# Person Centred Care Plan

# Westmorland and Furness Care Services

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# OA Residential

## 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. Staff must highlight where there are any conflict of interest and have a relative in the care home who they are going to be supporting. The service user / family / advocate will then be asked if the records will

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 Electronic care plan individual risk assessment or general risk assessment form.

### Referral / Admission

1. On receipt of a referral it is essential that a meeting with the service user be agreed ideally within 48 hours of a referral D2A assessments completed after admission dependent of pathway . This should be completed by visiting the service user and where possible the Social Worker, other professionals and family etc may also attend. It may also be that a link worker is identified and invited to the meeting, this will allow the link worker to get to know the service user and family and will help with the settling in process and ongoing support once in the service.

Occasionally it may be necessary to complete an assessment via the telephone or virtual media.

1. During the initial visit with the service user, [OA Residential Part 1 – What’s Important to Me](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523695233.docx) form must be filled in alongside the dietary assessment form Special dietary needs, which will then form part of the Malnutrition universal screening tool. This will record the pre-admission assessment and also be the basis for the first full ECP and should be drawn up with the involvement of the service user, link worker, family, advocates, representatives of the relevant agencies and specialists as required.
2. 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.
3. Page 1 of the PCCP on the ECP should be fully completed no later than the first day of the service user’s admission to the establishment. A full ECP should be completed by the end of the first week of admission.
4. When completing a person-centred care plan relevant risk assessments and the personal emergency evacuation plan (PEEP) must be a key factor whilst maintaining the service user’s individual life choices and independence.
5. This initial [OA Residential Part 1 – What’s Important to Me](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523695233.docx) will be transferred on to the ECP care plan. Any subsequent changes from then on will initiate changes to the ECP, highlighted in the review/meeting section and threaded through the ECP. The dietary information detail must be transferred onto the ECP MUST tool once the service user has been weighed on admission. Any old service user documents need to be scanned into the ECP and all up to date relevant information.
6. 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
7. Any known behavioural management / physical intervention strategy (individual handling assessment)/positive behaviour support 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.
8. The B2 body map must be completed on admission and at any time where the individual is admitted to/discharged from hospital, or for recording any other visible signs of injury. This record must be kept on the service users person centred care plan.
9. On admission ensure each service users daily notes are completed after every shift from this point onward. 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 be transferred to the daily notes held on the ECP.

### Updating the PCCP

When reviewing any part of the PCCP you must consider whether the review/meeting section requires specialist input from other professionals such as GP, District Nurse, Physiotherapist, Occupational therapist, Chess Team etc and recorded in detail and ensure the information/outcome are threaded through the service users ECP.

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?

1. The [OA Residential Part 1 – What’s Important to Me](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523695233.docx) initial assessment 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 via the ECP notification system and to all relevant in-house parties
2. 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 an update recorded in the review/meeting section and all relevant parties informed via the ECP notification system ensuring the monthly review (or sooner when required) is completed in a timely manner
3. All changes should be acknowledged in the review/meeting section once threaded through all relevant parts of the care plan
4. The EPC 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
5. The manager/supervisor will audit this policy as part of the policy and procedure audit schedule using the P5 tool.

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

EPC “what I can do” and “how I need you to support 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 keyworker/link worker – this is the person who provides the additional support to the service user as well as the daily care shared between the team.
* Must be used by staff to inform others of any changes that may initiate a review of the whole care plan, using the ECP notification system.
* Any changes to this documentation must initiate a new revied
* Each time a change to the care plan is made the agreement must be acknowledged and by the supervisor and service user and recorded in the daily notes notification can be sent to all parties informing them of a change and consent
* Must be reviewed monthly

If a DNACPR is in place the form should also go with the hospital passport to hospital.

**C9 Specialist dietary form** – this must be completed with the service user alongside the [OA Residential Part 1 – What’s Important to Me](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523695233.docx) (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, if service unable to be weighed on the scales Bapen should be used to monitor weight, if service user is in hospital then this should be highlighted on the MUST tool until discharge then weight should be recorded for changes.

**Mobility & Dexterity Section**- 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 the ECP on admission initial assessment. 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 notes** – 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 and a notification sent to all relevant parties.

**Supervisor diary notes** - Should be written in blue and a notification sent to the relevant team members when a concern has been highlighted. The supervisor must hold a communication 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.

#### In General

All records must be completed fully and not held in draft format but finalised before the end of shift. All entries should be legible, accurate and factual.

