Person Centred Care Planning Policy and Guidance

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Version Tracking

Version	Date Ratified	Brief Summary of Changes	Owner
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16v1	01 April 2020	Annual Issue change	JP
2	22 Jan 2021	Policy statement added (previously guidance only) Re-written to give more clarity	JP
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17v2	28 Jan 2022	Change (p4) re document management system and minor amends; no process changes	MBrad
V2	26 Jan. 2023	Minor amends	MBrad

1. Purpose of this document

This document provides employees with the information required to ensure an approach to care is supported and enabled which focusses on the holistic needs of the individuals they support

2. Policy Statement

It is Agincare's policy to provide a person-centred approach to all care and support functions ensuring that people using the service are valued, respected and have choice and control with the confidence to more effectively manage and make informed decisions.

This policy is held in accordance with Regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The intention of the regulations is to ensure that people using the service have care and support that is personalised specifically for them and is safe considering their capacity and ability to consent and that either they, or any person authorised to lawfully act for them, are involved in the planning, management and review of their care. (See also Agincare's Mental Capacity Act 2005 Policy)

Agincare's commitment to all those using the service and other stakeholders is based on the principles of respect and good communication. Before and during care provision, people will be provided with full and detailed information about the service they can expect, and should be party to any changes in the way in which their care and support is provided. Full and detailed information is provided on an on-going basis through clear, comprehensive planned care and risk management processes

3. General principles

The following general principles apply:

Dignity and respect

Upholding a person's dignity is one of the most important factors in ensuring they are valued and respected for who they are, what they believe in and how they live; treating people with dignity means treating them the way we would like to be treated ourselves.

Valuing people's diverse lifestyles, views, opinions and choices is central to enabling a person-centred approach to care; our values usually hold common themes including health and happiness, family, freedom and honesty and justice for example. We talk about person centred care but to deliver it we must develop our understanding of person-centred thinking and working and of relationship centred care.

Person centred thinking is a set of principles and core competencies that is the foundation for person centred planning and working and relational care helps us understand who is important to the person in their circle of care and how we can facilitate the service users inclusion in maintaining relationships.

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

Coordinated care and support.

To deliver consistent person-centred care, we must work collaboratively with other health and social care workers and services; the approach must remain person centred but working together will enable seamless care.

Agincare employees can provide care and support in a person-centred way but that which has been determined by a commissioner; for example, where a local authority purchases a package of care for a person who they say requires support for 30 minutes to get up in the morning and have their medication. Home Care workers work within these boundaries and

although time constrained, will support the person in a way which is respectful of their individual needs, preferences and choices within those 30 minutes. Outside of those 30 minutes, Agincare will still treat the person with respect, compassion and dignity with regard to information sharing, supporting the person remotely if required to access other health services, booking and enabling care reviews and to ensuring clear communication regarding their visit schedules, who shall be visiting etc.

In services where care and support are provided for longer periods whether this be in a residential setting, live in care or supported living environment, Agincare employees will work with others arranging and supporting access to other professional health and social care serves as needed by the individual, and always with their consent or in their best interests.

We need to work with other professionals in many aspects of the care and support we provide, whether that is working within a programme devised by a physio therapist to support someone's mobility, or with a community nurse on providing correct pressure relief and skin care; the following list shows some of the potential people we may need to work with for individual's when planning to support them in a person-centred way:

- Communication – IMCA, POA, other health professionals, family/representatives audiology, SALT, optician
- Nutrition and hydration – nutritionist, dietician, SALT
- Tissue viability – TVN, DN, dietician, GP
- Continence – continence advisory service, TVN, DN
- Mobility and dexterity – OT, physiotherapy
- Personal care – hairdresser, chiropody
- Medication – the prescriber, pharmacy
- Mental health – CMHT, psychology services
- Work, education and social care – Day centres, PA's, other providers, lunch clubs
- Spiritual and cultural care – ministers, church, lifestyle groups/clubs
- Advanced planning – POA, bereavement services, palliative care team

Working in adult social care, we are part of a much wider community of care and support services and, for the person we support, are part of their circle of care and it is imperative that all parties communicate whilst ensuring the person remains the focus of any discussion.

