ASCC Guidance sheet 8

Updated February 2009

Care Plan and Care Plan Variation

Creating the Care Plan

It happens automatically …

If a Needs Assessment, FACE Assessment or Care Plan Review is completed with a decision to **provide community based services,** either planned or already started – a Care Plan will be **automatically created** when it is approved by a manager.

Or manually …

You can create a Care Plan before a Needs or FACE Assessment has been completed as in some situations you may need to put in care quickly. So you can bypass the Assessment temporarily **but:**

- Although you can create the plan this way, it may not be approved till the related assessment has been completed/approved
- You will need to go back as soon as you can to complete the Assessment
- Needs on the Assessment must match what is recorded on the Plan

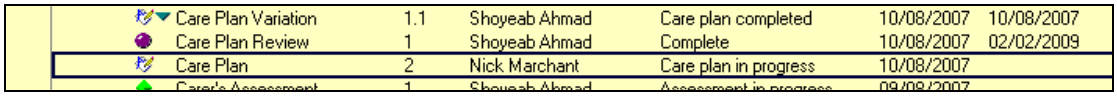
See **Guidance sheets 3 The Needs Assessment** and **3.1 The FACE Assessment** for more information about this.

Note. Before the Care Plan is created, make sure you have entered and saved your telephone number, under the Care Co-ordinator's name, on the Basic Information Sheet see **ASCC Guidance Sheet 2 The Basic Information Sheet.**

Filling in the Care Plan

If the plan has already been created automatically

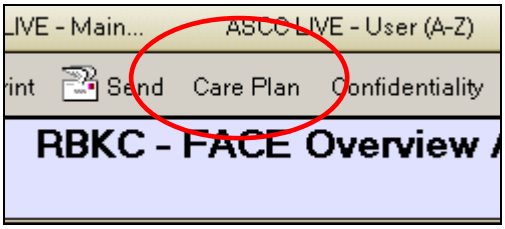
- Double click on the Plan in the A-Z View or highlight it and press [Enter]:



Care Plan Variation	1.1	Shoyeab Ahmad	Care plan completed	10/08/2007	10/08/2007
Care Plan Review	1	Shoyeab Ahmad	Complete	10/08/2007	02/02/2009
Care Plan	2	Nick Marchant	Care plan in progress	10/08/2007	
Carer's Assessment	1	Shoyeab Ahmad	Assessment in progress	09/08/2007	

If you are creating a CP before the assessment is completed/approved

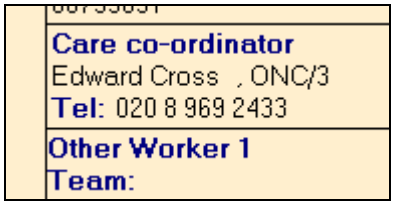
- Open most recent **Needs** or **FACE Assessment** document in the ***User A-Z***.
- Click the **Care Plan** button at the top of the screen:



A new care plan loads.

Filling in the form

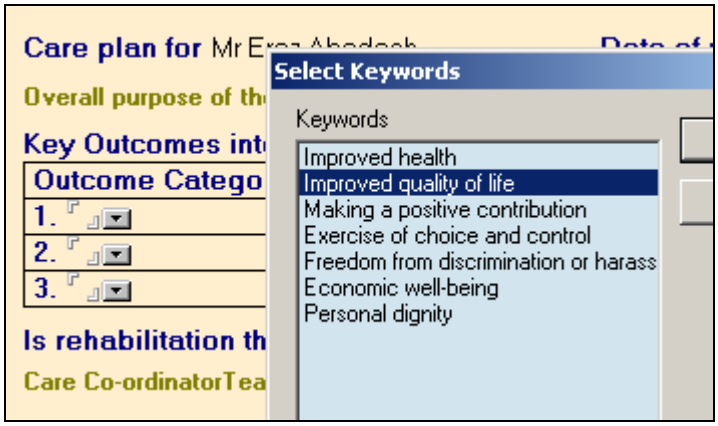
You will see it has the Care Coordinator's telephone number listed at the top under your name:



The **Date of Plan** defaults to today's date. This can be changed to a date in the past **but should not be before the assessment date.**

Key Outcomes

In the **Key Outcomes intended by this care package** section, press **[Enter]** and select a **Key Outcome** category (use the up/down arrows on your keyboard, or click with mouse). It is mandatory that you select at least one Key Outcome, and you may enter up to three if you wish:



For each Key Outcome category that you identify, explain **How will you know this has been achieved?** in the adjacent box. These Key Outcomes, and the text you entered about how you will know if they have been achieved, are carried over to the **Care Plan Review**.

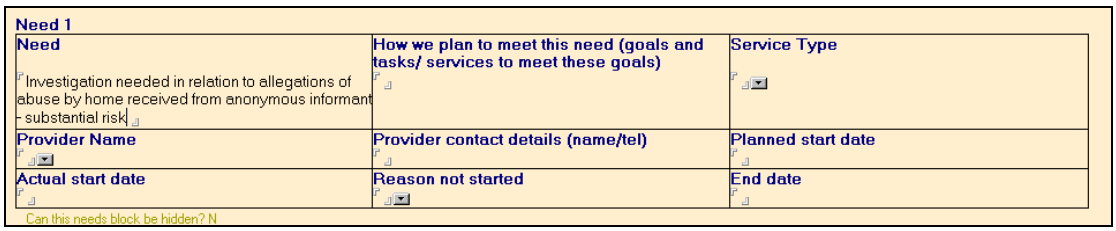
The next field **Is rehabilitation the main purpose of the care plan?** Please answer this question, which is mandatory.

The User Categories feed through from previous documents. They may be amended if they have changed. **Risk** and **Band** will also feed through from previous documents, or may be blank. These fields can be edited on the care plan, but this should not be used instead of a re-assessment if the service user's needs or circumstances have changed significantly. These fields are mandatory.

You have the opportunity of entering a **secondary diagnosis/ category** should you wish to, or indeed there may be one already there if this was entered on other documents.

Ignore the **Show Need** lines of radio buttons for the time being.

The service user's summary of needs will have rippled through from the Needs or FACE Assessment and each will be displayed in a numbered separate box (if the needs were entered on the Assessment), the number of boxes will depend on the number of needs you had on the Assessment.



Filling in the Needs boxes

Need

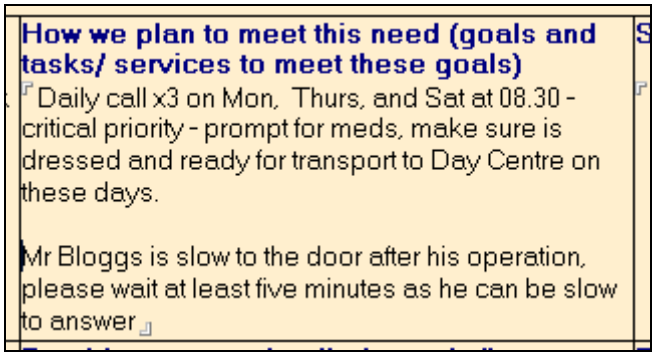
The first Need will be in the Need 1 box. You can amend the text if you wish. If it is blank (because you are creating the Care Plan in a hurry to get services in quickly) enter the need. This must also be added to the Needs or FACE Assessment later when you are able to complete that document and the needs must tally.

How we plan to meet this need.

