Introduction to the care planning process

This chapter will help you to:

➡ Identify the care planning process and its components.
➡ Explore the various models and frameworks for care planning.
➡ Identify a person-centred model of care planning.

Introduction

To be faced by a troubled conflicted person who is seeking and expecting help, has always constituted a great challenge to me. Do I have the knowledge, the resources, the psychological strength, the skills – do I have whatever it takes to be of help to such an individual?

(Rogers 1967: 31)

Every time we are approached for help from individuals or their carers we have to start thinking the same as Carl Rogers thought when he began his psychotherapy practice in the 1960s. However, although there is an expectation on each and every one of us to have some knowledge about what we are doing every day in our practice, more importantly we must know how to use that knowledge to obtain the best available help for the people in our care (Schön 1983; Ghaye 2000; Jaspers 2003). Accountability for our practice is increasingly evident in the public reports that result when things go wrong. However, this chapter is not about frightening practitioners into demonstrating good quality care, but is concerned with helping you to be accountable for your practice by making the best use of the processes available to you. The main process in which this can be evidenced is in the care planning process, and all practitioners, clients and carers are now expected to have some involvement in care planning. Even if you are not responsible for the whole care plan, knowing how your contribution develops into a good quality plan will help you understand that the process is there to help everyone involved.
What is care planning?

For those of us involved in health and social care practice and education, care planning affects most of our daily lives. The following professional standards clearly outline the expectations that are placed upon us. In *The Knowledge and Skills Framework* (KSF) (DoH 2004) for health and *The National Occupational Standards for Social Work* (Topss 2004) there is reference to the ability to organize and plan care. For example, the KSF states that at the following levels you should be able to:

- **Level 1**: undertake care activities to meet individuals’ health and well-being needs.
- **Level 2**: undertake care activities to meet the health and well-being needs of individuals with a greater degree of dependency.
- **Level 3**: plan, deliver and evaluate care to meet people’s health and well-being needs.
- **Level 4**: plan, deliver and evaluate care to meet people’s complex health and social care needs.

So at some level, if you work in an environment that provides health care, you must be able to address the health and well-being needs of individual people. For social care workers *The National Occupational Standards* (Topss 2004: 14) state that you should be able to ‘Plan, carry out, review and evaluate social care practice with individuals, families, carers’ groups, communities and other professionals’. This is also supported by the Quality Assurance Agency (QAA) *Subject Benchmark Statements* in the following areas:

- the identification and assessment of health and social care needs in the context of individual interaction with their environment;
- the development of focused intervention to meet these needs;
- implementation of these plans;
- critical evaluation of the impact of professional and service interventions on patients and clients.

(QAA 2006: 5)

When looking at the overall process of health and social care planning we therefore need to think about what will influence how we write or carry out care plans. This chapter explores some of those influences and how they affect our everyday practice of planning care. In Chapter 7 the basic quality structure of health and social care organizations is outlined in more detail, and individual and organizational accountability is discussed in more depth.

The need to be clear about how we plan care is important for a number of reasons that are often cited in policy documents and government guidelines. In general there are three main responsibilities that all of us have when carrying out practice in health and social care:

- Firstly, 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.
Secondly, we are accountable to our managers and team members in delivering a good quality service to the local community.

Thirdly, we are becoming more and more legally accountable for our practice to our professional bodies and to the government in the form of national guidelines within which we all practice. It is important to know what those laws and guidelines are but it is also just as important to be able to put them into practice every day.

These levels of responsibility will be referred to throughout this book and in each particular area of care planning. However, before we can discuss day-to-day care planning it is necessary to set the scene with some background theory.

