A guide for nurses working in partnership with multidisciplinary teams/agencies to enable people to receive coordinated care and support to meet their health care needs, respecting their choice and control.

Process Map for Decision Making

NIPEC
Northern Ireland Practice & Education Council

This process map clarifies the role of the Nurse as the key professional with responsibility for health care interventions as part of coordination of care within community/classrooms settings.

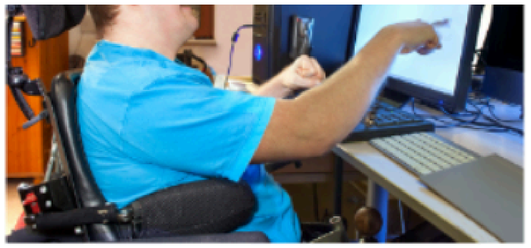
This process map refers to Support Worker as a collective term to describe: a Social Care Practitioner, Personal Assistant (PA) or Classroom Assistant. The key worker is a collective term to describe the member of staff who has overall responsibility for the wider support plan.

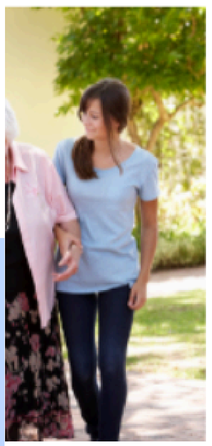
RIGHT CARE

People receiving health care should expect treatment and support that are evidence-based, personalised to their needs and choices, and delivered efficiently without unnecessary duplication between practitioners. This ensures a smoother, safer care experience and supports better overall outcomes.

RIGHT TIME

People receiving health care support should expect that their interventions are assessed, planned, and delivered at the point of greatest benefit; avoiding delays that might worsen their condition, cause unnecessary distress, or reduce the likelihood of a positive outcome.





RIGHT PERSON

People receiving health care should expect that all assessment, care delivery, monitoring and escalation are carried out by the most suitably qualified, skilled and competent staff member, ensuring safe, effective and person-centred care.

RIGHT PLACE

People receiving health care should expect their interventions to be delivered in the safest, most appropriate and accessible setting, where possible reflecting their individualised preferences.

1 Assessment of Health Care Needs and Goals

Nurses must lead the assessment of the person's physical, emotional, social and functional needs, considering their goals and personal preferences, as the first essential step for developing a personalised health care plan as part of coordination of care.

Outcome

A clear, comprehensive understanding of the person's physical, emotional, social and functional health care needs, alongside their goals and preferences.

