![C:\Users\XYZ\AppData\Local\Microsoft\Windows\INetCache\IE\ISQHTT4K\Vanamo_Logo[1].png]() **Promise Care Services Ltd**

 **CARE AND SUPPORT PLANNING**

# Scope

* **Policy Statement**
* Care Act 2014
* Local Authority Funded Person(s)
* **The Policy**
* Principles
* Assessment of Care Needs
* Sources of Information
* Information Gathering
* Physical and Emotional Wellbeing, and Mental Health
* Services Requested
* Passing Information to the Allocated Worker
* Referrals from Social Services Departments
* Emergency Service Provision
* Care Plan
* Those involved in Planning
* Creating the Plan
* Risks
* Implementing the Plan
* Review of Care Needs
* Changes in a Service User’s Care Needs
* Records
* Working with Service Users with Fluctuating Needs
* Principles
* Assessment of Mental Capacity
* Staff Involved
* **Related Policies**
* **Related Guidance**
* **Training Statement**

# Policy Statement

We are acutely aware of the importance of care and support planning and the impact it can have when it is not undertaken in a planned and systematic way. The individual's needs and preferences are at the core of the process and effective Information giving and sharing is a vital component of meeting peoples needs. People will be encouraged to share their aspirations, goals and preferences and will be in control of developing and agreeing on their care plan – this is the fundamental Principle of Person Centered Care

# Care Act 2014

It is often said that a service-led approach to delivering services is the Achilles’ heel of adult care. In trying to move things forward, the Care Act 2014 sets meeting needs at the centre of care and support planning, moving away from the previous terminology of ‘providing services’. This is to enable a much broader diversity and variety of approaches in how needs can be met, providing for a collaborative engagement process with the local authority (LA) and other commissioners concerning care services provided. We are aware that, due to the 2020 Coronavirus outbreak, the Coronavirus Act 2020 made changes to the Care Act 2014 and the need for assessments and review timelines were changed (the Coronavirus Act 2020 came into force in March 2020 and has a life span of two years).

# Local Authority Funded Person(s)

When individuals are assessed as LA funded, this means that they meet the eligibility criteria set by the government to have their care paid for by the state. There are now a variety of methods that can be used by LA’s to fund social care. These include:

* Personal budgets.
* Direct payments.
* Individual service funds (ISFs).
* Purchase of regulated and unregulated services.
* Mixed funding arrangements.
* Flexible choices of care and support.
* ‘Prescribed providers’ do not fit with the government’s vision of personalised care and should be avoided.
* No constraint on how needs are met, as long as this is reasonable.
* Steps should be taken to avoid decisions that assume the views of the professional are more valid than those of the individual.
* Persons lacking capacity are equal within the Care Act 2014, but the principles and requirements of the Mental Capacity Act 2005 must be adhered to in these cases.

All this good practice will be embedded for every user, including self-funders.

The importance of good information, advice and guidance cannot be underestimated, and, under the Care Act, LAs have a duty to provide such a service.

# The Policy

The Care Act 2014 has a huge implication, both for LAs and providers of services over the coming months and we, as the provider, are well placed to meet the challenge ahead. We set out below a set of principles that apply to all our care and support planning processes.

# Principles

* Information Advice and guidance will be available to all prospective users of services so that an informed decision on our ability to meet the assessed need can be determined.
* The user and their family, representative, or ‘relevant person’ will be involved from the start of and throughout the assessment and care and support planning process, to ensure their needs, choices, and preferences are reflected in the care plan agreement. This may be completed remotely, without visiting the individual.
* Consent will be discussed, formally recorded, and agreed upon within the care plan.
* The Mental Capacity Act 2005 Code of Practice will be followed where someone lacks capacity or where there are fluctuating needs identified, and a decision recorded in the care plan.
* Choice and control will be retained by the individual, including their ability to take or make unwise decisions where they have the capacity.
* Self-supported care and support planning will be encouraged and available to all users.
* ISFs will be developed in agreement with users and will be offered where requested.

The full guidance on assessment and eligibility is in the Care and Support Statutory Guidance updated on 9 May 2016, issued under the Care Act 2014: Chapter 10.