In working collaboratively with others, Agincare employees will also respect the individual's right to privacy and confidentiality and information will only be shared in accordance with the general principles of data protection

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 privy to sensitive, personal information. Good communication can make interpersonal relationships

positive, supportive, clear, and empowering; poor communication can damage relationships and trust.

Person centred working is not just about care planning, it is about valuing and respecting the person's choices and their dignity. A written care plan should communicate to the person the ways in which they can expect their care and support to be provided; and they should have the opportunity to read it, understand it and either agree it or request changes to it. Written communication and they way in which it is presented is an important part of showing a person they are respected and valued, any documentation should be presented in a format the person is able to understand meaning it should be clear and unambiguous.

4. Process

Agincare has systems and tools in place, used every day to demonstrate that both the legal requirements of compliance, and the person-centred care and support needs of the individual are being met. The assessments, planning, monitoring and reporting documents listed in Appendix 1 are available in Agincare's document management systems and, where digital care management processes are in place (Nourish/One Touch), are available in digital format and designed in accordance with published good practice guidance.

Guidance is available through Agincare policies, procedures and guidance documents regarding some of the specific, technical aspects of assessing and planning care such as the moving and handling guidance, or policies on mental capacity, continence or tissue viability.

Agincare services use different documentation in some cases but the principles are the same. Where digital care documentation is used, formatting and processes are overseen and monitored to ensure they remain in accordance with Agincare's policies and procedures and agreed ways of working.

The Health and Welfare Assessment is the starting point for any care and support process and is used to assess need and risk and identify support required and it stands as the working person-centred care and support plan in home care services. In care and nursing Homes the Health and Welfare Assessment is pre-admission assessment from which separate Care and Support plans can be produced

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 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, spiritual and cultural needs. In completing the assessment, you must consider the person's perception and experience of their change in lifestyle and consider how accumulated losses (of their home, or of being part of a wider community, the change in living circumstances, their altered intimacy, the changes in their

health and independence etc.) will impact on their care and support needs, on risks and on expected outcomes.

The statement at the start of this document says it is held in accordance with Regulation 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9 is concerned with person centred care but we must always ensure safe care - governed by regulation 12.

Regulation 12 is concerned specifically with risk management and learning from incidents so it is important we use standard risk assessment formats which are designed around good practice guidance. The assessor must have a knowledge of all the documentation available and understand their use. The Health and Welfare assessment is separated under various well-being headings such as 'Communication', 'Medication', 'Moving and handling' and 'Nutrition and Hydration'.

By understanding the need for associated risk assessments will enable the assessor, along with the individual and/or their representative, to determine the best outcomes in the safest way so for example, when assessing a person's mobility needs; the Moving and Handling risk assessment may be needed, when assessing a person's nutritional needs, a Choking Risk assessment may be required; Waterlow when assessing a person's skin care needs and risk of pressure ulcers, a Medication Management risk assessment for their health care needs etc.

Whilst this guidance is about 'Person Centred Care', there are some instances where very little information is available for instance where a person needs urgent or emergency support whether in the community or in a care home for a variety of reasons such as carer breakdown due to illness or stress.

In such cases, the receiving service must obtain enough essential information needed to keep the person safe whilst a person-centred approach can be established as they get to know the person.

Safe care processes will generally encompass physical safety and security so as a minimum we must know if the person has any medications, where they are and when they are taken, any allergies, any special dietary needs as well as other important factors such as how they communicate, mobilise, access the toilet etc.

5. Output

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 areas to identify needs and abilities, risks and support required. The health and welfare assessment is separate from the electronic care planning system available in Care and Nursing Homes and Agincare Enable (Nourish) so information from the assessment must be transferred to the Nourish Care and Support plan pages

The section headed 'Support required' (or 'How to achieve outcomes' on Nourish) is where care and support staff will be given direction on the processes needed to meet the assessed need, address any risk and work toward achieving the persons outcomes are identified.