### Review Meeting

1. A review of the whole ECP 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 ECP package with the service user to reflect the changing needs. The agreed changes must be recorded, actioned and circulated to the relevant people through the notification system.

### Access To Person Centred Care Plan Package

1. All service users shall have access to their ECP. person centred care plan.
2. The ECP’s are now fully accessible for all staff via their login accounts all laptops when not in use should have the screen lock activated ensuring GDPR.
3. All relevant documents should be scanned on to the ECP system and held in the scanned documents section.
4. Access to information will comply with the requirements of the Data protection Act and 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. The daily notes 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 the ECP can still be accessed in full the secondary address should be updated to highlight the move.

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

# Disability and Mental Health

## Policy

To ensure all service users have a person centred care plan which supports and promotes their independence, life style choices and assessed needs, whilst respecting their dignity at all times.

## Scope

The personal support plan ([DMH Personal Support Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523612012.docx)) forms the basis for, and gives a clear framework to, how we plan support to meet the assessed needs and choices of the individual service user in a person centred way.

The personal support plan is the main responsibility of the supervisor / senior support officer. It should be completed through consultation with the service user, family, advocates, carers, support staff and other professionals / agencies as appropriate.

## Procedure

1. The [DMH Appendix 6 – Getting to know you!](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523694822.docx) must be completed prior to the service user commencing the service. This should be issued to the service user or their representative for completion. The information from this should be used to provide initial care and support to the individual. Once the personal support plan is completed in full this document should be archived, preferably as a pdf document.
2. Section 1 of the personal support plan must be completed immediately on the service user’s admission. This contains important personal and health information about the individual and should be completed in full.
3. Section 2 of the personal support plan is the one page profile. This must be completed within the first week of the service user commencing the service. It should detail essential information about the choices and support needs of the individual, enabling staff to support the person effectively. Examples can be found on the Helen Sanderson Associates website

<http://helensandersonassociates.co.uk/person-centred-practice/one-page-profiles/>

There is a section for Social Care with examples of one page profiles for a person with autism and a person with dementia. The Health Care section has an example of a one page profile for a person with mental health issues.

1. Section 3 of the personal support plan is the person centred support summary and associated protocols.

The summary of person centred support needs should be completed in full. There is space to add any needs not already identified. If the person requires support or prompting in any area, then [DMH Appendix 1 – Protocol Recording Form](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/452369337.docx) detailing how support will be provided must be completed. This should contain sufficient information to enable staff to support the person fully. If the individual does not require support, then no protocol is required.

Each protocol must be numbered, and the number recorded on the summary of person centred support needs section. Each protocol must detail how choices have been made or consent given. If the individual lacks capacity to make choices or decisions for themselves, then it must be recorded how a best interest decision has been made on their behalf. Examples of protocols can be found at [DMH Appendix 2a – Example Protocol Continence](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523693611.docx) and [DMH Appendix 2b – Example Protocol Getting Up](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523693729.docx).

1. The personal support plan must be fully reviewed 6 monthly. This must be recorded on page 2 of the support plan – review section. All columns must be completed including date, name, changes made and date of next review. If there have been no changes during the six month period the review form should state “no changes”.
2. During the 6 month period, notes may be made on the personal support plan detailing any changes and updates required. These notes must be initialled and dated. Following review, notes should be typed into the document, the document “saved as”, and a new plan printed for everyday use.
3. [DMH Appendix 4 – Contact Information Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523694049.docx) must be used for logging any contact with the person’s family, friends, involved professionals and any other significant occurrences. Page 2 of the personal support plan must record where these sheets are stored. Sheets should be kept where they are easily accessible for recording information immediately. Contact sheets should be clearly numbered in consecutive order, and completed sheets should be archived into the service user’s file (S10).
4. Section 4 should contain any relevant and current assessments or strategies in place to support the individual’s needs. This could include risk assessments, IPHP (M2), epilepsy recue protocol etc.. These assessments and strategies should be reviewed in line with the personal support plan reviews. Updated documents should be “saved as”. If an assessment or strategy is no longer required it should be archived, preferably as a pdf document. The index of current assessments should be updated whenever an assessment or strategy is reviewed, updated or added.
5. Section 5 should contain the most recent review minutes / notes and details of consultation held with the service user. An example form for recording review notes is at [DMH Appendix 3 – Review Notes](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236125054.docx) and [DMH Appendix 5 – Example Consultation Questions Form](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523694627.docx). Previous review notes and consultation documents should be archived, preferably as pdf documents.

