Lancashire County Council

Older People Residential Settings

CARE PLAN FOLDER CONTENT GUIDANCE

Last review: February 2024
Next review: February 2025

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1. Introduction

This guidance has been developed to assist providers of residential and nursing homes for adults with their care planning. It contains suggestions on what could be included within your care plan folder along with care plan prompts which managers and staff may wish to consider when writing and/or reviewing each person's care plan. Whilst this care planning guidance referrers to paper files, the increased use of electronic care planning systems means this guidance may need to be slightly adapted.

Titles of documents are given as examples, and there is no obligation on the provider to use these titles, or for documentation to be set out in the order suggested in this guidance. These are entirely matters for the provider to decide as there is no one way of setting up a care plans folder so long as the information is present, and staff know where to look.
While we have used the term "Care Plan" we are aware that some Providers prefer "Support Plan". We are not suggesting that the term " Care Plan" must be used – again, this is for the provider to decide.

The purpose of a care plan is to describe the person's care and support needs. Where possible it should be developed and reviewed jointly with the person and, as appropriate, relatives or representatives – please see section around Consent, Care Planning & Mental Capacity for further information.

Care plans should include information on the person's personal history, strengths, preferences, interests, and aspirations. They should contain sufficient accurate and detailed information to enable staff (including new and temporary staff) providing care and support to the person to do so safely and in accordance with the person's wishes. It should be personalised, reflect the person's preferences, and should take a holistic approach to the person's physical, mental, emotional, and social needs (including the protected characteristics as defined within the Equality Act 2010) rather than just being task focused.

It is important that care plans and related documentation are accurate, complete, legible, up to date and always stored securely whilst being accessible to staff to refer to, to keep people safe. All records relating to the person are confidential to the person, the home's staff, Professionals who have authority to request them (e.g., CQC Inspectors, relevant Local Authority officers, Coroner), anyone the person specifically wishes to view them (e.g., relatives), and anyone who has Lasting Power of Attorney for Health & Welfare.

Providers should ensure their staff understand the importance of signing / initialling and dating all documents including daily records, care plans and any written amendments to evidence who wrote the entry and when.

This guidance has been developed by Lancashire County Council's Adult Service in conjunction with Healthier Lancashire & South Cumbria Integrated Care System Partners. It is based on publicly available good practice information and advice, experience and learning from contracts monitoring and quality improvement processes, and feedback from consultation with subject matter experts. It can be used by Providers if it is felt appropriate for them, the staff and people supported.

Lancashire County Council considers this resource to be acceptable and contract-compliant, but you may wish to check with CQC or other commissioners whether they consider the documents adequate to satisfy their regulations or contractual requirements.
Responsibility of the accuracy and completeness of documentation included in the care plan folders always rests with the Residential or Nursing Home Provider.

2. Person Centred Care Planning

There has been a shift towards outcome focused support for people in recent years compared to what services do for people, to what difference the person wants to make in their life.

'Outcome focused' means putting the person at the centre, firstly identifying what is important in their life and work backwards to thinking about how that difference could be achieved and who could help them. Detailing these in the care plans ensure that everyone is working together to achieve the same purpose of maximising the person's independence and quality of life.

What are outcomes?

There are lots of different outcome models and approaches already available, one approach is called 'Talking Points' which was developed in partnership with Services, people who use services and their carers. There are three types of outcomes in this model: -

- Maintenance or quality of life – this includes maintaining health and wellbeing.
- Change – with a focus on short term removal of barriers to quality of life or improving health and wellbeing.
- Process – with a focus on the way that services are delivered, or how the person feels they have been treated.

Quality of Life	Change	Process
Feeling safe	Improved confidence	Listened to
Seeing people	Improved skills	Having a say
Having things to do	Improved mobility	Treated as an individual
Being as well as you can	Reduced symptoms	Treated with respect
Dealing with stigma / discrimination		Being responded to

What difference does it make?

An 'outcome focused' approach supports an assessment and planning process that is based on conversations about what matters to the person along with their strengths and abilities, rather than a focus on tasks and what staff need to do for the person.

Each staff member's role is not about form filling, but is more about engaging with the person, supporting them to identify and achieve outcomes with a focus on relationship-based care between staff and the people within their service.

3. Care File Sections

The fundamental principle to remember is that this care plan is for the person, it enables the person to confirm and agree how they wish to be supported by staff.

Folder cover

It is important that all staff, including new and agency staff, are able to identify each person's care plan folder quickly and easily. We suggest the person's name, preferred name, and room number should be written on the folder spine, and on the front cover of the folder / ring binder.

Photograph

To assist with the identification of each person, a clear up to date photograph could be attached to the front cover / located towards the front of the Care File. Photographs may also help to note physical changes or ill health. For this reason, it would be advised that the photograph would be dated and renewed at least every 12 months, and older photographs archived.

Contents / Index sheet

A contents/index sheet is recommended to show the order of sections within the folder, including sub-headings to help staff locate particular documents. Numbering of sections or clearly written tabs will be helpful to for staff navigating the folder.

4. Important Documents

Consider having the following documents at the front of the file to ensure ease of access, for example in an emergency. It is crucial that these documents are incorporated into your review process and are updated where there has been a change in the person's need, along with the relevant care plans to ensure information is consistent.

Documents to consider including in this section
DNACPR (where applicable)
Personal Emergency Evacuation Plan (PEEPs)
One Page Profile / 'At a glance' summary
Hospital Passport

- It is important that your home has a system in place outside of the care planning process to inform staff quickly who is on a DNACPR in a dignified and discreet way. This information should also be included on handover documentation and office board as appropriate.

- Good practice would be for PEEPs to be kept in a grab file which is readily available in an emergency. Each PEEP should include the name, preferred name, and room number of the person it is for.

- Many homes use a "One Page Profile" for an 'at a glance' summary near the front of the folder. This sets out the important things a new / agency staff member needs to know about the person before providing them with care and support.
  This should only be a brief summary and not duplicate the care plan, detailing things such as person's allergies or intolerances, major health concerns, likes, dislikes and preferences. The summary does not eliminate the need for staff to make themselves familiar with the full care plan.

- The hospital passport is used to document and share important information about a person's needs, promoting communication and allowing more effective treatment. It does not replace the detailed information in a care plan but complements it.
  For people with dementia, the 'This is Me' document can also be used to provide a valuable way of letting medical and social care staff know more about the person, their preferences, routines and personality. It is important there is a system for keeping the hospital passport up to date if there are any changes made to the care plan.

5. Personal Information

Documents to consider including in this section
Personal Information
Support network / Relationship Circle
Professional contacts

- The 'support network' should contain details such as family and friends important to the person that they wish to stay in contact with.
- Ensure there are details on communication between the Provider and family members and/or representatives. With consent from the person (where appropriate) are there any communication arrangements? How is this done, who by and how frequently?
- Professional contacts should detail any professional involved in the care of the person and their contact details (e.g., GP, Social Worker, Dentist, Optician, Macmillan Nurse, Advocate)
- NB. If you are having any difficulties, it is important to discuss with the person's funding authority at the earliest opportunity for support.

6. Life History

This should contain information about the person's life, background, and interests. Where possible this should be based on information provided by the person, but also include information from relatives or representatives where appropriate.

This document should be built up and added to over time rather than created as a one-off information gathering exercise, and information contained should be reviewed. It gives staff a background to the person, provides them with starting points for conversations and an understanding of what is important. It also supports discussions and development of more personalised activities for the person.

There are a number of free and paid tools available to support you to undertake life story work such as;

- 'Life Story Book' – Dementia UK
- 'Life Stories' – Dementia Care
- 'Portrait of a Life' – Southwest Yorkshire Partnership NHS Trust
- 'Remembering Together' – Alzheimer's Society

The University of York have studied life story work and identified 9 good practice learning points for consideration.

