Belfast Health and Social Care Trust

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Care Management Procedures

STANDARDS & GUIDANCE

January 2020

1.0 Introduction to Care Management

Care Management and the assessment of individual needs are recognised as cornerstones of the delivery of safe and quality community care. They have been central to the effective implementation of the Departmental proposals contained in the policy document “People First; Community Care in Northern Ireland in the 1990’s” and are reflective of the pathways set out in the Care Management Circular 2010. Care Management is a person centred approach to the core activities of Assessment, Care Planning, Intervention and Review.

These Procedures are intended to:

- ❖ Provide guidance for staff who discharge the function and duties of care management, whether in the role as a Care Manager, Social Worker, CREST Practitioner or Assistant Care Manager.
- ❖ Ensure a uniform approach by all staff involved in the co-ordination of complex care.
- ❖ Provide information and guidance for other Trust personnel particularly regarding eligibility, making referrals, completion of assessments and care planning.
- ❖ Provide a reference point for users and carers.
- ❖ Provide information for independent sector providers.

2.0 Legislation and Policy

Care Management operates within a broad and evolving legal framework and this document is therefore subject to routine review.

2.1 Legislative Context

The primary legislation underpinning Care Management is:

- **Health & Personal Social Services Order 1972:**

  Article 4b – the duty of the ministry to “provide or secure the provision of personal social services in Northern Ireland designed to promote the social welfare of people in Northern Ireland”

  Articles 15 and 36: -- Boards are required to” arrange the provision of appropriate care, and charge the residents for their residential accommodation and care, with the aim of securing an appropriate contribution”.

- **Health & Personal Social Services (Assessment of Resources) Regulations (NI) 1993:**

  Sets out the legislative context for the financial assessment of a service user's resources in order to determine if they are in a position to make a contribution towards the cost of their care.

- **Chronically Sick and Disabled Persons (NI) Act 1978**

  This places a duty on the Trust within its area to proactively identify and promote the welfare of people who are physically disabled or have a mental health diagnosis.

- **National Assistance (Assessment of Resources) Regulations 1992**

  This sets out the requirement for the Trust to financially assess for services.

- **The Carers and Direct Payments Act 2003:**

  This places a statutory duty on Trusts to offer an assessment to a person identifying as a carer and to review this regularly should the carer wish to have ongoing support.

- **Human Rights Act 1998:**

  Any interference in the life of an individual citizen requires careful consideration. Any action or non-action by the Trust should reflect an understanding of the Human Rights engaged and the impact upon the person.

- **HPSS (Quality, Improvement and Regulation) NI Order 2003:**

  This sets out what the public can expect in terms of standards for care organisations. There are 5 key quality themes

  1. Corporate Leadership
  2. Safe and Effective Care
  3. To be accessible, flexible and responsive in service provision
  4. Promoting protecting and improving health and social well-being.
  5. Effective communication and information.

- **Mental Health (NI) Order 1986**

  This legislation remains in place and runs parallel to the Mental Capacity Act 2016 until the Mental Capacity Act is fully implemented. It requires the Trust to act to protect those with a diagnosed mental illness who present as a significant and immediate risk to themselves or others. The Trust can also consider the use of Guardianship under this legislation. It also sets out the role and responsibilities in relation to the management of service user property and finance.

- **Mental Capacity Act 2016**

  This new and evolving piece of legislation has far reaching significance in terms of how we deliver care and support particularly to those who lack capacity to make choices for themselves.

2.2 Policy Context

- **The DHSSPS Circular - ECCU 2010/1** sets out the key principles and duties of Care Management, in that Trusts must:
  - Respond flexibly and sensitively to the needs of individual clients and their carers;
  - Treat clients and their carers with dignity, respect and compassion
  - Explore a range of options for care in order to widen clients' choice in line with Self Directed Support Approach
  - Focus on enabling people to retain choice and control in how assessed needs are met
  - Intervene no more than is necessary
  - Encourage and equip clients and carers to play an active part in their care and lives
  - Prioritise individuals where there is significant risk to safety and vulnerability.
  - Promote the involvement of service users in the design and delivery of the service.

The circular articulates key objectives as:

  - Promoting choice to enable people to live in their own homes where feasible.
  - Ensuring that service provision gives priority to practical support for carers.
  - Making proper assessment of need and good care management as the cornerstones of high quality care.
  - Encouraging the development of a flourishing independent sector alongside good quality statutory services.

- **Circular HSS (ECCU) 2/2008: Regional Access Criteria for Domiciliary Care** sets out regional guidance to establish equity in access to resources following assessment.

The procedures written below should be considered in conjunction with current policy guidance and key documents. These include:

- Service Specification for Domiciliary Care.
- Service Specification and Contract for Residential & Nursing Home Care.
- Charging for Residential Accommodation Guidance (CRAG)
- Complaints Procedure
- Open Access Policy
- Adult Safeguarding; Protection and Prevention in Partnership 2015
- Hospital Discharge policy and procedures
- Choice Protocol for Hospital discharges
- HPSS – Good Practice in Consent
- Clinical and Social Care Governance Guidance
- GDPR
- Best Interest Toolkit
- MCA Code of Practice 2018
- Self Directed Support Guidance
- Transforming your Care 2011
- Systems not Structures 2016
- COPNI 2018 Home Truths

3.0 What is the Care Management Process?

Care Management refers to a total concept for assessing need and providing care in the most appropriate way in partnership with the service user and those who are important to them.

The Trust have a statutory obligation in relation to ensuring that it has in place processes for:

- Case finding
- Screening
- Assessing need
- Care planning implementation and co-ordination
- Monitoring care plan outcomes

- Reviewing Care Planning effectiveness
- Case closure

3.1 Who is supported under the Care Management process?

People who should be considered for the care management process in all client groups aged over 18years, will include those who:

- May require or are at risk of permanent admission to care homes or other long-stay care settings
- Are being discharged from hospital or other care settings after a period of long-term or Intermediate care
- Are being discharged following major intervention or serious illness requiring acute hospital care
- Are experiencing severe mental or physical incapacity and loss of independence;
- Are terminally ill and may require palliative care
- Have complex social and physical care needs
- Are at high physical risk and require care & support
- Have complex needs behaviour where high level support is necessary or whose care arrangements are at risk of breaking down. Have rapidly or frequently changing needs
- Are highly dependent on the input of a carer and
- Are carers of people with complex needs whose own care needs mean they are having difficulties in maintaining their caring role and require services in their own right

The Care Management Process is designed to give due attention to the inter-relationship of all relevant factors affecting an individual in their unique circumstances and environment.

Priority clearly has to be given to those in greatest need through physical or mental frailty. The support structure in place through family, friends or neighbours should be given an appropriate weight and consideration in any decisions reached. The Mental Capacity Act (2016) formalises the role of the Nominated Person in decision making for those deemed to lack capacity.

All efforts should be made to ensure the person who is being assessed retains control of decision and plans resulting from the assessment process. This may involves independent advocacy or other communication supports.

4.0 The Screening and Processing of Referrals:

Screening is the initial examination of all referrals and is used to determine if care management is the appropriate response to the identified need and if so, the level of assessment that will be required. Referrals should be screened against locally defined service area referral criteria and will require a professional judgement to be made. Each service area that it has in place defined referral criteria to the service. The fundamental aim of community care is to promote the independence of individuals so that they are able to live as normal lives as possible and achieve their full potential. Care Management (as the process through which user/carers gain access to services) should reinforce, not undermine, that aim.

4.1 Standards for Screening and Processing of Referrals

- Initial referrals can be received in a number of ways from a number of sources including potential service users, carers and other agencies.
- All referrals should be screened in line with the service area's referral criteria.
- Consent for the referral should be discussed with the referrer and this should be recorded on the referral form. *The requirement to gain permission for referral would not be required in cases of suspected abuse or neglect*
- Confirmation that the referral has been discussed with the service user/carer should be recorded on the referral form
- Reason for the acceptance or rejection of the referral should be recorded on the referral form

5.0 Assessment of Need

Comprehensive and proportionate assessment will continue to be the cornerstone of the care management process. Assessment aims to deliver safe and effective health and social care support in a setting, which is most appropriate to the person's needs. When a focused assessment has determined the requirement for services, this

should be effectively co-ordinated in a timely manner. Assessment is underpinned by core principles:

- Assessment must be person centred, taking full account of the individual's context and needs and be proportionate to the presenting circumstances
- Assessment should reflect the perceptions and wishes of service users and carers, as well as their strengths and preferences.
- Assessment should always include the identification of risks and risk management plan.
- Assessments should focus on maximising opportunities for service users to live independently at home or in as near domestic environment as possible, for as long as they wish where this is safe and appropriate.

See Appendix 1 for Department of Health Procedural Guidance for the Northern Ireland Single Assessment Tool (NISAT)

5.1 Undertaking the assessment

The level of assessment required is proportionate to the presenting needs of the individual. The Social Worker / Care Manager will be responsible for the coordination and completion of the assessment. Professionally qualified staff will normally complete the assessments unless responsibility for aspects of the assessment have been delegated to appropriately trained or qualified staff.

A comprehensive assessment should embrace the following factors:

- Physical Health
- Mental Health
- Capacity for Daily Living / Self-care.
- Abilities and Lifestyles
- Contribution of Carers, abilities and needs.
- Social network and support.
- Housing
- Risk assessment
- Client choice

The Social Worker/ Care Manager will meet with the service user and their carer to discuss with them their needs, strengths and risks. The views and wishes of the service user should be discussed and recorded, in so far as it is possible for them to do so. The Social Worker/ Care Manager will discuss with the service user and or carer the outcome of the assessment, based on assessed need and explore all options available for meeting their health and social care needs. This part of the process merges with Care Planning in that the discussion will attempt to reconcile

the assessed need with service user and carer's perceptions and choices within the available resources of the Trust. The Social Worker/Care Manager recommendations should take account of:

- The service users' views, wishes and aspirations
- The carers' views, including a discussion re: carers support services
- Their own professional analysis
- Opinions of other medical, nursing and allied health professionals involved in their care and formal updated assessments may be required from these professionals
- The capacity of the service user to give informed consent or express their views and detail all efforts made to include in decision making
- Risks and or concerns
- Resources available
- Identification of unmet needs

5.2 Managing disagreement with the assessment outcomes

Where there is disagreement with the service user/carer regarding the assessment outcome and the care options, the following steps should be taken:

- Ensure that all reasonable steps have been taken to determine the service users ability to make informed decisions and express their wishes, including being provided with full and appropriate information in a suitable format and at a time convenient for them
- Refer to an Independent Advocate if deemed as a necessary to ensure that the voice of the service user is at the centre of the decision making process
- The reason for disagreement should be recorded in the system (Paris, Activity recording)
- The Service user should be advised that they can refer back to the service at any time should their needs change to avail of support

5.3 Carers Assessment

Carers are entitled to a separate assessment of their needs and a Carers Assessment (Carers and Direct Payment Act, 2002) should be offered where appropriate. A carer's assessment must be completed upon the agreement for assessment, or where the carer has requested an assessment. Staff should note on Paris/Service case records the action of offering the assessment even if it is not accepted. The assessment should be recorded on the agreed assessment format in each Service Area. The carer is also entitled to an annual review and this must be offered. Carers experience and support needs must be part of the ongoing overall assessment.

5.4 Mental Capacity

Best Interest case discussion should only be considered when a person has been assessed as lacking capacity to make a decision about their care needs and where these are likely to be best met. The agreed practice under the Mental Capacity Act 2016 should be followed. Where it is impossible to reconcile different perceptions, these should be acknowledged and recorded in the Best Interests minutes/assessment document as they may contribute to an evolving understanding of an individual's needs over time.

