care inspectorate

GUIDE FOR PROVIDERS ON PERSONAL PLANNING

ADULTS

GUIDE 3:
Adults

Contents

Introduction

There is a growing commitment to shift from input health and social care systems to a system that will focus on personal outcomes for people who experience care. This means services have to record and measure '**what matters**' to a person in order to demonstrate how they are meeting their personal outcomes.

The aim of this guide is to support staff in services to develop personal plans for adults. This has been developed collaboratively by colleagues within the adult's inspection teams. National policy, legislation, evidence-based practice and real-life examples of people experiencing care have underpinned the development of the guide.

This guide is for managers and their staff to help improve how personal planning is undertaken. It will help inspectors to evaluate personal plans in a more consistent way during scrutiny and improvement work.

What is a personal plan?

The Health and Social Care Standards (HSCS) set out what we should expect when using health, social care or social work services in Scotland. During the development and consultation phase of the Health and Social Care Standards, 87% of respondents agreed that the standards described what people should expect to experience**.**

The standards apply across all health and social care services. They describe what people, irrespective of age or ability, should experience when using a care service, as we are all entitled to the same high-quality care and support.

The standards define a personal plan as:

'A plan of how care and support will be provided, as agreed in writing between an individual and the service provider. The plan will set out how an individual's assessed needs will be met, as well as their wishes and choices'

You can find relevant standards about personal planning referred to throughout this guidance.

Health and Social Care Standard

1.15 My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices.

The key message to consider is how effective personal planning enhances the quality of daily life for people experiencing care.

What are the key principles?

The guide supports the development of personal plan approaches. These contribute to improving people's experiences by making sure the plan facilitates high quality, safe and compassionate care. Planned care and support should promote people's rights, choices and individual needs and wishes. It does this through key principles of being included, promoting positive outcomes and defining the personal planning approach through learning for improvement.

Being included: Personal planning involves listening carefully to people experiencing care and having good conversations, including others that may be important, for instance families and carers. This involvement helps to promote people's rights, needs and choices through a clear and accessible written and visual plan. The plan should demonstrate people's needs, preferences, strengths, wishes and what matters to them, if possible, with a shared understanding between the person and others who may be relevant. There are many benefits to having an effective personal plan, which include:

- valuable information sharing
- consistency of approach across staff teams
- an underpinning assessment of need and risk
- a resulting informed assessment about required staffing arrangements.

Promoting positive outcomes: Personal planning can support the development of personal outcomes over time. It is crucial that this is done within the context of relationships and good conversations with people experiencing care. These can be critical in promoting a sense of identity, establishing hope, and enabling people who experience care to actively shape their own support. Recording this and demonstrating when outcomes have been met can promote increased health, wellbeing, and self-esteem. The quality of these recordings, and the language used within them, can be measured through quality assurance.

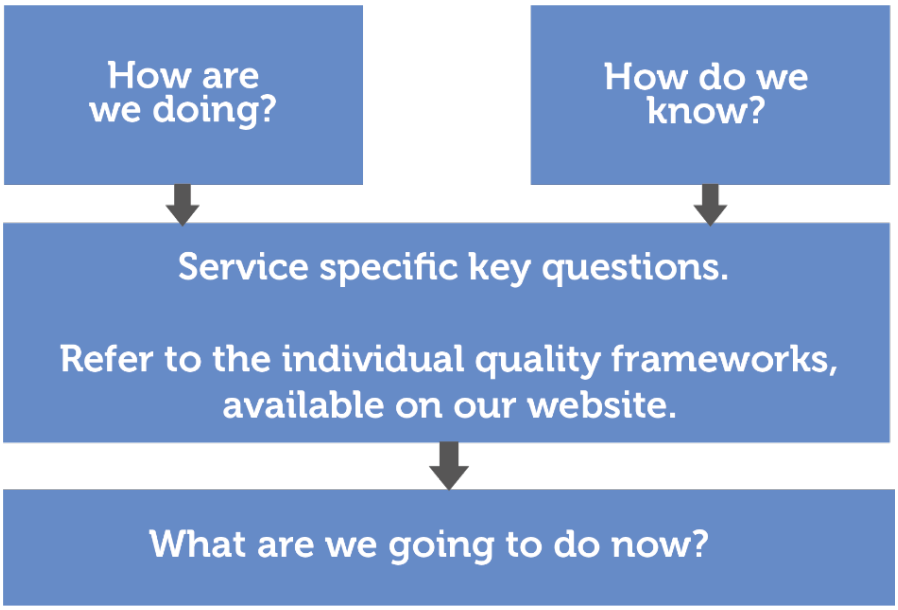
Learning for improvement: Personal planning requires a high level of skill and total commitment from everyone involved, especially staff. It can be useful to consider this as part of individuals' ongoing learning and development needs.

Self-evaluation

It is important to remember that whilst we have a role to support improvement, the primary responsibility for improving services lies with the organisations that provide them. We recognise that external scrutiny can also be a catalyst for improvement where it influences behaviour and culture of providers, leading to improvements in the way that services are delivered.

The quality frameworks have a primary purpose to support staff in services to self-evaluate their performance. The same framework is used by inspectors to evaluate outcomes for people. These evaluations provide independent assurance about the quality of care and support that people experience.

Self-evaluation is a core part of assuring quality and supporting improvement. The process of self-evaluation, as part of wider quality assurance approaches, requires a cycle of activity based round answering three questions:



How are we doing? This is the key to knowing whether you are doing the right things and that, as result, people are experiencing high quality, safe and compassionate care and support that meets their needs, rights and choices.

How do we know? Answering the question 'how we are doing' must be done based on robust evidence. The quality indicators, along with the views of people experiencing care and support and their carers can help you to evaluate how you are doing. You should also take into account performance data collected nationally or by your service.

What are we going to do now? Understanding how well your service is performing should help you see what is working well and what needs to be improved. From that, you should be able to develop plans for improvement based on effective practice, guidance, research, testing, and available improvement support.

What about GDPR?

With regard to personal plans and the requirements under GDPR we cannot give specific guidance in relation to records management. Decisions about providers' processing of personal data and document retention should be agreed at the highest level within your own organisation.

The National Records of Scotland have published a helpful guide on record keeping, which includes useful links. The National Archives also publish records management guidance on their website, which may assist when implementing internal records management processes.

If you are uncertain about setting up records management processes and implementing retention or destruction schedules, we advise that you seek legal advice, especially prior to the destruction of any records.

As a regulatory body we can advise what records will be scrutinised as part of our inspection process. We provide information about this on our website.

The Information Commissioner's Office also publishes a range of helpful toolkits for organisations. These will assist with managing the processing of personal data. This is available on their website.

What does the legislation say?

In accordance with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210, Regulation 5: Personal Plans, every person attending a registered service must have a personal plan within 28 days of them starting to use the service.

This includes people who attend services on an infrequent or irregular basis. People experiencing care and their families or representatives cannot opt out of having a personal plan.

Personal plans for adults

We are committed to improving the health and wellbeing of all people experiencing care in Scotland.

The purpose of this guide is to support staff in services to develop personal plans for people who experience care in Scotland. These plans are sometimes referred to as support or care plans.

We have developed this guide to support you to ensure that personal planning is meaningful and focuses on people's needs and what matters most to them. This is in line with the Health and Social Care Standards. Understanding the difference care and support makes to people's lives is an important part of everyone's work.

Case studies of positive personal planning processes have been used throughout the guide. Links to good practice have been provided to illustrate person centred planning.

This all contributes to making sure people experience high quality care and support that is right for them.

Records that all registered care services (except childminding) must keep and guidance on notification reporting also sets out some expectations around information that would normally be held in a personal plan. This will be explored in this resource.

