ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

Health Board / Trust					Hospital			
Admission Method	Emergency		Elective		Transfer		Source of Admission	

Ward / Team / Department	Consultant / Lead GP	Admission Date and Time		Transfer Date and Time	
		DD / MM / YYYY	HH:MM	DD / MM / YYYY	HH:MM
		DD / MM / YYYY	HH:MM	DD / MM / YYYY	HH:MM
		DD / MM / YYYY	HH:MM	DD / MM / YYYY	HH:MM
		DD / MM / YYYY	HH:MM	DD / MM / YYYY	HH:MM

Estimated Date of Discharge	DD / MM / YYYY	Date Fit for Discharge	DD / MM / YYYY	Actual Date of Discharge	DD / MM / YYYY

NHS Number							Hospital Number					
Surname							Forename(s)					
Title	Mr		Mrs		Miss		Ms		Preferred Name			
	Other								Date of Birth	DD / MM / YYYY		
Gender	Male		Non - binary		Not Specified		Sex at Birth	Male		Female		Intersex
	Female											
Religion			Ethnic Group				Occupation					

Permanent Address	Current Address (if different)
Postcode:	Postcode:

Tel. No. Home		Tel. No. Mobile	
Email Address			

Is patient wearing a patient identification band and are the details legible and correct?	Yes		No	

COMMUNICATION NEEDS

T

Do you have any concerns about the patient's capacity to engage in this assessment?	Yes		No	

If Yes, consider:

- **What support can be provided to help the patient participate in this assessment**
- **Whether patient has capacity to make decisions about care and treatment–see mental capacity section**

Preferred method of communication	Speech		Sign		Other	

First Language	English		Welsh		Other		Preferred Language	

Do you want this admission to be carried out in Welsh?	Yes		No		Interpreter required?	Yes		No	

Action:	Action:

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

KNOWN ALLERGIES / ADVERSE REACTIONS (If Yes, please list)	Not Known		Yes		No	

Name of Allergen / Adverse Reaction	Type of Reaction	Action Required				
		Epi Pen		Other		Details
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	

INFECTION CONTROL

Follow local and national policies and guidelines

Has the patient had any healthcare outside of the U.K. or in another Health Board/Trust in the last 12 months?	Not Known		Yes		No	
Does the patient have a history of multi-drug resistant organisms (MDRO) e.g. MRSA, CPO, CPE, VRE?	Not Known		Yes		No	
Does the patient have a history of any Alert infection e.g. Clostridium difficile, Tuberculosis, a Blood borne virus?	Not Known		Yes		No	
Are there any other current signs/symptoms of an infectious disease? e.g. diarrhoea, vomiting, respiratory like illness, pyrexia, Covid-19 related symptoms, suspicious rash etc	Not Known		Yes		No	
Does the patient have a recent history of exposure to an infectious disease in an environment and/or to a person(s)?	Not Known		Yes		No	
Any travel outside of the UK in the last 3 months?	Not Known		Yes		No	

GP Surgery Name (Current)		GP Surgery Name (Permanent)	
GP Surgery Address		GP Surgery Address	
Postcode:		Postcode:	
Telephone Number		Telephone Number	

CONTACT 1							CONTACT 2						
Name							Name						
Relationship							Relationship						
Main Carer	N/A		Yes		No		Main Carer	N/A		Yes		No	
Daytime Tel. No.							Daytime Tel. No.						
Evening Tel. No.							Evening Tel. No.						
Can they be contacted at any time (24hrs/day)?		Yes		No			Can they be contacted at any time (24hrs/day)?		Yes		No		
Are they aware of this admission?		Yes		No			Are they aware of this admission?		Yes		No		

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

CONTACT 3								CONTACT 4							
Name								Name							
Relationship								Relationship							
Main Carer	N/A		Yes		No			Main Carer	N/A		Yes		No		
Daytime Tel. No.								Daytime Tel. No.							
Evening Tel. No.								Evening Tel. No.							
Can they be contacted at any time (24hrs/day)?		Yes		No				Can they be contacted at any time (24hrs/day)?		Yes		No			
Are they aware of this admission?		Yes		No				Are they aware of this admission?		Yes		No			
Contact details not provided		Details:													

