

# **THE SOUTHEND ON SEA DARBY & JOAN ORGANISATION LIMITED**

## **Resident Plans of Care**

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### **Policy Statement**

This home will ensure that each resident has an individual plan of care which will provide the outline of the care to be delivered.

The plan will be drawn up on the basis of a thorough assessment of the prospective resident's needs, abilities and aspirations. This will be based on a summary of the care plan prepared under care management arrangements, the relevant plan produced under the Care Programme Approach, or an assessment made by the home's own staff before admission.

This assessment will cover all aspects of the prospective resident's health, personal and social care needs. The resident plan will set out in detail the action which needs to be taken by care staff to ensure appropriate attention to all aspects of the care needs of the resident.

The home recognises its duty towards the safety of its residents, but it does not guarantee a risk-free environment, and considers some risks to be necessary, important in maintaining independence and even enjoyable. Any action in the plan which involves a measure of risk will be subject to a risk assessment which will set out the balance of dangers and benefits for the resident to take an informed decision. Particular attention will be paid to the risk of falls.

The resident is always central in the home's procedures for planning care. The resident must therefore sign or otherwise signify active consent to the plan of care and to the attendant risk assessments. In instances where the resident is not able personally to take responsible decisions, every possible step will be taken to consult a friend, relative, advocate or other representative who can unequivocally represent the resident's interests in the planning process.

The home will make available relevant managerial, care and other staff as appropriate to assist in producing and carrying through the plan of care and, subject to the resident's permission and to recognised standards of confidentiality, will involve others from outside the home who may have a part to play. Reviews of the objectives, strategies, responsibilities, timescales, and risks in a plan of care will be carried out by the resident, relevant manager and appropriate care and other workers regularly, incorporating new information and changes in the resident's needs, abilities or aspirations.

All records relating to a resident's plan of care will be written in readily comprehensible language and kept in a secure place accessible to the resident.

### **Policy for Resident Plans of Care**

#### **Objectives and strategies**

1. The resident plan of care, will be drawn up on the basis of the assessment, and will identify the objectives which this home and the resident agree for the care this home will provide.
2. The aims of care will embrace all aspects of the resident's welfare.
3. For each stated objective, the home will develop a range of strategies to be used to attain the objective, to allocate responsibilities and to set time-scales.

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## **Risks and risk assessment**

1. Although this home attempts to provide for its residents an environment that is relatively free of danger it is not a totally risk-free environment.
2. Residents will not be denied the chance to take reasonable risks which they feel will enhance their fulfilment. As part of the process of planning care, this home will help each resident assess the risks involved in any proposed activity, weighing the benefits and possible adverse effects, and coming to a measured conclusion. Such risk assessments will be recorded as part of the resident's plan of care.

## **Planning and Meetings**

This home holds regular meetings on residents' plans of care. The first meeting takes place before or very shortly after the resident's admission, the initial objectives will then be discussed and agreed, and the resident should give formal consent preferably by signing the care plan and attendant risk assessments.

## **Implementation**

1. The plan of care will be readily accessible to both the resident and the care staff.
2. The plan of care will be regularly consulted by staff and others who have legitimate access, as a guide to the care they should be aiming to provide.
3. The manager and the key worker will continue to monitor the work undertaken with the resident to ensure that other staff are acting in accordance with the plan.

## **Reviews**

1. In addition to the regular monitoring of the plan on a day-to-day basis, the home will arrange more formal reviews at least Bi-monthly.
2. Reviews involve at least the resident, the manager, and the key worker where the progress of the plan will be discussed.
3. Reviews will critically consider the appropriateness of the original objectives, the feasibility of the strategies, the outcomes of any risks taken, the responsibilities allocated and the time-scales set.
4. Reviews will take into account any new information which is available and any significant changes in the resident's needs, abilities and aspirations.
5. Care will be taken to ensure that the resident is in full agreement with any modifications or additions made to the plan.
6. After each review, the other stakeholders involved in the care will be briefed on changes which require their action or attention.

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## Records

1. This organisation requires the Home Manager or in the Manager's absence the Senior Care staff to complete the Care Plan paperwork within the timescales set out below:

2.

<b>First 24 hours of Admission</b>	<b>Within 48 hours of admission</b>
Moving & Handling/Mobility Medication Body Chart Skin Integrity Eating & Drinking Continence Register/Fire role Admission paperwork to Head Office	Sleep & Rest Washing & Dressing Communicating

3. The full Care Plan will be completed within two weeks of a new resident entering the home.
4. The records will be written in a style and language readily comprehensible to the resident.
5. The records will be kept securely.
6. When changes are required to the resident's plan of care they will be made neatly, but from time to time some documents may become so heavily amended as to need replacing; old documents will not be destroyed during a resident's lifetime as they may contain important information about the resident's personal and care history.

This policy will be reviewed annually