE 2	Partial thickness skin loss or damage involving epidermis and/or dermis. The pressure ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.
GRADE 3	Full thickness skin loss involving damage of subcutaneous tissue but not extending to the underlying fascia. The pressure ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
GRADE 4	Full thickness skin loss with extensive destruction and necrosis extending to underlying tissue.
Dressing Guide	Use Local dressings formulary and/or www.worldwidewounds.

100mm (4 ins) cover plus adequate protection.

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BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name _____ Evaluator's Name_____

Date of Assessment_____ Time_____

SENSORY PERCEPTION: ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited.** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort..			
MOISTURE: degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine,etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist.** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.			
ACTIVITY: degree of physical	**1. Bedfast** Confined to bed.	**2. Chairfast.** Ability to walk severely activity limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room twice a day and inside room at least once every two hours during waking hours			
MOBILITY: ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance	**2. Very Limited.** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.			
NUTRITION: usual food intake	1. **Very Poor** Never eats a complete pattern meal. Rarely eats more than half of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate.** Rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum Amount of liquid diet or tube feeding	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.			
FRICTION & SHEAR:	**1. Problem.** Requires moderate to Maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem.** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent Against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair				

 TOTAL SCORE

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ADMISSION CHECK LIST

Room Number: _____

Residents Name: _____ Date of Birth: _____

Admitting Nurse: _____

Special aids/beds: _____

Admission check list (please tick and sign when complete)

1. **Introduction to staff / residents** ☐
2. **Layout of home toilets etc explained** ☐
3. **Call bell system explained** ☐
4. **Property unpacked / property book completed** ☐
5. **All clothes labelled YES / NO**
6. **Valuables entered to inventory list or sent home or handed in for safe keeping (please specify)** ☐
7. **Named carer explained** ☐
8. **Meal times and methods of choice explained** ☐
9. **Chiropody/Optician/Physiotherapy/Hairdresser/Laundry/Request for daily paper.** ☐
10. **Fire Alarms and testing explained, fire exits & exit door Alarm's explained** ☐
11. **Visiting policy explained** ☐
12. **Residents handbook given to resident and family** ☐
13. **Going out with family explained** ☐
14. **Medications (on arrival given to nurse) and recorded** ☐
15. **Complaints Procedure explained** ☐
16. **Smoking Policy explained** ☐

Signature of Assessing Nurse: _____ Date: _____ Time: _____

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RESIDENT COMPREHENSIVE ASSESSMENT FORM

Resident Name:_____ **Date of Birth:**_____ **Room No**_____

1. Communication

Speech: Clear ☐ Incoherent ☐ Other ☐
Dysphasia ☐ Apraxia ☐

Speech Therapy Referral: Yes ☐ No ☐ N/A ☐

Hearing: Normal ☐ Impaired ☐ Deaf ☐

Use of Hearing Aid: Yes ☐ No ☐

Hearing Aid: Right ☐ Left ☐ Both ☐

Vision: Normal ☐ Impaired ☐ Blind ☐

Use of Spectacles: Yes ☐ No ☐

Spectacles: Distance ☐ Reading ☐

1a. Emotional State

Alert ☐ Orientated ☐ Content ☐

Give details if ticked:
Depressed Confused Agitated Challenging

Details:
_____
_____
_____
_____
_____

Mental Test Score:
1d. Pain
Site: _____

How long have you had this pain?
_____

Effect on Daily Life: _____
_____
_____
_____

Pain Severity: None ☐ Moderate ☐ Worst possible ☐
Pain Scale assessment completed:
Yes ☐ No ☐ N/A ☐

2. Recreation / Social Interaction
Hobbies / Interest:
_____
_____

Social interaction with Staff:
_____
_____

Social interaction with Family / Friends:
_____
_____

Family Involvement:
_____
_____
_____

3. Maintaining a Safe Environment

Is there a safety risk related to:
Mobility ☐ Risk of Infection ☐

Other:
_____
_____
_____

Risk to patient safety discussed with:
Patient ☐ Relatives ☐

4. Mobility
Independent: Yes ☐ No ☐
_____
_____
_____
_____

Weight Bearing: Yes ☐ No ☐

Bed Mobility – Aided By:
1 ☐ 2 ☐ Hoist ☐
Transfers – Aided By:
1 ☐ 2 ☐ Hoist ☐
Walking – Aided By:
1 ☐ 2 ☐ Hoist ☐
Aids Used: Stick ☐ Zimmer ☐ Crutches ☐
Tripod ☐ Key-Grip ☐ Wheelchair ☐ Other ☐

Refer to Physiotherapist: Yes ☐ No ☐

Signature of Assessing Nurse _____ **Date / Time:** _____

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Resident Name:_____ **Date of Birth:**_____ **Room No:**_____

5. Controlling Body Temperature
Temperature
Ability to maintain normal body temperature:
Yes ☐ No ☐

6. Personal Cleansing & Dressing
Independent: Yes ☐ No ☐

Requires Assistance: Yes ☐ No ☐

6b. Skin Care & Integrity
Skin Intact: Yes ☐ No ☐

Condition of skin(rashes, Purpua, Dryness, Scars etc):
_____
_____
_____

7. Breathing & Circulation
Specify if history of Cardiac, Respirator, or Circulatory Disease (list):

_____
_____
_____

Blood Pressure: _____
Pulse: _____
Respirations: _____

Colour:
_____
_____

Breathing Pattern:
_____
_____

Use of inhalers – (specify):
_____
_____
_____

Positioning:
_____
_____
_____

Smoker: Yes ☐ No ☐

Resident informed of smoking policy: Yes ☐ No ☐

8. Nutrition
Weight: _____
Height: _____

Change in Appetite: Yes ☐ No ☐
Specify:
_____
_____
_____

Weight Loss: Yes ☐ No ☐
Specify:
_____
_____

Weight Gain: Yes ☐ No ☐
Specify:
_____
_____

Daily Eating Pattern:
Breakfast:
_____
_____

Dinner:
_____
_____

Tea:
_____
_____

Other:
_____
_____

Likes / Dislikes:
_____
_____

9. Self Image
Patient comment regarding sense of self:
_____
_____
_____

Preferred style of dress:
_____
_____
_____

Signature of Assessing Nurse _____ **Date / Time:** _____

Resident Name:_____ **Date of Birth:**_____ **Room No:** _____

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10. Elimination Urinary System

Continent: Day ☐ Night ☐

Incontinent: Day ☐ Night ☐

Mixed: Yes ☐ No ☐

Continence assessment required:
Yes ☐ No ☐ N/A ☐

Incontinence wear required:
Yes ☐ No ☐ N/A ☐

Catheter: Yes ☐ No ☐

Type: _____ Size: _____

Date last changed:

Bowel Pattern:
Continent: Day ☐ Night ☐

Incontinent: Day ☐ Night ☐

Frequency of bowel motions:

_____
_____

Prone to Constipation: Yes ☐ No ☐

History of laxative use:

11. Sleep & Rest

Day time rest:

_____
_____

Normal pattern by night:

_____
_____
_____

Aids Used:

_____
_____

12. Spirituality & Dying

Personal belief:

_____
_____
_____

Fears for the future:

_____
_____
_____

Patient wishes:

_____
_____
_____

Funeral/Burial arrangements (if applicable):

_____
_____
_____

Signature of Assessing Nurse _____ Date / Time: _____

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BARTHEL A.D.L. INDEX

Name of Resident: _____ D.O.B: _____ MRN: _____

Date										
FUNCTION	**SCORE**	**DESCRIPTION**								
1.Mobility	0 1 2 3	Immobile Wheelchair independent Walks with help Independent								
2. Transfer	0 1 2 3	Unable Major help Minor help Independent								
3. Stairs	0 1 2	Unable Needs help Independent up and down								
4. Bowels	0 1 2	Incontinent Occasional Accident Continent								
5. Bladder	0 1 2	Incontinent Occasional Accident Continent								
6. Toilet Use	0 1 2	Dependent Needs some help Independent								
7. Bathing	0 1	Dependent Independent								
8. Grooming	0 1	Needs help Independent								
9. Dressing	0 1 2	Unable to dress Needs help Independent								
10. Feeding	0 1 2	Unable to feed themselves Needs help Independent								
Total Score										

Please tick the appropriate box:

VISION	**Yes**	**No**
Glasses	☐	☐
Blind	☐	☐
Impaired Vision	☐	☐
Satisfactory	☐	☐
Hearing Aid	☐	☐
Deaf	☐	☐
Impaired Hearing	☐	☐
Satisfactory	☐	☐

Scores
Below 10-High Dependency
Between 10-14 Medium dependency
Between 15-20 Low dependency
HEARING Yes No

Mahoney FI, Barthel D "Functional Evaluation: the Barthel index" Maryland State Medical Journal 1965; 14:56-61 used with permission

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ABBREVIATED MENTAL TEST SCORE

Name: _____ Male / Female: _____

Married / Single / Widowed / Other: _____ Date of Birth: _____

IN EACH COLUMN MARK DATE OF EXAMINATION				
What is your age?				
What is the time? (to nearest hour)				
***WHAT IS THE NAME OF THIS PLACE? (If not known Inform and repeat the question At the end of the test)**				
Give the resident an address and Ask them to repeat it at the end of the test.				
Can you recognise two people? (Doctor, Nurse, Carer)				
What is your date of birth?				
What year did the first world war Start?				
What is the year?				
Count backwards from 20 - 1				
Who is the Taoiseach now?				
TOTAL SCORE				

EACH CORRECT ANSWER = **(*/Can be given for this question if answered correctly on the first or second occasion.**

EACH INCORRECT ANSWER =

SCORE / 10

(QUESTION WORTH 1 POINT) =

Signature of Assessing Nurse _____ Date / Time: _____

Abbreviated Mental Test Score Hodkinson HM "Evaluation of a mental test score assessment of mental impairment in the elderly" Age and Ageing 1972, 1:233-8

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LONG TERM RESIDENTIAL CARE CRITERIA, LEVELS OF CARE FOR USE BY PLACEMENT PANELS

Dependency Level I Care

An individual will be considered level one care needs if any one of the following conditions (which are associated with instability, complexity and life expectancy) is present.

