Care Planning Toolkit

Care Planning and Assessment Guidelines

Welcome

Welcome to HCPA Care Planning Toolkit. These have been designed to provide you with the key points to remember when completing the Care Planning and Assessment documentation. Remember, these are designed to support, prompt and act as a refresher for those that have received 'on the job' learning from an experienced colleague.

Enquiry Handling

From the point of enquiry, the priority is to gather the level of involvement of the potential Service User. To include:

What the potential Service User's level of capacity is to be involved
Whether they have consented to the enquiry being raised by the family/carer/ Local Authority
In the event of a lack of capacity – the legal powers in place

Discuss any concerns to the above with the Registered Manager before gathering any more information!

As much information as possible should be gathered to support the assessor to determine the key needs of the potential Service User, whilst balancing that with a 'need to know basis'.

Once the enquiry form or Local Authority Care Plan is complete it should be handed over to the Registered Manager or designated other immediately. The enquiry form will be added to the Service User's file once complete.

Service Commencement

The service commencement stage should only be completed by a person who has competence, experience and skill in this area. The Care Plan is a legal document and staff should be clear on record keeping standards when completing this document.

Helpful Tips

Gather as much information as possible and complete with the Service User or their family/carer

During the Care Planing stage assessing staff should (where they feel comfortable to do so) ascertain the wishes of the Service User to form the Advance Care Plan such as a DNAR. At this time they can also signpost to further information sources

Every section of the Care Plan has prompts to consider risk and further actions that need to be taken when the Service User commences a service with your organization. Where a support or care need has been identified, an individual assessment needs to be completed for each one

The Care Plan must be completed prior to the service commencing and no later than 2 days after. For emergency services, the Care Plan must be completed as soon as possible, it would be good practice to record on the Service User's record that this was an emergency admission. Care Plans should not be completed based on the enquiry form or Local Authority Care Plan alone

Risk Assessments

Risk Assessments are a vital part of any Service User's documentation. Their purpose is to identify what Service Users do and assess if this could cause harm. The Risk Assessment then goes on to detail what action needs to be taken to reduce the risk of harm.

We want to promote quality of life when caring for Service Users, so Risk Assessments should be viewed as a way of enabling people to do what they want to do whilst trying to eliminate and reduce the chances of harm. We must accept that we may not be able to remove all risks but if we stop people from doing what they want to do, we are affecting quality of life and impinging on human rights.

It is important to understand two key terms with Risk Assessments:

Hazard - A hazard is anything that has the potential to cause harm to a person
Risk - The likelihood or chance that someone could be harmed by those hazards and an indication of how serious the harm could be

You should complete a Risk Assessment when you know that something could cause harm.

For example, if you know a Service User cannot summon help, or is unable to grip anything with their hands, they cannot use a call bell. Someone else may be a smoker or need bed rails, or you may support someone with cognitive decline who wishes to leave their home.

Risk Assessments will provide a risk rating, and this is used as an indicator for staff action, e.g. if a hazard is low and the likelihood is low, there could be minimal chance of the risk happening and therefore no immediate action needs to be taken, however if hazards are high and likelihood is high, then staff need to act immediately for that issue.

Helpful Tips

Refer to the policy that the risk relates to. For example, with bed rails refer to the Use of Bed Rails Policy and Procedure. That way the procedures are clear on how staff must support that person based on current practice and recommendation
Remember it may not always be possible to eliminate all risks and promote quality of life. Be sensible in the approach to Risk Assessments and use open communication with colleagues and Service Users to make sure expectations are realistic
Involve and seek the agreement of the Service User and/or their family
Where a person lacks capacity to be involved, staff must refer to the Mental Capacity Act Policy and Procedures

ALL Risk Assessments need to be completed prior to the Service User's service commencing and thereafter reviewed as needs change or under specific timeframes. Reviews of Care Plans and assessments should be clearly recorded on the review form and within the daily record.