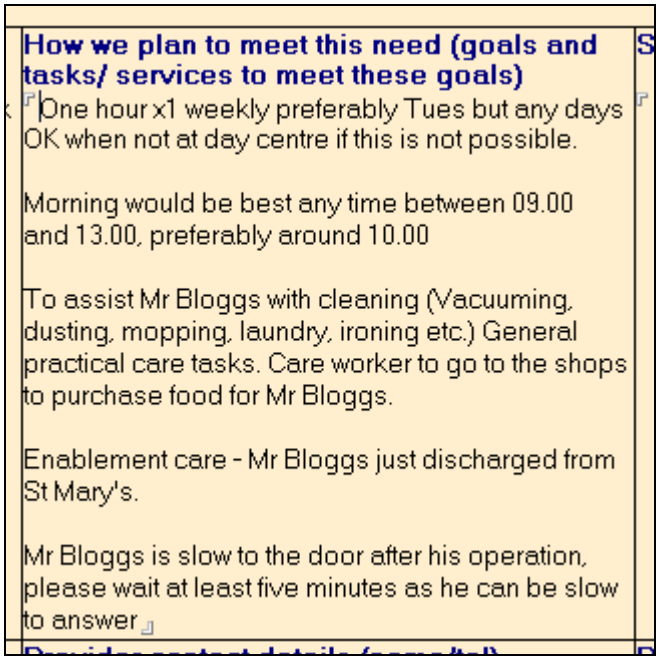
For all Care Plan Needs that include a **Home Care element**, the Electronic Monitoring Team need to know a specific set of information. Use the field "**How we plan to meet this need (goals and tasks/ services to meet these goals)"** to specify:

- The task/s to be carried out
- The amount of time to be spent at each visit
- The day/s the visit should occur – maximum flexibility should be indicated
- The time of day the visit should occur – maximum flexibility should be indicated
- The frequency the visit should occur – only specify if it is not every week – options are every 2, 3 or 4 weeks
- Any special requirements: e.g. double up visit, BME/LD provider needed, non-ordinary budget type (e.g. Enablement), non-standard visit priority*.

So this field will expand considerably. Here's an example -



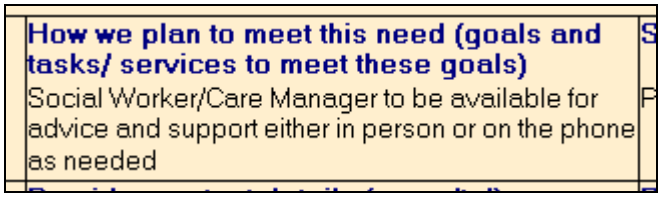
Here's another example on the same plan for the same person, but a different home care need:



Note - if the special requirements/instructions/additional information (e.g. Access information, risk factors, times service user goes out etc.) are quite complicated/detailed – refer reader to 'see attachment' and add detailed data as an attachment.

If the need is **not home care** this field does not need to be so detailed., e.g:

Or: -



Service Type

Enter the service type from the drop-down list

Provider Name

Select the specific Provider from the drop-down list. Note that the list of providers depends on the Service Type you selected in the previous field.

Provider Contact Details

Enter the name (if known) and numbers/e-mail addresses for the contact people at the provider

Estimated Start Date

Enter the date that you plan the service to start. If it has already started enter that date 9and if this is not known, estimate it)

Actual Start Date

We are required to record the date **all services started** for the first 'care package' for new clients as part of our Performance Indicators. We need to record **actual dates**, so that the 'latest' date can be calculated. However, the Actual Start Date will often not have happened yet at the point when you are completing the care plan – if this is the case **you should leave it blank**. You cannot enter dates in the future – the system will give you an error.

If you do enter a date**, it must be accurate as this information is audited.** Having said that, some services such as "professional support" do not really have a defined start date – use the date that you or another practitioner involved in the case were allocated.

If you don't enter a date, that is fine. You will be able to add the Actual Start Date when it occurs after the Plan has been approved by your manager – a special feature allows this – see below.

Reason not started

If relevant, **Reason not started** can be entered **but it will often not be known at this stage whether the service started on not**. If so, leave it blank, because as with Actual Start Date it can always be entered after the plan has been approved by your manager.

End Date

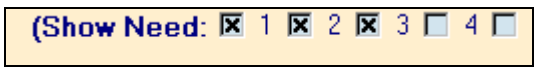
Very few services have a known **End Date** – and this is **optional**. **End Date** can only be entered if you have also entered an **Actual Start Date**. Again it can always be entered after the plan has been approved by your manager.

More Needs boxes

When you have completed the first need, move on to the next one (if there is one). Continue in this way until you have filled in all the boxes for all needs.

You can add **more needs** by clicking in the **Show Need** line of radio buttons at the top of the sequence of boxes.

For instance if 2 needs have come through from the Needs or FACE Assessment but you'd like to add a third, click **second** and the **third** radio button along, Xs will appear, like this: -

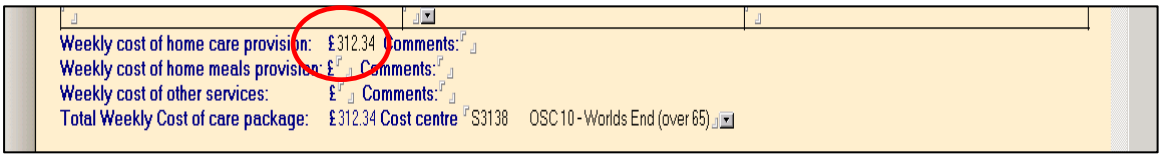


Scroll down the document and note that a third empty need box has appeared for you to complete.

You can make un-necessary **empty** boxes disappear by **unclicking** in the relevant box on the line of radio buttons. You can't make any of the boxes that have come across from the Needs disappear this way though. To do this, call GIST on 3999 for advice.

Weekly Costs section

If a **Home Care Order** exists for this person, with Current or Pending Visits, the Average **Weekly Cost** shown on that order will be displayed in the section on costs:



You may enter comments to describe the basis of this cost but this is not mandatory.

If a Home Care order does not exist, this section will be blank.

If you have entered **Meals** as a Service Type in any of the Need tables, you are required to enter the **Weekly cost of home meals** – enter the cost to the client. Check with your team or your manager what the current cost is per meal. Again, a comment may be helpful to explain the cost if you wish to add one.

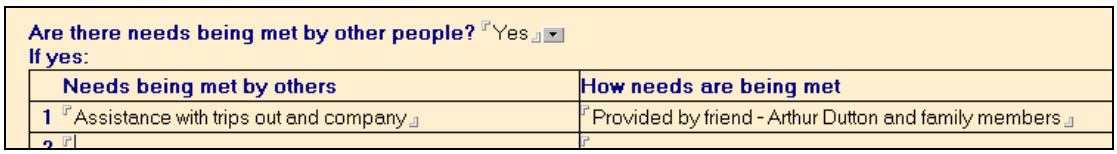
You can use the **Weekly cost of other services** if you are providing other services with a direct cost to your team's budget – e.g. one off blitz clean, transport for a specific event etc. If you enter a cost here, the comments field is mandatory to explain what the cost is for.

The system works out the **total weekly cost of the package.**

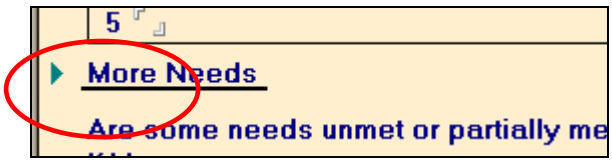
Select the **cost centre** for your team from the drop down list – this is the budget that will be charged for the cost of the care.

Needs Met by Others

Select either Yes or No to the question **"Are there needs being met by other people?"** If you have selected **Yes**, enter the details in the box below (which become mandatory if you have said Yes), for instance:



If required, you can create more lines for entering needs by clicking on the "twistie" next to "More Needs":



If you say **No** to the question, the fields **are hidden.**

Similarly answer **Are some needs unmet or partially met?** If you say Yes you will need to give details in the box provided. If you say No, the fields **are hidden.**

Moving Needs to "Needs Met by Others" or "Unmet" needs

If some of the summaries of need carried over from the Needs or FACE Assessment are in fact **met by others** (rather than by the Department), or are **unmet** or **partially met**, these should be "cut and pasted" from the need box higher up the document into the appropriate section here.

When the need box higher up the document is **completely** empty of all text and **Save** is pressed, the need box will disappear leaving the need in the **Met By Others** or **Unmet** section.

The rest of the form

Client on CPA?

Care Plan Approach. Press **[Enter]** and select an answer. If you select either Standard or Enhanced – further mandatory questions about contingency plans etc are displayed.

Review Date

Enter a date by either typing it or using the calendar button. This may be up to a year in advance, but no greater.

Did you issue the user with a copy of the care plan?

If **Yes**, enter the date given (though logic dictates this is likely to be in the future – so a date can be entered up to two weeks into the future).

If **No**, further fields then appear. You must select a **reason** from the list.

Also if **No** is entered you must say whether you issued a copy of the care plan to the user's representative. If **Yes** is answered, enter the date in the next field. If **No** is entered, select a reason from the subsequent list. If **Other** is selected you must give details in a further field which then appears.

Confidentiality and Network Sheet

You may edit the **Confidentiality Table** or the **Network Sheet** from the **Care Plan** if required by clicking the relevant button. These documents should obviously be kept up to date.

If you do update them, do so then click the **Save and Close** buttons on those documents to return to the Care Plan

Save the Care Plan with **Ctrl** and **S** or by clicking the **Save** button.

Check Form – click the Check Form. If you have missed any mandatory fields you get a message, click OK, go to the problem area and correct it, then click **Check Form** again until you get no messages.

You must **send** the document to your manager for approval. **Only Team Managers may approve Care Plans.**

Send the form to them by either clicking on the **Send** button.

A box appears inviting you to select the addressee and add any comments if you wish.

Once the Care Plan has been approved by your team manager it cannot be amended – except to add service start/end dates (see below).

Abandoning a Care Plan

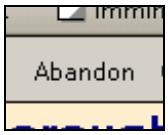
If a client has been assessed or reviewed as eligible for a community based service – they should **always** be issued with a Care Plan stating their needs and the support offered.

Exceptions to this rule are extremely limited – e.g. the client dies – **only managers are therefore able to abandon Care Plans** and must only do so for such exceptional circumstances. Only they will see the Abandon button on the Plan.

Care Plan Variations (see below) – created to record small changes to the care package – may still be abandoned by non-managers as they are more likely to be created as a genuine error. All workers see the Abandon button on the variation.

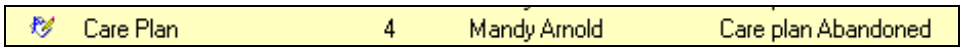
ABANDONING A CARE PLAN - MANAGERS ONLY:

1. Make sure the Care Plan has been **saved**
2. Make sure there is **no review date**.
3. Click the **Abandon** button at the top of the screen:



4. You must then enter a **reason** in the box which then appears and click **OK** or press **[Enter].**

5. Save the document and come out. The Care Plan is shown as **Care Plan Abandoned** in the View:



Once abandoned, if you do wish to create another one, go to the most recent **approved care plan review**, open it and click the **Create new CP** button.

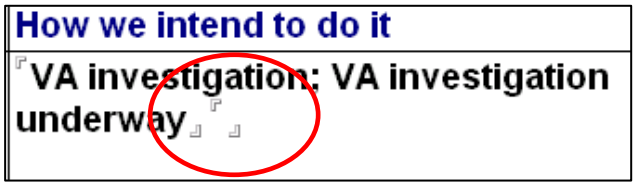
Care Plan for User

A large print version of the Care Plan can be produced to give to the service user.

