By the end of this unit you will have found out that to ensure a care plan is truly person-centred it must be based on accurate information about the person’s history, needs and preferences. All those involved in the care plan should have a clear understanding of its purpose and outcomes. You will also explore the need to carry out care plan activities in accordance with the wishes of the individual and the importance of tailoring those activities to the individual’s personal circumstances. You will look at how care planning must be done within ‘agreed ways of working’ and explore what that entails. You will also identify the roles of others in care planning.

By the end of this unit you will:
1. Be able to prepare to implement care plan activities
2. Be able to support care plan activities
3. Be able to maintain records of care plan activities
4. Be able to contribute to reviewing activities in the care plan.
LO1 Be able to prepare to implement care plan activities

AC 1.1 Identify sources of information about the individual and specific care plan activities

It is important to remember that the individual’s care plan is a reflection of their specific needs, how to meet those needs and the outcomes the individual prefers. The care plan is a guide to help us support the individual in a person-centred way.

Care plans
A care plan should be written after a thorough assessment of the individual has taken place. The assessor will probably have consulted a range of people, primarily the individual, but may also have approached family members, an advocate and other professionals.

Approaches to carrying out a care plan in accordance to the wishes of the individual include:

- Identifying – finding out about the individual and their care plan; gathering and sharing stories
- Establishing – understanding what the person wants to happen from their care plan; goal setting
- Confirming – checking out that understanding with other people who are involved
- Action planning
- Risk management – making it as safe as possible
- Reviewing – checking that the care plan is continuing to meet the needs of the individual.

Care plans should:

- Meet professional, local and national standards
- Outline aims, actions and responsibilities
- Interact effectively with other care planning systems like the ‘Care Planning Approach’ (CPA)
- Be a document that the service user (the individual) feels they own.

Care plans should not:

- Be a waste of time or paper – they are not a theoretical exercise but should be seen and used as a practical workable document
- Be a list of tasks.

People to consult
Family members are often the main carers for the individual and may understand their needs the best. In circumstances where the person is unable to express themselves because of their illness or level of disability, the assessor may consult the family members. It is vital that the consent of the individual is sought if at all possible.

Advocates are consulted when the person is not able to express their needs and wishes and may be vulnerable. In these circumstances they may require an independent person to support them and work in their best interests to ensure their needs are met.

Other professionals include district nurses, health visitors, GPs, social workers and mental health workers. They may have a particular role to play in helping to develop a care plan.

Key terms

Care plan can also be known as a support plan or individual plan. It is the document where day to day requirements and preferences for care and support are detailed.

Individual is someone who requires care and support.

CPA is a care planning approach used in Mental Health Services.

Advocate is usually an independent professional who acts on behalf of an individual who is unable to express their own views and may not have the capacity to make informed decisions for themselves.
AC 1.2 Establish the individual’s preferences about carrying out care plan activities

Figure 20.1 Factors to consider when carrying out care plan activities

A care plan may include practical tasks like support with activities of daily living (ADL), such as:
- washing
- dressing
- preparing meals
- shopping and cleaning.

Activities could also include support with social inclusion.

Key terms

Activities of Daily Living (ADL) usually refers to washing, dressing, cooking, cleaning, shopping, managing money etc.

Social inclusion enables the individual to participate in activities in society, for example recreational clubs, social events, visiting friends and family.
We all have preferences about aspects of our lives, whether it is what we wear, what we eat or the places we like to go. A person centred care plan takes these preferences into account. Remember, the person you support may have different priorities to you and it is important that those priorities are reflected in the plan.

When establishing the individual’s preferences about their care plan we must ensure we are using the appropriate communication skills. Think about Dorothy in the Evidence activity, she may not be able to tell you which dress she prefers but if you show her a choice of dresses she can point to the one she wants to wear.

