Silverlink Care Agency Ltd
Innovation Centre, Knowledge Gateway, Boundary Road, Colchester, Essex, CO4 3ZQ

Review Sheet

Last Reviewed 18 Jul 2025

Last Amended 17 Jul 2025

This policy will be reviewed as needs require or at the following interval: Annual

Business Impact:	LOW Minimal action required. Circulate information amongst relevant parties.
Reason for this Review:	Scheduled review
Changes Made:	Yes
Summary:	This policy will support staff with person-centred care and support planning. It has been reviewed with minor word changes. References and further reading links have been checked and updated to ensure they remain current.
Relevant Legislation:	• The Care Act 2014 • Equality Act 2010 • The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Human Rights Act 1998 • Mental Capacity Act 2005 • Mental Capacity Act Code of Practice • Data Protection Act 2018 • The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012 • UK GDPR
	• Author: Social Care Institute for Excellence, (2025), Mental Capacity Act (MCA) - Care planning, liberty and autonomy [Online] Available from: https://www.scie.org.uk/mca/practice/care-planning/liberty-autonomy [Accessed: 18/07/2025] • Author: DEPARTMENT OF HEALTH AND SOCIAL CARE, (2025), Care and support statutory guidance [Online] Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: 18/07/2025] • Author: Care Quality Commission, (2025), Regulations for service providers and managers [Online] Available from: https://www.cqc.org.uk/sites/default/files/2015024%20Guidance%20for%20providers%20on%20meeting%20the%20regulations.pdf [Accessed: 18/07/2025] • Author: Care Quality Commission, (2018), Equally outstanding - Equality and human rights – good practice resource [Online] Available from:

Underpinning Knowledge:	https://www.cqc.org.uk/sites/default/files/20181010_equally_outstanding_ehr_resource_nov18_accessible.pdf [Accessed: 18/07/2025] • Author: NICE, (2018), Decision-making and mental capacity - Guidelines NG108 [Online] Available from: https://www.nice.org.uk/guidance/ng108 [Accessed: 18/07/2025] • Author: NHS England, (2016), Personalised care and support planning handbook: The journey to person-centred care [Online] Available from: https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf [Accessed: 18/07/2025] • Author: Skills for Care, (2025), Good and outstanding care (GO) [Online] Available from: https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Good-and-outstanding-care/Good-and-Outstanding-Care-GO.aspx [Accessed: 18/07/2025] • Author: CARE QUALITY COMMISSION, (2025), Guidance for Providers - Regulation 9: Person-Centred Care [Online] Available from: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-9-person-centred-care [Accessed: 18/07/2025] • Author: NICE, (2021), End of life care for adults [Online] Available from: https://www.nice.org.uk/guidance/qs13 [Accessed: 18/07/2025]
Suggested Action:	• Encourage sharing the policy through the use of the QCS App
Equality Impact Assessment:	QCS have undertaken an equality analysis during the review of this policy. This statement is a written record that demonstrates that we have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

1. Purpose

I confirm that I have read and approved this policy as suitable for use at Silverlink Care Agency Ltd.

Approved by: Regina Chukwudi
Job Role: Registered Manager
Date: 20/10/2025
Date of next review: 19/10/2026
To be reviewed by name: Regina Chukwudi

Summary: I have read and reviewed the policy and confirm that it is suitable for use at Silverlink Care Agency Ltd.

1.1 To promote a culture of personalisation and person-centred Care which supports the values of Silverlink Care Agency Ltd to meet the needs, outcomes and aspirations of Service Users.

1.2 To set out the framework, standards and values of Silverlink Care Agency Ltd for planning and reviewing individualised Care.

1.3 This policy dovetails with other relevant documents and policies and procedures which should be referred to for further guidance and information:

- Pre-Service and Service Commencement Policy and Procedure
- QCS Care Planning and Assessment Guidelines
- Care Plan Contents List
- Timeline for Assessment, Care Planning and Review
- Risk Assessment Policy and Procedure

1.4

Key Question	Quality Statements
CARING	QSC2: Treating people as individuals
CARING	QSC1: Kindness, compassion and dignity QSC3: Independence, choice and control
EFFECTIVE	QSE4: Supporting people to live healthier lives
EFFECTIVE	QSE6: Consent to care and treatment
RESPONSIVE	QSR1: Person-centred care
RESPONSIVE	QSR4: Listening to and involving people
SAFE	QSS4: Involving people to manage risks QSS5: Safe environments
SAFE	QSS6: Safe and effective staffing
WELL-LED	QSW1: Shared direction and culture QSW2: Capable, compassionate and inclusive leaders

1.5 Relevant Legislation

- The Care Act 2014
- Equality Act 2010
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Human Rights Act 1998

- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice
- Data Protection Act 2018
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012
- UK GDPR

2. Scope

2.1 Roles Affected:
- Registered Manager - Have overall responsibility for the day-to-day running of the organisation
- Other management
- Care staff

2.2 People Affected:
- Service Users

2.3 Stakeholders Affected:
- Family
- Advocates
- Representatives
- Commissioners
- External health professionals
- Local Authority
- NHS

3. Objectives

3.1 To promote a system of assessment, planning, implementing and evaluating care, establishing a partnership with the Service User, and where possible, their relatives/representatives, enabling Service Users to retain their own identity and to be as fully involved in their care as possible.

