Doncaster and Bassetlaw Hospitals NHS Foundation Trust

COMBINED RISK SCREENING AND ASSESSMENT

AFFIX LABEL HERE IF AVAILABLE

NHS Number: .....
District Number: .....
Surname: .....
Forename(s): .....
Address: .....
.....
D.o.B.: .....

ALL ASSESSMENTS MUST BE COMPLETED WITHIN 4 HOURS OF ADMISSION AND AS SPECIFIED BELOW. DOCUMENT ALL ACTION IN CONTEMPORANEOUS NOTES.

Ward: .....

Consultant: .....

Infection, Prevention and Control
Complete on admission
Implement appropriate action and document in casenotes

Cannula Record/site assessment
Complete record at each insertion/removal of cannula.
Evaluate cannula site at least daily and as directed on Page 3 and document in care plan.

Waterlow Pressure Ulcer Risk Assessment
Reassess when there is a change in condition or situation (transfer of ward) and/or weekly.

'Malnutrition Universal Screening Tool' ('MUST')
Reassess or as determined by Dietitian and complete on discharge and/or weekly.

Falls Assessment
Reassess when there is a change in condition or situation (transfer of ward).

Patient Moving and Handling
Reassess weekly and when there is a change in condition or situation (transfer of ward).

Continence Assessment
Complete 'Continence Assessment' within 72 hours of admission if trigger question on initial assessment identifies incontinence as a problem or if incontinence is identified as a new problem during in-patient stay

Alcohol Screening
Complete on admission

Safety sides
Reassess when there is a change in condition or situation (transfer of ward).

Does this patient smoke? ☐ Yes ☐ No

If 'Yes':

- Notify patient of Trusts 'Smoke Free' Policy

☐ 'Smoke Free Assessment' completed

On Admission - Date: .....

Height: ..... cm estimated/measured*

Weight: ..... kg

BMI: ..... kg/m^2

Use this information for all initial assessments

Designation & Name: ..... Signature: .....

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INTRA / INTER-HEALTHCARE INFECTION CONTROL TRANSFER

This form must be completed in conjunction with other discharge/transfer documentation

Screened for MRSA Date: ..... Result: ☐ Positive ☐ Negative

If result 'Positive', please complete the 'Infection Control Source Isolation Care Sheet'.

Consultant: .....

GP: .....

Current patient/client location: .....

Transferring facility: ☐ Hospital ☐ Ward ☐ Care home ☐ Other: .....

Contact no: .....

Is the Infection Prevention and Control team aware of transfer? ☐ Yes ☐ No

Receiving facility: ☐ Hospital ☐ Ward ☐ Care home ☐ Community

Who is aware of the transfer:

Discussed with: ..... Date / Time: .....

Completed by: ..... Date completed: .....

Nurse's signature: ..... Print name: ..... Designation: .....

Is this patient/client an infection risk?

Please tick most appropriate box and give confirmed or suspected organism

☐ Confirmed risk Organism: .....

☐ Suspected risk Organism: .....

No known risk. Patient/client exposed to others with infection e.g. D&V ☐ Yes ☐ No

Is the patient/client aware of their diagnosis/risk of infection? ☐ Yes ☐ No

If patient/client has diarrhoeal illness, please indicate bowel history for last week: (based on Bristol stool form scale)


1. Separate hard lumps, like nuts (hard to pass)


2. Sausage-shaped but lumpy


3. Like a sausage but with cracks on its surface


4. Like a sausage or snake, smooth and soft


5. Soft blobs with clear-cut edges (passed easily)


6. Fluffy pieces with ragged edges, a mushy stool


7. Watery, not solid pieces ENTIRELY LIQUID

Day	Number of episodes	Is the diarrhoea thought to be of an infectious nature? Yes/No	Does the patient/client require isolation? Yes/No **Should the patient/client require isolation, please phone the receiving unit in advance**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Relevant specimen results (including admission screens - MRSA, C. difficile, other multi-resistant organisms) and treatment information, including antimicrobial:

Specimen		
Date		
Result		
Treatment		

Other information:

WATERLOW PRESSURE ULCER RISK ASSESSMENT

			Date								
			Time								
Build/weight for height:	Average (BMI 20.1 - 24.9)	0									
	Above average (BMI 25 - 29.9)	1									
	Obese (BMI ≥30)	2									
	Below average (BMI ≤20)	3									
Continence:	Complete/catheterised	0									
	Urinary incontinence	1									
	Faecal incontinent	2									
	Urinary and faecal incontinent	3									
Skin tissue:	Healthy	0									
(score for each type)	Tissue paper, Dry, Oedematous	1									
	Clammy/pyrexia	1									
	Non-blanching erythema - Category 1 PU	2									
	Category 2,3,4,UN	3									
Mobility:	Fully mobile	0									
	Restless/fidgety	1									
	Apathetic	2									
	Restricted	3									
	Bedbound/traction	4									
	Chairbound (eg wheelchair)	5									
Sex:	Male	1									
	Female	2									
Age:	14 - 49	1									
	50 - 64	2									
	65 - 74	3									
	75 - 80	4									
	81+	5									
Appetite:	Average	0									
	Poor	1									
	NG tube fluids only	2									
	Nil by mouth/anorexic	3									
Tissue malnutrition:	Terminal cachexia	8									
(score for each type)	Multiple organ failure	8									
	Single organ failure (resp., renal, cardiac)	5									
	Peripheral Vascular disease	5									
	Anaemia (Hb<8)	2									
	Smoking	1									
Neurological deficit:	Diabetes, MS, CVA	4 - 6									
	Motor/sensory	4 - 6									
	Paraplegia	4 - 6									
Major surgery trauma:	Orthopaedic, spinal	5									
	On table more than 2 hours	5									
	On table more than 6 hours	8									
Medication:	Long-term, high-dose steroids, cytotoxics, high-dose anti-inflammatory	4									
SCORE:		**Waterlow Score:**									
10+ At Risk, 15+ High Risk, 20+ Very High Risk											
If total Waterlow Score of 10+ is identified, complete care sheet		**Action required:**									
		Signature:									

'AT RISK' PRESSURE ULCER CARE SHEET

Problem: Patient is 'at risk' of pressure ulcer development and has a Waterlow score of 10+

Aim: Maintain skin integrity in order to prevent pressure ulcer development

This patient was put on this care sheet on (date): .....

Nurse's signature: ..... Print name: .....

Update the daily plan of care as specified below:

1. All 'at risk' areas should be checked by a Registered Nurse on admission and / or transfer.
2. All 'at risk' areas should be checked by a Registered Nurse at least 3 times per day.
3. Changes in skin condition should be documented in patient notes.
4. All patients 'at risk' of pressure ulceration should be encouraged to actively mobilise, change their position or be re-positioned as per plan of care (patient non-concordance should be recorded).
5. All position changes should be documented on the re-positioning schedule (patient non-concordance should be recorded).
6. Minimise pressure on bony prominences and avoid positioning on 'at risk' areas.
7. Sitting time should be restricted, and should not exceed 2 hours.
8. Assess need for pressure-relieving aids in accordance with Trust policies PAT/T3, PAT/T4 and PAT/T5.
9. Pressure-relieving equipment must be in-situ within 2 hours of identified risk
   (if >2 hours, document reason why)
10. **Equipment selection:** Date/time requested: Reference No: Date/time supplied:

Mattress	☐ Static mattress			
	☐ Alpha X cell	.....	.....	.....
	☐ Nimbus/transair	.....	.....	.....
Chair	☐ Karomed chair			
Stool	☐ Karomed stool			

11. Refer to Tissue Viability Specialist Nurse as per referral guidelines.
12. **Patient / Carer comprehension:**

    Ensure that the patient/ carers are fully aware of the patient's risk status and requirement for a pressure ulcer prevention plan. ☐ Yes ☐ No

    Patient: ☐ Good ☐ Needs reinforcement ☐ Unable to comprehend

    Carer: ☐ Good ☐ Needs reinforcement
13. Give patient information. Date information given: .....
14. If tissue damage occurs, commence Pressure Ulcer IPOC.

    Level of tissue damage ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ UN

    Date IPOC commenced: .....

Reassessment

15. Ensure initial and ongoing Waterlow pressure ulcer risk assessment is undertaken when there is a change in patient's condition, on transfer or weekly (whichever is more frequent).
16. Review equipment in-situ and down-grade or up-grade as patient's clinical condition dictates.

Problem resolved date: .....

Nurse's signature: ..... Print name: .....

Step 1 + Step 2 + Step 3

Step 1 — BMI Score

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

Step 2 — Weight Loss Score

Unplanned weight loss in past 3 - 6 months

%	Score
<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

If unable to obtain height and weight, see additional information for alternative measurements

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
- Repeat screening weekly and record score.
- Ensure nutritional needs are met through the standard menu.

