SHANNON COURT CARE HOME LTD.		
	Issue Date: April 2019	Reviewed May 2021
	Next Review: May 2024	

ADMISSION OF A RESIDENT POLICY

A: OBJECTIVE: To define the procedure for admitting a resident and for developing an appropriate individual Care Plan.

B: RESPONSIBILITIES: Manager/Clinical Lead/Person in charge of shift.

C: PROCEDURE:

1. A support plan is prepared pre-admission by a social worker or ward staff and this is sent to the Clinical Lead and Manager of the Home. 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 determines if the Home can meet the needs of the resident. The information evaluated includes their:

- Current situation
- Mobility, falls risks
- Eating and drinking
- Behaviour and risks
- Washing and dressing
- Continence issues

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.

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2. Contractual details will be finalised with the Manager and again must be signed and returned to the Home prior to admission date.

3. 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.

4. 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.

5. At admission the resident will be met by the person in charge of the shift, and taken to his / her room.

6. 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.

7. Particular attention is paid to showing the resident the Fire Exits and the evacuation procedure to be followed in the event of a fire.

8. The person in charge of the shift will enter the resident's details into the following:

- Admissions Book
- Resident Admission Form
- Handling Risk Assessment
- Waterlow Chart
- MUST Assessment
- Family Doctor Service Registration after speaking with family members
- Health Assessment Form for the GP
- Resident's Property List and a photograph of any jewelry that the resident is wearing
- Body Map and a photograph of any skin damage, marks or bruises on admission
- MAR Sheets
- Daily report detailing admission and general health.

9. The Staff will check that:
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.

10. The person in charge will check all medication boxes to ensure they are labelled with correct information. Medication is counted and the total is documented on the eMAR system.

11. 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.

12. When a resident is coming from 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.

13. Staff to encourage relatives not to leave valuables at the Home. Where possible relatives should take jewelry home and, if required, to substitute jewelry for less valuable jewelry 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.

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