1.0 Policy

Admission of residents to Cowper Care Centre DAC (known as Cowper Care) is timely and is planned in a safe, fair manner in accordance with the resident's assessed needs and Cowper Care's waiting list as appropriate.

Upon admission, all residents are orientated to Cowper Care. A comprehensive assessment is completed as soon as practical after their admission, but within a maximum of 14 days of admission, and used to create the resident's Individual Care Plans (JCI, 2012; HIQA, 2016).

2.0 Definitions

Assessment: A process by which the resident's needs are evaluated and determined, so that they can be addressed (HIQA, 2016).

Comprehensive Assessment: An interdisciplinary process that includes medical health, physical, social, and psychological functioning, and religious/spiritual issues (JCI, 2012).

Colonisation: When micro-organism or micro-organisms are living on or in a person without causing disease (HIQA, 2018).

Emergency Admission: An admission to Cowper Care that is unplanned, unprepared, or not consented to in advance (HIQA, 2016).

3.0 Responsibilities

3.1 *All Staff shall:*

- Welcome resident to Cowper Care.
- Engage with, and support, new residents during their transition to Cowper Care (Age Cymru, 2011).
- Encourage residents and key staff members to offer friendship and understanding to the new resident and their family (Age Cymru, 2011).

3.2 *Nursing Staff shall:*

- Conduct admission, initial assessment, and make relevant referrals.

3.3 *Care Manager/Assistant Care Manager/Clinical Nurse Manager shall:*

- Evaluate adherence to the process.
- Allocate Key Workers/Care Leaders (a nurse and a healthcare assistant) for each resident.
- Allocate a staff member to support each new resident during transition into Cowper Care.

3.4 *Key Workers/Care Leader shall:*

- Co-ordinate resident care.
- Be responsible for the provision of effective care to the allocated resident (JCI, 2012).

4.0 Principles of Assessment

4.1 Assessment of residents in Cowper Care shall:

- Be resident–focused and based on resident's actual, potential, and perceived needs.
- Provide baseline information on which to plan the interventions and outcomes of care to be achieved.
- Facilitates evaluation of the care given and is a dimension of care that influences a resident's condition and circumstances.
- Be a dynamic process that starts when problems or symptoms develop and continues with changes in the resident's condition throughout the care process, accommodating continual changes in the resident's condition and circumstances.
- Be an interactive process in which the resident actively participates.
- Consider optimal functioning, quality of life and the promotion of independence for the resident.

- Include observation, data collection, clinical judgement, and validation.
- Follow a structured process and be clearly documented (Dougherty and Lister, 2015).
- Assess the individual care and support needs of a resident, with maximum participation from the resident (HIQA & MHC, 2019). During all assessments, Cowper Care shall identify and clearly document potential risks and how they will be managed (HIQA & MHC, 2019).

4.2 Health and Social Care Professionals shall be involved in the assessment process, as deemed required by the Care Manager/Assistant Care Manager, based on the resident's identified needs.

4.3 Where the resident's condition change or deteriorate at any stage during the delivery of care, the assessment process shall be reviewed, and reassessment completed as deemed required (see HS-003 Resident Reassessment).

4.4 Residents with dementia/cognitive impairment have a unique set of care needs, which include, progressive cognitive impairment, diminishing capacity, communication difficulties, possible responsive behaviours and a prolonged illness trajectory leading to uncertainty in relation to prognosis (Irish Hospice Foundation, 2016). These needs shall be appropriately assessed and managed accordingly by Cowper Care staff and supporting Health and Social Care Professionals.

4.5 **Assessment Techniques**

4.5.1 Evidence based assessment tools shall be utilised for all assessments where available to:

- Ensure a standardised approach is used to obtain specific resident data, that can evaluate the effectiveness of clinical interventions and care.
- Encourage residents to engage in their care.
- To provide simple methods that are acceptable to the residents, have a clear and interpretable scoring system to demonstrate reliability and validity.
- (Dougherty and Lister 2015) (JCI, 2012)

4.5.2 Assessment interviews shall be utilised to:

- Make the resident feel comfortable telling their story.
- To allow the assessor to emphasise the confidential nature of the discussion and take steps to reduce any anxiety of the resident, including ensuring privacy as residents may modify their words and behaviour depending on the environment.
- Assist in the flow of information through the use of:
    - Open questions,
    - Restating what has been said to clarify certain issues,
    - Using verbal and non-verbal ques,
    - Verbalising the implied meaning,
    - Using silence,
    - Summarising.

(Dougherty and Lister 2015).

4.5.3 Where residents are unable to provide information, appropriate details shall be taken from relatives/representatives where possible (Dougherty and Lister 2015).

4.5.4 Assessment findings may also arise from self-reporting of issues by the resident, issues reported by the resident's relatives/representatives, direct observation, and medical records review.

4.6 Ordering of required tests and investigations arising from the assessment process, and the reporting of critical information arising from these tests, shall be directed as detailed within HS-023 Indications for Use Administration and Follow-up of Diagnostic tests.

4.7 On completion of the initial nursing and medical assessments, the resident data shall be integrated, analysed and an associated plan of care shall then be developed and implemented (JCI, 2012) (see HS-002 Resident Care Plan Development and Implementation). This process shall be completed with the required multidisciplinary involvement of those involved in the provision of the resident's care. Continuity of resident care shall be implemented by the Key Workers/Care Leaders (see section 7.0 of this policy).

4.8 Cowper shall consider the need to share information about the resident's admission details with medical practitioners, health and social care professionals and resident family/representatives and whether this could potentially constitute a data breach (see RR-012 Obtaining Resident Consent (incorporating Assisted-Decision Making Capacity Act, 2015) (NHI, 2018).

Access to resident personal information shall be restricted to individuals depending on their roles and responsibilities in relation to the resident. The restrictions are detailed within IM-007 Management of Personal Data in Line with Data Protection Requirements (incorporating GDPR).

4.9 Cowper shall use a standardised process for the collection, filing, storage, sharing, retention and destruction of the resident's information. The management and control of personal data shall be in accordance with IM-007 management of Personal data in Line with Data Protection Requirement (incorporating GDPR).

