**Activity 1: Person-centred care planning**

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| **Case study (enter name):** **Jacynda** | |
| **Consider:** | **Notes:** |
| Safeguarding, health and safety risks | High alcohol consumption could lead to liver disease.  High BMI means there is a risk of developing diabetes and possibly other health conditions. |
| Physical needs | The practice nurse could complete a social prescription for free gym membership. |
| Transport requirements | Local volunteer drivers’ scheme could be used for getting to and from appointments. |
| Specialist equipment | None needed. |
| Intellectual or cognitive needs | Jacynda has a mild learning difficulty. She should be given accessible information about healthy lifestyle choices using visual images and simplified vocabulary. |
| Emotional or mental health needs | Jacynda lives alone and is not in contact with friends or family. |
| Social needs | Jacynda is not in contact with any friends or family members. She can be signposted to a local social group for people with a learning disability. |
| Barriers | Learning disability; financial obstacles. |
| Informal carer’s role | No informal carer. |
| Who should be involved? What multidisciplinary service plans and provision should be made? How will these meet needs? | A care worker could help Jacynda find employment and teach her independence skills.  She can be signposted towards disability employment advisors at the Jobcentre and also the governments ‘Access to work’.  A Mencap volunteer could act as an advocate at a GP appointment. They could also support her with a debt repayment plan and budgeting, along with a social worker. |

#### Self-reflection

* Analyse areas you did well on and those you omitted or found more challenging.
* Think about how the activity helped you improve your understanding of social care provision.
* Are there any areas where you want to improve your understanding? How might you do this?

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| **Case study (enter name):** **Jagesh** | |
| **Consider:** | **Notes:** |
| Safeguarding, health and safety risks | Health risks from drug taking, needle sharing and malnutrition.  Engaging in drug dealing and associating with gangs can expose Jagesh to violence or coercion. As a homeless person, he may be vulnerable to exploitation or assault by others. |
| Physical needs | Access to nutritious food and basic hygiene supplies such as soap, shampoo and toothpaste.  Regular check-ups to monitor his physical health.  Access to addiction treatment programs to address his heroin addiction. |
| Transport requirements | He may need help getting to and from appointments. |
| Specialist equipment | None needed. |
| Intellectual or cognitive needs | None identified. |
| Emotional or mental health needs | Jagesh needs access to specialised programmes for substance use disorders. He could also be referred to a counsellor or family reconciliation services. |
| Social needs | Jagesh could be directed to support groups such as Narcotics Anonymous or an online forum for drug addiction support. |
| Barriers | Homelessness, financial issues, health problems, drug addiction.  Jagesh’s lack of a secure address means he cannot register at a doctor or dentist or have a bank account. |
| Informal carer’s role | No informal carer. |
| Who should be involved? What multidisciplinary service plans and provision should be made? How will these meet needs? | Addiction rehabilitation services.  He could be supported by Crisis, a charity dedicated to ending homelessness and giving support to people who need to get back into employment.  Jagesh would benefit from a specialist trained advocate. |

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| **Case study (enter name):** **Dianna** | |
| **Consider:** | **Notes:** |
| Safeguarding, health and safety risks | As Dianna is at risk of another fall, an occupational therapist (OT) assessment is needed.  Infection and discomfort may be caused by mismanagement of incontinence.  Confusion/memory problems are causing safety concerns. |
| Physical needs | Support required for all daily living tasks.  Hospital secondary care referral to physiotherapy and OT.  GP referral to community nurse and local authority social care.  GP to prescribe pain medication on repeat for the time being. |
| Transport requirements | Support getting to and from appointments, such as non-emergency ambulance minibus, local volunteer drivers’ scheme or family support. |
| Specialist equipment | Mobility adaptations and equipment; incontinence provision. |
| Intellectual or cognitive needs | GP memory assessment referral to memory clinic; local authority social care for safety at home assessment and mental capacity assessment. |
| Emotional or mental health needs | Specialist advocate for Robert and, separately, for Dianna.  Hospital referral to individual counselling and family counselling.  Social worker referral to community therapist offering appropriate activities in the local area. |
| Social needs | GP social prescription such as socialising with a charity such as Age UK, or a community group local tea and toast session for dementia/loneliness. |
| Barriers | Robert’s acceptance of safety concerns, objection to assessments and own capabilities as an informal carer for Dianna; difference of opinions within the family causing conflict; Dianna’s age, mental capacity and confusion; problems getting to appointments and frailty. |
| Informal carer’s role | Robert’s care capabilities need assessing to identify limitations.  Identify capability and willingness to support Dianna at home. |
| Who should be involved? What multidisciplinary service plans and provision should be made? How will these meet needs? | A multidisciplinary team meeting before Dianna is discharged from hospital; a contingency plan for more suitable accommodation after assessments are completed.  Robert will need to decide whether residential care or supported housing is the only safe option. |

