TITLE: **Management of Admission, Assessment and Care Initiation**

SCOPE: Oaklands Nursing Home

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1.0 Policy

Admission of residents to Oaklands Nursing Home is timely and is planned in a safe, fair manner in accordance to the resident's assessed needs and Oaklands Nursing Home's waiting list as appropriate.

To assess residents personal and social needs preadmission assessment is completed by Person in Charge before or on the resident's admission to Oaklands Nursing Home (Health Act 2007). Upon admission, all residents are orientated to Oaklands Nursing Home.
The Care Plan based on the comprehensive assessment is prepared no later than 48 hours after Resident was admitted to Oaklands Nursing Home (Health Act 2007).

2.0 Definitions

Assessment: A process by which the resident's needs are evaluated and determined so that they can be addressed (HIQA 2016).

Comprehensive Assessment: An interdisciplinary process that includes medical health, physical, social and psychological functioning and religious/spiritual issues.

Colonisation: When micro-organism or micro-organisms are living on or in a person without causing disease (HIQA, 2018).

Emergency Admission: An admission to a Oaklands Nursing Home that is unplanned, unprepared or not consented to in advance (HIQA, 2016).

Medication Reconciliation: Is the process of creating and maintaining the most accurate list possible of all medications a person is taking- including drug name, dosage, frequency and route – in order to identify any discrepancies and to ensure any changes are documented and communicated, thus resulting in a complete list of medications. Medication reconciliation aims to provide residents with the correct medications at all points of transfer within, and between, health and social care services while also striving to avoid incidents, omissions, duplications, incorrect dosing or drug interactions particularly in relation to transitions in care. There are three steps in the process-

- Collecting: of the medication history and other relevant information.
- Checking: ensuring that the medicines, doses, frequency and routes that are prescribed for a resident are correct.
- Communication: the final step where any changes to the prescription are documented.
  (HIQA, 2014).

3.0 Responsibilities

3.1 All Staff: Welcome resident to Oaklands Nursing Home. Engage with, and support, new residents during their transition to Oaklands Nursing Home (Age Cymru, 2011). Encourage residents and key staff members to offer friendship and understanding to the new resident and their family (Age Cymru, 2011).

3.2 Nursing Staff: Conduct admission, initial assessment and make relevant referrals.

3.3 Director of Nursing: Evaluate adherence to the process. Allocate a staff member to support each new resident during transition into Oaklands Nursing Home.

4.0 Principles of Assessment

4.1 Assessment of residents in Oaklands Nursing Home shall:

- Be resident–focused, it is based on resident's actual, potential and perceived needs.
- Provide baseline information on which to plan the interventions and outcomes of care to be achieved.

- Facilitates evaluation of the care given and is a dimension of care that influences a resident's condition and circumstances.
- Be a dynamic process that starts when problems or symptoms develop and continues with changes in the resident's condition throughout the care process, accommodating continual changes in the resident's condition and circumstances.
- Be an interactive process in which the resident actively participates.
- Consider optimal functioning, quality of life and the promotion of independence for the resident.
- Include observation, data collection, clinical judgement and validation.
- Include data collection from several sources by a variety of methods.
- Follow a structured process and be clearly documented.
  (Dougherty and Lister, 2015)

4.2 Health and Social Care Professionals shall be involved in the assessment process as deemed required by the Director of Nursing / Line Manager and the resident needs.

4.3 Where the residents' condition changes or deteriorates at any stage during the delivery of care, the assessment process shall be reviewed, and reassessment completed as deemed required.

4.4 Residents with dementia/cognitive impairment have a unique set of care needs, which include, a progressive cognitive impairment, diminishing capacity, communication difficulties, possible responsive behaviours and a prolonged illness trajectory leading to uncertainty in relation to prognosis (Irish Hospice Foundation, 2016). These needs shall be appropriately assessed and managed accordingly by Oaklands Nursing Home's staff and supporting Health and Social Care Professionals.

4.5 Assessment Techniques

4.5.1 Evidence based assessment tools shall be utilised for all assessments where available to:

- Ensure a standardized approach is used to obtain specific resident data that can evaluate the effectiveness of clinical interventions and care.
- Encourage residents to engage in their care.
- To provide simple methods that are acceptable to the residents, have a clear and interpretable scoring system to demonstrate reliability and validity.
  (Dougherty and Lister 2015) (JCI, 2012)

4.5.2 Assessment interviews shall be utilised to:

- Make the resident feel comfortable telling their story.
- To allow the assessor to emphasize the confidential nature of the discussion and take steps to reduce any anxiety of the resident, including ensuring privacy as residents may modify their words and behaviour depending on the environment.
- Assist in the flow of information using
  - Open questions
  - Restating what has been said to clarify certain issues
  - Using verbal and non-verbal ques
  - Verbalising the implied meaning
  - Using silence
  - Summarising

  (Dougherty and Lister 2015)

4.5.3 Where residents are unable to provide information, appropriate details shall be taken from the resident's family, where possible (Dougherty and Lister 2015).

4.5.4 Assessment findings may also arise from self-reporting of issues by the resident, issues reported by the resident's family, direct observation and medical records review.

4.6 Ordering of required tests and investigations arising from the assessment process, and the reporting of critical information arising from these tests, shall be directed.

4.7 On completion of the initial nursing and medical assessments, the resident data shall be integrated, analysed and an associated plan of care shall then be developed and implemented. This process shall be completed with the required multidisciplinary involvement of those involved in the provision of the resident's care.

4.8 Oaklands Nursing Home shall consider the need to share information about the resident's admission decisions with medical practitioners, health and social care professionals and family/others and whether this could potentially constitute a data breach (NHI, 2018).

Access to resident personal information shall be restricted to individuals depending on their roles and responsibilities in relation to the resident.

4.9 Oaklands Nursing Home shall use a standardised process for the collection, filing, storage, sharing, retention and destruction of the resident's information.

