

# Pre-Admission Assessment Form - Older Persons Services, CHO Area 8



<b>Name:</b>	<b>DOB:</b>	<b>PPS No:</b>		
<b>Name of Community Assessment Unit:</b>				
<b>Assessment completed by:</b>		<b>Grade/position:</b>		
<b>Location of assessment:</b>		<b>Phone assessment:</b>		
<b>Date of assessment:</b>		<b>Information received from:</b>		
<b>Next of Kin/ Point of Contact aware of assessment:</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>		
<b>Next of Kin/ Point of Contact present:</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>		
<b>Consent and GDPR discussed:</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>		
<b>Type of Assessment:</b>				
<input type="checkbox"/> Long Term Care <input type="checkbox"/> Dementia Specific Care <input type="checkbox"/> Respite Care <input type="checkbox"/> Transitional Care <input type="checkbox"/> Rehab <input type="checkbox"/> Step down bed <input type="checkbox"/> Emergency admission <i>(Give relevant info below)</i> <input type="checkbox"/> Social Admission <i>(Give relevant info below)</i>				
<b>Person/family concerns/wishes expressed:</b>				
<b>Other relevant information:</b>				
<b>Decision</b>				
<b>Date:</b>				
<table style="width: 100%;"> <tr> <td style="width: 50%;"> <b>Accepted to: Long Term Care</b> <input type="checkbox"/>  <b>Respite Bed</b> <input type="checkbox"/>  <b>Rehab Bed</b> <input type="checkbox"/> </td> <td style="width: 50%;"> <b>Dementia Specific Care</b> <input type="checkbox"/>  <b>Palliative Care Bed</b> <input type="checkbox"/>  <b>Other</b> <input type="checkbox"/> </td> </tr> </table>			<b>Accepted to: Long Term Care</b> <input type="checkbox"/> <b>Respite Bed</b> <input type="checkbox"/> <b>Rehab Bed</b> <input type="checkbox"/>	<b>Dementia Specific Care</b> <input type="checkbox"/> <b>Palliative Care Bed</b> <input type="checkbox"/> <b>Other</b> <input type="checkbox"/>
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<b>Not accepted</b> <input type="checkbox"/>				
<b>Rationale for decision not to accept:</b>				
<b>Referred back to Liaison Public Health Nurse/Referral source:</b> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>				
<b>Anticipated date of admission:</b>				
<b>If time lapse occurs between pre-assessment/acceptance to care facility and actual transfer to care facility is there any changes to person's health status?</b> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>				
Give Details:				
Follow up Actions/Requirements:				



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Name:

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**Personal Details**

First name(s):	Surname:	Preferred name:
Current Address:	Home/Past Address(if different):	
Date of birth:	Religion:	Occupation:
Contact phone no:	PPS No:	Medical Card No:

**Emergency Contact Person/s Details**

Name:	Relationship:	2 <sup>nd</sup> Point of Contact:
Address:	Contact phone no:	
	Contact at night: Yes <input type="checkbox"/> No <input type="checkbox"/>	

**Personal Circumstances**

<b>Marital status:</b> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other (please specify):	<b>Lives with:</b> Alone <input type="checkbox"/> With spouse <input type="checkbox"/> Family member <input type="checkbox"/> Partner <input type="checkbox"/> Carer <input type="checkbox"/> Other (please specify):	<b>Accommodation:</b> Own home <input type="checkbox"/> In family members home <input type="checkbox"/> Sheltered housing <input type="checkbox"/> Nursing home <input type="checkbox"/> Other (please specify)
<b>Informal Supports:</b> (please specify)		

<b>Fair Deal Approved</b> <input type="checkbox"/> <b>Ward of Court</b> <input type="checkbox"/> <b>EPOA</b> <input type="checkbox"/> <b>Safeguarding Concerns</b> <input type="checkbox"/> <b>Think Ahead Document</b> <input type="checkbox"/>	<b>Community Supports:</b> PHN/CMHN <input type="checkbox"/> Name/Address:  Therapy/other discipline <input type="checkbox"/>	<b>Services:</b> Day care <input type="checkbox"/> Day Hospital <input type="checkbox"/> Respite <input type="checkbox"/> Home Help <input type="checkbox"/> Home Care Package <input type="checkbox"/> Carers <input type="checkbox"/> Meals on Wheels <input type="checkbox"/> Refused services <input type="checkbox"/>
<b>Solicitors Name:</b> Address:  Contact No:	<b>Aids and appliances:</b> (please specify)	

