Care Planning & Risk Assessment Guidance

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

1. Each resident's "Medical History" and "Life Story" must be recorded in the "Information" section of Residata, and NOT in the Care Plan.
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. 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!)
5. Care plans for Body Temperature and Safe Environment are not required in Residata. The document immediately below this one on the website gives generic care plans for these for all residents.
6. Each time a Care Plan section is reviewed, 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.

ACTIVITY OF DAILY LIVING	NOW / CURRENT SITUATION	OBJECTIVES	PRESCRIPTION / HOW WE CAN DELIVER SUPPORT
Communication	• **Language:** What is the person's first/preferred language (only if not English)? Their level of understanding? Understands fully? Responds to short sentences? • **Speech:** clear / slurred / lucid / lack of speech **Behaviour/ Non-verbal communication** • **Can the person communicate their needs, choices and emotions?** Do staff have to anticipate their needs? • **Can they reliably use the call bell to communicate their needs?** • **Dual sensory loss** - impact • **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 • Can't use call bell – regular checks in their suite to ensure they are safe AND their needs are met. • Who is 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?	• 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

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	• 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? • Is the person under the care of the bowel and bladder team? • Does the person have a colostomy/ urostomy		• 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? • 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 **As soon as Step 5 is reached, <u>all other ADL's are to be deactivated</u>** and all care needs are now to be added to this plan.	**Describe the resident's current position along the "Six Steps for End of Life Care":** 1. Discussions as end of life approaches 2. Assessment, care planning and review 3. Co-ordination of care 4. Delivery of high quality services 5. Care in the last days of life 6. Care after death Also, cover the following areas: • Is there and advanced decision directive in place? Has the resident expressed a wish to be cared for at the home or do they wish to go to hospital? • Have they had opportunity to discuss treatment or options with GP or any other relevant health care professionals • Is there a DNCPR in place: if a DNAR is not in place specify in case of collapse staff must resuscitate and dial 999, if DNAR is in place specify in case of collapse resident is not for resuscitation and please see the signed DNAR in the paper file. • Is the resident for active treatment should an infection be diagnosed. **As soon as Step 5 is reached, provide the following information:** • When was end of life status diagnosed by the GP? • How is resident presenting at time of writing the care plan	• Plans in place to meet residents'/family's last wishes (e.g., care setting, Advance Directives, will, funeral) • Ensure (residents name) wishes are respected • Ensure (residents name) physiological, psychological social and spiritual needs are met **As soon as Step 5 is reached:** • Control pain • Prevent/manage symptoms • Maintain quality of life as much as possible	• Does the resident have any cultural, faith, feelings, beliefs and wishes – if so what are they and how are these to be supported. • After life wishes: is the resident for burial or cremation and is there a preferred undertaker. • Consider each step but acknowledge if it is not yet relevant to the person and that this will be reviewed when required. Write "To be reviewed when appropriate". **As soon as Step 5 is reached:** • Details of residents GP and how often they are visiting to review and the outcome of last visit. RN to refer to GP should condition deteriorate further and if any support needed. • Nutrition - document all input and output on food and fluid chart, sit upright to prevent aspiration. • Urine and bowels – Is resident using pads if so how often are they checked and the washing regime at each pad change re skin integrity, if catheter how often is this drained – when was last catheter change when is it due again, when was the last bladder wash out, • Skin integrity – mattress/special equipment, turn frequency, use turn chart. Special boots for heels? Check pressure areas during personal. Wound care? TVN referral required?

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	in respect of food/fluids, are they resistant to care or medication, are they anxious or distressed, how is their breathing, what is their skin integrity like, is the resident conscious or unconscious? • Who is to be contacted in the event of further deterioration and would they like to be called day/night/not from 10pm-7am • Are the family aware of the residents end of life status? • Is resident able to say how they are feeling and how are they coping with this.		• Hygiene – Washing and dressing details, how many staff and manual handling in bed (slide sheet, hoist). What is resident's favourite scent, clothing? • Symptoms management: Outline how each of the following (if relevant) is being managed by the staff: o Nausea o Shortness of breath o Anxiety/agitation/restlessness/delirium o Secretions o Dry Mouth o Pain – can resident advise of pain or is observation by body language e.g. grimace, wincing, frowning, shouting out, How is pain treated? Complete Abbey Pain Scale/Painad • Also consider: o How often is resident being checked by staff and is this documented o Social interaction: Music or TV, if so what? What can the staff do when visiting, e.g. talk gently about hobbies they used to enjoy
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 • Teeth: Wears dentures/ own teeth? • If the person is resistant, offer best interest decisions • Who is their chiropodist? Put contact details • Who is their hairdresser? Put contact details • Do they wear glasses?	• 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. • To maintain a feeling of self-worth	• 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? • Do they wash at the sink? Do they have a chair to sit on there? • What nail care do they receive including podiatry? • Glasses: how they should be cleaned and where they are kept? • 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

