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

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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 and respect their dignity at all times.

PROCEDURE

1. All people using the service will have a person centred care plan, which is generated from an assessment on referral. These will cover all aspects of personal care, social support and health needs. The plan will set out how current and specialist requirements will be met and describes who will be responsible for achieving the goals. Any identified risk will be documented on the risk assessment form.

2. The plan is drawn up with the involvement of the service user, together with carers, advocates, representatives of the relevant agencies and specialists as required.

3. All parties will be consulted as appropriate, with the aim of establishing the service users changing needs and personal goals and to review the current person centred care plan. Any changes will give an up to date person centred plan.

4. Maintaining independence and producing relevant risk assessments and personal emergency evacuation plan (PEEP) F5 must be a key factor when completing and reviewing a person centred care plan.

5. On receipt of a referral it is essential that a meeting with the service user be agreed. The pre-admission / person centred care plan form Part 3 must be completed with the service user ideally within 10 working days of a referral. This should be completed by visiting the service user or the service user visiting the day centre and where possible other professionals / family etc may also attend.

6. If after 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.

7. During the meeting with the service user the Pre-admission / person centred care plan form Part 3 and the Referral form / information Part 1 must be completed.

8. The person centred care plan package and any known behavioural management / physical intervention strategy must be in place with an

appropriate risk assessment on admission. The pre-admission assessment / person centred care plan Part 3 must be commenced on admission and in place within 4 weeks of the admission. It can then be agreed by all parties at the 4-week post admission review.

9. The stories and gifts form Part 2 needs to be completed with the service user, family or advocate along with the pre-admission assessment / person centred care plan Part 3.
This can also be used as an ongoing document to ascertain the service user's history. The service user and or family will be offered the opportunity to participate in life story work. The service user / family can opt not to participate if they feel this is not appropriate. If the service user / family have opted not to participate this should be re-visited at review, as they may wish to participate at a later stage.

10. The person centred care plan package can be reviewed by the link worker who must feed back any important information to the supervisor on a regular basis using the monthly changes form Part 4. A minimum of 6 monthly formal reviews must be completed, dated and signed by the supervisor / manager using the same form. The review must consist of the whole person centred care plan, all relevant risk assessments and manual handling assessments. The service user's relative / advocate may also be invited to contribute to the review.

11. Part 4 monthly changes form must be completed with any changes documented and actioned.

12. The supervisor must read the amended person centred care plan Part 3 in the top box's provided and must sign and date.

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

EMERGENCY ADMISSIONS

1. All relevant information 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.

Documentation

- **Communication file front sheet** – The name and address of the service user must be inserted and a recent photograph must be attached to the form. This form must be used as part of the Person centred care plan file.

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✓	x	x	x	x	x	✓

P14

- **Hospital Admission** (H2 in policy and procedures manual) – This form must be used if a service user has to be admitted to hospital.

- **Daily record** (Part 5) / **monthly changes sheet** (Part 4) - to be used by staff to record details about the service users day. Any issues of concern about the service user, which needs to be reported to the supervisor, must be recorded in the action-required column. The monthly changes sheet Part 4 can also be used to inform the supervisor of any changes.

- **Pre-admission assessment / Person centred care plan** (Part 3) – This form must be completed on initial assessment. Please use the first main box as prompts only to ascertain the service user's individual choices (What I can do now / how I would like to be supported). The person centred care plan agreement must be signed and dated by relevant parties on initial assessment. This form only needs to be completed once and held on file.

- **Referral / information** (Part 1) - This provides information such as next of kin, G.P, Marital status etc. This form is to be completed as the referral is taken or when on the visit to talk to the service user / family alongside the pre-admission assessment / person centred plan (Part 3).

- **Statement of purpose and service user guide** (S3 in the policy and procedures manual) – the service user / family must receive a statement of purpose and service user guide to gain relevant information from. The service user / family and the supervisor must both sign and date the back sheet of the document and a copy of this must be given to the service user and the original kept in the service users file.

- **Pre-admission assessment / Person centred care plan** (Part 3) - to be used to record identified needs from the pre-admission assessment form Part 3.
  - 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.

  - The person centred care plan agreement must be signed and dated by relevant parties on initial assessment. This form only needs to be completed once and held on file.

- **Stories and gifts (**Part 2) - this from provides relevant information about the service users life experience. It includes family links, previous work details, religion, hobbies etc. This form must be completed within the first 6 months of the service user coming to day services. This information can be collected via the family and friends or through life story work. The service user must be asked if he/she would like to have the opportunity to participate in life story work. Please identify how all the information on the form has been gathered.

- **General risk assessment / manual handling risk assessment forms / PEEP** (S10 in the policy and procedures manual) - These forms are to identify any risks to the Service User, staff and others.

- **Medication risk assessment** (M4 & S10 in the policy and procedure manual) – This form must be completed to ascertain issues such as whether the service user self- medicates.

Reviewing meetings

1. A formal review of the person centred care plan must take place at least 6 monthly using the monthly changes Part 4. The service user must be supported to attend the meeting with relatives / advocates as appropriate.

2. The service users designated supervisor / carer will update the care plan with the service user to reflect the changing needs. The agreed changes are recorded, actioned and circulated to the relevant people.

Access to person centred care plans

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

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

3. Access to information will comply with the requirements of the access to information Act.