Name: DOB: Contract No:
Date of Assessment: NHS Number:

HYWEL DDA UNIVERSITY HEALTH BOARD NURSING NEEDS ASSESSMENT

BASIC PERSONAL INFORMATION for NURSING NEEDS ASSESSMENT	
NAME OF RESIDENT:	**KNOWN AS:**
PREVIOUS ADDRESS: (include postcode)	**NAME OF CARE HOME:** **DATE OF ADMISSION:**
MAIN CONTACT / NEXT OF KIN: Name: Address: (including postcode) Telephone No: Relationship:	**EMERGENCY CONTACT / OTHER CONTACTS / POA** (If Required) Name: Address: Telephone No: Relationship to individual:

Dates of previous assessments in last 12 months	

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ADMISSION HISTORY:
SERVICE USERS PERSPECTIVE:
CARERS PERSPECTIVE:
SOCIAL HISTORY:

NAME OF CARE HOME REGISTERED NURSE INVOLVED IN THE ASSESSMENT:		
INFORMATION SOURCES:	Able to Consent: Yes / No	
Nursing notes: Yes/No	NOK/Representative: Yes/No	
GP notes: Yes/No	Prescription Chart: Yes/No	
Nursing Staff/ Care Staff: Yes/No	Hospital Notes: Yes/No	

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NAME AND ADDRESS OF GP

PROFESSIONALS INVOLVED IN CARE

- Social Worker:
- CPN:
- Speech & Language Therapist:
- Dietician:
- Specialist Nurse:
- Physiotherapist / Occupational Therapist:
- Other:

MEDICAL/NURSING HISTORY:

LATEST HOSPITAL ADMISSIONS:

GP/OTHER DISCIPLINE VISITS:

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BEHAVIOUR

Is a referral to the CMHT indicated? yes / no

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no

COGNITION

Is there currently a DoLS in place? Yes / No

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no

MENTAL HEALTH (PSYCHOLOGICAL AND EMOTIONALNEEDS)

Is the individual subject to the 1983 mental health act - (if YES please specify which section)

Is a referral to the CMHT indicated? - yes / no

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no

COMMUNICATION:

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no

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MOBILITY:

Falls risk score -

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no
Has the individual suffered a fall since the admission? (if yes please give details below)

Date and time of fall	**Description**	**Were Physical Observations Completed**	**Accident book completed (delete as appropriate)**
		Yes / No	Yes / No
		Yes / No	Yes / No
		Yes / No	Yes / No
		Yes / No	Yes / No

NUTRITION – FOOD AND DRINK

Height -
Weight -
BMI -

Home Nutritional Risk Score -

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no

ORAL CARE

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no

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CONTINENCE

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no

SKIN (INCLUDING TISSUE VIABILITY)

Home risk assessment score -

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no

BREATHING

Is there a care plan in place - yes / no
Is the care plan appropriate - yes / no

DRUG THERAPIES AND MEDICATION (Including pain / symptom control)
Able to self medicate: yes / no
Compliant with medication: yes / no (if not give details)
Allergies:

Medication	Dose	Frequency	Comments

Is a pain tool being used? (Please provide details) Is there a care plan in place - yes / no Is the care plan appropriate - yes / no
PERSONAL CARE Is there a care plan in place - yes / no Is the care plan appropriate - yes / no
ALTERED STATE OF CONSCIOUSNESS (ASC) Is there a care plan in place - yes / no Is the care plan appropriate - yes / no
OTHER SIGNIFICANT CARE NEEDS (e.g. Parkinson's disease, epilepsy, rapid deterioration) Is there a care plan in place - yes / no Is the care plan appropriate - yes / no
FREESPACE

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COMPLETE THE 4 KEY INDICATORS OF THE INDIVIDUALS CARE NEEDS

NATURE

INTENSITY

COMPLEXITY

UNPREDICTABILITY

NAME OF LONG TERM CARE SPECIALIST NURSE:

DATE OF COMPLETION:

SIGNATURE:

Assessment Reviewed by: Long Term Care Specialist Nurse Team Leader
(Division)

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ISSUES IDENTIFIED:

Details:

Please provide full details of the issue raised, including dates where necessary and name of service user(s) affected, if applicable

Name and Position of Individual (s) issues discussed with:

Date of Discussion:

Summary of Discussion:

Plan

Issues identified at assessment

Discussed with home manager	Yes / No	Date
Issues emailed to home	Yes / No	Date
Issues emailed to CIW	Yes / No	Date
Issues copied into care home folder	Yes / No	Date

Safeguarding

Safeguarding issues identified at assessment	Yes / No	
Referral made	Yes / No	Date

Pressure Damage

Pressure damage noted at assessment	Yes / No	
Datix completed	Yes / No	Date

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OUTCOME OF ASSESSMENT

Eligible for NHS Funded Nursing Care	
No Nursing needs identified which are unable to be managed by Community services – no longer eligible for NHS Funded Nursing Care	
Multidisciplinary Team meeting to be arranged to consider Continuing NHS Healthcare eligibility	
Continues to meet eligibility for Continuing NHS Healthcare	
Remains subject to Section 117	
Remains eligible for a joint Health and Social Care package	

Date of next Assessment /Review	

Copies to (delete as appropriate)

Social Services Yes

File Yes

If you have any questions or comments regarding the outcome of this assessment please do not hesitate to contact at: