

HUTTON PARK RESIDENTIAL HOME

ADMISSION PROCEDURE

Pre-admission information

On receiving an enquiry for accommodation the service user/representative will be provided with a copy of the Terms and Conditions under which the accommodation will be offered.

A brochure detailing the services provided and the cost of same, plus any other relevant information will be provided.

Introductory Visits

The person should visit the home in advance. The introductory visit needs to be long enough for the person to view the facilities, have refreshments and meet the staff on duty.

The visit should not be overplayed to create a false picture or atmosphere. Advice should be given about possessions which can be accommodated in the bedroom.

Admission to a home is a traumatic time for older people, which causes anxiety and stress, more so if the admission is for a long term. Service users therefore need good support from staff and the move into residential care should be viewed as positive and a chance to improve the quality of life.

Assessment Documents

In accordance with Hutton Park's care management process these should be completed and a recent social work assessment providing any recent medical history be provided.

Trial Stay

Service users who are contemplating a move into residential care on a long term basis need to be made aware that no final decision has to be made until after their four week trial period ends.

The Admission Day

First impressions of the home are important, therefore staff need to be aware of the anxiety that a new resident will feel when moving into a residential home. The admission process should not be hurried.

Timing of Admission – flexible to allow a warm welcome, refreshments for service users and relatives, settle in bedroom and unpack belongings.

Routines – meal times, location of bathrooms and lounges, are all new areas for a service user to absorb. A welcome pack will be provided in the bedroom for service users and relatives to refer to.

Existing service users – they should be prepared for the new arrival and some responsibility be given to them to welcome a new person into the home.

Staff responsibility – whenever possible the Key worker should be on duty at some stage of the admission day. Staff should establish how the person wishes to be addressed and should obtain information regarding medication and routines established by the new service user. Staff groups can be confusing to people not used to large numbers.

A detailed inventory of items brought into the home should be completed.

Support after Admission

All staff should continue to introduce themselves by name and check out regularly whether the new resident has any concerns or worries or issues with other service users.

Individual Care Plan

The appropriate timing of an individual Care Plan needs consideration. Some thought to this should be given before the first review and discussed with the service user.

All Care Plans should be realistic and achievable and agreed by the resident. There must be a Care Plan for each service user in the home which will be reviewed on a monthly basis. Care Plans should focus on the following:

The abilities, background, interests and wishes and needs of the individual.

The action necessary to maintain abilities, interests and meet needs of the individual.

Any special services, aids and care necessary.

Other people who may help, such as family, friends, community resources, relevant professionals.

Review – Initial and Ongoing

A review of the trial period should take place within four weeks of admission. If a decision is made by the service user to stay in the home the Care Plan should be agreed. If the service user decides not to stay at the home, the discharge policy should be implemented.

Ongoing reviews will be held on a six monthly basis. Relatives/representatives of the service user will be invited to attend these reviews. Reviews will be conducted in a non-threatening environment to the Service User.

Transfer to Hospital or Nursing Home

If a service user has to leave the home, either to go into hospital or a nursing home, the process needs sensitive handling. All the same anxieties will have been felt by the service user when they came into the home.

Hospital Admissions

Basic information will be required in writing – name, age, date of birth, GP, next of kin, and contact numbers, medication, and any special needs. (Service User's Profile Assessment and Medication Recording sheet to be taken with service user at the time of admission) Staff must notify the next of kin of the circumstances and admission to hospital.

Whilst in hospital the service user's room will be kept locked. The home will keep in regular contact with the hospital to enquire how the service user is progressing.

Transfer to a Nursing Home

There will be occasions when the home can no longer meet a service user's needs. If a service user is assessed as requiring nursing care by their GP or other medical professionals the home will support and facilitate the transfer to the appropriate home.

This situation will be treated with the utmost sensitivity to avoid feelings of rejection.