Adults with capacity are entitled to refuse the treatment or care being offered, even if this is detrimental to their overall health and wellbeing.

An Aide Memoire is available to support the Assessment section (see Appendix 2)

5.5 Risk Assessment

Whilst the assessment of risk is a core function of care assessment and planning, there may be occasions where it is necessary to complete a risk assessment tool. Each service area should articulate their local risk assessment arrangements.

Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for the service user. It should be based on and holistic risk assessment of safety issues and risks to the person, their family and others. Risk assessment and safety planning should be developed collaboratively with the service user and their carer, building on strengths/ resources and the roles of services and individuals. These plans should be clearly and effectively communicated to all concerned. The plan should include a summary of all risks identified, situations in which identified risks may occur and actions to be taken by practitioners and the service user.

An Aide Memoire is available to support the Risk Assessment section (see Appendix 3)

5.6 Standards for Assessment

- Each service area should articulate their service specific assessment and risk assessment tools
- The agreed assessment tool for the service area must be utilised. For example in Older Peoples and Physical and Sensory Disability, the Northern

Ireland Single Assessment Tool is the regionally agreed assessment framework

- Further consent should be attained from the service user (unless they do not have mental capacity) to participate in the assessment and care planning process and this should be documented and recorded. In Older Peoples and Physical and Sensory Disability this should be recorded on the NISAT consent form (see Appendix 4). In Mental Health and Learning Disability Services, consent is recorded as part of the assessment

- All new service users in receipt of commissioned services must have an assessment of their needs completed

- Where MDT assessment and care planning is required, evidence of consultation with other professionals must be recorded.

- All service users should be encouraged and enabled where possible to participate in their assessment. The views and wishes of service users should be recorded in their assessment. If they are unable to articulate their views and all communication tools have been utilised, the reason why the service user is unable to articulate their views should be recorded in the assessment

- The Social Worker / Care Manager will be responsible for the coordination and completion of the assessment, unless responsibility for aspects of the assessment have been delegated to appropriately trained or qualified staff

- The Social Worker/ Care Manager will discuss with the service user and/ or carer the outcome of the assessment based on assessed need and explore all options available for meeting these health and social care needs.

- Disagreements about the assessment process or the outcome of the assessment should be noted in the summary/analysis part of the assessment

- All Assessments should be signed and dated, in line with the requirements of the service specific assessment tool

6.0 Care Planning

Care Planning is an opportunity to consider all the options available for meeting assessed needs. The Care Manager/Social Worker/ CREST Practitioner should ensure that the Care/Support Plan is person-centred and focussed on preserving or restoring, as far as possible, normal patterns of independent living.

6.1 What is Care Planning?

The Care Manager/Social Worker/ CREST Practitioner should approach care planning as a series of linked activities:

- Setting priorities and goals
- Defining service requirements
- Exploring the individual strengths and resources of user/carers
- Reviewing existing services
- Considering alternatives to formal care services
- Discussing options and establish preferences
- Discussing any financial implications (moving into care)
- Reconciling preferences and resources
- Completing the Care/Support Plan
- Completing the Individual Support Plan (7 steps criteria) in line with SDS approach
- Identifying and managing risk
- Recording any unmet need

6.2 Developing the Care Plan:

The guiding principle of Care Plan implementation should be to put care and support in place to meet the assessed need of the service user, maximise use of voluntary and community resources with the minimum intervention necessary, seeking to minimise the number of service providers to ensure continuity of care. Care plans should be holistic.

The Care Manager/Social Worker/CREST Practitioner will be required to develop a Trust Care and Support Plan **for all people in Care Homes and Supported Housing settings and for those who are in receipt of domiciliary care**.

This care plan should be shared with the service user and provider, with a copy retained by the Social Worker/Care Manager. Staff should endeavour to attain the signature of the service user on the care plan where possible. (See Appendix 5)

Service users and their carers should be encouraged to play as active a part in the implementation of their care plan as their abilities and motivation allow. The service

user's sense of responsibility for their own life should not be diminished by the way in which assistance is given.

The Care/Support Plan should contain:

- Overall aims
- Assessed and agreed needs of the service user/carer
- Services provided by each agency which sets out a timetable of the specified care and how it is delivered
- Any points of difference between user, carer, care manager and provider
- Contact people with names, addresses and phone numbers
- Any additional information
- Monitoring arrangements
- Signatures or evidence of signatures

Staff must record the care plan under the Care and Support Plan heading in the assessment section of Paris. An Aide Memoire is available to support this document (see Appendix 6)

6.3 Where care planning identifies the need for a commissioned service

Domiciliary Care:

Once the need for a domiciliary care service has been identified, staff should identify what package of care is required, applying the Domiciliary Care eligibility criteria. The Service Plan Timetable should detail all inputs required including times, duration, duties and name of provider and this should be forwarded to the care bureau. Once a care package has been allocated to a provider by the Care Bureau the Care Manager/ Social Worker should forward the relevant assessment documentation along with the Care/Support Plan and Risk Assessment/Management Plan

Self-Directed Support:

The Care Management process is intended for people who are most at risk in the community and require an intensive level of care. Eligibility for statutory support will be established on the completion and commissioning of assessments by the social worker/ care manager. Assessed care needs can be met in a number of ways- domiciliary care (incorporating cooked chilled meals, day provision, in house and private provision) direct payments, managed budget. Care plans may involve a combination of all types of support.

Care Home Placements:

The Care Manager/Social Worker should always complete a BHSCT care plan on admission to a care home, which should be monitored and reviewed as needs, and circumstances change**.** When deciding the type of home that may be suitable, it is important to consider the different categories of care

Nursing Homes

To be eligible for Nursing Home care an individual must have a high level of physical dependency (for example people requiring assistance by 2 or hoisting) or require regular registered nursing intervention over the 24 hour period that cannot be sustained in the community or residential setting.

Residential Home

People considered for residential care may be assessed as needing it for social, behavioural or physical reasons. The criteria is less definitive and there is greater emphasis on the interaction between social, psychological and medical conditions and the interpretation of functional dependency. Medical or nursing needs can be maintained by visiting community nursing or medical staff. Individuals are unlikely to be considered eligible unless there is impaired capacity for self-care and or they are at substantial or critical risk and help is required with many of the activities associated with daily living e.g. maintaining a safe environment, medications management, feeding, toileting and dressing. Others options such as Supported Living may also be considered.

Specialist Homes

Within Older Peoples Services, Learning Disability and Mental Health Services there are people whose needs are complex and diverse. Specialist homes (e.g. dementia units) provide high levels of care and support. It is likely that there will be a deprivation of liberty involved and therefore use of the Mental Capacity Act will be necessary.

6.4 Mental Capacity

Where the service user has mental capacity, the care plan must demonstrate that the appropriate consent has been gained for any actions to be undertaken. If the service user does not have capacity *and* there is to be a deprivation of liberty, the Mental Capacity Act must be adhered to. In practice staff must ensure that:

- The DOL safeguards are in place.
- The appropriate forms have been completed.

Guidance can be sought from the Deprivation of Liberty Safeguards Code of Practice and the local operational process (see appendix 7).

In line with the DOL safeguards, the following are required:

- A full assessment, including a risk assessment must be completed. This requires face to face contact with the service user. Needs and wishes of the service user must be established with them as far as is possible. Consideration must be given as to how best to engage with the person. The use of Talking Mats and any other validated communication methods agreed to be appropriate should be considered. Staff should also make use of Sensory Support Services within the Trust and consideration of the Independent Advocacy Service.

- There must be full consultation with service user's Nominated Person.

- There must be full consultation with service user's GP and/or consultant psychiatrist (if they are involved). Their views on needs, wishes, and risks should be considered. This is also required in relation to any restriction of liberty

- There must be a mental capacity assessment to determine the service user's ability to make the relevant decisions

- The relevant assessment tool must be completed, and this should demonstrate the decision-making processes.

- The service user's Human Rights must be considered and recorded.

- The services user's best interests must be considered and recorded.

- Least restrictive options must be considered, and explanations recorded as to why these options are not suitable.

- In cases in which the assessment is challenged by the service user or their representative, the opinion of a second care manager/ social worker from another team must be sought or an independent advocate should be considered.

- In situations arising where the service user does not settle or seeks to leave the care home, and normal methods of intervention do not manage the situation, consideration should be given to discussion of Guardianship under

The Mental Health Order. This will require the involvement of Approved Social Workers, and liaison with the Directorate of Legal Services (DLS).

6.5 Monitoring and review of care plan

The implementation and monitoring the implementation of the Care Plan is an ongoing requirement carried out by all relevant staff involved in the service users care. Where needs are rapidly or frequently changing, adjustments must be made to the care plan reflective of changing need and circumstance. The type and level of monitoring should relate to the complexity of the needs being addressed. Monitoring may be both formal and informal. All service user/carers should have the benefit of a level of monitoring proportionate to their needs to ensure the continued appropriateness of the existing care plan. Staff should record the level of monitoring required in the Trust care plan and this should be kept under review:

- The Care Manager/ Social worker/ CREST Practitioner should discuss with the service user/carer the purpose of monitoring and be encouraged to actively participate in the process.
- Monitoring is not only the responsibility of the Care Manager/ Social Worker/ CREST practitioner, as such monitoring can be a delegated task in the joint working relationship of the social worker and social care staff. Moreover, the responsibility can be shared with others including service user and carer, Professional staff, significant others (neighbour), service providers and key worker. The Care Manager/ Social Worker/ CREST Practitioner should co-ordinate all monitoring arrangements in place.
- Significant issues identified by others should be brought to attention of the care manager/Social Worker/ CREST practitioner who will consider if a review or reassessment is required
- The Care Manager/ Social Worker/ CREST Practitioner should ensure that any monitoring is undertaken and recorded in a systematic way in line with the Trust's Record Management Policy.

The Social worker / Care Manager should ensure that the service user/carer has a written copy of the Care/Support Plan and that they have endeavoured to a achieve a signature for the care plan (See appendix 5)

The formal review of the Care Plan is an activity closely linked to review and this is described further in section 7.0.

Information Packs

The Service must ensure that copies of the Trust information packs describing Domiciliary Care or Admission to a Care Home, including financial information, should be given to the service user/carer for their information. The service user/ carer should sign acknowledgement sheet following receipt of this information.

6.6 Standards for Care Planning

- All people in Care Homes and Supported Housing must have a Trust care plan in place
- All people in receipt of domiciliary care must have a Trust care plan in place This care plan should be shared with the service user and provider
- Staff must record the care plan under the Care and Support Plan heading in the assessment section of Paris
- All sections of the care plan must be completed in full
- Review and monitoring arrangements must be recorded on the care plan
- Service users should be provided with a written copy of their care plan
- Staff should endeavour to attain the signature of the service user on the care plan where possible. Where this is not possible this should be recorded on the care plan
- All service users should be provided with information specific to the service that they will receive and a written receipt

7.0 Review

Review is the mechanism by which changing needs are identified and services adapted accordingly. A suitably qualified member of staff should complete the review. Like assessment, the review should be needs based; the prime focus should not be the services provided but the needs, views and preferences of service user/carers and the effectiveness of services in addressing those needs. The review should take place at the times or intervals specified in the Care/Support Plan or at any other time it would appear necessary. Reviews need not always involve large, formal meetings. The suitably qualified member of staff should, always ensure that:

- Changing needs or circumstances are recognised and re-assessment of need is undertaken, when necessary;
- The care plan is revised to take account of changing needs and circumstances:
- Services are consistent in meeting needs in an appropriate manner and in accordance with the expected standard of quality;
- Any unmet need is identified and a contingency plan is put in place to meet this need
- The views of service users and carers inform the review process and its outcomes
- Service users are offered a copy of their updated care plan and if they decline the decision is recorded.
- Consent is obtained from the service user to share relevant information from the review. The updated care plan is shared with those involved in delivering the care and/or services, and with the carer, where applicable.
- The care manager/social worker is responsible for ensuring that the written record of the review sets out the decisions taken, the actions agreed, who will take these forward and the timescales to be achieved.

