


CARE AND SUPPORT PLANNING

VERSION No	5	
REVIEWED BY	Registered Manager (MP)	
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1. Policy Statement

We are acutely aware of the importance of care and support planning and of the impact it can have when it is not undertaken in a planned and systematic way. The individual, their needs and preferences must be at the core of the process. Information giving and sharing, with the individuals needs preferences and choices being heard and listened to and their role influencing and controlling the shaping of their care and support plan is fundamental in ensuring person-centred care.

2. Care Act 2014

It is often said that a service led approach to delivering services is the Achilles (weak) heel of adult care. In trying to move things forward the Care Act sets meeting needs at the centre of care and support planning and moves away from the previous terminology of “providing services”. This is to enable a much broader diversity and variety of approach in how needs can be met. This will require providers such as us to reassess our current services, whilst keeping an open and honest dialogue with residents and commissioners to diversify the services available. As a provider, this means the utilisation of the voluntary sector, community groups and development of individual service funds, where appropriate. A collaborative engagement process will need to be developed and local authority guidance will be issued in order to facilitate the development stages of the relationship with other services.

a) Local Authority Funded Person(s)

Care and support funded by the local authority will reflect the Care Act 2014 requirements and these changes have been implemented since April 2015 and will continue through to April 2017. These will include changes to the following:

- i. Personal budgets
- ii. Direct Payments
- iii. Individual service fund (ISF)
- iv. Purchase of regulated and unregulated services
- v. Mixed funding arrangements
- vi. Flexible choices of care and support
- vii. “Prescribed providers” do not fit with the governments vision of personalised care and should be avoided
- viii. No constraint on how needs are met as long as this is reasonable
- ix. Steps should be taken to avoid decisions on the assumption that the views of the professional are more valid than those of the person
- x. Persons lacking capacity are equal within the Care Act 2014 but the principles and requirements of the Mental Capacity Act 2005 (MCA) must be adhered to if the person lack capacity

- b) All this good practice will be embedded for all of our users, including self-funders. As the Care Act 2014 begins to shape local authority practice, so too will it shape ours as providers. The importance of good information advice and guidance cannot be underestimated and local authorities, under this Act have a duty to provide such a service.

3. The Policy

The Care Act 2014 has huge implication both for local authorities and providers of services over the coming months and we, as provider, are well placed to meet the challenge ahead. We set out below a set of principles which applies to all our care and support planning process from April 2015.

a) Principles

- i. Information advice and guidance will be available to all prospective users of services in order that an informed decision on our ability to meet the assessed need can be determined.
- ii. The user, their family, representative or “relevant person” will be involved from the start, during the assessment and care and support planning process to ensure their needs, choices and preferences are reflected in the care plan agreement
- iii. Consent will be discussed, formally recorded and agreed within the care plan.
- iv. The Mental Capacity Act 2005 (MCA) Code of Practice will be followed where someone lacks capacity or where there is fluctuating needs identified and decision recorded in the care plan.
- v. Choice and control will be retained by the resident including their ability to take or make unwise decisions where they have capacity.
- vi. Self-supported care and support planning will be encouraged and available to all users.
- vii. Individual services funds (ISF) will be developed in agreement with users and will be offered where requested.
- viii. The full guidance on Assessment and Eligibility is in the Care and Support Statutory Guidance updated on 9th May 2016 issued under the Care Act 2014 - Chapter 10.

b) Assessment of Care Needs

- i. Before we enter into an agreement to provide a service, we ensure that a thorough assessment of a prospective resident’s needs has been undertaken.
 - + For people referred to this home by the social services department, this assessment will have been carried out as part of the care management process; we will be provided with at least a summary of it.
 - + For people who approach the organisation directly, we are responsible for carrying out a full assessment of care needs under our procedures for care needs assessment. All action considered for the resident plan must be soundly based on material in the care needs assessment.
- ii. Needs assessments are only carried out by competent members of staff, an RGN, who have been appropriately trained and who are specifically authorised for this task.
- iii. Throughout the care needs assessment process, the staff member carrying out the assessment should communicate with and actively involve the prospective resident and their representative.
- iv. It is particularly important to find out the resident’s wishes and feelings, and to take them into account; to provide the resident with full information and suitable choices; and to enable and encourage residents to make decisions about their own care.
- v. We will comply with any special local arrangement for self-assessment by residents.

