White boxes to be completed by care home staff as part of assessment

Yellow boxes to be completed prior to calling GP / Telemeds / Gold Line / 111 / 999

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Person’s name** | | | | | | | **DOB / /** | | | | | | | | | **NHS №** | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Care home**  Phone | | | | | | | | | | | | | | | | **Please indicate COVID HOME STATUS:** | | | | |
| **Next of kin’s name**  Relationship  Contact details | | | | | | | | | | Legal power of attorney? **YES / NO**  finance **YES / NO** health & wellbeing **YES / NO**  Contact details | | | | | | | | | | |
| **GP surgery** and phone number | | | | | | | | | | | | | | | | | | | | |
| **SITUATION** | | | | | | | | | | | | | | | | | | | | |
| Current concerns regarding this person | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **BACKGROUND** | | | | | | | | | | | | | | | | | | | | |
| **Last seen by GP** on / / for | | | | | | | | | | | | | | | | | | | | |
| New medication / treatment | | | | | | | | | | | | | | | | | | | | |
| **Allergies** | | | | | | | | | | | | | | | | | | | | |
| **Past medical history** – *Include hospital admissions, diagnosis etc* | | | | | | | | | | | | | | | | | | | | |
| Does the person require time critical medication? **YES / NO** details… | | | | | | | | | | | | | | | | | | | | |
| Is the person on oxygen therapy? **YES / NO** details… | | | | | | | | | | | | | | | | | | | | |
| **Continence** | | Full  continence | | | | Urinary incontinence | | | | Faecal incontinence | | | | Suprapubic  Catheter | | | | Stoma | | |
| Please tick ***✓*** | |  | | | |  | | | |  | | | | (size?) | | | |  | | |
| Is the person taking a supply of continence products to hospital? **YES / NO** | | | | | | | | | | | | Date catheter changed | | | | | | | | |
| Is the person an infection risk of **MRSA YES / NO C. diff. YES / NO** Other… | | | | | | | | | | | | | | | | | | | | |
| On a palliative care / end of life pathway? **YES / NO** | | | | | | | | | | Is the person registered with Gold Line? **YES / NO** | | | | | | | | | | |
| Is a **DNACPR** in place? **YES / NO** | | | | | | | | | | Is there an Advance Care Plan? **YES / NO** | | | | | | | | | | |
| Is there a preferred place of care? **YES / NO** details… | | | | | | | | | | | | | | | | | | | | |
| Any personal wishes or religious beliefs? | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **ASSESSMENT –** complete as appropriate | | | | | | | | | | | | | | | | | | | | |
| **Cognitive status ✓** as appropriate | | | | | | | | | | | | | | | | | | | | |
| no confusion | | |  | occasional confusion | | | |  | | long term confusion | | | | |  | | diagnosed dementia | |  |
| Any recent changes in behaviour in last 72 hours? **YES / NO** if Yes describe… | | | | | | | | | | | | | | | | | | | | |
|  | **normal** | | | | **current** | | | |  | | | | **normal** | | | | | **current** | | |
| Blood Pressure | **/** | | | | **/** | | | | Respiration Rate | | | |  | | | | |  | | |
| Pulse (bpm) |  | | | |  | | | | Blood Glucose | | | |  | | | | |  | | |
| Temperature (°C) |  | | | |  | | | | Oxygen Saturation | | | |  | | | | |  | | |
| Is there an outbreak within the home? **YES / NO** Diarrhoea? **YES / NO** Vomiting? **YES / NO** Other **YES / NO** | | | | | | | | | | | | | | | | | | | | |
| Level of Response **Alert** (responding normally) / **Drowsy** / **Confused** / **Unresponsive** | | | | | | | | | | | | | | | | | | | | |
| Pain **no pain / occasional pain / constant pain** | | | | | | | | | | | | | | | | | | | | |
| Is the skin intact? **YES / NO**  Pressure Ulcer? **YES / NO** Reported? **YES / NO** Category **1 / 2 / 3 / 4 / unstageable / moisture lesion**  Waterlow score: | | | | | | | | | | | | | | | | | | | | |
| Indicate any injury on the diagrams below and describe the type, size etc    R  R  L  L  FRONT  BACK | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **RECOMMENDATION & OUTCOME** | | | | | | | | | | | | | | | | | | | | |
| Record who you spoke to and what the outcome was of the phone call made. Including any actions to take whilst waiting for a GP/ambulance eg repeat observations. | | | | | | | | | | | | | | | | | | | | |
| Time of call | | | | | | | | | | | Time call returned (if applicable) | | | | | | | | | |
| Ambulance arrival time | | | | | | | | | | | Are the family aware? **YES / NO** | | | | | | | | | |

Staff name (print) Signature

Date Time

|  |
| --- |
| **Care home discharge plan** (patient’s condition to facilitate early discharge - nursing requirements, mobility/transfers etc) |
| Please see **This is me** document for my consent to share information with the care home |