Levels of responsibility and a philosophy of care

A philosophy of care is a broad statement that will identify the purpose and theoretical underpinnings of a particular practice. It should be made visible to all who use or work within that service. Milly Smith (2004: 64) identifies a philosophy as ‘the beliefs and values that shape the way each of us thinks and acts’. However, it is not only our individual philosophies that are important but how they work within the teams that we are all part of. A philosophy of care should therefore state the intention of the service and how people within it are going to go about providing such a service. In many areas of practice there will be slightly different philosophies, but you should be able to identify the basic ingredients of purpose and intention from among them. This will later be emphasized when you look at the guidance for that particular practice, which will in turn be based on evidence-based practice – i.e. research, policy, law. Social work practice, for example, is based on a set of values that all social care workers should work towards providing, including:

- human dignity and worth – respecting and valuing individual needs;
- social justice – ensuring fair access to services;
- service to humanity – ensuring society is taking care of its members;
- integrity – providing honest and accurate advice and support without judging a person or group;
- competence – maintaining skills and knowledge in order to provide good quality care.

Codes of ethics

Professional organizations often provide a code of ethics (and/or practice) which will set out what a person can expect when receiving care from services provided by that organization and can be used to remove people from the professional register if not adhered to. For example, the Nursing and Midwifery Council (NMC) allows anyone to check whether a person is currently registered with the Council by simply typing in their name on the NMC online database, and all employers are expected to check that
registrations are up to date. The new NMC (2008: 1) *Standards of Conduct, Performance and Ethics for Nurses and Midwives* includes the following brief guidelines:

*The people in your care must be able to trust you with their health and well-being.*

To justify that trust you must:

- Make the care of people your first concern, treating them as individuals and respecting their dignity.
- Work with others to protect and promote the health and wellbeing of those in your care, their families and carers and the wider community.
- Provide a high standard of practice at all times.
- Be open and honest, act with integrity and uphold the reputation of your profession.

A philosophy of care should therefore outline the principles of care that a person can expect from a service and to which that service can be held accountable. Often, managers will ask for an audit of the case notes to see whether the philosophy of care is being implemented. Where there is no philosophy, guidance such as a clinical and/or social governance framework may be used or other evidence-based practice guidelines (e.g. the Single Assessment Process or SAP) (DoH 2002b). The SAP was developed from the *National Service Framework for Older People* (DoH 2001c) and is an effort to improve the quality of older people’s care by taking a person-centred approach. Full details of the SAP can be obtained from the Department of Health (DoH) website. For the purpose of this book the SAP has been used as a guideline for all individual care planning as evidence of good practice and to develop the sample documentation used which can also be found in the appendix.

It is important to remember that no matter how experienced a practitioner is, there can never be enough care planning practice and there is never a perfect care plan, but we can always strive to achieve the best possible quality care for our clients and our documentation is one of the main ways of providing evidence for this. Although all documentation should remain confidential, you must be aware that if there is an incident in which practice is called into question it is your documentation that will be taken away, scrutinized and will ultimately justify the quality of your care.

Care pathways

To help people to understand the difference between a care plan and a care pathway readers need to become familiar with this term and what it means. Care pathways are previously designed care processes that are focused on a particular disease or service provision. Their aim is to improve the quality of service provision, but rather than focusing on the person, they focus on the standard of service a person can expect to receive. Their value is therefore in the standardization of care to an acceptable level but they do not teach people how to plan care on an individual basis. For more information, examples and checklists on care pathways see DoH (2003d). Care pathways may already exist in your areas of practice.
Practice point: the philosophy of care

The philosophy of care in each individual practice area may be slightly different or more focused on one particular aspect of care. Philosophies of care are not always very evident to staff or clients although they can often be seen posted on a wall at the entrance to a building or ward. It is useful to try and find out where you can find the philosophy of care in your own workplace and hence be able to inform clients and their carers of what they can expect from your service.

Components of a caseload audit

While we all complain about there being too much paperwork, it should be recognized why there is a need for such paperwork in the health and social care professions. Your documentation demonstrates the quality of your work and without such evidence it would be difficult to justify your professional practice. A caseload audit helps us to improve our practice by identifying flaws in the system and developing ways to improve:

Audit is one component of the risk management process, the aim of which is the promotion of quality. If improvements are identified and made in the processes and outcomes of healthcare, risks to the patients/clients are minimised and costs to the employer are reduced.

