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| **Patient Name:**  **NHS No:**  **ADDRESSOGRAPH**  **D.O.B:**  **Address**  **Tel no:**  **Male / Female (circle)** | | | **Date of Admission:**  **ReSPECT in place?**  **ADRT in place?** ☐  **DNACPR in place? Yes**  **No**  **Date completed:**  **MRFD**  **NMRFD**  **EDD:**  **TTO’s:**  **Discharge Summary:** | | **Referring Hospital**  **& Date:**  **Referring Ward:**  **Ward Contact Number:** |
| **GP Practice:**  **County:**    **Postcode:** |
| **Consultant / Specialty :** | | |
| **Ethnicity:**  **Religion:** | | | **Consent obtained from patient for:**  **Referral Yes**  **No**  **Share info Yes**  **No**  Has a conversation with the relative been had regarding discharge  **Yes**  **No**  Reason if not**:** | | **Next of Kin Name:**  **Relationship:**  **Address:**  **Contact number:** |
| **Preferred Language: English**  **Interpreter required: Yes** No | | |
| **Summary of admission (Inc. diagnosis, treatment & PMH.** | | | | | **Operation & Date: N/A** |
| **Secondary care follow up appointment date:** |
| **Current Medication & Support (tick) - send copy of drug chart**  **List any Allergies: Pain Score:** | | | | | |
| Can they self-administer? **Yes**  **No**  If no, please state who was providing support with this:  Is the medication supplied in BOXES/BLISTER PACKS at home  \*delete as appropriate | | | Was patient on insulin prior to hospital admission? **Yes**  **No**  Frequency of Insulin dose………………………….  Does the patient own a blood sugar monitor?  **Yes**  **No** | | Is the patient on Warfarin / DOACs?  **Yes**  **No** |
| Is patient on Eye drops?  **Yes**  **No** |
| PICC Line in-Situ: **Yes** ☐  IVs at Home: **Yes** ☐ |
| Current Observations: Date taken:  HR BP Resps SatsTemp Current NEWS2: | | | | | |
| Describe any Breathing problems: | | | | Home oxygen?  Yes  No  O2 Litres: Frequency: | |
| **Covid-19**  Test not required /  Date swab taken: ….. /….. /.. ….  & awaiting result  Exposed to C-19 & needs Isolation  Result Negative, no isolation  Result Positive & needs isolation | | **Flu Vac** - date if known:  ESBL (E.coli) Yes  No  Date:  MRSA +ve Yes  No  Date:  (site)  C/Difficile +ve Yes  No  Date: | | | Any evidence of infective diarrhoea? If yes, describe:  Other Infections: |
| **Wounds: If Yes**  **please send wound care plan with referral Nil**  **Purpose T Score: or BRADEN Score:**  **Are Pressure Areas Intact Yes**   **No**   **Grade (circle) 1 2 3 4** | | | | | |
| **End of Life Needs:** | Patient has a rapidly deteriorating condition entering a terminal phase: **Yes**   **No**  Anticipatory medications have been prescribed & provided: **Yes**   **No** | | | | |
| **Discharge Pathway Indicated (tick)**  **1**  **2**  **3** | | | | If the patient known to community nursing, provide details: | |

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| **Nutrition – Eating & drinking – current needs** | | | | | | | | | | | | |
| Independent | | | | AX1 | | | Full support | | | PEG/NG | | |
| MUST score: Weight: Girth: Height: BMI: | | | | | | | | | | | | |
| Dietician Referral: **Yes**   **No**   Date: | | | | | | | SALT Referral : **Yes**   **No**   Date: | | | | | |
| TPN prescribed: **Yes**   **No** | | | | | | | Dentures in situ: **Yes**   **No** | | | | | |
| **Continence – current support required e.g. pads/assistance** | | | | | | | | | | | | |
| Commode | Urinal/bottle | | | | Toilet | | | Wears pads | | Urethral/Suprapubic | | |
| Bladder: Continent or incontinent? | | | | | Catheter/ Conveen Catheter passport required | | | | | | | |
| Bowels: Date last opened : Type : Continent or incontinent? | | | | | | | | | | | | |
| **Night time needs - current** | | | | | | | | | | | | |
| Independent | Urinal/bottle | | | | Commode | | | Bedpan | | Turning | | |
| Night time assistance required – details: | | | | | | | | | | | | |
| **Cognition/current needs regarding Emotional & Mental Health / Behaviours (Select or tick as appropriate)** | | | | | | | | | | | | |
| Alert  Orientated  Confusion/ disorientated  Delirium? | | | Types of behaviour displayed (list)  Bay Buddy in place?  1:1 in place?  List Strategies to manage, Inc. night needs?    MH or Dementia team involved?  Section 117? | | | | | | | Any episodes of wandering during the day or night?  Mild memory issues | | |
| **Diagnosis** of mental health issues: Substance misuse/ self-neglect / significant anxiety +/- depression  **Diagnosed** cognitive problems: Dementia / Alzheimer’s / Bi polar | | | Can they be cared for in a side room? Yes  No  Can they use a call bell?  Yes  No  Has a care log been completed? Yes  No | | | | Describe any barriers to communication: | | | | | AMTS:  6CIT:  4AT:  MoCA: |
