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| **Standard 1 – Strengths based practice and engaging with people** |
| * The person should always be given the opportunity to be seen on their own, face to face or virtually (via video call).
* Where it is not possible to see the person face to face due to the person’s wishes or other factors, the reasons will be recorded.
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| * There is evidence of the person with support needs being engaged with in a proportionate, strength-based manner throughout our involvement with them.
* It should reflect a whole family approach, exploring the impact of the person’s needs on the people around them.
* There should be evidence of input from professionals with appropriate expertise to understand the presenting situation.
* Neighbourhood working should be used where the person has complex or long-term conditions which would benefit from joint assessment and planning.
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| * All case recording will be person centred, with the person’s voice, wellbeing, wishes and feelings evident in their documents and records.
* The recording will show consideration of the person’s relevant background, their culture, their current or past lifestyle, their upbringing, past experiences, their current or past working experience and promote related strengths.
* The recording shows that the practitioner has centred their approach of the conversation / assessment from an understanding of what is working well with the person, their aspirations, their relationships and opportunities to sustain and develop further networks of support. There is evidence that other options have been explored other than formal services.
* The person should be given a copy of their conversation or assessment, providing a clear statement of what has been agreed. If an assessment has been completed this should outline the person’s needs and eligibility. This should be provided irrespective of their eligibility or whether they go on to receive formal support. Information and advice regarding the assessment and review process has been explained and provided to the person in a timely way.
* Relationship dynamics will have been considered, giving a voice to the person and acting in their best interests with the consideration for advocates, further communication support and cultural sensitivities if required.
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| **Standard 2 - Identifying and Management of Risks** |
| * The initial conversation, assessment, planning and case recording proportionately identifies and manages areas of risk.
* The person is kept at the centre of the risk assessment process and plans to address risk.
* Where there are identified risks, the person’s capacity to make decisions in relation to those risks is evident.
* Where there are doubts about the person’s capacity to make a decision relating to risk, a robust capacity assessment has been undertaken to inform next actions in line with the Mental Capacity Act.
* Where the person has made decisions that put them at risk, there should be robust recording of conversations with the person about the assessed risks and any actions to minimise risks and ongoing monitoring if appropriate.
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| * There has been a review of relevant case history to identify incidents, patterns and concerns where the nature of risks relate to people or children involved in the person’s support network or where the council may hold historic information.
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| * There is appropriate consideration as to whether a Risk Assessment and Management Plan (RAMP) is required where circumstances dictate a more detailed exploration of risk issues covered in routine needs assessment, reviews and support planning – The RAMP has involved the relevant people, e.g. informal support, external agencies and / or the Safeguarding team.
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| * The recording has clearly identified risks including positive risks and potential hazardous occurrences using appropriate tools e.g. DASH, S-DASH, SHERMAN, Hoarding Rating Scale and that decision making is clear, and risk management is addressed in care and support planning.
* There is evidence that risks which trigger safeguarding duties have been addressed in line with Adult Care Safeguarding Policy and Procedures and in line with Prevention duties, potential risk to others has also been considered and action taken where identified.
* There is evidence that cases with significant risks requiring ongoing monitoring and review receive appropriate line management oversight.
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| **Standard 3 - Safeguarding everyone** |
| * Safeguarding concerns are addressed effectively to support everyone to live safely, (link to safeguarding policy and procedures?) with safeguarding concerns recorded and safeguarding referrals made where appropriate.
* The response is centred around the person's wishes and feelings and reflects the principles of Making Safeguarding Personal, ensuring communication with the person at all stages.
* The practitioner has demonstrated professional curiosity to establish an understanding of the situation, the persons wishes and the outcome they want to achieve.
* The person’s capacity to make decisions has been assessed, evidenced and actions are consensual wherever possible (where required). Where the person lacks capacity to give consent, practice will be in accordance with the Mental Capacity Act 2005.
* It is evident that a whole family approach has been adopted with consideration of any safeguarding children issues, and appropriate joint working with Children’s Service, Early Help or safeguarding teams has been considered.
* There should be accurate recording of relationships for any children that are in contact or impacted by the care needs of the person. The nature of the relationship is covered in the family and relationships section of assessments, and importantly, they are recorded and appropriately linked in related case records.
