Buckinghamshire Healthcare NHS
NHS Trust

Stoke Mandeville Hospital

ADULT NEEDS ASSESSMENT CHECKLIST

In order for this form to be scored up correctly,
PLEASE ENSURE ALL SECTIONS ARE FULLY COMPLETED.
Add any points in the comment box of each section which you feel are important to be noted when the final summary is prepared.

PATIENT NAME:	**DOB:**
ADDRESS:	**GENDER:**
	CIVIC STATUS:
	ETHNICITY:
(TO ENSURE ACCURACY, PLEASE AFFIX PATIENT STICKY LABEL)	

Level of Injury	ASIA grade	Cause	Date of Injury

Admitting hospital at injury	Current ward at NSIC	Mobilisation date

Date admitted to St Andrew's	Date admitted to rehabilitation ward	Date admitted to St Joseph's

Consultant		Named Nurse	
Keyworker		Clinical Psychologist	
OT		Case Manager	
Physio		Care Manager (community)	

Date of goal planning meeting *(if arranged at this stage)*

Date form completed	By whom *(staff member's name)*

Is this the patient's **FIRST** ☐ OR **SECOND** ☐ OR **THIRD** ☐ **NAC?**

If this is a **1st NAC**, have you given the patient a copy of the booklet on goal planning? **YES** ☐ **NO** ☐

If NOT, would the patient like a copy of the booklet sent with his/her summary sheet? **YES** ☐ **NO** ☐

Dear Keyworker/Named Nurse

In completing this Checklist the patient, with your support, is making an assessment of their current strengths, needs and abilities. As a Keyworker you will need to use your professional knowledge of spinal cord injury to support the patient in responding to the questions in each area.

Where the nature of a patient's injury makes physical independence impossible, the rating should be based on the patient's level of **verbal independence**, i.e. the extent to which the patient is able to instruct staff/carers in carrying out the activity in question. HOWEVER, if it is predicted that the patient will be **physically independent** on discharge (rather than verbally) then you should score according to what the patient can physically achieve now, rather than what he/she can verbally achieve at the present time. Please indicate throughout the assessment whether you have used the physical *(or verbal)* scale.

PLEASE READ THE FOLLOWING TO THE PATIENT WHEN YOU FIRST MEET TO COMPLETE THE NEEDS ASSESSMENT CHECKLIST:

"This Checklist highlights some of the main areas of need that you now have as a consequence of your spinal cord injury. It rates your involvement and awareness on a number of aspects of your rehabilitation on a scale according to the degree of physical/verbal independence you have achieved in carrying out each activity, as follows:

*0 = patient completely **DEPENDENT** on staff / carers; knows nothing about x / has never attempted to do x / never does x*

*1 = patient mostly **DEPENDENT** on staff / carers; knows a little about x / has perhaps attempted to do x once / sometimes does x*

*2 = patient moderately **INDEPENDENT**; knows a fair bit about x / may just need more practice at x / usually does x*

*3 = patient completely **INDEPENDENT**; has complete knowledge of x / can do x successfully / always does x*

*NA = **NOT APPLICABLE**. This section should only be ticked when the activity is not applicable to the patient.*

*There are a lot of questions, and it is important that you answer each question in relation to your knowledge/ability to do a task **at this particular moment in time**.*

These questions will help the team working with you in your rehabilitation to pinpoint the areas of need that you would benefit from working on, and those you wish to concentrate on.

Goal planning meetings can then be arranged in coordination with this Checklist, and goals set to ensure that you are fully knowledgeable and verbally/physically independent in all aspects of your rehabilitation here."

AFTER COMPLETING THE CHECKLIST:

"Thank you for your time and help in completing this important checklist. The information will now be drawn up on a graph and a brief summary of your achievements/goals typed up. A copy will be sent to you as soon as possible".

