Patient Admission to Discharge Plan (PADP)

Capital & Coast District Health Board
Ūpoko ki te uru hauora

SURNAME: ..... NHI: .....
FIRST NAMES: .....
DATE OF BIRTH: ..... / ..... / ..... SEX: .....
PLACE PATIENT ID HERE

Estimated date of discharge (EDD): / /

PATIENT DETAILS

	INITIAL	DATE TIME
Primary reason for admission:		
Medical history:		
Resuscitation documented ☐ Yes ☐ No		
Disability and other alert (MAP) ☐ Yes ☐ No Yellow envelope: ☐ Yes ☐ No		
Health Passport: ☐ No ☐ Yes - *ensure Health Passport or alert checked & PADP updated accordingly*		
Advance Care Plan (or discussions had): ☐ Yes ☐ No ☐ Not asked - *ask where applicable*		

INFECTION PREVENTION AND CONTROL GENERAL ASSESSMENT

	INITIAL	DATE TIME
Suspected/known infectious disease ☐ No ☐ Yes Recent contact with infectious disease? ☐ No ☐ Yes		
If yes, what: Isolation required: ☐ Contact ☐ Droplet ☐ Airborne		

MULTI-DRUG RESISTANT ORGANISM MDRO ASSESSMENT

	INTERVENTIONS		INITIAL	DATE TIME
Has patient:	**Assessment findings. If yes, take the following samples:**	**Contact precaution required:**		
Infection control MAP alert *e.g. Amp C, ESBL, CRE, VRE, MRSA, other MDRO*	☐ No ☐ Yes➔ No swabs needed	Yes **see standard precautions note*		
Had overseas hospitalisation or healthcare in the last 6 months? *Including IDC/SPC placement overseas*	☐ No ☐ Yes➔ Urine & rectal swab or faecal sample Wound swab	☐ Yes		
Been in India or Asia in the last 12 months?	☐ No ☐ Yes➔ Urine & rectal swab or faecal sample Wound swab	☐ No		
Extensive exfoliating skin or wound ooze?	☐ No ☐ Yes➔ Wound swab	☐ Yes		
Acute diarrhoea?	☐ No ☐ Yes➔ Faecal sample	☐ Yes		
Admitted with IC/SPC in situ from ARC facility? (and no known MDRO)	☐ No ☐ Yes➔ Urine sample	☐ No		
Cellulitis with intact skin?	☐ No ☐ Yes➔ Nasal swab	☐ No		

**standard precautions considered if ESBL E.Coli, Amp C Ecoli or non multi MRSA*

COMMUNICATION DIFFICULTIES AND SENSORY DEFICIT - *tick as appropriate*

	INITIAL	DATE TIME
☐ Sight ☐ Hearing ☐ Speech ☐ Aphasia ☐ Language ☐ Cognition ☐ Confusion		
Comments:		

SMOKING STATUS

Has the patient smoked in the last month?	☐ Yes	☐ No					
Cessation advice given	☐ Yes	☐ No	NRT offered?	☐ Yes	☐ No		
Complete Smoking Dependence Assessment & Cessation Referral Form (mandatory)							

SAFE FAMILIES ROUTINE ENQUIRY (SFRE)

Completed: ☐ Yes ☐ No

SFRE result: ☐ Pos ☐ Neg ☐ F/U ☐ Unable - state reason

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ADMISSION CHECKLIST	INITIAL	DATE TIME
☐ Orientation to ward and routines (toilets/exit etc)		
☐ Patient informed of their immediate treatment plan		
☐ Medical staff informed of patients arrival on ward		
☐ Special dietary/fluid requirements/diet code entered in MAP		
☐ Identification band attached		
☐ Patient aware of HDC rights and responsibilities (Mandatory check on admission)		
☐ Whānau/Pacific Support Care Services offered/brochure supplied		
☐ Whānau spokesperson identified:		
☐ Risk Screens completed and documented on patient care plan		
☐ EDD discussed with patient and family		
☐ Relevant allied health referrals made ☐ PT ☐ OT ☐ SW ☐ D ☐ SLT		
☐ ACC46 (previously ACC45) form completed and lodged		
☐ TrendCare updated		
☐ Enduring Power of Attorney documented on PIF form		

MEDICATIONS	YES	NO		INITIAL	DATE TIME
Has the patient brought medications in to the hospital with them?					
If patient self-medicating, ensure process discussed with patient					
Medications put in a green bag and place in the ward drug cupboard/locker					
Medications taken home by family?					

