**Care Stream Limited**

**Care and Support Planning Policy**

1. **Policy Statement**

1.1 As a company, Care Stream is acutely aware of the importance of effective support planning for individuals who receive a supported living service. We believe that the individual must be at the centre of the process and involved every step of the way. We pledge to share and give information during the process, listen, take our lead and influence from the individual in relation to their choices and preferences and encourage them to take the lead in terms of shaping their support package.

**2.0 Care Act 2014**

2.1 It is often said that a service user led approach to delivering services is the Achilles heel of adult care. In trying to move things forward, the Care Act sets meeting needs at the centre of care and support planning and moves away from the previous terminology of “providing services”. This is to enable a much broader diversity and variety of approach in how needs can be met. This will require providers such as us to reassess our current services, whilst keeping an open and honest dialogue with tenants and commissioners to diversify the services available. As a provider, this means the utilisation of the voluntary sector, community groups and development of individual service funds, where appropriate. A collaborative engagement process will need to be developed and local authority guidance issued in order to facilitate the development stages of the relationship with other services.

**3.0 Local authority funded persons**

3.1 Care and support funded by the local authority will reflect the Care Act 2014 requirements, and these changes have been implemented since April 2015. These include changes to the following:

* Personal budgets
* Direct Payments
* Individual Service Fund (ISF)
* Purchase of regulated and unregulated services
* Mixed funding arrangements
* Flexible choices of care and support
* “Prescribed providers” do not fit with the governments vision of personalised care and should be avoided
* No constraint on how needs are met, as long as this is reasonable
* Steps should be taken to avoid decisions on the assumption that the views of the professional are more valid than those of the person
* Persons lacking capacity are equal within the Care Act 2014, but the principles and requirements of the Mental Capacity Act 2005 (MCA) must be adhered to if the person lack capacity

All this good practice will be embedded for all our tenants, including self-funders, as the Care Act 2014 shapes local authority practice, so too will it shape ours as a provider.

The importance of good information advice and guidance cannot be underestimated and local authorities, under this Act have a duty to provide such a service.

**4.0 The policy**

4.1 The Care Act 2014 has huge implications both for local authorities and providers of services and we, as a provider, are well placed to meet the challenges ahead. We set out below a set of principles which applies to all our care and support planning process from April 2015.

4.2  **Principles**

* Information advice and guidance will be available to all prospective tenants in order that an informed decision on our ability to meet the assessed need can be determined.
* The tenant, their family, representative or “relevant person” will be involved from the start, during the assessment and care and support planning process to ensure their needs, choices and preferences are reflected in the support plan agreement
* Consent will be discussed, formally recorded, and agreed within the support plan.
* The Mental Capacity Act 2005 (MCA) Code of Practice and Deprivation of Liberty Safeguards (DoLS) 2009 will be followed where someone lacks capacity or where there is a fluctuating need identified and decision recorded in the support plan.
* Choice and control will be retained by the tenant including their ability to take or make unwise decisions where they have capacity.
* Self-supported care and support planning will be encouraged and available to all tenants.
* Individual services funds (ISF) will be developed in agreement with tenants and will be offered where requested.

**5.0 Assessment of care needs**

5.1 Care Stream accepts referrals for services from both private and funded sources.

5.2 Before Care Stream enters a contract to provide a support service in a person’s own home a thorough assessment of the individuals needs has to be undertaken.

5.3 For those referred by social services, the assessment forms part of the managed care process and a copy of the full assessment is supplied to the care manager as part of the process. Should the individual have referred themselves directly, Care Stream takes full responsibility for carrying out a full assessment and supplying the individual with a copy of their assessment in accordance with our assessment procedure.

5.4 The information contained in the assessment is used to formulate the initial placement offer and support plan.

5.5 Needs assessments are only carried out by competent members of staff, who have been appropriately trained and who are specifically authorised for this task. Throughout the support needs assessment process, the staff member carrying out the assessment should communicate with and actively involve the prospective tenant and their representative. It is particularly important to find out the tenant’s wishes and feelings, and to take them into account; to provide the tenant with full information and suitable choices; and to enable and encourage people to make decisions about their own care and support. We will comply with any special local arrangement for self-assessment by tenants.

