

**Nightingale Hammerson**

**Care Plan Guidelines**

May 2016

The purpose of these guidelines is to support staff with completing the care plan documentation in order to identify and meet resident’s needs and deliver excellent person-centred care.

Effective care planning is at the heart of Nightingale Hammerson’s commitment to person-centred care. It puts the focus on the individual - ensuring we understand and respect what makes them unique and tailoring their care accordingly.

Our ambition is for the care plan to be the result of a person-centred, holistic assessment of an individual’s physical, intellectual, emotional, cultural, religious, spiritual and social needs.

The care plan should be developed based on the initial assessment of needs carried out prior to admission, discussion with the resident and their relatives and the assessment of individual needs and preferences which includes a comprehensive nursing and medical assessment, as well as addressing other physical, psychological, social, religious, spiritual and cultural needs.

**General:**

* Initial care plans related to the important areas of the resident’s needs, are required to be completed within 48 hrs, for example the resident who cannot move and weight bear. The moving and handling care plan should be in place.
* All information obtained through the process of various assessments should be reflected in C1a\_health and well-being and daily care notes.
* Care plan index and care plan sub-indexes should be current as on NGH share drive (available under “care plan current”) and in correct order and place.
* Assessments/forms should only be included if needed (relevant). If any of the forms /assessments are not applicable, N/A should be written next to it on the index.
* All care plans should be rewritten yearly from the date when created.
* The old/irrelevant forms should be archived.

**\*For more information see Care Planning Policy, Record Keeping Policy and Records Management Policy**

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**A – Summary**

**A1 – Key Information Sheet**

All fields need to be completed. If the information is inapplicable for example resident hasn’t got a social worker write information “NONE” or N/A as not applicable. A current photo of the resident must be attached. Photo should be dated and should be renewed annually and if there are significant changes in the resident’s appearance.

The form should be updated immediately if any changes (for example NOK’s contact details or keyworker’s name).

**A2 - Mental Capacity Assessment**

**MAKING DECISIONS ABOUT CAPACITY**

The Mental Capacity Act (2005) sets out a two-stage test to determine whether a person lacks the capacity to make a particular decision.

**Stage 1 – Establish whether a resident has an impairment of, or disturbance in the functioning of, their mind or brain. This can be permanent incapacity, or temporal incapacity or fluctuating capacity** (Code of Practice paragraph 4.3 to 4.12)

This needs to be established as without this the resident will not lack capacity under the terms of the Act. The Code of Practice gives the following examples-:

* Conditions associated with some mental illnesses
* Dementia
* Significant learning disabilities
* The long-term effects of brain damage
* Physical or mental conditions leading to confusion, drowsiness or loss of consciousness
* Delirium
* Concussion
* The symptoms of alcohol or drug use

It should be stressed, though, that the issue is not the resident’s diagnosis, but their capacity to make a decision about a specific issue.

**Stage 2 – Establish whether the impairment or disturbance means that the resident cannot make a specific decision at that time.** (Chapter 3 of the Code of Practice – paragraph 4.13 to 4.25)

The following points need to be addressed. Every possible assistance and support must be given to the resident to help him/her make a decision.

* Can the resident understand information about the decision to be made?
* Can the resident retain that information in their mind?
* Can the resident use or weigh the information as part of the decision-making process?
* Can the resident communicate their decision?

If the resident cannot do any of these, then there may be an issue with their own capacity which could require the principles of the Act to be followed. Please remember capacity can fluctuate. Above information to precede assessment of mental capacity.

**Assessment of Mental Capacity**

This form should be completed where there is concern that a resident may lack capacity to make a specific decision about their own financial or welfare issues (Ref. The Mental Capacity Act 2005)

*You will need to check medical records (MMSE/AMT) and/or discuss with the GP*

The following parties should keep clear and detailed records of all decisions and the steps leading up to decisions made in relation to residents who lack capacity:

• Medical professionals (nurses, doctors, specialists etc.),

• Professional caregivers (care staff in nursing homes, hospitals, hospices etc.),

• Therapists (physiotherapists, occupational therapists etc.),

• Donees of a Lasting Power of Attorney,

• Deputies appointed by the Court,

• Professionals (lawyers, accountants etc.),

• Individuals acting or caring for the resident for a fee,

• Other professionals acting for a fee.

|  |  |
| --- | --- |
| **1.1 Decision required** | **Comments** |
| Full details of the issue on which a decision is required?  (*Note that capacity is decision specific and if there are several issues to be decided, each one must be considered separately)* |  |
| **1.2** State on what basis the capacity of the resident to make his or her own decision is in doubt? you will need to consider **if the resident is:** |  |
| 1. Able to ***understand*** the information relevant to the decision?   *That is understands the:*  *• nature of the decision to be made,*  *• reasons the decision needs to be made,*  *• options available, if there is more than one regarding the decision to be made,*  *• consequences that can be expected if he chooses each of those options, and*  *• consequences if no decision is made.*  *To help the resident to understand the information, it may be necessary to explain it in a way that is appropriate to his circumstances, such as using simple language, visual aids or some other means*. |  |
| 1. Able to ***retain*** the information?   *It is sufficient if the resident remembers the information for a short period of time as long as he can remember it long enough to understand it, weigh it up and communicate his decision.* |  |
| 1. Able to use the information in the process of making the decision? (i.e***. weigh up the*** ***pro’s and con’s***)   *The resident must be able to weigh up the information and use it to make a decision. Sometimes people may understand the information but an impairment or disturbance of the mind or brain prevents them from using it. In other cases, the impairment or disturbance leads them to make decisions without understanding or using the information* |  |
| 1. Able to ***communicate*** their decision (by any means)   *The resident must be able to communicate his decision. Some people find it difficult to communicate and need help to do so. All practicable steps should be taken to help the resident to communicate, for example, by using sign language, by writing*  *or some other means. Sometimes it is not possible for a resident to communicate,*  *for example, a resident who is:*  *• unconscious*  *• in a coma or*  *• suffering from locked-in syndrome.* |  |

|  |  |
| --- | --- |
| **1.3 Support** | **Comments** |
| What support or help has been offered or provided in order to help the resident make his or her own decision*?*  *For example, by providing information in more accessible formats such*  *as large font and drawings, and using different forms of communication such as sign language ,Braille etc*.  if the answer is **YES** to all the questions on **1.2** then the resident does have capacity to make a particular decision (Go to box 4)  If the answer of any of the questions on **1.2** is NO then undertake the two stage test **2.1** and **2.2** |  |

**Stage 1**

|  |  |  |
| --- | --- | --- |
| **2.1 Current diagnosis** is there an impairment of or disturbance in the functioning of the Resident’s mind or brain? (Tick appropriate box. *You will need to check medical records (MMSE/AMT) and/or discuss with the GP* )  *(it does not matter if this is permanent or temporary or fluctuating)* YES NO |  |  |
| Dementia |  |  |
| Psychotic illness |  |  |
| Learning disability |  |  |
| Depression |  |  |
| Stroke |  |  |
| Acquired brain injury |  |  |
| Alcohol/ drug problem |  |  |
| Other(s) |  |  |
| Other comments |  |  |

**Stage 2**

|  |  |
| --- | --- |
| **2.2 Mental Capacity** | **Comments** |
| **Capacity:**  does the impairment or disturbance make the resident unable to make the particular decision? YES NO  On what basis is the capacity of the resident  to make his or her own decision in doubt? |  |

|  |
| --- |
| **3. Are there any other issues for consideration?** |
| 1. Whether it is likely the resident will regain capacity at some time in the future to make the decision in question and when that is likely to happen.  2. Permit and encourage the resident to participate, or to improve his ability to participate, as fully as possible in any act done for him or any decision affecting him [section 6(4) Mental Capacity Act].  3. If the decision relates to the disposition of or settlement of property, e.g. sale of property or placing assets in trust, the decision-maker must  be motivated by a desire to ensure that the resident’s property is preserved for the resident’s maintenance during his life [section 6(6) Mental Capacity Act].  4. The resident’s past and present wishes and feelings, especially if they were written down when the resident had capacity.  5. The beliefs and values likely to affect that resident’s decision if he had capacity; e.g. cultural background, religious beliefs and past behaviour or habits.  6. Any other factors the resident would likely to have considered, if he had capacity to do so.  7. The views of anyone named by the resident as someone to be consulted on the matter in question or on matters of that kind.  8. The views of anyone engaged in caring for the resident or interested in his welfare  9. The views of any donee of any Lasting Power of Attorney granted by that resident.  10. The views of any court-appointed deputy. |

|  |  |
| --- | --- |
| **4. Conclusions** | |
| What is the present conclusion regarding the resident’s capacity to make the specific decision described above?  **If the answer to any of the questions on 1.2 is NO and the answers to questions 2.1 and 2.2 is yes** then the resident **does not** have mental capacity. (It is necessary that your findings are discussed with the GP, family and other professionals and an agreement is reached in the best interest of the resident to agree what is in the resident’s best interest.  If the answer is YES to all the four questions on 1.2 then the resident does have the capacity to make a particular decision. | [ ] The resident has the mental capacity to make the decision.  (If yes, please go to boxes 6 and 7)  [ ] The resident lacks the mental capacity (at this time) to make the decision.  (Please complete boxes (5,6 and 7 ) |

**To be completed following the decision surrounding Capacity (This may be referred back to the Decision Maker)**

|  |  |
| --- | --- |
| **5. Action Plan where resident lacks capacity:** | |
| What action(s) are necessary to enable the decision to be made on behalf of the resident who lacks capacity?  **Tick the statement(s) that apply and add any comments underneath the statement.** | |
|  | The resident has made a ‘valid and applicable’ **advance decision / statement** which confirm his/her decision. |
| Comments | |
|  | The decision cannot be made by others on behalf of the resident (i.e. decisions related to marriage, sexual activity, divorce, adoption, voting, making a will or entering into a contractual arrangement) |
| Comments | |
|  | The decision does not need to be made at this time as it is felt that the resident will regain / develop their capacity at a future date and the decision can wait until this happens. A review date will be recorded in the resident’s care-plan. |
| Comments | |
|  | There is somebody registered with the ‘Court of Protection’ who is legally able to make the decision on behalf of the resident (i.e. LPA Lasting Power of Attorney Health and Welfare or Property and Finance, or a Deputy appointed by the Court of Protection) **This resident is legally required to act in the resident’s ‘best interests’ and must be consulted.** |
| Comments | |
|  | A ‘best Interests’ decision needs to be made but it does not require a full meeting/best interests forum to be held. A written record of the decision made and who was involved will be detailed in the resident’s care-plan. |
| Comments | |
|  | A ‘**Best Interests Meeting/Forum’** needs to be held as the decision to be made is significant (e.g. the provision of medical treatment or social care). A ‘Decision Maker’ will be identified and an IMCA (Independent Mental Capacity Advocate) instructed if appropriate. |
| Comments | |
|  | Other (please describe fully) |
| Comments | |

|  |  |  |  |
| --- | --- | --- | --- |
| **6. Assessment Completed by:** | | | |
| **Name & Job Title:**  **Name & Job Title:**  **Name & Job Title:** |  | **Signature** | **Date** |
| **Organisation:** |  |  |  |
| **Contact No:** |  |  |  |
| **Authorised by:** |  |  |  |
| **7.Consent to Information Sharing** | | | |
| Please note that if an adult is determined to lack capacity regarding a decision specific issue this does not mean they also lack capacity to consent to the consent below. If there are issues regarding their capacity to do this, then another capacity assessment should be made.  I agree that information may be used for the purpose described in the Fair Processing Statement:  **Signature: Date:** | | | |
| If the resident does not have the capacity to consent, then please tick this box  **Assessor’s Initials:** | | | |

**\*For more information see Mental Capacity Act (policy)**

**A3 – End of life documentation**

The aim of the end of life documentation is to be able to provide the best care possible for all residents and their families, explore and establish what is important to them and what are their needs and preferences for the future.

The purpose of any discussion about thinking ahead, often called an Advance Care Planning Discussion, is to develop a better understanding and recording of peoples’ priorities, needs and preferences and those of their families and carers. This should support planning and provision of care, and enable better planning ahead to meet best these needs. This philosophy of ‘hoping for the best but preparing for the worst’ enables a more proactive approach, and ensures that it is more likely that the right thing happens at the right time.

This example of an Advance Statement should be used as a guide, to record what the resident DOES WISH to happen, to support planning of care. In line with the Mental Capacity Act (2005), this is different from a legally binding refusal of specific treatments, or what a patient DOES NOT wish to happen, which is called an Advance Decision (to refuse treatment) (ADRT).

Ideally an Advance Care Plan should be discussed to inform future care at an early stage. Due to the sensitivity of some of these issues, some may not wish to answer them all, or may quite rightly wish to review and reconsider their decisions later. This is a ‘dynamic’ planning document to be adapted and reviewed as needed and is in addition to Advanced Directives, Do Not Resuscitate plan, or other legal document.

**A3a - ACP Advance Care Plan**

This form should be used for residents with mental capacity. All fields need to be completed including date and name and signature of the resident and involved next of kin/staff/GP. This form needs to be reviewed yearly (ideally during MDT meeting) and when there are changes.

**\*For more information see Advanced Decision Policy, Consent Policy, Care Planning Policy, DNAR (policy) ,** **Mental Capacity Act (policy).**

**A3b - ECP Enabling Care Priorities**

This form should be used for residents without mental capacity. The rationale for this is to enable decisions to be made in the resident’s ‘best interests’ with as much input from the resident and their relatives as possible

All fields need to be completed including date and name and signature of involved next of kin/staff/GP. This form needs to be reviewed yearly (ideally during MDT meeting) and when there are changes.

