ADULT INPATIENT ASSESSMENT

ALL SECTIONS OF THIS DOCUMENT ARE TO BE COMPLETED IN BLACK INK

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

ADDRESSOGRAPH

Health Board / Trust				**Hospital**			
Admission Method	Emergency		Elective		Transfer		**Source of Admission**	
Ward / Team / Department		**Consultant / Lead GP**		**Admission Date and Time**		**Transfer Date and Time**	
				DD / MM / YYYY	HH:MM	DD / MM / YYYY	HH:MM
				DD / MM / YYYY	HH:MM	DD / MM / YYYY	HH:MM
				DD / MM / YYYY	HH:MM	DD / MM / YYYY	HH:MM
				DD / MM / YYYY	HH:MM	DD / MM / YYYY	HH:MM
Estimated Date of Discharge	DD / MM / YYYY	**Date Fit for Discharge**	DD / MM / YYYY	**Actual Date of Discharge**	DD / MM / YYYY		

NHS Number					**Hospital Number**				
Surname					**Forename(s)**				
Title	Mr		Mrs		Miss		Ms		**Preferred Name**	
	Other								**Date of Birth**	DD / MM / YYYY
Gender	Male		Non - binary		Not Specified		**Sex at Birth**	Male		Female		Intersex	
	Female												
Religion		**Ethnic Group**		**Occupation**					
Permanent Address					**Current Address (if different)**				
Postcode:					**Postcode:**				
Tel. No. Home					**Tel. No. Mobile**				
Email Address									
Is patient wearing a patient identification band and are the details legible and correct?	Yes		No						

COMMUNICATION NEEDS

T

Do you have any concerns about the patient's capacity to engage in this assessment?	Yes		No	

If Yes, consider:

- What support can be provided to help the patient participate in this assessment
- Whether patient has capacity to make decisions about care and treatment – see mental capacity section

Preferred method of communication	Speech		Sign		Other			
First Language	English		Welsh		Other		**Preferred Language**	
Do you want this admission to be carried out in Welsh?	Yes		No		**Interpreter required?**	Yes		No	
Action:					Action:			

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KNOWN ALLERGIES / ADVERSE REACTIONS (If Yes, please list)

Not Known ☐ Yes ☐ No ☐

Name of Allergen / Adverse Reaction	Type of Reaction	Action Required				
		Epi Pen		Other		Details
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	

INFECTION CONTROL

Follow local and national policies and guidelines

Has the patient had any healthcare outside of the U.K. or in another Health Board/Trust in the last 12 months?	Not Known	☐	Yes	☐	No	☐
Does the patient have a history of multi-drug resistant organisms (MDRO) e.g. MRSA, CPO, CPE, VRE?	Not Known	☐	Yes	☐	No	☐
Does the patient have a history of any Alert infection e.g. Clostridium difficile, Tuberculosis, a Blood borne virus?	Not Known	☐	Yes	☐	No	☐
Are there any other current signs/symptoms of an infectious disease? e.g. diarrhoea, vomiting, respiratory like illness, pyrexia, Covid-19 related symptoms, suspicious rash etc	Not Known	☐	Yes	☐	No	☐
Does the patient have a recent history of exposure to an infectious disease in an environment and/or to a person(s)?	Not Known	☐	Yes	☐	No	☐
Any travel outside of the UK in the last 3 months?	Not Known	☐	Yes	☐	No	☐

GP Surgery Name (Current)		GP Surgery Name (Permanent)	
GP Surgery Address		GP Surgery Address	
Postcode:		Postcode:	
Telephone Number		Telephone Number	

CONTACT 1							CONTACT 2						
Name							Name						
Relationship							Relationship						
Main Carer	N/A	☐	Yes	☐	No	☐	Main Carer	N/A	☐	Yes	☐	No	☐
Daytime Tel. No.							Daytime Tel. No.						
Evening Tel. No.							Evening Tel. No.						
Can they be contacted at any time (24hrs/day)?			Yes	☐	No	☐	Can they be contacted at any time (24hrs/day)?			Yes	☐	No	☐
Are they aware of this admission?			Yes	☐	No	☐	Are they aware of this admission?			Yes	☐	No	☐