4.10 Admission Techniques/Responsibilities

Administrator:

- Create Residents waiting list in the Vi-Care system
- During admission process update:
  - Residents general details
  - Medical Card number, PPS number
  - Relationship details
  - Remove Resident from waiting list
  - Scan all administrative documents to the V-care system.
  - Update Resident Laundry status

PIC:

- Preadmission assessment should be completed before or on the resident's admission to Oaklands Nursing Home and added to the V- care system.
- Supervise admission process

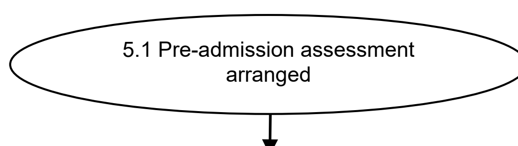
RN team:

- Continue admission process as per Admission checklist and update V- care system correctly.
- Inform Administrator about resident's laundry status.
- Update residents' details section in the – V-care
- Update medical, allergy section in the V-care
- Scan to V- care system all clinical documents

CNM:

- Supervise RN team admission process.

5.0 Management of Preadmission Assessments



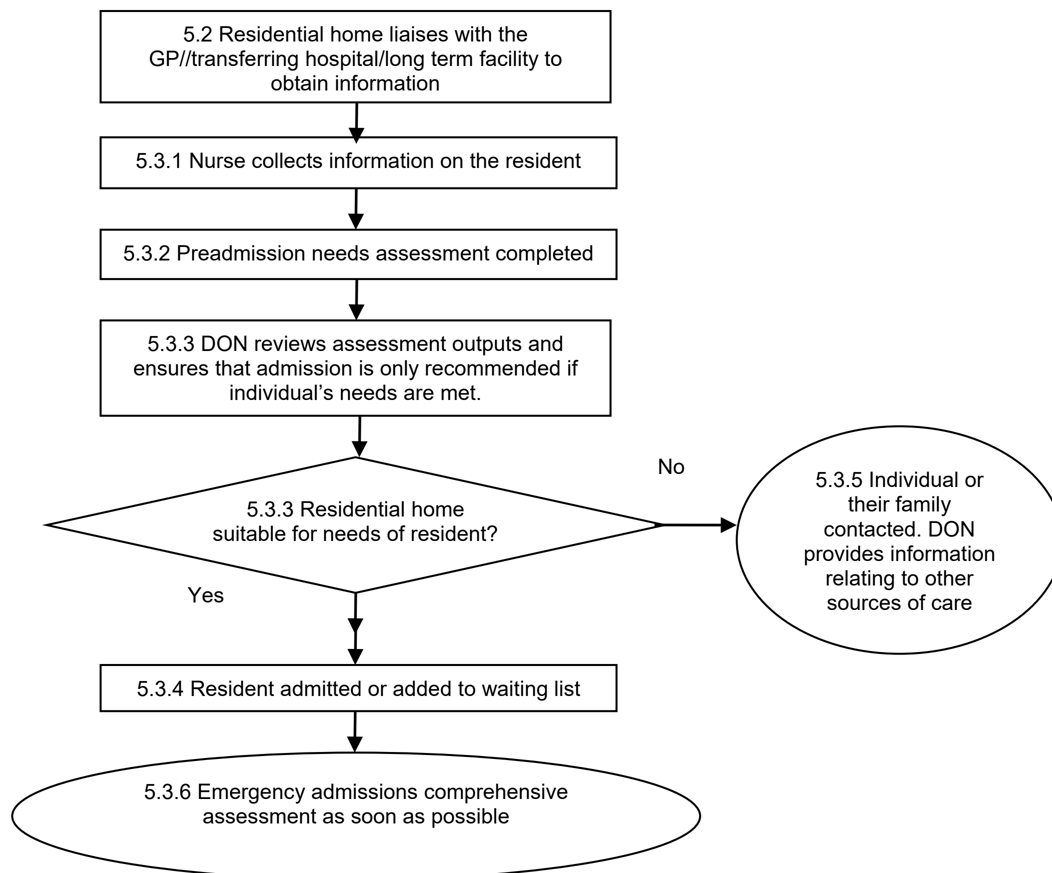


Figure 1.0 – Management of Preadmission Assessments

5.1 Prior to admission, Oaklands Nursing Home shall arrange a comprehensive preadmission assessment, by the Person in Charge/ Director of Nursing , to ensure its continued suitability to the needs of the prospective resident (HIQA 2016) and to obtain all necessary information relating to the resident's health, personal and social care needs (S.I. No. 415 of 2013). The Director of Nursing/Person in Charge shall identify an appropriate time and date to collate this information with the prospective resident, family and hospital, where applicable. If preadmission assessment is not completed before admission, comprehensive assessment should be completed immediately on the resident's admission to Oaklands Nursing Home.

The nursing staff shall establish an effective working relationship with prospective resident's family members. The resident's family members shall be encouraged and empowered to work with nursing staff to ensure each resident's needs are appropriately identified, understood and met prior to the transition into Oaklands Nursing Home (HIQA, 2013).

5.2 Where the resident is being admitted from another healthcare facility, the Director of Nursing shall take all reasonable steps to ensure that all relevant information about the resident is obtained from the other healthcare facility (S.I. No 415 of 2013).

With the prospective resident's consent, Oaklands Nursing Home shall liaise with the GP/transferring hospital/long term facility and obtain information about the prospective residents:

- Medical history.
- Social circumstances
- OT assessment if required

- list of medication
- Current treatment.
- Ongoing support being provided by medical and other professionals.
- Tests completed such as evaluation of swallow.
- Mental health assessments (NHI, 2008).
- Completed risk assessments for nutrition, moving and handling, pressure ulcer formation, continence, falls to ensure all services and equipment are in place prior to admission.
- (NHI, 2010)
- The resident's Common Summary Assessment (CSAR's) where the resident is admitted under the Nursing Home Support Scheme (HIQA, 2015b).
- Oaklands Nursing Home shall share necessary information about a resident's colonisation or infection status on admission within and between services, while respecting the privacy and confidentiality of the resident to whom the information relates (HIQA, 2018).

This information sourcing may occur via transfer letter, phone call or other correspondence. Where it is not possible to gather all information prior to the prospective residents' arrival, the information shall accompany the resident when they are transferred/admitted and shall be retained within the resident record.

This information shall immediately be transferred into the resident record and communicated to the relevant staff and Health and Social Care Professionals for utilisation to ensure continuation of care, including as part of the development of the resident's Individual Care Plans.

