Test of Competence: Supporting Documents
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</tbody>
</table>
Purpose

This document contains some supporting documents which may be used in the NMC Test of Competence (ToC 21). It is intended for candidates to have the opportunity to become familiar with these supporting documents prior to them taking the ToC 21.
<table>
<thead>
<tr>
<th>Surname:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename(s):</td>
<td>Height (m):</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Weight (kg):</td>
</tr>
<tr>
<td>NHS number:</td>
<td>Body mass index (BMI) (kg/m²):</td>
</tr>
<tr>
<td>GP Name:</td>
<td>Surgery address:</td>
</tr>
</tbody>
</table>

Number of prescription records: Chart 1 2 3 4 of 1 2 3 4

**Details of prescribers: must be completed by ALL prescribers**

<table>
<thead>
<tr>
<th>NAME</th>
<th>GMC/NMP Number</th>
<th>Signature</th>
<th>Contact details</th>
</tr>
</thead>
</table>

| Details of person administering medication: must be completed by ALL administering medication |
| --- | --- | --- | --- |
| NAME | Initials | Signature | Base |

**ALERTS: Allergies/sensitivities/adverse reaction**

<table>
<thead>
<tr>
<th>Medicine(s)/substance</th>
<th>Effect(s)</th>
</tr>
</thead>
</table>

IF NO KNOWN ALLERGIES TICK BOX ☐

| Signature: | Contact number | Tel: | Date: |

Allergy status MUST be completed and SIGNED by a prescriber/pharmacist/nurse BEFORE any medicines are administered.

**Medication risk factors**

- Pregnancy ☐
- Renal impairment ☐
- Impaired oral access ☐
- Diabetes ☐
- Other high-risk conditions ☐ – specify
- Patient self-medicating ☐

V.5 Updated July 2024
## Community Medication Prescription and Administration Record

<table>
<thead>
<tr>
<th>Surname:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename(s):</td>
<td>Height (m):</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Weight (kg):</td>
</tr>
<tr>
<td>NHS number:</td>
<td>Body mass index (BMI) (kg/m²):</td>
</tr>
</tbody>
</table>

| GP Name: | Surgery address: |

### Information for Prescribers:

- **Write in BLOCK CAPITALS using black or blue ink.**
- **Sign and date and include bleep number.**
- **Record detail(s) of any allergies.**
- **Sign and date allergies box. Tick box if no allergies know.**
- **Different doses of the same medication must be prescribed on different lines.**
- **Cancel by putting a line across the prescription and sign and date.**
- **Indicate the start and finish date where appropriate.**

### Medicine non-administration/self-administration:

1. **Medicine unavailable** – **INFORM DOCTOR OR PHARMACIST**
2. **Patient not present at time of administration**
3. **Self-administration**
4. **Unable to administer** – **INFORM DOCTOR** (alternative route required?)
5. **Stat dose given**
6. **Prescription incorrect/unclear**
7. **Patient refused**
8. **Nil by mouth** (on doctor’s instruction only)
9. **Low pulse and/or low blood pressure**
10. **Other** – state in nursing notes including action taken

### Community Patient-Specific Direction

<table>
<thead>
<tr>
<th>Date</th>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
<th>Frequency</th>
<th>End date</th>
<th>Prescriber name &amp; date</th>
<th>Given by: Sign date &amp; time</th>
<th>Pharmacy check</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

**Instruction/Indication:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Drug</th>
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**Instruction/Indication:**

V.5 Updated July 2024
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<th>Time</th>
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<th>Given by: Sign date &amp; time</th>
<th>Pharmacy check</th>
</tr>
</thead>
</table>

**COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD**

Surname:  
Forename(s):  
Date of birth:  
NHS number:  
Address:  
Height (m):  
Weight (kg):  
Body mass index (BMI) (kg/m²):  

**GP Name:**  
Surgery address:  

**Instruction/Indication:**

<table>
<thead>
<tr>
<th>Date</th>
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<th>Route</th>
<th>Time</th>
<th>Frequency</th>
<th>End date</th>
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<th>Route</th>
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<th>End date</th>
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<th>Given by: Sign date &amp; time</th>
<th>Pharmacy check</th>
</tr>
</thead>
</table>
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<table>
<thead>
<tr>
<th>Surname:</th>
<th>Forename(s):</th>
<th>Address:</th>
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</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>Height (m):</td>
<td>Weight (kg):</td>
</tr>
<tr>
<td>NHS number:</td>
<td>Body mass index (BMI) (kg/m$^2$):</td>
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</table>

<table>
<thead>
<tr>
<th>GP Name:</th>
<th>Surgery address:</th>
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</table>

**OMITTED DOSES OF MEDICINE AND DELAYED DOSES**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Instructions</th>
<th>Reason for omission or delay &gt;2 hours</th>
<th>Signature</th>
<th>Pharmacy check</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
## HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD

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<th>Surname:</th>
<th>Height (m):</th>
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</thead>
<tbody>
<tr>
<td>Forename(s):</td>
<td>Weight (kg):</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Body mass index (BMI) (kg/m²):</td>
</tr>
<tr>
<td>Hospital/NHS number:</td>
<td></td>
</tr>
<tr>
<td>Ward:</td>
<td>Consultant:</td>
</tr>
<tr>
<td>Date of admission:</td>
<td>Time of admission:</td>
</tr>
</tbody>
</table>

**Number of prescription records**

<table>
<thead>
<tr>
<th></th>
<th>Chart 1</th>
<th>2</th>
<th>3</th>
</tr>
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<tbody>
<tr>
<td>Number of prescription records</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### All prescribers MUST complete the signature record

<table>
<thead>
<tr>
<th>NAME</th>
<th>GMC/NMC Number</th>
<th>Signature</th>
<th>Bleep</th>
<th>NAME</th>
<th>GMC/NMC Number</th>
<th>Signature</th>
<th>Bleep</th>
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<tbody>
<tr>
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</tbody>
</table>

### Details of person administering medication: must be completed by ALL administering medication

<table>
<thead>
<tr>
<th>NAME</th>
<th>Initials</th>
<th>Signature</th>
<th>Base</th>
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</thead>
<tbody>
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</tr>
</tbody>
</table>

### ALERTS: Allergies/sensitivities/adverse reaction

<table>
<thead>
<tr>
<th>Medicine(s)/substance</th>
<th>Effect(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**IF NO KNOWN ALLERGIES TICK BOX**

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Bleep number:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Allergy status MUST be completed and SIGNED by a prescriber/pharmacist/nurse BEFORE any medicines are administered.

### Medication risk factors

<table>
<thead>
<tr>
<th>Pregnancy</th>
<th>Renal impairment</th>
<th>Impaired oral access</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Other high-risk conditions** – specify

Patient self-medicating

---

V.5 Updated July 2024
**HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD**

<table>
<thead>
<tr>
<th><strong>Surname:</strong></th>
<th><strong>Height (m):</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Forename(s):</strong></td>
<td><strong>Weight (kg):</strong></td>
</tr>
<tr>
<td><strong>Date of birth:</strong></td>
<td><strong>Body mass index (BMI) (kg/m^2):</strong></td>
</tr>
<tr>
<td><strong>Hospital/NHS number:</strong></td>
<td><strong>Ward:</strong></td>
</tr>
<tr>
<td><strong>Consultant:</strong></td>
<td><strong>Date of admission:</strong></td>
</tr>
<tr>
<td><strong>Time of admission:</strong></td>
<td><strong>Date of admission:</strong></td>
</tr>
</tbody>
</table>

**Information for prescribers:**

<table>
<thead>
<tr>
<th>Medicine non-administration/self-administration:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write in BLOCK CAPITALS using black or blue ink.</td>
</tr>
<tr>
<td>If a dose is omitted for any reason, the nurse should enter the relevant code on the administration record and sign the entry.</td>
</tr>
<tr>
<td>Sign and date and include bleep number.</td>
</tr>
<tr>
<td>Record detail(s) of any allergies.</td>
</tr>
<tr>
<td>1. Medicine unavailable – INFORM DOCTOR OR PHARMACIST</td>
</tr>
<tr>
<td>2. Patient off ward</td>
</tr>
<tr>
<td>Sign and date allergies box. Tick box if no allergies know.</td>
</tr>
<tr>
<td>3. Self-administration</td>
</tr>
<tr>
<td>4. Unable to administer – INFORM DOCTOR (alternative route required?)</td>
</tr>
<tr>
<td>Different doses of the same medication must be prescribed on different lines.</td>
</tr>
<tr>
<td>5. Stat dose given</td>
</tr>
<tr>
<td>6. Prescription incorrect/unclear</td>
</tr>
<tr>
<td>Cancel by putting a line across the prescription and sign and date.</td>
</tr>
<tr>
<td>7. Patient refused</td>
</tr>
<tr>
<td>8. Nil by mouth (on doctor’s instruction only)</td>
</tr>
<tr>
<td>Indicate the start and finish date where relevant.</td>
</tr>
<tr>
<td>9. Low pulse and/or low blood pressure</td>
</tr>
<tr>
<td>10. Other – state in nursing notes including action taken</td>
</tr>
</tbody>
</table>

