H. MEDICATION MANAGEMENT

☐ Assessed and not on any medications ☐ **Refer to Pharmacist** ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**
☐ Brought medication(s) to hospital ☐ Sent Home ☐ Locked up on unit
☐ Refer to Medication Reconciliation Comments: _____

Have you been taking your medications as prescribed (missed or skipped doses)? ☐ No ☐ Yes

☐ Unable to answer screening questions within 48 hours Reason: _____

Initials:_____ **Date:** _____ **Time:** _____

I. RISK ASSESSMENT SCREENING

I1. Suicide and Elopement

Suicide
☐ Injuries to self induced
☐ Threatening to harm self
☐ Cause of injuries unknown
☐ History of suicide attempt(s)

Elopement
☐ Refusing to sign admission consent
☐ Threatening to leave

☐ Reviewed and no concerns identified
☐ Concerns identified and documented
☐ Physician notified - Psychiatry consult requested

I2. Violence and Aggression Screening

Complete Violence and Aggression Screening on admission

☐ Reviewed and no risk identified
☐ Risk identified and ALERT process initiated

I3. Tobacco Screening - Smoking

Have you used any tobacco products in the last 6 months?
☐ No ☐ Yes (Provide QuitKit)
# of tobacco used/day?
☐ <10 ☐ 10-20 ☐ >20 ☐ Chewing tobacco
Last tobacco used: _____ (<7 days, initiate NRT if needed)
How soon after waking up do you have your first cigarette?
☐ <30 min ☐ >30 min

☐ Reviewed and no concerns identified

Concerns identified:
☐ Provide QuitKit
☐ Follow up with physician to initiate NRT
☐ Initiate RNIA for NRT (applicable to RN only)

I4. Alcohol/Medication and Drug Use (CAGE)

Tell me about your use of alcohol, medications, or drugs:
Have you ever felt like you ought to cut down on your use of alcohol, medications or drugs?
☐ No ☐ Yes
Have people ever annoyed or angered you by criticizing your use of alcohol, medications or drugs?
☐ No ☐ Yes
Have you ever felt guilty about your use of alcohol, medications, or drugs?
☐ No ☐ Yes
Have you ever used alcohol, medications, or drugs to start your day or steady your nerves?
☐ No ☐ Yes

☐ Reviewed and no concerns identified

Last drink/drug - Day: _____ Time: _____
CAGE Score: _____/4
(CIWA tool required if CAGE score is ≥ 2 OR when patient exhibits ≥ 2 signs of withdrawal)
☐ Referral sent/physician notified to perform CIWA
☐ Illicit drug use identified

☐ Unable to answer screening questions within 48 hours Reason: _____

Initials:_____ **Date:** _____ **Time:** _____

J. ACCOMPANYING PERSONAL BELONGINGS

		NA	Sent Home	Locked Drawer	Bedside	Safe-keeping
Optical	Glasses	☐	☐	☐	☐	☐
	Contact Lenses	☐	☐	☐	☐	☐
Dentures	Upper	☐	☐	☐	☐	☐
	Lower	☐	☐	☐	☐	☐
Hearing Aid(s)	Right Ear	☐	☐	☐	☐	☐
	Left Ear	☐	☐	☐	☐	☐
Prosthetics		☐	☐	☐	☐	☐
Clothing		☐	☐	☐	☐	☐
Money	$:	☐	☐	☐	☐	☐
Medications		☐	☐	☐	☐	☐
Others		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

Initials:_____ **Date:**_____

Vancouver CoastalHealth

Nursing Admission Assessment

Site:_____

Date to Hospital (dd/mm/yyyy):	Date to Nursing Unit (dd/mm/yyyy):	Time to Unit: Hrs.	By: ☐ Walked ☐ Stretcher ☐ Wheelchair ☐ Other:_____

A. ALLERGIES/REACTIONS ☐ None

Drugs:_____
Latex/Rubber:_____
Food:_____
Other:_____
☐ Allergy Band on Patient
☐ I.D. Band on Patient
☐ Patient Risk Profile Alert in Chart - See form VCH.0229
☐ Noted on Care Plan **Initials:**_____ **Date:**_____

B. COMMUNICATION

☐ English spoken ☐ Other ☐ Translator required:_____
☐ No Hearing Difficulty ☐ Hearing Difficulty: ☐ Left ☐ Right
☐ Corrective Aids: ☐ Left ☐ Right
☐ Information obtained from: ☐ Patient ☐ Family ☐ Other:_____
☐ Family is aware of current admission
☐ Family NOT to be informed about current admission
☐ Other (e.g., No info Client)
Comments:_____ **Initials:**_____ **Date:**_____

C. ADVANCED CARE PLANNING

If you were unable to make decisions for yourself, do you have any written wishes about your future healthcare?
☐ Yes - Place copy behind FaceSheet (green sleeve if in use)
☐ No - Would you like to discuss with social work? ☐ Yes, refer to SW ☐ No
☐ UNABLE TO OBTAIN HISTORY ON ADMISSION (obtain history from other sources within 48 hours)
Comments: _____ **Initials:**_____ **Date:**_____

