NHS
Dorset
Clinical Commissioning Group

Name: ______ D.O.B ______

FUNDED NURSING CARE ASSESSMENT **Overview Assessment**

Please attach demographic information form

Hospital ID:	SS ID:	NHS No:	NI No:

Surname: ______ **Forename:** ______ **D.O.B:** ______

Date of Assessment ______ **Location of Assessment:** ______

When assessing somebody, please consider what the person can do for themselves, what help or equipment is in place & what assistance is required.

Personal History & Current Social Situation: (include details of upbringing, family life, occupation, hobbies & interests, relationships & support network, caring arrangements (formal/informal), responsibilities/dependants & significant life events as appropriate).

Specify any specialist assessment required:

RISK ASSESSMENTS:

- **Behaviour**
- **Mobility**
- **Falls**
- **Nutrition**
- **Skin Integrity**
- **Other**

Physical Health: (include current & past medical health difficulties, including circulation, breathing, pain, tissue viability, bowels and bladder, vaccination status, allergies).

Name: **D.O.B**

Specify any specialist assessment required:

Behaviour: ("Challenging" behaviour that poses a predictable risk to self or others. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.)

Cognition: (High level of cognitive impairment which is likely to include marked short-term memory issues and maybe disorientation in time and place. The individual has a limited ability to assess basic risks with assistance but finds it extremely difficult to make their own decisions/choices, even with prompting and supervision.)

Psychological/Emotional: (Mood disturbance or anxiety symptoms or periods of distress that has/have a severe impact on the individual's health and/or wellbeing. OR Withdrawn from any attempts to engage them in support, care planning and daily activities.)

Name:		D.O.B	

Communication: (Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to do so have been taken.)

Mobility & Transfers: (In one position (bed or chair) but due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate. OR At a high risk of falls. OR Involuntary spasms or contractures placing themselves and carers or care workers at risk)

Nutrition & Meal Preparation: (Dysphasia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. OR Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers.)

Name: | **D.O.B**

Continence: (Continence care is problematic and requires timely and skilled intervention)

Skin Integrity: (Open wound(s), pressure ulcer(s) with "full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule" which are not responding to treatment and require a minimum of daily monitoring/reassessment. **OR** A skin condition which requires a minimum of daily monitoring or reassessment. **OR** Specialist dressing regime in place which is responding to treatment.)

Breathing: (Is able to breathe independently through a tracheotomy, that they can manage themselves, or with the support of carers or care workers. **OR** CPAP (Continuous Positive Airways Pressure). **OR** Breathlessness due to symptoms of chest infections which are not responding to therapeutic treatment and limit all activities of daily living activities.)

Name:		D.O.B	

Drug Therapies & Medication: Symptom control: (Requires administration of medication regime by a registered nurse or care worker specifically trained for this task, and monitoring because of potential fluctuation of the medical condition or mental state, that is usually non-problematic to manage. **OR** - Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.)

Altered States of Consciousness: (ASC that require skilled intervention to reduce the risk of harm.)

Summary of needs and Recommendation

Name:		D.O.B	

Carer's Views:

ACTION REQUIRED FOLLOWING ASSESSMENT:
(To include assessors action and referrals to be made)

Is person aware of referral: **Y** ☐ **N** ☐ **Has consent form been** **Y** ☐ **N** ☐

Additional Comments: (Individual, carer(s), assessor/managers comments).

Person: I have participated in this assessment and agreed with action: **Y** ☐ **N** ☐

Name of person completing this form:

Signature:

Date completed: **Contact No:**