vi. Sources of Information

- ✓ The general expectation is that the resident will give us the necessary information, but where this is not possible the resident’s carer, relative or representative or the relevant person is the most-likely source.
- ✓ In such cases the resident should, if at all possible, be present while information is gathered and recorded; as an indication that they agree that we should have access to the information, and that the information provided to us is true.
- ✓ The staff member carrying out the assessment needs to interview the resident (and carer / LPA / NOK, etc.) either pre-admission, or in the setting in which the service will be delivered.
- ✓ A specific appointment should be offered with a named staff member. The staff member should aim to create a warm and relaxed atmosphere for the interview, should give the prospective resident the opportunity to demonstrate his or her abilities, as well as discussing his or her needs. They should use the time to observe the resident.
- ✓ Information should be recorded at the time of the interview, or as soon as possible afterwards, on the Care Needs Assessment Form. The staff member should be quite open about recording the information and should show the prospective resident the

form if requested.

vii. Information Gathering

A full and comprehensive Assessment of Need should be completed with the resident, their relatives or representatives where requested. Staff need to ensure that consent is able to be given and where there are capacity issues advice should be sought.

viii. Physical and Mental Health and Abilities

✚ We record information about the resident's health and abilities. It is the task of the staff member carrying out the needs assessment to decide which items are relevant for the service that this organisation is being asked to provide.

✚ The form lists a range of possible needs and risks for consideration. Although we need as full a picture as possible of the needs of the resident, we do not wish to intrude on the resident's privacy any more than is necessary, so the RGN must use their judgement as to which assessments on the form are relevant and have to be completed.

✚ Care should be taken not to place too great a stress on disabilities. The staff member should emphasise from the outset that a key worker will work with the resident (and with the family if applicable) and try to support the resident's independence as far as possible.

✚ If there are health issues on which further medical or nursing details are required, the RGN should ask the resident or family to obtain and pass to us the necessary reports; or obtain consent to request the information from other organisations such as GP surgeries.

✚ Any written documentation about the resident's care needs should be appended to the form.

ix. Services Requested

This information is recorded on the form, detailing the services that this organisation is being requested to supply. At this point a manager or the deputy manager must take the formal decision that we are in a position to provide the requested services, given the details of the care needs assessment.

x. Passing Information to the Allocated Key Workers (RGN and HCA KW)

When the manager has decided that this organisation will supply services, identified key workers, RGN and HCA, should be allocated to the case. We believe that the matching of the workers to the resident is of paramount importance and so due consideration is given to the worker's availability. When all of the required elements have been agreed the resident will be informed of the staff team who will undertake the service. The key workers will be introduced personally to the resident on the commencement of the service. The allocated RGN key worker is responsible for devising the care planning with the contribution of the HCA key worker (KW) and the HCA KW must read and understand the care plan.

xi. Referrals from Social Services Departments

In cases where a potential resident is referred by the social services department, the manager, deputy manager or the RGN undertaking the pre-admission assessment must obtain a summary of the needs assessment that the department has undertaken. A care needs assessment form will be completed using some of the details provided by the social services departments own care plan or care diary. The summary of the social services needs assessment should be filed with the organisation's own pre-admission assessment form. We will comply with any special local arrangements for self-assessment by residents.

xii. Emergency Service Provision

✚ If this organisation has been requested to provide services at short notice or in a crisis, there may not be an opportunity to carry out a pre-admission assessment before starting to provide a service.

✚ A telephone discussion, to ascertain as much information as is possible before the commencement of the service, will be recorded and used as the care needs assessment for the first 72 hours of any immediate response on emergency service provision. The pre-admission assessment form should be used to record all information obtained.

- ✚ The manager or deputy manager must allocate the case to an RGN who is competent to undertake an initial contact assessment.
- ✚ In these circumstances only the managers or deputy manager of the home will make the decision if the service can meet the person's needs and if the person should be admitted or not.
- ✚ Within three working days, the deputy manager will arrange for a full assessment to be carried out and recorded where the admission is for long term care.
- ✚ Where the immediate response is of a short-term basis only, the pre-admission assessment form will be used in conjunction with any other details supplied by social services or health to assist in the service delivery.
- ✚ If the service is provided at the request of a social services department, the deputy manager must ensure that the social services department completes an assessment within two working days and passes the information to us as described above.

c) Care plan

This organisation's process of planning resident care is based upon the following principles:

- ✓ **PLANNING CARE IS PERSON-CENTRED.** *A plan of care will never be made without the active participation of the person to whom they relate, or, where necessary, this person's representative;*
- ✓ **PLANNING CARE INVOLVES OTHERS WHO ARE RELEVANT TO THE RESIDENT.** *Many residents want their carers or relatives to be involved in planning their care. We will ensure this happens, provided that it does not prejudice the principle that the resident must always remain central;*
- ✓ **PLANNING CARE OFTEN NEEDS TO BE MULTIDISCIPLINARY.** *Most residents have needs that span social care and health. We will ensure that the views and contributions of all relevant agencies and professions are collated into a single plan;*
- ✓ **THE PLAN OF CARE HAS TO BE BASED ON EVIDENCE.** *The plan of care for each resident will be based on a formal assessment of their care needs;*
- ✓ **THE PLAN OF CARE SETS OBJECTIVES.** *As a plan of care is intended to bring about some sort of desired change, we work with the resident to set objectives and to give thought as to how those aims are to be achieved;*
- ✓ **THE CARE PLANNED MUST BE REALISTIC.** *The plans of care we prepare are not merely expressions of aspirations; instead, they are based on realistic judgements about what can be achieved, including honest estimates of the resources involved.*
- ✓ **PLANS HAVE TO BE REVIEWED.** *A plan of care is not a static document; plans must be capable of being adapted if new evidence becomes available or if circumstances change. Every plan will be regularly reviewed and revised on a monthly basis or sooner if needed.*
- ✓ **PLANS HAVE TO BE ACTED ON.** *The planning of care is not a mere paper exercise. We are sincerely committed to putting every plan of care into action, and therefore set out defined responsibilities and a clear process for monitoring progress.*

i. Those Involved in Planning

The following people are involved in planning the care:

- ✓ **THE RESIDENT.** *The resident is always central. We emphatically do not plan for people; we plan with them. If a resident is not able to participate meaningfully in the care planning, we will always seek an appropriate representative or advocate who can faithfully put forward what they believe the resident would have contributed.*
- ✓ **RELATIVES, FRIENDS AND CARERS.** *Subject to the resident's agreement, we would wish to involve other people in the resident's circle who are likely to be involved in implementing the agreed resident plan. We recognise that carers and others sometimes have needs and interests of their own; we will take these into account but will insist always that the needs and preferences of the resident remain most important.*

✓ **STAFF OF THIS ORGANISATION.** In planning and reviewing the care we provide, we try to involve all of the people who know the resident well. This is likely to mean the RGN who carried out the care needs assessment, or who dealt with the social services referral; the care staff who are providing the day-to-day service; and the person who supervises the workers.

✓ **OTHER AGENCIES AND PROFESSIONALS.** As health and social care needs and services are closely related, it is likely that our residents will have been in touch with other agencies. Where appropriate, and with the resident's agreement, we will involve representatives of these bodies in planning care to ensure that the services we provide are as well co-ordinated as possible.

ii. **Creating the Plan**

✚ Before we start to provide a service or, in urgent cases, as soon as possible afterwards we will convene a meeting of all of the appropriate people to draw up the plan to our regular format.

✚ A central task is to identify the objectives of the care we will be providing and then to outline appropriate strategies to meet those objectives.

✚ Those involved in the process need to be realistic about what can be achieved, what resources are needed and available, who will undertake the agreed tasks, and the timescale(s).

✚ **IN ALL OF THESE DISCUSSIONS, THE USER'S VIEWS WILL BE CENTRAL.**

iii. **Risks**

✚ **Any plan is likely to include some risks for the resident.**

✚ **This does not mean that no action should be taken, however, since reasonable and responsible risks are inherent to quality of life.**

✚ **For any situation that entails risk which is identified during the creation of the plan, a formal risk assessment will be undertaken. This will list and weigh up the positive benefits against the possible adverse effects of the proposed action; the precautions that should be taken; and the arrangements for reconsidering the matter, when appropriate.**

✚ **These factors and the measured conclusion of the risk assessment will be recorded as part of the care plan.**

iv. **Implementing the Plan**

All of those who participate in the creation of the plan must accept responsibility for contributing to its implementation. We believe a plan is for action, and our staff will be supervised and monitored against the plan's objectives and time scales.

v. **Reviews of Care Needs**

✚ A minimum standard of a monthly review is the mechanism for this organisation.

✚ To ensure that the needs of the resident are relevant; we will, however, retain the flexibility to initiate a review whenever we feel it is in the resident's best interests.

✚ Whether or not any specific changes to a resident's needs and circumstances have been reported, the deputy manager should review the appropriateness of the service provided within six weeks of our starting to provide services, and the manager least annually.

✚ **Throughout the whole assessment process great importance should be attached to the resident's own views of their needs and wishes, and residents should be given every encouragement to express themselves.**

✚ In the local authority areas where systems of self-assessment are in place, managers should seek advice from their social services department about the precise implications for their procedures. At the initial assessment of needs visit a discussion will take place regarding the frequency of reviews.