With the Care Plan open, click the **CP for User** button at the top of the document:

The Care Plan for User appears. This is in a large font for ease of reading. It can then be edited (for instance to change technical expressions to something the service user will understand better) if required, but it **cannot be saved** so these additions will be lost once the Care Plan for User form is printed and exited.

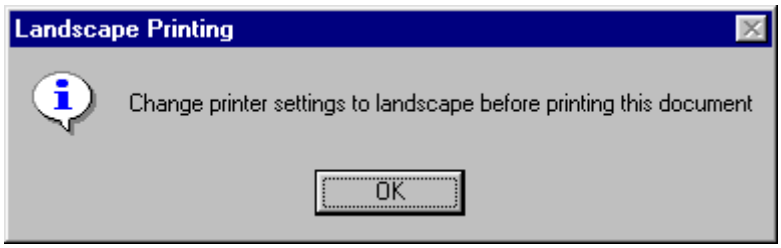
Note that in each part of the table describing the client's needs and how we are going to meet those needs, there is an additional data entry point:



This is intended for the insertion of **pictures** by the Learning Disability team staff, or other staff. Pictures can be copy and pasted into this field.

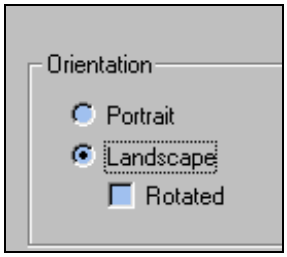
Printing the Care Plan for User

Print the document by clicking the print button. You will be invited to print **landscape** as the form looks better if you do:

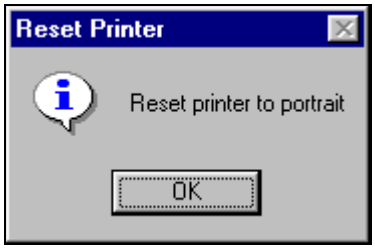


Press **[Enter]** to continue. A box will pop up with the name of your printer on. Click **setup** to the right of the box **:**

Select **landscape** from the next box (what the box says and looks like will vary depending on what printer you are linked to). Then press **[Enter]** or click OK.



The document prints landscape.



You are now prompted to return the printer setting to portrait (otherwise it will continue to print every other document from *Lotus Notes* landscape, which is not advisable).

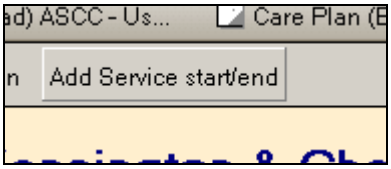
Repeat as above but this time select **portrait.**

Adding Service Start/End Dates

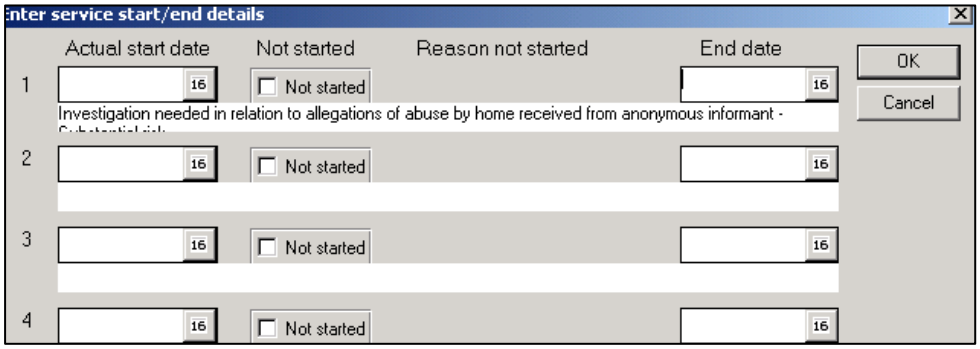
Once the Care Plan has been approved by your manager, the Actual Start Dates of the services will need to be entered, **once these become known.**

The Actual Start Date, or Reason Not Started, must be entered for every service before the Care Plan can be reviewed.

