Southern Health and Social Care Trust

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Southern Health and Social Care Trust (SHSCT) Older People Primary Care (OPPC) Integrated Care Teams (ICT) Care Management Standard Operating Procedure

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Southern Health and Social Care Trust (SHSCT)

Older People and Primary Care (OPPC) Integrated Care Teams (ICT) Standard Operating Procedure (SOP)

INTRODUCTION

AIM OF PROCEDURE:

To support the implementation of the Care Management, Provision of Services and Charging Guidance Circular (ECCU) 1/2010

CARE MANAGEMENT AND CASE MANAGEMENT

Care Management is a dynamic process tailored to the circumstances and needs of individuals and their family within the community setting. The term Care Management is used to describe key functions to be carried out (See Appendix A). These are separated into the following 7 stages:

Table 1: Case Management Stages

STAGES	NAME OF STAGE
1	Case Finding
2	Screening and Allocation
3	Assessment of Need
4/5	Care Planning and Implementation
6	Initial Review
7	Annual Review

The term Case Management is the activity within the Care Management Process of advocating and effectively coordinating timely services for "people with complex, or frequently or rapidly changing needs or for people with more straightforward and stable needs" (Page 1 - 2010 DHSSPSNI Care Management Circular).

The Southern Health and Social Care Trust (SHSCT) follows the Care Management Process as detailed within the Care Management, Provision of Services and Charging Guidance Circular (ECCU) 1/2010. In OPPC Integrated Care Teams, Care Management is in relation to people aged 65 years and over who meet one or more of the following Case Management Criteria:

- Require, or are at risk of, permanent admission to Residential Care, Nursing Homes or long-stay care settings.
- Are in need of care and protection.
- Are assessed as being at a high level of risk.
- Are experiencing severe mental or physical ill health and loss of independence.
- Have complex needs or challenging behaviour where high level support is necessary.
- Care arrangements are at risk of breaking down.
- Experiencing rapidly or frequently changing needs
- Are highly dependent on the input of a carer.
- Are people with complex needs whose carer's needs mean they are having difficulties in maintaining their caring role.
- Require a range of professional input and services to manage their needs.
- Have a chronic long-term condition.
- Are high intensity users of unplanned secondary care (frequent hospital admissions)

The 2010 Care Management Guidance acknowledges that Trust staff members have a duty to Service Users and taxpayers to ensure that quality services are procured and delivered in response to assessed need at a cost that represents best value for money within available resources. The guidance also acknowledges that:

- In Domiciliary Care Settings, eligibility criteria should be used to identify those most at risk and give these individuals priority. The Trust also has a statutory duty to use a Self-Directed Support approach in relation to Domiciliary Care which will consider service being provided by Direct Payments, a Trust Managed Budget or a Trust Arranged Option or a combination of these 3 options.
- It is recognised that there may be a point where the intensity of need; the safety of the individual/carers; pressure on the family and support network and the cost effectiveness of the domiciliary care means that Residential or Nursing Home Care become the most appropriate care option. This choice is often a positive one, providing a level of reassurance and security to Service Users/Carers.

PERSONS NOT ORDINARILY RESIDENT TO NORTHERN IRELAND

In accordance with the Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015, the Health and Social Care Trusts in Northern Ireland have a **legal obligation** to identify Service Users who are not 'ordinarily resident' in Northern Ireland as these Service Users may not be entitled to receive services free of charge. This legislation is health care specific and does not extend to social care services.

In recent years, Northern Ireland has seen a substantial change in the diversity of its population. Many of those living and moving to Northern Ireland will be entitled to publicly funded Health and Social Care but while

legislation on access to Health and Social Services will protect both human rights and public health this must be balanced with the need to ensure that resources are not being misused. Therefore before providing services, it is essential to ensure confirmation of a person's 'ordinarily resident' status has been validated.

Fundamentally, Healthcare is a residency-based entitlement and any visitors/non-residents are only entitled to immediately necessary treatment within the Emergency Department without charge. Any treatment outside of Emergency Department is chargeable unless the individual meets the exemption criteria. For urgent treatment, every effort should be made to secure payment in the time before treatment is scheduled. However, where this is not possible, the treatment should not be delayed or withheld for the purposes of securing payment. Where possible all entitlement queries should be dealt with prior to the treatment. Indeed most will be dealt with on a case-by-case basis.

Where there is any element of doubt regarding an Individual's permanent residency within Northern Ireland please refer to the "Access to Health Assessment to Entitlement Aid" via the link below for further information Entitlement Aid.

- **The main triggers are as follows:**
  - No Health and Care Number; **and/or**
  - No primary address in Northern Ireland; **and/or**
  - No registered GP

- For all queries in relation to patient entitlement, please contact Brigid Quinn, Access to Health & Social Care Team, located in Daisy Hill Hospital prior to processing a referral. **It is critical that the Care Management process is not triggered for individuals who do not meet the eligibility criteria.**

[redacted]

STANDARD OPERATIONAL PROCEDURE

This procedure is to assist Integrated Care Team (ICT) staff within the Southern Health and Social Care Trust OPPC Directorate to implement Case Management as outlined in the Care Management Provision of Services and Charging Guidance Circular HSC (ECCU) 1/2010 - see link below:
Case Management, Provision of Services and Charging Guidance Circular (ECCU) 1/2010

For the purpose of this document the term Carer is used throughout. This can be interpreted as a relative, friend or responsible person who is nominated by the Service User.
The term Service User is utilised. This can be interchanged with Patient or Client.

It is essential to seek the Service User's informed consent to share relevant information with other professionals in line with General Data Protection Regulation (GDPR) and Practice.

SOCIAL CARE WORKER (SCW) ROLE

The role of the SCW is fundamental within the Case Management process. The 'Delegation Framework for Social Care Worker Tasks' encompasses tasks that have been agreed for delegation from Key Workers (can include Professional Team Leads) to Social Care Workers (SCWs) within ICTs. It should be read in conjunction with the 'Escalation Triggers Framework for Social Care Workers in ICTs'. Please see SharePoint link **ICT Business Processes** to the following documents:

- Delegation Framework for SCW Tasks to be delegated from Key Worker/Case Manager
- Escalation Triggers for SCW
- SCW Client Monitoring Form

All Case Management documentation will be available on the OPPC Trusts SharePoint via this link:
Case Management SharePoint

STAGE 1	**CASE FINDING** Provide Case Management Information Pack to the Service User/Carer. **Contents of Case Management Information Pack:** ➢ Cover Letter (See Appendix B) ➢ We Value Your Views Leaflet ➢ Care Opinion Leaflet ➢ Case Management Leaflet ➢ Carer(s) Assessment Information Leaflet ➢ Carers' Register Leaflet ➢ Self- Directed Support: The User Guide February 2016 ➢ Guidance on Paying for Care in Residential/Nursing Home Information Booklet **NB**: It is important to check that the Case Management Information Pack contains the **current** financial year forms. Please click on the following Link: **ICT - Appendices** to access the Case Management Information Pack (Appendix B).
STAGE 2	**SCREENING AND ALLOCATION** 1. All referrals coming into the ICT PARIS Duty Desk will be screened as per current Professional PARIS Processes, as accessed through the following Link: **ICT PARIS Professional Processes** 2. Screening will be undertaken by a registered staff member to identify individuals who meet the Case Management Criteria, as listed on page 5. 3. Not all Service Users will meet the Case Management Criteria but they may still require services from the ICT. 4. A Key Worker/Case Manager must be identified as defined within the Older People & Primary Care Integrated Care Teams' Organising Person-Centred Care Position Paper (2017); NISAT Interim Procedural Guidance Version 4 (September 2016) and endorsed by the 2010 DHSSPSNI Care Management, Provision of Services and Charging Guidance Circular HSC (ECCU) 1/2010. 5. The Service User may choose not to avail of Case Management. The reason for opting out of the Care Management Process should be recorded in the Service User's eNISAT Initial Assessment/Short Term Intervention (IA/STI)/Core eNISAT and the Service User/Carer can be advised he/she can choose to avail of the Care Management Process at a future date. 6. In cases where there is a query around an individual's permanent residency within Northern Ireland the Service User is not entitled to avail of Case Management until the query is resolved.

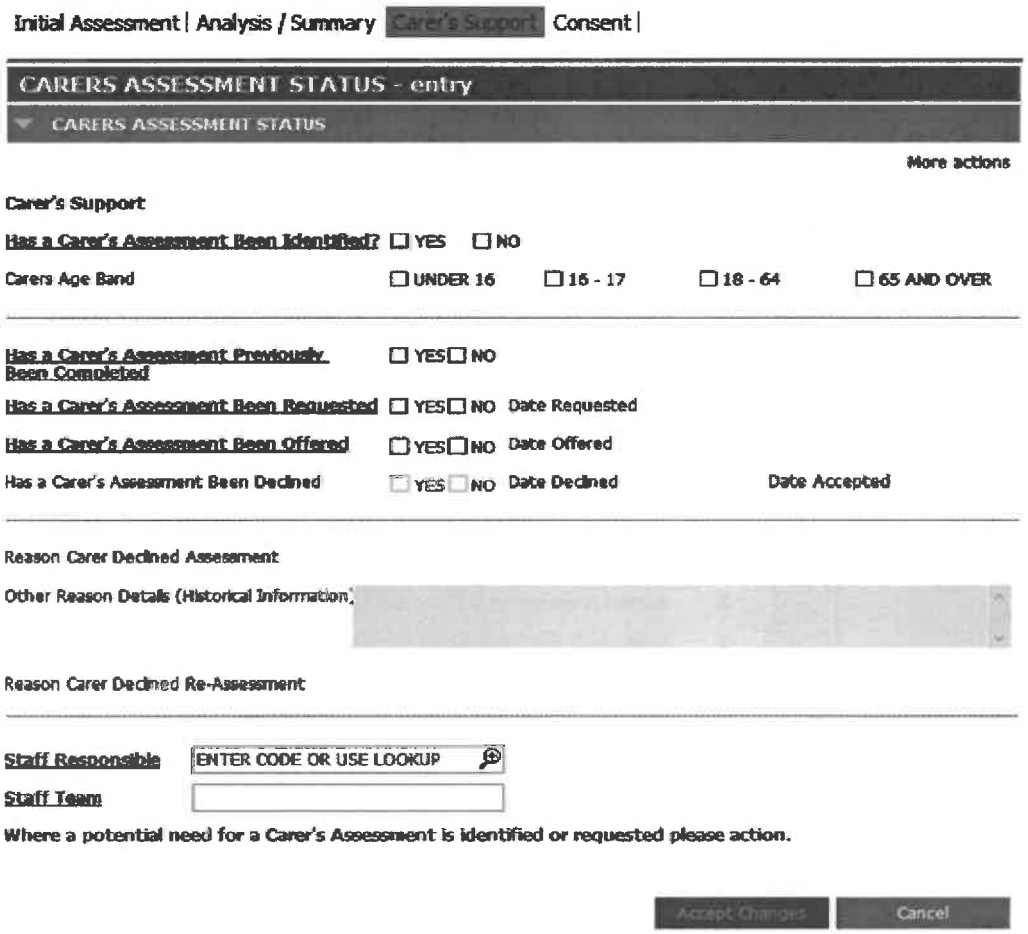
	Please contact [redacted], Access to Health & Social Care Team. [redacted]
STAGE 3	**ASSESSMENT OF NEED** 1. The Service User/Carer must be informed that the Case Management criteria has been met. The Key Worker/Case Manager will complete the following with the Service User/Carer; ➢ Explain the Care Management Process ➢ Explain the Key Worker/Case Manager role ➢ Explain the First Point of Contact (FPOC) role and ➢ Obtain consent both to proceed with assessment and to share the information with family/carers. 2. The Key Worker/Case Manager must record that the Service User/Carer has received a Case Management Information Pack, and the date issued should be recorded in PARIS case notes. 3. An eNISAT Core/Complex Assessment must be undertaken. The Assessor's Analysis, Summary and Action Details completed. 4. The Regional eNISAT Business Rules should be adhered to; ➢ An eNISAT Assessment cannot be used for any person under the age of 18 years. ➢ An Initial Assessment/Short Term Intervention Assessment (IA/STI) does **not** have to exist or be completed for each Service User **before** moving to a Core/Complex or Specialist Assessment. ➢ More than one IA/STI may be open concurrently (within a Team or across Teams). ➢ A second Core/Complex Assessment cannot be opened if an open Core/Complex Assessment already exists. ➢ A staff member in a different Team will be able to open a Specialist Assessment Summary. ➢ Multiple Specialists Assessments Summaries can be opened at any time. 5. The Key Worker/Case Manager **must** collate multidisciplinary assessments and ensure completion of the eNISAT **Complex** Assessment. The eNISAT Core/Complex Assessment should be **completed/end dated within 28 days from commencement date**. **NB**: For existing Service Users: If there is no eNISAT Core/Complex Assessment completed this must be undertaken as part of the Review Process. The Person-Centred Review Form has been discontinued. 6. Undertake an onward referral for additional multi-disciplinary assessments and/or eNISAT Specialist Assessment Summary. 7. Obtain other assessments which may inform the Care Plan such as: Moving and Handling Risk

Assessment (MHRA), Falls Risk Assessment Tool (FRAT), Malnutrition Universal Screening Tool (MUST), Restrictive Practice Plans.

8. If a Carer is identified the Key Worker/Case Manager must offer and/or complete a separate carers assessment using the Carers' Conversation Wheel which has now replaced the NISAT Carer(s) Support and Needs Assessment (Version 4).

9. The Carers Assessment Status section **must** be completed in PARIS, as per screenshot below. Completion of the Carers Assessment Status section will inform Departmental statistical information. See below:

Please select Carers Support and then insert a row.



10. Staff **must** commence the ICT Case Management Monitoring Form (See Appendix C) which is found within the Assessment Module on PARIS.

There should only be **one** ICT Case Management Monitoring Form open at any given time. The following sections should be recorded:

- Date Referred for Case Management
- Reason for Assessment
- Carried out by
- Case Management Criteria met
- Screening Outcome
  - Date screened is the date screened on duty desk
  - Outcome from screening
  - Comment (if required)
- Reports Requested (if applicable)

NB: If completing a hard copy of the ICT Case Management Monitoring Form this must be forwarded immediately to ICT admin for input to PARIS.

11. The following Checklists in (Appendix D) can be completed by the Key Worker/Case Manager to support each option discussed;

- Checklist 1: Self Directed Support
- Checklist 2: Commencing a Domiciliary Care Package
- Checklist 3: Admission to a Residential Home
- Checklist 4: Admission to a Nursing Home
- Checklist 5: Bed Based Short Breaks/Respite
- Checklist 5a: Flexible Short Breaks/Respite
- Checklist 6: Day Care
- Checklist 7: Resident's / Tenant's Review Record – Finance Section

12. If consideration is being given to the need for a long-term care placement the Key Worker/Case Manager should provide and discuss the Information Booklet titled 'Guidance on Paying for Care in Residential/Nursing Home', as found in the Case Management Information Pack.

13. When Temporary/Permanent, Residential or Nursing Home Placement is confirmed a Social Worker **must** be involved to support the admission/transition work.

14. Prior to discussion at the weekly Case Discussion Meeting, all relevant assessments/documentation **must** be completed as identified within OPPC Standard Operating Procedures for Assessment, Allocation and Commissioning of Service and Equipment (2017).

	15. The Key Worker/Case Manager **must** email ICT admin with Service User Name and PARIS ID requesting timeslot at weekly Case Discussion Meeting. (Appendix G) 16. Staff **must** update/complete the ICT Case Management Monitoring Form on PARIS by updating the following section: ➢ **Assessment Outcome Section** ▪ Date Assessed - Date all assessments have been collated by Key Worker (date should not be before the screened date) ➢ **Package Implemented Section** ▪ Date Package Implemented - Date services commenced (should be same as or after assessed date) 17. If there is a significant change in the Case Management Process, the ICT Case Management Monitoring Form should be end dated and a new one started. A significant change constitutes a Case Management reassessment for example, a Service User moving from Residential Home Placement to Nursing Home Placement. If completing a hard copy of the ICT Case Management Monitoring Form this must be forwarded immediately to ICT Admin for input to PARIS.
STAGE 4/5	**CARE PLANNING AND IMPLEMENTATION** 1. The Key Worker/Case Manager will agree a suitable date, time and venue with the Service User/Carer to facilitate the sharing of assessment outcomes and to formulate and agree the Service User Care Plan (See Appendix E). This may involve the attendance by some/all professionals involved if there are complex management issues that need addressed. 2. If the Service User is unable to attend the Key Worker/Case Manager must ensure outcomes of assessments are shared, taking into account the Service User's capacity, and discuss how these can be addressed with the Service User/Carer. 3. Should the ICT be approached requesting Health & Social Care Services for a resident from England, Scotland or Wales or a Non-UK country please consult with ICT Manager. Funding must be agreed in advance with the first authority (or placing authority) as they retain financial responsibility for the resident. Additional information regarding Extra Statutory Authority can be found from the attached link **Extra Statutory Authority.** For further queries regarding Non-UK nationals please contac[redacted] [redacted]n Access to Health & Social Care Team. [redacted]

Domiciliary Care Support

1. A Self- Directed Support approach must be adopted. All Service Users in receipt of domiciliary care support (domiciliary care packages, direct payments, managed budgets and day care) should have, at a minimum a 1 page SDS support plan which is required to be reviewed annually. This document should be attached to PARIS as an external document titled "SDS Support Plan" and guidance is included within the link below. Self-directed Support information can be found on this **SDS link**.

2. All Care packages agreed must be delivered in line with Departmental and SHSCT Guidance to ensure Domiciliary Care Resources are targeted to those in **most need** as identified through **assessment processes** and within **available resources.** The Key Worker/Case Manager **must** prioritise the needs identified with the Service User/Carer. See link to Departmental and SHSCT Guidance **Case Management SharePoint**

3. Where support is required, **All Staff** must negotiate and mobilise support from family, friends and community/voluntary sector agencies (Access and Information can support with information on resources) before considering provision of Domiciliary Care Services. Consideration should be given to the involvement of family support for Weekend & Bank Holiday cover, so reducing demand on Trust Services. Staff have a responsibility to **document** discussions and outcomes during the assessment process.

4. The Service User/Carer should be helped to identify the individual/family/community resources available to achieve the agreed care plan outcomes. The Personal Support Plan (See Appendix F) can be used to help the Service User/Carer with this process when the care needs are very complex.

5. During all assessments, care planning and reviews, Key Workers/Case Managers should adhere to the following:

    - Service Users and their Carers should be directly asked about any other person that co-habits with them that is also in receipt of domiciliary care services and/or other support services, ensuring any interdependency is given consideration in relation to imminent and future care planning and the utilisation of statutory and voluntary support services.

    - Acknowledge interdependency via appropriate recording of the information ensuring all communications in relation to interdependency are recorded and documented on the Trust's Patient record system, PARIS.

    - Gain consent for the recording of this information however acknowledging Service Users may choose not to consent to the sharing of their care planning with others in the home.

6. Following negotiations staff must identify the needs outstanding and provide information on the range of options via self-directed support which may be considered to meet these needs.

7. Staff must review these outstanding needs against the SHSCT OPPC Guidance for Organising Domiciliary Care Support 2018 Guidance for Organising Domiciliary Care Support Paper

8. Eligibility Criteria and application of decision making tools must be evidenced against the 4 Bands (Critical, Substantial, Moderate or Low need) to prioritise those most at risk. The Trust is currently working to CRITICAL Levels of Need Only.

9. Where intensity of the individual's needs, safety of the individual/care worker, pressure on the family and the cost effectiveness of the total care package provided by the Trust, costs an amount equal to or exceeding the cost of either Residential/Nursing Home Care, the option of a Residential/Nursing Home Placement must be considered as the Trust's preferred option to support the Service User's needs.

10. Staff members should be aware of the ICT Accessing Domiciliary Care Support Escalation Flowchart (See Appendix H).

NB: When a Service User's complexity of needs indicates that consideration should be given to a long-term Care Home placement, **a Social Worker must be appointed as Key Worker/Case Manager** to support the Service User/Carers through this process.

11. Staff should record unmet need in the eNISAT Need Identification Grid found within the Assessors Analysis, Summary and Action Details. Should unmet need be identified, appropriate risk management strategies should be put in place and the circumstances of the case **must** be kept under regular review.

12. Details of new and/or changed Service Provision must be discussed at the "Weekly ICT Case Discussion Meeting" as illustrated in Appendix G.

13. The Key Worker/Case Manager must commence the ICT Care Review (See Appendix I) Form in PARIS.

14. The procurement of Domiciliary Care Services should be initiated via existing Southern Trust processes by completion of the DC1 and sent to Care Bureau. Where there is a care plan initiated or a change to the existing care plan this must be approved by a Professional Staff member. **DC1 Information**

15. If Direct Payments is the option chosen by the Service User the Key Worker/Case Manager must complete Direct Payment documentation and forward to: [redacted] See SDS home Page **Self Directed Support**

16. All Service Users who choose Direct Payments **must** have a Social Worker as Key Worker/Case Manager.

17. The Social Work Professional Lead **must** ensure the agreed Finance Forms are completed for Direct Payment; Managed Budget or Trust Arranged Support Options.

18. It is the responsibility of the Key Worker/Case Manager to ensure a copy of the Service User Care Plan (See Appendix E) is shared, discussed and signed with the Service User/Carer and other relevant Professional staff as appropriate. The completed Service User Care Plan should be uploaded onto the Service User's Paris record as an external document and "document type" selected should be "Care Plan".

19. Where a Service User refuses receipt of the Service User Care Plan, that decision together with the reasons should be recorded on the PARIS case notes. This decision should be revisited periodically (at least annually) reminding the Service User of his/her entitlement to receive a copy of the Service User Care Plan. A record of reminders offered and their outcomes should be maintained within the Service User case notes.

20. Ensure agreed assessment documentation is forwarded to the relevant provider i.e. Risk Assessments, Manual Handling Assessments, Care Plans with safe systems and Standard Operating Procedure/Guidelines, where appropriate.

21. Where Emergency Self-Directed Supports are being utilised on discharge from hospital it is the responsibility of the Key Worker/Case Manager to review the arrangement and care plan within 4-8 weeks. Please see full information on ESDS **Emergency Direct Payments.** _All Service Users who choose Emergency Direct Payments **must** have a Social Worker as Key Worker/Case Manager.

NB: For Hospital Discharges from both Acute and Non-Acute, the Hospital care plan and associated risk assessments can be in place for up to 72 hours.

Day Care Placement

22. The Key Worker/Case Manager in conjunction with other appropriate Professionals will agree a suitable Day Care Setting.

23. The Key Worker/Case Manager provides request (via eNISAT) for the Weekly ICT Case Discussion Meeting for authorisation of day care placement by a Professional Lead.

24. The Key Worker/Case Manager must complete a separate carers assessment using the Carers' Conversation Wheel which has now replaced the NISAT Carer(s) Support and Needs Assessment (Version 4) if the reason for Day Care is to provide support/relief for Carers.

25. The Key Worker/Case Manager must commence/update the Care Review Form in PARIS.

26. The Key Worker/Case Manager must ensure DC1s reflect the day care provision provided. The Social Worker, if applicable, will keep the Key Worker/Case Manager informed/updated.

Admission to Residential/Nursing Homes (includes Temporary/Bed Based Short Break) Placement.

N.B. A Service User residing in a Care Home under a private arrangement is not the same as a Service User residing in a Care Home and self-funding. If a Service User organises a placement or bed based short break in a Care Home as a private arrangement between the Care Home and the Service User/Family; this is not considered a Trust facilitated placement and would not be subject to Case Management processes, monitoring and review and financial assessment. This has to be fully explained to the Service User and family by the Social Worker involved and that the Trust can only facilitate and review a placement that has been assessed by relevant Trust multi-disciplinary professionals and identified in collaboration with the Service User as the required support to meet their assessed needs.

When a Service User is assessed by relevant Trust multi-disciplinary professionals as requiring a bed-base short break, temporary placement or permanent placement, the Service User has the option of signing a non-disclosure in relation to their finances and to self-fund the placement but they continue to be supported via the Case Management process with the appropriate monitoring and review. A Service User may also disclose their finances and undergo a means-tested financial assessment and be deemed as required to self-fund. This is not the same as a private arrangement.

27. Details of Service Provisions must be approved through ICT Case Discussion Meeting Pathway as illustrated in (Appendix H). (Bed Based Short Breaks are exempt from this as they should be approved via Social Work Professional Lead following the outcome of a Carers Assessment.)

28. A Social Worker **must** support the admission/transition work.

NB: When a Service User's complexity of needs indicates that consideration should be given to a long-term placement, **a Social Worker must be appointed as Key Worker/Case Manager** to support the Service User/Carers through this process.

The Service User/Carer **must** be directed/informed of the following;

- To view Information on available homes on the RQIA Web site, please click the following link: **RQIA**
- The availability of beds within the SHSCT area from the most recent 'Bed List'. Please advise the Service User/Carer that this 'Bed List' is updated weekly.

29. The Social Worker will share all assessments at the ICT Case Discussion Meeting Pathway as illustrated in (Appendix H) to ensure appropriate placement.

30. The Social Worker will check with Community Contracts Team (CCT) as per Table 1, to ensure that the Trust has a contract in place with chosen Residential/Nursing Home.

