Affix patient label

NHS
Salisbury
NHS Foundation Trust

Nursing Assessment Record and Care Planning Document

Preferred name: ..... Admitted: .....

Ward: ..... Time .....

Reason for admission:

Mode of admission

Emergency ☐ Elective ☐ Expected date of discharge: _____

Is the patient currently competent to self medicate? Yes ❑ No ❑

If yes complete and ask the patient to sign a "self-medication consent form"

Patient has **name band** Yes ❑ Patient **property disclaimer** signed yes ❑ no ❑ n/a ❑

Patient consent to their name on bedside board/whiteboard Yes ❑ No ❑

Infection control screening on admission (refer to Policy): MRSA Yes ❑ No ❑ CPE Yes ❑ No ❑

Other (please state) .....

Ward transfers Yes ❑ No ❑ - complete SBAR transfer form

From	To	Date	Time

Nursing Assessment contents - please sign, date and time sections you have completed

pg.	title	Must be completed	Partially completed in POA/MAU/SAU by:	date & time	Completed by:	date & time
3	1. Social circumstances	within 6 hours				
4	2. Neuro/mental health	within 6 hours				
6	3. GI (eating, drinking & bowels)	within 24 hours				
8	4. Nutritional risk	within 24 hours				
10	5. GU (Micturition)	within 24 hours				
11	6. Manual handling/mobility	within 6 hours				
12	7. Hygiene	within 6 hours				
13	8. Pain	within 24 hours				
14	9. Respiratory	within 24 hours				
15	10. Cardiovascular	within 24 hours				
16	11. Pressure areas	within 6 hours				
18	12. Skin inspection	within 6 hours				
18	12a. Diabetic feet	within 6 hours				
19	13. Wound assessment	within 6 hours				
20	14. Falls	within 6 hours				
22	15. Bed rails	within 6 hours				

Nursing associates, trainee nursing associates, assistant practitioners, trainee assistant practitioners, therapy students and student nurses - all entries in this document must be countersigned by a registered nurse.

Signature sheet - must be completed by all who assess the patient and write in the care plans/evaluation record

Name	Band	Signature	Date

How to use this booklet

Assessment - to be signed or countersigned by a Registered Nurse

Care planning (prescribed care)

- Prescribing care needs are to be signed or countersigned by a Registered Nurse
- There must always be a current care plan. The date and time the care plan is to commence must be inserted
- Record changes to care on the relevant daily care plan evaluation sheet

Care delivery

- Anyone delivering care must record this
- Sometimes planned care cannot be delivered or the patient's condition has changed. In these cases reasons why care has not taken must be recorded on the care plan evaluation sheet

Evaluation of care

- Evaluation of care is to be signed once per shift
- Please be aware that when you sign your name in the appropriate shift box you are signing to agree that you have given all the care which has been prescribed in **all** care plans within this booklet

1. Multidisciplinary social circumstances and discharge planning

What are the patient's normal social circumstances?

Veteran ❑ Serving in the armed forces ❑ which service? _____ n/a ❑

Power of attorney (health): ..... Power of attorney (financial): .....

Donor card held: yes ❑ no ❑

On assessment today there are no concerns regarding the patient's social circumstances ❑

go to section 3

Does the patient have other care commitments? Yes ❑ No ❑

If yes please give details: .....

Is the patient cared for by a young carer? Yes ❑ No ❑

If yes please give details: .....

Section 1. Home environment

Style:	House ❑	Upstairs flat ❑	Downstairs flat ❑	Bungalow ❑
Type:	owned ❑	rented ❑	council ❑	Warden assisted ❑
	nursing home ❑	residential home ❑		
Access:	front ❑	rear ❑	steps ❑	rails ❑
	slopes ❑	internal steps ❑		
Bathroom:	upstairs ❑	downstairs ❑	toilet upstairs ❑	downstairs ❑

If you have any concerns about the patient's social circumstances, please inform the discharge team and discuss the need to refer to other social services for further assessment. Document your action in the healthcare record.

Section 2. Agencies

Is the patient known to social services or other agencies yes ❑ no ❑

Are they still involved with those agencies? yes ❑ no ❑

Are the relevant agencies aware of this admission? yes ❑ no ❑

Does the patient have a care package in place? yes ❑ no ❑ _____ times a day

Name of agency: ..... funded ❑ self funded ❑

Named social worker: .....

Refer to social work department ❑

Section 3. Risk factors

Is the patient an 'adult at risk / vulnerable adult'? yes ❑ no ❑

Definition: (Care Act 2014)

- Has needs for care and support (whether or not those needs are being met),
- Is experiencing, or is at risk of, abuse or neglect, and
- As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Is there a Safeguarding / Adult Protection concern yes ❑ no ❑

Have you completed a Consideration for DOLs yes ❑ no ❑ DOLs ❑ MCA ❑

date: ..... date: ..... date: .....

NB Refer to Safeguarding Policy on ICID if you are unsure

2 - Neurological Assessment — maintaining a safe environment/communication

Patient's normal condition prior to admission: (please summarise below)

Is the patient known to have neurological problems? yes ☐ no ☐

Is the patient known to have sensory problems? yes ☐ no ☐

Does the patient have problems with their communication? yes ☐ no ☐

Does the patient have a known learning disability (ask carer to complete a hospital passport if the patient has not come into hospital with one) yes ☐ no ☐

If yes to any question please attach **'communication' alert magnet** to the patient's name board

If no to all questions, go to section 2

Section 1 - Communication

Is the patient able to understand questions and conversations? yes ☐ no ☐

Is the patient able to verbally answer questions and talk? yes ☐ no ☐

If no, how does the patient express him/herself?