<b>GP Name:</b> Address:	Contact No: Fax No:	<b>Pharmacy Details:</b> (if relevant)
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**Current Diagnosis and Medical /Surgical History**

Presenting complaint/ diagnosis:

GP Letter: Yes ☐ No ☐ NA ☐

Consultant/ Psychiatry Report:

Yes ☐ No ☐ NA ☐

Past Medical/ Surgical History:

Details of relevant investigations:

Recent Blood Results ☐

X-Ray ☐

ECG ☐

Other:

Current Medications List:

Attached prescription ☐

1. ....

7. ....

2. ....

8. ....

3. ....

9. ....

4. ....

10. ....

5. ....

11. ....

6. ....

12. ....

Warfarin: Yes ☐ No ☐

Recent INR:

INR Parameters:

Depot Injection/s: Yes ☐ No ☐

Name of Depot:

Frequency/ date last received:

Medications: Ordinary Yes ☐ No ☐

Crushed: Yes ☐ No ☐

Self-administration of medication: Yes ☐ No ☐ Details:

Compliance with Medications: Yes ☐

Changeable ☐

No ☐

If **No** how are medications given?

Covert Medication administration: Yes ☐

No ☐

Falls History? Yes ☐ No ☐ Details:

Known Allergies (Foods/ Medications/ Other):

Dressings/ other requirements?

**Special Considerations**

**HCAI Status:** MRSA ☐ C-Diff ☐ VRE

☐

ESBL ☐ Norovirus ☐ Covid 19 ☐

CPE ☐

Details/ Other:

**Vaccination Status:**

Influenza ☐

Date received:

Pneumococcal ☐

Date received:

Covid 19 vaccine ☐

Date/s received:

Name of Covid 19 Vaccination:



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Other:

Date received:

**Fire Evacuation Needs Assessment (to meet HIQA Fire Regulations)**

**The persons/ resident's mobility and cognitive status**

**Is the person/resident:** Ambulant ☐ Semi-ambulant ☐ Non-ambulant ☐

**Has the person/resident any:** Visual Impairment ☐ Hearing Impairment ☐ Cognitive Impairment ☐

Further details if required:

**The ability of the person/ resident to understand the sound of the fire detection and alarm system going off**

**Is the person/resident able to follow instructions in emergency situation?** Yes ☐ No ☐

**Will the person/ resident require supervision after an evacuation?** Yes ☐ No ☐

Further details if required:

**Safe evacuation from room/centre. Method of evacuation (full bed evacuation, wheelchair, walking aids, ski sheets or other evacuation aids) for both daytime and night-time evacuation**

**Daytime evacuation:** Full bed evacuation ☐  
Wheelchair ☐ Walking aid ☐ Ski sheets ☐  
Other evacuation aids required:

Any other considerations (i.e. bariatric bed/equipment)?

No of staff required for daytime evacuation:

**Night time evacuation:** Full bed evacuation ☐  
Wheelchair ☐ Walking aid ☐ Ski sheets ☐  
Other evacuation aids required:

Any other considerations (i.e. bariatric bed/equipment)?

No of staff required for night time evacuation:

**Does the person/ resident wish to bring in their own furniture or belongings from their home?**

Does the person/resident wish to bring personal furniture or belongings from their home? Yes ☐ No ☐

Will the personal furniture or belongings impact on the safe evacuation of the person/resident from the designated bedroom/ centre? Yes ☐ No ☐

Further details if required:



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The centre should make a conscious effort to accommodate high- and medium-dependency residents in those bedrooms which are either the easiest to evacuate or which are located in a part of the centre where the threat from fire is lowest. For example, this may be on the ground floor beside an exit door or in the smallest building compartment.