(NMC 2007: 3)

The main components of what will be audited in a person's case notes are:

- general information obtained (e.g. name, date of birth, address, medication, GP, dependants);
- next of kin/lasting power of attorney/advocate;
- risk assessment (signed and dated by care coordinator and client);
- holistic assessment of need (signed and dated by care coordinator and client);
- evidence of client involvement (e.g. signature, own words used);
- crisis plan/advance statement signed and dated by care coordinator and client or advocate;
- daily record of interventions signed, dated, and designation provided;
- additional information (e.g. letter from/to GP, test results firmly secured in appropriate sections);
- a record of regular evaluation and reviews of the care plan;
- named care coordinator;
- other agencies involved identified and included in the review of the care plan with contact details recorded.

Some other basic guidelines that are transferable across all disciplines can be found in guidance on record-keeping from the NMC (2007: 2). Records should:
be factual, consistent and accurately written in a way that the meaning is clear;
be recorded as soon as possible after an event has occurred, providing current information on the condition of the patient/client;
be recorded clearly and in such a way that the text cannot be erased or deleted without a record of change;
be recorded in such a manner that any justifiable alterations or additions are dated, timed and signed or clearly attributed to a named person in an identifiable role in such a way that the original entry can still be read;
be accurately dated, timed and signed with a signature printed alongside the first entry where this is a written record and attributed to a named person with an identifiable role where this is an electronic record;
not include abbreviations, jargon, meaningless phrases, irrelevant speculation, offensive or subjective statements;
be readable when photocopied or scanned;
be recorded wherever possible with the involvement of the patient/client or their carer;
be recorded in terms that the patient/client can understand;
be consecutive.

Audit is therefore a quality measure that helps us to check our care plans and supporting documentation and to ensure that we adhere to a good standard of record-keeping.

Models and theories of health and social care

The World Health Organization (WHO 1998) monitors health inequalities across the world as part of its role in improving the basic human rights of people and reducing the cost burden of ill health. However, locally, it is the role of local health and social care commissioning groups to identify local health and social care needs and provide resources to address them. This is discussed in more detail in Chapter 7. It is important to become familiar with the different models and ways of working. These can vary from organization to organization, from team to team and from individual to individual, but everyone who is involved in health and social care should be aware of their local policy guidelines and ensure that they are implemented. McKenna (1997) identifies the wide variety of interpretation of these models and theories among professionals. He suggests that there needs to be some basic definitions in order to clarify meaning:

- a philosophy is an overall approach to providing care that is based upon the principles of knowledge and theory;
- a theory is a scientifically studied concept that in most instances has been researched and can be proven;
- a model is a more basic or scaled down version of a theory which may or may not be based upon research;
A framework is a visible process outline that can be used in everyday practice and may not be linked to a particular theory but can be used to attach to a theory or theories – i.e. a model.

Many policies that now inform our practice are based on government guidelines and models of health and social care delivery. These models fall into the following main categories (Tones 2001; Dziegielewski 2004):

- **The (bio)medical model**, which focuses on recognizing and treating signs and symptoms of disease. This model is used mainly by doctors and those working in the medical profession, especially where complex physical needs are involved.

- **The social model**, which focuses on developing the strengths and skills of individuals or groups to overcome disability and/or impairment. This model is used more widely in social care and where people suffer from a disability or long-term condition. The focus here is not upon cure but upon recovery as far as the person is able.

- **The holistic model**, which considers physical, social, psychological, spiritual and environmental needs to help the person to become more empowered over their lives. This model could be used in acute and community settings but is difficult to implement in full, given restrictions of resources and time.

- **The bio-psychosocial model**, which looks at the three main areas of people’s lives (the biological, psychological and social), and attempts to incorporate a holistic approach. However this model is not truly holistic as it reduces people to three aspects of living, perhaps at the expense of others.

