
Service User Planning and Recording Policy

References	
Other CLC policies relating to this policy	

Legislation relating to this policy	

NVQ units relating to this policy	

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White File

Service User Guide

The Service User Guide is required to meet the following standard

NMS Dom Care - Standard 1 – “There is a Service User’s Guide for current and prospective Service Users, their carers and their relatives. The guide contains up to date information on the agency, setting out the aims, objectives, philosophy of care, and parameters of the service provided, including terms and conditions.”

The Service User Guide is a file provided by the Consortium to each Service User. It contains all the information they need to know about the Consortium as well as specific information about the service they personally will receive. This guide is the property of the Service User, and will contain their copies of some of the service delivery information (e.g. the service delivery plan). The information in this guide is reviewed and updated annually. The agency will review in terms of the static information provided, the service co-ordinator will be responsible for the on-going housekeeping and keeping information relevant.

The Service User Guide is a working guide and as such The Consortium expects that staff will support services users and themselves to remain familiar with the information.

The Guide will include sections on:-

1. The Consortium

- Information about the Consortium
- Statement of purpose

2. Information about me

- My personal details
- About me workbook
- Important addresses and telephone numbers
- Participation involvement agreements
- Letters and reports about me

3. My tenancy

- copy of housing management plan
- tenants guarantee

4. My Support

- Individual planning information – overview assessment/ICP
service delivery plan and reviews

5. Complaints & compliments procedures –

- The Consortiums
- The landlords
- Social Services

6. My Money and personal belongings

- My financial support plan
- Bank statements
- My personal belongings list
- Insurance documents

7. Other people and information

- Information about other people or services that can help me

Each Service User will have their own individualized copy of this guide, which will be kept by them or stored and maintained with staff support as appropriate.

Where we are required to keep copies of important documents in the Service User Guide, The Consortium will keep the originals to ensure that if copies are required in the future they are of a good quality.

Service Users and/or their supporters may choose not to have copies of important documents. If this is the case then agreement must be recorded in the participation agreements.

Consideration must be given as to whether information provided to a Service User could become compromised by being given away or left in a public place. We wish to provide Service Users with as much information as it is safe for them to receive whilst protecting their interests.

The guide and information is dated, reviewed at least annually and updated as necessary. CSSIW inspectors may ask Service Users to view these guides.

Responsibilities:-

Service co-ordinator –

- to ensure that the guide is compiled and made available to Service Users.
- Ensure the information is dated
- Update information as necessary
- Review all the information annually

This should be done in conjunction with key workers

Contract managers –

- monitor that each Service User has a guide
- sample that the content is up to date and relevant

Blue File

Service delivery planning file

This is a file for each Service User containing all the information about the assessed needs of the individual and details of the support to be delivered. This file is the property of the Consortium. It is compiled and maintained by the staff team under the direction of the Service Co-ordinator.

Contents:

1. About me
2. Overview assessment/ICP
3. Service delivery plan & Service reviews
4. Participation & involvement agreements
5. Health Background
 - Barriers to community living
 - Psychological support
 - Behaviour Support Plan 1 – Background Information
 - Day care support
 - Transport
 - Holidays
6. Miscellaneous correspondence

For each of the above outcomes, there will be an agreement during the service delivery planning, whether additional assessment, detailed support or teaching plans and related recordings are to be included. If no support is required for a particular outcome, the section may be removed from the file.

The information relating to the following are stored in separate files:=-

- Housing support
- Medication
- Finances

Confidentiality & Access to Service User information:

The information contained in the file is confidential, and may only be shared with:-

- Support staff who are working with the Service User
- Consortium managers

Care Managers
Contract monitoring and CSSIW on request
Relatives/carers in accordance with involvement agreements

About me

AIM:

The aim of this section is to systematically collect information about each Service User in order to:-

- Give staff an understanding about the person they are supporting, to assist in the development of an effective working relationship.
- Contribute toward the assessment of the person's support needs
- To ensure that the person's wishes and preferences are included in the development of support plans.

GUIDANCE FOR STAFF IN USING DOCUMENT:

The information may be collected over a period of time from the following sources:-

- Discussion with the Service User
- Consultation with relatives and significant others
- Direct observation of the Service User
- Other service providers
- Care managers
- Past records

Information collected from sources other than the Service User must be checked out for relevance, currency and validity.

The method for recording this information will vary in line with the principles of inclusive communication and so can include symbols, pictures etc.

The information should be updated as necessary and must be reviewed at least once a year.

RESPONSIBILITIES:

It is the responsibility of the Service Co-ordinator to ensure that the information is collected and recorded appropriately. They may delegate the collection and recording to key workers/Support Co-ordinators.

COPY ALSO STORED IN: Service User Guide

Overview/Unified assessment

AIM:

The Consortium provides services to individuals referred from the local authorities. The local authority allocates a care manager to each individual Service User who is responsible for completing an overview assessment of the individual's specific needs. This overview assessment then informs the Consortium of the services they are required to provide.

The Consortium will use the overview assessment as a basis for the development and review of the Service delivery plan, ensuring that all support plans are delivered in accordance with the overview assessment.