- the patient is terminally ill and has a prognosis that they are likely to die in the very near future.
- the patient requires intensive medical care which cannot be provided outside an inpatient environment, for example, those who require mechanical ventilation and cannot be maintained at home; have end-stage multiple sclerosis; have had an extensive stroke with loss of vital functions; or are unconscious and are in a persistent vegetative state
- the patient requires intensive physical care, which cannot be provided outside of a protected inpatient environment, staffed by appropriately professionally qualified personnel. An example of an individual falling into this programme of care includes those with a recent onset of bulbar symptoms with aspiration risk or respiratory arrest.
- the patient requires an intensive period of therapy to enable them to adapt to a reduced functional or cognitive state which is of a long term nature.
- the patient requires intensive psychological care which cannot be provided outside a protected, specialist psychiatric inpatient environment. Examples include persons suffering from dementia with associated severe behavioral disturbance which requires specialist medical and nursing care.
- the patient has a very high level of disturbed behavior, placing themselves or others at substantial risk of harm.
- the patient has a violent response to care givers.

Dependency Level 2 Care

In Level 2 an individual will have any combination of the following conditions:

- a PEG (percutaneous endoscopic gastrostomy) system or parenteral feeding requiring daily specialist nursing supervision.
- haemo or peritoneal dialysis.
- double incontinence which is frequent, fails to respond to recognised interventions and contributes to a very high risk of skin breakdown.
- a need for specialist equipment to maintain skin integrity.
- immobility requiring two or more people to change position.
- has a multiple drug therapy requiring administration by nursing staff (e.g. intravenous medication) for prolonged period/drug regime. Requires review more than once a month.
- has a major impairment of ability to communicate as a result of cognitive deficit or sensory impairment.
- has a mental illness with associated disturbed behaviour, requiring intensive physical/psychological care, which can be provided outside of a protected in-patient environment by a community package, but still allows access to appropriately professionally qualified personnel.
- has an aggressive response to care givers.

Dependency Level 3 Care

The individual may have any combination of the following conditions:

- an inability to take food and drink by mouth because of risk to the airway caused by impaired swallowing reflex.
- a tracheostomy to aid respiration.
- incontinence which can be managed with standard equipment but which presents a significant risk to skin integrity.
- the presence of an open wound which requires specialist nursing advice.
- an inability to leave a bed or a chair or is self-propelled in a wheelchair, needing two to
- transfer.
- has a multiple drug therapy requiring trained nursing supervision or administration and regular review.
- has an unstable condition requiring a drug regime with specialist supervision.

- has a mental illness which necessitates specialist medical/nursing input but care could be provided either in a nursing home or by a community care package.
- has unpredictable episodes of disturbed behaviour occurring frequently, perhaps more than once a week.

Dependency Level 4 Care

An individual will be considered to have level 4 care needs if they have any combination of the following conditions:

- an inability to feed self.
- single or double incontinence occurring several times a week that can be managed with standard equipment but represents a risk to skin integrity.
- very limited mobility, needing two to assist.
- open wound/s requiring daily dressing.

- a stable drug regime requiring trained nurse supervision and administration and GP review.
- requires a review by Old Age Psychiatry service in the community or nursing home but there is a requirement for non-specialist nursing care.
- a requirement for non-specialist nursing care and intermittent review because of a moderate degree or behavioral disturbance.

Dependency Level 5 Care

In Level 5 Care an individual will have any combination of the following conditions:

- a requirement for assistance to eat and drink as poor dentition or musculature problems tend to limit range of acceptable food stuffs.
- intermittent single or double incontinence that can be managed with standard equipment and training.
- a need for some help with mobilising.
- a stable drug regime which can be administered by untrained staff and requires infrequent review.
- an inability to take initiative in personal care.
- a requirement for social care with access to review because of the inability to self care without supervision and support.
- needs assessment/advice by Old Age Psychiatry service in the community.

Primary community and continuing care Clinical pathways for long term residential care draft policy for the Expert Advisory group Older People (July 2007) Currently under review, used with HSE permission

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DEPENDENCY LEVELS

Evaluation Date	Level 1	Level 2	Level 3	Level 4	Level 5	Nurses Signature

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RE-ASSESSMENT OF ACTITITIES OF DAILY LIVING

Resident Name:_____ **Date of Birth:**_____**MRN:**_____

1. Communication:	
2. Recreation/Social Interaction:	
3. Safe Environment:	
4. Mobility:	
5. Controlling Body Temperature:	**Temperature:**
6. Personal Hygiene & Skin Integrity:	
7. Breathing and Circulation:	**Blood Pressure:**
	Pulse:
	Respirations:
8. Nutrition:	**Weight:**
9. Self Image:	
10. Sleep & Rest:	
11. Elimination:	**Urinalysis:**
12. Spirituality and Dying:	

Any problems identified to be referred to Problem Identification Sheet for detailed plan of care.

Signature of Assessing Nurse _____ **Date / Time:** _____

Residents signature_____ **Date&time**_____

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ASSESSMENT FORM FOR URINARY INCONTINENCE

RESIDENTS NAME: _____ SEX M / F DATE OF BIRTH: _____

ADDRESS: _____ TEL. NO: _____

_____ POSTCODE _____

ASSESSING NURSE: _____ GP/CONSULTANT _____

SOURCE OF REFERRAL_____ DATE OF ASSESSMENT _____

(Tick or ☐ circle statement as appropriate)

A. MEDICAL HISTORY

Parkinsons	☐	Cerebral Vascular Accident	☐	Diabetes	☐
Spinal Injury	☐	Multiple Sclerosis	☐	Dementia	☐
Hysterectomy	☐	Pelvic Floor Repair	☐	Difficult Births	☐
Prostatectomy	☐	Bladder Neck Surgery	☐	Urethral Stricture	☐
Physical Handicap	☐	Mental Handicap	☐	Confusional State	☐

B. URINARY SYMPTONS

1. When did it start? _____
2. Is it getting worse? YES/NO
3. How often do you change underwear? _____ day
4. How often do you wet the bed? _____ night
5. Amount of urine leaked? Light/Moderate/Heavy
6. Dysuria? YES/NO
7. Haematuria YES/NO

		POSSIBLE CAUSE
8. Do you leak when you laugh / cough / play sport / get up from a chair?	YES/NO	Genuine stress Incontinence.
9. Do you have an urgent need to use the toilet?	YES/NO	Unstable bladder
10. Do you sometimes leak before you reach the toilet?	YES/NO	Unstable bladder
11. Do you need to visit the toilet frequently? Frequency? _____ day Frequency? _____ night	YES/NO	Unstable bladder Retention with overflow.
12. Do you only pass small amounts of urine at a time? Amount passed in cups _____	YES/NO	Unstable bladder Retention with overflow.
13. Does your bladder still feel full after passing urine?	YES/NO	Retention with overflow.
14. Do you sometimes have difficulty passing water, e.g. having to wait or strain?	YES/NO	Retention with overflow.
15. Do you have a weak urine flow?	YES/NO	Retention with overflow.
16. Do you have frequent urine infections?	YES/NO	Retention

C. CONTRIBUTORY FACTORS

1. Fluid intake

   How many cups in 24 hours? _____
2. Present bowel habit: Daily ☐ Alternate day ☐

   Less often ☐ Constipated ☐ Laxatives ☐
3. Mobility:

   Is patient fully mobile? YES/NO

   Can walk with aid? YES/NO

   Get on and off toilet? YES/NO

   Chairbound? YES/NO

   Immobile? YES/NO

4. Environment:

Toilet facilities? _____

Distance to toilet? _____

Specific equipment used _____

5. Dexterity:

Manage clothing quickly /easily? YES/NO

Fine finger movement GOOD/POOR

6. Medication (Please list)

_____

_____

_____

_____

7. Psychological State

Is urinary problem causing anxiety/depression? YES/NO

Is urinary problem restricting activities/outings? YES/NO

D. PHYSICAL EXAMINATION

a) Abdominal palpation.

b) Peri-anal skin condition – healthy? YES/NO

c) Residual urine _____

d) Urinalylsis _____

e) Daily Record Chart (kept for one week and attached to assessment form).

f) Leakage on coughing _____

E. TREATMENT

NB. Dependent on contributory factors, treat problems caused by contributory factors.

TYPE OF INCONTINENCE	SUGGESTED NURSING ACTION	SUGGESTED MEDICAL ACTION
Genuine Stress Incontinence	- Pelvic Floor Exercises	Refer to Gynaecologist / Physiotherapist
Unstable Bladder	- Bladder Retraining Using Chart - Toileting Aids	- Urodynamic Studies - Anticholinergic Drugs
Outflow OBS Due to Prostatic Enlargement	- Catheter Care - Appliance	- Urodynamic Studies - Surgery
Retention with Overflow (Other than above)	- Teach Intermittent Self-Catherization - Catheter Care	- As above
Passive Incontinence, i.e. Loss of Awareness	- Habit Retraining - Aids & Appliances	

PRODUCTS REQUIRED		
	Type	Number Required
Appliance		
Pad – Day		
Pad - Night		
Pant		
Bed protection		

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GERIATRIC DEPRESSION SCALE

Name of Patient: _____ D.O.B: _____ MRN: _____

Ask the following questions

Q1. Do you feel pretty worthless the way you are now? ☐
Q2. Do you often get bored? ☐
Q3. Do you often feel helpless? ☐
Q4. Are you basically satisfied with your life? ☐
Q5. Do you prefer to stay at home rather than than going out and doing new things? ☐
Q6. Are you in good spirits most of the time? ☐
Q7. Are you afraid that something bad is Going to happen to you? ☐
Q8. Do you feel that your life is empty? ☐
Q9. Do you feel happy most of the time? ☐
Q10. Do you feel full of energy? ☐
Q11. Do you think it is wonderful to be alive now? ☐
Q12. Do you feel that your situation is hopeless? ☐
Q13. Have you dropped many of your activities and interests? ☐
Q14. Do you think that most people are better off than you are? ☐
Q15. Do you feel that you have more problems with your memory than most? ☐

GLOSSARY: Geriatric Depression Scale Scorecard

This tool is scored by allocating 1 point to each 'depressive' answer, where the answer associated with **depression** is 'yes' for each question except for questions 4 6, 9, 10,and 11.

Screening test scoring ranges:

- 0 to 4, Normal Range
- 5 to 8, Mild Depression
- 9 to 11, Moderate Depression
- 12 to 15, Severe Depression
- This scale was developed as a basic screening measure for depression in older adults.
-

Is Depression present?