Mandatory Risk Assessments for All Service Users

All organizations must have a suite of assessment tools available and these should be used on an individual need basis, e.g. the Care Plan review identified that the Service User has a breathing condition; therefore the Breathing Assessment should be completed. For Service Users that need support to help get washed and dressed, the Personal Hygiene Assessment should be completed.

There is a suite of Risk Assessments that are mandatory for all Service Users These are nationally recommended and as follows:
Moving and Handling
Falls

Water low
MUST
Choking
Oral Health

Once completed, outcomes and levels of risk of the Risk Assessments should be recorded within the relevant Care Plan as well as clear management strategies for reducing the risk.

Care Planning

Care Plans should be completed ahead of the service commencing and no later than 48 hours of a referral coming through. It is important to Care Plan high risk areas immediately.

Remember Care Plans only need to be written when there is an assessed need, so this means that not all Service Users will require the full set of Care Plans available. Care Plans must be reviewed as needs change or on a yearly basis, some Care Plans can be discontinued if no longer relevant! There is a suite of templates available to guide the content of a Care Plan, however, they should only be used as guidance as everyone will have different needs and abilities and support necessary. When writing Care Plans, remember that much of the information will be gathered in the first instance from the enquiry form or Local Authority care plan. Care Plans must be written based on:

Ability 'What can the Service User do?
Wishes 'How does the Service User want to be supported?'
Needs 'What does the Service User need support with?
Outcomes 'What is the expectation/outcome for the Service User?'

Visit Summaries

Visit Summaries are supplied for use and are available to provide a summary of the key wishes and needs of the Service User as detailed within the Care Plans and assessments. They should be placed within the Service Users Care Plan file so that staff can be provided with a quick reference to provide safe and effective care.

Staff are responsible for ensuring this document is reviewed in accordance with Care Plans and assessments to maintain accuracy and safe practice.

Writing a Person-Centered Care Plan

HCPA have produced these guidelines to support you to write an individual tailored Care Plan that is person- centered and, where possible, outcomes based. Please note these are guidelines and do not cover all eventualities so additional information will be required.

These guidelines should be used alongside the example Care Plans and assessments that you develop.

Record Keeping Standards:

Any entries in Service User's care/support file must be:

Factual, consistent, detailed and accurate
Written as soon after the event as possible
Current to care and condition
Written clearly in black pen to ensure no text can be erased
Written in a manner where alterations or additions are dated, timed and signed with no gaps
Written without abbreviation, jargon, meaningless phrases or words, irrelevant speculation and offensive language

In addition, they must:

evidence that they have been written with the involvement of the Service User (where this is not possible the Service User's relative or representative)
Be SMART – specific, measured, achievable, realistic and with a clear timescale
Detail issues that arise and action taken to rectify
Demonstrate ability, preferences and wishes in the first instance, with how to support following
Clearly detail the care planned, decisions made, and information shared
Always be written with a can-do approach first followed by how staff can support them to be as independent as possible

It is suggested that writing in the first person (i.e. 'I') makes the Care Plan truly person-centred, however, first person should be used with caution. The following rules should apply when considering writing in the first person:

You can use first person when the Service User wrote the plan (or section of the plan) or when you are quoting the Service User and what they told you
You can use first person when the Service User altered the plan with you and agreed with what was said and how it was said
First person can be used when a Service User cannot communicate effectively but only if those that know that Service User best can be sure that what is written is what that Service User would say, you are comfortable that you trust those closest to the Service User to truly know
And finally, what is written will be tested and altered by observation of the Service User's behavior. If there is any doubt, then always use the 3rd person, i.e. they, she, he, Service User name.

Principles of Care Planning

Please ensure that all care planning adheres to the underpinning principles of the Mental Capacity Act.
Consider Capacity including best interests, power of attorney, deprivation of liberty (if a Service User lacks capacity what steps have been taken to support decision making).

