Nursing Needs Assessment
Decision Record Training
Programme

Notes for Trainers
Notes for Trainers

This presentation is designed to be used as the core of a training programme to inform nurses in Wales about the processes of assessment, decision-making, determination of eligibility for services, funding and completion of the Nursing Needs Assessment Decision Record (NNADR). It should be used together with the Welsh Assembly Government document, 'Guidance on Assessment, Decision-making, Eligibility and Completion of the Nursing Needs Assessment Decision Record' incorporating the 'Workbook on NHS Funded Nursing Care by Registered Nurses In Wales' December 2006.

Trainers should adapt this presentation according to the level of knowledge and experience within the group, adding or omitting slides as necessary.

The presentation will need to be integrated with and supplemented by training initiatives which take account of locally agreed policy and arrangements for the implementation of the Unified Assessment Process, Continuing NHS Healthcare, NHS Funded Nursing Care and hospital discharge. The target audience for this presentation is primarily any registered nurse who undertakes nursing needs assessments in any care setting. However, awareness training will need to be provided for other health and social care professionals involved in care provision, and elements of this presentation will be useful in this context.
Aim of Programme

To equip nurses to make and record consistent and well-informed decisions about the needs of an individual, following a nursing assessment.
These are the five key options for care listed on the Nursing Needs Assessment Decision Record. Following a nursing assessment, the nurse is required to decide which of these is appropriate and record the rationale for this decision on the NNADR.

Following the training, nurses will be able to make and record the decision, following assessment, that:

A. The individual has health care needs which may give rise to eligibility for Continuing NHS Healthcare and requires further multidisciplinary assessment;

B. The individual has nursing needs and is eligible for NHS Funded Nursing Care in a care home with nursing;

C. The individual has health care needs which, through accessing other assessments or care options, (e.g. intermediate care, rehabilitation, mental health) will minimise the risk to independence;

D. The individual has nursing needs, which may be managed in a community setting or a residential care home;

E. The individual has no nursing needs.
Notes for Trainers

In order to make this decision the nurse will need a thorough understanding of the context within which the NNADR is used.

- Nursing Assessment within the context of Unified Assessment
- Continuing NHS Health care
- NHS Funded Nursing Care
- Local hospital discharge policies
- Locally available health & social care services

The NMC code of Professional conduct requires a nurse to communicate effectively, to be competent and deliver best practice at all times. The NNADR is a tool which will support nurses within this requirement.
Notes for Trainers

Nurses must make the process of decision making a conscious one, both in deciding which evidence to use and what decisions are relevant to which patients.

Clarity of decision making and transparency of decision making is essential not only between nurses but also when nurses are involved in multi-agency and multi-professional working but also for patients, relatives and carers. This is especially true within the Unified Assessment process.
The NNADR records that the assessing nurse has given consideration to an individual’s potential eligibility for Continuing NHS Healthcare and provides the rationale for eligibility decisions in relation to NHS Funded Nursing care. This is vital in ensuring that people receive appropriate care and funding for that care, as well as providing evidence in cases of dispute.

The All Wales Continuing Health Care Special Review Panel Co-ordinator has reported that the lack of Multi-disciplinary assessment relating to the patient’s eligibility for Continuing NHS Funded Healthcare prior to admission to a care home is a major problem in almost every case investigated so far at Special Review Panels.

Of the first 400 cases heard at Continuing NHS Funded Healthcare Special Review Panels in Wales, approximately 70% have been either fully or partially reimbursed.

There are many benefits in nurses recording their recommendations for care:
- Clarity of decision
- Justification of decision
- Inform patients, carers and others involved in care regarding decisions
- Transparency of process
- Avoid legal challenge
Notes for Trainers

Suggested exercise: Thought shower - ask the group to consider

1. What problems have arisen in your areas as a result of poor record keeping in relation to eligibility for services or long term care and
2. What are the wider benefits in using the NNADR, for the individual, the nurse, LHB, Trust and partner organisations.

