Sheffield City Council

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

NHS Sheffield Clinical Commissioning Group

Care Planning

Local Working Agreement and Toolkit for Care Homes in Sheffield

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In hospital and in the community

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Contents

LOCAL WORKING AGREEMENT

Local Working Agreement on Care Planning

Background

In November 2013 a workshop was held with senior representatives from Sheffield Clinical Commissioning Group and Sheffield City Council Commissioning, Contracts, Care Home Assessment and Care Home Support Teams to establish a local working agreement on key areas of care planning that were identified as requiring explicit clarification.

The key areas of care planning that were identified as requiring agreement related to:

- Structure/organisation
- Risk assessment/assessments
- Individualised care
- Review and evaluation

Whilst there is national and best practice guidance relating to record keeping and care planning the interpretation and application of these principles in practice can vary between professionals and organisations. This variance can result in care homes being presented with conflicting or confusing care planning advice.

The purpose of a Local Working Agreement and accompanying toolkit is to provide a consistent approach to care planning for those who work in or support care homes in Sheffield.

Agreement

Care Plan Structure and Organisation

Agreeing a framework for the way in which care plans are organised and compiled will help to ensure residents receive the right care at the right time by having the relevant information readily available for the many staff that are involved in providing and monitoring care. Key information about a resident can also be captured by the use of a ‘One Page Profile’, see Page 53.

Index

Care plans should be organised by use of an index system. This should include a ‘Core index’ which helps staff identify the fundamental Activities of Daily Living (ADL’s) essential to human wellbeing . In addition an ‘Optional index’ is offered which suggests other domains of care which some residents may require, either on occasion or continually – for more detail and examples see pages 49-55.

A care plan should only be written where a need has been identified in one of the domains of care in the core or optional indexes.

Assessment/risk assessment
Care plans should be developed through a continual process of assessment, risk assessment, planning, intervention and evaluation. Information in a risk assessment should be used to construct the care plan and the risk assessment filed with the relevant care plans

General statements
The use of general statements such as 'adhere to Standard Infection Control Procedures' or 'maintain privacy and dignity' should be avoided when writing a care plan.

Transcribing
Detailed information which is needed to support the care of a resident does not need to be transcribed into a resident's care plan if that information can be evidenced from another source, is referred to in the care plan and is filed alongside it.

Cross referencing
Cross reference can be made to other care plans where the same information would otherwise be repeated. For example elimination requirements do not need to be repeated in a rest and sleep care plan if they are already detailed in an elimination care plan so long as this link is clearly referenced.

Specialist Information
Information that is provided by specialist services should be included in the resident's care plan if the care is to be given by the care home staff. If the care is to be given by the specialist then this information should be referred to in the care plan and filed alongside it if available.

Observations
Care plans should include a record of core observations which are recorded as a baseline on a resident's admission to the home and thereafter when there is a change in condition or as part of ongoing medical review. Observations should include as a minimum Blood Pressure, Pulse, Temperature, Height and Weight recordings.

Daily Entries
Daily entries should be used to record any changes to the usual plan of care for a resident. This could include for example any change in the health and wellbeing of a resident, any significant events that have taken place on that day, any change to their usual occupation and activity and any new needs. Changes identified from daily entries can inform the need for a new care plan, a GP or health care professional review.

A daily record entry should be signed and the name of the person making the entry printed.

Timescales
Care Homes should allocate a named member of staff to be responsible for leading the care planning process for new admissions to the home, including the collation of all relevant information, for example from hospital, GP, resident or relative.

Risk assessments and core care plans should be completed within 24 – 48 hours to maintain resident's safety with the exception of skin inspection and Waterlow Risk Assessments which should be completed within **6** hours, see Pages 62-70.

A full care plan should be developed within 7 working days.

The care plan should be reviewed and information added as the admission progresses to ensure that the care plan is a dynamic working document that identifies the resident's needs and wishes at any given time.

Electronic Care Plans
Best practice guidance should be used to inform the development and use of care plans whether they are hand written, typed or electronically produced, see Page 15.

Signatures
Care plans should include a staff signature sheet, including the staff member's designation. A signature sheet should also include any visiting professional or agency staff who make a record in a residents care plan. A care plan should be signed by the person who writes it.

Individualised Care / Shared View
Care plans need to reflect a shared view about the person's needs in relation to the different areas highlighted in the care plan index. The phrase 'shared view' means that the views of all of those involved are considered.

Care plans must provide information about the person's views and wishes in relation to how their care is going to be provided and involve others who know the person, as well as those who are providing care and/or treatment. The person may need support to enable them to give their views, see Pages 19-27.

In order to comply with the principles of the MCA it should be assumed that the person is able to make their own decisions and choices unless proven otherwise.

It is important to remember that the person may be able to express their views and wishes even if they are not able to make a decision about a particular aspect of their care, see Pages 19-27.

An example of a shared view: "*Susan needs help with medication as she does not always remember what tablets she takes or when to take them because she experiences memory problems"*
Jane, Susan's daughter says that she worried about her mum taking her tablets when she was at home because she used to take too many, forgetting how many she had taken.

Toolkit

Section 1

Regulations and Guidance

Dignified Care

By respecting client's wishes and defending their dignity, we hope to achieve an environment where comfort and wellbeing is of optimum importance and where diversity of individuals, regardless of age, nationality, gender, religion, sexuality or talent, will value each other to create a positive welcoming environment.

Different

Individuals

Valuing

Each other

Regardless of
Religion

Skin/Sex/Sexuality

Intellect

Talent or Years

Defending your

Independence by

Genuinely

Noticing your

Individuality and

Tailoring care to

Your uniqueness

P*rotect your clients*
R*espect their wishes*
I*ndividualise care*
D*ignity first*
E*ncourage independence*

PRINCIPLES OF CARE PLANNING – CARE QUALITY COMMISSION (CQC)

CQC Essential standards of quality and safety

As the regulator of health and social care the Care Quality Commission have produced a series of outcomes which help providers comply with the regulations of the Health & Social Care Act 2008.
Compliance with CQC outcomes is linked to good record keeping and the following are some of the outcomes that relate to care planning.

Outcome 1: **Respecting and involving people who use services**

Outcome 2: Consent to care and treatment

Outcome 4: Care and welfare of people who use services

Providers who comply with regulations will reduce the risk of people receiving unsafe or inappropriate care, treatment and support by:

- Assessing the needs of people who use services
- Planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met
- Taking account of published research and guidance
- Making reasonable adjustments to reflect people's needs, values and diversity
- Having arrangements for dealing with foreseeable emergencies

Outcome 6: **Cooperating with other providers**

All those involved in the care, treatment and support of the person who uses services:

- Cooperate with the planning and provision of care, treatment and support
- Record the key points of care, treatment and support they have given

Outcome 16: **Assessing and monitoring the quality of service provision**

Ensure that important decisions about care, treatment and support involve the person who uses the service and are supported by a written description:

- The names or job roles of people who can take each kind of decision or action

Outcome 21: **Records**

Providers who comply with regulations will:

- Keep accurate personalised care, treatment and support records secure and confidential
- Keep records for the correct amount of time
- Store records in a secure, accessible way that allows them to be easily located
- Securely destroy records taking into account any relevant retention schedules
- Records about the care, treatment and support of people who use services are updated as soon as practical. In an emergency situation it may not always be possible to make notes at every step but it is vital to record information as soon as possible and by law within 24 hours.
- Social care records are kept or disposed of in accordance with the Data Protection Act 1998 and three years from the last date of entry (Data

Protection Act 1998 states; ‘Registered Nursing Homes should retain records for 5 years after the date the person ceases to be a patient in the home.’)

Guidance for Good Record Keeping

1. Handwriting should be legible.
2. All entries to records should be signed. In the case of written records, the person’s name and job title should be printed alongside the first entry.
3. In line with local policy you should put the date and time on all records. This should be in real time and chronological order and be as close to the actual time as possible.
4. Your records should be accurate and recorded in such a way that the meaning is clear.
5. Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation.
6. You should use your judgement to decide what is relevant and what should be recorded.
7. You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment.
8. Records should identify any risks or problems that have arisen and show the action taken to deal with them.
9. You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care.
10. You must not alter or destroy any records without being authorised to do so.
11. In the unlikely event that you need to alter your own or a colleague’s records, you must give your name and job title and sign and date the original documentation. You should make sure that the alterations you make, and the original record, are clear and auditable.
12. Where appropriate the person in your care, or their carer, should be involved in the record keeping process.
13. The language that you use should be easily understood by the people in your care.
14. Records should be readable when photocopied or scanned.
15. You should not use coded expressions of sarcasm or humorous abbreviations to describe the people in your care.
16. You should not falsify records.

Based on NMC Record Keeping 2009

Delegation of record keeping

1. Record keeping can be delegated to Health Care Assistants (HCAs), Assistant Practitioners (APs) and student nurses so that they can document the care they provide.
2. As with any delegated activity, the registered nurse needs to ensure that the student or HCA/AP is competent to undertake the task and that it is in the patient's best interests for record keeping to be delegated.
3. Supervision and a countersignature are required until the student/HCA/AP is deemed competent at keeping records.
4. Registered nurses should only countersign if they have witnessed the activity or can validate that it took place.
5. Organisations providing health care should supply clear guidance on record keeping for all staff, in line with the principles and guidance in the NMC's record keeping guidance.
6. Always refer to local policy in the first instance.

Countersigning

Local policies may require registered nurses to countersign clinical records made by an HCA/AP/student nurse. This is **not** an automatic requirement.

The key issues are:

- whether the HCA/AP/student has been trained to appropriate standards and is competent to produce such records as part of the overall provision of care
- whether it is in the patient's best interests for recording of care (as well as care provision) to be delegated

Accountability

1. We are accountable to the person for whom we are providing care and we need to be able to justify our practice based on the best available evidence.
2. We are accountable to our organisation, managers and colleagues in delivering a good quality service.

Section 2

Individualised Care

- **Mental Capacity Act (MCA)**
- **MCA & Best Interest Decisions (BIA)**
- **MCA assessment example**
- **MCA blank template**
- **Glossary of Terms - MCA & Deprivation of Liberty Safeguards (DOLS)**
- **Restraint and Restriction**
- **DOLS**
- **DOLS screening tool**

THE MENTAL CAPACITY ACT 2005

The Mental Capacity Act (MCA) 2005 is designed to promote and protect the rights of individuals who might lack capacity to make their own decisions. It is the foundation for the Deprivation of Liberty Safeguards (DOLS). The MCA protects the human rights of individuals. In the United Kingdom these human rights, which all citizens share, are set out in the Human Rights Act (HRA) 1998.

The rights contained in the Human Rights Act 1998 are:

Article 2: Right to life

Article 3: Right not to be tortured or treated in an inhuman or degrading way

Article 4: Right to be free from slavery or forced labour

Article 5: Right to liberty

Article 6: Right to a fair trial

Article 7: Right not to be punished for something which wasn't against the law at the time

Article 8: Right to respect for private and family life, home and correspondence

Article 9: Right to freedom of thought, conscience and religion

Article 10: Right to freedom of expression

Article 11: Right to freedom of assembly and association

Article 12: Right to marry and found a family

Article 14: Right not to be discriminated against in relation to any of the rights contained in the Human Rights Act

- The articles highlighted in bold text at 3, 5, and 8 are the most relevant when working with people who live in a care home.

- The MCA places a duty on all public authorities in the UK to respect the rights contained in the Act in everything that they do. Care homes are organisations that are carrying out duties on behalf of a public authority and therefore must comply with the Human Rights Act, the MCA and DOLS.

- Anyone who is paid to work with someone who might lack capacity to make some of their own decisions must work within the Mental Capacity Act and follow the code of practice.

- The MCA is built on **five** statutory principles, see below, that guide and inform all decision making in relation to people who may lack capacity for decision making in some aspect of their lives.

The Five Principles of the Mental Capacity Act

1 All adults have the right to make decisions for themselves unless it is shown that they are unable to make them. This means that you must not assume that a person cannot make a decision for themselves just because they have a particular medical condition or disability, or because of their age or appearance.

2 People should be supported as much as possible to make their own decision before anyone concludes that they cannot make their own decision. This may be through using different ways of communicating such as words, pictures or signs and providing information in different formats, such as audio or Easy read. In some cases an independent advocate may be able to help, see 'Top Tips Helping Someone to Make a Decision' Page 27.

3 People are allowed to make a decision that may seem to other people to be an unwise or strange. A person should not be treated as unable to make a decision because of this.

4 If a person lacks capacity any decisions or actions taken on their behalf must be taken in their best interests.

5 The final principle of the MCA is to make sure that people who lack capacity are not restricted unnecessarily. Anyone making a decision on another's behalf must consider whether it is possible to decide or act in a way that would interfere less with the freedoms and rights of the person who lacks capacity.

- The Mental Capacity Act provides a framework for making decisions on behalf of other people and explains how this should be done in a person's best interests. If a best interests decision is required then this should be made involving the people who know the person best and who may have a view on how the care needs to be provided. Any decision made relating to the person's care or treatment should be recorded in the care plan area that the decision relates to.

Best Interests

The law says that it is important that every reasonable effort has been made to try to support people to make their own decisions. If a person is unable to make a particular decision and hasn't made plans about this in advance then someone else will have to decide what should happen. In these circumstances the person should still be involved in the decision-making process as much as possible and all actions and decisions must be taken in their best interests.

Care planning documents must demonstrate how any decisions made on behalf of a person who lacks capacity are made in their best interests and the following checklist needs to be followed.

Best Interests Checklist
Although there is no single definition of what would be in a person's best interests, the MCA Code of Practice Chapter 5 (see link to document Page 84), provides a checklist of things that must be considered when making a decision for someone else:

- Consider all the relevant circumstances
- Consider a delay until the person regains capacity
- Involve the person
- Consider the individual's own past and present wishes and feelings
- Consider any advance statements made
- Consider the beliefs and values of the individual
- Take into account views of family and informal carers
- Take into account views of Independent Mental Capacity Advocate (IMCA) or other key people
- Show it is the least restrictive alternative or intervention
- Not be motivated to bring about the person's death

MENTAL CAPACITY ASSESSMENTS

The Mental Capacity Act 2005 provides a framework for working with people who lack capacity to make a wide variety of decisions for themselves. Staff in care and nursing homes are involved in this on a daily basis. Such decisions can relate to very simple matters such as what a person wants to wear to more complex matters such as their capacity to manage money.

Who carries out the mental capacity assessment?
The person responsible for carrying out the capacity assessment is usually the 'person who is directly concerned with the individual at the time of the decision' (the Code, chapter 4.38). It is also dependent on the type of decision. For everyday care planning care home staff will be involved in carrying out capacity assessments which relate to the person's ability to understand and make decisions about how their care is given.
For bigger decisions which relate to a change in care situation or medical treatment then this would also need to involve the Local Authority or Clinical Commissioning Group, the person's GP and their family or representative.

How to carry out a mental capacity assessment
There should **not** be a generalised statement made in the care plan that the person lacks capacity as this is not compliant with the Mental Capacity Act. What should be recorded is information in each care plan area about the person's ability to make a decision about that particular aspect of their care, documenting the point in time when it was discussed. Any assessment of the person's decision making ability needs to be done by following the two stage test:

The two stage test determines if a person lacks capacity to make a decision.
(1) *Is there an **impairment of, or disturbance** in the functioning of the person's mind or brain?* This will include for example people with dementia, acquired brain injury through illness, degenerative disease or accident; learning disabilities or the effects of mental illness or intoxication.

- **If a person does not have such a disease or impairment, they have mental capacity and can make their own decisions.**

AND
(2) *Is the impairment or disturbance **sufficient** to cause the person to be unable to make that **particular decision** at the **relevant particular time**?*
The way to determine this is through the assessment of capacity by establishing if a person can:

- **Understand** the information?
- **Retain** information related to the decision?
- **Use or weigh up** the information while considering the decision?
- **Communicate** the decision by any means?

If a person is unable to do any one of the above they lack capacity to make the specific decision at that time.

REMEMBER
Everything possible or practicable must be done to assist with a decision e.g. pictures, photos, videos or sign language. It could involve blinking or squeezing a hand. Involve others who can communicate and put the person at ease.

AND ?
Does the decision need to be made now? If there is a temporary loss or fluctuating capacity and the decision can be delayed, then wait until the person has regained capacity.

Understanding the information
The person must understand the decision they are being asked to make.
For example, a decision about taking medication will require understanding of what will happen if medication is taken and if it is not. Understanding the options and likely consequences of each means that the person will be able to **reasonably understand options and why they are being proposed.**

Retaining information related to the decision
The information needs to be retained long enough for the person to both understand the question and consider and weigh up the options. A good way of testing this is by asking the person to repeat back to you what has been said. It is only necessary to be able to retain the information long enough to make the decision, in other words, a very short time.

Weighing up the information while considering the decision
It is not enough to understand and retain the information; a person must also be able to weigh up the information. In weighing up there will also be a justification for the chosen option.
Changes in cognitive function may create a barrier to weighing up and may be evident when there is:

- Depression
- Persecutory beliefs
- Delusional views not grounded in the reality of the choices
- A person disorientated to time and place might want to return to circumstances that no longer exist
- There may also be a rigid thought process which renders the person incapable of weighing up the options. This can happen with people on the autistic spectrum, but not in all cases.

We must distinguish between could not and would not weigh up the options. The assessment is about determining a person's ability or inability to weigh up the options. A refusal to weigh up options is **not** evidence of a lack of capacity. There must be a **link** between the impairment of the mind or brain and the inability to weigh up the circumstances of the decision.

The ability to weigh up options is essentially about being able to have a reasoned dialogue about the risks and benefits of making a particular decision. It demonstrates the ability to **reasonably foresee the likely consequences of the decision**.

Communicate the decision by any means?
The final stage is the ability to communicate the decision. This is based on a simple premise that what cannot be communicated cannot be known. Every effort should be made using all available means to assist a person to communicate their decision, see 'Remember box, Page 22,

Consent: who gives it and when?

The duty to obtain consent

Where people have capacity the care and support plan can only be delivered with their consent. **Consent is critically important: it is the difference between care that is lawful and care that is not.** To enable a person to give their informed consent they need to:

- have been given all of the relevant information about their care, treatment or support
- understand the different options available and the possible consequences of each
- be free from any duress and understand that they have the right to refuse
- be able to weigh up the options and use this information to make a decision and communicate this

Consent may be communicated in a number of ways for example, verbally, or by blinking, or squeezing a person's hand. It may also be implied through actions, for example, a person holding their arms up so that they can be undressed, reaching out their hand to accept their medication or opening their mouth to accept food.

Care plans must provide evidence of consent, or, where people lack capacity to consent to their care and support plan, there must be a clearly recorded assessment of capacity with supporting evidence.

The Mental Capacity Act and decision making in care planning

Introduction

Making sure the person is as involved as possible in making choices and decisions is a key part of providing person centred care and developing a person centred care plan.

The care plan is the place to record information about the person's capacity to make decisions in relation to each of the areas of care or treatment set out in the Care Plan Index, see Page 50.

This care planning toolkit has been designed to show you how you need to work with a person to support them to make their own decisions and choices and what to do if you feel they aren't able to make a decision or choice in relation to particular aspects of their care or treatment.

Care plans can should:

Comply with the principles of the MCA and promote human rights
Consider questions of autonomy and liberty
Demonstrate how the care provided maximise people's capacity to be involved and to make their own decisions
Respect the rights of people who have capacity, to make unwise decisions.

Involving the person
Involving people in decisions about their care promotes the principles of the MCA and should be evident in every care and support plan. Meaningful involvement is based on a sharing of power between the person and whoever is providing the care. Involving people in putting together their care plans means:
- having a conversation with the person, anyone they choose to be involved and working together to help them to make a decision about their care and support
- that the person is considered as a whole in all aspects of their life
- that the plan belongs to the person, keeping them in control
- that the plan is only implemented or shared with others if the person gives consent (where they have capacity to do so), see section on Consent, Pages 24-27.

Promoting involvement may mean orientating the person to the decision. For example, helping to orientate a person with dementia to the time and place relevant to the decision and filling in the gaps of their understanding.
Each aspect of care and support needs to fit a person's life story. This means actively involving others who know the person and are part of their life. Bringing together all the information about them provides the basis for a care plan that is tailored to meet their specific needs and preferences and takes account of the person's views and wishes as to how they want their care and support to be provided.
Putting a care plan together in this way will help to improve the person's experience and promote their wellbeing rather than simply reacting to problems or crises.

Views and wishes
The person's views and wishes in relation to each area of their care plan need to be gathered by asking the person and involving their family or representative, see Shared View Page 9. Remember when talking to the person you need to take into account the principles of the MCA and:

What to include in the care and support plan and other records
- What is important to the person about how they live their life, for example, what they enjoy doing, their interests, likes and dislikes, who is important to them, who they like to see, where they like to go, their preferred routines (such as when they like to get up and go to bed, whether they like a bath or a shower, etc)
- Details of key life events and dates to assist with orientation to important dates and the order that events have happened
- How best to support and involve the person in decision-making
- Essential information for continuity of care and for use in emergencies
- Roles and responsibilities so that the person receives coordinated care and support to meet their needs
- Where a person lacks capacity to express their choices, how their families and others who are interested in their welfare have been consulted
- What outcome the person wants and any other options considered
- The associated benefits and risks of each option

Evidence that you ask people about their preferences each time you provide care or support for example, whether they want to take their medicines now,

whether they would like a cup of tea, coffee or a cold drink.
Evidence of systems for reviewing the care provided and obtaining feedback.

Recording Mental Capacity Assessments and Best Interests Decisions

Anyone involved in undertaking a Mental Capacity Assessment should keep adequate records that explain the grounds on which a person is found to have, or lack, capacity.

The blank template provided can be used to record and evidence that an assessment of the person's capacity has been undertaken. The outcome of the assessment should be clear, stating whether the person is able to make their own decision in relation to that aspect of their care. Remember that the two-stage test must be used, and you must be able to show that it has been. Most people will be able to make some decisions, even if they have a label or diagnosis that may seem to imply that they cannot.

An example to show you how an assessment of capacity can be recorded in relation to one of the areas of a person's care plan is provided see example, for Medication in 'Shared View Page 9.
Remember that information about the person's ability to make decisions and choices needs to be recorded in relation to each aspect of the care they receive.

Communication

The written care plan should contain a description of any communication needs and how these will be met.
● Where the person has limited communication ability, other non-verbal communication methods that the person may use.
● How the person was supported to be involved in decisions about their care and support.

