Agincare
Caring in your community

Person Centred Care Planning Guidance

Issue	Issue 16
Reference number	QP98
Name of responsible (ratifying) committee	Policy Review Group
Document Manager (job title)	Quality Manager
Date issued	October 2010
Review date	Jan 2021
Electronic location	Share-point/Policies and Procedures

Version Tracking

Version	Date Ratified	Brief Summary of Changes	Owner
1	25 January 2019	Minor amendments to some wording and to reflect updated ISO 9001 2015 compliance	JP
16v1	01 April 2020	Annual Issue change	JP

Contents:

1. Purpose of this guidance

This guidance is to support Agincare staff to provide a person-centred approach to care which is outcome based, focusing on the quality of care the person receives and on what matters to them most.

2. Understanding Person Centred Values

What is a value?

Values are a set of beliefs and ideas about what is good or bad, about how we should behave and react; we learn values from our parents, our lifestyles, our backgrounds, culture, religion and relationships. We all have our own values and these usually hold common themes including health and happiness, family, freedom and honesty for example.

In Health and Social Care the following terms are generally used to describe the generic values people hold:

Individuality Rights Choice Privacy Independence Dignity Respect Partnership

The Dignity in Care campaign (www.dignityincare.org) aims to put dignity and respect at the heart of UK care services; it describes 10 dignity factors (values)

1. Have a zero tolerance of all forms of abuse
2. Support people with the same respect you would want for yourself or a member of your family
3. Treat each person as an individual by offering a personalised service
4. Enable people to maintain the maximum possible level of independence, choice and control
5. Listen and support people to express their needs and wants
6. Respect people's right to privacy
7. Ensure people feel able to complain without fear of retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self-esteem
10. Act to alleviate people's loneliness and isolation

The Social Care Institute for Excellence (SCIE) (www.scie.org.uk) works with dignityincare.org and yet in its own website has the following dignity factors

1. Choice and control: Enabling people to make choices about the way they live and the care they receive
2. Communication: Speaking to people respectfully and listening to what they have to say; ensuring clear dialogue between workers and services.
3. Eating and nutritional Care: Providing a choice of nutritious, appetising meals, that meets the needs and choices of individuals, and support with eating where needed
4. Practical assistance: Enabling people to maintain their independence by providing 'that little bit of help'.
5. Personal Hygiene: Enabling people to maintain their usual standards of personal hygiene.
6. Pain Management: Ensuring that people living with pain have the right help and medication to reduce suffering and improve their quality of life.

7. Privacy: Respecting people's personal space, privacy in personal care and confidentiality of personal information.
8. Social Inclusion: Supporting people to keep in contact with family and friends, and to participate in social activities

So we can see there are different thoughts among professionals about what values are but they are all very similar and certainly all with the same intent – respecting the rights of people as *individuals* to have choice over the services they receive and to receive them in a respectful and dignified manner.

In addition to the above, there are countless things we as individuals may value for ourselves – tolerance, honesty, family, wealth, fun, goodwill, justice, trust, humour, forgiveness, love and discipline to name but a few so knowing how to put person centred values into our day to day work means giving a lot of thought to getting the process right in order to assist people achieve their desired outcomes; we talk about person centred 'care' but to deliver it we must develop our understanding of person centred thinking, and person centred working.

3. Effective Communication

Good communication enables us to build strong relationships based on trust. It is essential that the people we support trust us as we work very closely with them and are privileged to sensitive, personal information. Good communication can make interpersonal relationships positive, supportive, clear, and empowering, the opposite of this, poor communication, can damage relationships and trust people can have in us, and it can affect our performance, our self-confidence and our physical health.
Relationships are fuelled by communication. If we don't communicate, how can we reach an understanding? People usually feel satisfied when they communicate well with individuals. Good communication enables people's needs to be met and for care and support workers to feel they are not just doing the job but doing it in a way that allows people to have choice and control over their lives

Our basic training helps us understand the reasons that people communicate and methods of communication, whether verbal or non-verbal, through technology, the written word or pictures and our experience tells us that we have to adapt communication skills for the people we support. To offer truly person centred care, we must establish a person's communication and language needs and their wishes and preferences at the outset.

When we first receive a referral, we carry out an assessment of the person's needs and identify the support they need and the way in which they would like that support delivered

Accepting a referral is the starting point of the assessment process; we must establish as much information as possible in order to understand the very basics - what if the person does not have English as a first language or if they are hearing impaired and use sign language? If we are able, we would send a member of staff to carry out the assessment

who can speak the same language, who can sign or we can arrange for them to have a translator, interpreter or advocate with them for example.

At the assessment we should use the tools available to gain a holistic impression of the person's support needs where we must understand their communication needs first and foremost to know how they communicate their choices and decisions. Agincare's Mental Capacity Act 2005 Policy and Best Interest Decision Making Procedure provides guidance on what to do to support a person to make decisions and what actions to take when they are unable to make their own decisions. Here we are considering holistic assessment and starting with identifying and understanding a person's communication needs. To communicate effectively we use sight and sound as well as speech but think also about the person's dexterity; if necessary, can they turn their own hearing aid on, insert the batteries, put their own glasses on and keep them clean? can they hold a pen, use a keyboard or a telephone; and think of their literacy, can they read; do they need us to get care documents translated into large print or easy read?

4. Understanding Outcomes

What is an outcome? According to the Social Care Institute for Excellence (SCIE 2007):

- Outcomes refer to the impacts or end results of services on a person's life.

Person-centred care is about providing care and support that is focussed on the individual and their needs, what is important to them and what will support them to achieve their outcomes.