7. Admission

Documents to consider including in this section
Organisation's initial / pre-admission assessment
Organisation's Admission assessment
Personal Property Checklist
Referral documentation (e.g., from the Local Authority who arranged placement or hospital discharge)
Moving on Plans (MoPs) from previous homes when applicable

- During the admission process, it is important to ask people if they have any cultural or religious preferences and if there are any associated support needs; this information can be incorporated into the relevant care plans when appropriate.
- Information on the person's likes and dislikes should be gained along with any needs relating to race, culture, gender, age, religion/spirituality, disability, or sexuality.
- Nighttime care needs should also be identified as part of the pre-admission assessment and determine if staffing levels are adequate to meet needs.
- Consideration should also be given to the existing people already living in the home. e.g., will admitting person X take away care from person Y due to their needs.
- Is the layout of the building suitable for the prospective person e.g., does the environment allow for the equipment required.

8. Care Plans and Risk Assessments

The suggestions for care plan headings below are given as examples, and there is no obligation on the Provider to use them, or for the care plan to be set out in the order suggested in this document. These decisions for the Provider to make.
Where separate documents such as assessments relate to a particular section of the care plan, we suggest that these documents are filed with the relevant care plan page so that they can be easily found. Examples of such documents, dependant on the person's needs, are shown under each section.

Each care plan should include 'personal outcomes' that describe what matters to the person. They should be outcome focused, setting out what the person is aiming for, along with the actions required to achieve the outcomes.

It is essential to ensure risk management and mitigation is effectively reflected in the care plan. Clear actions should be listed for staff to follow to minimise the risk involved, whilst promoting choice and independence. Through the care planning process, Providers should encourage people to take positive risks to maximise their control over their care.

A good practice suggestion would be to use a visual traffic light system on your index for each individual care plan indicating the level of risk / need there is.

High Medium Low

Consent, Mental Capacity and Care Planning

Documents to consider including in this section
Consent to elements of support *(e.g., to receive care and support, to be photographed or medication administration)*
Decision specific Mental Capacity Assessments & associated Best Interest Decision documentation*
Applications & Authorisations for Deprivation of Liberty Safeguards (DoLS)
Lasting Power of Attorney or Court Appointed Deputy documents
Advance Statement
Advance Decisions to refuse treatment

Each person's needs and choices will be unique to them, and involving people in decisions about their care is fundamental to the principles of the Mental Capacity Act 2005.

When undertaking assessments and reviews of a person's care.

- Is the person able to make the decision? This would include:
  - Are they able to understand the information given to them?
  - Are they able to retain information that they have been given long enough to make the relevant decision?
  - Are they able to consider, weigh up or evaluate information to make a decision?
  - Are they able to communicate their decision?

If they cannot make the decision:

- Is there an impairment or disturbance in the functioning of the person's mind or brain?
- Is the person's inability to make the decision because of the identified impairment or disturbance of the persons mind or brain?
- If appropriate, has a formal Mental Capacity Assessment been undertaken? How is this recorded and who is / was involved?
- Where there is a Lasting Power of Attorney (LPA) or Court Appointed Deputy for Personal Welfare**, is this person identified within the person's care plan and are they appropriately involved in the best interest decision making process?
- Where a capacity assessment has been undertaken, has a Best Interest Decision been made? How is this recorded and who is / was involved?
- Is the person being deprived of their liberty in order to keep them safe (e.g., use of locked doors, keypads, bed rails)? If so, has there been a Deprivation of Liberty Safeguard (DoLS) application submitted for authorisation? For support, including which form to use, and when to request a review/ renewal Deprivation of Liberty Safeguards - Lancashire County Council.

Where you are assessing a person's capacity to make a number of different decisions, it is important to check before reaching a conclusion as to the person's decision-making capacity that the different decisions being assessed make sense together logically and there is no conflict with a conclusion of capacity to make some other decision.

Recording

What and when to record a person's capacity will vary. It is for Providers to use their judgement as to whether individual situations are significant enough to need a formal, written assessment of capacity, and who to involve in making the decision.

For the majority of decisions, formal and full assessment processes are unlikely to be needed e.g., Would you like a cup of tea, what would you like to wear today? However, all assessments whether formal or informal must be undertaken in line with the principles of the Act. Please refer to the MCA Code of Practice for guidance.

For formal assessments, any aspect of care which amounts to restrictive practices being used (e.g. physical restraint, mechanical restraint or chemical restraint) must have a formal MCA assessment recorded.

Routine assessment and planning of care should provide staff with full information on a person's capacity, and it should be regularly reviewed. Creating the care plan with the person and/or their chosen representative will keep the focus on what is important to that person and enable their care and support to reflect this.

Each care and support plan should include:

- The person's level of understanding and capacity to make decisions for that area of their care and support (and how this may fluctuate).
- How the person should be involved in their care and lifestyle choices, including making decision for themselves.
- What support should be provided by staff to help the person make choices and decisions about their care and support (some actions will be detailed on the Best Interest decision, where applicable)
- Details of how people who are deprived of their liberty have their rights protected.

Daily notes should reflect the steps that staff take to support people in decision making, and any actions they have taken where a person has declined support.

Overview of mental capacity within care planning

You should be mindful that although a person may be assessed as lacking capacity for one element of their care, they may have capacity to make other decisions about their support. It is important to remember that capacity is decision and time specific, and the overview below is a guide for recording.

Capacity	Lacks Capacity	Fluctuating Capacity
❖ A person with capacity should decide the content of their care plan. ❖ Written in the first person. ❖ The person should sign to indicate consent to actions and involvement. ❖ Record where the person refuses involvement in care planning process. ❖ Three stage tests may be used and evidence where there was a query or doubt about the person's capacity.	❖ The preparation of a care plan should always include an assessment of the person's capacity to consent to the actions covered by the care plan and confirm that those actions are agreed to be in the person's best interests. ❖ Care plans should be written in 3rd person; only indicators of 'preference' or elements of the care plan that the person does have capacity to decide about should be written in first person. ❖ E.g., the person may not be able to make the decision about managing personal care but may be able to state a preference about products to be used, such as a particular body wash. ❖ Evidence of use of the three-stage test. ❖ Their signature is not appropriate, and recording should indicate they lack capacity to consent to the care plan. ❖ Relatives can sign to say they have been consulted but cannot consent unless they have the legal power to do so i.e., as LPA or Deputy. ❖ The decision maker should record their name, date completed and their signature to verify their belief that the care proposed is in the person's best interest.	❖ Discuss with the person at the times when they have capacity in order to help plan and prepare best interest decisions at the times they lack capacity. ❖ Encourage involvement of the person in constructing a care plan that reflects actions they have consented to (when they have capacity) and indications of preferences and wishes (for when they lack capacity). ❖ This will inform best interest's decision making when they lack capacity. ❖ Always consider whether the decision can wait until the person is able to make the decision themselves.

*Decision specific Mental Capacity Assessments & associated Best Interest Decision documentation can also be filed alongside the relevant care plan & risk assessment. If this documentation is not kept with the relevant care plans, you need to ensure that it is referenced to which section of the care file this is kept.

**Where a person advises they are a Lasting Power of Attorney (LPA) or Court Appointed Deputy, clarification should be sought on whether this is for Personal Welfare or Property & Affairs (Finances), or both. Original documents must be seen, and copies of documentation should be taken and kept within the person's care file. If clarification is required e.g. due to paperwork not being available, you can also apply to search the Office of Public Guardian registers to see if someone has another person acting on their behalf.