No: Low GDS and no clinical signs
Possible: High GDS, no clinical signs
Low GDS, with clinical signs
Intermediate GDS score with or without clinical signs
Other subjective or objective indicators of depression
Probable: High GDS with clinical signs
Definite Yes :Previous history of depression with current clinical signs present

Recent medical diagnosis of depression

Clinical Signs: **Adapted from DSM III Diagnostic**
Criteria For Major Depressive Disorder

Predisposing Factors May Include:

1. Biological: Family history, prior episode

2. Physical: Chronic or other medical conditions – especially those that result in pain or loss of function e.g., arthritis, CVA, CHF, etc.
Exposure to drugs e.g., hypnotics, Analgesics and antihypertensives
Sensory deprivation

3. Psychological: Unresolved conflicts e.g., anger (bereavement) or guilt.
Memory loss of dementia
Personality disorders

4. Social: Losses of family and friends
Isolation
Loss of Job / Income

Additional Comments: Overall impression or other related comments.

Signature of Assessing Nurse _____ Date / Time: _____

Reference; Blink TL, Yesavage JA, Lum O, Heersema P, Adey MB, Rose TL, screne test for geriatric depression 1982

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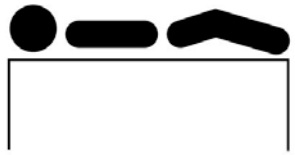
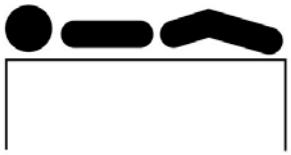
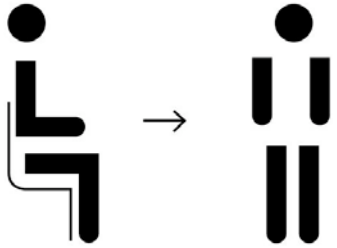
Manual Handling Chart

Residents Name: Date Of Birth: Assessment date: Signed:

Moving / Sitting Turning in Bed	In/Out of Bed	Transfer Chair – Chair On/ Off toilet – bathing	Stand – Sit Sit – Stand	Mobility
				
Instructions				
Comments				
Physiotherapy Special Requirements				

Colours Indicate

Red = Hoist
Yellow = Requires 1
Black = Supervision
Blue = Requires 2 (residents MUST be able to bear weight)
Orange = Slides
Green = Independent

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YEARLY MONITOR CHART FOR THE YEAR_____

January		February		March		April	
Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight
May		**June**		**July**		**August**	
Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight
September		**October**		**November**		**December**	
Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight

Signature of Assessing Nurse _____ Date / Time: _____

Name: _____ Date of Birth: _____ MRN: _____

Yearly Monitor Chart for the year …….							
January		February		March		April	
Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight
May		**June**		**July**		**August**	
Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight
September		**October**		**November**		**December**	
Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight	Date/Initial	Weight

Signature of Assessing Nurse _____ Date / Time: _____

'MUST'

'MUST' is a five-step screening tool to identify **adults,** who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

It is for use in hospitals, community and other care settings and can be used by all care workers.

This guide contains:

- A flow chart showing the 5 steps to use for screening and management
- BMI chart
- Weight loss tables
- Alternative measurements when BMI cannot be obtained by measuring weight and height.

The 5 'MUST' Steps

Step 1

Measure height and weight to get a BMI score using chart provided. ***If unable to obtain height and weight, use the alternative procedures shown in this guide.***

Step 2

Note percentage unplanned weight loss and score using tables provided.

Step 3

Establish acute disease effect and score.

Step 4

Add scores from steps 1, 2 and 3 together to obtain overall risk of malnutrition.

Step 5

Use management guidelines and/or local policy to develop care plan.

Please refer to *The 'MUST' Explanatory Booklet* for more information when weight and height cannot be measured, and when screening patient groups in which extra care in interpretation is needed (e.g. those with fluid disturbances, plaster casts, amputations, critical illness and pregnant or lactating women). The booklet can also be used for training. See *The 'MUST' Report* for supporting evidence. Please note that 'MUST' has not been designed to detect deficiencies or excessive intakes of vitamins and minerals and is of **use only in adults.**

'Malnutrition Universal Screening Tool' ('MUST')

BAPEN
Advancing Clinical Nutrition

MAG
Malnutrition Advisory Group
A Standing Committee of BAPEN

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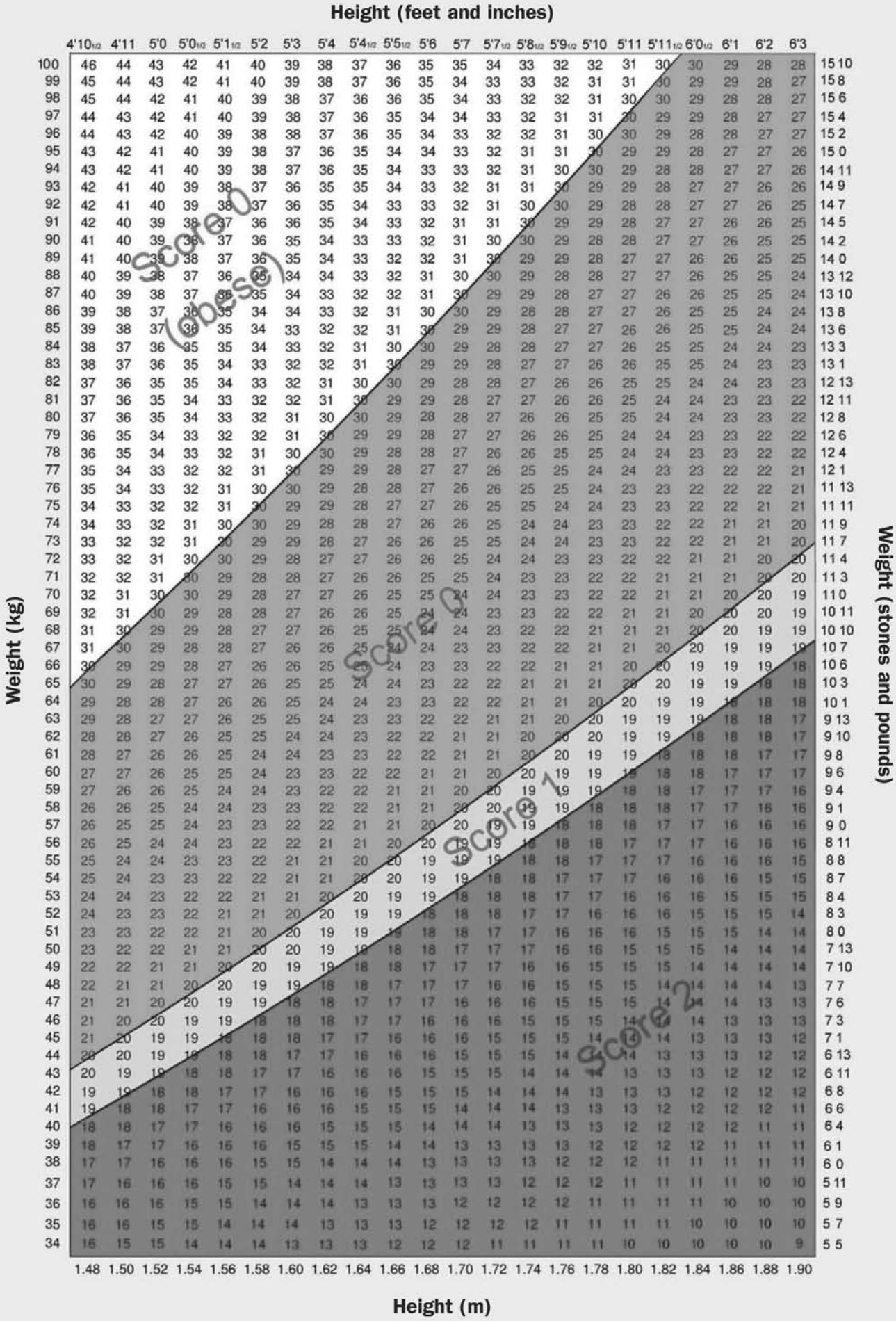
Step 1 – BMI score (& BMI)



Note : The black lines denote the exact cut off points (30,20 and 18.5 kg/m²), figures on the chart have been rounded to the nearest whole number.

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Step 1 + Step 2 + Step 3

Step 1 — BMI score

BMI kg/m²	Score
>20(>30 Obese)	= 0
18.5-20	= 1
<18.5	= 2

Step 2 — Weight loss score

Unplanned weight loss in past 3-6 months

%	Score
<5	= 0
5-10	= 1
>10	= 2

Step 3 — Acute disease effect score

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

If unable to obtain height and weight, see reverse for alternative measurements and use of subjective criteria

Step 4

Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition
Score 0 Low Risk Score 1 Medium Risk Score 2 or more High Risk

Step 5

Management guidelines

0 Low Risk

Routine clinical care

- Repeat screening
  Hospital – weekly
  Care Homes – monthly
  Community – annually
  for special groups
  e.g. those >75 yrs

1 Medium Risk

Observe

- Document dietary intake for 3 days if subject in hospital or care home
- If improved or adequate intake – little clinical concern; if no improvement – clinical concern - follow local policy
- Repeat screening
  Hospital – weekly
  Care Home – at least monthly
  Community – at least every 2-3 months

2 or more High Risk

Treat*

- Refer to dietitian, Nutritional Support Team or implement local policy
- Improve and increase overall nutritional intake
- Monitor and review care plan
  Hospital – weekly
  Care Home – monthly
  Community – monthly

* Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

All risk categories:

- Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary.
- Record malnutrition risk category.
- Record need for special diets and follow local policy.

Obesity:

- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.

Re-assess subjects identified at risk as they move through care settings

See *The 'MUST' Explanatory Booklet* for further details and *The 'MUST' Report* for supporting evidence.