For the MCA Code of Practice, please visit: www.hcpa.info/care-planning/MCA

CARE PLANS SHOULD BE…

- ✓ Personalised / tailored to the individual
- ✓ Easy to Navigate / Indexed
- ✓ Co-Produced with the Service User and/or Family/advocate (evidence of this needs to be provided)
- ✓ Reviewed, Evaluated and updated with Service User and/or family
- ✓ Enabling (focusing on what the Service User can do for themselves)
- ✓ Linking to Connected Lives Strategy where possible
- ✓ Precise / Descriptive
- ✓ Respectful
- ✓ A guidance on what care the Service User requires and how to provide that care
- ✓ Written in the first person, using plain English
- ✓ Available in a format appropriate to the Service User
- ✓ Mindful of identification of risk whilst undertaking care planning.

Note: This is generic guidance but may contain service specific advice e.g. *Support at Home*, *LD services* (which will be indicated by *italics*).

1. Are staff made aware of actions they should perform? Is the care plan clear how staff should support the individual?	Documentation should clearly signpost how staff are required to enable the service user i.e. assist, help, support, promote, encourage. Care Plans need to focus on the person's strengths to ensure they are enabling and personalised You will find more details on personalisation here http://www.thinklocalactpersonal.org.uk/ All Service User's should have goals that are personalised for them. These should be recorded in their care plan AND they should be enabling. There should be a mix of long-term and short-term goals, evidence of monitoring these goals should be evident in the care plan. Write goals in the first person, make use of 'I' statements i.e. "I would like" or "I want"
2. Are your Care Plans individual and personalised?	There needs to be evidence that assessments have included consideration of both the needs and aspirations of individuals, in line with the **Connected Lives** model. As well as recognising <u>all</u> the individual needs, consideration needs to be given to what an individual wants to happen in their life. eg. Sam needs personal support because he likes to walk to the shop for his newspaper …….Sam enjoys getting up slowly in the morning…….Sam is not worried about wearing the same clothes two days in a row. In these comments there should be clear evidence of the individual's involvement, families and advocates can also be quoted. It is ok to make suggestions on how to meet the Service user needs and an ongoing discussion between an individual and staff about personal preferences and changing desires is to be encouraged. If the care plan is written in the first person this needs to be genuine. If the person is unable to give a view then this needs to be clearly recorded so that it is obvious the words are the workers' (or families, advocates) interpretation of the person's needs. It is **not** good practise to have a pre-written template.

3. Is your terminology in care plans clear and is all writing legible and in good English?	Terminology needs to be clear and straightforward; try to avoid using abbreviations and in the first instance of usage please state clearly the full term. Writing should be legible and in good English. Do not use tippex, highlighter pens or coloured ink other than blue/black (other colours do not photocopy well). Important information needs to be asterisked e.g. *allergic to Penicillin*. **Be specific** e.g. *turn every 4 hours*, *change dressings when soiled*. Care plans should be written in a respectful way e.g. *Mary needs to be assisted to turn every 4 hours*. *Mary' dressing needs to be changed daily* and *Mary finds this uncomfortable so please explain the procedure, gain consent first and talk Mary through what you are doing* etc. You will need to be transparent – if an entry has been missed, record this.
4. Daily logs	These are crucial to effective, consistent care. Daily logs inform handovers and future staff contact. They should be used to describe a person's physical, emotional and mental wellbeing during that day/period of time the log is reflective of. A log should also document any care and support tasks offered and delivered. If you have turning charts, fluid intake etc. staff should be made aware that this data does not need to be duplicated in the daily log.

<table>
<tr>
<td>5. Do you have forms e.g. for Moving & Assisting (M&A) forms, continence, dysphagia (Speech and Language Therapy SLT) dietetics, allergies etc. – in the client's rooms as well as in the care plans?</td>
<td>
It is suggested that there is an aide memoire in the room with limited personal data e.g. my key needs (with a name, room number and a current photo). This needs to be reviewed regularly in line with the care plan.

Make sure that if any information is kept discretely, the location is communicated to the service user's regular care workers as necessary and any staff providing care at short notice.
Any dietary information should be kept in the kitchen but be aware of keeping this confidential if the kitchen is accessible by visitors or residents.