**AC 1.3 Confirm with others own understanding of the support required for care plan activities**

In this section we will look at how we ensure that all the relevant people involved in the individual’s care plan (including the health care support worker are clear about its aims and objectives. ‘Others’ might include:

- the individual
- family
- advocates
- managers
- other health and social care professionals.

As the individual’s needs increase and become more complex it is likely that more professional people will become involved in their care and support. These might include the District Nurse, specialist nurses like the Parkinson’s disease nurse, Occupational or Physiotherapists, Dieticians. This may mean there are more risk assessments or specialised care plans. It is crucial that the care support worker keeps up-to-date with these changes and seeks advice and clarification. Often in these circumstances the individual’s key worker or care co-ordinator may call a multi disciplinary meeting.
Dorothy

Consider this case study.

Megan has now been working with Dorothy for several months and they have established a good relationship. Unfortunately, Dorothy has become unwell and is unable to move without the help of two people. You have been assigned to work with Megan.

Megan introduces you to Dorothy and explains that you will be working with her as a result of the reassessment of her needs. She asks Dorothy if she is still comfortable about the changes and the three of you spend a little time chatting together.

Megan takes out Dorothy’s new care plan and talks through it with Dorothy and asks her if this sounds OK to her. The care plan includes her communication needs, dietary needs, choices and preferences, and risk assessment records in relation to various activities. Megan has checked the information with Dorothy first and then confirmed this with you. You have both been trained in moving individuals safely and you check the care plan for transferring Dorothy from bed to chair.

Megan notes that the care plan says that Dorothy needs to eat a high protein diet and needs her porridge to be made with cream. Megan asks Dorothy if she is looking forward to her porridge as well as checking the notes from the dietician to see if there is anything else she has to take into account.

Support required for care plan activities

After reading the Dorothy case study, list the areas of good practice and describe how Megan has confirmed with others her understanding of the care Dorothy requires.

Multidisciplinary meetings

In your own organisation, research how multidisciplinary meetings are conducted.

- When are they held?
- What are the main functions of the MDT?
- Who chairs them?
- Who is invited?
- How are they recorded?
- How is the individual included in the meeting?

Key terms

Care co-ordinator is the person who co-ordinates and oversees the care of the individual by bringing together the different specialists whose help them. The co-ordinator is also responsible for monitoring and evaluating the care.

Multidisciplinary means more than one different profession, e.g. nurse, Occupational Therapist and social worker.

You may be invited to the meeting but if not, it is your responsibility to discuss the outcome of the meeting with your supervisor or manager.
possible. They should work closely with other members of the team to carry out care plans.

Other people contributing to the care plan might include the following:

- **Social worker**: They might act as the care co-ordinator and ensure that everyone has signed up to the care plan which is carried out in accordance with agreed ways of working.
- **Occupational Therapist**: They may suggest activities to support the individual’s independence, particularly in regard to activities of daily living. They may also have undertaken a risk assessment which the care support worker must work within.
- **Dietician**: They will advise on the type of diet the individual should eat when they have particular needs such as diabetes.
- **Community or district nurse**: They support the individual with nursing needs – they dress injuries and pressure ulcers, administer injections, advise on nursing care and support people who may have long term conditions like cancer.
- **Community mental health nurse**: They support people with mental health needs and enable them to remain as independent as possible.
- **Physiotherapist**: They assess individuals who have problems with movement and co-ordination. They might prescribe particular exercises or write a care plan to enable the individual to mobilise.

Each part of the care plan contributes to the support of the individual and may also incorporate agreed ways of working or procedures. For example, the physiotherapist may have written a care plan to support the individual moving from bed to chair. There will also be a moving and handling policy within your organisation (see unit HSC 2028 on Moving and Handling). This is because by law (Health and Safety at Work Act 1974) certain precautions and regulations have to be put in place. The Health and Safety Executive (HSE) ensures these precautions are put in place. We looked at the requirements of the Health and Safety at Work Act in unit HSC 027.

