## **Person-centred care**

### Central to being a responsive service is your ability to deliver person-centred care. It’s one of the issues that the CQC is likely to explore the most as part of the monitoring and inspection process.

### Person-centred care plans means that staff understand the people they support, including their personal history, interests, and aspirations. This area of inspection looks at how successful your service is in engaging people in planning their care, taking into account their personal goals and ambitions.

### Recommendations checklist

These recommendations act as a checklist to help you consider what you could potentially evidence, but it’s not intended as a definitive list. We hope they help you reflect on what evidence you might wish to share with the CQC.

|  | Yes | No | N/A | How we evidence | Action |
| --- | --- | --- | --- | --- | --- |
| We can evidence how we provide person-centred care and respond to the needs and preferences of the people we support. | [ ]  | [ ]  | [ ]  |       |       |
| We work closely with the people we provide care and support to in order to understand what is important to them. | [ ]  | [ ]  | [ ]  |       |       |
| We provide consistent levels of person-centred care across our service, ensuring everyone is able to live as independently as possible. | [ ]  | [ ]  | [ ]  |       |       |
| The people we support are central to deciding and reviewing their care plan. We ensure that all care is planned with the people we support (and/or their families) rather than for them. | [ ]  | [ ]  | [ ]  |       |       |
| We clearly document any changes that have been made in the care plan and ensure these are signed off by the person (and/or their family). | [ ]  | [ ]  | [ ]  |       |       |
| We provide ample notice for review meetings with the people we support (and/or their families). This enables them time to think about what they would like to discuss. | [ ]  | [ ]  | [ ]  |       |       |
| We ensure that every care plan is detailed, person-centred and clearly describes the care, treatment, and support needs of the person we support. Where appropriate, we ensure health action plans are produced. | [ ]  | [ ]  | [ ]  |       |       |
| We ensure risks and associated mitigations are reflected in the care plan. This includes documenting clear procedures for staff to follow to minimise risk. | [ ]  | [ ]  | [ ]  |       |       |
| Our care plans include people’s interests, preferences and things that are important to them (including their culture, religion, etc.). | [ ]  | [ ]  | [ ]  |       |       |
| We ensure our care plans are produced in a way that everyone who needs to use or review them understands them. | [ ]  | [ ]  | [ ]  |       |       |
| Our care plans include information about people’s capacity and detail how they should be involved in their care and lifestyle choices (including making decisions for themselves or where best interest discussions may be needed). | [ ]  | [ ]  | [ ]  |       |       |
| We keep all care plans regularly updated and these are adjusted to levels of support required as people’s needs change. | [ ]  | [ ]  | [ ]  |       |       |
| Our staff are effectively inducted, trained and supervised so they understand their responsibilities around completing, using, reviewing and updating care plans. | [ ]  | [ ]  | [ ]  |       |       |
| Where relevant, we can evidence how we have engaged with family, friends and advocates with the authority to act on behalf of an individual. | [ ]  | [ ]  | [ ]  |       |       |
| We ensure our staff – including volunteers and temporary workers - have enough time to read an individual’s care plans and associated documentation (e.g., handover notes) before they commence supporting them. | [ ]  | [ ]  | [ ]  |       |       |
| Where relevant to our service, the people we support who’ve had a stroke have a structured health and social care review at six months and one year after the stroke, and then annually. This is in accordance with NICE quality standards. | [ ]  | [ ]  | [ ]  |       |       |
| Where relevant to our service, people who have the symptoms and signs of physical problems are recognised and recorded as part of their care plan. This is in accordance with NICE Quality Standards. | [ ]  | [ ]  | [ ]  |       |       |
| Where relevant to our service, the people we support who are growing older with a learning disability are involved in developing a plan for the future and reviewing it at least annually. This is in accordance with NICE Quality Standards. | [ ]  | [ ]  | [ ]  |       |       |

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| Resources to help**GO Online: Inspection toolkit**Learn more about how this is inspected via a short film, practical examples and resources [here](https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Good-and-outstanding-care/inspection-toolkit/Topic-focus.aspx?services=&kloe=responsive-1&topic=person-centred-care-1).**Recommendations checklists**Access the full range of all Recommendations Checklists, exclusively available to Skills for Care Registered Manager Members [here](https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Support-for-registered-managers/GO-guide-SAF.aspx).**Good and Outstanding care support**Skills for Care’s Good and Outstanding care resources include practical e-learning modules, guidance and seminars to support you to meet CQC expectations. Learn more about what is available [here](https://www.skillsforcare.org.uk/go). |