Key 0 = completely **de**pendent/never does 2 = moderately **inde**pendent/usually does (or instructs someone to)
1 = mostly **de**pendent/rarely does 3 = completely **inde**pendent/always does (or instructs someone to)

1. PHYSICAL HEALTH CARE

1.1 Medical

NB: PLEASE ANSWER ALL QUESTIONS	YES 3	NO 0	N/A 3	Comments
Have you had your diagnosis/prognosis explained to you and do you understand it?				
Do you know the name of the medications that you take?				
Can you describe why you take these medications?				
Do you know the dose of your medications?				
Do you understand the side effects and precautions regarding your medications?				
Do you know what your 'new normal' blood pressure is?				
Do you have any pre-existing medical problems, e.g. diabetes? IF "YES", what?				
Do you know how your spinal cord injury impacts on the management of any pre-existing medical problems?				
Have you received information on how to manage your weight?				
Do you have sight difficulties and require this to be assessed further?	0	3		
Do you have hearing difficulties and require this to be assessed further?	0	3		
Do you need to see the chiropodist to cut your nails?	0	3		

Do you smoke?

YES		NO	

NB: PLEASE ANSWER ALL QUESTIONS	YES 3	NO 0	N/A 3	Comments
IF YES, have you been given advice about the risks of smoking?				
IF "YES", would you like support in giving up smoking?	0	3		

1.2 Pain

Please rate your **pain unpleasantness** by circling the number that best describes your unpleasantness on average in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10

No pain *As bad as you can imagine*

NB: PLEASE ANSWER ALL QUESTIONS	YES 3	NO 0	N/A 3	Comments
Does pain interfere with your ability to get on with your rehabilitation?	0	3		
Have you had any information on the type of pain that you experience?				
Have you had as much information on pain management as you want?				
If you have medication prescribed for your pain, does this need review?	0	3		

1.3 Spasm and Spasticity

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: PLEASE ANSWER ALL QUESTIONS	YES 3	NO 0	N/A 3	Comments
Do you know what spasm and spasticity is?				
Do you know the advantages and disadvantages of experiencing spasm and spasticity?				
Do you *(INSTRUCT OTHERS TO)** handle your limbs safely when they spasm?				
Do you know what to check to find the cause of sudden increases in spasm?				
If you have medication prescribed for spasm, does this need review?	0	3		

NB:

ONLY ADMINISTER SECTIONS 1.4 - 1.7 TO PATIENTS WITH COMPLETE AND INCOMPLETE LESIONS ABOVE T6.

PUT A LINE THROUGH PAGES 5 & 6 IF THEY DO NOT APPLY AND GO DIRECTLY TO PAGE 7, SECTION 2.

1.4 Autonomic Dysreflexia

Have you experienced an episode of Autonomic Dysreflexia (AD)?	YES		NO		DON'T KNOW	
Are you prone to AD?	YES		NO		DON'T KNOW	

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: PLEASE ANSWER ALL QUESTIONS	YES 3	NO 0	N/A 3	Comments
Can you explain what AD is?				
Do you know what the signs and symptoms of AD are?				
Do you know what the common causes and risks of AD are?				
Can you *(INSTRUCT OTHERS TO)** manage an episode of AD?				
Do you know how to and how frequently to *(INSTRUCT OTHERS TO)** take Nifedipine?				
Do you have your own supply of Nifedipine to carry with you?				
Do you have an AD alert card to carry with you?				

1.5 Respiratory Management

NB: PLEASE ANSWER ALL QUESTIONS	YES 3	NO 0	N/A 3	Comments
Do you know what your normal vital capacity is?				
Can you identify when you have, or are developing, a respiratory problem?				
Can you recognise the early signs of a chest infection?				
Would you know how to sort the above problem out?				
Have you been given an incentive spirometer for continuing use?				

1.6 Secretion Clearance

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: PLEASE ANSWER ALL QUESTIONS	YES 3	NO 0	N/A 3	Comments
Do you know how to *(INSTRUCT OTHERS TO)** clear your secretions by assisted coughing in both the lying position and when sitting in a wheelchair?				
Do you know any other techniques that assist you in clearing secretions, e.g. postural drainage position, shaking, vibrations, cough assist machine etc?				
Have you trialled the cough assist machine to manage secretion clearance?				