Possible responses:

1. Lack of consistency, inappropriate placements, delayed discharges, emergency pressures, confusion for all parties, complaints, litigation, negligence, individuals not receiving the funding they may be entitled to.
2. Ensuring that care needs are met appropriately, avoiding unnecessary admissions to care homes, making best use of available resources and care home beds, facilitating the discharge process by providing clear information and direction to partner organisations, including social care services.
Notes for Trainers

Carroll and Johnson (1990) 7 Temporal stages of decision making

- Recognition of the situation
- Formulation of explanation
- Alternative generation of other explanations
- Information search to clarify choices and available evidence
- Judgment or choice
- Action
- Feedback

The aim in this situation is completion of the NNADR = action and feedback
To conclude and reinforce this section, the whole process of decision making depends on good record keeping for its effectiveness, to:

- Ensure continuity of care
- Prevent duplication and repeated questioning
- Ensure that the individual, carers and care team is informed about the needs to be met
- Ensure openness and transparency to service users
- Decisions taken can be justified if challenged

Notes for Training

This lists some key policy documents. There are many others, including those relating to specific groups of people e.g. older people, people with mental health problems etc. You may want to identify others, depending on the specific audience.

Improving Health in Wales - A Plan for the NHS with its Partners (July 2001) set out the Welsh Assembly’s plans for modernisation, including specific plans for the funding of long term care. It provided the Welsh Assembly’s response to the proposals made by the Royal commission on Long Term Care.

Designed for Life (WAG 2005) builds upon this, reinforcing and developing the policy direction set in 2001.

The Unified Assessment is the key context within which a nursing assessment is carried out and will be addressed in more depth within this presentation.

The new guidance on Continuing NHS Healthcare (2004), addresses issues raised by several legal judgments and the Health Services Ombudsman. The first consideration should always be the extent to which the identified needs of the individual may meet the criteria for Continuing NHS Healthcare. See also WHC(2006) O46/NAFWC 32/2006: Further advice to the NHS and Local Authorities on Continuing NHS Health Care.

NHS Funded Nursing Care in Care Homes, Guidance 2004 provides the information on all necessary arrangements for the implementation of NHS Funded Nursing.

Lastly, the Assessment, Decision-making etc. document contains the Workbook on NHS Funded Nursing and further guidance on the use of the NNADR. This is the key document for nurses using the NNADR and provides the foundation for this training. A more comprehensive list of related documents is included in Annex E to the Workbook.

1With Respect to Old Age: A Report by the Royal Commission on Long Term Care, Chaired by Sir Stewart Sutherland.
Identifying Nursing Needs in the Context of the Unified Assessment Process

- Creating a Unified and Fair System for Assessing and Managing Care (2002)
- Identifying registered nursing input is approached on an individual basis following an in depth assessment as part of the Unified Assessment Process

Notes for Trainers

The guidance ‘Creating a Unified and Fair System for Assessing and Managing Care’ (2002) provides the key context in which assessments and decisions relating to long term care are considered. The document Assessment, Decision-making, Eligibility and Completion of the Nursing Needs Assessment Decision Record builds on and reinforces the principles contained within the Unified Assessment guidance.

There are real gains to be made through the Unified Assessment Process involving all the health and social care agencies that are involved in the care of the individual. These include:

- Helping to bring about ‘person-centred care’ and provide flexible and appropriate care irrespective of the administrative boundaries between health and social care services.
- Professionals work together in the best interests of the person being assessed;
- The person’s (and carers’) views and wishes are central to the assessment process;
- Assessment builds a rounded picture of their problems and circumstances;
- The depth and detail of the assessment is proportionate to their needs;
- Assessment is supported by an appropriate evidence base;
- The process builds upon and supports existing good practice.
Notes for Trainers

The unified assessment process enables professionals to see and recognise each other’s contribution to care:

- It is useful to those practitioners responsible for its day to day operation;
- It enables professionals to see each others’ contributions to assessment, which are subsequently trusted and accepted;
- Information about problems is given once, no matter that the assessment and subsequent care planning and service delivery involves a number of professionals and agencies;
- It can produce sets of agreed, evidence based standardised assessment information and a single summary record on individual cases;
- It facilitates the sharing of case information between professionals and also generates large scale information for strategic planning and performance monitoring;
- It focuses on the outcomes of care for the individual and it uses the full range of shared assessment information to develop appropriate and effective care plans and services;
- It promotes the health, independence and quality of life of people seeking help.
The Wimpenny (2002) typology

The individual assessors mental model is shaped by their professional and life experiences, the service user and the situation found, carer etc.