The quality illustrations for very good personal planning in our quality framework for adults and older people states:

> 'People benefit from dynamic, innovative and aspirational care and support planning that consistently informs all aspects of the care and support they experience. People and, where relevant, their families, are fully involved in developing their personal plans. Strong leadership, staff competence, meaningful involvement and embedded quality assurance and improvement processes support this happening. Care and support planning maximises people's capacity and ability to make choices. This includes the potential for people to reduce the support they receive or change how it is provided. Where support is crisis-based or very short-term support is provided to people, safety plans are based on identifying warning signs, immediate risks and how to reduce these to stay safe, including coping strategies and who can help.
>
> People benefit from personal plans that are regularly reviewed, evaluated and updated involving relevant professionals (including independent advocacy) and take account of good practice and their own individual preferences and wishes. People are helped to live well right to the end of life by making it clear to others what is important to them and their wishes for the future. There is a range of methods used to ensure that people are able to lead and direct the development and review of their personal plans in a meaningful way'.

The quality illustrations show that people being included is essential to good outcomes. This includes the person, those who are important to them and support staff.

The quality frameworks include taking account of infection, prevention and control, particularly during the pandemic.

The frameworks can be found on our website here.

Note: The quality frameworks for care homes for adults and care homes for older people are currently under review.

Being Included

The importance of good communication

Personal planning involves listening carefully and having good conversations with people who experience care, and to include others who are important such as families and carers. This involvement helps to promote people's rights, needs and choices through a clear, accessible written and visual plan.

> Health and Social Care Standard
>
> 2. 'I am fully involved in all decisions about my care and support'

According to the Scottish Human Rights Commission (SHRC), a human rights-based approach is about empowering people to know and claim their rights. This increases the ability and accountability of staff in services who are responsible for respecting, protecting and fulfilling rights. One of the underlying principles of this approach is genuine participation that makes sure people are being included in all decisions about their care and support. Therefore, it is vital that people are fully involved in all decisions about their care. Staff play an important role in enabling this to happen.

> Health and Social Care Standards
>
> 4.1 'My human rights are central to the organisations that support and care for me.'

There is an increasing focus on the active participation of people experiencing care, including their right to be involved in shaping their care and support. This means that a greater focus is placed on personal outcomes. The Scottish Social Services Council (SSSC) define personal outcomes as the things that are important to people in their lives, significantly improving their health and wellbeing. People experiencing care need to feel confident that the things that matter most to them will be listened to, respected and responded to. Staff need to show how they work in partnership with people about any decisions that affect their life'.

When developing the quality frameworks for care homes for adults and older people, feedback was sought. The consultation events, involving people experiencing care and care providers, conveyed a strong and consistent message about the importance of collaborative personal planning. This was considered key in contributing to the quality of experience, with an emphasis on choice, control, empowerment and enablement. Working in partnership to embed a personal outcomes approach where people have an equal voice echoes what is stated in the Health and Social Care Standards

> Health and Social Care Standards
>
> 2.11 'My views will always be sought and my choices respected, including when I have reduced capacity to fully make my own decisions.'
>
> 2.12 'If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my independent advocate, formal or informal representative, are sought and taken into account.'

Good conversation approaches and tools

Central to person-centred care and wellbeing is people's ability to exercise their right to make decisions that affect their lives. The commitment to meaningful involvement should be set out in the provider's aims and objectives statement. By establishing this as an integral part of the culture within a care service, the expectation that people will work in partnership will be made clear from the outset. The diagram below, (figure 1), illustrates how the genuine involvement of the person, alongside those important to them and those involved in caring and supporting that person, can help identify desired outcomes.

Figure one: Understanding personal outcomes (Miller and Barrie 2016)

By supporting staff to develop their knowledge and skills around meaningful involvement, providers can promote a consistent approach that delivers positive outcomes for people experiencing care. Keeping people informed about the impact of their involvement will give reassurance and confirm a service's commitment to partnership working. The craft of 'good conversations' is a way to achieve outcome focused practice.

These examples are what people told us about being involved in personal planning.

"I was invited to be involved in discussing and developing care plans. I was involved in and updated on any changes deemed necessary and was invited to attend all reviews. I was grateful for the opportunity to be able to provide details about my mum that would help carers look after her properly and understand her needs."

"I would have liked to have a friendly discussion involving my relative to enable those caring for her to know the person she really was and to enable them to maintain her life the way she would have liked."

'It was readily accepted that I wished to be included in all aspects of my husband's personal care. I was not debarred from anything. It was important to both of us that my husband should be cared for in a manner that followed how he had lived previously and that his dignity should be preserved at all times.'

Good communication through good conversations is at the heart of outcomes-focussed care. It helps to make sure people are provided with opportunities to be involved which plays a key part in shared decision making.

Health and Social Care Standard

2.8 'I am supported to communicate in a way that is right for me, at my own pace, by people who are sensitive to me and my needs.'

In order to have a good conversation, there needs to be a relationship between the people having the conversation. This helps make the communication right for the person. It is the responsibility of support staff to adapt communication to meet people's needs. Some people may require more support or need more time for communication that is at a pace and in a manner suited to them. Staff knowledge and skills about the various methods and communication approaches and tools available will help to support good conversations. These include:

- using language meaningful to the person
- avoiding jargon
- communication aids such as Talking Mats
- voice output communication aids
- interpreters
- large print
- pictures or photographs
- Kinections tools.

'Challenges may be when a person is unable to communicate fully and have no family. I find the My Home Life/Kinections tools for communication has helped with this'.

Care home staff member

'The plan should be as accessible as possible and promote people's involvement in its creation and maintenance. The meeting should consider diverse forms of planning – text-based information, easy-read material, pictures, graphics and videos. This will help include people and promote their understanding'.

Inspector

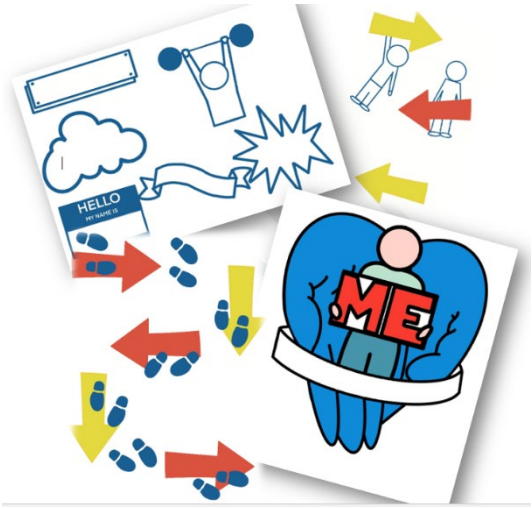
Here are some real-life examples of personal planning approaches and tools.

Example: Anton's personal care prompts

Anton's independence is very important to him. He likes routine and through visual step-by- step prompts, he is able to attend to his own personal care needs, ensuring that he does not miss any steps in his morning routine. Anton chose these images (behind him in his picture and some close up below) with his staff team.

Anton relates a task to each of these images. They are very meaningful for Anton and have helped him to maintain his independence. Anton relies on graphic visual prompts for many things in his life and the use of graphics have helped him with such tasks as preparing food and completing household chores.

He also uses graphic prompts to help have a level of predictability in his day-to-day life, which helps him manage well with any possible anxiety.



Anton's example considers how he uses graphics. When using graphics, you should ensure that these are clear simple images that are recognised by the person using them to relate to areas of their life. This means that people can use graphics to create their personal plan which they recognise and supports their understanding and involvement.

The visual aspect to it can also be fun and creative at the same time. It is not "one size fits all" but there are so many different areas to explore graphically to help people really get involved in the planning process.

Some of these include:

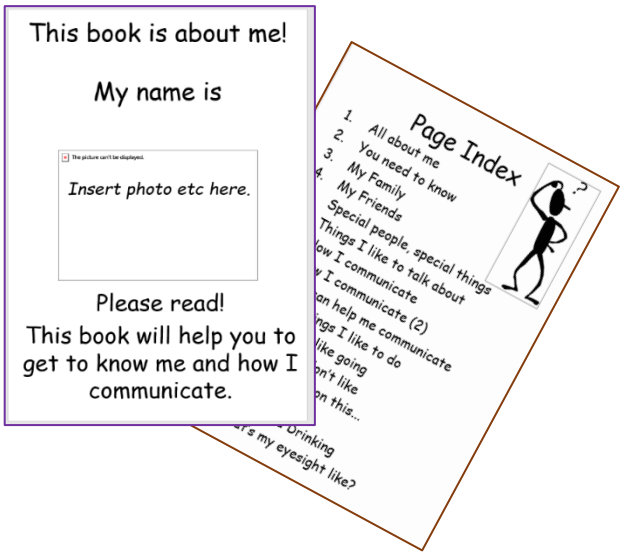
- talking mats
- map and path
- visual prompt cards
- support circles
- visual menu planning.

