Absolute Home Care

AT HOME NURSING CARE SERVICES
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Assessment & Clinical Pathway Entry Point

SMS #: _____ DVA #: _____
IHI: _____
Surname: _____
Given name(s): _____ Tel: _____
Address: _____
DOB: _____ Gender:

Date Assessment Commenced: _____

Reason for Referral: _____

_____

DVA Card Status: ☐ Gold ☐ White (If white card confirm eligibility with DVA)

Referral Source: ☐ LMO/GP ☐ Hospital Doctor/Discharge Planner ☐ VHC Assessor

LMO/GP Name: _____ Provider Number: _____

Address: _____

Phone number: _____ Fax number: _____

Carer Details: Does the veteran live alone? ☐ Yes or ☐ No - Lives with others

Relationship: _____

Carer's name: _____ Phone number: _____

Contact person if no carer or if person different to carer: _____

Relationship: _____ Phone number: _____

Veteran's Country of Birth: _____ Main language spoken at home: _____

Interpreter Required: ☐ Yes ☐ No

Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander

Are any special communication devices used/required? ☐ Yes ☐ No

Specify if yes: _____

_____

Allergies/Adverse Events: (Please list allergies & symptoms of the events): _____

_____

_____

Medical Diagnosis:

Primary: _____

Secondary: _____

_____

Surgical History: _____

_____

_____

_____

Fractures: _____

_____

_____

Assessment & Clinical Pathway Entry Point

MR 04000

DVA _____ Surname: _____ Given names: _____

Assessment Categories:

Medication Management

NOT TO BE USED AS A MEDICATION CHART

(Medications list including prescription, over the counter, complimentary medicines and topical preparations)

Name	Why taken (Veteran's description)	How taken (Veteran's description)	When taken (Veteran's description)	Commencement date

Polypharmacy – If the person has more than 5 unique medications or 12 or more medication doses per day consider a review by LMO/GP, Pharmacist and/or Home Medications Review (HMR)

Administration Details/Dose Administration Aids

☐ Self manages medications ☐ Requires prompting ☐ Uses dose administration aid

☐ Carer manages medications ☐ RN administers with appropriate LMO/GP orders

☐ EN administered (EN must be authorised to administer medications as per state registration requirements and medications administered with appropriate LMO/GP orders)

Polypharmacy ☐ Yes ☐ No Action: _____

Has a Home Medication Review (HMR) been undertaken? ☐ Yes ☐ No ☐ Required

Date: _____

Outcome: _____

_____

Are there any other medication issues (specify)? _____

_____

_____

Respiratory & Cardiovascular

☐ Nil problems

Heart Rate: _____ ☐ Regular ☐ Irregular

Blood Pressure: _____ Respiration Rate: _____

Use as baseline and compare at review. Record ongoing observations on Provider's observation chart.

Cough: ☐ Productive ☐ Non-productive Further description: _____

☐ Chest pain – describe: _____

☐ Palpitations – describe: _____

☐ Ankle oedema ☐ Peripheral cyanosis (fingers) ☐ Flushed/ruddy complexion

Shortness of breath ☐ On exertion ☐ At rest

Oxygen therapy: ☐ Yes ☐ No ☐ Required

If any of these symptoms are present consider commencing Respiratory/Cardiac Clinical Pathway

DVA: _____ Surname: _____ Given names: _____

Has the veteran ever smoked?

☐ No ☐ Yes ▸ ☐ Current or when did they quit _____

How long have they been a smoker? _____

How many did they smoke per day? _____

Comments: _____

_____

_____

Oral & Gastrointestinal

☐ Nil problems

Are there any conditions of the mouth identified? ☐ Ill-fitting dentures ☐ Loose teeth

☐ Dental caries ☐ Gingivitis ☐ Thrush

☐ Requires assistance with dental hygiene

☐ Other (specify): _____

Date veteran last saw Dentist or Denture Technician: _____

Are any of these identified? ☐ Dysphasia ☐ Dysphagia ☐ Laryngectomy

☐ Gastrointestinal ulcers (specify site/s): _____

☐ Reduced nutritional intake ☐ Weight loss ☐ Weight gain ☐ Malnourished

Appetite: ☐ Average ☐ Poor ☐ Decrease taste or smell sensation

Is the Veteran requiring ☐ small frequent meals ☐ Thickened fluids

Does someone monitor the Veteran's food & fluid intake (e.g. their carer)? ☐ Yes ☐ No