**AC 2.2 Encourage the active participation of an individual in care plan activities**

Active participation is a way of working that recognises an individual’s right to participate in the activities and relationships of everyday life as independently as possible. The individual is regarded as an active partner in their own care or support, rather than a passive recipient.

Let us think about the main elements of active participation:

- **Activities** – the level of support the individual requires in activities will depend on how their illness, disability or situation affects them as well as their personal choices and preferences. They may want to continue participating in a sport or a social activity. If they need support, this should be reflected in their care plan. The support team should work together to ensure the individual has access to stimulating, therapeutic or challenging activities.
- **Relationships** – people need to maintain contact with friends, family, neighbours and former work colleagues. It may not always

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**Case study**

2.1 **Support for care plan activities**

Dorothy’s Occupational Therapist has agreed a care plan with her in which she will help make her own breakfast. When you arrive in the morning Dorothy says she is too tired and doesn’t think the care plan will work. She tries to pour her tea but her hand shakes.

- How would you feel in this situation?
- What course of action would you take?
- How do you think Dorothy may be feeling?
be possible to maintain face to face contact, but there are other ways of communicating: letters, Skype, telephone, or people may meet at social clubs or family gatherings. It is important to find out what is significant for the individual and facilitate (help to make something happen) them keeping contact. It is also helpful to engage with friends and family to help support them to keep contact with the individual. Some people have difficulty in understanding how to support a friend or family member who is living with a disability or an illness. Part of our job is to give them information and ‘signpost’ to organisations that can advise them.

There are organisations to help individuals to live better lives:

These include:
- Mind
- Diabetes UK
- Headway
- Independence – all people should ideally live as independently as possible. We all experience different levels of independence, depending on our age, abilities, or personal circumstances. We must support the individual to be as independent as possible within their own capabilities. This does not mean we cannot help them access stimulating and challenging experiences, but activities should have goals to ensure the individual has a sense of achievement which in turn improves their self-esteem.
- Active partner – this is the person at the centre of their care plan and we should actively listen to them and respect their advice, comments, criticisms and suggestions.
- Passive recipient – this is the opposite to being active. Traditionally, in social care the individual was ‘done unto’ – the care was delivered to them and they ‘received’ it.

**Key term**

Facilitate means to help something happen.

**Evidence activity**

2.2 Encouraging active participation

Look at some care plans in your own work setting. Do they encourage active participation in activities? If you do not have access to a care plan, write one for a colleague. Discuss with them how you would make it person-centred.

**Research and investigate**

2.2 Different care plans

Investigate some examples of different care plans and make a list of the areas they cover. A helpful care plan should describe what the individual needs and the outcomes they want – they should not be just task focused. For example, the care plan might state that the individual needs help with personal care, but the outcome for the individual might be that they feel smart and happy with their appearance.

A written care plan should be as person-centred as possible and be written in plain English without jargon and abbreviations.

You should also consider:
- the reader’s level of literacy
- use of languages other than English (when English may not be the individual’s first language)
- sensory impairments and disabilities
- cognitive impairment
- age.

AC 2.3 Adapt actions to reflect the individual’s needs or preferences during care plan activities

When a care plan is written we must consider and understand the values of the individuals we support:
● the right to maintain as much of their original lifestyle as possible
● choices in the activities they want to pursue
● privacy in their personal life
● independence
● dignity
● respect for their right to express needs and preferences
● partnership with their support network
● equal opportunities to access activities
● individuality – each person is unique and should not be described by their illness or disability but rather their character, background, etc.

Consider a situation where the individual you support is from a particular cultural background. For example, they might be Greek Orthodox or Jewish. They view going to their particular place of worship as very important. ‘Supporting access to religious observance’ should therefore be added to their care plan. It would be helpful to add some detail about what this entails so that the support they receive is appropriate to their needs.

The care plan might also include transport and other community-based services that will help the care plan work.

To be truly person-centred and reflect the individual’s needs and preferences, the care plan should:

● Focus on the individual’s strengths: as the person’s situation changes we can adapt their care plan with them.

