Source material

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Admission form 1

<table>
<tr><th colspan="2">PATIENT ADMISSION FORM</th></tr>
<tr><td>Hosp no M/F
Name:
Address

Tel no
D.O.B.</td><td>Consultant
House officer
Type of admission
Date of admission Ward
Date of transfer</td></tr>
<tr><td>Prefers to be called
Marital status
Religion practising/non-practising
Occupation
Valuables
Where stored</td><td>History of present illness and reason for admission:</td></tr>
<tr><td>Next of kin
Relationship
Address

Tel no Home Work
Aware of admission?
Contact day/night</td><td>Relevant past medical history and medication on admission:</td></tr>
<tr><td rowspan="2">Other persons important to the patient
Name
Relationship
Address

Tel no Home Work
Contact day/night</td><td>Allergies</td></tr>
<tr><td>Provisional diagnosis</td></tr>
<tr><td>What does the patient know about his/her condition?

What do his/her family know about his/her condition?</td><td>Final diagnosis/Surgical procedures</td></tr>
<tr><td>Signature of nurse taking history
Designation
Signature of RGN</td><td>Tests and investigations</td></tr>
</table>

Section A – Social support Description of home situation and accommodation	**Section B – Community support** On admission GP
Section C – Discharge plan Planned date of discharge Discharge address	
Relatives/carers informed Y/N	Name Address Date
D/N informed Y/N / N/A	Name Address Date
Type of transport Own Hospital Taxi	Booked Y/N Date
TTOs ordered Y/N N/A	
GP's letter Y/N	
Other agencies involved	

Admission form 2

ADULT INPATIENT ASSESSMENT RECORD			Attach patient sticker if available or record
WARD (1)	NAMED NURSE (1)	TEAM (1)	UNIT NUMBER
WARD (2)	NAMED NURSE (2)	TEAM (2)	EPISODE NUMBER

CONSULTANT (1)	ADMISSION DATE TIME
CONSULTANT (2)	TRANSFER DATE TIME
SURNAME FIRST NAME PREFERS TO BE CALLED ADDRESS POST CODE TEL NO.	DOB 19___ AGE RELIGION SEX MARITAL STATUS ALLERGIES OCCUPATION GP
NEXT OF KIN NAME ADDRESS NIGHT CONTACT: YES/NO TEL NO. HOME WORK	2ND CONTACT NO. NAME ADDRESS NIGHT CONTACT: YES/NO TEL NO. HOME
RELEVANT PAST MEDICAL HISTORY	REASON FOR ADMISSION
RHESUS STATE / DATE 1 2	ACTUAL DIAGNOSIS — PATHWAY: YES / NO
PACEMAKER YES/NO	BP Temp Pulse BM Peakflow O_2 Sats Urinalysis Height Weight MSU YES/NO Waterlow score Man hand risk LOW/MED/HIGH
INFORMATION OBTAINED BY NAME DATE	

Patient assessment form 1

Activities of daily living	Normal	Present
SAFETY (vision, orientation, mobility)		Call bell given yes/no Costides yes/no
COMMUNICATION (hearing, speech, language)	Hearing aid yes/no	
BREATHING		
ELIMINATION bowels	Normal pattern	
bladder		
EATING & DRINKING (special diet, appetite restrictions)	Dentures yes/no	
MOBILITY (specify aids required)		
PERSONAL HYGIENE (ability, skin condition, physical appearance)		
WORK & PLAY		
Occupation		
BODY IMAGE (sexuality, paralysis) Prosthesis		
SLEEPING PATTERN	Normal pattern	
ANXIETY / FEARS		

PATIENT'S NAME ....

UNIT NO. .... CONSULTANT ....

Patient assessment form 2

Nursing assessment form
(Roper's model)

Name	
D.O.B.	Date of assessment
Hosp No	Nurse's signature
Ward	RGN signature

Activities of living

Usual behaviour / routine	Changes due to present condition / Admission
Communicating Body and verbal language, speech, understanding, senses and aids, mood. Usual religious observances.	
Breathing Resp rate and rhythm, cough, sputum, cyanosis, smoking habit and history, pain. Circulation, pulse rate and character, shock, cyanosis, pain.	P: R: B/P:
Eating Eating pattern, diet needs, likes and dislikes, feeding, swallowing, chewing, allergy, height/weight ratio, pain.	Wt: Ht:
Controlling body temperature Pyrexia, hypothermia, appropriate clothing, home heating	T:
Mobilising Dependence / independence, distances, aids used, pain, gait, deformity	

Eliminating Bowel habit and management, pain, bleeding, continence.
Urinary frequency, nocturia, dysuria, continence.
Urinalysis

Personal cleansing and dressing Dependence / independence, home routine, preference for bath or shower.
Condition of mouth, eyes, skin, hair, wound.