Note

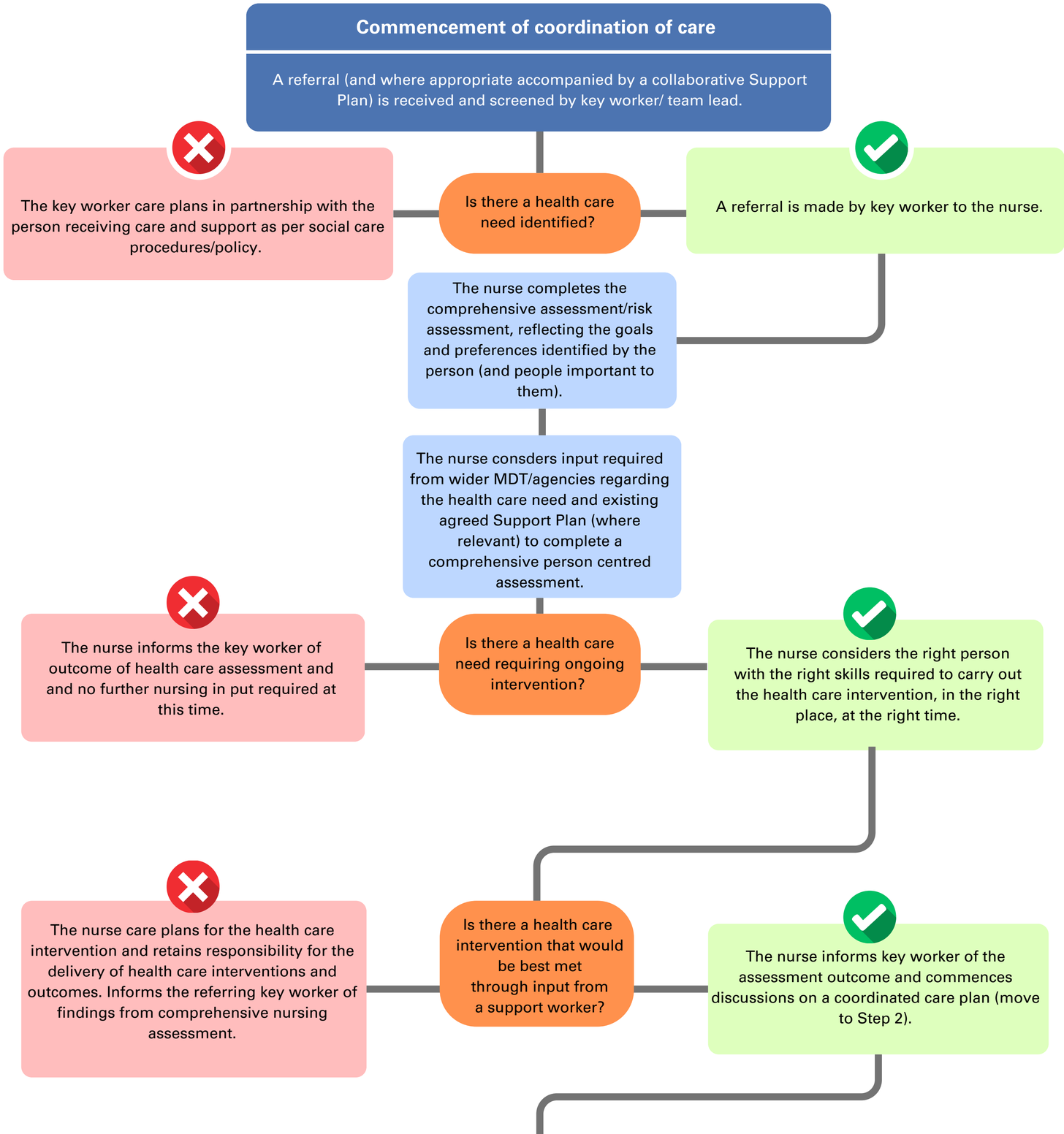
The assessment of a health care need must be carried out by a registered nurse who is competent in the role and accountable in relation to that aspect of the person's clinical care.

Assessment should:

1. have a named nurse leading the process;
2. be collaborative and done in partnership with the person being assessed;
3. be person-centred and tailored to individual needs, wishes and goals;
4. be holistic, recognise potential conflicts and outcome focused.

Risk Assessment: must consider the potential impact on the desired outcome of the health care intervention, including risks to individual failing to achieve their goals and aspirations as outlined in their ***Support Plan*** developed under the ***SDS Framework***.

The nurse must give consideration to the type of risk, its nature and context and any mitigating actions required/taken to manage the risk. Many people want choice and control for themselves and those they care for, but sometimes the decisions they make may seem to others as too risky. Nurses should work in partnership with the person receiving care and support to make decisions; ensuring the person understands the consequences and responsibility for the choices they make.



2 Shared Values and Vision

Nurses must lead effective collaboration, that builds trust, strong working relationships and a shared sense of purpose with the staff (across range of professionals and agencies), the person receiving care and support (and people important to them) as part of coordination of care.

Outcome

Shared understanding and agreement on health care priorities and interventions, aligned with the best practice to meet the person's assessed health care needs, their goals and preferences.

Note

People mostly want to be more involved in decisions about their health and care. When considering the 'right care, right person, right time, right place' decisions must involve both the person (or people important to them) and the nurse working together to reach a joint decision about care, now or in the future (for example, through advance care planning, or health care needs in a child's education setting). This requires providing the right information, advice and understanding of the person's health literacy, to support people to understand their conditions and how to live well in coordinating individualised health care and align with their Support Plan outcomes considering:

- goals and desired outcomes based on how the person prefers their health care need is met;
- who they would like to carry out the health care intervention, e.g. Social Care Practitioner, Personal Assistant or Classroom Assistant;
- understand the care, treatment and support options available and the risks, benefits and consequences of those options;
- the person's health needs - complexity; predictability and expected outcomes of the health care intervention;
- a decision making matrix can support outlined in the Delegation in Nursing and Midwifery | NIPEC;
- identified risks and mitigating actions;
- who is the most appropriate member of the wider team/agencies/education team to undertake the health care intervention, considering competence, confidence and experience of Health Care Workers, Social Care Practitioners, Personal Assistant, Classroom Assistant and their scope of practice;
- What level of supervision and monitoring of outcomes is required and who will carry out this role.

