Reshaping Care and Support Planning

Guidance notes

Guidance notes on personalised and outcomes focused care and support planning

Who are these notes for?

These guidance notes are intended for staff and managers in the care home and care at home sectors. People who use these services and their families might also be interested in them.

What is personalised and outcomes focused planning?

Personalised care and support plans should empower the person, promote their health, wellbeing and independence and should involve the person in making decisions about their care, support and daily life. This means listening to people, finding out what matters to them, and finding out what care and support they need to remain as independent as they can and to have the best quality of life possible. A plan is outcomes focused if it identifies the outcomes – or what the person wants to achieve or change in their life. An outcomes focused plan gives clarity of purpose and a sense of direction. This includes identification of what needs to happen to achieve the outcomes and also who will be responsible for achieving them.

A good care and support plan will include details about the person's history and who is important to them. It will identify the outcomes important to the person, as well as detailing how they want to manage their daily life. Care and support planning should address the full range of needs and outcomes of the person. It is not just about health, but also about social life, family, mental health, cultural background and spirituality. Where possible, a plan should include a photo of the person. Any staff member reading the plan should have a good sense of the person and their character, not just what they do on a daily basis. Where it is difficult to obtain the person's history, as might be the case with some people with advanced dementia and with no family contact, staff might need to work harder to find out what what they can about what matters to the person.

Many older people using long term care services have one or more long term condition. Within one service, people may also have very different levels of cognition, or understanding, of their condition and of what is going on around them. Depending on their needs, there may be several people involved in personal planning with the individual. A successful personal plan involves the person as far as is possible in contributing to the planning process. As a minimum, the person should be involved in identifying their outcomes, or what matters to them, and as far as possible should be involved in agreeing how the outcomes should be met. Many people will be able to play an active role in achieving their outcomes. Good support planning should enable the person to have strategies in place to cope with any deterioration in their health.

What are the benefits of personal planning?

The main aim of personalised, outcomes focused planning is to maximise quality of life and independence . The more the person is involved in the planning process, the more chance there is of making the most of their life, even at the end of life.

Particular care should be taken to ensure that people going through transitions in services have the earliest opportunity to be involved in their personal plan. Moving from one service to another or between settings can be a time of great anxiety and uncertainty for the person and their family. Involving them in decision-making and getting to know them at the earliest stage can help to smooth the transition. This also benefits staff, who enjoy developing relationships with people and their families. It also benefits staff because people who are unwell and/or

experiencing confusion through dementia, can be more challenging to work with if they are anxious or distressed.

Planning ahead

Anticipatory care planning means planning ahead and knowing what the person would like to happen if their health deteriorates, including if they become unable to make decisions for themselves. Not every person wants to do this and sensitivity is required. However, individuals and relatives have reported great peace of mind and reassurance from anticipatory care planning.

How do multiple care plans feed into an overarching personal plan?

A person may have one or several treatment/care management plans, depending on the complexity of their health and wellbeing. The range of plans which a person might have include;

Communication support plan

Multifactorial falls assessment

Medical Administration Records

Dietary plan

Continence plan

Anticipatory care plan

Medication management plan

Specific conditions plans, including skin/wound care/tissue and mobility

Some people may only require one or two of these plans to be completed. Where there is, for example, a single issue of note with regard to diet, such as vegetarianism, it might be more sensible to record this in the personal plan, without completing an entire dietary plan. Each plan will exist in its own right, and may have been completed by different members of staff. They should all however, feed into an overarching personal plan, providing key information relevant to the person and their daily routines. This core plan should ensure that everybody involved in working with the person understands what needs to happen to support their wellbeing, independence and quality of life. Professionals from other services should be familiar with the personal plan so that they understand how their intervention fits with the person's outcomes.

How do we ensure that the plan is put into action?

Personal plans record what matters to the person as well as what is important about their daily routines. In both sections of the personal plan it should be clear what needs to happen and who is responsible for making sure it happens. To support independence, this means that not all the actions are the responsibility of staff. The plan should record where the person is involved in doing things for themselves, both in daily routines and in achieving their outcomes. Where issues need to be communicated to non-care staff (e.g. kitchen staff in a care home) this should

be recorded in the personal plan. Where a person is too unwell to complete tasks for themselves, it is still important that what matters to them is considered and enacted by staff.

How do we include people with communication support needs in personal planning?

Many older people using long term care services have communication support needs. Qualified and unqualified staff can benefit from training opportunities in communication support and working with people with dementia. Ideally, opportunities should be available for staff to regularly revisit these skills and share good practice, possibly at staff meetings. A variety of tools can be used to involve people with communication support needs in planning their support, such as memory boxes and photographs. Talking Mats, which involves using pictorial symbols to construct a support plan which can then be photographed and kept on record for the person, can be used with people at the earlier stages of dementia. For people at later stages of dementia, the observational skills of staff in identifying what matters to the person and family contributions might play a bigger role.

Day to Day Recording

It is important to get a good balance with record keeping so that staff do not spend more time writing than they spend working directly with people. For example, on a day to day basis, it is not usually appropriate to record every intervention undertaken with each person. However, it is not sufficient to simply record 'all care given' on a daily basis. Staff should comment briefly on whether there are any changes evident in health or wellbeing of the person as well as how they are managing with daily activities. If it is not possible to complete interventions with a person, this should be recorded, with reasons. This is known as exception reporting. If any issues arise which might require a change to a specialist plan e.g. a deterioration in a skin condition, or an improved skill in the person, this should be recorded. Such changes should be recorded in both the specialist plan where relevant, and the core plan along with a note of who advised the change, the date and the signature of the member of staff.

What is the purpose of review?

Regular review of personal plans can be overlooked in busy services but should be a priority. Review is important because individual needs and outcomes can change quite quickly and this may require substantial changes to how staff care for and support the person. Some reviews might result in no changes to the core plan, but often they result in significant increases or reductions in the amount or type of care and support required. Again, as far as is possible, the person and their family if appropriate, should be involved in making decisions at their review, in considering whether their outcomes are being met, and in deciding on any changes required.

Who else might see the plan?

Records should be kept securely locked in accordance with the Data Protection Act. The only other people who might see the personal plans, other than the person, their family and directly involved staff are the regulators. The regulators check on care and support services to make sure that they are doing their job properly and that the people in their care are as well as possible. Staff should be aware that personal plans are important evidence for regulators, who want to know that the person's care and support needs are being met and that their outcomes are being considered and worked towards as far as possible.