7.1 Timeframes for Monitoring and Review process

Service area's may have local arrangements in relation to monitoring and review timescales, specific to the needs of the service users that they work with and these should be available to staff. Individual service user's needs may change and they may need additional monitoring and review arrangements reflecting their individual need and staff should ensure that these are articulated clearly on the care plan. However, as a minimum the following review and monitoring standards are:

Minimum Monitoring and Review Standards for service users	
People in Care Homes	**People in receipt of Domiciliary Care**
• First visit within 2 weeks of placement • First review at 12 weeks • Monitoring visit at 6 months • Annual Review at 12 months • Review annually thereafter	• Telephone call to service user and provider at 2 weeks • First review at 12 weeks • Monitoring visit at 6 months • Annual Review at 12 months • Monitoring visit at 6 months thereafter • Review annually thereafter

Deprivation of Liberty Safeguards must be reviewed as per the standards stipulated in the Deprivation of Liberty Safeguards Code of Practice.

7.2 Undertaking Care Home Reviews

The preparation for the formal review should commence approximately 6 weeks in advance of the review date. The care home should receive a copy of the Resident Review Form to complete ahead of a review meeting. Particular attention should be given to the wishes of the service user regarding time place and persons who are to be invited. Staff should ensure that all the relevant parties are notified in a timely way to maximise the opportunity for families to attend. When families are unable to attend the reason for this should be recorded, as well as evidence of what has been done to accommodate them to attend. Staff should also consider if they need to involved an independent advocate and/or are any communication aids required. All Care Home reviews should be chaired and the record of the meeting agreed by a suitably qualified member of staff. The purpose of the review should be clearly stated and recorded in the minutes and should be structured so that they do not inhibit the contribution of user/carers.

Everyone who attends the Review meeting should receive a copy of the record of the meeting and any points of difference should be noted with an agreed action plan regarding resolution. It is the responsibility of the Chair to ensure that actions are followed through. The Service User should kept informed of any changes to their care plan.

Nursing Home staff must have completed a Resident Review Form (for guidance Appendix 8a) in advance of the Review. The Care Manager/ Social Worker should refer to this during the review

Staff in Older People's, Mental Health and Physical and Sensory Disability services must ensure that the care review must be recorded on the regional review template on PARIS (for guidance see Appendix 8b). Learning Disability Services have their own local arrangements.

7.3 Undertaking Domiciliary Care Reviews

A suitably qualified person is responsible for the organising and chairing of the Domiciliary Review. The venue of the review should be governed by what is considered to be the most effective way of involving the user/carer and is likely to be

the service user's own home. A co-ordinated approach should be applied to the review process where there are a range of services involved. For example, if the service user in in attendance at a statutory day centre consideration should be given to a joint review.

All participants to the review should be given sufficient notice of the review to prepare their contribution. Service users should be given the opportunity to determine who they would like to attend the review. Families should be encouraged to attend and if this is not possible the reason why should be recorded, as well as evidencing what was done to facilitate them to attend. This also applies to the user/carer to whom the purpose and content of a review should be fully explained together with their entitlement to have a representative present, if they wish.

Attendees should normally consist of the Care Manager/Social Worker/Social Care Co-ordinator, service user/carer and service providers or representatives. Other professionals may be invited to attend depending on service user need.

The review should be recorded on the Regional Review Form located on the Paris system and the care plan should be updated to reflect changes. (See Appendix 9)

7.4 Standards for Review

- **Reviews should be undertaken by a suitably qualified person**
- **The frequency of review must comply with the Minimum Monitoring and Review Standards for service users**
- **Where increased monitoring and review is required these should be recorded on the care plan**
- **Reviews must be planned and the facilitation of the attendance of people who are important to the service user must be demonstrated**
- **The review must be recorded on the Regional Review Template on PARIS (excepting Learning Disability)**
- **A copy of the review form should be sent to the service user and/or family member within 28 days**
- **Staff must ensure that reviews are signed by all relevant parties**

8.0 Adult Safeguarding

In cases where Adult Safeguarding issues are suspected service area Adult Safeguarding arrangements are to be applied

9.0 Monitoring and reporting Complaints/Quality Issues

9.1 Complaints

Where possible staff should be able to demonstrate that they have attempted to resolve any issues arising locally. If local resolution is achieved this should be documented on the relevant paperwork and forwarded to the complaints department.

In the case of formal complaints, the Trust's Complaints Policy should be adhered to and the care manager/social worker must ensure that the service user and any person acting on their behalf have a copy of the complaints procedure.

9.2 Quality monitoring

With the exception of Learning Disability Services, a DATIX should be completed for all quality monitoring reports. This should be used by the Care Manager/Social worker/ Social Care/ CREST Practitioner to report quality concerns to the Quality Assurance Team for Commissioned Services.

It is the Care manager/ Social Worker/ CREST Practitioner responsibility to work with the home to investigate the quality concern and seek satisfaction that the actions agreed in the response from the provider are appropriate. This response should be shared with the service user and or their family to ensure overall satisfaction with the outcome of the investigation and agreed actions.

In Learning Disability Services, quality monitoring is reported and investigated within the service.

9.3 Independent Sector reporting

The Independent Sector are required to report all complaints, quality issues and adverse incidents to the Care Manager/ Social Worker/ CREST practitioner and the Quality Assurance Team for Commissioned Services. The Quality Assurance Team will collate all incidents, complaints and quality issues and report these quarterly. The Quality Assurance Team will register all Adverse Incidents reported by the Independent Sector on DATIX

Appendices

Appendix 1	DOH Procedural Guidance for Northern Ireland Single Assessment Tool
Appendix 2	Assessment (NISAT) Aide Memoire
Appendix 3	Risk Assessment Aide Memoire
Appendix 4	NISAT consent form
Appendix 5	Care Plan Agreement and Signature
Appendix 6	Care Plan Aide Memoire
Appendix 7	Deprivation of Liberty Safeguards
Appendix 8a	Care Home Resident Review Form
Appendix 8b	Care Home Regional Review Form
Appendix 9	Domiciliary Regional Review Form

Appendix 1

The DOH Procedural Guidance for Northern Ireland Single Assessment Tool is available on:

www.health-ni.gov.uk/publications/northern-ireland-single-assessment-tool-and-guidance

Appendix 2

Belfast Health and Social Care Trust
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AIDE MEMOIRE
Adult Community and Older People's Services
Assessment - Summary and Action Section

A Social Work Assessment is required to be completed for every service user, please find detailed below, guidance to inform the completion of the **Summary and Action Section** within the analysis summary on the NISAT tool. The aim of this section is to record the identified multi-disciplinary risks, needs and actions associated with the current assessment: The following **sub - headings** will support and guide how the assessment details should be recorded in the Summary and Action Section and what information is required:

Consent

The Department of Health's guidance defines consent as "The means by which service users can exercise control over the dissemination of their confidential information". Please record that consent has been obtained to share and use information recorded during the assessment process using the **NISAT consent form**, this should be stored in the **board forms section of the file.**

Social History

In this section detail rationale for referral to social work ie: case referred for social work involvement for risk assessment and management. In this section it is also helpful to include a brief social history, including past or present diagnosis, significant life events, family history; any relevant medical assessment information that may inform the overall intervention.

Involvement in Family and Community Life

This section refers to the individual's ability to be involved in family life and family involvement including who is in the household ie: living arrangements and accommodation type, relationships, social networks and activities within their

community. It also includes recognition of an individual's social roles and responsibilities, including caring for others. The ability of the individual to work, carry out training, education or past times. This may also include any involvement from the voluntary and community sector in the individual's life; special interests; social needs and spiritual needs; focusing on the strengths of the service user.

Health and Safety

This considers issues of risk to the health of the individual. It includes mental health, emotional well-being and physical health in relation to maintenance of current health status and prevention of deterioration. It is important to recognised that safety has 2 aspects: a) the safety of a person from harm, which could be caused by self, other or his/her environment and b) the safety of others, including family members, from harm caused by the person. In this section it is important to capture risks including category, level of severity and frequency, identified by who and consequences if risks are not addressed. The individuals understanding and acceptance of the risks identified should also be detailed in this section. **Please note this does not replace a Risk Assessment which should also be completed separately from this section if risks have been identified.**

Ability to Manage Daily Routines

In this section consideration should be given to the individual's ability to look after their own personal care focusing on a strengths based approach. This should include domestic needs including, meals provision/dietary needs and other daily routines, medication management, shopping; laundry. Consideration of physical health including mobility should also be included in this section, such as walking and movement, aids and adaptations.

Ability to Manage Financial Affairs

In this section, consideration should be given as to how the service user manage their finances, including how are bills currently being paid, is there anyone who supports with finances and are there any legal arrangements currently in situ, such as an Enduring Power of Attorney. Does the service user have any concerns about their finances; have others raised concerns about their ability to manage their finances such as outstanding debts or arrears and is there any supporting evidence.

Is there a need to consider a financial capacity assessment and/or is a referral to the Office of Care and Protection required. Is there a financial management plan in place.

Autonomy and Choice

This refers to the control a person has over their immediate situation and the extent to which they are able to make and act on informed choices. Within this section incorporation of Human Rights Legislation should be considered ie: Article 3,5 and 8. However, other Articles are also relevant and should be considered. In this section please consider the principles of Best Interests; Deprivation of Liberty and issues relating to capacity and consent to make decisions regarding future care needs and where these are likely to be best met. In this section consideration should also be given to maximising capacity to make informed decisions including effective ways of communication and identification of any communication difficulties ie: use of interpreting service or talking mats; Independent Advocacy service. This section should also include a discussion with the service user in relation to a nominated person (under the MCA definition). Some detail is required as to their rationale for nominating the person. This should be detailed in this section and documented in the central index under nominated person. This section should also be the start of discussions relating to Advanced Care Planning to support future care planning in the event of service users becoming unable to make these decisions. You may wish to consider the following as a guide: Service Users wishes for future care; Enduring Power of Attorney / Financial Management Support; Funeral Planning. If, during the assessment the need arises to consider this in more detail please discuss and refer if appropriate to the Palliative Care and Oncology team to undertake a specific piece of work with the person.

Service Users views

This section should include the expressed views and wishes, both past and present of the service user in terms of how they view their care needs, and anything else that they consider important. This section may also consider whether the service user has an Advanced Directive and or Living Will. In this section, consideration should be given to maximising the capacity of service users to make informed decisions including effective ways of communication and identification of any communication

difficulties ie: use of interpreting service, talking mats or Independent Advocacy service.

Views of others

This section relates to the views of people involved in the service users life and should information given by anyone else involved in the individuals care. These may be obtained from family members, informal carers or formal carers, or other professionals . **This may prompt to consider the need to refer for a Carers Assessment or document if one has already been completed.**

Other

This section should include any other areas identified during assessment that do not fall under the other categories above.

