Study Day: Manager & Compliance Study Session: Care & Support Planning in Homecare & Community settings

Starting 14.00

Please tell us where you are from

Join at slido.com
#3645 065

Welcome

Study Day: Manager & Compliance Study Session: Care & Support Planning in Homecare and Community Settings

Date: 9th of July 2024

This Session will begin shortly

Hertfordshire

Centre of Excellence
Valid until 11/2025
skillsforcare

Housekeeping

Please keep your mobiles on silent during the presentations

Exits

No planned fire drills

Comfort Break

Michelle Airey

Head of Education, Quality and Integration

Importance of accurate and outcomes focused care planning and recording

Deliver to current Best practice including MCA and Advance Care Planning

Meeting CQC and PAMMS Requirements

Clear Roles and Responsibilities

Ensure quality and compliant use of digital systems and information

Agenda

- 10:00 – Welcome and housekeeping
- Pre-Care Plan Creation
- Care Planning Resource
- Post Care Planning- Reviews and Audits
- Riddouts- Good Planning for CQC
- Break
- Regulation and Monitoring- What is expected?
- Capacity and Consent
- Advance Care Planning
- Key takeaways
- Event closes

Why do we record?

provide basic and essential information;	provide the person's relevant history and our involvement in their life;	explain decisions that are made and the person's views about these;	help communication between all those involved with the person;
promote consistency	reflect on our practice and its success;	help collect information;	promote analysis and decision making;
provide evidence for court, inspections, investigations and enquiries;	check the quality of our work	Centralised information	Promote person centred outcomes

DSPT covers Data Security & Protection across your entire organisation.

So, why complete your DSPT?

- Shows compliance with GDPR
- Helps to avoid fines
- Links to Templates, Guidance documents & eLearning within questions
- With eLearning, staff will know how to recognise a breach & how best to avoid
- Minimises risk of hacking opportunities & data breaches
- Ensures policies are fit for purpose
- Demonstrates you operate to high industry standards
  - Reassures service users, their loved ones & staff that data is managed secure
  - Helps with tenders
  - Increased business opportunities
  - Required when applying for NHSmail or Shared Services
- Ensures your Business Continuity Plan includes how to access to necessary data

CQC will expect a compliant DSPT

Digital Social Care Records

82% of Hertfordshire Providers are using a digital system

CQC Recognised Benefits of Digital Social Care Records

- provide ‘real time’ information recording
- help providers and staff to be more aware when people’s needs change
- help information to be shared quickly,
- help to minimise risks such as medication errors
- help to manage and support staff to do their job effectively and efficiently
- be easier to store, requiring less physical space

hcpa

Digital Transformation
Hertfordshire Care Providers Association

Digital Skills

Gain confidence with technology and explore our suite of free-to-access ‘bitesize’ digital skills eLearning modules.

To support adult social care staff to develop their knowledge and confidence in using digital technology, Skills for Care was commissioned by the NHS Transformation Directorate to develop a suite of free-to-access ‘bitesize’ digital skills eLearning modules, in line with the Digital Skills Framework.

The seven modules:

1.using technology to support person-centred care
2.technical skills in using technology
3.communicating through technology
4.using and managing data
5.being safe and secure online
6.ethical use of technology
7.digital learning, development and wellbeing.

Click here

Pre-Care and Support Plan Creation

Jessica Bentley

Why do an Initial assessment?

- Assessments can help to understand why you are being asked to provide care, and how the person would like to be supported.

- Assessments are a practical and social activity that help you to gather information about the person who is drawing on care and support

- You can use this information to personalise the service to meet the needs of the person, and align with their goals and aspirations.

- It is important to establish whether the person being assessed has an impairment of the mind or brain, and whether this is likely to impact on their ability to make decisions. This will determine whether they need anyone with them during the assessment.

What to include in your initial assessment?

Essentially, your initial assessment should be a skeleton draft of your main care plan.

You need to capture as much information as possible to be able to use that information to create the care plan.

However, you will not be able to glean ALL details on your initial visit, hence we say it's a skeleton plan.

How to conduct a Care and Support planning discussion:

- Do I communicate effectively?
- Do I listen?
- Do I support individuals to make informed choices?
- Do I support individuals to access appropriate information?
- Do I support individuals to maintain skills in self care?
- Do I discuss risk?
- Do I put aside my own health beliefs?
- Do I see the individual as a whole – not just their medical condition?
- Am I supporting this individual to take control?
- Do I ask individuals what they feel they need to better self manage?
- Do I ensure that those with complex needs are receiving coordinated care?
- Do I strive to promote safe information sharing?

Capability and dependency of packages

- It is important that you are realistic when it comes to taking on new packages
- You need to have a robust assessment in place, especially for more complex packages
- In order to assess a package, your assessors need to be skilled to carry out the assessment, and then be confident that your staff have the knowledge and skills to manage the package
- This includes having the right support from other professionals in place, access to the right equipment, and the workforce capacity

Collating Information from Current Assessments

Community Admissions

1) HCC Connected Lives Assessment
2) The Care Provider will do their own assessment with the Individual and Family
3) Handover documents from previous care setting

Hospital discharges

1) The hospital directly – Ward Handover, DIF
2) Social Care handover – Via D2A information or connected lives assessment
3) The care provider, who will do their own assessment with individual and family if possible

Information to be found in handovers or assessments

- Gold Standard Frameworks coding
- Advance Care Plan, Respect Form (Previously DNACPR)
- Pain Levels
- Delirium
- Treatment for current admission
- Medical history
- Medication Administration
- Skin Breakdown
- Speech and Language Therapy
- Dietician input
- Infection control risk
- Urinary & bowel management
- Psychological support /management
- Falls risk and equipment
- Mental Capacity (LPA)
- Next of kin
- Safeguarding raised
- District Nurse/ Community Support required
- Support required to complete assessment (Communication/Sensory)
- Who is important to me
- Important things I want you to know about me
- How can you reassure me
- What support can be offered to optimise independence
- Meal time requirements
- Personal Care support
- Desired Outcomes

Feedback- Hertfordshire County Council Connected Lives Assessment

1. What are your views on the quality/ information held in the Connected Lives Assessments? (language used, content, history)
2. What information is most important to you in making your initial decision to progress?
3. What information is not included which would assist further?

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Goals and Outcomes

- Under regulation 9 of the Providers will need to encourage the person to think about the things they wish to improve, maintain, and/or prevent, for each section of the care plan.

- To meet an enabling care approach, care providers should encourage setting SMART goals with the person.

- If the person does not have any desired goals for a section, this needs to be recorded.


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SPECIFIC
MEASURABLE
ACHIEVABLE
RELEVANT
TIME-BOUND

Care Planning- Resource

Joanna Vlismas- Care Education Team Manager

Care and Support Plans are…

- A Legal Document
- An Outline of Aims, Actions & Responsibilities
- A Tool for Safety
- A Partnership Process
- An Ongoing Activity

Care and Support Plans are not…

- A Bureaucratic Exercise
- A Wishlist
- Guesswork

Care & Support Planning Zone

- Introduction & Background
- Pre-Care Plan Creation
- Care & Support Plan
- Post Care Planning
- Service Specific Information
- Template & Tools
- Other Guidance and Best Practice

Introduction & Background

- Introduction
- Terminology
- General Care Planning Best Practice Guidance
- Guiding for Creating a Care and Support Plan

Pre-Care Plan Creation

- Initial assessment – Getting to know me/the person
- Mental Capacity

Care & Support Plan

- One-Page Profile
- Health & Wellbeing – Care & Support Plan
- Communication – Care & Support Plan
- Personal Care – Care & Support Plan
- Mobility – Care & Support Plan
- Moving & Assisting – Care & Support Plan
- Medication – Care & Support Plan
- Nutrition & Hydration – Care & Support Plan
- Financial -Care & Support Plan
- Community Access & Engagement – Care & Support Plan
- Domestic – Care & Support Plan
- Shopping – Care & Support Plan
- Companionship – Care & Support Plan
- Nighttime – Care and Support Plan
- Risk Assessments needed to meet Individuals Care & Support Needs
- My Personal Preferences
- Consent

Post Care Planning

- Care plan reviews
- Care plan and risk assessment audits

Service Specific Information

- Older person services
- Learning disabilities
- Mental health services

Template & Tools

- Appendix 1: Good Care and Support Plan example
- Appendix 2: Insert Glossary
- Appendix 3: How to understand local authority 'Needs Assessment' eligibility decision-making
- Appendix 4: Factsheet care/service manager care and support plans responsibilities

Other Guidance and Best Practice

- Digital Social Care

Care & Support Plan Sections

- One-Page Profile
- Health & Wellbeing – Care & Support Plan
- Communication
- Personal Care
- Mobility
- Moving & Assisting
- Medication
- Nutrition & Hydration
- Financial
- Community Access & Engagement
- Domestic
- Shopping
- Companionship
- Nighttime
- Consent
- Other

Risk Assessments

Here is a list of example risk assessments that you should have in place:

- Mobility risk assessment
- Health and Safety risk assessment
- Environment risk assessment – (including Bedroom risk assessment)
- Fire evacuation risk assessment (including PEEPs)
- Falls Risk Assessment (Multi-Factorial Risk Assessment -MFRA)
- Skin integrity risk assessment - (Waterlow)
- Moving and Assisting risk assessment
- Medication risk assessment
- Special condition risk assessment (Parkinson, dementia, diabetes)
- Medication risk assessment
- COSHH risk assessment
- Community access risk assessment
- Nutrition and hydration risk assessment – (Choking / Swallow)
- Malnutrition - (MUST)

Writing Care Plans

Why are we doing this?

What do we want to achieve?

How are we going to do it?

Who will do it?

Where will it be done?

When will it be done by?

How to Complete a Moving and Assisting Care and Support Plan

Level of support required:

- Does not need any support
- Needs some support
- Needs full support
- Needs verbal prompt
- Needs equipment

How to complete a Moving and Assisting care and support plan

Tasks requiring support:

- Standing up
- Sitting down
- Lying down
- Repositioning
- Moving on uneven surfaces
- Use of stairs
- Moving around inside my home
- Moving around outside (community, garden)
- Other

How to complete a Moving and Assisting care and support plan

Mobility equipment required

Does the individual need any equipment in place? **Yes / No**
Does the individual need any referral for an equipment/ extra equipment? **Yes / No**

- Hoist
- Standing hoist
- Rota stand
- Slide sheet
- Walking frame
- Wheelchair
- Sliding board
- Shower chair
- Other

How to complete a Moving and Assisting care and support plan

My Moving and Assisting Care and Support Plan

Please use the information above to create a detailed plan that details how the individual is to be supported and assisted with their moving and assisting.
If cared for in bed, please specify the times of day that support is required, such as am/ lunch/teatime/ pm. Please add if there have been any referrals made due to falls or mobility issues. It is also good practice to take photos of the specific equipment used and a to create a log of checks and audits e.g. slings are not frayed or broken.

How to complete a Moving and Assisting care and support plan

My Desired Outcomes for Moving and Assisting

In this section, please highlight the individuals desired goals in relation to Moving and Assisting e.g., ‘I would like to be able to walk to my bathroom'. Please detail how this goal will be met, what/who needs to be involved and timeframe.

Please add any professionals (GP, physio therapist, OT) that need to involved.

Delivery of the care plan & matching support

- Understand individual's needs and preferences
- Assess staff skills and qualifications
- Match based on compatibility
- Continue training and development
- Monitor and adjust as needed

Digital

There are now many options available when it comes to digital care planning systems.
It is important that you do your own research and choose a provider that has what you need.

Things to consider are:

- What is included in the basic package?
- Can you add your own sections?
- Can the system run audits and reports?

