

# CARE PLAN PROMPTS

*These care plan prompts have been jointly developed by Devon County Council's Quality Assurance and Improvement Team (Adult Commissioning and Health) and the Northern Devon Healthcare NHS Trust Care Homes Team (NDHCT), with input from colleagues from New Devon CCG, Northern Devon Healthcare Trust, Devon County Council and North Devon Hospice.*

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# Introduction

These care plan prompts have been developed to assist providers of residential and nursing home care for adults with their care planning. They include suggested headings, and a set of questions under each heading which managers and staff may wish to consider when writing, and/or reviewing, each resident's care plan.

The headings are given as examples, and there is no obligation on the provider to use these, or for the care plan to be set out in the order suggested in this document. These are entirely matters for the provider to decide.

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 a matter for the provider to decide.

The purpose of a care plan is to describe the resident's care and support needs and wherever possible it should be developed and reviewed jointly with the resident – it is their care plan and should state clearly their wishes and preference as to how care and support are delivered. Where it is difficult to fully involve the resident (for example because they lack capacity) their relatives, carers, or significant others should be involved. A suitable tool such as the RCN/Alzheimer's Society document 'This is me' may help with this process ([https://www.alzheimers.org.uk/download/downloads/id/3423/this\\_is\\_me.pdf](https://www.alzheimers.org.uk/download/downloads/id/3423/this_is_me.pdf)) It is good practice, where the resident has capacity, to ask them if they would like their relatives to be involved in developing the care plan. The resident's wishes and preferences, where these are known, should be taken into account at all times.

The care plan should contain sufficient accurate and detailed information to enable staff (including new or temporary staff) providing personal care and support to the resident to do so safely, effectively, and in accordance with the resident's wishes (including how to respond if the resident does not wish to receive care at any time). It should be personalised, i.e. reflecting the resident's wishes and preferences, and should take a holistic approach to the resident's social, emotional and physical support needs rather than being purely task-focussed. Where relevant the care plan should be based on identified risk. Some risk assessments are referred to in this document, such as MUST, Medley and Waterlow, but please note that other risk assessments may be required.

Where the resident has been involved in developing and reviewing their care plan it is appropriate to write in the first person, i.e. "I", "my". Where the resident lacks capacity to express their needs, wishes and preferences, or where they do not want to be involved in developing or reviewing the care plan, writing in the third person is more appropriate, i.e. "he / she", "his / hers". In this case the resident's name should be used where possible as this will emphasise that it is their individual care plan.

Residential and nursing home providers should ensure their staff understand the importance of signing / initialling and dating all documents including daily records, in order to evidence who wrote the entry and when. Staff should have received the training necessary to ensure that they are competent to meet residents' assessed needs at all times.

Responsibility for the accuracy and completeness of the care plan rests at all times with the residential or nursing home provider.

*NB; Some links are provided in this document with the intention of signposting to further information. DCC and the NHS do not take responsibility for the accurateness of this information.*

# LEVEL OF UNDERSTANDING

It is important to remember that capacity fluctuates, i.e. a person's level of understanding may vary depending on the decision to be made, and the time it is made (e.g. before or after a meal, immediately after waking or later in the day).

The care plan should describe the person's level of understanding (including how and why this might fluctuate), respecting their strengths and abilities, ensuring that all their needs are met safely and effectively, taking into account their preferences and choices, whilst maintaining their dignity, including:

- Can the person understand what is said to them?
- Can the person retain any information they have been given?
- Can the person express a preference?
- Is the person able to consider or evaluate the information when making a decision?
- Is the person able to communicate their decisions?
- Is the person able to express their needs and preferences (e.g. that they are thirsty, hungry, need the toilet, are feeling tired)?
- Is the person able to give informed consent for each aspect of their care / support?

Mental Capacity Act (MCA) practice guidance can be found via this link;

<https://new.devon.gov.uk/adultsocialcareandhealth/guide/mca-practice-guidance/>

**If you believe the person may lack capacity:**

- Has the person received a diagnosis of a cognitive impairment? If not, what indicates that their level of understanding is impaired?
- 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 in place for Health and Welfare, is this person identified within the care plan and are they appropriately involved in the best interest decision making process?

Example Mental Capacity and Best Interests Assessment can be accessed via this link;

[http://www.devon.gov.uk/mca\\_assessment\\_form.pdf](http://www.devon.gov.uk/mca_assessment_form.pdf)

- 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. through the use of locked doors or key pads)? If so, has a DoLS authorisation been applied for?

