Carriglea
Cáirde Services

Carriglea, Dungarvan, Co. Waterford.
T 058 41322 F 058 41432
E info@carrigleaservices.com

SD- 01

POLICY AND PROCEDURE

Access to Healthcare Services

Approved by: _____

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CARRIGLEA CAIRDE SERVICES

Procedures Manual

Title: ACCESS TO HEALTH CARE SERVICES

1.0 Scope

1.1 The process which enables service users to access health care services.

2.0 Aims and Values

2.1 To enable service users to access health information and appropriate health care services.

2.2 To ensure that residential service users receive adequate support to access health care services which meet their needs.

3.0 Contents

4.0 Referenced Documents

SD-03 Admission to Hospital
SD-33 Person Centred Planning
PC-06 End of Life Care and Bereavement
PC-04 Nutrition and Assisting Service users with Eating and Drinking
SD-15 Contacting a Doctor
Service User Care Plan.
Service User's Daily Report Record.

5.0 Responsibilities

5.1 Management and all staff.

Carriglea Cáirde Services supports all service users to live a healthy lifestyle and to take responsibility for their health. Service users are encouraged to have a well balanced diet *(See Policy on Nutrition and Assisting Service users with Eating and Drinking)* and to exercise appropriately in order to maintain good health. In order to support service users to maintain the best possible heath, Carriglea Cairde Services promotes access to mainstream medical services and multidisciplinary supports.

6.0 ASSISTING RESIDENTIAL SERVICE USERS TO ACCESS HEALTH CARE SERVICES

6.1 The manager in conjunction with the key worker must ensure that residential and respite service users receive a regular (at least annual) comprehensive assessment of their health needs and a review of their *Care Plans* and Health Action Plans. This is done by review of the Information Gathering Tool and carrying out of the action plans in the Person Centred Plan (see policy/procedure on *Person Centred Planning).*

6.2 Where it is identified that a residential service user requires access to health care services including oral, optical and aural services, and he/she is unable to arrange this themselves, the senior member of staff on duty should be responsible for arranging the required health care provision as soon as possible.

6.3 Each resident has a General Practitioner under the GMS scheme. Where there is more than one option available e.g. choice of GP, dentist, optician, etc. the senior member of staff on duty should consult with the service user regarding their preference.

6.4 Residents are given support to enable them to attend health care services (GP's surgery, dentist, optician, out-patient hospital appointments, etc). In Carriglea Residential, a medical room is provided where service users can meet with the GP, psychiatrist or psychologist or the GP may call to the service user's home.

6.5 The senior member of staff on duty is responsible for arranging transport for residential service users to attend external health care services/clinics and also providing staff support where required. Family members may be requested to support service users to attend medical appointments.

6.6 Carriglea Cáirde Services provides the services of a visiting chiropodist who residents can visit in a designated chiropody room, or in their own home, if required. The senior person on duty is responsible for ensuring that resident who require this service are referred for an appointment.

6.7 The manager is responsible for referrals for physiotherapy, speech and language therapy, occupational therapy or dietician assessments, when such services are required.

6.8 The manager shall ensure that residents receive support at times of illness and ensure that they are made as comfortable as possible. When a resident requires admission to hospital, see the policy and procedure for *Admission to Hospital* for further details.

6.9 Service users with life-threatening or life-limiting conditions are facilitated to access specialist palliative and end-of life care when appropriate. See policy and procedure on *End of Life Care and Bereavement* for further details.

6.10 The senior member of staff on duty is responsible for engaging the services of Care-doc when a resident requires out of hours medical care. (See policy on *Calling a Doctor).*

6.11 In some cases, family members may wish to make appointments and arrangements for service users to visit health care services. This should be done in consultation with the manager of the relevant area.

6.12 The health-care need of those who use respite services must be co-ordinated between the manager of the respite service, the family and the person's GP. The manager must ensure that up-to date health-care information is obtained in relation to all those who use respite services.

7.0 COMMUNICATION AND RECORDING

7.1 Staff should make every effort to ensure that the service users are actively involved in their own health care and that they take part in every decision concerning their health.

7.2 Residents medical and health care needs will be set out in care plans and health referrals in their *Person Centred Plans.* The relevant records including medical and laboratory reports, kept in the service users Medical/Multidisciplinary Support file.

7.3 The senior member of staff on duty should record all service users' health care appointments on the Health Referrals page of the *Person Centred Plan* and where appropriate, on the Service user's *Daily Report Record* and *House Diary.*

7.4 With regard to day service users, health-care information identified through the Information Gathering Tool should be recorded in the relevant Care Plan and Health Action Plan of the service user.

7.5 In instances where a resident refuses treatment, the matter should be brought to the attention of his/her GP and recorded in the service user's *Daily Report Record.* In instances where a service user refuses treatment on a continuous basis, his/her family should be informed.

7.6 The manager is responsible for effective communication and co-ordination between health care professionals involved in the support and treatment of each service users with due regard for their informed wishes about the sharing of information.

8.0 HEALTH INFORMATION AND CHOICE OF SERVICES

8.1 Service users are encouraged to access appropriate health information and education – this could include, diet and nutrition, mental health, exercise and physical activity, relaxation, risks associated with smoking, alcohol and drug consumption and sexual health.

8.2 Service users are supported to access appropriate screening programmes which are available in the community

8.3 Where delays occur in the provision of public health care services, the manager should inform the service user and his/her family or representative if appropriate, that the service might be provided more quickly if the service user is prepared to pay from his/her private funds. If agreed, the manager should make the necessary arrangements for appointments.

9.0 COMPLIMENTARY THERAPIES:

9 1 If considering an alternative therapy, e.g. acupuncture, herbal medicine, aromatherapy or reflexology, the person's GP should be consulted about the safety, effectiveness and possible interactions with prescribed medication.

9.2 Before engaging a complimentary therapy practitioner, the qualifications of the person to practice the therapy should be verified. Also, before a therapist is engaged to work with a service user in the person's home or on the premises of the Services, the Human Resources manager should be contacted to arrange for Garda Vetting and any other necessary documentation to be completed.

9.3 Conventional medical treatment should generally not be abandoned in favour of a complimentary therapy unless on the advice of the GP/Consultant.