'Malnutrition Universal Screening Tool' ('MUST')

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Step 2 – Weight loss score

Weight before weight loss (kg)

	SCORE 0 Wt Loss < 5%	SCORE 1 Wt Loss 5-10%	SCORE 2 Wt Loss > 10%
34 kg	<1.70	1.70 – 3.40	>3.40
36 kg	<1.80	1.80 – 3.60	>3.60
38 kg	<1.90	1.90 – 3.80	>3.80
40 kg	<2.00	2.00 – 4.00	>4.00
42 kg	<2.10	2.10 – 4.20	>4.20
44 kg	<2.20	2.20 – 4.40	>4.40
46 kg	<2.30	2.30 – 4.60	>4.60
48 kg	<2.40	2.40 – 4.80	>4.80
50 kg	<2.50	2.50 – 5.00	>5.00
52 kg	<2.60	2.60 – 5.20	>5.20
54 kg	<2.70	2.70 – 5.40	>5.40
56 kg	<2.80	2.80 – 5.60	>5.60
58 kg	<2.90	2.90 – 5.80	>5.80
60 kg	<3.00	3.00 – 6.00	>6.00
62 kg	<3.10	3.10 – 6.20	>6.20
64 kg	<3.20	3.20 – 6.40	>6.40
66 kg	<3.30	3.30 – 6.60	>6.60
68 kg	<3.40	3.40 – 6.80	>6.80
70 kg	<3.50	3.50 – 7.00	>7.00
72 kg	<3.60	3.60 – 7.20	>7.20
74 kg	<3.70	3.70 – 7.40	>7.40
76 kg	<3.80	3.80 – 7.60	>7.60
78 kg	<3.90	3.90 – 7.80	>7.80
80 kg	<4.00	4.00 – 8.00	>8.00
82 kg	<4.10	4.10 – 8.20	>8.20
84 kg	<4.20	4.20 – 8.40	>8.40
86 kg	<4.30	4.30 – 8.60	>8.60
88 kg	<4.40	4.40 – 8.80	>8.80
90 kg	<4.50	4.50 – 9.00	>9.00
92 kg	<4.60	4.60 – 9.20	>9.20
94 kg	<4.70	4.70 – 9.40	>9.40
96 kg	<4.80	4.80 – 9.60	>9.60
98 kg	<4.90	4.90 – 9.80	>9.80
100 kg	<5.00	5.00 – 10.00	>10.00
102 kg	<5.10	5.10 – 10.20	>10.20
104 kg	<5.20	5.20 – 10.40	>10.40
106 kg	<5.30	5.30 – 10.60	>10.60
108 kg	<5.40	5.40 – 10.80	>10.80
110 kg	<5.50	5.50 – 11.00	>11.00
112 kg	<5.60	5.60 – 11.20	>11.20
114 kg	<5.70	5.70 – 11.40	>11.40
116 kg	<5.80	5.80 – 11.60	>11.60
118 kg	<5.90	5.90 – 11.80	>11.80
120 kg	<6.00	6.00 – 12.00	>12.00
122 kg	<6.10	6.10 – 12.20	>12.20
124 kg	<6.20	6.20 – 12.40	>12.40
126 kg	<6.30	6.30 – 12.60	>12.60

Weight before weight loss (st lb)

	SCORE 0 Wt Loss<5%	SCORE 1 Wt Loss 5-10%	SCORE 2 Wt Loss>10%
5st 4lb	<4lb	4lb – 7lb	>7lb
5st 7lb	<4lb	4lb – 8lb	>8lb
5st 11lb	<4lb	4lb – 8lb	>8lb
6st	<4lb	4lb – 8lb	>8lb
6st 4lb	<4lb	4lb – 9lb	>9lb
6st 7lb	<5lb	5lb – 9lb	>9lb
6st 11lb	<5lb	5lb – 10lb	>10lb
7st	<5lb	5lb – 10lb	>10lb
7st 4lb	<5lb	5lb – 10lb	>10lb
7st 7lb	<5lb	5lb – 11lb	>11lb
7st 11lb	<5lb	5lb – 11lb	>11lb
8st	<6lb	6lb – 11lb	>11lb
8st 4lb	<6lb	6lb – 12lb	>12lb
8st 7lb	<6lb	6lb – 12lb	>12lb
8st 11lb	<6lb	6lb – 12lb	>12lb
9st	<6lb	6lb – 13lb	>13lb
9st 4lb	<7lb	7lb – 13lb	>13lb
9st 7lb	<7lb	7lb – 13lb	>13lb
9st 11lb	<7lb	7lb – 1st 0lb	>1st 0lb
10st	<7lb	7lb – 1st 0lb	>1st 0lb
10st 4lb	<7lb	7lb – 1st 0lb	>1st 0lb
10st 7lb	<7lb	7lb – 1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb – 1st 1lb	>1st 1lb
11st	<8lb	8lb – 1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb – 1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb – 1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb – 1st 3lb	>1st 3lb
12st	<8lb	8lb – 1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb – 1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb – 1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb – 1st 4lb	>1st 4lb
13st	<9lb	9lb – 1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb – 1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb – 1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb – 1st 5lb	>1st 5lb
14st	<10lb	10lb – 1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb – 1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb – 1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb – 1st 7lb	>1st 7lb
15st	<11lb	11lb – 1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb – 1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb – 1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb – 1st 8lb	>1st 8lb
16st	<11lb	11lb – 1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb – 1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb – 1st 9lb	>1st 9lb

Alternative measurements and considerations

Step 1: BMI (body mass index)

If height cannot be measured

- Use recently documented or self-reported height (if reliable and realistic).
- If the subject does not know or is unable to report their height, use one of the alternative measurements to estimate height (ulna, knee height or demispan).

If height & weight cannot be obtained

- Use mid upper arm circumference (MUAC) measurement to estimate BMI category.

Step 2: Recent unplanned weight loss

If recent weight loss cannot be calculated, use self-reported weight loss (if reliable and realistic).

Subjective criteria

If height, weight or BMI cannot be obtained, the following criteria which relate to them can assist your professional judgement of the subject's nutritional risk.

1. BMI

- Clinical impression – thin, acceptable weight, overweight. Obvious wasting (very thin) and obesity (very overweight) can also be noted.

2. Unplanned weight loss

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

3. Acute disease effect

- No nutritional intake or likelihood of no intake for more than 5 days.

Further details on taking alternative measurements, special circumstances and subjective criteria can be found in *The 'MUST' Explanatory Booklet*. A copy can be downloaded at www.bapen.org.uk or purchased from the BAPEN office. The full evidence-base for 'MUST' is contained in *The 'MUST' Report* and is also available for purchase from the BAPEN office.

BAPEN Office, Secure Hold Business Centre, Studley Road, Redditch, Worcs, B98 7LG. Tel: 01527 457 850. Fax: 01527 458 718.
bapen@sovereignconference.co.uk BAPEN is registered charity number 1023927. www.bapen.org.uk

 ISBN 1 899467 85 8 Price £2.00

Royal College of Nursing

THE BRITISH DIETETIC ASSOCIATION

Published November 2003 by MAG the Malnutrition Advisory Group, a Standing Committee of BAPEN. *Review date December 2004 and annually thereafter.*
'MUST' is supported by the British Dietetic Association, the Royal College of Nursing and the Registered Nursing Home Association.

Alternative measurements: instructions and tables

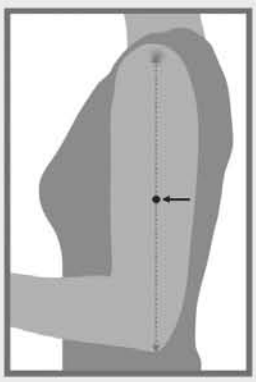
If height cannot be obtained, use length of forearm (ulna) to calculate height using tables below.
(See The 'MUST' Explanatory Booklet for details of other alternative measurements (knee height and demispan) that can also be used to estimate height).

Estimating height from ulna length

Measure between the point of the elbow (olecranon process) and the midpoint of the prominent bone of the wrist (styloid process) (left side if possible).

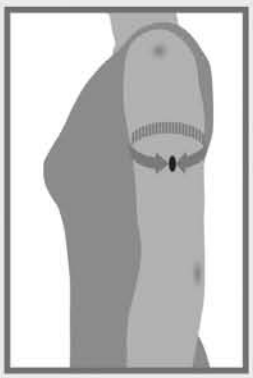
HEIGHT (m)	Men (<65 years)	1.94	1.93	1.91	1.89	1.87	1.85	1.84	1.82	1.80	1.78	1.76	1.75	1.73	1.71
	Men (>65 years)	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67
	Ulna length (cm)	32.0	31.5	31.0	30.5	30.0	29.5	29.0	28.5	28.0	27.5	27.0	26.5	26.0	25.5
HEIGHT (m)	Women (<65 years)	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.70	1.69	1.68	1.66
	Women (>65 years)	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.66	1.65	1.63
HEIGHT (m)	Men (<65 years)	1.69	1.67	1.66	1.64	1.62	1.60	1.58	1.57	1.55	1.53	1.51	1.49	1.48	1.46
	Men (>65 years)	1.65	1.63	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51	1.49	1.48	1.46	1.45
	Ulna length (cm)	25.0	24.5	24.0	23.5	23.0	22.5	22.0	21.5	21.0	20.5	20.0	19.5	19.0	18.5
HEIGHT (m)	Women (<65 years)	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47
	Women (>65 years)	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.44	1.42	1.40

Estimating BMI category from mid upper arm circumference (MUAC)



The subject's left arm should be bent at the elbow at a 90 degree angle, with the upper arm held parallel to the side of the body. Measure the distance between the bony protrusion on the shoulder (acromion) and the point of the elbow (olecranon process). Mark the mid-point.

Ask the subject to let arm hang loose and measure around the upper arm at the mid-point, making sure that the tape measure is snug but not tight.



If MUAC is < 23.5 cm, BMI is likely to be <20 kg/m^2.
If MUAC is > 32.0 cm, BMI is likely to be >30 kg/m^2.

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FOOD INTAKE CHART – SERVICE USERS AT HIGH AND MEDIUM RISK

Residents Name: _____ MRN: _____

Date: _____ D.O.B: _____ Room No: _____

Give careful description of the type and quantity of food in hand measures e.g. slices, scoops, tablespoons. For drinks state cup, mug, glass etc.

	Food / Drink Supplement / Snacks	Quantity Eaten or Drunk	Comments	Completed By
8 a.m.				
11 a.m.				
Midday				
2.30 p.m.				
1.30 p.m.				
8 p.m.				