3.2 To have an ordered, auditable way of managing Service Users' Care and create a usable framework which incorporates the views and consent of Service Users and their representatives.

3.3 For authorised staff of Silverlink Care Agency Ltd to understand their responsibilities and roles in relation to care planning.

3.4 Silverlink Care Agency Ltd will be transparent as an organisation in relation to its own capabilities and how it can meet the assessed needs of the Service User.

4. Policy

4.1 The Registered Manager - Have overall responsibility for the day-to-day running of the organisation, Regina Chukwudi, and Nominated Individual, Adejoke Asemota, of Silverlink Care Agency Ltd, have overall management responsibility for this policy and procedure. This is in line with the Policy Management Policy and Procedure at Silverlink Care Agency Ltd.

4.2 Person-Centred Care

Silverlink Care Agency Ltd believes that person-centred care planning is the only way to achieve a quality service for each individual Service User. Silverlink Care Agency Ltd will act holistically to develop and deliver individual, person-centred Service User care planning. To ensure that this is at the heart of Care delivery, Silverlink Care Agency Ltd will ensure that the following areas are developed for each individual Service User:

- Identify and maintain focus on areas in which the Service User is able to remain independent
- The goals and aspirations of the Service User
- The desired outcomes of what is to be achieved
- To ensure that information is presented to the Service User in a way that they can understand (Accessible Information Standard)
- To provide the Service User opportunities to make decisions about their own Care
- To understand that the Care is evolving at all times and adapt to the Service User's changing needs or preferences

All Service Users will have a full assessment prior to the start of the service which formulates a well-rounded view of the Service User, their history and their life now, and then a review within 6 weeks of Care commencing.

4.3 In Partnership with the Service User to Meet Their Needs and Wishes

The care planning process will work in complete partnership with Service Users and/or their family or legal representatives in planning and reviewing their Care to:

- Represent the wishes and aspirations of the Service User, including activities, relationships and end of life wishes
- Maintain and support improvement in mental, psychological, physical wellbeing, including personal and oral hygiene
- Represent the equality, diversity and human rights of the Service User
- Promote choice, self-care and independence wherever possible
- Ensure safety from avoidable harm

Silverlink Care Agency Ltd will always ensure that Service Users or their legal representatives have the right information and will support their need to give informed consent to care planning.

Options for Care and information around them will be shared to ensure informed choice.

Silverlink Care Agency Ltd promotes Service User empowerment, and as such, enables Service Users and where applicable, their families, to be listened to and be equal partners in their own Care.

4.4 Co-Production

Silverlink Care Agency Ltd will support Service Users to be involved and, where possible, to lead the Care Plan process.

Service Users will have their choices taken into consideration when involved in Care Plans and in reviews with others such as families, friends, advocates or legal representatives.

Silverlink Care Agency Ltd will ensure that Care Plans reflect work with other professionals to ensure continuity of Care, where services are joined up and where transition between services or providers takes place.

Sharing of information amongst healthcare professionals and others involved in the Service User's circle of support will be done so in line with the UK GDPR and data protection policies and procedures at Silverlink Care Agency Ltd.

4.5 Care Plan **Formats**

The Service User's Care Plan can consist of various formats:

- Paper
- Digital
- Photographs
- Scanned records
- Letters

All Care Plans will be legible, complete and easy to understand, detailed and practical, easy to follow and reflect fact.

The Care Plan is a legal and confidential document and the following must be adhered to:

- UK GDPR and the Data Protection Act 2018
- The Health and Social Care Act 2008

Staff registered with a professional body such as the Nursing and Midwifery Council (NMC) will be required to adhere to record keeping standards as defined by their registrant body.

Please refer to the Record Keeping Policy and Procedure at Silverlink Care Agency Ltd.

4.6 Advance Care Planning

Silverlink Care Agency Ltd will ensure that Care Plans are created and updated when end of life care is needed to give the right Care for Service Users to live and die well.

4.7 Mental Capacity

Silverlink Care Agency Ltd understands that an essential part of the Care Plan process is to obtain consent from the Service User to their Care and will support them to make informed decisions at all times. Silverlink Care Agency Ltd will support Service Users to be involved as much as possible where they do not have capacity to give consent.

Silverlink Care Agency Ltd recognises that capacity can change and will keep decisions under review.

4.8 Reviews

The Care Plan process is continuous, and is frequently reviewed with the Service User, their key worker and their representative where this is appropriate, according to individual Service User requirements. Silverlink Care Agency Ltd will respond to changes in the needs and wishes of Service Users and changes in best practice and/or legislation.