**ONCE-ONLY MEDICINES, PREMEDICATION, ANTIBIOTIC PROPHYLAXIS AND PATIENT GROUP DIRECTIONS**

<table>
<thead>
<tr>
<th><strong>Check allergies/sensitivities and patient identity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
</tr>
<tr>
<td>-----------</td>
</tr>
</tbody>
</table>
## Hospital Medication Prescription and Administration Record

<table>
<thead>
<tr>
<th>Surname:</th>
<th>Height (m):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename(s):</td>
<td>Weight (kg):</td>
</tr>
<tr>
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<td>Date of admission:</td>
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</tbody>
</table>

### Prescribed Oxygen

For most chronic conditions, oxygen should be prescribed to achieve a target saturation of 94–98% (or 88–92% for those at risk of hypercapnic respiratory failure i.e. CO₂ retainers.)

Is the patient a known CO₂ retainer? Yes [ ] No [ ]

- Continuous oxygen therapy [ ]
- ‘When required’ oxygen therapy [ ]
- Target O₂ saturation 88-92% [ ]
- Target O₂ saturation 94-98% [ ]
- Other saturation range: [ ]
  - Saturation not indicated e.g. end-of-life care (state reason) [ ]

If oxygen is in progress, check and record flow rate (FR) during clinical observations.

#### Starting device and flow rate:

<table>
<thead>
<tr>
<th>Administrator’s signature:</th>
<th>Print name:</th>
<th>Date</th>
<th>Time</th>
<th>FR/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start date:</td>
<td></td>
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#### Prescriber’s signature:

<table>
<thead>
<tr>
<th>Stop date:</th>
<th>Pharmacy check:</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

#### Print name:

<table>
<thead>
<tr>
<th>Codes for starting device and modes of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air not requiring oxygen or weaning or PRN oxygen</td>
</tr>
<tr>
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<td>Venturi 60</td>
</tr>
<tr>
<td>Patient on NIV system</td>
</tr>
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</table>

### Antimicrobials

Check allergies/sensitivities and patient identity

Review IV after 24-48 hours – Review oral after 5-7 days

| 1.Drug | | |
| Signature of nurse administering medications and code and signature if not administered. |

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<thead>
<tr>
<th>Date</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Duration</th>
<th>Time</th>
<th>Today</th>
<th>Tomorrow</th>
<th>Pharmacy check</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Start date</td>
<td>Indication/ Organism</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Finish date</td>
<td>Cultures sent?</td>
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</tr>
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#### Print name:

V.5 Updated July 2024
**HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD**

<table>
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<tr>
<th>Surname:</th>
<th>Height (m):</th>
</tr>
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<tbody>
<tr>
<td>Forename(s):</td>
<td>Weight (kg):</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Body mass index (BMI) (kg/m²):</td>
</tr>
<tr>
<td>Hospital/NHS number:</td>
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<tr>
<td>Ward:</td>
<td>Consultant:</td>
</tr>
<tr>
<td>Date of admission:</td>
<td>Time of admission:</td>
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**Check allergies/sensitivities and patient identity**

<table>
<thead>
<tr>
<th>Date</th>
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<th>Frequency</th>
<th>Route</th>
<th>Duration</th>
<th>Time</th>
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<th>Tomorrow</th>
<th>Pharmacy check</th>
</tr>
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<tbody>
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<tr>
<td>Finish date</td>
<td>Cultures sent?</td>
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**Check allergies/sensitivities and patient identity**

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<th>Route</th>
<th>Duration</th>
<th>Time</th>
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<th>Tomorrow</th>
<th>Pharmacy check</th>
</tr>
</thead>
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</tr>
<tr>
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<td>Indication/Organism</td>
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**REGULAR MEDICINES**

**Check allergies/sensitivities and patient identity**

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<th>Tomorrow</th>
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<th>Notes</th>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start date</td>
<td>Instructions / indication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
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V.5 Updated July 2024
# HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD

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<tbody>
<tr>
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<td>Weight (kg):</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Body mass index (BMI) (kg/m²):</td>
</tr>
<tr>
<td>Hospital/NHS number:</td>
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<tr>
<td>Ward:</td>
<td>Consultant:</td>
</tr>
<tr>
<td>Date of admission:</td>
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## Check allergies/sensitivities and patient identity

### 2. Drug

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<th>Time</th>
<th>Today</th>
<th>Tomorrow</th>
<th>Pharmacy check</th>
<th>Notes</th>
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<tr>
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### 3. Drug

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<th>Notes</th>
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</thead>
<tbody>
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<td>Instructions / indication</td>
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### 4. Drug

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<td>Instructions / indication</td>
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</table>
# HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD

<table>
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<th>Surname:</th>
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<tr>
<td>Hospital/NHS number:</td>
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<tr>
<td>Ward:</td>
<td>Consultant:</td>
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<tr>
<td>Date of admission:</td>
<td>Time of admission:</td>
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## ‘AS-REQUIRED’ MEDICINES

Check allergies/sensitivities and patient identity

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<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Duration</th>
<th>Time</th>
<th>Today</th>
<th>Tomorrow</th>
<th>Pharmacy check</th>
<th>Notes</th>
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</thead>
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<td>Instructions / indication</td>
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<td>Prescriber’s signature and bleep</td>
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## Check allergies/sensitivities and patient identity

<table>
<thead>
<tr>
<th>Date</th>
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<th>Time</th>
<th>Today</th>
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</thead>
<tbody>
<tr>
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<tr>
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## Check allergies/sensitivities and patient identity

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<th>Today</th>
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<tr>
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<tr>
<td>Prescriber’s signature and bleep</td>
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<td>Supply at home</td>
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</tr>
</tbody>
</table>
### Hospital Medication Prescription and Administration Record

#### Surname: [Surname]
#### Forename(s): [Forename(s)]
#### Date of birth: [Date of birth]
#### Hospital/NHS number: [Hospital/NHS number]
#### Ward: [Ward]
#### Consultant: [Consultant]
#### Date of admission: [Date of admission]
#### Time of admission: [Time of admission]

### Infusions

**Check allergies/sensitivities and patient identity**

Bolus IN injections should be prescribed on the standard section of the drug chart. If no additive is to be used, enter ‘nil’ in the ‘drug added’ column.

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<th>Infusion Fluid</th>
<th>Drug Added</th>
<th>Duration or Rate</th>
<th>Prescriber’s Signature</th>
<th>Pharmacy Check</th>
<th>Given by</th>
<th>Checked by</th>
<th>Start Time</th>
<th>Stop Time</th>
<th>Vol Given (ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name / strength</td>
<td>Name</td>
<td>Dose</td>
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<td>Volume (ml)</td>
<td>Route (IV/SC)</td>
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### Omitted Doses of Medicine and Delayed Doses

**Check allergies/sensitivities and patient identity**

<table>
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<tr>
<th>Date</th>
<th>Time</th>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Instructions</th>
<th>Reason for omission or delay &gt;2 hours</th>
<th>Signature</th>
<th>Pharmacy Check</th>
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<td><strong>A+B</strong></td>
<td><strong>Respirations</strong></td>
<td>Breath/min</td>
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<td>2</td>
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<tr>
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<td>21–24</td>
<td>18–20</td>
<td>15–17</td>
<td>12–14</td>
<td>9–11</td>
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<td>12–14</td>
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<tr>
<td><strong>A+B</strong></td>
<td><strong>SpO₂ Scale 1</strong></td>
<td>Oxygen saturation (%)</td>
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<td>3</td>
<td></td>
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<td>&gt;90</td>
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<td>81–85</td>
<td>&lt;83%</td>
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</tr>
<tr>
<td>&lt;90</td>
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<td>81–85</td>
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<td>95–99%</td>
<td>93–94%</td>
<td>≤91%</td>
<td>88–90%</td>
<td>≤83%</td>
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<td>&lt;97%</td>
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<td>93–94%</td>
<td>≤91%</td>
<td>88–90%</td>
<td>≤83%</td>
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<td></td>
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</tr>
<tr>
<td>&lt;140</td>
<td>250</td>
<td>180</td>
<td>120</td>
<td>110</td>
<td>80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pulse</strong></td>
<td>Beat/min</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥100</td>
<td>120</td>
<td>110</td>
<td>80</td>
<td>60</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;100</td>
<td>120</td>
<td>110</td>
<td>80</td>
<td>60</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D</strong></td>
<td><strong>Consciousness</strong></td>
<td>Score for NEWS (no score if chronic)</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alert</td>
<td>V</td>
<td>P</td>
<td>U</td>
<td>Alert</td>
<td>V</td>
<td>P</td>
<td>U</td>
<td></td>
</tr>
<tr>
<td>Confusion</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E</strong></td>
<td><strong>Temperature</strong></td>
<td>°C</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥39.1°</td>
<td>38.1–39.0°</td>
<td>37.1–38.0°</td>
<td>36.1–37.0°</td>
<td>35.1–36.0°</td>
<td>≤35.0°</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;39.1°</td>
<td>38.1–39.0°</td>
<td>37.1–38.0°</td>
<td>36.1–37.0°</td>
<td>35.1–36.0°</td>
<td>≤35.0°</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NEWS TOTAL</strong></td>
<td>Monitoring frequency</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escalation of care Y/N</td>
<td>Initials</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Chart 4: Clinical response to the NEWS trigger thresholds