How does the patient communicate?

	yes	no		yes	no
lip reads	☐	☐	hand gestures	☐	☐
eye movements	☐	☐	flash cards	☐	☐
electronic aid	☐	☐	interpreter	☐	☐

other, please specify

Section 2 - Hearing and vision

Does the patient have problems with their vision? yes ☐ no ☐

Does the patient have problems with their hearing? yes ☐ no ☐

If no, go to section 3

Vision

wears glasses ☐ contact lenses ☐

partially sighted ☐ blind ☐

false eye ☐ left ☐ right ☐

Hearing

total loss ☐ partial loss ☐

partial loss left ☐ partial loss right ☐

hearing aid L ☐ R ☐ both ☐

Section 3 - Motor function

Does the patient have any motor weakness? yes ☐ no ☐

If no, go to section 4

arms	R	L
left sided weakness	☐	☐
right sided weakness	☐	☐
spasticity	☐	☐
facial		
left sided weakness	☐	☐
right sided weakness	☐	☐

legs	R	L
left sided weakness	☐	☐
right sided weakness	☐	☐
spasticity	☐	☐
flaccid	☐	☐
foot drop	☐	☐

Section 4 - Sleep

Patient's normal sleep pattern:

Sleeping tablets at home: ☐

Section 5 - Assessment for delirium and cognitive impairment		
To be completed on all patients aged 75 and over and for any patient who shows any signs of cognitive impairment/confusion irrespective of age (consider also post-operative period)		
1 - Alertness		
This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name & address to assist rating	Normal (fully alert, but not agitated, throughout assessment)	0
	Mild sleepiness for <10 seconds after waking, then normal	0
	Clearly abnormal	4
2 - AMT4		
Age, date of birth, place (name of the hospital or building), current year.	No mistakes	0
	1 mistake	1
	2 or more mistakes/untestable	2
3 - Attention		
Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted Months of the year backwards	Achieves 7 months or more correctly	0
	Starts but scores <7 months / refuses to start	1
	Untestable (cannot start because unwell, drowsy, inattentive)	2
4 - Acute change or fluctuating course	No	0
Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs	Yes	4
4 or above: possible delirium +/- cognitive impairment 1-3: possible cognitive impairment 0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)	total	

score more than 0 - complete delirium care bundle
score 4 or above - give relative/carer 'This is me' document ❑ **and highlight to medical team**
And ask relative/carer for **5 key things we need to know** about caring for the patient (likes and dislikes)

1. .....

2. .....

3. .....

4. .....

5. .....

Neurological/communication - Care Plan (2)		Start date and initial	End date and initial
1	Discuss and write plan of care with the patient. Include their view during evaluation of care (and relatives/carer if appropriate)		
2	The patient has been assessed as lacking capacity to make decisions. Any decision/plan made on their behalf follows the MCA Best Interests checklist		
3	Communication plan:		
Additional care plan		Start date and initial	End date and initial
1			

3 - Gastrointestinal tract Assessment — Eating, drinking and bowel function

Patient's normal condition before admission to hospital: (please summarise below)

Fluid intake (must be completed on all patients)

is the patient now	yes	no
nil by mouth?	☐	☐
not drinking adequately?	☐	☐
receiving intravenous fluids?	☐	☐
Does the patient need help and encouragement to drink?	☐	☐
Does the patient have difficulty swallowing drinks?	☐	☐

Commence a fluid chart if you have answered yes to any of these questions

Dietary requirements prior to admission (must be completed on all patients)

normal diet ☐ independent ☐ needs assistance ☐ * use allergy aware menu

Diabetes - carbohydrate counting ☐ low residue ☐ gluten free* ☐ vegan ☐

vegetarian ☐ food allergy* ☐ other (specify): ☐ _____

Enteral and parenteral

nasogastric ☐ nasojejunal ☐ gastrostomy tube ☐ jejunostomy tube ☐ TPN ☐

Swallowing (must be completed on all patients)

Does the patient have a difficulty swallowing food? unknown ☐ yes ☐ no ☐ **if no go to section 2**

If yes, attach 'eating and drinking' alert magnet to the patient's name board

Is the patient on a modified diet? yes ☐ no ☐

Puree (texture C) ☐ Pre-mashed (texture D) ☐ Fork-mashable (texture E) ☐ Soft ☐

Does the patient have difficulty swallowing drinks? yes ☐ no ☐

Is the patient on thickened drinks yes ☐ no ☐

Stage 1 (syrup) ☐ Stage 2 (custard) ☐ Stage 3 (pudding) ☐

Does the patient have existing swallowing recommendations to be followed?
If yes, specify:

Does the patient need referral to Speech and Language Therapy for swallowing assessment?
Yes ☐ No ☐ If yes, use referral form on ICID after gaining written agreement by doctor in healthcare record

Section 2 - Bowel pattern (must be completed on all patients)

Is the patient independent with toileting needs yes ☐ no ☐

The patient has a stoma ☐ (specify) .....

The patient needs manual evacuation of the bowels yes ☐ no ☐

Comments:

If appropriate, using the Bristol Stool Chart, ask the patient to identify their normal stool:

type 1 ☐ type 2 ☐ type 3 ☐ type 4 ☐ type 5 ☐ type 6 ☐ type 7 ☐

When did the patient last open their bowels? .....

Is there a concern with:

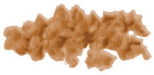
Faecal incontinence yes ☐ no ☐ Constipation yes ☐ no ☐

Diarrhoea yes ☐ (complete pathway) no ☐

Stool specimen sent (after discussion with doctors) ☐

GI tract - Care Plan (3)		Start date and initial	End date and initial
1	Record blood glucose levels ..... hourly and undertake interventions if necessary		
3	Monitor output of ..... drain/NG/stoma (delete) and record on the fluid balance chart. Escalate any abnormal output to medical or specialist team		
4	Observe for any change of appetite. Reassess nutritional needs as necessary		
5	Complete food chart and offer fortified drinks. Refer to dietician after 3 days ☐ ..... (date referred)		
6	Complete bowel chart on POET and escalate concerns to the medical team		
7	PEG in situ. Check insertion site and surrounding skin daily. Daily hygiene and dressing change. Flush as necessary		
8	NG tube in situ for feeding. Checklist completed every day (and when any changes). Monitor aspirate as per policy. Escalate as necessary		
9	Ensure adequate and appropriate food and fluid is provided to support a 'normal' bowel function for the patient		
10	Bowel plan:		
Additional care plan identified		Start date and initial	End date and initial
11			
12			
13			
14			