Open the Care Plan, and click on the button **Add Service start/end:**



A box is displayed showing 12 potential needs – but only the needs you actually entered on the care plan are displayed:



If the service to meet this need has **started** – enter this in **Actual Start Date**. This date cannot be in the future. **These dates will be audited, so must be accurate.** The target, in terms of Performance Indicators, is to start all services within 2 weeks of the Need Assessment being completed (new clients only).

If you have entered an **Actual Start Date**, you may also enter an **End Date** – if known. This is not mandatory.

If the service has not, or is not going to start – click on the box marked **Not Started**, and select a reason to explain why the service has not been started.

When you click on **OK**, you will get a message saying **Action Completed**.

You don't have to enter all the start dates at the same time, you can come back to the form at any stage by opening the Care Plan and clicking the **Add Service Start/End** button (it will have remembered the ones you have already put in) and add them one by one as they become known.

When you have entered **start dates/reasons not started** for **all** of the needs/services on your care plan, you will get a message saying **Service Details are Now Complete**. **The Care Plan cannot be reviewed until all Service Details are complete.**

Cases should not be transferred to other workers, or to a 'Review' allocation unless all Service Details are Complete.

Care Plan Variations

It is possible to **vary** the pre-existing approved Care Plan within **a defined set of circumstances**. These are: -

1) A **substantial** but **short term change** which is

   - less than 4 weeks
   - end date and reason clearly specified
   - up to the residential care cost limit

2) a **long-term** but **minor change** which is

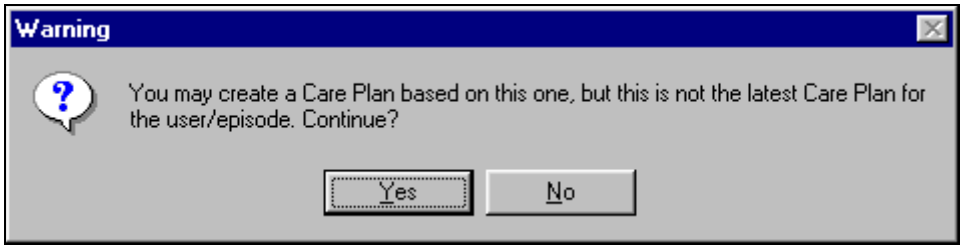
   - a variation of up to 4 hours a week, more or less care in an already funded service
   - does not take the total cost above the residential care cost limit.
   - does not involve a newly funded service

Variations should not be used in place of a Care Plan Review!

To do a variation, click the **Variation** button at the top of the **most recent completed care plan** screen:

A new plan loads which is a **copy** of the previous care plan, but with the title **Care Plan Variation**

- **Note** - if there has been a **care plan review** on the care plan you have opened, the system will point out:



This is OK, select **Yes** by pressing **[Enter]** or by clicking the Yes button.

Things you need to fill in or change

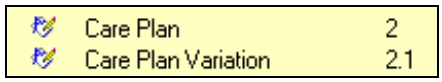
On the Variation, answer the question about **rehabilitation.**

Change the details of the plan as required within the remit of the set of circumstances described above. So for instance, you might bump up a person's home care by a couple of visits a week, as long as it does not total more than 4 hours. Insert these changes in the needs boxes. Make sure you describe what the visits are for and when in the **How we plan to meet this need** box.

Enter a new review date (it will probably default to the last one so be careful!) and also answer the questions about giving the user a **copy of the care plan** and **charging information leaflet**.

The variation **must be approved** by your team manager. **Save** the document. Use the **Check Form** button and then **Send** it to your team manager for approval.

Once the Variation document is approved, it will appear in the A-Z view with the original care plan's document number but with a full stop followed by 1: -



If there are further variations **on this original care plan** they will be numbered **2.2** then **2.3** etc.

The Variation can of course be printed **for the user** by using the **CP for user** button at the top of the variation. Follow the steps above in the section **Care Plan for User** for instructions on how to do this.