

Nourish Assessment and Care Plan Review Policy

Policy Statement:

Kingsley is committed to ensuring the well-being and safety of all individuals under our care. To maintain the highest standards of care and support, we have established a comprehensive assessment and care plan review policy. This policy outlines the frequency and process for reviewing both mandatory and optional assessments, as well as the creation and adherence to care plans.

Timescales

Pre-admission Assessment should be completed as indicated before admission and transferred to the need's assessment prior to admission.

Assessment should be created within 24-48 hours of admission

Care Plan a basic careplan should be on the system with 24 – 48 hours and built on over the next 4 weeks.

Profile

Please ensure this is completed in as much detail as possible.

If on the critical information page under resident type states onboarding then the residents need to be admitted correctly by completing the onboard signoff found in the timeline.

Circle of Care

As many contacts as possible should be added including the GP.

Assessments

Frequency of Assessment Review

All mandatory and optional assessments must be reviewed at least every 6 months or sooner if there is a change in the individual's condition or needs. Exceptions to this rule are Dependency assessment, MUST (Malnutrition Universal Screening Tool) and Waterlow assessments, which must be reviewed as needed but no less than every 1 months, or more frequently if there is a significant change in the individual's dependency, nutritional or pressure ulcer risk status. Any weekly weights will now be recorded under the MUST assessment.

Mandatory and Resident Specific Assessments

Needs assessment for all new residents as part of the pre-admission – **Mandatory**

Dependency assessment – **Mandatory**

Continence Assessment - **Mandatory**

Mental Capacity Assessment and Best Interest Decision- One per decision please refer to appendix 1

If lacks capacity- **Mandatory**

Multi factorial fall risk assessment and management tool - **Mandatory**

Moving and handling assessment - **Mandatory**

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Must - **Mandatory**
Diet and nutrition - **Mandatory**
Oral health assessment - **Mandatory**
Peep can be either long or short – **Mandatory**
Abilities - **Mandatory**
About me - **Mandatory**
Admission Checklist - **Mandatory**
Allergies and intolerances - **Mandatory**
Clinical history and medical condition- **Mandatory**
Cultural, religious and spiritual assessment - **Mandatory**
DN CPR or Respect Recommended Summary for emergency care and treatment decision - **Mandatory**
Emergency information - **Mandatory**
End of life/anticipatory/palliative care assessment - **Mandatory**
Infection, prevention and control assessment - **Mandatory**
Intimacy, Relationship and Sexuality Assessment - **Mandatory**
Medication Risk assessment - **Mandatory**
Sleep assessment - **Mandatory**
Waterlow – **Mandatory**

General Risk assessment – **Optional**
Bed rails – **Optional**
Choking Risk Assessment - **Optional**
Abbey pain scale – **Optional**
Activity assessment - **Optional**
Advance decision to refuse treatment - **Optional**
Breathing assessment - **Optional**
Catheterisation risk assessment – **Optional**
Communication assessment - **Optional**
DOLS - **Optional**
Diabetes assessment - **Optional**
Distress assessment – **Optional**
Enteral Feeding assessment - **Optional**
Financial Assessment – **Optional**
Smoking/vaping risk assessment - **Optional**
Social and relationship assessment - **Optional**
Stoma care Assessment – **Optional**

Consents that are available if required

Consent - Assistive Devices/Aids
Consent - Care and Treatment
Consent - Financial Arrangements and Management
Consent - Generic Specific Decision
Consent - Medical Treatment and Procedures

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Consent - Medication Support, Administration and Management
Consent - Needs and Risks Assessment Agreement
Consent - Photography and Videography for Marketing Purposes
Consent - Photography for Identification and Medical/Clinical Purposes
Consent - Sharing Information with Health and Social Care Professionals
Consent - Travel and Transport Arrangements.

Care Plan Agreement Signature

In order to ensure you involve a person in their plan of care you can record a signature of agreement to the content of their care plans. Throughout a person's care journey their needs, wishes and preferences may change, and this is regularly reviewed (at least 6 monthly) and evaluated by those supporting the person. At the time of conception of the care plan and at each review and change you are able to capture a signature of agreement either provided by the person being supported or their representative. At the bottom of an individual's care plan, within the "Care Plan Agreement Section", you will see three areas that allow you to report and manage ongoing consent:

Care Plans

Monthly Care Plan Review- All care plans must be reviewed on a monthly basis or sooner if there is a change to the residents needs to ensure they remain relevant and effective in meeting the individual's needs.

