

Care Planning & Personalised Assessment Policy

Introduction

Quality Statement associated with this policy:

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statement for *Safe systems, pathways and transitions*

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12

Scope

'A person-centred approach starts from the principle that the resident is at the centre of the assessment process as the expert in their own life' (SCIE).

This personalised assessment and care planning policy are relevant to all members of staff undertaking personalised assessments, care planning and providing personal care to people using this service.

It should be read alongside the following policies as they are closely linked:

- Person-Centred Care
- Promoting Independence
- Resident Risk Assessments
- Mental Capacity

This policy and procedure are provided for the regulated activity of accommodation for persons who require nursing or personal care.

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

The purpose of an assessment is to get a complete picture of that person and how they can be helped. It is an evolving process because people's needs change.

Assessments should involve the resident and must be done effectively so that the safety, continuity, and quality of the person's care meets their needs, and assures the legal and professional obligations of the care service.

Personalised care plans are developed in partnership with the person receiving care and support and are used as a tool to discuss their progress against identified needs and goals and/or agreed outcomes.

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It is essential that staff use them in partnership with the person and seek their consent to receive support in accordance with their care plan.

Managers and staff must make sure that residents are fully involved in their care planning. They must consider a resident's capacity and ability to consent, and ensure either they, or a person lawfully acting on their behalf, e.g. a Lasting Power of Attorney for Health and Welfare, are involved in the planning, management and review of their care and support.

Managers and staff must make sure that decisions are made by those with the legal authority or responsibility to do so, and they must work within the requirements of the Mental Capacity Act 2005, including best interests which includes the duty to consult others such as carers, families and/or advocates where appropriate.

Assessments and care plans must be reviewed when a resident's needs change or if there is no change, they must be internally reviewed each as per the Resident of the Day monthly review process and annual care plan evaluation.

Assessment

Is the systematic and continuous collection, organisation, validation and documentation of information (Berman et al, 2010).

Risk Assessments

Risk assessments identify risks associated with the delivery of care which may impact on the residents, visitors and staff, and which could cause harm. The organisation will undertake a range of risk assessments and identify mitigation actions to reduce the risk to minimise the threat to both residents and staff. Mitigation may include a range of activities such as modifying the environment where care is delivered, addition of equipment, e.g. hoists, additional training etc.

Care Plan

A care plan collates the information gathered through the assessment to easily describe the services and support provided to a person. Care plans should be written in collaboration with the person and other people that are important to them if required.

Policy Statement

The Accessible Information Standard (AIS) became a legal requirement in August 2016 for all organisations that provide NHS care and/or publicly funded adult social care. The guidelines were revised in 2017 and set out a consistent approach to ensure that the communication support needs of residents, family and parents with a disability, impairment or sensory loss will be met by the organisation's services.

The organisation will implement the five steps of the AIS:

1. Identification of needs (as part of the assessment process).
2. Recording of needs (within the care plan).
3. Flagging of needs (on electronic care systems).
4. Sharing of needs (transfer between care settings and internal handovers).
5. Meeting of needs (information in an accessible format).

The AIS is not a legal requirement for residents that are not publicly funded, however EFH will take the same approach to providing accessible information for privately funded residents in compliance with the Equality Act 2010.

Person-Centred Assessments and Care Planning

Person-centred assessments and care planning are essential components of providing safe, effective, caring and

responsive care and support. They support staff to better understand a resident including their needs, their strengths and what is important to them.

They reflect the regulations by providing an understanding of what is required to meet a person's needs, ensure they are protected from harm, recognise and value of their lived experience and expertise and empower them to shape and manage their own care.

They will be carried out and written by competent members of staff who have been appropriately trained and who are specifically authorised for the task.

People using our service can expect that:

- They will be involved in their assessment and care planning.
- They will be provided with relevant information to understand the options they have.
- Their assessment and care plan will be based on current legislation and evidence-based guidance/practice.
- Their assessment and care planning will be undertaken by staff with the right knowledge and skills.
- Their assessment and care plan will be reviewed whenever this is needed. This might include when the person transfers between services or is admitted or discharged from hospital or respite care.
- Where there is a shared responsibility for providing care, they can expect that we will work in partnership with other teams, staff and services.
- Care plans will be developed around their strengths to protect the resident's strengths, resilience, independence and ability to be in control of their life.
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Care reviews will be undertaken relevant to the complexity of care of the individual residents, and based on:

The monthly evaluation as part of the Resident of the Day (ROTD)

Reviews following changes to the resident's clinical condition e.g. Falls, Accident, Medical changes

Care assessments, care plans and care reviews will include the resident and the people they want to be involved to support them in the development of these documents, which could include:

- Family
- Friends
- Powers of Attorney
- Health and/or Social Care Professionals
- Carers
- Advocates
- Independent Mental Capacity Advocates (IMCAs)

This is not an exhaustive list, and the resident may wish support from other individuals within their circle of support.