Best Interests Decisions

Even though a person has been assessed as lacking capacity to decide about their care and support they should still be involved in the best interests decision-making process as much as possible. Any knowledge about them, their views and wishes, beliefs and values should be taken into account. The person making the decision is called "the decision maker" and needs to consider what the person might have wanted if they had been able to make the decision for themselves.
While the decision may not always be able to reflect what the person would have wanted, the impact of not following their wishes may have serious consequences for their wellbeing and so must be carefully considered.

The MCA Code of Practice in Chapter 5 provides a detailed checklist for deciding what would be in a person's best interests, for more information see to document on Page 84.

Who is the decision maker?

This is dependent on the type of decision to be made. For bigger decisions which relate to a change in care situation or medical treatment then this would need to involve the Local Authority or Clinical Commissioning Group, the person's GP and their family or representative.

For decisions that relate to the person's care on a day to day basis, then the decision maker is usually the person responsible for overseeing the person's care, this could be a Care Home manager, Nurse, care assistant or support worker.
No matter who the decision maker is, by law they must show that they have consulted with the person and their family or representative and must provide evidence that the checklist below has been followed.

What to include in the care plan
This list has been adapted from the Thirty Nine Essex Street checklists for best interests assessments and care planning, together with the MCA Code.

- How any decisions made on behalf of a person who lacks capacity are made in their best interests
- A summary of the person's care and support needs
- The person's wishes past or present (obtained from the person, an advance statement or others such as family members or paid carers)
- How the person was supported to understand the nature of the decision and the options available
- How the person was supported to express their views
- Other factors that the person would be likely to consider if they were making the decision for themselves
- Who else was consulted (e.g. family, close relatives, anyone previously named by the person as someone to be consulted, or other people involved in the person's welfare), and their views
- A record of any family members who were not consulted and why
- The options for care and support that were considered. This includes the option of doing nothing and options suggested by family members, even though these may have been discounted
- The risks and benefits of each option
- The likelihood of each risk occurring and the seriousness of impact if they did occur
- The care and support that is being proposed and why this option was decided upon as being in the person's best interests

Top Tips - helping someone to make a decision

1. Setting the scene (with person – why is worker there, what is the assessment about, how it can be done, how it will help, what will happen etc)

2. What does the Law say (helping a person to understand their rights and how the MCA is a legal process that supports the person)

3. Involving other people (spending time thinking about who else could be involved, how we involve other people and who else may have to be involved)

4. Information (making sure person has access to information about the decision and anything relevant to the decision they are making)

5. Making everything accessible (having information in formats/ways in which a person can make best use of and understand fully – thinking about things like pictures, symbols, language, place, time, trying, media etc)

Mental Capacity Act 2005
Form to record an Assessment of Capacity (Capacity Test)

Name of person being assessed: **Mr George Wild**

Date: **20.12.xxxx** **Time:** **14.30**

The decision required: **Can Mr Wild**

On the date and time given above and in relation to the decision the person:

(all practicable steps to help the person with the assessment should be taken by the person assessing capacity)

Answering NO on any one point means the person lacks capacity at this time in relation to the decision to be made

1) Understood the information relevant to the decision **(including reasonably foreseeable consequences of the *decision*) No**

George does not recognise when he has been incontinent and does not understand that he needs support from staff to wash and change his clothing. When approached following an episode of incontinence he will say that he is ok and that he does not need help. He will say that he can sort himself out and, but if left to do this, George is not able to organise his thoughts and actions to achieve this for himself and could not tell me when I asked him what the activities John does not understand the possible consequences of not washing and changing, which may include beginning to smell, becoming sore and developing skin problems and the increased risk of developing pressure sores, which if they get infected could pose a significant risk to his health.

And

2) Retained that information **(*long enough to make a decision*) No**

George has difficulty remembering information or events that have happened recently. George does not retain the information relating to his condition, where he is or the fact that he needs a significant amount of support to meet his personal care needs. George could not recall my name which I gave to him three times during our conversation. At the end of the conversation George had very little recollection of the discussion we had just finished.

And

3) Used or weighed the information to make a decision (***accepted and took account of the information*) No**

As George's understanding of his condition, situation and the need for support with personal care is limited as a result of dementia, he is unable to use all the information that is available to weigh up the benefits and consequences of accepting or not accepting personal care.

And

4) Communicated a decision **(in any way recognised by the person carrying out the mental capacity assessment) Yes**

George is able to express his views and wishes and frequently tells staff that he does not want their help, by telling them that he is able to do it himself. He also displays this through his behaviour towards staff when they attempt to help him wash and change.

If the answer to any of the above is Yes then the person has the capacity to make their own decision and should be supported to do so. Record the outcome in their care plan with a record of their decision.

If the answer to any of the above is No , you need to confirm the person lacked capacity to make the decision stated above BECAUSE OF an impairment of, or a disturbance in the functioning of, the mind or brain (stated below):

George has a diagnosis of Alzheimer's type Dementia which affects his ability to understand the care he requires in relation to personal hygiene. Mr Wild does not acknowledge that he requires support and will often refuse when this is offered, stating he does not need any help. He lacks insight into the activities required to meet his own personal care needs and is unable to demonstrate an understanding of the consequences of not receiving support with personal hygiene.

Completed by

Name (print):

Signature

Mental Capacity Act 2005
Form to record an Assessment of Capacity (Capacity Test)

Name of person being assessed:

Date: **Time:**

The decision required:

On the date and time given above and in relation to the decision the person:

(all practicable steps to help the person with the assessment should be taken by the person assessing capacity)

Answering NO on any one point means the person lacks capacity at this time in relation to the decision to be made

2) Understood the information relevant to the decision **(including reasonably foreseeable consequences of the *decision*) Yes/No**

And

2) Retained that information **(*long enough to make a decision*) Yes/No**

And

5) Used or weighed the information to make a decision (***accepted and took account of the information*) Yes/No**

And

6) Communicated a decision **(in any way recognised by the person carrying out the mental capacity assessment) Yes/No**

If the answer to any of the above is Yes then the person has the capacity to make their own decision and should be supported to do so. Record the outcome in their care plan with a record of their decision.

If the answer to any of the above is No , you need to confirm the person lacked capacity to make the decision stated above BECAUSE OF an impairment of, or a disturbance in the functioning of, the mind or brain (stated below):

Completed by

Name (print):

Signature

Glossary of terms relating to Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009.

Advance decisions to refuse medical treatment
This is a decision made by an adult who is 18 years of age or more and who has capacity to refuse a particular medical treatment. This refers to a future time when the person lacks capacity to consent to the particular medical treatment in question.

Advocate
An independent person who helps and supports a person who has difficulties with understanding issues. The advocate may put forward the person's views, feelings and opinions in meetings and reports.

Approved Mental Health Professional (AMHP)
A social worker or other professional approved by a local social services authority, to carry out a number of functions under the Mental Health Act (MHA) 1983.

Attorney
A person who has been appointed under a Lasting Power of Attorney (LPA), and who has the legal right to make decisions on behalf of the person who set up the LPA, known as the donor.

Best Interests Checklist
Section 4 of the MCA 2005, outlines the factors that need to be considered when making a best interest decision, see link to document Page 84. These factors are referred to as the 'best interests checklist'.
When making a decision in someone's best interests you must:

- Involve the person as much as possible.
- Find out the person's wishes and feelings.
- Consult people who know the person well.
- Consider all relevant information.
- Avoid making the decision if it is likely that the person might regain capacity.
- Think about what would be the least restrictive option.

You must not:

- Make assumptions based on the person's age, appearance, condition or behaviour.
- Make a decision involving life-sustaining treatment that is motivated by a desire to end the person's life.

Best Interests Decisions
Any act done or decision made on behalf of a person who lacks capacity must be done or made in their best interests.

Best Interests Decision-maker
A decision maker is a person who is responsible for deciding what is in the best interests of a person who lacks capacity.

Bournewood Judgement
The commonly used term for the judgment in the European Court of Human Rights made in October 2004 in the case of *HL v the United Kingdom.* This led to the introduction of the Deprivation of Liberty Safeguards.

Capacity
Capacity means a person's ability to make a decision about a particular matter at the time that the decision needs to be made.

Capacity assessments
An assessment of capacity must be made in relation to a particular decision, at the time the decision needs to be made.
Any assessment must start with the assumption that the person has the capacity to make the decision in question.

The Mental Capacity Act Code of Practice describes a test of capacity you can use to decide whether a person is able to make a particular decision.
An assessment that a person lacks capacity to make a decision must never be based simply on:

- their age
- their appearance
- assumptions about their condition
- any aspect of their behaviour

Conditions
Requirements that a Supervisory Body may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the best interests assessor.

Consent
For consent to be legally valid the person giving it must have the capacity to take the decision. They must have been given sufficient information to make the decision and not have been under duress or inappropriate pressure from others.

Court of Protection
The Court of Protection is the court which deals with issues relating to people who lack capacity to make specific decisions. The Court of Protection can make decisions or appoint Deputies in certain circumstances to protect people who cannot make particular decisions for themselves.

Deprivation of Liberty
Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. When a person lives in a care home or hospital and the person:

- Lacks capacity to consent to the arrangements in place regarding their care and/or treatment
- And is not free to leave should they choose to
- And those treating or looking after the person are exercising complete and effective control over their care and movements

That person is then considered to be Deprived of their Liberty.

Deprivation of Liberty Safeguards (DOLS)
Known as DOLS, these safeguards form part of the MCA 2005. They relate to Article 5 of the Human Rights Act 1998, the right to liberty and freedom.

They apply to people who are 18 years of age or over and the arrangements must in the person's best interests and be necessary to protect the person from harm.

Deputy
A Deputy is appointed by the Court of Protection to act on behalf of a person who lacks capacity to make certain decisions for themselves. There are two types of Deputy:
1. A Deputy for personal welfare, including healthcare.
2. A Deputy for property and affairs which may include receiving income such as benefit payments, retirement pension, occupational pension or interest and dividends earned on investments.

Enduring Power of Attorney (EPA)
An Enduring Power of Attorney (EPA) is a legal document appointing an Attorney to manage the property and financial affairs of the Donor. It does not deal with health and welfare decision making.

New EPAs can no longer be created but if a person made one before October 2007, registered or unregistered, it can still continue to be used.

European Convention 1950
The European Convention for the Protection of Human Rights and Fundamental Freedoms1950. The human rights it guarantees are incorporated into UK domestic law by virtue of the Human Rights Act 1998.

Guardianship
A Guardian is appointed to help and supervise patients with mental health problems. These are people who are living in the community and the Guardian is appointed to protect the patient and also to protect other people. The guardian may be either a local social services authority or someone else approved by a local social services authority.

Independent Mental Capacity Advocate (IMCA)
Is the term for someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no one else to support them. The IMCA service was established by the Mental Capacity Act 2005 and is not the same as an ordinary advocacy service.

Lasting Power of Attorney
A Lasting Power of Attorney is a legal document. It enables an adult who is at least 18 years old, to appoint one or more people to make decisions on his/ her behalf if they lose capacity to make these decisions in the future. The person who makes the LPA is called the donor. The person they appoint is called the done.

There are two types of Lasting Power of Attorney:

1. Health and Welfare Lasting Power of Attorney
2. Property and Financial Affairs Lasting Power of Attorney.

Liberty
This refers to a person's freedom of action, to come and go as they please. The term is used in Article 5 of the European Convention on Human Rights 1950.

Life sustaining treatment
Treatment that in the view of the person providing health care, is necessary to keep a person alive.

