# Admissions, Assessment and Care Planning Procedure

## Care Plan 72Hours checklist

This checklist should be used to track the completion of each individual person care plan file. **72 hours** after admission people **MUST** have a checklist completed.

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| Person’s Name: | Date of Birth: |
| Home: | Unit: |
| Information checked & by whom: | |

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|  | Check List – All sections | Yes | No | N/A |
| 1 | The front page fully complete with no blank sections |  |  |  |
| 2 | The initial assessment was completed in FULL prior to admission and signed off by manager or designated senior to say the home can meet the persons’ needs. |  |  |  |
| 3 | Any additional equipment and/or support identified during the pre-admission process was in place prior to the admission day. |  |  |  |
| 4 | The person’s photograph has been taken and attached with date noted. (This is to be updated annually at minimum) |  |  |  |
| 5 | The initial and ongoing assessment is complete with date, assessment type, name, status, and signature of assessor. Evidence of person/relative’s/ other representatives’ involvement in this assessment must be detailed. |  |  |  |
| 6 | The person’s known allergy status is documented on the assessment, MAR front sheet and MAR charts / EMAR in services where electronic system is used. |  |  |  |
| 7 | A summary statement of current care needs and abilities has been recorded on the front page of the care and support plan. (includes a summary of medical conditions). |  |  |  |
| 8 | DNACPR and advance directive section completed, if appropriate and is in date.  If a valid DNACPR is in place, the original documents which have been signed by an authorized person are kept in the office and are accessible by senior staff. The original DNACPR will also be uploaded to the online system used in connection to care planning. |  |  |  |
| 9 | Current illnesses and infections are accurately recorded, and each is supported with a Personal Care Plan (PCP). |  |  |  |
| 10 | All activities/abilities within individual assessment sections have identified assessment scores. |  |  |  |
| 11 | All assesses activities/abilities with scoring two or above have a documented Personal Care Plan written in bullet point.  The person choices and preferences section of the PCP has been completed |  |  |  |
| 12 | Daily Life and review records were started on the day of admission and at least one every 12 hours thereafter, following guidance and protocols outlined within the PCP document. |  |  |  |
| 13 | All applicable prompts and actions on the PCP documents have been completed in as much detail as possible. |  |  |  |
| 14 | Safety Risk assessments have been completed as applicable – bedrails, bedroom safety checklist, wheelchair, lap straps and specialist equipment etc. |  |  |  |
| 15 | GP and other medical staff/professional visits (non-GP) record sheet/ log is in place in preparation to record advice and outcomes following each future interaction/ visit. |  |  |  |
| 16 | The mandatory Waterlow risk assessment and skin integrity PCP have been accurately and fully completed on admission. These should be reviewed monthly at minimum. |  |  |  |
| 17 | A body map has been completed on admission. A body map should also be completed at the end of a service stay. |  |  |  |
| 18 | If wounds are present the Wound PCP has been fully completed, the body map is up to date, photographs are available and wound assessments completed. Each wound must have an individual PCP. Consented photographs are taken of affected areas, stored on the person’s file, and shared with relevant professionals when referral is required, where external input is needed such as that of a District Nurse. |  |  |  |
| 19 | The Moving and Handling and Mobility risk assessments are present, and every field has been fully populated and reviewed monthly. Maintaining a safe environment and mobility care plans are in place and are to be reviewed monthly or more frequently if the person’s needs/ abilities change. |  |  |  |
| 20 | The Falls risk assessment has been accurately and fully completed on admission and reviewed at least monthly. A PCP has been completed identifying actions needed to reduce risk and links with the safety section. |  |  |  |
| 21 | If the person has a condition that impacts on Mental state and cognition, the core PCP documents have been completed, and appropriate supplementary recording forms are used if needed.  Evidence is seen of planned outcomes representing best interest decisions |  |  |  |
| 22 | Is there any evidence that MCA/DoLS has been considered, referrals made as required, and PCP implemented. |  |  |  |
| 23 | A Breathing PCP has been completed if appropriate to a person’s medical condition and equipment used AND if the person is smoker. |  |  |  |
| 24 | The MUST nutritional risk assessment has been accurately and fully completed on admission. This should be reviewed at monthly intervals thereafter and relevant support should be sought in line with Food First procedures. |  |  |  |
| 25 | Admission weight has been recorded in the appropriate weight recording form and agreed intervals of weighing have been determined in connection with the risk assessment rating.  Outcomes and actions taken following weight checks to be recorded in the daily life and review records |  |  |  |
| 26 | The mandatory eating and drinking PCP has been completed and evidence actions needed. Outcomes of actions taken are to be evidenced in daily life and review records. |  |  |  |
| 27 | Where there is a clinical justification a food and/or fluid diary has been implemented and completed accurately. |  |  |  |
| 28 | The mandatory Hydration PCP has been completed and evidence of actions needed. Outcomes of the actions taken are to be evidenced in daily life and review records. |  |  |  |
| 29 | The continence PCP has been completed and evidence actions needed. Outcomes of actions taken are to be evidenced in daily life and review records. |  |  |  |
| 30 | Where there is a clinical justification has a fluid intake and output chart been implemented for accurate completion? |  |  |  |
| 31 | The personal Hygiene PCP has been completed. |  |  |  |
| 32 | The mandatory sleeping PCP has been completed. |  |  |  |
| 33 | The pain management PCP has been completed if required and supported with the appropriate pain assessment tool. |  |  |  |
| 34 | The medication PCP and medication history has been completed and must be updated following GP and or other healthcare professional’s reviews. |  |  |  |
| 35 | For people who are admitted for a stay of six weeks or more, the lifestyle PCP and map of life have been completed and must be reviewed as necessary following any change in need. |  |  |  |
| 36 | The Who am I document has been fully completed and should be updated as changes occur, or new information is provided. |  |  |  |
| 37 | Short-term plans are in place as required by changed in medical condition and must be reviewed when in use/activated. |  |  |  |
| 38 | The End-of-life PCP has been completed. |  |  |  |