

Referral and Admission Pathway

Referral Management

- All referrals received to be passed to the Customer Relationship Manager (CRM) **within 6 hours of receipt**
- CRM to coordinate all referrals & is responsible for feedback to Referrers

Referral Screening

- CRM to gather the basic information required for support screening & share with Registered Manager (RM) and Director of Operations (DO)
- CRM/RM/DO to review referral & identify if it is to progress to referral assessment **within 5 days**
- Consideration to include compatibility between the referred Service User and existing Service Users
- CRM to inform the Referrer of the outcome of the referral screening **within 2 days of decision**

Referral Assessment

- CRM to gather Service User’s Single Shared Assessment & other documents & share at Leadership Forum (CRM, RM, DO, Clinical Nurse Leads, Psychologist & Occupational Therapist) **within 5 days**
- RM to allocate Lead Assessor (Nurse) & Support Assessor (Therapist) to complete referral assessment
- Assessor(s) to complete Referral Assessment & provide report **within 5 days**
- If there is a delay in completing assessment, Assessor(s) to request extension via weekly Leadership Forum, agreeing timescale for completion
- Decision made on whether to offer placement at Deanston House, **within 5 days of receipt of report**
- CRM informs Referrer of referral decision **within 2 days of decision**

If placement offered:

- CRM completes Placement Agreement and CLDT Form and shares these with the Referrer
- On receipt of signed Placement Agreement and CLDT Form from Referrer, CRM informs RM to progress admission plans

Pre-Admission Assessment & Procedure

- Admission Transition Plan developed by RM/Clinical Nurse Lead (CNL) & shared with Referrer; duration of Plan to be determined by identified needs of Service User
- CRM/RM agree date of admission with Referrer
- RM to inform Stirling CLDT Lead of planned admission & confirm CLDT support for first 6 months
- CNL leads on delivery of Admission Transition Plan
- CNL leads on development of Service Users records required for admission, as a minimum:
 - My Information Sheet
 - My Essential Lifestyle Plan
 - My Communication Passport

- My One Page Profile
- My Personal Emergency Evacuation Plan (PEEP)
- Activities of Daily Living (ADL) Assessment
- My Daily Schedule, which will be updated following admission
- Health & Wellbeing Assessment
- Face Risk Screening Profile
- Initial Support Plans required to support Service User effectively from day of admission, including Positive Behavior Support Plan
- RM/CNL to ensure copies of legal documents are provided, i.e. Guardianship Orders
- CNL/NN to ascertain Service User's preferences regarding food, drinks, routines, showering/bathing, etc., & ensure this is reflected in initial Support Plans & Essential Lifestyle Plan
- CNL provided weekly feedback on progress of transition plan at weekly Leadership Forum
- Admission date to be re-confirmed during transition plan, to ensure it is suitable for Service User; CRM to liaise with Referrer regarding progress and admission date
- RM/CNL to allocate Named Nurse (NN) & Key Worker (KW), who will actively support transition plan
- RM to arranged delivery of staff training to support admission, if required
- RM/CNL to arrange environment requirements, including preparation of bedroom, with OT support
- RM/CNL to arrange equipment requirements to be provided in readiness for admission, with OT support
- RM/CNL as a minimum, to attend planned discharge meetings to support the admission
- RM/CNL, with support of Independent Advocacy if available, to facilitate Service User meeting, to introduce new Service User
- CNL to arrange for medications required to support admission & inform local Pharmacist of needs
- CNL to prepare GP referral forms ready for submitting on date of admission
- RM/CNL to agree admission arrangements with current service provider/family

Day of Admission

- Service User welcomed to Service on admission date
- If possible, NN and/or KW to be on duty to welcome and support Service User
- Admission Checklist to be completed by CNL/NN
- RN to commence implementation of all Support Plans, ensuring staff on duty aware of the Service User's support needs, commencing the following:
 - My Progress Notes
 - Support Plan monitoring charts, as required
 - My Therapist Clinical Notes
 - My Enhanced Support Records
- RM/CNL to ensure legal documents are available & placed in Service User file, i.e. Guardianship Order
- Service User supported to become familiar with environment, routines & meeting other Service Users
- CNL/NN to share Service User brochure with Service User, at their level of understanding
- Service User property to be recorded on Inventory Form by KW/Support Worker
- Service User property to be marked with their name/initials, as agreed with the Service User
- CNL/Registered Nurse (RN) to assess the Service User's capacity regarding managing own valuables
- If Service User has capacity, to be provided with bedroom and bedside cabinet drawer key
- If Service User does not have capacity, CNL/RN to arrange for safeguarding of valuables

- If smokes, RM/CNL to agree arrangement for safekeeping of tobacco products & inform of smoking policy and location(s)
- If drinks alcohol, RM/CNL to discuss expectations related to alcohol consumption with Service User
- RN to record medication received on blank Medication Administration Record & 2nd Nurse/staff member to check & countersign to confirm accuracy
- RN to re-confirm with Service User their personal preferences, re food, drinks, bathing, etc., and ensure this is accurately reflected in Support Plans, etc., informing relevant staff, i.e. Cooks, Support Workers, etc.
- RN to complete and record initial health check, as a minimum body map, height, weight, vital signs, Waterlow Assessment and MUST assessment, recording these on the Admission Checklist
- RN to submit all completed GP forms to the GP Practice

Within 1 Week of Admission

- CNL/NN to complete and/or commence the following with support from the Service User/relatives:
 - My Medication Information Record
 - My Hospital Passport
 - My Essential Health Contacts
 - My Health Calendar
 - My Health Appointments Outcome Record
 - My Circle of Support
 - My Daily Routine to be reviewed/updated as required
 - My Events Diary
 - My Family Contact Record
 - Specific Assessments required
 - Positive Risk Taking Assessments for Activities and Behaviours
 - My Personal Achievements Record
 - My Support Plans Aims and Outcomes Record
 - My Personal Distress Signature
 - Key Worker/Named Nurse Meeting Records
 - Support Plan Evaluation Records
- KW to share Service User Welcome Notes with Service User, at their level of understanding; this may be supported by a fellow Service User
- Service User to attend GP registration appointment, supported by CNL/RN within 48 hours of admission if possible & prescription obtained for prescribed medication
- CNL/RN to ensure GP reviews Service User's capacity and completes Section 47 Certificate of Treatment, if required
- CNL/RN to inform dispensing Pharmacist of Service User's medication prescription & obtain supply of prescribed medication, in line with the pharmacist supply cycle to Deanston House.
- CNL/RN to ensure any unused medication brought into the Service is disposed of via the Pharmacist
- CNL/RN to register the Service User with local health services, i.e. Dentist, Optician, etc.

Post Admission

Multi-Agency Review Meeting

- Membership: Service User, Care Manager, CRM, RM, Clinicians, family/representative & Advocate
- First Review Meeting held **6 weeks from admission date**; Clinical reports to be provided for meeting by CNL/NN, OT and Psychologist

- 2nd Review Meeting to be held within **6 months from admission date**, or earlier if deemed required
- Subsequent Review Meeting **held a minimum of every 6 months**

Internal Multi-disciplinary Meetings

- Membership: Service User, RM, CNL, NN, OT, Psychologist, Advocate
- Minimum of **monthly for 1st three months**
- Minimum of **quarterly thereafter**