<table>
<thead>
<tr>
<th>NEW score</th>
<th>Frequency of monitoring</th>
<th>Clinical response</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Minimum 12 hourly</td>
<td>• Continue routine NEWS monitoring</td>
</tr>
</tbody>
</table>
| Total 1–4               | Minimum 4–6 hourly      | • Inform registered nurse, who must assess the patient  
• Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required |
| 3 in single parameter   | Minimum 1 hourly        | • Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary                   |
| Total 5 or more         | Minimum 1 hourly        | • Registered nurse to immediately inform the medical team caring for the patient  
• Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients  
• Provide clinical care in an environment with monitoring facilities |
| Urgent response threshold| Continuous monitoring of vital signs | • Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level  
• Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills  
• Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU  
• Clinical care in an environment with monitoring facilities |
<table>
<thead>
<tr>
<th>Time</th>
<th>Spontaneous</th>
<th>To sound</th>
<th>To pressure</th>
<th>None</th>
<th>Not testable</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Eye opening:
- Spontaneous
- To sound
- To pressure
- None
- Not testable

<table>
<thead>
<tr>
<th>Time</th>
<th>Orientated</th>
<th>Confused</th>
<th>Sounds</th>
<th>None</th>
<th>Not testable</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Verbal response:
- Orientated
- Confused
- Sounds
- None
- Not testable

<table>
<thead>
<tr>
<th>Time</th>
<th>Obey commands</th>
<th>Localising</th>
<th>Normal flexion</th>
<th>Abnormal flexion</th>
<th>Extension</th>
<th>None</th>
<th>Not testable</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Best motor response:
- Obey commands
- Localising
- Normal flexion
- Abnormal flexion
- Extension
- None
- Not testable

<table>
<thead>
<tr>
<th>Time</th>
<th>Temperature (°C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Blood pressure and pulse rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>230</td>
<td></td>
</tr>
<tr>
<td>120</td>
<td></td>
</tr>
<tr>
<td>210</td>
<td></td>
</tr>
<tr>
<td>200</td>
<td></td>
</tr>
<tr>
<td>190</td>
<td></td>
</tr>
<tr>
<td>180</td>
<td></td>
</tr>
<tr>
<td>170</td>
<td></td>
</tr>
<tr>
<td>160</td>
<td></td>
</tr>
<tr>
<td>150</td>
<td></td>
</tr>
<tr>
<td>140</td>
<td></td>
</tr>
<tr>
<td>130</td>
<td></td>
</tr>
<tr>
<td>120</td>
<td></td>
</tr>
<tr>
<td>110</td>
<td></td>
</tr>
<tr>
<td>100</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

Respirations:
+ = reacts
- = no reaction
c = eye closed

Oxygen Saturations:

<table>
<thead>
<tr>
<th>Size</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Size</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PUPILS:
- Normal power
- Mild weakness
- Severe weakness
- Spastic flexion
- Extension
- No response

Arms:
- Normal power
- Mild weakness
- Severe weakness
- Extension
- No response

Legs:
- Normal power
- Mild weakness
- Severe weakness
- Extension
- No response

Limb movement:

Record right (R) and left (L) separately if there is a difference between the two sides.

PATIENT NAME:

HOSPITAL NO:

DATE:

DATE OF BIRTH:

TEMPERATURE (°C):

Blood pressure and pulse rate:

Respirations:

Oxygen Saturations:

PUPILS:

Arms:

Legs:

Limb movement:

Record right (R) and left (L) separately if there is a difference between the two sides.

V.5 Updated July 2024
<table>
<thead>
<tr>
<th>Total GCS Score</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initials:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>DOB:</td>
<td>Hospital No:</td>
<td>Ward:</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>--------------</td>
<td>-------</td>
<td></td>
</tr>
</tbody>
</table>

### PROMPT – MODIFIED OBSTETRIC EARLY WARNING SCORE CHART v3 (FOR MATERNITY USE ONLY)

Use identification label or: Name:

<table>
<thead>
<tr>
<th>Time</th>
<th>21-30</th>
<th>11-20</th>
<th>0-10</th>
<th>55-100%</th>
<th>&lt;55%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respirations (write rate in centigrade box)</td>
<td>&gt;30</td>
<td>&gt;20</td>
<td>&gt;10</td>
<td>55-100%</td>
<td>&lt;55%</td>
</tr>
<tr>
<td>Saturations if applicable (write rate in centigrade box)</td>
<td>95-100%</td>
<td>55-100%</td>
<td>&lt;95%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature (°C/min)</td>
<td>39</td>
<td>39</td>
<td>37</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>Heart rate (bpm)</td>
<td>170</td>
<td>160</td>
<td>150</td>
<td>150</td>
<td>140</td>
</tr>
<tr>
<td>Systolic blood pressure</td>
<td>210</td>
<td>200</td>
<td>190</td>
<td>190</td>
<td>180</td>
</tr>
<tr>
<td>Diastolic blood pressure</td>
<td>120</td>
<td>110</td>
<td>100</td>
<td>100</td>
<td>90</td>
</tr>
<tr>
<td>Urine passed (Y/N)</td>
<td>passed (Y/N)</td>
<td>passed (Y/N)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protein</td>
<td>Protein ++</td>
<td>Protein +++</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amniotic fluid</td>
<td>Clear (C)</td>
<td>Pink (P)</td>
<td>Clear (C)</td>
<td>Pink (P)</td>
<td></td>
</tr>
<tr>
<td>Neuro-response</td>
<td>Alert</td>
<td>Voice</td>
<td>Alert</td>
<td>Voice</td>
<td></td>
</tr>
<tr>
<td>Pain score (0-5)</td>
<td>0-1</td>
<td>2-3</td>
<td>0-1</td>
<td>2-3</td>
<td></td>
</tr>
<tr>
<td>Lochia</td>
<td>Normal (N)</td>
<td>Heavy (H) Fresh (F) Offensive (O)</td>
<td>Normal (N)</td>
<td>Heavy (H) Fresh (F) Offensive (O)</td>
<td></td>
</tr>
<tr>
<td>Looks unwell</td>
<td>NO (x)</td>
<td>YES (x)</td>
<td>NO (x)</td>
<td>YES (x)</td>
<td></td>
</tr>
</tbody>
</table>

Total number of amber boxes:
Total number of red boxes:
Monitoring frequency:
Escalation of care Y/N:
Initials: 
# Guidance for using Modified Obstetric Early Warning Score Chart

<table>
<thead>
<tr>
<th>A</th>
<th>Alert</th>
<th>Alert and orientated</th>
</tr>
</thead>
<tbody>
<tr>
<td>V</td>
<td>Voice</td>
<td>Drowsy but answers to name or some kind of response when addressed</td>
</tr>
<tr>
<td>P</td>
<td>Pain</td>
<td>Rousable with difficulty but makes response when shaken or mild pain is inflicted (e.g. rubbing sternum, pinching ears)</td>
</tr>
<tr>
<td>U</td>
<td>Unresponsive</td>
<td>No response to voice, shaking or pain</td>
</tr>
</tbody>
</table>

**Pain scores:** Record pain levels as follows:

0 – No pain
1 – Mild pain
2 – Moderate pain
3 – Severe pain

**Scoring and responding:** Document all the scores for all parameters at bottom of the chart. Follow the escalation algorithm.