Deprivation of Liberty Safeguards (DoLS) guidance can be accessed via this link  
<http://www.scie.org.uk/publications/ataglance/ataglance43.asp>

- Does the person need to be restrained in any way for their safety (e.g. through the use of bed rails, lap belt, pressure mat or medication)? Is a DoLS Authorisation in place?
- If a person has capacity and agrees to being restrained for their own safety, how is this documented?
- Can the person follow instructions? If not how can you support them to be involved?
- Has information been gathered and recorded about the person, their life, likes and dislikes, people who are important to them (e.g. an “all about me” document) which helps people understand the person and how they might be feeling?
- What is the person’s understanding of their environment? Do they know where they are, where their room is; are they able to find their way around the building?
- Does the person have difficulty recognising objects or what they are used for? (e.g. thinking buttons are sweets, flowers are food, shiny floors look like a puddle)
- Is the person’s memory affected? Can they follow the content of conversations, themes and plots in television programmes, books and newspapers? Do they remember what is said to them, recognise people they know, where they are, where their room is or where they have put things that are important to them?
- Does the person experience confusion due to an impaired level of understanding? (e.g. mistaking Monday for Tuesday or one daughter for another)
- Does the person have difficulty concentrating on what they want to do? (e.g. getting up and walking off part way through a meal)
- Does the person need support with learning anything new? (e.g. where their bedroom or toilet is)
- Does the person react adversely or unpredictably to the behaviour of others? (e.g. when another resident enters their personal space) and how is this managed
- Does the person act on impulse? (e.g. fully undressing when hot, hitting or biting people who are trying to help because they do not understand what is happening or the situation has not been explained)
- Does the person understand risks (e.g. hot water, hot surfaces, hot drinks) or do they neglect to use their walking aids because they don’t remember that they need them or how to use them?
- Does the person understand how to call for help (e.g. using the call bell)? What measures are in place if not? (e.g. Telecare, observation)
- Is the person orientated in time? (do they know what day it is, what time it is)
- Does the person know who their visitors are?

- Does the person need any visual prompts to help them live as independently as possible? (e.g. WC door with a picture of a toilet, a familiar item outside their bedroom door)

# COMMUNICATION

**The care plan should describe the person's communication needs, respecting their strengths and abilities, ensuring that they can communicate effectively, and that staff protect their dignity when communicating with them, including:**

- What does the person like to be called? (do they like to be addressed formally – Mr/Mrs/Miss/Dr/Captain/Reverend, first name, nickname or by a term of endearment – do not assume that everyone would find these endearing E.G dear, love, sweetheart, duck etc)
- What is the person's first language?
- Whether they are able to communicate verbally or in another format (e.g. pictures, signs or writing)?
- Their ability to communicate their needs, e.g. use a call bell, call for assistance
- Would the person benefit from electronic forms of communication such as Skype/mobile phone?
- Whether they have any difficulties with verbal communication that staff need to be sensitive to e.g. taking time to process what is being said to them (by staff using reflection and clarification techniques), difficulty in finding the right words or understanding what is being said. Consider potential barriers to communication, such as background noise or visual distraction
- Level of vision – do they have a visual impairment or wear glasses? (short or long distance?), use a magnifying glass or require sunglasses when outside. Can they read / write? Do they need large print books or audio formats? Do they have an Optician and how are their appointments arranged? Who is responsible for cleaning glasses? How are changes to vision/eye health identified and addressed? Are they particularly sensitive to light? How is this managed?
- Level of hearing - do they have a hearing impairment or wear hearing aids? (who will maintain these and how? E.g. batteries, cleaning/repair), can they lip read? Do staff need to ensure they have eye contact before speaking? What steps are in place to enable them to actively participate in communal activities? (Equipment?) How is ear care managed? is hearing loss monitored?
- Ability to understand and / or interpret what other people are saying and how staff need to support them (e.g. speaking clearly, using simple language, giving "either / or" choices)
- Any other ways that the person communicates such as sounds, tone of voice, speech patterns, facial expressions, body language, posture, behaviour, and how staff will recognise what they are trying to communicate
- Is the person is receiving support from a Speech and Language Therapist (SALT) or a Sensory Team, for example; <http://devoninsight.org.uk/> <http://www.livingoptions.org/>
- How the person would like people to communicate with them?

# MOBILITY

The care plan should identify and describe the person's mobility needs, respecting their strengths and abilities, and ensure that where they need assistance it is provided in a safe and dignified way, including:

- Has a Moving and Handling Assessment been completed? what actions are required to monitor and reduce risk?
- Has a Falls Risk Assessment been completed? (e.g. Honiton, FRAT) what actions are required to monitor and reduce risk?

See links below for guidance and practice examples

<http://www.nhs.uk/Livewell/healthy-bones/Pages/falls-risk-assessment-tool.aspx>

<https://www.nice.org.uk/guidance/cg161>

- The person's level of independence (what they can do for themselves, can they weight-bear, can they initiate getting up and moving around?)
- What level of assistance does the person need with the following:
  - Repositioning in bed
  - Getting in / out of bed
  - Getting on / off a commode / chair / wheelchair
  - Getting on / off the toilet
  - Sitting / standing
  - Walking / general mobility
  - Getting in / out of the shower / bath and washing
  - Other transfers (where applicable)
  - Using steps / stairs
  - Dressing / undressing

This can be recorded in a Handling Plan which includes the following:

- Number of care staff needed
- Equipment, e.g. wheelchair
  - hoist
  - slide sheet
  - walking frame
  - standing aid
  - handling belt (including type / size and how should these be used)
- Have any risks been identified in the person's moving and handling assessment or falls risk assessment in connection with their mobility? (e.g. having a catheter in situ or environmental factors which could include drugs or medication, impaired vision or hearing, foot or nail problems)
- How should staff help the person to reduce the identified risks? (e.g. when walking, standing up, sitting down, getting out of bed, transferring from bed to chair or chair to wheelchair, while using a hoist or while using stairs or steps)

- Does the person need staff to monitor them when they are moving independently in order to keep them safe? What steps should be taken in the event of a fall?

