

Holistic Needs Assessment Template

Assessment information and preferences	
Date of last assessment	<i>The assessor should have copies of previous holistic assessments on file, should be aware of the needs identified in previous assessments, and should be aware of actions taken to address those needs.</i>
Date of this assessment	
Name, role and contact details of assessor	
Key point / trigger	<i>Key point at which the assessment is being undertaken or the trigger for assessment (e.g. professional concerns, patient initiated, carer initiated)</i>
Site of this assessment	
Patient's ability to participate in face-to-face assessment	<i>The assessor should determine the patient's:</i> <ul style="list-style-type: none"> • Communication ability (hearing, vision, speech / voice / oral communication, use of alternative communication, language issues) • Cognitive ability (understanding, memory)
Sensitivities regarding assessment	<i>Cultural sensitivities</i> <i>Current health/fatigue</i>
Willingness for assessment and consent	<i>The assessor should determine the patient's willingness to take part in assessment and also the patient's willingness to 'self report' where possible. This discussion should identify any cultural sensitivities regarding assessment, identify any reservations the patient might have, and generally identify any other barriers to assessment.</i>
Preference for family member or carer to be present at assessment	
Demographic Information	
NHS number and other numbers Patient title (Mr, Ms, Mrs, Miss, Dr, Fr) other - specify Patient name Address - house number, road, locality, town, county, and postcode Preferred name Date of birth Age Gender Telephone numbers (land line and mobile) Marital status Religion Ethnicity Occupation (current or previous)	

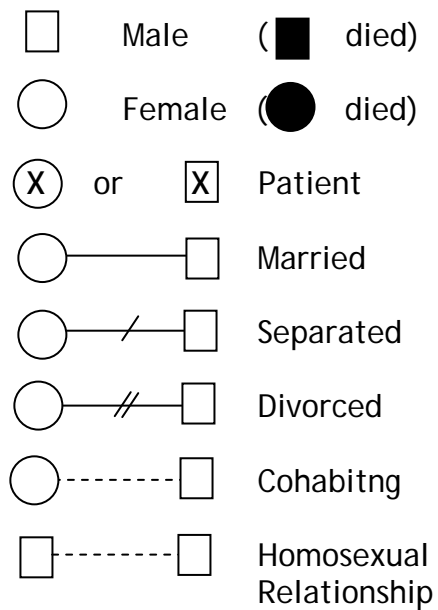
Next of kin Relationship Address Telephone numbers (home, work, mobile) Other contacts (relationship, address, and telephone numbers) Identify who to call first in case of a crisis and whether they want to be contacted at night	<i>This has a legal meaning as well as a practical one - the next of kin may not be the person nominated by the patient to be telephoned first in case of crisis</i>
GP, practice address, telephone and fax number District Nurse, address, telephone and fax number	
Consultants (names and hospitals) Specialist palliative care nurses (hospital and community) Specialist nurses Social worker Other key professionals	
Clinical History	
Medical Diagnosis Primary site Site of metastases Month and year of diagnosis Tissue diagnosis (yes/no) Histology	
History of current illness (With dates/details of any surgery, chemotherapy, radiotherapy or endocrine therapy and response or adverse effects of these treatments) Past medical history Previous and current illnesses Drug history Allergies Resuscitation status	<i>This will need updating with each assessment</i> <i>Include all significant conditions e.g. non insulin dependent diabetes, ischemic heart disease.</i> <i>An accurate drug history that is regularly updated is essential. It is important to check what is and is not working and to go through patient's concerns about their medication</i> <i>Teams have different ways of assessing this - a common way is for a doctor first to assess whether CPR would be futile, with a reason; if it is considered futile then many units do not go on to discuss it with the patient, unless they are known to want involvement in all clinical decisions. Often the question of CPR is raised within other discussions about future management and the aims of all treatments. The notes should say whether the matter has been directly discussed with the patient and/or their relatives (who should be named).</i>
Current problems Patient's current problems discussed, including physical, psychological, social and spiritual problems.	<i>Specific tools such as pain assessment tools may be used.</i>