CARE SUPPORT

Do you receive care support? If 'Yes' tick below ❗If carer identified, consider a carer's assessment								No	
Family		Paid Carer		3rd Sector					
Friends		Community Health		Care Home					
Carer		Social Care Agency		Residential Home					
Neighbour		Other:		If other:					
If Yes, details:									
Do you have carer responsibilities?						Yes		No	
If Yes, specify:									
T	**If over 18, does the patient wish to be referred for a carer's assessment?**					N/A		Yes		No	
	If under 18, does the patient wish to be referred for a young carer's assessment?					N/A		Yes		No	
Referral details:									
Does your admission / condition directly affect care of children / relatives / pets / assistance animal / others?						Yes		No	
If Yes, specify:									
Do you have any concerns regarding continuity of care for dependents?						Yes		No	
If Yes, actions taken:									
Do you mange your household without any help?						Yes		No	
Do you live alone?						Yes		No	

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ADDRESSOGRAPH

If No, Who do you live with?					
What type of accommodation is it?					
When you are discharged are you planning to return to your current address?	Yes		No		
If No, Where will you be going?					

SAFEGUARDING

Is there a concern that there may be an adult or child at risk of abuse or neglect?	Yes		No	
If Yes, actions taken: **If Yes, follow Wales safeguarding procedures**				
Are there any signs of abuse? (consider physical, emotional, sexual, financial and neglect)	Yes		No	
If Yes, details:				
Does the patient have any concerns for their safety ?	Yes		No	
If Yes, details:				
Are there any concerns about domestic abuse? If Yes, follow the local Ask and Act pathway	Yes		No	
Details: Support sites: Welsh Women's Aid: welshwomensaid.org.uk Male domestic abuse support: www.saferwales.com/domestic-abuse				
Do you need to report any concerns to another agency (Social Services or the Police)? If Yes, follow local safeguarding policies and procedures	Yes		No	
Details:				

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ADDRESSOGRAPH

REASON FOR ADMISSION

RELEVANT MEDICAL / SURGICAL HISTORY

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

MENTAL HEALTH HISTORY

Are you receiving or have you received support from a mental health specialist team?	Not Known		Yes		No	
If Yes, details:						
Is the patient detained under the Mental Health Act (MHA)?			Yes		No	
If Yes, which section of the MHA?						
Is the patient on s.17 MHA leave to this ward?			Yes		No	
Who is the patient's MHA Responsible Clinician?		Contact details:				

T	**If the patient is currently receiving in-patient assessment/treatment for mental disorder, then offer referral to Independent Mental Health Advocacy (IMHA), unless you are aware that the patient already has IMHA**

YOUR MEDICATION

Do you currently take any medications?	Yes		No	
Do you self-administer medication?	Yes		No	
If No, who administers your medication?				
Do you use a pill / medication organiser / Dosette box / multi-compartment compliance aid?	Yes		No	
Do you have your medication with you?	Yes		No	
If Yes, can we use them for this admission?	Yes		No	
Details:				

Disclaimer (where relevant)