GUIDANCE FOR STAFF:

The overview assessment is reviewed annually by care managers. Consortium staff (Service Co-ordinators, Support Co-ordinators & key workers) are required to contribute to this review process. Where possible Service Users should be involved in this process or at least consulted. This will usually take the form of a multi-disciplinary, multi-agency meeting, to which the Service Users and involved relatives or advocates will attend.

RESPONSIBILITIES:

It is the responsibility of the Care manager to complete the assessment and conduct annual reviews.

It is the responsibility of the Service Co-ordinator to ensure that it forms the basis of the service delivery plan

COPY ALSO STORED IN: Service user Guide (White File)

Service Delivery plan

AIM:

This is the process of evaluating the information collected during assessments and then deciding on what action is to be taken to meet the identified needs. It also ensures that the service delivered continues to meet any changes in the Service User's wishes and needs. The service will be monitored according to the information collected during assessment which will outline a plan for the Service User. This information will be used by contract and monitoring to ensure that what has been agreed is being delivered.

GUIDANCE FOR STAFF:

This plan is completed prior to commencement of a service and then reviewed annually. This should take place after the overview/unified assessment has been completed or reviewed.

The process may be completed in various ways, as appropriate for each Service User. Sometimes the best type of information gathering with Service Users often happens informally and individually, this information can then be brought to a formal planning meeting.

This meeting is chaired by the service co-ordinator and the following people invited:-

- Service User (as appropriate and in accordance with their involvement agreement)
- Key worker/Support Co-ordinator
- Care manager
- Relatives (in accordance with involvement agreement)
- Advocates (in accordance with involvement agreement)
- Contract Manager

The process includes;-

For each outcome in the plan;-

- the Service Users wishes or preferences are identified referring to the information gathered. It is good practice for staff to prepare Service Users by going through the previous service delivery plan and preparing for the new

one. Identifying wishes or preferences may include a Person Centred Planning approach, the About Me workbook or any other useful assessment documents.

- the needs identified in the overview/unified assessment are considered
- there is agreement about the service the consortium will provide
- the need for any further or specialist assessments are identified
- any risks and further risk assessment are identified
- the need to develop specific support plans are identified
- the additional optional recording formats are to be used to monitor service delivery and progress are agreed.
- Participation and Involvement agreements may also be completed. This may include other professionals, family or carers.

As each outcome is discussed and agreement reached the relevant section of the service delivery plan record must be completed.

The method for recording this information will vary in line with the principles of inclusive communication and so can include symbols, pictures etc.

This is dated, signed and copies given to the Service Users' and to their care managers and relatives in accordance with involvement agreements.

During the annual review of the service delivery plan:-

1. Each outcome contained in the previous service delivery plan must be reviewed along with feedback from the service reviews
2. For each outcome, relevant support plans should be reviewed, updated as necessary and the review date recorded on the support plan.
3. The recording relating to each outcome that are to be completed by staff in the coming year must also be reviewed and agreed.
4. The involvement agreements are to be reviewed, updated as necessary, signed and dated with the review date.

RESPONSIBILITIES:

The process is lead by the service co-ordinator and Service User, with the key workers/support co-ordinators making significant contributions.

It is the Service Co-ordinator responsibility to

- inform the Contract manager of significant changes in the plan
- ensure that the work to complete agreed assessments and development of support plans are allocated to key workers/support co-ordinators and completed within agreed timescales

- Ensure all the staff team are aware of the content of the service delivery plan and are working with the Service Users in accordance with it.
- Liaise with team co-ordinator to ensure the staff Rota is designed to meet the requirements of the service delivery plan.

COPY ALSO STORED IN: Service User guide (White File)

Service Reviews

AIM:

To gain feedback from the Service User about the service they are receiving

To evaluate the progress being made towards the goals and objectives identified in the service delivery plan.

To identify any changes in needs or wishes of the Service User that could affect the service delivered.

GUIDANCE FOR STAFF:

To review the plan effectively it may be necessary to carry out a review every 6 months. These plans can be reviewed more often if the needs of the Service User change. For some people this may not be enough whilst for others it may be too much. The frequency of review is agreed and recorded during the completion of the service delivery plan.

The whole review may take place in one occasion, or may have to be completed over a number of occasions, as appropriate to the Service User.

Others may be invited to contribute in accordance with the participation and involvement agreements.

Each of the outcomes must be reviewed in turn. Staff may use the questions on the service review recording format as a basis for discussion, but may need to be adapted in accordance with the Service User needs.

For each outcome, relevant risk assessment or support plans should be reviewed, updated as necessary and the review date recorded on the support plan.

The method for recording this information will vary in line with the principles of inclusive communication and so can include symbols, pictures etc.

RESPONSIBILITIES:

It is the Service Co-ordinator's responsibility to

- ensure the reviews are completed by the key workers/support co-ordinators
- inform the Contract manager of significant changes in plans
- ensure that the work to complete agreed assessments and development of support plans are allocated to key workers/support co-ordinators and completed within agreed timescales
- ensure all the staff team are aware of the content of the service delivery plan.

