Aut Even Hospital

Orthopaedic Department

Care Pathway for Total Knee Replacement.

Name	
Hospital Number	
Consultant/Surgeon	
Side	

User identification

Full Name (Print)	Title & Grade	Signature	Initials

Patient Property Disclaimer

I……being a patient of the Basingstoke and North Hampshire Hospital Foundation Trust, do not wish the hospital to take into Safe custody the money and valuables in my possession.

I understand this means that neither the North Hampshire Hospital NHS trust nor its staff can be held responsible for any loss or damage which may be incurred

Cash/Cheque Book/Credit Cards,etc…….....

…….....

Other items (eg TV)…….....

Ward/Department……Date of Admission…….....

Name of Patient…….....
(block capitals)
Signature of patient…… .....

Name and signature of witness…….....
(member of staff)

Guidelines For Completion of Care Pathway.

Anyone making an entry into the care plan must register in the front of the document

Sign in the appropriate space to confirm the prescribed care has been delivered and only document a problem/variation.

It is the responsibility of the team leader to co-ordinate the care, ensuring that the appropriate members of the team have delivered the prescribed care and completes the document and/or variations.

Variances should be recorded on the communication / variance boxes

If an accident/incident occurs to the patient, the relevant documentation should be completed and it should be record in communication/variance box on each page.

All questions should be completed; if they are not relevant for the patient then this should be stated.

Item marked with an asterisk (*), must have irrelevant information crossed out (i.e. Yes/No)

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Abbreviations

BP	Blood Pressures	NV	Neurovascular
CPM	Continuous Passive Movement	OT	Occupational Therapist
FBC	Full Blood Count	PCA	Patient controlled analgesia
G&S	Group and Save	Physio	Physiotherapist
GP	General Practitioner	SLR	Straight Leg Raise
Hb	Haemoglobin Blood	SQ	Static Quads
IRQ	Inner Range Quads	TPR	Temperature, Pulse and Respirations
IVI	Intravenous infusion	TTO's	To take out drugs
LMP	Last Menstrual period	U &Es	Urea & electrolyte Blood test
MUST	Malnutrition Universal Screening Tool	V	Variance
N/R	Not Required		

ACTS OF DAILY LIVING

ADDRESSOGRAPH

MOBILITY	Yes	No	
Can you move and walk independently?	☐	☐	
Do you use any mobility aids?	☐	☐	Sticks, Crutches, Walking frame, Wheelchair

HYGIENE	Yes	No	
Are you independent with washing and dressing?	☐	☐	
Do you use any aids?	☐	☐	Bath chair, bath board, sock aid, shoehorn, perching stool, raised toilet seat

Comments

ELIMINATION	Yes	No	
Do you have any problems with your bowels?	☐	☐	If yes what?
When did you last have your bowels open?			
Do you take any medication for your bowels	☐	☐	If yes what?
Do you have any problems passing urine?	☐	☐	
Do you get up at night to pass urine?	☐	☐	How many times?.....

Comments

NUTRITION	Yes No	
Do you have a good appetite?	☐ ☐	
Are you on any special diet?	☐ ☐	Diabetic, gluten free, low fat, low salt, Other.....
If you are a diabetic what type?	Diet, Tablet, Insulin controlled?	
Do you need any help eating or drinking?	☐ ☐	If yes what?
Do you wear dentures?	☐ ☐	Upper o Lower o
Have you got them with you	☐ ☐	
COMMUNICATION	Yes No	
Do you have any problems with your eyesight?	☐ ☐	If yes what?
Do you have any problems with your hearing?	☐ ☐	If yes what?
Do you have any problems with your speech?	☐ ☐	If yes what?
Any other problems with communication	☐ ☐	Language, Reading etc
Any other information you would like to tell us?		