**Is there a suitable bedroom available for the person/ resident that will meet their specific fire evacuation needs? Yes ☐ No ☐**

**Are there any revisions required to the fire precautions for the designated centre if the resident is admitted? Yes ☐ No ☐**

**Assessment of Care Domains** (adapted from NHS Continuing Healthcare Decision Support Tool, 2018, available at <https://www.gov.uk/government/publications/nhs-continuing-healthcare-decision-support-tool>. Licensed under the terms of the Open Government Licence v3.0, [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3))

Breathing	Level of need <i>Please circle</i>
<ul style="list-style-type: none"> <li>Normal breathing, no issues with shortness of breath.</li> </ul>	No needs
<ul style="list-style-type: none"> <li>Shortness of breath or condition which may require the use of inhalers or a nebuliser</li> <li>Does not impact on daily living activities.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Episodes of breathlessness that readily respond to management.</li> <li>No impact on daily living activities.</li> </ul>	Low
<ul style="list-style-type: none"> <li>Shortness of breath or condition which may require the use of inhalers or a nebuliser</li> <li>Limits some daily living activities.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Episodes of breathlessness that do not consistently respond to management which limits some daily living activities.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Requires any of the following: Low level oxygen therapy (24%) / room air ventilators via a facial or nasal mask/ other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. Continuous Positive Airways Pressure (CPAP) to manage obstructive apnoea during sleep.</li> </ul>	Moderate
<ul style="list-style-type: none"> <li>Is able to breathe independently through a tracheotomy which they can manage themselves, or with the support of carers / staff.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Breathlessness due to a condition which is not responding to treatment which limits all daily living activities.</li> </ul>	High
<ul style="list-style-type: none"> <li>Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bi-level positive airway pressure, or non-invasive ventilation).</li> </ul>	Very High
<ul style="list-style-type: none"> <li>Unable to breathe independently, requires invasive mechanical ventilation.</li> </ul>	Priority



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Smoker ☐      Nebulisers ☐      Oxygen therapy ☐      CPAP ☐      BIPAP ☐  
 Tracheostomy tube ☐      Date tracheostomy tube last changed:  
 Other:

Communication	Level of need <i>Please circle</i>
<ul style="list-style-type: none"> <li>Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language.</li> <li>May require translation if English is not their first language.</li> </ul>	No needs
<ul style="list-style-type: none"> <li>Needs assistance to communicate their needs.</li> <li>Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.</li> </ul>	Low
<ul style="list-style-type: none"> <li>Communication about needs is difficult to understand or interpret or is sometimes unable to reliably communicate, even when assisted.</li> <li>Carers may be able to anticipate needs through non-verbal signs due to familiarity with the person.</li> </ul>	Moderate
<ul style="list-style-type: none"> <li>Unable to reliably communicate their needs at any time and in any way, even when all practical steps to assist them have been taken.</li> <li>The individual has to have most of their needs anticipated because of their inability to communicate them.</li> </ul>	High
Hearing:                  Hearing aid <input type="checkbox"/> Vision:                  Glasses <input type="checkbox"/> Speech Coherent Yes <input type="checkbox"/> No <input type="checkbox"/> Specific needs of the individual:	

Cognition	Level of need <i>Please circle</i>
<ul style="list-style-type: none"> <li>No evidence of impairment, confusion or disorientation.</li> </ul>	No needs
<ul style="list-style-type: none"> <li>Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident.</li> </ul> OR <ul style="list-style-type: none"> <li>Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.</li> </ul>	Low
<ul style="list-style-type: none"> <li>Cognitive impairment (which may include some memory issues) requires some supervision, prompting and/or assistance with basic care needs and daily living activities.</li> <li>Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has</li> </ul>	Moderate