# Assessment of Care Needs

Before we agree to provide a service, we ensure that a thorough assessment of a prospective individual’s needs has been undertaken. For people referred to this organisation by a 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 the care needs assessment. All action considered for the service user plan must be soundly based on material in the care needs assessment.

Needs assessments are only carried out by competent members of staff who have been appropriately trained and who are specifically authorised for this task. Throughout the care needs assessment process, the staff member carrying out the assessment should communicate with and actively involve the prospective individual and their representative. It is particularly important to find out the individual’s wishes and feelings, and to take them into account; to provide the individual with full information and suitable choices, and to enable and encourage individuals to make decisions about their own care. We will comply with any special local arrangement for self-assessment by service users.

# Sources of Information

The general expectation is that the service user will give us the necessary information but, where this is not possible, the service user’s carer, relative or legally-appointed representative, or the relevant person is the most likely source. In such cases, the service user 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. Please note, during civil contingency measures these parties can be contacted separately and do not all have to be present. The staff member carrying out the assessment needs to interview the service user (and carer) either pre-admission, via multimedia technology, 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 allow the prospective service user to demonstrate his or her abilities, as well as discussing his or her needs. They should use the time to observe the service user. Within a domiciliary setting, it should be remembered that the service user’s home becomes the staff member’s workplace, so a full environmental risk assessment should be completed, as well as discussing what this organisation has to offer.

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 service user the form if requested.

# Information Gathering

A full and comprehensive assessment of needs should be completed with the service user and with their relatives or representatives, where requested. Staff need to ensure that consent can be given and, where there are capacity issues, assessment under the Mental Capacity Act needs to be completed and advice should be sought for a best interest assessor and the registered manager.

# Physical, Emotional Wellbeing and Mental Health

We record information about the service user’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 items for consideration. Although we need as full a picture as possible of the needs of the service user, we do not wish to intrude on the service user’s privacy any more than is necessary, so staff members must use their judgement as to which information is recorded.

Care should be taken not to place too great a stress on disabilities or any one area. The staff member should emphasise from the outset that a care worker will work with the individual and try to support the individual’s independence as far as possible. If there are health issues on which further medical or nursing details are required, the staff member should ask the individual or carer to obtain and pass to us the necessary reports. Permission will also be sought to obtain a list of medication and the GP patient summary sheet.

Any written documentation about the service user’s care needs should be appended to the form.

# Services Requested

This information is recorded on the assessment form, detailing the services that we are being requested to supply. At this point, a 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.

# Passing Information to the Allocated Worker

When the manager has decided that we will supply services, identified care workers are allocated to the case. We believe that the matching of the care worker to the service user is of paramount importance; due consideration is therefore given to the care worker’s availability. When all the required elements have been agreed upon, the service user will be informed of the staff team that will undertake the service. The care worker(s) will be introduced personally to the service user on the commencement of the service. The allocated care worker(s) are responsible for reading and understanding the care plan and ensuring that any required changes have been addressed.

# Referrals from Social Services Departments

In cases where a potential service user is referred by a social services department, the manager 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 department's care plan or care diary. The summary of the social services’ needs assessment should be filed alongside our assessment form. We will comply with any special local arrangements for self-assessment by individuals.

# Emergency Service Provision

If we have been requested to provide services at short notice or in a crisis, there may not be an opportunity to carry out a full assessment before providing 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. We will be following the Coronavirus Act 2020 principles as a statutory guide. The organisation has a form specifically to record the needs of an immediate response situation. When emergency services are provided, the manager must complete the basic information required and allocate the case to a worker who is competent to undertake an initial contact assessment. In these circumstances, only experienced managers of the service will make the decision to respond.

Within three working days, the manager will arrange for a full assessment to be carried out and the form to be completed with all relevant details for providing services over a longer term. Where the immediate response is on a short-term basis only, the immediate response form will be used in conjunction with any other details supplied by health or social services to assist in the service delivery. If the service is provided at the request of a social services department, the manager must ensure that the department completes an assessment within two working days and passes the information to us as described above.