Table 1: The Community Contracts Team Details

Name	Designation	Email	Contact Numbers
[redacted]	Head of Service	[redacted]	[redacted]
[redacted]	Contracts Officer	[redacted]	[redacted]
[redacted]	Contracts Officer	[redacted]	[redacted]
[redacted]	Contracts Officer	[redacted]	[redacted]

31. The Social Worker will check bed availability with the chosen home and liaise with the Home Manager to organise a pre-admission assessment (PAA) to ensure that the home can effectively meet the individual needs of the Service User.

32. When Service Users are being placed in a Care Home, discussions will occur between the Care Home Manager and the Social Worker/Social Care Worker in order to confirm that the Care Home has received the assessments relating to the Service User's current needs and support requirements and that the Care Home can accept the Service User and meet the particulars of the care being commissioned. Care Home Managers should provide prior confirmation that all pre-admission documentation has been read.

33. The Service User/Carer will be assisted by the Social Worker to complete the;
    - Admission/Discharge and Financial Referral Form
    - Agreement to Pay Form
    - Top-up Undertaking to Pay Form (where applicable)
    - Choice Assurance – If the first choice Home is not available at time of admission.

34. Please click the attached link for Financial Forms: **Financial Forms**

NB: the Standard Operating Procedure for Processing Temporary/Permanent Residential/Nursing Placement Details should be adhered to.

Whereby there appear to be issues in relation to any Service User independently managing their own finances or lacking capacity to appoint someone to manage finances, the Trust are required to refer to the Office of Care and Protection. Key Worker/Case Manager can consult with line manager to seek support with this process as required.

35. Checklist 7 "Resident's / Tenant's Review Record – Finance Section" (Appendix D) should be completed for all Service Users on admission to a Care Home and revisited for each review or sooner

as required.

36. Where applicable prior to an initial care home admission and prior to all annual reviews, the Key Worker must ensure contact with Finance for a balance of the Patient Private Property (PPP) account prior to the annual review taking place. *NB This financial information is provided for the purposes of the financial review of client needs. Under GDPR, the Trust is not permitted to disclose personal financial information to a 3rd party e.g. client family members.*

37. The ICT Social Work Professional Lead will oversee that the agreed financial forms have been completed.

38. If the placement of a SHSCT resident outside Northern Ireland is being considered refer to Extra Statutory Authority (ESA) information and consult with ICT Manager. Please ensure that early contact is made with the Financial Assessment Team to ensure arrangements can be made for completion of the Financial Assessment prior to admission. Please see link **Extra Statutory Authority**

39. The Social Worker in conjunction with other appropriate Professionals will agree the appropriate category of care e.g. Dementia Residential and Dementia Nursing. For Dementia Placements consideration should be given to a Specialist Assessment completed by the Memory Team.

40. The Finance Department will inform the Social Worker if the Service User is a Self-Funder.

41. Financial Assessment Officers will make contact with the Service User/ Service User's financial representative to complete the relevant financial information once a referral has been received from the Social Worker. Appointments to complete financial forms are available only at Ghana House, Daisy Hill Hospital, Newry. If unable to attend the financial assessment officer will either arrange a telephone appointment or forms will be emailed/posted out to the Service User/Service User's financial representative.

42. The Finance Department will inform the Social Worker if a Nursing Needs Assessment Tool (NNAT) is required. The NNAT needs to be completed by a Registered Nurse. (The NNAT form continues to be reviewed).

43. The Social Worker will agree the date for admission with the Service User/Carer and Residential/Nursing Home.

44. The Social Worker must commence/update the Care Review Form in PARIS with the Placement Name/Type/Date.

45. The Social Worker must ensure all relevant documentation is forwarded to the Residential/Nursing Provider i.e. eNISAT Core/Complex Assessment; Risk Assessment; Safe Systems; Service User Care Plan and List of Medication. The receiving Residential/Nursing Home must also be advised of any equipment needs.

46. On all occasions whereby the implementation of support whether formal or informal is being pursued, all professionals involved should give full consideration to the Mental Capacity Act (2016) DOLs whereby capacity is in question. Mental Capacity Act (2016) processes

Bed Based Short Break/Respite

For Bed Based Short Break placements update/complete:

47. The Social Worker will check bed availability with the chosen home and liaise with the Home Manager to organise a pre-admission assessment (PAA) to ensure that the home can effectively meet the individual needs of the Service User.
48. When Service Users are availing of bed based short breaks in a Care Home, discussions will occur between the Care Home Manager and the Social Worker/Social Care Worker in order to confirm that the Care Home has received the assessments relating to the Service User's current needs and support requirements and that the Care Home can accept the Service User and meet the particulars of the care being commissioned. Care Home Managers should provide prior confirmation that all pre-admission documentation has been read.

49. Charging for Respite Form - to be completed on the first episode of Respite/Short Break in each Financial Year.

50. Admission/Discharge and Financial Referral Form

51. Agreement to Pay Form.

52. Respite Admission Form – OPPC. This form must be completed for all **FIRST** time Respite/Short Break Service Users. For all financial processes for Bed Based Short Break/Respite please adhere to Standard Operating Procedure.

NB: the Standard Operating Procedure for Processing Bed Based Short Breaks details should be adhered to **ICT Business Processes**

53. If a Temporary Bed Based Short Break is happening **outside the SHSCT** area, a Top-up fee may be applicable. If so, a Top-Up Undertaking to Pay Form needs to be completed.

Flexible Short Breaks

54. Flexible Short Breaks should be explored with Service Users and Carers following the identification of the need for a Carer to be afforded a short break from their caring responsibilities via a Carers Assessment.

55. For Flexible Short Breaks the following must be completed:

- This process must be completed by a Social Worker.
- The Social Work Professional Lead **must** ensure the agreed Finance Forms are completed for Flexible Short Breaks which includes the necessary insurance documents and bank account arrangements and one-off direct payment form.

- Calculations for Flexible Short Breaks to be completed according to this guidance **Flexible Short Break Direct Payment Fact Sheet** **NB:** Pages 6 and 7 for staff use only.
- The Key Worker/Case Manager must complete Direct Payment documentation and forward [redacted]

56. It is the responsibility of the Key Worker/Case Manager to ensure a copy of the Service User Care Plan (See Appendix E) is shared, discussed and signed with the Service User/Carer and other relevant Professional staff as appropriate.

57. Where a Service User refuses receipt of the Service User Care Plan, that decision together with the reasons should be recorded on the PARIS case notes. This decision should be revisited periodically (at least annually) reminding the Service User of his/her entitlement to receive a copy of the Service User Care Plan. A record of reminders offered and their outcomes should be maintained within the Service User case notes.

Temporary Placements

58. The Social Worker must ensure that all Temporary Placements have an **exit strategy** recorded on the Service User Care Plan and if placement is due to be more than 8 weeks this must be approved by the relevant ICT Manager. The Social Work Professional Lead will ensure that there is a process in place to review the Temporary Placements. The Finance Department will issue a list of Service Users with a temporary status to Heads of Service each month. The Social Worker will keep the Social Work Professional Lead informed/updated in respect of the reason for temporary status.

ICT Business Processes

59. The management of Service User finances remain the responsibility of ICT for all temporary Service Users.

- The Key Worker/Case Manager should work with the Service User to identify how available personal resources can be incorporated to enhance an individual's quality of life.
- The Finance Department will provide the Key Worker/Case Manager with relevant updates on SHSCT held Patient Private Property account balances and any changes in benefits received. The sharing of information with 3rd parties, which includes family members, should be considered in line with the Data Protection Act 2018.
- The Finance Department will notify the Key Worker/Case Manager when invoices which are due to the SHSCT are not paid and/or where there is concern around financial abuse. In relation to concerns relating to financial abuse consideration should be given to the Adult Safeguarding Operational Procedures (September 2016)

Emergency Placement

60. If an Emergency Placement is required during working hours, the Key Worker/Case Manager must ensure the Emergency Admission to Nursing/Residential Home Form is completed. This is valid for the first week of placement. **Emergency Placement Form**

61. An Emergency Placement outside working hours can also be made by the Regional Emergency Social Work Service (RESWS). The RESWS will complete their own admission form. Please see link for the Regional Emergency Social Work Service **Emergency Social Work Service**

62. Thereafter, refer to the Admission to Residential/Nursing Home (includes Temporary/Bed Based Short Break) Placement Section within this document see Stage 4/5. The Social Worker will keep the Key Worker/Case Manager informed/updated, if applicable.

NB: This is a screen shot of the Emergency Admission to Nursing/Residential Home Form. **Nursing Care Homes - All Documents**

HSC Southern Health and Social Care Trust

EMERGENCY ADMISSION TO NURSING/RESIDENTIAL HOME

I, _____

of _____

do understand and accept that my admission to _____

Nursing/Residential Home is provisional.

Notification of Change Form

The Key Worker/Case Manager must ensure that when there is a change in the Service User's placement in a Residential/Nursing Home that the **Provider** is aware of the Notification of Change Form. This form which must be completed by the provider, details the 'Reason for Absence' and should be forwarded within one working day of any change to the Finance Department at Ghana House Daisy Hill Hospital Newry (this includes Permanent/Temporary/Bed Based Short Breaks Placement).

If the Service User is absent from the Residential/Nursing Home (e.g. admitted to Hospital) the weekly rate will continue to be charged to ensure the bed is held pending a return. The Key Worker/Case Manager **must** ensure that the Carer understands that it is their responsibility to cancel the bed should the Service User not wish to return to the Residential/Nursing Home and that it is their responsibility to notify the Key Worker/Case Manager.

NB: The following is a screen shot of the Notification of Change Form

NOTIFICATION OF CHANGE

Name of Client & Patient Identification Number	Date of Birth	Name & Address of Home	Care Manager	Date of Change	Reason for Absence e.g. Admission to Hospital, Transferred Home, Holiday, Re-Admission, Death etc.

Email Address: [redacted]

STAGE 6

INITIAL REVIEW - Monitoring the Implementation of the Service User Care Plan.

"Monitoring of the Service User Care Plan will be an ongoing task and where Service User's needs are changing rapidly or frequently, adjustments may have to be made to the Care Package. The main focus should be on whether the quality and appropriateness of the provision meets the agreed outcomes for Service users and, where appropriate, their carers" (Page 7 - 2010 DHSSPSNI Care Management Circular).

Domiciliary Care Support

1. Following the commencement of or any significant changes to the Domiciliary Care Support provided, the package of support must be monitored within 2 weeks to ensure that the care plan continues to meet the needs of the Service User.

2. A **Formal Review** must be arranged with the Service User/Carer to take place within the first 12 weeks of the package commencing.

3. Refer to Case Management Aide Memoire: "What Constitutes an 8 Week/12 Week/Annual/Unscheduled Review within OPPC ICT?" (August 2017). (See Appendix J for further guidance).

4. Refer to Template for 8 Week/12 Week/ Annual & Unscheduled Review Checklist (See Appendix K) for further guidance. This Template should be considered when completing all Reviews.

5. Table 2 below summarises the initial review requirements for Domiciliary Care Support:

Table 2 : Initial Reviews for Domiciliary Care Support

Time Scale	Contact	By Whom	Where to Record
Within 2 Weeks	Monitoring Home visit/contact	Key Worker/Case Manager can delegate this task to other staff members, as appropriate	Key Worker **must** ensure that a PARIS Case Note is completed stating **"Monitoring visit/contact has taken place"**
Within 12 Weeks	Formal Review	Key Worker/Case Manager must co-ordinate the Formal Review	PARIS Case Note and update Care Review Form

Ensure the views of the Service User/Carer remain central to the process.

For any changing needs that would require a change in Service Provision the Key Worker/Case Manager must consider referrals to other services such as Reablement, ICS Step-up Referral/ICT Physio, DCOT and Acute Care at Home etc.

6. The Key Worker/Case Manager must complete/update PARIS DC1 to capture all changes in Service Provision.

7. The Service User Care Plan should be updated.

8. The eNISAT Core/Complex Assessment must be updated/completed within 28 days from commencement.

9. The Care Review Form must be updated with the **new** review date.

NB: If completing a hard copy of the Care Review Form this must be forwarded immediately to ICT Admin in order to be entered in PARIS.

Temporary Admissions to Residential/Nursing Homes

10. Following admission to Residential/Nursing Home Placement, there should be follow-up and monitoring within 2 weeks to ensure that the care plan continues to meet the needs of the Service User. This contact should be recorded in PARIS Case Notes. Refer to Template for 8 Week/12 Week/ Annual & Unscheduled Review Checklist (See Appendix K) for further guidance. This Template should be considered when completing the 12 Week Formal Review. Any updated and relevant documentation to be shared with service users, carers, providers and any relevant stakeholders.