Support at Home – discuss with the Service User/Family/advocate where this should be kept. Ensure there is a system to keep it up to date so it is relevant at the time of using.

It is suggested that a clear summary is kept on the front of each service user file which is regularly updated every month and signed by the key worker, covering areas such as below:
<table>
<tr><td>Weight / Nutrition</td><td>Actions</td></tr>
<tr><td>E.g. swallowing issues, lack of appetite
Weight loss/ gain</td><td>E.g. Referral to GP, ensure prescribed, food & fluid chart needed etc.</td></tr>
<tr><td>Skin Integrity / Waterlow / Pressure Sores</td><td>Actions</td></tr>
<tr><td>E.g. DN referrals, record of treatment plan</td><td>How many staff required for personal care, preference of support staff/ gender</td></tr>
<tr><td>Personal Care</td><td>Actions</td></tr>
<tr><td>Care needs and routine</td><td>Continence routines, e.g. toilets independently, needs support with commode</td></tr>
<tr><td>Mobility (Moving & Assisting)</td><td>Actions</td></tr>
<tr><td>Current manual handling procedure</td><td>What equipment, sling size and guidance on how to interact with service user during the manoeuvre</td></tr>
</table>
</td>
</tr>
</table>

	Wellbeing	**Actions**
	E.g. stable mood / change in mood/ disengagement from interactions Change in service user's circumstances e.g. bereavement, anniversary of deaths, loss of contact with important others	GP/ CMHT referral, medication review and treatment
	Mental Capacity	**Actions**
	E.g. has MCA been completed by home and it is decision specific Is there diagnosed condition that will impact the decision making at the time e.g. dementia	E.g. MCA completed in relation to bed guards and BIA decision if no capacity
	DoLS /LPS https://www.scie.org.uk/mca/dols/practice/lps	**Actions**
	If service user lacks capacity has a DoLS / LPS application been made	Record of date of application and proof of receipt of application from the DoLS
	DNAR Status	**Actions**
	If service user has one	Make sure all staff and professionals are aware
6. Is your care plan overcomplicated?	Care files can become overfull. They should contain only the current documents (any documents over 2 years or with contradictory information should be archived). Keep contents relevant and easy to navigate to find information on key areas e.g. appointment sheets, transfer documents, other correspondence in one place (consider the back of folder or clearly index the care plan).	

7. Electronic records. Does your care plan use drop down menus?	Electronic records are acceptable – please choose a system where there is room for free text and free text is used. Note: If considering transferring care plans to a database, please ensure staff are able to access and update information about care needs at all times. You need to be able to provide a written/ printable copy should a service user move between services or in emergencies. You must assure yourself that any electronic record / electronic care plan is compliant with GDPR and your contractual terms and conditions, including where / how the information is stored (i.e. where is the 'cloud' actually based?'), security and data retention. You should consider Information Governance Impact Assessment.
8. Are there blank pages or blank sections in the Care Plan?	If there are sections in the care plan that are not relevant to a service user please state, 'Not Applicable' (write in full, do not abbreviate) and add the rationale. Please do not leave any section of the care plan blank.

9. Are consent forms in the care plan? E.g. Do Not Attempt Resuscitation's (DNAR). Are Advance decisions documented? Power of Attorney – this must be referenced in the care plan	You may hold these in a separate folder. If this is the case, please ensure you have a system within the care plan to identify where this information is kept. Some care homes have a system to quickly identify service users with a DNAR in place such as red dots on folders or butterfly stickers on their doors. Be careful to be respectful and talk to the individual/ their family/ advocate to ensure you have their agreement to do so. A Service User's DNAR decision should be reviewed regularly to ensure it is still relevant, this should be reviewed with the service user or family/advocate and GP if they lack capacity. A Best Interests Assessment should be completed along side a DNAR for anyone that lacks capacity to make this decision. DNAR must be accessible to ambulance crews. Make sure end of life planning is addressed with the service user and family/advocate. The status of 'do not resuscitate' should be considered alongside the question of an advance directive as this is the only document that a medic will take note of if they attend. Please ensure all of these are referenced into the main care plan and staff have easy access. You will find more information and guidance on advance decisions, advance statements and living wills here: www.hcpa.info/care-planning/facts-sheet