Checklist: Thickeners ☐ Others: _____

Supplements: Calogen ☐ _____

Polycal ☐ _____

Signature of Assessing Nurse _____ Date / Time: _____

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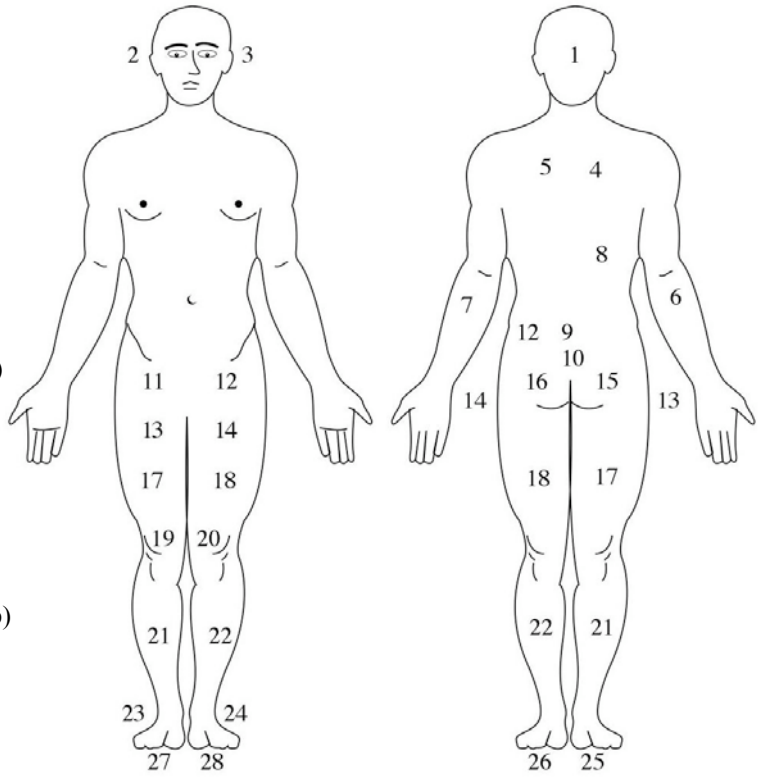
SKIN ASSESSMENT RECORD

Position of pressure ulcer

Identify the position of the pressure ulcer(s) on the torso figure using the numerical system provided. Grade the wound using the National Pressure Ulcer Advisory Panel (NPUAP) classification of wounds. Document all findings in the wound assessment form provided, using a separate form for each site.

1. Back of head
2. Right ear
3. Left car
4. Right scapula
5. Left scapula
6. Right elbow
7. Left elbow
8. Vertebrae (tipper-mid)
9. Sacrum
10. Coccyx
11. Right iliac crest
12. Left iliac crest
13. Right crochanter (hip)
14 Left crochanter (hip)



15. Right ischial tuberosity
16. Left ischial tuberosity
17. Right thigh
18. Left thigh
19. Right knee
20. Left knee
21. Right lower leg
22. Left lower leg
23. Right ankle (inner/out
24. Left ankle (inner/outer)
25. Right heel
26, Left heel
27. Right toe(s)
28. Left roe(s) toe(s)
29. Other (specify)

National Pressure Ulcer Advisory panel (NPUAP)

Classification of Wounds

GRADE 0	No Clinical evidence of a pressure ulcer
GRADE 1	Non - blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discolouration of the skin, warmth, oedema, indurance or hardness may also be indicators
GRADE 2	Partial thickness skin loss involving epidermis, dermis or both. The ulcer is usually superficial and pressure presents clinically as an abrasion blister or shallow crater
GRADE 3	Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue
GRADE 4	Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures e.g. tendon joint capsule Undermining and sinus tracts may be associated with stage 4 ulcers

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WOUND ASSESSMENT

Residents Name: _____ D.O.B: _____ Room No: _____

Wound Description:

Day							
Month and Year							
Time							
Nurse Initials							
Grade/Stage of wound							
Wound Type: 1. Pressure Sore 2. Traumatic 3. Surgical 4. Sinus-Fistuls 5. Ulcer 6. Burn 7. Malignant							
Location of the wound.							
Depth **Length**							
Width							
Wound Margin 1. Clean 2. Intact 3. Open							
Wound Bed 1. Necrosis (Black) 2. Slough (Yellow) 3. Infection (Green) 4. Granulation (Red) 5. Epitheliaisation (Pink)							
Surrounding Skin Colour 1. Pink 2. Red							
Surrounding Skin Temp 1. Cool 2. Hot							
Surrounding Skin Type 1. Shiny 2. Blistered 3. Wet							
Odour 1. None 2. Some 3. Offensive							
Exudate (amount) 1. None 2. Small 3. Moderate 4. Large							
Exudate (type) 1. Clear 2. Serosanguineous 3. Purulent 4. Blood 5. Faeces							
Pain 1. No Pain 2. At Dressing							

3. Intermittent 4. Continuous							

Pain Scale 0. No Pain 1, 2, 3, 4 5 Moderate pain 6, 7, 8, 910. Severe pain							
Infection 1. No Sign 2. Suspected & Swabbed 3. Confirmed 4. GP Notified 5. Antibiotics							
Swab Taken Date and Time. (if applicable) 1. Yes 2. No							
Freq of Dressing Change: 1. Twice Daily 2. Daily 3. Alternate Days 4. Every Three Days 5. Every Four Days 6. Every Five Days 7. Other 8. PRN							
Type of Dressing:							
Notes:							
Assessment should be supported by photographs And/or tracings (calibrated by a ruler).							

Signature of Assessing Nurse _____ Date / Time: _____

Adapted from Royal College of Nursing and National Institute of Clinical Excellence guidelines for management of pressure ulcers in primary and secondary care (2005)

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Goal of Care

Nursing intervention required to achieve goal:

No.	Intervention
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature:_____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Altered Communication Pattern

Goal of Care

To ensure that the special communication needs of the resident are addressed. To reduce the risk of the
development of challenging behaviours such as physical or verbal aggression.

Nursing intervention required to achieve goal:

No.	Intervention
	Ensure that the resident is in possession of his or her glasses at all times.
	That the resident has his or her hearing aid (if used) in situ at all times.
	That the resident is encouraged to interact with other residents.
	Encourage participation in activities program.
	Ascertain from close relatives information regarding interests and hobbies that could be used to stimulate a response.
	Communicating verbally: Stand face to face with the resident when speaking to him or her. Naming person by prefered name. Speak clearly, calmly and slowly. Use short sentences. Liste Adult language. Use touch, if appropriate. Use visual cues where possible. Give resident A chance to assimilate what is being said. Repeat if necessary.
	Avoiding physical or verbal outbursts: Work slowly at all times. Explain what you intend To do. Pay attention to non-verbal communication.
	Consider all challenging behaviors (verbal and physical aggression etc.) exhibited by resident as a sign of an underlying or unmet need, i.e. pain, wanting to use the toilet, disease progression e.g. cancer etc.
	Discuss with GP any changes in behavior/mood etc. as it may be indicative that further Tests need to be carried out to assess disease advancement.
	Respect the privacy, dignity and personal space of resident at all times as failure to do this could result in the exhibition of unnecessarily challenging behaviors as the patient Attempts to communicate their displeasure.
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Inability to ensure Recreation and Social activity

Goal of Care

To ensure the resident is engaged in meaningful activities and is not socially isolated.
To provide meaningful activities to ensure social inclusion and self actualisation.

Nursing intervention required to achieve goal:

No.	Intervention
	Establish what the resident's hobbies and interests are prior to admission.
	Establish what their previous occupation was.
	Encourage resident to participate in relevant home based activities and to try to establish New areas of interest.
	Encourage the continuation of older interests and the going out with friends and family To previous areas of interest if feasible.
	Provide quiet area or specific areas where smaller group activities can be facilitated.
	Encourage the keeping up to date with outside interests via newspapers, television, etc…
	Encourage links with the local community through trips out and by inviting groups in
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Inability to maintain a safe environment

Goal of Care

To maintain physical and psychological safety.

Nursing intervention required to achieve goal:

No.	Intervention
	Snug fitting footwear to be worn at all times.
	All walkways are kept clear of objects that could pose a threat to the safety.
	Walking aids etc. are within easy reach.
	Appropriate safety precautions are taken in the dining room to prevent burns or scalds.
	Showers/baths etc. will be supervised /assisted to decrease the risk of falling where assessed as necessary whilst also ensuring the residents dignity.
	Resident is orientated to time/place/person as appropriate.
	That side rails and any form of restraint will be used only following a full risk assessment and used as a last resort if necessary, the nurse in charge must ensuring the restraint form has been completed by Nurse/GP and discussed and agreed with the resident and the family.
	Next of Kin is informed regarding use of restraints and same is documented.
	The Resident is checked regular intervals please specify……..
	An opportunity for motion and exercise is provided for at least 10 minutes during each 2 hours that restraint is in use
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Impaired mobility

Goal of Care

To maintain current level of mobility; using aids only when necessary

Nursing intervention required to achieve goal:

No.	Intervention
	That the resident mobilises according to his/her level of ability/condition
	That all times a person/people are available to assist with transferring/mobilization
	Appropriate aids are used when mobilising e.g. walking stick, Zimmer frame etc.
	The resident is brought for short walks during the day and weather permitting the resident is brought outdoors
	That, if able, the resident is mobilised to bedside from sitting/dining area and that wheelchair is not used unnecessarily
	That resident is never left isolated due to his/her inability to mobilise freely and has easy access to call bell systems
	That all handling aids are utilised in a manner that is safe and effective (Hoist, slides etc.)
	If using the hoist ensure resident is well informed re reason for same and is happy for this device to be used to transfer him/her
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time_____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Inability to dress / undress

Goal of Care

To ensure that the resident is dressed in clothes of his/her choice. To ensure that clothes chosen are
Appropriate to age and environment.

Nursing intervention required to achieve goal:

No.	Intervention
	That resident is given the option of choosing clothing he/she wishes to wear
	In the case of resident who suffers from senile dementia who is unable to choose, his/her family asked to bring in clothes that the resident would prefer if he/she had the ability to make the choic
	Clothing is appropriate for the time of the year to maintain correct body temperature.
	Assistance given to resident when washing and dressing themselves if required.
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date& Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Inability to maintain adequate levels of personal hygiene

Goal of Care

To maintain a positive self image, and healthy skin

Nursing intervention required to achieve goal:

No.	Intervention
	That privacy and dignity is respected by ensuring that curtains are drawn around the bed And the door is closed during personal care procedures.
	That the resident has all the requirements necessary to carry out his/her own personal Hygiene unaided if appropriate.
	That resident is assisted by nursing staff in order to ensure an adequate level of Personal hygiene is maintained.
	That a full bed bath / assisted wash / shower are carried out daily.
	That all pressure areas are checked every time personal care is being attended to.
	That resident will be able to have a shower bath (a) When he/she requests (b) At the Discretion of the nurse (c) At least once a week.
	That length of fingernails/toenails are checked weekly and action taken to ensure that They are kept in good condition (e.g. regular chiropody appointments).
	That regular hairdressing appointments are arranged for resident as necessary and/or As requested by resident or his/her family.
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Inability to maintain an adequate nutritional state

Goal of Care

To ensure resident receives a nutritious diet and adequate fluids daily. To reduce incidence of
Urinary tract infections. To reduce the risk of constipation.

