Home Care Admissions Procedure
Derbyshire County Council - Adult Social Care

Contents

If you would like to make any comments, amendments, additions etc please email ASCH.adultcare.policy@derbyshire.gov.uk

1. This Procedure

1.1 This procedure sets out the process that must be followed when a person is admitted into Derbyshire County Council's (DCC) Adult Social Care Home Care Service. It details the minimum standards required to ensure we deliver safe, effective, consistent, and person-centred care when people enter the service.

2. The Home Care Service

2.1 New referrals into DCC's Adult Social Care Home Care Service will ordinarily be for short-term service. In the exceptional circumstances where new referrals are made into the service for people requiring long-term support in their home, this must be discussed and agreed with the relevant direct care service manager and group manager before any service is provided.

2.2 The short-term service is used to:

- support a person to gain or re-gain their independence with independent living tasks in their own home
- support a person to improve their level of independence through maximising their own strengths and/or through identifying the best approach to supporting them
- support a period of assessment
- respond to an urgently presenting need in the community whilst further assessment can be carried out by adult social care or others (see below)

2.3 The short-term service should be used in the following ways:

- to facilitate a discharge from hospital
- to prevent a hospital admission
- as a new home care response to support a new assessment of the person's need for care and support
- as a new or additional home care response where there is a significant change in need for a person already in receipt of our services

Please see 'Short-Term Service (Home Care) Standard Practice Guidance' for more details about the short-term service.

3. Decisions about Admission into the Home Care Service

3.1 Receiving referrals

When a new referral is received from the community or a hospital, and capacity in the Home Care Service has been identified, the domiciliary services organiser (DSO) or duty DSO must make the decision about whether to accept admission and whether the referral contains enough information to allow the service to be started safely.

3.2 What referrals must Include:

- a short-term assessment and plan, or
- an uploaded trusted assessment (also called 21c documentation, d2a referral)

3.3 Making a decision about new referrals:

When a referral is received by DSO or duty DSO, they must review the referral information and satisfy themselves that it contains sufficient information about the person and their environment to determine whether the service can safely meet the person's needs.

Decisions about the appropriateness of the service must be made on the individual assessment and not according to assumptions about a person's diagnosis, age or disability.

Where there are questions about the person's suitability for the service, the DSO should discuss with the person making the referral before making a decision, and seek advice from a service manager if required.

Where additional information is required, or the referral appears incomplete the DSO/duty DSO will discuss what is required with the referrer and agree how this information will be obtained. Further discussions may be required with the person being referred or their carer.

3.4 Where the DSO/Duty DSOs declines admission:

If the DSO/duty DSO needs to decline the admission they should discuss this with the referrer and decline the referral via Mosaic, clearly indicating the reason the referral has been declined.

Information about services declined is regularly collated and reviewed via Mosaic records and will be used to support the continuous improvement of the service.

4. Pre-Admission: What to do Before the First Care Call for Client Receiving Short-Term Services

4.1 The following provides details of what must be completed by the DSO/Duty DSO before the first care call. Where there is insufficient information provided by the referrer this information will be requested to enable the DSO to complete the appropriate paperwork.

4.2 Always required:

- essential information - the DSO will complete the essential information in the 'confirm start date' work step in Mosaic which will be sent to the scheduling team to add to the carers care management (CM) app so it is available prior to the first visit - this will contain information such as gender, conditions and presentation to be aware of (i.e. client has Dementia), information about whether the person lives alone or with other(s), access issues and environmental risks
- short-term personal service plan (PSP) sections 1 – 7 and 9 (the person's "goals" can be completed later if required but must be completed within 72 hours of the service starting in all cases)
- environmental checklist*, as part of the short-term PSP (likely to be completed remotely until visit made to the property)
- falls risk checklist*, as part of the short-term PSP
- skin integrity referral considered*, as part of the short-term PSP

4.3 Required when specific risks are identified:

- medication risk assessment* where support includes any assistance or prompting with medication as part of the short-term PSP
- confirmation a medical administration record (MAR) sheet is available at the property where support includes any assistance or prompting with medication
- falls risk assessment where the falls risk checklist indicates a risk of falls
- confirmation that an up to date and relevant moving and handling assessment is in place* for where a person's support requires assistance with their mobility from the short-term service

** This information will have been provided by the referrer as part of the referral information - the DSO should check this to ensure it is accurate and up to date and make any required updates.*

4.4 Where the care worker (community) (CWC) provides care to a person for the first time

It is essential that any care worker (community) (CWC) providing support to a person for the first time, allows sufficient time to read the person's care plan and associated risk assessments prior to providing care and support. The CWC will have received the essential information described at paragraph 4.2 above prior to entering a property for the first time; this will include basic details about the person, their needs and any known environmental risk. In exceptional circumstances, where a service is required in an emergency, the DSO must inform the CWC of the essential detail. This discussion must be case noted, and the relevant paperwork must be put in place at the property at the earliest opportunity.

