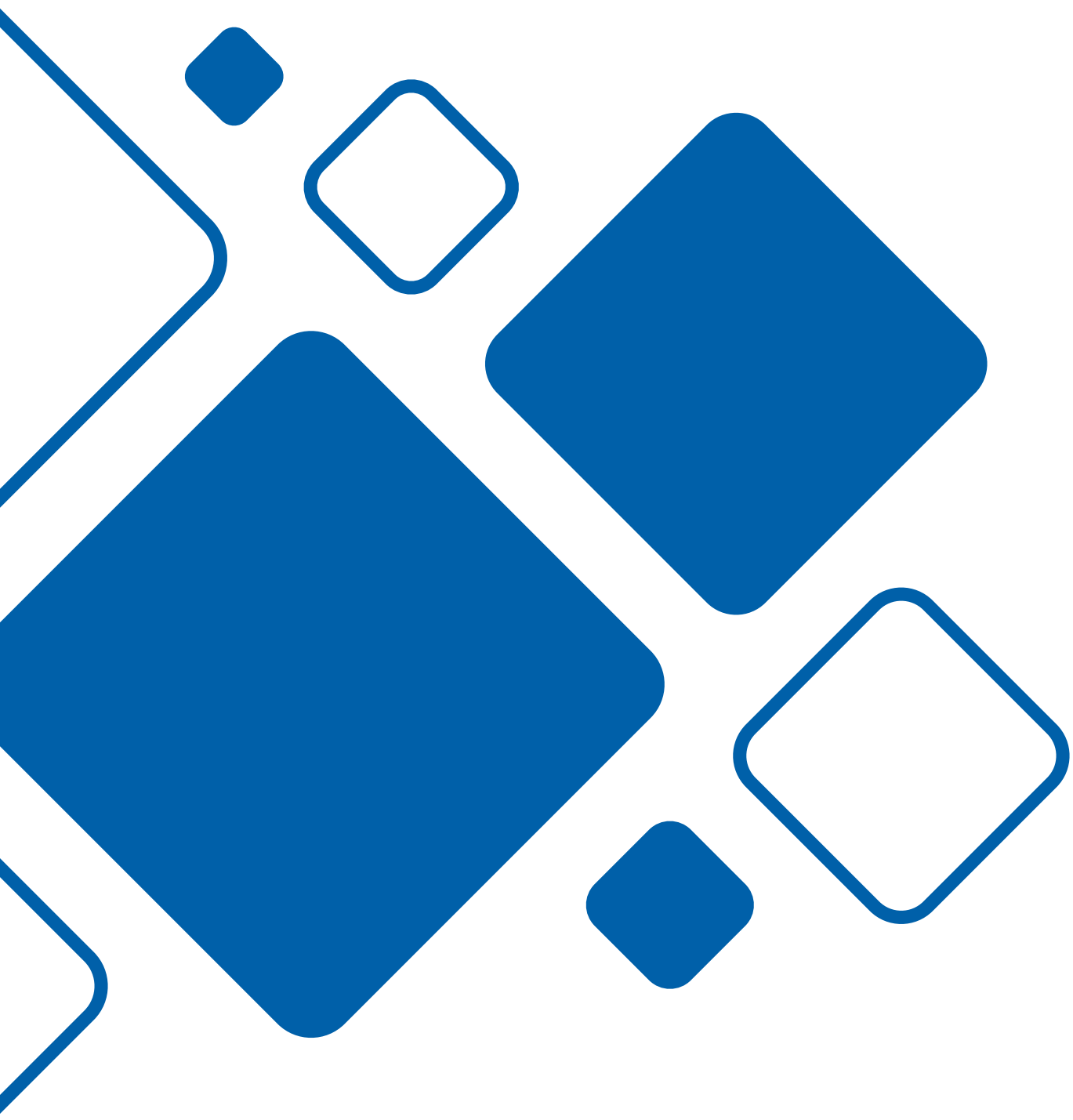
NURSDOC

POLICY NUMBER: **66**

POLICY TITLE: **HOME NURSING & HOMECARE**

WHO MUST ABIDE BY THIS POLICY? **ALL AGENCY STAFF**



HOME NURSING & HOMECARE

THE PURPOSE OF THIS POLICY

To inform staff and customers of Home Nursing & Homecare Policy.

HOME NURSING & HOMECARE POLICY

Nursdoc recognises that the service they supply to our homecare clients in their own homes has to be of the highest level and of a reliable nature as the customers do not have the support of a residential care setting.

Many customers many of whom have highly complex care needs, are safeguarded from abuse to the best of our ability.

The Team Care Manager is responsible for ensuring that care delivery and Agency worker allocation is planned with maximum efficiency, and speed and that they ensure that consultants understand the specific requirements respect of nursing and care supplied directly to customers requiring home nursing and homecare services.

A Lead person is appointed for each client to ensure that the quality of care is of the highest level is maintained and that decisions and changes are communicated to the Care Manager.

The agency obtains from the local authority, or the local health or primary care trust, a detailed needs assessment for be used together with the agency risk assessment. For individual customers who are self-funding, the agency will carry out a care needs assessment, prior to the provision of a home nursing or domiciliary care service (or within 2 working days in exceptional circumstances) using senior staff who are competent and trained in such procedures (Assessors).

Document: Care Plan & Service Records for Nursing & Care at Home
A Care Plan is completed for each new Home Nursing & Care Client, when the initial assessment is carried out.

Thereafter, the document is updated six-monthly or more frequently, if the condition of the Client changes.

- A copy of the Care Plan & Service Records is stored electronically and is accessed and updated by the Care Manager.
- The Care Manager is responsible for ensuring that training is provided in the completion of personal records held in Clients' homes, as required.
- The care needs assessment for individual customers has a number of elements including important information about the client; care needs assessment and a client's risk assessment.

Each part comprises a set of forms, for completion by the needs assessor. These forms are used throughout the care planning and delivery process, and are kept as part of the client's records in the agency's office. As they contain personal data, these records come under umbrella of the Data Protection Act and must be protected at all times from wrongful or inappropriate disclosure.

Copies of all forms completed by the agency should also be kept in the home of the client. If the client prefers NOT to have a copy of these forms, a statement to that effect, signed by the client, is held at the office.

This is designed to collect important information about a client, such as personal details, information about anyone living with the client, name of emergency contact/next of kin, main family carer: GP; Dentist etc.

Important additional information about the client
Care must be provided in a fashion which allows for the client's own wishes and preferences to be expressed and, where appropriate, followed. This form collects information, for example, on issues such as communication, entering the client's premises, any sensory impairments etc. This information allows the agency to design an individualised Care Plan which takes these matters into account, allowing for greater autonomy and independence together with input from the client.

Needs assessment
Where an assessment has been performed by a third party (Local Authority, CCG, Health Trust etc.) this is used together with the branch assessment and is the key part of the process, and this form invites an initial discussion between the client and the needs assessor on matters such as the client's own assessment of their physical and mental health, disabilities or impairments, and the client's own ideas about the support they need, how it should be delivered, when, etc. The form goes on to discuss a variety of tasks associated with daily living, such as dressing, personal hygiene, food and drink, housekeeping, leisure etc

Client's risk assessment
This part of the assessment discusses mainly health and safety issues relating to the client (as opposed, for example to health and safety issues relating to the client's home, electrical equipment, hazardous substances etc, which are dealt with separately), and examines slips, trips and falls, aspects of the client's chosen lifestyle which might present hazards, the potential for abuse or exploitation, risks to others, administration of medicines, manual handling and transfer etc.

NURSDOC