1.7 Ventilator Dependent Patients

NB: PLEASE ANSWER ALL QUESTIONS	YES 3	NO 0	N/A 3	Comments
Do you know your type and model of ventilator?				
Do you know your ventilator settings?				
Have you tried techniques to help you breath when off your ventilator e.g. glossopharyngeal breathing (frog breathing)?				
Do you know what your normal oxygen saturation levels are?				
Can you instruct someone on how to do a tracheal suction?				
Do you know when you need a suction?				
Do you know the size of suction catheters you use?				
Do you know how often you have your trache changed?				
Do you know what size trache you use?				
Do you know the type of trache you use?				

Key 0 = completely **de**pendent/never does 2 = moderately **inde**pendent/usually does (or instructs someone to)
1 = mostly **de**pendent/rarely does 3 = completely **inde**pendent/always does (or instructs someone to)

2. DAILY LIVING ACTIVITIES

2.1 Food Management

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** use cutlery (knives, forks, spoons etc)?						
Can you *(INSTRUCT OTHERS TO)** pick up a cup/glass?						
Can you *(INSTRUCT OTHERS TO)** get a drink?						
Can you *(INSTRUCT OTHERS TO)** carry/handle dishes and plates?						

Have you been involved in preparing a meal? YES 3 NO 0 N/A 3

Do you use any special equipment to help you eat? YES NO

IF YES, what?

Have you had a formal kitchen assessment in OT *(PRACTICAL/VERBAL)**? YES 3 NO 0 N/A 3

2.2 Dressing

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** dress your upper body?						
Can you *(INSTRUCT OTHERS TO)** undress your upper body?						
Can you *(INSTRUCT OTHERS TO)** dress your lower body?						
Can you *(INSTRUCT OTHERS TO)** undress your lower body?						
Can you *(INSTRUCT OTHERS TO)** put on shoes/tie laces?						
Can you *(INSTRUCT OTHERS TO)** use fasteners (zips, buttons etc)?						

Do you use any special equipment to help you dress? YES NO

IF YES, what?

Have you had any dressing practice with your OT? YES 3 NO 0 N/A 3

2.3 Facial Hygiene

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** wash your face?						
Can you *(INSTRUCT OTHERS TO)** shave/put make-up on?						
Can you *(INSTRUCT OTHERS TO)** comb/style your hair?						
Can you *(INSTRUCT OTHERS TO)** wash your hair?						
Can you *(INSTRUCT OTHERS TO)** brush your teeth (incl. toothpaste application)?						

Do you use any special equipment to help you in your facial hygiene?

YES ☐ NO ☐

IF YES, what?

2.4 Personal Hygiene

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** wash your upper body (front and back)?						
Can you *(INSTRUCT OTHERS TO)** wash your lower body (including feet)?						
Can you *(INSTRUCT OTHERS TO)** dry your upper body (front and back)?						
Can you *(INSTRUCT OTHERS TO)** dry your lower body (including feet)?						

Do you use any special equipment to help you in your personal hygiene?

YES ☐ NO ☐

IF YES, what?

Do you have any other personal care requirements which need addressing (e.g. hair removal, cream application, deodorant)?

Have you had advice on menstruation?

YES 3 ☐ NO 0 ☐ N/A 3 ☐

Can you *(INSTRUCT OTHERS TO)** use tampons/sanitary towels?

YES 3 ☐ NO 0 ☐ N/A 3 ☐

Key 0 = completely **de**pendent/never does 2 = moderately **inde**pendent/usually does (or instructs someone to)
1 = mostly **de**pendent/rarely does 3 = completely **inde**pendent/always does (or instructs someone to)

3. SKIN AND POSTURE MANAGEMENT

3.1 Skin Checks

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** check your skin with a mirror?						

Have you purchased a mirror?

YES	3	NO	0	N/A	3

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Do you know what to look for and where to look?						
Do you *(INSTRUCT OTHERS TO)** check your skin?						
Do you know what to do if you find a red mark or pressure ulcer?						
If you have a red mark, do you know how to decide if you should stay in bed or get up in your wheelchair, and how to keep pressure off the area?						
Do you (*INSTRUCT OTHERS TO)** check your feet regularly to avoid ingrowing toenails?						