1
Medium Risk
- Order and encourage high/ energy/fortified diet.
- Offer snacks between meals.
- Document dietary intake for 3 days.
- If no improvement in oral intake, commence Oral Nutrition Supplements (ONS).
- Repeat screening weekly.
- If weight stable/gained, continue.
- If weight continues to fall, **refer to the dietitian.**

2 - 3
High Risk
- Order and encourage enriched/ high-energy/fortified diet and
- Offer snacks between meals and/or ONS. Use ONS if parts of meals are not taken.
- Document dietary intake for 3 days.
- Repeat screening weekly.
- If weight stable/gained, continue.
- If weight continues to fall, **refer to the dietitian.**

Acute Disease Effect

Acute disease effect is applicable to patients who are acutely ill. For example: Critically ill, swallowing problems (after stroke), head injury, GI surgery etc.

4 - 6
High Risk
- Commence as above
- Contact dietitian immediately for full nutritional assessment

All risk categories:
- Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary.
- Refer patients on special diets or where underlying disease requires dietary management e.g. diabetes, COPD, cancers, liver disorders, renal disorders,
- Patients with pressure ulcer grade 3/4
- Patients with c. difficile with high 'MUST' score follow management guidelines

Obesity:
- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.
- If patient is clinically stable, has a BMI >30, or >28 with co-morbidities and wishes to lose weight, please use the Weight Management Information on Sheet Dysphagia your ward.
- If patient requests to see the dietitian, please use the dietetic referral form.

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

Note: re 'MUST' score interpretation
- For individuals with weight loss, contact dietitian for advice if no improvement in weight after appropriate strategies have been put in place.
- For patients who refuse to take food and drink, ensure that the strategies for dealing with food refusal have been considered and documented. If further guidance is then required and the patient continues to lose weight, contact the dietitian.
- Oral nutritional supplements and other nutritional supplements (e.g. vitamins) that are documented currently on the drug chart and are to be continued after discharge should be documented on the discharge chart and 7 days supply of the product provided.

BAPEN Advancing Clinical Nutrition charity 1023827

MAG Malnutrition Advisory Group A Standing Committee of BAPEN

Height: ..... cm measured/recall/estimate

Or Ulna: ..... cm and conversion to height: ..... cm **Or** MUAC: ..... cm

Weight (kg) prior to admission: ..... Take weight from last 3 - 6 months last 3-6 months estimated / actual*

Objective Criteria, (Steps 1- 4) should be used on all patients, if this is not possible, use subjective criteria below:

	Date:					
Weight (kg)						
Step 1	BMI =					
	BMI Score =					
Step 2	Weight loss (compared to original wt) Kg =					
	Weight loss % =					
	Weight loss score =					
Step 3	**Acute Disease Score =**					
Step 4	**'MUST' Risk Score (Total)**					

Subjective Criteria - Estimate a 'MUST' Risk Score based on your evaluation of information below only if objective criteria cannot be used:

(i) **BMI**

- Clinical impression - thin, acceptable wt, over wt, obvious wasting (very thin) and obesity (very over weight) can be noted

(ii) **Weight Loss**

- Clothes and/or jewellery have become loose fitting
- History of decreased food intake, reduced appetite or dysphagia (swallowing problems) over 3 - 6 months and underlying disease or psychosocial/physical disabilities likely to cause weight loss

(iii) **Acute Disease**

No nutritional intake or likelihood of no intake for more than 5 days

	Overall impression Score =					

Date/Time	**Action Plan**	**Signature/Print name**

Has the patient:

- Been admitted with a fall?
- Had a recent fall?
- Got a history of falling?
- Had a near miss in the last year?

- FALLEN ON THE WARD

Complete:

- *Critical Incident Form*
- *Yellow falls sticker*
- *Falls register form*
- *Productive ward safety cross*
- *Status at a glance board*

If the patient has banged their head / unwitnessed fall:

- *Assessment by Medical Practitioner*
- *Neuro Observations and EWS*
- *Check BM*
- *Refer to Trust guidance for further actions*

YES **NO**

OUTCOME 1

- Refer to doctor for Falls Assessment
- Refer to Ward Physiotherapist
- Nurse as close as possible to Nurse's Station (escalate to CSU bleep holder or Clinic Site Manager if bed not available)
- Ensure Call Bell in reach
- Ensure hearing aid / glasses used / in reach
- Footwear - secure fit, non-slip sole, no trailing laces (ask a relative to provide suitable replacement)
- Falls leaflet / booklet given to relatives or carers

Complete:

- Safety sides / bed suitability Assessment (below)
- Continence Assessment (regular toileting)
- Status At A Glance Board
- Send MSU for analysis

Does the patient require specialing? (see outcome 3)

CHECK

OUTCOME 3

Patient

- Can't follow instruction
- Can only stand not walk
- Is agitated / restless
- Has unpredictable behaviour

- Is the patient or relative / carer worried about the risk of falling?

