XC200880

Augusta Health Service

Resident Admission Assessment

(Residential Aged Care)

Doctor: Louise Marsh

Surname	UMRN / MRN	
JOHNSON	M2435498	
Given Name	DOB	Gender
RON	9/1/1954	M
Address		Post Code
5555 DONOVAN ST, AUGUSTA, WA		6290
	Telephone	
	02 9758 1227	

Admission Details — **Respite:** ☐ Yes ☒ No

Preferred Name: Ron — Admission Date:

Key Contact Person:

Name: Fred Collins | Relationship: Son | Phone: 0343094859

Name of General Practitioner: Dr Tragus

Medical Diagnosis on Admission: (from ACAT Assessment / doctor's summary)

Disc Bulge (L) L5, S1

TIA - 2016

Mild cognitive impairment

Safety Needs: (include tendency to wander, falls risk, smoking etc.)

Needs to use four wheeled walker at all times

Complete: ☒ Falls Risk Assessment and Management Plan (MR 521) within 24 hours

☒ Cognitive Impairment Assessment (MR66.4 AMTS) within 48 hours

Baseline Observations	**Date: 01/09/YY**	BP Lying: 126/86	BP Standing: 132/90
Temp: 36.5	Pulse: 72	Resp: 19	SaO^2: 98 %
Weight: 80kg	Height: 170cm	Pain Score: 2	Urine: N/A

Cultural & Communication Needs ☐ Interpreter required ☐ Interpreter arranged

Does the resident identify as being of:

Aboriginal or Torres Strait Islander origin? ☐ Yes ☒ No

A Culturally & Linguistically Diverse (CALD) background? ☐ Yes ☐ No

Does the resident have difficulty reading/writing English? ☐ Yes ☐ No

Glasses: ☐ No ☐ Yes ☐ 1 pair ☐ 2 pair

Hearing Aid/s: ☐ No ☐ Yes ☐ 1 ear ☐ 2 ear

Cultural considerations: ☐ Food ☐ Dress ☐ Healthcare ☐ Spirituality ☐ Lore

Advanced Health Directive / Not for Resuscitation Orders

☒ Advanced Health Directive ☒ Not for CPR (MR 39) ☒ End of Life Requests (RC 31)

☐ Enduring Power Guardianship ☒ Enduring Power of Attorney ☐ Future Care Plan discussed

Alerts – Allergies & Sensitivities

☐ Medication ☐ Food (Kitchen notified) ☐ Latex ☐ Tapes/Plasters ☐ Other ☐ MRSA ☒ Nil

Specify: None noted

Details:

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Current Medications: Complete MR170.1 Medication Management Plan (if required)

Is resident competent in self-administering medications? ☐ Yes ☒ No

If YES, complete Ability to Self-Medicate (RC26) Date of next review of competency:

Please ensure you have a list of current medications and directions from:

referral / hospital / pharmacy / family / resident ☒ Yes ☐ No

Pharmacy contacted – Medication Profile / Signing Sheets / Blister Packs available ☒ Yes

High Risk Medications: Is the resident on any high risk medications (A/PINCH) ☐ Yes ☒ No

☐ **A**nti-infectives ☐ **P**sychotropic ☐ **P**otassium ☐ **I**nsulins

☐ **N**arcotic (opioid) analgesics ☐ **C**hemotherapeutic agents ☐ **H**eparin / anticoagulants

☐ **>5 regular medications** – Needs review by Pharmacist / GP

Pain Assessment: If YES to pain, complete Pain Management Plan / Evaluation (RC 9 and RC 10)

Does the resident have pain? ☒ Yes ☐ No ☐ Acute ☒ Chronic

Location of pain: Lower back (left side)

Cause of pain: L5 S1 Disc bulge

What relieves the pain? ☐ Reposition ☐ Analgesia ☐ Ice ☒ Heat ☒ Other

What worsens pain? Sitting for long periods

☒ Pain Assessment required: Complete RC9 or Abbey Pain Scale for people who cannot verbalise

Behaviours / Mental State

Residents who have an identified behaviour of concern should have a full behaviour assessment. Complete 3 Day Behaviour Assessment (RC 13) and complete Behaviour Management Plan (RC 6)

Depression Score (from ACAT form): Delirium Screening (Complete AMTS MR 66.4)

Is behaviour and appearance appropriate / normal for the setting? ☒ Yes ☐ No

Does the resident have a diagnosed behavioural disorder / cognitive impairment / confusion? ☐ Yes ☒ No

Describe type: None noted

Describe the frequency of the behaviour, its severity, duration and patterns / triggers:

Describe any strategies that have been suitable to manage the behaviour:

Consultation with resident / representative / manager / doctor regarding restraint management