5.3 Preadmission Assessment:

5.3.1 To assess residents personal and social needs preadmission assessment is completed by Person in Charge before or on the resident's admission to Oaklands Nursing Home (Health Act 2007). The preadmission assessment may collect some or all of the following information:

- The name, address, date of birth, sex and marital status of the individual
- The name, address and telephone number of the resident's next of kin or of any person authorized to act on their behalf.
- The name, address and telephone number of the resident's General Practitioner (GP) and of any officer of the Health Service Executive whose duty it is to supervise the welfare of the resident.
  (S.I. No. 415 of 2013)

5.3.2 Preadmission Needs Assessment

The preadmission needs assessment shall include the following:

- Decision-making capacity
- Communication ability
- Recreation / Social Interaction
- Ability to maintain a safe environment
- Gait, strength, balance or mobility problems
- Risk/history of falls
- Fracture risk
- Controlling temperature
- Personal Cleaning and Dressing ability
- Breathing and Circulation
  - Blood pressure level
  - Pulse
  - Respiration level
  - Breathing pattern
  - Colour
  - Use of inhalers
  - Required positioning

- Smoker/non-smoker
- Nutritional and hydration status
- Elimination and Urinary system
- Sleep and rest
- The language needs of the resident
- Possible resident vulnerabilities
- Other additional assessments as deemed required:
  - Barthel ADL Index
  - Falls
  - Dependency Level
  - Mini Mental
  - Urinary Incontinence

5.3.3 On completion of the preadmission assessment, the Director of Nursing/PIC shall review the outputs and shall ensure that admission to Oaklands Nursing Home is only recommended if the needs of the resident can be met (NHI, 2010; HIQA 2016).

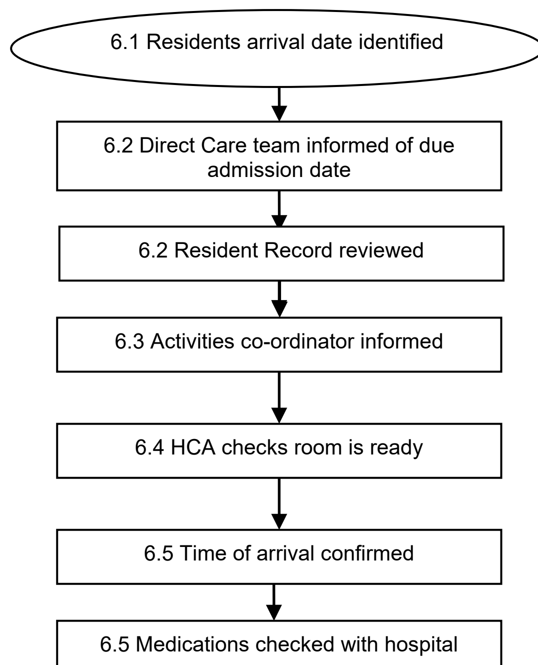
5.3.4 Where the Director of Nursing/PIC identifies that the individuals medical, nursing, psychological and social needs can be met by Oaklands Nursing Home, then the individual may be admitted or added to the waiting list for admission.

5.3.5 Where the Director of Nursing/PIC identifies that Oaklands Nursing Home is not suitable for the needs of the individual based on the results of the preadmission assessment, they shall contact the individual, and/or their family and/or the referral facility and inform them of this.

5.3.6 In the case of emergency admissions, or where a preadmission assessment was not completed prior to admission, the preadmission assessment shall be completed immediately of admission, to be followed by comprehensive assessment as soon as practical after their admission. (HIQA, 2016). Admission checklist is available in the V- care system.

6.0 Admission and Orientation

Resident admission and orientation shall be undertaken as per the process below:



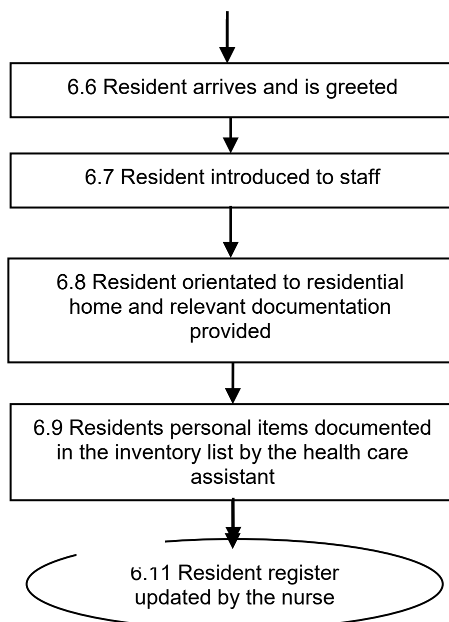


Figure 2.0 – Resident Introduction and Orientation

6.1 The arrival of a new resident at Oaklands Nursing Home shall always be expected. Transportation for the resident shall be arranged by the family or facility in which they are coming from. Where residents are received as emergency admissions, their arrivals shall still be expected, and introductions shall proceed as detailed from section 6.6 below.

6.2 During the handover process on date of due admission the residential care team shall be informed of the new admission due to arrive during the shift. A report shall be given to staff on key aspects of the resident's care prior to their arrival.

The resident record, which shall contain a copy of the resident's pre-admission assessment, shall be reviewed by the nurse. (V- care system)

6.3 The Activities Co-ordinator shall be informed of the pending arrival of a new resident to identify a date and time to meet with the new resident. The kitchen staff shall also be informed that a new resident shall be arriving and of any special diet requirements that they may have.

6.4 The nurse shall confirm with the transferring facility, or a family member, the time that the resident shall be arriving. The nurse shall obtain a copy of the resident's current medication from the hospital where possible and email it to the pharmacy.

6. 5 On arrival, the new resident shall be greeted at the reception of Oaklands Nursing Home by a member of staff. Where residents are being transferred via stretcher the ambulance personal shall enter through the ambulance doors. All other residents shall gain access through the main reception area. The staff member shall welcome the resident. The resident's visitor shall be requested to sign in the visitor's book and take the necessary infection control precautions.

6.6 The resident shall be introduced to staff as he/she meets them. The resident shall be brought to their room or the visitor's room if they are not in a private room.