5.0 Management of Preadmission Assessments

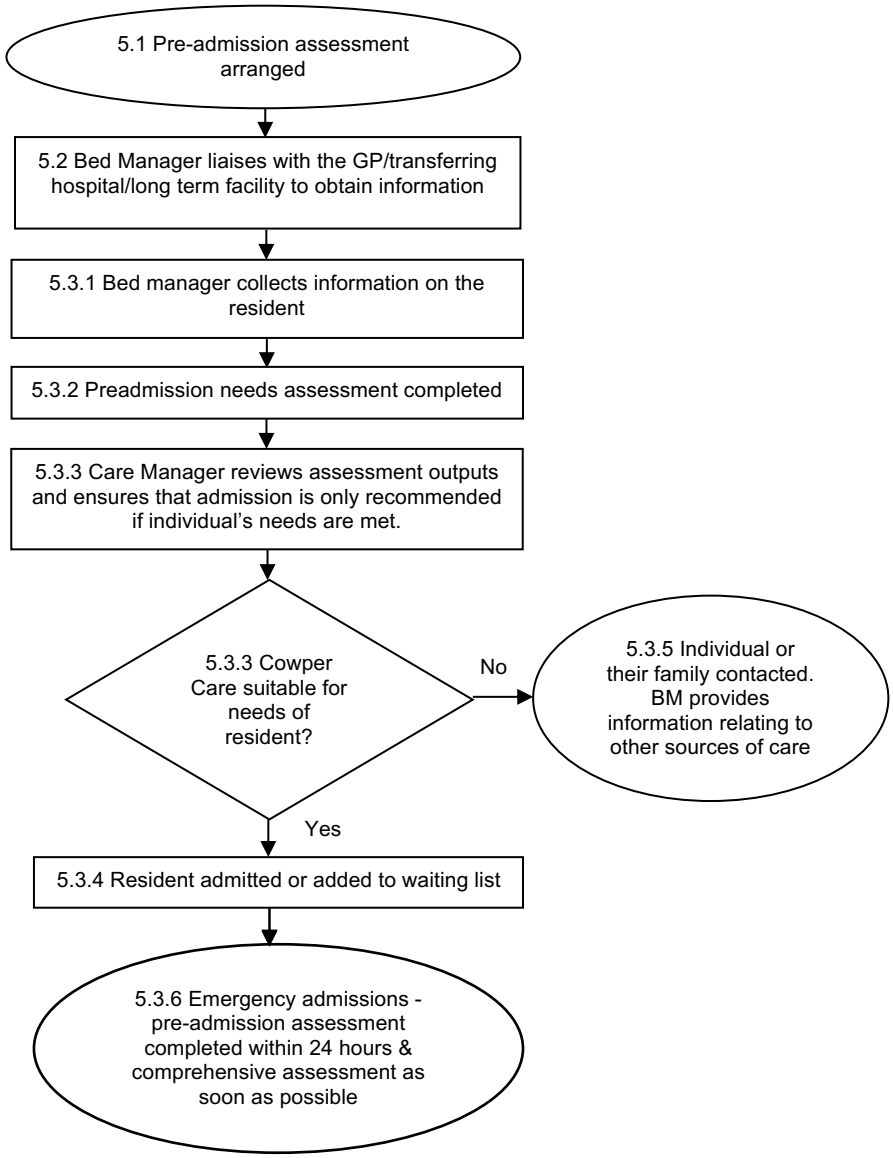


Figure 1.0 Management of Preadmission Assessments

5.1 Prior to admission, Cowper Care shall arrange a comprehensive preadmission assessment, by the Bed manager or an appropriately assigned person, to ensure its continued suitability to the needs of the prospective resident (HIQA 2016) and to obtain all necessary information relating to the

resident's health, personal and social care needs (S.I. No. 415 of 2013). The Bed manager shall identify an appropriate time and date to collate this information with the prospective resident, family, and hospital, where applicable.

The nursing staff shall establish an effective working relationship with prospective resident's family members. The resident's family members shall be encouraged and empowered to work with nursing staff to ensure each resident's needs are appropriately identified, understood, and met prior to the transition into Cowper Care (HIQA, 2013).

5.2 Where the resident is being admitted from another healthcare facility, the Bed Manager shall take all reasonable steps to ensure that all relevant information about the resident is obtained from the other healthcare facility (S.I. No 415 of 2013).

With the prospective resident's consent, Cowper Care shall liaise with the GP/transferring hospital/long term facility and obtain information about the prospective resident's:

- Medical history,
- Social circumstances,
- Historical list of medication (see HS-006 Prescribing, Ordering, Storage and Disposal of Medications Policy and Procedure),
- Current treatment,
- Ongoing support being provided by medical and other professionals,
- Tests completed such as evaluation of swallow,
- Mental health assessments (NHI, 2008) including behavioural concerns such as alcohol dependency, absconding,
- Completed risk assessments for nutrition, moving and handling, pressure ulcer, continence, falls to ensure all services and equipment are in place prior to admission (NHI, 2010),
- The resident's Common Summary Assessment (CSAR's), where the resident is admitted under the Nursing Home Support Scheme (HIQA, 2015b).
- Cowper Care shall share necessary information about a resident's colonisation or infection status on admission within and between services, while respecting the privacy and confidentiality of the resident to whom the information relates (HIQA, 2018).

This information sourcing may occur via transfer letter, phone call or other correspondence. Where it is not possible to gather all information prior to the prospective resident's arrival, the information shall accompany the resident when they are transferred/admitted and shall be retained within the resident record (see HS-032 Resident Transfer, Discharge and Overnight Leave).

This information shall immediately be transferred into the resident record and communicated to the relevant staff and Health and Social Care Professionals for utilisation to ensure continuation of care, including as part of the development of the resident's Individual Care Plans (see HS-002 Resident Individual Care Plan Development and Implementation).

5.3 **Preadmission Assessment**

5.3.1 The Bed manager shall arrive on site (at home/hospital) on the agreed date and time and shall show appropriate documentation and identification prior to meeting with the resident. The preadmission assessment may collect or confirm the following information:

- The name, address, date of birth, sex, and marital status of the individual.
- Preferred name and gender pronoun.
- The name, address, and telephone number of the resident's next of kin or of any person authorised to act on their behalf.
- The name, address, and telephone number of the resident's General Practitioner (GP) and of any officer of the Health Service Executive whose duty it is to supervise the welfare of the resident.

(S.I. No. 415 of 2013; HIQA & Safeguarding Ireland, 2019).

5.3.2 The preadmission assessment shall include the following:

- Decision-making capacity (see RR-012 Obtaining Resident Consent),
- Communication ability.
- Gait, strength, balance, or mobility problems.

- Risk/history of falls.
- Fracture risk.
- Ability to maintain a safe environment.
- Controlling temperature.
- Recreation and social interaction.
- Personal Cleaning and Dressing ability.
- Breathing and Circulation – Baseline levels:
    - Blood pressure level,
    - Pulse,
    - Respiratory level,
    - Breathing pattern,
    - Colour,
    - Use of inhalers,
    - Required positioning,
    - Smoker / non-smoker,
- Nutritional and hydration status (JCI, 2012).
- Elimination and Urinary system.
- Sleep and rest.
- The language needs of the resident (see RR-003 Resident Communication Techniques for checklist for assessing the language needs of a resident).
- Possible resident vulnerabilities (see PR-001 Safeguarding and Protection of the Resident).
- Fire safety and safe evacuation considerations (HIQA, 2021):
    - The residents' capacity and mobility.
    - Any wishes from the resident to bring their own furniture or belongings from their home.
    - Equipment requirements, both in terms of their rooms and equipment required for a safe evacuation from the residential home.
    - The availability of a suitable bedroom in a part of the residential home that meets the fire evacuation needs of the resident.
    - Any revisions required to the fire precautions for the residential home due to the needs of the individual.
- Other additional assessments as deemed required:
    - Barthel ADL Index.
    - Waterlow-Pressure Ulcer Prevention Assessment.
    - MUST Nutrition Assessment.
    - Mini Mental State Examination.
    - Scott Falls Risk Screen.
    - Geriatric or Cornell Depression Scale.
    - Agitated Behaviour Scale.

5.3.3 On completion of the preadmission assessment, the Bed Manager shall discuss the outcome of the assessment with the Head of Service – Care and the Care Manager, who shall ensure that admission to Cowper Care is only recommended if the needs of the resident can be met (NHI, 2010; HIQA 2016).

5.3.4 Where the Head of Service – Care and Care Manager identifies that the individuals medical, nursing, psychological and social needs can be met by Cowper Care, then the individual may be admitted or added to the waiting list for admission (JCI, 2012) (see RR-015 Management of Prospective Residents).

5.3.5 Where the Head of Service – Care and Care Manager identifies that Cowper Care is not suitable for the needs of the individual based on the results of the preadmission assessment, the Bed Manager shall contact the individual, and/or their family and/or the referral facility and inform them of this (JCI, 2012) (see RR-015 Management of Prospective Residents).

5.3.6 In the case of short notice admissions, or where a preadmission assessment was not completed prior to admission (e.g. a resident in the sheltered housing needs to be admitted in the nursing home within short notice), the pre-admission assessment shall be completed

within 24 hours of admission, to be followed by comprehensive assessment as soon as practical after their admission, but within a maximum of 14 days (JCI, 20212; HIQA, 2016).