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CONTACT 3							**CONTACT 4**						
Name							**Name**						
Relationship							**Relationship**						
Main Carer	N/A		Yes		No		**Main Carer**	N/A		Yes		No	
Daytime Tel. No.							**Daytime Tel. No.**						
Evening Tel. No.							**Evening Tel. No.**						
Can they be contacted at any time (24hrs/day)?		Yes		No			**Can they be contacted at any time (24hrs/day)?**		Yes		No		
Are they aware of this admission?		Yes		No			**Are they aware of this admission?**		Yes		No		

Contact details not provided	Details:

CARE SUPPORT

Do you receive care support? If 'Yes' tick below ❗ If carer identified, consider a carer's assessment						No	
Family		**Paid Carer**		**3rd Sector**			
Friends		**Community Health**		**Care Home**			
Carer		**Social Care Agency**		**Residential Home**			
Neighbour		**Other:**	If other:				

If Yes, details:

Do you have carer responsibilities?	Yes		No	

If Yes, specify:

Does your admission / condition directly affect care of children / relatives / pets / assistance animal / others?	Yes		No	

If Yes, specify:

Do you have any concerns regarding continuity of care for dependents?	Yes		No	

If Yes, actions taken:

T	**If over 18, does the patient wish to be referred for a carer's assessment?**	N/A		Yes		No	
	If under 18, does the patient wish to be referred for a young carer's assessment?	N/A		Yes		No	

Referral details:

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SAFEGUARDING

Is there a concern that there may be an adult or child at risk of abuse or neglect?	Yes		No	
If Yes, actions taken: If Yes, follow Wales safeguarding procedures				
Are there any signs of abuse? (consider physical, emotional, sexual, financial and neglect)	Yes		No	
If Yes, details:				
Does the patient have any concerns for their safety ?	Yes		No	
If Yes, details:				
Are there any concerns about domestic abuse? If Yes, follow the local Ask and Act pathway	Yes		No	
Details:				
Do you need to report any concerns to another agency (Social Service's or the Police)? If Yes, follow local safeguarding policies and procedures	Yes		No	
Details:				

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REASON FOR ADMISSION

RELEVANT MEDICAL / SURGICAL HISTORY

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MENTAL HEALTH HISTORY

Are you receiving or have you received support from a mental health specialist team?	Not Known		Yes		No	
If Yes, details:						
Is the patient detained under the Mental Health Act (MHA)?			Yes		No	
If Yes, which section of the MHA?						
Is the patient on s.17 MHA leave to this ward?			Yes		No	
Who is the patient's MHA Responsible Clinician?		**Contact details:**				

T	**If the patient is currently receiving in-patient assessment/treatment for mental disorder, then offer referral to Independent Mental Health Advocacy (IMHA), unless you are aware that the patient already has IMHA**

YOUR MEDICATION

Do you currently take any medications?	Yes		No	
Do you self-administer medication?	Yes		No	
If No, who administers your medication?				
Do you use a pill / medication organiser / Dosette box / multi-compartment compliance aid?	Yes		No	
Do you have your medication with you?	Yes		No	
If Yes, can we use them for this admission?	Yes		No	
Details:				

Disclaimer (where relevant)