Communication

Documents to consider including in this section
Communication Care Plan
Communication Boards / Passports
Family Communication log
Abbey Pain Scale*

The care plan should describe the person's communication needs and how to effectively communicate whilst protecting their dignity. (This should be revised as and when required)

- What does the person like to be called?
  - Do they like to be called by their first name, nickname, formally addressed or by a term of endearment e.g., love, sweetheart – do not presume that everyone would find these terms acceptable.
- What is the person's first language?
- Are they able to communicate verbally? Can they / do they prefer to communicate in another format? (e.g., gestures, pictures, writing)
- How would the person like people to communicate with them?
- Are they able to communicate their needs and summon assistance (e.g., use a call bell or emergency cord)
- Does the person use, or would they benefit from, electronic devices to support their communication (e.g., mobile phone, iPad, specialist handheld communication device)?
- Are there other ways that the person communicates e.g., sounds, facial expressions, body language, tone of voice or behaviour? How will staff recognise what they are trying to communicate? *Do any Behaviour Care plans need to be referenced here to guide staff to more information?*

*Consider the use of The Abbey Pain Scale for people who cannot easily communicate their needs e.g., due to dementia and where needed, build this assessment into the person's care plans. For people who experience pain, this will support their needs to be met in a more proactive way and increase their wellbeing.

Vision

- Does the person have a visual impairment or wear glasses (short or long distance?)
  - Where are they kept?
  - Who is responsible for cleaning them?
- Do they use any equipment to assist their reading or vision
  e.g., magnifying glass, additional lighting, talking appliances, smart speaker.
- Can the person read and write independently?
  - Do they need audio or large print books?
- How are changes to vision identified and addressed?
  - Do they have an Optician – how are appointments arranged?

Hearing

- Does the person have a hearing impairment or wear hearing aids?
  - Where are they kept?
  - Who will maintain these and how e.g., cleaning / batteries / repair?
  - How is ear care managed?
- What actions do staff need to take for that person to minimise the impact of their hearing impairment
  e.g., can the person lip read, do you need to ensure eye contact before speaking?
- How is the person supported to actively participate in communal activities?
- Does the person have input from professionals
  e.g., audiology or have regular ear tests?
  - Who is responsible for booking these?
  - How is hearing loss monitored and changes to hearing addressed?

All organisations that provide NHS / adult social care must follow the accessible information standard. The aim is to make sure people who have a disability, impairment or sensory loss receive information they can access and understand, and any communication support they need. Although part of the care plan, it is important to assess this at pre-admission/admission.

Mobility and Falls

Documents to consider including in this section
Mobility & Falls Care Plan
Moving and handling assessment
Falls risk assessment
Falls checklist
Falls Diary / log
^[1] Post Falls monitoring

The care plan should describe the person's mobility needs and ensure that where assistance is needed, it is provided in a safe and dignified way.
Some areas to consider within your care plan or associated documents include:

- Has a Falls Risk Assessment been completed e.g., FRAT? What is the level of risk, what areas of need have been identified and what actions are needed to monitor and reduce risk?
- Has a Moving and handling Assessment been completed? What actions are needed to reduce and monitor risk? Does it include describing how the person transfers and mobilises, what equipment is required and how many staff are required to support? Could an agency staff member read the moving and handling assessment and be able to move the person appropriately and safely?
- What is the person's level of independence / what are they able to do for themselves? How can the person's independence be promoted or increased?
- What level of assistance does the person need with areas such as:
  - Walking / general mobility (both short and longer distances)
  - Getting in and out of bed
  - Getting on and off the toilet / chair / commode / wheelchair
  - Sitting and standing
  - Getting in and out of the shower or bath
  - Using steps or stairs

[1] Monitoring Records marked with ^ within sections of the care plan

- Details of the number of care staff needed along with any equipment required e.g., hoist, slide sheet, standing aid, walking aids or slings (for hoist) including type / size and how these should be used.
    - Are there any checks or maintenance needed for these? If so, who does this and how frequently?
- Have risk assessments identified any risks in connection with their mobility? E.g., medication or drugs, impaired vision, hearing, foot or nail problems, environmental factors.
- How should staff help the person to reduce any identified risks?
- Does the person need staff to monitor or supervise them when they are moving independently to keep them safe?
- Are there any concerns about the person's posture or balance?
    - How do these need to be addressed?
- Does pain affect the person's mobility?
    - If so, does the person need pain relief before mobilising?
        - If yes, within what timeframes?
- If the person has equipment in place (including those that restrict movement) e.g., bed rails, pressure mat, lap belt or tilt chair.
- Is it with the person's consent or has a Best Interest Decision been made?
- Have risk assessments been completed for the use of equipment and have the results of this been recorded?
- Are bed rails required and if so, has a risk assessment been completed?
- Has singled handed care been considered? What equipment could be tried for one carer to use to support with staffing and improved interactions with the person.
- Does the person require more specialist equipment e.g., postural support, advice for more complex moving and handling? If so, should a referral be made to Community Occupational Therapy (0300 123 6720).

Ensure post falls protocols are in place, including monitoring, to support staff to understand what they need to do if a person has a fall. A monitoring form will ensure the observations are in one dedicated place.

Skin Care and Tissue Viability

Documents to consider including in this section
Pressure Ulcer risk assessment
Skin Care Plan
SSKIN bundle / React to Red
Body maps
Wound assessment & review chart
Wound care plan
^ Repositioning / turning charts

The care plan should describe the support a person needs to ensure that their skin remains intact and healthy, including consideration for infection control:

- Has a validated pressure ulcer assessment been completed? (e.g., Waterlow or Medley) What are the outcomes of the assessment and what actions are needed to reduce and monitor risk?
- What is the general condition of the person's skin (including areas where it is good)?
- Does the person bruise easily? How is this recorded? (e.g., body map)

- Does the person have any history of pressure ulcers or other skin damage?
- How often does skin need checking to ensure it is intact and good health e.g., when supporting with personal care? Does the person consent to this, or is there a Best Interest Decision in place?
- Does the person have any skin conditions or moles that require monitoring or support to manage?
- Does the person have any sensitivities / allergies which might affect their skin? (e.g., specific creams or lotions)
- Has the person been given any advice by a healthcare professional about how their skin needs to be looked after?
- Does the person have any specific risks to the integrity of their skin? e.g., incontinence, poor mobility or nutrition that need including (ensure you reference other care plans where needed to direct people to further information on how to manage the person's needs)
- Does the person use any specialist equipment e.g., pressure cushions, heel pads or mattresses (including the correct setting in accordance with their current weight)? How often is the use of equipment reviewed and by whom?
- Does the person have any pressure ulcers, and if so, what grade are these (as assessed by a Healthcare professional)? What nursing intervention is in place? How often is this reviewed?
- Has the person been advised to follow any turning or repositioning schedules, or any forms of self-movement in order to relieve pressure? What are the details of these, including frequency (this needs to be specific)? Can the person mobilise and reposition themselves or do they need support?
- Does the person have any prescribed or non-prescribed creams, ointments, emollients, or shampoos? What are these and how are they to be applied (referring to a body map where needed)?
- Are all prescribed skin care products listed on the TMAR sheets and signed for?

For nursing homes, documentation for use of wound care products should include:

- Site of application of wound care product
- Frequency of product change
- Wound measurements
- Evaluation and review (including planned timescales)

Good practice would be for photographs to be taken of any pressure sores or moisture lesions (consent for photographs needs to be sought as per legislation and local policy)

Body maps should generally be used to monitor skin conditions where changes may occur. As the mark or wound changes, a new record should be made, and a copy of all body maps must be kept in the care file. Good practice recording on body maps includes:

- The person's name
- Date of completion
- Name, signature, and designation of the person completing
- Sufficient information and detail of the type of mark e.g., red area, bruise, cut, laceration and wound, pressure ulcer, swellings, scalds and burns

Further information can be found:

- Lancashire Safeguarding Adults Board website: Pressure Ulceration
- NICE Quick Guide: Helping to prevent pressure ulcers

Nutrition and Hydration

Documents to consider including in this section
Eating, Drinking and Swallowing care plan
Malnutrition Risk Assessment (MUST or equivalent)
Dysphagia (swallowing) Risk assessment
Weight chart
^ Food morning charts
^ Food balance charts

The care plan should describe how to ensure the person is having sufficient food and drink to maintain their health, if they need support to eat and drink, and that it is carried out in a safe and dignified way.