Nursing intervention required to achieve goal:

No.	Intervention
	Establish what the resident normal dietary intake is.
	That resident will be provided with either a normal diet, soft diet or pureed diet.
	Special diet, low fat, low salt, diabetic, gluten free or other.
	Resident will be given a minimum of 1.5 L of fluids daily (if conditions allow).
	That food is served at appropriate temperature.
	That resident will be encouraged to come to the dining room but meals will be served In resident's room if deemed more beneficial.
	Assistance will be offered at meal times if necessary.
	Specialist cutlery and crockery used if required.
	Meals will Not be rushed.
	If nutritional intake is poor, then nutritional screening is required.
	Food supplements will be offered following discussion with GP e.g. cubitan build up drinks, forticremes etc.
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Inability to maintain/elimination requirements

Goal of Care

To ensure that, if possible, resident maintains his/her independence in this area. Or in the case of lost
Independence, to ensure that the resident is kept clean and comfortable at all times.

Nursing intervention required to achieve goal:

No.	**Intervention**
	Record urinary output if possible.
	Assess and record pattern of incontinence for 5 days using a frequency volume chart.
	Plan re-training programme with resident (if this is possible).
	Ensure close proximity to toilet.
	Prompt to use toilet, be discreet. Never ask a resident re toileting needs in front of Visitors/other residents.
	Record and encourage fluids.
	Use appropriate incontinence aids. State the type and size of aid.
	Maintain resident's privacy.
	Assess and record bowel elimination pattern.
	Ensure adequate vegetable, fibre and fruit (esp. prunes) in diet.
	Maintain normal bowel habit through regular toileting.
	Maintain mobility, and provide regular exercise where possible.
	Administer laxatives as prescribed but only if necessary as a last resort.
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Adequate Rest and Sleep

Goal of Care

To ensure resident does not become exhausted. Sleep deprivation leads to agitation, depression etc.

Nursing intervention required to achieve goal:

No.	Intervention
	Establish normal sleep pattern
	Ensure any aids to sleep at home are provided
	State aids, if any, used
	Ensure that the immediate corridor environment is quiet with dimmed lights
	Ensure call bell is within reach of the resident
	Ensure that any residents exhibiting disruptive behavior are not in the immediate area
	If apnoea persists offer periods of rest during the day
	Offer late breakfast
	If apnoea persists discuss with resident and GP if appropriate re use of night sedation
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time_____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Inability to express sexuality in his or her usual way.

Goal of Care

That resident will be able to express sexuality in a way that is normal to him or her

Nursing intervention required to achieve goal:

No.	Intervention
	That as much privacy and dignity as possible is afforded to the resident, especially during personal care procedures.
	That resident is aided in maintaining sexual attractiveness by assisting where necessary With personal hygiene, make-up, perfume or aftershave, clothing of their choice.
	Ensure resident has the freedom of choice in relation to all the above. That private Time and space will be provided, where possible, when partners or family or friends visit.
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Resident Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Potential problem of injuries from falls as resident has recent history of falls.

Goal of Care

To prevent falls.

Nursing intervention required to achieve goal:

No.	Intervention
	Complete falls assessment and record risk accordingly. Liaise with G.P. re medical reason for fa
	Ensure call bell is within easy reach.
	Provide falls prevention education to Resident and family.
	Refer to OT/Physio for further assessment if necessary.
	Monitor for side effects of medication, polypharmacy – refer to G.P.
	Monitor blood pressure check for postural hypotension
	Monitor for steadiness and balance and gait.
	Monitor and reassess resident frequently.
	Instruct Resident not to change position or stand up suddenly.
	Ensure falls hazard communicated to alert others to fall risks.
	Keep immediate environment obstacle free. Assess suitability of footwear.
	Provide hip protectors and ensure all staff are aware of same.
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature: _____ Date & Time

_____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Urinary catheter in situ.

Goal of Care

To maintain an effective urinary drainage system.

Nursing intervention required to achieve goal:

No.	Intervention
	Ensure fluid intake of approx. 2 litres per day. Change catheter bag weekly and catheter as Per manufacturers instructions / as needed.
	Attend to perineal hygiene twice daily, using warm soapy water and disposable wipes.
	Clean catheter with warm soapy water, in one direction away from perineum.
	Dry perineum and catheter by patting dry with towel.
	Avoid the use of talc, creams and strongly perfumed soaps.
	Ensure adequate hand hygiene and the use of gloves when dealing with catheter or bag.
	Ensure the catheter is situated below the level of the bladder and tubing length prevents Kinking, dragging or pulling when moving and handling.
	Ensure catheter is well supported on catheter stand, without touching the floor.
	Empty the catheter bag when _ full, ensuring the outlet valve does not come into contact With the jug and the port is dried on completion with a tissue.
	Use leg bag as indicated.
	When changing from leg bag tubing to large drainage bag or vice versa remove cap from Left bag tubing, clean end of tubing with swab and connect to catheter.
	Observe colour, clarity and odour of urine daily and monitor for symptoms of UTI. - Temp, pain, generally unwell. - Obtain sample for urinalysis and liaise with G.P. as necessary.
	Send C.S.U. to lab as per G.P. instruction.
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature _____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Wound

Goal of Care

To promote healing

Nursing intervention required to achieve goal:

No.	**Intervention**
	Treat wound as instructed by hospital/PHN or G.P.
	Monitor for signs of complications/infection in wound healing.
	Localised swelling, redness, heat.
	Cellulitis in surrounding tissues.
	Increased exudates.
	Pyrexia.
	Malodour.
	Delayed wound healing.
	Increased pain.
	Treat infection as instructed by G.P.
	M.R.S.A. as per guidelines.
	Provide optimum nutrition and increase protein intake.
	Provide supplement drinks to promote wound healing.
	Consult dietician is indicated.
	Ensure specialist equipment in place such as pressure relieving beds, cushions, etc
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature_____ Date & Time _____

Ongoing Re-evaluation Dates:

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PROBLEM IDENTIFICATION SHEET

Resident Name: _____ D.O.B: _____ MRN: _____

Problem Number:	Date:	Time:

Problem:

Non-insulin Dependent Diabetic

Goal of Care

To maintain stable blood sugar levels.

Nursing intervention required to achieve goal:

No.	Intervention
	Assess residents understanding of their diabetes and treatment and if possible teach self care skills.
	Check the blood glucose level. Administer oral hypoglycaemic if / as prescribed.
	Observe for any signs of hypo/hyperglycaemia. Educate resident on signs and symptoms of same.
	Educate resident and family re diabetic diet.
	Ensure catering staff are aware of dietary needs. Liaise with dietician if necessary.
	Check urine for glucose and ketones as necessary / as instructed and record results.
	Advise resident on the importance of foot care. Ensure footwear fits properly, does not pinch the feet and toes can move freely.
	Ensure the feet are kept clean and dried properly.
	Ensure Chiropodist reviews resident regularly.
	Encourage and assist gentle regular exercise.
	Ensure resident has regular optalmic reviews.
First Re-evaluation Date:	

Signature: _____ Date & Time _____

Residents Signature_____ Date & Time _____

Ongoing Re-evaluation Dates:

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RESTRAINT ASSESSMENT FORM

Residents Name: _____ D.O.B: _____ MRN: _____

Resident's Presenting Problem:

_____

_____

_____

Goal: _____

Behavioural cues	**Assessed for:**	**Date**		
o Wanders	o Infection			
o Attempts to Leave the home	o Unintended effects			
Attempts to get out of	of drug therapy			
o bed	o Depression			
o chair	o Pain			
o Verbalises wishes to go home	o Constipation			
o Agitated	o Electrolyte			
o Confused	imbalance			
o Challenging Behaviour	o Hypoxia			
o Potential for pulling at tubes	o Hunger			
o Other	o Thirst			
o Other	o Other			
o Other	o Other			

Interventions assessed to avoid Using Restraint	**Current Mobility Statue**
o Resident moved closer to	o Supervised
the Nursing station	o Minimal Assistance
o Seating assessed for	o Moderate Maximum Assistance
appropriateness	o immobile
o Arms, Feet and back	o Bed Rest
Well supported	**Decision to Use Restraint**
o Sonas	Date:
o Music Therapy	**Decision made by:**
o Activities department	1. Nursing Staff (Signature)
involvement	2. Doctor
o Reality Orientation	(Signature)_____
o Reminiscence Therapy	3. Family is aware and agreed
o Relaxation	4.
o One to one supervision	**Type of restraint(s):**
o other	o Bed rails
o other	o Reclining Chair o Seat Belt o Chemical o Other please specify

Signature of Assessing Nurse _____ **Date / Time:** _____

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RESTRAINT PLAN

RESIDENT'S NAME: _____

ROOM NUMBER: _____

DATE OF BIRTH: _____

PRESCRIBING NURSE _____

TYPE(S) OF RESTRAINTS:

_____

_____

RESIDENT REPRESENTATIVE INFORMED_____

COMMENCEMENT DATE: _____

TIME:_____

RESIDENT TO BE CHECKED AT_____ MINUTE INTERVALS

CHECKED BY_____SIGNATURE_____TIME_____

CHECKED BY_____SIGNATURE_____TIME_____

CHECKED BY_____SIGNATURE_____TIME_____

CHECKED BY_____SIGNATURE_____TIME_____

CHECKED BY_____SIGNATURE_____TIME_____

CHECKED BY_____SIGNATURE_____TIME_____

CHECKED BY_____SIGNATURE_____TIME_____

CHECKED BY_____SIGNATURE_____TIME_____

RESIDENT GIVEN AN OPPORTUNITY FOR MOTION AND EXERCISE AT LEAST FOR TEN MINUTES EVERY TWO HOURS

TIME:_____

MOTION/EXERCISE GIVEN

_____

_____

SIGNATURE_____

TIME RESTRAINT REMOVED_____SIGNATURE

DATE_____

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DAILY FLOW SHEET 1

Residents Name: _____ D.O.B: _____ MRN: _____

Date;											
Time											
Nursing Initials											
Communication 1. Alert 2. Orientated 3. Confused 4. Anxious 5. Depressed 6. Agitated 7. Content											
Presence of Pain 1. Yes 2. No											
Recreations 1. Outings 2. In-house activities											
Safe environment 1. Stick 2. Zimmer 3. Wheelchair 4. Crutches 5. Risk of Falls											
Mobility 1. Up/Ambulant 2. Assisted x 1 3. Assisted x 2 4. Chair 5. Bed Rest 6. Hoist											
Controlling Body Temp. 1. Independent 2. Assisted 3. Pyrexial											
Personal Care 1. Shower 2. Bed Bath 3. Assisted Wash 4. Self Care 5. Other											
1. Denture Care **2. Oral Care**											
Nail Care 1. By Staff 2. Chiropodist 3. Podiatrist											
Skin Integrity 1. Intact 2. Red 3. Broken											
Position Changed 1. 2 hourly 2. 3 hourly 3. 4 hourly 4. Other											
1. Press. Relieving Mattress **2. Press. Relieving Cushion**											