OR

- Has the mobility of the patient changed?

YES

NO

OUTCOME 2

Reassess at:

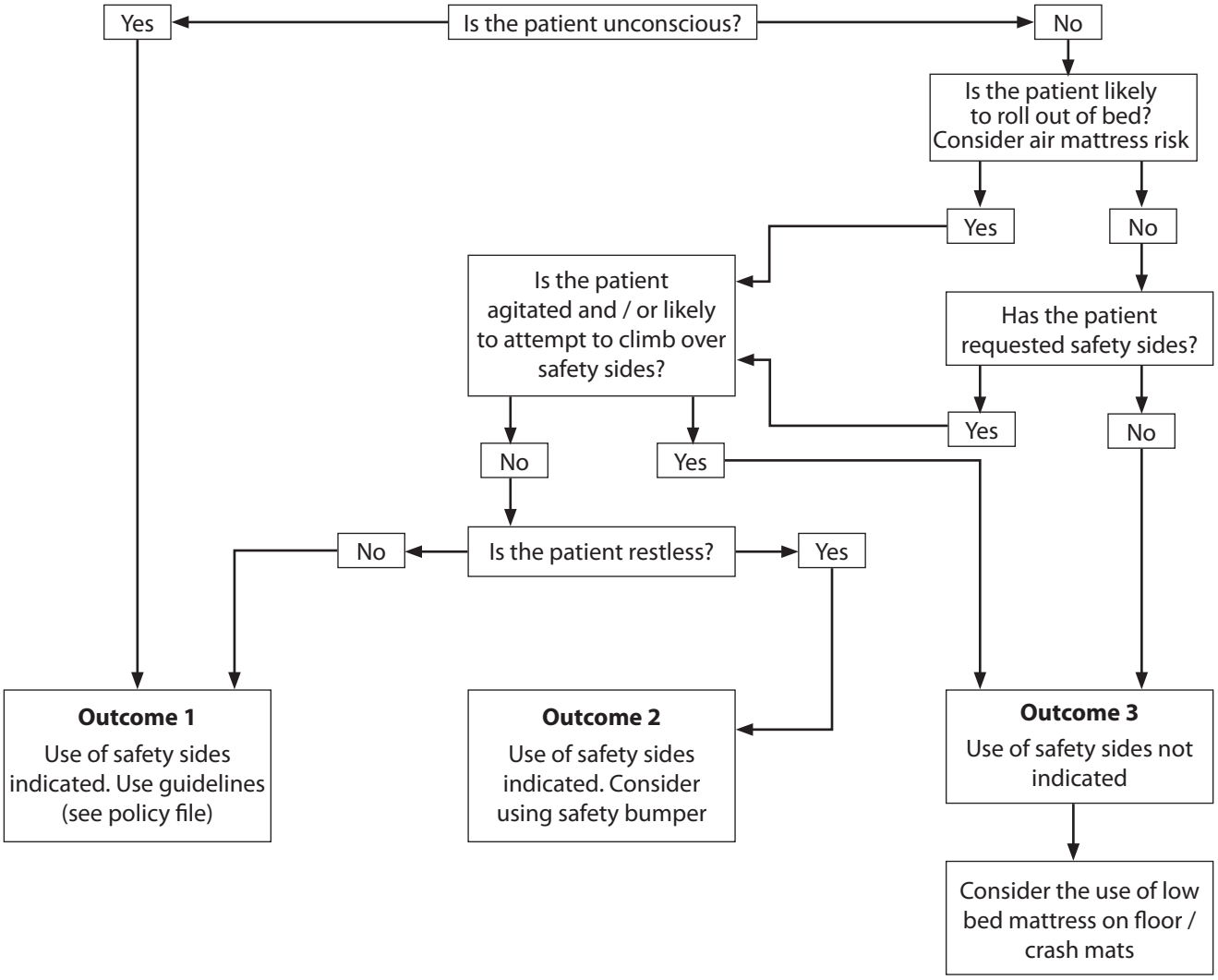
Change of condition / On transfer / Weekly

Outcome: ..... Signature: ..... Date: ..... Date discussed with patient / relative: .....

Outcome: ..... Signature: ..... Date: ..... Date discussed with patient / relative: .....

Outcome: ..... Signature: ..... Date: ..... Date discussed with patient / relative: .....

Outcome: ..... Signature: ..... Date: ..... Date discussed with patient / relative: .....