Actions

This section outlines the action type, details and responsibilities. Each action should then form the foundation for care planning. **Please note that by completing actions on the NISAT this does not mitigate the need to complete a BHSCT Care Plan**. Identify areas of agreement, disagreement, concerns and issues in relation to proposed actions and action taken to resolve these. Outline unmet need and action taken to address these. This section may also detail rationale for not taking action.

Please note there should only be one Assessment Summary and Action Details completed based on the most up-to –date assessment. This may be updated as necessary as needs change.

A formal review should be completed using the Regional Review Forms on Paris.

Completion of a Complex NISAT Assessment

The completion of a Complex NISAT is required where the level of support or treatment is likely to be intensive over a period of time whether short or long and where there are significant changes being made in an individual's life due to complex health and social care needs including where a change of domicile is being considered.

Appendix 3

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Risk Assessment and Safety Planning
AIDE MEMOIRE

For the purpose of this document, 'safety planning' will be used alongside 'risk management'. Language used is important to ensure that the service user retains ownership of their situation. Risk management can potentially create an obstacle to working together with the service user, therefore, discussions about 'staying safe' and 'how the organisation or individual can support with this can be more constructive and collaborative.' (Morgan, 2013)

Best Practice Points:

- Safety planning and risk management are an essential part of care planning and should be woven into the care plan
- It should be based on an holistic risk assessment of safety issues and risks to the person, their family and others
- Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for the service user
- Safety planning should be developed collaboratively with the service user and their carer, building on strengths/ resources and the roles of services and individuals
- Avoid professional jargon and use language the service user understands; use their own words where possible
- Safety and Risk Management plans should be clearly and effectively communicated to all concerned
- It should be based on a recognition of the service users strengths
- Good risk assessment and management involves developing strategies aimed at preventing any negative event from occurring or if this is not possible minimising the harm caused
- It should take into account that risk can be both general and specific and that good management can reduce and prevent harm

- The plan should include a summary of all risks identified, situations in which identified risks may occur and actions to be taken by practitioners and the service user
- All staff involved in risk management and safety planning should be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation
- Risk management must always be based on awareness of the capacity for the service users risk level to change over time and a recognition that each service user requires a consistent and individualised approach
- Risk Management plans should be developed by multidisciplinary and multiagency teams with openness and transparency

(*Best Practice in Managing Risk, DOH, 2007, updated in 2009)*

Guidance to support the completion of Risk Assessment

Aim of Risk Assessment	This section should identify the overall aim which includes: the outcome or outcomes to be prevented; consideration as to how to minimise risk and enhance quality of life to ensure that goals and aspirations identified by the service user are maintained; demonstrating awareness of the safety needs of the service user, their carer and others. Plans for recovery should also be included in this section. This should be completed collaboratively with the service user.
People involved in the completion of the risk assessment	Key to effective risk management and safety planning is a good relationship between the service user, carers and all those involved in providing their care. In this section staff should document who participated in the completion of the risk assessment, the overall aim should be to involve the service user in a collaborative approach to planning care. Full engagement is not always possible but the potential for it should always be at the forefront with the process and purpose of risk management being clearly shared with all involved If for whatever reason the service user is not involved in some element of the risk assessment this should be detailed in this section.
Views of Service User	
What is the service users understanding of the risks?	In this section staff should consider issues relating to people's rights including the right to make 'unwise' decisions. Recognise strengths and protective factors and highlight positive influences that promote their independence, personal well-being, protection and quality of life. Consider capacity to weigh up, retain and understand risks discussed and identified
What is the service user most worried about?	This section should be recorded using the service users own words, as far as possible. Points to consider may be finances and its management, potential for Adult Safeguarding concerns being raised, environmental factors, fearfulness of others; deteriorating health, loss of independence, loss of decision making, environmental

	factors, including housing issues. If they are not worried about anything in their life, please document. It is also relevant to assess how they are feeling, thinking and perceiving others as well as how they are presenting. Please document as your opinion/analysis of interaction if you observe any risks not identified by the service user.
What would make you feel safe?	In this section consider making decisions based on what is important to the service user i.e. what is needed to make them feel safe. This may be as simple as who they contact if they need help and that the person knows about their situation. Consider strategies to minimise risks identified, promotion of choice and control in decision making to manage the risk such as more creative ways of delivering support – direct payment, managed budget, support services, family involvement, role of community. If an Adult Safeguarding concern has been raised, discuss how they wish to proceed, including completing an APP1, PSNI involvement, MARAC, RIC/DASH. You may also consider if there are any protection plans already in place.
Views of Carer or Significant Others	
What is their understanding of the risks for the service user?	It is important to get a clear understanding of their views of the service user and associated risks. Please document any areas of disagreement or differences in opinion. Please include their understanding of services and how the service user is currently being supported. If the service user has raised issues in relation to the carer, please be mindful of what information can and should be shared with the carer at this stage (please refer to practice protocols).Discuss if a Carers Assessment has been offered previously re-offer at this stage. Discuss carers support services
What outcomes do they want for the service user?	Consider factors which may minimise the risks identified. Other things to consider may be engagement with support services to improve quality of life, promotion of independence; maintenance of safety, assistive technology; reconnecting with community supports
What support can they provide to the service user?	In this section document what support they are currently providing to the service user. Please remember that risk management is not just responsibility of individual practitioners. Think about contingency planning and their role within this for example if they as the main carer become unwell who should be contacted to support the service user to help prevent a crisis developing

Guidance to support the completion of Risk Analysis

Issue of concern (consider risk to self, others or from others)	Identified risks (please specify)	Desired outcome	Positive factors which minimise risk	Level of risk
This section should detail specific risks and whether this is a risk to self, others or from others For example: Risk to Self - mismanagement of medication	This section should include specific evidence of each risk and frequency of risk. Almost certain, likely, possible, unlikely, rare For example: Established pattern of behaviour and evidence that service user is not taking medication as prescribed; Build-up of medication discovered in the house during assessment visit	In this section Consider what intervention/strategy would prevent the negative event from occurring or if this is not possible minimising the harm caused. Consider preferred choice of the service user and state reasons for not taking action to minimise risk For example: Effective use of a blister pack; Introduction of a care package to support with medication management; use of assistive technology to prompt with medication; therapeutic interventions; appropriate placements	In this section consider evaluation of risk and what exactly is to be prevented Consider risk reduction factors or actions already in place. Build on the strengths of the service user This should help you formulate how the risk might become acute or triggered	Using the BHSCT Risk Matrix **Likelihood scoring descriptors:** Almost certain 5 Likely 4 Possible 3 Unlikely 2 Rare 1 **Consequence levels:** Insignificant 1 Minor 2 Moderate 3 Major 4 Catastrophic 5 For example: Almost certain 5 consequence is Minor 2 =**medium risk level**

Does the analysis identify a risk to others?	In this section, you will be prompted to tick yes or no, if yes, you will be prompted to tick either children or young person or vulnerable adult. Paris will direct you to what is needed if either of these boxes are ticked

Guidance to support the completion of actions to reduce risk

Identified risk	Action required to reduce risk	Who is responsible for managing the action?	Date Actioned	Date completed	Review of risks	Actions reflected in care plan
List each risk identified	This is likely to include consideration of the desired outcome from the risk analysis section	This should detail the responsibilities of service users, the Trust, carer/ family and other professionals involved	This should be the date that the risk was discussed/ action agreed and implemented	This should be the date when the risk has either been mitigated or there has been a change in circumstance and the risk is no longer relevant	This should consider the potential for changes in the level of risk. It is essential that a review is facilitated to be clear about the risks and why a risk assessment is being completed	This is a mandatory field All risks should be recorded in the care plan including actions

Content of Risk Assessment shared with the service user?	In this section you will be required to tick either yes or no, if no, you will be prompted to specify why? It is vital that the risk assessment and action plan is agreed and shared with the service user, to ensure openness and transparency. Please note that a risk management plan is only as good as the time and effort put into communicating its findings with others

Appendix 4

NISAT	Consent	Oct 2015

General Information

Assessed Person's Details	
Name	
DOB	
H&C No	
Address	
Post Code	
Contact Tel No	

Consent

Consent

- ☐ I agree that the information provided in my assessment may be shared with health and social care professionals and service providers who can contribute to my care
- ☐ I agree that information in relation to my health and social care needs may be shared with my carer(s)
- ☐ I agree that information in relation to my health and social care needs may be obtained from others involved in my care
- ☐ I understand that I may withdraw my consent to share information or have further assessment at any time, but that this may affect ability to provide full services for me
- ☐ I understand that I have the right to restrict what information may be shared and with whom, but that this may affect ability to provide full services for me

Restrictions					
Please specify which information you do not wish to share					
Please specify with whom you do not wish to share information					
Consent type Verbal Written None (please give reason)	Please select an item below Choose an item.				
Assessed person's signature				Date	
Print Assessor Name		Designation		Contact Tel No	
Assessor's signature				Date	

Appendix 5

Belfast Health and Social Care Trust
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Care Plan Agreement and Signature

In accordance with best practice principles and from the recommendations from the BSO Audit (2018) regarding compliance the Care Management Circular 2010, the following process has been developed.

Service users should **always** be offered the opportunity to sign their care plans and be provided with a copy.

- Completion of the care plan should happen in the usual way, following the undertaking of an assessment of need and discussion with the service user and family / nominated person (if appropriate).
- Two copies of the typed care plan should be posted to the service user / carer/ nominated person (as appropriate) with a stamped addressed envelope. This will enable the service user to sign the care plans and post one back to the social worker, without charge to them.
- The date on which the care plan was sent to the service user should be recorded
- A copy of the signed care plan should be kept in the service user's file under the section 'care plans'.
- A record of who has received a copy of the care plan should be retained on the service user's file.

If the service user and / or family decline to sign the care plan, this should be recorded on the service users record

Appendix 6

Belfast Health and Social Care Trust
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AIDE MEMOIRE

Care Planning

Principles of Care Planning

- The care plan is a written record of the service user's needs (identified through the assessment process) and plan of action to meet those needs negotiated with the service user and / or family member / nominated person.It is a plan of agreed elements of care and support that are required.
- The care plan should be person centred and developed in partnership with the service user
- The care plan is a dynamic document and should updated as new strengths, weaknesses or risks emerge
- The care plan is not a contract, but a commitment to a course of action from all those involved. Therefore, the contribution to delivery of the care plan to be made by the service user, family or carer (s) should be considered and recorded.
- The care plan is likely to include input and information from other professionals, who also know the service user well
- The care plan may include elements of crisis or contingency planning. The plan may include who the service user responds to best and how to contact them, previous strategies that have been successful in similar situations, early warning signs and responsibilities of all involved in the service user's care
- The care plan should always be able to be picked up and used by colleagues if the person coordinating or providing the care is not there (i.e. social worker / care worker), so must include enough information to implement the plan.
- The service user should be referred to by name throughout the care plan. Where service users have been involved in the writing of their own care plans, they may wish to use 'I' statements (i.e. I need help in the morning to dress….).
- Abbreviations should be kept to a minimum and only common abbreviations used.
- Where there are no needs identified in a particular section, it should be recorded as such. However, these areas should still be reviewed, as part of the overall review process, as there may be changes or new goals, which the service user later considers important.

