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
DNCPR 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
Consents – 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

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?

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

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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
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?
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

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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

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)
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
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

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Identified Needs
Any skin conditons, 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.

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.

Than 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.