Does the Veteran require education about a healthy eating plan? ☐ Yes ☐ No

Education provided? ☐ Yes ☐ No

Does the Veteran require a dietician review? ☐ Yes ☐ No

Referral attended? ☐ Yes ☐ No

Does the Veteran require referral to Meals on Wheels? ☐ Yes ☐ No

Referral attended? ☐ Yes ☐ No

Bowel Habits

☐ Normal consistency & frequency ☐ Constipated ☐ Diarrhoea

☐ Faecal incontinence – continence assessment required?

☐ Yes ▸ Continence assessment attended on (date) _____

If no, what is the reasoning for this? _____

If faecal incontinence is identified consider commencing Continence Clinical Pathway

Comments: _____

_____

Sensory

Eyes: ☐ Nil problems

☐ Glasses ☐ Contacts ☐ Glaucoma ☐ Jaundice ☐ Blurred vision

☐ Cataracts ☐ Macular degeneration ☐ Legally blind

☐ Other (specify): _____

Date Veteran last had vision tested: _____

DVA : _____ Surname: _____ Given names: _____

Ears: ☐ Nil problems

☐ Tinnitus Hearing loss: ☐ left ☐ right Hearing aid: ☐ left ☐ right ☐ bilateral

Date Veteran last had hearing tested: _____

Comments: _____

_____

Skin Integrity: ☐ Nil problems

☐ Rash ☐ Wound ☐ Sensation deficit ☐ Dry ☐ Moist ☐ Acne

☐ Other (specify): _____

Complete a pressure ulcer risk assessment tool at this time

☐ Pressure ulcer (specify site & stage): _____

Weight: _____ Kg Date: _____ Weight: _____ Kg Date: _____

Weight: _____ Kg Date: _____ Weight: _____ Kg Date: _____

The pressure relieving/reduction device in use should correspond with the outcomes of the pressure ulcer risk assessment tool of choice unique for this veteran.

If there is a wound consider commencing Wound Management Clinical Pathway

Comments: _____

_____

Musculoskeletal & Neurological

☐ Nil problems

Pain in: ☐ Muscles ☐ Joints ☐ Bones

Oedema in: ☐ Muscles ☐ Joints ☐ Bones

Please refer to the "Palliative Pain & Symptom Control Measurement Tool" to score pain. Please note this tool may be used in conjunction with any of the clinical pathways where pain issues require assessment.

☐ Weakness ☐ Limitations in movement ☐ Stiffness

☐ Unsteady on feet ☐ Paralysis ☐ Tremor

☐ Numbness ☐ Tingling

☐ Other (specify): _____

If veteran is experiencing any of the above consider a falls risk assessment (refer to environment assessment category).

Comments: _____

_____

Self-Care

ADL Complete agency's valid functional assessment tool for basic activities of daily living

Specify tool used _____

ADL Dependency Outcome: ☐ Low dependency ☐ High dependency

IADL Complete agency's valid instrumental activities of daily living (IADL) tool

Do limitations impact on ADL's or IADL's? ☐ No ☐ Yes ▸

Describe: _____

If any difficulties are evident consider commencing Post-Acute Care/Rehabilitation or Support & Maintenance Clinical Pathway.

Comments: _____

_____

DVA : _____ Surname: _____ Given names: _____

Cognition/Behaviour

☐ Nil problems

Disoriented to: ☐ Time ☐ Place ☐ Person

Memory loss: ☐ Short term ☐ Long term ☐ Confused or ☐ Episodes of confusion

Scores (e.g. MMSE/AMTS):

Score: _____ Date: _____ Score: _____ Date: _____

Score: _____ Date: _____ Score: _____ Date: _____

If any doubt – name 3 common unrelated objects such as pencil, truck and apple. Ask veteran to repeat the names immediately. Ask veteran to remember them for recall in 1 minute. Ask veteran to repeat the names after 1 minute. Inability to register and/or recall names indicates need for further assessment.