10. Do you use Purple folders for clients who have a Learning Disability (LD)?	For clients with a learning disability, they should have an up-to-date Purple Folder describing their needs in detail. The organisational annual health support plan must be available to monitoring officers. A GP health action plan should be kept in the purple folder. Purple folders should be held in a secure location. This can be in the service user's room so long as it is secure.
11. Does the care plan encapsulate the individual's preferences, e.g. likes and dislikes, wishes, aspirations, activities and dreams	Care plans need to be person centred and reflect the individual's choices e.g. *Claire likes to eat breakfast sitting in her armchair.* *Mark would like to be offered a choice of activities to fill his day.* Identify what support the service user needs to carry out activities. Include a history of the person, e.g. past and present hobbies and interests to help develop and shape personalised engagement.

12. Do you have action plans in place for individuals who may need Positive Behaviour Support?	Have you considered putting a positive behaviour support plan in place with clear outcomes linked to wellbeing? It is good practice to add these to the care plans. Antecedent, Behaviour, Consequence (ABC) charts are an applied psychology tool for identifying causes and patterns of behaviour. They rely on detailed descriptions of the behaviour as well as what was happening directly before and immediately after the behaviour in question. A template ABC chart as well as a completed example can be found here: www.hcpa.info/care-planning/ABC ABC behaviour charts may be kept in the individual's bedroom, although confidentiality arrangements must be considered. You will need to have up-to-date contacts for external support e.g. Adult Disability Service (ADS), Crisis Assessment Team (CAT), Social Worker via call centre, Single Point of Access (SPA) number for Hertfordshire Partnership Foundation Trust (HPFT). Referrals can be made through a GP or self-referral. Considerations: • Record incidents as soon as they start happening to start compiling a picture • Undertake a Mental Capacity Assessment (MCA)/ Best Interests (BI) to agree a Positive Behaviour Support Plan • Use a specific Positive Behaviour Support Plan • Check and document the medication regime

13. Does the care plan identify the client's first language (or preferred communication if non-verbal), cultural and religious preferences	This should be included in the Care Plan and guidance kept by the individual and a system in place to ensure these are updated in case of any changes. This document should give a quick snapshot of the individual including any names/ nicknames they might have and liked to be called by. This should also link to any special dietary requirements or events / days of specific cultural or religious significance. This also needs to be in the 'This is Me document'/ 'My Life'/ 'Purple Folder'
14. Where do you keep Key Contacts for the Individual's care e.g. GP, Optician etc.?	The Care Plan should contain a Key Contacts section providing full names and contact details of professionals involved in the care of the individual as well as their family and friends. This section must be easy to access and navigate. Do all staff know where to find contact details for key family members in an emergency? Do they know what the family will want to happen in an emergency i.e. some may only want to be contacted if it is the sort of crisis leading to hospital admission; others want to know about every incident. Remember about the duty of candour under the Care Act 2014.