Restraint Authorisation (RC 43) includes Secure Environment – signed? ☐ Yes ☒ N/A

Other specific treatment orders / requirements:

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Sleep Complete 7 Day Sleep Assessment within 28 days of admission

Usual bed time: 20:00	Usual waking time: 08:00	Pattern of waking:
Does the resident usually wake during the night?		☒ Yes ☐ No
Sedation: ☐ Yes ☒ No	Type:	Time:

Settling routine or specific sleep requirements
(e.g. hot drink, position, number of pillows, medication, door shut, light off / on)

Hot pack and PRN pain medication if required

Nutrition / Malnutrition Complete referral to Speech Pathologist and / or Dietitian ☐

Complete Malnutrition Screening for all residents (MR 60.1.5)

Weight: 80 kg Height: 1.7m BMI: 27 (BMI = weight + height m^2 or weight + waist circumference)

Refer to: Elevated BMI Policy and if resident weighs > 120kg refer to WACHS Heavier Patient Policy

Special Requirements Complete Form RC 15 to notify catering staff

☒ Normal Diet ☐ Diabetic ☐ Low Salt ☐ High Fibre ☐ Vegetarian ☐ Low Fat

☐ Other:

Food Allergies / intolerances: None noted

Dietary Requirements:

RC 15 Dietary Preference completed ☒ Yes ☐ No Kitchen Notified ☒ Yes ☐ No

* May require a fluid balance chart / continence assessment form to monitor / adjust fluid intake

Dietary Spiritual / Cultural Needs (e.g. no pork)

N/A

Alcohol / Tobacco Complete Alcohol & Tobacco Screening (MR202E) as per Alcohol, Tobacco & Other Drugs Clinical Practice Standard.

If Resident wishes to smoke complete RC 29 High Risk Behaviour Consent and RC 6 Specific Care Plan

N/A

Swallowing Assessment Difficulty swallowing or 'at risk' for dysphagia ☐

If YES to any of the questions below refer to Speech Pathologist and / or Dietitian

a). Is unable to initiate food / fluid intake	☐ Yes ☒ No
b). Is unable to sit at the table to consume food	☐ Yes ☒ No
c). Coughs while eating / drinking	☐ Yes ☒ No
d). Takes a long time to chew and swallow each mouthful of food	☐ Yes ☒ No
e). Has food residue in their mouth after meals	☐ Yes ☒ No
f). Has obvious drooling from the mouth	☐ Yes ☒ No

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Oral Health Assessment Complete dental referral if required ☐

ORAL HEALTH TOOL	Healthy	Changes	Unhealthy
Lips	☒ Smooth, pink, moist	☐ Dry, chapped or red at corners	☐ Swelling or lump, red / white / ulcerated bleeding / ulcerated at corners
Tongue	☒ Normal moist, roughness, pink	☐ Patchy, fissured, red coated	☐ Patch that is red and / or white / ulcerated, swollen*
Gums and Oral Tissue	☒ Moist pink, smooth, no bleeding	☐ Dry, shiny, rough, red, swollen, sore, one ulcer / sore spot, sore under dentures	☐ Swollen, bleeding, ulcers / white red patches, generalized redness under dentures
Saliva	☒ Moist tissues, watery and free flowing	☐ Dry, sticky tissues, little saliva present, resident thinks they have a dry mouth	☐ Tissues parched and red very little / no saliva present, saliva is thick, resident thinks they have a dry mouth
Natural Teeth	☐ No decayed or broken teeth or roots	☒ 1-3 decayed or broken teeth roots, or teeth very worn down	☐ Four or more decayed or broken teeth / roots or fewer than 4 teeth, or very worn down teeth
Dentures	☒ No broken areas or teeth, worn regularly and named	☐ One broken area or tooth, or worn 1-2 hours per day only or not named	☐ One or more broken areas or teeth denture missing / not worn 1-2 hours per day only or not named
Oral Cleanliness	☐ Clean and no food particles or tartar in mouth or on dentures	☒ Food tartar, plaque 1-2 areas of mouth, or on small area of dentures	☐ Food particles, tartar, plaque most areas of mouth or on most of the dentures
Dental Pain	☒ No behavioural verbal or physical signs of pain	☐ Verbal and / or behavioural signs of pain such as pulling at face, chewing lips, not eating, changed behaviour	☐ Physical pain signs (swelling of cheek or gum, broken teeth, ulcers) as well as verbal and / or behavioural signs (pulling at face, not eating, changed behaviour)

Personal and Social History

(Complete RC 22 Personal and Social History and Interests within 28 days)

Provided by: ☒ Resident ☐ Family / Representative

Physical Assessment

Conscious State (alert, drowsy, night time status etc.)