ADMISSION DAY

Patients Name Date

Nursing	*Initials*	*Time*
Assess Patient and complete assessment form		
Check Patch test result		
Introduce care team and discuss named nurse concept		
Check x-rays, notes, blood results, blood transfusion or G&S for theatre are present on ward		
AV impulse system explained		
Measure and fit anti-embolitic stockings (NPT patients)		
Adequate regular medication available for discharge Yes / No*		
Discuss initial post op care		
Diets until .... Clear fluids until……		
Complete Braden□ M&H □ Must □ Thrombosis □ & Falls □ Assessment s		
Seen by anaesthetist Yes / No*		
Pre-medication prescribed Yes / No*		
Confirm planned discharge date ……..		
Own transport available Yes / No*		
Shopping, washing, cleaning help available.		
Temporary GP arranged if required		
Ideal Chair height & Chair position..... Ideal bed height……		
Rapid Response or Home from Hospital arranged Yes /No*		
Physiotherapy	*Initials*	*Time*
Check chest Gait analysis Assess ROM		
Check use of walking aids		
Occupational Therapist	*Initials*	*Time*
Discharge equipment issued Yes / No*		

Record TPR ,BP & Sats		
Record pain score		

Communication / Variance

THEATRE DAY PRE OPERATIVE

Patients Name Date

Nursing	*Initials*	*Time*
Administer routine drugs as directed by anaesthetist		
Check TPR and BP.		
Check Glucose levels and record if required.		
Bath / Shower.		
Anti-embolitic stockings fitted (NPT only) Yes / No*		
Prepare clean theatre bed.		
Limb marked Yes / No*		
A.V. Boots available Yes / No*		
Bed Labelled		
Consent form re- signed		
LMP form signed		
Theatre Check List complete		

Communication / Variance

THEATRE DAY POST OPERATIVE

Patients Name Date

Nursing	*Initials*	*Time*
Receive patient and report from recovery nurse		
Post op instructions		
Complete Braden□ M&H □ Assessments		
Passed Urine Time……..		
Commence oral fluids		
When fluids tolerated commence light diet		
Assisted wash and mouth care		
Physiotherapy	*Initials*	*Time*
Check chest Check quads control Yes / No*		
Circulatory exercise		

Time									
Record TPR & BP/ Sats									
NV state of affected limb									
Wound clean & dry									
AV impulse system									
Check Venflon / IVI									
Fluid balance chart maintained									
O^2 therapy									
PCA pump									
Record pain score									
Analgesia required									
Anti-emetic required									

Communication/ Variance

POST OPERATIVE DAY ONE

Patients Name Date

House Officer	*Initials*	*Time*
Assess patient and review analgesia Order FBC's and U & E's & check X-ray		
Assess fluid balance and need for IVI/Blood transfusion		
Nursing	*Initials*	*Time*
Complete Braden□ M&H □ Assessments		
Remove Redivac drains Yes/No/NA*		
Assist with hygiene/mouth care/ foot care.		
Normal diet and fluids		
Encourage to dress in day clothes		
Assess urinary output*		
Physiotherapist	*Initials*	*Time*
Check chest, encourage circulatory exercises Static Quads IRQ		
CPM required Yes/No …… Required range		
Commence Flexion Active ……Passive……		
Straight Leg raise Performed Yes/No* * Quads control Yes /No		
Mobilised with……. Distance……		
Occupational Therapy	*Initials*	*Time*
Flat/Car Assessment Required Yes/No* Discharge equipment issued Yes / No		

Time									
Record TPR & BP									
NV status of limb									
Dressing reduced									
Redivac drain									
AV impulse system									
Check venflon/ IVI									
Maintain fluid balance									
O^2 therapy									
Record pain score									
Analgesia required									
Anti-emetic required									
Pressure area care									
Ice /Board exercises									

Communication / Variance

POST OPERATIVE DAY TWO

Patients Name Date

House Officer	*Initials*	*Time*
Assess patient and review analgesia		
TTO's prescribed		
Assess fluid balance Check FBC's and U & E's		
Nursing	*Initials*	*Time*
TTO'S ordered		
Complete Braden□ M&H □ Assessments		
Assist with hygiene/ Mouth Care / dressing needs		
Normal diet and fluids		
Remove redivac drains Yes / No*		
Venflon removed Yes/ No / NA*		
Assess elimination problems and action		
Physiotherapist	*Initials*	*Time*
Check chest, encourage circulatory exercises Static Quads IRQ		
CPM required Yes/No …… Required range		
Commence Flexion Active ……Passive……		
Straight Leg raise Performed Yes/No* * Quads control Yes /No		
Mobilised with……. Distance……		
Occupational Therapist	*Initials*	*Time*
Flat/Car Assessment Required Yes/No* Discharge equipment issued Yes / No*		