- Reviews will take place every 6 month as a minimum or as and when a change occurs, whichever is sooner
- Ensure Service Users' views are listened to so that they can be equal partners in their own Care. Service Users may choose to invite family, legal representatives or an advocate (if the Service User consents) and any relevant external professionals

- Reviews will make sure that the Service User's objectives, outcomes, goals or plans are being met, are still relevant or have been achieved within the timescales set. These are amended and updated according to the needs and wishes of the Service User
- Formal reviews will be by appointment arranged by Silverlink Care Agency Ltd, or at any other time if requested by the Service User or family member
- Reviews of the Service User's Care will also occur when Care changes or an incident, accident or near miss arises.
- Additionally, if any Service Users transfer between services, hospital, uses respite care or is re-admitted or discharged, a review may need to take place
- Reviews are designed to ensure that Service User goals or plans are being met and are still relevant, discussing new ones if desired

Only authorised persons who are trained and competent will plan, view, review and audit Care Plans in line with data protection. Each Service User's Care needs and preferences will be reviewed by the staff at Silverlink Care Agency Ltd who have the required levels of skills, training and knowledge for the particular task. Care planning will be undertaken in a space which respects the privacy and dignity of Service Users and will be treated as confidential.

4.9 Quality assurance systems at Silverlink Care Agency Ltd will audit and evaluate the care planning process to ensure its design and delivery is the best it can be, that it is easy to use and fulfils its intended purpose.

Measures will always be taken when issues are found and improvement needs identified.

4.10 Silverlink Care Agency Ltd will consider the continuing needs of the Service Users in relation to whether or not Silverlink Care Agency Ltd can continue to meet those needs, and whether the Service Users' needs require a referral to external healthcare professionals. Silverlink Care Agency Ltd will also deliver transparent reviews that establish the Service Users' satisfaction and address any discontent or concerns.

5. Procedure

5.1 Responsibilities

Silverlink Care Agency Ltd is responsible for the oversight of this policy and Regina Chukwudi for its management.

All staff at Silverlink Care Agency Ltd will receive the training necessary for their role in care planning and will receive regular updates when required.

5.2 Pre-service Assessment and Service Commencement

Silverlink Care Agency Ltd should always carry out an assessment of the Service User's needs before they can agree to provide Care.

This ensures that Silverlink Care Agency Ltd does not accept anyone whose needs they cannot meet.

A **Timeline for Assessment, Care Planning and Review** document is available in QCS Compliance Centre.

An assessment forms the basis of the Service User's Care Plans, which sets out the level of Care the Service User will need, as well as details of their medication, diet, social interests and end of life preferences.

The assessment is a discussion about what the Service User wants to achieve by receiving care at Silverlink Care Agency Ltd. The assessment is to talk about:

- What they need support with
- Who they are as a person
- Their preferences and goals

The assessment should:

- Have a named key worker leading the process
- Be person centred
- Be collaborative
- Be holistic and recognise potential conflicts
- Be based on outcomes

Overall:

- Through an initial assessment of the information provided, Silverlink Care Agency Ltd will identify whether it will be able to provide care, treatment and support for the Service User which meets their care, personal, social and safety needs
- This assessment will identify any specialist equipment and environmental requirements to meet the Service User's personal and safety needs, which should be available for use at the point of service commencement
- Any risks identified will be formally and individually assessed as part of the care planning process and an appropriate written risk management plan created for each risk

Silverlink Care Agency Ltd needs to get to know each Service User as an individual. They must conduct a needs assessment so they can plan how they will deliver the Service User's care. This is written in a Care Plan which any staff at Silverlink Care Agency Ltd delivering the Service User's care will read and follow.

It is recommended that the Service User seeking care has a family member or person they trust with them for the care assessment, particularly if they are living with dementia or cannot fully answer questions due to other medical reasons.

Staff at Silverlink Care Agency Ltd should refer to the **Pre-Service and Service Commencement Policy and Procedure** and the **Pre-service Assessment** form.

5.3 Supporting the Service User to be Involved and Involving Carers, Families and Friends

Every Service User has the right to be involved in their care planning, and where the Service User is unable due to capacity, they will have people to act in their best interest.

At the first point of contact the person should be asked whether, and how, they would like their carers, family, friends and advocates or other people of their choosing (for example, personal assistants) to be involved in discussions and decisions about their care and support, and their wishes followed. This must be reviewed regularly at reviews, or when requested.

- Silverlink Care Agency Ltd must ensure that any support or aid required to enable Service User participation is in place
- Care planning will take place in a confidential setting in which the Service User feels comfortable and supported. This will usually take place in the Service User's own

home

If the person would like their carers, family, friends and advocates involved:

- Explain the principles of confidentiality, and how these are applied in the best interests of the person
- Discuss with the person and their carers, family, friends and advocates what this would mean for them
- Share information with carers, family, friends and advocates as agreed.