3.2 Preventing Skin Problems

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

Have you attended your first appointment at the Posture and Seating Clinic?

YES	3	NO	0	N/A	3

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** relieve pressure by leaning forward or side-to-side in your wheelchair?						
Do you know how often and for how long to carry out pressure relief?						
Do you (*INSTRUCT OTHERS TO)** regularly do pressure relief?						
Are you aware of how often to turn in bed?						
Are you aware of factors that increase the risk of damage to your skin e.g. illness, hot objects, zips, seams, pockets, etc?						
Do you know how to *(INSTRUCT OTHERS TO)** avoid damage caused by accidental scraping/bumping when transferring?						

3.3 Posture

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Are you aware of correct posture in bed and in a wheelchair?						
Can you *(DO YOU INSTRUCT OTHERS TO)** position yourself and your pillows correctly in bed to prevent skin and posture problems?						
Can you *(DO YOU INSTRUCT OTHERS TO)** position yourself correctly in your wheelchair to prevent skin and posture problems?						
Do you understand that adjusting your wheelchair and cushion affects skin management?						

Do you use any special equipment to help you in your skin and posture management?	YES		NO	

IF YES, what?

3.4 Stretching

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** maintain a full range of movements in all your joints by stretching e.g. hands, arms, legs, trunk etc?						

Do you know why it is important to maintain joint mobility and a full range of movements in all your joints?	YES	3	NO	0	N/A	3

4. BLADDER MANAGEMENT

What method of bladder management do you use?

Are any other methods going to be tried?

YES		NO		DON'T KNOW	

If YES, what are they?

	YES		NO		DON'T KNOW		N/A	
Have you had a Renal Ultrasound?	YES	3	NO	0	DON'T KNOW	0	N/A	3
Have you had an Abdominal X-Ray?	YES	3	NO	0	DON'T KNOW	0	N/A	3
Have you had Urodynamics?	YES	3	NO	0	DON'T KNOW	0	N/A	3
Have you had a Cystoscopy?	YES	3	NO	0	DON'T KNOW	0	N/A	3

4.1 Bladder Care

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Do you know the make/brand/size of catheter/sheath that you use?						
Do you know how to get supplies of catheters/sheaths?						

4.2 Bladder Related Problems

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Do you know the possible causes of not passing urine e.g. blocked catheter, kinking in the catheter/drainage tubing?						
Do you know how to recognise when you are not passing urine?						
Do you know how to sort this problem out?						
Do you know the amount of fluid per day you should drink?						
Can you recognise the early signs of a urinary tract infection?						
Can you *(INSTRUCT OTHERS TO)** take a urine sample?						
Do you know what to do if you have difficulties with your catheter/sheath e.g. if it blocks, falls out, won't come out or bleeding occurs?						

ONLY COMPLETE THE RELEVANT SECTION BELOW: ie A, B OR C

A. Suprapubic/Indwelling Catheterisation

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Do you know how often to change your catheter/sheath and why?						
Can you *(INSTRUCT OTHERS TO)** hygienically change your catheter?						
Can you *(INSTRUCT OTHERS TO)** empty and change your leg and night drainage bag?						
Can you *(INSTRUCT OTHERS TO)** care for your suprapubic site?						
If you use a flip flow, can you *(INSTRUCT OTHERS TO)** clamp and release?						
Do you know how often to release the flip flow?						
Do you understand the importance of maintaining a 'closed circuit'?						
If you are unable to change your catheter after discharge, do you know who will change it for you and how often?						

B. Self-Intermittent Catheterisation

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Are you independent in *(DO YOU INSTRUCT OTHERS IN)** performing self-intermittent catheterisation in bed?						
Are you independent in *(DO YOU INSTRUCT OTHERS IN)** performing self-intermittent catheterisation in your wheelchair?						

C. Sheath Drainage

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Do you know how often to change your sheath and why?						
Can you *(INSTRUCT OTHERS TO)** change your sheath?						
Can you *(INSTRUCT OTHERS TO)** prevent blow-outs?						

