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Steps to effective care planning in older adult care homes

"The importance of a good care plan cannot be underestimated."

Deputy Care Home Manager



1.0, June 2025

Introduction



Care plans are the foundation of high-quality, person-centred care in older adult care homes. At their best, they are living documents that place the person at the heart of care and support—empowering an individual to live the fullest and most meaningful life possible, whatever their circumstances. A good care plan supports continuity of care, enhances well-being, and reflects each person's unique values, preferences, goals, and needs

This guide has been developed following extensive research, including a literature review of how care planning is undertaken internationally, in-depth interviews with care home staff, consultations with residents' family members, and a review of relevant policies and guidelines. This document's contents have also been shaped by the experiences of more than 100 care professionals working across England, who provided feedback through multiple survey rounds to refine and agree on the core principles.

This guide aims to support care home staff to develop care plans that are person-centred, align with best practices, and improve residents' quality of life. Many of the principles come from how care homes are already approaching care planning, while others reflect how care staff would like to conduct care planning. You may find that your approach to care planning already aligns with many of the principles outlined here.

A short version of this guide, which is focuses on how care planning can enhance someone's quality of life, can be found here.

This work was conducted by researchers from the University of Kent, the University of Bristol, the University of Liverpool, the University of Oxford, and the London School of Economics and Political Science, and supported by two members of the public who have lived experience of supporting relatives in care homes.

By embracing these key principles, care providers can make care planning a meaningful and inclusive process—one that respects individual wishes, enhances well-being and quality of life, and empowers individuals to lead fulfilling lives.



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Contents



Page	Topic
5	What is the purpose of an effective care plan?
7	How can care planning be approached in a person-centred way?
9	What should be contained within a care plan?
11	When will a care plan be developed and updated?
13	Who is likely to contribute to a care plan?
14	Who should have access to a care plan?
15	Future developments in care planning

1. What is the purpose of an effective care plan?

An effective **care plan** provides information about a person's life, including their goals, skills, abilities and the support they need to manage their health and wellbeing. A meaningful care plan will acknowledge that a person's abilities, needs, interests and preferences can change over time. When done well, care plans will empower a person to have as much choice, control and independence over their daily life as possible.

The information contained within a meaningful care plan should help:

- Staff to support a person to live a fulfilled life.
- To identify a person's care needs, interests, preferences and wishes each time staff provide support.
- To identify the views of the person regarding the care and support they receive. It can be helpful to supplement these with the views of family and friends. Wherever possible, the views of the person receiving care should be prioritised.
- To maintain continuity of care among other health and social care professionals – such as GPs, district nurses and physiotherapists - involved in the individual's care.
- Staff to document, understand and support a person's health and wellbeing over time.
- To give a clearer indication of a person's needs, choices and preferences. This information may help to inform the resources and staffing levels required in the care home.
- Show that the care a person receives achieves the standards set out in legislation, CQC, and NICE guidelines.



An effective **advance care plan** will enable a person to set out their preferences and priorities for future care, including end of life care. It is designed to help ensure that the care that people receive in the future is consistent with their beliefs, values, goals and preferences.

Advance care plans often include information about a person's **end of life care**, including where the person would like to die, if the person has completed a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form or Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form, and any, religious and/or spiritual requests. If not already in place, advance care planning can lead to the appointment of an attorney under the terms of a 'Lasting Power of Attorney' or a 'Court of Protection Deputy' who is empowered to make decisions on behalf of the person. Advance care plans may also document a person's future treatment preferences and where and how they would like to spend their last days.

" [A] Care Plan is a vital life written document that speak[s] for an individual ... [it] should be done with care, empathy, dedication and professionalism to show the true picture of the person it concerns all the time."

Registered Nurse





2. How can care planning be approached in a person-centred way?

Person-centred care planning affirms who a person is, their dignity, and prioritises their individual needs and wishes over and above generic routines and institutional practices. Where appropriate, and with a person's consent, person-centred care planning may involve consulting with a person's attorney and other important people in their lives.

Person-centred care can:

- Ensure that a person's voice is heard, and that their wishes shape both the care they receive and the life they want to lead.
- Empower a person to have as much choice, control, and independence as possible in all aspects of daily life.
- Build trusting relationships between the person and the care team, grounded in understanding what matters most to them.