**6.0 Sources of information**

6.1 The general expectation is that the tenant will give the assessor the necessary information, but where this is not possible their support worker, relative or representative or the relevant person is the most-likely source. In such cases the tenant should, if possible, be present while information is gathered and recorded; as an indication that they agree that we should have access to the information, and that the information provided to us is true and that they are happy to be prospectively receiving a service from us. The authorised person carrying out the assessment needs to interview the tenant either pre-admission, or in the setting in which the service will be delivered. A specific appointment should be offered with a named assessor. The assessor should aim to create a warm and relaxed atmosphere for the interview, should give the prospective tenant the opportunity to demonstrate his or her abilities, as well as discussing his or her needs. They should use the time to observe the tenant. Within a domiciliary setting it should be remembered that the person’s home becomes the potential support staff’s workplace, so a full environmental risk assessment should be completed, as well as discussing what this organisation has to offer. Information should be recorded at the time of the interview, or as soon as possible afterwards, on the initial assessment form. The assessor should be quite open about recording the information and should wherever possible ask the individual to sign the form.

**7.0 Information Gathering**

7.1 A full and comprehensive Assessment of Need should be completed with the tenant, their relatives or representatives where requested. Assessors need to ensure that consent can be given and where there are capacity issues, advice should be sought.

**8.0 Physical and mental health abilities**

8.1 We record information about the tenant’s health and abilities. It is the task of the assessor to decide which items are relevant for the service that this organisation is being asked to provide. The form lists a range of possible items for consideration. Although we need as full a picture as possible of the needs of the tenant, we do not wish to intrude on the person’s privacy any more than is necessary, so any assessor must use their judgement as to which items on the form have to be completed. If the assessor is visiting the prospective tenant in a current care setting or in their own home where a service is provided the assessor should endeavour to seek information from the current provider on areas of risk, challenging behaviours and other areas that may affect service provision in the future. This enables Care Stream to maintain a consistent approach for the individual in terms of what is currently working for them.

8.2 Care should be taken not to place too great a stress on an individual’s disabilities. The assessor should emphasise from the outset that a worker will work with the tenant (and with the carer if applicable) and focus on supporting the tenant’s independence as far as possible. If there are health issues on which further medical or nursing details are required, the assessor should ask the tenant or support worker to obtain and pass to us the necessary reports.

Any written documentation about the tenant’s support needs should be appended to the form.

**9.0 Services requested**

9.1 This information is recorded on the form, detailing the services that this organisation is being requested to supply. At this point a manager must take the formal decision that the company is able to provide the requested services, given the details of the support needs assessment. The manager should also recommend the number of hours and staffing levels that will be required. The assessment is then passed to the senior operations manager for formatting before being passed on to the referrer or individual.

**10.0 Staffing**

10.1 When the final decision has been made that this organisation will supply services, identified workers should be allocated to the case. The prospective tenant will, at this time, be invited to visit their accommodation by the landlord and will also have an opportunity to meet some of the staff that may be allocated to provide the service. We believe that the matching of the worker to the tenant is of paramount importance, and we seek feedback from the tenant as to which staff members they felt an immediate rapport with as well as seeking information on what sort of people they feel they gel best with. When all the required elements have been agreed, the tenant will be informed of the staff team who will be supporting them. The workers will be introduced personally to the tenant prior to commencement of the service. The allocated worker(s) are responsible for reading and understanding the initial support plans and to work with the tenant to add to the support plan with their own information to ensure that the document is living and grows with the individual and reflects their changing needs.

**11.0 Referrals from social services departments**

11.1 In cases where a potential tenant is referred by a social services department, the manager must obtain a summary of the needs assessment that the department has undertaken. This will also form part of the initial assessment. The summary of the social services needs assessment should be filed with the organisation’s own form. We will comply with any special local arrangements for self-assessment by tenants.

**12.0 Emergency service provision**

12.1 If this organisation has been requested to provide services at short notice or in a crisis, there may not be an opportunity to carry out a full assessment before starting to provide a service. A telephone discussion, to ascertain as much information as is possible before the commencement of the service, will be recorded and used as the initial assessment for the first 72 hours of any immediate response on emergency service provision. This organisation has a form specifically to record the needs of an immediate response situation. When emergency support is provided, the manager must complete the basic information on page one of the form and allocate the case to a worker who is competent to undertake an initial contact assessment. In these circumstances, only experienced managers of the service will make the decision to respond and only if the placement can be introduced safely.

12.2 Within three working days, the manager will arrange for a full assessment to be carried out, and the form to be completed with all relevant details for providing services over a longer term. Where the immediate response is of a short-term basis only, the immediate response form will be used in conjunction with any other details supplied by social services or healthcare to assist in the service delivery. If the service is provided at the request of a social services department, the manager must ensure that the department completes an assessment within two working days and passes the information to us as described above.