Policy & Process

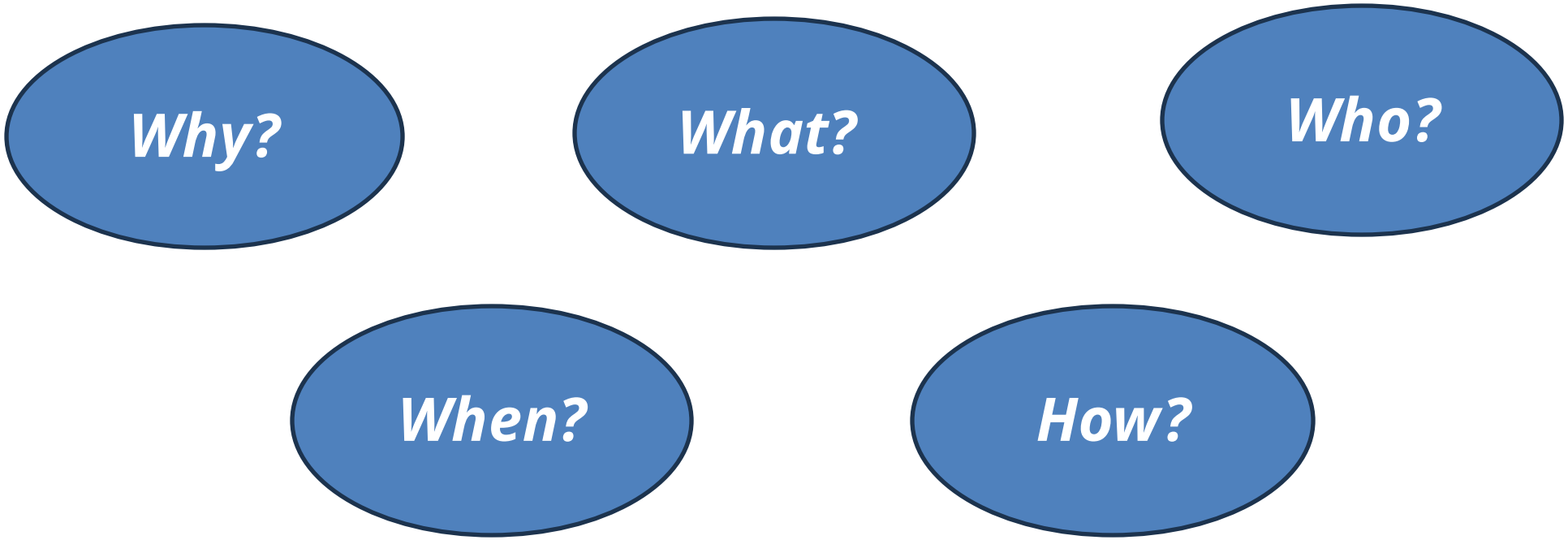
You will need to ensure that your organisation has a policy in place around effective care and support planning, and also a procedure that stipulates the timescales for creating and reviewing the plan.

Post Care Planning
Reviews and Audits

René Rogers & Noemi Varga

Post Care Planning Considerations

There are a number of things that need to be considered as part of the post care planning process reviews



Why must care & supports plans be reviewed?

- The Purpose of a post care plan review is to look at how well the care provision is going based on the original care and support plan to see if it's working or does anything need to change based on then needs.

- **Triggers:** The person is due for a full care plan review; or a focused care plan review is required in response to arising changes that need to be included in the care and support plan for the individual, or it may be just a monthly key worker session - a light touch check-in to see how the care is going.

- It is important to understand that a post care plan review is not a reassessment of an individual needs and support

- Under the Care Act the purpose of the care plan review should be to identify what is working and not working well; what may need to change about the care and support of the individual; ensuring that the care plan remains up to date, relevant to the person and the mitigation of the risk is based on safeguarding the individual

What should the care & support plan review focus on?

- **Establishing a regular ongoing review process:** Timely and as and when required reviews to identify changing needs. Reviews shouldn't be a blanket one-off processes.

- **Reflection on effectiveness and compliance of the end-to-end care planning:** Review what's working, what's not working.

- **Identifying any changing needs:** Has the person's needs, support, circumstances, environments, community support etc changed and how is it affecting the person? Has their risk level changed. Are new risk assessments required. Update care plan to include clear plans to meet changing needs.

- **Reviewing progress with outcomes:** What progress has been made, are there any new outcomes to be added and what needs to be in place to achieve the outcomes?

Who carries out the review?

- The person who is appointed to carry out the review should be competent to carry out the task.
- They should possess the knowledge, skills and competency based on the individuals needs and circumstances (e.g. being skilled to adapt their communication appropriately for someone with a learning disability). E.g. A Registered Manager

Who else needs to be involved?

- The person who the care plan has been created for and anyone else that the person has asked you to involve i.e. relatives/ friends that form their support network.
- Any professionals involved in the persons care provision i.e. District Nurses, Dietitian, Social worker, SALT team etc.
- The key worker of the person drawing upon the service
- An LPA representative if the person lacks capacity and or an Independent Advocate if they chose to involve one.

When to do a care and support plan review?

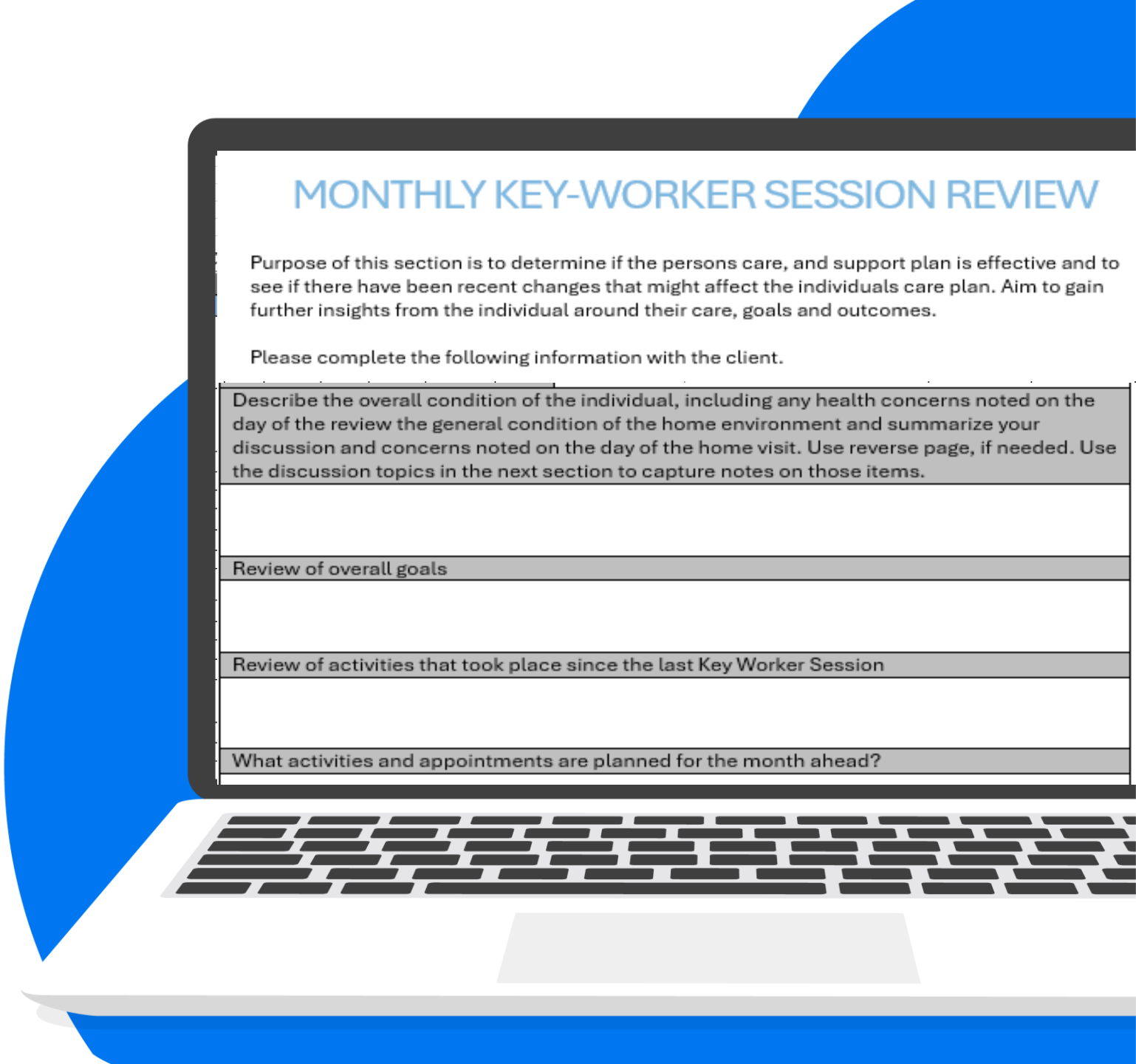
- Care plan reviews should be carried out in a timely manner, the next review date should be included in your care and support plan and should align with your policies and procedures.
- **The first care plan review:** Between 6-8 weeks after the care packages have started.
- **Frequency after the initial review:** Guidance states annually however, we recommend a model of 6 monthly and as and when required (i.e. when there is a change) as a bare minimum.
- **Good practice model:** have monthly key worker sessions (lite-touch) that feed into quarterly (in-depth) care plan reviews. To compliment this consider having monthly QA monitoring phone calls / checks
- **Hospital Discharges:** Should prompt a care plan review to ensure any changes to the care and support and medication are captured and updated.