The focus should be led by the person, their wishes and how this can be communicated and represented in a meaningful way.

Although the use of graphic art is very useful to aid the planning process there are times when people respond to more realistic images or pictures.

Photographs can be used to assist people to communicate. These should follow the same principles for the use of graphics, and they should be meaningful to the person.

Many people without speech use communication passports with pictures and letters/words to enable them to make their views known and to make choices. You can use a free template, shown below, from Call Scotland website:



The next example illustrates how they can be used.

Example: Menu planning with Karen and Alan

People plan their menu for the week using pictures of meals that staff have taken and provided. This helps people who are not able to verbally choose or read a menu to identify food that they like and make choices about what they eat. It enables people to make choices which are respected by staff.

By supporting staff to develop their knowledge and skills around meaningful involvement, providers can promote a consistent approach that delivers positive outcomes for people experiencing care. Keeping people informed about the impact of their involvement will give reassurance and confirm staff's commitment to partnership working.

The craft of 'good conversations' is a way to achieve outcome focused practice.

Having these good conversations about what matters to the person, how to go about achieving this and who will be involved, are necessary to deliver person-centred practice (figure two). Adopting an approach that focusses on people's strengths and abilities promotes independence and autonomy. Traditional assessments often steer staff towards asking questions about the support they need in their daily lives. While this is important, also asking the sort of questions that prioritise the wishes and aspirations that matter to the person concerned encourages the kind of good conversations that help deliver personal outcomes Social Care Wales: The anatomy or resilience toolkit.

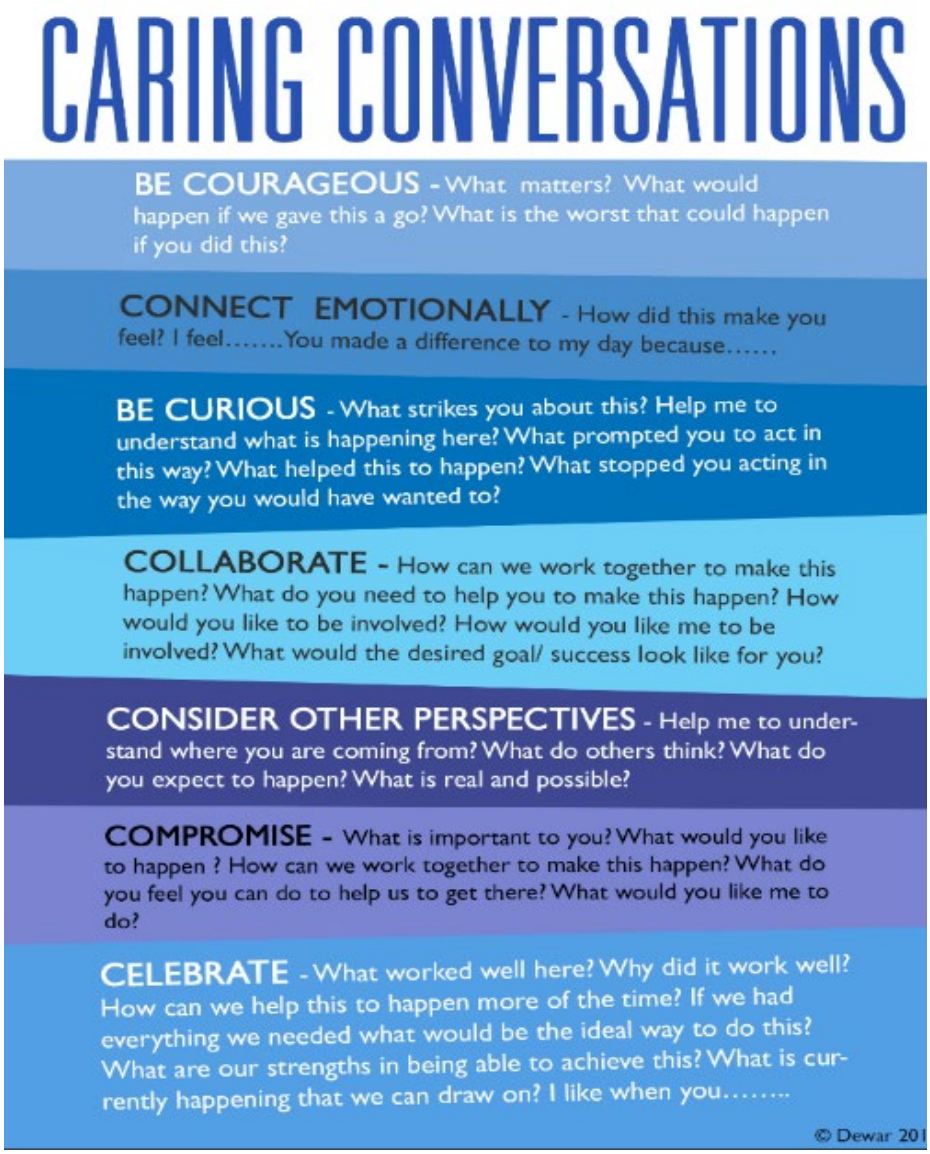


Figure two: Caring Conversations, My Home Life (My Home Life 2019)

To support good conversations, research was undertaken by IRISS who identify some barriers. Knowing about potential barriers can help make sure they do not get in the way. A framework for open, honest conversations about personal outcomes found that staff identified the biggest barrier to outcomes-focussed practice was lack of time. (Outcomes & CO: conversation openers):

Additional barriers to people being involved can include:

- organisational culture, values and beliefs
- family and carer relationships
- people experiencing care, or their family, resistance or competing objectives
- lack of engagement from people experiencing care or their family
- low expectations
- communication needs
- reduced capacity of the person experiencing care
- lack of representation
- poor access to advocacy services
- balancing risk management and risk enablement
- conflicting opinions about risk enablement.

The toolkit at the end of this guide and some of the examples and links throughout the resource help overcome these barriers.

Staff consulted during the development of this guide were able to identify with these barriers. Despite this, they had a good understanding of what could be achieved by creating time to work in partnership with people experiencing care and their families.

They told us:

'People who live in the care home's life will improve with a good personal plan. Staff can support them if we understand what a person wants and needs.'

'A personal plan is about how a person wants to live their life. Choices are respected. Goals are planned. A person's life should be about them, what they did before coming into the care home and how we can continue with this.'

'It should capture the individual's values, likes, dislikes, opinions, etc. It also needs to identify how they want to live their lives through positive risk taking. A plan should ideally be completed with the individual or their loved ones.'

'To ensure the individual is cared for in a way that meets their individual needs. To ensure they meet their full potential and have a great quality of life.'

'The overall aim is to identify what is important to an individual and the support they need to live the life they want.'

'If it was me, it would capture my life, my family, my achievements in life and what is important to me. I would like conversation to take place with my loved ones to help capture me as a person. I feel we are doing things differently now and I believe this is because of the new standards.'

One of the objectives of the Health and Social Care Standards is to encourage innovative practice. Identifying and overcoming challenges and constraints in creative ways offers real opportunities for people to influence their care, maintain self-esteem and self-confidence. Our inspections, focussing on the experiences of people living with dementia in care homes, found that 57% of plans did not fully reflect the past, present and future wishes, values and beliefs of people experiencing care.

Also, not all staff were aware of the content of personal plans. You can read more about this in our report 'My life, my care home'. When personal plans are known to staff and captures who the person truly is, then it is more likely that individual needs and preferences will be met.

Promoting positive outcomes

How personal plans are developed include the use of models of care and established approaches. Any model or approach should always include the person and/or those important to the person. Where the person legally requires support, this should be made clear within the process.

