Complete Care Plan Documentation System Training Course

Standex Systems care planning training is delivered in the following 4 stages:

1. An outline of the benefits of using our system such as

- Easy to understand and follow
- Colour coded for ease of use
- All the documents you require in one place
- A pick and choose system ensuring each individual resident gets exactly the paperwork they need Person centred
- Used to evidence that the outcomes are being met
- Evidence based and up to date assessments
- Can be used in conjunction with other documentation specific to the care home's local area such as Social
- Services/ PCT/ Doctors documentation. This is stored in the same folder.
- Special print service is available if there is a particular form the care home want developing/adapting

2. The contents of the care plan system

- We go through each form individually, explaining the reason the document is in the system and it's purpose. The trainer emphasises the ‚backbone of the system' which looks at the Support Plan which is an holistic needs assessment covering Cognition, Psychological, Physical, Social/Spiritual and End of Life needs.
- If a need has been identified then a care plan can be put into place to detail what the need is, what the resident's goal is in this area and what support they need to achieve this. The care plan also allows staff to detail what level of interaction the resident have in that area, especially important in those who have dementia. We teach that the care plan should be based on the resident's choice, decision and requests.
- The trainer discusses person centred care and how this can evidenced in the plans with the correct terminology and phrasing, and of course all being done with the inclusion of the resident or their advocate. For example explaining to staff that person-centred care is a way of caring for a person as an individual with unique qualities and that the person should be helped do things for themselves as much as possible. We also teach what terminology to use and which to avoid.
- All other forms are descibed in detail to the staff during training.
- The trainer emphasises the importance of reviewing the system so as to recognise and record that outcomes may change in a person's life journey and so should be revisited.

3. The Documentation Guide

- The trainer introduces staff to the Documentation Guide and the importance of using it as a resource for new staff and existing staff who are involved in writing care plans.
- The Documentaion Guide looks at each individual form and describes in what situation the form would be used and how each form can be used to evidence which particular outcomes are being met.

The Documentation Guide also informs staff of the evidence-based tools and assessments that we use. These are detailed below:

Support Plan – Holistic Assessment based on Roper, Logan and Tierney's Activities of Daily Living. End of Life Care section developed in conjunction with Dr Jo Hockley - Nurse Consultant in Palliative Care at St Christopher's Hospice, South London.

Mental Capacity Assessment and Deprivation of Liberty form - developed in line with Mental Capacity Act 2005

Future Wishes - developed in conjunction with Dr Jo Hockley (see above)

Bowel Chart – uses the Bristol Stool Chart (Dr KW Heaton, Reader in Medicine at the University of Bristol)

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Oral Assessment Tool – based on Rattenbury, Mooney and Bowen's Oral Assessment Tool (2006)

Manual Handling – based on the Liverpool and Sefton Manual Handling Assessment (March 2009)

Falls Risk Assessment – based on ‚Falls Risk Assessment for Older People in care Homes'; Telford and Wreakin Council Primary Care Trust.

MUST Tool – produced by the Malnutrition Advisory Group, BAPEN, www.bapen.org.uk

Infection Risk Assessment – based on Northamptonshire Primary Care Trust's Infection Risk Assessment Tool for the Community (2009)

Pressure Ulcer Risk Assessment – produced by Judy Waterlow (revised 2005)

Bedrail Assessment – based on best practice guidance from the Health and Safety Executive

General Risk Assessment – based on ‚5 Steps to Risk Assessment'; Health and Safety Executive (2003)

Pain Assessment – Numeric Rating Scale and Doloplus 2 Scale for those with a cognitive impairment; adapted from ‚Nursing Home Pain Assessment Chart' Dr Jo Hockley, Bridges Initiative, St Columba's Hospice, Edinburgh (2004)

Wound Assessment – developed with Tissue Viability Nurses at University Hospitals Leicester NHS Trust (2009)

Depression Scale – based on the Geriatric Depression Scale – developed by Yesavage, JA (1982)

Dependency Profile – based on NHS Continuing Healthcare Assessment

Deterioration Scale – based on the monthly ‚Prospective Prognostic Planning Tool' (Macmillan, 2004, Foundation in Palliative Care).

4. Nurse Advisor

- The trainer explains that there is support available from the Nurse Advisor (RGN) whose responsibility it is to keep up to date with legislation and changes in best practice. This ensures that all our documents are suitable for staff to evidence that they are meeting the essential standards of quality and safety as part of section 20 regulations of the Health and Social Care Act 2008.

Duration: 2 hours

Max. persons: 12

Content:

The ***training is led by your Business Manager*** who has extensive experience of the care planning process.

Your staff will be taken through each form and given an explanation of why each form is in the system.

The ***backbone of the system is explained to the staff*** e. g. the Support Plan triggering Care Plans and all related forms such as Falls Risk, MUST Tool, Pressure Ulcer Assessment and Manual Handling followed by Daily Reports and periodic reviews.

All other forms are explained in detail such as Mental Capacity and when they should be used.

Tips, hints and advice will be given along the way on how to word the care plans and daily reports using a person-centred approach.

There is ***opportunity to ask questions throughout the session*** and this is encouraged. Each staff member will receive a certificate of attendance.

Our nurse advisor is also on hand in the office to answer any further questions after the session has been given once the team begin to use the paperwork.

Follow up training is always available if there are new staff; you wish to divide the sessions in to smaller groups, or there are more than 12 people needing to attend.

Would you like to get further information about our training offers? Or make an appointment?

