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Admission, Assessment and Support Planning Policy

HP005 Homes Policies

January 2025

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1. Introduction
   1. This policy and associated procedures have been developed to provide an assessment and support planning framework, promoting person-centred approaches aligned to best practice guidance. Person-centred support begins with the identity of the individual. It focuses on their personal history and strengths, their hopes, and ambitions. It means you respect their past, support their present, and help them plan for living later life well.
   2. Over many years, person centred approaches have become embedded in social care policy. They include respect and ordinary courtesy; compassion and kindness; responsive care and treatment; openness and honesty when something goes wrong. These principles underpin MHA’s values to support people to live later life well ensuring the kind of care and support which we would all want for our families and ourselves.
2. Scope and Purpose
   1. The scope of this policy and associated procedures apply to all MHA colleagues responsible for initial assessment, support planning, reviewing and delivering support to individuals within MHA’s residential and nursing homes.
   2. This policy and associated procedures consider the requirements and guiding principles of legislative requirements across all nations:
   * Health and Social care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: safe care and treatment
   * The Regulation and Inspection of Social Care (Wales) Act 2016, Regulation 21: Standards of care and support, overarching requirements
   1. The information within this document also draws upon several sources and the best available evidence including:
   * National Institute of Health Care and Excellence (NICE)
   * NHS (England and Wales)
   * Care Quality Commission (CQC)
   * Care Inspectorate (Wales)
   * Social Care Institute for Excellence (SCIE).

Further information can be located via the links in the Resources section of this policy document.

1. Definitions

| Term | Definition |
| --- | --- |
| **Assessment** | A holistic assessment focuses on how needs for care and support impact on wellbeing including being treated with respect, physical, mental and emotional wellbeing and being protected from abuse and neglect including any risks.  An assessment will gather information to determine the level of support required and inform the support planning process |
| **Complex Clinical Decision-Making Panel** | Elected panel co-ordinated by the Senior Nurse Advisor when Dependency Assessment of Need scores very high (50+) and where additional clinical skills are required prior to admission or in situations where an individual has newly identified changing needs i.e., following hospital admission and proposed return to the home |
| **Dependency Assessment of Needs (DAN)**  [**Link to DAN app**](https://apps.powerapps.com/play/e/a6441d53-6065-eac1-833a-14f60ccce7a6/a/2a39a66e-471b-439d-a4fe-8723be5e7acc?tenantId=9bfa8a9a-ab2a-44ea-b902-441d8e4eb02e&hint=0efcda21-7028-4d81-a1bd-17e028a0beec&sourcetime=1707994122523) | Method of gathering information to assess individual needs based on levels of dependency (low/medium/high/very high), providing an indicative score which will inform staffing levels and provide an assessment of support needs for the home to review prior to admission  There are 2 methods of calculating dependency using the tools provided:   1. Paper version to be used during the preadmission assessment 2. Online application system (DAN) – which replicates the paper version. This must be completed when an individual’s information has been uploaded to Caresys   Once uploaded the Dependency Assessment of Need (DAN) application must be reviewed 4 weekly, with any changes or when an individual returns from hospital  Link to [DAN work instructions](https://intranet.mha.org.uk/page/15520)  Can also be located on the Learning Zone |
| **Person Centred Approaches** | Personalised care and support planning is a series of facilitated conversations in which the person, or those who know them well, actively participates to explore the support requirements of their health and well-being within the context of their whole life  The process recognises the person’s skills and strengths, as well as their experiences and the things that matter the most to them. It addresses the things that are not working in the person’s life and identifies outcomes and actions to resolve these |
| **Support plan** | A personalised support plan is developed following an initial holistic assessment about the person’s health and well-being needs.  Once relevant assessments have been completed with the person, their family or representatives an agreed personalised care and support plan is developed  A well written support plan should include a description of the person, what matters to them and all the necessary elements that would make the plan achievable and effective |