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

4 - Nutritional Risk Assessment - must be completed for all patients

Step 1: Height (A = actual E = estimated) _____ Weight (A = actual E = estimated) _____
BMI _____

Search for BMI on ICID for BMI chart

Step 2: Calculate the patient's Nutritional Risk Assessment score

Age in years	score	Weight changes in last 3 - 6 months	score	Diet	score	Appetite	score	Ability to eat	score	Reason for admission	score
Less than 40	1	no weight loss	1	Normal	1	Good. Manages 3 meals a day	1	Able to eat without help	1	No planned surgery or minor surgery	1
40 - 60	2	weight loss 5 - 10% in last 3 - 6 months or BMI <18.5 kg/m^2	2	Restricted	2	Eating ½ meals or less	2	Requires some help	2	Chronic medical conditions	4
60 - 80	3	weight loss > 10% in last 3 - 6 months or BMI <16-18.5 kg/m^2	3	Fluids only	3	Refuses or is unable to eat/drink	3	Needs assistance to eat	3	Major surgery Malabsorption Trauma Substance abuse Acutely ill	8
over 80	4	skeletal BMI <16 kg/m^2	4	Nil by mouth	4	Vomiting diarrhoea	4	Unable to swallow	4		

Step 3: Consider the NICE criteria for recognising patients at high risk of refeeding syndrome

Patient has one or more of the following	**Or patient has two or more of the following**
❑ BMI <16kg/m^2 ❑ Unintentional weight loss >15% within the previous 3 - 6 months ❑ Very little food intake >10 days ❑ Low levels of potassium, phosphate or magnesium prior to feeding	❑ BMI <18.5kg/m^2 ❑ Unintentional weight loss >10% within the previous 3 - 6 months ❑ Those with very little food intake for >5 days ❑ A history of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics

Is the patient at risk of refeeding syndrome yes ❑ no ❑
If yes, inform the medical team, document in the patient's healthcare record and refer to the policy

Nutrition - Care Plan (4)		Start date and initial	End date and initial
1	**Patient's Score ≤10 = low risk** • Encourage diet and fluids • Reassess nutritional risk score weekly • Weekly weight		
2	**Patient's Score 11 - 17 = moderate risk** • Encourage eating and drinking • Food chart for 3 days review - escalate/discontinue • Weekly weight • Replace missed meals with shakes or soups • Reassess nutritional risk score weekly - if no improvement refer to dietitian		
3	**Patient's score >18 = high risk** • Food chart for 3 days review - escalate/discontinue • Encourage high protein or small appetite menus • Use gold tray • Offer assistance with feeding if needed • Reassess nutritional risk score twice weekly • Weekly weights • Consider nutritional support • Refer to dietitians		

Nutritional screening re-assessment record - re-screened/weighed as appropriate to their clinical condition

Date and time	Age	Weight changes	Diet	Appetite	Ability to eat	Reason for admission	Risk score	Risk Category	Refeeding Risk	**Signature and band Supervisor if applicable**	**Date of next assessment**
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		
								Low ☐ Moderate ☐ High ☐	Yes ☐ No ☐		

Document any actions on the daily care plan evaluation sheet

5 - Genitourinary System/Lower GI - Micturition Assessment

Patient's normal condition before admission to hospital: (please summarise below)

Urinalysis:

On assessment today patient has no urinary problems ☐ **go to care plan**

Patient is continent ☐ Patient's bladder function is compromised ☐

An established urostomy ☐

Long term urinary catheter ☐ Suprapubic catheter ☐

Inserted: ..... Inserted: .....

Due for change: ..... Due for change: .....

Intermittent self catheterisation ☐ Mitrofanoff ☐

Other:

AKI/infections

Does the patient have a history of renal failure? yes ☐ no ☐

Commence a fluid chart if you have answered yes to the above question

When did the patient last pass urine? .....

Is there any evidence of:

Urinary infection	yes ☐ no ☐	urine specimen sent	yes ☐ no ☐
Urethral discharge	yes ☐ no ☐	swab sent ☐ date	.....
Vaginal discharge	yes ☐ no ☐	swab sent ☐ date	.....

Menstruation

Currently menstruating? yes ☐ no ☐ n/a ☐ LMP:

Comments:

GU - Care Plan (5)		Start date and initial	End date and initial
1	Staff to maintain patient's privacy and dignity during hospital admission		
2	Ensure daily catheter care is provided, complete CAUTI ongoing bundle every day		
3	Complete a daily fluid balance chart, input and/or output as indicated and escalate concerns to the medical team		
4	Continence plan:		
Additional care plan identified		Start date and initial	End date and initial
5			
6			

6 - Manual Handling & Mobility Assessment - update as patient/environment changes

Patient's normal condition before admission to hospital: (please summarise below)

The patient is independent yes ☐ no ☐ **If yes, go to care plan**
If no, attach 'mobility' magnet to patient's name board

Current patient assessment

No current issues with mobility ☐ Patient has a reduced level of mobility ☐

Pain	☐	Trauma (new)	☐	Other - please state	
Post surgery	☐	Amputee	☐		
Enforced bed rest	☐	Cognitive Impairment	☐		
Presenting medical condition	☐				

Indicate within the table below the equipment required (using the codes provided) and the number of staff required for each aspect of mobility	**STS** = sit to stand with assistance **WS** = walking stick **SA** = stand aid **BB** = Banana board	**ZF** = Zimmer Frame **H** = hoist **WC** = wheelchair	Other - please state

Always consider bariatric equipment

date								
time								
Action	equipment	No. of staff	equipment	No. of staff	equipment	No. of staff	equipment	No. of staff
Transfer (bed to chair, bed to commode)								