The theoretical model or professional model influences the questions asked, the needs uncovered and the outcomes agreed. Without a conceptual model or the use of an inappropriate model of assessment, the data collected will be less effective. It enables intervention and achievement of outcomes (Dougherty and Lister, 2004).

The surrogate model is the framework for assessment, re-assessment and review, the flow of information and the avoidance of duplication. It ensures that there is a process by which an individual’s eligibility may be reconsidered as their needs change.

The environment within which a person is assessed and the service model types available within the organisations is added. E.g. considering an intermediate care package is not a reality if the services don’t exist. However, it should be noted that the setting of care should not be a determinant of eligibility.

All of these impact on the assessment by the multi-disciplinary team, as to whether a person’s needs are identified and whether or not they meet the criteria for services.
**Notes for Trainers**

A reminder of all the domains of assessment considered in the overview assessment. Various other specialist assessments may be triggered and can be used to inform the in-depth nursing assessment.
Notes for Trainers

Agencies are developing systems based on four broad types of assessment which vary in their breadth and depth. They are likely to be undertaken within a unified process, rather than in discrete stages.

The contact assessment refers to the initial contact with services e.g. GP. The nature of the presenting problem is determined, and whether or not there are wider needs. Basic personal information is collected. For some people, the contact assessment will be sufficient to determine and address the person’s needs but if complex or multiple problems need to be examined the professionals may decide to proceed further.

The overview assessment is the stage at which all or most of the domains are covered and further, in-depth needs are identified. This stage may be sufficient to fully describe the person’s needs; if not, it will trigger the need for further assessment. If the needs for an overview assessment has been immediately apparent, this will have commenced as soon as basic personal information has been collected.

Specialist / In-depth assessment is the further exploration of specific domains that may have been indicated by the contact or overview assessment. In depth assessments require the judgement of appropriately qualified and experienced professionals e.g. O.T.s, physiotherapists, registered and specialist nurses, geriatricians. Overview and in-depth assessments may involve standardised tools / scales to support professional judgement e.g. Geriatric Depression Scale or Mini-Mental State Examination.

A comprehensive assessment may arise in different ways. The completion of in-depth assessment of all or most of the domains of the assessment process constitutes a comprehensive assessment. This may also be instigated at first contact where it is apparent that the person’s needs are complex and multiple. Comprehensive assessment should also be completed when the level of support and treatment likely to be offered is intensive and complex e.g. permanent admission to a care home, intermediate care services, intensive packages of care at home. The assessment will also need to consider what decisions may be required following the assessment, including eligibility for continuing NHS health care or NHS Funded Nursing Care. No decision should be made prior to the evaluation of all information generated by the comprehensive assessment (including potential for rehabilitation).
Who will undertake the nursing needs assessment?

- A registered nurse employed by the NHS (or otherwise acceptable to the LHB), in conjunction with the care co-ordinator (if a different person) and/or the multidisciplinary team.
- Nurses will be appropriately trained and familiar with nursing assessment models, local arrangements for Unified Assessment and the range of care available locally to meet the diverse needs which may be identified.

In which situations?

Notes for Trainers

A key point at which a nursing assessment may be undertaken is when an individual is ready for discharge from hospital. Assessors need to ensure that they follow local procedures for hospital discharge, which should follow the latest guidance issued by the Welsh Assembly Government in 2005.

Exercise

Can the group think of situations when the NNADR should be completed? Encourage discussion.

Ward nurses - discharge planning, transfer to secondary, community care or long term care placements.

Community nurses - If there is a change in the individual’s condition, i.e. to determine needs and appropriate placement.

Nurse Assessors/reviewers - for NHS Funded Nursing Care, as part of the assessment for eligibility for continuing NHS health care.
Notes for Trainers

The continuum cannot be reproduced on a slide - it is in the workbook document.

You may want to take the audience through the key stages of the process, and identify where and when the NNADR may need to be completed.
Notes for Trainers

Moving into a care home has enormous practical and emotional significance. While most people want to remain in their homes for as long as they can, and maintaining independence should be promoted wherever possible, there comes a time for some people when such objectives are neither realistic nor fair. Some people welcome admission as it offers appropriate and round the clock care, security and companionship. Other people approach such a move with some concerns, and everything should be done to minimise distress and provide reassurance. It is especially important therefore, to explain the purpose of assessment to the patient and that they - and their carers or family where possible – understand as far as possible what is happening. It is equally important to ensure the involvement of the patient and carers in the assessment process, and the subsequent decision-making on future care, as the decision should be made by the patient wherever possible.

