Beaumont Hospital FITT Initial Screening Tool

***(GREY SECTION FOR TRIAGE ONLY)***

| | | | |
|---|---|---|---|
| Addressograph<br><br>Patient contact no. | Functional Impairment<br>NH Resident<br>Acute/chronic confusion<br>Immobility<br>≥ 6 meds | | **ED attendance in the last 3/12** ☐<br>How many? ___<br>list dates:<br><br>No. of admissions in last year: 0 1 2 3 4+ |
| Skin Problems ☐ | Incontinence ☐ | EWS>1 _____ ☐ | **Frail Score ___/10** |

| | |
|---|---|
| ***SLT Screen*** N/A ☐<br>Respiratory: COPD ☐ LRTI ☐ Lung Ca ☐<br>CVA ☐ Progressive Neuro (eg PD, MS, MND) ☐ Dementia ☐<br>Aphasia ☐ Dysarthria ☐ Hoarseness ☐ Word Finding ☐<br>Coughing ☐ Choking ☐ Thickened Fluids ☐ Modified Diet ☐ | ***Dietetics Screen*** ☐<br>Unintentional weight loss in the last 6 months: Yes ☐ No ☐<br>Reduced appetite for > 7days: Yes ☐ No ☐<br>Pressure sores of Grade 2 or greater: Yes ☐ No ☐ |
| NOK: Relationship: | Contact no: |
| **PC:** ____ yr old M F presented to ED | **PMHx** |
| **Bloods**<br><br>**Imaging**<br><br>**Other** | **Meds** |

**Home Environment** 2 Storey House ☐ Bungalow ☐ [ ] Floor Flat ☐ Nursing Home ☐
Stairs: Yes ☐ No ☐ Rail: 1 ☐ 2 ☐ Stair Lift: Yes ☐ No ☐ House Access: _____
Bedroom: Upstairs ☐ Downstairs ☐ Adapted Bathroom: Yes ☐ No ☐ _____
Bathroom: Upstairs ☐ Downstairs ☐ Toilet: Upstairs ☐ Downstairs ☐ Equipment: _____

**Informal supports**: Lives alone ☐ **or** with _____
Patient is primary carer for vulnerable child/adult: Yes☐ No☐ If yes, who? _____
**Formal Supports/Home care: ( hours/day, days of week, no of carers, agency)** Pendant Alarm: Yes ☐ No ☐

| | |
|---|---|
| **Baseline Function**<br>Mobility:<br><br>Transfers:<br><br>Personal Care:<br><br>Domestic Tasks: | **4AT: Assessment for delirium & cognitive impairment**<br>**1. Alertness :** Normal **0** Mild sleepiness **0** Abnormal **4**<br>**2. AMT4:** Age, Date of Birth, Place (Hospital name), Year<br>No mistakes **0**<br>1 mistake **1**<br>≥2 mistakes **2**<br>**O3DY:** DLROW ☐ Day ☐ Date ☐ Year ☐<br>**O3DY Score: ____/ 4** *(<4 ? cog Impair.)*<br>**3. Attention:** Months of the year backwards<br>≥7 months or more correctly **0**<br>Starts but scores <7 months **1**<br>Untestable **2**<br>**4. Acute Change/fluctuating symptoms** (*over the last 2 weeks and still evident in last 24hrs)* NO **0** YES **4**<br>***4AT Scoring:*** *0 = Normal, 1 = ? Mild Cog. Impairment, 2-3 = ? Cog. Impairment*<br>***≥4 Suspect Delirium +/- Dementia*** **4AT Score:** ☐ |
| **Communication:** Glasses Yes ☐ No ☐<br>Hearing Aid Yes ☐ No ☐ | |

**Falls History:** No. in last 3/12: ____ How:_____ Ass. to get off floor Yes No:
Injuries:

**Summary/Recommendations** *(Home/Admission)*

| HSCP referrals sent | Dietician | MSW | OT | Pharmacy | Physio | SLT |
|---|---|---|---|---|---|---|

Name: Signature: Bleep:
Date & Time:

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| *Therapy Sticker* | *Therapy Sticker* |
|---|---|

## Subjective

**Consent obtained for assessment: Yes □ No □**

## Objective

**Affect:** Alert □ Fatigued □ Anxious □

**Falls Risk:** High □ Low □ Decreased Safety Awareness □

**Sitting Balance:** Static: Intact □ Impaired □ Dynamic: Intact □ Impaired □

**Standing Balance**: Static: Intact □ Impaired □ Dynamic: Intact □ Impaired □

**Mobility:**

**Transfers:**

**Bed Mobility:**

**Activities of Daily Living (ADL's):**

*(Additional information)...*

| Power | Right | Left |
|---|---|---|
| Shoulder | | |
| Elbow | | |
| Wrist | | |
| Hip | | |
| Knee | | |
| Ankle | | |

## Analysis

## Plan

Name: Signature: Bleep:

Date & Time:

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