15. Are Key Worker/Support Worker details in the care plan?	This information should be in the Key Contacts section of the Care Plan as well as shared with the service user in a format that suits the Service User's communication method and circumstance. The service should also display information regarding the key worker system. Please remember to support the individual and their family to understand the role of a key worker.
16. Are Personal Emergency Evacuation Plans (PEEP) and bedroom risk assessment in the care plan? **NB Bedroom risk assessment should cover: window restrictors; securing of wardrobes; radiator covers; bed rails; trip hazards etc.**	This should be in the care plan and in grab bags for emergency use. General risk assessments should be in the care plan but PEEP should be kept in the grab bag, however, be mindful of where this is kept because of confidentiality. PEEPs should reviewed monthly as well as when any changes occur in the Service Users needs. Note: It is good practice to have bedroom risk assessments. *Support at Home services – should have personal risk assessments for the environment accessible for inspection; should indicate that advice has been given to the service user and what that advice was. This should include advice given on areas of risk and outcomes.* *NB: It is often observed that there are risks to service users which staff cannot do much about. i.e. rugs, TV flexes, animals etc. Therefore, risk assessments should show that you have:* • identified the risk to them i.e. falling, tripping, safety, fire • *made suggestions about removing or getting help in (i.e. Age Concern to sort out the wiring putting slip protector strips on rugs to stop them moving)* • *taken safeguarding provisions for yourself and the service user whilst you are in their home.* *Tip: You can make a self-referral for a home fire safety check by calling: 0300 123 4040* *For some fire safety familiarisation training please follow www.tsa-voice.org.uk/e-learning*

17. Do you have a professional's page added to the care plan so that professionals can have input? What do you do with specialist advice?	These pages need to be accessible and easy to navigate. Consider putting in dividers, contents page etc. The order of individual sections as well as the maintenance of the care plan folder should be consistent throughout the service. These should be regularly reviewed to reflect the current needs of the individual. The provider should ask/insist that external professionals update this section of the Care Plan after each visit to ensure any new requirements are communicated effectively to staff. Where this is not the case, care staff should take notes from the appointment. Care Plans should be reviewed with a District Nurse on a regular basis. Where the district nurse is attending the nurse and the key worker should work together to co-produce a care plan for the treatment and to review where this has implications for other areas of care needs e.g. nutrition, Moving & Assisting, personal care, turning requirements and pressure mattress settings. Date when details have been transferred into the care plan. i.e. dietician review and instructions for thickeners. Dated and signed as relevant sections of the care plan are changed to reflect new instructions for staff. *LD services* – Health professionals should add an entry to the Purple Folder. Tip: Continuing Healthcare Checklist (CHC)– needs referencing and the role of the District Nurse (DN), Social Workers (SWs,) Community Psychiatric Nurse (CPNs) and other relevant professionals www.hcpa.info/care-planning/CHC

Where do you keep your audits –e.g. medications, infection prevention and control (IPC)? **Where do you keep actions from these and information around lessons learnt?**	These would **not** go in the care plan. Although there should be a sheet in the care plan showing evaluation and review and what the outcomes of actions are. In case of any changes to the Care Plan, these should also be noted in the daily notes. **Note:** Only while the audit actions are **being completed** should this be kept in the care plan but not long term.

Other things to think about…

Clearly there cannot be a definitive capacity line in the care plan however if for example there is a positive behaviour plan or methods of administering treatment where consent is an issue it would be appropriate for the care plan to mention where the capacity assessment and Best Interests (BI) decision is (for those that lack capacity) and how often it should be formally reviewed etc. You may also need special guidance for fluctuating capacity.

The Care Plan should sit with any documentation on statutory orders such as Deprivation of Liberty Safeguards (DoLS), Community Treatment Order (CTO) or Part 2 Mental Health Act (MHA) orders. This would be key to understanding if there are any practices being undertaken that require legal frameworks.

Finally, try to make your care plans aspirational. Check your care plan does not read as very functional (as in what we do to people even if agreed with them). All lines should lead to clear outcomes and care plans should have an outcome focus.
With regards to the Care Act: Try to make your care plans reference to citizenship and protecting / promoting people's rights and choice to engage and how this will be facilitated. Focus on wellbeing throughout.

Homecare electronic Care records guidance

Dear Provider
We have received an increased number of concerns and queries in the last few weeks relating to providers' use of electronic care records.