6.0 Admission and Orientation

Resident introduction and orientation shall be undertaken as per the process below:

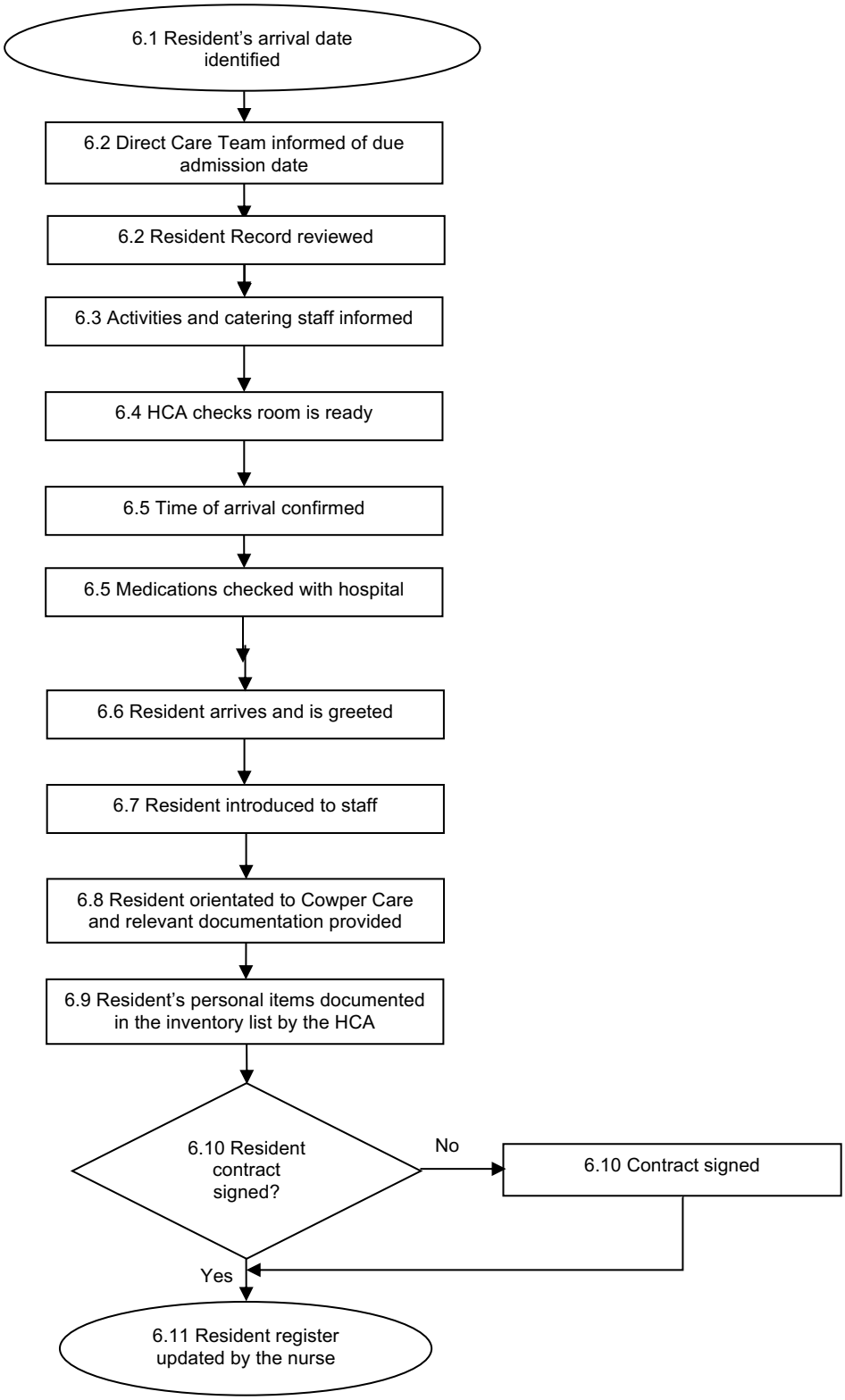


Figure 2.0 – Resident Introduction and Orientation

6.1 The arrival of a new resident at Cowper Care shall always be expected. Transportation for the resident shall be arranged by the resident's representatives/family member or facility from which they are coming from. Where residents are received as emergency admissions, their arrivals shall still be expected, and introductions shall proceed as detailed from section 6.6 below.

6.2 During the handover process on date of due admission, the direct care team shall be informed of the new admission due to arrive during the shift. A report shall be given to staff on key aspects of the resident's care prior to their arrival.

The resident record, which shall contain a copy of the resident's preadmission assessment, shall be reviewed by the nurse.

6.3 The Activities staff shall also be informed to identify a date and time to meet with new resident.

The catering staff shall be informed that a new resident will be arriving and of any special dietary requirements that they may have.

6.4 The pre-admission check list for the room shall be given to the resident's key worker, staff nurse or HCA, and they shall check the resident's room to ensure that it is ready for the resident.

6.5 The nurse shall confirm with the transferring facility, or a representative/family member, the time that the resident shall be arriving. The nurse shall obtain a copy of the resident's prescription from the hospital/ transferring facility/ resident's representative or family member/GP and send it to the pharmacy via *healthlink* as per HS-006 Prescribing Ordering Storage and Disposal of Mediations.

6.6 On arrival, the new resident shall be greeted and welcomed at reception of Cowper Care by the Care Manager/Assistant Care Manager. Where residents are being transferred via stretcher the ambulance personal shall enter through the ambulance doors. All other residents shall gain access through the main reception area. All the resident's representatives shall be requested to sign in the visitor's book and take the necessary infection control precautions.

6.7 The resident shall be introduced to staff as he/she meets them. The resident shall be brought to their room or the visitor's room if they are not in a private room.

6.8 Where the resident wishes, and where they are capable of doing so, the resident introduction to Cowper Care shall also include:

- a tour of the facility.
- orientation to their room including the bed and lights.
- how to use call bell.
- how to use the phone system/access to technology systems.
- an opportunity to meet with the chef to discuss dietary requirements and an information session regarding mealtimes, meal planning etc.
- valuables entered to inventory list, sent home, or handed to relatives/representatives for safe keeping.
- fire alarms and procedures explained.
- visiting and process for going out with relatives/representatives explained.
- Smoking policy explained.
- Resident's information board.
- The resident shall be provided with documents and information relating to the service and care provided within Cowper Care in an accessible format. Details of the information provided is specified within RR-001 Management of Resident Information and Education Materials. Staff shall spend time with the resident explaining the documents provided if the resident so wishes (HIQA, 2016). This time may be taken at admission or whenever requested by the resident.
- How the resident's transition into the service can be supported (see 6.12 below).

This orientation process shall take place at a pace appropriate to the resident's wishes and capabilities.

6.9 The nominated staff member shall document an inventory of the resident's clothes and personal items being brought in by the resident, in the resident property list. This must be dated and signed by the resident and/or their relatives/representative. All valuables shall be entered into an inventory list, sent home, or handed to the relatives/representatives for safe keeping.

6.10 The staff nurse shall ensure that the resident has completed and signed the Contract of Care (HIQA, 2016) (as per RR-014 Development and Agreement of Resident Contract/Statement of Terms and Condition).

6.11 Details of the resident shall be entered in the Resident Register as per IM-001 Resident Records – Initiation, Creation and Maintenance.

6.12 **Supporting Resident Transition into Cowper Care**

6.12.1 As part of the prospective resident's initial visit to Cowper Care, the Bed Manager and Care Manager/Assistant Care Manager shall discuss the individual's transition from their current living arrangements into the Cowper Care, and how it can be best supported (see RR-015 Management of Prospective Residents). As part of the admission process, this topic shall be further discussed and acted upon.

6.12.2 The resident shall be consulted with, supported, and involved in the planning for their transition from their current living arrangements into Cowper Care (HIQA, 2016).

Depending on the resident's identified needs, the Bed Manager and/or Care Manager/Assistant Care Manager shall spend adequate time with the resident, to plan support mechanism to ease the individual's transition into the service.

6.12.3 Non-emergency transitions between services shall provide for continuity in the residents' lives and seek to avoid or minimise any disruption. This shall be reflected in the resident's individual care plan (HIQA, 2016) (see HS-002 Resident Individual Care Plan Development and Implementation).

6.12.4 The Care Manager/Assistant Care Manager shall allocate a staff member to each new resident, and their family members, to help them to understand their feelings, the reasons for those feelings and why they might seem angry and suspicious (Age Cymru, 2011).