Outcome: ..... Signature: ..... Date: ..... Date discussed with patient / relative: .....

Outcome: ..... Signature: ..... Date: ..... Date discussed with patient / relative: .....

Outcome: ..... Signature: ..... Date: ..... Date discussed with patient / relative: .....

Outcome: ..... Signature: ..... Date: ..... Date discussed with patient / relative: .....

Date / Time	FALLS / SAFETY SIDES Progress, Action Plan and Exception Reporting	Signature / Print name Designation

OTHER PATIENT INFORMATION

Impaired hearing: ☐ Yes ☐ No Impaired sight: ☐ Yes ☐ No Other state: .....

	Tick factors identified or comment as appropriate	**Assessment 1**	**Assessment 2**	**Assessment 3**	**Assessment 4**
		Ward	**Ward**	**Ward**	**Ward**
		Date	**Date**	**Date**	**Date**
Handling Factors	Unpredictable behaviour				
	Variable/no co-operation				
	Variable/no comprehension				
	Pain (state where)				
	Pressure ulcer/wounds/at risk				
	Type of bed e.g. electric, manual, profiling (state)				
	Type of mattress (state)				
	Infusions/attachment to equipment				
	Traction/splints etc.				
	Oedema (state where)				
	Patient for rehabilitation				
	Muscular spasm/rigidity				
	Paralysis/weakness				
	Continence problems				
	History of falls (see page 8)				
	Additional factors e.g. barrier nursing				
	Other				
Mobility Factors	**Insert code**	**Code***	**Code***	**Code***	**Code***
	Turning (from one side to other)				
	Sitting up in bed				
	Moving up bed				
	Sitting up over edge of bed				
	Getting into bed				
	Transferring from bed/chair/bed				
	Sitting to standing				
	Toileting				
	Walking				
	Climbing stairs				
	Bathing				

***Code** I = Independent - patient requires no assistance whatsoever
S = Supervision - patient requires verbal encouragement/physical presence of handler but no assistance
A = Assistance - patient requires physical assistance of handler but able to help
U = Unable - patient requires assistance of handlers or hoist because unable to help

If codes A or U have been used there is a manual handling risk and a Patient Movement Plan MUST be completed.

☐ **Generic Assessment Relevant - see Manual Handling Assessment Folder**

	Assessment 1	**Assessment 2**	**Assessment 3**	**Assessment 4**
Assessor name (PRINT)				
Assessor designation				
Assessor signature				

PATIENT MOVEMENT PLAN

Tick method in date column and insert number of persons required

	Bed Mobility	**Date**	**Date**	**Date**	**Date**
Turning	Turning				
Sitting up	Sit up assisted from behind				
	Sit up assisted with towel				
Moving up bed	Sitting slide: **state:** towel: sheet slide				
	Supine sheet slide				
	Hoist - **state:** make and sling size				
Sitting up over edge of bed	Swivel method				
	Roll onto side method				
Getting into bed	Swivel method				
	Roll onto side method				
	Sit to Stand only				
From bed or chair or commode	Assisted stand patient supported at side				
	Standing hoist				
	Other aid - **state**				
	Transfers				
Trolley to bed	Lateral transfer with slideboard				
Bed to chair - chair to bed	Assisted stepping patient supported at side				
	Assisted stepping with walking frame				
	Shuffle transfer with slideboard				
	Shuffle transfer without slideboard				
	Reach across 1/2 standing transfer				
	Standing hoist - **state** make				
	Hoist - **state** make and sling size				
Chair to chair	Assisted stepping patient supported at side				
	Assisted stepping with walking frame				
	Shuffle transfer with slideboard				
	Shuffle transfer without slideboard				
	Reach across 1/2 standing transfer				
	Standing hoist - state make				
	Hoist - state make and sling size				
	Toileting				
On/off toilet or commode	Assisted stepping patient supported at side				
	Assisted stepping with walking frame				
	Commode placed behind standing patient				
	Shuffle transfer with slideboard				
	Shuffle transfer without slideboard				
	Reach across 1/2 standing transfer				
	Standing hoist - **state** make				
	Hoist - **state** make and sling size				
In bed	Bridging (raising of pelvis) onto bedpan				
	Roll onto bedpan				
	Hoist onto bedpan				
	Mobilising				
Moving around	Assisted walking patient supported at side				
	Assisted walking patient using frame				
	Assisted walking patient using stick(s)				
	Mobile in wheelchair				
Climbing stairs	Insert details				
	Bathing				
Personal hygiene	Hoist/ambulift into bath				
	Bed bath				
	Shower				
	Assessor Initials				

CONTINENCE ASSESSMENT

Key: ☑ Yes ☒ No

Is the patient: ☐ Continent - no further assessment needed

☐ Urinary incontinent ☐ faecial incontinent ☐ Catheterised - complete catheter care sheet

If 'Yes' to any of the above, is the patient able to manage the situation themselves? ☐ Yes ☐ No

(i.e. requiring minimal input/already under the care of the Community Continence Service)

If 'No' complete Continence Assessment below.