To gain a clear understanding of an outcome we need to recognise the difference between processes, outputs and outcomes. These differences are significant and important; the end product of a process is an output; an outcome is the result that the output has on the person using the service; the following shows examples of the differences:

Process	**Output**	**Outcome**
Preparation of meals (from shopping to preparing to cooking)	The meal	Mrs Smith is satisfied with the meals and/or Mrs Smith receives the nutrition she needs to lead a healthy life/maintain her lifestyle choices and preferences
Management and arrangements of social activities	The activity (a tea dance for example)	Mrs Smith is able to continue with her hobby of dancing once a week
Personal care	The bath/shower/ wash/hair styling/nail care etc	Mrs Smith is happy that she is able to maintain her personal appearance
Medication management	Assistance/ Administration with the particular prescribed	Mrs Smith is able to maintain her health/receive pain relief etc

	medicine	

From this we can see that an outcome is a level of performance, or achievement. In other words how effective is the care service and is it achieving what the person using the service wants?

In person centred care planning, we must ensure the process is right in order to achieve the outcome, so taking the above example away from people who use services for a minute and applying it as a model to what we do in planning care, think of the following:

Process	**Output**	**Outcome**
Assessing and planning care	Person centred care plan with risks and risk management identified	Care that is safe and that people using our services want to receive

If the process is wrong, the output will be and desired outcomes will not be achieved; take for example the process of preparing meals for Mrs Smith; the meals may be too hot or cold, poorly presented or there is too much or not enough to eat or something is served which the person doesn't like to eat, so imagine Mrs Smith's outcome as follows:

Process	**Output**	**Outcome**
Poor preparation of meals	Small portions of cold meals	Mrs Smith is dissatisfied with her meal and/or is not eating enough and is losing weight

It is the process that we must address; for example in the process of preparing Mrs Smith's meals the problem with the process could be:

- We allocated/appointed a member of staff for a cooking task who could not cook (poor scheduling process)
- The member of staff was not fit for the job (poor recruitment process)
- Mrs Smith does not have sufficient supplies of food (poor process of assessment and care planning for her household/domestic support needs)
- Mrs Smith does not have a working oven (poor process of health and safety assessment of her premises and planning)

Outcome based care is about putting the person at the centre of the care service, and not prescribing a standard service to everyone. It is about delivering meaningful outcomes to every individual and helping people to lead more fulfilling lives through the *process* of efficient and robust planning. We will discuss the *process* again later when we look at care plan summaries.

Because outcomes are about performance levels, we need to specify clearly what the expectations of the person using the service are and the processes and outputs that will demonstrate how the outcomes will be achieved.

So we understand the *process* of helping people achieve their outcomes through effective, timely and valued outputs but we must also consider the outcomes themselves. We know that people value different things for themselves and we also know that people have different abilities and needs; we could go from supporting a younger adult to learn new skills to caring for a person who is approaching end of life. Outcomes will therefore be just as diverse so we must acknowledge the difference between change and maintenance outcomes.

The Social Policy Research Unit (SPRU) at the University of York defined the important distinction between outcomes:

- Change Outcomes: Outcomes which reflect the intention to achieve improvement in a person's mental or physical condition over time, to a point where services could be reduced or withdrawn. Change outcomes include improvements in physical symptoms and behaviour, improvements in physical functioning and mobility and improvements in morale.

- Maintenance Outcomes: Outcomes which reflect situations in which only slight improvement, stability or deterioration in the person's condition was expected and where continuing maintenance of an acceptable quality of life was the aim. Maintenance outcomes can include meeting basic physical needs, ensuring personal safety and security, having a clean and tidy home environment, keeping alert and active, having social contact and company, including opportunities to contribute as well as receive help and having control over daily routines.

- Process outcomes: Outcomes which reflect the ways that services are accessed and delivered, including feeling respected and treated as an individual; having a say and control over services; good value for money and compatibility with other sources of help; respect for religious and cultural preferences.

Process in this context is not different from the process we've already discussed in relation to output and outcomes; the two definitions are fundamentally the same. To achieve Mrs Smith's outcome of meals that are satisfactory for her likes, dislikes, dietary needs and preferences etc, we have a *process* of employing people who can cook and who are fit for the work etc; in doing so we are achieving the process outcome as defined by the SPRU because we provide a service that respects Mrs Smith (and others), gives her control over the service because she has been able to tell the service her likes and dislikes etc and the service is valuing her as an individual.

5. The Process

Agincare has systems in place which you use every day, to demonstrate that both the legal requirements of compliance, and the personal care and support needs of the individual, are being met; i.e. the assessments, planning, monitoring and reporting documents listed at the

end of this document and available on share-point and designed in accordance with published good practice guidance.

a) Assessment and planning care

Referral

Any person enquiring about the service needs to be assured that we have the right resources and skills in order to meet their needs so when a call is received we must obtain as much information as possible. As well as basic information and contact details, ask what it is that is required and if for instance a person calling a care home wants some help with shopping and light housework we would know that perhaps a Home Care service would be more appropriate and can direct them to our nearest Home Care agency; or if a person calling a Home Care office indicates the person's needs as high dependency dementia care we can ask the right questions about them managing in their own home and perhaps direct them to Agincare's Live in Care Service or one of Agincare's Care Homes if their need is greater than that which the branch office can support.

Obtaining as much information from the first point of contact will help to reassure the person that we are able to meet their needs (subject to assessment) and so go some way to meeting the first *process* outcome; we are giving them choice and control and are valuing them as an individual with an individual, diverse set of needs. Understanding the level of support they feel they need at this stage is also an important part of the process to help us determine the extent of further assessment that is required for example, when you receive a referral from a social service department for 2 hours per week for support with a weekly shopping trip and laundry, you know you will not need to complete a full range of assessments regarding their personal care or medication needs although of course you will still need to understand their mobility and physical health if you are to escort them to town each week.

It is important to establish at the point of referral the communication needs of the person and their capacity for understanding and for making decisions. If the referrer tells us that the person does not have the capacity to make decisions (they may use different terminology) or that they have a diagnosis of dementia, acquired brain injury or learning disability for example, ask the referrer who the decision maker is and ask that they be present at the assessment.

Following the initial referral, an appointment should be made for the assessor to meet with the person and their representative if appropriate. The assessor should have with them a range of assessment tools as detailed below.