Managing Authority
The person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty. For the purpose of DOLS, the Managing Authority is the care home or hospital.

Mental Capacity Act (MCA) 2005
The Act governs decision making on behalf of people who lack capacity to make decisions for themselves. It also makes provision for people who currently have capacity and want to make preparations for a time when they may lack capacity.

The Act adopts a person centred approach, meaning that the person who lacks capacity is the focus of the decision or action that is being proposed.

Mental disorder
Any disorder or disability of the mind. As well as mental illnesses it includes conditions such as personality disorders, autistic spectrum disorders and learning disabilities.

Mental Health Act (MHA) 1983 and 2007
Legislation mainly concerned with the compulsory care and treatment of patients with mental health problems. It covers detention in hospital for mental health treatment, supervised community treatment and guardianship.

Mental illness
Mental illness includes conditions like depression, anxiety, bipolar affective disorder, schizophrenia, anorexia nervosa and dementia.

Office of the Public Guardian
The Public Guardian is supported by the Office of the Public Guardian.
The Public Guardian is a judge who is responsible for:

- Supervising Court Deputies
- Keeping registers of Deputies
- Lasting Powers of Attorney
- Enduring Powers of Attorney
- Investigating complaints about Deputies and Attorneys

P
This is the term used to refer to the “person” in question in Court of Protection proceedings.

Relevant Person
The term used to refer to a person who is, or may become, deprived of their liberty in a hospital or care home.

Relevant Person’s Representative or RPR
A person, independent of the relevant hospital or care home, who is appointed to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the operation of the Deprivation of Liberty Safeguards.

Restraint
The use of, or the threat of the use of force, in order to perform an act / task that the person resists. The MCA allows restraint to be used where a person lacks capacity, where it is necessary to protect them from harm, and it is proportionate to the risk of harm.

Review
A formal, fresh look at a relevant person’s situation when there has usually been a change of circumstances that may necessitate an amendment to or termination of a standard deprivation of liberty authorisation.

Statements of wishes and preferences
A statement of wishes and preferences, sometimes known as a statement of wishes and feelings, beliefs and values, is an expression made by a person **with capacity** about certain things that they would like to happen should they one day lack capacity.

That person’s wishes and preferences are important when another person, known as a decision maker, decides what is in their best interests. The decision maker is obliged to take into account the person’s wishes and preferences when working out what is in their best interests.

Standard authorisation
Is the term which applies to the authorisation given by a Supervisory Body, after completion of the statutory process of six assessments. It gives lawful authority to deprive a relevant person of their liberty in a particular hospital or care home.

Supervisory Body
A Local Authority that is responsible for considering a deprivation of liberty request received from a managing authority. The supervisory body will commission the six statutory assessments. If appropriate the supervisory body will authorise a deprivation of liberty.

Unauthorised deprivation of liberty
A situation in which a person is deprived of their liberty in a hospital or care home, without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.

Urgent authorisation
An authorisation given by a managing authority for a maximum of seven days, which may subsequently be extended by a maximum of a further seven days by a Supervisory Body. It gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard Deprivation of Liberty authorisation process is undertaken.

Restriction and Restraint under the MCA sections 5 & 6

The MCA allows the use of restriction or restraint in order to protect the rights of the individual who lacks capacity to consent to care or treatment and the staff who are providing care.
The MCA defines restraint as:

- the use, or threat of use, of force to secure the doing of an act which the resident resists, or restricting a resident's liberty of movement, whether or not they resist.
- Staff can exercise restriction and restraint if they reasonably believe it is in the person's best interests, necessary to prevent the resident coming to harm and that it is a **proportionate** response to the likelihood of the resident suffering harm and the seriousness of that harm.
- Restriction and restraint can be physical, chemical or verbal but it must always be a proportionate response to prevent the possibility of the resident coming to harm and must always be the **least restrictive option** available in the circumstances, to avoid the risk of criminal prosecution.

Homes will wish to ensure that:

• staff understand the legal framework around restriction and restraint
• staff are trained in the use of restriction and restraint techniques
• records are kept when restriction or restraint has been used
• restriction and restraint practice is audited regularly and where improvements are identified an action plan to implement them is developed
• guidance is given to staff on the relationship between restriction and restraint and deprivation of liberty.

If staff reasonably believe that the extent of restriction of movement and restraint required in the best interests of a resident goes further than what is permitted under Section 6 of the MCA, and may amount to a deprivation of liberty, the home must have clear policies and procedures in place to ensure that an application for DOLS is submitted as soon as practicable.

DEPRIVATION OF LIBERTY SAFEGUARDS 2009

KEY TERMS: check in the Glossary to make sure you understand these

Managing Authority
Supervisory Body
Standard Authorisation
Urgent Authorisation
Mental Health Assessor

What are the Deprivation of Liberty Safeguards?

Laws which protect the interests of people who are unable to make some of their own decisions.
Article 5 of the Human Rights Act 1998, states that everyone has the right to liberty and security.
A person who lives in a care home or hospital and who is not able to agree to being there, is not free to leave is subject to continuous supervision and control is deprived of his/her liberty.
The Deprivation of Liberty Safeguards might be more easily understood as "protection for me when my freedom /liberty has been taken away."

Recognising a deprivation of liberty

On 19th March 2014, the Supreme Court handed down a judgment in two cases
P v Cheshire West and Chester Council
and P and Q v Surrey County Council.

As a result of this judgement we must now consider a person to be deprived of their liberty if they are receiving care and treatment in a hospital or care home and they do not have capacity to agree to be there. There are two further key questions to ask:

(1) Is the person free to leave?
AND
(2) Is the person subject to continuous supervision and control?

This means that if a person lacks capacity to consent to the care and/or treatment arrangements, is not free to leave and is subject to continuous supervision and control, they are deprived of their liberty. This is now referred to as the Acid Test.

There is a legal requirement for Managing Authorities to recognise when a person who lacks capacity is being deprived of their liberty and to apply for an authorisation.

Consideration must always be given to the least restrictive options for delivering care and treatment.

Deprivation of Liberty and the Care Plan

Care homes need to review each person's care plan to determine if there is a less restrictive way to deliver their care and/or treatment. The person's care plan and the different areas within it need to include information in relation to the following:

- Is the person free to discharge themselves and live somewhere else that they choose?
- Is the person resisting or objecting to the care they are receiving in any way?
- Is the person subject to continuous supervision (they do not need to be within staff's line of vision at all times) and control - think about how much choice does the person have over everyday decision making and would they be allowed to do things that staff did not wish them to do?
- Control might also include: locked and coded doors that the person cannot access without support, lap straps, bed rails, bucket chairs, intervention that is intrusive and requires the use of restraint techniques, intervention using force, covert medication

Use the tool entitled DOLS screening tool to work out if the care the person is receiving includes any of the above.
If any of these factors apply then an application for authorisation under DOLS needs to be made.

What to do when you identify a deprivation of liberty
The Managing Authority has responsibility to apply for authorisation of a Deprivation of Liberty. The person who does this is usually the care home manager or a senior member of staff.
The Managing Authority must consult with the person, their carers and family members about the application for DOLS.
The Managing Authority can issue itself an urgent authorisation which will cover them legally for 7 days to take measures to keep the person safe. An Urgent Authorisation is not legal without a request to the Supervisory Body for a Standard Authorisation**.**
An application is made on combined forms 1 and 4 which are available here:
Sheffield City Council - Deprivation of Liberty Safeguards (DOLS)

The Mental Capacity Act Support Team are the supervisory body for the Deprivation of Liberty Safeguards (DOLS) in Sheffield. They offer both information and support via helpline and email:

Email: safeguardingadults@sheffield.gcsx.gov.uk Telephone: 0114 2736870

If a Deprivation of Liberty is not needed urgently within 7 days, a standard authorisation can be requested by completing form 4 only.

Copies of the application for an authorisation need to be kept in the relevant area of the person's care plan as they are legal documents.

DOLS, the assessment process
When a Managing Authority issues a request for an authorisation under DOLS, it is asking the Supervisory Body to undertake 6 assessments.

These are:
Mental capacity, Best Interests, No Refusals and **Age** assessments which are all carried out by the Best Interests Assessor.
Eligibilty and **Mental Health** assessments, which are carried out by a suitably qualified doctor or other mental health professional.
The BIA has to establish:

- That the person concerned is over 18, (age assessment) and whether there is any attorney or court appointed deputy who might object to or have a view about the DOLS(the no refusals assessment)
- The BIA carries out a mental capacity assessment, relating SOLELY to the question, "Does this person have capacity to consent to receiving their care and treatment in this home/hospital."
- The BIA has to establish whether receiving care and treatment in the home/hospital is in the person's best interests, using the MCA best interests checklist (best interests assessment)

The Mental Health Assessor has to establish:

- Whether the person is eligible for treatment under the Mental Health Act, rather than using the MCA (eligibility assessment)
- What is the person's diagnosis of disease of mind or brain. What impact is any DOLS likely to have on the person's mental health (mental health assessment)

If a DOLS authorisation is made, the BIA can attach up to 6 **conditions** to the authorisation. These have to be reasonable and the managing authority can object to them if it considers them impossible to achieve.

A representative, **or relevant person's representative** known as an **RPR,** is appointed by the Supervisory Body to ensure that the conditions are adhered to. This is normally a family member, but may be a paid representative if no family member is available or appropriate.

The death of a person subject to a DOLS has to be referred to the Coroner as it is considered to be a death in custody.

Care planning, liberty and autonomy
Care and support plans should promote people's liberty – the freedom to make decisions about their care and support as far as they are able and must demonstrate how people who are deprived of their liberty have their rights protected.
It is important to recognise that **people who have been deprived of their liberty are among the most vulnerable, and therefore care planning must demonstrate how their rights are being protected**.

There must be a continuous process of review to make sure that the deprivation of liberty is still necessary and that there are no other less restrictive interventions that could meet the need.

What to include in the care and support plan

- How a person's liberty is being promoted. This might be anything from going out to the local pub occasionally, to eating their preferred foods or shopping for their own clothes
- Attempts to take account of the person's wishes and views as far as possible
- How the relevant person and their representative are being assisted to be involved in their care and support
- How the person is supported to maintain contact with family and friends
- That conditions attached to the authorisation are being complied with
- That there are arrangements for regular review of the care and support in order to give the person more liberty and choice and see if the authorisation is still needed

Deprivation of Liberty Safeguards [DOLS] Screening Tool

1. List the restrictions placed on the person in the rows below

[restrictions can include actions or rules that actually enable or support a person to be safe and lead a normal life, for example a person is only allowed out if escorted]

Type of Restriction (doors locked, escorted outside, physical restraint, medication to manage behaviour etc)	**Degree/Intensity of restriction** Describe the restriction in practice: how often, how long, the degree or intensity of the restriction, regular and ongoing? (Examples: escorted outside for own safety and staff take out for x hours daily or personal care supported and supervised twice a day every day, no physical intervention but prompting required..)

2. Do the above restrictions mean the person is under complete supervision and control AND not free to leave?

[if the answer to both elements of this question is YES then the person is being deprived of their liberty and you should contact your local DoLS office for advice 0114 273 6870]

Complete supervision and control?	This would generally mean 24 hour care provision but it does not have to mean one to one [or in line of sight] staffing. Complete supervision and control could involve a number of actions such as not allowing the person out alone, controlling what they do during the day or when they eat and go to sleep, having control over the people they can and cannot see. A person can potentially be under complete supervision and control despite having unescorted leave if the care provider controls how long a person can go out and the person must return.
Not free to leave?	This does not mean whether the person is free to go out (with or without staff) for an outing of some sort but rather asking whether the person is free to discharge themselves and live somewhere else of their choosing (regardless of whether they actually have the mental capacity to make such a choice themselves)?