ACUTE CONTINENCE ASSESSMENT

Symptoms:

Urinary? Yes / No Bowels? Yes / No Did you have to get up at night? Yes / No Number: .....

Date of onset: ..... Related to event?: .....

Severity: ☐ Damp underwear ☐ Wet underwear ☐ Wet clothing ☐ Wet floor/furniture

How do you manage at the moment (pads, reduced fluids etc.)? .....

.....

.....

Questions to ask:

1. Does it sting or burn when you pass water? Yes/No
2. Is there blood in your water? Yes/No
3. Do you leak when you cough/laugh/bend/lift a heavy object? Yes/No
4. Do you have an urgent need to use the toilet? Yes/No
5. Do you need to visit the toilet frequently? Yes/No
6. Do you ever leak before you reach the toilet? Yes/No
7. Do you only pass small amounts of water at a time? Yes/No
8. Does your bladder still feel full after passing water? Yes/No
9. Do you ever have to wait or strain to pass water? Yes/No
10. Is your flow of water weak? Yes/No
11. Do you have frequent water infections? Yes/No
12. Do you dribble continuously, or after passing water? Yes/No
13. Have sudden wetness without warning? Yes/No
14. Are you ever unaware that you have been incontinent? Yes/No
15. Do you wet the bed? ☐ Small patch ☐ Large patch Yes/No
16. Do you have problems with mobility resulting in not getting to toilet in time? Yes/No
17. Do you have difficulty managing your clothes when going to toilet? Yes/No
18. Do you present facilities cause/contribute to your urinary problems? Yes/No
19. Do you need to be reminded to go to the toilet to prevent accidents? Yes/No
20. Have you had any operations on your bladder/bowel? .....

Obstetric history:

Number of pregnancies: ..... Number of live births: ..... Birth weights: .....

Quality of life due to urinary symptoms	**Delighted**	**Pleased**	**Mostly satisfied**	**Mixed** - about equally dissatisfied as satisfied	**Mostly dissatisfied**	**Unhappy**	**Very unhappy**
If you were to spend the rest of your life with your urinary condition **just the way it is now, how would you feel about that?**	**0**	**1**	**2**	**3**	**4**	**5**	**6**

Date: ....

Score: ....

CONTINENCE DIAGNOSIS/SUMMARY

Responses to questions

Positive answers	Possible causes	Guidance (see continence algorithm)
Questions 1, or 2	Infection	Urinalysis and/or MSU. Antibiotic treatment Repeated infection requires further investigation.
Questions 3 (stress)	Stress incontinence due to poor pelvic floor tone or incomplete sphincter closure	Teach pelvic floor exercises. Consider oestrogens If no improvement refer to Continence clinic for further investigation.
Questions 4, 5 or 6 (Urge)	Unstable bladder due to medical condition e.g. MS, CVA, post-prostatecomy. Poor fluid intake/type of fluids, 'bad' habits. Infection.	Bladder retraining. Advice on hygiene and fluids. Refer to Doctor for anticholinergic or antibiotic therapy. If no improvement in 3 months refer to Continence Clinic for review of medication and/or electrical stimulation.
Questions 7, 8 9, 10, 11, or 12 (Overflow/dribble)	Incomplete emptying due to enlarged prostate, stricture, faecal impaction, neurogenic bladder or spinal injury.	Aids appliances. Clear the impaction. Bladder stimulation. Intermittent catheterisation. Stricture therapy. Refer to Continence Clinic, with U+E results if residual volume > 200mls.
Questions 13, or 14 (Reflex)	Passive incontinence due to mental impairment, dementia or confusion. nerve damage.	Habit retraining. Aids and appliances. Adapt the environment. Prompting. Toilet programme.
Questions 15 (Bed wetting)	Nocturnal enuresis due to vasopressin deficiency. Prostatism. Over active bladder.	Review of fluid intake. Review of caffeine intake. Desmopressin. Bladder training. Intermittent (self) catheterisation. Anticholinergic.
Questions 16, 17, 18 or 19 (Functional)	Functional incontinence due to underlying clinical or environmental problems.	Adapt the environmental/clothing. Prompted toileting. Refer to Occupational Therapist and/or Physiotherapist.

