

SUPPORT PLANNING FOR DRH SERVICE USERS – POLICY AND GUIDELINES

1.0 INTRODUCTION

DRH exists to help service users to maintain and to continuously improve their quality of life. This goal is achieved through the Life and Support Planning process. Life and Support Plans will document service users preferences, health, safety and well-being needs and the actions required to enable preferences and needs to be met.

2.0 PRINCIPLES OF SUPPORT

Life and Support Planning reflects a Person Centred Approach to support. A Person Centred Approach involves:

- Enabling the individual to express preferences and choices by the forms of communication that are available to them.
- Discovering what is important to the person who is being supported. For example, how do they wish to spend their time and who with? What kind of things gives satisfaction and what are their dislikes? What life experiences and opportunities might enhance the person's life?
- Identifying and maximising opportunities, which match the individual's preferences.
- Allowing the individual to have control over as many choices as possible.

The Person Centred Approach recognises that all human beings, regardless of disability or mental health problems share certain basic needs. We may differ in our ability to meet those needs independently:

Apart from our basic physiological needs, we all have basic emotional needs, such as the need for love, security, connection and control, and the self-esteem, which arises from feeling competent in different areas of our lives.

Most Person Centred services have adopted John O'Brien's 5 Service Accomplishments as an expression of a commitment to meeting their client's basic emotional needs:

1. **Community Presence** – to support an individual's physical presence in their community in the same way as other citizens.
2. **Making choices** - individuals must be encouraged to understand their own circumstances, and have options in small and large matters. They must be able to act in their own interest.
3. **Competence** - individuals must be allowed to develop their own skills and attributes that are functional and meaningful in natural community environments.
4. **Respect** - services should help to promote people's perceptions of individuals with a learning disability or mental health difficulties.
5. **Community Participation** – to support an individual's relationships with neighbours, families and co-workers, and if necessary and appropriate to widen the person's pattern of relationships.

3.0 CHOICE & MENTAL CAPACITY

DRH supports a *functional* approach to the issues of choice and mental capacity. A functional approach to assessing capacity which recognizes that *a person's ability to make decisions may vary over time and depend on the level of difficulty of particular decisions, like choosing where to live or how to manage money. All practical steps should also be taken to enable that person to make that decision.*

A functional approach also means that we should not impose our own values. For example, what may be perceived to be an unwise or irrational decision may be the preference of that person and their choice should be respected – unless there is clear evidence that a person requiring support would be at

significant risk as a result of that decision. This approach allows for a person to make as many decisions as possible. It focuses on a person's ability to make a particular decision and allows for situations where a person is able to make some decisions and not others. For example, a person may be able to make decisions about what they want to buy, but not about how to manage their money.

This functional approach assumes that a person with an illness or disability can make some decisions about their own lives. It means that individuals are not prevented from making certain decisions just because they have a medical diagnosis of a disability or illness. This capacity may vary over time and depends on the circumstances and the level of difficulty of that decision.

An individual's ability to make decisions should be carefully assessed and documented. Support plans should reflect an intention to continually expand the areas of autonomy and decision making for the service user.

3.0 CHOICE, PREFERENCES AND A DUTY OF CARE

As service providers, social care workers or nurses we have a dual responsibility: to maximize the service users opportunities and autonomy while, at the same time, providing a relatively safe environment. Autonomy and choice (and life) are always accompanied by some element of risk. We are responsible for finding ways of minimizing the risk associated with preferences and opportunities – we are not responsible for eliminating all risk. Risks may be avoided by restricting choice and opportunity but this directly contradicts the primary purpose of DRH.

We should always start our planning by asking what would make the service user happy rather than asking what would make them safe. However, it is unacceptable to ignore the risks that may be associated with a particular choice or activity. Good risk assessment is based on the idea of weighing up the benefits of any decision against the probability and severity of an associated risk.