T	**Consider medication as a risk to falls**

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T MENTAL CAPACITY

Consider Dementia, Capacity, Delirium and Deprivation of Liberty Assessments

Do you have any reason to doubt the patient's mental capacity to make decisions about their care and treatment?	Yes		No	
If Yes, details of reasons / cognitive impairment: Consider Care Plan Follow MCA Code of Practice				
Is this due to a pre-existing diagnosis? (e.g. learning disability, dementia, stroke, other cognitive impairment) OR	Yes		No	
Is it a new presentation? (e.g. delirium, confusion, new head injury, new stroke)	Yes		No	
Consider what support can be provided to help the patient make decisions for themselves				
Do you think that the patient lacks capacity to consent to their hospital stay i.e. could they be deprived of their liberty?	Yes		No	
If Yes, make a Deprivation of Liberty Safeguards referral if the Deprivation is likely to be ongoing				
Is there / has anyone made you aware that the patient has an Advance or Future Care Plan?	Yes		No	
If Yes, is there a copy in the notes?	Yes		No	
Is there / has anyone made you aware that the patient has an Advance Decision to Refuse Treatment (ADRT)?	Yes		No	
If Yes, is there a copy of a written ADRT in the notes or has a verbal ADRT been recorded in the notes?	Yes		No	
Does the ADRT refuse life-sustaining treatment? (must be in writing, signed, witnessed and state that the refusal applies even if life is at risk)	Yes		No	
Is there / has anyone made you aware that the patient has a Health and Welfare Lasting Power of Attorney (LPA) or Court Appointed Deputy? (Note: LPA must be registered with the Office of the Public Guardian)	Yes		No	
If Yes, is there a copy in the notes?	Yes		No	
Is there / has anyone made you aware that the patient has a Property and Finance Lasting Power of Attorney (LPA) or Court Appointed Deputy? (Note: LPA must be registered with the Office of the Public Guardian)	Yes		No	
If Yes, is there a copy in the notes?	Yes		No	
Referral to an Independent Mental Capacity Advocate (IMCA) may be required if the patient has no family, friends, Attorney or Deputy to consult regarding best interests decisions.				
Does the patient have a learning disability?	Yes		No	
If Yes, consider the Learning Disability Care Bundle and Assessment				
Does the patient have a learning disability passport with them?	Yes		No	
If Yes, is there a copy in the notes?	Yes		No	
Does the patient have any specialist involvement with regards to Mental Capacity or Learning Disability?	Not Known		Yes	No
If Yes, details:				

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COMMUNICATION

Do you have a hearing problem?		Yes		No		**Are you registered as deaf?**	Yes		No	
If Yes, details:										
Do you have a sight problem?		Yes		No		**Are you registered as blind?**	Yes		No	
If Yes, details:										
Do you wear?	Hearing aids	Yes		No		with patient	Yes		No	
	Spectacles	Yes		No		with patient	Yes		No	
	Contact Lenses	Yes		No		with patient	Yes		No	
	Other	Yes		No		with patient	Yes		No	
Other details:										
Do you have difficulty reading?		Yes		No		**Do you have difficulty writing?**	Yes		No	
If Yes, details:										
Do you need any equipment to help you to hear or understand written information?							Yes		No	
If Yes, details:										
Do you feel that you can communicate clearly and make your needs understood?							Yes		No	
If No, details:										
Is this normal for you?							Yes		No	
If No, details: ❗ Consider Care Plan										

Do you have any specialist involvement?						Not Known		Yes		No
If Yes, details:										

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BREATHING

Do you have any difficulties breathing?			Yes		No	
If Yes, details:						
Is this normal for you?			Yes		No	
If No, details: ❗ Consider Care Plan						
Are you on home oxygen?			Yes		No	
If Yes, details: ❗ Consider Care Plan						
Do you have any specialist involvement?	Not Known		Yes		No	
Details:						
Do you use any special equipment relating to your condition?			Yes		No	
If Yes, details:						
Do you currently smoke?	No, but ex-smoker		Yes		No	
Do you currently vape?			Yes		No	
Do you currently use nicotine replacement?			Yes		No	
If Yes, do you require a nicotine replacement whilst in hospital?			Yes		No	
If Yes, do you agree to a referral to Help Me Quit services?			Yes		No	
If Yes, https://www.helpmequit.wales/professional-referral-form/						
❗ **Has the patient been informed that it is illegal to smoke or vape within a hospital and its grounds?**			Yes		No	

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T	**NUTRITION & HYDRATION**	**Admission Height:**	m / ft in	**Admission Weight:**	kg / st lb
	Complete Nutritional Risk Assessment				

Is the value for Height:	**Measured**		**Reported**		**Estimated**		**Unable to measure**	
Is the value for Weight:	**Measured**		**Reported**		**Estimated**		**Unable to measure**	

If unable to measure, details:

Do you have any problems eating?	Yes		No	

If Yes, details: Consider equipment, enteral or parenteral nutrition support Consider Care Plan

Is this normal for you?	Yes		No	
Do you have any problems drinking?	Yes		No	

If Yes, details: Consider Care Plan

Is this normal for you?	Yes		No	
Do you have any problems swallowing?	Yes		No	

If Yes, details: Consider referral to Speech and Language Therapy (SALT) Consider Care Plan