Manual handing - Care Plan (6)		Start date and initial	End date and initial
1	Encourage the patient to move safely		
2	Patient to wear suitable footwear before mobilising		
3	Ensure walking aids are within reach (select) Walking stick ☐ Zimmer ☐ Frame ☐ Crutches ☐ Wheelchair ☐ Other:		
4	Refer to physiotherapy ☐ OT ☐		
Additional care plan identified			
5			
6			
7			

7 - Hygiene Assessment

Patient's normal condition before admission to hospital: (please summarise below)

Current patient assessment for hygiene

Patient has pain or discomfort in the mouth yes ❑ no ❑ if yes complete Mouthcare Assessment

Chemotherapy	❑	Dysphagia	❑	Learning difficulties	❑	Severe mental health	❑
Delirium	❑	Frail	❑	Nil by mouth	❑	Stroke	❑
Dementia	❑	Head & neck radiation	❑	Palliative care	❑	Unable to communicate	❑
Dependent on O_2	❑	ICU/HDU	❑	Refusing food/drink	❑	Uncontrolled diabetes	❑

If any boxes are ticked in the list above please complete Mouthcare Assessment

Personal Hygiene				**Oral Hygiene**			
Independent	❑	Needs assistance	❑	Independent	❑	Needs assistance	❑
Needs all care	❑			Needs all care	❑		

Patient has:

Toothbrush	yes ❑	no ❑	provided ❑	Lower denture	yes ❑	no ❑	at home ❑
Toothpaste	yes ❑	no ❑	provided ❑	Denture pot	yes ❑	no ❑	provided ❑
Upper denture	yes ❑	no ❑	at home ❑	No teeth	yes ❑	will still need mouthcare	

Hygiene - Care Plan (7)		Start date and initial	End date and initial
1	Offer a choice of wash daily (including bed bath) or shower promoting independence where possible		
2	Ensure mouth care and / or eye care is provided ..... hourly ❑ twice a day ❑ daily		
3	Braden score is ..... . Skin bundle commenced (for score >15) ☐ Check pressure areas ..... times a day (including feet) and ensure the patient is repositioned ..... hourly to prevent pressure damage		
4	Review the patient's wound dressings daily or more frequently ..... . if required and record findings		
Additional care plan identified		Start date and initial	End date and initial
6			
7			
8			

8 - Pain Assessment

Patient's normal condition before admission to hospital: (please summarise below)

On assessment today patient is not complaining of any pain or demonstrating any signs/symptoms of pain ☐ **go to care plan**

Patient is experiencing pain ☐ complete the following assessment

Patient cannot verbalise/communicate their pain: Complete PAIN-AD 'behavioural pain assessment tool' ☐

Acute pain ☐	Chronic Pain ☐
Site of pain:	Type of pain: (e.g. stabbing, shooting, burning, aching)
Radiation:	Frequency / duration:
Aggravating factors:	Relieving factors:

Pain - Care Plan (8)		Start date and initial	End date and initial
1	Ensure the patient is offered and given appropriate analgesia. Offer positional changes to increase comfort. Consider other non-pharmacological interventions		
2	Assess the patient's pain. Observe for verbal/non verbal cues. Reassess and record pain score on POET		
3	Patient has cognitive impairment. Pain assessed and reassessed using PAIN-AD. Record on POET		
4	Observe for and treat any side effects. Refer to appropriate team (Acute ❑ Palliative Care ❑) for advice if symptoms are not resolved		
5	Administer prescribed PCA ❑ Epidural ❑ Syringe driver ❑ and undertake appropriate observations as per Trust policy		
Additional care plan identified		Start date and initial	End date and initial
6			
7			
8			

9 - Respiratory System Assessment

Patient's normal condition before admission to hospital: (please summarise below)

On assessment today patient has no respiratory problems ☐ **go to care plan**

Patient has compromised respiratory function & symptoms of compromised respiratory function are:

Reduced saturations ☐ Cough ☐ SOB ☐ Decreased respirations ☐ Increased respiratory rate ☐ Cyanosis ☐

Section 2

Home oxygen yes ☐ no ☐ Home nebulisers yes ☐ no ☐

Home NIV (BiPAP/CPAP) yes ☐ no ☐ (contact respiratory nurses on ext. 4220)

Equipment has been brought into hospital yes ☐ no ☐

Does patient carry an oxygen card? yes ☐ no ☐

Section 3

Tracheostomy yes ☐ no ☐ Laryngectomy yes ☐ no ☐ (if yes to either contact CCOT)
Obtain laryngectomy resuscitation equipment from main theatres

Section 4

SPO_2 target range set yes ☐

Oxygen prescribed yes ☐

Peak flow readings yes ☐ no ☐

Chest drain in situ yes ☐ no ☐

date inserted: .....

Respiratory - Care Plan (9)		Start date and initial	End date and initial
1	Monitor and record respiratory rate and escalate as per policy. Document abnormalities in nursing evaluation record		
2	Administer oxygen therapy as prescribed. Titrate to maintain required saturation. Position patient to maximise respiratory function. Provide mouth care whilst on oxygen. Nasal spec ☐ mask ☐		
3	A ..... infection is suspected. Obtain a..... sample Date obtained		
Additional plan of care identified		Start date and initial	End date and initial
4			
5			
6			

10 - Cardiovascular System & Controlling Body Temperature Assessment

Patient's normal condition before admission to hospital: (please summarise below)

On assessment today patient has a normal cardiac function ☐ **go to care plan**

On assessment today patient has a compromised cardiac function ☐

The symptoms of their compromised cardiac function are:

Tachycardia ☐ Pacemaker/device ☐ Bradycardia ☐ Hypertensive ☐ Hypotensive ☐

Oxygen ☐ Arrhythmia (specify)……..