6.12.5 Cowper Care shall support the resident's independence in order to deal with issues such as loneliness and adjustment to a new environment (HIQA, 2016) through:

- Facilitating and supporting the resident's choice of daily activities (see QL-007 Facilitating Resident Daily Living and Activities).
- Maintaining their autonomy within Cowper Care (see QL-001 Maximising the Resident's Autonomy and Independence).
- Encouraging and assisting the resident to maintain relationships with family members, friends, the community, and other individuals who may be able to help them with the transition (see QL-007 Facilitating Resident Daily Living and Activities).
- Encouraging the resident to take an active part in the life of Cowper Care, to help out through doing activities they used to enjoy doing at home (Age Cymru, 2011)
- Encouraging the resident to decorate their room in accordance with their wishes and with furnishings from their home, if they wish to do so (HIQA, 2016) (see RR-005 Management of Accommodation and Communal Space).

6.12.6 Cowper Care shall encourage residents and staff to introduce themselves to new admissions and visitors (Age Cymru, 2011).

6.13 Current residents are informed of new admissions, with due regard to the rights of the resident for admission (HIQA, 2016). This may be facilitated within the Residents Representatives Group (see RR-011 Resident Involvement, Consultation and Feedback).

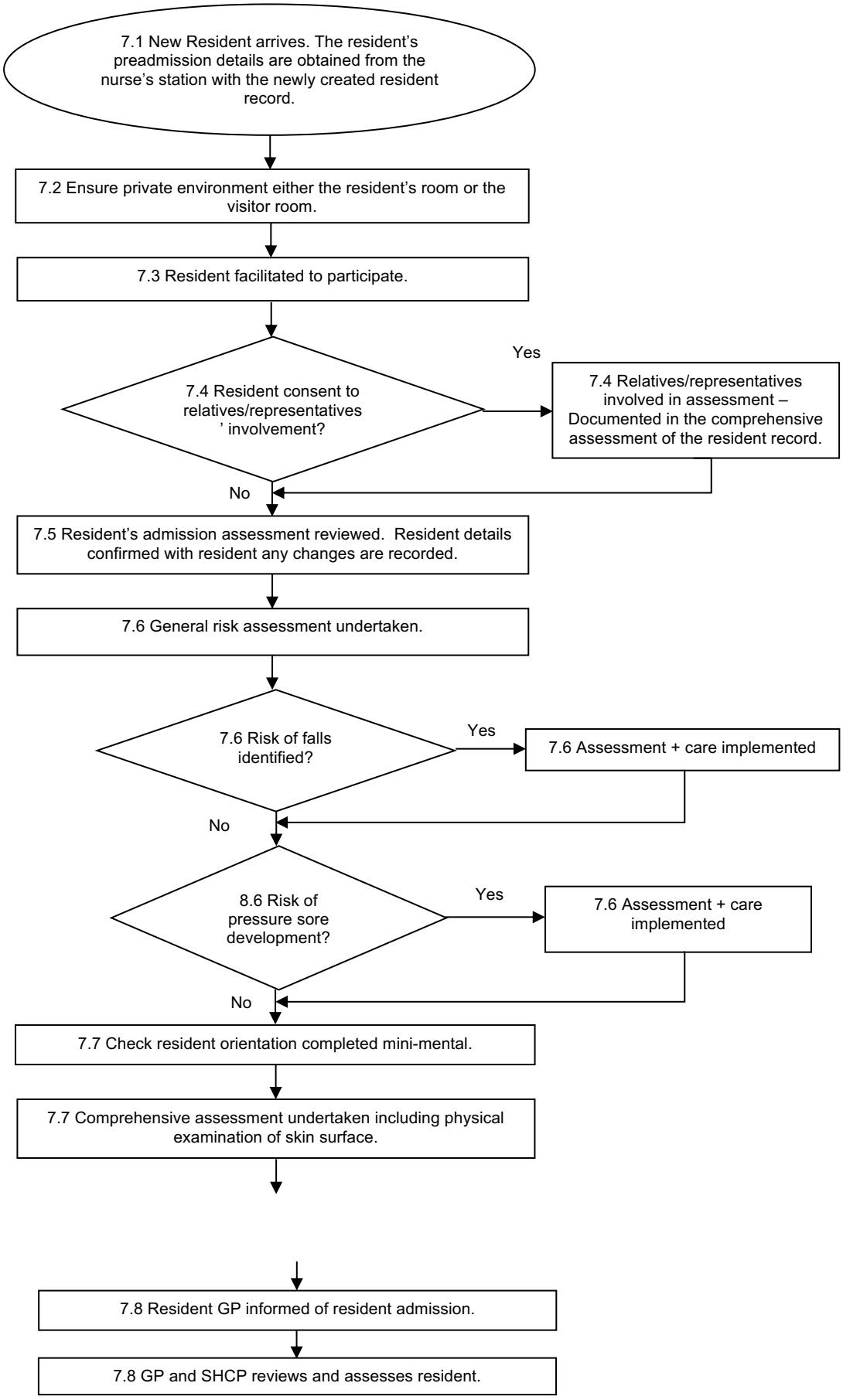
6.14 The resident, and where appropriate their relatives/representatives, shall be provided with basic safety and emergency planning education as part of the induction process. This shall include at a minimum:

- fire safety,
- electrical safety,
- environmental safety and mobility,
- bathroom safety,
- procedures to follow if a natural disaster or other emergency disrupts care or services.

(JCI, 2012) (see RR-011 Resident Involvement, Consultation and Feedback).

7.0 Assessment on Admission

Resident assessment shall be undertaken as per the process below:



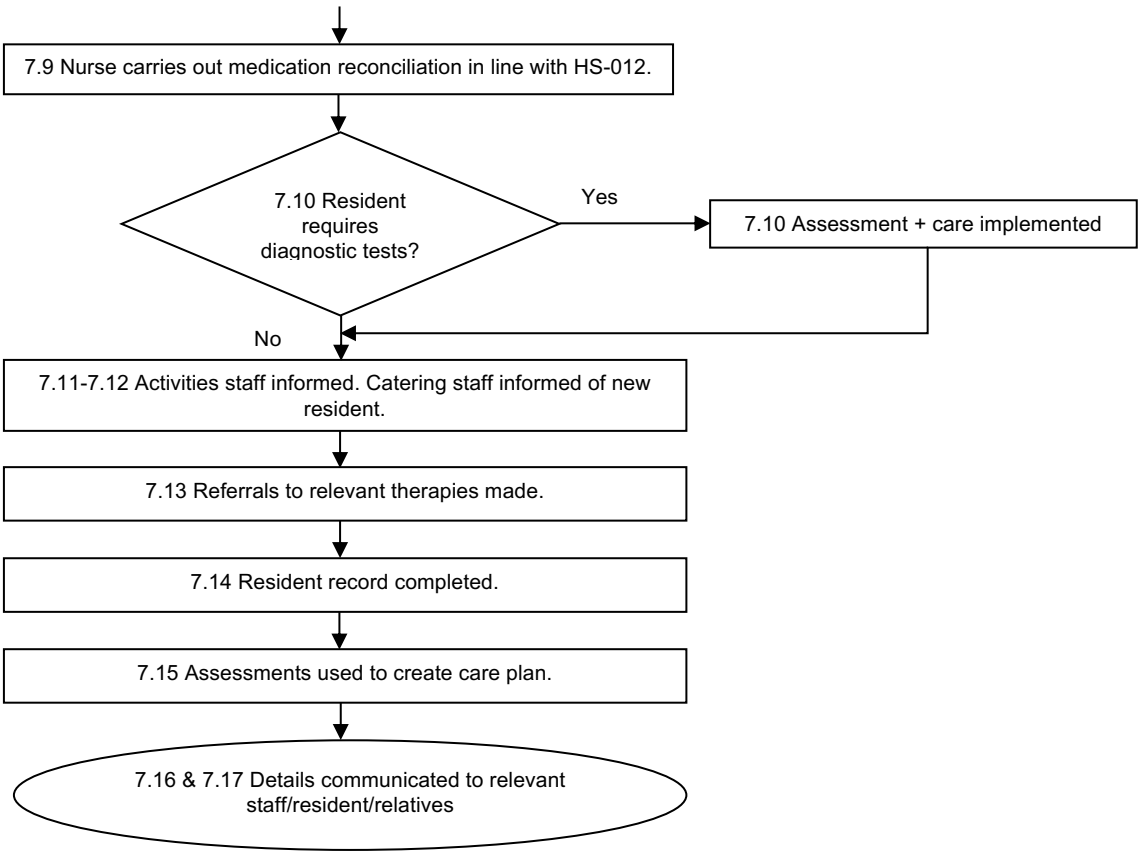


Figure 3.0 – Resident Assessment

7.1 The resident assessment shall be conducted by a suitably qualified staff member or Health and Social Care Professional where deemed required by the Care Manager. The resident's pre-admission details from the newly created resident record are obtained from the nurse with authorised access. The resident should be provided with information to facilitate consent for the assessment process (as per RR-012 Obtaining Resident Consent).