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			choice of two outfits?
			• Observe for any body marks, and report any to nurse/manager
			• Follow the NICE guidance for mouthcare:
			  • Natural teeth to be brushed at least twice a day with fluoride toothpaste using the resident's choice of toothbrush, either manual or electric/battery powered
			  • Daily oral care for full or partial dentures to be provided (such as brushing, removing food debris and removing dentures overnight) using their choice of cleaning products for dentures if possible

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. For Tenants, confirm that a DOL notification has been sent to the Local Authority. • 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. • Topical creams (chart needed) • Can the resident express when they require PRN medications, e.g. pain killers or laxatives? • Capacity to consent to medication regime • Record if they have a Lasting Power of Attorney for Health and Welfare that can make decisions regarding medications on their behalf. • Consider the need for the following **risk assessments**,	• 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". • Specify how to seek consent or act in their Best Interest if they cannot 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 in a medicine pot/ on a spoon/ in yoghurt • Describe how we know if a person requires PRN medications e.g painkiller or laxatives (if they cannot tell us) • Describe how we manage risks related to the risk assessments identified. • If any pain is noted, staff to complete the Abbey Pain Scale or PAINAD Scale to ensure pain relief adequately given and needs met.

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	depending on the assessment of need - include rational in the care plan: o Covert Medications o Self-Medication o Anti-coagulants o Epilepsy o Refusal of medication o Inability to express pain		
Mental Health/ Well being/ Cognition	• Specify if the Local Authority Safeguarding Team has been informed of a potential Deprivation of Liberty (tenants only) or if a DOLS authorisation has been applied for (nursing home residents only) • Make a Mental Capacity Act assessment if there are reasonable doubts the person lacks capacity in respect of: o Care/ support plan agreement o 3rd party access to Residata o Bed rails o Covert medication o Lap belt/ strap in a wheelchair o Tilt-in space chair o Going to hospital when unwell and/or for a trauma o Refusal to follow advice of GP/ Consultant or other medical professional such as SALT o Any decision to refuse nursing treatment/ intervention that would reasonably cause serious harm, including life sustaining treatment. • If the person lacks capacity in any area, facilitate a Best Interest decision, possibly involving other professionals as well as family/ representatives etc. • Cognition: What is this person's perception? Do they know where they are? Can they reason? Are they aware of date/time? Are they apprehensive? • Explain the resident's current mental state: happy, depressed, anxious, content, self-esteem. • Detail any mental health diagnosis, dementia schizophrenia, any anti-depressants? • Consider the need for the following **risk assessments**, depending on the assessment of need - include rationale in the care plan:	• 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 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, e.g. 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 their range of decision making, i.e. can they choose between coffee and tea? Clothes? Lunch? • Are there any activities that the person likes /wants to take part in that support cognition/memory - quiz, puzzles • If the resident is epileptic, specify what to do in the event of a seizure as follows: • One member of staff to stay with the resident and ensure their environment is safe and their head is protected. • If seizure lasts more than 5 minutes, nursing staff to use emergency medication as prescribed by doctor. • Once seizure has stopped, place resident in recovery position and check breathing until it returns to normal. • Ambulance to be called if: o Resident has badly injured themselves. o Has trouble breathing after the seizure has stopped, o Another seizure follows immediately.

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	o Deprivation of Liberty o Behaviour that is challenging (any occurrence) o Refusal of care (refusal of more than 50% of offered support within 24 hours) o Self-neglect (hygiene, medication, environment, medical assistance, finances or personal affairs) o Self-harm (any reported incidents) o Suicidal thoughts (any reported incidents) o If the resident has been diagnosed with epilepsy, describe any history of seizures.		o Medication doesn't improve situation.
Mobility	• Explain the resident's mobility • Is the person cared for in bed at all times? • Discuss any factors that affect mobility: CVA? Parkinsons • Discuss Equipment used • Discuss number of staff required For all residents, type **Mobility & Falls Risk Assessment** and then Score each person, as follows, to indicate level of Mobility & Falls Risk: Mental Status: • Alert – 0 • Confused at times – 1 • Confused – 2 • Agitated and restless – 3 Eyesight: • Good without glasses - 0 • Good with glasses – 1 • Visual Impairment – 2 • Blind – 3 Hearing (balance problems): • Good - 0 • Poor - 1 • Deaf - 2 Mobility: • Independent - 0 • Mobile with walking aid - 2 • Immobile - 3 • Unsteady, walking aid - 4 Ability to ask for help:	• To minimise risks of falls and the effects 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 risks	**Outcomes of the Mobility & Falls Risk Assessment:** • Low risk – 'Monitor regularly and record any change' • Medium Risk – Specify the identified risks and how to minimise these • High risk – Specify the identified risks and how to minimise these. Refer to falls specialist AND document all referrals made, dated and to who – follow these up with regular review (at least weekly until the risk has been reduced) List the actions necessary to address the resident's mobility issues. • 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 • If a wheelchair user, specify: o Who does the wheelchair belong to? The person, the home, other? o How do they use the wheelchair – support from carer? Self-propel? o Does the person use a lap belt? Does the person have capacity? Is there a best interest