Dizziness ☐ Peripheral oedema ☐ Falls ☐

Current patient assessment of body temperature:

Hypothermic ☐ Pyrexial ☐ Apyrexial ☐

Consider Bair Hugger

Cardiovascular/body temp - Care Plan (10)		Start date and initial	End date and initial
1	Monitor and record vital signs and escalate as per policy. Document abnormalities in nursing evaluation record		
2	Fluid restriction in place due to: ……		
3	Invasive device sited for:…….. Complete VIP each shift and record on POET (otherwise record on daily evaluation sheet)		
4	Daily weights		
Additional plan of care identified		Start date and initial	End date and initial
5			
6			
7			
8			

11 - Braden scale for predicting pressure sore risk

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours.
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than $^1/_3$of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR: Is nil by mouth and/or maintained on clear fluids or IV's for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.	

Document any actions on the daily care plan evaluation sheet

Braden Assessment Record

Step 1: Calculate the risk assessment score - this should be completed on admission, transfer and at least weekly or more frequently if the patient's condition changes

date									
time									
Sensory perception									
Moisture									
Activity									
Mobility									
Nutrition									
Friction & shear									
total score									

15 - 18 = at risk 13 or 14 = moderate risk 10 - 12 = high risk 9 or below = very high risk

please circle initial risk category	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high

Step 2: Identify other patient risk factors

If any of the following major risk factors are present, the risk level must be increased to the next level i.e. Low risk + acutely unwell = moderate risk

acutely unwell ❑ 75 years and over ❑ fever ❑ poor dietary intake ❑ diastolic pressure below 60 ❑ low systolic BP ❑ steroid ❑

previous pressure damage ❑ current pressure damage ❑

The score is for guidance only. Use clinical judgement to override any score e.g. patients with diabetes, peripheral vascular disease, stroke or any condition that seriously affects the patient's ability to move, or feel sensation are at HIGH risk of pressure damage including heel pressure ulcers

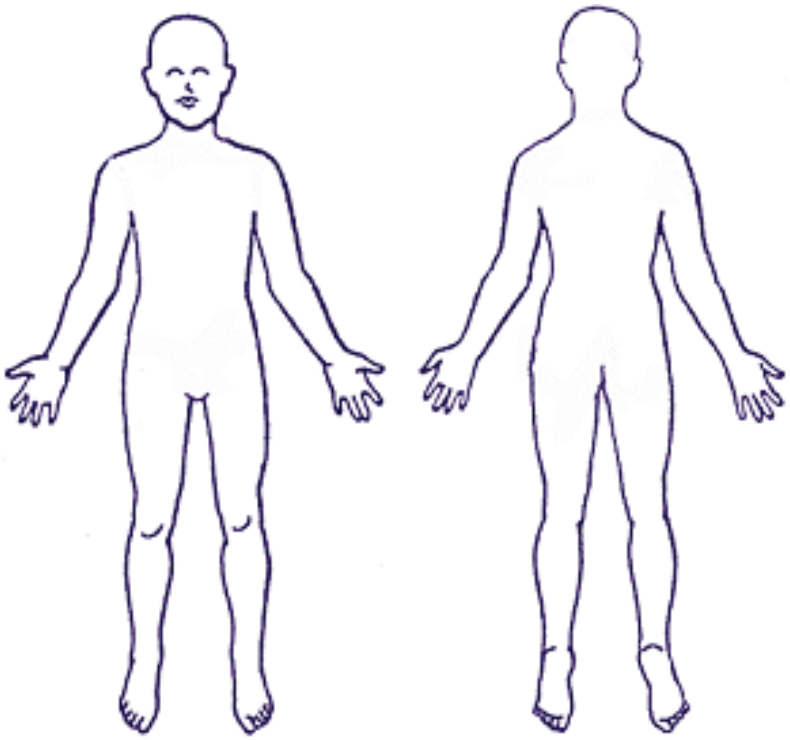
Step 3: Identify final risk category

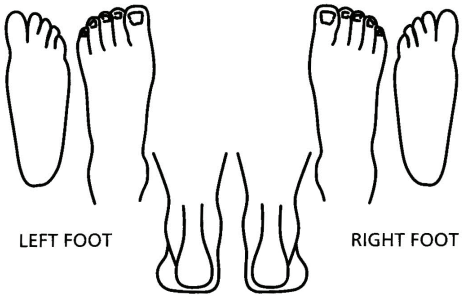
Patients with a total score of 18 or less are considered to be at risk of developing pressure ulcers, Consider re-positioning frequency, SKIN bundle, manual handling devices, specialist pressure relieving equipment, pressure re-distribution equipment and nutritional intake. A specific documented plan for skin inspection (SKIN bundle) including the feet and to relieve heel pressure required - please complete plan of care section.

Please circle final risk category	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high	At risk Moderate High Very high
Signature									
Supervisor									
Reassessment date									

12: Skin inspection (must be completed on all patients)

Step 1: Is there evidence of skin damage to the skin e.g. pressure ulcer, diabetic foot ulcer, leg ulcer, cellulitis, phlebitis, excoriation, trauma wound? No ❑ **go to step 2**
Yes ❑ identify the type of wound and mark any damage on the body maps below. Give any other description information required. For complex/multiple wounds please complete the complex wound assessment and attach to this document Complex wound assessment needed ☐





Step 2: diabetic patients only. Complete the following assessment within 6 hours of admission N/A ☐

Assessment (remove footwear and dressings and complete)	Yes	No
Is there an ulcer?	❑	❑
Is there inflammation or swelling or any sign of infection?	❑	❑
Is there unexplained pain in the foot?	❑	❑
Is there unexplained fracture dislocation?	❑	❑
Is there cyanotic discolouration or gangrene?	❑	❑

If yes to any of the above notify the diabetes SpR (bleep 1352) or nurse advisor (bleep 1223)
Refer for URGENT SURGICAL REVIEW and notify diabetes team if:

- Gas in the soft tissues
- Wet gangrene
- Critical ischemia / rest pain
- Abscess or rapidly progressive soft tissue infection
- Systemically unwell from foot sepsis (fever, shock, tachycardia, rigors, prostration)

Step 3: has the patient got evidence of pressure ulcers? Pressure ulcers must be graded according to their depth using the European Ulcer Advisory Panel Classification (EPUAP 1998) N/A ☐