Is this normal for you?	Yes		No	
Do you need help to eat or drink?	Yes		No	

If Yes, details: Consider Care Plan

Do you require a specific diet or nutritional supplements?	Yes		No	

If yes, details: Consider Care Plan

Do you have any food allergies or intolerances?	Yes		No	

If Yes, details: Consider Care Plan

Do you have any specialist involvement?	Not Known		Yes		No	

If Yes, details:

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T MOBILITY

- Complete Manual Handling Risk Assessment
- Complete Falls Risk Assessment

Do you have any difficulties mobilising?		Yes		No
If Yes, details:				
Is this normal for you?		Yes		No
If No, details: Consider Care Plan				
Do you have any difficulties with your balance?		Yes		No
If Yes, details:				
Is this normal for you?		Yes		No
If No, details: Consider Care Plan				
Do you normally use a mobility aid?		Yes		No
If Yes, details:				
Do you have them with you?		Yes		No
Do you have any specialist involvement?	Not known	Yes		No
If Yes, details:				
Have you fallen in the last 12 months?		Yes		No
If Yes, details: (to include number of times)				
Do you have any anxiety or fear of falling?		Yes		No
If Yes, details:				
Have you brought appropriate footwear with you?		Yes		No
If No, details:				
Do you have any foot or lower limb problems?		Yes		No
Details: Consider Care Plan				

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T BLADDER AND BOWEL ! Complete All Wales Continence Risk Assessment

What is your normal bowel pattern?				
Details:				
Do you currently have any problems or concerns with your bowels?	Yes		No	
If Yes, details: ! Consider a care plan				
Do you have, or experience any bladder problems?	Yes		No	
If Yes, details: ! Consider a care plan				
Is this normal for you?	Yes		No	
If No, details:				
Do you have any of the following?	Yes		No	
Colostomy ☐ Ileostomy ☐ Urostomy ☐ Catheter ☐				
If Yes, details: ! Consider separate care plans				

Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						

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PERSONAL CARE

Can you normally attend to your own personal hygiene needs?	Yes		No	

If No – in what areas do you require assistance?

Washing ☐ Showering ☐ Bathing ☐ Dressing ☐ Mouth care ☐ Foot and nail care ☐ Other ☐

Details: ❗ Consider Care Plan

Do you use any equipment to support personal care?	Yes		No	

If Yes, details:

Do you have any specialist involvement?	Not Known		Yes		No	

Details:

T MOUTH CARE ❗ Complete All Wales Mouthcare Assessment

Are you able to eat and drink unaided?	Yes		No	

If No, complete All Wales mouth care assessment ❗ Consider Care Plan

Would you describe your mouth as feeling comfortable? (e.g. no pain, not dry, no soreness)	Not Known		Yes		No	

If No or Not Known, complete All Wales mouth care assessment

Are you able to clean your teeth and mouth without assistance?	Yes		No	

❗ If No, complete All Wales mouth care assessment

Do you wear dentures?	Yes		No	
Do you have your dentures with you?	Yes		No	

Do you have any specialist involvement?	Not Known		Yes		No	

If Yes, details:

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T PAIN / COMFORT ❗ Complete Pain Assessment

Are you in pain?	Yes		No	

If Yes, details: ❗ Complete appropriate pain assessment

Is this normal for you?	Yes		No	

If No, details:

Are there things that you usually do to alleviate your pain?	Yes		No	

If Yes, details:

Does the pain affect any of the following?	Yes		No	

Mobility ☐ Sleep ☐ Breathing ☐ Eating & Drinking ☐ Toileting ☐ Other ☐

Details: ❗ Consider Care Plan

Do you have any specialist involvement?	Not Known		Yes		No	

If Yes, details:

T SKIN ❗ Complete Pressure Ulcer Risk Assessment

Do you have existing wounds/ulcers or other skin problems?	Yes		No	

❗ If Yes, complete body map and pressure ulcer risk assessment

Do you have any specialist involvement?	Not Known		Yes		No	

If Yes, details:

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SLEEP

Can you describe your normal sleep pattern including anything you do to help you sleep?