COPY ALSO STORED IN: Service User guide (White File)

Participation and Involvement Agreements

AIM:

The Consortium is committed to working in partnership with Service Users, their families, supporters, care managers, and other professionals. These agreements set out the level of involvement and participation these people require in the coming year.

STAFF GUIDANCE:

NB Where detailed or complex agreements have been developed in the past these could be put in the file as a supplement to the new form.

There are individual agreements for:-

- Service Users
- Family
- Care managers
- Other professionals
- Advocates or other supporters

The agreement includes a list of procedures they may be involved with and then specifies the level of involvement they would like with regards to each. Formats for these agreements may change but the current format needs to be completed.

There is also scope for any additional events the person would like to attend, decisions they would like to be involved in or information they would like to receive.

These agreements could be set up and reviewed during the service delivery planning and review meetings if appropriate, or may be completed with each individual at a time more appropriate and convenient to them.

The agreements must be signed and dated by the people making the agreement.

The agreements must be reviewed at least annually or more often if circumstances change

RESPONSIBILITIES:

The Service Co-ordinator is responsible for:-

- ensuring the agreements are completed and reviewed annually
- staff are aware of the content of the agreements
- people are invited to events and given information in accordance with the agreements

COPY ALSO STORED IN: Service User Guide (White File)

Health

This section should contain information and support plans that enable the service user to maintain their physical health and well being. It will contain:

Health history – this is a record of all the Service User's, diagnoses, major past illnesses and admissions to hospital.

Assessments from health professionals – e.g. an Occupational Therapist's assessment or any documents produced by community nurses if required

Personal care assessment

Aim:

To assess the person's ability and agree preferred methods of supporting personal care, ensuring dignity and respect whilst maximizing people's skills.

This section will contain all the information, assessments and guidelines relating to personal and intimate care, including personal hygiene, including:-

- Personal and intimate care assessment
- Risk assessments and Support plans relating to personal and intimate care
- If there is any amount of support identified there needs to be a support plan completed stating the exact support i.e. even if it is only verbal.

There may be an exception for those who require sessional support.

Behaviour Support Plans

Aim:

Behaviour Support Plan (1): Background Information

The ethos

Community Lives Consortium believes in developing a low arousal culture designed to use the least aversive way of managing behaviours. This can be defined as treating people with understanding, kindness and respect in spite of their behaviours.

Psychological health & well being

This optional section of the file would contain any information, psychological assessments and support plans relating to the mental and emotional well being of the Service User. It would also contain any information relating to the management of behaviour.

It would include:-

- **Psychological assessments**
- **Risk assessments**
- **Behaviour support plan 1 (Behaviour Support Plan 2 can be found in the Black File)** - Provided by the psychology support service (clinical team)
- **Reactive plans** - Provided by the psychology support service where Studio 3 physical management training has been provided.
- **Behaviour Monitoring Records** – this should be found in the red file

Day Care Support

This is an optional section which will contain plans relating to day care packages for Service Users. This may include:-

- Agreements relating to the provision of day care
- Plans of Day care activities – refer to Black File

Transport

This section contains any information assessments and support plans relating to transport the Service User may use.

It would include:-

- **Assessment information relating to vehicles**
- **Risk assessments for use of transport options**
- **Transport support plan** – to be completed by Service Co-ordinators with Care Manager, Contract Manager and Service User involvement. Ensure that all parties have signed the document in agreement.
- **Shared transport agreement if required** – this will be completed if more than one Service User shares a vehicle, either via Mobility or ownership (Mobility will discontinue as agreement expire).

For further guidance refer to **Transport policy**.

Holiday plans

This section contains information relating to the planning of holidays including the:-

- Holiday planning and costing form
- Correspondence relating to holidays
- Feedback from Service Users following holidays

For further guidance refer to the policy on **'Supporting Service Users in Holidays.'**

Completion of holiday costing form.

1. Team Co-ordinators and Service Co-ordinators to complete two rota's one for the scheme supporting the remaining tenants and one for the Service User's holiday
2. When completing the rota that remains at the scheme always ensure that there are safe staffing levels at the scheme, these hours will not include hours for activities for the Service User unless agreed within the house budget .If the hours are not available within the agreed hours the remaining tenants may purchase private packages to access activities with written agreement from their care managers.
3. Complete a separate rota for the tenant's holiday ensuring that there is identified time off for staff in line with legislation.
4. Add up the totals of hours required for both rota's
5. The difference from the agreed budget is what the tenant will need to pay.
6. All staff will be paid 12hrs for every day they are away even though they may work less than 12hrs.
7. Only the identified staff member on rota will be paid the sleep in
8. When calculating the cost of support hours remember that the charge is more than the normal payment to staff .

9. Service Co-ordinators to liaise with Tenant Services to confirm the hourly rate and sleep-in rate.

Always ensure that the Care manager and any other involved person to sign the [agreeing the holiday arrangements form].

No holidays are to be booked until the holiday costing form has been completed, agreed and signed by Care Managers unless stated otherwise on the Financial Support Plan.