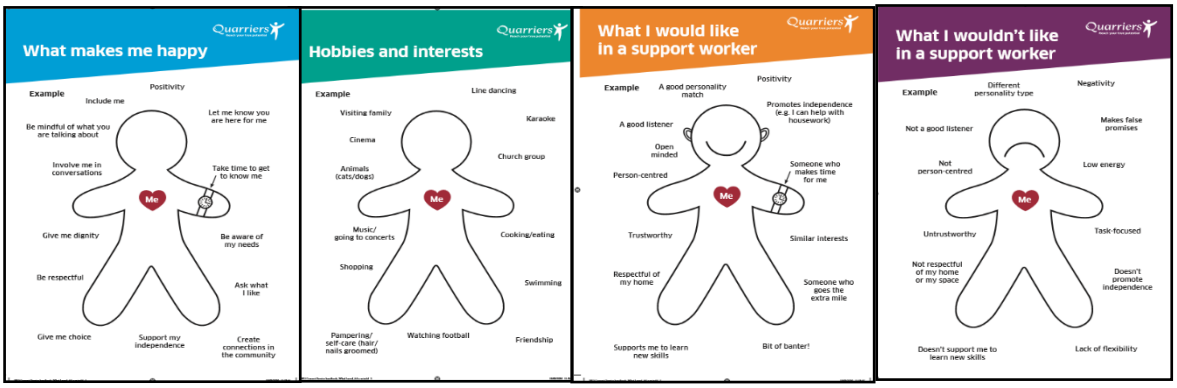
Models of care and a personal planning approach

There are many different models used to help organise and structure how a person's care and support is planned. What is important about using a model is that the system they create does not dictate how a person's plan is developed. Research and inspection findings show that when this happens areas are included that are not important to the person. Repetition, cumbersome paperwork and time conflicts occur that make care and support planning meaningless to staff and the person. CQC: Building bridges, breaking barriers

The following example shows how an organisation and people experiencing care developed a visual tool to support a person-centred approach.

Example: What Makes Me Happy

Quarriers worked in partnership with the people they support to develop a visual tool called 'What Makes Me Happy.' They held a consultation event with the people they support and staff. They listened to their views on how they could develop a visual tool that represents them. Within this visual tool, they are able to note their wishes either in a written format around the main graphic or displayed by graphics around this. It can be individualised and captures what they want and do not want from a support worker. It also includes their hobbies and interests. The main document shows exactly what makes them happy in life. It was a very inclusive piece of work that helps them to capture what is really meaningful for them personally.



The Health and Social Care Standards promote a collaborative approach, involving the person and those important to them.

Health and Social Care Standard

2.17 I am fully involved in developing and reviewing my personal plan, which is always available to me.

The quality frameworks for services also identify collaboration as essential to achieving positive outcomes and experiences for people.

Health and Social Care Standards

5.1 Assessment and care planning reflects peoples' needs and wishes
5.2 Families and carers are involved

Helen Sanderson and Associates highlight key questions that care and support planning should answer. These have been adapted below. The questions help staff to explore with people:

- what is important to you?
- what do you want to change?
- who is important to you in helping and supporting your actions and decisions?
- how will you arrange your care and support?
- how will you spend your money?
- how will you manage your care and support?
- how will you stay in control?
- who should be involved in negotiating and agreeing your care and support?
- what will you do next?

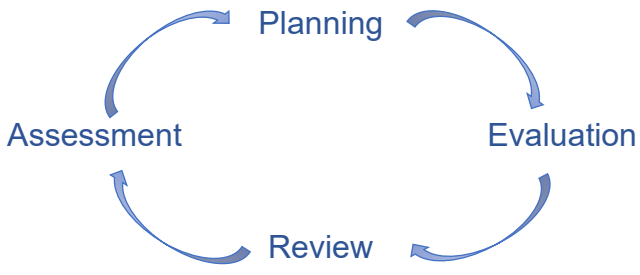
Alongside using models, the organisation of plans is helped by a personal planning approach. A five phased approach to planning care and support is widely used in adult services, and influences health and social care alike. The approach is recognised as:

- pre-assessment
- assessment, incorporating risk assessment
- care and support planning, incorporating goals and risk enablement
- evaluation
- review.

This approach to care and support planning follows the stages, outlined below, in the first months of a person using or accessing a service:

Pre-assessment → Assessment → Planning → Evaluating

However as time goes by, the pre-assessment becomes less important, and reviews of care and support takes its place. The approach becomes circular and overlapping.



As planned care and support is evaluated, assessments will need revisited or extended as people's needs, wishes and aspirations change. This in turn informs changes to care and support plans. Changes might imply it is time for a review to take place.

Before we look at each stage, this case study helps to demonstrate how the approach works in practice.

Example: Mr Stuart

Mr Stuart moved into a care home in Edinburgh following an operation. He recognised he needed a period of 12 weeks convalescence and rehabilitation.

Pre-assessment: The staff visited him in hospital to see what he would need and what he wanted.

Assessment: Mr Stuart moved into the home. The staff talked to him about his needs and wishes. They did lots of check-ups, like how healthy his skin was using a Waterlow Assessment. They checked his weight and how far he could walk using his walking frame. They looked at his risk of falling, which was high.

Planning: Together, Mr Stuart and the staff set some outcomes, or goals that he wanted to achieve. The big one was to get home, but there were lots of little goals to help him get there. This included risk enablement, where everyone recognised the risk of falling, but balanced that with the importance of promoting independence. Ways to reduce the risks were put in place, like only walking with the walking frame initially. But everyone recognised that to get stronger Mr Stuart needed to walk as much as he could, and this meant staff wouldn't always be with him.

Evaluation: Each day the staff chatted to Mr Stuart about his progress. They noted down how he was managing. After about three weeks Mr Stuart felt ready to use sticks and an update to his plan was made.

Review: After seven weeks Mr Stuart was feeling like he could now manage to walk short distances without his sticks. He felt stronger and that he had 'turned a corner'. The staff organised a review and asked him who he would like to attend. The physiotherapist was his key person along with his key worker who always motivated him. New goals were agreed at the review and Mr Stuart felt closer to his ultimate goal of getting home.

'I told my friends I was moving into the care home and they were horrified, but without this place I would never have managed. They promoted my independence, I had access to the gym and in a matter of weeks I was back on my feet. I still visit to meet old friends and keep me busy'

Mr Stuart

Pre-assessment

The purpose of pre-assessment helps the people and the staff in a service to explore if the service is right for them.

> Health and Social Care Standard
>
> 1.18 I have time and any necessary assistance to understand the planned care, support, therapy or intervention I will receive, including any costs, before deciding what is right for me

The pre-assessment also helps to determine a baseline from which care and support can be planned and evaluated. This should incorporate:

- a person's history and chronology by gathering and making sense of information
- considering family and friends, who is important to them and why
- hear from health and social care professionals who have been supporting people
- taking an holistic approach that considers all factors
- previous support and intervention offered and the response to this.

> Health and social care standard
>
> 1.13 I am assessed by a qualified person, who involves other people and professionals as required

Exploring people's hopes, wishes and aspirations are important, alongside meeting their care and support needs. It clarifies expectations and people's desired outcomes of care and support, sometimes referred to as goals. At this stage it is possible to determine if family and carers have different expectations than the person. This helps to clarify what is important to the person, explore differences and inform the care and support plan.

The pre-assessment also forms a baseline to help evaluations of care and support plans. Like, for example, Mr Stuart who had difficulties walking before using the service, the pre-assessment helped to measure his progress.

Depending on how long a person has used a service, there will come a time when the pre-assessment plan becomes less useful and should be archived.

Assessment

When a person starts to use a service lots of information is gathered and assessments undertaken that help to determine people's health and wellbeing. Assessments are often undertaken routinely when a person starts to use a service to determine their needs, actual or potential risks and strengths. Assessment tools need to be evidence-based and inform, rather than dictate, the care and support planned.

Assessment can help build a relationship with a person, stimulating good conversations. For this reason, it is not only good practice to complete assessments when you are with the person, but it is also extremely important. When used well, assessments can help people to discuss worries and concerns, as well as celebrate strengths and aspirations. People should be asked if they want support for the assessment from family, friends, or where appropriate, advocates. Where people cannot take part in assessments, their family or next of kin should be involved. They form the foundations for the care and support plan. Where assessments identify risk, it is important that the risks are explored with the person. Enabling people to take risks enhances their lives, but this is often the most difficult aspect of care and support to plan as risks will need to be mitigated. Staff, families, and friends often want to protect people from harm. Using the assessment to discuss outcomes that are important to the person will promote their human rights. It should mean people are enabled to do things that matter to them.

