# Support Planning and Risk Assessment Policy

Supportive Bridge Ltd | Community Support and Healthcare Staffing | Bradford, England

## POLICY AT A GLANCE

- **No support starts without an assessment,** a written support plan and a risk assessment. No exceptions, including urgent referrals.
- **Written with the person, not about them.** Their words, their goals, their routines. They get a copy and sign it.
- **Positive risk taking:** we help people do what matters to them and manage the risk, rather than stopping the activity to keep ourselves comfortable.
- **Every worker reads the plan** before their first shift with a person, and follows it.
- **Reviewed at 4-6 weeks, then at least every 6 months,** and straight away after any change, hospital stay, fall or incident.
- **If needs change beyond what we can provide,** including if someone now needs personal care, we say so and contact the funding authority.
- **The plan lives in the person's home** and a copy is held securely in the office.

## SERVICE DETAILS (fill in before issuing)

| | |
|---|---|
| **Registered Manager** | |
| **Nominated Individual** | |
| **Office phone** | |
| **Out-of-hours / on-call number** | |
| **Date issued** | |
| **Next review date** | |


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## 1. PURPOSE

1.1 This policy explains how Supportive Bridge Ltd ("Supportive Bridge", "we", "us") assesses what a person needs, writes and agrees their support plan, identifies and manages risk, and keeps both under review.

1.2 It reflects Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which requires care and treatment to be appropriate, to meet a person's needs and to reflect their preferences, and Regulation 12 (Safe care and treatment), which requires risks to be assessed and mitigated.

1.3 A support plan is not a form for our benefit. It is the instruction that tells a worker who has never met someone how to support them well, and it is what protects the person when their usual worker is away.

## 2. SCOPE

2.1 Supportive Bridge Ltd operates two arms, and this policy applies to both: our **healthcare staffing service**, supplying care and support workers to care homes, hospitals and other providers; and our **community support service**, where our own support workers visit adults and older people in their own homes, including council housing, on morning and evening shifts, to support them with daily living.

2.2 Supportive Bridge does **not** provide personal care. Personal care is a regulated activity under the Health and Social Care Act 2008 and we will provide it only if and when we are registered with the Care Quality Commission. Our support workers provide non-personal support such as companionship, meal preparation, shopping, domestic help, prompting, and support to get out and about. This policy is written to meet both local authority provider assurance requirements and the standards we will be assessed against at CQC registration.

2.3 This policy applies to every person we support through our community support service, and to everyone involved in assessing, planning, delivering and reviewing that support.

2.4 Where we supply a worker to a client organisation, that organisation holds the care plan and risk assessments for the people there. Our worker must be given access to them and must follow them, and must tell us if no plan is available.

2.5 Failure to follow a support plan or risk assessment may lead to action under our Disciplinary Policy.

## 3. BEFORE SUPPORT STARTS

3.1 An initial assessment is carried out, in the person's home wherever possible, by the Registered Manager or a Field Supervisor, before the first shift. We do not start support on the basis of a referral form alone.

3.2 The assessment involves the person and, with their consent, family, friends, advocates and professionals, and draws on any local authority or NHS assessment. It covers:

- who the person is: their history, routines, likes, dislikes, culture, faith, language and communication needs (the "Getting to Know Me" checklist);
- what they can do for themselves, and what they want help with;
- what matters to them and what they want to achieve;
- health conditions, medicines, allergies, mobility, continence, eating and drinking, sleep, and any mental health needs, as far as they affect our support;
- who else is involved: family, GP, district nurse, social worker, other providers;
- the home environment, access, key safe and pets;


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- risks to the person and to our workers;
- capacity to consent to support, and any attorney or deputy;
- preferences about who supports them and when.

3.3 Where the person's needs plainly fall outside what we provide, in particular where they need personal care, we say so before starting, and tell the person, their family and the funding authority in writing. We do not accept a package we cannot meet safely and lawfully.

3.4 Where support is needed urgently, the Registered Manager may authorise an interim plan covering essential tasks and known risks, with a full assessment completed within five working days. The interim plan is still written, and the reason is recorded.

## 4. THE SUPPORT PLAN

4.1 Every person has a written support plan before their first shift. It is written in plain English, in the second person where possible ("you like your tea strong, no sugar"), and uses the person's own words.

4.2 The plan sets out, for each part of the support:

- what the person can do independently, and what help they need;
- the agreed level of support for that activity (see our Person-Centred Care and Active Support Policy);
- exactly how the person wants it done, including the order, the timing and any particular way they like things;
- what the person is working towards;
- what to do if something is different from usual, and who to contact.