Black File

Contents

Section 1 – Administering Medication

- Support Plans
- Risk Assessment if required

Section 2 - Personal Care

- Personal and Intimate Care Support Plan
- Support Plan
- Risk Assessment
- Manual Handling Personal Plan

Section 3 - Saturday

- Activity Support Plan for Saturday
- Teaching plans relevant for Saturday
- Support Plan
- Risk Assessment
- Manual Handling Personal Plan

Section 4 - Sunday

- Activity Support Plan for Sunday
- Teaching plans relevant for Sunday
- Support Plan
- Risk Assessment
- Manual Handling Personal Plan

Section 5 – Monday

- Activity Support Plan for Monday
- Teaching plans relevant for Monday
- Support Plan
- Risk Assessment
- Manual Handling Personal Plan

Section 6 - Tuesday

- Activity Support Plan for Tuesday
- Teaching plans relevant for Tuesday
- Support Plan
- Risk Assessment
- Manual Handling Personal Plan

Section 7 – Wednesday

- Activity Support Plan for Wednesday
- Teaching plans relevant for Wednesday
- Support Plan
- Risk Assessment
- Manual Handling Personal Plan

Section 8 - Thursday

Activity Support Plan for Thursday
Teaching plans relevant for Thursday
Support Plan
Risk Assessment
Manual Handling Personal Plan

Section 9 - Friday

Activity Support Plan for Friday
Teaching plans relevant for Friday
Support Plan
Risk Assessment
Manual Handling Personal Plan

Section 10 - Communication and Senses

My Communication Needs
Support Plan

Section 11 - Behaviour Support Plans

Behaviour Support Plan 2
Risk Assessments

Section 12 – General Support Plans and Risk Assessments

Section 13 - Guidance for Support Plans

Activity Support Plan
Being Independent at Home
Support Plan
Risk Assessment
Mobility and Manual Handling
Personal Care forms

Good practice notes for prioritizing support plans: If new to the scheme and Service Users, ensure to first read the communication documents and behavioural support plans. If working regularly within the scheme and are familiar with communication and behavioural support plans then it would be sufficient to read individual day support plans in line with the activity support plan.

Support Plans
Risk Assessments

Personal care assessment

Aim:

To assess the person's ability and agree preferred methods of supporting personal care, ensuring dignity and respect whilst maximizing people's skills.

This section will contain all the information, assessments and guidelines relating to personal and intimate care, including personal hygiene, including:-

- Personal and intimate care assessment
- Risk assessments and Support plans relating to personal and intimate care
- If there is any amount of support identified there needs to be a support plan completed stating the exact support i.e. even if it is only verbal.

There may be an exception for those who require sessional support.

Activity Support Plan for Saturday

Teaching plans relevant for Saturday

Support Plan

Risk Assessments

Manual Handling Personal Plan

Sunday

Activity Support Plan for Sunday

Teaching plans relevant for Sunday

Support Plan

Risk Assessments

Manual Handling Personal Plan

Monday

Activity Support Plan for Monday

Teaching plans relevant for Monday

Support Plan

Risk Assessments

Manual Handling Personal Plan

Tuesday

Activity Support Plan for Tuesday

Teaching plans relevant for Tuesday

Support Plan

Risk Assessments

Manual Handling Personal Plan

Activity Support Plan for Wednesday
Teaching plans relevant for Wednesday
Support Plan
Risk Assessments
Manual Handling Personal Plan

Activity Support Plan for Thursday
Teaching plans relevant for Thursday
Support Plan
Risk Assessments
Manual Handling Personal Plan

Friday

Activity Support Plan for Friday
Teaching plans relevant for Friday
Support Plan
Risk Assessments
Manual Handling Personal Plan

Communication & senses

Aim:

To give staff information on the Service Users' preferred method and style of communication.

N.B. Please remember that most people by virtue of their learning disability will also be disadvantaged in their communication. Please ensure the correct tone of voice, body language and where necessary limit the amount of verbal communication e.g. keywords, pictures, objects of reference and signs. In addition some Service Users may have sensory impairment requiring additional support for hearing, vision or tactile. In addition some people may be sensory sensitive and may be overwhelmed by their environment.

This optional section of the file will include:-

My Communication Needs – This is a form completed by staff, together with the Service User and involved relatives. It describes how the person communicates themselves, how they prefer to be communicated with and what may help them to understand the communication from others better. This information should describe how the principles of 'Inclusive Communication' are applied to help more effective communication with this Service User. This information will need to be reviewed and updated at least annually.

Guidance for completing support plan:

- State the correct environment for communication e.g. distractions or noise
- The amount of people they can communicate to e.g. one-to-one or in groups
- Tools that are required i.e. personal passport, photos, symbols, objects of reference
- Any keywords and their meanings or signs and their meanings need to be recorded
- How well they understand people communicating to them
- The timings of communicating with the Service User e.g. not speaking to someone when they are tired or anticipating an activity.

Assessments and recommendations from Speech and language therapists

Sensory impairment – any information, assessments and guidelines relating to sensory faculties that will influence communication including:-

- vision
- hearing

- tactile
- smell
- taste

Behaviour Support Plans

Aim:

Behaviour Support Plan (2): Behaviour and Responses – this should enable staff to communicate and respond appropriately in a planned and consistent way to identify behaviour challenges.