- **The empowerment model**, which looks at wider influences on individual health and recognizes that some of these influences may be outside the control of the individual. Encouraging adaptation to a given environment empowers and involves the person in need of care and helps them to develop skills in their own health promotion.

It could be argued from the brief outlines above that the bio-psychosocial approach is far better than the biomedical or social models and is perhaps a more realistic way of developing and planning care. However, all these models can lead to some areas of a person’s life being excluded if they do not fit into a certain category. This scientific approach may ignore the whole person and the interpretation of the self by the client or patient. For example, spiritual care and what people believe in as individuals is often different from social care and the way in which groups or cultures might behave. Individual needs can therefore be ignored if we treat people simply as being part of a group (e.g. old, young, female, male etc.). It is important to remember therefore that spiritual care is not just about religion but about how a person sees themselves. This may indeed spring from religious beliefs about what it is to be human or about the personhood of the client, which can be described as how the person understands themselves through the eyes of others – for example, if a child is constantly told it is lazy by its parents the child eventually believes that it is lazy. This concept of personhood embraces spirituality and borders between psychological and social health, and is often ignored or simply overlooked. Kitwood (1997: 47) calls this...
'malignant social psychology', where whole groups of people can ignore the basic human need of maintaining personhood. Greenstreet (2006) suggests that personhood is an integral part of the whole person in which spirituality connects together as a whole (see Figure 1.1).

**Figure 1.1** A holistic approach to care planning

**Activity 1.1**

A classic example of how we ignore personhood can be found when a patient enters a hospital ward. Consider your own area of practice to see if any of the following apply. Patients can feel restricted in:

- Choosing what clothes to wear
- Choosing what foods to eat
- Choosing when to eat
- Choosing when to wake and when to go to sleep
- Choosing what personal belongings to take
- Choosing what name to be called
You will have seen from Activity 1.1 that it is easy to strip people of their identity and make them conform to the rules of the hospital or care home. This issue has been studied through the work of the social scientist Erving Goffman (1961) on institutionalization and does not apply just to health and social care settings but can be found in many of our institutions across the country (e.g. schools and other large organizations). Loss of personhood can lead to a loss of empowerment and control over one’s health which is important to restore or enable recovery (Greenstreet 2006). A holistic model is therefore more focused on the spiritual needs of the person as well as their bio-psychosocial needs, but this approach could fail if organizational needs are not also considered. In the UK, organizations such as the NHS and social services provide the majority of care but are limited in terms of money and resources (DoH 1997). It is therefore important to recognize this limitation in balancing needs with resources and creating realistic care plans that can be delivered in practice. This care planning process at the organizational level is known as clinical/social governance and is discussed in more detail in Chapter 7. In addressing the difficulties encountered with other models of care planning we will therefore follow an empowerment model of health and social care planning that has been developed specifically for this book from the theoretical background identified above. Should you wish to find out more about the background theory to care planning, the references provided in this book will help you to explore the literature further.

An empowerment model of health and social care planning

Empowerment seeks to help a person gain greater control over their health and social needs by taking a more holistic approach to providing support and information (Lloyd 2007). Tones (2001) suggests that an empowerment model must recognize the aspects of a person’s needs shown in Figure 1.2. The shaded boxes identify where a person may be helped to have more control over their own lives, and the remaining areas are those more dependent on local and national policy. Empowering practice therefore requires a collaborative approach between the person, the practitioner and the local service providers in order to address a person’s needs and access appropriate resources. Holistic or empowering practice cannot therefore be done to a person but rather is a theoretical or philosophical approach to working with people to ensure that all their needs are being met wherever possible.