Key 0 = completely **de**pendent/never does 2 = moderately **inde**pendent/usually does (or instructs someone to)
1 = mostly **de**pendent/rarely does 3 = completely **inde**pendent/always does (or instructs someone to)

5. BOWEL MANAGEMENT

What type of bowel function do you have?	Voluntary		Reflex		Flaccid		
Where is your bowel care performed?	Bed		Shower chair		Toilet		
Where will your bowel care be performed on discharge?	Bed		Shower chair		Toilet		

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Do you know how to avoid constipation through managing your diet?						
Do you know the dose and type of aperients you use?						
Do you know the dose and type of suppositories you use?						
Can you *(INSTRUCT OTHERS TO)** insert your suppositories?						
Can you *(INSTRUCT OTHERS TO)** perform digital rectal stimulation?						
Can you *(DO YOU INSTRUCT OTHERS TO)** do a manual evacuation of faeces?						
Can you *(INSTRUCT OTHERS TO)** do a digital 'PR' check?						
Can you *(INSTRUCT OTHERS TO)** hygienically cleanse yourself after using the toilet?						
Can you *(INSTRUCT OTHERS TO)** hygienically manage your bowel regime on the bed?						
Do you know where to seek help if you experience problems after discharge?	NO	0		YES	3	
Do you have access/transfer to a toilet at home?	NO	0		YES	3	

Is a shower chair assessment required?	YES	0	N/A	3	ALREADY TAKEN PLACE	3

Key 0 = completely **de**pendent/never does 2 = moderately **inde**pendent/usually does (or instructs someone to)
1 = mostly **de**pendent/rarely does 3 = completely **inde**pendent/always does (or instructs someone to)

6. MOBILITY

6.1 Transfers

Do you use a hoist? YES ☐ NO ☐ EMERGENCIES ONLY ☐

Do you use a sliding board? YES ☐ NO ☐ EMERGENCIES ONLY ☐

What type of hoist and/or sliding board do you use?

How will you transfer after discharge?

Any other equipment needed?

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** transfer to/from a bed?						
Can you *(INSTRUCT OTHERS TO)** transfer to/from a shower chair?						
Can you *(INSTRUCT OTHERS TO)** transfer to/from a toilet?						
Can you *(INSTRUCT OTHERS TO)** transfer to/from a bath?						

	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** transfer to/from a car?						

Have you considered alternative methods for using a car e.g. adapted vehicle? YES 3 ☐ NO 0 ☐ N/A 3 ☐

	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** transfer to/from the floor?						

Have you considered alternative methods for floor transfers e.g. staged lifts? YES 3 ☐ NO 0 ☐ N/A 3 ☐

6.2 Wheelchair Skills

Do you use a	Manual wheelchair?		Powered wheelchair?	

Have you been taught wheelchair skills?	YES	3	NO	0	N/A	3

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** move around the Centre?						
Can you *(INSTRUCT OTHERS TO)** move up/down slopes?						
Can you *(INSTRUCT OTHERS TO)** move around on uneven ground?						
Can you *(INSTRUCT OTHERS TO)** get your wheelchair in/out of a car?						
Can you *(INSTRUCT OTHERS TO)** go up/down kerbs in your wheelchair?						
Can you *(INSTRUCT OTHERS TO)** go up/down stairs in your wheelchair?						
Can you *(INSTRUCT OTHERS TO)** go up/down stairs on your bottom?						

6.3 Ambulation

Administer to patients with a lesion sufficiently incomplete or at a level giving potential for ambulation

Has your potential for functional ambulation been discussed with your physiotherapist?	YES	3	NO	0	N/A	3

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Can you ambulate with orthoses? IF SO, which?.....						
Can you ambulate with a frame? IF SO, which?……						
Can you ambulate with other equipment? IF SO, what? ……						
Can you go up/down stairs?						
Is your equipment needed for ambulation in place for discharge?						
Do you know how to replace your equip-ment for ambulation after discharge?						