VALUABLES

Make sure the patient understands that items are retained at their own risk and covered by their own insurance.

Has the patient brought valuables with them? *Tick as appropriate if retained onsite.*				INITIAL	DATE TIME
☐ dentures (circle): top / bottom		☐ spectacles	☐ hearing aid(s)		
☐ rings	☐ watch	☐ iPod	☐ iPad or tablet		
☐ laptop	☐ cell phone	☐ radio	☐ wheelchair		
☐ mobility aids – crutches/frame		☐ Other:			
If the patient has consented/arranged for valuables to be taken home by a family member, specify family member here:					

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TRANSFER CHECKLIST	YES	NO	N/A	INITIAL	DATE TIME
Handover to nurse in receiving ward/hospital					
PADP/patient care plan updated					
Current copies of medical records to go with patient (and any x-rays/scans)					

DISCHARGE CHECKLIST	YES	NO		INITIAL	DATE TIME
Patient informed of discharge					
Will the patient go to their own home on discharge?					
Alternate address and phone number:					
	Phone:				
Transport arranged: ☐ Own ☐ Other - specify:					
Patient's family/NOK/rest home informed					
Copy of Medical Discharge Summary					
IV access device removed/patent and appropriate follow up as required					
Patient's own medications returned and patient prescription given					
Medication from hospital pharmacy/special authorities (e.g. Clexane)					
Valuables and property returned					
Patient specific equipment to go with patient (e.g. frame, stick)					
Predischarge education completed and information leaflets supplied					
Medical certificate/ACC forms					
Outpatient follow up organised/GP follow up					
Cleared by Allied Health as applicable					
Yellow Envelope/Health Passport returned					
Transit lounge booked					

DISCHARGE REFERRALS			INITIAL	DATE TIME
☐ Community Health	☐ Hospice	☐ District nurses		
☐ Home Community Support Services (HCSS)		☐ Community ORA		

SAMPLE SIGNATURES

Name	Desgtn	Initial	Name	Desgtn	Initial	Name	Desgtn	Initial

SURNAME: .... NHI: ....
FIRST NAMES: ....
DATE OF BIRTH: .... / .... / .... SEX: ....
PLACE PATIENT ID HERE

FALLS RISK ASSESSMENT TOOL

Please ask your patient/families and assess and tick risk factors:

- if ANY criteria from initial assessment are identified then use falls action (page 5) and safety huddle to help you develop and update the patient care plan.
- re-assess after fall/near miss, medical status changes, and on transfer to new environment. Update the patient care plan.

☐ Aged 75+ (Māori/Pacifica aged 55+)	☐ Mobility and gait problems or use of mobility aids
☐ Slipped, tripped leading to near miss fall in the last 3 months	☐ Neurological changes or condition
☐ Falls history within the last 12 months	☐ Medication effects
☐ Mental status - agitated, confused, signs of delirium, depression or dementia	☐ Sensory deficit – vision or hearing impairment, altered peripheral sensation
☐ Fear of falling	
☐ Falls risk identified ➔	☐ Safety huddle preformed to identify prevention interventions
☐ No falls risk identified ➔	Ensure minimum standards are in place

MINIMUM STANDARDS – TO BE IMPLEMENTED FOR ALL PATIENTS

- Orientate patient to bed area, toilet facilities and ward
- Educate patient and family and provide information about the risk of falling and safety issues
- Demonstrate the use of call bell to patient and ensure it is in reach of patient
- Ensure frequently used items including mobility aids are within easy reach of patient
- Provide appropriate mobility assistance
- Bed and chair at appropriate height for patient
- Ensure bed brakes are employed at all times
- Position over-bed table on non-exit side of bed
- Place IV pole and all other devices/attachments (as appropriate) on exit side of bed
- Remove clutter and obstacles from room
- Ensure patient is using appropriate aids such as glasses or hearing aids
- Ensure patient wears appropriate footwear if ambulant

INITIAL ASSESSMENT RESULTS:

Name:	Designation:	Date: / /	Time:
☐ Interventions selected and updated in patient care plan OR		☐ for minimum standards only	