Post Falls Guidance pack For Care Providers (South Western Ambulance Service) can be found here;

<http://www.swast.nhs.uk/Downloads/SWASFT%20campaigns/PostFallsGuidance.pdf>

- If the person has bed rails or a pressure mat in place, or a lap belt or tilt chair is used to restrict 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 have the results of this been recorded?
- Are there any issues / concerns / suggestions about the person's footwear? (remember weight loss/gain and health conditions which affect gait can result in footwear not fitting correctly and possibly creating a risk)
- Are there any issues/concerns regarding the persons posture, balance etc? How do these need to be addressed?
- Does pain affect the person's mobility, and if so, how? Does the person need pain relief before mobilising, and if so, within what time scales?
- Are any special requirements necessary to protect the person's skin from damage? consider seating and posture – has an assessment taken place about the length of time someone should be seated in a wheelchair (if used)
- What support will the person need in the event that they have to be evacuated from the building because of fire or other emergency? Is there a PEEP (personal emergency evacuation plan) in place? Consider the need for reassurance and explanation as well as physical support

# PERSONAL CARE

**The care plan should describe how to provide the person with care and support in the way that they choose, ensuring that their dignity is respected at all times, including:**

- Does the person have any preferences for a particular routine (e.g. bath / shower / strip wash; time of day; day of the week)?
- What is their level of independence (i.e. what can they do for themselves) and do they wish to be left alone or have someone with them?
- What level of assistance do they need (i.e. how many carers)?
- Are there any concerns such as skin integrity, contractures, catheters, wounds, or pain which need to be taken into account when providing personal care?
- What would they like to happen to make personal care an enjoyable experience e.g. personal privacy for some aspects, soak in the bath, choice of toiletries?
- Does the person have a preference for male or female staff to provide their care and support?
- What equipment do they use (e.g. washing, bathing or showering aids, hoist, sling [including type and size], perching stool) and how was the decision made that this equipment was appropriate (e.g. involvement of OT or physiotherapist, trial of other equipment, personal preference)?
- What support do they need for specific aspects of their personal care e.g. prompting to brush their hair, encouragement to change their clothes?
- What aspects of their appearance are important to the person e.g. after shave/perfume, jewellery, make-up, type of clothes they like to wear (may be different if going out)?
- How do they manage their oral hygiene - own teeth or dentures? What is their routine (brush, floss, soak), what products do they use e.g. toothpaste, mouthwash denture fixative, how do they access a dentist and when was their last check up? Any gum disease, loose teeth?

(for more detailed guidance on oral care see separate Oral Care section)

- How does the person manage their nail care – cut, file, nail varnish?
- How do they manage their foot care – care of toe nails (access to a chiropodist), are shoes or slippers well fitting? Do they have any pain or discomfort (e.g. bunions, corns, sore areas, swelling, nail infections) and how is this managed?
- Do they need assistance with hair removal – wet/dry shave, type of razor, nose/ear hair, female facial hair?

- How do they look after their hair? Do they wash it separately or in the bath/shower, and how often? What products do they like to use? Do they visit the hairdresser/barber, how often and do they need help to organise this? If they wear a wig how do they like this to be cared for?

# CONTINENCE CARE

**The care plan should describe how to support the persons continence care in the way that they choose, ensuring that their privacy & dignity is respected at all times, including taking into consideration infection control measures:**

- What is the person's level of independence with using the toilet? What physical assistance (eg how many carers are required) or equipment (eg wheelchair/hoist/commode/urinal) are required to promote independence?
- What assistance is needed to promote and maintain continence (e.g. reminding/ regularly assisting to the toilet)?
- Does the person require assistance with personal cleansing? Do they require assistance with any prescribed creams or body worn pads?
- Does the person require emotional support, (for example anxiety around incontinence) if so, what kind of support?
- Is the person at risk of or experience urinary tract infections? If so how is this managed (eg increasing fluid intake where appropriate/looking for early warning signs such as increased confusion/frequency)
- Does the person have a routine for bowel movements? Do they need staff to monitor this for them/how is this documented?
- Does the person require prescribed 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 the Bladder and Bowel/Continence Team required? If so: does the person require assistance or guidance with any prescribed care from the Continence team such as pelvic floor exercises?
- Does the person require a special diet in relation to their bladder or bowel habits eg high fibre?
- Is the person continent 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 (such as a commode or urinal) to manage & support incontinence?
  - Does the person need products to support their incontinence (day and/or night time) E.g.; body worn pads (what type, size) and where these are stored to preserve dignity and are they easily accessible to the person?
  - Does the person require any prescribed creams (eg barrier cream), if so where are they applied and how often, how is this recorded?

