**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 |  |

|  |  |  |
| --- | --- | --- |
| 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?**  |
|  |
| **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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