1. Preadmission and Dependency Assessment of Needs
   1. On moving in each person’s emotions will be different, there may be a sense of loss, anxiety, or reluctance. Alternatively, a person may feel relieved, comforted and less isolated. Colleagues should discuss how the person is feeling and respond with compassion and understanding during the assessment process.
   2. Colleagues must contact the GP or other relevant health care professional if it becomes apparent that the person needs specialist assessment or treatment.
   3. For individual who want to move to an MHA care home a trial visit or period of respite can be arranged following an initial preadmission and dependency assessment, ideally within 2 weeks of the date of admission with the only exception being an unplanned or emergency admission.
   4. It is important to gather key facts relating to an individual’s legal status e.g., mental capacity, Lasting Power of Attorney (LPA), Court of Protection and any funding arrangements.
   5. Using MHA’s preadmission assessment, which includes the dependency assessment of needs tool, colleagues must complete the information based on the outcome of the preadmission assessment to identify support required.
   6. The colleague completing the assessments must –
   * Ask the person.
   * Ask family members / representatives (if present).
   * Ask other health care professionals (if present).
   * Read and take notes from existing care records (if available).
   * Have the confidence to delay acceptance in order to contact someone else involved in the person’s care, double check some information, discuss the referral with a senior colleague.
   * Maintain contact with the hospital or individual’s representatives to review any changes from the initial preadmission assessment
   * Consider everything, complete a holistic assessment – for example, can the service support the individual’s needs, is additional training required or does the service have capacity to support if the individual presents with complex needs?
   1. The responsible manager must make sure all information has been provided prior to admission, including residential care agreements, letters of acceptance, terms and conditions, the homes welcome pack and key facts document.
   2. Once the individual’s information has been uploaded to the Caresys system the information from the dependency assessment tool must be transferred to MHA’s Dependency Assessment Need (DAN) application for review and update as required i.e., if there are any changing needs since the initial preadmission assessment.
   3. Where the dependency assessment of need identifies a very high level of need [50+] or requires a complex clinical nursing intervention this must be discussed with the Area Manager and referred to the Senior Nurse Advisor to ascertain if the home can effectively and safely meet the individual’s needs, refer to Appendix 2 for Complex Clinical Decision Process.
   4. The Senior Nurse Advisor will review the information and co-ordinate a complex clinical decision-making panel to review clinical training needs identified during the preadmission and dependency assessment.
   5. If additional clinical nursing skills are required and been agreed, the home manager must complete a Clinical and Additional Training Request Form, approved by the area manager and submitted to the people development team, to arrange training prior to the individual moving to the home.
2. Unplanned or Emergency Admissions
   1. Unplanned / emergency admissions are not ideal, but they do sometimes happen. In this situation a senior colleague must complete an urgent pre-admission assessment. However, if this is not possible, the home manager must be informed of the following:
   * Why the person has to be admitted
   * The person’s essential care needs and that the home can meet them, any additional training required
   * What medication / dressings / specialist care (e.g. PEG) the person needs
   * What the person can and cannot do
   * The person’s DNACPR status
   * Whether or not the person has capacity and, if not, if the person has an appointed Lasting Power of Attorney (property & finance / health & wellbeing)
   * Who else is involved in supporting the person – family and professionals.
   * How the person’s care will be paid for. If self-funding, the manager must politely request payment in advance
   1. Within 48 hours of admission the following must be completed:
   * Preadmission assessment, dependency of needs assessment, relevant risk assessments, support plans and associated documentation in accordance with MHA’s care and support planning procedures (Appendix 1)
3. Risk Assessments
   1. Each person's care and support needs and preferences should be assessed by people with the required levels of skills and knowledge for the particular task.
   2. Assessments of people's care and treatment needs should include all their needs, including health, personal care, emotional, social, cultural, religious, and spiritual needs.
   3. Each person using a service, and/or the person who is lawfully acting on their behalf, must be involved in an assessment of their needs and preferences as much or as little as they wish to be.
   4. Commence completion of assessments the day the person moves in by meeting with the person and/or their representative(s) and using the information from the pre-admission assessment.
   5. Focus on the person as an individual and record their needs and personal choice. identify where there is a risk and agree with the person or, depending on the person’s capacity, their representative(s) how the risk can be managed or reduced.
   6. Using the assessments in Nourish complete all records, on the day the person moves in (day1) the responsible care colleague must complete:
   * Communication Assessment
   * Circle of Care
   * Abilities and Critical Information
   * Waterlow Assessment
   * MUST (Malnutrition Universal Screening Tool)
   * Choking Risk Assessment
   * Moving and Assisting Risk Assessment
   * Multifactorial Falls Risk Assessment and Management Tool (if known history)
   * Continence assessment (if known history)
   * Some assessments may prompt colleagues to include other ‘optional’ assessments such as depression scales, pain scales etc
   * Personal Emergency Evacuation Plan (PEEP)
   * Upload any paper documents and reports, including LPA
   1. Where there is no recorded known history, assessments must be completed within **7 days** of the person moving in, to make sure that all areas of care and support are assessed [Appendix 1]. For example, continence or falls.
   2. Where an individual lacks capacity, colleagues must –
   * Involve them as much as reasonably possible in the assessment process
   * Speak to and involve their representative(s) but remember that the only person with any legal right is the person’s lasting power of attorney (lpa) for health and wellbeing
   1. Complete relevant assessments and risk assessments to reflect any risks associated with support needs.
   2. For example, supporting assessments, i.e., diabetes or constipation, must be completed if a need has been identified and reviewed with the respective support plan.
4. Support Planning
   1. Refer to Nourish Support Plan Prompts for guidance on completion of support plans located on MHA’s intranet - [Support Plan Prompts](https://intranet.mha.org.uk/page/14547?SearchId=1394608)
   2. Based on the assessments colleagues have completed with an individual prior to and on moving in, the responsible care colleague will develop support plans