**Key**

<table>
<thead>
<tr>
<th>Amber</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amber</td>
<td>Red</td>
</tr>
</tbody>
</table>

## Identify the number of amber and/or red boxes

<table>
<thead>
<tr>
<th>1 Amber Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Repeat observations</td>
</tr>
<tr>
<td>- Increasing frequency of observations to every 1 hour</td>
</tr>
<tr>
<td>- Seek advice from senior midwife/midwife in charge</td>
</tr>
<tr>
<td>- Consider obstetric review within 30 minutes if not settled</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 or more Amber Boxes or 1 Red Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Inform midwife in charge</td>
</tr>
<tr>
<td>- Immediate referral to obstetric registrar</td>
</tr>
<tr>
<td>- Increase frequency of observations to every 30 minutes</td>
</tr>
<tr>
<td>- Woman should be reviewed within 30 minutes</td>
</tr>
<tr>
<td>- Consider obstetric anaesthetist review</td>
</tr>
<tr>
<td>- Consider review by obstetric consultant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 Red Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Inform midwife in charge</td>
</tr>
<tr>
<td>- Immediate referral to obstetric registrar/anaesthetist</td>
</tr>
<tr>
<td>- Increase frequency of observations to every 15 minutes</td>
</tr>
<tr>
<td>- Transfer to high level of care</td>
</tr>
<tr>
<td>- Consider transfer to HDU</td>
</tr>
<tr>
<td>- Consider review by obstetric consultant</td>
</tr>
</tbody>
</table>
Glasgow Depression Scale Questionnaire

Instructions:
- Each question should be asked in two parts.
  First, the participant is asked to choose between a ‘yes’ and ‘no’ answer.
  If their answer is ‘no’, then the score in the ‘no’ column should be recorded as ‘(0)’. If their answer is ‘yes’, they should be asked if that is ‘sometimes’ or ‘always’, and the score recorded as appropriate.
- Supplementary questions (italics) may be used if the primary question is not understood completely.
- If a response is unclear, ask for specific examples of what the participant means, or talk with them about their answer until you feel able to score their response.

Introduction:
To establish a frame of reference for ‘In the last week…’ remind the person about a specific event that happened 1 week ago that can serve as a reference point.

Start the interview by saying:
‘I am going to ask you about how you have been feeling in the past week or since [state specific event from 1 week ago].

<table>
<thead>
<tr>
<th>In the last week…</th>
<th>Never/No</th>
<th>Sometimes</th>
<th>Always/A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you felt sad?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Have you felt upset?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt miserable?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt depressed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you felt as if you are in a bad mood?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Have you lost your temper?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt as if you want to shout at people?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you enjoyed the things you’ve done?</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Have you had fun?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you enjoyed yourself?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you enjoyed talking to people and being with other people?</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Have you liked having people around you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you enjoyed other people’s company?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you made sure you have washed yourself, worn clean clothes, brushed your teeth and combed your hair?</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Have you taken care of the way you look?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you looked after your appearance?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you felt tired during the day?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Have you gone to sleep during the day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you found it hard to stay awake during the day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Have you cried?</td>
<td></td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>8. Have you been able to pay attention to things like watching TV?</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Have you been able to concentrate on things (like TV shows)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Have you found it hard to make decisions?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Have you found it hard to decide what to wear, or what to do?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you found it hard to choose between two things?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you found it hard to sit still?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Have you fidgeted when you are sitting down?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been moving around a lot, like you can’t help it?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Have you been eating too little or eating too much?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Do people say you should eat more or less? [positive response for eating too much or too little is scored]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Have you found it hard to get a good night’s sleep?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Have you found it hard to fall asleep at night?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you woken up in the middle of the night and found it hard to get back to sleep?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you woken up too early in the morning?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have you felt that life is not worth living?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Have you wished you could die?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt you do not want to go on living?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have you felt as if everything is your fault?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Have you felt as if people blame you for things?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt that things happen because of you?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

V.5 Updated July 2024
In the last week...

<table>
<thead>
<tr>
<th></th>
<th>Never/No</th>
<th>Sometimes</th>
<th>Always/ A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Have you felt that other people are looking at you, talking about you, or laughing at you? Have you worried about what other people think of you?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16. Have you become very upset if someone says you have done something wrong or you have made a mistake? Do you feel sad if someone disagrees with you or argues with you? Do you feel like crying if someone disagrees with you or argues with you?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17. Have you felt worried? Have you felt nervous? Have you felt tense/wound up/on edge?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18. Have you thought that bad things keep happening to you? Have you felt that nothing nice ever happens to you anymore?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19. Have you felt happy when something good happened? If nothing good has happened in the last week then ask: If someone gave you a nice present, would that make you happy?</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

**SCORING INSTRUCTIONS**

Note: At the conclusion of the interview, add up the scores. If you calculate a score of 13 or greater, please do one of the following:

1. seek a referral to the individual's general practitioner; or
2. seek the consultation of the psychologist on the interdisciplinary team.
# Glasgow anxiety scale for people with an intellectual disability (GAS-ID)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Worries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Do you worry a lot?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Do you have lots of thoughts that go round in your head?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Do you worry about your parents/family?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Do you worry about what will happen in the future?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Do you worry that something awful might happen?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. Do you worry if you do not feel well?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. Do you worry when you are doing something new?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. Do you worry about what you are doing tomorrow?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. Can you stop worrying?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10. Do you worry about death/dying?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Specific fears</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do you get scared in the dark?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12. Do you feel scared when you are high up?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13. Do you feel scared in lifts or on escalators?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14. Are you scared of dogs?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15. Are you scared of spiders?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16. Do you feel scared going to see the doctor or dentist?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17. Do you feel scared meeting new people?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18. Do you feel scared in busy places?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19. Do you feel scared in wide open spaces?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Physiological symptoms</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Do you ever feel hot and sweaty?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21. Does your heart beat faster?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>22. Do your hands and legs shake?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>23. Does your stomach ever feel funny, like butterflies?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>24. Do you ever feel breathless?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>25. Do you feel like you need to go to the toilet more than usual?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>26. Is it difficult to sit still?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>27. Do you feel panicky?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SCORING INSTRUCTIONS**

Note: At the conclusion of the interview, add up the scores. If you calculate a score of 13 or greater, please do one of the following:

1. seek a referral to the individual’s general practitioner; or
2. seek the consultation of the psychologist on the interdisciplinary team.
# Six-item cognitive impairment test (6CIT)

**Patient’s name:**

**Date of birth:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Date:</th>
<th>Score</th>
<th>Date:</th>
<th>Score</th>
<th>Date:</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What year is it?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correct = 0 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incorrect = 4 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What month is it?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correct = 0 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incorrect = 3 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Remember this name and address:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Smith, 42 High Street, Bedford</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>About what time is it, within one hour?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correct = 0 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incorrect = 3 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Count backwards from 20 to 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correct = 0 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 error = 2 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;1 error = 4 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Say the months of the year in reverse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correct = 0 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 error = 2 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;1 errors = 4 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What was the name and address I asked you to remember?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 error = 2 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 errors = 4 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 errors = 6 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 errors = 8 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 errors = 10 points</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total score** /28 /28 /28

### 6CIT scoring

- 0-7 = normal
- 8-9 = mild cognitive impairment
- 10-28 = significant cognitive impairment

**Referral**

- Referral not necessary
- Probably refer
- Refer

Kingshill version (2000) *Dementia screening tool*
## The Patient Health Questionnaire (PHQ-9)

**Patient name**

**NHS number**

**Date**

Over the past 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or that you’re a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Column totals

Add totals together
<table>
<thead>
<tr>
<th>PHQ-9 score</th>
<th>Provisional diagnosis</th>
<th>Treatment recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 – 9</td>
<td>Minimal symptoms</td>
<td>Support, educate to call if worse, return in one month</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Minor depression</td>
<td>Support, watchful waiting</td>
</tr>
<tr>
<td></td>
<td>Dysthymia</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Major depression, mild</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>15 – 19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>&gt; 20</td>
<td>Major depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
</tr>
</tbody>
</table>
MUST
Malnutrition universal screening tool
To identify those adults who are at risk of malnourishment or who are malnourished.

To be completed within **24 hours** of admission.
Assess weekly or if the person’s condition changes.