	Site	Grade 1	Grade 2	Grade 3	Grade 4
1					
2					
3					
4					

For suspected grade 3 or 4 pressure ulcers please refer the patient the Tissue Viability Team on bleep 2025 or ext 4062

Have the findings been documented in the healthcare record? yes ☐ date: _____
Has the site been photographed? yes ☐ date: _____
Has electronic referral been made to Tissue Viability yes ☐ date: _____
Has a Datix report been made? yes ☐ Datix No: _____
Has a nutritional assessment been completed? yes ☐ date: _____

13 - Wound Assessment	On assessment - no wounds ☐ go to Falls Assessment (14)			
	Wound 1	Wound 2	Wound 3	Wound 4
Type of wound and site				
Wound dimensions length, breadth and depth				
Tracing/photography	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐
Wound bed E = epithelialisation G = granulation Other = please specify Enter the % of each S = sloughy N (H/S) = necrotic (hard/soft)				
Exudate What colour? Any odour? and what amount (low/medium/high)				
Infection Are there signs of infection? Has a swab been taken? Has the infection been confirmed? Is it being treated?	yes ☐ ☐ ☐ ☐ no ☐ ☐ ☐ ☐	yes ☐ ☐ ☐ ☐ no ☐ ☐ ☐ ☐	yes ☐ ☐ ☐ ☐ no ☐ ☐ ☐ ☐	yes ☐ ☐ ☐ ☐ no ☐ ☐ ☐ ☐
Condition of skin H = healthy EC = eczema (state maximum distance from wound in cm) M = macerated E = erythema				
Wound edges H = healthy OG = Over granulated O = oedematous				
Pain at wound site C = continuous N = none I = intermittent DC = dressing change only				

Wound - Care Plan care (13) - Summary of action and treatment plan		start date/initial	end date/initial
1			
2			

Are there any known allergies/sensitivities to wound care products?

14 - Falls Assessment

Is the patient:
- 65 years or older?
- Aged 16-64 years and at higher risk of falls due to an underlying condition?

(Conditions that increase risk of falls include: Parkinson's disease, stroke, other neurological disorders, joint and mobility problems, dementia or alcohol misuse).

❑ yes — **Patient is at risk of falls.** Complete the multifactorial risk assessment below and consider interventions

❑ no — **Patient is not at risk of falls**. No further action required. **Go to part 15**

Multifactorial Risk Assessment	**If yes, interventions to consider (tick if implemented)**
History of falls in past 12 month? yes ❑ no ❑	Causes …… Injuries …… ❑ Add to safety brief
Fear of falling? yes ❑ no ❑	❑ Bed at lowest height
Presence of cognitive impairment? - Delirium yes ❑ no ❑ - Confusion yes ❑ no ❑ - Dementia yes ❑ no ❑	❑ Ultralow bed ❑ Observable bay ❑ Intentional Rounding ❑ Cohort multiple patients with cognitive impairment with staff member always present. ❑ Apply double grip slipper socks (even if in bed) ❑ 1:1 special ❑ Chair/sensor mat ❑ Falls mat ❑ Consider using activity box ❑ Use falls magnet on patient name board ❑ If dementia, consider use of specialist volunteer
Continence problems yes ❑ no ❑	❑ Intentional rounding ❑ Ensure clear route to the bathroom
Unsuitable/missing footwear or at risk of not using on exiting the bed? yes ❑ no ❑	❑ Apply double grip slipper socks (even if in bed)
Is the patient on the following **medications**: Antipsychotics yes ❑ no ❑ Antidepressants yes ❑ no ❑ Antihypertensives yes ❑ no ❑ Sedatives/hypnotics yes ❑ no ❑	❑ Medication review to be undertaken by doctor or pharmacist.
Mobility problems, postural instability or balance problems? yes ❑ no ❑	❑ Physiotherapy/occupational therapy assessment. ❑ Ensure patient has own walking aids and they are kept nearby and visible.
History of syncope? - Black outs, drop attacks, loss of consciousness before falling? yes ❑ no ❑ - Dizziness on standing, turning or before falling? yes ❑ no ❑	❑ Lying & standing blood pressures undertaken on 3 separate occasions (record on observation chart) and inform medical team.
Interventions are suggestions only. Please list any additional interventions that have been implemented for this patient:	

Falls - Care Plan (14)		Start date and initial	End date and initial
1	Call bell in reach. Orientate to ward. Falls patient information leaflet given to patient ❑. Discuss with patient/family if there are any of their own existing falls interventions being used already. Move locker, aids, belongings to the same side of bed they get out of at home		
2	Visual impairment - Patient wears glasses, has a history of eye conditions or cannot read visual check image 1 or 2. Ensure glasses with patient. Walking aids visible and within reach. Adequate lighting. Environment free from clutter. Bed/chair orientation suitable		

Reassessments - after a fall, whenever the patient's condition changes or weekly	
Date	Time
Sign	Print name
Changes made:	
Date	Time
Sign	Print name
Changes made:	
Date	Time
Sign	Print name
Changes made:	
Date	Time
Sign	Print name
Changes made:	
Date	Time
Sign	Print name
Changes made:	
Date	Time
Sign	Print name
Changes made:	
Date	Time
Sign	Print name
Changes made:	
Date	Time
Sign	Print name
Changes made:	
Date	Time
Sign	Print name
Changes made:	

15: Bed Rails Assessment

'The only appropriate use of bedrails is to reduce the risk of patients accidentally slipping, sliding, falling or rolling out of bed' (NPSA Safer Practice Notice 17, Feb 2007)

All patients to be assessed on admission and within 24 hours of transfer to ward and repeat assessment weekly or after a fall.

Indication for use	Indications for non-use
Fluctuating conscious levels	Agitation / confusion
Sensory loss	Risk of patient climbing over the bed rails
Lack of spatial awareness	Patient totally immobile
Physical limitations / to support the patient	Aware of limitations

Where appropriate ensure that the patient and their family are involved in the decision making process

If there is conflicting evidence, then using professional judgement in conjunction with the above assessment will allow you to determine whether or not to use bed rails. Please document your rationale in the comments section below.