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limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	
<ul style="list-style-type: none"> <li>Cognitive impairment that could, for example, include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues they are unable to consistently do so on most issues, even with supervision, prompting or assistance.</li> <li>The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.</li> </ul>	High
<ul style="list-style-type: none"> <li>Cognitive impairment that may, for example, include, marked short or long-term memory issues, or severe disorientation to time, place or person.</li> <li>The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate their basic needs and to protect them from harm, neglect or health deterioration.</li> </ul>	Very High
Specific risks / needs of the individual:	

<b>Behaviour</b>	<b>Level of need</b> <i>Please circle</i>
<ul style="list-style-type: none"> <li>No evidence of 'Responsive' behaviour.</li> </ul>	No needs
<ul style="list-style-type: none"> <li>Some incidents of 'Responsive' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or create a barrier to intervention. The individual is compliant with all aspects of their care.</li> </ul>	Low
<ul style="list-style-type: none"> <li>'Responsive' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers who are able to maintain a level of behaviour that does not pose a risk to self, others or property.</li> <li>The individual is nearly always compliant with care.</li> </ul>	Moderate
<ul style="list-style-type: none"> <li>'Responsive' behaviour of type and/or frequency that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks.</li> <li>Compliance is variable but usually responsive to planned interventions.</li> </ul>	High
<ul style="list-style-type: none"> <li>'Responsive' behaviour of severity and/or frequency that poses a significant risk to self, others or property.</li> <li>The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.</li> </ul>	Very High
<ul style="list-style-type: none"> <li>'Responsive' behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property.</li> </ul>	Priority



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- The risks are so serious that they require access to an immediate and skilled response at all times for safe care.

Specific risks / needs of the individual:

Are there any issues with sleeping pattern?

Psychological and emotional needs	Level of need <i>Please circle</i>
<ul style="list-style-type: none"><li>• Psychological and emotional needs are not having an impact on their health and well-being.</li></ul>	No needs
<ul style="list-style-type: none"><li>• Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts, distraction and/or reassurance.</li></ul> <p>OR</p> <ul style="list-style-type: none"><li>• Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.</li></ul>	Low
<ul style="list-style-type: none"><li>• Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which do not readily respond to prompts, distraction and/or reassurance and have an increasing impact on the individual's health and/or well-being.</li></ul> <p>OR</p> <ul style="list-style-type: none"><li>• Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities.</li></ul>	Moderate
<ul style="list-style-type: none"><li>• Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the individual's health and/or well-being.</li></ul> <p>OR</p> <ul style="list-style-type: none"><li>• Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.</li></ul>	High
Any specific social and recreational preferences/ needs identified?	
Any specific spirituality/ cultural needs identified?	
Any specific sexuality/ body image needs identified?	
Any other specific needs/ risks of the individual identified?	
Psychiatry / Psychiatry of Later Life referral <input type="checkbox"/>	





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Nutrition	Level of need <i>Please circle</i>
<ul style="list-style-type: none"> <li>Able to take adequate food and drink by mouth to meet all nutritional requirements</li> </ul>	No needs
<ul style="list-style-type: none"> <li>Needs supervision, prompting with meals, or may need assistance and/or a special diet (for example to manage food intolerances/allergies).</li> </ul> OR <ul style="list-style-type: none"> <li>Able to take food and drink by mouth but requires additional/supplementary feeding.</li> </ul>	Low
<ul style="list-style-type: none"> <li>Needs assistance to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed.</li> </ul> OR <ul style="list-style-type: none"> <li>Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.</li> </ul>	Moderate
<ul style="list-style-type: none"> <li>Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway.</li> </ul> OR <ul style="list-style-type: none"> <li>Subcutaneous fluids that are managed by the individual or specifically trained carers.</li> </ul> OR <ul style="list-style-type: none"> <li>Nutritional status "at risk" and may be associated with unintended, significant weight loss.</li> </ul> OR <ul style="list-style-type: none"> <li>Significant weight loss or gain due to identified eating disorder.</li> </ul> OR <ul style="list-style-type: none"> <li>Problems relating to a feeding device (for example PEG) that require skilled assessment and review.</li> </ul>	High
<ul style="list-style-type: none"> <li>Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring on-going skilled professional intervention or monitoring over a 24 hour period to ensure nutrition/hydration, for example I.V. fluids/total parenteral nutrition (TPN).</li> </ul> OR <ul style="list-style-type: none"> <li>Unable to take food and drink by mouth, intervention inappropriate or impossible.</li> </ul>	Very High
<div> <div>Specific dietary requirements:</div> <div>           Modified diet Yes <input type="checkbox"/> No <input type="checkbox"/> Type: _____            Dietician input Yes <input type="checkbox"/> No <input type="checkbox"/>            Specific needs of the individual: _____         </div> </div> <div> <div>Identified food allergies:</div> <div>           Peg/Gastroscopy tube Yes <input type="checkbox"/> No <input type="checkbox"/> Date last changed: _____            Speech &amp; Language Therapist input Yes <input type="checkbox"/> No <input type="checkbox"/> </div> </div>	
Mobility	Level of need <i>Please circle</i>
<ul style="list-style-type: none"> <li>Independently mobile.</li> </ul>	No needs
<ul style="list-style-type: none"> <li>Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.</li> </ul>	Low