# ORAL CARE

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

- Consider using a mouth care assessment tool (e.g. the NICE oral health assessment tool – see link below for example)

<https://www.nice.org.uk/about/nice-communities/social-care/quick-guides>

- Has the person got their own teeth, dentures or partial dentures?
- What is the person's oral cleaning routine (e.g. brush, floss, soak, preferred timing), what products do they use e.g. toothpaste, mouthwash, denture fixative? Should any products be avoided (e.g. those with high alcohol content)
- If the person has their own teeth, do they suffer from any gum disease or loose teeth which might impact on how they are cared for?
- If the person has dentures or partial dentures, do these sit correctly?
- If the person has dentures or partial dentures, are these marked or unmarked? If unmarked, would the person like them to be marked to assist identification?
- 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 or dental hygienist?
- Has the dentist or dental hygienist prescribed any specific products (e.g. type of toothbrush, mouthwash or type of toothpaste)?
- Does the person have a particular preference for type of toothbrush (manual or electric) and brand of over-the-counter products (toothpaste, mouthwash etc)?
- Does the person have a fear, phobia or negative experience associated with oral care and how is this managed?
- Has the person had any previous surgery to their mouth which would impact on their oral health care?

# NUTRITION & HYDRATION

**The care plan should describe how to ensure that the person has sufficient food and drink to maintain their health, and that if they need support to eat and drink what they choose this is carried out in a dignified way, including:**

- Has the person had a nutrition risk assessment (e.g. MUST, see link below)? What are the outcomes of the nutritional risk assessment and what actions are required to monitor and reduce risk?

<http://www.bapen.org.uk/screening-and-must/must/introducing-must>

- Does food / drink need to be fortified (see link below) or has the person been prescribed oral nutritional supplements? (Consider the timing of supplements as they can be filling and affect appetite)

<http://www.bapen.org.uk/nutrition-support/nutrition-by-mouth/food-first-project-leaflets>

- Is the person able to indicate whether they feel hungry or thirsty or where and when they would like to eat or drink? Is it necessary to identify staff resources to ensure this happens?
- Does the person experience a loss of taste or smell which impacts on their enjoyment and intake of food and drink.
- Can the person access food or drink independently?
- Where does the person like to eat, i.e. with other people or on their own?
- What would the person like to happen to make mealtimes an enjoyable experience?
- What level of assistance does the person need (supervision, prompting, encouragement, direct support, is sufficient time identified to provide required support without someone feeling rushed)?
- Is the person able to hold cutlery? Do they need any equipment or aids e.g. plate guard, adapted cutlery, clothing protection? Does cutlery and crockery provide sufficient contrast to be seen/identified against the tablecloth or food?
- Do they need a particular position or posture while eating (e.g. sitting in a dining chair rather than a wheelchair)?
- Does the person require a special diet (e.g. diabetic, allergies and intolerances, are cultural and religious preferences taken into account)?
- Do they have any known food and drink likes or dislikes? Are there any particular textures the person may like or dislike e.g. crunchy, soggy, slippery jelly? Does the person have any particular preferences re food or drink temperatures?
- Does the person have any specific needs such as swallowing issues?
- Have any specific risks been identified, e.g. malnutrition, poor nutrition, dehydration, dysphagia, choking or allergies?

***NB if the person is at risk of choking or has difficulty swallowing; consider whether they need a Dysphagia care plan (see p.32)***

- Has any advice or guidelines been given by the Speech & Language Therapist (SALT) or Dietician, e.g. thickening agents, e.g. level of consistency of food (stages)
- Do the person's dentures fit well?
- Does the person like a snack outside of mealtimes, e.g. in the evenings?
- Does the person require their meals at particular times e.g. due to medication regime, sleep pattern or social activity?
- Does the person prefer to eat little and often rather than at set mealtimes? How is this managed?
- Is there a requirement for staff to record the person's food or fluid intake? This may be prompted by their MUST score, where a health professional says this is needed, or where otherwise indicated.
- Does the person need staff to support their nutrition through artificial feeding (e.g. assisting the person to eat via PEG feed or NG tube)?

# SKIN CARE

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

- Has a validated pressure ulcer assessment (e.g. Waterlow or Medley) been completed? What are the outcomes of the pressure ulcer assessment and what actions are required to monitor and reduce risk?