11. Table 3 below summarises review requirements for Temporary admissions to Residential/ Nursing Homes:

Table 3: Review Schedule for Temporary Admissions to Residential/ Nursing Homes

Time Scale	Type of Visit	By Whom	Where to Record
Within 2 Weeks	Monitoring Home Visit	Key Worker/Case Manager will co-ordinate who is best placed to undertake this monitoring visit	Key Worker or Social Care Worker **must** ensure that a PARIS Case Note is completed stating **"Monitoring Visit has taken place"**
Within 12 Weeks	Formal Review	Key Worker/Case Manager will co-ordinate the Formal Review involving other professionals, as appropriate	PARIS Case Note and update Care Review Form
Thereafter, every 12 Weeks or as required.	Monitoring Home Visit	Key Worker/Case Manager will co-ordinate who is best placed to undertake this monitoring visit	Key Worker/Social Care Worker **must** ensure that a PARIS Case Note is completed stating **"Monitoring Visit has taken place"**

12. Following any Review, if a permanent placement is agreed the Service User needs to be transferred to the Care Home Support Team (CHST). Refer to CHST Referral Checklist (See Appendix L).

13. Ensure the views of the Service User/Carers remain central to the process. The Key Worker must update eNISAT Core/Complex Assessment, as appropriate.

Permanent Admissions to Residential /Nursing Homes

14. Following admission to Residential/Nursing Home Placement, there should be follow-up and monitoring within 2 weeks to ensure that the care plan continues to meet the needs of the Service User. This contact should be recorded in PARIS Case Notes.

15. The Key Worker/Case Manager should advise the appropriate Care Home Support Team (CHST) practitioner of the 8 week review date. It is expected that the CHST practitioner will attend this meeting to meet the Service User/Carer and assume responsibility for the case.

16. Refer to Template for 8 Week/12 Week/ Annual & Unscheduled Review Checklist (See Appendix K) for further guidance. This Template should be considered when completing the 8 Week Formal Review. Any updated and relevant documentation to be shared with service users, carers, providers and any relevant stakeholders.

17. Table 4 below summarises review requirements for permanent admissions to Residential/ Nursing Home:

Table 4: Permanent Review for Admissions to Residential/ Nursing Homes

Time Scale	Type of Visit	By Whom	Where to Record
Within 2 Weeks	Monitoring Visit	Key Worker/Case Manager will co-ordinate who is best placed to undertake this monitoring visit	Key Worker or Social Care Worker **must** ensure that a PARIS Case Note is completed stating **"Monitoring Visit has taken place"**
Within 8 Weeks if transferring to Care Home Support Team	Formal Review	Key Worker/Case Manager will co-ordinate the Formal Review involving other professionals, as appropriate including CHST Key Workers	PARIS Case note and update Care Review Form

18. Following the 8 week review if a permanent placement is agreed the Service User needs to be transferred to the CHST. Refer to CHST Referral Checklist (See Appendix L). Care Home Support Team

19. Ensure the views of the Service User/Carers remain central to the process. The Key Worker must update the eNISAT Core /Complex Assessment, as appropriate.

STAGE 7

ANNUAL REVIEW

"As a minimum, a formal review should take place once a year. However, more frequent reviews may be required in response to changing circumstance or at the request of the Service User/Carers or agencies involved in their care" (Page 8 - 2010 DHSSPSNI Care Management Circular).

1. The Key Worker/Case Manager **must** ensure that a formal review is scheduled to review the care plan within 12 months of the last review date.

2. Refer to Case Management Aide Memoire: "What Constitutes an 8 Week/12 Week/Annual/Unscheduled Review within OPPC ICT?" (October 2017) for further guidance. (See Appendix J). Any updated and relevant documentation to be shared with service users, carers, providers and any relevant stakeholders.

3. Update the Care Review Form in PARIS and agree the date for the next review which must be held within 12 months or earlier if required. (See Appendix I).

ADDITIONAL INFORMATION	1. Ensure Service User/Carer demographics (Address, Next of Kin and GP details) are up-to-date in PARIS Central Index. 2. Within PARIS **never** change the Service User Surname; Date of Birth; Gender; Health and Care Number without notifying the Data Quality Team, as this will result as a mismatch on the Northern Ireland Electronic Care Record (NIECR). 3. It is the responsibility of the Key Worker/Case Manager to inform the Finance Department and the Residential/Nursing Home if there is : ➢ A change in Residential/Nursing Home placement – This can occur whilst the resident is in Hospital. ➢ A notification of death. This must be updated in PARIS. 4. A comment, suggestion or compliment can be recorded on a 'We Value Your Views' leaflet. If you receive a comment, suggestion or compliment please ensure it is shared with your Line Manager and any relevant staff. An online form is available to record all compliments **SHSCT Compliments Form**. This information is recorded monthly by each ICT and forwarded to the Corporate Complaints Officer for recording purposes. Key Worker/Case Manager should consider seeking feedback via Care Opinion. 5. Service Users/Carers who are unhappy at any stage of the Care Management Process have the right to complain under the Trust HSC Policy for the Management of Complaints 2018. **NB:** Supporting Documentation to Point 4 and 5 above can be found on the Trust SharePoint website: **Clinical & Social Care Governance Complaints**
PARIS REPORTING	Refer to "How to...."Guidance Document PARIS – Core Service Validation & Data Quality Reports - High Level. This document is found In PARIS Guidance/Reports Section:  Or Please click the following link: **PARIS Guidance Documents**

FINANCIAL FORMS

Summary of Financial Forms are listed in Table 5 below:

Table 5: List of Financial Forms

FINANCIAL FORMS	LEGALLY BINDING FORMS	SERVICE USER/REPRESENTATIVE SIGNATORY REQUIRED
Admission/Discharge and Financial Referral Form	Yes	No
Agreement to Pay Form	Yes	Yes
Top Up- Undertaking to Pay	Yes	Yes
Respite Admission Form- OPPC ICT (This form must be completed for all First Time Respite Service Users)	No	No
Charging for Respite	Yes	Yes
Choice Assurance	No	No
Emergency Admission To Nursing/Residential Home	No	No
Notification of Change Form	No	No

FINANCE DEPARTMENT INFORMATION LINKS	
Contact Numbers	• Financial Services Accountant: [redacted] • Financial Assessments Team Managers: [redacted] • Financial Assessments Office: [redacted] Email: [redacted] • Access to Health & Social Care Team: [redacted] Email: [redacted]
Self- Directed Support & Direct Payments	• Direct Payments Lead: [redacted] • SDS/Direct Payments Finance Processing Team: [redacted]

APPENDICES

APPENDIX	NAME OF DOCUMENT
A	**Care Management- A Dynamic Process**
B	**Case Management Information Pack Letter**
C	**Case Management Monitoring Form**
D	**Checklists:** ➢ **Checklist 1:** Self Directed Support ➢ **Checklist 2:** Commencing a Domiciliary Care Package ➢ **Checklist 3:** Admission to a Residential Home ➢ **Checklist 4:** Admission to a Nursing Home ➢ **Checklist 5:** Bed Based Short Breaks/Respite ➢ **Checklist 5a:** Flexible Short Breaks/Respite ➢ **Checklist 6:** Day Care ➢ **Checklist 7:** Form 7 Resident's / Tenant's Review Record – Finance Section
E	**Service User Care Plan**
F	**Personal Support Plan**
G	**ICT Case Discussion meeting Pathway:** ➢ **ICT Case Discussion Meeting** ➢ **ICT Case Discussion Meeting Case Note** ➢ **Case Discussion Meeting Pathway**
H	**ICT Assessing Domiciliary Care Support Escalation Flowchart**
I	**Care Review Form**
J	**Case Management Aide Memoire:** **"What Constitutes an 8 Week/12 Week/Annual/Unscheduled Review within OPPC ICT?"**
K	**Template for 8 Week/12 Week/Annual & Unscheduled Review Checklist**
L	**CHST Guidance Checklist** (Currently under review)

APPENDIX A

Care Management - A Dynamic Process

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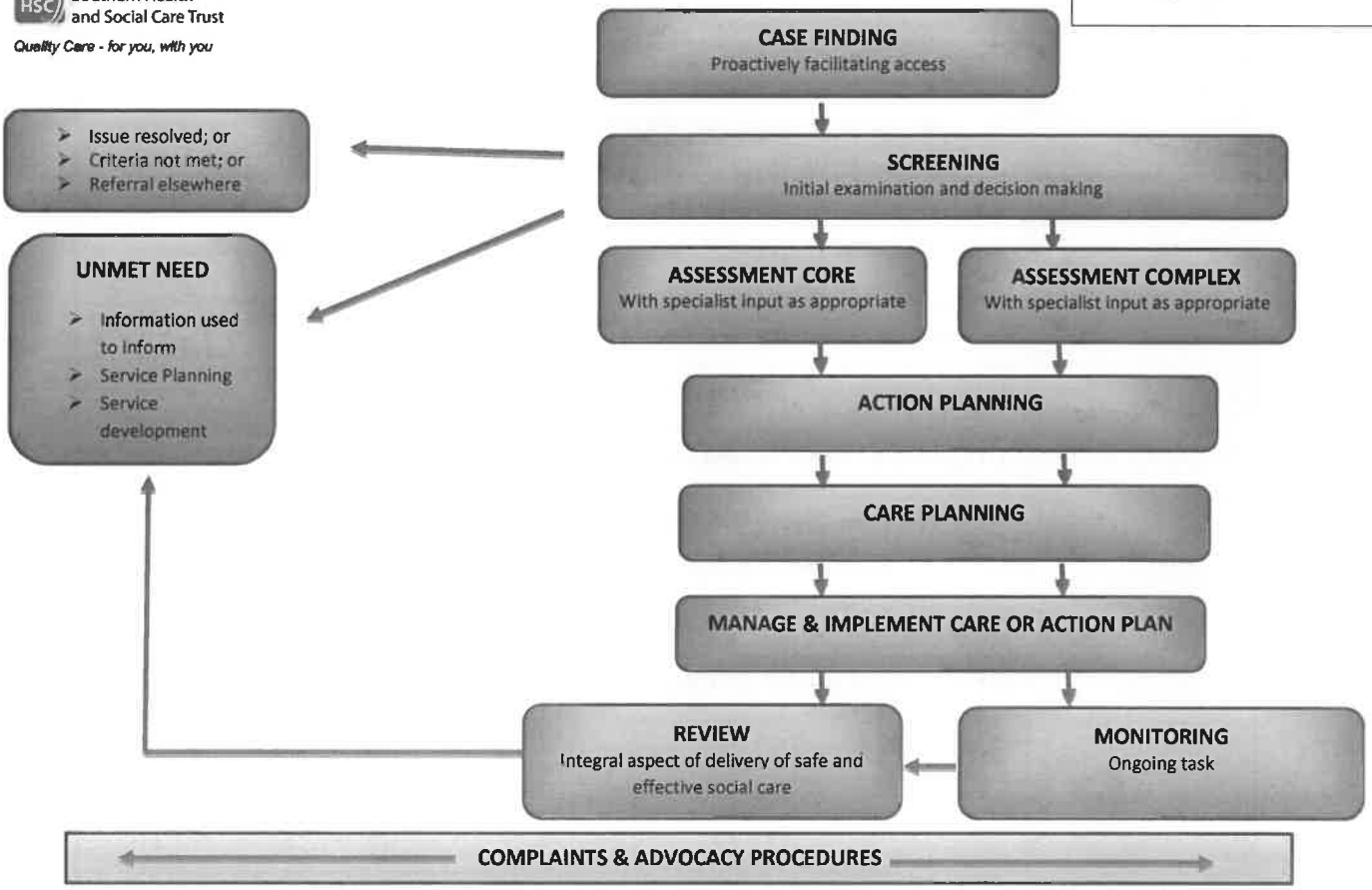

Case Management Information Pack

Please find enclosed Southern Health and Social Care Trust information which may be of interest to you at this time.

This pack includes:

- We Value Your Views Leaflet
- Care Opinion Leaflet
- Case Management Leaflet
- Carer's Assessment Information Leaflet
- Carers Register Leaflet
- Self- Directed Support: The User Guide February 2016
- Guidance on Paying for Care in Residential/Nursing Home Information Booklet

If you have any queries, please contact me on the Telephone Number below:

First Point of Contact: _____

Key Worker Name: _____

Designation: _____

Contact Telephone Number: _____

APPENDIX C:

Case Management Monitoring Form

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Case Management Monitoring Form (13/11/15)

Patient / Client Name		H&C No	
Address			

Date referred for Case Management / Date of Review		Reason for Assessment	☐ New Assessment ☐ Reassessment

Carried out by	

Which Case Management Criteria have been met?

The Service User / Patient / Client must meet one or more of the listed criteria before they can be considered for Case Management. Please tick any criteria met.