The ethos

Community Lives Consortium believes in developing a low arousal culture designed to use the least aversive way of managing behaviours. This can be defined as treating people with understanding, kindness and respect in spite of their behaviours.

Psychological health & well being

This optional section of the file would contain any information, psychological assessments and support plans relating to the mental and emotional well being of the Service User. It would also contain any information relating to the management of behaviour.

It would include:-

- **Psychological assessments**
- **Risk assessments**
- **Behaviour support plan 2 (Behaviour Support Plan 1 can be found in the Blue File)** - Provided by the psychology support service (clinical team)
- **Reactive plans** - Provided by the psychology support service where Studio 3 physical management training has been provided.
- **Behaviour Monitoring Records** – this should be found in the red file

Activity & support plans

Aim of Activity Support Plan

This plan is designed to direct staff to the activities and routine preferred or chosen by the Service User on a daily basis.

What are they?

There is an activity plan for each service user for each day of the week. The plan establishes the personal, domestic, social and leisure routine of the Service User.

The production of the plan is based on the assumptions that:-

- Ordinary living is based on a routine of things that have to be done to keep our lives going successfully e.g. feeding the dog, shaving, going to work, meeting friends
- Our ordinary routines are flexible. There are things that have to be done, but there are also options.
- Routines are important to maintain personal structure, motivation and energy

How are they produced?

These should be produced by the Service Users together with the staff team.

- Draw up a list of all the activities required to keep the house running, entering the relevant day and time.(e.g. washing up after each meal, putting the bins out on wed morning)
- list the personal routine of the Service User (e.g. gets up at 8am, visits brother sat pm)
- List optional activities that could be done that are not fixed to a specific time. Include a mixture of domestic chores and social or recreational activities
- Record all the above on the activity plan form and ensure there is a balance each day and across the week of purposeful and enjoyable activities.
- Make an accessible version of the plan for the Service User in accordance with their communication needs.

How are they used?

At the start of each shift, there should be a discussion between staff and Service Users where possible about the activity plan, identifying which optional activities are to be included and which staff are going to support which Service Users in identified activities.

The plan should not be a 'straight jacket' which quashes spontaneity, and some flexibility to respond to changes must be evident. However, it should be used to ensure Service Users engage in running their own homes and that they have balance and variety in the activities they are involved with during any week.

Being Independent at Home

Aim

The aim of this section is to have consistent teaching plans for the learning or supporting new skills identified in the Service Delivery Plan.

Active Support

This section relates to the planning of support to the Service User that increases their personal independence. This will include:-

Teaching Plans

Aim: To assist the Service User to learn new skills that will increase their independence and improve the quality of their lives.

Staff Guidance: A teaching plan should be set up for each of the skills identified in the Service Delivery Plan that the Service User would like to develop or improve. The plan is developed in accordance with the principles of active support and systematic instruction. If a Service User is struggling to achieve a goal set in 'Opportunity Planning' then a teaching plan should be set up to break the skill down into achievable steps and effective staff support planned. Any associated risks must be assessed and safety measures introduced to minimize them (see also 'Risk Assessments')

Assistive Technology

This includes information relating to the introduction and use of technology to reduce dependency on staff for support e.g. epilepsy alarms, bed sensors, alert systems etc.

The information stored in this section could include;

- Assistive technology assessments
- Assistive technology planning

Recording and monitoring can be found in the Red File.

General Support Plans and Risk Assessments

Guidance Notes for Support Plans

Support Plans, Risk Assessments and Mobility and Manual Handling Assessments

Aim:

To provide staff with guidance to support Service Users in a safe, secure and consistent environment. This will take into account people's individual ability, potential and preference, identify where there is a risk to their well-being and where this may be considered reasonable.

This section will include the Support Plan, the Risk Assessment (if required) for that Support plan and the Mobility assessment (if and when required). The section begins with an assessment of personal and intimate care.

N.B. These will be compiled on a daily basis reflecting people's activity support plan throughout any given week per rota.

Day/Time	Activity Support Plan	Support Plan	Risk Assessment	Mobility Assessment
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Support plans

AIM:

Support plans detail the exact support to be provided to an individual Service User in order for them to complete a specific task or achieve a specific outcome. All plans will be developed in accordance with the principles of active support and promoting the independence of Service Users at all levels.

Support plans are necessary to ensure that support is consistently delivered by all staff in accordance with:-

- the expressed or agreed wishes of the Service User
- the assessed needs of the Service User and the service delivery plan
- Consortium policy
- Agreed best practice

STAFF GUIDANCE:

During the completion of the service delivery plan, there will be an agreement whether a support plan is required to meet a particular need or outcome.

Therefore the range of support plans included will vary for each individual Service User.

As a general rule, if staff are required to provide any assistance to the Service User to complete the activity, a support plan should be in place.

Each support plan should include:-

What exactly the plan is intended to achieve for the Service User (i.e. outcome)

When - in what situations the plan should be followed

How – Risk Management – identifying any hazard that may arise and action to take to minimise the risk.