The conversation should bring together shared understanding across the team to coordinate care:

- the nurse's expertise, (drawing on other members of the MDT as required) such as treatment options, evidence, risks and benefits;
- what the person (and those important to them) knows best: their preferences, personal circumstances, goals, values and beliefs;
- mitigating actions to reduce risk;
- risks and anticipated outcomes of each health care delivery option.

The nurse together with the key worker, provide clear, accessible, and balanced information to support understanding; and empower the person (and those important to them), to actively participate in informed, person-centred decision-making regarding how their health care needs can be met to achieve agreed goals.

Is there an agreed position (between the person in receiving care and support of health care intervention, key worker and nurse) on the best approach to meeting the health care intervention?

The nurse retains responsibility for care planning to meet the health care interventions until an agreed position can be met based on the person's choice and preference (human rights) and nursing and social care regulation requirements/organisational procedures/policy.

The nurse considers the multiprofessional and persons position and formulates a coordinated approach to meet the health care interventions based on assessment, risk assessment and the person's identified personal goals and preferences, and availability of the wider health and social care team/agencies/education staff (move to Step 3).

3 Establish Responsibility (including delegation)

Nurses must ensure clearly defined roles and responsibilities for each member of the care team, the person receiving care and support (and people important to them) to ensure everyone understands their part and accountability arrangements as part of coordination of care.

Outcome

Health care interventions will be met to reflect the goals and preferences of the person receiving the care, ensuring the right care, carried out by the right person, at the right time, in the right place.

Note

Nurses often provide professional advice, make referrals onwards/allocate care to other professions/services and withdraw their ongoing input. In addition, they often delegate care to other members of the wider team, but retain accountability for ongoing input and the outcomes of the care interventions being provided by others - this is referred to as delegation of healthcare. To support the decision making of establishing responsibility the nurse should refer to:

- **The NIPEC Governance Framework for Delegation of Health Care Interventions;**
- **Delegation in Practice: a Governance Framework for Nurses & Midwives - Deciding to Delegate**
- **the NMC Code and supplementary standards for delegation of health care interventions where the health care intervention is being carried out by someone other than the Nurse (e.g. Support Worker);**
- **Delegation in Nursing and Midwifery | NIPEC;**
- **The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council;**
- **The NIPEC delegation checklist;**
- **The NIPEC recording delegated nursing care tool.**

The nurse must clarify their responsibility, input and accountability for the ongoing health care intervention/s: considering if their input constitutes:

- Delegation;
- Professional advice;
- Or onward allocation of care.

The nurse develops a care plan to meet the health care interventions as part of wider social care coordinated support plan, clarifying the roles and responsibilities of nurse, support staff and agrees with the person receiving the care and support, (those important to them) and the key worker.

The nurse establishes responsibility across teams/agencies.

The nurse must clarify if their input constitutes professional advice, referral or allocation of care onwards to another profession/service or delegation based on professional, legal, and safety considerations to ensure care reflects the choices of the person receiving the care (those important to them), remains safe, effective, and accountable.

- **Advice** → Providing guidance while retaining/or not retaining responsibility, but not accountabilty for outcome.
- **Referral** → Transferring care to another professional/service for assessment or intervention and no longer retaining accountability for outcome.
- **Delegation** → Assigning a task while retaining overall accountability for outcome.

Further guidance is provided in the Step 3 guidance of Principle Activities for Coordination of Healthcare (including Delegation).

Is further nursing input required and oversight for the outcome of the health care intervention?

Where the nurse has provided professional advice or referral of care onwards, they should provide guidance on escalation should there be changes in the persons health care. The key worker, will take forward the social care support plan. (the nurse will discharge their input for the specified health care intervention).

The nurse care plans for health care interventions as part of the person receiving care and support, wider support plan. (move to step 4).

4 Implement Shared Care Planning

Nurses must lead the implementation of the agreed health care plan to achieve specific health care intervention outcomes, as per agreed timelines and measurable goals, enabling each member of the care team to undertake their area of responsibility as part of the coordination of care.

Outcome

Coordinated, timely delivery of health care interventions resulting in measurable progress towards the person's agreed health goals and improved health and wellbeing outcomes: through delivering the right care, by the right person, at the right time, in the right place.