Health and Social Care Standards

1.14 - My future care and support needs are anticipated as part of my assessment.
2.6 I am as involved as I can be in agreeing and reviewing any restrictions to my independence, control and choice

Assessment is not an event but should be undertaken continuously to identify people's needs. Actions to reduce risks to their lowest practicable level should be clearly outlined within the plan of care, taking account of the persons wishes and a risk enablement approach.

'I see them (assessments) as sort of like my annual MOT. It's good to get a once over each year to make sure everything is in working order, oil a few joints! If anything goes wrong in-between times, just like a car you get it sorted out'.

Person being supported at home

Undertaking a comprehensive assessment is a way of helping good conversations that will inform how often the assessments need repeated. For some people they may need to be undertaken more often, for others they may only need reviewed every six months. It will be important for staff to have a planned approach for completing and re-evaluating assessments depending on peoples' needs and identified risks. Some assessments suggest repeat time frames, some are routinely repeated monthly. However, there is a balance needed that takes account of the duty of care of staff and the wishes of the person. Truly person-centred personal planning involves negotiation and agreement about what assessments are repeated, how often and why. Getting the balance right means taking account of relevant professional codes while also putting people's wants and wishes at the centre of decision making.

- NMC: The Code - Professional standards of practice and behaviour for nurses, midwives and professional associates
- SSSC codes of practice
- Standards of practice for Allied Health Professionals.

The person should be central to the assessments process.

Assessments should be holistic, taking account of physical, sociocultural, spiritual, psychological, and emotional aspects of need; however, it should be noted that there will be overlaps between elements of the assessment. For instance, psychological needs may have a bearing on physical health, and vice versa. For assessments to be comprehensive, it will be vital for staff to work in a collaborative way with not only the person experiencing care and their families, but also the wider health and social care team, along with partners from other organisations.

Good assessment of people's physical and mental health can result in positive outcomes for people. Sometimes assessment involves working with other professionals to provide wraparound care and support for people. For example, since the COVID-19 pandemic a framework is developing to support better integration of healthcare in care homes (Clinical and Professional Advisory Group Scottish Government 2021). This model is also likely to support care for people in their own homes. It will help with the implementation of some of the recommendations in the Independent Review of Adult Social Care in Scotland.

Figure three demonstrates the importance of a 'one team' approach.

Figure three - Developing an integrated framework for healthcare support for people living in care homes in Scotland

The Health and Social Care Standards support this approach:

> 1.13: I am assessed by a qualified person, who involves other people and professionals as required.
> 4.11: I experience high quality care and support based on relevant evidence, guidance and best practice.
> 4.27: I experience high quality care and support because people have the necessary information and resources.

It is widely recognised that a strengths-based approach to assessment will positively influence how people engage in the process, along with a focus on recovery if relevant. So, no matter what the assessment these should underpin approaches.

There are lots of tools which can facilitate a systematic approach to assessment. Importantly people must be involved in completing these with staff. We have listed some of the available assessment tools that help consider lots of aspects, from enablement assessments to risk assessments as well as health related assessments (see table one). The outcomes of the assessments help the person and staff to consider if access to a health or other professionals would be important. This is not an exhaustive list, and some may overlap physical and mental health assessments. Important to assessment is considering an approach that recognises the person, their needs and their wishes.

Table one – Possible assessments tools and access to relevant professionals

Mental Health	• Recovery Star • Drug and Alcohol Star • CHIME (Personal Recovery) • Geriatric Depression Scale, • Section 47 certificate (AWIA) • The Bradford Well-Being Profile • Heartfelt Cards • Key Care Questions • Emotion Cards • Instant Delights • Life Story Template • Insights into Me • Community Quality Cards • Wellbeing Star • Better Futures: An Outcomes Framework • Outcome Star • One Page Profile • MAP • Essential Lifestyle Planning • PATH • Scottish Government: Dementia - psychoactive medication summary	Dependant on the outcomes of assessments and with agreement and discussion with people and those important to them, referral and access to other health professionals may be important. For example to reduce or manage falls this may involve the physiotherapist or podiatrist. For poor skin integrity a tissue viability specialist. For distress the mental health team. For palliative care the community nurses. For nutrition the speech and language therapist, dietician and dentist.
Physical wellbeing	• Malnutrition Universal Screening Tool (MUST) • NICE: Improving oral health for adults in care homes • NHS GGC: SPHERE Bladder and Bowel Service - Care Home and Care at Home Zone - Hints & Tips • Prevention and Management of Pressure Ulcers Standards • Multifactorial falls risk assessment • National Early Warning Score (NEWS) 2 • Abbey pain assessment • http://www.doloplus.fr/en/pain-assessment/ • My Anticipatory Care Plan • DNACPR	

	• Scottish Palliative Care Guidelines	

Scotland's House of Care approach helps to demonstrate a wholistic approach to personal planning. Figure four illustrates the importance of planning care that considers all aspects of the person to ensure personal planning is holistic.

Figure four: Adapted from Health and Social Care Alliance Scotland https://www.alliance-scotland.org.uk/health-and-social-care-integration/house-of-care/house-of-care-model/ and Clinical and Professional Advisory Group Scottish Government 2021).

Care and support planning

Care and support planning reflects a person's desired outcomes/goals. It describes how people's needs are met, strengths are supported, risks are enabled and how wishes and aspirations might be achieved. If it is difficult for people to be involved, they should receive full support to use suitable methods of communication to express their views and preferences, including advocacy. They may be able to express their views creatively using drawing or talking mats. For more information about how to involve people to communicate in different formats, see the section above on participation or visit www.nhs.net.

The voice of the person must be heard throughout their care and support plan, however this does not mean they should always be written in the first person. If the person is unable or unwilling to engage, steps must be taken to include the voices of those who know the person best. Adults with incapacity can still be included in their personal planning. If the person has a welfare proxy, appointed under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), involve and consult them as appropriate.

Health and Social Care Standard

4.14 My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event.

Writing in an outcome focused way helps to capture expectations and desired goals. The Joint Improvement Team defined outcomes: 'Personal outcomes are about the impact or end result of a service, support or activity on a person's life'.

IRISS also highlight that: 'Outcomes are the answer to the question: So what difference does it make?'

The differences between inputs, processes, outputs and outcomes are often difficult to understand. Figure five shows the difference in the context of personal planning using the 'baking a cake' analogy.

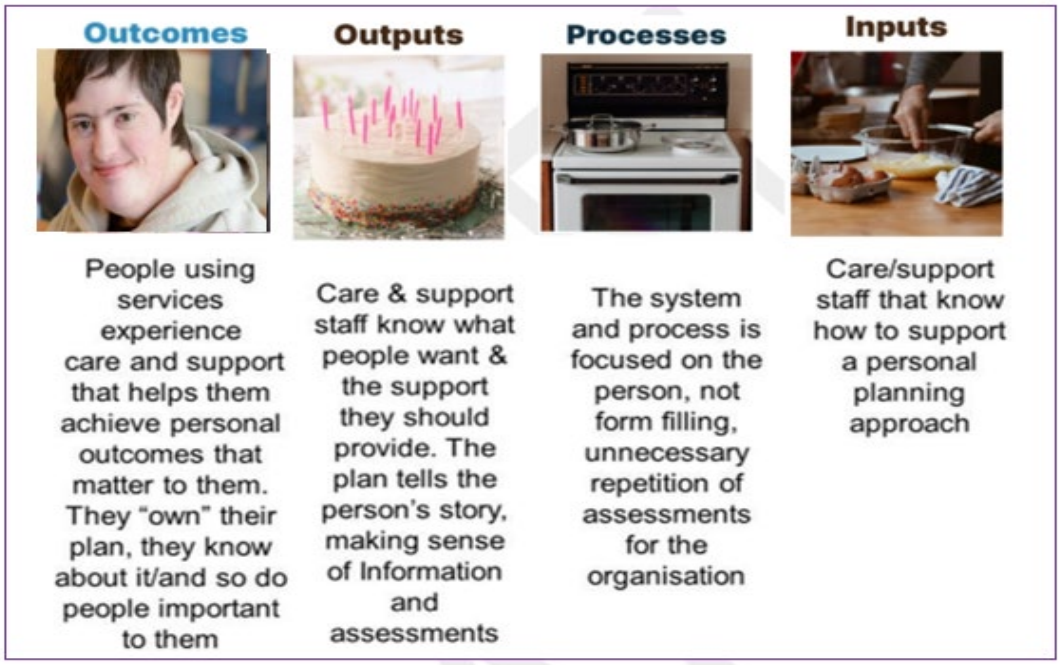


Figure five: Getting to the outcomes in personal planning approaches: adapted from https://personaloutcomes.network/

Good relationships between the person, those important to them and the staff are vital to planning care and support. In many services, one member of staff is allocated to a person. They are sometimes called a key worker or named nurse. They will help to develop the care and support plan with that person through good conversations (figure six). The key worker and person should have protected time to discuss and edit the plans and to answer any questions the person may have.