The nurse with authorised access shall only provide the relevant sections of the resident's record to the Health and Social Care Professionals who are responsible for providing or supervising the resident's care (as per IM-007 Management of Personal Data in Line with Data Protection (incorporating GDPR)).

7.2 The assessment shall be conducted in a private environment (*e.g.,* the resident's room) to maintain the dignity of the resident (see also RR-013 Respecting the Privacy and Dignity of the Resident).

7.3 Residents, including those with a cognitive impairment, shall be facilitated to participate in the assessment (HIQA, 2016) (as per RR-011 Resident Involvement, Consultation and Feedback).

7.4 Where residents provide consent, their relatives/representatives shall be facilitated to participate in the assessment (see also RR-004 Provision of Information to Resident's Relatives/Representatives) (JCI, 2012).

7.5 Resident details, including those detailed within section 5.3, shall be recorded / checked during the admission process:

- Resident's Details (e.g., Name and preferred name and gender pronoun, Date of Birth, Medical Card Number, Social Information etc.).
- Details of Family.
- Details of GP.
- Information received with resident from transferring facility/GP/Long term care facility.

(HIQA & Safeguarding Ireland, 2019)

7.6 A general risk assessment shall be carried out and recorded within 24 hours of admission to Cowper Care (JCI, 2012). This shall include:

- Allergies and Observations.
- Falls Risk Assessment: where a risk is identified, assessment and care are implemented as per HS-018 Prevention and Management of Falls.
- Risk Assessment for Pressure Sore Formation, using Waterlow. Where a risk is identified, assessment and care are implemented as per HS-013 Skin Care and Pressure Ulcer Prevention.

  Note: *It is recommended that the risk assessment for pressure ulcer is implemented within 6 hours of admission (NICE, 2015).*

- Introduction Checklist – ensure introduction/orientation is completed as per 6.0 above.

7.7 A comprehensive assessment of the resident's physical, psychological and social needs shall be completed as soon as practical after their admission, but within a maximum of 14 days or sooner if the risk assessment indicates (JCI, 2012; HIQA, 2016). This shall include the following evidence-based assessments and assessment interviews as applicable to the resident:

7.7.1 *Evidence Based Assessment Techniques*

- Barthel ADL Index: Activities of Daily Living Assessment.
- Tinetti/Cannard: Falls Assessment / Mobility level / Weight bearing ability *(part of the general risk assessment as per 7.6).*
- Dependency Level: based on HIQA dependency levels.
- Malnutrition Universal Scoring Tool (MUST): Nutritional Assessment (see HS-025 Nutritional status and Management Policy and Procedure).
- Abbreviated Mental Test Score: Cognitive Assessment.
- Urinary Incontinence Assessment: Elimination Urinary System assessment.
- Mobilization-Observation-Behaviour-Intensity-Dementia-2 (MOBID-1): Pain Assessment (see HS-022 Pain Management for Residents Policy and Procedure).
- Skin Assessment (Grading).
- Wound Assessment and tissue viability.
- Waterlow Assessment: Ulcer risk assessment *(part of the general risk assessment as per 7.6).*
- Oral care Assessment.
- Restrictive Procedures Assessment (see QL-008 Use of Resident Restrictive Procedures).
- Physical condition assessment/ Physical functioning ability (JCI, 2012; HIQA, 2015)), including inspection of the feet for abnormal pressure sites, infection, or ulceration (IDF, 2013).
- Sensory capabilities/impairments (HIQA, 2015; NICE, 2013).
- Psychological assessment:
  - Cognitive patterns – review for signs of delirium as well as dementia in confused residents (see HS-045 Management and Treatment of Delirium and HS-028 Care of Residents with Dementia).
  - Behavioural and psychological symptoms and signs of dementia, example Pain Assessment in Advanced Dementia (PAINAD).
  - Mood and behaviour, utilising, for example, the Geriatric Depression Scale.
- Palliative Care Assessment (JCI, 2012)
- Breathing and circulation (Baseline):
  - Blood pressure level
  - Pulse
  - Respiration level
  - Breathing pattern
  - Colour
  - Use of inhalers
  - Required positioning
  - Smoker / non-smoker

- Any other medical, nursing, or psychiatric assessments deemed appropriate to provide information on the condition of the resident at admission (S.I. No. 415 of 2013).
- Specialised assessments may be required for residents identified as being high risk:
    - Residents with additional needs due to their age, health, or disability, including:
        - Cardiovascular Disease (including Low Blood Pressure & Cerebral Vascular Accidents)
        - Respiratory Disease
        - Osteoporosis
        - Parkinson's Disease
        - Arthritis
        - Syncope syndrome
        - Neurological Disorders

      (NICE, 2015)
- Residents with acute or chronic condition or terminal illness, e.g., resident that is diabetic (or receiving/has received cancer treatment, etc. (see HS-048 Management of Residents with Diabetes Type 1 and HS-047 Management of Residents with Diabetes Type 2).
- Terminally ill residents.
- Residents with compromised immunity.
- Residents with suspected drug or alcohol dependency (see HS-044 Management and Treatment of Residents Alcohol Addiction / HS-044 Management and Treatment of Residents Drug Addiction).
- Residents with emotional or psychiatric disorders.
- Residents with mental or cognitive disabilities (JCI, 2012) (HS-040 Care of High-Risk Residents and Provision of High-Risk Services Policy and Procedure).
- Residents with specific needs that cannot be catered for within Cowper Care.
- Residents with Food Eating Drinking Swallowing disorders/dysphagia (see QL-002 Provision of Therapeutic and Modified Consistency Diets). These assessments may include observation of feeding, eating, drinking, and swallowing ability and collecting information on a resident's food/beverage preference (IASLT & INDI, 2014).

7.7.2 *Assessment Interviews:*

- Resident's personal background (HIQA, 2015).
- Allergies (part of the general risk assessment as per 7.6).
- Past medical and surgical history.
- Psychological assessment:
    - Grief/bereavement (JCI, 2012).
    - Family History.
- Behaviour patterns and Symptoms and signs of mental conditions:
    - History of aggressive/violent behaviour,
    - History of substance and alcohol abuse or withdrawal,
    - History of intent to harm others,
    - History of mental condition(s)/self-harm/suicide attempts (see QL-009 Meeting the Needs of Residents at Risk of Self Harm Policy and Procedure),
    - Previously detained under a section of the Mental Health Act,
    - Forensic, criminal related history, e.g., prisoners in hospital etc.,
    - Victim of abuse, neglect, or trauma (see PR-002 Recognising and Responding to Allegations of Abuse),

      Note: *Where a resident has been a victim of historical abuse or neglect, this information shall be provided to relevant care staff to enable them provide care within a manner considerate of the resident's experiences (JCI, 2012). This may be specifically relevant in the provision of personal hygiene care to the resident (see HS-029 Provision of Resident Intimate Care).*

    - History of disruption to service delivery and resources e.g., damage to property, equipment, disruption to staffing levels etc.
    - Current presentation of specific diagnoses, physical, cognitive, (especially communication) and psychological/emotional factors. (NHS, 2013; NICE, 2013).
- Emotional needs (HIQA, 2015).
- Emotional wellbeing (HIQA, 2015).
- Stress and coping:
    - The resident's perception of stress and its effect on their coping strategies.
    - Support systems are evaluated, and symptoms of stress are noted.
    - The effectiveness of the resident's coping strategies in terms of stress tolerance may be further evaluated.