**Mental Capacity Act 2005 - implementation is being planned for 2007**

The act sets out the best practice approach to determining capacity - whether an individual is able, at a particular time, of making a particular decision. It is decision specific. There is no recommended capacity test.

All decisions must be made in the best interests of the person who lacks capacity. Best interests is not defined but there is a checklist. All relevant circumstances must be considered:

- Must involve the person who lacks capacity
- Have regard for past and present wishes and feelings
- Consult with others who are involved in the care of the person
- There can be no discrimination

Refer to section 5 of NMC Code of conduct
Notes for Trainers

Bradshaw's taxonomy of need may remind the group that there are different perceptions of need:

**Normative need:** Is that which the expert or professional, administrator or social scientist defines as need in any given situation.

**Perceived (felt) need:** This reflects the individual's own assessment of his or her needs or requirement for health care.

**Expressed need (demand):** This is felt need converted into action by seeking assistance.

**Comparative need:** A person is defined as in need where they lack what a selected comparative group has e.g. poverty defined as below a certain % of average annual income (may overlap with Normative Need).
Know the feeling?! So we need to be specific about what needs are - our perception of need may be different from that of the individual we are assessing.
Notes for Trainers

Taken from Defining nursing (RCN 2003). It may be useful for the group to re-visit the defining characteristics of nursing, listed within this document.

It may be useful to refer to:-

- Defining Nursing, RCN (April 2003)
- What a difference a nurse makes: An RCN report on the benefits of expert nursing to the clinical outcomes in the continuing care of older people (May 2004)
Building on information gained from the overview assessment, all nursing needs should be identified.

Holistic assessment using recognised models of nursing within the context of the UAP. Full account should be taken of people's conditions and their usual behaviour over the course of a week or a number of weeks.

Consideration must be given to the potential outcomes if help was not provided, or provided in different ways.
Assessment is not just the collection of information about a person’s immediate problems and circumstances. It is also about analysing those problems to identify assessed need and make decisions on the most appropriate care options.

NB Individuals in care homes have the same access to NHS services as any other individual.

If there is no service available to meet an identified need, the assessing nurse should raise this issue through local reporting procedures.

What other referrals might your group make?
Notes for Trainers

These are the five main options for care listed on the Nursing Needs Assessment Decision Record. Following a nursing assessment, the nurse is required to decide which of these is appropriate and record the rationale for this decision on the NNADR.

Following the training, nurses will be able to make and record the decision, following assessment, that:

A. The individual has health care needs which may give rise to eligibility for Continuing NHS Healthcare and requires further multidisciplinary assessment;

B. The individual has nursing needs and is eligible for NHS Funded Nursing Care in a care home with nursing;

C. The individual has health care needs which, through accessing other assessments or care options, (e.g. intermediate care, rehabilitation, mental health) will minimise the risk to independence;

D. The individual has nursing needs, which may be managed in a community setting or a residential care home;

E. The individual has no nursing needs.

(Slide repeated, see discussion of options on next sheet).
Making a judgement on the most appropriate care options will require a full analysis of all assessment information, taking account of the prognosis of people’s conditions and the likely outcomes if help was not provided, or was provided in different ways. In making this evaluation, professionals should also focus on the impact of any decisions on people’s independence, and the risks involved for the person, their family and others close to them.

It is important to point out that all establishments providing accommodation with personal or nursing care are now described as care homes. Not all care homes are registered to provide nursing care. Those which are (previously called nursing homes) tend to be referred to now as ‘care homes with nursing’. They have a registered nurse on site at all times. They are distinct from other care homes (previously residential homes) which provide for people who are dependent, needing social and personal care, but who do not require access to nursing care other than that available in the community from the usual community nursing services.

In making a nursing assessment of someone in a care home, or potentially moving into one, the information will be used to determine what kind of care they need and, where appropriate, which type of care home will be most suitable to meet their needs. This information will therefore be the basis for determining whether or not they are eligible for NHS Funded Nursing Care, or what alternatives need to be considered.