Maintaining a safe environment Risks in environment – infection, accidents, self-medication, confusion, sensory problems.

Working and playing Occupation – present or previous, hobbies and interests, family role, social contacts and visitors.

Expressing sexuality Body image, relationships, cultural implications, embarrassment, menstruation, reproductive systems, pain, bleeding.

Sleeping Sleep and rest routines, what helps, disturbances, neurological status.

Dying Fears and anxieties, awareness of patient and family, grief / bereavement, culture, coping mechanisms.
Religious observance in cases of extreme illness.

Standard care plan 1

Name

Date of birth

Hospital number

Date

Problem

______________ is unable to maintain his/her own safety needs immediately after surgery.
Potential nausea and vomiting. Potential dehydration due to nil by mouth.

Goal

1. Patient will return to full consciousness safely.
2. To detect early signs of haemorrhage/shock.
3. To prevent dehydration.
4. To alleviate nausea and vomiting.

Interventions

Maintain and observe airways on return to the ward.
Monitor pulse, respiration and BP ____ hrly until stable.
Give patient call bell to hand.
Observe wound site for oozing.
Give anti-emetics as prescribed and monitor their effect.
Introduce fluids, then diet as tolerated.
Ensure patient passes urine.

Progress and evaluation	Date	Signature

Standard care plan 2

Name

Date of birth

Hospital number

Date

Problem
Potential pain due to surgery.

Goal
Pain to be controlled to a level acceptable to the patient.

Interventions
Assess patient's pain level using a pain scale or assessment tool.
Observe for non-verbal signs of pain.
Administer analgesia as prescribed and monitor effect.
Report to doctor if analgesia ineffective.
Position patient to maximize comfort.
Advise patient on strategies for pain relief.

Progress and evaluation	Date	Signature

Individual care plan 1

Name Edith Jones	Ward F6	Problem number 1
D.O.B 18/03/1934		
Hosp No 825621		

Date	Problem	Signature and designation
1/04/04	Difficulty in mobilising due to pain caused by	J. Robins
	osteoarthritis	1/04/2004
	Goal/objective	
	To minimize pain within 2–3 days	J. Robins
		1/04/04
	Review 4/04/04	J.R.
		1/04/04
	Care planned	
1.	Ensure Mrs Jones is nursed in comfortable position,	
	well supported by pillows.	
2.	Assist Mrs Jones in performing ADLs, washing and	
	dressing, offering commode as necessary.	
3.	Administer analgesics as prescribed and monitor and	
	evaluate effectiveness.	
4.	Refer to physiotherapist for management of mobility.	
5.	Encourage Mrs Jones to be as independent as possible	J. Robins
	within her limitations.	1/04/2004

Individual care plan 2

Name Edith Jones	Ward F6	Problem number 2
D.O.B 18/03/1934		
Hosp No 825621		

Date	Problem	Signature and designation
1/04/04	Difficulty in breathing due to asthma – increased shortness of breath, wheeze & chest tightness	J. Robins 1/04/04
	Goal/objective	
	For Mrs Jones's symptoms to resolve and return to previous respiratory pattern	
	Review 2/04/04	J.R. 1/04/04
	Care planned	
1.	Record oxygen saturation level 4 hrly report & treat any abnormalities (inform Dr if falls below 90%)	
2.	Monitor resp. rate, rhythm and depths 4 hrly.	
3.	Give nebulizers as prescribed & monitor effectiveness – record pre & post peak flows.	
4.	Nurse Mrs Jones in upright position to aid maximum lung expansion	
5.	Administer medications as prescribed to aid bronchodilation.	
6.	Observe for possible side effects of these drugs i.e. tremor and reassure patient if occur.	
7.	Liaise with physiotherapist to ensure regular breathing exercises performed.	J. Robins 1/04/2004

Individual care plan 3

Name Edith Jones	Ward F6	Problem number 3
D.O.B 18/03/1934		
Hosp No 825621		

Date	Problem	Signature and designation
1/04/04	Potential for skin impairment due to decreased mobility	J. Robins 1/04/04
	Goal/objective	
	To maintain skin integrity	JR 1/04/04
	Review daily	
	Care planned	
1.	Ensure Mrs Jones changes position 2 hourly while awake.	
2.	Ensure pressure relieving mattress and cushions are used if Waterlow scale indicates.	
3.	Encourage Mrs Jones to be as mobile as possible within her limits.	
4.	Explain the importance of keeping the skin clean and dry.	