☐	Require, or at risk of permanent admission to residential care, nursing homes or long-stay care settings
☐	Are in need of care and protection
☐	Are assessed as being at a high level of risk
☐	Are experiencing severe mental or physical ill health and loss of independence
☐	Have complex needs or challenging behaviour where high level of support is necessary
☐	Care arrangements are at risk of breaking down
☐	Experiencing rapidly or frequently changing needs
☐	Are highly dependant on input of carer
☐	Are people with complex needs where carer's own needs mean that they are having difficulty in maintaining their caring role
☐	Require a range of professional input and services to manage their needs
☐	Have a chronic long term condition
☐	High intensity user of unplanned secondary care (frequent hospital admissions)

Screening

Date screened		Screened by	
Outcome from screening	☐ Passed Screening	☐ Did not pass screening	
Comment			

(Once Screening completed please ensure this detail is inputted to PARIS)

Reports requested

Insert a row for each report requested

Date Requested	Type / Service	Requested by	Date Received	Recorded by
Comment (be specific about which Service / Type)				

Assessment Outcome

Date Assessed		Staff who Assessed	
Outcome of Assessment **Choose one only**	☐ Nursing ☐ Residential ☐ Respite ☐Domiciliary Care Package ☐ Day Care ☐No Care Package ☐Supported Living ☐ Direct Payments		
Reason for delay in implementation	☐ Agreement not reached on care ☐ Delay–Choice of home not available ☐ Items of equipment not available ☐ No capacity in Domiciliary care ☐ No capacity in nursing home ☐ No capacity in residential ☐ No funding available for care ☐ Other (Specify)_____		
Comment			

(Once Assessment Outcome agreed please ensure this detail is inputted to PARIS)

Package Implemented

Date implemented		Staff who implemented	
Service type implemented **Choose one only**	☐ Nursing Package ☐ Residential ☐ Respite ☐ Domiciliary Care ☐ Day Care ☐ No Care Package ☐ Supported Living *If you chose* **"Nursing" or "Residential"** *please select one of the following:* ☐ Private ☐ Statutory ☐ Voluntary		
Comment			

(Once Package Implemented please ensure this detail is inputted to PARIS)

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APPENDIX D

Checklists

Checklist 1: Self-Directed Support

Item Number	Documents	Please Tick if Completed	Date	Comments
1.	eNISAT Core/Complex Assessment - ➢ Consent Form ➢ Incorporating Assessors Analysis and Action Details	☐		
2.	Is there a signed Funding Approval Form?	☐		
3.	Is there a Letter of Offer?	☐		
4.	Is there an SDS Support Plan in place?	☐		
5.	Has SDS information been shared with Service User? Is there a signed information pack form?	☐		
6.	Is there a signed SDS/Direct Payment Scheme Agreement Form?	☐		
7.	Is there a completed Direct Payment Commissioning Form?	☐		
8.	Is there a copy of the current enhanced insurance certificate?	☐		
9.	Is there evidence of Access NI clearance? (if applicable)	☐		
10.	Update/Complete Care Review Form	☐		
11.	Update/Complete Case Management Monitoring Form	☐		
12.	Has the SDS 1 Page support plan be uploaded as a document on PARIS and labelled as SDS Support Plan as per this link.	☐		
13.	Has full consideration been given to the Mental Capacity Act (2016) Deprivation of Liberty Safeguards, whereby capacity is in question?	☐		
Self- Directed Support & Direct Payment Contacts	[redacted] SDS/Direct Payments Finance Processing Team: [redacted]			

Checklist 2: Domiciliary Care Package

Item Number	Documents	Please Tick If Completed	Date	Comments
1.	eNISAT Core and Complex Assessment - ➢ Consent Form ➢ Incorporating Assessors Analysis and Action Details	☐		
2.	NISAT Carers Support and Need Assessment Version 4 (if applicable)	☐		
3.	Review/discuss the funding for Domiciliary Care Package at the Weekly Case Discussion Meeting	☐		
4.	Update/Complete DC1 in PARIS	☐		
5.	Ensure all appropriate documentation is forwarded to the Provider (if applicable): DC1, Care Plan, Risk Assessments, Safe Systems, Equipment Needs, Telecare, Key Pad Number	☐		
6.	Update/Complete Care Review Form	☐		
7.	Update/Complete Case Management Monitoring Form	☐		
8.	Update/Complete Service User Care Plan	☐		
9.	Ensure there is an SDS Support Plan completed	☐		
10.	Has full consideration been given to the Mental Capacity Act (2016) Deprivation of Liberty Safeguards, whereby capacity is in question?	☐		

Checklist 3: Admission to a Residential Home

Item Number	Documents	Please Tick If Completed	Date	Comments
1.	eNISAT Core and Complex Assessment - ➢ Consent Form ➢ Incorporating Assessors Analysis and Action Details	☐		
2.	NISAT Carers Support and Need Assessment Version 4 (if applicable)	☐		
3.	Check with the Community Contracts Team regarding the potential Placement Facility	☐		
4.	Review/discuss the funding for placement at the Weekly Case Discussion Meeting	☐		
5.	Inform Domiciliary Care Provider, if involved, of admission and whether admission is permanent or temporary	☐		
6.	Update/Complete DC1 in PARIS	☐		
7.	Inform other Professionals involved regarding the admission	☐		
8.	Emergency Admission To Nursing/Residential Home Form (if applicable) NB: This Form will cover the first week at Respite Rate Only)	☐		

9.	Complete Admission/Discharge Financial Referral Form	☐		
10.	Complete Agreement to Pay Form	☐		
11.	Top-up Undertaking to Pay Form (if applicable)	☐		
12.	Complete Choice Assurance Form (if applicable)	☐		
13.	Ensure all relevant documentation is forwarded to the Provider e.g. NISAT Assessments/ Safe System/ Manual Handling Risk Assessment/Care Plan/ List of Equipment/List of Medication	☐		
14.	Ensure Residential/Nursing Home Provider is aware of the Notification of Change Form	☐		
15.	Update/Complete Care Review Form	☐		
16.	Update/Complete Case Management Monitoring Form	☐		
17.	Has full consideration been given to the Mental Capacity Act (2016) Deprivation of Liberty Safeguards, whereby capacity is in question?	☐		
18.	Finance Department to complete the following: * Declaration of Means – Residential & Nursing Home Accommodation completed by Financial Assessment Officer * Letter of Authorisation completed by Financial Assessment Officer * Non-Disclosure of Financial Assets Form completed by Financial Assessment Officer			

	* Notification letters to Benefits completed by the Financial Assessment Officer * Letter to resident/appointee regarding assessed charges to be issued by Financial Assessment Officer	

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Appendix D:
Checklists

Checklist 4: Admission to a Nursing Home

Item Number	Documents	Please Tick If Completed	Date	Comments
1.	eNISAT Core and Complex Assessment - ➢ Consent Form ➢ Incorporating Assessors Analysis and Action Details	☐		
2.	NISAT Carers Support and Need Assessment Version 4 (If applicable)	☐		
3.	Review/Discuss the funding for Placement at the Weekly Case Discussion Meeting	☐		
4.	Check with the Community Contracts Team regarding the potential Placement Facility	☐		
5.	Emergency Admission To Nursing/Residential Home (if applicable) NB: This form will cover first week at Respite Rate Only	☐		
6.	Complete Admission/Discharge and Financial Referral Form	☐		
7.	Complete Agreement to Pay Form	☐		
8.	Complete Top Up Undertaking to Pay Form (if applicable)	☐		
9.	Complete Choice Assurance Form (if applicable)	☐		
10.	Complete Nursing Needs Assessment Tool (Self /Private Funded Residents)	☐		
11.	Inform Domiciliary Care Provider, if involved, of admission and whether admission is permanent or temporary	☐		
12.	Update/Complete DC1 in PARIS	☐		

13.	Inform other Professionals involved regarding the admission	☐		
14.	Ensure Residential/Nursing Home Provider is aware of the Notification of Change Form	☐		
15.	Ensure all relevant documentation is forwarded to the Provider e.g. NISAT Assessments/ Safe System/ Manual Handling Risk Assessment/Care Plan/List of Equipment/List of Medication	☐		
16.	Update/Complete Care Review Form	☐		
17.	Update/Complete Case Management Monitoring Form	☐		
18.	Has full consideration been given to the Mental Capacity Act (2016) Deprivation of Liberty Safeguards, whereby capacity is in question?	☐		
19.	Finance Department to complete the following: * Declaration of Means – Residential & Nursing Home Accommodation completed by Financial Assessment Officer * Letter of Authorisation completed by Financial Assessment Officer * Non-Disclosure of Financial Assets Form completed by Financial Assessment Officer * Notification letters to Benefits completed by the Financial Assessment Officer * Letter to resident/appointee regarding assessed charges to be issued by Financial Assessment Officer			

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Appendix D: Checklists

Checklist 5: Bed Based Short Breaks/Respite

Item Number	Documents	Tick if Completed	Date	Comments
1.	eNISAT Core/Complex Assessment - ➢ Consent Form ➢ Incorporating Assessors Analysis and Action Details	☐		
2.	NISAT Carers Support and Needs Assessment V4	☐		
3.	Ensure there is an SDS Support Plan completed	☐		
4	Review/Discuss funding for Bed Based Short Break with the Social Work Professional Team Lead (in their absence please liaise with alternative Social Work Professional Team Lead or ICT Manager)	☐		
5	Respite Admission Form –OPPC ICT To be completed for 1ST Time Respite Care Only	☐		
6	Admission/Discharge and Financial Referral Form	☐		
7	Complete Charging for Respite Form	☐		
8	Complete Agreement to Pay	☐		
9	Top Up Undertaking to Pay Form (if applicable)	☐		
10	Ensure Residential/Nursing Home Provider is aware of the Notification of Change Form	☐		
11	Ensure all relevant documentation is forwarded to the Provider e.g. NISAT Assessments/ Safe System/ Manual Handling Risk Assessment/Care Plan/List of Equipment/List of Medication	☐		
12.	Update/Complete Case Management Monitoring Form	☐		
13.	Update/Complete Care Review Form	☐		
14.	Has full consideration been given to the Mental Capacity Act (2016) Deprivation of Liberty Safeguards, whereby capacity is in question?	☐		

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Appendix D:
Checklist

Checklist 5a: Flexible Short Breaks/Respite

Item Number	Documents	Tick if Completed	Date	Comments
1.	eNISAT Core/Complex Assessment - ➢ Consent Form ➢ Incorporating Assessors Analysis and Action Details	☐		
2.	NISAT Carers Support and Needs Assessment V4	☐		
3.	Review/Discuss funding for Flexible Short Break with the Social Work Professional Team Lead (in their absence please liaise with alternative Social Work Professional Team Lead or ICT Manager)	☐		
4.	Complete calculations for Flexible Short Breaks and complete "One-Off Direct Payment Commissioning Form" and discuss with and forward to Social Work Team Lead - Guidance for completion	☐		
5.	Social Work Professional Lead to check "One-Off Direct Payment Commissioning Form", sign and forward to Direct Payments team cc Key Worker.	☐		
6.	Ensure there is an SDS Support Plan completed	☐		
7.	Ensure all relevant documentation is forwarded to the Provider e.g. NISAT Assessments/ Safe System/ Manual Handling Risk Assessment/Care Plan/List of Equipment/List of Medication	☐		
8.	Has full consideration been given to the Mental Capacity Act (2016) Deprivation of Liberty Safeguards, whereby capacity is in question?	☐		
9.	Update/Complete Case Management Monitoring Form	☐		
10.	Update/Complete Care Review Form	☐		

Checklist 6: Day Care

Item Number	Documents	Tick if completed	Date	Comments
1.	eNISAT Core/Complex Assessment - ➢ Consent Form ➢ Incorporating Assessors Analysis and Action Details	☐		
2.	Update/complete ICT Care Review	☐		
3.	Seek approval for funding for Day Care at the Case Management Meeting	☐		
4.	Update/Complete Service User Care Plan	☐		
5.	Consider Transport requirements and completion of appropriate Transport documentation, if required or appropriate.	☐		
6.	Ensure there is an SDA Support Plan completed	☐		
7.	Update/Complete DC1 in PARIS	☐		
8.	Has full consideration been given to the Mental Capacity Act (2016) Deprivation of Liberty Safeguards, whereby capacity is in question?	☐		

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Checklist 7 - Resident's / Tenant's Review Record (Form 7)

Name of Client	
Health & Care Number	
Placement	
Date of Placement	
Date of Review	

1. Is the resident placed at the appropriate regional tariff rate for their assessed Category of Care (as per RQIA classifications)? **(For Residential/ Nursing Home only)**
   Regional Rate ☐
   Rate paid by Trust ☐

2. Please outline reasons if the payment is above the appropriate regional tariff rate. **(For Residential/ Nursing Home only):**

   _____

   _____

3. Does the file contain the necessary assessment and subsequent specialist letter from contracts (if appropriate) corroborating the need for payment above the appropriate regional tariff rate? **(For Residential/ Nursing home only)**

   Yes ☐
   No ☐
   If no, specify what action you have taken:

   _____

4. Does the resident/tenant have capacity to manage finances, confirmed at multi-disciplinary review?
   Yes ☐
   No ☐

5. Does the Tenant have a Financial Support Agreement (FSA) and is it up to date? (Statutory Supported Living Only)
   Yes ☐
   No ☐

6. Who is the Tenant/Resident's appointee (where applicable)?

   _____

7. Is there a Third party "Top Up" in place? **(For Residential/Nursing Home only)**
   Yes ☐
   No ☐
   Amount of Top up: - £_____

8. Has the Top-Up changed this year? **(For Residential/ Nursing home only)**

   Yes ☐ Complete a NEW "Top-up Undertaking to pay form".
   No ☐

9. Have there been any changes to arrangements for the management of finances since the last review?

   Yes ☐
   No ☐

10. List any changes to the services within the Care Plan/Individual Agreement since the previous review and record the reason for these.