Staff guidance precise instructions for the staff to follow

RESPONSIBILITIES:

It is the responsibility of the Service Co-ordinator to ensure that

- the relevant plans are in place for each Service User,
- the content is appropriate,
- that they are updated regularly and reviewed, at least annually.
- That staff are consistently implementing them
- That Service Users are satisfied with the support received.

The production of the plans may be delegated to key workers/Support Co-ordinators.

The plans may be shared and signed by care managers, relatives in accordance with the involvement agreements.

The plans must be read and initialed by all staff supporting that Service User.

Staff are required to give feedback to key workers/Support Co-ordinators and Service

Co-ordinators of the effectiveness of the support plans

Staff who do not follow the guidance in a support plan will be subject to investigation and possible disciplinary action.

Contract managers will be responsible for monitoring the quality of the support plans and their implementation

Risk Assessments

AIM: To ensure that the risk of accidents and harm happening to Service Users and staff is minimized.

STAFF GUIDANCE: Risk assessments must be completed as a part of each support plan and teaching plan

Risk assessment include the following 5 steps:-

1. Look for and list all hazards (hazard means anything that can cause harm, e.g., chemicals, electricity, behaviour).
2. Decide who might be harmed and how.
3. Evaluate the extent of the risks and decide whether existing precautions are adequate or whether more should be done. (The extent of the risk covers the number of people affected and the consequences for them. Therefore risk reflects both the **likelihood** and **severity** of the harm.)
4. Record your findings. (this may be recorded on the support plan/teaching plan format or on a separate risk assessment form)
5. Review your assessment at least annually, and revise it if necessary.

Some aspects of support may require specialist risk assessments from other professionals or services e.g. risks relating to behaviour management
Manual handling risk assessments require a different procedure (see manual handling risk assessments & plans)

RESPONSIBILITIES: It is the responsibility of the Service Co-ordinator to:-

- Ensure that the risk assessments are completed, reviewed and update regularly and in response to changes.
- Ensure that the Service User, involved family and professionals and the staff team are involved in the assessment of risk.
- That the staff team are aware of the risks and deliver support in accordance with agreed guidelines

It is the responsibility of all staff to:-

- work in accordance with guidance developed as a result of risk assessment
- to report new risks which may arise
- contribute to the review of the risk assessment and guidelines

Mobility and Manual handling

In this optional section are stored

1. Assessments support plans and information relating to the mobility of the Service User

This may include:-

- assessment reports produced by Physiotherapists or Occupational therapists
- guidance for completing exercises with Service Users
- recommendations and guidance for using specialised equipment e.g. wheelchairs, standing frames

2. Manual handling assessments and plans required to assist the Service User to move

A manual handling risk assessment must be completed for every activity that involves the staff providing physical support for the Service User to move.

The risk assessment can be completed by the staff team under the guidance of the Service Co-ordinator.

The activity is to be observed and the recording format completed to determine a 'score'. This will then give an indication of the level of risk and further action required as described

Low level risk - These activities present minimal risk of injury to staff and Service Users.

Action:-

- Consider whether any changes to the activity could reduce the risk further.
- Record the way the activity is to be completed with the lowest risk on the manual handling support plan.
- Ensure all staff are aware of this guidance and work in accordance with it.
- Review the risk at least once per year or if circumstances change.

Medium risk - These activities present a significant risk of injury to the staff or Service User.

Action:

- Using an action plan, consider how the staff guidance, working practices, environment, equipment or staffing levels are to be reviewed.

- Re-assess the level of risk and when at its lowest possible level, record the way the activity is to be completed on the manual handling support plan.
- Ensure all staff are aware of this guidance and work in accordance with it.
- Review the risk at least once per year or if circumstances change.

High risk – these activities are likely to present a significant risk of injury to the majority of individuals.

Action:

- Consider stopping the activity immediately.
- Implement immediate interim measures for preventing risk of injury as a priority.
- Using an action plan, consider how the staff guidance, working practices, environment, equipment or staffing levels are to be reviewed.
- Assistance may be required from Occupational therapists for complex situations, or when major equipment purchases are required. Referral to Occupational therapists must be made by the Care Manager
- Re-assess the level of risk and when at its lowest possible level, record the way the activity is to be completed on the manual handling support plan.
- Ensure all staff are aware of this guidance and work in accordance with it.
- Review the risk at least once per year or if circumstances change.

Red File

Service Users Record file

This is an individual file for each Service User, in which is stored all the records relating to:-

- the service delivered to that Service User
- daily events relating to that Service User
- monitoring of the Service User's health and well being.

The file is divided into sections for easy access.

Some of the sections are required for all Service Users, whilst others are optional.

It will be decided during the setting up and reviewing of the Service delivery plan, which specific records are to be kept for each individual Service User.