Time									
Record TPR & BP									
Wound clean/dry									
AV impulse system									
Maintain fluid balance									
Record pain score									
Analgesia required									
Anti-emetic required									
Pressure area care									
Board Exercises									
Ice Therapy									

Communication / Variance

POST OPERATIVE DAY THREE

Patients Name Date

House Officer	*Initials*	*Time*
Assess patient		
Complete district spell, Complete Sick Certificate		
Check x-ray seen Yes / No*		
Nursing	*Initials*	*Time*
TTO's received Yes / No		
Complete Braden□ M&H □ Assessments		
Encourage independence with hygiene/dressing needs		
Normal diet and fluids		
Assess elimination problems and action		
Discuss discharge plans		
Physiotherapist	*Initials*	*Time*
Progress flexion Active……Passive……..		
CPM Required Yes/No* Required Range ……		
Mobilising with…….. Distance……..		
S Q IRQ SLR Encouraged Stairs Yes/No*		
Occupational Therapist	*Initials*	*Time*
Flat /Car assessment completed Yes/No* Discharge equipment issued Yes/No*		

Time									
Record TPR & BP									
Wound check									
AV impulse system									
Record pain score									
Analgesia required									
Anti-emetic required									
Pressure area care									
Board Exercises									
Ice Therapy									

Communication / Variance

POST OPERATIVE DAY FOUR

Patients Name Date

House Officer	*Initials*	*Time*
Assess patient All discharge paperwork completed		
Nursing	*Initials*	*Time*
Complete Braden and Moving & Handling Assessments		
Independent with hygiene/dressing needs		
Assess Elimination problems and action		
Confirm discharge plans		
Confirm 6 week follow-up appointment		
List any other relevant care problems		
Physiotherapist	*Initials*	*Time*
Progress Flexion Active …… Passive……..		
CPM required Yes/No * Required Range…….		
Mobilising with…… Distance……..		
Stairs Yes/No* Outpatients PT appointment. Arranged Yes/No*		
Occupational Therapist	*Initials*	*Time*
Flat / Car assessment completed Discharge equipment issued		

Time									
Record TPR & BP									
Record NV status									
Wound check									
AV impulse system									
Record pain score									
Analgesia required									
Anti-emetic required									
Pressure area care									
Board Exercises									
Ice Therapy									

Communication / Variance

POST OPERATIVE DAY FIVE

Patient name Date

House Officer	*Initials*	*Time*
Assess patient All discharge paperwork completed		
Nursing	*Initials*	*Time*
Complete Braden and Moving & Handling Assessments		
Independent with hygiene/dressing needs		
Assess Elimination problems and action		
Confirm discharge plans		
Confirm 6 week follow-up appointment		
List any other relevant care problems		
Physiotherapist	*Initials*	*Time*
Progress Flexion Active …… Passive……..		
CPM required Yes/No * Required Range……..		
Mobilising with…… Distance……..		
Stairs Yes/No* Outpatients PT appointment. Arranged Yes/No*		
Occupational Therapist	*Initials*	*Time*
Flat / Car assessment completed Yes / No* Discharge equipment issued Yes./No*		

Time									
Record TPR & BP									
Record NV status									
Wound check									
AV impulse system									
Record pain score									
Analgesia required									
Board Exercises									
Ice Therapy									
Pressure area care									

Communication / Variance

POST OPERATIVE DAY SIX

Patient name Date

House Officer	*Initials*	*Time*
Assess patient All discharge paperwork completed		
Nursing	*Initials*	*Time*
Complete Braden and Moving & Handling Assessments		
Independent with hygiene/dressing needs		
Assess Elimination problems and action		
Confirm discharge plans		
Confirm 6 week follow-up appointment		
List any other relevant care problems		
Physiotherapist	*Initials*	*Time*
Progress Flexion Active …… Passive……..		
CPM required Yes/No * Required Range……..		
Mobilising with…… Distance……..		
Stairs Yes/No* Outpatients PT appointment. Arranged Yes/No*		
Occupational Therapist	*Initials*	*Time*
Flat / Car assessment completed Yes / No* Discharge equipment issued Yes./No*		

