Care Planning & Risk Assessment Guidance

This guidance must be used for all Residents' Personal Profiles and Care Plan Reviews

1. In the Review Section of Residata, enter "Reviewed with {insert staff members' names} on {insert date}. In addition, type "**Care Plan not changed**" if this is the case. DO NOT make changes to the Care Plan if the resident's needs have not changed.
2. "NOW" section should only contain current information, i.e. what is the situation TODAY?
3. The fields in Residata entitled "Risk Assessments" must not be used and old ones must be deleted straight away if found.
4. Each resident's "Medical History" and "Life Story" must be recorded in the "Information" section of Residata, and NOT in the Care Plan.
5. A section on "Breathing" should be added if the resident's specific needs warrant it, e.g. if he/she has COPD, Asthma, etc. (but not if they don't!)
6. The document immediately below this one on the website gives generic care plans for Body Temperature and Safe Environment. These must not be entered in Residata (as they would de-personalise the care plans), but the "prescriptions" must be followed for all residents.

ACTIVITY OF DAILY LIVING	NOW / CURRENT SITUATION	OBJECTIVES	PRESCRIPTION / HOW WE CAN DELIVER CARE
Communication	• **Language:** What is the person's first/preferred language? Their level of understanding? Understands fully? Responds to short sentences? • **Teeth:** Wears dentures/ own teeth? • **Speech:** clear / slurred / lucid / lack of speech • **Hearing:** Uses hearing aid? Lip reads? Uses sign language? • **Sight:** Registered blind? Wears glasses – reading or general wear? Long/short sighted	• That {resident's name} feels staff have understood her/his needs and responded accordingly • That {resident's name} continues to have meaningful interactions with others	• Uses picture board? • Speak in short sentences • Observe non verbal signals, i.e. grimacing, frowning • Who is dentist/ optician/audiologist? When is yearly appointment due? • How to clean/manage hearing aid, battery size, where stocks of batteries are kept or ordered from • Reminder to clean glasses
Elimination	• Is the person fully continent? Is the person incontinent? Explain in which way Does the person use continence aids Does the person wear pads? Day/Night? Type? Size? • Does the person have a catheter? Is it urethral or supra pubic? What size? Are there others in stock in the home? When is it due to be changed? • Does the person need support in remaining continent? Commode/ toilet raiser/ wall bars/bottle/bedpan • Does the person ever have retention of urine? • Does the person get constipated? Are they prescribed meds?	• To ensure and maintain dignity and privacy at all times • For {resident's name} to feel supported dry and clean at all times	• Discuss whether resident is able to find the toilet during the day and of a night (do they need the light to be on?) • Do they need support of staff to walk there? Any aids? • Hand hygiene • Continence aids • Size of pads • Disposing of pads • When is the best time to offer the toilet? • How often do the residents pads need to be checked and changed, by how many staff? With what equipment? • Do they need a toilet raiser or a toilet frame?

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	• Is the person under the care of the bowel and bladder team? • Does the person have a colostomy/ urostomy		• Catheter care. Ensure catheter bags are dated. State when bags are changed. How/where they are emptied. Date of catheter change. How are the disposed of? • When is the best time to offer aperients, suppositories/enemas? • How is the colostomy/urostomy managed?