A person-centred care plan will help to ensure the person's abilities are supported and their wishes, preferences, and needs are met. A person-centred care plan has the following qualities:

It provides a complete picture of who the person is, including their history, current interests and future ambitions. It will detail:

- The social, cultural, behavioural, environmental, emotional and health needs for which a person requires support.
- The person's beliefs, values and what is important to them.
- The person's abilities, to empower their independence and foster a sense of purpose, belonging and self-esteem.

It engages the person in decision-making. This can be achieved by:

- Involving individuals, if they wish, in decisions about their care to ensure their preferences guide the care they receive.
- Communicating in an accessible and jargon-free way so that the person can understand.
- This may involve using specialised visual, language and auditory sensory tools - such as Braille and translators - as well as staff insights into a person's specific communication methods.
- Inviting, where appropriate, the person, or their attorney, to consent to important people in their life - who know them well and understand their individual needs and wishes, and will act in their best interests - providing additional information.
- Ensuring that, with the consent of the person or their attorney, important people in their life can be provided with the information necessary to help them make decisions.
- Ensuring that the person is aware of all the available options and providing them with the information necessary to make informed decisions.
- Having first consulted the person, including input from external health and social care professionals that will support the person's wellbeing, without disregarding the person's wishes and preferences.





3. What should be contained within a care plan?

Care plans will contain different sections. High quality care plans are likely to include:

1. **A recent dignified photograph** of the person, which will be updated regularly.

2. Details about the **care plan itself**:
- A record of when the plan was created, revised and will next be reviewed, and who is responsible for providing particular care.

3. Background information about the **person's history**, which may include details of:
- The person's life immediately prior to moving into the care home and routines that were important to them.
- The person's gender identity, sexuality, family, culture, beliefs and religion.
- Key dates and life events, such as significant holidays, anniversaries, volunteering and service honours, and the support required from the home to enable the person to celebrate these milestones.

4.Information about a person's hobbies, interests, achievements and aspirations, past, present and future, including details of:
- How to support the person to maintain or build on their current community connections and interests.
- The person's preferences regarding activities and environments, including what they would or would not like to take part in and where they feel comfortable or uncomfortable.

5. Information about the key risks that the person may face, and steps that can be taken to keep them safe in the least restrictive way possible.

6. Information about **forthcoming appointments** – such as medical or social appointments - and the support that the care home should provide to enable these to take place.

7. Information about the **person's health**, including, but not limited to:

- Health observation, which can provide an important baseline to compare against in the future.
- Medication.
- The persons' nutrition and hydration needs and preferences.
- Their physical, mental, emotional and social wellbeing.

8. Information about the person's **day-to-day care needs** and **preference**s, including:

- The person's capability to meet their own day-to-day needs and their preferences for how support should be delivered.
- Details of any equipment that the person uses.

9. Information about a person's **end of life care**, including:

- Where the person would like to be cared for.
- Details of religious, spiritual and/or cultural practices.
- Key people to involve.
- Who the person would like to be with them in their final moments, either in-person or virtually using software such as MS Teams, WhatsApp or FaceTime.
- Palliative medical care and resuscitation preferences, which may be documented using a DNACPR or ReSPECT form.
- Details of any advanced directives.
- Funeral arrangements.
- Whether arrangements have been made for organ or body donations.

"These are all great examples of what should be included in a care plan and how to achieve it. Care plans should always be person-centred and we arrange our care to suit these needs."

Senior Healthcare Assistant

4. When will a care plan be developed and updated?

A care plan should be regularly reviewed, and updated, if necessary, to provide an accurate account of how to care for a person safely while meeting their needs and supporting their interests and preferences.

To provide safe and person-centred care from the outset, it is **important to gather as much information as early as possible** - ideally before the person arrives at the care home. This information - which should include the risks a person may face, their needs, interests and preferences - can be used as the foundation for their care plan.

The information collected prior to a person's arrival may be obtained by talking to them and, with their consent or that of their attorney, contacting previous care settings, health and social care professionals, and their family and friends.

Shortly after a person's arrival, as staff begin to get to know them better, it is important to set aside time to update their initial care plan.

An effective care plan will be regularly reviewed to ensure the document reflects a person's current needs, interests, and preferences. Reviews can take two forms: (1) in response to changes and/or (2) in accordance with a prearranged timeframe.