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DAILY FLOW SHEET 2

Residents Name: _____ D.O.B: _____ MRN: _____

Date:											
Time:											
Nursing Initials:											
Breathing											
1. No difficulty 2. Dyspnoea 3. Suction required											
Nursing Position 1. Supine 2. Erect 3. Supported 4: In Bed											
Nutritional Intake 1. Independent 2. Supervision 3. Full Assistance											
Breakfast 1. Full 2. Half 3. Refused 4. Nil											
Lunch 1. Full 2. Half 3. Refused 4. Nil											
Tea 1. Full 2. Half 3. Refused 4. Nil											
1. Nutritional Supplement **2. Supper**											
1. PEG Feeding **2. Subcutaneous Infusion** **3. Intravenous** **4. Naso-gastric feeding**											
Glucometer reading											
Self Image 1. Choose Own Clothes 2. Hairdresser											
Elimination											
Urinary System 1. Voiding 2. Incontinent											
Catheter 1. Urethral 2. Super pubic 3.Catheter Care given											
Incontinent Wear; Type; Changed **1 .2hr 2. 4hr 3. 6hr 4. Other**											
Aperients 1.Fibre Supplement2. Laxative 3. Suppositories 4. Enema											
Bowel function 1. BO 2.constipated											
Sleep & Rest 1.Normal 2.Broken 3.No sleep 4.Day time rest 5.Checked at night, -------Hourly											
Doctor 1.Verbal instructions 2. Seen by the doctor 3. Instructions given 4. No instructions given											

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PROBLEM IDENTIFICATION SHEET –EVALUATIONS SHEET

Residents Name: _____ D.O.B: _____ Room No: _____

Date & Time	Implementation & Progress	Signature

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COMMUNICATION SHEET

Residents Name: _____ D.O.B: _____ MRN: _____

Room: _____G.P. _____

Date & Time	Nursing Care Information / Instruction	Signature

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INVESTIGATIONS & OUTPATIENT APPOINTMENT RECORD

Residents Name: ___________________ D.O.B: ________________ Room No: ____________

Date	Investigation/OPD Apt.	Signature	Date Result Received	Signature

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THERAPIES

Speech & Language, Activity, Physiotherapy, Alternative Therapy

Residents Name: _____ D.O.B: _____ Room No: _____

Date	Progress Note	Signature

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COMPLAINTS RECORDING FORM

DETAILS OF COMPLAINTS AND OUTCOME

NAME_____

DATE OF COMPLAINT _____

NATURE OF COMPLAINT _____

MEMBER OF STAFF TAKING COMPLAINT _____

Brief. details of the complaint and any action required or taken:

Signature person taking the complaint_____

Signature of Director of Nursing or Deputy_____

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MEDICAL NOTES

Residents Name: _____ D.O.B: _____ Room No: _____

Date	Medical Notes	Signature

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CENTRAL PRESCRIPTION RECORD

ROOM NO.	NAME OF RESIDENT	DATE OF BIRTH	DOCTOR	HEALTH CENTRE	KNOWN ALLERGIES

	START DATE	REGULAR MEDICINES (NAME FORM & STRENGTH) [BLOCK LETTERS	DOSE	TIMES OF ADMINISTRATION						BEFORE FOOD (TICK)	G.P. SIGN	DISCONTINUED		COMMENTS
				8am	1pm	6pm	10pm	Odd	Odd			Date	GP Sign	
A														
B														
C														
D														
E														
F														
G														
H														
I														
J														
K														
L														
M														
N														
O														
		NON-REGULAR MEDICINES										DURATION		
P														
Q														
R														

SHEET REFERENCE NO:_____ DATE WRITTEN:_____ DATE REPLACED:_____

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CENTRAL PRESCRIPTION RECORD

ROOM NO.	NAME OF RESIDENT	DATE OF BIRTH	DOCTOR	HEALTH CENTRE	KNOWN ALLERGIES

	START DATE	REGULAR MEDICINES (NAME FORM & STRENGTH) [BLOCK LETTERS	DOSE	TIMES OF ADMINISTRATION						BEFORE FOOD (TICK)	G.P. SIGN	DISCONTINUED		COMMENTS
				8am	1pm	6pm	10pm	Odd	Odd			Date	GP Sign	
A														
B														
C														
D														
E														
F														
G														
H														
I														
J														
K														
L														
M														
N														
O														
		NON-REGULAR MEDICINES										DURATION		
P														
Q														
R														

SHEET REFERENCE NO:_____ DATE WRITTEN:_____ DATE REPLACED:_____

Resident Record Audit Tool

The Audit Tool should be used as a self assessment mechanism to ensure conformance to the local procedures in place for the management of the residents' records. The tool can be used on an ongoing basis to continually evaluate the quality of sample records, or as part of a regular audit programme. A resident record audit should be carried out at least annually. Self assessments may also be supported by external independent audits.

General Guidance
Each chart should be assessed against each of the fields in the Audit Tool. The Audit Tool assesses each section of the record as follows:

All Fields Completed
Have all the fields been filled out by the relevant members of staff? Each section can only be deemed as completed where fields that are not utilised have been indicated as "N/A" or "Not Applicable". Empty fields should be deemed as information over looked. Where this is not the case details should be recorded, as to the sections identified, under the "Comments" section.

Appropriate Sign Offs
Have all of the sections been signed off and/or initialled by the appropriate members of staff? Each new entry should be signed off/initialled by a members of staff identified on the staff signatures listing. Student nurse entries must be countersigned by a Registered Nurse. Where appropriate sign off is not the case, details should be recorded, as to the sections identified, under the "Comments" section.

Appropriate Information
Is the information recorded appropriate to the resident to whom the record relates? It is necessary to ensure that the information is the appropriate information for the resident. An example of where this may not be the case is information relating to a different resident being inappropriately recorded in the record. Where this is not the case, details should be recorded, as to the sections identified, under the "Comments" section.

Comprehensive Information
Has enough information being provided such that it is clear as to what is to be communicated to other members of staff? This is a subjective assessment by the auditor and rated base on the following:

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Ratings of 3 or less should be recorded, as to the sections identified, under the "Comments" section.

Clarity of Information
Is the information provided clear, unambiguous and legible? This is a subjective assessment by the auditor and rated base on the following:

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Ratings of 3 or less should be recorded, as to the sections identified, under the "Comments" section.

Timeliness of Entries
Have all entries been inputted in a timely fashion and in line with the related guidance. This should also include the need for reviews of care. In general, this would relate to the need for entries as soon as possible after the event, however, some sections may have specific time sensitive requirements, eg plan of care commenced within 48 hours. Where this is not the case, details should be recorded, as to the sections identified, under the "Comments" section

Alterations and Errors Correctly Managed
Have all alterations and/or errors recorded in the resident record been dated and signed with a single line crossed through? Where this is not the case, details should be recorded, as to the sections identified, under the "Comments" section.

Specific Audit Fields
Additional aspects may be identified for audit depending on the functionality of the section. Where this occurs additional guidance shall be provided.

Quality Improvement and Analysis
Following the completion of a resident record audit, specific quality improvement plans should be developed based on the findings. These improvement plans should aim to address any deficiencies identified such that additional audits shall result in more positive outcomes.

Where multiple records are audited, additional analysis, to identify any trends, is also possible. With this information it may be possible to determine any areas which are improving, or failing, and may require preventative actions, such as training or process improvements.

1.0 General – Good Documentation Practice

1.1 Is the record stored securely in an area which is inaccessible to the general public?
(Guidance: All records should be stored in a locked secure environment when not actively in use. Where this is not the case details should be recorded under the "Comments" section)

Yes [_] *No* [_]

Comments

1.2 Are all pages and sheets securely attached within the resident record?
(Guidance: All sheets must be securely attached to ensure that they do fall out of the record. No "sticky" note pads should be used. Where this is not the case details should be recorded under the "Comments" section.)

Yes [_] *No* [_]

Comments

1.3 Have all additional resident records, not within the central record, been referenced and location provided?
(Guidance: This may include records which have been archived, eg daily flow charts, or additional records such as separate medication charts. Where this is not the case details should be recorded under the "Comments" section.)

Yes [_] *No* [_]

Comments

1.4 Is there any duplication of information, from the resident record, being recorded elsewhere?
(Guidance: Duplication of information can lead to increased risk of error. Examples of duplication may include the use of communication books. Where this is the case details should be recorded under the "Comments" section.)

Yes [_] *No* [_]

Comments

1.5 Have any abbreviations been used which are not on the approved abbreviations list?
(Guidance: All abbreviations used must be previously approved. Where this is not the case details should be recorded under the "Comments" section.)

Yes [_] *No* [_]

Comments

1.6 Have any abbreviations been used within the transfer or discharge letters?
(Guidance: To minimise the risk of miscommunication no abbreviations should be in the transfer or discharge letters. Where this is the case details should be recorded under the "Comments" section.)

Yes [_] *No* [_]

Comments

1.7 Have any abbreviations been used within the transfer or discharge letters?
(Guidance: To minimise the risk of miscommunication no abbreviations should be in the transfer or discharge letters. Where this is the case details should be recorded under the "Comments" section.)

Yes [_] *No* [_]

Comments

1.8 Has the 24 hour clock been used on all occasions?
(Guidance: The 24 hour system of recording times should be used in all cases. Where this is not the case details should be recorded under the "Comments" section.)

Yes [_] *No* [_]

Comments

1.9 Has black ink been used on all occasions?
(Guidance: The use of black ink is ONLY acceptable for use in clinical records. All other colours must not be used for any reason. Where this is not the case details should be recorded under the "Comments" section.)

Yes [_] *No* [_]

Comments

1.10 Has correction fluid (eg 'Tippex') been used on any occasions?
(Guidance: Tippex must never be used in a resident's record. Where this is the case details should be recorded under the "Comments" section.)

Yes [_] *No* [_]

Comments

2.0 Resident Register and Contract of Care

2.1 Cover Sheet/Resident Register

2.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

2.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

2.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

2.1.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided

5 – All necessary information provided (Fully comprehensive)

Comments

2.1.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

2.1.6 Timeliness of Entries

Yes [_] *No* [_]

Comments

2.1.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

2.2 Contract of Care

2.2.1 Contract of Care/Statement or Terms provided and recorded
(Guidance: Each Resident is provided with a written contract/statement specifying the terms and conditions with the registered provider of the residential care setting.)