# Care Plan

This organisation’s process of planning service user care is based upon the following principles:

* **Planning care is user-centred**. A plan of care will never be made without the active participation of the person to whom it relates or, where necessary, this person’s representative.
* **Planning care involves others who are relevant to the service user and for which consent to contact has been given**. Many service users 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 service user must always remain central.
* **Planning care often needs to be multidisciplinary.** Most service users have both social care and health needs. We will ensure that the views and contributions of all relevant agencies and professions are collated into a care and support plan.
* **The plan of care must be evidence-based**. The plan of care for each service user 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 or maintain current wellbeing, we work with the service user 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; they are based on realistic judgements about what can be achieved, including honest estimates of the resources involved.
* **Plans must be reviewed.** A plan of care is not a static document; plans must be capable of being adapted if there are any changes or practices change. Every plan will be regularly reviewed and revised.
* **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.

# Those Involved in Planning

The following people are involved in planning the care:

* **The service user.** The service user is always central. We emphatically do not plan *for* people; we plan *with* them. If a service user is not able to participate meaningfully for themselves, we will always seek an appropriate representative or advocate who can faithfully put forward what they believe the service user would have contributed.
* **Relatives, friends and Informal carers**. Subject to the service user’s agreement, we would wish to involve other people in the service user’s circle who are likely to be involved in implementing the agreed service user plan. We recognise that carers and others occasionally have needs and interests of their own; we will take these into account but will insist always that the needs and preferences of the service user remain pre-eminent.
* **The staff of this organisation***.* In planning and reviewing the care we provide we try to involve all of the people who know the service user well. This is likely to mean the staff 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, our service users will likely have been in touch with other agencies. Where appropriate, and with the service user’s agreement, we will involve representatives of these bodies in planning care to ensure that the services we provide are as well coordinated as possible.

# 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 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 these discussions, the service user’s views will be central.

# Risks

Any plan is likely to include some risks for the service user; 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, as 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.

# 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.

# Reviews of Care Needs

A minimum standard of an annual review is the mechanism for this organisation. To ensure that the needs of the service user are relevant, we will, however, retain the flexibility to initiate a review whenever we feel it is in the service user’s best interests.

Whether or not any specific changes to a service user’s needs and circumstances have been reported, the manager should review the appropriateness of the service provided within six weeks of our starting to provide services, and then six-monthly or at least annually thereafter. Throughout the whole assessment process, great importance should be attached to the service user’s views of their needs and wishes, and service users should be given every encouragement to express themselves. In the LA 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 service user, 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.

# Changes in a Service User’s Care Needs

It is the responsibility of any worker providing service to report to their manager any significant changes in a service user’s needs and circumstances. The manager is responsible for considering whether any change in the service is required as a result of the change in the service user’s needs. If so, the manager should initiate a discussion with the service user or the service user’s carer or representative, if appropriate, and with the relevant social services department, if necessary. If the changes to the care plan are of a type not exceeding two hours more or less than the agreed care plan, this will be deemed to be a temporary change. If the change is to be a permanent one, a review will be instigated that will include a variation to the fees and charges.

# Records

The initial decisions about the service user’s plan, the risk assessments, and any other significant issues will be recorded and should be signed by all parties. Copies of the plan, both in its initial form and as subsequently reviewed, will be held by the service user, except where there are clear and recorded reasons against this. The plan is in a format intended to be accessible to service users and others. If appropriate, arrangements will be made to translate the plan into a language, or pictures, or larger fonts etc. so it is readily understood by the service user.

# Working with Service Users with Fluctuating Needs

When working with service users with fluctuating needs, we will be guided by the following principles:

* We will take decisions on behalf of a service user, only if there is evidence that they cannot take the decision (at the time it needs to be made) because of mental incapacity based on mental capacity assessment authorisations, best interest assessment, or public health legislation.
* We will co-operate with relatives and others involved with the service user in decision-making on behalf of a person on the same basis.
* We will not take or collude in taking decisions for a service user where, from our point of view, there is insufficient justification, and it does not appear to be in that person’s best interests.
* Our staff will only take a decision for one of its service users after they have exhausted every means of enabling the person to take it of their own accord. They will also demonstrate their actions in taking the decision are reasonable and, in the person’s, best interests.
* Where staff have information that suggests the person might occasionally be unable to make some decisions, they will carry out, or contribute to, an assessment of that person’s mental capacity.
* We recognise that the assessment procedure should follow the two-step assessment process recommended in the Mental Capacity Act 2005 Code of Practice.
* We ensure that we comply with all aspects of the law in the cases of service users who are subject to guardianship proceedings or who need legal protection on account of their lack of mental capacity. Included in this are service users who have assigned powers of attorney or who are subject to Court of Protection proceedings.
* Staff are familiar with and act upon any advance directives or advance decisions that its service users have chosen to make in contingency situations where they might lose the ability to make a decision.