* Consideration in given to previous occurrence, risks and patterns of abuse with evidence that a full case history has been obtained and any historic records have been requested and reviewed.
* There is evidence of engagement with partner agencies (where appropriate) in respect of the safeguarding concern.
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| * Recording will evidence all safeguarding case discussions held with Lead Practitioners and relevant line management, which will include consideration of risk factors, clear decision making, actions and rationale. All recording around safeguarding episodes and subsequent contact with safeguarding teams is clearly recorded in an accurate and proportionate way, including any agreed actions, timescales and advice.
* The care and support plan reflects measures to respond to safeguarding concerns, with a robust Risk Assessment and Management Plan (RAMP) evident in all situations where there is an on-going risk of harm.
* Appropriate warnings and alerts have been recorded in the person’s electronic record, and any related records of both victims and perpetrators will flag specific risks.
* The process should reflect an awareness and understanding of the impact of domestic abuse and the effect of repeated domestic abuse incidents on adults or children (everyone) including completion of DASH, S-DASH and referrals to MARAC where appropriate - see Lincolnshire County Council’s Domestic Abuse website.
* Where there are concerns that more than one person in a relationship is experiencing harm, including where they may also be a perpetrator, we will ensure that all people experiencing harm are subject to a DASH or S-DASH risk assessment and referral to MARAC where appropriate.
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| **Standard 4 - Maximising Independence** |
| The starting point is that people have potential, people have strengths which can be drawn upon. * There is clear evidence that we have supported people to identify their strengths and what they can do. We understand who and what is important to the person, what they did, what is working well in their lives, their abilities and strengths.
* There is a clear picture of the support network around the person, including family, friends, relevant professionals and how the support around them can help them live an independent, fulfilling life.
* There is evidence that technology has been considered as a way to support people to remain independent and part of their community. There has been a conversation with the person about how they can use technology and consideration of how it can delay or reduce the need for formal support.
* A whole family approach is taken to identify how family members can get the help they need to remain well and support each other.
* There is evidence that family or others in the persons support network have been involved and there has been input and advice from relevant professionals, including team members, neighbourhood teams, to ensure all options to maximise independence have been considered.
* Short term support options have been considered and tried including support available from partner agencies and the voluntary sector before putting in place longer term support.
* The recording clearly shows the outcomes and goals the person is trying to achieve and demonstrates how the person and the support around them will help achieve them.
* Formal support is the last option to be considered and where it is needed the aim must be to maximise the persons independence. We have ensured we utilise least restrictive practice and seek to prevent or delay needs increasing.
* Where a review has taken place, whether in the community or in residential care, there is evidence that we have explored whether the persons needs / outcomes are being met in a way that fully maximises their independence and uses the support around the person.
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| **Standard 5 - Maximising choice and control** |
| * The person is kept at the centre and there should be clear recording of the persons involvement in the creation of the care and support plan.
* A proportionate record of the options explored to meet the needs and achieve outcomes, clearly demonstrate a strengths-based approach. The record will evidence that the person is in full agreement with and has a copy of their care and support plan.
* There are clear links between the persons identified needs and the outcomes recorded, showing consideration of the person’s well-being, strengths, capabilities and hopes and inspirations. There will also be consideration of the person’s relationships, health conditions, cultural sensitivities, and community resources / informal services.
* A whole family approach is used to complete the plan with input and advice from relevant professionals, including neighbourhood teams, to ensure complex and long-term conditions are managed effectively.
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| * There should be evidence that the person has been given freedom to choose how best to meet the outcomes recorded in the care and support plan. Examples of this could be:- Choice of equipment- Direct payment- Direct provision (prime provider)
* A person should be given information of the number of ways / methods that they can receive and manage their Direct Payment i.e. prepaid card, virtual wallet, managed account and own bank account. The practitioner must follow direct payment policy and procedure including verifying the identity of the person holding the account and completing all required documentation.

In addition:* + Information and advice will be provided around services available from Penderels trust.
	+ The person should be given time to consider direct payments, including consideration of short-term arrangements to support later transition to direct payments.
	+ If appropriate the record will evidence that direct payments have been promoted as an option to receive a personal budget to meet ongoing care and support in full or part. The person should be given time to consider direct payments, including consideration of short-term arrangements to support later transition to direct payments.