- Has the person had a nutrition risk assessment? (e.g., MUST) What are the outcomes of the assessment and what actions are required to reduce and monitor risk? Has it been reviewed?
- What are their known food and drink likes or dislikes? Do they have any preferences e.g., food or drink portion sizes or temperatures, snacks outside of mealtimes or 'little and often' meals – how is this managed?
- Have any specific risks been identified e.g., poor nutrition, malnutrition dehydration, dysphagia, choking or allergies?
- Is the person able to indicate when they feel hungry / thirsty or when they would like something to eat or drink? Is it necessary to identify staff to ensure this happens?
- Can the person access food and drink independently?
- Where does the person like to eat – e.g., alone or with other people?
- What would the person like to happen to make mealtimes an enjoyable experience?
- Do they need a particular position or posture when eating? (e.g., sitting in dining chair rather than a wheelchair)
- What level of assistance does the person need (supervision, prompting, encouragement, direct support)? Is sufficient time identified to provide the required level of support?
- How should staff promote healthy, balanced diet with the person?
- Does the person need any equipment or aids to support mealtimes (e.g., adapted cutlery or crockery, clothing protection)? Is there sufficient contrast between the plate and food / tablecloth?
- Does the person need staff to support their nutrition through artificial feeding (e.g., PEG feed or NG tube)? Who is responsible and how frequently are they supported?
- Does the person need their meals at a specific time? (e.g., due to medication, sleep pattern or social activity)
- Does the person have well-fitting dentures? Do staff need to prompt that these are in ahead of mealtimes?
- Has any advice or guidelines been given by the Speech and Language (SLT) or Dietician e.g., calorie intake, thickening agents, level of consistency of food*?
- Does the person require a special diet? (e.g., diabetic, high protein, low fat, allergies and intolerances, cultural and religious preferences)
- Does food / drink need to be fortified or has the person been prescribed oral nutritional supplements? (Consider supplements timing to not affect mealtime appetite)
- Is there a requirement for staff to record the person's food and/or fluid intake? Where is this information recorded and stored? This may be prompted by their MUST score, requested by a healthcare professional, or where otherwise indicated.

- How often does the person need to be weighed? *This may be prompted by their MUST score, requested by a healthcare professional, or where otherwise indicated.* Where is this information recorded and stored? How is this monitored and by who? What actions do staff need to take where there is a change in weight?

*Ensure that care plans detail exact advice and recommendations from SLT, the International Dysphagia Diet Standardisation Initiative (IDDSI) Framework.

If the person has difficulty swallowing or is at risk of choking, consider if a specific Dysphagia Care Plan is needed – see below for more prompts.

Dysphagia

The care plan should describe how to support the person following the advice of health professionals in relation to their difficulties with swallowing and/or risk of choking, areas to consider include:

- Has a Dysphagia Risk Assessment been completed? Has it been reviewed and updated on a regular basis? Does the person require a referral to Speech and Language Therapy (SLT)?
- Does the person appear to have an impaired chew or swallow? Do they have any particular medical conditions that affect this?
- What difficulties has the person been experiencing that have led to their assessment by SLT?
- What is the **exact advice** provided by the Speech and Language Therapist? What date was the advice provided by SLT? When will the person be reviewed?
- If the person requires a specific texture or consistency of diet or fluids, what is this? This should be in line with the International Dysphagia Diet Standardisation Initiative Framework Levels, descriptors, and characteristics.
- Are there are any warning signs to look out for which may indicate that the support measures in place are not working adequately, and a review or re-referral is required to SLT? e.g., wet/gurgly voice, coughing or choking before or after meals or drinks?
- Are there any high-risk foods that the person needs to avoid?
- If the person requires staff to monitor or supervise them whilst they are eating or drinking due to risk of choking, what arrangements are in place to ensure the person is not left alone?
- How should staff respond if the person shows signs of aspiration / choking?

Does the person have the mental capacity to make decisions around eating and drinking where they are at risk of choking or aspiration?

If the person has capacity and chooses to eat food or drink fluids that they have been advised not to, ensure that you have documented the advice of professionals and any discussions that you have had with the person in relation to their decision.

Mental Health and Wellbeing

Documents to consider including in this section
Mental Wellbeing Care Plan
Behaviour Care Plan
^ Behaviour / ABC Charts
Pain Care Plan
Cornell Depression Scale*

The care plan should identify the person's mental health needs, ensuring that all their needs are met safely, effectively and with dignity, whilst considering their preferences and choices.

Does the person have a diagnosed mental health condition and if so, what is it?

- Does the person experience any periods of anxiety and if so, what triggers this?
- What makes the person feel safe and how can staff support this?
- What support, if any, does the person need to manage their mental health condition?
- How will any support the person needs be provided, and by who? (e.g., Staff, health professionals, support groups, other agencies)
- Is the person at risk e.g., of self-harm or suicidal thoughts if they are feeling unwell, if so, how can risks be minimised, and the person's safety maintained?
- Does the person see or hear things that are not there (hallucinations)
    - How does this affect the person and how they are supported?
- Are there any self-help techniques the person can use to help themselves (e.g., breathing exercises for anxiety or panic attacks)?
    - Is there anything that has been suggested by professionals?
- Are there any sources of information about the person's condition that may help them feel less isolated?
- How should staff speak to the person to help their situation and feelings?
- What signs do staff need to be aware of which may indicate a deterioration in the person's mental health? What actions should they take?
- How does the person's environment affect them (e.g., are they happier in their bedroom, in the garden or in communal areas, with company or without)?
- What does the person like doing that helps them reframe their thoughts / feelings?
- Are there any strategies that staff can use to take the person's mind off things, or change the pattern of their thinking (e.g., going for a walk, listening to music, offering them something to read)?
- Does the person have a crisis plan? If they do – where is this located? Has it been agreed by the person with the professionals involved in their treatment?
- Does the person take any medication that needs reviewing? How frequently?
- Does the person sleep well e.g., does any lack of sleep affect mood?
- How can staff support the person to maintain a healthy diet to improve their mental and physical health?
- Staff to consider encouraging physical activity, art, or music to support their wellbeing?
- Does the person ever feel isolated? How can staff help the person maintain their social life or develop relationships that are important to them?
- Does the person's mental health have any impact on their physical health (neglect, over-eating, under-eating etc)? Does the person need to engage with healthcare professionals to minimise any risks this creates?
- Are there any relevant current or earlier life events that affect the person's mood or wellbeing (e.g., death, loss of 'independence', family issues)? – Are there any triggers for these (e.g., time of year, anniversaries, a particular skill they wish to maintain)?
- Does the person need support in accessing external professionals (e.g., counselling) to manage any feelings from life events?

*Consider the use of the Cornell Depression Scale for people who cannot easily communicate their needs e.g., due to dementia

Does the person need separate Behaviour care plans to support understanding and management of behaviours that challenge – see additional information below.

Behaviour

For more detailed information on Restrictive Interventions and Positive Behaviour Support (PBS), including care planning, see guidance documents and resources here.

The Behaviour Care Plan should describe behaviours the person may exhibit which could impact the person themselves or others, how to prevent the behaviour, if possible (including early warning signs), and if this is not possible how to manage these. Consider that behaviour is always a form of communication although there may not always be a specific trigger.

Dependent on the person, behaviours and complexity, the person may need more than one Behaviour Care plan to guide staff to manage the behaviours and support the person in a dignified way, safely and effectively.