How - to carry out a post care plan review

- Be clear on how long the meeting will be held for, the purpose of it, and ensure all participants are aware of this and have agreed to it
- Ensure that the environment is sufficient for the meeting and the sharing of confidential information
- Ensure that you have a robust care and support plan review template that reflects the Individual care and support that is in place to guide the review meeting
- Facilitate and maximise the person's involvement and Support the information-gathering process;
- Be flexible and adaptable;
- Be appropriate and proportionate to the needs being met by the Care and Support Plan.
- Ensure that all attendees are noted and sign the care and support plan review documents

Covering

- Overall condition of individual
- Review of overall goals
- Review of activities
- Review of appointments
- Health and medical Review
- Wellbeing: has support system changed
- Concerns/ compliments & general feedback



New care & support plan acknowledgements...

- Have a system to ensure any changes to the plan have been acknowledged and understood by the staff supporting the individual.

Auditing a care and support plan

Have a robust auditing system to support quality assurance monitoring. When the care and support plan needs to be audited the following needs to be considered:

- **Who should audit the care and support plan? I**t needs to be a competent person who has good knowledge and understanding of how to audit care plans, what to look for, what to record and how to triangulate the findings into further actions and into practice. It needs to factor in a person-centred approach

- **The timeframe for auditing:** It is good practice to audit the care plans monthly and to base it around the complexity of the care

- **Auditing template:** The care and support plan audit template should mirror all the sections of the care and support plan and ask questions such as is this working, if not what needs to change and what can be put in place to support the changing needs.

You may also want to include the following prompts on your auditing template:

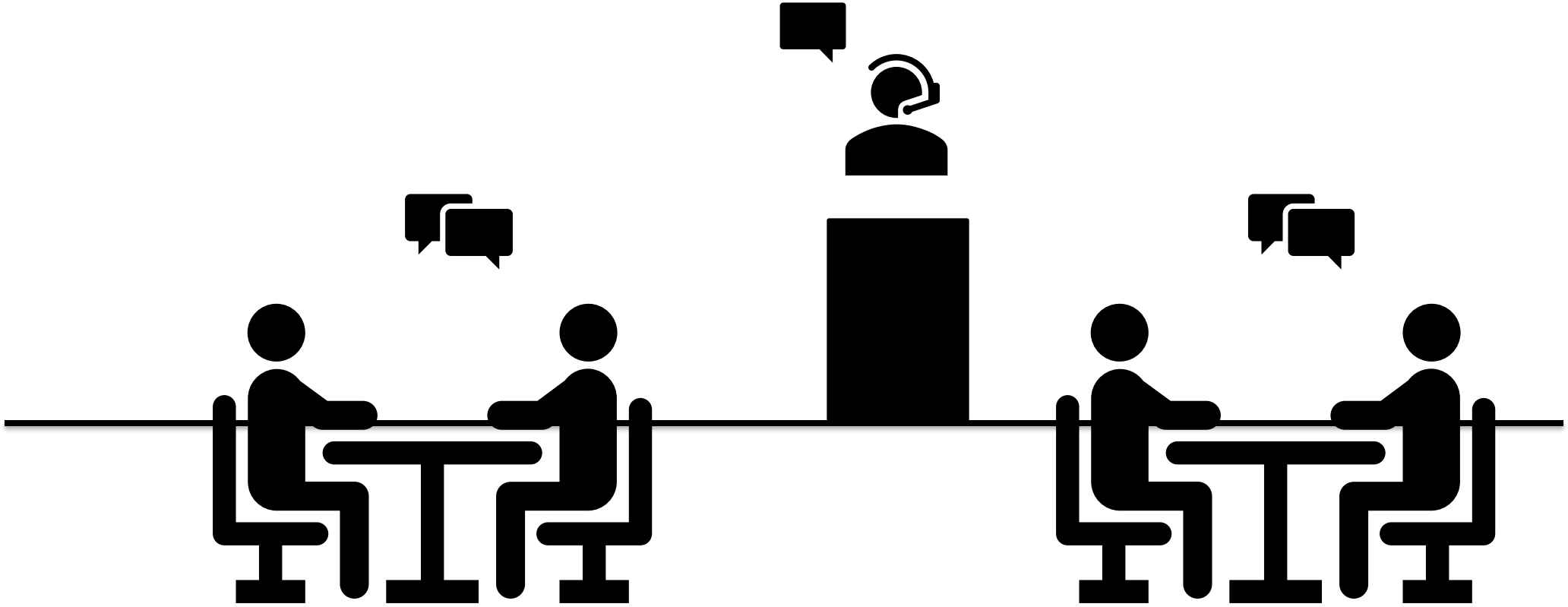
- Is the care plan person-centered and does it have enough detail i.e., symptoms associated with health conditions up to date
- Is the information in the care plan up to date, accurate and meeting the individual's needs?
- What changes have been made to the care plan? Is the joint working between professionals working?
- What follow-up actions are required and how do these feed into overall Governance/QA for Care planning?
- How is information communicated, has this been effective?
- What are the lessons learnt (including analysis on achieving outcomes), how will this information be shared?
- How is the general communication between all parties working, has it been effective?

