Personal Care & Home Help

Guidelines for:

- Health Care Assistants Personal Care
- Home Help Referral form and Care plan
- Signature forms

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Community Health Service

The Referral page

Alerts: Any potential safety issues that may impact the District Nurse (DN), Health Care Assistant (HCA).

Examples: Difficult driveway, house access, dogs, slippery pathway, poor lighting, no number on letterbox, no phone.

Present Diagnosis: What has been the precipitating factors leading to this referral being made. A reminder to enter the Diagnosis & not just the treatment. Example: RTHJ could be arthritis in R) Hip joint.

Section questions: Identify existing and previous support services and sources of provision inclusive of family situation.

Personal Care: There is an assumption that patients who require intermittent personal care will receive services between Monday and Friday. All personal care being delegated to a HCA is via a direct D/N handover. Details relating to that are entered in this section, including review dates. The patient must be reviewed two weekly, if short term and monthly for a long term patient. The HCA must make sure the patient is reviewed by giving the patient notes to the DN to review. Any communication about the patient must be entered in the DN and HCA patient notes.

Household Management: Tasks are carried out as negotiated with the patient and according to ticked boxes. The Charge Nurse Manager agrees to the house hold management entitlement.

Personal care, Communication, Mobility, Continence, Skin, Sensory/Perceptual sections: The following sections on the referral page are designed to give the HCA a sense of the patient's situation and care requirements, which will be specifically stated in the care plan on the second page. Each section must be completed by the DN.

The Health Care Assistant Care Plan: This is completed and updated by the Primary Nurse for each patient and details the care to be provided to the patient by the HCA. The D/N and HCA will carry out this plan of care jointly according to policy direction.

The D/N and HCA then agree on and document a day that discussion regarding the patient takes place. The day is recorded by the D/N in both Care plans.

Aim of care being provided: This will assist the HCA to know the rationale for the care being provided. For example: to promote rehabilitation, palliative care, energy sparing, and maintenance/control of continence and skin protection, to receive medication safely etc.

The Care Plan: Specific detail of the action required by the HCA at each visit including safety alerts. The time of the visit discussed with the patient needs to be recorded here as well. If a HCA is unable to meet that time frame on any occasion, an advance phone call can be made to tender an apology and inform of new arrangement.

A second Care plan can be added, if an evening visit is required and care requirements vary.

If a Care plan is being replaced, the original plan is to be crossed through and dated and signed by the relevant D/N, and kept with the HCA patient record.

Documentation

Each HCA visit is acknowledged by the HCA by entering notes into Concerto.

If a patient's condition has changed or they have sustained an injury or if care has not been able to be provided please write a brief statement about the issue and the name of the nurse the issue has been referred to.

Form Management

The Referral, Care plan and Signature forms, form part of the patient's records and should be retained in individual patient files.

It is therefore important that all pages are numbered sequentially and are retained as legal documents, which will be transferred to patient records on discharge.

Each form requires a set of numbers, i.e. the Signature form starts at (Number 1) as does the Care plan form.

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