# Enquiry Record Sheet

|  |
| --- |
| **Details of the Enquirer** |
| Name:\* |  |
| Address: |  |
| Telephone number:\* |  |
| **Re. Prospective Service User** |
| Name (if different from above, and given): |  |
| Relationship of Service User to enquirer: |  |
| Address or location of **Service User**:\* |  |
| Telephone number: |  |
| Date of birth:\* | Age now: |
| Brief details of needs:\* |
| Agreed dependency level:\* |
| Agreed service and charge level:\* |
| Long or short term service:\* |
| Potential service commencement date:\* |
| GP name address and telephone: |
| Where did you hear of us?Social Services? Hospital staff? GP? Friend? Yellow Pages? Other? |
| Date of enquiry: | Enquiry taken by: |
| If required, use the back of this form for further details. |
| Further action Required? (Specify): |
| Send Information Pack? |  |
| Other action? (specify) |  |

**\*Essential information**

**Premises and Environmental Risk to Staff**

**IF THIS ASSESSMENT INDICATES AN UNMANAGEABLE RISK TO STAFF ATTENDING, DO NOT PROCEED WITH THE ASSESSMENT AND REJECT THE SERVICE. GIVE THE COMMISSIONER THE REASONS.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk Area** | **Risk Description** | **Management Protocol** | **Next Review Date** |
| Property surroundings; lighting, isolation, approach roads etc. |  |  |  |
| Risk of attendance identifying occupant as vulnerable |  |  |  |
| Parking; risks to vehicle; risk travelling to and from |  |  |  |
| Property entrance and corridors |  |  |  |
| Gender associated risks |  |  |  |
| Other occupants risks |  |  |  |
| Flooring, trips, skids |  |  |  |
| Electrical installation, fittings, appliances |  |  |  |
| Gas appliances risk |  |  |  |
| Unstable/dangerous furniture |  |  |  |
| Hygiene risks |  |  |  |

**Use continuation sheet if necessary.**

**Service Commencement - Personal Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **SU Name:** |  | Preferred mode of address: |  |
| **Address:** |
| **Date of Birth:** | **Marital Status:** |
| **Start date:** | **Proposed:** | **Actual:** |
| **SU previous name:** | Photo |
| **General Practitioner:** |
| **Next of Kin: Name:** |
| **Next of Kin: Address:** |
| **Relationship:** |
| **Telephone number:** |
| **Wish to be contacted day or night?:**(Ask at service commencement) |
| **Second contact: Name:** |
| **Relationship:** |
| **Next of Kin:** | **Address:** |
|  | **Home:** | **Work:** |
| **Telephone number:** |
| **Social Worker:****Nurse:** |
| **Community** | **Speech Therapist:** | **Dietician:** |
| **Minister of religion:** |
| **Religion:** |
| **Solicitor:** |
| **Ethnic origin:** |
| **Nat. Ins number:** | **NHS number:** |
| **Names of practitioners involved with Service User in previous twelve months:** |
| **Has the Service User completed a Preferred Priority of Care or do they have an Advance Care Plan in place?** |
| **Accountability Signature:** | **Date:** |

**Service Commencement - Health Assessment**

|  |  |
| --- | --- |
| **SU Name:** | **Service start date:** |
| **Brief description of current general health state:** |
| **Brief description of current medical treatment:** |
| **Mobility, mobility aids used:** |
| **Specialist aids and equipment used:** |
| **Accountability Signature:** | **Date:** |

**Service Commencement - Medical History**

|  |
| --- |
| **GP/Consultant involvement:** |
| **Medication – Current:** |
| **Medication – Significant Previous:** |
| **Controlled drugs administered:** |
| **Dietary requirements and allergies. Include current weight:** |
| **Sight:** |
| **Accountability Signature:** | **Date:** |

**Service Commencement - Health Assessment**

|  |
| --- |
| **Hearing:** |
| **Communication:** |
| **Mobility and dexterity:** |
| **Wheelchair user?** |
| **Self-propelled or not?** |
| **Continence:** |
| **Confusion:** |
| **History of involvement with multi-disciplinary agencies:** |
| **Accountability Signature:** | **Date:** |

**Skin Marks/Bruising Record**

|  |
| --- |
| **SU name:** |
| **Date of assessment** |
| **Area assessed** |
| **Reason for assessment** |
| **Cause of marks/bruising identified? Describe:** |
| **Support Plan created: Yes/No** |
| **OR – No skin lesions apparent:** |
| **Accountability Signature:** | **Date:** |
| **Key worker/ Named Nurse:** |
| *Skin Marks/Bruising Diagram* |

**Skin Marks/Bruising Record –**

To be used to conduct reviews, unless changes are sufficient to call for a full repeat of risk assessment

|  |  |
| --- | --- |
| **Date & Signature** | **Review Details – Skin Marks/Bruising Record Review** |
|  |  |
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| **Now complete a full review using the original risk assessment.** |

# Service User Compatability Assessment

Service User’s preference for Care and support staff:

Suitable staff available:

Staff introduced to Service User:

Staff pool allocated to Service User:

# Accountability Signature: Assessment date:

**Repeat this assessment and allocation table each time new staff are introduced to the team servicing the area containing this Service User.**

**The Perception of the Service User and Service User’s Family**

|  |
| --- |
| The perception of the Service User’s family/nominated informal carer in relation to the Service User’s proposed transition into a support package: |
|  |
| Perception of the Service User or their advocate about their potential service: |
|  |
| **Service User’s religious, cultural and terminal Care matters (note: normally this section is completed after service start).** |
| Service User’s wishes in respect of cultural and religious matters: |
|  |
| Service User’s wishes in respect of terminal Care (Preferred Priority of Care and/or Advance Care Plan): |
|  |
| **Accountability Signature:** | **Date:** |
| **Next review date:** |  |

**Support Needs (ADL) Assessment Tool**

|  |  |
| --- | --- |
| **Service User’s Name:** | **Key Worker Name Accountability Signature:** |
|  | **Low dependency** | **Medium dependency** | **High dependency** | **Comments** |
| **Communication** | No problems | Understands, slow to respond. | Unable to respond appropriately. |  |
| **Bath** | Independent | Can bath alone. | Cannot be left unattended. |  |
| **Washing** | Independent | Can wash most parts of body, help with feet and back. | Can wash only face and hands. |  |
| **Dressing** | Independent | Needs help with buttons & straps. | Needs full help with dressing. |  |
| **Grooming** | Independent | Can shave with help. Can make up with help. | Needs full help with grooming. |  |
| **Toilet** | Independent | Can cleanse self after toilet with support. | Unable to cleanse self. |  |
| **Continence** | Independent | Needs support to use toilet. | Incontinent. |  |
| **Eating** | Independent | Needs food prepared, can then eat independently. | Requires full support and encouragement. |  |

**Continued on next page.**

**Support Needs (ADL) Assessment Tool (Continued)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Drinking** | Independent | Independent using adopted drinking utensil. | Needs full support and encouragement for drinking. |  |
| **pressure ulcer Care** | No problems | Regular pressure relief and overlay mattress. | High risk pressure relief monitoring.Specialist chair cushions and bed mattresses. |  |
| **Social & Recreational** | Independent & sociable | Needs encouragement to join activities. | Very reluctant to socialise and take part in recreational pursuits. |  |
| **Moving and Handling** | Independent & weight bearing | Weight bearing but needs support. | Non-weight bearing, hoist only. |  |
| **Memory** | No problems | Short term memory able to communicate. | Unable to hold a rational conversation. Disoriented in time and place. |  |
| **Personality** | Socialises well | Prefers solitude and one to one conversation. | Withdrawn, or Manic |  |
| **Moods** | No problems | Tending to depression. | Depressive illness |  |
| **Pain** | No problems | Controlled by medication. | Severe pain; unpredictable. |  |
| **Sleep** | No problems | Occasional sleepless nights. | Very unsettled. |  |
| **Accountability Signature:** | **Assessment date:** |
| **Next review date:** |  |

**Support Needs Assessment Tool –**

To be used to conduct reviews, unless changes are sufficient to call for a full repeat of risk assessment, or 6 reviews have taken place.

|  |  |
| --- | --- |
| **Date & Signature** | **Review Details – Support Needs Assessment Tool** |
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| **Now complete a full review using the original risk assessment.** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date:** |  |
| **Assessor:** |  |
| **0** | **1** | **2** | **3** | **Comments** |
| **DEPRESSION** | None at present. | History of depression. | Mild depression, medication. | Severe depression, specialist services. |  |
| **MOOD** | No mood disorder. | Predictable mood change. | Unpredictable mood change. | Unable to be rationalised. |  |
| **ANXIETY** | Calm under pressure. | Anxiety after stress. | Anxiety easily triggered. | Severe anxiety. |  |
| **MEMORY** | Long and short term intact. | Mild short term memory loss. | Disoriented at times. | Unable to form links with the present. |  |
| **AGGRESSION** | No history of aggression. | Isolated history of aggressive outbursts. | Random episodes of violence. | Aggressive behaviour a regular occurrence. |  |
| **CHALLENGING BEHAVIOUR – MODERATE** | No history | Aggressive, no violence. | Abusive | Rummaging |  |
| Shouting | Invading privacy of others. |
| **CHALLENGING BEHAVIOUR – SEVERE** | No history | Violent | Destructive | Severe deviance |  |
| Screaming | Smearing | Others |
| **SELF HARM** | No history | Previous history of accidental self harm. | Previous history of deliberate self harm. | Severe risk of self harm. |  |
| **SELF NEGLECT** | No history of any form. | Previous neglect of diet, hygiene or appearance. | Current intermittent self- neglect. | Severe current risk of self harm. |  |
| **SUICIDE** | No history of any form. | Professionally assessed low risk | Significant current risk of suicide | Severe current risk of suicide |  |
| COMMENTS FROM OTHERS, PROFESSIONAL OR INFORMAL CARER:Presentation of behaviour in shaded cells indicates that the potential Service User may be suitable for a mental health registered service, but unsuitable for a general registered service, irrespective of aggregate score. Further detailed assessment may be necessary to decide appropriate placement. |
| Behavioural issues and strategies to cope: |
| **Accountability Signature:** | **Assessment date:** |
| **Next review date:** |  |