Health and Welfare Assessment and care plan

The Health and Welfare assessment varies between Agincare UK Ltd, Agincare Homes Holdings and Agincare Live in Care Services but the premise is the same; the assessment covers a comprehensive range of health and social care needs and should be completed as fully as possible relative to the care and support being purchased prior to writing the care

plan and ideally prior to the start of the service (see also Agincare's Accepting a Care Package including Emergency Referral Policy and Procedure). The assessment will help you determine the person's self-care and functional abilities, their physical, psychological, social, mental health and spiritual and cultural needs. In completing the assessment you must consider the person's perception and experience to their change in lifestyle and consider how the accumulated losses (of their home for example, or of being part of the wider community, the change in living circumstances, their altered intimacy, the changes in their health and independence or their anticipated death) will impact on their care and support needs, on risks and on the outcomes they expect.

In Care Homes with Nursing, the assessment should be undertaken by a Registered Nurse in order that needs can be assessed clinically and the right course of treatment can be determined as well as personal and social care and support needs.

Some Agincare services are starting to use electronic versions of our forms and templates; if you are filling in a digital form, remember not to put your laptop as a barrier between you and the person, explain to them that you are collecting the information the same ways as you would with pen and paper and that they will get the opportunity to see the assessments and care plan when it is completed.

A section of the form is headed 'Pen Profile; this is the 'getting to know you' section of the assessment. Imagine how you would feel, particularly if you are vulnerable and anxious about your need for a care service and a person you have not met arrives at your home or hospital bed side and starts to question you about how you manage to get to the toilet, what you like to eat, what condition your skin is in and who does your shopping? This pen picture section has been introduced to the assessment form as a way of formalising what we do already; when arriving to carry out an assessment we introduce ourselves and have a chat first about who we are and what we are doing; use this opportunity to explain that when providing care or support we like to put the person at the heart of the service so it helps if we get to know a bit about them as a person rather than just their care and support needs. Ask them if they would tell you a little bit about themselves such as where they live, who they live with, their hobbies and interests. Use your judgement; some people will be happy to tell you things about themselves, others may value their privacy and not want to divulge too much.

You can complete the assessment form in any order but it is necessary to understand the person's needs in relation to communication and how they make decisions first. You should already have information from the referral about the person's mental capacity and if they are unable to make decisions or understand the assessment, their representative should be available to assist. If the representative is not available, or the assessment is being carried out in another care setting such as a hospital or care home you should be able to ask the staff for information from their own assessments and care plans. Other providers have the same responsibility as Agincare under the Health and Social Care Act (Regulated Activity) Regulations 12(2) regarding where care is shared or transferred between providers, those providers must work together to ensure timely and effective care planning and safety of the

individual. We still have a responsibility to carry out our own assessment and cannot always rely on the information provided however as a person's abilities and behaviours maybe very different in a hospital setting than they will be when the person is discharged home or to a Care Home. Remember, the assessment does not end when you leave the person; you can continue to gather information from other sources such as social services, CPN's, district nurses, family members as appropriate.
If you are relying on information from a third party representative, under the heading of mental capacity on the form you must indicate who provided the information and that a Mental Capacity Assessment will be undertaken if you do not have time to do so in part, there and then. (See Agincare's guidance on the Mental Capacity Act)

For Care Homes, the Health and Welfare assessment goes through a range of care and support needs with space for the assessor to comment, the second section of the form is headed 'Safe care and support' and whilst this guidance is about 'Person Centred Care', there are some instances where a person might move into a Care Home and very little information has been provided, particularly in urgent or emergency admissions. This section of the assessment is for essential information needed to keep the person safe whilst a person centred approach can be established over the first few weeks of admission as they get to know the resident.

In AUK Ltd and Agincare Live in Services Ltd the Health and Welfare Assessment and Care Plan are within one document; each section of the form is separated into 4 areas:

- Needs, Abilities and Outcome.
- Support Required.
- Risks.
- Other provider/professionals input.

The assessment looks at the practical support needed but also recognises a person's ability to self-care or where there is no specific need; you can write in these instances that this is not required as part of the support package and move to the next section.

Communication needs, abilities and outcome: (hearing aids, written/pictorial, verbal, non-verbal, translation needs etc.	*This first section in each area is the assessment. If a person communicates well and is able to state their choices/decisions regarding care or if a person uses hearing aids but is able to manage these themselves write it here; this indicates their **abilities.** If a person requires assistance with their hearing aids, or with specific communication methods identify it here; this indicates their assessed **needs.*** *The **outcome** should be expressed as the result of these i.e.: Mr x wishes to/it is in Mr Xs best interests to enhance/improve/maintain his abilities to make informed choices and be involved in his care through effective communication. These **needs, abilities and outcomes** can be written in any order so the outcome can be expressed first – Mr x would like to be able to…., to do this he needs….and is able to manage……. himself.*
Support required	*This is the plan (the output) and should provide detail as to how we are going to support the person to meet their needs, respect their abilities and so*

	achieve their outcome.
Risks	*This should relate to any risks noted and should cross reference to the person's needs, abilities, outcome and how we will be supporting them. In relation to communication the risks might be that Mr X would be a risk of not having his choices respected; or not being empowered to make decisions because we support his need to manage his own hearing aid but are aware (from other areas of the assessment) that his cognitive impairment often results in him not doing so – how do we mitigate this risk? – we plan to do so by indicating in the 'support required' section how we are going to support Mr x to manage his independence in this respect*
Other provider/professional input	*This could be an audiologist, a speech and language therapist, it could relate to assistive technology or supporting pets (guide dogs etc.)*

There will be sections of the form that you may have to re-visit for example, where there is an indication of risk for instance with a person's nutrition where their family carer or hospital staff are telling you that they have lost a significant amount of weight you might write for example the person's abilities as being able to eat independently, their needs are to have meals prepared for them and their outcome is not expressed as they do not have the capacity to understand the implications of the care and support being offered but a good outcome would be for them to gain weight/maintain current weight etc.. You may write here in the 'support required' box that a care worker will visit, three times a day to prepare meals and you may identify the risk as told to you. Before finalising the care plan you must assess the extent of the risk using the MUST tool; in the risk box you can then write for example that Mr x has a MUST score of 2 meaning he is at high risk of poor nutrition and further weight loss; in the 'support required box' you can identify the need for a fortified diet, or food supplements for example to direct the care staff to provide the proper support needed to reduce the risk. A list of additional risk assessment tools with a brief description is given later in this guidance.