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Record Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
</tr>
</thead>
</table>

**STEP 1: BMI SCORE** (BMI kg / m²)

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 20 (over 30 obese)</td>
<td>0</td>
</tr>
<tr>
<td>18.5 to 20</td>
<td>1</td>
</tr>
<tr>
<td>Less than 18.5</td>
<td>2</td>
</tr>
</tbody>
</table>

*MUAC less than 23.5 cm BMI likely <20
*MUAC greater than 32 cm BMI likely > 30

If unable to calculate BMI, estimating BMI category can be done from mid upper arm circumference (MUAC)

**STEP 2: WEIGHT LOSS SCORE** UNPLANNED WEIGHT LOSS IN LAST 3-6 MONTHS

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5%</td>
<td>0</td>
</tr>
<tr>
<td>Between 5-10%</td>
<td>1</td>
</tr>
<tr>
<td>More than 10%</td>
<td>2</td>
</tr>
</tbody>
</table>

**STEP 3: ACUTE DISEASE EFFECT SCORE**

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the person is acutely ill and there has been/is likely to be no nutritional intake for more than 5 days</td>
<td>2</td>
</tr>
</tbody>
</table>

**TOTAL MUST SCORE**

<table>
<thead>
<tr>
<th>Low Risk = 0</th>
<th>Medium Risk = 1</th>
<th>High Risk ≥ 2</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>Signature</th>
</tr>
</thead>
</table>

V.5 Updated July 2024
**Step 1**
BMI score

- **BMI kg/m²**
  - >20 (>30 Obese) = 0
  - 18.5 - 20 = 1
  - <18.5 = 2

**Step 2**
Weight loss score

- **Unplanned weight loss in past 3-6 months**
  - %
  - <5 = 0
  - 5-10 = 1
  - >10 = 2

**Step 3**
Acute disease effect score

- If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days
  - **Score 2**

**Step 4**
Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition
- **Score 0** Low Risk
- **Score 1** Medium Risk
- **Score 2 or more** High Risk

**Step 5**
Management guidelines

- **0 Low Risk**
  - Routine clinical care
  - **Repeat screening**
    - Hospital – weekly
    - Care Home – monthly
    - Community – annually for special groups e.g. those >75 yrs

- **1 Medium Risk**
  - **Observe**
    - Document dietary intake for 3 days if subject in hospital or care home
    - If improved or adequate intake – little clinical concern; if no improvement – clinical concern - follow local policy
    - Repeat screening
      - Hospital – weekly
      - Care Home – at least monthly
      - Community – at least every 2-3 months

- **2 or more High Risk**
  - **Treat**
    - Refer to dietitian, Nutritional Support Team or implement local policy
    - Improve and increase overall nutritional intake
    - Monitor and review care plan
      - Hospital – weekly
      - Care Home – monthly
      - Community – monthly
    - Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

- **All risk categories:**
  - Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary.
  - Record malnutrition risk category.
Record need for special diets and follow local policy.

**Obesity:**

Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.

**Re-assess subjects identified at risk as they move through care settings**

See The ‘MUST’ Explanatory Booklet for further details and The ‘MUST’ Report for supporting evidence.
## Oral health assessment tool

<table>
<thead>
<tr>
<th>Resident:</th>
<th>Completed by:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Scores** - You can circle individual words as well as giving a score in each category  
(* if 1 or 2 scored for any category please organise for a dentist to examine the resident)  

0 = healthy 1 = changes* 2 = unhealthy*

<table>
<thead>
<tr>
<th>Smooth, pink, moist</th>
<th>No behavioural, verbal, or physical signs of dental pain</th>
<th>No decayed or broken teeth or roots</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No behavioural, verbal, or physical signs of dental pain</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>There are verbal and/or behavioural signs of pain such as pulling at face, chewing lips, not eating, aggression</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>There are physical pain signs (swelling of cheek or gum, broken teeth, ulcers), as well as verbal and/or behavioural signs (pulling at face, not eating, aggression)</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dry, chapped, or red at corners</th>
<th>Normal, moist roughness, pink</th>
<th>Pink, moist, smooth, no bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Pink, moist, smooth, no bleeding</td>
<td>Dry, shiny, rough, red, swollen,</td>
</tr>
<tr>
<td>1</td>
<td>Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Swelling or lump, white, red or ulcerated patch; bleeding or ulcerated at corners</th>
<th>Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures</td>
</tr>
<tr>
<td>1</td>
<td>Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures</td>
</tr>
<tr>
<td>2</td>
<td>Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures</td>
</tr>
</tbody>
</table>

---

**Saliva:**

- **Moist tissues, watery and free flowing saliva**  
  0

- **Dry, sticky tissues, little saliva present, resident thinks they have a dry mouth**  
  1

- **Tissues parched and red, little or no saliva present, saliva is thick, resident thinks they have a dry mouth**  
  2

---

- **Lips:**
  - Dental pain: Natural teeth Yes/No:

---

- Organise for resident to have a dental examination by a dentist
- Resident and/or family or guardian refuses dental treatment
- Complete oral hygiene care plan and start oral hygiene care interventions for resident

---

V.5 Updated July 2024

**Oral cleanliness:**
- Clean and no food particles or tartar in mouth or dentures: 0
- Food particles, tartar or plaque in 1–2 areas of the mouth or on small area of dentures or halitosis (bad breath): 1
- Food particles, tartar or plaque in most areas of the mouth or on most of dentures or severe halitosis (bad breath): 2

**Dentures Yes/No:**
- No broken areas or teeth, dentures regularly worn, and named: 0
- 1 broken area or tooth or dentures only worn for 1–2 hours daily, or dentures not named, or loose: 1
- More than 1 broken area or tooth, denture missing or not worn, loose and needs denture adhesive, or not named: 2

**Tongue:**
- 0

**Gums and tissues:**
- 0
Peak expiratory flow rate chart:

Patient name: [Name]
D.O.B: [Date]
Address: [Address]

Normal values for peak expiratory flow (PEF)
EN 13826 or EU scale

![Chart showing normal values for peak expiratory flow by age and gender.](chart.png)
### PAEDIATRIC NORMAL VALUES

#### PEAK EXPIRATORY FLOW RATE

For use with EU/ EN13826 scale PEF meters only

<table>
<thead>
<tr>
<th>Height (m)</th>
<th>Height (ft)</th>
<th>Predicted EU PEFR (Umin)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.85</td>
<td>2'9&quot;</td>
<td>87</td>
</tr>
<tr>
<td>0.90</td>
<td>2'11&quot;</td>
<td>95</td>
</tr>
<tr>
<td>0.95</td>
<td>3'1&quot;</td>
<td>104</td>
</tr>
<tr>
<td>1.00</td>
<td>3'3&quot;</td>
<td>115</td>
</tr>
<tr>
<td>1.05</td>
<td>3'5&quot;</td>
<td>127</td>
</tr>
<tr>
<td>1.10</td>
<td>3'7&quot;</td>
<td>141</td>
</tr>
<tr>
<td>1.15</td>
<td>3'9&quot;</td>
<td>157</td>
</tr>
<tr>
<td>1.20</td>
<td>3'11&quot;</td>
<td>174</td>
</tr>
<tr>
<td>1.25</td>
<td>4'1&quot;</td>
<td>192</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Height (m)</th>
<th>Height (ft)</th>
<th>Predicted EU PEFR (Umin)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.30</td>
<td>4'3&quot;</td>
<td>212</td>
</tr>
<tr>
<td>1.35</td>
<td>4'5&quot;</td>
<td>233</td>
</tr>
<tr>
<td>1.40</td>
<td>4'7&quot;</td>
<td>254</td>
</tr>
<tr>
<td>1.45</td>
<td>4'9&quot;</td>
<td>276</td>
</tr>
<tr>
<td>1.50</td>
<td>4'11&quot;</td>
<td>299</td>
</tr>
<tr>
<td>1.55</td>
<td>5'1&quot;</td>
<td>323</td>
</tr>
<tr>
<td>1.60</td>
<td>5'3&quot;</td>
<td>346</td>
</tr>
<tr>
<td>1.65</td>
<td>5'5&quot;</td>
<td>370</td>
</tr>
<tr>
<td>1.70</td>
<td>5'7&quot;</td>
<td>393</td>
</tr>
</tbody>
</table>

Normal PEF values in children correlate best with height; with increasing age, larger differences occur between the sexes. These predicted values are based on the formulae given in Lung Function by J.E. Cotes (Fourth Edition), adapted for EU scale Mini-Wright peak flow meters by Clement Clarke.