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### Saving documents

* Each service user should have a separate folder within the service shared folder on the intranet.
* This should contain all current documents related to the care and support of the service user.
* The folder should contain an archive file, where any previous documents must be stored for future reference if required.
* New documents should be saved in the format:
* ND Personal Support Plan 2016.10.19
* Please use the date format YYYY.MM.DD as this will save documents in date order.
* Any updates must be “saved as” with the same title, but with the date in the file name updated to the date changes have been made. This should correspond with the review record on page 2 of the personal support plan.
* **To “save as”** – Open the document then click on the File tab at the top left of the screen – click on ‘save as’. Update the file name then click save. Then make any required changes and save prior to closing the document.
* This provides an ongoing record of changes to support provided.
* All documents, including protocols, risk assessments etc. should be saved in this way.

# OA Day Care

## 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. [OA Day Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236105913.docx) / [OA Day Care Part 3 – Pre-Admission Assessment Centred Care Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111017.doc) 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 [OA Day Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236105913.docx) / [OA Day Care Part 3 – Pre-Admission Assessment Centred Care Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111017.doc) and [OA Day Care Part 1 – Referral Information](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523610025.docx) 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 [OA Day Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236105913.docx) / [OA Day Care Part 3 – Pre-Admission Assessment Centred Care Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111017.doc) 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. [OA Day Care Part 2 – Story and Gifts](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236104916.docx) needs to be completed with the service user, family or advocate along with [OA Day Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236105913.docx) / [OA Day Care Part 3 – Pre-Admission Assessment Centred Care Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111017.doc)..

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.

1. 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 [OA Day Care Part 4 – Monthly Changes](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111130.docx). 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.
2. [OA Day Care Part 4 – Monthly Changes](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111130.docx) must be completed with any changes documented and actioned.
3. The supervisor must read the [OA Day Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236105913.docx) in the top box’s provided and must sign and date.
4. 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.

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### 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.
* **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 (**[OA Day Care Part 5 – Care Daily Record](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111251.docx)**) / monthly changes sheet (**[OA Day Care Part 4 – Monthly Changes](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111130.docx)**)** - 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. [OA Day Care Part 4 – Monthly Changes](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111130.docx) can also be used to inform the supervisor of any changes.
* **Pre-admission assessment / Person centred care plan (**[OA Day Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236105913.docx) / [OA Day Care Part 3 – Pre-Admission Assessment Centred Care Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111017.doc)**)** – 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 (**[OA Day Care Part 1 – Referral Information](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523610025.docx)**)** - 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 [OA Day Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236105913.docx) / [OA Day Care Part 3 – Pre-Admission Assessment Centred Care Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111017.doc).
* **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 (**[OA Day Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236105913.docx) / [OA Day Care Part 3 – Pre-Admission Assessment Centred Care Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111017.doc)**)** - to be used to record identified needs from the [OA Day Care Part 3 – Pre-Admission Assessment Centred Care Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111017.doc).
* 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 (**[OA Day Care Part 2 – Story and Gifts](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236104916.docx)**)** - 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 [OA Day Care Part 4 – Monthly Changes](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111130.docx). 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.

# Domiciliary

## 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. When a referral comes into Cumbria Care supervisors must ensure the short term intervention form completed (Appendix A).
2. 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 care 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.
3. 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. The [Dom Care Part 4 – Person Centred Care Plan Review / Feedback](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113751.docx) must be signed on the initial visit where possible and placed in the person centred care plan held in the office.
4. 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 on the review will generate an up to date person centred care plan. Using the [Dom Care Part 4 – Person Centred Care Plan Review / Feedback](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113751.docx) the supervisor will document any telephone calls received from either the carer/ service user / family or advocate requesting any that the individuals needs have changed.
5. Maintaining independence and producing relevant risk assessments must be a key factor when completing and reviewing a person centred care plan.
6. The person centred care plan will be reviewed on a regular basis when needs of the service user changes and with an annual review.

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### Documentation

Service user file kept in the home:

* Front sheet which has the service user name and the service details on the front.
* Part 2 What’s important to me- this give the carer an immediate résumé of the person and how best to support them.
* [Dom Care Part 3 – Task Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236112115.docx) / [Dom Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113612.docx) This form provides the carer with relevant information about the service users needs. This must be completed on the initial visit by the supervisor / manager and signed by the service user. If the service user cannot for whatever reason sign the care plan a relative / advocate must sign and the reasons why the service user cannot sign must be documented. [Dom Care Appendix 1 – Short Term Intervention Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236114015.docx) can also be used as a prompt for asking more person centred questions. The information from this can be used by the carer / supervisor / family members and the information from this can be added to [Dom Care Part 3 – Task Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236112115.docx) / [Dom Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113612.docx) and [Dom Care Part 2 – What’s Important to Me](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523612314.docx).