Where there are identified needs and / or risks, there should be consideration of how these will be met[i]. A brief summary at the end of the care plan will enable all involved to see clearly the risk / needs to be managed, the action to be taken to manage these and who is responsible. For example:

Need / Risk	Agreed Action to Meet Need / Risk	Responsible
Mary is unable to make her own meals due to high risk of falls in the kitchen.	Carer to call each morning to make breakfast and call back to make lunch. Jo (Mary's daughter) will call each day to make Mary's tea.	Homecare service. Jo

Guidance to completing the Care Plan

Overall Aim of Care Plan *(consider aims, objectives, expected outcomes, goals and if there is a deprivation of liberty in place)*	This section should include what will be achieved by making the care plan. Details of the environment, care and /or services to be provided should also be noted. The document 'Care Management, Provision of Services and Charging Guidance, 2010' states that all care plans should include the objectives and expected outcomes. Detail in this section what care and treatment will be provided to the service user during the Deprivation of Liberty
Consent	The care plan should record consent from the **assessed person / service user to share relevant information provided in the assessment and the care plan** with those involved in the delivering of care and / or services, as required. It is important that there is discussion with the service user about whom their information will be shared with and how this will be done. If the service user declines to provide consent, this should be recorded. **It is important that the documents relating to consent, agreed within your programme of care, are completed (e.g. NISAT consent form). Paper copies of these documents should be held in the board forms section of the service user's blue file**.
Physical Health *(consider relevant medical information, sleep, pain, breathing, skin, feet)*	This section will consider the actions required to support the service user with their Physical Health needs. Actions should include consideration of relevant medical information, appointments / clinics attended, any difficulties regarding pain, breathing, sleep, skin, feet or anything else that

	may be relevant and how these issues are being managed (e.g. attendance at medical clinic, use of oxygen, appointment at podiatry, pain relief, preferred routines at night to assist sleep). Other professionals may contribute to this section (e.g. respiratory nurse, podiatrist, district nursing, diabetic specialist nurse, palliative care and oncology team). Areas to be covered may include: • Medical conditions • Ongoing treatments • Pain • Breathing • Feet • Skin (including pressure damage) • Allergies • Infections • Oedema • Sleep
Mental Health and emotional Well Being *(consider mood, relevant diagnosis, impact of life events)*	This section will consider the actions required to support the service user with their Mental Health needs. Please consider any relevant diagnosis and how this has impacted upon the person on a daily basis. It may include dementia diagnosis, functional mental health or acute mental health episodes. Also, consider life events, social isolation and changes in the local community and the impact that these may have. Please note how any issues or difficulties are being managed (e.g. attendance at clinics, support from mental health services, counselling, and informal family support).
Awareness and Decision Making *(Consider capacity, impact of dementia, mental ill health or learning disability or other event, fluctuations in capacity, road safety and other risks)*	This section will consider the actions required to support the service user to maximise their decision making and to ensure that their Human Rights are protected, where they are not able to make their own decisions. Needs may have been identified in relation to a service user's awareness and decision-making. The Deprivation of Liberty Safeguards Code of Practice provides guidance. This section may record formal psychiatric assessments, as well as assessments by the social worker or other professional (as detailed in the code of practice). It will detail decisions that the service user is unable to make due to incapacity and the safeguards, which are (or will be) in place (i.e. EPA, Controllership, and use of MCA). Areas covered may include decision making (e.g. about care placements or management of finances) or the impact on daily living (e.g. safety awareness regarding roads, cooking, security or other risks).

	This section may record the decisions made by a service user (who has the capacity to make the decision) not to accept support or to accept risk(s) despite assessment / advice from professionals involved in their care.
Communication and Sensory Functioning *(hearing loss, speech difficulties, methods to communicate, language barriers, other senses)*	This section will consider the actions required to support the service user with their communication needs. Please consider how best to communicate with the service user. Is an interpreter needed, use of talking mats, texting instead of telephoning or is there a preferred time to visit (e.g. in the morning when the service user is more lucid)? Is there a particular way in which the service user should be approached? Is a specialist assessment required from the sensory support team? Is equipment needed to promote independence? Does the service user have needs / risks around the other senses (touch, taste or smell).
Walking and Movement *(consider manual handling assessments, equipment needed, falls, transfers, stairs, other factors i.e. SOBOE)*	This section will consider the actions required to support the service user with their presenting or assessed mobility needs. The higher the level of need identified, the greater the level of detail required in how these needs are to be met. A short comment may suffice for someone who is independent or maintains independence with the safe use of a walking aid as this minimises the risks. However, for those with greater needs, there should be detailed information of the manual handling assessment and equipment used. Input from the district nurse, occupational therapist or physiotherapist may be required. This section will also provide detail for carers who are using manual handling techniques and equipment to provide personal care safely.
Personal Care *(consider support needed to wash, dress & shower, areas of independence, other supports i.e. carer, hairdresser, podiatry)*	This section will consider the actions required to support the service user with their personal care needs. All aspects of personal care should be considered, including washing dressing, toileting, hair and personal grooming. There may be needs identified, which the service user or carer can organise and deliver (e.g. home hairdressing, daughter will supervise shower). Areas where the service user has independence should be highlighted. The Care Plan should include how the service user wants their personal care to be delivered and what is important to them (e.g. make up and mirror left within reach). There may be overlap with other sections if the service user has high dependency needs and requires manual handling and equipment to ensure that they receive personal care safely. Please consider how personal care might be delivered to minimise agitation or stress to the service user, especially if there is dementia or another condition, which would impact on their insight or

	understanding of what is taking place.
Diet and Mealtimes *(consider dietary needs, dentures / dental care, SALT, ability of use cutlery, areas of independence when making a meals or snack)*	This section will consider the actions required to support the service user with their dietary needs. This section may include what the service user enjoys eating and their mealtime routine.). Personal likes and dislikes will be recorded here (not necessarily a list of everything they like and do not like, but things that are of importance to the service user). It must consider what the service user can safely consume (e.g. restricted diets due to diabetes, SALT recommendations, allergies) as well as how they can do this (e.g. do they need specialist cutlery to help them maintain independence with eating, is assistance with eating required Independence or assistance needed when making a meal or snack should be recorded and what help or services are required. Dietary choices due to faith or religion should be recorded. This is especially important when the service user does not have independence in this area.
Continence Care *(level of care required, products, areas of independence)*	This section will consider the actions required to support the service user with their continence needs and to protect their dignity. All needs and risks should be recorded and may have input from the continence service or district nurse. Any continence products used should be noted, as well as how independence can be promoted (e.g. reminding service user to use bathroom, ensuring commode is easily accessible at night time).
Managing medications *(Consider ability to take medication as prescribed, blister packs, suspensions required due to SALT recs, ability to use inhalers, O2, etc.)*	This section will consider the actions required to support the service user with their continence needs and to protect their dignity. This is an opportunity to record any needs identified in this area, including assistance needed to take medication by a carer, delivery of medication, if a suspension is required, as well as ability to use nebulizers, oxygen, etc. Contributions from carers and family should be recorded (e.g. son collects medication). Some service users may require a locked box for medication and arrangements around this should be recorded.
Living Arrangements and Accommodation *(consider environment care*	Any number of needs and risks can be associated with the home environment and living arrangements. Needs and actions may be identified through the consideration of risk management (i.e.

is to be delivered in, upstairs / downstairs arrangements, plans for sheltered or supported accommodation, personalisation of room, issues of hoarding, access for care workers)	downstairs arrangement, issues of hoarding) to consideration of moving to sheltered / supported models of accommodation to promote independence, citizenship and life opportunities. **Access for care workers can be recorded here (key safe codes should not be recorded on the care plan).**
Finance *(consider controllership, EPOA, appointee, access to money for daily living, input from SW or care home, patients bank)*	**In accordance with the recommendations from the BSO audit (2019) in relation to the Care Management, Provision of Services and Charging Guidance 2010 circular, consideration of a service user's financial capacity needs to be properly documented.** This section will highlight areas of need in this area and any actions that need to be put in place or are currently in place to meet this need. Examples include referral to Office of Care and Protection, EPOA in place, referral to patients' bank and any input required from the social worker to meet an assessed need. This section may also record management of personal allowance and /or how a service user accesses money for daily living expenses.
Household Tasks *(consider shopping laundry, cleaning)*	Are there needs in this area and can the service user or family make their own arrangements? Is a service required because the level of need is reaching critical or substantial levels, as per the Domiciliary Care Policy[ii]?
Relationships *(consider how contact maintained with sig others / family, expression of sexuality, who provides emotional support, issues of no contact i.e. non-molestation orders)*	This section will consider the actions required to support the service user to participate in and retain important relationships in their lives and community. Consideration should be given to the relationships that are important to the service user and how contact is maintained with these people. The social networks / supports that the service user would like to engage with and how this could be achieved, may be part of the care plan. This is very individual and will be as diverse as looking at day care, connecting with the local LGBT community or joining the local men's group. If the service user has a nominated person, it should be noted here. Any issues of non-contact / non-molestation orders should be recorded, especially where this is part of a protection plan.
Work and Leisure *(Interests and hobbies, employment / voluntary work, support to develop social well-being, integration into new a*	It may be the service user's goal to reconnect with interests and hobbies they once had or want to consider something new. This could be very diverse and include education, voluntary work or paid work. This section also incorporates actions to support service users integrate into their new community (could be supported living or care placement).

<table>
<tr><td>community)</td><td></td></tr>
<tr><td>Spiritual Needs
(faith, place of worship and support needed to attend, important celebrations / observations / routines)</td><td>This section will consider the actions required to support the service user to express their spiritual needs.
What is important to the service user? May include, faith, place of worship, maintaining connections and social support with place of worship, important routines associated with faith (e.g. reading texts, prayer, attendance at place of worship). For services users moving to supported living or group care, how can these needs be met? How are others (family, friends, local community) helping to meet these needs.</td></tr>
<tr><td>Quality of Life / Goals</td><td>The aspirations and goals of service users should be central to care planning and actions to support them to achieve these should be included in the care plan.

What is the service users lived experience? What goals does the service user have and what would they consider to help them maximise their quality of life.</td></tr>
<tr><td>Promotion of Human Rights (Please consider human right principles of fairness, respect, equality, dignity and respect)</td><td>Are the service user’s human rights at risk? Do they need protecting or promoted? What needs are identified?</td></tr>
<tr><td>Deprivation of Liberty
(Please consider best interests / use of locked units / enhanced monitoring / continuous supervision)

If there is a Deprivation of Liberty in place</td><td>Is an assessment under the Mental capacity act required? What is the deprivation of liberty, what needs or risks is this addressing and what actions are required?

This section should be completed for all services users who are under continuous supervision and control[iii]. This may be in the form of placement in a dementia unit, enhanced one to one monitoring and the use of locked doors.

Include in this section what actions will be taken to ensure the Deprivation of Liberty can be ended as soon as practicable</td></tr>
<tr><td>Unmet Need</td><td>Any areas of unmet need should be recorded.</td></tr>
<tr><td>Summary of Risk Management</td><td>This is a synopsis of risks and needs and how these will be managed. It is not intended to replace a comprehensive risk assessment. This should provide all those involved information on the risks / needs, the action to be taken and who is responsible. For example:

<table>
<tr><th>Need / Risk</th><th>Agreed Action to Meet Need / Risk</th><th>Who is Responsible</th></tr>
<tr><td>Mary unable to hear</td><td>Referral to sensory support</td><td>Social worker to make</td></tr>
</table>
</td></tr>
</table>

	doorbell, when people call.	team for assessment of equipment that may be useful.	referral.
	Mary unable to see if clothing is stained and needs changing.	Care worker to assist Mary with selecting clothing for the day and ensure that any clothing that needs laundered is place in basket.	Social worker to request service. Care worker to carrying out tasks required and report any difficulties.
Monitoring and Review Arrangements	The care plan should clearly state the monitoring arrangements and the date of the next formal review. **If there is a Deprivation of Liberty in place the provisions for review of the intervention must be documented in this section**		
Additional Information	This section can contain any other information that may be pertinent to the care plan.		

