Staffordshire Social Care Workforce

CMDT
Care Market Development Team

# Care Planning Guide

V2 MAY 2024

# Contents

# Foreword

*This guide has been developed to introduce the subject and further research and learning is recommended to provide a complete understanding. Requirements are often unique to individual care services, and you should consider how best to implement practices.*

# Introduction

**The development and implementation of a care plan should be a collaborative and ongoing process, adapting to the individual's evolving needs and circumstances. Regular communication and feedback from the individual and their support network are crucial for the success of the care plan.**

**The individual should always be at the heart of the care plan, ensuring that their wishes and needs shape how their care is provided.**

# Conversation

Communication is essential to understanding the needs of an individual and ensuring the care plan is centred around them as a person. The conversation will include the individual and the people around them who are more important, such as their family.

It is important to ensure Health and Social Care Practitioners are also involved in the conversation as they will have assessed an individual's care needs.

Throughout these discussions, it's essential to approach the individual with respect, empathy, and a commitment to actively listening to their preferences, choices and any concerns they may have. Building a comprehensive understanding of their care and support needs lays the foundation for person-centred care and enhances the overall well-being and quality of life for the individual.

## Personal Information

There will be a range of information that you can gather in advance of a conversation around their care planning such as their name, age, gender, and contact details. You will need to confirm this with them as they may for example to be referred to by a different name.

## Background

Everyone is unique and each person's background will be unique. It is key to understand their family dynamics, cultural preferences, and their previous and current life history. This information will help you understand where they have come from.

## Health and Medical History

An individual's health, including any previous or existing medical conditions, and any recent medical events will need to be built into their care plan. You should discuss how they would like to be supported with any health conditions as each person is unique.

Discuss any ongoing treatments, therapies, or rehabilitation programs.

## Mobility and Physical Abilities

Assess the person's mobility and physical abilities, including any mobility aids or assistive devices they use or would benefit from using.

Identify specific needs related to transfers, walking, and other physical activities.

People must also be supported to express how they are supported with their mobility and what assistive technology they prefer to use.

## Equipment

Identify if the equipment needed to support the individual is available and if not, prioritise acquiring the required equipment.

## Cognitive and Mental Health

Explore cognitive abilities and any cognitive challenges the person may be facing, such as dementia or memory loss.

Discuss their emotional wellbeing, mental health history, and any ongoing emotional or psychological support needs.

In instances where you need to apply to deprive someone of their liberty, you should clearly document the rational and conversations, ensuring the application is promptly made to the Local Authority.

## Communication Preferences

Understand the person's communication preferences, including any language preferences, speech difficulties, barriers such as hearing difficulties or the use of alternative communication methods.

Identify the most effective ways to communicate and express needs.

Some people might not be able to verbally communicate but can express themselves through eye movement or subtle gestures. Learn what works for them and ensure staff have a clear understanding.

## Nutritional Needs

Discuss their dietary preferences, restrictions, and any specific nutritional requirements.

Identify any allergies, food intolerances, or cultural considerations related to their meals.

If there is an assessed need to follow specific food and fluid consistencies, in alignment with the International Dysphagia Diet Standardisation Initiative (IDDSI), ensure it is clearly documented and that care and kitchen staff are informed.

Understand their favourite foods and preferences for when they like to eat.

Discuss the level of support that they want to eat and drink. They might want no support and prefer to eat their meals over a longer time, while another person might only need assistance at a certain time of day.

## Personal Care Preferences

Explore the person's preferences regarding personal care activities, such as bathing, grooming, and dressing. Understand how much support they require to meet their desired outcome and how much they want to do independently.

Identify any specific routines or rituals that are important to the individual. They might specify that they like to dress up on a Saturday or wear certain clothes when watching their favourite sports team.

## Social and Recreational Preferences

Discuss the person's social preferences, including preferred activities, hobbies, and interests. Where possible, people should be supported to continue these activities and interests or even take them up again with support if they have not been able to do them for some time.

Identify opportunities for social engagement and participation in recreational or leisure activities. People should still be able to access the community if they wish and might enjoy visiting certain places.

## Spiritual and Religious Beliefs

Explore the person's spiritual and religious beliefs, practices, and preferences. This is a good opportunity to link in with a local religious group to support them to continue practicing their spiritual or religious beliefs.

## Independence and Autonomy

Discuss the individual's preferences for maintaining their independence and autonomy.

Identify areas where the person values self-determination and involvement in decision-making.

## Support Network

Understand the person's existing support network, including family members, friends, or advocates.

Explore their relationships and connections that are important to the individual. Ensure the names and contact details of individuals are clearly recorded.

## Previous Care Experiences

Discuss the person's past experiences with care, both positive and negative.

Identify what has worked well in the past and any concerns or fears related to care.