Information needs	
Preferred language - need for interpreter	<i>'Would it be helpful for you to have an interpreter from the hospital or community when we come to talk with you?' 'Are you comfortable with X from the family translating for you?'</i>
Any aids to communication needed e.g. hearing aid, Light writer.	
Current insight	<i>'What do you know about your illness at the moment?'</i>
Amount of information wanted	<i>As a rule do you like to have a lot of information about your illness, or just really general information "</i> <i>Are you the sort of person who likes to know everything about your illness or are you the sort of person who likes to leave things up to the doctors and nurses?'</i>
How information should be conveyed and with whom present	<i>'How do you like to get information about your illness - face to face like this, or written down?' 'Is there anyone you usually like to be with you if we have to tell you the results of tests or discuss treatments?'</i>
Wants / does not want copies of treatment plans	<i>'Would you like copies of the letters we write to your GP?'</i>
Preferred amount of involvement in decision-making and management planning	<i>'How much do you usually like to be involved in making decisions about your treatment?'</i>
Consent for sharing information with family/carers	<i>'Are you happy for your family to know details of your illness or treatments? Is it all right if we answer their questions without you?'</i>
Consent for sharing information with other professionals/ entering on patient record system.	<i>'Are you happy for what we've discussed to be shared with other members of the team/other professionals such as your GP or District Nurse?'</i> <i>Need to make sure they understand the extent the notes are shared.</i>
Social	
Practical living arrangements	<i>Type of accommodation(house, flat), access (access to entrance, stairs), toilet and bathroom (upstairs, downstairs),transport, mobility in and out of house</i> <i>Whether in nursing home or residential home, or staying with relatives</i> <i>Ability to carry out household duties e.g. preparing food, shopping, cleaning, laundry, manage pets</i>
Work	<i>Any issues around work</i>
Finances	<i>Any concerns about finances</i>
Benefits	<i>Patient receiving appropriate benefits Including DLA or Carer Allowance (under the special rules if prognosis less than 6 months)</i>
Legal arrangements	<i>E.g. Will made or not, Advance Decision to Refuse Treatment, Lasting Power of Attorney, plans for care/guardianship of</i>

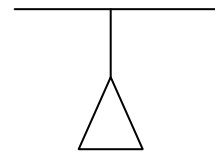
	<i>children.</i>
Services involved	<i>This should include all agencies involved when at home and some detail about the level of services provided. Does the patient attend day care? Are patient and carer aware of the out of hour services available locally e.g. Rapid Response Services?</i>
Interests	<i>Identify things patient has had to give up because of illness. Identify things patient would still like to do.</i>
Habits	<i>Smoking, drinking</i>
Psychological	
Mood –Depression, anxiety, anger, despair	<i>'How are you feeling about all this?'</i> <i>Use of the Distress thermometer)</i> <i>The distress thermometer adapted for EMCN attached as Appendix E can be used to measure distress but should only be used by health care professionals who have undertaken level 2 training.</i> <i>'How are you coping with all of this?'</i>
Coping mechanism for illness	
Effect of illness – body image, on relationships, on interests.	<i>'How do you feel when you see yourself in the mirror?'</i>
Spiritual	
Spiritual needs	<i>Consider using a spiritual need assessment proforma</i> <i>Start assessment with an introductory, exploratory question to determine patient's existing faith/belief</i>
Religious needs	<i>Someone to speak to: faith leader or minister e.g. chaplain, vicar, priest, imran, rabbi, church leader or other person. Religious items e.g. religious texts, prayer mat, religious objects, holy water. Things to help you practice e.g. chapel, prayer room, quiet room, ablution. 'Do you belong to any church?'</i>
Restrictions related to culture or belief system	<i>Diet. Medicines. Treatment products e.g. blood products</i>
Rehabilitation needs	
Impact of illness on activities of daily living	<i>Consider using a scale such as Modified extended Activities of Daily Living</i> <i>Ability to carry out personal care e.g. wash and dress, personal hygiene, manage medication</i> <i>Ability to carry out key transfers e.g. get in and out of bed, on and off chairs, on and off toilet, in and out of bath/shower</i> <i>Mobility around house and outside</i>
Dietary needs/preferences	<i>Does the patient have specific dietary needs e.g. diabetic, gluten free, kosher, halal, vegetarian. Specific tools may be helpful e.g. nutrition screening</i>
Complementary therapies	<i>Complementary therapies patients enjoys.</i>
Physical assessment of the patient	
Appropriate assessment by doctor, nurse and	