D. BRIEF HISTORY OF PRESENT ILLNESS

Do you understand the reason for your admission?: _____
What concerns you the most at this time?: _____
What treatments, if any, where you receiving at home?:_____Were they helpful? ☐ Yes ☐ No
Initials:_____ **Date:**_____

E. PERTINENT MEDICAL HISTORY (Include major hospitalizations, surgeries, physical or psychiatric illnesses, communicable or blood borne diseases)

F. VITAL SIGNS - Refer to Vital Signs Record

G. SYSTEMS / FUNCTIONAL ASSESSMENT

G1. Neurological Assessment ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

☐ Alteration in Level of Consciousness? ☐ Difficulty expressing self?
☐ Paralysis ☐ Dizziness ☐ Tingling ☐ Seizures ☐ Numbness ☐ Weakness
Pupils: ☐ Unequal/Irregular size ☐ Dilated ☐ Pinpoint ☐ Left ☐ Right
☐ See Neuro Vital Sign Assessment for further details **Initials:**_____ **Date:** _____ **Time:** _____

G2. Cognitive Function ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

Observe the general appearance of the patient (hygiene, grooming, facial expression, demeanor) during the interview

Behaviour: ☐ Agitated ☐ Crying ☐ Demanding ☐ Restless ☐ Shouting ☐ Withdrawn ☐ Drowsy
Affect: ☐ Flat ☐ Angry ☐ Sad ☐ Suspicious ☐ Inappropriate ☐ Labile
Cognition: ☐ Oriented ☐ Disorientated to: ☐ Person ☐ Place ☐ Time ☐ Fluctuates
☐ Admitted under Mental Health Act Certification Date:_____ Expiry Date: _____

In the past 2 weeks have you *(or family, or friends)* noticed any sudden changes in your:
a) Thinking ☐ No ☐ Yes
b) Memory ☐ No ☐ Yes
c) Feelings ☐ No ☐ Yes

In the past 2 weeks, have you *(or family, or friends)* noticed any changes in your behaviour?
☐ No ☐ Yes

If YES to any, do:
☐ CAMI/PRISME or
☐ Identify current tool used by facility to assess for delirium _____

☐ Unable to answer screening questions within 48 hours Reason: _____

Initials:_____ **Date:** _____ **Time:** _____

G3. Respiratory Assessment ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

☐ Shortness of Breath: ☐ Acute ☐ Chronic ☐ Dyspnea

☐ Cough: Since _____ ☐ Unproductive ☐ Productive ☐ Wheezing ☐ Crackles

Home O_2: How Much _____ How Often _____ ☐ Tracheostoma/ETT in place ☐ RT notified

Comments: _____ **Initials:**_____ **Date:** _____ **Time:** _____

G4. Cardiovascular Assessment ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

☐ Chest pain/discomfort Duration _____ See Pain Assessment

☐ Pallor ☐ Cyanosis ☐ Edema - Location: _____

Peripheral pulses: Left: ☐ absent ☐ weak Right: ☐ absent ☐ weak

☐ PICC ☐ IVAD ☐ Tunnelled CVC ☐ AV Fistula - Location: _____ IV Team Aware ☐ No ☐ Yes ☐ N/A

☐ States history of difficult IV starts

Comments: _____ **Initials:**_____ **Date:** _____ **Time:** _____

G5. Nutrition and Hydration ☐ **Refer to Dietitian** ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

Special diet or dietary restrictions? ☐ No ☐ Yes - Specify: _____

Feeding Tube? ☐ No ☐ Yes

☐ Nausea ☐ Vomiting Comments: _____

Have you lost / gain weight recently? ☐ No ☐ Yes	Weight: ☐ Loss ☐ Gain _____ kg since _____
Do you cough or choke when eating? ☐ No ☐ Yes	If YES, complete Swallow Screen

☐ Unable to answer screening questions within 48 hours Reason: _____

Initials:_____ **Date:** _____ **Time:** _____

G6. Bladder and Bowel ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

☐ Urethral Discharge: _____ Last voided: _____

Catheter: ☐ Intermittent q ____ hrs ☐ Indweling (see tube/drain form) ☐ External condom

Comments: _____

In the past 2 weeks have you had any new problems passing urine? ☐ No ☐ Yes	If YES, indicate below: ☐ Frequency ☐ Hematuria ☐ Urgency ☐ Nocturia ☐ Pain ☐ Bladder Incontinence

How often do your bowels move?: _____ Last bowel movement: _____

☐ Regular laxative use ☐ Abdominal pain ☐ Abdominal distension ☐ Stoma (type and care): _____

Comments: _____

In the past 2 weeks have you had any new problems with your bowels? ☐ No ☐ Yes	If YES, indicate below: ☐ Constipation ☐ Bloody Stools ☐ Diarrhea ☐ Bowel Incontinence