✚ Where social services are involved with the resident they retain responsibility for the setting up of reviews, however it should be noted that

this organisation reserves the right to initiate a review where there are concerns regarding the care or services provided.

vi. Changes in a Resident's Care Needs

- ✚ It is the responsibility of any worker providing service to report to the RGN in charge and the RGN in charge to the deputy manager or the manager any significant changes in a resident's needs and circumstances.
- ✚ The deputy manager and the manager are responsible for considering whether any change in the service is required as a result of the change in the resident's needs. If so, the deputy manager and the manager should initiate a discussion with the resident or the resident's carer or representative, if appropriate and with the relevant social services department, if necessary.

vii. Records

The initial decisions about the resident plan, the risk assessments and any other significant issues will be recorded and should be signed. The plan is in a format intended to be accessible to residents and others. If appropriate, arrangements will be made to translate the plan into a language the resident can readily understand.

d) Working with residents with fluctuating needs

i. Principles

- ✓ *We will take decisions on behalf of a resident only if there is evidence that they cannot take the decision (at the time it needs to be made) because of mental incapacity. We will co-operate with relatives and others involved with the resident in decision making on behalf of a person on the same basis;*
- ✓ *We will not take or collude in taking decisions for a resident where, from our point of view, there is insufficient justification and it does not appear to be in that person's best interests;*
- ✓ *Staff in this organisation will only take a decision for one of its residents after it has exhausted every means of enabling the person to take it of their own accord. It will also demonstrate its actions in taking the decision are reasonable and in the person's best interests; Where staff has information that suggests the person might be unable to take some decisions at some times it will carry out, or contribute to, an assessment of that person's mental capacity. It recognises that the assessment procedure should follow the two-step assessment process recommended in the Mental Capacity Act's Code of Practice;*
- ✓ *This organisation ensures that it complies with all aspects of the law in the cases of residents who are subject to guardianship proceedings or who need legal protection on account of their lack of mental capacity. Included in this, are residents who have assigned powers of attorney or who are subject to Court of Protection proceedings;*
- ✓ *Staff in this organisation familiarises themselves with and acts upon any advance directives or advance decisions that its residents have chosen to make in contingency situations where they might lose the ability to take a decision.*

ii. Assessment of Mental Capacity

- ✚ Staff ensures that a person's needs assessment and resident plan of care contain all the information needed that relates to a person's decision-taking capacity, as well as the decisions over which they might need help with, on account of their possible lack of capacity;
- ✚ The information included indicates:
 - *which decisions the person is able to take at all / most times;*
 - *those that the person has difficulty in taking; and*
 - *those that the person is unable to take;*
- ✚ In respect of each area of decision taking, where there are difficulties or an inability to take decisions the resident plan of care records the actions to be taken for the person that are deemed in their best interests;
- ✚ The individual is always as fully involved as possible. Decisions are only taken on the basis of the best information available and with the agreement of those

concerned in the person's care and future. All decisions taken for that person are fully recorded and made subject to regular review;

- ✚ Residents who lack mental capacity are only subject to restraint, in any form, when not doing so would result in injury or harm to them or to other people. All incidents where restraint has been used are recorded and reported.

iii. Staff Involvement

- ✓ *This organisation requires all staff (care and nursing) to implement the agreements and decisions that are identified in an individual's plan of care;*
- ✓ *This organisation also expect its staff to involve residents in all day-to-day decisions that need to be taken by seeking their consent and checking that the actions to be taken are consistent with their plan of care, if the individual resident lacks capacity at the time. Where the resident needs to take a decision that lies outside of their ability at the time, staff must do everything to help the person decide for herself or himself;*
- ✓ *This organisation expects its staff to avoid taking decisions on behalf of a resident unless it can be shown that it is necessary and that the resident at the time is unable to take that decision her or himself. Any such incident must be recorded in the daily notes;*
- ✓ *This organisation expects its staff to take decisions for residents lacking capacity only when they are reasonably believed to be necessary and in the person's best interests. When in doubt that they can act in this way they must seek advice from their line manager.*
- ✓ *Choice has become increasingly important for residents and this organisation will attempt to advance this principle throughout our operations; we will ensure that every resident who receives our service has consented. We will work to provide residents with the opportunities to exercise choice about the workers with whom they interact, and will when possible change the worker in instances when the resident requests it. We are particularly sensitive to matching workers and residents where issues of gender, culture or ethnicity play a role.*

4. Guidance

- ✚ *NICE Guidelines Older people with social care needs and multiple long-term conditions (NG 22 Published November 2015: This guideline covers planning and delivery of social care and support for older people who have multiple long-term conditions. It promotes an integrated and person-centred approach to delivering effective health and social care services. As an organisation, we are working towards ensuring these guidelines are implemented, proportionate to our service, using the tools and resources available from NICE*
- ✚ *NICE Clinical guideline [CG42] Pub. November 2006 updated: September 2016 Dementia: supporting people with dementia and their carers in health and social care*
- ✚ *NICE quality standard [QS1]: Dementia quality standard (Published June 2010).*
- ✚ *NICE quality standard [QS30] Dementia Independence and Wellbeing April 2013*
- ✚ *NICE quality standard [QS13]: End of life care for adults (Published August 2011). Updated March 2017*

5. Training statement

All staff involved in the Care and Support Planning process will undertake Care Act 2014 training and other relevant training.