**Notes for Trainers** (continued)

Understanding Care Options

These are the main outcomes likely to result from a nursing assessment:

- Has health care needs which may give rise to eligibility for Continuing NHS Healthcare (requiring further assessment)
- Is eligible for NHS Funded Nursing Care
- Requires other assessments or care options e.g. intermediate care
- Has nursing needs which can be met in the community
- Has no nursing needs
Notes for Trainers

All other care options should be considered. These may include: Rehabilitation, Intermediate Care, Hospital at home, Residential Care, Community nursing or therapy services, Day Care, Social care at Home…
Notes for Trainers

Long term or continuing care is a general term that describes the care which people need over an extended period of time, as the result of disability, accident or illness to address both physical and mental health needs. It may require services from the NHS and/or social care and can be provided in a range of settings.

More specifically, continuing NHS health care describes a package of health care arranged and funded solely by the NHS.

Where health needs are first described or suspected (e.g. during an enquiry or contact assessment), particularly where it appears likely that a person may need to remain in hospital, enter a residential or nursing home, or require a significant level of support in the community, a comprehensive assessment will normally be necessary. This should include an assessment for eligibility for continuing NHS health care.

When someone is eligible for continuing NHS health care, their care home fees will be paid in full by the NHS: alternatively a package of care at home may be provided, where all care provided to the individual is the responsibility of the NHS. Other agencies may be involved e.g. in support to carers, in provision of accommodation etc.
A wide variety of circumstances will trigger the decision to carry out a comprehensive assessment. More specifically, the need to consider eligibility for continuing NHS Healthcare within that assessment would be triggered by the answers to questions such as those above.

If the answer to any of these is yes, a comprehensive assessment, including assessment for eligibility for continuing NHS Healthcare, will be initiated. In addition to these triggers, in making decisions about the type or level of assessment required, assessors will need to rely on their judgement. In particular, in normal circumstances, an admission to a care home should not take place without a comprehensive assessment (including consideration of possible eligibility for continuing NHS healthcare). Where such an admission has occurred (e.g. in an emergency), an assessment should be undertaken as soon as possible after admission.
Notes for Trainers

Improving Health in Wales - A Plan for the NHS with its partners accepted that registered nursing care should be free of charge to the recipient, in all settings. It was therefore announced that the NHS would meet the costs of registered nurse time spent on providing, delegating or supervising care in any setting.

Introduced for self-funders Dec 2001 then extended to those supported by local authorities in April 2004. The standardised payment is currently £111 per week (2006-7), and is reviewed annually. You should check the current payment with the LHB. This is payable either directly to the care home or via local authorities where involved, to simplify the payment procedures.

The payment includes the cost of continence care and absorbent products.

The contracting for and monitoring of the Nursing care provided is the responsibility of the LHB in which the home is located. Each LHB has a responsibility to monitor the quality and consistency of nursing assessments and decision making, and providing professional nursing advice on assessment and care planning issues and service delivery plans.
Notes for Trainers

In making their assessments, nurses have to decide whether or not each person needs nursing care provided by a registered nurse, and this can only be provided in a care home providing nursing care, this will trigger the funding for the registered nursing care costs to be met by the NHS.

According to Section 49 of the Health and Social Care Act (2001) “nursing care by a registered nurse” means any services provided by a registered nurse and involving:

- The provision of care or the planning, supervision or delegation of the provision of care,
- Other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse.

This does not include:

- Time spent by non-nursing staff such as care assistants (although it does cover the nurse time spent in monitoring or supervising care that is delegated to others) or Personal or social care or the accommodation provided to residents.

Nursing care in these circumstances includes only nursing services which need to be provided by a registered nurse in accordance with section 49 of the Health and Social Care Act 2001, and are not of a quality or quantity beyond that of the community care services which may be provided by a Local Authority under section 21 of the National Assistance Act 1948. That is, they should not be more than incidental or ancillary to the provision of such services by a Local Authority and as being of a nature which a Social Services authority could not be expected to provide (or could have been expected to provide before the coming into force of section 49 of the Health and Social Care Act 2001).