Appendix 7

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards Code of Practice must be adhered to at all times when considering the deprivation of someone's liberty.

In order to be protected from liability, when depriving someone of his or her liberty, there must be reasonable belief of lack of capacity and best interests.

There are four additional safeguards. These are:

1. A formal assessment of capacity is required (chapter 8 of CoP).
2. The Nominated person is consulted (chapter 9 of CoP).
3. The prevention of serious harm condition is met (Chapter 7.6 of CoP).
4. Authorisation is applied for and granted (chapters 11 & 12 of CoP).

Formal Assessment of Capacity

The Code of Practice states that

> "A person is not to be treated as lacking capacity in relation to a DOL unless it is established that a person lacks capacity. A person lacks capacity in relation to a DOL is:
>
> *Unable to make a decision for himself or herself about the matter, because of an impairment of, or a disturbance in the functioning of, the mind or brain*."
>
> (Deprivation of Liberty Safeguards Code of Practice, p2).

A determination of a person's capacity is based on three elements, which are of equal importance:

1. The functional test
2. Diagnostic test
3. Causal link

A suitably qualified person, as determined by the Legislation, and thereafter, the Trust should complete the assessment of capacity.

The Nominated Person

The nominated person must be consulted when a deprivation of liberty is being made. Whilst the nominated person is not a decision maker, they are important in their contribution to the decision making process. Where a DOL is proposed, the staff member *will not* be protected from liability unless the nominated person has been consulted.

The CoP has guidance on the appointment of a nominated person. If the person or the review tribunal has not appointed a nominated person, one is selected from the default list, as long as he or she is over 16 and is not to be disregarded due declaration by the person or the review tribunal.

Prevention of Serious Harm (PoSH)

Section 7.6 of the CoP summarises the condition as follows:
"the person carrying out the detention amounting to DoL to believe that failure to detain the person would create serious risk of harm to P or serious physical harm to others."

The person carrying out the DoL also needs to ensure that the likelihood and seriousness of harm is proportionate to the detention.

Authorisation

Authorisation by a Trust panel is the final safeguard in this process. The Trust panel must always make a decision regarding the application for authorisation within seven working days. If the situation is an emergency, a DoL can go ahead, if the criteria and all other safeguards have been met. An application for authorisation must be made without undue delay. The CoP states that a period greater than 24 hours, since the DoL was made without an application is unlikely to be reasonable.

The Code of Practice, training and supplementary procedures from the Trust should be used at all times to ensure that any DoLs are completed in a person-centred and timely way.

The Deprivation of Liberty Safeguards Code of Practice and other material can be found at https://www.health-ni.gov.uk/mca

Appendix 8a

Belfast Health and Social Care Trust
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Resident Review Form

INFORMATION TO SUPPORT CARE HOME REVIEW

This Form is to be completed by a senior staff member within the Care Home prior to the Annual Formal Review and based on the persons assessed need and lived experience evidenced within the care plan.

Please attach relevant care plans.

Resident's Name		**D.O.B.**	
Admission Date			
Last Review Date		**Is this the first review?** Yes / No	
Name of Facility			
Name and Designation of Staff member completing this form			

Special medical conditions, disabilities or allergies

Health & Well Being	
How has the home ensured that care is Person Centred?	
▪ **What is important to the person** ▪ **What is important for the person (to keep them healthy and safe)** ▪ **What do others like and admire about the person?**	

▪ **What are their likes and dislikes?** ▪ **What makes them happy or sad?** ▪ **How do they communicate with others?** ▪ **How do others communicate with them?** ▪ **Do they have any significant routines or rituals?** ▪ **What places do they like to go to?** ▪ **Who are the important people in their life?** ▪ **What are their gifts, qualities and skills?** ▪ **What would the perfect week look like?**	
Has the person contributed to the design and furnishing of their room?	Yes/ No Details
Does the person have personal space where they feel safe & secure?	Yes/ No Details
What leisure activities and hobbies does the person enjoy?	Details
How is this supported by the home?	Details
How are relationships maintained with family and friends?	Details
Is the person happy and settled within the home? How is this measured?	Yes/ No Details
Indicators that the person is experiencing ill-being. Please identify how the person expresses feelings of ill-being.	Details
Is this reflected within the persons care plan, detailing management strategies?	Details
Is there any restrictive practices?	Yes/ No Details

Consultations					
Has the person been seen by any Health Care Professionals since the last formal review? Please state reasons, dates, and any outcomes of these. Please attach any relevant reports.					
Professional	**Date**	**Reason for referral**	**Recommendation**	**Outcome**	**Care Plan updated**
GP					
Community Mental Health for Older People Team					
Dementia Outreach Team					
Dentist					
Occupational Therapist					
Physiotherapist					
Speech and Language Therapy					
District Nursing					
Dietetics					
Tissue Viability Nursing					
Palliative					

Care Nursing					
24 Hour Nursing Service					
Podiatry					
Other					

Hospital				
Has the Service User attended hospital since the last review?				
	Where	**Duration of stay**	**Reason for intervention**	**Outcome**
Accident & Emergency				
In patient admission				
Outpatients				
Day Procedure				

Medication	
In accordance with Regulations & Standards how many times has the person's medication been reviewed?	Details
Does the person have any difficulties due to swallowing difficulties?	Yes / No Details
Is the person compliant with receiving their medication?	Yes / No Details

Does the person have a known history of Delerium?	Yes / No Details
Was this identified promptly, and how was it addressed?	Yes / No Details
Has the person had an episode of Delerium within the last review period?	Yes / No Details
Is the person prone to infection, if yes is there a care plan for early identification, effective management & prevention of further deterioration	Yes / No Details
How has this information been communicated with carer?	Details
Is the person on treatment for Depression or Antipsychotropic medication?	Yes / No Details of when last reviewed and by whom
What impact has this had on the person's mood, wellbeing & ability to function to their potential?	Details

Does the person require support with Breathing	
Strengths	
Does the person have any difficulties breathing?	Yes / No Details (e.g. at rest, Exertion)
How is this addressed within their care plan?	Details
What impact does this have on the persons quality of life and ability to participate in hobbies or activities	Details

Does the person require support with Mobility & Transfers
Strengths

Independent	Yes / No
Independent using aid	Yes / No
Assistance with 1 person	Yes / No
Assistance with 2 people	Yes / No
Wheelchair	Yes / No
Immobile / Hoist	Yes / No
History of falls since last review/Action plan to address or reduce further risk of falls e.g. referral to the Falls Team	Yes / No Details
Does this impact upon the person's quality of life? **For example:** Do they feel isolated, restricted, and unable to participate in Hobbies or activities?	Details:

Does the person require support with Personal Care and Personal appearance	
Strengths	
Independent	Yes / No
Assistance and level required	Yes / No Details
What is important to the person?	Yes / No Details
Have the person's preferences been considered and evidenced in their care plan?	Yes / No Details
Does this impact on the person's quality of life? **For example, is there a change in the person's behaviour? Do they become distressed, cry out or resist?**	Yes / No Details
How do you support the person with personal appearance & self-expression?	Details

Does the person require support with Toileting needs	
Strengths	
Is support required?	Yes / No Detail
Is this reflected within the person's care plan?	Yes / No Detail
Are there any environmental factors impacting on the person's quality of life?	Yes / No Detail

Does the person require support with promoting good skin care	
Strengths	
Has a Braden Score been recorded and reflected within the care plan?	**Date Assessed and Updated** Detail
How has this impacted on the persons quality of life	

Does the person require support with foot care	
Strengths	
Does the person receive care by a podiatrist?	Yes / No Detail
Does the person suffer pain as a result of blistering, bunions, foot ulceration or long toe nails?	Yes / No Detail
Does person find footwear comfortable?	Yes / No Detail
Does this have an impact on persons quality of life	Yes / No Detail
Does the person spend long periods walking/ pacing? Has this been reflected in the care plan?	Yes / No Detail

Does the person require support with Oral Hygiene	
Strengths	
Does the person receive Dental treatment?	**Yes / No** **Details**
Does the person wear dentures? **Are they well fitted?**	**Yes / No** **Details**
Is there a care plan to reflect appropriate level of support & manage risk	**Yes / No** **Details**

Does the person require support with Nutrition

Strengths	
Does the person require support with their nutritional needs?	Yes / No Details
Has the person's preferences, medical or cultural dietary needs been considered?	Yes / No Details
Has there been any change in relation to the person's needs?	Yes / No Details
Is this reflected within the persons care plan?	Yes / No Details
Does the person require any specialist equipment? Is this reflected in their care plan?	Yes / No Details
Does the person have an opportunity to dine outside of the home?	Yes / No Details
How has this impacted upon the person's quality of life?	Details

Does the person require support with Sensory and Communication Needs	
Strengths	
Does the person have any visual difficulties?	Yes / No Details
Does the person have any hearing difficulties?	Yes / No Details
Is this reflected within the person's care plan	Yes / No Details
Does the person have any communication difficulties?	Yes / No Details
How does the person express their needs and preferences?	Details
Is this reflected in the person's care plan?	Yes / No Details
How does this impact on the persons quality of life and ability	Details

to socially interact with others	

Does the person require support with their Spiritual Needs	
Strengths	
Does the person have any spiritual or religious beliefs	Yes / No Details
Does the person have any fears or anxieties?	Yes / No Details
Does the person discuss their wishes in the event of their death?	Yes / No Details
How are these supported and reflected in the person's care plan?	Details
Does the person have hobbies or interests?	Yes / No Details
How is the person encouraged to participate, is this reflected in the person's care plan?	Yes / No Details
How has this impacted on the person's quality of life?	Yes / No Details

Risk Minimisation		
Are there any further identifiable risks specific to the person that have not already been considered? E.g. smoking in their room, on-going family conflict		
Identified risk area	**Management strategies**	**Date**
Advanced Care Plan		
Has an Advance Care Plan discussion taken place with the person? If so, have their decisions been documented and reviewed? Who has been nominated to ensure person's wishes are followed?		

Any Other Issues / Comments
Include any current or on-going issues reported by person, family, or next of kin

Completed By:

Appendix 8b

Belfast Health and Social Care Trust
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Care Management
Care Home Service User's Review
This is to be filled in by a Trust representative

Service User's Name:			
Paris ID		**Date of admission:**	
Date of Birth:		**Review Date:**	
Summary of most recent assessment, made prior to review: *Reason for intial placement*			
Name of Facility:			
Type of Facility:			
Does the basic information require updating? *i.e. Next of Kin, changes in contact details, telephone numbers* If yes, please update with the Finance department and CIS.			

In Attendance

e.g service user, next of kin, care home representative, professional staff. Include apologies and reasons for non-attendance

Names	Invited	In Attendance Yes/No Apology

Does the service user consent for the review to take place?	
Does the service user consent for details provided by the care home to be shared with you?	
Does the service user have mental capacity to take part in the review? **If no, what steps have been taken to enable the service user to participate in the review, e.g. specialist communication tools such as "Talking Mats" or use of an Independent Advocate.**	

Is the service user subject to a Guardianship order or other legal ordinance?	No

Update on Care Plan:	
If this is a first review, have there been any significant issues to date?	No
If Yes details:	
Have all the tasks identified in the Outcome/Action Plan agreed at the previous review been completed? **If no, what is outstanding?**	

Care Needs Review

Details for this section should be completed in conjunction with a senior staff member within the care home and the Resident Review completed by them.