Time									
Record TPR & BP									
Record NV status									
Wound check									
AV impulse system									
Record pain score									
Analgesia required									
Board Exercises									
Ice Therapy									
Pressure area care									

Communication / Variance

ASSESSMENTS

FALLS RISK ASSESSMENT TOOL (ADULT)

Patients Name

Likelihood Score: During admission how likely is it that one of the below will increase the risk of your patient falling ?

a. Unlikely then score = 1
b. May fall then score = 2
c. Very likely then score = 3

		Score	Assessment 1 Score x Likelihood = Total	Assessment 2 Score x Likelihood = Total	Assessment 3 Score x Likelihood = Total
1.History of falls (In past 12 months)	None	0			
	One	1			
	More than One	2			
2. Medical Predisposition (see opposite)	None	0			
	One	1			
	More than One	2			
3. Medication (see opposite)	None	0			
	One to Three	1			
	Four Plus	2			
4. Symptoms (see opposite)	None	0			
	One to Three	1			
	Four plus	2			
5. Mobility	Walks Independently	0			
	Does not attempt to walk	0			
	Walks assisted / with aid	1			
	Holds onto furniture	1			
	Forgets, declines or uses aid badly	2			
	Unsafe transferring	2			
6. Activity	House / bed / chair bound	0			
	Walks occasionally	1			
	Walks frequently	2			
7. Continence	Independent / wearing appliance	0			
	Nocturia	1			
	Urgency	2			
8. Mental state / Co -operation level	Good	0			
	Fair	1			
	Poor	2			
9. Diabetic	No	0			
	Yes	2			
10. Diet & Hydration	Normal	0			
	Poor Intake	2			
11. Sensory Impairment	No	0			
	Yes	2			
12. Fear of falling	No	0			
	Yes	2			
13. Osteoarthritis	No	0			
	Yes	2			
14. Number of fractures	None	0			
	One	1			
	More than One	2			

Assessment 1

Risk score
Low
Med
High
(please✓one)

Sign
Print
Date

Assessment 2

Risk score
Low
Med
High
(please✓one)

Sign
Print
Date

Assessment 3

Risk score
Low
Med
High
(please✓one)

Sign
Print
Date

Update weekly until stable.

Review immediately if patient falls or becomes confused

Risk Scores

0 - 28 LOW

29 -56 MEDIUM

57 - 84 HIGH

FALLS RISK ASSESSMENT TOOL (ADULT)

Patient Name

Step 1– Complete for all patients at risk

Box 1– Low risk criteria
Score 0-28

	Needed	Achieved	Signed	Date
Education for prevention of falls				
Leaflets				
Educate Patients: Family Friends/ Carer				
Assess patient footwear				
Assess patient environment				
Exercise Class : Balance Training				
Functional Movement				

STEP 2 Discuss with patient and consider the following referrals:

Assessment 1	Referred
Podiatry	
Occupational Therapy	
Dietetics	
Physiotherapy	
Audiology	
Opthalmology	
Orthotics	
GP / Consultant	
Pharmacy	

Assessment 2	Referred
Podiatry	
Occupational Therapy	
Dietetics	
Physiotherapy	
Audiology	
Opthalmology	
Orthotics	
GP / Consultant	
Pharmacy	

Assessment 3	Referred
Podiatry	
Occupational Therapy	
Dietetics	
Physiotherapy	
Audiology	
Opthalmology	
Orthotics	
GP / Consultant	
Pharmacy	

STEP 3 Complete for all patients with medium to high risk score

Box 2 Medium to High risk criteria
Sore 29—84

	Needed	Achieved	Signed	Date
Increased Observation				
Require 1:1 Nursing				
Special Footwear				
Low Bed				
Medication review				