Section 3

Care Planning Structure & Organisation

Models, Templates and Worked Examples

Care Plan Structure

Why do we need a plan of care?

Legal requirement
Person specific care; to ensure the quality and consistency of care
An agreement between the home and the resident/advocate that:

- Indicates the present level of identified need
- Records the support required from staff to meet the level of identified need

A Care Plan should be:

- Written in legible, simple and clear terms that the resident or their advocate can easily understand
- Objective (Stating the facts, not an opinion)
- Dated and signed
- Reviewed regularly; updated when changes occur

A Care Plan consists of at least five pieces of documentation:

1. The initial assessment to gather basic information such as contact details of the person, their relatives and their doctor, any known allergies/conditions and medications taken.
2. A holistic assessment which seeks more in-depth information on the person's needs.
3. A risk assessment to identify need and prioritise risk.
4. A care plan.
5. A record sheet to document activities in relation to the care plan and as evidence for the evaluation stage.
6. A record of evaluation.

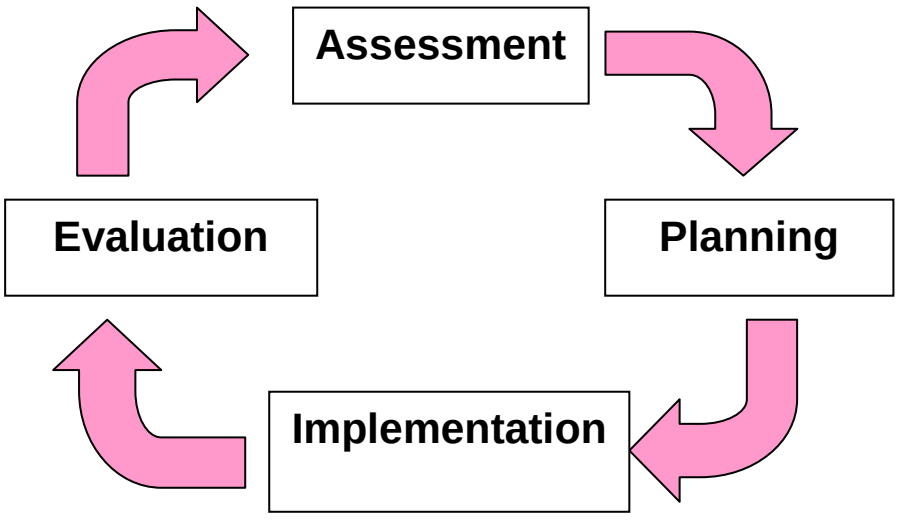
Empowerment Model of Care Planning

Assessment (Identifying the strength/need/problem)

Plan (What staff need to do to enable/assist the resident)

Implementation (What staff do to enable/assist, daily recordings information)

Evaluation (Review; reassess, change plan/interventions if not effective)



SUGGESTED DOMAINS FOR CARE PLANNING CORE INDEX

(based on Roper, Logan and Tierney's , Activities of Daily Living (ADL) checklist)

- Use of the Core Index directs staff to consider the key ADL's which are essential to human wellbeing.

- Using the Core Index as a guide when developing care plans for every resident should enable staff to put a care plan in place only where a need has been identified, while guarding against some domains of care being overlooked.

- Not every resident will need a care plan for each of these domains, as it is the needs of the individual which are the highest priority, but in most cases the majority will apply.

- The content of each care plan Domain should be directly relevant to that particular ADL, but it is acknowledged that there will be overlap e.g. Rest and Sleeping is likely to contain elements of elimination, personal cleansing & dressing etc, and should therefore be linked to other relevant plans (see worked example Page 58).

- Completed Risk Assessments and other associated paperwork need to be kept with the relevant care plan.

- The Optional Index offers other domains for consideration which may apply on occasion or in some cases be part of routine care needed for an individual.

Suggested Domains – Core Index for Care Homes in Sheffield

1. Maintaining a Safe Environment
2. Communication
3. Breathing
4. Drinking and Nutrition
   a) Drinking
   b) Nutrition
5. Elimination
   a) Bladder Care
   b) Bowel Care
6. Personal Care
   a) Personal Cleansing
   b) Personal Dressing
7. Skin
   a) Skin Care
   b) Protection of Skin Areas Vulnerable to Pressure or Other Damage
   c) Treatment and Management of a Pressure Sore
   d) Treatment and Management of a Wound
8. Moving & Handling/Repositioning/Mobilising
9. Activity & Occupation
10. Mental Well Being
    a) Specific Diagnosed Mental Health Issue
    b) Behaviour that Challenges
11. Expressing Sexuality
12. Rest & Sleeping
13. Medication
14. Death & Dying

See care plan template Pages 57-58, and care plan worked example Page 59

Suggested Optional Index for Care Homes in Sheffield

Short term conditions – which may include

- Acute infections e.g. chest infection, urine infection
- Instillation of eye drops
- Instillation of ear drops/olive oil etc
- Application of cream or lotions
- Treatments for MRSA decolonisation etc

Long term conditions – which may include

- Diabetes
- COPD
- Asthma
- Parkinson's Disease
- Heart Failure
- Stroke

See Long Term Condition Care Plan Template Page 58

Suggested Core Index with examples of key things for inclusion in each domain – this list is not exhaustive

1. Maintaining a Safe Environment
   - Include any Mental Capacity Assessments (MCA), Best Interests Assessments (BIA), Deprivation of Liberty Safeguard (DOLS) assessments
   - Effectively a 'list' of care plans required by the resident based on individual need

2. Communicating – needs to include:
   - Spoken – ability to effectively express self to others
   - Hearing – any difficulty/aids/visits to Hearing Clinic
   - Vision – any difficulty/aids/visits by Optician
   - Non – verbal e.g. type of communication aids, gestures
   - Ability to understand others

3. Breathing
   - No breathing problem? – **then you don't need a plan!**
   - Include any specific issues not covered in Long Term Conditions e.g. tracheostomy care, panic attack, tendency to Chest Infection (will need a Short Term Care Plan to manage)

4. Drinking and Nutrition

   There is likely to be considerable overlap in Section 4A and 4B – cross reference where necessary citing relevant care plan

   4a Drinking
   - Likes / dislikes / preferences recorded on dietary sheet which is kept in this section – *not in the body of the care plan*
   - Drink allergies
   - Swallowing difficulties – risk assessment, concerns, actions, referrals, advice received
   - Any modified fluids, if so what, keep SALT info sheets here
   - Type of drinking vessel preferred / needed etc
   - Levels of assistance required
   - Use of Fluid Intake Chart
   - Clothing protection

   4b Nutrition
   - Likes / dislikes / preferences recorded on dietary sheet which is kept in this section – *not in the body of the care plan*
   - MUST - weight records, concerns, actions, referrals , advice received
   - Food allergies
   - Swallowing difficulties – risk assessment, concerns, actions, referrals, advice received

- Any modified diet – if so what, keep SALT info sheets here
- Type of diet e.g. gluten free, vegetarian , fortified
- Adapted cutlery, plate guard, etc
- Levels of assistance required
- Clothing protection

5. Elimination

5a Bladder Care

- Assessment information, referrals, advice received
- State name of pad and number per day
- Level of assistance required
- Catheter – catheter hygiene information / detailed Catheter Diary
- Urostomy

5b Bowel Care

- Assessment information, referrals, advice received
- Need for laxative/enema
- Always need to include <u>usual Bristol Stool Type,</u> (this needs to be recorded after each episode on your daily monitoring charts)
- Stoma care – type of products, change/emptying information, self managing?
- PEC tube – how to manage
- State name of pad and number per day

6. Personal Cleansing and Dressing

6a Personal Cleansing – needs to include skin, hair, nails, mouth, teeth, denture/s, hearing aid, shaving etc

- Carer preference (gender)
- Levels of assistance required e.g. can wash and dry own hands and face when seated in front of sink/in shower/bath
- Preferences e.g. bath, shower, bed bath
- Make up, jewellery, etc
- Allergies to products/prescribed cleansing emollients
- Use of prescribed soap substitutes

6b Personal Dressing ***(including controlling body temperature)***

- Carer preference (gender)
- Levels of assistance e.g. can dress upper body but needs assistance with buttons
- Help to choose appropriate clothing according to weather/activity
- Consideration of environment/seasonal changes e.g. Heatwave & Winter planning

7. Skin Care

7a Skin Care – record the need for use of emollients, creams, lotions medicated or otherwise which are prescribed to treat skin conditions (use body map to show locations for application)

7b *Monitoring of Skin Areas Vulnerable to Pressure or other Damage* –this is a **must have** for all residents

- Waterlow – using issues identified used to construct care plan
- Body Map
- Pressure relieving equipment e.g. mattress, cushion, bootee
- Able to move self/repositioning frequency

7c *Treatment and Management of a Pressure Sore* – if needed

- Body Map
- Initial and ongoing wound assessment information
- Photographic evidence: consent obtained, appropriately photographed and identifiable (e.g. face not visible, patient identifiable information restricted to initials, DOB, NHS number), date obtained, location of pressure sore
- Type of dressing used
- Referrals to Tissue Viability or other specialist service
- Pressure relieving equipment e.g. mattress, cushion, bootee
- Able to move self/repositioning frequency

7d Treatment and Management of a Wound – if needed

- All the above

8. Moving and Handling (M&H) / Mobilising / Repositioning
   - M&H risk assessment paperwork
   - Falls Risk assessment paperwork
   - Walking/mobility aids – Zimmer frame, Stand Aid, hoist - **NB type and size of sling**
   - Transfer information
   - Type of seating
   - Bedfast
   - Repositioning information e.g. slippy sheet, 30◦ tilt

9. Activity and Occupation
   - Include Life Story Work, personal history and currently preferred activity & occupation
   - One Page Profile (see Page 84).
   - Where does the person usually spend their day
   - How do they spend time e.g. with others or prefer own company
   - Socialising

10. Mental Wellbeing – a **must have** for all residents **unless** there is a specific mental health issue and then this would be addressed elsewhere e.g.
    - How does the resident, care staff, family and professionals help to maintain mood, level of ability, independence, sense of purpose and control

    10a Specific/diagnosed mental health issue e.g. depression, Alzheimer Disease, vascular dementia

- How does this affect the person e.g. mood, activity levels, sleep pattern, delusions, hallucinations, cognitive decline – how to address
- How will they be supported e.g. memory clinic, rapid response mental health team, CPN, family visits, medication and monitoring, behaviour charts

10b Behaviour that Challenges

- What are the triggers which lead to the behaviour and how can we respond?
- Highlight how staff can use personal information about the resident to relieve anxieties, changes in mood and minimise challenging behaviours before they develop
- What do you do with information and who do we share it with once an incident has occurred

11. Expressing Sexuality – *if a resident expresses their sexuality, or expresses sexual behaviour in a way in which requires a care response they will need a care plan – e.g. explicit sexual acts, comments, gestures or issues about Mental Capacity (see Maintaining a safe Environment)*

12. Rest and Sleeping
    - Bedrails risk assessment paperwork
    - To include any specific issues related to sleeping which are **not already** covered in other ADL's
    - E.g. likes to lie on bed after lunch, preferred bed time, hygiene routine, sleeps in, wakes during, is restless at night, uses night sedation

13. Medications - *this should not be a list of the medications prescribed or taken – that exists on the MAR sheet*
    - To include any specific issues related to medications which are not covered by other ADL's
    - Allergies to medications
    - Specific medication issues e.g. timing of medications for Parkinson's Disease
    - Monitoring issues e.g. blood (warfarin)
    - Syrup/suspensions
    - How to take .e.g. from a teaspoon, self medicates – Risk assessment
    - PRN
    - Route e.g. via PEG
    - Covert administration (needs MCA assessment and links to Maintaining a Safe Environment)

14. Death and Dying –' *an individual plan of care which includes food & drink, symptom control, psychological, social and spiritual support is agreed co-ordinated and delivered with compassion'- One Chance to Get it Right*
    - DNACPR - keep the form at the front of the care folder, but must be referenced in this section
    - Any Preferred Priorities of Care (PPC) or Advanced Care Planning (ACP) information
    - GP plan of care

- Residents preferences e.g. remain at care home at end of life if possible where no PPC or ACP exists
- Religious / cultural / spiritual needs at End of Life

CARE PLANNING TEMPLATES AND WORKED EXAMPLES

The following Care Plan templates illustrate the suggested approach to:

- Identify need
- Identify the aim – what are you hoping to achieve by delivering this plan of care ?
- Set out the **actions** needed to achieve the aim of the care plan **NB –** this section should not become a list of needs/issues but what you (and the resident) will **do** to meet the aim

The Care Plan worked example 'Rest and Sleeping' provides the preferred style which should be adopted when developing a care plan and serves as an example of how to put the above 3 points into action. This style needs to be replicated across each domain.