Outcome of assessment:	**Yes**	**No**
Are bed rails indicated? If bed ails are used, ensure they are appropriate for the type of bed, securely attached.	☐	☐
Are bed rail bumpers required to prevent entrapment or patient harm?	☐	☐
Has the family been informed of the decision?	☐	☐
Has the patient/carer been involved in the decision	☐	☐

Comments:

Bed Rails - Care Plan (15)		Start date and initial	End date and initial
1	Always keep the bed at its lowest height and consider the use of ultralow beds/crash mats on floor alongside the bed. Ensure objects needed (including call bell) are within reach and offer toilet regularly. Intentional rounding. Move bed to side of wall / to a less isolated area if possible. Review medication with medical team. Orientate patient to surroundings		
Additional care plan		Start date and initial	End date and initial
2			
3			

Bedrail re-assessment record

Date	Are bedrails required?	Indications for use	Are bumpers required	Comments and rationale for identified actions	Signature & band Supervisor if applicable	Date of next assessment
	Yes ☐ No ☐		Yes ☐ No ☐			
	Yes ☐ No ☐		Yes ☐ No ☐			
	Yes ☐ No ☐		Yes ☐ No ☐			
	Yes ☐ No ☐		Yes ☐ No ☐			
	Yes ☐ No ☐		Yes ☐ No ☐			
	Yes ☐ No ☐		Yes ☐ No ☐			
	Yes ☐ No ☐		Yes ☐ No ☐			

Document any actions on the daily care plan evaluation sheet

Day 1 Care Plan Evaluation			
Date:			
To acknowledge that you agree with the plan of care please sign. If not, you must re-evaluate and then sign		Signature	Agency and agency booking reference number
AM	Time		
PM	Time		
Night	Time		

Care Plan 1 - social circumstances & discharge planning, Care Plan 2 - neuro (mental health, communication, cognitive impairment), Care Plan 3 - GI tract (eating, drinking and bowel function), Care Plan 4 - nutritional risk, Care Plan 5 - micturition, Care Plan 6 - manual handling, Care Plan 7 - hygiene, Care Plan 8 - pain, Care Plan 9 - respiratory system,
Care Plan 10 - cardiovascular system & controlling body temperature, Care Plan 11 pressure sore, Care Plan 12 - skin, Care Plan 13 - wounds, Care Plan 14 - falls, Care Plan 15 - bed rails.

Please note with any change in condition reassess - falls, bed rails, skin & nutrition

Complete the following if your ward is not using POET to record VIP scores		
shift	VIP Score	Document any action taken
AM		
PM		
Night		

Date and time	Care plan No.	Evaluation/variance to care Only record if the care is different to the planned care	Signature

Day 2 Care Plan Evaluation

Date:

To acknowledge that you agree with the plan of care please sign. If not, you must re-evaluate and then sign		Signature	Agency and agency booking reference number
AM	Time		
PM	Time		
Night	Time		

Care Plan 1 - social circumstances & discharge planning, Care Plan 2 - neuro (mental health, communication, cognitive impairment), Care Plan 3 - GI tract (eating, drinking and bowel function), Care Plan 4 - nutritional risk, Care Plan 5 - micturition, Care Plan 6 - manual handling, Care Plan 7 - hygiene, Care Plan 8 - pain, Care Plan 9 - respiratory system, Care Plan 10 - cardiovascular system & controlling body temperature, Care Plan 11 pressure sore, Care Plan 12 - skin, Care Plan 13 - wounds, Care Plan 14 - falls, Care Plan 15 - bed rails.

Please note with any change in condition reassess - falls, bed rails, skin & nutrition

Complete the following if your ward is not using POET to record VIP scores

shift	VIP Score	Document any action taken
AM		
PM		
Night		

Date and time	Care plan No.	Evaluation/variance to care Only record if the care is different to the planned care	Signature

Day 3 Care Plan Evaluation

Date:

To acknowledge that you agree with the plan of care please sign. If not, you must re-evaluate and then sign		Signature	Agency and agency booking reference number
AM	Time		
PM	Time		
Night	Time		

Care Plan 1 - social circumstances & discharge planning, Care Plan 2 - neuro (mental health, communication, cognitive impairment), Care Plan 3 - GI tract (eating, drinking and bowel function), Care Plan 4 - nutritional risk, Care Plan 5 - micturition, Care Plan 6 - manual handling, Care Plan 7 - hygiene, Care Plan 8 - pain, Care Plan 9 - respiratory system, Care Plan 10 - cardiovascular system & controlling body temperature, Care Plan 11 pressure sore, Care Plan 12 - skin, Care Plan 13 - wounds, Care Plan 14 - falls, Care Plan 15 - bed rails.

Please note with any change in condition reassess - falls, bed rails, skin & nutrition

Complete the following if your ward is not using POET to record VIP scores

shift	VIP Score	Document any action taken
AM		
PM		
Night		

Date and time	Care plan No.	Evaluation/variance to care Only record if the care is different to the planned care	Signature

Day 4 Care Plan Evaluation

Date:

To acknowledge that you agree with the plan of care please sign. If not, you must re-evaluate and then sign		Signature	Agency and agency booking reference number
AM	Time		
PM	Time		
Night	Time		

Care Plan 1 - social circumstances & discharge planning, Care Plan 2 - neuro (mental health, communication, cognitive impairment), Care Plan 3 - GI tract (eating, drinking and bowel function), Care Plan 4 - nutritional risk, Care Plan 5 - micturition, Care Plan 6 - manual handling, Care Plan 7 - hygiene, Care Plan 8 - pain, Care Plan 9 - respiratory system, Care Plan 10 - cardiovascular system & controlling body temperature, Care Plan 11 pressure sore, Care Plan 12 - skin, Care Plan 13 - wounds, Care Plan 14 - falls, Care Plan 15 - bed rails.

