Policy on Plans of Care and Review

Policy Statement

Ace Care will ensure that each client 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 client'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 Ace Care's own staff on acceptance. This assessment will cover all aspects of the prospective client's health, personal and social care needs. The client 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 client. The plan will meet all appropriate clinical guidelines produced by relevant professional bodies and will include objectives for care, strategies to meet those objectives, statements of responsibility for staff and others, and appropriate time-scales.
Ace Care recognises its duty towards the safety of its clients, 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 client to take an informed decision. Particular attention will be paid to the risk of falls.
The client is always central in Ace Care's procedures for planning care. The client must therefore sign or otherwise signify active consent to the plan of care and to the attendant risk assessments. In instances where the client 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 client's interests in the planning process.
Ace Care 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 client's permission and to recognised standards of confidentiality, will involve others from outside Ace Care who may have a part to play. It is for the client to specify which relatives, friends or others they wish to be involved in drawing up and implementing the plan.
Reviews of the objectives, strategies, responsibilities, time-scales, and risks in a plan of care will be carried out by the client, relevant manager and appropriate care and other workers at least monthly, incorporating new information and changes in the client's needs, abilities or aspirations.
All records relating to a client's plan of care will be written in readily comprehensible language and kept in a secure place accessible to the client.

Policy for Client Plans of Care

Objectives and strategies

1. The client plan of care, will be drawn up on the basis of the assessment, and

will identify the objectives which Ace Care and the client agree for the care Ace Care will provide.

2. The aims of care will embrace all aspects of the client's welfare.

3. For each stated objective, Ace Care will develop a range of strategies to be used to attain the objective, to allocate responsibilities and to set time-scales.

Risks and risk assessment

1. Although Ace Care attempts to provide for its clients an environment that is relatively free of danger it is not a totally risk-free environment.

2. Clients 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 Ace Care will help each client 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 client's plan of care.

Planning and meetings
Ace Care holds regular meetings on clients plans of care. The first meeting takes place before or very shortly after the client's admission, the initial objectives will then be discussed and agreed, and the client 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 client 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 or assistant manager and senior carers will continue to monitor the work undertaken with the client 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, Ace Care will arrange more formal reviews at least monthly.

2. Reviews involve at least the client, and one of the following members of staff. The manager, assistant manager or a senior carer 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 client's needs, abilities and aspirations.

5. Care will be taken to ensure that the client is in full agreement with any modifications or additions made to the plan.

6. Reviewing the plan of care is a continuing process of counting achievements, setting new goals and adjusting the care. After each review, the other stakeholders involved in the care will be briefed on changes which require their action or attention.

Records

1. Each client will have a file prepared on acceptance, which will contain:

- a sheet with basic information (name, age, etc)
- the initial assessment documentation
- the first plan of care
- risk assessments
- records of reviews of the plan.

2. The records will be written in a style and language readily comprehensible to the client.

3. The records will be kept securely either in the client's own room or in a place to which the client has easy access.

4. When changes are required to the client'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 client's lifetime as they may contain important information about the client's personal and care history.

5. If any information is stored in computer format, the additional requirements of the Data Protection Act 1998 apply.