4.3 It is the DSO's responsibility to ensure the personal held record (PHR) and radio frequency identification (RFID) are activated and available at the property on the first visit.

4.4 The PHR must not be held at any location other than the registered office or the person's property for any longer than 24 hours.

4.5 Where a start date is delayed or the service is cancelled, the file must be returned to the registered office within 24 hours.

5. Within 72 Hours

5.1 The DSO must visit the person within 72 hours of the first care call. Paragraph 5.2 provides details of what must be completed at this visit.

5.2 Reviewing service, plans and risk assessments

At this visit the DSO must review and update the following documents:

- short-term PSP - this includes smart goals, environmental checklist, medication assessment, skin integrity checklist, falls risk checklist, and the person's capacity to consent to the care and support.
- any risk assessments already in place
- the suitability of any moving and handling assessment in place
- the person's copy of 'guide to my short-term service - service user guide' must be signed by the person (or their representative where the person lacks the capacity to consent to their care and support) - this should be filed within the person held record

The DSO must ensure that these documents accurately reflect the person's present level of needs and any risks to themselves/those supporting them.

5.2.1 Following this review, if there are no changes required, a note will be made in logs to confirm the visit was undertaken and all paperwork and assessments remain reflective of the person's needs along with a corresponding case note on Mosaic.

5.2.2 Where changes are required to the PSP or risk assessments as a result of the 72-hour visit, a note will be left in the logs for the next carer to notify them of the changes. The electronic assessments will be updated within 24 hours and arrangements made with relevant scheduled carer to bring the old paperwork back to the office to be disposed of in confidential waste and the new paperwork added to the PHR in the appropriate section.

5.3 Setting SMART goals:

SMART goals must be agreed with the person and recorded onto the short-term PSP. This can be undertaken by any member of the Short-Term Services Multi-Disciplinary team. The DSO is responsible for recording how the goals will be met by the Home Care Service on the short-term PSP.

5.4 Referrals to other professionals:

Where it has been identified that referrals to other professionals are required, the DSO should make these referrals or arrange for them to be made by another member of the Short-Term Services Multi-Disciplinary team.

6. Long Term and Interim Clients

6.1 The appropriate DSO will create a relevant long-term PSP for a person receiving care from the Interim team within seven days of the person being transferred to the Interim team. The Mosaic Guidance for the Transfer to Interim teams available must be followed. The risk assessments will be reviewed and updated at this point.

6.2 People receiving long-term services must receive a review of their PSP whenever there is a change in need or on an annual basis as a minimum. The case co-ordinator should be notified via the Mosaic system. Risk assessments must be reviewed in accordance with the relevant policy.

6.3 People receiving an interim service should be reviewed regularly to ensure they are transferred to a longer-term option for them as soon as possible.

7. People Receiving Care and Support at End of Life

7.1 Where the person's support has been provided out of hours on behalf of Continuing Healthcare or the person subsequently is assessed as requiring Continuing Healthcare funding (including via a Fast-Track), a request will be made at the earliest opportunity for the support to be transferred to a provider commissioned directly by Continuing Healthcare.

7.2 The DSO should review within 72 hours as usual where the person is still receiving a service, giving particular consideration to whether the service is able to safely meet the person's unmet needs associated with their end of life care.

8. Leaving the Service

8.1 At the end of a service the PHR, all care logs and MAR sheets must be returned to the registered office along with the RFID tag. The MAR sheets must be scanned onto the relevant file and signed and audited by the DSO within 72 hours of the service ending.

8.2 Following a decision by the multi-disciplinary team (MDT) that a person's reablement journey has concluded then the process set out in the Mosaic guidance should be followed.

Author History

Approval and Authorisation History:

Authored by Quality and Compliance	February 2022
Approved by Senior Management Team	February 2022
Authorised by Helen Jones Strategic Director of Adult Social Care	February 2022

Change History:

Version 1	Quality and Compliance	February 2022	New Policy and Procedure