If a person lacks the capacity to make a decision about whether they wish their carers, family, friends and advocates to be involved, the provisions of the Mental Capacity Act 2005 must be followed.

5.4 Consent

All staff at Silverlink Care Agency Ltd must make sure that the organisation takes into account people's ability to consent, and either the Service User, or a person lawfully acting on their behalf (if they are unable to consent for themselves), must be involved in the planning, management and review of their Care.

Silverlink Care Agency Ltd must make sure that decisions are made by those with the legal authority or responsibility to do so, but they must work within the requirements of the Mental Capacity Act 2005, which includes the duty to consult others such as carers, families and/or advocates where appropriate.

Silverlink Care Agency Ltd must comply with the Data Protection Act 2018 and UK GDPR and should review how personal and special categories of data are managed in relation to Care Plans in line with its UK GDPR policies.

5.5 Next Steps

- The result of the assessment will be reviewed by management and staff in order to determine the ability of Silverlink Care Agency Ltd to meet the Service User's needs and preferences
- If the Service User's needs and preferences cannot be met, Silverlink Care Agency Ltd must consider the impact this has on them and explore alternatives, so that the Service User can make informed decisions about their Care
- The decision to offer or decline the service will be formally notified in writing to the Service User and any purchasing body as soon as possible. Silverlink Care Agency Ltd will need to take into account any contractual requirements
- Information about the care, treatment and support services available from Silverlink Care Agency Ltd and the associated costs, if applicable, will be provided to the Service User during the assessment in order to enable them to make an informed decision about the service

5.6 Risk Assessment

As part of the overall approach to Care provision, risk assessments must be completed alongside the Care Plan.

Risk assessments for all Service Users include but are not limited to:

- Moving and Handling
- Service User's own home environment
- Falls
- Pressure Ulcer Risk Assessment (Waterlow)
- MUST

- Choking
- Oral Health

Once completed, outcomes and level of risk of the risk assessment should be recorded within the relevant Care Plan, as well as clear management strategies for reducing the risk.

For further guidance, staff should refer to the Risk Assessment Policy and Procedure at Silverlink Care Agency Ltd.

5.7 Care Plan **Considerations**

Service User **Involvement**

- Service Users will have the care planning purpose and processes explained to them, and will be informed that they have the right to ask for a Care Plan review meeting at any time
- All Service Users will have an individual and personalised set of Care Plans which are designed to support their expressed requirements and desired outcomes from Care provided by Silverlink Care Agency Ltd
- The Care Plan must be written and designed to meet the health, psychological and social needs of the individual Service User
- Service Users or their personal representative will be encouraged and supported to be fully involved in the design of their Care Plan, and at each stage (where possible), will be given choices of actions from which they can choose their preferred option

Agency Involvement

- Silverlink Care Agency Ltd has the responsibility to ensure that all the relevant agencies are invited to have an input into the Care Plan process to support the effective management of the Service User's physical, psychological, social and personal health and safety needs
- Care Plans should reflect the recommendations of any external specialist service providers who have relevant input to the Service User's physical, psychological or social health and wellbeing

Equality and Diversity

- Care Plans must include any elements of Care to meet the equality and diversity needs of the individual Service User and must be designed not to constrain choices offered to the Service User because of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation

Informed Consent

- The Care Plan must be clear and easy to understand for the Service User, and their signature should be held on the Care Plan documents as evidence of their understanding of, and agreement with, its contents
- When Service Users do not wish to sign the Care Plan, this decision must be recorded in the Care Plan by the staff completing the document, with a supporting witness signature
- Service User consent to Care detailed in the Care Plan must be formally obtained before the Care Plan is implemented

Responsibilities

- Care Plans are to be developed by staff who are competent in care planning and who have the knowledge to inform and involve Service Users in all stages of the care planning process
- The Key Worker is responsible for the completion of the Care Plan document in full and signs all documents where indicated. This signature demonstrates the

accountability for the planning of Care to meet the Service User's needs

Completion

- All sections of the Care Plan documents will be completed. If a section is not deemed appropriate to that individual Service User, the words 'not applicable' must be entered on the document and signed and dated to indicate that this area is not applicable, stating reasons where possible
- Individual Care Plans will state in clear and factual language the detailed Care requirements needed to instruct staff to meet the individual Service User's needs identified by the individual assessment procedures
- Care Plans will be designed to manage Service Users' environmental, physical, psychological and social health needs in addition to the prevention or minimisation of potential personal health and safety risks to Service Users
- The involvement of the Service User in the process, the choices offered and the responses must all be recorded
- All Care Plan instructions carried out by staff must be recorded by those staff, reasonably simultaneously. Other actions and matters which may provide useful information for a subsequent review must also be recorded

5.8 The Care Plan

A Care Plan should:

- Be written and designed to meet the accommodation, health, psychological and social needs of the individual Service User, including:
  - Palliative and end of life care needs, if identified as a need
  - Health needs, including continence needs and chronic pain and skin integrity as well as the support needed to minimise their impact
  - Any requirements for managing medicines
  - Mobility and transport needs, adaptations to the home/service and any support needed to use them
  - Eating and drinking to maintain a balanced diet
  - Family and friends involvement
  - The help the Service User to look after their own care and support, manage their conditions, take part in preferred activities, hobbies and interests, and contact relevant support services
- Include instructions and statements based on best practice and professional standards of care and reflect the policies and procedures of Silverlink Care Agency Ltd
- For any clinical needs, reflect how those clinical needs are to be met and by whom, reflecting the Royal Marsden Guidelines (2020) for Clinical Procedures
- Reflect the recommendations of any external specialist service providers who have relevant input into the Service User's physical, psychological or social health and wellbeing
- State in clear and factual language, the detailed care, treatment and support instructions required to instruct staff to meet the bespoke Service User's needs identified by the individual assessment procedures
- Include any elements of care, treatment and support that meet the equality and diversity needs of the Service User which must be designed not to constrain choices offered to the Service User because of their personal values, ethnicity, age, gender, gender orientation, disability, nationality or religious beliefs

- Ensure care workers are able to deliver care and support in a way that respects the Service User's cultural, religious and communication needs

The Care Plan must be clear and easily understood by the Service User and their signature should be held on the Care Plan documents as evidence of their understanding and agreement to its contents.

When Service Users do not wish to sign the Care Plan, this decision must be recorded in the Care Plan by the Care Plan coordinator and there should be a supporting witness signature.

Silverlink Care Agency Ltd will consider alternatives to a wet signature, such as audio recordings and video recordings.

Care Plans are to be developed by staff who are competent in the Care Plan process and who have the knowledge to inform and involve Service Users in all stages of the Care Plan process.

All sections of the Care Plan documents should be completed or, if not deemed appropriate to that Service User, the words 'not applicable' must be entered on the document which should be signed and dated to indicate that this area is not applicable, stating reasons where possible. No section of the Care Plan procedure format should be left blank; if not required, the section can be removed.

All Care Plan instructions carried out by staff must be recorded by those staff, reasonably contemporaneously. Other actions and matters which may provide useful information for a subsequent review must also be recorded.

5.9 Personalised Care

When personalised care is fully in place, Service Users will have a better experience of health and care with Silverlink Care Agency Ltd.

Successful personalised care planning needs to be developed with Service Users, not done to them.

The key features of personalised care should include:

- The Service User is seen as a whole person within the context of their whole life, valuing their skills, strengths, experience and important relationships
- The Service User experiences hope and feels confident that the care and support they receive will deliver what matters most to them
- The Service User is able to access information and advice that is clear, timely and meets their individual information needs and preferences
- The Service User is listened to and understood in a way that builds trusting and effective relationships with people
- The Service User is valued as an active participant in conversations and decisions about their health and wellbeing
- The Service User is supported to understand their care, treatment and support options and, where relevant, to set and achieve their goals
- The Service User has access to a range of support options including peer support and community based resources to help build knowledge, skills and confidence to manage their health and wellbeing
- The Service User experiences a coordinated approach that is transparent and empowering

Enabling Service Users to maintain and develop their personal identity during and after their engagement with Silverlink Care Agency Ltd promotes dignity and has a positive impact on their sense of identity and mental wellbeing.

5.10 Writing a Person-Centred Care Plan

Care Plans must be written based on:

- Ability - What can the Service User do?
- Wishes - How does the Service User want to be supported?
- Needs - What does the Service User need support with?
- Outcomes - What is the expectation/outcome for the Service User?

Example Care Plans are available at Silverlink Care Agency Ltd.

Documentation:

Staff have a professional responsibility to ensure that records provide an accurate account of treatment, care planning and delivery, and are viewed as a tool for communication within the team. There should be clear evidence of the care planned, the decisions made, the care delivered and the information shared. The content and quality of record keeping are a measure of standards of practice relating to the skills and judgement of the staff member.

General Principles

- Entries must be written legibly in black, and are readable when photocopied
- Entries should be factual, consistent, accurate and not contain jargon, abbreviations or meaningless phrases
- Each entry must include the date and time (using the 24 hour clock)
- Each entry must be followed by a signature and the name printed as well as the job role
- If an error is made, it must be scored through with a single line and initialled with the date and time
- Correction fluids must never be used
- Entries may be made by staff who have received training in the process of Care Plan writing

The Care Planning and Assessment Guidelines in QCS Compliance Centre provide further guidance on record keeping standards.

5.11 Digital Care Planning

Digital systems can mean good outcomes for people who use services, for providers and for the broader health and care system.

They can:

- Provide ‘real time’ information recording about the care and support people need and receive
- Help providers and carers to be more aware when people’s needs change, and respond to them more quickly
- Offer the ability to use and compare data to improve Service User care
- Help information to be shared quickly, accurately and safely to support the provision of health and care services
- Help to minimise risks such as medication errors, dehydration or missed visits
- Help to support other important health and care functions, such as service management, planning and research

- Make it easier for people who use services to access their own records
- Help to manage and support staff to do their job effectively and efficiently
- Be easier to store, requiring less physical space
- Support better use of resources across the health and care system

What does a good digital records system look like?