In all models of health and social care delivery the consumer or client and their carer are now being encouraged to have a greater say in how their care is delivered and managed (DoH 2006b). However, the client or consumer and their carers still need to rely on the support and guidance of the practitioner who is coordinating the care, the primary health care team and the local authority to identify their needs and make appropriate provision for those needs (DoH 1997, 2001b, 2006b). The health or social care worker can play an important role as advocate for people in helping them to access the most appropriate care for their individual needs. The QAA (2006: 5) states that health and social care students/practitioners should be able to use their knowledge and skills to:
<table>
<thead>
<tr>
<th>Health and social care public policy and law (e.g. Mental Capacity Act 2005)</th>
<th>Physical needs Life skills Health skills Self-regulatory skills</th>
<th>Lobbying, advocacy and mediation from local groups (e.g. voluntary organizations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological needs Reframing and adjustment of personal beliefs and attitudes</td>
<td>The individual person</td>
<td>Social needs Relationships and community empowerment, including families, teams and services</td>
</tr>
<tr>
<td>Social, economic and environmental issues identified and addressed (e.g. access to health and social care, public transport etc.)</td>
<td>Spiritual needs Locus of control Self-efficacy Health literacy</td>
<td>Critical consciousness-raising of health and social care inequalities identified from lobbying and evidence-based practice (research)</td>
</tr>
</tbody>
</table>

**Figure 1.2** An empowerment model of health and social care (adapted from Tones 2001)

- work with clients and patients to consider the range of activities that are appropriate;
- plan care and do so holistically;
- record judgements and decisions clearly.

This indicates that as practitioners we need to be able to work with individual clients to involve them in their own care needs assessment and to help them choose from the options available to them within any given health or social care environment. Sometimes, if the options are too limited or unsuitable to meet the individual person's needs, we may need to help them apply for other resources such as direct payments so that they can obtain help in meeting their needs. Direct payments are a way of helping people to become more independent of services, at the same time empowering them to take more responsibility for their own requirements. These payments are organized and monitored by local authorities and although they represent a good attempt at addressing holistic care needs and developing choice and control, they are only available for purchasing social care needs at this moment in time (DoH 2006a).

**Models and frameworks for care planning**

The difference between 'models' and 'frameworks' is sometimes difficult to define and the terms may even be used interchangeably (McKenna 1997), but in general a framework is an outline or structure onto which we can attach a model. A robust model will be based upon theoretical and/or evidence-based practice (research). So whether we follow a medical, social, bio-psychosocial or empowerment model we will use our
knowledge and skills of that model to fill out the framework of the care plan. There are some slight variations on care planning frameworks but they can be seen as being fairly similar, as shown in Table 1.1.

Table 1.1 Care planning frameworks (adapted from Dziegielewski 2004)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Process</th>
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<tbody>
<tr>
<td>APIE</td>
<td>Assess current needs/problems presented upon referral/admission. Plan goals and outcomes to address needs and increase independence/recovery. Implement plans agreed with the client and reflect upon practice interventions/observations. Evaluate the whole process with the multidisciplinary team and the client.</td>
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<tr>
<td>PIRP</td>
<td>Presenting problem(s) upon referral/admission. Intervention to be carried out to increase independence/recovery. Responses to the intervention from the client. Plan to include client responses and review interventions.</td>
</tr>
<tr>
<td>SOAP and SOAPIER</td>
<td>Subjective information from referral/admission for health and social care provision. Objective information from client (actual words) and any diagnostic tests/assessment. Assessment of need/goals to be achieved to increase independence/recovery. Planning interventions to address needs/goals. Implementation of the plan in conjunction with the client and other agencies. Evaluation of the care planning process. Response of the client to the process.</td>
</tr>
<tr>
<td>DAP and DAPE</td>
<td>Data gathered upon referral/admission. Assessment of the client's needs/problems. Planning to address client's needs/problems and increase independence/recovery. Evaluation and education – information provided in meeting the above needs.</td>
</tr>
</tbody>
</table>

For the purpose of this book we will be using the APIE framework because it is a very familiar one to many people in health and social care practice and the stages help us to identify what needs to be achieved quickly and efficiently. The APIE framework is divided into four stages, as shown in Figure 1.3.