Comments: _____

Does the veteran have a formal assessment/diagnosis of dementia?

☐ No ☐ Yes ▸ By ☐ LMO/GP ☐ Geriatrician/Specialist

Does the veteran display signs of disruptive behaviours?

☐ No ☐ Yes ▸ Describe: _____

Does the veteran have a tendency to wander? ☐ No ☐ Yes

If any of these indicators are present consider commencing Dementia/Confusion Clinical Pathway

Comments: _____

_____

_____

Environment

Has the veteran had a fall in the last 3 months? ☐ No ☐ Yes

Cause identified? ☐ No ☐ Yes

Intervention: _____

_____

Falls Risk Assessment completed? ☐ No ☐ Yes

Outcome: _____

_____

Does the veteran have trouble with stairs? ☐ No ☐ Yes

Can the veteran safely use their bath/shower & toilet? ☐ No ☐ Yes

Are grab rails installed? ☐ No ☐ Yes

Is the toilet inside the house? ☐ No ☐ Yes

Is the toilet easy to access (consider distance, clutter etc.)? ☐ No ☐ Yes

Are there any potential hazards (consider uneven paths, loose floor mats, rips in carpet, clutter, pets etc.)? ☐ No ☐ Yes

If yes, specify: _____

Comments: _____

_____

_____

_____

DVA: _____ Surname: _____ Given names: _____

Genitourinary

☐ Nil problems
☐ Continence assessment required
☐ Continence assessment attended Date: _____

Outcomes: _____

☐ Urinary incontinence ☐ Frequency ☐ Retention ☐ Urgency
☐ Nocturia ☐ Prostate problems ☐ Erectile dysfunction
☐ Gynaecological issues

Specify: _____

If incontinence is identified consider commencing Continence Clinical Pathway

Education ☐ Pelvic muscle exercises ☐ Use of aids

☐ Other (specify): _____

Comments: _____

_____

_____

_____

Endocrine

☐ Nil problems
☐ Fatigue ☐ Depressed mood ☐ Weight gain ☐ Weight loss
☐ Urinary frequency ☐ Excessive thirst ☐ Hyperthyroidism

☐ Other (specify): _____

☐ Diagnosed diabetic Type: _____

Baseline Hb1Ac (if applicable): _____ Baseline BSL (if applicable): _____ Date: _____

Use as baseline & compare at review and if required record ongoing observations on Provider's observation chart

If any of these symptoms are present consider commencing Diabetes Clinical Pathway

Comments: _____

Pain

☐ Nil problems

Where does the veteran rate their pain on the pain scale?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No pain **mild** **moderate** **severe** **very severe** **worst possible**

Pain score on initial assessment _____

Site(s) of pain: _____

How long has the pain been present? _____

Please refer to the "Palliative Pain & Symptom Control Measurement Tool" to score pain. Please note this tool may be used in conjunction with any of the clinical pathways where pain or symptoms require assessment.

Type of Pain: ☐ Acute ☐ Chronic ☐ Somatic ☐ Visceral
☐ Incident ☐ Neuropathic ☐ Mixed ☐ Breakthrough ☐ Procedural
☐ Surgical ☐ Wound ☐ Other (specify): _____

_____

DVA: _____ Surname: _____ Given names: _____

How does the veteran describe the pain?

☐ Aching ☐ Stabbing ☐ Throbbing ☐ Pressure ☐ Gnawing
☐ Cramping ☐ Sharp ☐ Burning ☐ Shooting

☐ Other (specify): _____

What helps to relieve the pain? _____

What worsens the pain? _____

Associated Symptoms: ☐ Nausea ☐ Vomiting ☐ Sleep disturbance

Consider psychosocial/spiritual pain issues: ☐ Anxiety ☐ Fear

☐ Veteran/Carer distress ☐ Family support ☐ Cultural issues ☐ Religious issues

☐ Mental health history

Are there any environmental factors contributing to pain?

Specify: _____

If pain is identified consider discussing with or referring to LMO/GP or Pain Clinic/Specialist.