Health and Social Care Standard

1.15 My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices.

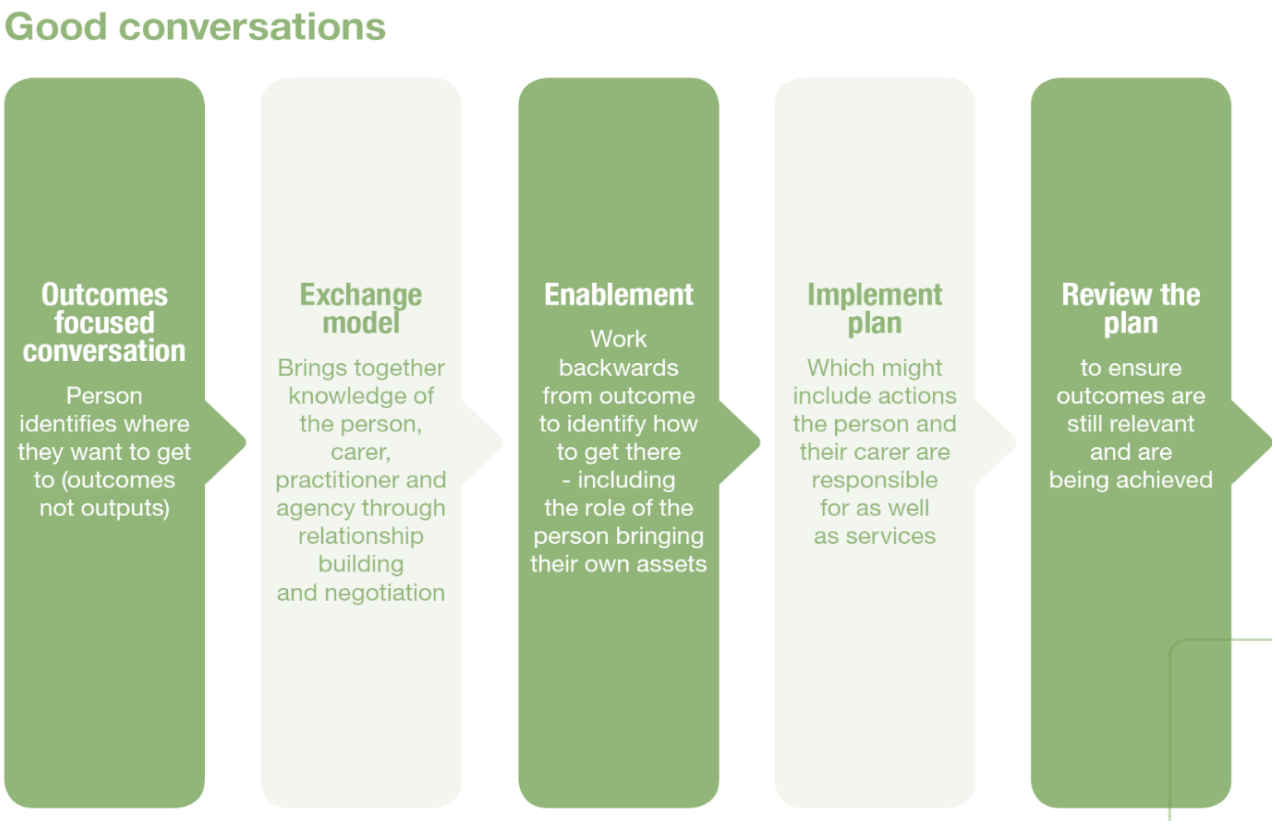


Figure six: [Joint Improvement Team - Good conversations]

Clear, short and long-term outcomes or goals, specific to needs, strengths, abilities, wishes and aspirations, should be in place for each person. These might include people's hopes, dreams, and ambitions as well as health related goals. A short-term outcome may cover a six month period, but it could be broken down further into weekly goals. For example, people may be keen to re-develop skills lost after a medical diagnosis such as a stroke.

> "The most important thing for me is to be able to get up myself. I've learnt to walk again, but until I can rise from my chair I still have to depend on staff".
>
> Person in a care home

Learning to be in control of an addiction may be the long-term outcome or goal, but in order to get there, several different outcomes may need to happen first. Outcomes should be both realistic and aspirational, while being highly individualised.

The next example shows an innovative way to undertake personal planning.

Example: Rita's map

Quarriers supported Rita to complete a map telling her story about her life and what is important to her future. Alongside her family, they started by engaging with Rita on her story. Rita and her family told them stories from her past. They asked Rita how she would like this to be represented graphically in the story part of her map. One person drew and they encouraged Rita to have a go herself. Rita helped colour in also.

They learned a lot about Rita that day that they never knew. They moved on to the dream part of the map and encouraged Rita to think of all the wonderful things she would like to do in her life. Rita shared some amazing dreams and wishes with them that day such as having a pet, going on holiday abroad, spending time with her family, doing her own art-work, going clubbing, staying healthy and learning to cook. They focused briefly on the nightmare for Rita just to let everyone know exactly how bad it would be for Rita if they did not support her to fulfil her dreams and wishes.

Through the centre of the map, they went on to put the plan into action. They discussed resources they currently have, what they need, then finally who was going to help her to achieve each of her goals. They detailed each action with clear timescales and agreed who was responsible. Rita helped colour her map with pastels. Each person then signed up to agree the map.

Rita was very proud of her map and as you can see, this is displayed in pride of place on her wall. Through having this visual stimulus, Rita has gained a sense of achievement as she has been able to tick off most of the things in her map and is working towards other goals that she has not yet achieved.

When agreeing a plan, SMART principles can be used to track progress in achieving outcomes for people and used to guide setting objectives. Traditionally SMART outcomes were classified according to the first set of definitions provided below. However, various alternatives are used and the definitions highlighted in bold have been found to be more compatible with a personal outcomes approach.

- **S** - Specific (or **Significant**)
- **M** - Measurable (or **Meaningful**)
- **A** - Attainable (or **Action-oriented**)
- **R** - Relevant (or **Rewarding**)
- **T** - Time-bound (or **Trackable**)

The care and support plan should be seen as an interactive document that grows with the person, not static, inaccessible and locked in an office. The quality illustrations in our quality framework highlight this.

> Quality illustration: 'People benefit from dynamic, innovative and aspirational care and support planning which consistently informs all aspects of the care and support they experience. People and where relevant, their families, are fully involved in developing their personal plans'

The care and support plan facilitates 'an approach' where the person and everyone involved in, and important to that person, can communicate. For people who do not communicate in conventional ways, the personal plan becomes even more important.

There are a variety of electronic personal planning tools available. They can support the care and support plan to be interactive and accessed remotely by the person and those important to them (with their permission). People can be given read and write access.

"I use my iPad to access my plan, I might be old, but I try to keep up with technology!"

Person experiencing care

'She has dementia and cannot tell me about things, but her personal plan is in her room and I look at it regularly and get updates and I can ask for changes if needed. It is very much a way of helping me to keep in touch with how mum is.'

Relative of a person experiencing care

The following example considers how this works in practice.