Note

The nurse is responsible in clarifying:

THE HEALTH CARE NEEDS TO BE SUPPORTED
- A clear description of the specific healthcare needs to be supported has been completed and recorded.
- There is a named registered nurse or midwife who is accountable for the delegated intervention is identified and recorded.
- The nurse/midwife delegating have the appropriate clinical knowledge and authority to delegate the intervention/task.

ASSESSMENT OF SUITABILITY FOR DELEGATION (REFER TO NIPEC DELEGATION DECISION MAKING MATRIX) AND CONSENT
- Confirmation that the intervention/task is appropriate for delegation.
- The person receiving the service has agreed with this approach.
- Delegation in the best interests of the person receiving care.

COMPETENCE AND ROLE OF THE SUPPORT WORKER
- Name, role, and scope of competence of the support worker undertaking the delegated intervention/task has been confirmed.
- The intervention is within the support worker's scope of competence and job description.
- Confirmation the support worker understands the intervention/task and their boundaries.
- The support worker has the capacity to take on additional work associated with the delegated health care intervention/task.

TRAINING AND COMPETENCY ASSESSMENT
- Details of training provided, including dates and trainer.
- Evidence that the support worker has demonstrated competence and verbally accepted the responsibility has been confirmed.
- Details of updates of training or renewal of competency have been considered and planned where appropriate.

INSTRUCTIONS PROVIDED BY THE NURSE/MIDWIFE
- Clear written instructions for how the intervention/task must be carried out have been completed and recorded in care plan/support plan.

RISK ASSESSMENT
- Risks identified and actions required to mitigate risks and enable safe practice have been considered.

The nurse takes the lead in developing and implementing a care plan for health care interventions as part of the person's wider support plan.

The nurse completes care plan for health care interventions developed in partnership and agreed with the person receiving the care and the key worker. The NIPEC delegation checklist provides guidance on the principle areas to be considered when implementing a shared care plan. The nurse completes and retains in the records:

- **The Nursing Delegation checklist: https://nipec.hscni.net/download/295/delegation-in-practice-a-governance-framework-for-nurses-and-midwives/3665/principles-of-delegation.pdf**
- **The Delegation of Care Nursing Record**

Are the conditions met (e.g. resources, competencies, and understanding of roles) to implement the shared care plan, in a safe and coordinated way, and agreed with the person receiving the care and support, the key worker and the providers of the care?

The nurse retains responsibility for care planning to meet the health care interventions until an agreed position can be met based on the person's choice and preference (human rights) and nursing and social care regulation requirements/organisational procedures/policy.

The nurse ensures a copy of the care plan for health care intervention (in a format accessible to all) is understood and shared with the key worker and all relevant parties (e.g. agencies, education setting). A copy must also be made available in the home/classroom of the person receiving the health care intervention - Move to Step 5.

5 Monitor, Follow up and Respond to Change

Nurses must lead the monitoring of the agreed goals and outcomes of the health care interventions to ensure ongoing effective care provision, facilitating response and adjustments to be made in a timely manner as part of coordination of care.

Outcome

Ongoing, responsive, and person-centred health care interventions that are regularly reviewed and adjusted to ensure goals are achieved and changing needs are met.

Note

The nurse is responsible for clarifying the monitoring arrangements of the outcomes against the goals outlined in the health care plan. The nurse's responsibilities in review and evalution of the health care interventions should ensure that the health care interventions are delivered effectively (not just planned). This step of the process should clarify:

SUPERVISION ARRANGEMENTS
- Type and level of supervision required for the health care intervention/task have been identified – direct/indirect.
- How and when supervision will be provided and by whom agreed with all the relevant parties (support worker and their employing organisation, person receiving care, other professionals).

MONITORING AND REVIEW
- How the nurse will monitor the outcome of the delegated intervention has been considered.
- Date for review of delegation health care interventions/task has been agreed and shared with relevant parties (support worker and their employing organisation, person receiving care, other professionals).

COMMUNICATION
- The person receiving the care agrees with the care worker undertaking the delegated health care intervention/task.
- Explanation of the intervention/task to be delegated to the support worker has taken place.
- The support workers confirm that they understand the required outcome of the delegated intervention/task and should not attempt to perform any further duties beyond what has been instructed.
- The person to whom you delegate is aware of their responsibility to raise issues of concern, report back and seek support when appropriate.
- All other members of the team involved understand what is to be delegated, to whom, the process involved, and their own accountability and responsibility.
- A shared care plan has been completed and shared with the relevant parties (care worker, employing organisation, person receiving care, other professionals).

