Assessment and Care Plan Policy

Turas Training

Approval date:

Revision date:

1.Responsibility for approval of policy	Management Team
2.Responsibility for implementation	Project Coordinator
3.Responsibility for ensuring review	Project Coordinator

1. Policy Statement

1.1. Turas is committed to good practice regarding assessment and care planning. Turas aims to provide a consistent standard of support to each service user.

2. Purpose

2.1. To provide an assessment procedure that will support services users to explore their substance use and related problems, needs, goals and motivation for change.

2.2. To outline how service users will be facilitated by a worker to identify goals and develop a care plan involving the appropriate services to meet such goals.

3. Scope

3.1. This policy will be applied to all service users who meet the services criteria for key working / case management.

3.2. This policy should be read in conjunction with the organisations: Case Management and Key Working Policy; Case Notes and Correspondence Policy; Case Meeting Policy, Risk Assessment policy and Confidentiality Policy.

4. Roles and Responsibilities

4.1. It is the responsibility of the manager to ensure that:

- 4.1.1. Staff are provided with adequate time and resources, and a suitable environment to undertake assessments and care planning.
- 4.1.2. Staff are adequately trained in the use of assessment and care planning tools.
- 4.1.3. Files are regularly audited.
- 4.1.4. Any barriers to an individual's care plan that have been raised by a staff member will be responded to with the intention of resolving the issue. Where these can not be resolved by the service then these will be bought to the Treatment & Rehab group or Task Force.

4.2. It is the responsibility of staff to ensure that:

- 4.2.1. Assessment and care planning is undertaken in accordance with the professional standards and processes as described in this policy.
- 4.2.2. All files are maintained to a high standard, as described in the Data Protection Policy and Case Notes and Correspondence Policy.
- 4.2.3. Any barriers or impediments to the progression of the services user's care plan will be brought to the attention of the manager as soon as possible.

5. Principles

5.1. Assessment and care planning can create opportunities for developing positive relationships. The aim of all interventions is to build a trusting and personalised professional relationship.

5.2. Assessments should be service user lead (see section 6), incorporating principles of confidentiality, dignity and respect.

5.3. The service user should have no more than one case manager and one interagency care plan.

5.4. Assessments will follow the service user, transferring from one lead agency to another.

5.5. Care planning should be done in conjunction with other agencies involved with the service user, as described in the Case Management and Key Working Protocols.

6. Conducting Service User Lead Assessments

6.1. All interventions relating to assessment will be service user lead. They will;

- 6.1.1. Be appropriate to the individual's personal goals and level of motivation.
- 6.1.2. Actively engage the service user in the process.
- 6.1.3. Be conducted at a pace conducive to the staff / service user relationship and may be conducted over a number of sessions where relevant.
- 6.1.4. Be conducted in an open, conversational way.
- 6.1.5. Be conducted sensitively.

6.1.6. Be conducted with respect for service user dignity. The service user will be informed:
6.1.6.1. Of the reason all information is sought
6.1.6.2. That they are not obliged to disclose information if they do not wish to and whether this will affect the services that can be provided.

6.2. Written comments will be easily understood by all who may potentially read the document, including the service user. Wherever possible the services user's own words will be recorded.

6.3. Staff can support a more conversational assessment process
6.3.1. Through familiarity with the assessment form.
6.3.2. By balancing responsiveness to the service user's priority issues with a structured conversation guided by the assessment tool.

6.4. Staff can proactively work with service user ambivalence through techniques such as solution focused therapy / motivation interviewing / other.

7. Initial Assessment

7.1. The purpose of the initial assessment is to:
7.1.1. Determine the seriousness and urgency of the drug / alcohol problem and other issues presenting, the service user's motivation to engage, and any immediate risk factors.
7.1.2. Establish which service is most appropriate for the service user: various treatment options including harm reduction, stabilisation, detoxification and rehabilitation will be explained to the service user.
7.1.3. Determine whether the individual would benefit from a key worker or case manager

7.2. All service users will be provided with an initial assessment as soon as possible, within the first two or three contact meeting of first accessing the service.