Areas to consider include:

- What behaviours does the person exhibit?
- Are there any physical reasons that might trigger the behaviour (e.g., infection / UTI, dehydration, constipation, diarrhoea, uncontrolled pain, poor sight, sleep deprivation, medication side effects)? Are any preventative and/or management strategies needed for these? What are they?
- Are there any other reasons that might trigger the behaviour (e.g., boredom, over-stimulation (noise, people, environment), feeling hungry / tired / thirsty / hot / cold, anxiety, emotional, continence needs, hallucinations, inability to communicate, the need for something that can't be expressed)? Are there any preventative strategies the person needs for these?
- How can any behaviours the person displays be managed in a safe and dignified way (e.g., how many carers are needed, does the person prefer or respond more positively to male or female carers)?
- Are there any risks (to the person or others) associated with the behaviour? Does the person need a risk assessment to determine how these can be best managed?
- How is it best to communicate with the person when they exhibit the behaviour?
- When the person displays the behaviour, do they need to be moved to a different environment (e.g., quieter) or be with fewer people?
- Are any distraction techniques appropriate, such as helping the person to do something they like?
- Do staff need to come back later if the person is refusing care and support?
- Does the person need "as required" (PRN) medications before or after interventions? This needs to be discussed with GP – also detail what needs to be tried before this.
- Should staff use safe hold techniques if the person is physically aggressive? If so, are staff trained appropriately to do this and is it in keeping with the principles and policies of the service?
- Does the person have a DoLS authorisation in place (or application awaiting authorisation) where appropriate?

Personal Care

Documents to consider including in this section
Personal Care care plan
Personal care chart (e.g., bathing / showering log)
Oral Health assessment
Oral Health care Plan*
Continence care Plan*
Catheter / Stoma Care
^ Bowel Chart (informed by Bristol Stool Chart)

The Personal Care care plan should describe how to provide the person with the care and support to manage their personal hygiene in a way that they choose, ensuring their dignity is always respected.

Areas to consider include:

- What is the person's level of independence i.e., what can they do for themselves when looking after their personal hygiene (including nails, hair, shaving, teeth, mouthcare)?
- Does the person have any preferences or a particular routine when managing their personal care (e.g., bath/shower/strip wash, time of day, day of the week, frequency)
- What would they like to happen to make personal care an enjoyable experience (e.g., personal privacy for some aspects, choice of toiletries, soak in the bath, dimmed lights, music, closed doors)?
- How is dignity protected for people going to and from the bathroom (e.g., dressing gown / robe)
- Preference of male / female staff providing any elements of their care and support?
- Does the person refuse personal care?
    - If so, what actions or plan is in place?
- What level of assistance does the person need for tasks (i.e., how many carers)?
- What support does the person need for specific aspects of their personal care e.g., encouragement to change their clothes, prompting to brush their hair or teeth?
- Does the person use any equipment (e.g., washing, bathing, or showering aids, perching stool, hoist, sling - including type and size)?
    - Has there been involvement from Physiotherapist or Occupational Therapist to determine equipment or is it personal preference to use?
- What aspects of their appearance are important to the person? e.g., aftershave, perfume, jewellery, makeup, types of clothes they like to wear (may be different if going out)
- Is the person able to dress themselves?
    - What can they do for themselves and what do they need support with? (e.g., can they manage zips, buttons, laces?
    - Are there any mobility issues that may impact ability with certain clothing?
- Does the person have access to weather appropriate clothing? E.g., have access to cardigans and blankets in colder weather and can take layers off in warmer weather.
- How does the person manage their nail care?
- How do they look after their hair? Do they wash it separately or in the bath / shower? How often do they do this? What products do they like to use? Do they visit the hairdressers / barber, how often and do they need help to organise this? If they wear a wig / toupee, how do they like this to be cared for?
- Do they need assistance with hair removal – wet / dry shave, nose / ear hair, female facial hair, what is needed for removal (e.g., type of razor or product used, appointment for beautician)?

- How does the person manage their oral hygiene – do they have their own teeth or dentures? What is their routine (brush, floss, soak), what products to they use (e.g., toothpaste, mouthwash, denture fixative)? How do they access a dentist and when was their last check up? Any gum disease or loose teeth?
- How do they manage their foot care (access to a chiropodist), are shoes or slippers well fitting? Do they have any special footwear? Do they have socks or tights? Do they have any pain or discomfort (e.g., dry skin, sore areas, bunions, corns, sore areas, ingrown toenails, or infections) and how is this managed?

*The person's care plan should consider independence and support required around Oral Health and Continence Care, there are prompts for the areas in the sections below - dependent on the person's level of need, consider a separate care plan.

Oral Care

The Oral Care plan should describe how to meet the person's mouth care needs and preferences, along with support and assistance if needed, to ensure this is carried out in a safe and dignified way.

- Consider the use of a mouth care assessment tool (e.g., NICE oral health assessment tool – Oral_health_assessment_tool.pdf (nice.org.uk))
- Does the person have their own teeth, partial or full dentures?
- If the person has their own teeth, do they have any loose teeth or issues with their gums or mouth (e.g., gum disease) which might impact on how they are cared for?
- If the person has dentures or partial dentures, do these fit correctly?
  Are they marked or unmarked? If unmarked, would the person like them to be marked to assist with identification?
- What is the person's oral cleaning routine (brush, floss, soak), what products to they use (e.g., toothpaste, mouthwash, denture fixative)? Do they have preferred timings?
- Does the person have a particular preference for type of toothbrush (electric or manual) or brand of over-the-counter products (toothpaste, mouthwash etc)?
- How do they access a dentist or dental hygienist and when was their last check up? How regularly should the person be seen by the dentist / dental hygienist?
- Does the person have any fears, phobias or negative experiences associated with managing their oral care and how is this managed?
- Is the person hesitant to being supported with their oral care e.g., due to cognitive impairment (taking into consideration MCA)? If so, how should care staff approach this with the person to reduce any anxieties. If they refuse, what should care staff do?

NICE Quick Guide for Care Home Managers Public library - UKHSA national - Knowledge Hub (khub.net)

Continence Care

The Continence care plan should describe how to support the person's continence care in a way that they choose, ensuing that their privacy and dignity is always respected, including taking into consideration infection control measures:

- What is the person's level of independence when using the toilet? What physical assistance (e.g., how many carers are required) or equipment (e.g. transfer board / handling belt / wheelchair / hoist / commode / urinal) are required to promote independence?
- What assistance is needed to promote and maintain continence (e.g., reminding at intervals throughout the day / regularly assisting to the toilet)?
- Does the person require assistance with personal cleansing? Do they require assistance with any prescribed creams or continence pads?
- Does the person need support to wash their hands after opening bowels or bladder. Is so, what support is needed?
- Does the person require any emotional support (e.g., anxiety around incontinence), if so, what kind of support?
- Consideration is given to the right type of underwear being worn e.g., if the person is wearing incontinence products, specialist incontinence underwear may be required.
- Is the person at risk of or experiences urinary tract infections? If so, how is this managed (e.g., increasing fluid intake where appropriate / looking for early warning signs such as increased confusion / frequency of urination – these should be personalised where specific early warning signs are known for the person)
- Does the person have a routine for bowel movements? Is the person able to recall / monitor this themselves and let staff know if there are any issues? Do they need staff to monitor this for them, if so how and where is this documented?
- Is the person prescribed any medication to manage any problems with bowel movements (e.g., laxatives to manage constipation)?
- If the person has problems in relation to continence, is a referral to external professionals needed (e.g., Continence Team)? Does the person require assistance or guidance with any prescribed care from external professionals (e.g., pelvic floor exercises)?
- Does the person require a special diet in relation to their bladder or bowel habits (e.g., high fibre, foods to support management of IBS)?
- Is the person being incontinent of urine, faeces, or both?
  If this is **not** the case, consider:
  - What assistance is needed to promote continence (e.g., reminding / regularly assisting to the toilet)?
  - Does the person require aids or equipment (e.g., commode or urinal) to support and manage continence?
  - How is the person's dignity protected when using the bathroom e.g., if the bathroom is too small to close the door, a divider or curtain is considered.
  - Does the person need products to support their incontinence (day and/or nighttime) e.g., pads, including type and size) and where are these stored to preserve dignity? Are they easily accessible to the person or staff supporting?
  - Does the person require any prescribed creams (e.g., barrier cream), if so, where are they applied and how often, how is this recorded? (Consider reference to other relevant care plans or TMAR).