Details:

Do you currently have difficulty sleeping?	Yes		No	

If Yes, details: ❗ Consider Care Plan

Do you have any specialist involvement?	Not Known		Yes		No	

If Yes, details:

CULTURAL AND SPIRITUAL BELIEFS

Do you have any specific cultural or spiritual beliefs that we need to consider?	Yes		No	

If Yes, details: ❗ Consider Care Plan

Would you like a visit from the chaplain or another faith leader?	Yes		No	

If Yes, details:

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HEALTH AND WELLBEING

Do you use recreational drugs?			Yes		No	
If Yes, details:						
Do you want information or advice on how to stop or take them safely?			Yes		No	
If Yes, details:						
Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						
Do you drink alcohol?			Yes		No	
If Yes, how many units per week?						
Do you wish to receive information/advice for reducing or stopping?			Yes		No	
If Yes, details:						
Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						

HAS A PROPERTY DISCLAIMER BEEN COMPLETED?			Yes		No	
Comments:						

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WHAT MATTERS TO ME

What is important to me at the moment?

What is preventing me from achieving this?

I would like to achieve the following from this admission:

My carer, advocate, family members could support me in the following ways:

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Signature List

This section MUST be completed on the first shift you are caring for the patient or prior to making an entry into the record.

Date	Ward/Unit	Role/ Qualification	Print Full Name	Signature	Initials

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Date & Time	Care Plan ref.	Details	Signature

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Date & Time	Care Plan ref.	Details	Signature

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Date & Time	Care Plan ref.	Details	Signature

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Date & Time	**Care Plan ref.**	**Details**	**Signature**

DISCHARGE CHECKLIST

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Relative informed of discharge date and time?	N/A		Yes		No	
Name of person informed:						
Details:						
Care providers informed?	N/A		Yes		No	
Confirmed by:						
Details:						
Nutritional needs considered and provisions supplied? (*Consider Nasogastric feeding, PEGs and feeding / nutritional supplements*)	N/A		Yes		No	
Details:						
Follow up appointment?	N/A		Yes		No	
Confirmed by:						
Details:						
Take home medication?	N/A		Yes		No	
Confirmed by:						
Details:						
Take home medication needing to be administered in the community?	N/A		Yes		No	
Details:						
Plaster of Paris check?	N/A		Yes		No	
Details:						
Peripheral Cannula removed?	N/A		Yes		No	
Wound check on discharge?	N/A		Yes		No	
Details:						
Wound care post discharge?	N/A		Yes		No	
Dressings Supplied	N/A		Yes		No	
Suture remover	N/A		Yes		No	
Staple remover	N/A		Yes		No	
Clip remover	N/A		Yes		No	
Drain(s) or device(s) In Situ?	N/A		Yes		No	
Details:						

Completed by	Designation	Date	Time	Reviewer Sig.	Review Date	Time
		DD / MM / YYYY	HH:MM		DD / MM / YYYY	HH:MM

DISCHARGE CHECKLIST

ALL SECTIONS OF THIS DOCUMENT ARE TO BE COMPLETED IN BLACK INK

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

Urinary Catheter In Situ?	N/A		Yes		No	
Catheter passport provided?			Yes		No	
Details:						
Central Venous Catheter In Situ?	N/A		Yes		No	
Details:						
Continence products provided on discharge?	N/A		Yes		No	
Details:						
Arranged Practice Nurse (non-housebound patients)?	N/A		Yes		No	
Details:						
Arranged District Nurse (if the patient is housebound)? *(Consider if the patient / carer / family are able to perform the care)*	N/A		Yes		No	
Details:						
Arranged Community Resource Team / Specialist Team?	N/A		Yes		No	
Details:						
Arranged Other:	N/A		Yes		No	
Details:						
Equipment?	N/A		Yes		No	
Details:						
Transport?	N/A		Yes		No	
Details:						
Copy of DNACPR sent?	N/A		Yes		No	
Details:						
Patient property returned?	N/A		Yes		No	
Details:						

Completed by	Designation	Date	Time	Reviewer Sig.	Review Date	Time
		DD / MM / YYYY	HH:MM		DD / MM / YYYY	HH:MM