The output must be clear and concise with information taken from the assessed need and any associated risk assessments. It must instruct staff on the correct way of supporting the person; a simple example might be:

- Assessed/identified need

Mr B needs support with transfers and to mobilise; he can take 4 or 5 steps only using his walking frame and with support from two people. He has a profiling bed and sits in his riser/recliner chair during the day. Mr B needs wheelchair support for distances.

- Outcome

Mr B feels supported and comfortable and able to get from (A to B) safely and with confidence

- Support required:

Two care workers are to support either side and taking their lead from Mr B support him with one hand under his elbow and one to his lower back. Place his walking frame in front of him and remind him to hold on to the hand grips and guide him with verbal encouragement to stand on the count of three; say 'one, two, three', support him to stand, and then encourage him to take 2/3 steps toward his chair; continue to support him to turn and lower himself into his chair. These processes can be undertaken when supporting Mr B to transfer from chair to chair, bed to chair, chair to wheelchair, to shower chair etc. When in his wheelchair, ensure Mr B has his feet placed flat on the footplates

In this instance, the moving and handling assessment will have various criteria completed regarding transfers, sitting to standing, bathing or showering etc; all should be transferred to the support plan detailing the process for care staff to follow

The extent of the information included in a care and support plan will often depend on the extent of the care being purchased; in Care Homes or Live in Care services for instance where full time care is required 7 days a week, a full, holistic assessment should be completed remembering of course that the person will have independence and abilities to maintain and direct their own care and support in some areas.

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; the 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 process include? We would need to consider referral to either the person's 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 them.

6. Outcomes

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 achieve outcomes, we have to go through various processes for example, to achieve the outcome of enjoying a lovely meal, we have to go through the process of cooking and preparing it. If we choose not to follow a process, a bit of experimental cooking maybe, that is our risk to take but the meal may not be quite as lovely as we'd have hoped. Supporting someone else to achieve their outcomes however needs the processes to be clear and explicit and any risks need to be understood by the person themselves; they are not our risks to take. People are at liberty to take risks and make unwise decisions as long as they have capacity to do so; we must however evidence that we have advised them of the risks and our care and support plan should identify these.

Considering Mr B's mobility for example; he may be at increased risk of falls if he mobilises unaided and without the support described in his plan, however if he knows and understands the risk and the consequences of injury and chooses to mobilise unaided between care and support visits this is his risk to take. In such cases, we need to re-assess and re-plan to try and find a way of supporting him in a way in which he prefers, which is safe and also acceptable to him. If care staff are not always available at the time he wants to mobilise, the care and support plan can indicate referral to OT for additional equipment, to his GP for a medication review, or it could simply be that other aspects of our plan didn't address how he likes to have access to his kettle, his computer, his telephone or how he likes to enjoy the view from the window later in the afternoon.

When planning person centred care; we may identify an outcome as a need or a safety factor, we then have to identify the steps to be taken to provide the support in the way in which they want that support as well as the safest way whilst all the time promoting their choice and control and respecting their individuality.

Outcomes can be either maintenance outcomes, or change outcomes, they can be anything the person may want to achieve, experience or need. A change outcome means the person is aiming to improve their quality of life whilst a maintenance outcome will support them to continue with their current quality of life in their chosen way.

When a person first comes to receive an Agincare service it is likely they need change outcomes where there is some aspect of their lifestyle or health that they are unable to manage independently. Examples might include a person with poor health who has not managed well at home independently; they request a service to enable them to change and improve their level of personal care, improve their health with good medication support or a better diet. When the person has been receiving a safe and effective service and that outcome is achieved, if the service is to continue it becomes a maintenance outcome whereby we continue to support them to maintain their personal hygiene, medical needs and diet.