Social Interests and Activities

Documents to consider including in this section
Daily routines care plan
Activities care plan
Spiritual and Cultural Wellbeing care plan
Social isolation & loneliness scale*

The care plans should describe how the person likes to spend their time, and the interests, activities, and people important to them. It should describe any support or assistance the person needs to engage in their choice of activities or community presence including:

- How does the person like to spend their time?
  (including location e.g., in their room, communal areas at certain times of the day)
  Do they have any familiar day to day life, weekly or monthly routines or habits?
  (*Consider routines and interests prior to admission*)
- What does the person need to happen for it to be a 'good day' or 'good night'?
  - Is there anything specific that would need to happen?
  - What should staff do to support that person to achieve this?
- Who are the important people in the person's life and how is the person supported to keep in touch with them (e.g., face to face, mobile phone, skype)? Does the person need staff support to keep in touch? Are there any significant birthdays or anniversaries the person would like to celebrate or remember?
- Does the person have any friendships or relationships, if so who with?
  - How are friendships promoted?
- How does the person like to engage with the local community? Friendship, clubs, support groups, courses, or voluntary work? Is there anything they would like to engage with that they are not currently? (*Consider interests prior to admission*)
- Does the person wish to be involved in communal activities within or outside the home? What type of group activity interests them?
- What sort of activities has the person communicated (verbally or non-verbally) that they do not enjoy or wish to engage in? How is regular feedback gained from the person on the activities they are involved with and what they like or dislike?
- What alternatives are made available to group activities that a person doesn't want to, or cannot, participate in (consider new ways and means to increase involvement).
- How does the person like to occupy themselves and feel useful?
- What does the person like to do to relax? (e.g., go for a walk, sit in the garden, gardening, soak in the bath, painting, listening to certain styles of music)
- Does the person have any desire to achieve better health or exercise more?
  How are activities reflective of this and what support does the person need to undertake or access these?
- What level of assistance would the person like to enable them to take part in activities that are important to them (both inside and outside the home)?
- Does the person have any interests or skills that they might enjoy learning or rediscovering? What activities are in place that the person did as a hobby or job which enables them to reminisce?
- Does the person have any skills, interests, or talents that they would be willing to share to support different activity provisions in the home (e.g., played a musical instrument, art teacher, travelled the world)
- Does the person ever feel lonely or isolated? (Consider this is a 'snapshot' on a particular day and feelings can fluctuate)? How is this addressed?

- Does the person enjoy an alcoholic drink?
  What support do they need to continue this safely? Are they on any medication that might cause contraindications or adverse reactions (have they had discussions with relevant health Professional about this if appropriate)?

Consider the use of a social isolation and loneliness scale periodically with people living within the home to support reduction of social isolation and improving their wellbeing. It will also support monitoring the impact, and continuous improvement of your activity provision.

More information about different scales, their strengths and limitations are available here: https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf

Spiritual and Cultural Wellbeing

This care plan should describe whether the person has a particular faith or belief that is important to them, any cultural requirements that they wish to continue, and / or any lifestyle preferences, including:

- Are there any religious and / or cultural beliefs that are important to the person?
- What is their level of independence (i.e., what can they do for themselves to continue to follow their beliefs or culture)?
- What assistance does the person need to continue to follow their beliefs or culture (e.g., food provision and / or preparation, being able to go out to religious services)
- Are there any special days or events that the person wishes to celebrate or commemorate (or any that they don't want to celebrate or be reminded of)?
- Are there any activities that support the person's chosen lifestyle and culture?
- Is there anything that has special meaning for the person e.g., incense, crystals, prayer beads, photographs, religious texts?

Physical Health & Wellbeing

Documents to consider including in this section
Physical Health and Wellbeing Care Plan
Health Action Plan (where appropriate)
Personalised Care and Support Plan (PCSP)*
Health Related Appointment Letters
Multidisciplinary Communication Log

The care plans should describe how to meet the person's health care needs and allergies in the way they choose, ensuring their dignity is always respected, consider the following:

- What medical conditions does the person have? What does each of these conditions mean and how might it affect the person's daily life? *Are health conditions recorded current and/or relevant?*
- Is there any specific care plan required to support the person to manage any conditions? (e.g., Diabetes, COPD, epilepsy, asthma, or an allergy)
- How is each condition managed? Are there any special arrangements that might need to be made (e.g., diabetes and special diet), any specific symptoms staff need be aware of, observe or monitor? How should they respond to this (e.g., contacting a medical professional, administering "as required" medication such as an inhaler or pain relief)?
- What is the person's understanding of their medical conditions? How is the person supported to make positive decisions / choices in relation to their health (e.g., activity level, food choices)?
- Are people encouraged to walk around if able, to avoid long periods of sitting down or raise their legs whilst sitting with footstools etc.
- Are there any specific risks (e.g., walking long distances in the case of COPD / asthma)
- Is the person able to tell staff when they are in pain or what signs may need to look out for (e.g., rubbing knee, head in hands, irritable, not wanting to move, fidgeting, making noises)?
- Does the person have any regular appointments with healthcare professionals to support management or monitoring of conditions (e.g., therapists, specialists, or consultants)? What arrangements are in place for the person to attend appointments, does the person need to be accompanied if so by who (and how many)?
- Have any specific instructions been given by health care professionals (e.g., Community Nurses, Occupational Therapists, Physiotherapists, Speech, and Language Therapists) which need to be followed? Is this time specific? Reference relevant care plans where people can find further information.
- Has the person had any illnesses (including infections) in the past which might re-occur? What specific symptoms should staff watch out for, and how should they respond to these (e.g., contacting a medical professional)

*The Personalised Care and Support Plan (PCSP) forms part of the framework. Health professionals involved in the person's care will develop this plan with their person and/or their representatives and Providers may support with information gathering for this.

On a Multidisciplinary communication log, there should be a record of outcomes of visits by or to, and conversations with, healthcare professionals e.g., GPs, Community Nurses, Hospital outpatients, specialists such as Occupational Therapy or Speech and Language Therapy, Chiropodists, Dentists, Opticians.

Medication Management

Documents to consider including in this section
Self-medication risk assessment
Medication care plan
PRN medication care plan
Controlled Drugs care plan
Topical cream / Patch Care Plan (including body maps)
Oxygen care plan
Covert Medication care plan
Short term medication care plan (e.g., antibiotics)
^ Blood glucose monitoring

The care plans required in this section will be dependent on the person's individual need, but the medication care plan should describe how to support the person to take their prescribed medication safely in a way that they choose, ensuring their dignity is always respected, areas to consider include:

- Has it been agreed whether the person is able to understand and manage their own medication safely (including undertaking a self-administration risk assessment) and how will they be supported to continue to manage their medication?
- Does the person have any allergies or known reactions to any medication (prescribed or non-prescribed)?
- Who is responsible for ordering, storing, and disposing of the person's medication? (In line with the home's medication policy)
- What medication is the person currently taking? Why do they need the medication? Are there any side effects or contraindications staff may need to be aware of? What date did the medication start and (where applicable) what date was it discontinued and why?
- Is the person taking any non-prescribed (over the counter) medication? What is the medication for and has this been checked with the person's GP / Pharmacy to ensure it will not interfere with their prescribed medication?
- Is the person prescribed any "as required" medication or medication that has a variable dose? Is there a record of why they may need the medication (e.g., symptoms, behaviours, triggers, type, and location of pain), how much to give, what the medication is expected to do and the minimum time between doses if the first dose has not worked? *Consider cross reference to positive behaviour support plan if relating to managing behaviours that challenge.*
- How does the person like to take their medication (e.g., taking tablets from medicine pot themselves; preferring staff to tip them one at a time into the person's hand; having a glass of water / juice when taking their tablets)?
- Does the person prefer to take their medication in an altered form (e.g., cut in half or crushed), and if so, is there a record of a discussion about each medication with their GP and/or Pharmacist to confirm that taking this action will not affect the licensed nature of the medication?
- If the person is unable to give or refuse consent to take their medication, have the principles of the Mental Capacity Act been followed in order to decide what is in their best interest? (*If a decision has been made for the person to receive their medication without their knowledge (covertly), is this recorded in accordance with the MCA and has the best way to achieve a positive outcome (e.g., how to disguise the medication) been discussed, agreed, and recorded?*)

- What strategies and approaches should staff use to encourage the person to take their medication e.g., try again later if the person is reluctant? Considering timing and liaising with GP as appropriate.
- Does the person need any regular blood tests (e.g., for Warfarin or Clozapine)? Where are these taken and who takes these? Does the person need any support to attend these (if not in the home)?
- When was the person's medication last reviewed by their GP and when is the next review due?
- Is there any PRN medication that needs to be regularly reviewed to ensure the current prescription is appropriate?
- Does the person require any rescue medication e.g., Diazepam, Midazolam, Epinephrine (EpiPen)? Where are these stored should they be needed? If the person is leaving the care home, what actions do staff need to take?