Key terms

Contingency arrangement is the ‘back up plan’ for a care plan – for example, if the care support worker is unable to visit at short notice, the contingency plan may be to contact the individual’s family member.

Unmet need means that an assessed need cannot be supported in the way the individual prefers.

● Include crisis and contingency arrangements: this is very important as you may be required to support the individual through an unplanned crisis or make other arrangements for them if their usual supportive arrangements are not available.
● Identify unmet needs: because they may help the individual and their care support network plan for future care – it may not be possible, for example, for Dorothy to go swimming at the moment because you cannot identify a support worker who is able to go with her, but this can be seen as an ‘unmet need’ and something to include in future planning.
● State the date of the next review of the care plan.

**Evidence activity**

2.3 Actions to reflect needs and preferences

How would you adapt a care plan for a person living with dementia who wants to continue to go swimming? The risk assessment indicates that they would be unsafe to go on their own.

What resources or people could you involve to adapt your actions?
profession, whether it is nursing, therapy or social care will include particular standards related to the type of support they are expected to provide. Guidelines are written to ensure that the laws that protect people are observed.

The Care Quality Commission has a legal responsibility to ensure that organisations are implementing and recording care plans in an effective way.

The Care Quality Commission’s Essential Standards of Quality and Safety’ includes the outcome ‘Care and Welfare of people who use services’.

This standard requires that:

- Assessment, planning and delivery of care, treatment and support are centred on the individual and consider all aspects of their personal circumstances and their immediate and longer term needs.
- The care plan is developed with them and/or those acting on their behalf.
- The care plan reflects their needs, preferences and diversity.
- The care plan identifies risks, and says how these will be managed and reviewed.
- We ensure that plans of care, treatment and support are implemented, flexible, regularly reviewed for their effectiveness, changed if found to be ineffective and kept up to date in recognition of the changing needs of the person using the service.

Other legislation (laws) include:

- NHS and Community Care Act 1990
- Children Act 1989
- Mental Health Act 1983

A care plan describes in an accessible way the services and support being provided, and it should be agreed with the individual through the process of assessment and planning. Care plans should be able to talk about the individual’s situation, how it affects their life and what they can and cannot do and the support they might need. Care plans should also recognise that the individual can be in control of their lives, to a greater or lesser extent. It should, as far as possible, be written in their own language, avoiding jargon and shortened forms like ‘DN’ – write district nurse instead.

Each organisation will have a care plan that has a particular layout, because all recording will be done in line with agreed ways of working at a particular place of work. It is important that you familiarise yourself with the format of the care plan so you can implement it. For example:

- What are the individual’s needs?
- What are we planning to achieve?
- How are we going to do it?
- Risk assessments:
  - Who will do it?
  - Where will it be done?
  - When will it be done by?
- Numbers to contact (important people in the individual’s life).

Key term

Accessible means easy to understand, easy to get hold of, and written in a way that suits the needs and abilities of the individual.
Agreement to share your plan with others

All about me
Personal background (personal and family history, strengths, culture, social network)

Day to day activities and relationships that you most value

Personal care, cooking, meal times, social life

Who are the most important people in your life?

Your main current concerns or difficulties (including how they impact on your life)

Other important information others should know about you

Any other information you would like to share

Do you have any personal preferences regarding your support or care?

What’s working in my life

What’s not working in my life

What do I want to happen in the future

Figure 20.2 A sample care plan

Case study

3.1 Record information

When you look at Dorothy’s care plan you notice that an entry has been removed by scribbling through the words and you can no longer read it. There is an additional request from the district nurse written on a sticky notelet, and there is a page missing relating to Dorothy’s dietary care plan. You know that her needs have changed and the dietician has removed that part of the care plan, but you cannot find anything in its place.

Why are these standards of recording not in line with agreed ways of working?

Evidence activity

3.1

Look for the relevant information in your organisation’s policies and procedures – these are part of agreed ways of working. List your organisation’s standards for recording, taking into account good and poor practice.

