Wellcome Care Homes are committed to ensuring that all residents are fully supported from admission to residing in the home. We have produced this policy to:-

- ensure that prospective residents know what to expect at each stage of the admission process
- explain the arrangements in place for the assessment of individuals' need; planning and reviewing of people's care.

Criteria for Admission

Annedd is registered with Care Inspectorate Wales (CIW) to provide residential personal and social care for up to 27 elderly people with variant degrees of dementia.

When a person requires a short, or long-term placement, they may be directly referred to Annedd by means of self-referral if privately funded; or, with their representative's consent, or from the local and out of county Social Services system.

Special Services and Considerations

Prospective residents and/or relatives are invited to visit prior to admission. They are welcome to have coffee, lunch or spend the day at the home to meet with staff and to gain a natural feel for the home.

The staff team will provide support to help deal with the emotional impact of the decisions to be made in moving into the care home.

We operate an 'Equal Opportunities' policy and do not discriminate.

Admission Procedure

Funding of each placement will have been previously assessed and agreed by the placing Local Authority.

Once referred and, prior to admission, the manager or a suitable qualified senior carer will carry out an assessment involving the prospective resident and/or your appointed relatives. This assessment may take place at the prospective resident's home or an appropriate care setting.

The manager will liaise with other health care professionals such as GPs social workers and/or district nurses to help determine your requirements in order to ensure that the home is suitable and able to cater for your needs and that any necessary equipment is in place, prior to admission.

Depending on the bed vacancies at the home you may be offered a place immediately or placed on a waiting list, if appropriate. A letter of confirmation stating that we are able to meet your needs will be sent to you.

New residents are accepted on a four-week trial basis whereby during this period, either party may give notice of termination of contract. This period may be extended if deemed necessary. At the end of the trial period, commissioning agents may decide to carry out a care review to assess the suitability of the placement in order to plan for a long-term stay.

After admission, opportunities will be available to review and discuss your placement and care, with you and/or representative or family member. This will involve a range of risk assessments in order to produce a care plan tailored to meet your individual physical, psychological, spiritual, social, cultural and emotional needs. You and/or your representative will be involved throughout this process and in ongoing care reviews thereafter.

Arrangements will be made by the manager to inform the residents GP of their admission into the home within 24 hours. It may be necessary to re-register with the homes if you are out of area. Any medication the resident has been taking, prior to admission will be continued as prescribed by their GP.

Emergency Admissions

Depending on availability of a bed at the time, emergency admissions may be arranged at the discretion of the manager; and only if your needs can be assessed and clearly met. In the event of a resident placed as an emergency admission, a copy of the homes' Statement of Purpose will be made readily available for you on arrival. A care plan will be developed within 24 hours based on your assessed needs and will be reviewed monthly or sooner if needed.

Documentation

On admission, personal details for all new residents will be entered into the 'admission book' which is held in a secure place in the manager's office. It is a legal requirement to hold this information.

A written care plan will be developed after the appropriate assessment criteria has been met. The plan will be drawn from the 'Activities of Daily Living' assessment tool, using the following topics:

Maintaining Safe Environment
Communicating
Breathing/Oedema

Nutrition
Personal Cleansing and Dressing
Controlling Body Temperature
Mobilising
Social Interests

Sleeping
Dying Wishes
Risk Assessments

Prior to admission a record of the 'resident's personal profile' will be completed which includes all of the important information.
Various assessments such as body weight and height; and skin integrity will be carried on admission.
As part of the overall plan of care the resident/relative will be asked about his/her chosen funeral arrangements, should this information be required. These details will be sensitively managed and recorded in the care plan file. Any special provisions for ethnic, cultural or religious requirements will also be documented to enable staff to care for each individuals' needs.
An individual care file will be used to store all care documents; care files are in a secure area and confidentiality maintained.

Ongoing care monitoring and care reviews

Once developed, each individuals' care plan will be reviewed monthly or more often, depending on any changes in the resident's condition. Any adverse reaction to the care plan will result in an immediate review by the Manager/Senior Carer in charge.

- Routinely, the care plans are reviewed at three levels:
    a. Daily, during handover
    b. At the end of a four- week settling in period assuming the resident continues to reside at the home
    c. On a monthly basis by Manager/Senior Carer in charge

Storage of Records

Residents records will be stored in a safe and secure place. They will be held in accordance with the Data Protection Act 1998.

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