A care plan should be **updated in response to changes in a person's life**. These changes may relate to a person's health; social or emotional wellbeing; interests and preferences; hospital admission; the death of someone important to them; changes in wider family circumstances; personal goals and ambitions; abilities; or newly identified safety risks.

If no changes have been observed, **reviews should take place in accordance with a prearranged schedule** to ensure that care plans remain accurate and up-to-date. These reviews often take place every four to six weeks. Where possible, and with a person's consent or that of their attorney, **significant people in their lives**, such as family or friends, **may contribute to prearranged reviews**.

Prearranged reviews, which should involve the person and, as appropriate, their attorney, will provide an opportunity to review the contents of their care plan, identify any changes in their care needs and document how these will be met.

"From [my] experience [caring for] elderly family [members], nursing in hospitals and nursing homes, developing clear and up-to-date care plans is essential."

Deputy Matron





5. Who is likely to contribute to a care plan?

- A person must be involved in developing and reviewing their care plan. The manner of a person's involvement will be informed by their capacity – for example, people with limited capacity may require a proxy or someone acting on their behalf to assist them.
- With the consent of the person or their attorney, family and friends can contribute to the care planning process, as they often provide valuable insight and information.
- Managers, senior carers or nursing staff are usually responsible for writing care plans; as part of this process, valuable information can be collected from the wider care team, including front-line care workers, and non-care staff, such as members of the housekeeping and catering teams.
- Up-to-date information provided by external health and social care professionals - such as speech and language therapists, chiropodist, social workers, GPs, occupational therapists, physiotherapists, nurses and psychologists - may be added to specific parts of the care plan. This information is important to ensure that care is clinically informed.

6. Who should have access to a care plan?

A person should be given a copy of their care plan and provided with any additional information required to contextualise the plan's contents.

If requested:

- A person's attorney should be provided with the information contained within the care plan which relates to the matters (financial or health and welfare) that they are responsible for. When sharing details of a person's care plan, only information relevant to their inquiry should be disclosed.

If requested, and with the consent of the person or the appropriate attorney:

- Members of a person's "circle of care", such as named family and friends, should be able to view their care plan. When sharing details of a person's care plan, only information relevant to a friend or family member's inquiry should be disclosed.

To be most useful, care plans will need to be accessible to:

- **Care home staff**, including bank and agency staff

When necessary to provide care:

- The relevant section of a person's care plan should be made accessible to **external health and care professionals** – such as speech and language therapists, medical consultants, social workers, GPs, occupational therapists, physiotherapists, nurses and psychologists.

External professionals and staff accessing a person's care plan must respect the principles of data protection.





7. Future developments in care planning

Technology, such as digital care planning software, is playing an increasingly important role in supporting care planning. Digital care planning can:

- Make it easier to update care plans, helping to ensure they remain current and relevant.
- Flag important information, helping staff to prioritise actions or risks.
- Help identify trends for individuals and across the whole care home, using real-time and aggregate data to support planning and service improvement.
- Over time, reduce the amount of time needed to complete and review care plans.
- Where appropriate consent is in place, allow information to be securely and quickly shared with relevant health and social care professionals, and/or the person's family and friends.

The move to digital care planning is a sector-wide priority. Care homes that have not yet adopted digital care plans should ensure that:

- There is sufficient internet connectivity across all areas of the care home, with contingency plans in place for any potential outages.
- They budget for the full range of associated costs, including software and updates, devices, robust data security measures, regular backups, technical support, and ongoing maintenance.
- They implement robust cyber security practices, supported by the Data Security and Protection Toolkit (DSPT), to safeguard sensitive information and ensure compliance with data protection standards.
- The care planning software supports the development of person-centred care plans that reflect the individual needs and preferences of residents.

- Sections of the digital care plan can be securely shared with relevant professionals involved in the person's care and that only appropriate people can update the care plan.
- They recognise and prioritise the time and commitment required to:
  - Transition from paper to digital care plans.
  - Train and empower staff to use digital care planning packages.
  - Provide ongoing support and development to maintain digital confidence and competence.



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We hope you have found this guide useful. If you have any comments or feedback, you are welcome to contact the team involved in developing this resource using the details below:

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