We are aware that many of our contracted providers are choosing to use such systems to support their businesses.
Whilst the Council supports the use of such systems, providers must be mindful that going entirely paperless will not be appropriate for every service user and their family/carer and the provider will need to facilitate access to information where this is required, this may for example be by secure email or in some circumstances through continued use of paper versions of diary records etc in the service user's home.
People using a service must be able to access and contribute to their own records in their preferred format, in line with the Accessible Information Standard https://www.england.nhs.uk/ourwork/accessibleinfo/
As a minimum the Council expects the following information to be in a service user's home:

- A Service User Guide
- A care plan so that the service user and/or their legal representative and any visiting professionals are able to see the care support that an individual has

Providers must ensure that systems are robust and secure with contingency in place should systems go down.
It is not appropriate for service users and their family/carers to incur a charge to access information for example via an app. Service users in receipt of care are financially assessed by the Council and pay an appropriate contribution towards their care service, they should not then be further charged in relation to their service.
Providers will need to evidence that they have discussed choices relating to information and documentation with the service user and their family/carer (where appropriate). It is not sufficient to assume individuals are happy with electronic care records because they have not specifically raised a concern or requested alternative options. Individuals must be made aware of the options open to them. This will be monitored by the Council through reviews and monitoring visits.
Providers will need to be mindful of confidentiality and steps will need to be undertaken to support the individual to decide who can have access to what information.
Social care professionals and Monitoring Officers employed by HCC will require access to information to support statutory reviews and quality assurance processes. Providers will therefore receive requests for data and information and must respond to these within 24 hours or sooner where requested, to avoid any delays.
If you have any queries relating to the use of electronic care records please speak to your Monitoring Officer in the first instance.

Care Plan Contents Checklist

The below checklist aims to provide a guideline and details all care plan documents must be available in every organization's system, please ensure that relevant documents are selected for each **Service User/Client** *and are specific to their service needs.*	
Initial Assessment Documents:	**Checklist**
Enquiry Form	
Care Plan Cover Sheet	
Personal History	
Care Plan & Risk Assessments	
Activity Assessment	
Behaviors That May Challenge Assessment	
Breathing Assessment	
Clinical Assessment	
Communication Assessment	
Continence Assessment	
Cultural, Spiritual, Social and Relationships Assessment	
Domestic Assessment	
Environment Assessment	
Equipment Assessment	
Financial Assessment	

Medication Assessment	
Mental Health Assessment	
Moving and Handling Assessment	
Nutrition and Hydration Assessment	
Oral Care Assessment	
Pain Assessment	
Personal Hygiene Assessment	
Activity Risk Assessment	
Behaviors That May Challenge Risk Assessment	
COSHH Risk Assessment	
Equipment Register	
Financial Risk Assessment	
Medication Risk Assessment	
Skin Assessment	
Sleeping Assessment	
Care Plans	
Activity Care Plan	
Advance Care Plan	
Behaviours That May Challenge Care Plan	
Breathing Care Plan	

Catheter Care Plan	
Chest Infection Care Plan	
Choking Care Plan	
Communication Care Plan	
Continence Care Plan	
Cultural, Spiritual, Social and Relationships Care Plan	
Diabetes Care Plan	
Domestic Care Plan	
Environment Care Plan	
Epilepsy Care Plan	
Falls Risk Management Care Plan	
Financial Care Plan	
Medication Care Plan	
Mental Health Care Plan	
Moving and Handling Care Plan	
Nutrition and Hydration Care Plan	
Oral Care Plan	
Pain Management Care Plan	
Personal Hygiene Care Plan	

Positive Behaviour Care Plan	
Skin Care Plan	
Sleeping Care Plan	
Stoma Care Plan	
Urinary Infection Care Plan	
Miscellaneous	
Care Plan Consent Form	
Care Review and Evaluation Record	
Visit Summaries	
Daily Progress and Evaluation Record	
Family and Advocate Communication Record	
Visiting Professional Record	
Care Plan Confirmation Form	

Factsheet: Care and Support Plans

The care service manager has responsibility for:

- helping all staff who are involved with service users to understand the importance of care planning
- relating the procedures for care planning to those for needs assessment and day-to-day care
- setting up a care plan for each service user as soon as possible after a service agreement has been made, including people referred as emergencies or after discharge from hospital, including all those who are recovering from Covid-19
- providing every service user with an individual care and support plan, which the service will deliver
- adapting the care plan in line with a person's assessed needs and involving all concerned with its implementation
- allocating lead responsibility for each service user's care planning to a named manager or care worker
- carrying out thorough risk assessments so that safe care and treatment is provided
- seeing that care plans are regularly monitored and diligently implemented
- recognising and building into their care and support plans service users' strengths and abilities to meet their own needs
- organising regular reviews and audits of care plans
- arranging for records to be kept of care plans and their implementation
- ensuring that each service user has easy access to their care plan
- arranging for relevant training in care planning for all staff concerned.

