Procedures Manual

Title: **ASSESSMENT AND PERSON CENTRED PLANNING FOR SERVICE USERS (RESIDENTIAL & RESPITE)**

1.0 Scope

1.1 Assessment, care planning and person centred planning arrangements for service users in residential & respite services.

2.0 Aims and Values

2.1 To ensure that service user's needs are identified through appropriate assessment and recorded.

2.2 To have an individual planning process that takes account of service users' needs and preferences.

3.0 Contents

4.0 Referenced Documents

C4-001	Accident / Incident / Near Miss Report Form.
C4-017	Daily Living and Needs Assessment Form.
C4-024	General Risk Assessment Form.
C4-055	Record of Medical Services Received.
C4-062	Risk Assessment Manual Handling of Service Users Form.
C4-066	Service User Behaviour Observation Chart.
C4-067	Service User Body Chart.
C4-069	Service User Epileptic Chart.
C4-070	Service User Menstruation Chart.
C4-072	Service User Normal Bowel Promotion Chart.
C4-073	Respite Services Referral Form.
C4-075	Service User's Assessment / Nursing Care Plan.
C4-075(A/B)	Service User's Person Centred Plan.
C4-077(A/B/C/D)	Service User's Daily Report Record / Nursing Report / Sleepover Report / After School Club Report.
C4-099	Waterlow Skin Condition Assessment.
C4-100	Weight Monitoring Chart.
C4-SCB	Staff Communications Book.
C4-SUANCPF	Service User's Assessment / Nursing Care Plan File.
C4-SUPCPF	Service User's Person Centred Plan File.
QP-09	Recording the Wishes of Service Users Policy.
QP-11	Service User's Medical Consent Policy.
QP-28	Best Practice Guidelines for Record Keeping.
QP-43	HIQA National Quality Standards.
SD-04	Service User's Daily Report Book Procedure.

5.0 Responsibilities

5.1 The manager and all staff.

This is the procedure to be followed

6.0 ASSESSMENT PRIOR TO ADMISSION

6.1 For residential only, an assessment of the service user's needs should be carried out by a suitably trained person prior to admission using the agency / service Daily Living and Needs Assessment Form, C4-017. For respite, a referral is done by the social worker; refer to Respite Service Referral Form, C4-073.

6.2 For residential only, the manager is responsible for ensuring that the agency / service Daily Living and Needs Form, C4-017, is up to date. Where information is incorrect or the service user's needs have changed substantially, an entry should be made in the Service User's Daily Report Record / Nursing Report / Sleepover Report, C4-077(A/B/C), the Staff Communications Book, C4-SCB, and if necessary an emergency Service User Assessment / Nursing Care Plan review carried out, C4-075.

6.3 The manager should ensure that staff are aware of, and understand the Recording the Wishes of Service Users Policy, QP-09.

7.0 ASSESSMENT FOLLOWING ADMISSION

7.1 The most senior member of staff is responsible for ensuring all health assessments, which need to be carried out, are done so by the appropriate health professional.

7.2 The most senior member of staff should ensure that all pre-admission documentation is incorporated and held within the Service User's Assessment / Nursing Care Plan, C4-075.

7.3 On the day of admission, each member of staff should refer to the assessment documents which are held within the Service User's Assessment / Nursing Care Plan, C4-075. These documents should provide care staff with the information necessary to meet the needs of service users.

7.4 On the day of admission a basic Service User's Assessment / Nursing Care Plan, C4-075, should be in place.

7.5 Staff on each shift should make appropriate entries in the Service User's Daily Report Record / Nursing Report / Sleepover Report / After School Club Report, C4-077(A/B/C/D), which relate to observations, service user's needs, physical condition, actions carried out or actions required.

7.6 Staff should follow the guidance and requirements of the Service User's Daily Nursing / Sleepover Report Record procedure, SD-04 or the Daily Report Record procedure, DSP-09, to ensure that changes are recorded and tracked in the appropriate way.

7.7 Information received from or relayed to any third party should be entered into the Service User's Daily Report Record / Nursing Report / Sleepover Report / After School Club Report, C4-077(A/B/C/D).

7.8 Where there is any conflict or difference of opinion in relation to the choices exercised by the service user and the Service User Person Centred Plan, C4-075(A/B), details should be entered into the Service User's Daily Report Record / Nursing Report / Sleepover Report / After School Club Report, C4-077(A/B/C/D), including a record of the actions taken. If necessary, the manager should notify relatives of the conflict and make a record in the Staff Communications Book, C4-SCB.

7.9 During the period between the admission of the service user and the first formal review, information should be entered into the Service User's Assessment / Nursing Care Plan, C4-075, and the Service User's Person Centred Plan, C4-075(A/B). This information should then form part of the first formal review.

7.10 The first formal review of the Service User's Assessment / Nursing Care Plan, C4-075, and the Service User's Person Centred Plan, C4-075(A/B), should take place at the end of the trial period. The trial period will be determined by the service.

7.11 At no time should the manager or any other member of staff include within Service User's Assessment / Nursing Care Plan, C4-075, and the Service User's Person Centred Plan, C4-075(A/B), decisions which might appear to give consent for medical treatment on behalf of a service user. The Service User's Medical Consent Policy, QP-11, should be observed at all times. If there is any doubt or conflict the manager should consult the service user's GP.