Continue through the form ensuring sufficient detail in the sections required; the extent of the information you include will often depend on the extent of the care being purchased; in Care Homes or Live in Care services for instance where 24 hour care is required 7 days a week, a complete, holistic assessment should be completed remembering of course that the person will have some independence and abilities to maintain and direct their own care so support may not be required in some areas; the care and support plan can be developed over the first days whilst getting to know the person.; In Home Care; support may be requested from anything from 1 hour a week to several hours a day and the assessment should reflect the level of support whilst not being intrusive into aspects of a person's life where they do not require our support. Where a local authority is purchasing care for a limited time, whether 4 half hour visits per day, or one hour a week, it is possible for an assessment to identify needs over and above that which time allows for example, a person may be assessed as at risk of poor nutrition but the local authority is asking you to provide 30 minutes of care each morning (process); the (output) plan might be to provide personal care and breakfast for instance; this alone will not mitigate the risk of poor nutrition and

hydration. So what else should our output include? As a result of our assessment (process), our plan (output) should also include how we are going to refer the person on, to either their GP for a dietician/nutritional assessment, back to social services for more time and consideration of provision of a community meals service etc; in such instances we are not in control of the outcome for the individual but can demonstrate that our process and output was aimed at achieving the right outcome for the person.

Where a person is funding their own care; our assessment should determine the extent of the care and support required. So for example, a family carer calls and asks for help with their relative; they give you information about the person over the telephone and may feel they just need someone to 'pop in' and keep an eye on them, or ensure they take their medication for example; they may say the person needs help in and out of the bath etc. When you arrive for the pre-arranged assessment however, you find the person needs more (or less) than was first requested. Remember what we discussed above about valuing people, respecting their rights and about good communication? We must use our communication skills with the person or their relative to ensure they understand the extent of the assessment, provide them with sufficient information about your findings from the assessment so they are empowered to make the right choice about their care and support needs decisions. Has the assessment shown for example that they would benefit from more than a 'pop in' visit, or that in getting them in/out of the bath they will also require support with daily personal care, with their mobility, with their household and domestic chores?

Once you have identified what the person wants from the service (their outcomes), what their specific needs are and what their abilities are, you can plan care and support required with them; be creative - where an individual's physical health stops them participating in something they have always enjoyed such as attending church, gardening or playing golf; think of ways you can enable this person to still enjoy a degree of this activity. For example you could use subject specific magazines, TV or radio programmes, and coach outings to public gardens or home visits from members of the church or ministers. The care plan should detail opportunities for recreation and activity (certainly in Care Homes and Live in Care Services and, to a lesser extent in Home Care where there are time constraints) Because an individual has become reliant on services for care and support does not exclude them from wanting to lead as full and active a lifestyle as possible. The people you are caring for should be valued as active members of the community who are able to contribute as well as be supported and should be able to access a wide range of life opportunities and services such as leisure, transport, housing, employment, education, social activities, and health promotion. Services should be available to support individuals when they or their families need them and specialist help should be arranged within the community promoting independence and a return to active life as far as practically possible. The care plan should reflect these opportunities and the processes we will undertake in order to help the person achieve their outcomes within the boundaries of the care and support that is being purchased; where a person has expressed during assessment that they would benefit from a more socially inclusive lifestyle, see what you can help them arrange as part of your planning or, if they are only receiving limited half hour visits, you can plan to refer them to other agents such as for a social services review, or to the voluntary sector.

Whether on a combined format or separate to the assessment, the care plan is exactly that, it is a plan, not just of the way in which day to day care routines will be carried out but a plan of how we, as a service, plan to meet a person's needs over a period of time. Timeframes can vary just as much as people do but you should be planning care for a minimum of two weeks to a maximum of one year. The shorter timescale would be used when planning for a person who:

- is receiving short term respite care
- has not been fully assessed prior to the start of the service (emergency placement)

Increased timescales, 4, 6 or 8 weeks for example would be planned for dependent upon

- contractual requirement (short term enablement or requirement for monthly review)
- end of life prognosis

The maximum length of time care would be planned for is one year after which a review must be carried out (where there is no contractual requirement for more frequent review)

Care must also be reviewed as and when people's needs change.

The length of time care is planned for will influence the way in which the care plan is written; the day to day care and support processes are addressed in the summary for care workers but what about the processes for the less frequent activity?

If a person is receiving support for a short, 2 week period we need not think about how they will get to their next opticians appointment which is six months away or we need not think about their medicines review with their GP next month or the Stepping Stones Club Christmas party they are looking forward to. When a person is receiving care over longer periods, we must plan for the support they require in relation to their long terms needs; do we need to arrange additional staff for escort duties, should the member of staff be a car driver or do we need to book a wheelchair taxi, when would they like to go shopping for the Christmas party outfit and how are their finances arranged for such purchases? Although we might not have the exact details of anticipated future events, we must be aware of the need to plan and for the plan to be flexible.

The personal choices that people make are critical in enabling their engagement in the care process and knowing that it is planned in their best interests with them so they don't miss important engagements and appointments; in making their own choices, the individual is regarded as an active partner in their own care or support, rather than as a passive recipient. Although choice is important, it has to be recognised that not all individuals make informed choices to assist the care process or about their well-being and the Care Worker has a responsibility to facilitate the individual's empowerment by providing sufficient, well communicated information through a well-planned care approach, sometimes by involving the Mental Capacity Act best interest decision process.