Example: Using electronic personal planning

Mrs MacDonald lives in a care home in Edinburgh. She has no family living locally, her daughter lives in Australia. Mrs MacDonald has dementia and can forget things that are important to her, like the dates of her grandchildren's birthdays.

After the care home staff moved the care and support plans to an electronic system, they realised it offered the opportunity for Mrs MacDonald's daughter in Australia to access it. They discussed this with Mrs MacDonald and her daughter and agreed to explore how it may help support Mrs MacDonald.

Now they have an additional way to communicate through the care and support plan. For example, making suggestions of appropriate gifts to purchase when one of Mrs MacDonald's grandchildren's birthday is coming up, so she can organise a present and card to be sent in plenty of time.

People should have a copy of their care and support plan in a format they choose or that best suits them. Some people may prefer the option to be able to access their plan electronically, for instance from their mobile phone. This allows them to look at it when it suits them and when ideas come to them. They may also prefer to be emailed their plan for comment and to respond in this manner, rather than face to

face, which can sometimes be more difficult for some people. They may also prefer to receive this in a visual format, like Rita's map, or supported by sign language.

Supporting and protecting people is a priority when it comes to ownership of plans. People have the right to have their plans with them. Consideration needs to be given when there is very sensitive information in the plan. The person may negotiate with staff about where such information would be held in order to protect them.

When any restrictions to a person's human rights are included in the care and support plan, this must be done within a legal framework of least restriction, and, wherever possible, inclusively with the person. This would include the use of keypads that restrict freedom of movement for people.

Health and Social Care Standard

2.6 I am as involved as I can be in agreeing and reviewing any restrictions to my independence, control and choice

For more information about people's rights, risks and limits to freedom visit the Mental Welfare Commission's website.

Evaluation

The term evaluation means: 'To form an opinion of the amount, value or quality of something after thinking about it carefully'. Oxford Learner's Dictionary

In care and support planning, evaluation is about deciding how effective care and support has been each time it is given and received. It isn't something done at set times, in an office and by someone who hasn't been caring for the person. It is undertaken after each episode of care and support. The most important person in the evaluation process is the person experiencing care and support.

This quote shows how important it is that recording the evaluation of care is written meaningfully, with the person.

'The carers evaluate my care with me. At first, they wrote stuff about me, but I checked and asked them why they had written 'had a good morning' when actually I'd had a very busy morning. Now we discuss what to write and I have a say.'

Person experiencing care

Recordings about a person's experience are evaluations of how they are feeling, how well expected outcomes have been met and if there is any progress towards aspirational or longer-term goals. Written and verbal handovers are also part of the evaluation of a person's care and support, but central to this must be the person's experience.

Health and Social Care Standard

1.9 I am recognised as an expert in my own experiences, needs and wishes.

Reviews

Reviews should take place when significant changes happen, and evaluations show regular changes are needed to some or all of the care and support plans. This may happen because:

- a person has a new medical diagnosis
- starts to have frequent falls
- staff have increased difficulty in understanding what a person wants because of communication differences
- outcomes and goals within the plan have been achieved and new ones need to be explored.

People who have recently started to experience a service may have a review at around eight weeks to see how things are. People who are ready to move on from a service will also expect a review. Every care and support plan should be reviewed with the person and those important to them at least every six months and a record kept of the review, as stated in SSI 2011/210, Regulation 5.

This is when assessments may be repeated to check if things like risk and health needs have changed, the 'M.O.T' referred to earlier.

Health and Social Care Standards - Principle

My health and social care needs are assessed and reviewed to ensure I receive the right support and care at the right time

People should be able to record their views and give feedback at the review. Staff should prepare people for reviews by discussing all that is going to be covered and supporting them. The preparation should include them knowing what others may say.

Helen Sanderson Associates has good information about how to make sure reviews are person centred. She highlights some important things to include.

- Making sure that we are truly taking into account the experiences of the person, their family and those supporting them when reviewing how well things are going.
- Creating an environment where people are made to feel comfortable in expressing themselves honestly.
- Developing actions that are based on experiences and learning, leading to an environment where we are constantly improving our support

'It is important to remember that going in to a review meeting with professionals who are all going to be speaking about you can make people very anxious. People may find this intimidating and embarrassing and therefore may not participate. It is important that people are aware of reviews, aware of any reports before the review meeting, people should be aware of what is to be discussed and they must be supported during and after the review.' Extract from http://helensandersonassociates.co.uk/

Quality assurance and self-evaluation

The manager of a service should have in place a system for quality assuring and self-evaluating the effectiveness of personal plans. This should include finding out if the plan has met the outcomes people wanted and if not why. Seeking the views and experiences of people will be important. This helps determine if their personal plan has been influential in making sure they have had the right care and support. The reviews of the personal plan will also be useful when quality assuring all personal plans.

Whilst we would not want to 'prescribe' how managers and staff quality assure personal plans, this guide has been developed, in response to provider requests to support them, to demonstrate what 'good personal planning' looks like. Therefore, we would strongly encourage that this guide is used a part of measuring the quality of personal plans and the quality of outcome focused practice.

The meaningful and measurable research identify things that can help quality assure care and support plans.

- There should be a clear distinction between outcomes and outputs.
- It is not all about services, is the person contributing to outcomes?
- Is the family role identified?
- Are resources other than services identified?
- Strengths and capacities of the person feature, not just deficits and needs.
- A story the person would recognise.
- Gets beyond the high level or general to the personal.
- Specificity about what is to happen to achieve outcomes.
- Distinguishes between professional/system goals and personal outcomes.

Improving personal plans may include providing training or guidance to staff on understanding outcomes and including people in writing their plans. Using the key questions in the quality framework, specifically key question five and the quality illustrations will also help to self-evaluate the effectiveness of people's personal plans. Progress for Providers is another useful tool to help assess how person-centred personal plans are. They should cover all areas important to the person and be holistic as described in this guidance. The House of Care Model (figure four above) gives a good framework for holistic care. Quality assurance processes should include review of the language used in personal plans. Including the person and those important to them in the quality assurance process; do they recognise themselves in the plan? Does it reflect things that are important to them? Does it detail their health and social care needs, wishes and support? Do they understand it? Is it kept with them? These are all important questions to consider when quality assuring personal plans.

The following example considers how Glasgow City Health and Social Care Partnership have approached improvement work on the personal planning process for people experiencing care.

Example: Test of change for revised care plans

Glasgow health and social care partnership (HSCP) identified that the 'My World' care plan for older people's residential care homes, was no longer fit for purpose and was not dynamic when being measured against the Health and Social Care Standards. As a provider we needed to evaluate ourselves in line with 'self-evaluation for improvement'. The responses from staff was that 'my world care plan' needed updated, it was agreed that a focus group be set up to look at a more user friendly and person-centred care plan for Glasgow HSCP residential care homes. Helen Sanderson Associates were commissioned to train staff in a person-centred approach and their tools were looked at to use within the new care plan.

A focus group was made up of a head of service, service managers, operational managers, a Care Inspectorate representative and senior officers to choose tools and also to incorporate the methodology from the person-centred approaches. They also linked this with the Health and Social Care Standards. The main aim was to set up a test of change to ask staff, residents and family using the new paperwork to identify if the new care plan:

- was easier to use
- had less duplication
- was person centred
- linked with the Health and Social Care Standards
- was embedded in staff everyday practice
- was updated in response to residents needs and after care plan reviews.

A test of change and project charter was sponsored by the head of service with initially a 30, 60 and 90 day review process across two of the units in Victoria Gardens care home. It was clear, through staff consultation, that staff were responding well to the new format, but that staff felt working two care planning systems in the same home was confusing. It was agreed that all five of the units within Victoria Gardens could test the new care planning format.

'I liked being involved in drawing up my one page profile it was nice to be asked "What do people appreciate about me and "What is important to me" I could easily have this in my room so that staff assisting me can look at it as they support me. Although I am able to tell staff how to support me, some residents can't.'

Person experiencing care

A four-weekly assessment of staffing needs takes account of people's physical, social, psychological, health and recreational needs and choices. This should be part of quality assuring personal plans, informing the staffing arrangements and skills of staff needed to support people well.