Alert

Trunk (observe breathing, cough / sputum, rashes / lesions / sores, spinal curvature etc.)

Stooped posture due to back pain

Complete: ☒ Comprehensive Skin Assessment (MR 124B)

☒ Braden Assessment (MR 124) Braden Score: If < 18 Resident is at risk

Consider: ☐ Wound Management Plan (MR 122) & Pressure Injury/Skin Tear sticker in Progress Notes

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ACTIVITIES OF DAILY LIVING

Mobility / Transfer Assessment

Activity	Intervention Used				
Walking	Independent:	☒ Yes	**Assistance required**	☐ Yes	
	No. of assistants:	☐ One person	☐ Two persons		
	Type of aid:	☐ Walking stick	☒ Wheeled Zimmer	☐ Zimmer	
		☐ Wheelchair	☐ Walk belt	☐ Other:	
Lying to sitting on edge of bed	Independent:	☐ Yes	**Assistance required**	☒ Yes	
	No. of assistants:	☒ One person	☐ Two persons		
	Type of aid:	☐ Lift belt	☐ Hoist	☐ Pull up bar	
		☐ Other:			
Bed to chair / chair to bed	Independent:	☒ Yes	**Assistance required**	☐ Yes	
	No. of assistants:	☐ One person	☐ Two persons		
	Type of aid:	☐ Lift belt	☐ Hoist	☐ Other:	
Toileting	Independent:	☒ Yes	**Assistance required**	☐ Yes	
	No. of assistants:	☐ One person	☐ Two persons		
	Type of aid:	☐ Over toilet seat	☐ Commode	☐ Urinal	
Sitting to standing	Independent:	☒ Yes	**Assistance required**	☐ Yes	
	No. of assistants:	☐ One person	☐ Two persons		
	Type of aid:	☐ Lift belt	☐ Hoist	☐ Other:	
Positioning in bed	Independent:	☒ Yes	**Assistance required**	☐ Yes	
	No. of assistants:	☐ One person	☐ Two persons		
	Type of aid:	☐ Slide Sheet	☐ Hoist	☐ Pull up bar	
		☐ Other:			

Shower / Personal Care

	Independent	Minor Assist	Moderate Assist	Total Assist	Comments
Selects appropriate clothing	✓				
Selects appropriate toiletries and care items	✓				
Ambulates to bathroom	✓				
Sits / stands to shower	✓				
Organises shower (water temp, height of shower head)		✓			
Washes self: Partial or Full		✓			Detail:
Dries self: Partial or Full			✓		Detail: Needs help with lower half
Dress self: Partial or Full		✓			Detail / Sequencing: Needs help with socks and shoes

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Shower / Personal Care continued

	Independent	Minor Assist	Moderate Assist	Total Assist	Comments
Grooming of hair-brushing, daily assistance washing of hair	✓				Detail
Shaving	✓				Detail
Teeth / Dentures	✓				Detail Assistance required
Glasses / Hearing Aids	✓				Detail Assistance required
Splints / Callipers / Support Stockings / Prosthetics	N/A				
Nail Care – Hands / Feet		✓			Needs help with feet

Toileting / Bladder / Bowels Refer to Continence Advisor if applicable ☐

Does the resident have:	Urine	Bowels
Frequency / Leakage	☐	☐
Retention / Urgency	☐	☐
Constipation / Incontinence	☐	☐
Use continence aids	☐	☐
Long term / intermittent catheter	☐	☐
Stoma	☐	☐

If YES to any question, proceed to Form RC 17 Continence Assessment Form

Commence Form RC 18 (Three Day Bladder Chart) within 1 – 2 weeks of admission

Pad Usage Comments (i.e. size, type of pads, frequency of change, when used)

N/A

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Referrals Required

Specialist Include name, (private or public) and location	Date Identified	Date referral sent	Date attended
Physiotherapy	**01/09/YY**	**02/09/YY**	
Occupational Therapist			
Dietitian			
Optometrist			
Podiatrist	**01/09/YY**	**02/09/YY**	
Speech Pathologist			
Diabetes Educator			
Social Worker			
Geriatrician			
Seniors Mental Health			
Palliative Care			
Nurse Practitioner			
Dentist			
Other:			

Form Completed By

Admitting Nurse 1

Name (Please Print)	Designation	Sign	Date
Jean Smith	RN	J Smith	01/09/YY

Admitting Nurse 2

Name (Please Print)	Designation	Sign	Date

Resident and / or Representative involved in completion of Assessment

Name (Please Print)	Sign	Date
Ron Johnson	R Johnson	01/09/YY

Complete Resident Care Plan (RC 7) within 72 hours — Date commenced: 04/09/YY

All specific assessments to be completed within 21 days

For temporary changes and alterations in care use Specific Care Plan (RC 6)

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