To be used to conduct reviews, unless changes are sufficient to call for a full repeat of risk assessment,

|  |  |
| --- | --- |
| **Date & Signature** | **Review Details – Mental Health Assessment Tool** |
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| **Now complete a full review using the original risk assessment.** |

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| --- | --- | --- | --- |
|  | Involved | Informed | Diagnosis |
| Service User’s Name: |  |  |  |
| Relative/Advocate: |  |  |
| Key Worker: |  |  |
| Assessor: |  |  |
|  | Independent | Supervised | 1Carer | 2Carers | Hoist (if ticked, note sling size) | Wheelchair Footrest Y/N | Other Aids | Fear | Pain |
| Inside the home |  |  |  |  |  |  |  |  |  |
| Outside the home |  |  |  |  |  |  |  |  |  |
| In and out of bed |  |  |  |  |  |  |  |  |  |
| Toilet |  |  |  |  |  |  |  |  |  |
| Transfer |  |  |  |  |  |  |  |  |  |
| Sit/Stand |  |  |  |  |  |  |  |  |  |
| Bathing |  |  |  |  |  |  |  |  |  |
| Stairs |  |  |  |  |  |  |  |  |  |
| General movement |  |  |  |  |  |  |  |  |  |
| Emergency situation |  |  |  |  |  |  |  |  |  |
| General Comments |  |
| Accountability Signature: | Assessment date: |
| Next review date: |  |

To be used to conduct reviews, unless changes are sufficient to call for a full repeat of risk assessment,

|  |  |
| --- | --- |
| **Date & Signature** | **Review Details – Service User’s Risk Assessment** |
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| **Now complete a full review using the original risk assessment.** |

To be used for risk areas not covered by specific assessments (not to be used where a specific assessment tool is available in this pack).

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| --- |
| Specific risk or hazard being assessed: |
| Identification of risk or hazard: |
| Existing risk control measures: |
| Further control action required: list any risks or hazards not adequately controlled and the action to be taken, where it is reasonably practical to do more: |
| **Accountability Signature:** | **Assessment date:** |
| **Next review date:** |  |

|  |  |
| --- | --- |
| **Date & Signature** | **Review Details – Generic Risk Assessment** |
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| **Now complete a full review using the original risk assessment.** |

# Letter of Placement Offer

Type on your letterhead. Change phrasing to suit letter either direct to Service User or representative. Date

Dear ,

Thank you for expressing an interest in the services offered by our organisation.

I confirm that we have carried out an assessment of your needs, and that we are able to provide the services which you require.

I enclose a copy of our Service User’s Guide which provides information which we are required to give you under Statutory Regulations, combined with some useful information about our services. The two copies of the Service Users Agreement have been signed by a representative of the service. Please sign the Provider’s Copy (at the back of the Guide), detach it from the Guide and returned it to us. You should keep the rest of the Guide for your own information.

I also enclose a copy of the summary of the latest Service User’s Satisfaction Survey carried out in on our service. We also include the summary page(s) of the latest **CQC report on our service.** A full copy can be supplied on request, and the report is also available on the **CQC** web site. If you require a personal copy, please contact me and I will arrange for a copy to be sent to you.

I confirm that we have arranged for (your) (your service start) (Mr/Mrs/Ms X’s service start for Xam/pm on (date). Our Manager, Miss MARIAMA NJIE mariana@mandnhealthcare.com 01212969496, and/or your proposed Key Worker/ Area Coordinator/Review & Assessment Officer will meet you on the first day to explain our services to you in detail, and ensure that you have all of our contact details.

We look forward to seeing you. Please contact us at any time in the meantime if you have any questions. Yours sincerely,

Miss MARIAMA NJIE mariana@mandnhealthcare.com 01212969496 Registered Manager

# Letter of Placement Rejection

Type on your letterhead. Change phrasing to suit letter either direct to Service User or representative.

Date Dear ,

Thank you for expressing an interest in the services offered by our organisation.