When you have completed the assessment (and other assessments if able to do so at the time) be sure to confirm your assessment findings with the person and agree with them the plan of action. This will include informing them that based on the information you have you believe the service can, or cannot meet their needs; let them know you will confirm this with your manager. In AUK your completed document detailing the assessed need and planned care can then be consented to; the person or their representative can sign to indicate that they agree with the planned care. In AHH and LICS, the person must be informed that the plan will be written which will be provided to them in order they can agree to it and consent to the care and support proposed

In AHH where separate care planning documents are in use the same principles apply; the care plans are separated into a page for each aspect of a person's wellbeing so there is a single page for personal care, a single page for recreational and social care, a single page for moving and handling etc. each page however follows the same format as already identified with 4 sections used to identify the person's needs, abilities and outcomes, the support required, risks and any other provider/professional input.

Electronic recording systems are being introduced throughout care homes and home care services, where these systems have been developed internally the format and requirements to input information are planned in line with Agincare's agreed ways of working and other documentation; where an external provider is used (as Nourish in care homes), the design of the required inputs are different with formats following different headings and set ups; this is particularly so with care plans in care homes. However whatever system is in place, the principles of person centred care remain the same

Whether in AUK, AHH or LICS the result should be that each person receiving the service has a completed, person centred care and support plan which is based on the assessment of their needs and abilities. Each service documentation is made up of the same materials, simply in different formats. All formats allow for the same information which includes:

- Assessed need, including needs to mitigate risks
- Pen profile
- Planned care to meet support needs
- A care summary
- A mental capacity assessment and record of best interest decision (if required)
- Consent to care and support

b) Risk and Risk Management

Risks that are identified will inform the way in which we work with people. Risk assessment is about making decisions which are logical, realistic and legal. Levels of risk can frequently change depending on circumstances that alter often over brief periods of time, therefore risk assessment and management will be subject to frequent review.

If we were new to health and social care we might look up the term risk assessment and find it is a subject usually discussed under health and safety laws and regulations, the definition generally being that a risk assessment is simply a careful examination of what, in

your work, could cause harm to people, and health and safety is generally defined as that which encompasses regulations and procedures intended to prevent accident or injury in workplaces or public environments and the avoidance and prevention of disease. Agincare provides staff with Health and Safety Training in which subjects such as fire safety, food hygiene and COSHH for example are covered along with the general principles of risk assessment.

In a person centred approach to care however, the process of assessment from the start is not just an assessment of a person's needs, or abilities, it is an assessment of the risks of those needs not being met or those abilities not being supported so in this context, health and safety and risk assessment are terms that cover the whole process. Go back to the start of this guidance when we talked about process, output and outcomes and think of Mrs Smith and her small portion of cold food. The process of a poor assessment and subsequently poor outputs (care planning) that did not value Mrs Smith and her needs lead to the risk of malnutrition and dehydration, which in turn can lead to risk of poor skin condition, of constipation and increased risk of infection etc

Had we had a person centred approach and put Mrs Smith at the centre of her care, we would have ensured that staff with the right skill to meet her individual needs were in control of the process and were assessing and reducing the risks to her health and safety.

The following are more examples show how risk can be managed:

- Mrs White has a MUST score of 3 putting her at high risk of malnutrition so receives a level 2 fortified diet and is prescribed Fortisip to be taken twice daily; all meals are to be prepared using cream, full fat milk, cheese etc... The rationale is the risk; the process is the preparation of a level 2 fortified diet. Remember to keep it person centred as well so for instance explain that Mrs White prefers..... (the outcome being that she gets the diet of her choice with respect for her tastes and preferences and gains weight)

- Mr Green becomes anxious and can become hostile in spaces involving close proximity; when taking him to the DET scheme on Wednesday always park on the ground floor of the car park to avoid having to use the lift. Anxiety and hostility is the rationale for the process of avoiding enclosed spaces (the risk) achieving the outcome of getting Mr Green to the employment training scheme safely and in good humour.

Agincare has a range of assessment tools to assess the risks to people's health and safety and subsequently their welfare; these are listed at appendix 1 with a brief explanation of how they are to be used.

Some of the assessments require strict measurement criteria for example, the MUST tool asks us to score against a set of criteria to establish a person's BMI and subsequent MUST score, this score once established is not negotiable. A person centred approach to this methodology would help us plan care so for instance where a person has a MUST score of 1, or 2, we must plan care around assisting them or encouraging them to gain weight. Now, think of the person who has always maintained a natural height weight ratio which gives them a MUST score of 1 or 2, they eat well and have no health problems; a person centred

approach would recognise this and would not identify it as a risk unless the person had lost weight or had other associated risk factors.

The management of risks should be included in the care plans for the people you are supporting. Using risk assessment processes effectively will enable the individual's you support to make informed decisions and choices for example they may want to bath alone or go out unaided, you have to be involved in the decision making process and explain the purpose of a risk assessment; if any risk is identified actions need to be indicated by which to lessen that risk but it must be remembered that in having all the required information, the person is at liberty to make choices, even if these choices to you seem unwise.

We also encourage positive risk taking so for instance where a person has full mental capacity to understand the consequences of decisions they might make and the associated risks, we can plan care around supporting them to do so. If for example a person is at risk of falls but understands that they may hurt themselves and understands how to summon assistance, we cannot plan care around confining them to bed, or a chair; or if someone has the capacity to understand the risks of drinking alcohol or smoking when they have a diagnosed condition that shows it could shorten their life, we cannot plan care to prohibit them; but we can plan it around assisting them to cut down or give up if they wish to.