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| * There must be evidence that the process for considering a customer's eligibility for NHS Continuing Healthcare (CHC) has been followed in compliance with the National Framework and local processes. As part of the assessment/review process, all relevant health needs and rationale for whether a CHC Checklist is required will be documented. The Practitioner will keep the customer informed, offering the Public Information Leaflet, and consent will be gained for any third-party information sharing (family/friend/representative). All checklists will be documented and sent to CHC. In cases where this progresses to an MDT/DST, the customer will be supported through this process and offered the Public Information Leaflet. Outcomes will be recorded within the individual’s electronic record.
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| **Standard 6: Monitoring, reviewing, reassessing support arrangements and closing cases** |
| * It will be evident that reviews have considered the current progress and effectiveness of the plan in meeting the person’s outcomes and has thoroughly considered how well their support/ budget is going and where there is opportunity to make changes to the plan and budget to meet needs differently.
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| * A copy of the completed review should be provided to the person. If it is evident from the review that any significant changes in the need have triggered the recording of a new needs assessment. The new needs assessment and revised plan has been shared with the person and their support providers.
* The frequency and nature of future reviews will be clear with reviews scheduled and recorded in the person’s case record.
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| * The record will evidence that persons or their representative have been informed that involvements are ceasing or transferring and advised what they can expect next from Adult Care and who to contact if any issues arise with their support.
* Decision making and rationale for closing cases is clear and recorded accurately. Where there is a need for cases to remain open for ongoing involvement, rationale is clearly evidenced in the record.
* Involvement closures and case transfers will be completed at the appropriate point in line with the correct case closure or transfer workflow process.
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| **Standard 7 - Informal Carers** |
| * Informal carers will be identified, their caring role understood and

acknowledged, and be offered carer support. This includes checking if the person with support needs are also carers. * Preparation checks will be made to determine if the person already has an identified carer or young carer and if they have involvement from the Lincolnshire Carer's Service or Children’s Service. If so, explore any opportunities for joint working.
* Carers are supported to actively participate in conversations and assessments, decision making, care and contingency planning and reviews for the person they care for if the cared for person consents to this. If appropriate, there should be consideration of family group conferencing where this may support families to sustain support arrangements.
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| * Carers sections in conversations, assessments and reviews should be directed towards the carer to understand and ensure:
	+ the nature, frequency, intensity of the informal support provided
	+ the impact on the carers and whole families physical and mental wellbeing
	+ the impact on any children
	+ the sustainability and willingness to continue the caring role
	+ what matters most to them
	+ their voice is heard
	+ and establish if carers needs have been met as part of the conversation/assessment/review
* If required, carers should be given information and advice about sources of further support, community resources and preventative services to promote sustainability of care and support arrangements.  Agreed actions taken in relation to the carer should be clearly recorded and followed up.
* If carers support is declined a clear rationale should be provided.
* There should be accurate and up to date recording of all carer relationships within the person’s record and linked to all related people within families.
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| * Children and young people who have or are at risk of taking on caring roles should be identified with evidence of liaison with Children’s Services and Young Carers support services to address any welfare, educational or support needs and be provided with information and advice. If appropriate, refer for an Early Help assessment.
* Where appropriate, there will be evidence of a referral for Adult Carer’s support to the Lincolnshire Carer’s Services or Young Carers Support to Children’s Services which will include a brief background, the urgency, reason for the referral and areas of support required.
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| **Standard 8 – The quality of our recording** |
| * The quality of the case recording conforms to the Adult Care Recording Guidance.
* All recording should be of a good written standard, including grammar and spelling.
* Recording should be clear, concise and factual and proportionate with any opinion expressed clearly distinguished and attributed.
* Recording shall be person centred and recorded in a way that would be meaningful to the person if they were to request access to their record.
* Records will show where there has been information and advice given in relation to care and support arrangements, including financial implications for receiving proposed care and support.
* The record will show clear rationale of all key decisions made with record of people involved in the decision and their rationale.
* Where a management decision and direction has been given relating to case work, this will be recorded clearly in the case notes.
* Case notes will include only information which is relevant to that case.
* Where emails are copied into case notes, they only include information relevant to the person and the case note does not include long or repeated conversation trails.
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