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| **Information Prior to Admission** |

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| ***Personal Information*** | |
| **Name:** |  |
| **Date of birth:** |  |
| **Address:** |  |
| **Age:** |  |
| **NI Number:** |  |
| **NHS Number:** |  |
| **Next of kin:** | Relationship:  Address:  Telephone No:  Mobile Telephone No: |

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| ***Social Worker – Care Manager Details*** | |
| **Name of Social Worker:** |  |
| **Referring Authority:** |  |
| **Address:** |  |
| **Telephone No:** |  |
| **Fax No:** |  |
| **Email:** |  |
| **Date of Assessment:** |  |
| **Signature of Assessor:** |  |

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| ***Present Accommodation*** |
| How long have you lived in your current accommodation? |
| What care and support are you currently receiving? |
| How do you feel about your current accommodation and are you having any problems? |

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| ***Required Accommodation*** | |
| Please detail your accommodation needs and requirements: | |
| Ground floor accommodation? | **YES/NO** |
| Wheelchair access? | **YES/NO** |
| Special bathing or showering facilities? | **YES/NO** |
| Do you need any other special considerations, such as any other equipment or adaptations that you may require? *If* ***YES*** *please give details:* | **YES/NO** |

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| ***Current Doctor*** | |
| **Name of Doctor:** |  |
| **Name of practice:** |  |
| **Address:** |  |
| **Telephone No:** | **Fax No** |

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| ***Current Consultant*** | |
| **Name of Consultant:** |  |
| **Name of Hospital:** |  |
| **Address:** |  |
| **Telephone No:** |  |
| **Fax No:** |  |

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| ***Physical Health*** | | | | |
| Do you have anyphysical health problems that you are currently being treated for?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| Do you have a medical diagnosis?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| When was the diagnosis made? | | | | |
| What treatment are you having for this condition and have you been prescribed medication? *Please give details.* | | | | |
| Have you ever been admitted into hospital for a physical health condition?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| Have you ever been colonised or infected with MRSA?  *If* ***YES*** *please give details.*  When did you last have an eye test?  *Date of last test: Do you want an eye test?* | | | | **YES/NO** |
| When did you last visit a dentist for treatment or a consultation?  *Date of last visit: Do you want a check-up?* | | | |
| Do you have a hearing impairment?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| When did you last visit a podiatrist for treatment or a consultation?  *Date of last visit: Do you want a check-up?* | | | | **YES/NO** |
| Do you have any special dietary needs due to a physical health need?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| Do you have any other physical health needs which may affect your accommodation needs?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| ***Mental Health*** | | | | |
| Do you have anymental health problems that you are currently being treated for?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you have a mental health diagnosis?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| When was the diagnosis made? | | | |  |
| What treatment are you having for this condition and have you been prescribed medication? Please give details. | | | |
| Do you suffer from any side-effects of prescribed medication?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| Have you ever been admitted into hospital due to deterioration in mental health?  *If* ***YES*** *please give details.*  Have you ever been subject Deprivation of Liberty Authorisation (DOLs)?  *If* ***YES*** *please give details.* | | | | **YES/NO**  **YES/NO** |
| Have you ever had any mental health problems in the past that no longer affect you? If ***YES*** *please give details.* | | | | **YES/NO** |
| Is there anything that can trigger your mental health problems, such as alcohol, drugs, stress, noise, other people?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| Do you have any problems managing and coping with stress and certain situations?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| ***Advanced Care Planning*** | | | |  |
| Have you discussed advanced care planning?  *If* ***YES*** *please give details.*  Do you have a Lasting Power of Attorney? *if* ***YES*** *please give details:*  Have you made an advanced decision to refuse treatment:  Do you have any Preferred priorities for care:  Have you made any wishes and preferences regarding future care needs in relation to deteriorating health needs and end of life care: | | | | |
| Do you self-administer all or part of your prescribed medication?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| Is any of your prescribed medication administered by a qualified nurse, such as a CPN?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| Do you take your prescribed medication regularly? | | | | **YES/NO** |
| Do you need support when taking your prescribed medication?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| Do you suffer from or have you ever suffered from any side effects?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| ***Alcohol*** | | | | |
| Do you consider your alcohol use to be a problem?  *If* ***YES*** *please give details and state what difficulties you experience:* | | | | **YES/NO** |
| How long have you had problems with alcohol and been alcohol dependant? | | | |  |
| What do you drink? | | | |
| How much alcohol do you drink? | | | |
| How often do you drink alcohol? | | | |
| Do you suffer from alcohol withdrawal and if so, what symptoms do you have when withdrawing?  *If* ***YES*** *please give details.* | | | | **YES/NO** |
| Have you ever undergone a detoxification programme or reduction programme?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Have you ever had a period of abstinence from alcohol?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Have you ever had any involvement or support from alcohol agencies, such as Community Alcohol Team, Alcoholics Anonymous, Brian Hore Unit or other agencies?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| What is your current drinking pattern?  *Please give details:* | | | | |
| ***Communication Skills*** | | | | |
| Are you able to read and write?  *Please give details:* | | | | **YES/NO** |
| If NO, would you be interested in literacy/remedial classes?  *Please give details:* | | | | |
| Do you find using the telephone?  *Please give details:* | | | | **YES/NO** |
| Do you have difficulty in communicating verbally and do you use any communication aids?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| ***Mobility*** | | | | |
| Do you have mobility problems?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you use or need any special aids or adaptations to assist you with your mobility?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you receive or have you ever received DLA mobility component?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you have or would you possibly qualify for a bus pass? | | | | **YES/NO** |
| Do you access community amenities and facilities?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Would you like to access community facilities with support?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Will an Occupational Therapist assessment be needed on admission?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Have you ever suffered from falls and sustained injury when you have fallen?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| ***Therapeutic Activities, Leisure and Hobbies*** | | | | |
| How do you like to relax:  *Please give details:* | | | | |
| How do you spend your day?  *(e.g. games, activities, day centres, education, sports, clubs, college, reading, TV, radio) –*  *Please give details:* | | | | |
| Do you have friends locally that you still have contact with on a regular basis?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Are there any educational or therapeutic activities that you are interested in?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| ***Friends & Family*** | | | | |
| Do you have family?  *Please give details:* | | | | **YES/NO** |
| Do you have contact with any members of your family and if so, how often?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Would you like to have more contact with your family?  *If* ***YES****, is there a reason why you cannot do this.* | | | | **YES/NO** |
| Do you have a next of kin or other person that you want us to contact in the event of an emergency or accident? *Please give details:*  *Name:*  *Relationship:*  *Address:*  *Telephone No:* | | | | **YES/NO** |
| Are there any safeguarding concerns or issues relating to family or friends contact that may need to be considered?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| ***Culture & Religion*** | | | | |
| What is your religious denomination? | | | | |
| Do you need any support with accessing religious or cultural services or organisations?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you have any specific dietary needs because of your cultural or religious needs?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you have any other religious or cultural needs that we need to be aware of?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you need any support with translation?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| ***Self-Help Skills*** | | | | |
| Do you need any support with personal hygiene? *If* ***YES*** *please give details:*  (e.g. washing, bathing, shaving, continence, etc). | | | | **YES/NO** |
| Do you need support with using public or other transport?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you need support with claiming benefits? What benefits do you receive?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you need support with managing your finances?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Have you got any current debts, loans or other bills to pay?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Can you cook and if so, what food do you cook?  *If* ***YES*** *please give details:*  Do you have any knowledge of healthy eating?  *Please give details:* | | | | **YES/NO** |
| Do you need support to do your laundry?  Do you have any problems with your memory or cognition that affect your self-help skills?  *If* ***YES*** *please give details:* | | | | **YES/NO**  **YES/NO** |
| Do you need have any difficulty in accessing local services?  (e.g. making and attending healthcare appointments).  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| Do you have any specific problems with managing your daily living activities and are there any areas that you need support with?  *If* ***YES*** *please give details:* | | | | **YES/NO** |
| ***Social Skills*** | | | | |
| **(To be completed by assessor)** | **None** | **Poor** | **Average** | **Good** |
| * ***Relationship with staff*** |  |  |  |  |
| * ***Relationship with other residents*** |  |  |  |  |
| * ***Relationship with family*** |  |  |  |  |
| * ***Relationship with figures in authority*** |  |  |  |  |
| * ***Appropriate behaviour outside the home*** |  |  |  |  |
| * ***Ability to travel independently*** |  |  |  |  |
| * ***Use of home facilities*** |  |  |  |  |
| * ***Level of insight into condition and needs*** |  |  |  |  |
| * ***Openness to counselling/therapy*** |  |  |  |  |
| * ***Use of community facilities*** |  |  |  |  |
| * ***Verbal communication*** |  |  |  |  |