Health and Social Care Standards

4.15 I experience stability in my care and support from people who know my needs, choices and wishes, even if there are changes in the service or organisation.

Learning for improvement

We recognise the importance of the skills that people completing the personal plan must have and the range of knowledge required to ensure plans reflect what people may need.

Consideration should be given to what learning and development needs are required to ensure you have the skills, knowledge and understanding to develop high quality, meaningful personal plans with people.

Examples of weak and very good illustrations are available in our quality frameworks.

- care homes for older people
- care homes for adults
- support services (care at home, including supported living models of support)
- support services (not care at home).

They can help support reflection in relation to the development of personal planning, and as part of quality assurance with a focus on self-evaluation.

Open badges are digital certificates you can use to record your learning and achievement. These are produced by the Scottish Social Services Council. They make it easy to capture and reflect on continuous professional development across informal and formal learning contexts.

We plan to develop an Open Badge that can be achieved as part of learning form use of this resource. This is an example of an Open Badge:

This badge is awarded to people who understand why it is important to apply new learning in practice and how they can go about doing this.

Learning for improvement toolbox

As well as the links throughout the document and in the reference list below, you may also want to visit The Hub where there is lots of information to help develop skills and knowledge around personal planning.

The Hub also has additional links to other resources such as the Scottish Social Services Council, the Mental Welfare Commission and NHS Education for Scotland.

Toolbox

Alfaro-LeFevre, R: Applying nursing process: The foundation for clinical reasoning (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Bradley, E: Mental Health Review Journal, 20(4), 232-241:
Carers and co-production: enabling expertise through experience?

Call Scotland

Self-evaluation for improvement, your guide

Records that all registered care services (except childminding) must keep and guidance on notification reporting

My life, my care home

A quality framework for care homes for adults

A quality framework for care homes for older people

A quality framework for support services (not care at home)

: A quality framework for support services (care at home, including supported living models of support)

Guidance for providers and applicants on aims and objectives.

Dementia - psychoactive medication prescribing and review

Care Quality Commission: Building bridges, breaking barriers

Clinical and Professional Advisory Group Scottish Government 2021: Developing an Integrated Framework for Healthcare Support for Adult and Older people Living in Care Homes in Scotland

Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A., & Barlow, S: Ordinary risks and accepted fictions: How contrasting and competing priorities work in risk assessment and mental health care planning. Health Expectations, 20(3), 471-483.

Commission for Social Care Inspection (CSCI): See me, not just the dementia – understanding people's experiences of living in a care home.

Cook, A. & Miller, E: Talking Points. Personal Outcomes Approach. Edinburgh: Joint Improvement Team. http://www.ccpscotland.org/wp-content/uploads/2014/01/practical-guide-3-5-12.pdf

Donnelly, S., Begley, E. & O'Brien, M: How are people with dementia involved in care planning and decision making? An Irish Social Work perspective. SAGE Journals, 18 (7-8), 2985-3003: https://journals.sagepub.com/doi/abs/10.1177/1471301218763180

Donnelly, S., Cahill, S., & O'Neill, D: Care planning meetings: Issues for policy, multi-disciplinary practice and patient participation. Practice: Social Work in Action, 30(1), 53-71.

Health and Social Care Alliance Scotland

Helen Sanderson Associates:

Information Commissioner's Office: For organisations

Institute for Research and Innovation in Social Services (IRISS): Leading for Outcomes: Children and Young People.

Institute for Research and Innovation in Social Services (IRISS): Outcomes & Co: conversation openers.

Joint Improvement Team: Meaningful and Measurable.

Kemp, D: Care plan redesign: Improving service user experience of the care programme approach. Mental Health Nursing, 36(1), 18-19.

Mental Welfare Commission: Person Centred Care Plans Good practice guide.

Miller, E. & Barrie, K: Meaningful and Measurable. Recording Outcomes in Support Planning and Review.

Miller, E. & Barrie, K: Personal outcomes, Learning from the meaningful and measurable project: Strengthening links between identity, action and decision making, summary version.

Miller, E. & Cook, A: Joint Improvement Team: Recording outcomes - The critical link between engagement and improvement. Edinburgh

My Home Life: Caring Conversations: My Home Life.

National Records of Scotland. (2019). Model Records Management Plan:

NHS Greater Glasgow and Clyde: SPHERE Bladder and Bowel Service / Care Home and Care at Home Zone:

How to care for someone with communication difficulties

NICE Guidelines: Improving oral health for adults in care homes

Oxford Learner's Dictionary: Evaluate

Personal Outcomes Network

Prevention and Management of Pressure Ulcers Standards

Progress for Providers: http://helensandersonassociates.co.uk/care-support-planning-checking-progress/

Roper, N., Logan, W. & Tierney A: Nursing Models, a process of construction and refinement. In B. Kershaw and J. Salvage (Eds.), Models for Nursing. Chichester: John Wiley and Sons.

Health and Social Care Standards: My support, my life.

National health and care standards: consultation analysis findings

Care about Rights

Understanding personal outcomes

A risk worth taking

Step into leadership resource.

The Independent Review of Adult Social Care in Scotland

How to manage your information

The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210

The anatomy of resilience toolkit.

Glossary

Empowerment	Empowerment involves: • developing a clear action plan to build an organisational culture which embraces the leadership of people who use services, their carers, the community, staff and colleagues at all levels in the organisation • working with colleagues in partner organisations to build collaborative leadership capacity and enable innovation and appropriate risk-taking across organisational boundaries • supporting professional autonomy and leadership from staff and people using the service. For more information visit the SSSC Step into leadership website.
Good conversations	Conversations about what is important to the person experiencing care and support. They are not about asking a set of questions, they are about exploring opportunities, listening, involving and sometimes answering questions. A good conversation helps to make sure people's strengths, assets, wishes, ambitions and needs all inform their personal plan. That way staff know how best to care people so that the quality of their life is enhanced by the care they receive.
Innovative practice	Health and social care practice that includes new and different ways to do things, resulting in better outcomes for people.
Key worker	A member of staff allocated to a person experiencing care. They oversee, assess, plan and evaluate care and support with the person and can be a point of contact if the person wishes to discuss or change things.
Named nurse	A nurse allocated to a person experiencing care. They oversee, assess, plan and evaluate care and support with the person and can be a point of contact if the person wishes to discuss or change things.
Personal outcomes	People's experiences resulting from an intervention, support or action. Personal outcomes are about things that matter to people. They can be positive or negative. When a person is experiencing care and support, personal outcomes should improve because of that care.

Personal plan	Planned care and support, as agreed in writing, between a person receiving care and the staff. The plan should detail how to care for someone. The daily evaluations make up the dynamic document and should be used each time care and support is delivered. While assessments, reviews and other health checks or screening are part of the personal plan, only the planned care and daily evaluations need to be accessible every day. The person receiving care, those important to them and staff caring for them should also be able to look at the other parts of the plan whenever they want to.
Proportionate approaches	This is an approach where lots of things need to be considered and used to inform actions. When applied to caring for people, it is about the least intervention possible to achieve what is important to the person. When applied to inspection, it means better performing services receive less scrutiny, so inspectors have more time to support poorer performing services.
Quality assurance	Checking the quality of a service. It involves inspection, but quality assurance should be done by managers and staff in services. An important part of quality assurance involves managers getting feedback from people experiencing care on what works well and what needs changed. Self-evaluation is an important part of quality assurance. For more information read our 'Self-evaluation for improvement – your guide'.
Risk Enablement	This is about making it possible for people to do things that might be risky, but that are important to them. This might be simple things like supporting them to make a cup of tea. It might be more complex things like supporting them to go out independently despite a physical, mental health or psychological disability. For more information read the SSSC's 'What is a risk worth taking' and our position statement on a positive approach to risk for early learning and childcare (ELC) services.
Risk management	This is about managing risk, not taking risk away altogether. For example, if a person finds handling a kettle difficult it might be about using adaptations to help them pour the boiling water. It could include using technology, for example, if a person has difficulty remembering how to get home after a walk, a device that tracks where they are can help staff to support them from a distance, rather than always having to be with them. For more information read the SSSC's 'What is a risk worth taking'

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This publication is available in alternative formats on request.

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