Have the service user's updated Care and Support Plan and any risk assessments (held by the Home) been made available to be viewed by you, the Trust representative? **Care plans reflect assessed health and social care needs** **Care plans are updated on a monthly basis or when there are significant health care changes.**	Yes

Have you seen any recent reports provided by Health Professionals	
Has the service user had changes to their medication since the last review?	
Are there any issues in relation to the management of the service user's personal property? **Please discuss any relevant concerns**	

Service User's Wellbeing	
How is the service user's physical health? Have there been any changes since the last review? *e.g appetite, weight loss, allied health professional input, mobility, dependency level,*	
SERVICE USER'S COMMENTS	**SERVICE USER'S REPRESENTATIVE'S COMMENTS**
How is the service user's mental health? Have there been any changes since the last review?	
SERVICE USER'S COMMENTS	**SERVICE USER'S REPRESENTATIVE'S COMMENTS**

Any other comments:
Please document any other points been raised during this review

Satisfaction Levels and Quality		
Please provide information on the following	**Service User's Comments**	**Service User's Representative's comments**
Care received		
Staff		
General environment		
Food		
Laundry		

Room		
Social *e.g communal activities, hairdressing*		
Has there been a need to make a complaint since admission or last review? If Yes, give details	nil	
Have there been any Quality Issues since admission or the last review? If Yes, give details		
Provide details of any issues identified or reported		
Does the care review reflect Person Centred Care? Yes/Please detail below		

Final Considerations	
Has the care home review highlighted any evidence that would indicate a breach of the service user's Human Rights? **Please consider the following articles in particular:** • **Right to peaceful enjoyment of personal possessions (Article 1)** • **Right to life (Article 2)** • **Right not to be treated in an inhuman or degrading way (Article 3)** • **Right to liberty (Article 5)** • **Right to respect for private and family life (Article 8)** • **Right to freedom of thought, conscience and religion (Article 9)** • **Right to freedom of expression (Article 10)** • **Right not to be discriminated against (Article 14)**	**No**

(See appendix document for further guidance) **Any issues should be discussed with Care Manager or Team Manager, who will consider if a 'best interests' meeting is appropriate.**	
Are you satisfied that the service user's assessed care needs are being met? **If no, please outline and identify any unmet need.**	
Have any specific risks been identified? **Please outline these and any strategies in place to manage these** **Falls – strategies in place to help manage and reduce the identified risk.**	
Have any Carer's needs been identified? *Has a Carer's Assessment been offered and/or completed?* *Please detail any actions taken.*	

Outcome / Action Plan following this Review:			
Action	**Who is to complete the action**	**Date Agreed to be Completed by**	**Date Completed**
Has a suitable timetable for this Action Plan been agreed?			
Have you arranged a date for the next review?			

Care Management Minutes of Care Home Service User's Review			
Name of Service User			
Name of Care Home			
Date of Review			
Signature of Service User		**Date**	
Or			
Signature of Service User's Representative		**Date**	
Print Name & Designation of Person Completing Review	Crest Practitioner		
Signature of Person Completing Review		**Date**	
Print Name of Care Manager			
Signature of Care Manager		**Date**	
Agreed Date of Next Review			

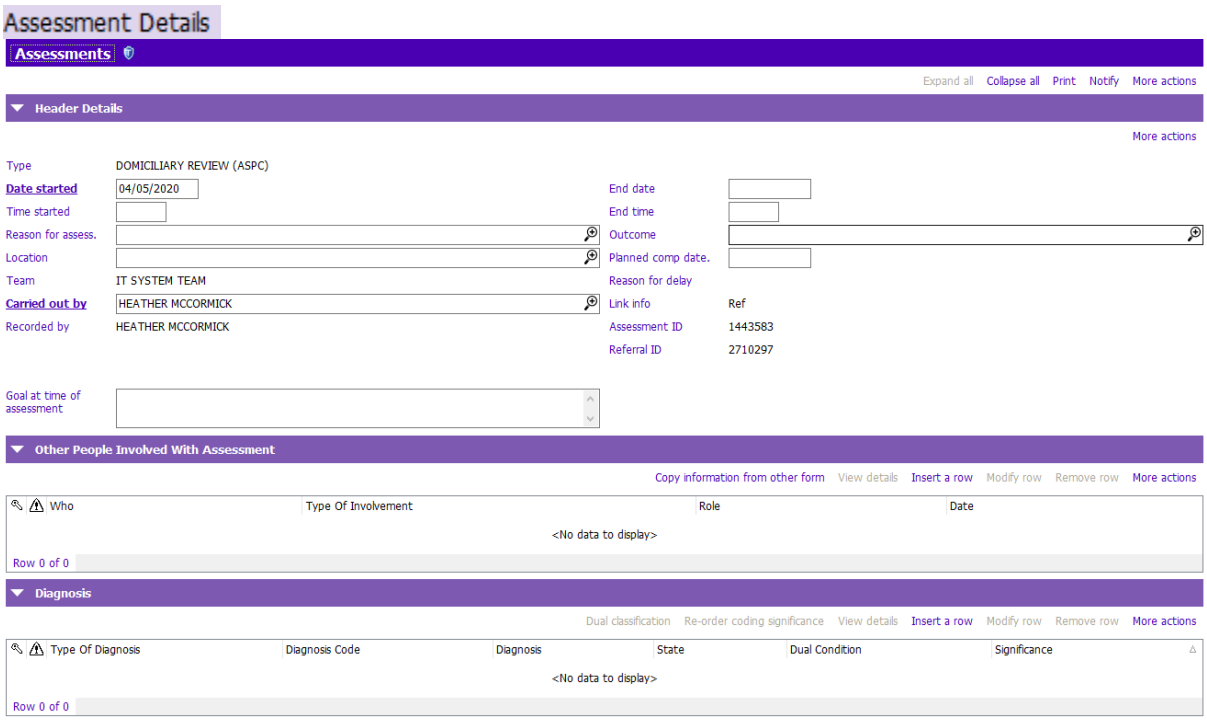
Finance: **Information on 1-4 can be obtained from Finance department and should be requested prior to review.** **When arranging review please request that the Home have a copy of the service user's financial record available.** **Information on 5-9 can be obtained from the Home following the review.**	
1. Are all bills for the care home placement being paid including Third Party Agreement, if applicable?	
2. Is there a Third Party Agreement to Pay (at current rate) in place?	
3. Is service user self funding? **If Yes, is there a current Agreement to Pay (full cost) form completed?** **Has the service user sufficient funds to continue to pay until the next review?**	
4. Who is managing the service user's personal allowance? *Finance will confirm if Trust are Corporate Appointee*	
5. Does the service user have a Power of Attorney or appointee in place?	
6. Is the personal allowance being used appropriately and are the personal needs of the service user being met? *Are they receiving a sufficient supply of toiletries, clothing, shoes, sleepwear, cigarettes?*	

7. Is the home holding a balance in the service user's personal allowance exceeding £150 or in the case of residents in receipt of mobility allowance £500?		
Balance: If yes, this balance must be forwarded to patient's bank at Knockbracken Healthcare Park.		Date:
8. Has the Home confirmed that all financial transactions are properly receipted in accordance with RQIA Standards? **Review the service user's financial record held by the care home by reviewing a sample amount of receipts** **Do these records accurately reconcile with the service user's personal finance record held by the Home?** **Are there two signatures against each transaction with corresponding receipts?**		Yes /no Yes /no Yes /no
9. Are there any additional expenditures being made from the service user's personal account since the last review? *For example, holidays, outings, payments to other parties including family and transport, funeral plans.*		No Details:
Record any other concerns raised by any party in respect of the service user's finances		
Detail any actions required, who is responsible for undertaking these actions, and the timescale for action.		

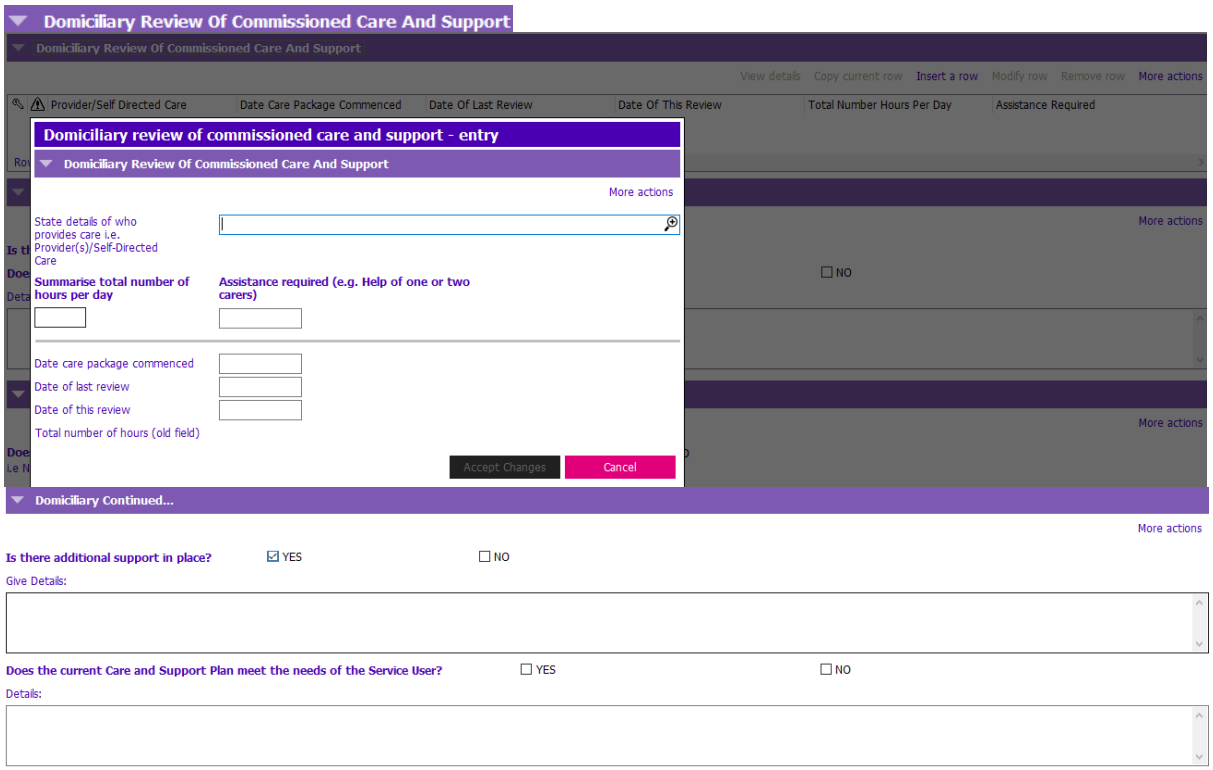
Appendix 9

Domiciliary Care Review

Assessment Details



Review Form



Does the basic information require updating? ☐ YES ☐ NO
i.e Next of Kin, Changes in contact details, telephone number, GP

Does the Service user have mental capacity to take part in the review? ☐ YES ☑ NO

If No, Please give details below:

Have all methods been explored to ensure that the service user can take part in the review? e.g. Talking mats, Makaton, Interpreter ☐ YES ☐ NO ☑ N/A

Does the Service user consent for the review to take place? ☐ YES ☑ NO

If No, Please give details below:

Is the service user subject to a Guardianship Order or other legal ordinance? ☑ YES ☐ NO

Detail below:

Update On Action Plan

More actions

If this is the first review, have there been any significant issues to date? ☑ YES ☐ NO

If Yes, Give Details:

Have the tasks from the previous Action Plan been completed? ☑ YES ☐ NO

Access

More actions

Have there been any issues regarding access? ☑ YES ☐ NO

Details:

Attendees

Grid to allow as many entries as required

IN ATTENDANCE (Include Apologies And Reasons For Non-attendance)

View details | Copy current row | Insert a row | Modify row | Remove row | More actions

Attendance	First Name	Surname	Invited	Attended
<No data to display>				

Row 0 of 0

IN ATTENDANCE (include apologies and reasons for non-attendance) - entry

IN ATTENDANCE (Include Apologies And Reasons For Non-attendance)

More actions

Attendance
First name
Surname
Invited? ☐ YES ☐ NO
Attended? ☐ YES ☐ NO

Accept Changes | Cancel

More actions

If this is the first review, have there been any significant issues to date? ☐ YES ☐ NO

Have the tasks from the previous Action Plan been completed? ☐ YES ☐ NO

Access

More actions

Have there been any issues regarding access? ☐ YES ☐ NO

Changes Since Last Review

YES and NO both activate text boxes

Physical, Oral Or Visual Health

More actions

Has there been any change related to Physical, Oral or Visual Health? ☐ YES ☑ NO

Comments:

Has there been any change related to Physical, Oral or Visual Health? ☑ YES ☐ NO

Issues related to Physical Health

Hospital admissions, any professional involvement

Service User's Remarks

Service User Representative

Medication

More actions

Has there been any change related to Medicaiton? ☐ YES ☐ NO

Communication

More actions

Has there been any change related to Communication? ☐ YES ☐ NO

Breathing

More actions

Has there been any change related to Breathing? ☐ YES ☐ NO

Pain

More actions

Has there been any change related to Pain? ☐ YES ☐ NO

Restraint

More actions

Has there been any change related to Restraint? ☐ YES ☐ NO

Mobility/transfers

More actions

Has there been any change related to Mobility/Transfers? ☐ YES ☐ NO

Toileting

More actions

Has there been any change related to Toileting? ☐ YES ☐ NO

Personal Care/Dressing

More actions

Has there been any change related to Personal Care or Dressing? ☐ YES ☐ NO

Skin

More actions

Has there been any change related to Skin? ☐ YES ☐ NO

Nutritional Needs/Feeding

More actions

Has there been any change related to Nutritional Needs/Feeding? ☐ YES ☐ NO

Sleep

More actions

Has there been any change related to Sleep? ☐ YES ☐ NO

Social Needs

YES and NO both activate text boxes

Have Spiritual needs changed since the last review? ☐ YES ☑ NO

Comments:

Have Spiritual needs changed since the last review? ☑ YES ☐ NO

If yes, please provide details below:

Does the service user attend a place of worship?

Service User's Remarks

Service User representative's remarks

Is there any update in relation to social needs/special interests? ☐ YES ☐ NO

Has there been any change in relation to family involvement and household members? ☐ YES ☐ NO

Has End of Life Care or Advanced Care Plan been considered? ☐ YES ☐ NO

Carer Needs

Option1. Accepted

Carer's Needs

More actions

Has the need for a carers assessment been identified?	☑ YES	☐ NO
Has a carers assessment been requested?	☑ YES	☐ NO
Has a carer's assessment been offered?	☑ YES	☐ NO
If offered was a carer's assessment accepted or declined?	☑ ACCEPTED	☐ DECLINED
If accepted, date referred to Professional Staff member:		
Carer's assessment previously completed?	☐ YES	☐ NO
Does the Carer avail of care relief e.g. short breaks?	☑ YES	☐ NO

Give details:

Option 2. Declined

Has the need for a carers assessment been identified?	☑ YES	☐ NO
Has a carers assessment been requested?	☑ YES	☐ NO
Has a carer's assessment been offered?	☑ YES	☐ NO
If offered was a carer's assessment accepted or declined?	☐ ACCEPTED	☑ DECLINED
Reason Declined		
Carer's assessment previously completed?	☐ YES	☐ NO
Does the Carer avail of care relief e.g. short breaks?	☑ YES	☐ NO

Give details:

CARER DECLINED REASONS lookup

Available Entries (8)

Include team

Type & find

Code	Description
A6	CONCERNED RE IMPACT ON BENEFIT
A4	DOES NOT REQUIRE SUPPORT
A2	DOESNT SEE THEMSELVES AS CARER
A8	NO REASON GIVEN
A5	PERCEPTION OF NO BENEFIT
A1	PRIVATE MATTER NOT DISCUSSED
A3	TIME UNSUITABLE - RECONSIDER
A7	TOO TIME CONSUMING

Unmet Needs

Unmet Needs

More actions

Please provide details of any unmet needs:

Finance

Option 1.

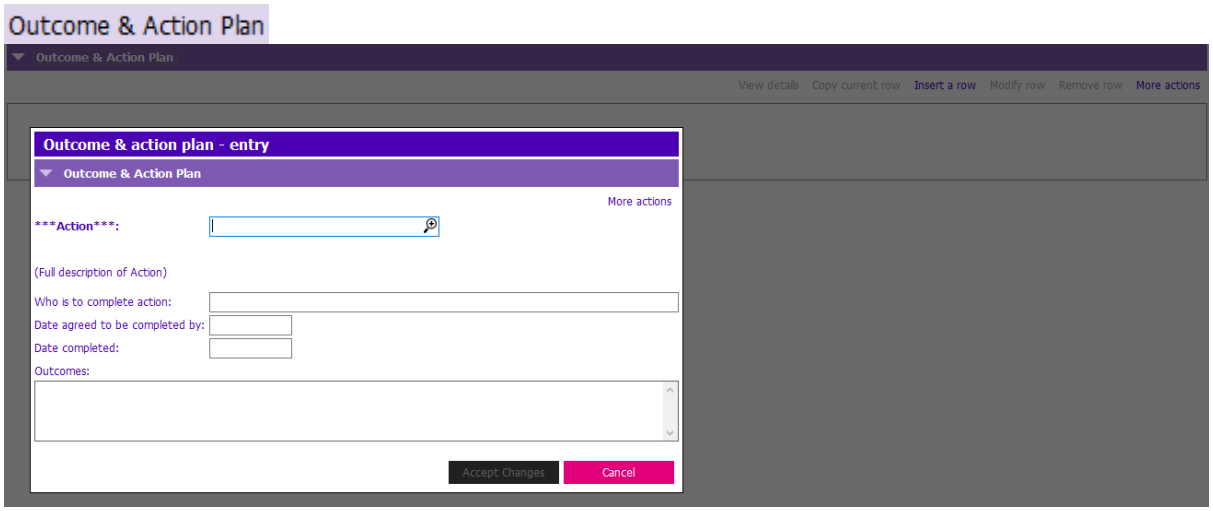
Finance

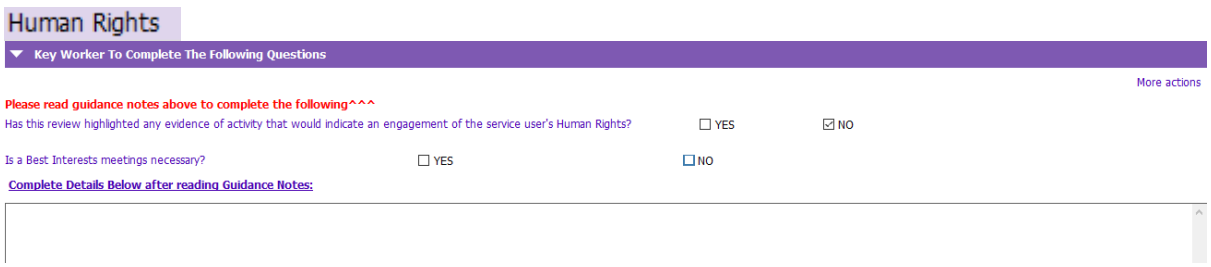
More actions

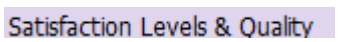
Care in:	☑ HOME	☐ PLACEMENT
Dwelling:	☐ OWN HOME	☐ SUPPORTED
Who manages your finances?	☐ THIRD PARTY	☑ SELF

Option 2.

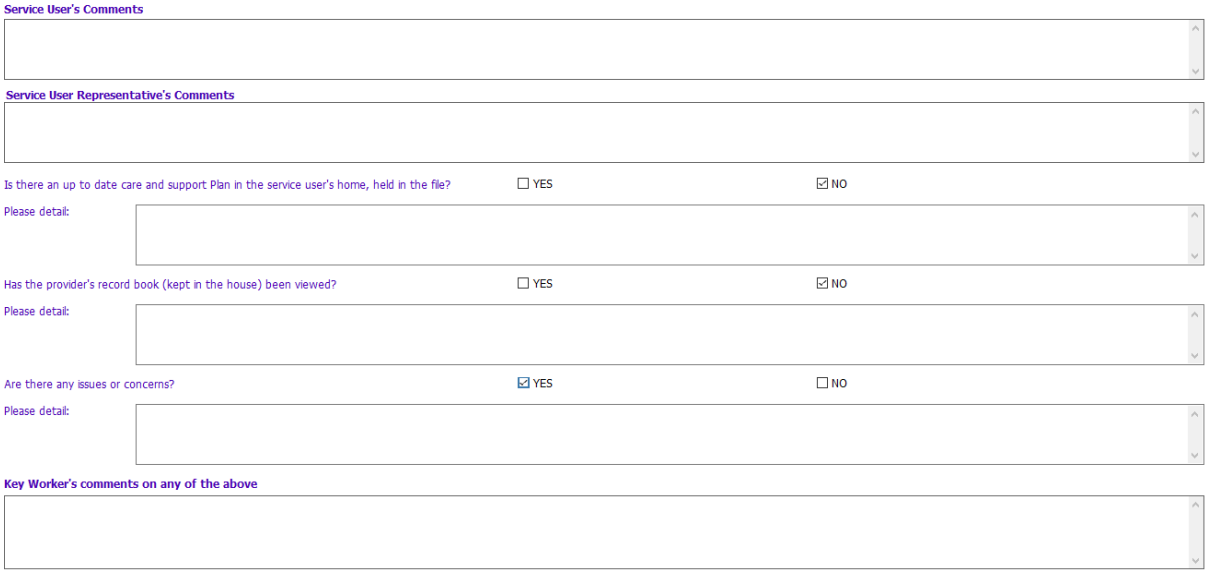
If YES, Risk assessment to be complete







Option 1.



Option 2.

Satisfaction Levels And Quality

More actions

Service User's Comments

Service User Representative's Comments

Is there an up to date care and support Plan in the service user's home, held in the file?	☑ YES	☐ NO
Has the provider's record book (kept in the house) been viewed?	☑ YES	☐ NO
Are there any issues or concerns?	☐ YES	☑ NO

Key Worker's comments on any of the above

Staff Signatures

Signatures

More actions

Signature of Service User/Representative:

Date:

Name of Person Completing Review: ENTER CODE OR USE LOOKUP

Designation of Person Completing Review:

Date:

Signature of Person Completing Review: ENTER CODE OR USE LOOKUP

Date:

Name and Countersignature of Trust Key Worker: ENTER CODE OR USE LOOKUP

Date: