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Care planning for older adults living in a care home: a guide for family and friends



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As a family member or friend, this guide is designed to help you understand care planning for older adults living in care homes in England and how you can contribute to the process. Supporting a person to move into a care home is often a challenging time and becoming involved in care planning may take time.

What is a Care Plan?

A care plan is a document that helps to ensure that someone receives high-quality care that respects their wishes and meets their needs. It's a living document that helps care providers to understand who they are, what matters to them, and how to support them to live a fulfilling life. Individuals who can contribute to a person's care plan include care home staff, family members and friends and external health and social care professionals. If appropriate, some parts of the care plan may be shared with external health and social care professionals involved in the person's care.

Why is it Important?

- Person-centred care: It helps tailor care to the person's unique preferences, abilities, and needs.
- Transparency and continuity: It ensures that all health and care professionals involved in the person's care know how to best support them. It helps family members and friends know how the person is being supported.
- Empowerment: It gives the person as much choice and control as is possible over their daily life.



What Goes into a Care Plan?

In addition to information about day-to-day care preferences and needs, a care plan typically includes information about the person's:

- History and background
- Hobbies, interests, and aspirations
- Capabilities and risk management
- Preferred ways of being supported
- Medication, dietary needs, allergies and intolerances
- Key people including attorneys, GP, consultants or other healthcare practitioners, local authority contacts and family members and friends
- End-of-life care preferences (these may be recorded in a separate document, often known as an Advance Care Plan).

Why Your Input Matters

As a family member or friend, you may wish to contribute to the care planning process by:

- Sharing insights: You may know the person's life history, interests, and values. This information can help the care team understand what matters most to the person and how best to support them.
- Supporting communication: If the person has difficulty expressing themselves, you can help communicate their preferences.
- Participating in reviews: Care plans should be reviewed regularly. With the person's consent, or where appropriate, you may be invited to these reviews to provide input.
- Helping to ensure that the person's end-of-life preferences, including funeral arrangements, where appropriate, are respected. This may involve helping the person to complete a DNACPR or ReSPECT form (see glossary).

Your level of involvement may vary over time based on changes in the person's health or their capacity to advocate for themselves.



When are Care Plans Developed and Updated?

Care plans are changing documents and should be updated regularly. The person's care needs and preferences should be assessed by people with the necessary skills and knowledge. You may wish to contribute to ensure that the information is accurate. Care plans are often developed:

- Prior to arrival in the care home: Information collected at this stage, which may be provided by a social worker, hospital, GP and/or former care home, is often used as the foundation of a person's care plan.
- On arrival at the care home: A care plan is developed shortly after admission, when staff will gather as much information as possible from the person, their clinicians, and, where appropriate, from family and friends.
- During regular reviews: Reviews may occur every 4-6 weeks (but may vary between care homes) or in response to significant changes in health, wellbeing, or preferences.

Viewing a Care Plan

The care plan should be made available to everyone involved in caring for the person. The person also has the right to see their care plan. If you are appointed an attorney, under the terms of a Lasting Power of Attorney (LPA), you can also request to view the sections of the person's care plan for which you have power of attorney, e.g. health and welfare, or financial matters.

If you have not been appointed an attorney, the person can consent for you to be given access to certain sections of the care plan. If they lack the capacity to make decisions and a LPA (Lasting Power of Attorney) is not in place, you may be able to apply to the Court of Protection to become a deputy and make some decisions for them.

Glossary

Advance Care Plan (ACP): An ACP relates to future care provision and is often focused on end-of-life care. ACPs are often developed in anticipation of someone's condition deteriorating.

DNACPR: Do Not Attempt Cardiopulmonary Resuscitation (CPR) - a form that records the person's wish not to receive CPR if their heart stops beating or they stop breathing.

ReSPECT Form: Recommended Summary Plan for Emergency Care and Treatment - a form that records what types of care and treatment the person would or would not want in an emergency.

Lasting Power of Attorney (LPA): This is a legal document that lets the person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. There are two types of LPAs:

1. Health and welfare.
2. Property and financial affairs.

The person may have one or both types of LPA in place.

Deputy: A deputy is appointed by the Court of Protection when someone lacks the mental capacity to make decisions for themselves and a LPA is not in place.

Person-centred care: An approach that puts the person at the centre of their care planning, focusing on their unique needs, preferences, and wishes, rather than standard routines.

Wellbeing: A broad concept that includes physical health, mental health, emotional state, social relationships, and overall quality of life.

Care Quality Commission (CQC): The independent regulator for health and adult social care in England.



Useful Links

Information and advice when moving into a care home: https://www.ageuk.org.uk/information-advice/care/arranging-care/care-homes/moving-into-care-home/ and https://www.ageuk.org.uk/siteassets/documents/information-guides/ageukig06_care_homes_inf.pdf

Care Quality Commission (CQC) website: https://www.cqc.org.uk/

How to raise and report complaints: https://www.ageuk.org.uk/information-advice/care/arranging-care/care-homes/problems-with-a-care-home/

How to apply to become someone's deputy: https://www.gov.uk/become-deputy

Social Care Institute for Excellence (SCIE) Key Messages from the Mental Capacity Act and Care planning Report: https://www.scie.org.uk/mca/practice/care-planning/key-messages/

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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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