7.3. After the initial assessment the organisation should know the following:
7.3.1. Whether their most pressing needs can be met by Turas or whether onward referral is more appropriate.
7.3.2. The seriousness / urgency of the drug / alcohol problem, and the service user's motivation to engage.
7.3.3. Whether the service user has an existing key worker / case manager.
7.3.4. Whether the service user would like a key worker / case manager.
7.3.5. What other services are engaged with the service user. Key contact names and phone numbers should be recorded.

7.4. The initial assessment aims to be brief and relatively informal; if the individual is deemed to be appropriate for key working or case management (i.e. requests this service and has the need for it) then a comprehensive assessment will be undertaken prior to a care plan being established.

7.5. The initial assessment will be recorded on Salesforce, as with all assessments.

7.6. The initial assessment will be conducted as follows:
7.6.1. Initial assessments can be completed verbally on first contact and filled in by the worker at a later point if required.
7.6.2. In the case of referrals, initial assessment can either be undertaken with the referrer or the service user over the phone or at initial contact through an interview.
7.6.3. On outreach, assessments will be undertaken informally, with referrals made as required.
7.6.4. In a drop-in setting, assessment will be conducted as appropriate opportunity presents.

7.7. If the outcome is that another service is best placed to meet the service user's needs; the staff member should ensure they have sufficient information and service user consent to make an appropriate referral. The referral should be made and where possible initial service user contact with the provider should be supported.

8. Service User Consent to Share Information Form

8.1. Prior to the beginning the initial assessment the service user will be informed about the service's Confidentiality Policy and asked to sign a Consent to Share Information Form (appendixed). This form provides permission for information to be used in relation to care planning for a period of six months, after which the form will need to be completed again.

8.2. The service user should read or be read all the information on the form prior to signing and should also be informed of the following:

8.2.1. The organisation will make every reasonable attempt to get the service users verbal consent prior to any information being shared with another service and will be informed of:
- 8.2.1.1. The third party with whom the information is to be shared.
- 8.2.1.2. Whether the third party has a confidentiality policy.
- 8.2.1.3. The reason for sharing the information.
- 8.2.1.4. That Turas has no control over the information once it is given to a third party.

8.2.2. That the service user can withdraw consent at any time, simply by asking their key worker / case manager.
- 8.2.2.1. The service user should be asked to sign the 'withdrawal of consent to share' section in the Consent to Share Information Form appendixed below.

9. Work to be Undertaken Prior to the Comprehensive Assessment

9.1. Prior to the comprehensive assessment being undertaken staff should contact services involved with the service user to check:
- 9.1.1. Whether a case manager has been assigned. If there is a case manager then there may be no need for a comprehensive assessment. Instead the task will be to engage the service user and case manager in agreeing how Turas can contribute to the existing care plan.
- 9.1.2. If there are two agencies wishing to case manage this should be resolved as described in the case management and key working policy.
- 9.1.3. If there is no case manager but a comprehensive assessment has been undertaken, staff will ask for a copy of this to avoid replication.

9.2. Staff should ensure that there is no overlap between assessments, i.e. that any information from the initial assessment is carried over into the comprehensive assessment.

10. Comprehensive Assessment

10.1. The comprehensive assessment is to establish the needs of the service user and their and goals. This is the foundation for the development of an interagency care plan.

10.2. The comprehensive assessment should identify other relevant services which the service user may be working that could have a role in shared care planning.

10.3. The comprehensive assessment will be carried out within the first month of being in the service. If the service user presents with crisis issues these should be dealt with. However the reason for the assessment and care plan, as well as the need to do this will be discussed and a time scheduled.

10.4. The comprehensive assessment should be undertaken by the nominated key worker.

10.5. The following standardised assessment form used is available on the CRM Salesforce system.

10.6. The assessment will be done in a suitable location i.e. one that is quiet and private, and where there will be no interruptions.