    _____

    _____

    _____

    _____

11. Does the resident/tenant have available resources to fund those services which he/she privately funds? (this does not refer to top up)

    Yes ☐
    No ☐

    If no, please highlight the issues:

    _____

    _____

12. What are the additional resources/activities required above contract? Does the person have assessed need?

    _____

    _____

13. What additional expenditure has been made from the resident's/tenant's personal account since the last review? For example: holidays, payments to other parties including family and transport costs.

_____

_____

14. Have these costs been agreed and recorded in the Care Plan?

Yes ☐
No ☐

If not, why? _____

_____

_____

15. Is the Home holding an accumulating balance in the Resident's Personal Allowance? If so please address how the Personal Allowance is being spent (refer to the resident's care plan).

_____

_____

_____

16. Please detail any changes to the weekly care fees since the last review and the reason for this. This should include changes to any third-party agreements in place.

_____

_____

_____

17. Are resident's/tenant's contributions (Assessed charge) to weekly care fees up to date? (key worker checks with Finance Department in advance of review)

Yes ☐
No ☐

If no, please outline why. _____

_____

_____

18. Has the Home confirmed that all financial transactions are properly receipted in accordance with RQIA Standards?

    Yes ☐
    No ☐

19. Keyworker to review a sample amount of receipts e.g. a month, during the last months in the resident's/ tenant's personal cash books? Do they reconcile and are they reasonable?

    _____

20. Record any other concerns in respect of the resident's/tenant's finances.

    _____

21. State actions taken to address the above concerns

    _____

    _____

Signed by Key Worker: _____

Designation: _____

Date: _____

Signed by Home/Facility Manager or Representative: _____

Designation: _____

Date: _____

Signature of Resident* or Relative/Representative* (*delete as appropriate):

_____

Date: _____

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APPENDIX E:

Service User Care Plan

Service User Care Plan

Surname		**Forename**	
Date of Birth		**H&C NO**	
This Care Plan relates to:		**Professional completing Care Plan:**	
Date Completed		**Signature**	
Date Reviewed		**Date**	

Professionals who contribute to Care Plan			
Name	**Designation**	**Assessment Carried Out Date**	**Report Provided**

Name			DOB		H&C No	

Identified Strengths/Needs	What is important to you now and in the future in relation to:	What needs to happen to meet identified need?	By whom/Timescale	Review / Evaluation Date
Domain 1 Physical Health				
Domain 2 Mental Health & Emotional Wellbeing				
Domain 3 Level of awareness & decision making skills				
Domain 4 Medicines management Attach medications plan as appropriate				
Domain 5 Communication and sensory functioning				

Name			DOB		H&C No	

Identified Strengths/Needs	What is important to you now and in the future in relation to:	What needs to happen to meet identified need?	By whom/Timescale	Review / Evaluation Date
Domain 6 Walking and movement; Attach Safe systems plan as appropriate.				
Domain 7 Personal care and daily tasks				
Domain 8 Living arrangements and accommodation				
Domain 9 Relationship				
Domain 10 Work, finance and leisure				

Name			DOB		H&C No	

POINTS OF DIFFERENCE:

SIGNED:

Service User		Date	
Carer/Advocate		Date	
Case Worker		Date	
AHP/Other Named party		Date	

Name			DOB		H&C No	

REVIEW DATE:	

SIGNED:

Service User		Date	
Carer/Advocate		Date	
Case Worker		Date	
AHP/Other Named party		Date	

Note: on completion of the Care Plan, please forward copy to the Manager/ User and Carer.

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APPENDIX F

Personal Support Plan

PERSONAL SUPPORT PLAN

Service User	
H&C	
DOB	
Domiciliary Service Start Date	

PROFESSIONAL /SERVICES INVOLVED			
Reason Involved/Frequency		**Reason Involved/Frequency**	
ICT Social Worker		**Memory Service**	
ICT District Nurse		**ICS/Community Stroke Team**	
ICT Occupational Therapist		**Reablement Service**	
Physiotherapist		**Speech and Language**	
Telecare		**Equipment**	
Other		**Other**	

SUPPORT PROVIDED BY CARERS/FAMILY /FRIENDS –TYPE OF HELP PROVIDED/LENGTH OF TIME REQUIRED						
MON	TUES	WED	THUR	FRI	SAT	SUN

SUPPORT PROVIDED BY VOLUNTARY/COMMUNNITY – TYPE OF HELP PROVIDED/LENGTH OF TIME REQUIRED						
MON	TUES	WED	THUR	FRI	SAT	SUN

OUTSTANDING SUPPORT PLAN FOR DOMICILIARY PROVISION									
Care Type	Mon Hrs/Mins	Tues Hrs/Min	Wed Hrs/Mins	Thurs Hrs/Mins	Fri Hrs/Mins	Sat Hrs/Mins	Sun Hrs/Mins	Total	Hrs/Mins
Domiciliary Support									
Other e.g. Day Care									

Signature of Professional	
Service User/Carer Signature	
Date	

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APPENDIX G:

ICT Case Discussion Meeting

Weekly ICT Case Discussion Meeting

Purpose of the Weekly ICT Case Discussion Meeting

- To govern the application of the eligibility criteria and decision support tools, to ensure critical need is met where possible
- To ensure there is equitable access to resources based on assessed need
- Opportunity to support staff and further discuss the identified assessed needs and sign post to appropriate resources/services/voluntary/statutory service
- To ensure the most appropriate Key Worker has been identified
- To review and discuss any increases/reconfiguration in Domiciliary Care Package, Change of Placement and Self Directed Support
- To screen against Case Management criteria

Weekly ICT Case Discussion Meeting Requirements

- The Case Discussion Meeting should be held weekly, however in exceptional circumstances the meeting can be deferred but this must be approved with ICT Managers
- A minimum of two Professional Leads or ICT Manager as the second person
- The ICT Case Discussion Meeting will be chaired by the Professional Leads to ensure a multidisciplinary approach
- Urgent access to resource must be discussed and can be agreed with Professional Team Lead if outside the weekly Case Discussion Meeting
- For Key Workers to present cases at the Weekly ICT Case Discussion Meeting, the Key Worker/Case Manager **must** email ICT admin with Service User Name and PARIS ID requesting timeslot at weekly Case Discussion Meeting
- Core eNISAT assessment to have been completed with recommended care plan
- Case Management Monitoring Form has been completed
- Care Review Form has been updated/ completed

APPENDIX G:
ICT Case Discussion Meeting

To be completed by Professional Leads Post Weekly ICT Case Discussion Meeting within Service User PARIS Case note, or:
To be completed by ICT Business Manager/Head of Service at ICT Managers Complex Escalation Meeting and returned to ICT Manager for uploading onto PARIS Case note

Patient / Client Name		H&C No	
Address			

Professional Leads Case Discussion Meeting Minutes	
Attendees	
Outcome:	• Eligibility criteria met ☐ • Eligibility criteria not met ☐ • More information required ☐ • Deferred ☐ • **Comments:**
Further Actions Required and By Whom	

Appendix G: ICT Case Discussion Meeting

Case Discussion Meeting Pathway

Referral Scenario	Referral Request	Immediate Action	Present at Weekly Case Discussion Meeting Yes/No	Documentation	Case Presenter	Time Frame To Present At Weekly Case Discussion Meeting
Scenario 1a	**Routine** New referral request with no accompanying previous/current assessments from self, family or GP	Consider referral to Reablement or ICS Step-up	Yes	eNISAT Core/Complex Assessment Specialist Assessments	Key Worker / Assessor	When the need has been identified and banded
Scenario 1b	**Urgent** New referral request with no accompanying previous/current assessments from self, family or GP	Consider referral to Reablement or ICS Step-Up Service implemented to meet critical need Specialist Assessments urgently requested eg Moving and Handling with appropriate documentation	Yes	eNISAT Core/Complex Assessment Specialist Assessments	Key Worker / Assessor	When the need has been identified and banded

Scenario 2	Referral following Reablement assessment and intervention or referral from ICS/Hospital SW	Social Work Professional Lead screens and implements DCP	Yes	Reablement recommendations eNISAT Core/Complex Assessment	Key worker	Key Worker presents at Case Discussion Meeting within 4 weeks of Service implementation following completion of eNISAT
Scenario 3	Referral from ICS **during** ICS rehab programme	ICS liaises with the ICT Social Worker ICT Social Worker must get approval from Professional Lead An application to attend the Case Discussion Meeting does not need to be completed	No			
Scenario 4	Referral from ICS on completion of ICS Rehab programme	Social Work Professional Lead screens and delegates the organisation of Domiciliary Care Package	Yes	ICS recommendations eNISAT Core/Complex Assessment Specialist Assessment	Key Worker	Key Worker presents at Case Discussion Meeting within 4 weeks of Service Implementation following completion of eNISAT
Scenario 5	Temporary Placements	To ensure financial implications of the placement are discussed fully with Service User and family and appropriate relevant documentation/referrals completed. To have an identified exit strategy	Yes	eNISAT Core/Complex Assessment Specialist Assessments	Social Worker	When the need has been identified and banded

Scenario 6	Urgent Bed Based Short Breaks/Respite	ICT Social Worker must discuss with Social Work Professional Lead for approval	No			
Scenario 7	Planned Bed Based Short Breaks/Respite/Flexible Short Break	ICT Social Worker must discuss with Social Work Professional Lead (In the absence of SW Professional Lead liaise with ICT Manager or covering SW Professional Lead)	No	NISAT Core/Complex Assessment Specialist Assessments Refer to SOP pages 13-15 for finance requirement **(NOTE PAGES MAY CHANGE)**	Social Worker	When the need has been identified and banded
Scenario 8	Reconfiguration of Services/Decrease of Services	Key Worker for discussion with any of the 3 Professional Lead/s to consider alternative options or pathway If unresolved proceed to Case Discussion Meeting	No			

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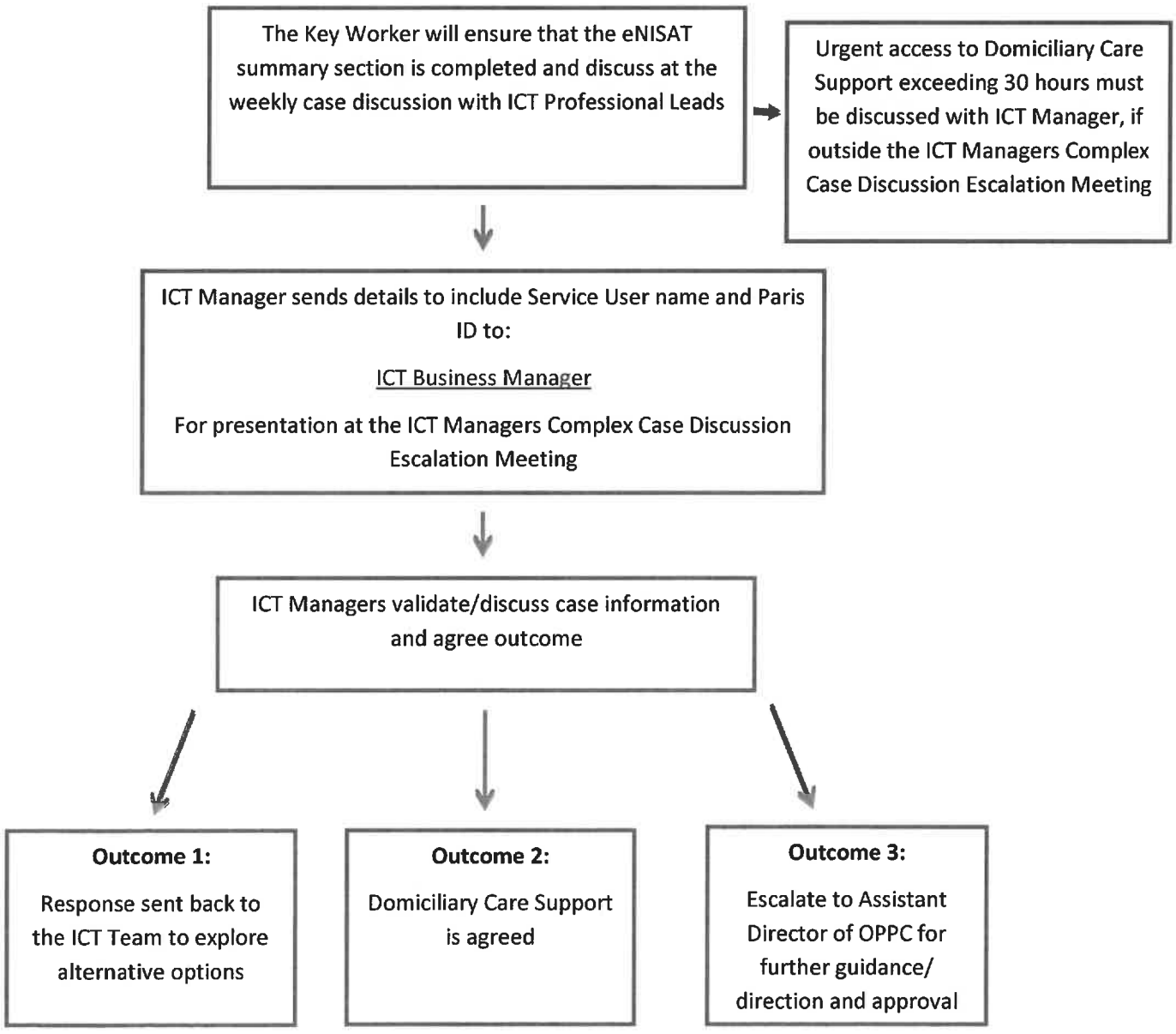
APPENDIX H:
ICT Assessing Domiciliary Care Support