CONSENT FOR ENABLER USE

Agreed enabler (please tick one): ☐ bedrails ☐ walking frame or mobility equipment ☐ lifting equipment ☐ tray ☐ lateral trunk support ☐ safety belt or vest ☐ floor bed without bedrails ☐ other:		
Rationale for use:		
Consent given by:	Signature:	Date: / /
Agreed enabler (please tick one): ☐ bedrails ☐ walking frame or mobility equipment ☐ lifting equipment ☐ tray ☐ lateral trunk support ☐ safety belt or vest ☐ floor bed without bedrails ☐ other:		
Rationale for use:		
Consent given by:	Signature:	Date: / /
Agreed enabler (please tick one): ☐ bedrails ☐ walking frame or mobility equipment ☐ lifting equipment ☐ tray ☐ lateral trunk support ☐ safety belt or vest ☐ floor bed without bedrails ☐ other:		
Rationale for use:		
Consent given by:	Signature:	Date: / /

Enablers: are equipment, devices or furniture that limits normal freedom of movement with the intent of promoting independence, comfort and or safety. They are used voluntarily by a consumer after an appropriate assessment.

Restraint: is the use of any intervention by a service provider that intentionally limits a consumer's normal right of freedom. If equipment or device is a restraint read policy 1.772 Restraint Minimisation and Safe Practice.

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FALLS ACTION

Mobility / functional ability	**Does the patient:** ▪ require assistance with mobility / transfer? ▪ have impaired gait / limb weakness? ▪ have poor coordination or balance? ▪ report foot pain and other foot problems?	**INTERVENTIONS** ▪ Determine mobility and weight bearing status ▪ Document mobility aids and appropriate level of assistance required ▪ Provide appropriate level of assistance ▪ Encourage participation in functional activities and exercise and minimise prolonged bed-rest ▪ If change of mobility from normal, consider referral to physiotherapist ▪ Ensure mobility aid available for patient to use ▪ Select and display correct falls signal card ▪ If using floor bed do not raise bedrail
Medications / medical conditions	**Has the patient been prescribed or does the patient have a medical condition that requires:** ▪ sedatives / hypnotics, laxatives and/or diuretics? ▪ any medication that may: » affect their balance or blood pressure? » cause dizziness or unsteadiness? » causes severe fatigue?	**INTERVENTIONS** ▪ Liaise with Medical Practitioner or Pharmacist for medication review ▪ Check lying/standing blood pressure ▪ Encourage patient to sit up or stand up slowly
Mental state	**Is the patient:** ▪ confused? ▪ disorientated? ▪ depressed?	**INTERVENTIONS** ▪ Check 4AT in doctors admission note on MAP or medical file ▪ Commence delirium cares if at risk (see delirium care plan) ▪ Assess and document need for supervision in toilet and shower ▪ Notify medical team immediately if any change in mental state ▪ Place bed against wall and use appropriate equipment (e.g. floor bed) ▪ Do not use bedrails with floor bed ▪ Avoid using bedrails, if absolutely required document consent (page 4) ▪ Provide reorientation board & clock ▪ Document and provide increased surveillance strategies ▪ Refer delirium care plan ▪ Consider referral to occupational therapist ▪ Consider observational, engagement and diversion strategies
Continence / elimination needs	**Does the patient:** ▪ require assistance with toileting? ▪ have urinary or faecal frequency / urgency or nocturia?	**INTERVENTIONS** ▪ Assess and document patient's normal toileting patterns ▪ Implement individual toileting plan ▪ Encourage fluids ▪ Ensure patient has easy access to toilet facilities (e.g. bottle, commode, raised toilet seat, slippers)

Braden Scale for Predicting Pressure Injury Risk

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK *Circle score and put in the column*					INITIAL SCORE
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 LIMITATIONS:** Makes major and frequent changes in position without assistance.	
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 the room at least twice a day and inside room at least once every 2 hours during waking hours.	
SENSORY PERCEPTION Ability to respond meaningfully to pressure related discomfort. Consider pts with diabetes & epidurals	**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 surface	**2. VERY LIMITED:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ the body.	**3. SLIGHTLY LIMITED:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. NO IMPAIRMENT:** Responds to verbal commands. Has no sensory deficit that 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.	
NUTRITION Usual food intake pattern. 1 NBM: Nothing by mouth 2 IV: Intravenously 3 TPN: Total Parenteral Nutrition	**1. VERY POOR:** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 serving or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NBM 1 and/or maintained on clear fluids or IV 2 for more than 5 days.	**2. PROBABLY INADEQUATE:** Rarely eats a complete meal and generally eats only about 1/2 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 the optimum amount of liquid diet or tube feeding.	**3. ADEQUATE:** Eats over half of most meals. Eats a total of 4 servings of protein (meats, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered OR is on a tube feeding or TPN 3 regimen that 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 AND 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 at all times.		