Utilise the auditing functionality available via your digital system to aid your auditing

Discussion:

Any challenges you are facing to achieve this?

Any examples of Good Practice



Laura Shelton

Partner, HCR Law

THE LAW FIRM WITH
A PASSION FOR PEOPLE

Good Care Planning and Record Keeping in the eyes of CQC

Laura Shelton, Partner

Healthcare Regulatory, HCR Law

This Session

- The importance of ensuring compliance with CQC's expectations around care planning and record keeping.
- What the regulations say and where to find guidance.
- The consequences of getting it wrong in terms of CQC enforcement powers.
- Case studies based on real examples of enforcement cases arising out of poor care planning and/or record keeping including Warning Notices and s31 conditions.

Care Planning and Record Keeping

Regulation 17.—

- *(1)Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.*
- *(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—…….*
- *17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;*

Guidance on the Regulation

Guidance on 17(2)(c)

https://www.cqc.org.uk/guidance-providers/regulations/regulation-17-good-governance

- Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Fit for purpose means they must:
- Be complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information, as far as is reasonable. This includes results of diagnostic tests, correspondence and changes to care plans following medical advice.
- Include an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service, their carers and those lawfully acting on their behalf. This includes consent records and advance decisions to refuse treatment. Consent records include when consent changes, why the person changed consent and alternatives offered.
- Be accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. This applies both internally and externally to other organisations.
- Be created, amended, stored and destroyed in line with current legislation and nationally recognised guidance.
- Be kept secure at all times and only accessed, amended, or securely destroyed by authorised people

Non-Compliance

- CQC cannot prosecute a breach of regulation 17 (2) on its own however they can if it is linked to for e.g. regulation 12.
- CQC can however take the other regulatory action set out in its enforcement policy
- Includes Warning Notices
- Noticed of Proposal to Cancel Registration
- Urgent s31 Imposition or Variation of Conditions of Registration with or without embargo

Warning Notice Examples – Regulation 12

- *"As the registered provider of the regulated activity: accommodation for persons who require nursing or personal care, you have a legal responsibility to provide safe care and treatment for service users. During the inspection, we identified you were not compliant with Regulation 12 and shortfalls in safety had put service users at risk of harm.*

- *Care plans and risk assessments were not always consistent or detailed to provide staff with the guidance they required in relation to skin integrity or nutrition and hydration risks."*

Warning Notice Examples – Regulation 12

- *“Service User X's support plan stated Service User X was at risk from developing pressure ulcers and required 2 staff to assist with repositioning. Service User C's support plan which had last been updated on 1 August 2023 showed Service User C's waterlow score as high risk. Service User C's support plan did not provide any guidance on the frequency of how often Service User C should be supported to reposition. This placed Service User C at risk of not receiving the required support to maintain their skin integrity.”*

Warning Notice Examples – Regulation 12

- *“Service User Y's support plan stated Service User A required repositioning every 2 hours as they are prone to having moisture lesions. Service User Y’s repositioning records contained gaps in the recordings of up to 15 hours and 57 minutes. The repositioning records did not demonstrate Service User Y was repositioned when required.”*

S31 Urgent Conditions – More serious shortfalls

- **Section 31(1) Health and Social Care Act (2008)**

*If the Commission has reasonable cause to believe that unless it acts under this section **any person will or may be exposed to the risk of harm**, the Commission may, by giving notice in writing under this section to a person registered as a service provider or manager in respect of a regulated activity, provide for any decision of the Commission that is mentioned in subsection (2) to take effect from the time when the notice is given.*

s31 Urgent Conditions - Example

- *“Immediately on receipt of the imposition of this condition the registered provider must designate a competent individual to undertake an audit of all care plans and assessments for service users at the Care Home.*
- *Within 7 days of the audit being complete, the registered provider must send a report to the Care Quality Commission detailing how service users’ needs and any risks associated with these needs have been assessed and planned in relation to: hydration; diabetes; management of incidents and safeguarding people from abuse; and management of medicines including the use of PRN medicines.*
- *The report must include actions identified by the registered provider to monitor and manage risk. The report must include timescales for completion of the actions and documentary evidence of actions completed. Within 28 days following the receipt of the initial report and on a monthly basis thereafter, an updated report must be sent to the Care Quality Commission”*

Consequences

- Warning Notices are usually published, picked up in press releases and appear in inspection reports.
- They impact ratings and can influence future enforcement action.
- You can make representations to a Warning Notice within 10 working days.
- Urgent s31 conditions imposed take effect **immediately** and will remain on the Provider's registration indefinitely, with the potential for criminal sanction for failure to comply.
- The question of compliance or non-compliance with the positive obligations imposed will remain a matter of judgment for the Respondent, with no mechanism for this to be independently considered unless the Provider submits an urgent appeal to the Care Standards tribunal within 28 days of receipt of the conditions.

Resources

- https://www.cqc.org.uk/guidance-regulation/providers/regulations
- https://www.cqc.org.uk/guidance-regulation/providers/enforcement/offences
- https://www.cqc.org.uk/about-us/how-we-do-our-job/prosecutions
- Https://www.cqc.org.uk/guidance-regulation/providers/enforcement

Articles

- https://www.hcrlaw.com/news-and-insights/be-wary-of-warning-notices/
- https://www.hcrlaw.com/news-and-insights/cqc-enforcement-notices-of-proposal-what-they-are-and-how-to-respond/
- https://www.hcrlaw.com/news-and-insights/a-little-known-cqc-enforcement-power-with-devastating-consequences-for-providers/

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Find out more about how we can help you

Comfort Break

Bryony Morris

Head of Provider Monitoring and Assurance, Adult Care Service
Hertfordshire County Council

Care Planning Study Day

Provider Monitoring and Assurance Team

Provider Monitoring and Assurance Team

Our approach to quality monitoring ensures:

- contracted providers deliver high quality care and support services in Hertfordshire
- services give people choice and control
- people are confident the care and support they receive will be of high quality and that they will be safe and treated with dignity and respect
- the approach to monitoring and assurance is consistent across all service types
- the provider market is clear of our expectations toward quality and safety
- HCC fulfils Care Act duties to *facilitate a diverse, sustainable high-quality market for their whole local population*
- PAMMS audit/assessment is aligned to the standards in the East of England Contract

PAMMs overview

- PAMMS is an online assessment tool used in monitoring visits by ACS Monitoring officers
- Provides assurances that the terms of the contract are being met and to provide an assessment of the quality of care delivered by commissioned providers of adult social care services.
- Five domains / outcomes
- 16 standards in PAMMs to assess the outcomes