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<ul style="list-style-type: none"> <li>Not able to consistently weight bear.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>At moderate risk of falls (as evidenced in a falls history or risk assessment).</li> </ul>	Moderate
<ul style="list-style-type: none"> <li>Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>At a high risk of falls (as evidenced in a falls history and risk assessment).</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Involuntary spasms or contractures placing the individual or others at risk.</li> </ul>	High
<ul style="list-style-type: none"> <li>Completely immobile and/or clinical condition such that, in either case, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.</li> </ul>	Very High

Frailty score and tool used: \_\_\_\_\_ History of falls Yes ☐ No ☐ Falls Risk

Score: \_\_\_\_\_

Walking stick ☐ Zimmer frame ☐ Wheelchair ☐ Hoist transfer ☐

Physiotherapist input ☐ Occupational therapist input ☐

Specific needs of the individual: \_\_\_\_\_

Skin	Level of need <i>Please circle</i>
<ul style="list-style-type: none"> <li>No risk of pressure damage or skin condition.</li> </ul>	No needs
<ul style="list-style-type: none"> <li>Risk of skin breakdown which requires preventative intervention once a day or less than daily without which skin integrity would break down.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound(s).</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.</li> </ul>	Low
<ul style="list-style-type: none"> <li>Risk of skin breakdown which requires preventative intervention several times each day without which skin integrity would break down.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Pressure damage, pressure ulcer(s) Category/Stage II, or open wound(s), which are responding to treatment.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>An identified skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.</li> </ul>	Moderate
<ul style="list-style-type: none"> <li>Pressure damage, pressure ulcer(s) Category/Stage II, or open wound(s), which are not responding to treatment.</li> </ul>	High



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<p><b>OR</b></p> <ul style="list-style-type: none"> <li>Pressure damage, pressure ulcer(s) Category/Stage III, or open wound(s) which are responding to treatment.</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>Specialist dressing regime in place (ie. NPWT /Vac ); responding to treatment.</li> </ul>	
<ul style="list-style-type: none"> <li>Open wound(s) or pressure ulcer(s) Category/Stage III which are not responding to treatment and require regular monitoring/reassessment.</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>Open wound(s) or Category/Stage IV pressure ulcer(s).</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>Multiple wounds which are not responding to treatment.</li> </ul>	Very High

Waterlow/Braden Risk Assessment Score:      Pressure ulcer present Yes ☐ No ☐      Category/stage:

Pressure Relieving Mattress ☐    Cushion ☐      Other ☐

Specialised seating required Yes ☐ No ☐      Type:

Dressings required Yes ☐ No ☐      Tissue Viability Nurse input Yes ☐ No ☐

Specific needs of the individual:

Continence	Level of need <i>Please circle</i>
<ul style="list-style-type: none"> <li>Continent of urine and faeces.</li> </ul>	No needs
<ul style="list-style-type: none"> <li>Continence care is routine on a day-to-day basis. Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc.</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>Able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.</li> </ul>	Low
<ul style="list-style-type: none"> <li>Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation or other bowel problems.</li> </ul>	Moderate
<ul style="list-style-type: none"> <li>Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs/irrigation, manual evacuations, frequent re-catheterisation).</li> </ul>	High

