Admission Assessment Record

Patient Name				Hospital No.	
Admission Details	Date		Time		Ward

	Assessment	Date completed	Time completed	Sign
Within 4 hours	Personal details			
	Baseline Observations			
	Resuscitation status discussed			
	Confirm correct ID bracelet			
	Barthel			
	Stratify Falls risk			
	Waterlow			
	Pressure area assessment			
	Assessment of Immediate Clinical Care needs			
	Moving & Handling assessment			

	Assessment	Date completed	Time completed	Sign
Within 24 hours	Nutritional assessment			
	Oral hygiene assessment			
	AMTS			
	Urinalysis			
	Weight			
	Full Nursing Assessment	**Assessment completed date**	**Care Plan initiated ✓ or N/A**	**Sign**
	Communication			
	Continence			
	End of Life care			
	Mobility			
	Nutrition & Hydration			
	Pain & Comfort			
	Personal Hygiene			
	Privacy & Dignity			
	Psychological Wellbeing			
	Skin Care			
	Self care, promotion of choice, involvement & independence			

	Assessment	Date completed	Time completed	Sign
Within 72 hours	Details of home situation			
	Discharge planning assessments			

Patient Name

Hospital No.

Nursing Assessment

Continence

Assessment should take account of the Older Persons previous, current and desired continence status and needs. Nursing staff should approach the subject with care and sensitivity.

Previous Ability/Status

Current Ability/Status

Patient wishes, goal /Desired outcome

Date Time	Plan of Care & Evaluation	Review Date	SIGN

Patient Name **Hospital No.**

Nutritional Screening Tool

		Initials										
		Date										
MEDICAL CONDITION	Mental Health Problem	2-4										
	Major Trauma	5										
	Malabsorption	5										
	Unconscious	5										
	Terminal illness	3										
	Neurological disturbance eg stroke	2-4										
	Abnormal blood biochemistry eg anaemia, hypoproteinaemia	2-4										
APPETITE/ DIETARY INTAKE	Normal	0										
	Reduced/Poor	3										
	Fluids only	4										
AGE	65 – 74	1										
	75 – 80	2										
	80+	3										
ABILITY TO EAT	Independent	0										
	Needs help	1										
	Swallowing/chewing difficulty	2										
	Unable to eat solid food	3										
	Unable to eat or drink	4										
GUT FUNCTION	Normal	0										
	Intermittent diarrhoea/vomiting	2										
	Frequent diarrhoea/vomiting 1+days	3										
	Prolific diarrhoea/vomiting 5+days	4										
	Constipation	2										
SKIN TYPE	Healthy	0										
	Dry/papery	1-3										
	Oedematous	1-3										
	Red/broken/wound	1-4										
BUILD/ WEIGHT FOR HEIGHT	Average	0										
	Obese	4										
	Underweight/overweight	2										
	Recent weight loss	2-4										
	Severely malnourished	5										
	TOTAL SCORE											

SCORE	INTERVENTION
0-7 (low risk)	1. Ensure balanced diet and adequate fluid intake 2. Record weekly/monthly nutritional score
8-14 (at risk)	1. Nutritional care plan required, see guidance notes for further details 2. Record weekly weight and nutritional score
15+ (high risk)	1. Nutritional care plan required, see guidance notes for further details 2. Record weekly weight and nutritional score 3. Refer to Dietician