Involvement and Information		Personalised care and support		Safeguarding and Safety		Suitability of Staffing		Quality of Management	
1	Respecting & Involving Service Users	3	Care & Welfare of Service Users	6	Safeguarding People who use the Service from Abuse	11	Requirements Relating to Staff	14	Assessing & Monitoring the Quality of Service provision
2	Consent	4	Meeting Nutritional Needs	7	Cleanliness & Infection Control	12	Suitability of Staffing	15	Complaints
		5	Co-operating with other Providers	8	Management of Medicines	13	Supporting Staff	16	Records
				9	Safety & Suitability of Premises				
				10	Safety, Availability & Suitability of Equipment				

Care Planning

Care plans cover the following standards:

Standard One: Respecting and Involving People
Standard Two: Consent
Standard Three: Care and Welfare of People
Standard Four: Meeting Nutritional needs
Standard Five: Co-operating with others
Standard Six: Safeguarding People from Abuse
Standard Eight: Management of Medicines

Key Areas

Aligned to Connected Lives – promoting strengths and independence, maintaining links with family and community

The care plan should be individually tailored, person centred, include appropriate information on the Individual's preferences and views and clearly evidence that they were involved in the decisions about how their care and support is to be delivered

Accessible – for the individual

Daily notes

Key Areas

In line with contractual, regulator and local and national guidance – e.g. use of Mental Capacity Assessments and Best Interest Decisions, DOLs, MUST, RESPECT paperwork

Appropriate Risk Assessments in place

Clear links with other services and professionals – e.g. day centres, district nurses, GPs

Clearly triangulate

Regularly reviewed and updated – especially on a change in care need or significant event

Connected Lives

Connected Lives is a model for social care in Hertfordshire that places more emphasis on prevention, enablement and community opportunities.

Hertfordshire

Creating a cleaner, greener,
healthier Hertfordshire

Capacity and Consent

Carolyn Mcintosh HCC

Consent & Mental Capacity Act 2005

A guide for Carers - Carolyn McIntosh – Deprivation of Liberty Safeguards Team Manager

Under what Authority am I acting ?

&

How do I know I have consent ?

A starting point The MCA 2005

- Three Stage test

- 1) Reasonable belief that the person may struggle to make the decision (To grant me consent)
- 2) I took all practical steps to support the person to make this decision
- 3) If with support the person still can't make the decision – is this because they have an Impairment in the way their brain or mind works?

To Act or Not to Act (That is the MCA question)

S5 MCA 2005 provides protection from liability ….However….

- P has capacity
- P gives their consent- go ahead
- P doesn't give their consent – Stop you don't have permission
- P withdraws their consent – Stop

- P lacks capacity
- You can still go ahead

But …..

- Only if the action is:
- **Necessary**
- **Proportionate**
- **In Ps Best Interests**

LPA Powers and Decision making

Lasting Power of Attorney for Property and finance – can be used before a person lacks capacity – with Consent – only for decision in Ps Best Interests

Lasting Power of Attorney for Health and Welfare Decisions – only comes into force once P lacks capacity – Only for decisions in Ps Best Interests

Where P lacks capacity LPA becomes the decision maker – as if they were P making the decision

Scenarios – Know the decision and who should assess for consent

- Can I come in?
- Day to day care and support – Intimate care
- Use of equipment
- Not to offer support – MCA 2005 says you can't do nothing
- Administering medication
- Arranging additional help from outside my organisation.

Hints for recording

- For larger decisions, its helpful to record these formally – think about levels of restrictiveness
- Daily decisions — think about recording prompts to support these decisions
- Record your thinking – Analysis
- Protection from liability – S5
- Essential information – copies of LPA or Advanced Decisions
- Easy access for other professionals

Thank You

- Any Questions?

- Dols Team – dolsteam@hertfordshire.gov.uk
- 01438 843800

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Advance Care Planning/DNACPR

Helping people live well, for as long as possible, and die with dignity in the place of their choice

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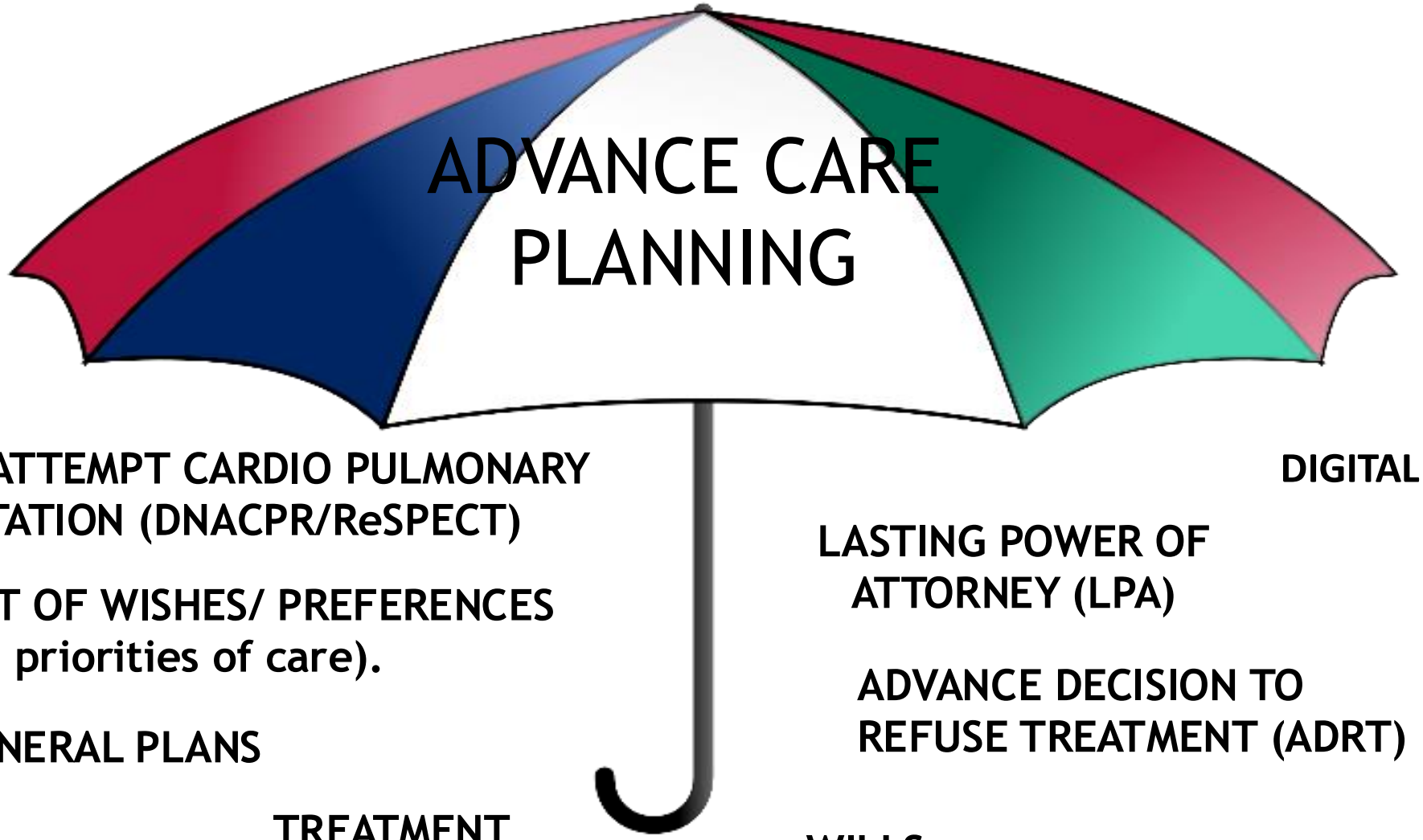
COURSE OBJECTIVES