ICT Accessing Domiciliary Care Support Escalation Flowchart

Criteria

1. A person with complex health and social care needs who requires a domiciliary package of care in excess of 28 hours and above and whose preferred option is to remain at home, (including pending transfers from other Directorates above 28 hours).
2. A person who requires domiciliary care support and is not identified as having a **critical** need, as defined within the SHSCT OPPC ICT Organising Person-Centred Care Position Paper (2015) and SHSCT OPPC ICT Guidance for Organising Domiciliary Care Support



APPENDIX I:

Care Review Form

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Care Review Form

To be completed by staff undertaking a review and returned to admin staff

Patient / Client Name		H&C No	
Address			

Date Service Assessed / Date of Review			
Carried out by		Team Name	

NEW Services / Equipment - Insert a row for each Type of Service / Equipment

Date Started	Type of Service e.g. Dom Care, SW / DN / MEM Service, Placements, Short Breaks, Day Care , Equipment etc.	Organised by e.g. (SW / DN / OT, MEM Service, CHST etc.)	Main Service*	Comment

*(List only One)Main service is the main package of care that the client is receiving e.g. Nursing / Residential Home Placement / Dom Care / Short Break / Direct Payments / Day Care / Self Directed Support / Sheltered Accommodation etc.

Placement Details

Placement Date		Sector (Pick1)	Private ☐ Stat ☐ Voluntary ☐
Accommodation Type (Pick 1)	Residential ☐ Nursing ☐ Short Break Res ☐ Nurse ☐ Sheltered ☐	Organisation [Placement name]	
Placement Type (Pick 1)	ICS ☐ Permanent ☐ Temp ☐ Short Break ☐	Bed type (Pick 1)	Dem Res ☐ Nurs ☐ General Res ☐ Nurs ☐
Short Breaks – Agreement to pay	☐ Yes ☐ No	Short Breaks – Block Contract	☐ Yes ☐ No
Comments			

Review Update Services / Equipment- Insert a row for each Service / Equipment

Date reviewed	Type of Service *e.g. Dom Care, SW / DN / MEM Service, Placements, Short Breaks, Day Care, Equipment etc.*	Outcome Increase / Decrease/ Same / Closed	Weeks to next review	Comment

Please note all fields must be completed

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APPENDIX J:

Aide Memoire,

What Constitutes an 8 week/12 week Annual/Unscheduled

Aide Memoire: What Constitutes an 8 Week/12 Week/Annual/Unscheduled Review within OPPC ICT?

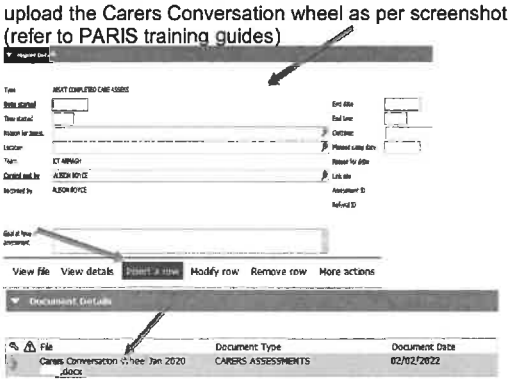
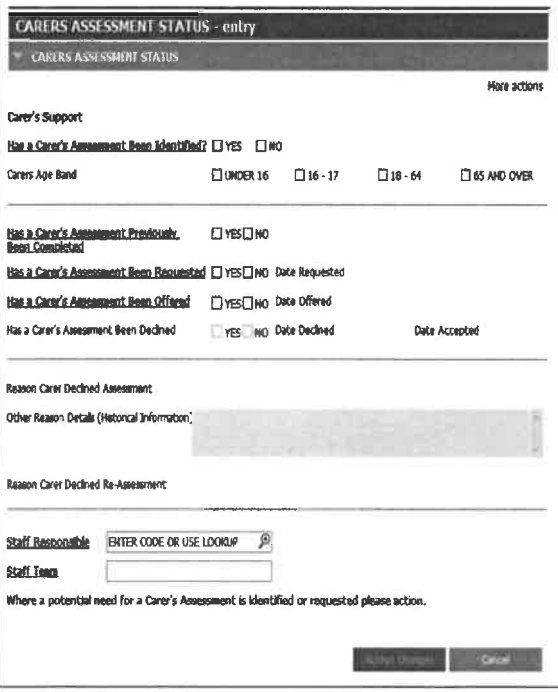
The ICT Team have a SOP in place to ensure that Service Users have an annual review of needs as per the Circular HSC (ECCU) 1/2010. The ICT Team will schedule a formal meeting with the Service User and their carer(s) and other relevant agencies/professionals to review the care plan within 12 months from the commencement of the domiciliary care support.

Definition of Review: "A planned procedure to determine whether or not the services supplied continue to meet the needs of the individual" (Circular HSC (ECCU) 1/2010, the Glossary on Page 32).

Types of Review:

1. **Annual Planned Review**: Where there has been no significant change for the Service User since last Review.
2. **Unscheduled Review**: Consideration must be given to undertaking a Review if there has been a significant change at home and/or following a Hospital admission or ICS/Reablement/ACAH/DCOT involvement, has occurred for the Service User before the next planned Review. The Service User/Carer(s) must be made aware that this was their Formal Review.
   NB: Care Review Form in PARIS and the Annual/Unscheduled Review Checklist must be recorded. Please refer to PARIS guidance documents **ICT Training Team - Paris**

Where to Record Review	Information to be Considered	Possible Actions
PARIS Case note	➢ Contact Service User/Carer to organise Domiciliary Care Review ➢ Complete Activity Recording Grid Section in PARIS Case note	
eNISAT Core/ Complex Assessment	➢ Copy across completed eNISAT Core/Complex Assessment. ➢ Enter Date of Assessment ➢ Complete Reason for Assessment: Reassessment	➢ Update Views of Service User/Carers Section. ➢ Update Consent Form: Service User is unable to sign, verbal consent gained and recorded as "Service User unable to sign" within the body of the consent form. ➢ Demonstrate a Self -Directed Support Approach: Self-Directed

	➢ Update/ Change Assessment based on current review/reassessment findings	Support (SDS) questions are found within a SDS grid section in eNISAT Core Assessment Service Tab and a SDS section in Complex Assessment. ➢ Complex Assessment: address Human Rights Issues.
NISAT Carers Support and Needs Assessment V4/Carers Conversation Wheel	➢ NISAT Carers Support and Needs Assessment V4/Carers Conversation Wheel outcome captured in eNISAT as per Screenshot Carers Assessment Status entry ➢ Undertake/Update NISAT Carers Support and Needs Assessment V2 (if applicable) ➢ All Carers Departmental statistical returns will be taken from PARIS. This will include the options Requested; Offered and Declined. Save eNISAT Carers and Needs Assessment V2 and upload the Carers Conversation wheel as per screenshot (refer to PARIS training guides) 	

<table>
<tr>
<td>PARIS Casenote

An 8 Week/12 Week/Annual/ Unscheduled Review Checklist is now available. This will help structure the Review Process.</td>
<td>
<u>Template for 8 Week/12 Week/Annual & Unscheduled Review Checklist</u>

This Template should be completed with every 8 Week/12 Week/Annual/Unscheduled Review undertaken. Where possible in order to avoid duplication of recording information within the checklist it is acceptable to refer to your eNISAT reassessment, outlining where the information can be found e.g. Domain 1: Assessors Perspective.

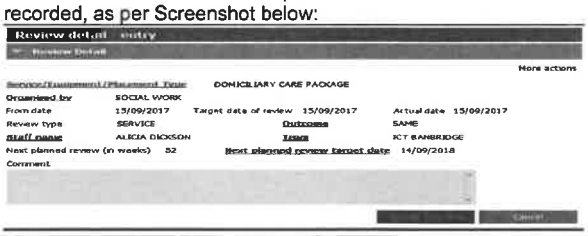
<table>
<tr><td>Service User</td><td></td></tr>
<tr><td>H&C</td><td></td></tr>
<tr><td>DOB</td><td></td></tr>
</table>

<table>
<tr><th>Review Checklist</th><th>Comments</th></tr>
<tr><td>Prior/after Review: Seek the views of the multidisciplinary team and service providers (e.g. ICS /Reablement/Domiciliary Care Providers) to inform the review process and its outcomes</td><td></td></tr>
<tr><td>Date of Actual Review:</td><td></td></tr>
</table>
</td>
<td>
Prior/After Review: Seek the views of the multidisciplinary team and service providers (e.g. ICS/Reablement/ACAH/Dom Care Providers/DCOT) to inform the review process. All updated and relevant documentation to be shared post review with service user, carers, providers, Key Worker and all relevant stakeholders – see additional professional documentation below for details.

➢ Ensure Service User/Carer demographics (Address, Next of Kin and GP details) are up-to-date in PARIS Central Index.
➢ Within PARIS never change the Service User Surname; Date of Birth; Gender; Health and Care Number without notifying the Data Quality Team, as this will result as a mismatch on the Northern Ireland Electronic Care Record (NIECR).

In order to avoid duplication of recording information within the 8 Week/12 Week/ Annual/Unscheduled Review Checklist it is acceptable to refer to your eNISAT reassessment, outlining where the information can be found e.g. Domain 1: Assessors Perspective.
</td>
</tr>
<tr>
<td>ICT weekly Case Discussion Meeting: How to Book</td>
<td>
Email ICT Admin to book ICT Case Discussion Meeting Slot

Information Required within email:
➢ Name of Service User.
➢ PARIS ID.
</td>
<td>To review and discuss any increases/reconfiguration in Domiciliary Care Package/, Change of Placement/Day Care and Self Directed Support</td>
</tr>
</table>

Record Care Review Form in PARIS	Each time a Review has taken place the Care Review Form in PARIS MUST be updated by Key Worker/Admin/Staff member undertaking the review	Discuss and agree the date for the next Review which must be held within 12 months or earlier if required. The new date should be recorded, as per Screenshot below: 
Record Case Management Monitoring Form	If there is a significant change in Case Management Process, the Case Management Monitoring Form should be end dated and a new one started. A significant change constitutes a Case Management reassessment for example a Service User moving from Residential Home Placement to Nursing Home Placement as this is known as an upgrade or moving from Nursing Home Placement to Residential Home Placement this is known as downgrade.	
Additional Professional Documentation	Any updates? ➢ Service User Care Plan ➢ NISAT CORE ➢ Template for 8 Week/12 Week/Annual & Unscheduled Review Checklist ➢ Professional Care Plans ➢ Safe Systems Plans/Risk Assessments ➢ DC1 ➢ Carers Care Plan ➢ SDS 1 Page Support Plan ➢ ASCOT ➢ Mental Capacity Act 2016 (DOLs)	Provide Service Users with a copy of their updated Service User Care plan and, if they decline same, the decision is recorded in PARIS Case note. Providers to be given copy of updated relevant documentation following care review e.g.: NISAT, professional care plans, etc.