Related Policies

*Assessment of Need and Eligibility
Advanced Care Planning
Consent
Dignity and Respect
Deprivation of Liberty Safeguards
Meeting Needs
Mental Capacity Act 2005*

Recommendations on the Care and Support Adults Receiving Social Care

- Overarching principles: *prescribes responsibilities of each party involved such as Local Authorities / Adult Social Care, Service Providers such as care / nursing homes, home help, etc.*
- Information
- Care and support needs assessment and care planning
- Providing care and support
- Staff skills and experience
- Quality check and service improvement

People have the right to be involved in discussions and make informed decisions about their care.

1. Overarching principles

- a) Recognise that each person who uses services is an individual. Use each person's self-defined strengths, preferences, aspirations and needs as the basis on which to provide care and support to live an independent life.
- b) Support people to maintain their independence. This means finding out what people want from their life, and providing the support and assistance they need to do this.
- c) Co-production and enabling people to make decisions
 - i. Respect people's right to make their own decisions, and do not make assumptions about people's capacity to be in control of their own care and support (for example, if the person is severely disabled).
 - ii. Actively involve the person in all decisions that affect them.
 - iii. Provide support to people, if they need it, to express their views, preferences and aspirations in relation to their care and support. Identify and record how the person wishes to communicate and if they have any communication needs (in line with the [Accessible Information Standard](#)). This could include:
 - ✓ advocacy support
 - ✓ an independent interpreter (that is, someone who does not have a relationship with the person or the services they are using) to enable people to communicate in a language they can readily converse in, including sign language
 - ✓ a carer, if that is what the person wants
 - ✓ [communication aids](#) (such as pictures, videos, symbols, large print, Braille, hearing loops)
 - ✓ evidence-based techniques for communication
 - ✓ additional time to understand and process information
 - ✓ environmental conditions that support communication, such as clear lighting, and minimal noise interference.
 - viii. If a person lacks the capacity to make a decision, the provisions of the [Mental Capacity Act 2005](#) must be followed.
 - ix. Use plain language and personalise the communication approach to encourage and enable people to be actively involved in their care and support. If technical language or jargon has to be used, or complicated ideas are being discussed, take time to check that the person, or a carer who knows them well, understands what is being said.
 - x. If a third party or advocate is supporting someone to give their views, ensure that enough time has been allowed for them to do it.
 - xi. Local authorities and service providers should work with people who use adult social care services and their carer as far as possible to [co-produce](#):
 - ! the information they provide
 - ! organisational policies and procedures
 - ! staff training.

d) Access to care

- i. Ensure that everyone with social care needs has access to services based on their needs, taking account of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation, and socio-economic status or other aspects of their identity.
- ii. Service providers should be aware of the cultural and religious needs of people who use services, and provide care and support that meets these needs. Examples include treatment choices, food choice and preparation, enabling people to dress in accordance with their culture or religion, personal grooming, or changes in timing of services around religious festivals, for example, during Ramadan.
- iii. **Commissioners** and service providers should consider seeking advice from **voluntary and community sector** organisations such as disabled people's organisations and user-led organisations with expertise in equality and diversity issues to ensure that they can deliver services that meet the needs and preferences arising from:
 - ❗ gender, including transgender
 - ❗ sexual orientation and sexuality
 - ❗ disability
 - ❗ ethnicity
 - ❗ religious and cultural practices.

e) Involving carers, families and friends

- i. Ask the person at the first point of contact whether and how they would like their carer, family, friends and advocates or other people of their choosing (for example, **personal assistants**) to be involved in discussions and decisions about their care and support, and follow their wishes. Review this regularly (at least every 6 to 12 months), or when requested.
- ii. If the person would like their carer, family, friends and advocates involved:
 - explain the principles of confidentiality, and how these are applied in the best interests of the person
 - discuss with the person and their carer, family, friends and advocates what this would mean for them
 - share information with carers, family, friends and advocates as agreed.
- iii. If a person lacks the capacity to make a decision about whether they wish their carer, family, friends and advocates to be involved, the provisions of the **Mental Capacity Act 2005** must be followed.