**A3c - DNAR/CPR**

This form should be used only for residents who do not wish to be resuscitated. All sections need to be filled in. The form always needs to be printed in colour. The original form needs to be kept in the care plan.

**\*For more information see DNAR (policy)**

**A4 - Key Needs Profile**

All circles need to be filled in with the relevant information relating to things that are important to the resident in day to day life (and help the resident to make every day a good day) in relation to meeting their psychological needs (comfort, attachment, occupation, inclusion and identity). Information should include the name the resident prefers to be called in the middle circle.

This form should be completed within first 2 weeks after admission and revisited during the six weeks review meeting with the resident, relatives and a keyworker.

**A5 - Acute Care Plan**

The Acute Care Plan is a summary of the action plan that needs to be followed (this includes any recommendation from health professionals (GP, ANP, tissue viability nurse, district nurse, dietician etc.) while the resident has an acute condition. If the condition lasts more than 3 months an additional care plan should be created and Enriched care plan (C1a\_health and well-being) should be updated to reflect the information about the condition where applicable.

This form should be reviewed at least weekly and immediately if any changes. Once the condition and health condition is resolved, the acute care plan form needs to be archived.

**A6 - Risk Profile**

The purpose of this assessment is to identify the level of risk that the resident is at and the action that needs to be taken to ensure the resident’s safety.

**This form should be reviewed every 3 months or immediately if any changes.**

* **Response to distress - Verbal abuse and Physical abuse**

**Indicators:**

* Shouting
* Hitting
* Bitting
* Swearing, etc

The level of the risk will depend on the frequency of resident’s behaviour and the impact that this will have on the resident themselves and the others (other residents and staff). It should be based on observation and distress reaction chart (E3\_Distress reaction chart).

**\*If a resident is at high risk the additional care plan should be created identifying risk- factors and action to prevent the resident from becoming distress (including verbal/physical abuse).**

* **Falls**

**Indicators:**

* Unexplained bruises
* Resident complaining of pain
* Prone to falling
* Medication
* Infection, etc

**\*The risk level needs to correlate with the level of risk in C7c\_Falls Risk Assessment.**

**\*If a resident is at high risk the additional care plan should be created identifying risk- factors and action to prevent falls and fall-related injuries. The action plan may include a referral to Physio/OT for further assessment, close supervision etc.**

**\*For more information see Falls slips and trips prevention policy**

* **Pressure ulcers**

**Indicators:**

* Body checks on admission from home/hospital
* Regular checks on residents who spend a long period of time sitting in a chair or nursed in bed.
* Checks when washing, etc

**\*The risk level needs to correlate with the level of risk in C9a&b\_Waterlow risk Assessment (where “at risk” should be interpreted as “low risk”).**

**\*If resident is at high risk the additional care plan should be created identifying risk- factors and action to prevent developing pressure ulcers. The action plan may include: a referral to the moving and handling advisor for further assessment and equipment (e.g. air-mattress), a turning chart in place, effective management of incontinence etc.**

**\*For more information see Pressure ulcer prevention and management policy**

* **Dehydration**

Indicators:

* Low fluid intake
* Dry lips
* Confusion
* Restlessness
* Infection, etc

**\*The risk level needs to correlate with the level of risk in C18\_Dehydration Assessment.**

**If a resident is at high risk the additional care plan should be created identifying risk - factors and action to prevent dehydration. The action plan may include: fluid intake monitored (fluid chart in place), close observation for any signs of dehydration (e.g. dark urine, decreased skin elasticity, headache, dry mouth, fatigue and lethargy, a sudden change in blood pressure upon standing up, dizziness, and increased heart rate- for more symptoms of dehydration see information under C18\_Dehydration assessment in these guidelines), a referral to speech and language therapist (if difficulty with swallowing), drink always available within resident’s reach, favourite beverage available etc.**

**\*For more information about dehydration see C18\_Dehydration Assessment in these guidelines and Nutrition and Hydration Policy**

* **Malnutrition**

**Indicators:**

* Weight loss
* Residents on diet supplement
* Low food intake
* Poor appetite

**\*The risk level needs to correlate with the level of risk in C12a\_Malnutrition Universal Screening Tool form.**

**If a resident is at high risk the additional care plan should be created identifying risk - factors and action to prevent malnutrition. The action plan may include: food and fluid intake closely monitored (food chart in place), close weight monitoring (once a week), offering favourite food to encourage resident to eat more, monitor BMI score and refer to a dietician when appropriate (BMI score 2 or more) etc.**

**\*For more information see Nutrition and Hydration Policy**

* **Leaving NGH unescorted (only for residents who haven’t got mental capacity)**

Indicators:

* New resident requesting to go home
* Restlessness
* Confusion, etc

**\*If a resident is at high risk the additional care plan should be created identifying risk - factors and action to prevent the resident from leaving Nightingale House unescorted. The action plan may include:**

* **identifying the reason why the resident wants to leave Nightingale. It may be that resident wants to go home because they feel they don’t belong here, they don’t feel safe or simply the resident wants to go shopping or for a walk and feel more independent, in control of their lives. The reason of why resident wants to leave Nightingale should be always explored. Some reasons may be of psychological nature and could be addressed and resolved with appropriate approach and reassurance which would result in reduced level of resident’s distress and urge to leave Nightingale.**
* **close supervision (considering one to one care);**
* **hourly monitoring chart in place etc.**

**For those residents who do not have capacity the risk always will be high of them leaving the building. As a result of this a DOLs application needs to be made immediately.**

**This risk area does not apply to residents with mental capacity, N/A should be written in the box.**

**\*For more information see Mental Capacity Act (policy)**

**A7 - Keyworking Team Care Plan Reviews**

This form should be completed after every keyworking team meeting. The meeting should take place monthly in the presence of keyworkers and cokeyworkers. Activity coordinator should be notified and invited to the meeting. The care plan of the resident needs to be in place and all resident’s needs (as following C1a\_ health and wellbeing care plan) and changes should be discussed during the meeting. The outcome of the meeting should be recorded on an evaluation form following each of the resident’s need (Enriched Care Plan).

**A8 - Inclusivity Signatures**

The resident and/or relatives should be involved in the process of drawing up a care plan.

Once the care plan is completed this form should be signed by resident/relative/keyworker as appropriate. All care plans need to be rewritten yearly and this form needs to be signed again.

**A9 - Personal Evacuation Plan**

This form should be completed within 48hrs of admission.

**How to complete it**?

Answer the questions starting from the top and going to the bottom. Follow the answer “Yes” or “No” as appropriate. Add all scores (each answer “Yes” or “No” has a score next to it in bracket eg. Yes (3)). Sum all scores to establish a level of risk and required guideline. Complete the box on the bottom of the form “Score/Comments”. This form should be revisited monthly and updated immediately if there are any changes in resident’s circumstances.

**B - Lifestyle, history and personality**

**B1 - Life story profile**

This form should be completed fully based on information given by resident/relative about:

* **resident’s early years and school days** – suggested information that should be taken into account while completing this section: recollections of grandparents, parents, brothers and sisters and anyone else who may have been significant to resident, memories of school, friends, what they did together, achievements and resident’s interests.
* **resident’s midlife years and working days -** suggested information that should be taken into account while completing this section: recollections of resident’s bar or bat mitzvah, wedding if resident is/was married, birthdays and any other special anniversaries, memories of work, colleagues, achievements and the holidays resident may have had, any sad or difficult times in resident’s life.
* **resident’s retirement days and present life -** suggested information that should be taken into account while completing this section: recollections of resident’s life after work, how they felt after they retired, what they did, including their hobbies, any travelling, their achievements, and those things that may have made them feel sad, any regrets that they may have and happiest memories, what they would see as their "best day."
* Any new information revealed after the completion of the resident’s life, should be added retrospectively.

**B2 - Personality profile**

The purpose of this form is to find out resident’s personality as this may influence the way they think, feel and react. Resident should be given the opportunity to describe and talk about their own personality and how they see themselves. You may need to get more information from other people and/or through observation, in which case you will draw your profile from observing the resident, spending time with them and talking to other people (family members, friends) who know the resident well.

Identifying needs in relation to personality requires you to know about individual characteristics that may affect the resident’s well-being in the current situation.

**How to complete it?**

If possible together with the resident identify anything important that would be relevant now.

Put X where the resident feels is on each line and then ask the resident to justify their choice.

Use the space underneath for the comments (evidence). Quote what the resident said about themselves, or describe what you have observed or what has been said to you by others about this resident’s personality.

Important information might include extremes of:

* nervousness
* shyness
* curiosity
* outspokenness
* wanting to be organised, in control.

The reason that these are more likely to be of relevance in this context is because these characteristics can often be perceived as ‘part of dementia’ or as ‘difficult’ or ‘challenging’ behaviour. Examples of how these things might be relevant to needs:

* Nervousness - the resident may need regular reassurance to prevent their anxiety from escalating.
* Shyness - the resident may be better in a one-to-one situation, they may not enjoy being put under pressure socially.
* Curiosity – this can make a resident active and determined.
* Outspokenness - can be perceived as hostility.
* Wanting to be organised, in control - the resident may become anxious and upset if this aspect of their personality is not supported.

**C - Assessment reports and care plans**

**C1a\_Health and Well-being Care Plan**

The purpose of this care plan is to identify resident’s needs, their abilities and the level of support should be provided in order to meet those needs. The resident should be always included and treated as a partner in a process of planning and developing care. The care plan should be based on information given by the resident, relatives, input from relevant professionals and staff observation.

The care plan should be always written from resident’s perspective and should reflect person-centred care philosophy which enables residents to use their remaining skills and maintain their sense of independence and being in control of their lives as long as possible.

**The care plan (each of the needs e.g. washing, dressing, communicating etc.) should be reviewed once a month during the keyworking meeting to assess its suitability and effectiveness and immediately if the condition or needs of an individual resident have changed.**

**Use C1\_Care Plan Evaluation at the back to record an outcome of the monthly keyworking meeting and any changes.**

**If there are any major changes to the needs of the resident the entire care plan needs to be rewritten.**

\*When formulating a care plan and addressing resident’s needs it is not enough to say “resident needs assistance/resident needs support”. Please specify what kind of support or assistance this resident needs exactly, to what extend the resident is able to do something on their own and when you need to assist the resident to complete the process.

If the resident is able to eat independently but sometimes needs support explain exactly when “sometimes” occurs and what kind of support this resident needs.

**\*For more information please see Care Planning Policy**

* **My current health issues include:** all information about the resident’s current health issues should be recorded in this section. These include long-term, known conditions that the resident needs help to manage in order to stay well and healthy. Retrieving information from medical documents such as medical notes, nursing notes, specialist reports and the initial assessment of needs carried out prior to admission and recorded on the pre-admission assessment form will be important.
* **These are the treatments (excluding medications) I have and this is what I feel about them (for example: chiropody, bloods, pacemaker, opticians):** in this section all treatments should be listed and special needs that the resident may have regarding taking bloods or visits of optician, chiropodist should be recorded here.

**1. MEDICATIONS**

The purpose of this care plan is to explore and identify how the resident prefers to take their medications and any support required.

It may happen that residents may decline their medication for various reasons for example:

* resident may be very sleepy at 8 am and has difficulty with taking medication so early, but they seem to be more alert later, during the day. In this situation staff should seek advice from pharmacist/ANP/GP regarding changing the time of administration of medication if appropriate;
* resident may have difficulty with swallowing a big tablet. Staff should seek advice from pharmacist/ANP/GP regarding crushing, halving the tablet or changing form of the medication to liquid if appropriate;
* resident may decline taking medications from some staff but may have a very good relationship build on trust with others and accept medications administered by them.

If the resident constantly declines taking medication this should be discussed further with the GP and appropriate action should be taken e.g. mini-MDT to take place, the GP to establish if resident has mental capacity and understands consequences of not taking medication.

If the resident lacks mental capacity, a covert administration of medication should be considered in the best interest of the resident. If medications are administered covertly the information about it should be recorded in this care plan.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

•is resident able to take medications independently

•how the resident feels about taking medications

•is there any preferred time for the resident to take medication

• what special support the resident may need to make their decisions about whether or not to take medication

• situations that cause the resident to have a negative reaction and how best to prevent these from happening, and what to do if they do happen (for example distress, agitation etc);

•is there any other medication requirements due to the resident’s health condition or some difficulties the resident may experience (for example liquid form of medication, crushing, halving the tablet etc)

•what carers will do if there are any problems with the resident’s medications

•does the resident has any medication allergy

**\*For more information see Pain Management policy, Administration of Medicines policy, Administration of drugs via inhalers policy, Guidelines For Covert Administration of Medicines.**

**2. PAIN MANAGEMENT**

The purpose of this care plan is to explore and identify how the resident express when they are in pain (especially if they have difficulty to communicate verbally) and any support needed in order to ensure resident’s comfort.

It is important to identify any form of pain and discomfort as soon as possible. Some residents are able to report when they are in pain and need help to manage it, others who experience difficulty to communicate, may express being in pain in a various ways. For this reason staff should observe and pay more attention to body language and other non-verbal cues to look out for any signs of pain.

There are number of ways this might be communicated:

**• behaviour**: unusual or changed behaviour such as fidgeting, restlessness, rocking, patting and other repetitive behaviour can be a sign that the resident is in pain. Also, holding the part of the body that hurts or curling up can indicate pain. A resident may become tense or “on edge” when they know physical care is about to be given and may be unusually resistive to care, pushing away carers. Sometimes they may become angry and frustrated if they cannot verbally express the pain they are experiencing;

**• mood**: untreated pain can cause a resident to become depressed, withdrawn or tense, anxious and agitated;

**•facial expression**: pain my cause frowning and grimacing;

**• verbalising**: calling out, shouting, swearing and groaning are all natural responses to being in pain.

Any signs that indicate that the resident is in pain it should be recorded in this care plan for example: ‘I suffer from headaches from time to time and when I rub my head repetitively that means that I’m in pain due to headache. My carer will offer me painkiller and explain that these tablets will make my headache go away.’