Build in means to avoid any aspect that they are concerned about.

## Advanced Care Planning

Discuss preferences for end-of-life care, advanced directives, and any specific wishes regarding medical interventions.

Explore the person's thoughts on quality of life and their values related to decisions.

Complete the ReSPECT document to clearly outline their wishes.

## Safety and Environmental Considerations

Identify any safety concerns or environmental considerations that need to be addressed in the care setting.

Discuss specific needs related to the physical environment to ensure a safe and comfortable living space.

## Feedback and Review Process

Establish a feedback and review process to continuously assess and adjust the care plan based on the person's evolving needs and preferences.

# Recording

A person's care and support plan belongs to them and should be used by others to understand how someone wants their care and support provided. The wishes and preferences of an individual should be thoroughly and clearly documented to ensure there is no confusion.

The goal is to enhance the person's wellbeing and quality of life through thoughtful and responsive care planning, this can be made possible through clear documentation.

## Person-Centred Approach

Tailor the care plan to the individual's unique needs, preferences, and goals.

Involve the person, their family, and relevant stakeholders in the care planning process to ensure their input is considered.

## Clear and Concise Language

Use plain and straightforward language to ensure the care plan is easily understood by everyone involved, including the person receiving care, their family, and staff.

A care plan should utilise plain English and avoid acronyms and abbreviations, to ensure everyone who reads it can understand.

Use inclusive and respectful language that promotes dignity and avoids stigmatizing terms.

## Accessibility

Ensure the care plan is accessible to individuals with different abilities, including those with sensory or cognitive impairments. Provide information and support to help the person in receipt of care actively participate in their own care.

Use large font sizes, clear formatting, and consider the use of visual aids or alternative formats as needed. Digital care systems should be able to tailor how information is presented.

Acknowledge and respect the individual's cultural, linguistic, and personal preferences.

## Goal-Oriented

Clearly outline measurable and achievable goals that reflect the person's desired outcomes. Break down larger goals into smaller, manageable steps to facilitate progress tracking.

Goals should be specific, measurable, achievable, relevant, and time-bound (SMART).

## Risk Management

Address and document any potential risks associated with the person's care.

Develop risk management strategies in collaboration with the person and relevant stakeholders.

For any potential risk identified in the care planning process, there should be an associated risk assessment that details the risk and the measures that are being implemented.

These risk assessments should be periodically reviewed or reviewed in the event of any concerns about their effectiveness.

# Implementation

The care plan will only work if it is effectively implemented and followed. Care plans might need to be refined and updated following their first draft when it is better understood if the care routines aren't working as well as they could, or expectations aren't being met.

## Collaboration

Collaborate with family, health and social care professionals, staff and the individual to monitor the effectiveness of the care plan and reflect on feedback to ensure it meets the needs of the individual.

## Communication

Ensure the individual can easily access their care plan and if they wish, provide access to family members. Staff should be familiar with the details and be clear on how to follow it.

## Training

Staff should have the appropriate training and necessary skills and knowledge to implement the care plan effectively. If staff require additional training, this should quickly be facilitated.

# Review

A person's care and support plan should be considered as a 'living document', being updated dynamically in response to changes in a person's circumstances, their care and support needs or their wishes.

Regular reviews help ensure that the care plan remains person-centred, responsive, and adaptable to the individual's evolving needs. It's important to involve the individual, their family, and relevant individuals in the review process to gather diverse perspectives and ensure the plan's ongoing effectiveness.

## Scheduled Reviews

Conduct a comprehensive review at least once a year, although ideally every six months, to assess the overall effectiveness of the care plan and to make any necessary adjustments.

## Changes in Health or Circumstances

If there are changes in the individual's health or circumstance, their care plan should be promptly reviewed to ensure it reflects the current situation.

## Transition between Care Settings

When an individual moves between different care settings, such as a period spent in hospital, there might be changes in their care and support needs. A discussion should take place to understand if there are any changes.

Existing care plans and risk assessments might need to be reviewed and updated. Information should be shared with staff to ensure they have a clear understanding of any changes to the level or type of support. This should be included during a hand over.

## Feedback

Gather feedback from the individual receiving care, their family members, and staff on a regular basis. Their input can provide valuable insights into the effectiveness of the care plan and identify areas for improvement.

## Emergency Situations

If there is an emergency or crisis, the care plan should be reviewed to assess any short-term or long-term impacts on the individual's care and support needs.

## Summary

Everyone should work collaboratively to maintain a person-centred care plan that meets the evolving needs of the individual. The care plan should detail their story, their needs and wishes.

Ensure the care plan is reviewed regularly to ensure it continues to be current and can be used by staff to support them.

Additional guidance is available through MiDoS for CARE.

# For further information, please contact cmdt@staffordshire.gov.uk

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