2. Information

- a) In line with the **Care Act 2014**, local authorities must provide information about care and support services for people and their carer, including:
 - ❗ the types of care and support available
 - ❗ how to access care and support, including eligibility criteria
 - ❗ how to get financial advice about care and support
 - ❗ local safeguarding procedures and how to raise safeguarding concerns or make a complaint
 - ❗ rights and entitlements to assessments and care and support services
 - ❗ personal budgets and all the options for taking a personal budget – for example, local authority managed, Individual Service Fund or direct payment.
- b) Local authorities should ensure that information about care and support services is widely and publicly promoted, for example, in GP surgeries and community spaces, as well as in specialist services such as homeless health centres.
- c) Local authorities should provide information about the circumstances in which independent advocacy is available, in line with the **Accessible Information Standard**, and how to access it.
- d) Local authorities should provide comprehensive information about community resources and support, including voluntary organisations, user-led organisations and disabled people's organisations, and about available housing options.

3. Care and support needs assessment and care planning

- a) Local authorities must, in line with the **Care Act 2014**, provide independent advocacy to enable people to participate in:

- ✓ care and support needs assessment and
- ✓ care planning and
- ✓ the implementation process and review

where they would otherwise have substantial difficulty in doing so.

- b) People who are supported by an independent advocate during care and support needs assessment and care planning should have enough time with their advocate:

- ✓ for preparation before the assessment or care planning session
- ✓ to ensure they have understood the outcome afterwards.

c) **Needs assessment**

- i. Local authorities must ensure that care and support needs assessment under the [Care Act 2014](#) focuses on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve in their day-to-day life.

- ii. Care and support needs assessment should:

- ✓ involve the person and their carer in discussions and decisions about their care and support
- ✓ take into account the person's personal history and life story
- ✓ take a whole family approach
- ✓ take into account the needs of carers
- ✓ take into account the person's housing status, and where and who they want to live with
- ✓ be aimed at promoting their interests and independence
- ✓ be respectful of their dignity
- ✓ be transparent in terms of letting people and their families and carers know how, when and why decisions are made
- ✓ take into account the potential negative effect of social isolation on people's health and wellbeing.

iii. **The assessment:**

- focuses on the person's needs and how they impact on their wellbeing
- focuses on the outcomes they want to achieve in their day-to-day life
- involves the person and, if they want, their carers in discussions and decisions about their care and support
- takes into account the person's personal history and life story
- takes a whole family approach
- takes into account the needs of carers
- takes into account the person's housing status, and where and who they want to live with
- is aimed at promoting their interests and independence
- is respectful of their dignity
- is transparent in terms of letting people and their families and carers know how, when and why decisions are made
- takes into account the potential negative effect of social isolation on people's health and wellbeing.

- iv. Local authorities should consider the person's preferences in terms of the time, date and location of the care and support needs assessment, and conduct the assessment face-to-face unless the person prefers a different method of assessment.

- v. Local authorities should ensure that:

- ! the person is given details of the care and support needs assessment process and timescale at the start
- ! the person is given details of the nature and purpose of the assessment
- ! the person can have someone they choose to be present at the assessment
- ! the assessment uses up-to-date information and documentation about the person
- ! the person does not have to provide the same information in subsequent assessments.

- vi. If a person who uses services has caring responsibilities, their care and support needs assessment should take account of this. In line with the [Care Act 2014](#), they must also be offered a separate carer's assessment which should identify whether the person they care for is a carer themselves.

- vii. Ensure that care and support needs assessment documentation about the person is accurate, up to date and well maintained and clarifies what assessed needs will be met and how.
- viii. Offer the person a copy of any or all of the care and support needs assessment documentation. It should be shared with the person's carer if that is what they want.

d) Care and support plans

- i. Equality and diversity considerations: People who are having a care and support needs assessment may have several needs, for example help with communication. Services should ensure that people have the help they need, for example through an independent advocate or communication aid, to participate fully in the assessment. People should be provided with information about the care and support needs assessment that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services about the assessment. Information should be in a format that suits their needs and preferences, for example produced in Braille format. It should be accessible to people who do not speak or read English, and it should be culturally and age appropriate. People should have access to an interpreter or independent advocate if needed.
- ii. As part of care planning, consider identifying a **named coordinator / key worker** who is competent to:
 - act as the first point of contact for any questions or problems
 - contribute to the assessment process
 - liaise and work with the person, their families, carers and advocates
 - liaise and work with all health, social care and housing services involved with the person, including those provided by the voluntary and community sector
 - ensure that any referrals needed are made and are actioned.
- iii. Local Authority should build in flexibility to the **care and support plan** to accommodate changes to a person's priorities, needs and preferences: for example, by using direct payments and agreeing a rolling 3-monthly budget so that people can use their money differently each week.
- iv. Local authorities and providers should ensure that the person's care and support plan includes clear information about what involvement from others (carers, family, friends and advocates) they want in their care and support, in line with the **Care Act 2014**.
- v. Ensure there is a transparent process for 'matching' care workers to people, taking into account:
 - the person's care and support needs **and**
 - the care workers' knowledge, skills and experience **and**
 - if possible and appropriate, both parties' interests and preferences.
- vi. Ensure care workers are able to deliver care and support in a way that respects the person's cultural, religious and communication needs.
- vii. Care and support plans should record and address the specific needs of people in relation to equality and diversity issues.
- viii. Care and support plans should be regularly reviewed, and include information on how and when these reviews should be carried out.
- ix. Care and support plans should include contingency planning and what to do in a crisis.