Pain should be always appropriately assessed and monitored in order to ensure resident’s well-being. For pain assessment see C10a\_Pain Assessment for residents who are not able to communicate pain or C10b\_ Pain Assessment for residents who are able communicate pain.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

•how the resident will express when they are in pain (verbal and non-verbal cues i.e. fidgeting, restlessness, rocking, patting, being withdrawn or tense, anxious, agitated, calling out, shouting, swearing, groaning, facial expression and body language that may suggest pain of discomfort)

•how to help the resident manage the pain including a nonpharmacological intervention e.g.: massage, repositioning etc.

• is there any specific time (before or after certain procedure or activity) or situation where the resident may be in pain or discomfort (e.g: prior to moving and handling, transfer, change of a dressing etc.)

•does the resident experience any chronic pain

\*This care plan should be used in conjunction with C10a\_Pain Assessment for residents who are not able to communicate pain or C10b\_ Pain Assessment for residents who are able communicate pain as appropriate.

**\*For more information see Pain Management policy and information in these Guidelines under Monitoring of Pain and Pain Interventions (page 39).**

**3. EATING & DRINKING, FOOD & NUTRITION**

The purpose of this care plan is to explore and identify the resident’s ability to eat and drink and support that they may need in order to ensure adequate nutrition and hydration.

It is also about exploring the resident’s preferences, likes, dislikes and routines the resident may have with eating and drinking for example having a cup of tea first in the morning when the resident wakes up.

The resident’s plan of care should include details of what assistance is needed to enable the resident to eat and identify how any nutritional and hydration risks will be managed. This will include types of nutritional support that may be required eg food fortification, enrichment, use of snacks or oral nutritional supplements.

**Information about food allergies, dietary requirements and all special needs that the resident has in order to eat and drink well should be recorded in this care plan**.

These needs might be in relation to the cutlery needed, the way that food is presented or in relation to the conditions under which the resident eats and drinks well. For example, it may be that a teaspoon is easier for the resident to eat from than a large spoon, that a plate guard or colour contrast between a plate and a table cloth is helpful, that the resident needs their food to be cut up or the resident is on soft/puree diet, or that they prefer to eat alone rather than in a group.

It is essential to recognise any difficulties the resident may have and seek advice as soon as possible from GP/OT/dietician speech and language therapist as appropriate, depending on the nature of the difficulty being experienced by the resident. Residents identified with swallowing difficulties should be referred to a speech and language therapist for a full assessment if necessary.

It should always be a priority to maintain the resident’s independence as much as possible by making adaptations tailored to individual needs.

Eating and drinking difficulties include:

* muscular or co-ordination problems:
* with face, mouth or throat causing the resident to choke or have difficulty with chewing, swallowing, sipping, sucking;
* with the arms and/or hands causing the resident to have difficulty holding or manipulating eating utensils/drinking vessels such as cups;
* with the arms and /or hands causing the resident to have difficulty performing eating actions such as cutting, scooping, getting food to the mouth/ reaching for or picking up drinking vessels;
* Cognitive problems causing the resident to have difficulty using eating utensils, initiating or performing eating/drinking actions such as reaching for, picking up sipping or swallowing.
* Medical, social, psychological or cultural problems affecting the resident’s ability or desire to eat/drink.

For a resident who lives with dementia, special needs for drinking might include the need to have fluids presented regularly, to have the drink placed in the resident’s hand, to be helped to start off drinking with verbal prompts, to drink from a special cup or to be given thickened fluids or fruit jelly as a way of keeping hydrated.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• what the resident is able to do independently

• any support the resident needs to eat and drink and to choose what to eat and drink

• any specially adapted cutlery/crockery the resident needs to use

•any dietary needs and preferences the resident has and how to meet them (including food allergies, diabetes etc)

•when the resident likes to have their meals

•what environment the resident prefers to have mealtimes in (eg people, place, noise, light)

• if the resident is at risk of under- or over- eating/drinking, how you will know (signs and symptoms) and how to help the resident stay healthy

•if the resident is at risk of choking and how to help the resident if they are choking

**\*For more information see Nutrition and Hydration Policy**

**4. COMMUNICATING**

The purpose of this care plan is to explore and identify the resident’s ability to communicate and any support they may need to express themselves verbally or non-verbally.

As people getting older they tend to slow down, needing more time to express themselves but also more time to process information and to respond.

It is important to remember that communication is not just talking. It also involves gestures, movement, facial expression and other non-verbal means. Body language and physical contact become more significant when verbal communication is difficult.

Communicating with a resident living with dementia needs you to use good observational and listening skills and to be aware that people with dementia often communicate indirectly – e.g. using metaphors, proverbs, and stories – things that are important to them. Knowing as much as possible about the resident’s life may help interpret what the resident is trying to say and express.

All non – verbal techniques that resident uses to communicate should be described in this care plan with an explanation of the meaning.

\*For more information about how to support residents with communication see “Communication Guidelines” on NGH share drive under care plan current/care plan guidelines.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• how the resident tends to communicate (eg body language, facial expressions, words, gestures, noises, actions) and how best to understand what the resident is expressing

• any support the resident needs to communicate their wants and needs

• eyes and vision, ears and hearing, memory and cognitive health

• if the resident regularly has any unpleasant feelings (eg anger, anxiety, sadness & depression) and how to help the resident get through them

**5. MOVING ABOUT (MOBILISATION & TRANSFERS)**

The purpose of this care plan is to identify the resident’s ability to move about and support that the resident may need including walking aids and any equipment.

This care plan should correlate with information and recommendations given by Physio/OT staff/moving and handling advisor in their assessments (e.g. C5a\_Moving and Handling Assessment, C5b\_Moving and Handling Plan, C7b\_ Initial Falls Assessment, C14a\_Occupational Therapy Assessment, C14b\_Physiotherapy Assessment) related to moving/mobilising, transfer and the level of assistance required to ensure the resident’s safety.

If the resident is at risk of falling and likes moving about a lot, we should not stop the resident but rather assess the risk and introduce safety measures (Physio/OT assessment) like for example assistance of one staff or walking aid if appropriate.

If the resident uses a walking aid such as a walking stick or zimmer frame or they use a wheelchair, or they need manual assistance for any part of their moving about routine, such as help out bed or out of a chair, or they need a cognitive support such as reminders or help to initiate and sustain a moving about routine this should be recorded with detail in this care plan.

It is important to remember that this care plan should not focus only on fall preventions but should be balanced with information about what the resident is still able to do and how we can maintain their independence.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• what the resident is able to do independently

• how the resident tends to move around (eg walking, wheelchair, zimmer frame)

• any support the resident needs to move around and transfer

• how the resident feels about moving around (eg confident, nervous)

• any factors that affect how well the resident is able to move around

• if the resident is at risk of falling and what to do if the resident falls

If there are any changes a referral should be sent to Physio/OT/moving and handling advisor as appropriate for further assessment and directions. This care plan should be reviewed once a month during keyworking meeting and immediately if there are any changes.

**6. ELIMINATION AND USING THE TOILET**

The purpose of this care plan is to explore and identify abilities and the resident’s needs and routine of using the toilet and the level of support they may need.

A person - centred approach is one where the physical care environment and the people working in it act to minimise any difficulties experienced by people, especially those living with dementia, in relation to going to the toilet. It is important to find out what the resident’s pattern is for going to the toilet (how often and when) and do so you can use a number of different methods including talking to the resident, observing them, communicating with family.

Some people empty their bowels three times a day, while for others it may be three times a week.it is important to find out what is ‘usual’ for the resident. If the resident is prone to constipation or other bowel or urinary problems, special preventative measures that they currently use to help should be recorded in this care plan such as incontinence wear, oral remedies and creams, the need for reminding or prompting or accompanying, the need for practical help with clothing, wiping clean, washing hands and/or getting on and off the toilet, the need for clear visual cues such as signage, use of colour contrast to help the resident see the toilet, objects that resident uses during their toileting routine such as toilet paper or grab rails, or the need for help to find the toilet. Problems with incontinence may be related to environment (signage not clear, toilet in in view, seat too high or too low) which may result in the resident using sink, cupboard, bin or other receptacle as toilet or to use substitutes for toilet paper. It may be also caused by cognitive and/or physical impairment such as:

* an overactive bladder resulting in the resident feeling very little warning of the need to pass urine. This is called ‘urgency’ – when this happens, there may not be enough time to reach the toilet resulting in urine leaking;
* enlarge prostate (in men only) causing difficulty passing water, or a ‘jumpy’ bladder triggering frequent trips to the toilet;
* poor mobility and/or limited range of movement making it difficult for the resident to get out of their chair/bed to go to the toilet, walk the distance to and from the toilet or manage their clothing through the toileting routine.

That is why it is important to explore all difficulties the resident may experience and tailor support to their needs.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• what the resident is able to do independently

• any support the resident needs to empty my bladder/bowels

• what support the resident needs to stay dry and clean throughout the day and night

• how does the resident feel about their ability to use the toilet / empty their bladder & bowels

• when the resident prefers to use the toilet /empty their bladder & bowels

• how to look for signs of ill health relating to elimination and what to do if you see these signs

• does the resident use a catheter/stoma bag and what support does the resident need if they use it

**7. SLEEPING AND NIGHT TIME CARE**

The purpose of this care plan is to identify the resident’s sleeping pattern, sleeping routine, preferences and support that they may need in order to sleep well and enough.

In order to deliver person – centred care, each individual’s usual pattern needs to be known. This is important for two reasons. First, if the pattern changes this can be looked into, it may be because the resident is worried, in pain, cold at night, unwell, depressed or needs a review of their medication. Second, it is important to prevent a ‘normal’ sleep pattern from being interpreted as challenging behaviour. It is not uncommon for older people to get up in the night, or to need one or more naps in the day. If it is usual for the resident to get up in the night, this needs to be recorded so that care plan will reflect what that resident needs when they get up at night.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• any support the resident needs to go to sleep (eg hot drink, music, doll, lighting)

• what environment the resident prefers to have at night time (eg door/window/curtains open/closed, music, lights on/off)

• when the resident prefers to go to sleep

• what the resident prefers to wear in bed

•if the resident sleeps well, and what tends to interrupt their sleep, what is the resident’s sleeping pattern

• how to support the resident during the night

• what time the resident prefers to wake up and get up in the morning

• does the resident prefer to have a rest/nap in the afternoon

**8. WASHING, DRESSING & SKINCARE**

The purpose of this care plan is identify the resident’s needs, preferences and support that they may need with washing, dressing and their skincare.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• what the resident can do independently

• any support the resident needs to have a wash (upper body, lower body, hair, teeth/denture)

• what the resident can do themselves and any support they need to get dressed (upper body, lower body)

• any support the resident needs and their preferences regarding shaving

• any support the resident needs and their preferences regarding their nails (length, colour)

• what clothes the resident prefers to wear (including colour)

• any support the resident needs to keep skin in good condition and moisturised

• how to look for signs of ill health relating to skin and what to do if you see these signs

• where and when the resident prefers to get washed & dressed and have their skincare attended to

• whether the resident prefers a male or female carer to help them

If there is any specific time when the resident would like to be supported with washing and/or dressing or if the resident prefers a shower over a bath this information also should be included.

**9. EXPRESSING SEXUALITY**

The purpose of this care plan is to identify how the resident expresses their sexuality and what their sexual needs are.

This is a delicate area, and needs to be approached and in a way that is acceptable to and manageable for the resident.

**Sexuality is multi-dimensional and complex. Sexuality is not entirely about sexual function. It is part of who we are, how we see and feel about ourselves, how we dress, our self-esteem, sexual self-esteem, body image and how we are perceived by others. It is also about how we are in our relationships with other people and the feelings we have about other people.**

Sexuality and attachment are often linked and it may be that the resident wishes to openly express his or her need for intimacy.

Engaging in sexual relationship can bring love, intimacy and closeness as well as physical release and these things can contribute a great deal to older people’s general well-being (Wallace 1992).

**For person-centred practice, we need to make accurate observations and use non-judgemental and respectful language to describe sexual activity. For this reason we should avoid using words ‘inappropriate’, ‘challenging’, ‘grabbing’, ‘groping’ and ‘obscene’ when describing sexual behaviour.**

Be aware that promoting an understanding of a person’s sexuality can bring benefits such as having a healthy self-image, psychological refuelling and re-energising, an outlet for personal anxieties and a means of preventing social disengagement and avoiding depression (Health 1999).

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• how the resident expresses their sexual needs (touching others, holding hands, cuddling, flirting, watching pornography, sexual stimulation, making comments of sexual nature and other)

• is the resident happy to share information about their sexuality or they would like to keep this information private (for example information about sexual orientation)

• how to ensure the resident and their carers have dignity and safety at all times relating to sexuality

• does the resident have anyone they are intimate with

The involvement of family members in a discussion about sexuality is also important however the resident may not wish their family to be involved in discussion or decisions about their sexual activity.

Residents have a right to fulfil their sexual needs and develop social relationships provided no harm is inflicted on others. In cases where the mental capacity of residents are concerned, personal relationships and sexuality should be discussed and seen as an integral part of the Care Planning process. Staff should at all times look to safeguard the best interests of the resident. If there is cause for concern regarding the appropriateness of a relationship, there should immediately be a review of the Care Plan and an investigation into the relationship to prevent the possibility of abuse.

