



# Care Plan Folder content guidance

## Older People Residential settings

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[www.lancashire.gov.uk](http://www.lancashire.gov.uk)

This guidance has been developed to assist providers of residential and nursing homes for adults with their care planning.

Its purpose is to suggest what documentation could be included in a care plan folder; the person's care plan should fully reflect their physical, mental, emotional and social needs, including the protected characteristics as defined within the Equality Act 2010. These should include their personal history, strengths, preferences, interests and aspirations. This needs to be understood by staff so that people have as much choice and control as possible whilst being cared for safely and effectively.

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, as long as the information is present and staff know where to look.

Every care plan folder should include an index, it is important that Managers and staff providing care and support are able to find the information they need quickly; the index is central to this aim, as it clearly indicates what is in the care plan and ensures documents are filed according to the index. Ideally the care plan folder should have dividers that match referencing.

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.

Responsibility of the accuracy and completeness of documentation included in the care plan folders rests at all times with the Residential or Nursing Home Provider.

Documentation contained within the Care Plan Folder should be dated and show the name of the person who completed them, and be signed by that person. The person should be actively involved in the assessment and review of their care needs, whilst applying the principles of the Mental Capacity Act 2005 and it is good practice to ask them to sign the documents which they have been directly involved in; such as care plans and their subsequent reviews, risk assessments and risk assessment reviews. Also to record how all contributors to the care plan are involved in the process.

It is important that care plans and related documentation are accurate, complete, legible, up to date and are stored securely at all times while being accessible to staff who need to refer to them to keep people safe. It is important that all records relating to individuals are confidential to the person, the home's staff, those 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), anyone who has Lasting Power of Attorney for Health & Welfare on the person's behalf.

This guidance has been developed by Lancashire County Council's Patient Safety and Safeguarding in conjunction with Healthier Lancashire & South Cumbria Integrated Care System Partners and Lancashire Care Foundation Trust. It is based on publically 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

**The fundamental principle to remember is that this care plan is for the individual, it enables the individual 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 and room number should be written on the folder spine, and on the front cover of the folder or ring binder.

**Photograph**

A clear, up to date photograph can be either attached to the front cover or located towards the front of the folder, this assists with identification of the resident. 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 being archived.

**Contents / Index sheet**

Should show the order of sections within the folder, it could include sub-headings to help staff locate particular documents. Numbering of sections or clearly written tabs will be helpful to for staff navigating the folder.

**1. Important Documents**

The following documents should be at the front of the file and easy accessible for staff, for example in an emergency.

It is crucial to ensure that these documents are incorporated within your review processes and are updated where there has been a change in the person's need along with the relevant care plans.

DNACPR (where applicable)

Personal Emergency Evacuation Plan (PEEPs)

One Page Profile / at a glance summary

Hospital passport

*Additional notes*

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 PEEP's to also be kept in a grab file which is readily available in an emergency.

Many homes use an at a glance summary (One Page Profiles are commonly used) near the front of the folder which sets out the important things to a new or agency staff member needs to know about the person before providing them with care and support. Ensure that it is only a brief summary and does not duplicate the care plan, it should detail a person's allergies or intolerances, likes, dislikes and preferences. The 'at a glance' 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 people's needs, this promotes communication and allows for more effective treatment. It does not

replace the detailed information in a care plan, but complements it. For residents 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.

If you are in an area where the Red Bag Scheme is live, there may be documentation within your care plans that would also need to include as part of the resident's hospital journey. You will need to review the documentation provided with your Red Bag which details the standardised documents.

## 2. Personal information

Resident personal information

Support network

Professional contacts

*Additional notes*

Support network should contain details such as family and friends important to the person and that they wish to stay in contact with.

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 and Advocate)

## 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 including information from relatives or friends where appropriate.

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

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'* – South West Yorkshire Partnership NHS Trust

*'Remembering Together'* – Alzheimer's Society

University of York have studied life story work and identified [9 good practice learning points](#) for consideration.

<b>3. Admission</b>
Organisation's initial / pre-admission assessment
Organisation's Admission assessment
Resident personal property checklist
Referral documentation (e.g. From the Local Authority who arrangement placement or hospital discharge documentation)
Moving on Plans (MoPs) from previous homes when applicable
<i>Additional notes</i>
<p>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.</p> <p>Information on the individual's likes and dislikes should be gained along with any needs relating to race, culture, gender, age, religion/spirituality, disability or sexuality.</p> <p>Night time care needs should also be identified as part of the pre-admission assessment and determine if staffing levels are adequate to meet needs.</p>

<b>4. Care Plans and Risk assessments</b>
<p>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 are entirely matters for the Provider to decide. 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 found easily. Examples of such documents, which will depend on the person's needs, are shown under each section.</p> <p>It is essential to ensure risk management and mitigation is effectively reflected in the care plan.</p>
<i>Additional notes</i>
<p>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.</p> <p> <span style="color: red;">●</span> High                <span style="color: orange;">●</span> Medium                <span style="color: green;">●</span> Low         </p>

<b>5. Consent</b>
Consent to elements of support (e.g. 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
<i>Additional information</i>
<p>Include information about people's capacity in their care plan and detail how they should be involved in their care and lifestyle choices (including making decisions for themselves). Where best interest decisions have been made; these should be recorded and detailed on</p>

the related care plan for the specific need the decision relates to.

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, clarification should be sought on whether this is for Health and Welfare, Finances, or both. Original documents must be seen and copies of documentation should be taken and kept within the person's care file and checked for registration with the Office of Public Guardian.

<b>Communication</b>
Communication Care Plan
Communication Boards / Passports
Family communication log
<i>Additional notes</i>
Consider the person's first language or any sensory / communication difficulties where an interpreter may be required. All organisations that provide NHS or adult social care must follow the accessible information standard. The aim of the accessible information standard 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. (This would be assessed as part of the care plan but is important to assess at pre-admission/admission).

<b>Mobility and Falls</b>
Mobility & falls Care Plan
Manual Handling risk assessment
Falls risk assessment
Falls Checklist
Bed rails risk assessment
Equipment assessment
Falls diary / log
^ Post falls monitoring
<i>Additional notes</i>
Within the equipment assessment include Information on equipment used; hoists, sling details, toilet aids, bed and chair (height, mattress).
Ensure post falls protocol in place includes monitoring to support staff to understand what they need to do if a resident falls – a monitoring form will ensure the observations are in one dedicated place.

<b>Skin care &amp; Tissue Viability</b>
Pressure ulcer risk assessment (e.g. Waterlow, Medley, PURAT)
Skin care Plan
SSKIN bundle / React to Red
Body maps
Wound assessment & review chart
Wound care plan
^ Repositioning / turning charts
<i>Additional notes</i>
<p>Care plans should clearly detail how a person needs to be supported to reduce their risk of developing pressure sores including areas such as the person's ability to regularly change position, checking for changes in the skin and promoting a healthy, balanced diet,</p> <p>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).</p> <p>Further information can be found on <a href="#">Best Practice Guidance for Safeguarding Individuals with Pressure Ulceration</a> on the Lancashire Safeguarding Adults Board website.</p> <p>Body maps: These should include the person's name, be dated and be signed and record the designation of the person making the record. They should sufficiently detail the type of mark e.g. Pressure ulcers, Red areas, Bruises, Cuts, lacerations and wounds, Scalds and burns, Swellings. NB. As the wound or mark changes a new record should be made. A copy of all body charts must be kept in the care file.</p> <p>For homes with nursing registration, documentation for use of wound care products - to include site of application of wound care product and frequency of product change as well as wound measurements and reviews.</p>

<b>Nutrition &amp; Hydration</b>
Eating, Drinking & Swallowing care plan
Malnutrition Risk Assessment (Malnutrition Universal Screening Tool (MUST))
Dysphagia (swallowing) Risk assessment
Weight chart
^ Food monitoring charts
^ Fluid balance charts
<i>Additional notes</i>
<p>Residents should be screened on admission and when there is clinical concern (NICE)</p> <p>Ensure that you record any allergies, dietary preferences and special requirements; also that any care plan details exact advice from SALT where applicable e.g. number of scoops of thickening products and consistency of product to achieve. The International Dysphagia Diet Standardisation Initiative (IDDSI) <a href="#">framework</a> has standardised terminology and definitions to describe texture modified foods and thickened fluids.</p> <p>Record of regular weight and MUST scores are particularly important for people prescribed food supplements. It is important for staff to know how to assess whether a person is hydrated and when it is appropriate for fluid balance charts to commence.</p>

For homes with nursing registration, as appropriate ensure that care plans are in place from Dietetics for specific feeding methods e.g. Enteral feeding plan which also includes details of consumables. Also reference to specialist diets such as high protein, low fat, diabetic.

LCFT has developed the [Hydration Toolkit for Care Homes](#) to promote the hydration of residents in Lancashire with access to a range of resources to support this within your home.

### **Mental health & wellbeing**

Mental wellbeing Care Plan

Positive behaviour support plan

^Behaviour / ABCD Charts

Pain Care Plan

Cornell Depression scale\*

Abbey Pain Scale\*

#### *Additional notes*

\*For people who cannot easily communicate their needs, for example due to dementia.

It is important to detail through care planning what makes a person feel safe and how staff can support this (as detailed in the Good & Outstanding care guide)

### **Personal Care**

Oral Health assessment

Personal care / hygiene Care Plan

^ Personal care chart (bathing / showering log)

Continence Care plan

Catheter / Stoma care

^ Bowel Chart (informed by Bristol Stool Chart)

#### *Additional notes*

Personal care (or personal hygiene) can incorporate a number of different areas for example; washing & dressing, bathing & showering, hair care, nail & foot care and oral health. Ensure that you record any individual preferences such as gender of staff, time of support.

Mouth care needs and the plan of support to address these needs should be recorded in the personal care plan for adults living in care homes. (NICE Oral health in Care Homes)

### **Social Interests & Activities**

Daily routines Care Plan

Activities Care Plan

Social isolation & loneliness scale

#### *Additional notes*

Care plans should reflect how the individual is involved in decisions about their environment and how you meet people's individual diverse care, cultural and support needs. Include people's interests, preferences and things that are/were important to them in the care plan (including employment/volunteering choices if applicable).



<b>Physical Health and Wellbeing</b>
Physical Health and Wellbeing Care Plan
Health action plan (where appropriate)
Health related appointment letters
Personal safety risk assessments
Infection risk assessment and care plan
Individual smoking risk assessment
Multidisciplinary communication log
<i>Additional notes</i>
<p>Include details of recent and upcoming health related appointments in care plans (e.g. hospital, GP, dentist, optician).</p> <p>Include referral information and advice from healthcare professionals in care plans and associated documentation.</p> <p>In this section there could be individual care plans to support the person to manage long term conditions based on their individual needs and circumstances, examples care plans may be; Breathing / COPD, Diabetes, Epilepsy.</p> <p>On the 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 OT or SALT, chiroprapist, dentist, optician.</p> <p>District Nurse notes should provide information on visits completed by District Nurses and their outcomes.</p>

<b>Personal Safety</b>
Personal safety risk assessments
Individual smoking risk assessment
Personal safety care plan
<i>Additional notes</i>
<p>Involve people who need care and support in discussions about their safety, it is important to understand what makes them feel safe and document this in their care plans.</p> <p>There may be more generic individual or environmental risk assessments which need to be completed specific to the person dependent on their needs.</p>

<b>Medication</b>
Medication Care Plan
PRN medication Care Plan
Controlled drugs care plan
Topical cream Care Plan (including body maps)
Patch Care Plan (where applicable)
Self-medication risk assessment
Oxygen Care Plan (where applicable)
Covert medication Care Plan
Short Term medication care plan (e.g. antibiotics)
^ Blood glucose monitoring
<i>Additional notes</i>
Ensure detailed and current information regarding people's medicines; including medication

which has been bought over the counter and/or administered as part of a homely remedy policy, any allergies and/or adverse reactions, how people preferred these to be administered are recorded in their care plans and medication review dates / follow ups.

Consider how staff assess the level of support a person needs to take their medicines safely; particularly where there are difficulties in communicating, when medicines are being administered covertly, and when undertaking risk assessments designed to promote self-administration.

Any covert medication care plan should be in line with Best Interests framework (DoLS applications / authorisations).

Controlled drugs care plan to include record of prescribed dose and regime to staff to follow.

Patch Care Plan to include body maps to ensure rotation of patches around the body.

Blood glucose monitoring documentation for any residents with diabetes.

### Sleeping and Night care

Night time risk assessment

Night Care Plan

*Additional notes*

Care planning should include preferences regarding their night routine; it can include everything around bedtimes/ getting up, their bed and bedding (for example, height of bed, number of pillows, and type of mattress), frequency of checking (if any) required based on risk assessment, environment / lighting, continence and nutritional & hydration needs at night.

### End of Life

Advance Care Plan

Individual Plan of Care and Support for the Dying Person\*

*Additional notes*

The General Medical Council (2010) define people "*approaching the end of life*" when they are likely to die within the next 12 months.

The person who might meet this definition should have a GP who is their lead contact for this process to confirm if this is the case and the GP should then instigate a multidisciplinary team discussion when considering end of life care. This should include the family and the resident themselves. This may well be an evolving process and might include a series of conversations and prompts over time as the person's condition changes.

If a person has considered their preferences they may well want to record these as an **Advance Care Planning** this helps a person's preferences and choices for their end of life care and where they wish to die including spiritual and cultural needs and their protected equality characteristics. They should be clearly recorded, communicated, kept under review and acted on. Consideration on whether the person holds a Donor card and detail this within their care plan. This should be supported through the MDT led by the GP.

It is also important to acknowledge and record, when approached, an individual does not want to discuss their wishes and preferences at end of life.

### **Individual Plan of Care and Support for the person in the last days of life\***

This should consider how are people reassured that their pain and other symptoms will be assessed, managed and reviewed effectively as they approach the last days of life, including having access to support from specialist palliative care professionals, particularly if they are unable to speak or communicate.

Always consider the appropriateness of involving family, friends, specialist palliative care teams, GP and other carers in planning, managing and making decisions about their end of life care and the last days of life and if the person lacks capacity this is a must do.

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

This would follow the 5 priorities of;

- Recognise
- Communicate
- Involve
- Support
- Plan and Do

When a person is deemed to be in the last days of life, it is good practice for the Individuals Plan of Care and Support for the Dying Person to move towards the front of the care file and includes reference to anticipatory planning and medications and 'what if' scenarios to support, keep the person to be cared for in their preferred place of care.

Sources to support in this process can be obtained from the individuals GP as the lead clinician and Specialist Palliative Care Teams usually based within your local hospice.

### **^ Monitoring Records**

These could be in place following agreement with a healthcare professional that these are required to monitor the health of a resident 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.

### **Care Plan review records**

The care plan reviews should be kept with the relevant care plan sections which would provide easy referencing.

Risk assessments should be reviews prior to updating care plans. Care plans and associated assessments must be evaluated and reviewed periodically, for example once a month, or sooner if needs change, including following a significant event or following recommendations from a Health or Social Care professional.

This is to ensure that it reflects current need and to establish how effective the support has been; when completing your evaluation, detail what resident's views are and what documents you have reviewed in order for you to make the decision if there are changes or not.

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

N.B. Following a change in resident's need, be mindful documents in other areas of the care file may need updating.

Information needs to be consistent between the documented risk assessment, care plan and the care and support that was provided.

## 6. Safeguarding, Accidents and Incidents

Accident / Incident reports (including body maps where applicable)

Safeguarding alerts log

*Additional information*

Accident / Incident reports should describe what happened, when it happened (date / time), where it happened, who was involved (residents / staff members / others), any witnesses, any subsequent actions, and any learning from the event / remedial actions to reduce the likelihood of it recurring. Actions should have a responsible person, appropriate timescales for completion and show when these have been completed.

All homes should have their own Investigation procedures following an incident. Following an incident there should be a review of the risk assessment, even if there are no changes, to demonstrate lessons are being learnt.

[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.

Appendix 1: 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 and accidents / incident forms should be reviewed to look for themes and trends and identify any lessons learnt from incidents; action plans should be developed where appropriate and monitored to ensure they are delivered.

## 7. Daily Records

Best practice would be that daily records are kept in the care plan folder. It is not obligatory for daily records to be kept in the care plan folder – they can be located elsewhere so as long as they are easy for staff to locate when required.

It is important to ensure that they are legible and filed in a logical and accessible way. There should be a time and date against each written entry along with initials / signature of the author and designation.

All entries in the daily records must be signed as above by the author, 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.

Daily records should ensure a detailed summary of the person's day/night rather than generic statements, they should be relevant and relate to the information in that person's care plans

**Care documents including daily records 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.**

#### **Useful Links**

[Skills for Care - Good and Outstanding Care Guide](#)

[Lancashire County Council – Practitioners Portal](#)

[NICE Guidance - Care Homes](#)

[CQC Guidance for providers - Adult Social Care](#)

[Care Improvement Works](#)

[Lancashire Safeguarding Adults Board - Good Practice](#)

[Skills for Care](#)

[Healthier Lancashire & South Cumbria Regulated Care Sector](#)

[Dying Matters - Resources](#)