TOTAL SCORE	
Date	
Signature	

Risk level: high ≤12 medium 13-18 low 19-23

SURNAME: ..... NHI: .....
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DATE OF BIRTH: ...../...../..... SEX: .....
PLACE PATIENT ID HERE

Pressure Injury Prevention and Management (PIPM)

SURNAME: ..... NHI: .....
FIRST NAMES: .....
DATE OF BIRTH: ..... / ..... / ..... SEX: .....
PLACE PATIENT ID HERE

1. **Braden assessment:** on admission, reassess daily, on transfer of care or more frequently if there is a change in patient condition requiring this
2. **3-step skin check:** on admission 1. Ask the patient "do you feel any discomfort where your body is pressing against the bed/chair?" 2. Educate SSKIN 3. Inspect skin for any discolouration, broken skin and discomfort on pressure points and under/around medical devices
3. **Provide:** PI Prevention Patient Information handout to patient/family/whānau
4. **Document** PIPM care bundle in PADP patient care plan & patient progress, treatments received and education given in clinical record
5. **Escalate:** any concerns to Senior Nurse and Medical teams

Pressure Injury Prevention and Management (PIPM) Care Bundle

		Braden High Risk ≤12	Braden Medium Risk 13-18	Braden Low Risk 19-23
S	**Skin Inspection**	**3 step skin check EACH SHIFT**	**3 step skin check TWICE DAILY**	**3 step skin check DAILY**
S	**Skin Surface**	▪ Ensure patient on appropriate pressure relieving/reducing mattress & cushion ▪ Keep linen wrinkle free & not tight over lower limbs, consider bed cradle ▪ Elevation of bed head no more than 30 degree unless contraindicated		▪ Ensure patient on appropriate mattress and cushion ▪ Keep linen wrinkle free & not tight over lower limbs
K	**Keep Moving**	▪ Indicate frequency of repositioning patient - 2hr, 4hr, 6hr depending on skin tolerance & document ▪ Educate patient and family on repositioning bed/chair ▪ Use slide sheets when moving patients to prevent friction & shear ▪ Reduce pressure points where possible under/around medical devices ▪ Elevate heels off bed ▪ Refer to Physio and Occupational Therapist for PI support if required		Encourage patient to mobilise & reposition
I	**Incontinence (Moisture)**	▪ Assess skin each shift for any issues causing moisture ▪ Implement appropriate action plan &/or referrals » skin barriers creams » incontinent products or » incontinent devices (IDC, urodome or faecal management system) ▪ Consider scheduled assisted toileting ▪ Use mild soap and soft disposable cloths or bath wipes		Encourage patients to report any moisture or incontinent concerns
N	**Nutrition**	▪ Complete nutritional screen ▪ Refer to Dietitian as indicated on MST or has stage ≥3 PI ▪ Implement appropriate actions ▪ Adequate hydration ▪ Right texture food & aids to eat ▪ Reassess weekly	▪ Complete nutritional screen ▪ Implement appropriate actions as MST ▪ Adequate hydration ▪ Right texture food & aids to eat ▪ Reassess weekly	

If the patient has a pressure injury/s

6. Assess PI stage using PI classification chart in Pressure Injury Prevention & Management policy – if stage ≤2 refer patient to CNS Wound care
7. Document using PI incidence sticker for every PI in the patient clinical record
8. **Regardless of Braden score** categorise patient as '**high risk'** of PI and use appropriate PIPM care bundle
9. Monitor and assess PI healing using Wound Care assessment and management documentation

Nutrition Screening

SURNAME: ..... NHI: .....
FIRST NAMES: .....
DATE OF BIRTH: ..... / ..... / ..... SEX: .....
PLACE PATIENT ID HERE

MALNUTRITION SCREENING TOOL (MST):

	INITIAL	DATE TIME

Weight *within 24 hours of admission* _____ **kg** Unable to weigh due to:

Question 1: Has the patient lost weight in the last 3-6 months without trying?