e) Personal budgets and direct payments

- i. The local authority must include the person's personal budget in their care and support plan, in line with the **Care Act 2014**.
- ii. Local authorities should:
 - ⚠ inform people that they have the option to control their own funding to buy different sorts of care and support that meets their needs and chosen outcomes
 - ⚠ provide information, advice and support so that the person can choose which option suits them best
 - ⚠ give people the opportunity to exercise as much control as possible over the way they use any allocated funds to purchase a care package
 - ⚠ inform people of the different options for managing their budget.
- iii. Local authorities should ensure that the direct payment process is:
 - ⚠ transparent about how the level of funding is decided

- ! straightforward
 - ! accessible to all adults who receive social care and are eligible for local authority funding
 - ! reviewed periodically to make sure that it is meeting the objectives of the care and support plan
 - ! able to meet the legal obligations of the person receiving that direct payment if they employ personal assistants.
- iv. Local authorities should provide accessible information about direct payments, and **peer support** for people to use them. For example, this could be provided through user-led **Centres for Independent Living**.
 - v. In line with the **Care Act statutory guidance**, local authorities should support local services that provide peer support. Their contribution could include:
 - ! financial support for local peer support services
 - ! providing physical space for people who give peer support to hold meetings with people who use services
 - ! helping peer support services with applying for grants for funding.

f) Personal assistants

- i. If people have eligible needs that could be met by employing a personal assistant, the local authority should ensure that this option is discussed with the person and understood by them at the care and support planning stage.
- ii. In line with the **Care Act statutory guidance**, local authorities should ensure that support is available for people employing personal assistants, and that they are told about where to get support with:
 - ! recruitment and retention of staff
 - ! their role and responsibilities as an employer (for example, payroll, terms and conditions, redundancy and contingency planning).
- iii. Local authorities should consider the following to deliver support for people who employ personal assistants:
 - ! user-led Centres for Independent Living
 - ! other peer-support arrangements.
- iv. In line with the market shaping duty in the **Care Act 2014**, local authorities should work with people who use social care services and their carers to enable access to personal assistants. For example, this could be done by providing training opportunities for people who are interested in becoming personal assistants.

4. Providing care and support

- a) **Care and support in all settings:** The following recommendations refer to care and support in all settings:
 - i. Service providers should foster a culture that enables practitioners to respect people's individual choices and preferences, in all settings where care and support is delivered, by:
 - co-producing policies and protocols with people who use services and their carers
 - ensuring that there are open channels of communication between practitioners and people who use services
 - using the communication methods that suit the person, in line with the **Accessible Information Standard**
 - supporting people to take managed risks to achieve their goals – for example, taking part in hobbies or sports
 - ensuring that there are systems in place for reporting concerns or abuse
 - ensuring that practitioners have the time to build relationships with people
 - training and supporting practitioners to work in this way, and checking they are doing so.
 - ii. Practitioners working in all settings where care and support is delivered should ask the person using services, their carers, family, friends and advocates what name they prefer to be called, and use their preferred name.
 - iii. Practitioners working in all settings where care and support is delivered should take time to build rapport with the people they support.

- iv. Practitioners working in all settings where care and support is delivered should respond flexibly to the priorities a person might identify each day. For example, a person might ask a home care worker to spend more time helping them get dressed and less time on other tasks if they have a special event to attend.
- v. Day care and residential care providers should offer a choice of activities that are led by the person's needs, preferences and interests. Encourage people to take part by including activities that motivate them, support them to learn new skills and increase their level of independence. Recognise that preferences are not fixed and may change.

b) Continuity and consistency: *Having continuity and consistency of care and support has a considerable impact on a person's happiness and quality of life, as it can lead to them forming positive relationships with their care workers. If care workers know the person, their preferences and care and support needs, it helps to ensure continuity of care. This focus will help the person achieve the outcomes they identified as important to them in the care and support needs assessment, for example taking part in activities and participating in social groups.*

Service providers (such as independent home care agencies, residential care services and voluntary sector organisations) ensure that people using adult social care services experience care and support from a consistent team of social care workers who are familiar with their needs. People using adult social care services should always be informed in advance if new staff will be providing their care. To ensure continuity of care, providers should ensure that staff are informed of the person's preferences and care and support needs before they see the person.