Continence wear/ aids required: Yes ☐ No ☐      Stoma present: Yes ☐ No ☐

Urinary /Suprapubic Catheter insitu: Yes ☐ No ☐      Date of last catheter change:

History of constipation: Yes ☐ No ☐      Neurogenic bowel care regime: Yes ☐ No ☐

Specific needs of the individual:



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Drug Therapies, Medication, Symptom Control	Level of need <i>Please circle</i>
<ul style="list-style-type: none"><li>Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.</li></ul>	No needs
<ul style="list-style-type: none"><li>Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime.</li></ul> <p>OR</p> <ul style="list-style-type: none"><li>Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care.</li></ul>	Low
<ul style="list-style-type: none"><li>Requires the administration of medication (by a registered nurse or carer) due to non-compliance, or type of medication (for example insulin), or route of medication (for example PEG).</li></ul> <p>OR</p> <ul style="list-style-type: none"><li>Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.</li></ul>	Moderate
<ul style="list-style-type: none"><li>Requires administration and monitoring of medication regime by a registered nurse, or carer specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects.</li><li>With such monitoring the condition is usually non-problematic to manage.</li></ul> <p>OR</p> <ul style="list-style-type: none"><li>Moderate pain or other symptoms which are having a significant effect on other domains or on the provision of care.</li></ul>	High
<ul style="list-style-type: none"><li>Requires administration and monitoring of medication regime by a registered nurse or carer specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects.</li><li>Even with such monitoring the condition is usually problematic to manage.</li></ul> <p>OR</p> <ul style="list-style-type: none"><li>Severe recurrent or constant pain which is not responding to treatment.</li></ul> <p>OR</p> <ul style="list-style-type: none"><li>Non-compliance with medication, placing them at severe risk of relapse.</li></ul>	Very High
<ul style="list-style-type: none"><li>Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition.</li></ul> <p>OR</p> <ul style="list-style-type: none"><li>Unremitting and overwhelming pain despite all efforts to control pain effectively.</li></ul>	Priority
Specific risks /needs of the individual:	

Altered States of Consciousness (ie Transient Ischemic Attacks (TIAs), Epilepsy and Vasovagal Syncope)	Level of need <i>Please circle</i>
<ul style="list-style-type: none"><li>No evidence of altered states of consciousness</li></ul>	No needs



**Pre-Admission Assessment Form  
Older Persons Services CHO Area 8**

Name:

DOB:

<ul style="list-style-type: none"> <li>History of altered state of consciousness but it is effectively managed and there is a low risk of harm.</li> </ul>	Low
<ul style="list-style-type: none"> <li>Occasional (monthly or less frequently) episodes of altered state of consciousness that require the supervision of a carer or care worker to minimise the risk of harm.</li> </ul>	Moderate
<ul style="list-style-type: none"> <li>Frequent episodes of altered state of consciousness that require the supervision of a carer or care worker to minimise the risk of harm.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Occasional altered state of consciousness's that require skilled intervention to reduce the risk of harm.</li> </ul>	High
<ul style="list-style-type: none"> <li>Coma.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Altered state of consciousness that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.</li> </ul>	Priority
Specific risks /needs of the individual:	

Any other significant care needs to be taken into consideration?	Level of need

**Summary Assessment of Care Domains**

Care Domain	Identified level of need						
tick as appropriate ✓	No needs	Low	Moderate	High	Very High	Priority	Note/Comment
Breathing							
Communication							
Cognition							
Behaviour							
Psychological and emotional needs							
Nutrition							



**Pre-Admission Assessment Form**  
**Older Persons Services CHO Area 8**

Name:

DOB:

<b>Mobility</b>							
<b>Skin</b>							
<b>Continence</b>							
<b>Drug Therapies, Medication, Symptom Control</b>							
<b>Altered States of Consciousness</b>							
<b>Other significant care needs to be taken into consideration</b>							