Central Bedfordshire

Admissions, Assessment and Care Planning Procedure

Care, Support and Quality Improvement

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Admissions, Assessment and Care Planning Procedure

Directorate:	Adult Social Care and Housing		
Division & Service:	Adult Social Care		
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Policy Owner Signatories

Name	Title/Role	Signature	Organisation	Date
Amy Thulbourne	Head of Care, Support and Quality Improvement		Central Bedfordshire Council	01/07/2025

CQC Assurance Key Areas:

This policy document supports CQC Assurance Key Areas:

Safe	Effective	Caring	Responsive	Well-led
●	●	●	●	●

This document is not controlled when printed.

It is the responsibility of every individual to ensure that they are working to the most current version of this document.

Contents

1. Introduction

1.1. This procedure covers the planning and undertaking of emergency, scheduled respite, and permanent admissions to the residential care home and short stay services from the person's own home, another residential care home, or hospital.

1.2. The procedure is linked to the Person-Centred Care Policy which it states that:

- Care and Support Plans are essential to ensuring people receive care, support, and treatment that is person-centred.
- Care and Support Plans must be developed using the principles that underpin the Mental Capacity Act.
- Person, or someone acting on their behalf, must be involved in a meaningful way in all discussions related to assessments, admission, and the development of care and support plans, including reviewing the continuity of care needs and any changes that may be required while receiving a service

1.3. The objective of the procedure is to ensure a smooth and safe admission to the service, respecting the person's choices.

2. Pre-Admission Assessment and Preparing for Admission

2.1. Prior to admission to the service, assessments must be carried out to ensure the service is suitable for the person.

2.2. Once a referral is made to the service, further information may be needed. If the service required is that of a full-time residential care home, a Trusted Assessor report may be appropriate to determine if the home is able to meet the person's needs. Alternatively, a face-to-face visit may be arranged for a suitable date and time where an appropriately trained member of staff, usually the registered manager or deputy manager to carry out an assessment. If the service requested is that of short stay such as Step Up Step Down, a Trusted Assessor report would be requested to identify if the service can meet the needs of the person. The aim of the pre-admissions assessment is to assess whether or not the care home will be able to meet the person's needs.

2.3. The pre-admission assessment should take place in the person's home. Although there may be occasion when circumstances mean the assessment needs to be undertaken elsewhere, such as in hospital or another care and support service.

2.4. It is important that the person and where appropriate their family, carer, or someone acting on their behalf are fully involved in the process. This will help ensure that the pre-assessment is as informative as possible.

2.5. To ensure that the service would be able to meet the person's needs the results of the pre-assessment must be discussed with the service manager or their deputy.

2.6. The person's social worker must be informed of the outcome of the pre-assessment and, if a place cannot be offered, the reasons why. Refusal of a place at the service must be based on the risk to the person in terms of suitability of accommodation available at the service.

3. Emergency Admission

3.1. An emergency admission is defined as an admission to the care home at any time of day without an assessment. This means that it will not be possible to complete the pre-admission assessment and preparing for admission procedure before admission.

3.2. However, the registered manager or senior member of staff should ensure that the following actions have been taken:

- The person's social worker is contacted for a copy their assessment of person's needs, this should be done prior to admission when possible.
- As many points as possible from Pre-Admission Assessment form are discussed in person or over the phone with the person / their representatives / their social worker / current carer / medical consultant prior to admission taking place.

3.3. Pre-admission Assessment form should be completed on admission.

4. Preparing for Admission

4.1. The registered manager will identify a named team leader and key worker for the new person and ensure they have an opportunity to meet prior to admission or on admission.

4.2. The person or their representatives should be encouraged to visit the service prior to admission. They will be encouraged to personalise the person's room and advised to label all of their belongings prior to admission.

4.3. The registered manager or a senior member of staff will explain to the person or their representative the admissions process. The following will be considered:

- Timing e.g. emergency / hospital referral.
- If the person lacks capacity a DOLs referral has been submitted.
- Current GP has been contacted and the medical summary obtained.
- The persons preferred timescales.
- Availability of equipment to meet the person's needs.
- Bedroom safety checks have been carried out by maintenance.

5. Admission

5.1. The person and their companion must be greeted by the person in charge that day or the administrator and offered to be taken to their room. If their next of kin is not with them, they should be informed that the person has arrived at the service.

