

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ NHS No: \_\_\_\_\_



### Permission to Share Information

The Information recorded during this assessment may be shared with others involved in your care. This assessment may be used for consideration of your eligibility for NHS Continuing Healthcare and NHS-Funded Nursing Care.

Do you give your consent for information recorded during this assessment being shared with others involved in your care and held securely on paper and on computer in accordance with the Data Protections Act (1998)?	<b>Yes</b>	<b>No</b>
Is there any specific information you would NOT wish to be shared? (Please give details below) <b><u>Information NOT to be shared :</u></b>	<b>Yes</b>	<b>No</b>
Are there any agencies or individuals with whom you would NOT wish information to be shared? (please give details below) <b><u>Information NOT to be shared with :</u></b>	<b>Yes</b>	<b>No</b>
Service User/Patient unable to give consent (please give details below)	<b>Yes</b>	<b>No</b>
Signature of Service User/Patient or their Representative	Date:	

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**SHORT NURSING NEEDS ASSESSMENT  
FOR PRIORITY PATIENT OR GENERAL INFORMATION**

**Patient Details:**

Name:		Date of Birth: «Date_of_birth»	
Address:			
Home Phone Number ☎ :			
GP:	Practice:	☎	Fax:
District Nurse:		☎	Fax:
Hospice At Home:		☎	Fax:
Consultant:		Hospital & Ward:	Palliative Care Handover & Priority Document completed? Y/N LCD FAX 01484 487299
Date Admitted:	Social Worker:		Area Office & ☎
Religion:	Practising? Yes/No		
Next of Kin:		Relationship & ☎:	
Next of Kin:		Relationship & ☎:	
Address inc postcode :			
Relevant medical history (e.g. likelihood of deterioration, unstable condition, diagnosis, prognosis)			

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<u>Care Needs</u>	<i>Details of frequency, predictability, intensity, complex ability, staff required and why</i>
<u>Behaviour</u> Is behaviour appropriate? <b>Is there evidence of behavioural problems overnight?</b> Is the patient compliant with care?	Is a Registered Nurse needed? <b>YES / NO</b>
<u>Cognitive Impairment</u> Is there a known mental health problem Yes / No <b>Has the patient had a mental health assessment? Yes / No</b> Is there a CPN involved? Name & Contact no.	Is a Registered Nurse needed? <b>YES / NO</b>
<u>Psychological and Emotional Needs</u> Is there evidence of mood disturbance or anxiety symptoms? Is Palliative Care involved?	Is a Registered Nurse needed? <b>YES / NO</b>
<u>Communication</u> Is the patient able to communicate? <b>Do they use any aids?</b> SALT Assessment completed? Yes / No	Is a Registered Nurse needed? <b>YES / NO</b>
<u>Mobility</u> No.s of staff required to transfer/walk <b>Equipment needed?</b> Is there a physio assessment? <b>Is there rehab potential?</b> Yes/no .if no give reason	Is a Registered Nurse needed? <b>YES / NO</b>
<u>Nutrition</u> Assistance needed to feed? Swallowing difficulties? <b>Any enteral feeding, special diets.</b> Subcutaneous fluids required. <b>Is the condition likely to improve?</b> SALT /dietician involved?	Is a Registered Nurse needed? <b>YES / NO</b>
<u>Continence</u> Bowels – any incontinence, loose stools, UTI's? <b>Do they require enemas/stoma care?</b> Date bowels last opened Any incontinence aids? <b>If catheter, frequency of changes, is it prone to blocking?</b>	Is a Registered Nurse needed? <b>YES / NO</b>
<u>Skin/Hygiene Requirements</u> Waterlow / Maelor score ..... Need for turning and frequency? <b>Pressure areas, pressure sores and treatment? Equipment required?</b> Frequency of dressings. Improving deteriorating wound? <b>Are carers required? How many?</b>	Is a Registered Nurse needed? <b>YES / NO</b>

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<b><u>Care Needs</u></b>	<b><i>Details of frequency, predictability, intensity, complex ability, staff required and why</i></b>
<b><u>Breathing</u></b> Intervention required e.g. position, oxygen, nebulisers, nippy etc. Is the condition likely to improve? If O2 required Litres per min/ %	Is a Registered Nurse needed? <b>YES / NO</b>
<b><u>Drug Therapies (Please List)</u></b> Are there problems with compliance? Does the patient require PRN/SC medication? Any anticipatory medication needed? How often? Administered by whom? Route of drug administration? <b>Allergies--</b>	Is a Registered Nurse needed? <b>YES / NO</b>
<b><u>Sleep pattern / Altered State of Consciousness</u></b> If at home – bed upstairs or down? Is care required at night? Is there evidence of altered states in conscious level? Evidence of fits?	Is a Registered Nurse needed? <b>YES / NO</b>
<b><u>Medical Condition &amp; symptoms / stability</u></b> Are patient & family aware of diagnosis/prognosis? Is the condition stable and predictable or likely to deteriorate? Are palliative care team involved? Are patient/family aware of CC funding? Has leaflet for NHS CC public information booklet been given?	Is a Registered Nurse needed? <b>YES / NO</b>
<b><u>Relevant Social Background / Carer Involvement</u></b>	

This document is based on the eleven care domains described in the *National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care 2007*.

**Nurse Completing Assessment:**

PRINT NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

QUALIFICATIONS \_\_\_\_\_