End of Life	• Have MCA considerations been taken into account?
	• Is there and advanced decision directive in place?
	• Is the person/family/LPA aware that their health is declining?
	• Have they had opportunity to discuss treatment or options with GP or any other relevant health care professionals
	• Has consideration been given to preferences, wishes, advanced decisions?
	• Managing the last days:
	  • Name any multidisciplinary teams and their contact details
	  • Has Pain control been considered? Are anticipatory meds in place? Is there suitable Equipment, i.e. syringe driver available?
	  • What Spiritual and emotional support would the person like?
	  • Is a DNAR in place? and is on the resident's file
	  • Has the GP undertaken a management plan to prevent needless hospital admissions
	  • Persons Point of contact (e.g. relative, solicitor, etc.) and funeral director (if known)
	  • After life wishes: burial or cremation
		• To fulfil wishes of {resident's name} and his/her family
		• &friends as far as it is possible to do so
		• To ensure pain free dignified and compassionate care in line with the 'one chance to get it right' document'
		• To maximise well-being
			• Create a personalised End of life care plan reflecting information gathered in the NOW section
			• Discuss any MCA restrictions, If a DOLS is in place the Coroner needs to be informed of a death
			• Support any meetings with any external professionals
			• Give the person time to discuss their thoughts and feelings. Ensure they fell listened to.
			• Discuss any equipment, charts etc that are in place
			• Observe and report any non verbal signs of pain i.e. wincing, frowning, grimacing
			• If a DNAR is not in place, specify "In case of collapse staff must resuscitate and dial 999".
			• If a DNAR is in place, specify "In case of collapse, please see the signed DNAR form in the paper file".
			• Provide details of preferred place for end of life Care.
			• If known, specify whether the person wishes to be admitted to hospital for treatment.
			• If known, describe the care regime the person wants
			• Discuss when meds are best given

Hygiene	• Describe what the resident can do themselves to assist? • Do they use aids, i.e. perching stool, shower chair? • Do they prefer bath/ shower or do they have their wash in bed? • Discuss whether assistance is required with choice of clothing • If the person is resistant, offer best interest decisions	• For privacy and dignity to be maintained. • Feeling clean and wearing clothing of his/her choice or that reflects a style similar to that which they would have chosen previously.	• Specify preference of bath / shower and frequency (e.g. every second day, etc.) • Preferences re toiletries • Specify help required by 1 or 2 carers • Specify if resident prefers male or female carer. • Explain support needed with grooming, ie do they use antiperspirant, aftershave, make up?

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	• Who is their chiropodist? Put contact details • Who is their hairdresser? Put contact details	• To maintain a feeling of self-worth	• Do they wash at the sink? Do they have a chair to sit on there? • How do they manage their oral hygiene, care of teeth or dentures. What nail care do they receive including podiatry? • Discuss support needed with shaving (wet or electric) • Explain how you facilitate choice of clothes, i.e. can they choose on their on? Do you give them a choice of two outfits? • Observe for any body marks, and report any to nurse/manager
Medication	• Explain why the resident is on each of his/her medications (groups of medicines only, no need to include specific doses, etc.) • Specify if medication is in soluble or liquid form due to swallowing problems. • Discuss covert medications and confirm details of a best interest decision making meeting regarding this. In the case of nursing home residents (but not tenants), confirm details of a DOLS application has been made in regards to this matter • Discuss crushing of medications and refer to MAR and best interest decision making. Confirm that the paper form has been signed by the GP. • List any major contra indications and side effects, i.e. asprin/ warfarin - look out for bruising • If the resident self medicates, write up a risk assessment here.	• To be informed about the medications that they are prescribed and have choice in regards to this where able. • Discussion with NOK/ POA etc where there is not suitable capacity to understand implications • To take medication as prescribed by GP &/or Consultant • For the effects or ill effects of medication to be monitored and reported to GP as appropriate	• “Suitably Assessed Person to administer medication as prescribed”. • Seek consent. • Explain anything specific to the resident • If applicable, specify mode of administration, e.g. PEG (enteral feeding should have a full care plan in itself in line with current NICE guidelines) • Describe covert administration if prescribed • If self medicating, specify “Provide medicines in lockable drawer and conduct monthly audit to ensure correct administration” • Describe how resident likes their medicine to be dispensed to them Ie in a medicine pot/ on a spoon