Factsheet: Risk Taking and Assessment for Service Users

Care service managers must ensure that:

- all required risk assessment policies and procedures are available and up to date, including for health and safety, and currently in line with Covid-19 requirements
- the risk policies are comprehensive and define unacceptable and dangerous risk-taking and behaviour for all kinds of risk
- all needs assessments, care plans and reviews include risk assessment and management plans as required by the care standards
- the risk assessments and any management plans for individual service users:
  - are comprehensive and they show a resident's capacity for positive and negative risk-taking
  - are not discriminatory or oppressive in any ways
  - consistently show the levels of support and supervision needed
  - are up to date and show changes in levels of risk
- care plan reviews indicate that any risks have been re-assessed and new plans made if required
- service users and their relatives are fully involved in risk assessment and reviews
- all staff have been made aware of the service's policies and procedures on risk
- all staff have received specific training in risk assessment and management policies and procedures

- risk assessments and management plans are discussed regularly in supervision.

How to Understand Local Authority Needs Assessment Eligibility Decision-making

The pathway from a local authority needs assessment, leading to a decision that the person is eligible to receive care and support and possibly funding from the local authority, and a request for service from a domiciliary care or care home provider, can be described as follows.

1. Identifying the Needs
On being assessed an adult's needs for care and support will arise from or be related to *a physical or mental impairment or illness*, which prevents the person being independent and is affecting adversely their wellbeing.
2. Outcomes
Because of the person's physical or mental impairment or illness, it is established (from the assessment) that the person cannot achieve *2 or more* of the following outcomes:

- managing and maintaining nutrition
- maintaining personal hygiene
- managing toilet needs
- being appropriately clothed
- maintaining a habitable home environment
- being able to make use of the home safely
- developing and maintaining family or other personal relationships
- accessing and engaging in work, training, education or volunteering
- making use of necessary facilities or services in the local community including public transport and recreational facilities or services

- carrying out any caring responsibilities the adult has for a child

3. Wellbeing

Because the person cannot achieve these outcomes (on account of their physical or mental impairment or illness) it is further assessed that there is or is likely to be a significant *impact* on the adult's wellbeing, which might include one or more of the following:

- loss of personal dignity (including from lack of treatment of the individual with respect)
- physical and mental health and emotional wellbeing suffers
- lack of protection from abuse and neglect (including self-neglect)
- loss of control by the individual over their day-to-day life (including over care and support provided and the way it is provided)
- lack of participation in work, education, training or recreation (and social isolation)
- social and economic wellbeing is suffering
- deteriorating or impaired domestic, family and personal relationships
- unsuitability of living accommodation
- inability to make a contribution to society

4. Implications for care providers

It follows that care providers will, by accepting the request for service, become responsible for:

- treating, addressing or working in the context of the person's physical or mental impairment or illness
- helping the person to achieve more positive outcomes in respect of those that the person has not achieved because of their impairment or illness e.g. to have a better diet, to be safe from abuse or neglect, to live in suitable accommodation and surroundings, which

- should improve their wellbeing by e.g. their regaining a sense of dignity and respect, better physical and mental health, feel more in control of their lives, and more engaged in their personal and social relationships and activities.

How the provider sets about meeting these needs and achieving the sought outcomes for each individual to whom they are providing a service, will be reflected in the respective care and support or personal plans.

(Source. Department of Health and Social Care Act 2014 Statutory Guidance Revised 2018)