Contents of the file:-

Section 1 – Appointment/Important information planner

Section 2 - Daily recordings

Diary (full or sessional)

Section 3 – Health (optional section)

Health calendar

Accident record

Epilepsy record

Diabetes chart

Bowel chart

Information and recommendations from appointments relating to health (e.g. GP, community nurse, consultant, dentist, admission to hospital)

Any other recordings requested by health professionals

Section 4 - Psychological / Behaviour records (optional section)

Diagnostic assessment recordings

Behaviour observation charts

Behaviour monitoring records

MOA records

Section 5 – Transport records (optional section)

Shared transport weekly planner

Staff vehicle charging format
Vehicle mileage record sheet
Annual transport budget sheet

Section 6 – Reports to CSSIW & CSU

Confidentiality & Access to Service User information

The information contained in the file is confidential, and may only be shared with;-

- Support staff who are working with the Service User
- Consortium managers
- Care Managers
- Contract monitoring and CSSIW on request
- Relatives/carers in accordance with involvement agreement.

Guidelines for completing the daily recordings

There are two forms of diary that can be used:-

A) The full daily diary – this is designed to be used where staff are providing 24 hour support every day

OR

B) The Sessional diary – this is designed to be used where staff are providing support only for a limited number of hours

- Start by completing the participation record for that shift / session or period of the day, by entering a 'tick' for each time the Service User has participated in each of the activities during that time.
- Complete the relevant sections in the diary;-

For full daily diary:-

At the start of the day,

1. All staff must ensure that they have read and initialed previous recordings referring back to their last shift worked if support co-ordinator/keyworker. Support workers will be expected to have read at least the last 48 hours.
2. Enter the Service Users' name, the day of the week and the date.
3. Check the appointment planner in section 1 of the file and record any appointments, visits or other events that are expected for that day.

During the day,

1. If it has been agreed that meals and drinks offered are to be recorded, then enter this in the section, indicating whether any were offered but refused.
2. Complete additional recordings – put a cross if there are no changes and a tick if there are.

At the end of the day, complete the following sections agreeing what is to be recorded with the Service User wherever possible. This includes

1. How I feel today/How staff feel I feel today – wherever possible get full involvement from the Service User
2. My day – summarise any activities that the Service User has been involved with in addition to those already recorded on the participation record.
3. Wakeful shifts → record information regarding the shift on the day that the wakeful commenced and not the morning after.

Any additional information that has not been recorded in the above sections can be entered at the end of the daily record, including anything that needs to be recorded during the night.

The diary is designed for **brief** entries and to act as a 'sign post to more detailed records stored elsewhere in the file. Long entries should be avoided on the diary record

NB Each person entering information on the diary must sign alongside their entry

Good practice for completing records

- Wherever possible try to include the Service User in completing the record. Explain to them what you are writing and why. Try to integrate it into natural breaks within the day e.g. coffee breaks, after lunch.
- Be accurate, factual and concise
- Try to be honest but positive about the service user – consider how we would feel reading these records about us
- Date and sign all entries
- Use black ink.
- If an error is made then cross out with a single black line and initial

Participation Record & Quarterly summaries

The participation record is a weekly record to chart the Service Users' participation in various activities. They may be individualized to reflect the range of activities each Service User participates in.

- At the beginning of each week a new form is to be placed in section 2 of the file immediately following the activity & support plan.
- Staff, together with the Service Users, can then record the activities they have participated in throughout each day (see completing daily records).
- At the end of the week, the total numbers for each section must be entered on the Quarterly Participation Summary which is stored in Section 3. That weekly sheet can then be removed from Section 2 of the file and stored in section 3 after the Quarterly Summary form.
- A new participation record can then be inserted into section 2 of the file, ready for the next week.

Health

This is an optional section and need only be completed if a health or behavioural need is identified.

Health calendar – this enables the recording of Bowel Movement signified by the letter B, Weight signified by the letter W and Menstruation signified by the letter M. The appropriate letter is to be written into the calendar under the relevant date, am or pm. If a pattern is identified the Service co-ordinator or a relevant professional needs to be informed.

Personal accident record – this enables a continuous record of personal accidents for individual Service Users. Staff are to record all injuries, for example; cuts, scratches, bruises, burns and pressure sores. Service Users with patterns of constant self-injury will have a separate recording agreed with the Clinical Team.

N.B This document does not replace the organizational Accident and Riddor recording forms. This form is designed to collate individual information of accident and injury. First complete the Personal Accident form and then inform Personnel department via the accident book and Riddor forms.

Body charts – any injury e.g. bruising, scratches, cuts observed please record in appropriate area on the body chart if required.

Diabetes record – to be completed when an individual is diagnosed with Diabetes – a support plan should be implemented.

Completion of form;

- Record date and time using the 24 hour clock
- The results and sites of tests
- Record of treatment including sights
- Diabetic Injection sights and blood test sights are on the reverse of the form.

It would be good practice for staff to record their actions and sign.

If the individual has a recording booklet from the diabetic clinic, this recorded information is suffice and the booklet can be stored in this section in a Polly pocket.

Epilepsy seizure record – to be completed when an individual is diagnosed with Epilepsy – staff would be required to have relevant training and a medication support plan and guidance completed.

Completion of form;

- Record date and time using the 24 hour clock
- How long has the seizure lasted
- Description of what happened. This should include any aura of warning experienced by the individual or explained by staff. Also the effects of the seizure on the individual and their recovery should be described. This should include any auditory or visual sensitivity or behavioural implications for example an individual becoming confused or aggressive.