Referrals

Referrals can be made to us in a variety of ways and by different individuals and organisations. An individual may refer themselves to us or we may get a request from their family member.

We may receive a referral from a local authority Adult Social Care team, or an integrated care board (ICB) or a hospital or a community healthcare team. In cases where a resident is referred by a social services department or health commissioner, the manager overseeing the referral and assessment must obtain a summary of the need's assessment undertaken by the agency. The overseeing manager will check the information to ensure that complete information is provided and that it is up to date and still relevant to the resident.

Referrals will not be accepted from local authority or health commissioners where information provided is incomplete and could lead to unsafe management and delivery of the resident's care and support.

Purpose of Assessment

The purpose of assessment is to identify the health and social needs of residents using the services so that we can

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provide them with the right level of support to meet their care and support their health needs. Our person-centred approach is designed to ensure collaboration and partnership working with all parties and agencies supporting the resident, and families, and to provide staff with the knowledge and information to deliver effective, responsive, safe and caring person-centred support for each resident.

The care plan will be written with and agreed by the resident.

Where the resident lacks the mental capacity to engage with the assessment and agree to the care plan development, the organisation will work in partnership with an Appointed Advocate, Power of Attorney, Court Appointed Deputy or other appropriate individual under the Mental Capacity Act 2005, such as a family members, in the best interests of the resident, to ensure the assessment and care plan meets their needs.

The assessment should include information about the residents:

- Background
- Lifestyle
- Family history
- Cultural preferences
- Health, illness or injury
- Personal care need
- Beliefs, choices and preferences

These areas are explored with the resident through conversation to gain their perspective and expertise on their needs and strengths in a holistic way.

In line with the Equality & Diversity Policy the assessment will ensure that the service delivery supports any protected characteristic which is appropriate to the resident, e.g. religious and cultural activities, and that their needs are met in a caring and supportive way. The assessment will include supporting their daily life as agreed within referral by the commissioner or with the resident and/or family.

Seeking their views of their activity level on a day-to-day basis and carrying out observations to support this will also help to formulate the care plan.

The assessment is the start of our relationship with the resident and is our first opportunity to learn what outstanding care and support will look and feel like for them. From our personalised assessment, we are able to formulate an effective, evidence-based care plan that is person-centred, thorough and provides staff with the information and guidance they require.

Assessments will consider specific issues common in certain groups of people and which can result in poor outcomes. For example, continence support and dementia in older people and diabetes in certain ethnic groups. In addition, the needs of the resident and their family will be considered in line with the Accessible Information Standard.

Principles of Assessment

Our principles for health and social care support are to provide residents with:

- Dignity & Respect
- Compassion
- Inclusivity
- Responsive and Effective Care and Support
- Well-being

What matters to the resident will be explored through good conversational listening and recording all relevant information about the person and what they would like to achieve.

Using an outcomes-focused approach to assessment gives control to the resident and prioritises the difference made to their lives.

The resident's views regarding their support and progress will be considered on a day-to-day basis and

observations will be carried out to support this. This activity-based approach will help to update their care plan. Where the trained staff undertaking the assessment identify that the organisation cannot safely deliver the service to the potential resident, this will be discussed with the potential resident and the commissioner, to ensure that the potential resident receives support from an organisation able to meet their assessed needs.

Where additional training is required for staff to be able to deliver the service safely to the resident, or alternative arrangements need to be arranged, these will be put in place before the service commences, e.g. PEG feeding training or alternative provision from District Nurse.

Changing Needs and Assessment

Assessment is an evolving process because people's needs can frequently change due to health or social care issues. This means that accurate and contemporaneous records must be kept reflecting any changing needs and how staff respond to this during the assessment and care planning phase.

Assessment of needs and care planning need to be done effectively so that the safety, continuity, and quality of the person's care meets their needs, and the legal and professional obligations of the care service can be effectively delivered. It is also important to support the resident to maintain and develop their independence wherever possible. A personalised care needs assessment and care plan will be completed, using details provided by any referring agency as the foundation for the service requirements for the resident.

The process will include:

'Discussing individual priorities and needs ...to identify what is important to them, what they feel they can do, what they want to be able to do and what will make them feel safe' (NICE 2016).

Therefore, a conversational approach to assessment will provide individuals with an opportunity to discuss what is important to them and what worries them.

The conversation should include the full range of support needed to help the person to live how they choose, including specific needs arising from:

- Physical problems,
- Mental health conditions, or
- Sensory loss.

