Care Planning & Care Reviewing Policy & Procedure

Statement and Purpose of Policy
Aim of Policy

This policy is intended to set out the values, principles and policies underpinning Serenta Homecare approach to the personal support services it offers to its client plans. Serenta Homecare believes that Clients have the right to the highest quality physical, emotional and mental health care.

Employees will provide sensitive and flexible personal support to maximize client's privacy, dignity, independence and control their own lives.

All services will be delivered by the service in accordance with the individual Clients Plan of care. The plan effectively becomes a yardstick for judging whether appropriate support is being delivered.

Clients will receive support to access additional specialist support and advice as needed from physiotherapists, occupational therapists, speech therapists and others for, e.g. positioning or modification of equipment, as specified in their plan of care.

Assessors Role and Commencement of Care Package

The procedure for set the up of new care packages

Upon commencement of a clients care package a meeting will be held with the assessor and client also involving significant professionals, family, friends and advocates as agreed with the client to discuss their needs and preferences of their tailored care package. On assessment the assessor will assess the client's needs, carry out all care assessments and appropriate risk assessments relevant to the plan of care. Risk assessments must only be carried out by risk assessment trained staff. The home file be delivered on initial assessment. For Clients that are commissioned by Sheffield City Council Serenta Homecare will have received referral paperwork outlining their plan of care.

The plan of care will be inclusive off:

- SCC paperwork should the client be commissioned
- Private agreement should the client be private to Serenta Homecare
- Care plan
- Key Contacts
- Risk Assessments relevant to the plan of care
- MAR chart if relevant to the plan of care

The Client will be made aware of the respective roles and responsibilities of all those

involved in their care or treatment and should be informed of how to contact them.

Assessment of Allergies

As part of the initial assessment, the assessor will obtain and record details of any known allergies, sensitivities or adverse reactions that may affect the Client's care. This includes, but is not limited to:

- Medication allergies.
- Food allergies or intolerances.
- Allergies to latex, dressings or adhesives.
- Environmental allergies where these may impact care delivery.

Where an allergy is identified, the information will be clearly documented within the Client's plan of care, risk assessments and, where applicable, the Medication Administration Record (EMAR) and if a food allergy/Eating and Drinking risk assessment. Any allergy that presents a significant risk to the Client's health will be highlighted to ensure all staff providing care are aware of the appropriate precautions and actions to take.

Care Reviewing

Reviews will be at least six monthly, at the request of the client or if a change in need arises.

On six monthly review Clients will be reviewed on their nutrition and hydration, this includes any changes to dietary requirements, weight loss or weight gain. Any changes highlighted are required to be escalated and medical advice is to be sought.

When Serenta Homecare enter into emergency business continuity contingency plans, or when other significant events occur which affect staffing levels, general care reviews may be placed on hold for a maximum period of eight weeks, however a care plan review will be completed if a client has a change in need to initiate the review.

Procedure for when a change in need arises to clients plan of care

It is policy at Serenta Homecare that personal support provided to clients is flexible, consistent, reliable and responsive to their changing needs and is based upon the development of client plans.

Changes in need are communicated in different ways to Serenta Homecare this could be:

- Updated paperwork from SCC
- Hospital discharge via resumptions
- Following a review
- Telephone calls

Once details of changes in need are communicated these will be detailed within care plans and risk assessments, all office based staff are aware that all sections of the care plan will

require updating.

When a change in need arises, the change will be detailed within the plan of care, this may be done flexible as above or following a review of care. Once details of the change are created this must be followed though into all areas of the care plan including,

- risk assessments
- MAR chart if applicable
- Key contacts if applicable
- care plan

Temporary changes in need

There may be times where a client requires temporary changes, this could be a temporary medication such as antibiotics. These changes in plans of care will be initiated with the creation of an event. All temporary changes are to be customed scheduled in access care planning with a start and end date.

Document Control

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