**\*For more information see Sexuality and Relationships policy and Safeguarding Vulnerable Adults policy.**

**10. MY END OF LIFE PREFERENCES**

The purpose of this care plan is to plan the resident’s end of life care and ensure that their needs will be met and their wishes will be followed.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• what treatments and medical interventions the resident wants and does not want to happen at the end of their life, does the resident have an advance decision to refuse treatment

• who the resident wants around them at the end of their life

• the resident’s preferred environment at the end of their life (eg in their room, music, curtains open)

• what the resident wants to engage in at the end of their life (eg massage, being read to, music)

• how the resident feels about death and dying, their thoughts and fears

**This care plan should reflect information about their preferences regarding the end of life care in A3 (ACP/ECP form).**

**There is no need to create an additional care plan for the resident on the end of life care.**

**When resident is on palliative care this care plan should be reviewed and updated respectively including pain management and GSF code.**

**Use C1\_Care Plan Evaluation at the back to record any changes/evaluate.**

**11. ENGAGEMENT AND WELL-BEING**

This care plan should be completed by keyworker together with an activity coordinator. The purpose of this care plan is to create a plan for the resident’s engagement based on the resident’s preferences, likes, dislikes, hobbies, skills and abilities to ensure their well-being.

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• what activities of daily living would the resident like to be doing?

Ideas: cleaning my shoes, housework, personal grooming, using the telephone

• is there anything related to the resident’s previous occupation that they would enjoy doing/be able to do?

• what skills does the resident have? What does the resident enjoy doing?

Ideas: I am creative, I enjoy playing games such as…, I speak other languages, I like talking about…; music I enjoy is….

• is the resident interested in exploring new activities such as….

Ideas: Skype and computers, crafts, discussion groups, physical fitness, musical activities

• where do I enjoy being? (i.e. in my own space, with others, outside…) and what places do I like to visit? (i.e. galleries, shops, tourist attractions, parks)

• what time of day does the resident like to be engaged /does the resident like to relax? (when does the resident have the most energy in the day?)

• people or objects that the resident feels attached to and what resident needs to feel close to them?

•other information about what the resident like to do and what resident doesn’t like to do

\*Also see signs of well-being and ill-being at the back.

**12. SPIRITUALITY**

Spirituality does not mean the same as being religious, although many people engage in religious activity as part of their own spirituality. Not every resident is religious but all people have their own way of finding meaning and purpose in life. The purpose of this care plan is to explore what spirituality means to the resident and how we can support the resident to meet their needs and maintain spiritual well-being (feeling at peace with a wider question such as the meaning of life, accepting the life they have lived).

Use suggested questions for the conversation with the resident/relatives and your observation which will help formulate the content of the care plan.

**To include:**

• what does spirituality and religion means for the resident

• does the resident observe religious festivals

• are there any \*Yahrzeits that resident wishes to observe (and the dates)

• does the resident want to go to the synagogue and when

• does the resident pray and when and where he/she prefers to do it

• any support the resident needs to meet the spiritual needs

• people or objects that the resident feels attached to, things that they like to look at, touch or hold that have special meaning or that feel important to them (e.g. in nature, buildings, images, statues, medals and pendants, prayer book, \*mezuzah,)

\*Yahrzeits – on the anniversary of the death of a parent, sibling, child, or spouse it is the custom to light a memorial light in the bedroom of the resident. The light remains for 24 hours. The Yahrzeits “candles” are electric plug in candles available from the Unit Manager or Religious Advisor Rafi. No real candles to be lit in rooms.

\*Mezuzah - is a piece of parchment (often contained in a decorative case) on the doorposts, inscribed with specified Hebrew verses from the Torah;

**Please Note:**

**If the resident wishes to keep information about their spirituality private this should be respected and recorded in this care plan.**

**C1b – Additional Care Plan**

This form should be used to address needs that are chronic and/or not identified in C1a\_health and wellbeing care plan, for example:

* diabetes, hypotension, depression, breathing problems, risk of developing pressure ulcers, chronic wounds, behaviour (distress reactions and other), DOLs etc.

Use C1\_Care Plan Evaluation at the back to record any changes/evaluate. The care plan needs to be reviewed on a monthly basis and when there are changes in the resident’s needs. When writing on the evaluation form avoid writing “no changes” but instead describe briefly the current situation.

**C2 - Capacity For Doing Profile**

Information recorded in this form should be used and referenced in C3\_Cognitive Profile. Although the profile talks only about eating, the information here can be translated to **all other activities of life.**

This form should be reviewed when there are changes.

If the resident is unable to complete it on their own, staff need to support the resident with answering questions (verbally or non-verbally). If the resident is unable to answer the questions, staff need to assess and observe the resident and consult with the family.

**How to complete it?**

Read each of the statements related to what the resident is able to do and tick [✔] an appropriate answer eg.:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **AUTOMATIC ACTIONS**  I am able to: | ***I manage this well*** | ***Sometimes this is difficult*** | ***I cannot do this*** | ***I’m not sure*** |
| Turn my head | ✔ |  |  |  |
| Open my mouth | ✔ |  |  |  |
| Swallow |  | ✔ |  |  |

**C3 - Cognitive Profile**

This form is to help identify any cognitive impairment that the resident has or may have and the support that resident may need.

This form should be completed fully and written from the resident’s perspective. Ideally a conversation with the resident/relative should take place to obtain all required information. This form should be reviewed when there are changes.

**How to complete it?**

Read each of the statements related to difficulties that the resident may experience and tick [✔] an appropriate answer. If you have ticked in the columns “This happens to me” or “I’m not sure”, the column “My carer will…” have to be filled in with specific information about support needed. These needs and type of support should be recorded in C1a\_health and wellbeing care plan respectively.

**C4 - Life at the moment**

This form is to help explore the resident’s experience of life at the moment and whether their psychological needs (comfort, occupation, attachment, identity, inclusion) have been met as these may be having a significant effect on their well-being.

This form should be completed fully and written from the resident’s perspective. Ideally a conversation with the resident/relative should take place to obtain all required information. This form should be reviewed when there are changes.

**How to complete it?**

Have a conversation with the resident/relatives about the resident’s feelings about living at Nightingale and complete the first field “These are my feelings about living my life here”.

The second section of this form helps to explore the extent of which the psychological needs of the resident are being met.

**See the explanation of psychological needs in A4\_Key Needs Profile**.

However asking the resident if his or her psychological need for occupation has been met it is not very clear and too complicated. Instead you can use some of the questions below:

**Comfort:**

* Do you feel loved and looked after here?
* Do you feel safe?
* Are you warm enough?
* Do you have any pain?
* Do you feel you can relax?
* What happens when you feel upset?
* Is there somewhere you can go or somebody to talk to when you feel worried or upset?

**Occupation:**

* Do you get bored?
* Are you occupied enough here?
* Is there anything you would like to be doing?
* Are there any special things you need to keep close to you so that you can hold or look at them whenever you want – like pictures, books?
* Is there anything I can do to help you feel useful and active?

**Attachment:**

* Are there people that you miss?
* What do you do to feel close to them?
* Is there a special resident that you carry around with you in your memory?
* Do you have a special friend here?
* Do you have a special belonging that you keep with you, for security?

**Identity:**

* Do you think that staff know the real you here?
* Are these your clothes, do you like them?
* Have you got your own special belongings here with you?
* Do you think that staff know about your family and your life story?

**Inclusion:**

* Do other people like you here?
* Are you asked to join activities here?
* Do you want to join in?
* Do you ever feel left out?
* Do you feel part of the group?

Once you identified whether the particular need has/hasn’t been met tick one of the answers: “Not met at all”, “Minimally and/or infrequently met”, “Moderately or sometimes met”, “Met to a considerable extent and/or often”, “Met fully and/or always”.

The last field needs to be completed fully and you need to record the evidence to support the statement made in this assessment for example: *“My need for comfort is met because I smile and appear relaxed at all times”. “My need for attachment is met when my handbag is with me at all times”.*

**If a need is not fully met there must be an action plan to change this.**

**C5a - Moving and Handling Assessment**

This assessment should be completed by staff on the resident’s admission as reasonably practical.

If the resident has complex needs that require moving and handling mechanical equipment (eg. hoist), this assessment will be followed up by the moving and handling advisor asap.

If the moving and handling advisor is not available, staff can fill in the form using the advice from the therapy team.

If changes are observed a referral should be sent to the moving and handling advisor for reassessment.

This form should be reviewed monthly and when any changes.

**Staff should always seek advice from the moving and handling advisor or therapy team,**

**if they have any questions/concerns about the resident’s moving and handling.**

**How to complete it?**

Fill in all the fields and give detailed information to describe what support the resident needs. Use Physio/OT assessment as a source of additional information.

Read each of the questions/statements and choose an appropriate answer “Yes” or “No”. In the comment section describe the resident’s situation and needs. Use the action column to detail the action needed to ensure resident’s safety and comfort.

**Example:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PHYSICAL HAZARDS** | **Yes** | **No** | **Comments** | **Action** |
| Could the resident’s height cause a problem? |  | ✔ |  |  |
| Could the resident’s weight cause a problem? |  | ✔ |  |  |
| Does the resident have swollen/fixed/flaccid limbs? | ✔ |  | Sometimes the resident’s legs are slightly swollen. | Refer to OT for a footstool.  Encourage the resident to elevate their legs. Observe and refer to GP/ANP if needed. |
| Does the resident have poor state of feet? i.e. swollen, painful, etc | ✔ |  | Sometimes the resident’s feet are slightly swollen. | Encourage resident to elevate their legs. Observe and refer to GP/ANP if needed. |
| Is skin condition poor? i.e. frail, fragile, pain, broken, |  | ✔ |  |  |
| Is the resident difficult to hold? |  | ✔ |  |  |
| Is the resident in pain when moving? | ✔ |  | Sometimes the resident experiences pain in hips when walking long distance. | Pain assessment to be carried out and painkiller offered when needed. |

**C5b - Moving and Handling Plan**

This assessment should be completed by staff on the resident’s admission as reasonably practical.

If the resident has complex needs that require moving and handling mechanical equipment (eg. hoist), this assessment will be followed up by the moving and handling advisor asap.

If the moving and handling advisor is not available, staff can fill in the form using the advice from the therapy team.

If changes are observed a referral should be sent to the moving and handling advisor for reassessment.

This form should be reviewed monthly and when any changes.

**Staff should always seek advice from the moving and handling advisor or therapy team, if they have any questions/concerns about resident’s moving and handling.**

**How to complete it?**

Fill in all the fields and give detailed information to describe what support the resident needs.

Use Physio/OT assessment as a source of additional information.

**C6 - Bedrails and Bumpers Assessment**

Risk assessment must be carried out before using rails and then reviewed monthly or when necessary.

The resident’s mental capacity needs to be assessed before using bedrails.

**When should bedrails used?**

* Bedrails should only be used where there is a risk of the resident falling out of bed, when using bedrails is considered to be the safest way forward.
* Bedrails should not be used where the resident is likely to climb over them to get out. This would be seen as a restraint as well as increase risk of injury.
* Other measures to reduce risk of falling from the bed include:
* lowering bed height, if bed is adjustable. Beds should always be left at lowest setting to reduce risk of injury from falls.
* putting a crash mat on the floor next to bed (consider trip hazard).
* sleeping on a mattress on the floor instead of the bed (consider bed transfers).
* using telecare peripherals such as a bed sensor or movement sensor to alert carers when the resident gets out of bed.

**Potential Risks of the bedrails:**

Be aware, that if the mattress is “squashy” there is potentially a gap between the surface and bottom rail. If this creates risk of entrapment then further control measures must be put in place eg. bumpers need to be considered or soft sides.

Where a resident has uncontrolled or unpredictable movement risk of entrapment may be reduced by the use of bumpers or soft sides.

If bed is profiling the rails designed for that make and model must be used. Consider entrapment issues with moving parts and mattress consistency. Also consider gaps, when bed is profiling and rail is static.

It is important to make sure that the height of the bedrails is sufficient when extra mattress or topper is used.

**How to complete it?**

Read each of the questions/statements and choose an appropriate answer “Yes” or “No” describing the resident’s situation and needs. Follow instruction indicated by the answer you chose.

**Example:**

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Is the resident likely to try to get of bed unsupervised? | Yes  No | Bedside rails **must not** be used.  Consider alternative measures.  Continue with assessment |

If you chose answer “Yes” that means that bedside rails **must not** be used and you need to consider alternative measures. If you chose “No” that means that you have to continue with assessment and move to another question.

Use “Risk assessment – bedrails – evaluation” to record any changes/evaluate.

Staff should revisit the form on a monthly basis and review immediately if there are any changes in the resident’s circumstances.

**\*For more information see Bedrails Policy**

**C7a - Falls Screening Tool**

This form should be completed by staff on admission and there is no need to review it. Complete all fields. Proceed with **C7b\_** **Initial Falls Assessment** if score at least 3 “yes” out of 5. If there were no previous falls write “None” or “N/A” in “Previous Falls (including injuries)”.

**C7b - Initial Falls Assessment**

This form should be completed by staff following **C7a – Falls Screening Tool** (filled in on admission)if scoreat least 3 “yes” out of 5.

If the score was less than 3 on admission and there was no need to complete **C7b - Initial Falls Assessment then,** but if the resident had a fall after admission this assessment should be completed.

It should be revisited every time the resident had a fall to see if there are changes in recommendations. If there are any changes a new assessment needs to be completed.

**How to complete it?**

Read the questions and choose answer “yes” or “no” then follow “Assessor’s guidance and prompts” and “intervention options”. Tick appropriate box and intervention e.g. refer to Physio/OT team etc.

**C7c - Falls Risk Assessment**

This form should be completed on the day when the resident had a fall. Otherwise it should be reviewed every 3 months.