For many residents, this will include practical, social and emotional support alongside personal care needs. For example:

- Interests
- What a happy day looks like
- Managing medication
- Accessing the community
- Socialising

Sources of Information

People requiring residential care are the experts on their situation and circumstances. Therefore, we expect that the resident will be an integral part of their assessment. Where this is not possible, the resident's carer, relative, or representative becomes the most likely source of information about their care and support needs. If there are health issues on which further medical or nursing details are required then the staff member should ask the resident or carer to obtain and pass to us the necessary reports, such as care plans or the patient summary record from the GP. Where necessary, due to complex health needs, it may be required to undertake the assessment with the input from a healthcare professional, e.g. District Nurse or Dietician. Additional training for care staff may be identified and this must be considered when assessing whether the organisation can deliver services for the resident and meet their needs. Any additional written documentation about the resident's care needs should be appended to the form.

Assessing Risk

Risk Assessment is an essential part of good quality care planning and should be balanced with the strengths/needs of each resident.

Risk assessments on the Access and Clinical Care Planning tool will be completed for all residents. This ensures safe working practices and a safe environment for staff and people who use our services.

When working in a personal outcome's way, staff need to make decisions regarding risks. These decisions must be made within their areas of expertise/competence and within the remit of their roles. The individual risk assessment should be used to inform decision making and should be updated in collaboration with all stakeholders.

There needs to be a balance, which involves considering the risks of taking away autonomy and reducing quality of life when the risks to immediate health and well-being are moderate and reasonable.

EFH takes a proactive approach to anticipating and managing risks and residents are involved in mitigations plans to manage their risks. This ensures residents to maximise their control over their care and support.

Examples of risk assessments which will be undertaken for each resident (relevant to their care and health needs) include:

- Safeguarding
- Moving and handling
- Medication management
- Environment
- Slips/trips and falls
- Challenging behaviour
- Food risks (e.g. allergies, choking, preparation risks etc.)
- Infection prevention (including COVID-19)
- Skin integrity and pressure ulcers
- Nutrition and hydration
- Transport
- Bed rails
- Hot surfaces

This is an indicative list and not exhaustive, and additional risk assessments will be added based on the needs of the individual resident.

Purpose of Care Plan

The care plan captures a record of an individual's needs, strengths, actions, and our responsibilities, and will be written in an accessible and jargon-free way. It summarises a person's needs identified from an assessment and how they should be met.

The care plan should provide each member of staff who reads it with the information necessary to:

Provide care and support to meet the resident's needs.

- Manage medication, e.g. Self-administration or administered by staff.
- Relevant information regarding:
- Health needs, e.g. skin integrity
- Care needs
- Circles of support
- Positive risk taking
- Social activities
- Preferences and choices
- Support their independence.
- Deliver person-centred services.
- Identify resident's life skills, capabilities and strengths.

- Risk management and assessment.

This is an indicative list and not exhaustive.

Principles of Person-Centred Care Planning

Care providers should follow the five Must Do Principles when putting people at the centre of their assessment process:

1. What matters to you?
2. Who matters to you?
3. What information do you need?
4. Nothing about me without me
5. Service flexibility

Interactions between people and staff are characterised by listening, dignity, compassion and respect.

Record personal outcomes at the time of the assessment and throughout the support planning (or as soon as possible afterwards).

At a minimum this involves noting:

- What matters to the person in life
- Why these things are important (personal outcomes)
- How to work towards these outcomes
- Who will be involved
- When and where

Residents should be given a copy or shown how to access their assessment, their care and support plan. Where possible a hard copy or a statement of agreement of the assessment should be sought.

The staff member will be open about recording the information and should show the prospective resident the form.

A summary care plan can be printed for the resident at the care review.

The care plan will identify how needs will be met. The focus should be on empowering the person as much as possible, by recognising what they can and want to do to support independence.

This basis for personalised assessment and care planning ensures staff:

- Find out the wishes and feelings of the resident and take them into account.
- Fully understand the person's care and support needs.
- Provide the resident with full information and suitable choices.
- Enable and encourage them to make decisions about their own care.
- Empower the resident by recognising their strengths and aspirations.
- Encourage self-support and independence wherever possible.

Care Planning

Our care plan template defines the areas that need to be explored with the person to agree with them the support we will provide. Ensure the care plan has SMART (Specific, Measurable, Achievable, Realistic, Timely) goals and actions. Care must be designed to make sure it meets their needs, and we must make every effort to meet people's preferences.

Residents who are unable to consent to care or communicate their needs

Residents who have capacity to decide about their care and support needs will need to consent to both the care plan and the ongoing support they receive.

When there is a concern that a person lacks mental capacity to consent to their care and support, a mental capacity assessment will be undertaken.

If this determines the person does lack capacity to make a specific decision at a given time, a best interests decision using the Mental Capacity Act 2005 best interest's checklist will be carried out.

As part of the best interest's decision, staff must ensure that every effort is made to involve the person and family or someone known to the person to understand their past and present wishes, their history, interests, values and beliefs. Please refer to our Mental Capacity Policy for further guidance.