ESCALATION PATHWAY
- A record is completed detailing who the support worker contacts if concerns arise, including emergency escalation instructions/ in hours and out of hours.

The nurse is responsible for clarifying the supervision, monitoring and review arrangements required for the health care intervention.
The nurse agrees the monitoring arrangements, communication processes and escalation pathways within a coordinated care plan; with the person receiving the care (those important to them) and the key workers, and relevant members of the wider support team/agencies/education authority.

The NIPEC delegation checklist provides guidance on the principle areas to be considered when monitoring a shared care plan.

The nurse carries out the scheduled or unscheduled monitoring of health care interventions as agreed.

The nurse responds in a timely manner to changes in health care needs, queries/concerns and escalation, revising plan of care as required.

The nurse records outcome of monitoring, shares with the person receiving the care, the key worker and worker/s providing the care. - updating on the relevant system (e.g. encompass, care plan in home/classroom setting).

The nurse contributes to the review schedule of the person's wider support plan overseen by the key worker, providing the relevant professional advice relating to the health care intervention.

Are the goals and outcomes of health care interventions being met?

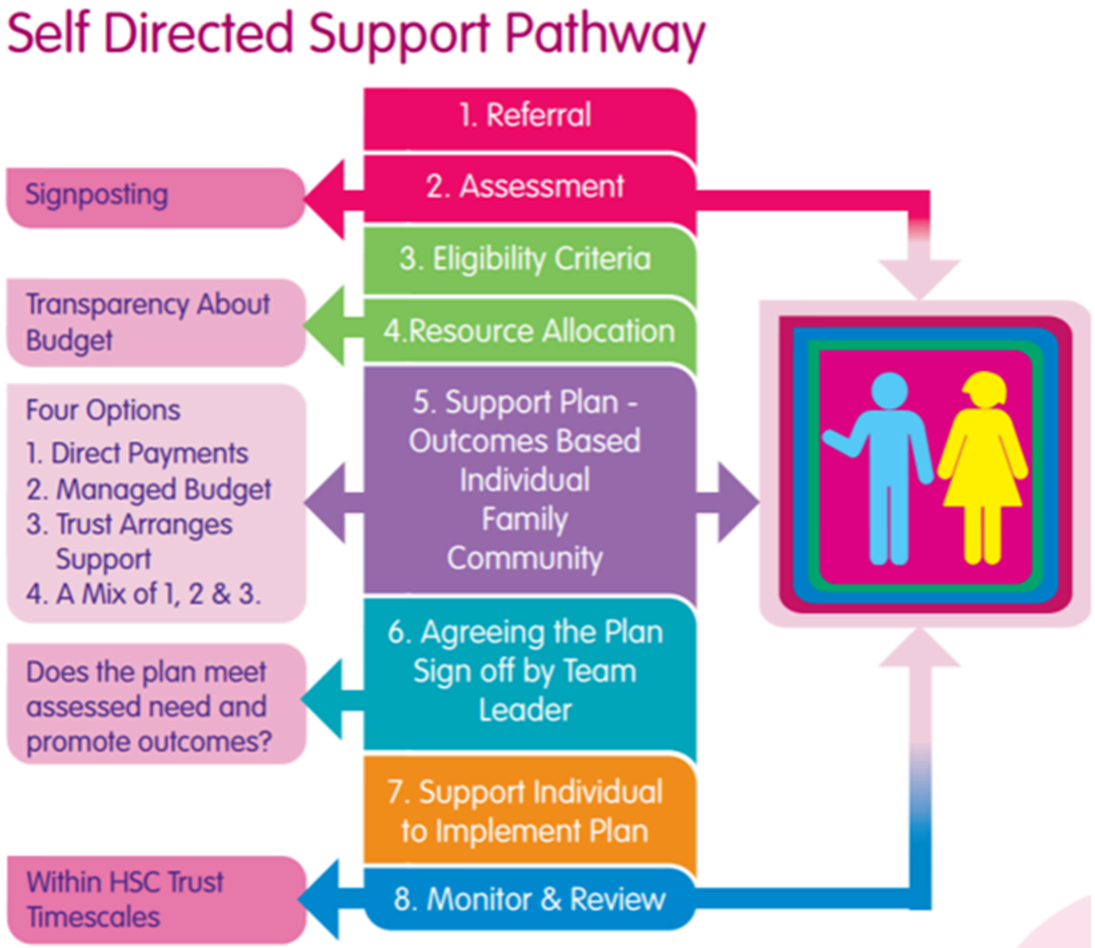
The nurse carries out a person centred nursing reassessment of the goals and health care need and care planning as outlined in Step 1, 2 and 3.