**13.0 Support Plan**

13.1 This organisation’s process of planning tenant support is based upon the following. principles:

* *Planning support is person-centred*. A support plan will never be made without the active participation of the person to whom they relate, or, where necessary, this person’s representative;
* *Planning support involves others who are relevant to the tenant*. Many tenants want their carers or relatives to be involved in planning their support. We will ensure this happens, provided that it does not prejudice the principle that the tenant must always remain central;
* *Planning support often needs to be multidisciplinary*. Most tenants have needs that span social care and health. We will ensure that the views and contributions of all relevant agencies and professions are collated into a single plan;
* *The plan of support must be based on evidence*. The plan of support for each tenant will be based on a formal assessment of their support needs;
* *The plan of support sets objectives and outcomes*. As a plan of support is intended to bring about some sort of desired change or development, and enhance independence, we work with the tenant to set objectives and to give thought as to how those aims are to be achieved; all support plans will be outcome focussed.
* *The support planned must be realistic*. The plans of support we prepare are not merely expressions of aspirations; instead, they are based on realistic judgements about what can be achieved, including honest estimates of the resources involved.
* *Plans must be reviewed*. A plan of support is not a static document; plans must be capable of being adapted if new evidence becomes available or if circumstances change. Every plan will be regularly reviewed and revised over time.
* *Plans must be acted on*. The planning of support is not a mere paper exercise. We are sincerely committed to putting every plan of care into action, and therefore set out defined responsibilities and a clear process for monitoring progress.

**14.0 Those involved in planning**

14.1 The following people are involved in formulating the support plan:

* *The tenant*. The tenant is always central. We emphatically do not plan *for* people; we plan *with* them. If a tenant is not able to participate meaningfully, we will always seek an appropriate representative or advocate who can faithfully put forward what they believe the person would have contributed.
* *Relatives, friends and carers*. Subject to the tenant’s agreement, we would wish to involve other people in the tenant’s circle who are likely to be involved in implementing the agreed support plan. We recognise that carers and others sometimes have needs and interests of their own; we will take these into account but will insist always that the needs and preferences of the tenant remain pre-eminent.
* *Staff of this organisation.* In planning and reviewing the support we provide, try to involve all the people who know the tenant well. This is likely to mean the staff who carried out the care needs assessment, or who dealt with the social services referral; the care staff who are providing the day-to-day service; and the person who supervises the workers.
* *Other agencies and professionals*. As health and social care needs and services are closely related, it is likely that our tenants will have been in touch with other agencies. Where appropriate, and with the tenant’s agreement, we will involve representatives of these bodies in planning care to ensure that the services we provide are as well co-ordinated as possible.

**15.0 Creating the plan**

15.1 A basic support plan will be formulated before the commencement of service. This will be formulated from the information collected during the initial assessment and any information gathered from other sources during the assessment process.

At commencement of services, the support plan should be populated further by the tenant with the help of the person supporting them.

Care Stream has a support plan template that is actively tailored to allow the tenant to have real input into its formulation. The document is in two sections. Section 1 is specifically for the tenant. It contains personal information, information about people that are important to them, professional contacts, what they enjoy and like to do and sections for them to write about their goals, aspirations and what they wish to do / achieve in the future.

The second section is more formal with the identified needs set out, how these will be met, who by and what the desired outcomes and objectives of the support are. This document does also however have sections for the tenant to write or draw on the plan as they wish, express their views, add photos or pictures and somewhere for them to sign to say they agree to the support. There is a separate document for each identified area where support is required.

There are also personalised consent forms for various areas of the support plan which form part of the document.

The index lists for the support plan file, health action plan and medication file are shown at the end of this policy.

**16.0 Risks**

16.1 All of the risks identified in the initial assessment will be assessed and management plans put in place for each individual, before commencement of service delivery. As the service progresses and the company learns more about the tenant on a personal level and what support is actually being provided, the management plans will be reviewed, and any new risks will be assessed.

The aim of the risk assessment process is to ensure that the tenant is able to live their life in the way they choose which we, as a company, understand will always involve a degree of risk, as does every life and every choice a person makes. It is our aim to ensure that we ensure that risks are minimised as far as is reasonably practicable without this infringing the tenant’s rights in terms of choices.

The risk assessments in place for each person will be documented in the sections to which each particular assessment applies and will be accompanied by management plans.

Care Stream uses a person-centred pictorial document that helps the service user to understand the document and the reason it is in place.

**17.0 Implementing the plan**

17.1 All of those who participate in the creation of the plan must accept responsibility for contributing to its implementation. We believe a plan is for action, and our staff will be supervised and monitored against the plan’s objectives and time scales.