Date of preparation - 7th October 2004

---

Mini-Wright (Standard Range) EU scale
Blue text on a yellow background

Single Patient Use: Part Ref: 3103388
Multiple Patient Use: Part Ref: 3103387
NHS Logistics Code: FDD 609

Mini-Wright (Low Range) EU scale
Blue text on a yellow background

Single Patient use: Part Ref: 3104708
Multiple Patient Use: Part Ref: 3104710

For more information, visit the website [www.peakflow.com](http://www.peakflow.com)
## Distress and Discomfort Assessment Tool

<table>
<thead>
<tr>
<th>Individual’s name:</th>
<th>Date of birth:</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS no.:</th>
<th>Your name:</th>
<th>Date completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Names of others who helped to complete this form:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### THE DISTRESS PASSPORT
Summary of signs and behaviours when content and when distressed

<table>
<thead>
<tr>
<th></th>
<th>When CONTENT</th>
<th>When DISTRESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>APPEARANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face:</td>
<td>- Passive/smiling</td>
<td>- Grimace/frightened</td>
</tr>
<tr>
<td></td>
<td>- Relaxed</td>
<td>- Rigid</td>
</tr>
<tr>
<td>Jaw &amp; tongue:</td>
<td>- Limited eye contact</td>
<td>- Screwed up/no eye contact</td>
</tr>
<tr>
<td>Eyes:</td>
<td>- Normal</td>
<td>- Normal</td>
</tr>
<tr>
<td>Skin:</td>
<td>- Passive/smiling</td>
<td>- Grimace/frightened</td>
</tr>
<tr>
<td></td>
<td>- Relaxed</td>
<td>- Rigid</td>
</tr>
<tr>
<td></td>
<td>- Limited eye contact</td>
<td>- Screwed up/no eye contact</td>
</tr>
<tr>
<td></td>
<td>- Normal</td>
<td>- Normal</td>
</tr>
</tbody>
</table>

| **VOCAL SOUNDS** |                                               |                                                       |
| Sounds:          | - Low, short, laugh                              | - High, short, cry out                                 |
| Speech:          | - Unclear, slow, soft                            | - Unclear, fast, loud                                  |

| **HABITS & MANNERISMS** |                                               |                                                       |
| Habits:            | - Fidgety                                        | - Rock back and forward                                |
| Mannerisms:        | - Relaxed arm movements                          | - Clenching fists and arms of chair                    |
| Comfortable distance: | - Close, only if known                           | - No-one allowed close                                 |

| **POSTURE & OBSERVATIONS** |                                               |                                                       |
| Posture:             | - Jerky – able to adjust position                | - Rigid and tense                                      |
| Observations:        | - Normal pulse, steady breathing. Sleeping and eating habits are good but eats quickly. | - Fast pulse with rapid breathing. Broken sleeping pattern and increased appetite, favouring sugary foods and drinks. |

**Known triggers of distress** (write here any actions or situations that usually cause or worsen distress):

---

V.5 Updated July 2024
Distress and Discomfort Assessment Tool

Please take some time to think about and observe the individual under your care, especially their appearance and behaviours when they are both content and distressed. Use these pages to document these.

We have listed words in each section to help you to describe the signs and behaviours. You can circle the word or words that best describe the signs and behaviours when they are content and when they are distressed.

Your descriptions will provide you with a clearer picture of their ‘language’ of distress.

### COMMUNICATION LEVEL *

<table>
<thead>
<tr>
<th>Description</th>
<th>Level when well</th>
<th>Level when unwell</th>
</tr>
</thead>
<tbody>
<tr>
<td>This individual is unable to show likes or dislikes</td>
<td>Level 0</td>
<td>Level 0</td>
</tr>
<tr>
<td>This individual is able to show that they like or don’t like something</td>
<td>Level 1</td>
<td>Level 1</td>
</tr>
<tr>
<td>This individual is able to show that they want more, or have had enough of something</td>
<td>Level 2</td>
<td>Level 2</td>
</tr>
<tr>
<td>This individual is able to show anticipation for their like or dislike of something</td>
<td>Level 3</td>
<td>Level 3</td>
</tr>
<tr>
<td>This individual is able to communicate detail, qualify, specify and/or indicate opinions</td>
<td>Level 4</td>
<td>Level 4</td>
</tr>
</tbody>
</table>

* This is adapted from the Kidderminster Curriculum for Children and Adults with Profound Multiple Learning Difficulty (Jones, 1994, National Portage Association).

### FACIAL SIGNS

**Appearance**

<table>
<thead>
<tr>
<th>What to do</th>
<th>Appearance when content</th>
<th>Appearance when distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ring the words that best fit the facial appearance. Add your words if you want.</td>
<td>Passive</td>
<td>Passive</td>
</tr>
<tr>
<td></td>
<td>Laugh</td>
<td>Grimace</td>
</tr>
<tr>
<td></td>
<td>Smile</td>
<td>Frown</td>
</tr>
<tr>
<td>In your own words:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Jaw or tongue movement**

<table>
<thead>
<tr>
<th>What to do</th>
<th>Movement when content</th>
<th>Movement when distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ring the words that best fit the jaw or tongue movement. Add your words if you want.</td>
<td>Relaxed</td>
<td>Relaxed</td>
</tr>
<tr>
<td></td>
<td>Drooping</td>
<td>Grinding</td>
</tr>
<tr>
<td></td>
<td>Biting</td>
<td>Rigid</td>
</tr>
<tr>
<td></td>
<td>Shaking</td>
<td></td>
</tr>
<tr>
<td>In your own words:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Appearance of eyes**

<table>
<thead>
<tr>
<th>What to do</th>
<th>Appearance when content</th>
<th>Appearance when distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ring the words that best fit the appearance of the eyes. Add your words if you want.</td>
<td>Good eye contact</td>
<td>Good eye contact</td>
</tr>
<tr>
<td></td>
<td>Little eye contact</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoiding eye contact</td>
<td>Avoiding eye contact</td>
</tr>
<tr>
<td></td>
<td>Closed eyes</td>
<td>Closed eyes</td>
</tr>
<tr>
<td></td>
<td>Staring</td>
<td>Staring</td>
</tr>
<tr>
<td></td>
<td>Sleepy eyes</td>
<td>Sleepy eyes</td>
</tr>
<tr>
<td></td>
<td>‘Smiling’</td>
<td>‘Smiling’</td>
</tr>
<tr>
<td></td>
<td>Winking</td>
<td>Winking</td>
</tr>
<tr>
<td></td>
<td>Vacant</td>
<td>Vacant</td>
</tr>
<tr>
<td></td>
<td>Tears</td>
<td>Tears</td>
</tr>
<tr>
<td></td>
<td>Dilated pupils</td>
<td>Dilated pupils</td>
</tr>
<tr>
<td>In your own words:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BODY OBSERVATIONS: SKIN APPEARANCE

<table>
<thead>
<tr>
<th>What to do</th>
<th>Appearance when content</th>
<th>Appearance when distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ring the words that best fit the appearance of the skin. Add your words if you want.</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Pale</td>
<td>Pale</td>
</tr>
<tr>
<td></td>
<td>Sweaty</td>
<td>Sweaty</td>
</tr>
<tr>
<td></td>
<td>Clammy</td>
<td>Clammy</td>
</tr>
<tr>
<td>In your own words:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

V.5 Updated July 2024
### VOCAL SOUNDS
(NB. The sounds that a person makes are not always linked to their feelings)

<table>
<thead>
<tr>
<th>What to do</th>
<th>Sounds when content</th>
<th>Sounds when distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ring</strong> the words that best describe the sounds</td>
<td>Volume: high medium low Pitch: high medium low Duration: short intermittent long Description of sound / vocalisation: Cry out Wail Scream laugh Groan / moan shout Gurgle</td>
<td>Volume: high medium low Pitch: high medium low Duration: short intermittent long Description of sound / vocalisation: Cry out Wail Scream laugh Groan / moan shout Gurgle</td>
</tr>
<tr>
<td>Write down commonly used sounds (write it as it sounds; 'tizz', 'eeiow', 'tetetetete');</td>
<td>In your own words:</td>
<td>In your own words:</td>
</tr>
</tbody>
</table>

### SPEECH

<table>
<thead>
<tr>
<th>What to do</th>
<th>Words when content</th>
<th>Words when distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ring</strong> the words which best describe the speech</td>
<td>Clear Stutters Slurred Unclear Muttering Fast Slow Loud Soft Whisper Other, eg. swearing:</td>
<td>Clear Stutters Slurred Unclear Muttering Fast Slow Loud Soft Whisper Other, eg. swearing:</td>
</tr>
</tbody>
</table>

### HABITS & MANNERISMS

<table>
<thead>
<tr>
<th>What to do</th>
<th>Habits and mannerisms when content</th>
<th>Habits and mannerisms when distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ring</strong> the habits or mannerisms, eg. “Rocks when sitting”</td>
<td>Fidgety with relaxed arm movements</td>
<td>Rocks back and forward when sitting, clench fists</td>
</tr>
<tr>
<td>Write down any special comforters, possessions or toys this person prefers.</td>
<td>Stress ball</td>
<td>Stress ball</td>
</tr>
<tr>
<td>Please <strong>Ring</strong> the statement which best describes how comfortable this person is with other people being physically close by</td>
<td>Close with strangers Close only if known No one allowed close Withdraws if touched</td>
<td>Close with strangers Close only if known No one allowed close Withdraws if touched</td>
</tr>
</tbody>
</table>

