Care Planning Policy

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1 INTRODUCTION - CARE PLANNING

In order for clients to receive the care and support they are looking for, 1st Homecare will undertake a number of steps at commencement of the service and throughout the duration of providing a service to clients.

2 CONDUCTING INITIAL ASSESSMENTS

Before the commencement of any care or support to a client, an initial assessment will take place in the client's home. This will be carried out to:

- assess the needs of the client. This will include assessing what if any communication and information needs he or she may have for the purposes of the Accessible Information Standard
- identifying any risks or hazards to the client and carers arising in the home environment and ways of avoiding or reducing them.

Where the support required by the client will include tasks necessitating moving and handling, the assessment will include a moving and handling risk assessment. Where, due to the client's physical or mental condition, support with medication is required, a medication risk assessment will be conducted. A mental capacity assessment will also be carried out where appropriate. The policy and procedures with regard to risk assessments are set out in the Risk Assessment Policy. The risk assessments will be subject to ongoing review, both in the initial phase after commencement of care and throughout as required by any changes in the client's condition or circumstances.

3 THE CARE PLAN

3.1 At commencement of the service

Having completed the initial assessments, the assessor will compile the Care Plan. The Care Plan will document the person-centred care needs of the client as established by the assessments and following careful discussion with the client. Family, any relevant friends, an advocate or person officially appointed to act on the client's behalf (e.g. a person with a registered health and welfare Lasting Power of Attorney), will be involved and consulted in the preparation of the Care Plan, as appropriate. The input of the client's GP and any other appropriate person, such as an Occupational Therapist, may be sought as well.

The Care Plan will set out among other things:

- The personal details of the client including their background history, interests and likes and dislikes
- Any allergies the client has
- If he/she has diabetes, that fact and the type
- Whether the client self-medicates or whether the carers will need to prompt, assist or administer medication to the client

- The care and support the client will receive
- Whether any person is legally appointed to act on the client's behalf and to what extent; and the client's known prior wishes and beliefs, if any, to help with decision making in the client's best interests, and any advance decisions to refuse treatment
- Any family member(s) or other person providing care and support to the client
- The tasks to be achieved
- The outcomes the client wants and the ways of achieving these
- Any communication and information needs he or she may have for the purposes of the Accessible Information Standard.

Where the care has been commissioned by a local authority or other body e.g. CHC, the Care Plan should reflect the care that is being commissioned as set out in the commissioning document.

The Care Plan is created in digital form on Access Care Planning, the care planning system used by 1st Homecare. The staff member who is writing the Care Plan will go through the Care Plan with the client once prepared, and the client will be asked to sign to confirm his/her agreement to the care and support to be provided as documented in the Care Plan, or if the client lacks capacity, a person acting lawfully on behalf of the client or a person acting in his/her best interests, as appropriate, will be asked to sign to confirm agreement.

The Care Plan can be viewed by the client's carers on their Company issued mobile telephones, by the client and/or by the client's Next of Kin (if any), who have the Next of Kin app set up.

3.1 Reviewing the Care Plan

The Care Plan will be reviewed annually or as frequently as may be required due to the changing care needs of the client.

4 CAPACITY AND CONSENT

It is a fundamental principle that people should be able to make their own decisions about their care and support. The agreement and consent of the client will be sought before any care and support is provided. When the Care Plan is drawn up and thereafter when it is reviewed, the consent of the client will be sought to the care and support set out in the Care Plan. Where there is evidence that the client may lack capacity, an assessment of capacity will be conducted in accordance with the Mental Capacity Act 2005, and a record of the assessment will be made including details of the extent to which the client is able to understand and make decisions about specific aspects of the Care Plan and how his/her care is provided. The carers will always seek the consent of the client before undertaking tasks for the client.

If the client's capacity may fluctuate, this should be documented. Where the client's capacity may depend on the time of day and effect of medication, or where the client may have fluctuating capacity eg. due to dementia, this will be documented also.

If the client lacks capacity, the Company will obtain information about any person who has legal authority to make decisions about the client on his/her behalf and the extent to which the person has power to do so. If a best interests' decision is required, the person making the best interests' decision will sign the Care Plan.

5 GENERAL

This Policy may be amended by the Company at any time as may be required and shall be reissued in this case and staff will be notified of the amended Policy.

CHANGE HISTORY

Issue	Date	Description of Change and Reason
1	October 2014	First Issue
2	June 2016	Second issue – change of address and care planning requirements of the Mental Capacity Act 2005
3	July 2016	Third issue – inclusion of reference to Capacity Assessment, deletion of references to action taken to meet the assessed needs of the client, personalising within the bounds of outcomes and regulations, and individual procedures regarding risk taking and aggressive, abusive or self-harming clients
4	November 2016	Fourth Issue – addresses of both offices added, logo added, wording amended to cover both offices, grammatical errors amended.
5	January 2017	Fifth Issue – to make applicable to LB and Oxford, also tidying up.
6	October 2018	Sixth Issue – change of address, change of reference from Care Manager to Branch Manager
7	January 2019	Seventh Issue – Care Plan to be reviewed annually unless required more frequently due to the changing care needs of the client
8	January 2020	Eighth Issue – Inserting KL address and inclusion of reference to Accessible Information Standards
9	July 2021	Ninth Issue – Amendments made to reflect the introduction of Access Care Planning, the digital care planning system used by 1st Homecare. Amendments to reflect the changes to the assessments made at commencement of the service.
10	July 2022	Tenth Issue – Amended wording about risk assessments, also addition of wording about carers seeking the consent of the client before undertaking tasks.

DOCUMENT CONTROL

Name of document	Care Planning Policy
Status	Approved
Issue	10
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Maintainer	1HC
Owner	1HC
File name	1HC Care Planning Policy

File location	Policies and procedures/Care
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