It is important here for nurses undertaking assessments to consider whether the extent of nursing or other health care required goes beyond that appropriate to be funded by NHS Funded Nursing Care, and may be sufficient to trigger possible eligibility for continuing NHS health care. In this case, referral for further assessment and consideration for eligibility for continuing NHS health care should be initiated. (See also Slide 32)
Notes for Trainers

The following are the explanation of the indicators contained in the NNADR form - see additional comment with next (duplicate) slide

Unpredictability: The unpredictability of the individual’s clinical condition, disease process or behaviour requires monitoring by a registered nurse. (Monitoring - When changes to the individual’s condition cannot be anticipated with certainty, requiring ongoing assessment or review by a registered nurse)

Complexity: The particular combination or complexity of the individual’s physical and/or mental health needs require the clinical judgement of a registered nurse in the frequent reassessment or adjustment of nursing interventions. (Clinical judgement - A registered nurse’s decision about an individual’s condition and the required resulting action, based on their observation, knowledge and experience, and any relevant information or advice from others.)

Stability: The individual’s unstable/alternating/irregular disease process (alternating or irregular) may require monitoring and/or prompt intervention or treatment from a registered nurse. (Intervention by a registered nurse - The actions undertaken by a registered nurse based on their clinical judgement of an individual’s needs.)

Risk: The risk of harm to the individual or others may require the immediate availability and intervention of a registered nurse, or makes the placement in a care home with nursing otherwise appropriate.
The issue may be raised that the language of decision-making used here is similar to that used in the criteria for Continuing NHS Health care. You may wish to discuss a number of points here:

1. These indicators (and the criteria for Continuing NHS Health Care) are more specific than that, and need to be considered in full. The use of the terms complex or unpredictable on their own are meaningless - e.g. there can be complex or unpredictable nursing, health or social care needs.

2. The focus here is on the need for care by a registered nurse only. While the guidance on Continuing NHS Health care does say that this may not be sufficient reason for receiving continuing NHS health care by itself, the intensity of the nursing care required may trigger eligibility for continuing NHS health care. The questions to be asked include:
   a. where or not the person needs the care of a registered nurse in a care home (or can be managed in a care home without nursing);
   b. whether the care of a registered nurse in a care home is sufficient care to meet the needs;
   c. whether all the nursing care and/or other health care provided, which needs to be provided, either by, or under the supervision of registered nurses or otherwise is incidental or ancillary to the person's need for accommodation, in accordance with section 21 of the National Assistance Act 1948, and is of a nature which a Social Services authority could be expected to provide (or could have been expected to provide before the coming into force of section 49 of the Health and Social Care Act 2001), or whether, alternatively, it is at a higher level in terms of quality or quantity;
Notes for Trainers (continued)

d Whether the person’s primary need is for health care.

(Responses to these questions will indicate where referral for further assessment and consideration of eligibility for continuing NHS health care should be arranged).

3 There will be circumstances where the nature and/or intensity of nursing need alone is such that it may trigger the need for further assessment and consideration of eligibility for continuing NHS health care, and this must be borne in mind.

4 It is a matter of professional judgement, based on an understanding of the nursing need indicators, and the criteria for eligibility for continuing NHS health care; this is why it is important that decisions are explained fully in the documentation.
Notes for Trainers

The following four slides are not exact replicas of the NNADR form. They are incorporated here to aid you in following through the explanation of the form. Students should work from the paper copy of the form supplied.

What it is Not

• It is not a placement record.
• It is not for the nurse, or nurse assessor to record the most appropriate placement, either on discharge from hospital, or transfer / admission to long term care in the community.
• That is a decision made by the multi-disciplinary team.
• It is not an assessment tool.
• It will be up to the individual nurse / organisation which assessment tool they use provided it is part of the Unified Assessment process, and covers the appropriate domains and sub-domains of assessment.

What it is

• It is a record of the decision made of any in-depth assessment of the individual’s nursing needs, whether it is to:-
• indicate the need for further multi-disciplinary assessment for Continuing NHS Healthcare
• give an indication of the most appropriate environment for that individual’s long term care needs on discharge from hospital
• determine eligibility for Funded Nursing Care

The options on page 1 are presented in order of importance.
Notes for Trainers

This page explains the indicators that determine the level of care needs of the individual, remembering that it is the intensity of the indicators that are important.

When it is printed in A3 format, they are purposefully placed opposite page 3 to inform the nurse when recording the process.

Each of the 4 pages has the individual's name, their "unique" identification number, and the date of the assessment or review. The main reason for this is that, even though it is an A3 document, there is a risk that if it had to be photocopied or faxed, the record could become broken up or separated.
Notes for Trainers

Looking at page 3 of the document it can be seen that there is a box for each indicator. This allows the nurse to indicate whether Yes or No – the individual does or does not meet that indicator.