Link to Pressure ulcers: prevention and management guidelines (NICE)

<https://www.nice.org.uk/guidance/cg179/chapter/1-recommendations>

- What is the general condition of the person's skin (including where this is good), do they have any moles or other skin conditions that require monitoring?
- Does the person have any past history of pressure ulcers or other skin damage?
- Does the person have any allergies/sensitivities (e.g. to specific creams or lotions) which might affect their skin?
- How should staff monitor and document the person's skin condition, including observation of high risk areas when supporting them with washing, bathing or showering?
- Does the person have any skin conditions and how do these need to be cared for including scalp conditions that may require medicated shampoo?
- Is the person prone to bruising? How is this recorded (e.g. body map)
- Are there any specific risks to the person's skin such as incontinence and how should staff manage these?
- If the person has any pressure ulcers, what grade are these (as assessed by a health care professional) and what nursing intervention is in place?
- Does the person use any specialist equipment such as pressure cushions, heel troughs or mattresses (including the correct setting which takes account of their weight)? How often is the use of this equipment reviewed and by whom?
- Has the person been advised to follow any turning or repositioning regimes or any forms of self-movement in order to relieve pressure? If they have, what are the details (including frequency)?
- Has the person been given any advice by healthcare professionals about how their skin needs to be looked after?
- 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 necessary)?
- Are all prescribed skin care products listed on the MAR sheets and signed for?

***NB: Consider the use of body maps to monitor skin conditions where changes may occur***

# SOCIAL INTERESTS AND ACTIVITIES

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

- How does the person like to spend their time – any familiar daily, weekly or monthly routines or habits? (consider routines and interests prior to admission)
- Does the person like to read a particular newspaper or magazine? How is this arranged?
- How does the person like to engage with the local community? Clubs, friendship or support groups? (consider interests prior to admission)
- What level of assistance would the person like to enable them to take part in activities that are important to them?
- Who are the important people in the person's life and how is the person supported to keep in touch with them? (mobile phone/skype) Does the person need staff support to keep in touch? Is there a list of significant birthdays or anniversaries the person would like to celebrate or remember?
- Does the person have any particular friendships, (who with?) how are friendships promoted? Does the person feel lonely or isolated? How is this addressed?
- What are the hobbies and activities that interest the person or which they are currently involved in? What support would the person like from staff to participate in these?
- What does the person like to do to relax? Go for a walk? Soak in the bath? Build model aeroplanes? Paint?
- What sounds does the person enjoy (e.g. crackling fire, waves on the sea shore, birdsong, a particular musical instrument)?
- How does the person like to occupy themselves and feel useful?
- Does the person have any skills or interests that they might enjoy sharing, learning or rediscovering? What activities are in place that the person did as a job or hobby which enables them to share their skills or reminisce?

Examples can be accessed via these links;

<http://u3a.org.uk/>

<https://www.pinpointdevon.co.uk/>

<http://www.ageuk.org.uk/devon/>

<https://www.alzheimers.org.uk/>

- Establish what the person actively dislikes doing and how this is managed.
- How can staff help them to avoid becoming bored?

- How should staff support the person to enjoy the activities they like (e.g. which TV programmes do they like to watch so that staff can remind them when these are on)?
- 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 activity have they communicated (verbally or non-verbally) that they do not enjoy or wish to engage in? What alternatives are made available to group activities a person doesn't want to participate in?
- Does the person smoke and what support do they need to continue this safely?
- Does the person enjoy an alcoholic drink and what support do they need to continue this safely? Are they on any medication that might cause contraindications or adverse reactions?

# NIGHT TIME SUPPORT

**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 or get up)
- Do they have a preference for male or female staff to provide their care and support?
- Is there any equipment they need during the night (e.g. bed rails, pressure mat) and where should the call bell be positioned?
- If the person has bed rails or a pressure mat in place, or a lap belt or tilt chair is used to restrict 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? (How?)
- Does the person have any personal preferences such as number of pillows, type of bedding, lighting on / off / dimmed curtains open or closed?
- What is their preference for staff checking them during the night (including frequency)?
- Do they have a turning or repositioning regime (including frequency) and does this take into account their personal preferences?
- If the person becomes anxious in the night? How do they communicate this, and how do they like to be reassured / supported?
- Do they like to have snacks and / or drinks during the night?
- Do they need medication at night to help them sleep?
- Do they have any "as required" night time medication and what is their preference for when they are offered this?
- Do they like to have a commode next to their bed to help them remain continent at night?
- Are they at increased risk at night due to any medical conditions?

# EMOTIONAL SUPPORT

**The care plan should describe what makes the person happy, sad or anxious, what staff can do to support and reassure them when they are worried or upset, and what they can do to keep them happy and content including:**

- What makes the person laugh?
- What fun things do they like to do?
- Who are the people whose company they most enjoy
- What are the things that make the person sad or anxious? What can staff do to support them at these times?
- How does the person present when they are feeling sad or anxious (e.g. tearful, withdrawn or irritable)?
- What can staff do to comfort the person when they are feeling sad or anxious (e.g. sit with them, talk to them, listen to them, reassure them or leave them alone and come back later to check how they are, contact their friends or relatives)?
- Should staff ask the person why they are feeling low or anxious, e.g. they might be in pain or feeling unwell, or upset by something or somebody?
- Are there any particular times of day, or events, or people that trigger the person's anxiety or low mood?
- Does the person experience periods of anxiety, restlessness or walking about? What may be the reason for this and does the person need help or intervention?
- If the person can't communicate what has made them sad or upset, who would they like staff to ask about this (e.g. carers, relatives or other people that know the person well)?
- If the person can't communicate what has made them sad or upset, who would they like staff to ask about this (e.g. carers, relatives or other people that know the person well)?