Research and investigate

3.1 Health and Care Professions Council

Investigate the Health and Care Professions Council. Which professions does this organisation support? What other standards of work performance does it talk about?

Time to think

3.1 Dorothy

Think about how Dorothy might feel, knowing that her care plan may have been updated without consulting her, and that as there are parts missing it does not fully explain how her needs should be met.

The Health and Care Professions Council standards for recording include the following:

- If you update a record, you must not delete information that was previously there. Instead, you must mark it in some way (for example, by drawing a simple line through the old information).
- You must not make that information difficult to read.
- You must keep records for everyone you treat or for who you provide care or services.
- You must complete all records promptly.
- If you are using paper-based records, they must be clearly written and easy to read, and you should write, sign and date all entries.
Whenever you review records, you should update them and include a record of any arrangements you have made for the continuing care of the service user.

- You must protect information in records from being lost, damaged or accessed by someone without permission.
- You should not change or complete records on behalf of another professional, or sign them on their behalf.
- If you are acting on instruction, this should be clearly recorded.

**AC 3.2 Record signs of discomfort, changes to an individual’s needs or preferences, or other indications that care plan activities may need to be revised**

We have thought about how we all change from day to day. One day we may be unwell or feel upset and another mood can change and we will be happy, maybe because of an event or anniversary. In the same way, some people can feel able to be more independent one day and then need more help with a particular task the next. Pain and discomfort can affect the individual. They may feel agitated or anxious. They may not feel able to co-operate with their plan of care or wish to delay their support until they feel better. When we support individuals with a care plan we must remember that the plan is a way of reflecting the needs of the individual. They may not be able to communicate their discomfort and therefore the care plan should include information about how to recognise and respond to that need.

For example, Dorothy’s care plan might say: ‘Dorothy can experience headaches, and when they occur she will often cry and rub her face.’ Of course, you still need to check with her through body language or signs if indeed she has a headache.

The care plan should also suggest a particular course of action, if necessary: ‘Offer Dorothy a glass of water and suggest she has a sleep as headaches often signify that she is tired.’

An individual’s needs may change temporarily – Dorothy may require support for a headache only occasionally, but we need to be aware of patterns occurring or changes becoming more permanent.

If her headaches start occurring daily or seem to happen after a visit from a particular relative, it is important that this is noted and discussed with your manager and Dorothy’s care co-ordinator.

Such changes would suggest that the care plan should be looked at again.

**Key term**

*Discomfort* means to feel uncomfortable – this can be both a physical or mental experience.

**Evidence activity**

**3.2 Changes in care plans**

Think about how you would portray these changes in Dorothy’s care plan.

- Who needs to know?
- What needs to happen?
- How will you review the changes?
**LO4** Be able to contribute to reviewing activities in the care plan

**AC 4.1** Describe own role and roles of others in reviewing care plan activities

Earlier in this unit, we have looked at the different professionals who contribute to care plans to help the individual manage their situation better. It is very important that you understand your own role and that of others in delivering a care plan because this is both a health and safety issue and a governance issue.

Therefore, you should not carry out any task or offer any support that you have not either been trained or asked to do. This is to protect the well-being and safety of the individual.

Governance means that we all have a responsibility to carry out the care and support as agreed with all those involved. If we ‘go our own way’, without consulting others, we are changing the care plan and this could have significant implications or consequences.

The consequences of changing care plans or ‘going our own way’ without consulting or talking to others can be serious both for the individual and their organisation. By doing so, the worker can introduce more risk into the situation, or they may not be working in accordance with the wishes of the individual, which may in turn lead to a complaint.

This does not mean we have to behave like robots – we still use our skills and knowledge, but by understanding our own and others roles, we can recognise when it is time to consult with others.

It might be helpful to understand more about others’ roles so that we can work meaningfully and co-operatively with them.