The nurse must then give an explanation of their decision in each box.

The individual may only have one indicator out of the four ticked as YES, but may determine them as eligible for Funded Nursing Care.

However, just because they may be only unpredictable, it may not necessarily mean that they will require nursing care in a care home providing nursing. For example, diabetic monitoring may be successfully achieved by the district nurses in the individual’s home, depending on local arrangements / resources.
Notes for Trainers

This is the most important part of the document.

It is where the decision made after the assessment is recorded.

It records that the individual and / or their representative has been involved in the process and that they are aware of the decision, supported by the signature of the assessor.

Should the individual be eligible for NHS Funded Nursing Care, there is a space for a separate signature on behalf of the responsible Local Health Board (as it is they who are responsible for paying the nursing care contribution). This is usually signed by the Lead Nurse, and indicates that they agree that the assessment was valid, recorded enough information to determine the level of needs of the individual, and that they will fund the nursing care element of their care home costs.

There is also a list of individuals who may, upon request, and with the permission of the individual or representative, receive a copy of the assessment and decision record.

If it is felt that the individual may require further consideration for Continuing NHS Healthcare, there is a space to record to whom, and when the individual was referred, according to local arrangements.
Exercise

Using example no. 2 in Annex F of the Guidance, complete the decision record for Mr. Davis, following the guidance given.

Notes for Trainers

The trainer will need to talk the group through the completed example, discussing the completed NNADR with the group – the answers are already given in the Workbook!
In conclusion, the process of nursing assessment is incorporated within the context of unified assessment. Therefore, decision making and the recording of that decision needs to be clear and accurate. A robust assessment can be achieved by ensuring that the nurse fully understands both the model of assessment used and the context within which he/she is practising. This will enable him/her to identify and define the patient’s needs.
Notes for Trainers

It is expected that, following a nursing assessment, nurses will be competent in making and recording the decision that the individual:-

- Has health care needs which may give rise to eligibility for Continuing NHS Healthcare (requiring further assessment)
- Is eligible for NHS Funded Nursing Care
- Requires other assessments or care options e.g. intermediate care
- Has health needs which can be met in the community (incl. residential care)
- Has no nursing needs

However, depending upon previous experience and training in relation to funded nursing care and continuing NHS healthcare in particular, further training and opportunities for learning may be required in order for the nurse to achieve competency as above. Nurses could take this opportunity to set such objectives. In addition, a period of support and supervision may be required in practice. Local arrangements for assessing competency and auditing decision making, will need to be put in place.

Note

The following slides are not intended as part of the presentation, but can be printed off with the other slides as part of the handout, to provide information on related documents and links, to enable follow up study.
DOCUMENT AND REPORT LINKS

Strategy Documents

The Review of Health and Social Care in Wales: [http://www.wales.gov.uk/subeconomics/content/hsc/contents-e.htm](http://www.wales.gov.uk/subeconomics/content/hsc/contents-e.htm)
Carers Strategy 2nd Report: [http://www.wales.gov.uk/subeconomics/content/hsc/contents-e.htm](http://www.wales.gov.uk/subeconomics/content/hsc/contents-e.htm)
Carers Strategy Implementation Plan: [http://www.wales.gov.uk/subsocialpolicy/content/pdf/carers_e.pdf](http://www.wales.gov.uk/subsocialpolicy/content/pdf/carers_e.pdf)
Guidance/Circulars:

NHS funded nursing care:
continuing NHS healthcare:
Joint working special grant report 2004:
http://www.wales.gov.uk/subsocialpolicy/content/grant/special-grant-report-2004-e.pdf
POVA: http://www.wales.gov.uk/subsocialpolicy/content/grant/special-grant-report-2004-e.pdf
Other useful docs/links:

NAO report - Ensuring the Effective Discharge of Older People from NHS Hospitals:
http://www.nao.org.uk/publications/nao_reports/02-03/0203392.pdf
LGA report A Whole in One – the whole systems approach to delayed discharges:
CSI report: Leaving Hospital – the Price of Delays:
CHI/SSIW Discharge Report:
http://www.wales.gov.uk/subsocialpolicysocialservices/content/inspections/thematic-e.pdf
House of Commons Select Committee report on delayed discharges:
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