☐ Unable to answer screening questions within 48 hours Reason: _____

Initials:_____ **Date:** _____ **Time:** _____

G7. Functional Mobility ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

Vision Assessment:

Corrected with: ☐ Glasses ☐ Contact Lenses Blurred vision: ☐ Left ☐ Right

Blindness: ☐ Left ☐ Right Redness: ☐ Left ☐ Right Discharge: ☐ Left ☐ Right Artifical Eye: ☐ Left ☐ Right

Comments: _____ **Initials:**_____ **Date:** _____

Musculoskeletal:

☐ Joint stiffness ☐ Muscular weakness ☐ Deformity ☐ Contractures

☐ Amputation: _____ ☐ Decreased range of motion: _____ ☐ Alteration in gait or balance?

Comments: _____ **Initials:**_____ **Date:** _____

In the past 2 weeks have you had any trouble or needed help with the following?: Getting out of bed or out of a chair? ☐ No ☐ Yes Walking or getting around? ☐ No ☐ Yes Climbing stairs? ☐ No ☐ Yes Getting dressed, bathing/showering, or toileting? ☐ No ☐ Yes	If current ability is significantly changed from patient's normal baseline, then: ☐ Refer to PT if YES to problems with getting out of bed, walking or climbing stairs ☐ Refer to OT if YES to ADL difficulties

☐ **See Fall Risk Assessment and Care Plan form**

Do family members assist with your care? ☐ No ☐ Yes	If YES, refer to SW, CML as applicable
Do you use any community support services? ☐ No ☐ Yes - ☐ Home maker service ☐ Meal delivery ☐ Home care	
Do you use any equipment to get around? ☐ No ☐ Yes - _____	

☐ Unable to answer screening questions within 48 hours Reason: _____

Initials:_____ **Date:** _____ **Time:** _____

G8. Skin and Wound Assessment ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

☐ Rash ☐ Redness/discoloration ☐ Bruises ☐ Poor integrity ☐ Dryness ☐ Diaphoresis

☐ Suture Line - Location: _____

☐ Pressure Areas - Location: _____ ☐ Initiated Braden Scale Flowsheet

Wounds: ☐ Yes ☐ Acute ☐ Chronic ☐ Wound Assessment Sheet initiated

Comments: _____ **Initials:**_____ **Date:** _____

G9. Reproductive Assessment ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

☐ Discharge - Type: _____ ☐ Perineal sores ☐ Itchiness ☐ Dryness

Last menstrual period dd/mm_____ ☐ Premenarche ☐ Post menopausal ☐ Pregnant _____wks

Number of pregnancies _____

Comments: _____ **Initials:**_____ **Date:** _____

G10. Pain Assessment ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

Chronic pain ☐ No ☐ Yes - Location(s): _____

Comments: _____

Have you had new pain or soreness in any part of your body in the past 2 weeks? ☐ No ☐ Yes - Location(s): _____	If YES, or unsure to any questions, assess further and document as OPQRST O = Onset P = Precipitating Q = Quality R = Region/Radiating S = Severity T = Timing/Treatment Detailed Assessment: _____
Does the patient have cognitive/language impairment and present with symptoms suggestive of pain? ☐ No ☐ Yes	If YES or unsure, perform focused assessment: ☐ Conduct a pain assessment using the Pain Assessment Tool used at your facility ☐ FACES-R Scale, or 0-10 ☐ Pain Behaviour Tool PAINAD for older adult ☐ Other - State: _____

☐ Unable to answer screening questions within 48 hours Reason: _____

Initials:_____ **Date:** _____ **Time:** _____

G11. Psychosocial ☐ **Refer to SW** ☐ **Assessed and no difficulty** ☐ **Problem to Care Plan**

Current Occupation: _____

Living Arrangements: ☐ Home ☐ Care Facility (Name: _____) ☐ Other

☐ Lives alone ☐ Lives with other adult(s)

Hospitalization will cause difficulty: ☐ at work ☐ with family/child/elder care ☐ N/A ☐ Family/Caregiver stress

Comments: _____

Do you feel safe at home? ☐ No ☐ Yes	If there is a risk to patient safety, determine extent and nature of risk *(i.e. who, relationshop, past history/pattern of violence, known criminal history)*
Do you have any financial issues impacting your health? ☐ No ☐ Yes	
Are other people dependent on you for care or support? ☐ No ☐ Yes	
Have you had any recent losses in your family/friends/pets? ☐ No ☐ Yes	

Would you like a visit from: ☐ Own pastor/Religious leader ☐ Hospital chaplain (where available) ☐ Referral made to Spiritual Care (where available)

What cultural practices, religious customs/rites, or health beliefs are important to consider in your care?

☐ None identified ☐ Specified: _____

☐ Unable to answer screening questions within 48 hours Reason: _____

Initials:_____ **Date:** _____ **Time:** _____