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|  **Review Sheet** |
| Last Reviewed Last Amended Next Planned Review in 12 months, or20 Sep '23 20 Sep '23 sooner as required. |
| Business impact | Changes are important, but urgent implementation is not required, incorporate into your existing workflow.**MEDIUM IMPACT** |
| Reason for this review | Scheduled review |
| Were changes made? | Yes |
| Summary: | This policy details how care plans are produced with service users as part of the support provided within the organisation. It has been reviewed with the addition of section 5.7 Supporting Adults with Learning Disabilities. Underpinning Knowledge and Further Reading links have also been reviewed and updated to ensure they remain current. |
| Relevant legislation: | * The Care Act 2014
* Care Quality Commission (Registration) Regulations 2009
* Equality Act 2010
* Freedom of Information Act 2000
* The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
* Mental Capacity Act 2005
* Nursing and Midwifery Council (NMC) Legislation
* Data Protection Act 2018
* UK GDPR
 |
| Underpinning knowledge - What have we used to ensure that the policy is current: | * Author: NICE, (2019), *People's experience using adult social care services*. [Online] Available from: [https://www.nice.org.uk/guidance/qs182/chapter/Quality-statement-1- Care-and-support-needs-assessment](https://www.nice.org.uk/guidance/qs182/chapter/Quality-statement-1-Care-and-support-needs-assessment) [Accessed: 20/9/2023]
* Author: NICE, (2018), *Decision-making and mental capacity - Guidelines NG108*. [Online] Available from: <https://www.nice.org.uk/guidance/ng108>[Accessed: 20/9/2023]
* Author: National Institute for Health and Clinical Excellence, (2018), *People's experience in adult social care services: improving the experience of care and support for people using adult social care services*. [Online] Available from: <https://www.nice.org.uk/guidance/ng86>[Accessed: 20/9/2023]
* Author: Social Care Institute for Excellence, (2017), *Mental Capacity Act (MCA) and care planning SCIE Report 70*. [Online] Available from: <https://www.scie.org.uk/mca/practice/care-planning>[Accessed: 20/9/2023]
* Author: Care Quality Commission, (2022), *Regulations for service providers and managers: related legislation*. [Online] Available from: [https://www.cqc.org.uk/guidance- providers/regulations-enforcement/regulations-service-providers-managers-related](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers-related) [Accessed: 20/9/2023]
* Author: [www.legislation.gov.uk,](http://www.legislation.gov.uk/) (2020), *Mental Capacity Act Code of Practice*. [Online] Available from: [https://www.gov.uk/government/publications/mental-capacity-act-code- of-practice](https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice) [Accessed: 20/9/2023]
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| Suggested action: | * Encourage sharing the policy through the use of the QCS App
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| Equality Impact Assessment: | QCS have undertaken an equality analysis during the review of this policy. This statement is a written record that demonstrates that we have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law. |

**1. Purpose**

* 1. To promote a culture of personalisation and person-centred care which supports the values of Corton House in meeting the needs, outcomes and aspirations of Residents.
	2. This policy dovetails with other relevant policies and procedures which should be referred to for further guidance and information:
		+ Pre-Admission and Admission Policy and Procedure
		+ QCS Care Planning and Assessment Guidelines
		+ Care Plan Contents List
		+ Timeline for Assessment, Care Planning and Review
		+ Risk Assessment Policy and Procedure
	3. To support Corton House in meeting the following Key Lines of Enquiry/Quality Statements (New):

# Key Question Key Lines of Enquiry Quality Statements

**(New)**

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| --- | --- | --- |
| CARING | C2: How does the service support people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible? | QSC2: Treating people as individuals |
| EFFECTIVE | E1: Are people’s needs and choices assessed and care, treatment and support delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes? | QSE1: Assessing needsQSE2: Delivering evidence-based care & treatment |
| EFFECTIVE | E2: How does the service make sure that staff have the skills, knowledge and experience to deliver effective care and support? | QSE2: Delivering evidence-based care & treatmentQSE3: How staff, teams & services work together |
| EFFECTIVE | E4: How well do staff, teams and services within and across organisations work together to deliver effective care, support and treatment? | QSE3: How staff, teams & services work together |
| EFFECTIVE | E7: Is consent to care and treatment always sought in line with legislation and guidance? | QSE6: Consent to care and treatment |
| RESPONSIVE | R1: How do people receive personalised care that is responsive to their needs? | QSR1: Person- centred care |
| SAFE | S2: How are risks to people assessed and their safety monitored and managed so they are supported to stay safe and their freedom is respected? | QSS4: Involving people to manage risksQSS5: Safe environments |
| RESPONSIVE | No equivalent KLOE | QSR2: Care provision, integration, and continuity |