with the person (refer to Appendix 1) and continue to update until the plan reflects the individual’s support needs including risk assessment sections as required.

* 1. The support plan must contain all the information needed for colleagues to provide care and support to the person and meet their needs whilst following best and safe practice.
  2. Where a person lacks the mental capacity to make specific decisions about their care and support, and no lawful representative has been appointed, their best interests must be established and acted on in accordance with the Mental Capacity Act 2005. Other forms of authority such as advance decisions must also be taken into account. Refer to MHA’s Mental Capacity and Deprivation of Liberty and Consent Policy.
  3. Mandatory Support Plans must be completed on day 1 of moving in to ensure essential support is planned and communicated with all relevant team members:
  + Capacity and Communication
  + Tissue Viability
  + Diet and Fluids
  + Personal Care
  + Mobility and dexterity
  1. By Day 7 the remaining support plans should be developed with initial information, completed with the person, taking into account any previous history, results from assessments and identified needs.
  2. The responsible care colleague must set aside time to be with person not only to complete the support planning process but also to get to know the person and answer any queries they may have. Support plans must remain live and active to reflect an individual’s preferences and any changing needs.
  3. When a person has a care plan provided by their funding authority, care staff must upload the document to Nourish and reference any pertinent sections in the person’s support plan(s).
  4. Colleagues must complete all sections of the support plan, as required, and identified during the assessment process. If a person does not wish to discuss or disclose any information, colleagues must record this and any dates of revisiting the topic.
  5. In the case of short-term needs - for example, a chest or urine infection, colleagues must complete a short-term or miscellaneous support plan. Once the care issue has resolved, this must then be archived. If the problem lasts for more than two months, or if the person has repeated episodes, colleagues must complete a full support plan to include long term approaches.
  6. Care assistants, student nurses etc. can update records in the Nourish system when provided with a system log in following training or if the system has been explained in detail prior to use. The system will automatically record the person making the record including date and time of entry.

Periods of Respite

* + 1. Create the resident in Nourish, just as you would for a permanent resident, but in the residents Profile, under Status in Organisation – Resident Type you need to choose Respite / Temporary. The support plans can then be completed, as required.

* + 1. When the individual leaves, complete the Care package ended / transfer interaction. A re-admission interaction will trigger so that if the same resident returns for respite care again, you can search for them in ‘Archived’ residents and complete this interaction. Their whole profile (including support plans) will be re-activated, re-assessing needs where prompted or required.
    2. If a resident who is respite becomes permanent, change the Resident Type to Permanent. This will not affect the Support Plan template.

Respite Assessments and Support Plans

* + 1. Mandatory assessments and support plans must be completed on day 1, refer to procedure flowchart (appendix 1).
    2. Remaining assessments and support plans to be completed by day 7 taking into account previous history, results from assessments and identified needs.