**18.0 Review of care needs**

18.1 Care Stream will carry out the following reviews of service:

18.2 Initially we would expect a six-week review from social services of any new service provision.

18.3 Care Stream would then carry out an initial 12-week review and pass the outcomes of this to the funder.

18.4 After this:

Every 6 months, an in-house review of the service provided and the documentation used will take place. The support plans and risk assessments will be reviewed for continued relevance and effectiveness. Further responsive reviews will take place as required, i.e. should needs change or incidents occur.

18.5 Annually Care Stream will participate in a full-service review with social services.

18.6 Care Stream will facilitate on-going reviews if requested by the tenant at any time. If the tenant or their representative raises an issue regarding the effectiveness of the service and wishes to have the provision reviewed, we will facilitate this.

18.7 Care Stream may also request a review in cases where we feel that the tenant is either not engaging with the provision, has a change in need that we are no longer able to meet, or in any safeguarding concerns where the tenant or other party is at risk.

**19.0 Changes in a tenant’s care needs**

19.1 It is the responsibility of any worker providing agreed support to an individual to report to their manager any significant changes in a tenant’s needs and circumstances. The manager is responsible for considering whether any change in the service is required as a result of the change in need. If so, the manager should initiate a discussion with the tenant, their carer or representative, if appropriate and with the relevant social services department, if necessary. If the change is to be a permanent one, a review will be instigated that will include a variation to the fees and charges. No additional hours will be provided until such times this has been agreed in writing by the funders.

**20.0 Records**

20.1 The initial decisions about the support plan, the risk assessments and any other significant issues will be recorded and should be signed by all parties. Copies of the plan, both in its initial form and as subsequently reviewed, will be held by the registered location and the tenant, except where there are clear and recorded reasons against this or if there is a signed declaration from the tenant stating they do not wish to have this. The plan is in a format intended to be accessible to tenants and others. If appropriate, arrangements will be made to translate the plan into a language the tenant can readily understand.

**21.0 Working with tenants with fluctuating needs**

21.1 **Principles**

* We will only take decisions on behalf of a tenant in accordance with The Mental Capacity Act 2005 and only if there is evidence that they cannot take the decision (at the time it needs to be made) because of mental incapacity. This will have been verified and agreed by their social worker. We will co-operate with relatives and others involved with the tenant in decision making on behalf of a person on the same basis;
* We will not take or collude in taking decisions for a tenant where, from its point of view, there is insufficient justification, and it does not appear to be in that person’s best interests;
* Staff in this organisation will only take a decision for one of its tenants after it has exhausted every means of enabling the person to take it of their own accord. It will also demonstrate its actions in taking the decision are reasonable and in the person’s best interests; Where staff has information that suggests the person might be unable to take some decisions it will carry out, or contribute to, an assessment of that person’s mental capacity that involves the persons MDT. It recognises that the assessment procedure should follow the two-step assessment process recommended in the *Mental Capacity Act*’s Code of Practice;
* This organisation ensures that it complies with all aspects of the law in the cases of tenants who are subject to guardianship proceedings or who need legal protection on account of their lack of mental capacity. Included in this are tenants who have assigned powers of attorney or who are subject to Court of Protection proceedings;
* Staff in this organisation familiarise themselves with and acts upon any advance directives or advance decisions that its tenants have chosen to make in contingency situations where they might lose the ability to take a decision.

**22.0 Assessment of identified capacity issues**

* Staff ensure that a person’s needs assessment and plan of support contain all the information needed that relates to a person’s decision-making capacity, as well as the decisions over which they might need help with, on account of their possible lack of capacity;
* The information included indicates: a) which decisions the person is able to take at all/most times; b) those that the person has difficulty in taking; and c) those that the person is unable to take;
* In respect of each area of decision taking, where there are difficulties or an inability to take decisions the plan of support records the actions to be taken for the person that are deemed in their best interests;
* The individual is always as fully involved as possible. Decisions are only taken on the basis of the best information available and with the agreement of those concerned in the person’s care and future. All decisions taken for that person are fully recorded and made subject to regular review;
* Tenants who lack mental capacity would only be subject to restraint, in any form, when not doing so would result in immediate injury or harm to them or to other people. Any incidents where restraint has been used, must be recorded and reported and an urgent review carried out to identify suitable next steps. NB. It is not the company’s policy to use any form of physical, chemical or environmental restraint on any tenant receiving support. Where such restraint is requested by social services, we will discuss this with them in terms of alternative management and obtaining DOLS through the COP.