Please contact our care planning experts at Standex Systems:

Phone: 01604 646 633

Fax: 01604 644 646

E-Mail: info@standexsystems.co.uk

Care Planning and Report Writing Course

"Comprehensive care plan training"
"Quality person centred care plans, and how to write them"
"Person centred and holistic care plan training for the care home sector"
"Understanding the importance of quality care planning and how to write them"

The training is for **up to 12 staff** and goes through the **importance of excellent care planning** and how to write a robust and thorough person-centred care plan.

Learning Aims

By the end of the training staff will understand the care planning process and how they can evidence that the service they are providing is:

- **Safe?** Service users, staff and visitors are protected from abuse and avoidable harm.
- **Effective?** People's care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible.
- **Caring?** Staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive?** Services are organized so that they meet people's needs.
- **Well-led?** Leadership, management and governance of the organization assures the delivery of high-quality person-centered care, supports learning and innovation, and promotes an open and fair culture.

Care plan training: 1 hour

Contents:

1) **Introductions**
2) **Disclaimer**
3) **Housekeeping**
4) **Aims and objectives of the training:**
   - What is a care plan
   - Why are they important
   - How do you write a quality care plan
   - Examples of good and bad practice
   - Evaluating your care plan
   - Key Lines of Enquiry (KLOEs) and Care Quality Commission (CQC)
5) **Products:**
   - Care planning handbook
   - Daily report handbook
   - Quick audit checklist
   - Comprehensive audit checklist

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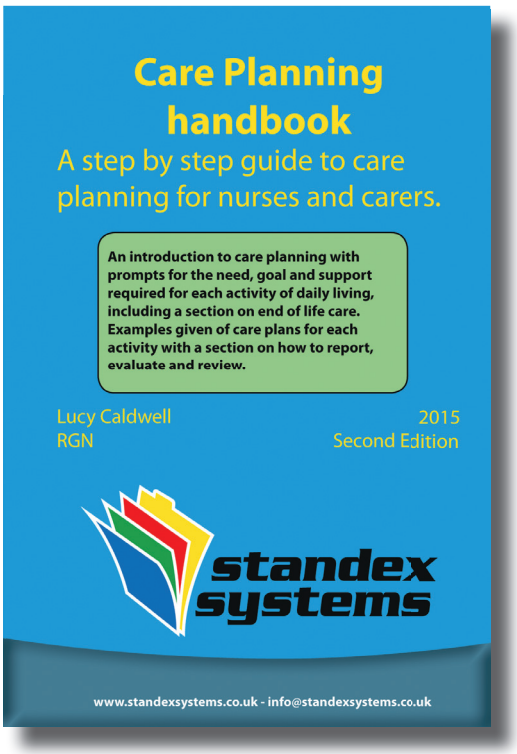
Handbooks

Care Planning Handbook

Daily Report Handbook



Care Planning Handbook
Price: £10.00 (per book)
(+Del & VAT)

Care Planning Handbook

The handbook explains what a care plan is and why they are so integral to the delivery of excellent care within the home. This easy to use care planning handbook offers a step by step guide to care planning for nurses and carers.

It looks at:

- What is a care plan?
- **Mental capacity and care planning**
- **Lasting Power of Attorney (LPA) and Deputies**
- **Deprivation of Liberty Safeguards (DoLS)**
- The care planning process
- Elements of a good care plan
- Elements of a poor care plan

Prompts are given for the need, goal and interaction required in each care plan along with **an example of how to write a care plan for each of the following areas:**

- Mental Capacity and Cognition
- Communication
- Psychological Well being
- Mobility and Falls
- Washing and Dressing
- Eating and Drinking
- Continence
- Personal Safety and Risk
- Breathing
- Skin
- Pain
- Infection Risk
- Medication and Symptom Control
- Sleeping and Nightcare
- Social Activities
- Final Days

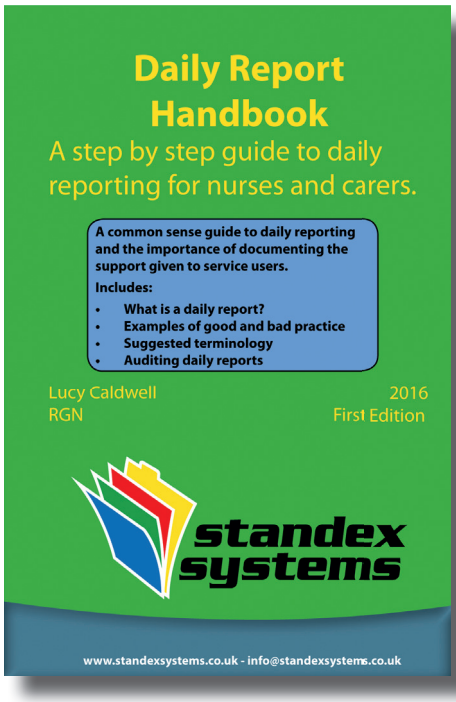
Care Planning Handbook

A common sense guide to daily reporting and the importance of documenting the support given to service users. The Daily Report Handbook is an essential reference tool for all staff involved in daily reporting. It has examples for each activity of daily living as well as general examples of what daily reports should look like.

No more 'slept well' and 'good day', instead examples of wording that truly reflects the excellent care given by staff.

Includes:

- What is a daily report?
- Examples of good and bad practice
- Suggested terminology
- Auditing daily reports



Daily Report Handbook
Price: £7.50 (per book)
(+Del & VAT)

Both handbooks are pocket sized. Ideal for all keyworkers, new starters and staff involved in care planning and daily reporting.

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