Key 0 = completely **de**pendent/never does 2 = moderately **inde**pendent/usually does (or instructs someone to)
1 = mostly **de**pendent/rarely does 3 = completely **inde**pendent/always does (or instructs someone to)

7. WHEELCHAIR AND EQUIPMENT

7.1 Wheelchair

NB: ANSWER ALL QUESTIONS	Yes	No	N/A	Comments
Has contact been made with your wheelchair service?				
Have you discussed your powered wheelchair requirements with OT?				
Have you attended a lightweight wheelchair clinic?				
Has it been decided which wheelchair you will be provided with on discharge?				

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Do you know your discharge wheelchair make and model?						
Do you know how to contact your wheelchair providers?						
Do you understand how to maintain your wheelchair?						

7.2 Cushion

NB: ANSWER ALL QUESTIONS	Yes	No	N/A	Comments
Has it been decided which cushion you should have on discharge?				
Has your cushion been ordered from your wheelchair service?				

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Do you know your discharge cushion size and type?						
Do you know how to recognise signs of wear and tear on your cushion?						
Do you know how and where to replace your cushion?						
Do you know how to position your cushion correctly in your wheelchair?						

7.3 Standing Frames

Will you be using a standing device after discharge?	YES		NO	

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Do you know the reason for standing?						
Do you know how often and for how long to use your standing device?						
Can you *(INSTRUCT OTHERS TO)** transfer in/out of a standing device?						
If you require assistance with transferring on discharge, has the person been identified and received training?						

7.4 Splints, Calipers and Brace

Do you wear upper limb splints?	Yes		No	
What type are they?				
Do you wear lower limb splints/orthoses?	Yes		No	
What type are they?				
Do you wear a trunk support/brace?	Yes		No	
What type is it?				

*** IT IS IMPORTANT TO NOTE WHETHER THE PATIENT IS PHYSICALLY OR VERBALLY INDEPENDENT BY HIGHLIGHTING ACCORDINGLY**

NB: ANSWER ALL QUESTIONS	0	1	2	3	N/A	Comments
Can you *(INSTRUCT OTHERS TO)** put your splints/orthoses/brace on and take off?						
Do you know the reason for using splints/orthoses/brace?						
Do you know when to review your splints/orthoses/brace?						
Do you know your splint/orthoses/brace wearing time?						

7.5 Equipment on Discharge

*Please add any extra equipment needed in the blank boxes provided below**

NB: TICK ONE BOX FOR EACH ITEM	To be ordered	Already ordered	N/A or already in place		To be ordered	Already ordered	N/A or already in place
Bed				Wheelchair			
Mattress				Cushion			
Sliding sheets				Standing device			
Hoist				Orthoses e.g. splints			
Transfer Board				Walking equipment			
Shower Chair				*			
Padded toilet seat				*			
Positioning equipment				*			

7.6 Disposable Supplies

Knowledge of brand and where to obtain it	0	1	2	3	N/A	Comments
Sheaths						
Leg bags						
Bed bags						
Catheters						
Disposables e.g. catheter valves, gloves etc						
Disposable sheets						

8. COMMUNITY PREPARATION

8.1 Community Skills

Have you been out of the Centre?	Not yet	0	Once or twice?	1	3 or 4 times?	2	5 or more times?	3

Please tick all applicable boxes:

Have you been to?						
	the local shop	1	the town centre	1	a restaurant	1
	a pub/hotel	1	Stoke Mandeville Stadium	1	a friend's house	1

Have you had information on/the opportunity to practise:

	YES		NO		N/A	
Shopping	YES	3	NO	0	N/A	3
Accessing your bank and handling money	YES	3	NO	0	N/A	3
Accessing your local library	YES	3	NO	0	N/A	3
Accessing disabled toilets and radar key	YES	3	NO	0	N/A	3
Accessing public transport	YES	3	NO	0	N/A	3
Computer skills/accessing the internet	YES	3	NO	0	N/A	3
Using a washing machine	YES	3	NO	0	N/A	3
Ironing	YES	3	NO	0	N/A	3

Do you know how to book the Barbara Bus?	YES	3	NO	0	N/A	3

8.2 Continuing Education

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	? 0	N/A 3	Comments
Have your options for further education been discussed with you by OT or other professionals?					
Have you made arrangements to return to further education?					
If you are returning to sixth form/college/ university, has an assessment visit been made?					

