Dorset County Hospital NHS
NHS Foundation Trust

Risk and Dependency Tool for Adult In-Patients with Additional Support Needs

Patient Name _____

Date of Birth _____ Hospital Number _____

Assessment completed by: *(print names)*

Ward staff _____

Family member(s) _____

Professional/Paid Support staff _____

Date _____

This assessment is designed to be completed at the earliest opportunity for any patient with additional support needs being admitted to hospital. It is essential that the assessment is completed by hospital staff **and** those who know the patient well; this may be family members, paid support staff or both. It is only in this way that likely areas of vulnerability and risk can be effectively and appropriately responded to.

The purpose of the assessment is:

- To identify any areas where the patient may be at risk
- To identify whether any additional support is required to reduce that risk
- To identify how any additional support needs will be managed

Any actions required to eliminate or reduce the risks identified during the completion of this tool, must be included in the patients care plan

Adapted from *Working Together: Guidance for Hospitals, Families and Paid Support Staff* (Home Farm Trust)

Risk Levels

Low Unlikely to impact on equality of outcome – Additional support not indicated.

Medium Likely to impact on equality of outcome – Additional support should be considered.

High Highly likely to impact on equality of outcome – Additional support essential.

What is the required level of additional support and who is the best person to provide it?

When a person with additional support needs is admitted into Dorset County Hospital, adjustments may be needed to provide support for the person's normal everyday needs. This may include additional staff support. Using this tool will enable you to identify if the person is at risk within DCHFT and what level of support is needed. When additional support needs are identified the assessment uses a number system to identify who can most effectively provide any required additional support as follows:

Level 1 Appropriate additional support can be provided by ward staff.

Level 2 Appropriate, additional support can be provided with voluntary input provided by family or existing paid support staff.

Level 3 Additional ward support required [DCHFT Nurse Bank]

Level 4 Additional support from paid support staff is required. Funding for this will need to be agreed with the Ward Sister and Divisional Manager

Where any additional support is provided by care staff or family members this should be carried out under the supervision of a Registered Nurse.

DCHFT remains responsible for all care until discharge.

Example below: 4 hours of additional support from Nurse Bank

Physical Health Needs	**Possible area of risk** [circle as appropriate]	**Risk Level** [circle as appropriate]	**Support Level** [circle as appropriate]	**Insert Number of additional hours required**
Is the patient at risk of choking or dysphagia?	(Yes)	Low	1	-
	No	(Medium)	2	-
	Unknown	High	(3)	4
			4	-

Please complete all the boxes in the assessment form working from left to right.

Communication and comprehension needs	**Possible area of risk** [circle as appropriate]	**Risk Level** [circle as appropriate]	**Support Level** [circle as appropriate]	**Number of additional hours required**
Can the patient orientate themselves?	Yes No Unknown	Low Medium High	1 2 3 4	
Can the patient communicate needs, including pain?	Yes No Unknown	Low Medium High	1 2 3 4	
Can the patient maintain their personal dignity?	Yes No Unknown	Low Medium High	1 2 3 4	
Can the patient understand simple explanation of procedures?	Yes No Unknown	Low Medium High	1 2 3 4	
Can the patient maintain their safety within the ward environment?	Yes No Unknown	Low Medium High	1 2 3 4	
Can the patient maintain their safety away from the ward environment?	Yes No Unknown	Low Medium High	1 2 3 4	
Mental Health Needs	**Possible area of risk** [circle as appropriate]	**Risk Level** [circle as appropriate]	**Support level** [circle as appropriate]	**Number of additional hours required**
Is the patient likely to self harm?	Yes No Unknown	Low Medium High	1 2 3 4	
Is there a risk of suicide?	Yes No Unknown	Low Medium High	1 2 3 4	

Is the patient likely to present destructive behaviour?	Yes No Unknown	Low Medium High	1 2 3 4	
Does the patient have epilepsy?	Yes No Unknown	Low Medium High	1 2 3 4	
Is the patient likely to present violent behaviour?	Yes No Unknown	Low Medium High	1 2 3 4	
Is the patient likely to present hyperactive behaviour?	Yes No Unknown	Low Medium High	1 2 3 4	
Is the patient likely to present inappropriate behaviour?	Yes No Unknown	Low Medium High	1 2 3 4	
Is the patient likely to experience anxiety?	Yes No Unknown	Low Medium High	1 2 3 4	

Physical Health Needs	**Possible area of risk** [circle as appropriate]	**Risk Level** [Circle as appropriate]	**Support Level** [Circle as appropriate]	**Number of additional hours required**
Can the patient maintain their own personal hygiene, including safe hand washing after using toilet?	Yes No Unknown	Low Medium High	1 2 3 4	
Can the patient maintain their own fluid intake?	Yes No Unknown	Low Medium High	1 2 3 4	

Can the patient maintain their own nutrition?	Yes No Unknown	Low Medium High	1 2 3 4	
Is the patient at risk of choking or dysphagia?	Yes No Unknown	Low Medium High	1 2 3 4	
Can the patient manage their own toileting needs?	Yes No Unknown	Low Medium High	1 2 3 4	
Can the patient maintain their own mobility?	Yes No Unknown	Low Medium High	1 2 3 4	
Does the patient have a regular sleep pattern?	Yes No Unknown	Low Medium High	1 2 3 4	
Is the patient at risk from pressure areas?	Yes No Unknown	Low Medium High	1 2 3 4	
Does the patient require any special equipment?	Yes No Unknown	Low Medium High	1 2 3 4	

Outcome of Assessment (transfer any actions to care plan).

Summary of how additional support needs will be met:

Communication and comprehension needs:

Mental health needs:

Physical health care needs:

Actions Taken:

Name of hospital staff_____ Designation_____ Date_____

Family Carer_____ Relationship_____ Date_____

Professional/Paid Carer_____ Designation_____Date_____

Ward Sister _____ Date_____