Maintenance outcomes involve working with a person to maintain their current well-being; a person who has lived in a care home for example for a while whose outcome is to get up each day, go to the lounge and sit with friends, have their meals provided, know they are safe and well cared for and where they can enjoy visits from their family. To support them to achieve this outcome, daily, processes must be in place to support them with personal care, mobility, social interaction and mealtime support. For Mr B, mentioned above, his outcome could be to *maintain* his current degree of mobility or it may be to *change* his current degree of mobility with the aim of improving his strength and muscle tone and taking a few more steps each day.

An outcome is a level of performance, or achievement which is measured by how effective the process is.

If the process is not effective we cannot assure ourselves, or the people we support, of safe effective and responsive care. With Mr B for example, if his needs and abilities are not assessed and recorded appropriately, the *process* detailing how to meet his needs cannot be detailed resulting in staff not having clear instruction and Mr B might receive unsafe care through poor, unplanned moving and handling activity

Person centred, outcome-based care is about more than writing a good care plan; person centred working will consider many variables to ensure we get it right. Using the example of Mr B the process needs to consider:

- Allocating staff who are trained and competent in moving and handling (scheduling/rostering process)
- Ensuring allocated staff are fit for the job (recruitment, training and support processes)
- Ensuring good communication with other providers such as an OT, or GP for example
- Ensuring risks are identified (the process of assessment and care planning to meet mobility needs in collaboration with others as required such as OT's, physiotherapists etc and, not least of all, with Mr B himself)

7. Risk and Risk Management

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.

Risk management is not separate from person centred planning; identification of risk is the purpose of the care and support planning process for example where a person did not receive a service they were at risk of self-neglect, of falls, of not taking prescribed medicines or at risk of abuse from well-meaning but poorly informed family members who were struggling to manage; in this context, health and safety and risk assessment are terms that cover the whole process.

Using risk assessment processes effectively will enable the individuals you support to make informed decisions and choices for example they may want to bathe 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 manage and reduce 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. 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.

The process of a poor assessment and subsequently poor outputs that do not value Mr B and his needs could lead to the risk of injury from poor moving and handling.

Had we had a person-centred approach and put Mr B at the centre of his care, we would have ensured that staff with the right skill to assess and plan his care and those with the right skill and competency to meet his individual needs at the time when he needed them would reduce risks to his health and safety.

8. Summary

In Home Care services, a summary of care and support can be written as an aide memoir for staff, the summary is an abstract of the care as planned and is a guide to remind care workers on the way and order in which things are to be done.

In Home Care services the purpose of the summary is to provide an 'at a glance' overview of care and support needs for staff who have short, time limited visits; it is not a replacement for planned care and the care worker must be familiar with the whole care plan. Although the summary is often a list of tasks, these tasks represent the *processes* that are essential to meet the person's outcomes.

9. Review

Evaluation and review don't just happen on a pre-determined date, it is part of 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 evaluate this on an on-going basis to ensure information remains current.

Some individuals will see an improvement in their independence and their ability to care more for themselves (their change outcomes are being met), others will not and their needs may increase with continued ageing, frailty or ill health (their quality of life outcomes are being maintained). Whatever the changes, they 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.

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 2023

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. Where electronic care planning processes are used, these templates are transferred in the right format to comply with Agincare's agreed ways of working

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 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
Choking Risk Assessment	To assess and describe any risks with swallow and possible referral to SALT
Dementia Care Agitation Scale	To be completed after 2 weeks monitoring using ABC chart to identify risk factors and necessity for referral to dementia support services
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 Risk Management	For use for any person who experiences seizures
Falls Assessment	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
General Risk Assessment	A format to be used to assess any risk there is not a specific format for; 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. As well as addressing environmental health and safety issues such as fire precautions, use of electrical equipment or access to stairs for example, in Home Care 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.
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)
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 each decision to be made must have an assessment.
Moving and Handling Assessment	To assess mobility and any support/aids required; however 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)	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.
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 in care homes.