

The Care Plan

Care at Night

Continence Care

Daily Life

Dementia

Eating & Drinking

Emergencies

End of Life Care

Family & Friends

Listening & Talking

Mouth & Teeth Care

Privacy & Choice

The Care Plan



We all make plans, for our future, our finances, our holidays. We often make them with friends and family and they often need to change. When someone moves into a care home it's no different. A plan for their care is essential to make sure they have all the support they need for their health and happiness in the home.

Not just a plan

Based on a full assessment, including health needs, the care plan introduces the person to everyone who will work with them. It covers not just their health and medication needs, but aspects of their life history and interests, their culture and religion, to help understanding of the whole person. It sets out the objectives the staff and often their family will have planned with the person for the future. It's a working document, so always subject to update and review by you, the family and the person.

Making the plan

Most homes use a standard format for care planning, clear for any new staff member to use to give support to a resident even when that person is unable to communicate. A good system will help inform and update the family so they can contribute to care planning.

It's helpful to involve the family from the start, with the resident, to record past and present lifestyle, likes and dislikes, employment history and skills they might continue and develop, remembering that life history information must be treated as confidential.

Assessment of physical, mental, mobility, sight and hearing capacity will be made and relatives may also be able to help with risk assessments, such as any history of falls, allergies or choking.

Sharing knowledge Remember to share your own knowledge with residents and those close to them. They may not know all the facts they need, like what health treatments or different leisure activities might be available.

Using the plan

A good care plan should let you see the person and their preferences, not just a list of ailments. It should give advice on how best to meet their needs and support them, to ensure they have a good quality of life in their care home.

It records medical conditions, such as Parkinson's disease, but also medical appointments they may have with specialist nurses, consultants, GP's,

CARE PLANS ARE A LEGAL REQUIREMENT

Every resident should have a care plan which is regularly reviewed to ensure their needs are being appropriately met and limiting risk of harm. *The Health & Social Care Act 2008 (Regulated Activities) Regulations 2014: No 9 Person centred care, No 12 Safe care and treatment, No 17 Good governance*



GOOD PRACTICE

Staff could see at once which was Brian's care plan. It had his photograph on the front. This was not just a dry file of information, but all about a person.

FAMILIES AND THE CARE PLAN

Surveys suggest that only 52 % of families are involved in residents' care planning.

Keynotes

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occupational or physiotherapists, as well as regular reviews of their health needs.

Does the person need a hoist to move them, if so, which type and do you have the right training?

Reviewing the plan

Remember, care plans hold active information. Unless there is good reason not to, those closest to the resident, who have contributed to the planning should be kept informed and included in reviews of the person's care needs.

Daily records As part of making sure that the needs of a person are being met, there should be a daily record of a person's care. Daily records help staff and residents work towards agreed goals set in their care plans, such as progress with exercises set by the physiotherapist to increase mobility, or to set new goals.

Care plans and daily records must be easily accessible and flexible for staff to check. How will you know amongst all the care needs of those in the home that Mr Evans is allergic to pasta or remember after a busy shift to tell the next shift that Mrs Jones's sister has been ill and she is upset?

Good care planning, including timely reviews and up to date and easy to access records help staff to have the right information at the right time. It can help give confidence to staff, reduce accidents and increase the quality of life for residents.

FAMILY KNOWLEDGE

Eileen had had a fall when her daughter Sally came in to see her. Her keyworker Maria had applied a plaster to stop the bleeding, but a rash was spreading and Eileen was agitated. "I recognise that," said Sally, "she's allergic to those plasters."

How would Maria see the care plan is updated to ensure this did not happen again?



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