### BODY POSTURE

<table>
<thead>
<tr>
<th>What to do</th>
<th>Posture when content</th>
<th>Posture when distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ring</strong> the words that describe how person sits and stands.</td>
<td>Normal Rigid Floppy Jerky Slumped Restless Tense Still Able to adjust position Leans to side Poor head control Way of walking: Normal / Abnormal Other:</td>
<td>Normal Rigid Floppy Jerky Slumped Restless Tense Still Able to adjust position Leans to side Poor head control Way of walking: Normal / Abnormal Other:</td>
</tr>
</tbody>
</table>
**BODY OBSERVATIONS: OTHER**

<table>
<thead>
<tr>
<th>What to do</th>
<th>Observations when content</th>
<th>Observations when distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Describe</em> the pulse, breathing, sleep, appetite and usual eating pattern, eg. eats very quickly, takes a long time with main course, eats puddings quickly, “picky”.</td>
<td><strong>Pulse</strong>: Normal limits</td>
<td><strong>Pulse</strong>: Fast</td>
</tr>
<tr>
<td><strong>Breathing</strong>:</td>
<td><strong>Breathing</strong>:</td>
<td><strong>Breathing</strong>:</td>
</tr>
<tr>
<td>Steady</td>
<td>Rapid</td>
<td><strong>Breathing</strong>:</td>
</tr>
<tr>
<td><strong>Sleep</strong>:</td>
<td><strong>Sleep</strong>:</td>
<td><strong>Sleep</strong>:</td>
</tr>
<tr>
<td>Uninterrupted</td>
<td>Broken</td>
<td><strong>Sleep</strong>:</td>
</tr>
<tr>
<td><strong>Appetite</strong>:</td>
<td><strong>Appetite</strong>:</td>
<td><strong>Appetite</strong>:</td>
</tr>
<tr>
<td>Good</td>
<td>Increased</td>
<td><strong>Appetite</strong>:</td>
</tr>
<tr>
<td><strong>Eating pattern</strong>:</td>
<td><strong>Eating pattern</strong>:</td>
<td><strong>Eating pattern</strong>:</td>
</tr>
<tr>
<td>Eats quickly</td>
<td>Eats quickly and favours sugary food and drink</td>
<td><strong>Eating pattern</strong>:</td>
</tr>
</tbody>
</table>
**Information and Instructions**

**DisDAT is**

**Intended** to help identify distress cues in individuals who have severely limited communication.

**Designed** to describe an individual's usual content cues, thus enabling distress cues to be identified more clearly.

**NOT a scoring tool.** It documents what many carers have done instinctively for many years thus providing a record against which subtle changes can be compared.

**Only the first step.** Once distress has been identified the usual clinical decisions have to be made by professionals.

**Meant to help you and the individual in your care.** It gives you more confidence in the observation skills you already have, which in turn will give you more confidence when meeting other carers.

**When to use DisDAT**

When the carer believes the individual is NOT distressed

The use of DisDAT is optional, but it can be used as a
- baseline assessment document
- transfer document for other carers.

When the carer believes the individual IS distressed

If DisDAT has already been completed it can be used to compare the present signs and behaviours with previous observations documented on DisDAT. It then serves as a baseline to monitor change.

If DisDAT has not been completed:

a) When the person is well known DisDAT can be used to document previous content signs and behaviours and compare these with the current observations

b) When the person is new to a carer, or the distress is new, DisDAT can be used document the present signs and behaviours to act a baseline to monitor change.

**How to use DisDAT**

1. **Observe the individual** when content and when distressed- document this on the inside pages.
   Anyone who cares for them can do this.

2. **Observe the context** in which distress is occurring.

3. **Use the clinical decision distress checklist** on this page to assess the possible cause.

4. **Treat or manage** the likeliest cause of the distress.

5. **The monitoring sheet** is a separate sheet, which will help if you want to observe a pattern of distress or see how the distress changes over time. It’s use is optional. There are three types to choose from the website- use whichever suits you best.

6. **The goal** is a reduction the number or severity of distress signs and behaviours.

**Remember**

- Most information comes from several carers together.
- The assessment form need not be completed all at once and may take a period of time.
- Reassessment is essential as the needs may change due to improvement or deterioration.
- Distress can be emotional, physical or psychological. What is a minor issue for one person can be major to another.
- If signs are recognised early then suitable interventions can be put in place to avoid a crisis.

**Clinical decision distress checklist**

Use this to help decide the cause of the distress

1. **Is the sign repeated rapidly?**
   If in time with breathing: see 2 below.
   If it comes and goes every few minutes: consider colic (bowel, bladder or period pain).
   Consider: repetitive movement due to boredom or fear.

2. **Is the sign associated with breathing?**
   Consider: rib damage or irritation of the lung’s outer membrane (this will need a medical assessment).

3. **Is the sign worsened or precipitated by movement?**
   Consider: movement-related pains.

4. **Is the sign related to eating?**
   Consider: food refusal through illness, fear or depression, swallowing problems or nausea.
   Consider: poor oral hygiene, indigestion or abdominal problems.

5. **Is the sign related to a specific situation?**
   Consider: frightening or painful situations.

6. **Is the sign associated with vomiting?**
   Consider: causes of nausea and vomiting.

7. **Is the sign associated with passing urine or faeces?**
   Consider: urine infection or retention, diarrhoea, constipation, anal problems.

8. **Is the sign present in a normally comfortable position or situation?** Consider: anxiety, depression, pains at rest (eg. colic, neuralgia), infection, nausea.

If you require any help or further information regarding DisDAT please contact:
Lynn Gibson and Dorothy Matthews on Dorothy.Matthews@cntw.nhs.uk or Claud Regnard claudregnard@stoswaldsuk.org

For more information see www.disdat.co.uk

**Further reading**


Distress may be hidden, but it is never silent
UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers use pain according to individual patient needs. Explain and use 0-10 Sale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Facial Expression</th>
<th>Behavioral Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>NO PAIN</td>
<td>![Green Face]</td>
<td>A1m</td>
</tr>
<tr>
<td>1</td>
<td>MILD PAIN</td>
<td>![Green Face]</td>
<td>Alm</td>
</tr>
<tr>
<td>2</td>
<td>MODERATE PAIN</td>
<td>![Blue Face]</td>
<td>Noh11mo, v</td>
</tr>
<tr>
<td>3</td>
<td>MODERATE PAIN</td>
<td>![Blue Face]</td>
<td>Nohow&lt;dbrow</td>
</tr>
<tr>
<td>4</td>
<td>MODERATE PAIN</td>
<td>![Blue Face]</td>
<td>Vvvrinkvv-</td>
</tr>
<tr>
<td>5</td>
<td>MODERATE PAIN</td>
<td>![Blue Face]</td>
<td>Slowblink</td>
</tr>
<tr>
<td>6</td>
<td>MODERATE PAIN</td>
<td>![Blue Face]</td>
<td>Eyadootd</td>
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<td>7</td>
<td>SEVERE PAIN</td>
<td>![Orange Face]</td>
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<td>8</td>
<td>SEVERE PAIN</td>
<td>![Orange Face]</td>
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<td>9</td>
<td>SEVERE PAIN</td>
<td>![Orange Face]</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>WORST PAIN POSSIBLE</td>
<td>![Red Face]</td>
<td></td>
</tr>
</tbody>
</table>