7.12 The manager should ensure that all relevant parties are invited to attend the review and may (with the service user's permission) include:

- Service user.
- Manager.
- Keyworker.
- Relative.
- Social Worker / Day Service.
- Other identified individuals who may be relevant (or requested by the service user).

8.0 PERSON CENTRED PLANNING

8.1 The manager and staff should consider methods of providing service user with information about their care and activities that are appropriate to their needs.

8.2 The Person Centred Planning Process Flow Chart contained in the Service User's Person Centred Plan, C4-075(A/B), should be followed by all staff engaged in the planning of services for service users.

8.3 At the formal review, the service user's needs should be identified from the information contained within all the assessment documents, which form part of the Service User's Person Centred Plan, C4-075(A/B). This will include the Service User's Daily Report / Nursing Report / Sleepover Report / After School Club Report, C4-077(A/B/C/D), as appropriate.

8.4 The Service User's Assessment / Nursing Care Plan, C4-075, and the Service User's Person Centred Plan, C4-075(A/B), should be compiled with input from a wide variety of sources. This should include:

- Service user.
- Manager.
- Keyworker.
- Relative.
- Medication information.
- General Practitioner, if necessary.
- Social Worker / Day Service.Other identified individuals who may be relevant (or requested by the service user).

8.5 The Service User's Person Centred Plan, C4-075(A/B), should be regarded as a flexible document which should be 'operational' at all times. Changes in the Service User's Person Centred Plan, C4-075(A/B), should be communicated to those staff affected by the changes as soon as possible using the Staff Communications Diary, C4-SCD, and Service User's Daily Report Record / Nursing Report / Sleepover Report / After School Club Report, C4-077(A/B/C/D). All changes should be considered to be 'with immediate effect' unless the manager indicates that a change will be 'effective from' and specify a date.

9.0 REVIEW OF SERVICE USER'S PERSON CENTRED PLAN

9.1 The continuing suitability and effectiveness of the Service User's Assessment / Nursing Care Plan, C4-075, and the Service User's Person Centred Plan, C4-075(A/B), should be reviewed by named key workers in the service once every six months or more frequently depending on the needs of the service user.

9.2 At each formal review of the Service User's Assessment / Nursing Care Plan, C4-075, the service user should be encouraged to attend and invite the following:

- Service user.
- Manager.
- Keyworker.
- Relative.
- Social Worker / Day Service.

- Other identified individuals who may be relevant (or requested by the service user).

9.3 At the time of the review, the key worker should remove from the Service User's Assessment / Nursing Care Plan, C4-075, all out-of-date documentation, old care plans and reviews. This information should be retained within the service in keeping with QP-28, Best Practice Guidelines for Record Keeping.

9.4 Up-to-date Service User's Assessment / Nursing Care Plan, C4-075, and the Service User's Person Centred Plan, C4-075(A/B), including Service User's Daily Report Record/ Nursing Report/ Sleepover Report/ After School Club Report, C4-077(A/B/C/D), should be kept in a place designated by the manager and should be readily accessible by all staff involved in direct service user care.

9.5 Following each formal review, the manager should ensure that all staff are informed that the review has taken place and any changes that need to be actioned, at the nearest staff meeting to the date of the changes/review.

10.0 RECORDS TO BE KEPT

10.1 All service users should have a Service User's Assessment / Nursing Care Plan, C4-075, and a Service User's Person Centred Plan, C4-075(A/B).

10.2 All assessment and care planning records should be dated in accordance with the requirements of the document and stored in the Service User's Assessment / Nursing Care Plan File, C4-SUANCPF.

10.3 The manager should ensure that all service user person centred planning documents are filed in the Service User's Person Centred Plan File, C4-SUPCPF, should be maintained so that all documents are easily accessible.

10.4 All key workers should be aware of the Service User's Person Centred Plan, C4-075(A/B), which should be checked on a regular basis to ensure that the requirements of the plan are being met.

10.5 The Service User's Assessment / Nursing Care Plan File, C4-SUANCPF, should contain the following documents as a minimum:

- A copy of the Service User's Assessment / Nursing Care Plan, C4-075.
- Daily Living and Needs Assessment Form, C4-017.
- Record of Medical Services Received, C4-055.
- Service User's Daily Report Record / Nursing Report / Sleepover Report /After School Club Report, C4-077 (A/B/C/D),
- Accident / Incident / Near Miss Report Form, C4-001.
- Risk Assessment Manual Handling of Service Users Form, C4-062.
- General Risk Assessment Form, C4-024 (risks of daily living).

- Monitoring forms in respect of weight or skin condition , C4-100, C4-099 respectively
- And where appropriate forms and charts monitoring and recording marks on the body, epilepsy, menstruation, , continence, bowel movements, and behaviour, C4-067, C4-069, C4-070, C4-017, C4-072, and C4-066, respectively.

10.6 The Service User's Person Centred Plan File, C4-SUPCPF, should contain copies of the Service User's Person Centred Plan, C4-075(A/B).

11.0 ACCESS TO RECORDS

11.1 The Service User's Person Centred Plan, C4-075(A/B), will be held in a place which allows confidentiality.

11.2 The service user, however, will have access to the plan whenever they wish. Each service user has a copy of their own person centred plan in accordance with HIQA National Quality Standards, QP-43.

11.3 If the service receives a request from anybody wishing to have access to information held in the service users plan, staff will follow procedure Confidentiality and Access to Records, MA-15.