Assessment 1

Refer to Social Services

Sign
Print
Date

Assessment 2

Refer to Social Services

Sign
Print
Date

Assessment 3

Refer to Social Services

Sign
Print
Date

Medical Predisposition examples

Postural Hypotension
Arrhythmia
TIA / Stroke
Epilepsy
Vertigo
Neurological Disease
Dementia - Lewy Body
Anxious
Agitated
Acute confusion
Alcohol misuse / withdrawal
High / low BMI score

Other

Medical examples

Hypnotics
Sedatives
Diuretics
Anti-Hypertensives
Some anti - depressants
Psychotropic
More than four medications

Other

Symptom examples

Pain
Limited joint mobility
Muscle weakness
Poor balance
Giddiness
Dyskinesia
Impaired eyesight
Abnormal gait
Other

BRADEN SCALE ASSESSMENT

Patients Name

Braden scale risk assessment	Date	REASSESSMENTS				RATIONALE for score	Initials	Date
Sensory Perception - Ability to respond meaningfully								
Completely Limited	1							
Very Limited	2							
Slightly Limited	3							
No Impairment	4							
Moisture - degree to which skin is exposed to moisture								
Constantly moist	1							
Very moist	2							
Occasionally moist	3							
Rarely moist	4							
Activity- degree of physical activity								
Bed bound	1							
Chair bound	2							
Walks occasionally	3							
Walks frequently	4							
Mobility- ability to change and control body position								
Completely immobile	1							
Very limited	2							
Slightly limited	3							
No limitations	4							
Nutrition- Usual food intake pattern								
Very poor	1							
Probably inadequate	2							
Adequate	3							
Excellent	4							
Friction and Shear								
Problem	1							
Potential problem	2							
No apparent problem	3							
Excellent	4							
	Total							
Signature / Designation								

Risk Score **Mild 15-18** **Moderate 12 - 14** **Severe < 11**

Braden Scale Notes on Completion

The assessment form should be completed by a trained member or staff

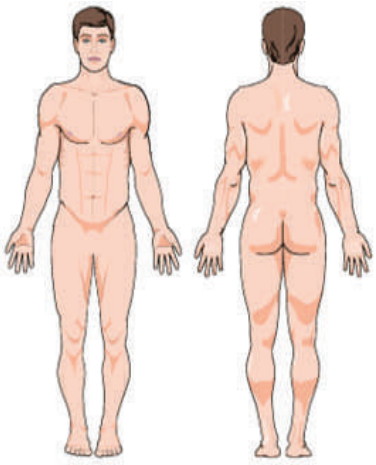
Reassessment

- The date should be entered at the top of the reassessment column.
- Allocate one score to each section then total at the bottom
- Carry out reassessment at least daily for first 5 days then alternate for at least the following 15 days
- Change frequency according to professional judgement
- Reassess post - operatively
- Reassess if any changes in patient condition

Rationale

- Enter brief account to support score.

A = Abrasion
B = Burns
C = Contusions
D = Dislocations
F = Fracture
H = Haemorrhage
L = Laceration
N = Numbness
P = Pain
S = Swelling
Pa = Paralysis
U = Ulcer



BRADEN SCALE ASSESSMENT

Patients Name

Braden scale risk assessment	Date	REASSESSMENTS				RATIONALE for score	Initials	Date
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Very Limited	2							
Slightly Limited	3							
No Impairment	4							
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Constantly moist	1							
Very moist	2							
Occasionally moist	3							
Rarely moist	4							
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Bed bound	1							
Chair bound	2							
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Walks frequently	4							
Mobility- ability to change and control body position								
Completely immobile	1							
Very limited	2							
Slightly limited	3							
No limitations	4							
Nutrition- Usual food intake pattern								
Very poor	1							
Probably inadequate	2							
Adequate	3							
Excellent	4							
Friction and Shear								
Problem	1							
Potential problem	2							
No apparent problem	3							
Excellent	4							
	Total							
Signature / Designation								