8.3 Employment

Were you employed at the time of your injury?	YES		NO		RETIRED		N/A	

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	? 0	N/A 3	Comments
Have you contacted your employer?					
Have you made plans to return to work?					
IF YOU ARE RETURNING TO WORK, are adaptations to the workplace required?	0	3			
Are you aware of the "Access to Work" information from OT?					
Have you been referred to the Employment and Careers Advisory Service through OT?					
Have you contacted the Disabled Employment Adviser (DEA)?					

8.4 Community Preparation and Teaching

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	? 0	N/A 3	Comments
Have you attended ALL the patient teaching sessions *(not just those listed below)*?					
IF NO, have you attended: Bladder?					
Bowel?					
Skin?					
Sexuality?					
Are you aware of the patient information leaflets?					
Has your family attended Relatives' Day?					

8.5 Driving and Related Issues

Do you plan on returning to driving?	YES		NO		N/A	

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	? 0	N/A 3	Comments
Do you hold a current full/provisional driving licence?					
Have you arranged a driving assessment through OT? (IF YES, give date: ……/……/……)					
Do you know how to obtain an appropriate vehicle e.g. motability scheme?					
Do you know how to get adaptations made to your vehicle?					
Have you informed DVLA and Insurance of your injury *(please state which, if only one informed)*					
Have you applied for a "Blue" badge?					

9. PSYCHOLOGICAL ISSUES

9.1 Mood

Indicate which best describes your feelings **OVER THE PAST WEEK** by ticking one box relating to each of the following eight questions:

1.	**DO YOU FEEL SAD?** *(tick one of the four boxes)*:						
	Not at this time	3	Sometimes	2	Most of the time	1	Always	0

2.	**ARE YOU DISTRESSED?** *(tick one of the four boxes)*:						
	Not at this time	3	Sometimes	2	Most of the time	1	Always	0

3.	**ARE YOU FRIGHTENED ABOUT THE FUTURE?** *(tick one of the four boxes)*:						
	Not at this time	3	Sometimes	2	Most of the time	1	Always	0

4.	**DO YOU FEEL PANICKY?** *(tick one of the four boxes)*:						
	Not at this time	3	Sometimes	2	Most of the time	1	Always	0

5.	**DO YOU WAKE IN THE EARLY HOURS OF THE MORNING AND HAVE DIFFICULTY GETTING BACK TO SLEEP?** *(tick one of the four boxes)*:						
	Not at this time	3	Sometimes	2	Most of the time	1	Always	0

6.	**DO YOU HAVE A POOR APPETITE?** *(tick one of the four boxes)*:						
	Not at this time	3	Sometimes	2	Most of the time	1	Always	0

7.	**DO YOU FEEL EXCESSIVELY TIRED?** *(tick one of the four boxes)*:						
	Not at this time	3	Sometimes	2	Most of the time	1	Always	0

8.	**ARE YOU WORRIED ABOUT THE FUTURE?** *(tick one of the four boxes)*:						
	Not at this time	3	Sometimes	2	Most of the time	1	Always	0

9.2 Adjustment Issues

The following questions ask how often you have certain feelings/beliefs about your injury. Please read each statement carefully, indicating how often you feel like this by ticking the appropriate number of the scale, as follows:

column 1 = **NOT AT ALL** column 2 = **SOMETIMES** column 3 = **FAIRLY OFTEN** column 4 = **ALMOST ALWAYS**

NB: ANSWER ALL QUESTIONS	1	2	3	4
I believe that this situation is manageable				
I feel that I have learnt the skills to cope with most of the problems that have arisen from my injury/illness				
I believe that I am able to continue to take part in activities that I find enjoyable and rewarding				
I feel supported by the people around me				
I am motivated to engage in what happens around me				

9.3 Sexuality and Relationships

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	N/A 3	Comments
Have you been informed of any changes in sexual function?				
Do you know how to manage these changes?				
Are you aware of the Sexual Relationships and Fertility Advice Clinic in Spinal Outpatients Dept?				
Have you had advice on your continued sexual health e.g. cervical smears, breast or testicular examination?				
Have you received fertility/contraceptive advice?				
Have you had as much information as you want about sexual issues?				

