NHS Continuing Healthcare

Assessment Prompts for Completing a Decision Support Tool (DST)

The following provides prompts for MDTs when completing the Decision Support Tool (DST), suggesting questions which it might be relevant to consider and the types of evidence which might be available. There may well be other relevant questions and other sources of evidence not listed here. MDTs are reminded that all assessments should be person-centred, proportionate and take account of views of the individual. It will depend on the individual circumstances as to which questions and which sources of evidence are necessary to consider.

This Assessment guidance should be used in conjunction with the User Notes within the DST.

1. Breathing

Questions to consider could include:	Evidence which might be useful to consider:
• What is the degree of any shortness of breath, and is this on exertion or at rest? • If breathlessness is having impact on the daily activities of living, what is the impact? • If they suffer with recurrent chest infections, how often do these present and do they respond to treatment? • What medication is required? • What treatment is provided for breathing e.g. inhalers, nebulisers, oxygen, continuous positive airways pressure (CPAP), ventilation? • Is any specialist intervention required?	• GP records • Care plans • Medication records • Specialist assessments

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
Normal breathing, no issues with shortness of breath.	Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not consistently respond to management and limit some daily living activities. **OR** Requires any of the following: • low level oxygen therapy (24%). • room air ventilators via a facial or nasal mask. • other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to treatment and limits all daily living activities	Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway. **OR** Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy **OR** A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bi-level positive airway pressure, or non-invasive ventilation)	Unable to breathe independently, requires invasive mechanical ventilation.

2. Nutrition – Food and Drink

Questions to consider could include:	Evidence which might be useful to consider:
• The individual's weight and whether there has been weight loss/gain over recent months • Are they able to eat independently? • Do they need assistance with feeding? (if yes, how much assistance and how often?) • Is feeding problematic? (if yes, describe how so) • Is feeding/giving fluids regularly taking longer than thirty minutes? • What are the dietary requirements (e.g. normal/soft/liquidised)? • What are the fluid requirements (e.g. normal/thickened)? • Are there any special dietary requirements? • Are they on any supplements? (if yes, what type and how often?) • Do they have dysphagia? What intervention is needed? • Have they had any specialist assessments e.g. dietician, SALT? • Are they at risk, and/or have they experience, of choking or aspiration (if yes, how often)? • Do they require any of the following - Nil by Mouth, Percutaneous Endoscopic Gastrostomy (PEG) feeding (Total Parenteral Nutrition/subcutaneous fluids)? If yes, is this problematic or routine? • What is the level and intensity of monitoring required?	• Weight • Malnutrition Universal Screening Tool (MUST) • Body Mass Index (BMI) • Food and fluid charts • Daily logs • Nutritional risk assessments • Medication records • Specialist input e.g. dietician, SALT

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
Able to take adequate food and drink by mouth to meet all nutritional requirements.	Needs supervision, prompting with meals, or may need feeding and/or a special diet (for example to manage food intolerances/ allergies). **OR** Able to take food and drink by mouth but requires additional/ supplementary feeding.	Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. **OR** Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.	Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. **OR** Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR** Nutritional status “at risk” and may be associated with unintended, significant weight loss. **OR** Significant weight loss or gain due to identified eating disorder. **OR** Problems relating to a feeding device (for example PEG.) that require skilled assessment and review.	Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled professional intervention or monitoring over a 24 hour period to ensure nutrition/ hydration, for example I.V. fluids/total parenteral nutrition (TPN). **OR** Unable to take food and drink by mouth, intervention inappropriate or impossible.	

3. Continence

Questions to consider could include:	Evidence which might be useful to consider:
• What is their continence status (continent/occasional incontinence/incontinent), and is this for urine or faeces or both? • Does their continence status fluctuate? • Are they independent with toileting? • Do they require assistance with regular toileting to maintain continence? • Do they require laxatives? (if yes, are these regular prescriptions or as required? What type of laxatives are required and are these suppositories or enema? State type and frequency) • Are there any specialist interventions and what is the frequency? • Do they have urethral catheter/suprapubic catheter? (if yes, state frequency of catheter changes/frequency of bladder wash outs) • Do they suffer with Urinary Tract Infections (UTIs)? (if yes, state how often, what treatment is required and whether they respond to treatment) • Do they have a stoma? (if yes, describe type and care required) • Is continence care problematic? (if yes, describe)	• Continence assessments • Drug charts • Care plans • District nurse records • Specialist nurse input

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
Continent of urine and faeces.	Continence care is routine on a day-to-day basis; Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. **AND** Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/ constipation.	Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation or other bowel problems.	Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation).		