| Is the patient open to Dementia/Mental Health/LD services?  Contact details: | | | | |
| **Mental Capacity**  Does the patient have capacity? **Yes**  **No**  Best Interests decision documented **Yes**  **No**  DoLS: In place whilst in hospital: **Yes**  **No** | | | | | | | **Lasting Power of Attorney/DEPUTY**  Health & Welfare: **Yes**  **No**  Finance: **Yes**  **No** | | | | | |
| Safeguarding concern details: | | | | | |
| **Brief social history e.g. How did patient manage pre-admission? Independent? Mobility? Lives alone?** | | | | | | | | | | | | |
| Accommodation Type: (tick) House  Bungalow  Flat  Supported living  Residential Home  Nursing Home  Mobile home  Bed & Breakfast  Homeless | | | | | | | | | | | | |
| **Previous POC** **Yes**  OD BD TDS QDS Double handed Reason: Care agency Contact no: No POC  Does patient have a live-in carer? **Yes**  **No**  Does patient have informal carers e.g. family, neighbour, friend? **Yes**  **No**  Are they able to continue this level of care? **Yes**  **No**  Details:  Self-Funding: **Yes**  **No**  **Unknown** | | | | | | | | | | | | |
| Does patient have an allocated Social Worker? **Yes**  **No**  S/W Name: | | | | Key safe:  **Yes**   **No**   **NA**  Contact details for key safe: | | | Stairs: **Yes**   **No**  Internal/external  Unable to use stairs **Yes**   **No**  Access to the patient’s home: steps etc. | | | Pendant alarm: **Yes**  **No** **Other:**  Telecare requested? | | |
| **Washing & dressing - current** | | | | | | | | | | | | |
| Independent | | With Supervision / AX1 | | | | AX2 | | | Non-compliant (details) | | Other | |
| **Mobility & transfer needs – current** | | | | | | | | | | | | |
| Independent | | With Supervision /  Elbow crutches AX1/AX2 | | | | Walking stick AX1/AX2 | | | Tripod/quadstick AX1/AX2 | | Walking frame AX1/AX2 | |
| Gutter/pulpit frame AX1/AX2 | | Rotastand/standaid  AX1/AX2 | | | | Hoist  AX2 | | | 4 wheeled walker AX1/AX2 | | FWB/PWB/NWB  AX1/AX2 | |

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| **Patient Goals & Priorities:** | | | | | | | | | | | | | | | | |
| **Safety Checklist for Discharge:** | | | | | | | | | | | **Risk of Falls? Yes**  **No** | | | | | |
| Patient is physically and cognitively safe to be left alone BETWEEN visits. Day & night? **Yes**  **No** | | | | | | | | | | | | | | | | |
| Describe how the patient will manage (plus any risks). Include how the patient will mobilise and transfer and any cognitive or communication issues: | | | | | | | | | | | | | | | | |
| **Current Equipment needed on discharge and date of delivery** | | | | | | | | | | | | | | | | |
| Hospital Bed | Pressure Mattress Type | | | | Standard / Bariatric | | | | Commode/Mowbray | | | | Other: | | | |
| **Size of Package of care needed on discharge (select):** None  OD  BD  TDS  QDS  Double Handed: **Yes**  Preference of carers? Female  Male  NA  Family to bridge care? **Yes**  **No** | | | | | | | | | | | | | | | | |
| **Frequency of support required:** | | | | | | | **Is this POC: New, Increase, Restart, Long term, Short term** | | | | | | | | | |
| **AM** | | Tick | | **Midday** | | | Tick | **Teatime** | | | | Tick | | **Evening** | | Tick |
| Enable wash & dress | |  | |  | | |  | Enable to get ready for bed | | | |  | | Enable to get ready for bed | |  |
| Empty commode | |  | | Empty commode | | |  | Empty commode | | | |  | | Empty commode | |  |
| Supervise downstairs | |  | |  | | |  | Supervise up stairs | | | |  | | Supervise up stairs | |  |
| Support with breakfast | |  | | Support with lunch | | |  | Support with evening meal | | | |  | |  | |  |
| Leave jug/flask | |  | | Leave jug/flask | | |  | Leave jug/flask | | | |  | | Leave jug/flask | |  |
| Transfers: bed/chair/toilet | |  | | Transfers:  bed/chair/toilet | | |  | Transfers: bed/chair/toilet | | | |  | | Transfers: bed/chair/toilet | |  |
| Prompt administer meds | |  | | Prompt /administer meds | | |  | Prompt / administer meds | | | |  | | Prompt / administer meds | |  |
| **Therapy only**  **Yes**  **No** | | | **Requires visit on day of discharge**  **Yes**  **No** | | | | | | | **Has a home visit been completed**  **Yes**   **No** | | | | | | |
| **Reasons:** | | | | | | | | | | | | | | | | |
| **Relevant / Additional Information:** | | | | | | | | | | | | | | | | |
| **Referrers Signature:**  **Designation** | | | | | | **Print Name:**  **Contact Number:** | | | | | | | | | **Date:** | |
| **Contributors Signatures:**  **Designation:** | | | | | | **Print Name(s):** | | | | | | | | | **Date:** | |
| **Discharge Hub Recommendation**  **Time:** | | | | | | **Placement Hub – confirmation of plan**    **Time:** | | | | | | | | | **Date of Transfer:** | |