4.3 It also records the agreed shift times and length, the tasks at each shift, who else is involved, communication needs, consent and capacity, and anything a worker must know before entering the home.

4.4 The plan must be specific enough to be useful. "Support with breakfast" is not a plan. "You like two slices of brown toast, butter only, and tea in the blue mug, made before you get up" is.

4.5 The person, or their representative, agrees and signs the plan and is given a copy in a format they can understand. Where they cannot or will not sign, this is recorded with the reason.

## 5. RISK ASSESSMENT

5.1 We assess risk in three areas, and all three must be complete before support starts: risks to the person, risks to our workers, and risks in the home environment.

5.2 For each risk we record what could happen, how likely and how serious it is, what we will do to reduce it, who is responsible, and when it will be reviewed. Common areas include:

- falls and mobility;
- moving and handling, including any equipment;
- nutrition, hydration, swallowing and choking;
- skin integrity and pressure areas;
- medicines;
- continence;
- fire safety and escape;


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- the home environment, including access, lighting, stairs and hazards;
- pets;
- lone working, aggression and anyone else in the household;
- distressed behaviour;
- self-neglect, hoarding and safeguarding;
- going out alone, and road safety;
- money, scams and financial abuse;
- isolation and mental wellbeing.

5.3 Risk assessments are written with the person, not imposed on them, and are held with the support plan in the home and in the office.

## 6. POSITIVE RISK TAKING

6.1 The purpose of risk assessment is not to stop people doing things. A life with no risk in it is not a good life, and removing risk usually removes independence, choice and enjoyment with it.

6.2 Where a person wants to do something that carries risk, for example going out alone, cooking, having a bath, smoking or seeing a particular friend, we:

- talk with them about the benefits to them, as well as the risks;
- check whether they have capacity to make that decision, and if they do, respect it;
- look for ways to reduce the risk rather than to stop the activity;
- agree what we will do, and what the person accepts, and write it down;
- involve family and professionals where the person agrees;
- record the decision, who was involved and why it was reached, so it is clear the risk was thought about rather than missed.

6.3 Where a person has capacity and chooses to take a risk against our advice, we record the conversation, keep offering support, and continue to review it. We never withdraw support as a way of pressuring someone to change their mind.

6.4 Where a person lacks capacity for that decision, we follow our Consent and Mental Capacity Policy and choose the least restrictive option.

## 7. MAKING THE PLAN WORK IN PRACTICE

7.1 A plan that sits in a folder unread changes nothing. Therefore:

- every worker reads the support plan and risk assessment before their first shift with a person, and signs to confirm they have;
- workers are briefed on anything specific, and on any change, before it takes effect;
- the office tells all workers supporting a person when the plan changes, and the old version is removed from the home;
- daily notes record what was actually done against the plan, including anything not done and why (see our Support Records and Record Keeping Policy);
- spot checks include checking that the plan is being followed, and that it still matches reality.


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7.2 If a worker finds the plan is wrong, out of date or does not work, they must tell the office the same day rather than quietly doing something different. Workers must not change a support plan themselves.

## 8. REVIEWS

8.1 Support plans and risk assessments are reviewed:

- within the first **four to six weeks** of support starting;
- at least every **six months** after that;
- immediately after any significant change: a fall, a hospital admission or discharge, an infection, a bereavement, a change in medication, a safeguarding concern, an incident or a complaint;
- whenever the person, their family, a worker or a professional asks.

8.2 The review is done with the person, looks at whether the plan still reflects what they want, whether goals are being met, and whether support can be reduced as well as increased. The keyworker helps the person prepare and speaks up for their views where they want that.

8.3 The outcome is recorded, the plan updated and re-signed, and all workers are told what has changed. A review that results in no change is still recorded, with the reason.

8.4 Where a person's needs have grown beyond what we can provide, the Registered Manager writes to the person, their representative and the funding authority, explains what is needed, and works with them on a safe handover. We continue to provide the support we can in the meantime, and give proper notice as set out in the service agreement.

## 9. ENDING SUPPORT

9.1 Where support ends, whether because the person no longer needs it, moves, goes into hospital or a care home, dies, or the arrangement ends for another reason, we record the reason, return or archive records as set out in our records policy, and hand over what the next provider needs with consent.

9.2 We never withdraw support without notice except where it is unsafe to continue, and in that case the Registered Manager informs the funding authority and, where there is a risk to the person, makes a safeguarding referral.