Problems identified/summary of assessment:

Initial diagnosis:

.....

.....

.....

.....

.....

Print Name: ..... Signature: ..... Designation: .....

Date: ..... Time: .....

ALCOHOL SCREENING

Date: .....

	Questions	Scoring System 0	1	2	3	4	Your score
1	How often do you have 8 (men) / 6 (women) or more units of alcohol on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is 'monthly' or 'less than monthly'							
2	How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
3	How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4	Has a relative/friend/doctor/health worker been concerned about you drinking or advised you to cut down?	No		Yes, but not in the last year		Yes during the last year	

Scoring

If Q1 scores 0, patient is not misusing alcohol - **no further questions**

If Q1 scores, 3 or 4 patient is a harmful, hazardous or dependent drinker - **no further questions**

If Q1 scores 1 or 2, **ask Q2, 3 and 4**

A total score of 3+ indicates hazardous or harmful drinking, follow flowchart (opposite) for action.

Daily units: ..... Weekly units: .....

Type of drinker: ☐ Safe ☐ Hazardous ☐ Harmful Dependent: ☐ Moderately dependent ☐ Severely dependent

This table tells you if you are at risk from drinking alcohol

Risk Level	Men	**Women**	**Common Effects**
Low Risk	≤21 units/week or upto 4 units/ day - with two alcohol-free days	≤14 units/week or upto 3 units/ day - with two alcohol-free days	• Increased relaxation • Reduced risk of heart disease • Sociability
Increased Risk	22-49 units/week or regular drinking of more than 4 units/day	15-35 units/week or regular drinking of more than 3 units/day	• Less energy • Depression/stress • Insomnia • Risk of injury • High blood pressure
High Risk	50 or more units/week	36 or more units/week	All of the above and ... • Memory loss • Risk of liver disease • Risk of cancer • Risk of alcohol dependence

UNITS

One standard drink is:

Half pint of regular beer, lager or cider

1 small glass of wine

1 single measure of spirits

1 small glass of sherry

1 single measure of aperitifs

The following quantities of alcohol contain more than 1 standard drink

Pint of Regular Beer/Lager/Cider

Alcopop or Can of Lager

Glass of Wine (175ml)

Single Measure of Spirits (25ml)

Bottle of Wine

ALCOHOL SCREENING

FAST Screening completed

↓

Alcohol Units daily/weekly identified

↓

Type of drinker identified

↓

SAFE	HAZARDOUS	HARMFUL	DEPENDENT
Sensible drinking is regular and consistent drinking over 2-3 units per day for women and 3-4 units per day for men. A unit is 8g of alcohol. This is equivalent to half a pint of beer, a small glass of wine or one measure of spirits.	**Hazardous drinking is** anyone drinking over recommended limits [21 units for men or 14 units for women] but without alcohol related problems. People drinking in excess of eight units in men six units in women in one session ['binge drinking'] are also at risk of harm even although some may not exceed the 'safe' weekly level.	**Harmful drinking is** anyone drinking over medically recommended levels, probably at somewhat higher levels than that in hazardous drinking. However, unlike hazardous drinkers, they will show clear evidence of alcohol-related problems but often without this having resulted in their seeking treatment.	**Moderate dependent drinker** are those people who present with significant drinking problems. **Severely dependent drinkers** are those people who present with a wide range of alcohol related problems. Some are drinkers with complex problems, such as co-existing physical or physical or mental health needs' polydrug dependence and social problems.