      (Dougherty & Lister, 2015)
- Perception/concept of self:
    - The resident's attitude towards self, including identity, body image and sense of self-worth,
    - The resident's level of self-esteem and response to threats to their self-concept may be identified,

  (Dougherty & Lister, 2015; HIQA, 2015)
- Perception/concept of self
    - The resident's attitude towards self, including identity, body image and sense of self-worth.
    - The resident's level of self-esteem and response to threats to their self-concept mat be identified.
    - Orientation to time, place, and person.

  (Dougherty & Lister, 2015; HIQA, 2015)
- Health perception and management:
    - The resident's perceived level of health and well-being, and on the practices, they use for maintaining health,
    - Habits that may be detrimental to health.

  (Dougherty & Lister, 2015)
- National Screening Programmes – Cowper Care shall support all eligible residents to access to National Screening Programmes in accordance with the resident's wishes. The criteria for eligibility and assessment is detailed in HS-004 Promoting and Maximising Resident Health, Rehabilitation and Well-Being.
- Roles and relationships:
    - The resident's roles in the world and relationships with others.
    - Satisfaction with roles, role strain and dysfunctional relationships may be further evaluated.
- Possible vulnerabilities (where not completed during the preadmission assessment).
- List of current and historical medications, the resident's medication needs and their prescription and non-prescription medications.
- History in relation to self-medication (see HS-010 Self-Administration, Complementary Therapies and Over-The-Counter Medications).
- Comprehensive pain history is taken from the resident, and where appropriate, their family and other Health and Social Care Professionals who have treated the resident in the past. A self-report of pain is sought from the resident, regardless of their level of dementia/cognitive impairment (Cornally, et al., 2016).
- Immunisation status: including *influenza*, *tetanus,* and *pneumococcus*. The residents' general practitioner may need to be contacted for vaccination details.
- Infection control history, e.g., MRSA. Where the resident is identified as having a communicable/ transmissible disease, this shall be managed as per CE-004 Infection Control and Prevention. Where additional diagnostic

testing is required, this shall be implemented in accordance with HS-023 Indications for Use Administration and Follow-up of Diagnostic Tests.

- Communication needs (see RR-003 Resident Communication Techniques), including translation requirements, speech, and language, etc.
- Personal cleansing and dressing abilities and required supports.
- Current contact with Health and Social Care Professionals i.e., Endocrinologist, Physiotherapy.
- Bowel Pattern.
- Sleep and rest patterns.
- Ability to maintain a safe environment. Actual or potential problems relating to safety and health management may be identified as well as needs for modifications in Cowper Care for continued care (Dougherty & Lister, 2015).
- Preferences and expectations.
    - Recreation/social interaction preferences.
    - Spiritual needs and preferences (HIQA, 2015).
    - Cultural preferences (HIQA, 2015).
    - Preferences and values relating to ethnicity or religious requirements, including dietary requirements (see RR-010 Resident Rights Policy and Procedure and QL-003 Meals and Mealtimes - Planning and Facilitating Resident Choice Policy and Procedure).
    - Preferences in relation to daily routines, interests, desires, fears, concerns, their family and significant others' life events. Information sought may include:
        - What time the resident likes to get up in the morning, go to bed at night,
        - What makes him/her laugh or cry,
        - What is his/her favourite time to bath or shower,
        - What he/she likes to eat when out for a treat,
        - Approaches or activities that have been useful to settle the resident when he/she has become cross, upset, or distressed.

      (Cahill and Moore, 2012)
    - Social care needs and preferences (HIQA, 2015):
        - Social interaction with staff.
        - Social interaction with family.
        - Social / recreation activity (JCI, 2012).
    - Privacy requirements and expectations in relation to the provision of care and treatment (JCI, 2012) (see RR-013 Respecting the Privacy and Dignity of the Resident).
    - Whether the resident has in place, or wishes to implement, an Advance Care Plan or Advance Healthcare Directive. This may include palliative and end of life care wishes, including wishes re organ donation (see HS-033 Management of Palliative and End of Life Care, HS-039 Management of Organ Donation and RR-012 Obtaining Resident Consent).
    - Resuscitation status.
    - Intimacy and sexual needs (HIQA, 2015) (see QL-001 Maximising Resident's Autonomy and Independence).
- Social status, including supporting economic factors where this has not been already addressed, as part of the preadmission process (JCI, 2012) (see RR-002 Communication with Prospective Residents and their Family).
- Education requirements of the resident and their families/representatives, including:
    - Learning preferences, e.g., do, practice, or talk,
    - Any barriers to learning,
    - Willingness to learn.

(JCI, 2012) (see Appendix 1: Assessing Barriers to Learning) (see also RR-011 Resident Involvement, Consultation and Feedback and RR-004 Provision of Information to Resident's Family).

7.7.3 Additional information and associated reports shall also be reviewed if available:

- Speech and Language Therapy (S.A.L.T.) completed to date,
- Dietitian reports to date,
- Occupational Therapist reports,
- Physiotherapist reports.

(NHI, 2008; NHI, 2010)

Where the resident is an emergency admission, this information is obtained as soon as possible after admission (HIQA 2016).

7.8 The resident's GP shall be contacted and informed of the resident's admission. The resident's GP shall attend Cowper Care, review the resident, and provide relevant information and instruction for the care of the resident.

7.9 The admitting nurse shall carry out medication reconciliation in accordance with HS-012 Medication Reconciliation and Audit (Incorporating Medication Management at Discharge, Transfer, Leave and for Respite Care).

7.10 Where the resident requires diagnostic tests (e.g., blood tests, urinalysis), these shall be obtained and conducted as per HS-023 Indications for Use, Administration and Follow up of Diagnostic Tests.

7.11 Activity staff shall be informed of the resident's arrival to initiate the resident's activity programme (HS-005 Resident's Activities Programme – Development and Implementation).

7.12 Catering staff shall be informed of the resident's arrival and of any dietary requirements and shall also confirm a time to discuss any dietary preferences, likes or dislikes with the resident as per QL-003 Meals and Mealtimes- Planning and Facilitating Resident's Choice.

All new residents shall have a food diary maintained for 3 days, when they arrive at Cowper Care. Where there is no identified issue in relation to nutrition, the food diary may be discontinued upon the direction of the Care Manager/Assistant Care Manager (NHI, 2008).

7.13 The requirement for specialised assessments if not yet identified on pre-admission, shall be selected by the Care Manager/Assistant Care Manager, in conjunction with the multidisciplinary team and the Keyworkers. The resident shall be made aware of the requirement for specialised referrals and the resident's needs and preferences shall be respected, including their desire for care and additional services and their response to previous services (JCI, 2012). All referrals shall be detailed within the resident's records.

Where specialised assessments cannot be supported internally by Cowper Care and its Social Health Care Professionals, the resident shall be referred externally for assessment by specialised service providers that are adequately qualified and have been specifically approved for that process in accordance with GM-009 Supplier Review and Approval Policy and Procedure.

Where the outcome of these specialised assessments cannot be supported by Cowper Care, the Care Manager/Assistant Care Manager shall provide information on alternative sources of care and services to the resident and/or their relatives/representatives (JCI, 2012).

7.14 Details of the assessment shall be recorded in the Resident's Record as per IM-001 Resident Records – Initiation, Creation and Maintenance. The relevant sections of the records shall be made available to all staff and health care professionals involved in the provision of care to the resident (JCI, 2012) (as per section 7.1 above and in line with the relevant requirements as detailed in IM-007 Management of Personal Data in Line with Data Protection Requirements (incorporating GDPR).

7.15 The outcomes of the assessment shall be used to create the residents' individual care plans (see also HS-002 Resident Care Plan Development and Implementation).