10.7. The assessment should be undertaken in line with section 6 of this policy.

10.8. The assessment should also include a risk assessment and safety plan that reviews any dangers and risks to the service user, such as suicide/self injury, violence, overdose etc. If any risks exist then a plan to manage these is agreed as part of the assessment.

10.9. For clarity of purpose at the end of each session, the work done will be positively summarized and any progress / outstanding issues recorded in the care plan.
Towards the end of the assessment staff will provide an overview that draws on the information provided, the goals stated and the emerging care plan. Staff will use their professional judgement about what to include, exclude, emphasize and deemphasize. Feedback should be objective, pragmatic and also optimistic.

10.10. After the comprehensive assessment the organisation should know the following:
- 10.10.1. Drug and alcohol use and measurement of severity of use.
- 10.10.2. An assessment of the service users place on the wheel of change and the degree to which they are ready and willing to participate in change.
- 10.10.3. Needs and goals in the following areas: drug and alcohol use, general health, mental health, employment, community integration, accommodation and independent living, education and training, legal issues, family support and childcare, and budgeting and money management.
- 10.10.4. Specialist services required.

10.11. Following the session the worker should enter the information into Salesforce and ensure details are correct.

10.12. All service users will be offered support and follow-up in the case that any of the questions or issues raised throughout the assessment has caused upset or concern.

11. Developing a Care Plan

11.1. A care plan will:

- 11.1.1. Be developed by a qualified key worker in collaboration with the service user.
- 11.1.2. Record as closely as possible the needs and goals of the service user as they have described them, though it may be necessary for the worker to suggest adapting entries. Entries in the care plan should not be recorded without agreement of the service user.
- 11.1.3. Be part of an on-going process to accommodate changing needs.
- 11.1.4. Reflect both long and short term goals of the service user. Long term goals can be broken into shorter term, more achievable goals.

11.2. The steps to establishing an interagency care plan are:

- 11.2.1. Contact all services to be involved in the interagency care plan including those with whom the service user is already working and those with whom there is no previous relationship.
- 11.2.2. Agree involvement in the care plan by phone or in a meeting.
- 11.2.3. Enter the main issues and goals arising from the assessment into a care plan in order of priority identified by the service user.

11.3. Where the service user is being case managed and is engaged with a prescriber around substance use (i.e. for benzodiazepines or methadone) the case manager should agree with the service user to make contact with their prescribing doctor. A copy of the full care plan should be sent with a cover note to the appropriate doctor to ensure they are aware of the care plan and to explore whether how the clinic / doctor would like to be involved in the care planning process.

11.4. In relation to each area of work the care plan requires the following fields to be completed:

- 11.4.1. Date
- 11.4.2. Objective and timescale
- 11.4.3. Who is responsible for each action, including the specific responsibilities of the service user and Case Manager / Key Worker
- 11.4.4. How will progress be measured
- 11.4.5. Work done to achieve objective
- 11.4.6. Referral: staff name and agency (the name of the key workers responsible for the action).
- 11.4.7. Outcome
- 11.4.8. Comment: (reasons achieved/not achieved)
- 11.4.9. The care plan will be signed by the Case Manager / Key Worker and the service user

11.5. All entries in the care plan should meet SMART criteria:

- 11.5.1.1. Specific: be as detailed as possible, i.e. rather than saying reduce drug use, state which drugs are being reduced and by how much.
- 11.5.2. Measurable: there will be a clear and (where possible) independent way of measuring whether an objective has been achieved.
- 11.5.3. Agreed: the goal should be agreed by the service user and the staff member, ideally the service user will be supported to generate the care plan actions wherever possible.
- 11.5.4. Realistic: both the service user and the worker should take time to reality check goals. If goals are very ambitious it may be best to stagger large goals into more short term goals.
- 11.5.5. Timed: all actions should have a clear time frame and the date of the next care plan review set.

11.6. Once the care plan is complete the actions should be addressed and reviewed in regular one-to-one sessions. When a new action is identified this should be added to the care plan with interagency communications being undertaken as required.

