CARE AND SUPPORT PLANNING

VERSION No	5
REVIEWED BY	**Mariana Philipova**
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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