Whichever risk assessments are used, the outcome of the assessment and action plan *must* be transferred to the care plan in order to inform staff of the action needed (the process) to control the risk so for example if a person is at high risk of pressure ulcers (Braden Scale), the care plan must indicate the process and actions in place to reduce pressure such as frequency of re-positioning, effective continence care, hydration, application of creams, use of pressure relieving equipment including mattress settings etc

c) **Summary**

A summary of care and support should be written to aid care staff in delivery of care; the summary is an abstract of the care as planned and is a guide to instruct care workers on the way and order in which things are to be done, it is not a replacement for planned care. The purpose of the summary is to provide an 'at a glance' overview of care and support needs but it must be made clear to the care worker that they must be familiar with the whole care plan and that the summary is a quick reference guide to the *processes* they need to follow in order to achieve the person's outcomes.

Although the summary is often a list of tasks, these tasks represent the *processes* that are essential to meet the person's outcomes. Remember Mrs Smith and her small portion cold meal? If the tasks had been carried out efficiently, the meal would have been satisfactory.

Look back to the section on Process, Output and Outcomes and consider the following for Mrs Smith

Process	**Output**	**Outcome**
Personal care	The bath/shower/ wash/hair styling/nail care	Mrs Smith is happy that she is able to keep up her personal

	etc	appearance

As an example this is very basic; the care plan must detail the process and the summary must ensure the essential parts of that process are outlined for care workers; it must detail what needs to be done and what Mrs Smith can do for herself in order for her outcome to be met.

Example in Home Care:

Summary
Always: • *Call out to greet Mrs Smith on entering her home; Mrs Smith is losing her sight and gets jumpy if people creep up on her without announcing themselves.* • *Mrs Smith walks with her tripod and care worker support on her right side* • *Always leave work area/Mrs Smith's home clean and tidy (kitchen, bathroom), empty bins into outside bin; ensure wheelie bin is out by the gate on Tuesday when the collection service comes* ***8.00- 8.30am Daily except Thursday:*** • *Escort Mrs Smith to the bathroom; leave Mrs Smith with her warm towel and toiletries on her perching stool, she is able to wash and dress herself* • *Make bed, clear night drink and empty commode.* • *Go to the kitchen, put the kettle on and prepare the breakfast tray* • *Return to the bathroom and help Mrs Smith fasten her buttons.* • *Escort Mrs Smith to the kitchen* • *Mrs Smith manages her own medicines; care worker to get eye drops out of the fridge and hand them to her* ***8.00 -8.30am Thursday*** • *Mrs Smith likes a shower and hair wash on Thursday before attending the day centre.* • *Escort Mrs Smith to the bathroom, she will sit on her perching stool by the shower to take off her night clothes and slippers.* • *Assist Mrs Smith into the shower chair, she will use the grab rails for support, steady Mrs Smith on her right side supporting her by her elbow. Mrs Smith will turn the shower on and wash herself.* • *Go to the kitchen to put the kettle on and lay the breakfast tray.* • *Return to the shower and ask Mrs Smith is she is ready to have her hair washed, shampoo and rinse hair taking the shower attachment from the wall to direct the spray.* • *Place a warm towel around Mrs Smith's shoulders. Ensure all residue soap products are rinsed from base of shower to prevent slipping before drying Mrs Smith's feet and lower legs and putting her slippers on.* • *Mrs Smith will stand using the grab rails, dry bottom, back and legs thoroughly. Mrs Smith likes moisturising cream to her arms and lower legs; this is not prescribed, ask if she would like assistance.* • *Assist Mrs Smith to her perching stool in the bathroom and towel dry her hair; leave her to dress whilst going to make the bed and empty the commode*

The summary will continue with the remainder of the tasks (process) for the day, including the evening visit

In Home Care the summary has to describe the process for brief visits over several visits a day or week, in a Care Home the summary is different as it should include all essential processes rather than a routine schedule

Example in a Care Home:

Care Home summaries are a lot longer, they have to cover a 24 hour period; the summaries should be held in the residents room with any other file information required such as cream charts; food and fluid charts etc. if a resident does not require other charts, the summary should still be available to care staff on a daily basis

Task	**Process**
Personal Care	• *At around 05.15 Care workers are to check to see if Mrs Jones is awake as she is an early riser and if so, encourage her to use the en-suite toilet.* • *Change Mrs Jones' pads/underwear if required and wash her bottom half drying thoroughly and applying Sorbiderm.* • *Hand Mrs Jones her dressing gown and her slippers, and remind her to turn her calendar for the day* • *If Mrs Jones bedding is wet, strip the bed and place in a bag, take the laundry to the laundry skip whilst escorting Mrs Jones downstairs, she likes a cup of tea first thing* • *At around 5.45am escort Mrs Jones back to her room to get washed and dressed; in her en-suite,* • *Mrs Jones 'will wash her hands and face.* • *Discreetly check Mrs Jones fingernails and offer her a manicure if they appear dirty (Do not tell Mrs Jones that her nails are dirty as this upsets her). Offering Mrs Jones an appointment for her manicure makes her feel pampered, arrange a time (before breakfast) to take her to the bathroom and soak and clean her nails.* • *Put toothpaste on her brush, Mrs Jones will then brush her own teeth.* • *Help her select the clothes she wants to wear and leave her to dress, assist her with her buttons and shoes as required;* • *Mrs Jones will brush her hair if reminded and handed the hairbrush*
Mobility and Dexterity	• *Mrs Jones is independently mobile but at risk of falls* • *Ensure her slippers are on securely and when wearing her shoes that they are strapped.* • *At night Mrs Jones has an alarm mat beside her bed to alert staff to her movement* • *Mrs Jones likes a bath twice weekly and needs assistance to get in and out using the bath seat; one care staff is to assist and operate*

	seat
Continence	• *Encourage use of toilet every 2-3 hours; Mrs Jones needs reminding where the toilet is* • *Ensure good personal hygiene following continence care; encourage and support Mrs Jones to wash her hands* • *Mrs Jones uses slip pads and is provided with three each day and one at night. She has a private supply in her wardrobe (purchased monthly) should she need additional pads throughout a 24 hour period*
Tissue viability	• *Mrs Jones to receive effective skin care at each continence care intervention. If she is wet, ensure good perineal hygiene and that skin is thoroughly dry.*
Diet	• *Eats independently using normal cutlery and crockery and must be given a cup and saucer if drinks are provided in a mug, she can very likely throw them at someone shouting that she is not a 'Navvy'* • *Mrs Jones has a small appetite* • *Mrs Jones likes to sit at the corner table between the window and the door and next to Mrs White; she claims this seat as hers. Ask Mrs Jones what she would like for breakfast and arrange to bring it; Mrs Jones makes her choice from the menu for lunch and supper each day but often forgets what she has ordered, staff are to inform her of the dish she has chosen when serving it* • *Weigh Mrs Jones on the 24th of each month*
Medication	• *All to be taken orally; hand Mrs Jones her medicines one at a time, she will swallow with water.* • *Mrs Jones's Allopurinol is best taken after food; leave half an hour after she has finished her meal before giving her medicines*
Social/recreational	• *Mrs Jones is usually happy to potter between her room and the upstairs lounge for a while; she is unable to use the call system so be vigilant knowing her whereabouts and activities; she is at risk of upsetting other residents as she sometimes goes in to their rooms for a 'chat' not realising it is still early morning* • *Mrs Jones sometimes likes to work and will busy herself sorting through the papers and filing them in the box which is kept in the sideboard; care workers are to ask her if she needs the typewriter and provide her with paper* • *Mrs Jones is firm friends with Mrs White; care workers are to ensure they are seated together at meals; they like to sit and chat in the afternoons*
Other	• *Mrs Jones has capacity to make limited choices, discuss the plan for the day with her, her likes, dislikes etc. is it a day her sister is visiting?, tell her about the cat and where he's been all night, inform her of any planned activities in the home and tell her whether Mrs White is up at breakfast yet and waiting to see her* *Other headings and information can be added to the summary*

	depending on the person's needs and outcomes

Availability of care workers who are able to deliver care to meet a person's needs falls within the recruitment, staff training and support functions of the Manager. The Manager must however ensure that where a person has specific or complex needs identified at assessment, that the staff have the skills and knowledge to provide the care that is planned

Care workers must familiarise themselves with the person's needs and abilities and read the care plan before providing support for the person for the first time; once familiar with the person and the planned care, the summary can be used as an aide memoir to refer to on a day to day basis. Regular care workers who get to know a person may not have to read the summary at each visit but must always read the recent entries in the Care Delivery Record to establish whether there have been any changes, incidents or significant events since their last visit.

Care workers are trained to deliver care as planned and any deviation from this could have implications for safety and safeguarding, health and safety and for the contractual and regulatory compliance of the service when care plans are not followed. However, if during care, a person receiving care makes a request for something that is not planned, care workers must be flexible and use their judgement with regard to the request with an understanding of professional boundaries and what they are trained and not trained to do. Flexibility within general day to day living tasks must be included as a normal, part of care delivery enabling the person to have choice and control and in some instances, flexibility and choice will dictate the level of support required from the care worker for example where a person is receiving support for a short period of time for enablement and the care worker arrives to find they have already, independently carried out the required tasks.

All care as delivered, must be recorded. Use the daily Care Delivery Record* and ensure all the care provided and interaction you had with the person and significant others such as family, district nurses, GP's or social workers is written down. This record is important not only as evidence that care has been delivered as planned but will assist the evaluation and review of the care needs and outcomes. Where the care plan specifies, any monitoring charts in place must also be completed alongside the care delivery record.
*For uses of Nourish, care delivery records are replaced with an electronic timeline. The 'interactions' (services) identified on the care plan will automatically feed the timeline over a 24 hour period, care staff simply have to check off 'tasks' as they are carried out; care staff should also however write daily notes on the timeline in the spaces provided. (NB: Nourishg supports voice activation where care workers can dictate their notes to be kept on record)

d) Evaluation and Review

See also section above regards review time-frames.

Evaluation and review isn't simply something that happens on a pre-determined date, it is an on-going, continuous process. Many of the things that a person needs or which make a

person 'tick', will be included in the care plan following assessment but it is important to try and find out as much as possible on an on-going basis (without being intrusive). Assessments can sometimes be wrong so care plans can always be updated and reviewed as required so for example if you find out something about a person that would improve the quality of their life by respecting their wishes and preferences, make a note of it so other care workers know and the care plan can be update accordingly.

Some individuals will see an improvement in their independence and their ability to care more for themselves, others will not and their needs may increase with continued ageing, frailty or ill health. Whether an improvement or a decline, all changes must be recorded in the care delivery records, a re-assessment undertaken and the care plan re-written to reflect the current needs of the individual.

By ensuring that all changes to health and welfare are recorded and that care plans reflect actual, current level of need we can be more certain of providing care in a person centred way.

An evaluation of a care plan would occur when you have systems in place to do so; Care homes for example evaluate the care plan every one, or two months (depending on the contractual requirement). The process involves a review of the care delivery records, any incidents, accidents or significant events and will evaluate the effectiveness of the planned care. Where minor changes to the care plan are required as a result of this evaluation; the changes are made.

A review of a care plan is similar to the evaluation but will involve, where required, re-assessment. At least annually, a re-assessment should be carried out using the relevant assessment forms; in AUK, the front page of the combined health and welfare form and care plan has space to indicate the reviewed date and the sections that have been reviewed should be indicated throughout the document.

Contractual impact

Agincare's policies and procedures are to be followed in conjunction with the requirements of the contracts under which you provide services. There may be occasions where the contract contains requirements which appear to contradict or be in addition to, standard Company policy. In these instances you are to:

- If the requirement is in addition to standard Company policy - adhere to the terms and conditions of your contracts
- If the requirement is lesser than standard Company Policy - follow Company policies and procedures

If you require any further clarification please contact the Commercial Department for guidance

Training

The management team of Agincare believe that, in order to provide a quality service, Agincare requires high quality staff who are suitably trained, supervised and supported.