T	**Consider medication as a risk to falls**

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

T MENTAL CAPACITY

Consider Dementia, Capacity, Delirium and Deprivation of Liberty Assessments

Do you have any reason to doubt the patient's mental capacity to make decisions about their care and treatment?			Yes		No	
If Yes, details of reasons / cognitive impairment: **Consider Care Plan** **Follow MCA Code of Practice**						
Has a mental capacity assessment been completed?			Yes		No	
Is this due to a pre-existing diagnosis? (e.g. learning disability, dementia, stroke, other cognitive impairment)			Yes		No	
Is it a new presentation? (e.g. delirium, confusion, new head injury, new stroke)			Yes		No	
Consider what support can be provided to help the patient make decisions for themselves						
Do you think that the patient lacks capacity to consent to their hospital stay i.e. could they be deprived of their liberty?			Yes		No	
If Yes, make a Deprivation of Liberty Safeguards referral if the Deprivation is likely to be ongoing						
If Yes, Has a Deprivation of Liberty Safeguards (Dols) application been completed?			Yes		No	
If No, Reason why it was not completed:						
Is there / has anyone made you aware that the patient has an Advance or Future Care Plan?			Yes		No	
If Yes, is there a copy in the notes?			Yes		No	
Is there / has anyone made you aware that the patient has an Advance Decision to Refuse Treatment (ADRT)?			Yes		No	
If Yes, is there a copy of a written ADRT in the notes or has a verbal ADRT been recorded in the notes?			Yes		No	
If ADRT present: Does the ADRT refuse life-sustaining treatment? (must be in writing, signed, witnessed and state that the refusal applies even if life is at risk)			Yes		No	
Is there / has anyone made you aware that the patient has a Health and Welfare Lasting Power of Attorney (LPA) or Court Appointed Deputy? (Note: LPA must be registered with the Office of the Public Guardian)			Yes		No	
If Yes, is there a copy in the notes?			Yes		No	
Is there / has anyone made you aware that the patient has a Property and Finance Lasting Power of Attorney (LPA) or Court Appointed Deputy? (Note: LPA must be registered with the Office of the Public Guardian)			Yes		No	
If Yes, is there a copy in the notes?			Yes		No	
Referral to an Independent Mental Capacity Advocate (IMCA) may be required if the patient has no family, friends, Attorney or Deputy to consult regarding best interests decisions.						
Does the patient have a learning disability?			Yes		No	
If Yes, consider the Learning Disability Care Bundle and Assessment						
Does the patient have a Learning Disability Passport/ Health Profile with them?			Yes		No	
If Yes, is there a copy in the notes?			Yes		No	
Does the patient have any specialist involvement with regards to Mental Capacity or Learning Disability?	Not Known		Yes		No	
If Yes, details:						

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ADDRESSOGRAPH

COMMUNICATION

Do you have a hearing problem?		Yes		No		Are you registered as deaf?	Yes		No	
If Yes, details:										
Do you have a sight problem?		Yes		No		Are you registered as blind?	Yes		No	
If Yes, details:										
Do you wear?	Hearing aids	Yes		No		with patient	Yes		No	
	Spectacles	Yes		No		with patient	Yes		No	
	Contact Lenses	Yes		No		with patient	Yes		No	
	Other	Yes		No		with patient	Yes		No	
Other details:										
Do you have difficulty reading?		Yes		No		Do you have difficulty writing?	Yes		No	
If Yes, details:										
Do you need any equipment to help you to hear or understand written information?							Yes		No	
If Yes, details:										
Do you feel that you can communicate clearly and make your needs understood?							Yes		No	
If No, details:										
Is this normal for you?							Yes		No	
If No, details: ❗ Consider Care Plan										
Do you have any specialist involvement?				Not Known			Yes		No	
If Yes, details:										

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

BREATHING

Do you have any difficulties breathing?			Yes		No	
If Yes, details:						
Is this normal for you?			Yes		No	
If No, details: ❗ Consider Care Plan						
Are you on home oxygen?			Yes		No	
If Yes, details: ❗ Consider Care Plan						
Do you have any specialist involvement?	Not Known		Yes		No	
Details:						
Do you use any special equipment relating to your condition?			Yes		No	
If Yes, details:						
Do you currently smoke?	No, but ex-smoker		Yes		No	
Do you currently vape?			Yes		No	
Do you currently use nicotine replacement?			Yes		No	
If Yes, do you require a nicotine replacement whilst in hospital?			Yes		No	
If Yes, do you agree to a referral to Help Me Quit services?			Yes		No	
If Yes, https://www.helpmequit.wales/professional-referral-form/						
❗ Has the patient been informed that it is illegal to smoke or vape within a hospital and its grounds?			Yes		No	

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

T	NUTRITION & HYDRATION Complete Nutritional Risk Assessment	Admission Height:	m ft in	Admission Weight:	kg st lb

Is the value for Height:	Measured		Reported		Estimated		Unable to measure		
Is the value for Weight:	Measured		Reported		Estimated		Unable to measure		
If unable to measure, details:									
Do you have any problems eating?							Yes		No
If Yes, details: Consider equipment, enteral or parenteral nutrition support Consider Care Plan									
Is this normal for you?							Yes		No
Do you have any problems drinking?							Yes		No
If Yes, details: Consider Care Plan									
Is this normal for you?							Yes		No
Do you have any problems swallowing?							Yes		No
If Yes, details: Consider referral to Speech and Language Therapy (SALT) Consider Care Plan									
Is this normal for you?							Yes		No
Do you need help to eat or drink?							Yes		No
If Yes, details: Consider Care Plan									
Do you have any food allergies or intolerances?							Yes		No
If Yes, details: Consider Care Plan									
Are you Diabetic?							Yes		No
If Yes, details: Consider Care Plan									
Do you require a specific diet or nutritional supplements?							Yes		No
If yes, details: Consider Care Plan									
Do you have any specialist involvement?		Not Known					Yes		No
If Yes, details:									