The stages flow into each other rather than following a linear pathway so it is important to recognize that care planning can be a 'spiral' process with many twists and turns throughout the course of a person's care plan. You may need to focus a lot
of attention on the assessment stage at first, but all the other stages are just as important for the care plan to work. Many health and social care textbooks focus on the assessment stage and will help you to identify a person’s individual needs; however, this is a rather useless exercise if you do not know how to follow the rest of the framework. You may find that as things develop you will need to change the care plan at short notice or re-assess a particular area of care.

The model used in this book to build on the APIE framework is the empowerment model, which helps us to stay focused on the needs of the individual as well as the needs of the organization.

**Activity 1.2**

How many assessment tools are used in your area of practice and how many of those are you familiar with? You will need to discuss your findings with a mentor or manager. Some assessment tools require training which you may identify as a need for your own continual professional development (CPD).

A multi-professional approach

In many health and social policy texts the World Health Organization’s (1978: 1) Declaration of Alma-Ata, USSR is often cited as providing an agreed definition of health, which includes a whole-person or holistic approach to care as: ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’.
This indicates that practitioners should not focus purely upon illness or disability but on the strengths of individual people and their environments. Many models for care provision are now following a multidisciplinary/multi-professional route to avoid duplication and to improve communication between services.

Components of a care plan

The care planning process consists of at least five pieces of documentation:

- 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.
- A holistic or bio-psycho-social assessment which seeks more in-depth information on the person’s needs.
- A risk assessment to identify need and prioritize risk.
- A care plan which outlines needs identifies plans or goals to address those needs, implements certain actions to achieve those goals and evaluates the whole process. The care plan is devised using a SMART approach: specific, measurable, achievable, realistic and timely. This acronym helps us to remember how to write a care plan and will be discussed in more detail in Chapter 3.
- A record sheet to document activities in relation to the care plan and as evidence for the evaluation stage.

These are the documents we will be using to complete a care plan for a fictitious client called Brian throughout the rest of this book. (They are also available in the appendix for photocopying.) Remember that these documents are for practise purposes only and you will need to make sure that you use the appropriate documentation for your area of practice. However, documents of this type all tend to follow a similar outline.

Example of initial assessment documentation

<table>
<thead>
<tr>
<th>Completed by .................................................. Date .........................</th>
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<tbody>
<tr>
<td>1. Name of person being assessed</td>
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<td>Date of birth</td>
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<td>2. Name of GP</td>
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3. Name of next of kin

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<th>Address of next of kin</th>
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| Telephone numbers(s) |

4. Marital status

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<th>Married</th>
<th>Single</th>
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<td>Divorced</td>
<td>Civil partnership</td>
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<td>Other ........................................</td>
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5. Religion

6. Medication currently being taken

(add separate sheet if necessary)

7. Disabilities or impairments (e.g. wears glasses, uses a hearing aid etc.)

8. Any known allergies?

9. Dietary requirements

10. Any dependants (e.g. children, elderly parents etc.)?

11. Other agencies involved (e.g. social worker, probation etc.)

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<tr>
<th>Contact details of dependants</th>
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| Contact details of other agencies involved |

12. Current or previous occupation

13. Any other requirements/urgent needs (e.g. diabetes, epilepsy)

| Personal assessment |

<table>
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<tr>
<th>Assessment information</th>
<th>Observations (please complete all boxes to show that they have been addressed)</th>
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<tr>
<td>Biological: do you have any needs in the following areas?</td>
<td>Please state in the person’s own words where possible and record any measurements (including frequency where required)</td>
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Breathing
### Eating (including appetite) and food preparation

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### Sleeping and rest

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### Washing and bathing

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### Dressing

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### Moving and walking

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### Exercise and activities

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### Hygiene and self-care (e.g. hair, nails, teeth, using the toilet, skin care etc.)