Risk Score **Mild 15-18** **Moderate 12 - 14** **Severe < 11**

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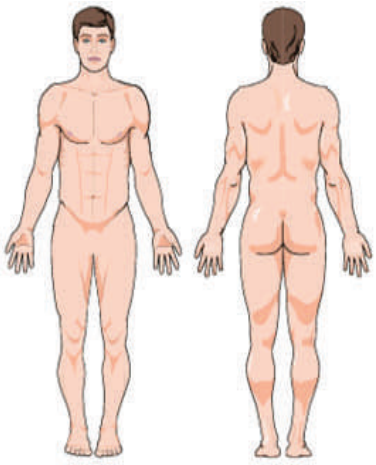


MALNUTRITION ASSESSMENT (ADULT)

MALNUTRITION UNIVERSAL SCREENING TOOL
Complete for all patients (tick one of the following) **Pre-assessment clinic** ☐ **Within 24 hours of admission** ☐

Initial	Date

Step 1
Calculate BMI Score
Using BMI score chart

BMI	Score
> 20	0
> 30 (Obese)	0
18.5 - 19.9	1
< 18.5	2

Step 2
Weight Loss Score
Calculate unplanned weight loss during last 6 months

%	Score
5 %	0
5 - 10%	1
> 10%	2

Step 3
Acute Disease Score
If patient is acutely ill **AND** they have had or are likely to have no nutritional intake for more than 5days:

%	Score
Yes	2
No	0

Step 4
Overall Risk of Malnutrition
Add Scores

BMI Score	
Weight Loss Score	
Acute Disease Score	
Total Score	

Step 5

Score 0 = Low Risk

- Routine Clinical Care
- Repeat screen on weekly basis during hospital admission

Score 1 = Medium Risk

- Observe
- Document 3 day dietary intake
- If intake improves - no further action
- If intake remains poor - encourage regular meals& nourishing snacks / drinks between meals
- Repeat screen on weekly basis during hospital admission

Score 2 or more = High Risk

Treat and Refer*

- Refer all patients to dietitian for assessment and advice
- Repeat screen on weekly basis during hospital admission
- Unless detrimental or no benefit expected from nutritional support (e g. imminent death)

All risk categories:

- Treat underlying condition and provide help and advice on food choice, eating and drinking.
- Record screen outcome on table below

Obesity

- For patients who are obese, the underlying condition is generally controlled before treating obesity.
- Obese patients are at risk of malnutrition and still require MUST to be completed.

Malnutrition Universal Screening Tool Record Chart
Complete the malnutrition screening tool once a week and document the information below:

	Weight or MUAC	BMI*	Step 1 Score	Step 2 Score	Step 3 Score	Step 4 Total Score	Dietitian/ Nutrition support team referral	Special dietary needs	Next screen date
Example 02/02/04	45 kg	18	2	1	0	3	(Tick if referred) ✓	Diabetic	09/02/04
									Date

Document calculations for weight adjustment before BMI is calculated, e..g Oedema, Ascites, Plaster Cast, amputation

Thrombosis Risk assessment

Patient Name

Thrombosis Risk Factor Assessment : Body Weight

Diagnosis / Type of Surgery	
Elective / Emergency Admission	

AV Boots Required YES NO
Applied YES NO
If No - Reason:

Please tick (✓) all relevant boxes (Each risk factor has a value of one (1) unless otherwise stated)

- Age 41 to 60
- Age 61 to 70 (Score 2)
- Age 70 or over (Score 3)
- Varicose veins
- Obesity
- MI / CHF / AF / CVA
- Malignancy
- History of DVT / PE (Score 3)
- Planned surgery > 2 hours
- Recent orthopaedic surgery > 2 hours
- Leg oedema / Ulcers / Stasis
- Leg oedema / Ulcers / Stasis
- Hormone therapy HRT / Cons. Pill (Score 2)
- Hypercoagulable states (SLE)
- Severe COAD
- Anticipated bed confinement > 72 hours
- Previous immobilisation > 72 hours
- Inflammatory bowel disease
- Previous major surgery < 3 months
- Confining travel air / rail / road > 4 hours
- Pregnancy / Post partum < 1 month
- Recent pelvic / long bone fractures