I confirm that we have carried out an assessment of your needs, and unfortunately we are not able to offer you a service, because we are unable to fully meet the full range of your needs which were identified during the assessment.

I am sorry that we have been unable to offer you a service. If I can be of any assistance in advising you as to other suitable services, please do not hesitate to get in touch.

Yours sincerely,

Miss MARIAMA NJIE mariana@mandnhealthcare.com 01212969496 Registered Manager

|  |  |
| --- | --- |
| **Service User Name:** | **Address of assessed premises:** |
| Service start date (if new check) |  |
| Smoke alarms (if fitted) |  |
| Cleanliness |  |
| Lighting |  |
| Temperature |  |
| Ventilation |  |
| Window opening checks |  |
| Sanitary conveniences |  |
| Washing facilities |  |
| Drinking water |  |
| Alarm/Call bell – bed (if fitted) |  |
| Alarm/Call bell – chair (or extension lead) (if fitted) |  |
| Chair height |  |
| Toilet height |  |
| Grab rails (if fitted) |  |
| Flooring (check for loose or worn carpet) |  |
| Bed safety rail (if fitted) |  |
| Doors and gates |  |
| Radiator surface temperature |  |
| Tripping hazards (i.e. trailing wires/cables) |  |
| Condition of external paths and steps |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Accountability Signature:** | **Assessment date:** |
| **Next review date:** |  |

|  |  |
| --- | --- |
| **Date & Signature** | **Review Details – Risk Assessment** |
|  |  |
|  |  |
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|  |  |
|  |  |
| **Now complete a full review using the original risk assessment.** |

# Pre-Service start Check List

|  |  |
| --- | --- |
| Service User Name: | Date and time of arrival: |
| **Action** | **Progress** |
| Enquiry sheet: |  |
| Information pack sent (enter date sent): |  |
| Brochure given to Service User: |  |
| Service User’s Guide sent (enter date sent): |  |
| Personal details: |  |
| Service commencement health assessment: |  |
| Skin/bruising record: |  |
| Service User and support worker compatibility assessment: |  |
| Support needs assessment tool: |  |
| Mental Health assessment: |  |
| Service User Risk Assessment: |  |
| Letter of offer of service: |  |
| Client accommodation assessed for suitability (risk assessed): |  |
| Person responsible for financial affairs of Service User identified: |  |
| Person responsible for financial affairs made fully aware of financial matters concerning service: |  |
| Contact name and telephone number given to Service User: |  |
| Person responsible for financial affairs made fully aware of financial matters concerning service: |  |
| Obtain recent photograph for Service User Support Plan: |  |
| Comments: |
| Signed: (Carer) | Date: |

**Service Consent Record**

|  |
| --- |
| Service User name: |
| For your protection and privacy, your consent is required before we request information from you, or carry out any examination or procedure.Please read the questions below, or ask someone to read them to you, and indicate clearly YES or NO to each question. You will be asked to sign against each answer. |
| Note to staff: the Service User must be given sufficient time to consider their responses to these questions. Do not pressurise the Service User into answering, and be prepared to leave the form with them and return. |
| **Date Consent Form given to Service User:** | **Date Consent Form received from Service User:**  |
| YES or NO (delete as appropriate) | (Signature) |
| 1 Do you consent to answering questions, giving information, and having that information recorded for the purposes of an assessment of your needs? |
| YES or NO (delete as appropriate) | (Signature) |
| 2. Do you consent to the service consulting with other professionals concerned with your Care or support for the sole purpose of obtaining information for the completion of this assessment? |
| YES or NO (delete as appropriate) | (Signature) |
| 3. Do you consent to having information recorded of any wounds or skin lesions for the purposes of considering your Care needs? |
| YES or NO (delete as appropriate) | (Signature) |
| 4. Do you consent to this assessment being read by staff who are or may provide Care and support for you (and only those staff)? |
| YES or NO (delete as appropriate) | (Signature) |

**Service Consent**

Used to conduct reviews of current assessment, unless sufficient changes require full risk re-assessment.

|  |  |
| --- | --- |
| Service User's Name: | Service start date: |
| **Review notes:**Consents requires repeating Y / N? |
| Date of review: | Next review date | Accountability Signature: |
| **Review notes:**Consents requires repeating Y / N? |
| Date of review: | Next review date | Accountability Signature: |
| **Review notes:**Consents requires repeating Y / N? |
| Date of review: | Next review date | Accountability Signature: |
| **Review notes:**Consents requires repeating Y / N? |
| Date of review: | Next review date | Accountability Signature: |
| **Review notes:**Consents requires repeating Y / N? |
| Date of review: | Next review date | Accountability Signature: |

# Note: All QCS Policies are reviewed annually, more frequently, or as necessary.