1. Transfer and Discharge Procedures
   1. A person may go into hospital for planned surgery or be taken in as an emergency due to illness or injury. The only difference in procedure is the time factor.
   2. In an emergency situation colleagues must work as a team to effectively co-ordinate an emergency transfer after dealing with the medical emergency:
   3. Complete the Hospital Admission Interaction including any infections, as applicable, this will automatically change the individual’s status to ‘suspended’ until the Re-admission from hospital interaction has been completed when the person returns
   4. Collect all medication and MAR for transfer (take and keep a copy of the MAR).
   5. send a copy of the DNACPR (DNR), signed by the paramedic as verification of observing the original
   6. Arrange for any clothing and toiletries for the person to take to hospital; refer to a red or green bag system where applicable
   7. Arrange an escort or for relatives to meet the person at the hospital
   8. Maintain regular contact with the hospital
   9. Contact the person’s GP
   10. Update Caresys/DAN application, recording the individual’s profile as ‘Inactive’

Returning to the Home

* + 1. If the person is due to return from hospital, ascertain any changes in support and dependency needs prior to returning, which should be recorded on the Re-admission from Hospital interaction, which will automatically reinstate interactions on the timeline.
    2. The manager is responsible for reviewing any changes to clarify that the home can safely and effectively support the individual taking into consideration any additional equipment or training required. If additional clinical training is required, follow Complex Clinical Decision-Making Process (appendix 2).
    3. Update the Dependency Assessment of Need (DAN) application to change the profile status to ‘Active’, updating any changing needs.
    4. Colleagues must complete the following immediately on return from hospital:

1. Complete Hospital Discharge Interaction recording all details
2. Skin integrity check – take a photograph of any damage found, upload and follow procedures in MHA’s Tissue Viability Policy
3. Medication – cross check the previous MAR with returning medication and discharge letters, carefully check for changes. If there is any uncertainty, confirm with the hospital, pharmacy, or GP
4. Upload any reports and documents
5. Review all related risk assessments within 24 hours
6. Update Nourish, Caresys and Dependency of Needs Assessment application (DAN) recording any changes to level of need
7. Review critical information and any additional information which may have been updated

Transferring to another MHA Care Home

* + 1. A manager (or superuser) would need to contact support providing:  
       - The full name of the individual to be transferred  
       - The home that the individual is being transferred from  
       - The home that the individual is being transferred to
    2. The manager will also need to be present in case there are any complications with the transferring process (Which is just interactions not being transferred until these interactions have been assigned to the destination home.

1. Assessment and Support Planning Review Process
   1. Colleagues must review all relevant assessments, risk assessments and support plans at least everymonth, additional review is required if there is a change in the person’s condition or on return from a stay in hospital.
   2. Complete the Responsible Person section on the digital support plan to include the colleague(s) responsible for reviewing the support plan. Review dates can be updated in the next review date section on the bottom of the support plan page. Previous reviews, and details, are automatically listed once completed with the name of the colleague completing the review.
   3. New admissions must receive a formal review within 4 weeks to assess progress and compliance with the support planning guidance.
   4. Colleagues must complete all monthly reviews within a calendar month. It may help colleagues to allocate people’s support plan reviews to week one, two, three or four of the months, and stagger their review process but the latest date must be the same as the previous months – i.e.,3July means that the latest review must be 3August. The review dates must be entered on the Review Note section of the support plan, which will automatically add to the timeline.
   5. The monthly review must involve the person if possible and be a summary of the previous month’s events in relation to a particular support plan.
   6. Colleagues must re-write a person’s support plans every year or if more than three amendments have been made or on return from a stay in hospital if needs have changed.
   7. MHA’s dependency assessment of need (DAN) application must be reviewed and updated every 30 days. The application will alert senior managers for review where any changes have been updated and this change affects resources or any additional skill or training requirements.
   8. The dependency assessment of need (DAN) application MUST be updated following an individuals return from hospital or leave.
2. Support Plan Auditing Procedures
   1. Every month a **10% sample per household** must be audited by the manager, deputy manager or person in charge including all new admissions within the previous 4 weeks.
   2. In addition, the Abilities and Critical Information sections must also be reviewed monthly to ensure all information remains accurate and is reflective of the person’s need.
   3. The manager must carry out the audits for each area in rotation (for example daisy household in January, rose household in February, lilac household in March). The minimum requirement for managers to audit care plans (files) is four times a year.
   4. The manager must make sure that colleagues audit care plans thoroughly and receive care plan training in order to do this.
   5. For households of less than 20 people, the minimum requirement is twocare files. If issues are found, a further 10% (minimum of two) must be audited. Findings must be reported to the manager.
   6. The manager must make sure that all support plans (files) are audited at least once every year using the verified support plan audit tool.
   7. The responsible care colleague must comply with the action plan to remedy any issues found and, when the actions are completed, re submit the support plan to the manager to sign off.