< 1 factor = Low Risk	1 Factor = Medium Risk	> 2 factors = High Risk
• No preventative measures needed • Early ambulation required • Re-assess if condition alters	• Anti - embolic stockings • Early ambulation required	• Anti - embolic stockings • Early ambulation required • Enoxaparin /Discuss with Med .Team

Contra - Indications

Anti - Embolic Stockings

- Severe Arteriosclerosis or other ischaemic vascular disease (unless advised by a Consultant Doctor)
- Patients with local leg conditions e.g. dermatitis, gangrene, recent skin graft
- Excessive leg oedema or pulmonary oedema (from congestive heart failure)
- Extreme deformity of the legs
- Thigh leg stockings should not be used if thigh circumference is greater than listed fitting instructions

Heparin

- IV Heparin therapy in progress
- Bleeding disorders, platelet imbalance
- Patient with active GI bleed
- Patient with history of haemorrhagic stroke
- All ENT / Opthalmology patients (unless advised by a Consultant Doctor)

Patient Measurements

Rt. Ankle	Rt.Calf	Rt. Thigh	Rt. Leg length
Lt.. Ankle	Lt. Calf	Lt. Thigh	Lt. Leg length
Stocking selected		Date fitted :	Date removed:

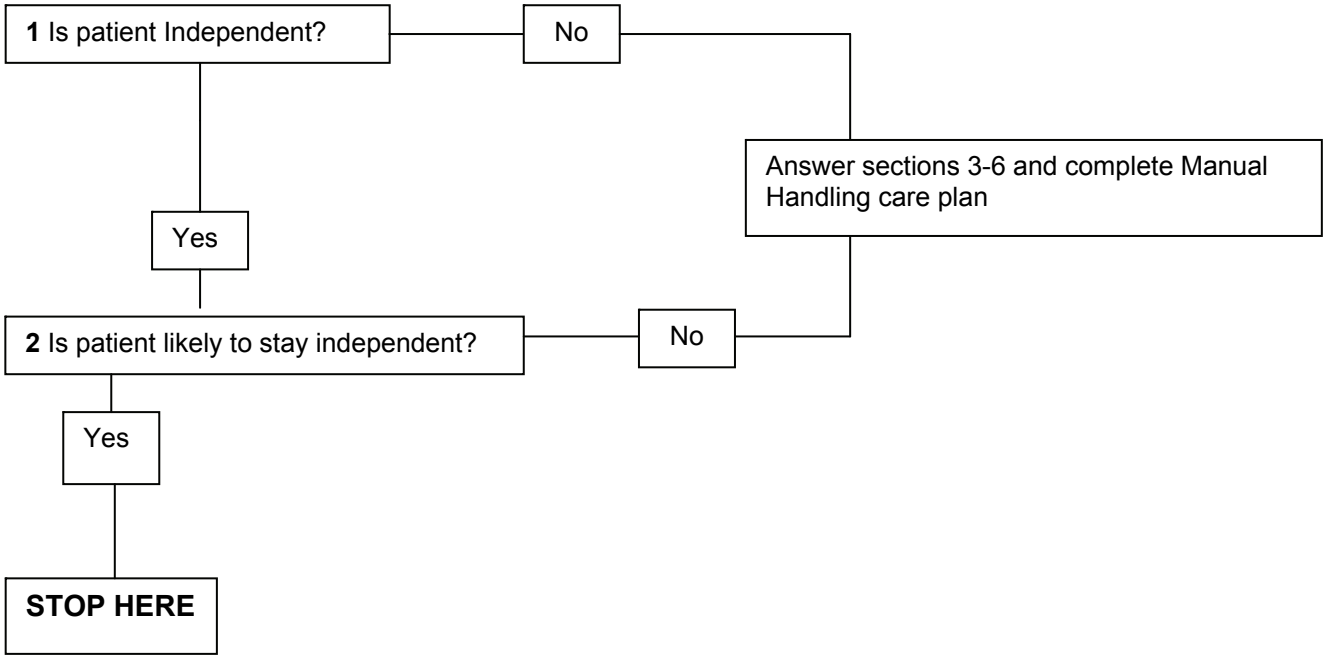
Reason for removal :

Pre op / Admitting Nurse (please circle as appropriate)
Sign_____ Date & Time_____