**23.0 Staff involvement**

* This organisation requires its support staff to implement the agreements and decisions that are identified in an individual’s plan of support.
* This organisation also expects its staff to involve tenants in all day-to-day decisions that need to be taken by seeking their consent and checking that the actions to be taken are consistent with their plan of support if the individual tenant lacks capacity at the time. Where the tenant needs to take a decision that lies outside of their ability at the time, staff must do everything to help the person decide for herself or himself;
* This organisation expects its staff to avoid taking decisions on behalf of a tenant unless it can be shown that it is necessary and that the tenant at the time is unable to take that decision her or himself. Any such incident must be fully recorded;
* This organisation expects its staff to take decisions for tenants lacking capacity only when they are reasonably believed to be necessary and in the person’s best interests. When in doubt that they can act in this way they must seek advice from their line manager.

**24.0 Choice**

* Choice is of paramount importance for our tenants and this organisation will attempt to advance this principle throughout our operations; we will ensure that every tenant who receives our service has consented. We will work to provide tenants with the opportunities to exercise choice about the workers with whom they interact, and will when possible, change the worker in instances when the tenant requests it. We are particularly sensitive to matching workers and tenants where issues of gender, culture or ethnicity play a role.

**25.0 Related Policies**

Assessment of Need and Eligibility

Support planning

Diversity and Equality

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

**26.0 Training statement**

All staff involved in the Care and Support Planning process will undertake Care Act 2014 training via the Care and Support statutory guidance with particular and emphasis on the chapter 10-13, accompanied by local authority guidance as it becomes available along with record keeping training.

28. Index lists:

**SUPPORT FILE**

| **SECTION** | **CONTENT** |
| --- | --- |
| **1.** | **Transition**   * **Plan** * **Records** |
| **2.** | **Initial Assessment**   * **Care Needs Assessment (Annual re-assessment of needs).** |
| **3.** | **Personal Details:**   * **Pen Picture** * **Consent Form** |
| **4.** | **MCA/DoLS**   * **Capacity Assessments** * **DoLS checklist / applications / authorisations** |
| **5.** | **Missing Person’s Profile** |
| **6.** | **Complaint Policy**   * **How to complain** * **Complaints Record** |
| **7.** | **Service user guide** |
| **8.** | **Service Contract with Care Stream** |
| **9.** | **Funded hours record** |
| **10.** | **Assured short hold Tenancy Agreement**   * **Easy read guide to tenancy agreement** |
| **11.** | **Support plan (Pictorial) Review support plan one year/**   * **Safeguarding Support Plan** * **Restrictions Support Plan** * **Staff read and Sign** |
| **12.** | **Risk Management**   * **Risk Checklist** * **Risk Assessment** * **Staff read and sign** |
| **13.** | **Behaviour Plan** |
| **14.** | **Goals and Aspirations** |
| **15.** | **Weekly activities Programme** |
| **16.** | **PEEPS** |
| **17.** | **Incident / Accident reports**  **Analysis** |
| **18.** | **Document review**   * **Staff read and sign** |
| **19.** | **Monthly Key-Worker’s Report/Pass system** |
| **20.** | **Reviews** |
| **21.** | **Financial Information** |
| **22.** | **Professionals Contact Sheet** |
| **23.** | **Previous Information** |
| **24.** | **Correspondence in/out** |

**HEALTH ACTION PLAN FILE**

| **SECTION** | **CONTENT** |
| --- | --- |
| **1** | **Health Action Plan Document** |
| **2** | **Record of appointments**   * **Annual Health Check** * **Dentist** * **Optician** * **Psychiatry** * **Psychology** * **Chiropody** |
| **3.** | **Hospital Passport** |
| **4.** | **GP Details** |
| **5.** | **Correspondence** |

**MEDICATION FILE**

| **SECTION** | **CONTENT** |
| --- | --- |
| **1.** | **Medication Times Colour Code** |
| **2.** | **Medication administration consent** |
| **3.** | **Medication Policy** |
| **4.** | **My medication Profile**  **How I like to take my medication**  **MARR sheets with counter signed copy**  **PRN Protocols/ Guidelines**  **Patient information leaflets / easy read guides**  **Blank medication error form** |
| **5.** | **Medication Risk Assessment** |
| **6.** | **Self-administration assessment** |
| **7.** | **List of current staff administering medication** |
| **8.** | **Medication discharge sheet** |
| **9.** | **Medication cabinet /fridge temperature** |
| **10.** | **Professionals contact sheet regarding medication** |
| **11.** | **Weekly Medication Audit** |