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APPENDIX K:

Template for 8 week/12 week Annual/Unscheduled Review Checklist

Template for 8 Week/12 Week/Annual & Unscheduled Review Checklist

This Template should be completed with every 8 Week/12 Week/Annual/Unscheduled Review undertaken. Where possible in order to avoid duplication of recording information within the checklist it is acceptable to refer to your eNISAT reassessment, outlining where the information can be found e.g. Domain 1: Assessors Perspective.

Service User	
H&C	
DOB	

Review Checklist	Comments
Prior/after Review: Seek the views of the multidisciplinary team and service providers (e.g. ICS /Reablement/Domiciliary Care Providers) to inform the review process and its outcomes	
Date of Actual Review:	
8 Week **12 Week** **Annual Review** **Unscheduled Review**	☐ ☐ ☐ ☐
Attendees at Meeting	
Any apologies from Agreed Attendees	
Case Summary	
Record Incidents/Accidents/Complaints/Compliments, whilst ensuring all reporting pathways with the Trust have been completed such as Contract Compliance, Datix or Adult Safeguarding	
Record any Hospital admissions from last Review	

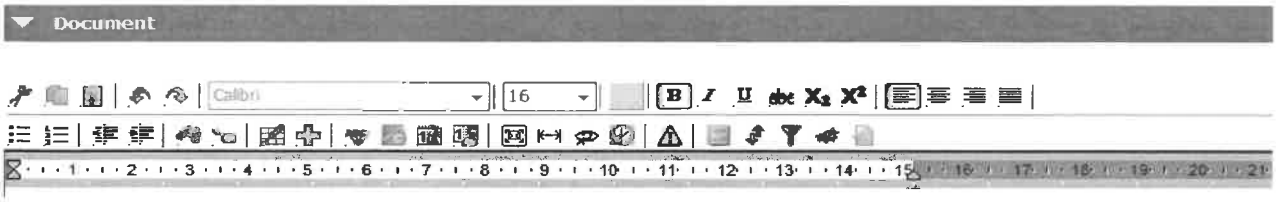
Record any Safeguarding Issues	
Reference any additional reports available	
Any agreements/disagreements	
Record Outcome/Recommendations/Follow-up actions required	
Complete Activity Recording Grid Section in PARIS Case note	
Placement Reviews Only: ➢ **Does placement continue to be most appropriate care plan to meet needs?** ➢ **Does Service User have access to their weekly allowance and are they content with what they are using it for?**	
Domiciliary Reviews Only: ➢ **Domiciliary Package Reviewed?** ➢ **Does Domiciliary Care plan remain appropriate?**	

Instructions following completion of Annual/Unscheduled Review Checklist

This Annual/Unscheduled Review Checklist Template can be completed in any of the 3 options detailed below:

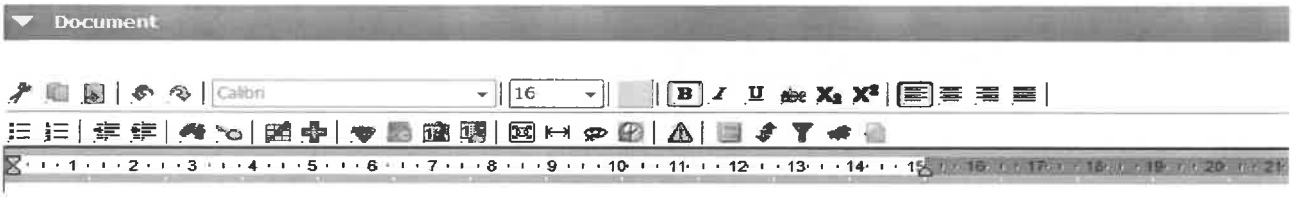
Option 1

Fully completed in a word document and then can be copied and pasted into the Document Section (as per screenshot below) into a PARIS Case note.



Option 2

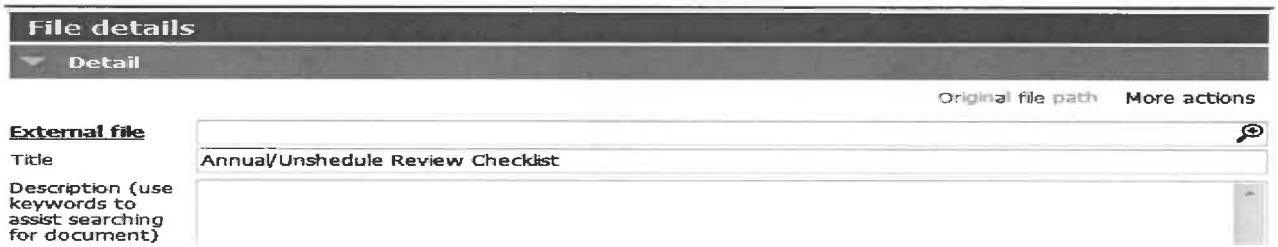
The Blank Template can be copied and pasted into the Document Section (as per screenshot below) in PARIS Case note and completed within the Case note.



Option 3

The Annual/Unscheduled Review Checklist should be completed manually, scanned and uploaded into the Document Details Section in PARIS Case note, as screenshot below;

Save as: Annual/Unscheduled Review Checklist



Appendix L – Care Home Support Team Guidance Checklist

This will be forwarded at a later date as it is currently under review

GLOSSARY

Assessment

A person-centred process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated, undertaken with the individual, his/her carer(s) and relevant professionals.

Bed Based Short Breaks/Respite

Temporary residential care, nursing home or social accommodation provided to an ill or disabled person to allow a carer a break from caring. Respite care may also be delivered in the service user's own home. The term **short breaks/Respite** is used interchangeably.

Care Management

Is a whole concept which embraces the key functions of: case finding; case screening; undertaking proportionate, person-centred assessment of an individual's needs; determining eligibility for service(s); developing a care plan and implementing a care package; monitoring and reassessing need and adjusting the care package as required.

Care package

A combination of services designed to meet a person's assessed needs.

Care plan

The outcome of an assessment. A description of what an individual needs and how these needs will be met.

Care planning

A process based on an assessment of an individual's need that involves ascertaining the level and type of support required to meet those needs, and the objectives and potential outcomes that can be achieved.

Care worker

A person who is paid to deliver care to an individual.

Carers

People who, without payment, provide help and support to a family member or friend who may not be able to manage at home without this help because of frailty, illness or disability.

Case finding

Includes proactively publicising information about health and social care services and how to access them in an accessible, informative and 'user friendly' manner which will assist both those who are likely to require support and/or services, and referring agencies (including General Practitioners) in making appropriate referrals.

Direct Payments

Money paid by HSC Trusts that allows individuals to arrange for themselves the social care services required to meet their needs as assessed.

Deprivation of Liberty Safeguards (DOLS)

A deprivation of liberty is when all of the following occur: a person is in a place where care or treatment is being provided, a person is not free to leave, a person is under continuous supervision and control.

A person can be deprived of liberty in any place, for example, a hospital, care home, supported living accommodation or other setting. Even if the person or others, such as a carer or a relative are happy with the care and the person or others want the person to be there, the law says that if the conditions above are met this is described as a deprivation of liberty.

The deprivation of liberty safeguards is the system to ensure that a person is only deprived of liberty when it is right to do so.

Domiciliary Care

This encompasses the range of services put in place to support the person in their own home, e.g. home help, meals on wheels, etc. This may also include respite care. Include information which refers to supported living Service Users.

Financial assessment

The process by which HSC Trusts assess a service user's capital and income to determine the balance of how much he/she will be expected to pay towards the cost of their care in a residential care or nursing home, and how much will be funded by HSC Trusts. This is sometimes also known as a '**means test**'.

Hospital discharge

The process of leaving hospital after admission as an in-patient

Independent sector providers

Includes private, voluntary and community organisations and social economy enterprises

Key Worker/Case Manager

A practitioner who, as part of their role, undertakes case management, i.e. the individual who maintains a single, overview of the needs and progress of a service user who may have complex needs or be in contact with several practitioners or agencies; embedding a common language of assessment; care planning; response; and improving trust, communications and information sharing between the service user, carers (as appropriate), practitioners and service providers. The terms Case Manager/ Key Worker, care co-ordinator or lead professional and, in the context of NISAT, Key Worker have also been used to describe this role.

Long term condition

Illnesses which last longer than a year, usually degenerative, causing limitations to one's physical, mental and/or social wellbeing. Long Term Conditions include Diabetes, COPD, Asthma, Arthritis, Epilepsy and Mental Health problems. Multiple long term conditions may result in care being particularly complex.

Main carer

The individual who, without payment, takes primary responsibility for

Providing help and support to a person who may not be able to manage at home without this help because of frailty, illness or disability.

MCA – Mental Capacity Act 2016

The Mental Capacity Act (NI) 2016 ("the Act") is a piece of legislation that, when fully commenced, will fuse together mental capacity and mental health law for those aged 16 years old and over within a single piece of legislation, as recommended by the Bamford Review of Mental Health and Learning Disability. The Act provides a statutory framework for people who lack capacity to make a decision for themselves and for those who now have capacity but wish to make preparations for a time in the future when they lack capacity. When the Act is fully commenced the Mental Health (Northern Ireland) Order 1986 ("the 1986 Order") will be repealed for anyone over the age of 16.

Monitoring

On-going oversight of people's needs and circumstances to ensure the quality and continued appropriateness of support and services to meet the agreed outcomes for the individual and, where appropriate, his/her carer(s). The person receiving the services, his/her authorised representative and carer(s), where appropriate, and service providers all have a part to play in formal and informal monitoring.

NISAT Northern Ireland Single Assessment tool, a person centred assessment based on a shared multi-disciplinary approach. **eNISAT –** Electronic version of NISAT.

Normal hours

Services provided during office hours or the normal working day, usually 9:00am to 5:00pm; Monday to Friday.

Nursing Home Care

This refers to care which takes place in nursing homes. These are as defined in Part III of the Registered Homes (Northern Ireland) Order 1992. They are residential facilities providing nursing care 24 hours per day.

Older People and Primary Care (OPPC)

Now known as Adult Community Services ("ACS")

Out-of-hours

Services provided outside of the normal working day, but not including "night-sitting" services, live-in or 24-hour services.

Patient Private Property Account (PPP)

This account is where each individual residents balance is held by the trust and is managed by the finance department.

Permanent

An admission to a residential or nursing home is **permanent** if the agreed intention is for the resident to remain in that accommodation as defined in Charging for Residential Accommodation Guide (CRAG).

Personal care

Includes the provision of appropriate assistance in counteracting or alleviating the effects of old age and infirmity; disablement; past or present dependence on substances such as alcohol or drugs; or past or present mental disorder; and, in particular, includes:

(a) Action taken to promote rehabilitation;

(b) Assistance with physical or social needs; and

(c) Counselling, but does not include any prescribed activity.

Person-centred assessment

An assessment, which places the individual at the centre of the process and which responds flexibly and sensitively to his/her needs.

Representative

An individual who is authorised to act or advocate on behalf of another.

Residential Care

This refers to care which takes place in either statutory residential homes or voluntary and private residential care homes. The latter are defined in Part II of the Registered Homes (Northern Ireland) Order 1992. They are staffed 24 hours a day, providing board and general personal care to the residents. Such premises are provided for those who require ongoing care and supervision in the circumstances where nursing care would normally be inappropriate.

Reassessment

A reassessment is either a complete rework of the comprehensive assessment or an amendment to aspects of the original comprehensive assessment. It is normally carried out in response to the changing needs of the Service User.

Review

A review is carried out to determine whether the services supplied meet the needs of the Service User. This procedure is normally planned. A reassessment would arise out of the review if the services are found to be inadequate or if the level of service is inappropriate.

Screening

Examining a referral to determine the most appropriate response and the further level of assessment that is required.

Self-care/Self-management

With appropriate support, many people can learn to be active participants in their own health and social care, living with and managing their conditions and meeting their own needs. This can help to prevent complications, slow down deterioration and even avoid getting further conditions and increased needs. The majority of people with long term conditions fall into this category - so even small improvements can have a huge impact. The development of direct payments for social care is an important development in the area of self-care/self-management.

Self-funder

An individual who is assessed as able, or declares themselves able to meet the full cost of his/her care.

Service User

A person who is receiving or is eligible to receive health and social care services. They may be individuals staying in their own homes, living in residential care or nursing homes, or being cared for in hospital.

Sitting service

A service, which provides someone to sit with a person to allow the carer to take a break.

Specialist assessment

An assessment undertaken by a clinician or other professional who specialises in a branch of medicine or care, for example, stroke, cardiac care, bereavement counselling.

Temporary

An admission to a residential or nursing home is **temporary** either if the agreed intention is for it to last for a limited time period, such as respite or intermediate care, or there is uncertainty that permanent admission is required. A temporary admission may last up to 52 weeks as defined in Charging for Residential Accommodation Guide (CRAG).