other health care professionals at the appropriate times	
Carer and family needs Name and relationship Insight into illness Any specific worries or concerns Level of involvement in care How other members of the family are coping e.g. children, elderly parents Needs – practical, emotional Sexual relations Bereavement needs	<i>See Appendix C for how to draw a genogram. The genogram should include family, children, and 'any significant others.'</i> <i>Conflicts/communication issues within family</i> <i>Is help needed talking to children about cancer, does the school know of child's relative's illness, children coping?</i> <i>Sexual difficulties caused by illness or treatment</i>
Goals/Expectations	<i>Patient's concerns or desires regarding a goal they may want to achieve e.g attending a family wedding, going on holiday.</i> <i>Expectations during the admission or visit should be checked regularly</i> <i>When you think it is appropriate, it is helpful to ask where the patient would like to die, then to record this and let other healthcare professionals know</i>
Summary of problems and plans	<i>This should be a list of the major concerns of the patient - the things that are stopping them living in the way they would like. It is usual to list them in the patient's order of importance. Need to summarize plans to help with each problem.</i>
Advance care plans Advance statement Advance decision to refuse treatment Personal Welfare Lasting Power of Attorney End of Life care tools	<i>A statement of wishes and preferences about their future management or place of care</i> <i>A specific refusal of treatment(s) in a predefined potential future situation</i> <i>Where another person has been given authority to make health and welfare decisions for a patient when they lose mental capacity</i> <i>End of life care tools should be implemented as necessary – Gold Standards Framework, Liverpool Care Pathway.</i>

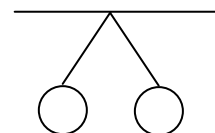
GENOGRAMS



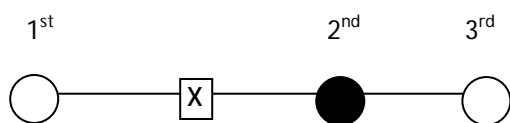
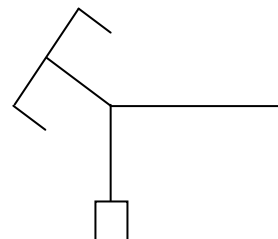
Pregnancy



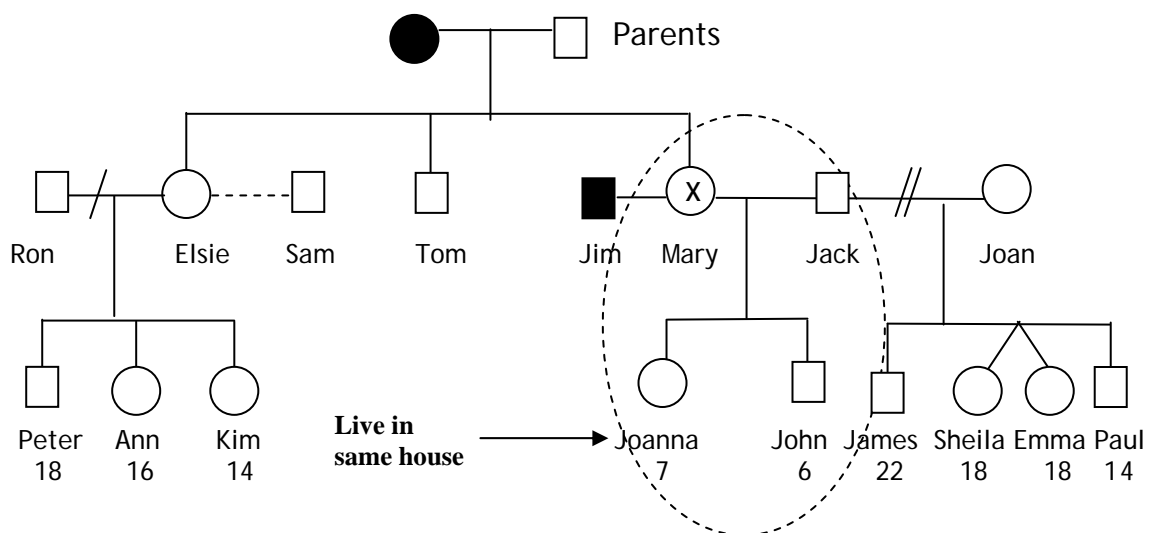
Twins



Adoption



1st, 2nd and 3rd Marriages



It is important to keep each generation on its own line