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### Research and investigate

#### 4.1 Roles of others

Ask your line manager if you can visit other services or organisations to find out about the roles of others. It may also be possible to ‘shadow’ someone – this can be arranged through your line manager. If none of this is possible, use a search engine to research some of the roles of others you may work with.

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### Case study

#### 4.1 Roles

Think about this scenario.

Dorothy is in a care home now. Her mobility is much improved and she has been assessed by the Physiotherapist as requiring a stick to mobilise. Dorothy has been practising and although she gets tired, she is doing well. This is written in her care plan.

One morning she complains to a care assistant that she is feeling tired using her stick. The care assistant brings Dorothy a spare **Zimmer frame** to use. Dorothy has never used a Zimmer before. She falls.

Discuss the issues with a colleague – think about the assessment and the care plan as well as the role of the Physiotherapist and the role of the care assistant.

What should the care assistant have done in this situation?

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### Key term

**Governance issue** means that your organisation expects you to perform your work to an agreed professional standard. These standards are usually explained in the organisation’s policies.

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### Research and investigate

#### 4.1 Policies and codes of conduct

Research and investigate the relevant policies or codes of conduct in your own organisation which help you to understand how you are expected to perform particular tasks, including how you record information about the individual.
**Zimmer frame** – a walking frame which is a tool for people who need additional support to maintain balance or stability while walking. They should not be used without an assessment from a qualified Occupational Therapist or Physiotherapist.

It is likely that the care plan will have been written by qualified staff – nurses, social workers and therapists – in consultation with the individual.

If the support and outcomes are unclear ask for more information and always check with the person you are supporting that they are comfortable with what you are doing.

There may be some occasions when you are supporting an individual with challenging needs and you are required to work together with another person. You must ensure that you understand your role and that you work as a team. Remember, the individual is the third member of that team, so include and consult with them as much as possible.

**Time to think**

**4.1 Teamworking**

What do you think are the main qualities of a good team? How does good teamworking help when you are supporting an individual?

**Evidence activity**

**4.1 Roles**

Look at your job description or job role. Make a note of what it says about your role in reviewing care plan activities. How does this fit into the role of others? Evidence this as follows:

- Role of assessors in reviewing care plans (describe the role of a manager, nurse, a social worker and occupational therapist)
- My role.

Summarise and describe your own role and the roles of others in reviewing care plan activities.

**AC 4.2 Seek feedback from the individual and others on how well specific care plan activities meet the individual’s needs and preferences**

All care plans should have a built in review date, when all the people involved in the plan meet to discuss any changes, how well the support is going and whether the individual’s needs have changed.

However, generally speaking, anyone can ask for the care plan to be reviewed at any time. This might be because there has been a change in circumstances for the individual, or a certain part of the support plan is not working well or is no longer necessary. The person at the centre of the care plan must be consulted with in all these circumstances as they are considered as the ‘expert’.

It is also important not to ‘store up’ issues. As we know that people are different every day, so it is necessary to check with the individual on a regular basis that the care plan is meeting their needs.

Others involved in the care plan may ask for particular feedback from you about how well the activities and support are meeting the individual’s needs and preferences. This is asking for objective feedback with examples, not your personal opinion. For example, the Physiotherapist may ask in the care plan for feedback about how well Dorothy is coping with her stick.

**Evidence activity**

**4.2 Feedback**

You have been asked to give feedback about Dorothy.

a) ‘Dorothy doesn’t like using her stick and I decided to give her a Zimmer frame.’

b) ‘Dorothy says that she gets tired using her stick. I have observed that she is steady walking short distances but does tire after several minutes. I have discussed this with Dorothy and we have agreed that I will contact the Physiotherapist for advice.’

Think about the two comments about Dorothy and explain why ‘b’ is the appropriate feedback.

How well does the care plan meet Dorothy’s needs and preferences? How could it be improved?
AC 4.3 Contribute to review of how well specific care plan activities meet the individual’s needs and preferences

In order to contribute to reviewing how well care plan activities meet the individual’s needs and preferences, you need to be able to measure the success of these outcomes.