4. Skin (including tissue viability)

Questions to consider could include:	Evidence which might be useful to consider:
• What is the pressure risk score? • What is the state of the skin? • Are there any skin conditions? (if yes, what treatment is being provided?) • Are there any preventative interventions e.g. monitoring, repositioning, wound care? (if yes, what is the frequency of interventions?) • Are there any wounds? (if yes, what is the type and frequency of dressings and arewounds responding to treatment?) • Is there any specialist input required e.g. tissue viability, dermatology, vascular? (if yes, what is the frequency of input?) • What equipment is being used e.g. type of pressure-relieving mattress, pressure cushions? • What medication is required?	• Pressure risk score e.g. Waterlow score • Turn charts • Wound charts • District nurse records • Care plans • GP records • Specialist assessments

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
No risk of pressure damage or skin condition.	Risk of skin breakdown which requires preventative intervention once a day or less than daily without which skin integrity would break down. **OR** Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound(s). **OR** A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Risk of skin breakdown which requires preventative intervention several times each day without which skin integrity would break down. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment. **OR** An identified skin condition that requires a minimum of daily treatment, or daily monitoring/ reassessment to ensure that it is responding to treatment.	Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is/are responding to treatment. **OR** Specialist dressing regime in place; responding to treatment.	Open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule' which are not responding to treatment and require regular monitoring/ reassessment. **OR** Open wound(s), pressure ulcer(s) with 'full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint capsule' or above **OR** Multiple wounds which are not responding to treatment.	

5. Mobility

Questions to consider could include:	Evidence which might be useful to consider:
• What level of mobility does the individual have? • Are they mobile without aid or with aid? (if so, which aid?) • What level of supervision is required? • What level of assistance is required and what number of carers? • Are they unable to weight-bear? • How many carers are needed to assist with transfers/positioning and can the individual co-operate? • What type of equipment is required (e.g. for transfers)? • How often do they require repositioning? • Are there any specialist positioning requirements? • Are they at moderate/high risk of falls (bearing in mind that a falls risk assessment might use the term 'high risk' but this doesn't necessarily equate to the high level on the DST)? • Have they received any specialist input from e.g. occupational therapist, physiotherapist, specialist nurse? • Does the person experience any contractures or spasms? (if yes, what treatment is required and what impact is this having on the individual and delivery of their care?) • Are there any risks associated with moving and handling/interventions e.g. risk of physical harm?	• Care plans • Specialist assessments (e.g occupational therapist, physiotherapist, specialist nurse) • Daily logs • Risk assessments • Manual handling assessments • Falls risk assessments • Falls diary/incident forms

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
Independently mobile	Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Not able to consistently weight bear. **OR** Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning. **OR** In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers. **OR** At moderate risk of falls (as evidenced in a falls history or risk assessment)	Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning. **OR** Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate. **OR** At a high risk of falls (as evidenced in a falls history and risk assessment). **OR** Involuntary spasms or contractures placing the individual or others at risk.	Completely immobile and/or clinical condition such that, in either case, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.	

6. Communication

Questions to consider could include:	Evidence which might be useful to consider:
• Can they communicate? In particular, can they communicate their needs? • Is their communication reliable? • Can they hold a conversation? (if yes, is this in context? If they only answer yes or no, is this reliable?) • Do they need an interpreter? • Do they have cognitive impairment? • How does cognitive impairment affect communication? • If communication is unreliable, can needs be anticipated? • Can they communicate reliably through non-verbal communication? • Can carers accurately interpret non-verbal communication? • Do they use a communication aid (if yes, which aid)? • Do carers need to assist with interpretation/anticipation of needs? • Are all needs anticipated because they have no reliable form of communication? • Does the person have any physical impairments (e.g. hearing or vision loss that restricts their ability to communicate)?	• Care plans • Specialist input e.g. Speech and Language Therapist (SALT) • Daily logs • Risk assessments

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.	Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The individual has to have most of their needs anticipated because of their inability to communicate them.		

7. Psychological & Emotional Needs

Questions to consider could include:	Evidence which might be useful to consider:
• Does the individual have a diagnosis of depression or anxiety? • Do they suffer with low mood, anxiety, agitation, periods of distress, frustration? (if yes, what is the frequency and/or duration?) • What is the severity of low mood or anxiety, and what is the effect on health and well-being? • Do they respond to reassurance? • Are they withdrawn due to psychological/emotional issues? • Are they withdrawn due to cognitive impairment? • Are they on medication (if yes, state which medication)? • Do they participate in daily activities and care planning? • Do they respond to 1:1 input? • Do they suffer with hallucinations? (if yes, are these distressing and are there any triggers?) • What specialist/skilled input is required?	• Care plans • Medication records • Specialist assessments from mental health team/psychologists • Daily logs • 72 hour behaviour charts • Activities charts • Risk assessments • Depression score

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
Psychological and emotional needs are not having an impact on their health and well-being.	Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts, distraction and/or reassurance. **OR** Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.	Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which do not readily respond to prompts, distraction and/or reassurance and have an increasing impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities.	Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.		