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

T MOBILITY

Complete Manual Handling Risk Assessment

Complete Falls Risk Assessment

Do you have any difficulties mobilising?			Yes		No	
If Yes, details:						
Is this normal for you?			Yes		No	
If No, details: Consider Care Plan						
Do you have any difficulties with your balance?			Yes		No	
If Yes, details:						
Is this normal for you?			Yes		No	
If No, details: Consider Care Plan						
Do you normally use a mobility aid?			Yes		No	
If Yes, details:						
Do you have them with you?			Yes		No	
Do you have any specialist involvement?	Not known		Yes		No	
If Yes, details:						
Have you fallen in the last 12 months?			Yes		No	
If Yes, details: (to include number of times)						
Do you have any anxiety or fear of falling?			Yes		No	
If Yes, details:						
Have you brought appropriate footwear with you?			Yes		No	
If No, details:						
Do you have any foot or lower limb problems?			Yes		No	
Details: Consider Care Plan						

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

T — BLADDER AND BOWEL ❗ Complete All Wales Continence Risk Assessment

What is your normal bowel pattern?				
Details:				
Do you currently have any problems or concerns with your bowels?	Yes		No	
If Yes, details: ❗ Consider a care plan				
Do you have, or experience any bladder problems?	Yes		No	
If Yes, details: ❗ Consider a care plan				
Is this normal for you?	Yes		No	
If No, details:				
Do you have any of the following?	Yes		No	
Colostomy ☐ Ileostomy ☐ Urostomy ☐ Catheter ☐				
If Yes, details: ❗ Consider separate care plans				

Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

PERSONAL CARE

Can you normally attend to your own personal hygiene needs?	Yes		No	
If No – In what areas do you require assistance?				
Washing ☐ Showering ☐ Bathing ☐ Dressing ☐ Mouth care ☐ Foot and nail care ☐ Other ☐ Details: ❗ Consider Care Plan				
Do you use any equipment to support personal care?	Yes		No	
If Yes, details:				

Do you have any specialist involvement?	Not Known		Yes		No	
Details:						

T MOUTH CARE ❗ Complete All Wales Mouthcare Assessment

Are you able to eat and drink unaided?	Yes		No	
If No, complete All Wales mouth care assessment ❗ Consider Care Plan				

Would you describe your mouth as feeling comfortable? (e.g. no pain, not dry, no soreness)	Not Known		Yes		No	
If No or Not Known, complete All Wales mouth care assessment						

Are you able to clean your teeth and mouth without assistance?	Yes		No	
❗ If No, complete All Wales mouth care assessment				
Do you wear dentures?	Yes		No	
Do you have your dentures with you?	Yes		No	

Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

T PAIN / COMFORT ❗ Complete Pain Assessment

Are you in pain?	Yes		No	
If Yes, details: ❗ Complete appropriate pain assessment				
Is this normal for you?	Yes		No	
If No, details:				
Are there things that you usually do to alleviate your pain?	Yes		No	
If Yes, details:				
Does the pain affect any of the following?	Yes		No	
Mobility ☐ Sleep ☐ Breathing ☐ Eating & Drinking ☐ Toileting ☐ Other ☐ Details: ❗ Consider Care Plan				

Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						

T SKIN ❗ Complete Pressure Ulcer Risk Assessment

Do you have existing wounds/ulcers or other skin problems?	Yes		No	
❗ If Yes, complete body map and pressure ulcer risk assessment				

Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ADDRESSOGRAPH

SLEEP

Can you describe your normal sleep pattern including anything you do to help you sleep?						
Details:						
Do you currently have difficulty sleeping?			Yes		No	
If Yes, details: ❗ Consider Care Plan						
Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						

CULTURAL AND SPIRITUAL BELIEFS

Do you have any specific cultural or spiritual beliefs that we need to consider?	Yes		No	
If Yes, details: ❗ Consider Care Plan				
Would you like a visit from the chaplain or another faith leader?	Yes		No	
If Yes, details:				