Personal Safety

Documents to consider including in this section
Personal safety risk assessments
Individual smoking risk assessment
Personal safety care plan

The information in this section, dependent on the person's individual needs and preferences, may require separate care plans around safety but some information may need including in relevant care plans in other sections of the care file.

- What does 'feeling safe' mean to the person?
- What risks to personal safety are there for the person within the care home environment?
- What risks to personal safety are there for the person when out of the care home environment in the local community?
- Are there any situations which make the person feel anxious or unsafe (e.g., fear of falling, anxious in the evening and overnight)
- How can staff support the person to feel safe? Can the person let them know when they are not feeling safe or secure? If not, what signs do staff need to look out for e.g., becoming withdrawn, anxious, self-neglect.
- Is there any equipment which supports the person to feel safe (e.g., mobile phone in their pocket, personal alarms / room call bells)?
- How is the person supported to 'have a voice' and feedback about the quality and safety of the care they receive? Do they have support from, or need a referral, to advocacy services?
- Does the person smoke? Do they want any information or support on stopping smoking? Include information following completion of the smoking risk assessment, what support do they need to continue this safely?

Sleeping and Night-Time Support

Documents to consider including in this section
Night-time risk assessment
Sleeping and Night support care plan
Bed rails risk assessment

The care plan should describe the person's preferred night-time routine and any support they need throughout the night, including:

- What is the person's level of independence (i.e., what can they do for themselves)?
- What level of assistance do they need with going to bed, during the night and getting up in the morning?
- What is the person's usual sleep pattern (including what time they like to go to bed and get up)?
- Do they have a preference regarding male / female staff providing their support?
- Does the person have any personal preferences such as number of pillows, type of bedding, lighting on, off or dimmed, curtains open or closed?
- Does the person need any support with toileting overnight? Do they like to have a commode next to their bed to support continence at night?
- Is there any equipment they need during the night (e.g., bed rails, pressure mat)?
- If the person has equipment which restricts or monitors their movement, is it with the person's consent or has a Best Interest Decision been made about this?
- Has a risk assessment been completed for the use of the equipment, and what actions are required to monitor and reduce risk?
- Is the person able to use the call bell or do they use another means to summon staff, if so, how? If they can use the call bell, where should this be positioned?
- Are they at increased risk during the night due to any medical conditions?
- What is the person's preference for staff checking them during the night (including frequency)?
- Do they have a turning or repositioning regime (include specific frequency) and does this consider their personal preference?
- If the person becomes anxious in the night, how do they communicate this, and how do they like to be supported and reassured?
- Do they like to have snacks and / or drinks as part of their routine before bed, during the night or first thing in the morning?
- Do they need medication at night to help them sleep? Do they have any PRN night-time medication and what is their preference for when they are offered this?

*There may be some crossover with equipment use with Mobility and Falls care plan – as a Provider, consider which section this would best fit for your service and the people who use it. If you choose to have information (or elements) within both, ensure there is a process in place to keep information up to date and consistent across care plans.

End of Life

Documents to consider including in this section
Advance Care Plan
Individual Plan of Care and Support for the Dying Person

The care plan should describe how to support the person at the end of their life, ensuring that their dignity is respected and that their wishes are always followed, areas to consider include:

Advance Care Plan

- Has the person already expressed their wishes in a document such as "Preferred Priorities for Care"? Have these been reviewed recently?
- Has the person made an Advance Decision to Refuse Treatment and where is this located?
- Who would the person like to be involved if it becomes difficult for them to make decisions? Does the person have a Lasting Power of Attorney for Health and Welfare, and who is this? (Do you have evidence that this is current?)
- If the person's wishes are not already documented, what are their particular wishes or preferences for how they are cared for and supported at their end of life (e.g., being able to remain in the care home rather than being admitted to hospital, who they would like to be contacted (e.g., relatives, friends), that any treatment options are discussed with them?
- Is there anything that the person would not want to happen to them?
- Does the person have any special requests and preferences relating to specific wishes, feelings, faith, beliefs, and values?
- Is there anything that would make the person feel relaxed and comfortable at the end stages of their life? E.g., music playing, flowers in their room, religious person in attendance, family present, personal belongings.
- How much information does the person want to be given if their condition worsens?
- Has the person already made arrangements in the event of their death, such as with a particular funeral director, and what are the relevant contact details?
- Does a relative of friend have the details of their arrangements, and if so, who is this?
- Are there any cultural, religious, or spiritual requirements to be respected as part of the person's end of life care or in the event of their death? *Can there be any proactive work completed with their local religious establishment to develop links and a guide to support staff to ensure the person's preferences are honoured.*
- Does the person have any particular wishes regarding organ or tissue donation (and where is the supporting documentation held if this has already been set up)?
- Has the person made a Will or would they like support to do this?

It is important to acknowledge and record, when approached, if an individual does not want to discuss their wishes and preferences for end-of-life care.

The 'Planning your future care' document can support conversations with people about advance care planning and the different options available to them.

The 'One chance to get it right' report provides further information on the 5 priorities of Care and Annex D (Page 80) details the Duties and Responsibilities of Health and Care Staff.

Individual Plan of Care and Support for the Dying Person

This separate care plan should be put in place for the final days of life, which will include:

- An individual plan of care which includes food and drink, oral care, pain and other symptom control and psychological, social, and spiritual support.
- Access to support from external health Professionals in managing the person's physical and emotional needs
  e.g., District Nurses, Specialist Palliative Care Professionals.
- The decisions and actions to be taken in accordance with the person's needs and wishes (which should regularly be reviewed, and decisions revised accordingly)
- The need for sensitive communication with the dying person, and those identified as important to them.
- How the dying person, and those important to them, will be involved in decisions about treatment and care to the extent that the dying person wants.

How the support needs of families and others identified as important to the dying person are actively explored, respected, and met as far as possible.

9. Monitoring Records

Monitoring Records are marked with **^** within sections of the care plan.

These could be in place following agreement with a healthcare professional that these are required to monitor the health of a person or support identification of patterns or trends. This could be a separate section used for monitoring records concerned with the person's health and well-being or documents can be kept under the relevant care plan sections.

It is not obligatory for these records to be kept in the care plan folder, they can be located elsewhere so long as they are easy for staff to locate when required, and it is referenced in the relevant care plan section.

10. Safeguarding, Accidents and Incidents

Documents to consider including in this section
Accident / Incident reports (including body maps and ABC charts where applicable)
Safeguarding alerts log

All homes should have their own investigation procedures following an incident. There should also be a review of any relevant risk assessments and care plans (even if there is no apparent changes) to ensure they remain reflective of need and reduce risk of reoccurrence.

Accident and incident reports should include:

- The date and time of the incident.
- Describe what happened and where.
- Who was involved (people, staff members, others), any witnesses?
- The result of the incident (including any injuries).
- Any actions taken following the incident – both immediate and subsequent (actions should have a responsible person, appropriate timescales for completion and show when these have been completed).
- Lessons learnt so the incident does not happen again.
- The views of the person affected to ensure Safeguarding is made personal.
- Consideration to MCA in relation to the person/s involved.

Incident reports should then be alerted to and reviewed by a manager (or other appropriate person as per Home's policy) to sign off – ensuring that appropriate actions have been taken and completed, and any potential further action needed.