VERBAL DESCRIPTOR SEAL

WONG-BAKER FACIAL GRIMACE SCALE

ACTIVITY TOLERANCE SCALE

V.5 Updated July 2024
## Braden Risk Assessment Chart

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>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.</td>
<td>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 of body.</td>
<td>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.</td>
<td>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moisture - Degree to which skin is exposed to moisture</th>
<th>1. Constantly Moist</th>
<th>2. Very Moist</th>
<th>3. Occasionally Moist</th>
<th>4. Rarely moist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient/client is moved or turned.</td>
<td>Skin is often, but not always, moist. Linen must be changed at least once a shift.</td>
<td>Skin is occasionally moist, requiring an extra linen change approximately once a day.</td>
<td>Skin is usually dry. Linen only requires changing at routine intervals.</td>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Confined to bed</td>
<td>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</td>
<td>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.</td>
<td>Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Does not make even slight changes in body or extremity position without assistance.</td>
<td>Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.</td>
<td>Makes frequent though slight changes in body or extremity position independently.</td>
<td>Makes major and frequent changes in position without assistance.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV’s for more than 5 days.</td>
<td>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 optimum amount of liquid diet or tube feeding.</td>
<td>Eats over half of most meals. Eats a total of 4 servings of protein (meat, 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 regimen which probably meets most of nutritional needs.</td>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Friction and Shear</th>
<th>1. Problem</th>
<th>2. Potential Problem</th>
<th>3. No Apparent Problem</th>
<th>Score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires moderate to maximum assistance in moving.</td>
<td>Requires moderate to maximum 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.</td>
<td>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.</td>
<td></td>
<td>Total:</td>
</tr>
<tr>
<td>TIME</td>
<td>INPUT</td>
<td>ORAL</td>
<td>PARENTERAL</td>
<td>HOUR TOTAL</td>
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</tbody>
</table>

PRINT NAME OF NURSE COMPLETING THE FLUID BALANCE CHART:            TOTAL BALANCE:
<table>
<thead>
<tr>
<th>SIGNATURE OF NURSE COMPLETING THE FLUID BALANCE CHART:</th>
<th>NEGATIVE/POSITIVE:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Phlebitis Score

All patients with an intravenous access device should have the IV site checked every shift for signs of infusion phlebitis. The subsequent score and action(s) taken (if any) must be documented on the cannula record form.

The cannula site must also be observed:
- Wilen bolus injections are administered
- IV flow rates are checked or altered
- Wilen solution containers are changed

With permission from Andrew Jackson – Consultant Nurse, Intravenous Therapy & Care, The Rotherham NHS Foundation Trust
(Adapted from Jackson, 1998)
# Overview and documentation

## Bowel assessment

### Candidate name: ____________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Type 1</th>
<th>Type 2</th>
<th>Type 3</th>
<th>Type 4</th>
<th>Type 5</th>
<th>Type 6</th>
<th>Type 7</th>
<th>Bowels</th>
<th>Comments</th>
<th>Staff initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Separate hard lumps like nuts (hard to pass)</td>
<td>Sausage shaped but lumpy</td>
<td>Like a sausage but with cracks on surface</td>
<td>Like a sausage or snake, smooth and soft</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
<td>Watery, no solid pieces (entirely liquid)</td>
<td>not opened</td>
<td>i.e. volume (small, medium, large) blood, mucous</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>![Type 1 Image]</td>
<td>![Type 2 Image]</td>
<td>![Type 3 Image]</td>
<td>![Type 4 Image]</td>
<td>![Type 5 Image]</td>
<td>![Type 6 Image]</td>
<td>![Type 7 Image]</td>
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</tbody>
</table>

V.5 Updated July 2024
Documentation
Blood glucose monitoring

Candidate name: _______________________

<table>
<thead>
<tr>
<th>Patient details</th>
<th>Date &amp; time</th>
<th>Blood glucose level mmol/L</th>
<th>Name &amp; signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
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<td></td>
</tr>
<tr>
<td>Address:</td>
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</tr>
<tr>
<td>Date of birth:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hospital number:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Allergies:</td>
<td></td>
<td></td>
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<tr>
<td>Consultant:</td>
<td></td>
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</tbody>
</table>
### Mid-stream sample of urine and urinalysis

#### Candidate name: _________________________

<table>
<thead>
<tr>
<th>Patient details:</th>
<th>Test strip:</th>
<th>Values:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Leucocytes</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Nitrates</td>
<td></td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Protein</td>
<td></td>
</tr>
<tr>
<td>Allergies:</td>
<td>pH</td>
<td></td>
</tr>
<tr>
<td>GP:</td>
<td>Blood</td>
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<td></td>
<td>Specific gravity</td>
<td></td>
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<tr>
<td></td>
<td>Ketones</td>
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<td></td>
<td>Glucose</td>
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</tbody>
</table>
### Documentation

#### Nutritional assessment

**Candidate name:** ____________________________

<table>
<thead>
<tr>
<th></th>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
<td>BMI score</td>
<td>Weight loss score</td>
<td>Acute disease effect score</td>
<td>Overall risk of malnutrition score</td>
<td>Staff name &amp; initials</td>
</tr>
<tr>
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</tbody>
</table>

V.5 Updated July 2024
## Prescription
### Administration of inhaled medication

**Candidate name:** ____________________________

<table>
<thead>
<tr>
<th>Patient details:</th>
<th>Medication:</th>
<th>Dose:</th>
<th>Signature:</th>
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<tbody>
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<td>Date of birth:</td>
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<tr>
<td>Hospital number:</td>
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<table>
<thead>
<tr>
<th>Allergies:</th>
<th>Weight:</th>
<th>Height:</th>
<th>Date:</th>
<th>Time:</th>
<th>Signature of doctor and date:</th>
</tr>
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</table>

**Name:**

**Address:**

**Date of birth:**

**Hospital number:**

**Allergies:**

**Weight:**

**Height:**

**Signature of doctor and date:**
Inpatient Maternal Sepsis Screening Tool

To be applied to all women who are pregnant or up to six weeks postpartum (or after the end of pregnancy if pregnancy did not end in a birth) who have a suspected infection or have clinical observations outside normal limits.

1. Has MEOWS triggered?
   OR does woman look sick?
   OR is baby tachycardic (≥160 bpm)?

2. Could this be an infection?
   Yes, but source unclear at present
   Chorioamnionitis/ endometritis
   Urinary Tract Infection
   Infected caesarean or perineal wound
   Influenza, severe sore throat, or pneumonia
   Abdominal pain or distension
   Breast abscess/ mastitis
   Other (specify):

3. Is ONE maternal Red Flag present?
   Responds only to voice or pain/ unresponsive
   Systolic B.P ≤ 90 mmHg (or drop >40 from normal)
   Heart rate > 130 per minute
   Respiratory rate ≥ 25 per minute
   Needs oxygen to keep SpO₂ ≥92%
   Non-blanching rash, mottled/ ashen/ cyanotic
   Not passed urine in last 18 hours
   Urine output less than 0.5 ml/kg/hr
   Lactate ≥2 mmol/l
   (note- lactate may be raised in & immediately after normal labour & delivery)

4. Any Maternal Amber Flag criteria?
   Relatives concerned about mental status
   Acute deterioration in functional ability
   Respiratory rate 21-24 OR breathing hard
   Heart rate 100-130 OR new arrhythmia
   Systolic B.P 91-100 mmHg
   Not passed urine in last 12-18 hours
   Temperature < 36°C
   Immunosuppressed/ diabetes/ gestational diabetes
   Has had invasive procedure in last 6 weeks
   (e.g. CS, forceps delivery, ERPC, cerclage, CVs, miscarriage, termination)
   Prolonged rupture of membranes
   Close contact with GAS
   Bleeding/ wound infection/ vaginal discharge
   Non-reassuring CTG/ fetal tachycardia >160

Low risk of sepsis. Use standard protocols, consider discharge with safety netting. Consider obstetric needs.

Send bloods if 2 criteria present, consider if 1 include lactate, FBC, U&Es, CRP, LFTs, clotting
Immediate call to ST3+ doctor/ Shift Leader For review within 1hr

Time complete
Initials

Time clinician/ Midwife attended

Is Acute Kidney Injury (AKI) present?
YES
NO
Red Flag Sepsis!! Start Sepsis 6 pathway NOW
This is time critical, immediate action is required.

Sepsis Six and Red Flag Sepsis are copyright to and intellectual property of the UK Sepsis Trust, registered charity no. 1158843. sepsistrust.org
**CANDIDATE NAME:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Gravida:</th>
<th>Para:</th>
<th>Hospital number:</th>
<th>Blood Group:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of admission:</th>
<th>Time of admission:</th>
<th>Ruptured membranes:</th>
<th>Hours of membrane rupture:</th>
</tr>
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<table>
<thead>
<tr>
<th>Hours</th>
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<th>2</th>
<th>3</th>
<th>4</th>
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<tr>
<td>Time</td>
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<thead>
<tr>
<th>Fetal heart rate</th>
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<tr>
<th>Amniotic fluid I = Intact</th>
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<td>Moulding / = none</td>
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<td>10</td>
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<tr>
<th>Cervix (cm) (Plot X)</th>
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<table>
<thead>
<tr>
<th>Descent of PP in relation to ischial spines (Plot O)</th>
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<tbody>
<tr>
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<td>+1</td>
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<td>+2</td>
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<th>Contractions per 10 mins</th>
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<td>4</td>
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V.5 Updated July 2024
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V.5 Updated July 2024