A good records system delivers good outcomes from the point of view of people who use services. These outcomes are the same whether the records are kept digitally or on paper, although what providers need to do to deliver them might vary. Good outcomes for Service Users are captured by the following 'I statements'. These are worded from the perspective of Service Users.

I have records that:

- Are person-centred - They describe what is important to me, including my needs, preferences and choices
- Are accessible - I can see the information that is important to me, in a way that I choose, and I can understand
- Are legible - Information about me is recorded clearly and can be easily read by the people who support me
- Are accurate - Information about me is correct and does not contain errors
- Are complete - There is no relevant or essential information about me that is missing
- Are up to date - They contain the latest relevant and essential information about me
- Are always available to the people who need to see them when they need them
- Are secure - My privacy and confidentiality are protected. Only the people who should see my records can see them (records are kept in line with data protection legislation, including UK General Data Protection Regulation (UK GDPR) requirements)
- Help the service that supports me to have good quality assurance systems and processes. They help the provider to assess, monitor and minimise the risks to my health, safety and wellbeing. They help the service that supports me to keep improving

What standards do digital records need to meet?

All records must also comply with:

- Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Data protection legislation (including UK GDPR) requirements
- Accessible Information Standard
- Data Security and Protection Toolkit (where providers have access to NHS patient data and systems)

5.12 Review and Reassessment Process

Care Plans are flexible, meaning that when, or if, the Service User's care needs change, the plan will be reviewed and adjusted accordingly to make sure it meets their needs and preferences.

Care Plan reviews should look at the records generated by staff in order to judge the success of the Care Plan in achieving the planned outcomes. They should also identify

changes to the Care Plan which are required to meet existing, changed or new needs. The tools in the assessment and Care Plan pack will guide the review.

Service User **Decisions and Consent**

There must be a review of Service Users' consent and any decision making they have been involved in that is related to their care, treatment and support.

Service User **Review Involvement**

The review is an ongoing process and Service Users should be actively involved in the review of their desired outcomes, centred on the wishes of the Service User and their family. They will have the opportunity to alter their desired outcomes or Care Plan implementation at any time.

Risk Review

The assessment of individual risks will be reviewed on an individual basis when there are any indications of altered risks. This includes both positive changes and a reduction in risk, or negative changes and an increased risk.

Timescales for Review

- Routine reviews will be carried out within 6 weeks from the start of the service and then at least annually or at any more frequent intervals specified. At Silverlink Care Agency Ltd, Care Plans will be reviewed every 6 month months, unless a change occurs. Reassessments may also vary in their review period according to Service User risks and needs
- Any change in need for the Service User will require a Care Plan review
- Routine reviews will include a review of visit records since the previous review date. This will allow Silverlink Care Agency Ltd to identify any Service User concerns which may indicate a need for a particular assessment review, and to gather additional information regarding the Service User's perception of their daily wellbeing

Reviews

All relevant staff will be involved in the Care Plan and review.

- Individual elements of the overall Care Plan can have different scheduled review periods
- Following Care Plan reviews, the staff skill mix and designated staff linked to the Service User will be reassessed to ensure that the changed Service User requirements can be met
- The involvement of the Service User in the process, the choices offered and the responses must all be recorded

Changing Needs

- The review of the Service User's needs may indicate changed needs which require a full, in-depth review of elements of assessment or a comprehensive assessment of needs and overall wellbeing
- Any change to the Service User's needs, as identified during a review, will be subject to a reassessment and the Care Plan will be changed and redesigned in order to meet the changed needs
- Any new issues that are identified during a scheduled visit must be reported to a senior member of staff so that any action can be taken and a review can be initiated immediately

Reassessment

- The Service User must be involved in the reassessment processes wherever possible
- The assessment of Service User requirements, or any professional assessment of needs, will be reviewed when there are changes in the Service User's requirements or changes in their accommodation or physical, psychological or social wellbeing
- Any changes in assessment outcomes will immediately result in a new Care Plan, shared with the Service User's Care Workers to meet the changed needs

End of Life Care

It is important to recognise and efficiently and smoothly implement changes in Care required for end of life. This will help ensure the correct agencies are involved and that the Service User receives Care which enables changing needs to be met with dignity and respect.

Signatures

- All reviewed assessments must be dated and signed by the person completing the assessment documents in order to support Care Plan tracking and accountability
- All reviewed assessments must be signed by the Service User or their representative in order to indicate their involvement in the process. Alternatives such as video or audio may be considered if appropriate

5.13 Outdated Care Plan**s**

Outdated Care Plans will be archived in line with the Archiving, Disposal and Storing of Records Policy and Procedure at Silverlink Care Agency Ltd.