The Long Term Conditions (LTC's) care plan provides the suggested approach to develop LTC's using the same principles as previously described above. This style needs to be replicated across each care plan for a LTC which may be needed for an individual.

Care Plan Template

Need / Problem	*Specific description as to what the issue is as identified in assessments (eg. admission, risk, nutrition, pressure area etc.)*
Aim	*What the resident wants to realistically achieve*
How the aim is achieved	• *What the resident can do; physically / communication (e.g. express choice)* • *What do the staff need to do to support the resident* • *Specific care that is effective for that resident (e.g. prefers to eat dessert first)* • *Aids, equipment & support needed* • *Methods of monitoring* • *Referral to other disciplines*

The care plan is devised using a SMART approach, for information see Page 84

S pecific,
M easurable,
A chievable,
R ealistic
T imely.

Long Term Condition Care Plan Template

Need / Problem	*Diagnosis of……long term condition (i.e. COPD)*
Aim	*What the resident wants to realistically achieve*
How the aim is achieved	• *What are the usual symptoms when well (breathlessness, cough, sputum. Cross reference to mobility and medication care plans* • *What the resident can do; physically/communication (express choice)* • *Signs and symptoms of becoming unwell (refer to self-management plan if in place - available from named health care professional i.e. GP or Specialist Nurse) is there anything different which staff recognises with the individual* • *Methods of monitoring* • *What do the staff need to do to support the resident* • *Referral to other disciplines -* *(is there a named specialist to contact)* • *What action to take in an emergency* *(see self-management plan)*

The care plan is devised using a SMART approach, for information see Page 84

S pecific,
M easurable,
A chievable,
R ealistic
T imely.

Care Plan Worked Example

	Care plan for **REST & SLEEPING**
Need / Problem	Albert experiences increased confusion at night time, presenting as anxious and disorientated. In the early part of the night he often gets up to search for his wife and he is getting around 3 – 4 hours continual sleep from 3 am onwards
Aim	For Albert to have a more restful night and increase his sleeping hours to a minimum of 6
Planned Care	Include exercise and access to sunlight in daytime activities (see Activity & Occupation) Enable Albert to watch early evening news programmes in the small lounge with Jack H and provide with the newspaper TV listings and TV remote Aim to spend 10 – 15 minutes talking with Albert about his day and plans for tomorrow. Enquire about any concerns he may have Provide supper (tea and digestive biscuits) around 9 pm (see Drinking, Nutrition). Enquire about need for pain relief and administer Paracetamol if required (see Medication) Ask Albert to assist with housekeeping tasks such as closing curtains, turning off TV, folding papers – in the lounge and his bedroom Take an unhurried approach to preparing for bedtime around 9.45 pm. Prompt to have a wash and clean dentures, providing help only as required. Assist to change into pyjama bottoms and vest – will need help to reach his feet and with button fastenings. Likes to wear his cap in bed (see Personal Care) Empty catheter leg bag and attach night drainage bag. Ensure Albert is wearing stated continence pad (see Elimination) Ensure Albert's bed has two pillows and a blanket on top of his duvet Leave ensuite light on and door ajar. Ensure photograph of Albert's late wife is on his bed side table. Keep his focus in the room by playing preferred CD at low volume Once in bed spend a few minutes talking with Albert before leaving, reminding him that you are around all night. Keep bedroom door closed and noise on the corridor to a minimum Check every xx hours, as agreed If Albert gets up gently remind him that it is night time. Check need for toilet, food/drink, pain relief or company and provide as required, returning to bed and helping to settle before leaving In conversation with Albert never argue or contradict. He is comforted by talking about his family, his sea fishing trips and looking at photographs

Section 4

Risk Assessment Examples

The Waterlow Pressure Sore Risk Assessment Tool

PRESSURE SORE RISK ASSESSMENT

A pressure sore is caused when the skin and soft tissues of the body become pressed between a bony structure (e.g. heel and sacrum) and the surface below, e.g. bed, chair etc. When this happens the blood supply to the area becomes reduced, and the skin and soft tissue can begin to die.

Pressure sores are more likely to develop in those who are seriously ill, have existing diseases, are less mobile and have reduced nutrition. This means care home residents will be in the At Risk group.

Pressure sores are also sometimes referred to as pressure ulcers, bedsores or decubitus ulcers but these are all names for the same thing.

Risk assessment

- A number of risk assessment tools are available to help you identify the individual risk factors a resident may have but they cannot predict who will/will not develop a pressure sore.
- The Waterlow tool is used by Sheffield Teaching Hospitals NHS Foundation Trust (STHNHSFT), and STHNHSFT Community Nursing Services, and is the preferred tool for Sheffield Care Homes to use.
- These tools are meant to be used in combination with all the other information you have about a resident e.g. discussion with resident and family members, discharge and medical information, as an aid to help you provide care for the individual.
- There may be some questions on the Waterlow about medical or other issues/conditions which you may need to discuss with the GP or other health care professional.
- The following information will help you understand how to use the tool and additional information is provided about the meaning of some of the terms used within it, Pages 66-67.

Completing the Waterlow and using the information gained

Identifying what the risks are to each resident is the first important step to protecting vulnerable areas of the body.

NB *the initial identification, subsequent plan of care and ongoing evaluation on the findings from the Waterlow should be undertaken for ALL residents and will become a requirement of Sheffield Clinical Commissioning Group in the near future.*

- The specific, individual risks should be charted on a scoring sheet, pages 68-69 within 6 hrs of admission to the home, and reviewed as the condition of the resident changes or at least weekly.
- Use the identified risks to help you develop a plan for prevention of damage occurring – 'Protection of Skin Areas Vulnerable to Pressure Damage' Page 52-53.

- Refer to specialist services when necessary following outcomes of risk assessment, see Flowchart Page70.
- For the nursing needs of residential clients the first point of contact is Community Nursing via Single Point of Access (SPA) Tel: 0114 3051460

Tissue Viability (TV)

- Tissue Viability Service work Mon-Fri general office hours (Tel: 0114 305 4248)
- TV accept referrals by fax (Fax: 0114 271 6417), however these may not always be picked up on the next working day. It is advisable to keep the fax transmission report and follow up faxes by a phone call to ensure they have been received – this is the responsibility of the referring home
- Any urgent referrals need to be marked as such
- TV also accept referrals by email and sending photographic images to the service assists the team with triage.
- However obtaining resident consent and following procedure for upholding resident confidentiality with regard to obtaining and emailing photographic images to TV is the responsibility of the care home - is your email secure?

***See also Minor Illnesses and Conditions Information Pack for Care Homes in Sheffield for more information about avoiding skin damage and identifying concerns*.**

Waterlow Risk Assessment Scoring Sheet – for example see Pages 68-69.
On admission to the home undertake the Waterlow risk assessment as soon as possible recording the findings on the scoring sheet and follow the next steps repeating the process at least weekly

1. Use the findings from completing the Waterlow to develop an individualised plan of care for the resident

2. Where scores in each section change, look at the associated Risk Assessments e. g. changes in mobility (Moving & Handling risk assessment), changes in appetite (MUST), and the relevant care plans e.g. Moving and Handling/Mobilising/Repositioning, Nutrition and Drinking to see if these still accurately reflect the residents abilities and needs.

NB - also check the daily recordings to help you identify improvements or deterioration in abilities and needs – this will help you to deliver accurate immediate care and anticipate what might be needed in future.

WATERLOW* PRESSURE SORE RISK ASSESSMENT TOOL (adapted CHST 2014)

RECORD SCORES ON WATERLOW SCORING SHEET AND ADD UP TOTALS TO FIND OVERALL SCORE. More than 1 score in some categories may apply e.g. Skin Type - Tissue Paper 1, Dry 1 =2

BUILD	♦	SKIN TYPE VISUAL RISK AREAS	♦	SEX & AGE	♦	WEIGHT	
AVERAGE BMI= 20-24.9 ABOVE AVERAGE BMI = 25-29.9 OBESE - BMI more than 30 BELOW AVERAGE - BMI less than 20 (see MUST for more info)	 0 1 2 3	HEALTHY TISSUE PAPER DRY ODEMATOUS CLAMMY, HIGH TEMP DISCOLOURED - e.g. Category/Grade 1** BROKEN - e.g. Category/Grade 2-4 **	0 1 1 1 1 2 3	MALE FEMALE 14-49 50-64 65-74 75-80 81+	1 2 1 2 3 4 5	A – HAS PATIENT LOST WEIGHT RECENTLY – (unplanned weight loss) YES – GO TO B NO – GO TO C UNSURE – GO TO C AND SCORE 2 C – PATIENT EATING POORLY OR LACK OF APPETITE 'NO' = 0 'YES' SCORE = 1	B – WEIGHT LOSS SCORE 0.5 – 5KG = 1 5 – 10KG = 2 10 – 15KG = 3 More than 15KG = 4 UNSURE = 2 NOW GO TO C **Complete MUST*** for **all residents regardless of combined scores from A,B & C**

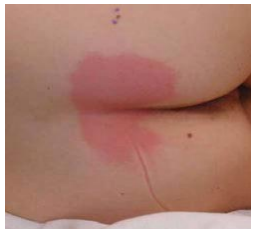
CONTINENCE	♦	MOBILITY	♦	SPECIAL RISKS – Refer to 'Using the **Waterlow' page 62-63 for** detail			
COMPLETE / CATHETERISED INCONTINENCE : URINE FAECES INCONTINENT OF BOTH URINE AND FAECES	0 1 2 3	FULLY RESTLESS/FIDGETY APATHETIC RESTRICTED BEDBOUND CHAIRBOUND e.g. WHEELCHAIR	0 1 2 3 4 5	TISSUE MALNUTRITION TERMINAL CACHEXIA MULTIPLE ORGAN FAILURE SINGLE ORGAN FAILURE PERIPHERAL VASCULAR DISEASE ANAEMIA haemoglobin less than 8 SMOKING – current or past	♦ 8 8 5 5 2 1	NEUROLOGICAL DEFICIT DIABETES, MS, CVA MOTOR SENSORY (e.g. Parkinson's, Motor Neurone , Huntingdon's Diseases PARAPLEGIA MAX OF 6)	♦ 4-6 4-6 4-6
				MEDICATION CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY DRUGS MAX SCORE OF 4	♦ 1 To 4	MAJOR SURGERY OR TRAUMA* **These do not apply once returned to the care home** ORTHOPAEDIC/SPINAL ON TABLE > 2 HR* ON TABLE > 6 HR * *scores can be discounted after 48 hours provided patient is recovering normally	 5 5 8

SCORE
10+ AT RISK
15+ HIGH RISK

For more information about:
*Waterlow / ** Category/Grade of Pressure Sores (see Page 65 for example & explanation
*** MUST see Page 84 for link to document.