6.7 The resident introduction to Oaklands Nursing Home shall also include:

- A tour of the building.

- Orientation to their room.
- How to use call bell.
- How to use the phone system/access to information technology systems.
- an opportunity to meet with the chef to discuss dietary requirements and an information session regarding mealtimes, meal planning etc.
- Valuables entered to inventory list or sent home or handed for safe keeping.
- Fire alarms explained.
- Visiting and process for going out with family explained.
- Smoking policy explained.
- The resident shall be provided with documents and information relating to the service and care provided within Oaklands Nursing Home in an accessible format. Staff shall spend time with the resident explaining the documents provided if the resident so wishes (HIQA, 2016). This time may be taken at admission or whenever requested by the resident.
- How the resident's transition into the service can be supported (see 6.12 below).

This orientation process shall take place at a pace appropriate to the resident's wishes and capabilities.

6.8 The HCA shall document an inventory of resident's clothes and personal items being brought in by the resident. This must be dated and signed by the resident and/or their family. All valuables shall be entered to inventory list or sent home or handed to the Director of Nursing/PIC for safe keeping.

6.9 The DON/PIC shall ensure that the resident has completed and signed the Contract of Care (HIQA, 2016).

6.10 Details of the resident shall be entered in the Resident Register.

6.11 **Supporting Resident Transition into Oaklands Nursing Home**

6.12.1 As part of the prospective resident's initial visit to Oaklands Nursing Home, the Director of Nursing/Clinical Nurse Manager shall discuss the individual's transition from their current living arrangements into Oaklands Nursing Home, and how it can be best supported. As part of the admission process, this topic shall be further discussed and acted upon.

6.12.2 The resident shall be consulted with, supported and involved in the planning for their transition from their current living arrangements into residential services (HIQA, 2016).

Depending on the resident's identified needs, the Director of Nursing shall spend adequate time with the resident to plan support mechanism to ease the individual's transition into the service.

6.12.3 Non-emergency transitions between services shall provide for continuity in the residents' lives and seek to avoid or minimise any disruption of the persons' lives and this shall be reflected in the resident's individual care plan (HIQA, 2016).

6.12.4 The Director of Nursing shall allocate a staff member to each new resident, and their family members, to help them to understand their feelings, the reasons for those feelings and why they might seem angry and suspicious (Age Cymru, 2011).

6.12.5 Oaklands Nursing Home shall support the resident's independence in order to deal with issues such as loneliness and adjustment to a new environment (HIQA, 2016) through:

- Facilitating and supporting the resident's choice of daily activities.
- Maintaining their autonomy within Oaklands Nursing Home.

- Encouraging and assisting the resident to maintain relationships with family members, friends, the community, and other individuals who may be able to help them.
- Encouraging the resident to take an active part in the life of Oaklands Nursing Home, to help out through doing jobs or activities they used to enjoy doing at home (Age Cymru, 2011).
- Encouraging the resident to decorate their room in accordance to their wishes and with furnishings from their home, if they wish to do so (HIQA, 2016).

6.12.6 Oaklands Nursing Home shall encourage residents and staff to introduce themselves to new admissions and visitors (Age Cymru, 2011).

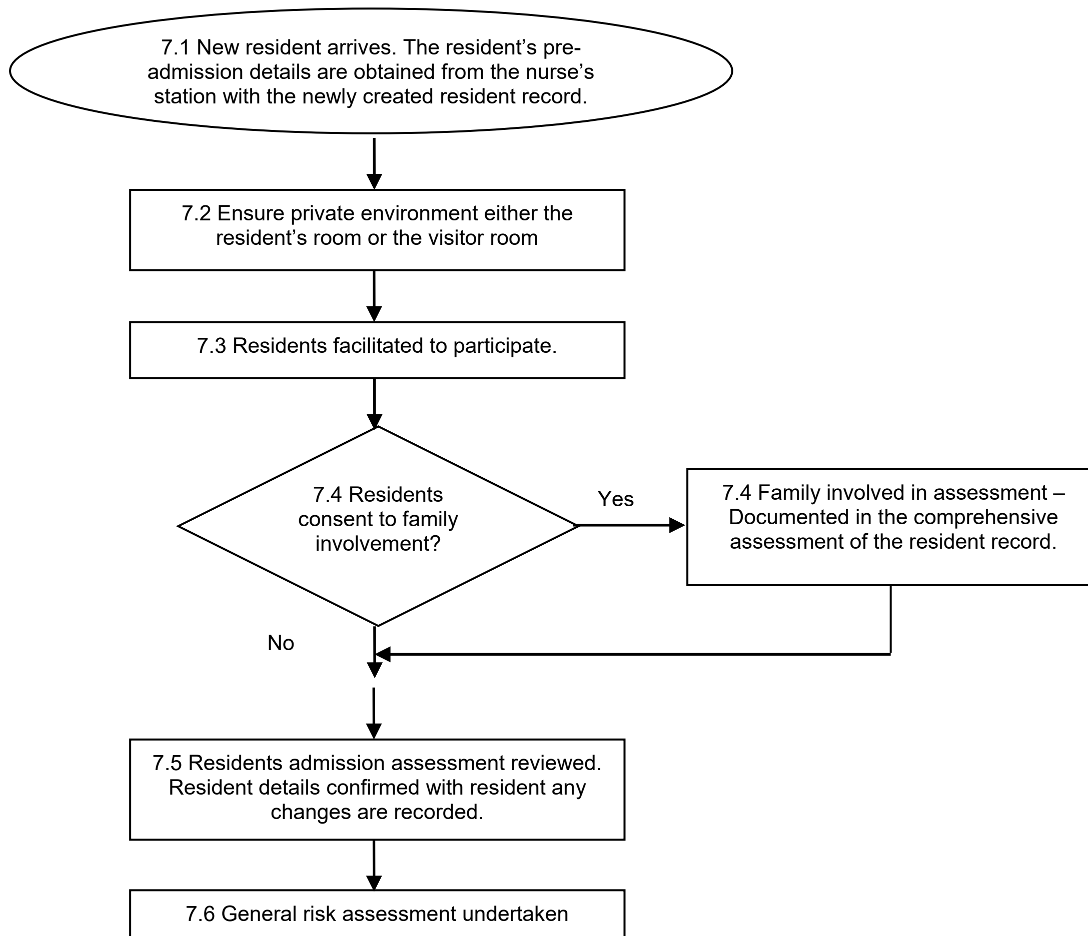
6.13 Current residents are informed of new admissions, with due regard to the rights of the applicant for admission (HIQA, 2016). This may be facilitated within the Residents Representatives Group.

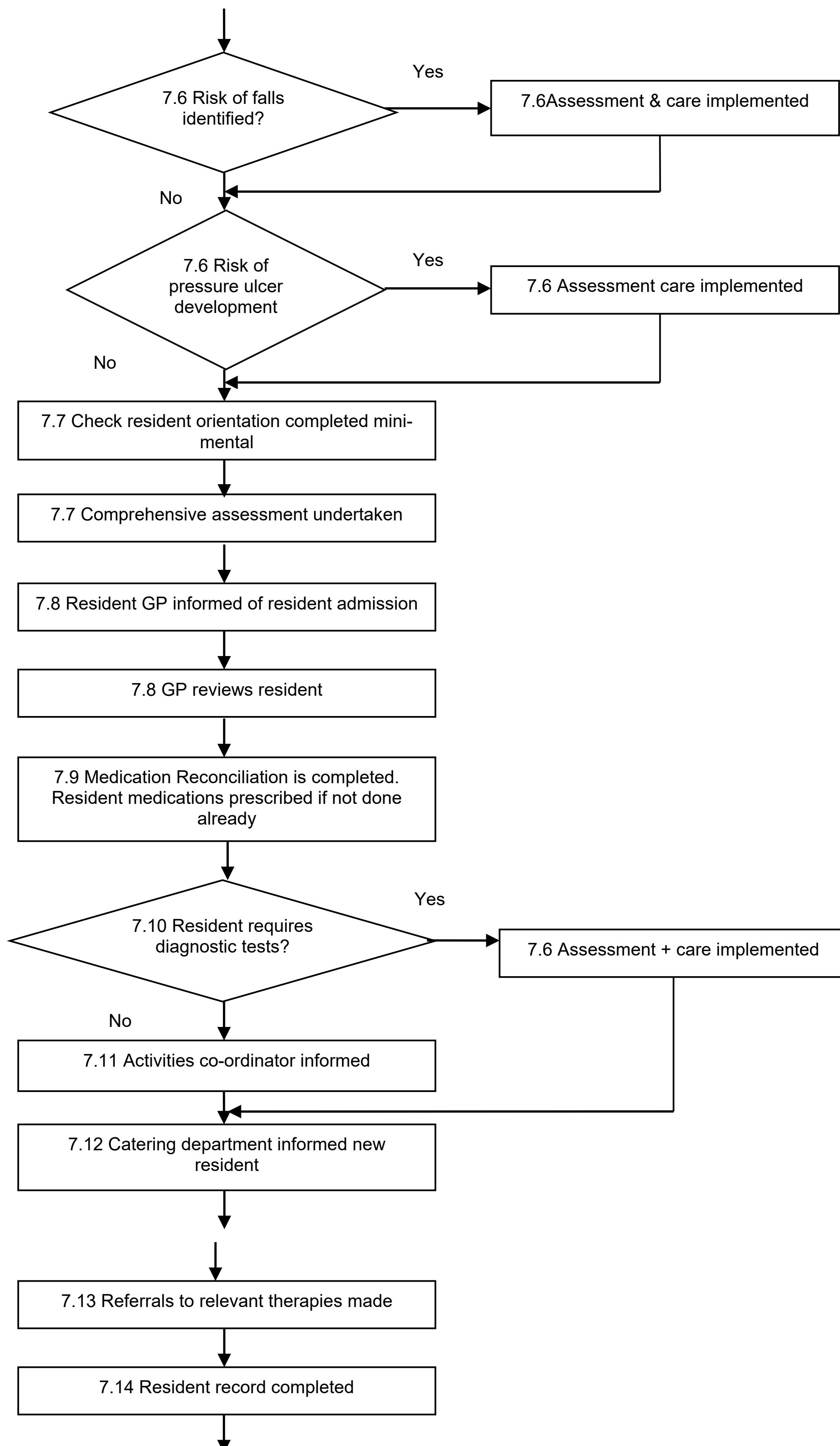
6.14 The resident, and where appropriate their family members, shall be provided with basic safety and emergency planning training as part of the induction process. This shall include at a minimum:

- fire safety
- electrical safety
- environmental safety and mobility
- bathroom safety
- procedures to follow if a natural disaster or other emergency disrupts care or service.

7.0 Assessment on Admission

Resident assessment shall be undertaken as per the process below:





7.6 Risk of falls identified?
Yes
7.6Assessment & care implemented
No
7.6 Risk of pressure ulcer development
Yes
7.6 Assessment care implemented
No
7.7 Check resident orientation completed mini-mental
7.7 Comprehensive assessment undertaken
7.8 Resident GP informed of resident admission
7.8 GP reviews resident
7.9 Medication Reconciliation is completed. Resident medications prescribed if not done already
7.10 Resident requires diagnostic tests?
Yes
7.6 Assessment + care implemented
No
7.11 Activities co-ordinator informed
7.12 Catering department informed new resident
7.13 Referrals to relevant therapies made
7.14 Resident record completed

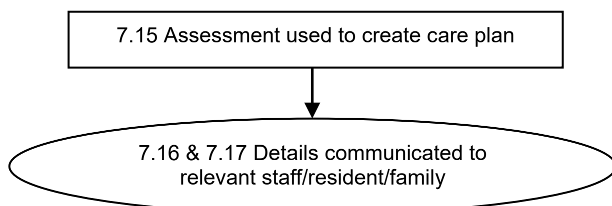


Figure 3.0 – Resident Assessment

7.1 The resident assessment shall be conducted by a suitably qualified staff member or Health and Social Care Professional where deemed required by the Director of Nursing. The resident's pre-admission details from the newly created resident record are obtained from the nurse with authorised access. The resident should be provided with information to facilitate consent for the assessment process.

The nurse with authorised access shall only provide the relevant sections of the resident's record to the Health and Social Care Professionals who are responsible for providing or supervising the resident's care.

7.2 The assessment shall be conducted in a private environment (e.g. the resident's room) to maintain the dignity of the resident.

7.3 The residents, including those with a cognitive impairment, shall be facilitated to participate in the assessment (HIQA, 2016).

7.4 Where residents provide consent, their family shall be facilitated to participate in the assessment.

7.5 Resident details, including those detailed within section 5.4, shall be recorded / checked during the admission process.

- Resident's Details (e.g. Name and preferred name, Date of Birth, Medical Card Number, Social Information etc.).
- Details of family.
- Details of GP.
- Information received with resident from transferring hospital/GP.

7.6 A general risk assessment shall be carried out and recorded upon admission (or within 24 hours of admission) to Oaklands Nursing Home. This shall include:

- Allergies and Observations.
- Falls Risk Assessment, using the Tinetti, Stratify or Cannard Tool. Where a risk is identified, assessment and care are implemented.
- Risk Assessment for Pressure Ulcer Formation, using Waterlow or Braden. Where a risk is identified, assessment and care are implemented. Note: It is recommended that the risk assessment for pressure ulcer formation is completed within 6 hours of admission (NICE, 2015).
- Introduction Checklist – ensure introduction/orientation is completed as per 6.0 above.

7.7 A comprehensive assessment of the resident's physical, psychological and social needs shall be completed as soon as practical after their admission (HIQA, 2016). This shall include the following evidence-based assessments and assessment interviews as applicable to the resident:

Evidence Based Assessment Techniques

- Barthel ADL Index: Activities of Daily Living Assessment.
- Tinetti / Cannard: Falls Assessment / Mobility level / Weight bearing ability *(part of the general risk assessment as per 7.6).*

- Dependency Level: based on HIQA dependency levels.
- Malnutrition Universal Scoring Tool (MUST): Nutritional Assessment.
- Abbreviated Mental Test Score: Cognitive Assessment.
- Urinary Incontinence Assessment: Elimination Urinary System assessment.
- Abbey Pain scale: Pain Assessment (see HS-022 Pain Management for Residents Policy and Procedure).
- Skin Assessment (Grading).
- Wound Assessment and tissue viability.
- Waterlow Assessment: Ulcer risk assessment *(part of the general risk assessment as per 7.6).*
- Oral care Assessment.
- Restrictive Procedures Assessment (see QL-008 Use of Resident Restrictive Procedures).
- Psychological assessment:
  - Cognitive patterns – review for signs of delirium as well as dementia in confused residents
  - Behavioural and psychological symptoms and signs of dementia, example Pain Assessment in Advanced Dementia (PAINAD).
  - Mood and behaviour- Geriatric Depression Scale.
  - Palliative Care Assessment.

- Breathing and circulation (Baseline):
  - Blood pressure level
  - Pulse
  - Respiration level
  - Breathing pattern
  - Colour
  - Use of inhalers
  - Required positioning
  - Smoker / non-smoker
- Any other medical, nursing or psychiatric assessments deemed appropriate to provide information on the condition of the resident at admission (S.I. No. 415 of 2013).
- Specialised assessments may be required for residents identified as being high risk:
  - residents with additional needs due to their age, health or disability, including:
    - Cardiovascular Disease (including Low Blood Pressure & Cerebral Vascular Accidents)
    - Respiratory Disease
    - Osteoporosis
    - Parkinson's Disease
    - Arthritis
    - Syncope syndrome
    - Neurological Disorders
      (NICE, 2015)
  - residents with acute or chronic condition or terminal illness, e.g. resident that is diabetic
  - terminally ill residents.
  - residents with compromised immunity.
  - residents with suspected drug or alcohol dependency.
  - residents with emotional or psychiatric disorders.
  - residents with mental or cognitive disabilities
  - residents with specific needs that cannot be catered for within Oaklands Nursing Home.
  - residents with Food Eating Drinking Swallowing disorders/dysphagia. These assessments may include observation of feeding, eating, drinking and swallowing ability and collecting information on a resident's food/beverage preference (IASLT & INDI, 2014).

Assessment Interviews

- Resident's personal background (HIQA, 2015).

- Allergies *(part of the general risk assessment as per 7.6).*
- Past medical and surgical history.
- Psychological assessment:
  - Grief/bereavement
  - Family History
  - Behaviour patterns & Symptoms and signs of mental health conditions.
    - History of aggressive/violent behaviour;
    - History of substance and alcohol abuse or withdrawal;
    - History of intent to harm others;
    - History of mental condition(s)/self-harm/suicide attempts
    - Previously detained under a section of the Mental Health Act;
    - Forensic, criminal related history, e.g. prisoners in hospital etc.;
    - Victim of abuse, neglect or trauma
    - History of disruption to service delivery and resources, e.g. damage to property, equipment, disruption to staffing levels etc.;
    - Current presentation of specific diagnoses, physical, cognitive, (especially communication) and psychological/emotional factors);

    (NHS, 2013; NICE, 2013)
  - Emotional needs (HIQA, 2015)
  - Emotional wellbeing (HIQA, 2015)
  - Stress and coping:
    - The resident's perception of stress and its effect on their coping strategies.
    - Support systems are evaluated, and symptoms of stress are noted.
    - The effectiveness of the resident's coping strategies in terms of stress tolerance may be further evaluated.

    (Dougherty & Lister, 2015)
  - Perception/concept of self
    - The resident's attitude towards self, including identity, body image and sense of self-worth.
    - The resident's level of self-esteem and response to threats to their self-concept mat be identified.
    - Orientation to time, place and person.

    (Dougherty & Lister, 2015; HIQA, 2015)
  - Health perception – management
    - The resident's perceived level of health and well-being, and on the practices, they use for maintaining health.
    - Habits that may be detrimental to health are evaluated.