Mental Health

☐ Nil problems

☐ Sad ☐ Withdrawn ☐ Anxious ☐ Restless ☐ Angry
☐ Hostile ☐ PTSD ☐ Suicide ideation ☐ Sleep disturbances
☐ Inability to enjoy activities ☐ Feeling worthless or guilty

☐ Other (specify): _____

☐ Depression – specify depression scale tool used _____

Depression Score: _____

Referrals: ☐ LMO/GP ☐ ACAT ☐ Social Worker or Counsellor
☐ Mental Health Services ☐ Vietnam Veteran's Counselling Service
☐ Other (specify): _____

Education ☐ Symptom recognition ☐ Activities

☐ Other (specify): _____

Comments: _____

_____

If any mental health issues are identified consider Support & Maintenance Clinical Pathway.

Well-being

If a carer has previously been identified assess carer strain using a valid strain tool.

Carer strain assessment date: _____

Tool: _____ Score: _____

Intervention: _____

Is the veteran and/or carer aware of carer support services and how to access them?

☐ Yes ☐ No ▸ Information provided? ☐ Yes ☐ No

Veteran's current hobbies/social activities: _____

Social isolation/problems identified (e.g. access to transport, driving capacity):

Describe: _____

_____

DVA: _____ Surname: _____ Given names: _____

Does veteran have an annual influenza vaccine? ☐ Yes ☐ No

Date of last vaccination: _____

When did the veteran last have a cholesterol test? Date: _____ Result: _____

Has the veteran had a tetanus vaccination in the last 10 year? ☐ No ☐ Yes

Date of last vaccination: _____

When did the veteran last have a pap smear (if applicable)? Date: _____

When did the veteran last have a mammogram (if applicable)? Date: _____

When did the veteran last have a prostate examination (if applicable)? Date: _____

If the veteran is unsure of these or has not had any recent annual screenings consider referral to LMO/GP.

☐ Substance misuse (specify): _____

Alcohol Screen (Audit-C)

How often does the veteran have drink containing alcohol?

☐ Never = 0 ☐ Monthly or less = 1 ☐ 2 – 4 times a month = 2

☐ 2 – 3 times a week = 3 ☐ > 4 times a week = 4

Score: _____

How many standard drinks does the veteran have on a typical day when they are drinking?

☐ 1 or 2 = 0 ☐ 3 or 4 = 1 ☐ 5 or 6 = 2 ☐ 7 to 9 = 3 ☐ 10 or more = 4

Score: _____

How often does the veteran have6 or more standard drinks on one occasion?

☐ Never = 0 ☐ Less than monthly = 1 ☐ Monthly = 2

☐ Weekly = 3 ☐ Daily or almost daily = 4

Score: _____

Total Score: _____

Maximum score is 12.

Score of 4 or more may indicate potential risk.

Score of 6 or more for women & 7 or more for men, over 65 years of age, indicates existing risky or high risk drinking.

In this case the complete AUDIT should be used, along with a brief intervention & follow up.

The AUDIT tool including an intervention guide & fact sheets are available at: http:/www.therightmix.gov.au/

Comments: _____

_____

Education:

☐ Harm reduction related to (specify) : _____

☐ 'Right Mix' brochure available from http:/www.therightmix.gov.au/

☐ Vaccinations/Annual screening

☐ Other (specify): _____

Referrals: ☐ LMO/GP ☐ ACAT ☐ Social Worker ☐ Counsellor

☐ Other (specify): _____

Culture

Identify any specific cultural needs or considerations: _____

_____

_____

DVA : _____ Surname: _____ Given names: _____

Religion/ Spirituality

Identify any specific religious or spiritual needs or considerations: _____

Body Image/Sensuality/Sexuality

Identify any specific body image or sensuality/sexuality concerns: _____

Legal

Does the veteran have capacity to make their own decisions about the treatment they are to receive?

☐ Yes ☐ No ☐ Unsure (if unsure refer to LMO/GP, ACAT and/or Social Work)

Does the veteran have capacity to make his or her own decisions about safety & lifestyle issues?

☐ Yes ☐ No ☐ Unsure (if unsure refer to LMO/GP, ACAT and/or Social Work)

Authorised Representative:

Is there an Enduring Power of Attorney in place? ☐ No ☐ Yes

Specify: ☐ Medical ☐ Financial ☐ Guardianship

Name of holder of Power of Attorney or Guardian: _____

Relationship to Veteran: _____

Contact details for Power of Attorney or Guardian:

Address: _____ Phone: _____

Comments: _____

Services in Place

Please use this pace to record all services currently being utilised by the veteran e.g. meals on wheels, domestic assistance, physiotherapy, personal care etc.