The outcomes of the assessments shall also be utilised to identify the appropriate Key Workers/Care Leader for the resident. This is specifically required where there are a number of Health and Social Care Professionals that are required to be involved in the provision of care to the resident. The Key Workers/Care Leader shall act as co-ordinator of care and shall be ultimately responsible for the provision of effective care to that resident (JCI, 2012). The Care Manager is responsible for the allocation of Key Workers/Care Leaders for each resident.

7.16 Details of the resident's assessment outcomes shall be communicated to all relevant staff during handover report. The Key Workers/Care Leaders shall document a date for the resident's reassessment and inform the Assistant Care Manager/Clinical Nurse Manager of same. The Assistant Care Manager/Clinical Nurse Manager shall then document this on the Assessment Schedule. Reassessment shall be completed at 3 monthly intervals at a minimum. The reassessment should incorporate the multidisciplinary group involved in the assessments, including registered nurse, Key Worker/Care Leader and HCA, the GP, the pharmacist and any other relevant Health and Social Care Professionals involved in the provision of care to the resident (NHI, 2010) (S.I No. 415 of 2013) (see HS-003 Resident Reassessment).

7.17 Every effort will be made by Cowper Care staff to involve the resident, including those with dementia/cognitive impairment, in the assessment process. The overall outcomes of the assessment process should be clearly communicated to the resident and, when appropriated, to their family/representatives by nursing staff (JCI, 2012).

Where the resident is unable to participate in the assessment, this shall be assessed in accordance with RR-012 Obtaining Resident Consent.

Where the expected results of the care to be provided by Cowper Care have changed based on the completion of the comprehensive assessment, this shall be discussed with the resident and/or their family/representative (JCI, 2012).

7.18 The resident records shall be kept for a period of no less than seven years after the resident has ceased to reside in Cowper Care (S.I. No. 415 of 2013). Disposal of records is addressed within IM-007 Management of Personal Data in Line with Data Protection Requirements (incorporating GDPR).

8.0 Admission to Cowper Care during COVID-19 (HSE & AMRIC, 2022) *(Refer also to Appendix 2 and CE-033 Management of COVID-19)* [*]

Note: 'Fully Vaccinated' includes booster vaccination. Refer to CE-033 for guidance on vaccine protection.

8.1 Testing Requirements for Pre-Transfer/Admission to Cowper Care(HSE & AMRIC, 2022)[*]

8.1.1 Testing of asymptomatic residents, regardless of vaccine status on transfer or admission, shall generally not be required.

8.1.2 Testing of asymptomatic residents on admission/transfer may remain appropriate for those on non-invasive respiratory support based on local risk assessment.

8.1.3 Where a resident is being transferred from an acute hospital to Cowper Care and surveillance testing is required before admission, it shall be carried out by the hospital 24 hours before the day of admission.

Where the resident is being admitted to Cowper Care from home, the GP or the care centre shall arrange for the resident to be swabbed 24 hours before admission.

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8.1.4 Irrespective of testing, all residents shall be assessed before admission to determine if they have clinical symptoms suggestive of COVID-19.

8.1.5 Residents who are COVID-19 Close Contacts may transfer to the care centre provided they have had a 'not detected' PCR test.

8.1.6 If an unvaccinated prospective resident is transferring from an acute hospital, they shall be offered the first dose of vaccine before transfer. The vaccine shall ideally be administered as long as possible in advance of transfer. Transfer of the prospective resident shall not be delayed for the purpose of allowing time for an immune response to the vaccine. The care centre shall arrange the remaining vaccination.

8.1.7 Testing for COVID-19 shall be performed in line with CE-033 Management of COVID-19 and HS-023 Indications for Use Administration and Follow-up of diagnostic tests.

8.1.9 After admission to the care centre, the resident will restrict their movement to their bedroom and small sitting room. If the new resident remains asymptomatic after 5 days, the restricted movement ends.

8.2 Requirements for placement and restricted movement of residents (HSE & AMRIC, 2022)*

8.2.1 Cowper Care shall undertake a risk assessment ahead of all transfers or new admissions to ensure sufficient resources are available within the care centre to support physical distancing and placement of residents.

8.2.2 Where possible, Cowper Care shall prioritise the use of single rooms for new transfers and admission from community or other healthcare facilities.

8.2.3 Where Cowper Care provides a blend of longer-term nursing home and short-term respite or convalescence care, Cowper Care shall consider where longer- and shorter-term residents shall be accommodated and where it is feasible, shall try and place residents for shorter-term accommodation in an area separate to the longer-term accommodation.

8.2.4 Cowper Care shall ensure that the identification of space for the 5-day period of restricted movements is managed carefully with residents, their families, and representatives. Cowper Care shall not move existing residents from their room in order to facilitate the creation of new areas to facilitate transfers.

8.2.5 Cowper Care shall ensure careful consideration is given to the consequences of closing facilities/rooms within Cowper Care for the purpose of having an isolation area should a need arise. The potential harms of such decisions shall be balanced against the likely requirement.

8.2.6 During the period of restricted movement, the following applies:

- Care delivered within the single room and shall be delivered with Standard Precautions plus surgical masks.
- The resident shall not be required to remain in strict isolation; however, they shall practice restricted movement:
    - The resident may leave their room, but shall remain separated from other residents (e.g., to go to the garden or for a short walk).

8.2.7 A resident shall be moved to a multi-occupancy room (where this is the planned accommodation for the resident in the longer term) after the 5-day period once the resident is symptom free and there is no evidence of infection in residents within the room where the resident is proposed to move to.

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8.3 **Transfer of Residents with COVID-19 to Cowper Care from Hospital (HSE & AMRIC, 2022)**

8.3.1 Any resident transferred to Cowper Care before their required isolation period has elapsed (10 or 14 days (depending on vaccination status) from date of onset of symptoms/positive test if asymptomatic – see CE-033 Management of COVID-19), must be isolated with transmission-based precautions on return to the care centre until their isolation period is complete. The transfer shall not take place if the receiving care centre has no other residents with infectious COVID-19 at the time.

8.3.2 In particular, existing residents from Cowper Care who require transfer to hospital for assessment or care related to COVID-19 shall be allowed to transfer back to the care centre following assessment/admission, if clinically fit for discharge and a risk assessment completed within the care centre determines that there is capacity for them to be cared for with the appropriate isolation and where the care centre represents the most appropriate place of care for the resident (e.g. ongoing need for palliative care).

8.3.3 Where the resident is diagnosed with COVID-19 while in hospital, Cowper Care shall assess if the resident was infected in the care centre before transfer to the hospital or the case is a hospital acquired infection. If it is likely that infection was acquired in hospital and there are no other known cases of COVID-19 in the care centre, transfer back to the care centre shall be delayed until the resident is no longer infectious to others.

8.3.4 The Public Health Team shall be notified immediately where a newly diagnosed case of COVID-19 is assessed as acquired within the care centre.

8.3.5 In all instances, the discharging hospital shall provide Cowper Care with the following information on the arrival of a resident:

- Date and results of COVID-19 tests (including dates of tests reported as not detected).
- Date of onset of any symptoms of COVID-19.
- Date of last documented fever while in hospital (particularly important where the resident is being transferred to the care centre within 14 days of COVID-19 diagnosis).
- Details of any follow up treatment or monitoring required.

8.4 **Residents Who Become Symptomatic during Admission (HSE & AMRIC, 2022)**

8.4.1 Following transfer/admission to Cowper Care, the resident shall be evaluated by their GP if they become symptomatic or if there are any changes in the resident's overall clinical condition. A further viral swab for SARS-CoV-2 shall be sent for testing and the resident may also require testing for other viruses, in particular influenza virus.

Note: *The rationale for this recommendation is that, in the context of a pandemic, there may have been contact between the resident and staff or other people who may have had COVID-19 infection, but who may have been in the pre-symptomatic incubation period or have had minimal symptoms/been asymptomatic at the time. In that case, there would be an associated risk of unrecognised onward transmission to the resident.*

8.5 **Cessation of New Admissions to Cowper Care during a COVID-19 Outbreak (HSE & AMRIC, 2022)**

8.5.1 Following the declaration of an outbreak within Cowper Care, admissions of new residents (i.e., residents not previously living in Cowper Care) shall be suspended until Public Health declares that the outbreak is over.