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

ADDRESSOGRAPH

HEALTH AND WELLBEING

Do you use recreational drugs?			Yes		No	
If Yes, details:						
Do you want information or advice on how to stop or take them safely?			Yes		No	
If Yes, details:						
Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						
Do you drink alcohol?			Yes		No	
If Yes, how many units per week?						
Do you wish to receive information/advice for reducing or stopping?			Yes		No	
If Yes, details:						
Do you have any specialist involvement?	Not Known		Yes		No	
If Yes, details:						

HAS A PROPERTY DISCLAIMER BEEN COMPLETED?

Yes		No	

Comments:

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ADDRESSOGRAPH

WHAT MATTERS TO ME

What is important to me at the moment?

What is preventing me from achieving this?

I would like to achieve the following from this admission:

My carer, advocate, family members could support me in the following ways**:**

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

Signature List

This section MUST be completed on the first shift you are caring for the patient or prior to making an entry into the record.

Date	Ward/Unit	Role/ Qualification	Print Full Name	Signature	Initials

ADDRESSOGRAPH

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

Date & Time	Care Plan ref.	Details	Signature

ADDRESSOGRAPH

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

NURSING NOTES			
Date & Time	Care Plan ref.	Details	Signature

ADDRESSOGRAPH

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

GIG CYMRU NHS WALES

NURSING NOTES

Date & Time	Care Plan ref.	Details	Signature

ADDRESSOGRAPH

ALL WALES ADULT INPATIENT ASSESSMENT

NHS Wales v2.3 (10/10/2024)

GIG CYMRU NHS WALES

NURSING NOTES

Date & Time	Care Plan ref.	Details	Signature

ADDRESSOGRAPH

ALL WALES ADULT INPATIENT ASSESSMENT: Discharge Plan

NHS Wales v2.3 (10/10/2024)

Relative informed of discharge date and time?	N/A		Yes		No	
Name of person informed:						
Details:						
Care providers informed?	N/A		Yes		No	
Confirmed by:						
Details:						
Nutritional needs considered and provisions supplied? (*Consider Nasogastric feeding, PEGs and feeding / nutritional supplements*)	N/A		Yes		No	
Details:						
Follow up appointment?	N/A		Yes		No	
Confirmed by:						
Details:						
Take home medication?	N/A		Yes		No	
Confirmed by:						
Details:						
Take home medication needing to be administered in the community?	N/A		Yes		No	
Details:						
Plaster of Paris check?	N/A		Yes		No	
Details:						
Peripheral Cannula removed?	N/A		Yes		No	
Wound check on discharge?	N/A		Yes		No	
Details:						
Wound care post discharge?	N/A		Yes		No	
Dressings Supplied	N/A		Yes		No	
Suture remover	N/A		Yes		No	
Staple remover	N/A		Yes		No	
Clip remover	N/A		Yes		No	
Drain(s) or device(s) In Situ?	N/A		Yes		No	
Details:						

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM

ADDRESSOGRAPH

ALL WALES ADULT INPATIENT ASSESSMENT: Discharge Plan

NHS Wales v2.3 (10/10/2024)

Urinary Catheter In Situ?	N/A		Yes		No	
Catheter passport provided?			Yes		No	
Details:						
Central Venous Catheter In Situ?	N/A		Yes		No	
Details:						
Continence products provided on discharge?	N/A		Yes		No	
Details:						
Arranged Practice Nurse (non-housebound patients)?	N/A		Yes		No	
Details:						
Arranged District Nurse (if the patient is housebound)? *(Consider if the patient / carer / family are able to perform the care)*	N/A		Yes		No	
Details:						
Arranged Community Resource Team / Specialist Team?	N/A		Yes		No	
Details:						
Arranged Other:	N/A		Yes		No	
Details:						
Equipment?	N/A		Yes		No	
Details:						
Transport?	N/A		Yes		No	
Details:						
Copy of DNACPR sent?	N/A		Yes		No	
Details:						
Patient property returned?	N/A		Yes		No	
Details:						

Name & Signature	Designation	Date	Time	Reviewer Name & Signature	Review Date	Time
		DD / MM / YY	HH:MM		DD / MM / YYYY	HH:MM