4.0 LIFE AND SUPPORT PLANNING

1. **VALUES** – This is a list of the sort of things that most of us feel are important for a good quality of life. Referring to a list of agreed human values is particularly important when a resident finds it hard to say what's important to them.
2. **PERSONAL PROFILE** – This is a short "potted" biography, which is agreed with the resident wherever possible. This is not a history of care, it is not a list of problems and symptoms, nor is it an assessment. The profile is an attempt to describe the "real" person behind the labels as they want, (or are likely to want) to be seen. The profile is a central element in Life and Support Planning and helps to avoid Support Teams developing "multiple personalities" for one individual.
3. **IDENTIFYING PREFERRED LIFESTYLE** - This involves agreeing with the resident (and all those who know the resident best) the kind of things *they* prefer in daily life. It also involves identifying new opportunities, which will enhance the resident's experience of life.
4. **IDENTIFYING BARRIERS TO PREFERRED LIFESTYLE** There are lots of reasons why people requiring support don't get to experience the kind of life that they would prefer:
 - Psychological/developmental/medical factors
 - Inadequate understanding of how the individual interprets the world around them
 - Low expectations by staff or carers
 - Tendency to overlook the individual's subjective emotional experience (How I actually "feel")
 - Failure to take full account of all the evidence pointing to the individual's preferences
 - Insufficient help for the service user to develop new skills
 - Over-emphasis on medical, health, risk and safety issues
 - Poor communication – the support team has not yet learnt how the individual communicated their preferences.
 - Inappropriate communication by service user (challenging behaviour)

- Inadequate resources
- Poor management of resources (particularly staff time)
- Poor planning
- Lack of skills within the staff team
- Poor joint agency collaboration
- Social prejudice

This stage of the process involves the identification of specific barriers to that individuals preferred lifestyle.

4. DEVELOPING INDIVIDUAL SUPPORT PLANS All the actions needed to help the resident develop their preferred life style should be identified within their Support Plan. These actions should address all the significant issues relating to preferred lifestyle including significant barriers..

5. HEALTH, SAFETY & WELL-BEING PLAN Each service user should have a Health, Safety and Well-being Plan which identifies all the measures/actions necessary to maintain their health and their safety. This plan will address health maintenance issues and personal care needs.

Many of the barriers to a persons preferred lifestyle are extrinsic to that person and may need to be addressed outside of their Life and Support Plan. For example, barriers such as inadequate planning and staff skill development will be better addressed in the Home's Development Plan.

5.0 RESPONSIBILITIES FOR ALL STAFFED HOMES

HOME MANAGERS are responsible for ensuring that:

- all service users have a current Life and Support Plan which has been developed in accordance with this Policy and Guidelines.
- the Support Plan and the Health, Safety and Well-being Plans are implemented consistently.
- daily Shift Plans clearly identify activities deriving from the Plans and that responsibilities for these activities are allocated appropriately.
- plans are reviewed at least 6 monthly, fully involving the service user as far as is practicable
- all staff have an adequate understanding of each Plan and their responsibilities towards each service user.
- as far as practicable, family members and others concerned in the welfare of the service user are consulted in the drafting of Life and Support Plans and in subsequent reviews and evaluations.

SHIFT LEADERS/SENIOR SUPPORT WORKERS are responsible for ensuring that:

- the Support Plan and the Health, Safety and Well-being Plans are implemented consistently.
- daily Shift Plans clearly identify activities deriving from the Plans and that responsibilities for these activities are allocated appropriately to members of the team.

ALL TEAM MEMBERS are responsible for ensuring that:

- plans are read and understood and subsequent changes are noted.
- plans are implemented in a timely and appropriate manner.
- they make a contribution to the development and review of Support Plans.
- support is appropriately documented

6.0 RECORD KEEPING

Service Users will have access to all records and information held about them and where practicable will participate in maintaining their personal records. Service Users will sign for and agree their Support Plans

Individual records will be secure, up to date and in good order.

There are a number of factors that contribute to effective record keeping. Service User records should:

- be factual, consistent and accurate
- be written as soon as possible after an event has occurred, providing current information on the care and condition of the service user
- be written clearly and in such a manner that the text cannot be erased
- be written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read clearly
- be accurately dated, timed and signed, with the signature printed alongside the first entry
- not include abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements
- be readable on any photocopies.
- wherever practical, be written in terms that the service user can understand
- be consecutive
- identify problems that have arisen and the action taken to rectify them
- provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

7 RESPONSIBILITIES FOR NON STAFFED HOMES

The Liaison Officer will be responsible for drawing up Support Plans in conjunction with the Service User and appropriate referring agency.

This Policy and Guidelines replaces "Procedure and Guidelines for the Care Planning Process in DRH Homes" (1999)

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