Staff must make every effort to support residents to participate in the assessment and care planning to communicate their needs, wishes and preferences. A specific appointment should be offered with a named staff member, and they must ensure there is a relaxed and caring approach to the conversation.

Consider what medium of communication will best suit the person, including verbal, written and pictorial. This must include considerations relating to the Accessible Information Standard.

Establish what time of day the person will be able to best make decisions and communicate their views and ensure they have support with them if required. This should be a trusted person that the resident knows well and who is able to support them to express their thoughts and feelings.

It is important to consider the setting, ensure it is a quiet area where the person feels comfortable, and consider your verbal and body language including tone and volume of voice, not placing your hand in front of your mouth, facing the person and checking for their understanding of what you have said.

Services Requested and Agreed

The services requested must be recorded on the Access and Clinical Preadmission form. A manager must then decide whether we are able to meet the resident's needs.

Matching residents with care workers are part of the assessment and care planning process. Gathering information about the type of care worker a resident feels they would like to be supported by (including age, gender, personality, interests etc) supports our delivery of person-centred care.

Continuity of care is a critical aspect of building rapport and confidence and result in a person feeling safe. For care workers, continuity means that they will better understand the person's needs and preferences and be able to recognise and respond to risk. It also ensures care workers can effectively communicate with the person and deliver the care the resident wants.

When the resident moves into the home they will be introduced to the staff team that will be supporting them at each new shift. The staff will be introduced personally to the resident. The allocated staff are responsible for reading and understanding the care plan.

Staff must check who has responsibility for a care plan so they can share information if details within it need to be changed or are no longer relevant. This is particularly important when the person is unable to communicate their needs for themselves.

Emergency Service Provision

If EFH has been requested to provide services at short notice or in a crisis then there may not be an opportunity to carry out a full assessment prior to providing a service. In these circumstances, only experienced managers of the service will make the decision to respond. If there remains any concern regarding the admission criteria against the registration details for the home. Clarification from a senior EFH manager must be sought.

A telephone discussion, to ascertain as much information as possible before commencing the service, will be recorded and used as the care needs assessment for the first 72 hours of any immediate response for emergency service provision.

A provisional care plan will be generated from this provisional assessment. There are defined timescales on the residents Access and Clinical Forms that indicate what forms are to be completed in the first six hours and then a full completion of forms within 48 hours until the full care assessment and care plan is completed.

Within a maximum of three working days, the registered manager will arrange for a full assessment review to be carried out and the relevant Access and Clinical forms to be completed with all relevant details for providing services over a longer term.

Changes in a resident's care needs

It is the responsibility of any worker providing a service to report to their manager any significant changes in a resident's needs or circumstances. The manager is 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 manager should initiate a discussion with the resident or their carer (or representative, if appropriate), and with any relevant commissioners.

Care Reviews

Regardless of whether any specific changes to a resident's needs and circumstances have been reported, the Registered Manager will review the appropriateness of the service provided at the end of the first week and then by the end of six weeks for new residents.

Care reviews will be undertaken relevant to the complexity of care of the individual resident.

The frequency of reviews will depend on resident circumstances and should be responsive to any changes in those circumstances. The frequency should be agreed with the person, and they should know who to contact if they want to request a review at a different time.

A review should always involve the person and seek their view of their needs and wishes and their view on the appropriateness of the care and support in place. Care reviews will include the resident and the people they want to be involved to support them in the review, which could include:

- Family
- Friends
- Powers of Attorney
- Health and Social Care Professionals
- Carers
- Advocates
- Independent Mental Capacity Advocates (IMCAs)

This is not an exhaustive list, and the resident may wish support from other individuals within their circle of support. Where social services/health commissioners are involved with the resident they retain responsibility for the setting up of commissioned reviews. However, EFH will complete internal care reviews and may request a commissioner review where there are concerns regarding the care or services provided, e.g. insufficient funding for the care needs.

Training

Everyone will read this Care Planning and Personalised Assessment Policy and receive care planning and preadmission assessment training where applicable to their role.

The Registered Manager will ensure that agency staff working at the home have completed the necessary assessment training for their role.

Supervision and Team Meetings

Supervision, team meetings and other learning opportunities should be used to:

- Share best practice in person centred assessment and planning of care
- Challenge poor practice or discuss uncertainty around person centred assessment

- Be able to demonstrate their own responsibility or accountability to ensure the assessment is current, accurate and completed in a timely manner.

Registered Managers should make particular efforts to involve staff who work alone or who get very little direct oversight (for example, night staff).

References and Further Reading

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Mental Capacity Act 2005 (<https://www.gov.uk/government/collections/mental-capacity-act-making-decisions>)

Seeking Feedback

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of person-centred care assessment and how these have been identified, reported, managed and actioned. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

| Review date | Next Review Date |
|--------------|------------------|
| January 2024 | January 2027 |