# EXPRESSING SEXUALITY

**The care plan should describe any aspects of the person's care and support which will help them to feel confident and fulfilled sexually, and ensure that where they need assistance it is provided in a safe and dignified way:**

- Does the person have any important intimate relationships? Would they like to have a relationship? How would this be supported?
- Does the person have any specific support needs (e.g. privacy to masturbate and / or be intimate with another person; shared bedroom; double bed)?
- How can staff support the person with their body image (the way they like to look and dress)?
- Where the person acts inappropriately towards others (residents or staff) or exhibits unwelcome behaviour how is this managed?

# SPIRITUAL AND CULTURAL WELLBEING

*'Spirituality/Faith' is about how we bring meaning and a sense of purpose into our life, Spirituality is sometimes used in a context separate from organised religious institutions (Faith).*

*'Culture' refers to the language, beliefs, values and norms, customs, dress, diet, roles, knowledge and skills, and all the other things that we have learned or adopted that make up our 'way of life'.*

**The 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 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 (e.g. acupuncture, aromatherapy, being close to nature)?
- Is there anything that has special meaning for the person – fresh flowers, particular aromas (incense), crystals, prayer beads, cross, photographs, religious texts?

# HEALTH CARE

**The care plan should describe how to meet the person's health care needs and allergies in the way that they choose, ensuring that their dignity is respected at all times, including:**

- What medical conditions does the person have? What does each of these conditions mean and how might it affect the person's daily life?
- Is a specific care plan required for any condition (e.g.; Diabetes, COPD, Epilepsy, Allergy or Asthma)
- 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. food choices, activity level)
- Are health conditions recorded current and/or relevant? (a hysterectomy undertaken 30 years ago may not be relevant information for the care plan)
- How is each condition managed? Are there any special arrangements that might need to be made (e.g. diet in the case of diabetes), any specific symptoms staff may observe or need to monitor, and how should they respond to these (e.g. contacting a medical professional, administering "as required" medication such as an inhaler or pain relief)?
- Are there any specific risks (e.g. walking long distances in the case of asthma)?
- Is the person able to tell staff when they are in pain or what signs staff may need to look out for (e.g. rubbing knee, head in hands, moaning, fidgeting, irritable, not wanting to move)?
- Has the person had any illnesses 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)?
- Does the person have any regular appointments with health care professionals such as specialists, consultants or therapists? What arrangements are in place for the person to attend appointments, and does the person need to be accompanied by staff (including how many)?
- Has any specific advice or instructions been given by health care professions (e.g. community nurses, physiotherapist, occupational therapist, Speech and Language Therapist) which need to be followed? Is this information time specific?

# MEDICATION MANAGEMENT

**The care plan should describe how to support the person to take their prescribed medication safely in the way that the person chooses, ensuring that their dignity is respected at all times, including:**

- 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 they will be supported to continue to manage their medication?
- Who is responsible for ordering, storing and disposing of the person's medication? (all medication should be given as per home policy)
- Does the person have any allergies or known adverse reactions to any medication (prescribed or non-prescribed)?
- What medication is the person taking currently? Why do they need the medication? Are there any side effects or contraindications staff may need to be aware of (e.g. grapefruit in the case of Simvastatin)? 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 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?
- How does the person like to take their medication (e.g. taking the tablets from the medicine pot themselves; preferring staff to tip them one at a time into the person's hand; having a glass of orange squash when taking their tablets)?
- Does the person need any aids to assist them to take their medication independently (e.g. Haleraid, pill popper)?
- Does the person prefer to take their medication in an altered form (e.g. crushed or cut in half), and if so is there a record of a discussion about each medication with their GP and/or the 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 referred to 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 Mental Capacity Act and has the best way to achieve a positive outcome (e.g. how to disguise the medication) been discussed, agreed and recorded?
- What strategies should staff use to encourage the person to take their medication e.g. try again later if the person is reluctant? Taking into account timing and liaising with GP as appropriate.

- Does the person need any regular blood tests (e.g. for Warfarin)?
- When the person's medication was 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?

