

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 Individual Support Planning process. Individual Support Plans will document preferred lifestyles; service users preferences; and interventions necessary to optimise the emotional and physical well-being of the service user.

2.0 PRINCIPLES OF SUPPORT

Individual 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.

Human Givens Approach - DRH is committed to using the Human Givens approach in all person centred support planning This approach recognises that all human beings, regardless of disability, intellectual ability, illness, ethnic, class, gender or cultural background share certain basic needs. These needs are said to be "hard-wired" that is they are built in to our neurological/genetic make up. We may differ significantly in our ability to meet those needs independently or in the particular way we prefer to meet or express those basic needs:

The Individual Support Planning process within DRH aims primarily to assist service users to meet their basic needs i.e.:

Our EMOTIONAL NEEDS include :

- the need for physical and emotional security (a stable home life and safe territory to live in)
- the need to give and receive attention
- the need for a sense of autonomy and control
- the need to feel connected to others and be part of a wider community (with opportunities to contribute to that community)
- Friendship, intimacy — to know that at least one other person accepts us totally for who we really are, "warts 'n' all" (unconditional positive regard)
- the need to feel competent - from successfully learning & applying skills (antidote to low self-esteem)
- the need for privacy (time to reflect & consolidate experience)
- the need to be "stretched" in what we do
- Meaning and purpose. – a general sense that life is worth living and that there are future events and opportunities to look forward to.

Our PHYSICAL NEEDS include:

- air
- water
- adequate & appropriate nutrition
- freedom to move
- sleep

While the Human Givens approach stresses that while we all share the same basic needs (a product of evolution and genetics) it recognises that there may be huge variations in our ability to meet these needs. In addition to our basic physical and emotional needs evolution has provided us with **psychological resources** which enable us to independently meet these needs e.g.:

- Imagination
- Memory
- Rational thought and reasoning
- Grasp of language and metaphor

These resources can be severely impaired or damaged by a developmental (learning) disability or a serious mental illness. This is why our service users need the specialist support provided by DRH.

3.0 PERSONAL PROFILE

This is a short “potted” biography, based on the Human Givens approach and which is agreed with the service user - 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 the individual service user wants, (or is likely to want) to be seen. The profile is the foundation block of Individual Support Planning and helps Support Teams to form a cohesive and complete understanding of how that individual perceives their world and their needs.

- The Personal profile is most useful when it was written as a “story” about the individual
- The personal profile should enable the reader to establish some kind of emotional connection to that individual rather than solely to learn a series of “facts”
- How the profile is written – whether it is written in the first person (i.e. “I”), or third person will be dependent on that individual and how well the staff know the individual
- As far as possible the language used within the profile should reflect that individuals personality
- The profile should reflect how life is experienced for that individual

The profile should determine and should link clearly to all support plans and activities
Profiles will help to identify actions to address wider environmental, organisational and skill issues which should be included in the Home development Plan including staff training needs. The quality of a service users life will owe as much (if not more) to actions which improve the emotional environment in which they live and the opportunities available to them rather than individual and therapeutic interventions.
(External barriers)

The Personal Profile should attempt to give its readers some indications as to how the individual service user might evaluate their own life – how they see the world from their own perspective i.e. their sense of subjective wellbeing. It is said that we have a positive state of well-being when the total of positive emotional moments in the day exceed negative emotional moments

(See Personal Profile Checklist Appendix A)

4.0 COMMUNICATION PROFILE

All service users will have a *communication profile* that details how the individual communicates with the wider world – specifying how the service user communicates needs and preferences. This will include all forms of communication used by the service user to communicate with others or the most effective means staff have found to communicate with the service user. As well as specifying the particular means of communication (e.g. normal verbal; key words; facial expression; vocalisations; gestures; symbols; pictures) the profile will also indicate important factors affecting communication e.g.

preferred staff; proximity; stance. These factors may be particularly important in terms of risk management. All service users will have a communication profile based on the agreed template (See Communication Profile Appendix B)

5.0 PREFERRED LIFESTYLE (24Hour/Weekly) PLAN

All service users will have a Preferred Lifestyle Plan which accurately reflects the Personal Profile and informs staff of the particular supports/interventions and actions which are necessary to enable the service user to achieve optimal quality of life and well-being. This Plan will clearly identify the service user's preferred daily and weekly activities and routines. The Preferred Lifestyle Plan for each 24 hour period/week will clearly identify which members of the team are responsible for assisting the service user to participate in their chosen activities and routines.