- At the end of the day participants will be able to describe and discuss relevance to their own practice :

- Key Advance Care Planning principles and tools

- The key documents to support DNACPR/ReSPECT.

- How to facilitate these important discussions.


ADVANCE CARE PLANNING
DO NOT ATTEMPT CARDIO PULMONARY RESUSCITATION (DNACPR/ReSPECT)
STATEMENT OF WISHES/ PREFERENCES (Preferred priorities of care).
FUNERAL PLANS
TREATMENT ESCALATION PLANS (TEP)
DIGITAL LEGACY
LASTING POWER OF ATTORNEY (LPA)
ADVANCE DECISION TO REFUSE TREATMENT (ADRT)
WILLS
ORGAN DONATION/BODY DONATION

Help carry out the persons wishes
Advance Care Planning

- How they would like to continue with ADL and what is important to them.
- What is important to me re spiritual beliefs.
- How I would like to be presented to my visitors, what is important?
- What gives me hope
- What music I like
- What TV programme I like
- How do I like to lie in bed when I sleep
- How I like to be addressed.
- What time do I like to go to bed or get up.
- How would I like to be cared for
- What are my likes/dislikes

Who would you like contacted in your final hours
Any religious needs, such as seeing a priest or a prayer offered.
Any personal requests such as music, flowers, dog on bed.
Light left on and curtains open.
Someone sitting holding their hand.
Mouthcare with their favourite tipple.
A poem / story read
Fairy lights around the bed.

Communicate to the whole Team these wishes.

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- ***Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.'***

- *International Consensus Definition of Advance Care Planning (Sudore et al 2017)*

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- **Advance Care planning** is a key means to improving **care** for **people** nearing the end of life and of enabling better **planning** and provision of **care**, to help them live **well** and die **well** in the place and the manner of their choosing. (WHICH 2020)


CHAT

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REMEMBER

- Compassion
- *Empathy*
- *Acknowledge emotions*
- *Listen*
- *Pause*
- *Reflect back*
- *Check understanding*
- *Document*

Templates to record ACP:

www.goldstandardsframework.org.uk/advance-care-planning.

www.eolc.co.uk RESPECT forms

www.ageuk.org.uk

www.macmillan.org.uk

www.coordinatemycare.co.uk (London Only)

www.dementiauk.org

www.compassionindying.org.uk

www.nice.org.uk

www.mariecurie.org.uk

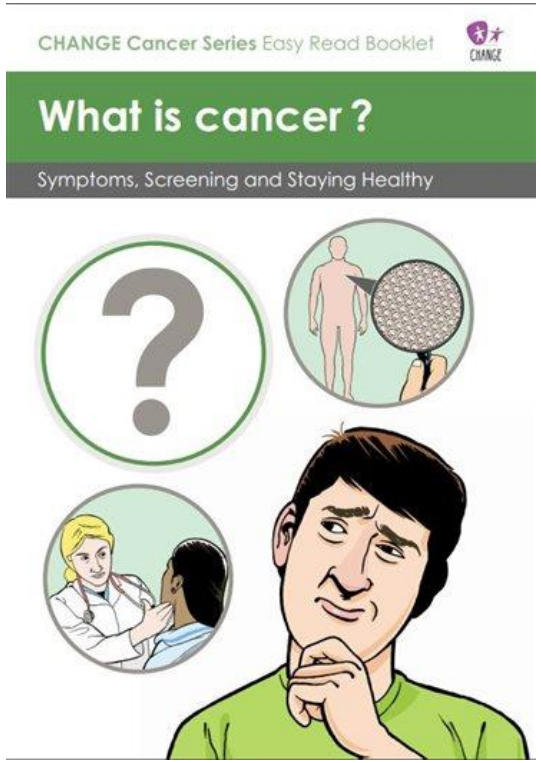
Easy Read

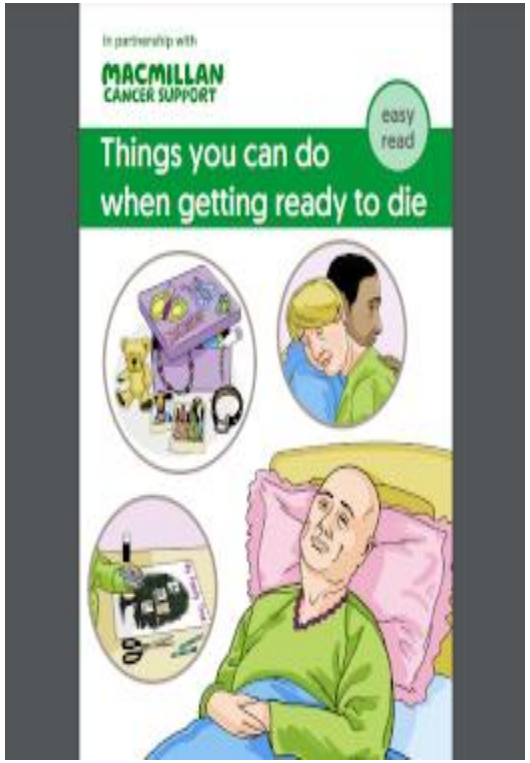
Cardio Pulmonary Resuscitation (CPR) Information

Although the decision about CPR is a medical decision, it is necessary for the clinician to discuss this decision with the patient and/or their family/carers/ Legal Power of Attorney for Health and Welfare to gain understanding of their views. This Easy Read information has been devised to support any conversations about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders with people with Learning Disabilities and/or their carers.

Easy Read Booklets that can help?

