**Care Homes Assessment Team (CHAT) Holistic Geriatric Assessment/New Resident Review**

**Care Home Visit Information (please click the boxes to indicate what happened or what is required)**

Once Complete Please share with GP and Upload a Copy to RIO

|  |  |  |  |
| --- | --- | --- | --- |
| Date & Time of Assessment |  | Location- Name of Care Home |  |
| Date Admitted to Care Home |  |

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| Routine Visit | Requested Visit | Emergency Call Out |
| New Resident Assessment | Family Meeting | Meds Review |
| Post Discharge Review | Palliative Review | Post Fall Review |

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| NHS Number |  | DOB |  |
| Name |  | Likes to be known as |  |

**Actions Undertaken at the Visit**

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| ACP Completed | DNAR Agreed | | DNAR reviewed and/or Updated |
| New Resident Health Check Completed | | | Prescription Issued or Medication Changed |
| Escalated to Hospital | | | Family Contacted |
| Admission Avoided | | Falls Review | Care Plan to Manage Needs Put in Place |

**Actions required**

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| ACP | DNAR | DNAR Review with NOK |
| New Resident Health Check Required | | Registered GP - Prescription Required |
| Blood Test | Med Review | Family Meeting to be arranged |
| Falls review ☐ | Mental Health Input ☐ | Referral to Other Service required |
| Contact Registered GP |  | |
| Other Action |  | |

**Attending Clinican/s – Please tick speciality and insert your name**

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| Doctor |  |  |
| CHAT |  |  |
| ECP |  |  |
| Pharmacist |  |  |
| HCA |  |  |

**CARE PLAN details**

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| --- | --- |
| **Name of Care Home** |  |
| **Name of Patient** |  |
| **Dob** |  |
| **NHS number** |  |
| **GP**  **Is this likely to change?** |  |
| **Consent for Chat/Medicus input** | **Yes/no/unable** |

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| **Diagnosis** | **Medication** | |
|  | **Any Allergies?** | |
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| **Is there evidence of cognitive impairment? Y/N** | **Any recent medication changes? Y/N**  **Was it GP actioned? Y/N**  **Was it hospital actioned? Y/N**  **Details**: |
| **Is there a formal diagnosis of dementia? Y/N** |
| **Do they suffer with depression? Y/N** |
| **Antipsychotic medication? Y/N** |

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| **Lasting power of attorney** | Name and Contact Details |
| LPA for health and welfare |  |
| LPA for health |  |
| LPA for welfare |  |

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| **Deprivation of liberty** | Date and Duration |
| DOLS in place |  |

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| **Allow natural death** | Name and Date |
| Allow natural death form signed |  |
| Allow natural death discussed with patient |  |
| Allow natural death discussed with family |  |

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| **Preferred place of care** | **Preferred place of death** |
| **Please state:** | **Please state:** |
| Preferred place of care discussed with patient | Preferred place of death discussed with patient |
| Preferred place of care discussed with family | Preferred place of care discussed with family |

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| **Advanced decisions** |  |
| Treatment escalation plan in place | Patient has an ADRT (advanced directive) |
| A/E attendance/admission avoided | Best interests decision made on behalf of the patent |
| Review of admission avoidance care plan | Patient able to give consent |

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| **Communication and Behaviour** |  |
| Hearing impairment? Y/N | Aids? Y/N Details: |
| Visual impairment? Y/N | Glasses? Y/N Details: |
| Speech problems? Y/N | Communication: |
| Behavioural Problems? Y/N | BPSD Details: |

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| **Functioning** | **Bladder and bowels** |
| Independent feeding  Dependant for feeding  Needs help with feeding | Bladder: fully continent  Bladder: occasional accident  Bladder: incontinent |
| Bowels: fully continent ☐  Bowels: occasional accident ☐  Bowels: incontinent ☐ | **Referred to continence nurse? Y/N**  **Continence Assessment Required Y/N**  **Continence Products Required Y/N**  **Details:** |
| Independent for dressing  Dependant for dressing  Needs help with dressing | **Is the patient constipated? Y/N**  **Stool chart? Y/N**  **Is Continence ref required? Y/N** |
| Independent to toilet  Dependant for toilet  Needs help to toilet | **Weight: Height:**    **BMI: MUST:** |
| Independent walking  Independent in wheelchair  Needs help to mobilise  Immobile  Uses:  stick/ZF/RF/WC/Chairbound/Bedbound | **Any Dietary or Cultural Needs:**  **Swallowing difficulty? Y/N**  **Referred to SALT? Y/N**  **Referred to dietician? Y/N**  **Food consistency:**  **Fluid consistency:** |
| Transfers:  indep/+1/+2/standing hoist/full hoist | **Referred to physio? Y/N**  **Referred to OT? Y/N**  **Does Equipment Need to be Ordered? Y/N**  **Details:** |

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| **WHO performance status** |  |
| WHO performance status grade 0  Fully active, able to carry on all pre-disease performance without restriction | WHO performance status grade 3  Capable of only limited self-care, confined to bed or chair more than 50% waking hours. |
| WHO performance status grade 1  Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature | WHO performance status grade 4  Completely disabled. Cannot carry out an self-care. Totally confined to bed or chair. |
| WHO performance status grade 2  Ambulatory and capable of all self-care but unable to carry out work activities. Up and about more than 50% of waking hours. | WHO performance status grade 5  Deceased |

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| **Falls** | **Frailty** |
| At risk of falls | Severe frailty |
| Able to get up from floor | Moderate frailty |
| Does not fall | Mild frailty |
| Recurrent falls |  |
| **Number of falls in the last 6months?** | **Is falls clinic review required? Y/N** |

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| **Pressure area** |  |
| **Skin intact? Y/N** | **Details:** |
| Nursing home acquired Pressure ulcer |  |
| Hospital acquired pressure ulcer | Stage 1 |
| pressure sore | Stage 2 |
|  | Stage 3 |
|  | Stage 4 |
| Any Known Skin Condition? Y/N | Details: |
| Waterlow Score: |  |
| **D/N or TVN referral made? Y/N** | **Details:** |

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| Plan |
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