Area Managers must see evidence of the support plan audits and actions being taken where scores are below 100%.

1. Archiving Support Plans

Nourish System

* + 1. The Nourish system automatically secures all data in accordance with ISO security standards.
    2. All records can be archived as required, according to permissions within the system, by senior colleagues.
    3. When a resident dies or permanently leaves the home, you need to complete either the Death / Deceased or Care package ended / transfer interaction. This automatically archives the resident and makes the full support plan read-only.

Paper Documents

* + 1. All paper records must be archived in accordance with MHA’s Archiving Policy

Colleagues must:

* 1. Make sure that the that all outdated documents are filed away (archived).
  2. Store outdated care documents in a locked filing cabinet in onecommon location (care office / admin office / manager’s office or lockable archive room). If a person moves out or is deceased, colleagues must keep all their records on site for three months. After this time, if the service uses an official archiving store, the records may be sent off site.
  3. Make sure everything leaving the site is named, labelled, dated, sealed, and receipted for retrieval (see archiving policy)
  4. Complete a risk assessment on archive rooms for fire, damp, and pests

1. Roles and Responsibilities

| Role | Responsibilities |
| --- | --- |
| **Regional Directors** | * Approve an increase or decrease in service staffing levels following discussion with Area Manager * Update the DAN application with any justification for approval or rejection |
| **Area Managers** | * Check new admissions are entered on Nourish, caresys and Dependency Assessment of Need (DAN) application * Approval of any additional clinical and additional training request forms, following review, if dependency score is very high (50+) and requires additional clinical nursing skills prior to admission or readmission – complete complex clinical decision-making assessment. * Advise the Senior Nurse Advisor for referral to a complex clinical decisions making panel for assessment in relation to skills required and ability to safely deliver support in respect of clinical nursing needs. * Review and approve any changes in an individual’s level of need (DAN application) advise home managers accordingly * Review the DAN application dashboard * Check that Home staffing levels are being reviewed every 30 days (DAN). * Refer any requests for an increase or decrease in staffing levels to the relevant Regional Director * Review support plans in accordance with Area Manager Quarterly Audit review 3 support plans - 1 recent admission, include wound, behaviour support and any other identified high-risk areas * Review evidence of the homes support plan audits and actions being taken where scores are below 100%. * Address any performance issues, offering advice, guidance and support as required * Maintain and monitor MHA’s continuous improvement plan (CIP) * Implement additional compliance audit if any concerns or issues are identified with recording on the Nourish system |
| **Senior Nurse Advisor** | * Responsible for coordinating complex clinical decision-making panels following referrals from area managers. |
| **Home Managers** | * Provide leadership support and guidance to colleagues and care teams in completing, reviewing, and auditing assessments and support plans. * Respond to any compliance issues reported during support plan audits * Refer any issues or concerns to the relevant line manager or seek advice regarding team performance issues * Completion of support plan audits as directed within this policy document * Comprehensive completion of additional clinical training request form, as applicable, Area Manager must approve prior to submission to people development * Where an assessment indicates a score of 50+ inform area manager to initiate the complex clinical decision making process. * Refer any concerns regarding admissions to the relevant line manager * Review residents dependency application (DAN) 4 weekly or as required in accordance with guidance * Review home staffing levels (DAN) every 30 days from the last review completed. * Review Nourish system using compliance monitoring documents. |
| **Service Administration Manager** | * Complete Residential Care Agreement (RCA), share with individual or representative, as applicable * Check systems for new admissions ensuring all information has been uploaded to Caresys * Manage users in the DAN application, removing and adding colleagues as required |
| **MHA Colleagues**  **(Care Homes)** | * Comply with all related policy documents relating to assessment and support planning * Review dependency application (DAN) 4 weekly or as required in accordance with guidance * Provide updates on an individual’s presentation or changes to their health and wellbeing to all colleagues * Complete support plan review and audits relevant to role and responsibilities |

1. Training and Monitoring
   1. The manager must make sure all colleagues have training in relation to the completion, review and auditing of assessments and support plans with additional input tailored to their workplace setting and job roles.
   2. Where it has been identified that an individual scores very high (50+) on the dependency assessment of need tool and requires additional clinical skills i.e., PEG, catheterisation (all types), syringe driver the home manager must complete a skills analysis of the current team to identify any additional training required to meet the individual’s need before admission/readmission.
   3. The Area Manager will review dependency scores of 50+ as to whether the outcome of the assessment should be referred to the Senior Nurse Advisor for referral to a complex clinical decisions making panel for assessment in relation to skills required and ability to safely deliver support in respect of clinical nursing needs.
   4. If additional training is required people development must be contacted to discuss, agree and arrange for appropriate training. This will require a minimum 2-week lead in time, prior to admission/readmission, to make sure the home can safely deliver the support required to meet clinical needs.
   5. The manager remains responsible for the development, completion, review and auditing of all assessments and support planning.
   6. Compliance is assessed through MHA’s internal Quality Assurance and Auditing process.
   7. Services are subject to external monitoring through local contract compliance and regulatory bodies i.e., Care Quality Commission (CQC) which will be reviewed and actioned where any concerns or issues have been identified
   8. Regulatory compliance is reviewed by MHA’s Quality Review and Governance Group.
2. Communication and Dissemination
   1. This policy is disseminated and implemented within all MHA services through MHA’s channels of communication.
   2. Each colleague’s line manager must ensure that all teams are aware of their roles and responsibilities.
   3. This policy will be available to the people we support and their representatives in alternate formats, as required.
   4. Any review of this policy will include consultation with our colleagues, review of support planning, incident reports, quality audits and feedback from other agencies.
   5. Queries and issues relating to this policy should be referred to the Standards and Policy Team [policies@mha.org.uk](mailto:policies@mha.org.uk)
3. Equality Impact Assessment (EIA)
   1. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.
4. Resources
   1. MHA policy documents and guidance located on the intranet

[Nourish - Frequently Asked Questions](https://intranet.mha.org.uk/page/14545?SearchId=1394568)

* Archiving Policy
* Consent Policy
* Continence, Bladder and Bowels Policy
* Enhanced Observation Policy and associated documents
* Falls Management, Prevention and Treatment Policy
* Mental Capacity and Deprivation of Liberty Safeguards
* Moving and Handling Policy
* Nutrition and Hydration Policy
* Nourish Support Plan Compliance Audit
* Safe Swallowing (Dysphagia) Policy
* Tissue Viability Policy
  1. External Resources
  + [Person Centred Care (Wales)](https://nwssp.nhs.wales/a-wp/governance-e-manual/putting-the-citizen-%09%09%09first/health-and-care-standards-with-supporting-guidance/person-centred-%09%09%09care/)
  + [Care Quality Commission (CQC) Regulation 9: Person Centred Care](https://www.cqc.org.uk/guidance-providers/regulations/regulation-9-person-%09%09centred-care)

1. Dependency of Need Assessment Procedure (DAN)

| Task | Instructions |
| --- | --- |
| **Perspective Resident**  **(Preadmission)** | * Dependency assessment (paper version) to be completed with pre-admission assessment. * If dependency score = Very High (50+), refer to Area Manager for discussion, referral to the Senior Nurse Advisor to coordinate a complex needs decision-making panel to review capacity, skills and any training requirements, if able to meet residents need agree admission date |
| **Caresys** | * Update Caresys - date of admission, indicative level of need and any other relevant information as required |
| **Resident goes live on DAN** | * Transfer information from dependency assessment (paper version) if more than two weeks when last completed a new assessment should be completed * Once assessment has been completed the Home Manager will receive an email to review the assessment on the system |
| **Caresys** | * Record revised level of need on Caresys, if applicable * Complete RCA and inform resident/relative, LPA or LA of fees |
| **Assessments Completed (DAN)** | * Direct care hours will be pulled through to the Care Home Dependency page * Home Manager will complete the dependency-based care shifts and allocate care staff to cover the day and night shifts and press calculator. * If agree with the DAN recommended staffing levels then click the drop down recommended staffing levels box to yes. * Ensure support plans and risk assessment reflects residents’ level of Need. |
| **Review** | * Assessment to be reviewed every 4 weeks or when change in need occurs   If any changes in the residents need the following to be completed:   * When there is a change in need, the home manager will receive an email making them aware of the residents change in need and should review the assessment, if they agree with the assessment they should: * Record any change of level of need on Caresys. * Discuss changes with resident, Family, LPA or paying LA. * Complete RCA and inform resident/relative, LPA or LA of fees * Ensure support plan and risk assessment reflects residents’ level of Need, discuss changes in support plan with resident, family, or LPA. |
| **Requesting an increase (level of need)** | * Go into the assessment press edit and request an increase in level of need. * Change the level of need to that you feel the resident should be (i.e. Low to Medium) * Record your justification in comments box for the increase and add approver (this would be the Area Manager) * Confirm selection and save * This will send a pending approval email to the Area Manager with a link to the assessment |
| **Approving level of need (Area Manager)** | * Area Manager is alerted via email they have a pending approval request (can also review on the DAN App of any pending approvals assigned to them) * Area Manager will review the assessment and along with the home managers justification and make their decision whether to approve or reject this by clicking on the respond button. * Approval decision should be recorded by clicking on the approval decision box along with recording their decision in the approval comments box, then press send. |
| **Level of need approved** | * Home manager will receive an email with the Area Managers decision to approve or reject. * If approved the following actions should be completed: * Record level of need on Caresys * Complete RCA and inform resident/relative, LPA or LA of fees. * Ensure support plan and risk assessment reflects residents’ level of Need. |
| **Requesting an increase/decrease in staffing levels** | * The Home Manager should review the recommended staffing levels every 30 days, or sooner if there has been a significant change in relation to occupancy levels in the home   If home manager after reviewing the DAN recommended staffing levels does not agree, the following should be completed:   * Home manager will go into care home on DAN and use the recommended staffing levels box and record they do not agree * Home Manager will then select the role/roles they wish to change and complete the appropriate boxes recording the number they wish to change and record their comments in the justification box. * Then click on the Approver box and record Area Manager email then save changes * Even if staffing levels are approved, the home manager will still need to review the recommended staffing levels every 30 days, if they disagree with these staffing levels, they should make a request for what they see the appropriate staffing levels should be |
| **Approving/Rejecting staffing level request** | * Area Manager will receive an email through DAN App following Home Managers request, or by going into the DAN app and going into the Area Managers Dependency Report page which will show they have pending approvals to review. * Area Manager will review the staffing request and following a discussion with the Regional Director will either approve or reject the request by using the drop-down buttons and record their comments in the approver comments box then press save. * The home manager will receive an email with the Area Managers decision through the DAN app |
| **Managing Users** | * Service Administrators are responsible for removing colleagues who have left MHA and adding new ones who will be responsible for completing the assessments |

1. Appendix 1 - Procedure Flowchart



1. Appendix 2 – Complex Clinical Decision-Making Process
2. Version Control

| Version | Version Date | Revision Description / Summary of Changes | Author | Next Review Date |
| --- | --- | --- | --- | --- |
| 1 | February 2024 | Policy documents HP005/a/b/c reviewed due to identified concerns regarding timeframes for completing assessments and support plans  Additional procedures included for completing dependency tool and application  Admissions and Assessment policy amalgamated into this policy document  Preadmission assessment amalgamated with paper dependency tool  HP003/4 withdrawn  Procedures aligned to Digital Support Planning System  Introduction of complex clinical decision-making panel | Head of Standards and Policy  Regional Directors  Head of Quality Improvement  Associate Director of Operations  Senior Nurse Advisor | March 2025 |
| 2 | June 2024 | Roles and Responsibilities updated – home manager and area manager  Check that Home staffing levels are being reviewed every 30 days (DAN). | Project team  Head of Standards & Policy | March 2025 |
| 3 | October 2024 | * Section 6.6 – included Communication Assessment * Appendix 1 procedure flowchart – updated to include Communication Assessment and respite requirements * Section 7.13 additional section for guidance on respite assessment and support planning | Head of Standards & Policy  Head of Quality Improvement | March 2025 |
| 4 | January 2025 | * Full Compliance review * Nourish version withdrawn, includes references to Nourish system and processes within this policy * Included instruction on including all assessments in support plan review – section 10 | Head of Standards & Policy  Head of Quality Improvement | January 2027 |