**How to complete it?**

Read each of the statements and choose appropriate answer and score respectively. Sum all the scores to obtain a final result. The final score will determine the level of risk: **Low Risk Score: 0-25, Medium Risk Score: 30-55, High Risk Score: 60-125**

**The level of risk (Low, Medium, High) should correlate with the level of risk in A6\_Risk Profile.**

**C7d- Falls History Records**

This form should be completed on the day of the fall. No need to review it monthly!

**Reference needs to be made to this form each time mobility care plan C1a\_health and well-being/’4. Moving about’ is evaluated.**

**C8 - Monthly Scores and Results**

This form needs to be completed every month. All fields need to be filled in. If blood sugar level not applicable write N/A.

**C9a&b - Waterlow Risk Assessment**

Waterlow risk assessment is to estimate a level of risk of a resident developing a pressure ulcer.

The Waterlow consists of seven items: build/weight, height, visual assessment of the skin, sex/age, continence, mobility, and appetite, and special risk factors, divided into tissue malnutrition, neurological deficit, major surgery/trauma, and medication.

**How to complete it?**

To establish a level of risk choose an appropriate answer in each of the categories and enter score into “Risk Evaluation Record” (right side of the table) respectively.

**Special Notes**: **More than one score may be allocated to a classification e.g. 'Sex/Age' requires two scores.**

Sum up all the scores to obtain a final result which will indicate a level of risk as follows:

* a score of 10-14 indicates 'at risk'
* a score of 15-19 indicates 'high risk', and
* a score of 20 and above indicates very high risk.

Please see table below for reference.

|  |  |  |
| --- | --- | --- |
| PRESSURE AREA RISK DEFINITIONS | | |
| **A** | **B** | **C** |
| **BUILD / WEIGHT** | **CONTINENCE** | **SKIN TYPE** |
| **FOR HEIGHT** |  | **VISUAL RISK AREAS** |
| **Use Body Mass Index to decide the appropriate classification** | **Catheterised -** Tube inserted into bladder allowing drainage | **Oedema -** Excessive accumulation of fluid in body tissues |
| **Incontinence -** Inappropriate, Involuntary passing of urine |  |
|  | **Doubly Incontinent -** Inappropriate, Involuntary passing of urineand faeces. |  |
|  |  |
| **D** | **E** | **F** |
| **MOBILITY** | **SEX / AGE** | **APPETITE** |
| **Apathetic -** Unemotional | Note: The total score for 'E' is the client's 'SEX' and 'AGE' scores added together | **N.G. Tube -** A tube inserted into the stomach via the nose for feeding |
| **Inert -** Dull / Sluggish |
| **Traction -** Force exerted by weights |  | **N.B.M -** Nil by Mouth |
|  |  |  |
| **SPECIAL RISKS** | **SPECIAL RISKS** | **SPECIAL RISKS** |
| **G** | **H** | **I** |
| **TISSUE MALNUTRITION** | **NEUROLOGICAL DEFICIT** | **MAJOR SURGERY / TRAUMA** |
| **Cachexia -** Abnormally low weight | **Diabetes -** Disorder of metabolism |  |
| **Cardiac Failure -** Heart Failure | **M.S -** A chronic disease of the nervous system |  |
| **Peripheral -** Narrowing of blood vessels in the legs | **C.V.A -** Cerebrovascular Accident (i.e. Stroke). |  |
| **Vascular -** occasionally arms, restricting blood flow | (Cerebral = Brain, Vascular = Blood Vessels, Stroke = Ruptured blood vessels in brain) | **J** |
| **Disease -** causing pain. | **MEDICATION** |
|  | **Motor/Sensory -** Relates to nervous system | **Cytotoxics Drugs:** Treatment which destroys cells (e.g. in cancer treatment) |
|  | **Paraplegia -** Paralysis of both legs. Loss of power. |
|  |  | **Steroids -** Organic compounds, includes male and female sex hormones. Controls processes of inflammation and allergy. |
|  |  |
|  |  |
|  |  | **Anti-Inflammatory:** Reduces inflammatory |
|  |  |  |

**Please Note:**

**Residents at high risk /very high risk of developing pressure ulcers should have an additional care plan in place.**

**C9c - Body Map**

The body map must be marked accordingly showing where any bruising, skin tears, injuries, red marks etc., give as much details as possible such as size, colour and so on.

**How to complete it?**

* Indicate area of pressure ulcer / wound/ injury by marking the affected area with a circle. This information should be supported by acute care plan and recorded in the resident’s daily care notes.
* For a full description of the injury/wound please complete page 2.

**Use only one form for any skin injury/wound noted on each particular day**.

**\*For more information see Bruising policy;** **Pressure ulcer prevention and management policy**

**C9d - Open Wound Assessment**

This assessment should be carried out when the resident has got an open wound as a result of trauma, pressure, surgery or other.

**How to complete it?**

Look at the information in the first column and choose an appropriate answer describing the wound, surrounding skin and pain if any. Repeat every time when the assessment is taking place to monitor the progress. Complete “Action” field.

**The fields with “date” and “Name and signature” of staff need to be completed.**

**Important:**

* **Treatment and evaluation statement should be detailed in acute care plan;**
* **One open wound chart for each wound;**
* **Wound needs to be measured and picture taken weekly.**

**MONITORING OF PAIN AND PAIN INTERVENTIONS**

A pain assessment is vital to identify and monitor the intensity of pain and the effectiveness of pain interventions and management.

It is important that staff focus on the potential value to residents, which is being pain-free and the impact of pain and treatments effects on a resident’s physical and emotional function and quality of life versus meeting requirements.

Pain management is the responsibility of all members of the multidisciplinary team. All residents should receive an initial and ongoing pain assessment as part of their treatment and care and residents with pain should have evidence of pain management and a plan recorded in their care plan.

**General procedures:**

If there is a concern that a resident experiences pain, the pain assessment should be performed before a pain-relief intervention (administration of pain relief). Use C10a - Pain Assessment for Residents who are not able to communicate pain or C10b - Pain Assessment for residents who are able to communicate pain.

Pain should be reassessed after each pain intervention, once sufficient time has elapsed for the treatment to reach peak effect (when pain relief action is anticipated for example, 15 to 30 minutes after a parenteral medication (non-oral means of administration, but is generally interpreted as relating to injecting directly into the body, bypassing the skin and mucous membranes) and 1 hour after oral medication or a nonpharmacological intervention e.g.: massage, repositioning etc).

Complete the evaluation of pain management to determine the effectiveness of pain-relieving intervention. A reassessment should be conducted one hour after any intervention.

If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate. Reassessment should include whether the resident's goal for pain relief was met (for example, pain intensity, physical or psychosocial effect on function, resident satisfaction with pain relief, whether side effects had occurred and were tolerable).

Complete the pain scale hourly, until the resident appears comfortable, then four-hourly for 24 hours, treating pain if it recurs. Record all the pain-relieving interventions undertaken. If pain/distress persists, undertake a comprehensive assessment of all aspects of the resident’s care and monitor closely over a 24-hour period, including any further interventions undertaken. Staff must recognise the boundaries of their clinical competence, and seek appropriate support and advice when necessary.

If there is no improvement during that time, notify the medical practitioner (ANP/GP) of the pain scores and the action/s taken. If the pain relief is not effective it should be reviewed (type, dose, route, timing of administration) by ANP/GP/Pharmacist as appropriate.

If the resident’s pain still does not seem to be managed well after medication has been reviewed, staff need to inform the GP to consider an onward referral as appropriate.

**Pain should be reassessed and documented:**

* **Within an appropriate time after pain relief intervention (i.e. when pain relief action is anticipated);**
* **After any procedure or activity anticipated being painful e.g.:** prior to moving and handling, transfer, change of a dressing etc **;**
* **At intervals determined by ongoing chronic pain issues;**
* **With each new report of pain;**

Pain assessment, intervention and effectiveness should be documented. Ineffective pain relief should be documented and acted upon.

A systematic process by which pain is recognized, assessed, documented, and reassessed on a regular basis will result in improved pain management for all residents. All staff should become “pain vigilant,” be constantly alert to cues that suggest the resident may be experiencing pain, and adapt assessment approaches to meet the needs of each individual.

**Residents on PRN (as needed) medication**

For residents on PRN medications, a pain assessment should be performed before a pain-relief intervention (administration of pain relief) and 1 hour after or sooner when pain relief action is anticipated. Furthermore it should be reevaluated at significant intervals depending on pain trigger e.g. moving and handling, transfer, change of a dressing. If resident needs to take a pain relief before being transferred this also should be recorded in the resident’s care plan C1a\_health and wellbeing care plan under 4. MOVING ABOUT (MOBILISATION & TRANSFERS).

Use C10a - Pain Assessment for Residents who are not able to communicate pain or C10b - Pain Assessment for residents who are able to communicate pain as appropriate.

**Where the PRN medication is being taken regularly for more 7-days, the GP should be notified to review the resident and medication.**

**\*For more information see Pain Management policy, Administration of Medicines (policy), Guidance for Homely Remedies (policy).**

**Residents at end of life care**

It is very likely that residents at end of their life may experience pain for various reasons. Pain assessment and management will depend on individual condition and medication the resident is on. Pain should always be assessed particularly for the resident at end of life using either C10a\_Pain Assessment for residents who are not able to communicate pain (the Abbey assessment tool) or C10b\_Pain Assessment for residents who are able to communicate pain on a frequent basis before and after pain relief is administered and continued hourly. This information should be recorded on the evaluation section as it is useful in determining the dosage when prescribers are considering a syringe driver. Once a syringe driver is set up, a pain assessment tool should continue to monitor the effectiveness of medication.

Where there are concerns, the prescriber or GP should be contacted immediately in order for necessary reviews to be made. Staff should also consider alternative pain relief methods such as music, massage, engagement with the resident where possible and repositioning where appropriate.

All these interventions should also be recorded in the evaluation section of the pain assessment and daily notes. A referral should be done to the Palliative Care Specialist nurses at Trinity Hospice for support if the resident’s pain does not seem to be managed well at the earliest assessment.

**Pain assessment score should also be recorded in C10c\_GSF Observation chart for residents on code C and D.**

**\*For more information see Administration of Medicines (policy), Syringe driver policy**

**C10a - Pain Assessment for residents who are not able to communicate pain**

This assessment is to determine the level of pain of the resident who cannot communicate verbally and whether the pain management is effective.

* The pain scale is an instrument designed to assist in the assessment of pain in residents who are unable to articulate clearly their needs. This could be due to their learning disabilities and/or dementia.
* The scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential.

**How to complete it?**

Score questions while observing the resident where: Absent 0, Mild 1, Moderate 2, and Severe 3.Add scores for Q1 to Q6 and record total pain score. Complete ‘Evaluation on Pain Management’ to determine the effectiveness of pain-relieving intervention and give information of appropriate action to be taken/being taken in response to results of the assessment.

Complete the evaluation of pain management to determine

* It is recommended that the Abbey Pain Scale be used as a movement-based assessment. The staff recording the scale should therefore observe the resident while they are being moved, e.g. during pressure area care.
* A resident with a pain intensity of 2 or 3 will trigger pain relief intervention.

**Follow the procedure of pain management (under ‘MONITORING OF PAIN AND PAIN INTERVENTIONS’ in these guidelines) regarding reassessment and further action.**

Complete the pain scale hourly, until the resident appears comfortable (score 0-1), then four-hourly for 24 hours, treating pain if it recurs.

**C10b - Pain Assessment for residents who are able to communicate pain**

This assessment is to determine the level of pain and whether the pain management is effective for the residents who are able to communicate their needs verbally or non-verbally. Please note that this form can be used when assessing residents living with dementia who are able to express their needs verbally.

**Follow the procedure of pain management (under ‘MONITORING OF PAIN AND PAIN INTERVENTIONS’ in these guidelines) regarding reassessment and further action.**

**How to complete it?**

Talk to the resident to obtain information about cause of pain (if known) and the resident’s own description of the pain (examples: sharp pain, burning, aching, throbbing) and what makes it better or worst.

Establish intensity of pain using the pain scale where:

0 - no pain, 2- mild pain, 4- moderate pain, 6- severe pain, 8 – very severe and 10 - worst pain possible**.**

Use the body map in the form to mark pain at sites using letters A, B,C, D. Complete the table, including the date and time, pain at sites, type of analgesic given and information about alternative methods of pain relief when moving/turning if appropriate. Complete the evaluation of pain management to determine the effectiveness of the pain-relieving intervention.

**C10c - GSF Observation chart for residents on code C and D**

**Guidelines for using Observation chart**

**This form should be completed for bed bound/chair bound residents under code C and D and in conjunction with the GSF Minimum Protocol.**

**Please note:** This form can be completed by a qualified nurse or health care assistant – provided it is completed accurately.

* Complete ALL sections of the form;
* Make sure you know the resident’s Resuscitation status & the contents of their advance care plan;
* Ensure you know which relatives/friends you need to contact (especially those who want to be contacted at night);
* If there is not enough room in the sections entitled Pain score outcome & Mouth care outcome just add the score then ‘*see notes’* and write a detailed account in the residents care plan &/or notes – (seek clarity over this process);
* Number pages;
* Ensure your name & signature is readable;
* Use a **BLACK** pen;
* Ensure date and time are completed;
* Report any concerns to the resident in charge;
* If analgesia needed or given – document in notes as well as Mar sheet
* Complete this form **one to two hourly** **by day** (depending on the resident’s condition);
* Complete this form **one to two hourly at night** (depending on the resident’s condition);
* If the resident is under the care of Royal Trinity Hospice palliative care nurses; they are able to advise about symptom control throughout the night **IF it is an emergency.**

**C11a - Continence Assessment**

This form is to assess the resident’s continence and identify a level of support that resident needs. The assessment should be carried out after the resident’s admission as soon as possible. Should be reviewed when any changes.