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Mental Health/ Well being/ Cognition	• Explain the resident's current mental state: happy, depressed, anxious, content their self esteem. • Do they have moods, when do they occur, how do they present? • And any mental health diagnosis, dementia schizophrenia • Discuss their past mental health history if relevant if it impacts on their feeling happy. • Anti depressants? • Specify whether they have mental capacity to make decisions • Signify who undertook, when a mental capacity assessment and where this can be found. • Specify if a DOLS authorisation has been obtained (nursing home residents only, <u>not</u> tenants) • For those who pose a risk to themselves or others ensure there is a risk assessment in place • Describe any behaviours that challenge the service? • Cognition What is this persons perception? Do they know where they are? Can they reason? Are they aware of date/time? Are they apprehensive?	• To optimise {resident's name} mental wellbeing • To promote an environment of well being- calm relaxing, settled • To manage safely behaviours which may cause distress to themselves or others • To ensure safeguarding through the MCA DOLs processes. • To support to maintain cognitive skills, i.e. perception, attention, memory, motor skills, decision making , problem solving, sequencing, as far as possible	• Specific areas might include: challenging behaviour, i.e. leave alone and approach again later • Any actions to improve depression, i.e. looking at the pictures of grandchildren/ singing a favorite song • Any actions required from Risk assessments • Discuss the best time for the person to make decisions is? • Discuss their range of decision making ie can they choose between coffee and tea? Clothes? Lunch? • Are they completely cognitively able? • Are there any activities that the person likes /wants to take part in that support cognition/memory - quiz, puzzles

Mobility	• Explain the resident's mobility
	• Discuss any factors that affect mobility: CVA? Parkinsons
	• Discuss Equipment used
	• Discuss number of staff required
	• For all residents, type RISK ASSESSMENT and then only type the following statements which apply:
	  • Mr/s X has had at least one fall in the last 12 months
	  • Mr/s X is on four or more medications per day
	  • Mr/s X has a diagnosis of stroke or Parkinson's Disease
	  • Mr/s X is unable to rise from a chair of knee height without using her arms
	If less than three of these statements apply, add "Mr/s X
		• To minimise risks of falls and the affects of immobility(tissue viability)
		• If non-weight bearing: to be moved safely and securely
		• If resident is mobile: to be as mobile as possible within the limitations of his/her condition
		• For the person and their families/ supporters to understand associated
			• List the actions necessary to address the resident's mobility issues, especially their risk of falling
			• If a wheelchair user, specify:
			  • Who does the wheelchair belong to? The person, the home, other?
			  • Does the person use a lap belt? Does the person have capacity? If not has this been discussed within a DOLS? Is there a best interest decision in place?
			  • Who maintains the chair?
			• Specify how many carers to transfer
			• Specify whether hoist required and, if so which type (stand aid, oxford maxi etc, type and size of sling. Frequency of laundering the sling.

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	is at low risk of falling. If three or four of these statements apply, type: "This means that Mrs X is at risk of falling and, to manage this risk, the following risk factors need to be taken into account (obviously only cover those that apply): • History of falling in the previous year: Review incident(s), identifying precipitating factors • Four or more medications per day: Identify types of medication prescribed & ask about symptoms of dizziness. • Discuss balance and gait problems: Can they talk while walking? Do they sway significantly on standing? • FOR NURSING HOMES: Postural hypotension (low blood pressure): Take two readings: (1) After rest five minutes supine and (2) one minute later standing. If drop in systolic BP more than 20mmHg and or drop in diastolic more than 10mmgHg • Indicate other health care teams involved: Physio, falls clinic, etc. Give contact numbers • Is the person cared for in bed at all times?	risks	• Specify if the resident uses a walking frame/walking stick and details of use. • Specify details of checking the ferrules (the rubber at the bottom) how often, how to order more • Specify if resident requires supervision when walking. • Specify anything else specific to the resident Example: {resident's name} is non weight bearing and requires the use of a hoist. Ensure two staff are present to use the hoist and that a size X sling is used. • Discuss that you tell the person what you are going to do • For people that are cared for in bed: • What type of bed • Discuss how you roll them • Do you use a slide sheet • How often you move them, is it recorded on a chart? • What is their favorite position? • Discuss any physio input
Nutrition	• For all residents, refer to the MUST tool form and write up the assessment steps in the "NOW section, i.e. type "MUST Tool scores = Steps 1 + 2 + 3 = Step 4 and then describe management guidelines (Step 5)" • Does the person have any allergies? Describe where the protocol can be found in case of anapylaxis • List likes and dislikes • What type of diet do they have? • Is assistance required? • Do they use specific cutlery/crockery • Do they have nutritional support, vitamins, cream shots, supplements • Outline history of weight gain/loss • Give any history of choking and, if so, write a choking risk assessment here. • Specify if there has been referral to GP/Dietician/SALT. • Does the person have an Enteral feeding tube?	• To be able to enjoy his/her meals • To put on/maintain/lose weight • To support choice of diet • To support religious observance.	• Specify preferred venue for meals. • Specify normal or adapted cutlery/crockery • Specify if clothes protector/serviette preferred. • List any special dietary requirements. • Give details of prompting/supervision/ assistance required. • Specify if fluid/diet chart required • Discuss any protocols for enteral feeding • Discuss any protocols for religious observance