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	• Good - 0 • Reluctant to ask - 2 • Unable to ask - 3 Medication: • Diuretics - 1 • Hypnotic (sleeping tab) - 2 • Sedative (hypotension) - 2 • Antipsychotic - 1 • Antihypertensives -1 • Anti-depressants -1 Anti-emetic -1 Environment • Inappropriate footwear – 2 • Clutter – 3 Once completed total the score to indicate level of risk: • 0 to 5: Low Risk • 6 to 10: Medium risk • 11 and above: High Risk (See "Prescription" for required outcomes for each level of risk) Also consider the following points separate to the risk assessment: • 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 CARE: 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		decision in place? o 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 and the frequency of laundering the sling. • 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.
Nutrition	• For all residents, refer to the MUST tool form and write up the assessment steps in the "NOW section, i.e. type	• To be able to enjoy his/her meals	• Outcomes of the Choking Risk Assessment: • Low Risk - Staff to be aware of choking risk.

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	"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 have nutritional support, vitamins, cream shots, supplements
	• Outline history of weight gain/loss
	• Is the resident a diabetic? If so, state what their target blood sugar is and if in addition they are insulin dependent, state any outlying symptoms of hypoglycemia.
	• Give any history of choking and, if so, conduct a choking risk assessment as per **"Choking Risk Assessment"** in Section 1.1 of "Documents" in the home's website and specify the scores for each of the following:
	  • Cognitive Function
	  • Alertness
	  • Postural Control
	  • General Health
	  • Fatigue
	  • Oral Health
	  • Respiratory Function
	  • Mental Health
	  • Pain Management
	  • Environment
	  • Distractibility
	  • Medical Conditions
	• Specify if there has been referral to GP/Dietician/SALT.
	• Does the person have an Enteral feeding tube?
	• Discuss concerns for Hydration for example ANY event of a UTI, person unable to initiate drinking and complete Hydration Risk Assessment as below. Specify the scores for the following (one score from each section):
		• To put on/maintain/lose weight
		• To support choice of diet
		• To support religious observance.
			• Medium Risk – Refer to GP/SALT.
			• High/Severe Risk - Refer to GP/SALT and specify safest consistency/texture, feeding strategies, positioning, utensils and quantities.
			• 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
			• If the resident is an insulin dependent diabetic, specify when blood sugar readings are taken and when insulin is administered. Specify that the glucose meter should be calibrated and that the site must be rotated.
			• Specify how to treat an episode of hypoglycemia as follows (reading 4mmols or below):
			  • Specify where their hypo box is.
			  • First give one item from box if possible.
			  • Retest blood sugar and if there's no change, give another item.
			  • If reading is above 4mmols, give starchy food such as sandwich or cereal bar.
			  • If above isn't effective, apply glucose gel to inside of cheeks and massage gently.
			  • If they have several episodes of hypoglycaemia a week, contact professional to find out the underlying cause. Medication may need to be adjusted, or there may be another condition causing hypoglycaemia that needs to be treated.
			
			Hydration risk assessment outcomes:
			Score 0-4 – low risk – repeat screening monthly.
			Score 5 - 10 Medium Risk. Push fluids, encourage fluids every 2 hours.

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	<table><tr><td>1) Fluid Intake: •1500- 2000mls or more daily •Less than 1500mls daily</td><td> 0 5</td></tr><tr><td>2) Mental Condition: •Mentally alert at all times •Confused at times •Confused •Agitated and restless</td><td> 0 3 4 5</td></tr><tr><td>3) Ability to drink: •Independent •Requires prompting •Requires encouragement •Requires assistance •Swallowing difficulties</td><td> 0 1 2 4 4</td></tr><tr><td>4) Ability to ask for help: •Good •Reluctant to ask •Unable to ask</td><td> 0 2 4</td></tr><tr><td>5) Medical condition: •None •Infection •Constipation •Bowel disorder •Urinary Tract Infection • Kidney disease</td><td> 0 2 3 3 4 5</td></tr><tr><td>6) Medication: •None •Diuretics</td><td> 0 3</td></tr></table> • Are there any Religious considerations?		Score 11 + High Risk. Commence fluid intake and output chart and reassess, if no increase in scoring, refer to the GP. Record how we manage the risks and what steps are taken to improve the person's fluid intake. Record how this is monitored.

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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?
	• If the resident is prescribed any anticoagulants, specify that they are at higher risk of bleeding.
	• 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

Sleeping	• Specify preferred times for going to bed and getting up. • Give any history of walking at night • Is the person orientated to day/ night time • 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, provide an explanation and confirm if other, less restrictive options have been explored. • Type the following Risk Assessment in the "NOW" section	• ……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.

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	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 ……". • Confirm if the person can consent to bed rails or if a MCA assessment and BI decision has been made and why. Confirm that the Local Authority has been notified of a potential DOL/S (depending on their residency status)		
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 • How do we ensure that we minimise social isolation if a person is at risk.