**Information in this assessment should be referenced in C1a\_health and wellbeing/ 5. Elimination and using the toilet.**

**How to complete it?**

Read each of the statements and tick an appropriate answer. Give details and additional information if any.

**Useful terms:**

**\*Colostomy** - a surgical procedure in which an opening (stoma) is formed by drawing the healthy end of the large intestine or colon through an incision in the anterior abdominal wall and suturing it into place. a surgical operation in which the cut end of the colon is brought through the abdominal wall to create an opening called a stoma. Digestive waste is then collected in a bag which is fitted over this opening and attached to the skin. It may be temporary or permanent.

**\*Ileostomy** - a surgical operation in which the cut end of the ileum is brought through the abdominal wall to create an opening called a stoma. Digestive waste is then collected in a bag, which is fitted over this opening and attached to the skin. It may be temporary or permanent.

**\*Urostomy** - a surgical procedure that creates a stoma (artificial opening) for the urinary system. A urostomy is made to avail for urinary diversion in cases where drainage of urine through the bladder and urethra is not possible, e.g. after extensive surgery or in case of obstruction.

**\*Nephrostomy** - is a thin, plastic tube (catheter) that is inserted through the skin on back and into kidney. It can relieve a build-up of urine in the kidney, which can happen due to a blockage, and prevents the kidney from being damaged.

**\*For more information see Continence policy**

**C11b - Catheter Record Chart**

This form should be in place only for residents using a catheter. It should be completed immediately after catheterisation and updated as appropriate.

The form should be completed immediately after admission and reviewed yearly and when changes.

**\*For more information see Urinary catheterisation and catheter care policy**

**C12a - MUST Tool (Nutritional Risk incl. BMI)**

The nutritional status of all residents should be assessed within 24 hours of admission using the nutritional risk assessment tool (MUST tool).

Staff need to identify residents losing weight, despite interventions and refer to a dietician as appropriate (BMI score 2 or more).

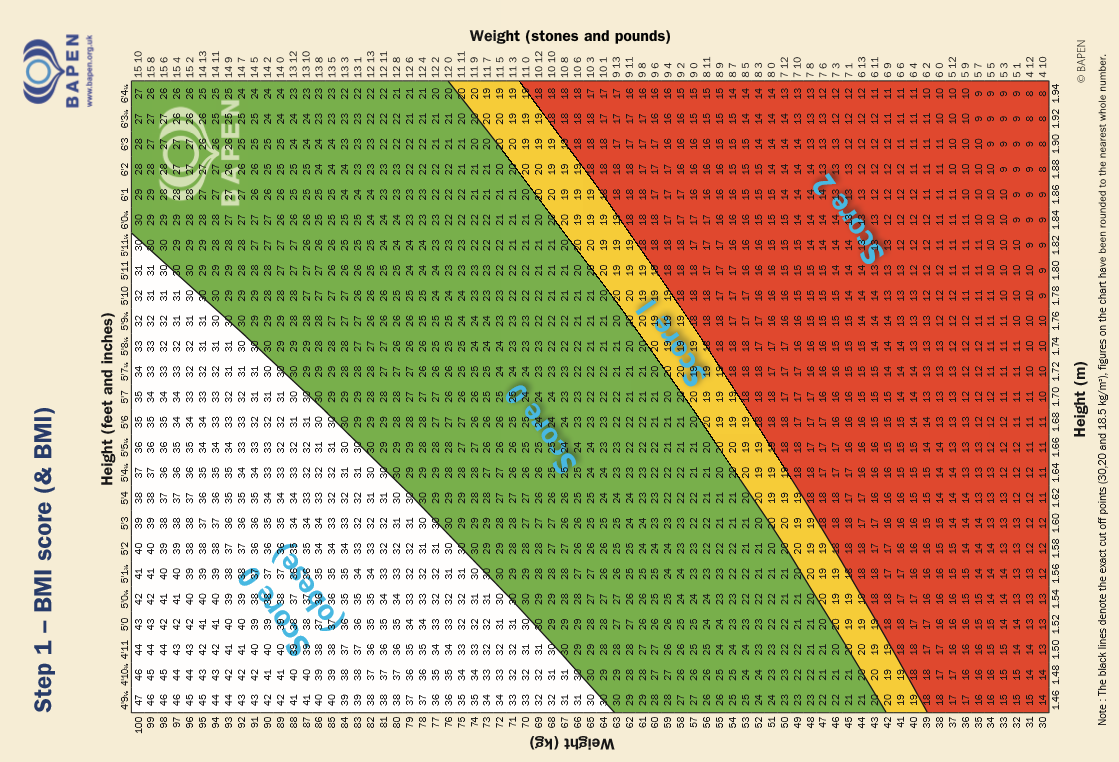
Nutritional assessment should be reviewed on a monthly basis or when a resident’s care needs change or there is a clinical concern.

‘MUST’ is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese.

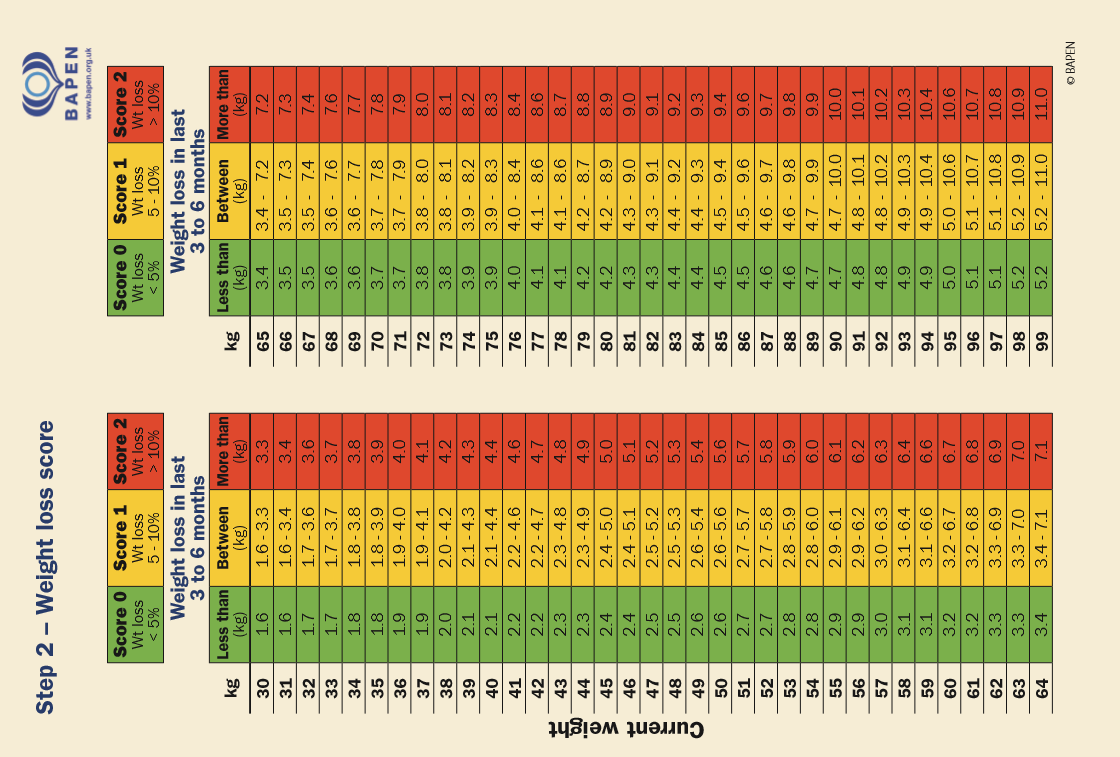
**How to use the tool?**

STEP 1: Measure the resident's height and weight to determine BMI score (using chart – ‘Step 1 – BMI score’) where BMI > (more than) 30 (Obese) indicates score 0, > (more than) 20 indicates score 0, 18.5 – 20 indicates score 1, < (less than) 18.5 indicates score 2.

(for BMI chart see next page)



STEP 2: Note percentage unplanned weight loss in past 3-6 months and determine score using tables below ‘Step 2 – weight loss score’.



STEP 3: Establish acute disease effect and score.

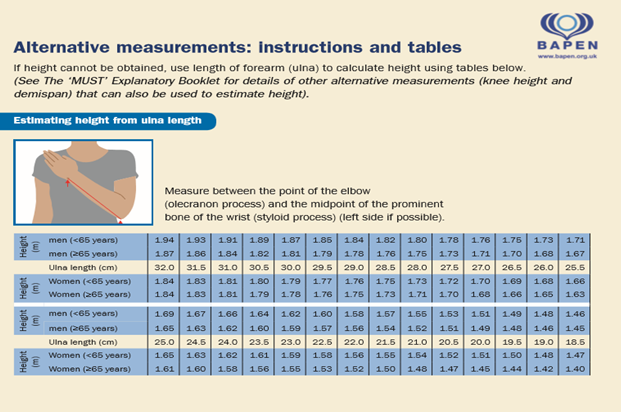
If the resident is acutely ill (e.g. diabetes, renal, liver diseases etc.) and there has been or likely to be no nutritional intake for > (more than) 5 days this indicates score 2.

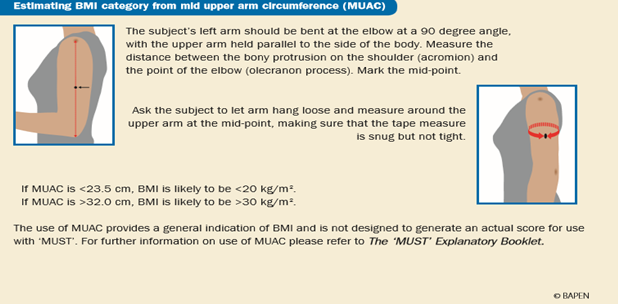
STEP 4: Add scores from STEPS 1, 2 and 3 together to obtain the overall risk of malnutrition where score 0 indicates **Low** **Risk**, 1 indicates **Medium Risk** and 2 or more indicates **High** **Risk.**

STEP 5: Prepare an appropriate Resident Care Plan.

|  |  |  |
| --- | --- | --- |
| **0 = LOW RISK** | **1= MEDIUM RISK** | **2 or more = HIGH RISK** |
|
| **Routine Clinical Care** | **Observe** | **Treat** |
| **Review monthly** | * Monitor dietary intake for at least 3 days. If no improvement, prepare Care Plan. * Review at least monthly. | * **Refer to dietician.** * Prepare and update Resident's care plan. * Review monthly or more frequently if required. |

\* If it is not possible to obtain height and weight, BMI can be estimated using the Mid Upper Arm Circumference (MUAC). If MUAC is less the 23.5 cm, BMI is likely to be less than 20 kg/m² (i.e. Resident is likely to be underweight). If MUAC is more than 32.0 cm, BMI is likely to be more than 30 kg/m² (i.e. Resident is likely to be obese).





If height, weight or BMI cannot be obtained, the following criteria which relate to them can assist your professional judgement of the resident’s nutritional risk category. Please note, these criteria should be used collectively not separately as alternatives to steps 1 and 2 of ‘MUST’ and are not designed to assign a score. Mid-upper arm circumference (MUAC) may be used to estimate BMI category in order to support your overall impression of the resident’s nutritional risk.

1. BMI Clinical impression – thin, acceptable weight, overweight. Obvious wasting (very thin) and obesity (very overweight) can also be noted.

2. Unplanned weight loss - Clothes and/or jewellery have become loose fitting (weight loss). History of decreased food intake, reduced appetite or swallowing problems over 3-6 months and underlying disease or psycho-social/physical disabilities are likely to cause weight loss.

3. Acute disease effect - Acutely ill and no nutritional intake or likelihood of no intake for more than 5 days.

**\*For more information see Nutrition and Hydration Policy**

**C12b - Food and Fluid Intake Chart**

This form is to be used if there are concerns regarding the resident’s eating and drinking and the intake of food and fluid needs to be closely monitored.

**How to complete it?**

Enter information on the top of the form “week commencing date”, “resident’s name” and the unit. Circle an appropriate answer next to each meal during the day where:

**Food Intake**: 1 = ate nothing, 2 = ate a little, 3 = ate most, 4 = ate all

**Drink:** W = Water, T = Tea, C = Coffee , H = Hot Chocolate, J = Juice , S = Supplement, TF = Fortified Tea, CF = Fortified Coffee , HF = Fortified Hot Chocolate (with fortified milk/ double cream)

\*After recording information sign with your initials.

**C12c - Fluid Intake and Output Chart**

This form is to be used only for residents whose fluid intake and output need to be closely monitored for example if the resident is at risk of dehydration.

Good level of hydration in older people can help prevent or aid the treatment of: pressure ulcers, low blood pressure, urinary infections, constipations, confusion etc.

**For more information about signs, symptoms, prevention and assessment of dehydration see information under**

**How to complete?**

Record information of time, fluid type and amount, comment (e.g.: declined, action taken) and output (urine, catheter, pad, vomit) and amount. See information on the bottom of the form (under the table) for further references:

\*Standard cup=180mls, Small glass=100mls, Beaker=200mls

\*Catheter bag=record urine in mls. Urine in pads to be estimated =Small+, Medium ++, Large +++

\*If urine passed in toilet and has not been measured =PU

**Input and output should be totalled every 24 hrs and an action plan devised how to support adequate rehydration.**

**Information about amount of the resident’s fluid intake should be also recorded in the resident’s daily care notes**.

**C12d - Blood Sugar Chart**

This form should be used only for residents whose blood sugar level needs to be monitored.

**\*For more information see Blood glucose monitoring guidelines (policy)**

**C13 - Temperature, Blood Pressure, Pulse and Respiration Chart**

This form is to record information of temperature, blood pressure, pulse, respiration and O2 saturation when needed. Date, time and signature field needs to be filled in every time vital signs recorded.