The care plan might say, for example, that Dorothy likes to be supported in attending a local singing group. However, if you are unaware of the quality of that outcome — that attending the singing group helps Dorothy with her memory and social skills — you cannot contribute to the review in a constructive manner.

You may know that Dorothy enjoys singing, but unless the care plan indicates, you would not be aware that you should also be observing any changes or improvements in Dorothy’s memory or the way she copes in groups, etc.

Quite often, as the care support worker, you will be the person who has the most contact with the individual and as such will get to know their habits, routines, needs and preferences well. Other professionals will expect you to be able to feedback on any significant changes. Sometimes when we work with an individual a lot and get to know them well we may notice subtle differences and it is important to seek the views of colleagues.

There may be situations where you have a concern but are not sure whether it is significant or not — this can sometimes be referred to as having a ‘gut feeling’. This usually means that through your experience and knowledge of the individual you have noticed something different but you need another person to confirm your opinion. For example, you may think that Dorothy is becoming withdrawn, but as she has quiet days anyway, you may need to ask a colleague for their opinion the next time they see her.

There are some obvious changes, when the individual stops eating or sleeping well or communicating. If there is a sudden or dramatic change it is important to relay that information as soon as possible.

You should record your observations in a factual and objective way and contact the most relevant person as soon as possible, this may be the GP or your line manager or another relevant professional, depending on the situation.

AC 4.4 Contribute to agreement on changes that may need to be made to the care plan

Any changes, both positive and negative, should be reflected in the care plan. As we have just seen, it is important that we communicate changes as soon as possible to ensure the individual has the opportunity to have their care reviewed to better meet their needs.

Evidence activity

4.3 Preferences

Write a care plan for Dorothy which explains her preference to go to the singing group. Explain the benefits and outcomes that should be reviewed. How could you contribute to the review of how well her care plan meets her needs and preferences?
Individuals should be consulted about any changes to their care plan. When contributing to agreed changes, the emphasis should be on both the words:

- Contribute
- Agree.

Your contribution should be factual, with dates and examples, if necessary. It is not enough to use generalisations like ‘Dorothy gets tired’. ‘In my opinion, Dorothy is becoming more tired because she asks me to help her to lie down each afternoon and this has been the pattern for the last two weeks’ is a more acceptable and accurate comment.

Professionals will disagree about a particular course of action at times. In these situations it is extremely important that we remember to put the needs, choices and preferences of the individual at the centre of any discussions. Agreed changes should be for the benefit of the individual. If the individual is not in agreement with the changes, you may need to involve an advocate or someone who is not directly involved in their care to support the process so that the changes are agreed in the best interests of the individual. This is particularly important when the person may lack capacity. These people might include an Independent Mental Capacity Advocate (IMCA), a general advocate from the advocacy service, or a solicitor.

**Evidence activity**

**4.4 Agreement on changes**
You have attended Dorothy’s review and you disagree with a part of the care plan being changed. How does this make you feel?

Dorothy also disagrees. What is the next step?

Think about all the learning throughout this unit and apply it to this evidence activity.

Has Dorothy’s care plan been prepared in an appropriate way? Are you able to support her current care plan and if not, why not? Ensure that you record any activity or outcomes accurately and in the approved (agreed) manner – explain how you would do this.

**Legislation**

- Health and Safety at Work Act 1974
- Mental Health Act 1983
- Mental Capacity Act 2004
- NHS and Community Care Act 1990
- The Children Act 1989

**Useful resources**

**Websites**
- SCIE (Social Care Institute for Excellence) [www.scie.org.uk](http://www.scie.org.uk)
- Health and Care Professions Council [www.hpc-uk.org](http://www.hpc-uk.org)
- Care Quality Commission [www.cqc.org.uk](http://www.cqc.org.uk)
- Health and Safety Executive [www.hse.gov.uk](http://www.hse.gov.uk)