Record of health appointment – completion of form;

- Complete date
- Health professional the appointment was with e.g. GP, Chiropodist, Dietician, Chiropodist or Consultant Psychiatrist.
- Summary report of the appointment and any actions
- Where actions require a change of medication this should be recorded in the back of the individual's medication booklet.

Psychological/Behavioural Records

This section will be influenced by the clinical support team and the Clinician for the network. This section may contain;

- ❖ Behavioural observation charts
- ❖ Behavioural monitoring records
- ❖ Diagnostic assessments
- ❖ Management of aggression form as relevant

Behavioural observation charts –

- Record the individual name, date, where in the scheme or community the incident occurred and the time of day using the 24 hour clock.
- Record the activity – was the person involved?
- Did they choose the activity? This is designed to show whether the person is disinterested or feels that there have been excessive demands to participate.
- Other influences that may have occurred affecting the person's mood or physical well being.
- Environmental issues designed to monitor noise levels, temperature, person proximity and atmosphere.
- Staff should then record a list of the people who were around at the time of the incident.
- Complete section requesting information regarding the person being tired, in pain or with relation to female menstruation.
- The next section records the person's mood prior to the incident and length of time in the 24 hour clock.

On reverse of the form:

- Antecedents – please describe what has been happening prior to the incident e.g. David was sitting in the lounge waiting for his tea which was cooking in the kitchen.
- Details of the behaviour/incident – describe exactly what the behaviour was e.g. David stood up and walked over to John who was also sitting in the lounge and hit him with his right hand across his left shoulder.
- Events after – please record distraction e.g. I asked John to go to his room and sit quietly. I later joined him and sat on his bed whilst he was upset and David said that it was because he was hungry and John had had food before him.

Behavioural monitoring records (for the individual) - this form is designed to monitor patterns of behaviour but also to give staff an indication of the person's level of arousal. The form should contain;

- Details of the person's normal or positive behaviours
- A section on the person's warning signs indicating that they are becoming agitated and therefore influencing staff responses.
- Challenging behaviours – these should illustrate that the person needs particular response from staff that may include distraction, time and space or PRN.

Diagnostic assessments – recording for a specific period of time agreed with Clinician – this may include psychometric testing.

Management of aggression form as relevant – These forms will be completed in the event that physical management has taken place. This form should be monitored by the Service Co-ordinator or Support Co-ordinator/keyworker and completed by the staff member(s) that was involved in the incident and forwarded to the clinical team monthly. It should indicate if successful management has taken place for example low arousal approaches. If a physical intervention has been required staff will have to record the day, date and time of day using the 24 hour clock. What method of restraint has been used will also need to be recorded e.g. walking, adaptations or the chair method. Staff should also record if the Service User or staff are injured.

N.B. If no physical management has been used within 12 months then managers are to review whether this is needed.

Day Care Record

This is a quarterly document to be completed when a Service User has not attended day care for the following reasons;

DC = Day Care provided by the organization that requires invoicing

H = Home day

S = Service User sickness

SNA = Service not available

The date of absence, hours used within the scheme, the reason (see above code), any mileage that may have been used and staff signature are to be recorded.

We can only claim hours if by providing support we have gone over our agreed budget.

Bank holidays and agreed closures for day centres i.e. Christmas cannot be charged for as this service is not available as these are entitled holidays.

At the end of each quarter please forward to the office for invoicing.

Transport

Shared Transport Weekly Planner

This document needs to be completed if people are going to enter into a shared transport agreement.

This document highlights agreed priority over the vehicle.

Staff Vehicle Charging Format

This should be sent to the Finance Department on completion (quarterly).

Staff should enter all mileage after each journey and ensure that it is authorized by the Service Co-ordinator and Contract Manager before it is sent to the Finance Department.

Shared Vehicle Mileage Record

This is a record kept when staff are not claiming mileage and the Service Users are in a Shared Agreement.

Annual Transport Budget Sheet and the Shared Vehicle Mileage Record are coded.

A = First Service User

B = Second Service User

J = If both are using the vehicle

It is important when recording the date to then use the proper code i.e. under User write A. Follow the direction in the headings for the rest of the columns.

Supported Living – Complaints, Accidents, Commissioning Support Unit Recordings

This document needs to be completed in the event of any incidents described on the form occurring. For example medication errors, Service Users going into hospital, a Service User going missing or death of a Service User.

There needs to be three copies; one to stay within the scheme, one for Contract and Monitoring officer and one for the Contract Manager. A copy should be sent to the Care Manager if requested in the Participation Agreement.

The Contract Manager must be informed of any incidents immediately after the incident has been managed. If unavailable then On Call must be contacted to ensure all relevant documentation is completed.

How to complete the form:

- Ensure that you record the date and time of the incident.
- Any Service Users or staff involved in the incident.
- The environment that the incident occurred in.
- Actions taken
- People informed
- Only record factual information

N.B. Ensure to inform the Contract Manager within 24 hours of incident. If unavailable please contact the On Call.