    (Dougherty & Lister, 2015)
  - Roles and relationships:
    - The resident's roles in the world and relationships with others.
    - Satisfaction with roles, role strain and dysfunctional relationships may be further evaluated.
- Possible resident vulnerabilities (where not completed during the preadmission assessment)
- List of current and historical medications, the resident's medication needs and their prescription and non-prescription medications.
- The resident's history in relation to self-medication.
- A comprehensive pain history is taken from the resident, and where appropriate, their family and other Health and Social Care Professionals who have treated the resident in the past. A self-report of pain is sought from the resident, regardless of their level of dementia/cognitive impairment (Cornally, et al., 2016).
- Immunization status: include influenza, tetanus and pneumococcus. The residents' general practitioner may need to be contacted for vaccination details.
- Infection control history, e.g. MRSA. Where additional diagnostic testing is required this shall be implemented.
- Communication needs including translation requirements, speech and language, etc.

- Personal cleansing and dressing abilities and required supports.
- Current contact with Health and Social Care Professionals, i.e. Endocrinologist, Physiotherapy.
- Bowel Pattern.
- Sleep and rest patterns.
- Ability to maintain a safe environment. Actual or potential problems relating to safety and health management may be identified as well as needs for modifications in Oaklands Nursing Home for continued care (Dougherty & Lister, 2015).
- Preferences and expectations
  - Recreation/social interaction preferences.
  - Spiritual needs and preferences (HIQA, 2015)
  - Cultural preferences (HIQA, 2015)
  - Preferences and values relating to ethnicity or religious requirements, including dietary requirements.
  - Preferences in relation to daily routines, interests, desires, fears, concerns, their family and significant others' life events. Information sought may include:
    - What time the resident likes to get up in the morning, go to bed at night;
    - What makes him/her laugh or cry;
    - What's his/her favourite time to bath or shower;
    - What he/she likes to eat when out for a treat;
    - Approaches or activities that have been useful to settle the resident when he/she has become cross, upset or distressed.

    (Cahill and Moore, 2012)
  - Social care needs and preferences (HIQA, 2015)
    - Social interaction with staff.
    - Social interaction with family.
    - Social / recreation activity
  - Privacy requirements and expectations in relation to the provision of care and treatment
  - Whether the resident has in place, or wishes to implement, an Advance Care Plan or Advance Healthcare Directive. This may include palliative and end of life care wishes.
  - Resuscitation status.
  - Intimacy and sexual needs (HIQA, 2015)
- Social status, including supporting economic factors where this has not been already addressed as part of the preadmission process.

Additional information and associated reports shall also be reviewed if available:
- Speech and Language Therapy (S.A.L.T) completed to date.
- Dietitian reports to date.
- Occupational Therapist reports.

(NHI, 2008; NHI, 2010)

Where the resident is an emergency admission, this information is obtained as soon as possible after admission (HIQA 2016).

7.8 The resident's GP shall be contacted and informed of the resident's admission. The resident's GP shall attend Oaklands Nursing Home, review the resident and provide relevant information and instruction for the care of the resident. If residents GP is so far from Oaklands Nursing Home, local GP should be offer to residents.

7.9 **Medication Reconciliation (MR) at initial assessment.**

7.9.1 Medication Reconciliation (MR) shall be completed during the initial assessment process in a timely manner. Where possible, the staff shall involve the resident and/or their family in the medicine's reconciliation process (NICE, 2015b).

7.9.2 The following information is required to reconcile medications and shall be documented:
- A complete list of all medications currently prescribed for the resident, including those bought over the counter;
- Any co-morbidities;
- Any swallowing difficulties and if liquid or crushed medications are required;
- The dose, frequency, formulation and route of all the medicines listed;
- Any medications for short term use e.g. antibiotics;
- The resident's allergy status, including no known allergies and the type and detail of known allergies (as per 7.6 above);
- Any previous adverse drug reactions;
- The resident's nominated pharmacy.
(HSE, 2016; HSE, 2014)

7.9.3 Where the resident is transferred from another healthcare facility, and the appropriate documentation shall be transferred to Oaklands Nursing Home in accordance with IM-007 Management of Personal Data in Line with Data Protection Requirements (incorporating GDPR).

7.9.4 Any problems associated with current drug therapy, including any possible relationship with the current medical condition shall be reviewed by the resident's GP and, where appropriate, the Multidisciplinary Team (HSE, 2014).

7.9.5 Where appropriate, formal written consent shall be obtained from the resident for disposal of any of their own medications brought into Oaklands Nursing Home, that will not be continued (HSE, 2014).

7.9.6 On completion of the MR process, Oaklands Nursing Home staff shall provide the resident and/or their family with verbal and written information about their medication regime and any changes made to it (HIQA, 2014).

7.9.7 Following the medication reconciliation process, the resident's current medication requirements shall be prescribed by the GP. For initial medication prescriptions, the GP shall review the list of medications ordered against the list of medications taken by the resident prior to admission to consider any risks associated with any changes to the medications.

In the time between the resident admission and the GP writing the drug kardex, Oaklands Nursing Homes hall follow the medication instructions which accompany the resident, and which were obtained in the pre-assessment (5.0 above). This shall be no longer than 24 hours.

7.10 Where the resident requires diagnostic tests (e.g. blood tests, urinalysis) these shall be obtained.

7.11 The Activities Coordinator shall be informed of the resident's arrival to initiate the resident activities programme.

7.12 The catering department shall be informed of the resident's arrival and of any dietary requirements. The catering person shall also confirm a time to discuss any dietary preferences likes or dislikes with the resident.

All new residents shall have a food diary maintained for one week when they arrive at Oaklands Nursing Home. Where there is no identified issue in relation to nutrition the food diary may be discontinued upon the recommendation of the nurse (NHI, 2008).

7.13 The requirement for specialised assessments shall be made by the Multidisciplinary Team and the Clinical Nurse Manager. The resident shall be made aware of the requirement for specialised

referrals and the resident's needs and preferences shall be respected, including their desire for care and additional services and their response to previous services. All referrals shall be detailed within the resident's individual care plan.

Where specialised assessments cannot be supported internally by Oaklands Nursing Home and its Health and Social Care Professionals, a timely referral shall be made and followed up. Specialized service providers shall be adequately qualified and shall be specifically approved for the service to be provided.

Where the outcome of these specialised assessments cannot be supported by Oaklands Nursing Home, the Director of Nursing shall provide information on alternative sources of care and services to the resident and/or their family.