## 10. ROLES AND RESPONSIBILITIES

| Role | Responsibilities |
|---|---|
| Nominated Individual | Makes sure assessment and planning are properly resourced and that no package is accepted that we cannot meet. Reviews audits at least quarterly. |
| Registered Manager | Makes sure every person has a current plan and risk assessment, signs off new packages and reviews, and acts where needs exceed what we provide. |
| Field Supervisor / Care Coordinator | Carries out assessments and reviews, writes and updates plans with the person, briefs workers, and checks plans are followed during spot checks. |
| Keyworker | Knows the person well, keeps their plan accurate day to day, tracks goals, and raises changes. |
| Support workers | Read and follow the plan, record what they did, and report anything that has changed or any part of the plan that does not work. |


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## 11. TRAINING

11.1 All workers are trained at induction in person-centred support planning, risk assessment, positive risk taking and record keeping. Those who write plans and assessments receive additional training and have their first plans checked by the Registered Manager.

## 12. MONITORING AND REVIEW

12.1 The Registered Manager audits support plans and risk assessments monthly, checking that they are in date, specific, signed, written with the person, and matched by the daily notes. Findings are fed back and actions tracked.

12.2 The Nominated Individual reviews a summary at least quarterly. This policy is reviewed every year, or sooner if the law or guidance changes or an audit shows it needs to change.

## 13. LEGISLATION AND GUIDANCE

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, especially Regulation 9 (person-centred care), Regulation 11, Regulation 12 and Regulation 17
- Care Act 2014 and the Care and Support Statutory Guidance (wellbeing, assessment and care planning)
- Mental Capacity Act 2005
- Equality Act 2010 and Human Rights Act 1998
- Health and Safety at Work etc. Act 1974 and Management of Health and Safety at Work Regulations 1999
- NICE guideline NG21: Home care
- NICE guideline NG108: Decision-making and mental capacity
- Skills for Care: person-centred planning and positive risk taking guidance

## 14. RELATED POLICIES AND FORMS

Related policies: Person-Centred Care and Active Support; Consent and Mental Capacity; Safeguarding Adults; Positive and Safe Support; Health and Safety; Lone Working; Nutrition and Hydration; Medication; Support Records and Record Keeping; Missed and Late Visits; Complaints, Concerns and Compliments; Governance and Quality Assurance.

Forms: Initial Assessment; Getting to Know Me checklist; Support Plan; Risk Assessment (Appendix A); Positive Risk Taking Record (Appendix B); Home Environment Risk Assessment; Support Plan Review Record; Worker Sign-Off Sheet.

## 15. DOCUMENT CONTROL

| Version | Date | Approved by | Role | Reason |
|---|---|---|---|---|
| 1.0 | | | Nominated Individual | New policy for local authority assurance and CQC registration |


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## APPENDIX A: RISK ASSESSMENT

Complete with the person before support starts. Review at 4-6 weeks, then at least every 6 months and after any change or incident.

Person: _____ Completed by: _____ Date: _____ Review due: _____

| Risk area | What could happen | L / M / H | What we will do to reduce it |
|---|---|---|---|
| Falls and mobility | | | |
| Moving and handling, and equipment | | | |
| Nutrition, hydration, swallowing and choking | | | |
| Skin integrity and pressure areas | | | |
| Medicines | | | |
| Continence | | | |
| Fire safety and escape | | | |
| Home environment, access and hazards | | | |
| Pets | | | |
| Lone working, aggression, others in the household | | | |
| Distressed behaviour | | | |
| Self-neglect, hoarding, safeguarding | | | |
| Going out alone and road safety | | | |
| Money, scams and financial abuse | | | |
| Isolation and mental wellbeing | | | |

Agreed with the person: Yes / No Signed (person or representative): _____ Signed (assessor): _____


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## APPENDIX B: POSITIVE RISK TAKING RECORD

Use when a person wants to do something that carries risk. The aim is to find a way to make it possible, not to stop it.

| | |
|---|---|
| Person / date / who was involved | |
| What does the person want to do, in their own words? | |
| Why does it matter to them? What are the benefits? | |
| What could go wrong, how likely, how serious? | |
| Does the person have capacity for this decision? (evidence) | |
| Options considered to reduce the risk | |
| What we agreed we will do | |
| What the person agreed they will do | |
| Who else was consulted (family, GP, social worker, advocate) | |
| Review date and outcome | |
| Signed (person) / signed (Registered Manager) | |


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