- The plan should include all the information required to enable staff to meet service users "day to day" needs
- The amount of detail within the plan will reflect individual needs and circumstances
- The plan should include all known routines and regular planned activities
- The plan should include all "known" information about how these routines need to be carried out, i.e. what, when, where, who, how and what not to do!
- These plans will then form the basis for daily/weekly shift planning to ensure that staff/time is allocated appropriately
- The plan should cover the whole 24 hour period
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5.0 LONG TERM PLAN

All service users will also have a Long-Term Plan which reflects their Personal Profile and the Human Needs approach. The Long-Term Plan will identify aspirations and hopes for the future e.g.:

- Acquiring new skills that will help the service user to better meet certain human needs (e.g. to enhance self-esteem; purpose and meaning)
- Goals for achieving greater independence and possibly alternative accommodation
- Travel plans
- Widening circles of friendship and strengthening relationships
- Saving for high cost goods
- This plan should include all non regular/routine activities, plans for the year ahead and plans for the future
- Short-term actions which may enable the service user to realise long term goals should then be incorporated into the 24 hour/weekly plans

6.0 HEALTH, SAFETY & WELL-BEING PLANS

All service users must have a detailed and comprehensive Health, Safety and Well-Being Plan. This plan should include as a minimum:

- Health Action Plan (including actions/supports necessary for service user to maintain optimal physical health)
- Risk profiles & Risk management Plans,
- Financial Capability Assessment

Where necessary the Health, Safety & Well-Being Plan should include:

- Behavioural profile
- Psychiatric profile
- Mental Capacity profile

This plan provides a back up to the 24 hour support plan and should be clearly linked to meeting human needs and addressing resource issues.

6.0 HOME DEVELOPMENT PLAN

Many of the significant barriers to a person's preferred lifestyle are extrinsic to that person (dependent on factors outside of that person's control) and may need to be addressed outside of their Individual Support Plan. For example, barriers such as inadequate planning, poor coordination and staff skill deficiencies will be better addressed in the Home's Development Plan (HDP). The HDP should identify the actions required to address problems in the service user's wider environment or resource issues. HDP's should be reviewed at every Team meeting and amended as necessary.

7.0 CHOICE & MENTAL CAPACITY

DRH supports a *functional* approach to the issues of choice and mental capacity.

A functional approach to assessing capacity is one 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. It will also depend critically on the information that is available to help that person make a decision. All practical steps should also be taken to enable the individual to make their own decisions.

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.

The Mental Capacity Act 2005 states that:

A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

A person must be assumed to have capacity unless it is established that he lacks capacity.

A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests

8.0 CHOICE, PREFERENCES, RISK AND A DUTY OF CARE

As service providers, support 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. As support providers we have a duty of care to find ways of minimizing any risk associated with preferences and opportunities so that service users may enjoy their preferred lifestyle – 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.

Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way

(Mental Capacity Act, 2005)

9.0 RESPONSIBILITIES FOR SUPPORT PLANNING

HOME MANAGERS/TEAM LEADERS are responsible for ensuring that:

- all service users have a current Individual Support Plan which has been developed in accordance with this Policy and Guidelines.
- the Support Plan, Communication Plan and the Health, Safety and Well-being Plans are implemented consistently by all members of the team.
- daily Shift Plans clearly identify activities deriving from the Support Plan and that responsibilities for these activities are allocated appropriately.
- plans are reviewed by all involved in the service users support at least 6 monthly, fully involving the service user as far as is practicable
- accurate records are kept of each review meeting
- all staff have an thorough understanding of each Plan and of 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 Individual Support Plans and in subsequent reviews and evaluations.