**\*For more information see Observations respirations policy, Observations pulse policy,** **Observations blood pressure policy, Observations - body temperature policy.**

**C14a - Occupational Therapy Assessment**

This assessment should be carried out by one of the staff in the Occupational Therapy team and reviewed when needed. If any changes (a referral must be sent to the Occupational Therapy Department), the resident must be reassessed and a new assessment form must to be provided. If no changes the assessment should be reviewed annually.

**C14b - Physiotherapy Assessment**

This assessment should be carried out by one of the staff in the Physiotherapy team and reviewed when needed. If any changes (a referral must be sent to the Physiotherapy Department), the resident must be reassessed and a new assessment form must be provided. If no changes the assessment should be reviewed annually.

**C15a - Purchase of Goods and Services**

**Mental Capacity Act 2005**

**This form relates to purchase of goods and services for residents who do not have capacity.**

It is determined that the resident lacks capacity to make a decision for goods and/or services that are deemed necessary this form is to be completed in all such cases. If consent is given for a carer to sign for the purchase of goods/financial transactions on the resident’s behalf please delete Y/N or N/A where applicable. There are items such as dentist, optician, wheelchair maintenance, escort charges etc. will be as required.

**Procedure for completing the purchase of goods and service form:**

All residents will have an assessment of their mental capacity to determine whether they are able to look after their own finances.

Residents Services and Finance will have a list of residents with the outcome of MCA assessment, in respect of managing finances and purchase of goods.

The Assessment of Mental Capacity form (MCA01) must be completed, signed and dated.

The Purchase of Goods & Services form (MCA02) must be completed within one week of admission for residents who **do not** have capacity.

Formulate a care plan to reflect this procedure, stating the agreed £20 cash limit to spend per month. Details of the resident carrying out the assessment, the date of review, and next of kin agreement/consent should be completed.

Care plan reviews should be carried out monthly after the initial agreement and at multidisciplinary meetings, or where there is a change in the condition of the resident.

Completed forms to be distributed to relevant departments and original copy filed in the individual resident’s care plan.

**C15b - Abbreviated Mental Test Score**

This assessment should be carried out when needed or requested eg. before MDT meeting and the result should be included in MDT report.

**How to complete the form?**

Score every correct answer as “1” and incorrect as “0”. Add up all scores to obtain a final result.

A score of six or less suggests dementia. If a score of six or less and there is no diagnosis, discuss further intervention with GP and consider the MDT meeting. Also take into account any other factors which can temporarily affect resident’s cognitive abilities for example UTI, depression etc.

Name, signature of staff and date of assessment need to be in place.

**C16a - Depression Assessment**

The assessment should be carried out when any concerns occur for the resident having depression.

**If the result indicates that the resident may be depressed further intervention needs to be discussed with GP as soon as possible. The care plan should be created using C1b – Additional Care Plan with a plan of support and intervention needed. Use C1\_Care Plan Evaluation at the back to record any changes and progress.**

**Common symptoms and signs of depression:**

* Low mood and pervading feeling of sadness;
* A loss of interest in life and inability to take pleasure in things;
* Tiredness and sleep problems ie difficulty falling asleep or staying asleep, oversleeping, daytime sleepiness;
* Loss of appetite, weight loss;
* Poor concentration and memory;
* Anxiety, agitation and tearfulness;
* Feelings of worthlessness, guilt ie worries about being a burden;
* Loss of motivation, energy or interest in previous hobbies or activities;
* Hopelessness;
* Physical aches and pains;
* Social isolation and withdrawal ie reluctance to be with friends, have visitors, eat with others;

**Risk factors:**

* Recent (less than 3 months) major physical illness or hospital admission;
* Social isolation and loneliness;
* Recent or multiple bereavement;
* Pain and physical illness;
* Multiple adverse events or a change in circumstances;
* Family history of past episodes of depression;
* Persistent sleep problems;
* Dementia.

**How to complete it?**

Talk to the resident and ask how often they have experienced any of the listed problems over the last 2 weeks. Use tick [✔] to indicate answer.

**For initial diagnosis:**

If there are at least 4 ✔s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

**Consider Major Depressive Disorder** - if there are at least 5 ✔s in the shaded section (one of which corresponds to Question #1 or #2)

**Consider Other Depressive Disorder** - if there are 2-4 ✔s in the shaded section (one of which corresponds to Question #1 or #2)

**To monitor severity over time for newly diagnosed residents or residents in current treatment for depression**:

1. Residents may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.

2. Add up ✔s by column. For every ✔ : Several days = 1, More than half the days = 2, Nearly every day = 3. Add together column scores to get a TOTAL score.

4. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.

5. Results may be included in resident’s files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

**Scoring:** add up all checked boxes

For every ✔ Not at all = 0; Several days = 1;

More than half the days = 2; Nearly every day = 3

**Interpretation of Total Score:**

|  |  |
| --- | --- |
| **Total score** | **Depression Severity** |
| **1-4** | **Minimal depression** |
| **5-9** | **Mild Depression** |
| **10-14** | **Moderate depression** |
| **15-19** | **Moderately severe depression** |
| **20-27** | **Severe depression** |

**C16b - Cornell Scale for Depression in Dementia**

The Cornell Scale for Depression in Dementia (CSDD) was specifically developed to assess signs and symptoms of depression in patients living with dementia.

The assessment should be carried out when any concerns occur for the resident having depression.

**If the result indicates that the resident may be depressed further intervention needs to be discussed with GP as soon as possible. The care plan should be created using C1b – Additional Care Plan with a plan of support and intervention needed. Use C1\_Care Plan Evaluation at the back to record any changes and progress.**

**See more information about symptoms of depression and risk factors under C16a - Depression Assessment in these guidelines.**

**How to complete it?**

1. Ideally the same staff should conduct the interview each time to ensure consistency in response.

2. The assessment should be based on the resident's normal weekly routine.

3. If uncertain of answers, questioning other staff may further define the answer.

4. Answer all questions by placing a tick [✔] in the column under the appropriately numbered answer where a = unable to evaluate, 0 = absent, 1 = mild to intermittent, 2 – severe.

5. Add the total score for all numbers ticked for each question.

6. Place the total score in the "Score" box and record any subjective observation notes in the "Notes/Current Medications" section.

7. Scores of twelve (12) points or more indicate probable depression.

Ratings should be based on symptoms and signs occurring during the week before interview. No score should be given if symptoms result from physical disability or illness.

**C17 - Oral Care Assessment**

The purpose of this assessment is to identify any changes in the resident’s mouth which may cause pain or discomfort. If there are any concerns staff should initiate interventions and evaluate progress.

Oral care is important for residents’ health and well-being for a variety of reasons. Not only is the mouth vital for eating, drinking, taste, breathing, verbal and non-verbal communication, saliva also has antibacterial properties and is part of the body’s defence against infection.

Oral problems can lead to reduced dietary intake and increase the possibility of malnutrition and lead to infections.

Initial assessment should be conducted:

* For all residents at end of life on code C and D (also as part of C10c - GSF Observation chart for residents on code C and D which should be in place);
* For residents who are not eating/drinking well;
* If any signs of pain/discomfort in mouth noticed;

**Oral care at End of Life**

When residents are nearing end of life, staff need to assess and provide oral care frequently in order to keep the mouth, lips moist and comfortable for the resident. This can be done using mouth swabs, water and applying prescribed solutions/gels to the lips. A record of mouth care should be used to evidence practice and this could be included in the hourly turn charts, daily notes or fluid balance charts. In view of safety, privacy and dignity, staff need to consider whether a resident can still wear dentures safely as sometimes residents lose weight therefore dentures presenting with the risk of choking especially if the resident is not alert.

**Reassessment should be conducted when there are any changes in condition and hourly for residents at end of life**.

**How to complete it?**

Read each of the statements and choose appropriate answer and score respectively.

The intervention should be based on the rating for each category:

|  |  |  |
| --- | --- | --- |
| **Rating** | **Description** | **Nursing Interventions** |
| 1 | Normal findings | Continue with routine oral care  No treatment |
| 2 | Mild abnormality | Continue with routine oral care;  Close monitoring;  Create an acute care plan with an action plan;  Inform ANP/GP |
| 3 | Severe abnormality | Perform oral care with caution;  Close monitoring;  Create an acute care plan with an action plan;  Inform ANP/GP  Perform treatment as ordered |

**\*For more information see Oral care guidelines (policy)**

**C18 – Dehydration Assessment**

The purpose of this assessment is to identify if the resident is dehydrated and at risk of dehydration.

**The assessment should be carried out on admission when any concerns about the resident being dehydrated or at risk of dehydration.**

**The form should be reviewed when there are changes in resident’s condition and/or symptoms are resolved. It should be part of monthly care plan review.**

Staff need to use the fluid chart (C12c\_Fluid intake and output chart) where dehydration is a concern. This should be totalled every 24 hrs and an action plan devised how to support adequate rehydration.

Good level of hydration in older people can help prevent or aid the treatment of: pressure ulcers, low blood pressure, urinary infections, constipations, confusion etc.

Dehydration occurs when a resident's body loses too much water. When a resident stops drinking water or not drinking enough or loses large amounts of fluids because of diarrhoea, vomiting, or sweating, the body reabsorbs fluid from the blood and other body tissues.

By the time a resident becomes severely dehydrated, there is no longer enough fluid in the body to get blood to the vital organs and the resident may begin to go into shock, which is life-threatening.

The sense of thirst often diminishes with age. Residents with dementia might not be able to recognise or communicate their need for drinking. As a result, all residents should be actively encouraged to drink at least 1600 ml of water a day.

Fresh water should be readily available and always put in easy reach of residents, especially those in bed.

In periods of hot weather, staff should be particularly vigilant and when necessary, a fluid chart should be completed for bed-bound residents to enable their intake to be monitored more closely.

**Dehydration is very dangerous for older adults. Watch closely for its early signs especially when there is an illness that causes a high fever, vomiting, or diarrhoea.**

**Early signs of dehydration include:**

* Increased thirst;
* Dry mouth, lips and sticky saliva;
* Reduced urine output with dark yellow urine;
* Tiredness;
* Headache;

**Symptoms of moderate dehydration include:**

* Extreme thirst;
* Dry appearance inside the mouth and the eyes don't tear;
* Decreased urination, or half the number of urinations in 24 hours (usually 3 or fewer urinations). Urine is dark amber or brown;
* Light-headedness that is relieved by lying down;
* Low Blood Pressure
* Increased heart rate

**If the resident shows symptoms of moderate to severe dehydration and/or resident is unable to take required amount of fluid (e.g. due to swallowing difficulties) the ANP/GP should be informed and acute care plan should be in place.**

**Severe dehydration is life-threatening. Symptoms that require emergency care (even if only one of them is present) include:**

* Altered behaviour, such as severe anxiety, confusion, or not being able to stay awake;
* Faintness that is not relieved by lying down, or light-headedness that continues after standing for 2 minutes;
* Weak, rapid pulse;
* Cold, clammy skin or hot, dry skin;
* Little or no urination;
* Loss of consciousness.

An increase or decrease in a resident’s fluid needs is based on a number of factors. Use clinical judgment to adjust fluid estimates as needed.

**The following factors can increase fluid requirements:**

Fever

Nasogastric tube for suctioning

Fistula wound drains

Diarrhoea

Vomiting

Hyperventilation

Respirator

Excessive perspiration

Pressure ulcer (stages II, III, IV)

Circulating air bed for wound-healing treatment

**The following factors can decrease fluid requirements:**

Congestive heart failure

Cardiac disease

Renal disease

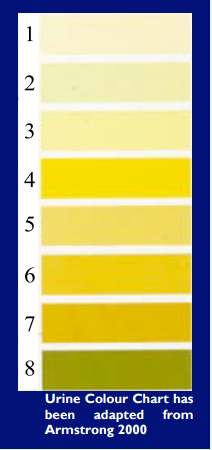
Delusional hyponatremia

Oedema or ascites

**How to complete it?**

To complete GULP (Gauge, Urine, Look, Plan – C18\_Dehydration assessment) tick the boxes which represent your findings. Add up the total tick scores and follow the risk care plan accordingly. The assessment should be conducted when the resident doesn’t reach an appropriate amount of fluid requirement and/or any signs of possible dehydration present (e.g. dark urine, state of confusion and irritability, dry mouth, lips, coated tongue, headache etc.) Dark urine may also indicate a urinary tract infection (UTI).

**For more information about UTI see ‘Near patient urinalysis protocol’ on NGH share drive under ‘Pharmacy’.**

**For residents on a fluid restriction seek medical advice before making or suggesting any changes to fluid intake.**

**Interpretation:**

The urine colour should be compared to the chart to the right. The lower the number, the better the result. A urine colour rating of 1, 2 or 3 is considered to be well-hydrated (Armstrong, 2000).

If the water in the body is balanced, the urine will be a pale straw or lemonade colour. When water loss from the body exceeds water intake, the kidneys need to conserve water, making the urine much more concentrated with waste products and subsequently darker in colour.

Dark yellow urine is a sure indicator that the individual is dehydrated and that the fluid consumption must be increased.

The aim is to produce urine no darker than colour 3 of the Urine Colour Chart. Desire to urinate less than twice per day and/ or producing urine darker than colour 3 in the chart indicate severe dehydration; the individual must start drinking immediately.

**Based on these results, changes in fluid should be made.**

**Precautions:**

Certain medicines and vitamins may cause the colour of the urine to change. If any of these have been taken, this test is unreliable. The colours you see on this chart should only be used as a guide.

**\*Fluid overload -** It is a condition which often affects people with heart or kidney disease.

Staff have to consult with the GP and create a care plan with an action plan of how much fluid needs to be supported in 24hrs for residents who are at risk of fluid overload. Fluid charts should be used to monitor intake. Symptoms including the following:

• Swelling of ankles, feet, fingers, hands;

• Weight gain;

• Decreased urine output;

• Shortness of breath;

• Increased heart rate;

• Skin that appears tight, smooth and shiny

**\*The level of risk of dehydration needs to correlate with the level of risk indicated in A6\_Risk Profile.**

**\*For more information see Nutrition and Hydration Policy**

**D - Professional visits record**

**D1 - Record of Doctor/Nurse Practitioner Visits**

This form is to be used for recording information from GP’s and Advance Nurse Practitioner’s visits including a date, time and the outcome. Additionally, this information should be also written in the daily care notes.

**D2 - Record of All Other Professional Visits**

This form is to be used for recording information from all professional visits (eg. dietician, podiatrist, dentist, optician etc.) including a date, time and the outcome. Additionally, this information should be also written in the daily care notes.

**D3 - MDT Meeting Minutes**

The MDT report should be prepared 2 weeks prior to MDT meeting. All fields should be filled in with the relevant information/feedback.

**When to fill in particular sections of the report:**

* **Section A** – **Introductions** - should be completed fully prior to MDT meeting;
* **Section B – Feedback:**

1. Feedback from Resident (questions, concerns, compliments): the resident should be invited by their keyworker to attend MDT meeting. If the resident declines attending MDT upon invite, keyworker to hold interview with the resident and/or gather evidence as to the resident’s own communication and expression about their well-being. Information from the interview included questions, concerns, compliments should be recorded as a feedback.
2. Feedback from relatives should be recorded during the meeting unless relative is unable to join the meeting and has given their feedback prior to MDT meeting.
3. Feedback from care/nursing staff should be detailed and accurate and should be completed fully prior to the meeting (description of resident’s needs and required support, dates of the professional visits, vital signs and weight for the last 6 months, Abbreviated Mental Test score, information about Potential Risks - how identified, interventions and triggers, action plan, medical history etc.).
4. Feedback from Activity Coordinator should be recorded during the meeting unless activity coordinator is unable to join the meeting and has given their feedback prior to MDT meeting;
5. Feedback from Pharmacist (if any): should be recorded during the meeting or prior, depends whether the presence of pharmacist is required.
6. Feedback from Occupational Therapy, Physiotherapy and Manual Handling Teams should be recorded during the meeting or prior, depends if representatives will be present and their feedback is required;
7. Feedback from the GP should be recorded during the meeting.
8. Feedback from Dementia Care Mapping (in any) should be recorded prior the meeting.

* **Section C - Additional Care Records:**

1. Next of Kin name & contact details – should be filled in prior to the meeting;
2. Power of attorney (finance / health & welfare / other) if any - should be filled in prior to the meeting;
3. Resident’s resuscitation wishes, Resident’s hospital admission wishes and Resident’s end-of-life care wishes must be re-confirmed and recorded each MDT meeting;
4. Date of discussion and names of all participants of the meeting need to be provided.

* **Section D – Actions -** needs to be recorded during the meeting and followed up after the meeting. Staff to review actions and agreements as determined in meeting.

**Important:**

**The printed MDT minutes form, photocopy of MARs and any other relevant supporting docs have to be provided by staff to MDT meeting. Form to be gone through in order and remaining blank boxes filled in by hand in meeting.**

**The minutes needs to be typed up by staff, share with all participants and added to care plan.**

For more information about the process of preparation of MDT meeting see Multi-Disciplinary Team (MDT) Meeting Protocol (see next page).

**Step 1** **(2 months prior to MDT):** Unit Manager (or delegated staff) arranges MDT date and time with Carol James and resident’s Social Worker/Wandsworth Social Services

**Step 2** **(2 months prior to MDT):** Relative(s) invited to attend MDT

**Step 3 (1 month prior to MDT):** Unit Manager (or delegated staff) ensures one of resident’s keyworkers is on rota to attend MDT. Keyworker, activity coordinator, therapists and all relevant parties then informed of MDT date & time

*Relative confirms attendance*

*Relative cannot attend at that time*

**Step 4 (2 weeks prior to MDT):** Care team prepare MDT minutes document, save copy of template in resident’s file and fill in information marked with asterisk

**Step 5 (1 week prior to MDT):** Keyworker invites resident to their MDT

**Step 6 (1 week prior to MDT):** Keyworker to hold interview with resident and/or gather evidence as to resident’s own communication and expression about their well-being.

**Step 7: MDT meeting:** Staff member to bring printed MDT minutes form, photocopy of MARs and any other relevant supporting docs to MDT. Form to be gone through in order and remaining blank boxes filled in by hand in meeting

*Resident declines and/or it is not appropriate that s/he attends*

*Resident accepts*

**Step 8 (1 week after MDT):** Designated staff member to type up minutes, share with all participants and add to care plan

**Step 9 (ongoing):** Staff to review actions and agreements as determined in meeting

*done*

*done*

*done*

*done*

*done*

*done*

**E - Ongoing monitoring**

**E1 - Daily Records (incl. therapy and doctor notes if appropriate)**

It is important to see daily care notes as a story of the resident’s experience and care needs (since the last entry).

Typically a resident experiences engagement with activity, food and drink, using the toilet, washing and skincare, each shift. Staff also need to record the resident’s well-being and mood during these experiences, and what, if any, support was needed. It is important that the daily records evidence that we are providing person-centred care. It is not enough to say that the resident is happy or sad. We need to give an explanation and evidence supporting the statement.

Any experiences that staff did not witness first hand must be documented accordingly, for example. “It was handed over by… that…”or “I was informed by…that…” or “It was documented in the activity log by ...…that … engaged in …with… and felt…..”

There is guidance provided at the top of the daily notes form E1 in the care plan. Basic principles are:

• Tell a story of the resident’s experience of the shift;

• Use facts and evidence not assumptions or speculations (remember it is a legal document);

• Record events as soon as possible. Notes should be detailed and accurate.

If anything critical occurs - for example a fall, a GP visit, a change in meds - this must be written in the daily care notes immediately. Create a timeline of when exactly something happened eg. if the resident had a fall give specific information what time the resident had a fall, what time ambulance was called and arrived, what time the resident was taken to hospital, what time NOK was informed etc.

• Avoid vague, generic terms and instead use details;

These are examples of very out-dated, clinical language which shouldn’t be used because they are meaningless and don’t give any specific information about the resident’s experience: “received…”(always address the resident by their name), “monitored”, “no concerns”, “needs met as per care plan” personal hygiene care done” (always explain whether resident had a bath, shower, body wash, was supported with washing, what the resident was able to do independently).

• Remember – if you didn’t document it you haven’t done it. Value what you do and record it.

**E2 - Dementia Care Mapping**

This form should be completed by the mapper based on the outcome of the DCM feedback session. The action plan should be followed up by staff within 7 days from the feedback session.

**E3 – Distress Reaction Chart**

This record is a tool to help carers to understand the possible triggers and intentions of any distress and or distressing behaviour. Although we are using the word "behaviour" in this chart it is used to simplify the recording process. All actions and inactions by any human being have meaning and must be viewed as such.

People living with dementia are often associated with “challenging behaviour,” but if we look closely we can see this behaviour is often simply a natural response to way people are interacting.

**All behaviours are meaningful and so-called "challenging behaviour" needs to be recognised as an attempt made by the resident to communicate, usually related to feelings, needs and wishes (often physical or emotional discomfort).**

People living with dementia will react in the same way that anyone else might, if they perceive a threat which may trigger activation of a powerful threat-response system “fight or flight”, often left unharmed with dementia.

The Fight or Flight response is a physiological response triggered when we feel a strong emotion like fear. Fear is the normal emotion to feel in response to a danger or threat.

The Fight or Flight response evolved to enable us to react with appropriate actions: to run away, to fight, or sometimes freeze to be a less visible target.

**The difference for people living with dementia is that far more things may seem threatening,** without the ability to effectively judge situations, manage feelings and emotions, make decisions and plan and prioritise responses due to brain damage in certain areas.

**See below examples of threat signals and possible response to it:**

|  |  |
| --- | --- |
| **Threat present** | |
| **activate “fight or flight” system** | |
| **Threat signals** | **Threat Response** |
| **Unfamiliarity**  **Chaos/business**  **Unfriendly or unconcerned people (eg negative body language, facial expressions, tone of voice)** | **‘Fight’- aggression, anger, agitation**  **‘Flight’- anxiety, escape**  **‘Freeze’- withdrawal, apathy**  **‘Flock’ – following**  **Signs of ill-being** |

**How to complete it?**

**Give as much information and detail as possible about the incident and the resident’s reaction and complete following section:**

* Date and time - needs to be as accurate as possible;
* Describe what resident was doing just before the incident happened, how did the resident appear at the time of the incident. You can use some of the examples listed below:

|  |  |  |
| --- | --- | --- |
| **Anxious** | **Frustrated** | **Agitated** |
| **Angry** | **Happy** | **Frightened** |
| **Bored** | **Irritable** | **Worried** |
| **Content** | **Physically unwell** |  |
| **Depressed** | **Restless** |  |
| **Despairing** | **Sad** |  |

* Triggering Factor /possible reasons for behaviour - Understanding potential causes or triggers of behaviours are the key.

Record what was happening, to the best of your knowledge, around the resident that may have a bearing on their distress/action. It is not enough to record "not known". It may be helpful in evaluation to look back on how the resident slept the night before, whether the resident was in pain, what analgesics have /have not been given/ was the resident alone/in a crowded/noisy room/ having a bath etc. As, at this stage, we do not know what the trigger may be, it is important to give as much detail as possible.

* Distress Reaction / Behaviour (describe) - Although we are using the word "behaviour" in this chart it is used to simplify this section. It is not enough in this section to record "agitated” or "aggressive". It is important to record what the resident is actually doing/not doing, saying that indicates that they are in distress. Record how long this has gone on, where it took place etc.
* Intervention by staff - Describe what the care team did to intervene in the distress - what exactly has been done, what support has been offered and action taken.

All interventions should be measured against outcomes and therefore here we would expect to see each intervention linked to an outcome. Interventions that do not resolve the distress should be evaluated and then a further intervention attempted.

* Outcome - These should link to the interventions and should measure effectiveness and should describe in detail what happened as a result of the intervention. Give as much information and detail as possible including resident’s reaction and feelings.
* Name and signature - always write your name and signature.

**Only include E3 in care plan if appropriate. Use this form in conjunction with a distress reaction care plan (create distress reaction care plan using C1b\_additional care plan). Change to distress reaction care plan? Every episode of distress reaction should be also recorded in daily care notes.**

**In distress reaction care plan** describe the possible triggers, resident’s reactions and interventions that help the resident to settle so that the whole team can learn and reflect on how to help this resident live well.

Include action plan to eliminate the triggers and support that should be offered to the resident to reduce/minimise the level of distress and prevent any future incidents from happening.

For example if the distress reaction was due to pain, further assessments may be required and resident’s analgesics should be reviewed and evaluated for effectiveness.

**Ensure the GP reviews the resident for further behavioural management. Further referrals may be required to Physio/OT or specialist team.**

**Use C1\_Care Plan Evaluation at the back to record any changes/evaluate. Care plan needs to be reviewed on a monthly basis and when there are changes in resident’s needs. When writing on the evaluation form avoid writing “no changes” but instead describe briefly the current situation.**

\*For more information about how to understand and interpret behaviour please see “Understanding Behaviour as expression of needs” on NGH share drive under care plan current/resources.

**E4 - Bowel Movement Monitoring Chart**

Indicate a date and time every time the resident opens bowel. Indicate a type of stool using Bristol stool chart attached on a second page of the chart. If bowel not open write “BNO”.

Do not include if resident is independent in using the toilet.

**E5 - Hourly Monitoring Chart**

This chart should be only used for residents on close observation. The information should include where and what resident is doing.

**E6 - Night Time Hourly Observations Chart**

This chart needs to be completed for all residents monitored hourly from 8pm to 7:30am. Exception – residents who wish not to be disturbed/monitored hourly. However this should be reflected in the care plan of the resident.

Use appropriate acronym (under the table) to indicate where and what mainly resident has been doing:

**SB: Sleeping in bed;**

**A: Awake;**

**W: Walking;**

**L: Lounge;**

**O: Out;**

**H: Hospital;**

**SC: Sleeping in chair;**

**WT: Watching TV;**

**T: Toilet.**

**Please complete as per example:**

|  |
| --- |
| **W**  **AC** |

**Information from observation**

**Staff’s Initials**

**E7 – TURNING CHART**

Turning chart is an important part of prevention and treatment of pressure ulcer. It should be used for residents at risk of developing pressure ulcer and/or those with existing pressure ulceration.

**How to complete it?**

Specify frequency of repositioning by writing information on how often the resident needs to be turned or repositioned.

Write in the appropriate position column “right”, “left” or “back” at the time when the position was changed. Complete the” comment” column with additional information if any and sign.

**G - Hospital Passport**

Hospital Passport form should be completed fully except “Reason for transfer to hospital” (on page 4). A current photo of the resident must be attached. Photo should be dated and should be renewed annually and if there are significant changes in the resident’s appearance. The form should be photocopied when the resident is being transferred to hospital and then the reason for transfer should be recorded accordingly. Hospital passport should be reviewed monthly and updated immediately when there are any changes in resident’s condition.

If you have any suggestions that could improve these guidelines and result in more comprehensive completion of the care plan please contact Anna Ciejek (PCC facilitator) [aciejek@nightingalehammerson.org](mailto:aciejek@nightingalehammerson.org)

**Guidelines compiled by Anna Ciejek (PCC Facilitator)**

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Nightingale Hammerson policies available on Nightingale shared drive under ‘Policies 2013-2016’