BASINGSTOKE AND NORTH HAMPSHIRE NHS FOUNDATION TRUSTS NHS TRUST
DETAILED RISK ANALYSIS FOR THE MOVING, HANDLING & TRANSFERRING PATIENTS

PATIENT DETAILS		
Patient Label:	Age:	History of Falls? Yes / No
	Weight: Kg	Mobility Aid Used? Yes/No If Yes What type?
	BMI	Braden Score
Diagnosis (Where Known)		

PATIENT ABILITY – ALGORITHM



		Initial Assessment		Revised Assessment (1)		Revised Assessment (2)	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
3	Patient aware of surrounds: may have ability to assist to some degree						
4	Patient able to assist in a limited way: but may be uncooperative or likely to behave unpredictably						
5	Patient is unable to assist in any way: may be unconscious: should be considered as a "dead weight"						
6	Patient is unable to assist in any way and is likely to behave unpredictably						
	Assessor's signature						
	Date and time						

	Date:			Date:		
	No of Staff Required	**Equipment Required**	**Specific Manoeuvre**	No of Staff Required	**Equipment Required**	**Specific Manoeuvre**
Turning in bed						
Moving up/down bed						
Sit to Stand / Vice - versa						
Walking						
Toileting						
Bathing						
	Name:		**Signature:**	**Name:**		**Signature:**
	Date:			**Date:**		
	No of Staff Required	**Equipment Required**	**Specific Manoeuvre**	No of Staff Required	**Equipment Required**	**Specific Manoeuvre**
Turning in bed						
Moving up/down bed						
Sit to Stand / Vice - versa						
Walking						
Toileting						
Bathing						
	Name:		**Signature:**	**Name:**		**Signature:**

	Date:			Date:		
	No of Staff Required	**Equipment Required**	**Specific Manoeuvre**	No of Staff Required	**Equipment Required**	**Specific Manoeuvre**
Turning in bed						
Moving up/down bed						
Sit to Stand / Vice - versa						
Walking						
Toileting						
Bathing						
	Name:		**Signature:**	**Name:**		**Signature:**

Sling Inspection *		Size * (S) (M) (L) (XL)		Arjo/Liko*		Disposable/non Disposable*	
Attachment Points intact	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Sling Free from Damage	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
All stitching intact	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
W/C / /	Sun	Mon	Tue	Wed	Thur	Fri	Sat
W/C / /	Sun	Mon	Tue	Wed	Thur	Fri	Sat
W/C / /	Sun	Mon	Tue	Wed	Thur	Fri	Sat
W/C / /	Sun	Mon	Tue	Wed	Thur	Fri	Sat
(*) Delete as appropriate	**Please initial relevant day following completion of sling inspection**						

DISCHARGE CHECK LIST

Patients Name

For Patients/ Carers	Information	Signature	Date
Written advice give to patient			
Patient care discussed with family /carer			
Family carer advised of discharge date			
Property retuned from safe	Yes / No Type:		
Patient has outdoor clothing for travelling home e.g. footwear			
House keys			
Heating turned on			
Food available			
Equipment installed in patient home			
TTO's	**Information**	**Signature**	**Date**
Prescription ordered /dispensed			
Patient able to administer medication			
Medication instruction discussed and understood by patient / carer			
Medication devise egg NOMAD or Dossette box NOMAD ordered..... Dossette filled by.....			
Transport		**Signature**	**Date**
Own transport			
Hospital transport booked	Date Time Type		
Transport notified patient taking equipment with them	Yes / No		
Community Services	**Information**	**Signature**	**Date**
District Nurse CPN referral completed Given to patient/faxed/sent/telephoned			
Dressing catheter pack and equipment provided (7 days provision)			
GP letter given / faxed/ sent / telephoned			
Care package in place or restarted			
Appointments	**Information**	**Signature**	**Date**
Physiotherapy appointment Yes / No			
Given to patient / sent			
Community Physiotherapy required Yes/No			
Safe for discharge	**Information**	**Signature**	**Date**
Venflon removed			
Patient / Carer Signature Date Time			
Nurse discharging Signature Date Time			