11.7. If the service user has any problems with the plan or any of the services involved they should be encouraged to discuss this with their case manager at the earliest opportunity.

11.8. If the case manager or key worker is not able to effectively address issues that arise through advocacy and interagency communications, they should complete a 'Gaps and Blocks' form as described in the Case Management and Key Working Policy.

11.9. The care plan should be signed and dated by both the service user and Key Worker / Case Manager

11.10. Every two months a formal care plan review should be undertaken. The date of next care plan review should be explicitly stated in the care plan at the end of the care planning session and at the end of each subsequent case review.

12. Conducting Care Plan Reviews

12.1. Care plan reviews provide an opportunity to focus and reflect on general progress towards stated long and short term goals.

12.2. A review can provide an opportunity to brainstorm blocks to progress, changes needed and additional supports required.

12.3. Generally, the care plan review will be undertaken by the case manager and service user, however there may be occasions where it is appropriate to invite other agencies.

12.4. The review should include the following questions:

- 12.4.1. Have other agencies/key workers completed tasks as agreed in the care plan?
- 12.4.2. What has been the involvement of other agencies?
- 12.4.3. Has the case manager completed tasks as agreed in the care plan?
- 12.4.4. Has the service user completed tasks as agreed in the care plan?
- 12.4.5. What has been achieved / what has been the service users progression?
- 12.4.6. What has not been achieved – what barriers exist and what changes need to be made?
- 12.4.7. What new needs and goals are emerging?

12.5. The care plan will be updated at the end of the review.

13. Onward Referral

13.1. See the Case Management and Key Working Policy for further information on onward referral.

13.2. As a general principle once a service user has a care plan and case manager this service should be continued until no longer required or wanted by the service user.

13.3. Where an onward referral or transfer of case managing duties is requested and appropriate, this should be done through a formalised, structured handover meeting.

14. Planning Aftercare

14.1. An aftercare plan will be made with a service user when they have completed their care plan and achieved their goals thereby no longer requiring case management from Turas.

14.2. Turas is committed to ensuring that aftercare is accessible to any person finishing their engagement with the service.

14.3. Aftercare will be provided in the following ways:

- 14.3.1. 1-2-1 support meetings available on request
- 14.3.2. Referral to other support service

14.4. Where aftercare requirements cannot be met by the service the service user will be referred to a more appropriate service. If a service is not available the project commits to providing aftercare supports as comprehensively as possible taking into consideration service restraints for a period of up to 6 months following case closure.

14.5. In the instance that appropriate aftercare supports are not available a Gaps and Blocks form will be completed.

Consent to Share Information Form

We would like your permission to collect and share information between workers involved in your care. We want to do this so we can understand your needs better, improve services and avoid asking you for the same information more than once. This information will only be shared on a need to know basis. This might include sharing information with your nurse, social worker or other relevant workers as agreed with yourself as part of your care plan. This agreement covers information in your assessment and care plan.

As some of the information that agencies hold about you is sensitive, they must follow the principles of the Data Protection Act. These ensure that the information agencies have is:

- Used fairly and legally
- Only used for the purposes for which it was collected
- Adequate, relevant and not excessive
- Correct and up to date
- Kept only for as long as needed
- Processed in accordance with a person's rights
- Stored safely

Your confidentiality is assured except when there is an issue around; child safety; violence to yourself or others; the courts request a report from a worker or the you inform a staff member that you have or intend to commit a criminal act.

Is there any agency which you do not want your information to be given to, if so please name the organisation/s here, and a brief reason:

_____

_____

Is there any specific information which you do not want shared with the above named agency? If so, please be specific and state the exact information which you do not want shared, and the reason:

_____

_____

I agree that personal information about me may be shared with other agencies and with other professionals. This agreement is only valid for 6 months and needs to be renewed after that.

Signature of service user _____

Date of signing this agreement _____

You can change your mind at any time by contacting one of the workers here. This will be recorded on your file and logged onto this original consent form.

Date consent withdrawn _____

Signature of worker _____