Risk assessments must be identified and documented if appropriate and a risk / [Dom Care Hazard Identification Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611174.docx) completed.

The original person centred care plan must be copied and a copy kept in the service users home. The original must be kept in the main domiciliary office in the service users file. The issue date is the first date that the referral form was generated and so this will remain the same date throughout the service users stay with Cumbria Care. This must be kept in the main domiciliary office in the service users file.

* S3 Service user guide and S5 statement of purpose – The S3 has information about the service. The [Dom Care Appendix 1 – Short Term Intervention Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236114015.docx) service user guide confirmation form must be signed by the service user / advocate / relative / manager and or supervisor. A full copy of the guide must be left with the service user. The [Dom Care Appendix 1 – Short Term Intervention Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236114015.docx) Confirmation form must be kept in the main office in the service users file.

A copy of the S5 Statement of purpose Cumbria Care must be left with the service user.

* General risk assessment / Manual handling risk forms / [Dom Care Hazard Identification Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611174.docx) / Personal emergency evacuation plan PEEP – These forms are to identify any risks to the service user, staff and others. This is generated from the care plan. These documents will need to be completed for service users and staff only where there is a need. Where a PEEP / manual handling risk / [Dom Care Hazard Identification Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611174.docx) / general risk assessment is required it must be completed on initial assessment and a copy kept in the home and one kept in the office. A PEEP may also be generated for members of staff only where there is a need.
* Medication prompt – This form is only to be used by the carer when he /she is prompting the service user to take medication. NOT FOR ADMINISTRATION.
* Suggestions and complaints – this is to help Cumbria Care improve our services.
* [Dom Care Part 5 – Communication Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611391.docx) - to be used by staff when recording details about the service user’s day. Any issues of concern about the service user, needs to be reported to the supervisor. This must be recorded in the informed via telephone column.

### Service user file kept in the domiciliary care office:

* Front sheet which has the service user name and the service details on the front.
* [Dom Care Part 1 – Referral Form](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111839.docx) – my details This gives details about the service users important information.
* [Dom Care Part 2 – What’s Important to Me](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523612314.docx) - this give the carer an immediate résumé of the person and how best to support them.
* [Dom Care Part 3 – Task Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236112115.docx) / [Dom Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113612.docx) – This form provides the office / supervisor with relevant information about the service users needs. This must be completed on the initial visit by the supervisor / manager and signed by the service user. If the service user cannot for whatever reason sign the care plan a relative / advocate must sign and the reasons why the service user cannot sign must be documented. [Dom Care Appendix 1 – Short Term Intervention Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236114015.docx) can also be used as a prompt for asking more person centred questions. The information from this can be used by the carer / supervisor / family members and the information from this can be added to [Dom Care Part 3 – Task Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236112115.docx) / [Dom Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113612.docx) and [Dom Care Part 2 – What’s Important to Me](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523612314.docx).

Risk assessments must be identified and documented if appropriate and a risk / [Dom Care Hazard Identification Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611174.docx) completed.

The original person centred care plan must be copied and a copy kept in the service users home. The original must be kept in the main domiciliary office in the service users file. The issue date is the first date that the referral form was generated and so this will remain the same date throughout the service users stay with Cumbria Care. This must be kept in the main domiciliary office in the service users file.

* [Dom Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113612.docx) –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.
* [Dom Care Part 4 – Person Centred Care Plan Review / Feedback](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113751.docx) – must be used to record any information / changes which may affect the person centred care of the service user. This must be held on care plan file in the office.
* General risk assessment / Manual handling risk forms / [Dom Care Hazard Identification Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611174.docx) / Personal emergency evacuation plan PEEP – These forms are to identify any risks to the service user, staff and others. This is generated from the care plan. These documents will need to be completed for service users and staff only where there is a need. Where a PEEP / manual handling risk / [Dom Care Hazard Identification Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611174.docx) / general risk assessment is required it must be completed on initial assessment and a copy kept in the home and one kept in the office. A PEEP may also be generated for members of staff only where there is a need.
* S3 Service user guide and S5 statement of purpose – The S3 has information about the service. The [Dom Care Appendix 1 – Short Term Intervention Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236114015.docx) service user guide confirmation form must be signed by the service user / advocate / relative / manager and or supervisor. A full copy of the guide must be left with the service user. The [Dom Care Appendix 1 – Short Term Intervention Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236114015.docx) Confirmation form must be kept in the main office in the service users file.