VHC –

☐ Domestic assistance ☐ Home & garden maintenance ☐ Respite ☐ Personal care

☐ Other (specify): _____

Equipment Aids & Appliances

Please use this pace to record equipment, aids & appliances that are currently being utilised by the veteran e.g. mobility aids, footwear, shower chair etc. pressure relief/reduction devices (not previously recorded).

DVA : _____ Surname: _____ Given names: _____

Veteran Classification

☐ Assessment only	☐ Acute/Post-Acute	☐ Short term	☐ Medium term
☐ Long term	☐ Support & Maintenance	☐ Short term	☐ Long term
☐ Low dependency	☐ High dependency	☐ Palliative	☐ Stable
☐ Unstable	☐ Deteriorating	☐ Terminal	☐ Bereavement

Outcomes of Care

What is the expected outcome or goal of this nursing episode of care?

☐ Complete recovery – no ongoing care required
☐ Incomplete recovery – rehabilitate to maximum level of functioning – no ongoing nursing required
☐ Incomplete recovery – rehabilitate to maximum level of functioning – ongoing nursing required
☐ End stage illness/maintain at home – ongoing nursing care required
☐ Unable to be maintained at home for extended period – suitable facility care
☐ Well veteran for preventative/maintenance program – no ongoing nursing care required
☐ Individualised goal for this veteran _____

_____

_____

_____

Referrals

Referrals not previously recorded and require action

☐ LMO/GP	☐ Asthma Educator	☐ Chronic Illness Support Group
☐ Physiotherapist	☐ Occupational Therapist	☐ ACAT
☐ Social Worker	☐ Counsellor	☐ Mental Health Service
☐ Fitness/Falls Program	☐ Diabetes Support Group	☐ Dietician
☐ Dentist	☐ Continence Consultant	☐ Speech Pathologist
☐ Low Vision Clinic	☐ Veterans Home Care	☐ Optometrist
☐ Ophthalmologist	☐ Audiologist	☐ Wound Specialist/Consultant
☐ Respite Services	☐ HACC	☐ Carer Support Services
☐ Pain Clinic/Specialist	☐ Palliative Care Service/Consultant	

☐ Vietnam Veteran's Counselling Services

☐ Other (specify): _____

Action Taken: _____

_____

_____

_____

Education

Education needs not previously recorded

☐ Diagnosis	☐ Self-management plan	☐ Medication equipment and use
☐ For family	☐ BSL monitoring	☐ Hygiene
☐ Sign & symptoms of hypo/hyperglycaemia		☐ Falls risk and prevention
☐ Exercise	☐ Nutrition	☐ Pain management
☐ Quit programs	☐ Repositioning and pressure relieving	

☐ Other (specify): _____

DVA : _____ Surname: _____ Given names: _____

Action Taken: _____

_____

_____

_____

Additional Notes:

Assessment – No Ongoing Community Nursing Care Required

For veterans assessed as 'no ongoing community nursing care required' and to acknowledge that the above reflects and accurate account of the assessment, the nurse and the veteran and/or carer or authorised representative (as referred to in the 'Legal' section) should sign below.

Assessment Date: _____ Signature of Nurse: _____

Print name: _____

Signature of Veteran or authorised representative: _____

Assessment – Ongoing Community Nursing Care Required – Clinical Pathway(s) Entry Point

Where an assessment has identified the need for ongoing community nursing care, please complete the relevant clinical pathway(s) that will form an attachment(s) to this Entry Point pathway and complete the signature block at the end of the principal clinical pathway.

Tick to indicate relevant pathway(s) identified and commenced.

NB: More than one clinical pathway may be appropriate for some veterans

☐ Continence

☐ Dementia/Confusion

☐ Diabetes

☐ Discharge

☐ Palliative Care

☐ Respiratory/Cardiac

☐ Post-Acute Care/Rehabilitation

☐ Support & Maintenance

☐ Wound Assessment/Management