- What to expect in the last few days of life
- What if: celebrating my life: ACP Template
- Changes that can happen at the end of life
- Choosing where to die
- Making the decisions about the future if you are dying
- Thinking about your funeral
- Getting ready to die





Food for thought

- How do we tell other residents/ patients/ friends when someone with a learning disability has died?
- How do we involve them in the funerals/ plans?
- How do we remember someone who has died?
- What literature can you access?
- How do we get support for ourselves?
- Where can we access further support?

An Advance Decision to Refuse Treatment.

- A decision to refuse specific treatment.
- Treatments declined must be named with the statement ‘even if my life is put at risk’
- Needs to be written down if it is life threatening, signed by the patient and witnessed
- Recommended to be done in conjunction with a competent clinician and ensure GP/Consultant is aware of your wishes.

- **Is an advance decision legally binding?**
- Yes it is, as long as it:
- complies with the Mental Capacity Act
- is valid
- applies to the situation

ADVANCE DECISION TO REFUSE TREATMENT (ADRT)

- An advance decision to refuse treatment is when a person decides to refuse to have specific medical treatment.
- It is sometimes called a living will or advance directive
- An advance decision to refuse treatment must be in writing, signed and witnessed and include the statement " even if my life was at risk"
- Cannot override comfort measures such as warmth, shelter and basic care (hygiene and offers of food and drink by mouth)
- It only comes into effect if the person loses the ability to make their own decisions at sometime in the future.

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continued

- It should be retained by the person it is about
- Valid ADRT **ARE** legally binding
- If the person agrees, a copy should be available to other people and recorded in relevant areas.
- You should always refer someone who wants to put an ADRT in place to their healthcare team

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Let us dispel the myths and fears of DNACPR?

Do not attempt Cardio-Pulmonary Resuscitation DNACPR

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

DNACPRadult.1(2015)

Name _____

Address _____

Date of birth _____

NHS number _____

Date of DNACPR decision: / /

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.

1 **Does the patient have capacity to make and communicate decisions about CPR?** YES / NO
If "YES" go to box 2

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? If "YES" go to box 6 YES / NO

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? YES / NO
If "YES" they must be consulted.

All other decisions must be made in the patient's best interests and comply with current law.
Go to box 2

2 **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:**

3 **Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:**

4 **Summary of communication with patient's relatives or friends:**

5 **Names of members of multidisciplinary team contributing to this decision:**

6 **Healthcare professional recording this DNACPR decision:**

Name _____ **Position** _____

Signature _____ **Date** _____ **Time** _____

7 **Review and endorsement by most senior health professional:**

Signature _____ **Name** _____ **Date** _____

Review date (if appropriate):

Signature _____ **Name** _____ **Date** _____

Signature _____ **Name** _____ **Date** _____

NEWS FLASH

RESPECT

Recommended Summary Plan for Emergency Care and Treatment

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

1. This plan belongs to:

Preferred name

Date completed

Full name

Date of birth

Address

NHS/CHI/Health and care number

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ **Yes** ☐ **No**

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me — **Quality of life and comfort matters most to me**

What I most value:	What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	Balance extending life with comfort and valued outcomes	Prioritise comfort
clinician signature	clinician signature	clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

CPR attempts recommended Adult or child	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

www.respectprocess.org.uk

5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? Document the full capacity assessment in the clinical record.	☐ Yes ☐ No →	If no, in what way does this person lack capacity? If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.

☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

☐ **C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):

- ☐ **1** They have sufficient maturity and understanding to participate in making this plan
- ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
- ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

If this page is on a separate sheet from the first page: **Name:** **DoB:** **ID number:**

DNACPR does not mean no care!!

- **DNACPR means ensuring a dignified death.**
- **DNACPR** is on an individualised basis **not** blanket policies

- Reversible conditions will be treated.
- Symptoms will be controlled.

- DNACPR is a treatment, is not legally binding unless in ADRT document, is a discussion that should be had with all concerned but it is a medical decision.

- We are going to offer maximum attentive and conservative care now to keep them comfortable in their final days.

“You are very sick. Your organs are failing. You lose consciousness; your breathing gets weaker. You are dying. Eventually even your heart stops. CPR will not change anything. It will not rescue you from anticipated dying. CPR is not a treatment for you now”

.

“At death there are no choices: not CPR or brain surgery or a heart transplant. CPR only works, and then only sometimes, when the heart stops first. In dying, the heart stops last. No options left.”

'Can I give you a certificate, to tell everybody that, if your heart stops, they should hold your hand instead of thumping on your chest?’ My relative was delighted with her 'Protection from CPR certificate.' I've used that phrase ever since.

CPR succeeds in saving somebody’s life if they have a cardiac arrest in hospital for 2 people out of 10. For people who are not in hospital when they have a cardiac arrest, it’s 1 in 10. A significant proportion of survivors have permanent brain damage. It’s not like on TV hospital dramas.

(2020 Marie Curie talk about with Dr Kathryn Mannix)

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Language is important

- (Study by E. Barnato (2013) in the June edition of Critical Care Medicine)

1. When asked to choose having their loved one

- receive CPR if their hearts should stop 60% choose CPR

- 2. When the alternative was described as to *''allow natural*

- *death''*, the number choosing CPR dropped to 49%.

- Find the right language for you both (HCP and the patient) *"natural conclusion to your life"* – *"decisions may be taken from you"* – *"need to go on and die again"*
- Distinction between *dying* and *cardiac arrest*.

Key issues

- Very sensitive issue -needs to be handled carefully by staff involved
- Remember, if an ambulance is called and there is no evidence of a DNACPR form in place, the ambulance crew are obliged to start CPR.
- For many elderly, frail people, it is often most appropriate to allow a “natural death” and not let them suffer the indignity of CPR.
- Do ask if there is a DNACPR in place if you are concerned the person is deteriorating and may be dying


Plan ahead...
it wasn't raining
when Noah built
the ark

THANK YOU FOR LISTENING

Any questions?

Remember we are here for you

WENDY FREEMAN
ISABEL HOSPICE
07843 218 316

24 hr Advice Line:
Isabel Hospice
01707 382575

24 hr Advice Line:
Garden House Hospice 01462 416 794

Education Team
Garden House Hospice
01462 416 788

Respect

Join at
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What are your key takeaway actions from today?

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Hertfordshire Care Provider Support Service Directory

HCPA Provider Hub

HCPA Members Zone

Download our Care Home Directory poster which displays key contact information for services East & North South & West

Below you can search our Support Services Directory by viewing all services, filtering by criteria, or searching for a keyword.

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Filter By

Search services

Search

[Support Service Directory - HCPA]

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- Training and education
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HCPA: 'Sharing best practice in care through partnership'

Feedback