- LSAB Guidance for Safeguarding Concerns is a support tool to assist in managing risk for safeguarding concerns. The guidance aims to ensure that concerns are reported and responded to at the appropriate level and to have a consistency of approach.
- The Safeguarding Concerns Checklist can be completed following an incident and used as an aide to ensure that your service is taking appropriate actions to protect the person from a recurrence, and evidence reporting procedures where appropriate. Copies can be kept within the person's file.

Safeguarding alerts, accidents and incident forms should be reviewed (for example monthly) to look for themes and trends and identifying any lessons learnt from incidents. Action plans should be developed where appropriate and monitored to ensure they are delivered.
Any changes to practice due to safeguarding alerts, accidents and incidents should be documented and effectively communicated with the staff team – including the date these changes should be applied from.

11. Daily Records

Should it be required, daily records may be used in a court of law to clarify what happened and in what order any events occurred – it is important to ensure they are clear and legible (poor handwriting, spelling and events omitted or in the wrong order can make daily records difficult to follow).

Remember in a court of law if it hasn't been written down it hasn't happened.

Although not obligatory, best practice would be to keep daily records in the care plan folder. They can be located elsewhere so long as they are easy for staff to locate when required.

Daily records should:

- Reflect how the person's needs are met, as described in every section of the care plan. Entries should focus on what the carer / nurse has observed, what was done and how the person responded.
- Ensure a detailed summary of the person's day / night including interactions with other people (e.g., staff, other people living in the home, relatives, visitors) rather than generic statements. They should be relevant and relate to the information in that person's care plans.
- Be completed as soon as possible after an occurrence or change in a person's condition. Entries must never be written on behalf of a staff member, as the person who has signed will be held responsible for the accuracy of what has occurred.
- Include time and date against each written entry along with initials / signature of the author and designation.
- Don't use jargon or abbreviations (unless these have been permitted to use in documentation, there should be a list if this is the case),
- If there has been an error, follow the Home's policy for correcting which usually includes drawing one line through the error and initialling it and write "mistaken entry". Never use 'Tippex' to erase an entry and do not correct someone else's error, instead tell that person (or management if they are not available) that you have noticed a mistake in their entry.

Daily records should also avoid generic phrases and statements and information should be factual and specific, e.g.:

✗ "*All personal care given.*"
Include information about what support the carer has given to the person with their personal care, making reference to choices and preferences.

✓ June got out of bed at 8:30am, she had already brushed her teeth, but I supported her to the toilet and changed her pad. June did not wish to have a shower this morning and preferred a wash at the sink – as requested by June, I washed and dried her legs and feet as she could not reach them. June then picked her clothes for the day, assistance given with dressing lower body. She then walked with her frame to the dining room for breakfast. June requested a bath instead of a shower tomorrow evening – included in handover information.

✗ "*Had a good day*"
What has the person done in the day? What have they said or did to make you believe it was enjoyable for them?

✓ June's Granddaughter Rachel visited this afternoon, they had a cup of tea and carrot cake in the garden. June said she "really enjoyed her afternoon, my granddaughter is special to me, and I love her visits". Next time, June is going to suggest a visit to the local café around the corner.

✗ "*Slept well"*
Has the person said they slept well or poorly? Did they get up in the night? Use the call bell? Have checks been undertaken? What could you see and/or hear? Was any support provided?

✓ Ron said he got up twice during the night to use the toilet and was able to get back to sleep quickly. As per Ron's care plan, night checks completed 3 hourly at 1am and 4am and was sleeping; noted chest movement and could hear him breathing.

✗ "*He was confused and aggressive"*
What behaviours is the person displaying which makes you believe they were confused or being aggressive? Were there any apparent triggers for this? What did you do in response and how did this help the person? *

✓ Peter was raising his voice, calling out his Wife's name and pacing down the corridor. When I asked, he wasn't able to find the words to explain what he wanted but noticed that he was adjusting his trousers and touching his belt. I asked Peter if he needed the toilet to which he replied he did and so I walked with him to show him where the toilet was. ABCD chart completed, and Mental Health and Wellbeing care plan review completed.

12. Care Plan review

It is recommended that the care plan and risk assessments, are reviewed monthly (as good practice) and when a person's needs change, including as their end-of-life approaches.
Care Plan review documentation should be kept with the relevant care plan sections which would provide easy referencing. Reviews should take place in accordance with the home's policy but consider when to re-write the care plan if there have been significant changes in need (archiving previous versions as appropriate).
Care Plans should be reviewed to ensure it reflects current need, preferences and choice and establish how effective the support has been. In the event there have been no changes, ensure the review is still clearly reflected.

Have there been any significant events since the last review?

- Hospital appointments / admissions.
- Illnesses or new medical conditions diagnosed.
- Visits or advice from Health or Social Care Professionals.
- Medication changes.
- Accidents, incidents, or Safeguarding alerts.
- Medication changes.
- Changes to care and support needs.

Check each separate risk assessment:

- Example risk assessments detailed in Care Plan and Risk assessment section.
- Do any significant events suggest a specific risk assessment should have been updated? Check that this has happened.
- Reassess and complete each risk assessment noting any changes that require information in the care plan(s) to be updated.

Read the Daily Notes:

- Does what you read raise any concerns or demonstrate a pattern or theme you feel may need looking into further e.g., has anything been recorded that may be 'out of character' for the person?
- Check a sample of other recording charts e.g., food and drink intake, repositioning charts, bowel records, activities participation – does the information confirm that the person's care and support needs are being met according to their care plan? Do any changes need to be made based on this information?

Involve the person:

- What is working well?
- What has not been working so well?
- How are they feeling (or settling in)?
- Do they have any concerns or worries?
- Are they happy with the staff supporting them?
- Is there anything the person would like to do different or new (in or inside the home)?

- Where the person does not have capacity to be involved in the review, involve their representatives (e.g., relatives or advocates) where possible.
  Where the person has capacity, check who they would like to be involved in their reviews and record their wishes.
- Agree with the person (and their representatives where appropriate) how frequently they would want to be involved in the review and record their wishes.

- Let the person and their representatives read the care plan at their leisure – encourage questions and suggestions. If the person has capacity, check they are happy for their representatives to read their care plan.
- Do these conversations result in any important information that you need to know and record in the care plan? Are there any changes to their preferences or choices?
- Record your review discussion, who was involved, any actions agreed and sign / date the document.

During the review of a person's care, it is important for Providers to be aware of when it may be appropriate to refer the person back to Adult Social Care for a re-assessment of their needs and ensure the appropriate level of placement.

Following a change in a person's need, be mindful documents in other areas of the care file may need updating to ensure information is consistent across risk assessments and care plans.

Care documents including daily records should be audited regularly to identify discrepancies and themes. They should be archived periodically, ensuring that only the most up to date and recent documentation is kept in the care plan folder. These should be retained in accordance with the home's policy and relevant legislation.

13. Useful links

Good and Outstanding care resources / Skills for Care – Skills for Care
Care Homes guidance, pathways and quality standards – NICE
Guidance for Adult Social Care Providers – CQC
Care service provider engagement - Lancashire County Council– Lancashire County Council
Good Practice Information for Providers – Lancashire Safeguarding Adults Board
Care Providers Area – Lancashire and South Cumbria Health and Care Partnership
Dying Matters Resources – Hospice UK
Mental Capacity Act 2005 Code of Practice
Social Care Resources – Lancashire and South Cumbria Training Hub (lscthub.co.uk) – Lancashire & South Cumbria NHS Foundation Trust. Hydration toolkit and other resources

14. Example Individual Care Plan Template

[Insert title of area of need]	
Goals / Desired Outcomes to be achieved	
Assessment of Needs and Risks	
Actions and Support required	
Describe how the person has been involved (or others on their behalf) and how the person makes decisions in this area of their care and support:	
Date implemented:	
Employee name:	
Employee Role:	
Employee Signature:	
Signature of the Person living in the home:	
Relative / Advocate Signature:	