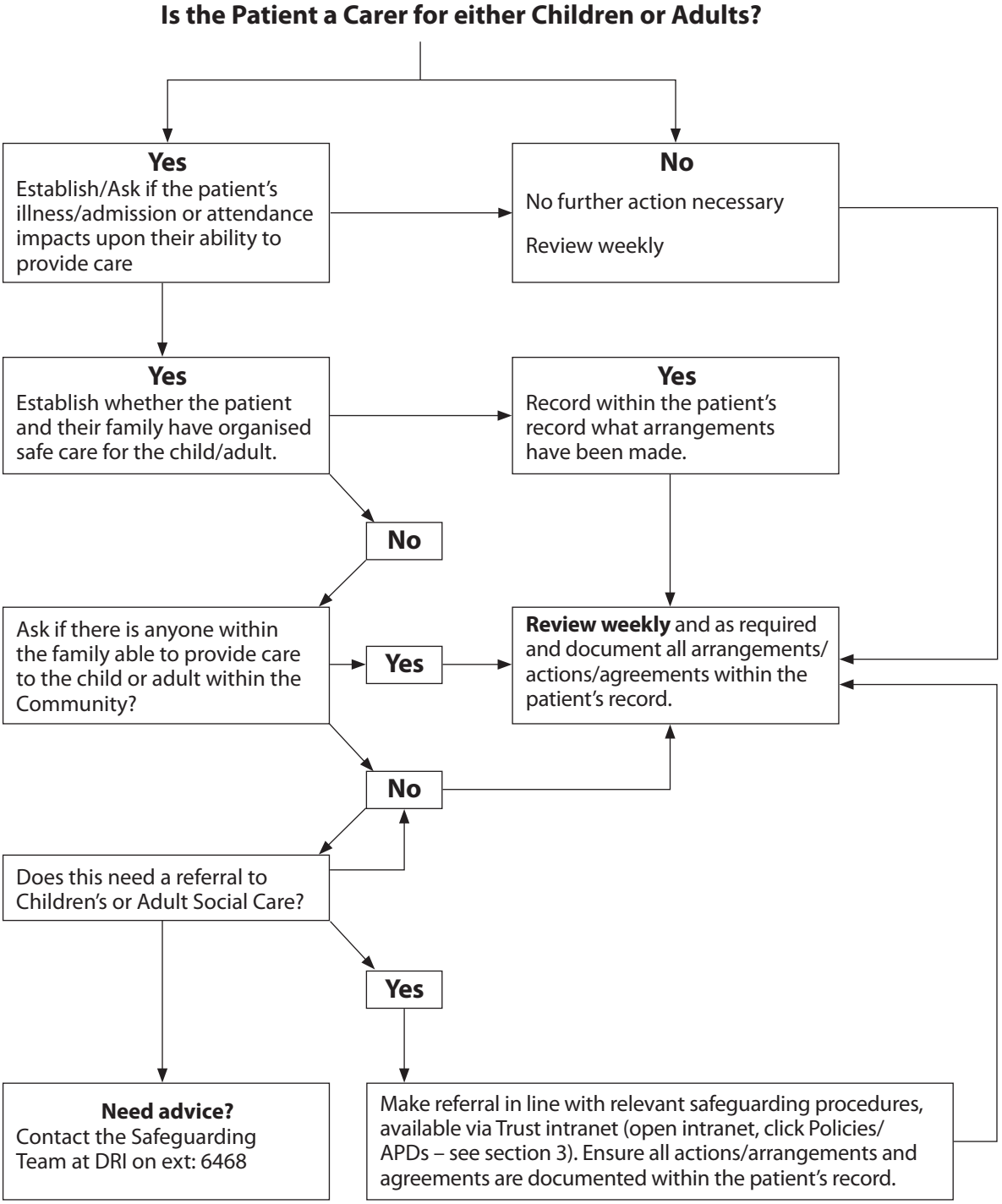
↓

INTERVENTION

↓

None required.	• Offer brief interventions and support • Encourage reduction of alcohol consumption • Reduce alcohol-related harm • Refer to DANS Service	• Offer brief interventions and support • Encourage reduction of consumption • Reduce alcohol-related harm • Deliver treatment that is designed to control both medical and psychological complications which may occur after a heavy sustained alcohol use • Enable patients to achieve abstinence safely and effectively with the minimum discomfort • Relieve physical withdrawal by appropriate pharmcotherapeutic interventions • Enable to adopt an alcohol free lifestyle • Deliver effective psychosocial interventions as determined by a formulated care plan • Refer to DANS Service	• Provide targeted screening for dependent drinkers • Treat alcohol dependent drinkers in a safe and effective manner

NOTE: This documents reflects the contents within the policy document - PAT/T25 Version 1 'Guidelines for the management of alcohol issues in the acute general hospital setting' June 2006


Is the Patient a Carer for either Children or Adults?
Yes
Establish/Ask if the patient's illness/admission or attendance impacts upon their ability to provide care
No
No further action necessary
Review weekly
Yes
Establish whether the patient and their family have organised safe care for the child/adult.
Yes
Record within the patient's record what arrangements have been made.
No
Ask if there is anyone within the family able to provide care to the child or adult within the Community?
Yes
Review weekly and as required and document all arrangements/ actions/agreements within the patient's record.
No
Does this need a referral to Children's or Adult Social Care?
Yes
Need advice?
Contact the Safeguarding Team at DRI on ext: 6468
Make referral in line with relevant safeguarding procedures, available via Trust intranet (open intranet, click Policies/ APDs – see section 3). Ensure all actions/arrangements and agreements are documented within the patient's record.