8.5.2 Residents normally cared for in Cowper Care who are admitted to hospital while an outbreak is ongoing may have their discharge to Cowper Care facilitated if it is deemed to be clinically appropriate and a risk assessment has been carried out which identifies that the resident can be isolated, and Cowper Care has capacity to manage their care needs

and where that transfer represents the most appropriate place of care for the resident (e.g., ongoing need for palliative care).

8.6 **Residents who Routinely use Ventilatory Support ((HSE & AMRIC, 2022)[*]**

8.6.1 Cowper Care is aware that the use of CPAP or BiPAP shall be considered an aerosol generating procedure.

8.6.2 Where a resident who routinely uses ventilatory support, the resident shall be admitted to a single room with a window that can be opened to improve ventilation (subject to weather and security). The door of the room shall remain closed as much as possible when ventilatory support is in use.

8.6.3 If the resident has any new clinical features to suggest viral infection, any care delivered by staff members during the use of CPAP or BiPAP, shall be delivered with airborne precautions (minimise the numbers and time in the room, maximise ventilation as far as is practical and use of appropriate PPE).

8.6.4 Where the resident's test result is reported as not detected, the resident is not a COVID-19 close contact, and there are no clinical features to suggest viral infection, the care provided by staff shall be delivered with Standard Precautions plus the use of a surgical mask.

8.6.5 If the resident who does not have vaccine protection is on CPAP or BiPAP is not a contact of COVID-19, where they have no new symptoms of respiratory deteriorations to suggest acute infection and if the sample taken before or on admission was reported as COVID-19 not detected, the resident shall be allowed to move around outside their room and participate in activities subject to confirming each day that there is no deterioration in their condition that could suggest COVID-19.

8.6.6 Where the resident who uses CPAP or BiPAP develops symptoms consistent with COVID-19 at any point of their admission to Cowper Care, airborne precautions shall be reintroduced immediately. Arrangements for assessment of the resident by their GP and the resident's return to a single room for management as for a suspected case shall be made.

9.0 Staff Education and Training

9.1 All individuals completing assessments shall be appropriately qualified and competent to implement the requirement assessment activities (JCI, 2012).

9.2 The staff shall be trained to recognise the need for early intervention and thus establish measures to detect, diagnose and refer to external health professionals for diagnosis, and treat impairments at an early stage, and also to develop effective guidelines for early detection and intervention measures (NDA, 2006).

10.0 Records

10.1 Resident information, both paper and electronic, shall be held securely in line with the legislation and shall only be accessed by those who need to see it (HIQA, 2018) (as per IM-007 Management of Personal Data in line with Data Protection (incorporating GDPR)).

10.2 The following records shall be kept by Cowper Care:

- Resident Records
- Transfer Information
- Referrals
- Resident's Consent.

[*] *Removal of content from previous document version*

- Resident's Contract of Care
- Staff Training Records

11.0 Audit and Evaluation

Regular Audits shall be undertaken to determine compliance to this policy and procedure. The Head of Service – Care, in conjunction with the Care Manager, shall complete this via a review of relevant records, including incident reports, through observation and by utilising the appropriate audit tool. Results of these audits are presented to the Executive Management Team.

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13.0 Appendices

13.1 Appendix 1 Assessing Barriers to Learning

Your first step in the process of resident teaching is assessing the resident's learning needs, learning style, and readiness to learn. Assessment includes finding out what residents already know, what they want and need to learn, what they are capable of learning, and what would be the best way to teach them.

Begin the process by interviewing the resident. First, find out more about the resident as an individual and what his life is like. Questions you might ask include:

- Tell me what an average day is like for you
- How has your average day changed since you've been sick?
- What do you like to do in your spare time?
- Tell me about your family
- Tell me about your work

Second, start assessing the resident's learning needs. Questions you might ask include:

- What are you most concerned about?
- What are your goals for learning how to take care of yourself?
- What do you feel you need to know to achieve your goals?
- What specific problems are you having?
- What do you know about your condition?
- What are you most interested in learning about?
- How will you manage your care at home?

Third, find out what the resident's learning style is so you can match teaching strategies as closely as possible to the resident's preferred learning style. Questions you might ask to determine the resident's learning style are:

- What time of day do you learn best?
- Do you like to read/what types of books or magazines do you enjoy reading?
- Would you prefer to read something first, or would you rather have me explain information to you?
- Do you learn something better if you read it, hear it, or do it hand on yourself?

Forth, gather information about the resident's readiness to learn. Questions you might ask include:

- How do you feel about making the changes we've discussed?
- What changes would you like to work on now?
- Are there any problems that would prevent you from learning right now?

Forth, gather information about the resident's readiness to learn. Questions you might ask include:

- How do you feel about making the changes we've discussed?
- What changes would you like to work on now?
- Are there any problems that would prevent you from learning right now?

After you've talked with the resident, interview the family. Conversations with the resident's family can fill in missing information, change your understanding of what you've heard from the resident, or affect your

view of what the resident's home situation might be. Do family members ask to be present during teaching, and when teaching occurs, do they actively participate? Do they seem supportive of the resident's need to change health behaviours and to learn new tasks and skills?

You can also consider using checklists and questionnaires to obtain information about learning needs, learning style, and learning readiness. Written materials also help you determine the resident's literacy level and ability to understand written information. Confer with other health care team members. Each health care team member has valuable information about the resident and his or her learning needs and abilities. Collaborating with others who care for the resident can give you-and them-a better picture, allowing all of you to design more effective teaching strategies.

If the resident identifies the need -" What exactly will this process involve?" he or she is already demonstrating motivation to learn. If you, rather than the resident, identify the need, your job will be not only to deliver the information in such a way that the resident is able to understand it, but also to demonstrate to the resident why the information is important.

Determining learning style involves assessing how resident learn best, when they learn best, and how able they are to learn what they need to know. Finding out whether the resident learns best by hearing, reading, or hands-on learning is relatively straightforward. However, factors such as the resident's educational and literacy levels also need to be considered. Sometimes residents and families may seem uninterested in learning because they don't know what to ask or don't yet realize that they will need information. For example, family members of a resident with a stroke may have never known anyone else with a stroke and thus may have no idea of what to plan for or what to ask. In some instances, nurses and other health professionals may take it for granted that residents have a better understanding of their condition and treatment than they actually do.

(Euromed Info Centre, Accessed 3rd Feb 2015)

13.2 Appendix 2: Transfer/Admission of a Resident to a Residential Home (HSE & AMRIC, 2022)

CLINICAL SCENARIO	RECOMMENDED PRECAUTIONS ON ARRIVAL TO LTRCF	PRE-ADMISSION TEST FOR SARS-CoV-2 (COVID-19)	TIMING OF TRANSFER TO LTRCF	DAY OF TRANSFER
CONFIRMED COVID-19 & will be still infectious to others on planned date of transfer (less than 10 days since onset/test date note extension to 14 days if not boosted)	Transmission-based Precautions for not less than 10 days from date of onset of symptoms and with minimal symptoms or symptoms resolved for the last 2 of those days. The period is extended to 14 days if they are eligible for booster and have not had booster.	Not required, as already confirmed COVID-19	**LTRCF has other resident(s) with COVID-19:** Transfer when fit for discharge to LTRCF AND provided LTRCF can meet care needs **LTRCF has no other resident with COVID-19 -** Remain in hospital until no longer infectious to others	Confirm date of onset/first positive test result Confirm date last febrile
CONFIRMED COVID-19 & **no longer infectious to others (no longer subject to transmission based precautions)**	No requirement for Transmission based Precautions or restricted movement	Testing not required as already confirmed COVID-19	When fit for discharge to LTRCF	Confirm date of onset/first positive test result
ASYMPTOMATIC Transfer/new admission	No requirement for Transmission based Precautions or restricted movement **[may be exceptions based on risk assessment]**	Testing generally not required	When fit for discharge to LTRCF	Confirm details of vaccination Ensure no new symptoms

(HSE & AMRIC, 2022)