PRESSURE SORE GRADING

The accurate Categorisation/Grading of pressure sores can be a complicated process. The International EPUAP/ NPUAP Pressure Ulcer Advisory Panel tool is the recommended reference tool for Categorising/Grading pressure sores. This information is provided below and is meant to be used for guidance only. If you do not understand the terms or you are unsure about any aspect of skin inspection you will need to seek help from e.g. Community Nursing (residential clients), or Tissue Viability (nursing clients). *All images sourced from NPUAP and TV community service Sheffield.*

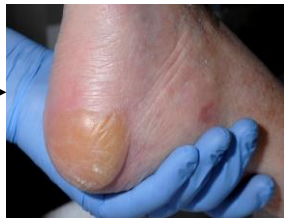


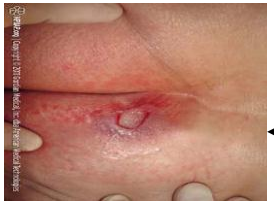
CATEGORY 1

Persistent redness of intact skin even when pressure is applied to the area = looks red and stays red
In darker skins look for a change in colour from surrounding skin, this area may be bluish or purple
Warmth, swelling, inflammation and hardness compared to surrounding skin may be noted
May be itching or painful

CATEGORY/GRADE 2

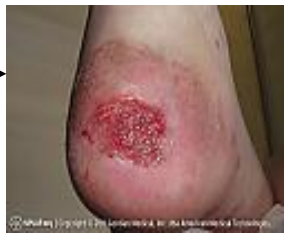
Superficially broken skin which may look like a graze
Skin which is blistered is also in this category

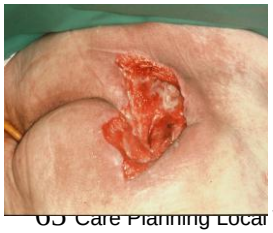




CATEGORY/GRADE 3

Described as full thickness skin loss , where fat may be visible (depending on site e.g. heel may appear as 'shallow')





CATEGORY/GRADE 4

Described as full thickness skin loss which may extend to muscle, tendon and bone.

NOTES TO SUPPORT COMPLETION OF THE WATERLOW RISK ASSESSMENT TOOL (CHST 2015)

Risk Factor	Scoring relevance/reason
BUILD	Relates to BMI (Body Mass Index). The BMI is described as an assessment of weight in relation to height – for more information e.g. how to calculate when no height is recorded, see MUST tool
CONTINENCE	Urine & faeces on the skin will increase the risk of damage. Wet skin has reduced strength and is 5 times more likely to develop pressure damage
SKIN TYPE	For TISSUE PAPER, DRY, OEDEMATOUS (swollen/puffy) & CLAMMY skin as many as applicable can be ticked. DISCOLOURED relates to a Category/Grade 1 pressure sore BROKEN relates to a Category/Grade 2, 3 or 4 pressure sore
MOBILITY	RESTLESS, FIDGETY – more prone to sheer & friction. APATHETIC – loss of interest or will to do things e.g. residents with depression – resident may need encouragement to change own position RESTRICTED – e.g. urinary catheterisation, long term oxygen therapy, plaster casts, splints BED-BOUND - unable to change position independently CHAIR-BOUND – patients who are unable to stand unaided from a seated position
SEX	Females score higher = differences in body structure to men, more difficult to keep clean and dry due to incontinence (J.Waterlow 2005)
AGE	Score as applicable
WEIGHT A, B, C	WEIGHT LOSS SCORES – calculate totals and then complete MUST tool, recording scores on MUST document
TISSUE MALNUTRITION	TERMINAL CACHEXIA – Unplanned weight loss, associated with terminal illness MULTIPLE ORGAN FAILURE – when a number of major organs stop working properly often after serious injury, major surgery or as a result of serious infection, e.g. kidney, liver , heart SINGLE ORGAN FAILURE e.g heart = results in fluids building up especially in lungs, sacrum and legs - mobility can be reduced due to this PERIPHERAL VASCULAR DISEASE – a disease affecting the blood vessels caused by reduced passage of blood - usually caused by fat in the vessels ANAEMIA – Haemoglobin 'blood iron count' below 8 SMOKER – includes ex-smokers

NEUROLOGICAL DEFICIT	Diseases and conditions resulting in changes to movement and sensation e.g. DIABETES, MULTIPLE SCLEROSIS (MS), STROKE (CVA) MOTOR SENSORY e.g. PARKINSON'S, MOTOR NEURONE, HUNTINGDON'S DISEASES, PARALYSIS Dependant on severity - scores between 4 - 6 up to a maximum score of 6 IN TOTAL
MAJOR SURGERY OR TRAUMA	Discounted if 48 hours post op and recovering 'as expected' so would not apply on return to care home
MEDICATION	Cytotoxics e.g. Methotrexate, Long Term/High Dose Steroids e.g. Prednisolone, Anti-inflammatory e.g. Azathioprine The above medications may affect skin quality making it more prone to damage from pressure / shear / friction. Where these drugs are used in combination or at higher doses the risk is increased e.g. use of long term steroids and anti-inflammatories could score between 1 - 4 The maximum score in this section for these drugs used in any combination / strength is 4

Residents Name:		**DoB:**			**NHS No:**				
NAME OF NURSE / PERSON ASSESSING		PRINT							
DATE (date, month and year)									
TIME (24hr clock)									
BUILD	Average = BMI 20 - 24.9	0							
	Above Average = BMI 25.29.9	1							
	Obese =BMI more than 30	2							
	Below average = BMI = less than 20	3							
CONTINENCE	Completely continent / Catheter in place	0							
	Urine incontinence	1							
	Faecal incontinence	2							
	Doubly incontinent	3							
SKIN TYPE – visual inspection	HEALTHY	0							
	TISSUE PAPER	1							
	DRY	1							
	OEDEMATOUS – (swollen)	1							
	CLAMMY/HIGH TEMPERATURE	1							
	DISCOLOURED e.g. Category/Grade 1	2							
	BROKEN SKIN e.g. Category/Grade 2,3 or 4	3							
MOBILITY	Fully	0							
	Restless/Fidgety	1							
	Apathetic	2							
	Restricted	3							
	Bedbound	4							
	Chairbound	5							
SEX	MALE	1							
	FEMALE	2							
AGE	14-49	1							
	50-64	2							
	65-74	3							
	75-80	4							
	81+	5							
Carry fwd									

Brought fwd									
WEIGHT A Has patient lost weight recently (which is unplanned) ?	Yes (go to B)	0							
	No (go to C)	0							
	Unsure ? And go to C	2							
WEIGHT B How much weight has been lost?	0.5 - 5kg	1							
	5 - 10kg	2							
	10 - 15kg	3							
	More than 15kg	4							
	Unsure	2							
WEIGHT C Patient eating poorly or loss of appetite	No	0							
	Yes	1							
TISSUE MALNUTRITION	Terminal Cachexia	8							
	Multiple organ failure	8							
	Single organ failure	5							
	Peripheral Vascular Disease	5							
	Anaemia – haemoglobin less than 8	2							
	Smoking past or current	1							
Neurological Deficit	Diabetes, MS, CVA – score between 4-6	4-6							
	Motor/Sensory – score between 4-6	4-6							
	Paraplegia – score between 4-6	4-6							
Major surgery or trauma ***– not applicable on return to care homes***	Orthopaedic/Spinal	5							
	On table > 2hr	5							
	On table > 6hr	8							
	*do not apply 48hrs post surgery								
Medication – Cytotoxics, Long Term/High Dose Steroids, Anti-inflammatory	A maximum of 4 applies in this section	Score 1 to 4 max							
Waterlow pressure sore risk TOTAL									

10+ AT RISK **15+ HIGH RISK**

GOOD PRACTICE INFORMATION FOR THE PREVENTION & MANAGEMENT OF PRESSURE SORES FOR CARE HOME STAFF IN SHEFFIELD

Undertake pre-admission assessment obtaining the following information :
Current Waterlow score
Current MUST score
Current condition of skin particularly over areas associated with pressure e.g. heels, sacrum
Type of equipment currently in use e.g. mattress, cushion, in order to ensure appropriate equipment is available prior to admission

On admission **as a priority i.e. within 6 hours**
Look at the residents skin as soon as appropriate checking for signs of damage/ healing completing a Body Map – then repeat formal check & recording process at least weekly thereafter

Complete Waterlow Risk Score for all residents on admission to home and then **at least weekly** thereafter

Existing Pressure sore/s or history of pressure sore/s ?

No - remains At Risk

Yes - is at High Risk

Use the findings from the Waterlow to help you develop a care plan for *'Protection of Skin Areas Vulnerable to Pressure or other Damage'* see Page 52-53. Complete other relevant Risk Assessments & Core Care Plans associated with the risk of developing pressure ulcers e.g. Nutrition & Drinking (use MUST tool), Personal Care – Washing, Bladder and Bowel Care, Mobility/Repositioning, see Page 53. Evaluate monthly or sooner if necessary

Refer to appropriate services for help with managing identified risks e.g. Continence Service, Tissue Viability Service (TV), Sheffield Equipment Loan Store (SCELS) Nurse Advisor for advice about equipment. For nursing advice about residential clients refer to Community Nursing Service via SPA

If there is an existing pressure sore, undertake full assessment and Categorise/Grade using EPUAP tool, Page 65. Enter findings onto *Initial Wound Assessment* form. Complete detailed/ on-going Wound Assessment **at least weekly** or sooner if required. Commence Care Plan for '*Treatment and Management of a Pressure Sore*', See page 53. Evaluate & update as necessary according to above findings.

