Care and Support Plans (England) Policy

Policy Statement

This care service always develops an individual plan of care which describes what care and support is needed and how it will be delivered. It recognises the key role of well-documented care in the provision of high-quality care in line with the requirements of the Care Act 2014, and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care and support plan is drawn up with people's involvement after a thorough assessment of the prospective service user's needs, strengths, abilities and aspirations. It could be based on the following sources of information.

- A summary of the care plan prepared under any previous health and care assessments.
- An assessment made by the care service's own staff (including where the care and support is being obtained privately).
- A plan produced under the (mental health) Care Programme Approach (if applicable).

In line with the relevant care regulations, the assessment covers all aspects of the prospective service user's health, personal and social care needs. The ensuing care and support plan sets out in detail the actions to be taken to meet the service user's care and support needs.

A care and support plan will follow all appropriate clinical guidelines produced by relevant professional bodies. It includes the person's care goals and how they will be achieved within agreed timescales and staff responsibilities.

Any service user who has learning disabilities will have access to health services in line with Health Action Planning policies and will have the opportunity for an annual health check in addition to any other healthcare and treatment needed. (*Include where applicable.*)

The service recognises its duty to provide safe care and, accordingly, assesses all risks that threaten individual safety and wellbeing. The service user is always central to the procedures for planning their care. The service user must, therefore, sign or otherwise signify active consent to their plan of care and to the attendant risk assessments.

Where the service user cannot take responsible decisions, best interests' assessments will be carried out in line with the requirements of the Mental Capacity Act 2005 to develop their care and support plan.

The service will make available relevant managerial, care and other staff as appropriate to assist in producing and carrying through the care and support plan, and subject to the service user's permission and to recognised standards of confidentiality, will involve other professionals and agencies in the care planning.

It is for the service user to specify which relatives, friends or others they wish to be involved in drawing up and implementing their care and support plan.

Service users are central to the reviewing of their care and treatment. Reviews are carried out regularly with the involvement of the service user, their relevant others, the service's management and care staff and, where applicable, other professionals who contribute to their care and wellbeing.

The care and support plan is always written in language and formats that the service user and others involved in their care can understand. It is kept in a secure place (in a care home or the person's own home), and service users know that they can always have access to it.

Purpose and methods

The care and support plan:

- is drawn up from the needs assessment and identifies the goals agreed with the service user for their care and support, and how the goals will be achieved
- will embrace all aspects of the service user's welfare agreed from the needs assessment, including any risks and how they will be managed
- recognises and builds on service users' strengths and abilities to meet their own needs
- will describe the care service's responsibilities for the service user's welfare and limits to their responsibilities
- will relate the care service's responsibilities to those of other professionals and agencies so that everyone's contributions are clear to all concerned.

Risks and Risk Assessment

1. Risk assessments and corresponding management plans are integral to the care planning process. They are made to ensure that the service is providing safe care and treatment in line with their registration requirements.
2. The service recognises that service users have the right to take risks, but through the care and support plan, it will take all reasonable steps to ensure any risks to which service users are exposed, are well controlled.

3. As part of the care planning, the service helps each service user to assess the risks involved in any proposed care and treatment, weighing the benefits and possible adverse effects, and coming to a measured conclusion. All risk assessments are recorded on the care plan.

4. If a person does not already have the mental capacity to take part fully in their care planning, the plans will be drawn up with the involvement of their relatives and lawful representatives, including anyone with power of attorney for their welfare following Mental Capacity Act 2005 (and Mental Capacity Amendment Act 2019) procedures. Care plans will include any restrictive measures agreed under deprivation of liberty safeguarding authorisation procedures. These will be regularly reviewed and will always be available to CQC inspection.

Planning and Meetings

The care service holds regular meetings on service users' care and support plans. The first meeting takes place before or very shortly after an agreement about the service to be provided has been made. At this meeting, the purpose of the care and the care provision will be discussed and agreed. The service user (or lawful representative where the service user lacks mental capacity) should then give their formal consent to the care and treatment proposed by signing the care plan.

Implementation

1. The care and support plan will be readily accessible to both the service user and the care staff.

2. It will be regularly consulted by staff and others who have legitimate access, as a guide to the care they should be aiming to provide.

3. The manager and the key worker/care co-ordinator will continue to monitor the work undertaken with the service user to ensure that other staff are acting in accordance with the plan.

Emergencies and Discharge from Hospital

Where the service agrees to provide a service in an emergency, and where no pre-service assessment and personal planning has been possible, it will develop a provisional plan within 24 hours of the start of the service.

The plan will then be developed and reviewed with all concerned by the end of the first week after the start of service, and further reviewed by the end of the first month (if still applicable).

The service will follow all professional needs assessments, advice and guidance for people who are being discharged from hospital and include these in their care and support plans, including any rehabilitation and reablement recommendations.

Reviews

1. In addition to regular monitoring, the service will carry out monthly checks wherever practical of the plan with the service user and key others, and no less than three monthly formal reviews with all involved.

2. Reviews involve the service user, their relevant others, a care manager, key worker or care co-ordinator, and where involved, other professionals, where the progress of the plan will be discussed.

3. Reviews will, among other matters, critically consider the appropriateness of the original plans, the feasibility of the care methods being used, the outcomes of any risks taken, respective roles and responsibilities, and timescales.

4. Reviews will take into account any new information which is available and any significant changes in the service user's needs, abilities and aspirations.

5. Care will be taken to ensure that the service user is in full agreement with any modifications or additions made to the plan.

6. Reviewing the care and support plan is a continuing process of counting achievements, setting new goals and adjusting the care. After each review, the other stakeholders involved in the care will be briefed on changes which require their action or attention.

Records

1. Each service user will have a file prepared before start of service, which will contain:

    a. a sheet with basic information (name, age, etc)

    b. the initial assessment documentation

    c. the first plan of care

    d. risk assessments

    e. records of reviews of the plan, with any changes made to the plan from the monitoring and reviewing procedures.

2. The records will be written in a style and language readily comprehensible to the service user, particularly where the service user's first language is other than English.

3. The records will be securely kept, where practical, in the user's accommodation, with authorised access for care staff who need to record their work and for management and administrative purposes. Service users have access to their own care plans in line with data protection laws and the service's access to records policy.

4. When changes are required to the service user's care and support they will be made neatly, but from time to time some documents may become so heavily amended as to

need replacing; old documents will not be destroyed during a service user's lifetime as they may contain important information about the service user's personal and care history.

5. All care and support plans, including those that are kept electronically, must comply with the General Data Protection Regulation and Data Protection Act 2018.

Training

All new staff are given training in the development and use of the service's person-centred care plans and further training as required, following the Care Certificate standards framework.

Staff with or who are studying for a formal qualification are expected to develop their knowledge and skills in line with their roles and responsibilities for care planning, eg as key workers/care co-ordinators/managers. Their training is tailored to their specific learning needs.