Adherence to Care Plan Template Staff must strictly adhere to the designated care plan template on Nourish. There should be no need to deviate from the template.

Interactions

These interactions listed under each care plan template play a vital roll in the way you can see things on the devices and under no circumstances should they be removed. You can add to them if you feel it is appropriate. There is also no need to write anything under the descriptions.

Care plans template categories:

Advanced Planning

Key identified needs should include:

Past medical history
Is there a LPA or deputy and what type?
Is there a living will/advance decision?
Are they for hospital admission?
Is there a DNR/Respect form?
Preferences
Cremation or burial & prepaid plan in place?

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Planned outcomes

Outcomes required from any of the above

Interactions which are included within this care plan:

Contact with Family / Friend / Representative

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decision

Faith Service

Multi-disciplinary (GP, DN, SW, Optician, etc)

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) V3

Abbey Pain score

Communication

Key identified needs should include;

Any communication difficulties or disorders, such as those with speech impairments, hearing impairments, autism spectrum disorders, or neurological conditions like aphasia. We should also include communication with families, representatives and multi-disciplinary team.

Planned outcomes

The goal of a communication care plan is to ensure that these individuals receive effective and appropriate communication support to improve their quality of life and overall well-being. To develop a communication care plan, it's important to identify the specific needs of the individual.

Any triggers if unable to communicate needs. Whether the person wears any aids, e.g. glasses, hearing aids etc.

Use of call bell

Interactions which are included within this care plan:

Abilities

Communication Assessment

Contact with Family / Friend / Representative

Hearing Aid Maintenance

Multi-disciplinary (GP, DN, SW, Optician, etc)

Creams

Identified Needs

This plan is for the prescribed creams and these should be listed out.

How to achieve this

Should list how often prescribed and to where.

Interactions which are included within this care plan:

Cream Application

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Cream Application Am
Cream Application PM
Skin Integrity Check

Eating and Drinking

Identified Needs

This section should cover specific dietary needs or conditions that impact the individuals ability to eat and drink safely and comfortably.

Where does the person like to eat their meals?

Any weight loss or gain

Is the person on a fluid target?

Is there any specialised equipment needed?

Choking risk

Any religious or cultural requirements

Any enteral feeding

Likes and dislikes

IDDSI level – (refer to diet and nutrition)

Level of supervision/assistance required

Does the resident need to have the nutrition intake monitored.

How to achieve Outcomes

How often is the person weighed?

Not weighted in best interest, GP agreed

Any referrals to the Dietician or salt team

Emergency plan for Choking.

What you are going to do to encourage someone?

Interactions which are included within this care plan:

Allergies and Intolerances

Breakfast

Choking Risk Assessment

Diet and Nutrition

Dinner

Lunch

MUST (Malnutrition Universal Screening Tool)

Snack

Weight Record (LD ONLY)

Elimination

Identified Needs

Levels of continence whether continent or not

Any medication that effects elimination

Are they under any professional?

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Do they have catheters, stomas etc

How to achieve Outcomes

Type of products if any?

Frequency of changing/assisting to the toilet/bathroom

Any triggers if unable to communicate needs

Interactions which are included within this care plan:

Continence

Bowel Record

Health

Identified Needs

This should include any medical condition including diabetes

Any MDT input

Is there a DNR/Respect form?

Pain

Interactions which are included within this care plan:

Appointment

Blood Pressure Measurement

Blood Sugar Level Test

COVID-19 Vaccine

Clinical History and Medical Condition

Diarrhoea and Vomiting

Emergency Information

Flu Vaccine

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) V3

Respiration Rate

Sample / Test (Urine, Stool, Blood, Sputum)

Temperature

Abbey Pain Score

Multi-disciplinary (GP, DN, SW, Optician, etc)

Maintaining safe environment

Identified Needs

Risk of absconding

Risk of self-harm

Risk of falls

PEEPS

Active smoker – please add smoking RA

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How to achieve Outcomes

Bed rails/bumpers
Sensory mats
Call bell
Footwear
Bed at correct height – when in use and not

Interactions which are included within this care plan:

Bed Rail Risk Assessment
Deprivation of Liberty Safeguards (DoLS)
Emergency Information
Moving and Handling Assessment
Multifactorial falls risk assessment and management tool (includes an osteoporosis risk screen)
Personal Emergency Evacuation Plan (PEEP)
Sensor Check

Managing medication

Identified Needs

Any allergies
Self-medication?
Any specialist medication e.g. Anticoagulant
Covert medication

How to achieve Outcomes

How does this person like their medication administered
including any special instructions for administration (e.g., with food, without food, on a spoon, covert, time specific etc.).