5.14 Supporting Adults with Learning Disabilities

Silverlink Care Agency Ltd supports main national objectives for reducing and eliminating health inequalities experienced by people with learning disabilities.

- Where a health action plan is not already in place, it will be offered to Service Users with a learning disability
- Service Users will be fully supported to complete their own plans and trained staff will be available to contribute to areas that the Service User is unable to complete
- Alternative formats will be available to aid Service Users' understanding and involvement
- Health action plans will be kept by the Service User, used like a diary and updated accordingly
- The Service User will take the plan when transferring between Care services or when attending outpatient and other appointments
- The Health Action Plan will be audited and reviewed in line with the Care Plan at Silverlink Care Agency Ltd, with agreed review and reassessment processes

5.15 Audit

- Care Plans will be regularly audited against a standardised format for the purpose of identifying any issues or further training by the Registered Manager - Have overall responsibility for the day-to-day running of the organisation or a delegated individual to ensure that competencies are being met against the competence standards of Silverlink Care Agency Ltd
- Regina Chukwudi or a nominated person will audit Care Plans monthly. Audits must be kept as evidence for compliance monitoring purposes
- Where there are shortfalls in the standard of documentation, this will be addressed by the Registered Manager - Have overall responsibility for the day-to-day running

of the organisation who will give clear directions for improvement to appropriate individuals

- The analysis of the Care Plan audits will be reported to the management meeting and, where improvements can be made, an action plan will be put in place to track the completion of them

5.16 Learning and Development

All staff should have privacy and dignity training which should focus on meeting the personalised needs of each Service User.

In addition, relevant staff who implement and contribute to the Care Plan process must have relevant Care Plan training which highlights how to implement a plan of care that is personalised, responsive to individual needs and focused on choice and independence, and which promotes positive risk taking and a multidisciplinary approach.

6. Definitions

6.1 Care Planning

- An audited way of planning person-centred Care which should be completed and reviewed in partnership with the Service User wherever capacity allows
- Care planning is only delivered with the consent of the Service User or their legal representative if the Service User is unable to do so due to lack of capacity
- It forms the way Care is to be carried out
- A Care Plan is a living document and can be either paper or electronic. It should be changed after review to represent the changing life of the Service User
- The Care Plan is individual and owned by the Service User who can see it or have it reviewed when they wish
- Care planning should be joined up with any other care or treatment the Service User is receiving to ensure a seamless service

6.2 End of Life Care

- End of life care is support for people who are in the last months or years of their life
- End of life care should help Service Users to live as well as possible until they die, and to die with dignity
- The people providing care should ask about the Service User's wishes and preferences and take these into account as they work to plan their care. They should also support families, carers or other people who are important to the Service User

6.3 Risk Assessment

- A process to look at any risks to safety that an action may cause the Service User or aspects of the wider service
- Where risks are identified, a mitigation to the risk should be decided upon, or an alternative action
- Risk assessments should be reviewed. Changes in Care may have an effect on the risk assessment

6.4 Assessment

- A process to identify what a person's Care needs are against agreed criteria

6.5 Care Plan Review

- Checking that the assessed needs and the Care put in place to address those needs are right and working for the Service User
- A review may trigger a 'reassessment' if a review finds it is not working or changes need to be made
- The review should be multidisciplinary if appropriate, and carried out in a sensitive and person-centred manner

6.6 Person-Centred Care

- Care planned around an individual - not a standard set of actions or 'one size fits all' solution
- This takes into consideration the diverse needs and wishes of individuals in a service tailored for them

6.7 UK General Data Protection Regulation

- The UK GDPR is the retained EU law version of the GDPR (EU) 2016/679 regulation which forms part of the EU (Withdrawal) Act 2018. From 01 January 2021, organisations need to bear in mind both the UK GDPR and the Data Protection Act 2018

6.8 Consent

- Consent can only be given by the Service User. Service Users are able to give valid consent as long as they have sufficient understanding to fully comprehend what is being proposed.
- This includes:
  - Having the capacity to make treatment decisions
  - Being able to weigh the risks and benefits involved
  - Understanding, in broad terms, the nature and purpose of the care

7. Key Facts - Professionals

Professionals providing this service should be aware of the following:

- Care planning will always be undertaken using a person-centred approach as this allows an insight into what is happening from the Service User's perspective and from other people's perspectives by trained and competent staff
- Only Service Users or their legal representatives can consent to care planning. Care reviews help to improve the quality of Care that Service Users receive. Enabling Service Users and/or their families to review Care and make recommendations will lead to improvements in safety and Care
- Service User care planning is the road map to person-centred Care for Silverlink Care Agency Ltd
- Silverlink Care Agency Ltd will work in partnership with other professionals when required, and share information when it is appropriate to do so, in line with data protection principles
- Personal care is a regulated activity and therefore the care review process is vital in demonstrating how Silverlink Care Agency Ltd works in partnership with Service Users, makes reasonable adjustments and provides support to help them understand and make informed decisions about their Care options