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| --- | --- | --- |
| RESPONSIVE | No equivalent KLOE | QSR5: Equity inaccess |
| RESPONSIVE | No equivalent KLOE | QSR6: Equity in experiences and outcomes |
| SAFE | No equivalent KLOE | QSS2: Safe systems, pathways and transitions |

* 1. To meet the legal requirements of the regulated activities that {Corton House} is registered to provide:
* The Care Act 2014
* Care Quality Commission (Registration) Regulations 2009
* Equality Act 2010
* Freedom of Information Act 2000
* The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
* Mental Capacity Act 2005
* Nursing and Midwifery Council (NMC) Legislation
* Data Protection Act 2018
* UK GDPR

**2. Scope**

* 1. The following roles may be affected by this policy:
* Registered Manager
* Nurse
* Care staff
* Kitchen
* Activities
* Manager
	1. The following Residents may be affected by this policy:
* Residents
	1. The following stakeholders may be affected by this policy:
* Family
* Advocates
* Representatives
* Commissioners
* External health professionals
* Local Authority
* NHS

**3. Objectives**

* 1. To promote a system of assessment, planning, implementing and evaluating care, establishing a partnership with the Resident, and where possible, their relatives/representatives, enabling Residents to retain their own identity and be involved in their care.
	2. To set out the framework, standards and values of Corton House for the delivery of effective, outcome- focused Resident Care Plans and reviews.
	3. To maintain accurate and up-to-date records in accordance with the Care Quality Commission requirements, best practice guidance and policies and procedures at Corton House, and for nurses at Corton House in accordance with the Nursing and Midwifery Council.
	4. To ensure that all employees are aware of, and follow, any procedure or guidance contained in the Care Plan for each individual Resident before carrying out any care.

**4. Policy**

* 1. A care plan, according to the National Institute for Heath and Care Excellence (2018) is:

A written plan after a Resident has had an assessment, setting out what their care and support needs are, how they will be met (including what they or anyone who cares for them will do) and what services they will receive.

The Department of Health (2011) defines care planning as:

Personalised care planning empowers individuals, promotes independence and helps Residents to be more involved in decisions about their care. It centres on listening to Residents, finding out what matters to them and finding out what support they need.

Personalised care planning is essentially about addressing the Resident’s full range of needs, taking into account their health, personal, family, social, economic, educational, mental health, ethnic and cultural background and circumstances. It recognises that there are other issues, in addition to medical needs, that affect a Resident’s total health and wellbeing.

It is, therefore, a holistic process, treating the Resident 'as a whole' with a strong focus on helping Residents, together with their carers, to achieve the outcomes they want for themselves.

* 1. Good quality Care Plans underpin safe, effective, compassionate, high-quality care. They communicate the right information clearly, to the right people, when they need it. They are an essential part of achieving good outcomes for Residents.
	2. The Resident's Care Plan can consist of various formats:
		+ Paper
		+ Digital
		+ Photographs
		+ Scanned records
		+ Letters

The Care Plan is a legal and confidential document and the following must be adhered to:

* + - UK GDPR and the Data Protection Act 2018
		- The Health and Social Care Act 2008

Staff registered with a professional body such as the Nursing and Midwifery Council (NMC) will be required to adhere to record keeping standards as defined by their registrant body.

Please refer to the Record Keeping Policy and Procedure at Corton House.

* 1. All Residents may have access to their own Care Plan and must be involved in the assessment and planning of their care. The Care Plan is a legal and confidential document.
	2. The Care Plan process is a continuous process and is frequently reviewed with the Resident, their key worker and their representative where this is appropriate, according to individual Resident requirements. Resident Care Plan reviews should take place monthly or more often if changes occur. Reviews should take place with the Resident and their representative as appropriate.
	3. Staff will be trained appropriately and supervised by a senior member of staff to assess their competence and capability before they work unsupervised.

**5. Procedure**

# Assessment

Corton House should always carry out an assessment of a Resident’s needs before they can agree to provide care at Corton House.

This ensures that Corton House does not accept anyone whose needs they cannot meet. A **Timeline for Assessment, Care Planning and Review** document is available in the QCS Management System.

An assessment forms the basis of a Resident’s Care Plans, which sets out the level of care and support the Resident will need, as well as details of their medication, diet, social interests and end of life preferences.

The assessment is a discussion about what a Resident wants to achieve by receiving care at Corton House. The assessment is to talk about:

* + - What they need support with
		- Who they are as a person
		- Their preferences and goals The assessment should:
		- Have a named Key Worker leading the process
		- Be person centred
		- Be collaborative
		- Be holistic and recognise potential conflicts
		- Be based on outcomes

Corton House needs to get to know each Resident as an individual. They must conduct a needs assessment so they can plan how they will deliver the Resident’s care. This is written in a Care Plan which any staff at Corton House delivering the Resident’s care will read and follow.

It is recommended that the Resident seeking care has a family member or person they trust with them for the care assessment, particularly if they are living with dementia, or cannot fully answer questions due to other medical reasons.

Staff at Corton House should refer to the **Pre-Admission and Admission Policy and Procedure** and the

# Pre-Admission Assessment form.

* 1. **Involving Carers, Families and Friends**

At the first point of contact the person should be asked whether and how they would like their carers, family, friends and advocates or other people of their choosing (for example, personal assistants) to be involved in discussions and decisions about their care and support, and their wishes followed. This must be reviewed regularly at reviews, or when requested.

If the person would like their carers, family, friends and advocates involved:

* + - Explain the principles of confidentiality, and how these are applied in the best interests of the person
		- Discuss with the person and their carers, family, friends and advocates what this would mean for them
		- Share information with carers, family, friends and advocates as agreed.

If a person lacks the capacity to make a decision about whether they wish their carers, family, friends and advocates to be involved, the provisions of the Mental Capacity Act 2005 must be followed.

# Consent

If the Resident does not have capacity and does not wish to, or is unwilling to participate in the process of producing a Care Plan, the chosen representative must be competent and willing to act on behalf of

the Resident in the Care Plan process.

Where a Resident does not have capacity, decisions are made in their best interests. The required assessment must have been carried out to evidence this.

# Assessment of Need and Managing Risk

Where a support or care need has been identified, an individual assessment needs to be completed for each one.

Assessment tools can be used to assess a Resident's general needs or assess a specific area, such as:

* + - Moving and Handling Assessment
		- Oral Care Assessment
		- Continence Assessment
		- Skin Care Assessment

A suite of assessment tools are available at Corton House and should be used on an individual basis to assess the needs of the Resident.

Care and support needs assessment should:

* + - Focus on the Resident's needs and how they impact on their wellbeing
		- Focus on the outcomes they want to achieve in their day-to-day life
		- Involve the Resident and their families in discussions and decisions about their care and support
		- Take into account the Resident's personal history and life story
		- Be aimed at promoting their interests and independence
		- Be respectful of their dignity
		- Be transparent in terms of letting Residents and their families know how, when and why decisions are made
		- Take into account the potential negative effect of social isolation on the Resident's health and wellbeing

The management of risk can have a major impact on Residents achieving their goals. Risk management should be integral to the care planning process.

Staff can support Residents by promoting a culture of choice that entails responsible and supported decision making.

The governing principle behind good approaches to choice and risk is that Residents have the right to live their lives to the full as long as it does not stop others from doing the same, and does not cause harm to themselves.

By taking account of the benefits in terms of independence, wellbeing and choice, it should be possible for a Resident to have a Care Plan that enables them to manage identified risks and to live their life in the way that best suits them.

# Risk Assessment

Mandatory risk assessments for all Resident include:

* + - Moving and Handling
		- Falls
		- Pressure Ulcer Risk Assessment (Waterlow)
		- MUST
		- Choking
		- Oral Health

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

For further guidance, staff should refer to the Risk Assessment Policy and Procedure at Corton House.

# Resident Involvement

A Care Plan is crucial to ensure the Resident receives the right level of care and that it is given in line with their wishes and preferences.

The Resident is involved in care planning to ensure they will be looked after the way they want and that they can keep doing the things they enjoy, such as pursuing hobbies and interests.

Additionally, a Care Plan is important because it helps the family and others to understand the Resident's wishes and how they can also support them.

Residents will have:

* + - The Care Plan purpose and processes explained to them and will be informed that they have the right to ask for a Care Plan review meeting at any time
		- An individual and personalised set of Care Plans which are designed to support their expressed requirements and desired outcomes from the accommodation, care, treatment and support provided by Corton House

Residents and their families will be encouraged and supported to be fully involved in the design of their Care Plan, being given at each stage, where possible, choices of action from which they can choose their preferred option.

The involvement of the Resident in the process, the choices offered, and the responses must be recorded. Although each Care Plan is unique to the Resident, they serve the same purposes, including:

* + - Ensuring that the Resident receives the same care regardless of which staff member is on duty
		- Ensuring that the care the Resident receives is recorded
		- Supporting the Resident to identify and manage their care needs A care planning discussion should focus on:
		- Agreeing the Resident’s goals
		- Providing information
		- Supporting Residents to self care, to take a more active role in their own health
		- Agreeing on any treatments, medications, or other services such as access to support groups
		- Agreeing any actions
		- Agreeing a review date

Care Plans should be completed in a timely fashion; it is important to Care Plan high risk areas immediately.

# Supporting Adults with Learning Disabilities

Corton House supports main national objectives for reducing and eliminating health inequalities experienced by people with learning disabilities.

* + - Where a health action plan is not already in place, it will be offered to Residents with a learning disability
		- Residents will be fully supported to complete their own plans and trained staff will be available to contribute to areas that the Resident is unable to complete
		- Alternative formats will be available to aid Residents understanding and involvement
		- Health action plans will be kept by the Resident, used like a diary and updated accordingly
		- The Resident will take the plan when transferring between care services or when attending outpatient and other appointments
		- The health action plan will be audited and reviewed in line with the Care Plan at Corton House, with agreed review and reassessment processes

# Key Worker/Named Co-ordinator

As part of care planning, consideration should be given to identifying a key worker or named co-ordinator who is competent to:

* + - Act as the first point of contact for any questions or problems
		- Contributes to the assessment process
		- Liaise and work with the Resident and their family
		- Liaise and work with all health, and social care services involved with the Resident, including those provided by the voluntary and community sector
		- Ensure that any referrals needed are made and are actioned
		- Complete the Care Plan document in full and sign all documents where indicated. This signature demonstrates the accountability for the planning of care to meet the Resident’s needs
		- Ensure that all the relevant agencies are invited to have an input into the Care Plan process in order to support the effective management of the Resident’s physical, psychological, social and personal safety and health needs

# Care Plan List

Care Plans only need to be written when there is an assessed need, so this means that not all Residents will require the full set of Care Plans available at Corton House.

Care Plans must be reviewed as needs change; they can be discontinued if no longer relevant. There is a Care Plan Contents List available in the care planning section of the QCS Management System. However, this is guidance only as Residents will have different needs.

# Care Plan

A Care Plan should:

* + - Be written and designed to meet the accommodation, health, psychological and social needs of the

individual Resident, including:

* + - * Palliative and end-of-life care needs, if identified as a need
			* Health needs, including continence needs and chronic pain and skin integrity as well as the support needed to minimise their impact
			* Any requirements for managing medicines
			* Mobility and transport needs, adaptations to the home/service and any support needed to use them
			* Eating and drinking to maintain a balanced diet
			* Family and friends involvement
			* The help a Resident needs to look after their own care and support, manage their conditions, take part in preferred activities, hobbies and interests, and contact relevant support services
		- Include instructions and statements based on best practice and professional standards of care and reflect the policies and procedures of Corton House
		- For any clinical needs, reflect how those clinical needs are to be met and by whom, reflecting the Royal Marsden Guidelines (2020) for Clinical Procedures
		- Reflect the recommendations of any external specialist service providers who have relevant input into the Resident's physical, psychological or social health and wellbeing
		- State in clear and factual language, the detailed care, treatment and support instructions required to instruct staff to meet the individual Resident’s needs identified by the individual assessment procedures
		- Include any elements of care, treatment and support that meet the equality and diversity needs of the individual Resident and must be designed not to constrain choices offered to the Resident because of their personal values, ethnicity, age, gender, gender orientation, disability, nationality or religious beliefs
		- Ensure care workers are able to deliver care and support in a way that respects the Resident's cultural, religious and communication needs

The Care Plan must be clear and easily understood by the Resident and their signature should be held on the Care Plan documents as evidence of their understanding and agreement to its contents.

When Residents do not wish to sign the Care Plan, this decision must be recorded in the Care Plan by the Care Plan coordinator and there should be a supporting witness signature.

Care Plans are to be developed by staff who are competent in the Care Plan process and who have the knowledge to inform and involve Residents in all stages of the Care Plan process.

All sections of the Care Plan documents should be completed or, if not deemed appropriate to that individual Resident, the words 'not applicable' must be entered on the document which should be signed and dated to indicate that this area is not applicable, stating reasons where possible. No section of the Care Plan procedure format should be left blank; if not required, the section can be removed.

All Care Plan instructions carried out by staff must be recorded by those staff, reasonably contemporaneously. Other actions and matters which may provide useful information for a subsequent review must also be recorded.

# Personalised Care

When personalised care is fully in place, Residents will have a better experience of health and care at Corton House.

Successful personalised care planning needs to be developed with Residents, not done to them. The key features of personalised care should include:

* + - The Resident is seen as a whole person within the context of their whole life, valuing their skills, strengths and experience and important relationships
		- The Resident experiences hope and feels confident that the care and support they receive will deliver what matters most to them
		- The Resident is able to access information and advice that is clear, timely and meets their individual information needs and preferences
		- The Resident is listened to and understood in a way that builds trusting and effective relationships with people
		- The Resident is valued as an active participant in conversations and decisions about their health and wellbeing
		- The Resident is supported to understand their care, treatment and support options and, where relevant, to set and achieve their goals
		- The Resident has access to a range of support options including peer support and community based resources to help build knowledge, skills and confidence to manage their health and wellbeing
		- The Resident experiences a coordinated approach that is transparent and empowering

Enabling Residents to maintain and develop their personal identity during and after their move to Corton House promotes dignity and has a positive impact on their sense of identity and mental wellbeing.

# Writing a Person-Centred Care Plan

Care Plans must be written based on:

* + - Ability - What can the Resident do?
		- Wishes - How does the Resident want to be supported?
		- Needs - What does the Resident need support with?
		- Outcomes - What is the expectation/outcome for the Resident? Example Care Plans are available at Corton House. **Documentation:**

Staff have a professional responsibility to ensure that healthcare records provide an accurate account of

treatment, care planning and delivery, and are viewed as a tool for communication within the team. There should be clear evidence of the care planned, the decisions made, the care delivered and the information shared. The content and quality of record keeping are a measure of standards of practice relating to the skills and judgement of the staff member.

# General Principles

* + - Entries must be written legibly in black, and are readable when photocopied
		- Entries should be factual, consistent, accurate and not contain jargon, abbreviations or meaningless phrases
		- Each entry must include the date and time (using the 24 hour clock)
		- Each entry must be followed by a signature and the name printed as well as the job role
		- If an error is made, it must be scored through with a single line and initialled with the date and time
		- Correction fluids must never be used
		- Entries may be made by staff who have received training in the process of Care Plan writing

The Care Planning and Assessment Guidelines in the QCS Management System provide further guidance on record keeping standards.

# Care Planning and Long-Term Conditions

Residents with long-term conditions must have a Care Plan that focuses on their physical and mental health needs.

A long-term condition is defined as one that generally lasts a year or longer and impacts on a Resident's life. Examples include arthritis, asthma, cancer, dementia, diabetes, heart disease, mental health conditions, stroke, and hearing and sight loss. The impact and symptoms of these conditions can fluctuate, and people may or may not need to take medicines for their conditions.

Care Plans should reflect each individual long-term condition and the management and support required. This may also include information on any external health professionals who are involved and when to escalate any concerns.

The Department of Health has produced a series of information sheets for healthcare professionals on improving care for Residents with long- term health conditions: [Improving care for people with long term](https://www.gov.uk/government/publications/improving-care-for-people-with-long-term-conditions-at-a-glance-information-sheets-for-healthcare-professionals) [conditions: 'at a glance' information sheets for healthcare professionals - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/improving-care-for-people-with-long-term-conditions-at-a-glance-information-sheets-for-healthcare-professionals)

# Digital Care Planning

Digital systems can mean good outcomes for people who use services, for providers and for the broader health and care system.

They can:

* + - Provide ‘real time’ information recording about the care and support people need and receive
		- Help providers and carers to be more aware when people’s needs change, and respond to them more

quickly

* + - Offer the ability to use and compare data to improve Resident care
		- Help information to be shared quickly, accurately and safely to support the provision of health and care services
		- Help to minimise risks such as medication errors, dehydration or missed visits
		- Help to support other important health and care functions, such as service management, planning and research
		- Make it easier for people who use services to access their own records
		- Help to manage and support staff to do their job effectively and efficiently
		- Be easier to store, requiring less physical space
		- Support better use of resources across the health and care system

# What does a good digital records system look like?

A good records system delivers good outcomes from the point of view of people who use services. These outcomes are the same whether the records are kept digitally or on paper, although what providers need to do to deliver them might vary. Good outcomes for Residents are captured by the following 'I statements'.

These are worded from the perspective of Residents. I have records that:

* + - Are person-centred - They describe what is important to me, including my needs, preferences and choices
		- Are accessible - I can see the information that is important to me, in a way that I choose, and I can understand
		- Are legible - Information about me is recorded clearly and can be easily read by the people who support me
		- Are accurate - Information about me is correct and does not contain errors
		- Are complete - There is no relevant or essential information about me that is missing
		- Are up to date - They contain the latest relevant and essential information about me
		- Are always available to the people who need to see them when they need them
		- Are secure - My privacy and confidentiality are protected. Only the people who should see my records can see them (records are kept in line with data protection legislation, including UK General Data Protection Regulation (UK GDPR) requirements)
		- Help the service that supports me to have good quality assurance systems and processes. They help the provider to assess, monitor and minimise the risks to my health, safety and wellbeing. They help the service that supports me to keep improving

# What standards do digital records need to meet?

All records must also comply with:

* + - Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
		- Data protection legislation (including UK GDPR) requirements
		- Accessible Information Standard
		- Data Security and Protection Toolkit (where providers have access to NHS patient data and systems)

# Care Plan Review

Care Plans are flexible, meaning that when or if the Resident's care needs change, the plan will be reviewed and adjusted accordingly to make sure it meets their needs and preferences.

* + - Routine reviews will include a review of daily reports since the previous review date; in this way the Care Plan coordinator/key worker will be able to identify any Resident reports which may indicate a need for a particular assessment review, and to gather additional information about the Resident’s perception of their daily wellbeing
		- Any new issues which are identified with the Resident must be reported to senior staff so that their Care Plan can be reviewed immediately
		- The daily review of the Resident may indicate changed needs which require a full, in-depth review of elements of assessment or a comprehensive assessment of the Resident's needs
		- Any change to the Resident's needs that are identified during a review should be subject to a reassessment and the Care Plan changed and redesigned to meet the changed needs
		- Reviews should be carried out monthly, or at any more frequent intervals specified. Reassessments may vary in their review period according to individual Resident risks and needs
		- Staff must avoid stating 'no change' but detail on the review what is going well, what is not going well and what changes need to be made if any
		- The assessment of individual risks will be reviewed on an individual basis when there are any indications of altered risk. This applies in the case of both a positive change and reduction in risk, or a negative change and increased risk
		- The review is an ongoing process and Residents should be actively involved in the review of their desired outcomes and have the opportunity to alter their desired outcomes or Care Plan implementation at any time
		- The Care Plan review should take place together with the Resident in a private location according to the Resident's preferences, whether it is the personal room of the Resident or an alternative private room at Corton House
		- There must be a review of the Resident's consent and any decision making they have been involved in related to their care, treatment and support
		- All reviewed documents must be dated and signed by the person completing, in order to support Care Plan tracking and accountability
		- All reviewed documents must be signed by the Resident or their representative in order to indicate their involvement in the process
		- The involvement of the Resident in the process, the choices offered and responses must be recorded
		- All relevant staff should be involved in the Care Plan review
		- Following Care Plan reviews, the staff skill mix and designated staff linked to the Resident should be reassessed in order to ensure that the Resident’s changed requirements can be met

# Audit and Monitoring

* + - Care Plans will be regularly audited against a standardised format for the purpose of identifying any issues or further training that may be required to meet the competency standards of Corton House
		- A 72-hour short audit will be undertaken on new admissions to ensure that key risk assessments are in place
		- Jason Parker or a nominated person will audit Care Plans monthly. Audits must be kept as evidence for compliance monitoring purposes
		- Any shortfalls in the standard documentation will be addressed by Jason Parker who will give clear directions for improvement to appropriate individuals
		- The analysis of the Care Plan audits will be reported at the next management meeting

# Learning and Development

All staff should have privacy and dignity training which should focus on meeting the personalised needs of each Resident.

In addition, relevant staff who implement and contribute to the Care Plan process must have relevant Care Plan training which highlights how to implement a plan of care that is personalised, responsive to individual needs and focused on choice and independence, and which promotes positive risk taking and a multidisciplinary approach.

**6. Definitions**

# Advocate

* + - An advocate can help Residents find appropriate services, make sure they are treated fairly and challenge decisions
		- They can help a Resident express their needs and wishes and support them to weigh up and take decisions about different options

**Key Facts - Professionals**

Professionals providing this service should be aware of the following:

* + - The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 explains the intention of this regulation which is to make sure that Residents have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each Resident receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences
		- Providers must make sure that they take into account Residents' capacity and ability to consent, and that either they, or a person lawfully acting on their behalf, must be involved in the planning, management and review of their care and treatment. Providers must make sure that decisions are made by those with the legal authority or responsibility to do so, but they must work within the requirements of the Mental Capacity Act 2005, which includes the duty to consult others such as carers, families and/or advocates where appropriate

**Key Facts - People affected by the service**

People affected by this service should be aware of the following:

* + - Your Care Plan should be individual to you, and you should be allowed to have as much involvement in the development of your Care Plan as you wish
		- You should be fully involved in the preparation of your Care Plan, and you, and anyone else you request to do so, can be involved
		- The care and support you receive should help you to live independently, having as much control over your life as possible, participating in society on an equal level and having the best possible quality of life whilst maintaining dignity and respect

**Further Reading**

As well as the information in the 'underpinning knowledge' section of the review sheet we recommend that you add to your understanding in this policy area by considering the following materials:

# GOV.UK - Improving Care for People with Long-term Conditions: 'At a Glance' Information Sheets for Healthcare Professionals:

[https://www.gov.uk/government/publications/improving-care-for-people-with-long-term-conditions-at-a-](https://www.gov.uk/government/publications/improving-care-for-people-with-long-term-conditions-at-a-glance-information-sheets-for-healthcare-professionals) [glance-information-sheets-for-healthcare-professionals](https://www.gov.uk/government/publications/improving-care-for-people-with-long-term-conditions-at-a-glance-information-sheets-for-healthcare-professionals)

# GOV.UK - to ensure the basic principles and foundations for care planning we recommend the following as further reading:

<https://www.scie.org.uk/mca/practice/care-planning/key-principles-in-care-planning> <https://www.gov.uk/government/collections/mental-capacity-act-making-decisions> **CQC Regulation 9: Person-centred Care:**

<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-9-person-centred-care>

# Nursing & Midwifery Council - The Code:

<https://www.nmc.org.uk/standards/code/>

# The Royal Marsden Manual of Clinical Nursing Procedures:

The Royal Marsden NHS Foundation Trust (202) Chichester: Wiley Blackwell

# What is a health action plan? - Mencap:

[www.mencap.org.uk/sites/default/files/2016-06/What%20is%20a%20health%20action%20plan%3F.pdf](https://www.mencap.org.uk/sites/default/files/2016-06/What%20is%20a%20health%20action%20plan%3F.pdf)

**Outstanding Practice**

To be ‘ outstanding ’ in this policy area you could provide evidence that:

* + - The wide understanding of the policy is enabled by proactive use of the QCS App
		- The service shows evidence that all needs are assessed and long term conditions have separate Care Plans
		- Corton House will be creative and innovative in its methods, ensuring that Residents or their representatives are involved, at every opportunity, during the Care Planning process
		- Corton House will provide individualised care, respecting the Resident's wishes, with opportunities for enhancing their quality of life and independence
		- Residents' best interests will be managed appropriately under the Mental Capacity Act (2005)
		- Residents will be involved in the assessment of their needs and have consented to their care, treatment and support
		- Staff will be well supported through training and development and have the right skills and knowledge to meet the Resident's assessed needs

**Forms**

The following forms are included as part of this policy:

|  |  |  |
| --- | --- | --- |
| **Title of form** | **When would the form be used?** | **Created by** |
| Audit and Action Plan - CP11 | As part of a monthly audit of care/support records. Identify a random 10% to review on a rotation basis. | QCS |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Area/Item audited** | **Score 1****– 5** | **Action required** | **By date** | **Signed** | **Action completed (date)** | **Signed** |
| Admission docs completed |  |  |  |  |  |  |
| Admission assessments |  |  |  |  |  |  |
| Risk assessments |  |  |  |  |  |  |
| Advocacy details available |  |  |  |  |  |  |
| Resident Care Plans |  |  |  |  |  |  |
| Personal care recording is accurate |  |  |  |  |  |  |
| Recording of Resident health |  |  |  |  |  |  |
| Recording of Resident social activities |  |  |  |  |  |  |
| Care reviews current |  |  |  |  |  |  |
| Risk assessments reviewed |  |  |  |  |  |  |
| Care Worker sex choice available |  |  |  |  |  |  |
| Continence assessments |  |  |  |  |  |  |
| Continence reviews |  |  |  |  |  |  |
| Nutritional reviews |  |  |  |  |  |  |
| Pain assessment |  |  |  |  |  |  |
| Pressure area risk assessment |  |  |  |  |  |  |
| Review of pressure area risk |  |  |  |  |  |  |
| Resident involvement in assessment |  |  |  |  |  |  |
| Resident involvement in Care Planning |  |  |  |  |  |  |
| Resident involvement in reviews |  |  |  |  |  |  |
| Fluid balance |  |  |  |  |  |  |
| Discharge admin completed |  |  |  |  |  |  |

**Date of Audit:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Area/Item Audited** | **Score 1****– 5** | **Action Required** | **By date** | **Signed** | **Action completed (date)** | **Signed** |
| Discharge questionnaires |  |  |  |  |  |  |
| Key workers in place |  |  |  |  |  |  |
| Medications policy followed |  |  |  |  |  |  |
| Pre-admission assessment |  |  |  |  |  |  |
| Welcome carried out |  |  |  |  |  |  |
| Recreational activities |  |  |  |  |  |  |
| Restraint register |  |  |  |  |  |  |
| NHS treatment information |  |  |  |  |  |  |
| Resident surveys |  |  |  |  |  |  |
| Family surveys |  |  |  |  |  |  |
| Medication |  |  |  |  |  |  |
| Self-medication |  |  |  |  |  |  |
| Named Nurse in place |  |  |  |  |  |  |
| **Score: 1**. Many significant shortcomings **Score 2.** Shortcomings outweigh good practice **Score 3.** Minimum acceptable standard**Score 4.** Good practice outweighs shortcomings**Score 5**. No significant shortcomings |