Category/Grade 1&2
Pressure sore (Superficial) – Residential Client – refer to Community Nursing Team via Single Point of Access (SPA) on 0114 3051460. Nursing client seek advice if unsure of how to manage

Category/Grade 3 & 4 Pressure Sore (Deep) – refer to Safeguarding Team as soon as seen: Tel 0114 2734908
For **Residential Clients** - contact Community Nursing Team **urgently** via SPA – Tel: 0114 3051460
Nursing Client - seek advice/support if required from the TV service by fax or email (Page 63) Any urgent referral needs to be marked as such . Email to:brendaking@nhs.net **or** Kim.drewery@nhs.net

Remember!
Damage to skin can occur for a number of reasons including pressure, moisture, shear/friction – if unsure of cause or how to manage contact Community Nursing Team for residential clients, Tissue Viability or SCELS Nurse Advisor. See also 'Minor Illnesses and Conditions Information Pack' for Care Homes in Sheffield

Section 4

Risk Assessment Example Falls

Multifactorial Falls Risk Assessment. LEVEL 2 Sheffield Integrated Falls Pathway.			
Name of Professional: Signature…… Date…… Designation: Contact no. Base / Service:	**Client Name:** DOB: Address: Cons: Ward: Hospital no. NHS no.		
Information collected from: **Patient / Carer** Consider mental capacity / best interests when explanation of assessment given & consent obtained. Signature……..…… Date…….	GP: Address: Tel:		
History of Falls: How many falls in last 6 months?	Unexplained – further assessment required Explained – and further assessment required		
Activity at time? When? Where? Pattern? **Date:**			
Any signs of infection? Eg ear, chest, UTI	Y / N	Ref to Doctor	
Any black outs or loss of consciousness before falling?	Y / N	Ref to Doctor / Specialist services	
Any dizziness before falling?	Y / N	Taking BP: Lie patient flat for 5 mins and record. Then repeat at 1 & 3 mins in standing.	
Any dizziness on standing or turning?	Y / N	**Lying** BP **=** **Standing** 1 min = 3 min = Symptomatic on standing? Y / N Ref to Dr (name) ……	
Taking four or more medications – and no recent review? Taking drugs associated with increased falls risk? Started on any new drugs / dose?	Y / N Y / N Y / N	Ref to Doctor / Pharmacist for review name…… eg sleeping tabs, antidepressants, antihypertensives, antipsychotics, antiparkinson's, diuretics – when?.....	
Bone Health: Known to have Osteoporosis?	Y / N		
Any bone fracture since the age of 40?	Y / N	Ref to Doctor for further assessment / investigation / Calcium and Vit D therapy.	
Taking oral steroids or have done previously?	Y / N		
Concern of Falling:		**FES – I (short)** Score =	
Client 'concerned' about falling or has poor confidence with mobility?	Y / N	Ref to : - Therapy services……..……... Citywide Care Alarms + / or Telecare	
Cognitive Impairment / Mental Capacity:		**MMSE =**	
Any memory problems? Any Anxiety / Depression? Known to Mental Health (MH) Services	Y / N Y / N Y / N	**HADS: A** = **D** = Ref to MH Services / Doctor…….	
Vision:		Check glasses are clean. Recommend annual vision check. Brincliffe House have list of domiciliary opticians (Tel: 2263114)	
Wears glasses? Any change in vision? Has related pathology?	Y / N Y / N Y / N		
Hearing:		Check hearing aid works. Check for ear wax. Ref to Audiology / Hearing Services	
Wears hearing aid /s?	Y / N		

Continence		If Urinary / Faecal continence assessment	**Date:**
Is there a problem? Day / Night	Y / N	needed:-	
Has appropriate aids?	Y / N	Ref to nurse or specialist service.	
Access to commode / toilet / night light?	Y / N	Referral for commode.	
Hydration			
Any signs of dehydration?	Y / N	Recommend 8 (250mls) glasses of water	
Any dizziness?	Y / N	per day.	
Any UTI?	Y / N	Referral to Doctor ……..	
Nutrition		Give healthy eating advice.	
		Ref to Dietetic Services	
Any reduced appetite / intake?	Y / N	S&LT – for swallowing	
Any difficulties eating? eg dentures	Y / N	Dental Services	
Any special dietary needs?	Y / N	Equipment to facilitate eating	
Alcohol		Provide sensible drinking advice.	
		Consider ref to local specialist support	
Is intake above recommended units?	Y / N	service.	
Feet / footwear		If yes for either / both:	
		Ref to Podiatry / Orthotic services for	
Foot problem inhibiting gait / balance	Y / N	treatment	
Unstable, loose, or poorly fitting shoes worn?	Y / N	Advice given re suitable footwear	
Pain		Check analgesics taken correctly.	
Is pain affecting mobility?	Y / N	Ref to Doctor for analgesia review.	
Where is the pain?……..			
Functional ability		Consider referrals to service for:	
Problem with PADL?	Y / N	- Therapy	
Problem with DADL?	Y / N	- Social Services	
Need for Home Assessment identified?	Y / N	- Equipment / Adaption	
Problem with mobility?	Y / N	**Elderly Mob Scale =**	
Home Hazards		Ref for Equipment:	
Home environment checked?	Y / N	Aids & adaptions:	
Any problems with stairs?	Y / N	Ref to Stay Put:	
Any other identified issues?	Y / N	Other ……	
Gait and Balance		**TURN180:** Steps= Touches =	
		Otago level =	
Is there a problem with balance?	Y / N	**Timed Up and Go =** secs	
Is there a problem with muscle strength / joint ROM?	Y / N	Ref to Physiotherapy for assessment,	
Is there a problem with gait?	Y / N	Otago Exercises or Assessment for	
Is mobility aid appropriate & used safely?	Y / N	mobility aid	
Strategies following a Fall		Teach Backward Chaining Method	
Able to move about & get up from the floor independently?	Y / N	or refer to Physiotherapy:	
Able to summon help?	Y / N	Consider referral to CWCA/Telecare:	
Know how to keep warm / relieve pressure if have a long lie?	Y / N	Advice & strategies discussed:	
Following this Level 2 assessment does the cause of falls remain unclear? (Ref to Level 3 Specialist Services by GP/Cons)	Y / N	Consider: referral to Community Geriatrician / liaison with GP or ward medical staff	
Additional Information:			
Multifactorial Assessment completed on Date: …… Signature: ……			
If referring on to other services on the pathway send a copy of this Level 2 Multifactorial Assessment & any other relevant documents / assessments / outcome measures. Ensure any referrals made are documented.			

LES Care Home GPs Are you using the… Falls Prevention Team?

- **40% of those 75+ are at falls risk and these are often preventable**
- **Over 2,200 75+ were emergency admitted for a fall in Sheffield last year, up 20%**
- **All falls in care homes should be classed as a "serious untoward incident" and a significant event review completed**
- **This is why we have worked with local GPs to invest £600k in falls prevention. Primary care is making good use of the new Team with over 2,000 referred last year**
- **Early data suggests that for those treated by the Team, falls emergency admissions are down by 38% and A&E attendances by 31%†**
- **The Team can help reduce falls risk even for the frail elderly in long stay settings**
- **The Team offers specialist physiotherapy interventions in line with NICE ††**
  - Assist care home staff to assess environmental hazards, e.g. thresholds, bad lighting, position of commode
  - Advise on assistive technology, such as alarms that let you know the client is out of bed
  - Assessment of activities of daily living and mobility
  - Advising on how to maintain activity, e.g. independence in dressing, standing to brush teeth, walking to the toilet – one-step simple goals
  - Promoting a culture of well being and physical activity
  - Reviewing bone health medication, liaising with yourself regarding vitamin D and calcium supplements
  - Provide an MDT assessment of fallers for those with complex histories
  - Advise on the use of hip protectors to minimise the impact of a fall-
  - Signposting for:
    - Further bone health assessment for osteoporosis
    - Medication review by the GP
    - Other services such as podiatry, opticians and continence care

To make best use of time, we suggest speaking with Christine Marciniak, Team Leader, to organise multiple assessments and join your planned weekly visit, christine.marciniak@nhs.net 07870 676684.

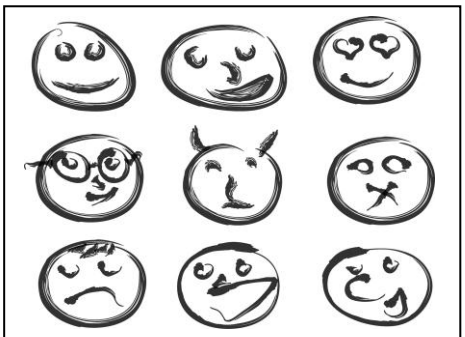
† Based on first 560 treated after being discharged from service for at least 6 months. Of the 560 sample patients, 454 had hospital activity in the 12 months prior/ 6 months after discharge from the Team. Prior to pilot, 34% of patients identified at risk were admitted to hospital for a fall. After the pilot, this had reduced by 35% to 22%.

†† http://www.nice.org.uk/nicemedia/pdf/CG021quickrefguide.pdf

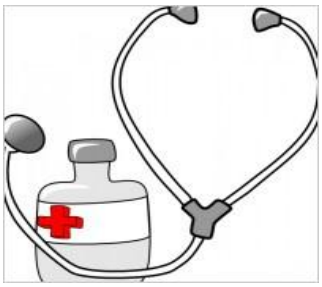
Section 5

Daily Records

Daily Records: What to include



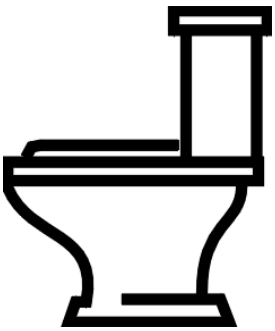
Mood;
'Quote from the resident'



Health & Medication

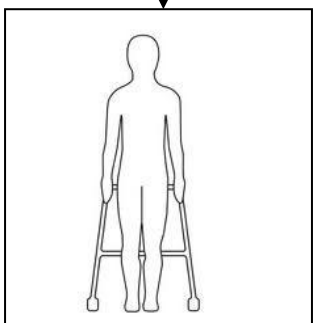
Occupation & Activity

Daily Records

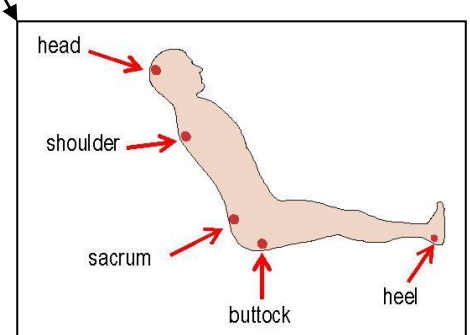


Continence

Personal Care



Mobility



Pressure Area Care

Eating & Drinking

Fact not opinion:
What has happened?
Why has it happened?
What happens now?

Section 6

References

References

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Deprivation of Liberty Safeguards (2009) www.gov.uk/government/publications/mental-capacity-act-deprivation-of-liberty-safeguards - Elements of Nursing : Roper, Logan & Tierney (1990)

Essence of Care; Benchmarking: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216691/dh_119978.pdf

European Pressure Ulcer Advisory Panel (EPUAP) www.epuap.org

Guidance about compliance; Essential standards of quality and safety: Care Quality Commission (March 2010)- www.cqc.org.uk

Human Rights Act (1998) www.legislation.gov.uk/ukpga/1998/42/contents

Introduction to the care planning process: McGraw, Hill (2010)

Mental Capacity Act (2005): - www.legislation.gov.uk/ukpga/2005/9/contents

Mental Health Act (2007) -Link

Malnutrition Universal Scoring Tool (MUST) www.bapen.org.uk/pdfs/must/must_full.pdf)

National Pressure Ulcer Advisory Panel (NPUAP) www.npuap.org
National Institute of Clinical Excellence (NICE): - www.nice.org.uk

One Change to Get it Right (Department of Health) - Link

One Page Profiles - www.onepageprofiles.wordpress.com, www.careuk.com (contact Fran Winney)

RCN Delegating record keeping and countersigning records (2012) - www.rcn.org.uk

Record Keeping; Guidance for nurses and midwives: NMC (2009) - www.nmc-uk.org

SMART tool: Ambler (2006)

Section 7

Contributors

The following specialists have contributed to the content of this agreement and toolkit.

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