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	• Are there any Religious considerations?		

Pressure Care/ Skin Integrity	• For all residents, complete the Waterlow in Residata and describe the risks in the "NOW" section, i.e. type "Waterlow score is X due to AA
	• Explain the condition of the skin: dry/red/tissue paper etc
	• If the resident has any Pressure Ulcers, refer to the "Pressure Ulcer Assessment Chart & Body Map" in Section 1.1 of "Documents" on the home's website and describe any Pressure Ulcers under the following headings:
	  • Wound dimensions
	  • Category
	  • Tissue Type
	  • Surrounding Skin Condition
	  • Wound Margins
	  • Exudate
	  • Exudate Colour
	  • Odour of Wound
	  • Level of Infection
	  • Pain at Wound Site
	  • Resident's description of Pain
	• What Input is being provided from multidisciplinary teams. TVN, D/Ns?
	• Is there anything that will prevent healing, i.e. is the person nutritionally compromised?
	• Does the person have diabetes?
	• If grade 3 or over clarify that safeguarding and CQC have been notified
	• Describe any skin tears
		• ……to have healthy skin free from sores
		• To promote healing and prevent further damage/infection
			• Discuss aids that help to support skin integrity:
			• Specify type of bed/mattress
			• For air mattress, state pressure required per persons weight
			• Specify if turning/moving required, and frequency of turning/moves
			• How are moves recorded?
			• Any other aids? Bed cradle?
			• For any Pressure Ulcers, give individual details about the type of dressing, frequency of application, measurements, etc. List any specific creams required.
			• Discuss disposal of dressings
			• Is there anything specific you do to prevent skin damage?
			• Provide a high protein diet
			• Observe skin on bony prominences?
			• Hydrating the person?
			• Ensure sheets aren't crumpled
			• Ensure that skin tears are reported on an accident/incident form
			• Ensure that there is sufficient body mapping
			• If appropriate photograph and document in care records

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Sleeping	• Specify preferred times for going to bed and getting up.
	• Give any history of wandering
	• Outline night time routines (e.g. getting up to use the toilet, drinks/snacks, help needed to change pads, etc.).
	• If bed rails are attached or if they are required, type the following statement in the "NOW" section if they <u>all</u> apply: The risks of using bed rails on Mrs X's bed appear acceptable as:
	  • Their head/body is too large to become trapped.
	  • The resident is not agitated in bed
	  • The resident stays in bed all night.
	  • In any one of these statements does not apply, type in the "NOW" section: "Bed rails must <u>not</u> be used as ……".
		• ……to ensure adequate rest and sleep	• Specify if bed rails required and, if so, specify that bumpers are required and bed to be in lowest possible position.
			• Detail any specific support needs during the night
			• Specify any crash mats, pressure sensors which may be required.

Social Interaction	Note: Each resident's "Life Story" should be in the "Information" section of Residata, • Describe the persons Hobbies &interests • Describe activities that the resident gets involved with in the home • Describe the residents sociability with other residents. Do they have any particular friends/friendship groups?. • Describe their Spirituality/faith • Consider whether the person is at risk of isolation	• To ensure that the person continues to have meaningful relationships • To ensure that the person feels that they have purpose/purposeful things to do • Ensure that they do not become isolated	• Explain the things which need to be done so that the resident's social/spiritual objectives can be met