8. Key Facts - People Affected by The Service

People affected by this service should be aware of the following:

- You may want other people like family members or close friends to be a part of this process, and if this is what you want, they can be
- Other professionals may be involved in your care planning and this will be discussed with you
- Care planning is an ongoing process to record what you need and how Care will happen within the service you will receive from Silverlink Care Agency Ltd
- You will always be involved in making decisions about your care and you will be given the information you need to understand the decisions you need to make
- Reviews help Silverlink Care Agency Ltd to ensure that you are receiving the right Care to meet your needs and goals. Staff will continuously review your situation and more formal reviews will look at the Care in more detail
- Silverlink Care Agency Ltd will always ask if you agree with what has been written by asking for your consent. This is not a one-off thing, it is ongoing. When changes are made to your care and support, you should be able to consent to it
- Care planning will start before you start at the service, it will be updated when things change for you and will be looked at regularly to see if there is anything that can be improved
- Care planning will look at a range of information about your life to help plan for you, including your health and care needs, what you like and do not like, your ethnic, cultural, religious, sexual and disability needs and what your wishes are for end of life care as part of your Care

Further Reading

To ensure the basic principles and foundations for care planning, we recommend the following as further reading:

SCIE - Using the MCA Key Principles in Care Planning:

https://www.scie.org.uk/mca/practice/care-planning/key-principles-in-care-planning

GOV.UK - Mental Capacity Act: Making Decisions:

https://www.gov.uk/government/collections/mental-capacity-act-making-decisions

GOV.UK - Improving Care for People with Long-term Conditions: 'At a Glance' Information Sheets for Healthcare Professionals:

https://www.gov.uk/government/publications/improving-care-for-people-with-long-term-conditions-at-a-glance-information-sheets-for-healthcare-professionals

Think Local Act Personal - What is Personalised Care and Support Planning?

https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/What-is-personalised-care-and-support-planning/

Mencap - Health - FAQs:

https://www.mencap.org.uk/advice-and-support/health/health-faqs

Outstanding Practice

To be "outstanding" in this policy area you could provide evidence that:

- Staff levels reflect the needs and goals of Service Users as set out in their person-centred Care Plans
- There is strong evidence that Service Users are given the right support to enable them to understand and contribute to their Care Plan to their full ability
- There is evidence that Service Users and their legal representatives know that they can ask for a review of their Care Plan at any time and are supported when they do so
- There is a clear, identifiable correlation between identified risks and imaginative solutions to enable Service User choice in managing risk
- The wide understanding of the policy is enabled by proactive use of the QCS App

Forms

The following forms are included as part of this policy:

Title of form	When would the form be used?	Created by
Audit and Action Plan - CP20	As part of monthly care/support records. Identify random 10% to review on a rotation basis.	QCS
Care Review Form - CP20	When a care plan is reviewed.	QCS
Care Plan Review Amendments - CP20	When a care plan is amended.	QCS

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Audit and Action Plan - CP20

Area/Item audited	Score 1 – 5	Action required	By date	Signed	Action completed (date)	Signed
Pre-service commencement documents completed						
Service commencement assessments						
Risk assessments						
Advocacy details available						
Service User Care Plans						
Personal Care recording is accurate						
Recording of Service User health						
Recording of Service User social activities						
Support or care reviews current						

Carer gender choice available						
Behaviours that may challenge assessments						

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Area/Item audited	Score 1 – 5	Action required	By date	Signed	Action completed (date)	Signed
Clinical assessments, where applicable						
Continence assessments						
Continence reviews						
Nutritional reviews						
Medication assessment						
Moving and handling assessment						
Pain assessment						
Pressure area risk assessment						
Review of pressure area risk						
Miscellaneous assessments (please list)						

Service User involvement in assessment						
Service User involvement in support planning						
Service User involvement in reviews						
Fluid balance						

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Area/Item audited	Score 1 – 5	Action required	By date	Signed	Action completed (date)	Signed
Service cessation administration completed						
Service cessation questionnaires						
Key workers in place						
Medications policy followed						
Pre-commencement assessment						
Welcome carried out						
Recreational activities						
Restraint register						
NHS treatment information						
Service User surveys						

Score 1 = Many significant shortcomings

Score 2 = Shortcomings outweigh good practice

Score 3 = Minimum acceptable standard

Score 4 = Good practice outweighs shortcomings

Score 5 = No significant shortcomings

Date of Audit:_____

Name of Person Completing the Audit: _____

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Care Review Form - CP20

Care Plan Number:				
Date	**Evaluation**	**Signature**	**Designation**	**Service User's/Representative's Signature**

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Service User name:	**ID No:**

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Care Plan Review Amendments - CP20

Date:		
Problem/Need	**Signature**	**Evaluation Date Due**
Aim/Objective	**Signature**	**Evaluation Date Due**
Plan of Care	**Signature**	**Evaluation Date Due**

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Service User's/Representative's Involvement:	**YES**	**NO**
Service User's/Representative's signature:		