People using adult social care services have the same team of social care workers who are familiar with their needs and preferences. People are told in advance if new staff will be involved in their care and support. The staff caring for them record details of the person's preferences and the care they have had so that other members of the team can make sure there is continuity in their care.

Continuous and consistent care and support includes ensuring that:

- ! all practitioners involved with the person's care and support are familiar with how that person likes support to be given
- ! where possible, the same people support the person
- ! if the same staff are not available, there are good handover arrangements
- ! all staff supporting the person have similar levels of skills and competency

- i. Service providers in all settings, with oversight by commissioners, should review staffing numbers and skill mix regularly to ensure that staffing and skill levels are sufficient.
- ii. Commissioners and managers in all settings should ensure that there is continuity in care and support for people, including:
 - ! ensuring that all practitioners involved with the person's care and support are familiar with how that person likes support to be given
 - ! where possible, the same people are supporting the person
 - ! if the same staff are not available, ensuring there are good handover arrangements
 - ! ensuring that all staff supporting the person have similar levels of skills and competency
 - ! using the same independent advocate where possible.
- iii. Providers and managers in all settings should ensure that:
 - ! people are informed in advance if staff will be changed **and**
 - ! any changes to care and support – for example, when visits will be made, are negotiated with the person.
- iv. Support people to make decisions about entering a new care setting or moving to a different setting. For guidance on transitions between particular settings, see the NICE guidelines on:
 - [transition between inpatient hospital settings and community or care home settings for adults with social care needs](#)
 - [transition between inpatient mental health settings and community or care home settings.](#)

- v. To support collaborative working between services, commissioners and managers should consider putting the following in place:
- ✓ a local policy for sharing information relevant to people's care within and between services in line with the Caldicott principles and the [Health and Social Care \(Safety and Quality\) Act 2015](#)
 - ✓ joined-up policies, processes and systems.
- c) **Personal care:** All practitioners providing personal care should ensure that personal care needs are responded to in a timely, appropriate and dignified manner in line with the person's wishes and their support plan: for example, making sure that people can go to the toilet when and how they want.
- d) **Promoting positive relationships between people who use services:** Service managers and practitioners in day care and [residential settings](#) should promote a sense of community and mutual support: for example, by facilitating interactions and building social connections between residents through activities such as social events.
- e) **Residential settings:** Practitioners and managers in residential settings should:
- ensure that the environment allows for people's preferences, self-expression and choice – for example, enabling people to have their own furniture and pictures
 - support people to have control over their own medicines where possible (see the NICE guideline on [managing medicines in care homes](#))
 - deliver care and support in a [personalised](#) and friendly way
 - give people privacy, especially when delivering personal care
 - treat people with dignity and respect.
- i. When designing residential services, providers should ensure that environments:
- ❗ create space where practitioners and residents can have positive interactions
 - ❗ are welcoming to visits from family, friends, carers and advocates
 - ❗ are stimulating, while not creating additional challenges for residents, including those with sensory impairments or dementia (for example, if the layout is frequently changed or there is poor lighting)
 - ❗ enable positive risk taking (for example, being able to use outside spaces)
 - ❗ support residents' autonomy (for example, by adapting kitchen facilities for people with physical disability).
- ii. Ensure that support in residential care is based on a good understanding of people's needs, including:
- ❗ providing practical and emotional support
 - ❗ accommodating speech and communication needs
 - ❗ helping people to maintain the personal relationships and friendships that are important to them
 - ❗ supporting people to take part in activities and social groups that they want to be involved in, both in the residential setting and in the community
 - ❗ viewing behaviour that challenges as communication
 - ❗ providing access to community health teams and specialist support.
- iii. Practitioners should support people to participate fully in tasks and activities by ensuring that:
- ❗ the environment is conducive to their needs
 - ❗ they have access to the equipment they need (for example, hoists or recliner chairs).
- iv. Managers should ensure that practitioners are trained to support residents to use any equipment they need.
- f) **End-of-life support in residential settings** (*For more information on end-of-life care, see NICE's guideline on care of the dying adult*)
- i. Managers in residential settings should co-produce a policy on end-of-life care with people who use services and their carers. This should include information about:
- ❗ documenting treatment and care preferences at the earliest opportunity (including formal ways of documenting preferences such as Lasting Power of Attorney for health and care decisions, advance statements of wishes and care preferences or advance decisions to refuse treatment)
 - ❗ a named lead in the residential setting

People should be provided with information that they can easily read and understand themselves, or with support, so that they can communicate effectively with health and social care services when providing feedback on services. The information should be in a format that suits their needs and preferences, for example produced in Braille format. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or independent advocate if needed. For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in Accessible Information Standard.