OA Day Care	OA Residential Care	Domiciliary Services	DMH Day Services	DMH Supported Living	DMH Residential Services	EIA'd
x	✓	x	x	x	x	✓

P14
PERSON CENTRED CARE PLAN

POLICY

To ensure all service users have a comprehensive person centred care plan package and staff promote the service users independence, chosen life style choices and identified needs whilst respecting their dignity at all times.

PROCEDURE

1. All people using the services will have a person centred care plan (PCCP) package. This will cover all aspects of a person's life and identified needs. Any identified risk will be documented on the general risk assessment form.

REFERRAL / ADMISSION

2. On receipt of a referral it is essential that a meeting with the service user be agreed ideally within 48 hours of a referral. This should be completed by visiting the service user and where possible the Social Worker, other professionals and family etc may also attend. Occasionally it may be necessary to complete an assessment via the telephone.

3. During the initial visit with the service user, the Part 1 "What's important to me" form must be filled in alongside the dietary assessment form, which will then form part of the M10 Malnutrition universal screening tool. This will record the pre-admission assessment and also be the basis for the first full PCCP and should be drawn up with the involvement of the service user, carers, family, advocates, representatives of the relevant agencies and specialists as required.

4. If after the pre-admission assessment it is agreed that the needs of the service user cannot be met, the service user and Social Worker must be informed and the reason explained.

5. Page 1 of Part 1 of the PCCP should be fully completed no later than the first day of the service user's admission to the establishment. A full part 1 of the PCCP should be completed by the end of the first week of admission.

6. When completing a person centred care plan relevant risk assessments and the personal emergency evacuation plan (PEEP) F5 must be a key factor whilst maintaining the service user's individual life choices and independence.

7. This initial Part 1 "what's important to me" will become care plan 1. Any subsequent changes from there onwards will initiate changes to the numbered care plans. The dietary information must be transferred onto the MUST tool once the service user has been weighed on admission. Any old numbered care plans and the dietary assessment must be held on the service user file S10 under section 3.

8. The Part 2 hospital passport must also be filled in on admission and held with the person centred care plan. This must be reviewed monthly or earlier if the need arises. A copy of the Part 2 hospital admission form must be used in the event of a service user being admitted to hospital. Where the service user has a known infection diseases, hospital staff / Emergency Services must be made aware that PPE is required. Where applicable the DNACPR record must also be attached with the hospital passport.

9. Any known behavioural management / physical intervention strategy must be in place with an appropriate risk assessment on admission. These must be put in place within the first week of admission. There will be a 6 week post admission review with all relevant parties which can then be fully agreed.

10. The B2 body map must be completed on admission and at any time where the individual is admitted to hospital, or for recording any other visible signs of injury. This record must be kept on the service users person centred care plan.

11. On admission ensure each service user has a daily diary is in place and it is completed after every shift from this point onward. This will be held with the care plan. The supervisor will also hold a book in the main office to record information such as GP / professional visits / maintenance repairs etc. Any specific service user related information must e.g transferred to the diaries held on the care plan.

UPDATING THE PCCP

When reviewing any part of the PCCP you must consider whether the review requires specialist input from other professionals such as GP, District Nurse, Physiotherapist, Occupational therapist, Chess Team etc.
Questions to ask yourselves: Does this individual have the mental capacity to make informed choices for themselves, are DOLS required, is a best interest / multi-agency meeting required?

12. The Part 1 "what's important to me" should be used to identify any permanent changes that may have been identified either by the carer

or supervisor. Changes identified by the carer must be fed back to the supervisor and written in pen on the PCCP and / or the M10 MUST Tool and must be signed and dated.

13. The supervisor must decide if these changes are immediate or if they can wait until the review period. If immediate this must be followed up and a new care plan written with a new number attached.

14. All changes should be signed and dated.

15. The plan is drawn up with the involvement of the service user, together with carers, family, advocates, representatives of the relevant agencies and specialists as required. All parties will be consulted as appropriate, with the aim of establishing the service users changing needs and personal outcomes and to review and update the current PCCP.

16. The manager/supervisor will audit this policy as part of the policy and procedure audit schedule.

DOCUMENTATION (has to be reviewed monthly or earlier if the need arises, and should be held in the following order):

P14 Part 1 "What's important to me" – to be used to record identified needs starting from pre-admission and ongoing.

- What I can do / what I like – this section must identify the service user's abilities, personal choices, likes and dislikes.

- How I need you to support me – this section must identify how staff can allow the service user to maintain independence, choice and preference, offer practical and emotional support when needed whilst promoting positive risk taking.