7.14 Details of all of the assessments completed shall be recorded in the Resident's Record .The relevant sections of the resident's records shall be made available to appropriate staff and Health and Social Care Professionals involved in the provision of care to the resident (as per section 7.1 above)

7.15 The assessment outcomes shall be utilised to create the residents' individual care plans.

The outcomes of the assessments shall also be utilised to identify the appropriate Care Leader for the resident. This is specifically required where there are a number of Health and Social Care Professionals that are required to be involved in the provision of care to the resident. The Care Leader shall act as co-ordinator of care and shall be ultimately responsible for the provision of effective care to that resident. The Director of Nursing is responsible for the allocation of a Care Leader for each resident.

7.16 Details of the resident's assessment outcomes shall be communicated to all relevant staff with authorised access of the resident's care during handover report. The nurse shall document a date for the resident's reassessment on the Assessment Schedule. Reassessment shall be completed at 4 monthly intervals at a minimum. The reassessment should incorporate the multidisciplinary group involved in the assessments, including nursing staff, the GP, the pharmacist and any other relevant Health and Social Care Professionals involved in the provision of care to the resident (NHI, 2010; S.I No. 415 of 2013) .

7.17 Every effort shall be made by Oaklands Nursing Home to involve the resident, including those with dementia/cognitive impairment, in the assessment process. The overall outcomes of the assessment process should be clearly communicated to the resident and, when appropriate, to their family by nursing staff.

Where the expected results of the care to be provided by Oaklands Nursing Home have changed based on the completion of the comprehensive assessment, this shall be discussed with the resident and/or their family.

7.18 The resident records shall be kept for a period of no less than seven years after the resident has ceased to reside in the designated centre concerned (S.I. No. 415 of 2013). Disposal of records is addressed within IM-007 Management of Personal Data in Line with Data Protection Requirements (incorporating GDPR)).

8.0 Staff Education and Training

8.1 All individuals completing assessments shall be appropriately qualified and competent to implement the required assessment activities.

8.2 The staff shall be trained to recognise the need for early intervention and thus establish measures to detect, diagnose and refer to external health professionals for diagnosis, and treat impairments

at an early stage, and also to develop effective guidelines for early detection and intervention measures (NDA, 2006).

9.0 Records

9.1 Resident information, both paper and electronic, shall be held securely in line legislation and shall only be accessed by those who need to see it (HIQA, 2018) (as per IM-007 Management of Personal Data in line with Data Protection (incorporating GDPR)).

9.2 The following records shall be kept by Oaklands Nursing Home:

- Resident Records
- Transfer Information
- Referrals
- Residents Consent.
- Resident's Contract of Care
- Staff Training Records

10.0 Audit and Evaluation

Regular audits shall be undertaken to determine compliance to this policy and procedure. The Director of Nursing shall complete these via a review of relevant records, including incident reports, through observation and by utilising the appropriate audit tool. Results of these audits are presented to the Management Team.

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12.1 Appendix 1 Assessing Barriers to Learning

Your first step in the process of resident teaching is assessing the resident's learning needs, learning style, and readiness to learn. Assessment includes finding out what residents already know, what they want and need to learn, what they are capable of learning, and what would be the best way to teach them.

Begin the process by interviewing the resident. First, find out more about the resident as an individual and what his life is like. Questions you might ask include:

- Tell me what an average day is like for you
- How has your average day changed since you've been sick?
- What do you like to do in your spare time?
- Tell me about your family
- Tell me about your work

Second, start assessing the resident's learning needs. Questions you might ask include:

- What are you most concerned about?
- What are your goals for learning how to take care of yourself?
- What do you feel you need to know to achieve your goals?
- What specific problems are you having?
- What do you know about your condition?
- What are you most interested in learning about?
- How will you manage your care at home?

Third, find out what the resident's learning style is so you can match teaching strategies as closely as possible to the resident's preferred learning style. Questions you might ask to determine the resident's learning style are:

- What time of day do you learn best?
- Do you like to read/what types of books or magazines do you enjoy reading?
- Would you prefer to read something first, or would you rather have me explain information to you?
- Do you learn something better if you read it, hear it, or do it hands on yourself?

  Forth, gather information about the resident's readiness to learn. Questions you might ask include:
- How do you feel about making the changes we've discussed?
- What changes would you like to work on now?
- Are there any problems that would prevent you from learning right now?

Forth, gather information about the resident's readiness to learn. Questions you might ask include:

- How do you feel about making the changes we've discussed?
- What changes would you like to work on now?
- Are there any problems that would prevent you from learning right now?

After you've talked with the resident, interview the family. Conversations with the resident's family can fill in missing information, change your understanding of what you've heard from the resident, or affect your view of what the resident's home situation might be. Do family members ask to be present during teaching, and when teaching occurs, do they actively participate? Do they seem supportive of the resident's need to change health behaviours and to learn new tasks and skills?

You can also consider using checklists and questionnaires to obtain information about learning needs, learning style, and learning readiness. Written materials also help you determine the resident's literacy level and ability to understand written information. Confer with other health care team members. Each health care team member has valuable information about the resident and his or her learning needs and abilities. Collaborating with others who care for the resident can give you-and them-a better picture, allowing all of you to design more effective teaching strategies.

If the resident identifies the need-"What exactly will this process involve?" he or she is already demonstrating motivation to learn. If you, rather than the resident, identify the need, your job will be not only to deliver the information in such a way that the resident is able to understand it, but also to demonstrate to the resident why the information is important.

Determining learning style involves assessing how resident learn best, when they learn best, and how able they are to learn what they need to know. Finding out whether the resident learns best by hearing, reading, or hands-on learning is relatively straightforward. However, factors such as the resident's educational and literacy levels also need to be considered. Sometimes residents and families may seem uninterested in learning because they don't know what to ask or don't yet realize that they will need information. For example, family members of a resident with a stroke may have never known anyone else with a stroke and thus may have no idea of what to plan for or what to ask. In some instances, nurses and other health professionals may take it for granted that residents have a better understanding of their condition and treatment than they actually do.

(Euromed Info Centre, Accessed 3rd Feb 2015)