☐ No-**score zero.** *If unsure, ask if clothes are looser* ☐ If no, **score zero** ☐ If still unsure, **score 2**

☐ Yes-1-5kg, **score 1** ☐ 6-10kg, **score 2** ☐ 11-15kg, **score 3** ☐ >15kg, **score 4** ☐ Unsure, **score 2**

Question 2: Has the patient been eating poorly because of decreased appetite?

☐ No = **score zero** ☐ Yes - s**core 1**

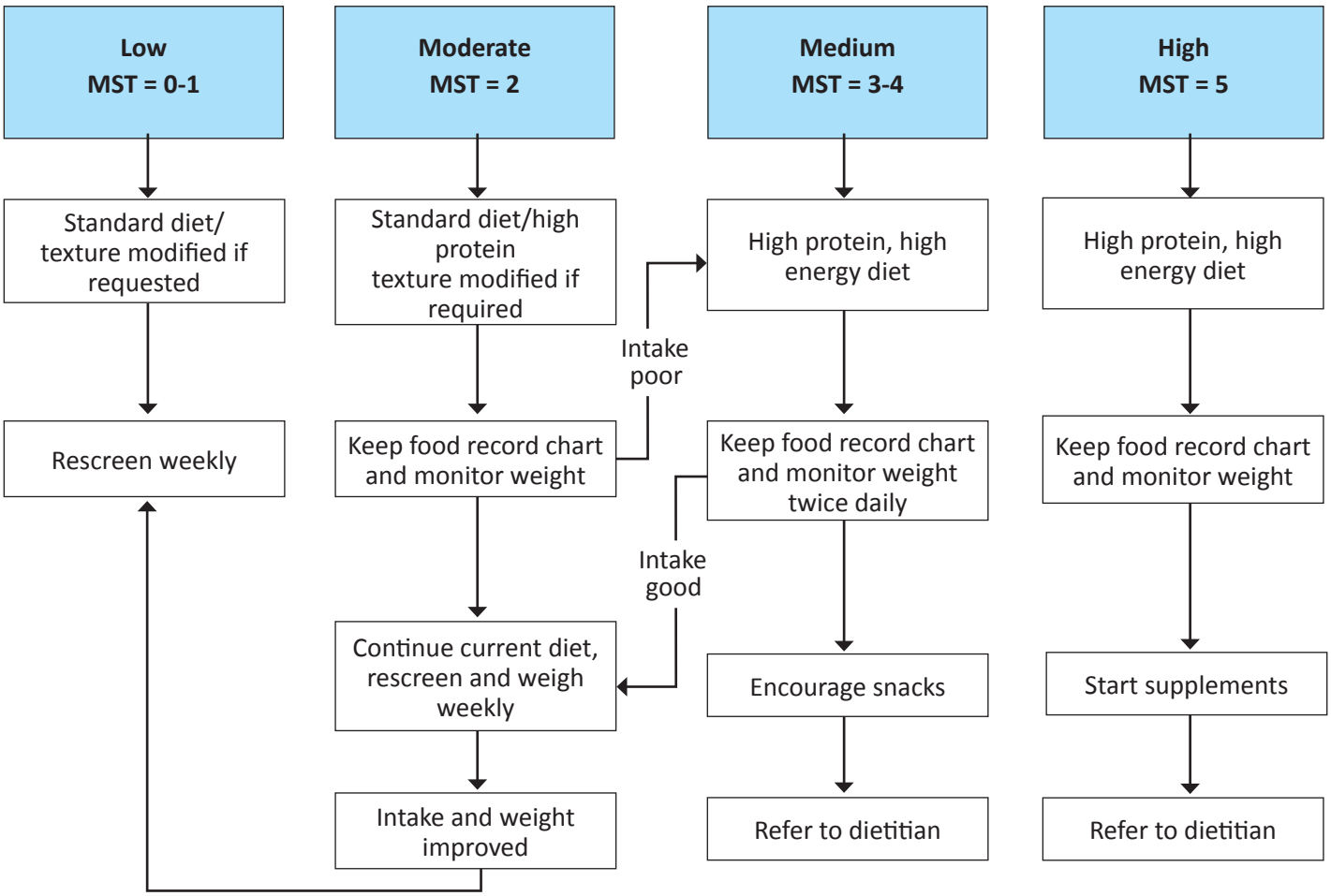
Total MST score: question 1 score ____ + question 2 score ____ =

If scores ≥3 refer to dietitian ☐ Referral made date: / /

The MST should be repeated at least every seven days to capture deteriorating nutritional status.
Please record patient's initial risk score on care plan and any re-screening scores.