Agincare policies, procedures and guidance are referenced in the induction programme and are available for staff in their work place (Care Home or Branch office). Staff will be informed of how to access all policies, procedures and related documentation and of how to seek further advice regarding Agincare's agreed ways of working. Staff should be provided with regular updates to encourage continuous improvement and include latest good practice.

REVIEW OF THIS GUIDANCE

Review of this document is recorded on the controlled index and reviewed annually as part of the management review systems.

Policy Review Group

Date: January 2019

Appendix 1

The following provides an A to Z of assessments to support the care planning process and risk management process appropriately and in a person centred way.

A guide to completing forms is available on share-point in the file forms and letters/service users/sample forms.

Assessments	**Purpose**
Bed Rails Risk Assessment	To be used for anyone who has bed rails fitted; if the person is unable to consent to the use of bed rails, a mental capacity assessment and best interest decision must also be recorded.
Behaviours that Challenge Risk Assessment	To be used for a person whose behaviour is taxing or demanding and where we have to put certain strategies in place to manage such behaviour, usually used after 7 to 10 days monitoring behaviour using an ABC chart
Body map and wound assessment	To describe any wounds or marks to a person's body and to review/assess after three days to evidence healing or further action required
Braden Scale (See also Waterlow)	An assessment for use with any person at risk of tissue damage or developing pressure ulcers.
Dementia Care Agitation Scale	To be completed after 2 weeks monitoring using ABC chart to identify risk factors and necessity for referral to mental health professionals
End of Life Care: Helping you make Decisions (AHH)	A letter to be issued to any person and/or their family carer to help them consider their future and to open discussions for those who have not already made plans;
Epilepsy Activity Assessment	For use only where a cared for person with epilepsy wants to undertake a specific activity that is not part of their usual routine
Falls Assessment (AHH)	Based on FRASE, a clinically based tool for assessing people at risk of falls if they meet the criteria in the first section of the form
Falls Assessment (AUK/LICS)	A falls assessment designed for use in Home Care for a person considered at risk when they meet the criteria on the first part of the form concerning their circumstances.
General Risk Assessment	A format to be used to assess any risk there is not a specific format for; in AUK/LICS for example, to be used where the Health and Safety Checklist identifies concerns that have to be managed
Health and Safety Checklist and Safe Working Methods Guide	To identify any concerns with the person's environment in Home Care (AUK/LICS). As well as addressing environmental health and safety issues such as fire precautions and use of electrical equipment for example, this should also identify factors relating to the safety of staff who are lone workers. Any concerns identified should be addressed on the General Risk Assessment form. The end of the form had a guide to safe working practices in relation to Fire and COSHH; where any of the Risks or Hazards are identified, the safe working methods must be transferred to the care plan..

Health and Welfare Assessment (and Care plan combined)	The Health and Welfare form is the starting point for all client assessments; the format is different in AHH and in AUK/LICS. This document provides detail on the completion
MUST (Malnutrition Universal Screening Tool)	To be used to measure, record and monitor a person's BMI and weight loss/gain if at risk of malnutrition. Depending on the risk score, this is to be completed weekly, 2 weekly, or monthly; care workers in Home Care should be aware of how to calculate a person's MUST score and how to record it as well as reporting actions if the risk factor has increased/decreased. If a person is identified as at risk, a nutritional plan must be recorded in the care plan (See nutrition and hydration policy and fortified diets)
Medication Risk Assessment	To assess the risk of unsafe medication management in order to identify the actions required by staff to reduce risk
Mental Capacity Assessment (MCA) and Best Interest Decision Record	To be completed for any person who is unable to make a decision about something you believe to be in their best interests. The MCA must be decision specific and one for each decision to be made
Moving and Handling Assessment	To assess mobility and any support/aids required; this is not an OT assessment
Nutritional Assessment and Preferences	To identify a person's nutritional needs and preferences; to be used in all Care homes and in home care where staff are responsible for meal preparation and assistance with eating and drinking
Pain Assessment for people with cognitive impairment	To identify the degree of pain experienced by a person who does not have the capacity to articulate their pain and request pain relief. This is to be held alongside any MAR chart where the care plan directs the use of PRN pain relief (see prn plan below)
Personal Emergency Evacuation Plan (PEEP) AHH	To be used in care homes to identify what support a resident will need to evacuate the building in the event of an emergency; PEEPS are to be available to fire and rescue services if they are called
PRN As Required Medication Plan	Where staff are involved in managing a person's prescribed medication this form is to be used to identify for staff how, when and why it is to be taken. The form details the maximum length of time it can be taken, the minimum time between doses, the maximum doses in 24 hours, what it should be given for and how the person expresses a need for it – this could be verbally but for a person who lacks capacity, the PAINAD chart identified above should be used for PRN pain relief and the care plan (medication section) should identify how to recognises the need for other PRN medication such as laxatives for example. The outcome of use of any PRN medication should be monitored e.g., recording in care delivery records whether pain relief was effective in reducing pain, have prn laxatives had the desired effects etc. where these outcomes are not satisfactory, the person should be referred back to their GP for review.

Temporary Emergency or Respite Care Plan AHH	This can be used instead of the health and welfare assessment and care plan formats in care homes where a person moves to the home prior to the opportunity to assess (Carer breakdown/crisis etc) in order to provide a baseline of information for staff to meet the person's needs; a full assessment should begin once it is known a person is to become a permanent resident but no later than within 2 weeks
Urinary Continence assessment	Although used by AHH Care homes with Nursing this is not a form we generally need to do as a person with incontinence will have either been referred for assessment to the continence advisory service or have been already assessed. However if a person is occasionally incontinent and you request a referral, this form can be used to back up your referral as evidence of the current position.
Waterlow	An assessment for use with any person at risk of tissue damage or developing pressure ulcers. This Tissue viability assessment is used more routinely in care homes with nursing

On completion of all assessments; any identified risks action plans must be transferred and identified in the person centred care and support plan with controls in place to reduce and manage the risks (the process).