Assessment, Diagnosis, Treatment and Care Procedure

Approved by: Rod Laight, Chairman Originator: Katy Power, Head of Clinical Services Date of approval: June 2018	Signature: ……………………………………

Policy area

Treatment and Care

Aim and Scope of Procedure

To provide instructions on the assessment, diagnosis, treatment and care of the patient or carer while accessing any service provided by Primrose Hospice.

Covers:

- Identifying the senior clinical staff responsible for ensuring that all clinical care is timely, accurate and appropriate.
- Identifying the skills required of clinical staff and the need for clinical supervision.
- Identifying the process for timely, accurate and appropriate assessment of the need of the patient or carer across all domains.
- Identifying the process for timely, accurate and appropriate diagnosis, treatment and care.
- Identifying the need to discuss care and treatment options with the patient and carer ensuring that their preferences and requests are taken into account.
- Identifying the need to ensure that dignity, privacy and confidentiality are respected at all times.
- Identifying the process for referral to other members of the multi-professional team or external agency.
- Identifying the process for regular review.
- Documentation requirements.
- Reporting structures.

Staff Responsibilities

Registered Manager/ Head of Clinical Services

- To ensure that the policy and procedure regarding assessment, diagnosis, treatment and care are adhered to; and that services are provided which are timely, appropriate and accurate.
- To ensure that the environment within which care is provided facilitates privacy, dignity and confidentiality.

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Day Hospice Team Leader

- To ensure that assessment, diagnosis, treatment and care provided by the organisation is timely, appropriate and accurate.
- To ensure that full assessment has been completed within a designated time-frame.
- To ensure that the treatment and care provided to the patient and carer is subject to regular re-assessment and review.
- To ensure that documentation regarding assessment, diagnosis, treatment and care is completed contemporaneously within the electronic clinical notes system.
- To ensure that adequate supervision is in place to assess individuals' clinical competence.

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Nursing staff and Allied Health Care Professionals

- To follow all internal procedures regarding assessment, diagnosis, treatment and care.
- To be able to assess the needs of patients and carers across all domains.
- To provide the care necessary for the patient and carer, taking into account the preferences and requests of the patient and carer, and ensuring that consent/ agreement is given.
- To ensure that dignity, privacy and confidentiality are maintained at all times for both the patient and carer.
- To ensure that referrals are made to members of the multi-professional team or to external health and/or social care agencies where appropriate and with the patient's consent.

Nursing staff and Allied Health Care Professionals	• To complete all clinical and audit documentation as required identifying responsibility and completing it contemporaneously. • To work within the limits of own clinical competence and seek advice where appropriate.

Method:

- Appropriate referrals to be made within the multi-professional team at Primrose Hospice and external liaison as necessary.
- Regular reassessment to be made to take account of the changing needs of individual patients.
- Written information about Primrose Hospice in the form of the patient booklet will be given to all Day Hospice and CNS clinic patients on their first visit. Other patients will be provided with a copy of the hospice information booklet either before or during their first visit.
- Patients new to Day Hospice will be welcomed on their first visit by a member of staff, and will have the opportunity during the day for a full tour of the building and facilities.
- A full clinical assessment by key worker and other appropriate members of the team will have been completed by the end of the second visit unless justifiable reasons can be given relating to the individual's physical or emotional needs.
- Assessment will also be made of the needs of the patient's family or carer, as appropriate.
- All new patients to be discussed in the weekly multi-professional meeting, a record of which will be sent to the GP, including the plan of care and the name of the key worker at Primrose Hospice and other Health Care professionals involved in their care.

Nutritional screening

To include:

- Nutritional history.
- Specific dietary needs.
- Whether assistance is required with eating or drinking.
- Presence or absence of swallowing difficulties.

Where a risk has been identified of poor nutrition, dehydration or swallowing difficulties, a formal nutritional assessment and a care plan will be completed, and if indicated, external referral to a dietician organised.

Staff Training Requirements

- Assessment skills across all domains: physical, psychological, social, religious and spiritual and cultural.
- Establishing the preferences of patients and carers.
- Forming a clinical diagnosis or accurately presenting problems and issues.
- Discussing care options with patients and ensuring that patients have understood and agreed to proposed care.
- Providing necessary care for the patient within the limits of individual clinical competence and skill.
- Referring a patient or carer to appropriate members of the multi-professional team and/or referring a patient to an appropriate external health and/or social care agency.
- Providing care which ensures that dignity, privacy and the need for confidentiality are respected at all times.
- Re-assessment and review of care.

Support and supervision on all aspects of clinical care will be provided to all clinical staff, by means of regular multidisciplinary discussions, team discussions, caseload supervision and individual clinical supervision for individuals working in isolation or more senior positions.

The internal documentation system within Primrose includes:

- A single set of electronic notes across all parts of the service.
- A common assessment tool and system of documentation.
- Relevant referral protocols to all members of the internal multi-professional team and to external agencies.
- A system to record re-assessment, review and any changes in care.

Clinical Records are to be used:

- To record assessment of the patient and/or carer across all domains.
- To record the preferences and requests of both the patient and carer.
- To record diagnoses and presenting problems and issues.
- To record proposed care options.
- To record the outcome of discussion with the patient and carer regarding proposed care.
- To record care provided for the patient.
- To record evaluation of care provided.
- To record re-assessment and review and changes in care.

Internal management systems:

- Weekly clinical meeting for all staff to discuss issues regarding assessment, diagnosis, treatment and care with senior colleagues.
- Quarterly reporting on complaints, critical incidents and near misses.

References:

1) Essential Standards of Quality and Safety, CQC
2) Guidelines for Records and Record Keeping: NMC 01/05
3) Record Keeping – computer held records NMC