8. Cognition

Questions to consider could include:	Evidence which might be useful to consider:
• Are they disorientated with regard to time/place/person? • What is the degree of memory loss (short-term and/or long-term)? • Do they recognise carers or family? • Have they had formal cognitive tests e.g. Mini Mental State Examination (MMSE) and Frontal Lobe Test (FLT)? • Are they able to make basic choices/decisions? • Do they need assistance to make key decisions regarding health/care/finances? • Do they have awareness of risks and are able to maintain their own safety (are they able to assess basic risks or are reliant on carers to maintain safety)? • Do they have formal diagnosis of dementia or relevant mental health diagnosis? • Do they have input from specialist teams? • What medication (if any) has been prescribed in relation to cognitive impairment? • Is the individual alert and orientated?	• 72 hour behaviour charts • Daily logs • Community Mental Health Team assessments • Medication records • Care plans • Formal cognitive testing (MMSE, FLT, clock face etc.) • Psychiatric assessments • Mental health/risk assessments

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
No evidence of impairment, confusion or disorientation.	Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. **OR** Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Cognitive impairment that could, for example, include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues they are unable to consistently do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.	Cognitive impairment that may, for example, include, marked short or long-term memory issues, or severe disorientation to time, place or person. The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate their basic needs and to protect them from harm, neglect or health deterioration. .	

9. Behaviour

Questions to consider could include:	Evidence which might be useful to consider:
• Is there risk of harm to self, others or property (if yes, how severe is the risk and how frequently does it occur)? • Is the individual always compliant with care? • Are they non-compliant with care (if yes, how frequently and what are they non-compliant with)? • Do they respond to prompting, reassurance or distraction? • Are they on medication to manage behaviour (if yes, which medication)? • Do they require skilled or specialist input to manage their behaviour (if yes, who)? • Is their behaviour predictable? • Are there any known triggers? • Are there any behaviours that fall outside normal care plan? • How rapid does the response to challenging behaviour need to be – does it need to be prompt or immediate? • What happens if the challenging behaviour isn't addressed when it arises? How significant are the consequences? • What is the range and type of skilled interventions in place and required to support the individual? • What is the intensity and frequency of interventions needed to address behaviour and reduce the risks posed to self or others?	• 72 hour behaviour charts • Incident forms • Daily logs • Assessment from Community Mental Health Team (CMHT) • Medication records • Care plans • Risk assessments • Behaviour management plans

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
No evidence of 'challenging' behaviour.	Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The individual is compliant with all aspects of their care.	'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The individual is nearly always compliant with care.	'Challenging' behaviour of type and/or frequency that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	'Challenging' behaviour of severity and/or frequency that poses a significant risk to self, others or property. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.	'Challenging' behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property. The risks are so serious that they require access to an immediate and skilled response at all times for safe care.

10. Drug Therapies and Medication: Symptom Control

Questions to consider could include:	Evidence which might be useful to consider:
• Is the individual able to self-medicate? • Do they need carers to administer medication? • Are they compliant with medication? • If non-compliant, how often are they non-compliant, and how is this managed? • Is their medication routine? • Are they on a titrating medication regime (does a carer have to make a decision as to what drug to give or what dose to give according to a clinical condition)? • How urgent is the decision to titrate medication and what are the consequences if delayed? • Is patient on covert medication policy? • Is medication in liquid form? Is medication oral or PEG or sub cut? • Is medication only able to be administered by a registered nurse/carer trained specifically for the task? • Are there any underlying conditions that affect the management of medication (e.g. diabetes)? • Any specialist monitoring of medication regime? • Do they require blood tests to ensure therapeutic levels e.g. warfarin, lithium? • Is level of pain mild, moderate, severe? • Is pain predictable, are there any triggers, what causes pain, does current medication adequately control pain?	• GP records • Care plans/risk assessments • Medication records including PRN (when necessary) medication • Pain Chart • Specialist Assessment • Covert policy

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.	Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. **OR** Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care.	Requires the administration of medication (by a registered nurse, carer or care worker) due to: non-compliance, or type of medication (for example insulin), or route of medication (for example PEG). **OR** Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage. **OR** Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.	Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Even with such monitoring the condition is usually problematic to manage. **OR** Severe recurrent or constant pain which is not responding to treatment. **OR** Non-compliance with medication, placing them at severe risk of relapse.	Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition. **OR** Unremitting and overwhelming pain despite all efforts to control pain effectively.

11. Altered States of Consciousness (ASC)

Questions to consider could include:	Evidence which might be useful to consider:
• Is there a history of ASC e.g. cerebrovascular accident (CVA), transient ischaemic attack (TIA), epilepsy, vasovagal syncope, postural hypotension? • What is the frequency, severity and length of ASC? • What is the recovery time from each episode of ASC? • Are there any triggers or warnings? • Are the episodes of ASC predictable or unpredictable? • What intervention is required e.g. monitoring only, medication, skilled intervention? • Do they resolve without medication? • Do they respond to medication? • What type of medication is required and is it routine/regular? • Is medication PRN (as required)? If PRN, how often given in last month? • What is the risk of harm to the individual with or without intervention, and what level of harm would this be?	• GP records • Hospital records/discharge summary • Care plans • Medication records • Seizure charts • Incident forms • Daily logs

No Needs	Low Needs	Moderate Needs	High Needs	Severe Needs	Priority Needs
No evidence of altered states of consciousness (ASC).	History of ASC but it is effectively managed and there is a low risk of harm.	Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. **OR** Occasional ASCs that require skilled intervention to reduce the risk of harm.		Coma. **OR** ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.