Please note with any change in condition reassess - falls, bed rails, skin & nutrition

Complete the following if your ward is not using POET to record VIP scores

shift	VIP Score	Document any action taken
AM		
PM		
Night		

Date and time	Care plan No.	Evaluation/variance to care Only record if the care is different to the planned care	Signature

Day 5 Care Plan Evaluation			
Date:			
To acknowledge that you agree with the plan of care please sign. If not, you must re-evaluate and then sign		Signature	Agency and agency booking reference number
AM	Time		
PM	Time		
Night	Time		

Care Plan 1 - social circumstances & discharge planning, Care Plan 2 - neuro (mental health, communication, cognitive impairment), Care Plan 3 - GI tract (eating, drinking and bowel function), Care Plan 4 - nutritional risk, Care Plan 5 - micturition, Care Plan 6 - manual handling, Care Plan 7 - hygiene, Care Plan 8 - pain, Care Plan 9 - respiratory system,
Care Plan 10 - cardiovascular system & controlling body temperature, Care Plan 11 pressure sore, Care Plan 12 - skin, Care Plan 13 - wounds, Care Plan 14 - falls, Care Plan 15 - bed rails.

Please note with any change in condition reassess - falls, bed rails, skin & nutrition

Complete the following if your ward is not using POET to record VIP scores		
shift	VIP Score	Document any action taken
AM		
PM		
Night		

Date and time	Care plan No.	Evaluation/variance to care Only record if the care is different to the planned care	Signature

Day 6 Care Plan Evaluation

Date:

To acknowledge that you agree with the plan of care please sign. If not, you must re-evaluate and then sign		Signature	Agency and agency booking reference number
AM	Time		
PM	Time		
Night	Time		

Care Plan 1 - social circumstances & discharge planning, Care Plan 2 - neuro (mental health, communication, cognitive impairment), Care Plan 3 - GI tract (eating, drinking and bowel function), Care Plan 4 - nutritional risk, Care Plan 5 - micturition, Care Plan 6 - manual handling, Care Plan 7 - hygiene, Care Plan 8 - pain, Care Plan 9 - respiratory system,
Care Plan 10 - cardiovascular system & controlling body temperature, Care Plan 11 pressure sore, Care Plan 12 - skin, Care Plan 13 - wounds, Care Plan 14 - falls, Care Plan 15 - bed rails.

Please note with any change in condition reassess - falls, bed rails, skin & nutrition

Complete the following if your ward is not using POET to record VIP scores

shift	VIP Score	Document any action taken
AM		
PM		
Night		

Date and time	Care plan No.	Evaluation/variance to care Only record if the care is different to the planned care	Signature

Day 7 Care Plan Evaluation

Date:

To acknowledge that you agree with the plan of care please sign. If not, you must re-evaluate and then sign		Signature	Agency and agency booking reference number
AM	Time		
PM	Time		
Night	Time		

Care Plan 1 - social circumstances & discharge planning, Care Plan 2 - neuro (mental health, communication, cognitive impairment), Care Plan 3 - GI tract (eating, drinking and bowel function), Care Plan 4 - nutritional risk, Care Plan 5 - micturition, Care Plan 6 - manual handling, Care Plan 7 - hygiene, Care Plan 8 - pain, Care Plan 9 - respiratory system,
Care Plan 10 - cardiovascular system & controlling body temperature, Care Plan 11 pressure sore, Care Plan 12 - skin, Care Plan 13 - wounds, Care Plan 14 - falls, Care Plan 15 - bed rails.

Please note with any change in condition reassess - falls, bed rails, skin & nutrition

Complete the following if your ward is not using POET to record VIP scores

shift	VIP Score	Document any action taken
AM		
PM		
Night		

Date and time	Care plan No.	Evaluation/variance to care Only record if the care is different to the planned care	Signature

Day 8 Care Plan Evaluation

Date:

To acknowledge that you agree with the plan of care please sign. If not, you must re-evaluate and then sign		Signature	Agency and agency booking reference number
AM	Time		
PM	Time		
Night	Time		

Care Plan 1 - social circumstances & discharge planning, Care Plan 2 - neuro (mental health, communication, cognitive impairment), Care Plan 3 - GI tract (eating, drinking and bowel function), Care Plan 4 - nutritional risk, Care Plan 5 - micturition, Care Plan 6 - manual handling, Care Plan 7 - hygiene, Care Plan 8 - pain, Care Plan 9 - respiratory system, Care Plan 10 - cardiovascular system & controlling body temperature, Care Plan 11 pressure sore, Care Plan 12 - skin, Care Plan 13 - wounds, Care Plan 14 - falls, Care Plan 15 - bed rails.

Please note with any change in condition reassess - falls, bed rails, skin & nutrition

Complete the following if your ward is not using POET to record VIP scores

shift	VIP Score	Document any action taken
AM		
PM		
Night		

Date and time	Care plan No.	Evaluation/variance to care Only record if the care is different to the planned care	Signature

Day 9 Care Plan Evaluation

Date:

To acknowledge that you agree with the plan of care please sign. If not, you must re-evaluate and then sign		Signature	Agency and agency booking reference number
AM	Time		
PM	Time		
Night	Time		

Care Plan 1 - social circumstances & discharge planning, Care Plan 2 - neuro (mental health, communication, cognitive impairment), Care Plan 3 - GI tract (eating, drinking and bowel function), Care Plan 4 - nutritional risk, Care Plan 5 - micturition, Care Plan 6 - manual handling, Care Plan 7 - hygiene, Care Plan 8 - pain, Care Plan 9 - respiratory system,
Care Plan 10 - cardiovascular system & controlling body temperature, Care Plan 11 pressure sore, Care Plan 12 - skin, Care Plan 13 - wounds, Care Plan 14 - falls, Care Plan 15 - bed rails.

Please note with any change in condition reassess - falls, bed rails, skin & nutrition

Complete the following if your ward is not using POET to record VIP scores

shift	VIP Score	Document any action taken
AM		
PM		
Night		

Date and time	Care plan No.	Evaluation/variance to care Only record if the care is different to the planned care	Signature