Yes [_] *No* [_]

Comments

2.2.2 Has the Contract of Care/Statement or Terms been reviewed for each duration of stay?
(Guidance: Each written contract/statement specifying the terms and conditions should be reviewed and signed off for each stay within the residential care setting)

Yes [_] *No* [_]

Comments

3.0 Admission Details and Risk Assessments

3.1 Biographical Information: Residents Admission Form

3.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

3.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

3.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

3.1.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

3.1.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

3.1.6 Timeliness of Entries

Yes [_] *No* [_]

Comments

3.1.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

3.2 Signature Page

3.2.1 All Signatures Completed

Yes [_] *No* [_]

Comments

3.3 Falls Risk Assessment

3.3.1 All Fields Completed

Yes [_] *No* [_]

Comments

3.3.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

3.3.3 Appropriate Information

Yes [_] *No* [_]

Comments

3.3.4 Timeliness of Entries

Yes [_] *No* [_]

Comments

3.3.5 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

3.4 Pressure Sore Risk Assessment

3.4.1 All Fields Completed

Yes [_] *No* [_]

Comments

3.4.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

3.4.3 Appropriate Information

Yes [_] *No* [_]

Comments

3.4.4 Timeliness of Entries

Yes [_] *No* [_]

Comments

3.4.5 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

3.5 Admission Checklist

3.5.1 All Fields Completed

Yes [_] *No* [_]

Comments

3.5.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

3.5.3 Appropriate Information

Yes [_] *No* [_]

Comments

3.5.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

4.0 Comprehensive Assessments

4.1 Residents Comprehensive Assessments

4.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

4.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

4.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

4.1.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

4.1.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

4.1.6 Timeliness of Entries

Yes [_] *No* [_]

Comments

4.1.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

4.2 Barthel Assessment

4.2.1 All Fields Completed

Yes [_] *No* [_]

Comments

4.2.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

4.2.3 Appropriate Information

Yes [_] *No* [_]

Comments

4.2.4 Timeliness of Entries
(Guidance: The Barthel assessment is to be undertaken on all residents within 48 hrs)

Yes [_] *No* [_]

Comments

4.2.5 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

4.3 MMSE or Abbreviated Mental Test Score

4.3.1 All Fields Completed

Yes [_] *No* [_]

Comments

4.3.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

4.3.3 Appropriate Information

Yes [_] *No* [_]

Comments

4.3.6 Timeliness of Entries
(Guidance: To be completed on all resident within 48 hours of admission and retested on at least three monthly intervals or sooner if the residents condition changes.)

Yes [_] *No* [_]

Comments

4.3.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

4.4 Reassessment of Activities of Daily Living

4.4.1 All Fields Completed

Yes [_] *No* [_]

Comments

4.4.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

4.4.3 Appropriate Information

Yes [_] *No* [_]

Comments

4.4.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

4.4.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

4.4.6 Timeliness of Entries
(Guidance: Residents should be formally reassessed at least every three months or sooner if there is a change in the resident's condition.)

Yes [_] *No* [_]

Comments

4.4.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

5.0 Further Assessments

5.1 Continence Assessment

5.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

5.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

5.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

5.1.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

5.1.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

5.1.6 Timeliness of Entries
(Guidance: To be completed during the first week of admission if continence is assessed as a problem and reassessed at

three monthly intervals or sooner if there is a change to the Resident's condition.)

Yes [_] *No* [_]

Comments

5.1.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

5.2 Manual Handling Chart

5.2.1 All Fields Completed

Yes [_] *No* [_]

Comments

5.2.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

5.2.3 Appropriate Information

Yes [_] *No* [_]

Comments

5.2.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

5.2.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

5.2.6 Timeliness of Entries
(Guidance: Reassess at least three monthly or sooner if condition improves or deteriorates in any way.)

Yes [_] *No* [_]

Comments

5.2.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

5.3 Geriatric Depression Scale

5.3.1 All Fields Completed

Yes [_] *No* [_]

Comments

5.3.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

5.3.3 Appropriate Information

Yes [_] *No* [_]

Comments

5.3.6 Timeliness of Entries
(Guidance: To be completed on a resident if any signs of low mood, withdrawal or depression is evident.)

Yes [_] *No* [_]

Comments

5.3.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

6.0 Nutrition

6.1 MUST (Nutrition Screening)

6.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

6.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

6.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

6.1.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

6.1.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

6.1.6 Timeliness of Entries
(Guidance: Reassess at least three monthly or sooner if condition improves or deteriorates in any way.)

Yes [_] *No* [_]

Comments

6.1.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

6.2 Weight Chart

6.2.1 All Fields Completed

Yes [_] *No* [_]

Comments

6.2.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

6.2.3 Appropriate Information

Yes [_] *No* [_]

Comments

6.2.4 Timeliness of Entries
(Guidance: Chart at least once a month and more frequently if necessary.)

Yes [_] *No* [_]

Comments

6.2.5 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

6.3 Food Intake Chart

6.3.1 All Fields Completed

Yes [_] *No* [_]

Comments

6.3.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

6.3.3 Appropriate Information

Yes [_] *No* [_]

Comments

6.3.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

6.3.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

6.3.6 Timeliness of Entries
(Guidance: To be completed on residents at nutritional risk.)

Yes [_] *No* [_]

Comments

6.3.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

7.0 Wound Care

7.1 Skin Assessment Record

7.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

7.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

7.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

7.1.4 Timeliness of Entries

Yes [_] *No* [_]

Comments

7.1.5 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

7.2 Wound Assessment

7.2.1 All Fields Completed

Yes [_] *No* [_]

Comments

7.2.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

7.2.3 Appropriate Information

Yes [_] *No* [_]

Comments

7.2.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

7.2.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

7.2.6 Timeliness of Entries

Yes [_] *No* [_]

Comments

7.2.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

8.0 Problem identification and Care Plans.

8.1 The Residents Care Plan/Problem identification *(Repeat for All Records)*

8.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

8.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

8.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

8.1.4 The care plan has been discussed and drawn up with the involvement of the resident or his/her representative.

Yes [_] *No* [_]

Comments

8.1.5 Comprehensive Information
(Guidance: The care plan should reflect the assessment findings and sets out in detail the action and interventions to be taken by staff..)

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

8.1.6 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

8.1.7 Timeliness of Entries
(Guidance: Commenced within 48 hours of admission or earlier. Short term problems may need to be evaluated each shift. Longer term problems must be reviewed at least three monthly if the condition of the person has not changed.)

Yes [_] *No* [_]

Comments

8.1.8 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

8.2 Problem identification and Evaluation Sheet *(Repeat for All Records)*

8.2.1 All Fields Completed

Yes [_] *No* [_]

Comments

8.2.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

8.2.3 Appropriate Information

Yes [_] *No* [_]

Comments

8.2.4 Comprehensive Information
(Guidance: Each entry must related to the objective of the original care plan.)

1 – No necessary information provided
1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

8.2.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

8.2.6 Timeliness of Entries
(Residents should be formally reassessed at least every three months or sooner if there is a change in the resident's condition.)

Yes [_] *No* [_]

Comments

8.2.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

8.3 Restraint Assessment *(Repeat for All Records)*

8.3.1 All Fields Completed

Yes [_] *No* [_]

Comments

8.3.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

8.3.3 Appropriate Information

Yes [_] *No* [_]

Comments

8.3.4 Comprehensive Information
(Guidance: Should include complete assessment and discussion with the GP multidisciplinary team and family, to be signed by the Resident if possible, the nurse and GP (following the homes policy on restraint) and discussed with the family.)

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

8.3.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

8.3.6 Timeliness of Entries
(Guidance: Regular checks on the resident and of release from restraint for at least ten minutes every two hours to undergo an exercise and movement programme.)

Yes [_] *No* [_]

Comments

8.3.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

9.0 Daily Flow Chart and Communication

9.1 Daily Care Flow Chart *(Repeat for All Records)*

9.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

9.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

9.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

9.1.4 Timeliness of Entries
(Guidance: To be completed daily.)

Yes [_] *No* [_]

Comments

9.1.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

9.2 Communication Page *(Repeat for All Records)*

9.2.1 All Fields Completed

Yes [_] *No* [_]

Comments

9.2.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

9.2.3 Appropriate Information

Yes [_] *No* [_]

Comments

9.2.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

9.2.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

9.2.6 Timeliness of Entries

Yes [_] *No* [_]

Comments

9.2.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

10.0 Therapies and Outpatient and Investigations Record

10.1 Investigations and Outpatient Appointment Record

10.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

10.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

10.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

10.1.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

10.1.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

10.1.6 Timeliness of Entries

Yes [_] *No* [_]

Comments

10.1.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

10.2 Therapies Record

10.2.1 All Fields Completed

Yes [_] *No* [_]

Comments

10.2.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

10.2.3 Appropriate Information

Yes [_] *No* [_]

Comments

10.2.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

10.2.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

10.2.6 Timeliness of Entries

Yes [_] *No* [_]

Comments

10.2.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

10.3 Complaints Record

10.3.1 All Fields Completed

Yes [_] *No* [_]

Comments

10.3.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

10.3.3 Appropriate Information

Yes [_] *No* [_]

Comments

10.3.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

10.3.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

10.3.6 Timeliness of Entries

Yes [_] *No* [_]

Comments

10.3.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments

11.0 Medical Notes

11.1 Medical Records

11.1.1 All Fields Completed

Yes [_] *No* [_]

Comments

11.1.2 Appropriate Sign Offs

Yes [_] *No* [_]

Comments

11.1.3 Appropriate Information

Yes [_] *No* [_]

Comments

11.1.4 Comprehensive Information

1 – No necessary information provided
2 – Little necessary information provided
3 – Some necessary information provided
4 – Most necessary information provided
5 – All necessary information provided (Fully comprehensive)

Comments

11.1.5 Clarity of Information

1 – None of the information provided is clear and understandable
2 – Little of the information provided is clear and understandable
3 – Some of the information provided is clear and understandable
4 – Most of the information provided is clear and understandable
5 – All information provided is clear and understandable (Full clarity)

Comments

11.1.6 Timeliness of Entries

Yes [_] *No* [_]

Comments

11.1.7 Alterations and Errors Correctly Managed

Yes [_] *No* [_]

Comments