Rescreen MST score:

MALNUTRITION ACTION FLOW CHART



To refer to dietitian: use Allied Health Referral form. Include weight and MST score and clinical condition.

Delirium Assessment

SURNAME: ..... NHI: .....
FIRST NAMES: .....
DATE OF BIRTH: ..... / ..... / ..... SEX: .....
PLACE PATIENT ID HERE

ON ADMISSION:
Did the patient have a diagnosis of delirium on admission or a 4AT score >3 ?

YES

PROBABLE OR CONFIRMED DELIRIUM
- ☐ **Give delirium brochure to the patient or family**
- ☐ **Initiate delirium cares to treat it**
- ☐ **Signal delirium cares on the whiteboard**

NO

Does the patient have any of the following risk factors for delirium?
- > 75 years of **age**
- Current **severe illness**
- Current hip fracture
- Known or possible **cognitive impairment** (or 4AT score 1-3)

NO

☐ **NO IMMEDIATE ACTION REQUIRED**

YES

AT RISK OF DELIRIUM
- ☐ Initiate delirium cares to prevent it
- ☐ Follow Delirium Care Plan (back page)

DURING HOSPITAL STAY:
Monitor all inpatients for hospital acquired delirium.

Is the patient more confused than before?

YES

Repeat 4AT *PTO*

>3

PROBABLE HOSPITAL-ACQUIRED DELIRIUM
- ☐ **Request medical review**
- ☐ **Attach delirium sticker to progress notes**
- ☐ **Give delirium brochure to the patient or family**
- ☐ **Initiate delirium cares to treat it**
- ☐ **Signal delirium cares on the whiteboard**

1-3

☐ **NO IMMEDIATE ACTION REQUIRED. Inform medical team if any changes**

4AT Delirium Assessment Tool

SURNAME: ..... NHI: .....
FIRST NAMES: .....
DATE OF BIRTH: ..... / ..... / ..... SEX: .....
PLACE PATIENT ID HERE

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
1 - ALERTNESS: This includes patients who may be 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 patients to state their name and address to assist rating.								
Normal (fully alert, but not agitated, through out the 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	0 ➔							
2 or more mistakes/untestable	4 ➔							
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.								
Achieves 7 months or more correctly	0 ➔							
Starts but scores < 7 months/refuses to start	0 ➔							
Untestable i.e. cannot start because unwell, drowsy, inattentive	4 ➔							
4 - ACUTE CHANGE OR FLUCTUATING COURSE: Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) over the last two weeks and still evident in the last 24 hours.								
No	0 ➔							
Yes	4 ➔							
4AT SCORE TOTAL								

✔=if completed x=if not completed M=morning E=evening N=night

4AT score: >3: possible delirium +/- cognitive impairment. **1-3:** possible cognitive impairment.
0: delirium or severe cognitive impairment unlikely. **NOTE:** if 4AT = 0 for 2 days, no further 4AT is required.

DELIRIUM CARES - indicate which interventions to implement, to prevent and/or treat delirium

Start date: / /		Day 1			Day 2			Day 3			Day 4			Day 5			Day 6			Day 7		
	Intervention	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N	M	E	N
Is pain present?	Ensure analgesia prescribed and given																					
Disorientated	Orientation board updated																					
	Good lighting by day																					
	Quiet and low stimulus by night																					
	Implement distraction activities																					
	Document mental state daily																					
Maintain function and mobility	Mobilise as much as able																					
	Maintain function and routine																					
	Engage patient in meaningful activities																					
	Encourage independence with usual self-care routines																					
Elimination	B/O																					
	Bowel chart (replicate usual pattern +/- regular toileting schedule)																					
Hearing impairment	Ensure hearing aids are working																					
	Impaired hearing sign at bedside																					
	Document language requirement																					
	Use communication white boards																					
Visual impairment	Glasses cleaned and applied																					
	High contrast cups and plates																					
Concerns re nutrition or hydration	Sit out in chair																					
	Complete nutrition score weekly																					
	Observe +/- assist at mealtimes																					
	Inform doctor if fluid intake <1 L/day																					
Variance:																						
	Signature																					

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