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### Maintaining/losing weight

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### Vital signs: blood pressure, temperature, pulse, skin colour and texture

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### Psychological: do you have any needs in the following areas?

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<tr>
<td>Memory</td>
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|     |
| Thought disturbances |

|     |
| Moods and emotions |
Beliefs about others

Perceptions

Sensations (e.g. taste, touch, smell, sight and sound)

Social: do you have any needs in the following areas?

Family support

Friends/peer support

Meaningful occupation (including work, hobbies etc.)

Group membership

Recreational activities

Significant relationships

Spiritual: do you have any needs in the following areas?

Personal religious beliefs

Personal cultural beliefs
## General risk assessment

<table>
<thead>
<tr>
<th>Area of risk</th>
<th>Current needs</th>
<th>Positive risks taken</th>
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</thead>
<tbody>
<tr>
<td>Hypothermia</td>
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<td>Neglect</td>
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</tr>
<tr>
<td>Abuse, physical, emotional, financial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploitation</td>
<td></td>
<td></td>
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<tr>
<td>Slips, trips and falls</td>
<td></td>
<td></td>
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<tr>
<td>Isolation</td>
<td></td>
<td></td>
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<tr>
<td>Nutrition and hydration</td>
<td></td>
<td></td>
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<tr>
<td>Suicide/self-harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence/aggression</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Care plan using the SMART formula (if only using one sheet remember to number needs in order of priority)

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Needs</strong> (Specific: in person's own words where possible)</td>
<td><strong>Goals</strong> (Measurable and achievable: including any assessment tool measurements)</td>
</tr>
</tbody>
</table>

| Signatures | Care coordinator | Client | Date |

Daily record sheet: to be completed by care coordinator or by designated person and countersigned by care coordinator

| Date | Record to be made at least once daily or on every contact | Signature and designation |

An empowerment model of care planning must consider the needs of the individual and the resources available to meet those needs. It is ineffective not to consider these two basic components in equal weighting. Focusing on one area of need without
identifying the resources available to meet that need can lead to failure in the care plan before you even begin. The constant balancing act between resources and needs can be addressed through regular contact with your colleagues and by working as a team towards meeting individual needs (see Chapter 3 for more information on working in a multidisciplinary team). Often needs and resources are diverse and some creativity may be required in matching them up. This is the skill of an experienced practitioner which we all have to learn, sometimes through trial and error or by taking positive risks. The process involves a constant awareness of being person-centred, identifying diverse needs or skills and team working towards achieving specified individual goals. Consider the following hot topic before we go on to explore these ideas in more detail.

**Hot topic**

There will be legal and ethical implications when we identify that we cannot meet particular individual needs. How might we overcome this problem and what laws might be used to ensure the needs of our clients are met? You are not expected to know every law available but you should be familiar with some of the laws in everyday use in your own areas of practice (e.g. The Mental Health Act, The Mental Capacity Act, The Human Rights Act etc.).

Taking a person-centred approach

The empowerment model should always centre on individual needs, paying full attention to biological, psychological, sociological and spiritual needs to maintain personhood (Kitwood 1997; Greenstreet 2006). This requires a flexible approach so that we do not try to slot people into particular categories. Each person is unique in their skills and abilities and it is our responsibility to help them use those abilities to aid their recovery. Wherever possible people should be encouraged to make their own decisions based on the best available evidence we can present to them. However, they also have the right to make the wrong decision (under the Mental Capacity Act 2005) and we should not deny our help to them if they do. Too many people are denied services because they do not fit into a particular category or label within our organizations. It is well worth remembering the five principles of the Mental Capacity Act 2005 when planning individualized care:

1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
2. A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
3. Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
4. Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.
Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