9.4 Support

In relation to children:

Are you aware that there is a family room on the ground floor of the NSIC that can be used by children when visiting patients?

YES	3	NO	0	N/A	3

Are you a parent or carer of children under 18 years of age or of an older or vulnerable person?

Yes		No	

If YES, are there any aspects of care that you need help or advice with?	*Please briefly explain …*

Does your partner/family/child require support/counselling?

YES	0	NO	3	ALREADY TAKING PLACE	3

IF YES, PLEASE STATE NAME AND RELATIONSHIP TO PATIENT: ……

10. DISCHARGE COORDINATION

Do you require a review of your seating at the Posture and Seating Clinic prior to discharge?	Yes	3	No	0	N/A	3
Do you know about the services provided by Spinal Out-Patients?	Yes	3	No	0	N/A	3

10.1 Community Issues

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	? 0	N/A 3	Comments
Have you met your Case Manager from the NSIC?					
Has your Case Manager assessed/discussed your discharge needs/concerns e.g. benefits, housing, possible care needs, solicitors, armed forces etc?					
Has a referral been made to the necessary departments, where appropriate e.g. your local Social Services Department, Primary Care Trust?					
IF APPLICABLE, do you know how to contact these services?					
Have you had/arranged a discharge planning meeting?					
Have you been given a provisional discharge date? (If YES, give date: ……/……/……)					
Have you applied for all the appropriate benefits?					
IF APPLICABLE, has your Case Manager offered/ given you the SIA Personal Injury Solicitor Book?					

10.2 Accommodation

What accommodation do you currently have?

Privately owned		Privately rented	
Council owned		Housing Association	
Homeless		Other	

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	? 0	N/A 3	Comments
Have you spent time in the NSIC bungalow?					
Have you been referred for an environmental control assessment?					
Has a Community Occupational Therapist visited and assessed your home?					
Do you intend on returning to your home?					
Do you need rehousing?	0	3			
IF SO, has a housing needs report and application been made to your housing department?					
Has your OT explained to you the timescale of adaptations and the reasons?					
Is your home suitable for overnight visits now?					
IF IT IS SUITABLE, have overnight visits begun?					
Are adaptations needed in your home?	0	3			
IF YES, are they: minor adaptations?					
major adaptations?	0	3			
IF APPLICABLE, do you plan on applying for a Disabled Facilities Grant (DFG)?	0	3			
IF REQUIRED, have you obtained planning permission for work to be done at your home?					
Has a building date been set?					

10.3 Arrangements for Discharge Accommodation

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	? 0	N/A 3	Comments
Will your home be ready to return to by your discharge date?					
IF NO, have options been discussed with respect to identifying/visiting suitable interim accommodation?					
Does a long-term residential/nursing home placement need arranging?	0	3			

10.4 Care Package

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	? 0	N/A 3	Comments
Have care arrangements for overnight home leave been discussed and agreed?					
Have you completed the independent living programme talks and your own care plan?					
Has an assessment of your needs been undertaken by the community?					
Have you received, read and approved a copy of your social worker/care manager 'care plan'?					
Have the funding options for your care been explained and agreed?					
Have you completed all the relevant funding forms e.g. Independent Living Fund, Continuing Care and Social Services?					
Have arrangements been made to train people who will be giving you care e.g. carers' day etc?					
IF APPLICABLE, do you know how to contact your Agency or Care Manager?					

10.5 District Nursing Service

NB: ANSWER ALL QUESTIONS	Yes 3	No 0	? 0	N/A 3	Comments
Do you know how to contact your District Nurse both in and out of working hours?					
Has your Named Nurse contacted your District Nurse to discuss your specific needs?					

TURN OVER TO BACK PAGE TO MAKE A NOTE OF ANY NON-SPECIFIC GOALS

11. NON-SPECIFIC GOALS

Please list below any areas that are not included in this questionnaire which you feel you would benefit from by including them in your goal planning programme?

GOAL:	TARGET:

Amended August 2008