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| **Case study (enter name):** **Bartek** | |
| **Consider:** | **Notes:** |
| Safeguarding, health and safety risks | Bartek is unable to understand blood glucose readings and insulin measurements. He may not be able to protect himself from inappropriate or controlling relationships and is therefore at risk from dangers such as cuckooing if he is living on his own. |
| Physical needs | Bartek needs repeat prescriptions and medication reviews. He can carry out most daily tasks, but he will not be able to complete the social benefit process unsupported or budget for paying bills and buying food. He may not understand how to maintain a nutritious balanced diet. |
| Transport requirements | Bartek will not have a driver’s licence and might find bus or train timetables difficult to read and understand. |
| Specialist equipment | No specialist equipment is needed. |
| Intellectual or cognitive needs | Bartek needs to understand the reality of safeguarding issues around living on his own in a way that will make sense to him. An independent advocate specialist from Mencap, a learning disability charity, could support him and be separate from his parents, professionals and services. He also needs to work with a social worker or at a day/education care centre to improve his maths and English. |
| Emotional or mental health needs | He needs to work through his frustrations and emotions – Mencap may have specialist counsellors or volunteers to support. |
| Social needs | Bartek is not engaging with his parents or any services so he is currently not socialising; an advocate could support with family mediation. He would benefit visiting the supported living accommodation, speaking to peers and being introduced to the local youth and community provision. |
| Barriers | Learning disability, communication has stopped, his young age.  He is unrealistic about his capabilities to manage his diabetes, independent living, budgeting and safe socialising. |
| Informal carer’s role | His parents are willing to support a move into supported living with 24-hour care. |
| Who should be involved? What multidisciplinary service plans and provision should be made? How will these meet needs? | GP for repeat prescriptions for his diabetes medication and booking medication reviews, plus any other acute illness.  Pharmacy to collect or deliver Bartek’s medication. Bartek will need to see a dentist every 6-12 months and have an eye test every two years. Local authority social care can take Bartek to a supported living shared house for peers; he could also have an advocate. |

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| **Case study (enter name):** **Sadie** | |
| **Consider:** | **Notes:** |
| Safeguarding, health and safety risks | Sadie’s mental well-being will need a specialist assessment to find out whether she is at risk of suicide. Sadie is at risk of falling at home without adaptions and equipment she can use safely. |
| Physical needs | A GP will monitor medications, e.g. antidepressants, referring Sadie to secondary care services if necessary.  An occupational therapist (OT) will assess Sadie’s capability to self-care and her balance and mobility, putting in place equipment, e.g. a shower seat, and a care plan.  Sadie will need assistance to carry out some daily living tasks; her needs can be met by domiciliary home care using a care plan; the support will reduce as she improves and moves towards independence, reviewed by an OT.  A social worker will organise for Sadie’s shopping to be delivered. |
| Transport requirements | Sadie is dependent on organised transport; she will be booked onto a non-emergency ambulance minibus for hospital appointments and attend GP appointments using a volunteer drivers’ scheme. |
| Specialist equipment | Adaptations such as a shower rail and equipment such as a walking frame can be organised by the OT; a housing officer can find her more suitable accommodation. |
| Intellectual or cognitive needs | A speech and language therapist and a physiotherapist will work to stimulate new nerve pathways to restore speech and independent movement. |
| Emotional or mental health needs | Sadie will need to attend appointments with a counsellor, a community mental health nurse and a psychiatrist; the crisis team will be available.  Sadie would benefit from counselling and from attending a community support group for stroke survivors and people experiencing depression; a community therapist will facilitate activities for her to express her feelings. |
| Social needs | Sadie will meet people in a community group, at church and in a local cultural group. |
| Barriers | Independent mobility, lack of confidence, depression, financial obstacles. |
| Informal carer’s role | There are no informal cares to support Sadie’s recovery. |
| Who should be involved? What multidisciplinary service plans and provision should be made? How will these meet needs? | Sadie’s GP, rehabilitation therapists, counselling services, the local authority social services, community groups, religious leader and volunteers will meet and make person-centred plans. |

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