A copy of the S5 Statement of purpose Cumbria Care must be left with the service user.

* Medication prompt – This form is only to be used by the carer when he /she is prompting the service user to take medication. NOT FOR ADMINISTRATION.
* Suggestions and complaints – this is to help Cumbria Care improve our services.
* [Dom Care Part 5 – Communication Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611391.docx) - to be used by staff when recording details about the service users day. Any issues of concern about the service user, needs to be reported to the supervisor. This must be recorded in the informed via telephone column.
* [Dom Care Part 4 – Person Centred Care Plan Review / Feedback](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113751.docx) – this is used to log information which is passed between carer / family / service user and the office. This information will alert the supervisor of any changes that the service user may require. These changes may prompt a review of the person centred care plan. This must be held locally in each office. When each sheet is complete it must be transferred into the service user file. If there is no change to the annual review please state this on the review / feedback sheet.

All records must be completed fully with a full date e.g 27/07/10, circling the person who requested the changes and the managers / supervisors signature for approval. The annual review date must only completed at the annual review stage.

**All entries should be legible, accurate and factual.**

### Review Meeting

1. A review of the person centred care plan [Dom Care Part 3 – Task Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236112115.docx) / [Dom Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113612.docx) must take place at least annually. The service user must be supported to attend the meeting with relatives / advocates as appropriate. If the service users need changes during this time it maybe necessary to review the plan sooner. Information from the review and feedback sheet may also inform a review of the care plan. The personal emergency evacuation plan (PEEP) must also be reviewed at this stage.
2. The service users designated supervisor will update the person centred care plan with the service user to reflect the changing needs. The agreed changes are recorded, actioned and circulated to the relevant people. The person centred care plan will need to be amended and the review date completed, the issue date will remain the same as the original form completed.
3. Where there are no changes to the person centred plan at a review meeting this must still be documented as “no change” on the [Dom Care Part 4 – Person Centred Care Plan Review / Feedback](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113751.docx).

### Access To The Person Centred Care Plan

1. All service users shall have access to their person centred care plan.
2. The current person centred care plan in the service users home must be placed where other care staff can access it on a daily basis.
3. Copies of all person centred care plans must be maintained in the service users file in the main office in lockable storage.
4. Access to information will comply with the requirements of the access to information Act.

# Appendices

### Older Adults – Residential

[OA Residential Part 1 – What’s Important to Me](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523695233.docx)

[OA Residential Part 2 – Communication](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236115737.docx)

[OA Residential – Dietary Requirements](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523695553.docx)

### Disability Mental Health

[DMH Personal Support Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523612012.docx)

[DMH Appendix 1 – Protocol Recording Form](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/452369337.docx)

[DMH Appendix 2a – Example Protocol Continence](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523693611.docx)

[DMH Appendix 2b – Example Protocol Getting Up](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523693729.docx)

[DMH Appendix 3 – Review Notes](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236125054.docx)

[DMH Appendix 3 – Example Review Notes](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523693855.docx)

[DMH Appendix 4 – Contact Information Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523694049.docx)

[DMH Appendix 5 – Example Consultation Questions Form](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523694627.docx)

[DMH Appendix 6 – Getting to know you!](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523694822.docx)

### Older Adults – Day Care

OA Day Care Service User Communication File

[OA Day Care Part 1 – Referral Information](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523610025.docx)

[OA Day Care Part 2 – Story and Gifts](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236104916.docx)

[OA Day Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236105913.docx)

[OA Day Care Part 3 – Pre-Admission Assessment Centred Care Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111017.doc)

[OA Day Care Part 4 – Monthly Changes](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111130.docx)

[OA Day Care Part 5 – Care Daily Record](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111251.docx)

[OA Day Care Hospital Passport](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611145.docx)

### Domiciliary Care

[Dom Care Hazard Identification Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611174.docx)

[Dom Care Part 1 – Referral Form](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236111839.docx)

[Dom Care Part 2 – What’s Important to Me](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523612314.docx)

[Dom Care Part 3 – Task Sheet](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236112115.docx)

[Dom Care Part 3 – Person Centred Care Plan Agreement](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113612.docx)

[Dom Care Part 4 – Person Centred Care Plan Review / Feedback](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236113751.docx)

[Dom Care Part 5 – Communication Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/4523611391.docx)

[Dom Care Appendix 1 – Short Term Intervention Plan](https://cumbria.gov.uk/elibrary/Content/Internet/327/38541/38630/45236114015.docx)