- Person responsible – this is the person who provides the support to the service user.

- Must be used by staff to inform others of any changes that may initiate a review of the whole care plan.

- Any changes to this document must initiate a new version (remember to change the care plan number at the top of the document)

- Each time a change to the care plan is made the agreement must be signed and dated by relevant parties.

- Must be reviewed monthly.

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P14 Part 2 Hospital Passport – this provides initial information relating to the service user's name, date of birth, next of kin etc. This must be the first document of the person centred care plan package. A copy of the hospital admission form must be used in the event of a service user being admitted to hospital. This must be reviewed monthly, which should be recorded in the box provided on the last page. Any additional information in relation to the medical treatment of the service user should also be stored in this section e.g DNACPR, Advanced care statement. If a DNACPR is in place the form should also go with the hospital passport to hospital.

Initial Dietary Assessment form – this must be completed with the service user alongside the Part 1 (at pre-admission stage), prior to admission. This form must stay on the person centred care plan until the M10 Malnutrition universal screening tool is in place and reviewed. The dietary assessment can then be moved to the S10 file.

M10 MUST Tool – Must be completed on admission and reviewed monthly thereafter. Where there is a high risk the service user must be weighed weekly.

Manual Handling Records – Must be completed on initial assessment and reviewed monthly.

Risk Assessment – If applicable – must be completed at admission and reviewed monthly.

PEEP (Personal emergency evacuation plan) – Must be completed on initial assessment and held with the person centred care plan. The detailed results should be included and updated if required on the PEEP spreadsheet and held in the emergency box. This must be reviewed as and when the need arises (at least annually).

B2 Body Map – The body map must be used on admission and at any time where the individual is admitted to hospital, or for recording any other visible signs of injury. This record must be kept on the service users person centred care plan. Each time a service user is supported with personal care the staff member must check for any signs of bruising / sores / scratches / redness on the body. Where there are visible signs that a change in the skin condition has occurred this must be documented onto the body map and it should be reflected on the person centred care plan. The supervisor / manager must also be informed. It may require the GP / District nurse to be informed. Where this is the case the GP / District Nurse instructions must be followed and recorded on the person centred care plan and in the daily records. The sore must be monitored until it has healed. Where there are concerns that this may need referred to the safeguarding team the manager must be informed. The

manager must take appropriate action and follow the safeguarding procedures.

Service user daily diary– must be used by staff to record details about the service user's day after EVERY shift. Always ensure a time / date is recorded with each entry and is signed by the member of staff. Any issues of concern about the service user which needs to be reported to the supervisor must also be recorded.

Supervisor diary - The supervisor must hold a book in the main office to record information such as GP / professional visits / maintenance repairs etc. Any specific service user related information must be transferred to the diaries held on the care plan.

Any information the supervisor records must include time of visit, name of professional, date of visit and why. Where it relates to a GP / professional visit the following relevant code must be entered on the top of the page of the service user's daily diary to identify who has visited:

G.P – Doctor DN – District Nurse C – Chiropodist OT – Occupational Therapist
D – Dentist O – Optician H – Hospital SW- Social Worker
CPN- Community Psychiatric Nurse O - Other

All diaries must be A4 size.

In General

All records must be completed fully with signatures of the person completing the document, signatures of service users and or relatives / advocates as appropriate and forms dated. All entries should be legible, accurate and factual.

REVIEW MEETING

1. A review of the whole person centred care plan must take place monthly or earlier if the needs of the service user change. It may involve the service user, relatives / advocates and other agencies where appropriate.

2. The service user's link worker and designated supervisor will update the person centred care plan package with the service user to reflect the changing needs. The agreed changes must be recorded, actioned and circulated to the relevant people.

ACCESS TO PERSON CENTRED CARE PLAN PACKAGE

1. All service users shall have access to their person centred care plan.

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2. The current person centred care plan should be kept in a lockable cupboard in suitable storage for staff to access on a daily basis.

3. Copies of all previous person centred care plans must be maintained in the service users file in the office in lockable storage.

4. Access to information will comply with the requirements of the Access to Information Act.

RESPITE / EMERGENCY ADMISSIONS

1. All relevant information as above must be gathered on admission from appropriate sources available as far as practicably possible, thus enabling Cumbria Care to meet the individual identified needs of the service user. An A4 diary however must be completed from day 1 of admission. If a respite service user returns to Cumbria Care, but to a different location, the diary must be transferred to the new place of care.

RESPITE / EMERGENCY DOCUMENTATION (To be used as above unless stated otherwise below)