The nurse agrees and updates the ongoing care plan arrangements for the health care intervention, the scheduled and unscheduled monitoring arrangements with the person receiving the care (those important to them), the key worker and those providing the care.

The nurse plays a key role in supporting people who access the self-directed support pathway, including the use of direct payments, by enabling individuals to have greater choice and control over how their care is planned and delivered, while ensuring that clinical needs are safely met. This involves assessing and clearly identifying health care needs, providing professional advice on what aspects of care require appropriately trained or regulated input, and supporting the individual (and those involved in their care) to understand how those needs can be met, based on best practice and organisational policies.

For Further Consideration:

SDS Practitioners
Support Plan contents as per Service User and Practitioners Guides



Developing a Support Plan: 7 Questions

Question	What this should include
1. What is important to me?	Your Strengths, including what others appreciate about you. Significant people in your life. Important routines, activities, interests. What matters to you. How you like to be supported. Dreams and aspirations.
2. What I want to change and achieve?	Changes you want to make. Positive, achievable goals that are personal to you. E.g. Where you live; What you do; Your Support; Short and long term.
3. How will I be supported?	What is needed to support you? Include enough detail for others to know how best to support you. Cover health issues and safety. Deal with any risks. When? Where? Who? Include 'natural' supports and paid supports.
4. How will I use my personal budget?	A breakdown of how the money will be spent. Include detailed costs (in and out). Who will the money be paid to? Weekly; Monthly; Yearly
5. How will I manage my suspport?	Meet legal requirements Clear Responsibilities to deal with issues Have a backup plan Specify review arrangements
6. How will I stay in control?	How will you make decisions? Important Decisions in my life; How must I be involved; Who makes the final decision
7. What will I do to make this plan happen?	Clear Action Plan What? Who? When?

GLOSSARY OF TERMS

Agencies:
refers to an organisation operating outside of the statutory HSC system that delivers regulated care and support services to children, adults, or older people.

Classroom Assistant:
refers to a non-teaching support role that works under the direction of a teacher to support pupils' learning, care and wellbeing within the classroom and wider school environment.

Health Care Plan:
(often called a care plan) is a comprehensive, clinically informed document that outlines an individual's health needs, diagnoses, treatment goals, and the interventions required to maintain or improve their health.

HSC Trust staff:
refers to a Health and Social Care (HSC) Trust employees who deliver health and social care services to the population.

Key Worker:
refers to a named professional who is responsible for coordinating an individual's care and acting as a point of supportive contact for the person, family and carers. It is also a collective term to describe the member of staff who has overall responsibility for the wider support plan.

Personal Assistant:
refers to an individual employed directly by a person who has assessed social care needs, or by their nominated representative, to provide personalised support that enables the individual to live independently, safely and with dignity in their own home and community. Commonly employed through Direct Payments awarded by their local HSC Trust.

Social Care Practitioner:
refers to a regulated Social Care Worker who provides professional, values based care and support to individuals, families, and communities with the aim of promoting wellbeing, safeguarding and social inclusion. They are registered with Northern Ireland Social Care Council (NISCC) and work in accordance with its Standards of Conduct and Practice. It is a generic term and may refer to; Social Workers, Residential and Domiciliary Care Workers, Family Support and Children's Services Practitioners, Mental Health and Learning Disability Support Practitioners.

Support Plan:
refers to a person centred, structured document that sets out an individual's needs, goals, the agreed necessary actions and the supports required to help people live as independently and safely as possible. It is developed collaboratively with the individual, and where appropriate, their family/carers and relevant professionals.

Support Worker:
refers to a frontline professional who provides practical, emotionaland social support to individuals.They typically work under the supervision of registered professionals (e.g. nurses or social workers) and can be employed by statutory services or independent care providers.