Interactions which are included within this care plan:

Allergies and Intolerances
Emergency Information
Medication Risk Assessment

Mental Health

Identified Needs

What is the behaviour that challenges?
Early warning signs/triggers
Finance
Mental Capacity
DOLS
Any Power of Attorney (POA)

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Risk of self-harm

Does the person have an advocate to help with planning/changes to plan?

How to achieve Outcomes

DIST/mental health involvement

Actions to take at the early warning signs and how to reduce the triggers

The following assessment/interactions are included within this care plan which are

Deprivation of Liberty Safeguards (DoLS)

Financial Assessment

Interactions which are included within this care plan:

Current Mood

Deprivation of Liberty Safeguards (DoLS)

Financial Assessment

Mobilising

Identified Needs

Level of mobility

Falls

Any medication that effects mobility

Any medical conditions that effect mobility

How to achieve Outcomes

What aids are used, e.g Zimmer frames, walking stick, hoist type of sling etc.

Wheelchairs and use of lapbelts

Falls team involved, OT, physio etc

Interactions which are included within this care plan:

Abilities

Moving and Handling Assessment

Multifactorial falls risk assessment and management tool (includes an osteoporosis risk screen)

Personal Emergency Evacuation Plan (PEEP)

Personal Care and Dressing

Identified Needs

Level of input needs e.g. full assistance etc

Preferences to gender of person assisting

Preferred time

Oral care – to include for example e.g. full set of dentures, can brush own teeth etc

Preferences to clothing

Preferences for bathing or showering

How to achieve Outcomes

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Type of products used
Is chiropodist involved?
Is the hairdresser involved?

Interactions which are included within this care plan:

Hairdressing
Nail Care
Oral Health Assessment
Personal Care - AM
Personal Care - PM

Skin

Identified Needs

Any skin conditions, e.g. pressure ulcer, dry skin etc
Is skin prone to bruises and skin tears – if so why
Any creams to be applied (you can refer back to cream care plan)
Do they require any special diet/fluids for skin integrity?

How to achieve Outcomes

Any special mattress, - to include type and settings
Frequency of turning/repositioning
Any MDT input
Any dressing regimes

Interactions which are included within this care plan:

Allergies and Intolerances
Cream Application
Mattress Pressure
Skin Integrity Check
Turning & Positioning
Waterlow Assessment
Multi-disciplinary (GP, DN, SW, Optician, etc)

Wellbeing

Identified Needs

Sleeping preferences e.g. time to rise and go to bed.
Any special interest/hobbies
If they like activities group or one to one
Likes and dislikes
Any Cultural, Religious and Spiritual needs
Where they like to spend the day and how
Any intimacy, relationship and sexuality needs.

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How to achieve Outcomes

Interactions which are included within this care plan:

About Me
Activity Assessment
Cultural, Religious and Spiritual Assessment
Sleep Assessment

Personalised interactions

These should only be added when you need to schedule specific interactions. There is no need to have too many or irrelevant interactions. Most interactions can and should be recorded at point of care and they would be no need to schedule for example personal care unless there is an identified need.

Please ensure that you review any missed warnings as these slow down your system and should be accounted for.

Skin Integrity/Body map

You can record a new wound or skin integrity concern from the Timeline or from within the Wound Management View. Select the blue plus button and find the relevant interaction.

Select the 'Skin Integrity Check'. Use this interaction if your purpose is solely to check an individual's skin.

Select 'Record Concern With Skin Integrity/Wound'. Use this interaction if you are providing care for an individual, notice a wound and you wish to record it.

Complete the required information by detailing the location, wound type and upload associated images. You can see descriptions of all wound types here. Ensure a picture is uploaded.

Then it is important to Complete the Initial Assessment

Within the 'Initial Assessment' for the nursing assessments you will be required to describe the wound in detail and define a treatment plan. Depending on what you enter into this assessment will trigger a suite of further assessments relevant to the care and treatment of the wound to promote swift healing and resolution. Once completed you will see an 'Ongoing Assessment' appear on the Timeline on your chosen scheduled date. The wound will be moved to 'Active'. (Residential homes please make sure you fill in as much as possible from the District Nurse).

Please ensure wounds are reviewed and closed when no longer active.