Recognizing strengths and respecting diversity

An empowerment model can only work by recognizing strengths and respecting individual diversity (Lloyd 2009). In order to be empowered, a person must feel in control of their own destiny within their particular spiritual and sociological environment. When we take someone out of their familiar environment we weaken them by taking away their resources. This is why it is important to help people stay as close to their own homes as possible and in a safe and comfortable environment. This will be discussed in more detail in Chapters 3 and 4. Diverse skills within a team of practitioners should also be identified and matched with the needs of the individual person. In this way, the best care can be provided using the skills of the most appropriate practitioner for that person. The DoH (2008a) has refocused the care programme approach to be more person-centred by recognizing individual needs and strengths. This approach requires that there is more choice and more options for people to choose from rather than a standard approach to care planning. It can be very difficult therefore in practice to ensure that individual needs, strengths and wishes have been addressed without some model to remind us.

Working in partnership with individuals and teams towards common goals

An empowerment model requires that all members of the health and social care team work together to ensure that good quality care is provided according to their clinical and social governance agendas (see Chapter 7 for more information on clinical and social governance). This includes ensuring that the patient or client features strongly throughout the whole process (Lloyd 2009). This is not a sole venture but requires the support or ‘reciprocal determinism’ (Tones 2001: 7) of family, friends, other professionals and resources. This is discussed in more detail in Chapter 6, but requires maintaining the individual person at the centre of the process and then using our resources, knowledge and skills to support them. Figure 1.4 outlines the whole care planning framework with the empowerment model attached.

As can be seen in Figure 1.4, the whole person and their support system must remain at the centre of care planning. The different stages require the practitioner to take different approaches to providing care that most suits the individual at the centre of the care plan. All of the stages are just as important as each other and each stage requires different skills. The main four stages of care planning each have their own unique contribution to the process that if not addressed will contribute to poor quality care being provided. The following points outline the main practice areas of each stage.

- **Assessment** is mentioned in all the policy documents as a right of most individuals and their carers in need. This can be carried out using assessment tools to produce an in-depth analysis of the person’s need. Assessment requires good communication...
skills and the ability to observe physical, social and psychological changes. The appropriate documentation must be used and must be available as evidence of involvement.

- **Planning** requires the ability to identify goals with the person in need and offer a choice of approaches or interventions to address those goals. Goals can be short- or long-term but it is important that they are written in a way that the individual person understands. They should also be carried out as close to home as possible using the strengths and supports that are already familiar and available to the person.

- **Implementation** of the care plan requires identifying ways to achieve goals that will demonstrate to the person (and our managers) that the health and social care provided will lead to recovery for the individual. These outcomes should be measurable and focused on individual need, so may involve some positive risk-taking.

- **Evaluation** is the stage where the whole care plan is reviewed formally with the team who are contributing to the delivery of health and social care. This may be only one or two people in less complex cases. The evaluation stage reminds us that we must re-assess the person’s needs at regular intervals to ensure that the current care plan is still required and to identify any changes that have taken place in the meantime. If we do not evaluate our care formally we may not notice subtle changes that take place over a period of time that can indicate recovery, however
small. The opportunity to discuss the overall care plan during supervision is necessary to help us find our blind spots or to find alternative ways of supporting the client.

The following chapters will look in more detail at each stage of the care planning process and will identify the skills and knowledge that will help you to provide person-centred care for an individual.

**Activity 1.3**

Before moving on to the next chapter, take some time to explore current care planning practices in your own area of work.

- Are there many different types of care planning taking place or is there one main care plan that all practitioners work to?
- How involved is the person in creating their own care plan and how would you know this?

**Chapter summary**

- Models and frameworks help us to use knowledge and skills in practice.
- Care planning needs to be aware of a whole-system approach.
- An empowerment model helps us to keep the individual at the centre of the process.
- The care planning process is a continuous one of assessment and evaluation in practice.

**Self-assessment questions**

- Why do we need a framework to outline the process?
- What are the five main components of the care planning documentation?
- Why is it important to maintain personhood during care planning?
- Identify the four main areas of a basic care plan.