# Assessment of Mental Capacity

* Staff ensure that a person’s needs assessment and service user plan of care contain all the information needed that relates to a person’s decision-making capacity, as well as the decisions over which they might need help, on account of their possible lack of capacity.
* The information included indicates the decisions that the service user:
	+ Is able to take at all or most times,
	+ Has difficulty in taking, and
	+ Is unable to take.
* In respect of each area of decision making, where there are difficulties or an inability to take decisions, the service user’s plan of care records the actions to be taken for the person that is deemed in their best interests.
* The individual is always as fully involved as possible.
* Decisions are only taken based on 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.
* Service users 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 other people.
* All incidents where restraint has been used are recorded and reported.

# Staff Involvement

* This organisation requires its care and nursing staff to implement the agreements and decisions that are identified in a service user’s plan of care.
* This organisation also expects its staff to involve service users 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 service user lacks capacity at the time. Where the service user needs to make a decision that lies outside of their ability at the time, staff must do everything to help the person decide for themself.
* This organisation expects its staff to avoid taking decisions on behalf of a service user unless it can be shown that it is necessary and that the service user at the time is unable to take that decision themself. Any such incident must be fully recorded.
* This organisation expects its staff to take decisions for service users 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 service users and this organisation will attempt to advance this principle throughout our operations. We will ensure that every service user who receives our service has consented. We will work to provide service users with the opportunities to exercise choice about the workers with whom they interact and will, when possible, change the worker in instances when the service user requests it. We are particularly sensitive to matching workers and service users where issues of gender, culture, or ethnicity play a role.

# Related Policies

Accessible Information and Communication

Assessment of Need and Eligibility

Advance Care Planning

Consent

Dignity and Respect

Deprivation of Liberty Safeguards

Meeting Needs

Mental Capacity Act 2005

# Related Guidance

NICE Guidelines: Older people with social care needs and multiple long-term Conditions [NG 22], November 2015. Updated April 2021.

https://www.nice.org.uk/guidance/ng22/resources https://pathways.nice.org.uk/pathways/social-care-for-older-people-with-multiple-long-term-conditions

NICE Quality Standard [QS184] June 2019: Dementia. updated December 2020.

www.nice.org.uk/guidance/qs184

NICE Quality Standard [QS144] March 2017: Care of dying adults in the last days of life: updated March 2018.

https://www.nice.org.uk/guidance/QS144

NICE Guideline [NG97] June 2018: Dementia: assessment, management and support for people living with dementia and their carers:

https://www.nice.org.uk/guidance/ng97

Nice Pathways, November 2020:

https://pathways.nice.org.uk/pathways/dementia-disability-and-frailty-in-later-life-mid-life-approaches-to-delay-or-prevent-onset

NICE Homecare Pathway, June 2020:

https://pathways.nice.org.uk/pathways/home-care-for-older-people

Bupa Care Homes (CFC Homes) (19 007 103), ombudsman judgement:

https://content.govdelivery.com/accounts/UKLGO/bulletins/28932d7

# Training Statement

All staff involved in the care and support planning process will undertake Care Act 2014 training via the care and support statutory guidance with particular and emphasis on Chapter 10-13, accompanied by LA guidance as it becomes available along with record keeping training. All staff, during induction, are made aware of the organisation’s policies and procedures, all of which are used for training updates. All policies and procedures are reviewed and amended where necessary, and staff are made aware of any changes. Observations are undertaken to check skills and competencies. Various methods of training are used, including one to one, online, workbook, group meetings, and individual supervisions. External courses are sourced as required.

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Person responsible for updating this policy: **IFEYINWA ODOEMENAM**

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