Abbeyfield The Dales Limited
Policy & Procedure / Good Practice Guidelines
Policy Ref: C017P
Effective Date: July 2026
Next Review Date: July 2029

Needs Assessment

1. Background

This policy and procedure have been developed to ensure a consistent approach across all Abbeyfield The Dales services to the assessment of residents' needs.

2. Objectives

The aim of this policy and procedure is to ensure that:

- All staff within the service will understand the importance for each resident to have a thorough and accurate needs assessment prior to admission and then ongoing assessment to deliver safe and appropriate person-centred care.
- Abbeyfield The Dales will comply with relevant current legislation and regulations.

3. Scope

All established staff, agency staff and volunteers working in the service.

This policy applies to Abbeyfield the Dales Limited and its corporate trustee responsibilities for registered providers Charles Edward Sugden Almhouses, and Frank Crossley's Almshouses, also for the non-registered provider The Pawson Cottage Homes, and its subsidiary Abbeyfield Court Limited.

4. Policy

All prospective residents, regardless of their circumstances, will have their needs assessed by the registered service prior to admission to ensure the service can meet their needs and expectations.

All residents can be assured that their needs will be reviewed with them and their family or advocate (as needed) regularly following admission, and that safe and appropriate personalised care, treatment and support will be provided which meets their individual needs and preferences.

5. Finance, Value for Money & Social Value

N/A

6. Supported Appendices

APPENDIX 1: Pre-admission Needs Assessment Form.
APPENDIX 2: Day One Assessment Form - This form is the same as the Pre-Admission Needs Assessment but gives more information about the answers given in the Pre-Needs Assessment.

7. Linked Policies

Admission of Residents (C002P)
Care Planning and Key Working (C008P)
Personal Risk Management (R012P)
Consent to Treatment and Personal Care(C009P)
Mental Capacity Act (C015P)

8. Legislation/Regulation

Section 20 regulations of the Health & Social Care Act 2008 - Essential Standards of Quality and Safety

Outcome 4: Care and welfare of people who use services

9. Review

Every 3 years, subject to any regulatory or legislative updates.

10. Procedure/Guidance

10.1. Pre-Admission Needs Assessment

A suitably trained person should carry out an initial needs assessment with all prospective residents (and their family or advocate where appropriate), regardless of their circumstances, prior to admission. The assessment will take account of the prospective resident's personal circumstances and will reflect their individual needs, preferences and diversity. The assessment should include any known or foreseeable risks to the individual's health or wellbeing.

The assessment process should involve the prospective resident's relatives or advocate if the prospective resident so wishes, and other health and social care professionals and providers involved in their care to ensure a coordinated needs assessment.

The initial needs assessment should capture as much information as possible and must include sufficient information to enable a decision to be made about whether the service can meet the prospective resident's needs. Abbeyfield The Dales' Pre-admission Needs Assessment should be used to ensure all the required areas of care are assessed. The Pre-admission assessment that must be used is attached at appendix1.

Where a prospective resident's needs have also been assessed by a local authority, a copy of this needs assessment should be given to the service.

Written confirmation (via e-mail) of the outcome of the pre-admission needs assessment and whether the service can meet the prospective resident's assessed needs should be sent to the prospective resident. A copy of the e-mail should be retained and attached to the resident's PCS file.

Prospective residents should be given the opportunity to appeal against the outcome of the needs assessment if they are dissatisfied and should be referred to the Abbeyfield The Dales Complaints Procedure.

If a placement or tenancy for an applicant is agreed and a move in date confirmed, then the details of the pre-admission assessment must be entered onto our resident care plan system, Person-Centred Software (PCS), and other parts of the initial care plan must be complete at least the day prior to the applicant moving in.

An appointment must be made with the resident and their family (or advocate) for the day they move in so more information can be gathered about our new resident to ensure a more tailored and person-centred service can be provided from day 1.

10.2. On Admission

The Registered Manager must ensure that the Day1 Assessment form is complete during the scheduled meeting with the new resident and their family or advocate. The resident's care plan on PCS must be updated with the additional information from the Day1 Assessment Form within 48 hours; this means a comprehensive care plan will be created within 72 hours of a new resident moving in.

During the meeting, the accuracy of the pre-admission needs assessment should be reviewed, especially where it is more than 7 days since it has been completed, checking that all the information provided remains current, paying particular attention to the resident's medication and care needs.

If the resident has a legally appointed advocate, a copy of the supporting documentation should be provided by the prospective resident.

The Day1 assessment includes a Personal Risk Screening Tool which can be used for up to six weeks for long stay residents during their initial trial period and for short stay residents. As we get to know the resident better, we can assess the levels of risk derived from the initial risk screening, and a formal review should be carried out within the first 6 weeks of their stay if the resident decides the move is permanent.

The service's approach to the management of risk should be explained to the resident and their relative or advocate on admission if this has not already been discussed. Agreement should be reached with the resident and their relative or advocate about the level of acceptable risk which ensures the resident has control over their daily life whilst minimising the risk of harm.

Where an area of risk has been identified, actions to reduce or remove risks must be agreed and recorded in the care plan. A full risk assessment must be completed within 48 hours and any further actions to reduce or remove the risks must be added to the care plan.

Referral should be made to the GP or other relevant health, or social care professionals should be made within the first 48 hours of a resident moving in with us if the need for specialist advice or treatment has been identified during the assessment process.

The resident should be asked to sign a consent form, within their first week of their stay, to indicate their participation and agreement to the care detailed in their care plan. Where the resident is unable to consent to the care in their care plan, the resident's relative or advocate should be asked to sign to indicate their involvement in the development of the care plan in the resident's best interests.

10.3. The First 6 Weeks

Staff should be sensitive to the worries and fears of new residents and understand that residents may exhibit unusual behaviour because of their worries and fears. Staff should be aware of the symptoms of grieving in response to loss and that residents may experience some of these symptoms because of their move to the service. Staff must document their welfare visits; updating or adding to the care plan with any new insight or information they have been told during their discussion with a resident..

The information we have gathered pre-admission and on Day1 and recorded on PCS should be further developed with the resident and, or their relatives or advocate as we get to know them better, and more information of detail becomes available through conversation with the resident, their family or advocate through discussion with their GP or other Healthcare Professional, or through our own observations. This will form the basis of the resident's long-term care plan should they decide to make the service their permanent home.

All care and treatment should be planned and provided in a person-centred way and should take account of the individual resident's age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have.

The Personal Risk Screening Tool completed as part of the resident's Day1 meeting should be reviewed within the first 6 weeks of their stay to ensure it remains valid, and adjustments made to the care plan, and actions are updated and agreed accordingly to reduce or remove risks; the review and any changes need to be recorded in the resident's care plan on PCS.

The resident should be asked to share their life story or personal history, and this should be written down, at the same time residents should be sensitively encouraged to complete their My Wishes document with a trusted member of staff and with appropriate support. The purpose of life story work is to enable the staff within the service provide a person-centred approach which focuses on what is important to the resident and this should be explained to the resident and their family or advocate. The resident may be happy to write these themselves or may prefer a relative to do this with them. They may want a member of staff to spend time with them and to write down the things that they are happy to share. However, if the resident is unable to actively participate, then they should be asked to nominate a person who they would like to do this on their behalf. If this is not possible, then this should be discussed with the resident's relatives or advocate, and contributions should be sought from people who know the resident. Although life story work is an ongoing activity, this should be commenced within six weeks of admission.

10.4. After 6 Weeks

After six weeks a formal care review meeting should be held with the resident, and their relative or advocate if the resident so wishes, to review the resident's experience of the service during this initial period of their stay, and if the placement is permanent. If it is agreed that the service can meet the resident's expectations and needs and the resident decides to stay at the service, the care plan will be further developed with them. The Pre-admission Assessment, Day1 Assessment, and Personal Risk Screening Tool should not be used beyond this point.

The following risk assessments should be completed with all permanent residents:

- A skin and pressure sore risk assessment using a suitable risk assessment tool, e.g. Waterlow assessment, which is then reviewed monthly or if there is a significant change in the resident's condition.
- A moving and positioning risk assessment which is then reviewed monthly or if there is a significant change in the resident's condition. The resident and their relative or advocate should be aware of the moving and positioning policy and the possible use of equipment such as hoists and slings.
- A falls prevention risk assessment which is then reviewed monthly or if there is a significant change in the resident's condition.
- A nutritional risk assessment using the MUST screening tool and a record of their weight (Residential only) which should then be reviewed monthly or if there is a significant change in the resident's condition.
- A Fire safety risk assessment and Personal Evacuation Plan which is reviewed at specified intervals or if there is a significant change in the resident's condition.

The resident's care plan which will meet their needs, including their personal risk assessments, should be reviewed with them and updated every month. There should be a formal care review at least once a year or sooner if requested by the resident or their relative or advocate, or if there is a significant change in the resident's condition. If a resident is local authority funded a nominated Social Worker will undertake the annual review as opposed to the service.

APPENDIX 1: Pre-admission Needs Assessment and Personal Risk screening Tool.

Abbeyfield The Dales Ltd

Pre-Admission Needs Assessment

Personal Information

Full Name (Including title):			
Preferred Name:		Date of Birth:	

1. Breathing

Do you have any difficulties with your breathing such as Asthma or COPD?	
Do you use any medication or equipment to assist your breathing?	

2. Communication

Do you require an interpreter?	
Do you have any difficulties communicating, if yes please describe?	

What is your first language?	
Do you use any equipment to aid communication?	

3. Continence

Do you wear continence products, if so what brand and type? Are you registered with the continence service?	
Do you have a catheter or stoma? Do you manage this independently?	
Are you prone to urine infections?	
Are there any other needs and preferences we should know about?	

4. Daily Life, Lifestyle, social activities and social contacts

Details of important personal relationships and places?	
What is your religion and is it important to you?	
Tell us how you worship, can you access your place of worship independently?	
Tell us about your social interests and hobbies.	
What did you do for a living?	
Tell us about your daily routines.	

5. Death and Dying

Do you have DNACPR in place?	
Do you have an advance decision in place?	
Have you thought about where and how you would like to be cared for at end of life?	
Do you have funeral arrangements in place?	
Are you happy to complete the My Future Wishes document?	

6. Emotional Support

Do you or have you suffered with anxiety or depression?	
Are there any recognised triggers that can cause anxiety or depression?	
What makes you feel better?	
Do you take medication to help with anxiety or depression?	
What can staff do to support you if you feel anxious or depressed?	

7. Finance

Do you look after your own finances?	
Does anyone assist you in looking after your finances?	
Does anyone have Power of Attorney for Property and Finance?	

8. Maintaining a Safe Environment

Are you able to go out unaccompanied?	
Do you smoke?	
Are there any Safeguarding issues we need to be aware of?	

Are you able to keep your environment free from slip and trip hazards?	
Would you be aware when you or others are in danger?	

9. Medical

Do you have any medical conditions? Do any of these require specialist needs, such as District Nurse, physiotherapist etc?	
Do you currently have an infection e.g. CDif, MRSA etc?	

SIGHT		Optician contact details:
Do you have a visual impairment?		
Do you wear glasses or contact lenses?		

HEARING		Details of who services your aids:
Do you have a hearing impairment?		
Do you wear any hearing aids?		
FOOT CARE		Chiropody contact details:
Do you require any support to care for your feet?		
ORAL CARE		Dentist contact details:
Do you wear dentures or a plate?		
Do you need support in caring for your oral health (ie brushing your teeth)?		
Weight on admission (residential care).		

10. Medication

Do you have any medication allergies?	
Do you take medication?	
Are you able to manage your medication independently, including ordering, self administration, disposing of?	
Have you ever taken too much or too little medication or taken it at the wrong time?	

With regards to medication, if you are unable to manage independently would you like staff to:

Prompt you to take medication?	☐ Yes ☐ No	
Assist you to take medication?	☐ Yes ☐ No	

Administer your medication?	☐ Yes ☐ No	
Order your medication?	☐ Yes ☐ No	
Dispose of medication?	☐ Yes ☐ No	

11. Mental Capacity

Do you have capacity to make decisions about your life?	
If no, do you have someone who helps you make decisions about your life? If yes who is this?	
Does this person have POA and if so is this for Health and Wellbeing? Property and Finance or both?	

Have you or are you receiving any treatment or medication for a mental health problem?	
Are you currently under the care of a mental health specialist?	
How does your mental health affect your daily life?	
Would you know if you were in danger?	
Are you prone to leaving your home unexpectedly?	

Psychological and Mental Health Risk Assessment

	Level of Risk	Action to reduce risks?
Mental Capacity:	Describe their behaviour and responses throughout the interview, if there is an issue with capacity then please ensure a mental health assessment is completed before admission.	
Behaviour that may pose risks to self or others:	☐ Low ☐ Medium ☐ High	How are social isolation risks to be managed?

12. Mobility

Do you have any mobility issues?		
Have you had any falls within the last 12 months?		
Do you have any exercises from a physiotherapist or OT?		Physiotherapy or Occupation Therapy Contact Details:
Do you need assistance to do these?		
Do you use any aids to assist your mobility? If yes what are they? Please include things like walking aids/bed levers		
Can you get in and out of a chair independently? Can you get in and out of bed independently?		

Mobility, Fitness and Falls Prevention Risk Assessment

	Level of Risk	Action to reduce risks?
Moving and Handling:	☐ Low ☐ Medium ☐ High	☐ One ☐ Two carers to assist with transfer
Environmental factors:	☐ Low ☐ Medium ☐ High	
Risk of falling:	☐ Low ☐ Medium ☐ High	How are risks to be managed?

13. Nutrition/Hydration

Do you have any food allergies?	
Can you eat and drink independently?	
Does your culture or religion require you to eat specially prepared food?	

Do you have any issues with swallowing? If yes have you had a Speech and Language Therapy assessment?		Speech and Language Therapy details.
Do you have any conditions such as diabetes which require a special diet?		Diabetic Nurse Contact Details:
What are your food preferences or dislikes (ie, non spicy , vegetarian, vegan)		
Do you require any special crockery or cutlery to make eating and drinking easier for you?		
Have you lost any weight in the last 6 months?		
What is your appetite like?		

Do you have to eat at set times due to medication or health limitations, if so what are they?	
Do you drink alcohol?	

Mobility, Fitness and Falls Prevention Risk Assessment

	Level of Risk	Action to reduce risks?
Risk of malnutrition:	☐ Low ☐ Medium ☐ High	Please weigh on admission and discharge (Residential Only).
Risk of dehydration:	☐ Low ☐ Medium ☐ High	How are risks to be managed?
Known food allergies:	Please inform the catering staff immediately.	

14. Pain

Do you suffer with any regular pain?	
Where is the pain?	
How does the pain affect your life? Does it restrict you from doing things?	
Do you take pain relief?	
Can you administer this yourself?	

15. Personal Care

Please describe your personal care needs:

In a morning?	
At lunch time?	
At teatime?	
At bedtime?	
At any other time?	

16. Sexuality

Do you identify as male, female or neither?	
How would you like us to address you? (Mr, Mrs etc)	
How do you like to dress?	
Do you need any support in expressing your sexuality?	

17. Skin Integrity

Are you able to move around and change position without help?	
Do you have any pressure injuries at present?	

Are you prone to pressure injury?	
Do you have any issues with your skin which we need to assist you with?	
Have you been prescribed any creams for your skin?	
Do you use any pressure relieving equipment?	

18. Sleeping

Describe your usual sleep pattern.	
Do you get up during the night?	

If yes do you need any support?	
Do you use any special equipment in bed? Eg bed lever?	
Do you use a commode through the night?	
Do you need help with anything during the night or do you prefer not to be disturbed unless you ask for support?	

PLEASE LIST ANY OTHER RELATIVE OR USEFUL INFORMATION NOT INCLUDED IN THE ASSESSMENT ABOVE

Outcome of Assessment

Where did the assessment take place?	
Who was present at the assessment?	
Is it possible for us to meet the needs of the individual?	
What is the moving in date if a place has been offered and accepted?	
Details of any special equipment or arrangements needed prior to arrival.	
Any identified areas of concern about the placement, and agreed actions to address these.	

Prospective Resident

Signed:		Date:	

Representative

If this assessment has been completed on behalf of the prospective resident, state their name, address and the nature of this relationship if different from NOK or Emergency contact.

Name:		Telephone:	
Address:		Relationship:	
Signed:		Date:	

Assessor

Name:			
Signed:		Date:	