

OAKWORTH MANOR CARE HOME LTD.	Issue Date: April 2019	Reviewed September 2026
	Next Review: 09/29	
<u>ADMISSION, TRANSFERS AND DISCHARGE OF A RESIDENT POLICY</u>		

A support plan is prepared pre-admission by a social worker or ward staff and this is sent to the Deputy Manager/Manager of the Home either by email or through connecttosupport. When able, a face to face assessment of the individual is performed at the place they are currently residing, when unable to have a face to face assessment, a further verbal handover is taken by the Home. This will determine if the individual meets the criteria of the Home, If the Home can meet their needs and if the assessment has identified the correct placement.

The information evaluated includes

- Current situation/medical history
- Mobility, falls risks, equipment needed, moving and handling
- Eating and drinking any dietary requirements
- Behaviour and risks towards other residents, staff and property
- Washing and dressing
- Continence issues
- Medication lists
- Previous safeguarding concerns
- When coming from hospital , what care level are they receiving
- Has the ward/home had any recent outbreaks
- Do they require specific mattress types or any other equipment
- Family involvement

This along with observations in the first few days of admission and family input where possible will form the basis of a full care plan for each of these needs.

When conducting a face to face visit ask the staff when they last had medication administered

Social workers /discharge teams will be informed of Home fees including top ups. Funding must be agreed before admission.

Families are to be offered to view the Home

Where a relative has legal control of the resident's financial affairs, then the social worker, if appointed, will deal directly with the relative on financial matters.

Prior to admission, the Manager or the person in charge of the shift will arrange with the Domestic Staff for the new resident's room to be cleaned and prepared in readiness for admission. The bed will be checked to be in working order and that the correct mattress is in place.

At admission, the resident will be met by a member of staff and directed either to the lounge area or to their room

The new resident will be shown around the Home if they are able to do so, orientated to the layout of the Home, and introduced to other residents and the staff.

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All clothing is marked with the resident's name, to ensure traceability through the laundry system. If not marked, laundry staff will be informed.

Any electrical equipment has a label confirming that it has been tested in the last twelve months. PAT testing of portable equipment is carried out internally.

Zimmer frames, glasses and false teeth should be named.

When a resident is admitted from hospital, the medication will be checked to ensure it matches with the discharge paperwork. If there is no discharge paperwork, this will be obtained by contacting the ward to verify what medication the person is taking, before any administration and prior to adding on to the EMAR. All controlled drugs will be locked into the CD cupboard after booking in.

When a resident is coming from another home, an up to date medication list must be obtained from the resident's GP. If the resident is staying permanently, staff will discuss with family members the need for a change of GP and a registration form will be completed and sent to the GP as soon as possible.

Staff to encourage relatives not to leave valuables at the Home. Where possible relatives should take jewellery home and, if required, to substitute jewellery for less valuable jewellery so the resident does not become distressed. A responsibility form must be signed by relatives who wish to have the valuables remain in the Home.

Staff to inform relatives of the residents arrival if they haven't accompanied them to the Home.

Personal details, NOK details, medical history and date of admission must be added to log my care and risk assessments completed. Care plans must be commenced immediately after admission (to be completed within 7 days) and a DoLS applied for if required.

Mental capacity will be considered on a case by case basis. Where restrictions on the resident may amount to a deprivation of liberty, this will be assessed in accordance with current Mental Capacity Act and deprivation of liberty guidance. A referral to the relevant local authority will be made where required or where there is doubt.

A body map Must be completed and photograph taken of any bruising etc and baseline observations

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Discharges and Transfers

When a residents care transfers to hospital the following items must accompany them:

- Up to date hospital passport. NOK details included
- Up copy of their most current EMAR chart.
- Any medication that is required that will not be readily available on arrival to hospital.
- Body map to be completed prior to discharge

Planned admission to hospital

- Up to date hospital passport.
- Clothing for their stay, including dentures etc.
- Any medications requested by the hospital
- Body map to be completed prior to admission

Discharge to another Home

- Ensure a full handover is given to who is responsible for the residents care
- All Medications
- Care plan.
- Most current Emar chart.
- All personal belongings including and monies held by the Home
- Body map to be completed prior to discharge