# MENTAL HEALTH

**The care plan should identify the person's mental health needs, respecting their strengths and abilities, ensuring that all their needs are met safely and effectively, taking into account their preferences and choices, whilst demonstrating respect and maintaining the person's dignity when supporting them.**

- Does the person have a diagnosed mental health condition and if so, what is it? (a list of mental health conditions is included at the end of this page, this is not exhaustive)
- 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 (staff, health professionals, support groups, other agencies etc)?
- 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 really there (hallucinations) how does this affect the person and how are they supported?
- Are there any self-help techniques that the person can use to help themselves (such as breathing exercises if they suffer from 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? Is loneliness leading to feelings of isolation?
- How should staff speak to the person to help their situation and feelings (e.g. calmly, respectfully)?
- 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)?
- 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)?
- What are the things the person likes doing which helps them reframe their feelings/thoughts?
- Does the person need reassurance, positivity or encouragement?
- 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 need their medication reviewed? How frequently?
- Does the person sleep well?

- How can staff support the person to maintain a healthy diet to help improve their mental and physical health?
- Should staff encourage physical exercise, art or music to help the person feel better?
- How can staff help the person maintain their social life and maintain or develop relationships that are important to them?
- Does the person need to engage with healthcare professionals to ensure they have adequate / appropriate support (GP, mental health services)?
- 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?
- Does the person need support or encouragement to engage in meaningful activities?
- Does the person need help to ensure all their needs are met, e.g. assistance with finances?

Mental health conditions could include:

- *Depression*
- *Stress and anxiety*
- *Psychosis, hearing voices and schizophrenia*
- *Obsessive compulsive disorder (OCD)*
- *Post-traumatic stress disorder*
- *Bi-polar disorder*
- *Personality disorders*
- *Phobias*
- *Eating disorders*

# END OF LIFE PREFERENCES

**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 followed at all times, including:**

- Has the person already expressed their wishes in a document such as the “Planning for your Future Care” booklet? (link below)

[http://www.nhs.uk/Livewell/Endoflifecare/Documents/Planning\\_your\\_future\\_care%5B1%5D.pdf](http://www.nhs.uk/Livewell/Endoflifecare/Documents/Planning_your_future_care%5B1%5D.pdf)

- Does the person have a Treatment Escalation Plan (TEP) in place? and where this is located?
- Has the TEP been reviewed annually (as best practice), where the person’s condition has changed, or if the person has moved between care settings?
- Has the person made an Advance Decision to Refuse Treatment and where this is located?
- Does the person have a Lasting Power of Attorney for Health & 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 the end of their 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?
- Who would the person like to be involved if it becomes difficult for them to make decisions?
- 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 or friend have the details of their arrangements, and who is this?
- 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?

NB: It is recommended that a separate care plan should be put in place for the final days of life, which will include:

- The decisions and actions to be taken in accordance with the person's needs and wishes (which should be regularly reviewed and decisions revised accordingly)
- The need for sensitive communication between staff and 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
- An individual plan of care which includes food and drink, symptom control and psychological, social and spiritual support.

# BEHAVIOUR

The care plan should describe any behaviour the person may exhibit which could impact on the person themselves or on others, how to prevent the behaviour if possible, and if this is not possible how to manage it in a dignified way. Consider that behaviour is always a form of communication although there may not always be a specific trigger.

- What behaviours does the person exhibit?  
(A list of behaviours is included at the end of this page, this is not exhaustive)
- Are there any physical reasons that might trigger the behaviour? (e.g. poor sight, infection / urine infection, dehydration, constipation, diarrhoea, urinary retention, uncontrolled pain, sleep deprivation, abnormal glucose levels, side effects / toxicity of medications, withdrawal from alcohol or drugs) 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), feeling hot / cold / hungry / tired / thirsty, emotions, anxiety, hallucinations, delusional thoughts, continence needs, 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 behaviour the person exhibits be managed in a safe and dignified way (e.g. how many carers are needed, does the person prefer male or female carers)?
- Are there any risks (to the person or others) associated with the behaviours? Does the person need a risk assessment to determine how these can best be managed?
- How is it best to communicate with the person when they exhibit the behaviours?
- When the person exhibits the behaviours do they need to be moved to a different environment (e.g. quieter) or be with fewer people?
- Are distraction techniques appropriate, such as helping the person to do something they like?
- Do staff need to come back at a later time if the person is refusing care and / or treatment?
- Does the person need "as required" (PRN) medications before or after interventions (discuss with GP)?
- Should staff use safe holding techniques if the person is physically aggressive / resistive (if so are staff trained correctly 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 where appropriate?