5.2. The person should be offered a hot drink and allowed some time to settle.

5.3. The person in charge will provide the person and their representative with a detailed, step-by-step explanation of the admissions process. They will also be given information about the available services and the operation of the service.

5.4. The person will be offered the opportunity to meet staff, people who live at the service and familiarise themselves with their surroundings. This must be done at a time that is suitable for the person, when they feel comfortable and relaxed.

5.5. Once the person has had time to settle and relax, the following actions will be taken (staff must ensure that consent is obtained from the person or their representative where required):

- The person's name will be entered into the fire register and the fire evacuation procedure will be explained.
- All belongings will be checked in and recorded on a property list which will be signed by the person or their representative and the member of staff carrying out the checking process.
- The person's photograph will be taken, and a copy will be place on their file front sheet, their biographical details sheet and on their medication front sheet.
- The person will be weighed and their height measured.
- The person will be shown how to use the call system.
- All risk assessments must be carried out and documentation completed and in place.
- A maintenance person will carry out a PAT test on all electrical equipment that the person has brought with them.
- A body map will be completed even if a body map has been provided by a previous health care setting.

6. Assessment

6.1. Within 72 hours of the person moving into the service, a full needs assessment must be carried out. This must be conducted by an appropriately trained person and is the responsibility of the team leader or a more senior member of staff.

6.2. The needs assessment will help to identify the level of support the person requires, any health issues, medication, requirements related to eating and drinking, and lifestyle, cultural, and social interaction preferences.

6.3. A comprehensive list of documentation that should be completed, where appropriate and relevant to the person's needs, see Appendix 1. These will form the basis of the person's care and support plan.

7. Care and Support Plans

7.1. The purpose of a Care and Support Plan is to clearly explain how care and support will be delivered to a person. It will ensure continuity of care and provide a record of service delivery.

7.2. All Care and Support Plans should be overseen by the Registered Manager.

7.3. Care Plans must be clear, legible, and free from jargon and abbreviations. They should be based on the assessment, be factual, accurate, and include information about the following:

- The individual's personal choices, likes, dislikes, and preferences
- Identified issues, concerns, and risks
- Any goals or outcomes the person wants to achieve
- Physical care
- Mental health and mental capacity
- Social care
- Personal relationships
- Emotional care
- Hobbies and activities
- Religious and spiritual beliefs

See the Appendix 1 - Care and Support Plan 72-hour checklist and Appendix 2 - Care Plan support document.

7.4. To ensure continuity of care, care staff must ensure that Care and Support Plans are kept up to date so that they provide an accurate record of:

- Any changes to the planned care
- Any decisions about the person's care and how they were made
- A date when the Care and Support Plan will be reviewed – this should be done monthly
- New entries, which must include a time, date, and signature
- Corrections fluid should not be used. Instead, a line should be put through the text to indicate a correction.

7.5. A change of circumstances, such as a new health-related condition, must result in a review of the Care and Support Plan.

7.6. Care staff must keep up to date with care and support plans to ensure they are aware of needs and preferences.

7.7. Daily life entries must be made by each shift over a 24-hour period. Entries must include day-to-day care and activities, visits by GPs and other health professionals, and any incidents or accidents.

7.8. All daily life entries must be legible, accurate, include the date and time, and be signed.

7.9. Registered managers and senior members of the team must monitor and audit care plans regularly.

8. Relevant Policies

- Person Centred Care
- Falls Prevention and Management
- Nutrition and Hydration
- Pressure Ulcer Prevention and Management
- Medication Management

9. Monitoring and Reporting Arrangements

9.1. The implementation of this procedure will be monitored by managers via regular audits and supervision. The results of these audits will be reported to Operations Manager, the Head of Service and during managers meetings.

10. Evaluation and Review

10.1. This policy will be reviewed 2 yearly. In addition, the policy will be amended when new legislation is introduced, including identification of risks identified during investigations, to ensure that the services are meeting the needs of people safely.

11. Appendices

- Appendix 1 – Care and Support Plan 72-hour checklist
- Appendix 2 – Care Plan Supporting Guidance

12. Reader Confirmation

Reader Confirmation
Please click the link below to complete the reader confirmation form. This form is to verify that you have read and understood the contents of this document: ASC Policy Reader Confirmation Form