SHIFT LEADERS are responsible for ensuring that:

- the Support Plan and the Health, Safety and Well-being Plans are implemented consistently.
- Daily/weekly 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:

- support plans are implemented as agreed
- 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

10.0 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. Whenever practical, staff will always attempt to seek agreement from service users for the contents of all aspects of their individual Support Plan. Every practicable effort will be made to ensure that service users understand the contents of their support plans and any documentation that relates to them. Documented records of consultation and agreement with the service user will be kept.

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 written in a way that is fully respectful of the service user
- 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.

All DRH staff are responsible for ensuring that service users documentation (whether paper or electronic) is stored or transported safely and securely. Confidentiality should be maintained at all times.

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

Revised August 2004 and May 2005

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Next revision due August 2011

APPENDIX A



PERSONAL PROFILE CHECKLIST

Does the Personal Profile adequately address answer the following questions?

	<p>SAFETY & SECURITY (Stable & safe home life)</p> <ul style="list-style-type: none"> • Does this person generally feel safe and secure? • How do we know? • What appears to threaten this person's peace of mind (situations; places; people)? • What does this person find comforting when anxious or fearful? • What seems to make this person sad? • How does this person try to avoid situations people that seem threatening? • How do we know if this person is anxious? • How do we know when this person feels relaxed? • How do they "communicate" anxiety or security to us?
	<p>INTIMACY & FRIENDSHIP</p> <ul style="list-style-type: none"> • Who are the most important people in this person's life? • How do we know that? • How does this person communicate friendship and intimacy to others? • How does this person prefer to receive indications of friendship and warmth from others? • How does this person relate to physical touch? • What kind of physical contact is preferred? • Does this person appear to have sexual needs? • How are these met?
	<p>CONNECTION TO OTHERS & PRIVACY</p> <ul style="list-style-type: none"> • How does this person communicate with others? • Has this person developed a form(s) of communication that is effective to communicate with others? • Overall, does this person show a preference for the company of others or a preference for their own company? • How does this person indicate a wish for greater privacy? • How does this person indicate a wish for greater social interaction? • What factors appear to influence this person's choices for company or privacy? • Does this person choose to confide in certain people rather than others? • How wide is this person's "circle of friends"? • Does this person have a preference for particular social settings?

	COMPETENCE
	<ul style="list-style-type: none"> • What skills does this person have? • How frequently are these skills practised? • In what circumstances are these skills practised? • Is this person currently learning new skills? • Does this person ever show frustration because of poor skills? • What was the last new skill acquired by this person? • What opportunities does this person have for making genuine choices and decisions? • Does this person value the opportunity to make decisions (however small)?
	SELF-ESTEEM
	<ul style="list-style-type: none"> • What are the indicators that tell us whether this person is feeling good/bad about themselves? • What factors seem to help this person to feel more positive about themselves? • What factors appear to cause this person to feel bad about themselves? • Is this person frequently subjected to negative attention (e.g. criticism/correction)
	ATTENTION
	<ul style="list-style-type: none"> • How does this person indicate a need for attention? • How does this person initiate attention from others? • How attention is normally offered? • What opportunities exist for this person to receive positive attention (i.e. unrelated to a personal care or similar task) • Does this person communicate frustration when attention from others is not currently available? • Does this person communicate frustration when they feel that they are subject to too much attention (negative/positive)? •
	PURPOSE & MEANING
	<ul style="list-style-type: none"> • What relationships; activities; experiences etc seem to be particularly important to this person? • What factors tend to make this person feel that life is generally worthwhile? • Does this person have particular daily routines that they value? • Does this person have any personal beliefs that they value? • Does this person have the opportunity to enjoy the anticipation of particular events e.g. holidays? • Does this person enjoy the memory of past events? • What makes this person laugh? • What hopes and goals does this person have for the future • Does this person express a wish for greater independence?

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