Behaviours could include:

- *Resistance / refusal to care / treatment*
- *Verbal / physical aggression towards others*
- *Disinhibition (to others and / or self)*
- *Restlessness*
- *Wandering*
- *Shouting / calling out*
- *Attempting to leave the care home*
- *Urination / defecation in inappropriate places*
- *Invading others' personal space*
- *Taking others' belongings*
- *Accusations against staff / other residents*
- *Inappropriate behaviours with others*

# DYSPHAGIA

(Dysphagia is the medical term for swallowing difficulties)

**The care plan should describe how to support the person to follow the advice of health professionals in relation to their difficulties with swallowing and/or risk of choking, ensuring that their dignity is respected at all times, including:**

- Does the person appear to have an impaired chew or swallow? Does the person have any particular medical conditions that affect their ability to chew or swallow?
- Has a Dysphagia Risk Assessment been completed? (example via link below) Has it been reviewed and updated on a regular basis? Does a person require a referral to SALT (Speech and Language Team)

[http://www3.hants.gov.uk/npsa\\_dysphagia\\_risk\\_assessment\\_form\\_formatted.pdf](http://www3.hants.gov.uk/npsa_dysphagia_risk_assessment_form_formatted.pdf)

- What difficulties has the person been experiencing that have led to their assessment by a Speech and Language Therapist?
- What is the **exact advice** provided by the Speech and Language Therapist, including their name and date of the advice and when/whether the person will be reviewed?
- Are there any danger signs (listed in the dysphagia risk assessment) to look out for which may indicate that the support measures in place are not working adequately e.g. wet/gurgly voice, coughing or choking before or after meals or drinks?
- If the person requires thickening agents to be added to their fluids what consistency does this need to be?
- If the person requires a specific texture of diet what is this? (stages)
- Are there any high risk foods that the person needs to avoid?
- If the person has any favourite foods that they wish to continue eating has the possibility of using a soaking solution been considered?
- If the person requires staff to supervise or monitor them whilst they are eating or drinking because they are at risk of choking, what arrangements are in place to ensure the person is not left alone?
- How are staff expected to respond if the person shows signs of choking / aspiration?

***NB: If the person chooses to eat foods or drink fluids that they have been advised not to, please ensure that you have documented the advice of professionals and any discussion that you have had with the person in relation to their decision.***

# OXYGEN

**The care plan should describe how to support the person to follow the advice of health professionals in relation to the prescription of oxygen to support their breathing.**

**It is suggested that where Oxygen is in use the care plan should be attached to the Medication Management section of the care plan**

- What is the flow rate and length of time oxygen should be used for? (only the prescriber can specify/alter this)
- Are there any instructions for use 'as required', if relevant, and do they give clear instructions as to when or in what circumstances 'as required' oxygen is to be administered?
- Have the person and staff been advised not to use oil based products e.g. Vaseline, sun cream or oil based moisturiser or make-up and to wash their hands to remove grease before touching the mask or nasal cannula? Alcohol hand gel should not be used prior to touching the mask or nasal cannula.
- Have the person and staff been advised not to use aerosols, e.g. deodorant or hair spray in the area where a person is receiving oxygen?
- Have the person and staff been advised not to leave oxygen on when not in use and not to place the mask or nasal cannula on bedding or clothing?
- How should the equipment (e.g. mask, tubing, nasal cannula) be cleaned and how often? Who will be responsible for this? Where is this recorded?
- Who is responsible for the checking of the oxygen supply and re-ordering? If using an oxygen concentrator when is the next service due?
- How will oxygen therapy be managed when going outside?

Practice points to consider:

- How will Fire and Rescue services be informed of the location of oxygen (cylinders and/or concentrator) if they are required to attend in the event of a fire/fire alarm?
- Is there a risk assessment for the safe and suitable storage and use of oxygen?
- Are there Hazard warning notices where oxygen is stored or used?
- Is the **safety advice** of the supplier being followed?
- Are staff confident in the use of the equipment and do they have access to the supplier's safety information and contact details?

# PROMPTS FOR REVIEWING CARE PLANS

**It is recommended that the care plan and relevant risk assessments, are reviewed monthly as good practice and whenever a persons needs change, including as the end of life approaches. Reviews should take place in accordance with the home's policy,**

Have there been any **significant events** since the last review?

e.g. hospital appointments/admissions, illnesses or new medical conditions diagnosed, visits/advice from Health or Social Care Professionals, medication changes, changes to care and support needs, accidents, incidents etc.

Check each separate **risk assessment**

e.g. moving and handling, falls, MUST, Waterlow / Medley – do any of the 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 to be updated.

Read over each individual **care plan section**

e.g. Level of Understanding, Personal Care, Mobility to ensure that they contain up to date information and that the content describes the person's current care and support needs. Do any of the significant events suggest a specific section of the care plan should have been updated? Check that this has happened.

Read the **daily notes**

Does what you read raise any concerns or demonstrate a pattern or theme you feel may need looking in to 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, bowel records – does the information confirm that the person's care and support needs are being met according to their care plan?

Involve the person:

- Do they have any concerns or worries?
- How are they feeling or settling in?
- What is going well?
- What is not going so well?

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 whether they would like their relatives to be involved and record their wishes.

Agree with the person and their representatives how frequently they 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 that 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?

Record your review discussion, who was involved, any actions agreed, and sign / date the document.

# DAILY RECORDS

**Ensure daily records reflect how the person's needs as described in every section of the care plan are met.**

**Daily records should be clear, accurate, easy to read, written at the time and describe how the person spent their day and night including interactions with other people (staff, residents, family, visitors and anyone else).**