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| ***Behavioral Issues*** | |
| Verbal aggression towards staff?  *If* ***YES*** *please give details:* | **YES/NO** |
| Verbal aggression towards residents?  *If* ***YES*** *please give details:* | **YES/NO** |
| Physical aggression towards staff?  *If* ***YES*** *please give details:* | **YES/NO** |
| Physical aggression towards residents?  *If* ***YES*** *please give details:* | **YES/NO** |
| Any history of self-harm?  *If* ***YES*** *please give details:* | **YES/NO** |
| Any history of being sexually inappropriate, either verbal or physical?  *If* ***YES*** *please give details:* | **YES/NO** |
| Any history of criminal activity, detailing any convictions?  *If* ***YES*** *please give details:* | **YES/NO** |
| Any history of obsessional behaviour, OCD presentation?  *If* ***YES*** *please give details:* | **YES/NO** |
| Any behaviour that could be challenging and need additional support from staff?  *If* ***YES*** *please give details:* | **YES/NO** |
| ***Staff Support Required*** | |
| ***Please detail level of support needed; support throughout the day, minimal support, daily monitoring and any other support requirements.*** | |
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| **Risk Assessment** | |

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| ***Personal Information*** | |
| **Name:** |  |
| **Address:** |  |
| **Date of birth:** |  |
| **Date:** |  |
| **Social Worker:** |  |
| **Other Professionals Involved:** |  |
| **Diagnosis and medical conditions:** |  |

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| ***Identified risks to self:*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of cross-infection:*** | ***Risk Management Plan:*** |
| |  |  |  |  | | --- | --- | --- | --- | | ***MRSA*** | ***HEPATITIS*** | ***C-DIFF*** | ***ANY OTHER*** | | Yes/No | Yes/No | Yes/No | Yes/No | |  |
| ***Identified risks to others:*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of vulnerability/exploitation:*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of self-neglect:*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks when away from home:*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of taking prescribed medication:*** | ***Risk Management Plan:*** |
|  |  |
| ***PEEP – Personal Emergency Evacuation Plan*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of smoking:*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of alcohol use:*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of falls:*** | ***Risk Management Plan:*** |
|  |  |